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

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **12 January 2023**

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

Membership:

Councillors Shane Ralph (Chair), Terry Piccolo (Vice-Chair), Tony Fish, Georgette Polley, Jane Pothecary and Sue Sammons

Georgina Bonsu (Thurrock Lifestyle Solutions) and Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Alex Anderson, Adam Carter, Victoria Holloway, John Kent and Elizabeth Rigby

Agenda

Open to Public and Press

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1. Apologies for Absence

2. Minutes **5 - 20**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 3 November 2022.

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. To agree any relevant briefing notes submitted to the Committee.

4. Declarations of Interests

5.	**HealthWatch**	
6.	**EPUT (PowerPoint)**	
7.	**Integrated Medical Centres Update (PowerPoint)**	
8.	**Self-Care in the Context of Living with Long Term Conditions - A Joint Strategic Needs Assessment**	**21 - 160**
9.	**Adult Substance Misuse Needs Assessment**	**161 - 320**
10.	**Active Travel Needs Assessment**	**321 - 422**
11.	**Report of the Cabinet Member for Adults and Health**	**423 - 456**
12.	**Work Programme**	**457 - 460**

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **4 January 2023**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

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 Overview and Scrutiny Committee held on 3 November 2022 at 7.00 pm

Present:	Councillors Shane Ralph (Chair), Terry Piccolo (Vice-Chair), Tony Fish, Georgette Polley, Jane Pothecary and Sue Sammons Georgina Bonsu, Thurrock Lifestyle Solutions Kim James, Healthwatch Thurrock Representative
In attendance:	Jo Broadbent, Director of Public Health Ceri Armstrong, Acting Assistant Director of Adult Social Care and Community Development Ian Kennard, Commissioning Manager - Personalisation I Adults, Health and Housing Catherine Wilson, Strategic Lead Commissioning and Procurement Katie Arnold, Mid and South Essex Integrated Care System Dr Ronan Fenton, System Medical Director, Mid and South Essex Integrated Care System Claire Hankey, Director of Communications and Engagement, Mid and South Essex Integrated Care System Tiffany Hemming, NHS Basildon and Brentwood CCG Stephen Porter, Interim Director, Thurrock Alliance Dr Peter Scolding, Assistant Medical Director, Mid and South Essex Integrated Care System James Wilson, Transformation Director, Mid and South Essex Community Collaborative Jenny Shade, Senior Democratic Services Officer

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

20. Minutes

Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 1 September 2022 were approved as a correct record.

21. Urgent Items

There were no urgent items.

22. Declarations of Interests

Councillor Polley declared a non-pecuniary interest in relation to her employment with the NHS Ambulance Service.

Councillor Fish declared a non-pecuniary interest in relation to him being a Blue Badge user.

23. HealthWatch

Kim James referred to the work undertaken by Thurrock HealthWatch with a report being produced on “Access to general practitioner Surgeries” and agreed to share that report with members for information.

Work would also commence following lots of issues being raised by communities to HealthWatch around access to services, such as no community transport and there had been issues with the criteria for non-urgent ambulance services. HealthWatch would like to invite anybody in the community who had experienced these issues to contact them so their comments could be included in the report.

Councillor Ralph suggested that once the report had been finalised, it could be presented to members under the HealthWatch item of the agenda. Councillor Ralph made this personal thanks to Kim James for the work she had undertaken on a number of cases with local residents which had been very helpful.

24. Community Inpatient Beds in Mid and South Essex

Members were updated on the work that was ongoing across Mid and South Essex (MSE) Integrated Care System (ICS) on the potential future configuration and focus of community inpatient beds.

Councillor Ralph thanked James Wilson for the update.

Councillor Pothecary referred to the stroke rehabilitation centre and questioned whether under the consultation there would be a proposal for the stroke rehabilitation centre to be focused away from Thurrock. As there tended to be a trend to have centres less local, less embedded in the local community and further away for residents to travel. James Wilson stated under the current configuration of the stroke community rehabilitation there were two sites across Mid and South Essex, in Rochford and St Peters in the Maldon area. The preferred option following the next phase of work, would be the requirement of two sites that would increase the overall volume of stroke rehabilitation beds and would be looking for sites in the north and the south which would not significantly change any points of access for Thurrock residents. An updated report, once proposals had been confirmed, would be presented back to the committee. It was confirmed that Thurrock residents requiring stroke rehabilitation services would go to Rochford unless it was appropriate for them to have their stroke rehabilitation in their own homes.

Kim James referred to the report that was due to be presented to the committee on the 1 September 2022 to which the chair stated this report had been deferred. Democratic Services would send a copy of that report to members.

Councillor Ralph referred to the current pressures of discharges from hospitals and with the potential of services moving to new sites questioned whether this would mean the closure of the Rochford facilities. Councillor Ralph also questioned whether services could potentially be moved to Bishop Stortford which would mean Thurrock residents having to travel even further for recovery. James Wilson stated that one of the key themes fed back from the pre consultation exercise had been the importance of local facilities and with the plans taking place in terms of the winter response would be to reopen the capacity not in existence. This would mean there would be more local capacity opening and there were no current plans to move the services to Bishop Stortford and there were no current active plans to close the centre in Rochford.

RESOLVED

1. **The Health and Wellbeing Overview and Scrutiny Committee noted the update.**

2. **Agreed to receive detailed proposals on any potential public consultation at a future meeting**.

25. Under Doctoring in Thurrock

The following presentation was delivered to members:

(Public Pack)Item 7 - Under Doctoring Presentation Agenda Supplement for Health and Wellbeing Overview and Scrutiny Committee, 03/11/2022 19:00 (thurrock.gov.uk)

Councillor Ralph referred to the 12 fellowship general practitioners and questioned how many of those were currently engaged on this program at the Corringham IMC to which he was informed that interest had been shown by six of the 12 posts which were going through the process and starting soon. A team in Basildon had done a fabulous job selling this concept and would be undertaking a similar exercise on general practitioner trainees in Southend. The message being delivered was “tell us what you want like out of your career” and help would be given to achieve that.

Councillor Ralph referred to data being made available on appointments and questioned whether these would be physical, or telephone appointments being recorded to which Stephen Porter agreed to find the answer and email Councillor Ralph following this evening’s meeting.

Councillor Ralph stated his concern that residents are unable to get physical appointments, misdiagnosis were possibly being given through telephone appointments, illnesses were being missed and with A&E now being used as a general practitioner’s service he felt there needed to a push back to physical appointments.

Councillor Ralph referred to the 1000 telephone line connections and questioned whether these calls would go to a call-centre rather than the general practitioner practice to which he was informed this would possibly be a digital solutions based on telephony which would use the internet to manage these calls and agreed to find out more information and forward to members.

Councillor Pothecary referred to telephone appointments and agreed that sometimes a telephone appointment might be fine and adequately suitable and for other times not ideal, she then gave an example of a terrible experience with her own general practitioner trying to organise a face-to-face appointment. Councillor Pothecary referred to the telephony solution and was not convinced the answer was a technology solution for more telephone lines, the issue would be around sorting out appointments so that residents can get to see their general practitioner. Councillor Pothecary referred to the 8am lottery with a lot of residents not being able to make a call that time of day due to travel or other commitments and reiterated that a better system should be available for residents to make appointments. Stephen Porter acknowledged Councillor Pothecary's points and stated that work would continue with clinical directors and would put this issue on the agenda for their next meeting and report back to the committee.

Councillor Fish referred to the "ease of getting through on the phone" slide and referred to the two categories of "easy" and "not easy" and stated there was insufficient information to get a realistic picture. A realistic picture being more than the 59% who found it harder to get an appointment. Stephen Porter stated this was a national survey and would be able to provide these comments from the feedback.

Councillor Fish referred to "social subscribers" and stated these were a fantastic innovation into surgeries and questioned what model they would work to. As this would depend on how long they would get with each patient to make a real difference, if they were to work along the same lines as general practitioners and have little time with each patient, then these would not be successful. Stephen Porter stated they would not work to the same constraints that general practitioners were under, they would be more flexible in terms of time, may hold walk-in sessions, make referrals and spend more time depending on the need of patients. Members were informed that a close eye would be kept on the model of working to ensure that it fitted the needs of Thurrock residents.

Councillor Fish stated that his own general practitioner surgery had the additional roles refurbishment scheme, but he still had to wait two weeks to see a doctor. Stephen Porter stated this was a triage, filtering process that would take place with some patients not having seen a doctor, as they did not need to, some patients would be happy with that, some would not. It was vital that these experiences were heard as it was important to go back to surgeries, clinical directors, practice managers and liaise with patients.

Councillor Polley also referred to the additional role's refurbishment scheme, and stated the 30 paramedics were not additional roles they had probably

been poached from another service as working at general practitioner surgeries would be more attractive because of the working hours. These were not new paramedics they had been taken from another service. Councillor Polley referred to the new initiative which would work within the Monday to Friday, 8am to 4pm constraint, general practitioners were potentially small businesses. Councillor Polley stated she did not know of any other businesses that would close their doors one day a month to undertake training and based on the shortage of appointments this was a disservice to the residents of Thurrock. Stephen Porter stated that new practitioners coming into Thurrock would find the offer of training once a month very attractive. With the way practices were evolving and changing, new research was required, and NHS England would expect that regular training was carried out. Stephen Porter stated they would continue to push for the right balance. Also stated there had been no intentions of poaching paramedics, that it was a free market and that paramedics could work where they wanted.

Councillor Piccolo praised and appreciated the work undertaken of his general practitioner surgery.

Councillor Ralph stated that general practitioner had worked through some unique times but should not continue to use covid as a means to avoid face to face appointments.

Councillor Ralph thanked members for their valued input and comments.

26. Integrated Medical Centres Update

The following presentations were delivered to members:

(Public Pack)Item 8 - IMC Presentation Agenda Supplement for Health and Wellbeing Overview and Scrutiny Committee, 03/11/2022 19:00 (thurrock.gov.uk)

Councillor Ralph agreed although the opening of the Corringham IMC today would be a fantastic facility which had a friendly and pleasant atmosphere he questioned that the whole project was not now affordable. Tiffany Hemming stated that this was a question which had been put to NHS England around whether enough money could be obtained to pay for the project but agreed at this time it was not looking great in terms of having enough money to pay for all the sites, particularly the funding gap for Grays IMC. That work was being undertaken, as a solution needed to be found before the closure of Orsett Hospital, this would require their governance to come together through the system finance leaders' group to work out how this would be funded, where the funding would come from and how it would be prioritised over other items that were needed from the system. Tiffany Hemming reiterated at this present time; money was the biggest risk.

Councillor Ralph referred to the reassurances that himself and the committee had received over the last three years that the project was moving full steam ahead but to now be told of all the project constraints and with the proposed

closure date of Orsett Hospital closing being 2025. Councillor Ralph questioned whether there would be a point in time the NHS would agree that Orsett Hospital should remain open. Councillor Ralph stated he had serious concerns on this project, the whole program. That the Corringham IMC had been a great opportunity to see how the program worked and should have been seen as a flag-ship example for other authorities to follow. With NHS England making the decision to close Orsett Hospital and having proposed these fantastic new sites for integrated care, Councillor Ralph could not see where the project was heading and what the answer would be.

Councillor Pothecary echoed the chairs comments and was utterly unconvinced with the current plans. That the centre currently opened happened to be location in the area of Thurrock that was at least in need of extra primary care, in an area that suffered from fewer health inequalities and also the closest located to Basildon hospital. There was now a question over whether other communities, the proposed sites, would get the required level of service with too many funding gaps. Councillor Pothecary questioned whether a guarantee could be given that there would be a parity of service between what was current in Corringham and the other three sites. Tiffany Hemmings stated that Corringham IMC was the first site to be completed because this program was already in progress with NELFT. The sites would not provide more or improve the primary care services, the sites would provide a better environment for the current primary care services to move into. Confirming as part of the presentation that the focus would be moved away from the buildings to making sure we had integrated care services across the whole of Thurrock. This would ensure that the services delivered are enhanced to every patient in Thurrock regardless of there being a building in place, this would mean a better service, better integrated for the patient rather than starting with a pathway which was the traditional way that NHS looked at this.

Councillor Pothecary referred to the proposed drift away from initial plans and the considerable gaps of funding, questioned where residents would have to go for their care. Tiffany Hemmings stated that the majority of services at three of the four sites would not have the services currently at Orsett Hospital, with the vast majority of services currently being planned to be relocated to the Grays site. To which Councillor Pothecary reiterated where there was the massive funding gap and whether there would be a funding to repurpose the buildings on that site to fit in all the services.

Councillor Piccolo stated the current state of play was atrocious, the plan was for four integrated medical centres following the closure of Orsett Hospital, it now appeared there will only be one and the other three would be disjointed and stated this was appalling for all Thurrock residents.

Councillor Polley stated this was a moveable feast, the rationale behind closing Orsett Hospital was that it was not fit for purpose but were now looking to extending the closure date. Councillor Polley had concerns on whether residents and health care staff who used the building may be harmful to them or whether the first assessment that stated the building was not fit for purpose

had been incorrect. Councillor Polley questioned if the building was not fit for purpose how this can be continually extended. The constant message presented to this committee was the closure of Orsett Hospital and stated that the committee, cross-party, had repeatedly supported that this was the wrong way to be looking at this, when the services had been delivered was the time to close the hospital. Councillor Polley referred to the growth agenda in Thurrock and stated her concern that health care cannot be provided to residents of Thurrock now and questioned where the figure of £6 million had come from in regard to the valuation for Orsett Hospital site. Councillor Polley concluded that the project was not affordable, not deliverable and questioned whether this should go back to the drawing board.

Councillor Polley referred to the Purfleet IMC and asked for definition on what was meant by “acute services” to which she was informed the acute services were generally outpatient appointments provided by the Mid and South Essex NHS Foundation Trust and that was how the NHS trust described services currently at Orsett hospital as outpatient appointments.

Councillor Fish questioned whether the plan was now to keep Orsett Hospital open to which Tiffany Hemmings stated no, this was not the current plan, the backlog maintenance costs were potentially more than the rebuilding cost to rebuild somewhere else.

Councillor Sammons questioned regardless of the IMCs being completed that Orsett Hospital would still close to which Tiffany Hemmings stated the plan was that Orsett Hospital cannot close until the services had been safely relocated to appropriate locations in Thurrock. Councillor Sammons questioned where these sites would be to which Tiffany Hemmings stated the current plan was for the IMWCs, if that proved to be completely unaffordable as the process had gone through with NHS England a report would need to come back to this committee to find an alternative way of delivering those services but reiterated, they were still waiting for NHS England to come back to them with an answer. Councillor Sammons stated that in the meantime, residents of Thurrock would suffer to which she was informed that services would still be delivered, to the same standard, as required by the NHS in Thurrock and reiterated again there was no plans to close Orsett Hospital until services had been safely relocated to elsewhere in Thurrock.

Councillor Ralph thanked the committee for their valid input, and all agreed that some serious questions needed to be asked in particular to the £6 million gap on the site valuation. Tiffany Hemmings stated this valuation related to some particular circumstances of the hospital on the site which would reduce the overall value because of the issues with removing the current building which would be extremely expensive.

Councillor Ralph stated he could not see the answer to these issues, if Orsett Hospital was to close but the IMCs were not going to be built where would these services be located. Serious questions need to be answered, involve local MPs and come up with a solution. That the medical care of Thurrock

residents was being played with and all that was being presented was problems after problems.

Councillor Polley stated the members here this evening were passionate about health in their communities and it was their job to challenge and scrutiny such reports and asked whether as a committee there was anything that they could do to help assist, to which Tiffany Hemmings stated she was in the process of arranging a meeting with Councillor Arnold to look at what could be done to potentially move this forward.

27. Community Diagnostic Centres

The Chair agreed to an update on the Community Diagnostic Centres and members were referred to the following presentation:

(Public Pack)Item 8 - Community Diagnostic Centres Presentation Agenda Supplement for Health and Wellbeing Overview and Scrutiny Committee, 03/11/2022 19:00 (thurrock.gov.uk)

Councillor Ralph thanked Katie Arnold for the report which was a great opportunity that would help the backlog of diagnostics in Thurrock.

Councillor Polley stated this was one of the best reports she had seen for a long time and questioned the hours that the services at the community diagnostic centres would be open and available. She also questioned whether an ambulance would be able to take a care home patient to the centre to have their scans rather than taking them to a hospital. Katie Arnold stated the aim would be to build up to a seven-day service for MRI, CT scan and ultra-sound which would run from 8am to 8pm, 12 hours a day. With the other tests, lung, heart and blood tests more likely to be shorter hours, not seven-days a week, but looking to extend those hours. In the terms of the question on care home patients, it was reiterated that the centres would focus on planned activity therefore elective patients which in turn would reduce the capacity at acute sites and allow access to the emergency flow.

Councillor Pothecary stated the community diagnostic centre sounded an amazing step forward in terms of making sure extra diagnostic capacity would be available. She questioned as it would form part of the Gray's IMC but with the Gray's IMC having potential issues around cost and configuration, she asked how tied the community diagnostic centres were to the Gray's IMC. Councillor Pothecary also questioned whether the community diagnostic centre would happen no matter what happened to the Gray's IMC. Councillor Pothecary asked how future proof the planning of the community diagnostic centre was, questioned the timeline and how could members have that assurance that this project would start in spring 2023. Katie Arnold stated that nationally the community diagnostic centre could stand alone. The benefit of having the community diagnostic centre at Thurrock community hospital was there were hospital services already available on that site. With community clinics and MSK triage assessment already on-site and frequent requestors for diagnostic testing. Katie Arnold agreed this was a very tight timeline, the

national community diagnostic centre team wanted to ensure every system had their first community diagnostic centre early on were being pushed for tight timelines, a pre-application for planning had already been submitted, an architect was currently on-board, all planning information had been sorted. The design and appointment of contractor, at risk, would be run along planning but were committed to start this project in spring 2023.

Councillor Ralph thanked Katie Arnold for the very positive report.

28. Transforming Health and Care in Thurrock

The chair agreed to defer this item to a future meeting.

At 9.00pm, Councillor Ralph extended standing orders to enable the meeting to go past the scheduled 9.30pm finish time.

29. Request to Consult for the Charging of Assistive Technology Monitoring Service

The report presented to members stated that it was a statutory requirement under the Care Act (2014) for the Authority to provide Assistive Technology free of charge to eligible individuals if the item was under £1k. These devices were, at present, monitored 24 hours a day 7 days a week by an Alarm Receiving Centre that was based in Harty Close in Grays. The purpose of this monitoring service was to support individuals living at home for longer my mitigating risks such as falling, wandering etc. There are 21971 individuals accessing this monitoring service at present that were eligible for support via Adult Social Care via a variety of devices and pay nothing to access this. Adult Social Care would like to consult with individuals accessing this service around potentially charging for this so we can offset some of the financial pressures the Authority faces.

Councillor Ralph stated his concern was affordability, that meant testing had been the key item and although acknowledged the report was a request to go out to consultation there were questions on how the consultation would be undertaken.

Councillor Fish referred to the level of charging and the means testing of residents and questioned whether everybody would be paying something and whether there would be a limit to what anybody would pay. Ian Kennard stated that Thurrock currently was not set on a particular fashion and if means testing were to take place a consultation would have to take place, evaluate the feedback and present again to committee. If the council got to the position of means testing for contribution it would be applied in the same fashion as applied to all other non-residential means testing. Therefore, you would pay what you can afford to pay.

Councillor Piccolo questioned whether the means testing would be carried annually as resident’s circumstances could change within the course of a year and were the staff costs known for means testing those 2000 residents and

having deducted those savings from what was being made at present. Ian Kennard stated there was an obligation to review means test each year, initial means testing would be undertaken face to face with the following year a light touch review as information would be more readily available at that point. The first assessment would be more time intensive and would then get progressively easier to undertake reviews in subsequent years. A financial assessment officer would normally undertake eight face-to-face assessments each day but if they were to undertake desk based assessments could carry out about 40-50 a day so would become more viable the longer its progressed.

RESOLVED

That Health and Wellbeing Overview and Scrutiny Committee commented on and supported the recommendation to consult with individuals using assistive technology on potentially charging a fixed fee for accessing the monitoring service subject to a means test.

30. Annual Public Health Report 2022

The Director of Public Health presented the report on reducing the Impact of Cardiovascular Disease in Thurrock. Members were referred to the presentation PowerPoint:

https://democracy.thurrock.gov.uk/documents/b19178/Item 11 - Annual Public Health Report 2022 Presentation 03rd-Nov-2022 19.00 Health and Wellbeing O.pdf?T=9

Councillor Ralph thanked Jo Broadbent for the brilliant report and thanked her for all the work and effort to produce such a great piece of work.

Councillor Ralph questioned whether the vape initiative was still happening to which Jo Broadbent stated this had been severely impacted by the covid pandemic, with shops closing and people moving to on-line ordering. There was still an agreement with one shop but there was definitely less traffic through that shop. Jo Broadbent stated that the service model needed to change.

Councillor Ralph questioned whether there was any evidence from retailers that the sale of tobacco had gone down in Thurrock to back up the figures that people were smoking less to which Jo Broadbent stated she did not have those figures to hand but would find out and let members know. Following the meeting it was confirmed the most up to date data we had was presented in the Tobacco Control Needs Assessment. This included data on illicit tobacco sales but not legal tobacco sales. Smoking was more usually monitored locally through survey of smokers not tobacco sales. The assessment can be view from the following link:

https://www.thurrock.gov.uk/sites/default/files/assets/documents/jsna-tobacco-2021-v01.pdf

Kim James referred to the increase in numbers diagnosed with atrial fibrillation since 2016 and the monitoring that was undertaken by general practitioners, questioned whether the increase in numbers diagnosed was from then, as there was a lot of diagnostic activity at that time in primary care and was this being done more recently as patients had less face-to-face contact with GPs. Questioned whether the facts and figures were recent or within that period of time. Jo Broadbent stated she would have to go back and look at the exact figures for atrial fibrillation but what was looked at was 2016 up to the most recent data. Generally, for each of the indicators looked at saw an upward trend year on year, with the general trend upwards identified clearly that people who were at higher risk of atrial fibrillation were getting identified and diagnosed.

Councillor Fish questioned why some minority ethnic groups had a higher prevalence of cardiovascular disease. Jo Broadbent stated that this was probably multifactorial with no single answer, there may be a genetic component, a health risk behaviour component and potentially access to services and getting access to preventative support, early diagnosis could also impact on the outcomes.

Councillor Fish referred to access to services and questioned what the challenges were to which Jo Broadbent stated that for cardiovascular disease in Thurrock there was a higher rate of under-diagnosis in all non-white ethnic minority groups than the white ethnic minority groups. This was a complex area and that across a number of services there was an under representation of non-white ethnic minority groups and agreed this needed to be looked into and understood better.

Councillor Fish stated that where services were being delivered may need to be addressed to which Jo Broadbent agreed.

Councillor Polley stated some education was required to be put in place to help identify that overweight and shortness of breath was a cardiovascular disease concern with the biggest piece of work that needed to be done was in the more deprived areas of Thurrock. Jo Broadbent stated the council had a whole system obesity strategy but with everything that had happened during covid and time moving on it had been recognised the strategy needed to be refreshed so work was ongoing. This needed to a whole system approach as they were all complex issues, with a stakeholder workshop being planned for January 2023 and a report would be presented back to the committee next year.

Councillor Ralph thanked Jo Broadbent again for the excellent report and how this had to be a whole overview of health and questioned whether the use of recreational cannabis could be included going forward. As although the reduction of smoking had been looked into, the use of cannabis which was often mixed with tobacco had been identified in Thurrock and could be an issue especially for those people with mental health problems.

RESOLVED

That Members noted the contents of the Annual Public Health Report 2022 and approved its publication.

31. Adults, Housing and Health - Fees and Charges Pricing Strategy 2023/24

The report presented sets out the fees and charges in relation to services within the remit of this overview and scrutiny committee. Charges will take effect from the 1st of April 2023, unless otherwise stated. In preparing the proposed fees and charges, directorates had worked within the charging framework and commercial principles set out in Section 3 of the report. Considered the effect that the increase in interest rates and the cost-of-living crisis had on the local economy, services and the continued implications from Covid. Further Director delegated authority would be sought via Cabinet to allow Fees and Charges to be varied within financial year in response to changes in government legislation, all other changes in year would be brought back to Cabinet via the Service Director for transparency. Members were referred to the updated proposed charges detailed in Appendix 1, and the proposed deletion of current fees and charges in Appendix 2 to this report.

Councillor Pothecary thanked officers for the report and was pleased and encouraged that library members were still being given two hours free internet access. Councillor Pothecary referred to individual charging prices and questioned whether there was any further information or progress in putting adult social care onto a funding model which had some parity with health funding to Catherine Wilson stated she was not aware that any progress had been made but agreed to check and let members know.

Councillor Polley referred to recommendation 1.1, consultation, to which Catherine Wilson stated there was nothing in the report at this stage that would need to be consulted on. The only item that would need consultation on was the report this evening on assistive technology, for the increase in residential charges each individual would be individually financially assessed. Members were informed this was just a point in the report that should consultation need to be undertaken a report would be presented to committee. Catherine Wilson reiterated the adult social care charges outlined in appendix 1 there would be nothing to consult on because nothing had increased apart from the domiciliary care which had already taken place.

Councillor Ralph recognised that recommendation 1.1 had been added to the report in error. Officers confirmed the recommendation had been added in error and that no consultation would take place. It was noted that members of the committee were given the opportunity to comment on the report and all members noted the contents of the report and appendices. Therefore, resolved item 1, reflected the above.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee note the revised fees and charges including those no longer**

applicable; and comments on the proposals currently being considered within the remit of this committee.

2. **That Health and Wellbeing Overview and Scrutiny Committee noted that Director delegated authority would be sought from Cabinet to allow Fees and Charges to be varied within a financial year in response to legal or regulatory requirements.**

32. Service Harmonisation Mid and South Essex ICB

The report presented had updated the committee on the Service Harmonisation Consultation for Mid and South Essex Integrated Care Board. It had set out the ambition to harmonise the provision of six service areas due to differing historic commissioning policies within the five clinical commissioning groups. Members were presented with the following presentation:

(Public Pack)Item 13 - Service Harmonisation Thurrock Presentation Agenda Supplement for Health and Wellbeing Overview and Scrutiny Committee, 03/11/2022 19:00

Councillor Pothecary questioned what “routine funded” meant to which she was informed that this was a process that had no thresholds, for an example an emergency operation such as an appendicitis which could not have been planned.

Councillor Ralph noted that on page 113 of the agenda under “Smoking” the word “not” should be removed.

Councillor Ralph referred to the sensitive issue of breast reduction and IVF and noted these were people’s lives, people’s dreams and hopes and quite often a sensitive issue and asked for clarity on IVF, that the offer of two free shots were being offered in Thurrock. Peter Scolding stated that yes, with the policy within an age bracket of 23 to 39, two cycles of IVF, 14 above if it had been funded previously, with same sex couples having a maximum of one cycle as provided previously.

Kim James stated HealthWatch, nor CVS were unaware of the planned public event at the Beehive and asked for further information.

Councillor Pothecary stated that currently treatment for breast reduction was open to smokers but with the new policy this opportunity would be taken away from smokers and questioned what the clinical justification for this was. The clinical justification of this, following the process going through the clinical multi-professional groups, specialist groups in that area on the thresholds that would be placed was that the impact of smoking was the healing of relatively large wounds that would be involved in breast reduction surgery and the benefit of people stopping smoking would be important in the outcome from that surgery. Councillor Pothecary requested that as part of the consultation the clinical justification was made clear.

Councillor Ralph questioned what the timeframe was of becoming a smoker to a non-smoker to which he was informed that preliminary discussions had taken place on this, and exact definitions would need to be clarified.

Jo Broadbent referred to the fertility policy and questioned was one of the criteria for getting funded IVF was to have been through a certain number of IUI cycles previously to which she was informed yes that was one of the principles to qualify for IVF was to demonstrate infertility for men and female couples was a period of two years of trying without conceiving. In male-female couples there would no requirement to go through any process of IUI, for same sex couples, who are unable to demonstrate infertility in the same way so the requirement in terms of demonstrating and fertility had been six cycles of IUI that had not been funded previously under the CCG policy, therefore that part of the policy had stayed consistent.

Councillor Pothecary questioned how much, roughly, was a round of private IUI to which this information would be provided for members.

Councillor Piccolo questioned how the definitions of “how long being a smoker” and how checks would be undertaken before and after treatment to which he was informed that discussions were taking place and would be defined as part of the consultation.

Councillor Ralph wondered whether vaping would be classed as smoking due to the nicotine element.

RESOLVED

1. **The Health and Wellbeing Overview and Scrutiny Committee noted this update and supported the promotion of the consultation.**

2. **Agreed to receive the analysis of public consultation at a future meeting.**

33. Work Programme

Councillor Ralph requested that EPUT attend the next meeting to discuss the Channel 4 Programme on mental health support. Councillor Piccolo, as vice-chair would chair this item as Councillor Ralph was the Thurrock Council Governor to EPUT.

Members agreed to remove the Health and Air Quality report from the 12 January 2023 meeting as a similar report would be presented to the Cleaner Greener and Safer Overview and Scrutiny Committee on the 8 November 2022.

The meeting finished at 10.08 pm

Approved as a true and correct record

CHAIR

DATE

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

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12 January 2023	ITEM: 8
Health and Wellbeing Overview and Scrutiny Committee	
Self-Care in the Context of Living with Long Term Conditions – A Joint Strategic Needs Assessment	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Emma Sanford, Strategic Lead for Healthcare Public Health	
Accountable Assistant Director: Sara Godward, Assistant Director of Public Health	
Accountable Director: Jo Broadbent, Director of Public Health	
This report is Public	

Executive Summary

Increasing demand across the NHS and social care system in England, in both the number of patients and the associated cost of service delivery, can largely be attributed to: an ageing population; staffing issues; and a rising number of people with long-term condition (LTCs):

1) Around half of all GP appointments take place with patients with LTCs.
2) In the last five years, there were large increases in A&E attendances per day and even larger increases in emergency admissions. Patients with LTCs account for a large proportion of this activity, with a sizeable number having multiple conditions.
3) People with LTCs often struggle with daily activities. Social care provides a range of services supporting these activities. Nationally, the demand for social care support is increasing.

As a result of their use of services, the annual health and social care cost for a person with an LTC is three times higher than for a person without an LTC. This leads to 70% of the NHS budget being spent on patients with LTCs.

Self-care activities support improving the Quality of Life (QoL) and the health outcomes of those with LTCs, and thus could assist in reducing LTC associated demands and costs. However, they are not currently prioritised or sufficiently supported in the health care system.

This JSNA provides an evidence-based review of local services to support the development and expansion of the self-care provision in the Mid and South Essex ICS area, with a focus on three particular LTCs: Diabetes Mellitus (DM); Chronic Obstructive Pulmonary Disease (COPD); and, Heart Failure (HF).

Issues identified throughout this report are of multivalent, hence require action at different levels across the system: personal, local, regional and national level.

Six main themes were observed:

1) services that contribute to self-care across the STP are fragmented and irregular (largely due to a lack of strategic direction across the patch);
2) information is not readily available to patients, providers and commissioners (with issues due to lack of data collection and sharing);
3) patients and primary care providers lack the capacity and skills to make the most out of their interactions;
4) multimorbidity is increasing and needs to be addressed holistically;
5) the need for financial redistribution (with most of the funding going towards treatment in secondary care rather than prevention and support in the community);
6) self-care as a topic is in its infancy and evidence still needs to be developed.

To facilitate a coordinated effort to address these identified issues it is recommended that a joint strategy that aligns the prevention, early intervention and management agendas and addresses place-based barriers to self-care is developed at the ICS level.

Recommendations also focus on education and training of professionals. Upskilling programmes in *Making Every Contact Count*, patient activation, coaching and motivational interviewing all empower staff to hold the difficult conversations needed to engage patients in programmes that can support them.

At the neighbourhood level there is an opportunity to pool resources to offer education and specialist support to patients that have harder to manage conditions. Moreover, variation within the ICS Alliance areas and PCNs reflect struggles that some practices might have locally. Building on other's successes and sharing best practice between these local practices can support with reducing the variation currently seen.

Patients should also be supported and empowered to use varied tools to manage their health and make the most out of a meeting with a health professional. Patients and carers can and should share information and be encouraged to empower each other through face-to-face and online support groups.

1. Recommendation(s)

1.1 That the Committee review the needs assessment and the recommendations contained within and provide comment.

2. Introduction and Background

2.1 The National Health Service (NHS) is facing increasing demand and year-round pressures across all levels of care. Secondary care, and in particular

emergency care, is being badly affected with an evident increase in both the number of patients and the associated cost of treatment.

2.2 This increased demand is largely attributable to two factors: the ageing population and a rising number of people living with chronic conditions such as diabetes, cardiovascular disease, and depression. Furthermore, the complexity of individual cases is increasing, with an estimated 2.9 million people in England in 2018 having multiple conditions, also called multimorbidities.

2.3 As a result, current health policy and research now places greater emphasis on the need for healthcare to adopt the principles of self-care as routine practice. The NHS' 'Long Term Plan' highlights the priority for people to have more control over their own health and personalised care when they need it.

2.4 Supporting people to self-care is vital and should be a key activity in our health and social care systems. For patients with LTCs and multimorbidities, optimal outcomes and quality of life depend on engagement in effective self-care activities. However, self-care is often not prioritised to the same level as traditional medical interventions by professionals and the healthcare system. As a result, there is an apparent lack of emphasis on support and referral to services that can assist patients in maintaining or improving lifestyle behaviours or in self-managing their conditions.

2.5 This Joint Strategic Needs Assessment (JSNA) focuses on self-care. It aims to provide an evidence base for the development and improvement of the care and the ways in which we support and empower patients to self-manage LTCs and their general health. In line with the current NHS strategy and the Five Year Forward View, this assessment focuses on the Mid and South Essex Integrated Care System (ICS; formerly Sustainable Transformation Partnership / STP). This will allow for the report to influence system-wide priorities and contribute to the planning of more coordinated services.

2.6 As self-care practices span across numerous health and wellbeing domains, the assessment and recommendations of this paper are focused on three main long term conditions: diabetes, heart failure (HF) and chronic obstructive pulmonary disease (COPD). These have been identified to be of higher need and impact due to their complexity and increased effect on patients and the system alike.

2.7 Based on our analysis, in 2018/19 more than £20 million was spent on hospital care alone across the STP for patients with Diabetes, COPD and HF. This is an under-estimation of how much these LTCs cost the system as we only quantified visits to A&E, emergency admissions and elective admissions which were coded as being related to the three LTCs. With no change to how we support patients to self-care, this amount will almost double by 2030.

2.8 A good collaboration between service providers and patients, where patients are supported to self-care, is essential to this. The King's Fund describes this

shift as a cultural change towards ‘shared responsibility for health’ and proposes patient activation as a way to conceptualise and measure patient engagement in their own care.

2.9 The NHS Long Term Plan also highlights the need for a fundamental shift in the way care providers are working with patients and their caregivers. The report calls for a more patient-centred approach where patients are fully involved in planning their care. The 10-year long plan commits to facilitating better support for patients to improve their skills to self-care, particularly for patients suffering from long term conditions (LTCs).

2.10 Investments in building a model of care that supports patients to self-care better are proven to be very cost-effective. For example, studies looking at patient activation show that proper support in primary care results in decreasing utilisation of services, specifically in secondary care. With a 20-point increase in Patient Activation Measure (PAM) scores, evidence shows 9% fewer GP contacts (95% CI, 0.89–0.93), 20.90% fewer A&E attendances (95% CI, 0.75–0.83) and 23.3% fewer emergency admissions (95% CI, 0.71–0.83) per person (123). Moreover, increase in PAM scores also contributes to decreased length of stay, fewer hospital readmissions and reduced ‘did not attend’ rates for primary and secondary care appointments (25). For Mid and South Essex Health and Care Partnership, this means an opportunity to avoid costs of over £8.6 million by 2030.

2.11 The document contains many recommendations from page 77 to 95, however most of these are for implementation at a Mid and South Essex footprint by the ICS. These are being highlighted to the Personalisation of Care subgroup of the new ICS Population Health Improvement Board. They can be grouped into 6 themes:

1. Services that contribute to self-care across the ICS are fragmented and irregular (4.2.1)
2. Information is not readily available to patients, providers and commissioners (4.2.2)
3. Patients and primary care providers lack the capacity and skills to make the most out of their interactions (4.2.3)
4. Multimorbidity is increasing and needs to be addressed (4.2.4)
5. Funding needs to be redistributed (4.2.5)
6. Self-care as a topic is in its infancy and evidence still needs to be developed (4.2.6)

2.12 The main recommendations that can be implemented at a Thurrock place level in the current financial situation include:

1. There are some recommendations contained in the report about case finding and management, however these are superseded by the 2022 Annual Report of the Director of Public Health on the management of CVD conditions in Thurrock.

2. Education and specialist support should be provided for diagnosed patients (specific to their conditions).
3. Make aggregate data sharing with ICS partners a contractual obligation for community care providers and ensure regular data quality and completeness activities are undertaken.
4. Shift towards outcome based targets and KPIs rather than performance based.
5. Deliver motivational interviewing and other coaching techniques training to GPs and primary care staff.
6. Plan group meetings for patients with multi-morbidity to facilitate share of resources and experience.
7. Improve CBT offer for LTC patients to reduce anxiety and improve Quality of Life.

2.13 In addition there are some recommendations aimed at helping patients to get the best out of the services we offer, that could be achieved through a good communications plan. They include:

1. How to plan an appointment with care provider
2. Keeping symptom log/diary
3. Accessing free / online services
4. Being open to access support

It is also proposed that self-care forum events are run across the ICS to inform patients and carers about their role in managing their health.

3. Issues, Options and Analysis of Options

3.1 This needs assessment has previously been reviewed and approved by the Public Health Leadership Team, the Adults, Housing and Health Directorate Management Team, and the Mid and South Essex Health and Care Partnership Board.

3.2 As this is a needs assessment there is no requirement of the Committee in relation to options, beyond reviewing the content and offering comment.

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

4.1 Consultation was undertaken as below:

Service mapping	Service information was collected during engagement with professional stakeholders (please see the row below for more info). Additional to face to face engagement, internet search and remote liaising with provider and commissioner organisations was carried out. Each council collected information for their covered areas and

Thurrock Council Team collated the information.

Professional stakeholder views

Thurrock Council employed hosting workshops and various meetings in order to engage with local stakeholders. In addition, Essex County Council employed an online survey approach and face-to-face meetings with key professional stakeholders. There was a lack of capacity to undergo similar activity in Southend. However, the engagement included professionals serving all areas across the STP:

- Public Health Commissioners at Essex County Council, Southend Borough Council and Thurrock Council
- Thurrock Clinical Commissioning Group (CCG)
- Essex Partnership University Trust (EPUT)
- Adult Social Care (ASC) in Thurrock including the Community Led Support Team and the Local Area Coordination (LAC) Team
- North East London Foundation Trust (NELFT) Community LTC Services
- Healthwatch Thurrock
- Thurrock Community and Voluntary Services (CVS)
- Southend Voluntary Services (SAVS)
- Chronic Health Psychology Service (CHPS)
- Thurrock Housing Services
- Essex Local Pharmaceutical Committees (LPC)
- Basildon & Brentwood CCG

Patient views

To understand people's experience of diagnosis of an LTC, perceived barriers to self-care and what could help support them to better self-care a range of engagement activities were carried out. In Thurrock, local Healthwatch engaged with a total of 66 people through group surveys and in-depth interviews. Similarly, Healthwatch Essex engaged with 48 residents living with long term conditions using the same methods. Southend Council did not have enough capacity to commission this work.

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

5.1 This needs assessment supports delivery of the Thurrock Health and Wellbeing Strategy 2022-26 Domain 3, which focuses on person-led health and care, and the Better Care Together Thurrock adult health and care strategy.

6. Implications

6.1 There are no financial, legal and diversity and equality implications to this report.

We have addressed the impact on health inequalities in 7.4

All information regarding Community Equality Impact Assessments can be found here: https://intranet.thurrock.gov.uk/services/diversity-and-equality/ceia/

6.2 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

Long Term Conditions disproportionately affect individuals who are:

- Living in poverty or relative deprivation
- From certain BAME groups

What is more, our efforts to address the management of these Long Term conditions tends to be less successful in these same groups widening the gap in health outcomes.

Any efforts to support self-care would need to be targeted at these groups to mitigate against these inequalities in health outcomes.

7. 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):

- This report was prepared to pull out elements of the Mid and South Essex JSNA document entitled "Self-Care in the context of living with Long Term Conditions". No other documents or papers were used in preparation though the JSNA has an extensive bibliography that should be noted.

8. Appendices to the report

- The full JSNA is included as a separate document.

Report Author:

Emma Sanford (JSNA written by Monica Scrobotovici)
Strategic Lead – Public Health
Adults, Housing and Health – Public Health

Self-care in the context of living with Long Term Conditions:

A report focusing on Diabetes, COPD and Heart Failure, Mid and South Essex JSNA

Mid and South Essex Health and Care Partnership

thurrock.gov.uk

Self-care in the context of living with Long term Conditions: A report focusing on Diabetes, Chronic Obstructive Pulmonary Disease and Heart Failure

Mid and South Essex

August 2021

Lead author: Monica Scrobotovici

Co-authors: Karen Balthasar and Emma Farrow

Acknowledgements:

- For contributions: Mark Parker, Sean Maguire, Adam Shutz, Harinder Bhamra,
- For editing: Phil Gregory
- For organising patients and professionals' engagement: Faith Stow
- For evidence review Lisa Burscheidt

Author's note

Mid-way through the development of this paper WHO officially declared the COVID-19 pandemic. Due to lockdown and other disease containment measure taken in England, there was a significant impact on how all care services were delivered. This led to services being fully stopped, accepting only emergency cases, or suffering radical transformation such as a switch to only online delivery. Currently, patients with long term conditions have minimal access to all sectors of care, specifically for routine procedures, and self-care practices are becoming the norm. This report does not reflect these changes as the pandemic is still undergoing.

It is recommended that an update of the local context data and the service map is undertaken once the services across the system are stabilised.

CONTENTS

Abbreviations

A&E - Accident and Emergency

ASC – Adult Social Care

BMI – Body Mass Index

BP – Blood Pressure

BTUH – Basildon and Thurrock University Hospital

CBT – Cognitive Behavioural Therapy

CCG – Clinical Commissioning Group

CHD – Coronary Heart Disease

CMHD – Common Mental Health Disorder

COPD - Chronic Obstructive Pulmonary Disease

CPR – Castle Point and Rochford (CCG)

DALY – Disability-Adjusted Life Years

DoHSC - The Department of Health and Social Care

ECG- Echocardiogram

EPUT – Essex Partnership University NHS Foundation Trust

GBD – Global Burden of Disease Tool

GP – General practitioner

HDL – High-Density Lipoproteins

HF - Heart Failure

HLP – Healthy Living Pharmacy

HoC - House of Care

ICS – Integrated Care System

JSNA – Joint Strategic Needs Assessment

LAC – Local Area Co-ordinator

LDL – Low-Density Lipoproteins

LTC - Long Term Condition

MECC – Making Every Contact Count

NDA – National Diabetes Audit

NELFT – North East London Foundation Trust

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

NHS LTP – NHS Long Term Plan

NDPP – National Diabetes Prevention Programme

ONS - Office for National Statistics

PAM – Patient Activation Measure

PCN - Primary Care Network

PHE – Public Health England

PHM – Population Health Management

PR – Pulmonary Rehabilitation

QOF – Quality Outcomes Framework

QoL- Quality of Life

SES - Socioeconomic status

STP - Sustainability Transformation Partnership

WHO - World Health Organisation

YLL- Years of Life Lost

YLD – Years lost to Disability

Executive Summary

Increasing demand across the NHS and social care system in England, in both the number of patients and the associated cost of service delivery, can largely be attributed to: an ageing population; staffing issue; and, a rising number of people with long-term condition (LTCs).

In primary care, around half of GP appointments take place with patients with LTCs. High workloads are required to review and provide advice to these patients. When complications arise workloads increase further still, alongside the cost of treatment and use of secondary care services. In the last five years, there were large increases in A&E attendances per day and even larger increases in emergency admissions (10.3% and 24.2%, respectively over 5 years). Patients with LTCs account for a large proportion of this activity, with a sizeable number having multiple conditions - one in three emergency patients have 5 or more conditions (2015/16).

As a result of their use of services, the annual health and social care cost per year for a person with an LTC is three times higher than for a person without an LTC. This leads to 70% of the NHS budget being spent on patients with LTCs.

People with LTCs often struggle with daily activities. Social care provides a range of services supporting these activities, with the majority provided informally through individuals' family and friends. Adult social care is the biggest spend for local authority (£17.9 billion, 2017/18). Nationally, the demand for social care support is increasing, with up to 5,000 additional requests per day, but government spend is reducing. This could result in high financial pressures in meeting demand with high quality of care, and could potentially increase the number of informal care arrangements.

Self-care activities support improving the Quality of Life (QoL) and the health outcomes of those with LTCs, and thus could assist in reducing LTC associated demands and costs. However, they are not currently prioritised or sufficiently supported in the health care system. Given the growing demand, need for self-care therefore has begun to be emphasised in newer policies, such as: the *NHS Long-Term Plan 2019*, *Care Act 2014*, *NHS House of Care Framework* and *Public Health England's 2019 prevention green paper*.

In the *Theory of Self Care of Chronic Illness* 'self-care' definition is multifaceted and includes: self-care maintenance; self-care monitoring; and self-care management. Relevant behaviours to self-care include behaviours that promote health, reduce risks for illness and restore wellness. Additionally, the concept of patient activation, which describes the feeling of autonomy and control over health, is essential in understanding barriers and the best ways to support patients to self-care.

This JSNA provides an evidence-based review of local services to support the development and expansion of the self-care provision in the Mid and South Essex STP area, with a focus on three particular LTCs: Diabetes Mellitus (DM); Chronic Obstructive Pulmonary Disease (COPD); and, Heart Failure (HF). These are amongst the most prevalent conditions in England and have a significant impact on both individual's health and the sustainability of the system. Self-care activities are essential to maintaining good health when living with any of the three conditions.

Diagnosis and treatment of these LTCs happens mostly in Primary care. Our analysis shows that there is high gap between the number of people thought to have one of the three LTCs and the

number of people who are diagnosed. Interestingly, when it comes to COPD there is also a concern about over-diagnosing in certain areas, not just under-diagnosing. A common theme is that the prevalence and recording of these conditions varies greatly between the five CCGs within the STP and between GPs in each CCG. Moreover, being diagnosed by a care provider is not sufficient to receive the appropriate care. For example, in 2018/19 only about a half of registered diabetic patients were receiving all 8 care processes as recommended and in Thurrock only 21.6% of patients with COPD and severe breathlessness were referred to pulmonary rehabilitation. The lack of diagnosis, treatment or referral leads to a significant number of ill-health events, making a significant impact on utilisation of secondary care services.

The provision of specialised services outside of primary care comes across as fragmented and inconsistent. Due to services being delivered by different providers, there is a variability of programme structure and delivery across the footprint. For example, pulmonary rehabilitation services vary by offering additional benefits such as psychological support in certain areas. The heart failure services take place mostly in secondary care and seem to be the most consistent across the STP (this is due to the merging of the three main hospitals into the Mid and South Essex Trust).

While there is a wide range of services offered for people with the conditions discussed above, patients, carers and professionals alike identify a series of barriers that make it difficult to access or fully benefit from them. Barriers people face are across the continuum of self-care – from initial diagnosis (lack of advice on self-care or information on support groups and other tools such as online support or apps) to managing the condition and its effects on wellbeing (such as having to manage multiple medications and a lack of equipment or access to services). Moreover, factors affecting self-care do not act in isolation. Self-care should not be thought of solely at an individual level – family and community play a large role in encouraging self-care. A lack of social support highly impact on effectively managing the disease.

Issues identified throughout this report are of multivalent, hence should be addressed at different levels across the system: personal, local, regional and national level.

Six main themes were observed: services that contribute to self-care across the STP are fragmented and irregular (largely due to a lack of strategic direction across the patch); information is not readily available to patients, providers and commissioners (with issues due to lack of data collection and sharing); patients and primary care providers lack the capacity and skills to make the most out of their interaction; multimorbidity is increasing and needs to be addressed; the money is in the wrong place (with most of the funding going towards treatment in secondary care rather than prevention and support in the community); and self-care as a topic is in its infancy and evidence still needs to be developed.

To facilitate a coordinated effort to address these identified issues it is recommended that a joint strategy that aligns the prevention, early intervention and management agendas and addresses place-based barriers to self-care is developed at the STP level. Additionally, the development of a Task Force to include representatives from community care, the voluntary sector, primary care, public health, secondary care and social care could support addressing the variability of outcomes and integrating of local services. While the direction and quality standards have to be STP wide, it is highly important that the commissioning of programmes and delivery is co-produced with the affected residents, is built on local resources and matches the local picture.

Recommendations also focus on education and training of professionals. It is essential that professionals have a good understanding of what self-care is and how to support patients to practice self-care activities. Upskilling programmes in *Making Every Contact Count*, patient activation, coaching and motivational interviewing all empower staff to hold the difficult conversations needed to engage patients in programmes that can support them.

At the neighbourhood level there is an opportunity to pool resources to offer education and specialist support to patients that are harder to manage. Moreover, variation within the CCGs and PCNs reflect struggles that some practices might have locally. Building on other's successes and sharing best practice between these local practices can support with reducing the variation currently seen.

Lastly, patients can also be educated and empowered to use varied tools in their favour and make the most out of a meeting with a health professional. Patients and carers can and should share information and empower each other through face-to-face and online support groups.

CHAPTER 1

INTRODUCTION

The National Health Service (NHS) is facing increasing demand and year-round pressures across all levels of care. Secondary care, and in particular emergency care, is being badly affected with an evident increase in both the number of patients and the associated cost of treatment.

This increased demand is largely attributable to two factors: the ageing population and a rising number of people living with chronic conditions such as diabetes, cardiovascular disease, and depression (1; 2). Furthermore, the complexity of individual cases is increasing (2), with an estimated 2.9 million people in England in 2018 having multiple conditions, also called multimorbidities (3).

As a result, current health policy and research now places greater emphasis on the need for healthcare to adopt the principles of self-care as routine practice. The NHS' 'Long Term Plan' highlights the priority for people to have more control over their own health and personalised care when they need it (4).

Supporting people to self-care is vital and should be a key activity in our health and social care systems. For patients with long term conditions (LTCs) and multimorbidities, optimal outcomes and quality of life depend on engagement in effective self-care activities (5; 6). However, self-care is often not prioritised to the same level as traditional medical interventions by professionals and the healthcare system. As a result, there is an apparent lack of emphasis on support and referral to services that can assist patients in maintaining or improving lifestyle behaviours or in self-managing their conditions (7).

1.1 Scope and purpose of the document

This Joint Strategic Needs Assessment (JSNA) focuses on self-care. It aims to provide an evidence base for the development and improvement of the care and the ways in which we support and empower patients to self-manage LTCs and their general health.

In line with the current NHS strategy and the Five Year Forward View, this assessment focuses on the local Sustainable Transformation Partnership (STP), Mid and South Essex Health and Care Partnership. This will allow for the report to influence system-wide priorities and contribute to the planning of more coordinated services.

As self-care practices span across numerous health and wellbeing domains, the assessment and recommendations of this paper are focused on three main long term conditions: diabetes, heart failure (HF) and chronic obstructive pulmonary disease (COPD). These have been identified to be of higher need and impact in the covered area

due to their complexity and increased effect on patients and the system alike.

1.1.1 Key question this JSNA will answer

1. What is the local picture in terms of demographics and LTC prevalence and outcomes? (Chapter 2, Section 2.1 to 2.4)
2. What is the support that patients with diabetes, COPD and Heart Failure receive to assist them with self-care? (Chapter 2, Section 2.5)
3. What is the patients' experience of coping with their LTC and what are the barriers to self-care? (Chapter 2, Section 2.6)
4. What does the evidence state should be provided in terms of self-care support? (Chapter 3)
5. What is the impact on services and population if no changes are made and how can we mitigate that? (Chapter 4)

1.1.2 Mid and South Essex STP

STPs join together local NHS organisations and Councils in a specified area to work on shared proposals to improve health and care for the rising number of people who need health services. The Mid and South Essex Health and Care Partnership is one of 44 STPs across the NHS in England and includes the districts and boroughs of Braintree, Maldon, City of Chelmsford, Castle Point, Rochford, Southend, Thurrock, Basildon and Brentwood (see Error! Reference source not found..1).

Figure 1.1: Mid and South Essex Map of STP

Source: http://v1.nhsmidandsouthessex.co.uk/about-the-stp/

1.2 Definition of self-care

Anecdotal data has shown that the meaning of self-care can differ from person to person. To standardise the understanding of what we mean by self-care in this report, we define it below.

Within this JSNA, the definition applied has come from the Theory of Self-care of Chronic Illness. This addresses both the prevention and management of chronic illness, with core elements of self-care maintenance, self-care monitoring, and self-care management (8).

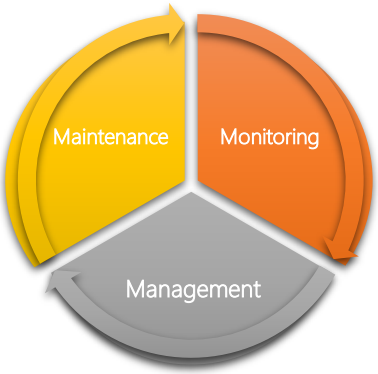


Figure 1.2 – Core elements of self-care

Self-care maintenance involves a process through which the individuals and their families/carers maintain health through health promoting practices and managing illness. This might include adopting behaviours such as not smoking, having a healthy diet, and taking regular exercise.

Self-care monitoring involves a process of self-observation for changes in signs and symptoms. For example this might include regular self-monitoring of blood glucose levels in those who are diabetic.

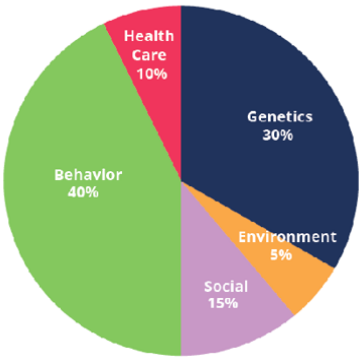
Self-care management is the process of taking action in response to signs and symptoms when they occur. This might include taking a prescribed medication or seeking immediate GP advice during an illness flare up.

1.2.1 Self-care behaviours

Self-care practices are embedded in one's regular daily activities, whether living with or without a chronic health condition; they range from actions to promote health such as exercising and eating healthily, to more complex approaches to restore health such as receiving medical treatment and rehabilitation activities (9)

There are a variety of factors that are thought to influence our health and wellbeing. The most impactful of these factors is behaviour, accounting for 40% of the total impact on one's health; healthcare use only accounts for 10% (see figure 1.3) (10).

Figure 1.3: Main factors that influence health



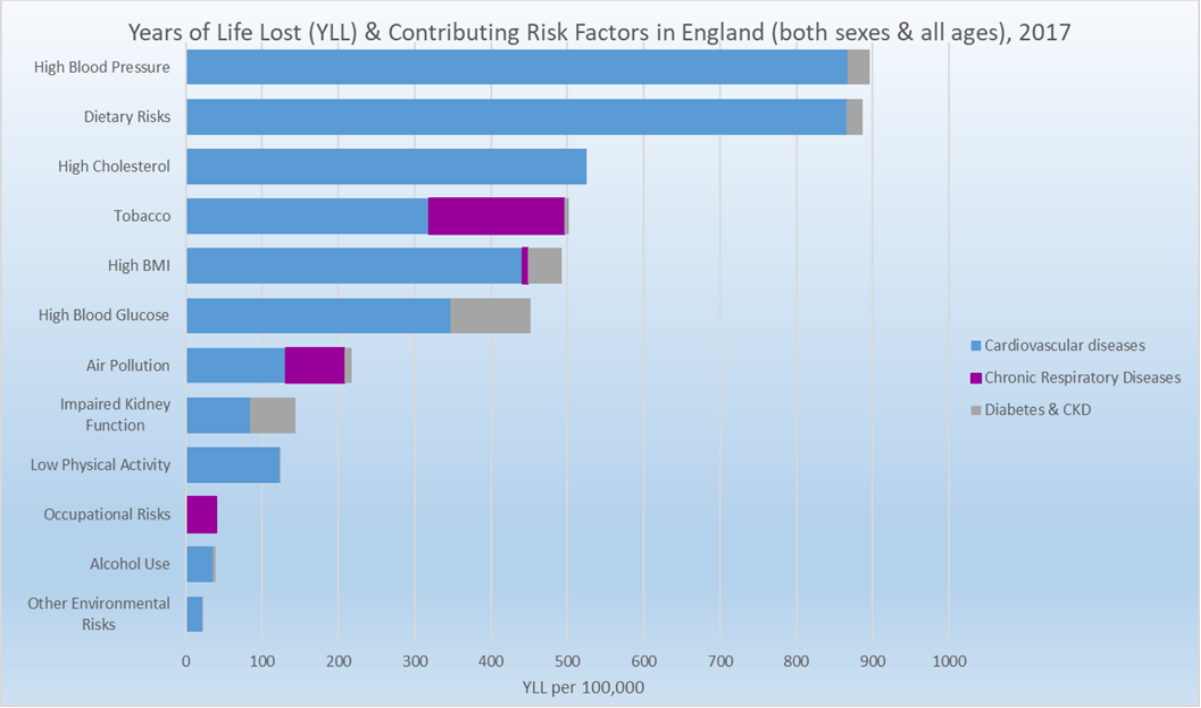
Source: National Academy of Medicine

From a general self-care perspective, relevant behaviours include: autonomy and understanding role in own care, having a

healthy and balanced diet, maintaining a healthy weight, exercising regularly and not smoking.

In England, failure to sufficiently adhere to these behaviours is known to be responsible for a significant amount of years of life lost (see figure 1.4). The incidence of numerous LTCs is directly associated with these behavioural risk factors (11). Much, if not all, of this burden is potentially preventable.

Figure 1.4: Years of Life Lost and contributing risk factors in England, both sexes, all ages (2017)



The most notable benefit of adopting healthy behaviours is reducing the risk of developing LTCs such as type 2 diabetes (see table 1 for more details). People with LTCs must adopt additional self-care behaviours to manage their health and prevent worsening of their condition, which could result in the need for urgent care.

When it comes to self-care as either a preventative measure or a disease management tool, the feeling of control over one's health is highly important. Those who experience greater sense of control tend to display healthier behaviours, are highly motivated, have lower incidence of drug and smoking use, and tend to eat healthier (12). One's engagement in their own care is also called patient activation. Evidence shows a range of benefits of greater patient activation compared with people who score lower on the activation scale, including:

- Increased likelihood to attend screenings, regular check-ups and immunisations;
- Significant improvement in engagement in healthy behaviours, such as having a healthy diet or exercising regularly; and
- Increased adherence to treatment and condition monitoring, as well as engagement in regular care associated with the condition

Conversely, patients with lower activation are significantly less likely to have:

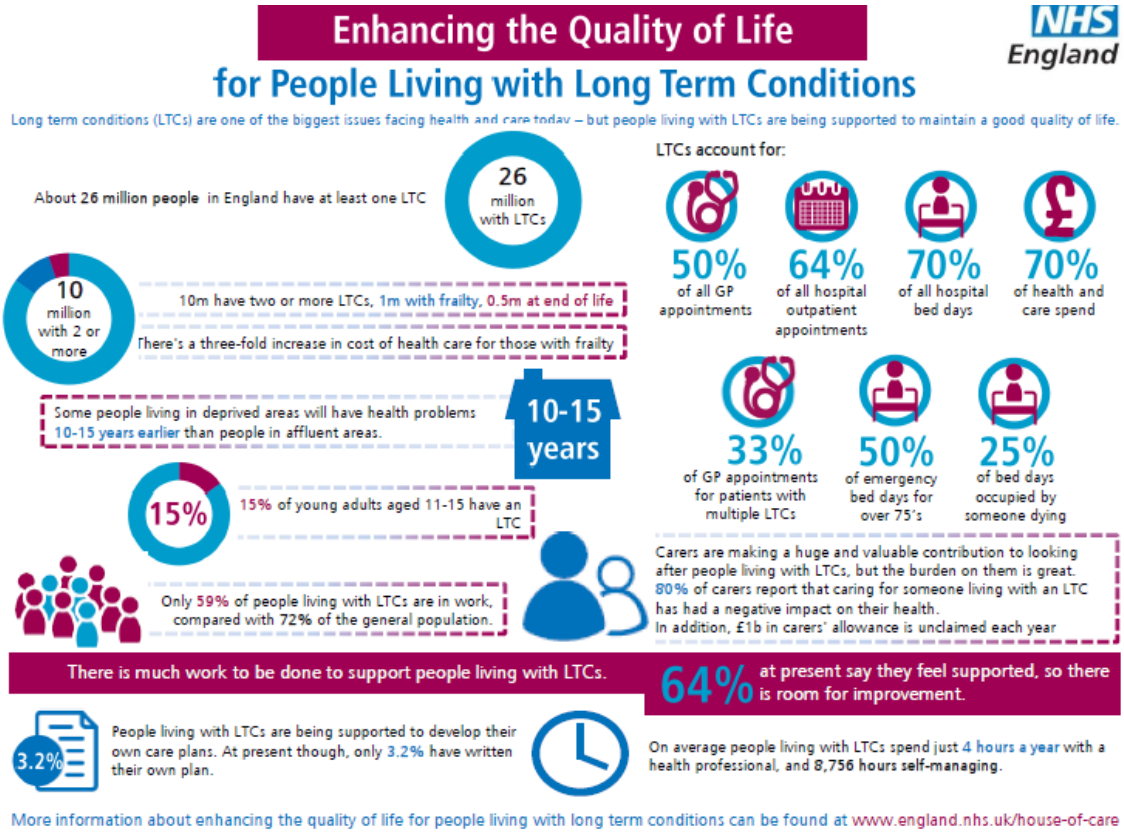
- Prepared questions for a visit to the doctor;
- Knowledge about treatment guidelines for their condition or to be persistent in asking if they don't understand what their doctor has told them; and
- Met medical needs; they are two to three times more likely to have unmet medical needs and to delay medical care, even after controlling for income, education and access to care (13).

1.2.2 Long Term Conditions

A Long Term Condition (LTC) is defined as "*a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies*" (14). More than 15 million people in England are known to have an LTC (3). The most prevalent conditions in England are: diabetes, chronic obstructive pulmonary disease (COPD), chronic heart failure, osteoporosis and dementia. While the total number of people with LTCs is projected to remain stable over the next years, the number of people with multiple conditions is increasing. This is creating an additional pressure on both the NHS and social care (15).

The first three conditions, diabetes, COPD and heart failure, are the main focus of this JSNA as, when living with these conditions, self-care is an essential element to maintaining good health and preventing

Figure 1.5 – LTCs and Quality of Life



Source: **https://psnc.org.uk/wp-content/uploads/2018/02/Infographic-FINAL.pdf**

any secondary health outcomes that could lead to hospital admissions, reduced quality of life, or even death. Further rationale is described below. For local data on each condition, please see Chapter 2: Local context.

Diabetes

Diabetes UK defines diabetes as a condition where your blood glucose level is too high (over a long period of time). This is due to your body being unable to break glucose down into energy because of a lack of insulin in the blood stream.

There are two main types of diabetes:

- Type 1 diabetes – where the body's immune system attacks and destroys the cells that produce insulin; and
- Type 2 diabetes – where the body does not produce enough insulin, or the body's cells do not react to insulin.

It is estimated that 3.8 million people aged 16 years and over in England have diabetes (diagnosed and undiagnosed). This is equal to 8.6% of the population of this age group (16). However, the 2018-19 Quality Outcomes Framework (QOF) report suggests just over 3 million people aged 17 and over have been diagnosed in primary care, equating to only 6.8% of the registered population (17). By 2035, diabetes prevalence is expected to increase to 4.9 million or 9.7% (17).

Regular primary care visits and self-care for diabetes are essential as, if not managed properly, diabetes can lead to life-threatening complications. Over a long period of time high levels of glucose in the blood stream can irreversibly damage the heart, eyes, feet, and kidneys. Due to these complications, people with diabetes have medical costs that are two to three times more than age and sex matched patients without diabetes (18).

Investing in self-care as a preventative measure for developing diabetes or diabetes complications was recommended as a pressing action in the 2016 Thurrock Annual Public Health report (19).

Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease is caused by lung damage due to inhaling toxic substances, most commonly due to smoking. The damage leads to breathing difficulties and other symptoms, such as coughing, wheezing and chest infections.

COPD includes two main conditions:

- Emphysema – damage to the air sacs in the lungs; and
- Chronic bronchitis – long-term inflammation of the airways.

The diagnosed prevalence of COPD underestimates the total burden of the disease because usually the disease remains undiagnosed until severe symptoms appear. General Practices in England have currently identified 1.9% (over one million) of their registered population as suffering from the disease (17). This is significantly lower than Public Health England estimates of 3.2% published in 2015. The United

Kingdom (UK) is among the top 20 countries in the world (third in Europe) for deaths due to COPD, with nearly 30,000 people dying from the disease annually (20). Furthermore, COPD accounts for more than 140,000 hospital admissions (with 97% of them being emergency admissions) and a million bed days each year across the UK (1.7% of all hospital admissions and bed days).

The damage to the lungs caused by COPD is permanent. The breathing problems tend to get gradually worse over time and can limit normal activities. Appropriate treatment and care is highly important for slowing down the progression of the disease. People with COPD are required to implement self-care activities and strategies directed towards the prevention, control and management of the physical consequences of the disease, such as respiratory and sleep problems, limitations in daily activities and exacerbations.

Heart Failure

Heart Failure (HF), sometimes called congestive or chronic HF, is a progressive LTC that cannot be cured; however, the symptoms can often be controlled for many years. In this condition the heart is unable to pump blood around the body properly. It usually occurs because the heart has become too weak or stiff.

It is estimated that only about half of people suffering from heart failure have been identified by their GP and added to the disease register; 0.83% (470,000) (17) compared to 1.4% - total estimates (including undiagnosed) (21). Additionally, the prevalence of HF is steadily growing, with an increase of 14% from 2002 to 2014 (22). It is likely that individuals not yet diagnosed will only be identified after an acute episode results in the accessing of secondary care services.

Healthy lifestyle changes are one of the top recommendation for treatment on the NHS website, alongside medication and surgery. Furthermore, the National Institute of Health and Care Excellence (NICE) recommends that everyone diagnosed with Heart failure has a care plan which includes follow-up, rehabilitation, and access to social care plans (23). Self-care should therefore be considered of major importance for individuals with HF in order to maintain a stable condition and continue to achieve a good quality of life.

1.3 Current pressures on the health and social care system

The rising pressure on the NHS and Social Care in England can be attributed to a combination of the following factors:

- Ageing population and people living longer
- Increased prevalence of people with health conditions
- Increased prevalence of people with multimorbidities
- Rising incomes and expectations of healthcare
- Demographic changes
- Cost pressures
- Issues with recruiting staff into the NHS and social care e.g. GPs, Nurses, Social Care workers.

1.3.1 Primary care

Patients with LTCs tend to be heavy users of the healthcare system and require greater attention from their care providers. Whilst disease specific figures are not available, we know that between 50-55% of all GP appointments are used by patients already identified as having an LTC (3). As part of the normal care plan, patients with Diabetes, COPD and HF need to have at least one annual review with their GP and regular checks to monitor significant parameters such as blood pressure, glucose and breathlessness.

Furthermore, there is an added burden with some patients not being diagnosed until they experience an acute episode. Treating patients with complications adds to GPs' workloads and the overall cost of care. For example, the cost of prescribing medication for complications of diabetes is around 3 to 4 times the cost of prescribing medication for diabetes itself (18). Moreover, additional to spending time with patients to review and provide advice, GPs also spend a significant amount of time collecting information from secondary and community care providers though communication channels that are not always straight forward.

1.3.2 Secondary care

A failure in the timely identification of patients with LTCs and variable management in primary care may have contributed to a rise in the number of emergency admissions to hospital (24). It is estimated that in England in 2015/16, patients with LTCs accounted for 61% of all hospital emergency admissions, a 200% increase from 2005/06 (25). The steep increase in the use of secondary care has put a significant strain on the system; 70% of the entire NHS budget is spent on patients with LTCs (3).

Why does this matter?

The annual health and social care cost per year for a person without an LTC is £1,000, this rises to £3,000 for those with one LTC and £8,000 for those with three LTCs (15). Annual inpatient care, to treat short and long term complications of diabetes only is estimated at between £1,807 and £2,552 per diabetic patient (4):. As the number of patients with LTCs and those with multimorbidity rises greater demands and pressures will be put on the NHS.

Clearly some of the demand and costs from patients with LTCs could be avoided through improved self-care of conditions. For example, most of the cost associated with the care of patients with heart failure is the result of rehospitalisation for exacerbations of the condition, many of which can be traced to failed self-care (3).

1.3.3 Social care

Demand for adult social care services has increased by 1.6% since 2015/16 to 2017/18, equating to an additional 5,000 requests for support received per day by local authorities (26).

Individuals with LTCs often have difficulties with activities of daily living, such as

cooking, washing and getting dressed. Social care includes a broad range of non-medical services that support people with these activities. It is common for both health and social care to be required by the same individuals (27).

Social care differs to healthcare in that the majority of social care is provided on an informal basis by family, friends or neighbours, or purchased privately. Estimates of the value of informal care are as high as nearly £100 billion per year (28).

Why does this matter?

The increasing pressures faced by local authorities to meet demand and provide high quality care are of major importance. The cost implications alone of meeting the adult social care burden are placing local authorities under severe financial pressure. However, the importance is not restricted to operational concerns. Individuals themselves are facing ever increasing challenges. People in need of social care are rarely able to be fully involved in society, reducing their quality of life. Additionally, recent reductions in spend alongside increases in demand have the potential to result in more informal care arrangements being made outside of the social care system. This can lead to additional pressures on family members and personal finances.

1.4 Self-care in policy and practice

The growing demands on the health and social care system has led to the development of policy and practice that places greater emphasis on self-care, including the *Care Act 2014*, the *NHS House of Care Framework*, and the *NHS Long Term plan 2019*. It is clear that people's ability to self-care will impact on their quality of life and the amount and type of care they require from services. This is becoming more important as people live longer and their needs become more complex.

1.4.1 Care Act 2014

Preventing, reducing, or delaying the need for care, where feasible, is a key element of the Care Act 2014. It stated that 'effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer' (29). The act also talks about the role that local authorities have in promoting wellbeing when carrying out any of their care and support functions in respect of a person.

At the local authority level, Increasing prevention and early intervention efforts are important in realising the planned savings in and adult social care. Additional to reducing Council spend, it contributes to relieving pressures on the most expensive part of the healthcare system, secondary care. The National Audit Office has estimated that 20% of emergency hospital admissions could be prevented if patients are managed effectively by primary, community or social care (1).

1.4.2 House of Care Framework

The House of Care (HoC) framework is a service delivery model for person centred care of all people with LTCs, not just those with a single disease or in high risk groups. It was first introduced in 2011 based on the findings of the Year of Care programme pilot evaluation which revealed improvements in patients' experience of care and in self-care behaviour (30). HoC illustrates a whole-system approach (see figure 1.6) where care planning is at the centre of the house; the left wall represents the engaged and informed patient, the right wall represents the health care professionals committed to partnership working, the roof represents organisational systems and processes, and the base represents the local commissioning plans (31).

Figure 1.6 – House of Care Illustration

The HoC framework assumes an active role for patients, with collaborative personalised care planning at its heart. Implementing the model requires health care professionals to move away from traditional thinking; that they are the primary decision-makers, and instead shift to a partnership model in which patients play an active part in determining their own care and support needs. A key element of the HoC is supporting the self-care of patients with the aim that people should have the knowledge, skills and confidence to manage their condition effectively in the context of their everyday life (32).

1.4.3 NHS Long Term Plan 2019

The NHS Long Term Plan (4), published in January 2019, has a greater focus on prevention and supporting self-care. The plan mentions various new programmes and tools for self-care and self-managing health conditions. These included:

- The creation of fully integrated community-based health care where NHS 111 can directly book into GP practices across the country and refer onto community pharmacies who can support urgent care and promote patient self-care. CCGs will also develop pharmacy connection schemes for patients who don't need primary care medical services;
- Shaping the role of pharmacists to support patients to take their medicines to get the best from them, reduce waste and promote self-care;
- Implementation of the Ottawa model for stop smoking in NHS hospitals; all people admitted to hospital who smoke being offered NHS-funded tobacco treatment services by 2023/24;
- Expanding provision of structured education and digital self-management

support tools. This includes expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes and is expected to be ready to access in 2020;

- New rehabilitation models for those with mild COPD, including digital tools that provide support to a wider group of patients around rehabilitation and self-management to be implemented over the next ten years;
- Increasing the number of patients with COPD who are referred to pulmonary rehabilitation where appropriate through the use of the COPD discharge bundle; and
- Expanding access to support such as the online version of ESCAPE-pain (which aims to support patients to develop self-management and coping strategies to manage arthritic pain through exercise), a digital version of the well-established, face-to-face group programme.

Additionally, the Universal Personalised Care document, which is the delivery plan for the personalised care that follows the Long Term Plan direction, specifically mentions the need to better include patients in creating their care plans and aid understanding of the level of knowledge, skills, and confidence to self-care.

1.4.4 Community Pharmacy Contracts

The 2019/20 to 2023/24 Community Pharmacy Contractual Framework supports the delivery of the NHS Long Term Plan through the Healthy Living Pharmacy (HLP) Framework. All HLP will have trained health champions in place to deliver interventions on key issues such as smoking and weight management as well as providing wellbeing and self-care advice, and signposting people to other relevant services (33).

1.4.5 PHE Green Paper 2020

According to Public Health England's new prevention green paper, published in July 2019, prevention is everyone's responsibility, from the NHS to employers, schools, local authorities and individuals. The vision is that in the 2020s, people will not be passive recipients of care but instead will be co-creators of their own health. In order for this to happen, they must be given the skills, knowledge, and confidence to become enabled and empowered to help themselves (34).

1.5 Methodology: How this assessment was conducted

The details of how this assessment was conducted are listed in Appendix 1. In summary, the main activities undertaken to develop this report are:

- engagement sessions with professionals and residents
- collection and analysis of demographic and health measures data from diverse sources such as Public Health England's Fingertips and Global burden of Disease websites, secondary care reports and primary care patient records
- evidence reviews were conducted by Aubrey Keep Library Service by searching peer-reviewed publications from online journal databases.

CHAPTER 2

LOCAL CONTEXT

2.1 Demographics

What does the Mid and South Essex Health and Care Partnership look like as a place?

The areas that are covered by the Mid and South Essex Health and Care Partnership (referred to as the STP from this point forward) are multifaceted, diverse and complex, as illustrated by Figure 2.1 below[1]. In terms of the population, the largest proportion of residents are recorded as from white ethnic groups (90.6% average across the STP)[2]. The adult population (18+ year olds), is set to increase across the STP between 2018 and 2038. This means that over the next two decades there are likely to be more people who are diagnosed with an LTC including Diabetes, HF and COPD.

An increasing population does not necessarily mean that people are living healthier lives. Advances in medicine and improved support in the community lead to people living longer, hence the average age is increasing as well. Average life expectancy for both males (79.8 years) and females (83 years) across the STP is lower than both the East of England and England figures (not significantly different).

Across the STP 12.2% (N~150,000) of residents are living in the 20% most deprived areas in England and many residents are engaging in health harming behaviours such as smoking (14.5%) or being physically inactive (22.9%). These behaviours are considered risk factors for some LTCs. The figure below highlights the prevalence of several diseases within the STP. The figure for percentage of obese adults (8.8%) could be an underestimate due to poor recording. Just over a quarter of all residents within the STP are recorded as having Hypertension or a Common Mental Health Disorder (CMHD).

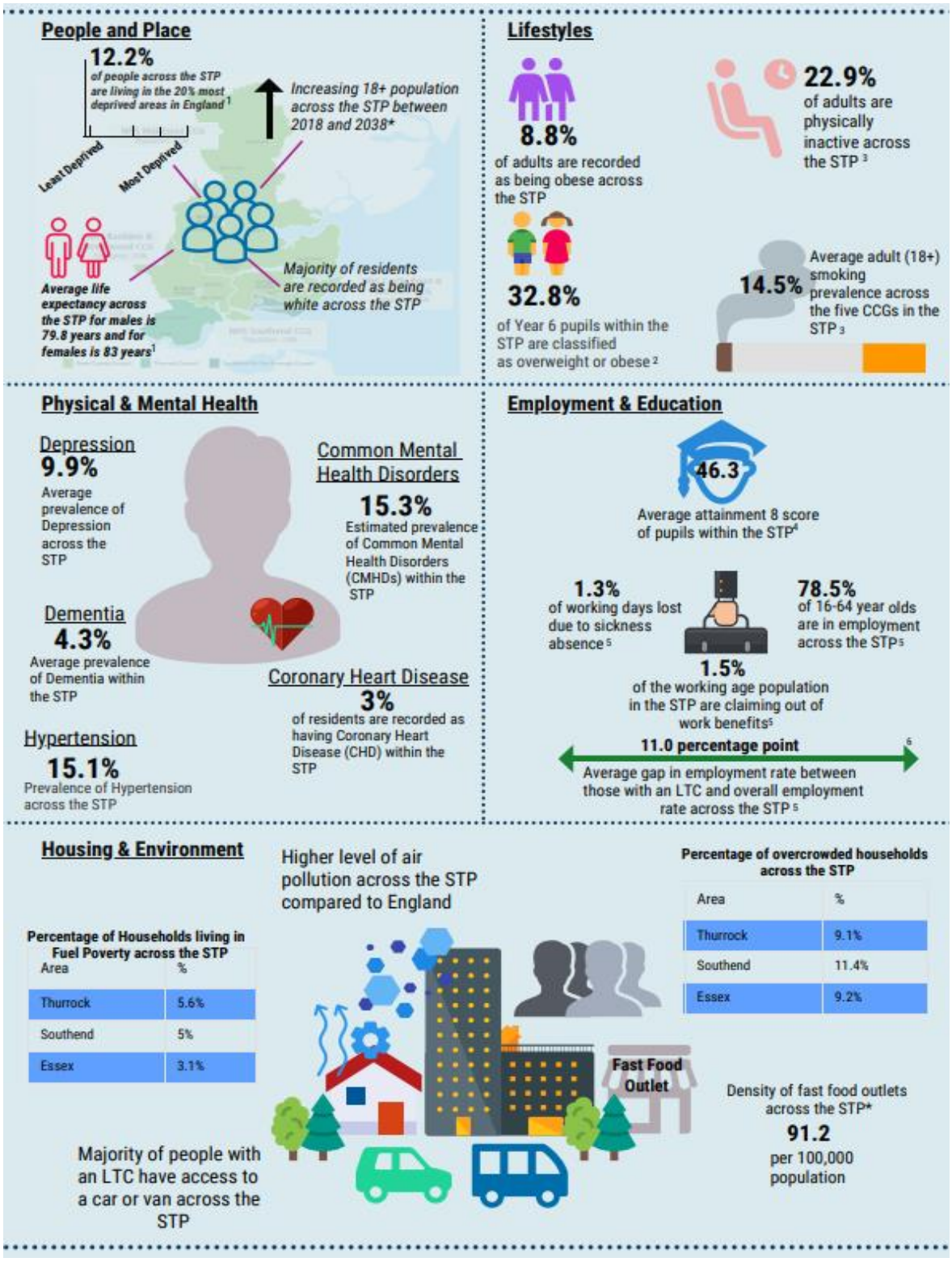
The environment in which people live may also impact on their health and wellbeing. Air pollution levels are higher in all areas within the STP than the regional and national levels (not significantly different). Similarly, the density of fast food outlets in all areas of the STP is higher than the East of England and England rates (not significantly different).

All of the abovementioned factors play a role in the overall health and wellbeing of the population that the STP serves. This JSNA will focus on these demographic and health factors as they relate to the three conditions, in scope and self-care more generally.

[1] The majority of the figures provided within the above infographic are based on calculated averages for the STP by the authors, weighted against the population and therefore, may not show the entire picture in terms of the demographics of the STP. Furthermore, some of the data is at Essex level which is a wider area than the STP covers and may therefore indicate a larger issue than is accurate. Based on how the STP figures were calculated, significance levels compared to the region and national figures were not calculated. This has been represented in the narrative as "Not Statistically Different".

[2] Some caution needs to be taken when interpreting the ethnicity data as it is from 2011 and we are aware that population changes may have affected ethnicity prevalence for this population. Migration patterns into and out of the borough may also affect the diversity of the STP. Further information can be found in the Demography JSNA.

Figure 2.1: Mid and South Essex Health and Care Partnership as a place



Key for above diagram

1 – Figures calculated using an all age population distribution from the total CCG population (2018).
2- Figures calculated using the 10-11 year old population distribution from the total CCG population (2018).
3 – Figures calculated using an 18+ population distribution from the total CCG population (2018).
4 – Figures calculated using the 15-16 year old population distribution from the total CCG population (2018).
5 – Figures calculated using the 16-64 year old population distribution from the total CCG population (2018).

Each of the conditions in scope is discussed in turn below. At the beginning of each section there is a diagram which shows key data (e.g. prevalence and mortality) at an STP level. Each indicator within the diagram is then discussed in more detail (e.g. broken down to CCG level) in a series of sub-sections. It should be noted that we are aware that there is variance at a GP practice level across all CCG areas, and for all indicators relating to the conditions of interest, and therefore this should be assumed to be the case where it is not stated. Where data has been broken down to GP practice level, this has been included for one CCG only (out of all within the STP), to give a picture of the variance but to ensure that the report does not become too onerous for the reader. All of the data at either the CCG or GP practice level takes into account differences in population size and make up (this is stated throughout the chapter at varying points). Finally in terms of Diabetes, some of the data relates to Diabetes as a whole (Type 1 and Type 2), and some is specific to Type 2 Diabetes; this is specified where relevant

2.2 Diabetes

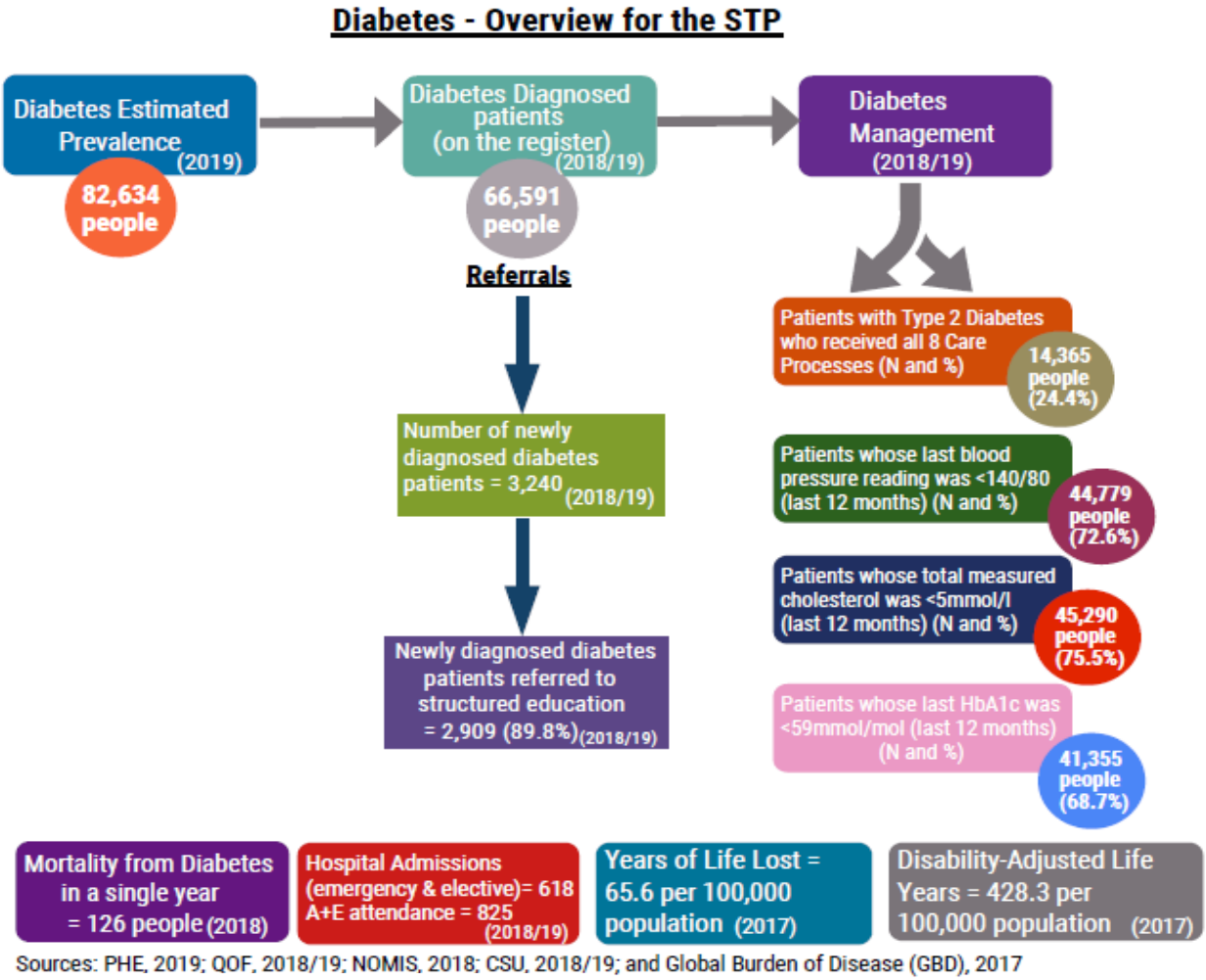
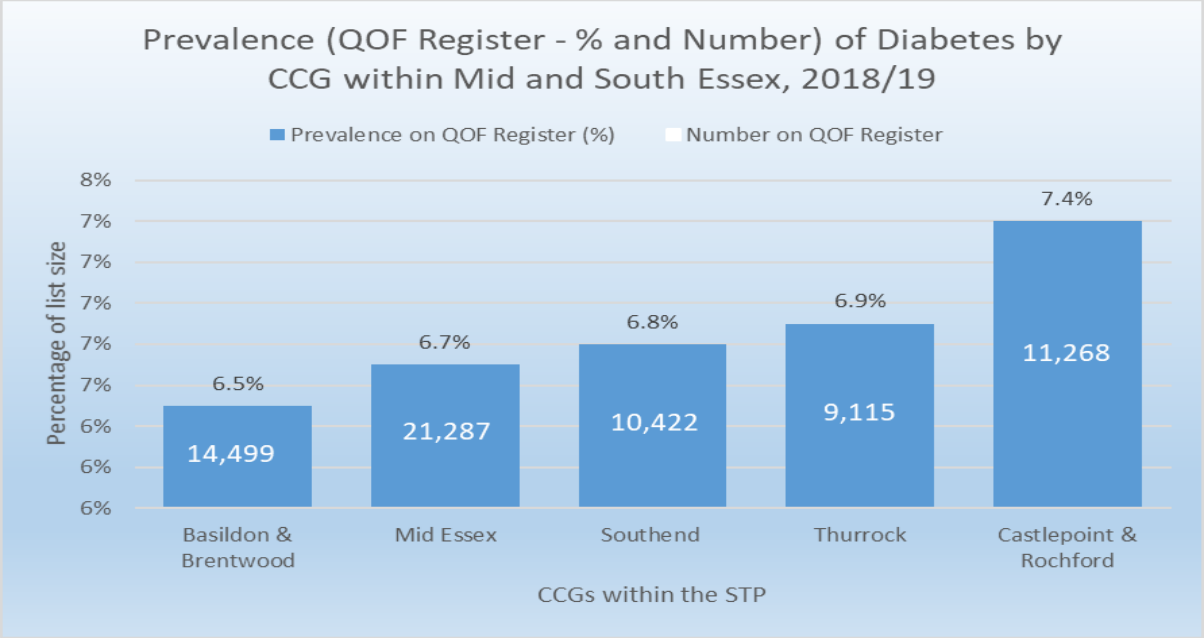


Figure 2.2: Diabetes Overview for the STP

2.2.1 Diabetes Prevalence

Recorded Diabetes prevalence (QOF) across the STP has been steadily increasing year on year since 2012/13, ranging from 5.9% (N=55,789) in 2012/13 to 6.8% (N=66,591) by 2018/19[3]. This rising prevalence at STP level is in line with the England prevalence during the same time period. When broken down by the CCGs, within the STP, and taking into account differences in population size, the most recent data (2018/19) shows that Castlepoint and Rochford (CPR) CCG had the highest QOF recorded prevalence of Diabetes at 7.4% (N=11,268) of all patients aged 17+ who are registered at all GP practices under this CCG (see figure 2.3).

Figure 2.3 Diabetes prevalence by CCG



There is quite a lot of variance in prevalence at GP practice level within and across each of the CCGs within the STP. For example, the prevalence of Diabetes in GP practices in Thurrock ranged from 4.3% (Thurrock Health Centre) to 9.9% (The Rigg Milner Medical Centre) of all patients aged 17+ registered at each individual GP practice in Thurrock during 2018/19 (see table 2.1 below)[4]. As well as planning services for the existing and known cohort of patients with diabetes, it will be important to find the 'missing thousands' who are as yet undiagnosed. The modelled estimated prevalence of diabetes calculated by Public Health England (PHE) in 2019 refers to the total number and percentage of patients thought to have diabetes within a specified area (e.g. at the national, regional, STP, CCG, borough and GP levels), whereas the recorded diabetes prevalence is defined as those who are already diagnosed and included on the disease register (again at the same levels noted above). Figure 2.4 shows the total number/percentage of people thought to have diabetes at each CCG within the STP.

[3] See Methodology section for how this was calculated.

[4] It should be noted that the QOF prevalence for Derry Court Medical Centre is from 2017/18, as the data was not available for this GP practice in 2018//19 due to some data quality and validation issues.

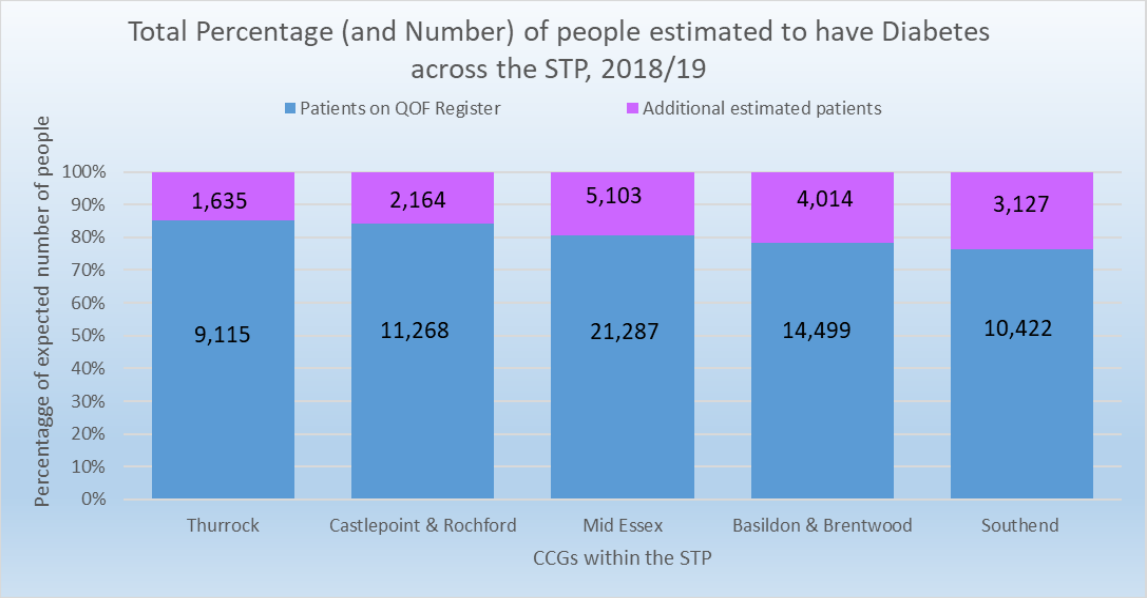
Table 2.1: Range of QOF Recorded Diabetes Prevalence by CCG, 2018/19.

Area	GP Practice with lowest recorded prevalence (%)	GP Practice with highest recorded prevalence (%)	Difference (percentage point/range)
Southend CCG	5%	8.6%	3.6
Mid Essex CCG	4.1%	8.9%	4.8
Basildon & Brentwood CCG	4.3%	9.6%	5.3
Castle Point & Rochford CCG	4.7%	10%	5.3
Thurrock CCG	4.3%	9.9%	5.6
Mid & South Essex	**4.1%**	**10%**	**5.9**

Source: NHS Digital, QOF

As can be seen it is broken down into the number/percentage of people diagnosed, the estimated number/percentage of additional people who likely have diabetes and the total number expected to have diabetes (calculated by adding the two former figures together). Taking into account differences in population size, in 2018/19 Southend CCG had the largest gap between the expected and observed cases of the condition; a gap of 23.1% (N=3,127).

Figure 2.4: Total Percentage (and number) of people estimated to have Diabetes across the STP, 2018/19



Source: QOF 2018/19 & PHE Fingertips – Diabetes Profile 2017

2.2.2 Diabetes Management

9 Care Processes

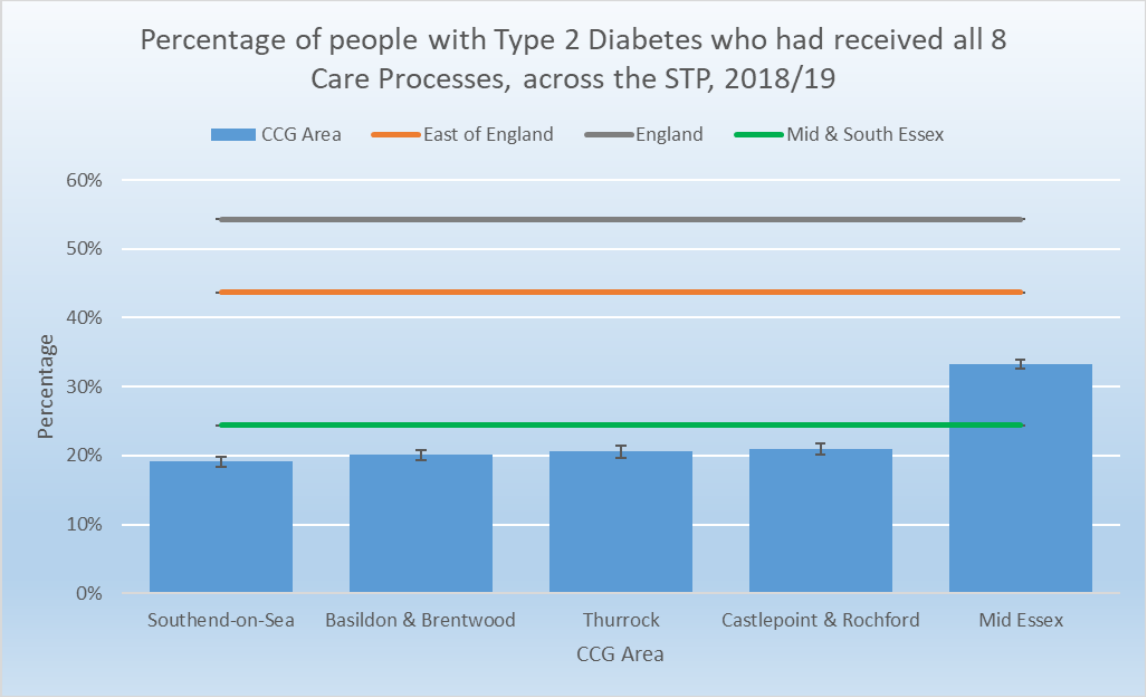
NICE recommend nine care processes for diabetes Type 1 and 2 (prior to 2019 only eight care processes were recommended). Five of the processes focus on risk factors including: body mass index (BMI), blood pressure, smoking status, glucose levels (HBa1C) and cholesterol. The remaining four processes

include tests that aim to identify potential complications, namely: urine albumin creatinine ratio, serum creatinine, foot nerve and circulation examination and eye screening (this is held by NHSEDES) (35).

The National Diabetes Core Audit (NDA) is an annual audit that measures the effectiveness of diabetes healthcare within Primary Care and specialist diabetes services against the NICE guidelines. It covers care processes, treatment targets, complications and mortality. For the purpose of this JSNA, examination of the 8 care processes undertaken in Primary Care within the NDA will be the focus (36).

Locally, as depicted in figure 2.2 above (entitled Diabetes Overview for the STP), 24.4% (14,365) of people with Type 2 diabetes across the entire STP received all eight care processes in 2018/19. When broken down to CCG level to explore variation across the STP, the percentage of people who received all eight care processes was significantly lower than the STP, regional and national averages for all of the CCGs; with Southend CCG having the lowest percentage at only 19.1% (1,695) (see figure 2.5 below).

Figure 2.5: Percentage of patients with Type 2 Diabetes, who received all 8 care processes, across the STP, 2018/19



Source: National Diabetes Audit.

Blood Pressure Checks

Regular blood pressure checks are an important part of Diabetes care, to reduce the risk of complications such as a Stroke. The ideal blood pressure (BP) reading is 140/80mmHG or less to support and maintain good health (37). Across the STP during 2018/19, 72.6% (N=44,779) of diabetic patients' last BP reading was 140/80mmHG or less, measured within the preceding 12 months[5]. When broken down to a CCG level and taking into account variation in population size and make-up,

[5] See Methodology section for how this was calculated.

CPR CCG had the lowest percentage of diabetic patients whose last BP reading fell within the ideal range at 69.3% (N=7,351). Conversely Thurrock CCG had the highest percentage of patients with the ideal BP at 78.8% (N=6,843).

Cholesterol Checks

For people with diabetes it is important to maintain a good balance in HDL (good cholesterol) and LDL (bad cholesterol). As such one of the care processes for diabetes involves regular cholesterol checks to monitor levels and reduce the risk of cardiovascular complications. The ideal reading is 5mmol/l or less (38). Across the STP during 2018/19 the percentage of patients' whose total measured cholesterol was 5mmol/l or less (in the last 12 months) was 72.6% (N=45,290)[6]. When broken down to a CCG level and taking into account variation in population size, Southend CCG had the lowest percentage of diabetic patients whose last total measured cholesterol fell within the ideal range at 72.5% (N=6,711). Conversely Mid Essex CCG had the highest percentage of patients with the ideal total measured cholesterol at 77.3% (N=14,450).

HbA1c Checks

Monitoring the blood glucose levels in diabetic patients is of upmost importance in reducing the risk of complications. The ideal HbA1c level is 59mmol/mol or less. In 2018/19 the percentage of patients across the STP whose last recorded HbA1c was at the ideal level was 68.7% (N=41,355) [7]. When broken down by the CCGs, Southend CCG had the lowest percentage of patients with the ideal HbA1c level at 67.4% (N=6,411). Conversely, CPR CCG had the highest percentage of patients with the ideal HbA1c at 70.9% (N=7,561).

2.2.3 Diabetes Referrals

When an individual is first diagnosed with diabetes, there is an onus on the GP to refer the individual to a structured education programme within nine months of diagnosis. This is included as one indicator within the QOF programme; a voluntary annual reward and incentive programme which encourages GPs to meet various targets in relation to specific disease management. During 2018/19 there were 3,240 newly diagnosed diabetes patients across the STP. Of these patients, 89.8% (N=2,909) were referred to a structured education programme (QOF Code DM014) (see figure 2.2 above – Diabetes – Overview for the STP). When broken down to explore variation within the CCGs that make up the STP, the percentage of newly diagnosed patients referred to a structured education programme ranged from 87.4% (N=466) in CPR CCG to 90.8% (N=638) in Basildon and Brentwood CCG during the same time period.

2.2.4 Diabetes Outcomes

Hospital Admissions, and A&E attendance

During 2018/19 across the STP there were a total of 825 A&E attendances attributable to diabetes. These attendances may have arisen as a result of patients experiencing symptoms for an unknown cause, perhaps leading to a diagnosis or due to complications with their

[6] See Methodology section for how this was calculated.
[7] See Methodology section for how this was calculated.

diabetes. Of the total attendances only 661 patients attended A&E, which means that some patients attended A&E on more than occasion during that year.

Hospital records show a total of 618 admissions; 543 emergency admissions and 75 elective admissions due to diabetes in 2018/19. As with A&E attendance there were fewer patients who were admitted on an emergency basis (N=478) than total admissions, which means that some patients were admitted to hospital on multiple occasions during that time period. Brought together, this suggests that, overall self-care for diabetes is not effective for all patients living within the STP footprint.

Quality of Life

Quality of life (QoL) can be measured in numerous ways. One way of exploring the QoL of people living with diabetes is by calculating the Disability Adjusted-Life Years (DALYs). The World Health Organisation (WHO) define one DALY as one lost year of 'healthy life'. The sum of the DALYs represents the gap between current health status and the ideal health status of a population, if the entire population live to an advanced age and without disability or ill health. In terms of specific health conditions DALYs are calculated as the sum of Years of Life Lost (YLL) due to premature mortality, the Years Lost due to disability (YLD) or the consequences of a disease (39).

The Global Burden of Disease (GBD) tool models DALYs for those with any condition as a rate per 100,000 population. Across the STP the rate of DALYs due to Diabetes was 1032.5 (1021.9–1043.1) per 100,000 population in 2019. At national level, the rate of DALYs relating to Diabetes for England was similar at 1019.8 (740.5–1344.5) per 100,000 population whereas the East of England showed the higher rate of 1077.2 (777.5-1418.4) per 100,000 population. Years of life lost is a summary measure of premature mortality. As with DALYs, the GBD models this for all conditions as a rate per 100,000 population. The YLL due to Diabetes across the STP was 141.5 (130.3–152.7) per 100,000 population (2019)[8]. Similar rates were observed across England and the East of England, the YLL rate relating to Diabetes across England was 133.5 (124.2–138.7) per 100,000 whereas the East of England YLL rate was 139.7 (125.1–154.02) per 100,000 (2019).

In comparison to chronic kidney disease (CKD), an LTC often concomitant with Diabetes, across the STP the rate of DALYs due to CKD was 246.7 (244.1-249.3) per 100,000 population (2019). Furthermore, across the STP the rate of YLLs due to CKD was 145.9 (144.3-147.5) per 100,000; a similar rate to the rate of YLLs due to Diabetes observed across the STP. National and regional DALY rates for CKD were slightly lower compared to STP DALY rates, in England the rate of DALYs for CKD was 230.9 (202.2-263.8) per 100,000 and DALY rate of 240.5 (207.6-276.4) across the East of England.

Mortality

In terms of mortality, across the STP, 0.2% (N=126) of patients died due to diabetes during 2018[8]. It is possible that some of the patients who died during this time period, were not diagnosed with diabetes at the time of their death and that this was uncovered as part of an autopsy. On the

[8] See Methodology section for how this was calculated.

whole, the modelled rate of mortality attributable to diabetes in the STP is 3.8 per 100,000 population (2017), (40)[9].

It will be important to reflect all of the above variances in the planning and delivery of interventions and services for diabetes self-care within and across the STP.

2.3 COPD

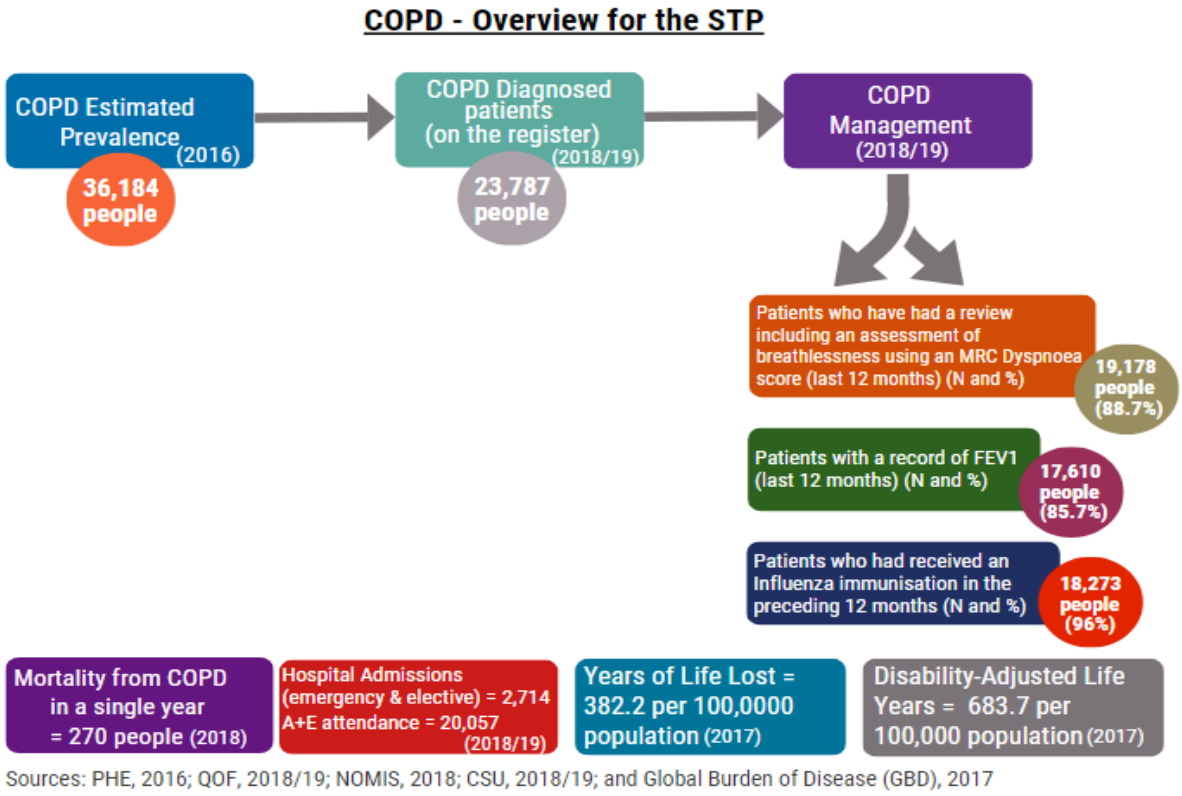


Figure 2.6 COPD Overview for the STP

2.3.1 COPD Prevalence

COPD prevalence (QOF) has seen a slight year on year increase across the STP ranging from 1.7% (N=19,970) in 2012/13 to 1.9% (N=23,787) in 2018/19[10]. The yearly increases in prevalence are in line with the England prevalence during the same time period.

At the CCG level within the STP during 2018/19 CPR CCG had the highest recorded prevalence of COPD at 2.4% (N=4,383) of all patients (all ages) who are registered at all GP practices under this CCG (see figure 2.7). As with Diabetes, there is quite a lot of variance at GP practice level in terms of COPD prevalence across all GP practices within the STP. For example, the prevalence of COPD in GP Practices in Basildon and Brentwood in 2018/19 ranged from 0.8% (The Highwood Surgery) to 4.4% at two of the practices (Dr Ma Sims practice and Malling Health – Dipple Medical Centre) of all patients (all ages) registered at each individual GP practice in Basildon and Brentwood (see Table 2.2).

[9] The modelled mortality attributable (rate) to Diabetes is based on data at Thurrock, Southend and Essex level, and as such may be an overestimate, as Essex covers a larger area than the three CCGs in scope.
[10] See Methodology section for how this was calculated.

Figure 2.7: COPD Prevalence by CCG (2018/19)

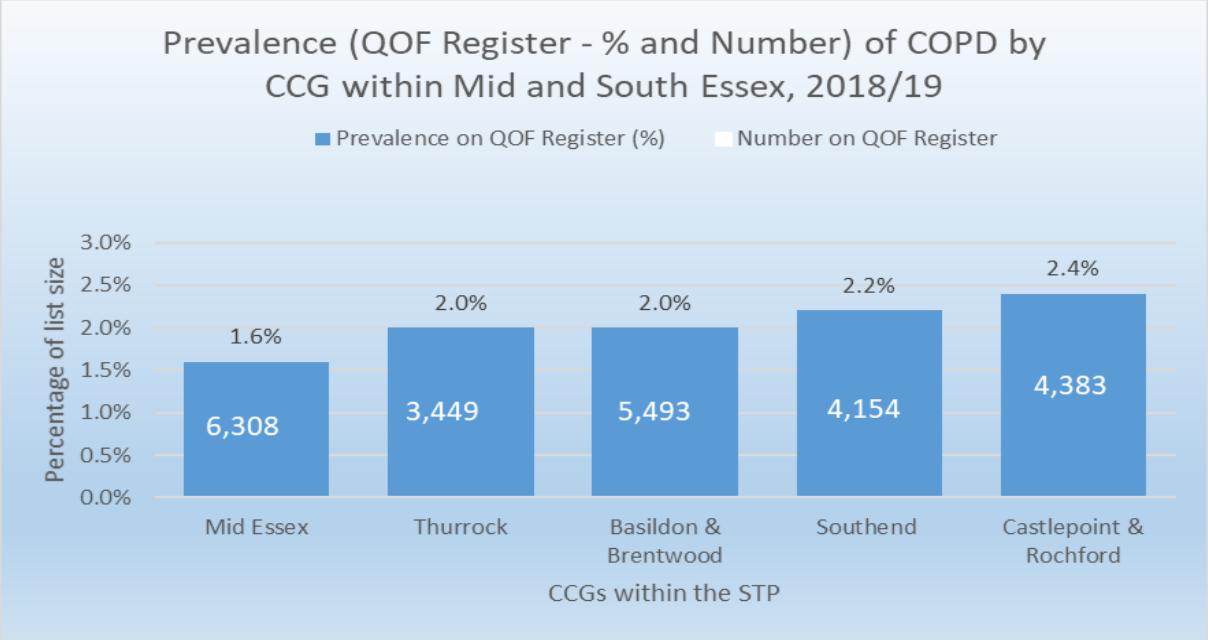


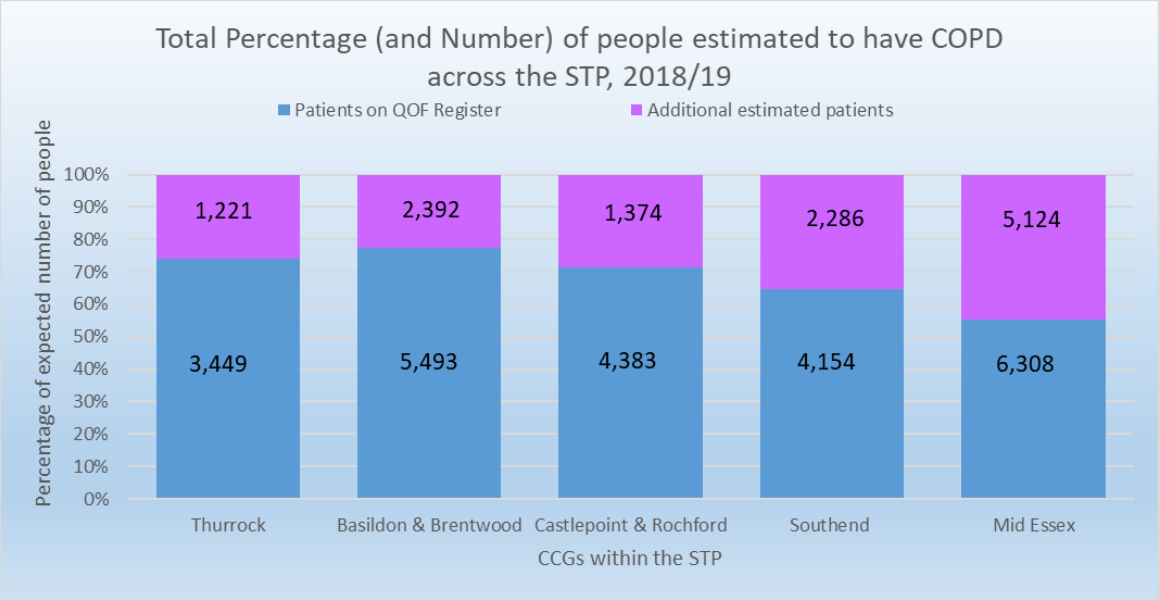
Table 2.2 Range of QOF Recorded Prevalence of COPD by CCG 2018/19.

Area	GP Practice with lowest recorded prevalence (%)	GP Practice with highest recorded prevalence (%)	Difference (percentage point/range)
Southend CCG	1.5%	3.1%	1.6
Mid Essex CCG	0.6%	2.7%	2.1
Thurrock CCG	0.7%	3.4%	2.7
Castle Point & Rochford CCG	1.2%	4.2%	3
Basildon & Brentwood CCG	0.9%	4.4%	3.5
Mid & South Essex	**0.6%**	**4.4%**	**3.8**

Source: NHS Digital – QOF.

As with Diabetes there were differences between the number/percentage of observed (diagnosed) versus expected cases of COPD across all CCGs within the STP in 2018/19 (see figure 2.8 below). Using PHE modelled estimates from 2015/16 it can be seen that of the CCGs, Mid Essex CCG had the largest gap in the number/percentage of diagnosed versus expected cases of COPD; a gap of 44.8% (N=5,124) as well as the highest total estimated prevalence (N=11,432).

Figure 2.8: Total Percentage (and Number) of people estimated to have COPD across the STP, 2018/19.



Source: QOF 2018/19 & 2016 PHE Modelled Estimates

2.3.2 COPD Management

COPD Review (including Assessment of Breathlessness)

Within the STP in 2018/19, 88.7% (N=19,178) of people with COPD had a review including an assessment of breathlessness within 12 months[11]. When broken down at the CCG level, and accounting for variation in population size, Thurrock CCG had the lowest percentage of COPD patients who had received a review at 87.1% (N=2,871). Southend CCG had the highest percentage of patients who received a review of their COPD at 90% (N=3,400) during the same time period.

Record of FEV1

One of the QOF indicators that GPs can be incentivised to deliver in the treatment and management of COPD, is ensuring that all patients have a record of FEV1. Across the STP, the percentage of COPD patients who had a record of FEV1 in 2018/19 was, 85.7% (N=17,610) [12]. When broken down by CCG to compare performance across each area of the STP, Mid Essex CCG had the lowest proportion of COPD patients who had a record of FEV1; 83.8% (N=4,296). Conversely, Southend CCG had the highest percentage of patients who had this record at 86.9% (N=3,207).

Influenza Immunisation

The influenza vaccine is one of the main protective factors for those with COPD to support them to manage their condition effectively. Across the STP during 2018/19, 96% (N=18,273) of patients had received their vaccine in the preceding 1st August to 31st March[13]. When broken down by CCG, the uptake of the vaccine ranged from 95.3% (N=4,294) in Basildon and Brentwood CCG to 97.3% (N=3,089) in Southend CCG. It is worth noting that Southend CCG consistently performs better than all of the other CCGs within the STP,

[11] See Methodology section for how this was calculated.
[12] See Methodology section for how this was calculated.
[13] See Methodology section for how this was calculated.

against all of the COPD QOF management indicators, included above.

2.3.3 COPD Referrals

The Pulmonary Rehab service run by NELFT is designed to support COPD patients to manage their condition more effectively. The service is primarily designed for patients who experience breathlessness. It is a 12 week exercise and education programme. Referral data provided by NELFT for Thurrock and Basildon and Brentwood CCGs, suggests that 783 COPD patients were referred to this service during 2018/19. However, we were unable to get any data for the other three CCGs within the STP and as such cannot provide an accurate picture of how many people accessed the service at an STP level. Of those who were eligible (the number of residents who were classified as MRC3+ patients) an estimate of 21.6% were referred during this time period.

2.3.4 COPD Outcomes

Hospital Admissions, and A&E attendance

During 2018/19 across the STP there were a total of 20,057 A&E attendances attributable to COPD. These attendances may have arisen as a result of patients experiencing symptoms for an unknown cause, perhaps leading to a diagnosis or due to complications with their COPD. Of the total attendances only 16,778 patients attended A&E, which means that some patients attended A&E on more than one occasion during that year.

During the same year, there were a total of 2,714 hospital admissions; 2,605 emergency admissions and 109 elective admissions due to COPD. As with A&E attendance there were fewer patients who were admitted on an emergency basis (N=2,068) than total admissions, which means that some patients were admitted to hospital on multiple occasions during that time period. Brought together, this suggests that, overall self-care for COPD is not effective for all patients living within the STP footprint.

Quality of Life

Across the STP the rate of DALYs relating to COPD was 1335.8 (1322.2-1349.4) per 100,000 population (2019)[8]. Similar rate at national level was observed; across England the rate of DALYs was 1246.2 (1121.6-1363.3) per 100,000 population, whilst the DALY rate due to COPD across the East of England was slightly lower at 1203.1 (1077.8-1318.02) per 100,000 population (2019). Furthermore, the rate of YLL due to COPD was 900.3 (887.1-913.5) per 100,000 population across the STP during the same year[8]. Similar trends were seen across England with YLL rate relating to COPD of 851.4 (745.8-938.3) per 100,000, whereas for the East of England the YLL rate was 792.8 (704.4-878.5) per 100, 000 (2019).

In comparison to trachea, bronchus and lung cancer, another leading respiratory cause of disease burden (1142.2 (1139.4-1145.03) per 100,000 population in 2019[8]), the DALY rate for COPD was higher. Furthermore, the YLL rate for trachea, bronchus and lung cancer was 1124.7 (1121.5-1127.9) per 100,000 population. The higher YLL rate of trachea, bronchus and lung cancer compared to the YLL rate of COPD can be attributed to trachea, bronchus and lung cancer being a highly fatal condition.

Mortality

During 2018, across the STP the percentage of people who died due to COPD was 1.1% (N=270)[14]. It is possible that some of the patients who died did not have a diagnosis of COPD at the time of their death and that this was uncovered as part of an autopsy. The overall modelled mortality rate from COPD across the STP was 27.9 per 100,000 population (40)[15]. It is important to reflect all of the above variances in the planning and delivery of interventions and services for COPD self-care within and across the STP.

2.4 Heart Failure

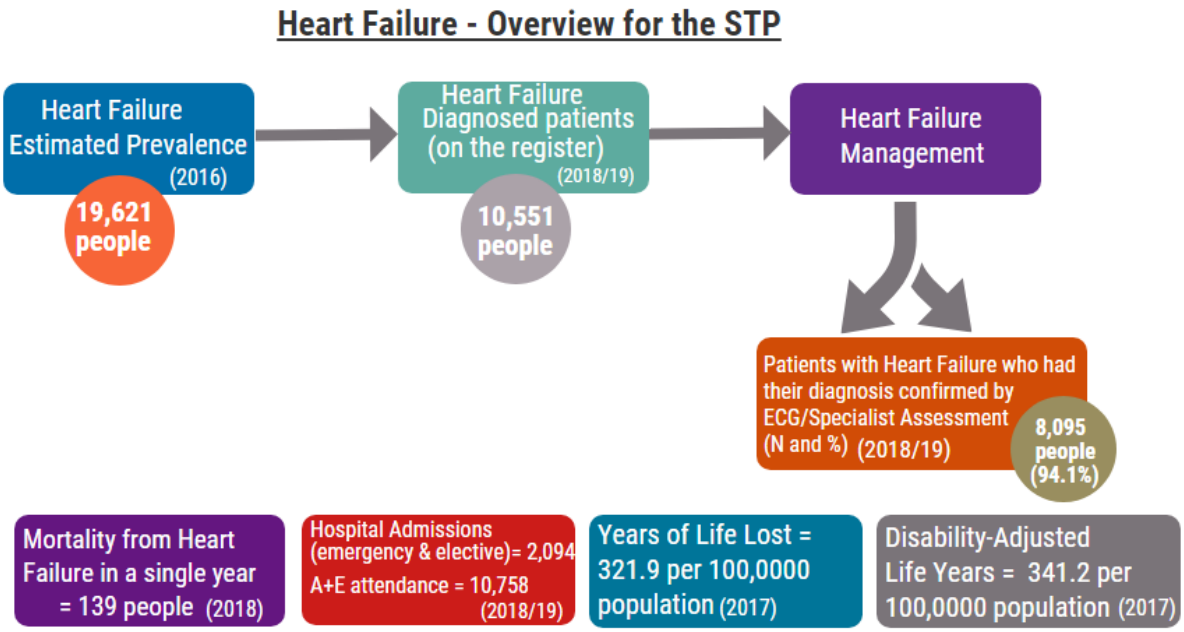


Figure 2.9: HF Overview for the STP

2.4.1 Heart Failure Prevalence

The prevalence of Heart Failure (HF) across the STP has ranged from 0.7% (N=8,554) in 2012/13 to 0.9% (N=10,551) in 2018/19[16]. This is in the line with the England prevalence during the same time period.

When broken down by CCGs, within the STP, Southend CCG had the highest prevalence of HF in 2018/19 at 1.1% (N=2,018) of all patients (all ages) who are registered at all GP practices under this CCG (see figure 2.10). As with the other two conditions there is quite a lot of variance across the GP practices within each area of the STP. For example, in GP practices in Mid Essex the prevalence ranges from 0.3% at two of the practices (Dickens Place Surgery

[14] See Methodology section for how this was calculated.
[15] The modelled mortality (rate) attributable to COPD is based on data at Thurrock, Southend and Essex level, and as such may be an overestimate, as Essex covers a larger area than the three CCGs in scope.
[16] See methodology section for how this was calculated.

and Blyth's Meadow Surgery) to 1.4% (Collingwood Road Surgery) of all patients (all ages) registered at each individual GP practice in Mid Essex during the same time period (see table 2.3 below).

