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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **13 October 2015**

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

Membership:

Councillors Graham Snell (Chair), Steve Liddiard (Vice-Chair), Yash Gupta (MBE), James Halden, Charlie Key and Tunde Ojetola

Ian Evans, Thurrock Coalition Representative
Kim James, Healthwatch Thurrock Representative

Substitutes:

Councillors Leslie Gamester, Martin Kerin and Susan Little

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes **5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 23 July 2015.

3 Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4 Declarations of Interests

5	**Items Raised by HealthWatch** This item is reserved to discuss any issues raised by the HealthWatch co-opted member or designated representative.	
6	**2014/15 Annual Complaints and Representations Report**	**15 - 34**
7	**Consultation on proposed changes to the way Social Care is provided in Thurrock**	**35 - 56**
8	**Meals on Wheels Update**	**57 - 70**
9	**Annual Public Health Report 2014**	**71 - 160**
10	**Regeneration, Air Quality and Health**	**161 - 176**
11	**Work Programme 2015/16**	**177 - 178**

Queries regarding this Agenda or notification of apologies:

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **5 October 2015**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

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 Overview and Scrutiny Committee held on 23 July 2015 at 7.00 pm

Present:	Councillors Graham Snell (Chair), Steve Liddiard (Vice-Chair), Russell Cherry, Yash Gupta (MBE) and James Halden (substitute for Charlie Key) Ian Evans, Thurrock Coalition Representative Kim James, Healthwatch Thurrock Representative
Apologies:	Councillors Charlie Key and Tunde Ojetola
In attendance:	Councillor Barbara Rice, Cabinet Member for Adult Social Care & Health Roger Harris, Director of Adults, Health and Commissioning Ian Wake, Director of Public Health Mandy Ansell, (Acting) Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group Dr Anand Deshpande, Chair of Thurrock NHS CCG Board Don Neame, North East London Commissioning Support Unit (NELCSU) Andrew Pike, Director of Commissioning Operations, NHS England Yomi McEwen, Deputy Medical Director, NHS England Alastair McIntyre, Locality Director South and West Essex Midlands and East (East), NHS England Jenny Shade, Senior Democratic Services Officer

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

The Chair announced that he had changed the order of the agenda slightly so that the NHS items would be heard first.

1. Minutes

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee, held on 17 February 2015, were approved as a correct record.

2. Urgent Items

An urgent item of business was raised for the Members attention by the Chief Operating Officer of HealthWatch Thurrock on Coach House, a residential care home. The providers, Family Mosaic, have served notice to the CCG.

The Officer confirmed that Family Mosaic was no longer in the market to run this service and keeping this home open was not an option. There are currently nine Thurrock residents in the home. The Officer confirmed that the options for replacement were not huge and that each patient would need to be dealt with individually and in a sensitive manner.

The Chair asked for clarification on how long it would take to find replacement homes for the residents. The Officer confirmed that clinical assessments will be carried out individually for each patient so therefore no timescale can be given at this time.

The Committee agreed that the Coach House item be referred back to the Committee in October 2015 for review.

RESOLVED:

1. **That an update on Coach House be included on the work programme for October 2015 under Items Raised by HealthWatch.**

3. Declarations of Interests

Councillor Cherry declared a non-pecuniary interest in respect of Agenda 9 'Adult Social Care – Budget Review and Service Reduction' as his wife works for SERCO in the Thurrock Therapeutic Service.

Councillor Gupta declared a non-pecuniary interest in respect of Agenda 9 'Adult Social Care – Budget Review and Service Reduction' as he was a carer.

4. Terms of Reference

The Health Overview and Scrutiny Committee Terms of Reference were noted.

5. The Future of the Thurrock Walk-in Service

The Officer presented the report which highlighted a summary of the findings and feedback from both the pre-consultation and public consultation process which informed the Thurrock CCG's decision to close the walk in service from April 2016 and reinvest the funds in four GP hubs across Thurrock.

The Officer referred Members to Appendix A – Evidence of completion of the Public Consultation Plan.

The Officer confirmed that the Corringham and Tilbury hubs were up and running. Open for three hours, 9.00-12.00am, on a Saturday and Sunday. The Grays hub was due to open by the end of July 2015 and the South Ockendon hub were due to be opened in September 2015.

The Committee agreed that more information on the locations and the opening times of the hubs was required so this could be more available to residents.

Councillor Gupta asked the Officer if the data received from the consultation was sufficient to make the decision to close the Walk in service which would have an impact on residents. The Officer confirmed that the report data was from the public meetings and consultation feedback. HealthWatch Thurrock also publicised and shared the consultation and consultation document at a further 700 meetings. The Officer confirmed that all the evidence received was sufficient.

Councillor Gupta asked what happened to the petition on the Walk in Service. The Officer confirmed that they had heard of such a petition but never saw any evidence and it was not presented to the CCG.

The Chair asked for clarification on why the South Ockendon hub is now located in Purfleet. The Officer confirmed that over the past six months they had visited four different premises and the Purfleet site was the only one that the CCG had agreement to run the weekend GP hubs. The Officer also confirmed that if you lived in South Ockendon or Aveley you would have the option to go to the Grays hub if you wished.

The Grays hub will be situated at the Thurrock Hospital. If a more central location became available the Officer confirmed that they could shift the hub.

Councillor Gupta stated that the hubs were not proper GP appointments but more for an emergency appointment. He stated that a patient is in more need of an appointment with a GP rather than an emergency appointment.

Councillor Halden asked the Officers where the funding had been found to open the hubs as the Walk In service had not yet closed. He understood that the walk in service had to be closed first so that invested funds could then be used to open the hubs. The Officer stated that the GP hubs were being funded by a pot of money awarded by NHS England. The money saved from the walk in service would be used to invest further in the hubs to develop them further.

A discussion took place on the challenges of GPs in the borough and how these were being addressed.

The Chair stated that he was broadly in favour of the report and that it was a step in the right direction.

RESOLVED

1. **That the decision of the Thurrock CCG Board to decommission the Thurrock Walk In Service from 1 April 2016 is noted and agreed by all members except Councillor Gupta who abstained.**

2. **That the full completion of the communications and engagement plan which was implemented during the public consultation process is noted.**

6. Primary Care

The Director of Commissioning Operations, NHS Midlands and East presented the report that provided a summary of the key issues for NHS England with regards to primary care strategy.

It was agreed by Members that Alastair McIntyre from NHS England be invited to future Health Overview and Scrutiny Committee meetings.

Councillor Halden commented that he found the report helpful but was expecting a bigger picture. Particularly on those areas that were under-doctored and what was being done to recruit GPs.

The Officer apologised that the report wasn't more specific to what Councillor Halden expected. His report focused on the recent challenges in the Tilbury area. The Officer continued to state that Thurrock had the lowest ratio of GPs to patients and that the area must be targeted to develop primary care and make it more attractive, with better infrastructure and GP schemes.

The Officer stated that the Estate Strategy for Tilbury would be ready by December 2015.

The Officer confirmed that the buildings/GP premises were a significant part of the process. The CCG is working with the Director of Adults and is currently in the interview process for recruiting a new primary care lead.

Councillor Gupta asked for regular updates on the progress of recruiting GPs from the NHS which will be discussed at future committees.

The HealthWatch Thurrock Representative commented that it is their role to represent the Thurrock residents and that communities need to be involved in the decision process.

The Officer confirmed that patients were being written to, informing them of all GP changes and issues.

The Chair asked the Portfolio Holder, Councillor Rice, if items would be referred to Cabinet so that they could be made available to the press.

A discussion took place on how to improve GP surgeries and highlighted the following:

- New GPs do not want to have their own practice
- New GPs do not want premises responsibility
- Ratio between GPs and Patients needs to be right – higher patient to GP ratio than average

- Packages to attract new GPs
- Other options and incentives – but not just focusing on the money
- Training to ensure current GPs are supported
- Be aware that practices nurses and other primary care roles were also in crisis and needed to be addressed

Councillor Halden left the meeting at 8.22pm.

The Director of Adults requested Director of Commissioning Operations to streamline the system on how the buildings can be used. He confirmed that he was already working on this.

The Chair agreed with the report but agreed that residents need to be consulted on changes.

The Committee agreed that the Primary Care item be referred back to the Committee in December 2015 for review.

RESOLVED

1. **That the update report on Primary Care in Thurrock be noted.**

2. **That the item Primary Care be added to the work programme for December 2015.**

3. **That Officer Alastair McIntyre, NHS England, be added to the Health Overview and Scrutiny distribution list.**

7. NHS Five Year Forward View: The Success Regime: A Whole Systems Intervention

The Officer presented the report which stated that the Essex Health and Care Economy had been selected for the first wave of the newly announced Success Regime. The two other areas selected were Devon and Cumbria.

The Officer stated that this was a national directive to address long standing and deep rooted issues that were affecting the quality and sustainability of services for patients and the public.

The Officer explained that the success regime would not solve all of Essex problems as it is a large and complex area with a population of more than 2 million. The key issues for Essex were recruitment and the high turnover of staff.

The Officer explained that arrangements were still to be put in place, the most important being the recruitment of the Programme Director who would oversee the work. Further updates will be reported back to Members in the December 2015 committee.

The Chair commented that it sounded like an exercise of taking facilities from one area and putting them into another and why Essex could not be split into two (North and South).

The Officer confirmed that no assumptions had yet been made on facilities and confirmed that as Essex is such a large authority this may have to be the case.

The Chair and Members agreed that it was actually only a name at this time and nothing else seems to be in place.

Councillor Gupta stated that there should be more services rather than structures.

The Director of Adults stated that there is some nervousness as to where this success regime is taking us but at this time it should not stop anything else happening and permission will be given to do something new if required.

Councillor Cherry asked the Officers how Thurrock will cope with more people moving into the area. The Officer confirmed that funding is in relation to population, so regeneration of the borough generates more opportunities and more budgets. Hence more people would mean an increased budget for more staff and services. The Officer confirmed that the population growth in the borough should not be seen as a negative.

Councillor Rice stated that forward thinking of services should be more around the demand of today and not what they were like years ago.

The Committee agreed that the Success Regime item be referred back to the Committee in December 2015 for review.

RESOLVED

1. **That the contents of the report to introduce the regime and any implications that emerge for Thurrock were noted.**

2. **That the item Success Regime be added to the work programme for December 2015.**

Officers Andrew Pike, Alastair McIntyre, Yomi McEwen and Dr Anand Deshpande left the meeting at 8.52pm.

8. Adult Social Care - Budget Review and Service Reductions

The Director of Adults, Health and Commissioning introduced the report which highlighted a series of Council budget savings which were no longer deliverable and required all directorates to make additional in-year savings. The report looked at how these savings will be realised and what areas will require consultation.

The Officer stated that the directorate's contribution to the Council's in-year savings target is £500,000 – to be delivered this year.

The Officer talked Members through the list of proposals to deliver the £500,000 savings. Four savings proposals will be subject to consultation which will commence on 1 August and will run for 8 weeks working with the Thurrock Coalition. Other savings will be implemented immediately by management action to ensure the figure is delivered this year.

The Thurrock Coalition representative agreed that the appendices will have a major impact and cause emotional distress to residents.

Councillor Gupta asked the Officer if any analysis on the management structure had been undertaken. The Officer confirmed that there is evidence that the management structure is not top heavy, that there is a right balance for the service delivery and that the structure is continually looked at. In fact manager workload had increased significantly including new duties and responsibilities.

The Officer also stated that credit was due to his team for implementing the Care Act and that Service Users will see these impacts over some time.

Thurrock HealthWatch Representative asked the Officer to consider changing the consultation period of 8 weeks to 12 weeks as it currently states in the Compact.

The Officer confirmed that he is happy for this to be changed but stated that savings may not be fully delivered this year if this time is extended and that further saving opportunities would have to be identified in addition to those detailed in the paper. The Officer will finalise the document and share the consultation paper in mid to late August.

The Chair suspended standing orders at 9.15pm. All members agreed to continue.

Mandy Ansell, (Acting) Interim Accountable Officer of Thurrock CCG stated that the cuts would most definitely put further pressure on NHS services, with more people going to A&E. She appealed that the cuts be made elsewhere that did not directly impact on the most vulnerable people.

Councillor Rice stated to the committee that there was no easy option. A 25% reduction in adult social care already had staff working over and above and it is now time to listen to the consultations and look at undertaking services differently.

Councillor Cherry asked for some examples of the items of equipment up to the value of £50. The Officer stated that they were preventative measures such as raised toilet seats or towel rails. These items will be part of the consultation. The Officer also confirmed that residents who have difficulties

installing such items could use the services handy man or work with the local community to do tasks. Councillor Cherry supported this.

The Committee agreed that the Meals on Wheels Paper item be referred back to the Committee in October 2015 for review.

The Committee agreed that the Budget Review and Service Reduction item be referred back to the Committee in December 2015 for review.

RESOLVED

1. **That the contents of the report were considered and comments on the proposed budget reductions as part of the wider consultation exercise were noted.**

2. **That a change to the consultation period from 8 to 12 weeks on the Proposal for Consultation Paper be made.**

3. **That the item Meals on Wheels be added to the work programme for October 2015.**

4. **That the item Budget Review and Service Reduction be added to the work programme for December 2015.**

Councillor Gupta left the meeting at 9.30pm.

9. Health and Social Care Transformation Update

The Officer introduced the report which provided the committee with an update on the Health and Social Care Transformation Programme.

The Officer stated that since the report was been issued the Department of Health had confirmed that Part 2 of the Care Act would be delayed until 2020. The Officer stated that further clarification was still required.

The Members were advised that Part 1 of the Care Act became operational as of April 2015 and that although the Council had met the requirements of Part 1 of the Act there were still a number of risk areas and that it will take time for some of the changes to be embedded. The Officer stated that through the Care Act Implementation Group activity will be undertaken to measure how well embedded certain elements of the Act were.

The Officer also updated the Committee on progress made to implement the Better Care Fund Plan (BCF). An Integrated Commissioning Executive has been established to oversee the delivery of the BCF and its accompanying project plan.

The Committee agreed that the Health and Social Care Transformation Update item be referred back to the Committee in December 2015 for review.

RESOLVED

1. **That the contents of the Health and Social Care Transformation Update Report be noted.**

2. **That the Item Health and Social Care Transformation Update will be added to the work programme for December 2015.**

10. Public Health Grant 2015/16 - Proposed Reductions

The Officer introduced the report which detailed that following the Chancellor's pre-budget statement the Public Health Grant was to be cut nationally by £200 million.

The Officer confirmed that if this figure is applied pro-rota to all local authorities it will amount to a cut of £614,000 to Thurrock's allocation. The Officer stated that further clarification was still required to understand how this will be delivered.

The Chair stated that the reason why it had gone so quiet is that local authorities had already signed their public health contracts. The Officer agreed that this might be the case.

The Officer referred the Members to the proposed reductions on page 143 of the Report.

All members agreed that these cuts should be publicised as a means of communicating and educating residents on what services are available and how to utilise them better.

The Chair agreed and that the introduction of the community hubs may also help get this message across.

RESOLVED

1. **That the contents of the report to consider and comment on the proposed reductions to the Public Health Grant for 2015/16 are noted.**

11. Work Programme

The Chair and Members agreed that the following items be added to the work programme:

- That an update on Meals-on-Wheels be included on the work programme for October 2015.
- That an update on Coach House be included on the work programme for October 2015.

- That an item on HealthWatch be included on the work programme for all meetings.
- That an update on Primary Care be included on the work programme for December 2015.
- That an update on Success Regime be included on the work programme for December 2015.
- That an update on Transforming Adult Social Care be included on the work programme for December 2015.
- That an update on Savings will be included on the work programme for December 2015 under Item Budget Update.

Members were in agreement with the proposed changes to the work programme, following which the Chair requested that an updated work programme be circulated to the Committee and officers following the meeting.

The Chair advised the committee that the October 2015 committee would be cancelled due to insufficient business. The Chair requested that Members, officers and co-optees will be notified of this following the meeting.

RESOLVED

1. **That the work programme be noted subject to the amendments detailed above.**

2. **Pursuant to Chapter 5, Part 2, Committee Procedure Rules, Paragraph 2.2 and after consultation with the Chair the September meeting is duly cancelled for insufficient business to transact.**

The meeting finished at 9.45 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

13 October 2015	ITEM: 6
Health & Wellbeing Overview and Scrutiny Committee	
2014/15 Annual Complaints and Representations Report	
Wards and communities affected: All	**Key Decision:** Non Key
Report of: Harminder Dhillon, Statutory Complaints and Engagement Manager	
Accountable Head of Service: Les Billingham, Head of Adult Social Care	
Accountable Director: Roger Harris, Director of Adults, Health & Commissioning	
This report is public	

Executive Summary

The annual report for Thurrock Council on the operation of the Adult Social Care Complaints Procedure covering the period 1 April 2014 – 31 March 2015 is attached as Appendix One. It is a statutory requirement to produce an annual complaints report on adult social care complaints.

The adult social care complaints procedure is operated in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The report sets out the number of representations received in the year including, the number of complaints, key issues arising from complaints and the learning and improvement activity for the department.

A total of 356 representations were received during 2014-15 as detailed below:

- 198 Compliments
- 68 Complaints received
- 33 Concerns and issues received
- 16 MP enquiries
- 40 Member enquiries
- 1 Ombudsman enquiry

1. Recommendation(s)

1.1 That scrutiny committee consider and note the report.

2. Introduction and Background

2.1 This is the annual report for Thurrock Council on the operation of the Adults Social Care Complaints Procedure covering the period 1 April 2014 – 31 March 2015. It is a statutory requirement to produce an annual complaints report on Adults Social Care complaints.

2.2 The Adults social care complaints procedure is operated in accordance with the Local Authority Social Services and National Health Service Complaints (England) regulations 2009.

3. Issues, Options and Analysis of Options

3.1 This is a monitoring report for noting, therefore there is no options analysis. The annual report attached as Appendix One includes consideration of reasons for complaints, issues arising from complaints and service learning and improvement activity in response.

3.2 **The headline messages for this report are:**

3.3 **Summary of representations received 2014/15**

- 198 Compliments
- 68 Complaints received
- 33 Concerns and issues received
- 16 MP enquiries
- 40 Member enquiries
- 1 Ombudsman enquiry

3.4 **Compliments**

Compliments are expressions of good feedback. The team recorded 198 compliments this year compared to 201 recorded last year and 160 recorded for 2012/13. Examples include:

Just wanted to say how grateful I am for everything that Rapid Response have done – I can't believe the difference it has made. Rapid Response Team

Thank you for your kindness and patience with me when I was in panic mode! And of course, thanks for the arrangements you made for Mum now that she is at home. It is really appreciated. Basildon Hospital Team

Thank you so much for all your help, it has been much appreciated. Safeguarding Team

Call received from Mr W to say his equipment has arrived and is really happy with both the equipment and service he has received He would like to compliment both D&R and the service. Occupational Therapy Service.

3.5 Complaints

The department received a total of 68 complaints in 2014/15, which is an increase of 18% on the number of complaints (56) received for 2013/14.

While in recent years there has been a falling trend in terms of complaints numbers, for this reporting year the complaints have increased which is mainly due to the volume of complaints regarding domiciliary care.

The majority of complaints are resolved quickly and without the need for formal investigation. In addition, increasing numbers of issues /concerns are successfully resolved without recourse to the formal complaints procedure.

3.6 Concerns and Issues

The complaints team recorded 40 concerns and issues for this reporting period which were successfully resolved within the teams without a need to record them as formal complaints. This has been a slight increase this year on the numbers received and recorded in the previous year 2013/14 (33). If a concern cannot be resolved quickly, it will be processed as a formal complaint in accordance with the complaints procedure.

3.7 MP and Councillor Enquiries

The complaints team also records MP and Member enquiries as are received on behalf of service users regarding adult social care. These are acknowledged and responded to in line with the Council's corporate timescales. However completion times for these enquiries were exceeded for some of the enquiries this year, which were as a result of work pressures and more complex enquiries requiring more time.

16 MP enquiries were received and recorded by adult social care in 2014/15 which increased slightly on the figure recorded last year (12). 40 councillor enquiries were received in 2014/15 compared to 39 recorded for the previous year.

3.8 Local Government Ombudsman

There was one case received from the Ombudsman's office for this reporting year compared with six received in the previous year.

The complainant challenged the outcome of the assessment of her needs. There was no finding of maladministration by the Ombudsman. However, the case highlighted that an independent review of the complainant's needs had not been recorded on the case file; therefore an apology was issued and records updated accordingly.

3.9 **Learning from Complaints**

Complaints and feedback provide the service with an opportunity to identify things that can be improved. The learning from complaints is an essential part of the process. Examples of the learning received this year are shown below. Further details are shown in section 18 of the annual report (Appendix One).

Staff reminded of the procedure for contacts taking messages when out of hours.

Case files to be kept in good order and case recordings to be in sequence and recorded in detail.

Provider to ensure that staff follow correct procedures for handling medication by cross referencing the medication packaging with medication blister packaging AND MAR sheet and to be supported with the appropriate training from Manager and e-training

3.10 **Looking Forward**

Adult social care is continuing to undergo a period of significant transformation across all services within Thurrock with high pressures on resources against an increase in demand for services which inevitably has an impact on the community and provision of social care services. This may lead to further queries and complaints received within the department and the focus will continue to ensure that a high quality and responsive complaints service delivers in accordance with the statutory requirements and effectively captures service user feedback.

Working closely with external partners such as Health, advocacy groups and relevant stakeholders will remain a strong focus for 2015/16.

Complaints activity and learning will continue to be reported to the department throughout the year and disseminated to all staff.

A rolling program of refresher complaint training for all social care teams will be implemented during 2015-16 to highlight the importance of learning from complaints and compliments, to ensure that all complaints and compliments are recorded and to promote the expertise available from the Complaints Manager in assisting complaints management.

4. Reasons for Recommendation

4.1 It is a statutory requirement to produce an annual complaints report on adult social care complaints. It is best practice for this to be considered by Overview and Scrutiny. This report is for monitoring and noting.

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

5.1 This report has been agreed with the Adult Social Care senior management team. Consideration of complaints issues and learning and improvement arising from them are identified as an ongoing priority in the report. .

