Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Board

The meeting will be held at **10.30 am** on **23 November 2018**

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

Membership:

Councillors James Halden (Chair), Robert Gledhill, Susan Little, Barbara Rice and Tony Fish

Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board
Steve Cox, Corporate Director for Place
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Roger Harris, Corporate Director of Adults, Housing and Health
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust
Rory Patterson, Corporate Director of Children's Services
David Archibald, Independent Chair of Local Safeguarding Children's Board
Andrew Pike, Managing Director Basildon and Thurrock Hospitals Foundation Trust
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust
Michelle Stapleton, Director of Integrated Care, Basildon and Thurrock University Hospitals Foundation Trust
Gillian Ross, Lay member, Thurrock CCG
Ian Wake, Director of Public Health
Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways
Adrian Marr, NHS England - Essex and East Anglia Region.

Agenda

Open to Public and Press

1 Apologies for Absence

2 Minutes **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 21 September 2018.

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 Declaration of Interests

5 STP Update

A verbal update will be provided to members by Mandy Ansell, Accountable Officer Thurrock CCG

6 Plan on a Page and Educational Attainment Outcomes (Provisional) **13 - 26**

Item will be presented by Andrea Winstone, School Improvement Manager, Children's Services. A copy of the PowerPoint presentation is included within member's packs

7 Whole Systems Obesity Strategy **27 - 66**

Item will be presented by Faith Stow, Public Health Programme Manager.

Members have been provided with a copy of the Whole Systems Obesity Strategy and PowerPoint presentation in their meeting papers

8 Annual Report of the Director of Public Health - Healthy Housing for the Third Age: Improving Older People's Health through Housing **67 - 112**

Item will be presented by Andrea Clement, Assistant Director, Public Health.

Members have been provided with a covering report and the executive summary within their meeting papers.

Members were sent a copy of the full report electronically with the meeting papers

9 Integrated Care Alliance Memorandum of Understanding **113 - 122**

Members are being provided with an update on the Integrated Care Alliance Memorandum of Understanding.

Members have been provided with a covering report and copy of the Memorandum of Understanding

10 Integrated Commissioning Executive Minutes **123 - 126**

For members to consider and comment upon ICE minutes of August 2018

11 Work Programme **127 - 130**

To consider future work-plan for HWB

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - Commissioning by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **15 November 2018**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

Minutes of the Meeting of the Health and Wellbeing Board held on 21 September 2018 at 10.30am

Present:	Councillors James Halden (Chair), and Tony Fish Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group (Thurrock CCG) Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG Roger Harris, Corporate Director of Adults, Housing and Health Kim James, Chief Operating Officer, Healthwatch Thurrock Malcolm McCann, Executive Director of Community Services and Partnerships South Essex Partnership Foundation Trust Andrew Pike, Managing Director BTUH Jeanette Hucey, Director of Transformation, Thurrock CCG Ian Wake, Director of Public Health Gillian Ross, Laymember, Thurrock CCG
Apologies:	Cllr Robert Gledhill, Susan Little and Barbara Rice Dr Anjan Bose, Clinical Representative, Thurrock CCG Graham Carey, Independent Chair of Thurrock Adults Safeguarding Board David Archibald, Independent Chair of Local Safeguarding Children's Board Adrian Marr, NHS England Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust Julie Rogers, Chair Thurrock Community Safety Partnership / Director of Environment and Highways Kristina Jackson, Chief Executive Thurrock CVS Rory Patterson, Corporate Director of Children's Services Tom Abell, Deputy Chief Executive and Chief Transformation Officer Basildon and Thurrock University Hospitals Foundation Trust Steve Cox, Corporate Director for Place
Did not attend:	Dr Anand Deshpande, Chair of Thurrock CCG
In attendance:	Tania Sitch represented by Rita Thakaria, Maria Payne (Public Health) Malcolm Taylor (Thurrock Council, Children's Directorate) Elozona Umeh (Public Health).

1. Welcome and Introductions

Apologies were noted.

2. Minutes

The minutes of the Health and Wellbeing Board meeting held on 20 July 2018 were approved as a correct record.

3. Urgent Items

There were no urgent items raised in advance of the meeting.

4. Declaration of Interests

There were no declarations of interest.

5. Mid & South Essex Sustainability and Transformation Programme (STP) Update

Mandy Ansell, Accountable Officer, Thurrock CCG provided members with a verbal update. The following points were made:

- The first meeting of the People Panel, created to help inform the relocation of services and ensure continued community engagement, had taken place and membership has been agreed.
- It has previously been agreed that services provided to Thurrock residents by Orsett will remain available in Thurrock and that Integrated Medical Centres are key to facilitating a transfer of services between locations.
- Members were advised that Cabinet had approved the request to tender for building works for Tilbury and Chadwell IMC.
- Members raised concern about the limited planning and project management material that is readily available for partners. It was agreed that Roger Harris, Corporate Director for Adult Housing and Health, Mandy Ansell, Accountable Officer Thurrock CCG and Andrew Pike, Managing Director BTUH will meet and consider pathways and plans for implementation.

Action Roger Harris, Mandy Ansell and Andrew Pike

RESOLVED: HWB members noted the update and provided comments.

6. SEND

SEND JSNA
Thurrock Council and Thurrock CCG SEND Priorities

Members were provided with three presentations by Helen Farmer (Thurrock CCG), Malcolm Taylor (Thurrock Council, Children's Directorate) and Elozona Umeh (Public Health). Key points included:

<u>JSNA</u>

- Thurrock Council has a statutory duty to provide certain children and public health services to children and young people aged 0-19 living in the borough. This includes provision for children with Special Educational Needs and Disability (SEND) from age 0-25 years.
- To enable the council's Public Health team alongside Children's Services and the CCG to commission services effectively, a Joint Strategic Needs Assessment (JSNA) is required to identify level of

need, characteristics of children and young people with SEND, their health and wellbeing needs as well as current and future demand for services.

- The main recommendations identified within the JSNA included greater collaborative work between education, health and social care, development of a SEND strategy, further improvement in local data to aid detailed modelling of expected demand on services, enhancement of the local offer, strengthening of transition between child and adult services and re-commissioning of short break provision.
- The number of children and young people aged 0 - 25 in Thurrock is set to increase over the next decade by approximately 10%.

Thurrock Council and Thurrock CCG SEN Priorities

- All CCG key priorities underpinned by The Children and families ACT 2014 and SEND Code of Practice 2014
- Thurrock CCG has a designated SEND Clinical Officer who has oversight across the range of health professionals delivering care to children with SEND, promotes best practice and works across service boundaries to enhance the provision of health care to children with complex health needs and medical conditions.
- The SEND Champions Health Forum Meeting meets monthly with provider agencies. The Forum aims to raise visibility and awareness across providers and enhance practice through, empowerment, effective communication and inter team working. The Forum also shares best practice and specific case discussions to provide opportunities to reflect on practice.
- Thurrock CCG and Council are utilising an integrated audit tool which can align priorities and support coordination of action plans.
- NHS England East – Collating data and forming networks to support the health SEND agenda supported by the DFE regional advisor.
- Key areas identified: Multiagency outcome measures, joint commissioning intentions, co-production.
- Thurrock Council is responsible for the Local Area Special Educational Needs and Disability Strategy 2018-2020. Key Strategic Priority Areas include to ensure:
    - That children and families are at the heart of an effective SEN system
    - Every child and young person is making good progress and attends a good place to learn
    - Children and families are well supported
    - An effective and responsive approach to assessing and meeting children and families' needs.

During discussions the following points were made:

- It is important to ensure that transitional arrangements are robust and enable people to continue to access relevant services during the transition from being a child to adulthood.
- Substantial work that has been undertaken over the last few years was acknowledged by members and action has been taken to improve performance which includes a staffing review and utilising data across the system to inform medium to long term planning.

- Members noted that East Tilbury Primary School has made impressive progress and specialist schools Treetops and Beacon Hill are rated as outstanding.

RESOLVED: Health and Wellbeing Board members:

- Provided comments upon the JSNA and approved the recommendations made Agree to the publication of the SEND JSNA and noted SEND priorities and action for both Thurrock Council and Thurrock CCG.

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7. Mental Health Peer Review follow up report and recommendations - Adult Mental Health Service Transformation in Thurrock

Ian Wake, Director of Public Health introduced this item. Key points included:

- There has been considerable effort undertaken within Thurrock to transform local health and care services over the last three years including plans to create four new Integrated Medical Centres, a *New Model of Care* for Tilbury and Chadwell, the *Stronger Together* programme of community development and asset-based approaches, a Thurrock *Integrated Care Alliance,* the joint *For Thurrock in Thurrock* CCG-Adult Social Care programme and considerable efforts to transform Primary Care services. However mental health systems transformation has not perhaps featured as strongly as it should within these programmes to date.
- Public Health have committed to fund a new Strategic Lead post a key remit of working with all stakeholder organisations and local service users to develop a new Thurrock Mental Health Systems Transformation strategy and associated new models of care and commissioning arrangements.
- By triangulation of the intelligence, evidence and recommendations set out in the Mental Health JSNA, LGA Peer Review and User Voice, this paper proposes five Key Themes that warrant attention of local system leaders in order to improve and transform local mental health services for the benefit of Thurrock residents. These are summarised below and then discussed in turn in the context of the published evidence base, policy and other local intelligence.
    - Addressing Under-Diagnosis
    - Getting into the system
    - A new treatment offer for Common Mental Health Disorders
    - A new 'enhanced treatment' model including a greater focus on prevention and early intervention
    - Integrated Commissioning

During discussions the following points were made:

- Thurrock CCG are leading the commissioning of mental health services across Mid and South Essex. It was agreed that Ian Wake would be invited to an event scheduled for 27 September which will consider redesigning mental health support.
- Board members welcomed the report and the clear sense of direction which it provides. It was acknowledged that mental health should be embedded and made available within the new Integrated Medical Centres. It will be important to ensure that IMCs are not primarily focussed on providing primary and acute care services.

- The Winter Planning Operational Group is now established and will consider mental health. It was agreed that a strategic mental health planning group should be established to support improved planning and stimulate capacity modelling.
- The challenging environment within which EPUT operates (across 7 CCGs and 3 Local Authorities) was acknowledged given each area wishes to create comprehensive mental health support. The merits on considering services that could be focussed across Essex or within specific geographical locations were acknowledged
- Members acknowledged the increased demand experienced at BTUH which is often used as a place of safety for people detained under Sections 135/136 of the Mental Health Act.

RESOLVED: Health and Wellbeing Board members provided feedback on the high level recommendations made within the 'Next Steps' sections of the paper and on the questions posed within it.

8. Emotional Wellbeing in Schools Thurrock Dementia Local Action Plan

Elozona Umeh, Public Health, presented this item. This Key points included:

- It is clear from both local research and discussions with Head Teachers and NHS partners, that there is a need for more mental health support for children and young people (CYP) and schools in Thurrock.
- There is an increase in demand for treatment services and pressure is being placed on schools and colleges to cope with emerging issues around mental health.
- The CYP JSNA 2018 discussed the increasing incidence of mental health problems in children and young people at both a national and local level, and the associated rising demand on treatment services.
- The School Wellbeing Service is a partnership model between Thurrock Council, Thurrock Clinical Commissioning Group and Thurrock schools and academies that will primarily focus on prevention in order to strengthen and improve the emotional and mental wellbeing of children and young people as well as school staff, in response to feedback from the Schools Mental Health Summit.

During discussions the following points were made:

- Members welcomed the link to Open Up Reach Out and that Children's Directorate and Thurrock CCG has been engaged in developing proposals for school wellbeing teams in schools in response to the Government's Green Paper.

RESOLVED: members approved the strategic direction of travel for improving children and young people's mental health and wellbeing and provided feedback on the proposed school wellbeing service model.

9. Integrated Care Alliance Memorandum of Understanding (MOU)

Roger Harris provided members advised members that Thurrock Integrated Care Alliance comprising key partner agencies had developed a MOU to support the alignment and integration for planning and delivering health and care services. Members were advised that the draft MOU would be presented to the Board at its meeting in November for comment.

Board members acknowledged the importance of ensuring that the MOU is right and shows how partners will work together as a single system.

10. Report on BTUH visit

Cllr Halden introduced the item by explaining that Health and Wellbeing Board members visited BTUH on Friday 24 August 2018 to consider the impact of interventions introduced within the hospital to effectively manage an increase in demand experienced by the A&E department.

The visit was arranged as part of understanding how measures taken were impacting on the patient's experience in A&E and to explore how previous issues considered by the HWB are managed at BTUH. These included:

- The potential increase in Sepsis and the work that has been done so that people can identify early signs of Sepsis.
- A&E waiting times and performance
- The work that the BTUH had undertaken to stream patients to the most appropriate service
- The impact of providing a GP service based at BTUH whose role is to divert patients that can be seen by the GP away from A&E
- Work of the Social Care discharge team
- Creating of space within A&E to effectively manage patients experiencing mental ill health
- Cllr Fish's experience when he visited A&E during a particularly busy time

Members welcomed the visit and those that participated found it helpful. Members learned about the robust presentation on action being taken by BTUH on identifying and treating Sepsis.

11. Cancer Care Report

Andrew Pike, Managing Director BTUH, provided members with a presentation on Cancer Care. Key points included:

- The number of people waiting 28 days for diagnosis now been halved
- A range of control documents have been developed that support the effective management of the identification and treatment of cancer
- Senior management consider a weekly dashboard that sets out referrals and outpatients
- Every single patient is now monitored and a daily escalation process has been introduced,
- As a result of action taken approximately 96% of patients will not be diagnosed with cancer at the two weeks referral.
- GP referral system can help patients to understand the pathway that they are on and the importance of attending appointments within two weeks for diagnosis.

During discussions the following points were made:

- Members acknowledged and welcomed the comprehensive action taken to ensure cancer can be diagnosed and treated earlier.
- Health Watch may be able to provide support with identifying whether patients understand the two weeks wait target and what it means for them.

12. Integrated Commissioning Executive and Health and Wellbeing Executive minutes

RESOLVED: Members considered and noted ICE minutes for meetings that took place in May, June and July 2018

13. Work Programme

RESOLVED: The Board noted the future work programme.

The meeting finished at 13.20hours. Approved as a true and correct record

CHAIR……..

DATE……

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thurrock.gov.uk

School Improvement-

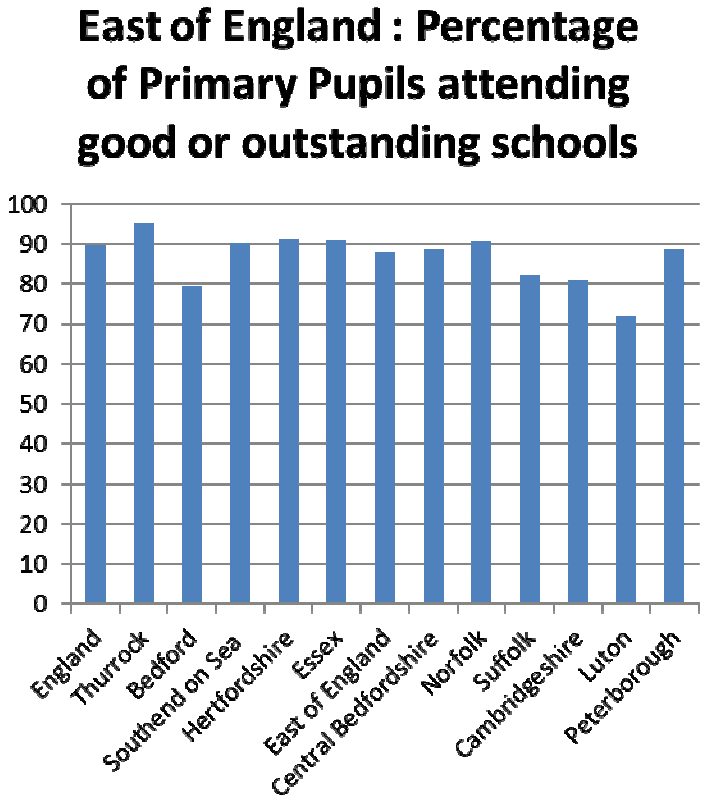
Andrea Winstone
School Improvement Manager

September 2018

Health and Wellbeing Strategy – Goal 1 Opportunity for All

We want to achieve better educated children and residents who can access employment opportunities

- **Objective 1A. All children in Thurrock making good educational progress**
- Objective 1B. More Thurrock residents in employment, education and training
- Objective 1C. There will be fewer teenage pregnancies
- Objective 1D. Fewer children and adults will live in poverty


East of England : Percentage of Primary Pupils attending good or outstanding schools
100
90
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70
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50
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England
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Hertfordshire
Essex
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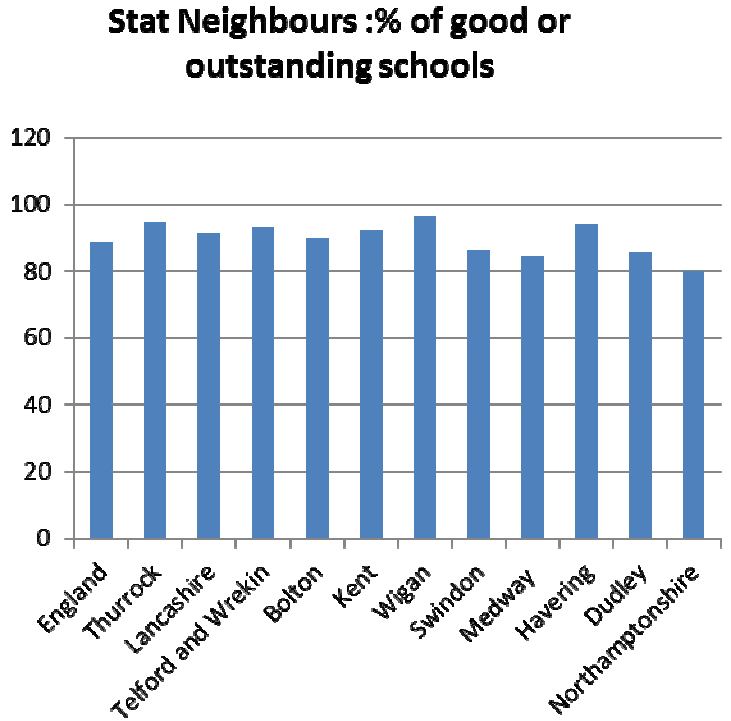
Central Bedfordshire
Norfolk
Suffolk
Cambridgeshire
Luton
Peterborough


Stat Neighbours :% of good or outstanding schools
120
100
80
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40
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England
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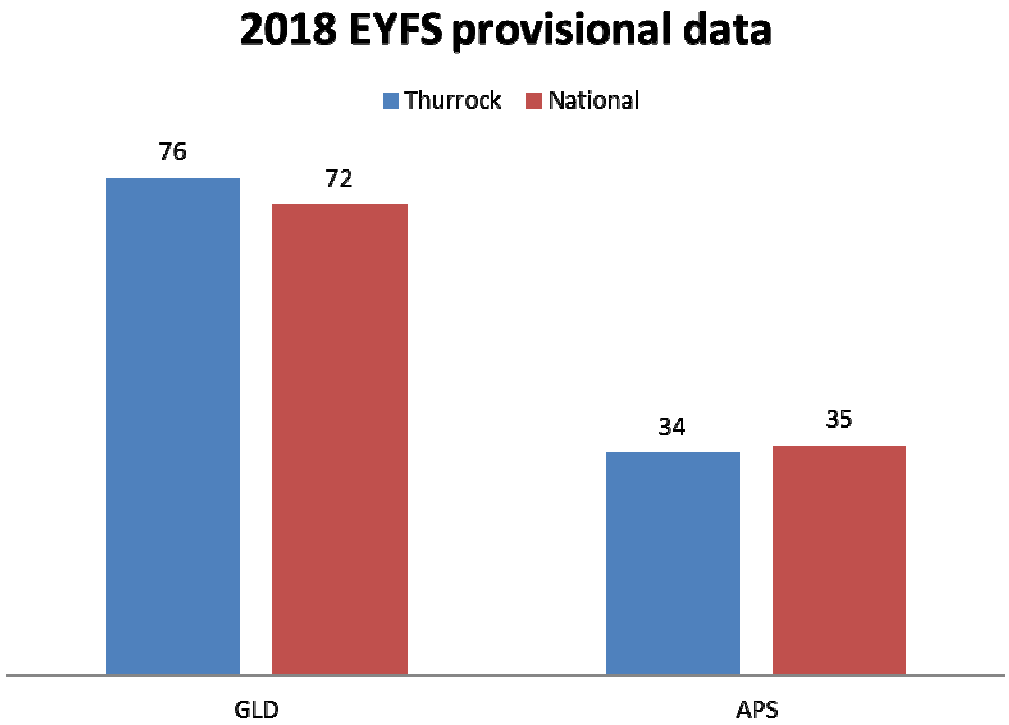
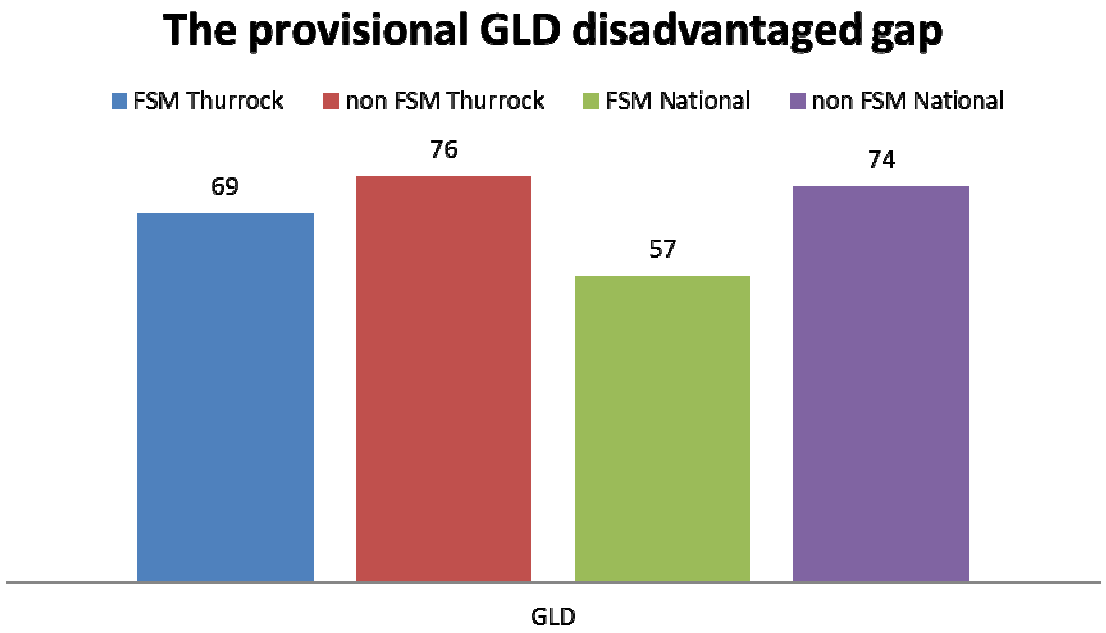
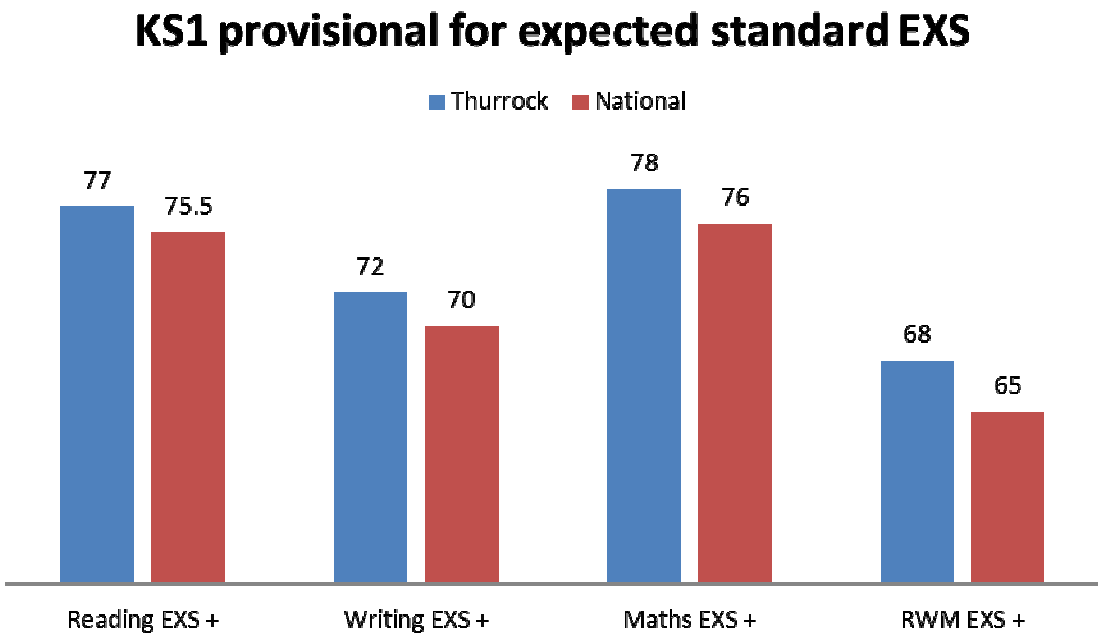


The provisional GLD result for Thurrock is very encouraging as it puts the borough scores above the national and above others in the East of England region. This is an outcome of significant investment in school improvement staff for this phase and expertise in training and supporting staff in schools and settings.

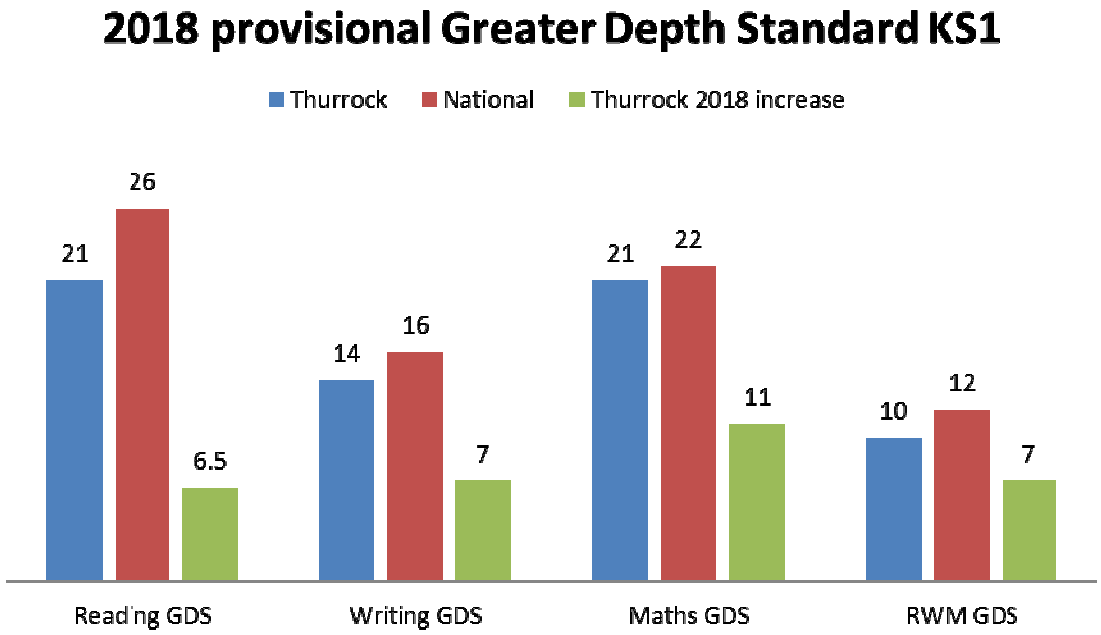
This shows the percentage of children who achieved a Good Level of Development (GLD) at the end of their Reception year



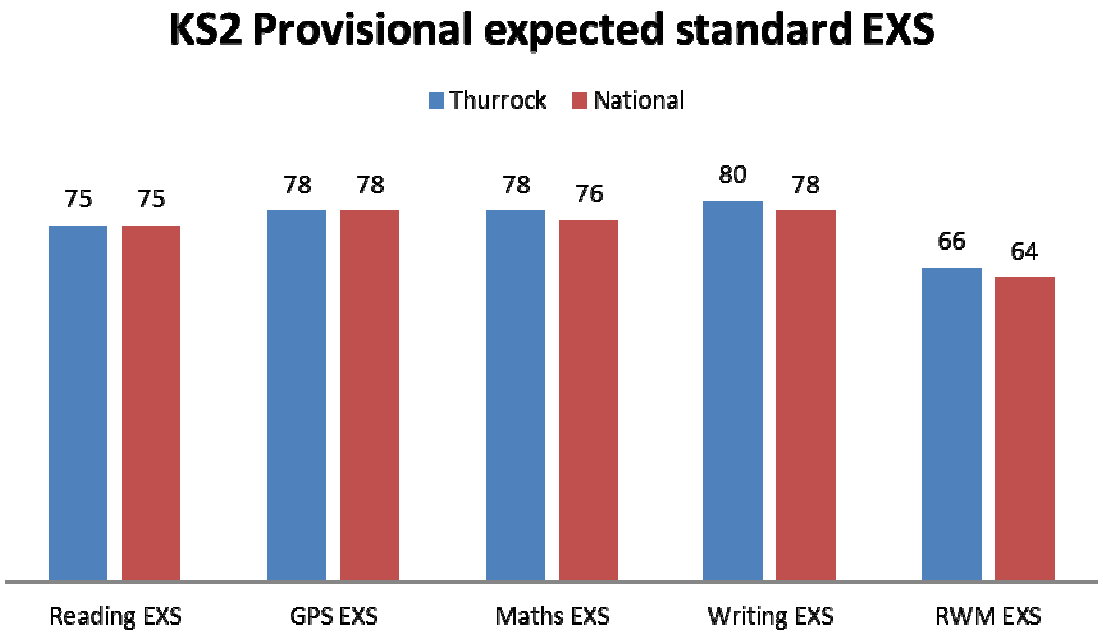
The disadvantaged gap measures the percentage gap in GLD between the children eligible for free school meals and all other pupils. The target is to close the gap to ensure disadvantaged pupils achieve at least as well as their peers. The national gap remains high at 18%, whilst the gap for Thurrock pupils is 7%. This is a reduction on the previous year of 11%.



There has been a three year improving trend in all subjects at key stage 1 for the percentage of pupils achieving the expected standard.

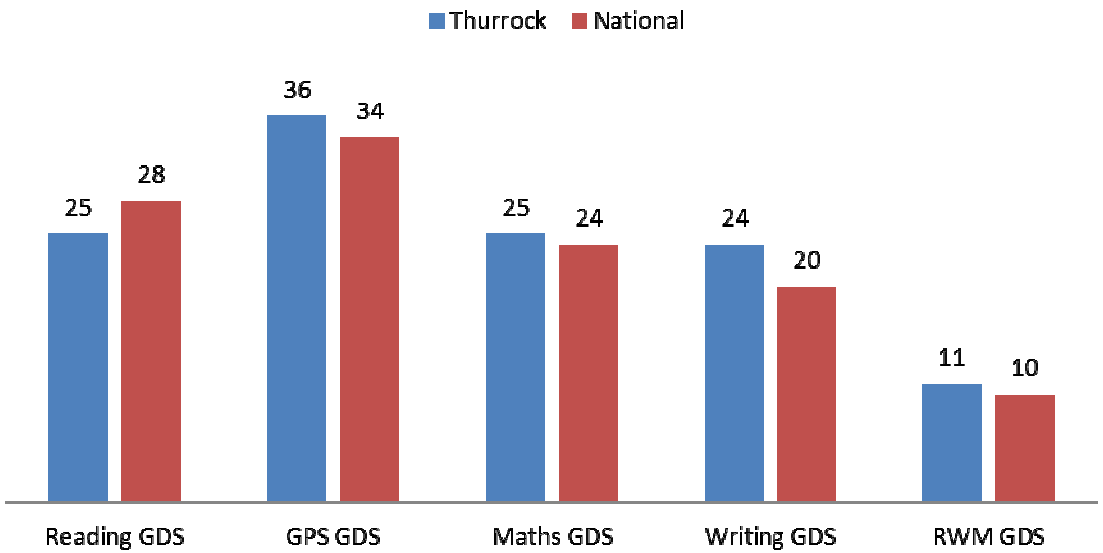


Whilst the percentage of pupils achieving the greater depth is lower than the national, Thurrock has seen a marked improvement on the previous year (green column). This is as a result of greater teacher confidence in the revised curriculum and a focus on ensuring more pupils achieve greater depth.



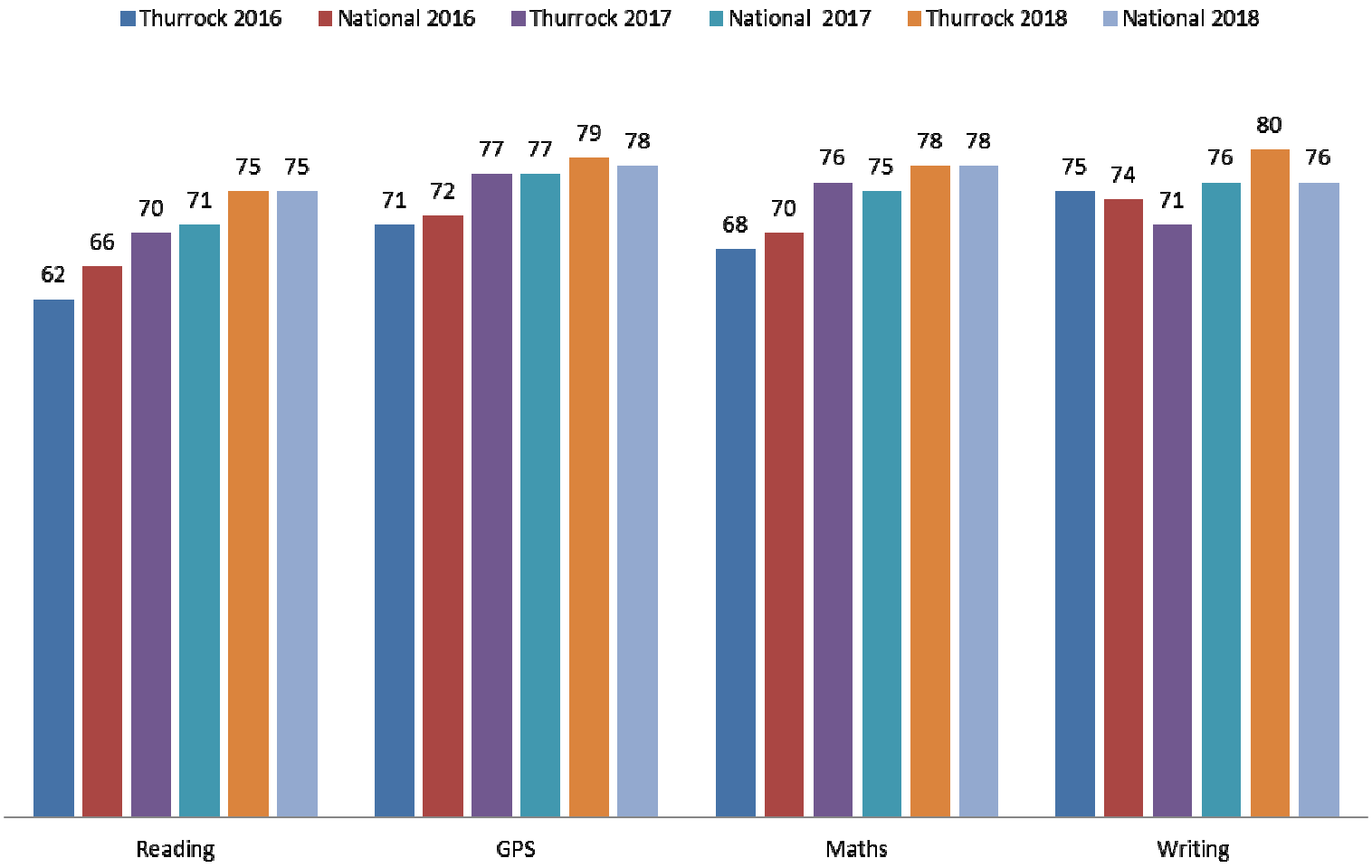
End of KS2 results have continued to improve. The outcomes for Thurrock are now in-line or better than national averages in most areas.