Figure 2.10: Heart Failure prevalence (2018/19)

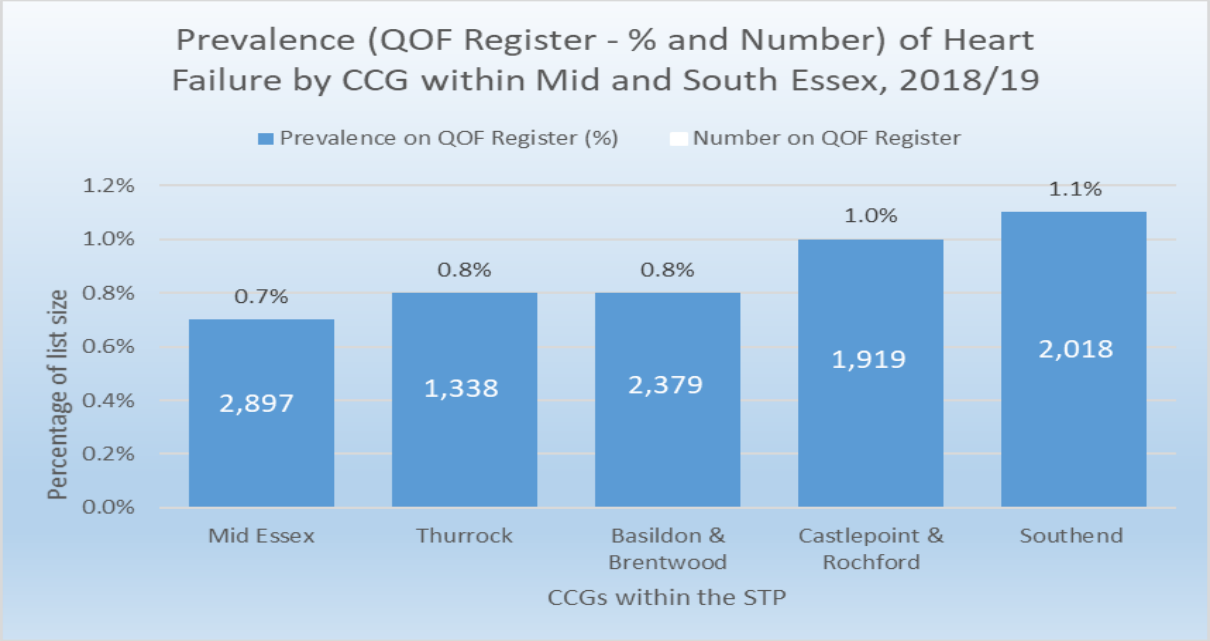


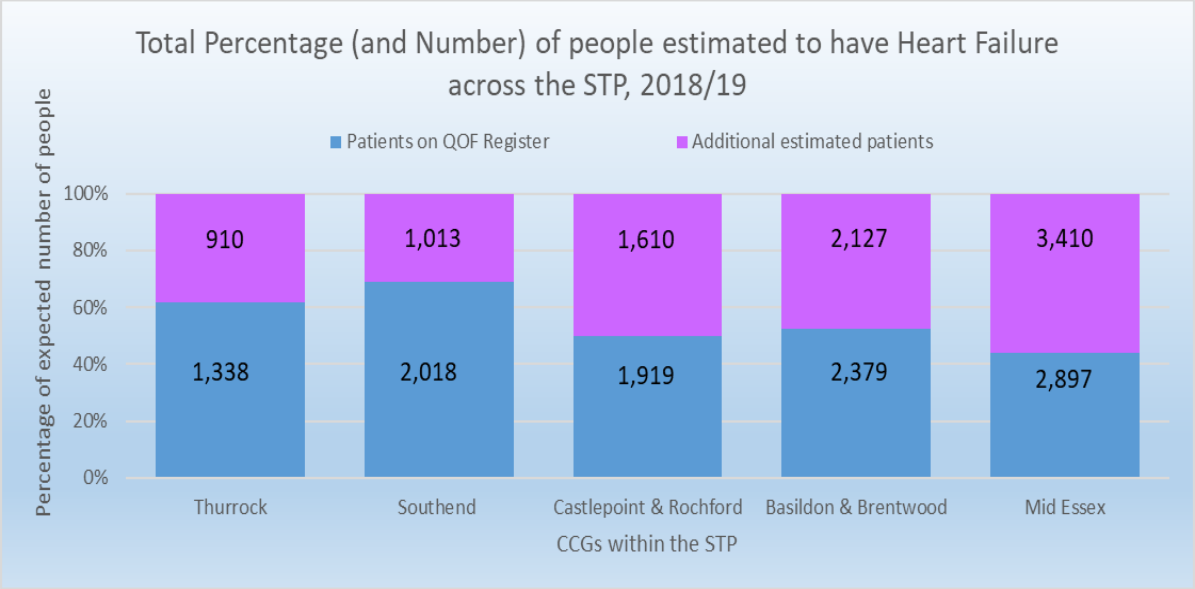
Table 2.3: Range of QOF Recorded Prevalence of Heart Failure by CCG, 2018/19

Area	GP Practice with lowest recorded prevalence (%)	GP Practice with highest recorded prevalence (%)	Difference (percentage point/range)
Southend CCG	0.7%	1.7%	1
Mid Essex CCG	0.3%	1.4%	1.1
Castle Point & Rochford CCG	0.3%	1.5%	1.2
Thurrock CCG	0.2%	2%	1.8
Basildon & Brentwood CCG	0.1%	2.1%	2
Mid & South Essex	**0.1%**	**2.1%**	**2**

Source: NHS Digital - QOF

Figure 2.11 below shows the total number of people estimated to have Heart Failure across each CCG within the STP. As described earlier, the estimated prevalence is the total number of people thought to have a specific condition (based on PHE modelled estimates from 2015/16) and the recorded prevalence is the total number of people who have already been diagnosed and are recorded on disease registers. The CCG with the largest gap in the number/percentage of patients who were diagnosed with Heart Failure in 2018/19 was Mid Essex CCG; the gap was 54.1% (N=3,410) and as with COPD, this CCG had the highest estimated prevalence of Heart Failure across the STP (N=6,307).

Figure 2.11: Total Percentage (and Number) of people estimated to have Heart Failure across the STP, 2018/19



Source: QOF 2018/19 & 2016 PHE Modelled Estimates

2.4.2 Heart Failure Management

Heart Failure Diagnosis Confirmation Assessment

The main management indicator (QOF) for Heart Failure is confirmation of diagnosis. This is defined as the percentage of patients who have had their diagnosis confirmed by either an echocardiogram (ECG) or via a specialised assessment either three months before, or 12 months after going onto the register. Across the STP, 94.1% (N=8,095) of patients had their diagnosis confirmed during 2018/19[17]. When broken down at a CCG level and taking into account differences in population size, the percentage of patients who had their diagnosis confirmed ranged from 92.9% (N=1,830) in Basildon and Brentwood CCG to 95.3% (N=1,045) in Thurrock CCG.

2.4.3 Heart Failure Referrals

The Community Heart Failure Service provides long term management and support for patients living with chronic Heart Failure. Anecdotal referral data provided by NELFT for Thurrock and Basildon and Brentwood CCGs, suggests that 816 (22%) Heart Failure patients were referred to this service during 2018/19. However, we were unable to get any data for the other three CCGs within the STP and as such cannot provide an accurate picture of how many people accessed the service at an STP level. It is likely that the number is higher than depicted here.

2.4.4 Heart Failure Outcomes

Hospital Admissions, and A&E attendance

During 2018/19 across the STP there were a total of 10,758 A&E attendances attributable to HF. These attendances may have arisen as a result of patients experiencing symptoms for an unknown cause, perhaps leading to a

[17] See Methodology section for how this was calculated.

diagnosis or due to complications with their HF. Of the total attendances only 9,551 patients attended A&E, which means that some patients attended A&E on more than occasion during that year.

During the same year, there were a total of 2,084 hospital admissions; 1,866 emergency admissions and 228 elective admissions due to HF. As with A&E attendance there were fewer patients who were admitted on an emergency basis (N=1,594) than total emergency admissions, which means that some patients were admitted to hospital on multiple occasions during that time period. Brought together, this suggests that, overall self-care for HF is not effective for all patients living within the STP footprint.

Quality of Life

Across the STP in 2019 the rate of DALYs relating to Heart Failure was 2131.4 (1207.7-2155.1) per 100,000 population[8]. Furthermore the rate of YLL due to HF was 1657.2 (1656.02-1658.4) per 100,000 population across the STP during the same year, indicative of the highly fatal burden component of HF. Similar rates were observed across the East of England, DALYs relating to HF were 2103.6 (2050.4-2156.8) per 100,000 population with YLL rates of 2009.3 (1959.2-2060.3) per 100,000 (2019). Whereas England showed slightly higher rates of 2163.2 (1997.5-2329) DALYs per 100,000 population and YLL rates of 2076.4 (1916.9-2235.9) per 100,000 population. Comparing the rate of HF to the rate stroke across the STP shows reduced diseased burden, the rate of DALYs relating to stroke was 1016.2 (1011.3-1021.1) per 100,000 population in 2019, whilst the YLL due to stroke was 869.3 (867.6-871.1) per 100,000 population.

Mortality

In 2018, across the STP the percentage of people who died due to Heart Failure was 1.3% (N=139)[18]. It is possible that some of the patients who died did not have a diagnosis of Heart Failure at the time of their death and that this was uncovered as part of an autopsy. The overall modelled mortality rate from Heart Failure across the STP was 63.2 per 100,000 population in 2017 (40) [19].

2.5 Current Service Offer

It is important to reflect all of the above variances in the planning and delivery of interventions and services for Heart Failure self-care within and across the STP. People living with diabetes, COPD and HF in the Mid and South Essex Health and Care Partnership footprint benefit from a large range of services that support them to self-care. Stakeholder engagement and online searches led to identifying a total of 68 services across the STP. Of those, 43 services are for people diagnosed with diabetes, COPD or HF and are commissioned at the CCG or borough level. A majority of these services are offered by community providers such as North East London NHS Foundation Trust (NELFT), Essex Partnership University NHS Foundation Trust (EPUT) and Provide or the voluntary sector, such as Diabetes UK,

[18] See Methodology section for how this was calculated.
[19] The modelled mortality (rate) attributable to Heart Failure is based on data at Thurrock, Southend and Essex level, and as such may be an overestimate, as Essex covers a larger area than the three CCGs in scope.

British Heart Foundation or British Lung Foundation. They consist of: specialist care or rehabilitation geared at managing the disease and complications; structured education to increase knowledge/understanding and to improve self-efficacy; support groups to share experiences and learning; and technology based support such as online platforms and apps. Very few identified services are geared towards multiple conditions despite the fact that most people with diabetes, COPD and HF tend to have multimorbidities. For example, the average number of other conditions at first presentation of HF is five (41). In Southend and CPR, EPUT offers a case management programme, delivered both in clinics and at home, specifically designed for people with complex needs, including multimorbidity, who are or can become very high intensity users of primary and secondary care. The service aims to maximise independence and achieve optimum treatment outcomes through good care navigation and use of advanced clinical skills.

The remaining 25 services, are more holistic and address social or behavioural risk factors. Residents with no record of diabetes, COPD or HF are supported to assess their risk and prevent the onset of any of these diseases. Local Healthy Lifestyle services, pharmacies and Primary Care providers are delivering health checks and screenings and refer those identified to be at risk to tailored programmes. Additionally, self-care support provision has also been identified outside of the historic healthcare or public health settings. Varied Adult Social Care teams and the Job Centres work with residents to enable them to tackle social barriers such as lack of employment or housing. They aim to support residents to stay strong, safe, well, resilient, independent and connected. Furthermore, patients with complex needs, both health and social, can access services that link them to the appropriate resources. Social Prescribers and Local Area Coordinators (LACs) are trained to act as a one stop shop and offer a bespoke service to these people. However, if multiple needs are identified most of the times patients have to access multiple services on separate occasions – making it difficult for them to stay engaged. Due to a high range of commissioners, providers, and referral pathways, mapping the services in the area proved to be very challenging. Some relevant services might be missing from the service mapping analysis. A full map of the services found can be accessed separately in the appendices section (Appendix 2).

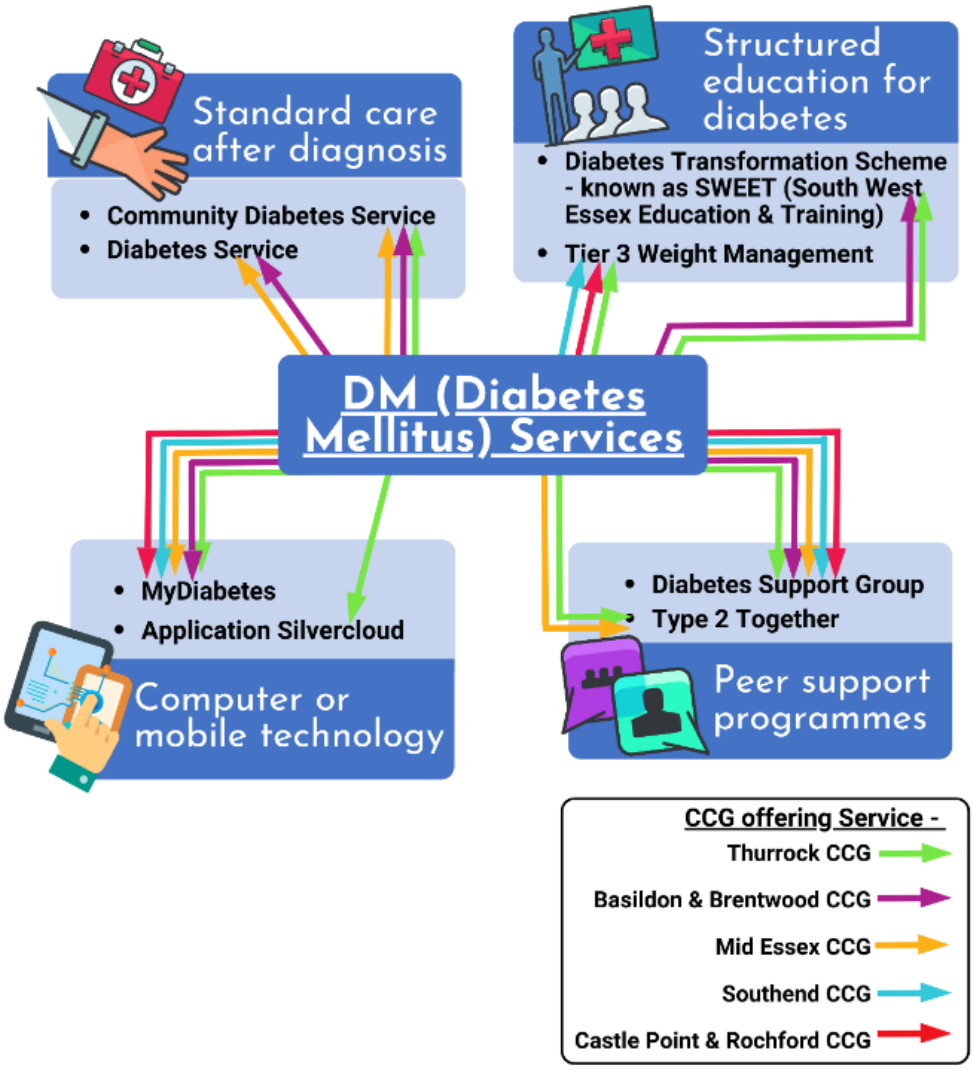
Diabetes

Diabetic patients in Mid and South Essex benefit from a large range of services that support them. Currently, all CCGs offer Community Diabetes Services delivered by multidisciplinary teams usually made up of consultants, diabetes nurses, podiatrists and dieticians. However, the provision came across as fragmented and inconsistent. Due to services being delivered by different providers, there is a variability of programme structure and delivery across the footprint. For example, Mid-Essex services, delivered by Provide, are using a GP with a special interest in diabetes rather than a consultant as the other areas do. Similarly, in Thurrock and Basildon and Brentwood, NELFT is using lay educators for the educational classes instead of healthcare professionals. Additionally, while in most areas the service is either in the

community or Secondary Care, CPR and Southend have recently commissioned an integrated service in conjunction with Secondary Care at Southend Hospital. The service acts as a single point of contact for patients and triages them for a better and quicker experience. These differences in structure and delivery make it very difficult to compare services and ascertain which one is more effective and efficient in supporting patients to self-care.

Similarly, across the STP, diabetes education courses have very different formats in regards to length and content covered. SWEET in Thurrock is only three hours long, while CREDIT and DESMOND in the other areas are a full day course. DESMOND has been thoroughly evaluated and is proven to be effective, whereas it is unclear whether the other two formats have been evaluated for effectiveness or not. Additional to education, patients also benefit from a number of diabetes support groups run by the voluntary sector, such as Diabetes UK and South East Essex Type 1 Diabetes family support group. Being community led and often under resourced, these groups are struggling with catering to people of different backgrounds in terms of education and language.

Figure 2.12: Diabetes Services Infographic



Knowing that patients with diabetes are at high risk for depression and anxiety, Mid Essex and Thurrock CCGs are also providing mental health support services for patients with diabetes. The treatment offered uses Cognitive Behavioural Therapy (CBT) which is effective at reducing symptoms of low mood, anxiety and other emotional problems.

Additional to face to face support, in 2019 the mHealth app, MyDiabetes, was commissioned across the STP. The app contains a comprehensive diabetes education course for patients with both Type 1 and Type 2 Diabetes and enables them to monitor their blood glucose, HbA1c and other risk factors to reduce the risk of serious long term complications.

A visual overview of the services available for diabetic patients across the STP can be seen in figure 2.12 above.

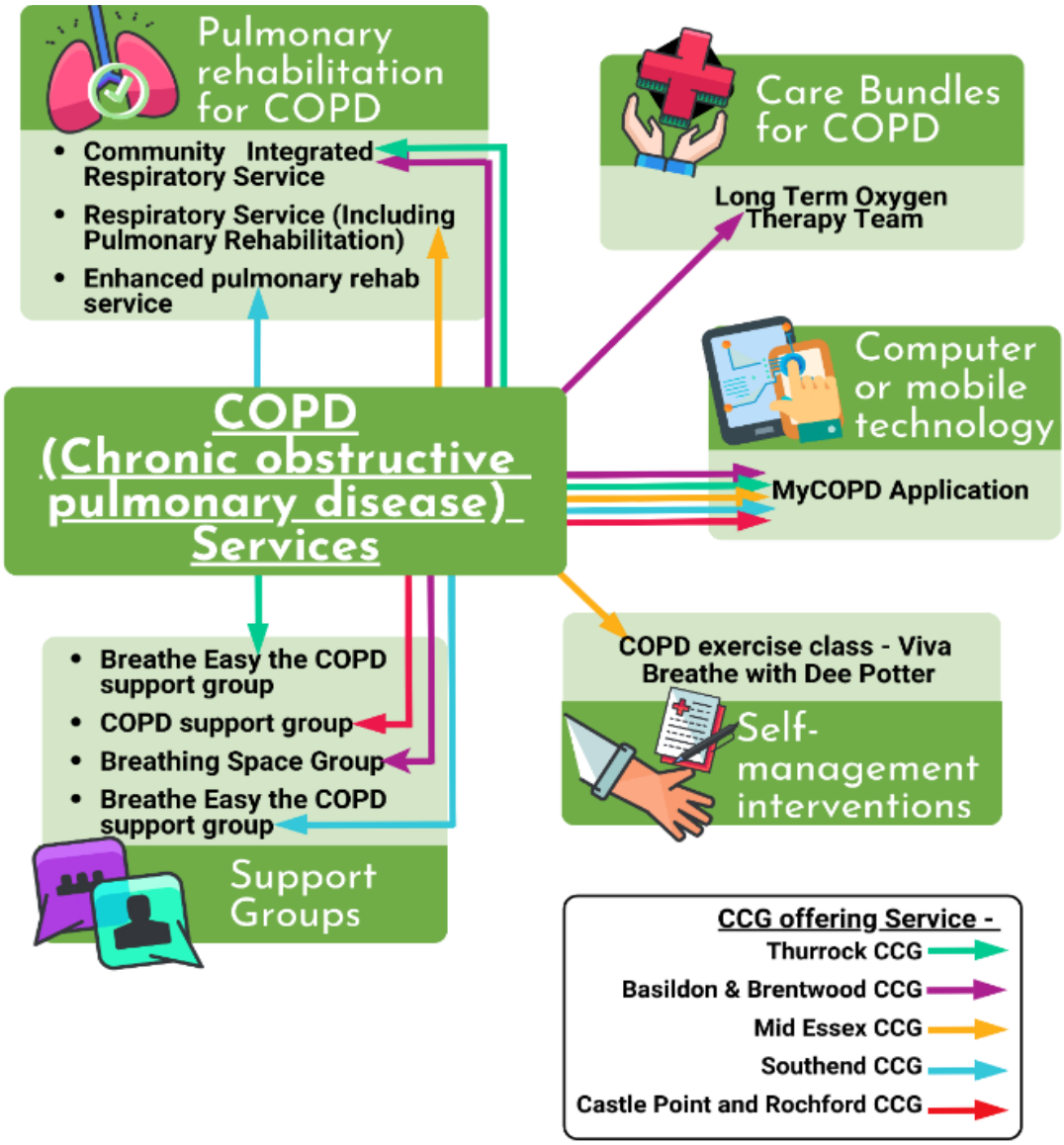
COPD

There are a variety of self-care services available to people diagnosed with COPD across Mid and South Essex. They range from face-to-face specialised services to structured education and digital help. All CCG areas offer a Pulmonary Rehabilitation (PR) programme; however, similarly to the diabetes services, there are differences in structure and delivery of the programmes across the area. The Mid Essex programme appears to be more diverse in the service it offers in comparison to the other CCG areas. In addition to the common services amongst the CCGs, such as a PR service, a COPD Team, and Oxygen Therapy, Mid Essex also offer access to a Breathe Easy support group once a month, a telehealth monitoring service, and palliative care. Additionally, from the information provided, Thurrock, Basildon and Brentwood, Southend and CPR services give patients the option to be referred on to psychological therapy services in case they need extra support or therapy. The Mid Essex service specification does not mention any referral pathway to psychological support services. In terms of location, Southend and CPR services were recently remodelled to deliver pulmonary rehabilitation through either a centre-based, a home-based or a hybrid programme. The hybrid programme offers a mixture of centre-based sessions with exercise and education at home.

Mid Essex also offer their services at varied locations within the CCG, whereas Thurrock's PR service is only based at BTUH. Current research shows that there is a wide provision of free COPD exercise classes across Mid and South Essex. However, most of these classes are located at a single location and meet once a month. It is difficult to ascertain whether these classes reach maximum capacity; however, if that is the case, some patients would have to travel to distant locations to attend a class every month.

There are free COPD Rehabilitation classes available across South East Essex, which we assume would also be the main service available in Mid-Essex, as the current service 'Viva Breathe' in Mid-Essex is a pay as you go service. It could be that the requirement of a payment may deflect patients from attending these classes regularly, especially if there is a free service providing a similar type of service within their locality. However, there are no statistics available to illustrate whether these free exercise classes are at maximum capacity each month and/or patients are willing/not willing to pay for

Figure 2.13: COPD Services Infographic



similar services in their area. MyCOPD app is a digital provision, similar to MyDiabetes, available to people with COPD across Mid and South Essex. There is currently no data which can illustrate how many people have downloaded this App, and/or how engaged app users are. The current barrier around this App is promoting it to COPD patients. Going forward, mHealth is looking to distribute licences via Primary Care and Secondary Care pathways, as well as Social Prescribers.A visual overview of the services available for COPD patients across can be seen in Figure 2.13 above.

Heart Failure

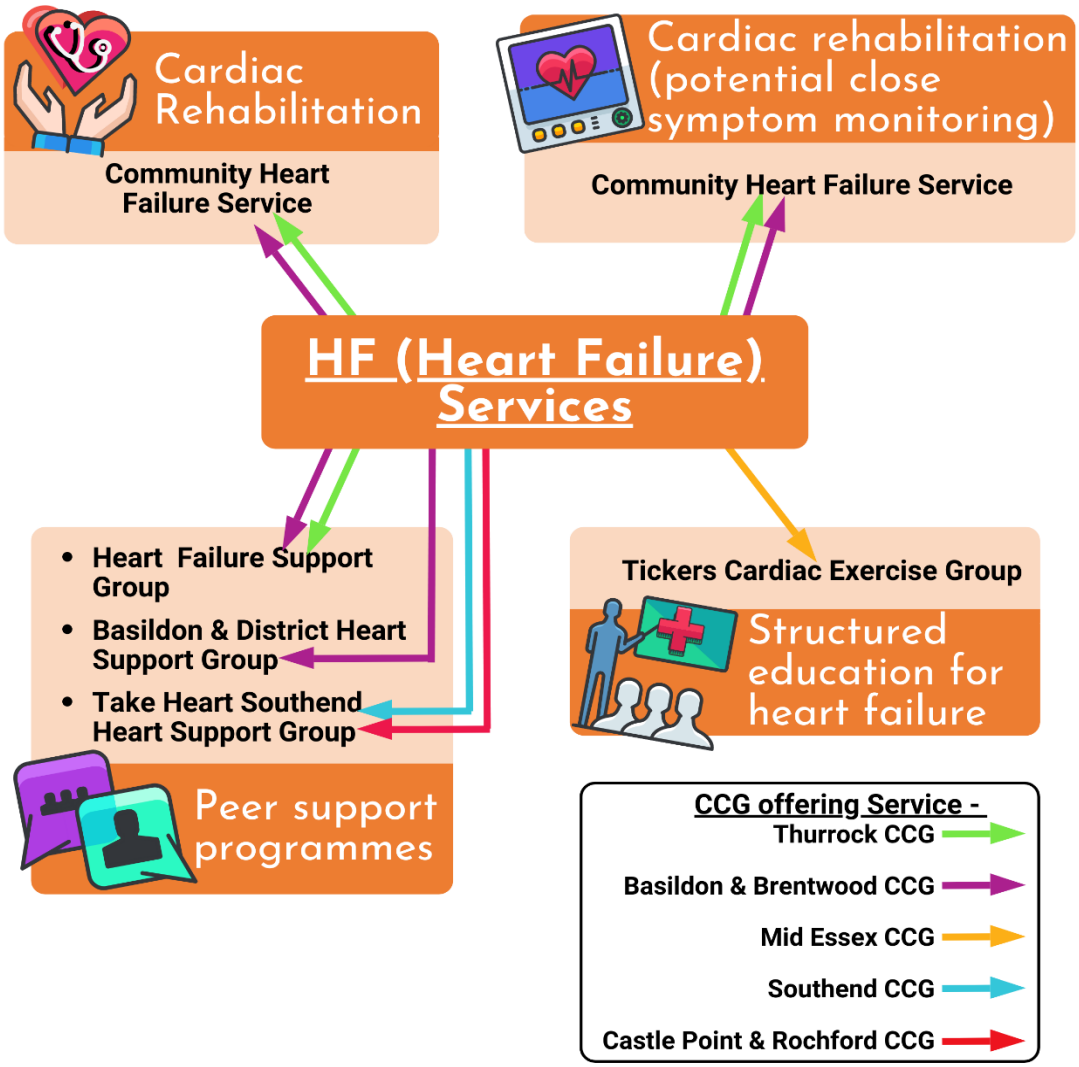
All CCGs in the area offer a specialised Heart Failure Service (Thurrock, Basildon and Brentwood, Southend, and Castle Point and Rochford) or a Cardiac Service (Mid Essex only). The heart failure service aims to increase the patients' ability to self-manage their heart condition(s) through specialist support and educational programmes.

Additionally, people with heart failure can access cardiac rehabilitation services with structured exercise programmes across all areas. In Mid-Essex it is part of the Cardiac Service, while Basildon and Thurrock

Hospitals NHS Foundation Trust (BTUH, for Thurrock and Basildon and Brentwood residents) and Southend University Hospital (for Southend, Castle Point and Rochford residents) have it separately. The programmes are designed for patients who can/do attend sessions at various locations within their area, and for patients who wish to complete the programmes at home.

Of all, the Mid Essex Cardiac Service appears to be more diverse in their service delivery specifications, and include a larger range of services. While Mid Essex and BTUH run their services in various areas, the service in Southend is only at Southend University Hospital. These variations in service delivery are going to be addressed by the new structure put in place by the merging of Mid-Essex, BTUH and Southend into one hospital trust (see figure 2.14 above for a visual overview of services available for HF patients across the STP).

Figure 2.14: HF Services Infographic



2.6 Stakeholder Views

Professionals' Views

A variety of professionals were involved in consultation work to gather their views relating to the current health and social care system for people with LTCs; either completing an online survey or attending one of a number of workshops/face-to-face interviews (See methodology section for further details about how the consultation was conducted). Analysis of the surveys and minutes from workshops and interviews identified a variety of issues, which have been grouped into five main themes, namely: Professionals' knowledge, skills behaviour and capacity, Patients' attitudes and behaviours, Barriers to Self-care (perceived and actual), Commissioning/Services and the System (see Table below).

Each of the main themes, have a number of sub-themes contained within them. It is important to note that there are overlaps and interlinks between the themes and sub-themes as the self-care landscape is complex. For example, capacity issues within the healthcare system are cited as an issue in delivering self-care support (Professionals' knowledge, skills, behaviours and capacity) however, some of this may be combatted if services and the system are designed to make effective use of the multi-skilled workforce (Commissioning/Services); see table 2.4 below.

Some of the sub-themes that emerged from this consultation work with professionals are similar to the findings of the evidence review (see Chapter 3). One example of this, is the need for the system to focus on prevention. For Diabetes, this could be through promotion of, and signposting to the National Diabetes Prevention Programme (NDPP), an evidence based prevention programme centred on supporting behavioural and lifestyle change. Furthermore, the perceived or actual barriers to self-care identified by professionals reflect some of the barriers outlined within the evidence review.

The findings of this consultation were used to inform the recommendations of this JSNA (see Chapter 4).

Table 2.4: Professionals' Views on Self-care barriers

Professionals' Consultation - Key Themes				
Professionals' knowledge, skills, behaviour & capacity	*Patients' attitudes & behaviours*	*Barriers to Self-Care (perceived & actual)*	*Commissioning/Services*	*The System*
• Increased knowledge of the services/support available required. • Need for improved communication between organisations and services e.g. Adult Social Care (ASC), Public Health and the health system. • Lack of knowledge about where/how to signpost patients to, related to the complexities of service pathways and organisations. • Capacity issues within the healthcare system.	• Increased knowledge of the services/support available required. • Patients are concerned that services will be withdrawn. Some patients may perceive signposting as a risk to their care. • Need for patients to engage in their own self-care.	• Transport and access issues. • Engaging with harder to reach groups such as those who are homebound, the teenage cohort. • Patients' own attitudes towards their health. • Role of wider determinants of health e.g. density of fast food outlets inhibiting people from making healthier choices.	• Need for a single point of access in terms of services, with a unique referral system. • Need for a bottom-up approach and co-production of services with patients • Opportunities to better link services e.g. Primary Care and pharmacies e.g. healthy living pharmacies. • Review how we measure self-care outcomes, moving away from process focused to outcome focused KPIs. • Role of online support targeted towards some population groups. • Gap in specialist support for those with multiple conditions. • Importance of making effective use of multi-skilled workforces.	• More focus on prevention needed • No formal shared strategy, vision, and agreed targets/outcomes for self-care. Need for a culture change in how we think about self-care. • Importance of a place-based model for self-care. • Balancing the need for innovative services with making best use of existing services. • Building support within communities. • Role of care navigation in supporting people to self-care. • Role of wider determinants of health in self-care e.g. through improved infrastructure that supports active travel. • Need to understand the demography of a place in order to organise services.

Residents' Views

A total of 109 residents were involved in consultation work undertaken by Healthwatch Thurrock (N=61) and Healthwatch Essex (N=48) to gauge and understand their experiences of living with an LTC; primarily Diabetes, COPD or Heart Failure. The consultation work focussed on the following: initial diagnosis, experience of support services, perceived barriers to self-care and mechanisms for supporting residents to self-care more effectively (See methodology section for further details on how the consultation was conducted). Healthwatch Southend were unable to complete similar consultation work, and as such we will make the general assumption that patients' views are likely to be similar in this area of the STP to the other two areas. The findings presented in this section will be organised based on the main themes identified as part of analysis of the two Healthwatch reports. These will be applied at a local level, as due to differences in methodology it is difficult to directly compare the findings. However, any similar findings across the STP will be emphasised.

Thurrock

Perceived barriers to self-care

When asked "What may, if anything, be hindering your ability to self-manage at home?" The responses were themed as follows (in order of weighting):

- Home barriers – for example needing a bath to make washing easier, stairs making it more difficult to move around the home or the oven being positioned too low down;
- Health status – for example having another condition that was making it difficult to manage and self-care e.g. poor eye sight or pain;
- Medication management – for example having to take multiple and/or regular medication;
- Health Services – for example lack of nearby services, and not feeling supported by the GP; and/or
- Social support – for example needing additional support generally and wanting to have someone available who could provide advice.

> *"I was shocked to get this diagnosis (of COPD). I have smoked in the past and if I had not smoked I probably would not have got COPD. My GP diagnosed me and referred me to the COPD nurses who have been very helpful. I go online for advice and tips on my condition but I like the rehab exercises that I go to (at Thurrock Hospital) as I find being with others is helpful. I have been told to not smoke again, and also to get more active and lose a bit of weight. I am trying to do all of these things and I don't feel too bad. I am in control of my illness. I wished I had never smoked as this has made me get the COPD."*
>
> *Female, 48 years, from Thurrock with COPD*

Information to support self-care

When asked "What information did you receive that supported you to self-manage?" The responses were themed as follows (in order of weighting):

- Health Professional's condition specific advice and guidance – for example from a consultant or specialist;

"Without my husband who is my Carer I could not manage."

Female with Multiple Sclerosis Thurrock.

- Take home information - for example condition specific leaflets;
- Medication advice – for example how to medication such as administering injections; and/or
- Information about Local support groups such as Breathe Easy

"It's helpful because you're talking to people who've got the same thing as you… perhaps theirs is a bit worse or a bit better, but it gives you an idea of what people out there go through".

Focus Group Attendee, Female*, Essex*

Further support for self-care

When asked "Is there anything that could further support you to self-care at home?" The responses were themed as follows (in order of weighting):

- Equipment - for example, a walk in shower or side rails in bathroom;
- Advice/knowledge - for example, more advice and direction when diagnosed;
- Social support - for example, more local support groups or someone on the end of the phone; and/or
- Access - for example, treatment closer to home and easier access to GP.

Other responses related to financial support and the need for improvements to local transport routes which are currently causing issues in terms of getting around Thurrock; for example being able to travel to/from medical appointments.

Essex

Diagnosis and initial support

Experience differed between conditions, in terms of ease of getting an initial diagnosis and provision of information following diagnosis. Most people who were diagnosed with COPD mentioned the difficulty in getting an initial diagnosis. However, it was noted that once diagnosis was confirmed the person was given detailed information about the condition and how to manage it. In Essex the opposite appeared to be true for diabetes, with participants commenting that getting diagnosed was easy, but follow up information was patchy or incomplete. Participants often felt that the condition and next steps were not explained well enough, with a need for more consistent education.

"It took five years messing around to diagnose me, I had obscure symptoms and it was only after I got a lot of chest infections… I saw a totally different guy and he said this has gone on too long, so he sent me for a high definition scan… and that showed COPD and Bronchiectasis. It was the first time I had a clear diagnosis… five years… and that changes all the drugs I was on".

Focus group attendee, Male, Essex, with COPD

In terms of emotional responses to diagnosis, many participants stated that they wanted to self-manage their long term condition independently but also be able to live their lives. One participant made reference to 'taking charge of your own condition'. Others reported that they felt panicked, depressed and as though their condition was taking over their lives.

Patient experience of support groups

Some participants felt that the NHS run support groups felt more like tick-box exercises and were very target driven, with professionals running the groups needing to be 'more mindful'. For example, one participant recounted their experience in which they sought advice about not being able to get their blood glucose level down, despite removing high sugar foods from their diet. The response they received from the professional running the group was that they doing well as they had cut out high-sugar foods from their diet but this did not address the patient's concerns.

Others mentioned that some of the NHS staff would only recognise certain things relating to the management of a condition. For example, there seemed to be some confusion about what doctors would recognise as 'exercise', with many participants mentioning 10,000 steps as a benchmark.

> *"My feelings are, doctors, because you are of a large frame immediately think "junk food"... had no thought that you might not eat junk food and I find that very difficult"*
>
> *Focus group attendee, male, Essex, with Diabetes*

A recurring theme was the importance of support groups being run by volunteers who had a long term condition themselves and were self-managing; it was felt that advice provided by someone with the same lived experience would be more useful.

The social aspect of support groups was consistently mentioned as positive and really important to self-care. Some participants talked positively about exercise, especially where this could be undertaken in a social environment, e.g. via walking groups. Some participants suggested that the social element of support groups should be strengthened further.

Local Services and support

Participants highlighted that understanding and empathy from NHS staff is important for people, to enable self-care, with some patients feeling that the attitudes of some health professionals needed to be 'more supportive'. Some individuals felt judged or blamed for the development of their condition due to lifestyle factors such as smoking or being overweight. Other participants cited the excellent support they had received from health professionals.

They also felt that access to services was crucial, with some participants reporting feeling concerned about service closures or sessions coming to an end. One patient reported that a local eye-screening service had shut down and that it now cost them £30 in taxi fares to travel to the next closest service. Another patient reported difficulties in being supported with her foot care, due to waiting times and lack of appointments.

"It's nice to know you've got a number you can ring and someone to talk to… have that contact it gives you that feeling of security".

Focus Group Attendee, Female, Essex

The role that specialist nurses play in supporting people with LTCs was consistently praised in terms of their knowledge, understanding and empathy. Conversely, participants felt that other professionals working in other areas of the system did not have the same level of knowledge e.g. pharmacists.

Knowledge of local peer support networks were rated as extremely valuable, however, some participants felt that GPs could be signposting more and supporting local groups more, by attending them to speak to patients directly. It was recognised that health professionals are under a lot of pressure to deliver services with limited time and resources. It was also clear from this consultation work that patients feel that professionals need to know what is available locally, and where they can signpost individuals to for further support.

Findings across the STP

Experience of diagnosis, in terms of ease and initial support offered was highlighted by participants across the STP. In Thurrock, some participants felt that the way they were given their diagnosis was 'good' or 'easy' with others stating that their experience was 'bad' or 'could have been better'. Although the majority of Thurrock participants stated that they had received information in a variety of formats, some felt that they did not receive enough information, with a small number stating that they had received no information at all. This is similar to the picture in Essex (as outlined above).

It appears as though the majority of participants across the STP do not believe that the development of their long term condition could be prevented, with some citing genetic and hereditary factors. Although some participants did mention that they could 'be fitter' or 'lose some weight', others found it difficult when health professionals made assumptions about them relating to their weight status.

Some of the findings from this patient consultation reflect the views of professionals', particularly in terms of capacity and knowledge about where to signpost patients to. As with the professionals' views, the findings from this consultation work were used to inform the recommendations of this JSNA (see Chapter 4).

CHAPTER 3

EVIDENCE REVIEW

Key Findings

Self-care practices contribute to maintaining or promoting health, including in improving LTC management. Autonomy, understanding and responsibility, a healthy diet and physical activity, and smoking cessation are examples of self-care behaviours that improve the development or symptom progression of Diabetes, Heart Failure and COPD. For example, such behaviours among diabetes have been found to correlate with improved glycaemic control, decreased complications and increased quality of life.

There are 137 behaviour change techniques (BCTs) to support and empower patients to improve their lifestyle used in primary care. Previous reviews show that behavioural counselling, motivational interviewing, and educational advice and support are most effective in primary care. However, effectiveness has been found to be dependent on the use of different BCTs specific to targeted behaviours, and the programme delivery and structure.

Ability to self-manage LTCs depend on a range of factors: active condition monitoring, treatment adherence, improving or maintaining lifestyle and interacting with health care professionals. Many patients also face difficulties in their personal life, regularly take many medications, and report that their condition limits their ability to carry out daily activities.

A literature review was conducted to assess intervention effectiveness at improving self-management ability among those with Diabetes, Heart Failure and COPD.

Self-care practices are widely varied and are beneficial to anyone, regardless of health status, as they can contribute to maintaining good health or promote improvements to health. Current evidence shows a broad range of self-care interventions (both clinical and behavioural) are effective at improving health outcomes. For the purpose of this review we focus on those directed at promoting healthy lifestyles and management of the three LTCs within scope: diabetes, heart failure and COPD.

The following behaviours and their outcomes make a direct contribution to improving LTC management as they are

3.1 General self-care

factors which impact on the development and/or worsening of symptoms for diabetes, heart failure, and COPD.

Autonomy, understanding self-care and self-responsibility - Not being passive in one's own care and understanding personal responsibility for health varies between individuals. Those with low levels of activation, or sense of control in managing health, have a greater risk of attendance at A&E, hospitalisation or being readmitted to hospital after discharge (13). In contrast,

people who show self-responsibility for their health are more likely to engage in healthy lifestyle behaviours. The current ways in which services are delivered to people may not be set up to support individuals' and families' understanding of their role in their own health, instead taking a paternalistic view historic to the set-up of the NHS.

Healthy Diet - Self-care related to diet can be challenging as often it is focussed on modifying existing behaviour rather than learning a new behaviour such as doing more exercise. This involves changing habitual behaviours that are embedded in culture and may have social consequences (42). In England, average intake of saturated fat, sugar, and salt are above recommendations while intake of fruit and vegetables, oily fish, fibre and some vitamins and minerals are below recommendations in some groups (43). Poor diet is a risk factor for being overweight or obese and makes a significant impact on an individual's physical and mental health and wellbeing (44).

Weight control - Carrying excess weight can have significant implications for an individual's physical and mental health. Being overweight or obese is linked to a wide range of diseases, most commonly: type 2 diabetes, hypertension, some cancers, heart disease, stroke and liver disease. Of all risk factors for ill health, obesity is the leading cause of premature death and morbidity (45). Additionally, obese adults are more likely to suffer from stigma, hence being obese is associated with poor psychological and emotional health, and poor sleep. Causes of weight gain and obesity are multi-factorial, including: biological, physiological, psycho-social, behavioural and environmental factors (46).

Physical activity and exercise - The Chief Medical Officer (CMO) currently recommends that adults undertake a minimum of 150 minutes (2.5 hours) of moderate physical activity per week, or 75 minutes of vigorous physical activity per week or an equivalent combination of the two, in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity or frequency (47). NICE also has a number of clinical pathways that highlight the role of physical activity in preventing and managing illness (48).

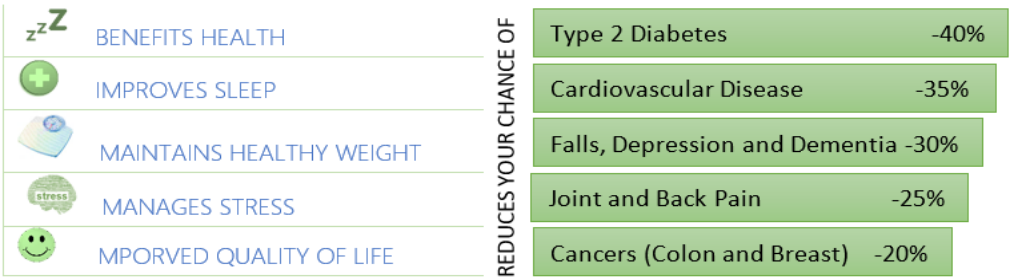


Figure 3.1: Effects of physical activity on health

Strong evidence demonstrates the benefits of physical activity in the prevention of ill-health, maintenance of good mental health and rehabilitation of LTCs, such as, cardiac rehabilitation, pulmonary rehabilitation and reducing weight etc... (44) However, people's physical activity levels are influenced by numerous factors, including: whether their job involves sitting at a desk, their physical health status, social networks and the environment they live in. This makes it difficult for people to follow health professionals' recommendations.

Smoking cessation - Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population (49). However, smoking is still the one of the greatest causes of preventable ill health and premature mortality in the UK. NHS Digital estimates that 484,700 hospital admissions in 2016/17 were attributable to smoking (50). It is a major risk factor for many diseases, such as lung cancer, COPD and heart disease (49).

3.2 Interventions for lifestyle change

Changing behaviours has always proven to be a very challenging task for both health providers and patients. Simple advice about behaviour change is very common practice in our healthcare system; however, there is no evidence of this intervention being effective by itself. A study from 2008 found that there are as many as 137 behavioural change techniques (BCTs) used in primary care (51). Although challenging, it is vital to understand which interventions are the most effective at empowering patients to make better choices and improve their lifestyle.

When it comes to primary care, a review of evidence from 2012 (52) shows that the most effective ways to support patients to change their behaviour is through behavioural counselling, motivational interviewing, and education and advice. Nevertheless, when it comes to education and advice, a more patient-centred approach seems to be most effective.

There is a lack of evidence to advocate for one particular model over another. However, clusters of intervention techniques particular to behaviours targeted at specific long term conditions (which patients are at risk of or suffer from) which are described in detail by Michie et al (53) could be more effective. For example, for dietary behaviours, applying a theoretically specified cluster of 'self-regulatory' intervention techniques may improve effectiveness (54).

Furthermore, the structure and delivery of the programme is essential to its success.

3.3 LTCs and Self-management

Patients at risk of developing CVD or Type 2 Diabetes, for example, have improved outcomes when the interventions target both diet and physical activity, involve a planned use of BCTs, have a clear plan for supporting the maintenance of behaviour change, and have medium to high frequency contact with patients (54). Because of this added complexity, it is difficult to evaluate whether certain methods such as health coaching and counselling are effective, hence the inconsistent study results (55).

The National Diabetes Prevention Programme (NDPP) is an example of a successful delivery model and combination of BCTs. The national roll-out was based on extensive evidence around lifestyle interventions being effective at preventing type 2 diabetes (56; 57; 58). The structure of the programme also follows NICE guidelines (59), which suggests ongoing tailored advice, support and encouragement, involvement of a family member or friend, use of self-regulatory techniques, and application of a combination of BCTs. Examples of BCTs are: exploration and reinforcement of reasons to change, setting goals, action planning, developing coping plans and relapse prevention. A PHE report (60) on return on investment (ROI) for cardiovascular disease prevention interventions found the NDPP to be the most cost effective of all lifestyle interventions studied; it was the only one to return higher savings over a 20-year period, without monetising health benefits. When taking into account health benefits, NHS England estimates an economic net benefit of £1.2bn over 20 years for a 5-year cohort (390,000 patients) at £270 average cost per patient (61).

How people cope with LTCs varies broadly and is dependent on a range of factors. Self-management requires people to actively monitor their disease, take medication as prescribed, improve or maintain their lifestyle, and interact with healthcare professionals while also maintaining a healthy social life. Evidence shows a third of people with LTCs encounter problems in their personal and social life, such as financial, marital, employment and housing (62). Furthermore, an estimated 19% of the population in the UK take 5 or more medications on a regular basis (63). Research shows as many as 50% of patients with chronic conditions do not take their medicines as intended (64; 65)

Carrying out basic tasks and activities that support daily life and also general health can become more of a challenge. For example, the 2018 GP Patient Survey (GPPS) reported that among those with a long-term physical or mental health condition, disability or illness, 19.2% responded 'yes a lot' and 39.5% answered 'yes a little' to the question "Do any of these conditions reduce your ability to carry out your day-to-day activities? (63). Evidence shows that a third of adults with cancer have difficulty with basic activities for daily living such as personal hygiene and walking (66). People with dementia find it more difficult to bathe independently amongst other things (67) and people who have had a stroke may find basic tasks such as walking and eating a challenge (68).

When it comes to disability, whether someone was born with the disability or acquired it during their life plays a great role in how they deal with it. Additional to the physical and psychological burden, people with disabilities can experience an increased level of fear. For example, people suffering from joint or muscle pain can experience kinesiophobia, the fear of movement. Evidence shows that higher levels of kinesiophobia are directly associated with increase in levels of pain and disability and reduced quality of life over time (69).

3.3.1 Diabetes

KEY FINDINGS

Within primary care, there are Quality Outcome Framework (QOF) indicators in place to support diabetes care, such as referrals to structured education. NICE guidelines also recommend 8 care processes to be received annually, including measurement of cholesterol, blood pressure and HbaC1. These support effective condition management, yet many patients do not receive all processes.

Other NICE guidelines for diabetes self-care include: receiving individualised care, tailored to patient needs and circumstances such as comorbidity and polypharmacy; dietary and weight loss advice integrated in a personal management plan, with targets set for those who are overweight; self-monitoring of blood glucose for patients on insulin, with annual structured assessment of skills in interpreting results and action to take; and being offered structured patient education at time of diagnosis with annual reinforcement and review.

Structured education for diabetes has been implemented nationally, with one example being DESMOND. DESMOND includes face-to-face education covering, for example, understanding glucose and complications, lifestyle choices and medication adherence. Although lacking long-term behavioural change, improvements in patient activation and HbAc1 levels have been found.

Evidence also suggests potential for multi-faceted interventions, such as the addition of blood glucose monitors to education, with positive long-term biomedical outcomes seen. Family orientated education is also promising via face-to-face or telephone methods with improvements found in blood glucose monitoring, foot care and cholesterol. The face-to-face method had additional benefits in diet and physical activity.

Peer support programmes involve bringing together people sharing similar life experiences and characteristics. There are mixed results of effectiveness in primary care settings in clinical outcomes, self-efficacy and treatment adherence. A meta-analysis showed that these programmes may be more effective for those of minority groups when culturally appropriate interventions are delivered. Self-efficacy also needs to be integrated to support long-term behaviour improvements.

MHealth, mobile phones and other wireless technology such as webchats, are commonly used as educational tools to support preventative behaviours. Technology-enabled education and support programmes for diabetes self-management have potential to improve outcomes, while increasing access and decreasing costs. Studies have found that educational support programmes delivered by such methods improve glycaemic control, with one study showing this in the long-term along with improvements in self-efficacy. Such methods may be most effective when all feedback loop components are included: 2-way communication, patient data analysis, and individualised education and feedback. They may also not be as effective amongst specific demographics, such as pregnant women.

There are several essential self-care behaviours that those with diabetes must adopt in order to manage health. These include healthy eating, being physically active, monitoring of blood sugar, being compliant with medications, having good problem-solving skills, healthy coping skills and risk-reduction behaviours (70). These seven behaviours have been found to be positively correlated with good glycaemic control, reduction in complications and

improvement in quality of life (71; 72; 73; 74).

Care provided to adults with diabetes should be patient-centred and involve individualised care planning. Patients should have the opportunity to make informed decisions about their care and treatment in partnership with healthcare professionals. Older adults with type 2 diabetes also need to have their broader health and social care needs considered, due to the greater likelihood of co-existing conditions and a potential greater number of medicines (75). Their ability to benefit from risk-reduction interventions (for example structured education programmes) in the longer term may also be reduced (75), although age is not a reason to dismiss recommending such a programme.

There are also specific quality outcome framework (QOF)[20] indicators related to diabetes care within the primary care context (76). These include measures such as establishing and maintaining a register of those diagnosed with diabetes by type, referrals into structured education, dietary review by a suitably competent professional and recording blood pressure.

As discussed in the previous chapter, the national audit of diabetes care in the UK in 2018/19 showed that very low numbers of people with diabetes received all care processes nationwide and locally (36). This indicates that a substantial proportion of people with diabetes may not be receiving the care they need to effectively manage their condition.

In addition to the nine care processes, other NICE guideline actions most pertinent to self-care for type 2 diabetes include the following (75):

Receiving individualised care - An individualised approach tailored to the needs and circumstances of the person. For example, taking into account their personal preferences, comorbidities, risks from polypharmacy, and ability to benefit from long-term interventions because of reduced life expectancy. This approach is especially important in the context of multimorbidity.

The NICE guidelines state that all people with a diagnosis of diabetes should receive the following healthcare checks, known as the nine care processes, at least once a year (75):

- Glycated haemoglobin (HbA1c) measurement
- Blood pressure (BP) measurement;
- Cholesterol level measurement
- Retinal screening
- Foot checks
- Urinary albumin testing
- Serum creatinine testing
- Weight check
- Smoking status check

[20] The QOF is a voluntary reward and incentive programme. It rewards GP practices, in England for the quality of care they provide to their patients and helps standardise improvements in the delivery of primary care.

Dietary advice and weight loss - Dietary advice should be integrated within a personalised diabetes management plan, including other aspects of lifestyle modification such as increasing physical activity and losing weight. For adults with type 2 diabetes who are overweight, an initial 5-10% body weight loss target should be set. Lesser degrees of weight loss may still be of benefit and larger degrees of weight loss in the longer term will have a positive metabolic impact.

Self-monitoring of blood glucose - Self-monitoring of blood glucose should be offered to patients on insulin. Patients who self-monitor their blood glucose levels should receive a structured assessment at least annually to assess self-monitoring skills ensuring the person knows how to interpret the blood glucose results and what action to take.

Be offered patient education - Adults with type 2 diabetes, and/or their family members or carers, should be offered structured education at or around the time of diagnosis, with annual reinforcement and review. Patients and their carers should be advised that structured education is an integral part of diabetes care.

3.3.1.1 Structured education for diabetes

NICE guidance states that adults with type 2 diabetes should be offered a structured education programme at diagnosis (77). Structured self-management education programmes have been implemented nationally for diabetes.

The Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) intervention is one such programme and delivers face to face educational courses. This covers, for example, thoughts and feelings of the participants around diabetes; understanding of diabetes and glucose; understanding of risk factors and complications associated with diabetes; monitoring and medication; food choices; and physical activity amongst other things. The DESMOND programme has been shown to significantly increase patient activation and improve glycated haemoglobin (HbA1c) levels (78; 79), although evidence has demonstrated a lack of significant sustained biomedical or lifestyle outcomes in the long term (80).

Diabetes Education

DESMOND (Diabetes Education and Self-Management Programme for Newly Diagnosed Diabetics) has been very successful in increasing a patient's understanding on how to manage their condition. It has also improved high blood glucose levels in diabetics. But is it sustainable long term?

In America, the Livongo for Diabetes Programme combines coaching with a certified diabetes educator and blood glucose monitors in order to reduce the occurrence of abnormal blood sugar readings. A 2017 study (81) conducted on 4,544 diabetes patients looked at the effectiveness of the programme. Over one year, results indicate an 18.4%

decrease in the likelihood of low blood glucose (hypoglycaemia) and 16.4% decrease in high blood glucose (hyperglycemia) compared with baseline. The addition of a two-way messaging device delivering blood glucose readings in real time to an otherwise standard education support programme explores the potential of multifaceted interventions for diabetes self-care.

Diabetes Education – a Family Oriented Approach

Self-Care behaviours, such as better diet control and more physical activity, increased where patients had face to face group sessions with peers

Whilst many education-for-self-care programmes focus on educating the patient, it is worth exploring more family-oriented approaches. A 2017 randomised controlled trial tested the effectiveness of a family-oriented intervention for diabetes patients. The control group was compared to two groups: one group received the education programme in face-to-face sessions, and one group received the education over the telephone. Overall, self-care behaviours increased. For example, blood glucose monitoring, and lipid profiles significantly improved in the groups receiving the education when compared to the control group. Face-to-face sessions had better results for dietary adherence and physical activity while both intervention groups had comparable results for blood glucose monitoring, foot care and cholesterol levels (82). The family-oriented education trial also demonstrates the potential value of telephone engagement in delivering effective diabetes support.

3.3.1.2 Peer Support Programmes

Peer support programmes are characterised by bringing together a group of people who are sharing similar life experiences or characteristics. Peer health coaching relies on the premise that the patient will connect better to people who have had similar experiences. They have been proven to be effective in primary care settings, but mostly for people who are part of a minority group (83; 84). Randomised control studies have found mixed results in regards to improvement in clinical markers such as HbA1c or secondary outcomes such as self-efficacy or adherence to treatment for the general population (83; 84; 85; 86; 87). Self-reported change in ability to self-care post this type of intervention tends to be positive (87). Yet, there were no definitive answers about the effectiveness and possible impacts of these interventions. Despite finding overall small, but statistically significant improvements in HbA1c, a recent (2016) meta-analysis

Peer Support Groups

Where a group of people share similar life experiences and can relate to each other. This has been shown to be positive for minority groups, but changes have not been sustained long term.

concluded that peer support programmes are more effective for minority groups (84). When the researchers looked at ethnic subgroups in seven studies, the effect size between the subgroups was statistically significant. However, these results were only seen when culturally appropriate interventions were delivered. Moreover, improvements in behaviour are not always sustained long term post intervention. In order to make results last longer, a focus on patients' self-efficacy and illness perception needs to be integrated into the intervention (88).

3.3.1.3 Technology enabled diabetes self-management

Technology-enabled diabetes self- management education and support was examined in a 2017 systematic review. The results found that the most effective interventions incorporated all components of the feedback loop: 2-way communication, analysis of patient generated health data, tailored education and individualised feedback. These elements should therefore be considered when designing and implementing self-management education and support programmes for diabetes patients (89).

The use of technology, such as webchats and mobile health (mHealth), has the potential to reduce the cost while increasing the accessibility of tailored health education. Mobile health (mHealth) is a general term for the use of mobile phones and other wireless technology in medical care. A common use of mHealth are educational tools to support preventative behaviours; this makes it well placed for promoting and supporting self-management of conditions.

In China, a diabetes education programme delivered to Type 2 diabetes patients via webchat saw a significant improvement in HbA1c and diabetes management self-efficacy scores at 6 and 12-months follow-up when compared to the control group (90). This suggests that health education of diabetic individuals via a webchat platform in combination with conventional diabetes treatment could therefore improve glycemic control and positively influence other aspects of diabetes self-care skills.

Similarly, a tailored self-management support programme delivered to mobile phones via text message (91) resulted in modest improvements in glycaemic control in a group of 366 adults with poorly controlled diabetes. While the clinical significance of these results is unclear, they support the potential of mHealth interventions to assist in diabetes self-care.

Technology and Diabetes

By tailoring educational programmes through patient feedback, digital platforms could be very successful in managing diabetic individuals.

A study in China highlighted that using a web-based chat platform to educate diabetic patients while undergoing their usual diabetic treatment, improved their overall symptoms.

3.3.1.4 Two-way monitoring of diabetes

My Diabetes My Way (MDMW) is an online monitoring programme launched in 2008 by NHS Scotland to support patient with diabetes to self-care. In the first year the page was accessed more than 1,400 times. Eight years later, in 2016, the MDMW information website received an average of 101,382 page accesses per month (56.9% increase from 2015) with an average of 1,907 users each month (92). However, findings show that the patients more likely to use the resource are of white background and younger than the average population with diabetes.

My Diabetes My Way Survey results from 2015 show that (92):

- 90.3% of users said that the website helped them improve their knowledge of diabetes;
- 89.3% said that accessing their information helped to improve their motivation
- 89.6% said that accessing the online information has helped them make better use of consultation time;
- 95.9% found the graphs on the website helpful to monitor changes; and
- 83.5% said that online access to diabetes information helped them meet their diabetes goal.

A similar programme, HeLP-Diabetes, was studied in a randomised control trial of 374 diabetes patients from 21 primary care practices in England. The programme is based on an interactive web-based, theoretically informed, self-management platform. Participants in the intervention group had, on average, 0.24% lower HbA1c scores than those in the control, a difference that was found to be significant (p=0.014). Subgroup analysis found participants who had been more recently diagnosed with diabetes experienced a beneficial impact on their diabetes-related distress after using HeLP (93). The NHS Long Term Plan suggests rolling out HeLP-Diabetes nationally in 2020.

While online monitoring tools have been shown to have a positive impact on self-care for general groups, evidence for effectiveness amongst specific demographics is not as strong. For example, a web-based support programme trialled on 174 pregnant women with type 1 diabetes showed no improvement for general wellbeing or self-efficacy of diabetes self-management. The web-based support consisted of evidence-based information, a self-care diary for monitoring of daily activities and reporting of self-measured blood glucose, and peer support in a discussion forum. Low activity levels and stressors of motherhood were cited as potential reasons for the lack of efficacy (94).

3.3.2 Chronic obstructive pulmonary disease

KEY FINDINGS

NICE guidelines that support COPD self-care include: development of individualised self-management plan with patients and their family; development of individualised exacerbation plans for those at risk to encourage prompt response to symptoms; and implementation of telephone health interventions. A good individualised self-management plan should have regular review and include a cognitive behavioural component to support patients to cope with breathlessness and anxiety. Other key NICE recommendations include: smoking cessation; assessment of inhaler technique at start of and during treatment; referral to pulmonary rehabilitation, for new patients and within 4 weeks among those admitted to hospital for acute exacerbations; and vaccinations (annual flu and pneumococcal) and anti-viral therapy.

Self-management training is considered increasingly important to the clinical practice of COPD treatment and management, providing emotional support and supporting health behaviour change. A meta-analysis found such interventions effective in reducing respiratory related and all-cause hospital admissions, and long-term improvements in health-related quality of life. Success is dependent on co-operation with health care professionals, with training including how to develop exacerbation action plans more effective in above outcomes.

Pulmonary rehabilitation is a key recommended approach for COPD, with exercise an important component, and can also include other interventions (e.g. education, psychological support, dietary advice). There's strong evidence for effectiveness, with improvements found in health-related quality of life, clinical symptoms (breathlessness and fatigue), and sense of control.

Care bundles are packages of interventions intended for delivery during hospital stay, including: checking inhaler technique; providing written COPD management plan and medicines; assessing willingness to stop smoking and suitability for pulmonary rehabilitation; and arranging a 2-week post-discharge follow-up. However, very few patients receive all 5 interventions, suggesting that there is implementation difficulty.

There is insufficient evidence for effectiveness of computer or mobile technology in supporting COPD self-management. A Cochrane review found some improvements for health-related quality of life versus face-to-face/hard copy delivery, but it's unknown whether this is sustained long-term. One study included also found no effect on health behaviours, and engagement with the programme, crucial to technology-enabled effectiveness, was very low. However, local evaluations of Sound Doctor, an online education platform found improved disease understanding and reductions in GP visits.

Telehealth care involves remote data exchange of patient physiological measures and symptoms to optimise and coordinate COPD management, and has been used in primary care alongside coaching to promote smoking cessation, increase physical activity, medication management and action planning. Evidence shows potential for telehealth coaching in improving self-management behaviours among people with COPD, with benefits in related outcomes (increased physical activity rates, receiving a care plan, and provision of an inhaler skill assessment) found.

For the management of COPD there are a range NICE guidelines that support self-care from primary care, community care and secondary care upon discharge (95). One of the guidelines focuses directly on self-management and includes actions such as:

- Development of an individualised self-management plan in collaboration with the patient and their family members or carers, and reviewing the plan at regular intervals;
- Development of an individualised exacerbation action plan in collaboration with each patient who is at risk of exacerbations, and encouraging them to respond promptly to exacerbation symptoms by following their action plan;
- Discussing and reviewing treatment options;
- Considering a cognitive behavioural component in their self-management plan to help them manage anxiety and cope with breathlessness; and
- Implementing Telephone Health Interventions.

Furthermore, there is a strong association between lower socio economic status and COPD incidence and outcomes; therefore, interventions should focus on reducing health inequalities in this group (96).

Other key recommendations from NICE include, but are not limited to, the following:
Stop smoking - All COPD patents still smoking, regardless of age, should be encouraged to stop, and offered help to do so, at every opportunity.

Inhaler technique - People with COPD who are prescribed an inhaler should have their inhaler technique assessed when starting treatment and then regularly during treatment.
Pulmonary rehabilitation (PR) - People with stable COPD and exercise limitation due to breathlessness should be referred to PR. People admitted to hospital for an acute exacerbation of COPD should start a PR programme within 4 weeks of discharge.
Vaccination and anti-viral therapy – Patients with COPD should be offered the pneumococcal vaccination and an annual flu vaccination.

Additionally, people with COPD are advised to consider planning ahead daily tasks such as showering or shopping as well as taking steps in response to the weather (certain conditions may acerbate COPD symptoms such as hot and humid conditions) (97)

3.3.2.1 Self-management training

Self-management training is considered to be an increasingly important component of treatment and management of COPD; it provides emotional support and assists people with COPD to make changes in their health behaviours that will help them to control the disease and lived well. A 2016 meta-analysis (98) of data from 3,282 patients found that self-management interventions resulted in positive effects on respiratory-related and all-cause hospitalisations and modest effects on 12-month HRQoL. This evidence supports the implementation

of self-management strategies in clinical practice.

Exacerbations Action Plans

Self-management interventions with exacerbations action plans have improved the health related quality of life (HRQoL) for COPD individuals. They have also reduced the number of hospital admissions due to respiratory-related conditions.

However, success is dependent on effective co-operation between patient and healthcare providers (99). Using action plans for managing exacerbations of COPD within a self-management intervention provides training for people with COPD to recognise symptoms earlier, accelerate the initiation of appropriate treatment, and lead to better control of deteriorating symptoms. Robust evidence from a Cochrane Review[21] in 2017 shows that COPD self-management interventions that include exacerbation action plans[22] are associated with improvements in health-related quality of life (HRQoL) and lower probability of respiratory-related hospital admissions when compared to 'usual COPD care' (99).

3.3.2.2 Care Bundles for COPD

Care bundles are packages of interventions which aim to improve care and ultimately outcomes. They are intended to be delivered during hospital stay (either at admission or before discharge) and include:

- Checking inhaler technique and medication use;
- Providing a written plan for COPD management and supply of emergency medicines;
- Assessing willingness to stop smoking (where applicable);
- Assessing suitability for pulmonary rehabilitation; and
- Arranging for follow-up within two weeks of discharge.

COPD Care Bundles

Designed to be delivered during hospital stays or prior to being discharged. Care bundles are made up of certain interventions/processes which need to be delivered, to improve care for COPD patients. A recent study showed not all interventions are generally delivered and there is no evidence to suggest that these are effective in preventing readmission or reducing lengths of stay in hospital.

However, a recent large-scale study of 31 NHS hospitals over two years found that

[21] Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognised as the highest standard in evidence-based health care. They investigate the effects of interventions for prevention, treatment and rehabilitation.

[22] COPD exacerbation plans provide a guide to the individual to follow if their COPD related symptoms get worse or flare-up (COPD exacerbation).

less than 30% of people admitted with COPD received all five interventions in the care bundle (100). There was also no evidence of benefit found in terms of readmission rates, length of stay or costs. The study suggests that very few tasks were delivered as planned, as care bundles are difficult to implement. More research is therefore needed to find out which components of the care bundles for COPD are hard to implement and why. Until this is understood, the care bundles approach is unlikely to be cost-effective.

3.3.2.3 Pulmonary Rehabilitation for COPD

Pulmonary rehabilitation (PR) is one of the key recommended approaches in the treatment and management of COPD. Exercise is an important component of PR; however, other interventions such as education, psychological support, and dietary advice can be included. There is strong evidence for the benefits of PR. It has been found to improve the health-related quality of life (HRQoL), relieves dyspnoea (breathlessness) and fatigue, improves emotional functioning and enhances the sense of control that individuals have over their condition (101). These improvements are moderately large and clinically significant.

An example of a comprehensive community-based rehabilitation programme for COPD patients is COPE-active in the Netherlands. It is a community-based physiotherapeutic exercise programme within a self-management programme, with a main goal of achieving behaviour change towards exercise in daily life. One study of 153 participants randomly assigned them to either the intervention (COPE-active) or the control group. All patients attended four self-management sessions, and patients in the intervention group participated in an 11-month community-based exercise programme led by physiotherapists. Intervention group patients trained three times per week for six months and two times per week during the subsequent five months. Results found the exercise programme to be effective in maintaining higher levels of daily physical activity (avg. 1193 steps per day more) after 2 years. However, the intervention did not result in increased maximal exercise capacity (102).

Pulmonary Rehabilitation

Evidence highlights that exercise can significantly improve COPD symptoms, such as breathlessness and fatigue. A PR programme in the Netherlands showed that the exercise programme enabled patients to effectively maintain higher levels of daily physical activity after 2 years. Although, the intervention did not increase their maximal exercise ability, it was still effective in allowing patients to maintain daily physical activity.

3.3.2.4 Computer or mobile technology

A Cochrane Review in 2017 evaluated the effectiveness of interventions delivered by computer and mobile technology versus face-to-face or hard copy/digital documentary-delivered interventions, or both, in facilitating, supporting, and sustaining self-management among people with COPD. The review showed some evidence for improvements to HRQoL but it is unknown whether this can be sustained past 4 months. Overall, there is insufficient evidence of effectiveness of computer or mobile technology as a means to support COPD self-management (103).

Technology and COPD

There is insufficient evidence to suggest that the use of technology, over face-to-face or digital interventions, is more effective in supporting COPD self-management.

One of the studies in the above review, a 2015 Dutch trial, tested the effectiveness of a web-based, computer-tailored COPD self-management intervention on physical activity and smoking behavior. Of the 1,325 participants, 1,071 (80.8%) completed the 6-month follow-up questionnaire. No significant treatment effect was found for either physical activity or smoking. However, the web application was used by only 36% of the participants in the experimental group. As engagement with the programme has been shown to be crucial for the effectiveness of computer-tailored interventions, this may be the reason for lack of efficacy (104). It is key to ensure that patients attend support sessions and make regular use of resources in order to achieve self-care benefits.

3.3.2.5 Telehealth for COPD

Telehealth care involves the remote data exchange of physiological indicators and symptoms, allowing health care personnel to optimise and coordinate the management of individual patients' chronic disease. To evaluate the effectiveness of telephone health coaching on COPD self-management, 577 patients from 71 general practices in England participated in a trial of a telehealth coaching intervention. The coaching was delivered by a nurse to support self-management in a primary care population with mild symptoms of COPD. The intervention was underpinned by Social Cognitive Theory and the

Telehealth and COPD

There is great potential in implementing telehealth interventions to increase self-management activities in COPD patients. A trial study showed that the COPD individuals who received coaching by a nurse on self-management reported more physical activity, with more receiving a care plan, antibiotic rescue packs, and inhaler use technique demonstrations.

coaching promoted accessing smoking cessation services, increasing physical activity, medication management, and action planning (4 sessions over 11 weeks; postal information at weeks 16 and 24). The control group received a leaflet about COPD and no coaching. Compared with patients in the control group, the intervention group reported greater physical activity, more had received a care plan, rescue packs of antibiotics, and an inhaler use technique check. However, there was no difference in HRQoL scores between the groups after 12 months. This trial shows potential for telehealth interventions to increase self-management activities in COPD patients (105).

3.3.3 Heart Failure

KEY FINDINGS

NICE guidelines state that certain actions should be done to support people with heart failure to self-care. These include giving the person regular monitoring & clinical assessments, providing lifestyle support, and offering personalised rehabilitation & vaccination programmes.

A Cochrane review found evidence that cardiac rehab leads to a reduction in hospitalisation of people with heart failure, and an improvement in health-related quality of life. Evidence from the review suggested that these improvements are seen if people with heart failure have access to *any* level of cardiac rehab.

There is some evidence that collaborative care – where the patient is seen by a range of health professionals, rather than just their GP – can potentially help in supporting people with heart failure to self-care. A study on heart failure patients who were engaged in a symptom-directed, collaborative care (CASA) intervention showed a reduction in levels of depression and fatigue experienced by participants.

Mental health issues are common in people with heart failure, and can have an impact on a person's self-care behaviours. Depression can increase the risk of hospitalisation and mortality in people with heart failure. Cognitive Behavioural Therapy has been shown to be an effective treatment for depression in people with heart failure.

There is mixed evidence on the effect telehealth interventions have on people with heart failure.

For most people, heart failure (HF) is an LTC that can't be cured. Nevertheless, treatment can help keep the symptoms under control, possibly for many years. Three key self-care behaviours important to health outcomes include medication adherence, diet (low sodium intake), and seeking timely medical care for escalating symptoms (5). Patient's ability to recognise symptoms and take appropriate steps in a timely manner is an area where self-care commonly fails (5).

As with diabetes and COPD, treatment and care for those with HF should take into account the needs and preferences of the patient. It is recommended that patients, in partnership with healthcare professionals, are involved in making informed decisions about their care and treatment.

NICE guidelines state a number of actions that should be followed in order to provide the person with the best care and best chance of self-managing their condition effectively; these include, but are not limited to:

Monitoring treatment – regular monitoring including clinical assessments, cognitive status, nutritional status and reviews of medication. More detailed monitoring if the patient has significant comorbidity or if their condition has deteriorated since the previous review;

Advice and support around lifestyle support - Patients with HF should receive lifestyle advice including salt and fluid intake, advice about not smoking and alcohol consumption;

Cardiac Rehabilitation (CR) - Adults with stable HF should be offered personalised, exercise-based CR programme. The service should include a psychological and educational component; and

Vaccination and anti-viral therapy - Patients with HF should be offered the pneumococcal vaccination and an annual flu vaccination.

Evidence demonstrates that patients with HF can be supported to change their self-care behaviours and have better health outcomes. However, not all interventions are effective (106). A recent meta-analysis of 20 randomised trials (5624 patients) evaluating self-care interventions in HF patients found that interventions of longer duration reduced mortality risk, risk of HF related hospitalisation, and HF-related hospitalisation at 6 months post-intervention (106).

3.3.3.1 Cardiac Rehabilitation

A Cochrane review of 44 trials of exercise-based CR found improvements in HRQoL, and all-cause and HF-specific hospitalisations (although did not reduce risk of all-cause mortality). Additionally, when looking at the structure of the programmes and delivery, improvements appeared to be consistent, with no differential effects found. This suggests that no matter how comprehensive the programme is, it is likely to see positive patient outcomes (107).

A simple intervention that does not require a lot of resource to support is diary use. Evidence has shown that patients who were engaged in diary use to monitor weight and symptoms had better survival rates (108).

Cardiac Rehabilitation

With consistent results and improvement in the health related quality of life in HF patients, cardiac rehabilitation programmes have yielded positive outcomes for patients.

3.3.3.2 Close Symptom Monitoring

The Collaborative Care Model (CCM) has previously been proven to be effective for a number of mental health conditions and emphasises the need for close monitoring of patient progress and systematic adjustments to treatment. CCM incorporates three core concepts:

population-based care, measurement-based care and stepped care. In CCM, provision of care and health outcomes are defined based on the population of patients; each patient's progress is closely tracked using validated clinical rating scales; treatment is systematically adjusted, i.e., if patients do not improve as expected, initial adjustments can be made.

A 2017 trial explored the efficacy of CCM for HF patients (109) by administering the intervention to an experimental group and monitoring the results through caregivers and the case nurse. Compared with usual care, CCM significantly enhanced self-care abilities of patients with chronic HF, including self-care maintenance, self-care management and confidence. Moreover, CCM significantly improved the physical and mental quality of life of participants. This suggests that, compared to usual care, a personalised, collaborative approach has the potential to improve self-care, quality of life and the cardiac function of patients with HF.

Collaborative Care Model (CCM)

The provision of care in CCM is based on the population of patients receiving a personalised and collaborative approach, between the care team and caregivers, for the patients' health needs.

A CCM trial for HF patients showed that their overall physical and mental quality of life significantly improved, in comparison to receiving the usual care for HF.

However, a further study (110), involving a multidisciplinary, symptom-directed, collaborative care intervention (CASA) did not show any health outcome improvements in patients with HF. The CASA intervention included three components: symptom care by a nurse, psychosocial support by a social worker, and palliative care, treatment review and tests by a specialised multidisciplinary team. The intervention was focused on the patients' choice of one of the following symptoms: pain, breathlessness, fatigue, or depression, and was carried out mostly by telephone. There were no significant changes to heart-failure specific health outcomes or mortality, but there was an improvement seen in secondary outcomes such as depression and fatigue.

Overall, this suggests the collaboration of the care team with caregivers might be more effective in improving health outcomes and self-care ability in heart failure patients rather than adding highly specialised professionals to the team.

3.3.3.3 Structured Education for HF

There is limited evidence to show how structured education (SE) impacts the ability to self-care in HF patients. The delivery of SE can take multiple forms and can be delivered by varied clinical and non-clinical staff. Current evidence focuses on groups of patients from rural areas, and has found improvements in self-management skills and self-care behaviours, but limited impact on rehospitalisation.

For example, one trial was conducted in rural China, a trial of a nurse-led structured educational intervention (111) delivered during hospitalisation and after discharge. This resulted in improved self-management skills in patients with chronic HF and reduced the readmission rate within the first 12 months of implementation.

Structured Education for HF

Currently there is not enough evidence to highlight whether SE is effective in impacting a patient's ability to self-manage their HF condition.
Results from clinical trials in rural areas have highlighted different results, though the programme structure was similar. One trial reduced the readmission rate within first 12 months after an SE intervention, but a similar trial elsewhere showed the readmission rate to be higher after 30 days.

A similar study, the PATCH intervention (a home-based activation intervention) was trialled on 100 HF patients discharged from a rural critical access hospital. PATCH consists of a 12-week self-management training and coaching programme delivered by telephone and tailored to clients' activation levels[23]. The intervention group reported significantly greater improvement in self-care behaviours (weighing themselves, following a low-sodium diet, taking prescribed medication, and exercising daily) than the usual care group. These improvements were maintained at 3- and 6-months following discharge. However, the readmission rate after 30 days was higher in the PATCH intervention group (19.6%) than the control group (6.1%) though these differences were not seen at 90 or 180 days (112). This shows that such approaches might be of particular effectiveness for populations which have reduced access to cardiac management services.

3.3.3.4 Mental Health Interventions for HF

A more light touch way of delivering structured education (SE) is through SMS messages or structured telephone support. One study looked at the impact of SMS messages and structured telephone support versus usual care on self-care ability and hospital readmission following discharge.

This intervention involved educational information through text and reminder SMS. The educational messages were condensed with information about HF

Technology and HF

Due to the low cost and positive effects, SMS based interventions and telephone support could be a useful tool for HF patients in self-managing their condition.

[23] Patient activation level is the level of knowledge, skills and confidence an individual has to manage one's own health and healthcare. It refers to one's understanding of the importance of self-managing their condition and the confidence that they can do so. Patient activation is assessed with the Patient Activation Measure (PAM).

(e.g. symptoms of HF decompensation), while the reminder SMS were brief messages that prompted patients to take action (e.g. taking medicine or weighing). It was found that SMS was associated with a reduction in all-cause mortality/readmission at 180 days as well as improved self-care behaviour when compared to usual care (113). Due to the low cost and potential positive effects seen in this trial, this suggests integrating SMS interventions into HF management could be a useful aid.

Cognitive Behavioural Therapy (CBT)

Effective in treating mental health issues and changing behaviour, CBT has been proven to be effective in reducing anxiety and fatigue in HF patients, as well as increasing the health related quality of life. Though there was no improvement in self-care behaviours, this evidence suggests that CBT can improve mental health and quality in life in HF patients.

Depression and inadequate self-care are common, interrelated problems that increase the risks of hospitalisation and mortality in patients with HF. Cognitive behavior therapy (CBT) has been found to be effective in treating a wide range of mental health issues as well as changing behaviour.

A 2015 clinical trial tested the efficacy of a CBT intervention for depression and HF self-care on 158 patients. Compared to usual care, anxiety and fatigue scores were lower while mental health, HF-related QoL and social functioning scores were higher after 6 months in the CBT group. Additionally, fewer hospitalisations were registered for those receiving the intervention. However, self-care behaviours saw no improvements in either group (114). Cognitive behavioural therapy may be an appropriate accompanying therapy for improving mental health and QOL in HF patients.

Telehealth and HF

Evidence suggests that telehealth may not be the most cost-effective option in delivering self-care for HF patients. Trials and studies have showed varying results, with significant improvements in mental health, but no consistent advantages in physical health.

3.3.3.5 Telehealth for HF Patients

Evidence of telehealth interventions for patients with HF is mixed. For example, an RCT in 2019, demonstrated statistically significant improvements in HRQoL when looking at mental health measures, but not in physical health (115). Similarly, a 2017 meta-review of telehealth interventions to support self-care of long-term conditions (including HF) compared results from 53 systematic reviews (9 of which were HF specific). The meta-review did not find a consistent advantage of telehealth support compared to usual care, though some of the reviews included did indicate reduced mortality and hospital admissions and no negative effects were reported (116). This suggests that telehealth care is a safe option for delivering self-care

support for HF, but may not be the most effective option. A heart failure specific meta-analysis of studies looking at the effectiveness of telemonitoring and telephone support found that cost effectiveness was dependent on the intensity and the technology used in the intervention. However, most studies showed decreased costs due to fewer hospital stays (117).

3.3.4 Self-care in the presence of multimorbidity

KEY FINDINGS

At the time of this report, there are no QOF measures for multimorbidity. This makes it difficult to look at STP level variation in self-care support offered to people with multimorbidity.

The evidence base on interventions designed to support people living with multimorbidity is underdeveloped and mixed.

A 2012 Cochrane review looking at interventions for improving outcomes in people with multimorbidity found no clear improvements in terms of clinical outcomes, health service use, medication adherence, health behaviours, or cost. Other reviews have shown modest improvements in terms of patient mental health, and functional outcomes.

The review suggests that interventions designed to target specific risk factors (e.g. support with depression) may be more effective.

Multimorbidity is usually defined as the presence of two or more LTCs in the same individual (118). NICE defines the LTCs that multimorbidity can include as being wider than this traditional definition. The guidance also suggests including: ongoing conditions, such as a learning disability condition; symptom complexes, such as frailty or chronic pain; sensory impairments, such as sight or hearing loss; and alcohol or substance dependency (119).

People with multiple conditions face a greater challenge in that they are required to manage multiple medications, treatment and appointments whilst also attempting to maintain their general physical and emotional health.

As of 2018/19, there were no QOF indicators specifically for multimorbidity. However, NICE guidelines published in 2016 set out key good practice actions that relate mostly to care within Primary Care settings (119). These include:

- The use of validated tool such as eFI, PEONY or QAdmissions, if available in primary care electronic health records, to identify adults with multimorbidity who are at risk of adverse events such as unplanned hospital admission or admission to care homes:
- Assessment for frailty within primary care or community care;
- Establishing disease and treatment burden of the patient and being alert to possible mental ill-health;Reviewing ways to reduce treatment burden, for example through non-pharmacological means; and

- Establishing patient goals and ways to stay independent, and agreement of an individualised management plan.

The evidence base on interventions designed to support people living with multimorbidity is still underdeveloped (120). This group are the most challenging to support particularly through a single intervention or activity. For example, a Cochrane Review in 2012 (121) of interventions for improving outcomes in patients with multimorbidity in primary care and community settings found mixed results. There were no clear positive improvements in clinical outcomes, health service use, medication adherence, patient related health behaviours, health professional behaviours or costs. However, seven studies included in the review illustrated modest improvements in mental health outcomes for patients with depression. Two other studies targeting functional difficulties in participants also found improvements in functional outcomes. The review suggests that interventions designed to target specific risk factors (for example treatment for depression) or interventions focused on difficulties that people experience with daily functioning (for example physiotherapy treatment to improve capacity for physical activity) may be more effective.

Patients with COPD and chronic HF face similar problems relating to breathlessness and disability. Research in the UK in 2016, suggests that existing pulmonary and cardiac rehabilitation services should seek to provide sufficient flexibility to accommodate patients with both conditions. Development of new services could consider adopting a patient-focused rather than disease-based approach. Exercise training is a core component, but rehabilitation should include other interventions to address wider symptoms such as breathlessness, psychological and educational needs of patients and needs of carers (122).

3.4 Patient Activation and PAM

There is growing evidence that person-centred approaches to care can lead to improved health outcomes, especially for people with multiple conditions (120). Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. People with greater patient activation benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions (13). Rather than making assumptions about a person's ability to self-manage, tools such as the Patient Activation Measure (PAM) can help determine which types of support people may need by building on existing capabilities.

The Patient Activation Measure (PAM) is particularly helpful at assessing the activation level and quantifying improvement. To assess the activation level, individuals are asked to answer a series of questions and are scored accordingly. The total score places the individual at one of the four levels of activation, from level 1, where individuals tend to be disengaged and overwhelmed, to level 4, where

individuals are highly engaged in their care and have adopted many healthy behaviours.

However, understanding the level of patient activation is not sufficient for a successful intervention; support needs to be built on assessing and addressing barriers faced by ill patients. A recent study of more than 12,000 PAM questionnaires from 9,348 patients found that the most activated patients (level 4) have the lowest utilisation of healthcare, with fewer GP appointments, outpatient and A&E attendances, or emergency admissions (123).

Following the Kings Fund Report on patient activation (13) in 2014, the NHS has piloted PAM in 5 CCGs and the UK Renal registry. Due to positive results, in partnership with Insignia Health, NHS purchased licenses and pushed for a national use of PAM. By April 2019, 138,000 licenses were used across more than 100 sites nationwide.

3.4.1 Barriers to self-care

KEY FINDINGS

Factors affecting self-care do not act in isolation. Self-care should not be thought of solely at an individual level – family and community play a large role in encouraging self-care.

A 2019 literature review by the Aubrey Keep Library & Knowledge Service identified two types of barriers to self-care: the built system and personal factors:

- Built system barriers include access to services. This barrier particularly affects people with multimorbidity, due to a lack of access & coordination, poor communication between service providers, and little to no data sharing. People in vulnerable or underrepresented groups are also affected by this barrier. They often find it harder to access services. This can act as a driver for health inequalities.
  New models of care and integrated care partnerships are aiming to reduce these inefficiencies
- Examples of personal factors which impact on self-care are where people live (personal home & community), and the work they are employed in. Personal home & community barriers include transport links, and the level of support people receive from close friends & family members. Experience of stigma or lack of support from close friends & family members can negatively influence a person's capability to self-care.

A recent metasynthesis by Schulman & Green found that three major factors which influence self-care are financial resources, self-care equipment, and psychosocial support. Access to, or lack of, any of these factors can have a large impact on a person's capability to self-care.

Personal characteristics also have an impact on self-care. An individual's culture and beliefs play a role in self-care, and health professionals should be mindful of this when supporting people to self-care. A lack of knowledge about their long-term condition, and life transitions (such as losing a job, or birth and bereavement) have also been identified as potential triggers which make it hard to maintain self-care routines.

To better support people to increase their activation and ability to self-care, it is essential that healthcare professionals assess the existing barriers to accessing resources and building the skills required to self-care for individual patients. A recent literature review (December 2019) completed by Aubrey Keep Library and Knowledge Service[24] identified evidence that describes barriers in two categories, the built system and personal factors.

The built system refers to both environmental factors and the healthcare system. The healthcare system is particularly inefficient for people with multimorbidity due to a lack of access and coordination, poor communication with and between service providers, and little or no data sharing (124; 125). Access to care services is predominantly a barrier to those who are part of vulnerable groups, acting as a driver for further health inequalities. New models of care and integrated care partnerships are aimed at reducing these inefficiencies; however, while proven to be cost-effective and positively impacting patients' health, implementation is key to their success.

When it comes to the environment, where people live (personal home and community) and work plays a great role in their ability to self-care. For example, the most notable barriers in the community are transportation and availability of healthy food options. The lack of both hinders the ability to adopt healthy lifestyle behaviours. Additionally, relatives and friends can play an important role in negatively influencing a person's capability to self-care. A lack of understanding of one's chronic illness, or, even worse, stigmatising them for their illness can result in a lack of support and pressure that prevents them from properly self-caring. Simple actions such as serving unhealthy foods at family dinners or social events act as barriers to maintaining or adopting a healthy diet. Furthermore, those who work can face additional barriers to adopting healthy diets, exercising, or complying with their medication dues to time and schedule constraints (125).

Personal characteristics are grouped into three main areas: lifestyle characteristics, health status and resources (see figure 3.1 for more details on the type of barriers in each area).

Some notable examples of lifestyle characteristics that health professionals should be mindful of are those relating to culture and beliefs. For example, studies show that patients of Vietnamese ethnicity might consume foods that are not recommended if offered by others to avoid offending them (125). Furthermore, healthcare professionals should be mindful of patients who are practicing Ramadan or other types of fasting, and advise them accordingly. Patients who come from different cultures might struggle to adhere to a prescribed diet and lifestyle if it is against what they believe in.

Additional to the resistance to change due to culture and beliefs, patients might struggle to adhere to prescribed programmes due to a lack of knowledge about their condition. The health belief model (126), a behavioural change model, explains how understanding of the

[24] Evidence search: Barriers to accessing long term conditions self-management interventions. Lisa Burscheidt. (6th December, 2019). ILFORD, UK: Aubrey Keep Library and Knowledge Service.

susceptibility to complications, severity of the disease and benefits of the treatment are critical to successful lifestyle changes or treatment adherence.

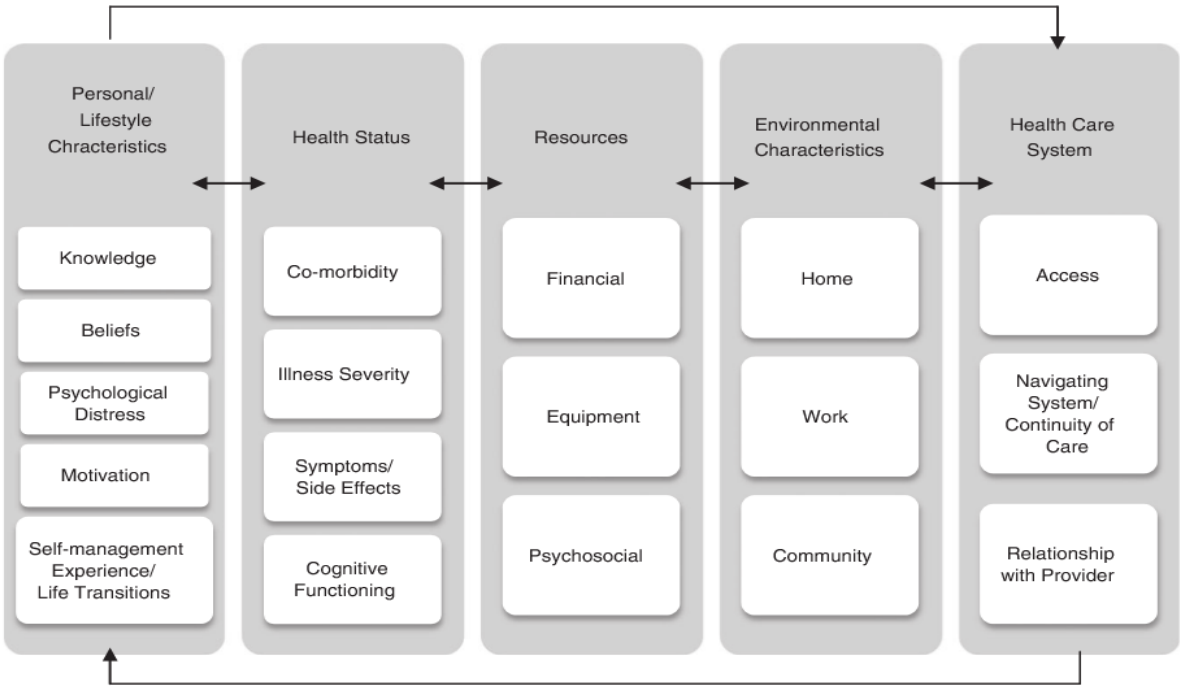


Figure 3.1 Barriers to self-care

Life transitions can also add difficulty to adopting and maintaining healthy changes. For example, the uncertainty unemployment brings, the lack of a structure in a college student's life, and life changing events, such as giving birth or bereavement, highly impact on adherence to certain healthcare routines (125). Getting older is also a life transition that has been documented to impact on self-care. People of older age might struggle with physical and mental abilities, have comorbidities and other complications, and take numerous medications at a time (127).

Health status also influences how people adhere to self-management practices. Comorbidities and complications add complexity to health regimens, and contribute to symptoms that reduce one's self-efficacy[25] and overall effort (125). The prescription of numerous medications or treatments, known as polypharmacy, to one individual can result in a high treatment burden and can be difficult and stressful to manage (128). Co-morbid mental health problems can reduce ability and motivation to self-manage, and people with these forms of co-morbidities may need particular support if they are to self-care effectively. It is also complicated by the fact that those with mental health problems also have higher rates of unhealthy behaviours such as smoking, and also higher rates of non-compliance with medication compared to those without mental health as a comorbidity (129). Recent evidence

[25] Self-efficacy is a person's estimate or confidence of his or her own ability to succeed in reaching a specific goal, for example, quitting smoking or losing weight. Enhanced self-efficacy has been shown to be a consistent positive influence self-care.

indicates that people with co-morbid mental health problems can gain particularly large benefits from inclusion in self-management support programmes, suggesting that they should be targets for referral. Peer support may also play an important role in empowering people with co-morbid mental health problems to manage their own condition (130).

According to Schulman-Green's metasynthesis (125), resources that influence self-management include: financial resources, equipment and psychosocial support. Financial resource barriers are more likely to impact on vulnerable groups and play a key role in health inequalities. Financial instability leads people to focus on their economic survival and basic needs, rather than focusing on living a healthy lifestyle or following a prescribed treatment (125). The high cost of medication, healthy foods, and gym memberships can act as barriers to accessing resources that support self-care. Moreover, assistive devices such as smartphones, internet, and other electronic equipment cost patients money if not offered by the care team (125). Additional to the financial burden, the need of such equipment can act as a barrier to people with lack of digital literacy[26]. The internet could also hinder the ability to self-care because of the overwhelming amount of information available and the difficulty to distinguish between factual and non-factual information (131).

Factors affecting self-care do not act in isolation, and can interact and affect the ability and motivation to engage in proper self-care (125). Self-care should not be thought of solely at an individual level, but also at the family and community level. Isolation is an important factor that influences people's ability to self-care. People of older age tend to struggle with this the most (132). Peer support groups have been highlighted as extremely beneficial for people, enabling them to find a community and feel supported and connected (125).

3.4.2 Condition specific barriers

Each condition people suffer from has its own particularities and self-care can be affected by barriers specific to that condition. The table below (Table 3) lists the condition specific barriers described by the current literature.

Table 3 LTC specific barriers

Diabetes	**Personal** • Health literacy and knowledge , specifically knowledge of a diet plan, lack of understanding of the plan of care (133; 134) • Helplessness and frustration from lack of glycaemic control and continued disease progression despite adherence (133) • Lack of formal education (135) • Language barriers (peer support programmes) • Lack of awareness of existing programmes

[26] Digital literacy refers to an individual's ability to find, evaluate, and compose clear information through writing and other mediums on various digital platforms. While digital literacy initially focused on digital skills and stand-alone computers, the advent of the Internet and use of social media, has caused some of its focus to shift to mobile devices.

	• Age (135) • Perception that the physician needs to manage the disease with little or no input (136) • Low perception of seriousness and susceptibility to complications (136) • No or low perceived benefits of attending structured education (136) • Polypharmacy as diabetics tend to have comorbidities (134) • Comorbidities, for example shortness of breath could contribute to inability to exercise (128) • Symptoms and side effects, particularly pain and fatigue (128) • Cost of medication or assistive devices (134) • Lack of time – competing priorities (134) Community • No social support (134) Care provider and healthcare system • Patient-physician communication and relationship (135; 134) • Lack of physician or care provider follow-up with the patient (134)
COPD	Personal • Patient knowledge and understanding of the disease and beliefs about medication (137; 138) • Health literacy (137) • Language barriers (137) • Cognitive problems (137) • Disease severity (137); Patient frustration with the disease taking over their life (139; 138) • Patient lack of self-efficacy and digital literacy to use digital technology (139) • Patient perception of services being too stretched to treat them (138) • Fear of being judged for unhealthy behaviours – such as smoking (138) • Lack of motivation particularly within older or multimorbidity population (138) • Short time since diagnosis, lack of trial and error, adaption, and normalisation. (138) • Mental health: Anxiety, panic, and fear due to symptoms; frustration, depression, low mood, and worthlessness due to loss of functionality can impact on motivation (138) Care provider and healthcare system • Physician time constraints and insufficient resources to create an action plan (137; 138) • Physicians or care providers lacking trust that the patient is able to self-manage or understand the instructions (137; 138) • Physicians lack of knowledge and skills to create an individual care plan or action plan (139; 137; 138) • Physicians feel more comfortable with a traditional health care approach (139; 137; 138)

	• Lack of a pathway or structured programme, poor communication between health professionals and lack of understanding regarding referrals (139; 138) • Frustration with conflicting information from health professionals (138) • Patient perception of services being too stretched to treat them (138)
HF	Personal • Depression (20-30% of HF patients) and depressive symptoms (42; 140) • Cognitive decline (30-75% HF patients) commonly includes: deterioration in memory and learning, attention, executive function, psychomotor speed, and visuospatial recall (42; 140) • Decreased levels of self-efficacy (42) • Physical limitation, feeling a lack of energy (140) • Feelings of hopelessness relating to decision making and motivation for symptom management (140) • Perceived social support (42) • Avoidance, acceptance and/or denial to obtain new information about caring for themselves, and to participate in decision making (140) • Misconception about CHF / medical and regimen adherence (140) • Cultural issues, health seeking behaviours, using herbal medicine (140) • Lack of understanding about the benefit of self-care action such as salt limitation (140) • Financial burden (140) • Side effects of medicine and interference in work and normal life (140) • Multimorbidity (42; 140) • Insufficient knowledge (140) • Poor communication skills (140) • Adverse coping mechanisms (140) • Atypical and puzzling symptoms of CHF (140) Community • Loneliness (140) • The size and diversity of one's social network or capital (informal connections available for support, help, and information) (42) • Poor family functioning (140) • Lack of family knowledge/ misconception about treatment preference (140) Care provider and health system • Lack of facilities / access to medical care (140) • Conflict between values of patients and nurses (140) • Insufficient knowledge of educators and nurses (140) • Dissatisfaction with care received (140) • Lack of trust physicians / medical system (140) • Confusing or contradictory information provided by multiple healthcare providers (42; 140) • Complexity of the self-care process (140)

CHAPTER 4

DISCUSSION AND RECOMMENDATIONS

4.1 Impact Modelling

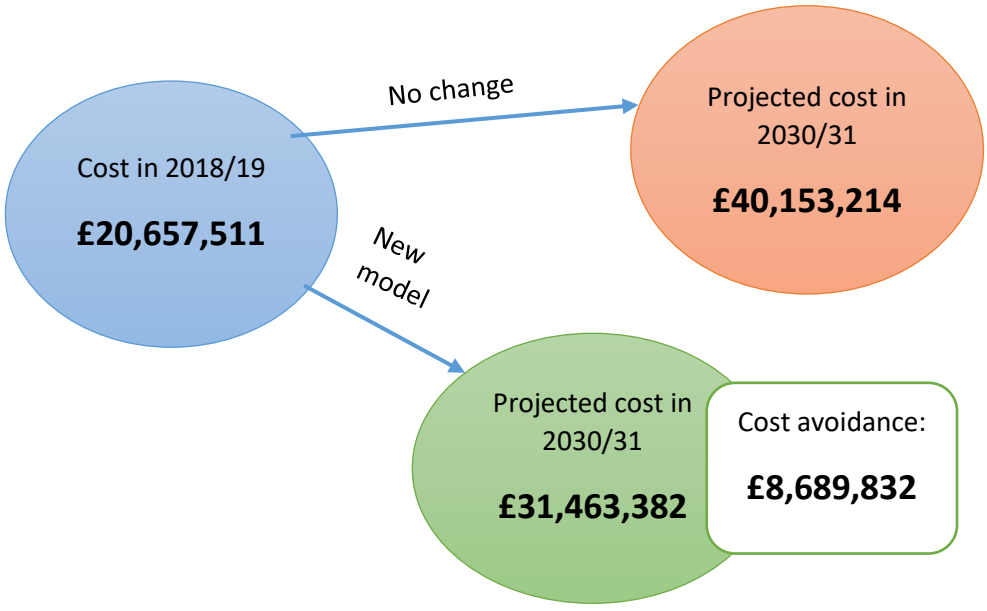
Mid and South Essex, similar to the whole of the UK, is facing pressing challenges and struggling to meet service demand. The STP population is growing and ageing, adding complexity to their needs. The health and social care system needs to rapidly adapt in order to remain financially sustainable and effective. Based on our analysis, in 2018/19 more than £20 million was spent on hospital care alone across the STP for patients with Diabetes, COPD and HF. This is an under-estimation of how much these LTCs cost the system as we only quantified visits to A&E, emergency admissions and elective admissions which were coded as being related to the three LTCs. With no change to how we support patients to self-care, this amount will almost double by 2030 (see figure 4.1).

A good collaboration between service providers and patients, where patients are supported to self-care, is essential to this. The King's Fund describes this shift as a cultural change towards 'shared responsibility for health' and proposes patient activation as a way to conceptualise and measure patient engagement in their own care (141).

The NHS Long Term Plan also highlights the need for a fundamental shift in the way care providers are working with patients and their caregivers. The report calls for a more patient-centred approach where patients are fully involved in planning their care. The 10-year long plan commits to facilitating better support for patients to improve their skills to self-care, particularly for patients suffering from long term conditions (LTCs).

Investments in building a model of care that supports patients to self-care better are

Figure 4.1: Projected acute care cost for diabetes, COPD and HF



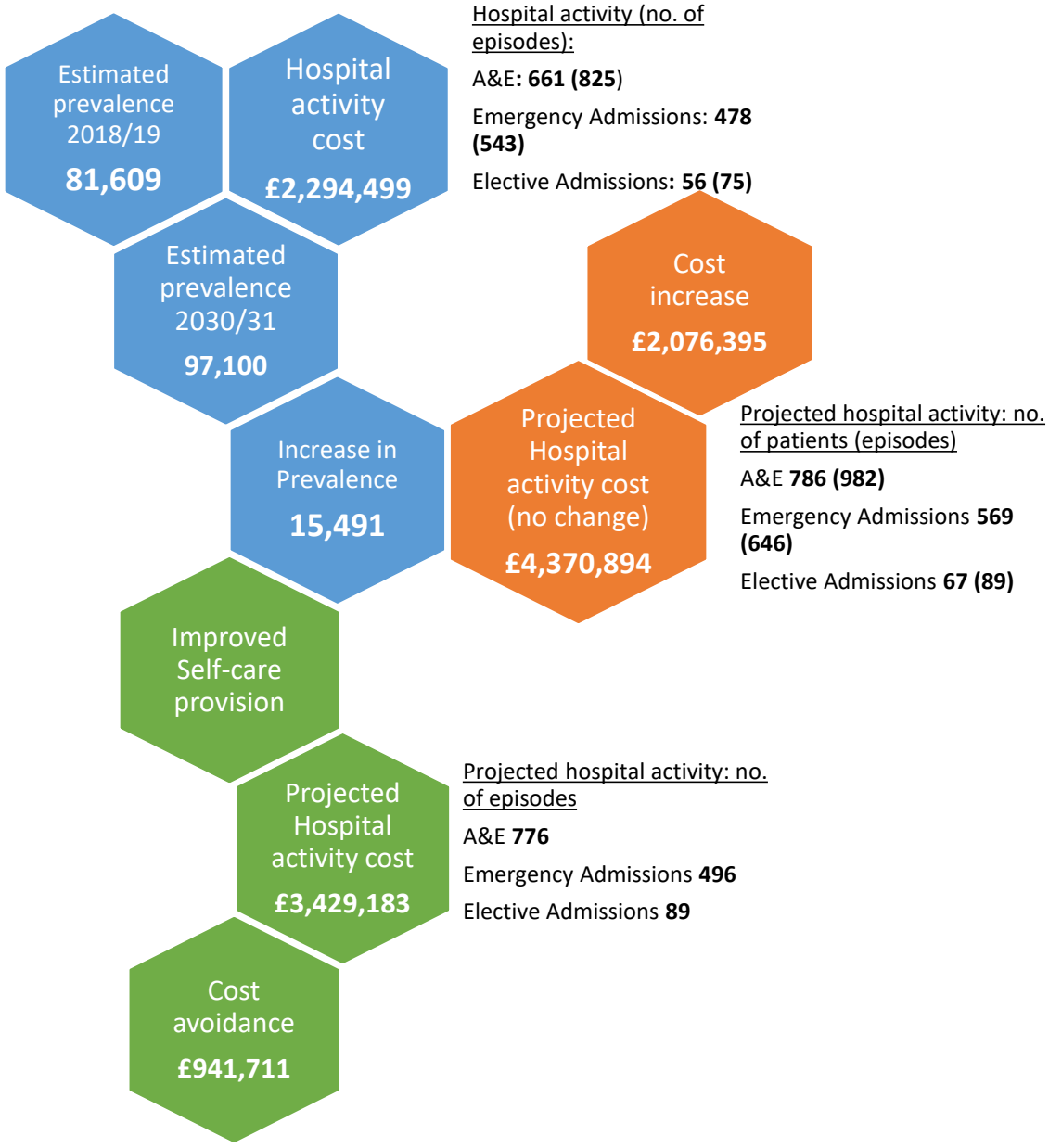
proven to be very cost-effective. For example, studies looking at patient activation show that proper support in primary care results in decreasing utilisation of services, specifically in secondary care. With a 20-point increase in Patient Activation Measure (PAM) scores, evidence shows 9% fewer GP contacts (95% CI, 0.89–0.93), 20.90% fewer A&E attendances (95% CI, 0.75–0.83) and 23.3% fewer emergency admissions (95% CI, 0.71–0.83) per person (123). Moreover, increase in PAM scores also contributes to decreased length of stay, fewer hospital readmissions and reduced 'did not attend' rates for primary and secondary care appointments (25). For Mid and South Essex Health and Care Partnership, this means an opportunity to avoid costs of over £8.6 million by 2030.

Diabetes

As discussed in the Local Context chapter, the estimated number of people with diabetes in Mid and South Essex in 2018//19 was 81,609. Based on local hospital data, eight in 1,000 patients with diabetes accessed the A&E department, six patients in 1,000 were admitted as an emergency and less than one in 1,000 were admitted electively during the year. Modelled estimates show, based on changes in population size and disease prevalence, that by 2030 the diabetes prevalence will increase to more than 97,000 people. Applying the same rate of secondary care activity, it is estimated that A&E attendances will increase by 157 people and emergency and elective admissions by 103 and 14 people, respectively. The financial burden of the increased activity is estimated at almost £700,000. Moreover, when taking into consideration cost increase due to inflation (4% per year (142)), the increase in spend on hospital activity (A&E attendances, emergency and elective admissions) is £2,076,395, almost doubling the current total cost. A model to support decreases in hospital activity is therefore imperative. Due to inflation, even the same level of activity will cost more in 2030. An improved model of care can alleviate the burden by supporting patients to self-care, hence decreasing the activity in secondary care and the cost of each visit.

Currently, every patient attending the secondary care services has a 25% chance of revisiting A&E in the same year, 14% being readmitted via an emergency admission and 34% being readmitted via an elective admission. Despite a steep increase in diabetes prevalence, investment in self-care support can return a decrease in hospital activity as follows see figure 4.2.

Figure 4.2: Projected acute care cost due to Diabetes (scenarios)

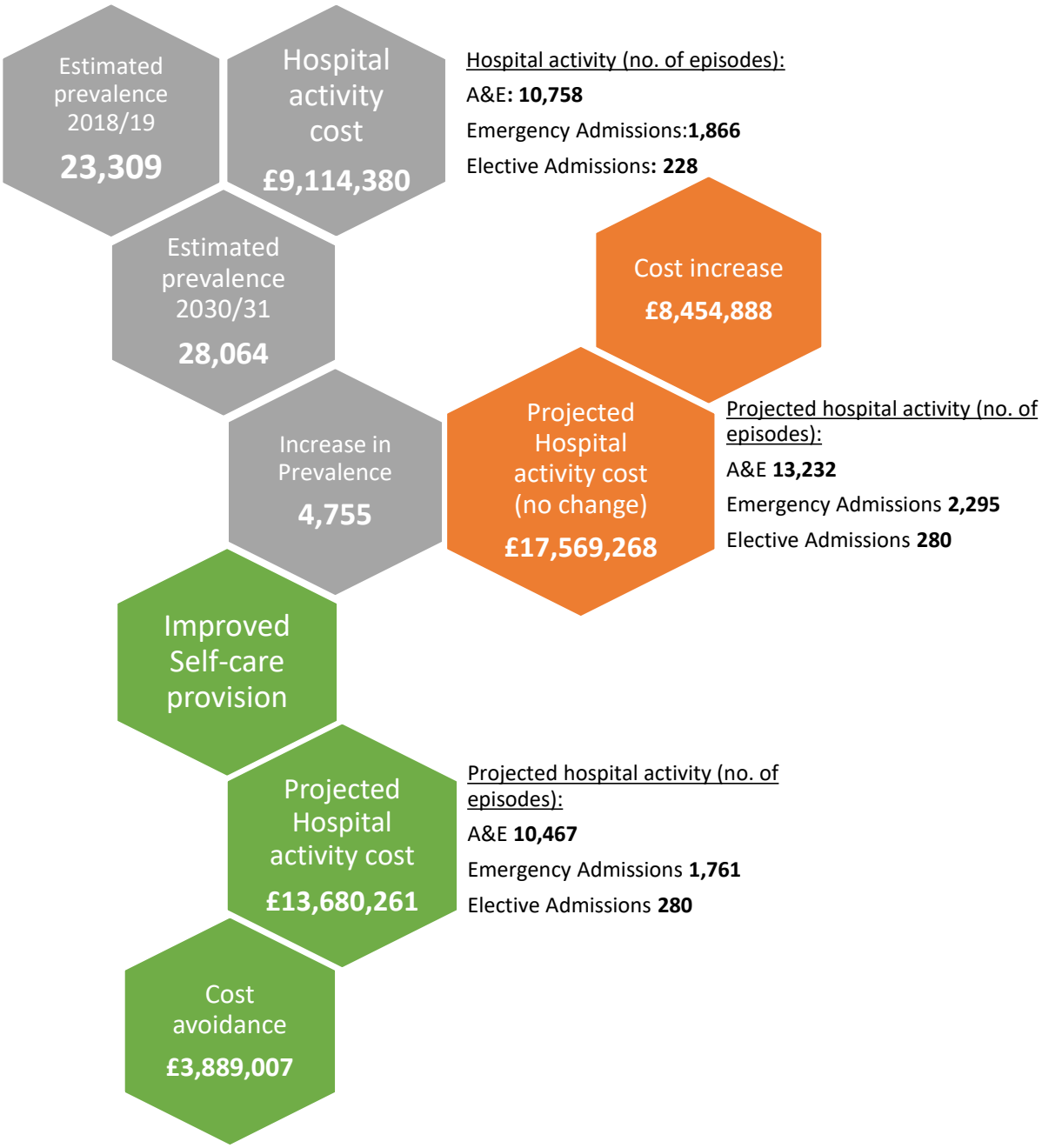


COPD

Similarly to diabetes, COPD cases are projected to increase by 4,755 people across the STP by 2030. Modelled estimates show that no changes to how patients are managed (in primary care and at home) will lead to an increased burden on secondary care of an additional 4,092 A&E attendances, 531 emergency admissions and 22 elective admissions. The total cost of secondary care activity due to COPD in 2030 is estimated at £17,569,268, £8,454,888 more than in 2018/19.

With the appropriate measures in place to empower people to self-care, an estimate of £4 million can be saved through a reduction in hospital activity (see figure 4.3).

Figure 4.3: Projected acute care cost due to COPD (scenarios)

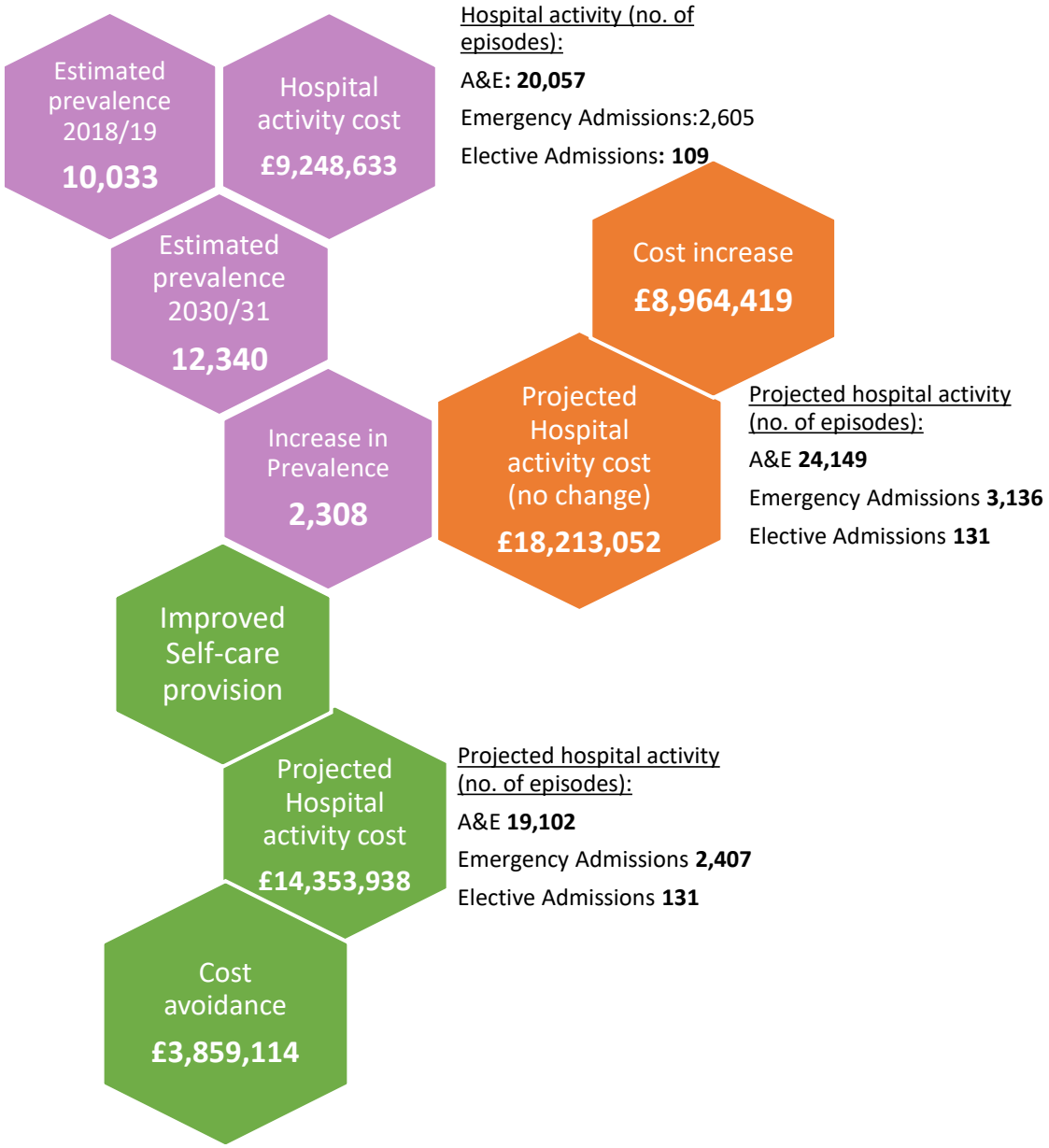


Heart Failure

Heart failure hospital use is the most expensive of the three conditions. In 2018/19 a total of £9,248,633 was spent on hospital care for HF patients (based on local hospital data for A&E attendances). On average, there was at least one attendance to A&E per HF patient (107%), one emergency admission per five patents (19%) and two elective admissions for every 100 HF patients (2%). Data shows an average cost of £200 for A&E, £4,208 for emergency admissions and £2,998 for elective admissions for each patient attending the

hospital with an HF related diagnosis. When adjusting for an increase in prevalence and inflation, the estimated hospital cost across the STP for HF in 2030 is £18,213,052. An improved model can save almost £4 million (see figure 4.4 for more details).

Figure 4.4: Projected acute care cost due to HF (scenarios)



4.2 Recommendations

This report aims to support the implementation of an infrastructure which enables patients to build and improve skills to self-care, to prevent or manage their conditions. Therefore, we are forming recommendations at four different levels: the individual (patient and caregivers), the neighbourhood (GPs, PCNs and local groups), the place (CCG, Council and local organisations) and the system (STP and NHS). The recommendations address the six main themes identified in the previous sections.

4.2.1 Services that contribute to self-care across the STP are fragmented and irregular

Our analysis shows a high number of services from different level providers making an impact on self-care across the STP. However, we identified that people with diabetes, COPD and HF receive a different service based on where they access the services. There is a variability in the offer each area has in place for patients needing support to self-care (see the service map for more information in Appendix 2). The evidence suggests the most effective support has to be multifaceted, with a mixture of direct support, education and online access to resources. This calls for a whole system, coordinated approach to self-care. Moreover, the same type of services seem to have a different structure and format based on the locality they are offered in, and often there is no evidence to back their effectiveness. Additional to aligning the LTC support offer across the STP, there is an increased need to make services consistent and equal by commissioning evidence based services and replicating examples of high performance across the patch.

Case Study 1

In Leeds a three-month long programme involving 11 practices aimed to reduce the variation in nursing care and administrative processes.

Each practice mapped how they worked in some specific areas and then all of the maps were compared. This highlighted a striking variation within practices, leading to a locality wide collaboration and development of a consistent approach. The outcome was reduced misdiagnosis, reduced waiting times and increased information sharing.

"The programme helped us continue building on working on a wider scale, finding out what good practice is and taking the best bits to roll out across the locality." Andrea Mann, Managing Partner, Colton Mill and The Grange Medical Centre and Head of Nursing Quality and Governance Leeds CCG Partnership.

Source:
https://www.england.nhs.uk/gp/case-studies

We know from the previous section that the ability to self-care is not only dependent on the built environment, availability of resources or access to healthcare services. Personal characteristics, one's lifestyle and health status are also possible barriers. Despite these being already documented by evidence, the services that aim to support self-care are rarely jointly produced

Case Study 2

Six rural practices in West Cheshire came together as the Rural Alliance. As part of the Learning in Action programme run by the NHS, they worked collaboratively to tackle common issues and improve patient experience.

The practices implemented a system of sharing GP specialties, IT support, bookings (e.g. diabetes clinics) and best practice, leading to improved access to services across the area.

Making these services available closer to patients' homes, the Alliance is saving them time and money spent on travelling. Patients no longer have to travel into the city for specific clinics and services such as diabetes clinics, sexual health services or dressings.

"In working together we have all found ways to become more efficient and improve patient care. […] We are no longer re-inventing everything six times." Kate Evans, Practice Manager, The Village Surgeries Group

Source: https://www.england.nhs.uk/gp/case-studies

with the users. In order to firstly understand what the desired outcomes are for people who are affected by diabetes, heart failure and COPD, and then to engage with them throughout the entire process of designing, delivering and monitoring and evaluating the services the right systems need to be put in place. Co-production[27] goes beyond the traditional engagement or involvement of users in the process, it recognises that those who use the said services should have an equal say throughout the entire design and delivery process. (143)

Co-design and co-delivery help to:

- uncover and leverage existing assets, resources and networks
- identify opportunities for co-delivered support, taking account of both professional and user perspectives
- better identify opportunities for recovery and independence
- focus on the aspirations of service users, breaking down barriers between services and sectors
- share responsibility for outcomes and a move away from over-dependency on particular services and methods of care
- facilitate a conversation around the possibilities of experience-based evidence

Source: the_power_of_co-design_and_co-delivery.pdf (nesta.org.uk)

Since 2013 when the aforementioned NESTA report was published, co-production, co-design and co-delivery became frequently used terms nation-wide. However, it is often the case that commissioners and health and social care leaders are using the term inappropriately.

[27] Co-production is a method used when designing, delivering and evaluating public health and care services and it involves service user involvement from very early stages of planning. This means working in equal partnership with communities in spaces where power is shared, making services more effective and efficient, and in the long-term more sustainable.

With no changes within the system to put in place the necessary structures for service users to have the power to influence how services are shaped, these terms are only seen as a rebranding of the previous engagement and involvement. A collective ownership of health is only possible when service users feel empowered and are involved in shaping services at all layers of the system. It will require for clinicians to start from the position of not necessarily knowing the right answer and commissioners to build the necessary trust with service users and creating safe spaces for users to genuinely influence the service redesign.

The new development of Integrated Care Systems (ICS) is an opportunity to homogenise services across the area whilst ensuring high quality. Furthermore, Primary Care Networks (PCNs) can additionally support with ensuring quality and reducing the variance at the neighbourhood level. This allows for services to be customised to the specific need of the community they are offered in, whilst following a high level of standards.

The practical guide The King's Fund and Picker have produced on behalf of NHS England and NHS Improvement in 2021 (144) highlights the importance of community involvement in order to accelerate the integration of services. Integrated care is all about person-centred care. Its aim is to increase coordination of services and bring them closer to people for an increased impact on people's health outcomes and experience. However they recognise there is no one-size-fits-all solution and that good involvement requires a range of methods and approaches, but that listening and learning from each other should sit at the core of this.

Anecdotal evidence from Mid and South Essex shows there is overall lack of confidence in adopting co-production methods. This is due to a lack of both skills and resources. This is not to say good quality co-production is not happening locally. Local Healthwatch bodies are at the front of championing community involvement and are currently supporting partners in Mid and South Essex to deliver co-production. Unfortunately, this is not widely spread and there is no clear local framework that commissioners, providers and system leaders can follow.