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

6.1 All learning and key trends identified in the complaints and compliments reporting has a direct impact on the quality of service delivery and performance. The reporting ensures that valuable feedback received from service users and carers is captured effectively and regularly monitored with the primary focus on putting things right or highlighting and promoting where services are working well.

7. Implications

7.1 Financial

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

There are no specific issues arising from this report.

7.2 Legal

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

There are no legal implications as the report is being compiled in accordance with regulation 18 of the Complaint Regulations.

7.3 Diversity and Equality

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

There are no specific diversity issues arising from this report.

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 One – Adult Social Care Complaints and Representations Annual Report 2014/15

Report Author:

Harminder Dhillon

Statutory Complaints & Engagement Manager

Adults, Health & Commissioning, Children's Services

Appendix One

Adult Social Care Complaints and Representations

Annual Report 2014-15

Thurrock Council

Harminder Dhillon
Statutory Complaints & Engagement Manager
Adults, Health and Commissioning Services
August 2015

Contents

1. Introduction

This is the annual report for Thurrock Council on the operation of the Adult Social Care Complaints Procedure covering the period 1 April 2014 – 31 March 2015. It is a statutory requirement to produce an annual complaints report on Adult Social Care complaints. The Adult social care complaints procedure is operated in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Thurrock adult social care arranges and supports provision of a wide range of commissioned and in house to support people to live independently in their homes and increasing levels of choice and control over the support they receive. It also supports residential or nursing care when this becomes necessary. The department also has lead responsibility for safeguarding adults and provides some services jointly with Health.

The report provides a summary analysis in relation to the number of representations received and processed in relation to adult social care including details of the complaints received, the key issues arising and learning for the department.

2. The Complaints Process

The Local Authority Social Services and National Health Services Complaints Regulations (England) 2009 changed the process for handling complaints within Adult Social Care on 1 April 2009. The revised regulations aligned the complaint processes for Adult social care and Health to enable joint handling of complaints across both services.

The Complaints Procedure is a two stage process:

Stage 1 – Council aims to resolve a complaint using a variety of methods
Stage 2 – Local Government Ombudsman

Staff are encouraged to resolve issues at the first point of contact in line with good practice as outlined by the Local Government Ombudsman.

The complaints procedure provides the Council with an additional means of monitoring performance and improving service quality as well as an important opportunity to learn from complaints and service user feedback.

3. Roles and Responsibilities

The Department of Health Guidance requires local authorities to have a Complaints Manager responsible for the management of the complaints procedure.

In order to contribute effectively to service development, the complaints management function is based within the Adults, Health and Commissioning Performance and Business Support service area.

The Complaints and Engagement Manager also has responsibility for Children's Social Care complaints and representations and produces a separate Annual Report for these.

4. Leaflets and Information

The complaints leaflet is distributed electronically to all service teams and front line services. Information on making a complaint or providing feedback is available on the Thurrock Council website.

The complaints procedure has been reviewed during 2014/15. As the statutory guidance remains unchanged for adult social care complaints, there are no fundamental changes to the process. However under the Care Act 2014, there have been proposals to introduce an Appeal System for assessments and funding which may run alongside the complaints procedures. The proposals have not been finalised and therefore no changes will be made to the current complaints procedure.

Adult social care welcomes feedback about its services. This can be received via a complaints form, telephone contact, in person, writing or emailing the complaints team and through the call centre.

5. Advocacy for vulnerable people

Thurrock Council commissions advocacy services including Mental Capacity advocacy encompassing Deprivation of Liberty Safeguards. It is available for people who have substantial difficulty in understanding decisions that need to be made or in expressing their views, when there is no one else who can assist or speak on the persons behalf. The scope of our contract covers, older people with mental health aged 65 and over, adults of working age with mental ill health and adults who have a learning disability or sensory impaired aged over 18yrs.

The service is independent of statutory organisations and service provider agencies. POhWER is the main commissioned provider for advocacy within Thurrock and supports service users with various concerns and queries across a range of services including housing, social care and debt management.

6. Summary of Representations received

A total of 356 representations were received during 2014-15 which is an increase of 5 on the previous year (351), as detailed below:

198 Compliments
68 Complaints received
33 Concerns and issues received
16 MP enquiries
40 Member enquiries
1 Ombudsman enquiry

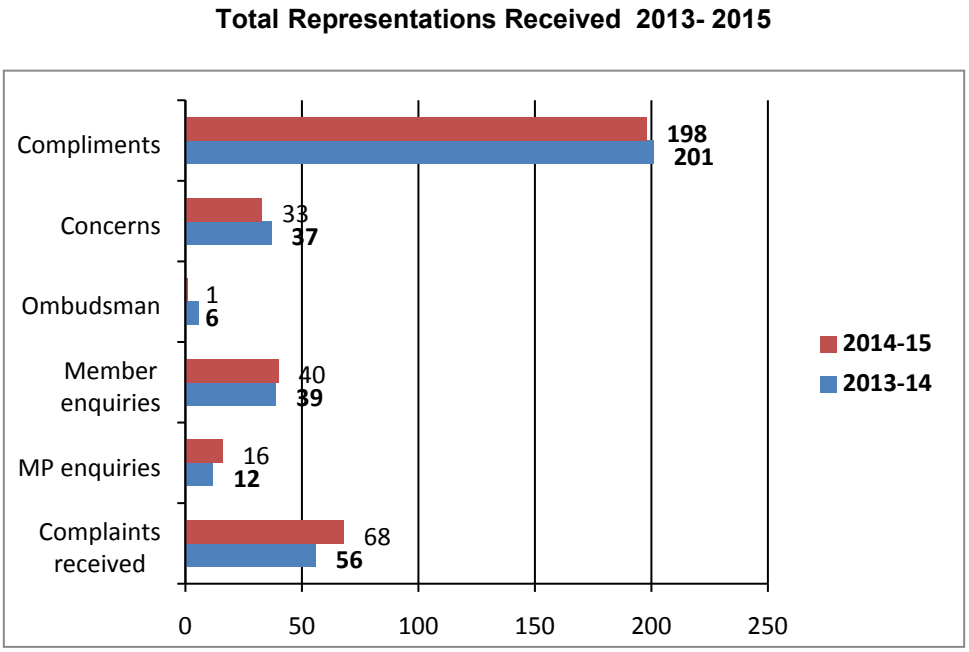


Figure 1

It is essential that all teams delivering services formally capture and record complaints. This includes any commissioned services.

Feedback is recorded as received from service users by telephone, email and in writing as well as in person.

Other complaints and representations are referred directly to Ascfeedback as received by the Corporate Complaints team and the service teams directly. All complaints are acknowledged within 3 working days as set out in the statutory guidance.

7. Complaints

The department received a total of 68 complaints in 2014/15, which is an increase of 18% on the number of complaints (56) received for 2013/14. During this reporting period, the department dealt with 8452 referrals and 3447 service users were receiving a service under social care, including residential and nursing care.

Trends in complaints received from 2010-2015 are detailed in Table 1.

Year	Complaints
2014/15	68
2013/14	56
2012/13	74
2011/12	91
2010/11	111

Table 1

Table 1 indicates that the previous declining trend of complaints has changed this year to a slight increase of 18%. This was due mainly to the increase in complaints regarding domiciliary care providers which are detailed further in the report.

8. Complaints breakdown by Service for 2013-15*

* the breakdown below includes provider complaints for domiciliary care and residential care

Service	**2013/14**	**2014/15**
Contracts & Commissioning	5	-
Blue Badge	1	3
ECDP	1	0
Customer Finance	6	5
Occupational Therapy	1	5
Safeguarding	1	0
Collins House	3	1
Reablement Team	3	0
Locality 1&2	2	3
Locality 3&4	1	1
Basildon Hospital	1	3
Grays Court Care	1	1
Hollywood Rest Home	1	1
Bennett Lodge	2	1
Ladyville Lodge	1	0
Bluebell Court	3	3
Merrie Loots Rest Home	1	0
John Stanley	4	4
Grapecroft (now Willow Lodge)	2	2
Mental Health	2	2
Intervention & Transition	3	1
Performance Quality	1	1
General social care	10	-
Sanctuary Care	-	10
Shortbreak Service	-	2
Careline	-	1
TLS	-	2
Emergency Duty	-	2
TLC		4
Kynoch Court	-	2
Temp Exchange	-	1
Balfour Court	-	1
Whitecroft	-	1
Oak House	-	1
Other**	-	3
Total	**56**	**68**

Table 2

**Legal Services (1), SEPT (1) and Daycentre Transport (1)

9. Complaint issues

Complaint Issue	2013/14	2014/15
Assessment/Decision Making	2	4
Communication	6	4
Service Quality	18	23
Delays	-	6
Finance/Charging	10	10
Multiple Issues	2	-
Health linked	5	-
Safeguarding/Welfare	1	1
Staff conduct	8	12
Other*	4	8
Total	**56**	**68**

Table 3

- *Missed carer appointments, transport issues, incorrect medication, legal issues*

Table 3 shows that issues concerning finance and quality of service were the main reasons for complaints during 2014/15.

10. Externally Commissioned Services

The Care Quality Commission requires all care providers to have in place clear and robust complaint procedures. Anyone who receives a service from an externally provided service will usually complain directly to the provider and these will be responded to in accordance with the provider's own complaints process. Feedback received by the Council about externally provided services is closely monitored by the Contract Compliance team in line with the statutory Contracts Monitoring Framework. This helps to identify any areas of poor performance which require additional monitoring and support.

Direct Payment Scheme

Personal budgets are used to pay for support for services such as homecare or to employ a personal assistant (PA). The Council has a contract with ECDP with the delivery of the Direct Payment service for Thurrock residents to manage the scheme and raise awareness of how social care users can have greater choice and control in relation to their care.

Residential Care

The Council commissions independent care home providers for service users requiring residential care, based on an assessment of their individual needs. Any complaints received regarding commissioned providers are referred to the Home provider to investigate in accordance with their own complaints procedure. The Care Quality Commission requires all providers to have effective complaint procedures in place. This is regularly monitored by the Council's Contract Compliance team.

There were approximately 600 service users receiving residential care (including nursing care funded by adult social care) during 2014/15. For the same period, 13 complaints were

received by the Council which is a very slight increase of 1 on the previous year (12). Generally, the issues most frequently queried are in relation to the quality of care received by the service user and the charges for care.

Providers have a duty to log and investigate complaints received directly by their service. There were 115 complaints registered by twenty residential providers which were investigated in accordance with the provider's own complaint procedure. Of those, 38 were upheld and 76 were not upheld and one complaint was still in progress at the end of the reporting period.

Domiciliary care

There is a high demand for home care within Thurrock and the commissioned provider agencies work closely with Thurrock's commissioning and contract teams to ensure that service users receive care packages that directly meet their needs.

Over 700 service users received externally provided home care services during 2014/15. The issues raised as complaints were mainly in relation to the quality of care provided, delays to home visits, communication issues and funding. The provider agencies generally respond directly to service users and their families when responding to complaints and concerns about their service.

Complaints made directly to the Council will be investigated if the response by the care provider is not satisfactory to the complainant. Twenty one complaints were recorded as received by the Council, which is an increase of 57% on the previous year when 9 complaints were recorded with the council.

For complaints directly received by the commissioned services, 28 complaints were investigated directly by three home care providers. Thirteen complaints were upheld, 14 complaints were not upheld and one complaint was in progress.

The Council's Contract Compliance Monitoring Team discusses all key issues arising from complaints on a regular basis with providers and ensures that any outstanding issues and key themes arising from complaints are addressed.

In all instances for complaints regarding adult social care, the complaints procedure may be superseded by the Safeguarding procedure if a referral is made which identifies safeguarding alerts. The complaint will be placed on hold awaiting the outcome of the safeguarding investigation.

11. Response Times

Since the introduction of the Social Services and National Health Service Complaint Regulations in 2009, the only mandatory requirement is that complainants should receive an acknowledgement within 3 working days. The legislation allows flexibility where it is negotiated that a complaint investigation be formally investigated within three months and the overall timescale for complaint to be resolved within six months. If there is further delay, a new action plan must be negotiated. However the department's aim is to resolve most complaints within 20 working days.

The time limit for making a complaint is within 12 months of the matter being complained about. However, the Council can exercise its discretion to allow complaints that are made

over the 12 month rule, where it is satisfied that the complainant had good reason and where it is still possible to investigate the complaint effectively and fairly.

33% of the 49 completed complaints exceeded 20 working days. Where complaints were complex by nature or required a multi- agency response, the response timescale was extended and delays were also caused by staff absence. There were 4 complaints that were incomplete at the end of the reporting period and 15 were either withdrawn or outside the jurisdiction. In all cases, the complainant is kept involved and informed of the progress of the complaint.

12. Complaint outcomes

Decision	2013/14	2014/15
Upheld	15	15
Partially Upheld	18	10
Not Upheld	10	24
Withdrawn or Cancelled	12	15
In progress	1	4
Total	**56**	**68**

Table 4

Of the 49 complaints completed, 31% were upheld, 20% partially upheld and 49% were not upheld. Table 4 indicates that in the previous year 2013/14, the majority of completed complaints were partially upheld. For 2014/15, the majority of completed complaints were not upheld for reasons that the investigation did not find a fault by the service and/or that correct processes were followed by the service team or provider.

Further details regarding complaint outcomes and those complaints that were upheld are set out under 'Learning from Complaints' section of this report.

13. Benchmarking

Thurrock is a member of the Eastern Regional Complaints Group and Public Sector Complaints Network and information is shared on a periodic basis in terms of key national legislative changes that affect the complaints process together with any relevant key learning from specific complaints including public reports from the Local Government Ombudsman.

The following councils have provided their data on complaints received which may be reasonably comparable by size of population. The East England regional performance group monitors a range of performance data on a quarterly basis. For 2015/16 this will include complaints data and we expect to see additional opportunities for comparing information and sharing learning through this.

Council	Complaints	Population	Per 10,000 pop
Thurrock	68	157,705	4.3
Sutton	68	190,146	3.6
Milton Keynes	51	248, 821	2.0
Slough	34	140,205	2.4
Luton	60	203,201	3.0

Table 5

14. Local Government Ombudsman

If a complainant is not satisfied with the outcome of the independent review panel, they have the right to take their complaint to the local Government Ombudsman and at any time. However, the Ombudsman may refer the complaint back to the Local Authority if it has not been fully considered through the complaints procedure.

The Ombudsman investigates complaints of injustice caused by 'maladministration' or 'service failure'. The Ombudsman cannot question whether a Council's decision is right or wrong simply because a complainant disagrees with it. The Ombudsman must consider whether there was fault in the way the decision was reached. If there has been fault, the Ombudsman considers whether there has been an injustice, and if there has, a remedy will be suggested.

One enquiry was received from the Ombudsman for this reporting year compared to 6 received in the previous year, as detailed below:

Case – Complainant challenged the outcome of the assessment of her needs. The complaint outcome was **no maladministration** by the Ombudsman. However, the case highlighted that an independent review of her needs had not been recorded on the case file and therefore an apology was issued to the complainant and records updated accordingly.

15. Concerns/enquiries

Apart from complaints, the complaints team recorded all other representations received about adults social care services, as it is required to do. Representations can be positive comments and feedback or queries regarding a service.

The complaints team recorded 33 concerns and issues for this reporting period which is a slight decrease on the previous year (37). Concerns are successfully resolved within the teams without the need to record them as formal complaints. If the concern cannot be resolved, it will be become a complaint and be processed in accordance with the complaints procedure.

16. MP and Member enquiries

The complaints team also records MP and Member enquiries that are received on behalf of service users regarding adult social care. Complex queries and work pressures has resulted in some responses exceeding the 10 working day timescale and response times will be a priority focus for improvement during 2015/16.

MP enquiries increased by four this year. Member enquiries also only increased slightly on the previous year.

		2012-2013	2013-2014	2014-2015
Members	Volume	27	39	40
	on time	27	39	36
Total	**% on time**	**100%**	**100%**	**90%**
MP	Volume	12	12	16
	on time	12	12	14
Total	**% on time**	**100%**	**100%**	**88%**

Table 6

17. Compliments

Compliments are expressions of good feedback. There was a slight decrease (198) in compliments this year compared with 201 recorded last year.

What they have said:

"Just wanted to say how grateful I am for everything that Rapid Response have done – I can't believe the difference it has made." **Rapid Response and Assessment Service**

Mr N complimented how all the carers are very helpful and caring. He also wanted to mention one carer in particular, C, is an exceptional carer, and she is very much appreciated and goes to all lengths when doing the care for the above service user**. Joint Reablement Team**

Call received from Mr W to say his equipment has arrived and is really happy with both the equipment and the service he has received he would like to compliment both D R and the service. **Occupational Therapy Team**

Thank you so much for all your input and help with this - without your visit it would not have happened so easily at all as no one could not quite understand the inner workings of the (dosset) box! **Locality 1 & 2 Team**

"Thank you for your kindness and patience with me when I was in panic mode! And of course, thanks for the arrangements you made for Mum now that she is at home. It is really appreciated." **Basildon Hospital Team**

Thank you card and flower arrangement - "Thank you so much for all your help, it has been much appreciated" **Safeguarding Team**

Mrs D thanked staff member for her help and said that everyone on the team is very helpful, she has spoken to X in the past and has always found that when she rings this team, people are always ready to listen and help, X was very helpful last time. **Contracts Compliance Team**

"Thank you for trying for the chair although we both thought that it was a no-no. I will not look into buying one until we hear back from OT. Once again thank you for your understanding and being a social worker that is helpful. You made me feel at ease." **Locality 3 & 4 Team**

"Big thank you for your support with Mr & Mrs B, I have spoken to the son-in-law this morning who was very impressed with your support and stated his parents-in-law really enjoyed the day care and are looking forward to Saturday" **Daycare services**

"Just to let you know I visited this client this week. Mr M and his wife advised that a lady from Finance called X had been out to visit her and that she was most helpful." **Customer Finance Team**

"Please would you pass on my thanks to the staff at Thurrock Council Careline. The BT work man told me that staff had got in touch with them to tell them I was a customer of theirs. Instead of it taking three working days, it only took one working day. I really appreciate the team doing this for me. Without the landline I am totally lost. Is this not a good well-being factor that you should know about." **Careline service**

18. Learning from Complaints

Complaints that are upheld or partially upheld identify areas of learning for the service or provider involved. These are recorded on a learning log and actioned. The learning is highlighted in the quarterly reports for Senior Management and cascaded to service teams. Listed below is the learning that was addressed for complaints during 2014-15.

Providers

Staff

- Shortages of staff resulted in a domiciliary care provider experiencing specific operational issues particularly with changes to carers, late and missed calls and new carers working without appropriate training. These issues generated several complaints which were monitored by the Contracts Compliance team. The provider has since recruited and trained more permanent carers
- Carer failed to inform the service user that they were running late due to traffic. This was addressed directly by the provider by reminding staff in a team meeting to ensure that they keep service users informed if delayed on their journey and the implications of not doing so.
- Staff to follow correct procedures for handling medication by cross referencing the medication packaging with medication blister packaging and MAR sheet and to be supported with the appropriate training from Manager and e- training on the safe administration of medication

Staff Training

- Case files to be kept in good order and case recordings to be in sequence and recorded in detail
- Carers to read their schedule's correctly and attend the service user appropriately (domiciliary care provider)

Communication

- The homecare provider to liaise with Thurrock Council and service user and/or their next of kin, if there are capacity issues
- Direct Payments Provider to contact their clients as a matter of courtesy wherever possible, prior to removing under-spends from the Direct Payments account

Internal

Review of Procedure

- To improve public awareness of cost implications of care
- Seamless timing as a consideration when looking at collaborative working between departments i.e. sending and sharing information between departments on tighter timescales
- Process of reviewing blue badge applications generally takes around 6 weeks, however this process to be reviewed for people with a terminal illness
- To review the process of communicating charges and invoices between providers, customer finance and sundry debtors

- Review of EDT procedure for contacting EDT managers out of hours
- Policy drafted for day care process and how it is prioritised
- Day care handbook drafted for service users explaining the minimum standard of service and information on complaints/brief appeal process
- Day care to routinely record information on the adults social care system (LAS)
- To look at the charging procedure between providing homecare reablement and interim residential reablement as there appears to be a difference of approach with same listed remit. The Council do not charge for homecare reablement up to six weeks, but for 24hrs care reablement there could be a service user charge following financial assessment, service users and families need to be made aware of this

Staff Training

- Training was identified for a social worker to understand the Deprivation of Liberty applications as provided and monitored by the assigned supervising social worker
- The same social worker to be monitored on the standards of good social work practice to be addressed through supervision sessions
- Staff to be reminded of procedure for contacts and messages when out of hours
- Day care staff to inform relevant professionals/service team if unable to deliver a service.
- Staff to make service users aware that costs are involved when care is commissioned including increase in care and costs, and this should be recorded
- Procedural training for staff on reablement remit and integrated assessment procedures with a focus on the differences and definition between providing interim care and rehabilitation support; to ensure timely copies of assessments and care plans are sent to the service users and the importance of timely interventions and communications. The learning to be implemented through good practice and auditing practice

Communication

- More pro-active working with Housing colleagues, particularly when housing needs must be undertaken, policy of joint working identified
- Clear communication needs to be recorded on the adult social care database and outcomes to be clearly clarified with the service user

19. Training

Teams will receive complaints handling training sessions throughout the year. This is to highlight good customer care, responding to complaints, meeting timescales the importance of learning from complaints and compliments and to promote the expertise available from the Complaints Manager in assisting complaints management.

The Workforce Planning and Development team also provides an e-learning course on handling complaints.

20. Going Forward

The Complaints Manager will continue to work closely with community and user groups to ensure all feedback about adult social care is captured and to engage user participation regarding the changes to services and their experiences.

Working closely with external partners such as Health, advocacy groups and relevant stakeholders will remain a key focus for 2015/16.

Complaints activity and learning will continue to be reported to the department throughout the year and disseminated to all staff.

Response times and quality of responses will be the primary areas for staff training and monitoring.

13 October 2015	ITEM: 7
Health & Wellbeing Overview and Scrutiny Committee	
Consultation on proposed changes to the way Social Care is provided in Thurrock	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Councillor Barbara Rice, Deputy Leader and Cabinet Member for Adult Social Care & Health	
Accountable Head of Service: Les Billingham, Head of Adult Services	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is public	

Executive Summary

This report provides further details on the proposed changes to the way social care is provided in Thurrock, and outlines the arrangements for consulting on the proposals through a range of channels.