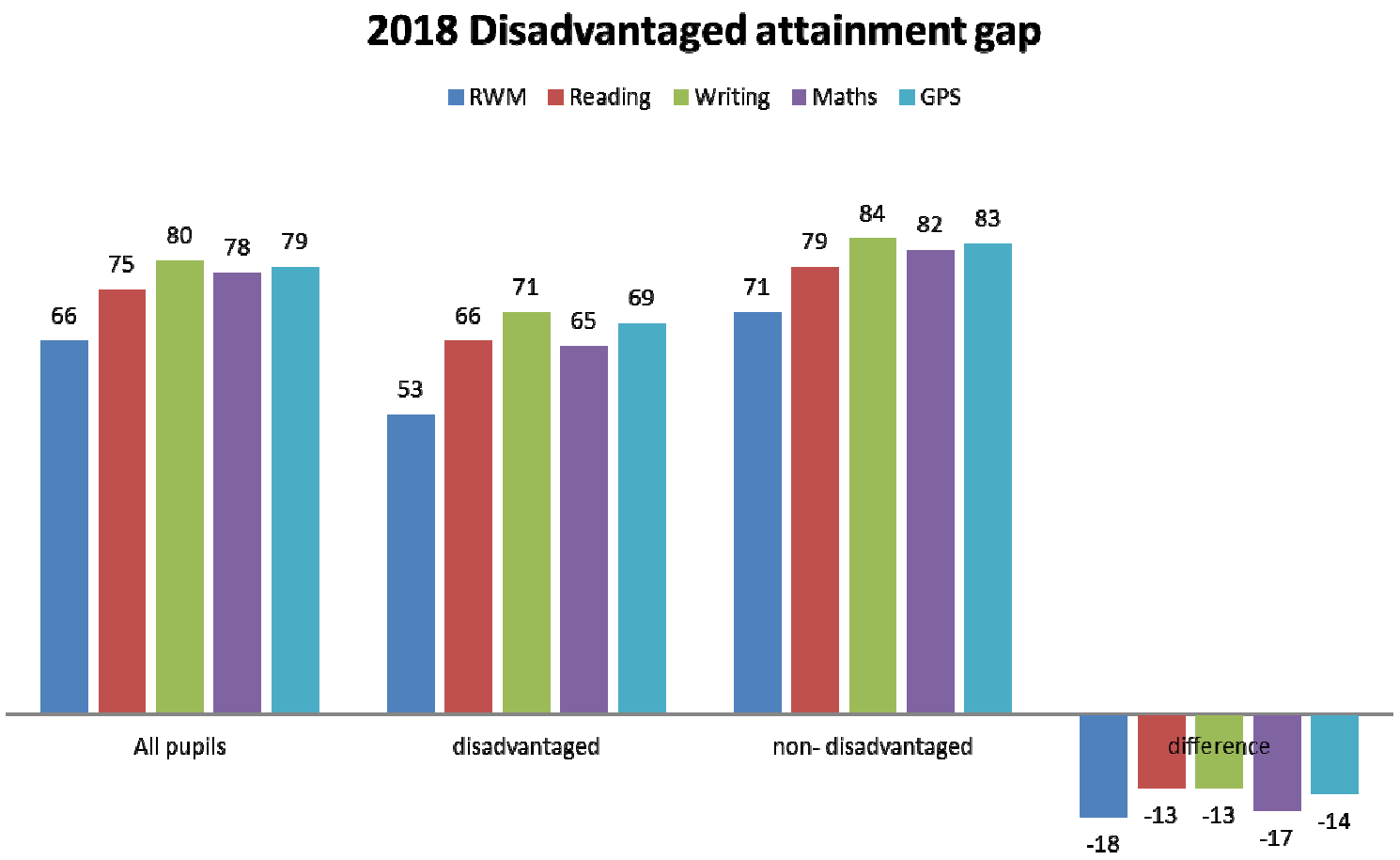
KS2 provisional greater depth standard GDS



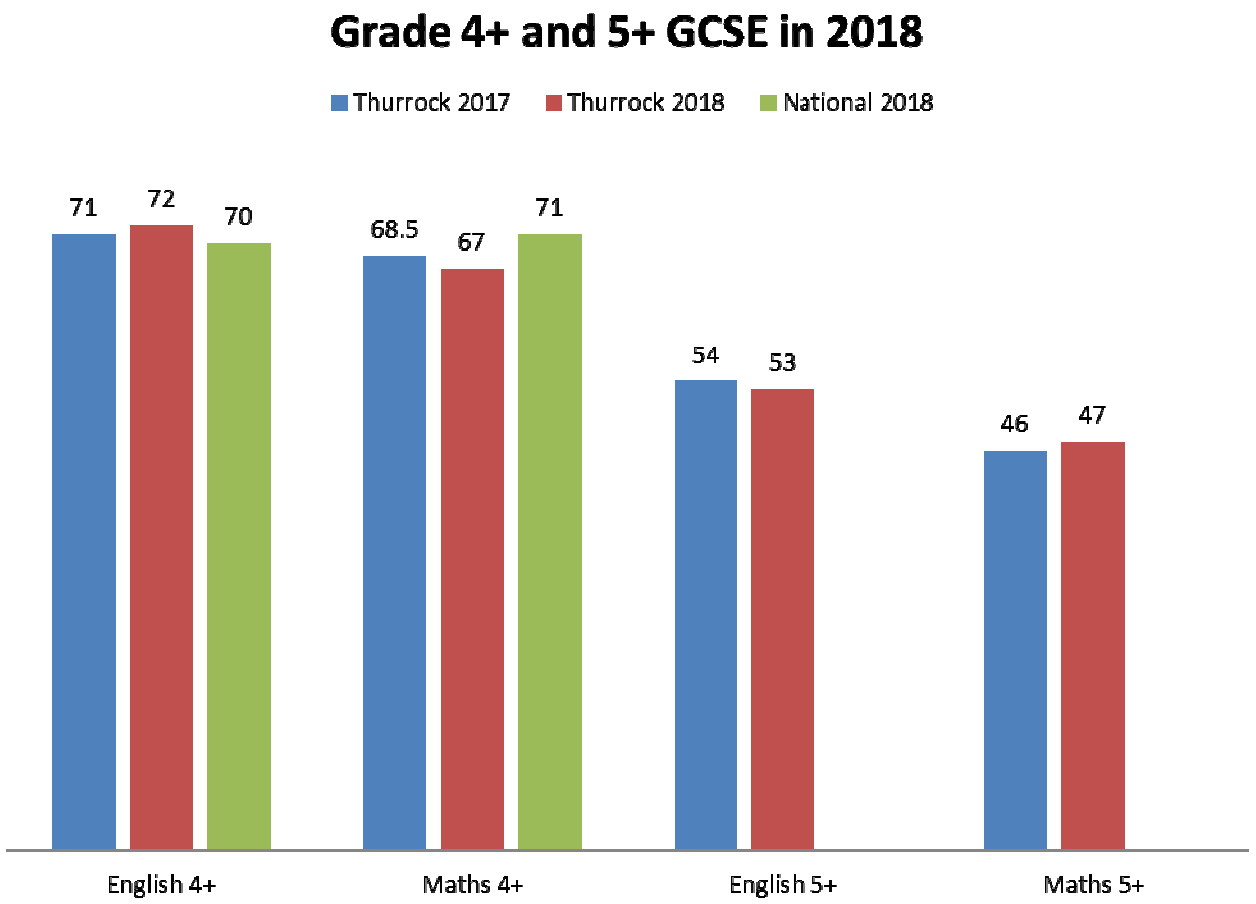
The percentage of pupils achieving greater depth has improved in all measures since 2017 and in most areas, (except reading) are now better than national. This is the first time these measures have exceeded national averages in Thurrock

2018 Provisional KS2 assessment data

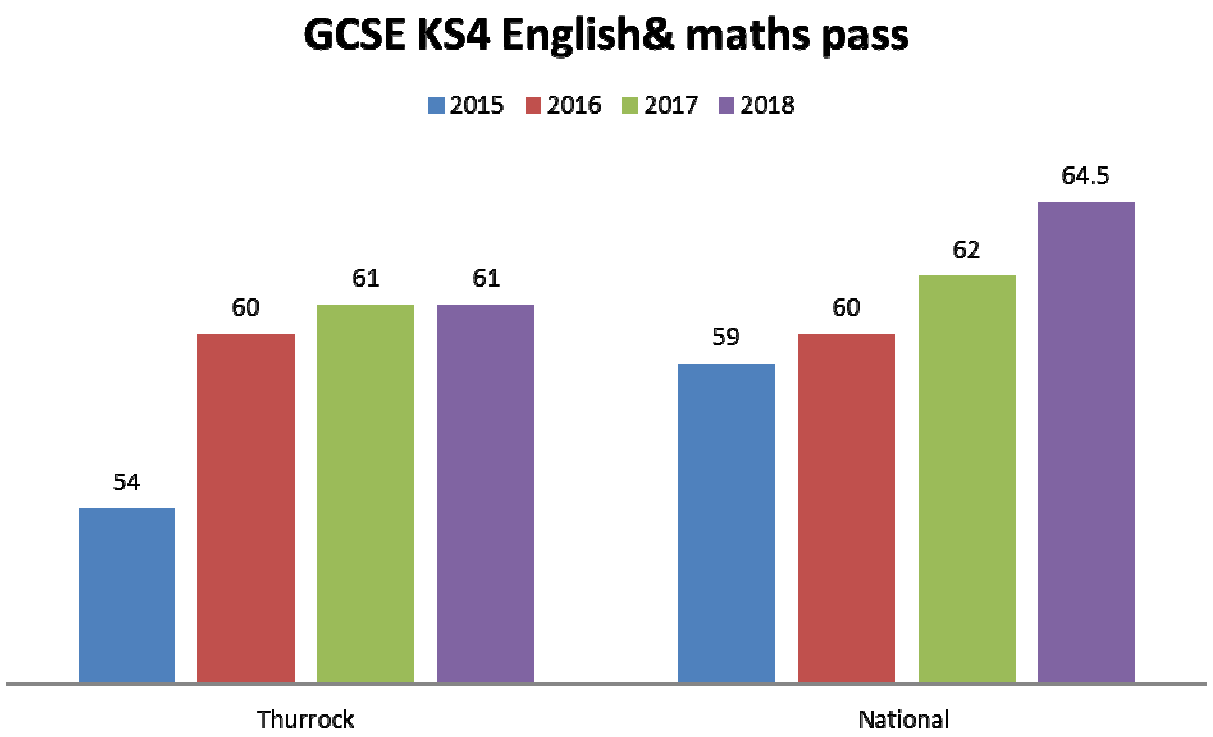




The disadvantaged pupils in year 6 do not achieve as well as their non-disadvantaged peers.



Early GCSE data suggests that 72% of the pupils in Thurrock achieved a grade 4+ in English and 67% achieved a grade 4+ in maths (standard pass).



GCSE KS4 (age 16)
- Indicative results

A*-C/9-4 in both English and maths

In Thurrock provisional data shows that 62% of pupils achieved the combined English and maths grade 4+ measure, compared to 61% in 2017. The proportion of pupils who achieved the 'strong' combined English and maths grade 5+ increased by 1 percentage point in 2018.

23rd November 2018	ITEM: 7
Health and Wellbeing Board	
Whole Systems Obesity Strategy	
Wards and communities affected: All wards	**Key Decision:** Non-key
Report of: Faith Stow, Public Health Programme Manager	
Accountable Head of Service: Helen Forster, Strategic Lead Public Health	
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This report is public.	

Executive Summary

The Whole Systems Obesity Strategy (WSOS) has been developed as the key driver for preventing and reducing obesity in Thurrock and outlines five goals highlighting areas within the system where there is scope to influence and promote healthier lifestyles leading to healthier weights in the local population. The Strategy is based on the evidence of the Whole Systems Obesity Joint Strategic Needs Assessment (WSO JSNA) published in 2017 by the Public Health Team.

1. Recommendation(s)

1.1 The Health and Wellbeing Board to approve the WSOS and its proposed governance arrangements.

1.2 The Health and Wellbeing Board are to note the work of the WSOS as being pivotal in contributing to outcomes within the overarching Health and Wellbeing Strategy 2016-2021.

2. Introduction and Background

2.1 This report presents a WSOS for Thurrock and describes next steps to develop an associated WSOS Action Plan.

2.2 Obesity is one of the most serious and complex public health challenges of the 21st century. On a simplistic individual level, it is caused by consuming more calories than are burned off over a sustained time period. However, the evidence base highlights a huge array of factors that drive this equation related to physiology, biology, individual psychology, parenting, community, daily activity, food production

and marketing, food consumption, transport and the physical built environment. The interaction of these factors has been labelled '*the obesogenic environment'.*

2.3 The current obesogenic environment appears to work in favour of individuals gaining weight, and in-line with many other western democracies, the prevalence of obesity in the UK has increased significantly over the last 40 year as the obesogenic environment has become more pervasive. Without action, the health of individuals will continue to suffer. Health inequalities associated with obesity will remain and the economic and social costs will increase to unsustainable levels.

2.4 The consequences of obesity presents a major public health challenge. Obesity is associated with significantly increased incidence of hypertension, heart disease, stroke, 13 types of cancer, asthma, musculoskeletal conditions including osteoarthritis, liver disease, reproductive complications and mental ill health including depression and anxiety, placing potentially avoidable demand on health and care services. People who are obese are three times more likely to use adult social care services compared to those who are a healthy weight.[1]

2.5 Obesity is a key public health priority in Thurrock. 70% of the adult population are overweight, and 30% are obese in Thurrock. This prevalence is significantly greater compared to England and is the highest in the East of England and worst compared to our CIPFA comparator* local authority population. Prevalence of childhood obesity in Thurrock at year reception and year 6 are 7.5% and 20% respectively. The year 6 prevalence is also statistically significantly greater than England's prevalence.

2.6 Obesity is positively associated with deprivation, meaning that differences in prevalence of obesity between affluent and deprived communities is a major driver of health inequalities.

3. A Whole Systems Approach to Obesity

3.1 A whole systems approach refers to the network of broad and interlinking factors that contribute to a solution or problem. Traditional approaches that focus on single interventions have been shown to be ineffectual at reducing the prevalence of obesity at a population level. Conversely collaboration across stakeholders to deliver coordinated action and multiple initiatives is vital to success. Multiple sectors including health, social care, planning, housing, transport and environment all have a role to play, as do our local businesses, workplaces and the wider community themselves all by jointly making better use of resources and working towards a vision of better health and wellbeing.

3.2 In 2017, the Public Health Team produced and published a Joint Strategic Needs Assessment product on a Whole Systems Obesity approach.[2] The product made a

* CIPFA Comparators aid local authorities in comparative and benchmarking exercises based on socio-economic indicators. Source: CIPFA Stats Publisher: IPF Geographic coverage: England

series of detailed recommendations for stakeholders and was agreed at the September 2017 meeting of the Health Wellbeing Board.

3.3 Building on the findings and recommendations of the WSO JSNA, the Public Health Team have now produced a WSOS for Thurrock. The strategy is centred around five high level goals:

- Goal A - Enabling settings, schools and services to contribute to children and young people achieving a healthy weight
- Goal B – Increasing Positive Community Influences
- Goal C – Improving the food environment and making healthier choices easier
- Goal D – Improving the built environment and getting the physically inactive active
- Goal E – Improving the identification and management of obesity

3.4 In line with the theoretic underpinnings of a *Whole Systems* approach, the strategy remains deliberately high level. Our approach is one of *'distributed leadership'*, aiming to engage the entire council and our partner stakeholders and the wider community in developing and agreeing to implement meaningful action under the each goal.

3.5 Due to the multifactorial nature of the issue, the WSOS supports a significant number of goals and associated objectives within the Health and Wellbeing Strategy highlighted in Table **1** below. The highlighted green areas show where the WSOS will directly support the strategy and in yellow will indirectly support the strategy.

Table 1: Health and Wellbeing Strategy for Thurrock - Goals

Goals	A. Opportunity For All	B. Healthier Environments	C. Better Emotional Health And Wellbeing	D. Quality Care Centred Around The Person	E. Healthier For Longer
Objectives	A1. All children in Thurrock making good educational progress	B1. Create outdoor places that make it easy to exercise and to be active	C1. Give parents the support they need	D1. Create four integrated healthy living centres	E1. Reduce obesity
	A2. More Thurrock residents in employment, education or training.	B2. Develop homes that keep people well and independent	C2. Improve children's emotional health and wellbeing	D2. When services are required, they are organised around the individual	E2. Reduce the proportion of people who smoke.
	A3. Fewer teenage pregnancies in Thurrock.	B3. Building strong, well-connected communities	C3. Reduce social isolation and loneliness	D3. Put people in control of their own care	E3. Significantly improve the identification and management of long term conditions
	A4. Fewer children and adults in poverty	B4. Improve air quality in Thurrock.	C4. Improve the identification and treatment of depression, particularly in high risk groups.	D4. Provide high quality GP and hospital care to Thurrock	E4. Prevent and treat cancer better

3.6 There are also key opportunities to capitalise on Thurrock's growth, regeneration and place making strategic agenda to address the obesogenic environment, and synergies with the work of the Community Safety Partnership.

4. Next Steps and Proposed Governance

4.1 Form a Whole Systems Obesity Working Group

The purpose of the working group is to take a whole systems approach to preventing and reducing obesity in Thurrock using the WSOS Delivery and Outcomes Framework as the principle guide. The group includes Senior and Strategic Leads from a range of areas within the council and externally including the voluntary sector and Thurrock CCG. The group will meet twice yearly to review and measure progress against the delivery framework.

4.3 Hold a *Whole Systems Obesity Summit*

A WSO Summit will be held early in 2019 to raise the profile of the WSOS and to scope and develop opportunities for halting and preventing the upward trend in obesity in Thurrock as a system. The agenda will include a review of the WSO JSNA findings and recommendations, presentation of the WSOS and five themed workshops centred on the five goals, in which facilitated discussion with delegates will lead to development of detailed action plans to support the strategy.

4.4 Develop a WSO Delivery and Outcomes Framework

The specific and measurable outcomes will be set out within a Delivery and Outcomes Framework. This will be produced in collaboration with a variety of stakeholders, recognising that a joined up approach (a whole systems approach) is essential, whilst also ensuring ownership of the relevant department leads. The key output of the WSO Working Group and the WSO Summit in 2019 will the development of the framework.

The WSO Delivery and Delivery and Outcomes Framework will be taken to Health Overview and Scrutiny Committee for sign off once ready.

4.5 Governance of the WSOS

The Strategy identifies intentions to 2021, after this period it will be reviewed to ensure it is still relevant and in-line with the overarching Health and Wellbeing Strategy. Outcomes and progress will be measured through the Delivery Framework, and high level outcomes through the Health and Wellbeing Strategy Outcomes Framework (see table 2). A progress report will go to Health and Wellbeing Board on an annual basis to ensure progress against outcomes shown below.

Table 2: HWB Strategy Targets (goal E)

Goal E: Healthier for Longer	Baseline 2016/17	Target
Proportion of children overweight or obese in year 6	36.9%	Year on reduction of 0.5%
Proportion of adults who are overweight or obese in Thurrock	65.3%	Year on reduction of 0.5%
Proportion of adults who are physically inactive in Thurrock	28%	Year on reduction of 0.5%

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant Social Care & Commissioning

The WSOS details a series of opportunities for tackling health inequalities related to obesity in the population which should contribute towards reducing demand on primary and secondary health care and social care services. The delivery of the WSOS may have a future financial impact for the council but would be subject to the full consideration of the cabinet before implementation, and in the case of the NHS, by the relevant Boards of NHS Thurrock CCG and provider foundation trusts. Detailed business cases will have to be worked up before any investment decisions will be made and these will go through the usual governance routes.

7.2 Legal

Implications verified by: **David M G Lawson**

Solicitor

There are no legal implications; the WSOS has been developed to support and achieve targets within the overarching Health and Wellbeing Strategy.

7.3 Diversity and Equality

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The WSOS seeks to reduce health inequalities as a result of obesity whilst continuing to support and promote diversity and equality.

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

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

8.1 Professional Consultation

The WSOS has been presented at a series of internal and external meetings including all Directorate Management Teams, the Primary Head Teachers' Association, and at key meetings within health and third sector partners in order to raise the profile and get early feedback on the strategy.

8.2 Public Engagement

Public engagement, including an online survey, run for four weeks (12th September 2018 to 15th October 2018) and a focus group was also held (6th November 2018). The public engagement provides the opportunity for public views on the strategy and captures qualitative data on perceived barriers and opportunities to achieving or maintaining a healthy lifestyle. A report will be produced with the findings and shared with the WSO Working Group; it will also be made publishable online so that those who have participated can see the results.

8.2 **Health and Wellbeing Overview and Scrutiny Committee**
The WSOS and WSO Delivery and Delivery and Outcomes Framework will be taken to Health Overview and Scrutiny Committee for sign off. Timing is likely to be towards end of the financial year 18/19.

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

10. Background papers used in preparing the report:

1. Health and Wellbeing Strategy 2016-2021. Available from: https://www.thurrock.gov.uk/sites/default/files/assets/documents/hwb-strategy-2016-v03.pdf
2. Whole Systems Obesity Joint Strategic Needs Assessment, 2017. Available from: www.thurrock.gov.uk/sites/default/files/assets/documents/jsna-obesity-201709-v01.pdf

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Thurrock
Whole Systems
Obesity Strategy
2018-2021

Foreword

This is the first Whole Systems Obesity Strategy for Thurrock. Obesity is a complex problem that is linked to poorer health outcomes and can lead to a number of health conditions such as Type 2 Diabetes and high blood pressure. The influencing factors of obesity are vast, and include things like our social, economic and living environments, this is why we need a new approach. A whole systems approach refers to the network of broad and interlinking factors that contribute to a solution or problem. Traditional approaches that focus on single interventions will not make an impact at a population level, collaboration with partners and the community is vital to the success of the Strategy. Multiple sectors including health, social care, the community and voluntary sector, planning, housing, transport, regeneration and environment all have a role to play. As do our local businesses, workplaces and the wider community themselves all by jointly making better use of resources, seeking opportunities for change and working towards a vision of better health and wellbeing.

Ian Wake
Director of Public Health

Vision statement

Everyone in Thurrock can achieve and maintain a healthy weight, lead an active life, eat a healthy diet and reach a healthy long life expectancy.

Background

Obesity is considered to be one of the most serious and complex public health challenges of the 21st century because of the numerous, interrelating factors associated with obesity. The current obesity system, which operates at a local, regional, national and international level, and as described by the Foresight 2007 report on tackling obesities[1] currently works in favour of individuals gaining weight. Without action the health of individuals will continue to suffer, health inequalities associated with obesity will remain and the economic and social costs will increase to unsustainable levels. The Government is implementing a number of measures to address the national problem of obesity such as the Soft Drinks Levy and reducing sugar in commonly purchased products as set out in the Child Obesity – A plan for action in 2016 [2] and further update in 2018.[3] It is clear that to have a significant impact, we as a Local Authority and the wider local system, must also take action alongside these policy measures.

Drawing on the emerging material from the Whole Systems Obesity Pilots, the system needs "disrupting" in a way that halts this preference for gaining weight and instead works and interacts to assist people in the achievement of healthy lifestyles. This essentially means that, not only do we need to tackle the issue with a comprehensive portfolio of interventions and actions, but more important to this, the interactions between them need to be defined and linked. Essentially the whole is greater than the sum of its parts.

Reducing obesity and reducing the inactive population is a top health and wellbeing priority in Thurrock and is identifiable as a key objective to achieving the Thurrock Health and Wellbeing Strategy. [4] In 2017, Public Health published the Whole System Obesity (WSO) Joint Strategic Needs Assessment (JSNA) which sets out in detail the scale of the issue of obesity for Thurrock and made recommendations about how it can be addressed.[5]

[1] Government Office for Science. Foresight Tackling Obesities: Future Choices – Project Report. 2007.
[2] Childhood Obesity: A Plan for Action. 2016. Available from: www.gov.uk/government/publications/childhood-obesity-a-plan-for-action
[3] Childhood Obesity: A Plan for Action. 2018. Available from: www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2
[4] Health and Wellbeing Strategy Thurrock. 2016. Available from: www.thurrock.gov.uk/strategies/health-and-well-being-strategy
[5] Whole Systems Obesity Joint Strategic Needs Assessment Thurrock. 2017. Available from: www.thurrock.gov.uk/sites/default/files/assets/documents/jsna-obesity-201709-v01.pdf

Strategy Purpose

The Strategy places focus on the wider determinants of health and the impact that multiple sectors can have on health and lifestyle related to obesity through a whole systems approach. By tackling obesity we can also reduce health inequalities.[6] The strategy is central to achieving the vision, for gaining sector buy in and is the tool for having positive conversations with stakeholders around what can be done to tackle obesity in our local population.

The Strategy has five goals, as informed by the WSO JSNA, and which set out how the vision can be achieved using the whole system approach. Recommendations for each goal come from the evidence base of the JSNA work. Stakeholders will be identified and invited to form a new Healthy Weight Working Group. This group will consider the recommendations and co-produce a delivery framework to set out the achievable and relevant actions that will bring about the necessary changes to realise each goal. By nature of a complex system, it will be likely that some of the actions within the goals will cross over with each other.

The Strategy identifies intentions up to 2021, when it will be reviewed and updated. Outcomes and progress of the Strategy will be measured through the measurable actions within the delivery framework and will contribute towards achieving the targets within the overarching Health and Wellbeing Strategy for Thurrock. The Health and Wellbeing targets this strategy will contribute to are outlined in Table 1 below.

Table 1: Thurrock Health and Wellbeing Strategy Targets (related to healthy weight)

Goal E: Healthier for Longer	Baseline 2016/17	Target
Proportion of children overweight or obese in year 6	36.9%	Year on reduction of 0.5%
Proportion of adults who are overweight or obese in Thurrock	65.3%	Year on reduction of 0.5%
Proportion of adults who are physically inactive in Thurrock	28%	Year on reduction of 0.5%

Whole Systems Obesity Goals

Goal A: Enabling settings, schools and services to contribute to children and young people achieving a healthy weight

Goal B: Increasing positive community influences

Goal C: Improving the food environment and making healthy food choices

Goal D: Improving the physical activity environment and getting the inactive active

Goal E: Improving identification and management of obesity

[6] National Institute for Health and Care Excellence. Preventing obesity and helping people to manage their weight. NICE local government briefings. 22 May 2013.

Goal A: Enabling settings, schools and services to contribute to children and young people achieving a healthy weight

We aim to halt the upward trend of childhood obesity levels in Thurrock. There are numerous factors that affect a child's health and can lead to them becoming overweight or obese. Healthy behaviours can be promoted in many ways through increasing the opportunities for children and young people around healthy eating and physical activity and making it easier for families to adopt a healthy lifestyle. Collaboration with partners is key to the success of this goal; including influencing early years, schools, colleges, the Brighter Futures Services the voluntary sector and other universal, prevention and support services. Importantly, we must not forget the role of families, parents and carers too.

Why?

Focus on prevention in childhood is a priority due to the impact on health and wellbeing during this time in combination with the impact that is carried through to adulthood. Overweight and obese youth have an increased risk of becoming overweight adults.[12] Obesity prevalence rises with increasing socioeconomic deprivation.[13]

In Thurrock:

- More than 2 in 10 (22.1%) of Reception aged children are overweight or obese, statistically similar to the England figure of 22.6%.
- Almost 4 in 10 (36.9%) of Year 6 age children are overweight or obese, statistically worse than the England figure of 34.2%.[11]

Objectives:

- reducing overweight and obesity in children in Year 6 (age 11) by at least 0.5% a year to be statistically similar or below than the national average
- preventing obesity in pre-school age children as well as adolescents aged 11 plus
- increased physical activity in Primary school aged children
- more children accessing a healthy diet

Wider system impacts:

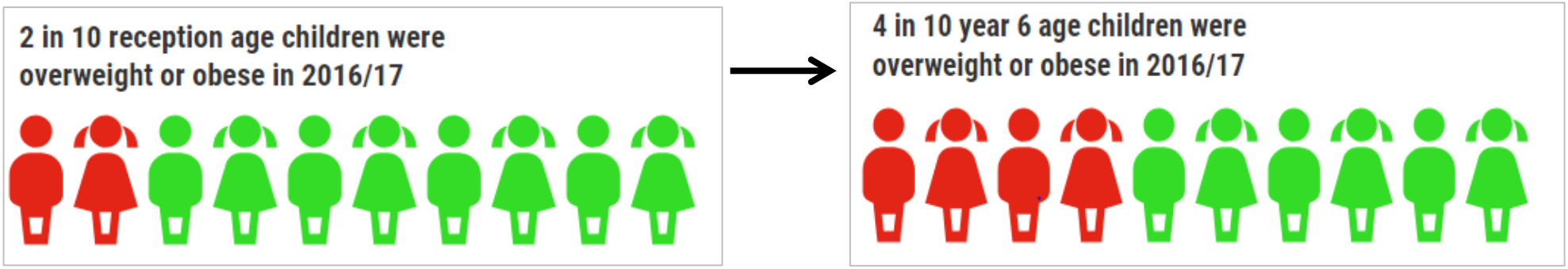
- healthier children and healthier families through behaviour change within the family
- Improved oral health and hygiene through sugar reduction and healthier diet promotion[7]
- improved pupil concentration and engagement within school time[8]
- fewer school absences and improved educational attainment[9]
- improved emotional wellbeing[10], body image and reductions in bullying[11]

[7] Public Health England. Local authorities improving oral health: commissioning better oral health for children and young people. June 2014.
[8] National Institute for Health and Care Excellence. Preventing obesity and helping people to manage their weight. NICE local government briefings. May 2013.
[9] Pan L, Sherry B, Park S, Blanck HM. The association of obesity and school absenteeism attributed to illness or injury among adolescents in the United States, 2009. Adolesc Health. 2013 Jan;52(1):64-9.
[10] Griffiths LJ, Dezateux C, Hill A. Is obesity associated with emotional and behavioural problems in children? Findings from the Millennium Cohort Study. International Journal of Pediatric Obesity 2011;6(2-2):e423-32.
[11] Rees R., Oliver K., Woodman J. & Thomas J. Children's views about obesity, body size, shape and weight: a systematic review. EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, London. 2009.
[12] Singh AS, Mulder C, Twisk JW, van Mechelen W, Chinapaw MJ. Tracking of childhood overweight into adulthood: a systematic review of the literature. Obes Rev. 2008 Sep;9(5):474-88.
[13] National Child Measurement Programme. 2016/17. Available from: www.fingertips.phe.org.uk

WSO JSNA Recommendations for Goal A

Considerable focus on preventative measures in children is crucial due to the impact on health and wellbeing during childhood and the impact this has on later on in adulthood. These measures may include the following as recommended by the JSNA:

1. A detailed review o f the local Healthy Start scheme is undertaken by public health and children's services and a recommendation to understand the effectiveness of the scheme and to focus on increasing the uptake of the scheme locally.
2. Children's services and health commissioners should ensure Maternity services, Health Visitors and Children's Centres work to increase healthy weight in pregnancy, increase breast feeding rates and support healthy weaning.
3. To support the development of family healthy weight opportunities including nutritional advice, cookery sessions and physical activity, making this a normalised behaviour within communities.
4. Review and consider the provision for Tier 2 childhood weight management and its impact on population childhood obesity outcomes.
5. Schools, particularly in neighbourhoods of high childhood obesity, should consider taking up the Modeshift STARs[14] scheme to promote active travel methods into school. How this links into the built environment in Thurrock and perceived safety should be considered.
6. Review and consider what options in schools would encourage children to be more active. Schools, particularly in neighbourhoods of high childhood obesity, should use this understanding to work to encourage children to take part in daily physical activity.
7. A review of how the PE and School Sport premium is being spent by schools across Thurrock, with a view to understanding impact, sharing best practice and to understand opportunities to increase physical activity in children across the borough through this route.



[14] Available from: https://modeshiftstars.org/

Goal B: Increasing positive community influences

There are wider system factors including economic, cultural and social factors that impact on the health of individuals. Furthermore, obesity does not affect all groups equally. We aim to understand the barriers to health in our local communities, including the impact of worklessness and housing, to identify opportunities that will support health and encourage physical activity and healthy eating. A collaborative approach with the wider community in Thurrock and key local connectors is needed to identify solutions and opportunities to influence positive behavioural change at an individual and population level.

Why?

There are stark **health inequalities** and an established link between deprivation and obesity.[17] Thurrock is ranked 84th most relatively deprived out of 152 Local Authorities in England (1 most deprived). The level of child poverty is worse than England with 17.8% of children aged under 16 years living in poverty (2015). The rate of family homelessness is worse than the England average (2016/17).[18] The estimated cost to society related to obesity is £27 billion a year and in Thurrock this equates to more than £170,000 per year.[19] This is partly due to obesity related potential sickness absence and employment adjustments. Obese people are also less likely to be in employment than people of a healthy weight.[14]

The **ethnic diversity** of Thurrock's population has increased at a faster rate than the national average and this trend is to continue. School children in Thurrock are a more ethnically diverse population than their parent's population. Prevalence of obesity is higher among women of Black Caribbean, Black African, and Pakistani ethnicities, compared to the other ethnic groups. For men, obesity prevalence is highest in Black Caribbean, White and Irish ethnic groups.[20] There is variation in obesity prevalence by ethnic group for children too. Programmes and initiatives should be designed with this in mind and target accordingly.