Issue	Recommendation	Responsible party
There is a need for strategic direction to support a whole system self-care programme As evidence in chapter 2 Service map section and professionals' view, there is variability of offer across the area and no clear understanding of what needs to be done for self-care to become easier to practice.	Develop a joint self-care strategy and joint targets to support the development of a self-care programme that aligns the prevention, early intervention and management agendas and addresses place-based barriers to self-care. The strategy should prioritise: • A consistent approach to education programmes for patients diagnosed with diabetes, COPD and HF, and other LTCs; • New models of care where non-clinical staff, such as social prescribers, coach and support patients to navigate the system; • A digital offer for continuous education and self-monitoring; • Mental health support for patients with a long term condition; • Guidance on health coaching for the newly diagnosed; and • Integration of services between local authorities, Adult Social Care (ASC), and CCGs in order to address the wider determinants of health.	**MSE ICS** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options. And for Diabetes: piloting the MyDiabetes app with 500 newly diagnosed Type 2 diabetics to support them to understand and better manage their condition
Services across the STP are fragmented and outcomes vary For all three conditions discussed and all levels of care – prevention, management and referral – there seems to be a variation in outcomes both at system and place level.	Develop a monitoring and evaluation system for Diabetes, COPD and HF programme outcomes to address high variability at the PCN, CCG and STP level.	**MSE ICS** Aligned with the MSE Five Year plan for Diabetes: Reducing the impact of diabetes among harder to reach/less engaged groups
	Start a Task force to include representatives from community care, voluntary sector, primary care, public health, secondary care and social care to address variability of outcomes and support with integration of services.	**MSE ICS** Aligned with the MSE Five Year plan for Diabetes: Reducing the impact of diabetes among harder to reach/less engaged groups
	Plan Quality Improvement activities to share best practice and address variability of clinical outcomes for the three LTCs at the PCN level.	PCN
	Pool resources to offer education and specialist support to patients who are diagnosed:	PCN

	• Diabetes specialist support for those newly diagnosed with diabetes; • Clinical pharmacists to educate newly diagnosed COPD patients and review patients with exacerbations; • Telehealth capability for online coaching (evidence shows cost-effectiveness for COPD); • Social prescribers to identify mental health needs of patients with long-term conditions; and • Technical support with identifying high impact users of the healthcare system.	
	Develop queries to aid GPs with finding the missing thousands (from disease registers) and patients who are on registers, but are not receiving the recommended treatment and support services.	CCGs/CSU
Service users are not consistently involved in the design, delivery and monitoring and evaluation of the services Recommendations based on the Co-production model from Coalition for personalised care	Develop a clear framework for co-production and a system structure to support providers and commissioners to practice it: • Champion co-production at most senior leadership level, including co-production in local plans such as the local Health and Wellbeing Strategies • Name a co-production lead and assign it under a board such as the Health Inequalities Board • Use open and fair approaches to recruit service users, with an emphasis on under-represented groups • Put systems in place that reward and recognise the contribution people make – pay people for their contribution on order to balance the power • Map system-wide areas where co-production would make most impact and make it mandatory • Involve service users in the shaping of projects and programmes at the very early stages • Provide training and resources on co-production such as the toolkit from Point of Care foundation EBCD: Experience-based co-design toolkit - Point of Care Foundation • Regularly review and report back on changes and progress to maintain residents' involvement	MSE ICS/HI Board

4.2.2 Information is not readily available to patients, providers and commissioners

Providers and patients alike find it difficult to identify services and resources that support self-care. Due to the very diverse and dynamic provision of services, keeping track of available services and their specifications is challenging. This leads to a local lottery where access to services is dependent on which GP you are seen by and the level of information they possess. Investing in a publicly available signposting system to all of the different community services available could be the solution. However, a lack of accountability can make updating it particularly difficult. Such a resource needs constant capacity dedicated to maintaining the database and requires financial investment. Nevertheless, local areas are already moving towards building such tools. For example, Southend Council is currently working on developing a local online library of services which directs users to service providers' websites for more information. The limitation of developing such a tool at the local level is that there is a significant number of patients across the STP who access primary care services in a different jurisdiction than where they live. A few areas in the UK such as London, Greater Manchester and East Midlands are currently using an online platform, 'Making Every Contact Count (MECC) Link', which serves the exact same purpose, but on a broader area. This platform is available to both patients and caregivers, and those who offer an intervention. Expanding it to Mid and South Essex could be the solution. Currently, Public Health England is working on ways to bring this service to East of England.

Moreover, the current service offer proved to be very difficult to map by the team working on this report. Not only that we couldn't develop a full map of services, it was difficult to analyse the demand and capacity to make recommendations in regards to patient engagement and referrals. There is an increasing need to improve partnerships between NHS organisations and the local authorities to facilitate the flow of such information (within information governance limits). The development of Mid and South Essex STP is a great opportunity for improving the collaboration between the two, also therefore facilitating the development of JSNAs and similar products.

Case Study 3

MECC Link was developed by the MECC Community of Improvement for Yorkshire and the Humber to help enable MECC to happen in the area. The strategic network recognised the need for a signposting system to support MECC providers to raise awareness, motivate and signpost patients to services.

Since April 2019 MECC Link became a multi-regional service with 6 regions hosting information about their local services, including London.

Source:
https://www.mecclink.co.uk/about-us/

Issue	Recommendation	Responsible party
Information about existing services is not readily available to patients and providers As expressed by both residents and professionals and discussed in Chapter 2, people do not know what services are available even if they are professionals working in the field. This proves to be even more difficult if those advised live in a different area within the STP.	Develop a single point of access platform for services that assess risk and provide self-care interventions, to be made available to both patients and health and social care providers.	**MSE ICS/ Place** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.
	Contribute to maintaining and promoting a single point of access platform and engage providers in using it.	CCGs/ Place
There is difficulty in the process of data collection between local authorities, CCGs, and service providers making the development of JSNA products challenging and acting as a barrier to improvement. As discussed in chapter 2, it was very difficult to collect information on existing services across the system and their outcomes. This left gaps in the analysis and required us to take caution in how we interpret the results of this report.	Lead a data sharing team (BI virtual hub) to support the development of JSNA products across the STP.	MSE ICS
	Make aggregate data sharing with ICS partners a contractual obligation for community care providers and ensure regular data quality and completeness activities are undertaken.	CCGs and other commissioners
	Shift towards outcome based targets and KPIs rather than performance based.	CCGs and other commissioners
	Fund a technical solution for data integration across the ICS to enable access to aggregated data for all partners.	MSE ICS
	ICSs will have a key role in helping to deliver these programmes and in working with local authorities, the voluntary sector and other local partners to improve population health and tackle the wider determinants of ill health.	**MSE ICS** Aligned with the MSE Five Year plan for prevention: Work on reducing childhood obesity and increasing physical activity in adults through adoption of programmes delivered in schools and private

4.2.3 Patients and primary care providers lack the capacity and skills to make the most out of their interaction

GPs and other health professionals are not trained in motivational interviewing and coaching, which would enable them to effectively identify needs and motivate patients to take action in regards to self-care. On the other hand, patients lack the understanding of what their responsibility is when it comes to managing or monitoring their disease or do not possess the right skills or resources to do so. Similarly, when caregivers or family members are not receiving any form of education in this regard, they might act as a barrier to self-care. The solution to this is improving education and training offered to both clinical staff and newly diagnosed patients or their carers.

Case Study 4

In South Somerset as a response to the current pressures on healthcare and GP shortage, the South Somerset GP Federation (19 practices), Yeovil District Hospital, Somerset Partnership NHS Foundation Trust and Somerset County Council partnered and created the Symphony Programme.

The network developed a new model of care to improve support for LTC patients, improve the working lives of staff and relieve the pressure on secondary care.

The model has three tiers all focused on supporting people to understand and manage their own conditions, linking into the voluntary sector locally and navigating the healthcare system through a team-based approach where different professional groups operate at the top of their license.

The introduction of health coaches was essential as they work directly with patients to develop their self-efficacy and also effectively liaise patients who need services.

Source:
https://www.england.nhs.uk/gp/case-studies

Case Study 5

Champs Public Health Collaborative is a partnership approach in Cheshire & Merseyside. Their aim is to embed MECC into organisational strategies to create a culture shift towards prevention across the STP and wider system.

Three task and finish groups have been established to support training, communications and engagement, and evaluation. Each organisation identified a MECC champion to ensure that MECC maintains a high profile within each organisation, embedding MECC into existing policies, processes and initiatives so that MECC is seen as part of the everyday practice. Additional financial resources were secured through a bid to the Local Workforce Action Board.

The partnership is a great example of collaboration between public health, the STP, Public Health England and individual care organisations.

Source:
https://www.makingeverycontactcount.co.uk/media/

Moreover, even when these skills are not lacking, professionals find it difficult to find the time to have meaningful conversations with their patients. Motivational interviewing and coaching take a long time to be effective and time is what primary care does

not have. As discussed in the Local Context chapter, Mid and South Essex is a heavily under-doctored area with a particularly high need due to a number of factors including deprivation. To overcome these local challenges, new models of care need to be piloted to explore ways of using, in addition to GPs and nurses, a higher range of non-clinical staff to support patients with LTCs.

Also, where possible, it is recommended that support for people with LTCs is brought outside of primary care and into the community. For example, new evidence shows that local pharmacies can successfully deliver interventions for health promotion (145). There is an opportunity to build on current NHS efforts, described in the LTP, to expand the use of pharmacies from carrying out medication reviews to seeing patients with minor injuries. Their role can slowly evolve into supporting patients to self-care.

Issue	Recommendation	Responsible party
Primary care staff lack the skills to identify needs and barriers to practicing self-care and to address them As discussed in Chapter 2 – professionals' views, many professionals working with those needing to manage a condition are not confident in offering counselling/coaching support.	MECC training to become mandatory at least every two years for primary care professionals who are patient facing.	**MSE ICS** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.
	Plan an upskilling programme to equip primary care professionals with coaching and behavioural change skills.	MSE ICS
	Deliver Motivational interviewing and other coaching techniques training to GPs and primary care staff.	CCG/ Place
Patients are not educated about their role in health maintenance, and disease monitoring and management Discussions with residents show us that many of them have never been taught what and how to do to self-care.	Plan self-care forum events across the STP to inform patients and carers about their role in managing their health.	**Place** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.
	Commission digital programmes to deliver patient education throughout every stage of the disease.	**MSE ICS** Aligned with the MSE Five Year plan for prevention:

		Providing information and support for people to look after themselves including on-line and digital options.
	Prepare and write down questions for a medical visit prior to seeing a care professional.	Patient and caregiver
	Ask care professionals for reliable sources of information to do own research about the conditions they are suffering from.	Patient and caregiver
	Develop and distribute 'Making the most of your consultation' guide to educate patients across the STP.	**MSE ICS** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.
	Plan group meetings for patients with multi-morbidity to facilitate share of resources and experience.	PCN
	Commission self-care education in pharmacies for clients who pick up specific medication.	**MSE ICS/Place** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.

4.2.4 Multimorbidity is increasing and needs to be addressed

Despite evidence showing that patients with diabetes, COPD and HF increasingly tend to have a comorbidity, the NHS LTP fails to address this. Patients with multiple LTCs receive a varied number of interventions to support their needs, but most of the time these are delivered in silo. The focus on single diseases fails to recognise that unhealthy behaviours tend to cluster and are further deepening health inequalities. Our analysis shows there is a lack of integration between LTC services, which causes engagement from people with multimorbidity to be time consuming. Moreover, patients receiving multiple interventions sometimes receive conflicting

information. For example, someone suffering from COPD and diabetes might be advised to limit their brisk exercising to avoid COPD exacerbations, but when attending a diabetes class they learn to do the opposite. This leads to confusion and frustration, therefore resulting in an overall lack of engagement. Likewise, when there is no communication between providers, the prescribing of multiple drugs for diverse conditions can lead to confusion and lack of compliance to treatment. Programmes need to acknowledge multimorbidity and address the challenges that come with it.

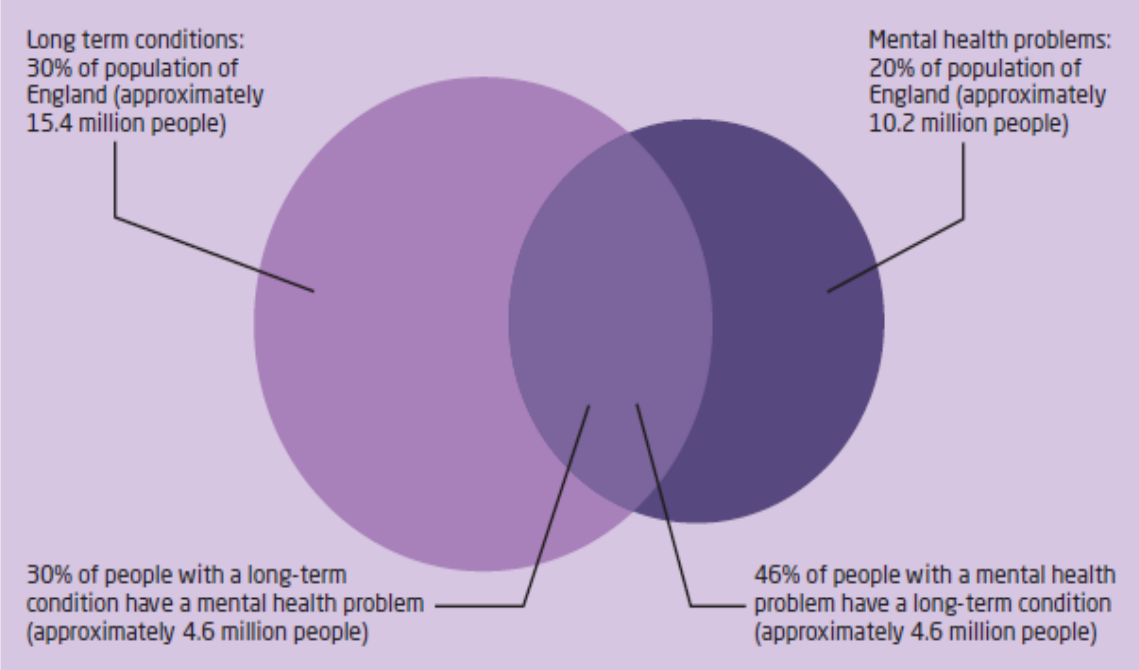


Figure 4.5: Long term conditions and mental heath

More specifically, mental health is a very prevalent co-morbidity among patients with LTCs. Recent evidence indicates that people with co-morbid mental health problems can gain particularly large benefits from inclusion in self-management support programmes, suggesting that they should be targets for referral (130). Peer support may also play an important role in empowering people with co-morbid mental health problems to manage their own condition.

This has started to be recognised both locally and nationally, hence more efforts are being put in place to address it. The

Case Study 6

Since 2010 Cornwall general practices are working directly with Age UK to support older patients. The initial cohort of 106 patients saw a 30% reduction in emergency admissions.

After expanding to 9 sites, supporting 4,000 patients, they observed a 31% decrease in all hospital admissions and 26% decrease in emergency admissions for the cohort. Additionally, GP workload reduced while community providers' workload stayed the same.

Source:
https://www.england.nhs.uk/gp/case-studies

NHS LTP reaffirms increases in mental health funding, committing to developing new models of care and increasing funds by £2.3 billion by 2023/24 (141). Locally, as seen in the service map, Inclusion Thurrock now offers mental health services specific to patients who have diabetes. Local third sector organisations, such as Thurrock and Brentwood Mind, could build on their local expertise and complete this offer with peer support groups. The voluntary sector is an essential asset and building relationships with them can support the development of a more personalised offer at the local level.

These types of services need to be properly evaluated and rolled out across the STP if proved to be effective.

Issue	Recommendation	Responsible party
Multimorbidity is increasing and self-care programmes are not addressing it sufficiently As evidenced in the discussion about current services, Chapter 2, most services are not fit for people who have multiple conditions. If multiple needs are identified most of the times patients have to access multiple services on separate occasions – making it difficult for them to stay engaged. For example, the average number of other conditions at first presentation of HF is five (41)	Develop a multimorbidity upskilling programme to educate providers (particularly GPs) on polypharmacy and multimorbidity patients' needs.	MSE ICS/CCGs
	Commission a social marketing research project to explore the barriers to self-care for patients with multimorbidity which can be used to inform the commissioning of programmes.	**MSE ICS** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.
	Promote the use of a validated tool such as eFI, PEONY or Qadmissions in primary care to identify adults with multimorbidity who are at risk of adverse events such as unplanned hospital admissions or admission to care homes.	MSE ICS/CCGs
	Create a pooled resource at the PCN level with social prescribers, care navigators/coordinators and health coaches to support more complex-need patients.	**MSE ICS/PCN** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.
	Extend the offer of personalised budgets to patients with multimorbidity to support them with getting personalised care that fits their needs.	CCGs/Place

	Research the most common association of conditions across the STP to inform a more robust offer for patients with multiple conditions.	MSE ICS
Many people with Long term conditions have mental health needs and not enough support As evidenced in chapter 2, most services are not fir for supporting people with a long term condition and mental health needs. Statistics show that 30% of people with long term conditions have a mental health condition as well.	Commissions a CBT offer for HF patients to reduce anxiety and improve Quality of Life.	CCGs/Place
	Log symptoms in a diary each day.	Patient/resident
	Access free online resources available, such as Every Mind matters from PHE and NHS.	Patient/resident
	STP wide audit of Severe Mental Illness (SMI) Health checks delivery to better understand the needs of people with SMI.	MSE ICS
	Commission national interventions such as Every Mind Matters to develop tools specific for patients with long term conditions.	NHS
	Commission support for close family members and carers of these patients to enable knowledge sharing and empowerment.	CCG/Place Aligned with the MSE Five Year plan for Mental Health: Creating safe places for people to walk-in such as community cafés

4.2.5 The money is in the wrong place

Diabetes

Evidence shows structured education such as DESMOND to be effective at increasing patient activation. This paired with coaching and a two-way monitoring system can deliver significant return. The NHS LTP suggests rolling out a two-way monitoring system, HeLP-Diabetes, nationally. This is a great opportunity for the STP if implemented properly. The NDPP model can be replicated to create a structured education offer across the STP for diabetes and other LTCs.

Patient education should be supplemented with online platforms; they support patients with continuous education, are easier to access and have the potential to be tailored to the needs of people belonging to

Case Study 7

Local evaluations, based on patient feedback, show that education delivered through online platforms, such as the Sound Doctor, could improve the understanding of the disease and confidence to manage it. Wolverhampton CCG's survey of 46 patients and carers found that those using this tool reported to have visited their GP less often than prior to using it.

Source: https://www.surveymonkey.com/stories/SM-CRPKC9Y/

minority groups. MyDiabetes was rolled out in Mid and South Essex in 2019. Proper monitoring and evaluation of the programme should inform quality improvement projects that can improve reach and engagement. Additionally, patient and carers can greatly benefit from peer support groups, especially those belonging to a minority group. These are very sporadic across the STP and tend to be under-resourced since they are community-led. Being community-led is an advantage and this service should stay in the community. However, the CCGs supporting these groups could lead to an improved structure and reach, hence increased impact and returns.

COPD

The key recommended approach for COPD management is pulmonary rehabilitation. Currently, all CCGs in the STP commission this service. Our analysis shows there is a variance in how the programme is offered, but we were unable to evaluate which one is more effective due to lack of access to information. With the STP coming together as an organisation, there is an opportunity to share best practice and align services to specific standards. For example, evidence shows better results when education, psychological support and dietary advice are embedded in the programme.

Case study 8

A notable example of an STP wide programme that has been very successful is the NDPP. Geared towards prevention of diabetes rather than management, the programme teaches skills that are helpful for diabetic patients too.

In the past 2 years the programme has seen a steep increase in Mid and South Essex, referrals surpassing its capacity in 2019/20. Hence, the current focus is on improving the quality of referrals rather than increasing referrals. This allows for a better targeted approach where the most vulnerable are identified and offered support.

Case study 9

Islington CCG commissions GP practices to offer collaborative care and support planning consultations with their patients with a list of long-term conditions, historically agreed in collaboration with Islington Public Health department. These conditions include chronic obstructive pulmonary disease (COPD), diabetes, heart failure and many more.

Commitment to engagement with the PAM project was embedded into the long-term condition work, which was initiated in October 2013. Practices were incentivised to calculate and register PAM scores to patient records.

An independent evaluation of the Year of Care diabetes care planning work was conducted in 2015 and found that high performing practices (in terms of number of care plans completed) were achieving better patient outcomes. Additionally, the evaluation found that care providers were willing to adhere to the new approach, however, they lack some skills in coaching and motivational interviewing.

Source: Independent evaluation of the feasibility of using the Patient Activation Measure in the NHS in England, The Health Foundation, April 2017

Additionally, computer or mobile technology and telehealth can support by reaching out to patients who find it difficult to engage with services in person. Essex Council commissioned SoundDoctor in 2019 to make it available to all patients, including COPD patients. A thorough evaluation of the impact can inform an STP wide programme.

Evidence also shows that primary care is essential to ensuring proper training and continuous monitoring of the disease. A further analysis of how patients' training is delivered in primary care can inform whether there is an opportunity for additional resources to be allocated. For example, telehealth support alongside coaching has been proven to be cost-effective for improving self-care behaviours.

For patients attending secondary care, interventions delivered in the hospital are proven to be very effective at preventing readmission (as described in the evidence chapter). STP data from 2018/19 shows 2,605 emergency admissions for COPD for 2,068 patients that were admitted. This shows that each patient admitted had a 26% chance of being readmitted in the year. Similarly, there were 109 elective admissions for 92 patients, an 18% chance of readmission.

Secondary care interventions for COPD, also called a care bundle, can include: checking inhaler technique; providing written COPD management plan and medicines; assessing willingness to stop smoking and suitability for pulmonary rehabilitation; and arranging a 2-week post-discharge follow-up.

Heart Failure

Similar to pulmonary rehabilitation, cardiac rehabilitation is fragmented and varies in structure across the STP. Evidence shows that any level of cardiac rehabilitation is effective. However, the service mapping process identified possible issues with access due to what is currently available. There is an opportunity for the STP to implement collaborative care (CASA) interventions where the patient is seen by a range of health professionals, rather than just their GP. This approach also shows a reduction in levels of depression and fatigue.

Wrong incentives

Our analysis shows that most Key Performance Indicators (KPIs) and quality indicators, such as the Quality Outcomes Framework for primary care, are focused on the process rather than the outcomes. Moreover, these incentives can drive conflicting priorities, sometimes leading to healthcare providers choosing not to follow the best practice guidelines. Additionally,

Case Study 10

Cumbria Quality Improvement Scheme was developed to improve the health outcomes of residents, reduce inequalities, ensure cost-effectiveness and enable primary care practices to work together.

The Scheme measures improvements on a value-added basis while recognising each practice is different and has varied needs. It incentivises practices on outcomes for seven indicators using the triple aim approach from the Institute for Healthcare Improvement, rather than incentivising for processes.

Early outcomes from the scheme in 2017 show:

• 83% of practices achieved metrics for Cancer;

• 61% of practices are achieving the metrics set for unplanned hospitalisations for chronic ambulatory care sensitive conditions; and

• 81% of practices achieved metrics on End of Life care.

Focussing incentive schemes upon outcomes instead of processes can lead to reductions in unwarranted variation and improved outcomes for patients.

critics of the pay-for-performance scheme claim that it diverts attention from inter-personal elements of care provision with a higher impact on those with multiple conditions. (146) A clear focus on health outcomes provides a framework for providers to offer personalised care while maintaining a good quality of service.

Additional to incentivising on health outcomes, reinforcement of quality improvement work can lead to improved processes and increased efficiency of care. (147) The NHS now recognises this and QOF 2019/20 has a quality improvement domain with two indicators. However, with lack of training and capacity in primary care, quality improvement work can take varied forms. This again leads to this scheme working more effectively for better resourced practices. The new development of PCNs can support with creating a good quality improvement infrastructure.

Issue	Recommendation	Responsible party
The current incentives and KPIs are not outcome focused, hence are not conducive to increased impact Evidenced by the analysis discussed in chapter 2 – local context and discussions with local professionals.	Revise QOF indicators to become more outcome focused or create a similar scheme locally.	NHS/MSE ICS
	Incentivise GPs to keep a record of markers of good self-care such as patient activation, BMI or overweight/obese status, Smoking status and physical activity.	MSE ICS/CCGs
	Additional to existing incentives to increase referrals into self-care services (including weight management services due to its link with Diabetes and cardiovascular disease), incentivise reduced Did Not Attend rates.	CCG and commissioners
Peer support groups are under-resourced and struggle to function Based on information gathered at workshops with both professionals and local residents.	Inform and support hard to reach patients to engage with support groups.	**GP** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.

	Co-support development of free support groups (e.g. with space, engagement, promotion, materials and translation) while still keeping them community led. This will ensure increased accessibility of such groups.	CCG/Place
	Get involved in leading or participating in peer support groups to share experiences and learn from peers with similar conditions.	patients and caregivers
There is a poor take-up of the national patient activation programme Evidenced by discussions with professionals and the national team rolling out PAM.	Improve the availability of PAM licenses to roll out across primary care.	NHS/MSE ICS
	STP to support CCGs and GPs to embed PAM use in practice.	MSE ICS
	Embed PAM in initial assessments and action plans.	Community providers and social prescribers
	Primary care to use PAM to evaluate the level of patient activation post diagnosis and at regular reviews.	GP
	Roll out training and education sessions to improve primary and community care engagement with PAM.	CCGs/Place
The digital offer is poor and sporadic As evidenced in chapter 2 – professionals' views and service map.	Develop an infrastructure for offering online classes and consultations/follow-up for patients with long term conditions.	**MSE ICS/CCGs** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including on-line and digital options.
	Commission online services for patients with multimorbidity who might struggle with accessing services in a traditional way.	MSE ICS
	Support enrolment in self-help online programmes such as: Silver Cloud, MyDiabetes app, MyCOPD app, HeLP-diabetes programme.	**GP** Aligned with the MSE Five Year plan for Diabetes: Piloting the MyDiabetes app with 500 newly diagnosed
	Commission an online group offer (e.g. on social media) to provide peer support with self-care.	**CCG/Place** Aligned with the MSE Five Year plan for prevention: Providing information and support for people to look after themselves including

		on-line and digital options.
	Evaluate variance in self-care online programmes enrolment and share best practice with GPs who are lagging behind.	PCN
Funding goes towards treatment rather than prevention As evidenced in Chapter 4 – impact modelling, the lack of prevention and poor management of the conditions lead to high cost acute episodes and this creates a vicious cycle.	Improve funding and links into mental health support such as IAPT & talking therapies, or online mental health services for patients with LTCs.	**CCGs/Place** Aligned with the MSE Five Year plan for Mental Health: Improving how we support people with a personality disorder and creating safe places for people to walk-in such as community cafés
	Identify local cost-effective primary and secondary prevention programmes and extend commissioning across the STP.	**MSE ICS** Aligned with the MSE Five Year plan for Prevention
	Provide health promotion services in pharmacies within the new pharmacy referral model.	NHS/LPC
	Commission group consultations (in person and online) for patients with long term conditions and multimorbidity.	CCG/Place

4.2.6 Self-care as a topic is in its infancy and evidence still needs to be developed

Evidence for self-care is still under development. A significant number of identified interventions have not been evaluated yet and are not backed by any data to show their impact. Moreover, self-care is multifaceted and difficult to quantify; therefore, where there is evidence, it lacks consistency across the outcomes measured, making it difficult to compare. This gap acts as a barrier to securing funds and trialling innovative ideas that could potentially be successful.

A lack of evidence should not discourage providers and commissioners to trial new ways of delivering interventions. However, it is imperative that measures are put in place to collect and analyse appropriate information to evaluate and create the evidence needed to back up the new programmes.

Issue	Recommendation	Responsible party
There are many innovative solutions to supporting self-care, but there is not enough evidence to support them As evidenced in Chapter 2 – service map - and Chapter 3 there is not enough information to support a specific approach to self-care and some innovative solutions are not properly evaluated to create evidence.	Evaluate impact of the Sound Doctor in Essex to inform a possible rollout across the STP.	Essex county Council
	Trial integration of SMS intervention in HF management services.	HF service providers and CCG
	Develop a systematic trial/pilot to evaluate the impact of Care-bundle use in Secondary care for COPD patients.	Mid and South Essex Hospital Trust
	Evaluate MyCOPD and MyDiabetes programmes to inform future decisions across the STP.	**MSE ICS** Aligned with the MSE Five Year plan for Diabetes: Piloting the MyDiabetes app with 500 newly diagnosed
	Identify examples of best practice and positive impact and share with the appropriate commissioners across the STP.	MSE ICS

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Appendix 1

Methodology of the assessment

Report Section	Activity
Local Context	
Demography data	• Data contained in the demographic infographic (entitled "What does the Mid and South Essex Health and Care Partnership look like" – see Figure 2.1) was calculated using available data. Where possible, already calculated STP level data was used. Where this was not possible CCG level data was used to calculate an STP average. For some of the indicators the only available data was at a

	borough level. Where this was the case, the Essex level data was applied to each of the 3 CCG's populations (Basildon and Brentwood, Mid Essex and Castlepoint and Rochford). Additionally, all figures contained within the infographic were weighted to account for population size (using 2018 population figures), or the population sub-group of interest for the indicator (see the key on page 19 for more details). For example, for the percentage of Y6 pupils categorised as obese, figures were calculated using 10-11 year old distribution from the total of each CCG's populations. Significance level compared to the regional and national figures were not calculated, where the data was not already available at an STP level, and therefore no comparison has been applied to those figures.
LTCs data	Prevalence of conditions • The STP level prevalence (%) of Diabetes was calculated by dividing the total combined number of people diagnosed with Diabetes in each CCG, by the total number of people (aged 17+) on all GP practice registers across the STP and multiplying it by 100. • The STP level prevalence (%) of COPD and HF were both calculated by dividing the total combined number of people diagnosed with COPD or HF in each CCG, by the total number of people (all ages) on all GP practice register across the STP and multiplying it by 100. Management of Conditions *Diabetes* • 8 Care Processes - The STP figure was calculated by adding together the total number of people with Type 2 diabetes who had received all 8 care processes at each CCG to get a number for the STP. This number was then divided by the total number of patients with Type 2 diabetes at an STP level (again by adding the total number of people on the register in each CCG to get an overall total for the STP) and multiplying by 100. This means that the significance level compared to the regional and national figure has not been calculated, and therefore no comparison has been applied to this figure. • Blood Pressure – The STP figure was calculated by adding together the total number of people with diabetes who had a blood pressure reading of 140/80 or less (QOF Code DM003) at each CCG to get an overall total for the STP (the numerator). This was divided by the combined CCG total (to give an overall STP number) of patients who were able to have the blood pressure check (the denominator; this figure excluded those who had been exception reported) and multiplied by 100. This means that the significance

level compared to the regional and national figure has not been calculated, and therefore no comparison has been applied to this figure.

- Total Measured Cholesterol – The STP figure was calculated by adding together the total number of patients who had total measured cholesterol of 5mmol/l or less (QOF Code DM004) at each CCG to get an overall total for the STP (the numerator). This was divided by the combined CCG total (to give an overall STP number) of patients who were able to have the cholesterol check (the denominator; this figure excluded those who had been exception reported) and multiplied by 100. This means that the significance level compared to the regional and national figure has not been calculated, and therefore no comparison has been applied to this figure.
- HbA1c – The STP figure was calculated by adding together the total number of patients who had an HbA1c level of 59mmol/moll or less (QOF Code DM007) at each CCG to get an overall total for the STP (the numerator). This was divided by the combined CCG total (to give an overall STP number) of patients who were able to have their HbA1c measured (the denominator: this figure excluded those who had been exception reported) and multiplied by 100. This means that the significance level compared to the regional and national figure has not been calculated, and therefore no comparison has been applied to this figure.

COPD

- COPD review – The STP figure was calculated by adding together the total number of patients who had an annual review (QOF Code COPD003) at each CCG to get an overall total for the STP(the numerator). This was divided by the combined CCG total (to give an overall STP number) of patients who were able to have the annual review (the denominator; this figure excluded those who had been exception reported) and multiplied by 100. This means that the significance level compared to the regional and national figure has not been calculated, and therefore no comparison has been applied to this figure.
- Record of FEV1 – The STP figure was calculated by adding together the total number of patients who had a record of FEV1 (QOF Code COPD004) at each CCG to get an overall total for the STP (the numerator). This was divided by the combined CCG total (to give an overall STP number) of patients who were able to have the record (the denominator: this figure excluded those who had been exception reported) and multiplied by 100. This means that the significance level compared to the regional and national figure has

	not been calculated, and therefore no comparison has been applied to this figure. • Influenza Vaccine – The STP figure was calculated by adding together the total number of patients who had received an Influenza Vaccine (QOF Code COPD007) at each CCG to get an overall total for the STP (the numerator). This was divided by the combined CCG total (to give an overall STP number) of patients who were able to have the vaccine (the denominator: this figure excluded those who had been exception reported) and multiplied by 100. This means that the significance level compared to the regional and national figure has not been calculated, and therefore no comparison has been applied to this figure. *Heart Failure* • Confirmation of diagnosis – The STP figure was calculated by adding together the total number of patients who had, had their diagnosis of HF confirmed (QOF Code HF002) at each CCG to get an overall total for the STP (the numerator). This was divided by the combined CCG total (to give an overall STP number) of patients who were able to have their diagnosis confirmed (the denominator: the figure excluded those who had been exception reported) and multiplied by 100. This means that the significance level compared to the regional and national figure has not been calculated, and therefore no comparison has been applied to this figure. <u>Mortality from all conditions</u> This percentage of mortality attributable to each condition was calculated using the number of people diagnosed with Diabetes/HF or COPD on the Disease Register in 2017/18 divided by the total number of deaths attributable to Diabetes/COPD or HF in 2018 and multiplied by 100.
Service mapping	Service information was collected during engagement with professional stakeholders (please see the row below for more info). Additional to face to face engagement, internet search and remote liaising with provider and commissioner organisations was carried out. Each council collected information for their covered areas and Thurrock Council Team collated the information.
Professional stakeholder views	Thurrock Council employed hosting workshops and various meetings in order to engage with local stakeholders. In addition, Essex County Council employed an online survey approach and face-to-face meetings with key professional stakeholders. There was a lack of capacity to undergo similar activity in Southend. However, the engagement included professionals serving all areas across the STP:

	• Public Health Commissioners at Essex County Council, Southend Borough Council and Thurrock Council • Thurrock Clinical Commissioning Group (CCG) • Essex Partnership University Trust (EPUT) • Adult Social Care (ASC) in Thurrock including the Community Led Support Team and the Local Area Coordination (LAC) Team • North East London Foundation Trust (NELFT) Community LTC Services • Healthwatch Thurrock • Thurrock Community and Voluntary Services (CVS) • Southend Voluntary Services (SAVS) • Chronic Health Psychology Service (CHPS) • Thurrock Housing Services • Essex Local Pharmaceutical Committees (LPC) • Basildon & Brentwood CCG
Patient views	To understand people's experience of diagnosis of an LTC, perceived barriers to self-care and what could help support them to better self-care a range of engagement activities were carried out. In Thurrock, local Healthwatch engaged with a total of 66 people through group surveys and in-depth interviews. Similarly, Healthwatch Essex engaged with 48 residents living with long term conditions using the same methods. Southend Council did not have enough capacity to commission this work.
Evidence chapter	
LTC interventions	To find evidence for specific interventions that are effective at improving the ability to self-manage the three chronic conditions (diabetes, heart failure, and COPD), an initial search was conducted by Aubrey Keep Library Service on the 16th May, 2019 and a refresh was done on the 25th February 2020. The main sources searched were CINAHL, EMBASE, KnowledgeShare, and MEDLINE. Only articles in English and published in the past 10 years were included. Additional to this, the public health team also conducted searches in PubMed using combinations of the terms: self-care, self-management, COPD, chronic obstructive pulmonary disorder, heart failure, diabetes, type 2, intervention. The following filters were applied to narrow down usable results: English, full-text available; preference was given to research published in the last 5 years, projects from the UK, and evidence reviews or studies with sample sizes greater than 100.
Barriers to self-care	For general barrier to self-care, Aubrey Keep Library ran an evidence search in December 2019: Barriers to accessing long term conditions self-management interventions. Studies specific to the three long term

	conditions (diabetes, COPD and HF) were searched independently by the authors.

Appendix 2

Service Name	Long Term Condition /Target	Type of Service/Support	Provided in	CCG	Provider/Teams/Centre	Service description	Eligibility/Access	Referral Type	Notes
ACE Lifestyle Southend	All Conditions /General	Rehabilitation/Lifestyle Management Support and Education	Southend on Sea	Southend/ Castle Point and Rochford	Anglian Community Enterprise	The service includes a personalised programme to help people reach their health goals. This could include 1-to-1 support or referral to other programmes such as weight management, physical activity or stopping smoking.	This service is for residents of Southend who wish to make positive changes to their lifestyle to improve their health and wellbeing.	GP/ Healthcare professional / Self	
Brain in Hand	Mental Health	Digital	All areas	All	Thurrock Council	Brain in Hand is an app that gives people access to detailed personalised support from their smartphone, putting the individual more in control of their own support. It gives easy access to reminders, notes, coping strategies and a team of trained professionals to give help when and where it's needed.	It is aimed particularly for people living with autism, a mental health condition or learning difficulty.	Social Care Professional referral	Service is running as a small pilot in 2019/20.
Breathe Easy the COPD support group	COPD	Community/Support Group	Southend on Sea	Southend/ Castle Point and Rochford	British Lung Foundation	This is a support group for people with COPD and their family or carers. The group meets once a month.	People with COPD, their family or carers	Self-Referral	
Breathe Easy the COPD support group	COPD	Community/Support Group	Thurrock	Thurrock	British Lung Foundation	A support group for people with COPD and their family or carers. The group meets once a month.	People with COPD, their family or carers	Self-Referral	
Breathing Space Group	Heart failure	Exercise Programme	Billericay	Basildon and Brentwood	British Lung Foundation	This group provides self-management plans for people diagnosed heart conditions.	People diagnosed with heart conditions	Physiotherapist	

Breathing Space Group	Heart failure	Exercise Programme	Canvey Island	Southend/ Castle Point and Rochford	British Lung Foundation	This group provides self-management plans for people diagnosed heart conditions.	People diagnosed with Angina and long term medical management for those with heart failure, from diagnosis to end stage.	Physiotherapist	
Cardiac Rehabilitation	Heart failure	Rehabilitation/Lifestyle Management Support and Education	Southend University Hospital	Southend/ Castle Point and Rochford		The programmes focus on the long-term nature and management of coronary heart disease, helping patients to come to terms with it and facilitate any recommended changes to their lifestyle. It encompasses psychological support, education and information, smoking cessation, physical activity, healthy eating and medication in order to help patients improve their health, prevent further problems related to the patients' heart health, and reduce symptoms to improve a patients' quality of life. They also offer a telephone programme for those who do not wish to or are unable to attend the hospital programme.	Any patient from the Southend, Castle Point and Rochford area who has had a recent cardiac event may access the service following: A heart attack Angioplasty and/or insertion of stent Coronary Artery Bypass Surgery		
Cardiac rehabilitation psychology service	Heart failure	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Basildon and Brentwood	Thurrock and Basildon and Brentwood	North East London NHS Foundation Trust (NELFT)	This service is based in a hospital setting. A psychologist works with patients on difficulties associated with having a heart condition. Difficulties include: depression, anxiety disorders, overcoming trauma/the shock of diagnosis, loss of confidence, difficulty in adjustment, change of lifestyle.	Adults who have experienced major heart acute conditions that require rehabilitation, educational and psychological input.		

CTC cardiac rehabilitation	Heart failure	Rehabilitation/Lifestyle Management Support and Education	Basildon and Thurrock University Hospital	Hospital Provision		The cardiac rehabilitation process starts in hospital and continues to provide support for many weeks after. There are three phases of the rehabilitation process which The Essex Cardiothoracic Centre facilitates. Phase 1 happens while the patient is in hospital, phase 2 when the patient is at home and phase 3 is an exercise and education programme which can be attended locally or done at home. This service also has a cardiac support group called Hearts and Minds, run by previous patients. They have an informative website that includes patient stories of their experiences, a question and answer section and much more - www.basildonheart.org.uk	For patients requiring rehabilitation due to heart issues.		
Cardiac Service	Heart failure	Rehabilitation/Lifestyle Management Support and Education	Mid Essex	Mid Essex	Provide - Care Co-ordination Centre	This service provides self-management plans for people diagnosed with heart conditions. Angina and long term medical management for those with heart failure, from diagnosis to end stage.	For people diagnosed with heart conditions, such as Angina and long term medical management for those with heart failure, from diagnosis to end stage.	GP	Provided at Home or in Mid Essex local hospitals and clinics

Case Management Long Term Conditions	All Conditions /General	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Southend/ Castle Point and Rochford	Essex Partnership University NHS Trust (EPUT) - Specialist Nursing	This service provides case management and advanced clinical skills to patients with one or more long term conditions, that have, or would have become Very High Intensity Users (VHIU's) of primary or secondary care health services without the intervention of case managers/community matrons.	For people with one or more long term conditions and are high users of primary/secondary care services.	Any health care professional.	Provided at Home or in Local Centres/Clinics
Chronic Health Psychology Service (CHPS)	Mental Health	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Basildon and Brentwood	Thurrock and Basildon and Brentwood	NELFT	The CHPS is a service for people with LTCs and comorbid mental health needs. the service uses Cognitive Behavioural Therapy (CBT) and Mindfulness training. CBT is a talking therapy. They utilise CBT to help clients to look at the relationship between thought, feelings and behaviours enabling them to better cope with difficulty.	People with LTCs and comorbid mental health needs	Patient need to screen positive for depression or anxiety	
Community Diabetes Recommended Education in Type 2 Diabetes (CREDIT) programme	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Mid Essex	Mid Essex	Provide - Care Co-ordination Centre	This educational programme is designed to support the patient in making decisions about the day to day management of their diabetes; whether this is diet, tablet or insulin controlled.	Diabetes patients	Free access	

Community Diabetes Service	Diabetes	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Southend/ Castle Point and Rochford	EPUT - Specialist Nursing	The Community Diabetes Service is a nurse led service that facilitates self-management, enabling people with diabetes to make the necessary adjustments to remain well, reducing mortality, morbidity and the need for hospitalisation. The Service is delivered through a combination of satellite clinics in the community, sessions in GP practices, education programmes, telephone support, domiciliary visits, school visits and multidisciplinary clinics at Southend Hospital.	Diabetes patients	Self-referrals accepted for drop in clinics or advice line. For on-going care GP or other healthcare professional referral is required	The Service also provides care to patients in nursing and residential care homes.
Community Diabetes Service	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Basildon and Brentwood	Thurrock and Basildon and Brentwood	NELFT	The service is offered by a multidisciplinary team including Diabetes Specialist Nurses and Diabetes Specialist Dietician, associate practitioner, lay educators and consultant diabetologists. The community based service provides specialist advice and support for adults with diabetes. The service delivers specialist clinical management and care to people with diabetes, assessing their needs, working to stabilise their condition, optimising their diabetes control and treatment, and giving them confidence through self-management. The aim is to discharge back to care of the GP once condition is stable and targets met. It includes community based support, education programmes, for type 1 and type 2 diabetes, telephone support, domiciliary visits and multidisciplinary clinics.	For adults (18+) diagnosed with type 1 and type 2 diabetes, their carers and other healthcare providers.	Referrals must come from a healthcare professional. For education programme self-referral or HCP referral is accepted.	The service is community based with satellite clinics in the various locations, sessions in GP practices. Also provides care to patients in nursing and residential care homes.

Community Heart Failure Service	Heart failure	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Basildon and Brentwood	Thurrock and Basildon and Brentwood	NELFT	The Community HF Service provides long-term medical management and support for patients suffering from chronic HF. The service aims to be patient centred and provides specialist nursing and support, titrate medication and therapy. Education and resources are provided to patients, carers and health practitioners to enable increased self-management. There are local clinics and home visits to those who are housebound. The service offers a help/advice line for patients/ carers/ GPs etc. which operates during office hours.	For patients suffering with chronic Heart Failure	Referrals are accepted by faxing, posting, via SystmOne, or telephone call. Patients can also self-refer.	
Community Heart Failure Service	Heart failure	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Southend/ Castle Point and Rochford	EPUT	The Community Heart Failure Service provides a patient centred, community based, specialist nursing, education and therapy service for heart failure. The overall aim is to enhance a patient's quality of life, improve physical health and optimise their social and psychological well-being and reduce acute hospital readmissions. Specialist support, education and resources are provided to patients, carers and health practitioners to enable increased self-management and delivery of community based integrated, proactive and personalised care across south east Essex. The service offers a help/advice line for patients/carers/GP and others which operates during office hours.	For patients suffering with chronic Heart Failure	Referrals are accepted from all primary and secondary healthcare professionals.	

Community Integrated Respiratory Service	COPD	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Basildon and Brentwood	Thurrock and Basildon and Brentwood	NELFT	The service offers specialist care for patients with respiratory disease, which may cause breathlessness, particularly COPD. The three main services are Pulmonary Rehabilitation, the COPD Service and the Oxygen Service. Pulmonary rehab is offered to increase fitness levels and also confidence around breathing techniques particularly when feeling breathless. The COPD service aims to provide holistic clinical assessment and management of COPD by giving specialist support through carrying out annual reviews, performing annual spirometry and titrating their inhaled therapy as per NICE guidelines and GOLD stratification. Breathlessness management is incorporated into the long term management plan for these patient groups. The Oxygen service is provided by Home oxygen Nurses to meet the long term oxygen demands of patients in the community. The service works closely with Fire service to identify patients with high risk of fire and put measures in place to minimise identified risks.	For patients with respiratory disease, which may cause breathlessness, particularly COPD	Referrals must come from a healthcare professionals - GPs, Acute hospitals, specialist centres other community services.	The Integrated Respiratory Service links to the Chronic Health Psychology Service and can refer patients with potential depression or anxiety for support therapy.
COPD Rehab Classes	COPD	Exercise Programme	Basildon and Southend on Sea	Basildon and Brentwood Southend/ Castle Point and Rochford	British Lung Foundation	This service aims to create a healthy lifestyle and encourage life extending habits by allowing the patient to exercise together with others that understand the patient's thoughts and worries.	COPD patients	COPD Rehabilitation units can refer following the patient's attendance at their in-house sessions.	

Diabetes Service	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Mid Essex	Mid Essex	Provide - Care Co-ordination Centre	This service provides specialist care for people with type 2 diabetes, and some with type 1, to help them self-manage their condition.	Adults (19+) with diabetes who are registered with a GP in the NHS Mid Essex area	Referral by healthcare professionals	Provided at selected locations in the community
Diabetes Care service profile (hospital based care)	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Mid Essex	Mid Essex	Provide	The Mid Essex integrated diabetes service delivers an integrated care pathway for patients with Type I and Type II Diabetes Mellitus, on both an inpatient and an outpatient basis at Broomfield Hospital. The team also works closely with the paediatric service to deliver transition care. The service includes new patient diabetic assessment, telephone advice for admission avoidance and treatment titration, inpatient care, education programme for Type I and Type II patients, including insulin conversion, continuous Blood Glucose monitoring, education for both primary and secondary staff, insulin pump service and pre-conceptual care clinic	Diabetes patients	GP referral	Provided at Broomfield Hospital Some specific services under this umbrella includes foot care, nutritional support, education and assessments, and/or midwifery services for pregnant diabetics.
Diabetes Support Group	Diabetes	Community/Support Group	All areas	All	Diabetes UK	Diabetes UK provides support in terms of resourcing and training for the establishment of support groups in local areas. The local groups provide people the chance for peer support through meeting other people with the condition and sharing experiences and tips on living well with diabetes. Groups typically meet once a month, but they often also take part in many other activities such as fundraising, campaigning and raising awareness.	Diabetes patients	Self-Referral	

Enhanced Pulmonary Rehab Service	COPD	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Southend/ Castle Point and Rochford	Southend University Hospital	This service is a rehabilitation service which consists of 12 supervised sessions run over a six week period by qualified health professionals. It delivers pulmonary rehabilitation through either a centre-based programme, a home-based programme or a hybrid programme offering a mixture of centre-based sessions with exercise and education at home. An additional centre has also been set up in St Luke's community centre in Southend.	COPD patients	GP/ Healthcare professional	Provided in Local Hospital/Clinic
Essex Heartbeat	Heart failure	Community/Support Group	All areas	All	British Heart Foundation	Essex Heartbeat offer support to people in Essex who are living with heart rhythm problems or with an implantable cardiac device, including Pacemakers and Implantable Cardioverter Defibrillators (ICD). They provide support and information to individuals and their family and friends.	For people living with heart rhythm problems or with an implantable cardiac device, including Pacemakers and Implantable Cardioverter Defibrillators	Self-Referral	Provided in Basildon and Chelmsford
Exercise on Referral (EOR) scheme	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Mid and South Essex	All	Lifestyle Teams	The EOR scheme is a prescribed exercise programme offering specific programmes for people with LTCs who are inactive, of which there are 9 different conditions eligible. The participant are placed into a group with people with the same or similar condition. The course is run over 12 weeks with two sessions per week. The programme has physical and mental health benefits to the participant. Also being in the group provides a social opportunity useful for sharing ideas and tips around self-management of their condition.	People with one or more long term conditions	GP/ Healthcare professional	Provided in Leisure Centres

Expert Patients Programme (EPP)	All Conditions /General	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Basildon	Thurrock and Basildon and Brentwood	NELFT	This is a self-management support (free courses) service for people living with long-term health conditions. . The courses run for six weeks and each session is 3 hours long including a refreshment break.	Adults over 18 years old are eligible. The courses are not suitable for patients with dementia, those who are house bound and patients whose mental health is not well controlled.	Patients can be referred by their GP/health professional and can also self-refer	The courses are held at local venues which provide appropriate facilities and comfort
Health in Mind	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Mid Essex	Mid Essex		This service offers Cognitive Behavioural Therapy (CBT) which is effective at reducing symptoms of low mood, anxiety and other emotional problems. The service is provided by working alongside GPs and health professionals in mid Essex to provide better support to patients with diabetes.	Diabetes patients	Self-Referral	
Heart Failure Support Group	Heart failure	Community/Support Group	Basildon and Brentwood	Basildon and Brentwood	St Luke's Hospice	This is a voluntary support group, which meets once a month.	Heart Failure patients	Self-Referral	
Heart Failure Support Group	Heart failure	Community/Support Group	Thurrock	Thurrock	St Luke's Hospice	This is a voluntary support group, which meets once a month.	Heart Failure patients	Self-Referral	
Hearts and Minds	Heart Failure	Community/Support Group	Basildon	Basildon and Brentwood	British Heart Foundation - Hearts and Minds	Hearts & Minds is a self-funding and voluntary group, which has been started by people with heart problems so that they can offer support and information to others in the Basildon district area who are suffering from heart problems.	People in the Basildon district area with angina, heart attack and other heart related problems.	Self-Referral	

Inclusion Thurrock	Mental Health	Community/Support Group	Thurrock	Thurrock		A psychological therapy service and Recovery College Inclusion Thurrock offers a simple gateway for those wanting to access talking therapies.	Adults worried about their mental health		
Integrated Community Team	Mental Health	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Brentwood	Thurrock and Basildon and Brentwood	NELFT - Thurrock Pathway Services	This service offers a wide range of nursing care to people who are unable to leave their homes even with the support of family, friends or carers. Qualified nurses and experienced competent health care assistants work with the patient to provide care such as: chronic wound management, pressure ulcer management, diabetes management, elderly and frail with a nursing need and end of life care. They support the patient in looking after their own general health and wellbeing, giving advice, support and reassurance to the patient and their family and carers.	For house-bound/bed-bound patients		Provided at Home or Local Community Hospitals
Integrated Diabetes Service	Diabetes	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Hospital Provision	Southend University Hospital/EPUT	The new Integrated Diabetes Service has been commissioned by local Clinical Commissioning Groups (CCGs) and is being delivered through a partnership arrangement with Southend University Hospital Trust and Essex Partnership Trust. The aim of the service is to improve patient experience and reduce ill health and complications due to diabetes through: single point of contact and triage for all diabetes referrals; consultant-led Multi-disciplinary Team (MDT) one stop clinic to develop a collaborative care plan; support ranging from dietary needs to podiatry needs; increased patient education; and repatriation of Insulin Pump service	Diabetes patients	All community and hospital diabetes patients are automatically transferred to the service	Multidisciplinary clinics are being held in various locations across Southend, Castle Point and Rochford. Individual clinics continue across the south east Essex area.

Long Term Oxygen Therapy Team	COPD	Rehabilitation/Lifestyle Management Support and Education	South East Essex	All	EPUT - Specialist Nursing	This service is a nurse/physiotherapist led community service providing assessment, treatment and management of patients in the community who require home oxygen therapy, long term oxygen therapy (LTOT) and ambulatory oxygen.	For people who require home oxygen service	GPs and other healthcare professionals	Provided at Home or Care homes & Clinics in Southend and Rochford
Managing Health Programme	All Conditions /General	Rehabilitation/Lifestyle Management Support and Education	Mid Essex	Mid Essex	Provide - Essex Lifestyle Service	The Managing Health Programme supports individuals through tools and tips to help them better self-manage their long-term conditions. There are several programmes available, as well as group programmes and telephone support services, so the patients will have a choice about what feels right for them. The programme looks at how to improve health, self-management, and how to get the best from consultations with health professionals.	People with one or more long term conditions		Courses are run dependant on demand and delivered in accessible community venues across Mid Essex.
MyCOPD Application	COPD	Digital	All areas	All	mHealth	The app, named MyCOPD, is a clinically approved NHS app and is a registered class one medical device. It helps users to manage breathing difficulties caused by COPD by offering useful advice including inhaler technique videos, education from experts and a complete online pulmonary rehabilitation class. It can be downloaded onto any internet connected smart device using a licence code provided by specialist doctors and nurses at hospitals and community services when treating people with the condition.	COPD patients	Free via secondary care services	CCGs aiming for licences to be distributed by primary care services.
MyDiabetes Application	Diabetes	Digital	All areas	All	mHealth	The myDiabetes app contains a complete, structured, online, comprehensive diabetes education course for patients with both Type 1 and Type 2 Diabetes and enables them to monitor their blood glucose, HbA1c and other risk factors to reduce the risk of serious long term complications.	Diabetes patients		

NHS Diabetes Prevention Programme (NDPP)	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Mid and South Essex	All	NHS England/PHE /Diabetes UK - ICS Health & Wellbeing	The NDPP is for people who have been identified as having a high risk of developing type 2 diabetes based on clinical markers. It is a behaviour change programme consisting of a series of predominantly group based sessions delivered in person across a period of at least 9 months. There are at least 13 sessions and 16 hours of contact time. Sessions last between 1 and 2 hours and cover topics geared towards the programme's main goals of dietary improvements, increased physical activity and weight reduction.	Those at risk of developing Diabetes	Referrals must come from a healthcare professional or patients can self-refer by registering online	Digital NDPP service is also an option for those who are unable to attend face to face. Referral forms are available in SystmOne & EMIS to be completed by Primary care then emailed to the provider.
Physiotherapists	Mental Health	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Southend/ Castle Point and Rochford	EPUT	This service is provided by Physiotherapists specialising in mental health needs. They have specific physical and mental health training to bridge the gap between physical and mental health needs of patients.	General Service for people with any physical and mental health needs		
Rapid response and assessment service (RRAS)	All Conditions /General	Response Service	Thurrock	Thurrock	NELFT - Thurrock Pathway Services	The rapid response and assessment service (RRAS) provides rapid health and social care assessment for service users and carers who are in or approaching a crisis. The team includes advanced nurse practitioners (independent prescribers); social workers; health care assistants and administration support.	For service users and carers who are in or approaching a crisis.	Via Telephone	

Recovery College	Mental Health	Rehabilitation/Lifestyle Management Support and Education	Thurrock	Thurrock		Recovery College is a partnership between its students, Inclusion Thurrock, part of the NHS and Thurrock Mind (a local charity with a proud tradition of helping those experiencing difficulties with their mental health).	For those who are experiencing difficulties with their mental health needs		
Respiratory Service (Including Pulmonary Rehabilitation)	COPD	Rehabilitation/Lifestyle Management Support and Education	Mid Essex	Mid Essex	Provide - Care Co-ordination Centre	This service provides an oxygen assessment service, and care and support for people with Chronic obstructive pulmonary disease (COPD). This includes a self-management programme for patients with pulmonary disease. Other services include: Pulmonary rehabilitation (an exercise programme, education and nutrition advice to help improve the independence of people with lung disease); Palliative care; and a Telehealth service (a self-monitoring system which checks the patient's blood pressure, oxygen saturations and changes to the patient's breathing pattern). The team includes respiratory and oxygen assessment nurses, physiotherapists, healthcare support workers and admin staff. They work closely with various other healthcare professionals, such as GPs, respiratory consultants, hospital and community teams.	COPD patients	Referrals must come from healthcare professionals. Patients who have been seen by the service previously can self-refer.	Provided in local Hospitals
Silvercloud	Mental Health	Digital	Thurrock	Thurrock	Inclusion Thurrock	SilverCloud is an online course to help manage stress, anxiety and depression by use of cognitive behavioural therapy (CBT). It currently includes a specific programme for patients with diabetes.	For people who need help managing stress, anxiety and depression.		

Social Prescribing	All Conditions /General	Community/Support Group	Mid and South Essex	All	Local Councils	The Social Prescription Programme aims to support people with health and well-being needs including chronic conditions. Patients may have a social need or chronic condition and regularly attend the GP surgery or are at risk of unplanned admission. Navigators will meet patients referred by their GP at their practice and will signpost them to appropriate services from a range of over 500 available in Thurrock. Referrals from the social prescriber may include information, advice and guidance to support health, finance and social isolation.	For Patients who may have a social need or chronic condition and regularly attend the GP surgery or are at risk of unplanned admissions.		
Sound Doctor	All Conditions /General	Digital	Mid and South Essex	All	Essex County Council & The Sound Doctor	The Sound Doctor is a film and audio programme designed to help healthcare professionals advise their patients on managing long-term conditions safely and effectively at home.The programme includes courses of educational material focusing on the causes, symptoms, risks, treatment and management of each condition.	People with one or more long term conditions		
Southend Chronic Obstructive Pulmonary Disease (COPD) Psychology Service	COPD	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Southend/ Castle Point and Rochford	EPUT - Essex Mental Health Services	This service includes various courses to help manage stress associated with COPD. The service also provides Psychological input and joint work in Hospital Pulmonary Rehab program. As well as specialist support, education and training to other professionals to enable them to understand and work with the emotional needs of our client group.	COPD patients		Provided in Southend University Hospital
Southend Health Information Point (SHIP)	All Conditions /General	Community/Support Group	South East Essex	Southend/ Castle Point and Rochford	Southend Borough Council Southend CCG Vibrance SAVs	SHIP is the central point for information, advice and guidance on local services and organisations that aim to help increase independence and wellbeing in Southend Residents. http://www.southendinfopoint.org/	For Southend residents' general health and wellbeing		

Southend Therapy and Recovery Team (START)	All Conditions /General	Response Service	South East Essex	Southend/ Castle Point and Rochford	EPUT - Specialist Nursing	START are a joint health and social care domiciliary rehabilitation and reablement team, providing short term, goal based rehabilitation programs to patients in their own home to prevent admission or facilitate early discharge from hospital.	For Southend patients in their own home to prevent admission or facilitate early discharge from hospital.	GP	
Southend Responsibility Deal	All Conditions /General	Rehabilitation/Lifestyle Management Support and Education	South East Essex	Southend/ Castle Point and Rochford		This service assists employers in managing the health of their workforce, to include those suffering from long term conditions via support, assessments and health checks.	For Southend employers to manage the general wellbeing of their workforce		
SWEET (South West Essex Education and Training)	Diabetes	Rehabilitation/Lifestyle Management Support and Education	Thurrock and Basildon and Brentwood	Thurrock and Basildon and Brentwood	NELFT	This course is a Structured Education (SE) scheme aiming to improve self-management and reduce complications caused by poor management of Type I and Type II Diabetes. Structured as a 3 hour, group based, one off session to help newly diagnosed patients manage and cope with diabetes and improve long-term outcomes.	Newly diagnosed Diabetic patients	Self-referral and Health Professional referral	
SWIFT	All Conditions /General	Response Service	South East Essex	Southend/ Castle Point and Rochford	EPUT	SWIFT is a community team structure which helps patients stay at home when they are feeling unwell, rather than be transferred to hospital. The SWIFT service is designed with a 'home first' ethos and will provide specialist, nurse-led care in people's own homes. They will visit patients within two-hours of receiving a referral from their GP practice to stabilise their immediate health need. They will support patients to feel better by visiting at home to provide the necessary assessments, medication and nursing interventions and aim to stabilise patients within five days.	For residents who would benefit from being seen at home prior to being transferred to a hospital.	GP referral	

Take Heart Southend Heart Support Group	Heart Failure	Community/Support Group	South East Essex	Southend/ Castle Point and Rochford	British Heart Foundation - Essex Cardiac Group	Take Heart is a cardiac support group covering the areas of Southend, Castle Point, Rayleigh and Rochford, Essex. Their aim is to offer a support network for all who have become affected by Cardiac problems whether as a patient, carer or family members. They are a non-medical voluntary group, helping the patient to consider a new approach to life both during and after cardiac problems, in order to restore the patient to a more active life.	For patients, carers or their families who have been affected by a cardiac condition	Self-Referral	
Thurrock Diabetes Support Group	Diabetes	Community/Support Group	Thurrock	Thurrock	Local group	The Thurrock Diabetes Support Group gives people in Thurrock the chance to meet with others and share experiences and tips on living well with diabetes.	Thurrock Diabetic patients	Self-Referral	
Thurrock First	Mental Health	Community/Support Group	Thurrock	Thurrock	NELFT	Thurrock First is the first point of telephone contact for adults living in Thurrock who want to talk to someone about: adult social care, mental health, health problems that have been diagnosed and for which on-going care is needed or care that is available in the community.	Adults in Thurrock who want to talk about any health problems, mental health needs, or local care		Telephone Service
Thurrock Mind	Mental Health	Community/Support Group	Thurrock	Thurrock	Local Mind Charity	Thurrock Mind provide a range of interventions including talking therapies, supported housing, peer mentoring, positive pathways and advocacy. They are also active participants in a 'shared care protocol' which supports clients discharged from EPUT services to stay well and reduce re-admissions to secondary care. The Emotional Well Being Forum supported by Thurrock Coalition and MIND is an opportunity for those with lived experiences of services and mental health and carers to meet together for support, to gain information and to influence service developments	For people who want to extra support for their physical and mental health needs.		

Tickers Cardiac Exercise Group	Heart Failure	Rehabilitation/Lifestyle Management Support and Education	Chelmsford	Mid Essex	British Heart Foundation	This group provides exercise sessions for people with heart failure	Heart Failure patients	Referred by a healthcare professional on completion of a phase 3 exercise programme	
Tier 3 Weight Management	All Conditions /General	Rehabilitation/Lifestyle Management Support and Education	Mid and South Essex	All	More Life	The MoreLife programme is delivered and supported by weight management practitioners and a range of health and research clinicians such as GPs, Dieticians and psychologists. The programme is delivered in a group format and lasts for 12 months in total starting with a 14-week intensive programme, then monthly meetings and finally ongoing drop in support.	For people with health conditions which would be better managed and controlled through weight loss.	GP/ Healthcare professional	
Type 2 Together	Diabetes	Community/Support Group	Mid Essex	Mid Essex	Diabetes UK	'Type 2 Together' is a patient led diabetes group, offering a friendly environment for patients to discuss any aspects of Type 2 diabetes and support each other in making healthy lifestyle changes.	For patients with Type 2 Diabetes	Self-Referral	Provided in local surgeries
Viva Breathe	COPD	Exercise Programme	Chelmsford	Mid Essex	Charity/Voluntary	This class provides self-management plans for people diagnosed with Angina and long term medical management for those with heart failure, from diagnosis to end stage.	For people diagnosed with heart conditions	Self-referral	Paid service

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12 January 2023	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
Adult Substance Misuse Needs Assessment	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Philip Gregory, Senior Public Health Programme Manager	
Accountable Assistant Director: Andrea Clement, Assistant Director of Public Health	
Accountable Director: Dr Jo Broadbent, Director of Public Health	
This report is Public	

Executive Summary

The Council's Public Health team have recently completed an Adults Alcohol and Substance Misuse Needs Assessment.

This needs assessment is intended to represent the evidence base from which the Adult Substance Misuse service will be re-commissioned. In line with the expiry of the existing Adult Substance Misuse service contract, this revised service will commence from April 1st 2024.

Based upon a combination of national and local data and intelligence, the voices of people who use the existing service, the expert input of key professionals from across the local health and care system, and a review of the latest evidence base for harm minimisation and effective practice, the needs assessment is considered to be the robust evidence base needed to inform a revised service specification.

The document has identified the scale of local need, highlighted limitations of the current service scope and shone a light on under-representation of certain local populations. Subsequently it has made 20 recommendations for working with substance misuse in the future covering: strategic approaches; partnership working; service development, information and evaluation; and. the role of individuals who access services.

The needs assessment has been considered by the Public Health Leadership Team and the Adults, Housing and Health Directorate Management Team. Following feedback and requests for some amendments to the document's content and recommendations, both teams subsequently provided their approval in October 2022.

1. Recommendation(s)

1.1 That the Committee review the needs assessment and the recommendations contained within and provide comment.

2. Introduction and Background

2.1 Substance misuse causes increased harm to individuals, those closest to them and to wider society

2.2 The most recent national government drug plan was launched in 2021. '*From harm to hope: A 10-year drugs plan to cut crime and save lives'* recommends a national effort to reduce the availability and demand for drugs, as well as enhancing treatment and recovery services

2.3 Guidance is clear that while the 10-year strategy focusses on the use and supply of illegal drugs, local partnerships should also ensure plans sufficiently address alcohol dependence and wider alcohol related harms including capturing relevant activity and performance monitoring

2.4 Thurrock Council currently commissions Midlands Partnership NHS Foundation Trust, operating under the brand name Inclusion Visions, for the delivery of an Adult Substance Misuse Service. The existing contract expires on March 31st 2024.

2.5 At the point this contract expires the Council should have completed a comprehensive re-commissioning exercise which will allow a revised service provision to be in place from April 1st 2024 onwards. This revised provision will be based upon a robust evidence base which has identified what is the most effective and efficient delivery model for meeting the needs of the people of Thurrock

2.6 The robust evidence base for this revised provision is the recently completed Adult Substance Misuse Needs Assessment. This health needs assessment explores the needs of adults living in Thurrock who have accessed or would benefit from accessing drug and alcohol misuse treatment services

2.7 The needs assessment has five key objectives:

- to present qualitative and quantitative data to inform the recommissioning of local drug and alcohol misuse services
- to identify gaps in the local service provision
- to describe examples of harm minimisation approaches
- to estimate the number of Thurrock residents with co-occurring conditions of substance/alcohol misuse and mental illness
- to seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems co-design approach

2.8 Data and information for the needs assessment was gathered in the form of:

- quantitative data from national datasets
- qualitative information from semi-structured interviews with relevant professionals
- questionnaires completed by individuals who use the current service
- A review of national and local policy and strategic approaches
- A literature search of evidence on effective approaches

2.9 The needs assessment established from the most recent estimates that there are lower rates of opiate use in Thurrock compared to England, and similar rates of crack cocaine use in Thurrock compared to England. However, local figures do still suggest there are approximately 493 people using opiates and 450 people using crack cocaine in Thurrock.

2.10 There were an estimated 1,600 adults with an alcohol dependency in Thurrock in 2018/19. The proportion of people abstaining from drinking and those drinking over 14 units of alcohol per week were both significantly lower for Thurrock than England.

2.11 People were most commonly in specialist treatment in Thurrock for opiate misuse. The second most common reason for treatment in specialist services was alcohol misuse.

2.12 Since 2015/16 the number of people in treatment has decreased from 715 to 330, and new referrals have decreased from 430 in 2015/16 to 170 in 2020/21 It is unclear why this is the case but referrals are likely to have been affected by the pandemic. People with co-occurring conditions and complex needs represent a significant proportion of those seen by the drug and alcohol service.

2.13 Overall, the target of successful completions of opiate treatment was met for the three-year period from April 2019 to March 2022. There is much more variability for successful completion rates for the other substance types. Rates of unplanned exits from treatment are higher in Thurrock than for England for all four substance types.

2.14 When service users were asked about their views, they were very positive about the service and their experience.

2.15 Limitations of the existing service level agreement has restricted the remit of the adult drugs and alcohol service. For example, where people are reluctant to engage with the service there is little the provider has been able do to support them as assertive outreach has not been part of the contracted service. This will be addressed as part of service re-commissioning.

2.16 The difference in approach between the young people's and adults' services mean that when young people move to an adult service and the statutory

support changes, it can be a difficult transition. Older teenage and young adult group have particular needs and vulnerabilities.

2.17 The collection of access to and sharing of data and intelligence between services was highlighted as an important gap in the current system, and a limited understanding by teams about how other teams work.

2.18 A total of 20 specific recommendations have been made by the needs assessment covering: strategic approaches; partnership working; service development, information and evaluation; and. the role of individuals who access services. These will be addressed through quality improvement of the existing service and service re-commissioning as appropriate.

3. Issues, Options and Analysis of Options

3.1 The final version of the needs assessment was completed in August 2022 and was subsequently approved by the Public Health Leadership Team and the Adults, Housing and Health Directorate Management Team.

3.2 As this is a needs assessment there is no requirement of the Committee in relation to options, beyond reviewing the content and offering comment.

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

4.1 The needs assessment itself contains significant engagement with relevant professionals and individuals who use services. As such every effort to capture the voices of local people has been made.

4.2 The needs assessment was reviewed by the Public Health Leadership Team in August where conditional signoff was granted. Subsequently the document was reviewed by the Adults, Housing and Health Directorate Management Team who requested some amendments to the content and recommendations. Following completion of these amendments the document was approved by the Adults, Housing and Health Directorate Management Team in October 2022. The Public Health Leadership Team subsequently reviewed the amended document in October 2022 and provided their unconditional signoff.

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

5.1 The Thurrock Health and Wellbeing Strategy 2022-26 contains a goal to reduce substance misuse in all communities in Thurrock. It commits to doing so by addressing unmet need in relation to drug and alcohol misuse.

5.2 The Adult Substance Misuse service is not a mandated service but it is a condition of the Public Health Grant that monies be spent on ensuring there are public health services aimed at reducing drug and alcohol use.

6. Implications

6.1 Financial

Implications verified by: **Bradley Herbert**

Senior Management accountant

There are no direct financial implications of reviewing the content of the Adult Substance Misuse Needs Assessment and providing related comments.

The publication of the needs assessment however does ensure that the Council can conduct the re-commissioning process for the Adults Substance Misuse Service and can be confident that it is doing so from a robust evidence base. The Council is ensuring that it commissions a future service that meets the needs of local people to the best of its ability, and as such represents a best value approach.

Finance will need to be included when the commissioning proceeds in the near future to ensure that the contract price stays within the budgetary allocation.

6.2 Legal

Implications verified by: **Kevin Molloy**

Principal Solicitor

There are no legal implications of reviewing the content of the Adult Substance Misuse Needs Assessment and providing related comments The document contains no confidential information and has been produced through a combination of publicly available information and research conducted in line with standard ethical guidelines.

6.3 Diversity and Equality

Implications verified by: **Becky Lee**

Team Manager, Community Development and Equalities

There are no Diversity and Equality implications of reviewing the content of the Adult Substance Misuse Needs Assessment and providing related comments.

The Adult Substance Misuse service is in itself a universal service. The content of the needs assessment however has identified some groups of individuals who are under-represented in terms of service engagement. In publishing this assessment, the Council will be better placed to commission a future service that seeks to address inequality and inequity where it has been

identified. It will also be able to better tailor a service which meets the needs of some of societies most vulnerable and at-risk individuals.

6.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, or Impact on Looked After Children

None

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

None

8. Appendices to the report

- Adult Alcohol and Substance Misuse Needs Assessment

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Public Health

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SPH Solutions for Public Health

NHS Arden and Greater East Midlands Commissioning Support Unit

Thurrock Council

Alcohol & Substance Misuse: epidemiological population health needs assessment

August 2022

This HNA was commissioned by Thurrock Council from Solutions for Public Health (SPH), an NHS public health team based in Arden and Greater East Midlands Commissioning Support Unit. SPH are a multidisciplinary, senior team of clinical, public health, research and analytical experts. We work with decision makers across the public and third sectors to improve health and reduce health inequalities. Our work is centred on evidence, health intelligence, assessment of need and evaluation, which we use to understand and promote better health and better value health care. For more information contact: agem.sphsolutions@nhs.net

Acknowledgements

SPH would like to acknowledge the considerable effort by Thurrock council and Inclusion Visions Thurrock to ensure we received documents, data, consent for interviews, completed questionnaires and answers to our many queries. Thank you also to all those gave their time to participate in interviews and answer our questions.

Contents

Executive Summary

Introduction and methodology

This health needs assessment (HNA) explores the needs of adults living in Thurrock who have accessed or would benefit from accessing drug and alcohol misuse treatment services. Substance misuse causes increased harm to individuals, those closest to them and to wider society. People misusing alcohol and /or drugs often have other difficulties in their lives such as mental health conditions, problems with housing and employment, or are engaged in crime. An effective population-based strategy concerned with prevention and minimising the impact of harm on individuals, their families, and the communities where they live requires systemwide partnership working between agencies that have traditionally worked as standalone teams, with a fixed referral process and prescribed interventions. This alcohol and substance misuse HNA aims to inform the development of an integrated strategy to commissioning across Thurrock.

Five key objectives for the HNA were agreed with Thurrock Council following contract award:

1. To present qualitative and quantitative data concerning service needs and provision, to inform the recommissioning of local drug and alcohol misuse services. The focus is on organisations in contact with people with substance misuse problems, and how services support the needs of the residents in Thurrock.
2. To identify gaps in the local service provision, including consideration of those who do not engage with services, and seeks to identify any barriers and potential solutions to lack of engagement. This includes the transition between the CYP alcohol and substance misuse service and the adult service, and those with co-occurring conditions.
3. To describe examples locally or from other areas concerning harm minimisation approaches, in particular for alcohol misuse. This includes how to support the evolving demands on teams for post-pandemic reset and recovery.
4. To estimate the number of Thurrock residents with co-occurring conditions of substance/alcohol misuse and mental illness, and those with complex needs involving other difficulties such as housing and employment (recognising that this is an area where data are sparse, and information limited).
5. To seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems (HLS) co-design approach.

Five methods of data and information gathering were used for this HNA:

1. Quantitative data were obtained from national datasets in to outline the demography of Thurrock and epidemiology of drugs and alcohol within the population. Data from the National Drug Treatment Monitoring Service (NDTMS) and local providers were used to outline drug and alcohol treatment service provision in Thurrock.
2. Qualitative information about the barriers, enablers, and gaps in service provision in Thurrock was gathered from 16 semi-structured interviews with professionals
3. Questionnaires were completed by 47 drug and alcohol misuse service users to gather their experiences about the barriers, enables and gaps in services

4. A document review of national and local policy and strategic approaches to drugs and alcohol misuse prevention and treatment provided information about the local and national context of current policy.
5. A literature search of evidence about effective approaches to prevention of drug and alcohol misuse also informed the HNA.

A series of recommendations were developed from the emerging themes identified from the quantitative and qualitative information.

National Context, Policy and Guidance

The most recent national government drug plan was launched in 2021. 'From harm to hope: A 10-year drugs plan to cut crime and save lives' recommends a national effort to reduce the availability and demand for drugs, as well as enhancing treatment and recovery services.

The theme of this plan is to cut off the supply of drugs by organised crime gangs (OCGs), and to provide sufficient resources and help for those overcoming drug addiction. The plan highlights that over £3 billion will be invested into delivering three strategic priorities to reduce drug-related crime, death, harm, and overall drug use:

1. Break drug supply chains
2. Deliver a world-class treatment and recovery system
3. Achieve a general shift in demand for drugs

The 10-year approach set out by the Government specifically focuses on the following:

- Combating the supply of heroin and crack cocaine
- Delivering high quality treatment for drug addiction
- Reducing non-dependent recreational drug use such as cocaine
- Incorporating a whole system approach as recommended by Dame Carol Black (cut off supply, prevent/reduce drug use)
- Investing in education and resilience in children and young people to level up the whole country

This strategy focuses on encouraging people to change their attitudes to drug use and to ensure that children and young people are not drawn towards drugs, being fully aware of the harm they would be causing to themselves and others by using drugs.

The guidance is clear that while the 10-year strategy focusses of the use and supply of illegal drugs, local partnerships should ensure plans sufficiently address alcohol dependence and wider alcohol related harms including capturing relevant activity and performance monitoring. A local partnership called the Combating Drugs Partnership should be created in each area which will be a multi agency forums accountable for delivering a set of outcomes, understanding, and addressing shared challenges related to alcohol and drug related harm.

It is important that the partnership includes people who have been affected by drug related harm. NHS England and the DHSC has recently published statutory guidance on the legal public involvement duties of the integrated care system, describing ways to include community and service users in co designing and co-producing services.

To support the decision making of the CDP a National Combating Drugs Outcome Framework (NCDOF) has been developed. The Framework includes six overarching outcomes, to reduce drug related crime, harm, overall use, supply and to increase engagement in treatment and improve long term recovery.

Thurrock drug and alcohol strategies

Thurrock Council are exploring a Human Learning Systems (HLS) approach to integrated working. This way of working continuously explores the complex reality of how outcomes that matter to a person might be achieved in their unique life context. The Human Learning System approach has been described in 'Better Together Thurrock: the case for further change 2022-2026'. This is a collective plan to transform improve and integrate health care and third sector services to improve people's wellbeing.

Four integrated medical centres are in the process of being established in Thurrock that align with the four Thurrock PCN footprints. The hubs are the basis of single locality networks with teams from health care and third sector organisations building relationships, collaborating, and co-designing single integrated solutions with residents. There will be staff from the drugs and alcohol service at each of the hubs working with other teams such as mental health, primary care, and social care colleagues. To facilitate this an integrated treatment service with outreach workers aligned to and operating with Community Led Solutions teams with assertive outreach and timely access to treatment for those with the most complex needs.

In addition to Thurrock Council's overall approach, many teams who encounter people who misuse drugs and alcohol have strategic aims concerning this cohort of people. The Health and Wellbeing strategy focuses on addressing unmet need and developing an approach that can lead to the co-production of services with residents and service users, integrating mental health and housing support for those with co-occurring conditions and complex needs. Other teams and organisations with strategic aims concerning people with drug and alcohol misuse include Essex Police, the Community Safety Partnership, Brighter Futures Children's Partnership, Thurrock Violence Against Women and Girls team, Adult Mental Health Services, and Thurrock Housing and Homeless services.

Thurrock borough demography

The national 2021 census data reports that the Thurrock population is around 176,300 which the Office for National Statistics (ONS) estimates this will rise 192,787 by 2031.

Deprivation

There are many wider societal determinants experienced by resident populations associated with increased risk of drug or alcohol dependence and reduced likelihood of successful treatment outcomes. These factors include higher deprivation and problems with housing, and employment. Being in education, employment and having good physical health can increase chances of successful substance misuse treatment.

Areas of highest deprivation are in the south and west of Thurrock particularly in parts of Tilbury and South Ockendon. Around 4% of Thurrock residents live in areas nationally described as the most deprived and 1% in areas of lowest deprivation. Around 6% of Thurrock children aged 0 to 15 live in income deprived families.

Housing

In 2020- 2021 in England around 17% of adults in treatment for substance misuse said they had a housing problem. This ranged by type of substance with 10% of those treated solely for alcohol dependence, 30% of those with opiate misuse and 45% of those with new psychoactive substance problems reporting housing difficulties. Around 66% of people experiencing homelessness cite drug or alcohol use as a reason for first becoming homeless. Those who use drugs are 7 times more likely to be homeless.

Thurrock has significantly more households in temporary accommodation (3.5 per 1,000 households) than East of England (2.4 per 1,000 households) but fewer than England (4 per 1,000 households). Latest data available for Thurrock shows that rates of households assessed as being homeless and those threatened with homelessness has reduced significantly between 2019/20 (10 per 1,000) and 2020/21(6 per 1,000 households). Rates are now comparable to England and East of England whereas in 2018/19 and 2019/20 Thurrock rates were significantly higher.

Employment

In a 2016 review of the impact of alcohol and illegal substance dependence on employment outcomes, Dame Carol Black noted that “Alcohol misuse may also be a cause or a consequence of unemployment. It is certainly a predictor both of unemployment and of future job loss, but evidence also suggests that increased alcohol consumption may follow job loss”. In Thurrock the proportion of people claiming unemployment benefit in 2022 was similar in Thurrock (4.2% of the resident population) compared to East of England (3.5%) and England (4.3%). Rates of unemployment are highest at around 6% in Tilbury Riverside and Thurrock Park, Tilbury St Chads and Belhus wards.

Crime

Crime and substance misuse are known to be closely associated, and people with substance misuse problems are common in criminal justice settings. Specific types of crime have been linked to particular types of substance misuse. People using alcohol compared to other substances are more likely to commit assault, and those committing burglary are more likely to be using opiates rather than other substances. Generally, the pharmacological effect of substance misuse is to reduce inhibitions, increase confidence and impair judgement in relation to criminal activity. Overall crime rates have been generally higher in Thurrock compared to England and East of England since 2018/19. Rates of violence against the person crime rose year on year from 2015/16 (18 per 1,000 population) to 2019/20 (33 per 1,000 population) then decreased in 2020/21 (30 per 1000 population). Rates in Thurrock are higher than England and East of England which are both around 25 per 1,000 population

Substance misuse features in around half of all UK domestic homicides and since 2011 substance use has been detected more than four times as often in perpetrators compared to those who have been killed by them. Up to 60% of men in domestic violence perpetrator programmes have problems with alcohol and/or drugs. Rates of domestic violence in Thurrock have increased from 21.3 per 1,000 population in 2015/6 to a peak in 2019/20 of 29.1 per 1,000 population. Similar rates and trends are seen in England and East of England.

Young people

There are a range of factors linked to the likelihood that children and young people will misuse drugs and alcohol; and this can continue and be problematic into adulthood. This includes children and young people drawn into crime, those who are in the care system and those who experience hidden harm.

Amongst school-aged pupils truancy, substance misuse, crime and anti-social behaviour tend to cluster together. For example, early alcohol use not only increases the risk of subsequent criminal activity but is also associated with cannabis use, truancy, and disengagement from school. One study reported that 41% of young offenders report that they had been drinking at the time of their offence.

The number of offences proven to be committed by children in Thurrock has fallen from 255 in 2017/18 to 110 in 2020/21. The greatest reduction was for theft and handling stolen goods (42 vs 6), violence against the person (79 vs 42), drugs (30 vs 8), and criminal damage (33 vs 11).

Looked after children are children in the care of a local authority. Young people in care aged 11–19 years have a four-fold increased risk of drug and alcohol use compared to their peers. A national survey of care leavers in England showed that 32% smoked cannabis daily and data from 2012 showed that 11.3% of young people in care aged 16–19 years had a diagnosed substance use problem. Rates of looked after children in Thurrock (31 per 10,000 child population) are higher than for England (21 per 10,000 child population) and East of England (18 per 10,000 child population).

Epidemiology of Drug and Alcohol misuse in Thurrock

National government and local key performance data typically categorise the misuse of drugs and/or alcohol into four substance groups, these are

- Alcohol only
- Non-opiate and alcohol
- Opiate only and
- Non-opiate only

Non opiate drugs include cannabis, cocaine, crack cocaine, MDMA, ketamine, amphetamines steroids and novel psychoactive substances such as spice. Opiate drugs include heroin, and a range of medications available on prescription such as codeine, fentanyl, and morphine.

Prevalence

Based on 2016/17 estimates there are around 4.3 opiate users per 1,000 aged 16 to 64 years in Thurrock compared to the significantly higher England average of 7.4 per 1,000. There are similar rates of crack cocaine users (4 to 5 per 1,000) in people aged 16 to 64 years in England and Thurrock. When applied to 2021 populations these prevalence rates equate to around 493 people using opiates and 450 people using crack cocaine in Thurrock.

Cannabis is one of the most commonly used drugs and in the most recent survey in England and Wales, 7.6% of adults said that they had used cannabis in the last year, the highest proportion since 2008/09. In 2018/19, cannabis use in the last year among 16- to 24-year-olds

was 17%, its highest point for a decade. If this rate is applied to the Thurrock population this would equate to around 10,000 adults and around 3,400 young people aged 16 to 24 using cannabis at least once in the past year. However, this doesn't give an indication about the frequency of cannabis use by individuals and it is unclear from these figures how many people would benefit from treatment services compared to the benefits of a wider harm minimisation approach across the population of Thurrock.

There were an estimated 1,600 adults with an alcohol dependency in Thurrock in 2018/19 at a rate of about 1.2 per 100 residents. The proportion of people abstaining from drinking and those drinking over 14 units of alcohol per week were both significantly lower for Thurrock than England.

The table below shows the estimated percentage of people who are dependent on opiates and/or crack cocaine but are not in the treatment system, for Thurrock and England in 2021/22. For alcohol, the percentages in the table below relate to the population aged 18 and over, but for opiates/non-opiates the percentages relate to the population aged 15 – 64. Data are based on reported drug and alcohol usage by clients that are not currently in treatment. The unmet need in Thurrock, for all substance types, is substantially higher than the estimated unmet need in England indicating that the majority of people in Thurrock experiencing drug and alcohol problems, who may benefit from treatment, are not currently receiving support.

Table i: The estimated proportion of people in your area who are dependent on opiates and/or crack cocaine or alcohol not in the treatment system, 2021/22

Estimated prevalence of unmet need for opiates and/or crack cocaine or alcohol		
Drug and/or alcohol issue	Thurrock	England
Opiate	79.2%	53.7%
Non-opiate	69.2%	47.1%
Alcohol	82.2%	57.6%
Non-opiate and alcohol	90.4%	80.5%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

Mortality

Rates of death due to drug poisoning between 2018 to 2020 are half that in Thurrock (3.2 per 100,000) compared to East of England (6.4 per 100,000) and England (7.6 per 100,000). Alcohol related mortality was lower in Thurrock (27.1 per 100,000) compared to East of England (32.4 per 100,000) and England (37.8 per 100,000) but these differences are not significantly different. In 2017-19 alcohol specific mortality in Thurrock (7.2 per 100,000) was significantly lower than in England (10.9 per 100,000) but not East of England (8.2 per 100,000)

Service use

Around two thirds of people in treatment are male and one third female and in 2020/21 people were most commonly in specialist treatment in Thurrock for opiate misuse (43%) similar to the proportions in England (47%) and East of England (41%). The second most common reason for treatment in specialist services was alcohol misuse (around 25% for Thurrock, England, and East of England). Since 2015/16 the number of people in treatment has decreased from

715 to 330, and new referrals have decreased from 430 in 2015/16 to 170 in 2020/21 It is unclear why this is the case.

The proportion of drug and/or alcohol misuse clients in treatment in Thurrock belonging to white ethnic groups was consistently around 90% in the period from 2015/16 to 2020/21. The most recent information about ethnicity and prevalence of drug and alcohol misuse in England is from 2014. This indicates that around 9% of white people consume illicit drugs compared to 12% Black/African/Caribbean/Black British people and these proportions are 15% and 7% respectively for misusing alcohol at hazardous, harmful, or dependent levels. In Thurrock people of Black ethnic groups make up 7.8% of the population yet make up only around 3.1% of those treated in 2020/21. In comparison less than 4% of people from Asian ethnic groups consume or misuse drugs or alcohol, and make up 3.6% of the population in Thurrock, yet in 2020/21 they comprised a similar proportion in treatment to those from Black ethnic groups. It is likely therefore that there is an under representation of people from Black ethnic groups in treatment services in Thurrock.

Services Working Together

Adult Substance misuse service- Inclusion Visions

This HNA has gathered data and the views from professionals who provide adult drug and alcohol prevention and treatment services as well as teams who are likely to come in contact with people who misuse drugs and alcohol. These include:

- Adult drug and alcohol treatment services
- Children and Young People's substance misuse services
- Probation Service
- Essex Police
- Violence Against Women and Girls
- Young Offenders Service
- Housing and Homeless Service
- Adult mental health service
- Alcohol Liaison Service
- Primary Care
- Individual Placement Support Service

Inclusion Visions Thurrock (IVT) is the drugs and alcohol treatment service in Thurrock with a service level agreement(SLA) focussed on:

- A prescribed assessment and treatment process
- Outreach and engagement
- Working with other organisations to support people and reduce harm from alcohol and drug misuse

Around 70% of referrals are self or originate from the family, 9% through the criminal justice system and 7% via the GP. These rates are similar to England.

Overall, the target of successful treatment completions for opiate treatment was met for the three-year period from April 2019 to March 2022. There is much more variability for successful completion rates for the other substance types with a dip in all three below target in mid to late

2020, with improvement in Spring 2021 which is maintained for April 2021 to March 2022. The dip may have been due to a response of IVT to the pandemic to hold on to people in treatment for longer to support them through the difficult period. Rates of unplanned exits from treatment are higher in Thurrock than for England for all four substance types.

When service users are asked about their views, they are very positive about the service and their experience. Feedback was very useful about preferences for how interventions are delivered. A combination of face to face and phone calls was preferred which supported service users need to meet with IVT key workers and the flexibility to work around jobs and childcare demands. Identifying service users who would be willing to be part of future discussions will be helpful in planning an approach to co-design of a new service.

Currently the service is working hard to increase engagement and outreach across Thurrock as this had dwindled due to the pandemic.

Other services treating Thurrock residents for drug and alcohol misuse are the Alcohol Liaison Service in Basildon University Hospital, part of Mid and South Essex NHS Foundation Trust and GPs in primary care. People are screened for alcohol misuse in both settings, often with the AUDIT-C questionnaire and interventions are tailored to their response. These can be lifestyle advice, health education, signposting to services brief interventions, pharmacological support, and referral to specialist treatment services. The ALS can also refer to the High Intensity User (HIU) service based at Basildon Hospital. Third sector support from community groups, Community Interest Companies and the voluntary sector are also important focussing on harm minimisation and recovery from substance misuse.

People with co-occurring conditions and complex needs

People with substance misuse challenges frequently have mental health problems alongside other difficulties such as with housing, employment, and relationships. People with co-occurring conditions and complex needs represent a significant proportion of those seen by the drug and alcohol service. Table ii shows the proportion of adults in treatment for drug and alcohol misuse who have a co-occurring mental health condition in 2020/21. The rates across Thurrock, and England are similar as confidence intervals overlap, however, those in the East of England appear to be lower than those in England.

Table ii: The proportion (%) of service users entering drug or alcohol treatment identified as having, and in treatment for a mental health need, for England, East of England, and England in 2020/21

Area	Co-occurring mental health and drug treatment needs			Co-occurring mental health and alcohol treatment needs		
	%	Lower 95% CI	Upper 95% CI	%	Lower 95% CI	Upper 95% CI
England	74	72.7	75.2	83.5	82.1	84.8
EofE	71	70.6	71.4	80.4	80.0	80.8
Thurrock	63.8	52.0	74.1	79.2	65.7	88.3

Source: OHID Co-occurring substance misuse and mental health issues Fingertip's tool data provided by NDTMS

CI- Confidence interval

When these rates are analysed by substance type (Table iii) there is a higher proportion of people with mental health problems having treatment for non-opiate misuse (86.4%) in

Thurrock compared to England (68.5%). In contrast, mental health issues were identified in only 49.1% of people treated for opiate misuse in Thurrock compared to 63.5% of those in England. It is unclear if these are important differences as confidence intervals are not available.

Table iii: Service users entering treatment identified as having a mental health treatment need

Substance Category	Latest period 2021/22		National Average
	%	n	
Opiate	49.10%	26/53	63.50%
Non-opiate	86.40%	19/22	68.50%
Alcohol	76.10%	51/67	68.30%
Alcohol and non-opiate	68.30%	28/41	74.30%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

Table iv shows the proportion of people with an identified mental health treatment need who are being supported by the drug and alcohol services and whether they are in receipt of mental health support. In Thurrock 58.1% of people in drug and alcohol treatment were receiving support compared to 73.2% nationally. The gap appears to be associated with receiving mental health treatment from GPs, which shows a 20% difference between England and Thurrock.

Table iv: Service users identified as having a mental health treatment need and receiving treatment for their mental health

Service user mental health treatment type	Latest period 2021/22		National Average
	%	N	
Already engaged with the Community Mental Health Team/other mental health services	11.3%	14/124	19.2%
Engaged with IAPT (Improving Access to Psychological Therapies)	5.6%	7/124	1.7%
Receiving mental health treatment from GP	38.7%	48/124	58.3%
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	2.4%	3/124	1.1%
Has an identified space in a health-based place of safety for mental health crises	0.0%	0/124	0.6%
Treatment need identified but no treatment being received/Declined to commence treatment for their mental health need/Missing	41.9%	52/124	26.8%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

County Lines

The gangs and organised criminal networks exporting illegal drugs in and around Thurrock known as County Lines (because they use mobile phones as their deal line) has been described in two recent reports; the 2019/20 annual report by the Director of Public Health -

Youth Violence and Vulnerability: the crime paradox and a public health response; and the Children's partnership strategy for 2021-2026 - Brighter Futures: developing well in Thurrock.

The Brighter Futures strategy draws heavily on the 2019 annual public health report which includes young people aged 10-24, spanning the transition period between the young people and adults' substance misuse treatment services. There are a range of risk factors predictive of someone becoming involved with serious youth violence and gang involvement, including family dysfunction, individual behaviour or cognitive issues, exclusion from education, criminality, and substance misuse.

Thurrock's proximity to London, transport links and comparatively lower rent has resulted in displacement of gang associated children and adults into the borough from the capital. There has been a 33% increase from 2017/8 to 2018/19 reported by the Gang Related Violence Operational Group. With this increase there has been a shift in ethnicity with an increase from 19.1% to 28.4% of people who are white gang members between 2017/18 and 2018/19 with a concomitant 10% decrease in the proportion of Black/Black British gang members from 66.7% to 56.8% respectively.

There is limited data available to understand the full connection between youth violence, gangs, and drugs as there is no linked data set between the Youth Offending Service, drug treatment services and police data.

As a proxy for the trend in gang related crime and trafficking, table v shows the number and proportion of children in need assessments, which indicated some involvement between 2018 and 2021. Trafficking is recorded where a child is moved for reasons of exploitation whether or not the child has been deceived. Involvement in gangs is recorded where a child is part of a street or organised crime gang for whom crime and violence are a core part of their identity. The proportion of children recorded in gangs varies between 2.9% and 3.7% of all children in need assessments whilst trafficking is recorded in 0.7% to 1% of cases. Despite the proportions of children identified as being involved in trafficking or gangs through the assessments being similar across the years, the number of assessments undertaken has more than doubled and the number of cases increased by 70%.

Table v: Number and proportion of Children in Need assessments highlighting involvement in gangs or trafficking in the household as a factor for Thurrock, 2018 to 2021

Year	Number		Percentage of Assessments	
	Involvement in Gangs/total No assessments	Involvement in trafficking/total no assessments	Involvement in Gangs	Involvement in trafficking
2018	73/2,027	15/2,027	3.6%	0.7%
2019	119/3,216	33/3,216	3.7%	1.0%
2020	134/4,060	35/4,060	3.3%	0.9%
2021	124/4,276	30/4,276	2.9%	0.7%

Source: Department for Education. Children in Need Statistics. Characteristics of Children in Need, 2020/21

The total number of people with police recorded crimes relating to drugs between 2015/16 and 2020/21 is shown in Table vi below. The number of recorded crimes for drug trafficking has more than doubled since 2015/16 as has possession of cannabis, whereas possession of controlled drugs excluding cannabis has fallen from 21% to 9% of total drugs offences over the same period.

Table vi: Number of police recorded crimes relating to drugs, 2015/16 to 2020/21

Total Number of Police Record Crime Related to Drugs, all Thurrock						
Type of Drug Offence	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Possession of controlled drugs (cannabis)	181	214	243	289	346	369
Possession of controlled drugs (excl. cannabis)	61	60	63	61	59	46
Trafficking in controlled drugs	48	57	57	84	100	111
Other drug offences	0	5	1	3	4	1
Total	**290**	**336**	**364**	**437**	**509**	**527**

Source: Home Office - Police recorded crime

Thurrock Council has set out the strategic approach to address the challenge of increasing County Lines activity in the Brighter Futures children's partnership strategy. The aims focus on both universal population-based approaches and targeted mechanisms to support people to make different life choices. The key strategic aim involving the drugs and alcohol teams includes creating a locality based multi-disciplinary panel that can address risk factors strongly associated with serious youth violence and gang involvement by:

- Sharing intelligence across stakeholders from children's social care, health providers, Brighter Futures, young people and adult drug and alcohol treatment services, education, schools, community safety, housing, the police, local area coordinators and relevant third sector organisations
- Undertaking rapid operational action to reduce and mitigate risks through enforcement activity, community development, estates management
- Addressing identified drug availability/dealing within neighbourhoods
- Further develop surveillance to identify the most at-risk children and families and intervene with tailored intervention packages
- Deliver targeted and tailored primary prevention for populations of greater need

Current activity where IVT and the police collaborate include advice sought from IVT about vulnerable people identified by Essex Police via Operation Raptor. Typically, this group of vulnerable people are used by gangs and supplied with drugs and alcohol whilst gang members take over their accommodation and finances (known as cuckooing).

A further initiative is Operation Cloud involving the police texting all contacts on burner phones associated with gang activity seized by police, advising people of alcohol and drug misuse support services available to them with the message; 'Your drug supply has been cut have you thought about now's a good time to enter treatment'. It is unclear as yet whether this has resulted in people engaging with either the children's and young peoples or adult substance misuse services.

Activities enabling delivery or access to substance misuse treatment services

There are several initiatives to link the adult drug and alcohol service to other teams so they can work together to support people with co-occurring conditions and complex needs. Many of these initiatives are in the process of being implemented.

The Blue Light Project has been in place since 2018 and aims to develop alternative approaches and care pathways for drinkers who are not in contact with treatment services, but who have complex needs. Referrals are made to one of the two Local Action Groups (LAG) that comprise of the police, IVT, housing (both council and private housing associations) and the adult mental health teams. Agencies discuss and agree the best approach to supporting and engaging with the person.

The Supported Living Plus pilot for people in supported living accommodation and Housing First for people in council or social housing aims to provide immediate support for those with co-occurring conditions and complex needs. These pilots are in the process of being implemented. A senior substance misuse worker with specialist skills for working with, for example, people with learning difficulties, or those who are older with mental health challenges will work with people who are finding it hard to recover from difficulties in their lives. This worker will provide leadership to the rest of the team and facilitate access to the relevant service the person needs to stabilise their situation.

A recent initiative with the refuge in Thurrock has seen IVT developing ways to support women and children who may have substance misuse problems.

The collaboration between the police, probation and IVT around the integrated offender management programme is working well with consistency across the county.

Staff co-located with IVT include:

- A substance misuse worker whose role is to work with young adults and link with the young people's service
- Probation service staff working in IVT offices for some days of the week
- Open Road, provides that the individual placement support service to help people back into work or volunteering

Barriers to delivering or accessing services

Limitations of the IVT service level agreement restricts the remit of the adult drugs and alcohol service. For example, where people are reluctant to engage with the service there is little IVT can do to support them as assertive outreach is not currently part of the IVT remit.

The difference in approach between the young peoples and adults' services mean that when young people move to an adult service and the statutory support changes, it can be a difficult transition. Older teenage and young adult group have particular needs and vulnerabilities and it's important that both adult and young people's services provide a similar coordinated approach to ensure the transition is as seamless as possible.

Relationships between the adult drug and alcohol service and primary care and the ALS is not as strong as with Essex Police, the probation service, and the mental health teams. Strengthening these relationships and developing new pathways are underway. IVT working in the planned Integrated Medical Centres will also be beneficial.

Gaps in support for users of the substance misuse services

The collection of access to and sharing of data and intelligence between services was highlighted as an important gap in the current system. This will need addressing with increased integration of services and systems. This was mentioned by Essex Police, the Adult Mental Health Teams, the Community Safety Partnership, Trading Standards team, and the young person's substance misuse service.

There is limited understanding by teams about how other teams work. For example, people in the housing team are keen to understand better how IVT works. There is the potential to upskill staff in the housing team in contact with people who would benefit but do not currently engage with drug and alcohol services. Similarly, the IVT team may benefit from upskilling in some areas of mental health support and vice versa.

There is a lack of evaluation of initiatives, so it is unclear what works and what does not. With a rapid cycle testing approach new processes and pathways can be rapidly assessed with ongoing adjustments to ensure the system works effectively for residents and professionals alike.

Historically CGL Wize Up the children and young people's substance misuse service was considered by stakeholders to have provided a good service to Thurrock. However, the service is highly dependent on a small number of key staff members some of whom have been absent for some time, whose roles are being covered by agency and interim staff. The maintenance of the relationships between agencies and the work with schools and outreach activities has dwindled and there is concern that this is impacting on the visibility of the service. This includes a gap in the information, intelligence and CYP substance misuse expertise available to the range of partnership and multidisciplinary fora they would usually attend. In the community and schools, the lack of visibility makes it difficult to create a credible voice to facilitate the trusted relationships necessary for this type of service and to upskill teachers in having difficult conversations that may lead to referrals into the service.

What would staff and service users would most like to see….

Professionals and service users were asked what they thought would be of most benefit to people with substance misuse problems.

Responses included:

- A green space for community projects to bring all service users together (e.g., people in contact with mental health, housing, social care services)
- A small, combined substance misuse/mental health team
- Specialised support for people in refuge with co-occurring conditions
- Development of more peer led support/mentoring for young people and adults
- Development of the soup kitchen into a hub where people could meet services and other agencies
- Cross-agency mentoring
- Time to build relationships and think creatively about co location of services
- Funding to increase salaries to solve the workforce problem

Recommendations

The prevention and reduction of drug and alcohol misuse is included in strategies of a broad range of agencies involved in health, care, and the criminal justice system in Thurrock. However, there is no overarching strategy that brings all those elements together. The Department of Health have asked local authorities to develop a Combating Drugs Partnership (which can include alcohol) which would see all the agencies develop and implement a joint strategic approach. This will support Thurrock's current integration plans and the human learning system perspective to service provision. The facilitation of closer relationships between services, removal of barriers to accessing them and a focus on what is important to the resident aims to improve outcomes for all residents misusing drugs and alcohol but especially those with co-occurring conditions and complex needs.

The strategic transformation of alcohol and drugs misuse prevention and treatment provision is underway. In supporting this the HNA has identified some additional recommendations for consideration by services.

Area	Finding	Recommendations
Strategy		
National drug and alcohol strategy	New national guidance has been produced about implementing a Combatting Drugs Partnership (CDP), that takes responsibility for the agreement of a local drugs and alcohol strategy delivery plan that reflects the national strategic priorities. Activities of the group include producing an HNA, a strategy and establishing processes to collect metrics required for National Combating Drugs Framework.	Ensure action plan is put in place to meet national timeline for set up of CDP, completion of HNA, development of strategy and process to collect relevant metrics.
Local alcohol strategy (CLeaR)	The CLeaR recommendations from the 2019 peer assessment have yet to be implemented.	Ensure the CLeaR recommendations are included in the CDP agenda (as it covers both drugs and alcohol) and are part of delivering the local plan.
Commissioning	The current service level agreements for substance misuse services are limited in scope and constrain staff in what they can do to engage and support individuals in the most effective ways.	When the current contract ends, re-commission a systems level drugs and alcohol service in line with Thurrock Councils' ambition to use a human learning system approach to service delivery..
Partnership working		
Harm minimisation	There is considerable unmet need concerning use of drugs and alcohol in Thurrock. In terms of the proportion of the population affected this is greatest for young people's use of cannabis and adult alcohol misuse. However, there is considerable unmet need for all types and combinations of drug and alcohol misuse.	Implement a whole systems approach to harm minimisation, particularly around the areas of cannabis use in young people and alcohol use at a population level. This requires a collaborative approach combining the following sectors; community; health; social care; police; environment and voluntary organisations
Suicide awareness	Substance misuse is an important factor in many suicides. Teams from substance misuse, housing, and homeless services working with people known to use drugs or misuse alcohol are not trained to pick up signs of someone with an increased risk of suicide	Suicide awareness training should be carried out with all agencies working with individuals considered to be at higher risk of suicide. The need for training should be captured in future service specifications for both the Adult and Young Persons' Substance Misuse services.
Working together	Teams that work together do not always understand the limitations of each other's remit and the best way of working together.	Ensure that service and role specifications outline how support will work between agencies for people with complex needs i.e. they have substance misuse problems co-occurring with one or more challenges concerning, housing, mental health, physical health, and the criminal justice system.

What does integration really mean?	With a new way of working it will be important to be able to clearly describe how integration will work across teams, to wider professional groups and service users.	The CDP should facilitate development of case studies for how integration will work across teams with bespoke versions disseminated to wider groups of professionals and service users, including but not limited to those in health, social care, housing and the police.
Relationship building	The relationship between drug and alcohol prevention and treatment services and partners in health was not strong.	The CDP should facilitate relationship building between drug and alcohol prevention and treatment services and primary and secondary care. There should be an increase in the number of referrals arising from health settings into the relevant drug and alcohol services.
Service development		
Transition between young peoples and adult services	The difference in approach between the young peoples and adults' services mean that when young people move to an adult service and the statutory support changes, it can be a difficult transition.	The commissioner should ensure the successful integration of a transition worker into the adult drug and alcohol service where the remit is to develop a seamless pathway between children and young peoples and adult services and to develop an approach tailored to the needs of young adults.
Cross working between teams	There is an aspiration towards a Human Learning System approach to providing services, however working in siloed teams is still prevalent.	The Thurrock Mental Health Transformation Board should foster a culture of collaboration and cross-working between Adult Mental Health Services, Housing, Homeless services and substance misuse services in line with a human learning systems approach. This could for example involve upskilling of housing officers in mental health and substance misuse awareness and training.
Alcohol liaison service	The Alcohol Liaison Service has not returned to pre-pandemic activity levels. In some part this is due to clinical staff having less time to screen patients for alcohol misuse when ALS are unavailable.	Through joint working with Essex County Council, the commissioner should facilitate a move towards an ALS where all individuals are screened, regardless of availability of specialist ALS staff. The short-term ambition should be for the ALS to return to activity levels seen pre-pandemic.
High Intensity User Service (HIU)	The HIU was implemented as a way of reducing winter pressures in 2020 in Basildon Hospital. It is unclear whether any referrals of Thurrock residents have been made.	The commissioner should ascertain if Thurrock residents identified as a high intensity users of secondary care services by the ALS are referred to the HIU service and if not, how the HIU service can be utilised
Information and evaluation		
Data sharing	It is not possible to see all the contacts an individual has had with different agencies so decisions are made with partial information which may not result in the most effective outcome for individuals.	Facilitated by the CDP, all relevant partners should develop sustainable systems of data sharing for staff working with service users so they have access to a full picture of the engagement and interventions recorded from all health, care, and criminal justice organisations

Intelligence sharing	Intelligence sharing between agencies is limited and it is not possible to link important information which would enable better outcomes for individuals whilst reducing harm and criminal activity.	As part of the CDP, develop an approach to intelligence sharing between agencies. This includes, but is not limited to, information sharing between the Local Authority, Police, Prison and Probation service, and the Integrated Care Board
Evaluation	There is little evaluation of any initiatives to reduce harm from drug and alcohol misuse so it isn't clear what is working well and what is less effective.	Rapid evaluation of local interventions relevant to alcohol and substance misuse should be undertaken, with priority given to those in receipt of grant funding. The outcomes of initiatives should be determined to establish if they are making a difference and how, or if resources could be better directed elsewhere
Topics to explore	Several questions have arisen during this HNA. These include:	The relevant commissioner (mental health or substance misuse services) should explore these questions with relevant partners and report the outcomes to the CDP. This will inform future decision making concerning reducing inequalities and improving the quality of services.
	What is the relationship between suicide (and attempted suicide) and drug and alcohol misuse?	
	Why has there been a reduction in referrals to the substance misuse service over the past 5 years?	
	In addition to Black ethnic groups which other groups are under represented in treatment services and what are the specific barriers to access?	
	What is the reason for the reported low levels of follow up by GPs of those with severe mental illness who have a positive screen for alcohol or drug misuse?	
Service Users		
Co production	The CDP will need to include people who have been affected by drug related harm. NHS England and the DHSC has recently published statutory guidance on the legal public involvement duties of the integrated care system, describing ways to include community and service users in co designing and co-producing services.	The commissioner should develop a methodology for ongoing co-production of the local alcohol and drugs strategy delivery plan, system specification, service development and for the exploration of the experience of service users in line with a human learning systems approach. This should include the IVT volunteer coordinator and the service user involvement lead, as well as service users who have indicated a willingness to be contacted in the future for this purpose.
Service user wellbeing	The need for support for the wellbeing of service users as they recover and post -recovery was emphasised with a focus on outdoor community activities that could be for the benefit of all.	The commissioner, in partnership with providers, should explore options for service users to carry out purposeful activities with a community action approach for the benefit of all.

1 Introduction

1.1 Introduction

This health needs assessment (HNA) explores the needs of adults living in Thurrock who have accessed or would benefit from accessing drug and alcohol misuse treatment services. Substance misuse causes increased harm to individuals, those closest to them and to wider society. People misusing alcohol and /or drugs often have other difficulties in their lives such as mental health conditions, problems with housing and employment, or are engaged in crime. An effective population-based strategy concerned with prevention and minimising the impact of harm on individuals, their families, and the communities where they live requires systemwide partnership working between agencies that have traditionally worked as standalone teams, with a fixed referral process and prescribed interventions. This alcohol and substance misuse HNA aims to inform the development of an integrated strategy to commissioning across Thurrock.

This report includes nationally and locally collected quantitative data about the level of need and type of services required to support people with drug and alcohol misuse problems. The report also draws on qualitative information gathered from stakeholders about where local services are working well, and where there are barriers to support that some people experience. In addition, how service providers and agencies work together, and the gaps in provision for some population cohorts, particularly those with co-occurring conditions or complex needs are explored.

The focus of the HNA is on adults and their needs. It is clear however, that the age threshold of 18 between the adult and children and young people's services can be a barrier to young adults accessing support. Information about young people's services has been included where it has a bearing on adult services and the transition between the two.

1.2 Aims and Objectives

Five key objectives for the HNA were agreed with Thurrock Council following contract award:

6. To present qualitative and quantitative data concerning service needs and provision, to inform the recommissioning of local drug and alcohol misuse services. The focus is on organisations in contact with people with substance misuse problems, and how services support the needs of the residents in Thurrock.
7. To identify gaps in the local service provision, including consideration of those who do not engage with services, and seeks to identify any barriers and potential solutions to lack of engagement. This includes the transition between the CYP alcohol and substance misuse service and the adult service, and those with co-occurring conditions.
8. To describe examples locally or from other areas concerning harm minimisation approaches, in particular for alcohol misuse. This includes how to support the evolving demands on teams for post-pandemic reset and recovery.
9. To estimate the number of Thurrock residents with co-occurring conditions of substance/alcohol misuse and mental illness, and those with complex needs involving other difficulties such as housing and employment (recognising that this is an area where data are sparse, and information limited).
10. To seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems (HLS) co-design approach.

2 National Context, Policy and Guidance

Summary: National context, policy, and guidance

Prevention programmes and initiatives aim to reduce the use of alcohol and drugs, and there are key elements important to ensure the effective implementation of prevention strategies. These include:

- Strong leadership
- Effective data sharing and analysis to inform partnership responses
- Broad, universal population-level evidence-based approaches
- Targeted interventions for those at higher risk
- Highly skilled workforce to deliver evidence-based treatment and recovery services

Approach to Alcohol Misuse

A 'what works' universal approach to alcohol misuse for the local population includes making use of licensing powers and managing the accessibility and availability of alcohol. The 2012 national Alcohol Strategy recommends introducing a minimum unit price for alcohol, banning the sale of multi-buy alcohol discounting, and giving local areas and communities the power to control the density of licensed premises. The 2010 to 2015 policy paper aimed at reducing harmful drinking touches on making alcohol less appealing to young people as well as making cheap alcohol less available as potential prevention methods to reduce alcohol misuse. There is an expectation that the alcohol industry will share responsibility in promoting sensible drinking amongst the population by making less harmful products, and by providing unit information on drinking products by 2013.

Approach to Drug Use

Preventing and reducing the harms from illicit drug use can be approached from a public health perspective and/or through enforcement activities in the criminal justice sector. Both approaches are needed with universal and targeted interventions to reduce drug use and the risk factors leading to drug use in the population, in addition to law enforcement for serious offences. Partnership working between agencies employing each of these approaches is important for a coordinated approach and is outlined in the June 2022 guidance from the government 'From harm to hope: a drugs plan to cut crime and save lives'. It's also recommended that the partnership forum is concerned with both alcohol and drug misuse.

Support for professionals working with people misusing substances

The government have set up various boards and frameworks, as well as toolkits, and referral pathways to assist healthcare professionals, practitioners, frontline staff, teachers, youth workers, and any others who may be come across someone experiencing drug and alcohol misuse or are at risk of drug or alcohol misuse. For people with co-occurring conditions the need for collaboration between providers and services from across the sector is of paramount importance. For both drugs and alcohol, data sharing that informs local enforcement activity, and education of younger people is important. Ensuring there are drug and alcohol specific resources available for professionals who can refer and signpost people to the appropriate service is essential.

Young people

There is a focus on prevention and early intervention for children and young people, as it is fundamental to deter people from drug and alcohol misuse as early as possible to avoid problems and behaviours becoming complex and entrenched. This includes working with parents and carers and ensuring a whole family approach is taken when dealing with drug or alcohol misuse. One recommendation drawn from the United Nations Office on Drugs and Crime (UNODC) international standards is to work with children in infancy and on into adolescence, focusing on early intervention, personal and social skills, and working on risk and resilience amongst children.

National guidance and reviews acknowledge that to ensure that vulnerable children are identified at early stages of drug and alcohol misuse, front line staff and those coming in to contact with these children need to be adequately trained to recognise the signs. The guidance documents on county lines highlight the signs that frontline staff need to be aware of to recognise vulnerable children at risk of exploitation.

Core20PLUS5

In addition to the national government drugs and alcohol policy and guidance, NHS England and NHS Improvement has a national focus on reducing inequalities called Core20PLUS5. Five clinical areas focussing on the 20% most deprived populations and groups most likely to experience inequality including those with drug and alcohol dependency will be supported by national and regional teams to meet national targets.

Whilst national policy and guidance about drugs and alcohol related harm are two distinct areas of focus, there is undoubtedly overlap between them. This chapter describes the national approach to alcohol and drugs policy separately and then explores the overlap. An important group of people with drug and alcohol misuse problems are those with co-occurring conditions and complex needs, and this topic is explored at the end of the chapter

2.1 Alcohol

Analysis by Public Health England (PHE) in 2016 estimated that, nationally, 10.4 million adults drink at levels that increase their risk of harm[1]. The current NHS guidelines are to drink no more than 14 units of alcohol a week, spread across 3 days or more to reduce harmful impacts of binge drinking and general alcohol misuse[2]. In 2018 PHE developed a set of slides for local authorities to use as a basis for making the case for investment[3]. This outlined how harm related to alcohol misuse affects health, families, and communities. Hazardous effects on health include the likelihood of a person developing conditions such as liver disease and cancers. Alcohol misuse leads to increased hospital admissions (up to 1.1 million alcohol-related admissions a year), and in severe cases will be the cause of death. Around 24,000 people with an average age of 54 died from alcohol related causes in 2016. Parents who depend on alcohol are more than likely to harm the health and wellbeing of children. Misuse use of alcohol can impact decision making, resulting in inappropriate caring behaviour. It is estimated that the annual social and economic costs of alcohol related harm in the UK amounted to £21.5bn. This includes costs associated with deaths,

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf
[2] Drink less - Better Health - NHS (www.nhs.uk)
[3] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

the NHS, crime, and lost productivity. It is estimated that investing into specialist interventions targeted at young people can result in £4.3m health savings and £100m crime benefits per year. Evidence suggests that a 7-10% reduction in the number of young people dependent on alcohol, the lifetime societal benefit of treatment could equate to between £49-159m. For every £1 invested, there could be a potential saving of £5-£8[3].

2.1.1 National alcohol policy

The UK Government's most recent national strategy around alcohol was published in 2012[4]. With a focus on reducing binge drinking, alcohol related violence and the number of people drinking to damaging levels, the alcohol strategy contained several recommendations, including:

- Introducing a minimum unit price for alcohol
- Banning the sale of multi-buy alcohol discounting
- Giving local areas and communities the power to control the density of licensed premises,
- Piloting sobriety schemes to challenge alcohol-related offending

Following the 2012 strategy, the UK Government subsequently published a policy paper, 2010 to 2015 government policy: harmful drinking[5] relating specifically to alcohol misuse and harm. This policy paper outlined the Government's wish to see:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others
- A reduction in the amount of alcohol-fuelled violent crime
- A reduction in the number of adults drinking above the lower-risk guidelines
- A reduction in the number of people binge drinking
- A reduction in the number of alcohol-related deaths
- A reduction in the number of people aged 11 to 15 drinking alcohol and a reduction in the amount they drink

Specifically, the Government outlined:

- The Change4Life campaign which informs people about risks of drinking and provides tools and tips to reduce their drinking
- An alcohol risk assessment be made available in the NHS health check for adults aged 40 to 75.
- A desire to improve treatment for alcohol dependence through a drug and alcohol recovery pilot programme that involves a 'payment by results' scheme
- Shared responsibility with the alcohol industry though a Public Health Responsibility Deal
- Making cheap alcohol less available and reconsidering marketing methods which make alcohol more appealing to young people are also recommendations in this policy

After the national 2012 Alcohol Strategy some of the alcohol harm related policy was subsumed by the Modern Crime Prevention Strategy[6], published in 2016. Contained within this document were several alcohol-related crime objectives, however the document itself marked a departure from a single, health focused, central alcohol policy.

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

5 https://www.gov.uk/government/publications/2010-to-2015-government-policy-harmful-drinking/2010-to-2015-government-policy-harmful-drinking

6 https://www.gov.uk/government/publications/modern-crime-prevention-strategy

This Modern Crime Prevention Strategy focused on three areas for addressing alcohol harm[7]:

- Improving local intelligence
  - Information on where alcohol-related crime and disorder is occurring to be published by the police
  - NHS Trusts to share alcohol-related violence data to support licensing decisions
  - Licensing authorities to share information about problematic premises and individuals
  - Local authorities to be equipped with the right analytical tools and capability
- Effective local partnerships
  - Police to work alongside local businesses to devise local strategies and solutions
  - Local Alcohol Action Areas launched. The new programme will strengthen the capacity and capability of local areas to build effective partnerships, address alcohol related harms by focusing on a number of core challenges and provide access to experts and advice. Areas will be able to bid for inclusion in the programme, which will launch in autumn 2016.
  - Working with industry partners to support local action amongst businesses
  - Diversifying the night-time economy
  - Challenge 25 policy[8] - supporting staff locally to take action, for example by introducing 'Challenge 25' which encourages the responsible sale, marketing, and promotion of alcohol, and improving knowledge of the law on the sale of alcohol to people who are drunk.
  - Influencing positive behaviour change
- Equipping the police and local authorities with the right powers
  - Licensing framework that allows the police and local authorities to take the right action
  - More flexible Late-Night Levy. Improve the late-night levy by making it more flexible for local areas, fairer to business and more transparent. At the same time, the Government will create a greater role for Police and Crime Commissioners, by giving them a right to request that local authorities consult on introducing a levy to contribute towards the cost of policing the evening and night-time economy.
  - Premise inspection powers for civilians in place of police

Outside of this Strategy, health services and prevention relating to alcohol continued to be overseen by the Office for Health Improvement and Disparities (OHID).

2.1.2 National alcohol misuse guidance

In the absence of any new national strategy with a prevention focus since 2012, government departments have continued to produce guidance around alcohol related harm.

'All our Health' was published in 2015 by PHE and has been updated in June 2022 by the Office for Health Improvement and Disparities (OHID)[9]. This framework of evidence is a guide for healthcare professionals in preventing illness, protecting health, and promoting wellbeing. The guidance is relevant to those on front-line health care services and managers at different levels who would seek to embed interventions and take action to combat alcohol-induced harm. Guidance aims to equip professionals with the skills necessary to be confident in identifying those

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf
[8] https://rasg.org.uk/about/#:~:text=Challenge%2025%20is%20a%20retailing,they%20wish%20to%20buy%20alcohol
[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

at risk from alcohol and in delivering advice to change behaviour. Examples of resources and interventions include:

- The free Alcohol Identification and Brief Advice (IBA) e-learning tool - helping professionals to identify those individuals whose drinking might impact their health, now or in the future and to deliver simple, structured advice aimed at reducing this risk. Courses available include delivering alcohol IBA in four settings: Primary Care; Community Pharmacy; Hospitals; Dental Teams. All four pathways were developed in collaboration with Public Health England[10].
- Asking people, a set of questions from a validated alcohol use screening test and scoring answers
- Giving patients an AUDIT-C scratch card to self-complete
- Signposting patients to the mobile/digital apps such as 'Drink Free Day' app (other available apps are Drinkaware, Try Dry, Stay Sober)
- Referral to alcohol addiction services

The National Institute for Health and Care Excellence (NICE) also continue to produce guidance for tackling alcohol related harm. Produced in 2010, NICE[11] published specific guidance for public health bodies, 'Alcohol-use disorders: prevention', citing some key recommendations for policy and practice. These recommendations suggested that policy change is the more effective and most cost-effective way of reducing alcohol-related harm amongst the population.

NICE guidance signposts professionals to various online toolkits and pathways to enable health professionals to act as required, understand the local need, and measure the impact of interventions.

Further NICE guidance, 'Alcohol interventions in secondary and further education' released in 2019[12] covers information for unitary authorities, school staff, health and social care practitioners and anyone working with children and young people. The guidance presents interventions which can be considered in secondary and further education to prevent and reduce alcohol use among children and young people aged 11 up to and including 18. It also covers people aged 11 to 25 with special educational needs or disabilities in full-time education. Recommendations are focused on planning alcohol education, delivering universal alcohol education, and targeted interventions.

Finally, the alcohol CLeaR (Challenge services, Leadership and Results)[13] initiative is an evidence-based approach that local alcohol partnerships can use to think about how effective their local system and services are at preventing and reducing alcohol-related harm. The model comprises a self-assessment questionnaire allowing review of local arrangements and activity to reduce alcohol harm against NICE guidelines, backed by an optional challenge process from a team of external peer assessors. This was carried out in Thurrock in 2020 and the results of the peer assessment are outlined in Chapter 6.