A report on the consultation and the responses received, together with recommendations for any changes to the provision of social care, will be made in early 2016. It is likely that, subject to the views of the Committee and the decision of Cabinet, any changes could be introduced from April 2016.

1. Recommendation(s)

1.1 Committee are asked to note the arrangements for the consultation.

2. Introduction and Background

2.1 At its last meeting on 23 July Committee agreed that four savings proposals will be subject to consultation which will commence in mid to late August, and run for 12 weeks, working with the Thurrock Coalition.

2.2 This report gives further details of the proposals and outlines the arrangements for the consultation.

3. Issues, Options and Analysis of Options

3.1 The council has launched a consultation on its proposals to make savings in its Adult Social Care budget in the next financial year.

3.2 The consultation went live on the consultation portal on Monday 14 September asking for the views of local people and service users about the proposals.

3.3 The proposals centre around four areas: day care for older people and the Carers' Service; charges for adult social care services; equipment and adaptations costing less than £50; and the provision of Extra Care Housing.

3.4 The consultation is available through the council's website (thurrock.gov.uk) and clicking on 'Have my say' where more details are available.

3.5 The Director has written to all service users who may be affected by the proposals giving further details, and inviting them to respond on-line or to request a hardcopy of the consultation to be returned in a free post envelope. An easy read version of the consultation documents has been sent to people with learning difficulties. This is also available on-line.

3.6 A series of meetings throughout the next 12 weeks to let people know the impact the proposals may have, and the Thurrock Coalition and Healthwatch Thurrock will also contact service users and carers to enable them to discuss the changes with someone independent of the council.

3.7 A series of briefings for social care and health care staff are planned for late October to ensure they can contribute their ideas through the consultation. A briefing will also be offered to other public sector commissioners as well as public, private and voluntary sector providers and community organisations.

3.8 After the consultation ends on 7 December a report on the consultation and the responses received will be made to the Committee in early 2016. The report will also make recommendations for changes in the light of the responses. Subject to the views of the Committee, and the decision of Cabinet, it is likely that any changes could be introduced from April 2016.

4. Reasons for Recommendation

4.1 The report provides details of the consultation arrangements on proposed changes to the provision of social care in Thurrock in line with the decision of the Committee on 23 July 2015.

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

5.1 Details of consultation are contained in the body of the report.

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

6.1 An equality impact assessment will be undertaken following the completion of the consultation on 7 December 2015. This will be informed by the consultation responses, as well as by the work of Thurrock Coalition and Healthwatch Thurrock during the consultation.

7. Implications

7.1 Financial

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

The financial implications of the proposed changes will be reported to the Committee following the completion of the consultation on 7 December 2015.

7.2 Legal

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

The legal implications of the proposed changes will be reported to the Committee following the completion of the consultation on 7 December 2015.

7.3 Diversity and Equality

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

The consultation is being undertaken with due regard to diversity and equality issues. The Equality and Diversity implications of the proposed changes will be reported to the Committee following the completion of the consultation on 7 December 2015.

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

All other implications of the proposed changes will be reported to the Committee following the completion of the consultation on 7 December 2015.

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

- None

9. Appendices to the report

APPENDIX 1 - Consultation document and questionnaire
APPENDIX 2 - Easy read consultation document and questionnaire

Report Author:

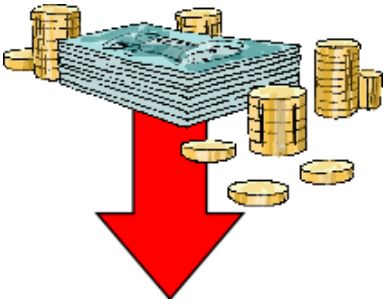
Christopher Smith
Programme Manager
Adults, Health and Commissioning

Civic Offices, New Road, Grays
Essex RM17 6SL

Adult, Health and Commissioning

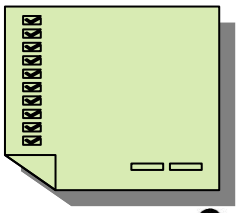
Dear Sir or Madam

This letter is from Thurrock Council.



Thurrock Council has some ideas about future care and support and we would like your views. We have to make some changes because there is less money for social care services.

You can give us your views in three ways:



There is a form with this letter that you can use to tell us what you think

You can attend one of the meetings being held by Thurrock Coalition and Healthwatch Thurrock.

To get the dates of the meetings you can call Thurrock Coalition on 01375 389864 or Healthwatch on 01375 389 883

Or you could use the internet by typing 'Have My Say' on Thurrock Councils Website. Or send an email to Social.care@thurrock.gov.uk

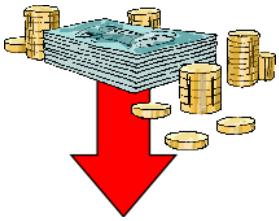
We would like to hear what you think by Monday 7th December

Yours Sincerely

Roger Harris
Director Adults, Health and Commissioning.

We want to hear what you think!

Thank you for taking time to tell us about charging for Social Care. There is less money now for social care services. The Council has to make some difficult decisions



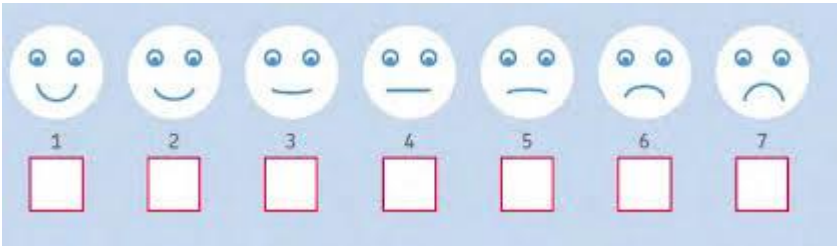
Thurrock Council is allowed to charge people who use social care services. Thurrock Council is thinking about ways this may need to change over the next three years.

There are three ideas that may affect you.

1. The first idea is to charge the full cost for Careline emergency services. This could be up to £2.52 per week

This would happen over three years from April 2016 to March 2019.

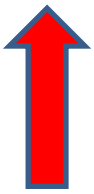
What do you think about this idea? Please tick



If you would like to say something else about this idea please write here

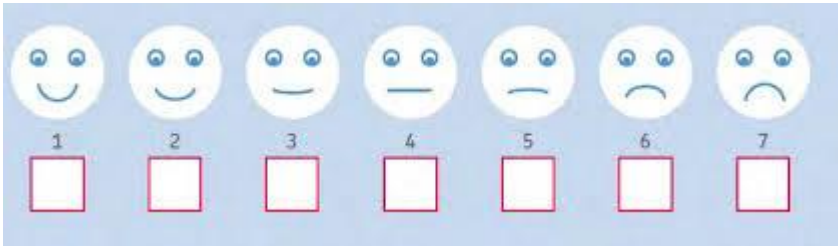
2. The second idea is to charge people more for short breaks.

This would go up over three years from April 2016 to March 2019



This would mean you would have to pay more. This could be up to £55 per night

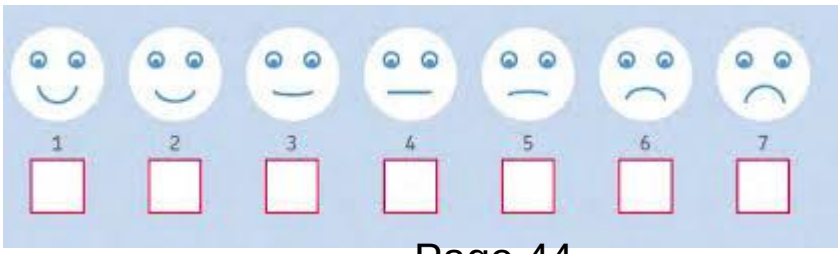
What do you think about this idea? Please tick 



If you would like to say something else about this idea please write here

3. The third idea is for Thurrock Council to stop paying for equipment under £50. For example grab rails, toilet seats and stools.

What do you think about this idea? Please tick



If you would like to say something else about this idea please write here

What happens next?

If you wish to attend a meeting you can contact Thurrock Council or Thurrock Coalition or Healthwatch Thurrock on:

Thurrock Council Community Solutions Team
01375 652868

Healthwatch Thurrock
01375 389 883

Thurrock Coalition

01375 389864

If you wish to email us you can contact us at:

social.care@thurrock.gov.uk

If you wish to send this response

Please post this in the envelope provided


THANK
YOU !

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Proposed changes to the way Social Care is provided in Thurrock

The demand for public services, including social care and health care, is increasing. This is mainly because our population is ageing, but also because there has been a significant increase in the number of people living with long term conditions: for example heart disease, diabetes and high blood pressure.

At the same time as demand is rising, public funding for services provided by the council from grants from central government, is reducing.

We all need to decide how best to use the available resources to ensure citizens have the opportunity to enjoy independent, rewarding and healthy lives in communities that are welcoming, inclusive, supportive, safe and secure.

In Thurrock our Adult Social Care Service needs to save £500,000 this financial year, and more next year. The Council wants to maintain services as far as possible for the people who need them now and in the future. So it is taking action to reduce costs, and to improve the effectiveness and efficiency of services.

The proposals here affect 4 main areas of social care services:

1. Day Care for older people and the Carers' Service
2. Charges for adult social care services
3. Equipment and adaptations costing less than £50
4. The provision of Extra Care Housing

You may wish to comment on all of these proposals, or just one or two that may directly affect you.

You may also have your own suggestions that could help us make social care services continue to help as many people as possible.

All your comments and suggestions will be carefully considered.

After the consultation ends on the **7th of December** a report on the responses received will be considered by the Council before changes are made. It is likely that the agreed changes will be introduced from **April 2016**.

1. Proposals affecting Day Care for older people and the Carers' Service

Day Care Services offer a range of activities for older adults living alone, or with their families or carers. Attending Day Care can:

- help prevent you feeling lonely
- help you to meet new people
- help you remain as independent and socially active as possible
- provide a break for your carer

Day Care currently offers a service to people who may experience mild memory loss or dementia. Between 12-15 people attend Day Care each day at the following sites:

- **Harty Close in Stifford Clays** on Tuesdays, Wednesdays and Fridays
- **Arthur Barnes Court in Chadwell** on Mondays and Thursdays
- **The Lodge at Piggs Corner in Grays,** Monday to Friday
- **Kynoch Court in Stanford-le-Hope,** Monday to Friday
- **Bell House in South Ockendon,** Monday to Friday

Most users of these services are given transport and arrive between 9:30am to 11am and leave between 3pm to 4:30pm.

Some service users attend both Day Care and the Carers' Service.

Our Carers' Service also offers activities for older vulnerable people at the **Carers' Centre at Cromwell Road Grays**, to give carers a break at the following days and times:

- Mondays: 1pm to 5pm
- Tuesdays and Wednesdays: 1pm to 6pm
- Fridays: 10am to 5pm
- Saturdays and Sundays: 9am to 5pm

The Council wants to improve what is on offer at a number of these sites, and to provide a more responsive service that costs less. We would like to hear your views on the following options:

Some of the sites, because of their location and size, are not suitable for Day Care and so it is proposed not to offer a service there in the future.

Q1. Should we extend the proposals and only provide the service at the larger sites (including the Carers' Centre Cromwell Road) with longer hours, possibly 7 days a week?

☐ **Yes** ☐ **No**

Comments:

Q2. Should Day Care offer it's services to people on a more flexible basis? This could be hourly sessions, or half days as well as full days.

☐ **Yes** ☐ **No**

Comments:

Q3. Should the service be offered to people who arrange and pay for their own social care, as well as those who are assessed eligible for Council provided care?

☐ **Yes** ☐ **No**

Comments:

The Council acknowledges that there will be a growing need for more specialist services, particularly dementia care, and will be exploring ways in which this can be introduced in Thurrock.

Q4. Is there a need for specialised dementia Day Care services or should all Day Care and the Carers' Services aim to meet all needs?

☐ **Specialised dementia day care** ☐ **Aim to meet all needs** ☐ **Other**

If 'other', please specify:

Comments:

Q5. Should transport be offered to:

☐ **All people attending day care**
☐ **Only when people cannot provide their own transport or use public or community transport instead**
☐ **Other**

If 'other', please specify:

Comments:

Q6. Can you suggest any other ways to improve the quality and reduce the cost of Day Care and the Carers' Service?

2. Proposals affecting charges for adult social care services

The Government says that councils are allowed to charge for social care services, and services you buy with your personal budget. The Council tries to make this fair and keep charges as low as possible. The amount you have to pay depends on your financial circumstances, not your care needs. You shouldn't be prevented from having the care you need because you can't afford it.

Because most people will have to pay something towards their care, the Council carries out an assessment of each person's own particular financial circumstances. This will determine how

much you have to pay. However, at present, the Council provides a range of very different types of services, and each is charged in a different way.

The Council wants to maintain its social care services but needs to ask those who use services to make a contribution if they can. Options being considered include:

- Moving towards charging half the full cost of providing the **Day Care service** over a period of three years. That approach would result in a charge of around £10 per day in the 1st year, around £20 per day in the second year and then around £30 per day in the 3rd year.
- Charging half the full cost of providing the **Sitting service.** This would mean a charge of £11 per hour from 2016.
- Offering sessions at the **Carers' Centre** on an hourly basis, or as 3 hourly or half day sessions, as well as on a whole day basis. A range of charges could then be set according to the length of the session, with the Council funding up to half the full cost.
- Adding the cost of any **transport** provided to the charge for the Day Care service and charging that at half the full cost.
- Charging the full cost of providing the **Careline emergency home alarm** where this is provided as a part of a social care service.

Points to consider:

- The Council acknowledges that some service users and carers may not feel they can afford to use these services in the future, and this may mean that they no longer get the benefit of the service.
- However, increasing charges over a period of three years would allow the Council, service users and carers to evaluate the impact of the introduction of the charge. Service users and carers would be offered a Financial and Benefits Assessment to ensure the charges do not reduce their income below Income Support +25%.
- Offering a range of different length sessions will help ensure Day Care and the Carers' service remains affordable for service users and carers, some of whom will use both services.

Q7. Looking at the above options, which of these proposals would affect you?

☐ **Day Care services**	☐ **Sitting Service**	☐ **Carers' Centre**
☐ **Transport**	☐ **Short breaks**	☐ **Careline emergency home alarm**
☐ **None of the above**		

Please tell us how these proposed changes would affect you:

Q8. Please tell us about any ideas or other ways of improving the quality or reducing the costs of these services:

3. Proposals affecting equipment and adaptations costing less than £50

The Council provides equipment and home adaptations to make life at home easier and safer for older adults and people with disabilities.

Equipment is usually something that is fixed permanently in the home. Examples include:

- raised toilet seats
- perching stools
- bath lifts
- telecare

An adaptation may be any change made to the home including:

- hand rails
- stair rails
- half steps

Under Department of Health regulations equipment and adaptations provided by the Council up to the value of £1,000 must be provided free of charge. However, the list of equipment the Council currently provides includes many low value items which service users and carers could easily purchase in the High Street, or from on-line retailers. In addition, the delivery of these items of equipment can cost the Council between £15.50 and £41.00.

The Council is considering changing the list of equipment and adaptations it provides so that in future only items which cost £50 or more would be provided. The Council will continue to provide information and advice about how items of equipment or adaptations costing less than £50 can help in the home or, whether instead of buying equipment, it may be better to change the way you do everyday things to make them easier. Council staff will be able to suggest where the items may be purchased, and organisations which may be able to assist with fitting, installation and maintenance.

Other councils have adopted this approach for low cost items of equipment and adaptations and it does appear to work satisfactorily. However, Thurrock Council intends to keep the arrangement under review in case service users or carers have any difficulty obtaining the equipment or adaptations they need.

The Council will also take a risk based approach to the list of equipment it provides to ensure that care can be delivered safely. Where it is necessary, items which cost less than £50, for example, slide sheets and transfer belts, will be provided.

Before making any changes the Council would like to know how they may affect you.

Q9. Given the information above, please let us know how the proposal to only provide items costing £50 or more will affect you:

Q10. Please tell us about any ideas or other ways of improving the service or reducing costs of providing adaptations or equipment:

4. Proposals affecting Extra Care Housing

Extra Care Housing at Piggs Corner and Kynoch Court was introduced by Thurrock Council in 2003. Since then our understanding of how best to deliver Extra Care has grown enormously. In 2013 the Council, in a partnership with Hanover Housing and Care Watch East London, commissioned a new purpose built Extra Care scheme at Elizabeth Gardens, drawing on a number of successful examples from across England. However the Piggs Corner and Kynoch Court schemes have not changed to take advantage of this greater understanding and so they do not, in their current form, reflect best practice, nor are they financially sustainable.

Changes planned at Piggs Corner and Kynoch Court include:

- Sheltered Housing Officers will be on duty between 9am and 5pm Monday to Friday to manage the schemes. There will also be a 24 hour concierge service to manage the facilities.
- The costs of providing these accommodation related support services will in future be included in the costs of the tenancy but the Council will ensure no current residents are worse off.
- A subsidised flat rate charge of £40 per week will also be introduced as a contribution towards the cost of providing the 24 hour core care and support service.
- The Council will arrange for a home care service provider to provide the night time care and support service.
- The council is proposing to stop providing extra care at Kynoch Court. Existing residents will have the option of continuing to have their care and support needs met on site by a care and support provider commissioned by the Council but vacant flats will not be relet as Extra Care.
- No decision has been taken regarding the long term future of the cafes at Piggs Corner and Kynoch Court. However, the Council will engage with community groups and local charities to explore if the cafes could be provided by such a group, in the expectation that in future they would be entirely self-funding.

The Council also wants to make sure that all residents and anyone wishing to move into Extra Care Housing at Elizabeth Gardens is clear about the charges for care and support there. In future the Council will ask Hanover Housing to provide all prospective residents (whether tenants or leaseholders) with an information leaflet setting out all the charges for care and support in the scheme. This will clearly state that those who wish to enter Elizabeth Gardens will be deemed to have made a request for a care and support service because of the nature of the scheme.

Q11. Please give any comments that you may have about these proposals:

These proposals involve a significant change in the way Extra Care Housing is provided and charged for in Thurrock. It is vital that the model is right and so your help is needed.
The council will be holding a series of meetings throughout the next 12 weeks to gain an understanding of the impact of the proposed changes on you as members of staff/users of the service/individuals whose family member/s will be affected etc.

Q12. Would you like to take part in these meetings?

☐ **Yes** ☐ **No**

If 'yes', please give your name and contact details (phone number or email):

About you
Thurrock Council wants to deliver high quality services to everyone, whatever their background. It is also important that everyone feels their views are valued and included. You are not required to complete any of these sections, but telling us about your background will help us to make sure that we are meeting the needs of all our communities and help us to evaluate what parts of the community have had an input to this consultation. If you feel that the group you identify with is not listed feel free to write this in the 'other' boxes provided.
All responses will be treated in confidence.

How are you responding to this survey?

☐ **As someone who uses social care services**
☐ **As a carer**
☐ **As a member of the general public**
☐ **On behalf of an organisation**
☐ **Other**

If 'other', please specify:

Are you a:

☐ **User of the Day Care, Carers', Careline, Sitting Services or Short breaks**
☐ **Resident of Extra Care Housing**
☐ **User of social care equipment or home adaptations**
☐ **User of other Adult Social Care services**
☐ **Other**

If 'other' please specify:

What is your ethnic group? ***Choose ONE and tick the appropriate box***

White
☐English/Welsh/Scottish/Northern Irish/British
☐Irish
☐Gypsy or Irish Traveller
☐Any other White background

Mixed
☐White and Black Caribbean
☐White and Black African
☐White and Asian
☐Any other Mixed background

Asian or Asian British
☐Indian
☐Pakistani
☐Bangladeshi
☐Chinese
☐Any other Asian background

Black or Black British
☐Caribbean
☐African
☐Any other Black background

If you selected other, please write your preferred ethnic group in the box below

Other ethnic group
☐Arab
☐Prefer not to say
☐Any other ethnic group

Please specify your gender
☐Female
☐Male
☐Transgender
☐Prefer not to say

Please specify your age group
☐17 or under
☐18-24
☐25-44
☐45-59
☐Over 60 years old
☐Prefer not to say

How would you define your sexual orientation?
☐Heterosexual
☐Gay
☐Bisexual
☐Lesbian
☐Prefer not to say

What is your religion?
☐No religion
☐Christian
☐Buddhist
☐Hindu
☐Jewish
☐Muslim
☐Sikh
☐Any other religion

If other, please specify below:

Do you consider yourself to be a disabled person?
☐Yes
☐No

If you are disabled, how would you describe your impairment?
☐Visual impairment
☐Hearing impairment
☐Mobility (not a wheelchair user)
☐Long term medical condition
☐Hidden impairment
☐Speech Impairment
☐Mobility (a wheelchair user)
☐Mental health condition
☐Learning disability
☐Other

If other, please specify your disability in the box below

Please send your completed questionnaire to the Council using the Freepost envelope provided before 7 December 2015

13 October 2015	ITEM: 8
Health & Wellbeing Overview and Scrutiny Committee	
Meals on Wheels Update	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Allison Hall, Commissioning Officer, Adults, Health & Commissioning	
Accountable Head of Service: Roger Harris, Director of Adults, Health and Commissioning	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

On 12 November 2013 the Committee were asked to review options and ascertain a preferred option regarding future provision of a meal service. This report is attached as Appendix 1.

On 3 September 2014, after a full consultation Cabinet were asked to support the recommendation to discontinue the current meals on wheels service when the contract with Royal Voluntary Service (RVS) came to an end on 31 March 2015. In its place Cabinet agreed that eligible service users would receive a personal budget from which they could purchase a meal of their choice or use Havering Catering Services who had at that time agreed to deliver a hot meal to an individual's home.

In late 2014, Havering advised that they could no longer commit to this arrangement. As such, contingency arrangements were put in place and the current contract with RVS extended until March 2016 to allow sufficient time to secure a long term solution.

Due to a reducing demand for a tradition meal service the current contract is unattractive to other providers. As such, we cannot continue with the same service model.