Socioeconomic factors such as poor housing and lack of cooking facilities/ skills, as well as inherited cultural cooking methods, can contribute to social and family norms that may encourage unhealthy behaviours around eating and physical activity.

Objectives:

- the development of community driven health initiatives particularly focusing in areas of deprivation
- a wider range of departments and sectors such as Housing, the Voluntary Sector and local businesses contributing to reducing obesity and improving health

Wider system impacts:

- empowered communities particularly around tackling weight related issue
- greater public resilience
- greater social cohesion, reduced social isolation and loneliness[15]
- increased participation, volunteering and reductions in worklessness[16]

[15] Available from: www.noo.org.uk/LA/tackling/leisure
[16] National Institute for Health and Care Excellence. Preventing obesity and helping people to manage their weight. NICE advice [LGB9] May 2013.
[17] Public Health England. Adult obesity and socioeconomic status data factsheet. August 2014
[18] Public Health England. Available from: https://fingertips.phe.org.uk/profile-group/child-health/
[19] McPherson, K, Marsh, T. Modelling Future Trends in Obesity and the Impact on Health. Foresight Tackling Obesities: Future Choices. 2007. Available from: www.gov.uk/government/publications/reducing-obesity-. modelling-future-trends
[20] Public Health England. Adult slide set. Adult obesity prevalence by ethnic group. Health Survey for England 2006-2010. 2013.

WSO JSNA Recommendations for Goal B

Focus should be on developing a joined up approach between multiple sectors including businesses, health care, social care and communities to better understand the opportunities and potential solutions to tackling obesity in Thurrock. Measures to achieve this may include the following as recommended by the JSNA:

1. To instigate work with communities, including schools and colleges, to identify behavioural change methods that would be successful in creating a cultural shift away from health harming social norms to healthy ones.
2. To work in partnership with local employers to develop a holistic health and wellbeing workplace model.
3. Work with businesses should be undertaken to understand the links with obesity, mental health and employment.
4. To keep a watching brief on further national research to develop a better understanding of any association between ethnicity and obesity and how this can influence our action.
5. For housing, planning and environment departments to ensure that there are opportunities for physical activity, for accessible healthy food outlets and suitable food preparation/ storage areas within housing, to include private tenants.
6. To support and assist in the promotion of national campaigns locally, such as Dry January and One You to spread their messages and encourage a greater take up amongst communities through the identification of relevant departments, services and agencies.
7. Regeneration and public health should work with employers, unemployment agencies and relevant voluntary and public organisations to identify and develop healthy lifestyle opportunities to increase life chances.
8. Focus on, existing and new, prevention opportunities and small behaviours changes that could have a population impact should be implemented at the key ages of increase from the age of 16 through to age 45. For example One You and Active 10 initiatives.
9. Strategies to tackle overweight and obesity should give a greater focus on community based methods of engagement with those from deprived geographical areas.
10. Strategies to tackle overweight and obesity should consider more relevant methods of engagement and focus with those from Black and Minority Ethnic groups and communities where obesity and excess weight has been observed to be higher.
11. Adult social care should consider targeted opportunities towards those with limiting long term health problems and older people.

Goal C: Improving the food environment and making healthy food choices easier

We aim for healthy food choices to be a simpler and easier task especially for families. The food environment is the collection of the physical, biological and social factors that affect eating habits and patterns. The makeup of the food environment influences our decision making around food choices and this can lead to habitual and social food preferences. Where we can start to have an impact is the high-street, our local hospitals, workplaces and within educational settings such as nurseries, schools and colleges. This will involve working with local food outlets and businesses to ensure that the nutritional quality of food and drinks available is considered in-line with the recommended food standards and factored into the local food supply.

Why?

Eating a healthy diet is important not only to prevent weight gain but also to reduce the risk of developing certain diseases.[24] Figures from the latest National Diet and Nutrition Survey (NDNS) collected from 2014-2016 show the UK population is consuming too much saturated fat and not enough fruit, vegetables, and fibre.[25]

Measures for **5-a-day fruit and vegetable** consumption in Thurrock is significantly lower than the regional and national averages. The data for Thurrock shows less than half of 15 year olds (49.2%)[22a] and just over half of adults (51.3%)[26b] are meeting the national '5-a-day' standard on a usual day. The uptake of free school meals, which tend to be healthier than lunch boxes, in Thurrock is low, with only 12.7% of pupils who are eligible taking up the offer in 2017.[27]

There are **27 allotment sites** in Thurrock providing opportunities for people to grow their own food. However, there are not enough sites to meet demand and the recommended quota of land. The JSNA showed that there is a strong relationship with deprivation and rate of fast food outlets in England and although diluted at a local level the relationship can still be seen in Thurrock.

Objectives:

- a healthier food environment in Thurrock
- improved opportunities for access to healthy food
- increase the number of schools serving healthier food
- increase the number of children taking up free school meals

Wider system impacts:

- healthier workplaces and less staff time off sick[21]
- improved productivity within the workplace and other settings such as education[22]
- engaged local businesses that are supporting local health
- positive community outlook on healthy food supply[23]

[21] Butland B, Jebb S, Kopelman P, et al. Tackling obesities: future choices – project report (2nd Ed). London: Foresight Programme of the Government Office for Science, 2007.
[22] National Institute for Care and Health Excellence, Workplace health. NICE advice[LGB2] July 2012
[23] Public Health England. Obesity and the environment briefing: regulating the growth of fast food outlets. March 2014.
[24] Global Burden of Disease 2016 Risk Factors Collaborators. A systematic analysis for the Global Burden of Disease Study 2016. Lancet; 390: 1345–422, 2017.
[25] Available from: www.gov.uk/government/statistics/ndns-results-from-years-7-and-8-combined
[26a] What About YOUth (WAY) survey, 2014/15 and 22[b] Public Health England (based on Active Lives, Sport England), 2016/17. Available from: www.fingertips.phe.org.uk
[27] School Census. Available from: https://fingertips.phe.org.uk

WSO JSNA Recommendations for Goal C

There should be a shift of strategic focus to improving the food environments across the Borough to promote small lifestyle changes and to prevent gradual increases in body weight, impacting at a population level. This may include the following measures as recommended by the JSNA:

1. Children's Services to conduct a review of early years, childcare and school settings to understand the provision of healthy food environments locally and to ensure the nutritional quality of food supplied in early year and school settings is of a good standard.
2. Develop an understanding of why eligible children and families in Thurrock do not take up free school meals. There should be a concentrated effort to increase the uptake of Free School Meals in primary and secondary schools in Thurrock.
3. The school catering team should work with schools to change and shift the culture of packed lunches to school meals or to encourage more nutritionally balanced packed lunch contents.
4. Schools have huge potential to make a positive impact for reducing obesity and chronic related disease risk, as does the local school environment, the school curriculum should deliver consistent messages on food and diet to its pupils.
5. Planning policy should consider the options around the restriction of the growing number of fast food outlets in Thurrock, in particular in the areas where there is the highest childhood obesity at Year 6.
6. Explore opportunities to influence the built environment through planning and regeneration, to enable better access to affordable healthy food.
7. To work with environmental health around existing fast food outlets to review the provision and offer alternative options and healthier food or healthier ways of cooking food e.g. via the TUCK IN initiative.
8. Work with planning to increase allotment availability and accessibility, link them to community growing schemes and release excess food grown to communities.
9. Work with local supermarkets on healthy food promotion and marketing schemes and areas of food waste.
10. Ensure issues relating to food storage and cooking skills are identified and addressed in populations and groups where this is a highlighted barrier to eating a healthy and balanced diet, for example through the Well Homes Good Food Pilot.
11. Consider the potential to pilot of a healthy eating zone to test whether this is something which might have an impact on the food system.
12. To work with the Food Banks and other community initiatives to identify healthy eating/ preparation ideas for their users.

Around half of the Thurrock population are not meeting the '5 a day target' (2016/17).

Goal D: Improving the physical activity environment and getting the inactive active

We aim to improve the areas in our local environment that will encourage physical activity and the use of outdoor space, to improve health and increase the number of active people in our population. Through the planning and housing growth agenda that is being developed within Thurrock we have a unique opportunity to shape our environment to encourage behaviour change around physical activity. Through the use of tools to assess the health impact during planning, the creation of quality outdoor spaces and the development of active travel initiatives will all contribute towards achieving this goal.

Why?

Low physical activity is one of the top ten causes of disease and disability in England.[31] National guidelines state that for healthy lives, adults and children should be physically active every day.[32] The health benefits of physical activity are not just about maintaining a healthy weight, but also relate to healthier ageing, reduced risk of falls, positive effect on mental health and a reduced risk of diseases including cancer. Around one in two women and a third of men in England are damaging their health through a lack of physical activity.[33] This is unsustainable and costing the UK an estimated £7.4bn a year.[34]

The Active Lives survey showed that almost half of adults in Thurrock (47.2%) are not meeting the recommended physical activity guidelines and that there are statistically fewer adults who do any cycling; only 1.2% of adults cycling are 3 times a week.[35] We know there are particular groups in our communities who have lower levels of physical activity; these include females, older adults, people with limiting illness or disability, people on a lower income, part time employees and those with a higher body mass index (BMI).[36] We also know that in areas in Thurrock where parks and gardens have a lower quality rating have higher rates of childhood obesity.[37]

Objectives:

- improvements to the physical environment in the Borough that promote physical activity and wellbeing
- active travel prioritised in transport and planning policies
- reduction in the inactive population

Wider system impacts:

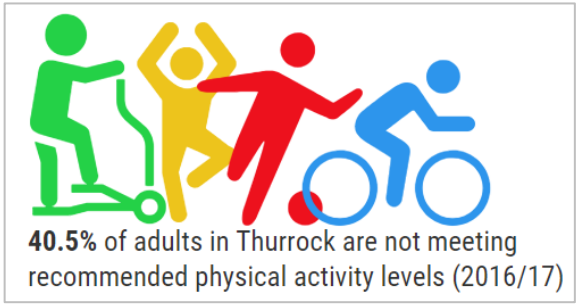
- greater social cohesion, reduced social isolation and loneliness[28]
- local communities positive about the environment and where they live
- healthier workplaces and increased productivity[29]
- reduction in car travel, air pollution, carbon dioxide emissions and congestion[30]

[28] Available from: www.noo.org.uk/LA/tackling/leisure
[29] Butland B, Jebb S, Kopelman P, et al. Tackling obesities: future choices – project report (2nd Ed). London: Foresight Programme of the Government Office for Science, 2007.
[30] Public Health England. Obesity and the environment briefing: increasing physical activity and active travel. November 2013.
[31] Murray et al. UK health performance: findings of the Global Burden of Disease Study 2010. The Lancet; 381: 997-1020, 2013.
[32] UK Physical Activity Guidelines. Available from: www.gov.uk/government/publications/uk-physical-activity-guidelines
[33] Health and Social Care Information Centre (2013) Health Survey for England 2012. Volume 1: Chapter 2 – Physical activity in adults. Leeds: Health and Social Care Information Centre.
[34] Scarborough et al. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs. Journal of Public Health; 33 (4): 527-535, 2011.
[35] Active Lives Survey. 2015. Available from: Available from: www.fingertips.phe.org.uk
[36] Essex County Council. Sport and Exercise Physical Activity Needs Assessment. June 2014. Available from: www.essexinsight.org.uk/get/ShowResourceFile.aspx?ResourceID=973
[37] Health and Wellbeing Strategy Thurrock. 2016. Available from: www.thurrock.gov.uk/strategies/health-and-well-being-strategy

WSO JSNA Recommendations for Goal D

Greater strategic focus on promoting physical activity in order to increase the amount of adults meeting government activity recommendations and reduce the number of people who are inactive in the borough. Measures to achieve this may include the following as recommended by the JSNA:

1. Continue to influence future planning to prioritise the need for communities to be physically active as a routine part of their life, with strong consideration for Active Design Principles (Sport England) and healthy weight environments.
2. Environment department to seek to improve the quality and quantity of local sports facilities, green spaces and pitch and play provision in response to local need and population growth as evidenced by the Active Place Strategy.
3. Using the Active Place Strategy findings as a benchmark, undertake further evaluation around sport and physical activity levels to identify any specific demand for additional services/club and obtain a clearer understanding of local demand for sport and physical activity to help shape future vision.
4. Focus provision and commissioning on localities with lower levels of physical activity and the least active groups to address Thurrock's health inequalities.
5. Develop consultation activities to try and identify perceived barriers to physical activity within different communities.
6. Collective action should be undertaken to promote, encourage and support the community to get active and travel actively via walking and cycling including inspiring the community to use their parks, gardens and open spaces more.
7. Thurrock Council should consider the development and enhancement of new and existing relationships and partnership working with Active Essex, Sports England and other external organisations.
8. Regeneration to seek to integrate future development of further sports facility infrastructure with prospective integrated medical centres/ educational facilities where possible.
9. Active travel should be enshrined in transport policies. Planning and transport policy should encourage new developments to maximise opportunities for active travel with appropriate infrastructure (e.g. cycle lanes, cycle parking) and ensure these are prioritised over car transport as part of designing safe and attractive neighbourhoods.
10. Improve the provision of high quality, local, accessible and safe green space in line with recommendations by organisations including the Design Council Commission for Architecture and the Built Environment. Including improving the aesthetics of green space, alongside appropriate safety and crime prevention initiatives to encourage people to use their local green space.



Goal E: Improving identification and management of obesity

We aim to improve the identification of obesity in our population through primary care settings, including brief advice and promotion of current services that can support a person around their weight. Research shows that brief, opportunistic interventions delivered in primary care can result in a 5-fold increase in the proportion of patients engaging in weight management services.[41] Simple advice from a health or care professional to lose weight increases patients' intentions to lose weight, whilst referring people to weight management services can more than double the amount of weight they lose.[41] There are a range of local services in Thurrock that can support people in making healthy lifestyle changes including physical activity and weight management programmes, however, more understanding is needed whether these services are accessed equitably.

Why?

Obesity is associated with an increased risk of developing a range of health problems, including heart disease, type 2 diabetes, osteoarthritis, sleep apnoea and some cancers, as well as emotional and mental health problems.[38] Most of the complications of obesity can be reduced by weight loss.[42] Body Mass Index (BMI) provides a practical estimate of weight status in adults. Research has shown that GPs perceived overweight and obese weights as being of lower BMI and weight status than they actually are, and this was associated with a lower intention of discussing weight management with a potential patient.[43] In Thurrock, figures show:

- **69.4%** of adults are overweight or obese in Thurrock, statistically worse than the England average of 61.3%.[44]
- There is variation at GP practice level in the identification of obesity in adults.[45]
- **66%** of Thurrock patients referred to tier 3 weight management had one or more long term health conditions, with **22%** having three or more. [39]

Objectives:

- improve education in the prevention of obesity within Primary Care and other local services
- improve identification and management of obesity within Primary Care including awareness and signposting resulting in increased referrals into services that can support a healthy weight
- improved join up and signposting between services for LTCs and weight management
- local weight management services that are equitable

Wider system impacts:

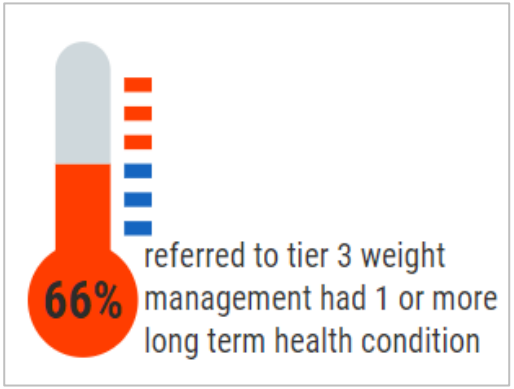
- improved management of long term conditions including depression through better linked referral pathways
- halting increase in incidence of obesity associated conditions such as diabetes[38]
- reductions in use of primary care and secondary care services resulting in NHS cost savings[39]
- reductions in social care packages resulting in savings to local authority adult social care[40]

[38] National Institute for Health and Care Excellence. Obesity: identifying, assessing and managing obesity in adults, young people and children. November 2014. Available from: www.nice.org.uk
[39] The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs
[40] Estimated annual Social Care costs* of obesity to Local Authorities is £352m. Preliminary analysis of Health Survey for England combined data 2011 and 2012. Obesity Knowledge and Intelligence. PHE 2014.
[41] Public Health England. Let's Talk About Weight. 2017. Available from: https://assets.publishing.service.gov.uk
[42] National Institute for Health and Care Excellence. Obesity. Clinical Knowledge Summary. October 2012. Available from: www.nice.org.uk
[43] Robinson E, Parretti H, Aveyard P. Visual identification of obesity by healthcare professionals: an experimental study of trainee and qualified GPs. Br J Gen Pract; 64(628):e703-8, 2014.
[44] Public Health England (based on Active Lives survey, Sport England). 2016/17. Available from: www.fingertips.phe.org.uk
[45] Whole Systems Obesity Joint Strategic Needs Assessment Thurrock. 2017. Available from: www.thurrock.gov.uk/sites/default/files/assets/documents/jsna-obesity-201709-v01.pdf

WSO JSNA Recommendations for Goal E

Greater focus on identifying and supporting those who already measure as overweight or obese to adopt a healthy lifestyle and achieve a healthier weight. Measures to achieve this may include the following as recommended by the JSNA:

1. Thurrock Clinical Commissioning Group to encourage GPs to identify and refer more obese patients for weight management support.
2. Practice-level variation in the identification of obesity to be supported through the work of the Healthcare Public Health Improvement Managers
3. A health equity audit undertaken of weight management provision to understand if local groups and communities within the Thurrock population are accessing weight management services equitably.
4. Future weight management provision to continue to target patients in more deprived areas as well as males.
5. Tier 2 Weight Management Programmes to provide a varied range of options, including physical activity options, to ensure it reaches all sectors of the community.
6. Public Health and NHS Commissioners should ensure that there is clear connectivity between weight management and mental health support services.
7. Analysis of the Tier 3 data indicates that a large proportion of patients have more than one long term condition. In order to prevent development of further ill-health, Tier 3 Weight Management Programmes obesity support and long term condition support should be delivered in an integrated way.



Next steps

Public Health are leading the roll out of this Strategy. The initial steps are to invite cross-sector members to form a new Healthy Weight Network. Using a whole system approach this group will give direction and steer to take forward the JSNA recommendations. A co-produced delivery framework will set out the specific and measurable actions to achieve the five goals of this strategy. The progress of this group will report into the Health and Wellbeing Board.

Please submit any queries or comments to publichealth@thurrock.gov.uk.

Thurrock

Whole Systems Obesity Strategy

thurrock.gov.uk

Version 1.0

November 2018

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thurrock.gov.uk

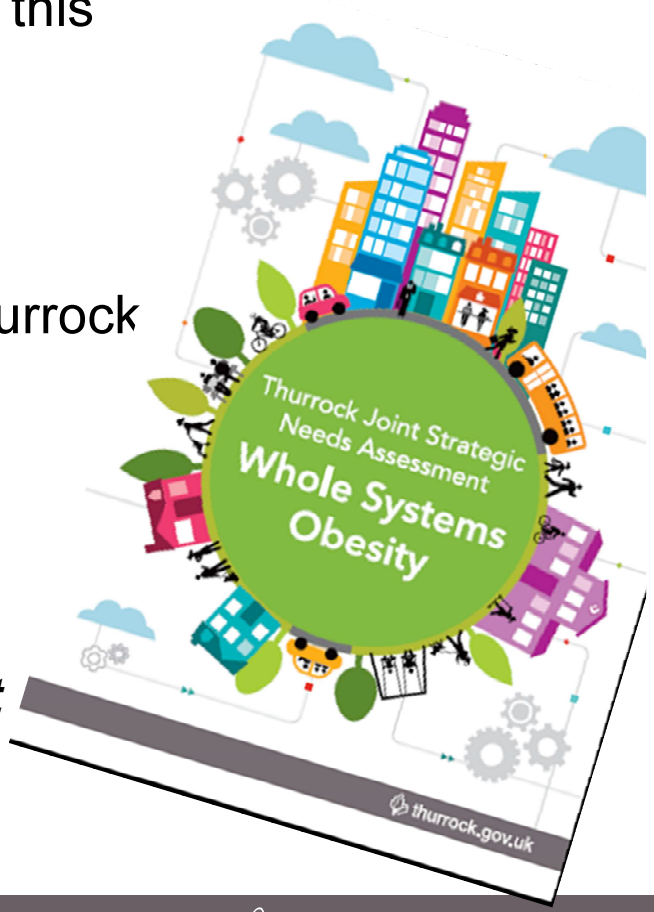
Faith Stow
Public Health
Programme Manager

23 November 2018

Introduction

The WSO JSNA laid the foundation to start from, providing a comprehensive overview of obesity and the associated causes and factors within the Thurrock system. Covered in this presentation:

- The current issue of obesity
- Obesity in Thurrock
- A new whole systems approach
- The Whole Systems Obesity Strategy for Thurrock
- Strategy next steps



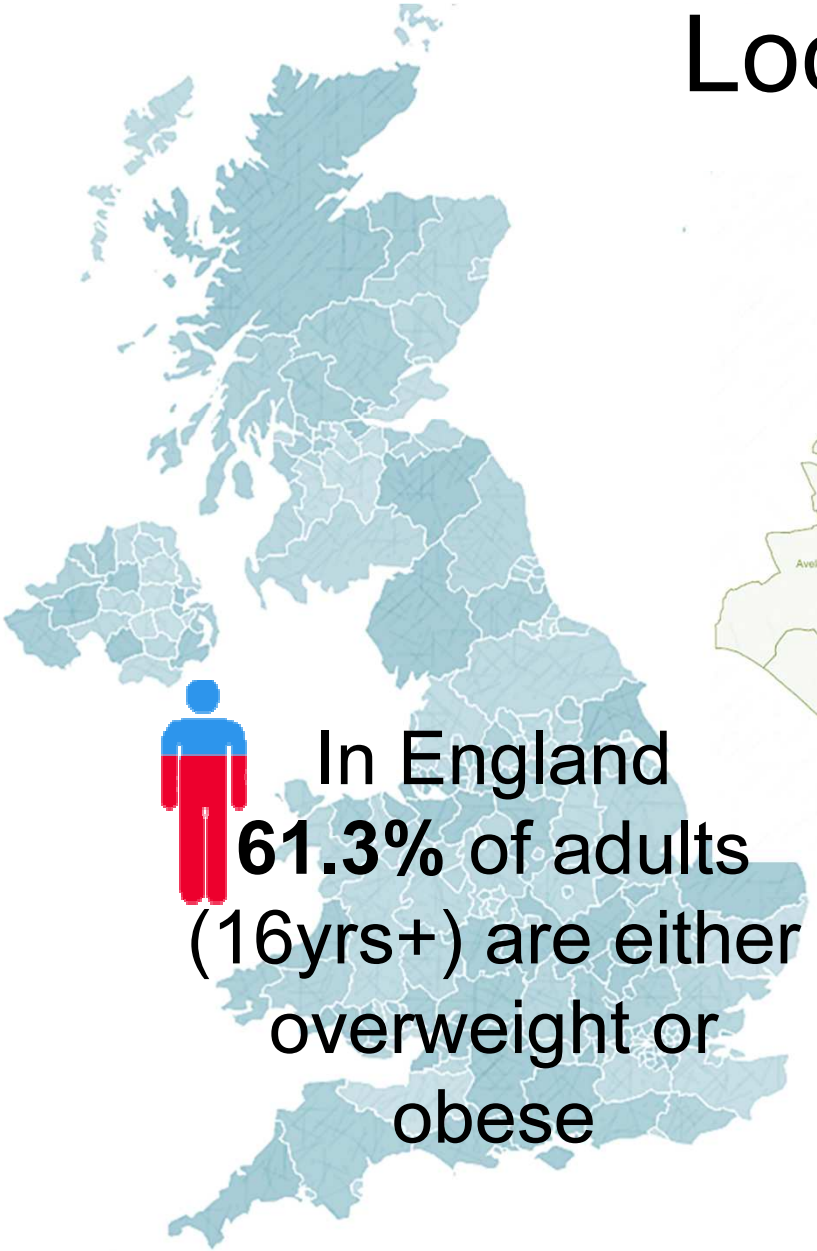
Vision statement

Everyone in Thurrock can achieve and maintain a healthy weight, lead an active life, eat a healthy diet and reach a healthy long life expectancy.

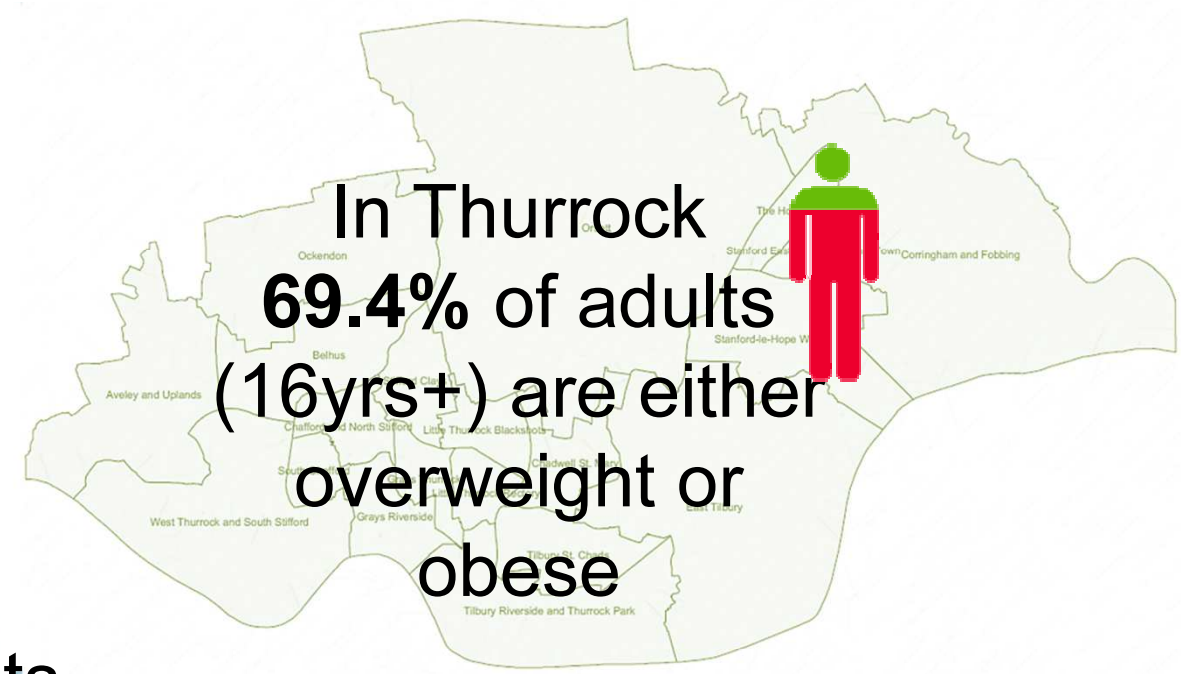
Background

- Obesity is considered to be one of the most serious and complex public health challenges of the 21st century.
- The current system, operates at a local, regional, national and international level, works in favour of individuals gaining weight.
- Government is implementing a number of measures to address national problem - as set out in the Child Obesity – A plan for action (2016 and 2018).
- A new whole systems approach to address the problem, drawing on the emerging material from the Whole Systems Obesity Pilots.
- The system needs “disrupting” in a way that halts this preference for gaining weight and instead works and interacts to assist people in the achievement of healthy lifestyles.

Local Picture



In England
61.3% of adults
(16yrs+) are either overweight or obese



In Thurrock
69.4% of adults
(16yrs+) are either overweight or obese

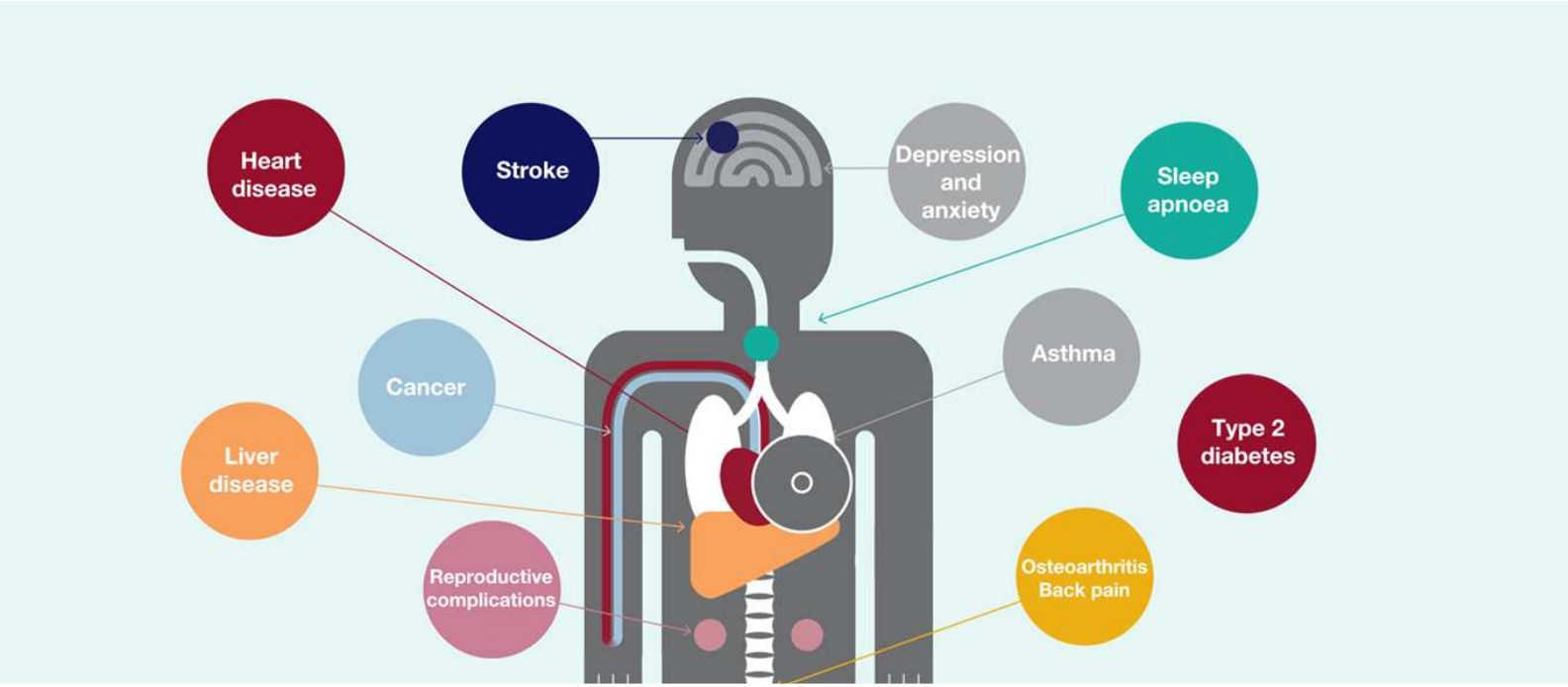
PHE 2016/17

Local Context: In Thurrock…

- **More than 1 in 5 children (22.6%)** at age 5 are overweight or obese
- **More than 1 in 3 children (39.3%)** at age 10 and 11 are overweight or obese (2017/18)
- **7 in 10 adults** are overweight or obese (2016/17)
- Just over **half of adults** in Thurrock are physically active (2016/17)
- Statistically worse than average U75 mortality rate from cardiovascular disease and cancer (2015-2017)
- **Creates a highly challenging demand on the health and social care system**

Obesity harms

- Obesity is associated with the development of numerous long term conditions (LTCs).
- Severely obese people are over 3 times more likely to need social care than those who are a healthy weight resulting in increased risk of hospitalisation and associated health and social care costs (PHE, 2017).
- Consequences of excess weight are far reaching including: social, economic, mental and physical harms - resulting in people unable to reach their full potential.



Health Inequalities

- Obesity prevalence is strongly correlated with deprivation and is highest in the most deprived areas.
- Deprivation varies in Thurrock.**17.8%** of children (under 16) are living in low income families, England (16.8%), East of England (13.9%).
- Obesity rates also vary in:
  - Between ethnic groups
  - Older age groups
  - People with disabilities and life limiting illness

66% of those referred to tier 3 More Life programme had one or more LTC with 22% having three or more (2016/17).