[10] https://www.e-lfh.org.uk/programmes/alcohol/
[11] https://www.nice.org.uk/guidance/ph24
[12] https://www.nice.org.uk/guidance/ng135/chapter/Recommendations
[13] https://www.gov.uk/government/publications/local-alcohol-services-and-systems-improvement-tool/the-alcohol-clear-approach-to-system-improvement-excellence-in-preventing-and-reducing-alcohol-harm#:~:text=The%20alcohol%20CLeaR%20(Challenge%20services,and%20reducing%20alcohol%2Drelated%20harm

2.2 Drugs

PHE estimated in 2016 that nationally around 2.7 million adults took an illicit drug in the previous year, with the most deprived local authorities having the highest prevalence of problematic drug users[14]. An independent review 'Misuse of Illegal drugs in England' by Professor Dame Carol Black was published in 2021. The reviews recommended a new long-term approach, with large-scale investment and changes to oversight and accountability, delivered by the whole of government. The review found that the harm from drug misuse costs society £19.3 billion per year of which 86% of which is attributable to the health and crime-related costs of the heroin and crack cocaine markets[15].

A collaboration of central government bodies such as No. 10, the Home Office, the Ministry of Justice, and others, are part of a drugs delivery board which will look to deliver a national outcomes framework set out with measurable goals to reduce drug misuse. There is initial funding of £148 million to cut crime and protect people from harms caused by illegal drugs, and £40 million has been invested to tackle drug supply and county lines.

2.2.1 National drugs policy

The most recent national government drug plan was launched in 2021[16]. 'From harm to hope: A 10-year drugs plan to cut crime and save lives' recommends a national effort to reduce the availability and demand for drugs, as well as enhancing treatment and recovery services.

The theme of this plan is to cut off the supply of drugs by organised crime gangs (OCGs), and to provide sufficient resources and help for those overcoming drug addiction. The plan highlights that over £3 billion will be invested into delivering three strategic priorities to reduce drug-related crime, death, harm, and overall drug use:

4. Break drug supply chains
5. Deliver a world-class treatment and recovery system
6. Achieve a general shift in demand for drugs

The 10-year approach set out by the Government specifically focuses on the following:

- Combating the supply of heroin and crack cocaine
- Delivering high quality treatment for drug addiction
- Reducing non-dependent recreational drug use such as cocaine
- Incorporating a whole system approach as recommended by Dame Carol Black (cut off supply, prevent/reduce drug use)
- Investing in education and resilience in children and young people to level up the whole country

This strategy focuses on encouraging people to change their attitudes to drug use and to ensure that children and young people are not drawn towards drugs, being fully aware of the harm they would be causing to themselves and others by using drugs.

[14] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest
[15] https://www.gov.uk/government/publications/independent-review-of-drugs-by-dame-carol-black-government-response/government-response-to-the-independent-review-of-drugs-by-dame-carol-black
[16] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

In June 2022, the government published guidance for local delivery partners[17] based on the 10-year plan. The steps in the guidance had specific deadlines from August 2022 to April 2023. Table 1 outlines the timetable and activities local authorities and their partners have been tasked with undertaking central to which is the establishment of a Combating Drugs Partnership (CDP), it's governance and footprint, developing a local Combating Drugs Framework to measure performance, and publishing a health needs assessment and strategy.

Table 1: Guidance for steps in delivery of local plans

Activity	Deadline
Nominate local senior responsible officer	August 1st 2022
Form Combating Drugs Partnership bring together organisations and individuals who represent and deliver the drugs strategy goals and coordinate activity to reduce drug harm in the local area	August 1st 2022
Confirm footprint for partnership	August 1st 2022
Agree terms of reference and governance structure for local partnership	September 30th 2022
Conduct joint needs assessment reviewing local drug data and evidence	November 30th 2022
Agree a local drugs strategy delivery plan including data recording and sharing	December 31st 2022
Ensure that partners agree a local performance framework to monitor the implementation and impact of local plans	December 31st 2022
Regularly review progress, reflecting on local delivery of the strategy and current issues and priorities	April 30th 2023

Alcohol is a factor in many drug-related deaths alongside drugs including heroin and methadone. In the night-time economy, drugs such as cocaine and MDMA are frequently used alongside alcohol. Moreover, specialist treatment and recovery services tend to be integrated for alcohol and other drugs. Therefore, while the 10-year drugs strategy focuses on the use and supply of illegal drugs, local partnerships should ensure that their plans sufficiently address alcohol dependence and wider alcohol-related harms including capturing relevant activity and performance monitoring. considering deaths, hospital admissions and treatment for alcohol as well as other drugs. The guidance recommends partnerships should consider the multiple complex needs of people who use alcohol as well as other drugs and references Greater Manchester[18] and their drug and alcohol strategy as an integrated approach which is working well.

2.2.1 Combating Drugs Partnership

The role of a combatting drugs partnership will be multi agency forums accountable for delivering a set of outcomes, understanding, and addressing shared challenges related to alcohol and drug related harm. Figure 1 shows the people expected to participate and be a member of the Combating Drugs Partnership (CDP).

[17] From harm to hope: a 10-year drugs plan to cut crime and save lives. Guidance for local delivery partners June 2022
[18] https://www.greatermanchester-ca.gov.uk/media/2507/greater-manchester-drug-and-alcohol-strategy.pdf

Figure 1: Recommended core members of a combating drugs partnership

It is important that the partnership includes people who have been affected by drug related harm. NHS England and the DHSC has recently published statutory guidance on the legal public involvement duties of the integrated care system, describing ways to include community and service users in co designing and co-producing services[19]. For the CDP, people who are part of Lived Experience Recovery Organisations such as students from Recovery College in Thurrock are likely to be key to gathering service user insight.

Thurrock are planning and implementing the steps involved is setting up the CDP.

2.2.2 National combating drugs outcomes framework

In order to evaluate the progress of the delivery of the 10-year drugs strategy, a National Combating Drugs Outcome Framework (NCDOF) has been developed. The Framework includes six overarching outcomes, to reduce drug related crime, harm, overall use, supply and to increase engagement in treatment and improve long term recovery. The headline metrics are set out in Table 2. A further set of supporting metrics is due to be published later in 2022 which will provide information about the direction of travel of the strategic outcomes and monitor the health of the whole system to check if there are any unexpected impacts from implementation. The metrics are based on data currently available, and it is likely that further efforts to improve data quality and develop new measures will be a future focus. In addition, data matching through existing government programmes such as Better Outcomes through Linked Data (BOLD) focussing on

[19] Working in Partnership with People and Communities Statutory Guidance, NHS England and DHSC July 2022

people with multiple and complex needs will be explored to understand how services could be better joined up.

Table 2: Headline metrics of the National Combating Drugs Outcome Framework

National Combating Drugs Outcomes Framework **Our ambition: a safer, healthier and more productive society by combating illicit drugs**	
What we will deliver for citizens (strategic outcomes)	**Measured by:**
Reducing drug use	• the proportion of the population reporting drug use in the last year (reported by age) • prevalence of opiate and/or crack cocaine use
Reducing drug-related crime	• the number of drug-related homicides • the number of neighbourhood crimes
Reducing drug-related deaths and harm	• deaths related to drug misuse • hospital admissions for drug poisoning and drug-related mental health and behavioural disorders (primary diagnosis of selected drugs)
What will help us deliver this (intermediate outcomes)	**Measured by:**
Reducing drug supply	• the number of county lines closed • the number of moderate and major disruptions against organised criminals
Increasing engagement in drug treatment	• the numbers in treatment (both adults and young people, reported by opiate and crack users, other drugs, and alcohol) • continuity of care – engagement with treatment within three weeks of leaving prison
Improving drug recovery outcomes	• the proportion who are in stable accommodation and who have completed treatment, are drug-free in treatment, or have sustained reduction in drug use **Key additional components integral to recovery include housing, mental health, and employment**

In addition to collecting metrics for the NCDOF, it will be important to undertake qualitative evaluation of the system from the experience of both service users and staff. Where new initiatives are put in place, rapid short iterative evaluations of quantitative and qualitative information can give a useful snapshot of where things are working well and less well, so ways of working can be tweaked to further meet the needs of the population.

2.2.3 National drugs guidance

National guidance about reducing drug related harm often includes guidance about alcohol. OHID routinely publishes guidance around approaches to reducing drug related harm amongst different groups. Published in 2021, "Parents with alcohol and drug problems: adult treatment and children and family services[20]" represents planning and operation guidance for Directors of Public Health, and commissioners and providers of adult alcohol and drug treatment and children and family services. The recommendations in this guidance highlight the need for dedicated safeguarding leads to protect children from abuse and neglect; senior leadership and strong multi-agency partnerships, as well as capable and confident frontline staff who can identify and appropriately refer parents and children to support services.

In order to ensure local needs are appropriately met, the guidance states that local areas need to understand the landscape of drug and alcohol problem in their area. This includes being knowledgeable around current prevalence estimates, the rate of parents who use alcohol and drugs problematically, how well the families' needs are met and what services have been offered to them.

Collaborative assessment, information sharing and clear pathways between systems and services are vital to identifying families affected by drug and alcohol problems, and ensuring they

[20] https://www.gov.uk/government/publications/parents-with-alcohol-and-drug-problems-support-resources/parents-with-alcohol-and-drug-problems-guidance-for-adult-treatment-and-children-and-family-services

receive appropriate support early. The recommendation is that authorities need to adopt a 'whole family' approach when needed by treating the family as a whole entity, and to also consider therapeutic services for children and families as demand can be high. Removing stigma and barriers to engagement; reducing parental conflict; and providing peer-to-peer support for children and adults are also key themes discussed in this guidance.

'Misuse of illicit drugs and medicines: applying All our Health'[21] is a national framework and guidance document aimed at assisting healthcare professionals to identify, prevent, or reduce drug-related harm; identify resources and services available in their local area to help those with drug misuse; it recommends actions for strategic managers as well as staff.

Some recommendations listed for front-line health and care professionals include reference to NICE clinical guidelines to routinely assess at-risk groups for drug misuse or those vulnerable to drug misuse and a link to Alcohol, Smoking and Substance Involvement Screening Tool – Lite (ASSIST-Lite) to identify alcohol, drug, and tobacco smoking-related risk. This section provides a detailed guideline on how to ask a patient about their drug use, indicating all the considerations healthcare professionals need to take when liaising with the person such as their personal circumstances, mental health, and other potential determinants.

This is followed by guidance for staff on offering help, information, and advice to individuals for their drug use, referring them to a specialist service, advice on reducing or stopping their drug use, and reviewing their drug use at each session.

PHE released guidance 'Alcohol and Drug prevention treatment and recovery: Why invest' in 2018.[22] This guidance recommends targeted prevention and reduction in harm caused by drug misuse; relaying needle and syringe programmes to prevent infection and spread of blood-borne viruses as well as advice; testing and vaccination provision; and targeting at-risk groups of the population such as the homeless and sex workers. Further advice on specialist treatment and recovery included assessing need amongst the community; services focusing on recovery to factor in employment, health and wellbeing, and housing; and services for parents to address concerns and their needs. This document also discusses cost-benefit of each suggested prevention programme/intervention, indicating that for every £1 invested, this equates to a potential £5-£8 benefit.

Prior to this publication, in 2015 PHE published 'The international evidence on the prevention of drug and alcohol use: Summary and examples of implementation in England'[23] which included a summary of the United Nations Office of Drug Control (UNODC) prevention standards and gives corresponding examples of relevant UK guidelines, programmes, and interventions currently available in England. Its aim is to help people who commission, develop and implement prevention strategies and interventions to translate the standards into the English operating landscape. It also aims to support local authority commissioners to develop their prevention strategies and implement them in line with evidence.

This evidence summary separates drug and alcohol misuse prevention interventions in to three categories as applied by UNODC: Universal (entire population at risk of substance misuse); Selective (Specific sub-populations such as individuals, groups, families at risk of substance misuse); and Indicated (non-dependent drug users, showing signs of problematic use and

[21] https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health
[22] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest
[23] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774743/Preventing_drug_and_alcohol_misuse__international_evidence_and_implementation_examples.pdf

required targeted prevention). This is an evidence-based paper which has outlined factors and types of interventions linked to positive outcomes and those which lead to no or negative outcomes.

Successful interventions/factors leading to positive outcomes include:

- Early interventions, particularly generic pre-school programmes, improving literacy and numeracy
- Personal and social skills education
- Links to school interventions including school environment improvement programmes: positive ethos; disaffection; truancy; participation; academic and social-emotional learning
- A focus on 'risk and resilience' factors
- Multi-component programmes involving parenting interventions and support for individuals and families, which may require joined up commissioning and planning
- Staff who are qualified and competent to deliver the interventions they provide

Interventions/factors leading to no or negative outcomes include:

- Scare tactics and images
- Knowledge-only approaches
- Ex-users and the police as drug educators where their input is not part of a wider prevention programme
- Peer mentoring schemes that are not evidence-based

The summary of evidence UNODC found for the various types of interventions span through a life course beginning at infancy and childhood, to adolescence and adulthood. The general recommendations stated that consistent and coordinated prevention activities in the form of programmes built into various settings, such as home, schools, workplaces, peers, community, tend to demonstrate more positive outcomes. Modifying the environment where risky behaviour takes place, by controlling alcohol sales, density of alcohol outlets, and alcohol prices could also increase positive outcomes and reduce harm.

2.3 County Lines

County lines is a major, cross-cutting issue involving drugs, violence (including sexual violence), gangs, safeguarding, criminal and sexual exploitation, modern slavery, and missing persons. The response to tackle this involves the police, the National Crime Agency, a wide range of Government departments, local government agencies, and voluntary and community sector organisations. In Essex a Violence and Vulnerability Unit was set up in 2019 which works across Thurrock, Southend, and Essex councils to reduce the volume of serious violence focussing on gangs, County lines and exploitation. This involves Essex Police, health and care, probation, criminal justice, education, and voluntary sector groups. The 2019/20 Annual Report of the Director of Public Health[24] focused on serious youth violence and vulnerability and discussed the nature and impact of county lines activity in Thurrock

The review launched by Dame Carol Black in 2020-2021 revealed that up to 1,716 Organised Crime Gangs are active in the UK, and county line drugs are more prominent than ever in increasing violence within the drugs market, exploiting young and vulnerable children. Since October 2019, the enhanced operational activity by law enforcement has reduced the number of potentially active county lines, but the number of referrals of children suspected to be victims of county lines increased by 31% in 2020.

[24] https://www.thurrock.gov.uk/sites/default/files/assets/documents/annual-health-report-2019-v01.pdf

The 'County Lines Exploitation guidance'[25] published by the Home Office in 2018 provides guidance for frontline staff who work with children, young people, and vulnerable adults, and is applicable to professionals from many working sectors such as education health, housing, and law enforcement. It provides information around recognising the signs of vulnerable children and adults at risk of exploitation by county line gangs. It also illustrates the local safeguarding process and referral pathways (Home Office Schematic Outline) which need to be carried out when a person at risk of exploitation comes to attention[26]. The Home Office Schematic Outline is illustrated as a diagram, highlighting the local safeguarding process and the preferred referral pathways.

Furthermore, County Lines Exploitation – 'Practice guidance for YOTs and frontline practitioners' published by the Ministry of Justice in 2019[27] gives best practice guidance focusing more on clear referral pathways for local authorities and Youth Offending Services in England. It can also be applicable to frontline practitioners, professionals, stakeholders, parents, carers, law enforcement, and for anyone working with vulnerable children and young adults involved in county lines. This guidance also provides information on looking for indicators of county lines exploitation, referral pathways, National Referral Mechanism (NRM), and links to useful resources.

The recommendations on tackling county line drugs are embedded in to the current 10-year plan by government and the independent review by Dame Carol Black.

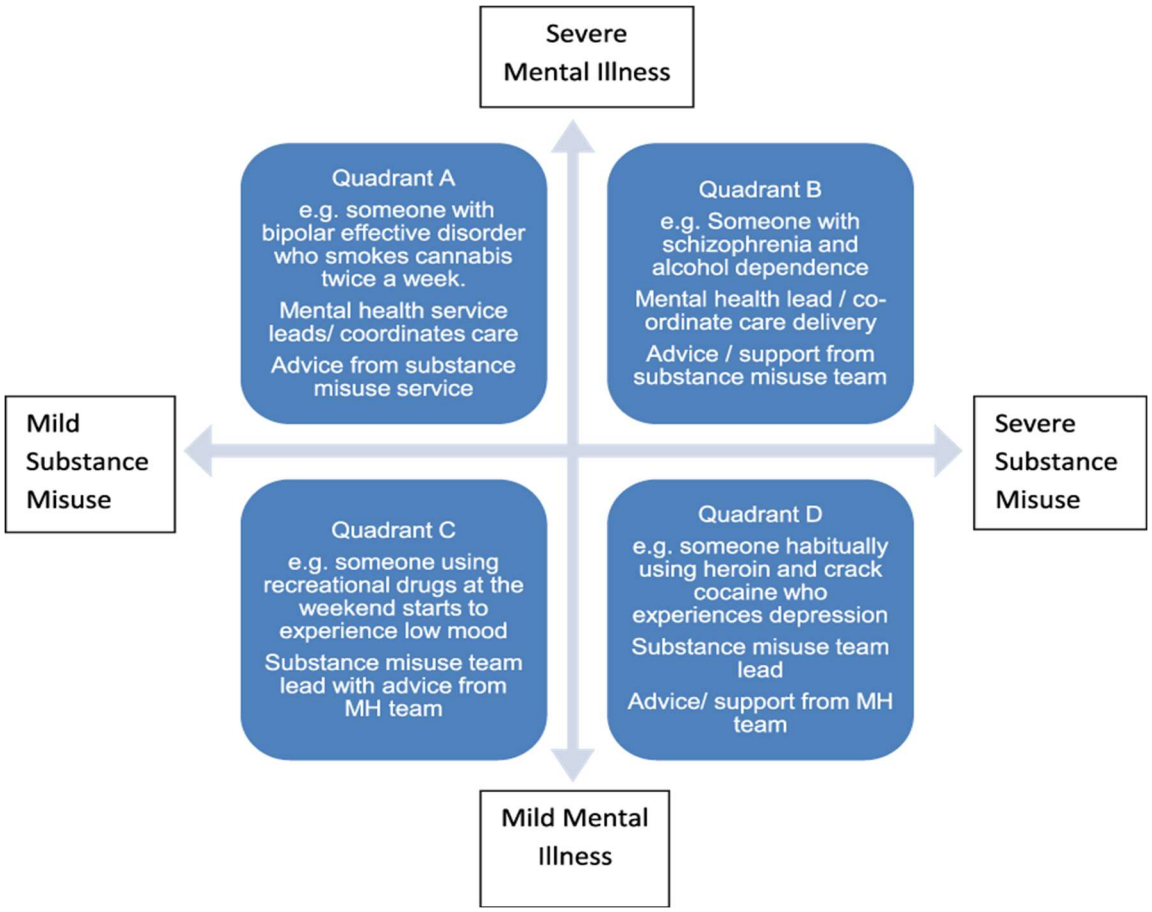
2.4 People with Co-occurring Conditions and Complex Needs

When someone has co-occurring conditions, this means they have both a mental health condition and alcohol or drug misuse problems. The term dual diagnosis is sometimes used but is restricted to people with severe mental illness, typically psychoses and/or personality disorders combined with drug and/or alcohol misuse. This is also known as coexisting severe mental illness and substance misuse. In addition, people may have other complex needs associated with housing, social care, the criminal justice system or relationships with friends and family. Figure 2 shows four presentations of people with co-occurring conditions based on levels of severity: mild substance use and severe mental illness; severe substance use and severe mental illness; mild substance use and mild mental illness; severe substance use and mild mental illness.

PHE estimated in 2017 that approximately 70% of drug users and 86% of alcohol users in community substance misuse treatment, experience mental health problems. Of the people with mental health problems who take their own life, 54% have a history of alcohol or drug misuse recorded. Furthermore, despite the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with co-occurring conditions are often excluded from services.[28]

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863323/HOCountyLinesGuidance_-_Sept2018.pdf
[26] https://www.gov.uk/government/publications/county-lines-exploitation-applying-all-our-health/county-lines-exploitation-applying-all-our-health - Raising concerns schematic outline
[27] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839253/moj-county-lines-practical-guidance-frontline-practitionerspdf.pdf
[28] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

Figure 2: Presentation of different types co-occurring condition



Source: The complexity and challenge of 'dual diagnosis' (findings.org.uk)

2.4.1 National policy about co-occurring conditions

There is no standalone national strategy with a focus on co-occurring conditions. Sections of national strategies relating to Drugs, Alcohol and Mental Health address some elements of co-occurring conditions, however there is no overarching national document seeking to align these three areas. Early guidance focussed on those with dual diagnosis including 'Dual diagnosis policy and implementation guide' launched by the Department of Health in 2002 and 'A guide for management of dual diagnosis in prisons' launched by Department of Health and Ministry of Justice in 2009.[29] Latterly, PHE widened the guidance to include all those with co-occurring conditions publishing 'Better care for people with co-occurring mental health and alcohol/drug use conditions', in 2017. This described guidance for the commissioning and delivery of care and a high-level framework for delivering care for this cohort of the population. The guidance informed the implementation of the Five Year Forward View for Mental Health including development of evidence-based treatment pathways (EBTPs). All EBTPs should address co-occurring mental health and alcohol/drug use conditions in line with relevant NICE guidance.

The underpinning themes of this guidance are:

1. Everyone's job – referring to commissioner and providers of mental health and alcohol and drug use service as having a joint responsibility

[29] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

2. No wrong door – having an open-door policy by providers in alcohol and drug, mental health, and other services, for individuals with co-occurring conditions, making every contact count

These should be delivered based on the following priorities:

- Agree a pathway of care which will enable collaborative delivery of care by multiple agencies in response to individual need
- Appoint a named care coordinator for every person with co-occurring conditions to coordinate the multi-agency care plan
- Undertake joint commissioning across mental health and alcohol/drugs (including primary care, criminal justice settings and specialist/acute care, supported by strong, senior, and visible leadership
- Enable people to access the care they need when they need it and, in the setting, most suitable to their needs
- Commission a 24/7 response to people experiencing mental health crisis, including intoxicated people
- Commission local pathways which enable people to access other services such as homelessness, domestic abuse, or physical healthcare
- Make sure people are helped to access a range of recovery supports, while recognising that recovery may take place over several years and require long term support

The guide also recommends a framework for delivery of care based on the following factors:

- Strong therapeutic alliance
- Collaborative delivery of care
- Care that reflects the views, motivations and needs of the person
- Care that supports and involves carers (including young carers) and family members
- Therapeutic optimism
- Episodes of intoxication are safely managed
- Stop smoking advice/support is a routine part of care
- The guide points to resources available to support development of a competent workforce with the requisite values, knowledge, and skills, include those with sufficient expertise to provide clinical leadership and supervision
- Developing a shared understanding of local need across mental health and alcohol and drug commissioning through local needs assessments, utilising national datasets and profiles available
- Agree a lead or joint lead commissioner with authority to commission across NHS (mental health services) and local authority public health (alcohol, drugs, and tobacco services) sectors
- Agree an appropriate senior strategic board to oversee commissioning activity and monitor outcomes
- Undertake joint commissioning across mental health and alcohol/drugs/tobacco with a named lead, working closely with National Offender Management Service (NOMS) and NHS England commissioners to ensure continuity of care between community and prison settings for all those with co-occurring conditions moving between community and criminal justice care settings
- Ensure that co-occurring substance use and mental health conditions are addressed as an integral part of all relevant care pathways locally through adequate resources and experts. The latter includes having staff that are supported and competent to meet all the required needs and demands of the individual

- Commission an effective and compassionate 24/7 Urgent and Emergency Mental Health Care (UEMHC) response, for all ages which includes adequate health-based places of safety (HBPoS) provision
- Monitor providers particularly closely on the effectiveness of their response to intoxicated people in mental health crisis and those frequently judged as not requiring services as their condition is not severe enough, as well as children and those deemed vulnerable
- Ensure there are local suicide prevention plans in place for those at increased risk of suicide, and that the multi-agency partnership group is sighted on commissioning decisions and service developments

Along with the above, some key guidance aimed for both commissioners and providers include:

- Collaborate across services to develop an integrated 'offer' of care which addresses physical health, social care, housing, and other needs as well as mental health and alcohol/drug/tobacco use.
- Review service access criteria with expert, such as not excluding people based on levels of alcohol and/or drug dependency, or on diagnoses (or lack of diagnoses) of mental illness but are used to actively support people to get the help they need.
- Ensure there are local arrangements for reporting and investigation of serious untoward incidents and management of risks. Quality governance and local safeguarding for the co-occurring group should be shared across mental health and alcohol/drugs services.
- Consider what changes might be needed to enable practitioners to work assertively and flexibly to engage people– particularly supporting people with chaotic lifestyles and complex needs to manage appointments.
- Consider what changes might be needed to enable practitioners to work assertively and flexibly to engage (and assertively re-engage) people– particularly supporting people with chaotic lifestyles and complex needs to manage appointments.

Other guidance available from NICE focussed on a subset of those with co-occurring conditions in the form of 2016's 'Coexisting severe mental illness and substance misuse: community health and social care services'[30].

This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse and should be read in conjunction with NICE's 2011 guidance on 'Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings'[31]. The aim of the 2016 guideline is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.

Recommendations included relate to:

- First contact with services - for all staff who may be the first point of contact with young people and adults with coexisting severe mental illness and substance misuse
- Referral to secondary care mental health services, on acceptance to secondary care mental health services; involving people with coexisting severe mental illness and substance misuse in care planning; and ensure carers who are providing support are aware they are entitled to, and are offered, an assessment of their own needs
- The care plan: multi-agency approach to address physical health, social care, housing, and other support needs. The person's care coordinator should adopt a collaborative approach with other organisations (involving shared responsibilities and regular

[30] https://www.nice.org.uk/guidance/ng58/chapter/Recommendations
[31] https://www.nice.org.uk/guidance/cg120

communication) when developing or reviewing the person's care plan. Hold multi-agency and multidisciplinary case review meetings annually, as set out in the Department of Health's guidance[32] or more frequently, based on the person's circumstances.

- Partnership working between specialist services, health, social care and other support services and commissioners – consider using an agreed set of local policies and procedures, and working across institutional boundaries, ensuring joint strategic working arrangements. Information sharing by agreeing an information sharing protocol between secondary care mental health services and substance misuse, health, social care, education, housing, voluntary and community services
- Improving service delivery - Making health, social care, and other support services more inclusive; Adapting existing secondary care mental health services; support for staff.
- Maintaining contact between services and people with coexisting severe mental illness and substance misuse who use them – building relationship with the person, showing empathy, providing consistent services and explore reasons why the person may have stopped using their services.

2.4.2 Core20PLUS5

In addition to the national government drugs and alcohol policy and guidance, NHS England and NHS Improvement has a national focus on reducing inequalities called Core20PLUS5. The approach defines a target population as:

- Those identified in the most deprived 20% of the population,
- Population groups who typically experience inequity including those with drug and alcohol dependence[33].

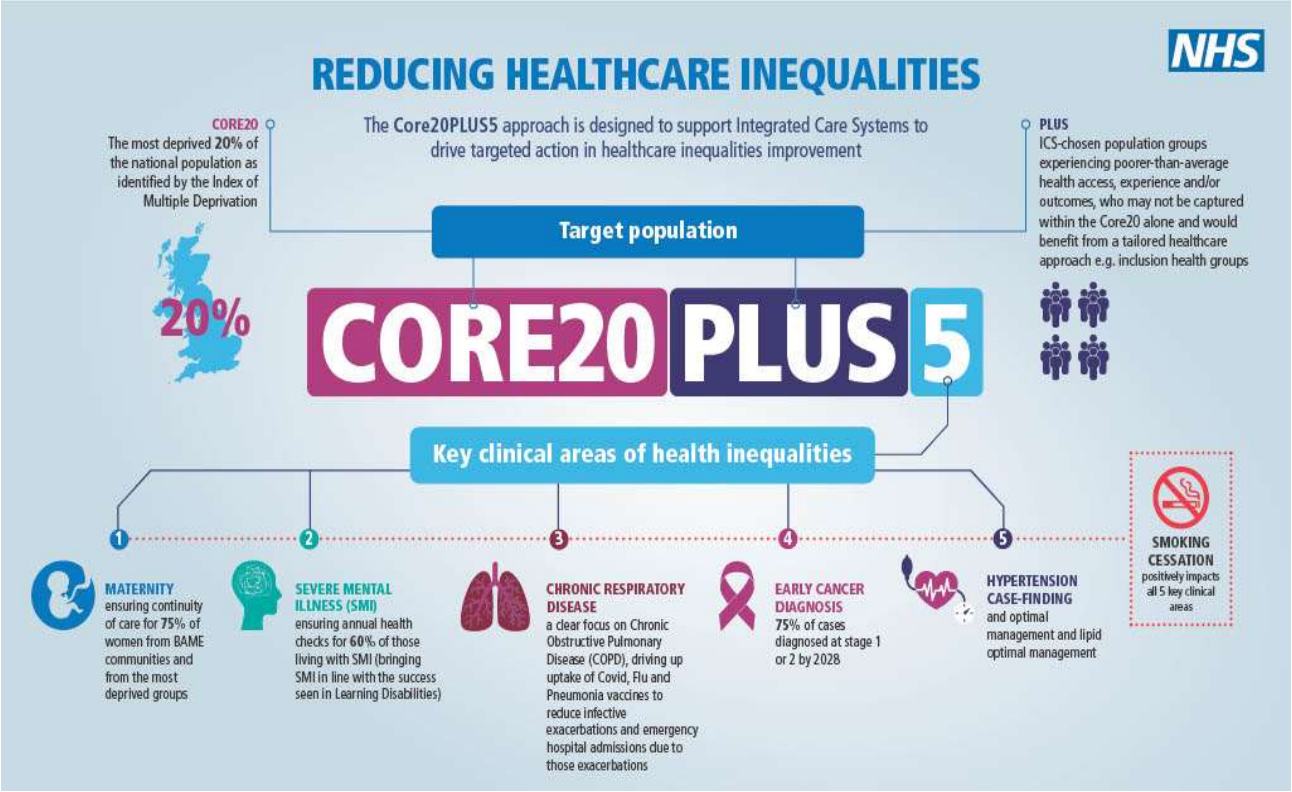
For these cohorts there are 5 clinical areas of focus in reducing health inequalities. They include maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case finding[34]. Governance for the five areas will be with the national programmes and national and regional teams will coordinate the local systems to achieve national aims. Figure 3 outlines the national aims for each clinical area.

[32] [ARCHIVED CONTENT] Refocusing the Care Programme Approach: policy and positive practice guidance : Department of Health - Publications (nationalarchives.gov.uk)

[33] PLUS population groups are ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others. Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

[34] NHS England » Core20PLUS5 – An approach to reducing health inequalities

Figure 3: Core20PLUS5 and reducing healthcare inequalities



Source: NHS England » Core20PLUS5 – An approach to reducing health inequalities

3 Methodology

Summary of HNA Methodology

Five methods of data and information gathering were used for this HNA.

1. Quantitative data were obtained from national datasets to inform the demography and epidemiology chapters of the HNA whilst data from the National Drug Treatment Monitoring Service (NDTMS) and local providers were used in the service provision chapter
2. Qualitative information about the barriers, enablers, and gaps in service provision in Thurrock was gathered from 16 semi-structured interviews with professionals
3. Questionnaires were completed by 47 drug and alcohol misuse service users to gather their experiences about the barriers, enables and gaps in service provision
4. A document review of national and local policy and strategic approaches to drugs and alcohol misuse prevention and treatment formed the basis of chapters 2 and 6
5. A literature search of evidence about effective approaches to prevention of drug and alcohol misuse also informed the HNA.

3.1 Demographics, Epidemiology, and High-Risk Populations

Data showing the key demographic characteristics of Thurrock was collated from national data published by Office of National Statistics and NHS Digital. These showed the different organisational geographies for Thurrock such as the constituent electoral wards, and Primary Care Networks (PCNs). The latest available data were analysed to show differences in the resident and GP registered populations and to highlight areas of greater and lesser deprivation using the Index of Multiple Deprivation (IMD) 2019.

The latest publicly available data on risk factors for drug and alcohol misuse were compiled from sources including Public Health England's (now the Office for Health Improvement and Disparities) suite of Fingertips indicator tools for the following factors:

- Unemployment
- Homelessness
- Criminality
- Domestic abuse
- Children in poverty
- Looked after children

Data were analysed at the most granular level available to highlight differences between geographical areas within Thurrock and over time to show any differences in risk factors before, during and after the Covid-19 pandemic.

Available information was also collated for high-risk populations for drug and alcohol misuse in Thurrock, including people with mental illness, those with housing problems and those in contact with the criminal justice system.

3.2 Use of Current Services

Data on recent trends in the usage of current services for Thurrock residents was collated from national and local sources such as the National Drug Treatment Monitoring System (NDTMS), GP practice systems and locally collected key performance indicator data from different service providers.

Data presented in the demographic, epidemiology and service use sections have had figures suppressed where numbers were less than 5 and greater than zero.

3.3 Evidence about Prevention

A literature search was carried out by Northeast London NHS Foundation Trust (NELFT) on the prevention and emerging innovative approaches in relation to alcohol and drug misuse. The evidence identified by the search was used to inform the HNA.

3.4 Review of Policy and Guidance

A high-level summary of the most recent and relevant national policies for drug and alcohol misuse was prepared by the Public Health team at Thurrock Council. A further summary of the recently described approach to integrating services was gathered from current strategies covering, health, care, and the criminal justice system in Thurrock.

3.5 Engagement with Service Commissioners and Providers

In order to understand how the current services were provided to people with drug and alcohol problems in Thurrock, a range of key stakeholders were contacted and asked if they were happy to share their views and experiences in a brief interview or in writing. Thurrock Council drew up a list of stakeholders which was discussed with the HNA team who checked that relevant representation from the main organisations was included. A list of questions was drafted and agreed (see Appendix 1); these covered:

- How services were provided,
- Barriers and enablers to delivering the services
- Service risks
- Service gaps
- The impact of the pandemic
- Suggestions for improving services to residents

Representatives from the following organisations and teams were invited for interview (also see Appendix 2):

- Thurrock Council:
    - Drug and alcohol commissioners
    - Mental health commissioners
    - Housing Solutions
    - Homeless coordination
    - Community Safety Partnership
    - Adult Housing and Health directorate
    - Violence Against Women and Girls
- Essex Police

- Adult drug and alcohol misuse services
- Alcohol Liaison Service
- Young People's Substance misuse services
- Mid and South Essex Clinical Commissioning Group (CCG).
- Youth Offending Service
- Healthwatch
- Drug and alcohol service volunteer
- Changing Pathways refuge

Interviews were summarised and the key emerging themes included in the relevant sections of the report.

3.6 Service Users' Engagement

The views of service users were gathered by the adult drug and alcohol service using a questionnaire drafted by the SPH HNA team. Five brief questions were asked covering satisfaction with the service, difficulties engaging with the service, suggestions for improvement and any other feedback about their experience they wanted to share (Appendix 3). A total of 47 questionnaires were completed, returned, and analysed. The questionnaire also asked if people would be willing to be contacted in the future to help with further co production and co design of drug and alcohol services.

The adult drug and alcohol service also provided service user feedback from 137 people they had seen in 2020 and 2021. The feedback asked to rate support they had received with a focus on different methods to deliver the service including face to face, phone, and video consultations and online groups.

4 Thurrock Borough Demography

Summary of Thurrock Borough Demography

Population

- National 2021 census data reports that the Thurrock population is around 176,300. The ONS estimates this will rise to 192,787 by 2031
- There are currently a higher proportion of younger adults aged 25 to 40 in Thurrock than in England and a smaller proportion of people aged 60 and over
- Over 85% of Thurrock residents are White. Thurrock has more than double the proportion of Black African/Caribbean/Black British people (7.8%) in its resident population than England (3.5%) and East of England (2%). In contrast Thurrock has half the proportion of Asian/Asian British people (3.6%) than England (7.6%)

Deprivation

- Areas of highest deprivation are in the south and west of Thurrock particularly in parts of Tilbury and South Ockendon
- Around 4% of Thurrock residents live in areas considered the most deprived nationally (decile 1) and 1% in areas of lowest deprivation (decile 10)
- Around 6% of Thurrock children aged 0 to 15 live in income deprived families

Housing and Homelessness

- Thurrock has significantly more households in temporary accommodation (3.5 per 1,000 households) than East of England (2.4 per 1,000 households) but fewer than England (4 per 1,000 households)
- Latest data available for Thurrock shows that rates of households assessed as being homeless and those threatened with homelessness has reduced significantly between 2019/20 (10 per 1,000) and 2020/21(6 per 1,000 households). Rates are now comparable to England and East of England whereas in 2018/19 and 2019/20 Thurrock rates were significantly higher

Employment

- The proportion of people claiming unemployment benefit in 2022 was similar in Thurrock (4.2% of the resident population) compared to East of England (3.5%) and England (4.3%)
- In Thurrock rates of unemployment are highest at around 6% in Tilbury Riverside and Thurrock Park, Tilbury St Chads and Belhus wards

Crime

- Overall crime rates have been generally higher in Thurrock compared to England and East of England since 2018/19
- Rates of violence against the person crime rose year on year from 2015/16 (18 per 1,000 population) to 2019/20 (33 per 1,000 population) then decreased in 2020/21 (30 per 1000 population). Rates in Thurrock are higher than England and East of England which are both around 25 per 1,000 population
- Rates of domestic violence in Thurrock have increased from 21.3 per 1,000 population in 2015/6 to a peak in 2019/20 of 29.1 per 1,000 population. Similar rates and trends are seen in England and East of England
- The number of offences proven to be committed by children has fallen from 255 in 2017/18 to 110 in 2020/21. The greatest reduction was for theft and handling stolen

goods (42 vs 6), violence against the person (79 vs 42), drugs (30 vs 8), and criminal damage (33 vs 11)

Young people

- Rates of looked after children in Thurrock (31 per 10,000 child population) are higher than for England (21 per 10,000 child population) and East of England (18 per 10,000 child population)

This section describes the key demographic characteristics of Thurrock and the organisational geography used to present data on geographical areas within Thurrock throughout the HNA. There are a range of demographic factors that are linked with increased likelihood of drug and alcohol misuse such as unemployment, deprivation, housing status, and criminal activity. These along with the age, ethnicity, and distribution of the population in Thurrock and other key metrics are described in this section.

4.1 Population

4.1.1 Resident and registered populations

Thurrock is a local authority in the County of Essex and has been a unitary authority since 1997. The initial results of the 2021 Census published by the Office for National Statistics (ONS) suggest that Thurrock had a resident population of around 176,300 in March 2021 (see Table 3).

Table 3: Resident population of Thurrock in 2021, by age band and gender

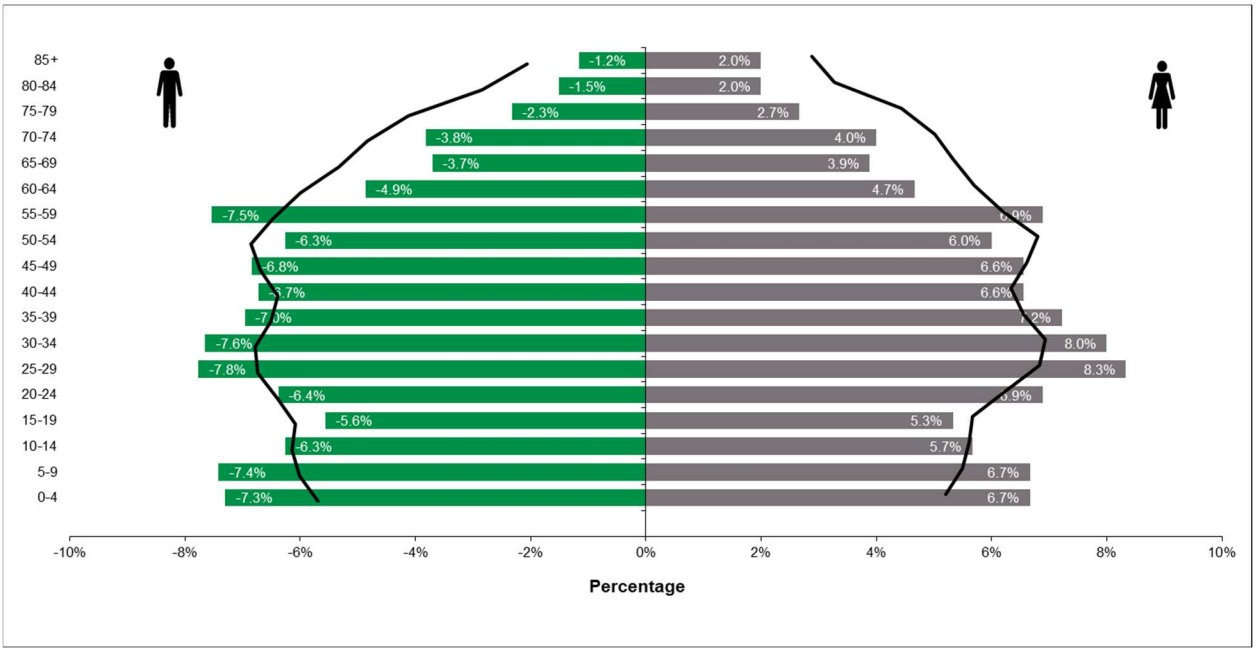
Age Band	Numbers			Percentages		
	Males	Females	Persons	Males	Females	Persons
0-9	12,800	12,200	25,000	14%	15%	14%
10-19	11,800	11,100	22,900	12%	14%	13%
20-29	10,300	11,000	21,300	12%	12%	12%
30-39	13,300	14,700	28,000	16%	15%	16%
40-49	11,800	12,400	24,200	14%	14%	14%
50-59	11,300	11,300	22,600	13%	13%	13%
60-69	7,400	7,700	15,100	9%	9%	9%
70-79	5,300	6,000	11,300	7%	6%	6%
80-89	2,000	2,900	4,900	3%	2%	3%
90+	300	700	1,000	1%	0%	1%
All ages	**86,300**	**90,000**	**176,300**	**100%**	**100%**	**100%**

Source: Office for National Statistics (ONS). 2021 Census Results. The Population Numbers for England and Wales on 21st March 2021

Table 3 suggests that Thurrock has a relatively young population, with 27% of residents aged 0-19 years compared with 10% aged 70 years and over. Although there are slightly more females than males in Thurrock overall, the reverse is true of the 0-19 population where there were estimated to be 24,600 (51.4%) males and 23,300 females (48.6%). The median age of the Thurrock population in 2020 was 36 years old, compared to 40 years old for England as a whole.

Figure 4 below compares the age and gender structure of the 2021 Census Thurrock population to that of England. The bars in Figure 4 represent the proportions of the Thurrock population in each age band whilst the vertical wavy black lines represent the England population.

Figure 4: Comparison of the proportions of the Thurrock population by gender and age band with the England population, 2021



Source: Office for National Statistics (ONS). 2021 Census Results. The Population Numbers for England and Wales on 21st March 2021

For both males and females, England has a higher proportion of older people than Thurrock in every age group from 60 - 64 onwards. Conversely, Thurrock has a higher proportion of both its male and female population aged 25-44 than England as a whole. Thurrock also has a higher percentage of children than England in the 0-4, and 5-9 age groups.

Table 4 below compares the latest available resident population data for Thurrock by age group and gender with the latest available GP registered population (as of 1st April 2022).

Table 4: Comparison of resident and GP registered populations

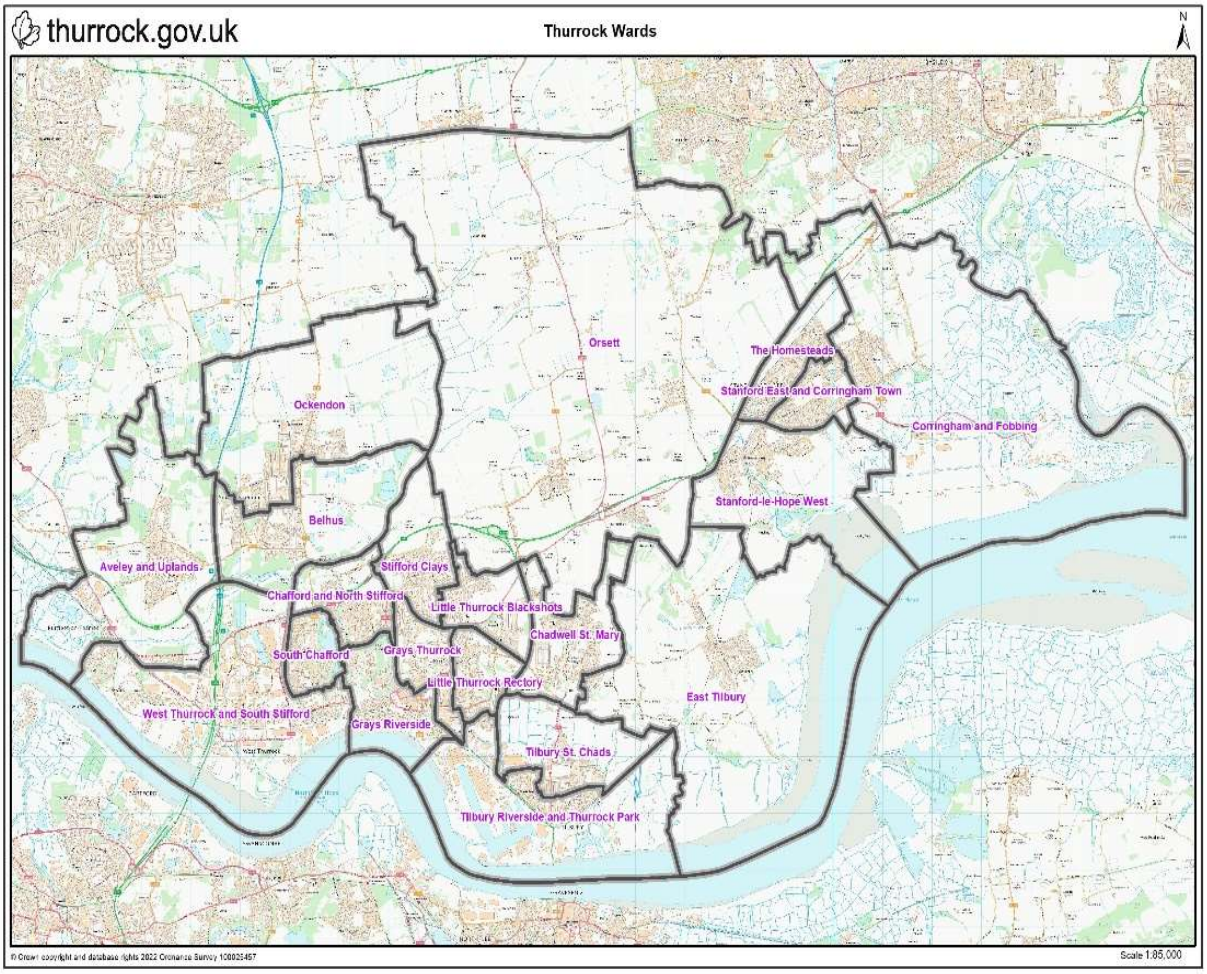
Gender	Age Band	Resident Population (Census 2021)	GP Registered Population (April 2022)	Difference (GP vs Registered Population)	% Difference
Male	0-19	24,600	25,547	947	3.80%
	20-64	50,900	55,035	4,135	7.80%
	65+	10,800	11,478	678	6.10%
	Total	86,300	92,060	5,760	6.50%
Female	0-19	23,300	23,895	595	2.50%
	20-64	53,600	54,890	1,290	2.40%
	65+	13,100	13,696	596	4.40%
	Total	90,000	92,481	2,481	2.70%
Persons	0-19	47,900	49,442	1,542	3.20%
	20-64	104,500	109,925	5,425	5.10%
	65+	23,900	25,174	1,274	5.20%
	Total	176,300	184,541	8,241	4.60%

Source: ONS Census 2021 and NHS Digital GP registered populations April 2022

Table 4 shows that the Thurrock GP registered population is 4.6% higher than the resident population overall. This difference is less for the 0–19-year-old age group (GP registered population is 3.2% higher) but greater for the 65+ year old age group (5.3% higher).

Figure 5 below shows a map of the electoral wards in Thurrock.

Figure 5: Map of Thurrock Wards



Source: Thurrock Council

Figure 5 shows the 20 electoral wards in Thurrock which vary significantly by geographical area with Orsett ward being the largest and South Chafford being the smallest. The map suggests that the wards also vary by their degree of rurality with some wards like Orsett covering a large, predominately rural area and others covering smaller more urban areas. Most of the more urban wards are concentrated along the north bank of the River Thames.

Table 5 shows the population of each of the 20 Thurrock wards by broad age group.

Table 5: Mid-2020 population of Thurrock wards by broad age group

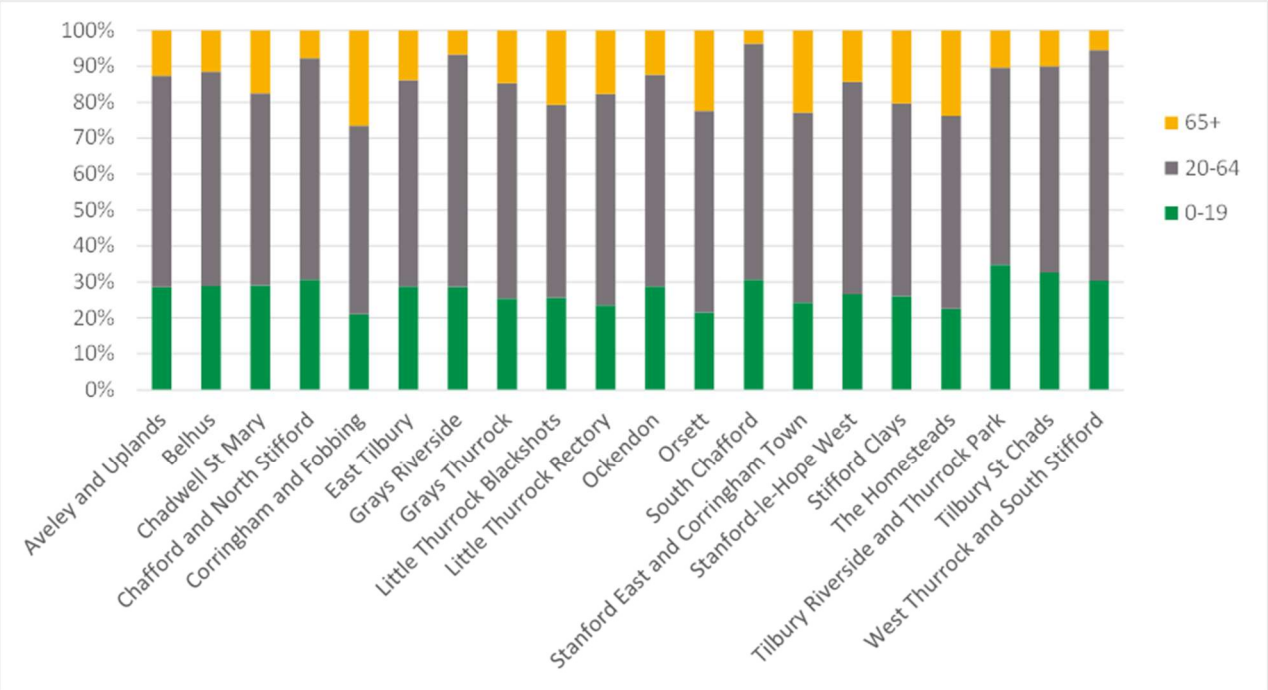
Total Thurrock resident population estimates, all ages, by ward, by broad age band				
Ward	0-19	20-64	65+	Total
Aveley and Uplands	3,036	6,256	1,347	10,639
Belhus	3,088	6,364	1,227	10,679
Chadwell St Mary	3,045	5,605	1,839	10,489
Chafford and North Stifford	2,556	5,119	649	8,324
Corringham and Fobbing	1,144	2,842	1,439	5,425
East Tilbury	2,107	4,186	1,016	7,309
Grays Riverside	4,075	9,187	948	14,210
Grays Thurrock	2,548	6,001	1,470	10,019
Little Thurrock Blackshots	1,717	3,586	1,392	6,695
Little Thurrock Rectory	1,453	3,639	1,094	6,186
Ockendon	3,391	6,937	1,462	11,790
Orsett	1,279	3,329	1,336	5,944
South Chafford	2,503	5,352	305	8,160
Stanford East and Corringham Town	2,014	4,379	1,895	8,288
Stanford-le-Hope West	1,891	4,204	1,020	7,115
Stifford Clays	1,761	3,629	1,370	6,760
The Homesteads	1,870	4,441	1,971	8,282
Tilbury Riverside and Thurrock Park	2,843	4,491	847	8,181
Tilbury St Chads	2,220	3,911	682	6,813
West Thurrock and South Stifford	4,329	9,105	789	14,223
Thurrock Total Population	48,870	102,563	24,098	175,531

Source: ONS mid-2020 population estimates for electoral wards

Table 5 shows that West Thurrock and South Stifford and Grays Riverside are the most populous wards with over 14,000 residents each. Corringham and Fobbing is the least populous ward with less than 5,500 residents.

Figure 6 shows the percentage of the population resident in each ward by broad age group.

Figure 6: Percentage of resident population by age band for Thurrock Wards, mid-2020



Source: ONS Mid-2020 Population Estimates for 2020 Wards and 2021 LAs in England and Wales

Figure 6 shows that in 2020 Tilbury Riverside and Thurrock Park ward has the highest proportion of children and young people aged 0–19 (35%) of any of Thurrock wards. Corringham and Fobbing ward has the lowest proportion of residents aged 0-19 (21%). South Chafford ward has the highest proportion of residents aged 20-64 (66%) and Corringham and Fobbing ward the lowest (52%). The reverse position was true of the 65 and over population, with Corringham and Fobbing ward having the highest proportion of residents in this age group (27%) and South Chafford ward having the lowest proportion (4%).

Table 6 below shows the GP registered population of each of the four primary care networks (PCNS) in Thurrock in April 2022.

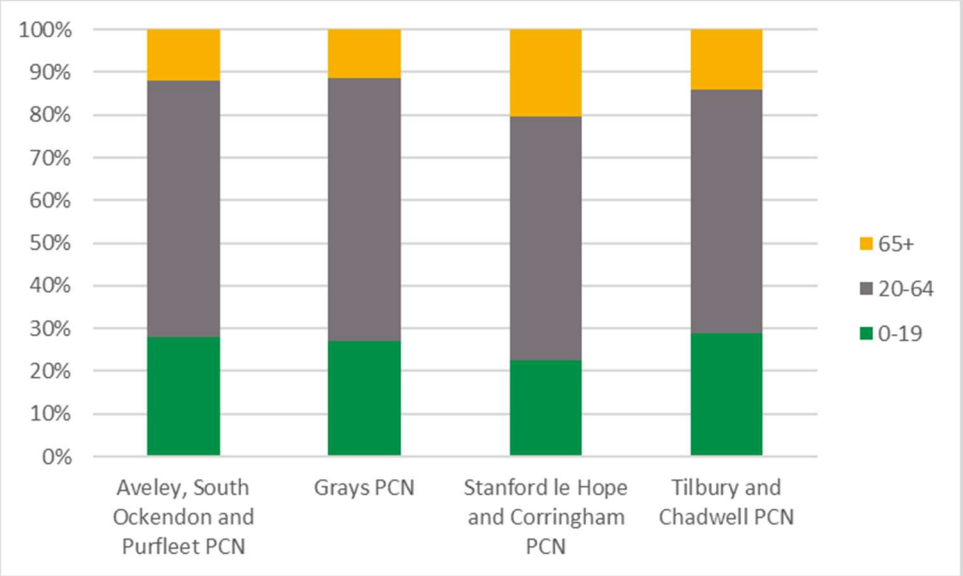
Table 6: Population of Thurrock Primary Care Networks (PCNs) by age band, April 2022

PCN Name	0-19	20-64	65+	Total
Aveley, South Ockendon and Purfleet (ASOP) PCN	11,238	24,323	4,811	40,372
Grays PCN	19,917	45,212	8,390	73,519
Stanford le Hope and Corringham PCN	7,375	18,696	6,673	32,744
Tilbury and Chadwell PCN	10,912	21,694	5,300	37,906
Thurrock Registered Population (all ages)	**49,442**	**109,925**	**25,174**	**184,541**

Source: NHS Digital Patients Registered at a GP Practice, April 2022

Table 6 shows that Grays PCN has the largest population, being over twice the size of Stanford le Hope and Tilbury and Chadwell PCNs. Figure 7 shows the proportion of each PCNs registered population by broad age band.

Figure 7: Proportion of each Thurrock PCN population by broad age band, April 2022



Source: NHS Digital Patients Registered at a GP Practice, April 2022

Figure 7 shows that ASOP PCN and Grays PCN have very similar proportions of their registered populations in each of the three broad age groups. Stanford le Hope PCN has the highest proportion of the registered population aged 65 and over (20%). Tilbury and Chadwell PCN has the highest proportion of the registered population in the 0-19 age group (29%).

4.2 Ethnicity

Table 7 below shows the population of Thurrock by broad ethnic group from the 2011 Census. Ethnicity results from the 2021 Census are expected to be published around October 2022.

Table 7: Population of Thurrock by ethnic group, 2011

Ethnic Group	Number of Persons
White British / All Other White	135,429
Mixed / Multiple Ethnic Groups	3,099
Black / African / Caribbean / Black British	12,323
Asian / Asian British	5,927
Other Ethnic Group	927
Total	**157,705**

Source: Office for National Statistics (ONS) Census 2011

Table 7 shows that Thurrock had a predominately white population in 2011, with the Black African/Caribbean/Black British being the largest ethnic minority population.

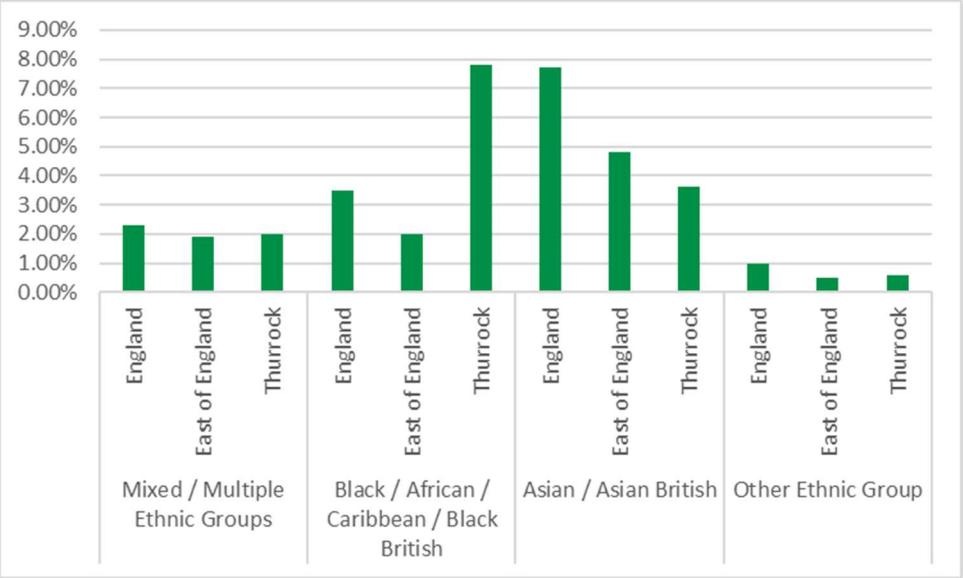
Table 8: Percentage of the population of Thurrock, the East of England and England by ethnic group, 2011

Ethnic Group	Region	% Of Total Population
White British / All Other White	England	85.4%
	East of England	90.8%
	Thurrock	85.9%
Mixed / Multiple Ethnic Groups	England	2.3%
	East of England	1.9%
	Thurrock	2.0%
Black / African / Caribbean / Black British	England	3.5%
	East of England	2.0%
	Thurrock	7.8%
Asian / Asian British	England	7.7%
	East of England	4.8%
	Thurrock	3.6%
Other Ethnic Group	England	1.0%
	East of England	0.5%
	Thurrock	0.6%

Source: Office for National Statistics (ONS) Census 2011

Table 8 shows that 86% of the Thurrock population in 2011 was of white ethnicity. This was a slightly lower proportion than the East of England as a whole, but a higher proportion than for England. The Black African/Caribbean/Black British ethnic group accounted for 7.8% of the Thurrock population, a higher proportion than for both the East of England (2.0%) and England (3.5%).

Figure 8: Proportion of population of Thurrock, the East of England and England from non-white ethnic groups, 2011



Source: Office for National Statistics (ONS) Census 2011

Figure 8 shows that in 2011 Thurrock had a lower percentage of its population from Asian/Asian British ethnic groups than both the East of England and England but a higher proportion of its population from Black African/Caribbean/Black British ethnic groups.

4.3 Population Projections

Table 9 below shows the 2019-based ONS population projections for Thurrock unitary authority by gender and broad age group for the years 2022 to 2031.

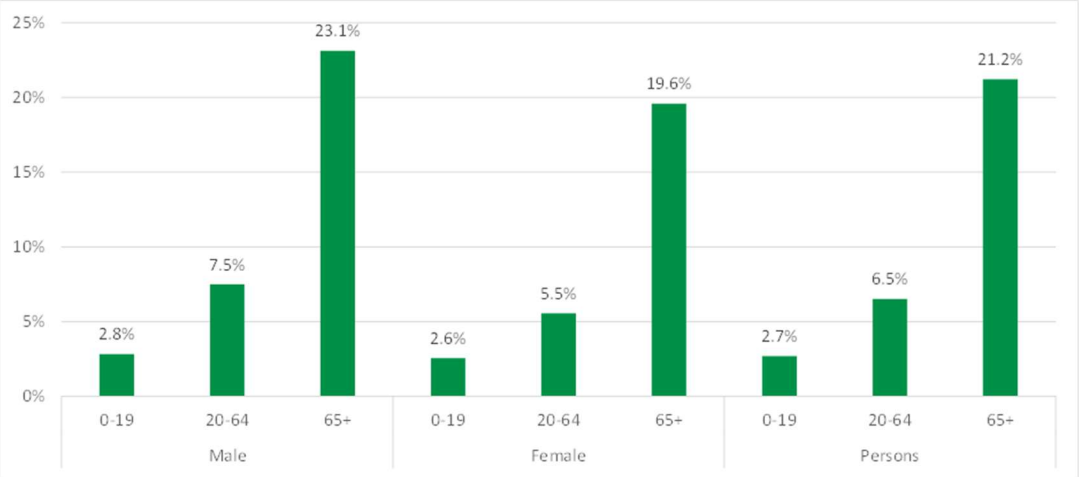
Table 9: Thurrock resident population projections 2022 to 2032

Gender	Age Band	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
Male	0-19	25,777	26,082	26,311	26,472	26,584	26,661	26,659	26,696	26,695	26,625
	20-64	51,990	52,423	52,846	53,246	53,688	54,078	54,505	54,849	55,148	55,503
	65+	11,481	11,653	11,855	12,096	12,310	12,565	12,841	13,132	13,474	13,804
	Total	**89,248**	**90,158**	**91,012**	**91,814**	**92,582**	**93,304**	**94,005**	**94,677**	**95,317**	**95,932**
Female	0-19	24,445	24,723	24,925	25,076	25,186	25,186	25,162	25,168	25,168	25,123
	20-64	53,294	53,703	54,060	54,454	54,729	55,070	55,375	55,614	55,836	56,041
	65+	13,411	13,546	13,742	13,904	14,165	14,419	14,715	15,034	15,343	15,691
	Total	**91,150**	**91,972**	**92,727**	**93,434**	**94,080**	**94,675**	**95,252**	**95,816**	**96,347**	**96,855**
Person	0-19	50,222	50,805	51,236	51,548	51,770	51,847	51,821	51,864	51,863	51,748
	20-64	105,284	106,126	106,906	107,700	108,417	109,148	109,880	110,463	110,984	111,544
	65+	24,892	25,199	25,597	26,000	26,475	26,984	27,556	28,166	28,817	29,495
	Total	**180,398**	**182,130**	**183,739**	**185,248**	**186,662**	**187,979**	**189,257**	**190,493**	**191,664**	**192,787**

Source: ONS 2019-based sub-national population projections for unitary and local authorities

Table 9 and Figure 9 shows that the resident population of Thurrock is expected to increase from 180,398 in 2022 to 192,787 by 2031, or by almost 7.5%. The population aged 65 and over is expected to increase by 21.2% by 2013 compared with only a 2.7% increase in the population aged 0-19. In all three broad age groups, the percentage increase for males is expected to be slightly higher than for females.

Figure 9: Expected percentage change in Thurrock resident population by broad age group 2022 - 2031

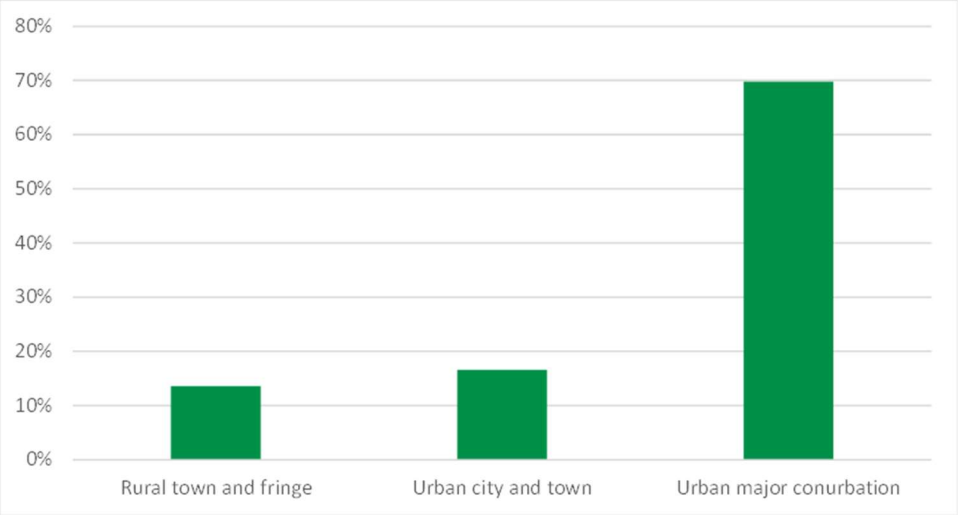


Source: ONS 2019-based sub-national population projections for unitary and local authorities

4.4 Urban and Rural Populations

Figure 10 shows the percentage of the Thurrock resident population in 2020, living in urban and rural areas. The ONS classifies areas into several urban and rural classifications based on a system established in 2013, based on 2011 Census data.

Figure 10: Proportion of the Thurrock resident population by urban/rural classification, mid-year 2021???



Source: ONS rural urban classification 2011 of wards in England and Wales

Figure 10 shows that 69.8% of the resident population of Thurrock live in areas designated by the ONS as 'Urban major conurbation' whilst 16.6% live in areas classified as 'Urban city and town' and 13.6% live in areas classified as 'Rural town and fringe'.

4.5 Multiple deprivation and local inequalities

There are many wider societal determinants associated with increased risk of drug or alcohol dependence. These factors including housing, employment and deprivation are associated with substance misuse and moderate treatment outcomes. Being in education, employment and good physical health can increase chances of successful substance misuse treatment. Substance misuse can also impact on education outcomes. Having housing problems or living in an area of higher deprivation can reduce the chances of successful treatment.

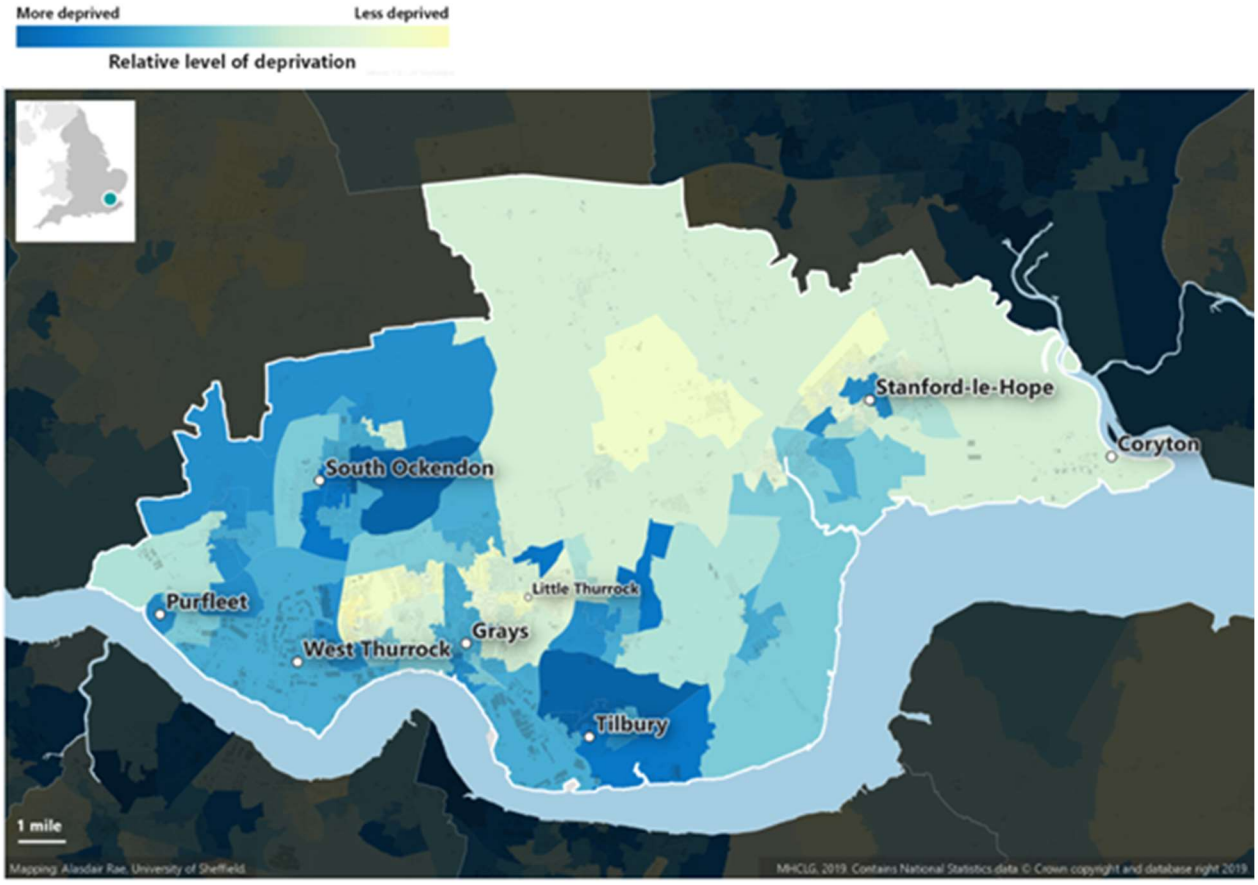
The socio-economic deprivation of a specific geographical area in England is most commonly measured using the Index of Multiple Deprivation. They have been produced by the Ministry of Housing, Communities and Local Government and its predecessors since the year 2000. The

Indices provide a set of relative measures of deprivation for small across England, based on seven different domains, or facets, of deprivation:

- Income Deprivation
- Employment Deprivation
- Education, Skills and Training Deprivation
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment Deprivation

Figure 11 below shows the IMD 2019 deciles for all lower super output areas (LSOAs) in Thurrock. The dark blue areas on the map are the LSOAs with the highest levels of deprivation and the creamy coloured areas on the map are the LSOAs with the lowest levels of deprivation.

Figure 11: Map showing Index of Multiple Deprivation 2019 deciles for Thurrock LSOAs



Source: Ministry of Housing, Communities and Local Government IMD 2019

Figure 11 shows that the areas of highest deprivation in Thurrock are concentrated in the south and west of the authority, particularly in parts of Tilbury and South Ockendon. The less deprived areas are concentrated in the north and east of the authority around the town of Stanford-le-Hope.

Table 10 shows the number and proportion of the mid-2015 resident population of Thurrock in each of the IMD 2019 deciles based on the total IMD score, the income sub-domain score and the Index of Deprivation Affecting Children (IDACI) score.

Table 10: Number and proportion of Thurrock population in each IMD 2019 decile for overall IMD 2019 score, Income sub-domain score and Index of Deprivation Affecting Children Index (IDACI) score

Total and percentage of Thurrock resident population by IMD, Income and IDACI, all deciles						
Decile	Number			Percentage		
	IMD	Income	IDACI	IMD	Income	IDACI
1 (most deprived)	6,586	7,997	10,044	4.00%	4.80%	6.00%
2	11,537	18,669	21,598	6.90%	11.20%	13.00%
3	24,264	23,103	28,226	14.60%	13.90%	17.00%
4	36,178	34,716	27,771	21.80%	20.90%	16.70%
5	23,689	12,072	23,259	14.30%	7.30%	14.00%
6	7,614	16,404	11,045	4.60%	9.90%	6.70%
7	23,039	12,097	18,619	13.90%	7.30%	11.20%
8	13,269	20,792	19,830	8.00%	12.50%	11.90%
9	18,162	17,140	5,648	10.90%	10.30%	3.40%
10 (least deprived)	1,702	3,050	0	1.00%	1.80%	0.00%

Source: Ministry of Housing, Communities & Local Government, English Indices of Deprivation, 2019

Table 10 shows that for the Index of Multiple Deprivation overall, around 4% of the Thurrock population live in LSOAs regarded as being in the 10% most deprived nationally (Decile 1) whereas only 1% live in LSOAs regarded as being in the 10% least deprived nationally (Decile 10). The percentage of the Thurrock population living in the more deprived deciles is higher for the IDACI than for the IMD 2019 overall and for the Income sub-domain, with 53% of the Thurrock population living in IDACI deciles 1 – 4. The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. It is a subset of the Income Deprivation Domain which measures the proportion of the population in an area experiencing deprivation relating to low income.

4.6 Housing and Homelessness

In 2020- 2021 in England around 17% of adults in treatment for substance misuse said they had a housing problem[35]. This ranged by type of substance with 10% of those treated solely for alcohol dependence, 30% of those with opiate misuse and 45% of those with new psychoactive substance problems reporting housing difficulties.

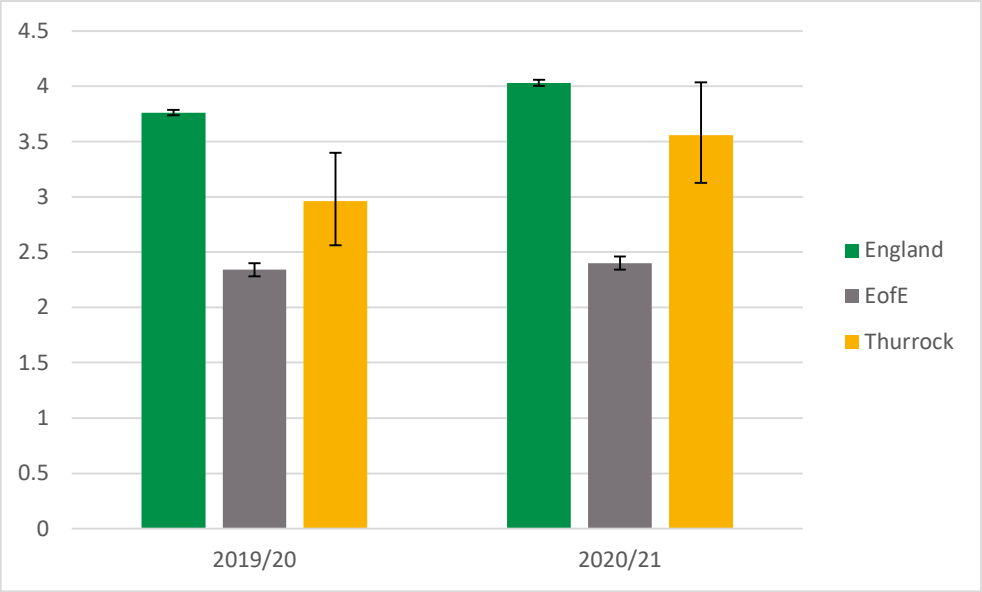
Around 66% of people experiencing homelessness cite drug or alcohol use as a reason for first becoming homeless. Those who use drugs are 7 times more likely to be homeless[36].

Figure 12 below shows the number of households living in temporary accommodation in Thurrock, the East of England and England as a rate per 1,000 households in 2019/20 and 2020/21.

[35] National statistics: Adult substance misuse treatment statistics 2020 to 2021 https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report

[36] Crisis Skylight Final Report Of thr University of York https://www.crisis.org.uk/ending-homelessness/health-and-wellbeing/drugs-and-alcohol/

Figure 12: Rate (per 1,000 households) of the number of households in temporary accommodation, Thurrock compared to East of England and England, 2019/20 and 2020/21

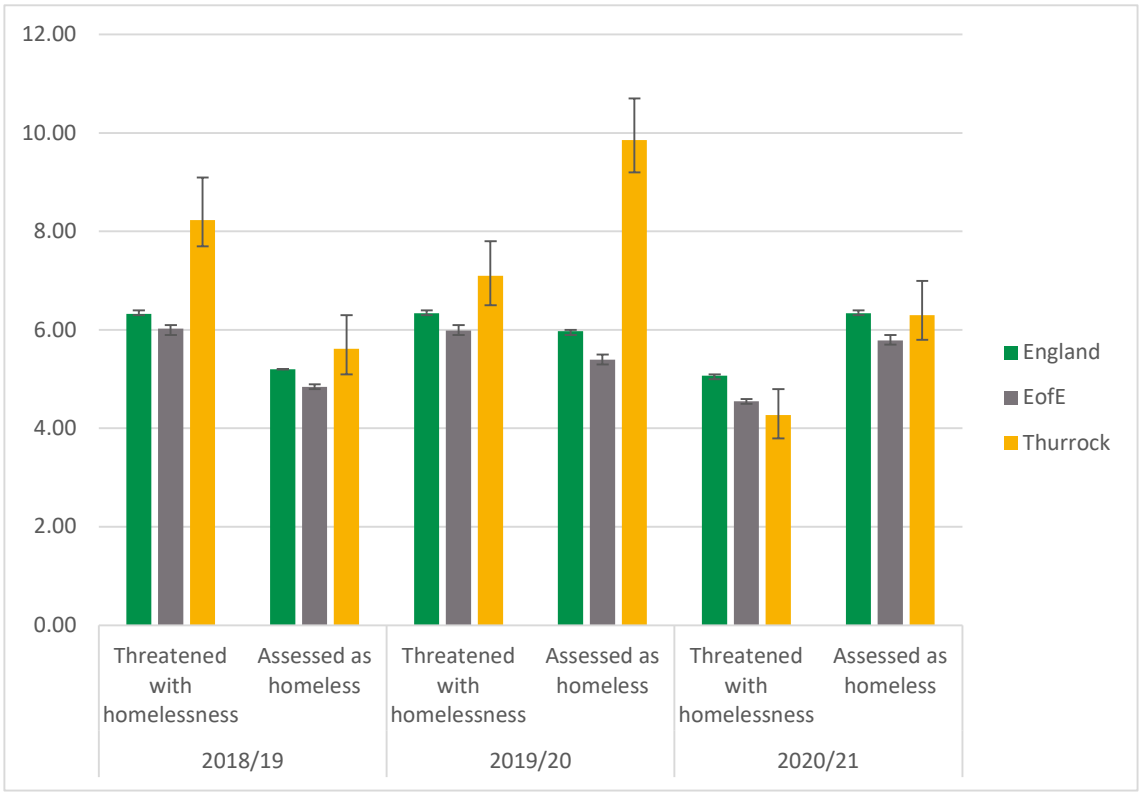


Source: Department for Levelling Up, Housing and Communities H-CLIC Homelessness returns (quarterly)

Figure 12 suggests that Thurrock had a statistically significantly higher rate of households in temporary accommodation than the East of England in both 2019/20 and 2020/21, but a lower rate than for England in both years, although this was only statistically significantly lower in 2019/20.

Figure 13 shows the rate of households per 1,000 households assessed as being homeless or threatened with homelessness for Thurrock, the East of England region and England for 2018/19, 2019/20 and 2020/21.

Figure 13: Rate (per 1,000 households) of households assessed as being homeless or threatened with homelessness, Thurrock compared to the East of England and England, 2018/19 to 2020/21



Source: Department for Levelling Up, Housing and Communities H-CLIC Homelessness returns (quarterly)

Figure 13 suggests that the rate of households threatened with homelessness in Thurrock declined from 2018/19 to 2019/20 and again in 2020/21. In 2018/19, the Thurrock rate was higher than both the East of England region and England rates, but by 2020/21 it had reduced to a rate lower than both the regional and national rates.

4.7 Employment

In a 2016 review of the impact of alcohol and illegal substance dependence on employment outcomes, Dame Carol Black noted that *"Alcohol misuse may also be a cause or a consequence of unemployment. It is certainly a predictor both of unemployment and of future job loss, but evidence also suggests that increased alcohol consumption may follow job loss."*[37]

Recent trends in the number and proportion of Thurrock residents, claiming Job Seeker's Allowance for over 12 months compared with the East of England and England are shown in Table 11 and Figure 14 below.

Table 11: Number of residents aged 16-64 claiming Job Seeker's Allowance for over 12 months in Thurrock, East of England and England in March 2020, March 2021, and March 2022

Residents claiming Job Seekers Allowance, all ages 16-64, for Thurrock, the East of England and England									
Sex	March 2020			March 2021			March 2022		
	Thurrock	EofE	England	Thurrock	EofE	England	Thurrock	EofE	England
Males	70	3,830	58,220	65	3,560	53,050	20	2,455	34,865
Females	60	2,450	35,570	70	2,355	33,155	30	1,565	21,155
Persons	**130**	**6,280**	**93,795**	**135**	**5,910**	**86,205**	**50**	**4,020**	**56,020**

Source: NOMIS Job Seekers Allowance claimants

Table 11 suggests that the number of Thurrock residents aged 16 – 64 claiming Job Seeker's Allowance for 12 months or longer declined sharply in March 2022 compared with March 2021 and March 2020. This reduction was also reflected in the regional and England figures for these months. In March 2020 and March 2021 there were more males than females claiming Job Seeker's Allowance for more than 12 months however, Table 12 beliw shows that in March 2022 there were fewer than 0.0% males claiming Job Seeker's Allowance for 12 months or longer.

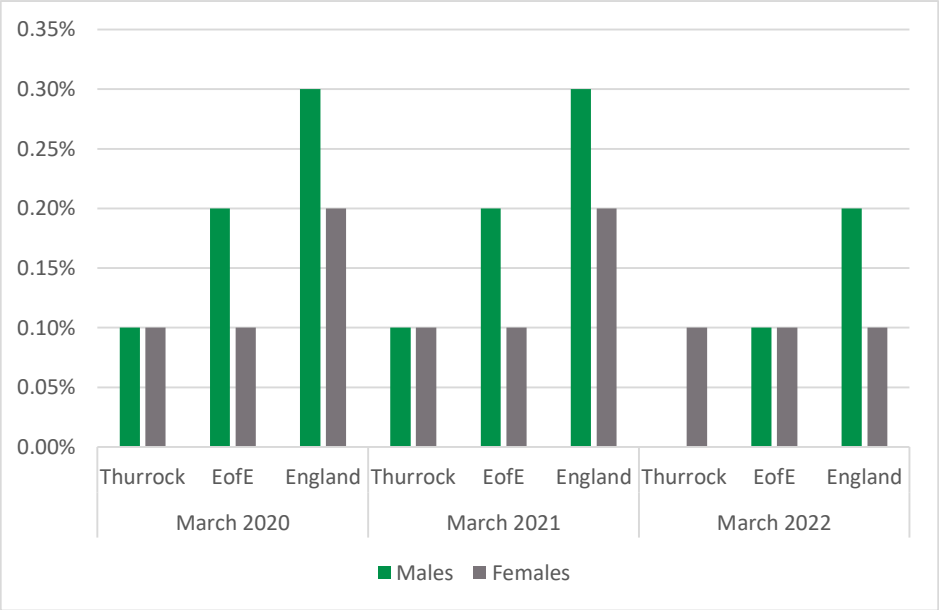
Table 12: Proportion of residents aged 16-64 claiming Job Seeker's Allowance for over 12 months in Thurrock, East of England and England in March 2020, March 2021, and March 2022

Percentage of residents claiming Job Seekers Allowance, all ages 16-64, for Thurrock, the East of England and England									
Sex	March 2020			March 2021			March 2022		
	Thurrock	EofE	England	Thurrock	EofE	England	Thurrock	EofE	England
Males	0.1%	0.2%	0.3%	0.1%	0.2%	0.3%	0.0%	0.1%	0.2%
Females	0.1%	0.1%	0.2%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%
Persons	**0.1%**	**0.2%**	**0.3%**	**0.1%**	**0.2%**	**0.2%**	**0.0%**	**0.1%**	**0.2%**

Source: NOMIS Job Seekers Allowance claimants

[37] Dame Carol Black. Independent review into the impact on employment outcomes of drug or alcohol addiction or obesity. 2016

Figure 14: Proportion of population aged 16-64 receiving Job Seeker's Allowance for more than 12 months in March each year for Thurrock, East of England, and England



Source: NOMIS Job Seekers Allowance claimants

Figure 14 shows that the proportion of the population aged 16-64 receiving Job Seeker's Allowance in March 2020, 2021, and 2022 in Thurrock compared to the East of England region and England. It shows that for Thurrock this was a stable proportion of about 0.1% for both males and females. England had a higher proportion in 2020 and 2021 particularly for males at around 0.3% of the population aged 16 – 64, although this reduced to about 0.2% in 2021.

Table 13 shows the number of Thurrock residents in receipt of unemployment related benefits (known as the 'Claimant Count') in March 2020, March 2021, and March 2022.

Table 13: Number of people in receipt of unemployment related benefits (claimant count) in March 2020, March 2021 and March 2022 in Thurrock, East of England, and England

Resident claimant count, all ages 16+, for Thurrock, the East of England and England									
Sex	March 2020			March 2021			March 2022		
	Thurrock	EofE	England	Thurrock	EofE	England	Thurrock	EofE	England
Male	1,820	50,780	618,990	4,310	121,160	1,348,400	2,525	74,845	878,100
Female	1,770	39,895	444,515	3,500	89,350	945,715	2,155	56,920	630,310
Persons	**3,585**	**90,675**	**1,063,50**	**7,810**	**210,510**	**2,294,110**	**4,680**	**131,765**	**1,508,410**

Source: NOMIS Claimant Count by age and sex

Table 13 shows that the number of people receiving unemployment related benefits in Thurrock more than doubled between March 2020 and March 2021, before declining sharply in March 2022. These trends are likely to have been impacted by the Covid-19 pandemic.

Table 14: Proportion of people in receipt of unemployment related benefits in March 2020, March 2021 and March 2022 in Thurrock, East of England, and England

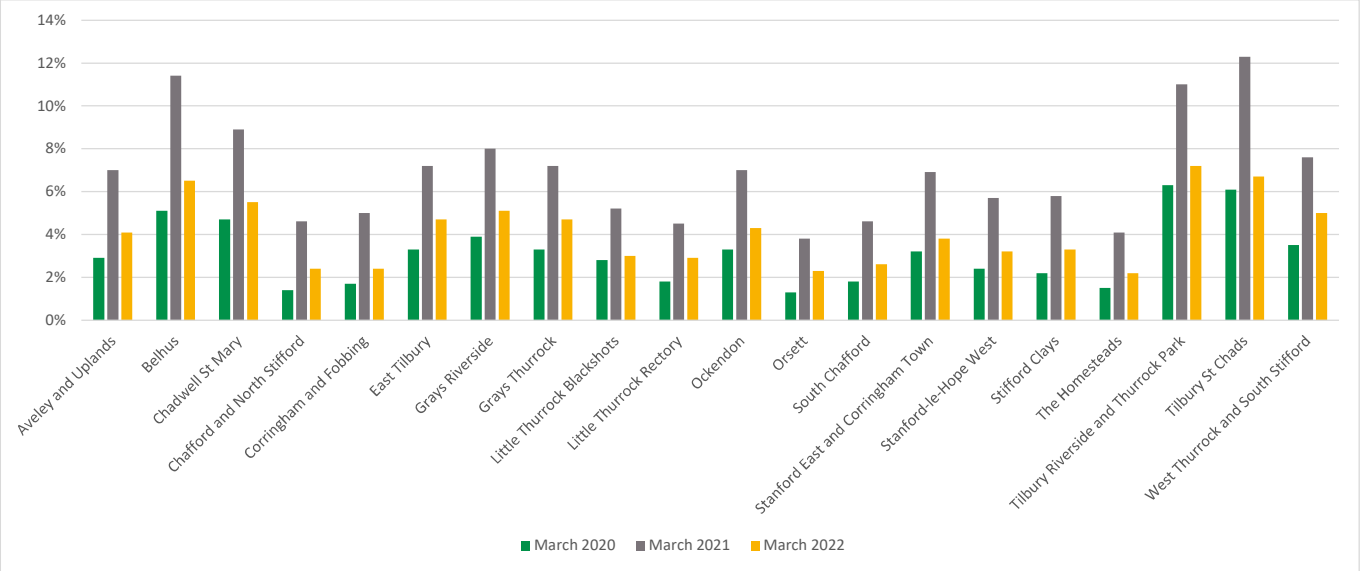
Resident claimant count percentage, all ages 16+, for Thurrock, the East of England and England									
Sex	March 2020			March 2021			March 2022		
	Thurrock	EofE	England	Thurrock	EofE	England	Thurrock	EofE	England
Males	3.3%	2.7%	3.5%	7.9%	6.4%	7.7%	4.6%	4.0%	5.0%
Females	3.2%	2.1%	2.5%	6.3%	4.7%	5.4%	3.9%	3.0%	3.6%
Persons	**3.3%**	**2.4%**	**3.0%**	**7.1%**	**5.5%**	**6.5%**	**4.2%**	**3.5%**	**4.3%**

Source: NOMIS Claimant Count by age and sex

Table 14 shows that in March 2020, at the time of the start of the Covid-19 pandemic, 3.3% of the Thurrock population aged 16 – 64 were in receipt of unemployment related benefits. There was relatively little difference between the proportion of males and females receiving such benefits at this time. In March 2021, the proportion receiving unemployment related benefits had increased to 7.1% and there was a greater difference between males and females (7.9% for males and 6.3% for females). In March 2022, the overall proportion of the Thurrock population receiving unemployment related benefits declined to 4.2%, with a reduced difference between males and females (4.6% males versus 3.9% females). These trends were broadly reflected in the regional and national figures for the East of England and England.

Figure 15 below shows the proportion of Thurrock residents receiving unemployment related benefit in each electoral ward in March 2020, March 2021, and March 2022.

Figure 15: Proportion of Thurrock residents receiving unemployment related benefits by ward, March 2020, March 2021, and March 2022



Source: NOMIS Claimant Count by electoral ward

Figure 15 suggests that the ward level data reflects the trends seen in Table 11 above, with the proportion of each ward's population receiving unemployment related benefits increasing in March 2021 compared to March 2020 and then decreasing in March 2022. Tilbury Riverside and Thurrock Park, Tilbury St Chads and Belhus wards consistently had the highest proportion of residents in receipt of unemployment related benefits.

4.8 Crime

Crime and substance misuse are known to be closely associated and substance misuse disorders are common in criminal justice settings[38]. Specific types of crime have been linked to particular types of substance misuse. People using alcohol compared to other substances are more likely to commit assault, and those committing burglary were more likely to using opiates than other substances. Generally, the pharmacological effect of substance misuse is to reduce inhibitions, increase confidence and impair judgement in relation to criminal activity[38].

Table 15 shows the total crime rate per 1,000 population for police recorded crime for Thurrock, the East of England region and England overall between 2015/16 and 2020/21.

[38] Bennett T, Holloway K. The causal connection between drug misuse and crime. *Br J Criminol.* 2009;49:513–531

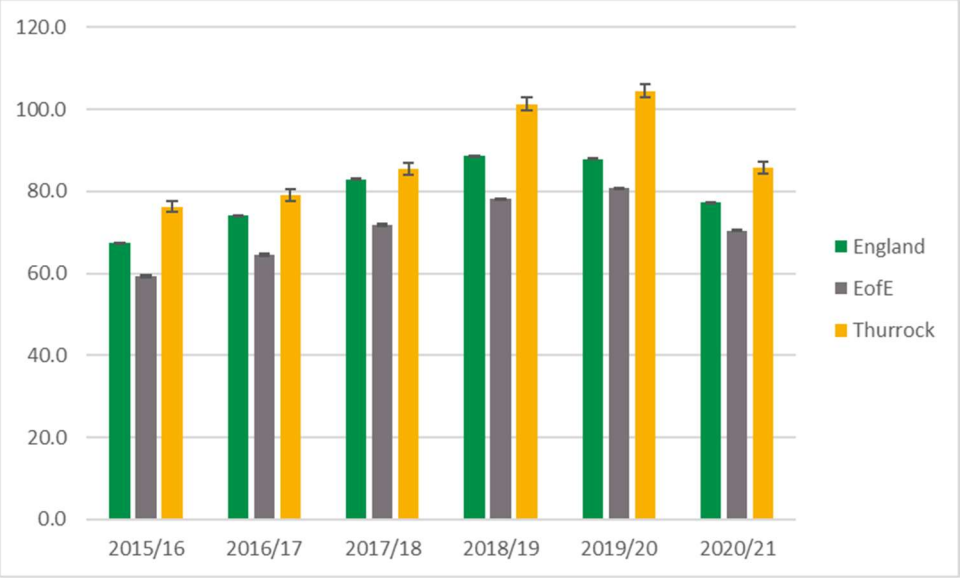
Table 15: Total crime (excluding fraud) rates per 1,000 population for Thurrock, East of England (EofE) and England

Rate of Total Crime (excluding fraud) per 1,000, for Thurrock, the East of England (EofE) and England						
Area	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
England	67.3	74.1	83	88.7	87.9	77.2
EofE	59.3	64.5	71.8	78.1	80.7	70.4
Thurrock	76.2	79	85.6	101.3	104.4	85.8

Source: Home Office - Police recorded crime

Table 15 shows that Thurrock had a higher overall crime rate than both the East of England region and England in all six years from 2015/16 to 2020/21. The total crime rate in Thurrock increased from 76.2 per 1,000 population in 2015/16 to 104.4 per 1,000 population in 2019/20 or by 37%. However, in common with both the East of England and England, the total crime rate in Thurrock dropped sharply to 85.8 per 1,000 population in 2020/21, perhaps in part due to the impact of the Covid-19 pandemic.

Figure 16: Total crime (excluding fraud) rates per 1,000 population for Thurrock, East of England, and England



Source: Home Office - Police recorded crime

Figure 16 shows that total crime recorded by the police was statistically significantly higher in Thurrock than in both the East of England region and England in 2018/19, 2019/20 and 2020/21.

4.8.1 Burglary and crime against the person

Table 16 shows the number of violence against the person offences, residential burglary offences and drug offences per 1,000 population for Thurrock, the East of England region and England from 2014/15 to 2020/21.

Table 16: Rates per 1,000 population for violence against the person, residential burglary and drug offences for Thurrock, East of England, and England, 2014/15 to 2020/21

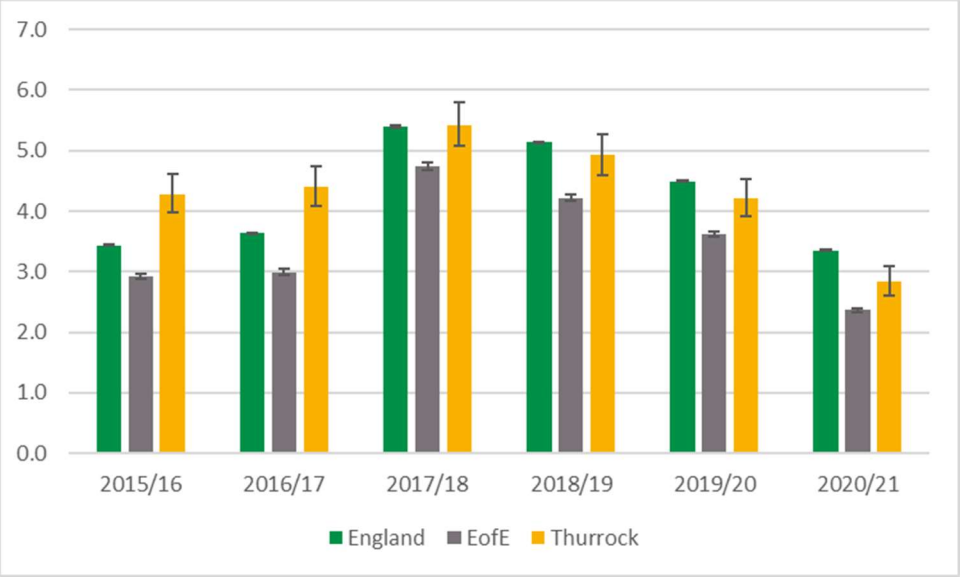
Rate of Crime per 1,000 people, for Thurrock, the East of England and England							
Category of Offence	Area	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Violence Against the Person	England	17.2	20	23.7	28.2	29.5	29.8
	EofE	15.6	17.8	21	25.5	28.5	28.8
	Thurrock	18.6	19.8	23.4	33.4	38.2	35.5
Residential Burglary	England	3.4	3.6	5.4	5.1	4.5	3.4
	EofE	2.9	3	4.7	4.2	3.6	2.4
	Thurrock	4.3	4.4	5.4	4.9	4.2	2.8
Drug Offences	England	2.5	2.3	2.3	2.5	3.1	3.4
	EofE	2.0	2.0	2.0	2.2	2.7	3.0
	Thurrock	1.8	2.0	2.1	2.6	2.9	3.0

Source: Home Office - Police recorded crime

Table 16 indicates that Thurrock has generally had higher rates of violence against the person than both England and the East of England region, with rates having increased from 18.6 per 1,000 population in 2015/16 to 38.2 per 1,000 population in 2019/20. For residential burglary rates for Thurrock have been consistently higher than for the East of England region, but lower than for England in 2018/19, 2019/20 and 2020/21. For drug offences rates in Thurrock have been lower than for England in every year apart from 2018/19, when they were slightly higher than the England average. Compared to the East of England region, Thurrock has had the same or slightly higher rates since 2015/16.

Figure 17 shows the rate per 1,000 population for police recorded burglary offences in Thurrock, the East of England region and England for 2015/16 to 2020/21.

Figure 17: Rates per 1,000 for residential burglary offences, Thurrock compared to East of England and England, 2015/16 to 2020/21

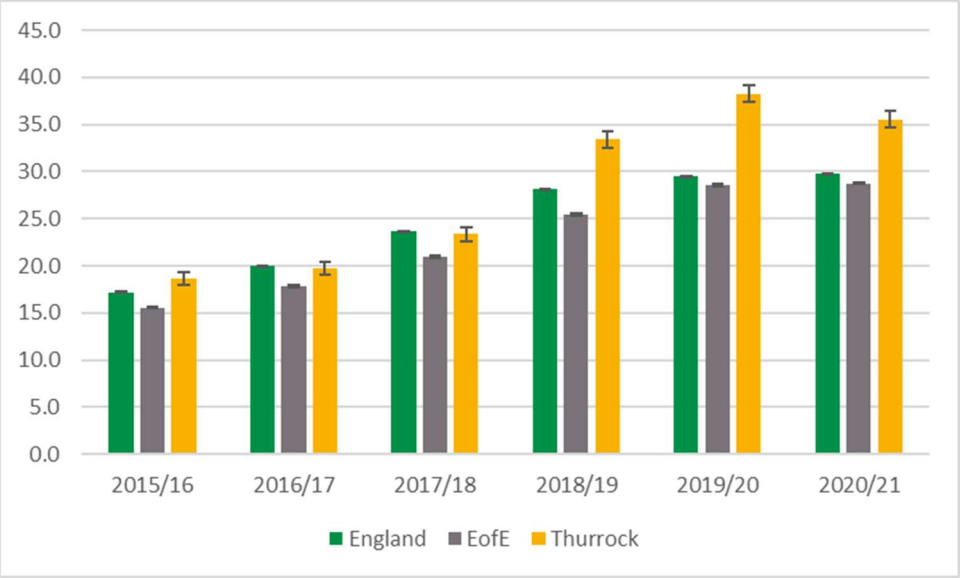


Source: Home Office - Police recorded crime

Figure 17 shows that in 2015/16 and 2016/17, Thurrock had a higher rate of recorded burglary offences than both the East of England region and England. However, from 2018/19 to 2020/21, the rate of burglary offences in Thurrock has remained higher than the East of England region rate but has been lower than the England rate.

Figure 18 shows the rate per 1,000 population of police recorded violence against the person offences in Thurrock, the East of England region and England from 2015/16 to 2020/21.

Figure 18: Rates per 1,000 for violence against the person offences, Thurrock compared to East of England and England, 2015/16 to 2020/21



Source: Home Office - Police recorded crime

Figure 18 shows that rates of violence against the person per 1,000 population increased in Thurrock year on year between 2015/16 and 2019/20, before declining in 2020/21. The rate of violence against the person offences was higher in Thurrock than for both the East of England region and England in every year except for 2016/17 and 2017/18, when the Thurrock rate was higher than that of the East of England region but marginally lower than for England.

4.8.2 Domestic violence

Substance misuse features in around half of all UK domestic homicides and since 2011 substance use has been detected more than four times as often in perpetrators compared to those who have been killed by them[39,40]. Up to 60% of men in domestic violence perpetrator programmes have problems with alcohol and/or drugs[41].

Table 17 shows the rate of domestic abuse related incidents and crimes[42] recorded by the police for Thurrock, the East of England region and England. These data are calculated by allocating local authorities the crude rate per 1,000 population of the Police Force Area (PFA) in which they sit. Therefore, the figures for Thurrock local authority reflect the extent and trends of domestic abuse related incidents and crimes recorded by Essex Police across the whole PFA not just in Thurrock.

Table 17: Rate per 1,000 population (aged 16+) of domestic abuse related incidents and crimes, for Thurrock, East of England, and England

[39] Gadd D, Hendersen J Radcliffe P, Stephens-Lewis D, Johnson A, Gilchrist G 2019 The dynamics of domestic abuse and drug and alcohol dependency Brit Criminol vol 59 1035-1053

[40] Domestic Homicide Reviews https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

[41] Home Office Doestic abuse: Draft Statutory Guidance framework 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/896640/Draft_statutory_guidance_July_2020.pdf

[42] Domestic abuse-related offences and incidents recorded by the police in those aged 16 or over. Domestic abuse related offences and incidents are defined as threatening behaviour, violence, or abuse (psychological, physical, sexual, financial, or emotional) between adults, aged 16 and over, who are or have been intimate partners or family members, regardless of gender or sexuality.

Rate per 1,000 people of domestic abuse related crime, for Thurrock, East of England, and England						
Area	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
England	23.9	24.4	25.5	27.8	28.6	30.3
EofE	20.5	21.4	23.6	24.5	26.3	26.9
Thurrock/Essex PFA	21.3	21.6	23.6	28.1	29.1	28

Source: Office for Health Improvement and Disparities (OHID) developed from ONS Domestic abuse prevalence and victim characteristics

Table 17 shows that rate of recorded domestic abuse incidents and crimes in the Thurrock/Essex PFA area increased each year between 2015/16 and 2019/20 before declining slightly in 2020/21. The Thurrock/Essex PFA rate was below that of England in 2015/16 to 2017/18 inclusive but was higher than the England rate in 2018/19 and 2019/20. The Thurrock/Essex PFA rate has been consistently higher than the East of England region rate each year apart from in 2017/18, when it was the same.

Table 18 shows the number and proportion of children in need assessments where domestic violence was noted as a factor. Children in need assessments are undertaken for any child who has been referred to children's social care services with a request that services be provided. A child in need is a child that is unlikely to reach their potential without intervention from services available from the local authority. Domestic violence in the household is one of the factors that Social Services consider when deciding whether a child needs their support. The domestic violence can involve the child directly or other members of the household.

Table 18: Number and proportion of Children in Need assessments highlighting domestic violence in the household as a factor for Thurrock, 2018 to 2021

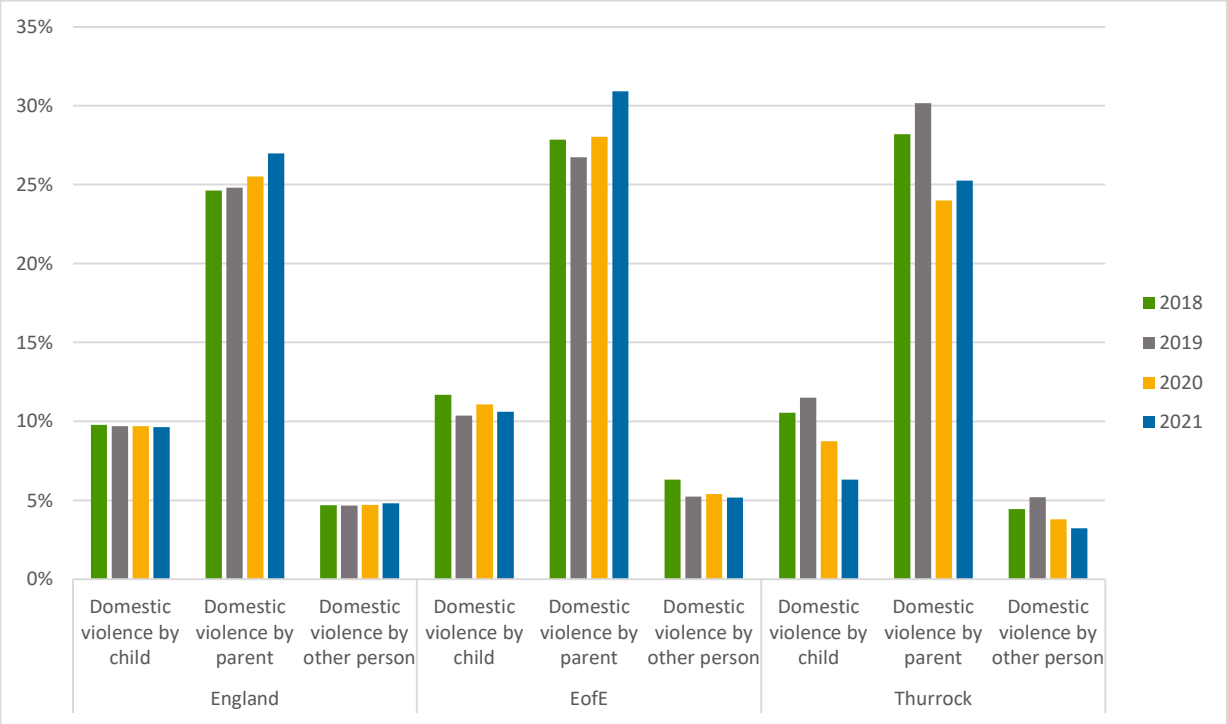
Year	Number			Percentage		
	Domestic violence by child	Domestic violence by parent	Domestic violence by other person	Domestic violence by child	Domestic violence by parent	Domestic violence by other person
2018	214	572	90	10.6%	28.2%	4.4%
2019	366	960	165	11.5%	30.2%	5.2%
2020	352	965	153	8.8%	24.0%	3.8%
2021	266	1,063	136	6.3%	25.3%	3.2%

Source: Department for Education. Children in Need Statistics. Characteristics of Children in Need, 2020/21

Table 18 shows that the most common category of domestic violence recorded during children in need assessments was domestic violence by a parent. The number of assessments where domestic violence by a parent was noted as a factor increased year on year between 2018 and 2021 and increased from 572 assessments in 2018 to 1,063 assessments in 2021. However, as a proportion of the total number of assessments carried out, domestic violence by a parent was noted as a factor in 25.3% of assessments in 2021 compared to 28.2% of assessments in 2018. This is because the total number of assessments carried out each year increased significantly between 2018 and 2021, increasing from 2,028 in 2018 to 4,209 in 2021. The number of assessments noting domestic violence by the child or by another person in the household have both declined since 2019.

Figure 19 shows how the proportion of children in need assessments noting domestic violence as a factor in Thurrock compare to both the East of England region and England in the period 2018 to 2021.

Figure 19: proportion of Children in Need assessments highlighting domestic violence in the household as a factor for Thurrock, 2018 to 2021



Source: Department for Education. Children in Need Statistics. Characteristics of Children in Need, 2020/21

Figure 19 shows that the proportion of assessments noting domestic violence by a parent in Thurrock was similar to the East of England region and England at between 25% and 30%. The proportion of assessments noting domestic violence by a parent was higher than England in 2018 and 2019 but lower in 2020 and 2021.

4.9 Children and Young People

There are a range of factors linked to the likelihood that children and young people will misuse drugs and alcohol; and this can continue and be problematic into adulthood. This includes children and young people drawn into crime, those who are in the care system and those who experience hidden harm.

Amongst school-aged pupils truancy, substance misuse, crime and anti-social behaviour tend to cluster together. For example, early alcohol use not only increases the risk of subsequent criminal activity but is also associated with cannabis use, truancy, and disengagement from school[43] . One study reported that 41% of young offenders report that they had been drinking at the time of their offence[44]

Table 19 below shows the number of proven offences committed by children in Thurrock by type of offence from 2013/14 to 2020/21.

[43] Young People's Alcohol Consumption DfE 2010
[44] Alcohol Concern 2016 Alcohol in the System: An examination of alcohol and youth offending in London https://www.trustforlondon.org.uk/publications/alcohol-system-examination-alcohol-and-youth-offending-london/

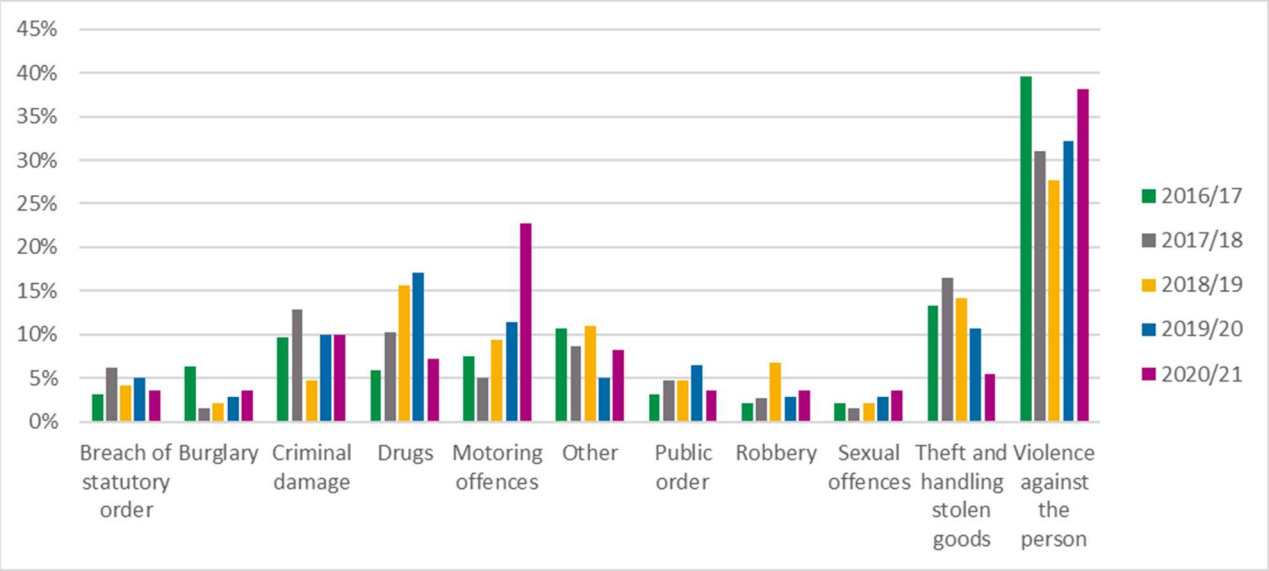
Table 19: Number of proven offences committed by children resident in Thurrock by offence category, 2013/14 to 2020/21

Total number of proven offences committed by children by category of offence, all Thurrock								
Offence Group	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Breach of statutory order	8	15	10	<5	16	8	7	<5
Burglary	15	8	12	12	<5	<5	<5	<5
Criminal damage	16	23	27	18	33	9	14	11
Drugs	18	9	10	11	26	30	24	8
Motoring offences	<5	7	14	14	13	18	16	25
Other	17	23	16	20	22	21	7	9
Public order	8	17	<5	<5	12	9	9	<5
Robbery	10	5	6	<5	7	13	<5	<5
Sexual offences	<5	9	<5	0	<5	<5	0	0
Theft and handling stolen goods	47	42	15	25	42	27	15	6
Violence against the person	48	46	56	74	79	53	45	42
Total	**194**	**204**	**173**	**187**	**255**	**191**	**140**	**110**

Source: Youth Justice Board for England and Wales. Youth justice annual statistics for 2020 to 2021 for England and Wales

Table 19 suggest that the number of offences proven to have been committed by children in Thurrock declined from 255 in 2017/18 to 110 in 2020/21. Violence against the person offences was the offence category with the highest number of offences committed by children in each year from 2013/14 to 2020/21. Theft and handing of stolen goods offences committed by children declined to 6 in 2021, from 47 in 2013/14 and 42 in 2017/18 and 2014/15. Drugs offences were also lower in 2020/21 than in the immediately preceding years.

Figure 20: Percentage of proven offences committed by children resident in Thurrock by offence category, 2013/14 to 2020/21



Source: Youth Justice Board for England and Wales. Youth justice annual statistics for 2020 to 2021 for England and Wales

Figure 20 shows that violence against the person offences accounted for the largest proportion of crimes committed by children and young people in Thurrock each year from 2016/17 to 2020/21. There appears to have been a spike in motoring offences in 2020/21 which resulted in the proportion of motoring offences within total recorded crime for children and young people

roughly doubling compared with the previous year. Note that any numbers less than 5 in the chart above have been treated as 4's to reduce the risk of identification of individuals.

Tables 20 and 21 show the number of children resident in Thurrock aged 10-17 that were cautioned or sentenced from 2013/14 to 2020/21 by age group (Table 20) and gender (Table 21).

Table 20: Number of children resident in Thurrock cautioned or sentenced by age band, 2013/14 to 2020/21

Total number of children cautioned or sentenced by age band, all Thurrock								
Age Band	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
10-14	22	22	18	22	24	19	11	12
15-17	92	72	65	54	79	61	51	40
Total	**114**	**94**	**83**	**76**	**103**	**80**	**62**	**52**

Source: Youth Justice Board for England and Wales. Youth justice annual statistics for 2020 to 2021 for England and Wales

Table 21: Number of children resident in Thurrock cautioned or sentenced by gender, 2013/14 to 2020/21

Total number of children cautioned or sentenced by gender, all Thurrock								
Age Band	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Male	93	82	70	61	91	68	55	45
Female	21	12	13	15	12	12	7	7
Persons	**114**	**94**	**83**	**76**	**103**	**80**	**62**	**52**

Source: Youth Justice Board for England and Wales. Youth justice annual statistics for 2020 to 2021 for England and Wales

Tables 20 and 21 show that the number of children in Thurrock cautioned or sentenced has reduced from 114 in 2013/14 to 52 in 2020/21. Figures for 2020/21 may have been influenced by the Covid-19 pandemic, but there had been a reducing trend in the years immediately prior to the pandemic. Most children cautioned or sentenced each year in Thurrock were from the 15 -17-year-old age group. The vast majority were also male, with only 7 females aged 10- 17 being cautioned or sentenced in both 2019/20 and 2020/21.

4.9.1 Looked after children

Looked after children are children in the care of a local authority. Young people in care aged 11–19 years have a four-fold increased risk of drug and alcohol use compared to their peers[45]. A national survey of care leavers in England showed that 32% smoked cannabis daily and data from 2012 showed that 11.3% of young people in care aged 16–19 years had a diagnosed substance use problem[46,47].

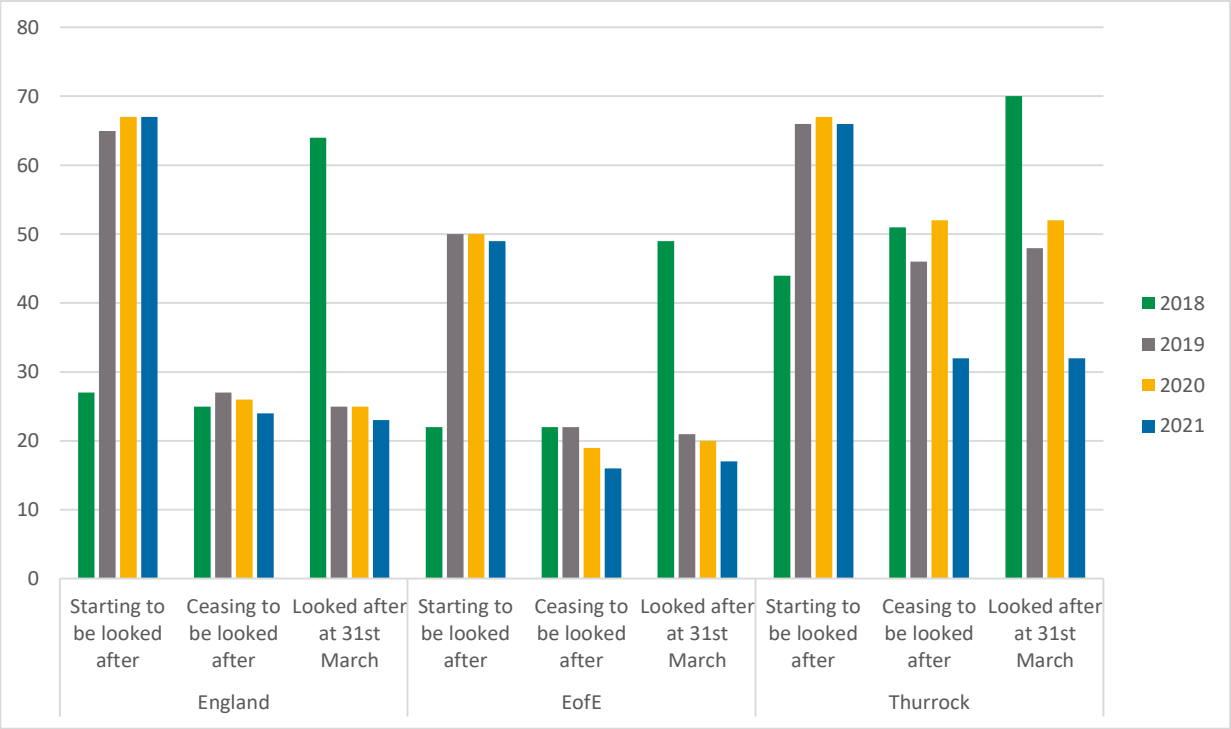
Figure 21 below shows the number of children per 10,000 child population (aged 0 – 17) starting and ceasing to be looked after each year from 2018 to 2021 in Thurrock the East of England region and England. It also shows the number of looked after children in each area on 31st March each year expressed as a rate per 10,000 child population.

[45] Alderson H, Kaner E, McColl E, Howel D, Fouweather T, McGovern R, et al. (2020) A pilot feasibility randomised controlled trial of two behaviour change interventions compared to usual care to reduce substance misuse in looked after children and care leavers aged 12-20 years: The SOLID study. PLoS ONE 15(9): e0238286. https://doi.org/10.1371/journal.pone.0238286

[46] Meltzer H. The mental health of young people looked after by local authorities in England. London: H.M.S.O.; 2003

[47] Blyth L. Outcomes for Children Looked After by Local Authorities in England, as of 31 March 2012. Office of National Statistics; 2012.

Figure 21: Rate per 10,000 population of looked after children in Thurrock, East of England, and England 2018 to 2021



Source: Department for Education. Children looked after in England including adoptions: 2020 to 2021 (SSDA903)

Figure 21 suggests that Thurrock had similar rates of children starting to be looked after to the England average in 2019, 2020 and 2021, but a higher rate than England in 2018. Thurrock's rates were higher than the East of England region in all four years. For children ceasing to be looked after, Thurrock had higher rates than both the England and East of England averages in all four years. In terms of the rate of looked after children per 10,000 on 31st March each year, the highest rates were seen in 2018 for Thurrock, the East of England and England.

Table 22 shows that number of looked after children placed within Thurrock by other local authorities and the number of children placed in other local authorities by Thurrock Council on 31st March 2018, 2019, 2020 and 2021.

Table 22: Number of children starting and ceasing to be looked after and total looked after on 31st March 2018 to 2021

Total number of Looked After Children who were looked after on March 31st by local authority of placement and net gain, for Thurrock				
Characteristic	Year			
	2018	2019	2020	2021
Children who are the responsibility of other LAs in Thurrock LA	91	88	98	110
Children who are Thurrock LA responsibility placed outside the LA	176	170	194	197
Net gain of children by responsible LA	-85	-82	-96	-87

Source: Department for Education. Children looked after in England including adoptions: 2020 to 2021 (SSDA903)

Table 22 shows that Thurrock Council has consistently placed more looked after children in other local authorities than it is has taken in children from other local authorities. The net difference between the number of children accepted into Thurrock from other local authorities and the number of children placed by Thurrock Council in other local authorities varied from 82 to 97 per year from 2018 to 2020.

5 Epidemiology of Drug and Alcohol Misuse in Thurrock

Summary of Drugs and Alcohol Misuse Epidemiology in Thurrock

National government and local key performance data typically categorise the misuse of drugs and/or alcohol into four substance groups, these are

- Alcohol only
- Non-opiate and alcohol
- Opiate only and
- Non-opiate only

Non opiate drugs include cannabis, cocaine, crack cocaine, MDMA, ketamine, amphetamines steroids and novel psychoactive substances such as spice. Opiate drugs include heroin, and a range of medications available on prescription such as codeine, fentanyl, and morphine. Published research data may group drug and alcohol misuse in different combinations.