In early 2015 all remaining options were explored. A desktop review of all meals on wheels service users was carried out, followed by a face to face assessment of a sample of this group (to test whether the desktop assumptions were correct). Social care practitioners in the community, hospital team and the rapid response service were also consulted on the options. Based on the findings of the review and practitioner feedback, only one option meets the needs of service users whilst offering a long term and viable solution. This solution would be that eligible service users will meet the cost of a frozen meal, a personal budget allocation for a carer to

reheat the meal (either through a contract or direct payment), this cost will be met by the council (or charged if part of a wider domiciliary care visit).

It has become clear however, following some soft market testing that the local market (private and voluntary sector) is not developed enough for this option to be realised by the end of March 2016. We have therefore decided to further extent the current contract until April 2017 to allow us the time to develop the market but also explore working more closer with the local community and voluntary sector to grow a wider range of providers. We will be doing this at the same time as the review of the Domiciliary Care contract. All service users that have meals on wheels service will receive a re-assessment.

The current provider has agreed in principle to a further year's extension until the end of March 2017. However, this rest on a review and agreement of the current unit price to take into account the introduction of the National Living Wage which comes into force April 2016. This is likely to see an increase to the current unit cost of £7.78 to a proposed cost of £7.93, approximately £300pa.

1. Recommendations:

1.1 To support the extension of the contract with RVS or a further year and note that the future of the service will be considered as part of the wider review of domiciliary care

2. Introduction and Background:

2.1 The number of people receiving meals on wheels has reduced over the last few years. In 2011/12 the average number of service users supported per quarter was 575, by 2014/15 this had reduced to 496 per quarter. As a result the number of hot meals provided has also reduced, in 2011/12 the number of hot meals provided was 48,108, by 2014/15 this had reduced to 39,138.

2.2 The price of the meal is dependent on volume levels. As at March 2015 the current cost of each meal is £7.78, with the service user contributing £4.00 of this cost. (In 2011/12 the cost per meal was £6.62). Should the meal volume drop to below 35,000 per annum this will increase the price further to £8.48 per meal – see pricing table below:

Current	
Volume Banding Price per meal	
100,000 - 104,999	£4.56
95,000 - 99,999	£4.57
90,000 - 94,999	£4.72
85,000 - 89,999	£4.74
80,000 - 84,999	£4.92
75,000 - 79,999	£4.96
70,000 - 74,999	£5.18
65,000 - 69,999	£5.25

60,000 - 64,999	£5.53
55,000 - 59,999	£5.89
50,000 - 54,999	£6.12
45,000 - 49,999	£6.62
40,000 - 44,999	£7.01
35,000 – 39,999	£7.78
30,000 – 34,999	£8.48
25,000 - 29,999	£9.86
20,000 - 24,999	£11.44

2.3 The wider availability of lower priced frozen meals that can be reheated at a time to suit the individual (e.g. in the evening) has resulted in falling demand for this product/service.

2.4 This low volume of meals is making the current contract economically unviable and unattractive to potential providers.

3. Issues, Options and Analysis:

Option	Pro's	Con's
Stop providing a meal service and provide a subsidy (in the form of a personal budget) to the service user to reheat a frozen meal (frozen meal to be purchased by service user).	Council could save money depending on the level of subsidy offered. Council meets identified need. May provide more choice to service users and their families. Service users can afford a meal service.	Could place vulnerable people at risk if insufficient alternative provision in the market.

4. Reasons for Recommendation:

4.1 This would appear to be the only viable option for the service over the long term.

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

5.1 Legal advice has been sought as to whether further consultation is required on the proposed model – Thurrock Council's Legal Department has concluded that a further consultation is not required as this option was considered in the original consultation.

6. Impact on Corporate Policies, Priorities, Performance and Community Impact

6.1 The decision to change the model of provision could have a significant impact on the wellbeing of the most vulnerable people in our community. It specifically impacts on priority 4 of our Community Strategy; Improve Health and Wellbeing by ensuring that people stay well for longer by having a nutritious and hot meal every day.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Management Accountant

A savings target of £60,000 was made within the Adult Social care budget, which was predicated on the alternative service delivery options detailed within the original report of 12 November 2013. This is no longer achievable, but has been financed by alternative savings from elsewhere within the service budget.

There will be a financial implication is so far as extending the current contract will result in a small increase to the unit cost of each meal, and a variable elements linked to the volume of meals provided. These will be contained within, and have been factored into the forecast outturn of the Adult Social Care budget for 2015/16.

7.2 Legal

Implications verified by: **Dawn Pelle**

Legal Officer

Pursuant to Section 2 of the Chronically Sick and Disabled Persons Act 1970 the Council has responsibility to make arrangements for the provision of meals to eligible people.[1] Further implications in relation to consultation are contained under item 5 of this report.

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development & Equalities Manager

[1] NB: The provisions of the Chronically Sick and Disabled Persons 1970 relating to adults has been repealed by the Care Act 2014. However for those persons whose care plan is to be reviewed will only qualify for a Needs Assessment under the Care Act 2014 if through a review or otherwise their needs or circumstances have changed. Paragraph: 23.4 Care and Support Statutory Guidance 2014

Having explored options, the recommendation to extend the current contract ensures service is provided whilst alternative provision is developed. Previous data determined that many users were older people and women. All recipients have either a physical disability, sensory impairment and/or cognitive impairment. As such, we need to ensure that current and potential users are supported to have a voice in this process.

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

N/A

8. Background Papers used in preparing this Report (include their location and identify whether any are exempt or protected by copyright):

N/A

9. Appendices to this Report:

Appendix 1- HOSC Report of 12 November 2013.

Report Author Contact Details:

Allison Hall
Commissioning Officer
Adults, Health & Commissioning

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12 November 2013	**ITEM:**
Health and Well-Being Overview and Scrutiny Committee	
MEALS ON WHEELS	
Report of: Sarah Turner – NDS Lead and Older People Commissioner	
Wards and communities affected: All	**Key Decision:** Yes
Accountable Head of Service: N/A	
Accountable Director: Roger Harris – Director of Health, Adults and Commissioning	
This report is Public	
Purpose of Report: Options appraisal on the future of meals on wheels provision	

EXECUTIVE SUMMARY

The Council currently holds a contract with RVS (until 31st March 2015) to provide hot meals to people who have been assessed as critical or substantial under the Adult Social Care FACS (Fair Access to Care) criteria[1]. The meals on wheels service is in place to ensure that people who are unable to prepare their main meal (including reheating frozen food) have the facility to receive one hot and nutritionally balanced meal each day. In addition to the meal, RVS also carry out welfare checks and medication prompts (where it has been assessed as a need).

This report has been prepared to give the committee all future commissioning options in advance of the contract end date so that officers have sufficient time to implement the Committee's preferred option.

The service is used for people where the risk has been identified as to great (i.e. they would not eat). We have the responsibility to meet this need under the Chronically Sick and Disabled Personal's Act 1970 (Section 2) but it may be able to be met in an alternative way to current provision.

[1] Full Title of document: Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care – guidance on eligibility criteria for adult social care: England 2010

1. RECOMMENDATIONS:

1.1 For the Committee to review the options detailed in section three of this report and to agree their preferred option/s.

1.2 For the preferred option/s to go out to public consultation.

2. INTRODUCTION AND BACKGROUND:

We currently have 146 people in receipt of meals on wheels (September 2013). Although the number of people receiving meals on wheels has reduced over the last few years (In 2009/10 56,535 hot meals were provided, it is estimated in 2013/14 this will be down to 33,000 meals) there has been an increase in the amount of meals per week each service user has (60% of recipients now have a meal 7 days a week).

The price of the meal is dependent on volume levels. Currently each meal costs £7.78, with the client contributing £4.00 of this cost.

Local Authority	Charge to Service User (per meal)	Provider	Service
Thurrock	£4.00	RVS	Hot meal and pudding. Can also provide a tea time pack for additional charge.
Essex	£3.95	SODEXO	Hot meal and pudding
Southend	£4.60	RVS	Hot meal and pudding. Can also provide a tea time pack for additional charge.
Barking & Dagenham	N/A	N/A	No directly commissioned or contracted service. Service users are given contact details and can directly purchase from neighbouring authorities meal service (see below)
Havering	£5.25 (full cost recovery)	Meals service is council run (Havering Catering Services)	Hot meal and pudding. Can also provide a tea time pack for additional charge. Not a contracted service.
Luton	£3.40	Meals service is council run (LBC Catering Service)	Hot meal and pudding. Can also provide a tea time pack for additional charge.

Table 1: MOW comparator table

Table 1 gives a brief description of client contribution and service provision in neighbouring and comparator local authorities

In conjunction with service provision and costs a full review of the demographics of users of meals on wheels in Thurrock has been undertaken. They are as follows;

- Although there are people as young as 46 using meals on wheels, the average age of user is 84 years old.
- 94 (64%) recipients are female and 52 (36%) male.
- 123 of the 146 people in receipt of meal on wheels live alone.
- Of the 23 people who live with others, 14 people are partners (i.e. 7 couples both with care needs, often one partner also has dementia), the remaining 9 live with a family member who are either at work during the day or they are in a co-dependent relationship e.g. elderly father and son who has learning disabilities who both require a meal.
- 30 people (21%) receive meals on wheels because they have a cognitive impairment (this is largely dementia or short term memory loss but does include younger adults with enduring mental health issues). Typically they require a meal as they unable to remember to eat.
- 75 people (51%) receive meals on wheels for physical issues. This is largely people with restricted mobility who are unable to stand to heat a frozen meal. This is due to a number of health conditions but most commonly osteoporosis, arthritis or Parkinson's (although a number of these are combined with sensory impairments).

- 41 people (28%) of people have both physical and cognitive impairments i.e. unable to mobilise and have dementia.

3. ISSUES, OPTIONS AND ANALYSIS OF OPTIONS:

Based on the information gathered, the table below details all of the options available to the committee and the pros and cons of each.

Option	Pros	Cons
1. Continue with current service delivery model (although this will be retendered during 2014).	Vulnerable people receive a hot meal, welfare check and medication prompt (where appropriate).	If the drop in level of demand continues we will be paying a higher unit price making the service financially unviable. Poor response to tender opportunity last time. This does not offer the service user choice.
2. Continue with current service delivery model but implement full cost recovery	The council would save between £120k and £150k per annum. Vulnerable people continue to receive a hot meal and welfare check.	• Based on current demand and prices, service users would have to pay £7.78 per meal. An increase of £3.78 in addition to the £4.00 they currently contribute • This would result in older people meeting an addition £1,380 cost per year. This may put older people in a position where they could not continue to meet the cost of provided meals.

		• This could also result in a significant drop in demand, resulting in a higher unit price and the service becoming financially unviable.
3. Stop providing a meal service and provide only signposting information.	The council would save between £120k and £150k per annum. May be able to secure a reputable provider to work in the area without a contractual relationship with the Council e.g. LBBD model (although for those in receipt of a medication prompt this need will not be met by the meals service).	• Could place vulnerable people at risk if insufficient alternative provision in the market. • Council may need to replace this service with additional home care calls (see option 5) as we have a responsibility to meet identified need (as the people currently receiving the service do not have either the capacity or capability to reheat meals) and for welfare checks and medication prompts. • Due to the high level of people who live alone receiving this service there may not be friends or family who can help arrange the meal service. • Possible increased cost to service users.
4. Provide only a frozen meal service.	The council would save between £120k and £150k per annum as the cost of the meal would be met by the service user.	• This is not a viable option as our current recipients are either unable to stand to heat a meal or alternatively are unable to remember to heat and eat a meal.
5. Provide a frozen meal service plus 15 minute call from a home carer to reheat the meal.	Ensure that vulnerable person's nutritional and welfare needs are being met. May provide more choice to service users. May be better for service users with dementia as they can receive a visual prompt.	• Without subsidy it could result in significant cost to older people as they would be paying for both the cost of the meal and a 15 minute visit. • Capacity issues in home care contracts (and the care sector as a whole) may make it difficult for this amount of additional calls to be met. May take trained carers out of the system to prepare meals when unqualified staff are able to meet this need.
6. Stop providing a meal service and provide a subsidy (in the form of a direct payment) to the services user.	Council could save money depending on the level of subsidy offered. Council meets identified need. May provide more choice to service users and their families. Service users can afford a meal service.	• Could place vulnerable people at risk if insufficient alternative provision in the market.

4. REASONS FOR RECOMMENDATION:

4.1 It is recommended that the Committee review all options prior to public consultation.

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

5.1 The purpose of this paper is to consult the Committee on this issue to ascertain their preferred option/s before going out to public consultation and ultimately Cabinet.

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

6.1.1 This decision could have a significant impact on the wellbeing of the most vulnerable people in our community. It specifically impacts on priority 4 of our Community Strategy; Improve Health and Wellbeing by ensuring that people stay well for longer by having a nutritious and hot meal every day.

7. IMPLICATIONS

7.1 **Financial**

Implications verified by: **Sean Clark**
Telephone and email: **01375 652010**
sclark@thurrock.gov.uk

The report clearly sets out the financial implications. Members will be aware that the Council faces unprecedented financial pressures over the medium term and that significant savings will need to be achieved and some difficult decisions will be required. However, these have to also be balanced against the Council's statutory responsibilities and the Council's priorities.

7.2 **Legal**

Implications verified by: **Dawn Pelle**
Telephone and email: **020 8227 2657**
dawn.pelle@bdtlegal.org.uk

Pursuant to Section 2 of the Chronically Sick and Disabled Persons Act 1970 the Council has responsibility to make arrangements for the provision of meals to eligible people.

The Council needs to ensure that any change to service provision is fully consulted upon otherwise this decision could be open to challenge. The Sedley Guidelines as to consultation should be adhered to strictly. A good period for public consultation would be a minimum of 6-8 weeks but 12 weeks would be best practice.

7.3 **Diversity and Equality**

Implications verified by: **Samson DeAlyn**
Telephone and email: **01375 652472**
sdealyn@thurrock.gov.uk

This is an options paper and as such the diversity and equality implications will be dependent on the Committee's preferred option. The two main areas of implication and age and gender as the average age of recipient is 84 and a high percentage of users are female. All recipients have either a physical disability, sensory impairment and/or cognitive impairment. As such, we need to ensure that current and potential user's are supported to have a voice in this process.

7.4 **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:

- N/A

Report Author Contact Details:

Name: Sarah Turner
Telephone: 01375 652857
E-mail: SAturner@thurrock.gov.uk

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13 October 2015	ITEM: 9
Health & Wellbeing Overview and Scrutiny Committee	
Annual Public Health Report 2014	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Helen Horrocks, Strategic Lead Commissioner for Public Health, Public Health Team	
Accountable Head of Service: Ian Wake, Director of Public Health	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning / Ian Wake, Director of Public Health	
This report is public	

Executive Summary

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

1. Recommendation(s)

1.1 That the contents and recommendations of the 2014 Annual Public Health Report be noted.

2. Introduction and Background

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

2.2 The Annual Report of the Director of Public Health is intended to be an independent assessment of the health of the community based on sound epidemiological evidence and interpreted objectively. With the transfer of public health into local authorities, the Health and Social Care Act 2012 has placed a statutory duty on the Director of Public Health to prepare an Annual Report and on the local authority to publish it.

3. Issues, Options and Analysis of Options

The 2014 Thurrock Annual Public Health Report: Key Issues

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

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

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

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

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

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

4. Reasons for Recommendation

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

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

5.1 None

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

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

7. Implications

7.1 Financial

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

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

7.2 Legal

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

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

7.3 Diversity and Equality

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

An equality impact assessment on the annual report of the Director of Public Health has not been carried out. The report contains key data which should inform equality impact assessments of health and social care programme areas, strategies and policy. Each programme included in the annual report identifies relevant inequalities and variations.

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

There are no other implications.

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

Background papers are referenced in the Annual Public Health Report.

9. Appendices to the report

APPENDIX 1 - Ageing Well - Opportunities of a healthy later life in Thurrock.

Report Author:

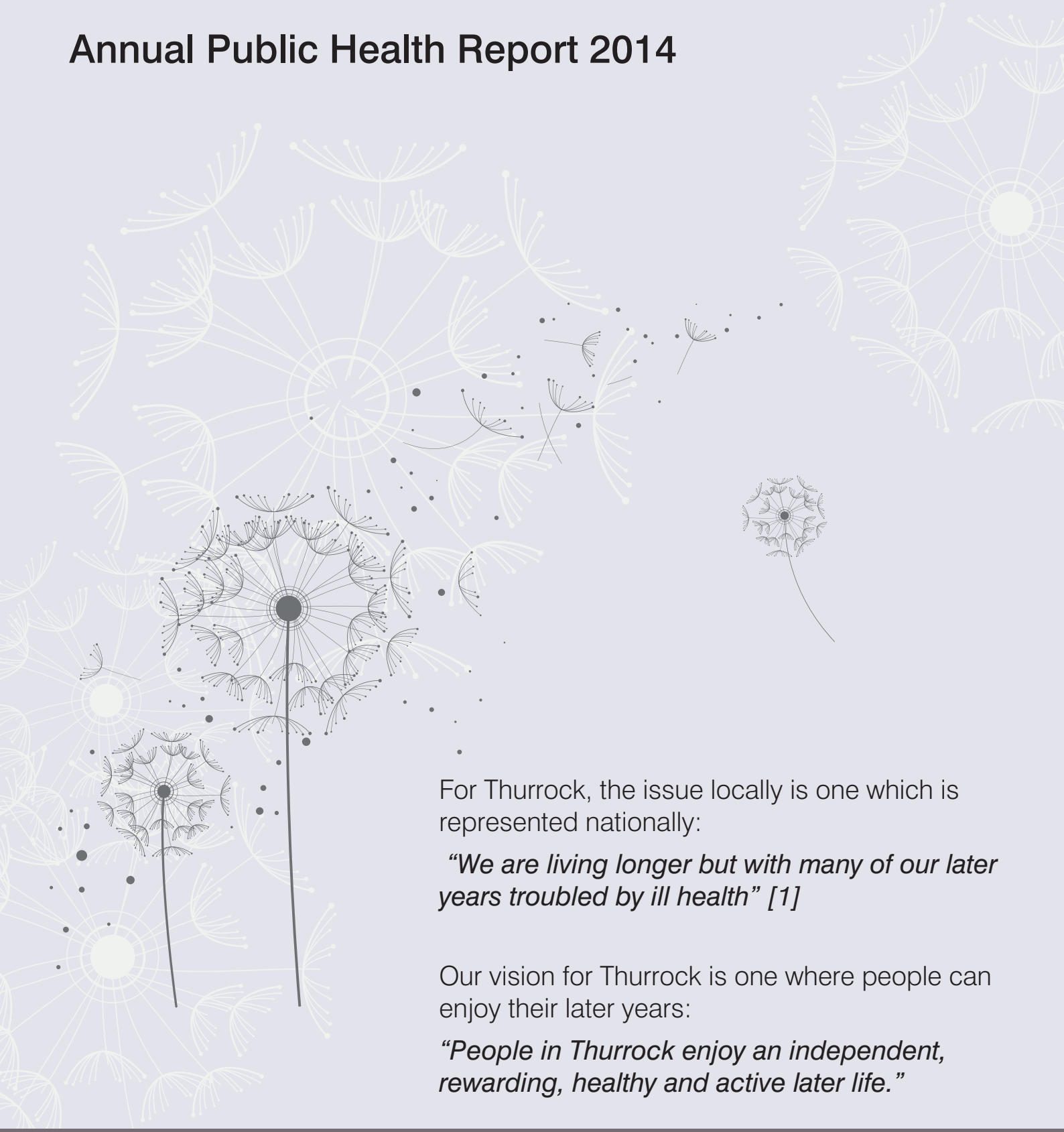
Helen Horrocks
Strategic Lead Commissioner for Public Health
Public Health Team

Andrea Atherton
Director of Public Health
Adults, Health and Commissioning

Ageing Well

Opportunities of a healthy later life in Thurrock

Annual Public Health Report 2014



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

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

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

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

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CONTENTS

Acknowledgements

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

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

Foreword

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

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

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

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

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

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

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

Dr Andrea Atherton
Director of Public Health, Thurrock Council

Executive summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary of Recommendations

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

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

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

- Encourage and support people in later life to quit smoking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 1 A Profile of Older People in Thurrock