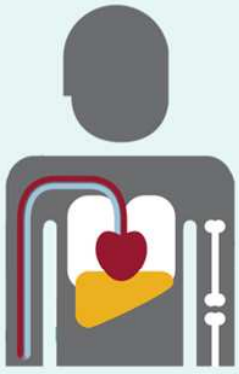
Public Health England

Obesity harms children and young people

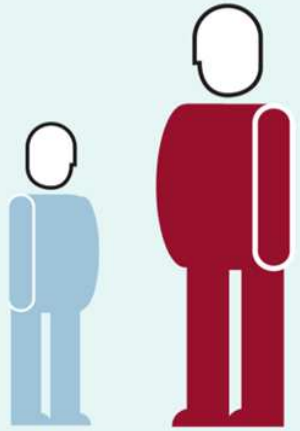
Emotional and behavioural

- Stigmatisation
- bullying
- low self-esteem

School absence



- High cholesterol
- high blood pressure
- pre-diabetes
- bone & joint problems
- breathing difficulties



Increased risk of becoming overweight adults

Risk of ill-health and premature mortality in adult life

PHE, Case to Invest, 2015

Public Health England

Obesity harms adults

Less likely to be in employment

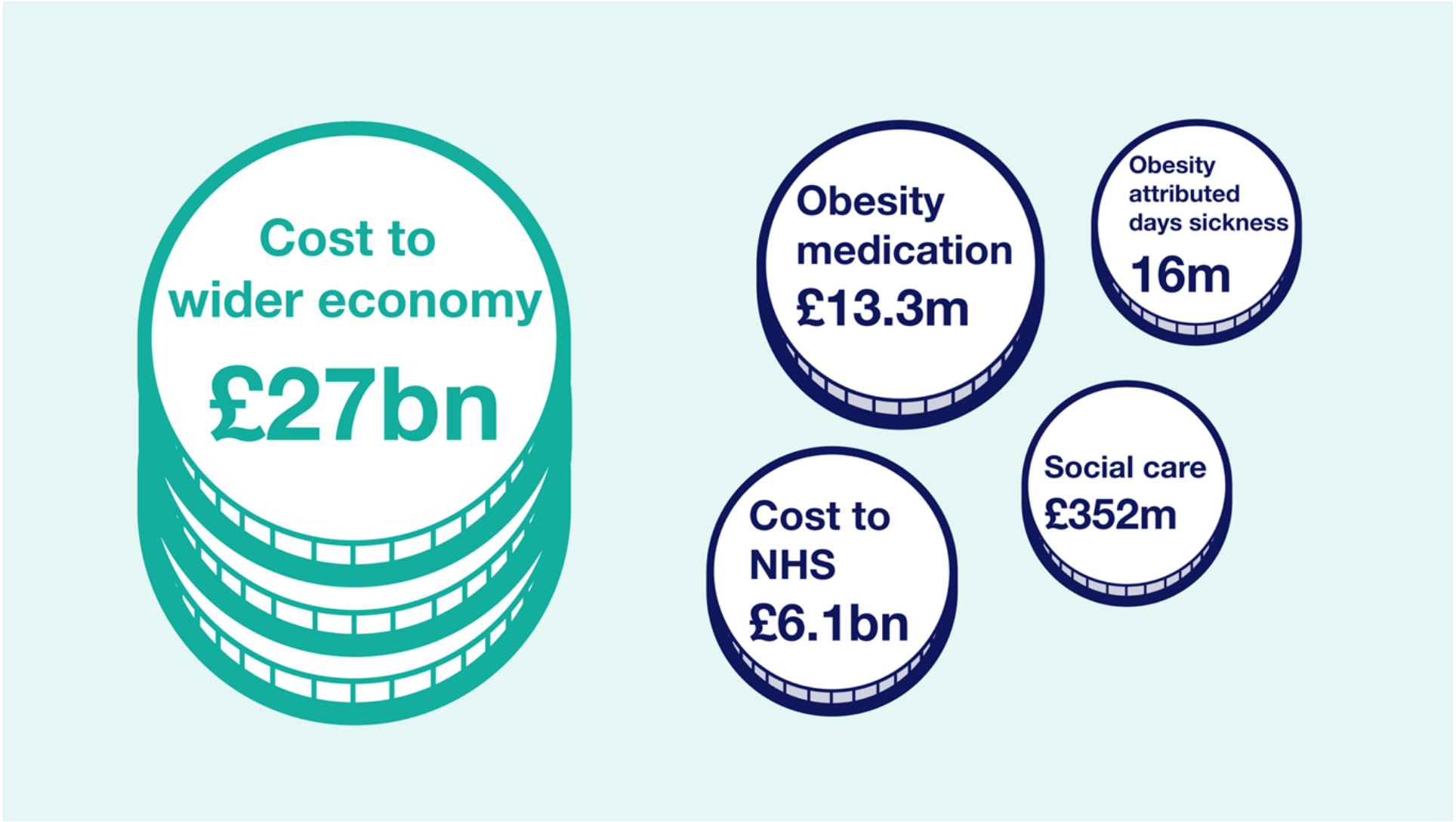
Discrimination and stigmatisation

Increased risk of hospitalisation

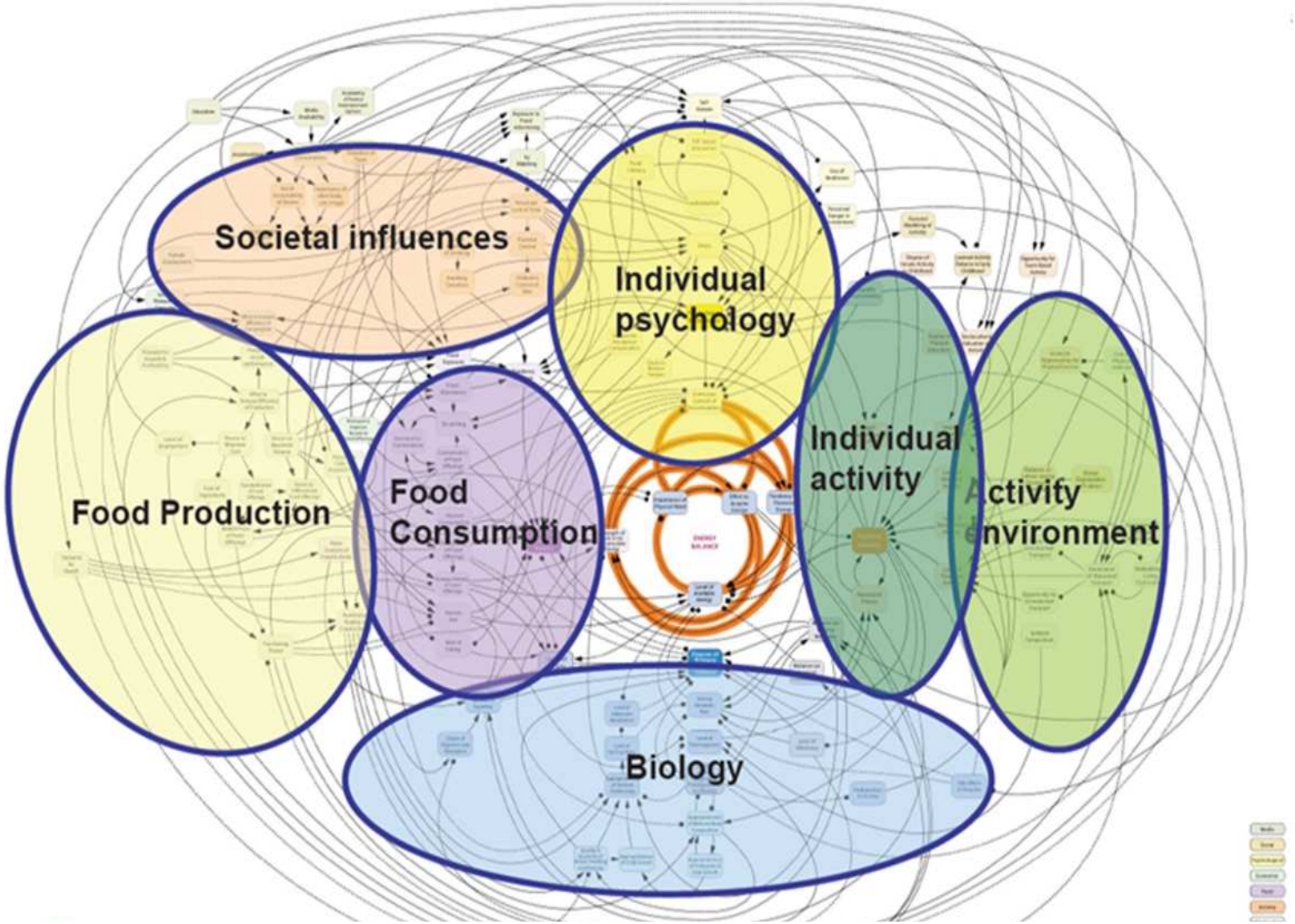
Obesity reduces life expectancy by an average of 3 years

Severe obesity reduces it by 8-10 years

PHE, Case to Invest, 2015


Cost to wider economy
£27bn
Obesity medication
£13.3m
Obesity attributed days sickness
16m
Cost to NHS
£6.1bn
Social care
£352m

People become obese in a system. We need to respond as a system



Locally can't change whole system, but can maximise impact on what we can influence through join up

Whole Systems Obesity Strategy

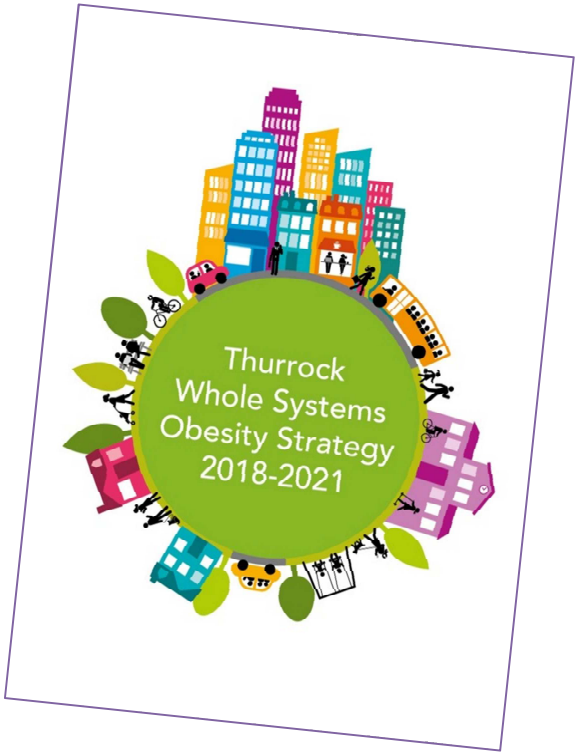
Goal A: Enabling settings, schools and services to contribute to children and young people achieving a healthy weight

Goal B: Increasing positive community influences

Goal C: Improving the food environment and making healthy food choices

Goal D: Improving the physical activity environment and getting the inactive active

Goal E: Improving identification and management of obesity



Health and Wellbeing Strategy

Goals	A. Opportunity For All	B. Healthier Environments	C. Better Emotional Health And Wellbeing	D. Quality Care Centred Around The Person	E. Healthier For Longer
Objectives	A1. All children in Thurrock making good educational progress	B1. Create outdoor places that make it easy to exercise and to be active	C1. Give parents the support they need	D1. Create four integrated healthy living centres	E1. Reduce obesity
	A2. More Thurrock residents in employment, education or training.	B2. Develop homes that keep people well and independent	C2. Improve children's emotional health and wellbeing	D2. When services are required, they are organised around the individual	E2. Reduce the proportion of people who smoke.
	A3. Fewer teenage pregnancies in Thurrock.	B3. Building strong, well-connected communities	C3. Reduce social isolation and loneliness	D3. Put people in control of their own care	E3. Significantly improve the identification and management of long term conditions
	A4. Fewer children and adults in poverty	B4. Improve air quality in Thurrock.	C4. Improve the identification and treatment of depression, particularly in high risk groups.	D4. Provide high quality GP and hospital care to Thurrock	E4. Prevent and treat cancer better

Wider System Impacts

Wider system impacts expected are as follows:

- Reducing health inequalities
- Supporting better mental health
- Supporting health-related quality of life for older people
- Local services that are joined up better e.g. mental health and lifestyle services
- Reduce social care and health care costs
- Improved school attendance (and attainment)
- Healthier work places (starting with the Council)

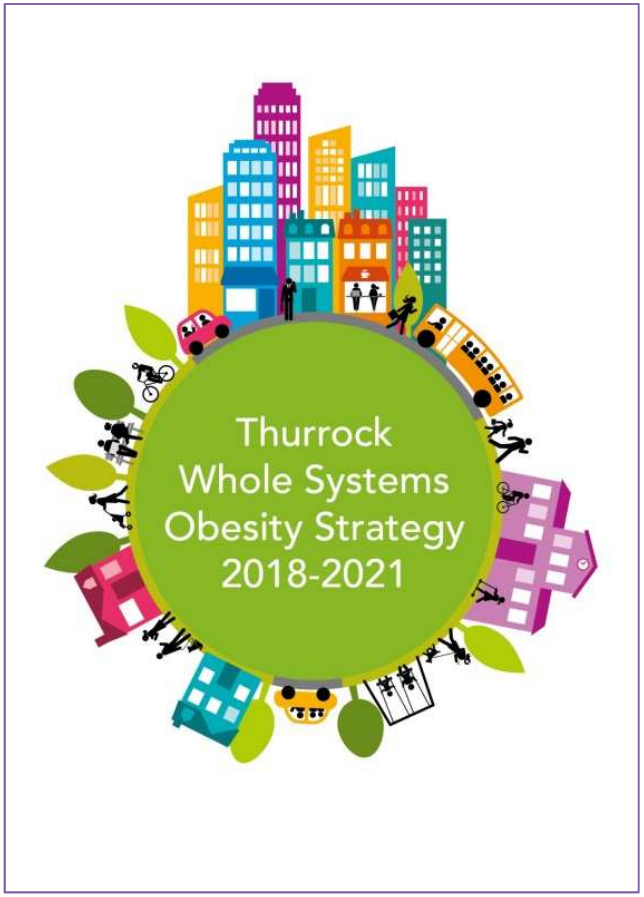
WSOS next steps

1. **Develop a WSO Delivery and Outcomes Framework:** this will detail the specific and measurable actions to achieve the WSOS. A draft has been produced based on evidence and recommendations from JSNA and feedback from PH colleagues.
2. **WSO Working Group:** has formed with senior/strategic leads from around the council and externally. Network will meet twice a year to monitor progress against the Delivery Framework.
3. **Hold Whole Systems Obesity Summit** (8th Feb 2019): to launch the strategy and seek further opportunities to reduce and prevent obesity.
4. Finalise the **WSO Delivery and Outcomes Framework.**
5. **Governance** of the framework will be monitored via the working group with a report of progress going to the HWBB on an annual progress to demonstrate progress against the targets.

Members of WSO Working Group:

- Public Health
- Children Services Lead
- Adults Services Lead
- Transport and Planning Lead
- Environment and Leisure Lead
- HR and OD Lead
- Housing Lead
- Thurrock Healthy Lifestyle Lead
- Thurrock CCG Commissioner
- Primary School Head
- CVS and Healthwatch representative

Feedback and questions



Thank you

23 November 2018	ITEM: 8
Health and Wellbeing Board	
Healthy Housing for the Third Age: Improving Older People's Health through Housing. **Annual Public Health Report 2018**	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ian Wake, Director of Public Health	
Accountable Head of Service: Andrea Clement, Assistant Director and Consultant in Public Health	
Accountable Director: Ian Wake, Director of Public Health	
This report is Public	

Executive Summary

It is the statutory duty of the Director of Public Health to prepare an independent report on the health and wellbeing of the local population each year. Last year's Annual Public Report focussed on the sustainability of Children's social care in Thurrock. This year, the report considers the current and future needs of older people with respect to housing.

The report reviews evidence for what works for older people's housing to describe a vision for Thurrock, and then analyses local and national data, including residents' views, to identify older people's needs and preferences, then translating these into a set of specific recommendations.

1. Recommendation(s)

1.1 That Health and Wellbeing Board note and comment on the content and recommendations contained within the report.

1.2 That Health and Wellbeing Board consider how the findings of the report can best be used to influence strategy relating to older people's housing and The Local Plan

2. Introduction and Background

2.1 One of the main goals of our Health and Wellbeing Strategy is to make sure Thurrock provides “Healthier Environments” and this encompasses ensuring that homes are developed that keep people well and independent and that strong, well connected communities are built.

2.2 There is a wide body of evidence that shows the link between good housing and health. Housing is widely accepted to be a key determinant of health and can impact positively and negatively on an individual’s physical and mental health, in turn affecting the demand for and use of health and social care resources.

2.2 Thurrock has a growing and ageing population. Nationally the population is living longer, albeit not necessarily healthier, lives. Within Thurrock, the over 65yrs+ population is estimated at 23,700 (2017) and is projected to grow by 5% by 2020, and potentially by 46% by 2035. As a result, it is anticipated that there will be a significant increase in the number of older people requiring health and social care services. Housing can contribute positively or negatively to the prevalence and management of health conditions.

2.3 Evidence suggests that issues related to accessibility, affordable warmth, managing gardens, maintenance requirements and running costs, and in some cases isolation from facilities, services and friends and family can make the existing homes of the population unsuitable for their needs in older age.

3. Issues, Options and Analysis of Options

3.1 These are set out in detail in the report itself.

4. Reasons for Recommendation

4.1 This report fulfils a statutory duty of the Director of Public Health (Health and Social Care Act 2012). The specific recommendations contained in the report arise from a detailed analysis of local and national data, as well as a review of evidence about what works for older people’s housing.

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

5.1 A wide range of stakeholders were consulted and contributed to this report. These are set out in the acknowledgements section of the report. Additionally, a local public engagement exercise was undertaken to ascertain the views of residents as to their housing needs and preferences and this is set out in the Appendix of the report.

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

6.1 The report makes the case for focus on four key areas for older people's housing: the need to build a bespoke range of specialist homes, the need to build mainstream homes which are suitable across the life-course, the need to ensure existing housing is suitable for older people, and a need to develop healthy places which incorporate age friendly features.

6.2 The report suggests that these changes will help mitigate the effects of unhealthy, unsuitable, unsafe or insecure houses on the health of older people. Additionally, the report suggests that there are a number of ways in which housing can be used as a vehicle within which to enhance existing services and engage hard to reach groups to improve health.

6.3 The recommendations contained within the report have implications for planning and housing policy, and the development of The Local Plan

7. Implications

7.1 Financial

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

The report looks at potential future needs for older people's housing. Whilst forecasting has not been done as part of this report, the report indicates that health and social care costs will increase as the population of older people increases, and that by ensuring housing is appropriate for this population, there is an opportunity to mitigate this increase in costs.

The report makes a number of specific recommendations about reviewing and developing/expanding current initiatives for which there may be a financial implication. Specific investment decisions arising from the recommendations in this report would be subject to the approval of detailed business cases for individual services and these would be approved through the normal governance processes.

7.2 Legal

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

There are no legal implications. This report has been prepared in accordance with the statutory duties of the Director of Public Health.

7.3 Diversity and Equality

Implications verified by: Roger Harris, Corporate Director Adults Housing and Health

The report outlines evidence that older people's health and housing needs are not uniformly distributed across the borough and that older people cannot be classed as a homogenous group with regards to attitudes and preferences about housing. The recommendations made in this report would reduce or prevent the escalation of health and social care needs and help older people live independently and healthier in the home of their choice for longer.

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

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

- Detailed references are given in the main report.

9. Appendices to the report

- Annual Public Health Report 2018: Executive Summary
- Annual Public Health Report 2018: Full Report (Sent separately by email due to the size of the report)

Report Author:

Andrea Clement

Assistant Director and Consultant in Public Health

Public health

Annual Report of The Director of Public Health 2018

Healthy Housing for the Third Age:

Improving Older People's Health Through Housing

Executive Summary

Editor:
Ian Wake, Director of Public Health

Authors:
Andrea Clement, Assistant Director and Consultant in Public Health
Maria Payne, Senior Programme Manager: Health Intelligence
Nicola Smith, Public Health Information Analyst
Katie Powers, Public Health Graduate Trainee
Kelly Clarke, Public Health Information Support Officer

November 2018

Foreword

This is my third Annual Public Health report, and this year following discussion with a wide range stakeholders across the council including colleagues in Planning, Regeneration, Communities, Adult Social Care and Housing we have chosen to concentrate on the topic of Older People's Health and Housing.

There is a wide body of evidence that shows the link between good housing and health. Thurrock has a growing and ageing population, and significant opportunity and plans for regeneration, including the building of new homes. Evidence suggests that issues related to accessibility, affordable warmth, managing gardens, maintenance requirements and running costs, and in some cases isolation from facilities, services and friends and family can make the existing homes of the population unsuitable for their needs in older age. As a local authority, our ambitious place making agenda provides a once in a lifetime opportunity creating attractive housing and communities that meet the needs of our population as they age, and keep them as healthy and independent for as long as possible.

Thurrock is about to develop an Older People's Housing Strategy, and I hope that this report will be a useful resource in informing this vital piece of strategic planning.

Finally, I would like to thank Andrea Clement, Assistant Director and Consultant in Public Health who has led production of the main report, and to the members of my team and wider council officers, who have contributed to its production

Ian Wake, Director of Public Health, November 2018.

TO FOLLOW

Councillor James Halden, Cabinet Portfolio Holder for Education and Health.

Chapter 1:

Introduction

1. Introduction

One of the main goals of our Health and Wellbeing Strategy is to make sure Thurrock provides "Healthier Environments" and this encompasses ensuring that homes are developed that keep people well and independent and that strong, well connected communities are built.

There is a wide body of evidence that shows the link between good housing and health. Housing is widely accepted to be a key determinant of health and can impact positively and negatively on an individual's physical and mental health, in turn affecting the demand for and use of health and social care resources. The housing and health link becomes increasing important as we age, with Older People spending an average of 80% of their time at home.

Thurrock has a growing and ageing population. Nationally the population is living longer, albeit not necessarily healthier, lives. Within Thurrock, the over 65yrs+ population is projected to grow by 5% by 2020, and potentially by 46% by 2035. Evidence suggests that issues related to accessibility, affordable warmth, managing gardens, maintenance requirements and running costs, and in some cases isolation from facilities, services and friends and family can make the existing homes of the population unsuitable for their needs in older age.

Given the growing and ageing population in Thurrock, this report aims to answer the following four key questions for the population aged 65+:

1. What impact will demographic change have on the needs for new and existing housing stock across all tenures in the next 20 years?
2. What types of housing do our elderly population want and what are the impacts of choosing to move to a home more suitable for later life?
3. When considering a move to more suitable housing, what would make the option attractive to our older population?
4. What impacts does housing have on health and how can we enhance the positives and mitigate against the negatives? And how can we ensure they are better understood by those affected, thereby enabling them to better care for themselves?

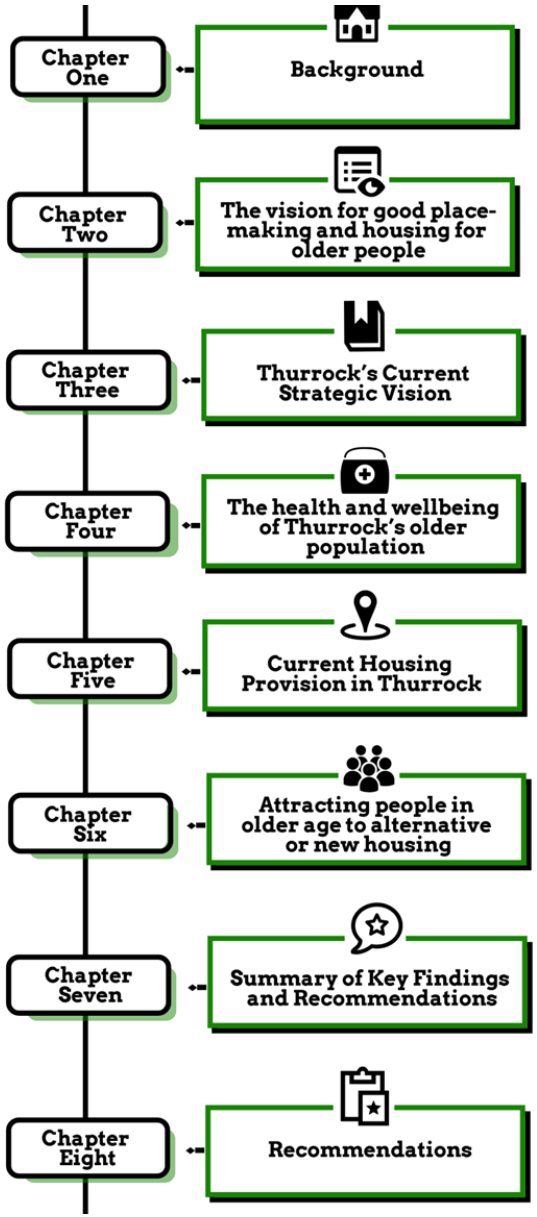
There are five main categories of housing (figure 1). This report only considers accommodation options that provide a self-contained unit of accommodation (kitchen, bathroom, toilet behind a front door which only that household can use).This covers 'mainstream' housing options, sheltered housing schemes and specialist retirement housing schemes that provide self-contained units of accommodation alongside communal facilities (lounges, dining rooms etc.) and care packages. Residential and nursing home provision falls outside the scope of this report but were discussed in detail in the 2016 Annual Public Health Report on a sustainable adult health and care system for Thurrock.

This report is organised into seven chapters, as shown in figure 2. Chapters two to six deal with specific topics relating to the complex issue of older people's housing and health.

Chapter seven aims to bring together the learning throughout this report in order to answer the four key questions above, and make recommendations for health and housing policy moving forward.

Figure 1 – The five main categories of housing

Figure 2 – How this report is organised



Chapter 1. Introduction

1.1 How does housing impact on health?

The relationship between housing and older people's health and wellbeing is complex one, encompassing the issues of cold/fuel poverty, air quality, discharge from hospital, falls, mental health and economic factors.[1] These are demonstrated in figure 3. Accessible and well designed homes and neighbourhoods can significantly enhance health and wellbeing[2] Conversely, vulnerable people aged over 75 are the group most likely to be living in poor housing.[3]

The current UK 'housing crisis' has been well documented in the media. However recent research commissioned by *Sky News*[4] identified that the UK is in fact facing five different types of housing crisis, playing out simultaneously across the country. (Figure 4). Thurrock is ranked 45th worse out of 390 local authority areas in terms of lack of supply. Affordability, distribution, quality and demand rate comparatively better at 261st, 345th 326th and 309th respectively.

Figure 3: The Relationship Between Housing and Health

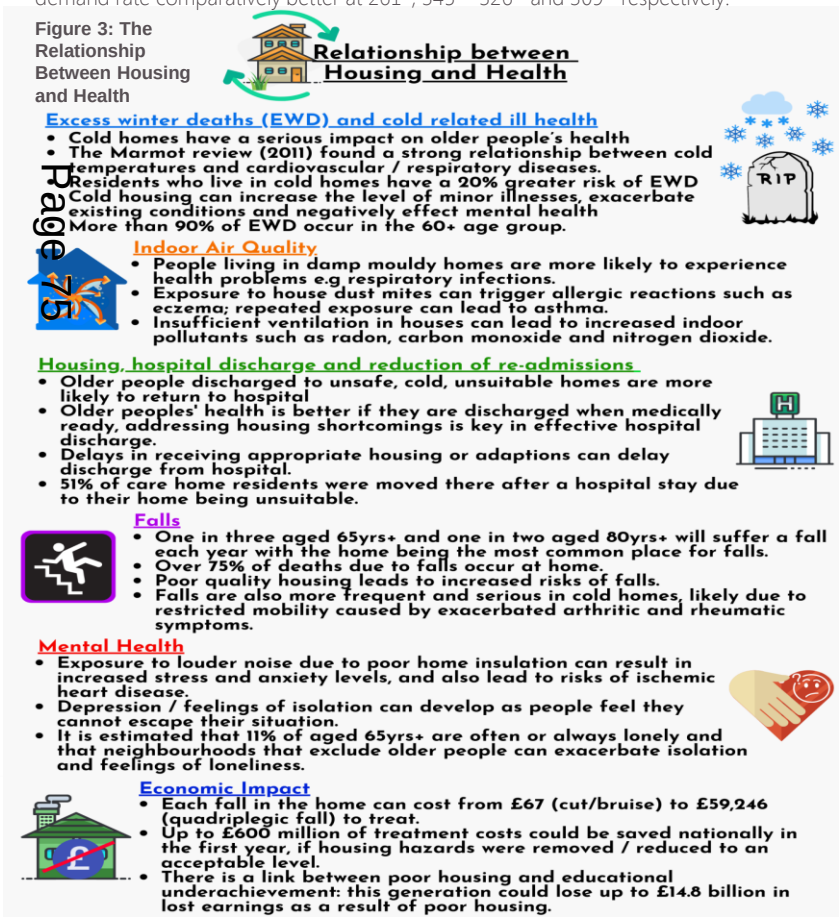


Figure 4: The Five Housing Crises Facing the UK in 2018

1.2 National Strategic Context

The Housing White Paper – Fixing our Broken Housing Market references Older People as a key group for which additional new homes are required and makes five recommendations including the need for ambitious plans for new housing at a local level; giving communities a stronger voice in the design of new housing; developing housing that meets future population need; supporting the most vulnerable; and developing sustainable approaches. Offering older people more housing choice that empowers them to live independently for longer to reduce costs on social care and health systems is stressed. The paper also promises a new statutory duty for local planning authorities to address the needs of older people's housing through their Local Plan.

Communities and Local Government Select Committee Enquiry (2018) made a series of recommendations including: to assist older people to overcome barriers to moving house; implement a national planning policy framework for the older population; require local authorities to publish a strategy for older people's housing and identify provision within their Local Plan; and that all new homes should be 'age proofed' to meet future population need.

The Prime Minister's Four Challenges were published in May 2018 as part of the Industrial Strategy and included *"an Ageing Society"*. This referenced the need to use innovation to help meet the needs of an ageing population, with housing recognised as a key element of this challenge.

Care Act (2014) [5] states that housing is a crucial for health and that services should be integrated with health and social care. The act places a statutory duty on local authorities to ensure sufficient capacity and capability to meet older people's needs, and to develop market position statements to promote a variety of accommodation.

National Memorandum of Understanding (2018) was devised to bring together key organisations from across he public and 3rd sector to maximise opportunities to embed the role of housing in joined up action on improving health and care services.

Chapter 2:

A Vision for Good Place-Making and Housing for Older People

Chapter 2: *The Vision for Good Place-Making and Housing for Older*

2.1 Introduction

This chapter explores the vision for both housing and good place-making in the context of older people, by appraising the national and local policy guidance along with evidence from the academic literature and case studies from other areas. A more detailed discussion is provided in the full text of the Annual Public Health Report. Visioning has been undertaken on four key topics:

1. **The vision for good place-making** describes what a healthy place looks like, and what age-friendly features should be incorporated into the design of new developments
2. **The vision for new mainstream housing** describes the features that all new property should incorporate to make them better suited to the older population
3. **The vision for existing stock** considers how older people who live in existing mainstream housing can be supported
4. **The vision for specialist housing** describes what excellent specialist housing looks like and how this could be developed and incorporated into our Local Plan.

2.2. A Vision for Good Place-Making

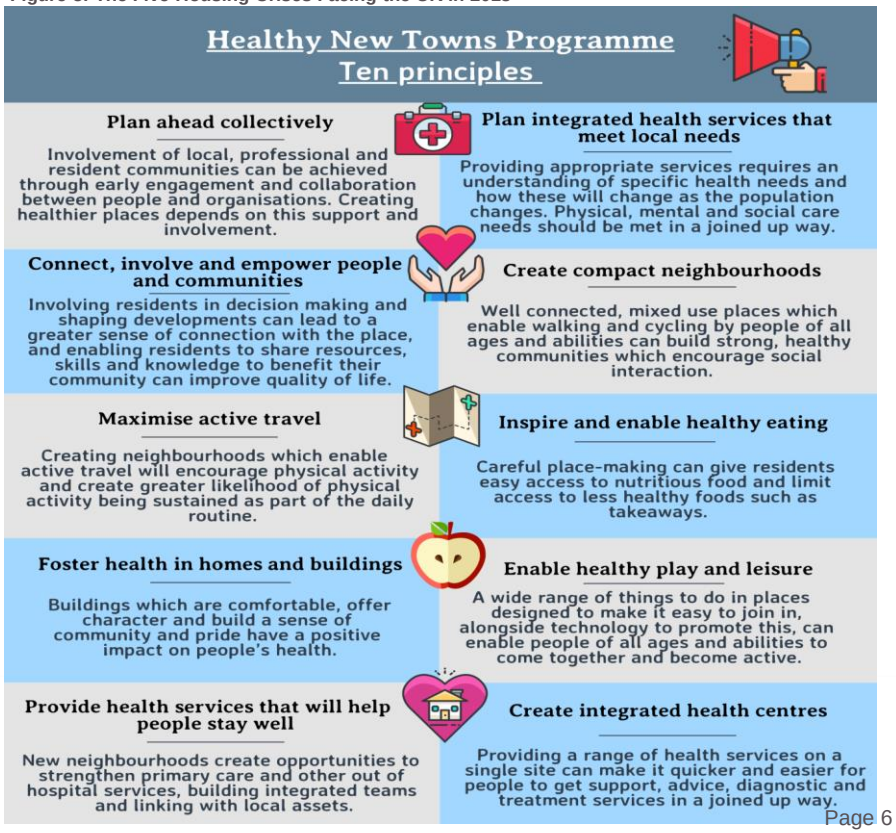
Place-making is a multi-faceted approach to the planning, design and management of public spaces. Place-making capitalises on a local community's assets, inspiration, and potential, with the intention of creating public spaces that promote people's health, happiness, and well being. There is a growing evidence base on the components of a healthy place and on taking a people centred approach to understand how a place is used by its residents.[6] The National Planning Policy Framework (13) updated in 2018 states that planning policies should aim to achieve health, inclusive and safe spaces that promote social interactions, are safe and accessible, and enable and support healthy lifestyles. NHS England recently proposed 10 principles for a healthy place, emerging from its Healthy New Towns Programme[7]. (Figure 5)

A significant amount of work has been undertaken both globally and nationally specifically on older people and the wider place-making agenda, most notably by the World Health Organisation with its age friendly agenda. The age-friendly initiative aims to promote active ageing to be a life-long process shaped by several factors that, along and together, favour health, participation and security in older adult life.[8] Older people are arguably more susceptible to the positive and negative impacts of a place, and therefore incorporation of age-friendly features within a healthy place is important as these can enhance the potential benefits of a healthier place by better enabling older people to be active participants in it

Summary of Our Vision

- All new developments should have the principles of the *Healthy New Towns Programme* at their core
- All new developments should have age-friendly, place-making design, including public transport, green space, community, employment and volunteering opportunities, safety and security and digital inclusion.
- All new housing, including mainstream housing, should be built according to HAPPI principles
- Older people wishing to continue living in existing stock will be supported to do so through the use of adaptions and telecare where appropriate.
- There will be a wide range of specialised housing available of the appropriate tenure and high quality.
- Local people will be involved in the design of new specialised housing

Figure 5: The Five Housing Crises Facing the UK in 2018



Chapter 2: *The Vision for Good Place-Making and Housing for Older*

The WHO identified five core principles for designing an age-friendly community[9] are shown in figure 6. Figure 7 summarises the age-friendly features that should be considered in the wider place-making context, from the published evidence base.

Figure 6: The World Health Organisation Five Core Principles for an Age-Friendly Environment/Community

Figure 7: Age Friendly Considerations in Place-Making

Community

It is widely acknowledged that being part of a community and participating in social, leisure, cultural, and spiritual activities and community events can help to address social exclusion and isolation, and improve physical and mental health. it is widely accepted that older people should be included as full partners in their community with respect to decisions which affect them and they should be consulted by public, voluntary and commercial services on ways to serve them better.

Work, Volunteering and Education

Age friendly community's should enable and provide options for older people to continue to contribute to their communities through paid employment, voluntary work, micro-enterprise, timeBank, education and/or civic/political activities. This can support older people using a strength based approach, linking the skills of the wider community with the need of an older person who may just need a small amount of help to stay more independent and boosting mental capital which in turn increases individual resilience in later life.

Getting around

Public transport is preferred for many older people, and the availability, affordability, and accessibility of public transport can impact on an older person's ability to move around a place, access services, and participate in community activities. It should be comfortable, safe, not overcrowded, with appropriate stopping points, appropriate frequency and good signage. Older people also walk more, however their walking speed/distance decreases. It is important that places have safe walkways, with resting places and safe pedestrian crossings.

Health Facilities

Integrated, holistic services are the most effective way of providing care and this is even more relevant in the case of older people who are more likely to have multiple comorbidities alongside social factors. Taking a joined up place based approach can help in preventing, delaying and reducing future demand for health and care services. These health services need not only to be provided in a joined up way, but it is also important that these health care services are accessible close to an older person's home and with good transport links.

Shops and Leisure Facilities

Older people's housing tends to be best located in non-remote areas that have good access to town centre amenities and facilities. Several features of age friendly buildings which should be considered are: lifts, escalators, ramps, wide doorways and passages, suitable stairs (not too high or steep) with railings, non-slip flooring, rest areas with comfortable seating, adequate signage, public toilets with disabled access.