Prevalence

- Based on 2016/17 estimates there are around 4.3 opiate users per 1,000 aged 16 to 64 years in Thurrock compared to the significantly higher England average of 7.4 per 1,000
- There are similar rates of crack cocaine users (4 to 5 per 1,000) in people aged 16 to 64 years in England and Thurrock
- When applied to 2021 populations these prevalence rates equate to 493 people using opiates and 450 people using crack cocaine in Thurrock
- There were an estimated 1,600 adults with an alcohol dependency in Thurrock in 2018/19 at a rate of about 1.2 per 100 residents
- The proportion of people abstaining from drinking and those drinking over 14 units of alcohol per week were both significantly lower for Thurrock than England
- Estimates of unmet need in Thurrock suggest that 79.2% of people using opiates are not currently being supported to reduce or stop this type of drug use. For non-opiates this is 69.2%, for alcohol this is 82.2% and for combined non opiate and alcohol this is 90.4% Rates of unmet need in England are considerably lower than in Thurrock

Mortality

- Rates of death due to drug poisoning between 2018 to 2020 are half that in Thurrock (3.2 per 100,000) compared to East of England (6.4 per 100,000) and England (7.6 per 100,000)
- Alcohol related mortality was lower in Thurrock (27.1 per 100,000) compared to East of England (32.4 per 100,000) and England (37.8 per 100,000) but these differences are not significantly different
- In 2017-19 alcohol specific mortality in Thurrock (7.2 per 100,000) was significantly lower than in England (10.9 per 100,000) but not East of England (8.2 per 100,000)

Service use

- Most commonly people were in specialist treatment in 2020/21 in Thurrock for opiate misuse (43%), similar to the proportions in England (47%) and East of England (41%).
- The second most common reason for treatment in specialist services was alcohol misuse (around 25% for Thurrock, England, and East of England)
- Since 2015/16 the number of people in treatment has decreased from 715 to 330, and new referrals have decreased from 430 in 2015/16 to 170 in 2020/21

- Around two thirds of people in treatment are male and one third female
- Around 90% of people in treatment are White, 3% are Asian/Asian British people and 3% are Black African/Caribbean/Black British. This is an under representation of Black people who make up around 7.8% of the Thurrock population

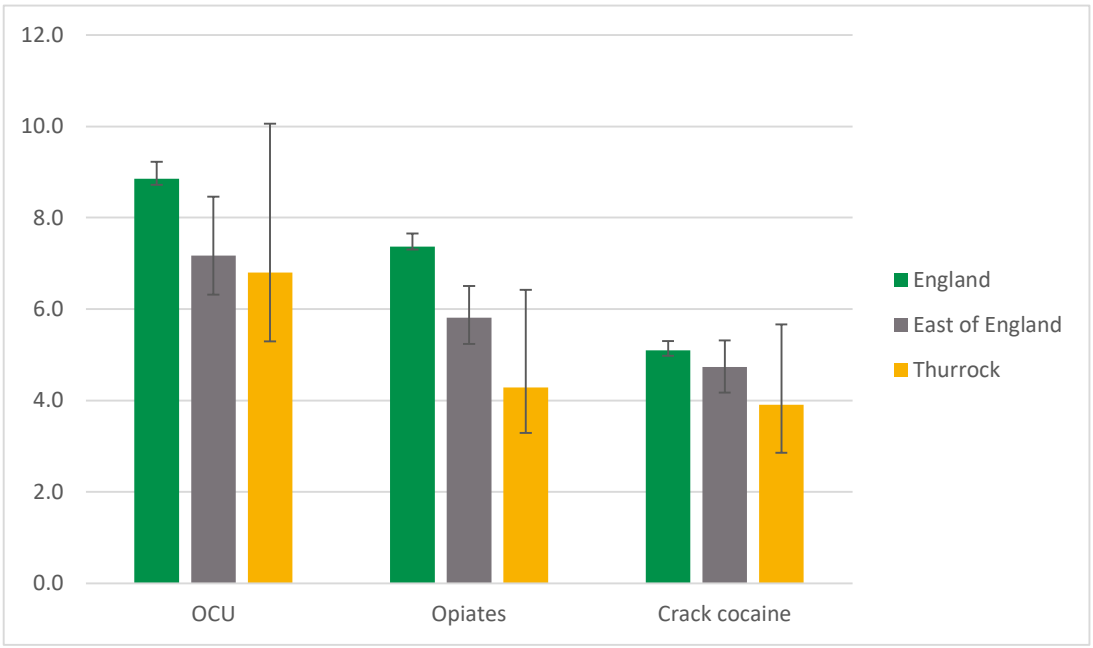
5.1 Drugs and Alcohol Misuse

National government and local key performance data typically categorise the misuse of drugs and/or alcohol into four substance groups, these are alcohol only; non opiate and alcohol; opiate only and non-opiate only. Non opiate drugs include cannabis, cocaine, crack cocaine, MDMA, ketamine, amphetamines, steroids, and novel psychoactive substances such as spice. Opiate drugs include heroin, and a range of medications available on prescription such as codeine, fentanyl, and morphine. Published research data may group drug and alcohol misuse in different combinations.

5.1.1 Prevalence of drug misuse

Figure 22 shows the estimated prevalence rates per 1,000 population aged 15 – 64 for opiate and/or crack cocaine users (OCUs[48]), opiate users and crack cocaine users in Thurrock, the East of England and England in 2016/17. These prevalence estimates were produced by the Public Health Institute within Liverpool John Moores University in 2019.

Figure 22: Estimated rates per 1,000 population aged 15 to 64 of OCU, opiate and crack cocaine users in Thurrock, the East of England and England in 2016-17



Source: Public Health Institute, Liverpool John Moores University. Estimates of the prevalence of opiate use and/or crack cocaine use (2016-17)

Figure 22 suggests that Thurrock had lower rates of OCUs, opiate and crack cocaine users than both the East of England region and England. However, none of these differences were statistically significant, except for opiate users, where Thurrock had a rate per 1,000 population nearly half of the England rate (4.3 per 1,000 vs 7.4 per 1,000).

[48] Note: 'OCU' refers to use of opiates and/or crack cocaine. It does not include the use of cocaine in a powder form, amphetamine, ecstasy, or cannabis. Although many opiate and/or crack users also use these drugs it is very difficult to identify exclusive users of these drugs from the available data sources.

Table 23 shows the estimated number of opiate and/or crack cocaine users in Thurrock, the East of England and England in 2016/17, based on the population rates from Figure 22.

Table 23: Estimated number of opiate and crack cocaine users (OCUs) aged 16 - 64 in Thurrock, East of England, and England in 2016/17

Area	OCU	OCU Range	Opiates	Opiate Range	Crack Cocaine	Crack Cocaine Range
Thurrock	742	578 – 1,098	468	359 – 701	427	311 - 618
EofE	27,509	24,249 - 32,475	22,308	20,099 - 24963	18,170	16,033 - 20,400
England	313,971	309,242 - 327,196	261,294	25,9018 - 27,1403	180,748	176,583 -188,066

Source: Public Health Institute, Liverpool John Moores University. Estimates of the prevalence of opiate use and/or crack cocaine use (2016-17)

Table 23 suggests that there were an estimated 742 opiate and/or crack cocaine users in Thurrock in 2016/17, of whom 468 used opiates alone or in combination with crack cocaine and 427 used crack cocaine alone or in combination with opiates.

Table 24 shows the prevalence estimates used to create the 2016/17 numbers of OCUs applied to the 2021 Census populations for Thurrock, the East of England region and England.

Table 24: Estimated number of opiate and crack cocaine users (OCUs) aged 16 - 64 in Thurrock, East of England, and England in 2021, based on 2016/17 prevalence rates

Area	OCU	OCU Range	Opiates	Opiate Range	Crack Cocaine	Crack Cocaine Range
Thurrock	781	609 – 1,156	493	378 – 738	450	327 – 651
EofE	28,500	25,122 – 33,645	23,111	20,823 – 25,862	18,824	16,660 – 21,135
England	320,985	316,151 – 334,506	267,131	264,805 – 277,466	184,786	180,528 – 192,267

Source: Public Health Institute, Liverpool John Moores University. Estimates of the prevalence of opiate use and/or crack cocaine use (2016-17) and 2021 Census

Table 24 shows that applying the 2021 Census populations aged 15 – 64 to the 2016/17 prevalence estimates suggests that the number of OCUs in Thurrock may have increased to an estimated 781 of which 493 use opiates alone or in combination with crack cocaine and 450 use crack cocaine alone or in combination with opiates.

Cannabis is one of the most commonly used drugs and in the most recent survey in England and Wales[49], 7.6% of adults said that they had used cannabis in the last year, the highest proportion since 2008/09. In 2018/19, cannabis use in the last year among 16- to 24-year-olds was 17%, its highest point for a decade. If this rate is applied to the Thurrock population this would equate to around 10,000 adults and around 3,400 young people aged 16 to 24 using cannabis at least once in the past year. However, this doesn't give an indication about the frequency of cannabis use by individuals and it is unclear from these figures how many people would benefit from treatment services compared to the benefits of a wider harm minimisation approach across the population of Thurrock.

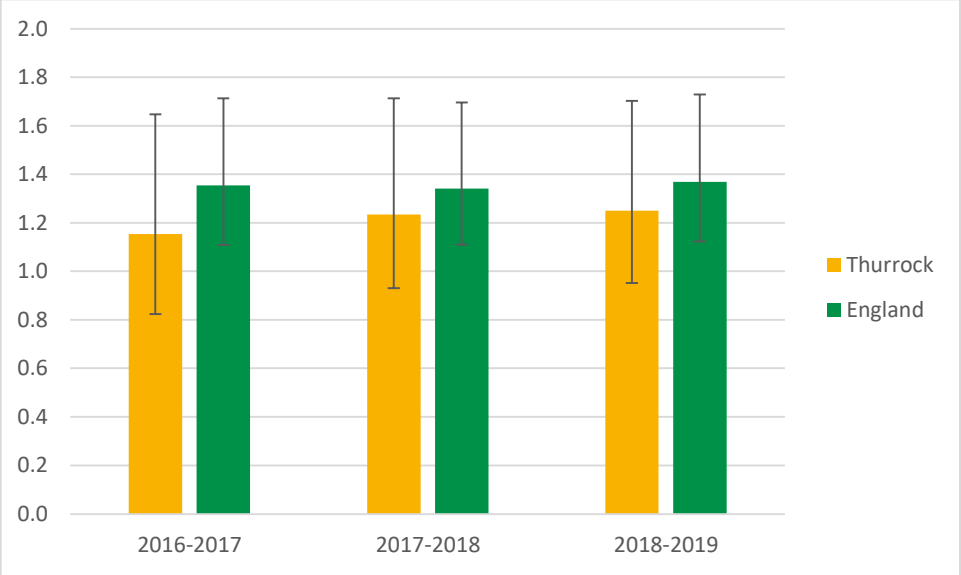
5.1.2 Prevalence of alcohol misuse

Figure 23 shows the rate per 100 adults with alcohol dependency potentially in need of specialist treatment for Thurrock and England in 2016/17, 2017/18 and 2018/19. These rates are

[49] Drug misuse: findings from the 2018 to 2019 CSEW - GOV.UK (www.gov.uk)

prevalence estimates produced by the University of Sheffield in 2017[50], and are based on data taken from the 2014 Adult Psychiatric Morbidity Survey[51].

Figure 23: Rate per 100 of adults with alcohol dependency in Thurrock compared to England, 2016-17 to 2018/19



Source: University of Sheffield. Estimates of the number of adults in England with an alcohol dependency potentially in need of specialist treatment

Figure 23 suggests that Thurrock had lower rates of alcohol dependency potentially in need of specialist treatment than England in all three years, although none of these differences are statistically significant at the 95% Confidence Levels. The Thurrock rates imply that there were an estimated 1,600 adults aged 18 and over with an alcohol dependency potentially requiring specialist treatment in 2018/19. This number had increased from an estimated 1,450 in 2016/17.

Table 25 shows the estimated percentage of adults in Thurrock and England who abstain from alcohol and the estimated percentage that drink 14 or more units of alcohol per week. The data are a weighted estimate taken from the Health Survey for England 2015-2018. Guidance issued by the Chief Medical Officer in 2016[52] advised that in order to keep to a low level of risk of alcohol-related harm, adults should not regularly drink more than 14 units of alcohol a week.

Table 25: Patterns of alcohol consumption for Thurrock and England, 2015-18 weighted estimate

Indicator	Thurrock (%)	Lower 95% CI	Upper 95% CI	England (%)	Lower 95% CI	Upper 95% CI
Adults who abstain from alcohol	7	3.6	13.0	16	15.8	16.6
Adults drinking over 14 units of alcohol a week	11.6	6	21.6	23	22.4	23.3

Source: Adults Alcohol Commissioning Support Pack 2022/23

CI – confidence interval

[50] Alcohol dependence prevalence in England - GOV.UK (www.gov.uk)
[51] Adult Psychiatric Morbidity Survey: Mental Health and Wellbeing, England, 2014 - GOV.UK (www.gov.uk)
[52] UK Chief Medical Officers' Alcohol Guidelines Review: Summary of the proposed new guidelines - January 2016 (publishing.service.gov.uk)

Table 25 shows that Thurrock had both a lower proportion of the adult population that abstained from drinking alcohol and drank more than 14 units per week than England. The 95% statistical confidence intervals suggest that both these differences are statistically significant.

5.1.3 Unmet need

The table below shows the estimated percentage of people who are dependent on opiates and/or crack cocaine but are not in the treatment system, for Thurrock and England in 2021/22. For alcohol, the percentages in the table below relate to the population aged 18 and over, but for opiates/non-opiates the percentages relate to the population aged 15 – 64. Data are based on reported drug and alcohol usage by clients that are not currently in treatment.

Table 26: The estimated proportion of people in your area who are dependent on opiates and/or crack cocaine or alcohol not in the treatment system, 2021/22

Estimated prevalence of unmet need for opiates and/or crack cocaine or alcohol		
Drug and/or alcohol issue	Thurrock	England
Opiate	79.2%	53.7%
Non-opiate	69.2%	47.1%
Alcohol	82.2%	57.6%
Non-opiate and alcohol	90.4%	80.5%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

Table 26 suggests that Thurrock has higher levels of unmet need than England across the opiate, non-opiate, alcohol, and non-opiate plus alcohol substance misuse categories.

5.2 Mortality from Drug Misuse

Table 27 shows the number of deaths related to drugs poisoning[53] and the death rate per 100,000 population for Thurrock, the East of England region and England for the years from 2014-16 to 2018 – 20.

Table 27: Number of deaths and age-standardised mortality rate per 100,000 population for deaths related to drug poisoning for Thurrock, East of England, and England, 2014-16 to 2018-20

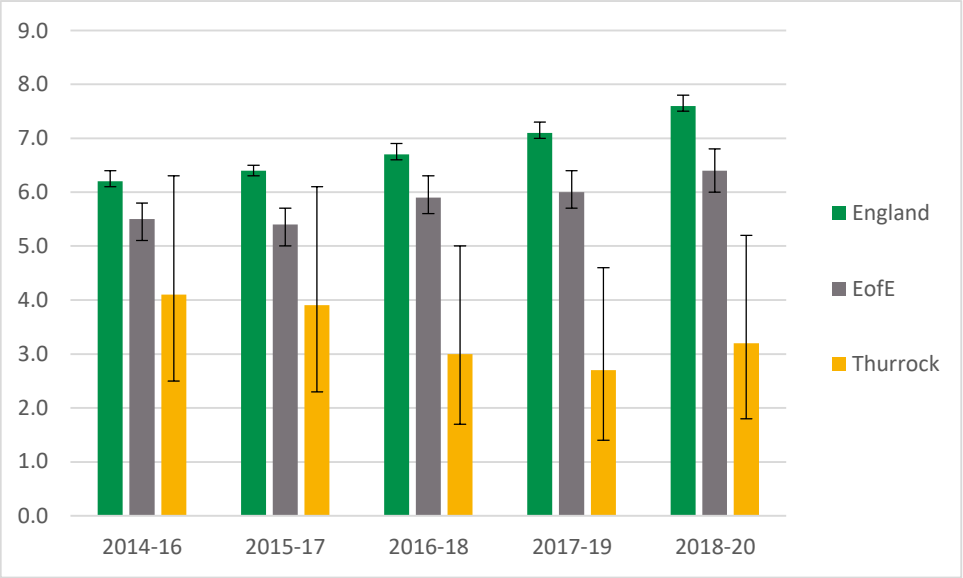
Area	Number of deaths					Rate per 100,000 Population				
	2014-16	2015-17	2016-18	2017-19	2018-20	2014-16	2015-17	2016-18	2017-19	2018-20
Thurrock	20	19	15	13	16	4.1	3.9	3	2.7	3.2
EofE	969	958	1,059	1,081	1,149	5.5	5.4	5.9	6	6.4
England	10,022	10,348	10,915	11,580	12,410	6.2	6.4	6.7	7.1	7.6

Source: Office for National Statistics. Deaths related to drug poisoning by local authority. England and Wales, 1993 to 2020.

Table 27 suggests that the number of drug related deaths in Thurrock has declined slightly from 20 in the three-year period from 2014-16 to 13 between 2017-19 before increasing to 16 in the period 2018-20. In comparison to the East of England region and England, Thurrock has had consistently lower rates per 100,000 population over all of the rolling three-year periods since 2014 and had rates less than half of the regional and national averages in 2016-18, 2017-19 and 2018-20.

[53] Deaths related to drugs poisoning include ICD10 codes for: mental and behavioural disorders due to drug use (excluding alcohol and tobacco) (F11-F16, F18-19); accidental poisoning by drugs, medicaments, and biological substances (X40-X44); intentional self-poisoning by drugs, medicaments, and biological substances (X60 - X64); assault by drugs, medicaments, and biological substances (X85); poisoning by drugs, medicaments and biological substances, undetermined intent (Y10-Y14).

Figure 24: Age-standardised mortality rate per 100,000 population for deaths related to drug poisoning for Thurrock, East of England, and England, 2014-16 to 2018-20



Source: Office for National Statistics. Deaths related to drug poisoning by local authority. England and Wales, 1993 to 2020.

Figure 24 shows whilst age-standardised mortality rates per 100,000 population for deaths related to drug poisoning have increased since 2014-16 in both England and the East of England, Thurrock has seen a decrease. The mortality rates for Thurrock have been statistically significantly lower than for both England and the East of England region in 2016-18, 2017-19 and 2018-20.

5.3 Mortality from Alcohol Misuse

The Office for Health Improvement and Disparities (OHID) publishes two indicators of mortality associated with alcohol misuse in the Local Alcohol Profiles for England (LAPE)[54]. These are:

- Alcohol-specific mortality: Deaths from conditions wholly caused by alcohol. This definition is also used by the Office of National Statistics in their annual UK data release.
- Alcohol-related mortality: Deaths from conditions which are wholly or partially caused by alcohol. For partially attributable conditions, a fraction of the deaths is included based on the latest academic evidence about the contribution alcohol makes to the condition.

Table 28 below shows the directly age-standardised mortality rate per 100,000 population (all ages) for alcohol related mortality, for Thurrock, the East of England region and England for the years from 2016 to 2020.

Table 28: Directly standardised rate per 100,000 population for alcohol related mortality for Thurrock, the East of England and England, 2016 to 2020

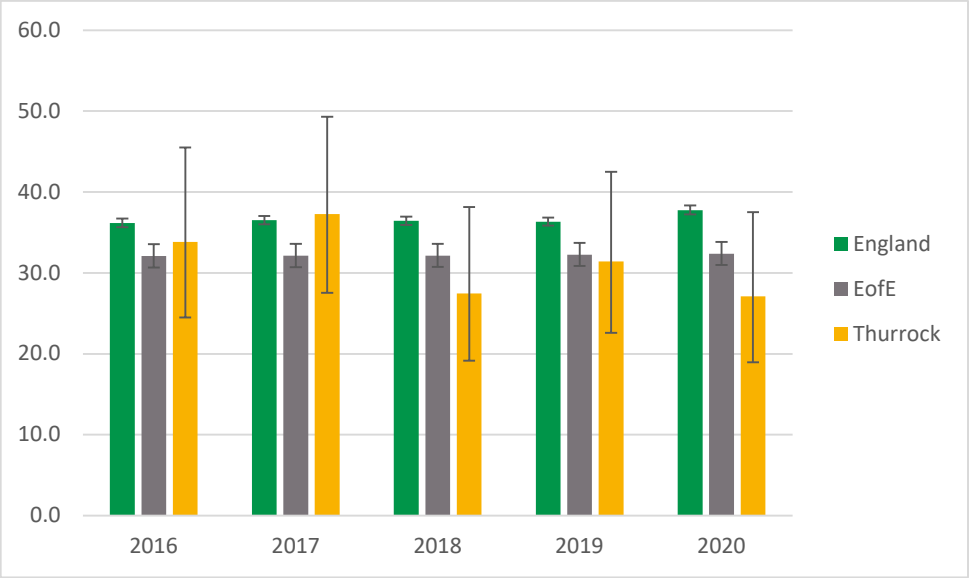
Area	2016	2017	2018	2019	2020
Thurrock	33.8	37.3	27.5	31.4	27.1
EofE	32.1	32.1	32.2	32.3	32.4
England	36.2	36.5	36.5	36.4	37.8

Source: OHID. Local Alcohol Profiles for England (LAPE)

[54] Local Alcohol Profiles for England - Mortality due to alcohol - OHID (phe.org.uk)

Table 28 shows that since 2018, Thurrock has had a lower rate of alcohol related mortality per 100,000 population than both England and the East of England region. Alcohol related mortality in Thurrock has reduced from 37.3 per 100,000 population in 2017 to 27.1 per 100,000 population in 2020.

Figure 25: Directly standardised death rate per 100,000 population for alcohol related mortality for Thurrock, the East of England and England, 2016 to 2020



Source: OHID. Local Alcohol Profiles for England (LAPE)

Figure 25 shows that despite Thurrock recording lower alcohol related mortality rates than both the East of England and England in 2018, 2019 and 2020, none of these rates were statistically significantly different at the 95% confidence level.

Table 29 shows the directly age standardised mortality rate per 100,000 population (all ages) for alcohol specific mortality (deaths wholly attributable to alcohol misuse) for Thurrock, the East of England region and England for the rolling three-year periods from 2012-14 to 2017-19.

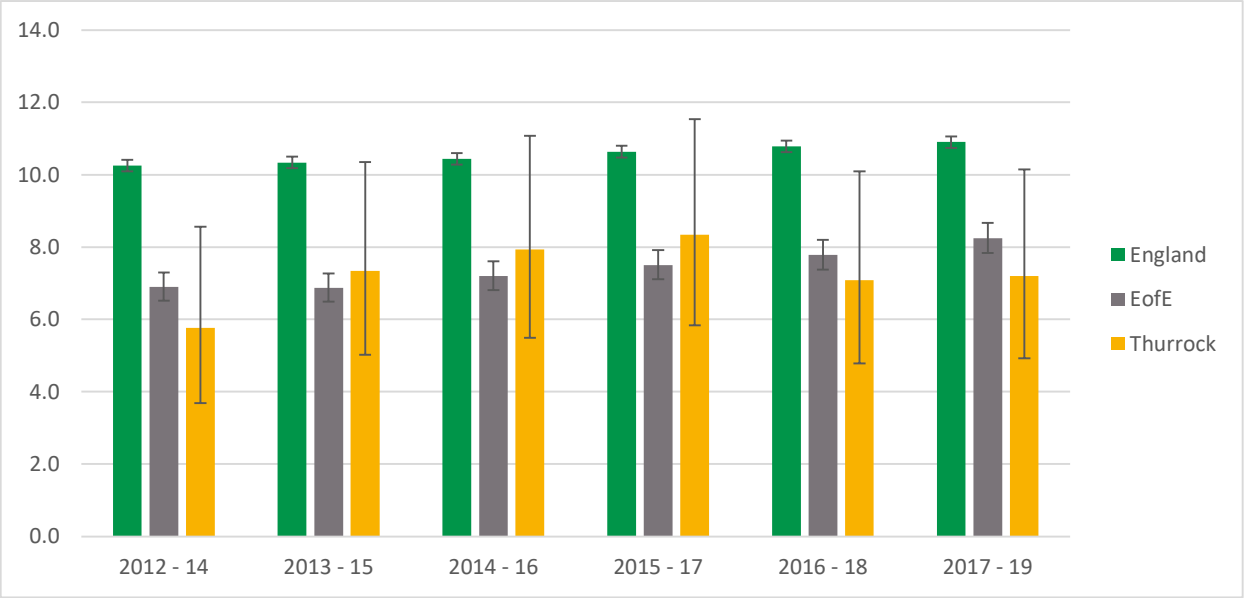
Table 29: Directly age-standardised mortality rate per 100,000 population for alcohol specific mortality for Thurrock, the East of England and England, 2012-14 to 2017-19

Area	2012 - 14	2013 - 15	2014 - 16	2015 - 17	2016 - 18	2017 - 19
Thurrock	5.8	7.3	7.9	8.3	7.1	7.2
EofE	6.9	6.9	7.2	7.5	7.8	8.2
England	10.3	10.3	10.4	10.6	10.8	10.9

Source: OHID. Local Alcohol Profiles for England (LAPE)

Table 29 indicates that Thurrock has had lower alcohol specific mortality rates per 100,000 population than England in every 3-year period from 2012-14 to 2017-19. Compared to the East of England region, Thurrock had lower alcohol specific mortality rates in 2016-18 and 2017-19 but higher rates in the previous 3-year periods.

Figure 26: Directly age-standardised rate per 100,000 population for alcohol specific mortality for Thurrock, the East of England and England, 2012-14 to 2017-19



Source: OHID. Local Alcohol Profiles for England (LAPE)

Figure 26 shows that Thurrock has had statistically significantly lower alcohol specific mortality rates than England in 2012-14, 2016-18 and 2017-19. However, none of the differences in alcohol specific mortality between Thurrock and the East of England region over these periods have been statistically significant.

Table 30 shows the estimated number of years of life lost due to alcohol-related conditions for Thurrock and England in 2018.

Table 30: Years of life lost due to alcohol-related conditions for Thurrock and England, 2018

Years of life lost due to alcohol-related conditions by sex	Thurrock			England		
	DSR per 100,000 population	Lower 95% CI	Upper 95% CI	DSR per 100,000	Lower 95% CI	Upper 95% CI
Female	144	38	311	353	341	365
Male	574	302	925	926	906	946

Source: Adults Alcohol Commissioning Support Pack 2022/23
CI – Confidence interval, DSR - Directly age standardised rate

Table 30 shows that the directly age-standardised rate of years of life lost due to alcohol-related conditions was lower for Thurrock than for England for both males and females. The difference in the directly standardised rates between males and females in Thurrock was not statistically significant, but it was for England. For both Thurrock and England, the rate was much higher for males than for females.

5.4 Morbidity from Drug Use

Table 31 shows the hospital episode rate per 100,000 age-standardised population for alcohol related conditions for males and females for Thurrock and England in 2019/20.

Table 31: Inpatient hospital episode rates per 100,000 age standardised population for alcohol related conditions by gender for Thurrock and England, 2019/20

Admission Episode Condition	Sex	Thurrock			England		
		DSR per 100,000	Lower 95% CI	Upper 95% CI	DSR per 100,000	Lower 95% CI	Upper 95% CI
Alcohol-Related Cardiovascular Disease	Male	1,506	1,407	1,609	1,482	1,477	1,487
	Female	159	131	191	239	237	241
Alcoholic Liver Disease	Male	111	88	137	192	190	194
	Female	50	35	68	89	88	91
Alcohol-Related Unintentional Injuries	Male	95	75	120	96	95	97
	Female	14	7	24	14	13	14
Mental and Behavioural Disorders due to Alcohol	Male	50	36	67	104	103	105
	Female	23	14	35	45	45	46
Intentional Self-Poisoning from Alcohol	Male	35	24	50	40	39	40
	Female	38	26	53	53	52	54

Source: Adults Alcohol Commissioning Support Pack 2022/23
CI- Confidence interval, DSR – Directly standardised rate

Table 31 shows of the conditions listed, alcohol-related cardiovascular disease had the highest hospital episode rates for both males and females for both Thurrock and England in 2019/20. Alcoholic liver disease had the second highest hospital episode rates for both males and females in both Thurrock and England. Rates for males were higher than for females for every episode condition except for 'Intentional self-poisoning by and exposure to alcohol'.

Table 32 shows the incidence rate of alcohol related cancer per 100,000 population for males and females in Thurrock and England from 2016-18.

Table 32: Directly standardised Incidence rate per 100,000 population of alcohol-related cancer for Thurrock and England, 2016-18

Incidence of alcohol-related cancer by sex	Thurrock			England		
	DSR per 100,000	Lower 95% CI	Upper 95% CI	DSR per 100,000	Lower 95% CI	Upper 95% CI
Female	33.1	25.7	41.8	36.8	36.4	37.2
Male	40.2	31.4	50.6	39.2	38.8	39.7

Source: Adults Alcohol Commissioning Support Pack 2022/23
CI – Confidence interval, DSR – Directly standardised rate

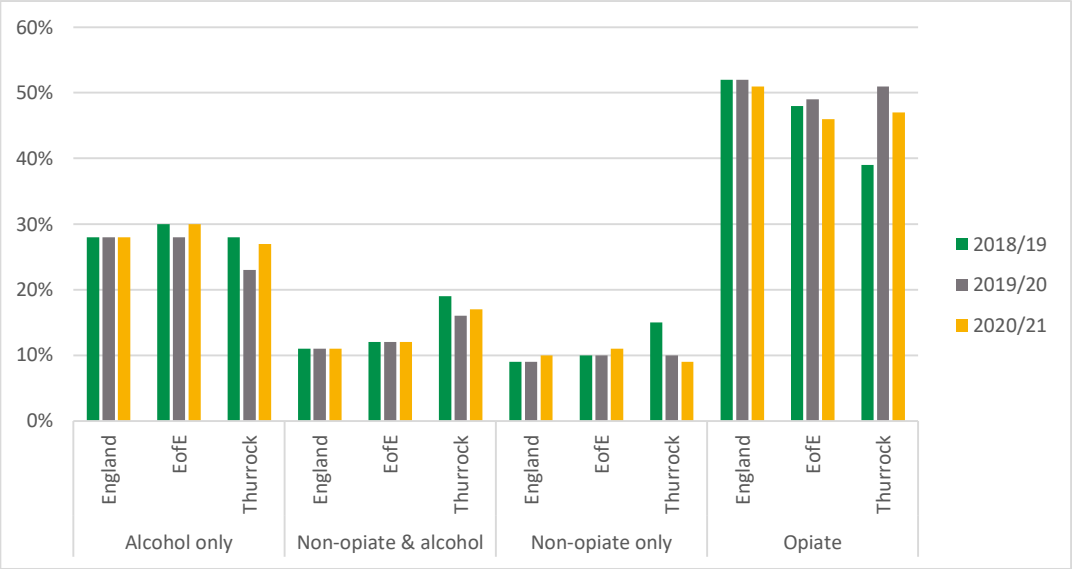
Table 32 shows that compared to England females in Thurrock had a lower but not statistically significant incidence rate of alcohol related cancer than England. Males in Thurrock had a slightly higher rate of alcohol related cancer compared to England, but this was not statistically significant.

5.5 Treatment

5.5.1 Type of substance misuse

Figure 27 shows the proportion of patients in treatment in Thurrock, the East of England region and England by type of substance misuse.

Figure 27: Proportion of clients currently in treatment, by type of substance misuse, for Thurrock, East of England, and England



Source: NDTMS ViewIT Adults

Figure 27 shows that Thurrock had a higher proportion of clients in the non-opiate and alcohol category than both England and the East of England in 2018/19, 2019/20 and 2020/21. In 2018/19, Thurrock also had a higher proportion of clients in the non-opiate only category, but this proportion reduced in both 2019/20 and again in 2020/21 to be below the East of England regional and England averages.

Table 33: Numbers and proportion of adults in alcohol and/or drug treatment by drug groups for Thurrock and England, 2020-21.

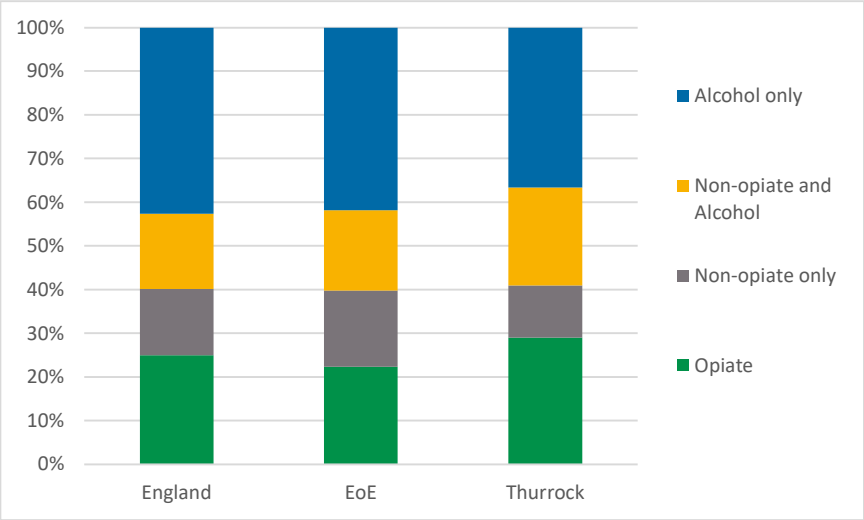
Alcohol and drug users in treatment	Thurrock (n)	Thurrock (%)	England (n)	England (%)
All alcohol	173	48%	131,391	44%
Alcohol only	89	25%	76,740	26%
Alcohol and opiate	7	2%	6,590	2%
Alcohol and non-opiate	56	16%	30,688	10%
Alcohol, opiates, and non-opiate	21	6%	17,373	6%
Alcohol cited crack	18	5%	15,565	5%
Alcohol cited cocaine	47	13%	17,207	6%
Alcohol cited cannabis	24	7%	18,805	6%
Non-opiate	31	9%	27,605	9%
Opiate	154	43%	140,863	47%
Total	358	100%	299,859	100%

Source: Adults Alcohol Commissioning Support Pack 2022/23

Table 33 suggests that compared to England, Thurrock had a slightly higher proportion of adults in treatment for alcohol misuse (48% compared to 44%), but a lower proportion of adults in treatment for opiate misuse (43% compared to 47%).

Figure 28 shows the proportion of new presentations for drug/alcohol treatment in each substance category in 2021/22 for Thurrock compared to England and the East of England region.

Figure 28: Proportion of new presentations from April 2021 to March 2022 by substance misuse category



Source: NDTMS Community Adult Treatment Performance Reports

Figure 28 shows that England and the East of England region had very similar proportions of new presentations to treatment in each of the substance misuse categories in 2021/22. By comparison, Thurrock had a higher proportion of new presentations in the opiate and alcohol and non-opiate categories and a lower proportion in the non-opiate only and alcohol only categories.

Table 34 shows the number of adults in treatment in Thurrock and England citing the use of prescription only medicines (POM) or over the counter (OTC) medicine misuse in 2020/21.

Table 34: Number of adults in drug treatment citing Prescription Only Medicine (POM) or Over the Counter (OTC) use, for Thurrock and England, 2020/21

POM/OTC Use	Thurrock (n)	Proportion of treatment population (Thurrock)	England (n)	Proportion of treatment population (England)
Illicit use	12	5%	19,346	10%
No illicit use	8	3%	7,608	4%

Source: Adult Drug Commissioning Support Pack 2022/23
OTC – over the counter, POM - Prescription only Medicines

Table 34 shows that 5% of adults in drug treatment in Thurrock also cited problems with the illicit use of prescription only or over the counter medications. This was around half of the proportion of adults in drug treatment in England as a whole.

5.5.2 Trends of treatment over time

Table 35 shows the number of people receiving drug and/or alcohol treatment in Thurrock each year from 2016/16 to 2021 by gender.

Table 35: Total number of Thurrock clients in treatment, by treatment category and gender, 2015/16 to 2020/21

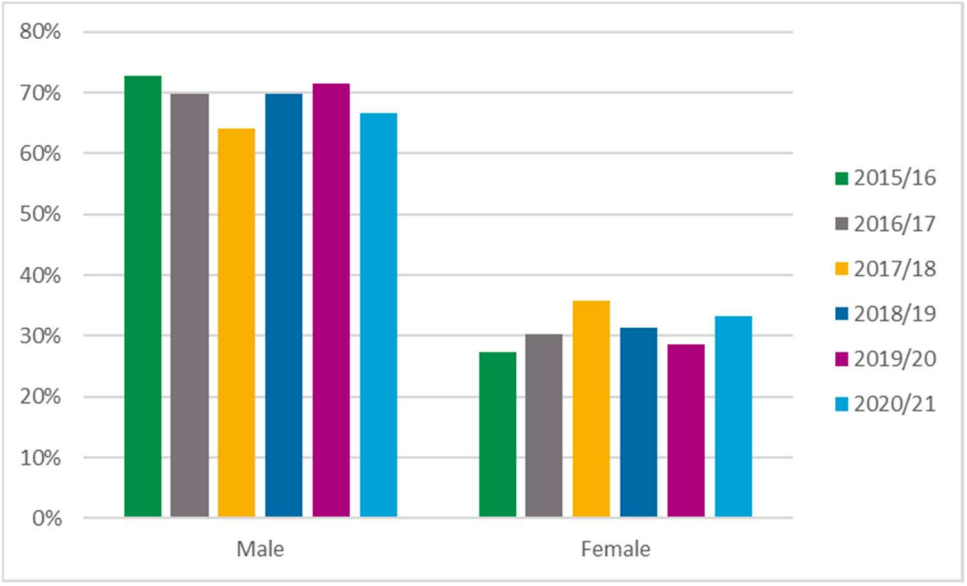
Total number of people in treatment, by sex, all Thurrock							
Category Type	Sex	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Alcohol only	Male	150	125	70	75	55	45
	Female	80	80	55	60	35	40
	Persons	**235**	**205**	**125**	**135**	**90**	**90**
Non-opiate & alcohol	Male	130	90	50	75	40	40
	Female	35	25	25	20	20	15
	Persons	**165**	**115**	**75**	**90**	**60**	**55**
Non-opiate only	Male	75	85	35	50	30	20
	Female	25	40	30	20	10	10
	Persons	**100**	**125**	**65**	**70**	**40**	**30**
Opiate	Male	165	160	140	135	150	115
	Female	55	50	55	50	45	40
	Persons	**220**	**210**	**190**	**185**	**195**	**155**
Total	**Male**	**520**	**460**	**295**	**335**	**275**	**220**
	Female	**195**	**200**	**165**	**150**	**110**	**110**
	Persons	**715**	**660**	**460**	**480**	**385**	**330**

N.B. Numbers in this table have been rounded to the nearest five to prevent identification of individuals
Source NDTMS ViewIt Adults

Table 35 shows that the number of people receiving treatment for alcohol and/or drug misuse in Thurrock has declined from 715 in 2015/16 to 330 in 2020/21. There were declines in the number of people in treatment in all four substance categories between 2015/16 and 2020/21. The number of males in treatment reduced from 520 in 2015/16 to 220 in 2020/21 whilst the number of females declined from 195 in 2015/16 to 110 in 2020/21.

Figure 29 shows the proportion of adults in treatment in Thurrock by gender from 2015/16 to 2020/21.

Figure 29: Proportion of Thurrock adult clients in treatment, by gender, 2015/16 to 2020/21

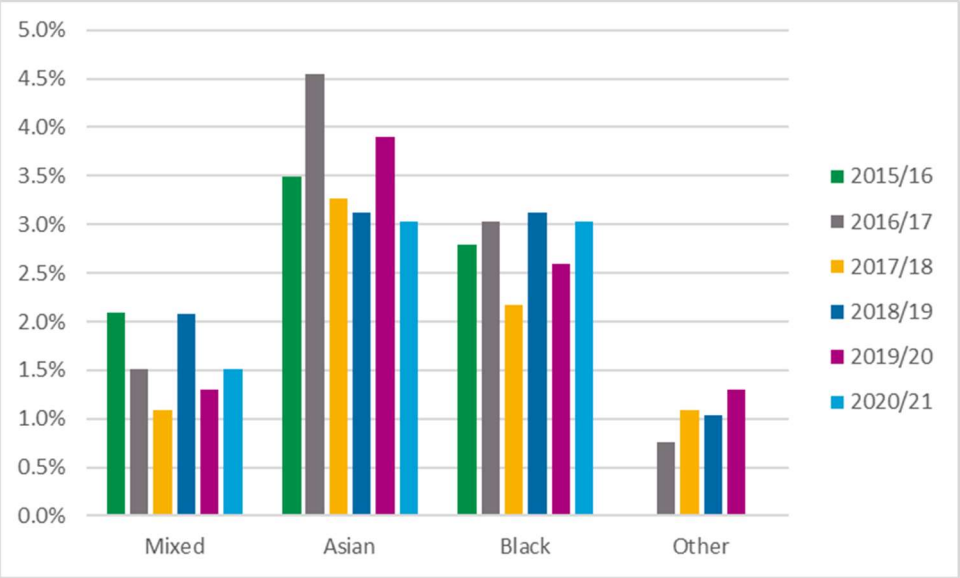


Source: NDTMS ViewIt Adults

Figure 29 shows that on average between 2015/16 and 2020/21 around 70% of adult clients in treatment have been male and 30% have been female. In 2020/21, 67% of adult clients in treatment in Thurrock were male and 33% were female.

Figure 30 shows the proportion of adult clients in treatment for alcohol and/or drug misuse in Thurrock belonging to non-white ethnic groups from 2015/16 to 2020/21.

Figure 30: Proportion of Thurrock adult clients in treatment from non-white ethnic groups, 2015/16 to 2020/21



Source: NDTMS ViewIt Adults

The proportion of drug and/or alcohol misuse clients in treatment in Thurrock belonging to white ethnic groups was consistently around 90% in the period from 2015/16 to 2020/21. Figure 30 shows that in all but two years (2018/19 and 2020/21) the Asian ethnic group was the largest ethnic minority group in the Thurrock treatment population, followed by the Black ethnic group. It is likely that there is an under representation of people from Black ethnic groups in treatment services. The most recent information about ethnicity and prevalence of drug and alcohol misuse in England is from 201441. This indicates that around 9% of white people consume illicit drugs compared to 12% Black/African/Caribbean/Black British people and these proportions are 15% and 7% respectively for misusing alcohol at hazardous, harmful, or dependent levels. In Thurrock people of Black ethnic groups make up 7.8% (Table 8) of the population yet make up around 3.1% of those treated in 2020/21. In comparison less than 4% of people from Asian ethnic groups consume or misuse drugs or alcohol, they make up 3.6% of the population in Thurrock yet they comprised a similar proportion to those from Black ethnic groups in treatment in 2020/21.

The proportion of the Thurrock adult treatment population belonging to ‘other’ ethnic groups has increased since 2016/17. In 2015/16 there were no service users recorded as ‘other’

5.5.3 Age in treatment

Table 36 shows the new people receiving treatment in 2015/6 to 2020/21 for each of substance misuse categories and by broad age group. Most people enter treatment between the ages of 30 and 49 for treatment across the years. People receiving treatment for non-opiate misuse only, aged 18 to 29 are similar in number to those aged 30 to 49 but for all other treatment groups those aged 30 to 49 number far higher than the 18 to 29 or 50 plus age groups. The 50 plus age group are mostly being treated for alcohol misuse only.

Table 36: New presentations by substance misuse category and gender, 2015/16 to 2020/21

Total number of new presentations, by sex, all Thurrock							
Category Type	Sex	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Alcohol only	Male	110	85	35	60	35	35
	Female	50	55	35	45	25	35
	Persons	**160**	**140**	**70**	**105**	**60**	**70**
Non-opiate & alcohol	Male	95	60	25	60	30	30
	Female	25	15	15	10	15	10
	Persons	**115**	**75**	**45**	**70**	**45**	**40**
Non-opiate only	Male	55	70	25	35	25	15
	Female	20	30	10	15	10	10
	Persons	**75**	**95**	**35**	**55**	**35**	**25**
Opiate	Male	60	55	35	45	55	20
	Female	15	15	15	15	15	10
	Persons	**75**	**75**	**50**	**60**	**75**	**35**
Total	**Male**	**320**	**270**	**120**	**200**	**150**	**105**
	Female	**110**	**115**	**80**	**90**	**60**	**70**
	Persons	**430**	**385**	**200**	**290**	**210**	**170**

Source: NDTMS ViewIt Adults

Table 37 shows the number and percentage of adults receiving drug treatment by age group and gender in Thurrock in 2020/21 compared to England.

Table 37: Age of adults in drug treatment for Thurrock and England, 2020-21.

Age group	Thurrock				England			
	Thurrock (n)	Proportion in treatment	Male (%)	Female (%)	England (n)	Proportion in treatment	Male (%)	Female (%)
18-29	37	15%	11%	26%	31,920	16%	15%	20%
30-39	78	32%	34%	28%	64,332	32%	31%	36%
40-49	81	34%	35%	31%	66,667	33%	35%	30%
50-59	35	15%	17%	9%	30,388	15%	17%	12%
60-69	10	4%	3%	6%	5,322	3%	3%	2%
70-79	0	0%	0%	0%	500	0%	0%	0%
80+	0	0%	0%	0%	27	0%	0%	0%

Source: Adult Drug Commissioning Support Pack 2022/23

Table 37 shows that the age profile of adults in treatment in Thurrock in 2020/21 was very similar to the age profile of adults in treatment in England. However, there were some differences in the proportions of males and females in each of the age bands, with females aged 18 – 29 accounting for 26% of all females in treatment in Thurrock compared with 20% for England.

Table 38 shows the age profile of adults in alcohol only treatment in Thurrock compared to England in 2020/21.

Table 38: Age of adults in alcohol only treatment for Thurrock and England, 2020/21

Age Group	Thurrock				England			
	Thurrock (n)	Proportion in treatment	Male (%)	Female (%)	England (n)	Proportion in treatment	Male (%)	Female (%)
18-29	11	12%	9%	17%	6,928	9%	9%	10%
30-39	19	21%	26%	17%	17,901	23%	23%	24%
40-49	26	29%	30%	29%	22,244	29%	29%	29%
50-59	21	24%	23%	24%	20,050	26%	27%	25%
60-69	11	12%	13%	12%	7,870	10%	10%	10%
70-79	<5	N/A	0%	N/A	1,628	2%	2%	2%
80+	0	0%	0%	0%	119	0%	0%	0%

Source: Adults Alcohol Commissioning Support Pack 2022/23

Table 38 shows that the proportions of adults receiving alcohol only treatment in Thurrock were similar to those of England in 2020/21. England had a slightly higher proportion of clients in the 70 and over age groups and a slightly lower proportion in the 18 – 29-year-old age group than Thurrock.

5.5.4 Drug treatment type and settings

Table 39 shows the number of clients in treatment in Thurrock each year from 2015/16 to 2020/21 for each broad intervention category. These high-level interventions are usually delivered in a specialist setting.

Table 39: Category of high-level intervention provided to Thurrock clients in treatment, 2015/16 to 2020/21

Category of intervention for all clients in treatment, all Thurrock						
Intervention type	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Pharmacological	235	230	210	200	225	215
Psychosocial	710	650	450	480	385	330
Recovery Support	350	380	375	470	370	315
Total Patients Receiving Treatment*	715	655	455	480	385	330

NB. * 2019/20 & 2020/21 data is 0 on the raw data but is recorded as the same values as Psychosocial Intervention on the NDTM ViewIt tool. Values have been rounded to the nearest 5 to prevent identification of individuals
Source: NDTMS ViewIt Adults

Table 39 shows that psychosocial interventions were the most commonly used high level intervention for adults in treatment in Thurrock in 2015/16 to 2020/21 being used in nearly 100% of cases each year. Recovery support interventions have consistently been the next most used, followed by pharmacological interventions.

Table 40 shows the number and proportion of adults in drug treatment in Thurrock receiving each high-level intervention by treatment setting in 2020/21.

Table 40: Number and percentage of adults in treatment in high level interventions and settings across the treatment journey for Thurrock, 2020/21.

Setting Type	Pharmacological		Psychosocial		Recovery Support		Total Adults**	
	Total adults	Percentage	Total adults	Proportion	Total adults	Percentage	Total adults	Percentage
Community	166	100%	238	100%	230	100%	240	100%
Inpatient Unit	<5	N/A	<5	N/A	<5	1%	<5	1%
Primary Care	0	0%	0	0%	0	0%	0	0%
Residential	0	0%	<5	0%	<5	0%	<5	0%
Recovery House	0	0%	0	0%	0	0%	0	0%
Young Persons Setting	0	0%	0	0%	0	0%	0	0%
Missing / Incomplete	0	0%	0	0%	0	0%	0	0%
Total individuals*	166	100%	239	100%	231	100%	241	100%

NB. *This is the total number of adults receiving each intervention type and not a summation of the setting the intervention was delivered in.
**This is the total number of adults receiving any intervention type in each setting and not a summation of the pharmacological, psychosocial and recovery support columns
Source: Adult Drug Commissioning Support Pack 2022/23

Table 40 shows that for Thurrock almost all interventions are delivered within community settings with a very small number also being delivered in in patient or residential settings. There were no clients recorded as receiving high level interventions in primary care, in recovery house or young person settings in 2020/21.

Table 41: Number and percentage of adults in treatment in high level interventions and settings across the treatment journey for England, 2020-21.

Setting Type	Pharmacological		Psychosocial		Recovery Support		Total Adults**	
	Total adults	Percentage	Total adults	Percentage	Total adults	Percentage	Total adults	Percentage
Community	132,154	96%	189,663	98%	155,528	98%	194,588	98%
Inpatient Unit	4,874	4%	4,643	2%	3,946	2%	5,074	3%
Primary Care	17,896	13%	10,169	5%	4,835	3%	18,863	10%
Residential	938	1%	2,425	1%	1,585	1%	2,655	1%
Recovery House	34	0%	58	0%	147	0%	193	0%
Young Persons Setting	<5	N/A	76	0%	27	0%	77	0%
Missing / Incomplete	0	0%	0	0%	0	0%	0	0%
Total individuals*	138,252	100%	194,482	100%	159,100	100%	197,931	100%

N.B: *This is the total number of adults receiving each intervention type and not a summation of the setting the intervention was delivered in.
**This is the total number of adults receiving any intervention type in each setting and not a summation of the pharmacological, psychosocial and recovery support columns
Source: Adult Drug Commissioning Support Pack 2022/23

Table 41 shows that similar to Thurrock almost all adult clients in drug treatment in England received interventions in community settings in 2020/21. However, unlike for Thurrock, 13% of those receiving pharmacological interventions, 5% of those receiving psychosocial interventions and 3% of those receiving recover support interventions received these interventions in primary care settings.

5.5.5 Alcohol treatment settings

Table 42 shows the number and proportion of adults in alcohol treatment in Thurrock receiving each high-level intervention by treatment setting in 2020/21. These are high level interventions for people in structured treatment who have not responded to brief advice on alcohol misuse and require a care plan possibly with Multiple Planned Extended Brief Interventions (EBIs), group work, counselling, and other specialist treatment options.

Table 42: Number and proportion of adults in treatment in high level interventions and settings across the treatment journey for Thurrock, 2020-21

Setting Type	Pharmacological		Psychosocial		Recovery Support		Total Adults**	
	Total adults	Percentage	Total adults	Percentage	Total adults	Percentage	Total adults	Percentage
Community	50	100%	89	100%	84	100%	89	100%
Inpatient Unit	<5	N/A	<5	N/A	<5	N/A	<5	N/A
Primary Care	0	0%	0	0%	0	0%	0	0%
Residential	0	0%	0	0%	0	0%	0	0%
Recovery House	0	0%	0	0%	0	0%	0	0%
Young Persons Setting	0	0%	0	0%	0	0%	0	0%
Missing / Incomplete	0	0%	0	0%	0	0%	0	0%
Total*	50	100%	89	100%	84	100%	89	100%

NB.*This is the total number of individuals receiving each intervention type and not a summation of the setting the intervention was delivered in.

**This is the total number of individuals receiving any intervention type in each setting and not a summation of the pharmacological, psychosocial and recovery support columns

Source: Adults Alcohol Commissioning Support Pack 2022/23

Table 42 shows that similar to those receiving treatment for drug misuse all clients in treatment for alcohol misuse received high level interventions in community settings. In addition, a small number of clients received interventions in inpatient units. No interventions were recorded as being provided in any other settings in 2020/21.

Table 43 shows the number and proportion of adults in alcohol treatment in England receiving each high-level intervention by treatment setting in 2020/21.

Table 43: Number and proportion of alcohol adults in High level interventions and settings for England, 2020-21

Setting Type	Pharmacological		Psychosocial		Recovery Support		Total Adults**	
	Total adults	Percentage	Total adults	Percentage	Total adults	Percentage	Total adults	Percentage
Community	9,978	80%	74,231	98%	59,516	98%	74,669	99%
Inpatient Unit	2,631	21%	2,607	3%	2,108	3%	2,690	4%
Primary Care	221	2%	439	1%	251	0%	660	1%
Residential	514	4%	1,107	1%	776	1%	1,311	2%
Recovery House	5	0%	22	0%	55	0%	64	0%
Young Persons Setting	0	0%	5	0%	0	0%	5	0%
Missing / Incomplete	0	0%	0	0%	0	0%	0	0%
Total*	12,547	100%	75,458	100%	60,564	100%	75,778	100%

NB. *This is the total number of individuals receiving each intervention type and not a summation of the setting the intervention was delivered in.

**This is the total number of individuals receiving any intervention type in each setting and not a summation of the pharmacological, psychosocial and recovery support columns

Source: Adults Alcohol Commissioning Support Pack 2022/23

Table 43 shows that compared to interventions for drug misuse in England in 2020/21 there were fewer high-level interventions recorded as being provided in primary care. Around 10% of drug treatment clients received interventions in primary care in 2020/21 compared with only 1% of alcohol clients. Similarly, 96% of clients in drug treatment received interventions in community settings compared to 80% of clients in alcohol treatment.

6 Local Strategy for Drug and Alcohol Services

Summary of local drugs and alcohol strategy in Thurrock

In July 2022, the NHS and Department of Health and Social Care set out a requirement for local authorities to set up a Combating Drugs Partnership (CDP) which it was suggested included alcohol within its remit. The CDP would include all relevant agencies to address the shared challenges of alcohol related harm which often include, housing, mental health, employment, and criminal justice problems. There is an emphasis on developing an approach that included gathering insight from people with lived experience of drug and alcohol misuse difficulties and treatment. In tandem with the CDP, local authorities will be required to gather data to populate a National Combating Drugs Framework (NCDF).

Thurrock Council are exploring a Human Learning Systems (HLS) approach to integrated working. This way of working continuously explores the complex reality of how outcomes that matter to a person might be achieved in their unique life context. The Human Learning System approach has been described in 'Better Together Thurrock: the case for further change 2022-2026'. This is a collective plan to transform improve and integrate health care and third sector services to improve people's wellbeing.

Four integrated medical centres are being established in Thurrock that align with the four PCN footprints. The hubs are the basis of single locality networks with teams from health care and third sector organisations building relationships, collaborating, and co-designing single integrated solutions with residents. There will be staff from the drugs and alcohol service at each of the hubs working with other teams such as mental health, primary care, and social care colleagues. To facilitate this an integrated treatment service with outreach workers aligned to and operating with Community Led Solutions teams with assertive outreach and timely access to treatment for those with the most complex needs.

In addition to Thurrock Council's overarching strategy, many teams who come into contact with people who misuse drugs and alcohol have strategic aims concerning this cohort of people. The Health and Wellbeing strategy focuses on addressing unmet need and developing an approach that can lead to the co-production of services with residents and service users, integrating mental health and housing support for those with co-occurring conditions and complex needs. Other teams and organisations with strategic aims concerning people with drug and alcohol misuse include Essex Police, the Community Safety Partnership, Brighter Futures Children's Partnership, Thurrock Violence Against Women and Girls team, Adult Mental Health Services, and Thurrock Housing and Homeless services.

This chapter outlines the current local guidance and strategies that are in place in Thurrock. In July 2022, the NHS and Department of Health and Social Care set out a requirement for local authorities to set up a Combating Drugs Partnership (CDP) which it was suggested included alcohol within its remit. The CDP would include all relevant agencies to address the shared challenges of alcohol related harm which often include, housing, mental health, employment, and criminal justice problems. There is an emphasis on developing an approach that included gathering insight from people with lived experience of drug and alcohol misuse difficulties and

treatment. In tandem with the CDP, local authorities will be required to gather data to populate a National Combating Drugs Framework (NCDF).

6.1 Thurrock Drugs and Alcohol Strategic Objectives

This section briefly outlines Thurrock Councils future vision for integrated health, wellbeing and care and the particular strategic objectives concerning drug and alcohol misuse extracted from a range of current strategy documents.

6.1.1 Human learning systems approach to providing services in Thurrock

Thurrock Council have a vision about how the integration of health, wellbeing and care for Thurrock residents will work in the future. This is a move away from a centralised, deficit driven approach with prescriptive interventions, to a way of working that recognises the uniqueness of each resident, the importance of co-designing solutions that meet their needs, based on the strengths and assets of the individual, their family and friends, the wider community, and the system. This aligns with Thurrock's Health and Care Transformation Programme[55].

The range of people and organisations involved in creating outcomes for residents is typically beyond the management control of a single person or organisation. When a resident comes to the attention of one of many health and social care services in Thurrock, the professional may identify a range of needs that can be met by other services in addition to their own. What follows can be a winding path for the resident of repeating the same information to multiple professionals who do not always appear to talk to one another, have different criteria for the access to their service and may not be able to offer support until other actions by other organisations are completed. In the meantime, the outcome of most importance to the resident is lost amongst the various services offering prescribed interventions may not be what the resident actually needs.

Acknowledgment that each resident is complex and unique, and the current arrangement of services may not meet their needs, leads to the search for a different strategy.

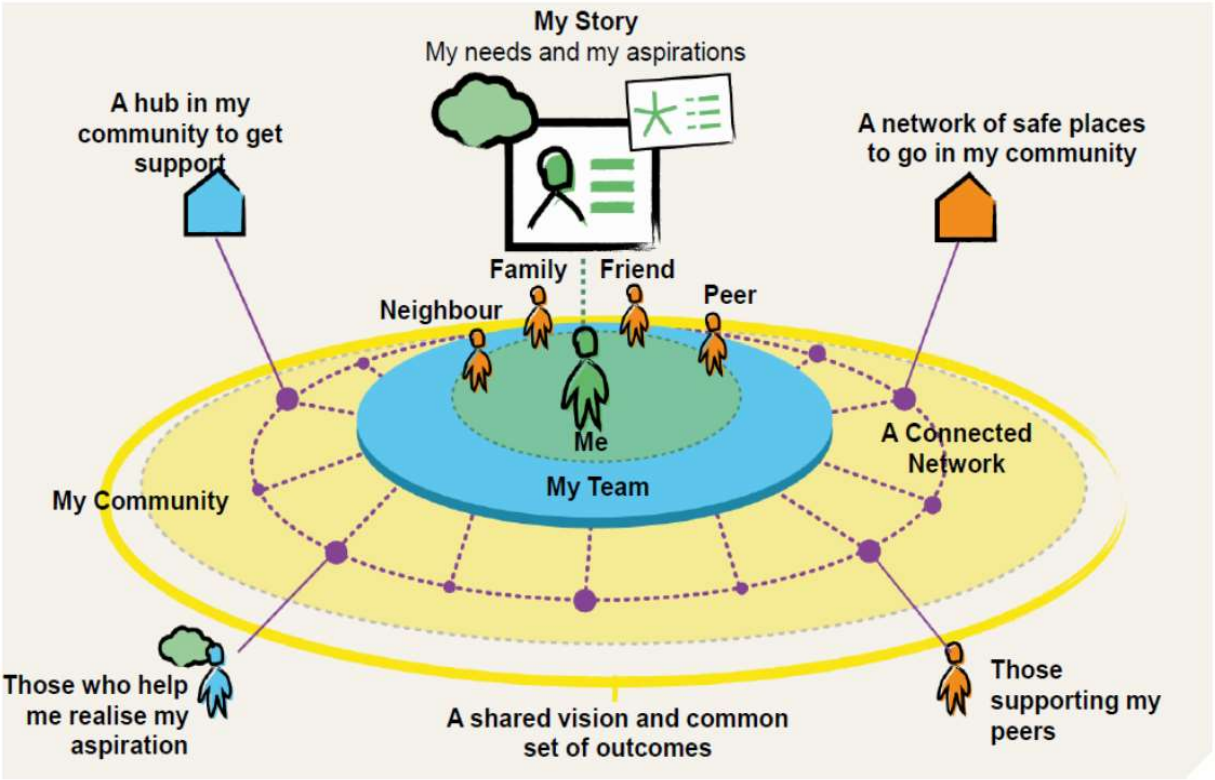
Thurrock Council are exploring a Human Learning Systems (HLS) approach to integrated working. This way of working continuously explores the complex reality of how the outcomes that matter to each person might be achieved in their unique life context. The three elements of the HLS approach are:

- The **capacity to respond to human variation** - recognising that individual strengths and needs are most effectively met by bespoke solutions that staff are empowered to provide.
- The **ability of the system and services to evolve and change** using continuous process of learning and adaptation. Interventions can be tweaked depending on circumstances with a recognition that ‘what works today may not work for other individuals or the same individual in the future
- The **ability to shape the chaotic system through collaboration and influencing**. Outcomes in response to particular interventions cannot be reliably predicted in chaotic human systems. However, building relationship, increasing visibility and emotionally intelligent engagement with residents, is helpful in shaping how residents and services relate to one another. This will have an impact on outcomes

The sought-after outcomes for the individual and the community from this approach are represented in the figure below. The individual can voice the things that matter to them most, services are co-produced around a common vision and the existing strengths and assets within the community are harnessed.

[55] Better Together Thurrock: the case for further change 2022-2026

Figure 31: The aim of the Human Learning System (HLS) approach:



Source: Plymouth City Council Alliance for people with complex needs- Alliance Specification 2018

The human learning systems approach has been described in 'Better care together: the case for further change 2022-2026'[56] which is a collective plan to transform, improve and integrate, health, care and third sector services aimed at Thurrock's adults and older people to improve their wellbeing. In addition, the Health and Wellbeing strategy (2022-2026)[57] aiming to tackle the causes of poor health unequally experienced by people across the population of Thurrock, and the Brighter futures Children's Partnership Strategy (2021-2026) focussed on the health and wellbeing of young people to the age of 19, underpin their vision with principles aligned to the human learning systems approach.

The plan to transform and integrate, health, care and third sector services is underway with the development of the first integrated medical centre (hub) based around Stanford le Hope and Corringham PCN footprint. Hubs will be developed around the other three Thurrock PCN footprints over the next 18 months. These hubs will be the basis of single locality networks with teams from health, care and third sector organisations building relationships, collaborating and co-designing single integrated solutions with residents rather than referring on or signposting elsewhere. Where specialist advice is required, staff from small teams will be allocated to each integrated locality network rather than being fully embedded. The key elements of this approach are:

- Staff are empowered to co-design solutions together with residents
- The solutions are coordinated and timely with a focus of what matters to the residents
- Staff are encouraged to develop a learning culture around what works and does not work
- For people with the most complex challenges single integrated care plans will be developed

[56] https://democracy.thurrock.gov.uk/documents/b18974/Item%208%20-%20The%20Case%20for%20Future%20Change%20Presentation%2007th-Jun-2022%2019.00%20Health%20and%20Wellbeing%20Overview.pdf?T=9
[57] https://www.thurrock.gov.uk/sites/default/files/assets/documents/hwb-strategy-2022-v01.pdf

In terms of the drug and alcohol services, there will be staff based at each of the hubs which will ensure the opportunity for effective relationship building between staff from different agencies. It will also be a venue where people who attend the hub may be more likely to talk to staff but who would not have attended a drug and alcohol centre. In this way it may be possible to engage with harder to reach groups and shift the perception of support for drug and alcohol misuse in a positive direction.

6.1.2 Local drugs and alcohol strategic objectives

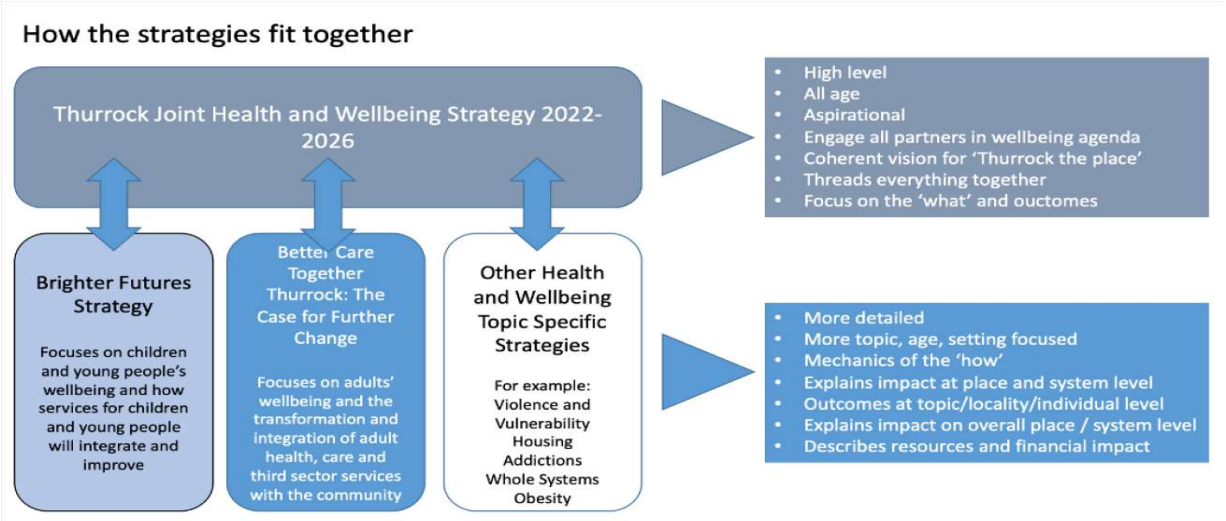
Governance around the substance misuse contract is through standard Council processes, with direct oversight through the Public Health Leadership Team, the Adults Housing & Health Directorate Management Team, and the Council Procurement function. Governance around partnership working involving substance misuse is through revised structures under the Mid & South Essex Integrated Care Board (from 1st July 2022). The Thurrock Integrated Care Alliance (TICA) is a Committee of the Integrated Care Board (ICB) with associated delegated functions. Under the TICA there is a revised governance structure, including a sub-group, chaired by the DPH leads on Health Inequalities, Prevention and Long-Term Conditions. This provides leadership on the wider prevention landscape, and jointly with other sub-groups such as the Mental Health Transformation Board, enables partnership governance through the TICA.

In Thurrock, the most recent Health and Wellbeing Strategy (2022-2026) sets out the high-level plans and actions to address health inequalities across six domains each linking to the Council's three key priorities of People, Place and Prosperity:

1. Quality care centred around the person
2. Staying healthier for longer
3. Building strong and cohesive communities
4. Opportunity for all
5. Housing and the environment
6. Community Safety

Two further strategies sit under the Health and Wellbeing Strategy, namely the 'Brighter Futures Strategy' and the 'Better Together Thurrock: the case for further change' strategy. The latter outlines the approach to meeting the first three domains of the Health and Wellbeing Strategy. In addition, there are also a number of topic specific strategies such as violence and vulnerability, housing and whole systems which also fit within the overarching Health and Wellbeing Strategy.

Figure 32: Health and wellbeing and associated strategies



Source: Better Together Thurrock - the case for further change 2022-2026

Figure 32 outlines how the strategies relate to each other. There is no overarching drug and alcohol strategy in Thurrock. As people with drug and alcohol problems can be seen by more than one agency across their life course, there are references to substance misuse strategic aims in all three strategies. In addition, strategies developed by other parts of the council, the NHS and police also include Thurrock strategies concerning prevention and reduction of substance misuse.

Table 44 below outlines drug and alcohol specific recommendations or objectives within current local strategies that include Thurrock residents.

Table 44: Specific alcohol and drug-related objectives from strategies that include Thurrock residents

Strategy	Strategic objectives relating to drug/alcohol misuse
Thurrock Joint Health and Wellbeing Strategy 2022-2026 Levelling the playing field in Thurrock – a strategy created through the partnership of Thurrock Health and Wellbeing Board. The aims are to tackle the many causes of poor health unequally experienced by people across the population of Thurrock.	As part of domain 1 with the goal to work together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock strategies include: • Co-producing with service users and families a new substance misuse model integrated with wider services such as mental health and housing • Addressing unmet need in relation to drug and alcohol misuse including intergenerational affects and the impact on the wider determinants of health
Better care together: the case for further change 2022-2026 A collective plan to transform, improve and integrate, health, care and third sector services aimed at boroughs adults and older people to improve their wellbeing	Moving forward we will recommission an integrated treatment service with drug and alcohol treatment and outreach workers aligned to and operating within Community Led Solutions teams with assertive outreach and timely access to treatment for those with the most complex needs.
The Brighter futures Children's Partnership Strategy 2021-2026 A strategy taking into account government priorities and the ambitions of Brighter Futures key strategic partners with due regard	• Reduce the incidence of harms caused by alcohol in pregnancy • Create locality based multidisciplinary panels that meet regularly to swiftly address risk factors strongly associated with serious youth violence and gang involvement by sharing intelligence across stakeholders from children's social care, health providers, Brighter Futures, drug and alcohol treatment, education schools' community safety, housing the police, local area coordinators and relevant third sector organisations • Further evaluation work to understand why there is a cohort of young people accessing youth offending services (YOS) who are committing multiple violence/drug offences and for whom current

to the voice of young people aged 0-19.	interventions appear to be unsuccessful in terms of future desistence. Pilot and evaluate new approaches where appropriate. • Use locality risk profiles to inform the priorities of the planning and regeneration functions of the local authority and the work of the Violence and Vulnerability Board and ultimately the Joint Health and Wellbeing board, Community Safety Partnership, and its subgroups.
Youth violence and vulnerability: The Crime Paradox and a Public Health Response 2019/20 Thurrock Public Health Annual Report focussed on youth (ages 10-24) violence and vulnerability, including urban street gangs and how this can be tackled using a public health approach	Implement 8 strategic actions effective in preventing and reducing serious youth violence and gang membership of which 6 (in bold) aim to mitigate against substance misuse: • **Promote family environments that support healthy development** • Provide quality education early in life • **Strengthen youth skills in communication, empathy, problem solving, conflict resolution and emotional intelligence** • **Connect youth to adults and activity that role model positive behaviour** • Address the wider determinants of serious youth violence and gang membership • **Intervene early to reduce harms of exposure to violence and violence risk behaviours** • **Prevent gang membership and crime caused by gangs** • **Enforce the law to disrupt and deter violent offenders and crime connected with gangs** Investigate why despite the number of people estimated to be using crack cocaine has increased whilst the numbers entering treatment remain the same. There may be a range of reasons for this, but essentially a focus on improved engagement to increase the reach of the drug treatment service to the group of people misusing this substance is needed.
Community Safety Assessment 2021 and Community Safety Partnership Annual delivery plan 2022/23 The strategy and plan of priorities for the Thurrock Community Safety Partnership 2022/23	• Once the health needs assessment in relation to drugs and alcohol is complete the re-offending plan for Thurrock should be reviewed to address and identified gaps. • The 5 wards with the highest rates of reported domestic violence should be targeted for community engagement including wider services such as drugs and alcohol

Police Fire and Crime Commissioner for Essex: Police and Crime plan 2021-2024 The strategic priorities of the police and aims for keeping Essex safe.	• Work with the National Crime Agency to tackle and reduce the number of gangs and criminals operating nationally • Provide further investment in the Essex Police Serious Violence Unit to dismantle more County Lines drug gangs • Work with the government and local partners to deliver a new, more effective addiction strategy so more people enter treatment and recover • Improve the quality and accessibility of addiction and substance misuse services and ensure services match local demand • Improve the criminal justice journey of addictive offenders
Thurrock Violence Against Women and Girls Strategy 2020-23 Strategic priorities for VAWG building on the government's strategy and the LA duties under the Domestic Abuse Act 2021	There should be specialist drug and alcohol support for resident adults and children in refuge
CLeaR (Challenge services, Leadership and Results) peer-assessment of local alcohol partnerships in Thurrock 2020 Outcome of peer assessment of the self-assessment of performance of local alcohol partnerships providing objective feedback and recommendations against NICE guidelines.	• Establish a formal partnership which brings together all stakeholders involved in work to reduce alcohol harm. This is to ensure a strategic focus on preventing/reducing alcohol misuse • Identify senior leaders as named champions promoting wide participation and active engagement in this new partnership • All relevant organisations should be involved in the production of a local alcohol strategy to inform future strategic direction and operational activity • The local strategy should be based on an updated assessment of local need • Increase local commissioning and analytical capacity to support the achievement of the aspirations of the new partnership • Senior strategic leaders are encouraged to use contact with their counterparts in other partner agencies to ensure ongoing appropriate representation at the alcohol partnership • The proposed strategy and any associated action plan should seek to clarify individual partner roles and responsibilities in achieving the identified outcomes, develop processes for evaluating progress against these and strengthen local governance arrangements.

Thurrock Young Persons Substance Misuse Needs Assessment 2018 To inform the refresh of the service specification for the young persons (Age 0-17) substance misuse service in 2019	• Strengthen links with sexual health services and engagement in sexual health screening • Regularly review novel psychoactive substances and respond by adapting treatment offer • Reach treatment naïve parents who require treatment for substance mis use to limit adverse outcomes from children experiencing hidden harm • Explore why referral pathways from children's and young people's health and mental health services are lower compared to the national average • Explore why harm reduction interventions offered is far lower than national average • Explore why fewer referrals received from young people in apprenticeships or employment compared to national average • Continue to offer stop smoking support • Specification to include up to 18-year-olds with exception for up to 25-year-olds if appropriate for those with special educational needs or disabilities • Continue to co-locate a young person's substance misuse service worker in the Youth Offending Service at least once a week and recommend this in the updated service specification • Brighter Futures partners to be vigilant of SEND children being disproportionately represented in YOS data and cater for their additional needs • Remain vigilant to gang activity and links to emerging drugs markets locally • Preventative interventions should continue to be part of service delivery • Service design should involve further development of peer-led programmes to enhance and diversify offer to reflect need and experiences of young people • A partnership approach to delivering services to CYP in Thurrock is important. An integrated approach is needed to maximise benefits to children and their families whilst offering appropriate professional support to other staff involved in their care • Where practicable programmes should be co-produced with young people • Family therapy should be part of a refreshed service specification and offered where appropriate particularly where adults are also being treated for alcohol or substance misuse • Future treatment options should include motivational interviewing, cognitive behavioural therapy and twelve step programmes • Continue to offer hidden harm support • Continue to work closely with the mental health services for those with co-occurring conditions • Further integrate with mental health services as part of the Brighter Futures partnership • Ensure the service remains vigilant to the heightened risk of suicide in service users • The service specification should ensure there continues to be partnership working with the adult alcohol and drug misuse service to ensure effective transition between services at age 18

	The current service model should be retained in the new service specification

Southend, Essex, and Thurrock Mental Health and Wellbeing Strategy 2017-2021
 	
Mental health strategic priorities for the whole of Essex.
	• Develop an integrated approach throughout the criminal justice system and across mental health, learning disability and substance misuse agencies. Services focussed in this area:
	  ○ Full circle – Offenders with Complex Needs service for people with substance misuse, mental health, learning difficulties, housing and other problems will continue with the aim of reducing re-offending
	• For those with mental health and substance misuse issues who are not necessarily in contact with the criminal justice system there is the following service which will be further developed:
	  ○ Integrated Support, Advice, Referral, and Mentoring Services (ISARMS) will continue to be the basis of service development of people affected by mental illness and substance misuse
	• To provide renewed focus looking at the mental health and substance misuse services, responses to perpetrators and victims of domestic abuse and test new ways of working

Thurrock housing strategy 2022-2027	• Bring housing together at locality level and empower front line staff from housing to form relationships and networks across the system and work with residents to design and deliver meaningful, personal, and holistic solutions • Embed housing support and services within the Integrated Locality Networks encompassing a wide range of health, care and third sector partners allowing staff to collaborate with each other and residents to co-design bespoke integrated solutions, rather than making referrals • Expand the knowledge and skills of housing staff relating to health, care and social needs to improve support that can be offered directly to residents within localities • Implement ‘test and learn’ pilots to create new community caseworker’ roles, able to deliver a wider range of solutions to residents, usually delivered by teams from Adult Social Care, NHS functions (e.g., drug and alcohol reduction in harm interventions), housing, debt, community, voluntary and faith sectors

7 Services Working Together

Summary for Services Working Together

This HNA has gathered data and the views from professionals who provide adult drug and alcohol prevention and treatment services as well as teams who are likely to come in contact with people who misuse drugs and alcohol. These include:

- Adult drug and alcohol treatment services
- Children and Young People's substance misuse services
- Probation Service
- Essex Police
- Violence Against Women and Girls
- Young Offenders Service
- Housing and Homeless Service
- Adult mental health service
- Alcohol Liaison Service
- Primary Care
- Individual Placement Support Service

The information gathered describes how the services link with the adult drug and alcohol misuse service, data about service users and the perception of barriers, enablers, and gaps in current services.

Inclusion Visions Thurrock (IVT) is the drugs and alcohol treatment service in Thurrock with an SLA focussed on:

- A prescribed assessment and treatment process
- Outreach and engagement
- Working with other organisations to support people and reduce harm from alcohol and drug misuse

Around 70% of referrals are self or originate from the family, 9% through the criminal justice system and 7% via the GP. These rates are similar to England.

Overall, the target of successful treatment completions for opiate treatment was met for the three-year period from April 2019 to March 2022. There is much more variability for successful completion rates for the other substance types with a dip in all three below target in mid to late 2020, with improvement in Spring 2021 which is maintained for April 2021 to March 2022. The dip may have been due to a response of IVT to the pandemic to hold on to people in treatment for longer to support them through the difficult period. Rates of unplanned exits from treatment are higher in Thurrock than for England for all four substance types.

Service users

When service users are asked about their views, they are very positive about the service and their experience. Feedback was very useful about preferences for how interventions are delivered. A combination of face to face and phone calls was preferred which supported service users need to meet with IVT key workers and the flexibility to work around jobs and childcare

demands. Identifying service users who would be willing to be part of future discussions will be helpful in planning an approach to co-design of a new service.

Currently the service is working hard to increase engagement and outreach across Thurrock as this had dwindled due to the pandemic.

Other services treating Thurrock residents for drug and alcohol misuse are the Alcohol Liaison Service in Basildon University Hospital, part of Mid and South Essex NHS Foundation Trust and GPs in primary care. People are screened for alcohol misuse in both settings, often with the AUDIT-C questionnaire and interventions are tailored to their response. These can be lifestyle advice, health education, signposting to services brief interventions, pharmacological support, and referral to specialist treatment services. The ALS can also refer to the High Intensity User (HIU) service based at Basildon Hospital.

Enablers

There are several initiatives to link the adult drug and alcohol service to other teams so they can work together to support people with co-occurring conditions and complex needs. Many of these initiatives are in the process of being implemented.

The Blue Light Project has been in place since 2018 and aims to develop alternative approaches and care pathways for drinkers who are not in contact with treatment services, but who have complex needs. Referrals are made to one of the two Local Action Groups (LAG) that comprise of the police, IVT, housing (both council and private housing associations) and the adult mental health teams. Agencies discuss and agree the best approach to supporting and engaging with the person.

The Supported Living Plus pilot for people in supported living accommodation and Housing First for people in council or social housing aims to provide immediate support for those with co-occurring conditions and complex needs. These pilots are in the process of being implemented. A senior substance misuse worker with specialist skills for working with, for example, people with learning difficulties, or those who are older with mental health challenges will work with people who are finding it hard to recover from difficulties in their lives. This worker will provide leadership to the rest of the team and facilitate access to the relevant service the person needs to stabilise their situation.

A recent initiative with the refuge in Thurrock has seen IVT developing ways to support women and children who may have substance misuse problems.

The collaboration between the police, probation and IVT around the integrated offender management programme is working well with consistency across the county.

Staff co-located with IVT include:

- A substance misuse worker whose role is to work with young adults and link with the young people's service
- Probation service staff working in IVT offices for some days of the week
- Open Road, provides that the individual placement support service to help people back into work or volunteering

Barriers

Limitations of the IVT SLA restricts the remit of the adult drugs and alcohol service. For example, where people are reluctant to engage with the service there is little IVT can do to support them as assertive outreach is not currently part of the IVT remit.

The difference in approach between the young peoples and adults' services mean that when young people move to an adult service and the statutory support changes, it can be a difficult transition. Older teenage and young adult group have particular needs and vulnerabilities and it's important that both adult and young people's services provide a similar coordinated approach to ensure the transition is as seamless as possible.

Relationships between the adult drug and alcohol service and primary care and the ALS is not as strong as with Essex Police, the probation service, and the mental health teams. Strengthening these relationships and developing new pathways are underway. IVT working in the planned Integrated Medical Centres will also be beneficial.

Coordination of joint assessments between IVT and Adult Mental Health Services is difficult as waiting times in for mental health services are longer than those in IVT.

Gaps

The collection of access to and sharing of data and intelligence between services was highlighted as an important gap in the current system. This will need addressing with increased integration of services and systems. This was mentioned by Essex Police, the Adult Mental Health Teams, the Community Safety Partnership, Trading Standards team, and the young person's substance misuse service.

There is limited understanding by teams about how other teams work. For example, people in the housing team are keen to understand better how IVT works. There is the potential to upskill staff in the housing team in contact with people who would benefit but do not currently engage with drug and alcohol services. Similarly, the IVT team may benefit from upskilling in some areas of mental health support and vice versa.

There is a lack of evaluation of initiatives, so it is unclear what works and what does not. With a rapid cycle testing approach new processes and pathways can be rapidly assessed with ongoing adjustments to ensure the system works effectively for residents and professionals.

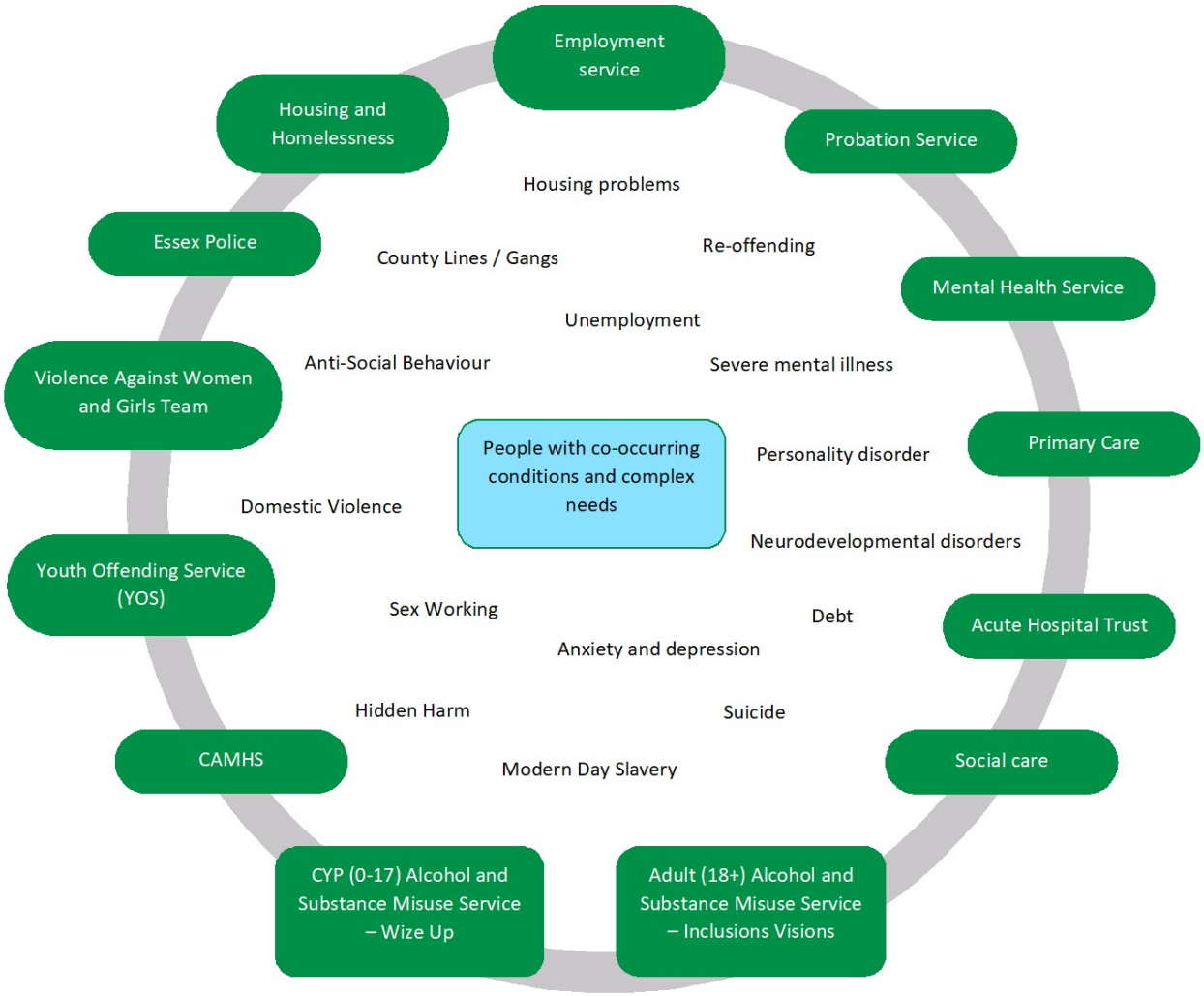
What would you most like to see….

Professionals interviewed were asked what they thought would be of most benefit to people with substance misuse problems if funding was no object. These were:

- A green space for community projects to bring all service users together (e.g., people in contact with mental health, housing, social care services)
- A small, combined substance misuse/mental health team
- Specialised support for people in refuge with co-occurring conditions
- Development of more peer led support/mentoring for young people and adults
- Development of the soup kitchen into a hub where people could meet services and other agencies
- Cross-agency mentoring
- Time to build relationships and think creatively about co location of services
- Funding to increase salaries to solve the workforce problem

People accessing the drug and alcohol service in Thurrock may simply need support dealing with their current misuse of drugs and/or alcohol, however very often such people have other challenges in their lives. These may include co-occurring conditions such as mental health or other health problems, or complex needs such as difficulties with family or relationships, gaining or staying in employment, challenges finding somewhere to live, or engaging in criminal activity. Therefore, it is important to establish strong links between the drug and alcohol service and the other services supporting people who have complex needs. Figure 33 shows the other key services in Thurrock that may also be involved with a person encountering the drug and alcohol service.

Figure 33: Key services in Thurrock supporting people with co-occurring conditions and complex needs and drug and/or alcohol misuse



In addition to enforcement, health, and care agencies it is important that people have access to wellbeing activities often provide by third sector organisations. There is a range of evidence which shows how participation in different types of activities such as physical activity[58],spending

[58] Linke S and Ussher M 2015 Exercise based treatments for substance use disorders:evidence, theory and practicality. The Americal Journal of Drug and Alcohol Abusr Vol 41 Issue 1

time in the natural environment[59] and engaging with the community[60] can complement formal treatment and aid recovery from addiction. Community groups, Community Interest Companies and voluntary sector organisations are key partners in provision of these wider wellbeing activities. The Stronger Together Thurrock directory holds a list of relevant activities which residents can access to support with their wider wellbeing.

This chapter outlines how the drugs and alcohol service is currently provided in Thurrock and how it links with the other services supporting people with drug and alcohol problems.

7.1 Drug and Alcohol Service: Inclusion Visions Thurrock (IVT)

An integrated drug and alcohol misuse treatment service for adults is provided by Inclusion Visions Thurrock (IVT), an NHS service which is part of the Midlands Partnership NHS Foundation Trust. The service is commissioned by the Public Health Team in Thurrock Council and is accountable to the Thurrock Health and Wellbeing Board (HWB). There is currently no overarching local Thurrock substance misuse strategy to use as a framework for commissioners, so the HWB focus is on the performance of IVT in meeting the aims and requirements of the Service Level Agreement (SLA).

The aims of the provision of alcohol and substance misuse services set out in the SLA are:

- To reduce the harm caused by drugs and alcohol
- To promote independent healthy living
- To improve the health, social, psychological, legal, welfare and life chances of people who are vulnerable through the use of alcohol and drugs

The service provides a single point of contact and a range of interventions focussed on the recovery of adults from illicit and other harmful drug and alcohol misuse for residents registered with a Thurrock GP. Access to the service is via referral, self-referral and engagement with outreach initiatives undertaken by IVT.

Following contact with the service, residents are briefly assessed within two weeks to determine which intervention will be appropriate. A full assessment is then carried out and a key worker allocated if structured treatment is required. Full assessment comprises taking a medical and psychological history along with family, social, sexual, and drug use histories. Organising support for smoking cessation, sexual health screening and psychological therapies can all result from the assessment.

There are four drug and alcohol treatment interventions depending on the level of need:

- A one-off appointment to provide brief intervention, guidance, and advice
- Extended brief intervention of 3-4 face to face appointments
- Light structured treatment
- Full structured treatment, face to face individual appointments and groupwork, plus prescribing appointments

[59] Martin L Pahl S, White M, May J 2019 Natural environments and craving: The mediating role of negative affect Health and Place vol 58
[60] Collinson B and Best D 2019 Promoting recovery from substance misuse through engagement with community assesys: Asset Based Community Engagement Substance Abuse Research and Treatment vol 13 1-14

7.1.1 IVT outreach and engagement

Outreach initiatives are considered increasingly important offering more opportunities to engage with residents following the lifting of pandemic restrictions. Community connectors undertake outreach, examples of which include:

- Home visits with Adult Social Care if people have drug and alcohol needs
- Visiting places with the police where anti-social behaviour is prevalent
- Visiting soup kitchens, community hubs and hostels
- Setting up a group in the refuge with the expectation that drop-in sessions will also become available
- Working with police to be able to see people in custody
- Participating in the Blue light pilot – assertive outreach with people with complex issues
- Visits to community groups

Many of these activities are just being implemented following the lifting of pandemic restrictions. Improved visibility of services and constructive conversations engaging with people in the community raises awareness of the issues of drug and alcohol misuse in Thurrock and the services available for support when people are ready to make changes to their lives.

7.1.2 IVT working with other organisations

In order to achieve the aims of the service, IVT works with a range of organisations and groups of commissioners and providers to be able to understand and better plan, engage and support residents with co-occurring conditions and complex needs. These include, but are not limited to:

Thurrock Council:

- Thurrock Community Safety Partnership
- Thurrock Council Violence Against Women and Girls
- Thurrock Housing Options
- Thurrock Trading Standards Thurrock
- Thurrock Adult Social Care
- Thurrock First

National Health Services:

- Thurrock GPs and the 4 Thurrock Primary Care Networks
- Alcohol Liaison Service Mid and South Essex NHS Foundation Trust
- Inclusion Thurrock Improving Access to Psychological Therapies
- Adult Community Mental Health Teams, Essex Partnership University NHS Foundation Trust

Criminal justice system:

- Essex Police
- Thurrock Probation service
- Thurrock Youth offending service

Third sector services:

- Thurrock Children and Young Persons Substance Misuse Service
- Open Road – getting people in contact with IVT into employment
- Turning Corners Football Club

Drug and alcohol misuse is an important concern in other Thurrock partnership groups. For example, the Thurrock Safeguarding Adults Partnership are concerned with modern day slavery

which can include vulnerable adults who have drug and alcohol problems and the Thurrock Children's Safeguarding Partnership who are concerned with county lines gangs using youngsters to carry drugs in the community. The Thurrock Community Safety Partnership works closely with both safeguarding groups to ensure actions are coordinated.

7.1.3 Drug and alcohol treatment service use

IVT reports service usage data against key performance indicators to Thurrock Council on a monthly basis. These data along with information from other services is compiled nationally, analysed, and reported via the National Drug Treatment Monitoring Service (NDTMS), in the adult drug and alcohol commissioning support packs, and the Diagnostic Outcomes Monitoring Executive Summary (DOMES). The information in the remainder of this section is drawn from a combination of these sources.

7.1.4 Source of referral to alcohol and treatment services

The table below shows the trend in the source of referrals into treatment for 2015/16 to 2020/21. Over this period the number of referrals has reduced by around 60%, from 425 to 175. The latest reported year was during the pandemic when there were considerable restrictions on services which may account for some of this reduction, however this trend was evident prior to the beginning of the pandemic with 210 referrals in 2019/20 (50% of 2015/16 figures). The greatest proportion of referrals were from self-referral or via family and friends which comprised 58% and 65% in 2015/16 and 2020/21 respectively. The increased proportion of referrals coming from self/family and friends indicates that services were referring proportionately fewer people. Referrals from the Alcohol Liaison Service and the criminal justice system have both proportionately reduced since 2015/16.

Table 45: Source of referral for people entering treatment, 2015/16 to 2020/21

Source of referral for new presentations entering treatment, all Thurrock						
Referral Source	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Criminal Justice System	100	60	30	40	35	25
Alcohol Liaison Service	15	10	10	5	5	0
Self-Referral or via Family/Friends	245	265	140	200	120	115
Health and Social Care Services	55	45	20	40	40	20
Other	10	5	5	5	10	15
Unknown	0	0	0	0	0	0
Approximate Total*	425	385	205	290	210	175

Source: NDTMS ViewIt Adults

Further detail about referrals for either drug or alcohol misuse treatment compared to England by gender for 2020/21 is outlined in Tables 46 and 47 and Figure 34.

Similar patterns in referrals for drug and alcohol treatment are reported for Thurrock and England via the criminal justice system and GP practices. Self-referrals and those by social services are higher in Thurrock compared to England and those from the Alcohol Liaison Service and other referral routes are lower.

Table 46: Sources of referral for those starting treatment for drug misuse in Thurrock and England, 2020-21.

Referral	Thurrock (n)	Thurrock (%)	Male (%)	Female (%)	England (n)	England (%)	Male (%)	Female (%)
Self-referral	65	64%	60%	71%	46,199	59%	59%	61%
Referred through Criminal Justice System (CJS)	17	17%	19%	11%	12,247	16%	19%	8%
Referred by GP	<5	N/A	N/A	0%	3,128	4%	4%	4%
Hospital/A&E	0	0%	0%	0%	1,850	2%	2%	3%
Social Services	5	5%	4%	6%	2,395	3%	2%	6%
All other referral sources	12	12%	12%	11%	12,193	16%	15%	18%

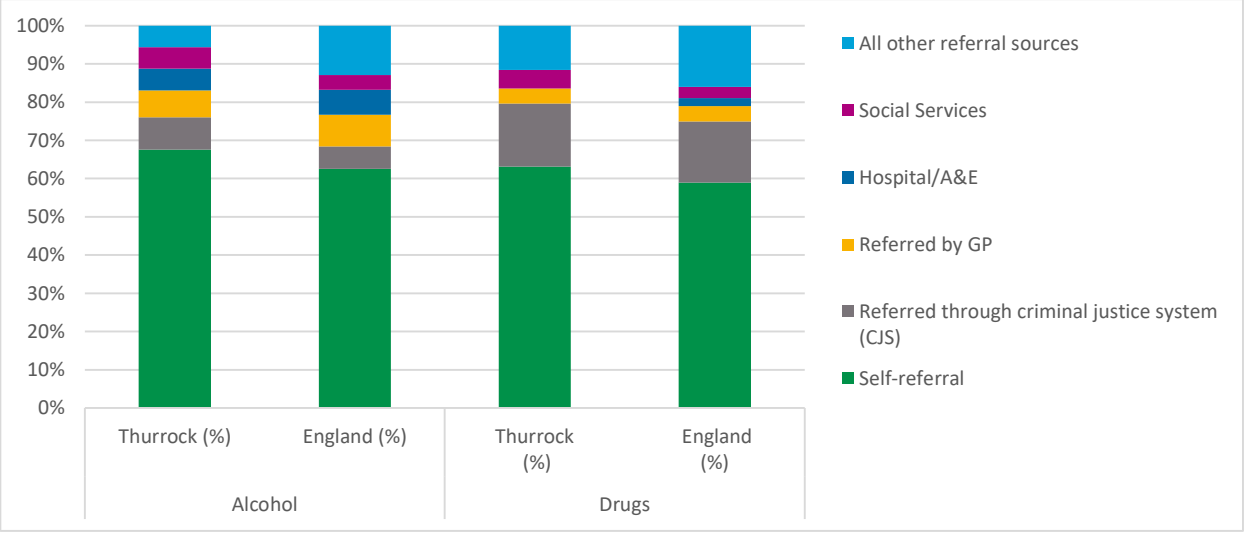
Source: Adult Drug Commissioning Support Pack 2022/23

Table 47: Sources of referral for those starting treatment alcohol misuse for Thurrock and England, 2020-21

Referral	Thurrock (n)	Thurrock (%)	Male (%)	Female (%)	England (n)	England (%)	Male (%)	Female (%)
Self-referral	48	70%	72%	67%	32,574	63%	62%	64%
Referred through criminal justice system (CJS)	6	9%	14%	3%	3,014	6%	8%	3%
Referred by GP	5	7%	11%	3%	4,342	8%	8%	9%
Hospital/A&E	<5	N/A	N/A	3%	3,420	7%	7%	6%
Social Services	<5	N/A	N/A	12%	2,000	4%	3%	5%
All other referral sources	<5	N/A	N/A	12%	6,722	13%	13%	13%

Source: Adults Alcohol Commissioning Support Pack 2022/23

Figure 34: Sources of referral for those starting drug and/or alcohol treatment for Thurrock and England, 2020-21.



Source: Adult Drug and Alcohol Commissioning Support Packs 2022/23

Note that in Figure 34 where there were less than 5 referrals in any referral source category in Thurrock (this situation did not arise for England) these numbers have been changed to 4 to reduce the risk of identifying any individuals. This does slightly alter the percentages shown across all referral source categories.

Waiting time targets for new referrals are consistently met by IVT. For 97-99% of referrals, people receive their first intervention within three weeks, and this has been achieved each month for the previous three years.

7.1.5 Numbers of people in drug and alcohol treatment

Chapter 5 describing the epidemiology and burden of disease provides detail about the numbers and types of people receiving drug and alcohol treatment. The table below shows the overall number of people in treatment and the number of new presentations entering the system for the year to April 2022. This includes people in community, inpatient, residential and primary care settings. Most people in 2021/22 entered treatment for alcohol misuse (36.6%) followed by opiate use (29.0%) whilst of those already in treatment 44% were being treated for opiate use and 28.6% for alcohol misuse.

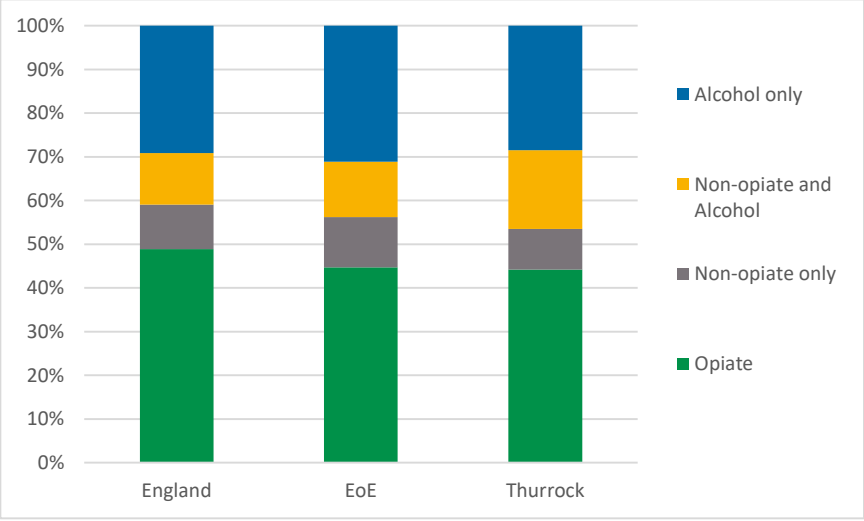
Table 48: Number of people currently receiving treatment and new people entering treatment for 2021/22

Number of people in drug and alcohol treatment in Thurrock		
Substance type	Number in treatment Mar 2021 to April 2022	New referrals Mar 2021 to April 2022
Opiate	147 (44.1%)	53 (29.0%)
Non-opiate only	31 (9.3%)	22 (12.0%)
Non-opiate and Alcohol	60 (18.0%)	41 (22.4%)
Alcohol only	95 (28.6%)	67 (36.6%)
Total	**333**	**183**

Source: NDTMS Community Adult Treatment Performance Reports

The figure below compares the proportions of those in treatment by type of substance with East of England and England for 2021/22. Thurrock has a higher proportion of people treated for non-opiate plus alcohol misuse compared to East of England and Thurrock and lower proportions of people being treated for either alcohol or non-opiate misuse only.

Figure 35: Proportion of those in treatment from April 2021 to March 2022 by substance category



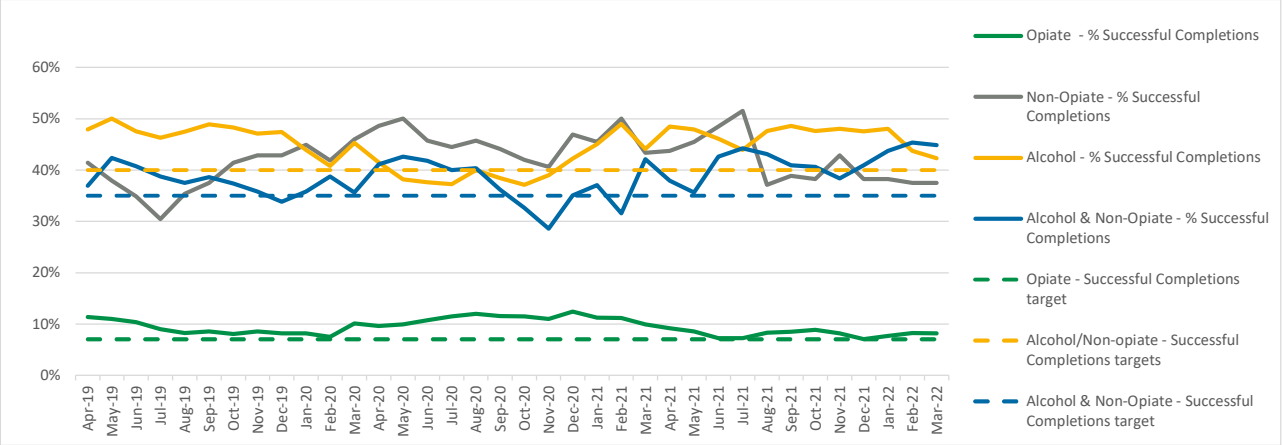
Source: NDTMS Community Adult Treatment Performance Reports

7.1.6 Treatment outcomes

There were two main sources of information about latest treatment outcomes for people in treatment over the past two years. These were key performance data from IVT and DOMES reports.

Figure 36 shows the proportion of people who successfully completed treatment with IVT for each of the four substance types against the target. Overall, the target of 10% successful completions for opiate treatment is met for the two-year period from April 2019 to March 2022. There is much more variability for successful completion rates for the other substance types with a dip in all three below target in mid to late 2020, followed by an improvement in Spring 2021 which is maintained for April 2021 to March 2022. The dip may have been due to a response of IVT to the pandemic to hold on to people in treatment for longer to support them through the difficult period. There are separate completion targets, each of 40%, for the non-opiate only and the alcohol only client groups. These targets are represented by a single yellow coloured dotted line in the graph below, as separate dotted lines would overlap, and both would not be visible.

Figure 36: Percentage of successful completions per month by substance category



Source: Inclusion Vision Adults Drug and Alcohol Service Key Performance Indicators 2019/20 to 2021/22

The table below compares the number of successful treatment completions with baseline 2020/21 figures, latest 2021/22 figures and the top quartile range for comparator local authorities. Thurrock is within the top quartile for the rate of successful treatment completions for people with opiate, non-opiate and alcohol and non-opiate misuse but not alcohol only treatment.

Table 49: Successful completions as a proportion of all in treatment

Substance Category	Baseline April 2020 to March 2021		Latest period April 2021 to March 2022		Top Quartile Range for Comparator LAs
	%	n	%	n	
Opiate	9.7%	15/154	9.5%	14/147	8.43% - 15.53%
Non-opiate	45.2%	14/31	35.5%	11/31	44.38% - 64.63%
Alcohol	41.1%	37/90	41.1%	39/95	45.12% - 58.96%
Alcohol and non-opiate	42.9%	24/56	45.0%	27/60	40.29% - 56.72%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

Another measure of treatment outcomes is either drug or alcohol misuse abstinence or reliably reduced misuse. Table 50 shows the numbers of people who at their 6 months review are abstaining from use of opiates, cocaine, crack, or alcohol or who have cut down on their frequency of use. Numbers have been supressed where they are below 5, however rates were within the expected abstinence range for all substance types.

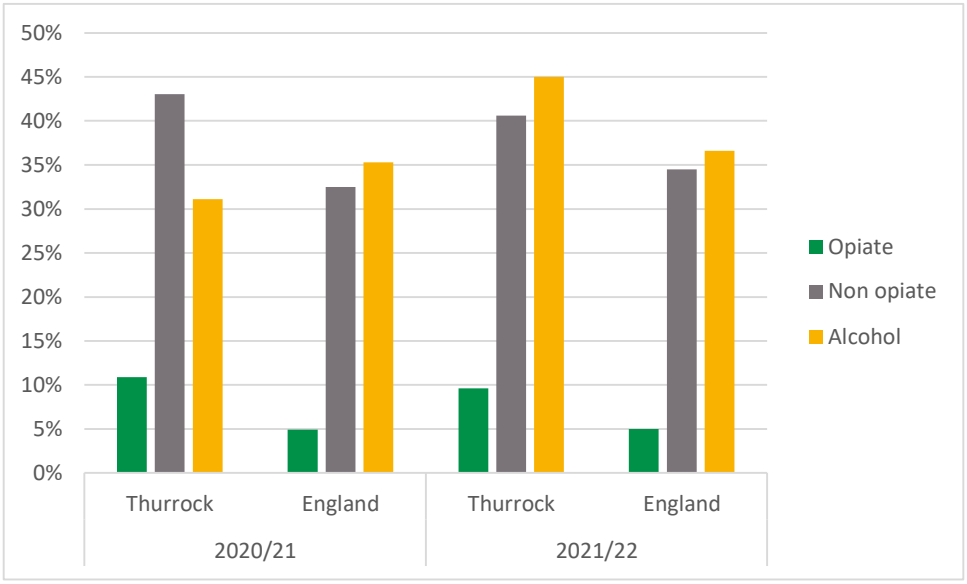
Table 50: Abstinence and reliably improved rates at 6 months review in the last 12 months

Abstinence and reliably improved rates	Abstinence Rates		Expected abstinence Range [61]	Reliably improved
	%	n	%	%
Opiate abstinence and reliably improved rates	53.3%	8/15	25.4% - 76.0 %	26.7%
Crack abstinence and reliably improved rates	75.0%	6/8	10.5% - 79.4%	25.0%
Cocaine abstinence and reliably improved rates	N/A	<5/11	17.2% - 76.2%	36.4%
Alcohol abstinence and reliably improved rates	N/A	<5/34	4.9% - 30.5%	38.2%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

Following successful treatment, a proportion of people will re-present to the service having started to misuse drugs and alcohol again. IVT has a target of no more than 8 re-presentations in any one year for each substance category. This target has been met in each of the last three years (2019/20, 2020/21 and 2021/22). Across all four substance categories there were 6 re-presentations in 2019/20, 4 in 2020/21 and 4 in 2021/22. Figure 37 compares the re-presentation rates following successful treatment completion for Thurrock and England for opiates, non-opiates, and alcohol in 2021/21 and 2021/22. Rates in Thurrock are higher than in England but without confidence intervals it is not clear if these differences are significant.

Figure 37: Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months



Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

[61] The expected range takes into consideration the case mix profile of the population. For each substance a formula has been developed based on the relationship between factors reported at presentation by clients citing the substance (nationally) and their likelihood of achieving abstinence from that substance at 6-month review. This formula is then used to determine the expected range of performance for each individual area, using factors reported at presentation by clients that are now due for 6-month review. Performance either side of the expected range is exceptional. Source: PHE Diagnostic and Outcome Monitoring Executive Summary (DOMES): Partnership Report Guidance Document

7.1.7 Numbers exiting treatment

People exit treatment once it is completed and for a range of other reasons including dropping out and transferring into custody. From April 2021 to March 2022 there were 177 exits from treatment.

The table below shows the exits from treatment for the years 2015/16 to 2020/21. In 2015/16 52% of exits were due to successful completion of treatment whilst 35% dropped out which is similar to 2020/21 when the rates were 55% and 33% respectively.

Table 51: Thurrock clients exiting treatment by method of exiting treatment, 2015/16 to 2020/21

Method of exit from treatment for patients currently in treatment, all Thurrock						
Exit Method	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Inconsistent Treatment	0	0	0	0	0	0
Treatment Withdrawn	0	0	0	0	0	0
Treatment Declined	0	5	10	5	0	0
Referred On	0	0	0	0	0	0
Transferred into Custody	25	20	5	5	15	0
Transferred Not in Custody	30	25	20	15	20	10
Prison	0	0	0	0	0	5
No Appropriate Treatment	0	0	0	0	0	0
Moved Away	0	0	0	0	0	0
Dropped Out	145	140	105	115	85	55
Successful Completion	215	195	120	145	100	90
Passed Away	5	5	5	0	0	5
Other	0	0	0	0	0	0
Unknown	0	0	0	0	0	0
Total	**415**	**385**	**265**	**285**	**220**	**165**

N.B. Numbers in this table have been rounded to the nearest 5 to prevent identification of individual patients
Source: NDTMS ViewIt Adults

In terms of unplanned exits or transfers Table 52 compares the proportion of these within Thurrock with the national average. For all substance types, Thurrock unplanned exits and transfers are higher than the national average; for alcohol and non-opiate and non-opiate only treatment this is around 40% higher. However, these are small numbers, and it is not clear if these differences would be important without calculating confidence intervals.

Table 52: Proportion of new presentations who had an unplanned exit or transferred and not continuing a journey before being retained for 12 weeks

Substance Category	Latest period Jan to Dec 2021		National Average
	%	N	
Opiate	20.9%	9/43	16.4%
Non-opiate	30.4%	7/23	18.1%
Alcohol	15.9%	11/69	13.2%
Alcohol and non-opiate	31.1%	14/45	17.2%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

7.1.8 IVT service user involvement and feedback

IVT works with most adults requiring drug and/or alcohol treatment in Thurrock. Feedback is gathered from service users through a variety of routes. A service user forum is held on the first

Thursday of every month and IVT use Care Opinion; a not-for-profit independent feedback platform for health and social care; to gather narrative feedback from people. A service user strategy is currently being implemented and a post will be advertised for a band 5 coordinator of volunteers and service user involvement lead.

Below are three very positive, recent quotes from service users about IVT via Care Opinion:

Service user A

'The support I've got from Inclusion is 2nd to none, they helped me make changes that I couldn't do on my own, they didn't judge me when I stumbled, just showed me how to get back up and look forward. Looking forward to trying acupuncture' July 2022

Service user B

'I'm 36. I've been drinking for 22 years through many issues including mental health. I have been to Thurrock inclusions many times and have detoxed and relapsed. They have never turned their back on me and have now given me another chance. I got my key worker back, who said she will help me if I help myself. I was binge drinking every day and going to Inclusions groups and meeting all the other staff. Going to the groups has reduced my alcohol dependency'. June 2022

Service user C

'I stopped the binge drinking. Every meeting I go to has helped me in every way. They have got me detoxed in a rehab and am doing many other recovery groups. Everyone there are brilliant they have saved my life. I could never thank them so much - they are brilliant, and I now feel brilliant'. June 2022

Service user feedback on delivery of interventions during the pandemic

During the pandemic in 2020/21, IVT undertook a survey of 137 service users in Thurrock to ask them about their satisfaction with the service and their views on delivering parts of the service online. Of those 137 service users, two thirds (66%) were receiving support for heroin use, 12% for alcohol addiction, 10% for alcohol problems, 5% for prescription/over the counter medication and 3% for use of crack cocaine.

When asked about the support they had received by phone 50% said it was excellent, 34% that it was good and 22% that it was okay. No one reported the service as poor or very poor. In terms of difficulties accessing telephone support service users were asked to indicate any and multiple problems. Of 137 people, 135 (99%) said they were happy to receive an intervention over the phone. However, 17% said they did not or do not often have phone credit, 6% said they do not often have or had no access to a phone and 5% said they did not have access to a quiet, private, or safe space for their appointment.

Service users were asked to indicate any difficulties they had accessing online or digital support. Although 71% said they did have the right equipment and connectivity, 30% of service users said they were unconfident about using it and 13% did not have a quiet or safe space to talk privately.

When asked about their willingness to access interventions in different ways 93% and 99% were happy to meet face to face or receive phone support respectively. For digital interventions 27% were willing to have video consultations, and 23% to access online interventions. Only 24% were willing to attend face to face groups and 19% to attend online groups.

The proportions of people happy to receive interventions in different ways were similarly reflected in their preferences. Table 53 below shows that most people preferred face to face (91%) or telephone support (91%) whilst a high proportion (68%) did not prefer online digital interventions. Clearly a considerable proportion of people did not want to participate in group work either face to face (69%) or online (74%).

Table 53: Service user preference for method of accessing support

Please rate from 1 (do not prefer) to 5 (prefer) which access methods do you prefer?						
Access Method	1 - do not prefer	2	3 - no preference	4	5 - prefer	Total
Online digital interventions	68%	5%	9%	9%	9%	100%
Face to face groups	69%	3%	6%	5%	17%	100%
Online groups	74%	4%	7%	9%	6%	100%
1-1 face to face	2%	1%	3%	4%	91%	100%
Video consultation 1-1	33%	5%	37%	14%	11%	100%
Telephone support	0%	2%	3%	4%	91%	100%

7.2 Service User Views of IVT

As part of the HNA, service users seen in July were asked a small number of questions (Appendix 3) about their satisfaction with the service at the time of their appointment. A total of 47 service users provided feedback.

Of the 47 respondents, 34 (72%) were male and 13 (28%) were female. Of the females 70% were aged 30 to 49 years and 23% were over aged 50. Of the men 50% were aged 30 to 49 and 47% were 50 and over. A total of 33 (70%) respondents were being treated for opiate use, 8 (17%) for alcohol and non-opiate use, 7 (15%) for non-opiate use and 5 (10%) for alcohol misuse only.

A total of 18 (38%) people were in contact with one or more other services. Of the 10 people in contact with mental health services, nearly half were also supported with their housing needs.

Figure 38: Proportion of respondents in contact with different services

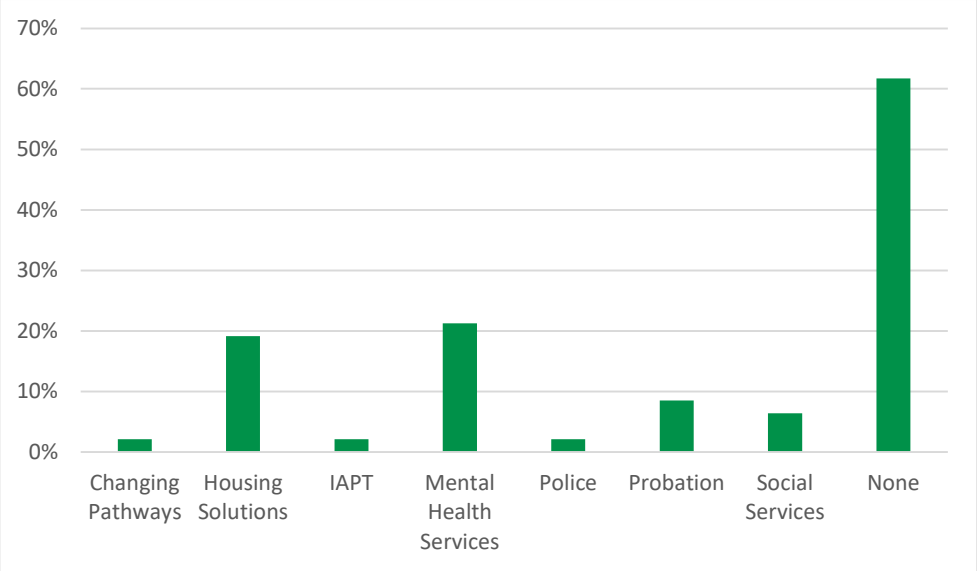


Table 54: Responses to questions about IVT service

Question	Always	Often	Sometimes	Rarely	Never
1.Could you contact the service when you needed to?	40 (85%)	6 (13%)	1 (2%)	0	0
2.Could you use the service when you needed it?	36 (77%)	11 (23%)	0	0	0
	Very positive effect	Some positive effect	Neutral	Some negative effect	Very negative effect
3.Do you think the COVID-19 pandemic had an effect on how you were able to use the service?	23 (49%)	12 (26%)	7 (15%)	5 (10%)	0
	Completely satisfied	Very satisfied	Moderately satisfied	Slightly satisfied	Not at all satisfied
4.Did you receive what you expected from the service	33 (70%)	13 (28%)	1 (2%)	0	0

Of the 47 respondents asked if they had any other comments 19 (40%) provided very positive comments such as:

"Enjoy coming to the service. Staff are so nice and helpful. I like the drop in and other groups."

"Staff have always been there for me; Thank you for sticking with me as I have been a nightmare."

"Very happy with the service, people understand you here, they give you hope, and they don't judge me."

There were three other comments; two mentioning how they really benefitted from the flexibility of the mix of phone and face to face appointments so they could fit them around their work and one person said they would like to access IVT via another door instead of the main entrance.

Of the 47 respondents 18 (38%) were happy to be contacted in the future to have a conversation about what you think the best drug and alcohol treatment service would look like.

One of the limitations with this approach is that service users were asked questions by IVT staff members which limits the independence of the results. Importantly people were asked if they would be happy to take part in discussion about future drug and alcohol services and 38% agreed. The volunteer coordinator and service user involvement lead will be able draw on the experiences and views of this group, for the co-design and co-production of a future service. This approach aligns with the elements embedded in the Thurrock wide strategy of transformation to an integrated system using human learning systems approaches.

7.2.1 IVT service: barriers, enablers, and gaps

From the stakeholder interviews with professionals, it was clear IVT is perceived very positively by people and agencies working alongside them. The service was described as good at partnership working, approachable, transparent, and diligent in terms of financial planning and performance. The other positive features of the service mentioned included longevity of staff in post, their persistence in working with people, a flexible open approach to finding solutions and sensitively matching key workers to residents. Being part of a large NHS Foundation Trust was also valued, enabling the service to weather peaks and troughs in the system. Their consistent engagement with partnership working and MDTs was seen as essential to address some of the council's priorities such as reducing re-offending and community based anti-social behaviour.

Partnership working will continue be consolidated given the likelihood of the planned transformation of services delivered by Thurrock Council to a human learning systems way of working[62].

During the pandemic, IVT managed to carry out all its contacts with people virtually, including treatment and prescription services. This required a lot of work centrally and locally to rapidly change policies and procedures. Some people preferred virtual contacts and were more likely to engage better than with face-to-face meetings, particularly people with opiate issues. It is now a challenge to persuade some people return to face-to-face meetings, which may be a result of a lack of confidence in social skills following isolation. For some people it will be appropriate to continue with virtual meetings, but for others it may only be through face-to-face meetings that staff can see that the person needs additional support.

The current priority for IVT is to restore the drug and alcohol services so that they can be accessed from all the pre-pandemic community access points. This includes outreach venues and police custody suites. The other pressing need is to focus on people who have unequal access to services, especially those with co-occurring conditions and complex needs such as mental health issues and alcohol dependency, combined with housing and social care needs. IVT felt having a small specialist team focussed on substance misuse and mental health with an NHS band 7 psychologist and band 6 substance misuse worker would bridge the current gap.

From a conversation with an IVT volunteer it was clear that there is still considerable fear around asking for help, especially for single parents who are fearful of having their children removed and the stigma surrounding alcohol and drug misuse. Within the community, having a peer mentor who people can come to for advice prior to asking for help from the statutory agencies would be helpful. In addition, once they have asked for help a peer mentor could be an informal support as they journey through the system and raise awareness of all the resources available to them across the agencies.

Key population groups were mentioned as being underrepresented in referrals to drug and alcohol treatment services. These included the traveller community, sex workers, white professional males using cocaine and people originating from the Asian subcontinent.

Community groups and community projects were seen as being very important for service users and there are some community resources already available such as the Turning Corners Football Club a grassroots group that counts a number of residents recovering from substance misuse amongst its members. The club has recently been profiled in the Mid and South Essex ‘Moments that Matter’ campaign, was set up by a local resident who was in recovery from addiction with assistance from his keyworker at IVT. The club now has 70+ members, and feedback from participants has shown they see being part of this ‘brotherhood’ as being vital to their recovery. This emphasises the importance of continued work with third sector partners to ensure community organisations can be supported to continue with this sort of programme. However, there is still a view that community activity to directly improve the environment such as a green space for community projects open to a range of people with vulnerabilities as a place to connect for support and health and wellbeing activities, for adults and children would be beneficial. This would bring people together, integrate people more into the community, build confidence and resilience in service users, with the aim of being sustainable. It is important that when someone stops using a substance which has been their coping mechanism for so long that there is something positive that can fill the gap.

[62] Better Together Thurrock; The case for Further Change 2022-2026

7.3 Thurrock Community Safety Partnership

In Thurrock the 5 responsible authorities (local authority, the police, probation, fire and rescue and health services) form the Community Safety Partnership (CSP), working together to implement strategies to tackle local crime and disorder. The CSP 2021 strategic assessment formed the basis of the CSP action plan for 2022/23 outlining local priorities and planned actions. The CSP covers the whole resident population of Thurrock including adults and children. The public health drugs and alcohol lead who commissions both the children and young person's substance misuse service and the adult drugs and alcohol service are represented as non-statutory members of the CSP board. The drug and alcohol service partners and collaborates with each of the five responsible authorities, developing strategies to engage with and offer support to those involved with anti-social behaviour, criminal activity and people experiencing domestic abuse.