Key Messages

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

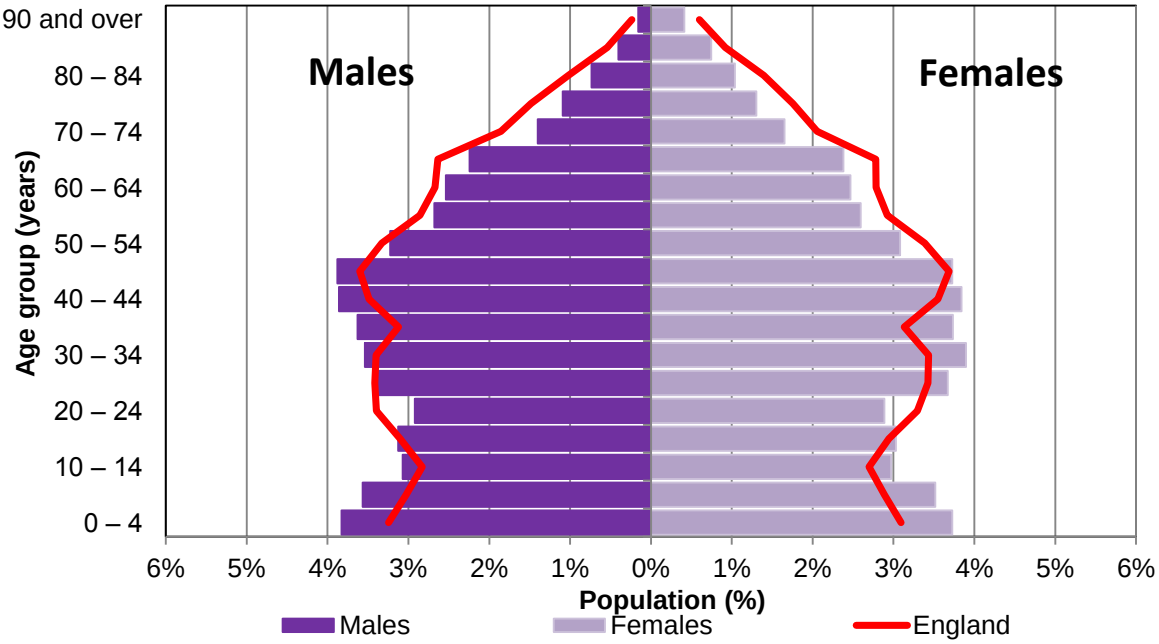
Introduction

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

The Current Population

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

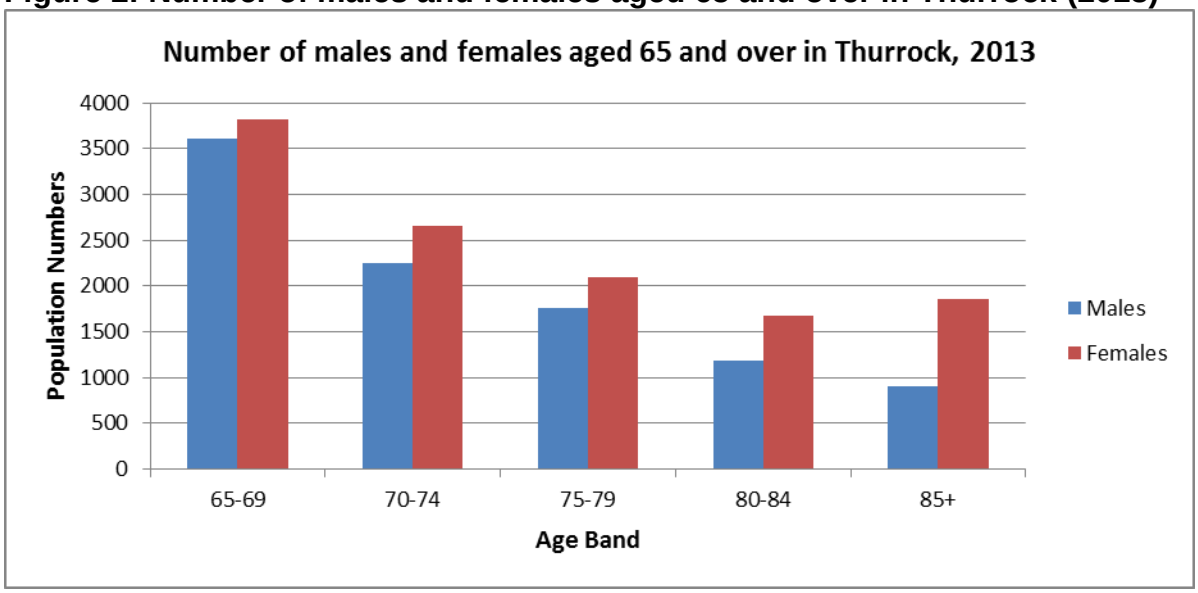
Figure 1: Population Structure of Thurrock, all ages (2013)



Source: ONS, Population Mid-Year Estimates 2013

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

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



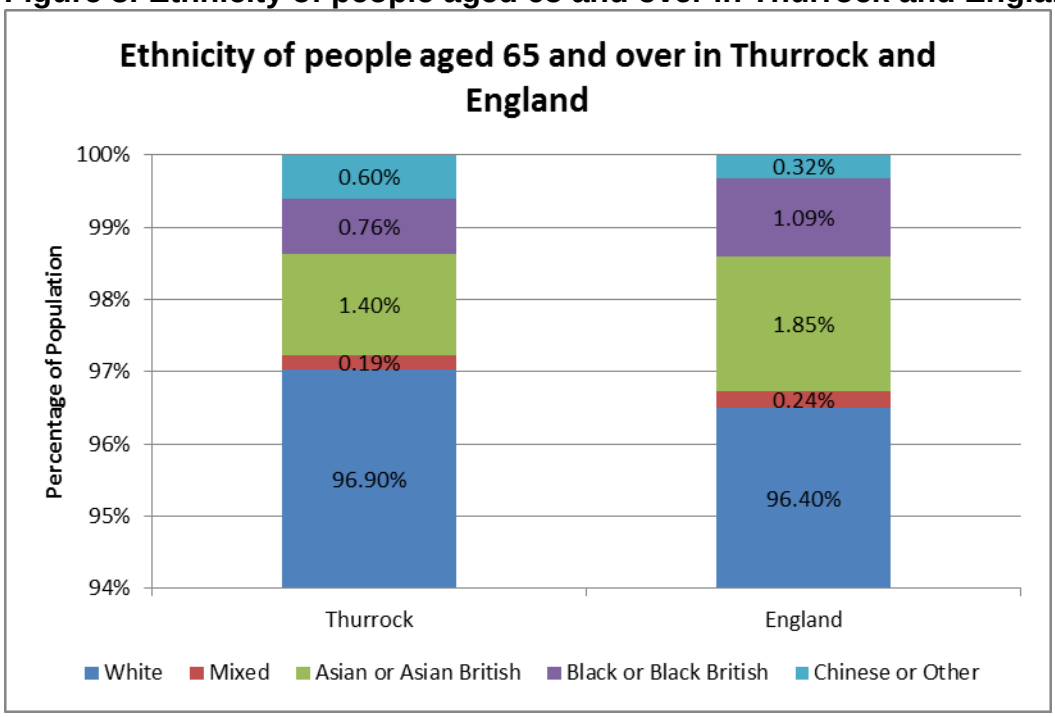
Source: ONS, Population Estimates 2013

Ethnicity

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

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

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

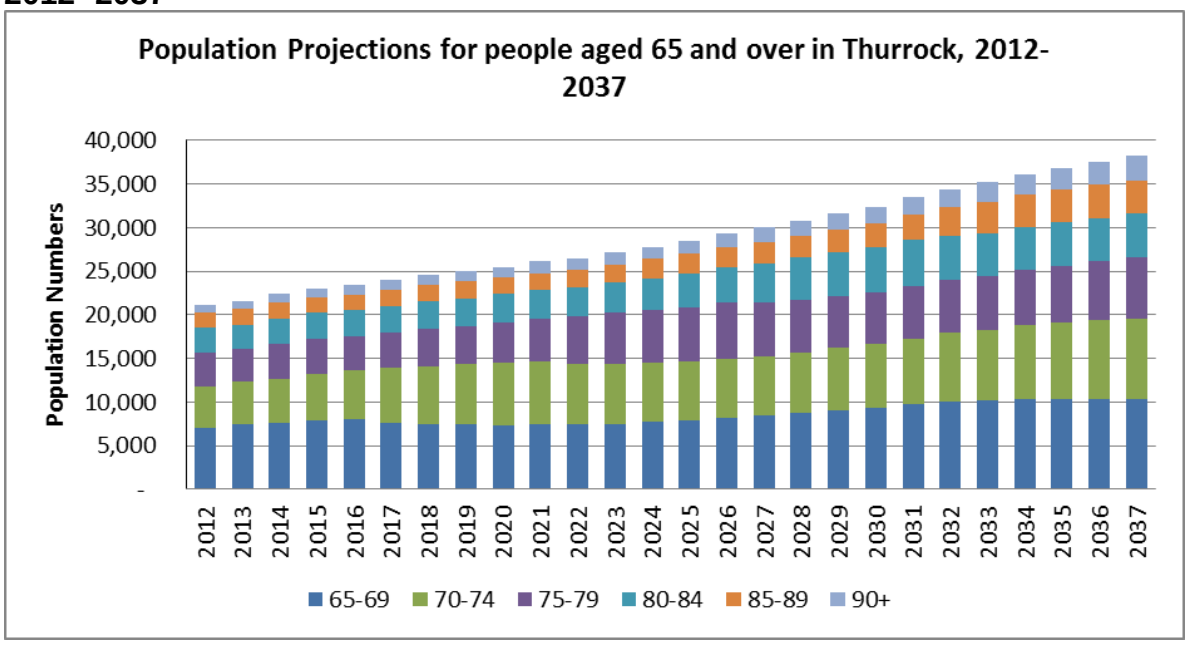


Source: POPPI (calculated using ONS statistics, 2011)

Population Change

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

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

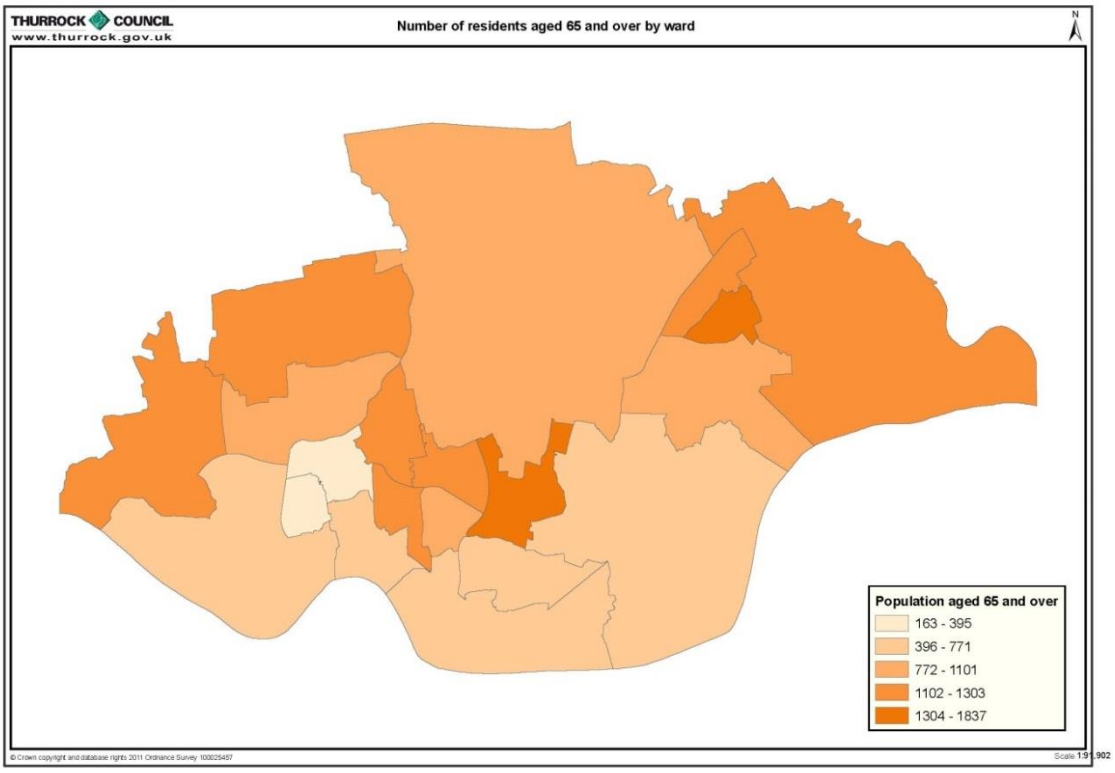


Source: ONS, Subnational Population Projections 2012

The Location of Older People in Thurrock

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

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



Source: ONS, 2011

Household characteristics

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

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

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

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

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

Source: POPPI – based on 2007 figures

Chapter 2 Ageing Well

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

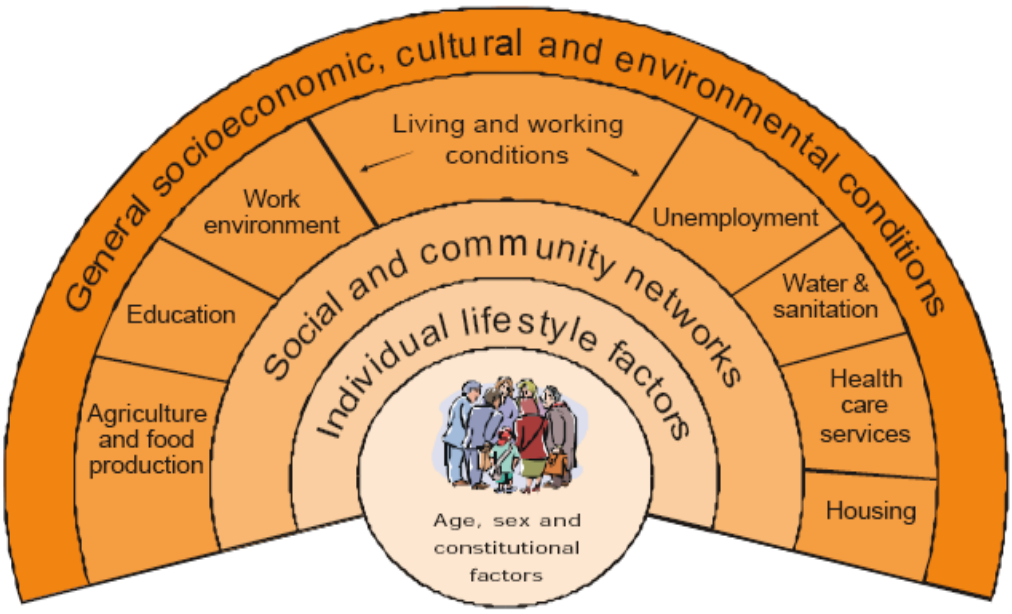
The ageing process itself is caused by a gradual build-up of subtle faults in the cells and organs of our bodies, with genes influencing cellular repair. However, evidence suggests that genetic factors only account for 25% of human longevity and much can be gained from targeting the non-genetic factors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

2.1 Healthy, Supportive and Safe Environments

Determinants of Health

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

Figure 1: The Determinants of Health



Source: Dahlgren G and Whitehead M, 1991.

Poverty and Deprivation

Key Messages

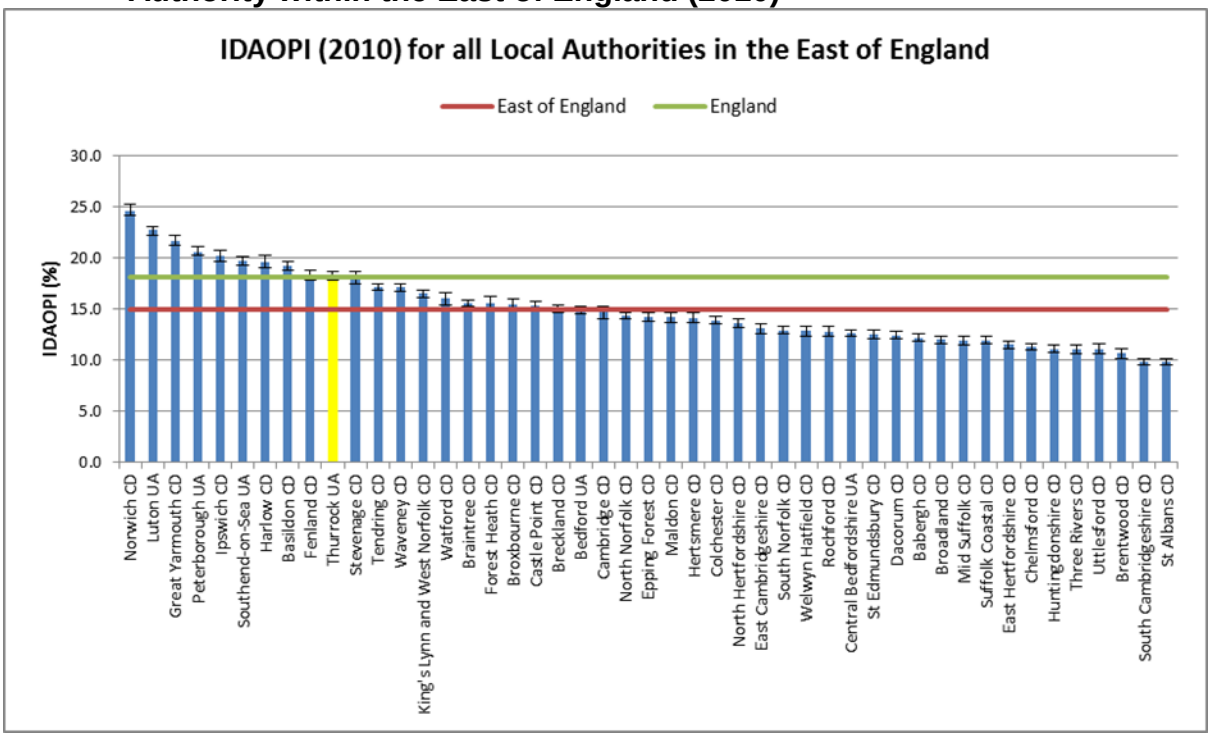
- Thurrock has the 10th highest level of older people living in poverty in the East of England
- This has the potential to impact on the health and well-being of older people in Thurrock

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

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

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

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

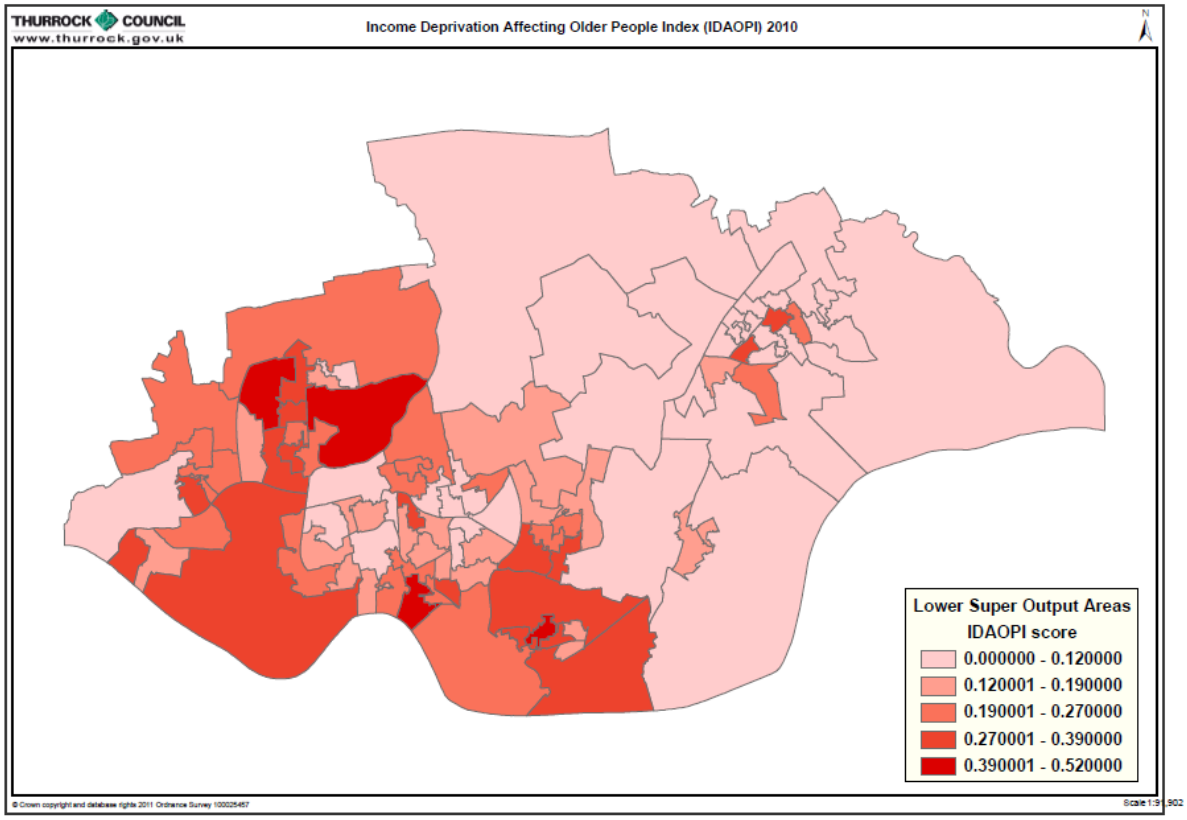


Source: APHO

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

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

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



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

Local Action

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

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

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

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

Housing and Well-homes

Key Messages:

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

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

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

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

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

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

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

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

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

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

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

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

Source: POPPI – based on 2011 figures

Local Action

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

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

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

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

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

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

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

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

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

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

Fuel Poverty

Key Messages:

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

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

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

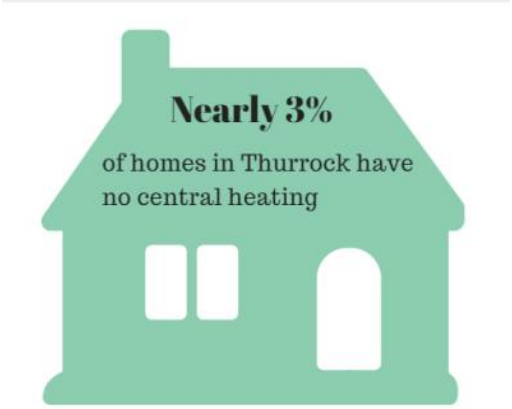
- they have required fuel costs that are above average (the national median level)
- were they to spend that amount, they would be left with a residual income below the official poverty line.

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

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

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

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



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

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

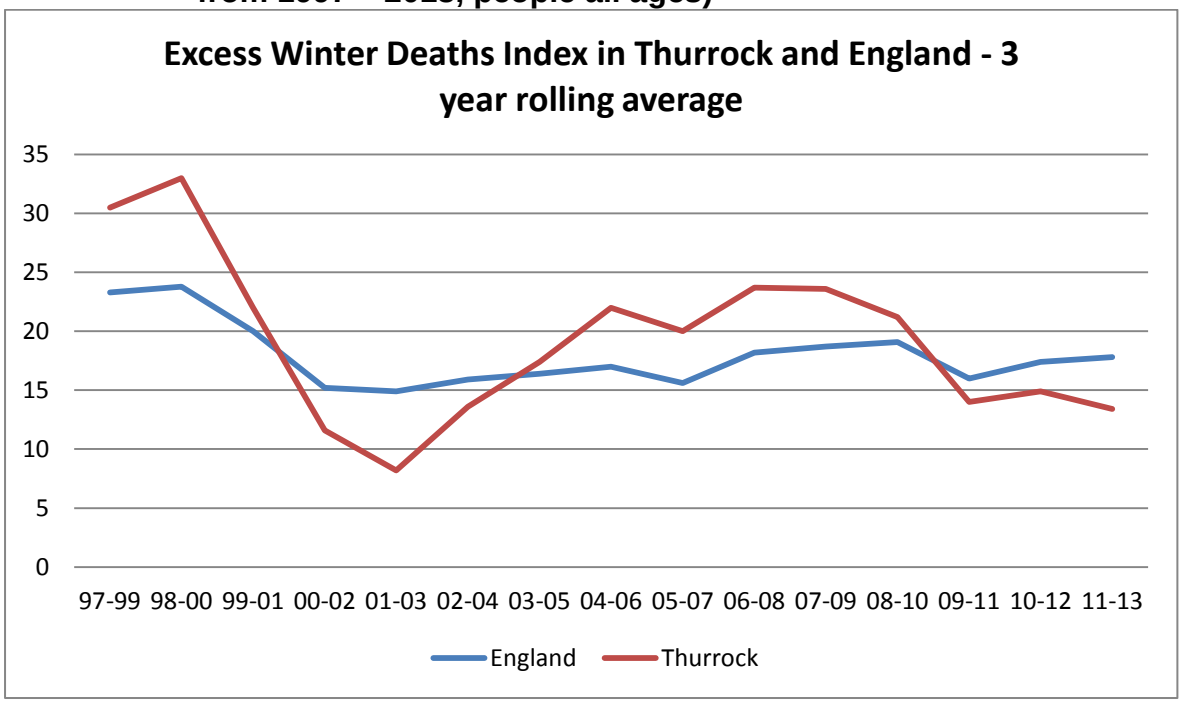
Fuel poverty can also contribute to excess winter deaths in all age groups, but the proportion of excess deaths is greater in older age groups.