Crime and Neighbourhood Safety

A secure environment strongly affects older people's willingness to move about in the local community which in turn affects their independence, physical health, social integration and emotional well-being. Street lighting, violence, crime, drugs and homelessness in public places are concerns expressed everywhere.

Green Space

Green space should be available to all and in the UK the Green Flag Award is a recognised standard of quality for green spaces. Green space is of social, environmental and economic value, as it can contribute toward social connectedness, and have a function in overcoming loneliness, isolation and inactivity.

Digital Environment

A great value to older people with information readily available, it can be socially beneficial with social media helping them to stay in contact with friends/relatives and people who share an interest. Internet usage decreases with age, therefore older people may not be benefiting as much from the potential social benefits of technology. Technologies can provide access to in home health and social care i.e. telemedicine which includes alerts to remind people to take their medications and apps to track dementia patients.

Chapter 2: *The Vision for Good Place-Making and Housing for Older*

2.3 A Vision for New Build "Mainstream" Housing

Not everyone can, or would wish to live in a specialist home. Therefore new mainstream housing needs to be built in a way that ensures that it is appropriate across the life to enable healthy ageing. This requires property be designed to enable flexibility, reducing the need for major adaptions which often require costly building work and are difficult to retro-fit in poorly designed homes.

Building regulation standards have been updated to make homes more accessible.[10] However, some of these regulations remain optional. Additionally they do not incorporate other important features which would make the more suitable to healthy ageing. The ten HAPPI (Housing our Ageing Population Panel for Innovation) criteria are best practice for older people's housing suitability, are considered to be an exemplar standard for all housing and should be applied more widely (figure 8).

The DWELL study[11] also found that adaptability or future proofing of homes is important. It describes how flexible design strategies fall into three broad categories:

- Construction – the ease by which the structure of the home can be changed e.g. the ability to knock through walls
- Plan – the size, connectivity and definition of internal spaces, which allows flexibility on how space is used
- Services – the ease of changing or replacing building services such as heating during the life span of the building.

A partial regulatory impact assessment conducted by the Communities and Local Government Department [12] suggested that building to lifetime homes standards could reduce or delay the need for people to move into residential care, reduce the demand for temporary residential care when people are discharged from hospital, free up hospital beds where people are ready to be discharged but cannot due to shortages in care arrangements or accommodation and reduce the need for home care.

Whilst further research is needed, this demonstrates that building future proofed mainstream homes have the potential to result in cost savings to both the NHS and wider system.

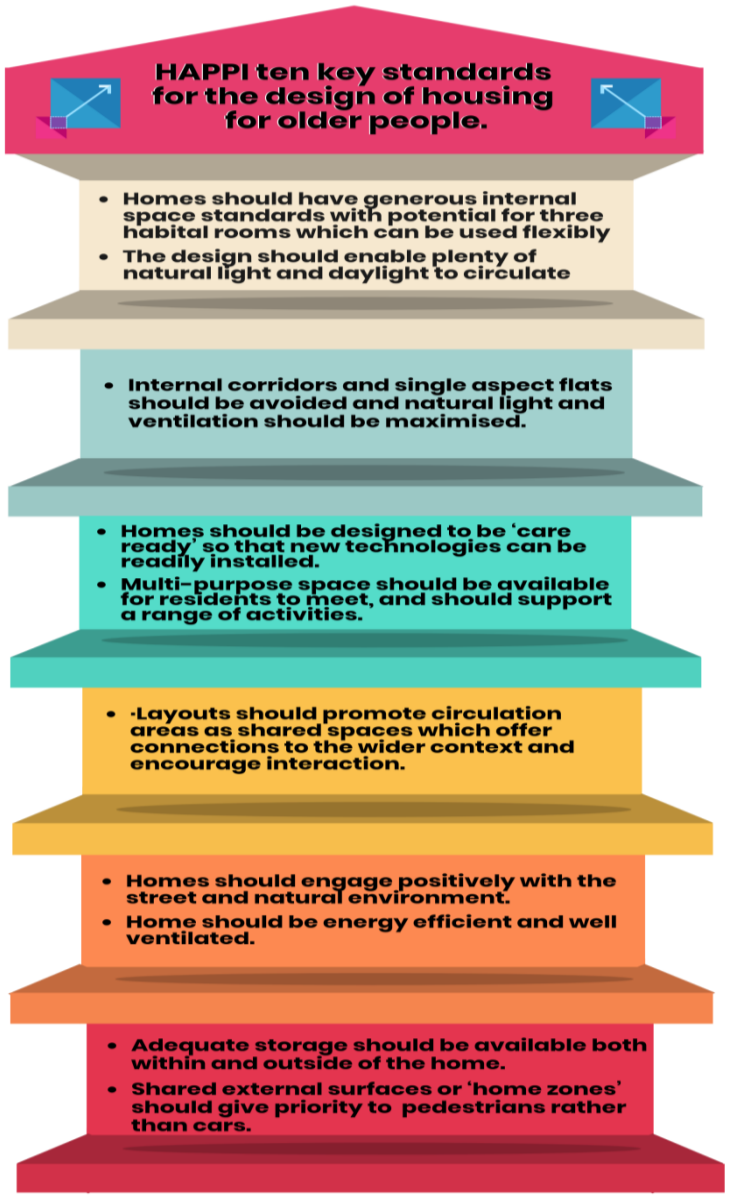
2.4 A Vision for Existing Homes

We know that the majority of the older population wish to remain in their current homes, however many mainstream homes are unsuitable for changing health and social care needs.

The Local Government Association in 2016 identified the three key issues of energy efficiency, safety and security which make housing less appropriate to the population as they age.[13] Older people are much more likely to be affected by a cold home and suffer from fuel poverty (defined as using in excess of 10% of household income to heat a home. There is evidence to suggest warmth and energy efficiency can lead to improvements in respiratory health, mental health and cardio-vascular disease.[14]

Older people are at increased risk of unintentional injury in the home due to falls, trips and slips for example. There are several ways in which safety can be improved in existing housing stock, for example through housing adaptations and telecare solutions. As the risk of having an accident decreases, the ability and confidence of a person is likely to increase which may enable them to have greater independence and which in turn can lead to improvements in quality of life.

Figure 8: Ten HAPPI standards



Chapter 2: *The Vision for Good Place-Making and Housing for Older*

There is strong evidence that minor home adaptations are effective and cost effective for preventing falls and injuries, improving performance of everyday activities and improving mental health. There is also strong evidence that minor adaptations are particularly effective at improving outcomes and reducing risk when they are combined with other necessary repairs and home improvements, such as improving lighting and removing trip and fall hazards [15]Evidence for major adaptions is more limited, but what is available suggests that the greatest outcomes are achieved when the individual, their family and their carers are involved in the decision making process, focusing on what the resident wants to achieve in their home[15]

Evidence of cost effectiveness is strongest on falls prevention with one study suggesting that programmes that mitigate hazards associated with trips on staircases have a return on investment of 62% and a payback time of fewer than 8 months. The study concluded that adapting homes could offset the need for residential care and highlighted that the average disabled grant award for such adaptions was £7,000 compared to the average residential care cost per person for £29,000.

Assistive technology (telecare) including Smart Homes has also been shown to maintain functional status[16] promote independence[17]. and lead to savings in formal care services[16]. One economic modelling study[18] found that adaptive technologies could lead to reductions in the demand for other health and social care services worth an average of £579 per recipient per annum, and an improvement in the quality of life of recipients worth £1522 per person per annum.

Handyman services which assist older people with minor home repairs, safety and home security measures and energy efficiency checks have also been found to be cost effective. One study (48) found that every £1 spent on such services delivers £4.28 in savings to health and care services from falls prevention, and that such services reduced falls risk by 36%.

2.5 A Vision for Specialist Housing

Around 25% of the older people population nationally would consider moving, and many of these would consider moving into a specialist home. The key barrier to moving into a specialist home is the lack of appropriate homes.[19.] The vision for Thurrock is to take the opportunity presented through the Local Plan, to invest in building the mix of new specialist homes that older people want and need..

Predicting the demand for specialist homes is subject to great uncertainty and estimates range from an increase by between 35 and 70% nationally.

Encouraging older people to downsize may have the impact of freeing up larger families homes which may contribute towards alleviating overcrowding, however this issue is highly complex.

Older people may not free up finances by downsizing and there needs to be emphasis on other 'pull' factors to make specialist housing more attractive.

A 2012 Market Assessment of Older People's Housing in England[20] found that there was very limited choice for older person households moving home to accommodate their support needs. It also found that there had been little progress in integrating a housing offer for older people into mainstream developments. The Market Assessment identified three types of movers amongst older people households:

- Lifestyle Movers (typically younger older) moving to the coast or abroad for a better quality of life
- Planners (typically middle aged older) moving before they need to and while they still have the energy from a realisation of changing health status or that current housing is becoming unsuitable
- Crisis Movers (often the eldest group) who remain in their existing home until an accident or ill health forces a move.

The UK generally lags behind other international western democracies in developing new models of specialist housing for older people (box below), and has favoured models more traditional models that promote and extend independence including sheltered housing and Extra-Care (self-contained specialist housing units with a care team on site providing 24-hour care, seven days a week, and access to communal facilities, such as a restaurant or activities room). Most of these schemes provide some form of communal space and social activities for residents, and the evidence suggests that residents of extra care can enjoy a better quality of life than community dwelling older people. [21,22,23] There is a lower mortality rate in extra care than care homes[24] and a lower likelihood of entering institutional care than those receiving domiciliary care in the community [25] At the very least, there is evidence that extra care can help residents maintain their health status where it would have declined in a community context.

The evidence for the cost effectiveness of extra-care is somewhat mixed. Though many studies have shown long-term savings for extra-care over other institutional options, there is also evidence for higher costs [23,26,27,28,29] This is likely due to the variability of service provision and size between schemes

.

Specialist housing should be co-produced/co-designed with local people to ensure it is designed with their needs in mind.

International Models of Specialist Housing for Older People

Co-Housing communities are created and run by their residents. Each household has a self-contained, private home but residents come together to mange their community and share activities. Cohousing is a way of combating alienation and isolation by creating 'neighbourly support'.

Garden Suites are a specialist version of a "tiny house", designed with features specifically for older people to support intergenerational living. A garden suite has a self-contained living area usually on the ground floor of a larger family home. In the UK they have been referred to as "Granny Annexes"

Intergenerational Housing Developments house older people alongside young people to create a dynamic community. Schemes have 'buddy programmes' which match older and younger residents for mutually beneficial social relationships as well as practical help for the older person.

Chapter 2: *The Vision for Good Place-Making and Housing for Older People.*

2.6 Case Studies

Though nearly all of the little available evidence focuses on extra-care, there are other models of older adult housing that may be worth consideration. Below are three case studies each outlining a different type of scheme, some unique features and key elements or ideas to apply to future schemes.

Case Study #1: Older Women's Co-housing (OWCH) group

Cohousing is a new concept in UK housing, though it has a long tradition in northern Europe and the USA. The cohousing model originated in Denmark in the 1960s. It aspires to encourage independent living within a social environment through shared goods, services, meals and chores. Residents self-manage the scheme and agree to a set of shared values which are intended to foster social cohesion.

The UK's first cohousing scheme was recently completed, after 18 years of planning and development, in High Barnet. New Ground opened in late 2016 consisting of 25 purpose built homes for 26 women aged between 51 and 88 as well as communal spaces and facilities. New Ground is a self-managed intentional community in which the residents were active in the design process from the very beginning to ensure that the result fit the needs and wants of its intended community.

The OWCH group was not just a consultation of future residents, members set up regular social activities in the years before the site opened to build a strong social structure which resulted in an active community where the women know and can rely on their neighbours for help and support. There are outings and activities that residents arrange as well as a weekly communal meal. The women were motivated by the avoidance of loneliness as they got older as well as retaining autonomy and agency over their lives.

A cohousing model like this one requires forethought and the acknowledgement of the realities of aging as well as a desire to live in a community of other older people. Support for senior cohousing projects is encouraged by the authors and contributors of the HAPPI reports.

Key principles:

1. Consult with end users when designing housing for older adults
2. Communal facilities
3. Social architecture- facilitate meaningful relationships through activities etc.
4. Mixed ages
5. Allow for an element of self-management to allow residents to engage and retain agency

Case Study #2: Halton Court, Greenwich, London

Halton Court is a 170-unit scheme for over 55s, part of Kidbrooke Village, the regeneration of the now demolished Ferrier Estate in Greenwich, London. Halton Court provides part of the affordable housing contribution under the Section 106 Agreement for Kidbrooke Village. At design stage the scheme Halton Court won the HAPPI category of the 2010 Housing Design Awards. It is distinguished by: award winning quality design; very generous private and communal spaces; the scale and range of facilities; a dense urban setting; located on a prominent site of a major regeneration scheme; prioritised for older people seeking to downsize. Lettings in the first two months of opening were at double the rate anticipated.

The scheme challenges the orthodoxy of large extra care housing schemes in that, although this is a large scheme with generous facilities, it is firmly a housing-led scheme rather than driven by social care. There are no requirements for residents to have any care needs to live here, and currently any care needs are met through domiciliary care services. Lettings are made through the choice-based lettings system of Greenwich's housing department rather than social care referrals from social services. However, the scale of this development will allow both on-site care and operation of the scheme to be developed on a more flexible basis than traditional extra care housing.

Sixty percent of the self-contained apartments are 2-bedroom, in response to this being the most common size desired by older 'downsizers'. There are a large number of communal facilities, which serve both residents and the public including a restaurant, hairdressers, spa and a Village Hall that all ensure the scheme is at the heart of the community. There are also guest suites for visitors to stay in, allowing connections with family and friends to remain active.

Key Principles:

1. Future-proof care ready design can attract older people wishing to move to a smaller home regardless of care needs
2. Incorporate HAPPI design principles
3. Ensure the scheme is in a dynamic location at the heart of the community
4. Priority for the rented homes is given to council or housing association tenants who are living in family-sized housing and want to downsize

Case Study #3: Buccleuch House, Hackney, London

Buccleuch House, a purpose-built 41-apartment scheme for older Hackney residents which is integrated within a larger mixed apartment block. The Hanover flats for older people are targeted at tenants for affordable rent, and although not an extra care housing scheme, also provide communal facilities at ground level. The scheme won the HAPPI award at the 2013 Housing Design Awards in addition to a Project Award.

The final design provides a total of 107 new homes. Of this total, 41 are designed for older people for affordable rent and with associated communal facilities, 28 are affordable rent and shared ownership apartments and 38 are private sale. The new homes vary from 1 bedroom flats to 4 bedroom homes. All homes meet or exceed London Housing Design Guide standards, including Lifetime Homes and give residents the choice to be alone or socialize with others.

Design follows the HAPPI recommendations from overarching principles through to detailed design. For those who want to remain fully independent and arrange care at home as and when they need it, this often means new types of easy to manage, spacious, accessible, two bedroom houses, or flats with lift access. For those who prefer to live in a managed, group setting or have higher care needs, it means extra care housing and residential care facilities that welcome those with dementia. And for the growing 'middle ground' - those who value their independence but would like to know they can always find company when they seek it - it means new forms of 'care ready' retirement homes. It also means more local shops, community and health facilities and better public transport.

Designed for local people, it reflects and accommodates Hackney's diverse population in a dignified, practical and equitable way. As a contemporary, high density, mixed residential building on the edge of a common in one of London's poorest and most densely populated boroughs, the new Buccleuch House exemplifies these principles.

Key Principles:

1. Make strategic use of smaller development opportunities
2. Flexible, open flat layouts
3. It can be appropriate for housing for older people to be physically and socially integrated with other types of housing.

Chapter 2: *The Vision for Good Place-Making and Housing for Older*

2.6 Vision for Dementia

Dementia prevalence is predicted to increase by over 75% over the next 20 years from 1,526 in 2017 to 2,673 in 2035. (See Chapter 4 for more details). People with dementia have specific needs in terms of housing and environment, and there is a drive to create dementia-friendly communities.

Dementia Friendly Community

Ensuring that people with dementia have their needs understood, respected and supported within the context of a wider community, and are able to contribute to community life. In a dementia-friendly community people are aware of and understand dementia, and people with dementia feel included and involved, and have choice and control over their day-to-day lives. A dementia-friendly community is made up of individuals, businesses, organizations, services, and faith communities that support the needs of people with dementia".[30]

The aim of dementia friendly communities is to improve quality of life for people with dementia regardless of where they live. At present the majority of people with dementia choose to remain in their own homes with support or move into a residential or nursing home setting. Issues for older people, such as loneliness and isolation tend to be exacerbated when the older person has dementia.[31]

The Alzheimer's Society (2018) has published guidance on delivering a dementia friendly approach to housing[30] suggests that the three key areas for consideration: are people with dementia are:

People: All housing staff including landlords, housing teams, and support workers should have awareness and understanding of dementia, have ability to interact with and communicate effectively with people who have dementia and be able to recognise needs.

Place: The creation and maintenance of suitable housing can support people living with dementia including the interior and exterior of buildings, areas around buildings and locations and includes retrofitting existing housing..

Process: Accessing residential provision and housing related services such as adaptations should be designed to reduce barriers for people with dementia and provide clear opportunities for people with dementia to contribute to decisions about their homes.

Many of these principles reflect general age-friendly principles however, there is also likely to be a need for specific developments to cater for the needs of people with dementia.

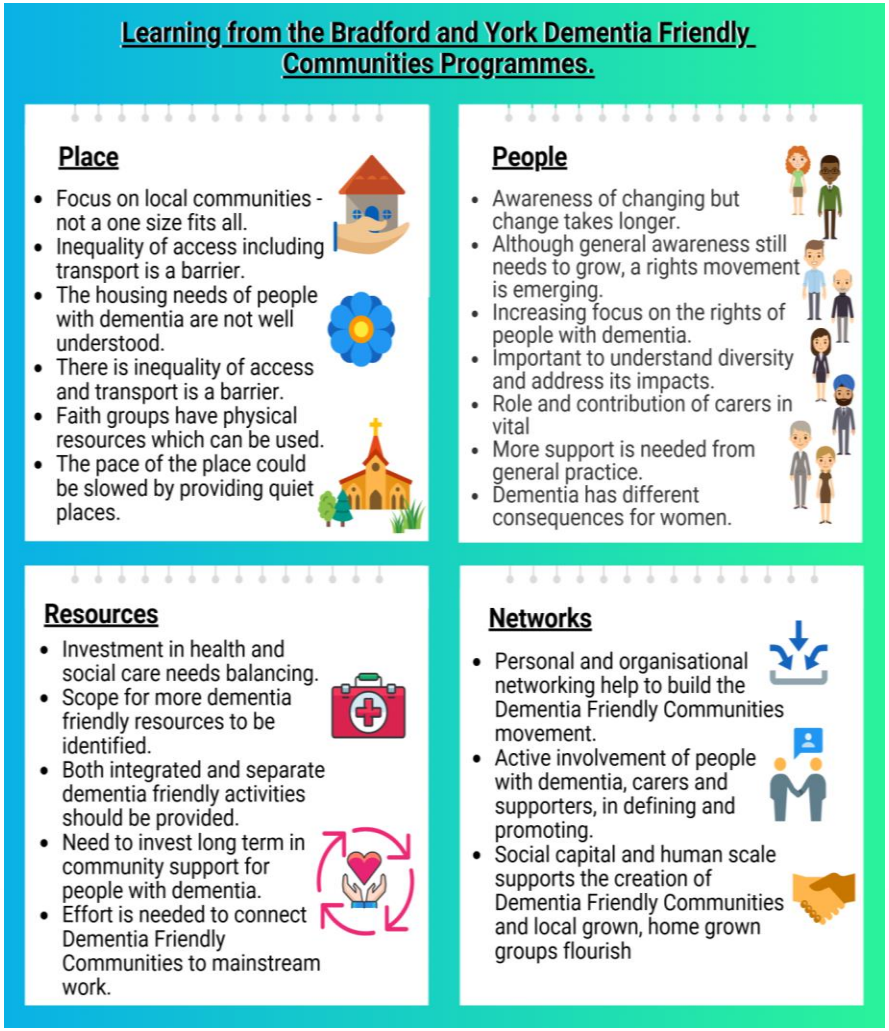
Dementia Care (2015) identified that extra care housing is increasingly being provided however this is an extra step in the dementia journey which delays but does not remove the need for residential or nursing care. It felt that some form of specialist dementia housing model is needed as an alternative to moving to care home, where people often decline quickly and developed a model which is discussed in more detail in the full version of this report.

The Local Government Association (LGA) suggests that Councils should encourage developers to consider how design can support dementia friendly communities in for example, the layout of roads and streetscape, the design of adequate and legible signage, the design of wider and pedestrian only pavements with clearly defined edges, provision of more drop off and pick up points outside of public venues, good lighting and acoustics, appropriate seating and toilet facilities and the provision of more handrails at road crossings.

The LGA also suggests that housing providers, people with dementia and their carers should to consider assistive technology such as aids and adaptations, both low and hi-tech which can help them remain independent for longer.

Both Bradford and York have developed new approaches to developing *Dementia Friendly Communities.*[32,33] The learning from their models is shown in figure 10

Figure 10: Learning from the Bradford and York Dementia Friendly Communities



Chapter 3:

Thurrock's Strategic Vision

Chapter 3: *Thurrock's Strategic Vision*

3.1 Introduction

This Chapter summarises the current strategic vision and priorities for Thurrock and how they are relevant to older people.

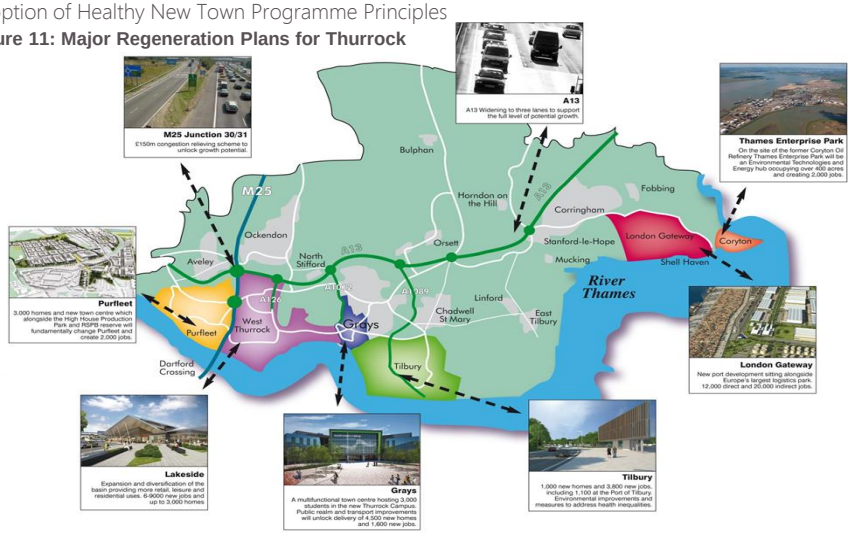
3.2 Planning

Thurrock Council's Local Plan will determine the amount and distribution of new development providing a comprehensive and long term planning framework for the period up to 2035 (along with planning policies for the determination of planning applications). The draft of the local plan is due to be published in the latter months of 2018 and adopted in 2020. Currently the Council is in the process of assessing over four hundred and fifty sites to see if they could be deemed as deliverable housing sites. [76] including a strategic housing market assessment (housing needs for South Essex), economic development needs assessment (employment land needs for South Essex), green belt assessment (how well Thurrock's green belt performs against the green belt purposes set out in national policy), active place strategy (quality of existing open spaces and sports facilities). In March 2017 the Thurrock Design Guide was adopted by Cabinet setting out the overarching principles that need to be considered by anyone putting forward a new development scheme in the borough. There is an opportunity presented through this work stream to influence the local plan and planning policies with respect to older people to ensure that the needs of the older population are met going forwards.

3.3 Regeneration

The main priority for Regeneration in Thurrock is responding to the anticipated demand for 32,000 new homes by 2037 and ensuring that this growth comes with the required level of infrastructure (for example schools, health facilities, and high quality public realm). There will also be a need to contribute towards the need for 24,500 new jobs in the area. Activity in Thurrock is currently formed around six growth hubs namely Purfleet, Lakeside and West Thurrock, Grays, Tilbury, London Gateway and Thames Enterprise Park. (figure 11). The quality of the design of this regeneration has the potential to positively impact on the health of the population including older people through adoption of Healthy New Town Programme Principles

Figure 11: Major Regeneration Plans for Thurrock



3.3 Housing

In 2015, the council published its five year Housing Strategy (figure 12) which also lays out the long term vision for housing over the next 30 years. The strategy aims to ensure quality housing across all tenures, and to build 1,000 new homes by 2020 and to deliver high quality housing services that proactively support residents to maximise health, wellbeing and employment opportunities and create sustainable communities.

Figure 12: Thurrock Council Housing Strategy 2015-2020

Leading the way *in providing well-designed, high quality, sustainable and aspirational homes that promote community cohesion and a healthy lifestyle*	**Increasing the supply** *of family homes to support growing families, making best use of our existing stock.*	**Enabling young people** *and single households to access the housing market with financial assistance including shared equity and increasing the provision of studio and one bedroom homes*
Creating apprenticeship opportunities *with our partners and support residents to access training and employment pathways with targeted programmes for council tenants*	**Creating attractive housing for older people** *that encourages independence and wellbeing*	**Reducing health inequalities** *across the borough through targeted interventions and joint working*
Safeguarding our residents *and deliver preventative measures to reduce violent crime and anti-social behaviour*	**WHAT DOES THIS MEAN FOR THURROCK?**	**Providing a range of suitable accommodation** *to support those with learning disabilities and mental health needs now and in the future*
Improving the quality *of our own stock, prioritising those with damp and mould*	**Ensuring that residents** *living in the private sector also benefit from high quality housing*	**Engaging with private landlords** *to increase the availability of homes in the private rented sector working with neighbouring boroughs*
Attracting and working collaboratively *with private developers and registered providers to boost housing supply*	**Upskilling our staff** *to better support our residents with specific training on mental health, dementia and domestic abuse*	**Regenerating existing estates** *to improve and increase affordable housing provision*

The Council plans to make better use of existing adapted properties while supporting residents in need of new home aids and adaptations as well as rolling out some sheltered housing services to those in general needs and private sector housing to increase independence. Through providing innovative and aspirational housing for older people, it hoped that older people could be supported to move into move suitable accommodation and downsize, freeing up family housing. It also aims to support the borough's most vulnerable residents by embedding safeguarding into the housing team and continuing to offer free home security equipment to residents of sheltered housing.

Chapter 3: *Thurrock's Strategic Vision*

The Council is reviewing its supply of extra-care housing to identify requirements for further schemes. Bruyns Court in South Ockendon is Thurrock's first older adult housing scheme built with HAPPI design principles, Progress is also being made at Calcutta Road, the Council's second HAPPI scheme. The Council is also aspiring to apply HAPPI principles to other housing schemes with the view to build adaptable homes that will support people throughout their lives. All new supported accommodation will meet REACH standards and the Council are working with Thurrock Coalition to better understand the needs of disabled and older people to inform the design of future schemes

3.4 ICT

The "Connected Thurrock" Digital strategy intends to work collaboratively with the private sector and government to complement these ambitions by ensuring that Thurrock is properly positioned to take advantage of all of the opportunities that are available to a vibrant 21st century community. Further details are available on the council's website,

3.5 Health and Communities

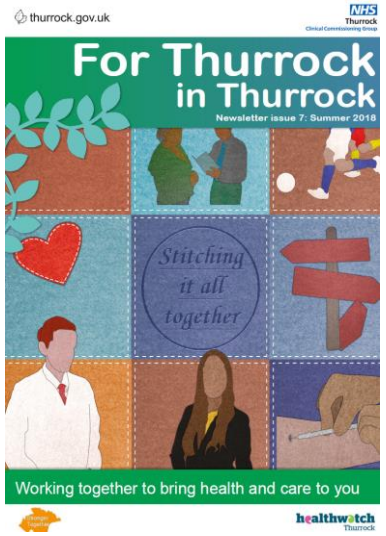
The Stronger Together programme was developed to integrate a range of initiatives provided by the council's Community Development Team, Thurrock CVS and *Ngage*. The programme operates on five key principles:

1. *Place Based* – recognising that work needs to happen at a neighbourhood level that connects people to their immediate environment
2. *Focus on Strengths* – focusing on individual strengths and neighbourhood assets rather than on what's wrong.
3. *Citizen led* – putting communities in the driving seat
4. *Relationship building* – focusing on improving community connectivity and social capital
5. *Social justice* – an inclusive approach at the heart of community building

The programme includes successful and valued initiatives including Local Area Coordination, Asset Based Community Development, Community Organisers and Time Banking, and plays a key role in improving the wellbeing of older people including addressing issues such as loneliness.

Figure 13: Artist's Impression of the Proposed Integrated Medical Centre in Tilbury

For Thurrock In Thurrock is the joint strategic health and care service transformation programme between the Council's Health and Adult Social Care functions and NHS Thurrock CCG that proposes new models of integrated health and care that places greater emphasis on neighbourhood based care in communities. It includes plans to develop four Integrated Medical Centres across the borough in Grays, Tilbury, Purfleet and Corringham. It also includes a new model of care *Better Care Together Thurrock* which encompasses significantly increasing the capacity and capability of Primary Care using a mixed skill clinical workforce centred around locality based networks of GP surgeries, a suite of projects to improve the diagnosis and clinical management of long term health conditions, and proposals to integrate health and care community services including new *Wellbeing Teams* and *Community Led Support Teams* based from our locality community hubs.



A new *Thurrock Integrated Care Alliance* of all major health and care providers has developed an MOU which commits stakeholders to working in collaboration to integrate commissioning and delivery of care on a single health and care systems basis, together with a new outcomes framework to support transformation. Sign off of this is imminent. This approach aims to prevent avoidable demand on the most expensive elements of the system; namely unplanned hospital admissions and entry to residential care by intervening earlier to improve the health and wellbeing of the population.

The Mid and South Essex Sustainability and Transformation Partnership (STP) is a new transformation programme for NHS services across Thurrock, Basildon and Brentwood, Castlepoint and Rochford, Southend-on-Sea and mid Essex. It has already developed a programme of hospital transformation between the three District General Hospitals including developing specialist centres for stroke, cardio-vascular disease, cancer and elective care on different hospital sites. A new STP Primary Care Strategy is replicating plans developed for Primary Care transformation as part of *Better Care Together Thurrock* across the entire STP footprint

All of these initiatives should have a major positive impact on the health and wellbeing of older residents, seeking to intervene earlier to prevent serious health events, promote independence, address the wider determinants of health including social isolation and loneliness, and bring simplified, easier to access, higher quality health and care services closer to home.

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Chapter 4:
An Overview of the health and wellbeing needs of older residents

Chapter 4: *An overview of current and future health and wellbeing needs of older*

4.1 Introduction

Understanding the current and projected future health and wellbeing needs of our older residents is important in helping us ensure our future housing offer keeps them as well and independent as possible. This chapter summarises the current and predicted health and wellbeing needs of our older residents and discusses the implications for the council, health partners on the third sector. More in-depth analysis is presented in the main report.

4.2 Population Growth and Segmentation

Our population is living longer, but not necessarily healthier lives. Within Thurrock, the older population (aged 65+) is predicted to grow by 5% by 2020 and 46% by 2035. This rate of growth is considerably greater than for the all-age population and does not factor in further population growth that may occur from migration into the borough as a result of our plans to build new homes. Whilst our increasing life expectancy is clearly a positive thing, a population of older people growing at a faster rate than the general population presents policy challenges in terms of increased demand on health and care services, and ability to raise revenue from taxation of the working age population to pay for them.

Older people are not one homogenous group. MOSAIC has undertaken population segmentation of the UK's older population (aged 65+) to create 14 distinct sub-categories shown figure 14, with differing characteristics. Some care needs to be taken when interpreting national MOSAIC population segments, as they may not always translate perfectly to local population characteristics.

Figure 14: MOSAIC Population Segments for UK Population Aged 65+

A04	Village Retirement	Retired couples and singles	Larger village location	Like to be self-sufficient	Enjoy UK holidays	Most likely to play cricket and golf	Often prefer post for communications
F22	Legacy Elders	Oldest average age of 78	Mostly living alone	Own comfortable homes outright	Final salary pensions	Low technology knowledge	Broadsheet readers
F23	Solo Retirees	Elderly singles	Small private pension	Long length of residence	Own a suburban semi or terrace	Keep bills down by turning things off	Don't like new technology
F24	Bungalow Haven	Elderly couples and singles	Own their bungalow outright	Neighbourhoods of elderly people	May research online	Like buying in store	Pre-pay mobiles, low spend
F25	Classic Grandparents	Elderly couples	Traditional views	Not good with new technology	Most likely to have a basic mobile	Long length of residence	Own value suburban semis and terraces
G27	Outlying Seniors	Aged 60+	Low cost housing	Out of the way locations	Low income	Shop locally	Dislike being contacted by marketers
I37	Community Elders	Older households	Own city terraces and semis	Have lived there 20 years	Some adult children at home	Multicultural neighbourhoods	Respond to direct mail charity appeals
I39	Ageing Access	Average age 63	Often living alone	Most are homeowners	Modest income	1 or 2 bed flats and terraces	Pleasant inner suburbs
N57	Seasoned Survivors	Very elderly	Most are living alone	Longest length of residence (29 years)	Modest income	Own mostly 2 or 3 bed terraces	Retired from routine / semi-skilled jobs
N58	Aided Elderly	Developments for the elderly	Mostly purpose built flats	Most own, others rent	Majority are living alone	Have income additional to state pension	Least likely to own a mobile phone
N59	Pocket Pensions	Retired and mostly living alone	1 or 2 bedroom small homes	Rented from social landlords	Low incomes	Prefer contact by landline phone	Visit bank branch
N60	Dependent Greys	Ageing singles	Vulnerable to poor health	1 bedroom socially rented units	Disabled parking permits	Low income	City location
N61	Estate Veterans	Average age 75	Often living alone	Long term social renters of current home	Living on estates with some deprivation	Low income	Can get left behind by technology
O62	Low Income Workers	Older households	Renting low cost semi and terraces	Social landlords	Longer length of residence	Areas with low levels of employment	2 or 3 bedrooms

Figure 15 shows the distribution of Thurrock's population aged 65+ across the MOSAIC categories. In Thurrock, our three biggest segments are Solo Retirees, Classic Grandparents and Seasoned Survivors. These population groups appear to generally own some sort of property already and have modest amounts of incomes; however we don't know if they will have taken steps to already adapt their homes for future needs. This could be something to consider promoting. The Mosaic characteristics also suggest that many of them might not be confident with new technologies, which is something to consider if telecare / telehealth options are used or if digital technologies are otherwise used within new homes.