7.3.1 The Blue Light project

The CSP was instrumental in supporting the setup of the 'Blue Light Project' within Thurrock. This is an initiative promoted by the national UK charity, Alcohol Change, implemented locally, aiming to develop alternative approaches and care pathways for drinkers who are not in contact with treatment services, but who have complex needs. It challenges the belief that only drinkers who show clear motivation to change can be helped and sets out positive strategies that can be used to manage risk, reduce harm, and promote change. The cohort of people targeted are those with a long-standing alcohol problem and are usually frequent users of health, social care or emergency services or had contact with the authorities through domestic abuse, crime, anti-social behaviour or housing and homeless agencies.

Referrals are made to one of the Local Action Groups (LAG) of which there are two in Thurrock. Representatives on the LAG from the police, IVT, housing (both council and private housing associations) and the adult mental health teams are involved in assessing the referrals. Most referrals come from housing officers who are visiting housing stock and tenants and find people in chaotic circumstances, but who have not yet asked for help or engaged effectively with services. The other key referrer is the adult safeguarding team. Following referral there is a discussion between agencies about the best approach to supporting and engaging with the person and actions agreed. Once people are in a more stable situation the person is discharged from the service. However, they may be re-referred and require further support if their situation deteriorates.

There is currently no evaluation or data about how and what difference this project is making to the targeted cohorts however, there is significant partnership working between agencies which are perceived as very positive and effective. The project has cemented people's ideas and awareness about how drug and alcohol services are central to the solution for improving the lives of those with complex needs.

7.4 The Children's and Young People's Services

The integrated young person's substance misuse treatment service is commissioned by Thurrock Council and provided by Change Grow Live (CGL) Wize up. The aims of the provision of the service set out in the SLA are to contribute towards:

- A reduction in drug related ill health
- An avoidance of drug related deaths
- A reduction in drug related offending
- A reduction in the supply of illegal drugs

- A reduction in alcohol related harms
- A reduction in young people misusing substances who go on to be problematic substance misusers as adults
- Breaking the cycle of intergenerational substance misuse
- A reduction in young people not in education, employment, or training

The service offers general prevention interventions in schools and the community and specific treatment services for individuals. These are focussed in the following areas:

- Consultancy and support for universal services
- Substance misuse education and prevention in universal and targeted settings
- Advice and information
- Outreach
- Psychosocial interventions including motivational interviewing, cognitive behavioural therapy and 12 step programmes,
- Complementary therapies
- Specialist harm reduction
- Family therapy interventions
- Peer led programmes

CGL Wize Up work in schools and the community to ensure children and young people have the information about the risks associated with substance misuse and how to reduce harm if they take risks and where to go for help if necessary. Treatment services are available for individual young people who are 17 or younger, and their families if appropriate, who have been referred for support through a range of routes such as schools, social care, and the YOS. The service also works with children and young people exposed to hidden harm due to experiencing parents or carers misusing substances and who may themselves have started misusing substances. CGL Wize Up staff are co-located with the YOS to deliver support to children and young people who are affected by substance misuse themselves or of a significant other. The adult service will also refer children whose parents or other significant others they are treating, to the CYP service in order to support children exposed to the hidden harm of witnessing drug and alcohol misuse.

CGL Wize up work with the Thurrock Multi Agency Safeguarding (MASH) hub in order to engage in effective multiagency interventions. Other agencies include, early intervention, prevention and support services, Healthy Families, Troubled families, Youth Offender Service, schools/ academies, the adult drug, and alcohol treatment service and voluntary and third sector organisations. Representation of CGL Wize up is sought on any MDT involving safeguarding, panels for children in need, child protection and the exploitation panels involved with county lines and community safety.

Early identification of county lines and other types of exploitation are a large part of CGL Wize Ups work. This may be a referral from YOS or school, when students exhibit concerning behaviour, such as increased unaccounted time missing from school, or suddenly having more money or expensive belongings

In working with young people considerable time is taken describing the consent process in a way that can give them autonomy and to build trust in the relationship. This is important as there are circumstances when it is in the best interests of the person to breach their confidentiality such as when harm to other young people is likely or serious crime is involved.

7.5 Transition from Young Peoples to Adult Services

Children and young people will often present with what they consider to be recreational alcohol and drug use so an approach to motivational interviewing and engagement is somewhat different

to the work of the adult services who are likely to be working with people with much more complex, entrenched problems.

There are arrangements in place for people who reach the age of 18 and still need support from drug and alcohol services to be transferred to the adult service. People with learning needs and other disabilities can continue to be supported by the Children's and Young people's service until the age of 25. However, where these criteria do not apply the differences in the approach between the young peoples and adults' services mean that when they move to an adult service and the statutory support changes, it can be a difficult transition. For example, a young person supported by CGL Wize Up for binge drinking and cannabis use may receive a broad holistic service, but on entering the adult service at age 18 they receive a single harm reduction session, because they are not problematic drinkers or substance dependent.

Work is underway to improve the young people's experience of transition by creating a pathway that feels safe and predictable so they know what they can expect from the adult service. A transition support worker currently sits with the adult service to help with the integration of services and where possible for those aged 18 to 21 the decision as to whether they stay with the young people's service or transition to the adult service is considered on a case-by-case basis. Further work is likely to be necessary for the young peoples and adults' services to mesh effectively at the transition point between them. The older teenage and young adult group have particular needs and vulnerabilities and it is important that both services provide a similar coordinated approach to ensure the transition is as seamless as possible. Solutions to the transition issues in other areas includes integrating young peoples and adults' services using one provider (e.g., in Slough and Hillingdon) and re-commissioning across both adults and young people's systems focussing on the 'whole family' to improve outcomes (Sutton).

7.6 Children's and Young People's Use of Services

The young people's drug and alcohol service provider CGL Wize up, reports service usage data against key performance indicators to Thurrock Council. These data along with information from other services is compiled nationally, analysed, and reported via the NDTMS, the adult drug and adult alcohol commissioning support packs, and the Diagnostic Outcomes Monitoring Executive Summary (DOMES). The information in this section is drawn from a combination of these sources.

7.6.1 Numbers of children and young people in treatment

The latest figures reported for young people in treatment in Thurrock comes from the young people substance misuse commissioning support pack 2022/23: key data. The latest available year was 2020/21 when 50 young people were in treatment of which 76% were male, compared to 64% for England. There were 35 new young people entering treatment of which 74% were male, compared to 65% for England.

Referrals were highest for those aged 15 (35%) followed by those aged 16 (25%) and then 17-year-olds (16%) and 14-year-olds (12%). Referral sources were predominately via education (28%), children and family services (26%) and youth justice settings (28%) with a further 9% coming from health and mental health services, and 6% from self-referral or family and friends. A similar pattern is seen for England although the proportion of referrals from self or family and friends (12%) is double that for Thurrock. Most young people (85%) were living with their parents and 6% were living in care.

The most commonly reported problem substance was cannabis (84%) followed by nicotine (48%), alcohol (28%) and cocaine (8%). For England reported substances were lower for nicotine (12%) and higher for cocaine (13%) and ecstasy (11%) and ketamine (5%).

In 2020/21, 19 young people, 40% of those in treatment had a co-occurring mental health and substance misuse problem, similar to the England proportion (42%). Of those identified 14 (74%) were identified as having mental health treatment.

In Thurrock for 2020/21, 26 of 29 (90%) young people who exited treatment left it successfully compared to 79% in England. In 2020 of the 20 young people who exited treatment successfully none re-presented to specialist services within 6 months.

7.6.2 Hidden harm

Hidden harm is an important focus for the children and young people's service, and a proportion of children at risk are identified through the adult services when parents or adult carers are assessed for treatment. Table 55 shows the proportion of adults entering drug and alcohol treatment services for Thurrock and England who live with children in 2020/21. There were similar rates of parents entering treatment with a drug problem in Thurrock (17%) compared to England (13%) and for alcohol 25% and 22% respectively.

Table 55: Number and proportion of adults presenting for drug or alcohol treatment by parental status, for Thurrock and England, 2020-21.

Parental Status	Thurrock Drugs (n)	Thurrock Drugs (%)	Thurrock Alcohol (n)	Thurrock Alcohol (%)	England Drugs (n)	England Drugs (%)	England Alcohol (n)	England Alcohol (%)
Parents living with children	17	17%	17	25%	10,071	13%	11,626	22%
Parents not with children	14	14%	9	13%	17,016	22%	9,389	18%
Other contact, living with children	1	1%	0	0%	3,434	4%	1,222	2%
Not parent - no contact with children	70	69%	43	62%	46,652	60%	28,974	55%
Missing / incomplete	0	0%	0	0%	1,097	1%	1009	2%

Source: Adult Drugs and Alcohol Commissioning Support Packs 2022/23

A proportion of parents in drug and alcohol treatment will be in contact with children's social care.

Children in Need are a group supported by children's social care, who have safeguarding, and welfare needs, including:

- Children on child in need plans
- Children on child protection plans
- Looked after children
- Disabled children

All of these children have needs identified through a children's social care assessment or because of their disability, meaning they are expected to require services and support in order to have the same health and development opportunities as other children.

The table below shows the proportion of children in need receiving help from social care along with those who received early help and those who are looked after children for Thurrock and England for the period 2021/22.

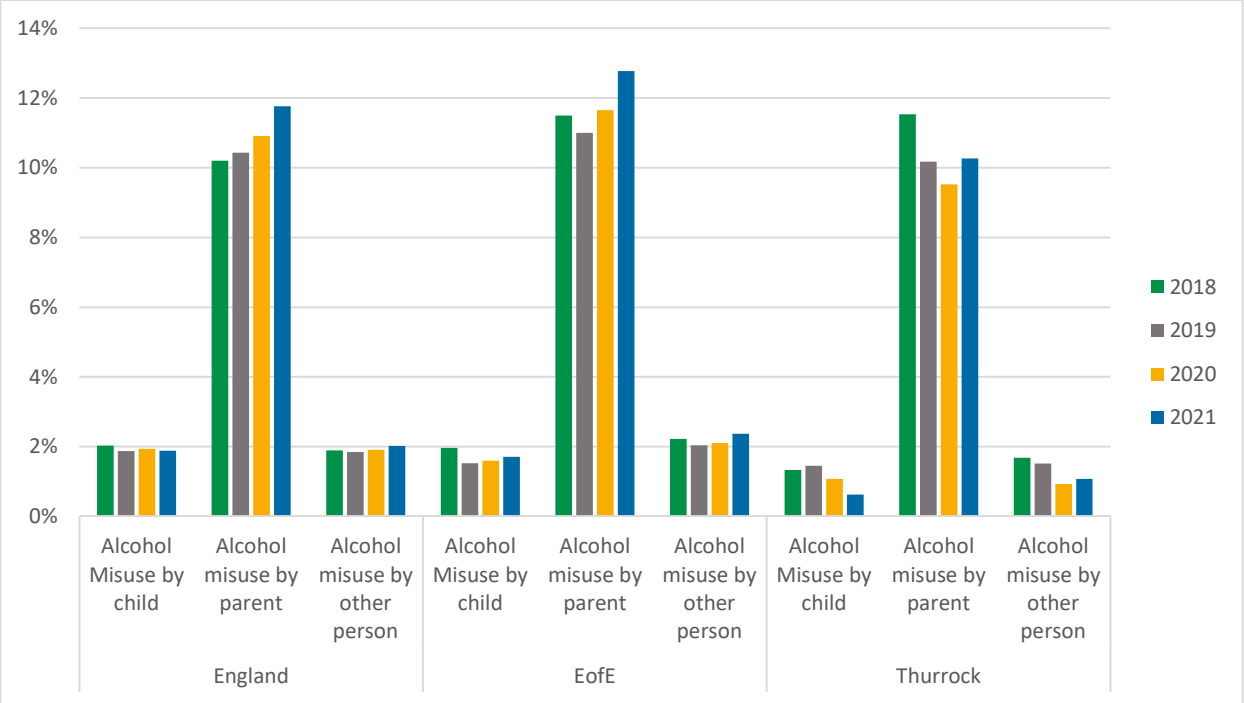
Table 56: Service users children receiving early help or in contact with children's social care

Contact with Children's Services	Latest period 2021/22		National Average
	%	N	
Early help	7.0%	5/71	6.3%
Child in need	12.7%	9/71	7.3%
Child protection plan in place	7.0%	5/71	11.8%
Looked after child	N/A	<5/71	6.8%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

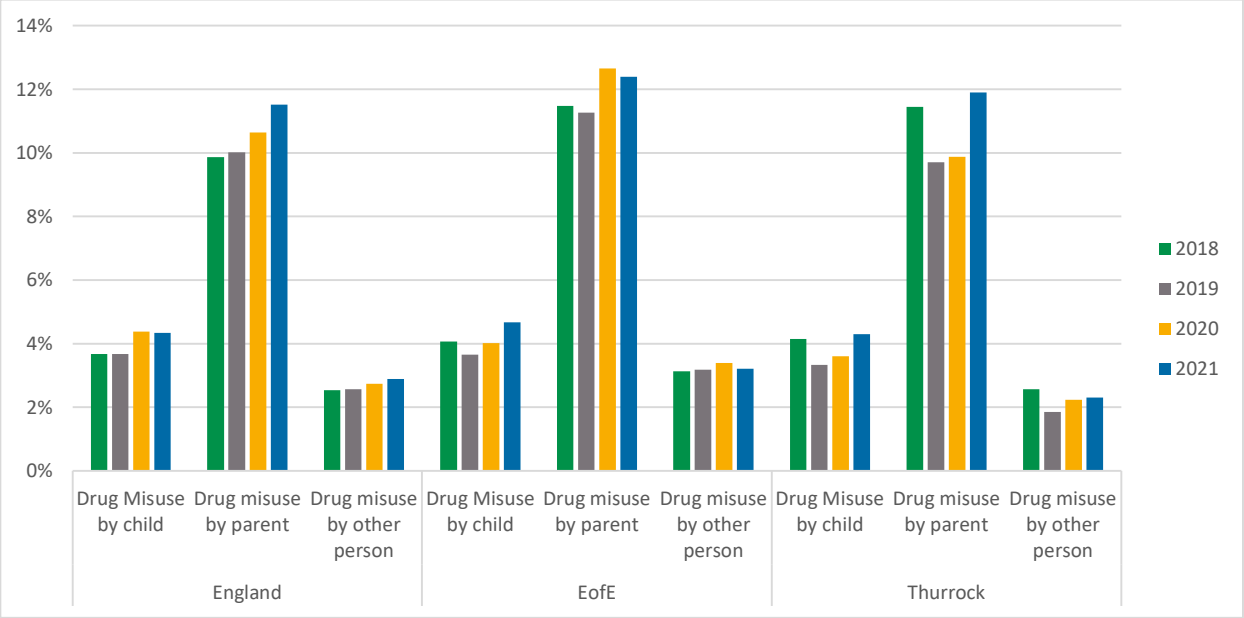
Of the total children in need assessments carried out since 2018 around 10-12% identify adult parents misusing, alcohol and a similar proportion misusing drugs in Thurrock, similar to the figures for East of England and England. Much smaller proportions were identified for children or another adult misusing drugs and alcohol. Figures 39 and 40 show the comparisons of rates of children in need assessments identifying drug and alcohol misuse between Thurrock, England, and East of England.

Figure 39: Proportion of Children in Need assessments highlighting alcohol misuse in the household as a factor, Thurrock, the East of England, and England, 2018 to 2021



Source: Department for Education. Children in Need Statistics. Characteristics of Children in Need, 2020/21

Figure 40: Proportion of Children in Need assessments highlighting drug misuse in the household as a factor, Thurrock, the East of England, and England, 2018 to 2021



Source: Department for Education. Children in Need Statistics. Characteristics of Children in Need, 2020/21

The outcomes for adults in treatment who live with children in Thurrock and England for 2021/22 are in Table 57. For adults in alcohol and non-opiate treatment and those in opiate only treatment a much higher proportion of people in Thurrock (61.1% and 16.7% respectively) compared to England (39.9% and 5.9% respectively) have a successful treatment completion. No confidence intervals are included and the small numbers in Thurrock mean it is unclear if these differences are important.

Table 57: Successful treatment completions of service users who live with children as a proportion of all service users in treatment who live with children under the age of 18

Substance Category	Latest period 2021/22		National Average
	%	N	
Opiate	16.7%	6/36	5.9%
Non-opiate	N/A	<5/10	43.6%
Alcohol	48.1%	13/27	42.9%
Alcohol and non-opiate	61.1%	11/18	39.9%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

7.6.3 CGL Wize Up: barriers, enablers, and gaps

Historically CGL Wize Up were considered by stakeholders to have provided a good service to Thurrock. However, the service is highly dependent on a small number of key staff members some of whom have been absent for some time, whose roles are being covered by agency and interim staff. The maintenance of the relationships between agencies and the work with schools and outreach activities has dwindled and there is concern that this is impacting on the visibility of the service. This includes a gap in the information, intelligence and CYP substance misuse expertise available to the range of partnership and multidisciplinary fora they would usually attend. In the community and schools, the lack of visibility makes it difficult to create a credible voice to facilitate the trusted relationships necessary for this type of service and to upskill teachers in having difficult conversations that may lead to referrals into the service.

There was concern in some areas that parents and young people were unaware how to find the information they needed that would answer their questions and fear of the consequences of approaching services for support was considerable.

In the past, there have been several beneficial initiatives such as the 'Youth at Risk' group in schools, comprising a small cohort of pupils on the periphery at risk of exploitation. CGL Wize Up would provide information and a session for this group, but this is no longer possible. Another example of good practice includes when CGL Wize Up worked on campaign in schools about nitrous oxide. CGL Wize up provided expertise and information whilst the young people in school/college developed, posters, T shirts as part of their course within the curriculum.

Work to build the visibility and integration of the young people's substance misuse service with other organisations is essential in order to meet their aims. Areas for further work include working closely with the adult team to produce a more integrated young people's pathway to the adults and other services, working with schools and other agencies more closely and focussing on peer mentor and family support.

From a broader perspective it is important that young people have other avenues to explore other than substance misuse and investing in community-based projects offering a variety of experiences is important.

7.7 Adult Mental Health Services

The 2022-2026 strategy for adults and older adults 'Better Care Together Thurrock: The Case for Further Change' outlines the proposed Thurrock integrated primary and community mental health service model at PCN level. The model has been implemented in one PCN area and will be rolled out to the remaining three. The model brings together clinicians from primary, community and secondary care, users of services, carers, families, voluntary sector organisations, public health specialists, and commissioners. This includes representatives from IVT. The aim of the new service model will be to apply the following approach to how people will be offered services:

- Earlier intervention rather than later (replacing thresholds)
- Provide a coordinated approach to deal with multiple issues in a timely way
- Focus on reducing need for reliance on future services

The mental health team and IVT work closely together as they progress with integrating services. Currently operational processes between the services about general collaborative working are being agreed which will also be aligned with primary care. Along with the drug and alcohol service, the IAPT service is delivered by IVT with the same commissioners and governance structure, this enables a close working relationship between services.

7.7.1 People with co-occurring conditions and complex needs

People with substance misuse challenges frequently have mental health problems alongside other difficulties such as with housing, employment, and relationships. People with co-occurring conditions and complex needs represent a significant proportion of those seen by the drug and alcohol service. Table 58 shows the proportion of adults in treatment for drug and alcohol misuse who have a co-occurring mental health condition in 2020/21. The rates across Thurrock, and England are similar as confidence intervals overlap, however, those in the East of England appear to be lower than those in England.

Table 58: The proportion (%) of service users entering drug or alcohol treatment identified as having, and in treatment for a mental health need, for England, East of England, and England in 2020/21

Area	Co-occurring mental health and drug treatment needs			Co-occurring mental health and alcohol treatment needs		
	%	Lower 95% CI	Upper 95% CI	%	Lower 95% CI	Upper 95% CI
England	74	72.7	75.2	83.5	82.1	84.8
EofE	71	70.6	71.4	80.4	80.0	80.8
Thurrock	63.8	52.0	74.1	79.2	65.7	88.3

Source: OHID Co-occurring substance misuse and mental health issues Fingertip's tool data provided by NDTMS
CI – confidence interval

When these rates are analysed by substance type there is a higher proportion of people with mental health problems having treatment for non-opiate misuse (86.4%) in Thurrock compared to England (68.5%). In contrast, mental health issues were identified in only 49.1% of people treated for opiate misuse in Thurrock compared to 63.5% of those in England. It is unclear if these are important differences as confidence intervals are not available.

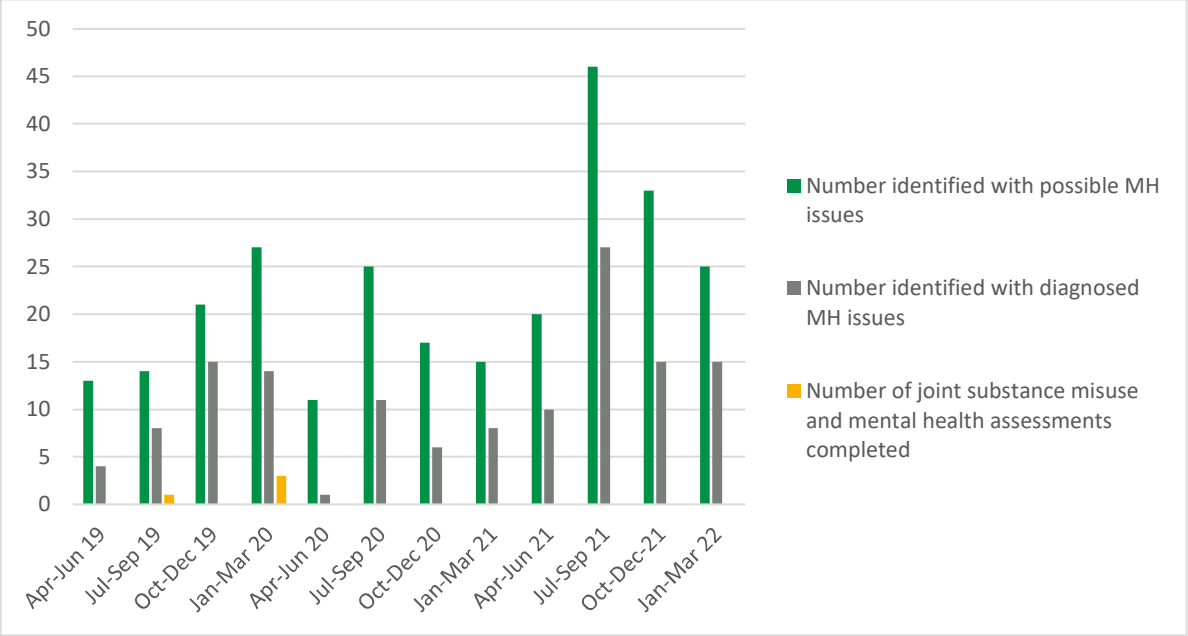
Table 59: Service users entering treatment identified as having a mental health treatment need

Substance Category	Latest period 2021/22		National Average
	%	n	
Opiate	49.10%	26/53	63.50%
Non-opiate	86.40%	19/22	68.50%
Alcohol	76.10%	51/67	68.30%
Alcohol and non-opiate	68.30%	28/41	74.30%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

Services face challenges in effectively working together largely due to a traditional SLA contracting arrangement. This leads to separate multiple assessments, referrals, and differing thresholds for people to be able to access services. In addition, waiting lists in any of the services results in delays and a lack of joined up support for individuals. This is frustrating for both service users and professionals. For example, the figure below shows the number of people with alcohol issues seen by the Alcohol Liaison Service who were identified with a possible mental health problem or where one was already diagnosed. Very few joint assessments have taken place since 2019. This may be largely due to the challenges of the pandemic, but even prior to the pandemic in 2019, only a very small proportion of assessments were jointly completed.

Figure 41: Number of individuals seen by the Alcohol Liaison Service identified with possible mental health issues or diagnosed with mental health issues and for whom joint assessments were completed by quarter, April – June 2019 to January to March 2022



Source: ALS Hospital Based Alcohol Interventions – Thurrock Only

The table below shows the proportion of people with an identified mental health treatment need who are being supported by the drug and alcohol services and whether they are in receipt of mental health support. In Thurrock 58.1% of people in drug and alcohol treatment were receiving support compared to 73.2% nationally. The gap appears to be associated with receiving mental health treatment from GPs, which shows a 20% difference between England and Thurrock.

Table 60: Service users identified as having a mental health treatment need and receiving treatment for their mental health

Service user mental health treatment type	Latest period 2021/22		National Average
	%	N	
Already engaged with the Community Mental Health Team/other mental health services	11.3%	14/124	19.2%
Engaged with IAPT (Improving Access to Psychological Therapies)	5.6%	7/124	1.7%
Receiving mental health treatment from GP	38.7%	48/124	58.3%
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	2.4%	3/124	1.1%
Has an identified space in a health-based place of safety for mental health crises	0.0%	0/124	0.6%
Treatment need identified but no treatment being received/Declined to commence treatment for their mental health need/Missing	41.9%	52/124	26.8%

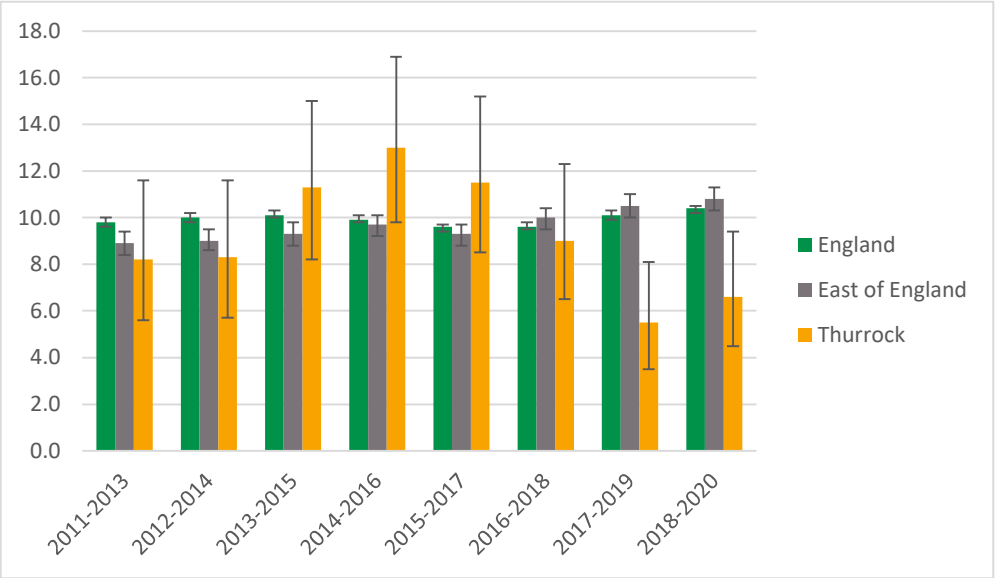
Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

7.7.2 People who take their own lives

People who take their own lives frequently have mental health problems and associated substance misuse issues. Drugs and alcohol are known to play a role in a significant proportion

of suicides nationally. Figure 42 shows that the rate of suicide in Thurrock in the past have been similar to those in England and the East of England, but in 2019 and 2020 they were considerably lower.

Figure 42: Age-standardised suicide rates per 100,000 population for Thurrock, East of England, and England, rolling three-year aggregates, deaths registered 2001 to 2020



Source: Office for National Statistics. Suicides in England and Wales by local authority

All local authorities are recommended to undertake suicide audits and develop a suicide prevention strategy and/or action plan that is based on the national strategy and local data. An update of the Essex suicide prevention strategy in 2019 reports that in 2017 83% of suicides of people aged 18 to 25 years involved drugs and alcohol, whilst in those aged over 25 years, 31% had a history of alcohol misuse and 21% had a history of misuse of drugs. In 2020 there were 14 suicides in Thurrock. Real Time Suicide Surveillance for Southend Essex and Thurrock is drawn from Sudden Death Forms completed at the time of an incident and in 2021/22 129 suspected suicides were reported. The second most common method accounting for 33 suspected suicides was death by drugs, either over the counter and prescription medicines or illicit substances. There were 12(9%) people with substance misuse problems known to Essex police reported as a risk factor in their suicide. However, there are likely to be other people who took their own lives with substance misuse problems not known by the police, so this figure is likely to be under reported and may be closer to the figures reported in the 2019 suicide prevention strategy.

Exploring how data could be captured and analysed in future suicide audits to better understand the role that alcohol and drug misuse play in such deaths would be beneficial. In addition, compiling data about the role of drugs and alcohol for people who attempt suicide would be helpful, but may be a complex task as this information is held across a range of data sets with different reporting structures.

To improve awareness of suicide there is a recommendation that training is offered to agencies that in contact with those likely to be at higher risk in order to intervene to reduce the likelihood of suicide being attempted. This is planned for IVT staff.

7.7.3 People with severe mental illness

People with a diagnosed severe mental illness registered with Thurrock GP practices are offered an annual health check. As part of this health check people are asked about their alcohol consumption and tobacco use. An optional component to the health check is to ask people about illicit drug misuse and a medication review.

The table below shows the completion rates for each of the health check elements for health checks completed between June 2021 and May 2022. Of 1,324 people having a health check 780 (59%) all six elements were completed. Around 81% were asked about alcohol consumption and 45% about the use of illicit drugs.

7.7.4 SMI health check

Table 61: Physical health checks completed in primary care on patients registered on GP practice serious mental illness registers, June 2021 - May 2022

Type of Check	Name	Count	%
Completed Health Checks	All SMI health check components completed	780	59%
SMI Register	SMI register excluding patients 'in remission'	1,324	100%
Mandatory Components			
BMI	Measurement of weight	1,105	83%
BP	Blood pressure	1,103	83%
Blood Lipid	Blood Lipid/Cholesterol / QRISK	943	71%
Blood Glucose	Blood Glucose test	998	75%
Alcohol	Assessment of Alcohol Consumption	1,066	81%
Smoking	Assessment of smoking status	1,148	87%
Optional Components			
Meds Review	Medicines reconciliation and review	1,022	77%
Illicit Drugs	Use of illicit substance/non-prescribed drugs	594	45%

Source: Public Health Team, Thurrock Council

Where the health check flags a concern the follow up interventions by the GP are recorded. Table 62 shows the proportion of follow ups completed. This shows that 70 of the 594 who were asked about illicit drug use, gave a response which indicated they were eligible for follow up support, yet only 11 had a read code of a follow up action completed (i.e., a referral). Similarly with alcohol use, 33 of the 1,066 who were asked about alcohol consumption, were deemed eligible for support, but only 12 had a read code of follow up support.

Table 62: Follow up interventions received by primary care patients on GP practice SMI registers receiving a physical health check for drugs and/or alcohol misuse

Substance Category	Interventions Required & Completed	Count	%
Alcohol	Follow-up interventions required	33	2.5%
	Follow-up interventions completed	12	36.4%
Substance Misuse	Follow-up interventions required	70	5.3%
	Follow-up interventions completed	11	15.7%

Source: Public Health Team, Thurrock Council

It is unclear why so many people completing the health check were not asked about illicit drug use or the reason why the GP follow up rate is so low. It is possible GPs have not coded their response correctly such as a referral to IVT or specialist advice. However, from the IVT data it is

clear that in 2020/21 in total (i.e., not just people with severe mental illness) there were fewer than 5 referrals for drug misuse and a total of 5 referrals for alcohol misuse.

7.7.5 Adult mental health services: barriers, enablers, and gaps

The working relationship between the adult mental health services and the drug and alcohol services is good, however, there are some barriers to enabling the best outcomes for people. Despite IVT staff being open to new ways of working, the limitations of the SLA mean that sometimes they are not able to offer the support they would like to. For example, when someone is referred but does not want to engage with the drug and alcohol service there is little else, they are able to offer to foster future possible engagement. Another limitation is that data collection systems differ between IVT, primary care and mental health services, so the data cannot be readily linked making it difficult to obtain an overview of a person's health, care, and wellbeing activity. It is also difficult for the services to coordinate efforts for joint assessments as waiting times in the mental health services are considerably longer than in the drug and alcohol service.

Due to the substantial proportion of people with co-occurring conditions there was a suggestion that each team explore training in each other's specialist area, for example mental health training around working with people who have had trauma or are a suicide risk and drug and alcohol training in areas that would be helpful for the mental health team.

Some other parts of the population are underrepresented in the mental health and drug and alcohol misuse services. People from the black and minority communities and people from the travelling community are less likely to present to services due to stigma and the perception that services are not tailored for their needs or understand their culture.

The mental health team reflected on the issues that had risen during the pandemic which were primarily about people presenting with acute mental health difficulties who were new to the service. Prior to the pandemic, if people required admission for a mental health problem they are often known to the service and there was an understanding of the problem and the usual trajectory of the episode. However, during the pandemic admissions were needed more frequently for people with no prior history known to the services. This was challenging when people were misusing drugs and alcohol and suddenly had no access to it on the ward resulting in a risk of abuse of staff and other patients.

As the integration of services into systems continues to be implemented, it will be possible to build stronger relationships with all the relevant services. This will help the drug and alcohol teams to develop further their outreach service to people in the community and in reach services to those in other settings when they need support.

7.8 Thurrock Housing and Homeless Service

The Thurrock Housing Strategy 2022-2027 aligns with other key council strategies including the Health and Wellbeing strategy 2022-2026, Better Together Thurrock the case for further change (adult health and care) and the Brighter Futures Strategy (children and young people's health and care). With a focus on integration, the housing strategy has reframed the approach to support households interacting with the council, to move away from dealing with issues in isolation by disconnected teams, to develop a strengths-based 'whole person' approach. This connects the wider system of adult social care, children's services, public health, NHS teams, voluntary and faith sector, and other assets within the community. The council have also developed a housing resident engagement strategy which ensures the establishment meaningful engagement with residents in the future based on resilient and respectful partnerships formed between the housing department and those who access the services.

The Housing Strategy 2022-2027 also incorporates the previously developed Homelessness Prevention and Rough Sleeping Strategy (2020-2025). There are four strategic priorities focussed on health and wellbeing, partnership and collaboration provision and accessibility and customer excellence. The Housing Strategy 2022-2027 aims to:

- Redefine and simplify pathways for vulnerable households to access health and wellbeing services across the borough, especially in relation to mental health
- Increase awareness of the physical impact of homelessness and work with partners to improve access to primary care services for those experiencing rough sleeping
- Explore opportunities to deliver improved services to armed forces veterans who are homeless or at risk of homelessness
- Review and revise the existing joint protocol for supporting those at risk of homelessness as a result of fleeing domestic and sexual abuse

The housing services are provided to adults, including young care leavers. The advice and support cover tenancy management, problems with anti-social behaviour, safeguarding, sheltered housing, hostels, and temporary accommodation. The team carry out homeless assessments, rent collection, leasehold management, repairs, and resettlement support to applicants.

Agencies within Thurrock have identified a cohort of individuals who have mental illness, and or behavioural challenges, which despite multiple attempts, have not achieved improved outcomes or stability using mainstream statutory services. In the majority, if not all of cases the individual has a diagnosed mental illness, high usage of multiple statutory services, behaviour that causes disruption to their local community, inability or unwillingness to acknowledge and act upon the impact that their behaviour has on others, and present a risk to themselves and along with distressed (usually described as challenging) behaviour that negatively impacts their quality of life, and the ability of all agencies to meet their needs within the mainstream service offer. Anecdotal evidence from frontline workers in mental health services, housing, the police, and adult social care all indicate the individuals are people who require a different approach to the current options available and/or the current practice applied. The risks associated with their needs remaining unmet are significant to the individual due to increased vulnerability to sanctions e.g., criminal or eviction, the community due to anti-social behaviour, disproportionate use of services reducing capacity and statutory services due to the risk of harm to individuals and ongoing ineffective use of resources. All agencies involved are keen to avoid punitive measures and develop a new approach to providing care, support, and treatment in the community.

There are currently two pilot initiatives in development based in the Housing department managed by the Strategic Lead for Housing Operations. One is focussed on people living in supported accommodation (Supported Living Plus) and the other focussed on those living in social or council accommodation (Housing First). Adults with complex needs who are unlikely to engage with services are in many cases, in contact with housing officers and they may be the first person who can see that immediate support is needed. This immediate support is not always available if there are thresholds the person has to meet before they can access the relevant services. Both the Supported Living Pilot and Housing First pilots will access a multi-disciplinary personalised support team to meet the requirements of individuals irrespective of their formal diagnosis or willingness to engage with statutory services. The team will be a small, multi-disciplinary and highly specialised in their field, who will bring together expertise to devise bespoke high intensity support and care plans. They include a clinical psychologist lead, specialist mental health housing officer, a substance misuse outreach worker, and a local area coordinator

They will work closely with the Adult Mental Health Social Work Team, Community Led Support Teams, Local Area Coordinators, local Police, the Older People's Mental Health Team, the Community Mental Health Team, and all other agencies that are relevant to providing support to the individual. The aim is to meet the need of the individual in an adequate and timely way, whilst reducing the anticipated service costs, such as the likelihood of a failed tenancy, multiple calls to emergency services and deteriorating physical and mental health.

There is a Housing Mental Health and Homelessness Forum which works with a range of partners including IVT. It provides an opportunity for colleagues to network and explore opportunities to discuss concerns and identify opportunities to support residents and colleagues.

The table below shows the housing situation for people entering drug and alcohol misuse treatment from 2015/16 to 2020/21. Just prior to the pandemic (2019/2020) the proportion of people with a housing problem (10%) entering treatment was within the range the previous four years (range 9-17%) whilst those with an urgent problem (10%) were the highest for the same period (range 5-10%). Over the first year of the pandemic the proportion with a housing problem was again similar to previous years (9%) whilst those with an urgent problem had dropped to the lowest over the previous five years due to the government policy of supporting people into accommodation during the pandemic.

Table 63: Housing situation for new presentations entering treatment, 2015/16 to 2020/21

Housing Situation	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
No Problem	355 (83%)	300 (78%)	135 (66%)	235 (82%)	170 (80%)	150 (88%)
Housing Problem	40 (9%)	65 (17%)	20 (10%)	35 (12%)	20 (10%)	15 (9%)
Urgent Problem (no fixed abode)	30 (7%)	20 (5%)	15 (7%)	15 (5%)	20 (10%)	5 (3%)
Other	5 (1%)	0	0	0	0	0
Unknown	0	0	35 (17%)	0	0	0
Total	**430**	**385**	**205**	**285**	**210**	**170**

Source: NDTMS ViewIt Adults

A comparison between Thurrock and England of accommodation status for people entering drug treatment shows they are similar with around 15% of people with housing difficulties in 2020/21 (Table 64).

Table 64: Accommodation status of adults in drug treatment at the start of treatment, for Thurrock and England, 2020-21.

Housing Status	Thurrock (n)	Proportion of new presentations	England (n)	Proportion of new presentations
Urgent problem (No Fixed Abode)	5	5%	6,308	8%
Housing Problem	15	15%	11,244	14%
No housing problem	81	79%	60,244	77%
Other	0	0%	31	0%
Missing / Incomplete	<5	N/A	443	1%

Source: Adult Drug Commissioning Support Pack 2022/23

For those entering treatment for alcohol misuse there are far fewer housing difficulties reported in both Thurrock (1%) or England (10%) than for those entering drug treatment (20% and 22% respectively). Table 64 shows that in Thurrock approxamitely 1% of people had housing problems and no one had an urgent problem, whilst in England 7% a housing problem and a further 2% had an urgent issue.

Table 65: Accommodation status of adults in alcohol treatment at the start of treatment for Thurrock and England, 2020-21

Housing Status	Thurrock (n)	Proportion of new presentations	England (n)	Proportion of new presentations
Urgent problem (no fixed abode)	0	0%	1,055	2%
Housing Problem	<5	~ 1%	3,886	7%
No housing problem	68	99%	46,983	90%
Other	0	0%	<5	~ 0%
Missing / Incomplete	0	0%	295	1%

Source: Adults Alcohol Commissioning Support Pack 2022/23

7.8.1 Housing and homelessness services: barriers, enablers, and gaps

The partnership working between housing, mental health services and drug and alcohol services is important as currently there is a gap in how services work together to identify and support residents in need. It is hoped the pilot initiatives Housing First and Supported Living Plus will lead to more opportunities for joint working with mental health and the drug and alcohol services. Sharing of information and improving communication between teams, would be beneficial, for example:

- Helping housing officers to understand the drug and alcohol treatment service referral process
- Upskilling housing officers in the areas of criminal justice
- Knowing the support available from family social workers
- For staff with housing duties understanding alcohol and drug awareness and harm reduction approaches would be helpful in order to directly support residents

There have been occasions when it has not been possible access support through the IVT single point of contact and as the system becomes more integrated it will be important to ensure there is an easy communication flow. Ideally, the housing department would benefit considerably by having someone from the drug and alcohol team co-located with the team to provide support and guidance. In addition, understanding how joint solutions will work practically with case studies would support the change in the way of working.

For people who are homeless with co-occurring conditions who have not ever engaged with services, it is challenging as health is not their highest priority. Many of this group visit the soup kitchen regularly at a particular time each week and that might be a key place for services, including drug and alcohol services to meet with people and informally build relationships. However, it is important to recognise that this is 'their' space and that they have some say in how and when services enter it.

7.9 Thurrock Probation Service

The CSP have a statutory duty to assist with reducing reoffending which is one of the CSP action plan priorities for 2022/23. Partners such as the police, probation and IVT work together to support offenders to make changes in their lives which lead to a change in behaviour. A high proportion of people who reoffend are misusing substances at the time of the offence or offending to fund their need for drugs and alcohol. Of those entering treatment in 2021, 47% of people with opiate misuse, 43.4% with non-opiate misuse, 40.6% of people with combined alcohol and non-opiate misuse and 22.7% of people misusing alcohol were recorded as committing an offence in the previous two years.

The probation service work with people on their caseload who have court mandated requirements or who have been identified as needing support with alcohol or drug misuse. The probation service delivers some of the interventions around attitudes and thinking behaviour while IVT deliver other interventions such as treatment. IVT will provide the drug rehabilitation requirements for people whose offending is linked to drug and alcohol misuse. In the pre-sentence period people need to agree to engage with IVT and this condition becomes part of their community service. There is information exchange between probation and IVT including results of drug testing, in addition to reporting on engagement with treatment. For offenders with alcohol misuse issues and dependency there is no testing. In addition, some people who leave prison on license will have a special condition of their release to engage in drug rehabilitation. In these cases, referrals to IVT can be made pre-release to ensure they can access services as soon as possible following release.

Table 66 shows the proportion of those in treatment who were in contact with the criminal justice system in 2021/22 in Thurrock and in England. The proportions of those in Thurrock are similar to England for Opiate and non-opiate substance types but are 0% for alcohol and alcohol plus non opiate for Thurrock compared to 6.5% and 11.7% for England.

Table 66: Proportion of the treatment population in contact with the criminal justice system

Substance Category	Latest period 2021/22		National Average
	%	n	
Opiate	12.9%	19/147	18.5%
Non-opiate	N/A	<5/31	11.1%
Alcohol	0.0%	0/<5	6.5%
Alcohol and non-opiate	0.0%	0/6	11.7%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22

Table 67 below shows the proportion of people released from prison with a substance misuse treatment need who successfully engaged with community based structured treatment on release. Overall, the proportion is greater in Thurrock (60%) than for England (37.3%).

Table 67: Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison

	Latest period 2021/22		National Average
	%	n	
Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	60.0%	12/20	37.3%

Source: Diagnostic Outcomes Monitoring Executive Summary (DOMES) Report Q4 2021/22 Latest period: 01/01/2021 to 31/12/2021

7.9.1 The Probation Service barriers enablers and gaps

The relationship between IVT and the probation service is very good with someone from the probation service spending a day a week co-located with IVT. This is helpful for joint planning, exchanging information and simplifies things for people on probation. The probation service has limited office space, so it is not possible to have people co-located on their premises.

There is always an inherent tension between people who have an enforcement mentality and people who want to provide multiple opportunities to improve and change. The perception is that it can be difficult to get the balance right and judge when someone has insight into their own behaviour and is willing to change versus ticking the boxes to avoid further penalties.

There is a long-standing trend of decreasing numbers of community sentence treatment requirements for engagement in drug, alcohol, or mental health treatment services. Those

numbers are reducing partly as a consequence of the rehabilitation activity requirement having been introduced. This is a generic requirement which is broad and easier to use rather than having a specific assessment for a specialist intervention at the pre-sentence stage. Data indicates there are more Class A drug users and problematic drinkers than the number of people with court mandated treatment requirements. It may be an erosion of trust about whether community orders work so there may need to be some work showing how it can make a difference to reoffending and the seriousness of reoffending.

It is important that there is an increase in the number of people coming through the courts who are treated for alcohol and substance misuse. In order to do this more members of staff are needed and an improvement in the understanding of how community orders work for those sentencing offenders.

There is a dearth of data about the adult probation service, so it is difficult to understand the needs of offenders. Having a systematic way of collecting information in relation to people with co-occurring conditions in the criminal justice system would be very helpful.

Better premises would be beneficial for co-location and cross agency working and mentoring. This would be useful especially for people with co-occurring conditions who would benefit from the support alongside the social navigator service.

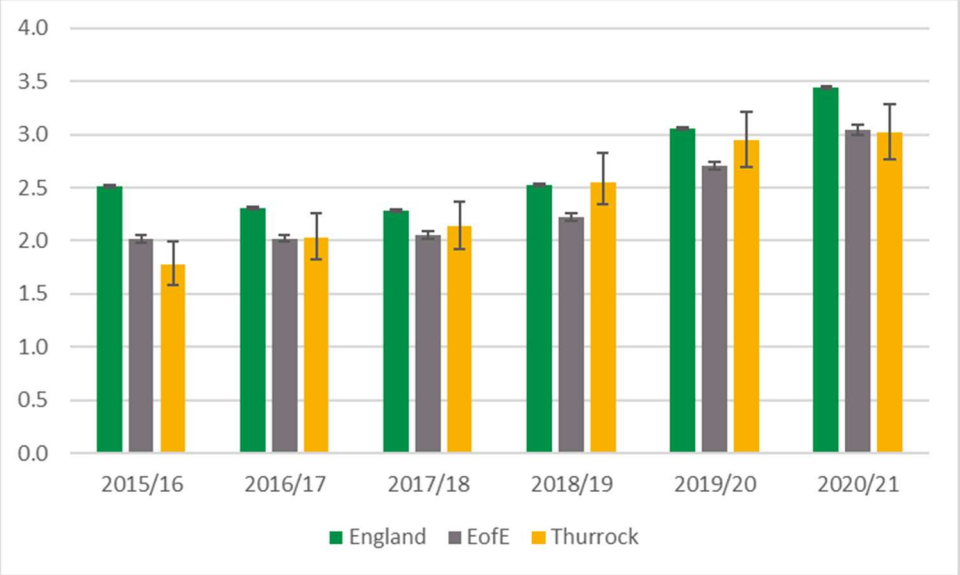
7.10 Essex Police

The Essex police and crime plan 2021-2024 outlines how they aim to work with local partners to deliver a more effective strategy so more people enter treatment and recover from alcohol and substance misuse. This entails improving the accessibility of addiction and substance misuse services, improving the criminal justice journey of addicted offenders, and working with partners to intervene when the early signs of addiction or vulnerability are spotted.

Essex police and IVT work together to identify people who may benefit from receiving support to manage drug and alcohol misuse. For example, a Blue Light Project worker sits on Locality Action Groups with a focus on anti-social behaviour. The project worker will carry out joint visits with the Anti-Social Behaviour team or Local Area Coordinators in order to engage with people. IVT community connectors have also been part of the ‘Safer Streets’ project including a focus on Grays High Street where a public space protection order bans drinking in order to reduce anti-social behaviour. At the launch of the project IVT, visited Grays High Street, built relationships with other members of the enforcement team, and talked to people who would have been ticketed for breaching the protection order and were asked to visit the nearby IVT offices with enforcement officers instead.

IVT are also currently working with the police to be able to visit people in custody following an offence who are identified as likely to benefit from IVT support.

Figure 43: Rates per 1,000 for drug offences, Thurrock compared to East of England and England, 2015/16 to 2020/21



Source: Home Office – Police recorded crime

Figure 43 shows the rate per 1,000 population of police recorded drug offences in Thurrock increased from around 1.7 per 1,000 population to 3.0 per 1,000 population. Drug crime rates per 1,000 population have also increased in the East of England region and in England over this period, but Thurrock has seen a slightly bigger increase over this time period.

7.10.1 County lines

The gangs and organised criminal networks exporting illegal drugs in and around Thurrock known as County Lines (because they use mobile phones as their deal line) has been described in two recent reports; the 2019/20 annual report by the Director of Public Health - Youth Violence and Vulnerability: the crime paradox and a public health response; and the Children's partnership strategy for 2021-2026 - Brighter Futures: developing well in Thurrock.

The Brighter Futures strategy draws heavily on the 2019 annual public health report which includes young people aged 10-24, spanning the transition period between the young people and adults' substance misuse treatment services. There are a range of risk factors predictive of someone becoming involved with serious youth violence and gang involvement, including family dysfunction, individual behaviour or cognitive issues, exclusion from education, criminality, and substance misuse.

Thurrock's proximity to London, transport links and comparatively lower rent has resulted in displacement of gang associated children and adults into the borough from the capital. There has been a 33% increase from 2017/8 to 2018/19 reported by the Gang Related Violence Operational Group. With this increase there has been a shift in ethnicity with an increase from 19.1% to 28.4% of people who are white gang members between 2017/18 and 2018/19 with a concomitant 10% decrease in the proportion of Black/Black British gang members from 66.7% to 56.8% respectively.

There is limited data available to understand the full connection between youth violence, gangs, and drugs as there is no linked data set between the Youth Offending Service, drug treatment services and police data.

As a proxy for the trend in gang related crime and trafficking, Table 68 shows the number and proportion of children in need assessments which indicated some involvement between 2018 and

2021. Trafficking is recorded where a child is moved for reasons of exploitation whether or not the child has been deceived. Involvement in gangs is recorded where a child is part of a street or organised crime gang for whom crime and violence are a core part of their identity. The proportion of children recorded in gangs varies between 2.9% and 3.7% of all children in need assessments whilst trafficking is recorded in 0.7% to 1% of cases. Despite the proportions of children identified as being involved in trafficking or gangs through the assessments being similar across the years, the number of assessments undertaken has more than doubled and the number of cases increased by 70%.

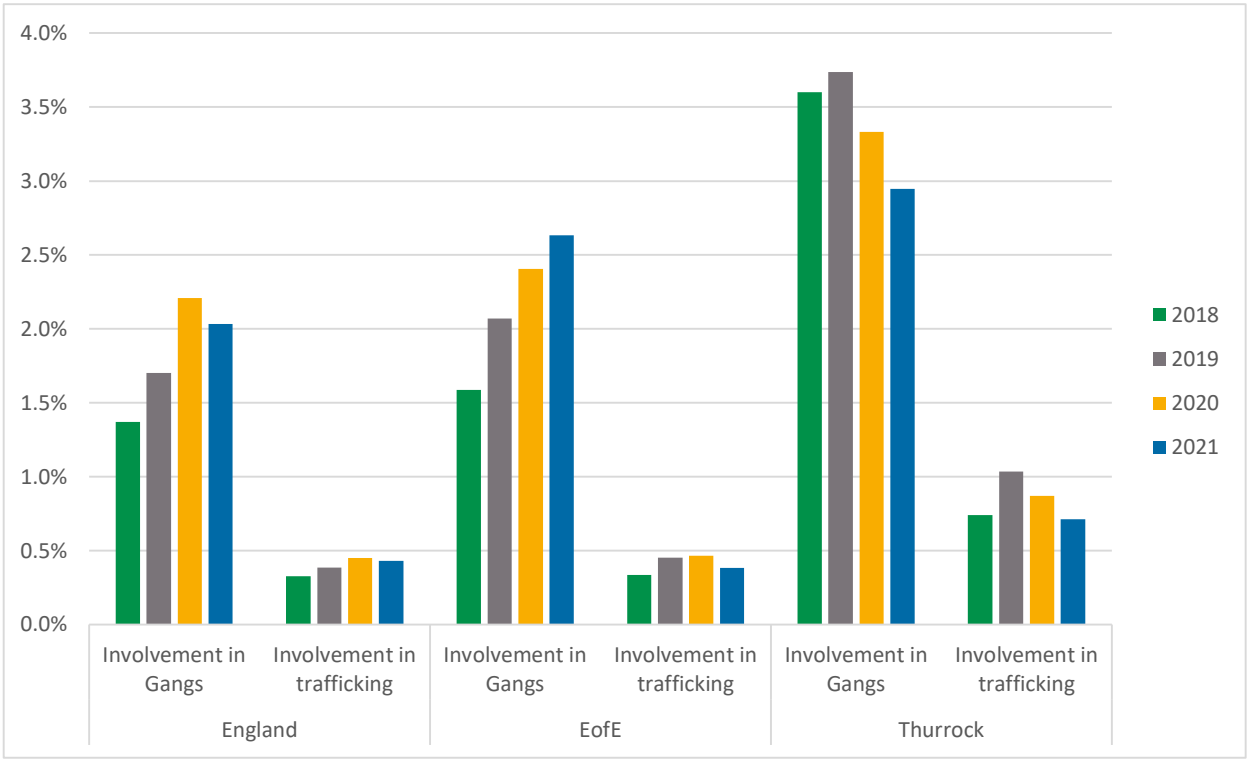
Table 68: Number and proportion of Children in Need assessments highlighting involvement in gangs or trafficking in the household as a factor for Thurrock, 2018 to 2021

Year	Number		Percentage of Assessments	
	Involvement in Gangs/total No assessments	Involvement in trafficking/total no assessments	Involvement in Gangs	Involvement in trafficking
2018	73/2,027	15/2,027	3.6%	0.7%
2019	119/3,216	33/3,216	3.7%	1.0%
2020	134/4,060	35/4,060	3.3%	0.9%
2021	124/4,276	30/4,276	2.9%	0.7%

Source: Department for Education. Children in Need Statistics. Characteristics of Children in Need, 2020/21

Figure 44 compares the Thurrock figures for the proportion of children in need assessments reporting gangs or trafficking involvement with East of England and England. Overall children in need assessments for Thurrock report a higher involvement in gangs than the East of England region or England for all years from 2018. Trends in proportions of children in need assessments recording trafficking involvement for Thurrock are also higher for all years than the East of England or England.

Figure 44: Proportion of Children in Need assessments citing involvement in gangs or trafficking as a factor, Thurrock, East of England, and England, 2018 to 2021



Source: Department for Education. Children in Need Statistics. Characteristics of Children in Need, 2020/21

The total number of people with police recorded crimes relating to drugs between 2015/16 and 2020/21 is shown in Table 69. The number of recorded crimes for drug trafficking has more than doubled since 2015/16 as has possession of cannabis, whereas possession of controlled drugs excluding cannabis has fallen from 21% to 9% of total drugs offences over the same period.

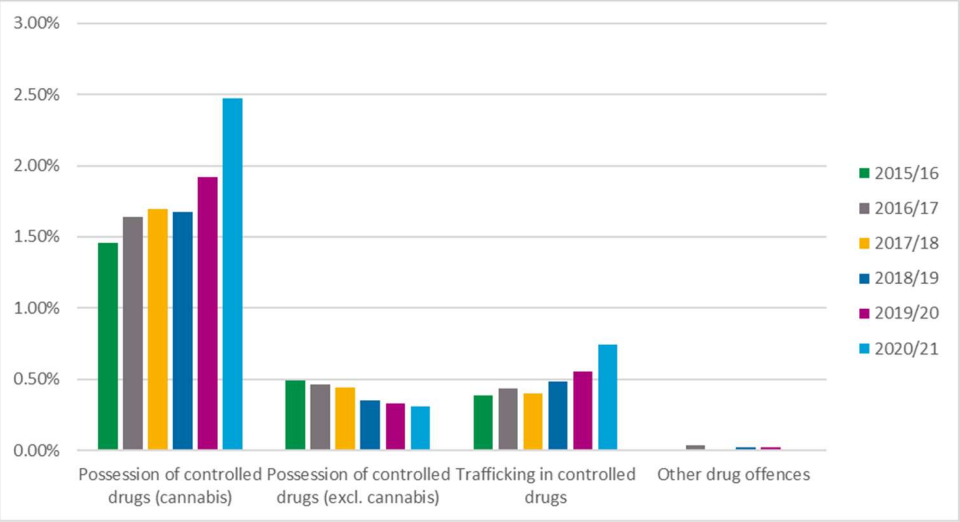
Table 69: Number of police recorded crimes relating to drugs, 2015/16 to 2020/21

Total Number of Police Record Crime Related to Drugs, all Thurrock						
Type of Drug Offence	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Possession of controlled drugs (cannabis)	181	214	243	289	346	369
Possession of controlled drugs (excl. cannabis)	61	60	63	61	59	46
Trafficking in controlled drugs	48	57	57	84	100	111
Other drug offences	0	5	1	3	4	1
Total	**290**	**336**	**364**	**437**	**509**	**527**

Source: Home Office - Police recorded crime

Figure 45 shows more clearly the change in the proportions of drug offences as a percentage of total recorded crime between 2015/16 and 2020/21.

Figure 45: Trend in number of drug related offences, 2015/16 to 2020/21



Source: Home Office - Police recorded crime

Figure 45 shows that cannabis possession has accounted for an increasing proportion of total recorded crime in Thurrock since 2015/16. In 2015/16 cannabis possession accounted for just under 1.5% of all crime in Thurrock but this increased to nearly 2.5% during 2020/21. In contrast possession of controlled drugs other than cannabis has declined since 2015/16. Trafficking in controlled drugs offences have increased in Thurrock since 2017/18 but still account for less than 1% of total crime.

Thurrock Council has set out the strategic approach to address the challenge of increasing County Lines activity in the Brighter Futures children's partnership strategy. The aims focus on both universal population-based approaches and targeted mechanisms to support people to make different life choices. The key strategic aim involving the drugs and alcohol teams includes creating a locality based multi-disciplinary panel that can address risk factors strongly associated with serious youth violence and gang involvement by:

- Sharing intelligence across stakeholders from children's social care, health providers, Brighter Futures, young people and adult drug and alcohol treatment services, education, schools, community safety, housing, the police, local area coordinators and relevant third sector organisations
- Undertaking rapid operational action to reduce and mitigate risks through enforcement activity, community development, estates management
- Addressing identified drug availability/dealing within neighbourhoods
- Further develop surveillance to identify the most at-risk children and families and intervene with tailored intervention packages
- Deliver targeted and tailored primary prevention for populations of greater need

Current activity where IVT and the police collaborate include advice sought from IVT about vulnerable people identified by Essex Police via Operation Raptor. Typically, this group of vulnerable people are used by gangs and supplied with drugs and alcohol whilst gang members take over their accommodation and finances (known as cuckooing).

A further initiative is Operation Cloud involving the police texting all contacts on burner phones associated with gang activity seized by police, advising people of alcohol and drug misuse support services available to them with the message; 'Your drug supply has been cut have you thought about now's a good time to enter treatment'. It is unclear as yet whether this has resulted in people engaging with either the children's and young peoples or adult substance misuse services.

7.10.2 Essex Police; barriers, enablers gaps

There are very good working relationships between IVT and the police in relation to gang related violence and anti-social behaviour. The collaboration between the police, probation and IVT around the integrated offender management programme is also working well with consistency across the county.

Further collaboration in line with Thurrock's strategic aims such as the development of a reporting mechanism to capture intelligence about dealers and other criminal activity associated with drugs and alcohol is important. This was especially noted by the Trading Standards team who consider that they would benefit from understanding the areas where alcohol is not being sold appropriately which would support investigative work and a coordinated response. Further targeting of drug dealers' customers would also be beneficial.

A systematic collection of information about the initiatives implemented has been suggested to evaluate which approach works best to achieve Thurrock's strategic aims. Other suggestions included supporting people coming out of prison by determining the best way to help them move away from the environment and the circumstances that drew them into offending in the first place. This could be a central rehabilitation facility that people could go to after prison to be treated for substance misuse and mental health issues, where they could work through housing and employment needs.

7.11 Thurrock Council Violence Against Women and Girls (VAWG)

Members of the Thurrock Community Safety Partnership led by the Violence Against Women and Girls (VAWG) coordinator have developed a strategy informed by local priorities and Southend, Essex, and Thurrock Domestic Abuse Board[63] for 2020-2023. The strategy focusses on the following types of VAWG:

[63] Southend Essex and Thurrock Domestic Abuse Board Strategy 2020-2025

- Sexual violence abuse and exploitation
- Stalking
- Sexual harassment
- Modern day slavery and human trafficking
- Domestic violence and abuse
- Female genital mutilation
- Forced marriage
- 'Honour' based abuse

These issues disproportionality affect women and girls although the VAWG strategy[64] includes men and boys who also experience harm.

Alcohol and drug misuse increase the likelihood and severity of domestic violence and abuse and there is a frequent co-existence between them. Perpetrators are more than likely to have been drinking at the time of assault and women who have experienced extensive physical and sexual violence are more than twice as likely to have a problem with alcohol than those with little experience of being abused[65,66]. Victims can be turned away from refuges due to their alcohol needs, with only 26% of refuges reporting that they "always" or "often" accept women who use alcohol or other drugs.[67] In addition, the harm for children witnessing domestic abuse or experiencing it themselves is significant. Around 37% of cases where a child was seriously hurt or killed between 2011 and 2014 involved parental alcohol use as a documented factor.[68]

The Domestic Abuse Act in 2021 introduces a new statutory duty on local authorities to ensure people who have experience domestic abuse and reside in refuges have their needs met including support from drug and alcohol misuse services.

In Thurrock both IVT and the CYP drugs and alcohol service are members of the VAWG Strategic Board. Drug and alcohol support was identified as a need for residents of Refuge in the recently completed statutory domestic abuse needs assessment. This resulted in a new relationship between IVT and Refuge staff, with group sessions planned and a view to hold a drop-in service in the future.

7.11.1 VAWG: barriers, enablers, and gaps

Despite being in the very early stages of strengthening the relationship between VAWG and IVT it is working well.

It's important to improve collection and linkage of data where people have revealed they are a perpetrator and there are children and women in refuge. This could initiate a whole family approach to support.

Other areas to focus on in the short to medium term include:

- Ensuring there is broad communication of how the referral process works
- Ensure staff working with women are trained and used to working effectively with people with trauma

[64] Thurrock violence against women and girls' strategy 2020-2023
[65] Home Office (2020) Domestic abuse - draft statutory guidance framework.
[66] Women's Aid, the nature and impact of domestic abuse
[67] Against Violence and Abuse (2014) Case by Case: Refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems, p.17
[68] Department of Education (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014

- Continue to strengthen the relationship with the Children and Young People's substance misuse service which was also identified as an action in the Thurrock domestic abuse HNA
- Work with services to plan how to collect data which could be used to see how the service was being used

Ideally, there would be further investment into specialised support in the refuge for drug and alcohol users which would cover those with co-occurring conditions and complex needs. People are likely to hide their drug or alcohol habit if they know they cannot stay at the local refuge, and yet there needs to be adequate safeguarding strategies in place for all the residents.

7.12 Thurrock Youth Offending Service (YOS)

The youth offending team become involved with a young person up to the age of 18 if they are arrested by the police, are charged with a crime involving a court appearance or are convicted of a crime and given a sentence. The Thurrock YOS is based in Corringham, close to the town centre. It is fully staffed with experienced permanent workers and a number of seconded staff from the Probation Service, Inspire Youth, Children and Adolescent Mental Health Services (CAMHS), Drug and Alcohol Service, Essex Police and Speech and Language Therapists. The Team also has a specialist Gangs and Child Exploitation Worker, who works alongside Children's Social Care

The work of Thurrock YOS set out within their strategic plan for 2021-24 is directly linked to the priority to reduce overall levels of crime and anti-social behaviour in line with the local Community Safety Partnership targets. There is also a close alignment to the local Public Health plan around reducing violence and vulnerability.

Young people are screened for drug and alcohol misuse and those that require support will be referred to the children and young people's substance misuse service who are co-located with them in Thurrock.

7.12.1 Youth Offending Service: barriers, enablers, and gaps

Currently the challenge for the YOS is that the one co-located worker for the children's substance misuse service has been absent due to sickness. Usually, referrals are very straightforward and the YOS reported a very good relationship with the Children and Young People's Substance Misuse Service which met the needs of the young adults referred to them. Young people did not always engage with the service as some do not perceive they have a problem, but they are offered support if they are ready to change their behaviour.

The YOS does not routinely link with IVT and people who are aged 18 may continue to be under the children's and young people's service despite this service only being commissioned to support those up to the age of 17. The reluctance to transfer people to the adult service is partly due to a perception that:

- They would be supported more appropriately by the children's service due to their level of maturity
- The adult service is structured differently and most young adults entering the service would receive limited treatment for less complex drug and alcohol misuse which might not meet their whole needs
- There is a view that young adults would not be seen quickly due to waiting list length

No priorities or preferences about changes to the service were suggested.

7.13 Thurrock Individual Placement Support Service

The charity Open Road is currently commissioned by Thurrock Council to support people back into work who were referred to IVT for support. Two workers from Open Road are co-located with IVT and work with people who are not in work, but keen to get back into employment. They need to show motivation and commitment to work with the employment specialist who makes connections with employers and offers benefits counselling. This is a new one-year pilot which will then be evaluated.

Tables 70 and Table 71 show the employment status of adults at the start of treatment for drugs and alcohol respectively compared to England in 2020/21. A higher proportion of people were in employment who were treated for alcohol misuse in Thurrock (41%) compared to those receiving drug treatment (33%) and both these proportions were higher than for England (drugs =21% alcohol = 36%).

Table 70: Employment status of adults in drug treatment at the start of treatment, for Thurrock and England, 2020-21.

Employment Status	Thurrock		England	
	Total adults	% New presentations	Total adults	% New presentations
Regular employment	34	33%	16,590	21%
Unemployed / economically inactive	52	51%	39,349	50%
Unpaid voluntary work	0	0%	106	0%
Long term sick or disabled	11	11%	16,132	21%
In education	<5	N/A	779	1%
Not stated / missing	<5	N/A	4,324	6%
Other	<5	N/A	990	1%

Source: Adult Drug Commissioning Support Pack 2022/23

Proportions of people who were unemployed or economically inactive were very similar in Thurrock and England for drugs (51% vs 50% respectively) and alcohol (both = 41%).

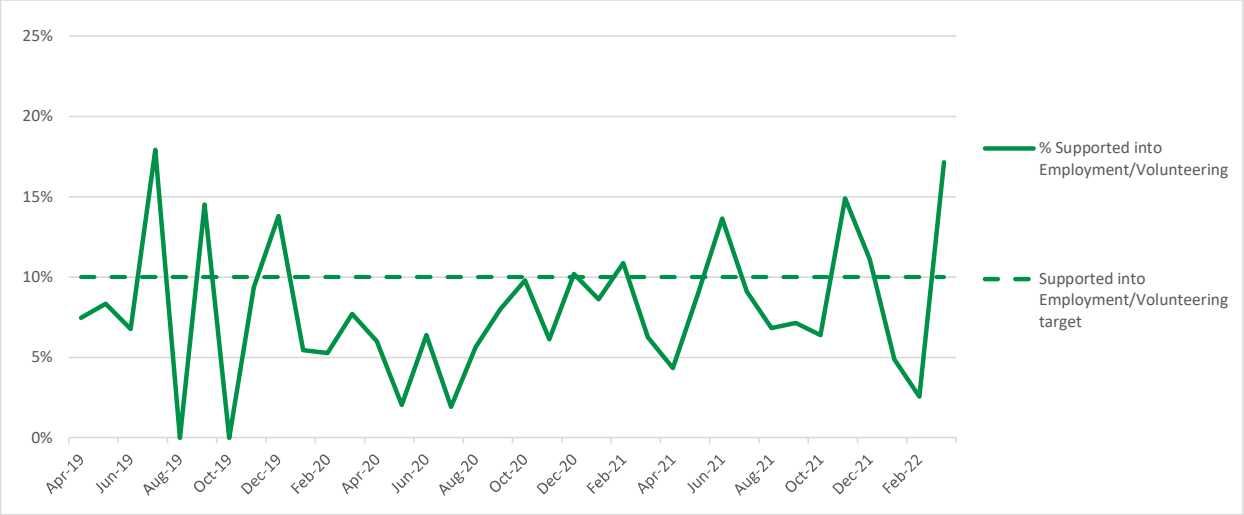
Table 71: Employment status for alcohol only adults at the start of treatment for Thurrock and England, 2020-21

Employment Status	Thurrock Total adults	Thurrock (%)	England Total adults	England (%)
Regular employment	28	41%	18,793	36%
Unemployed / Economically inactive	28	41%	21,436	41%
Unpaid voluntary work	<5	N/A	121	0%
Long term sick or disabled	11	16%	9,278	18%
In education	0	0%	355	1%
Other	<5	N/A	646	1%
Missing / Incomplete	0	0%	1,591	3%

Source: Adults Alcohol Commissioning Support Pack 2022/23

The figure below shows the proportion of people who have been supported into employment of those who were eligible to receive support since August 2019. This shows variable success at meeting the target of getting 10% people into work prior to the Open Road support worker co locating with IVT (February 2022). It is hoped that there will be a sustained increase in people supported into work as the pilot continues.

Figure 46: Percentage of service users eligible for employment/volunteering support successfully entered into employment/volunteering



Source: Inclusion Vision Adults Drug and Alcohol Service Key Performance Indicators 2019/20 to 2021/22

7.13.1 IPS service: barriers, enablers, and gaps

This service has only been in place for a few months, so it is unclear how effective it will be. People must be ready to work mentally and physically and be prepared to put considerable effort in working with Open Road to secure a job. This requires confidence in understanding the strengths and limitations of their own skills and the ability to communicate those effectively. There were no reports available about the planned and actual interventions carried out by Open Road and how much they are making a difference to people. Hopefully the evaluation planned for the end of the pilot will provide the information required about whether it is effective.

7.14 Working with Primary Care

With the move to integrated medical centres based on a PCN footprint outlined in Better Care Together Thurrock, it is planned that a whole range of services will sit alongside primary care including the drug and alcohol misuse treatment services. Currently GPs contact IVT if they need advice to support a patient, or to make a referral, but this is very infrequent. There is no primary care lead for drugs and alcohol misuse in Thurrock.

GP practices screen patients for alcohol misuse, often on joining the practice and then periodically and during NHS health checks. Table 72 shows the alcohol intake recorded following screening, for people with high alcohol consumption between July 2021 and June 2022 in Thurrock. Males accounted for over 70% of those with high alcohol intake, whether for units per week, units per day, and spirits per week. Those that score over 20 when screened with AUDIT-C have the highest risk of dependency and of those with this score 92% were male.

Table 72: Number of people screened in Thurrock between July and 2021 and June 2022 with higher levels of consumption

Units of alcohol per person	Male	Female	Total
>14 units per week	818 (73%)	308 (27%)	1,126
>2 units per day	137 (70%)	58 (30%)	195
>14 units a week and >2 a day	74 (71%)	30 (29%)	104
Spirits intake >14 units per week	8 (100%)	0 (0%)	8
AUDIT C score of >20	47(92%)	4 (8%)	51

Source: Thurrock CCG, GP practice data

Table 73 shows the numbers of people screened who were recorded with higher levels of alcohol consumption by PCN. It is unknown the total number of screens completed for each PCN. Grays has the highest number of people recorded as consuming over 14 units of alcohol per week, over two units of alcohol per night, over 14 units of spirits per week and those with an AUDIT C score of over 20. Either GP practices in Grays PCN have been screening much higher numbers of people in total, which would lead to identifying a higher number of people with increased alcohol consumption, or there are more people in Grays who consume higher levels of alcohol. It may be a combination of both factors especially as there has been problems with anti-social behaviour linked to drinking in public leading to a ban on consuming alcohol on Grays High Street.

Table 73: Numbers of patients recorded as having higher levels of alcohol consumption for following screening by Thurrock GPs between July 2021 and June 2022

PCN	>14 units per week	>2 units per day only	>14 units a week and >2 a day	Spirits intake >14 units per week	AUDIT C score of >20
Grays PCN	371	40	33	5	31
Aveley, South Ockendon and Purfleet (ASOP) PCN	283	20	12	3	11
Stanford le Hope and Corringham PCN	329	16	40	0	3
Tilbury and Chadwell PCN	184	15	19	0	6
Total	**1,177**	**91**	**104**	**8**	**51**

Source: , Thurrock CCG, GP practice data

Once people have been identified as consuming higher levels of alcohol there are a range of different types of interventions open to GPs. These include lifestyle advice, health education about alcohol, brief interventions, and referral to specialist treatment service.

Table 74 shows the number of patients in Thurrock who received alcohol education through their GP practices and referral to specialist treatment services between July 2021 and June 2022. Nearly 40% of people were offered lifestyle advice whilst nearly 15% received brief interventions for excessive alcohol consumption.

Table 74: Number of patients receiving different types of alcohol misuse intervention in Thurrock between July 2021 and June 2022

Alcohol intervention	Thurrock all ages	Thurrock (%)
Health education – alcohol	302	19.2%
Advice on alcohol consumption	327	20.6%
Patient advised about alcohol	101	6.4%
Lifestyle advice regarding alcohol	608	38.5%
Referral to specialist alcohol treatment service	6	0.4%
Brief intervention for excessive alcohol consumption completed	237	14.9%
Total	**1,581**	**100**

Source: Thurrock CCG, GP practice data

Table 75 shows the number of interventions by age group for those offered support of which the highest proportion came from the 45 to 54 age group (21.5%). In total of those receiving an intervention 54% were men. Of the six referrals for specialist treatment five were male, three were people aged 35 to 44, and one person was referred from each of the age groups, 45 to 54, 55 to 64 and 75 plus.

Table 75: Number of patients receiving alcohol intervention by age band for Thurrock between July 2021 and June 2022

Age bands	Number of patients	(%)
0-17	25	1.6%
18-24	75	4.7%
25-34	163	10.3%
35-44	213	13.5%
45-54	341	21.5%
55-64	320	20.2%
65-74	266	16.8%
75+	178	11.2%
Total	**1,581**	**100%**

Source: GP practice data, Thurrock CCG

The table below shows the number of interventions by PCN and the crude rate of interventions per 100,000 population for each PCN. The rates of interventions per population will be dependent on the number of screens carried out, whether all the interventions are recorded and differences in the alcohol misuse rates within each PCN footprint.

Table 76: Number of patients receiving alcohol intervention by Thurrock PCNs between July 2021 and June 2022

PCN	Number of patients	Registered population	Interventions Per 100,000 population between Jul 2021-Jun 2022
Aveley, South Ockendon and Purfleet (ASOP) PCN	275	40,372	681
Grays PCN	560	73,519	762
Stanford le Hope and Corringham PCN	418	32,744	1,276
Tilbury and Chadwell PCN	328	37,906	865
Thurrock	**1,581**	**184,541**	**857**

Source: Thurrock CCG, GP practice data

7.14.1 Prescribing

Prescribing in the community for drug and alcohol misuse is predominantly through IVT for opioid dependency and via the GP practice for alcohol dependency

There were only 18 prescriptions for methadone prescribed by Thurrock PCNs between April 2018 and March 2022 whilst IVT are currently prescribing medication for opioid dependency to 85 service users

In contrast GP practices prescribed 843 items to treat alcohol dependency between April 2018 and March 2022 and currently IVT are not prescribing any similar items. If GPs refer a patient to IVT for treatment they will continue with the prescribing role, however only 6 people were referred to specialist alcohol services between July 2021 and June 2022. Table 77 shows the items prescribed for alcohol dependency by PCN between April 2018 and March 2022.

Table 77: Prescribing PCN and number of items prescribed for alcohol dependency between July 2021 and June 2020

Prescribing PCN	Prescriptions for medications to treat alcohol dependency
Grays PCN	254
Aveley, South Ockendon and Purfleet (ASOP) PCN	480
Stanford le Hope and Corringham PCN	36
Tilbury and Chadwell PCN	70
Out of hours	2
Unknown PCN	1
Total	**843**

Source: GP practice data, Thurrock CCG

7.14.2 Primary care; barriers, enablers, and gaps

Primary care carries out a range of prevention activities focussed on screening for alcohol misuse, providing advice and brief intervention. Most people identified as being dependent on alcohol by a GP will be treated in primary care. Of 51 people identified as likely to be dependent on alcohol due to an AUDIT C score of over 20, around 6 were referred to specialist treatment services. In contrast IVT had 67 new referrals for alcohol misuse none of which were from primary care. Although primary care is focussing on prevention and IVT focusses on people with complex needs it will be helpful for the services to build stronger relationships when the integrated medical

centres are in place. In addition to alcohol misuse, IVT can also support GPs and patients with addiction issues with over the counter and prescription drugs. Currently the use of AUDIT C and the proportion of interventions offered to residents varies between the 4 PCNs. It is unclear if this pattern is a genuine reflection of the need in the population or whether there is scope for practices to focus on using the Making Every Contact Count (MECC) approach to the opportunistic delivery of healthy lifestyle conversations.

7.15 Working with Secondary Care

People requiring admission to hospital for alcohol and drug related problems will predominantly go to Basildon University Hospital, part of Mid and South Essex NHS Foundation Trust. Table 78 shows the hospital admissions for people over and under 18 years of age by PCN for:

- Admissions for wholly drugs attributable conditions
- Admissions with a primary diagnosis of drug related mental and behavioural disorders
- Admissions with a primary diagnosis of poisoning by drug misuse

This shows that there has been a considerable increase in the number of people with conditions wholly attributable to drugs and those with a drug related mental health disorder between 2018/19 and 2020/21 and a subsequent decrease in 2021/22.

Table 78: Number of drug related hospital admissions for those aged ≤17 and ≥18 years of age for 2018/19, 2019/20 and 2021/22

Admission type	PCN	Apr 2018 to Mar 2019		Apr 2019 to Mar 2020		Apr 2020 to Mar 2021		Apr 2021 to Mar 2022	
		≤17	≥18	≤17	≥18	≤17	≥18	≤17	≥18
Admissions for wholly drugs attributable conditions	Stanford le Hope and Corringham PCN	0	<5	<5	<5	0	8	0	<5
	Aveley, South Ockendon and Purfleet (ASOP) PCN	<5	5	0	12	<5	22	0	6
	Grays PCN	<5	6	<5	16	<5	33	<5	7
	Tilbury and Chadwell PCN	0	<5	0	5	0	22	0	7
	Thurrock	**<5**	**19**	**<5**	**40**	**<5**	**91**	**<5**	**26**
Admissions with a primary diagnosis of drug related mental and behavioural disorders	Stanford le Hope and Corringham PCN	0	0	0	<5	0	8	0	<5
	Aveley, South Ockendon and Purfleet (ASOP) PCN	0	<5	0	9	<5	22	0	6
	Grays PCN	<5	5	0	14	<5	33	0	7
	Tilbury and Chadwell PCN	0	<5	0	5	0	20	0	6
	Thurrock	**<5**	**14**	**<5**	**32**	**<5**	**86**	**<5**	**24**
Admissions with a primary diagnosis of poisoning by drug misuse	Stanford le Hope and Corringham PCN	0	<5	<5	<5	0	0	0	0
	Aveley, South Ockendon and Purfleet (ASOP) PCN	<5	<5	0	<5	0	0	0	0
	Grays PCN	0	<5	<5	<5	0	0	<5	0
	Tilbury and Chadwell PCN	0	<5	0	0	0	<5	0	<5
	Thurrock	**<5**	**5**	**<5**	**8**	**0**	**5**	**<5**	**<5**

Source: Thurrock Council based on coding from PHE Local Alcohol Profiles for England (LAPE)

Table 79 shows the hospital admissions for people over and under 18 years of age for:

- Admissions for wholly alcohol attributable conditions
- Admissions with a primary diagnosis of alcohol related mental and behavioural disorders
- Admissions with a primary diagnosis of poisoning by alcohol misuse

Overall, in Thurrock the number of alcohol related conditions and admissions for those with a co-occurring mental health and behaviour disorders were similar over the 4 years for those under 18 and over 17 years of age from April 2018 to March 2022. In 2018/19 people from Grays accounted for a much higher proportion of admissions (44%) for people with a primary diagnosis of alcohol related mental and behavioural disorders compared to the other 3 PCNS. By 2021/22 although the numbers of people in Thurrock with this type of admission remained similar the split by PCN had changed with three of the four PCNS with similar numbers of admissions.

Table 79: Number of alcohol related hospital admissions for those aged ≤17 and ≥18 years of age for 2018/19, 2019/20 and 2021/22

Admission type	PCN	Apr 2018 to Mar 2019		Apr 2019 to Mar 2020		Apr 2020 to Mar 2021		Apr 2021 to Mar 2022	
		≤17	≥18	≤17	≥18	≤17	≥18	≤17	≥18
Admissions for wholly alcohol attributable conditions	Stanford le Hope and Corringham PCN	0	12	0	16	0	18	0	22
	Aveley, South Ockendon and Purfleet (ASOP) PCN	<5	45	0	40	0	33	0	36
	Grays PCN	<5	54	0	51	0	53	<5	50
	Tilbury and Chadwell PCN	<5	36	<5	25	0	32	0	42
	Thurrock	**<5**	**162**	**<5**	**143**	**0**	**146**	**<5**	**173**
Admissions with a primary diagnosis of alcohol related mental and behavioural disorders	Stanford le Hope and Corringham PCN	0	7	0	7	0	12	0	7
	Aveley, South Ockendon and Purfleet (ASOP) PCN	<5	16	0	12	0	19	0	23
	Grays PCN	<5	43	0	34	0	36	<5	25
	Tilbury and Chadwell PCN	<5	20	<5	19	0	11	0	26
	Thurrock	**<5**	**97**	**<5**	**80**	**0**	**88**	**<5**	**100**
Admissions with a primary diagnosis of poisoning by alcohol misuse	Stanford le Hope and Corringham PCN	0	0	0	0	0	0	0	0
	Aveley, South Ockendon and Purfleet (ASOP) PCN	0	0	0	0	0	0	0	0
	Grays PCN	0	0	0	0	0	0	0	0
	Tilbury and Chadwell PCN	0	0	0	0	0	0	0	0
	Thurrock	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Source: Thurrock Council based on coding from PHE Local Alcohol Profiles for England (LAPE)

7.15.1 Alcohol Liaison Service

Essex County Council commission an Alcohol Liaison Service (ALS) provided by Phoenix Futures based in Basildon University Hospital, part of Mid and South Essex NHS Foundation Trust. Thurrock Council contribute £27,000 annually for the service. The scope of the service includes:

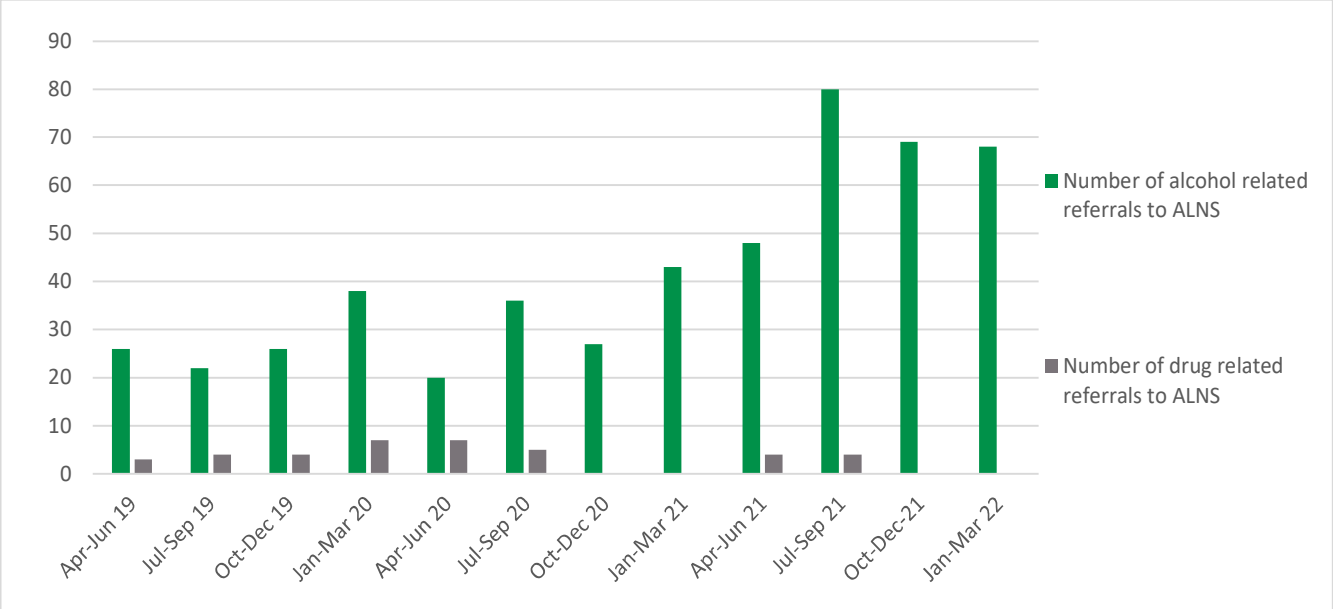
- Alcohol specialist intervention with inpatients as required.
- Training in identification and brief advice (IBA) within appropriate hospital departments to enable identification and response to alcohol issues at all levels.
- Professional input to the establishment and strengthening of an effective pathway for acute inpatients requiring alcohol services.
- Support for an alcohol champion within the acute setting.

Interventions with identified patients will include:

- Liaison, advice, and support to hospital medical staff regarding the care and detoxification of patients admitted where alcohol dependence is a co-morbidity.
- Assessment to and provision of brief interventions/extended brief intervention for harmful drinkers where appropriate, or referral to external organisations.
- Support for relatives/carers of patients referred.
- Referral and signposting for patients into other specialist alcohol specific services post discharge.

One alcohol liaison nurse specialist (ALNS) works with the inpatient wards and two alcohol liaison practitioners work in Accident and Emergency (A&E) department, emergency assessment unit (EAU), clinical decision unit (CDU) and acute medical unit (AMU). As people come into hospital, they are screened with Alcohol Use Disorders Identification Tool C (AUDIT C) screening questionnaire. Ideally all people would be screened, but the team do not provide a 24 hour a day service. Some clinical staff are trained in AUDIT C to screen people when ALS staff are not available, but whether this happens or not is contingent on the priorities and demands on clinical staff time. Figure 47 shows the number of referrals made to the ALNS following screening. Prior to the pandemic this was around 25 per quarter which had increased to 80 per quarter by July to September 2021.

Figure 47: Number of alcohol and drug referrals to ALNS by quarter April – June 2019 to January to March 2022



Source: ALS Hospital Based Alcohol Interventions – Thurrock Only

Following screening people who drink moderately may receive brief advice about the safe number of units to drink, the benefits of having days from drinking whilst people with hazardous or harmful drinking levels will receive extended brief advice which may result in signposting or referral to IVT. People dependant of alcohol will be seen by the Alcohol Liaison Nurse Specialist to check if they are in treatment and on a detox programme. Where IVT know that their service users are coming into hospital they can flag this to the ALS team. For people who are referred the Alcohol Liaison Nurse Specialist follows up with a call to check on whether the person has taken up the opportunity of treatment.

Table 80 shows the number of interventions the ALS and A&E staff carried out over the last 3 years. In 2019/20 A&E staff were carrying out a higher proportion of brief interventions than the ALS staff. At that time there were no A&E alcohol practitioners only the alcohol liaison nurse who focussed on inpatients. With the pandemic and the change in priorities A&E staff stopped the alcohol screening and brief interventions and the ALS staff were limited to largely working from home and contacting people by phone. In 2021/22 there has been a marked increase in delivering all interventions by ALS staff who now have 2 alcohol practitioners working in A&E. The alcohol screening and interventions by staff in A&E has not yet recovered to pre-pandemic levels. Compared to 2019/20 there has been a doubling of people referred for treatment for alcohol misuse in 2021/22.

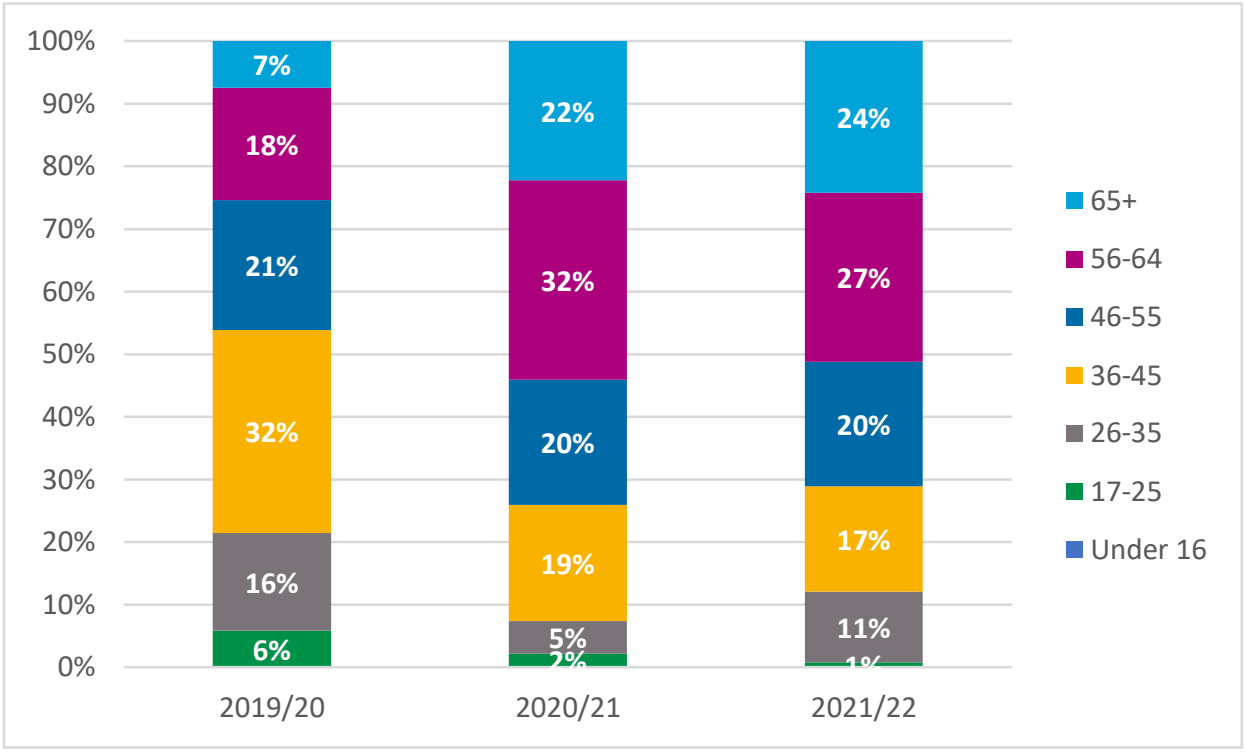
Table 80: Number of interventions completed by ALNS and A&E staff in 2019/20, 2020/21 and 2021/22

Intervention	2019/20			2020/21			2021/22		
	A&E staff	ALNS	Total	A&E staff	ALNS	Total	A&E staff	ALNS	Total
Don't Bottle It Up	0	0	0	0	0	0	0	0	0
Brief Intervention	84	39	123	<5	55	58	12	95	107
Extended Brief Intervention	18	45	63	0	48	48	10	93	103
Prescribing support (patients)	<5	68	70	0	64	64	7	97	104
Prescribing support (staff)	0	87	87	0	78	78	12	143	155
Signpost to Treatment System	82	36	122	<5	127	130	20	245	265
Referral to Treatment System	<5	62	63	0	68	68	15	126	141
Signpost / Referral to Other Support Service	18	15	33	0	16	16	0	23	23
Relatives supported	<5	22	23	0	13	13	<5	25	29
Intervention declined	0	21	21	0	49	49	<5	55	58

Source: ALS Hospital Based Alcohol Interventions – Thurrock Only

Figure 48 shows the ages of the people screened by A&E and ALS staff. Prior to the pandemic in 2019/20 just over 50% of people seen were 45 and under but in 2020/21 this dropped to around 25% and increased slightly to 30% in 2021/22. The impact of the pandemic meant people coming into A&E were unlikely to be screened although the service did continue for those admitted which were likely to be an older cohort of unwell people.

Figure 48: Percentage of individuals seen by alcohol staff by age group, 2019/20, 2020/21 and 2021/22



Source: ALS Hospital Based Alcohol Interventions – Thurrock Only

Table 81 shows the number of people who started and completed an alcohol detox programme during 2019/20, 2020/21 and 201/22. Double the people have started and completed an alcohol detox in 2021/22 compared to the previous 2 years.

Table 81: Number of alcohol detoxes started and completed in 2019/20, 2020/21 and 2021/22

Detox Status	2019/20	2020/21	2021/22
Number starting alcohol detox in hospital	43	43	94
Number completing alcohol detox in hospital	42	43	94
Number completing alcohol detox in community	0	0	0
Number discharged during detox against ALNS advice	8	0	<5

Source: ALS Hospital Based Alcohol Interventions – Thurrock Only

People who are repeatedly admitted or come into A&E can be referred to the High Intensity User (HIU) service by the ALS. This service commissioned by Mid- Essex CCG in 2020/21 to ease winter pressures, works specifically with individuals from Mid and South Essex system hospitals. People who are referred are contacted by the HIU worker who will provide support in the key areas of their life that lead them to repeatedly use emergency services. Examples of the areas where support might be available includes mental health, housing, drugs and alcohol misuse, or financial difficulties. The HIU worker will facilitate improvements in these key areas for the person and act as a single point of contact for support. The service aims to work intensively and offer a consistent and persistent approach and will therefore keep the cohort relatively small (10-15 individuals at any one time) in to ensure that the individuals are supported adequately to address all their complex needs. All issues that lead to frequent attendances, are addressed rather than focusing on alcohol in isolation. It is unclear whether any Thurrock residents have as yet been referred to the HIU service.

Table 82 shows the data available about re-presentations and people with alcohol problems who frequently attend the hospital. There has been a substantial impact on the ALS and the accurate

gathering of data due to the shift in priorities during the pandemic. More than double the individuals re-presented in A&E within one month in 2020/21 compared to 2019/20, but none were identified as having an alcohol problem. No individuals were identified as re-presenting to A&E within one month during 2021/22 despite 17 in 2019/20 and 43 in 2020/21.

Table 82: Number of re-presentations, readmissions, and frequent attenders, 2019/20, 2020/21 and 2021/22 for Thurrock residents

Representations, readmissions, and frequent attenders	2019/20	2020/21	2021/22
Number of individuals re-presenting to A&E staff within 1 month*	17	43	0
Number of re-presentations to A&E staff within 1 month*	25	43	0
Number of individuals re-admitted within 1 month	9	0	<5
Number of alcohols related re-admissions within 1 month	8	0	0
Number of frequent alcohol attenders	14	0	0
Number of contacts with alcohol frequent attenders	22	0	0
Number of frequent attenders - hospital definition	<5	0	0

*Will not capture those who re-present outside of A&E alcohol practitioners working hours
Source: ALS Hospital Based Alcohol Interventions – Thurrock Only

7.15.2 Secondary care: barriers enablers and gaps

The Alcohol Liaison Service (ALS) cover residents from a range of local authorities who become patients at Basildon University hospital.

IVT are developing the relationship with the ALS with more work to be done for the referral process to be smoother. The challenges are currently that:

- Referrals are not timely - sometimes they are not received from the ALS until after the person has been discharged from hospital when they are no longer concerned about their alcohol misuse
- When people are contacted about the referral sometimes, they did not know they were being referred
- When IVT clients are admitted to hospital this is not always flagged to IVT by the ALS
- Referral data from the ALS does not match the referrals received by IVT

IVT felt that the two newly appointed ALS staff members were proactive and the relationship with them was working well which may result in a smoother referral process.

IVT are exploring two changes in pathways involving the ALS. The first is where a patient requires detox following admission to hospital. It may be possible to start the detox programme in hospital then free up their bed by continuing the process in the community. The second change involves potentially greater use of the High Intensity User service. This focusses on people with complex needs who are frequently admitted to hospital or call emergency services. For people who meet the criteria for this service and have alcohol misuse problems IVT can refer to their alcohol misuse workers who have the resources to meet with people in the community. There is the potential for the ALS, IVT and HIU to coordinate how they work with this group of patients.

8 Summary and Recommendations

The prevention and reduction of drug and alcohol misuse is included in strategies of a broad range of agencies involved in health, care, and the criminal justice system in Thurrock. However, there is no overarching strategy that brings all those elements together. The Department of Health have asked local authorities to develop a Combating Drugs Partnership (which can include alcohol) which would see all the agencies develop and implement a joint strategic approach. This will support Thurrock's current integration plans and the human learning system perspective to service provision. The facilitation of closer relationships between services, removal of barriers to accessing them and a focus on what is important to the resident aims to improve outcomes for all residents misusing drugs and alcohol but especially those with co-occurring conditions and complex needs.

The strategic transformation of alcohol and drugs misuse prevention and treatment provision is underway. In supporting this the HNA has identified some additional recommendations for consideration by services.

Area	Finding	Recommendations
Strategy		
National drug and alcohol strategy	New national guidance has been produced about implementing a Combatting Drugs Partnership (CDP), that takes responsibility for the agreement of a local drugs and alcohol strategy delivery plan that reflects the national strategic priorities. Activities of the group include producing an HNA, a strategy and establishing processes to collect metrics required for National Combating Drugs Framework.	Ensure action plan is put in place to meet national timeline for set up of CDP, completion of HNA, development of strategy and process to collect relevant metrics.
Local alcohol strategy (CLeaR)	The CLeaR recommendations from the 2019 peer assessment have yet to be implemented.	Ensure the CLeaR recommendations are included in the CDP agenda (as it covers both drugs and alcohol) and are part of delivering the local plan.
Commissioning	The current service level agreements for substance misuse services are limited in scope and constrain staff in what they can do to engage and support individuals in the most effective ways.	When the current contract ends, re-commission a systems level drugs and alcohol service in line with Thurrock Councils' ambition to use a human learning system approach to service delivery..
Partnership working		
Harm minimisation	There is considerable unmet need concerning use of drugs and alcohol in Thurrock. In terms of the proportion of the population affected this is greatest for young people's use of cannabis and adult alcohol misuse. However, there is considerable unmet need for all types and combinations of drug and alcohol misuse.	Implement a whole systems approach to harm minimisation, particularly around the areas of cannabis use in young people and alcohol use at a population level. This requires a collaborative approach combining the following sectors; community; health; social care; police; environment and voluntary organisations
Suicide awareness	Substance misuse is an important factor in many suicides. Teams from substance misuse, housing, and homeless services working with people known to use drugs or misuse alcohol are not trained to pick up signs of someone with an increased risk of suicide	Suicide awareness training should be carried out with all agencies working with individuals considered to be at higher risk of suicide. The need for training should be captured in future service specifications for both the Adult and Young Persons' Substance Misuse services.
Working together	Teams that work together do not always understand the limitations of each other's remit and the best way of working together.	Ensure that service and role specifications outline how support will work between agencies for people with complex needs i.e. they have substance misuse problems co-occurring with one or more challenges concerning, housing, mental health, physical health, and the criminal justice system.

What does integration really mean?	With a new way of working it will be important to be able to clearly describe how integration will work across teams, to wider professional groups and service users.	The CDP should facilitate development of case studies for how integration will work across teams with bespoke versions disseminated to wider groups of professionals and service users, including but not limited to those in health, social care, housing and the police.
Relationship building	The relationship between drug and alcohol prevention and treatment services and partners in health was not strong.	The CDP should facilitate relationship building between drug and alcohol prevention and treatment services and primary and secondary care. There should be an increase in the number of referrals arising from health settings into the relevant drug and alcohol services.
Service development		
Transition between young peoples and adults services	The difference in approach between the young peoples and adults' services mean that when young people move to an adult service and the statutory support changes, it can be a difficult transition.	The commissioner should ensure the successful integration of a transition worker into the adult drug and alcohol service where the remit is to develop a seamless pathway between children and young peoples and adult services and to develop an approach tailored to the needs of young adults.
Cross working between teams	There is an aspiration towards a Human Learning System approach to providing services, however working in siloed teams is still prevalent.	The Thurrock Mental Health Transformation Board should foster a culture of collaboration and cross-working between Adult Mental Health Services, Housing, Homeless services and substance misuse services in line with a human learning systems approach. This could for example involve upskilling of housing officers in mental health and substance misuse awareness and training.
Alcohol liaison service	The Alcohol Liaison Service has not returned to pre-pandemic activity levels. In some part this is due to clinical staff having less time to screen patients for alcohol misuse when ALS are unavailable.	Through joint working with Essex County Council, the commissioner should facilitate a move towards an ALS where all individuals are screened, regardless of availability of specialist ALS staff. The short-term ambition should be for the ALS to return to activity levels seen pre-pandemic.
High Intensity User Service (HIU)	The HIU was implemented as a way of reducing winter pressures in 2020 in Basildon Hospital. It is unclear whether any referrals of Thurrock residents have been made.	The commissioner should ascertain if Thurrock residents identified as a high intensity users of secondary care services by the ALS are referred to the HIU service and if not, how the HIU service can be utilised
Information and evaluation		
Data sharing	It is not possible to see all the contacts an individual has had with different agencies so decisions are made with partial information which may not result in the most effective outcome for individuals.	Facilitated by the CDP, all relevant partners should develop sustainable systems of data sharing for staff working with service users so they have access to a full picture of the engagement and interventions recorded from all health, care, and criminal justice organisations

Intelligence sharing	Intelligence sharing between agencies is limited and it is not possible to link important information which would enable better outcomes for individuals whilst reducing harm and criminal activity.	As part of the CDP, develop an approach to intelligence sharing between agencies. This includes, but is not limited to, information sharing between the Local Authority, Police, Prison and Probation service, and the Integrated Care Board
Evaluation	There is little evaluation of any initiatives to reduce harm from drug and alcohol misuse so it isn't clear what is working well and what is less effective.	Rapid evaluation of local interventions relevant to alcohol and substance misuse should be undertaken, with priority given to those in receipt of grant funding. The outcomes of initiatives should be determined to establish if they are making a difference and how, or if resources could be better directed elsewhere
Topics to explore	Several questions have arisen during this HNA. These include:	The relevant commissioner (mental health or substance misuse services) should explore these questions with relevant partners and report the outcomes to the CDP. This will inform future decision making concerning reducing inequalities and improving the quality of services.
	What is the relationship between suicide (and attempted suicide) and drug and alcohol misuse?	
	Why has there been a reduction in referrals to the substance misuse service over the past 5 years?	
	In addition to Black ethnic groups which other groups are under represented in treatment services and what are the specific barriers to access?	
	What is the reason for the reported low levels of follow up by GPs of those with severe mental illness who have a positive screen for alcohol or drug misuse?	
Service Users		
Co production	The CDP will need to include people who have been affected by drug related harm. NHS England and the DHSC has recently published statutory guidance on the legal public involvement duties of the integrated care system, describing ways to include community and service users in co designing and co-producing services.	The commissioner should develop a methodology for ongoing co-production of the local alcohol and drugs strategy delivery plan, system specification, service development and for the exploration of the experience of service users in line with a human learning systems approach. This should include the IVT volunteer coordinator and the service user involvement lead, as well as service users who have indicated a willingness to be contacted in the future for this purpose.
Service user wellbeing	The need for support for the wellbeing of service users as they recover and post -recovery was emphasised with a focus on outdoor community activities that could be for the benefit of all.	The commissioner, in partnership with providers, should explore options for service users to carry out purposeful activities with a community action approach for the benefit of all.

List of Abbreviations

Abbreviation	Stands For
ALS	Alcohol Liaison Service
BOLD	Better Outcomes through Linked Data
CCG	Clinical Commissioning Group
CDF	Combating Drugs Framework
CDP	Combating Drugs Partnership
CLeaR	Challenge services, Leadership and Results
CSP	Community Safety Partnership
CYP	Children and Young People
DHSC	Department for Health and Social Care
DOMES	Drug Outcome Monitoring Executive Summaries
EBI	Extended Brief Intervention(s)
EBTP	Evidence Based Treatment Pathway(s)
EofE	East of England Region
GP	General Practitioner
HIU	High Intensity User
HLS	Human Learning Systems
HNA	Health Needs Assessment
HWB	Health and Wellbeing Board
IBA	Interventions and Brief Advice
ICD10	International Classification of Diseases 10th Edition
IDACI	Income Deprivation Affecting Children Index
IMD	Index of Multiple Deprivation
ISARMS	Integrated Support, Advice, Referral, and Mentoring Services
IVT	Inclusion Visions Thurrock
LAG	Local Action Group
LAPE	Local Alcohol Profiles for England
LSOA	Lower Super Output Area
MDMA	3,4-Methylenedioxymethamphetamine
NDTMS	National Drug Treatment Monitoring Service
NELFT	NHS Northeast London Foundation Trust
NICE	National Institute for health and Care Excellence
NOMS	National Offender Management Service
NRM	National Referral Mechanism
OCG	Organised Crime Gang(s)
OCU	Opiate and/or crack Cocaine User(s)
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
OTC	Over The Counter
PCN	Primary Care Network
PFA	Police Force Area
PHE	Public Health England
POM	Prescription Only Medicine(s)
SEND	Special Educational Needs and Disability
SLA	Service Level Agreement
SPH	Solutions for Public Heath
TICA	Thurrock Integrated Care Alliance
UEMHC	Urgent and Emergency Mental Health Care
UNODC	United Nations Office on Drugs and Crime
YOS	Youth Offending Service(s)

Appendices

8.1 Appendix 1: Questionnaire for professional stakeholders

Thurrock Council Alcohol and Substance Misuse, Health Needs Assessment
Questions for Stakeholder semi structured interviews

INTERVIEW DETAILS

Date:

Name(s):

Organisation:

Role(s):

Questions

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1 Can you briefly describe your role(s) in relation to alcohol and substance misuse services in the Thurrock LA area (adult, CYP or both)?

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2 Could you briefly describe the service(s) your organisation provides, and the catchment population served by your service (adult, CYP or both)? Have you got a doc of overview of services in Thurrock?

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3 What do you think are the strengths of the drug and alcohol misuse services for adults and for children and young people in Thurrock?

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4 What do you think are the main challenges in respect of drug and alcohol services for adults and for children and young people in Thurrock?

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5 Are there any significant risks/gaps Thurrock faces in terms of the current and future provision of drug and alcohol misuse services for adults and for children and young people –

---

6 What are your views on current service accessibility to the range of culturally diverse groups in Thurrock (adult, CYP or both)?

---

7 How effective is multi-disciplinary working and/or collaboration with other teams or services that are working with adults and/or children and young people with drug and alcohol misuse problems?

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8 Do you have any comments on the committee/ governance structure for services for drug and alcohol misuse? What is good and what could be improved?

---

9 COVID-19 will have had an impact on many services for drug and alcohol misuse over the past two years. Is there any important learning, good and/or bad, that can be built on from this experience?

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10 What do you consider to be the single most important strategic priority for action currently in respect of services drug and alcohol misuse in Thurrock (adult, CYP or both)?

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11 If you had any amount of funds to spend to meet your key priorities how would you spend it?

Any further comments?

8.2 Appendix 2: Roles of people agreeing to participate in Semi-Structured Interviews

The HNA team would like to thank all the people who contributed their time and energy to talk to us or complete a questionnaire about their role, their views of the drug and alcohol services and the needs of the Thurrock population.

Role	Organisation
Head of Mental Health Commissioning	Mid and South Essex Integrated Care System
Regional Young Person Manager (South)	Change Grow Live Wize-up
Thurrock Community Safety Partnership Manager	Thurrock Council
Contracts Lead	Inclusion Visions
Service Manager	Inclusion Visions Thurrock
Regional Director	South Essex Probation Delivery Unit
Violence Against Women and Girls Coordinator	Thurrock Council
Operations Manager Thurrock Youth Offending Team	Thurrock Youth Offending Team
Trading Standards Manager	Thurrock Council
Strategic Lead – Public Health (Public Mental Health & Vulnerable Populations)	Thurrock Council
Corporate Director for Adults, Housing and Health	Thurrock Council
Strategic Lead Public Health	Thurrock Council
Police Sergeant	Essex Police
Narcotics Anonymous volunteer link with IVT	Volunteer
Alcohol Liaison Nurse	Phoenix Futures
Senior Hospital Alcohol Liaison Practitioner	Phoenix Futures
Rough Sleeper Coordinator	Thurrock Council
Partnership Director	Thurrock Council
Strategic Lead - Housing Solutions	Thurrock Council

8.3 Appendix 3: Questionnaire for drug and alcohol service users

Drug and alcohol service users' voices

Aim: To ask people using the drug and alcohol service what the barriers and enablers they experienced in accessing the service

Setting: Staff to ask people appropriately nearing the end of an appointment if they are willing to answer a few questions about how they have found the service. The answers will be anonymised but will really help in working out how to improve the service. Under the Data Protection Act 2018 there is a legal duty to protect any personal information collected from people. Responses may be described in the report, but it will be impossible to identify individuals from the description.

PLEASE EMAIL QUESTIONNIARES TO xxx AS SOON AS POSSIBLE AFTER THEY HAVE BEEN COMPLETED. Thank you – to both service users and staff for your time and effort in answering the questions.

Data items in blue are likely to be able to be collected from patient records and those in yellow will be questions asked of people.

Question	Response
Patient number: 01 *(we just need a unique number for each person –**NOT** NHS number/ hospital number or other number that could be linked to other info about the person)*	
Age band choose from one of these: 10-14, 15- 19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89	
Gender:	
What type of drug or alcohol issue are they being treated for- choose from one of these? • Alcohol only • Opiate • Non opiate • Alcohol and non-opiate	
What kind of treatment are they receiving? • Structured • Unstructured	
Are they in contact and receiving support from other agencies including: • Housing Solutions • Mental health services • Open road • Probation • Young offenders service • Police • Refuge • Other (state which)	

- None of these

1. Could you contact the service when you needed to?

e.g., to make an appointment, ask a question or get a response to an enquiry

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

If you couldn't contact the service, why was this?
Bullet points:

2. Could you use the service when you needed it?

e.g., appointments were available at convenient times, any transport or childcare issues, any disability or access issues

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

If you had difficulty accessing the service, can you say why? NA

Bullet points:

3. Do you think the COVID-19 pandemic had an effect on how you were able to use the service?

e.g., staff availability, use of phone/digital appointments

1	2	3	4	5
Very negative effect	Some negative effect	Neutral	Some positive effect	Very positive effect

What were these effects:

Bullet points:

4. Did you receive what you expected from the service (e.g., advice, treatment?) and was it satisfactory?

1	2	3	4	5
Not at all satisfied	Slightly satisfied	Moderately satisfied	Very satisfied	Completely satisfied

Can you tell us about any improvements that you think would help make the service better for people? NA

Bullet points:

Is there anything else you'd like to say about your experience with the service?
Bullet points:

5. Would you be happy to be contacted in the future (later this year) to have a conversation about what you think the best drug and alcohol treatment service would look like?

For details about our full range of services, please contact us:

www.ardengemcsu.nhs.uk

@ardengem

contact.ardengem@nhs.net

12 January 2023	ITEM: 10
Health and Wellbeing Overview and Scrutiny Committee	
Active Travel Needs Assessment	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Joanne Ferry, Strategic Lead for Place, Environment and Communities	
Accountable Assistant Director: Sara Godward, Assistant Director of Public Health	
Accountable Director: Dr Jo Broadbent, Director of Public Health	
This report is Public	

Executive Summary

The Council's Public Health team have completed an Active Travel Needs Assessment, it was developed in consultation with internal stakeholders from planning, transport, education and road safety. It examines the potential for active travel, how the situation currently looks, identifies needs, and describes factors that should be addressed. In doing so this will ensure Thurrock is providing a co-ordinated and effective approach to delivering the physical infrastructure, information and support that will generate the necessary changes required to increase levels of active travel.

Key Objectives of the document:

- Provide a summary of local data analyses and evidence to describe the current status of active travel within Thurrock.

- Provide information on evidence of effectiveness of interventions that promote and enhance active travel which will help to shape future plans.

- Review local approaches and barriers identified within Thurrock's Active Travel Strategy 2020 and include any new evidence that supports active modes of travel or prevents people walking/cycling to their destinations.

- Provide an understanding of current policies relating to active travel (including any updates since the production of the Active Travel Strategy).
- Inform and guide the development assessment of future policies and strategies within Thurrock ensuring active travel requirements are fully supported.

- Review the local economic impact of active travel, highlighting benefits that will inform the strategic narrative to help secure future investment.

- Provide an understanding of the potential of active travel for improving air quality in Thurrock.

- Contribute to the borough's aims for improving health and the local environment by encouraging more active lifestyles.

- Provide evidence on the potential of new developments and regeneration schemes to include walking and cycling infrastructure as standard.

- Provide relevant and reliable data to cabinet members and decision makers to help them make evidence-based decisions in favour of active travel.

1. Recommendation(s)

1.1 That the Committee review the needs assessment and the recommendations contained within and provide comment.

2. Introduction and Background

2.1 Thurrock's Transport Strategy states 'Thurrock is a well-connected borough although there is not always efficient movement of goods and people'.

2.2 As our population grows so has a prevailing driving culture, and some road networks are now struggling to cope.

2.3 Continued investment in more roads from many perspectives is no longer accepted as positive, with consequences such as poor air quality, obesogenic environments and increasing congestion now prevalent in many areas.

2.4 The benefits of Active Travel are outlined within this document. There is evidence that walking and cycling can have significant **mental and physical health benefits**, creating a fitter population as well as saving the NHS and local authority money in health and social care costs.

2.5 For **society**, Active Travel has the potential to make our high streets and public places more prosperous and vibrant, it can create a better quality of life and more cohesive communities.

2.6 For the **environment**, Active Travel, can reduce congestion, thus lowering emissions of Nitrogen Dioxide (NO2), particulate matter (PM) and CO2 helping to tackle climate change and improve air quality.

2.7 Studies have consistently shown that investment in active travel delivers value for money in achieving these health, community, environmental and transport benefits.

2.8 Cost benefit analysis studies of walking and cycling investment suggests substantial economic benefits of walking and cycling interventions.

2.9 On average cycling and walking schemes within the UK have a very high benefit to cost ratio of around 5.62:1, for every £1 spent an investment return equivalent to £5.62 is achieved once you consider health savings, reductions in congestion and pollution, and other associated co-benefits such as lower school transport costs.

2.10 Despite our understanding of the long-term benefits of active travel, the National Travel Survey published in 2018 by the Department for Transport (DfT) confirm that cycling and walking have remained almost at the same level for the last two decades.

2.11 Figures from the latest National Travel survey show that whilst Thurrock residents maintain similar rates of walking to residents in neighbouring areas, they have lower rates of cycling, and have shown little improvement in either domain in recent years.

2.12 A total of 21 specific recommendations have been made by the needs assessment covering: strategic development; statistical analysis; schools and workplaces; road safety; and funding for active travel.

3. Issues, Options and Analysis of Options

3.1 The final version of the needs assessment was completed in April 2021 and was subsequently approved by the Public Health Leadership Team.

3.2 As this is a needs assessment there is no requirement of the Committee in relation to options, beyond reviewing the content and offering comment.

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

4.1 The needs assessment itself contains significant engagement with relevant professionals from planning, transport, education and road safety. It also captures the voice of local residents through reference to Local Plan consultation, ‘Your place, your voice’.

4.2 The needs assessment was reviewed by the Public Health Leadership Team where conditional signoff was granted.

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

5.1 The Thurrock Health and Wellbeing Strategy 2022-26 is committed to improving accessibility and equity of access to education, employment,

healthcare and green spaces **through walking and cycling infrastructure**, and improved public transport.

6. Implications

6.1 Financial

Implications verified by: **Bradley Herbert**

Senior Management accountant

There are no direct financial implications of reviewing the content of the Active Travel Needs Assessment and providing related comments.

6.2 Legal

Implications verified by: **Kevin Molloy**

Principal Solicitor

There are no legal implications of reviewing the content of the Active Travel Needs Assessment and providing related comments. The document contains no confidential information and has been produced through a combination of publicly available information and research conducted in line with standard ethical guidelines.

6.3 Diversity and Equality

Implications verified by: **Becky Lee**

Team Manager, Community Development and Equalities

There are no Diversity and Equality implications of reviewing the content of the Active Travel Needs Assessment and providing related comments.

6.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, or Impact on Looked After Children

None

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

None

8. Appendices to the report

- Active Travel Needs Assessment

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Thurrock

Active Travel Needs Assessment

thurrock.gov.uk

This document was produced by Thurrock Council

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V4.3: Final

April 2021

Note to the reader:

Active travel is the choice of travel modes requiring physical activity, usually walking or cycling, for all or part of the journey in preference to motor transport either for a complete journey or as part of a longer journey. These must be for the purpose of transport (getting from place to place) such as journeys walking to the shops, cycling to work, cycling to the station to catch a commuter train or walking to school and not for sport or fitness purposes.

This document focuses exclusively on walking and cycling as a means of travel.

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Executive Summary

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Background

Thurrock's Transport Strategy states '*Thurrock is a well-connected borough although there is not always efficient movement of goods and people'*. As our population grows so has a prevailing driving culture, and some road networks are now struggling to cope. Continued investment in more roads from many perspectives is no longer accepted as positive, with consequences such as poor air quality, obesogenic environments and increasing congestion now prevalent in many areas.

The benefits of Active Travel are outlined within this document. There is evidence that walking and cycling can have significant mental and physical health benefits, creating a fitter population as well as saving the NHS and local authority money in health and social care costs. For society it has the potential to make our high streets and public places more prosperous and vibrant, it can create a better quality of life and more cohesive communities. For the environment it can reduce congestion, thus lowering emissions of Nitrogen Dioxide

(NO2), particulate matter (PM) and CO2 helping to tackle climate change and improve air quality.

Studies have consistently shown that investment in active travel delivers value for money in achieving these health, community, environmental and transport benefits. Cost benefit analysis studies of walking and cycling investment suggests substantial economic benefits of walking and cycling interventions. On average cycling and walking schemes within the UK have a very high benefit to cost ratio of around 5.62:1, for every £1 spent an investment return equivalent to £5.62 is achieved once you consider health savings, reductions in congestion and pollution, and other associated co-benefits such as lower school transport costs.

Despite our understanding of the long-term benefits of active travel, the National Travel Survey published in 2018 by the Department for Transport (DfT) confirm that cycling and walking have remained almost at the same level for the last two decades. Figures from the latest survey show that whilst Thurrock residents maintain similar rates of walking to residents in neighbouring areas, they have lower rates of cycling, and have shown little improvement in either domain in recent years.

Key walking and cycling findings from statistical analysis

1. Cycling:

Individual factors: levels of regular cycling[i] in Thurrock are worse than national averages (1.2% compared to 4.4% nationally). The benefits of cycling are not equally spread - age and gender are the most significant demographic variables, men are almost 3 times more likely to cycle than women and cycle almost four times further. Adult males in their 40s made the most cycling trips, females aged 17-20 made the least.

Environmental factors: No single factor correlates consistently with higher levels of cycling although journey distance, safety and cycling facilities/infrastructure appear to be significant influences. Areas with dedicated cycle lanes (and cycle parking), separation of cyclists from other traffic and proximity of cycle paths have consistently shown to have higher cycling levels. The design and location of routes are also important.

The main incentives motivating cycle use are convenience and exercise. The main disincentives are safety concerns around traffic danger, long trip distances and steep inclines. Weather does not seem to be correlated with interest in cycling except as a seasonal and daily variable in the decision to cycle.

2. Walking:

Individual factors: Levels of walking in Thurrock are similar to national averages, with almost 77% of the population walking for 10 minutes or more at least once a week (80% nationally), although this declines to 48% for regular walking (51% nationally). The number of trips and reasons for walking varies with gender. Females walk around 10% more than males and women in their 30's – 40's walk the most.

Environmental factors: As with cycling no single factor correlates with increased walking levels although attractive, safe, well designed neighbourhoods with local accessibility to services

[i] defined as the main mode of travel, more than 3 times per week

have consistently demonstrated higher levels of walking. Evidence indicates that walking among urban residents living in high density areas is far more prevalent than among less dense and suburban areas and understandably there is a much higher prevalence when destinations are less than a mile.

The main walking motivators for women are the social element and enjoyment of interacting with other people whereas men and children are likely to find competition more motivating. The majority of men responding to surveys did not consider walking a form of exercise. Similar to cycling the main disincentives are safety concerns, lack of time and a limited range of how far they are prepared to walk. Secondary reasons include the inconvenience of carrying things, poor weather and not being fit enough.

3. Travel patterns and lengths

Workplaces: Data provided by the England and Wales National Census 2011 found that Thurrock residents are travelling longer and further to their workplaces, spending an average of 40 minutes of travel time (one way) compared to the national average of 29 minutes. Only 41% of residents live less than 10km from their workplace compared to 52% nationally and 59% of Thurrock residents drive a car or van to work. This is higher than the national average of 54%. Over a third of working adults commute to London or surrounding area and one in seven commuters are spending two hours or more each day travelling to and from work.

Schools: According to the most recent School Travel Strategy for Thurrock the average education trip distance has increased by nearly 25% to 3 miles since 1997. With increased distance school children made relatively fewer active trips. The proportion of children aged 5-10 who walk to school drops by 52% when the travel distance increases from under 1 mile to between 1 and 2 miles, likewise for those aged 11-16 the drop off rate is almost 30%.

Some journey lengths are too impractical for walking or cycling alone, but could be used instead as a stage in the journey such as cycling to the train station in the morning.