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

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

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

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



Source: ONS

Local Action

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

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

Keep Warm Keep Well – Key Messages

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

Recommendations:

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

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

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

2.2 Promoting Healthy Ageing

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

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

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

[13]

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

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

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

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

Smoking

Key Messages:

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

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

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

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

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

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

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

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

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

Local Action

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

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

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

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

The Stoptober Campaign 2014

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

Stoptober 2014 resulted in 857 estimated sign ups

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

Recommendations:

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

Healthy Eating and Obesity

Key messages:

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

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

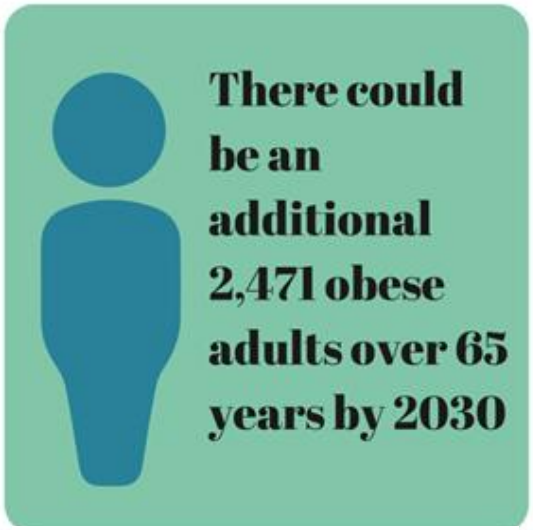
Nutritional guidelines for fat, carbohydrate and fibre are the same for older people as for adults of working age. However, low dietary intake is not uncommon among healthy older adults. **Malnutrition**, defined as 'state of nutrition in which a deficiency, excess or imbalance of energy, protein, and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

There are multiple risk factors for malnutrition, including:

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

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

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



Source: POPPI

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

Local Action

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

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

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

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

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

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

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

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

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

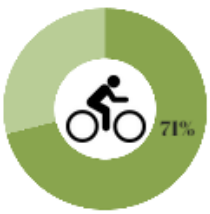
Physical Activity

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

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

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

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



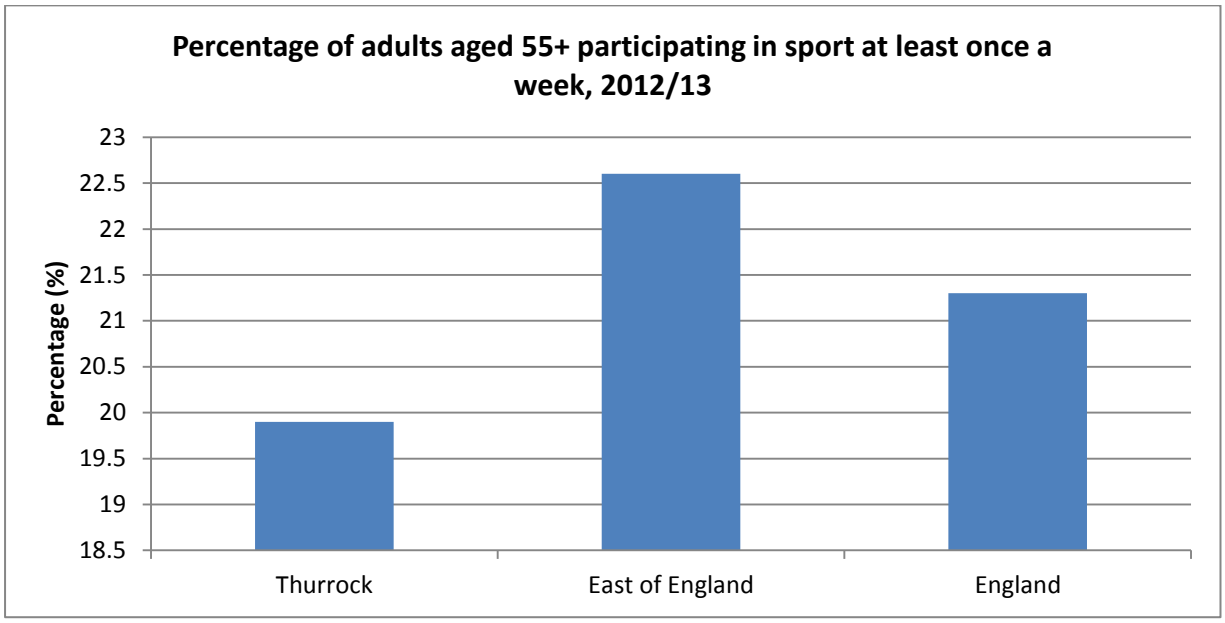
of those aged 16-18 years meet the recommended physical activity guidelines

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

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

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

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



Source: Active People's Survey

Local Action

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

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

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

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

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

Recommendations:

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

Alcohol

Key Messages:

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

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

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

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

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

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

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

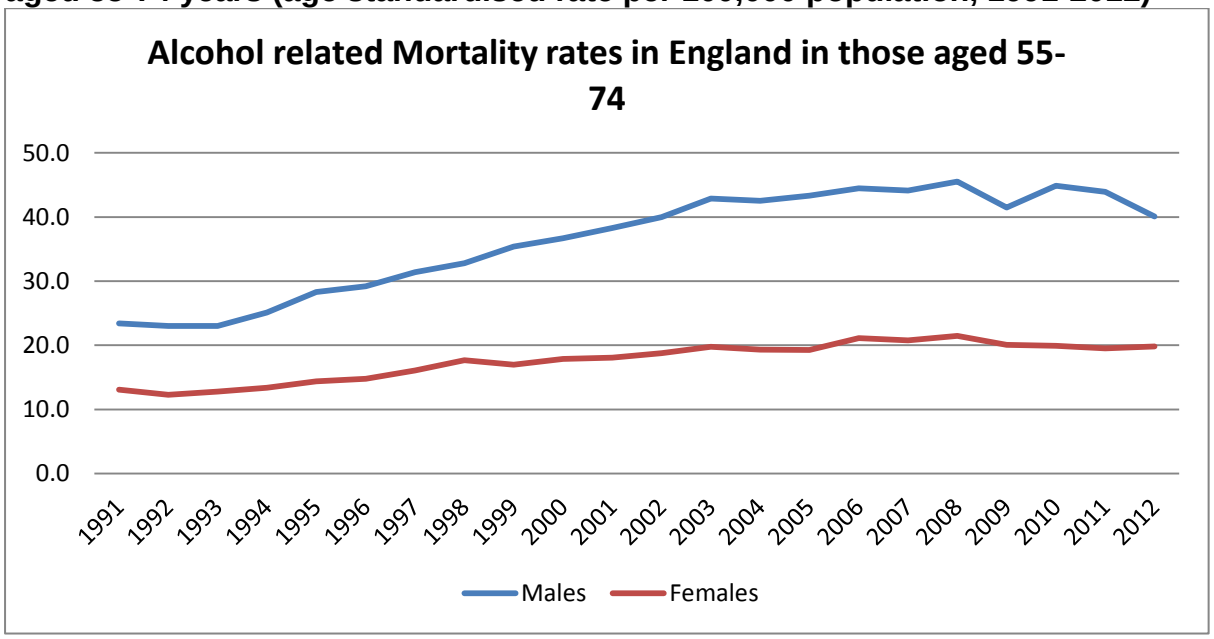
Alcohol misuse in older people can be linked to, or exacerbate, a number of physical, mental, social and practical problems such as:

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

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

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

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

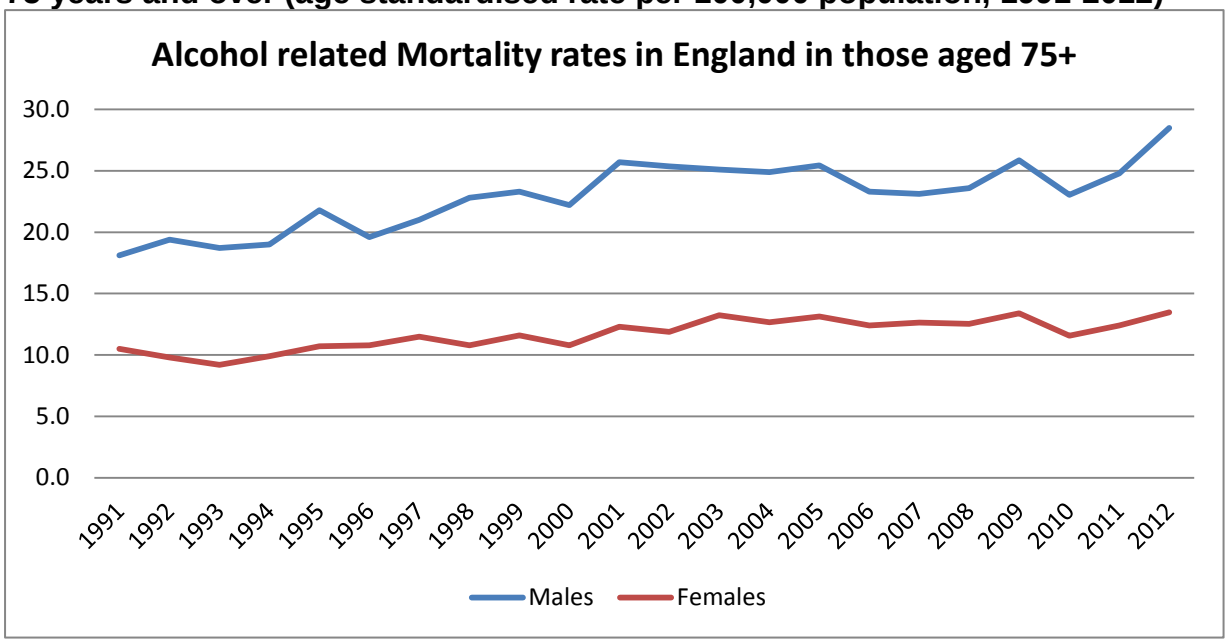


Source: Office for National Statistics 2014

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

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

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



Source: Office for National Statistics 2014

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

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

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

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

Local Action

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

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

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

Recommendations:

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

Mental health and social interaction in later life

Key Messages:

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

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

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

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

Loneliness

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

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

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

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

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

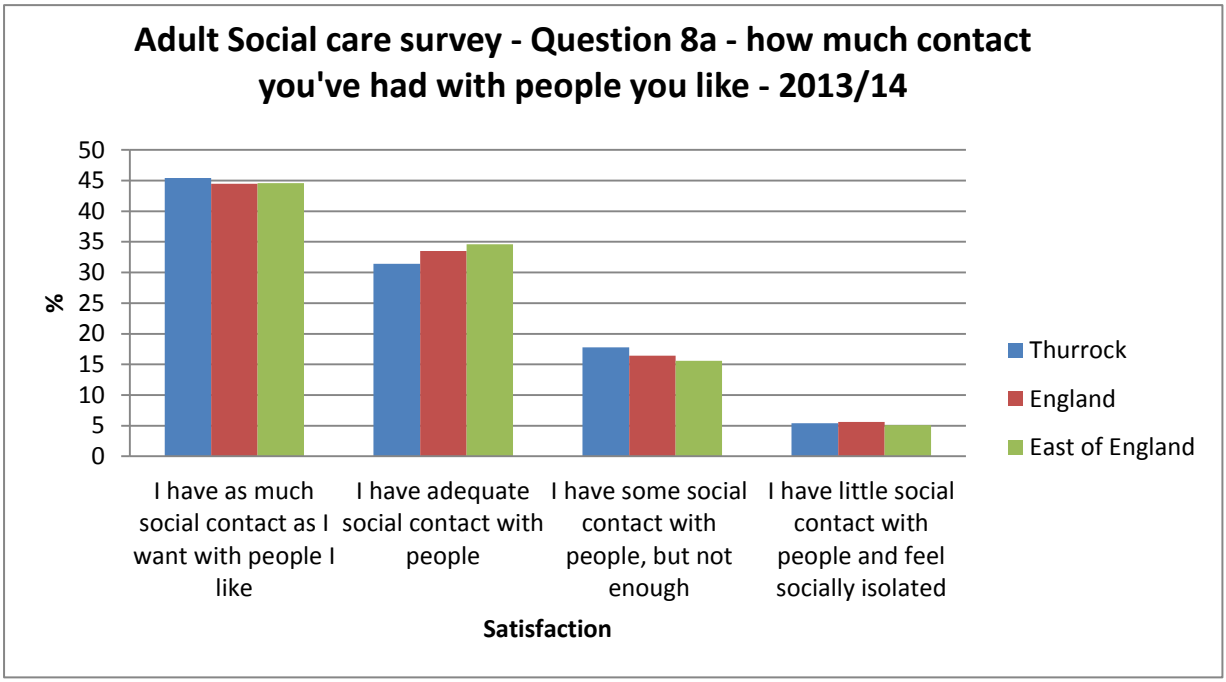
Research has shown that poor mental health and sensory impairments are associated with smaller and less satisfying support networks, as well as lower levels of contact with social networks. Loneliness increases the risk of cognitive decline and dementia, while frequent emotional support and social activity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

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

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

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

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



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

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

Local Action

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

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

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

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

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

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

Depression

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

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

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

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

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

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

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

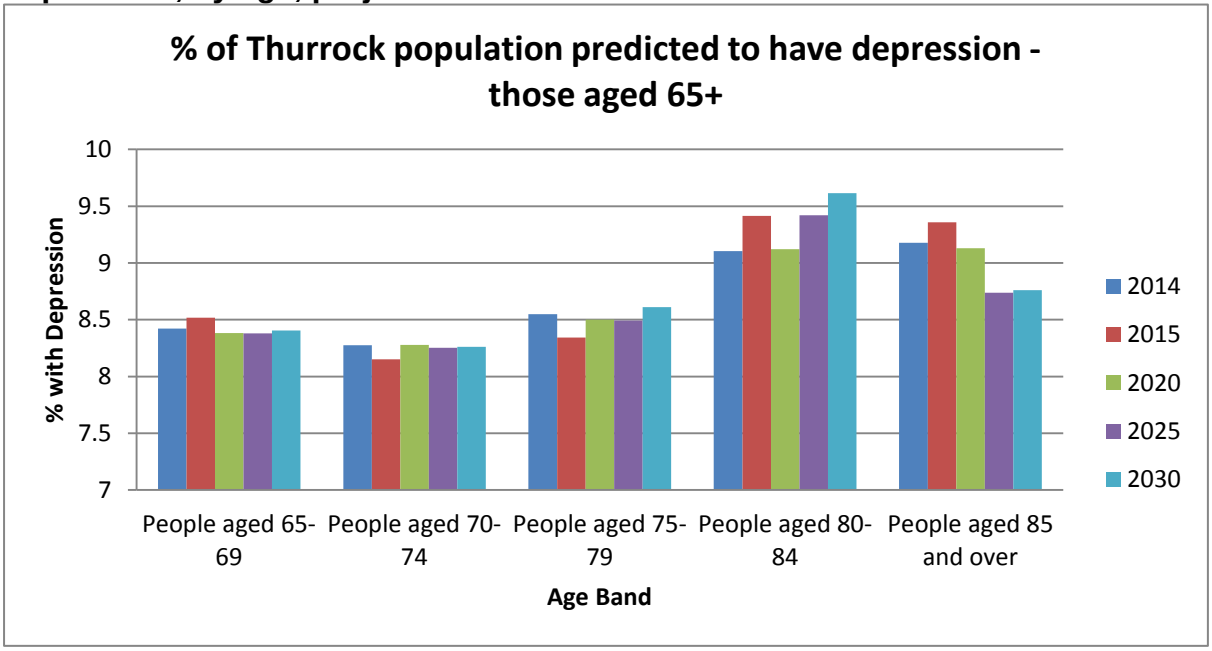
Untreated depression can have a detrimental impact on quality of life in older people, but in addition to this it can increase need for other services, including residential care [27].

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

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

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

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



Source: POPPI (2013)

Local Action

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

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

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

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

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

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

Recommendations:

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

2.4 Protecting health in later life

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

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

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

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

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

Seasonal Influenza

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

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

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

The Influenza Immunisation Programme

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

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

- People aged 65 years or over
- All pregnant women

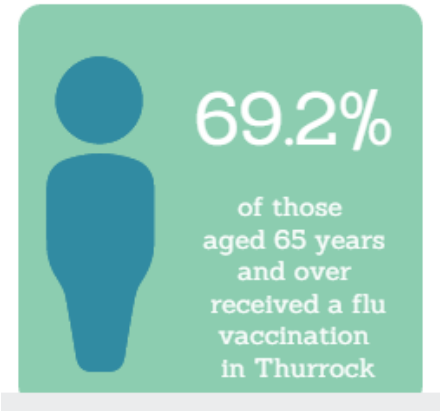
- People with a serious medical condition such as:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease
  - chronic liver disease
  - chronic neurological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

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

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

Local Statistics

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



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

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

Local Action

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

Shingles

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

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

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

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

Screening

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

The Breast Cancer Screening Programme

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

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

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

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

The Bowel Cancer Screening Programme

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

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

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

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

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

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

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

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

Abdominal Aortic Aneurysm Screening (AAA)

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

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

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

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

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

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

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

Recommendations:

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

Chapter 3 In Focus - Dementia in Thurrock

Key messages:

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

Introduction

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

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

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

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

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

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

What is dementia?

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

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

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

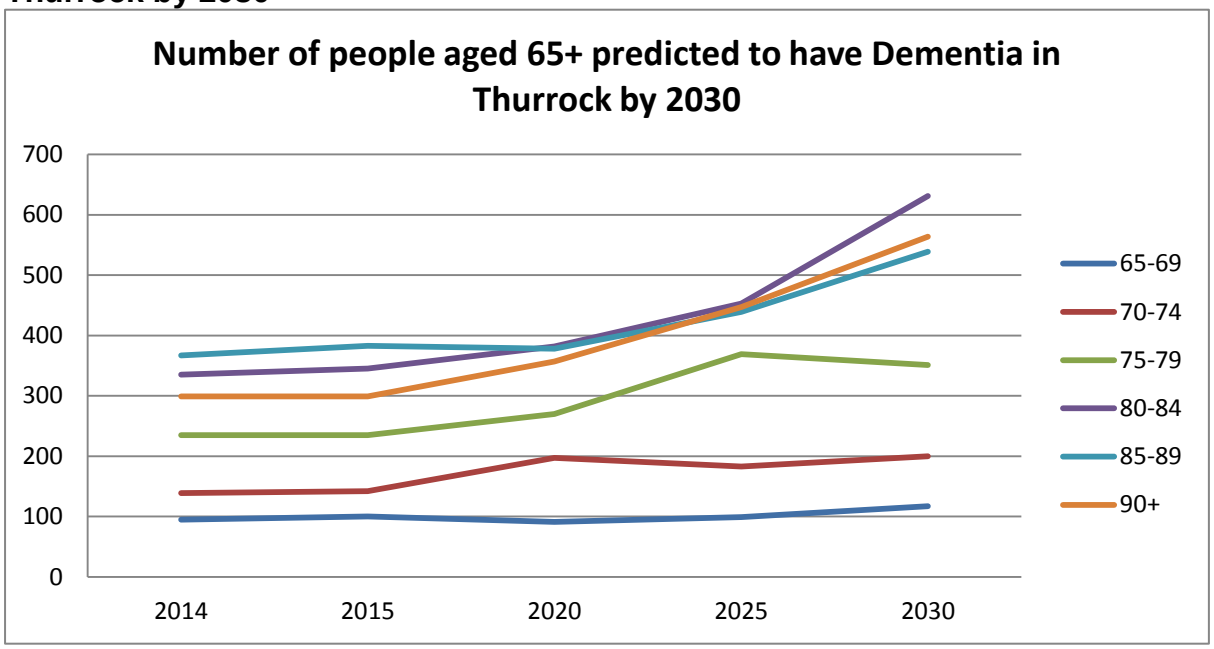
- Alzheimer's disease, which is the most common cause of dementia and accounts for around 62% of cases in England. Brain cells are surrounded by an abnormal protein resulting in their damage and loss.
- Vascular dementia. This results from damage or loss of brain cells due to a reduced or loss of the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

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

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

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

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



Source: POPPI

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

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

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

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

Source; Knapp et al, 2014 (1)

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

The cost of dementia

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

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

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

Prevention

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

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

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

Early intervention

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

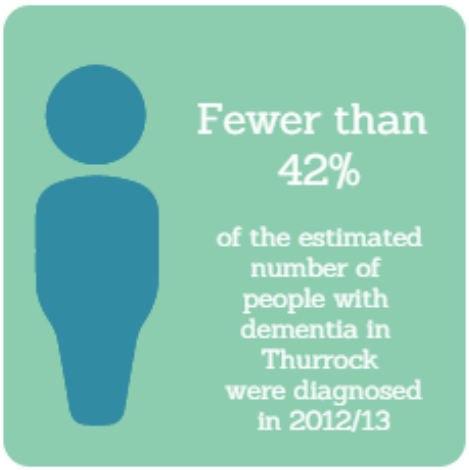
Diagnosis is not an end in itself, but a gateway to making informed personal life choices. It should provide access to a full range of treatment, including medical and psycho-social interventions, and importantly, post-diagnosis support and services. There is also strong evidence that early diagnosis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