Figure 15: Number of Thurrock Residents in each MOSAIC Population Segment

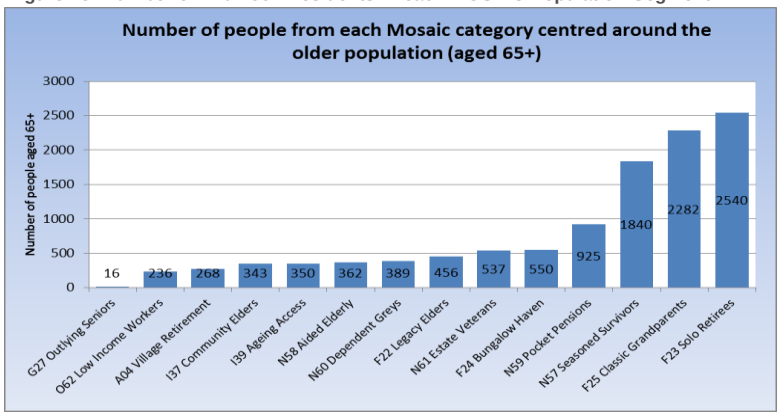
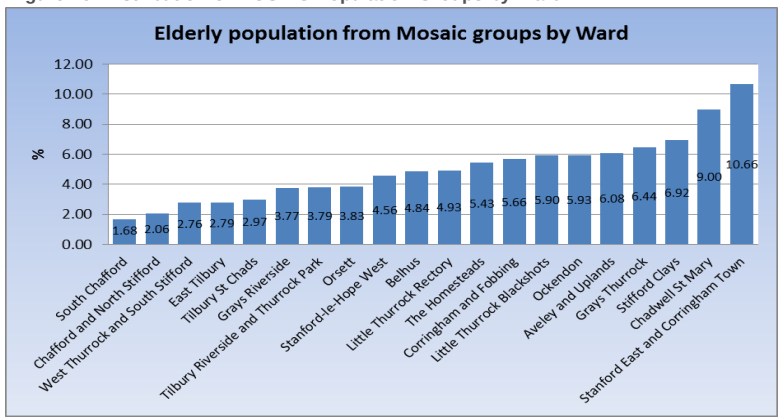


Figure 16 shows that older people are not distributed evenly across different Thurrock Wards, ranging from 1.68% of the ward population in South Chafford to almost 11% in Stanford East and Corringham Town. This has implications for where future health and care service development for older people should be prioritised, including the mix of services delivered from different Integrated Medical Centres.

Figure 16: Distribution of MOSAIC Population Groups by Ward

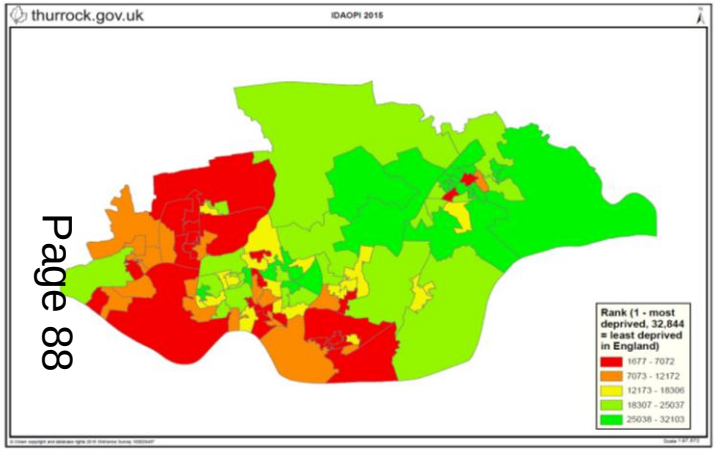


Chapter 4: *An overview of current and future health and wellbeing needs of older residents*

4.3 Deprivation

Deprivation is highly positively associated with poor health outcomes and is therefore the major driver of health inequalities. It can be measured using the Income Deprivation Affecting Older People Index (IDAOPI) which is based upon the percentage of older people living in income-deprived households. Figure 17 shows that deprivation faced by Older People in not evenly distributed across the borough, with the majority of the highest levels older people's deprivation centred in Purfleet and South Ockendon and Tilbury and Chadwell. Older people in these areas are highly likely to have higher levels of morbidity and mortality, and require health and care services at an earlier age.

Figure 17: Index of Deprivation Affecting Older People (IDAOPI) 2015 by Lower Super Output Area



4.4 Fuel Poverty

Fuel Poverty occurs when households have above average fuel costs and meeting those costs leave them with a residential income below the official poverty line.[34]. In 2016, 5638 households in Thurrock were estimated to be in fuel poverty, with significant variation in fuel poverty prevalence between wards; Tilbury St. Chads and Grays having the highest prevalence.

Warmth and energy efficiency leads to improvement in general, respiratory and mental health and reduces the risk of cardio-vascular disease[14], and is particularly important for older people who are already at significantly increased risk of these health conditions. However evidence suggests that older people are often unaware of energy efficiency schemes that they could benefit from. Addressing this through promotion of schemes like *Well Homes* is particularly important.

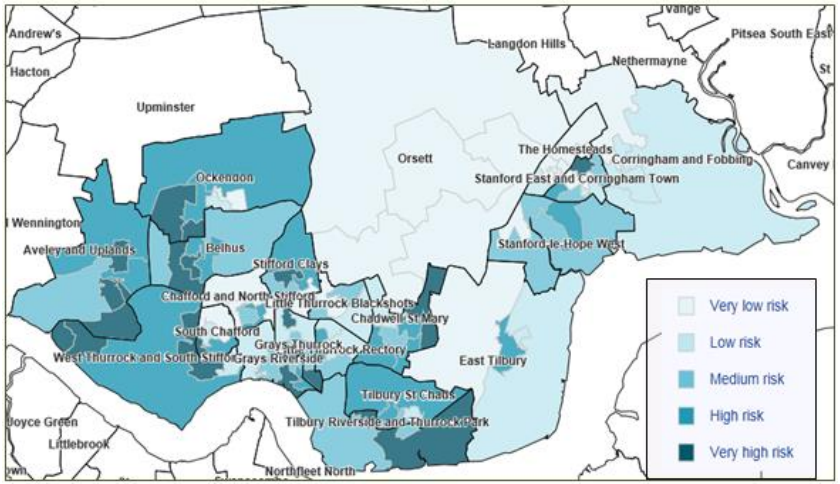
4.5 Community Connectivity and Social Capital

There is a growing body of evidence that suggests that feeling 'connected' to your community is vital to wellbeing and as such a key factor in the quality of life of older-people. Thurrock has almost 6000 residents aged 65+ with no access to a car or van, leading to a reliance of public transport and potential social isolation. The evidence shows that whilst older people walk more, their risk of falling increases. This finding emphasises the importance of designing places which have age friendly features such as safe pedestrian routes with resting places and no hazards, and providing homes in locations where facilities can be easily accessed; and for those parts of the borough with higher numbers of lone-person households with no car/van, ensuring that community facilities can be reached by public transport.

The Adult Social Care survey found that 47.2% of respondents do not have as much social contact as they would like, 36.7% stated that they do not generally leave their home, and another 14.9% felt that they were unable to get to all the places they wanted to. Whilst the reasons were not given, this highlights the importance of a) ensuring the home is safe and fit for purpose, b) looking at ways to support people to leave their homes if they should want to, and c) migrating additional hospital services closer to where people live. It might be that provision of telecare equipment (e.g. pendant alarms) or support with accessing appropriate public transport may facilitate this group of older people to access the places they wish to.

Social Isolation and loneliness can have serious implications for health and wellbeing. A recent meta-analysis of over 3.4 million people suggested that prolonged social isolation carries the same health risk as smoking 15 cigarettes a day. Age UK recently produced data showing the relative risk of loneliness in the population aged 65+ across Thurrock based on the 2011 Census data. The wards identified has carrying the highest risk of loneliness in Thurrock were Aveley and Uplands and Tilbury St. Chads. (Figure 18)

Figure 18: Risk of Loneliness in the Population Aged 65+ (Age UK)



Thurrock's approach to community development in terms of local area coordination, social prescribing and community hubs are vital in promoting social contact and reducing the risk of loneliness particularly amongst these higher risk groups, however there is clearly still more to do.

The case studies in Chapter 2 outline some examples of housing developments that incorporate elements of social spaces and facilities which could reduce the likelihood of loneliness in older age.

New models of care, particularly our proposed new *Wellbeing Teams* and *Community Led Support Teams* aim to deliver a more holistic, strengths based offer to older people, set in the context of linking residents to assets in the community that may improve their wellbeing, as opposed to simply meeting basic care needs. This approach, currently being launched in Tilbury and Chadwell should be rolled out across the borough if shown to be successful.

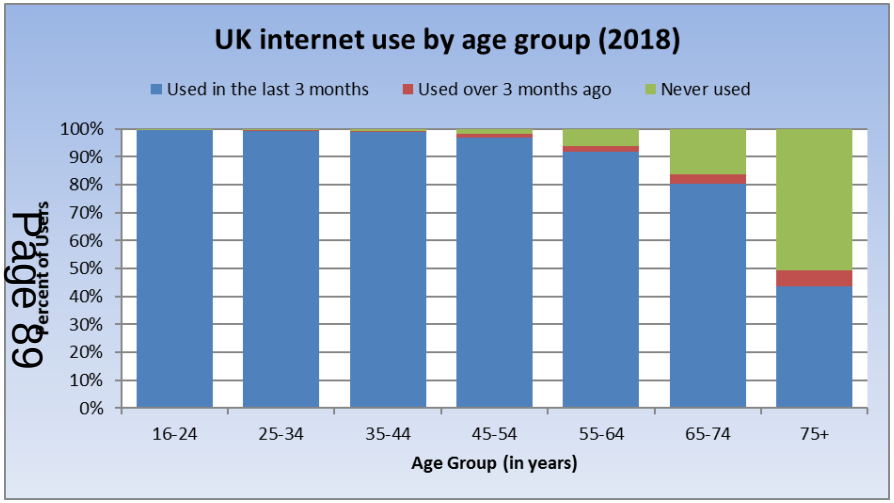
Chapter 4: *An overview of current and future health and wellbeing needs of older*

4.6 Digital Connectivity

A growing amount of social contact is undertaken via the internet both through emails and websites or via social media. This can offer the opportunity to facilitate and enable contact with others, and have the potential to increase connectivity and reduce risk of loneliness. When compared to the UK, However concerns are regularly raised by members that some of their older residents may be being 'left behind' in terms of this digital revolution.

National evidence bears out this concern, with figure 19 suggesting a significant fall in regular internet use in the population groups aged 65+ compared to middle aged and younger adults.

Figure 19: UK Internet Usage by Age Group (2018)



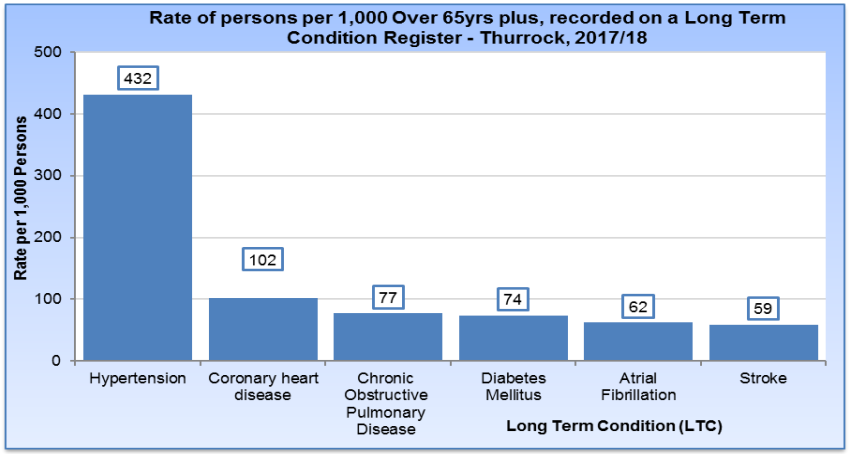
Evidence suggests that digital connectivity can bring benefits to older people. Using technology including Skype and Amazon Echo to deliver programmes such as Virtual Chair Based Exercise is about to piloted as part of our new Wellbeing Team approach to delivering a more holistic home care offer to our residents. Triangulating national data with the segmentation data on our older population group set out in section 4.2, it is likely that we will have some residents who may benefit from support with using new technologies via education and training. This should also be considered when promoting new telecare and telehealth solutions and the council and healthcare partners need to be mindful of potential limited digital skills in our older population when implementing future roll-out of digital solutions to accessing our services. There are opportunities to provide an expanded offer to digital skills training through our community hubs.

Conversely, the data show that we are likely to have large numbers of "younger older people" who are confident using the internet. As this cohort continue to age over the next decade, it is inevitable that digital skills across the entire population will increase.

4.7 Long Term Health Conditions

As we age, the risk of developing one or more long term health conditions rises significantly. Figure 20 shows prevalence of different diagnosed long term health conditions within the population aged 65+ in Thurrock. High blood pressure (hypertension) is the most common diagnosed LTC followed by coronary heart disease and COPD.

Figure 20: Prevalence of Diagnosed Long Term Health Conditions in those aged 65+ in Thurrock, 2017/18.



Modelling work by Public Health England and stated within the Thurrock Annual Public Health Report 2016 indicates that there are a large number of patients who have long term health conditions who are not yet diagnosed and therefore not receiving any form of treatment. Whilst numbers are not available for 65+ only, we suspect some of the undiagnosed LTC patients will be older adults.

Undiagnosed or poorly managed long term conditions significantly increase the risk of serious cardio-vascular and respiratory health events and are often the precursor to avoidable hospital admissions and early entry into the care system. This highlights the importance of

a) preventative interventions such as smoking cessation and weight management services to support all adults to reduce the likelihood of developing long term conditions;
b) diagnostic interventions such as NHS Health Checks and Hypertension detection programmes which aim to diagnose early before conditions worsen;
c) increasing the holistic treatment offer of care for patients with more than one long term condition.

Whilst there are a number of programmes in place already to address all of the above, more could be done to embed them within the Housing work programme – e.g. using communal sheltered housing complexes to host long term condition detection interventions, training more staff in Making Every Contact Count and ensuring housing improvement programmes such as Well Homes (see later section) adequately identify and refer patients to relevant health services.

4.8 Mobility and Falls

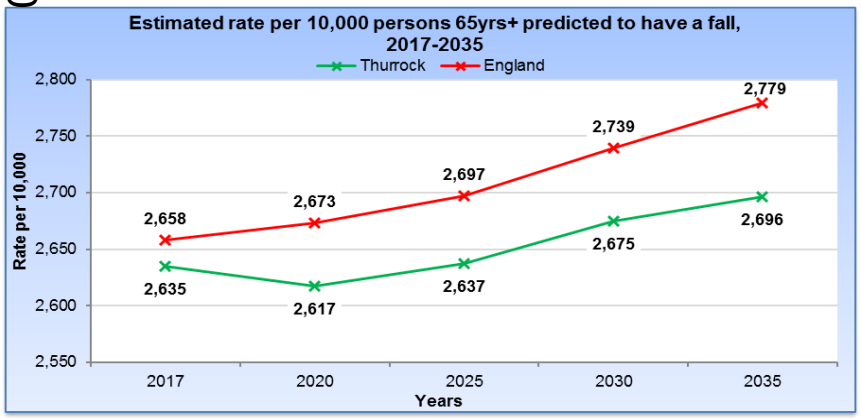
As our population ages, it is likely to become less mobile. Analysis from the main report suggests that up to 4,388 more older people will be unable to manage at least one self-care activity alone by 2035, with 2600 more struggling with increased mobility issues, indicating a significantly increased demand for adult social care support.

This indicates both a need to increase capacity all models of current provision, and more broadly to consider new innovative ways of delivering care within the community. It also highlights the importance of preventative and early intervention approaches that seek to keep people as well and independent as possible for as long as possible.

Falls are common in older people and are the leading cause of injury related admissions to hospital in people aged 65+, accounting for 14% of all hospital admissions in this age group.[35] Falls are also preventable and there is a strong evidence base relating to the efficacy of medication reviews, home safety checks, eyesight checks and postural stability training in reducing falls risk.[36]

Rates of falls in older people are predicted to increase over the next 20 years (figure 21) perhaps reflecting changes in age structure of the population aged 65+, as the numbers of our oldest residents increases. Converting the rates in figure 21 into absolute numbers, suggests an increase from 6,245 to 9,759 (35%) in falls from 2017 to 2035.

Figure 21: Predicted falls rate per 10K residents aged 65+, 2017-2035



Despite figure 21 showing, a lower rate of falls in Thurrock compared to England, data in the Public Health England Outcomes framework shows that our rate of fractures of neck of femur is significantly higher than England's This suggests that when older people are falling locally, their falls are more severe.

In 2017/18 there were 287 admission spells for Thurrock patients to Basildon Hospital with a recorded fall. The total cost of these was £1,344,620, with an average cost per spell of £4,685.

The wider impact of these falls to the longer term health and social care system is vast - one estimate from Craig et al.[37] indicates that the long term care costs resulting from a fall could be as much as £29,479 per person. Applying this to the Thurrock estimated number of falls (rather than just hospital activity presented above would give long term care costs of £184,096, 355 for the 6,245 older adults estimated to have fallen in 2017, and costs of £287,685,561 for the 9,759 adults estimated to fall in 2035.

Falls prevention approaches can therefore provide a large return on investment - this can be seen through the activity to date from the Well Homes service in terms of the Category 1 Hazards they have removed to date (see section on Private Housing).

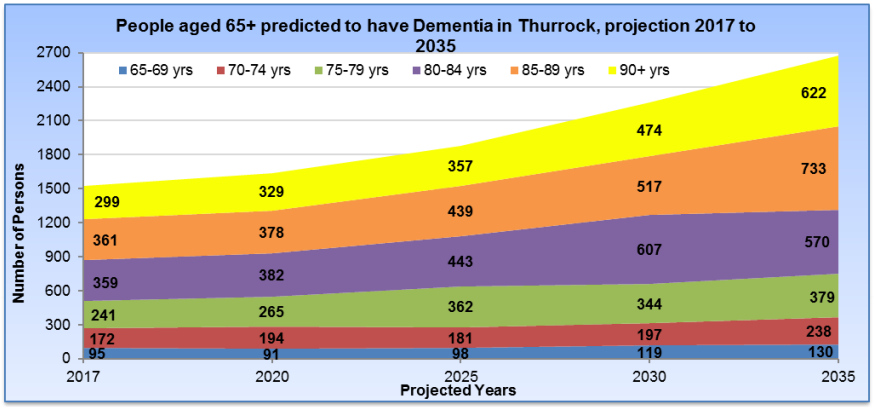
Thurrock has been operating a falls prevention service run by NELFT, which is part of the Older Adults Health and Wellbeing Service. The service includes a multi-agency team consisting of a Pharmacist, Consultant Geriatrician, Dementia Nurse, Nurse, HCA, Physio-therapist and Associate Practitioner. The team provide a Geriatrician led falls clinic, home therapy assessment including home hazard check, 12 week falls prevention group programme and direct support to care homes.

However, given the predicted increase in falls, together with further analysis in the main report suggesting that the severity of falls may vary between different GP practice populations and the highly cost effective nature of falls prevention programmes, there is a need to explore further how the current offer can be better used and perhaps expanded to mitigate projected rises in demand.

4.9 Dementia

Figure 22 shows the projected rise in dementia prevalence in Thurrock to 2035. Dementia is projected to rise by just over 75% with the biggest increases in the population aged 85+. This underlines the importance of planning for communities that are perceived to dementia friendly, as discussed in Chapter 2.

Figure 22: Projected rise in prevalence of Dementia in Thurrock, 2017-2035



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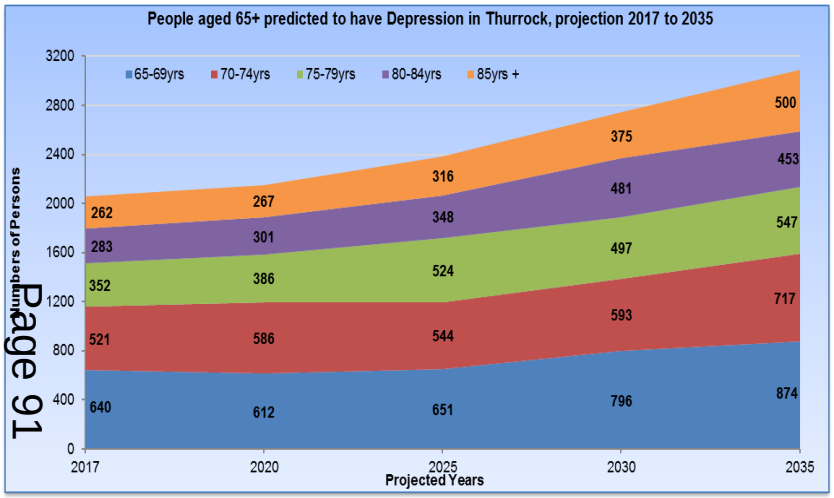
4.10 Depression

Risk of depression increases with age. Depression affects around 22% of men and 28% of women aged 65 years and over and up to 40% in those aged 85+[38], yet it is estimated that 85% of older people with depression receive no help at all from the NHS.[39] The number of older people in Thurrock with depression is predicted to rise as our population ages (Figure 23)

Figure 23: Projected risk in the prevalence of depression in older age groups in Thurrock, 2017-2035. Source: POPPI 2018



The impact of depression on the wider health and social care system is huge – information from the 2018 Thurrock Mental Health Joint Strategic Needs Assessment found that between 12-18% of all NHS spend on long term conditions is related to poor mental health, and the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year. Applying this to the expected increased number of older people with depression locally by 2035, we calculate an additional £563,000 in treatment costs for long term health conditions.

There are already a number of initiatives underway to improve the diagnosis of depression in the adult population as a whole, including the cleansing of GP registers to identify patients likely to have a diagnosis but not accurately recorded as such, the implementation of depression screening in primary care for patients with Diabetes, and the use of practice level data on IAPT referral activity to drive referrals to treatment services. However more could be done to embed depression screening into the day job of more front line staff (e.g. housing officers) and those professionals who see older people regularly.

Work is also commencing in Thurrock to develop new, more integrated and holistic models of care for treating common mental health disorders.

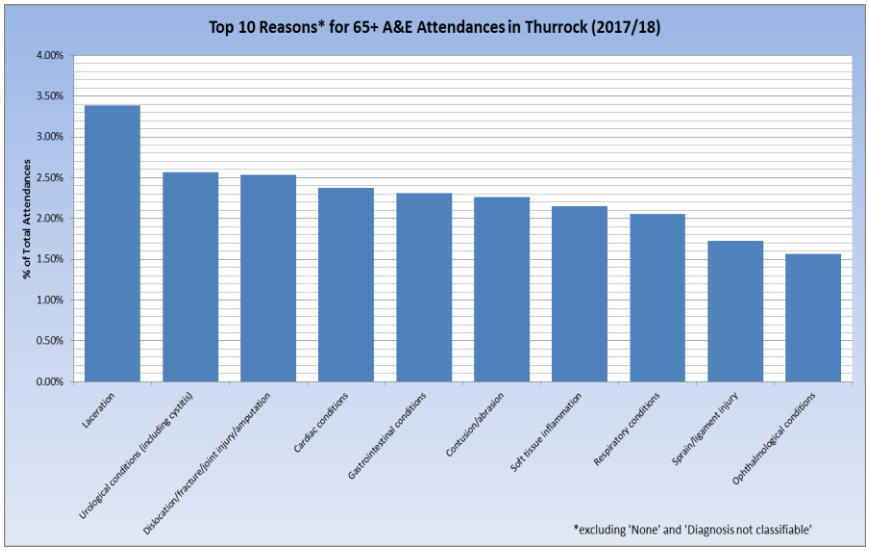
These will aim to link traditional clinical intervention with asset based community approaches including physical activity, addressing loneliness and isolation and support returning to work. Use of the community hubs and local area coordination are key to this process.

4.11 Hospital Use

In 2017/18 there were 12,173 A&E attendances for people aged 65+ in Thurrock, with the most popular diagnoses at admission being 'none' (65.31%) This suggests both on-going coding issues and potentially a cohort of older patients accessing A&E attendances were from people needing advice only; something that can and should be provided in Primary Care, and indicates ongoing issues with the populations ability and/or willingness to access local GP surgeries in a timely way.

Figure 24 shows the most common diagnoses from A&E attendances where coded. It is striking that many of the diagnoses are for conditions that could be treated within the Primary and Community care, if adequate access and facilities were available, highlighting the need for the proposed Integrated Medical Centres and for roll out of Primary Care Mixed Skill workforce proposals

Figure 24: Most Common Reasons for A&E Attendance in those aged 65+ where diagnosis was recorded.



Overall A&E attendances in Thurrock for 65+ remained relatively stable with a small increase of 134 attendances between 2016/17 (12,039) and 2017/18 (12,173). However the cost increased from £1,545,024 in 2016/17 to £1,740,997 in 2017/18 – an increase of 12.7%. This could signify an increase in the complexity of patients attending A&E.

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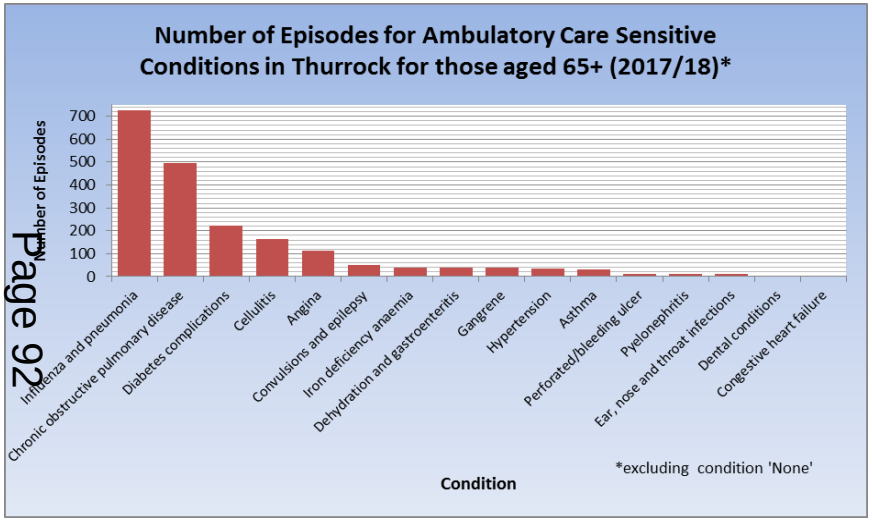
Ambulatory Care Sensitive Conditions

In 2017/18 there were 19,747 inpatient episodes of Ambulatory Care Sensitive Conditions (ACSC) for adults aged 65+ in Thurrock. This represents the number of inpatient episodes that could potentially have been avoided if a chronic condition had been managed better in primary or community care. Figure 25 shows the most common ACSC Hospital Episodes in Thurrock for those aged 65+.

Figure 25: Hospital Episodes for ACSC in those aged 65+ (2017/18). Source: HES



The top two causes for ambulatory care sensitive conditions are respiratory-based, and therefore could be influenced by work to improve housing quality (see sections on Well Homes and Transforming Homes). In addition, continuing to embed Making Every Contact Count principles across the wider front line workforce is key to earlier prevention or detection of conditions which could be managed within primary care and should not lead to an admission. This also underlines the importance of promoting healthy lifestyle interventions such as smoking cessation, and encouraging older adults to receive their free flu jab during winter months.

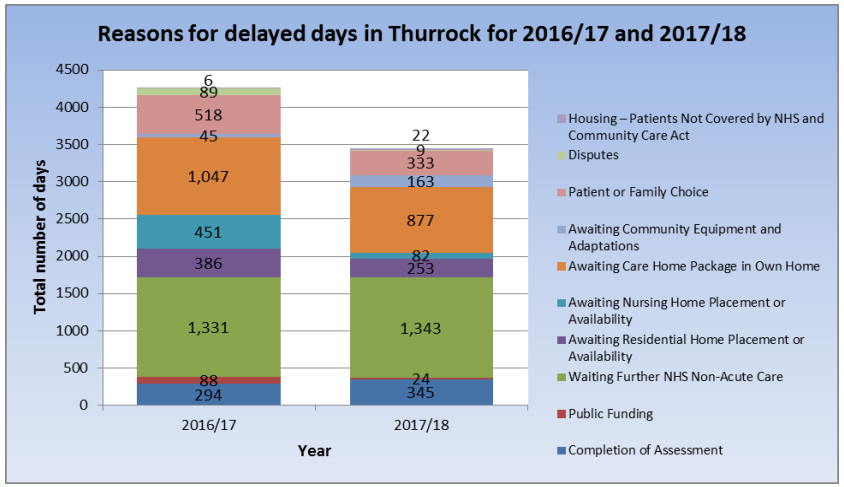
4.12 Delayed Transfers of Care (DTOC)

Reducing how long older people stay in hospitals can have benefits for patients, hospitals and reduce demand for adult social care. However discharging people from hospital relies on a suitable home environment which is equipped to meet their recovery and support needs. In 2017/18 there were 3,451 "delayed days" in Thurrock, which is a reduction from the number in 2016/17 (4,255). The latest data available at the time of writing this report was for April-June 2018, during which there were 385 delayed days in total. Comparing this to the same time period during the last two years, this is lower than the April-June period in both years.

Compared to its CIPFA comparators, Thurrock has very low levels of delayed transfer of care activity suggesting that the suite of initiatives commissioned from our Better Care Fund is effective in reducing DTOCs. Figure 26 shows the reasons for DTOC in 2016/17 and 17/18.

Whilst Thurrock has decreasing levels of delayed transfers of care, there are some delays caused by lack of equipment or a housing issue which have not decreased over time. This means there could be patients in a hospital bed who are well and could be discharged home if the correct equipment or adaptations were available, and consequently compounding the demand on the healthcare system unnecessarily

Figure 26: Reasons for DTOC: 2016/17 and 2017/18 in Thurrock



The delays due to awaiting community equipment and adaptations could be due to either the NHS or Adult Social Care, it is something that should be monitored and could be unpicked further. Further information on the main types of equipment and adaptations accessed by Thurrock residents can be seen in the section on Housing Adaptations in the main report.

Chapter 5: *Current Housing Provision in Thurrock*

Chapter 5: *Current Housing Provision in Thurrock*

5.1 Introduction

Understanding current local housing provision is key helping make strategic policy decisions on future provision. This Chapter summaries findings in the main report related to the borough's housing stock in terms of type, tenure, affordability, quality and suitability for older people.

5.2 Housing Type and Tenure

There are approximately 70,000 dwellings in the borough of which 12% are detached, 33% semi-detached, 32% terraced, 21% flat/maisonette/apartment and 1% bedsit/house of multiple occupation (HMO). The distribution of housing type is not uniform across the borough and varies considerably by ward. (See main report for more details).

The majority of housing stock in Thurrock (63.8%) is owner-occupied, and the rented sector split roughly evenly between private sector rented and socially rented (18.2% and 18.4% respectively). The data in figure 27 suggests a possible trend from owner occupied compared to privately rented over the last four years, although this change is not statistically significant.

Figure 27 Trends in Owner Occupier and Privately Rented Tenure in Thurrock 2012-15. Source: Sub-national dwelling stock by tenure estimates, ONS

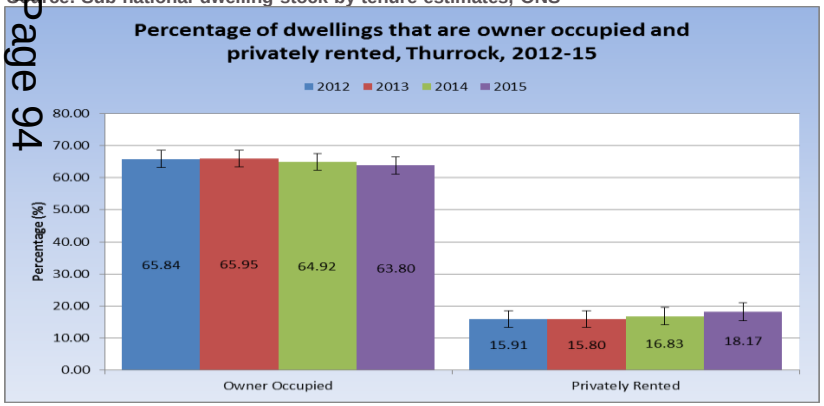


Figure 28 Home Ownership by Ward in Thurrock 2011. Source: Census, ONS

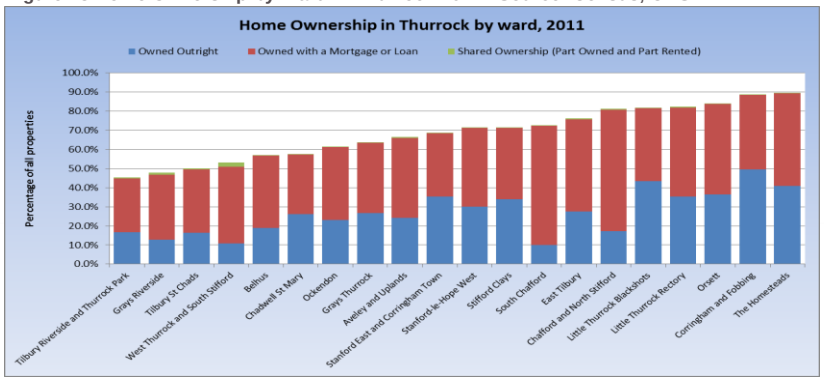
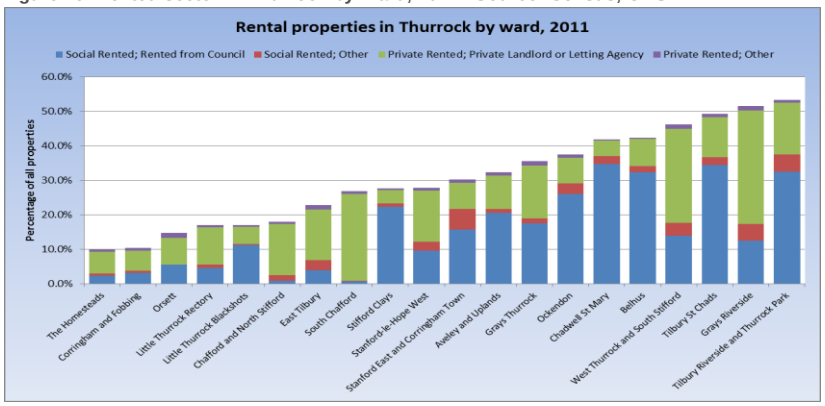


Figure 29 Rented sector in Thurrock by Ward, 2011. Source: Census, ONS



Housing tenure varies considerably between wards (Figures 28 & 29) In the Homesteads, almost 90% of housing stock is privately owned, whilst in Tilbury Riverside and Thurrock park, this figure falls to only 45%. This will in part a function of both where the council's own housing stock is located and partly where private sector landlords have chosen to invest which in turn will reflect demand within the private rented sector. (Figure 29)

Existing tenure needs to be considered when planning strategic planning for future housing provision for older people. A high level of home ownership could also mean a number of older people in homes they have lived in for some time, and therefore the responsibility for adapting these for future needs would lie with the individual. Evidence shows that it is cost-effective to adapt a home in order to prevent falls, or onward admission to residential care because a person cannot live independently, equally delays in receiving adaptation can negatively affect the effectiveness of that adaptation. The data above suggests that support for and access to adaptations within Thurrock should be reviewed to ensure that owner-occupiers in need as well as rental tenants are accessing the necessary adaptations. Additionally, this data may assist in identifying the need for the proportion of homes by tenure that are built in the future, particularly in terms of specialist homes, where the lack of options to buy a property may act as a barrier to moving for existing owner-occupiers. A range of homes for older people, of different tenures, are likely to be required.