As indicated earlier, travel distance is a significant factor in choice of travel mode, predictably rates of walking and cycling decrease with distance. Most trips are relatively short, figures from the Department for Transport (DfT) show that 25% of trips were under 1 mile, and 68% under 5 miles. Walking was the most frequent mode used for short trips, 80% of trips under one mile were walked but there is a notable decrease in distances of between 1 and 2 miles where only 28% of trips were walked.

The potential for travel behaviour change

This statistical data suggests cycling and walking are not as widely used for transport as they could be and Thurrock clearly has substantial untapped potential. These DfT figures (showing that 25% of trips were under a mile and 68% under 5 miles) are considered by the government as '*a realistic distance for cycling for the majority of people, with many shorter journeys suitable for walking'*, yet within our borough on average walking made up 21% and cycling only 1% of all trips. The car is the most common mode of transport accounting for 62% of all journeys.

Cars account for half of the journeys to Thurrock's primary schools and almost a third of journeys to secondary schools. Travel for education contributes significantly to peak time traffic, accounting for almost a third of all car journeys between 8 and 9 a.m. On average, an

estimated 38% of Thurrock children walk to school and 4% cycle (figures based on limited survey data).

These low uptakes conflict somewhat with both local and national ambitions. Surveys conducted by the DfT and locally through school travel plans suggest a significant population wide impetus to walk or cycle more. For example school travel plan data showed that 29% of primary school children in Thurrock say they would like to cycle to school (but only 4% did) and 40% of adults express a willingness to switch from our car to walking or cycling for shorter journeys.

Consultation undertaken as part of the local plan 'Your place, your voice' events organised in 2019 demonstrated notable public support for active travel, with 71% of participating Thurrock wards identifying *'improved walking and cycling routes'* as a specific community requirement.

The challenges

There are a number of complex and interrelated factors why we are still choosing cars for journeys that could ideally be walked or cycled, but there are some key themes that consistently prevent people from making the choice to walk or cycle:

1. Safety and perceptions of safety

There is much evidence showing that a fear of traffic is the most significant barrier to both cycling and walking. Many people often do not feel confident on a bike or walking distances outside of their immediate area, many are put off cycling in particular because of fears for their safety on busy roads. These findings are reaffirmed in attitudinal surveys conducted by the Department for Transport where 62% of adults agreed that '*it is too dangerous for me to cycle on the roads'*. Parental concerns around safety are a significant barrier affecting travel modes to school. Removing perceptions of danger and the lack of safe routes are fundamental to tapping the existing potential of walking and cycling.

Studies conclude there is no single intervention that will transform road safety for cycling or pedestrians, however, infrastructure measures that appear effective include thoughtful urban design that includes segregated cycle lanes along main roads and speed restriction measures where segregation is not possible. The design and quality of segregated routes are also an important factor. For walking, the removal of barriers and parked vehicles on pavements appeared effective in some studies. Attractive well designed environments that are regularly maintained had positive correlations with perceptions of safety for both walking and cycling.

2. Lack of Infrastructure/Infrastructure in the wrong place

There is much evidence suggesting a causal relationship between the quality of the built environment and health behaviours – we are as healthy as our environment allows us to be. For example studies consistently demonstrate in areas that prioritise and promote walking and cycling as a normal part of life and where there has been significant investment in accessible, safe walking and cycling routes, levels of active travel has increased.

This can partially be achieved locally through good spatial planning which gives priority to cycling and walking into all aspects of urban design. Streets should be designed in favour of people not cars, with local highways incorporating safe and attractive walking and cycling

routes as standard. These principles can be supported further by the use of strategic planning policies embedded in key documents such as the new Local Plan and Design Guidance.

The Netherlands and Denmark have a strong culture of active travel, particularly cycling, and there is much to learn from these places. Since the 1980s both countries have developed extensive cycle networks including cycle superhighways. Studies have concluded their success is partially attributed to these extensive infrastructure routes that offers fast, safe routes that connect residential areas with places people need to get to for their daily lives.

3. Convenience

There is a clear connection between travel distances and modal choice; the proportion of people who use active travel decreases as distance increases. Providing the right physical environment for people to walk or cycle, especially focussing on reducing the distances to key services compared to other modes of travel is important. If walking or cycling provides the easiest and most convenient travel mode, which can easily be fitted into daily routines, then people are much more likely to leave the car at home. The concept of the 20 minute neighbourhood, sometimes called by other names such as '15 minute cities' has become a popular model for creating places where services and destinations that support daily living can be met within a short walk or cycle. The implementation of the 20 minute neighbourhood principle within other places have shown hugely positive outcomes, particularly through enhancing the benefits identified earlier that can be achieved through increased levels of walking and cycling. The benefits of this concept has become even more apparent since the COVID-19 pandemic lockdowns, which has enhanced the importance of the liveability of our local neighbourhoods.

4. Culture and Behaviour change

Thurrock, like many other places in the UK has a strong culture of car use. While improvements are being made in some areas there is some way to go before cycling and walking become the natural choices for shorter journeys. Evidence has consistently shown that with the right interventions it is possible to change cultures and ingrained behaviour. Tackling the different barriers that prevent people from being active, taking into account social and economic inequalities, age and gender and understanding local barriers that may exist at a household level can bring about significant change.

When assessing barriers to active travel, consideration should be given to different socio-demographic groups. For example, men undertake almost three times as many cycling trips and cycle four times further than women and males in their 40's cycle the most. There must be investment in specific behaviour change programmes that understand local barriers in order to normalise walking and cycling; the most successful programmes are ones that are tailored to local circumstances and needs.

Reviews studying effective interventions consistently support a combination of balanced and coordinated measures. Combining more traditional measures (such as supportive infrastructure and place making improvements) with softer measures (such as behaviour change programmes providing targeted information, marketing and incentives) is likely to be the most efficient way to encourage walking and cycling.

The Government approach

In 2017 the Government published its first Cycling and Walking Investment Strategy to promote walking and cycling in England, including guidance for local authorities on preparing Local Cycling and Walking Infrastructure Plans (LCWIPs). These plans are intended to help local transport authorities take a long-term approach to identifying and delivering interventions fit for their own local areas. Local authorities are not required to adopt an LCWIP, but the Government has said that it is "keen that as many areas as possible do so". These infrastructure plans enable local authorities to bid into various government funding streams to deliver their own improvements. At present Thurrock has not implemented this specific plan and is considering its future strategic approach.

In support of the strategy the government committed £316m per annum to active travel, although there is no dedicated funding stream for each local authority (each local authority must enter a bid process to access much of the funding). A parliamentary review in February 2020 estimated that £1.2 billion has already been invested with a further £1.2 billion projected spend from 2019 to 2021 for infrastructure and other active travel projects.

LGA's have been told that a further review setting out Government spending limits will be agreed in 2020/21 but this has since been delayed due to Brexit, political circumstances and, more recently, the COVID-19 pandemic. Nevertheless, Thurrock must manoeuvre itself into a positon to access these funds by developing a model for investment to ensure any benefit from future government funding is maximised. At present we do not have an infrastructure plan that aligns with the Government's preferred approach or a sound model for investment.

In terms of local transport budgets, funding is often reliant on whether local authorities choose to prioritise active travel and the proportions spent on active travel vary hugely. In councils where there is dedicated funding this can be below 5%, whereas in areas that have received funding from local government grants up to 40% of transport capital budgets are spent on active travel. The Government would like to see at least 15% of local authority transport budget spent on active travel.

Within Thurrock capital funding for infrastructure improvements will be sought from developer contributions, local highway budgets and external sources such as the Government.

COVID-19 update

In May 2020 the government announced a £250 million emergency active travel fund for local authorities to access for temporary measures to help combat the pandemic. The Government's 2020 review of the Cycling and Walking Infrastructure Strategy reported that the overall sum allocated was set to increase to a further 2.4 billion of ring-fenced funding for walking and cycling. These new tranches of funding will be overseen and administered by a new inspectorate – Active Travel England and released over the coming year.

Thurrock's strategic approach

The strategy and policy framework across all relevant directorates does appear to be supportive of active travel, although these are not always aligned to an overarching vision that is likely to drive any system improvement.

Any significant improvements will require local policy specific to sustainable transport that is bold enough to break the status quo and ambitious enough to generate changes that will support, enable and nurture a shift towards more active travel choices.

Better coordination (and a collective will to make things happen) between the relevant policy areas would be beneficial to realise the potential of active travel. The shared outcomes (in public health, transport, environment, education, and planning) should be identified, highlighted and used to gather support for cross portfolio delivery and funding.

Partnership working with local bodies and the wider public and private sector to build a local commitment is also key. Changes in travel behaviour will require the backing and commitment of communities and businesses, engagement and support from both sectors are important in developing, building and delivering successful active travel projects.

Locally, specific documents are identified as having the potential to drive forward and support better delivery of an active travel vision. The preparation/production/development of the new Thurrock Transport Strategy (TTS) will be fundamental to driving a long term vision, a key component of the strategy should include the delivery of a **Local Cycling and Walking Infrastructure Plan (LCWIP)** that revises the current network and identifies a prioritised programme of infrastructure improvements for future investment.

Amongst the challenges documented earlier, safety, poor infrastructure and convenience can be largely overcome through good 'cycling and walking infrastructure'. The formation of a **LCWIP** will ensure these factors are adequately considered.

Changing the way we travel

There is no reason why walking and cycling should not be a normal part of everyday life in Thurrock, and the natural choices for shorter journeys - such as going to school, college or work, travelling to the station, and visiting local shops. There are many ways to improve local levels of active travel and research conducted as part of this assessment identifies a common thread of measures that will determine any sustained improvement. These include supportive policy and strategies that align to a central vision, the long term investment of quality walking and cycling routes combined with local initiatives that incentivise people to use them and, most importantly, the leadership and support to make things happen.

Recommendations

1. The policy and strategy approach to active travel would benefit from update and review Active travel is referenced within some of the current related strategies and plans but there is a multiplicity of measures that are not always aligned and therefore difficult to monitor impacts or refine into priority goals that are likely to drive any system improvements.

2. The creation of a refreshed Transport Strategy and the associated Local Plan technical work should provide the principle vision for active travel supported by an Infrastructure Plan for walking and cycling (LCWIP) that will assess the current network and identify locations for priority routes. Both documents will assist in overcoming some of the barriers that prevent people for choosing active travel and provide a model for future investment. Any new strategy should be ambitious in its proposals, reflecting Thurrock's substantial growth agenda.

3. Integrate active travel into planning. The production of planning policy documents such as the new Local Plan must incorporate a strong advocacy for sustainable transport. The development of the new Design Guide (supplementary to the Local Plan) should incorporate

clear design and quality standards for the delivery of new and upgraded walking and cycling routes which planners and developers will be expected to prioritise and follow.

4. Supporting the delivery of high-density, mixed used developments through implementation of the 20 minute neighbourhood concept - with provision of more localised neighbourhood schools, shops, health centres and other local facilities to reduce travel distances will help ensure Thurrock's growth achieves much higher levels of walking and cycling.

5. Working with Thurrock's communities and local businesses to gain insights into local behavioural and motivational aspects is an important factor. Policies and behavioural initiatives will need to address both the objections to active travel and the advantages associated with driving a car. The most effective mix of intervention being dependent on local characteristics and local needs.

6. Safety and perceptions of safety is one of the biggest considerations when choosing travel mode. Allocating more highway space to dedicated cycle lanes and provision of cycling superhighways should be considered where there is potential to encourage a growth in cycling. Working with local businesses and the community to create at least one successful superhighway within the next few years could provide a useful momentum for future schemes.

7. More ambitious plans for active travel**;** for cycling and walking to play a far bigger part in our transport system from now on requires a unified, forward-thinking vision for transformation. This aspiring vision will need to be supported by the knowledge and investment necessary to deliver the changes that are needed before walking and cycling will become a natural part of life within our neighbourhoods.

1. Introduction

Those that live, work and visit Thurrock will be fully aware of the significant change and growth that has occurred locally in recent years and the ambitions for the future. On average the local population has increased by 10% every decade[ii] with predictions estimating an even bigger increase during the most recent ten years from 143,000 in 2011 to around 178,000 at the time of the next census in 2021. Future population estimates from the Office for National Statistics predict that Thurrock's population will have risen to over 209,000 by 2038[iii].

This population increase is placing housing and infrastructure under significant pressure as demand for new homes and supportive infrastructure outstrips supply. These increases are echoing what is happening in many other parts of the country, resulting in government plans to embark on the biggest house building programme since the 1970's. In addition to the creation of around 30,000 new homes in Thurrock alone, future economic development in the borough is set to create over 24,000 new jobs. Thurrock's Transport Strategy 2013–2026, which is currently being refreshed, identifies the main changes in our local transport network are likely to be from this planned growth in new homes and jobs.

Road traffic calculations conducted by the DfT predict growth increases in motorised traffic of between 29% and 59% by 2050, mainly from the forecast increases in the number of car trips and trip distances, as well as increasing Light Goods Vehicle traffic. Locally this level of traffic increase will be unsustainable from a number of perspectives, most notably the corresponding increases in congestion has the potential to negatively impact environmental and health outcomes as well as economic prosperity.

Future growth and planning within Thurrock requires an equilibrium with a sustainable transport system that supports our future objectives and most importantly, creates an efficient and attractive place where populations will want to live and work. This will mean thinking differently about our mobility needs and the way we travel. Reducing the current number of local trips made by car journeys and replacing them with walking or cycling is one of the best ways to achieve this.

Not everyone can increase their levels of walking and cycling. The structure and topography of Thurrock is not always conducive to easy local travel, not all trips are suitable and not all people live in places where they can walk or cycle – but many people could.

This needs assessment looks at why it's so necessary to increase rates of active travel, how we can improve uptake by drawing on the evidence of successful places, and how we can facilitate positive change through understanding and responding to our own local needs.

[ii] Since NOMIS official population data sets first available (1981)

[iii] ONS (2019) Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland [online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

2. Strategy and Policy Context

The aim of this section is to identify and understand the context of national and local policy on promoting active travel while providing updates since inclusion in the Active Travel Strategy (2020).

2.1 National Strategy

Government Walking and Cycling Strategy

Following aspirations to increase the levels of walking and cycling, in 2017 the Government published its first Cycling and Walking Investment Strategy (CWIS). The Strategy sets out the Government's ambition, targets and financial resources to make walking and cycling the natural choices for shorter journeys or as part of a longer journey.

The strategy (published in 2017) outlines targets to:

- Double the amount of cycling stages[iv] by 2025 to 1.6 billion trips per year
- Increase walking activity to 300 stages per year by 2025.
- Reduce the rate of cyclists killed or seriously injured on England's roads, measured as the number of fatalities and serious injuries per billion miles cycled by 2020.
- Increase the percentage of children aged 5 to 10 that usually walk to school from 49% in 2014 to 55% in 2025.

The strategy also provides a range of tools and support to local authorities when developing their own long term plans and strategic approach. The strategy identifies Local Cycling and Walking Infrastructure Plans (LCWIPs) as the preferred approach to developing cycling and walking networks.

LCWIPs are a strategic approach to identifying cycling and walking improvements required at the local level. The key outputs of these plans are:

- A network plan for walking and cycling which identifies preferred routes and core zones for further development; and
- A prioritised programme of infrastructure improvements for future investment.
- Details of the underlying analysis carried out and a narrative which supports the improvements and networks identified to increase the number of walking and cycling trips.

Setting out this long-term plan enables local authorities to bid for various government funding streams to deliver these improvements. Currently Thurrock does not have a LCWIP that aligns with the governments approach and thus a revised infrastructure plan is a key priority going forward. Further information on LCWIPs and funding is included as appendix C of this document.

Gear Change: A bold vision for cycling and walking 2020-2025

The 'gear change' policy document released by the Department for Transport (DfT) in August 2020 sets out the Government action required to improve walking and cycling infrastructure

[iv] Stage: **Trips** consist of one or more stages. A new stage is **defined** when there is a change in the mode of **transport**.

across the country including the creation of a new body – Active Travel England. The document is described by Boris Johnson as "*the most ambitious plan yet to boost cycling and walking*" and includes an ambitious revision to its existing targets and objectives.

Some of the key policies outlined within the document to deliver active travel improvements include:

- £2bn of ring-fenced funding for walking and cycling overseen and administered by Active Travel England a new inspectorate, which will ensure projects meet new design standards, and be delivered on time.
- The creation of a 'national e-Bike programme' – this will enable the elderly, or those who travel far to take to bikes as part of journeys.
- A new approach on health will be piloted in selected places with poor health rates to encourage GPs to prescribe cycling, with patients able to access bikes through their local surgery.
- Improvements to the National Cycle Network.
- Making streets safer by consulting to strengthen the Highway Code to better protect pedestrians and cyclists; improving legal protections for vulnerable road users; raising safety standards.

Further details of these new plans will be included in the forthcoming update of the Government's Walking and Cycling Investment Strategy expected later in 2021.

The National Planning Policy Framework (NPPF)

This NPPF, updated in 2019, sets out the Government's planning policies and how these should be applied. It has several policy links to active travel:

• Para 81 states planning policies and decisions should aim to achieve healthy, inclusive and safe places which (amongst other things) encourage walking and cycling.

• Para 102 states "transport issues should be considered from the earliest stages of plan-making and development proposals, so that opportunities to promote walking, cycling and public transport use are identified and pursued."

• Para 104 encourages local authorities to draw on Local Cycling and Walking Infrastructure Plans to "provide for high quality walking and cycling networks and supporting facilities such as cycle parking."

National Childhood Obesity Plan Chapter 1 & 2,

The plan includes a range of policies which aim to halve childhood obesity by 2030, with walking and cycling to school key actions to keep children physically active (1).

Clean Air Strategy 2019

The strategy sets out a range of interventions to halve the harm to human health from air pollution in the UK by 2030 by looking at a range of actions to reduce emissions and pollution. Investment in active travel compliments clean air zones and other traffic restraint measures identified within the plans.

2.2 Local Strategy and Plans

Thurrock Council Cycle Infrastructure Delivery Plan (CIDP 2019)

The CIDP sets out priority cycling routes for Thurrock, consisting of 46 individual cycling schemes. Each scheme sets out the improvement required, the reason for inclusion and the likely deliverability of the scheme. Deliverability and progress of the plan would benefit from review prior to the development of any new strategic approach. This will ensure that the schemes identified continue to align with both future objectives and the government's preferred approach to infrastructure plans. Technical guidance for developing a new plan is outlined within the Government's document - *Local Cycling and Walking Infrastructure Plans, Technical Guidance and Tools for Local Authorities* (2).

Thurrock Council Rights of Way Improvement Plan (RoWIP 2007)

This plan focuses upon the network of 170km of Public Rights of Way including footpaths, byways and bridleways across Thurrock. The plan details how improvements can be delivered as well as opportunities to enhance provision. The RoWIP is undergoing review at the time of producing this needs assessment and will include ambitions to improve existing routes and identify new routes that will enhance connectivity throughout Thurrock. The age of the existing document has the potential to impede the successful deliverability of any future schemes.

Thurrock Council Active Travel Strategy 2020

During 2017 Thurrock Council's strategic planning team commissioned consultants *Knight, Kavanagh & Page (KKP)* to develop an Active Travel Strategy, a refresh of the strategy was undertaken by KKP during 2019 and published in 2020. The strategy focused on the supply and use of an active travel network, with specific relation to walking and cycling and aims to identify the following outcomes:

- The strategy reviewed existing walking and cycling routes alongside those identified as part of the current Cycle Infrastructure Delivery Plan and Public Rights of Way review. This network was compared using 'mesh density' as an attribute tool providing a route analysis with any gaps (based on this mesh density approach) identified.
- Outlines some of the benefits and potential barriers to active travel.
- Key journeys and routes for commuter cycle flows were mapped with 'desire lines' plotted between start and end point of a trip, establishing routes most likely to be used to make the journey between point A & B.
- The DfT's National Propensity Tool (PCT) was used to analyse this flow and comparisons made against future scenarios to assess commuting cycling potential only at an area and route level by comparing current levels from the 2011 Census data against three possible scenarios 'Government Target', 'Gender Equality', and 'Go Dutch'.
- Established a delivery plan for new cycling routes based on existing cycle priority schemes and results from the PCT for commuter cycling.

It is acknowledged that a number of nationally recognised methods and tools are used within the strategy to identify priority routes and consultants took into account the information which was available to them at the time. However the cycling routes identified and subsequently recommended as 'priority routes' are based on limited data, for example the desire lines and PCT tool used to inform the analysis have only considered existing commuter flows (based on a very small cohort of cyclists from 2011 census data). Any future strategy update and

development of the LCWIP should seek to consider an alternative approach to route priorities (based on the findings from this assessment) which includes demand/need for routes and include a wider range of destinations such as healthcare settings, local High Streets and primary schools.

A light refresh of this strategy was recently undertaken to include new data has been completed by KKP as part of the Active Place Strategy for Thurrock. An initial review of the draft of this strategy was conducted as part of this assessment. A summary of the review has been included as part of the overall recommendations section at the end of this document.

The refresh of the Transport Strategy, the associated Local Plan technical work and the development of the LCWIP should accommodate the findings of this report.

Thurrock Sustainable Modes of Travel to School Strategy (SMOTS 2015-2018)

Each academic year local authorities must prepare a document which sets out their strategy to promote the use of sustainable modes of travel to meet the school travel needs of their area[v], this is a statutory requirement under the Education Act 1996.

There are five main elements to the duty which local authorities must undertake:

- an assessment of the school travel needs of children, and young people within the authority's area;
- an audit of the sustainable travel and transport infrastructure within the authority's area that may be used when travelling to and from, or between schools/institutions;
- a strategy to develop the sustainable travel and transport infrastructure within the authority so that the travel and transport needs of children and young people are best catered for;
- the promotion of sustainable travel and transport modes on the journey to, from, and between schools and other institutions; and the publication of Sustainable Modes of Travel Strategy.

Thurrock's Sustainable Modes of Travel to School (SMoTS) Strategy applies to transport for all children travelling to school in the Borough. It sets out to increase the number of children and young people who travel by sustainable modes for educational journeys, and to ensure educational sites are accessible in order to promote modal choice.

The current SMoTS for Thurrock ended in 2018, the strategy was supported by a delivery plan of actions and key performance indicators pertaining to 2016/17 and would therefore benefit from review and refresh. As well as being an annual statutory requirement it is recognised as a key document by local schools for achieving improved uptake of active travel. The refresh of this strategy should be identified as a priority and form part of a suite of education, travel and transport policies and strategies being developed or already adapted by the Council to help meet its corporate objectives.

Thurrock Traffic Management Plan (2012-2026)

The traffic plan aims to improve the flow of traffic and reduce congestion by identifying the following objectives:

[v] Section 508A (1) (a) of the Education Act 1996.

- Delivery of a targeted programme of measures to encourage a modal shift to more sustainable modes of transport such as walking and cycling, particularly in the urban area;
- Managing the existing network so as to improve its efficiency;
- Develop and deliver further connections along the National Cycle Network 13 route (from the west of the borough to the north east of the borough) including connections to local cycle links.

Progress against objectives and current relevance of the plan would benefit from review prior to informing any future transport related policy or strategy.

Thurrock Transport Strategy (2013-2026)

The strategy identifies substantial scope within Thurrock for encouraging a modal shift in travel to more sustainable modes of transport, highlighting improvements to conditions for cyclists and pedestrians with focus on accessibility and safety. It identifies a number of aims to improve accessibility by walking or cycling by implementing safe and convenient walking and cycle networks, with core pedestrian and cycle routes supported by traffic management such as 20 miles per hour speed limits.

The strategy identifies and emphasises improvements in accessibility by walking, cycling and public transport to services, but especially education, employment and healthcare. The priority will be 'to deliver *these accessibility improvements where deprivation is most apparent, in order to help tackle deprivation and promote equality of opportunity, and where significant levels of growth need to be delivered and accommodated sustainably'.*

This strategy is currently being refreshed as part of the Local Plan process and the update to the Thurrock Transport Strategy in 2021 should be informed by the findings of this assessment.

Thurrock Air Quality and Health Strategy (2017)

The Council has already laid out commitments to reducing the high levels of transport emissions in the Thurrock Air Quality and Health Strategy (excerpt below). A number of these environmental pledges involve increasing active travel as a means of achieving motor vehicle use reduction:

The council will deliver transport interventions aimed at reducing emissions from transport generally across the borough, but in particular within Air Quality Management Areas as part of Air Quality Action Plans. This will be achieved through:

- *Implementing infrastructure to make walking, cycling and public transport more accessible to reduce the number of vehicle trips*
- *Enabling people to reduce car use and vehicle trips, such as by car sharing and encouraging walking and cycling*
- *Using travel planning and other means to promote low emission cars, car sharing, and modal shift to walking, cycling and public transport*

Air Quality and health is discussed further in section 3.7.

All of these individual and interrelated strategies and frameworks come together in support of the Council's overall vision for Thurrock which is set out in its Corporate Plan.

2.3 Summary of local strategies and plans

Active travel is widely referenced within local strategies and plans (summarised in section 2.2 above), with each identifying broad ambitions and measures. The multiplicity of ambitions are not always aligned and are therefore difficult to distil into an achievable and realistic number of priority goals. Moreover this presents a risk in terms of policy misalignment and uncoordinated interventions or initiatives.

The production of a refreshed Active Travel Strategy should provide the principle lead strategic vision for walking and cycling in the borough that is operationally clear on how this will be delivered. Working alongside the strategy the Council needs to establish a borough wide walking and cycling infrastructure plan (LCWIP) developed in line with the government's process. This infrastructure plan will identify core zones and preferred routes and provide a programme of improvements which will be a crucial element for securing future investment. The strategy and outputs from the plan, together with the principle strategy can then be aligned and integrated into planning and transport policies, strategies and delivery plans.

2.4 Other related documents

Thurrock Health and Wellbeing Strategy (2016-2021)

This Strategy is in its final year of delivery and currently undergoing a refresh for 2021 onwards. Goals within the existing strategy focus on healthier environments and this will remain a priority, with active travel forming an important contribution to achieving this.

Locally the document will seek to supplement delivery of the following linked objectives:

Priorities 2 and 4:

Healthier environments	• Create outdoor places that make it easy to exercise and be active • Building strong well connected communities • Improve air quality in Thurrock
Healthier for longer	• Reduce obesity
Better Emotional Health and Wellbeing	• Reduce social isolation and loneliness

Thurrock's Local Plan (in progress)

Local Planning Authorities are required to prepare a Local Plan that outlines plans for future development, in accordance with the NPPF. Policies outlined within the NPPF reflect the growing evidence of the importance of planning decisions for the health and wellbeing of local residents, recognising the environments where we live influence our decisions and behaviours.

Research conducted by the Town and Country Planning Association (TCPA) found 74% of Local Plans have a policy on sustainable transport that refers to the health and wellbeing benefits which will be considered when determining planning applications. A new Local Plan for Thurrock is currently in development, the plan has ambitions to include a policy framework

to support planning decisions with an expectation of better, healthier places for Thurrock's communities.

The new Local Plan should include a strong policy focus requiring the prioritisation of walking and cycling through high density, mixed use developments that enable jobs, education and services to be easily accessed by foot and bicycle, reducing the need to travel by car.

Thurrock's Design Guide (in progress)

The Design Guide Supplementary Planning Document (SPD) was adopted by Cabinet in March 2017, and is a material consideration in the determination of planning applications. In June 2020 the government revised national guidance for local authorities and designers on cycle infrastructure design. The core message behind the new guidance is that '*cycling must be placed at the heart of the transport network and no longer treated as a marginal afterthought'.* Infrastructure design is covered further in chapter 7.

Thurrock's Design guide is currently being updated and aims to align with this national approach. The guide will inform design and safety principles for the delivery of new and upgraded walking and cycling routes that the Council will follow, and developers will be expected to follow, when implementing infrastructure schemes and new developments.

3. The Case for Active Travel

The benefits of cycling and walking investment are significant and well proven. This chapter provides some compelling evidence demonstrating that investment in active travel has created better and more successful places.

NB: Some of the benefits of active travel included in this section underpins much of what has been identified within the 2020 Active Travel Strategy for Thurrock. This chapter seeks to emphasise new evidence and more detailed information pertaining to specific benefits for Thurrock, not otherwise identified in earlier documents.

Key messages

Investment in Active travel has the potential to deliver economic, environmental and social benefits as well as many ongoing benefits.

Economic benefits

- The benefit cost ratio of investments in walking and cycling are estimated at 5.62:1 (or 'very high' value for money).
- Evidence suggests that if the majority of the population in Thurrock switched to an active travel mode for 20 minutes a day, 5 days a week, it could save £34.3 million in NHS costs over a 10 year period.
- A more active workforce can lead to reductions in absenteeism and increased productivity; employees that are physically active take 27% fewer sick days.
- Walking and cycling can contribute significantly towards economic performance by reducing congestion and supporting local businesses.
- High Streets benefit from increased trade as people who walk or cycle to their local shops visit more frequently and spend more than those visiting by other means.

Environmental benefits

- Traffic related pollution along busy roads are one the main sources of air pollution in Thurrock.
- Getting people to travel by bike and foot, rather than by car can result in reduced emissions of Nitrogen Dioxide (NO2), particulate matter (PM) and CO2 helping to improve air quality and tackle climate change.
- Transport emissions and the particulate matter (PM) from vehicles have been linked with a range of health conditions. Mortality rates attributable to air pollution are higher in Thurrock when compared with the average for England.
- A third of all greenhouse gases come from transport. The short journeys we make every day by car contributes to 20% of all car related CO2 emissions.
- Places that prioritise active travel over motorised transport are generally greener, quieter and cleaner.

Health benefits

- Incorporating walking or cycling into daily travel routines is the easiest way to stay active and help manage weight – nearly 76% of adults and nearly 40% of children in year 6 are overweight or obese in Thurrock.
- A growing body of direct evidence supports specific physical and mental health benefits for both walking and cycling - regular walking and cycling is beneficial to over 20 chronic conditions and diseases.
- Improvements in local air quality can help those with pre-existing cardiovascular and respiratory diseases.

Social Benefits

- Neighbourhood communities with less motorised traffic have more positive contact with each other.
- Streets with active travel connectivity increases independence for vulnerable groups such as the elderly and young and those with mobility afflictions.
- Urban areas that prioritise active travel reduce the dominance of the highway network and other public places by cars. This creates a higher quality public realm, and more attractive and pleasant places to live, work and invest in.

3.1 Economic Benefits

Findings from Public Health England's report W*orking Together to Promote Active Travel* (3) found the overall costs to society from road transport are considerable. The report included statistics from the Environment Agency that estimated half of the UK's £10bn cost per annum of air pollution comes from road transport. The cabinet office has estimated that excess delays, accidents, poor air quality, physical inactivity, greenhouse gas emissions and some of the impacts of noise resulting from road transport costs English urban areas £38-49 billion a year (4). Physical inactivity is the fourth leading risk factor for death worldwide and contributes to one in six deaths in the UK (5). A lack of physical activity is harmful, contributing to an increased risk of diabetes, cardiovascular disease and cancer.

To address this problem, the NHS recommends that adults carry out 150 minutes of moderate aerobic activity per week, such as cycling and brisk walking, or 75 minutes of vigorous activities such as running or sport[vi]. This level of activity can almost be achieved by incorporating just two 10-minute periods of brisk walking or cycling into our everyday lives.

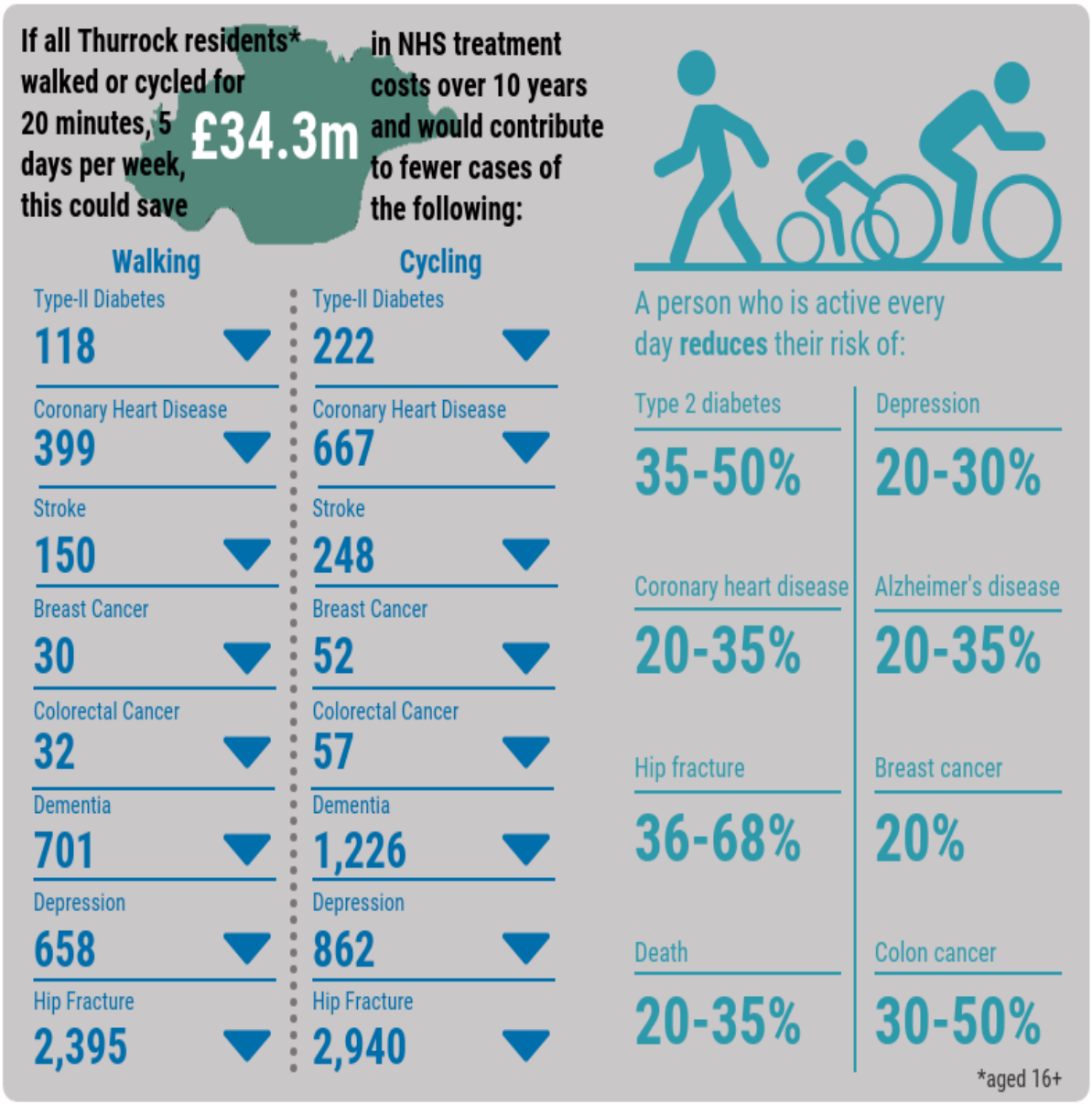
Thurrock's Whole Systems Obesity JSNA identifies that only 60.9% of adults (+18) in Thurrock are reporting this level of activity. This is significantly lower than the England average of 66.3% identified by Public Health England. Children (from age 5 upwards) and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes a day. Only 45.7% of those aged 5 to 16 in Thurrock meet these recommended levels of activity compared to the England average of 46.8%. Research consistently demonstrates that walking and cycling can contribute to improved physical, mental, and social health. The National Institute for Health and Care Excellence (NICE) has recently recommended that local authorities prioritise active travel to help people of all ages become more physically active (6).

The figure below estimates the potential cost savings for Thurrock using Sport England's MOVES tool (7) (developed by Sports England and the University of East Anglia's Medical School Heath Economics Consulting Group). The tool was designed to help measure the impact sport and physical activities can have on the population's health and the economy by providing an economic assessment of the quantifiable health benefits of interventions such as walking and cycling. The tool calculates this by estimating the risk reduction due to reduced cases across seven different diseases due to an increase from specific amounts of physical activity.

For our local calculation we have applied these recommendations as two practical scenarios: if everyone aged 16 and over in Thurrock walked briskly for 20 minutes 5-days-per-week or if that same population cycled at a moderate level for 20 minutes 5-days-per-week. It is most likely that there would be a combination of these activities across the population with some preferring one method to another, however we were unable to calculate a mixed outcome. Therefore, the savings to the NHS is the most conservative estimate from the outputs and the reduction in cases would likely fall somewhere between the all walking and all cycling estimates.

[vi] NHS, 2020

Figure 1: Moves-tool – Thurrock outcomes



This local calculation suggests that physical inactivity may contribute to at least 20% of deaths in Thurrock. This figure broadly correlates with findings from Public Health England (identified earlier) that suggest 1 in 6 UK deaths are attributable to physical inactivity. Levels of morbidity could be greatly reduced with only modest increases in walking and cycling. The scenario will save over £34 million pounds in local NHS treatment costs within 10 years and this figure does not account for savings in social care costs or the wider economy.

Further evaluations of NHS financial savings was included in a 2014 report by Cambridge University for British Cycling which estimated that the NHS would save £250 million a year if people replaced five of the 36 minutes they spend each day in a car and instead went by bike (8).

Boosting the high street and local town centres:
Walking and cycling improvements can increase retail spend by up to 30%

3.2 Increase Trade in Town Centres Economic benefits are also realised in studies about town centres, sustainable streets that work well for people generate increased footfall and more trade for local businesses because people who tend to walk or cycle to their local shops stay longer, visit more frequently and spend more money there than people who get there by other means (9). The scale of the impact varies between studies, on average Lawler (2014) estimates **retail vitality is boosted by 30% in cities where active travel is prioritised**. Raje and Saffrery (2016) estimates that provision for cycle parking delivers **5x** the retail spend per square metre than the same area of car parking. Carmona et al (2018) found retail vacancy was **17%** lower after walking and cycling improvements to High Streets and Town Centres and retail rental values rose by **7.5%.**

Attracting employees and businesses:
Businesses see walking and cycling as key to attracting and retaining the staff they need to thrive

3.3 Business Benefits Findings from the British Council for Offices (2017) reported that 85% of businesses agree that active travel is important for their business performance. Wider research found businesses are prioritising and more keen to invest in areas where there are safe and attractive places to walk and cycle. In terms of employee benefits, research from the *National Institute for Health and Care Excellence* (NICE) found employees who are physically active take **27% fewer sick days** than their colleagues. Three quarters of employees who cycle felt it made them more productive at work (10) and enjoy their job more.

Healthier communities:
Travelling by active modes is one of the easiest ways to build more physical activity into daily routines

3.4 More Active Populations Physical inactivity and sedentary lifestyles are now one of the biggest threats to our health, the convenience and comfort of car travel is a key factor in the decline of physical activity levels. Both nationally and locally, levels of walking and cycling have not been increasing, while the use of cars motor transport has increased (11). According to Public Health England (PHE) half of all women and a third of men in England are damaging their health due to a lack of physical activity (11). Encouraging active travel to get to and from work, school and local facilities is identified as one of the best ways of incorporating activity into daily routines, and therefore has greater likelihood of being habitually sustained (12). These types of journey are also recognised as being the main way in which groups at risk of poor health can gain their exercise.

There is vast potential within Thurrock for increasing exercise through active modes of travel, for example within Thurrock 41% of commutes to work are under 10km. A cycling distance

under 8km is cited by the British Medical Association as a distance the average person can easily cover.

Studies have consistently shown that in areas with convenient local access to shops, public transport, pavements, bicycle facilities and recreational facilities, communities are 20-50% more likely to meet physical activity guidelines than if they lacked these amenities (12).

Levels of activity decline amongst those from economically disadvantaged backgrounds, groups of people from the most deprived communities have almost twice the levels of inactivity than those from the least deprived.

A report published in 2018 by Public Health England *cycling and walking for individual and population health benefits,* included an evidence review by Kelly et al. The review found that both walking and cycling as modes of travel are associated with numerous positive health outcomes and beneficial to over 20 chronic conditions and diseases. A full summary of this review is included as Appendix A. In support of this review, in the general literature on cycling and walking, studies have reported that residents of more multi-modal communities exercise more and are less likely to be overweight than residents of car-orientated communities (13).

Better mental health: Active travel can boost individual wellbeing as well as reduce social isolation by facilitating more neighbourhood contact

3.5 Improved Mental Health and wellbeing

Recent studies suggest that even short periods of walking and cycling associated with active travel have been shown as beneficial to mental health. The scoping evidence review published by Kelly et al. (Appendix A) looks at the mental and neurological health outcomes of walking and cycling.

The walking review found a positive association for both psychological and subjective wellbeing, with consistent beneficial effects for depression, anxiety, self- esteem and psychological stress.

The cycling review found insufficient literature that met the criteria for inclusion of the mental or neurological health benefits. The limited studies that were conducted provided indications that cycling could benefit mental wellbeing and sickness absence from work, psychological stress, subjective well-being and social isolation and loneliness.

Findings from our own local analysis found that walking and cycling for 20 minutes a day could prevent over 600 cases of depressive illness in Thurrock. Other findings from wider studies found increased motorised traffic reduced positive contacts between neighbourhood communities. It is widely documented that the lower the traffic on a street, the more community interaction and healthy physical activity we see. A recent study in Bristol concluded that residents living in streets with heavy traffic had significantly fewer friends and less social support than those living in a quiet one (14).

The impact of social isolation can particularly affect the elderly. Research based on the English Longitudinal Study for Aging found that elderly populations experiencing high levels of social isolation had significantly higher mortality rates than those with low or average levels of isolation (15). Carmona et al (2018) found walking and cycling improvements to High Streets led to a **216%** increase in people stopping, sitting and socialising.

Peaceful living:
Reducing noise from motor traffic can lead to better sleep, concentration, and general quality of life as well as reducing health risks

3.6 Reduced Noise Consequences of noise from motor traffic has also been shown to impact on mental health and wellbeing. Traffic noise can have a significant effect on our quality of life typically of sleep disturbance and annoyance. In children it can affect memory and concentration, impacting on school performance. It is also agreed by many experts that environmental noise can lead to chronic health effects. For example, associations have been found between long term exposure to some types of transport noise, particularly from aircraft and road traffic, and an increase in the risk of cardiovascular effects (heart disease and hypertension) (16).

3.7 Improved local air quality Thurrock's Transport Strategy[vii] highlights congestion problems on some local road networks and these are forecast to worsen with the planned levels of growth and regeneration. Busy roads and slow moving traffic have considerable environmental and health impacts as well as affecting the quality of life for residents and visitors by contributing to the degradation of public spaces. Exhaust emissions from motorised vehicles contain a range of air pollutants notably particulates and nitrous oxide, these can affect the air quality of the surrounding environment and the air we breathe.

Healthier environment:
Reducing transport emissions will improve air quality in Thurrock and contribute to a reduction in lung cancer, COPD and overall mortality

As well as nationally, air pollution is a particular issue for Thurrock. Air Quality Management Areas (AQMAs) are specific locations designated as having exceeded DEFRA air pollutant objectives and therefore require monitoring and an Air Quality Action Plan to bring the air quality within acceptable limits. There are 28 AQMA's in South Essex (17), the majority (18 in total) are within Thurrock. Source apportionment exercises determined that the primary cause of exceedance in all of the 18 AQMAs was road transport.

The Public Health Outcomes Framework includes an air pollution indicator, which is expressed as the fraction of mortality attributable to PM2.5 for a local authority such as Thurrock. With a score of 6.2 in 2018, Thurrock scores higher than anywhere else in the East of England region (avg. 5.5), and higher than the average for England (5.2) although the significance of these differences are not calculated. Estimates based on Public Health England methodologies suggest that Thurrock had the equivalent of the following due to particulate air pollution in 2018:

- 80 deaths in those aged over 25 years of age
- 960 years of life lost from the population

Although the proportion of attributable mortality declined by almost 6% between 2010 and 2015 (from 6.5% to 5.9%), it has risen again since to the current level of 6.2%. Though this

[vii] https://www.thurrock.gov.uk/sites/default/files/assets/documents/ex118_nppf_transport_strategy_2008.pdf

pattern mirrors the decline and rise nationally, the average England levels have consistently been below Thurrock levels since 2010 (earliest available data).

Air pollution can cause and worsen health effects in all individuals, particularly the most vulnerable populations. Long-term exposure to air pollution can cause chronic conditions such as cardiovascular and respiratory diseases as well as lung cancer, leading to reduced life expectancy. Short-term increases in levels of air pollution can also cause a range of health impacts, including effects on lung function, exacerbation of asthma, increases in respiratory and cardiovascular hospital admissions and mortality (18). This will cause strain on our primary care services and hospitals through long term health conditions and make the borough a less attractive destination.

Areas of high deprivation are known to suffer a greater burden from air-pollution-related morbidity and mortality. Epidemiological studies show that traffic related air pollution has contributed to widening health inequalities in urban areas, as emissions are more concentrated in the heavily trafficked roads where socially disadvantaged people are more likely to live, work and shop (19). For example, sensitive receptors to traffic related pollution include residential properties, schools or residential care homes. More vulnerable population groups include populations living in the most deprived income quintiles, children and the elderly. The effect of further increases in road traffic and subsequent air quality changes on these receptors has the potential to further increase health inequalities.

Reducing emissions: Air quality will continue to be detrimental to the health of residents, workers and visitors to Thurrock unless action is taken to reduce the emissions at source. Replacing the journeys that are taken by car, that could easily be walked or cycled, will reduce the number of polluting vehicles on the road and reduce congestion on local road networks (An idling engine can produce up to twice as many exhaust emissions as an engine in motion).

Further information and data pertaining to transport emissions are included within Appendix E.

Vibrant communities: Active towns are desirable places to live and visit - they are friendlier, safer, and cleaner than those that prioritise cars

3.8 Higher Quality of Life Active travel has the potential to transform neighbourhoods, making town centres and residential areas walking and cycling friendly can enhance their attractiveness. Areas become healthier, cleaner, have less traffic noise and are generally more desirable places to live. Case studies of towns and cities where priority is given to active travel over car use found communities interact more with each other, experience less crime and attract more visitors. Everyone benefits, even those who are not walking or cycling.

3.9 Other significant studies

DfT Cost Benefit Analysis of walking and cycling investment

Further evidence to support the case for investment in walking and cycling for active travel in terms of cost benefit analysis has been undertaken by the DfT. To gain an understanding of the wider benefits the Department commissioned an independent report in 2014: C*laiming the Health Dividend – A summary and discussion of value for money estimates from studies of*

investment in walking and cycling. The report appraises the latest cost benefit evidence for investing in support for people to take up walking and cycling, examining the economic, environmental, social and distributional benefits.

The appraisal examines both former studies together with more recent peer reviewed evidence and grey literature. The findings reported substantial economic benefits of walking and cycling interventions stating in terms of value for money, the DfT values 'very highly' any scheme which returns more than £4 for every £1 invested. Benefit cost ratios were reported as of 'impressive magnitude', the mean benefit to cost ratio of all the schemes identified for the UK revealed ratios of 5.6:1.

The report concludes that investment in infrastructure or behaviour change programmes which enable increased activity levels through walking and cycling is ***'likely to provide low cost, high-value options providing benefits for our individual health. This improvement also has major benefits for the NHS and social care system in terms of cost savings, for the transport system as a whole, and for the economy through more efficient use of our transport networks'.***

A link to the full report including the outcomes of Benefit Cost Ratio analysis of specific schemes is included at the end of this document (20).

3.10 Potential dis-benefits

Road Casualties

Any relative increase in pedestrians and the number of cyclists may inevitably impact the number of road traffic injuries and who is affected, as the risk is higher for pedestrians and cyclist than car drivers (20).

Statistics provided by the DfT (RAS53001) reveal that per billion passenger kilometres (approximately 621 million passenger miles), 3,860 cyclists and 1,281 pedestrians are killed or injured, compared with 172 people travelling in cars and 121 on bus or coach. However, road safety user studies demonstrate that most of the danger arising from walking and cycling (90%) arise from conflicts with motorised traffic (21).

Over the last decade a large number of global studies have been undertaken on this topic that accept there is an inverse relationship between active travel rates and accidents; as active travel increases, the safety risks of active travel decreases - there is safety in numbers. In scenarios taken from the Netherlands where there is a strong encouragement of cycling and changes to infrastructure that offers good provision for pedestrians and cyclists, models actually show a reduction in road traffic injuries due to changes in infrastructure, road speed and a reduced number of cars on the road (22).

Both actual road traffic injury and perceived danger are identified as major barriers to active travel uptake. Infrastructure and safety is considered further in part 6 of this document.

4. National and local statistics and analysis

Key messages

Nationally:

- There is significant scope for changes in travel behaviour, 68% of journeys are less than 5 miles, and 42% of journeys less than 2 miles – a realistic distance for cycling or walking for the majority of people.
- Bicycle ownership falls dramatically between the teenage years and young adults; between the ages of 11-16 ownership peaks at 69%, declining to 41% (17-20 years) and further still to 31% (21-29 years).
- Men cycle more often and further than women, and adults in their forties cycle the most.
- Conversely women walk more than men and women in their thirties walk the most.
- There is a direct correlation between income and distance travelled, those with the highest income travel the furthest.
- People in households without a car are twice as likely to travel by active means.
- Just 38% of people over the age of 16 have access to a bike.

Locally:

- Levels of regular walking in Thurrock are similar to other areas (48% compared to 50% nationally).
- Levels of regular cycling is significantly worse than other areas (1.2% compared to 4.4% nationally).
- Over three quarters of adults in Thurrock walk at least once a week, but only half are regular walkers. Walking made up 21% of all trips.
- Almost a fifth of adults in Thurrock find some time to cycle at least once every month although cycling by active travel means made up only 1% of trips.
- Walking and cycling activity drops significantly between primary and secondary school transition.
- Cars are still the most common mode of transport, accounting for 62% of journeys.
- The majority of children within Thurrock live within 30 minutes walking or cycling time to a primary or secondary school, although many are travelling greater distances to schools outside their local catchment and therefore unable to utilise travelling by active means.
- Only about 4% of Thurrock children cycle to school; contrast this with a figure as high as 59% in the Netherlands.
- Thurrock commuters spend longer travelling for their daily commute than national averages (40 minutes compared to 30 minutes nationally).

4.1 About the data

The DfT present annual statistical releases on walking and cycling in England using two main sources - The National Travel Survey (NTS) and the Active Lives Survey (ALS). Statistics from both these sources were assessed by the UK Statistics Authority and confirmed as National Statistics since 2011[viii].

[viii] An assessment report was published in October 2010. Statistics from the Active Lives Survey are Official Statistics.

The figures presented in the charts below are prepared using either specific DfT data gathered from the latest statistical releases or data sourced from the 2011 national census.

In areas where local data is limited or non-existent, we have reverted to national data for the purposes of this report until any results from more local studies become available.

Walking in these tables refers to any continuous walk of over 10 minutes, adults are defined as those over the age of 16. Cambridgeshire was the local authority where statistics for cycling in particular were consistently better than most other parts of the UK and has been included as an aspirational comparison. Further information on statistical sources included within this assessment are included in the methodology notes at the end of the document (Appendix D).

4.2 Walking for any purpose

In Thurrock, three quarters of respondents (78%) walked at least once a week, but this falls to less than half of the population for regular walking (at least 5 times per week). Levels of walking in Thurrock are statistically similar to the rest of Essex and regional averages.

Figure 2: Adults walking at least once a week

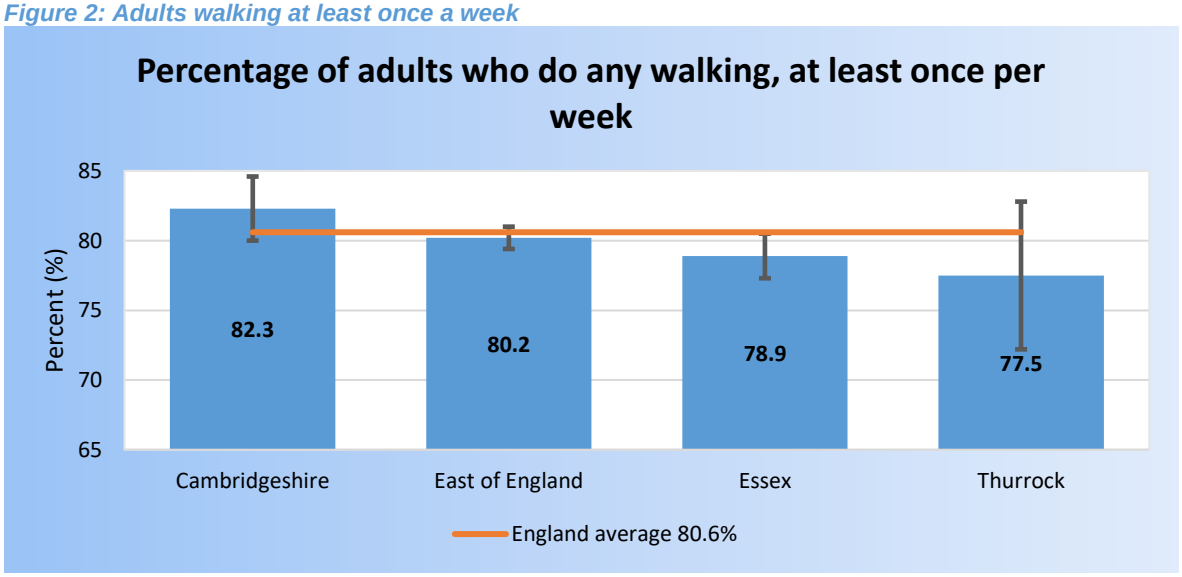
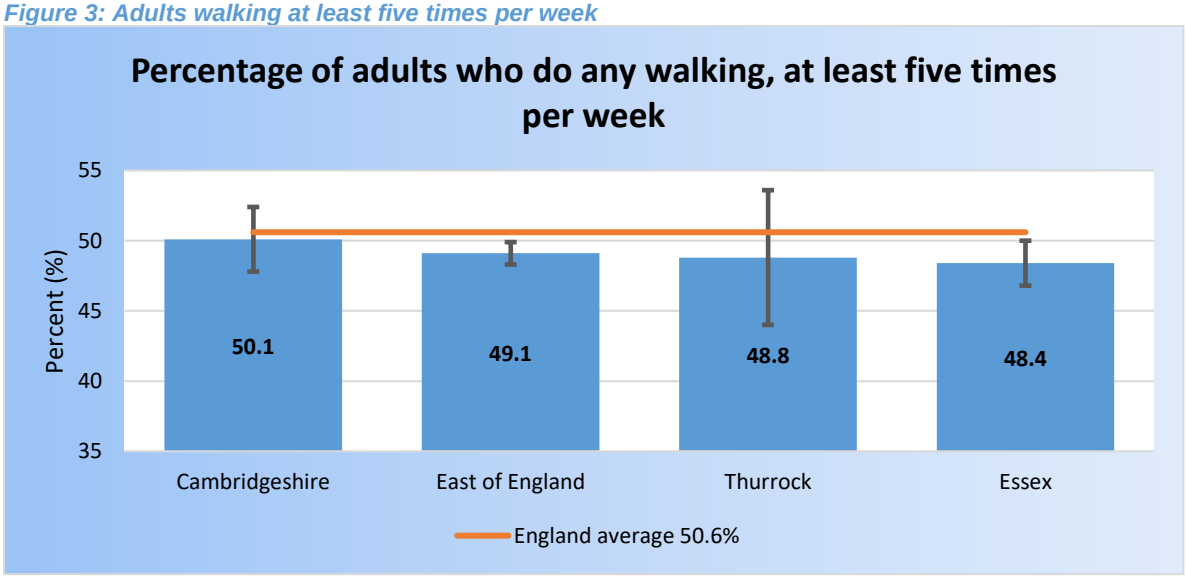


Figure 3: Adults walking at least five times per week

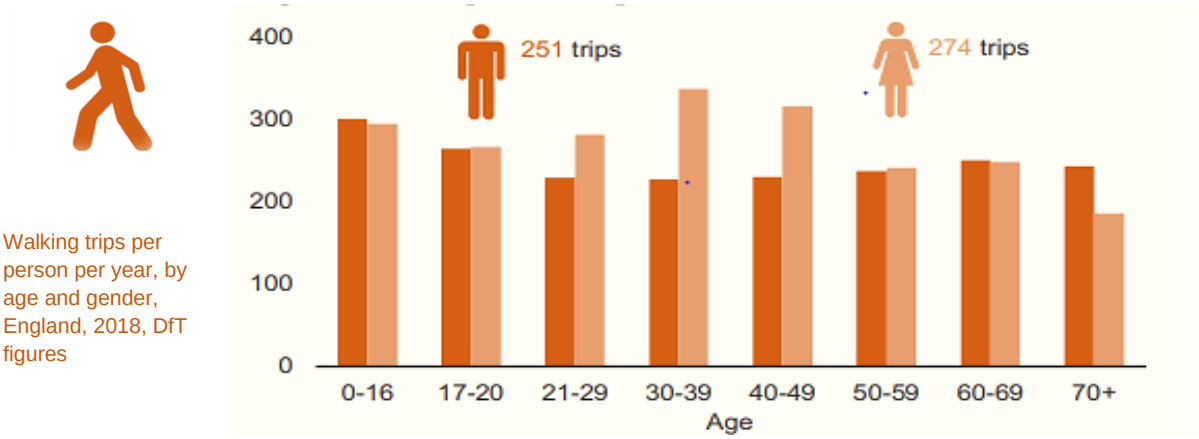


Source: DfT 2018

4.3 Age and gender

The number of walking trips[ix] and the reasons for walking varies by age and gender. In 2018, females on average made 23 more walking trips than men (10% more). On average people in all age groups tend to walk a similar amount, slightly increasing for women in their thirties and forties, and women aged 50 and older walking slightly less. One possible reason for the increase in middle aged women is that women in their thirties make four times as many education trips than men of the same age, and walking is the most common mode used to make these trips (23).

Figure 4: walking trips by age and gender



Walking trips per person per year, by age and gender, England, 2018, DfT figures

4.4 Cycling for any purpose

The prevalence of cycling varies by frequency of trips taken, the proportion of adults who cycle in Thurrock either regularly or infrequently is lower than East of England and the rest of Essex. Only around 6% of adult's do any cycling once per week in Thurrock (figure 5). By comparison, almost three quarters (71%) of the Dutch population cycle at least once a week.

Regular cycling levels decreased for all regions with an increase in frequency (at least 3 times per week), with only around 1.2% of residents in Thurrock cycling on a regular basis (figure 6).

[ix] A "**cycling or walking trip**" is one where the greatest part was cycled or walked. Stage: **Trips** consist of one or more stages. A new stage is defined when there is a change in the mode of transport.

Figure 5: adults cycling once a week

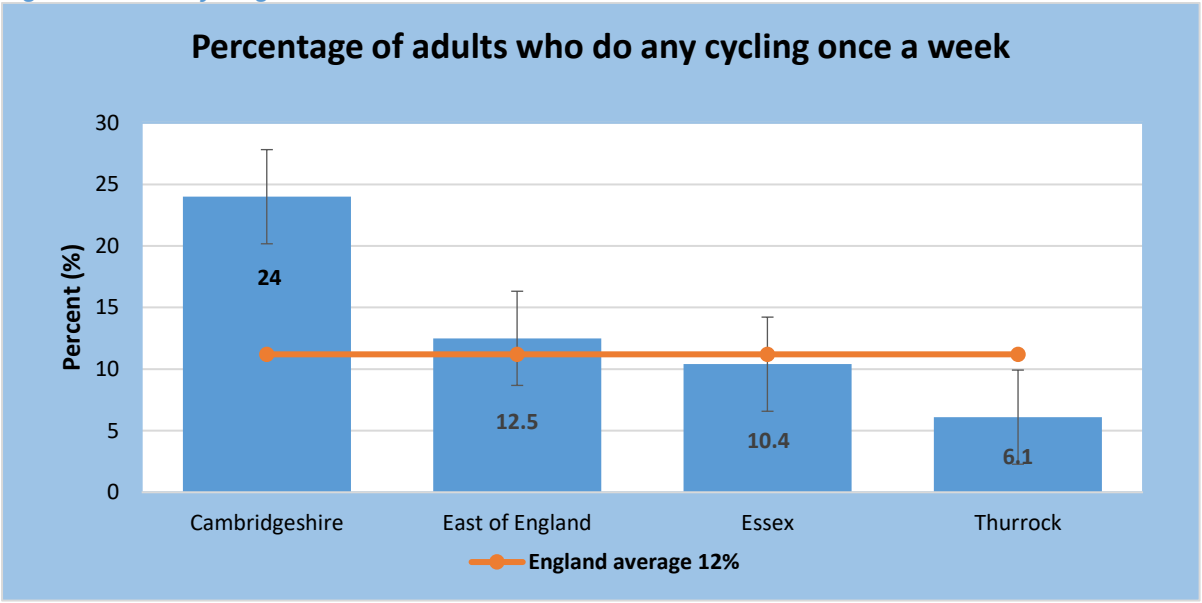
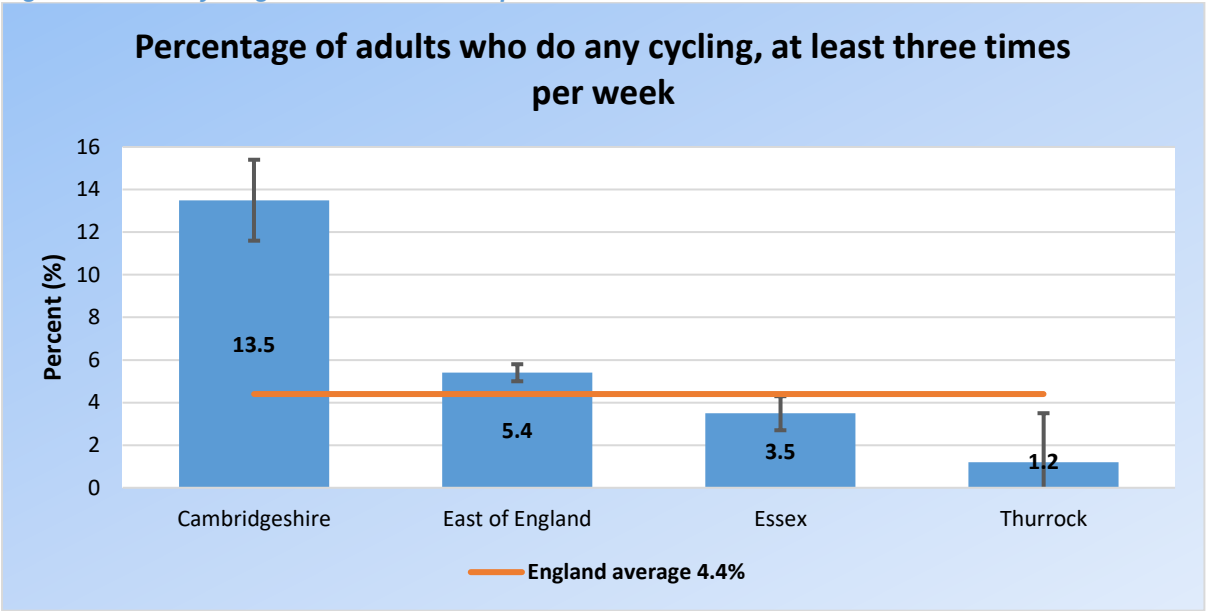


Figure 6: adults cycling at least three times per week

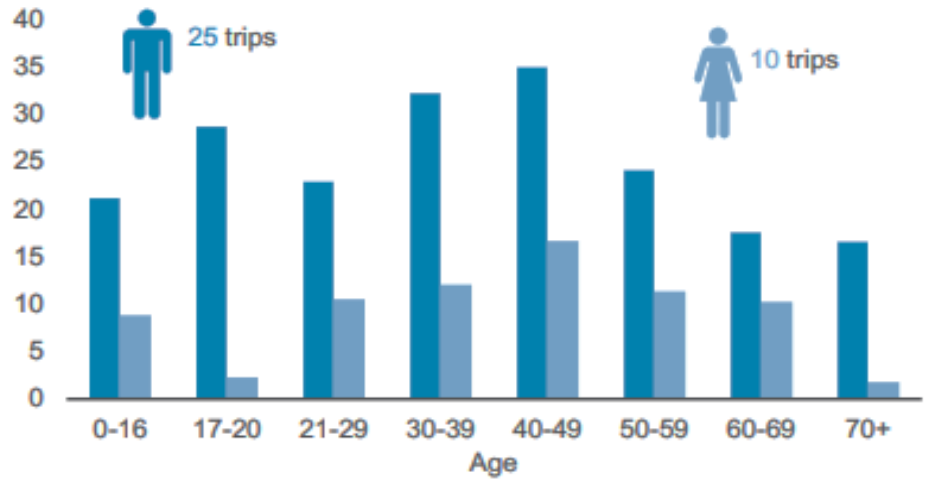


Source: DfT 2018

4.5 Age and gender

Data provided by the Department for Transport (Figure 7) shows men cycle more often and further than women, adults aged 40–49 made the most cycling trips for both men and women with levels falling over the age of 50 (23). Yearly data from the National Travel Survey showed men made 15 more cycle trips than females (25 trips compared to 10 trips), and cycled almost four times further than women (92 miles compared to 25 miles). There are no age groups where females make a comparable number of trips to males. The lowest cycling rates across all ages and genders were particularly pronounced in girls aged 17-20.

Figure 7: cycling trips by age and gender



Cycling trips per person per year, by age and gender, England, 2018, DfT figures

Findings from The International Journey of Behavioural Nutrition and Physical Activity conducted in 2013 looked at the physical activity profile of active children in England and found that girls in most deprived areas cycled significantly less that girls in less deprived areas. There was no significant different in socioeconomic status for boys, or for levels of walking in boys or girls (24).

Research undertaken as part of the 2019 Sustrans[x] guide for inclusive cycling in towns and cities (25) found that lower cycling rates in women were most likely to be attributed to concerns with personal safety and experiences with anti-social behaviour while travelling. Women are also more likely to use different modes that involve multiple stops partially due to family commitment such as balancing childcare, work and other household responsibilities.

The same study found that 36% of women who currently do not cycle, would like to.

Research specific to age:

Walking remains a popular choice for local journeys as we grow older but rates of cycling decline in the over 60's. During 2019, Sustrans conducted specific research comprising a number of focus groups for those over the age of 60. The study found that older people felt transport had become harder in towns and cities as car use and populations have grown, with many older people reluctant to travel during the busy rush hour because of safety and physical ability concerns. Planning for the needs of older mobility is required if cycling is to be embedded in the lives of Thurrock's increasingly older population. National survey figures show that cycling remains a desirable form of transport as we grow older and 18% of older people who do not cycle would like to start cycling.

Places such as the Netherlands, Denmark and Japan have shown that uptake can be much higher with the right environment, highlighting the use of electric cycles and routes segregated for busy traffic is helpful in encouraging cycling participation amongst older groups.

4.6 Walking and cycling for travel

The prevalence of active walking in Thurrock (excluding walking for leisure) is statistically similar to other areas with just over 21% walking for travel on a regular basis. However, regular cycling activity in Thurrock is lower than national and regional averages with only 1% of the

[x] sustrans.org.uk/ is a registered charity in the UK making it easier for people to walk and cycle.

population cycling for travel on a regular basis compared to Cambridgeshire where 11% of the population regularly commute by bike.

Figure 8: Adults walking at least three days per week

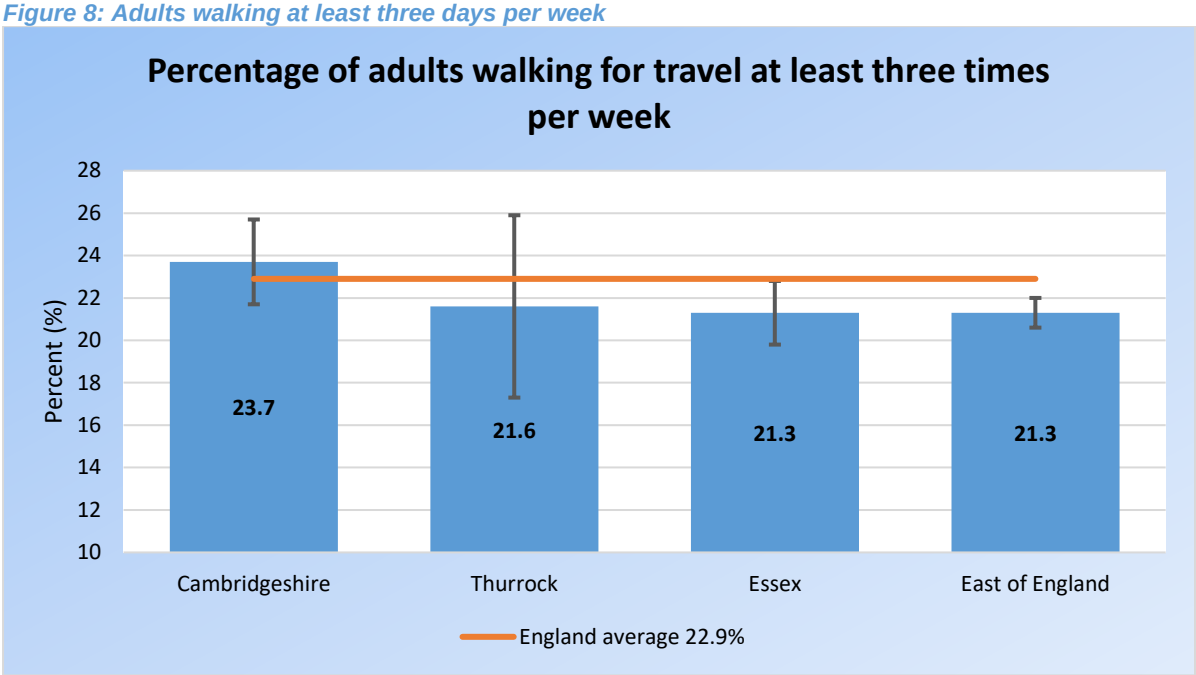
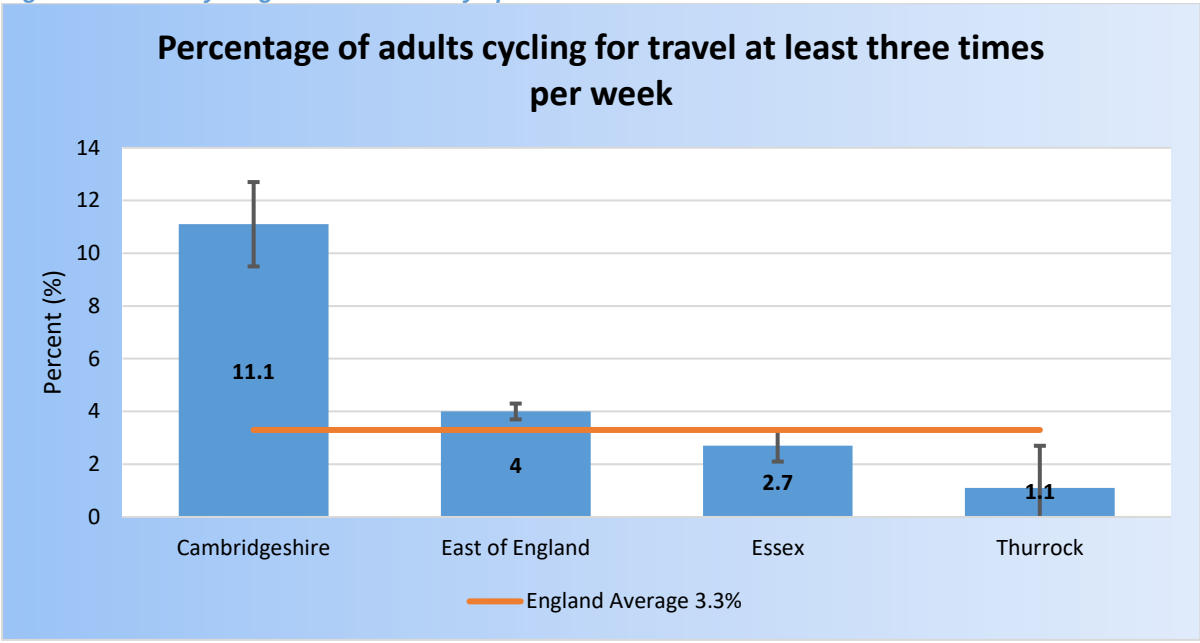


Figure 9: Adults cycling at least three days per week



Source: DfT 2018

The figures illustrated suggest levels in Thurrock are not reaching full potential; there are a substantial amount of people that could walk or cycle more but feel unable to. Research conducted for this report found there were no specific local studies that explore possible barriers that prevent people from walking or cycling, section 6 of this documents looks at the probable generic reasons.

Community consultation was undertaken during stage 2 of the Local Plan agenda which included some elements relevant to active travel. A total of 17 events entitled 'Your Place, Your Voice' ran from December 2018 to March 2019 that engaged with residents in 7 wards.

Results from the consultation revealed concerns with air quality and traffic congestion in some areas, and demonstrated considerable public support for walking and cycling infrastructure. **Improved walking and cycling links were identified as a specific community requirement by residents in 71% of participating wards.**

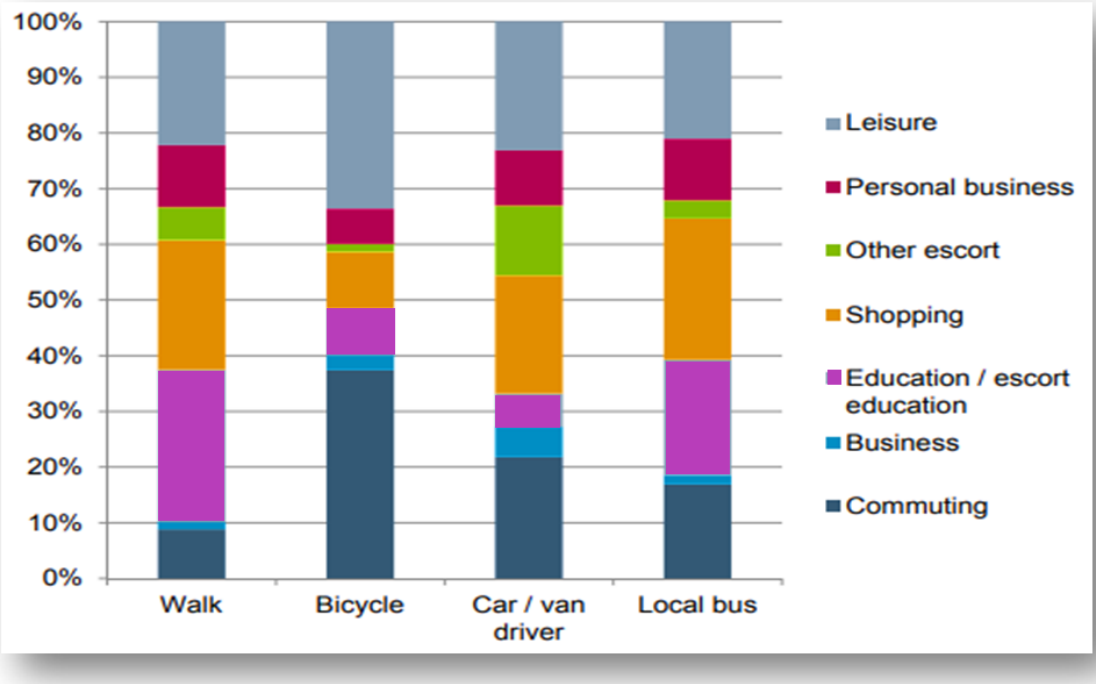
4.7 Global comparisons

Walking rates nationally and locally as a whole are statistically similar to other European countries but the UK is far behind when it comes to cycling. In the Netherlands 26% of commuting journeys are made by bike, followed by Denmark at 18% and 10% in Germany. Austria, Belgium, Finland, Norway and Sweden all have rates of between 4% and 9% (26).

4.8 Trip purpose by mode

The table below compares journey purpose split of walking and cycling with those of car/van drivers and bus users nationally.

Figure 10: Journey purpose and mode of travel



Source: National Travel Survey NTS0401 2017

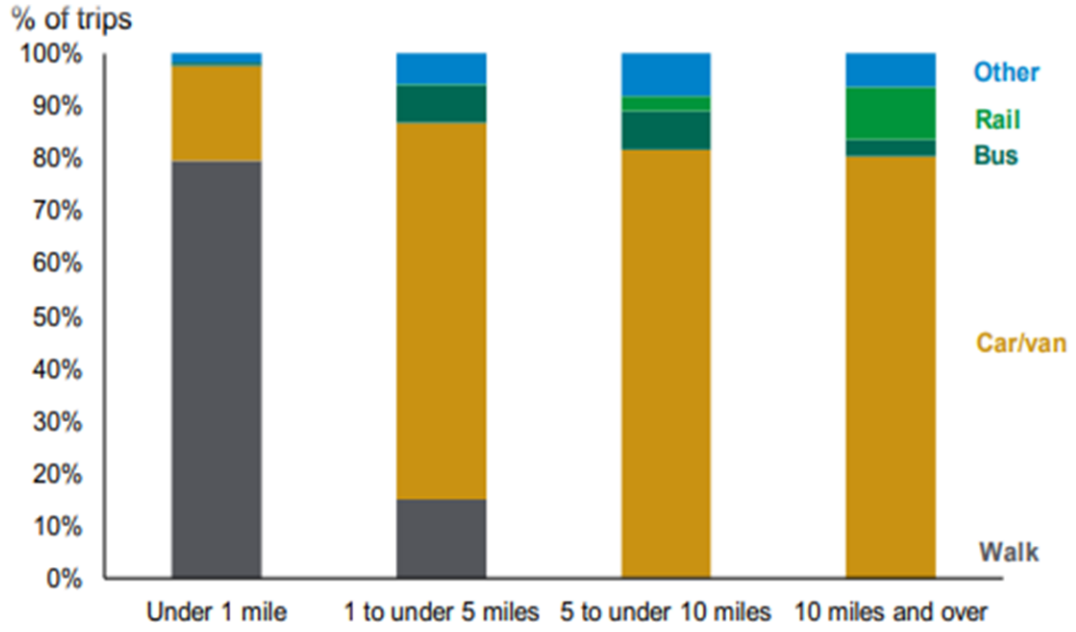
Education, shopping and leisure make the top 3 purposes for walking which together account for over 70% of trips while commuting and leisure are the main reason for cycling trips. Specific category information is included within the NTS summary at the end of the document.

4.9 Trip distance and mode

Most trips are relatively short. In England in 2018, 25% of trips were under 1 mile, and 68% under 5 miles. Walking was the most frequent mode used for short trips: 80% of trips under one mile were walked but this decreases significantly between 1 and 2 miles where only just under a third of trips were walked. The government considers this “an achievable distance to cycle for most people, with many shorter journeys also suitable for walking” (27). Having such a large number of trips that could easily be made by alternative modes such as walking or cycling, together with a relatively low uptake rate, suggests there is considerable scope to increase this cohort.

The following data outlines share of trips by mode and distance travelled within England, and although not available at local authority level, provides useful generic information on travel patterns.

Figure 11: Mode share of trips by main mode for different trip lengths: England 2017



Source: National Travel Survey data 2017

Replacing these shorter car journeys i.e. popping to the local shops, dropping the kids to school or driving to the station has some of the greatest potential in improving uptake and therefore achieving the greatest benefits. Studies suggest walking and cycling is particularly important in dense urban areas, where a high volume of people undertake a large number of shorter trips.

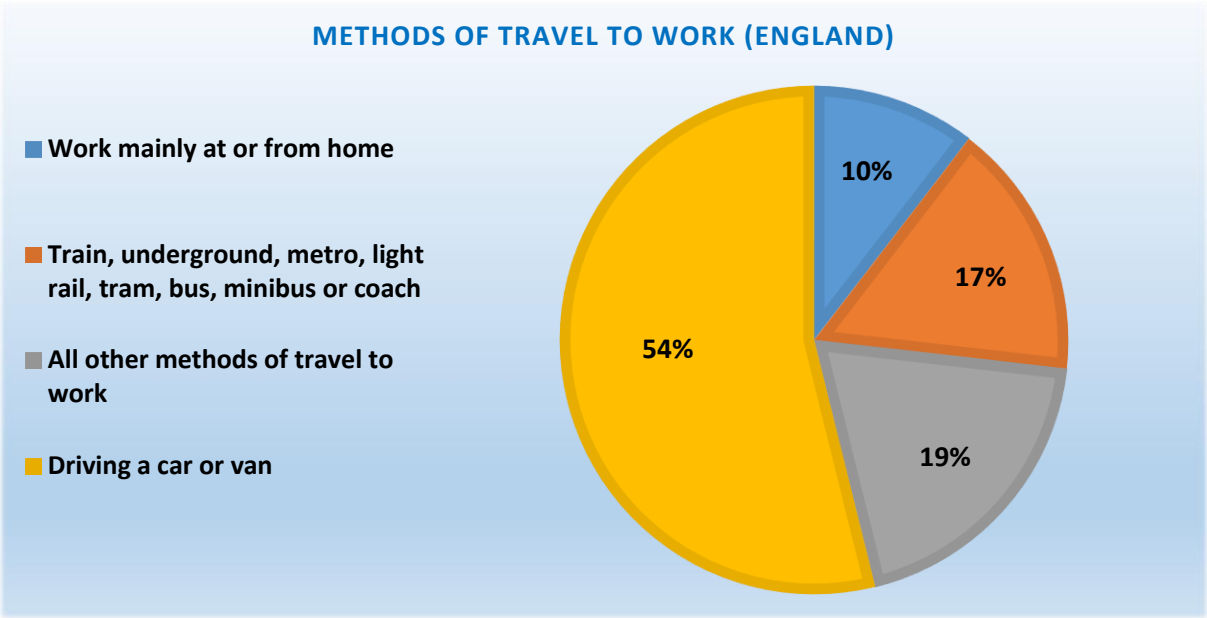
4.10 Travelling to work

4.10.1. Method of travel to work in Thurrock

The travel mode share (figures 12 and 13) describes the proportion of trips made by a given mode of transport for Thurrock. The statistics combine walking and cycling into ‘other’ category and while not especially helpful in identifying specific walking and cycling behaviour, the charts provide some useful generic information on travel activity.

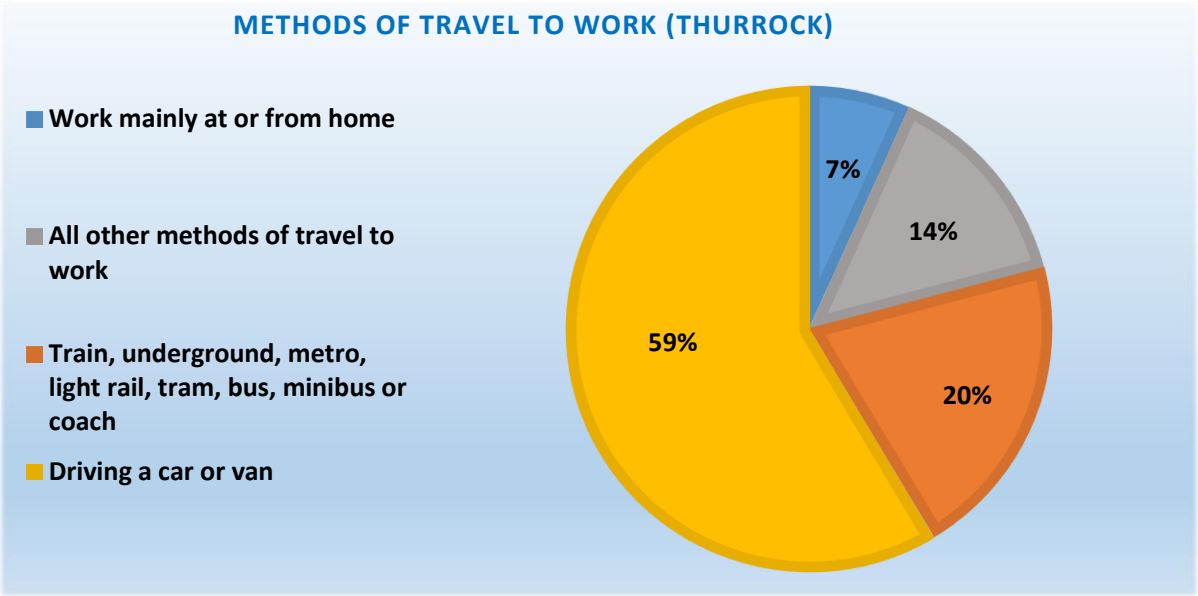
More than half of the population are reliant on a car when travelling to their place of work while cycling and walking trips (included in 'other methods of travel') accounts for only a small proportion of the travel mode share both nationally and locally.

Figure 12: Methods of Travel to Work (England)



Source: 2011 Census QS701EW, Office for National Statistics (ONS) © Crown copyright

Figure 13: Methods of Travel to Work (Thurrock)



Source: 2011 Census QS701EW, Office for National Statistics (ONS) © Crown copyright

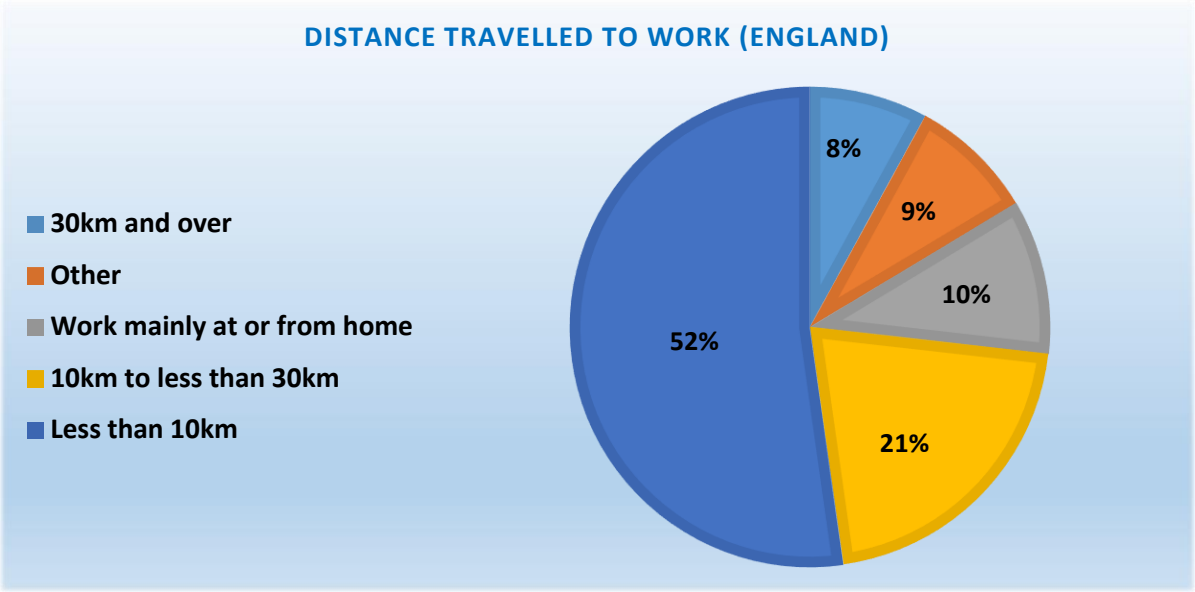
'All other methods of travel to work' includes 'Motorcycle; scooter or moped', 'Taxi', 'Passenger in a car or van', 'Bicycle', 'On foot'.

The following charts illustrate the distances travelled from the workplace to home. The data suggests that in 2011 residents in Thurrock were travelling further distances than national averages to access their workplaces. The number of adults working from home is less than the national average, this could be partly attributed to the dominance of transport, logistics

and retail sectors within the local area, or perhaps local employers are not realising the full potential for employees to work from home.

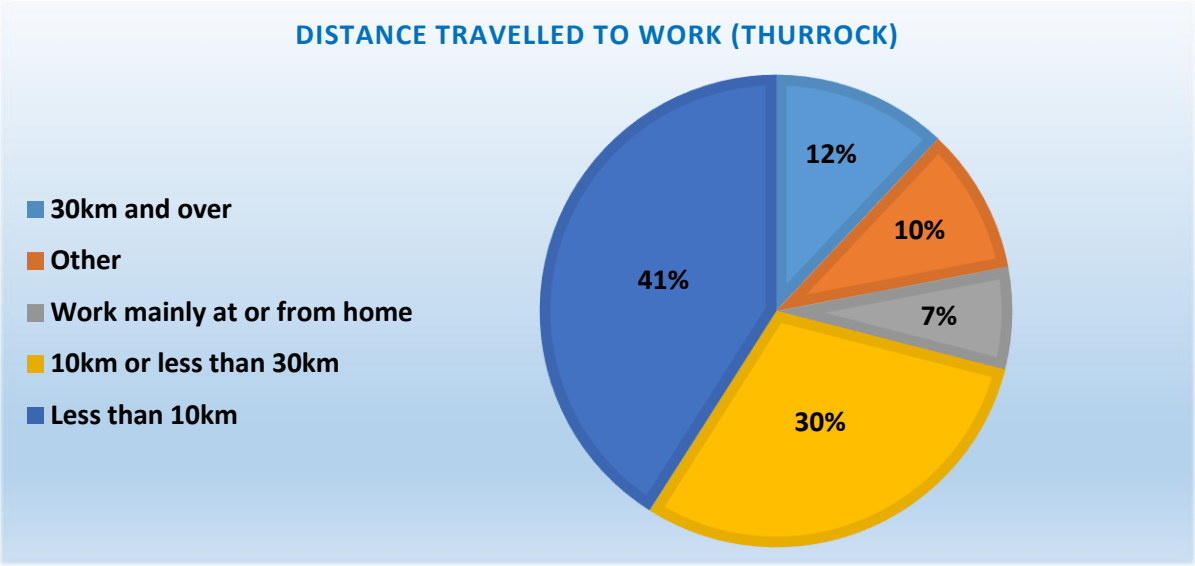
Data from the census estimates that with the present infrastructure 31% of commuting trips could be transferred from the car to walking or cycling.

Figure 14: Distance travelled to work (England)



Source: 2011 Census QS701EW, Office for National Statistics (ONS) © Crown copyright

Figure 15: Distance travelled to work (Thurrock)



Source: 2011 Census QS701EW, Office for National Statistics (ONS) © Crown copyright.
'Other' includes no fixed place of work, working on an offshore installation and working outside of the UK.

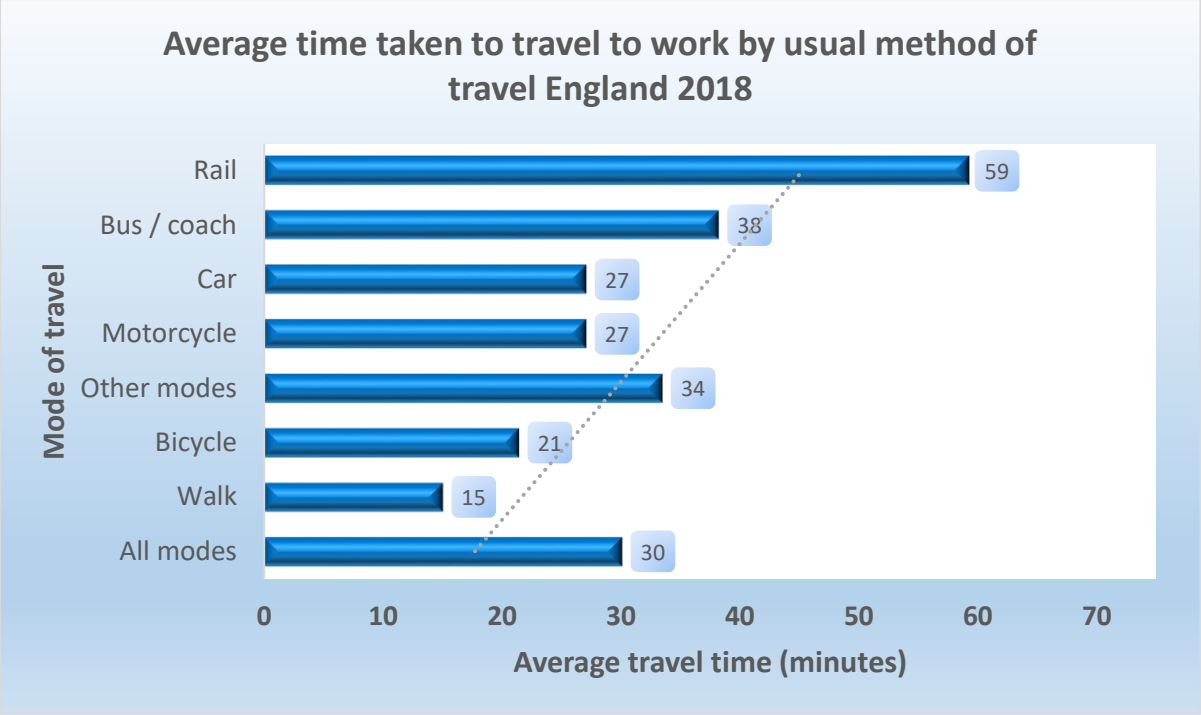
4.11 National travel time to work Journey times

Data provided by ONS labour force survey estimated usual home to work travel time for all modes of travel in the UK in 2018. Average journey times for Thurrock was 40 minutes compared to 31 minutes in the East of England and 29.9 minutes in England as a whole. Travel time does not necessarily indicate a longer journey distance when considered

alongside variables such as traffic congestion or less direct routes. However when travel times in Thurrock are considered alongside distances travelled (identified earlier) the figures broadly correlate, suggesting the journeys to work for Thurrock residents are both longer and further than average. Thurrock's Economic Growth Strategy (28) identifies *'a significant proportion of residents out-commuting for work with London a particular draw'* with journey times into the capital longer than the average commute. According to the 2011 census over a third of working adults in Thurrock commute to the capital or immediate area for work.

Travel distance is a significant factor in choice of travel mode, some journey lengths to work by active travel means exceed what is considered practical by active modes alone. In England for example one in seven commuters are now spending two hours or more each day travelling to and from work. This data is not available at LA level.

Figure 16: Average time taken to travel to work by usual method of travel (England 2018)



Source: DfT 2018

Understandably the data illustrates shorter journey times for walking and cycling, average travel times can be useful when considering the potential of walking and cycling to given destinations.

4.12 Integration with public transport for longer journeys

Travelling by active modes need not be restricted to shorter journeys, cycling is perfect for the first or last few miles of a long-distance commute. Bike-rail is one option, or in some parts of Europe Bus-rail is frequently used to combine journey modes with cycling.

A recent report from Cycling UK that explored integrating active travel with public transport found a whole package of improvements is necessary for better integration between cycling and public transport. The report stated *'It is no good simply focusing on only one aspect of provision; for example, there is little use in providing cycle parking at a station if access to the*

station feels unsafe and deters people from cycling there in the first place and there is no provision or cycling carriages on trains'. Cycling UK[xi] believes that all new and refurbished rolling stock on trains must be equipped with dedicated space for cyclists. Bikes are allowed free of charge on *most* British trains at *most* times of day. Some companies ban bikes on particular services at certain times, such as commuter trains into London. A common workaround for this is to invest in a folding bike (29).

Bikes on buses however are different; generally buses aren't able to accept bikes unless it folds up and fits into the luggage rack, although some bus companies allow it to be brought on board at the driver's discretion. The UK has some way to go compared to other countries where active travel is embedded in the culture of towns and cities.

Evidence from the Cycling UK study found integrating cycling and public transport requires a combination of:

- access to, from, within and through stations and interchanges
- cycle parking and (where appropriate) storage and hire facilities
- reasonable provision for cycle carriage on public transport
- good information, both prior to and during the journey
- stakeholder engagement and accountability

4.13 The Local Picture

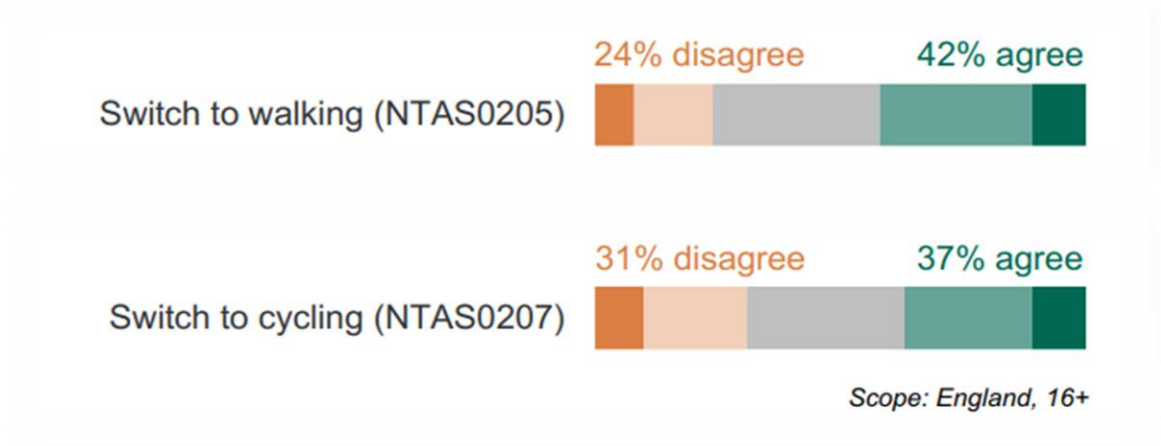
In the past the transport team within the council has worked collaboratively with the local train operating company (C2C), developing station travel plans to deliver the improvements required to encourage more sustainable journeys by rail and to encourage active modes of travel to and from the station. The council developed travel plans for all eight stations in Thurrock, the plans reflected some of the recommended evidence identified earlier such as secure cycle storage and better pedestrian and cycle access to stations. The train franchiser C2C independently refreshed station travel plans in 2018. These travel plans were reviewed with limited engagement from the Council and there is currently no coordinated monitoring process in place.

4.14 Willingness to switch to other travel modes

Annually the DfT collates information on public attitudes towards transport and their options. These include statistics on people's willingness to switch to other travel modes to reduce the amount of car journeys. When asked about the potential of taking other travel modes instead of travelling by car for journeys of less than two miles, a higher proportion of people were willing to walk or cycle to make this journey (30). The results suggest an encouraging population wide impetus to switch to walking and cycling as more active modes of travel.

[xi] One of the leading charitable organisations for cycling

Figure 17: Willingness to switch to other travel modes for journeys under 2 miles

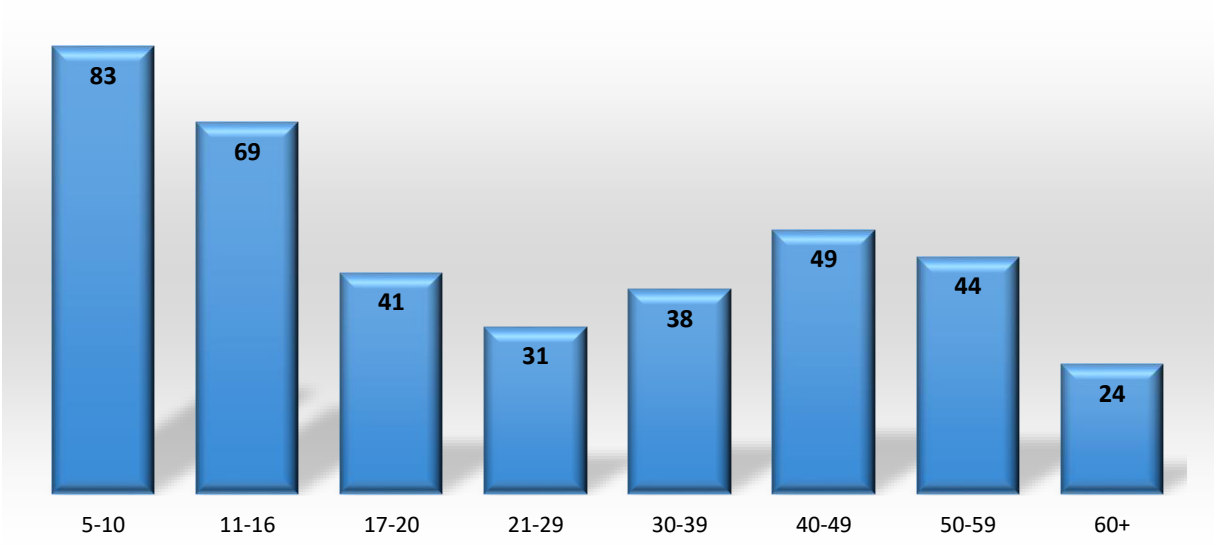


Source: National Travel Attitudes Survey 2018 (further information on NTAS is included in Appendix D - data methodology)

4.15 Bicycle ownership

In England about 47% of people aged over 5 years owned or had access to a bicycle in 2018, this proportion has remained at a similar level as previous years. Bicycle ownership is most prevalent amongst people under the age of 17 years old with ownership declining rapidly thereafter, only 31% of people in their 20's own or have access to a bike. This figure starts to rise again in 30's, peaking in 40's and 50's and then declines again as we grow older.

Figure 18: % of cycle ownership and age



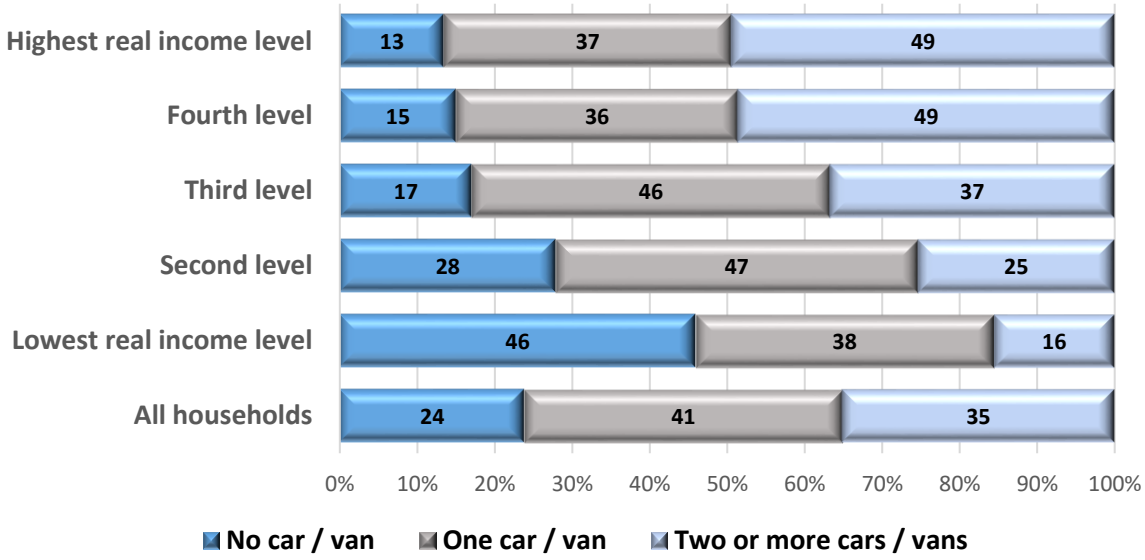
Source: DfT 2018

4.16 Household car access by income

There is a direct correlation between household income and car ownership, those with the highest income have the greatest levels of car availability with a corresponding decrease relative to income levels. Lower income households consist of females, children, young and older people, ethnic minorities and disabled people are all concentrated in this group.

Car ownership understandably affects travel behaviour, people without access to a car are far more reliant on walking and cycling as a mode of transport. People in households without access to a car made 53% of all their trips and 11% of their distance travelled by foot. This compares to 23% of trips and 3% of distance for those in households with access to a car. There is also a correlation between income and distance travelled, those with the highest income travel the furthest (31).

Figure 18: Household car availability by household income quintile (England 2018)



Source: DfT Household car access [NTS0703] Household car availability, by household income: 2018

Affordability issues with car ownership can lead to a risk of transport poverty. Active travel can help people who do not have a car to access essential services and amenities including places of work and improving access to health services.

Active travel planning and investment should be designed around the local needs of people (in response to local resident views) as well as areas with the greatest demand. Planning routes in areas with the lowest household income can potentially offer some of the greatest benefits (36).

5. Active Commuting to Schools and Workplaces

Key messages

- Data from school travel plans suggest that many more children would like to travel to school by active means than already do so. Schools with travel plans in Thurrock have cycling rates of around 5% but surveys indicate that over 21% of primary school children would like to cycle to school every day.
- Data from the schools that participated in the Brighter Futures Survey found over 50% of primary school children and 30% of secondary school children are driven to school in Thurrock.
- It is estimated that trips for education are responsible for over a third of traffic on roads between 8 and 9 am.
- Virtually all children in Thurrock live within a 30 minute walk or cycle to a primary or secondary school.
- Nationally distance and safety are identified as the most significant barriers to active travel to school.
- Boys that cycle regularly to school are 30% more likely, and girls 70% more likely to meet recommended physical activity levels

5.1 Active Travel in schools

Cycling and walking to school or college is widely recognised as a way of increasing children's daily physical activity and helps them maintain a healthy weight. The chief medical officer recommends that 5-18 year-olds take at least 60 minutes of physical activity every day, citing activities such as walking and cycling as a contributor to these activity levels. Recent data provided by Public Health England found that In Thurrock, almost a quarter of children in reception class, and over a third of children in year 6 are overweight or obese, these figures are higher than national averages.

A meta-analysis of the contribution of walking to and from school to individual and population level physical activity estimates that it contributes 23% of moderate to vigorous physical activity (MVPA) on school days in primary school age children, and 36% of MVPA on school days in secondary school pupils (32).

Cycling and walking has also shown positive impacts in children for developing their confidence, independence, self-esteem, and road safety skills. It also contributes to reducing traffic volume, pollution and road danger created by increased congestion during the school run period. Travel for education contributes significantly to peak time traffic, accounting for 29% of trips between 8 and 9 am in the UK.

Parental viewpoints (and sometimes frustration) of local cycling experiences are frequently expressed on cycling websites, the following parent account was extracted from the National Cycle Plan website blog: (57)

> *To give some clarity: My son was quite a small 10 year old.*
>
> *We cycled for 6 months, through hail, rain and -4 degrees. The journey was 2.5 miles to school (which I then cycled back from) so he cycled 5 mile per day, (I did 10) I cycled behind him, coaching him in the beginning on crossing roads, bike handling and awareness of other people, always give way, and assume people haven't seen you or aren't aware you are there. Give plenty of notice to change line, and indicate your intentions. After a while, I used to cycle behind him, just to keep an eye on how he was handling himself and the bike ready for when he was old enough to cycle to school himself, but the traffic, roads, and conditions are treacherous.*
>
> *The positive side was immense:*
>
> *He arrived at school wide awake, ready to learn.*
> *Regardless of how cold it was outside, he arrived in the classroom warm and healthy even in the depths of winter.*
> *He suffered from no viruses or colds in that time, and the heating in the house had to be turned much lower or off.*
> *He no longer complained about PE outside in the winter, (it's amazing how children today think they shouldn't do Games/PE outside if it's cold!)*
> *It gave him an added confidence.*

5.1.1 Proportion walking or cycling to school

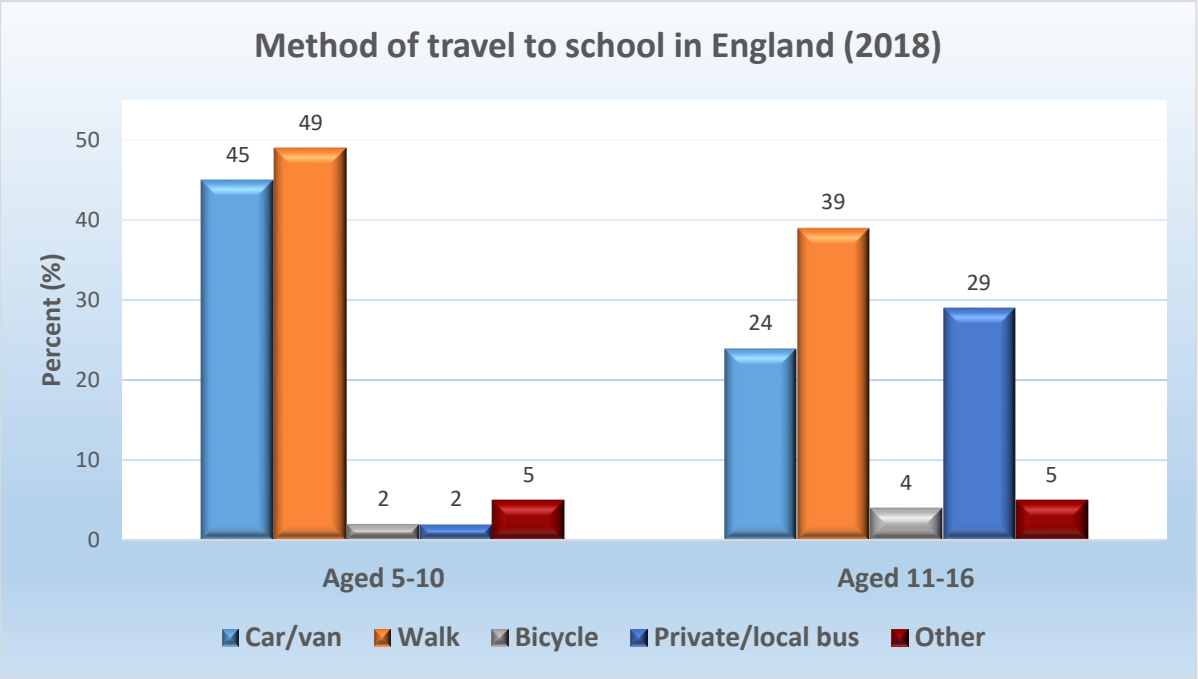
National picture

The proportion of children using active methods of travelling to school has seen only a small variance since 2002 with a higher proportion of journeys now being undertaken by car.

In 2018, 44% of all children (aged 5-16) usually walked to school, with 49% of primary school children and 39% of secondary school children did so. This is a decrease of around 8% since 2002 and an even bigger decrease since 1976 when an estimated 64% of all trips to school were made by walking (within the UK). The lower rate in part reflects the longer distances secondary school children in particular now travel to school (3.5 miles compared to 1.5 miles) and increasing car availability.

Cycling to school accounts for only a small proportion of all travel modes at only 3% of all children. This proportion has remained between 2% and 3% since 2002, (23) by contrast at least 49% of children in the Netherlands regularly cycle to school.

Figure 19: Usual mode of travel to school by age group (England 2018)



Source: DfT 2018

Local picture

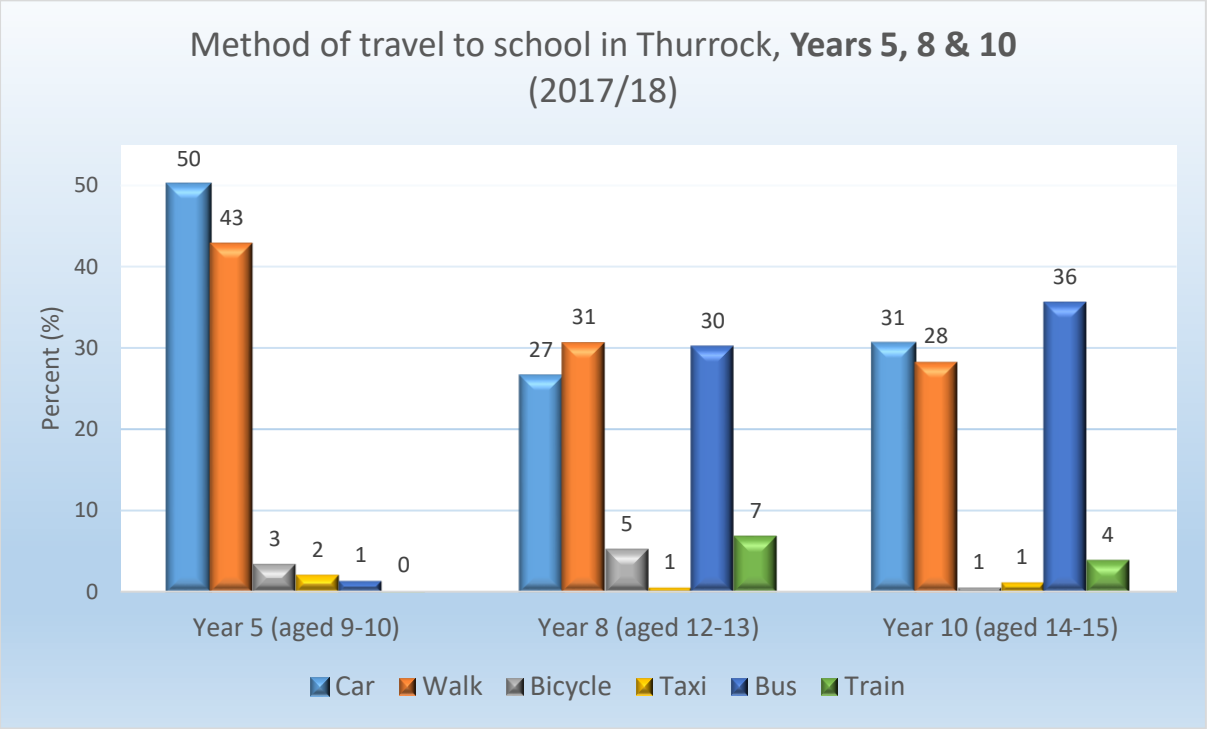
Data collated by the DfT on mode of travel to school is collated nationally and not available at local authority level. School travel data for Thurrock is collated by the council via the Brighter Futures survey commissioned by public health and via the online Modeshift Stars programme[xii] – a collaborative tool between the council and school institutions.

Brighter Futures data

Brighter Futures is a two-year survey conducted during the 2016/17 and 2017/18 academic years in both primary and secondary schools. It provides quantitative data and insight into child and adolescent experiences, attitudes and development, including method of travel to school. During the 2017/18 academic year 1,158 children and young people from 2 secondary schools and 15 primary schools completed the Brighter Futures survey. All secondary schools that participated in the survey completed both the year 8 and 10 survey during the 2017/18 academic year, primary schools completed the year 5 survey.

[xii] Modeshift STARS (Sustainable Travel Accreditation and Recognition for Schools) is a national school awards scheme.

Figure 20: Methods of travel by mode and age



Source: Brighter Future Survey, Thurrock council 2018

Data from the participating 17 schools (representing 38% of primary schools and 20% of secondary schools) suggest that within year 5 primary 3.4% of pupil's cycle, 43% walk to school and 50% are driven by car every day.

Within secondary school year 8 data suggest that 5.2% of pupil's cycle to school but this figure drops to only 0.6% in year 10. Bus or walking are the most common modes of travel while almost 30% are driven to school every day.

While the data provides a useful snapshot of travel behaviour in some schools, results are not directly comparable to national data given that not all schools take part and the variances with baseline data between the two surveys.

Modeshift STARS data

Data on school travel is also captured by the transport team via the Modeshift STARS website, although schools need to be registered to the programme and have a travel plan in place to participate. Currently data is captured from 10 schools in Thurrock via this method.

There are 52 schools in Thurrock; 39 primary, 11 secondary and two special schools, 48 of these have a travel plan in place and 10 schools have been awarded bronze, silver or gold status as part of the scheme. Although the majority of Thurrock schools have signed up, there is considerable scope to expand the accreditation status for many of the schools. Enhancing the status provides a useful mechanism to improve walking and cycling rates by encouraging schools to increase initiatives, share best practice and develop working groups.

Figure 21: Methods of travel to school Thurrock Primary with travel plans

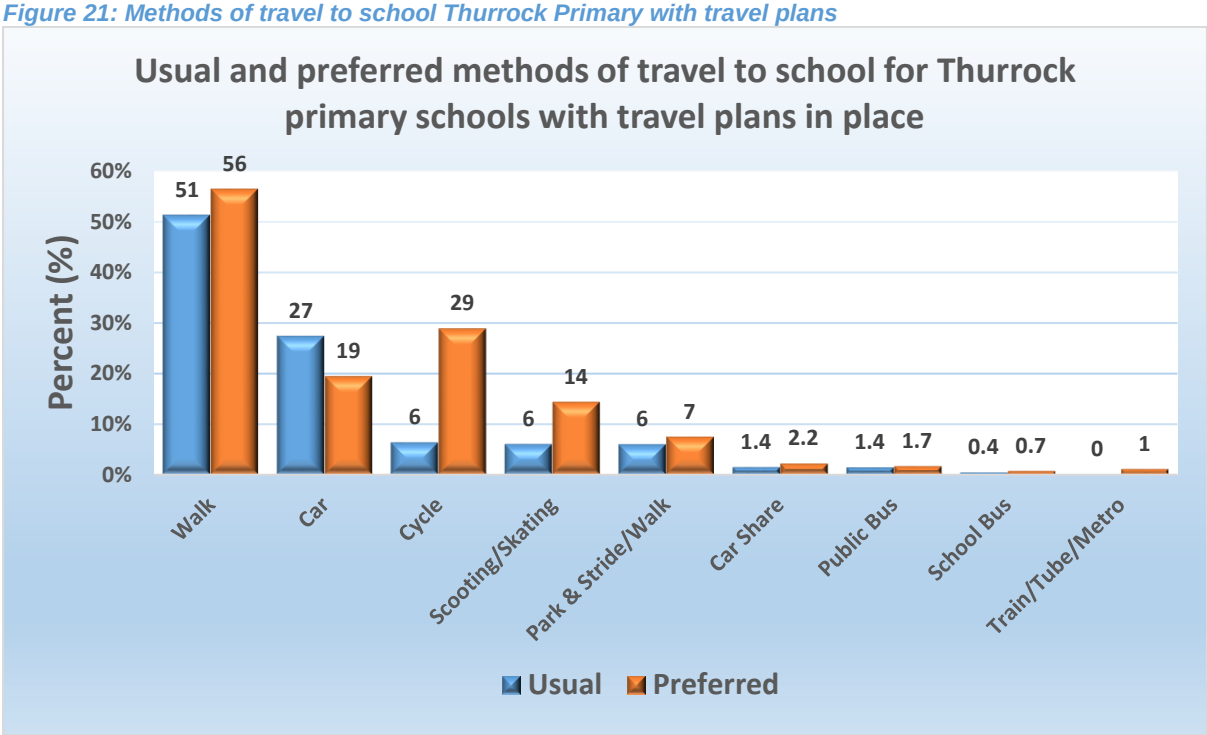
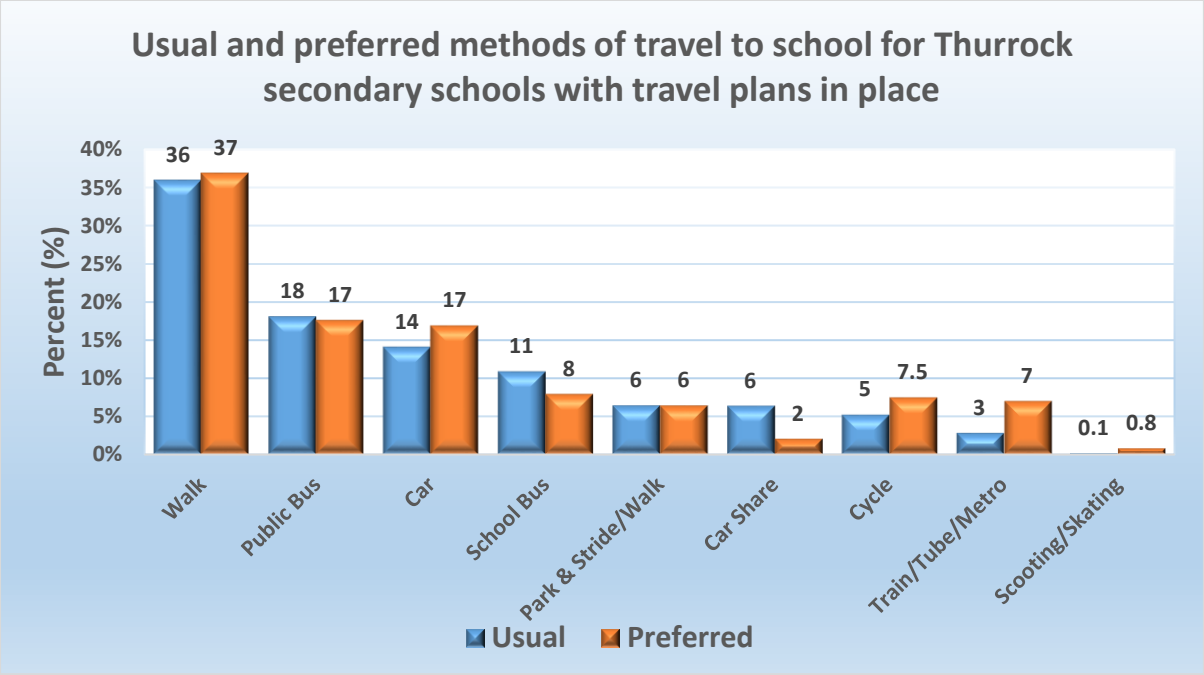


Figure 22: Methods of travel to school Thurrock Secondary with travel plans



Source: Mode shift Stars travel plan data Thurrock 2018/19

Results from the above local survey are not comparable to other results due to variances with methods of data collection and differences in participatory schools. However the data collated from schools with a dedicated travel plans in place suggest a 10% increase of walking and a 1.5% increase in cycling with a corresponding decrease in car use of 12% when compared to the Brighter Future Survey. Further analysis would be required at individual school level to verify this assumption i.e. some of the schools that participated in the Brighter Futures Survey may also have travel plans in place.