Diagnosis

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

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

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



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

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

Living with dementia

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

Post-diagnosis help and support includes:

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

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

Supporting carers

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

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

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

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

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

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

End of life care

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

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

Dementia Friendly Communities

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

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

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

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

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

Establishment of Dementia Action Alliances

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

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

Local Action

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

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

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

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

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

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

National initiatives to support an earlier diagnosis of dementia include:

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

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

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

Recommendations:

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

Chapter 4 Maintaining Independence and Self-care

Introduction

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

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

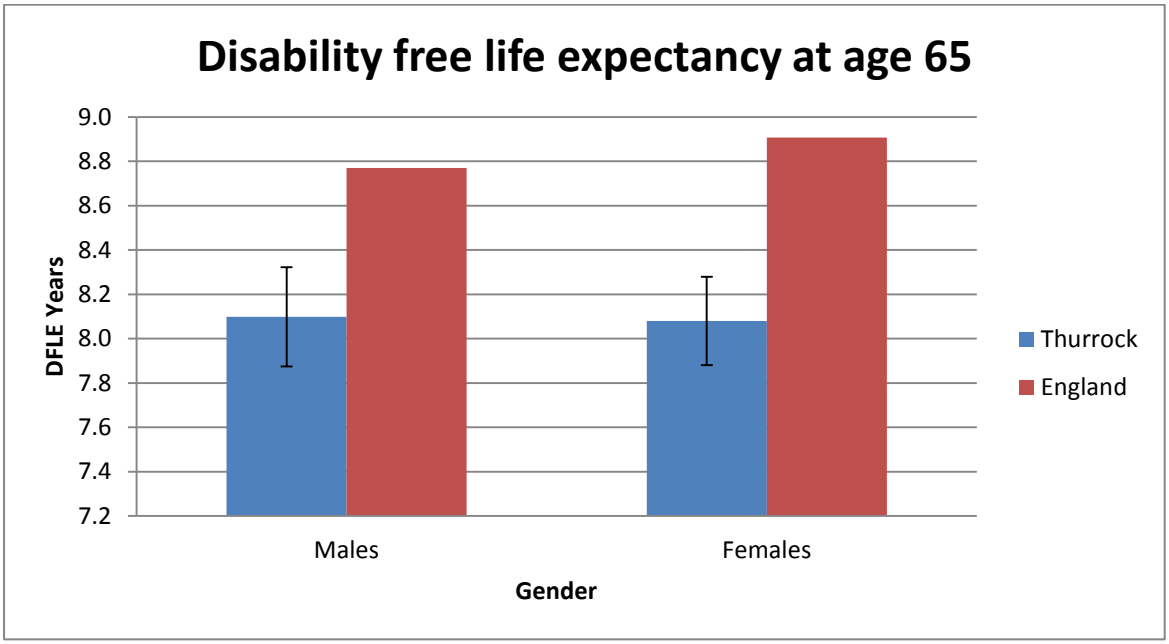
Prevention is embodied by the Care Act, approved by Parliament in May 2014. The Act establishes new duties and responsibilities on councils. The key changes include:

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

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

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

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



Source: ONS

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

4.1 Hospital Admissions

Key Messages

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

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

Emergency Hospital Admissions

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

For people aged 65 years and over

In 2013/14:

There were 4,935 emergency admissions

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

admissions and had the highest associated cost.

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

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

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

Source: SUS data

Emergency Re-admissions

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

For people aged 65 years and over

In 2013/14:

There were 1,175 emergency readmissions

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

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

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

Source: SUS data

Urinary Tract Infection

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

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

Chronic obstructive pulmonary disease

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

Pneumonia

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

Falls

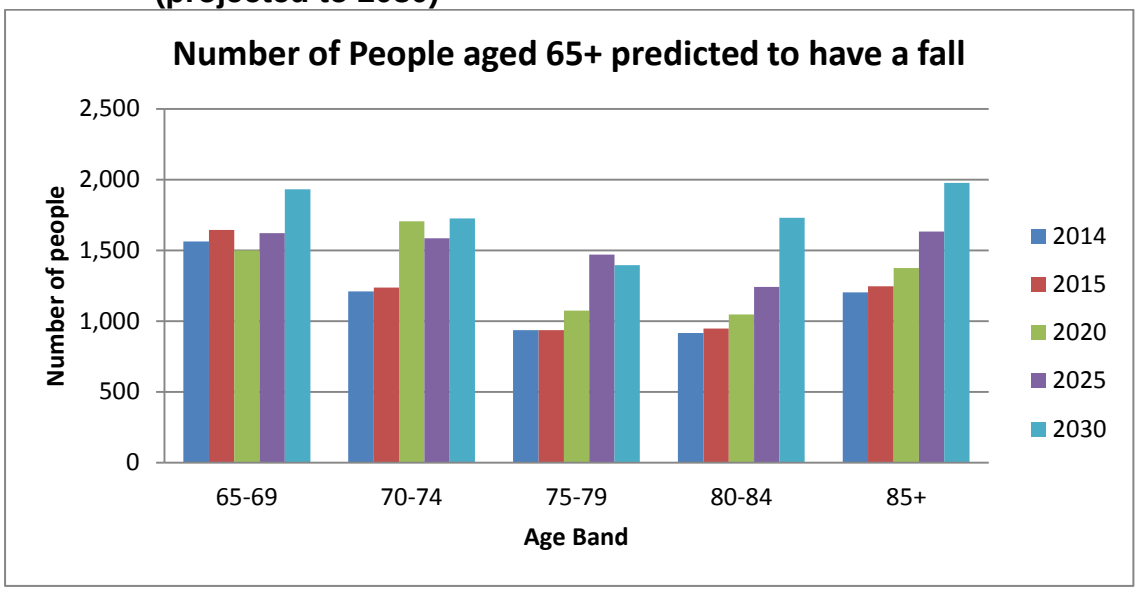
Hip fracture is the most common injury related to falls in older people and is a major cause of disability and the leading cause of mortality due to injury in older people aged 75 and over. NICE [66] report that 30% of people aged over 65 and 50% of people aged over 80 have a fall at least once a year.

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

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

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

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



Source: POPPI, version 9.0

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

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

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

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

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

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

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

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

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

Local Action

COPD & Pneumonia

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

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

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

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

Falls

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

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

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

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

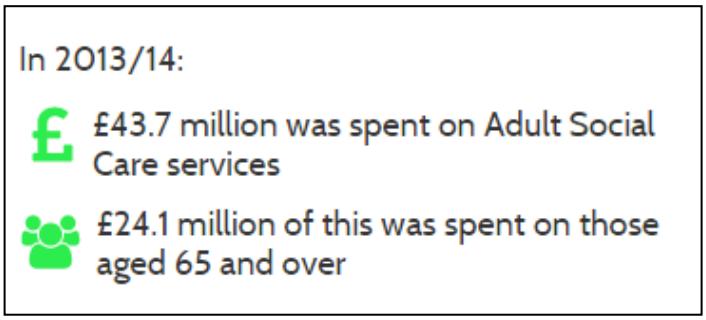
The **Well Homes project** which works with private sector housing, includes the identification and rectification of trip hazards.

4.2 Use of Social Care

Key Messages:

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

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



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

Source: [59]

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

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

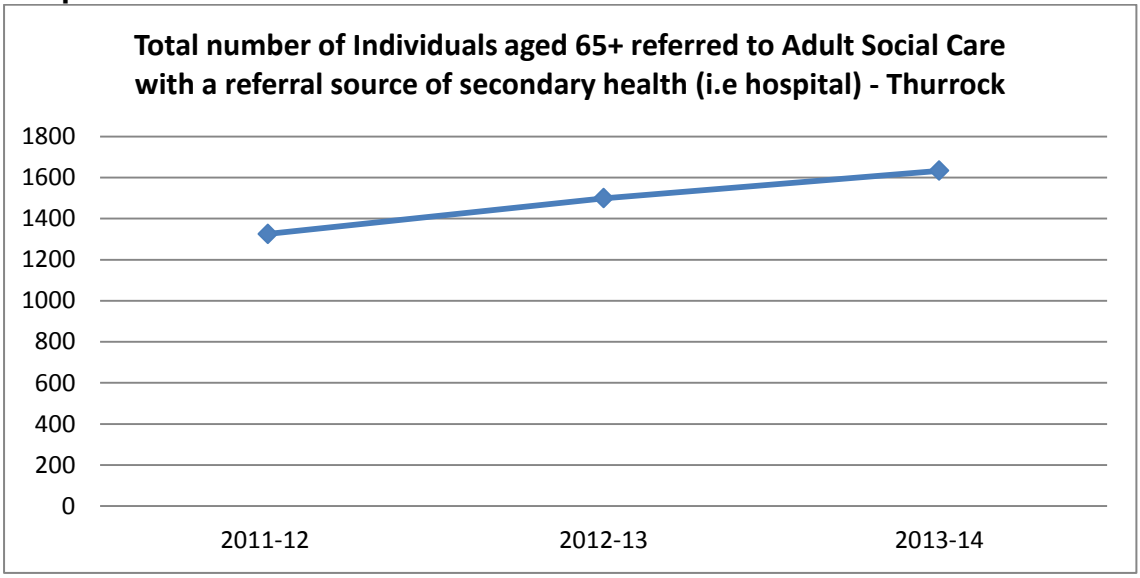
Table 3: Adult Social Care Outcomes Framework indicators relating to supporting people to maintain independence.

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

Source: HSCIC, 2014

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

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



Source: Thurrock Council Referrals to Social Care

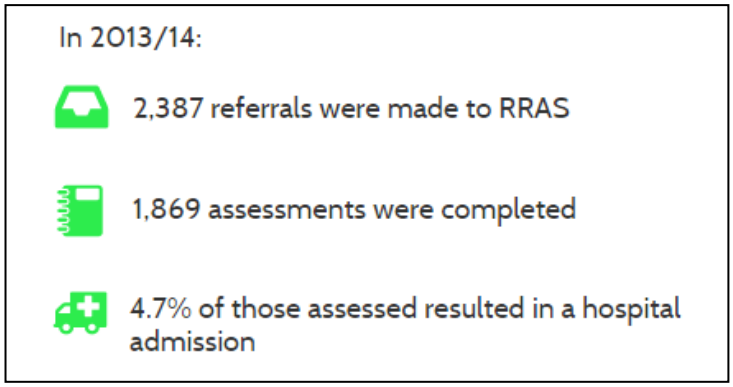
Figure 3 shows that there has been a steady rise over the last three years in those aged 65 and over being referred to adult social care from a secondary health source i.e. hospital. There were an additional 300 referrals in 2013/14 compared to 2011/12, which equates to a 23% increase.

Local Action

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

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

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



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

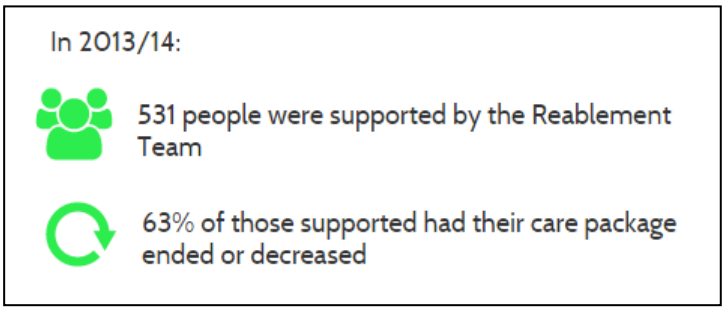
provider aimed at identifying individuals who are at risk of hospital admission and preventing that admission. The service relies heavily on GPs recognising those at risk and linking in to the service.

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

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

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

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



4.3 Long term conditions

Key Messages:

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

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

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

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

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

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

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

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

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

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

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

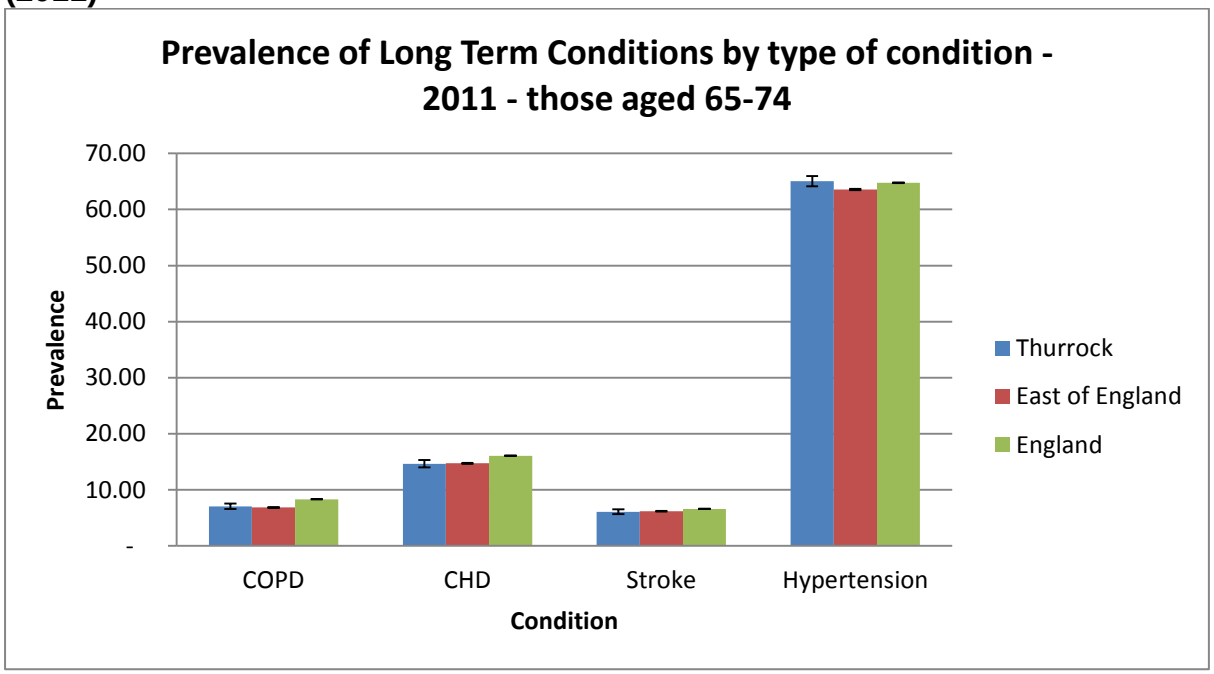
Table 4: Number of people on GP disease registers in Thurrock with a long term condition in 2013/14 (People aged 16 and over)

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

Source: Quality and Outcomes Framework (QoF)

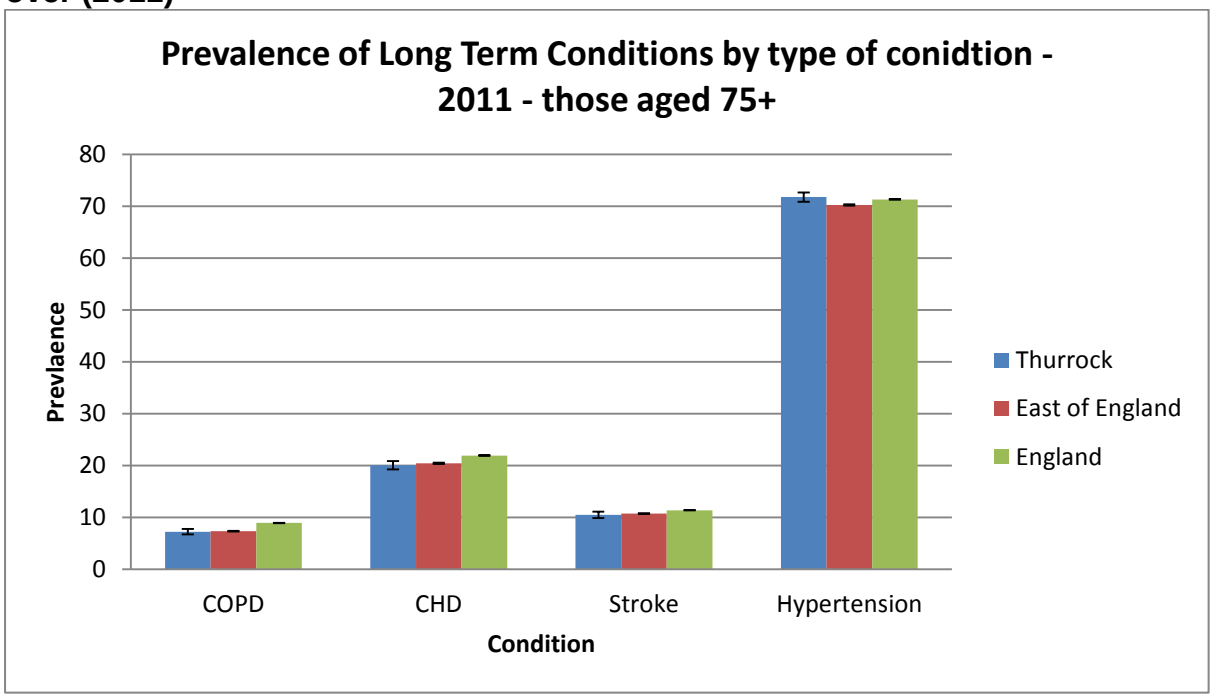
Modelled estimates of long term conditions based on local demographics for those aged 65-74 years (Figure 4) and those aged 75 years and over (Figure 5) indicate that the prevalence of these diseases is not significantly different to the national average.

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



Source: ERPHO

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



Source: ERPHO

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

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

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

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

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

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

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

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

Prevention of long term conditions - lifestyle behaviours

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

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

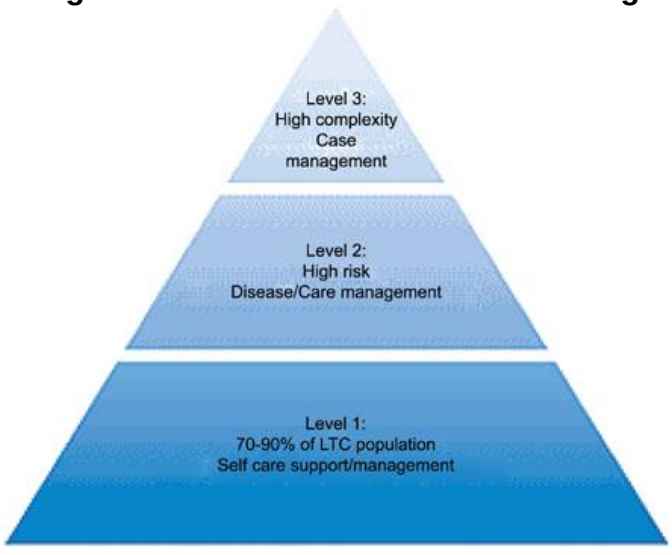
- vascular disease such as coronary heart disease, diabetes, chronic kidney disease
- some cancers e.g. lung and bowel
- respiratory disease such as chronic obstructive pulmonary disease (COPD)

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

Risk prediction and stratification

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

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



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

Source: Department of Health

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

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

Local Action

Early Diagnosis and Early Intervention

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

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

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

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

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

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

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

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

Local Action

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

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

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

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

Primary Care Management of Long Term Conditions

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

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

Community Based Care and Resources

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

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

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

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

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

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

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

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

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

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

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

Self-care

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

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

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

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

4.4 End of Life Care

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

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

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

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

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

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

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

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

Local Action

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

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

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

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

Recommendations:

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

Chapter 5 Carers

Key Messages:

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

Introduction

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

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

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

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

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

[91]

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

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

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

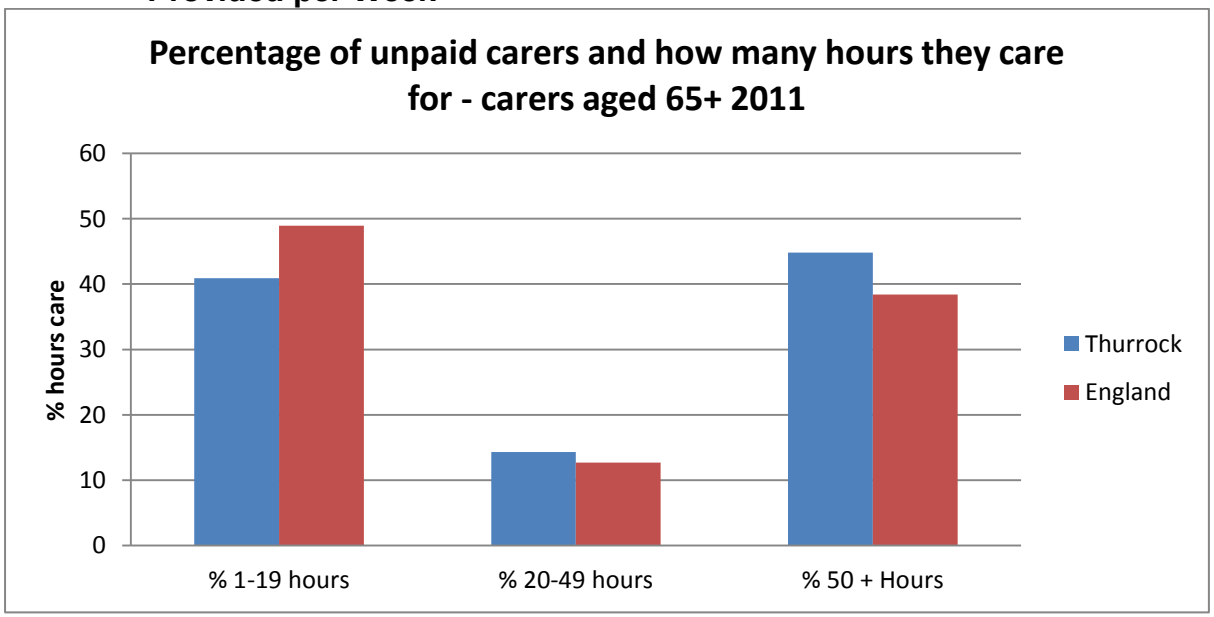
Although for many the experience of providing care can be rewarding, the consequences of caring can have detrimental effects on physical and mental health [93].