5.3 House Prices

In 2017 the average cost of a property in Thurrock was £275,000, which is higher than the national average (£230,000) but lower than our the majority of our geographical neighbours, with only Southend having a lower median house price than Thurrock [see chart below]. It should be noted that the percentage increase from 2013-17 in median house price was 59.6% in Thurrock, which was more than double the increase seen nationally (24%).

Lower quartile house prices show a similar pattern with Thurrock having the second lowest (£224,000) of its geographical neighbours, but higher than England's £151,000 figure.

Chapter 5: *Current Housing Provision in Thurrock*

5.4 Housing Affordability

Considering median and lower quartile house price figures across all dwelling types risks disguising variation in price increases by house type. Figure 30 shows change in median house price by type of property. It suggests that the least expensive types of housing have increased the most in price, and at a rate that considerably outstrips England's.

Figure 30 Trends in Owner Occupier and Privately Rented Tenure in Thurrock 2012-15. Source: Sub-national dwelling stock by tenure estimates, ONS

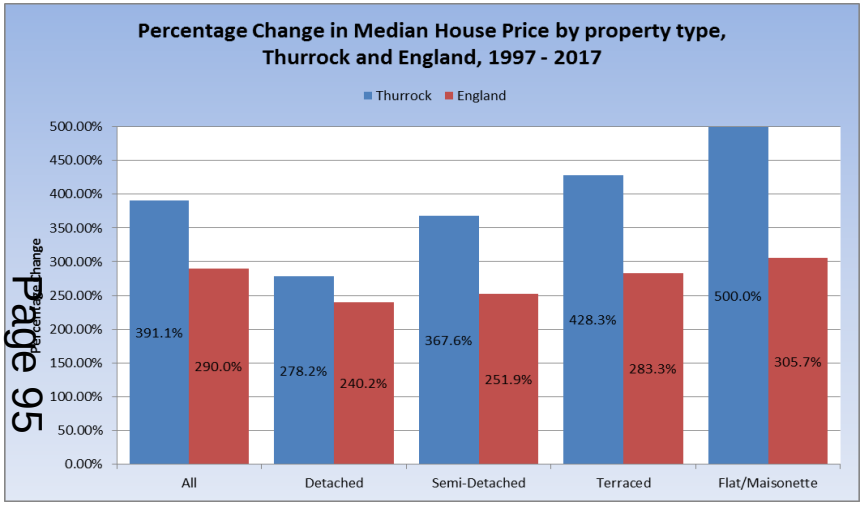


Figure 31 Growth in Average weekly rent, Thurrock and England 2007-8 to 2016-17

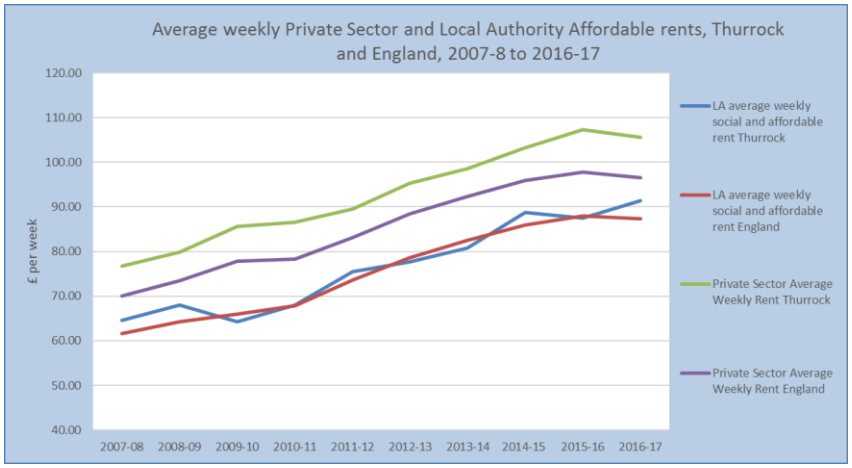


Figure 31 shows the growth in average private sector rents for Thurrock and England. Rents in Thurrock remain higher than England's, perhaps unsurprisingly as rent charged is likely to be associated with the capital value of property (rental yield) and hence the size of mortgage required by a private sector landlord to acquire it. The growth in private sector rent is largely in line with England's which suggests that rental yield from property in Thurrock is falling. Social and affordable rent in Thurrock have risen by a greater amount than the private sector over the last 10 years (41.6%) although remain lower than the private sector. Growth in both private and social/affordable rent sector increases are likely to present affordability challenges to older people who do not own their own home, if their income has not risen at the same rate.

The data in the section indicate that whilst Thurrock could be seen as more 'affordable' than its geographical neighbours, the recent trends in both house prices and rents indicate this will not continue to be the case – particularly in flats. As Thurrock is still more 'affordable' than London, it remains an attractive prospect for families moving from the capital, thereby potentially reducing the housing stock available for Thurrock residents.

For older people who bought their property over a decade ago, these data are likely to be good news as they are likely to have benefited from significant capital appreciation of their house at a time of enjoying historically low interest rates on their mortgage. Should they choose to move, the capital that they have amassed could provide considerable choice in retirement. National evidence suggests that many older people are likely to under-occupy larger houses. Whilst modelling the impact of downsizing on housing affordability is complex, creating attractive new options for older people is likely to free up the entire housing market and may impact positively on affordability.

Conversely, for older people who do not own their own home, the opposite is true. Rents have risen at a faster rate than income in all sectors, making housing more unaffordable. If this trend were to continue, this will present future affordability to challenges in the future, particularly as younger older people's incomes drop as they come to retire

5.5 Housing Quality

Thurrock Council is currently part-way through a home improvement programme called Transforming Homes, which aims to bring all Council homes beyond the Decent Homes Standard. The programme covers:

- kitchens that are over 20 years old
- bathrooms that are over 30 years old
- boilers that are over 15 years old
- electrics that are over 25 years old
- windows that are either over 30 years or are single-glazed
- roofs that are over 40 or 50 years old, depending on type

The work also aims to maximize energy efficiency and eradicate damp and mould.

The Council had improved over 7,800 homes as of March 2018, with the intention for all to be completed by 2021. Our data shows that there are 3,002 residents in council homes in Thurrock aged 60+ claiming housing benefit. This programme will improve the quality and mitigate the risks of ill health associated with poor housing.

Chapter 5: *Current Housing Provision in Thurrock*

Private Sector Housing Quality

Public Health has commissioned a *Well Homes* project over the past three years aiming to support residents in the private sector to live healthily in their homes by addressing home hazards and promoting health, wellbeing and independence. The service is considered to be an innovative and integrated approach as health determinants have been considered broadly with signposting to services such as, but not limited to grants to improve energy efficiency including home insulation and boiler replacement, together with employment support, debt management and lifestyle modification.

The project has so far focussed on older people, people with long term or mental health conditions, and people on low incomes, although it operates on an open access basis. Evaluation for the project between August 2016 - August 2017 reported positive outcomes:

- 910 people were reached, of which 246 (27%) were aged 60+. This resulted in 470 homes being improved.
- 879 hazards were removed, estimating savings to the NHS and society of £1,542,455.
- 203 boilers were installed by *Warm Zones*
- Thurrock Lifestyle Solutions (handyman service) carried out 152 jobs, the majority of which were fitting PIR security lights.
- Essex Country Fire and Rescue Service also conducted 736 visits during this year, installing smoke alarms, removing trip and fall hazards and conducting fire risk assessments and oven cleaning where needed.

To date a total of 2111 people have been reached over the three years that Well Homes has been running and due to its success two additional schemes are being piloted in the upcoming year, one of which is focussed around supporting *Well Homes* residents in Tilbury locality with long term conditions to better manage their illnesses from their home setting as part of the *Healthier Together* campaign. As a result, the budget for the programme has been doubled. Autumn 2018 will also see Well Homes being re-launched as an in-house service with a further evaluation of this arrangement planned for the following summer

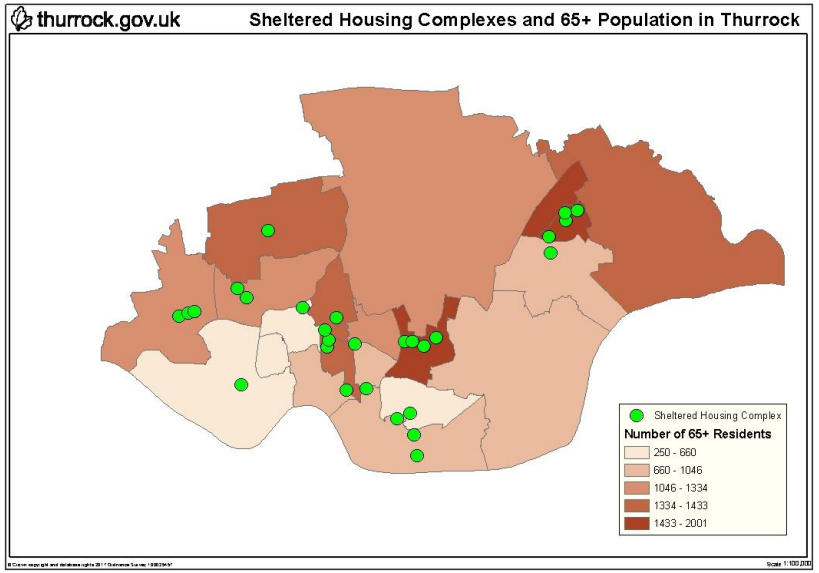
5.6 Specialist Housing Provision for older people

The Council offers some specialist accommodation in the form of Sheltered Housing, which is targeted towards older people who require some support to continue living independently. There are currently 1,240 properties owned by the Council across the borough, with the locations mapped on figure 32. It can be seen that there are several complexes in the areas with the most older residents.

The most common additional need of our Sheltered Housing residents is *Hearing Impairment (14%)*, followed by *Wheel Chair User, Mental Health and Visual Disability (all 5%)*. Our data suggests there is currently unmet demand for council sheltered housing. There are currently 1177 applicants on the housing register who are eligible to bid for sheltered housing, with the Council having advertised 135 properties in sheltered housing, and receiving a total of 952 bids. This averages out at 7.05 bids per property, however the median is 6 bids per property.

The Council also provides Extra Care Housing operating an 89 unit scheme *Piggs Corner* in Grays for rent, and a scheme at *Elizabeth Gardens* in Grays were 69 units are available to rent or buy. There are currently 6 applicants waiting for Extra-Care housing, again suggesting a level of unmet demand.

Figure 32 Sheltered Accommodation Provision in Thurrock by geographic density of population aged 65+. Source: ONS and Thurrock Council



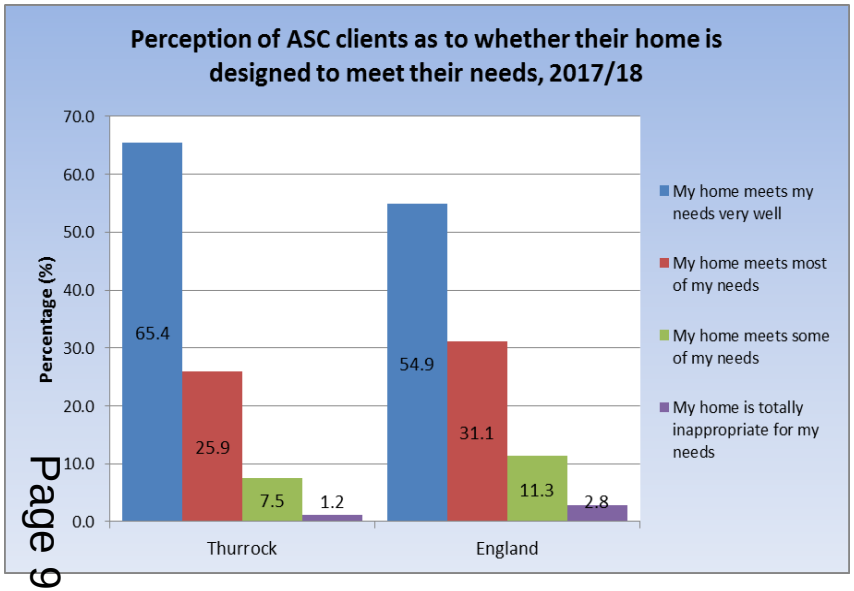
Housing Adaptions

Thurrock Council undertakes adaptions to their stock where needs are identified, the most common being changes to make showers more accessible and the installation of stair or step lifts. This suggests that these residents have mobility issues which are affecting their ability to undertake activities of daily living, be it independently or with help. This data gives an indication of the important features to consider when building homes which are appropriate across the life-course such as the flexibility to include a graded floor shower without major works and at relatively low cost.

91.3% of Thurrock social care users feel that their home meets all or most of their needs, which is very positive as the aim is to keep people safe and well in their own homes for longer. There are however 7.5% of respondents who felt their home only meets some of their needs, indicating there could be unmet need for adaptations, and 1.2% feel the home is totally inappropriate, indicating a potential need for alternative accommodation. These results do compare favourably to England however, where only 86% of social care users feel their home meets all or most of their needs (figure 33 overleaf)

Chapter 5: *Current Housing Provision in Thurrock*

Figure 33: Perception of ASC clients regarding their home 2017/18. Source: ASC User Survey



Specialist Equipment and Minor Adaptions

Adult Social Care provides a range of equipment and home adaption solutions for residents with eligible care and support needs. Solutions are explored through the assessment process between social care staff and clients. In 2017/18 157000 pieces of equipment were provided to 53,430 clients ranging from simple daily living aids to assist service users to bathe and toilet, to more complex equipment designed to facilitate nursing care such as profiling beds and hoists.

Telecare

Telecare is specialist electronic equipment shown can maintain function status and promote independence.[16,17] It can range from pendent alarms through to falls sensors, systems to turn lights, taps and cookers on and off or alert a central operator if a client has not returned to bed during the night after a specified amount of time. Evidence suggests it is likely to be cost effective.[18]

There is a large amount of work underway within the Council looking to embed technology enabled care in its future approaches to Adult Social Care. Pilot work happening in Tilbury and Chadwell locality is aligned with the roll out of the new approach to Social Care via the implementation of Community-led Support teams and Wellbeing teams. It is also forming part of the 'Connected Thurrock' Digital Strategy Connected Place theme.

This pilot aims to:

- Raise community awareness of telecare and telehealth equipment/devices/apps
- Encourage the take up of appropriate technology enabled care to support vulnerable people to be safe, independent and connected both within their homes and outside
- Support carers through greater use of technology enabled care
- Combat loneliness through connecting isolated people to the wider community and family and friends
- Encourage greater digital health literacy
- Prevent, reduce or delay the need for social care or acute health interventions (e.g. through falls prevents, swift hospital discharge)

However evidence from local residents indicates that there may be barriers to accessing these services (see Chapter 7). Local available data on uptake and cost of these services at the time of producing this report is patchy, and moving forwards, the Council should seek to ensure that the adaptations and telecare offer is evaluated fully to ensure they are being accessed, and are effective for those in greatest need.

Additionally, we know from national level evidence that the design of a home can impact upon the need for adaptations and telecare, the ease with which adaptations and telecare can be installed, and subsequently the cost to provide these. Moving forwards, consideration to the design of new homes should be given to make them appropriate and flexible across the life-course, and where telecare and adaptations are required these can be easily and cheaply installed. (see Chapter 2).

Chapter 6: *Attracting Older People to Alternative or New Housing*

Chapter 6: *Attracting older people to alternative or new housing*

6.1 Introduction

We know that many older people remain in larger homes which have become under-occupied. These may not always be suitable for their long-term needs and this phenomenon could have negative implications for the liquidity and hence affordability of the entire local housing market. However, the older adult market is very diverse; some older people are interested in moving to smaller properties, some don't intend to move and some even want to upsize to a larger property. As older adults become a larger proportion of the population, it is important to consider their housing needs as well as taking into account their own desires and opinions relating to their homes. This chapter discusses the issue of attracting older people to alternative housing types, drawing on the national evidence base considers the national evidence base and local data including recent survey work undertaken with Thurrock residents.

6.2 Views from national work

According to a NHBC 2017 report,[40] two-bedroom homes were the most common choice for about half of those who had moved into smaller properties, this was followed by three-bedrooms which accounted for about a quarter of moves. This shows an appetite for smaller homes amongst older adults; and in fact, for those over 55 who moved into new-build homes, 39% had fewer bedrooms than their previous home. However, it is important to remember that not all older adults who are considering moving want a smaller home. The NHBC report also revealed that four-bedroom homes were desirable amongst the over-55s for the extra space, which allows for hobbies or friends and family to stay over. There is also a large proportion of those 55 and over who do not want to move at all.

It has been estimated that between a quarter to a third of older people are interested in moving and that about 25% of those interested in moving are interested in specialist retirement housing.[41] Flats were viewed favourably for ease of maintenance and security in some studies, as were bungalows, green space and a sense of community[42]. Retaining home ownership is favoured by those who are already homeowners[42].

Reasons for wanting to move were diverse and include personal or family reasons such as the death of a partner or moving closer to family members, reduction in bills/running costs of their home, releasing capital equity, easier maintenance of home and garden and 'right sizing their home after reduction in size of household.

Evidence on what facilitates older people's moving

Concerns preventing a move centre around physical difficulties in moving, emotional ties to their existing home and financial constraints. Conversely many older adults who do move report that they wish they'd done it five to 10 years earlier.[40]. The following have been shown to be effective in facilitating downsizing:

- *Smoothmove* services that assist with packing, selling and storing of belongings
- Marketing of properties to reflect what is likely to be important to older people e.g. emphasizing nearby GP/NHS facilities, and good transport links
- Locations central to communities
- Technology including fast internet that allows Skype and better control over the home environment e.g. smart temperature control

6.2 Local Residents' Views

Survey and consultation work undertaken by Public Health with local residents sought to understand:

- The respondent's current housing situation and how well this meets their needs.
- What is important to the respondent in terms of the building in which they live
- What is important to the respondent in terms of the place in which they live
- What the barriers and enablers are to moving home in older age
- How older people could be supported to start planning for older age sooner.

A full evaluation report is included in Appendix 1 of the full version of this Annual Public Health Report.

In summary, the local survey reflects evidence from elsewhere – 'national views'.

- Increasing the stock of attractive and appropriate homes could increase the number of people willing to move as the top barrier to moving was the 'availability of suitable properties' and the top option that would encourage people to move was 'greater availability of preferred housing'.
- Older people want to remain home owners with 30% stating that they would consider buying their own specialist property, although interestingly 30% also said they would consider renting a specialist property.
- The most common reason for wanting to move was care needs. Important features for a new home were low maintenance, reduced running/maintenance costs, and level access highlighted.

Chapter 6: *Attracting older people to alternative or new housing*

- The process of moving is difficult and costly and that Incentive to Move schemes may be beneficial; including 'Advice', 'Financial help' and 'Practical help'
- Just under half of respondents said that they would consider moving (47%), with an additional 24% stating that they would "maybe" consider moving which is slightly higher than national evidence.
- Less than half (44%) of respondents over 60 years old have started planning for their future housing needs (albeit 22% of respondents said they already live in specialist accommodation). However, just over a third of respondents have not yet started to plan.
- A call for better information/advice (evidenced by the 17% of people that say advice/guidance might help them plan towards meeting their future housing needs,

In line with the national evidence, a large proportion of people do not want to move at all. Of concern to local residents was finding out about local support services and the reliance on the internet for disseminating information. Residents commented that they often seemed to find out about services 'by chance'. Residents expressed a desire for face to face opportunities to speak to staff about their needs. Additionally, residents were concerned about the cost of services, such as adaptations and how long these took to receive.

In terms of place, it appears as if residents view the connectivity of their home as important, evidenced by them ranking 'close to family/friends' and 'close to town/facilities' as important. Through the conversations with residents, a sense of community emerged as a strong theme that was important to them and feeling that neighbours were looking out for one another.

6.2 Downsizing in council housing stock

Councils often offer incentives to encourage downsizing amongst older residents. Thurrock Council currently offers an incentive to existing Council housing tenants who wish to downsize from their existing property, both in terms of a financial payment (currently up to £1,000) and support arranging removals services. Further information on this can be found on the Council's website: Downsizing Scheme.

Table 1 shows a summary of the downsizing requests received by the Council to date.

Table 1: Downsizing activity of existing Council tenants

Year	Number of requests received	Average Number of bedrooms	Average number of bedrooms released	Payments issued by the Council
2015/16	77	Not known	Not known	£58,825
2016/17	51	Not known	Not known	£36,651
2017/18	82	2.89	1.47	£55,589
2018/19 (to date)	28	2.65	1.35	£22,527

National data indicates that the proportion of older people who under-occupy in socially rented properties is typically quite low (around 19% compared to 68% of owner-occupiers (68)), however analysis of this data suggests that the take up of the offer of removals support is still very limited.
The Council also runs a Right Size scheme aimed at older owner-occupiers who are happy to move into Council-owned accommodation for older people (e.g. sheltered, extra care or HAPPI) and lease their homes to the Council on a fixed-term basis. The scheme is open to residents meeting the following criteria:

- Aged over 60 or 55-59 with a disability
- Requiring sheltered, extra care or HAPPI accommodation
- Downsizing from a larger property – at least 2 bedrooms
- Willing to sign up a minimum 5 year lease with the Council

Details on this scheme are set out in the Housing Allocations Policy: Rightsizing Scheme. However the interest in this scheme appears to be very limited, with only one homeowner taking up this offer since the pilot launched in 2017.

This supports the residents view both nationally and locally, that there needs to be a range of pull factors to encourage older people to move, and no one size fits all.

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Chapter 7: *Bringing it all Together: Summary of Key Findings*

Chapter 7: *Bringing it all together: Summary of key*

At the outset of this report, it was stated that there were four key questions that were to be answered. The answers to these questions are summarised below:

7.1 What impact will demographic change have on the needs for new and existing housing stock across all tenures in the next 20 years?

Within Thurrock, the over 65yrs+ population is is projected to grow by 5% by 2020, and potentially by 46% by 2035. This equates to an additional 10,900 older people by 2035 albeit caution should be exercised with this projection. This population increase means that there will need to be a larger number of properties in Thurrock which are suitable for older people, be it mainstream housing or specialist housing. This broadly resonates with the current Housing Strategy (2015-2020) for Thurrock which proposed to build 1,000 new homes over the next five years (to 2020).

The proportion of new homes which should be mainstream homes or specialist homes is influenced by a multitude of factors, not least the personal preferences and wishes of the individuals involved. The survey undertaken as part of this report indicated that changing care needs were the most common reason for moving or considering moving, and our analysis tells us that by 2035 there is likely to be:

- An additional 2,600 older people who cannot undertake at least one mobility activity by themselves
- An additional 4,538 older people who are unable to undertake at least one self-care activity by themselves.
- An increase of 2.3% in falls
- An additional 1,147 people with dementia
- An increase in long term conditions which research suggests impacts upon the ability of an individual to self-care

This means that there will be a larger group of people in Thurrock in the future who require support from health and social care services in order to manage their health and activities of daily living. Given the anticipated increase in population, and increase in people with health and social care needs, it is likely therefore that there will be a need for further specialist housing to accommodate the increase in the older population. Modelling the demand for specialist housing in the future is incredibly difficult due to the multiple influences on housing demand and supply, personal preferences and uncertainty about the future. The current older population is likely to be different to older people in future - retirement ages changes, medical advances, and different social and political attitudes may affect housing needs and preferences, additionally society is more mobile now and more likely to travel and less likely to stay in or around the place of birth or close to family members. Although modelling has not been undertaken as part of this report; national estimates have indicated that the demand for specialist housing may increase by anywhere between 35-70%.

That being said, even with an increase in supply in specialist housing there would not be capacity for every older person to live in a specialist home, and neither would all older people wish to, or indeed have a need to. In fact we know that the majority of older people want to remain living in their current mainstream home. This means that existing mainstream stock needs to be made suitable for older people, and mainstream stock built going forwards needs to be developed with the whole life course in mind.

Existing stock can be unsuitable, unsafe, unhealthy and insecure for older people. More than 5,600 households in Thurrock are estimated to be in fuel poverty and a local survey of social care users indicated that 7.5% of social care users felt that their home only met some of their needs which indicates a potential unmet need for changes to their home. The latter is supported by engagement work for this report in which 16% of respondents indicated that their home was not appropriate for them in terms safety and security, 15% in terms of proximity to health and leisure facilities, 14% in terms of accessibility, 12% in terms of size and social networks, and 10% in terms of their ability to cope and also quality of life, and 14% in terms of accessibility. Notwithstanding the small sample size of this survey, this suggests that a sizeable proportion of people in Thurrock are living in a home which is either not suitable now, or which they predict will become unsuitable as they age and this will have a negative impact on their health. There therefore needs to be appropriate support in place to mitigate these negatives.

Within Thurrock, initiatives such as Well Homes (for private housing) and the Transforming Homes programme (for Council housing) have tackled aspects of ensuring homes are suitable and the Well Homes programme has been evaluated recently to show positive outputs. Options to develop this project further are currently being explored.

Housing adaptations and telecare are also provided for Thurrock residents and a pilot is currently underway in Tilbury and Chadwell as part of the new approach to social care and Connected Thurrock Digital Strategy, to increase knowledge and take up of telecare. Evidence suggests that housing adaptations and telecare are effective and potentially cost effective mechanisms to increase the independence of older people living in their own homes, and they can be acceptable to the older population. There are however gaps in the evidence in specific user groups and in the UK context, in the terms of cost effectiveness, additionally residents views collected as part of this report indicated that there may be barriers to accessing these, for example in terms of waiting time and cost and also some older people may not know what options are available. This means that evaluation of local initiatives, including the Tilbury and Chadwell pilot are required to demonstrate how these may be effective, cost effective, accessible, equitable and relevant to the older population in Thurrock.

High Level Recommendation	*Ensure all older people who wish to stay in their own home are supported to do so for aw long as possible, by providing appropriate and accessible information and services to meet the needs identified*
Key Questions	• How can information about support services be made more readily available? • Are there any other cost effective schemes that can support people to remain in their own homes? • How effective is the local falls prevention service and how can it be improved to mitigate the projected increase in falls • How affordable and what are the waiting times for adaptions?
Existing Assets to Build upon	• Stronger Together • Community Hubs and Libraries • Tilbury and Chadwell Telecare Pilot • Lifestyle modification programmes • Social Prescribing • *By Your Side* home from hospital programme • Tilbury and Chadwell Telecare Pilot • *Well Homes* initiative • *Thurrock U3A*

Chapter 7: *Bringing it all together: Summary of key*

For new housing, the vision for Thurrock is to have a life course approach to ageing which includes ensuring that all new homes built are appropriate across the life course. Homes which are appropriate across the life-course are more easily adaptable and have features already which enable healthier ageing in place, such as good lighting and adequate ventilation. Despite the recent changes to building regulations to partially incorporate lifetime home standards, these remain largely optional; indeed in Thurrock these are not currently part of mandatory policy. This means there is currently little obligation or incentive for developers to build homes with these features.

Thurrock's current Housing Strategy (2015-2020) states that 100% of new council properties will be built to the lifetime homes standard and London space standards however it is unclear how many have actually incorporated these standards to date. Arguably limiting to only council properties does not go far enough. The ten HAPPI principles are widely regarded as the gold standard for not only housing for older people, but for all housing. These are not currently incorporated in plans for new homes as standard, although they are encouraged. To enable older people to age healthier in their current homes going forwards, all mainstream homes should be built which incorporate age friendly and life-course features such as those outlined by HAPPI and this should be reflected in the local plan.

High Level Recommendation	*Explore the impact of mainstreaming HAPPI design principles into planning guidance within the Local Plan*
Key Questions	• What will the impact of the above recommendation be on encouraging new home building? • Why is affordability of housing an issue in Thurrock? How can it be alleviated and mitigated? • How should new developments best be quality assured during the design and building process?
Existing Assets to Build upon	• Active By Design • Secure By Design • Health Impact Assessment expertise within the Public Health Team • Council's Planning and Advisory Group

Existing stock can be unsuitable, unsafe, unhealthy and insecure for older people. More than 5,600 households in Thurrock are estimated to be in fuel poverty and a local survey of social care users indicated that 7.5% of social care users felt that their home only met some of their needs which indicates a potential unmet need for changes to their home. The latter is supported by engagement work for this report in which 16% of respondents indicated that their home was not appropriate for them in terms safety and security, 15% in terms of proximity to health and leisure facilities, 14% in terms of accessibility, 12% in terms of size and social networks, and 10% in terms of their ability to cope and also quality of life, and 14% in terms of accessibility. Notwithstanding the small sample size of this survey, this suggests that a sizeable proportion of people in Thurrock are living in a home which is either not suitable now, or which they predict will become unsuitable as they age and this will have a negative impact on their health. There therefore needs to be appropriate support in place to mitigate these negatives.

7.2 What types of housing do our elderly population want, and what are the impacts of choosing to move to a home suitable for later life?

Older people are not a homogenous group and should not be treated as such and it is therefore important to ensure that more suitable housing is defined by the older person and is specific to the older person's needs and preferences, rather than being a generic definition. The wishes of older people and personal choice should be respected; and evidence from both national level surveys and local engagement indicates that the majority of older people wish to remain in their current home and as stated previously, services such as adaptations and telecare should be available to support people to do this. From the MOSAIC analysis in Chapter 2 we know that the three biggest population segments in Thurrock are likely to own their own home which may present an issue with us knowing if any adaptations are needed or have already been made. The MOSAIC characteristics suggest that many of these households may not be confident with technology which may need to be considered if options such as telecare/telehealth are to be used or if digital technologies are otherwise used in new homes.

There is a high level of home ownership in Thurrock and evidence from the local engagement exercise indicates that 30% of residents would consider buying a specialist property and 30% would consider renting a specialist property (although these residents may not be mutually exclusive). However, in Thurrock, the bulk of sheltered housing is council owned (1240 properties); there are only 146 retirement properties and 18 age exclusive properties which are leasehold properties. This demonstrates that whilst there is interest in specialist housing; potentially there are not enough properties of the correct tenure. The Council and developers need to ensure that the tenure of future specialist housing matches preferences; certainly the national evidence indicates a shortage of specialist homes that are available to buy; and also that some older people are averse to leasehold properties which can also act as a barrier.

Our local engagement indicated that the most important property features are low maintenance or being easy to maintain and having own garden or some outside space. Accessible features and at least one space bedroom were also rated as important. Being close to friends and family and being close to a town centre were rated as the most important features of the area.

It has not been possible to quantify the impact of choosing to move to a more suitable home in later life on the individual (if that more suitable home is deemed to be specialist housing) because the evidence of effectiveness of specialist housing is very limited. Whilst there is some evidence from the literature of positive outcomes associated with Housing with Care, which can improve quality of life, promote health improvement and reduce social isolation, few studies have been conducted on other types of specialist housing. Scrutiny of schemes in other areas and the available literature tells us that there is no 'best practice' in terms of a model of housing which works for older people, as this is very much dependent upon the needs of the population who will be living there. This means that there is no specific model that Thurrock can exactly replicate to realise the same effects. There are some common themes which emerge however in successful case study models such as autonomy and control over living environment being very important and these can be applied to any new schemes to enable a wide offer of options to a diverse market of older adults. National guidance suggests that housing for older people should be co-produced with older people. For Thurrock, this means that there is a need to design and develop bespoke specialist housing alongside and in partnership with local residents which takes into account the themes evident from successful schemes elsewhere.

Chapter 7: *Bringing it all together: Summary of key*

High Level Recommendation	*With older people as active participants, develop and build a range of bespoke housing for older people and ensure the need for these specialist homes is reflected in the Local Plan. As a minimum, this would include 563 sheltered units, 90 enhanced sheltered units and 113 units of extra care by 2030*
Key Questions	• What are the best ways to engage older people throughout this process? • How can we better predict the number and type of specialist homes we need in Thurrock? • How can be best incentivise developers to build specialist homes?
Existing Assets to Build upon	• Opportunities for engagement of older people through the Thurrock *Over Fifties* forum and *Older People's Parliament* • Thurrock U3A • Women's Institute

When considering a move to move suitable housing, what would make the option attractive to our elderly population?

A key action within Thurrock's Housing strategy is to create attractive housing options for older people that encourage independence and wellbeing. Evidence from national and local public engagement work suggests that a key pull factor is the availability of suitable and attractive properties and for older people to have a greater awareness of these options.

Around 25% of older people nationally, and 47% of older people surveyed locally, express that they would consider moving in the future. An additional 24% of older people locally indicated that they would "maybe" consider moving. Given the sizeable proportion of residents who are unsure, potentially many of these could be encouraged to move if the options available were suitably attractive and potential barriers were removed.

A key barrier is the lack of suitable properties as discussed previously in this section, however other barriers to moving identified through both local and national surveys include cost of moving, lack of information on the options, practicalities of moving, not wanting to leave current home due to sentimental reasons, risk of losing existing support networks or a wish to retain the equity in the property.

Evidence suggests that downsizing, for many, will not free up finances as is often one of the main benefits promoted to encourage older people to move. Additionally in Thurrock, the Council offers downsizing payments to Council tenants which has had some uptake, however a rightsizing scheme implemented in 2017 aimed at owner-occupiers has not been successful in attracting applicants since its inception in 2017. This means that there needs to be greater 'pull' factors which encourage people to move.

Moving forward there should be appropriate support with the planning and moving process for people who do wish to move, and to encourage those who may be open to but undecided about moving, information about housing options and awareness of the assistance with planning and moving available should be provided.

Evidence from surveys indicates that older people need to be encouraged to start to plan for their older age sooner and more advice and guidance on housing options may be a way to do this. More in depth resident engagement work needs to be undertaken to look into practical solutions to tackle these issues further. Additionally, there is further work that needs to be undertaken to identify issues around affordability of this housing.

What impact does housing have on health and how can we enhance the positives and mitigate against the negatives? And how can we ensure they are better understood by those affected?

It is widely accepted that housing can have a significant impact on health in terms of excess winter deaths and cold related ill health, indoor air quality, mental health including loneliness and social exclusion, falls, and demand and access to health services. Additionally, we know that the wider public realm can also have a significant impact, for example on social isolation and physical activity levels. We also know that housing can have a negative influence on health and wellbeing if it is unsuitable, unsafe, insecure and unhealthy, and these negative influences can be mitigated through provision of focused services. This report only considers services which directly impact upon the home itself and there would be value in exploring other services in greater depth such as home-sharing.

Housing Operations functions could be better engaged to affect health positively through encouraging and enabling a healthier lifestyle. For example, we know that, in Thurrock, there is a high rate of people with hypertension, with substantial numbers who have not yet been diagnosed, many of whom will be aged over 65. If not identified and managed appropriately these patients may be at risk of an emergency hospital admission. Housing provides a vehicle with which to try and impact upon these conditions and outcome - in terms of identifying conditions earlier, enabling people to better manage these conditions possibly limiting further deterioration, and also by preventing these conditions arising, or delaying the onset of these conditions through a healthier lifestyle, better access to services and increased social capital and integration. Health improvement work could be complemented with the continued support of Making Every Contact Count amongst front line staff, including housing staff, widespread use of community groups and hubs to increase service promotion and awareness of the consequences of not improving lifestyles for example.

We know that older people are much more likely to have long term conditions and whilst there are a number of programmes in place already, more could be done to embed them within the Housing work programme, for example, using communal sheltered housing complexes to host long term condition detection interventions, training more staff in Making Every Contact Count and ensuring housing improvement programmes such as Well Homes adequately identify and refer patients to relevant health services. We also know that, in Thurrock, mental health problems such as depression are set to increase in the future and the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year. More could be done to embed depression screening into the day job of more front line staff (e.g. housing officers) who may have access to older people who would be hard to reach by other professionals and there would be benefit in improving pathways between mental health services and Housing. In addition, by building developments that encourage community cohesion and reduce the risk of isolation, we could reduce the risk of developing depression.

Chapter 7: *Bringing it all together: Summary of key*

We know that inappropriate housing is likely to result in savings to the NHS. We know in Thurrock that many emergency admissions of older people could have been prevented with better managed care, and nearly 5% of all delayed transfers of care are due to awaiting community equipment and adaptations. For Thurrock, this mean that there needs to be integration of housing into NHS pathways to ensure a holistic provision of services is provided, and also that the home is routinely seen as a place in which health promoting activities can be actioned.

Alongside enhancing the positives directly through appropriate housing, wider place making elements are also extremely important and can have a huge impact. The Housing strategy states that it will consider green space requirements for new council properties, however there is a need for further steps to be taken to ensure wider place-making elements are included and across all new properties. There are two aspects to this; firstly in terms of developing healthy places for all, and ensuring that residents of a place have opportunities for active travel, enabling healthy eating and having access to appropriate healthcare for example. The principles set out in the NHS Healthy New Towns Programme provide a good standard upon which to base planning guidance in this regard. This is important because keeping people healthy throughout the life course has an impact on how healthy a person is in older age. The second aspect is incorporating age-friendly features into a healthy place. We know that just under half of all residents in Thurrock aged over 75 have no access to a car or van which may mean that they have difficulty getting around, and 39% of older people live alone which may be a risk factor for loneliness or social isolation. This emphasizes the importance of giving due attention to the wider place making agenda. Evidence from around the world indicates that there are specific considerations with regards to transport, green space, community, safety and crime prevention, work and volunteering and the digital environment that may impact on the lifestyle and health of an older person and how active and valued they feel within a community. Whether building new mainstream housing with life-course features, or new specialist housing, it should be a key feature of the local plan that particular importance is placed upon the wider public realm with regards to these features.

High Level Recommendation	*Ensure that healthy place making principles, such as those outlined by the NHS Healthy New Towns Programme, and age friendly features are incorporated into the Local Plan*
Key Questions	• How can we ensure that these principles are being adhered to in the new place planning and design? • How can we best encourage the development of Dementia Friendly communities?
Existing Assets to Build upon	• Integrated Public Health and Place Council functions • Stronger Together including LACs and Timebanking • For Thurrock In Thurrock/Thurrock Integrated Care Alliance strategic working • Community hubs and libraries • Housing and Planning Advisory Group • Public Health's Health Impact Assessments (HIA)

To ensure these issues are better understood by those affected, we need to ensure that awareness and communication with older people is improved. Evidence suggests that older people do not know what is available to them, and there is a concern that if they do not use the internet as is the case with just over 13% of Thurrock residents, that there is a risk that they will miss out on help and support. Within the context of the Council's digital strategy, this indicates that there is a need to enhance the existing methods of face to face communication such as through volunteer hubs harnessing the skills of "younger older people" who are confident in using the internet, then considering whether there is a need to provide training specifically to older people to improve their competence and confidence in using the internet.

Chapter 8: *Recommendations*

Chapter 8: *Recommendations*

1. Ensure that all older people who wish to stay in their own home are supported to do so, for as long as possible, by providing appropriate and accessible information and services to meet needs identified.

Sub-Recommendation	Rationale	Chapter(s)
1a. Produce a single directory identifying the range of support services available to older people across the Local Authority, NHS, and third sector including adaptions, telecare an home help.	• Feedback from residents identified that they were not aware of what support was available and the process for accessing this	6
1b. In line with the digital strategy, increase the availability and confidence of older people to use technology	• Feedback from local residents indicates that they feel that they miss out on support if they cannot access the internet • MOSAIC data shows that are most common older population segments who may not be confident in using technology	4,6
1c. As part of the strategic vision of 'Connected Thurrock' and the possibilities for future houses to be built with appropriate technologies embedded within them, undertake a detailed evaluation of existing/proposed telecare and adaptations services to ensure these are fit for purpose, equitable, effective and cost effective for Thurrock	• There is a Council strategic work stream around keeping people independent at home • Evidence that it is acceptable to older people and also cost-effective (£579 per person according to Snell evidence review) • Data we have got on our current uptake • The sheer cost of a residential care/nursing home care package • MOSAIC data shows we have lots of older population segments who may not be confident using technology – so we need to make easier to use and access	
1d. Expand the Well Homes scheme to include an winter check for homes and further input into home energy efficiency.	• The savings it has shown so far • The reach it has had so far • There are pockets of deprivation in the borough which will impact upon the ability to afford a home and adequately run in • There are inequalities within the borough in terms of fuel poverty	4,5
f) Develop better pathways between EPUT and Housing teams in supporting the increased number of older people with MH issues.	• The number of older people with mental health issues such as depression, dementia or psychotic disorders is set to increase in future years. • 12-18% of all NHS spend on long term conditions is related to poor mental health • The presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year.	4

Chapter 8: *Recommendations*

2. Ensure that all new homes in the Local Plan incorporate HAPPI design principles.

Sub Recommendation	Rationale	Chapter(s)
2a. Develop an older persons housing strategy	• There is a lack of detail in the current housing strategy 2015-2020 relating to older people's housing • The older people's population are not a homogenous group and require a specific and detailed action plan; evidence suggests that many local authorities do not have such a plan.	2,3
2b. Ensure there is buy in to HAPPI principles across the Council and this is incorporated into mandatory planning guidance	• Most people want to continue living in their own home, so housing needs to be appropriate across the life course. • HAPPI principles are considered to be an exemplar for all housing, including both specialist housing and mainstream housing.	2

Chapter 8: *Recommendations*

3. With older people as active participants, develop and build a range of bespoke specialist housing for older people and ensure the need for these specialist homes are reflected in the local plan.

Sub Recommendation	Rationale	Chapter(s)
3a. Co-Design and build a bespoke range of specialist housing for older people with older people. The foundations for this should be based on evidence of what has been successful elsewhere however the design should be tailored towards what the target group of older people in Thurrock specifically need.	• Local and national residents views suggest that a key barrier to moving is a lack of suitable properties. • Evidence from published literature indicates that the effective housing solutions involve older people their design. • Encouraging some older people to downsize may have the benefit of freeing up some larger family homes.	6, 2
3b. Undertake some focused additional public engagement on specific issues relating to specialist housing planning for housing in older age and the process of moving home. This may be as part of programmes such as "Your Place, Your Voice" or as separate exercises depending upon the topic and target group.	• National residents views indicate that there may be value in designing services which tackle barriers to moving. • Questions raised through the local resident engagement suggests there would be value in exploring these issues in more depth.	6
3c. Consider developing a package of support for people in terms of moving to include: help with removals, negotiating with energy suppliers, redirecting mail, selling unwanted goods, dealing with administrative and legal issues and post move support (subject to outcome of action 3b)	• National and local residents views indicated that that may be value in designing services which tackle barriers to moving • There is an offer to council tenants currently; however this is not available to owner-occupiers or those privately renting.	6
3d. Develop the quality and accessibility of advice on housing options available to residents.	• Local and national residents views indicate that people do not know what is available to them or how to find this information.	6
3e. Develop the relationship between sheltered housing and public health	• Sheltered Housing complexes are distributed all over the borough, with halls in the areas with the most older people. • There is an opportunity to improve these relationships as Sheltered Housing are reviewing their data collection requirements, plus they often have capacity to host PH events etc in communal areas	5
f) Produce a separate product seeking to identify the need for older people's mental health specialist accommodation	• Growing number of older people plus adults likely to have Mental Health crises • Market position currently unknown – recent Market position statement did not drill down into this in much detail • Other work has shown fragmentation of Mental Health and Housing pathways • This is not within the scope of this report.	4

Chapter 8: *Recommendations*

4. Ensure that healthy place making principles, such as those outlined by the NHS Healthy New Towns Programme, and age friendly features, are incorporated in the design process of all new homes in the Local Plan, whether mainstream homes or specialist homes.

Sub Recommendation	Rationale	Chapter(s)
4a. Ensure that healthy place principles such as those outlined in the NHS Healthy New Towns Programme are embedded in place-making policy. This could be achieved by taking forward the draft interim planning guidance developed by the Public health and place team.	• There are a number of older adults at risk of loneliness (e.g. there are a number of lone older person households, many who cannot access a car/van, and there are 2,057 older adults we estimate to have depression currently • ASC survey findings – some residents say they are feeling socially isolated and can't get to all the places they want to • Recognition of certain areas in Thurrock with lower accessibility	2, 4
4b. Ensure that age friendly principles are embedded in place-making policy.	• Evidence from literature suggests that there are a number of place-making factors which can impact upon a person's health and wellbeing.	2

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November 2018	ITEM: 9
Thurrock Health and Wellbeing Board	
Developing an integrated approach to health and care in Thurrock	
Wards and communities affected: All - Commencing in Tilbury and Chadwell	**Key Decision:** None
Report of: Andy Vowles	
Accountable Head of Service: Not Applicable – external report	
Accountable Director: Roger Harris, Corporate Director Adults Housing and Health	
This report is Public	

Executive Summary

Partners across Thurrock have for some time been working together to align and integrate the planning and delivery of health and care services. There are a number of successful joint work programmes in place, including the Better Care Fund.

Statutory and non-statutory partners are keen to build on progress to date and further develop the existing joint working arrangements. To this end, a Memorandum of Understanding (MoU) has been developed and is being presented to the HWB and partner agency Boards for consideration and comment during Autumn. It is intended that endorsement of the final MOU is sought in the New Year.

1. Recommendation(s)

1.1 The Health and Wellbeing Board is asked to:

- Consider and comment upon the draft MOU, provided at Appendix A, with a view to endorsing the final version at its meeting in January 2019

2. Introduction and Background

2.1 In February 2016 Thurrock CCG shared its transformation plan with system partners (through executive to executive meetings and discussions with Thurrock Health and Wellbeing Board) to gain support for a partnership approach to improving out of hospital health and the wider wellbeing offer to the population of Thurrock.

2.2 Our plan "*For Thurrock in Thurrock*" outlined the vision for providing health and care closer to home in line with our strategic direction and the local Health and Wellbeing Strategy. It also provided the foundation for a commitment to work in partnership to develop a locality based new model of care.

2.3 In September 2017 Public Health Thurrock launched "*The Case for Change: A New Model of Care for Tilbury and Chadwell*" underpinned by detailed Tilbury Needs Assessment products. The document set out a vision for transformation of health and care services aimed at three distinct population cohorts: those that are largely healthy but need improved access to episodic care provided by primary care; those with diagnosed and undiagnosed long term conditions; and those with high levels of health and care need.

2.4 Endorsed by Thurrock Health Overview and Scrutiny Committee in November 2017, the new model of care, which complements the *Integrated Medical Centre (IMC)* developments proposed in each locality, is now being piloted in Tilbury and Chadwell and is being held up as an exemplar. It will be replicated across the other three localities in the borough over the next 18 months, subject to decisions taken by the Secretary of State for Health and Social Care in response to the representations made by Southend Authority on the Mid and South Essex STP.

3. Reasons for Recommendation

3.1 We are now at a point where we want to consolidate and embed our partnership arrangements in order to accelerate delivery of our strategy. We have prepared a Memorandum of Understanding which sets out how we will work together. Whilst the MOU is not legally binding, by adopting it organisations will be confirming their intent to work in a collegiate fashion. Working in this way will require the continued deepening of trust across the Thurrock Alliance. To achieve this senior leaders need to be confident that they have the support of their Boards and Governing Bodies.

3.3 As a next step, we are exploring producing a formal Alliance Agreement which will set out in much greater detail how we will in partnership plan, commission and provide services to the people of Thurrock. We anticipate that a draft of this agreement will be available by early 2019, so that it can be operational in 2019/20.

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

5.1 Consultation continues with Thurrock Health and Wellbeing Board, CCG Board and key partner Boards and Governing Bodies

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

6.1 Community Impact for this Project

6.2 N/A External Report

7. Implications

7.1 **Financial**

Implications verified by: **Not Applicable External Report**

7.2 **Legal**

Implications verified by: **Not Applicable External Report**

7.3 **Diversity and Equality**

Implications verified by: **N/A External Report**

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

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

- N/A

9. Appendices to the report

- Draft Memorandum of Understanding

Report Author: via Andy Vowles November 2018

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Memorandum of Understanding (MOU)

An Integrated Approach to Health and Care in Thurrock

Parties to this Memorandum of Understanding

This Memorandum of Understanding is between: Thurrock Council; Basildon and Thurrock Hospitals NHS Foundation Trust (BTUH); Essex Partnership University NHS Foundation Trust (EPUT); NHS Thurrock Clinical Commissioning Group (TCCG) and North East London NHS Foundation Trust (NELFT).

What is a Population Health System?

A Population Health System typically involves a range of partners (statutory and non-statutory) working together to define and agree a set of desired health and wellbeing outcomes and committing to working collaboratively to ensure they are delivered. There is generally a strong focus on place and, in some of the most advanced systems, a single population based capitated budget is established.

Existing population health systems share a number of characteristics, including: a strong history of partnership working for a defined population; access to population-level data so that needs are well understood; a strong focus on prevention and the wider determinants of health such as housing and education; a willingness to integrate services and be 'organisationally agnostic'; ensuring that there is a strong user 'voice'; and developing new ways of commissioning and providing services that incentivise all parties to deliver the agreed outcomes.

When applied to the Thurrock context, there are two key aspects that need to be highlighted:

- Firstly, to deliver shared objectives and outcomes, it will be increasingly important to take a different approach to funding. For example, financial plans will need to be longer term than has historically been the case – delivering key priorities in areas such as prevention, promoting independence and ensuring equity of care are long term objectives, not generally amenable to 'quick wins' solutions. In addition, funding routes that are at present separate and siloed will increasingly need to be challenged and opportunities to pool funds in a more flexible way will need to be explored. Thinking will need to move away from organisational budgets towards the 'Thurrock health and well-being pound'
- Secondly, over time it will be vital that across the Alliance investment and other strategic decisions are taken collectively rather than separately. The delivery of a set of shared outcomes will require organisational priorities, work programmes and investment decisions to be aligned. Investment decisions taken by organisations within the Alliance will increasingly need to prioritise the benefit of the system over and above individual organisational self-interest, whilst recognising the need to mitigate risks for individual organisations.

Purpose of this Memorandum of Understanding

The purpose of this MoU is to describe a framework within which partners can work with the residents of Thurrock and our community assets to build a Population Health System. By working closely together, we already have a shared understanding of the needs of the people who live in Thurrock, what needs to change if we are to better meet these needs in future, what our new service models should look like - and how we need to change how we work together in order to deliver on our promises.

What is absolutely clear from our work so far is that none of our organisations can meet the needs of local people alone – as our case for change identified, *"actions taken by one organisation in isolation of others cannot achieve system sustainability*".

We have for some time been working more and more closely together – through our work on the Better Care Fund, our shared Health and Wellbeing Strategy and in implementing our New Model of Care in Tilbury Chadwell.

This Memorandum of Understanding builds on these foundations of joint working. It is part of our wider journey that started with organisations largely operating independently and is intended to develop into a fully integrated approach to planning and delivery.

This MOU codifies how we work together now, how this will develop in the future and articulates what we are trying to achieve. It also outlines a series of clear 'commitments' that we all sign up to.

Our integrated approach to planning is inclusive: we welcome input into our work from a wide range of local partners, including those that are not formal signatories to this MoU.

Aims and Objectives

We are clear that joint or integrated work is not an end in itself – it must always be for a purpose that benefits residents and patients.

Last year, our Cabinet and Boards agreed a number of key aims that encapsulate what we are trying to do by working together as a single system. These aims cut across primary, community and acute care and include physical and mental health: :

1. Reducing the number of unplanned hospital and residential admissions
2. Reducing the number of A&E attendances for conditions that could have been treated elsewhere within the community
3. Reducing the number of Delayed Transfers of Care
4. Keeping people as independent as possible for as long as possible, and reduce/prevent/delay entry into care and support services
5. Moving more services out of hospital/acute care into the community

All parties to this MOU have agreed that these are the four tests that we will continue to use to measure our success in working in partnership together.

Our pledge to our local community is that:

- You are less isolated and have the opportunity to be well connected where you live;
- You are able to get the majority of the support you need from within your neighbourhood and as a result you access health and care services less frequently;
- You are enabled to live a healthy and happy life based on the quality of services that you receive;
- Our health and care system treats you as an individual and does not define you by your illness or condition;
- You can get the physical and mental health support and care you need at the right place and at the right time;
- By bringing health and social care services and resources together we will reduce duplication, improve efficiency and provide a better response;

- We act before you reach crisis point and reduce the number of times you need emergency health or care services.

Values

By agreeing to this MoU, all parties are agreeing to a set of values setting out how we will work together. These are based on:

- Equality;
- Mutual respect and trust;
- Open and transparent communications;
- Co-operation and consultation;
- A commitment to being positive and constructive in outlook;
- A willingness to share and learn from others;
- An inclusive approach.

Commitments

Although this Memorandum of Understanding is not legally binding, it is a statement of intent. By signing up to it, we are not only committing to continuing to deepen our partnership working, but also to how we will work together.

We commit to:

- **Agree a set of Population Health System Outcomes** so that our objectives are fully aligned and so that we can move away from process measures and focus on population outcomes

- **Plan together** – for example, we will align the way in which we plan NHS and council services, and will include all partners – encompassing providers and commissioners – in our discussions. Longer term considerations will include developing a single planning timetable with the ambition of synchronising contracting timeframes.

- **Change the way we commission services** including:

    - Encouraging and incentivising service providers to develop joint proposals rather than compete with one another

    - Developing longer term (e.g. 5 years plus) contracts to enable a long-term focus on delivery of shared outcomes without restricting organisations from terminating contracts in the event of providers not achieving agreed contractual requirements

    - Being open minded about who is best placed to deliver services, recognising the vital role of the third sector and other alternative providers

    - Ensuring that all providers are treated equally and fairly, regardless of whether they are statutory or third sector partners

    - Aligning financial incentives so that all parts of the system are encouraged and enabled to work in the interests of the population needs

    - Developing an approach to financial risk and gain sharing, so that the decisions we take are always in the best interests of the population, rather than those of individual organisations

- **Prioritise Prevention** – we will work collectively to commission and deliver services that aim to intervene at the earliest possible opportunity to keep people as healthy and independent as possible for as long as possible

- Develop **shared or common models of care** that integrate services around the person and reduce fragmentation

- **Enable staff to work more flexibly across organisations and settings** so that they have greater autonomy and can focus on meeting the needs of individuals, not organisational or professional boundaries

- Ensure we have an **equal focus on physical and mental health**

- **Reduce bureaucracy and transactions costs** – for example by sharing assets between us and avoiding complex cross-charging arrangements

- **Put the improvement of health and well-being for the people of Thurrock at the forefront of all of our decision making,** even when they may appear challenging to the priorities of the organisations within the Alliance

- **Ensure that all areas of service whether they support acute or primary care or adults or children's services work in an integrated way**

Next steps

We want to use this Memorandum of Understanding to further embed partnership working at the heart of the Thurrock health and care system.

Over the next few months we plan to develop a more formal 'Alliance Agreement' – this will set out in detail how we will increasingly take decisions together once, as a single system. In it, we will describe how a more integrated approach to governance and decision making will work, how we will plan and pay for services, what targets we are setting and how we will assess the progress we are making.

We plan to ask Cabinet and our Boards to consider our draft Alliance Agreement in late 2018 or early 2019.

Over the longer term as the Alliance matures and develops other providers including GPs, the community and voluntary sector and the private sector may be invited to sign up to this agreement.

Review

We will review this MoU annually, alongside the Terms of Reference of the Alliance.

September 2018

Signatories

Roger Harris
Corporate Director of Adults, Housing & Health,
Thurrock Council

Mandy Ansell
Accountable Officer,
NHS Thurrock CCG

Malcolm McCann
Executive Director of Community Services
Essex Partnership University Foundation NHS Trust

Tom Abell
Chief Transformation Officer,
Basildon and Thurrock University Hospitals NHS Trust

Stephanie Dawe
Chief Nurse & Chief Operating Officer
North East London NHS Foundation Trust and Provide

Cllr James Halden
Chair Thurrock Health and Wellbeing Board

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NHS Thurrock Clinical Commissioning Group

MINUTES

Integrated Commissioning Executive (ICE)

30 August 2018

Attendees

Mandy Ansell – Accountable Officer, NHS Thurrock CCG (Joint Chair)
Roger Harris – Corporate Director of Adults, Housing and Health, Thurrock Council (Joint Chair)
Les Billingham – Assistant Director for Adult Social Care and Community Development, Thurrock Council
Jeanette Hucey – Director of Transformation, NHS Thurrock CCG
Maria Wheeler - Interim Chief Finance Officer, NHS Thurrock CCG
Tendai Mnangagwa - Head of Finance, NHS Thurrock CCG
Tania Sitch – Integrated Care Director, NELFT/Thurrock Council (Trusted Assessor item)
Philip Clark – Continuing Health Care Transformation Lead (for AOB), Thurrock CCG
Catherine Wilson – Strategic Lead for Commissioning and Procurement, Thurrock Council
Ian Wake – Director of Public Health, Thurrock Council
Ceri Armstrong - Senior Health and Social Care Development Manager, Thurrock Council
Allison Hall – Commissioning Officer, Thurrock Council
Ann Laing - Quality Assurance Officer, Thurrock Council

Apologies

Mike Jones – Strategic Resources Accountant, Thurrock Council
Jo Freeman – Management Accountant, Thurrock Council
Mark Tebbs – Director of Commissioning, NHS Thurrock CCG
Jackie Groom - Strategic Lead – Performance, Quality and Business Intelligence, Thurrock Council
Jane Foster-Taylor – Chief Nurse, NHS Thurrock CCG
Christopher Smith – Programme Manager Health and Social Care Transformation, Thurrock Council

1. Minutes of the last meeting (26 July 2018)

The minutes of 26 July were approved as an accurate record with one amendment on page 2 as follows:

- The action owners for investigating the current pattern of use of interim beds at Collins House and identifying an appropriate target for stays in interim beds are Catherine Wilson and Ann Laing.

2. BCF Plan 2017-19 – Finance

Tendai Mnangagwa presented the position for month 4 of 2018-19:

- The underspend position is relatively unchanged from the previous month
- The predicted end of year carry forward is £233k
- Following the July meeting, the pharmacy element of the Hypertension pilot has been ceased, but the GP element will continue
- Members agreed that CCG and Council contributions towards the Alliance work Andy Vowles is carrying out will be from the BCF (confirmed as £6,400)

- Members agreed that the DTOC coordinator post would be funded by the BCF
- It had been agreed that the BCF would fund an extension to the Bridging Services and Catherine would confirm the length of the extension
- Phillip raised a concern that Thurrock interim beds were used to provide capacity for non-Thurrock residents and that this might lead to a shortage
- Some monies allocated from the BCF to initiatives were unspent to date – Thurrock First (£20k), Integrated Data Set (£10k), DTOC (£70k) and confirmation was required as to whether the funding was still required

3. BCF Plan 2017-19 – Performance DTOC Report, BCF scorecard, 18-19 Performance Targets

Ann Laing provided an update on the BCF scorecard:

- With the exception of Non Elective Admissions, all BCF targets are on track to be met
- There is an ongoing issue with the Non Elective Admission target – with the new reporting arrangements not matching the date contained within the BCF quarterly return. This has been raised with the regional BCF manager. Performance against this target is only slightly below target
- Ian stated that there was an issue relating to the number of beds at the Hospital being taken up by people with a Mental Health crisis. Mandy commented that she had already been part of discussions concerning this matter and a further conference call was to take place with Andrew Pike. Additionally, a review of the Mental Health crisis pathway was currently taking place
- Whilst Long Stay Patients was not a BCF indicator, it had been agreed to monitor this indicator at the previous meeting. Data provided by NHS England did not currently match data held locally and this had been raised with the regional BCF manager.

Delayed Transfers of Care Report:

- Thurrock continued to perform extremely well – with the current rate of performance at 3.3 (delayed days from hospital per 100,000 population). Thurrock performs best in the region and against its comparator group
- Thurrock's DTOC target from September onwards is 6.6 – performance is to be maintained or improved

BCF Performance Targets 2018-19

- ICE members confirmed that there would be no changes to targets for 18-19 – apart from the DTOC target that had been set nationally
- Clarification on the NEA target/data was expected from NHS England and would be shared once received

4. Better Care Fund Plan 2019-20

Ceri Armstrong introduced the item and recommended that whilst it was likely that BCF arrangements for 2019-20 would be rolled over from 2017-19, ICE members might like to ensure that the Direction of Travel reflected within the Plan matched that of the ambition for the whole system. This would ensure that the BCF Plan was consistent with arrangements for the Alliance and also the Better Care Together Thurrock whole system transformation programme. It would ensure that the BCF reflected a whole system approach:

- ICE members agreed that the BCF Plan should reflect the direction of travel for the whole system in Thurrock
- This might mean that the BCF would expand to incorporate funding elements not currently included – e.g. Learning Disabilities, Mental Health
- Consideration should be given to governance arrangements – e.g. BCF sitting beneath the Alliance
- If the BCF was to reflect arrangements for the Alliance, then providers should be included as should the entirety of budgets across the system
- Consideration needed to be given to QIPP and how this would interact with BCF arrangements

5. Trusted Assessor (taken as item 3)

Tania Sitch provided an updated on the Trusted Assessor 'High Impact Change Model':

- There were a number of ways in which the Trusted Assessor model could be defined
- Our model focused on working with care homes in the Borough to provide assurance that someone was safe to be discharged back to their care
- Progress was actually far more advanced than actually reported and this needed to be reflected in the next quarterly return
- The Trusted Assessor had been employed by the Hospital and would be alerted as soon as someone from a care home had been admitted which enabled them to manage issues that often prevented someone from leaving hospital when medically fit to do so
- The next phase of the work would be to work with care homes to prevent more people from being admitted to hospital – e.g. management of UTIs was one issue requiring further work
- Phillip made the comment that there were a number of initiatives in place focusing on care homes, but these were not always well coordinated. Catherine stated that work was being carried out to review pathways for older people and to review how they worked (Phillip to be included within this work)
- Tania also reported that the 'Red Bag' initiative had been implemented with an increasing number of patients from care homes arriving with a red bag

6. Complex, Palliative, End of Life Care Beds – Proposal

At the July meeting, Phillip had identified a need for beds for complex, palliative and end of life care. The report followed on from this discussion in exploring opportunities to expand the community bed offer in Thurrock for people requiring palliative or end of life support:

- There was a need to invest in community capacity for complex, palliative and end of life care beds
- Opportunities to explore could include utilising spare/available capacity within existing residential care homes and supporting St. Luke's Hospice to provide the provision required
- 8 beds have been earmarked by Basildon and Thurrock University Hospitals Foundation Trust (BTUH) for extremely frail patients (those scoring 8 or 9 on the Rockwood Clinical Frailty Scale) with location to be confirmed (likely to be Brentwood Community Hospital)
- A further update will be brought back to ICE at a later date when the future model is clearer

7. Delayed Discharge from Specialist Commissioned Neurological Rehabilitation Placements

Phillip stated that when there were delayed transfers of care from specialist commissioned neurological rehabilitation placements, the CCG was charged regardless of who was at fault for the delay. This could lead to the CCG incurring a significant charge as placements were often expensive.

It was agreed that a decision on the approach to be taken on charges arising from delayed discharges on such specialist placements would be taken forward by Catherine, Roger, Maria, and Phillip.

8. Risk Register

At the July meeting, it had been agreed that a refresh of the risk register would be undertaken. This was provided for discussion and agreement.

The revised risk register was agreed, but members asked that Christopher link with Nicola Adams (CCG Head of Governance) to discuss linkages and parallels with the CCG risk register.

Action – Christopher Smith

9. Any Other Business

Roger highlighted a digital technologies fund that was being made available via STPs. It was possible that the funding could be utilised for further investment in the Mede-Analytics tool that Public Health was leading on. Maria Wheeler agreed to lead on behalf of Thurrock and would link with Emma Sanford (Public Health) and Jackie Groom (Adult Social Care) to identify possible funding bids.

Action – Maria Wheeler

Mandy identified clashes with the November and March ICE meetings and these would be rearranged.

Action – Ceri Armstrong

Meeting Planner

Health and Wellbeing Board

Health and Wellbeing Board Executive Committee

HWB Membership

Leader of the Council* (Cllr Robert Gledhill) Portfolio Holder for Education and Health (Chair) (Cllr James Halden), Portfolio Holder for Children's and Adult Social Care (Cllr Sue Little), Cllr Barbara Rice, Cllr Tony Fish, Corporate Director of Adults, Housing and Health * (Roger Harris), Corporate Director of Children's Services * (Rory Patterson), Director of Public Health* (Ian Wake), Accountable Officer: Thurrock NHS Clinical Commissioning Group* (Mandy Ansell), Chief Operating Officer HealthWatch Thurrock * (Kim James), Clinical Representative: Thurrock NHS Clinical Commissioning Group (Dr Anjan Bose), Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board (Dr Deshpande), Executive Nurse: Thurrock NHS Clinical Commissioning Group (Jane Foster-Taylor), Lay Member Patient Participation: Thurrock NHS Clinical Commissioning Group (Gillian Ross), Corporate Director – Place (Steve Cox), Director level Executive, NHS England Midlands and East of England Region (Adrian Marr) Chair Thurrock Community Safety Partnership Board / Director – Environment and Highways (Julie Rogers), Chair of the Adult Safeguarding Board or their senior representative (Graham Carey, Independent Chair or Jane Foster-Taylor, Thurrock CCG), Chair Thurrock Local Safeguarding Children's Board or their senior representative (David Archibald), Integrated Care Director Thurrock, North East London Foundation Trust (NELFT) (Tania Sitch), Executive member, Basildon and Thurrock Hospitals University Foundation Trust (Andrew Pike), Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Malcolm McCann), Chief Executive Thurrock CVS (Kristina Jackson)

HWB Executive Committee membership

Roger Harris (Chair), Ceri Armstrong, Les Billingham, Jane Foster-Taylor, Jeanette Hucey, Kim James, Mandy Ansell, Rory Patterson, Malcolm Taylor, Ian Wake, Carol Hinvest, Julie Rogers

Meeting	Meeting date and time
Exec Committee	24/5/18 (2-3:30pm)
HWB	8/6/18 (10:30-1pm)
HWB	20/7/18 (1:30-4pm)
Exec Committee	16/8/18 (2-3:30pm)
HWB	21/9/18 (10:30-1pm)
Exec Committee (Cancelled)	27/9/18 (2-3:30)
Exec Committee	18/10/18 (2-3:30)
HWB	23/11/18 (10:30-1pm)

Meeting	Meeting date and time
Exec Committee	29/11/18 (2:30-4pm)
Exec Committee	Dec 18 To be arranged
HWB	25/1/18 (10:30-1pm)
Exec Committee	14/2/19 (Meeting to be arranged and room to be booked)
HWB	29/3/19 (10:30 – 1pm) (invitations to be sent to members)
Exec Committee	
HWB	31 May 19 (10.30 – 1.00pm) (**Invitations to be sent to members**)
Exec Committee	
HWB	19 July 19 (10.30-1.00pm) (**Invitations to be sent to members**) To include DAAT Annual Report TOR for HWB HWB Strategy Annual Report HPAG Annual Report

Meeting	Date	Agenda	Key Deadlines	Secretariat Notes
Health and Wellbeing Board meeting	**Friday 23 November 2018** **10.30 – 1.00pm** **Committee Room 1**	1. Plan on a page and Education attainment results (Michele Lucas / Andrea Winstone and Malcolm Taylor) (This item reflects agenda item being included on Nov 17 HWB) 2. Whole Systems Obesity Strategy for Approval Faith Stow (25 minutes, confirmed) 3. Thurrock Integrated Care Alliance MOU (15 minutes, confirmed) 4. STP Update (Verbal Mandy Ansell) 5. APHR 2018. Ian Wake / Andrea Clements (30 minutes - confirmed) 6. Ward Profiles (suggested by Ian Wake on 19 Oct)	Implications and papers ready to brief Cllr Halden: Fri 2 Nov Publishing date Thurs 15 Nov	Request sent to room hire on Mon 26 March – Invitations sent to members
Exec Meeting	Thursday 29 November 2018 2.30-4.00pm. 3rd floor room 5			Room reserved, invitations sent to members
Exec Meeting	December 2018			
Health and Wellbeing Board meeting	**Friday 25 January 2019** **10.30 – 1:00pm CR1**	1. Open Up Reach Out Year Four Sign Off emotional wellbeing and mental health services for young people. Paula McCullough 2. Air Quality (Requested by Cllr Halden) (Dean Page / Mark Gentry / copy in Peter Reynolds) 3. The East of England Ambulance Service 4. Considering the relationship between HWB and Crime / Community Safety 5. Thurrock Integrated Care Alliance MOU 6. Ward Profiles (suggested by Ian Wake on 19 Oct)	Implications Fri 4 Jan Final papers to me: Monday 14 Jan Publishing date 18/1/19	Request sent to room hire on Mon 26 March – Invitations to be sent to members Papers to be sent to Ceri as I will be on AL