The Carers UK (2014) Carers Manifesto reported that:

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

[94]

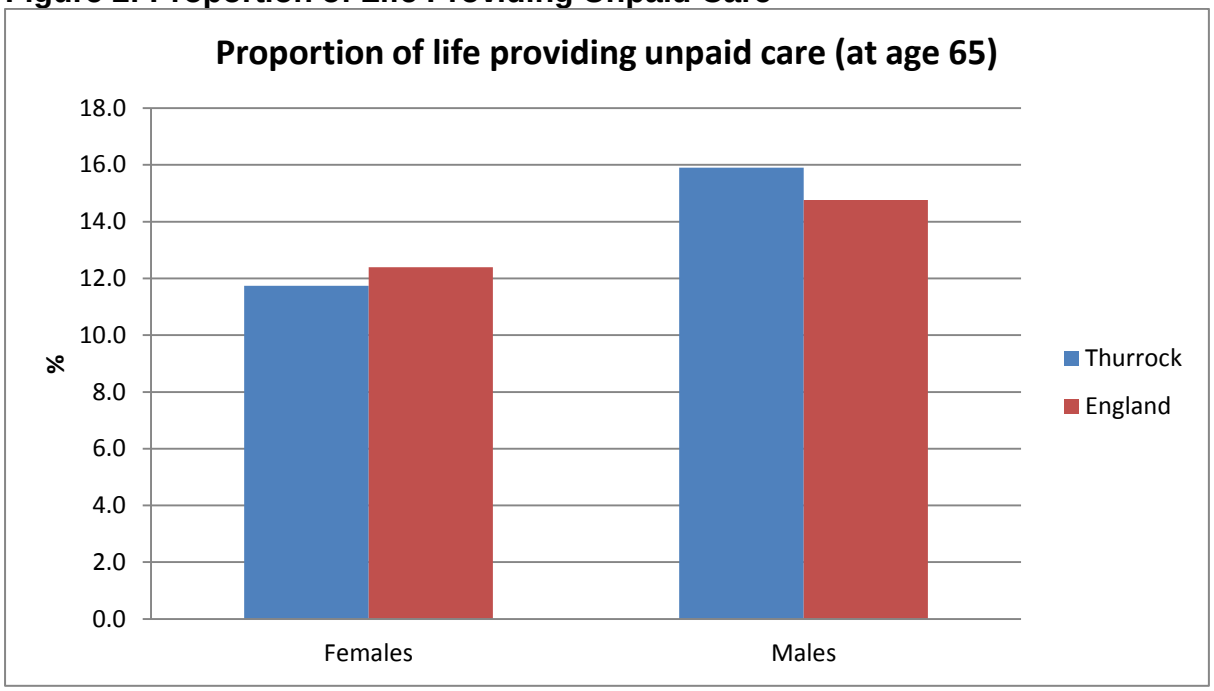
Figure 1: Unpaid Carers Aged 65+ years and Number of Hours of Care Provided per Week



Source: ONS

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

Figure 2: Proportion of Life Providing Unpaid Care



Source: ONS

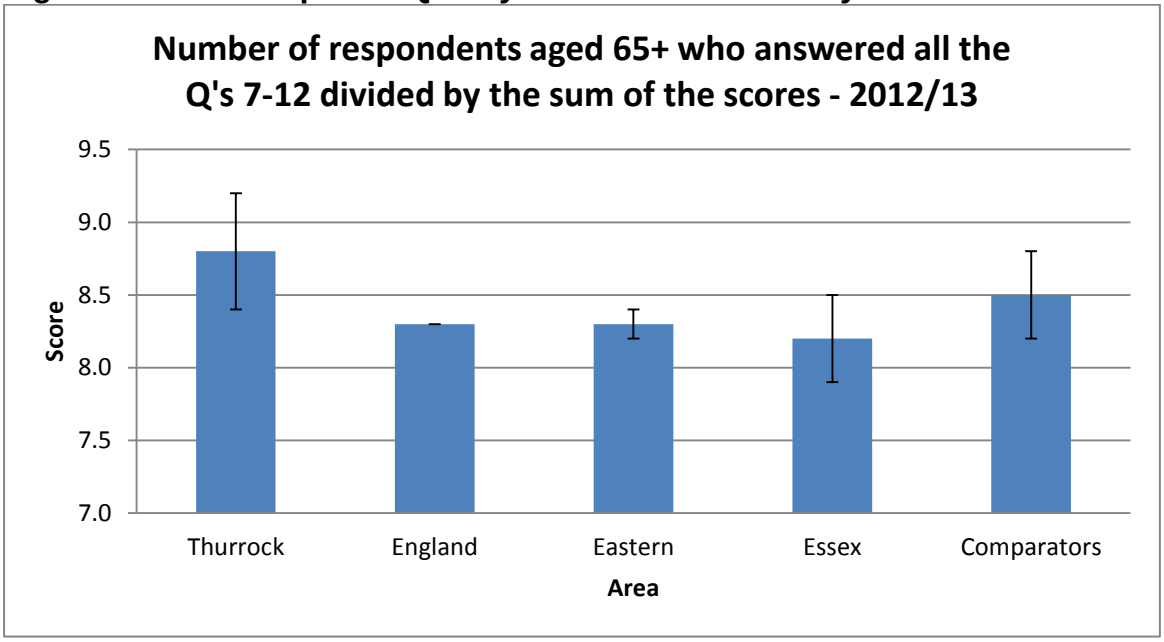
Figure 2 shows the proportion of life that is expected to be spent on unpaid care at age 65. It can be seen that in females the percentage (11.7%) is slightly lower than that of England overall (12.4%) but for males in Thurrock it is slightly higher (15.9%) than the England average (14.8%). In Thurrock,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

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

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

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

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



Source: HSCIC, 2013

Local Action

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

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

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

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

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

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

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

Recommendations:

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

Appendix 1 Update on Recommendations of 2013 Annual Public Health Report

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

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

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13 October 2015	ITEM: 10
Health & Wellbeing Overview and Scrutiny Committee	
Regeneration, Air Quality and Health	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Maria Payne, Health Needs Assessment Manager	
Accountable Head of Service: Ian Wake, Director of Public Health	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning / Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

A report by Dr Cate Edwynn, Interim Public Health Consultant, was presented to this committee on 17 February 2015 which summarised the evidence regarding health impacts of air pollution. This report provides an update on the subsequent actions taken by Thurrock Council, including the commissioning of an integrated Air Quality Strategy for the borough.

1. Recommendation(s)

1.1 The Health and Wellbeing Overview and Scrutiny Committee is asked to note the progress made from the previous report in developing an integrated approach to improving air quality to mitigate health risks.

1.2 The Air Quality Officers' Working Group presents the completed Air Quality Strategy to a future meeting in 2016, together with a proposed action plan.

2. Introduction and Background

2.1 A report previously presented to this committee on 17 February 2015 outlined the multiple sources and types of air pollution, and the associated acute and chronic health effects from exposure to air pollution. The committee subsequently supported the establishment of a cross-directorate Officers' Working Group with responsibility for identifying integrated actions and approaches to minimise the impact of air pollution on Thurrock's health and wellbeing.

3. Issues, Options and Analysis of Options

3.1 An Officers' Working Group has been established, and its membership includes officers from a range of disciplines including Planning, Public Health, Transport and Environment officers. The Group has discussed several opportunities to lower exposure to air pollution as well as reduce emissions; however resources and expertise were not available in-house to fully evaluate which options would be most effective in Thurrock.

3.2 A decision was taken to appoint SmallFish Strategy Consultants to develop an integrated Air Quality Strategy. SmallFish were selected due to their previous experience in developing air quality management plans for Thurrock Council and their extensive knowledge of the area.

3.3 The Strategy will be delivered in three sections:

- An Air Quality Evidence Base – this will incorporate local data and intelligence to improve understanding of the causes and extent of air quality issues in Thurrock.

- An Issues and Options report – this will address the key issues highlighted in the Evidence Base, identifying a list of potential options or interventions that could be used to improve air quality and related health. Each of these interventions will be assessed through a cost-benefit analysis in order to help prioritise measures.

- An Air Quality Strategy – this will be an expression of the preferred/ prioritised measures from the Issues and Options report, with an action plan and monitoring programme for realising the expected benefits.

3.4 The Air Quality Evidence Base has been completed in draft, and was produced in conjunction with Thurrock Council officers. It includes a detailed analysis of the most recent air quality monitoring data and modelling of other potential contributory factors. This is presented alongside analysis of numerous health data indicators which enable identification of communities who are particularly vulnerable to the impacts of poor air quality, such as those with respiratory and cardiovascular conditions.

3.5 SmallFish Consultants are currently in the process of producing the Issues and Options report. The Officers' Working Group is working with SmallFish to ensure the agreed potential options are effective and achievable.

3.6 The deadline for completion of the Strategy is January 2016.

4. Reasons for Recommendation

4.1 The committee is advised to note the process in place for mitigating the health impacts of air pollution in Thurrock and approve presentation of the Strategy at a future meeting to enable further discussion regarding the proposed action plan.

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

5.1 A report on Air Quality and Health was presented to the Health and Wellbeing Board on 15th June 2015. This was received favourably by members.

5.2 A presentation outlining the evidence of health impacts of air pollution, the key drivers for Thurrock and the proposed approach for an integrated strategy and Officers' Working Group was presented to the Health Watch Advisory Group on 3rd March 2015. Interest in this approach was noted by members.

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

6.1 The development of an integrated Air Quality Strategy and continued work of the Officers' Working Group will support the delivery of two of the Council's priorities:

- Improve health and well-being
- Promote and protect our clean and green environment

7. Implications

7.1 Financial

Implications verified by: **Michael Jones**

Strategic Resources Accountant

There are no direct financial costs arising from this report. Costs associated with monitoring of air quality must be contained within the associated revenue budget for Environmental Protection.

7.2 Legal

Implications verified by: **Chris Pickering**

Principal Solicitor

There are no legal implications – the previous report acknowledges the duties imposed upon local authorities by statute and that measures are being taken

to address Air Quality Management Areas (AQMAs) in Thurrock. Furthermore, the report is for noting only.

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 respiratory system or those with cardiovascular disease.

The implementation and ongoing monitoring of an integrated Air Quality Strategy will help to tackle existing air quality problems, particularly reducing the health impacts for people living and working in and around Air Quality Management Areas.

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 benefit of this integrated approach to reduce air pollution is the topic of this 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):

9. Appendices to the report

- "Air Quality, Regeneration and Health" – A report to Health & Wellbeing Overview and Scrutiny Committee on 17 February 2015.

Report Author:

Maria Payne

Health Needs Assessment Manager

Public Health Team

17 February 2015	**ITEM: 7**
Health and Wellbeing Overview and Scrutiny Committee	
Air Quality, Regeneration and Health	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Dr Catherine Edwynn, Interim Consultant in Public Health	
Accountable Head of Service: Debbie Maynard, Head of Public Health	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning / Dr Andrea Atherton, Director of Public Health	
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 to mitigate health risks.

There are a number of new local 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 The Health and Wellbeing Overview and Scrutiny Committee is asked to note the contents of this report.

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. LAQM is the main tool for local authorities to deal with problem areas of pollution.

[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

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.

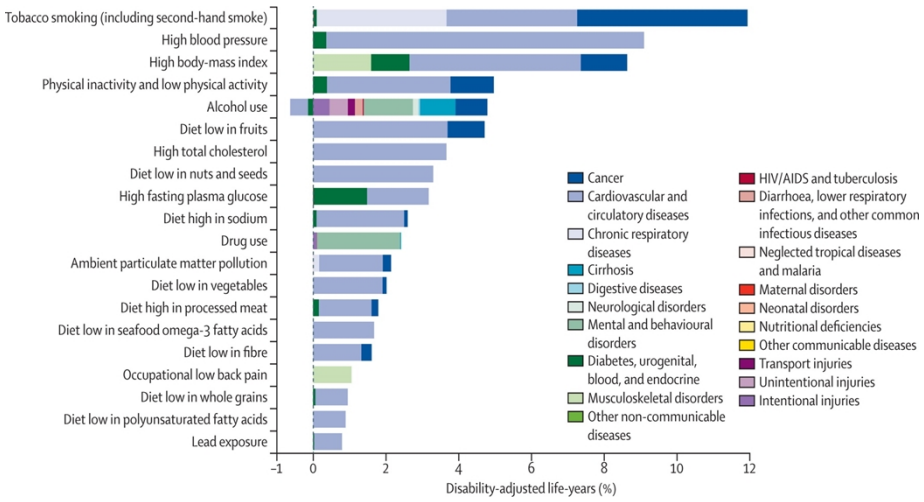
3. Issues, Options and Analysis of Options

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 Figure 1).

Figure 1: Ranking of risk factors for UK



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.

[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.

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 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

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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

[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.

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:
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, (≤ 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

[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

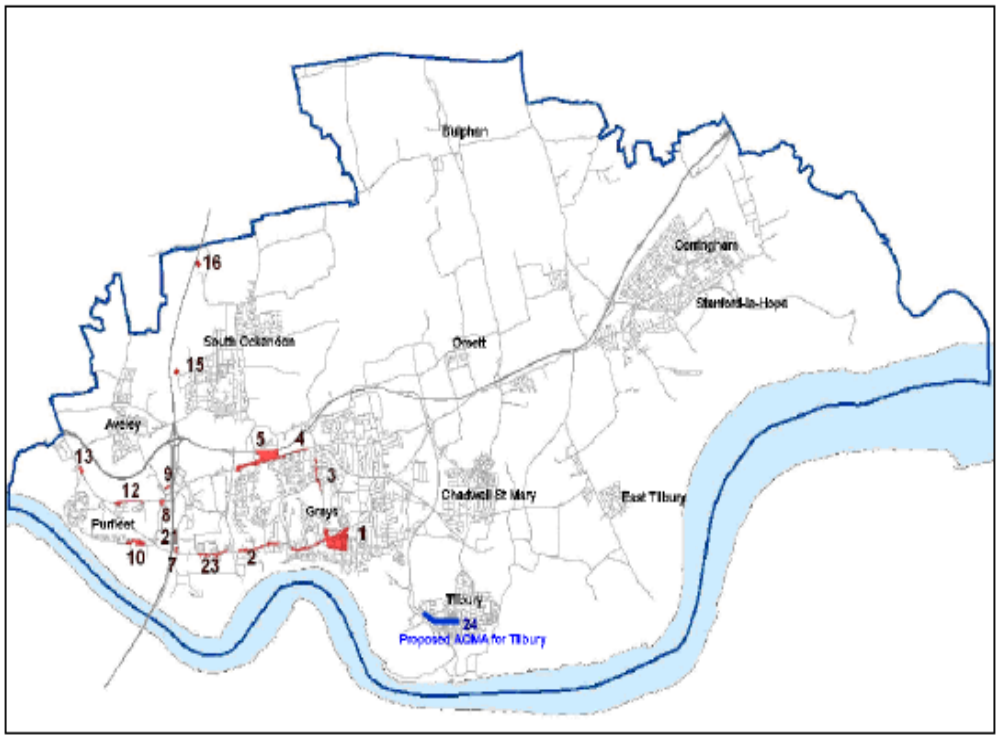
'Review of evidence on health aspects of air pollution (REVIHAA) project': suggests there is no safe level below which no adverse health effects occur.

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 Figure 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.

Figure 2: Thurrock Air Quality Management Areas



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

[13] Thurrock Council, July, 2014

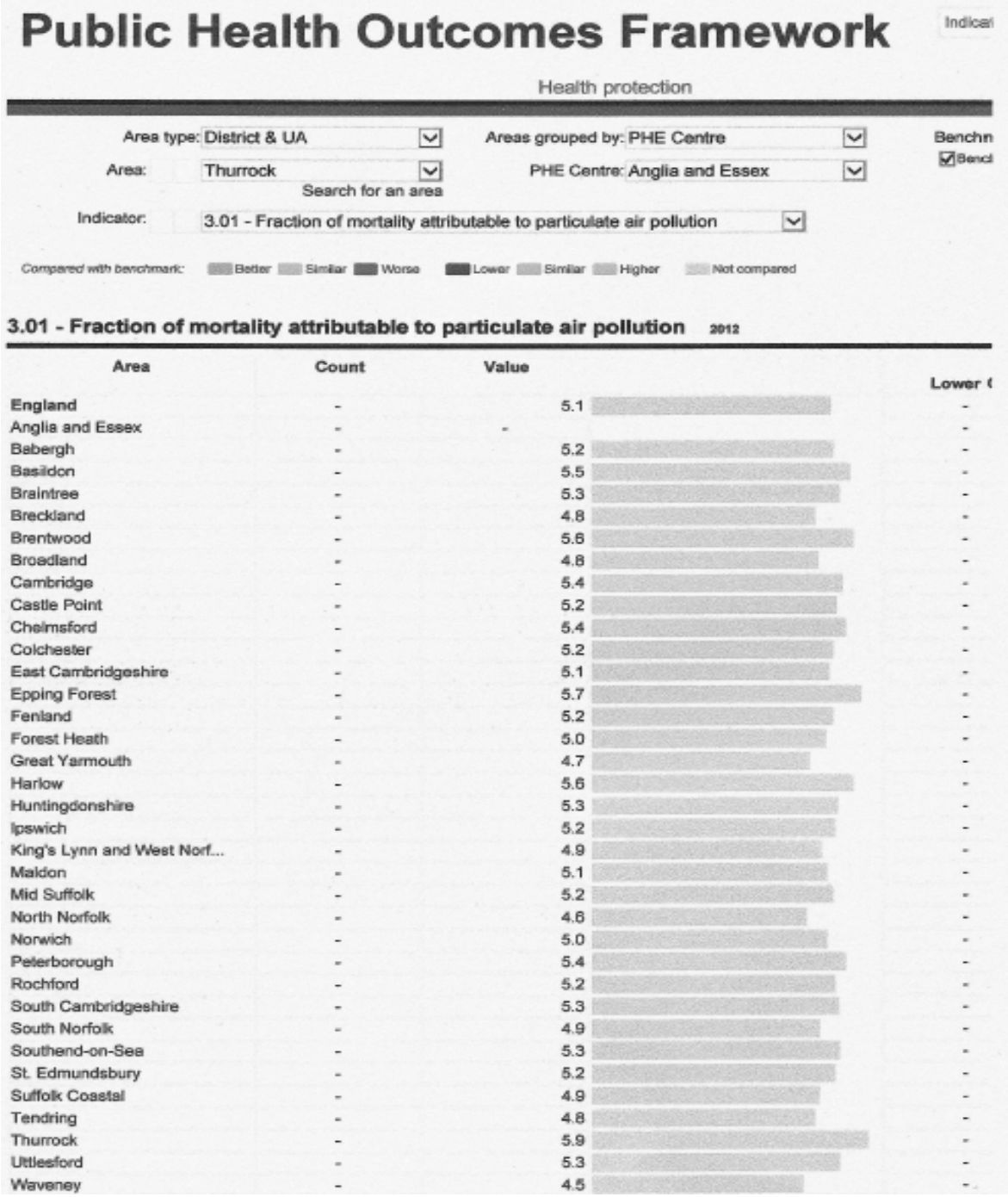
improvements required in order to comply with the air quality objectives. One of the main issues for Thurrock is that it is a major transport hub for Heavy Goods Vehicles (HGV's) and most of the current AQMA's in the west of the borough are impacted by the weight of traffic and HGV's moving along the 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 indicator on air pollution**
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, (Figure 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.

Figure 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	-

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. 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 That the Health and Wellbeing Overview and Scrutiny Committee notes the evidence regarding health impacts of air pollution and supports actions to mitigate the impact on the people of Thurrock.

4.2 That the Health and Wellbeing Overview Scrutiny Committee supports a cross-directorate response focused predominantly on lowering exposure as well as reduction of emissions to achieve health impact. This would be achieved by establishing an Officer Working Group which would report into Health and Wellbeing Board to help to identify and prioritise joined up action and approaches to improve the health experience of individuals and communities in Thurrock.

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

5.1 None

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 retained 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

None

Report Author: Dr Cate Edwynn

Report author contact details:

Name: Dr Cate Edwynn
Telephone: 01375 655035
E-mail: cedwynn@thurrock.gov.uk

Health Overview & Scrutiny Committee
Work Programme
2015/16

Dates of Meetings: 23 July 2015, ~~1 September 2015~~, 13 October 2015, 1 December 2015, 12 January 2016, 16 February 2016

Topic	**Lead Officer**	**Date**
Shaping the Council Budget Update – Proposals from Adult Social Care to meet savings target	Roger Harris	23 July 2015
Transforming Adult Social Care	Roger Harris/Ceri Armstrong	23 July 2015
Thurrock Walk-in-Centre	Mandy Ansell	23 July 2015
Success Regime	Mandy Ansell	23 July 2015
Primary Care	NHS England	23 July 2015
Reduction in Public Health Grant	Roger Harris/Ian Wake	23 July 2015
MEETING CANCELLED DUE TO INSUFFICIENT BUSINESS		1 September 2015
Items raised by HealthWatch (include Coach House)	Kim James	13 October 2015
Annual Complaints Report	Harminder Dhillon	13 October 2015
Consultation on proposed changes to the way Social Care is provided in Thurrock	Roger Harris	13 October 2015
Meals on Wheels Update	Roger Harris	13 October 2015
Annual Public Health Report 2014	Ian Wake	13 October 2015
Regeneration, Air Quality and Health	Ian Wake	13 October 2015

Last Updated: 31 July 2015

Learning Disability Health Checks	Cowie Alison, Head of Primary Care Commissioning, NHS England	1 December 2015
Fees and Charges Report	Laura Last / Sean Clark	1 December 2015
Primary Care	Mandy Ansell – NHS England	1 December 2015
Success Regime	Mandy Ansell	1 December 2015
Transforming Adult Social Care	Roger Harris/Ceri Armstrong	1 December 2015
Items raised by HealthWatch	Kim James	1 December 2015
Shaping the Council Budget Update on themed items as and when required	Sean Clark	12 January 2016
Health and Wellbeing Strategy 2016-2019	Ceri Armstrong	12 January 2016
Items raised by HealthWatch	Kim James	12 January 2016
Shaping the Council Budget Update on themed items as and when required	Sean Clark	16 February 2016
		16 February 2016
Items raised by HealthWatch	Kim James	16 February 2016