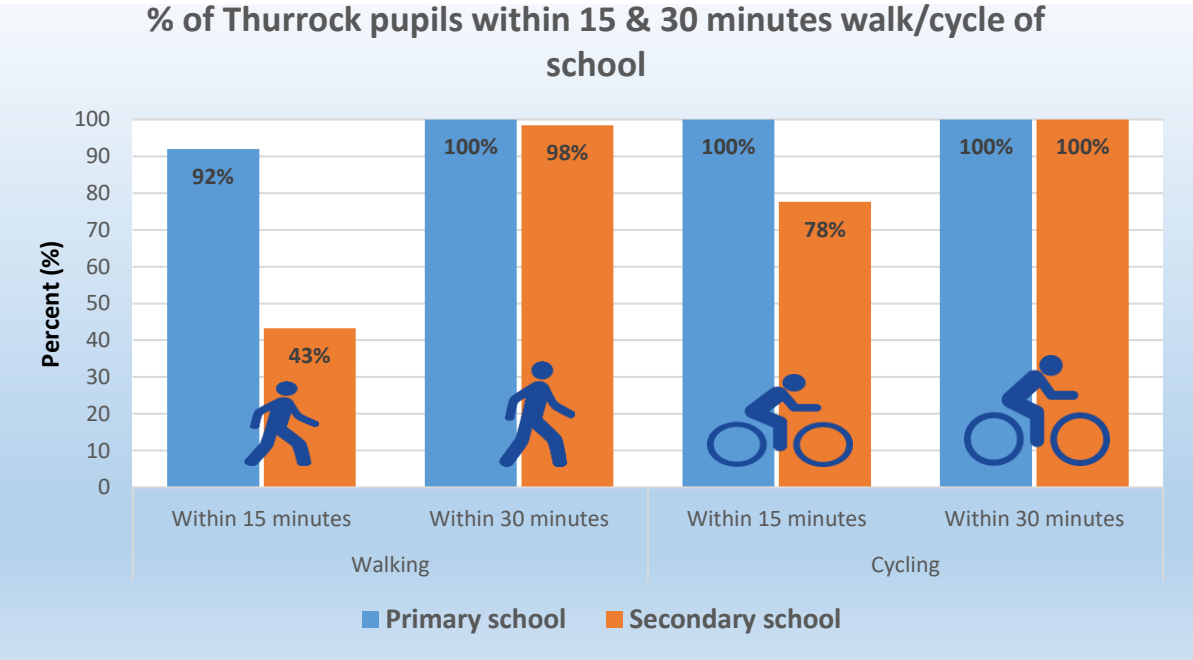
School Travel data from the charts above demonstrates significant ambition from children in the borough to walk, cycle or scooter to school. For example almost a third of primary school children would like to cycle to school but only 6% do so, suggesting there is much untapped potential.

Analysis from both sets of local data demonstrate walking to school reduces significantly between primary and secondary school transition with a marginal increase in cycling rates. Evidence suggest the reduction in walking is likely to be attributed to the greater distances generally associated with secondary school travel. This transitional point from childhood to young adult can be identified as a crucial 'shift point' in travel behaviour with an opportunity to promote active travel, particularly for improving cycling uptake to secondary school.

5.1.2 Distances from schools

There is an obvious connection between travel distances and modal choice, with the proportion of pupils who walk or cycle decreasing with distance. The DfT provides annual data by local authority area on travel times and distances from homes to the nearest school. It is important to note that data is calculated against the nearest school and not necessarily the school that the pupil attends.

Figure 23: Thurrock pupils within 15 and 30 minute walk or cycle distance of school



Source: DfT 2018

There are many complex reasons why children do not attend their local school; but most commonly is due to parental choice or a school place may not be available locally. Academies can set their own admissions criteria i.e. are able to accept children from other areas in preference to their catchment, all of these reasons can result in further travel distances. Due to the investment in business and new homes, Thurrock has attracted many new families which has impacted school capacity and led to pressures in some areas, with children travelling further distances to alternative schools. The law states that where the nearest suitable school with a place is over the walking distance set for a child's age (2 miles for under 8 years and 3 miles for ages 8 and above) the local authority has a statutory duty to provide transport to that school. Thurrock spends a far greater portion of funds on school travel per

pupil compared to other local authority areas which has led to a recent review of school transport, currently being led by the Contract and Performance Manager for Education.

5.1.3 Factors affecting Travel Modes in children

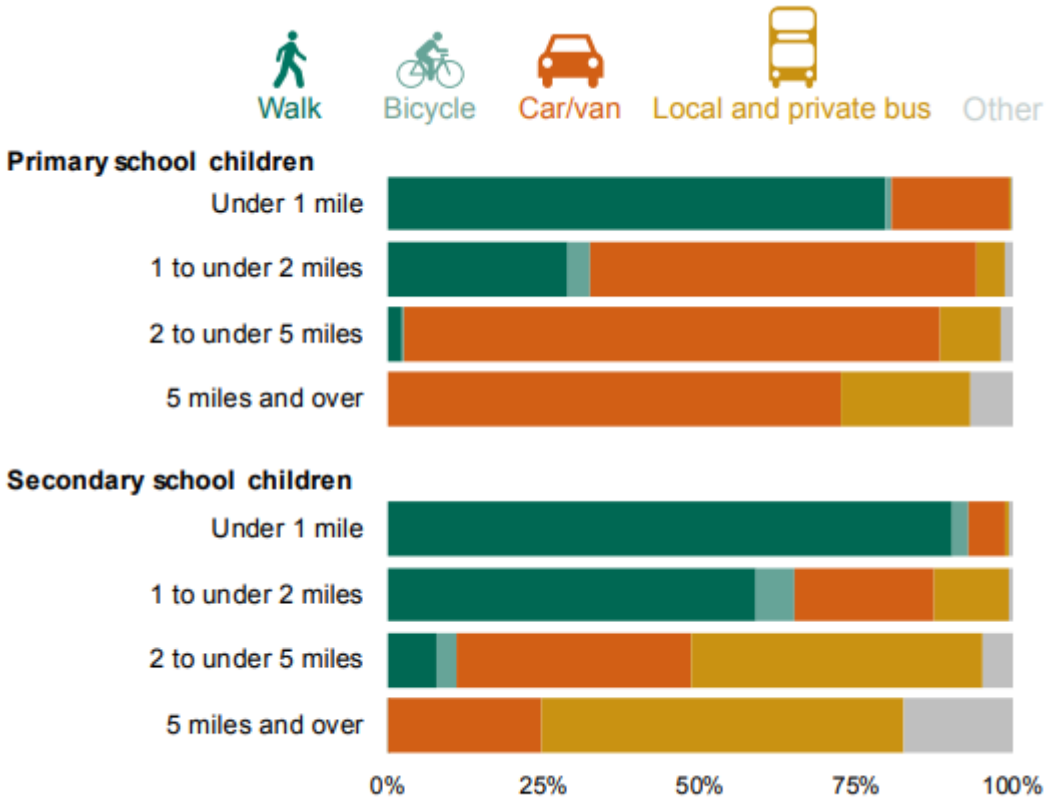
To reverse the declining trend of active travel to school studies have attempted to identify the barriers that prevent children from walking or cycling. Reviews have consistently found that greater distance, increasing household income and increasing car ownership are all associated with lower rates of active travel among children.

With increased distance children made relatively fewer active trips:

- The proportion of children aged 5 – 10 who walk to school drops from 78% for distance under 1 mile to 26% for distance between 1 mile and under 2 miles.
- The proportion of children aged 11-16 who walk to school drops from 87% for distance under 1 mile to 57% for distance between 1 mile and under 2 miles.

Few children aged 5 to 10 years old walk or cycle to school if travel distance is over 2 miles and only about 8% and 2% of school age 11-16 walk and cycle to school respectively if the distance is between 2 and 5 miles.

Figure 24: Method of travel to school primary and secondary school



Source: Department for Transport 2018

5.2 Barriers to active travel in schools

A systematic review (38) explored perceived barriers to children's active travel. The results agree with the findings above, suggesting that the distance travelled and parental concerns around safety are the most significant barriers affecting travel modes to school.

Studies around school travel behaviour and distance were limited within the UK but four significant international studies (two Australian studies, a Canadian study and one US study) identified proximity to school as the prime variable for both walking and cycling. The Australian study showed that a one unit increase in trip distance was associated with a **10-fold decrease** in use of active transport modes (39).

Other studies highlight a difference in viewpoints between parents and children; with parents citing factors such as age, fitness level, the provision of safe walking paths and adult supervision all influenced their decisions regarding their child's transport modes. Some studies found parental influences are often more starkly pronounced towards girls from a safety/security perspective which can suppress interest and engagement, whereas many parents though it was more socially acceptable for boys to walk or cycle. Children mainly cited commuting distance as a barrier.

The complexity and contingency associated with everyday travel for many households is also identified as a major barrier to the use of more sustainable travel modes. The car is often the quickest and most convenient choice, especially when parents continue their journeys into workplaces.

An earlier review (33) considered the attitudes of children and parents on walking and cycling in the UK and found some common themes which stood out clearly:

- Parents' and children's lack of time (e.g. due to existing commitments)
- Travel distance
- Lack of cycle lanes and lack of facilities to store bikes
- A strong culture of car use
- Fear and dislike of local environments
- Children as responsible transport users
- Parental responsibility for children (parents wanting to accompany their children or drive them to school to ensure they arrive safely).
- Perceived image of cycling and a dislike of wearing cycling helmets (studies showed differences in individual perceptions between genders – girls were more concerned with image and physical appearance)
- Parents' fears for children's safety, including dangers from traffic and danger of intimidation or attack by other people (this was more pronounced amongst parents with girls, it was considered more socially acceptable for boys to cycle or walk).
- Conflicting messages from schools
- Poor Weather
- Need to carry heavy bags (e.g. to school);

5.3 Evidence of effective interventions in schools

To summarise, evidence and reviews largely support the NICE guidance analysis which replicates community wide approaches - system wide initiatives that involve the school, parents and the local community, often supported by an external coordinator, and that engage the children are most likely to demonstrate improvement in active travel behaviour. In terms of infrastructure, recreational facilities and good walk/bike routes present are associated with higher rates of active travel in children.

It is well documented that the patterns established in childhood are perceived as a key determinant of adult behavior and initiatives aimed at this cohort are particularly important as they have the potential to influence life-long physical activity habits in children, and children who walk and cycle are more likely to be adults that walk or cycle.

5.3.1 Initiatives to promote active travel in schools

School travel plans have the most research surrounding them although there is inconsistent evidence to demonstrate an effect of the plans. School Travel Plans (STPs) look at the journeys that schools generate and how to make them more sustainable. Plans are developed with consultation with the whole school community and present clear targets, specific interventions and agreed monitoring criteria to shift journeys that are normally made by car to walking, cycling or scootering.

At present there is no legal duty for schools to produce a travel plan, although section 508A of the Education Act 1996 outlines a duty to promote sustainable modes of travel. STPs are an ideal way of fulfilling this duty.

Thurrock Council currently has a Road Safety Team that provides encouragement and support to schools with the development of their plans. The majority of schools (48 of the 52) in Thurrock are registered and working on updating their travel plans. Once schools enter bronze, silver or gold status they can participate in the Mode shift Stars national accreditation scheme. The scheme helps create uniform School Travel Plans for all Thurrock schools and enables other agencies within the Council to access the plans in the case of work needed or for requests from the school such as planning or traffic management.

STP's usually include a survey of pupils asking them not only how they currently travel to school, but also how they'd like to travel to school including:

- a description of the school and its environment
- a summary of established good road safety practice and initiatives – specifically pedestrian training, cycling skills, road safety in the curriculum
- a summary of any road safety or schools transport problems
- proposed initiatives with objectives and targets, e.g. a walking bus or car sharing scheme
- a baseline survey
- a clear achievable plan of action
- plans for monitoring and review

Every school in Thurrock can participate in travel plans and the Modeshift STARS programme for free.

Walking school buses are a popular initiative in local communities as they address the main safety concerns of parents. When a walking school bus is implemented effectively, walking to

school increased significantly. However, to succeed a walking school bus must be paired with positive attitudes towards active travel, willing volunteers, a clear coordinator and enforce that children arrive on time at the bus stops.

Walking promotion initiatives are most effective when a multifaceted approach is used. The biggest increase in active travel was shown where there was a strong involvement of schools and teachers paired with specific materials directed at parents. Research in 'gamification' initiatives shows that children who engage with the initiative are likely to change their behaviour. Initiatives such as 'beat the street' have demonstrated success in the short term but there is limited evidence on long term behaviour change. Pilot work should be considered which incorporates both infrastructure and behaviour change initiatives in a smaller geographical area to understand impact on long term behaviour change.

Bikeability Training – Nationally, schools who have piloted the Bikeability Plus programme, which aims to tackle specific barriers to cycling, saw an increase in children who normally cycle to school from 4% to 10% with some areas achieving even higher gains, from 5% to 25%. Studies from school based surveys suggest 93% of parents whose children had been 'Bikeability' trained said that it had a positive impact on their child's on-road cycling safety. A Cambridge survey found that 13% more trained than untrained pupils reported 'normal frequent cycling' to school; and that 37% of untrained pupils cycled on pavements, but only 10% of trained pupils did the same (34). Thurrock obtains government funding annually to deliver Bikeability training in all Thurrock Schools.

5.5 What's currently happening in schools – Thurrock Initiatives

For schools there are many key initiatives offered by the council, outlined below, these schemes could compliment any new initiatives to promote active travel.

Initiative:	Target:	Effect:	Notes:
Bikeability	Balance Bike Training - reception age pupils offered Level 1, off road cycle training- Year 4 pupils Level 2 on road cycle training - Year 6 pupils Learn to ride lessons- offered to all residents of Thurrock and every primary school	Encouraging more cycle use for the whole family- parents feel reassured after children have received Level 2 on road training.	A cycle training programme designed to educate young people about cycling by developing the skills, mind-set and confidence needed to cycle independently.
School Travel Plans/ Mode shift Stars	Borough wide	Development of School travel plans – Accreditation levels are dependent on the amount of input schools and the community contribute at given times. Thurrock has 48/52 schools registered to participate with 3 Gold, 2 Silver, 5 Bronze school travel plans in place. These awards reflect the schools efforts in the promotion and	Travel to school accreditation scheme. Look at promoting walking and cycling as a method of travelling to school by ensuring schools provide suitable cycle training to pupils, safe routes to walk to school are mapped, recruit volunteers to run initiatives like the walking bus, develop parents and carers awareness of the wider benefits of walking and cycling to school (e.g. social

		development of their Travel Plan.	wellbeing, confidence and independence).
Sustainable Travel & Road Safety Initiatives.	All children in Thurrock Schools.	Various initiatives are promoted throughout all schools in Thurrock enabling pupils to journey plan and feel safe and confident when walking or cycling out on local roads and pavements.	Road Safety Initiatives: • Pedestrian on road training for Reception age pupils and parents, Year 3 and Year 5 pupils. • Scooter training for Year 3 pupils. • Junior Road Safety Officers. • Other: Jofli Bear – a bear given to schools to encourage pupils to take sustainable journeys (35)
Safer Routes to school	Borough wide	Five-year programme of funding for safer routes to schools and road safety engineering schemes each annum is allocated circ. £250k out of the local authorities ITB funding.	At least 10 safer routes to schools initiatives have been identified to be delivered during 2019/20, of which four are already in place, with plans for schemes in a further six schools to be delivered during 2021.

Gaps in Initiatives

Statistical analysis demonstrates a significant shift in travel behaviour between primary and secondary school transition, this 'shift point' can present opportunities for influencing behaviour to encourage greater uptake of active travel. Further research would be beneficial to understand underlying barriers, motivations and influences at this crucial point to help ensure young people's travel needs are being met. Understanding what children want from transport and travel will help identify gaps between this and what they get, the findings can be used to inform appropriate targeted interventions. Examples of Interventions (not identified above) could include individual pupil support to assist with journey planning before leaving primary school, (which could also identify barriers that may exist). Interventions should be dependent on individual needs and administered before the transition from primary to secondary school takes place.

On the same principle, there is also further potential to offer travel planning advice to those parents whose children are starting primary school. This would help increase awareness of any school travel initiatives such as walking buses, before other travel habits are formed.

5.6 Statutory Duties for local authorities

Sustainable Modes of Travel Strategy for schools (SMOTS)

Each academic year, as part of its duty under the education act, local authorities are required to produce and publish their strategy to promote the use of sustainable modes of travel to meet the school travel needs of their area[xiii]. Most local authorities have adopted the name

[xiii] Section 508A (1) (a) of the Education Act 1996.

SMoTS. **The five main elements of the strategy along with further narrative are set out in section 3 - *'Local Strategy and Plans'*.**

This document has been identified by local schools as a key strategic component to develop sustainable travel within their schools. The latest School Sustainable Modes of Travel Strategy for Thurrock (SMoTS 2015-2018) is not currently being updated due to reallocation of transport funding to other areas and consequently there is no strategic guidance in place. The Education team are currently reviewing school transport policy and is considering a refresh of the SMOTS as part of the approach.

5.7 Commuting to Work in Thurrock

Walking or cycling during the journey to and from work provides an opportunity for working adults to accumulate recommended physical activity levels (at least 150 min of moderate intensity physical activity in bouts of at least 10 min throughout the week). The Government recognises that increasing physical activity requires '*weaving incidental activity into our daily lives*' including using bikes for transport (36).

Adults who cycle to work are more fit, less likely to develop cardiovascular diseases and cancers, live longer lives (37) and have been shown to have significantly lower body mass index (BMI) and percentage body fat than those who use cars (38). Cycling to work has also been associated with other health benefits such as higher mental wellbeing, compared to individuals who do not use active modes (39).

In Thurrock 41% of our journeys to work are less than 10km (a cycling distance of less than 8km is identified as a distance most people could achieve). A switch to cycling for only a small proportion of these shorter journeys brings enormous potential to make substantial improvements to local population health as well as the co-benefits such as reductions in noise, traffic congestion and air pollution.

Despite clear evidence of these benefits the use of the car for the daily commute is by far the most common mode of travel to work in Thurrock, accounting for almost 60% of journeys.

5.7.1 What Interventions increase commuter cycling?

Many evaluations of workplace interventions to increase commuter active travel are available but systematic reviews of these interventions suggest most are poor quality and often rely on self-reported anecdotal evidence, did not always use control groups and lacked statistical analyses. This does not necessarily mean that interventions were not effective but there was a lack of robust evidence to demonstrate their effectiveness.

The few more robust studies worthy of note that have examined cycling to work have found mixed results, with some finding an association between workplace support such as bicycle racks, showers, and policies that support cycling commuting (40) while others have found no association (41). Those that have shown greater success in commuter shift tended to have cycling 'champions' or facilitators within the workplace themselves suggesting that a supportive culture and peer support is an important factor.

Findings from the same studies indicate that there is not necessarily one particular workplace intervention that is the most important for cycle commuting although studies did find a positive correlation between:

- the more bicycle commuting ‘champions’ present, the more likely it will be that an employee cycles to work
- workplaces with polices in place that support active travel
- those with supportive physical infrastructure

Although there is limited evidence for the effectiveness of these initiatives the cost of implementing some of the support identified above in the studies would be relatively minor, particularly the development and implementation of supportive policy and the installation of bicycle racks in workplaces. Therefore, any businesses within Thurrock that are looking to increase levels of active travel among their employees should consider how their infrastructure and workplace culture can be changed to support this behavior.

6. Motivations and barriers to cycling and walking in adults

Both motivations and barriers are not experienced equally throughout the population and are impacted by factors such as social exclusion, living in rural areas, access to a car and the skills and confidence to use active travel modes.

A literature search found there were no local studies on this topic and generic national reviews on motivations and barriers for both walking and cycling is not especially widespread in the reviewed literature, but, where available, is considered of good quality. Research on this topic was found especially limited to the motivations for cycling.

The most relevant points from the available literature suggested differences in motivations according to socio-demographics (particularly age and gender) of the study groups. The main findings have been summarised below.

6.1 Motivation

6.1.1 Cycling motivators

The two key motivators for cycling were identified as **the convenience of cycling** and the **opportunity to improve fitness**.

- Those who cycled for their daily commute cited health reasons, environmental benefits, efficiency, speed, sense of autonomy and freedom as motivations (42).
- Regular cyclists cited the most common reasons for cycling was enjoyment, fitness, low cost, flexibility and relative speed, cyclists that participated specifically for the daily commute were more motivated by the relative flexibility of cycle travel (43).

6.1.2 Walking Motivators by socio-demographic

With respect to walking, the social element of **interacting with other people** appears to be a key motivator for some groups (particularly for women, school children and the elderly) whereas men and young people are more likely to find competition more motivating.

Unlike cycling, fitness was not mentioned in the literature as a motivator for walking – one possible reason suggested that walking is not perceived as an exercise by some.

The main motivators for active travel to school is the social aspect of walking and spending time with friends or parents alongside the health benefits. Peer pressure was also identified as an important factor in children's travel choices (its influence could go either way) (42).

6.2 Barriers

6.2.1 Cycling Barriers

Barriers to walking or cycling are documented more widely and recognised in Thurrock's Active Travel Strategy. Part four of the strategy identifies both mental and physical barriers that limit or prevent usage and access to walking and cycling.

The barriers identified broadly align with more recent studies for which the vast majority of evidence assessment identified the main cycling barriers as:

- Safety concerns due to lack of appropriate infrastructure
- Travel distance
- Various practical and contextual issues such as the weather, topography, travel distances and the need to carry heavy bags.

Similar to motivators, barriers vary between different population groups, other factors cited by different groups were inconsiderate drivers, heavy traffic, pollution, bad weather and not being fit enough (42).

6.2.2 Walking Barriers

As with cycling, barriers vary between different population groups:

Older people cited barriers to walking as limited mobility, fears of safety, fear of falling and fast traffic. In areas of deprivation key barriers to walking have been identified as:

- Safety fears
- And lack of motivation

Also in deprived areas, for women in particular, safety fears, family commitments, lack of motivation and lack of walking companions were barriers (43).

Men from all socio-economic groups did not consider walking sufficiently vigorous to be considered as 'exercise' (44).

6.3 Other influencing factors

Some factors cannot be controlled for, greater distance, increased household income and increasing car ownership are consistently associated with lower rates of active travel. Of the barriers identified that could be influenced, safety was continually raised as an issue with traffic safety and road crossings being the main concern. An unpleasant environment was noted in some areas as a strong factor that reduced levels of active travel.

There is also evidence about attitudes towards interventions intended to boost walking and cycling. This evidence (which is more prevalent for walking interventions) tends to highlight the importance of social interaction of e.g. walking groups; the importance of convenience (i.e. accommodating the intervention into already busy lives); and the power of group support in helping to make and sustain change.

The evidence also strongly suggests that it is mainly women that respond to behavioural interventions such as walking groups, training etc. Women are also more likely than men to respond positively to cycling routes separated from traffic.

In general, however, there appears to be a lack of evidence about how different groups in society – age, ethnicity, health-needs and so on – respond to different interventions (45).

8. Safety

Key messages:

- Safety concerns may be deterring children and adults from walking and cycling, some 62% of adults aged 18+ in England agreed that **"***it is too dangerous for me to cycle on the roads".*
- The number of pedestrians and cycling casualties killed or seriously injured has generally been decreasing, cycling casualties have fallen by 70% since 1984.
- Road traffic crashes and collisions disproportionately affect vulnerable road users such as pedestrians and cyclists.
- Cyclists were less likely to believe that cycling was too dangerous for them than non-cyclists (50% to 65%) and those over 60 were more likely to consider roads unsafe.
- Speed reduction measures such as 20mph zones are an effective measure for improving safety for cyclists and their perceptions of safety.
- Most casualties and injuries could be prevented, particularly using separation from motorised traffic.

8.1 The government approach

Global road safety statistics show that roads in the UK are among the safest in the world, but cyclists and pedestrians remain particularly vulnerable road users. Aside from the effect that casualties have on individuals and their families, safety concerns are often cited as one of the main reasons why people do not cycle or parents do not allow children to walk or cycle to school.

The Government has a holistic view of road danger reduction, in line with the 'safe system' approach. This recognises that there may be no single intervention which will transform road safety, but that many smaller measures can make a difference. The approach also emphasises the importance of addressing perceptions of risk, acknowledging safety fears are often cited as a barrier to cycling and walking. It is important to note that walking and cycling are not generally considered intrinsically dangerous activities, it is the road environment that is dangerous.

8.2 Perceptions of cycling safety

Bike Life, the largest assessment of cycling in twelve major cities and urban regions in England found only 28% of residents thought cycling safety was good. Less than one in five (17%) felt that the safety of children's cycling was good (46).

These findings were similar to data from the National Travel Attitudes Study (NTAS) (47) which found 61% of adults aged 18+ in England agreed that "it is too dangerous for me to cycle on the roads". Women were more likely than men to agree (68% to 54%) and people over 60 were marginally more likely to agree than if they were aged 25-59.

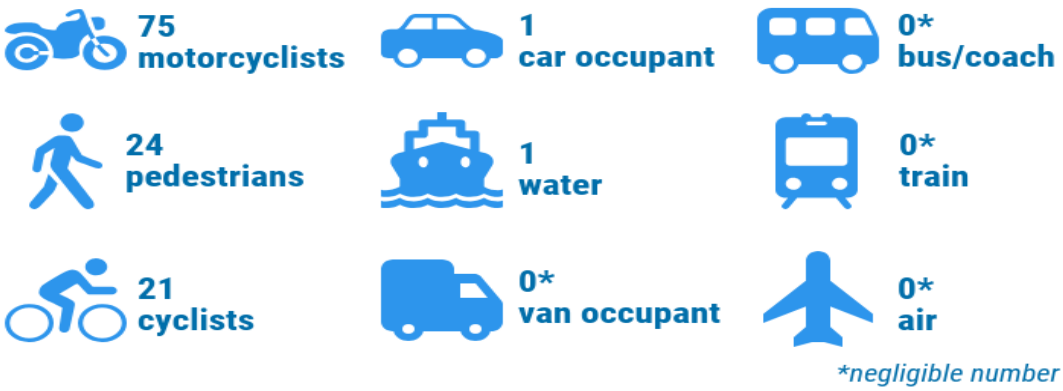
Cyclists were less likely to believe that cycling was too dangerous for them than non-cyclists (50% to 65%) and those over 60 were more likely to consider roads unsafe.

Figure 25: Proportion of adults aged 18+ who agree with the statement "It is too dangerous for me to cycle on the roads", by gender, age band, cycling and driving status, England 2018

DfT statistics for England (2017) showed that cyclists accounted for an average of 2 fatalities and 62 serious injuries per week between 2011 and 2016. The number of casualties has fallen by 70% since 1984 (48).

A significant study conducted by academic Dr Rachel Aldred – the *'near miss research project'* – questioned whether the number of casualties and injuries reported captured all of the fears expressed by cyclists. The study found near misses an everyday experience for cyclists in the UK, over half the cyclists surveyed as part of the report suggested that most could be prevented, particularly using separation from motorised traffic (49).

Figure 26: Fatalities per billion passenger kilometres by mode: 2008-2017 average



Source: figures 25 and 26 DfT 2017

8.3 Interventions aimed at improving safety for active modes of travel

Some interventions aim to eliminate some forms of risk such as with cycle tracks that separate cyclists from the carriageway. Some aim to mitigate risk through training and education. The effectiveness of the different interventions have been the subject of a number of systematic reviews although the quality is variable, with some unable to address potential confounding factors. However, there is consistent evidence supporting several types of interventions that can reduce the risks for cyclists and pedestrians.

The strongest evidence is for the benefits resulting from reductions in the speed of traffic and the wider use of 20 mph speed limits.

The evidence is mixed on cycle tracks that physically separate cyclists from traffic, although there is clear evidence that cycle lanes reduce risk, the design of the cycle track itself is an important factor in determining effectiveness, especially at intersections. Advance stop lines appear to have no significant impact on cyclist safety (possibly due to the low level of accidents making improvement difficult to measure) although studies suggest they do appear to increase cyclists' perception of safety. N.B: Although there is a lack of definitive evidence that demonstrates separating cyclists from traffic improves safety, there is good evidence that separated cycle infrastructure can encourage people to cycle (56).

For walking, the removal of barriers and parked vehicles on pavements and good neighbourhood maintenance are all perceived as positive factors.

Urban design that prioritises walking and cycling over car use, street lighting and safe routes to school have also found to be effective in some studies. Behavioural interventions to improve safety practices include cycle training, cycle helmets and visible clothing and equipment (56).

8.4 The Local Approach

Much is already being done to improve road safety, Thurrock's approach to reducing the overall number of Road Traffic Accidents on the transport network is identified within the Thurrock Transport Strategy:

The Strategy aims to ensure accidents involving vulnerable road users do not increase and will need to ensure that road safety interventions help to deliver a modal shift through removing safety concerns that pedestrians and cyclists have.

Policy TTS26: Safer walking and cycling: The Council will improve the road safety of pedestrians and cyclists and will aim to mitigate safety concerns that currently act as barriers to the use of these modes. An overall safer urban environment will be created such as by reducing traffic speeds, so that not only will accidents be less likely, but when accidents do happen they will be less serious. Widespread 20mph zones will therefore be implemented on residential streets.

The Council will ensure that routine maintenance procedures and interventions, such as dealing with pot-holes or raised drainage grating, take account of the need to promote the safety of pedestrians and cyclists. For example, pot-holes on Walking and Cycling Core routes will be given additional priority.

Structural maintenance programmes will give a priority to promoting the safety of the core walking and cycling routes, such as by improving the quality of street lighting on these routes. This will work to reduce the fear of crime on these parts of the transport network, with a view to encouraging a modal shift towards these modes, especially after dark.

Furthermore it will target such road safety interventions in those areas of Thurrock where efforts are also being made to improve accessibility by walking and cycling and deliver modal shift. This will include integrating road safety schemes into Workplace Travel Plans and, especially, School Travel Plans. Most of the measures are likely to be relatively low cost. However, major road improvements or network management measures can contribute to road safety by transferring traffic to higher quality roads where accident rates should be much lower than those of typical local urban roads. In this case the Council will be careful not to allow the effect to be eroded by increased traffic speeds. This measure could be particularly useful to remove traffic from roads being developed as cyclist and pedestrian routes, and could make widespread speed limit reductions more acceptable.

Recent evidence demonstrates some successes in areas such as Thurrock's Safety Plus initiative that ensures defects such as trips, potholes and raised ironwork are identified and fixed. As part of this initiative 98 percent of potholes were repaired within target. The Council is also developing an asset management strategy that will ensure roads, pavements and cycle ways are safe for use and repaired at the most economically advantageous time.

Progress against safer walking and cycling policy would benefit from review prior to any new strategy, alongside the review of current safety initiatives to ensure they are still relevant. Measures at reducing traffic speeds has already been identified, these measures should continue to be implemented together with enhancement of cycle tracks that separate cyclists from the carriageway.

7. What works?

There is strong consensus across the literature that the most effective mechanisms for increasing walking and cycling comprise of a complementary package of measures. A coherent, convenient and safe network of routes is necessary but not sufficient to bring about change, while campaigns and behaviour change interventions are unlikely to be successful without the infrastructure to support them.

Prior to the publication of the governments walking and cycling strategy the DfT commissioned an evidence assessment to better understand the impacts of walking and cycling investment. The assessment recognised that although some singular interventions have shown positive outcomes the most sustainable and effective investment strategy must consist of a variety of approaches.

The review examined a range of interventions that have been used to impact on walking and cycling acknowledging the difficulties of assessing the variety of interventions (considering the underlying determinants of behaviour and the challenges of measuring changes), urging that any findings should be interpreted as 'indicative rather than definitive'.

7.1 Findings from the review

Given there is no ideal singular intervention, the assessment identifies a mix of infrastructural improvements/provision, community-wide communications/campaigns, targeted (usually community-level) support and some individually-specific support.

A range of soft measures were also shown to be important, particularly in terms of encouraging and incentivising trips. Studies suggested that local level population changes are required in attitudes and behaviour related to active travel. These should be viewed as long term projects, the most effective mix of intervention being dependent on local characteristics and local needs.

The most effective individual interventions that emerged from the literature reviewed (effective in general terms) are outlined below, although there are very few studies where single interventions have been studied in isolation:

- Provision of dedicated cycling lanes (and bicycle parking)
- Personal travel planning
- Walk/Cycle to work days
- Cycle-hire/bike-share schemes
- Some school based interventions

The report identified that directly attributing any benefits or savings to specific local interventions is complex and dependent on factors such as the size of the scheme, the context of the setting and the characteristics of the population.

The full DfT report discusses each intervention in more detail, a link has been included at the end of this document (50).

7.1.2. Physical Infrastructure improvements

A wide range of factors influence whether or not people walk or cycle, of particular note were environmental factors such as the design, quality, accessibility and availability of walking and cycling networks were all likely to be important. In neighbourhoods where there are accessible, safe walking and cycling routes, studies consistently show communities are walking and cycling more (46).

Areas that have successfully increased levels of walking and cycling have all aimed to prioritise people and place first, with cars being a 'guest' in the area.

Other successful attributes of infrastructure improvements:

- Routes should be designed with the continuity of the route in mind.
- Routes should be legible and not dependent on signage to be followed.
- Cyclists should be segregated from traffic on busy roads or junctions
- Ensure participatory design at a local level, address the needs and concerns from residents to maintain support (46).

7.1.3 Design of routes

The initial focus of any planning and design of new routes should consider how people live and move around; who will be using the route and for what purpose. If this can be done at the earliest stage of new developments or regeneration projects, even better. New cycling routes or improvements to existing routes are often included after new housing schemes are completed; behavioural studies demonstrated people then got into bad habits and therefore were less likely to use them. Providing specific support for people at a 'transition point' in their lives, for instance, when they are changing job, house or school has been shown to be highly effective in promoting a change in travel behaviours (51).

Design guidance standards for active travel infrastructure should be explicitly outlined within Thurrock's new Design Guide, ensuring information is readily available to planners at the beginning of any new scheme. Any guidance should incorporate as a minimum, the current standards outlined within the DfT's Cycle Infrastructure Design (52) and Highways England Design Manual for Streets 2 (53). This guidance includes pavement and cycle route design and maintenance, both of which has been developed from internationally leading research on excellence in standards development. The manual includes a guide for developing a quality audit process. Other useful resources when considering route design principles that should be embedded within Thurrock's approach:

- TfL's Healthy Streets Check for Designers, the guide incorporates the latest design approaches and tools to improve walking and cycling performance.
- TfL's London Cycling Designs Standards
- Handbook for Cycle Friendly Design – Sustrans
- DMRB CD 195 – Designing for cycle traffic – Highways England.

Some local authorities have successfully implemented quality audits as part of the design process, measured against the mantra of these documents on all development proposals which involve new streets. These assessments are carried out in partnership with Highways Teams and the Development Management Team.

7.1.4 Quality of routes

There were many evidence contributions that found the likelihood of people using infrastructure to walk or cycle on is highly dependent upon its perceived quality. Not only fit for purpose but they must also be well maintained and safe to use. Poor lighting, litter, cracks and potholes were all identified as issues (53).

Maintenance costs should be factored into funds for upkeep of active travel infrastructure, this is a significant issue for Thurrock as there is no specific funds allocated to maintenance of routes.

7.1.5 Location of routes

Creating a network of well-designed, good quality routes is only relevant if the routes are in the right places. Understanding how people live and move around is an essential component when identifying routes.

Studies have shown areas which have invested in quality infrastructure that take people where they want to go have shown significant increases in active travel uptake. Since 2017, Transport for London has doubled the provision of protected cycling routes, this transformation is modelled around other successful places (New York, The Netherlands and Copenhagen) that have used major data analysis to show where routes could be built to get the greatest number of people walking and on their bikes.

TfL has published exemplary examples of strategic data analysis for both walking (54) and cycling (55). The use of this analysis approach will help to identify a Thurrock wide priority network that comprises of new routes based on areas of greatest need and current and/or potential demand and then routeing walking and cyclable trips. Actions from the analysis should build towards the long term network, encompassing existing routes and creating or enhancing networks to local places such as key workplaces, schools, shops and healthcare facilities. Routes should also take into account future housing and regeneration areas and neighbourhoods with a high proliferation of households within lower income bands.

This analysis should be used as the framework to inform a Local Cycling and Walking Infrastructure Plan (LCWIP) and any future investment should be targeted to this. These infrastructure plans are currently the government's preferred approach (which enables access to funding bids).

7.1.6. High-density mixed used developments

Studies have consistently demonstrated that people walk or cycle more in places with higher population densities and mixed land uses, such as mixing housing with shops, schools, local amenities and green spaces. These places are associated with between 25% and 100% greater likelihood of walking (58).

The concept of '20 minute neighbourhoods' – sometimes called by other names such as '15 minute cities' has become a popular model for creating places whereby services and destinations that support daily living can be met within a short walk or cycle. Most importantly for active travel, they reduce trip generation at source by removing the need to get into a car.

Research undertaken by the Town and Country Planning Association (TCPA) (56) demonstrated multiple benefits of mixed used neighbourhoods in countries that have already implemented the concept. Benefits ranged from reduced traffic, improved air quality, thriving

local shops and businesses, more cohesive communities and improvements in physical and mental health.

The impact of the COVID-19 pandemic lockdowns has highlighted the importance of the liveability of our own neighbourhood areas as people have spent more time than ever within their own localities.

7.2 Lessons from successful schemes

7.2.1 Cycle Superhighways

A number of towns and cities across the country have constructed Cycle Superhighways as a means to make roads more cycle friendly. Cycling highways have been shown to provide a safe, fast, and efficient way of getting around by bicycle along recognised commuter routes. The first 'city to city' cycle superhighway opened between Leeds and Bradford in 2016 and the first segregated superhighway opened in London in 2015 with further routes constructed each successive year thereafter.

London's Superhighways: Studies conducted as part of the Santander Superhighway routes in London demonstrated significant success with its segregated blue routes. Analysis of cycle counts recorded before and after the launch showed an increase of 46% on one route, with most routes experiencing more than a 100% growth in the number of cyclists. These Dutch-style segregated lanes and junctions are at least 1.5m in width, the road surface was improved and a skid resistant blue surface applied, evaluation studies demonstrated a greater feeling of safety and contentment in two thirds of the sample identified (57). These findings are consistent with other studies that frequently demonstrate increased uptake of cycling in areas with segregated routes, in some areas this uptake was rapid. According to the Walking and Cycling commissioner for London, financial investment in the capital equates to £17 per head (2019) - a comparable spend to cities such as Copenhagen. Some parts of London are now recording a year on year growth of 50% in levels of active travel. The superhighway routes were chosen to provide good coverage in areas where there are many existing cyclists and where there is the greatest potential for people to cycle to work if provided with the right facilities. The routes have been established taking a number of factors into consideration such as current and potential cycling demand, availability of highway space and wider connectivity with local routes.

Supporting measures – alongside the introduction of the superhighway infrastructure further investment was made to compliment the routes and maximise the number of trips. The measures were identified as an essential part of success as they helped to reduce the barriers to cycling, these included:

- A package of measures for businesses on or near to the Cycle Superhighways (with face to face engagement with local businesses).
- Borough funding for cycle parking, training and travel awareness activities
- Targeted interventions, covering safety, security and future commuters
- A monitoring and evaluation programme

Research conducted as part of the evaluation suggested that up to 27 per cent of the increase in cycling could be attributed to these cumulative measures (57).

Thurrock is home to many established businesses and industry, providing opportunities for partnership working and local sponsorship to create new cycling superhighways around the borough that could connect homes with key services such as workplaces and schools. The creation of these sponsored cycle superhighways will offer a genuine alternative to car journeys and provide potential for large scale modal shift in the way we travel.

7.3 What is 'best practice' in other countries?

Countries such as The Netherlands and cities such as Copenhagen rank as some of the most cycle-friendly places in the world, with participation rates much higher than the UK. Reasons for success are frequently given as 'because it's part of the culture' or 'because the land is very flat' but the evidence consistently show it is because the streets have been designed to prioritise people, not cars.

This has not always been the case, during the 1970's the Dutch had the same problems as the UK – the use of cars was growing rapidly and dominating the transport network, the difference was they developed a real rejection of urban planning that favoured cars. Since the 1980's Danish planners have had policies in place for consistently putting in walking and cycling facilities and have provided the funding to support them.

In line with the consensus across studies there is no singular intervention for success, instead they have developed a multiplicity of approaches, comprising of all the right factors. They have built environments that gives cyclist separate space to cycle, that treats people who ride bikes normally under a concept that 'the bike is right'. Extensive networks of cycle paths are clearly marked, have smooth surfaces, separate signs and lights.

They also take road safety for cyclists very seriously, design manuals classify roads depending on the speed of the cars traveling in them. If there's any major difference in speed, then full separation is required with particular attention given to infrastructure concerns at junctions, combined with pro-bicycle traffic laws, education and positive promotion.

Education plays a key role, the concept of cycling is introduced to children in nursery school where they run around on push bikes. But the biggest education is when pupils around the age of 10 and 11, start taking cycling skills courses. Cycling proficiency lessons are a compulsory part of the Dutch school curriculum. Between the ages of 11 and 12 they have to take a written exam to show that they

understand the rules of the road. They also undertake a practical exam where every year hundreds of Dutch students go out onto the street and travel on their routes to get to school, on a designated pathway. The Fietsersbond (which is their national cycling advocacy group), supports the children in real life situations. All schools have places to park bikes and at some schools 90% of pupil's cycle to class.

Cycle parking facilities are everywhere - outside schools, office buildings and shops, the railway station in the main city has spaces for 10,000 bikes.

In summary, many people cycle in the Netherlands primarily because of a supportive environment, including but not limited to high quality cycling infrastructure. The status as a nation of walkers and cyclists didn't happen because of the culture or flat land, according to the countries ministers it took three strategic steps, *'finding the capital to build the infrastructure, finding the right places and spaces for infrastructure and finding the will to change. This took a lot of hard work, a certain degree of stubbornness, and forward-thinking leaders and politicians to get where we are'* (58).

With the right conditions in place there is no reason why Thurrock cannot aim for a "Copenhagen" cycling network.

9. Funding for Active Travel

The Governments 2017 Walking and Cycling Strategy outlines targets to double the level of cycling and reverse the decline in walking by 2025 although there was no new government funding attached to the strategy.

Findings from the recent House of Commons Transport Committee report described the current funding arrangements for active travel as 'piecemeal and complex' with the government failing to provide local authorities with the certainty they need to prioritise active travel and make long-term funding commitments (59). The Government has committed £400 million per annum on active travel during the current parliament (2016-21), although there is no dedicated funding stream for each local authority and is equivalent to around 1.5% of transport spending in England (60). Independent research conducted by the Walking and Cycling Alliance estimated that to meet the Government's targets outlined in the CWIS "transport spending on active travel must immediately increase to 10% of total transport spending over the next five years".

Recent updates on funding released this year as part of a House of Commons Report (61) found that the Government's own analysis recognised need for "substantial further investment" over the next five-year period and undertook a spending review in 2020.

The Ministry of Housing, Communities and Local Government (MHCLG) provides local authorities with the bulk of their funding for local active travel, while the DfT provides discrete pots of capital funding.

In addition to government funding, capital funding for infrastructure improvements can be sought from developer contributions (section 106 in Thurrock) and other grant funded streams from the Department of Transport.

Within Thurrock (and with most areas of local authority spending), investment in active travel is not ring-fenced and money for improvements for pedestrians and cyclists comes from the overall local authority funding settlement. This means that funding competes against other local services and as a council we must therefore decide how to prioritise investment in active travel.

Covid-19 impact and Government funding review for 2020 onwards

In May 2020, the government allocated a £250 million emergency active travel fund which forms part of the first stage of a £2 billion investment in new funding announced earlier in 2020. The funding purpose is to help combat the pandemic and in the words of the prime minister *'to kick off the most radical change to our towns and cities since the arrival of mass motoring'*.

This additional funding will be allocated in 2 tranches to support local authority transport departments to increase local cycling and walking facilities.

- Tranche 1 will support the installation of temporary projects such as pop up cycle lanes and Low Traffic Neighbourhood Schemes (LTNs).
- Tranche 2 will support the creation of longer-term projects

Thurrock's local response to its individual funding allocation is currently being considered, funding from tranche 1 has already been allocated for improvements to station frontages, cycle paths and waymarking.

Furthermore, to support these additional funding measures the government is set to publish an updated Cycling and Walking Investment Strategy in 2021 to support a more transformative ambition that includes some new developments that include:

- The creation of a national cycling and walking commissioner and inspectorate
- Higher standards for permanent infrastructure
- Getting GPs to prescribe cycling and exercise
- Creating a long-term budget for cycling and walking similar to what happens for roads

Further guidance surrounding these new ambitions is set to be released in 2021. The government is keen to sustain the increased momentum towards walking and cycling generated since the beginning of the COVID-19 restrictions. The Department for Transport reported in 2020 that there was a 100% increase in weekday cycling and an increase of 200% at the weekends when compared to pre-Covid levels.

The opportunities are being created to think differently about the way we travel, how we use them to generate change within Thurrock is largely up to us.

10. Recommendations

Strategic Development

- The policy and strategy environment for active travel is uncoordinated and in some instances needing to be updated. Future action should not be left to the department with specific responsibility for transport alone, a joined up approach between transport, highways, planning, public health, environment and education is needed, with each department understanding it's opportunities to prioritise active travel.
  The leadership teams should agree objectives, interventions and targets and each departmental strategy should reflect how this vision will be delivered. This will ensure active travel is embedded across a full range of policy and strategy documents to ensure it is delivered effectively.

- Planning documents for Thurrock such as the new Local Plan should include a strong advocacy for active travel while the new Design Guide (supplementary to the new Local Plan and currently in preparation) needs to set out quality criteria that includes minimum design and quality standards for walking and cycling infrastructure that must be adhered to. These standards will need to conform to the new Cycle Infrastructure Design code LTN 1/20 (the government has made this a condition in its new 2020 funding arrangements).

- Sentiments within the current written evidence of related strategies and plans does not match the delivery capacity available resulting in disparities between ambitions and/or commitments, and the work that is actually being completed. In order to achieve any improvements, active travel must be given higher priority, with longer term dedicated funding streams identified to support the delivery of such plans.

- Development of future policy should create **targets for active travel** that reflect ambitious aspirations. Consideration towards targets should be based on level of local and government funding, ensuring a match between resources and targets. However the needs of cyclists and pedestrians should be addressed before allocating targets, as targets are unlikely to be achieved if cars continue to be given priority.

- The collective impact of active travel strategies/plans and related policies should be **measured and monitored** against any new targets and key performance indicators. The type of evidence (data) that needs to be monitored relates to the cross-portfolio outcomes that are associated with the delivery of active travel projects, e.g. air quality improvements, road safety, health benefits and local economics. Consistent monitoring will ensure we assess any progress against our objectives.

- Priorities initially identified within the Active Travel Strategy for Thurrock 2020 would benefit from further review and refresh as part of the wider Transport Visioning and Strategy Development:

  - While the mesh density tool and route identification within the strategy provide some useful information, identification of future route priorities for cycling should take a much wider approach. We need to look at trips that aren't currently cycled, but could be, and in addition to employment and retail, the route priorities for cycling should consider a greater focus on other key destinations such as education, healthcare and local High Streets.

  - The route analysis and zones identified within the strategy require further detailed analysis i.e. are there specific barriers that prevent usage, the quality of the routes and do they take people where they want to go? Assessment could then be made for routes with the greatest potential for growing walking or cycling trips or routes which need improving. In addition to route demand, consideration should be given to the planning and delivery of walking and cycling routes to help reduce the health, economic and societal inequalities that some populations encounter. Focusing both on these inequalities and the areas with the greatest need would deliver the most benefit. **It is understood that this analysis was out of scope for the existing Active Travel Strategy and it is recommended that this is brought into scope of the future Transport Vision and Strategy.**

  - The strategy could be strengthened further with the inclusion of specific actions. It is unclear who is responsible for any of the priorities or approaches outlined within the document.

- Thurrock Councils Rights of Way Improvement Plan 2007 would benefit from complete review including an analysis of routes to identify any improvements to pedestrian access. This could be achieved through the creation of new or more direct footpath links, widening or improvements to existing footpaths and by employing measures that provide improved pedestrian security through natural surveillance, lighting and signage.
  Improving the walking environment should include setting standards through design guides and applied to all new streets where there is high density activity and key walking routes.

- The Transport Strategy would benefit from refresh and core strategic review incorporating a much bolder vision for active travel in the future. Any new strategy should include measures for cycle reviews of the road systems and cycle audits of proposed traffic schemes. These should involve an objective assessment of local problems and opportunities, consistent with the overall transport strategy in the area. **A policy of reducing urban traffic and transferring carriageway space to cycling superhighways should be considered here.**

- Policy TTS11 of Thurrock's Transport Strategy identifies the extensive use of travel plans for workplaces, schools and new developments. Travel plans are only effective when recommendations are implemented effectively. In accordance with this policy *"Where travel plans have been adopted, the Council will require an annual review to analyse effectiveness of delivery and overall contribution towards travel conditions."* Monitoring of active travel is important, this element would benefit from further resource to facilitate this policy**.**

- The current walking and cycling infrastructure plans for Thurrock would benefit from a comprehensive review. First and foremost we must conduct a strategic walking and cycling analysis of our network (using the examples identified within section 10.1.5). Actions from the analysis should build towards the long term network, encompassing existing routes and creating or enhancing networks to local places such as key workplaces, schools, shops and healthcare facilities. This will establish a new model and any future investment should be targeted to this local Cycling and Walking Infrastructure Plan (LCWIP). These plans are currently the government's preferred approach (which enables access to funding bids). In addition it is worthy of note the government is set to announce future plans (and budgets) for active travel this year.

- Criteria for increasing levels of walking and cycling must include the delivery of safe and accessible infrastructure (identified above) combined and co-ordinated with appropriate behaviour change programmes, using planning policy, evidence based approaches and best practice. There is strong consensus across the literature that the most effective approach to increasing cycling and walking is to implement a complimentary package of measures – both hard and soft interventions. Delivery of these local approaches should be included within the updated Active Travel Strategy.

Statistical Analysis

- Further local research would be beneficial to understand and address the behavioural and motivational aspects that support people to use active travel modes. A useful starting point would be qualitative approaches working with a range of local communities to explore how people travelled to services, whether they faced challenges in reaching them and possible solutions. Insights into these aspects is an important factor to inform future strategies and facilitate increases, including the targeting of initiatives.
  Efforts to encourage active travel are more effective when they are tailored to local circumstances. Understanding local barriers and opportunities specific to the community will help develop initiatives that directly works around those barriers. Without fully understanding the influences of travel behaviour and their likely impacts across the Thurrock population any future policy or initiative could lead to limited success. Events such as the summer cycle marathon held at Blackshots would provide a captive audience for local surveys, these could be organised concurrently with wider community discussions.

Schools and workplaces

Schools:

- Partnership working with local schools on travel planning should continue to be developed with particular focus on performance targets (accreditations) which are audited annually and form part of delivery plans. Travel plans have been successfully introduced into most schools in Thurrock (48/52) and 10 of these accredited with Gold (3), Silver (2) and Bronze (5) status. Setting ambitious targets to increase the number of Gold-accredited schools will improve the number of children using active modes of travel.

- At present there is a significant amount of children in Thurrock not attending their local catchment school, the reasons for this are complex and would benefit from review. Travel distance is understandably a significant barrier when choosing active modes of transport.

- This report highlights culture of car use is sometimes influenced by a fear and dislike of local environments and parental responses that emphasise children's safety at the expense of developing their independence. Any interventions need to address pedestrian and cyclist safety so that children and parents feel confident to travel by these means. Interventions should include perceived risk and parental norms regarding children's independence and continued support for the provision of suitable cycle and road safety training for all pupils. Monitoring and targets to increase the number of adults and children receiving Bikeability training would help to increase uptake and improve confidence and skills.

- The refresh of the current School Transport Strategy (SMOTS) will form an essential part of a suite of strategies that will help identify strategic priorities and support a unified vision. Any actions to increase uptake should encourage united and consistent support from pupils, parents, teachers and governors ensuring a school culture where walking and cycling are the assumed modes of travel.

- The Government wants to support schools in encouraging their pupils, parents and staff to walk and cycle more often. The governments Cycling and Walking Investment Strategy sets a target to increase the percentage of children aged 5 to 10 that usually walk to school from 49% in 2014 to 55% in 2025. At present the data collated within Thurrock includes only a portion of schools and would need to be

extended to enable comparisons (and progress) with national levels. Locally, the raw data collated on school travel via the Brighter Future Survey should be aligned with data collated from School Travel Plans to allow for both convergences and comparisons.

Workplaces:

- Partnership working with local businesses will be key to encouraging a commuter modal shift. Potential new routes around existing business and growth areas should be co-developed with the businesses themselves, encouraging local 'buy in' and creating opportunities for sponsorship.

Road Safety

- Safety and perception of safety is one of the biggest considerations when choosing travel mode. The national evidence base identifies that restrictions to speed limits have consistently been cited as effective alongside the separation of cyclists from traffic. The role of dedicated cycle lanes, junction improvements, traffic calming and 20mph speed limits in residential areas should be considered where there is potential to encourage a growth in cycling or walking. Some of these elements are already a priority in Thurrock's Transport Strategy and progress should be reviewed to establish effectiveness in areas where restrictions have been implemented. Consideration towards the infrastructure model used in other areas for 'Cycling Superhighways' allows full separation of cyclists from traffic in areas where there are high speeds of traffic and should be a key consideration for Thurrock.

Funding for active travel

- The delivery of a revised Active Travel Strategy supported by a Local Cycling and Walking Infrastructure Plan (LCWIP) will establish a model for investment. Any future strategy, LCWIP or proponent documents should follow the guidance and principles set out within relevant central government guidance. Access to government funding is often dependant on specific criteria and local compliance will enable access to future funding bids.

- Securing Investment - further strategic work is needed to establish the level of funding required to achieve the recommendations within any new LCWIP or strategy, followed by an assessment of the financial options available to the Council to deliver this funding level. Whether from the revision of government funding sources/bids, a revised basis for securing Section 106 investment, local funding measures including the identification of capital costs related to the provision of additional facilities, together with analyses of committed expenditure (or all). **Funding for active travel often competes against wider transport objectives or other local services and is often not given the priority status it deserves.**

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Appendix A

Table 1 Review level evidence for effect of walking on disease incidence, disease incidence and mortality, and all-cause mortality from PHE Cycling and Walking for individual and population health benefits, a rapid evidence review for health and care system decision-makers 2018

Potential benefits of walking	Findings	Type of evidence for benefits	Quality assessment[2]
All-cause mortality	A systematic review and meta-analysis (search date 2013) of cohort studies (14 studies; 280,000 people) reported an 11% (95% confidence intervals (CI) 4 to 17%) reduced risk of all-cause mortality in those who meet physical activity guidelines through walking (11.25 MET.hours/week) compared to those with no walking [14]. These findings are supported by another systematic review and meta-analysis (search date 2009) of cohort studies (five studies; 217,042 people) which also reported an 11% (95% CI 4 to 18%) reduced risk of all-cause mortality in those who meet physical activity guidelines through walking (11.25 MET.hours/week) compared to those with no walking [15].	Systematic review level (cohort)	From 14 studies, 10 scored 8 or 9/9 (none less than 7) [14]; mean 6/9 [15]
Cardiovascular disease	One systematic review and meta-analysis (search date 2007) of 18 cohort studies (459,833 people) found that high levels of walking reduced cardiovascular disease risk by 31% (95% CI 23 to 39%) compared with low levels of walking [16].	Systematic review level (cohort)	Mean score of 5.3/7
Coronary heart disease	One systematic review (search date 2007) of 11 cohort studies and one RCT (295,177 people) found a dose response relationship for walking and coronary heart disease risk. Walking for 30 minutes/day five days per week was associated with a 19% (95% CI 14 to 23%) reduced risk of coronary heart disease compared with no walking [17].	Systematic review level (cohort and RCT)	No quality assessment reported
Cancer	One systematic review and meta-analysis (search date 2012) of cohort studies (five studies; 304,123 people) reported a 3% (95% CI 2 to 5%) reduction in breast cancer risk for every 10 MET.hours/week of walking [18]. Another systematic review and meta-analysis (search date 2014) of ten studies (four cohort, one case-cohort and three case control studies; 251,693 people) reported an 18% (95% CI 3 to 31%) reduction in risk of endometrial cancer in high versus low levels of walking [19].	Systematic review level (cohort and case-control)	No quality assessment [18]; 20/33 studies scored >6/9 [19]
Type II diabetes	One systematic review (search date 2006) of cohort studies (five studies; 240,605 people) found that walking for 2.5 hours/week at a brisk pace is associated with a 17% (95% CI 9 to 25%) lower risk of developing type II diabetes compared with no walking [20]. Experimental design evidence also reports that walking is protective against progressing to diabetes [21] and improving glucose tolerance [22, 23].	Systematic review level (cohort, crossover and RCTs)	No quality assessment reported

2 As reported by the review authors in included reviews. Higher scores mean better quality rating e.g. 0/9 lowest quality; 9/9/ highest quality.

Table 2 Review level evidence for the physical health benefits of walking on intermediate risk factors

Table 2 continued

	Another review (search date 2007) of RCTs and observational studies (seven studies; 192 people) also found no significant effects (-0.09 95% CI -0.32 to 0.15) of walking interventions on blood lipids (average increase of 2491 steps/day in the RCTs; observation data not reported) [26]. A third review found that physical activity can reduce postprandial lipemia [29]. Whilst the latter review was not specific to walking, Gill and Hardman [30] suggest that energy expenditure during the activity rather than either the intensity or mode of activity is the most important determinant of lowering lipids.		
Haemostatic, inflammatory and immune function markers	One review (search date 2015, number of participants not reported) included three cross-sectional studies and one crossover trial and found preliminary evidence for improved haemostatic, inflammatory and immune function markers with regular walking [31]. Intervention descriptions/physical activity duration and intensity were not reported.	Narrative review level (cross-sectional & crossover trial)	No quality assessment
Body composition	Three systematic reviews found evidence to suggest that walking can lead to improvements in body composition. One systematic review and meta-analysis (search date 2012) of RCTs (25 studies; 1275 people) found that walking interventions were associated with an average weight loss of -1.37kg (95% CI -1.75 to -1.00) [24]. The same review also found that walking interventions (23 RCTs; 1201 people) led to reductions in BMI of -0.5 kg.m-2 (95% CI -0.72 to -0.35), and -1.51cm (95% CI -2.34 to -0.68) reductions in waist circumference (11 RCTs; 574 participants) [24]. Intensity and duration of interventions for each outcome were not separately reported (as the review reported other outcomes) but the average walking intervention duration for the review as a whole was 18.7 weeks long (for 20-60 minutes, 2-7 days per week). Another systematic review (search date 2007) of RCTs and non-randomised interventions (18 studies; 562 people; number of RCTs and non-randomised interventions in each analysis not reported) found that walking (average increase of 2491 and 2183 steps/day in the RCTs and non-randomised interventions respectively) led to a -0.38 kg.m-2 (95% CI -0.05 to -0.72) reduction in BMI [26]. Finally, a systematic review (search date 2015) of RCTs (22 studies; 1524 people) found that walking (average 46 minutes, moderate intensity for four sessions/week for 12 to 16 weeks) was associated with a -2.13kg (95% CI -3.20 to -1.06) average weight loss, a -0.96 kg.m-2 (95% CI -1.44 to -0.48) reduction in BMI and -2.83 (95% CI -4.13 to -1.53) reduction in waist circumference [32].	Systematic review level (RCTS, interventions & observational)	Only 2/18 studies rated as low risk of bias [24] No quality assessment [26] Predominantly moderate quality [32]
Musculoskeletal health	One non-systematic review (search date 2015) noted there is inconclusive evidence for walking to improve musculoskeletal health in healthy individuals, however the review did not report details of this evidence [31]. The same review identified two further systematic reviews that found evidence that walking interventions can benefit musculoskeletal health in postmenopausal women [33] and adults with chronic back pain [34], suggesting that walking may benefit individuals with impaired musculoskeletal health. A systematic review and meta-analysis (search date 2006) found that walking interventions had significant positive effects at the femoral neck of 0.014g/cm^2 (95% CI 0.000 to 0.028) (four RCTs, one non-randomised trial; 302 people) but not the lumbar spine 0.007g/cm^2 (95% CI -0.001 to 0.016) (four	Systematic review level (for individuals with impaired musculoskeletal health) (RCTs and non-randomised	Average quality score 2/5 [33] 3 low risk, 1 unclear, 3 high risk [34]

Table 2 continued

	RCTs, one non-randomised trial; 427 people) in postmenopausal women [33]. Interventions were predominantly three sessions/week, ranging from 20-50 minutes per session and 7-24 months duration. Intensity of walking was not reported. The second systematic review (search date 2015) of RCTs (seven studies; 869 people) found that walking is as effective as usual care in people with chronic back pain [34]. Interventions ranged from 4 weeks to 12 months and the volume ranged from 40 minutes twice/week to walking programs that were individually tailored and increased in volume each week. Intensity of walking was not reported.	trials)	

Table 3 Mental and neurological health outcomes of walking* adapted from Kelly et al., 2018 [8]*

Mental health benefits of walking	Evidence	Strength of evidence for benefits
Depression	Five systematic reviews found evidence to suggest that walking may be beneficial in both the prevention and treatment of depression. For example, one included systematic review and meta-analysis of RCTs (eight studies; 341 people) found that walking can treat clinical depression (effect size -0.86, large effect size) [35].	Systematic review level (interventions & observational)
Anxiety	Based on 14 studies (five cross-sectional, one prospective, five interventions, four acute studies), the authors found evidence that walking is beneficial for preventing and treating anxiety.	Consistent study level (interventions & observational)
Self-esteem	Evidence from 11 studies (two cross-sectional, seven interventions, four acute studies) suggests that walking interventions can have a positive effect on self-esteem but observational findings were limited.	Inconsistent study level (interventions & observational)
Psychological stress	The authors found emerging but limited evidence from six studies (two cross-sectional, three acute studies, one intervention) that walking is associated with lower psychological stress in observational studies, and that walking could be used as a potentially promising intervention to decrease psychological stress.	Study level (interventions & observational)
Psychological well-being	The evidence base is limited but promising, with three cross-sectional studies and one prospective study identifying positive relationships between walking and psychological well-being. The findings from the intervention studies are mixed with only two of seven studies demonstrating positive effects on psychological well-being compared with control groups.	Inconsistent study level (interventions & observational)
Subjective well-being	11 studies (four cross-sectional, two prospective cohort, five acute studies) indicated an association between walking and subjective well-being. The only long-term intervention study was inconclusive and further studies are clearly needed.	Inconsistent study level (interventions & observational)
Resilience	No published journal articles were identified addressing the association between walking and resilience. However, there is emerging evidence suggesting a relationship between physical activity and resilience.	-
Social isolation and loneliness	The evidence base for walking on social isolation and loneliness is limited. One cross-sectional study found a significant positive association between frequency of contact with neighbours, neighbours social support and neighbourhood involvement and participation in walking behaviour, whilst four intervention studies showed mixed evidence.	Fragmented (interventions & observational)
Neurological conditions [1]	Reduced risk of dementia, improved cognitive function, reduced feelings of anxiety and depression in healthy people and in people with medical conditions, reduced incidence of depression, and improved cognition in people with dementia.	Systematic review level (observational)

*Total number of people included for each outcome and study quality not reported in review.

*As a scoping review, there was no quality assessment of the included studies.

Table 4 Effect of Cycling on disease incidence, disease mortality, and all-cause mortality

Potential benefits of cycling	Findings	Strength of evidence for benefits	Quality assessment (systematic reviews only)
All-cause mortality	Two cohort studies found that cycling was associated with a 21% reduced risk of all-cause mortality in 67,143 women [36] and a 28% reduce risk of all-cause mortality in 30,640 adults [37]. A meta-analysis (search date 2013) of seven cohort studies (187,000 people) found that a cycling level corresponding to WHO guidelines of 150 minutes of moderate physical activity per week was associated with a 10% (95% CI 4 to 17%) reduced risk of all-cause mortality, compared with no cycling. A dose-response relationship of cycling was also estimated, which suggested that physical activity benefits per unit of cycling are about twice as high for the first 1-2 hours of cycling per week, compared with significantly more time spent cycling [14].	Systematic review level (cohort)	From 7 studies, mean score was 7.7/9 [14]
Cardiovascular disease	A review (search date 2018) identified cohort studies (12 studies; 722,407 people) and found that seven out of 12 studies reported a statistically significant reduced risk of cardiovascular disease incidence and/or mortality with cycling compared to low or no cycling, and five studies found no significant associations [38].	Review level (cohort)	No quality assessment
Cancer	A review (search date 2018) identified cohort studies (nine studies; 1,074,480 people) and found that six out of nine studies found no statistically significant association between cycling and cancer incidence, while three out of nine studies found that cycling was significantly associated with cancer incidence and mortality compared with no cycling [38].	Review level (cohort)	No quality assessment
Type II diabetes	A review (search date 2018) identified cohort studies (four studies; 193,273 people) and found that two out of four studies found a statistically significant association between cycling and reduced risk of type II diabetes compared with no cycling [38].	Review level (cohort)	No quality assessment

Table 5 Physical health benefits of cycling

Potential benefits of cycling	Findings	Strength of evidence for benefits	Quality assessment (systematic reviews only)
Cardiorespiratory fitness	Three reviews were identified that reported associations between cycling and cardiorespiratory fitness. The first review (published 2011) identified two RCTs and one controlled clinical trial and found evidence to suggest that cycling benefits cardiorespiratory fitness in adults. The same review found inconclusive evidence for benefits in adolescents (two cross-sectional studies, one prospective study) [39]. Another review (search date 2018) found four RCTs (281 people) of cycling to school/work interventions and reported that three out of the four studies found that the intervention groups significantly increased cardiorespiratory fitness [38]. The final review (search date 2012) identified four cross-sectional and one prospective study (10,918 children) and found that cycling benefits cardiorespiratory fitness in young people [25].	Systematic review level for adults; inconclusive for children (RCTs, controlled clinical trial, cross-sectional and prospective)	Adults – predominantly strong; children – moderate [39] Predominantly moderate quality [25] No quality assessment [38]
Blood pressure	A cohort study (23,732 people) found that cycling to work at baseline was associated with lower odds of hypertension compared with passive travel after adjusting for confounding factors [40]. A review (search date 2018) also identified one RCT (48 adults) which found no change in blood pressure following a cycling intervention [38].	Inconclusive (cohort and RCT)	No quality assessment
Blood lipids	A cohort study (23,732 people) found that cycling to work at baseline was associated with lower odds of hypertriglyceridemia (OR=0.85, 95% CI 0.76 to 0.94) compared with passive travel after adjusting for confounding factors [40].	Fragmented (cohort)	-
Body composition	A systematic review (search date 2010) identified three studies (15,062 people) reporting an association between cycling and lower body weight in adults [41]. A further review (search date 2018) identified cohort studies (four studies; 61,272) and one RCT (48 people) and found that three out of the four cohort studies showed that cycling is significantly associated with reduced risk of developing obesity and the RCT significantly decreased body fat compared with no cycling [38]. In children, a prospective study of 890 children found that cycling to school was associated with lower body weight [42]. A randomised cycling intervention targeting young people with Down Syndrome (46 young people) found that the intervention led to reductions in BMI and percentage body fat amongst those who successfully learned how to ride a bicycle, however 44% of the intervention group did not learn how to ride a bicycle during the training period [43].	Review level (interventions & observational)	Mean score 3.7/10 [41] No quality assessment [38]
Musculoskeletal health	A systematic review (search date 2012) of observational and intervention studies (31 studies; 2922 people) examined the evidence on cycling and bone health. The authors concluded that "from our comprehensive survey of the current available literature...road cycling does not appear to confer any significant osteogenic benefit." [44]	Systematic review level (interventions & observational)	Mean score 4/7

Appendix B

Further notes on government funding for active travel

There is widespread concern about the extent to which funding has been distributed across the country. The Local Government Association has stated that the Government's focus has been on funding for 'cycling demonstration towns', 'cycling towns' and then 'cycling ambition cities', but this has not been replicated nationally, stating that funding for active travel needs to be made available to all local authorities.

LGA's have been told that, as a further spending review setting Government spending limits will be agreed shortly.

Other points worthy of note:

Earlier this year the Walking and Cycling Alliance[n] together with the former Minister for Transport said further investment would be needed if the Government was going to meet its targets set out in the strategy. In response, the DfT confirmed *"it will shortly be informing local authorities and others what future funding will be available in 2020/21 for various Government-funded walking and cycling schemes. And goes onto state that longer-term funding decisions will be a matter for the next Budget and the 2020 Spending Review.* Further note – the impacts of the pandemic are likely to affect this statement.

Appendix C

Local Walking and Cycling Infrastructure Plans

The Government has stated that *"LCWIPs are used by Local Authorities to identify and prioritise investment for cycling and walking schemes from local funds and relevant national funding streams, such as the Highways Maintenance Fund, Integrated Transport Block, Transforming Cities Fund, Future High Streets Fund, Housing Infrastructure Fund and the Clean Air Fund. Decisions on future funding for cycling and walking will be made in the context of the forthcoming Spending Review".*

The Government has produced guidance for local authorities on preparing Local Cycling and Walking Infrastructure Plans (LCWIPs). These plans are intended to help local transport authorities take a long-term approach to identifying and delivering interventions fit for their own local areas. Local authorities are not required to adopt an LCWIP, but the Government has said that it is "keen that as many areas as possible do so". Phil Jones, an independent transport planner who is helping a number of local authorities develop these plans, said that LCWIPs are "seen by DfT as the main vehicle for delivering the aims and objectives of [its] Cycling and Walking Investment Strategy".

To help local authorities develop these plans, the Government has provided funding for technical support—which includes study visits and training for highway engineers. This was made available on a competitive basis; 78 local authorities in England expressed an interest in the support, and 46 received it. Guy Boulby, Head of Cycling and Walking at the DfT, told

[n] The Walking and Cycling Alliance, made up of the Bicycle Association, British Cycling, Cycling UK, Living Streets, Ramblers and Sustrans.

LGA that the local authorities receiving this support covered about 40% of the population of England.

Local Government Association (LGA) comment:

While the guidance on and support for developing LCWIPs has been largely welcomed some local transport authorities complained that support had been insufficient. Kent County Council stated that they had not been one of the first local authorities to receive support to develop an LCWIP, which disadvantaged districts in their area who had matched funding available to invest in active travel and needed help earlier. Brighton and Hove City Council, said that they had bid for but not been successful in securing support for developing an LCWIP, and that more support in this area would be helpful. The then Minister told LGA that the Government had a role in assessing how LCWIPs were being implemented, with a view to rewarding good behaviour, best practice and consistent investment.

The Head of Cycling and Walking at the DfT, told LGA that LCWIPs were a pilot programme at present, and that the 46 authorities currently being supported were the first tranche although it is not clear what plans the Department has to further role out this support. Phil Jones, an independent transport planner said that the Government should require local authorities to produce local plans for active travel, so that there was a duty to plan for walking and cycling.

LGA comment - If LCWIPs are to be the main mechanism by which the Government's Cycling and Walking Investment Strategy will be delivered, it is important that the Government has a clear plan for encouraging local authorities to develop LCWIPs.

Appendix D

Methodology Notes

The National Travel Survey (NTS) is administered by the DfT and is a household survey designed to provide a rich source of data on personal travel. In 2017, the sample size was around 6,000 households and 14,000 individuals.

The Active Lives Survey (ALS) is a push-to-web survey administered by Sport England and is used to derive official estimates of participation in sport and physical activity. The ALS had a sample size of around 180,000 adults in England in mid-November 2017 to mid-November 2018, the survey enables analysis at local authority level.

The National Travel Attitudes Study (NTAS) is a survey of public attitudes about travel and transport. It is asked of people who have previously responded to the National Travel Survey (NTS) and who have consented to being contacted for further studies. This has the advantage of allowing a comparison between attitudes to travel and actual travel behaviour. The sample size in this first wave of the NTAS is only based upon NTS respondents between January 2018 and June 2018. This first wave has approximately half the sample size expected in future years, and as the years progress the survey size is expected to continue growing. Consequently for the first wave, the NTAS sample size is lower than BSA sample size, apart from a selected module of questions (for example, NTAS0301/ATT0324)

Categories for Escort or other escort – definition escorting another person for example walking or cycling with a child to school.

British Social Attitudes (BSA) Survey is conducted by National Centre for Social Research (NatCen), and has been running since 1983. Questions are asked of a probability sample based upon postcode across England, Scotland and Wales. Between 2002 and 2018 questions on transport were procured by the DfT. Between 2002 and 2017 all BSAs were conducted in a face-to-face interview, including the use of computer-assisted personal interviewing (CAPI). For the final year of DfT transport questions being included on BSA, some questions were asked instead via self-completion. All individual responses are weighted to allow inferences about the general public. For the 2018 BSA (which is currently unpublished), - DfT questions were on Version A, C and D of BSA - Total achieved BSA sample size for the versions the DfT questions were on is 2,873 - Fieldwork was carried out between July and November 2018.

Census Data

Distance travelled to work:
This applies to the distance in kilometers between a person's residential postcode and their workplace postcode, measured in a straight line. Derived distances that result in a distance travelled that exceeds 1200km are treated as invalid and a value is imputed. A distance travelled of 0.1km indicates that the workplace postcode is the same as the residential postcode.
'Work mainly at or from home' is comprised of those that ticked either the 'Mainly work at or from home' box for the address of workplace question or the 'Work mainly at or from home' box for the method of travel to work question.

'Other' includes no fixed place of work, working on an offshore installation and working outside of the UK.

Distance is calculated as the straight line distance between the enumeration postcode and the workplace postcode.

Method of travel to work:
The method of travel used for the longest part, by distance, of the usual journey to work. This topic is only applicable to people who were in employment in the week before the census.

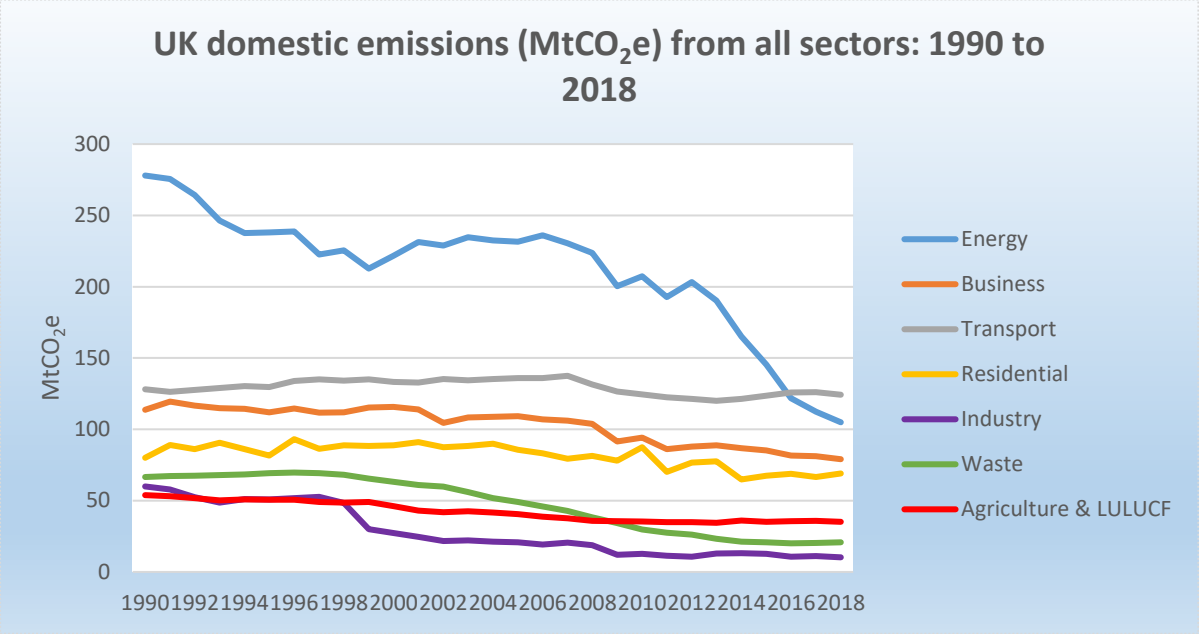
'All other methods of travel to work' includes 'Motorcycle; scooter or moped', 'Taxi', 'Passenger in a car or van', 'Bicycle', 'On foot' and 'Other method of travel to work'.

Appendix E

Transport and climate change

It is estimated that about a third of the UK’s greenhouse gas emissions come from transport (62), and is now the single biggest contributor to poor air quality. (63) Short journeys of less than 8 kms (a distance that could be cycled by many) contributes to 20% of all car related carbon dioxide emissions (those related to climate change) (WYLES, 2016).

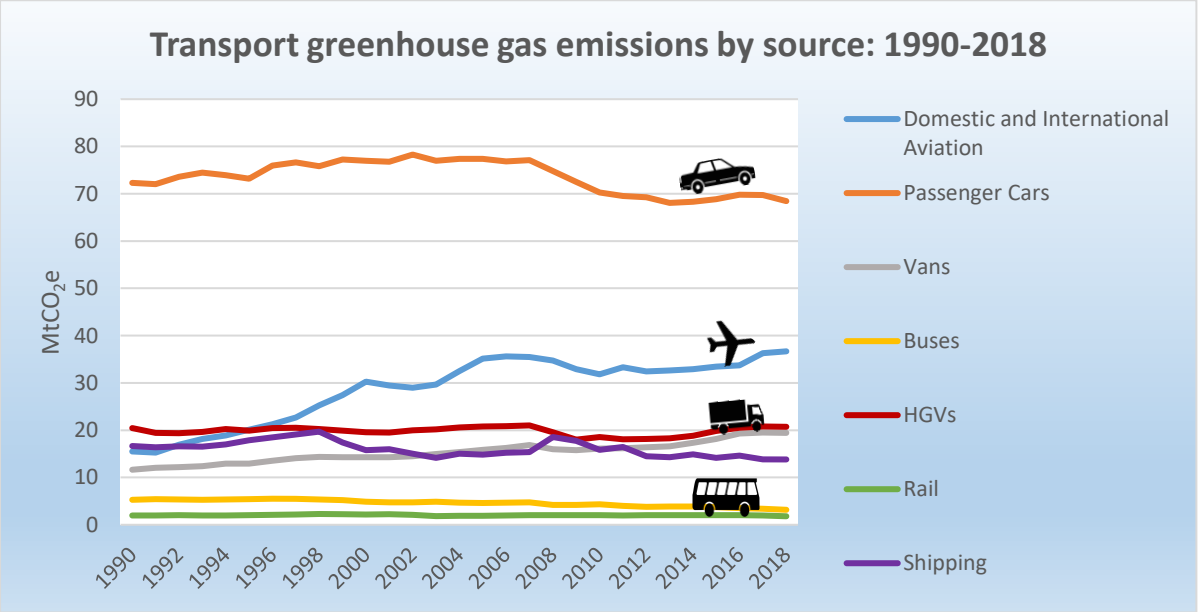
Domestic and international carbon dioxide emissions: 1990 to 2016



***LULUCF: Land Use, Land Use Change and Forestry**
Source: DfT 2020

Regional composition shows 79% of traffic flows are comprised from cars and 20% are goods vehicles. There has been a 3% decrease in car emissions since 1990, even though car traffic rose by 22% over the same period. This can be partially attributed to cars becoming more fuel efficient and are set to fall even further if government ambitions for electric vehicles and active travel are met.

During the same period, van traffic almost doubled, from 24.8 to 49.2 billion vehicle miles, mainly due to the growth in home delivery services.



Source: DfT 2020

New cars powered by petrol or diesel are to be banned from 2030, although second hand cars will stay on the road, the Climate Change Committee (CCC) estimates that by the end of this decade electricity will power 43 per cent of all cars, and by 2035 this will have doubled.

Populations from lower income groups tend to live in areas of the highest pollution but contribute least to transport pollution with the most polluted streets home to some of the poorest communities (64).

Active Travel Needs Assessment

thurrock.gov.uk

12 January 2023	ITEM: 11
Health and Wellbeing Overview and Scrutiny Committee	
Report of the Cabinet Member for Adults and Health	
Report of: Councillor Deborah Arnold	
This report is public	

1. Executive Summary

1.1. This is the first report of the Cabinet Member for Adults and Health. The portfolio holder is also the Chair of Thurrock's statutory Health and Wellbeing Board.

1.2. This report outlines the key areas of the Portfolio and highlights the achievements across the last year including: the continued transformation work across Adult Social Care and the integrated person-centred approach being taken by the Council, the ongoing commitment to the development of four Integrated Medical and Wellbeing Centres across the borough and the launch of the refreshed Health and Wellbeing Strategy. The report also identifies key challenges the Council faces such as the Social Care Charging Reform, the Fair Cost of Care and social care market fragility.

1.3. The report is split into two sections: Adults and Public Health. For Adults, the following subject areas have been considered:

- Health and Social Care Transformation – Better Care Together Thurrock;
- Front line Social Work Teams;
- Mental Health Service Transformation;
- Hospital Discharge (Previously Delayed Discharges of Care - DToc)
- Safeguarding;
- Preparing for Adulthood Strategy;
- Social Care Charging Reform;
- Fair Cost of Care;
- Carers;
- Micro Enterprises;
- Integrated Medical and Wellbeing Centres (IMWCs);
- Finance.

1.4. The Public Health section (from page 20) covers the following topics:

- Health and Care:
  - Population Health Management (PHM);
  - Tackling Health Inequalities through NHS Services;

    - Annual Public Health Report 2022 – Improving Quality of Care for Cardiovascular Disease.

- Health Protection:
    - Continued impact of COVID-19.
- Health Improvement:
    - Thurrock Healthy Lifestyle Service, Tobacco, Alcohol and Drugs, Sexual Health, Whole System Obesity and Weight Management and Mental Health Improvement - Suicide Prevention and Postvention Support.
- Wider determinants of health:
    - Health and Wellbeing Strategy 2022-2026, Economic Growth, Housing, Place Making and Youth Violence and Vulnerability.
- Finance.

Part 1 - Adults

2. Health and Social Care Transformation – Better Care Together Thurrock (BCTT)

2.1. In 2017, the Director of Public Health developed a whole system strategy in response to under-doctoring in Thurrock. The 'Case for Further Change' focused on enhancing capacity in Primary Care, but also on improving identification and management of long-term conditions and on shifting the health and care system to focus on enabling people to achieve a 'good life'. The Strategy introduced a new model of care for the local health and care system and launched a new phase of transformation known as Better Care Together Thurrock (BCTT). The early phase of BCTT included the development of Primary Care Networks (PCNs), the introduction of capacity building roles in Primary Care (now funded across all PCNs through Additional Roles Reimbursement Scheme, ARRS) and a successful long-term conditions programme – which enhanced the identification, management, and treatment of different long-term conditions.

2.2. Building on the Case for Change, the next phase of Thurrock's transformation programme aims to establish a new operating model for health and care. This is encapsulated within the system strategy called 'The Case for Further Change'. The new Strategy was published in 2022 and is divided into several separate but interconnected chapters that set out and identify how a clear integrated health and care vision will be achieved. These include General Practice and Primary Care; Population Health Management; an integrated and community-based workforce; a new model for Residential Care; a new model for support delivered in the home; and a new model for community engagement and empowerment. The Strategy also outlines a new model for commissioning and details governance arrangements.

2.3. Previous transformation initiatives as part of, or separate to, previous Strategies have enabled the Council to get to the point where it can deliver Thurrock-wide place-based integrated care systems and solutions. This has included the embedding of place-based social work teams (Community Led Support); implementation of targeted health interventions and the development of place-based relationships meaning a reduction in team-to-team referrals. The transformation of health and care is an iterative process and will continue to expand based on constant learning, testing and experimentation – all linked by a common set of principles as set out within the Integrated Care Strategy. For example, the development of Community Led Support has now led to the development of integrated social work teams at place and integrated health and care networks. The development of Wellbeing Teams and Better Care Together Nurses has led to the testing of 'blended roles' and a new model for care in the home.

2.4. The operating model contained within The Case for Further Change recognises that many people require multi-faceted solutions – but that they often have to go through numerous 'front doors' with numerous onward referrals.

This often results in them not finding the right solution or anyone to own and oversee that solution. The Strategy details an approach that starts with the individual and that provides a bespoke solution. This means existing services and organisations working together – often across existing boundaries and thresholds and focusing on solutions that are preventative or that intervene at the earliest opportunity.

2.5. The Council's transformation programme spans the next five years and will be regularly reviewed and updated. Governance arrangements focus on ensuring delivery. This includes overseeing several 'test and learn' experiments that enable existing partners to test new approaches – for example blended roles which span more than one current function, integrated teams – for example those spanning health, care and housing and the identification of 'signals' that enable the early identification of people requiring support – prior to crisis (for example those reaching the point of eviction). Much of this work will be developed and delivered through the Human Learning Systems programme which is both Council-wide and multi-organisational.

2.6. Several of the following sections describe elements of the Council's transformation programme and are not separate to it.

3. Front line Social Work Teams

3.1. Social Work Teams are the Council's professional leads in Adult Social Care (ASC). They support and protect some of the most complex and vulnerable adults in Thurrock. Thurrock has one of the lowest turnover rates of Social Workers in England allowing long term care relationships between staff and residents to be maintained. This is achieved through recruiting through Social Work Apprenticeships and then offering staff career progression opportunities and the opportunity to work in a strengths-based, holistic way embedded within the borough's communities.

3.2. There is now Thurrock-wide coverage for the Local Authority's place-based Social Work Teams (known as Community-Led Support Teams). Each of the Teams is aligned to one of four NHS Primary Care Network geographical footprints, supporting the provision of integrated health and care services.

3.3. The Social Work Teams are easily accessible – offering regular drop-in sessions known as 'Talking Shops' at key locations within the community. During the pandemic, the Teams offered 'virtual' talking shops but are now back doing face-to-face sessions. The Council has also continued with a virtual offer of support for people that prefer this way of making contact. There have been lots of benefits from the Community-Led Support (CLS) way of working. For example, reduced hand-offs, cases are

allocated quicker, and residents are not having to re-tell their story. The CLS principles and approaches are being fully evaluated by the transformation leads and the full evaluation report is pending.

3.4. The Community-Led Support Teams undertake the Council's statutory duties of care and support needs assessment, as well as safeguarding of individuals with eligible needs and carers needs. In addition, to approaching ASC, people continue to want to connect and do the things that have made their lives enjoyable. For example, ASC has often been able to link people with some gardening help so that they can continue to enjoy their garden or help to ensure they can get to clubs and organisations that reflect their interests. The Teams introduce and connect people to other members of the community and community led groups. For example, residents may seek support from a range of services provided by the Council and other community organisations. This is achieved through effective engagement with community builders and Local Area Coordination.

3.5. Following the successful implementation of Local Area Coordination and the continued emphasis on community and place with the likes of emerging social prescribers and community builders, Thurrock Council is further taking forward the principles of CLS and now focussing current staffing capacity to work differently therefore delaying and preventing the need for longer term social work and ASC support. As part of the integrated placed based approach, the Council has continued to integrate specialist teams into the Community Led Support Teams to provide the needed social work and strengths-based support. A test and learn exercise commenced in June 2022 by moving staff from the Reviews Team, Adult Social Work Mental Health, and Complex Care Fieldwork Teams into one of the locality teams and this will be implemented across the remaining three localities across Thurrock by February 2023. Initial feedback indicates that residents are receiving the right support at the right time by the right support services. The CLS principles and approaches are being fully evaluated by the transformation leads and the full evaluation report is pending.

3.6. The Hospital Social Work Team will also be part of the test and learn and will be embedded as part of the integration work. This piece of work will start in February 2023.

3.7. Over the past year, joint working has improved, including a collaborative approach with better holistic views of Thurrock's residents being understood and captured, and subsequently informing and directing the right support options. Historically, while staff across different teams and directorates communicated, feedback from residents and staff indicated service areas were perceived to work in silo. With the adoption of Human Learning System principles also, there is better collaborative work between ASC and Housing, and this is being extended to other departments within and outside the Council, especially Health colleagues. Members of CLS and Housing work from the same community hubs and engage in conversations as opposed to referrals, and this avoids people being bounced around the system and for Teams to improve the individual experience. A very early example highlighted

a member of ASC had made three enquiries to Housing services regarding support options available, but within the first day of moving into the hubs along-side Housing colleagues, support options were able to be identified and resolved for all three residents on that day.

3.8. Within the last month, a series of place based network workshops have been run with Housing, ASC, Rents and Health Services and it was found that conversations between all staff, inside and outside the Council has improved. With the principles of CLS being adopted by all parties, there has been a reduction in formal referrals being progressed, but support via joint visits and joint working improved with reduced delay being experienced for the resident. ASC are also seeing a reduction in duplication, for example, rather than a member of CLS progressing a formal referral to Occupational Therapy (OT) Services, the OT service has walked along-side the CLS member of the Team and progressed the support options needed for the resident, without the need to trigger a referral or another assessment, thus avoiding the resident telling their story again.

4. Mental Health Service Transformation

4.1. Having a home with the right levels of support is fundamental to someone's wellbeing, the Mental Health Transformation plan in Thurrock recognises this and has been focused on two projects that will support people with mental health challenges to have the best possible quality of life. Adult Social Care (ASC) is committed to transforming its approach to how accommodation and support are provided.

4.2. Supported Accommodation for people with mental health challenges is being transformed to make sure the person has support at the right level to ensure they can have as much control as possible over their lives that they are able to engage with support, with family and friends and their local community. It is really important to have skilled professionals to offer early intervention and preventative to wherever possible to enable the person to stay at home. It is often difficult for people who have mental health challenges to remain in accommodation as they do not have the right levels of support and the Council's approach is to deliver support as flexibly as possible so that it can wrap around someone when they are really struggling and ease away as the person becomes more settled while ensuring regular contact.

4.3. To enable this to happen the Council is developing a Complex Care Team, this will be a multi-disciplinary team to support people to maintain their accommodation when their mental health becomes more challenging, to have intense support when needed and to have access to appropriate health, social care and housing interventions. The Team will be led by a psychologist with a senior social work practitioner, a substance misuse worker, and support from the Local Area Coordinators. It will be linked into the Thurrock Mental Health Multidisciplinary Team (MDT) to ensure that a positive and prompt response can be made when required by the mental health system.

4.4. The Team will work in a therapeutic way supporting people to find solutions to prevent the loss of tenancies and subsequent homelessness, reduce the risk

held by the Housing Directorate and support individuals to develop where possible insight into their mental health and achieve stability which will support an improvement in their quality of life.

4.5. This complex care team will be delivered as a one-year pilot and be part funded by the Mid and South Essex Integrated Care System (ICS). The outcomes achieved with people during the pilot will be evaluated to enable learning and adjustment to the approach if needed.

4.6. ASC is supporting with Housing the development of the Housing First Scheme which comprises five general needs housing properties that will be allocated to five people with mental health challenges helping them to maintain a tenancy with the support from a Mental Health Practitioner (MHP). The MHP will provide individual support until the person is ready to manage their needs with a stepped down level of support where required. It is hoped that this expansion of the service will support people who find it difficult to obtain accommodation to have their own safe home with the right levels of flexible support.

4.7. On 31 March 2021, the Section 75 Agreement with Essex Partnership University Foundation Trust (EPUT) came to an end; resulting in the Adult Mental Health Social Workers and Support Planners returning to the direct management of Thurrock Council and relocation to the Civic Offices. Shortly after this the Approved Mental Health Profession (AMHP) service which facilitates requests for Mental Health Act Assessments for children, young people and adults was also brought back in house. This has been a very successful move enabling the development of positive social work practice. EPUT and ASC continue to work closely together ensuring high quality provision. A task and finish group has now been established across all partners to evaluate the process that dissolved the Section 75 Agreement to gain an understanding of how cases were transferred, how records were continued to be shared and if there is any learning or anything that could be done differently. To undertake this review, the Council will talk with people who have lived experience, Social Workers, Community Nurses and other professionals along with the wider system.

4.8. The AMHP service continues to face challenges in meeting demand due to a lack of AMHPs to carry out assessments; this is an issue experienced in many Local Authority areas. Thurrock Council is working hard to resolve this through encouraging Social Workers to undertake the AMPH training, advertising for AMPH practitioners and looking to introduce a triage function with qualified Social Workers offering advice and support in making decisions as whether an assessment is required. Often a Mental Health Act Assessment results in the need for hospital admission - currently there are significant shortages of beds available. This is monitored daily through a system wide call and EPUT and ICS commissioners look to purchase beds outside of Essex whenever they can. This is a National problem and both the ICS Mental Health Board and Urgent and Emergency Care Board are aware of the situation and raise it nationally with NHS England.

4.9. ASC currently has a contract with Thurrock and Brentwood Mind to deliver Counselling and Group Work Services to all adults residing in Thurrock and Day Opportunities for adults with serious mental health problems. Both contracts come to an end on 31 March 2023.

4.10. The two services are currently open to public consultation which has been supported by the Thurrock Centre for Independent Living (TCIL) to ensure that the Council obtain views of current users and carers. The feedback will be incorporated into the new service specification, which will go out for tender during winter 2022 and the new contract awarded in Spring 2023.

4.11. To ensure a safe and smooth transition to the new provider (if Thurrock and Brentwood Mind were to be unsuccessful) the current contracts will be extended for a period of two months. The counselling service continues to work well, providing choice to individuals who require low level mental health support.
Improving Access to Psychological Therapies (IAPT) services work closely with Inclusion Thurrock to ensure the individuals needs are met by the most appropriate service. The Day Opportunities service continues to see an increase in demand, utilising a mixed model of digital and face to face services proving beneficial for those who find it difficult to leave the house.

4.12. A Southend, Essex and Thurrock Mental Health Strategy is being produced by Tricordant, an external organisation who were commissioned by the Mid and South Essex Mental Health Partnership Board to write an all-age, public facing Mental Health strategy. Tricordant are overseen by a Strategy Group which includes representatives from the ICBs, Local Authorities and EPUT. The Strategy is currently in draft format and there are ongoing place-based meetings with Tricordant and stakeholders to gain their views. Additionally, Tricordant will be meeting with the VCSE sectors. This Strategy will inform the development of a multi-agency Mental Health Collaborative who will be tasked with implementing the recommendations. The Strategy is due to be delivered early in 2023.

4.13. A Partnership Director has been appointed to drive a strategic approach across the Council, the North East London NHS Foundation Trust (NELFT) and EPUT, which will add tremendous strength in delivering the Better Care Together Thurrock Strategy – Case for Further Change, which will support development and delivery of holistic outcomes for individuals, and system benefits covering both physical health, mental health and adult social care.

4.14. To improve the efficacy of the mental health offer for people with serious mental illness and their families/loved ones, the Council is working with the Mid and South Essex Mental Health system to implement Open Dialogue, which is an evidence based, systemic and strengths-based approach which will support individuals to reduce their reliance on services, improve stability and independence which will also support a reduction in failure demand.

4.15. Recognising the poorer life expectancy for those with a serious mental illness in Thurrock, the Local Authority is actively working to improve access to

physical health interventions for these residents in partnership with clinical and Public Health colleagues. This is placed in the parity of esteem agenda supporting equal support and care being available to those with mental health and physical health needs.

For example, ensuring that GP's are able to identify patients who have mental health challenges and as such can offer health checks, that appropriate support is available through the Council's Social Work Team and the EPUT Health Team for individuals to access population based interventions such as smoking cessation, health lifestyles together with early detection of depression through screening at health and social care appointments.

5. Hospital Discharge (Previously Delayed Discharges of Care - DToc)

5.1. Delayed Transfers of Care (DToCs) were national metrics that were monitored under the Better Care Fund. DToCs are where someone is medically fit to leave hospital, however, are delayed from leaving the hospital due to waiting for appropriate care and support to be put into place. This could be where the individual needs to move to specialist accommodation with support, or where they need support in their home. DToC's could be attributable to the NHS, the Local Authority, or both.

5.2. As a result of the COVID-19 pandemic, DToC recording has been suspended nationally since 20-21. It is not currently clear if recording will be reinstated. However, the Council monitor the situation locally via the Hospital Team and twice weekly operational meetings. Although the metrics are no longer reported upon Thurrock continues to perform very well in that we know anecdotally that we experiencing relatively few delays compared to other areas. The pressure in the system on discharge, and the rise in demand caused by the switch in criteria for discharge from medically fit to medically optimised, has meant that the ability for Thurrock to maintain its performance is compromised. Rises in demand for homecare are very high and the availability of carers is proving insufficient to meet demand; another key factor is the increased pressure that this situation is placing upon budgets. despite challenging circumstances.

6. Safeguarding

6.1. Safeguarding adults who may be at risk of abuse or harm has long been an absolute priority for ASC. The statutory Board led by Thurrock Council, the Integrated Care Board and Essex Police is now well established, and the Safeguarding Team provide skilled and person-centred interventions.

6.2. In 2021-22, a total of 1097 safeguarding alerts were received, a slight increase on alerts received in the previous year. The increase is in line with national data during the pandemic. This will be closely monitored by the Safeguarding Teams and the statutory Safeguarding Adults Board. The Council and partners continue to work closely with individuals, local communities, and other agencies to ensure that those at risk have the support they need to live their lives free from harm or abuse.

6.3. The Safeguarding Board has attended the Thurrock Council Talking Shops which are an opportunity to talk with someone from ASC.

6.4. They offer advice and guidance on a range of ASC needs. For example:
- Local services;
- Equipment;
- How to find a carer;
- How to find local clubs;
- Pendant alarms, fall detectors and other devices.

6.5. The Thurrock Safeguarding Adults Board (TSAB) will be providing safeguarding literature such as leaflets, posters, pens, trolley coins etc to all Talking Shops. Safeguarding information is also shared with partners for other events such as Community Safety engagement activities.

6.6. The Safeguarding Team is also responsible for managing the Deprivation of Liberty Safeguard Service. The Team will be implementing the new Liberty Protection Safeguards scheme, which is due to replace the Deprivation of Liberty Safeguard Service some time in 2023-24 (the implementation date is still unclear). The two schemes will run alongside each other for the first-year post implementation. A process is currently in place to develop the necessary systems and processes and ensure effective implementation of the new scheme.

6.7. Thurrock Council has always been proactive in ensuring that the necessary procedural safeguards are in place for those at risk of being deprived of their liberty; and remain confident that this strong Human Rights based practice will continue under Liberty Protection Safeguards. There has been an increase of 9% in Deprivation of Liberty (DoLS) applications granted in 2021-22 compared to 2020-21.

7. Preparing for Adulthood (PfA) Strategy

7.1. The Thurrock Preparing for Adulthood Strategy is a three-year plan that is relevant for all agencies and staff who work with disabled young people between the ages of 14-25 years in Thurrock. Throughout its three-year life cycle, all accountable parties joined in updating the action plan to include progress and evidence every year. The PfA strategy was recently refreshed for the period of 2022-2025 and this will be presented to the SEND Development Board in December 2022.

7.2. There is focus on four main areas and through working with partners including young people, the Council has identified these four main areas as key priorities. These 4 key areas as outlined by National Development Team for Inclusion (NDTI) as they move into adulthood are:
- Preparing for independent living;
- Health and wellbeing;
- Friends relationship and community;
- Further/Higher Education and Moving towards Employment.

7.3. The Council's vision is that "All children and young people in Thurrock with special educational needs and/or disabilities (SEND) aged 14-25 have good social relationships, stay healthy and are supported in their aspirations. Partners across Education, Health and Social Care will work together to ensure that these young people reach their full potential and are given every opportunity to live independent lives."

7.4. Thurrock Council acknowledges its responsibility to young people with SEND who are preparing for adulthood and recognises that positive outcomes will only be achieved with commitment from the Council, with partners, young people and their families, and carers.

7.5. With the right support at transition, young people with SEND can build the confidence and independence they need to have choice and control over their own lives. For some young people with the most complex needs, it is about celebrating each small step towards greater independence.

7.6. Thurrock's Preparing for Adulthood strategy is about the aspirations and opportunities for the young person. It is recognised that as young people with SEND move towards adulthood, they experience many changes which can be challenging and the Council is committed to supporting young people during this transition to be at the centre of planning and decision-making, to ensure a good transition into adulthood.

8. Social Care Charging Reform

8.1. As a result of the Chancellor's Autumn Budget, the Charging Reform was set to come into place as of October 2023, has now been delayed until at least 2025. The following is based on the Council's overall position in line with current Department of Health and Social Care (DHSC) guidance notes. It is possible that Thurrock's position will change between now and 2025 based on the different reform elements.

8.2. The Charging Reform is part of wider social care reform which includes significant changes in the way Councils charge for care. Changes include a new cap on the amount charged for the cost of care, that any individual would be expected to pay in their lifetime (often referred to as the 'Care Cap'). This is proposed to be £86,000.00 with the understanding this will rise over the years in line with inflation. The Care Cap excludes charges for daily living costs (fees not directly linked to personal care); these will remain payable by the service user, where means tested to contribute, throughout their time receiving care services.

8.3. In addition to the Care Cap, capital limits included in the means test are set to increase substantially, meaning that more people will be eligible for Local Government funding towards their care costs. Table One below outlines the current and proposed savings limits.

Lower Capital Limit	Higher Capital Limit
Current: £14,250	Current: £23,250
Proposed: £20,000	Proposed: £100,000

Table One: Current and proposed savings limit.

8.4. Changes proposed will see self-funders invited to access care and support directly through the Local Authority where they reside and places a new duty on Local Authorities to undertake an eligibility assessment of needs to provide commissioned services. Only the care cost deemed appropriate from the assessment of needs will be eligible for metering towards the Care Cap. As this is something Thurrock already allows, under its discretion, few changes if any will need to be made locally to support this new duty, however a small increase in resources is anticipated to accommodate.

8.5. Thurrock Council's current readiness position is strong. The organisation has a clear plan on implementation to meet proposed guidance. The Council will ensure that communication will be clear both internally from a change management perspective and externally to service users. Communication plans will be re-initiated in line with the Department of Health and Social Care's guidance.

8.6. IT system developers are confident in their ability to provide the necessary packages to support the Local Authority's duty to keep care accounts on all service users metering towards the cap, there is minimised risk in timescales now the delay has been confirmed.

8.7. Workforce and resource have been identified to be one of the biggest risks to meet the increase demands faced by the Council and it is predicted that this will still be the case when the new proposed date comes around in 2025. Data modelling will continue to be undertaken to ensure mapping of resources is as accurate as possible, and some works will continue in the background to ensure our readiness.

9. Fair Cost of Care

9.1. Section 5 of The Care Act 2014 sets out a Local Authority's duty to promote the efficient and effective operation of a market and to promote diversity and quality in provision of services.

9.2. In December 2021, the Government published a white paper, People at the Heart of Care, that outlined a 10-year vision that puts personalised care and support at the heart of adult social care. As part of these reforms the Market Sustainability and Fair Cost of Care Fund was announced.

9.3. The primary purpose of the fund is to support Local Authorities to prepare their markets for reform, including the further commencement of Section 18(3) of the Care Act 2014 in October 2023, and to support Local Authorities to move towards paying providers a fair cost of care.

9.4. As a condition of receiving future funding, Local Authorities needed to evidence the work they were doing to prepare their markets and submit the following to DHSC by 14 October 2022:

- Cost of care exercises for 65+ care homes and 18+ domiciliary care;

- A provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market, with consideration given to the further commencement of S18(3) of the Care Act 2014 (final MSP's to be submitted by February 2023);
- A spend report detailing how funding allocated for 2022 to 2023 is being spent in line with the fund's purpose.

9.5. Thurrock Council had a good response to the Cost of Care exercise resulting in 82% of homes submitting their data. No submissions were rejected. As such, the organisation has a sufficient level of submissions for the data to be valid. The median weekly average of these submissions are as follows:

- Residential Care: £845.91
- Nursing Care: £1,008.11 (would be inclusive of FNC)

9.6. Table Two (below) provides details of the current rates. Although the Cost of Care exercise has created an average, Thurrock Council pays a variety of rates depending on need.

9.7. As such, comparisons can be complex as the difference between the mean average and the current rates vary depending on need. The Council has a high needs dementia specialist home in the area (dementia with challenging behaviour) as well as homes that have a separate unit for dementia care. As these require more staffing and additional training, these differences have been absorbed into the average, again making comparisons difficult. A more sophisticated assessment of the difference between average cost and current rates will need to be developed in partnership with providers if the Council is to continue setting rate levels based on need, and a review of the existing fee setting arrangement will be required to ensure that these are fit for purpose.

RESIDENTIAL	COST PER WEEK
Standard Residential	£572.23 (Shared £543.60)
High Dependency	£609.91 (Shared £579.43)
Dementia Care	£617.24 (Shared £586.30)
High Needs Dementia (Specialist Home Only)	£646.63 (shared £614.22)
Nursing (local authority contribution) Nursing (inclusive of FNC)	£633.73 (Shared £602.04) £842.92 (Shared 811.23)

Table Two: Current rates paid by Thurrock Council.

9.8. The Council were disappointed to not replicate the high rate of return for residential care with only 33% of domiciliary care providers choosing to submit. Various activities were carried out, including extending the deadline for submission but were unable to secure more returns. Due to such a low response rate and as the organisations who responded were not

representative of the market, the Local Authority are unable to rely fully on the data submission. Instead, it will provide a basis for more in-depth conversations with providers and to review the current fee setting process.

9.9. The Fair Cost of Care exercise identified that the average cost per hour of standard home care was £23.15.

9.10. Thurrock Council's current rates are £18.93 per hour for standard home care and £19.93 for reablement. The difference between the Fair Cost of Care average and the Council's declared standard rate for home care is £4.22 per hour - an increase of 22%. Whilst some Fair Cost of Care Implementation monies are available to bridge this gap, the amount is inadequate to do so fully. The extra funding also is only for two years therefore not recurrent funding. As part of the Fair Cost of Care programmes Thurrock will have to produce a Market Sustainability Strategy which will explore how the council can move to a position where we are paying at rates that enable stability. This is due to be completed by February and the Council is on course to achieve this.

10. Carers

10.1. A carer is a child, young person or adult who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

10.2. Unpaid carers provide £132 billion of support to vulnerable people in the UK, an average of £19,336 per carer. The numbers of people caring, and the amount of care being provided has increased significantly since the pandemic. It is accepted that ASC and Health could not meet the needs of service users (physically or financially) in the community if carers did not continue within their roles.

10.3. Carers UK estimate that overnight, an additional 4.5 million people became unpaid carers in March 2020, meaning one in four (26%) UK adults were providing unpaid care to an older, disabled or ill relative or friend at the height of the pandemic. Carers' support was valued at a staggering £530 million per day during the pandemic, or £193 billion a full year – outstripping the value of the NHS. However, this came with high personal costs.

10.4. The numbers of unpaid carers have been rising significantly as the population ages and healthcare continues to improve. Locally, the number of adult carers seeking support from the Council's Carers Services has increased 100% compared to pre-pandemic levels. In Thurrock, it is estimated that some 20,000 people are carers. The 2011 census showed that 26% of those identifying as caring in Thurrock provide more than 50 hours per week. This is higher than region and national averages. Those carers providing the highest amount of care are twice as likely to be permanently sick or disabled as the general population.

10.5. Caring responsibilities can have an adverse impact on carer's employment and education opportunities. Carers are also likely to have much poorer physical and mental health outcomes compared to the general population. This increased health risk is attributed by carers to a lack of support. Early identification and support to carers is imperative, which is why there are two services available to support carers in Thurrock – one for adults and one for young carers aged eight to eighteen. Both are established services operated by voluntary sector organisations.

10.6. Thurrock Carers Service (adult carer service) has a dedicated presence within a Hub in Grays Shopping Centre, run a variety of face-to-face peer support groups and facilitate WhatsApp carer support groups. These include generic carer groups and groups aimed at specific demographic groups of carers/ carers of specific conditions, for example, young adult carers (transitioning from being young carers), male carers, Special Educational Needs (SEN) carers, carers for people with dementia, carers for people with drug and alcohol misuse and/or dependency.

10.7. The service has various aims; however, the focus is the identification of 'hidden carers' ('hidden carers' refers to informal carers who may not recognise themselves as carers and so do not, or struggle to, access support). Early identification and support are imperative in improving the physical and mental wellbeing outcomes of carers. The Carers Information, Advice and Support Service carries out a wide variety of activities during Carers Week/Carers Rights day and throughout the year to increase the number of people identifying as a carer. Due to this activity, there has been a significant increase in the number of carers coming forward.

10.8. The Carers Service has started to be part of the locality Test and Learn pilot where it will be trialled as being part of much a wider and integrated team. If this proves successful, the service will move to delivering in a place-based way across Thurrock.

10.9. Already, more integrated, and closer working between the Grays based Social Work locality team and the Carers Service (sharing Thurrock Minds Hub in the town centre on set days) has led to an increased identification of carers – with approximately 50% of new carers now coming from this locality. Placed based and integrated working will ensure increased identification and support to carers. Support will be centred around the community in which they live and lead to a more integrated approach to carer support internally and with partners such as Health.

10.10. The Carers Service will also start to carry out carer assessments on behalf of the Local Authority – this is in response to carer feedback about having consistent support throughout their caring journey. The Council were moving to this approach pre-pandemic but had to pause due to the situation. In addition to implementing an IT solution to allow an external partner to undertake assessments, the organisation has been working with carers and as a result, have agreed a new assessment process that is more meaningful and shaped by carers.

10.11. In addition, Thurrock Council wish for the first time to produce an all-age Carers Strategy (historically they have always been separate). Healthwatch Thurrock have undertaken a full engagement exercise with carers (adult and young carers) to gain their feedback and to understand what the main issues are for carers locally since the pandemic. This exercise is now complete, and all the feedback has been collated.

Several events will now be held with both carers and partners in the new year to turn these issues into an action plan that reflects their priorities.

10.12. Carer support in Thurrock is at the start of its transformation – many improvements that were delayed by the pandemic are now in transit. Further improvements will be genuinely shaped by the experience of carers in Thurrock. This is happening whilst the organisation tries to meet a significant increase in carers seeking support.

11. Micro Enterprises

11.1. Micro Enterprises are small services delivering local services to local people, providing personal and flexible support to give people more choice and control over the support they receive.

11.2. Thurrock's award-winning Micro Enterprise scheme, now in its sixth year has recently been featured as a case study in the Association for Public Service Excellence news. Micro enterprises are key to changing the adult social care provider market and providing more choice so that people can still achieve what matters to them regardless of their health and care situation.

11.3. More than 150 services are now available for residents. There is a very diverse range on offer from personal care to lunch clubs, gardeners and handymen to leisure and fitness activities. All are community focussed and provide a wide choice of services. Many services are run by volunteers and not dependent on an individual's ability to pay providing wider inclusivity for Thurrock residents.

11.4. There is ongoing interest in the scheme especially as Thurrock moves out of the pandemic and people are reassessing their lives.

11.5. The scheme has already provided opportunities for people who have been made redundant and there are plans to work alongside the Department for Work and Pensions and as other local business re-start initiatives to offer the scheme as a potential for employment. Many other Local Authorities have sought Thurrock's expertise and are also now implementing similar schemes to the Micro-Enterprises that have been created in Thurrock.

11.6. Thurrock's Micro-Enterprises are part of a tangible and successful, innovative, and collaborative approach to health and care transformation that delivers on all aspects, whether they be a vehicle for people realising a passion or a way of obtaining care and support that is personalised to the individual.

11.7. Local residents interested in setting up an enterprise can find more information about the scheme and an application form on the following link on the Council's website: https://www.thurrock.gov.uk/community-enterprises-for-care-and-support/supporting-local-people

11.8. A full list of available services can be found on the Stronger Together website - https://strongertogetherthurrock.org.uk/thurrock-micro-enterprise/

12. Integrated Medical and Wellbeing Centres (IMWCs)

12.1. The Council remains committed to working with NHS partners to develop four Integrated Medical and Wellbeing Centres (IMWC) across Thurrock.

12.2. The Council, Mid and South Essex Integrated Commissioning Board and NHS Trusts have worked closely together and have submitted Outline Business Cases (OBC's) to NHS England seeking approval to proceed with Tilbury and Purfleet IMWC's; all partners are awaiting their response.

12.3. However, at the last Health Overview and Scrutiny Committee dated the 3rd November 2022, the Integrated Care system representative, expressed concerns that the IMWC programme post covid maybe unaffordable for various reasons, including high rises in material cost and suggested a switch away from focus on buildings towards more integration of services on the ground may be necessary. The Council still remains committed to the building of all four IMWC's but clearly this is ultimately a decision for the NHS and NHS England to make. There still exists a direction from the then Secretary of State that the four IMWC's need to be built and operational before the closure of Orsett Hospital can be completed, therefore the Council will want to see due consideration is given to this undertaking before any final decision is made.

Corringham IMWC (Graham James site)

12.4. The North East London Foundation Trust led Corringham IMWC (to primarily serve Stanford and Corringham) had its official launch on 3 November 2022. The new health and wellbeing centre is a key opportunity for collaborative holistic personalised care and support for the community. Everyone working from the centre will aim to work with the community. It already offers a range of health and care services from the site and is currently preparing for support groups commencing programmes of opportunities from the site. The site is also finalising creating a warm space for residents this winter. The centre will shortly accommodate up to 12 GP fellows who will offer Thurrock residents additional GP appointments, as well as access to specialist clinics including long term condition appointments. Next steps will also consider how local volunteers can continue to shift traditional models of care within sites.

Tilbury and Chadwell IMWC (Civic Square site)

12.5. Subject to the caveats outlined above, the Council is leading work on developing and financing the Tilbury site, although when complete, most of the building will be leased to NHS partners. The OBC for both has now been submitted to NHS England and the Council await their decision. The aim remains to have this IMWC completed by 2024/5.

Purfleet on Thames IMWC (Town Centre site)

12.6. Subject to the caveats above, the IMWC for Purfleet on Thames is being developed by Purfleet Centre Regeneration Limited under the terms of a Section 106 Agreement for Mid and South Essex Integrated Commissioning Board (ICB). In March 2022, the Council, Mid and South Essex ICB and NHS Trusts agreed and submitted an Outline Business Case to NHS England for approval. The IMWC, which will primarily serve Purfleet, Aveley and South Ockendon, is to be leased to a body nominated by the Mid and South Essex ICB. Completion is expected by 2024/5.

Grays IMWC (Thurrock Community Hospital site, Long Lane, Grays)

12.7. The master planning for the Grays IMWC (primarily to serve Grays but also to act as a Central Hub for the whole of Thurrock) has been completed. Mid and South Essex Foundation NHS Trust and Essex Partnership University NHS Foundation Trust have reviewed their services to take account of the backlog in acute health care, and the greater potential for remote consultations.

12.8. The aim remains to have Grays IMWC completed by 2025. However, this timing is dependent on the extent to which the existing buildings on the Thurrock Community Hospital site can be repurposed.

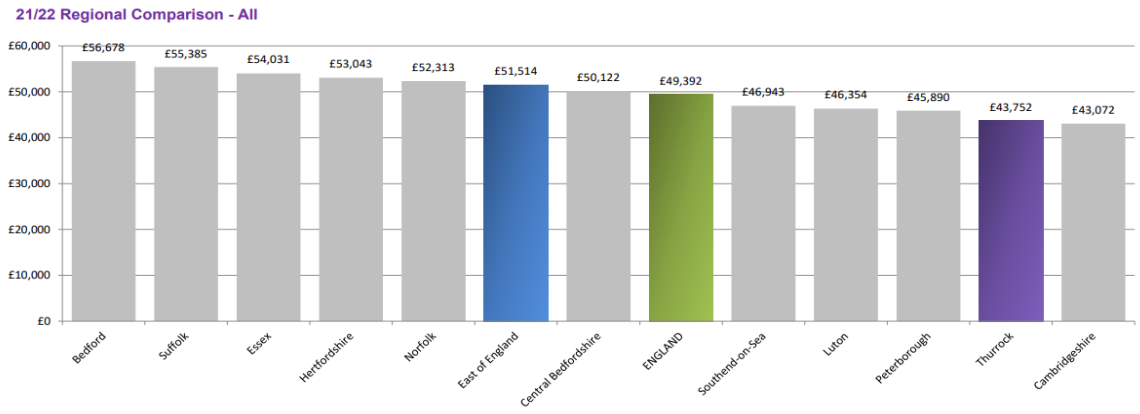
12.9. The Mid and South Essex Foundation Trust, covering the Thurrock footprint has been awarded £13 million to be the first area in Mid and South Essex to receive a Community Diagnostic Centre. This will be placed on the Thurrock Community Hospital site. The centre is part of a national initiative to support faster diagnosis and access to tests and scans closer to home.

13. Finance

13.1. The total net budget for ASC in 2021/22 was £46.659m.

13.2. It is worth noting that almost 50% of the total Adult Social Care spend is attributable to only 1% of the population (less than 2000 people), with 6% (less than 11,000 people) consuming a further 35% of the budget. This shows a growing trend of rapid increases in the level of acuity of people requiring adult social care, and health, intervention, which makes managing demand all the more complex. Put simply, any reductions in service levels to the vast majority of those Thurrock Council supports would carry enormous risk. This is why Thurrock's transformation programme aims to intervene more effectively and earlier in the lives of those at risk of developing complex issues requiring highly intensive and costly support.

13.3. Across the Eastern Region, Thurrock had the second lowest gross spend per 100,000 head of adult population, which is used as one of the standard indices of comparison. This demonstrates that the service has continued to contain expenditure and demand within the limits of the budget.



Graph One: 21/22 regional comparison of ASC spend per 100,000 head of adult population.

13.4. For 2021-22, ASC received £1.296m through the Social Care Support grant, and £0.736m via the ASC Council Tax precept. This funding was used in the base budget to support the increase in demand and costs within ASC residential, homecare and supported living placements. In addition, the Council was able to increase the rates which external providers are paid for supporting service users, this was essential to support the fragile care market.

13.5. As part of the Government's COVID-19 actions, the department received specific grants funding in the of support for infection control, rapid testing and workforce capacity grants throughout the year. The conditions attached to this funding was to ensure that additional financial support was given to care providers. The department has a pivot role in the allocation and administration of the funds, as well as providing detailed reporting to inform the Government of the situation locally.

13.6. The current financial year 2022/23 has seen considerable additional demand for services, leading to significant increases in costs and expenditure. This rapid rise in demand and complexity is, to a large extent, both attributable to the aftermath of the pandemic and the need to target resources at those directly affected by the virus, and as a consequence of the criteria for discharge from hospital changing from "medically fit" to "medically optimised" to assist with the hospital being able to manage the significant rise in demand that they are experiencing. Although some financial support has been provided by the NHS this has proved insufficient to cover the impact of this change; locally it is estimated that this has led to an unfunded increase in pressure of circa £2.5m to the Council's domiciliary care provision. This situation is not unique to Thurrock, with the vast majority of authorities across the Country reporting growing financial pressures within their ASC care budgets. There has been some mitigation of this through the announcement of new Discharge Funding in the Autumn Statement by the Chancellor (for Thurrock this will be circa £500K in 2022), however, it is anticipated that this

will need to be used to fund the anticipated rise in demand over the winter period and will not, materially, impact upon the current financial pressures.

Better care Fund (BCF)

13.7. Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75 Agreement between the Council and NHS, was approved in 2015. The arrangement has allowed the creation of a pooled fund, to be operated in line with the terms of the Plan and the Agreement, to promote the integration of care and support services.

13.8. The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home.

13.9. Despite 2021/22 being another year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Plan Scorecard were met by year-end.

13.10. The Better Care Fund Plan for 2022/23 has been developed to reflect and implement the new Strategy for Adults: Better Care Together Thurrock – The Case for Further Change 2022-26. A review programme has now commenced which will seek to align each service within the Better Care Fund Plan with the new Strategy, while also ensuring it meets the National Conditions set by NHS England and ensuring best value for money.

13.11. The next section of the report provides an overview of the Public Health portfolio.

Part 2 - Public Health

14. Overview

14.1. Public health is the science and art of preventing disease, prolonging life and promoting health through organised efforts and informed choices. It is generally thought of as three inter-related areas of work:

- Health and Care Public Health focuses on service quality improvement, which incorporates healthcare systems, service quality, evidence-based practice, clinical effectiveness and health economics;
- Health Protection, which incorporates communicable disease control; environmental, chemical, radiation and nuclear threats; and occupational health;
- Health Improvement, which draws heavily on the local government roots of the profession, socio-economic influences and health promotion, tackling the underlying determinants of health.

14.2. Public Health is funded via a Grant arrangement with the Department of Health and Social Care. Certain Public Health services, such as Sexual Health services, are mandated in legislation; other services, such as

Substance Misuse treatment, are stipulated as a condition of the Grant; and other services are discretionary.

15. Health and Care Public Health

15.1. The Council's broader priorities in relation to the health and care of adults are described above. Public Health-led health and care quality improvement is described below.

Population Health Management (PHM)

15.2. Thurrock Council hosts a dedicated PHM Team on behalf of the Mid and South Essex Integrated Care System (MSE ICS). PHM is a process of using data to identify population cohorts for whom the ICS (including the Council) can provide early intervention and prevention programmes, tailored to their specific needs, to improve their health outcomes. By design, it will directly contribute to the health inequalities agenda.

15.3. This year the PHM Team has produced Health Inequalities Data Packs that have helped each of the four Alliances in the ICS and their respective Primary Care Networks (PCNs) to make decisions on how to spend their allocated Health Inequalities resource. They are also supporting several service improvement projects such as three PCN-based projects including one in Tilbury and Chadwell, as well as working with the six ICS stewardship groups.

15.4. The Team has also helped to drive infrastructure developments including the production of the PHM segmentation model and integrated data set including pseudonymised data for 1.2m MSE ICS residents. They are working on ensuring that all appropriate system partners can gain access to this.

15.5. Thurrock specific PHM projects that are being driven by the Public Health Team include a new Cardiovascular (CVD) Local Enhanced Service (LES) for primary care which replaces the previous stretched QOF model.

15.6. The LES looks to fund multi-morbidity clinics for patients with multiple CVD conditions and who are considered "medium risk" with a view to prevent/delay them from escalating to "higher risk" (see also Annual Public Health Report section).

Tackling Health Inequalities through NHS Services

15.7. The Mid and South Essex Integrated Care System (ICS) has allocated £443,000 to address Health Inequalities in Thurrock in line with the NHS Core20Plus5 inequalities framework.

15.8. Following the implementation of an EOI process across Thurrock, Public Health supported Thurrock Integrated Care Alliance (TICA) to agree priorities and review bids received from across the borough. It was recommended that the following ten Health Inequalities schemes should be supported for delivery in 22/23 and 23/244:

ASOP & SLH PCN Obesity Transformation Project	Improving health outcomes, by reaching out to seldom heard groups with cancer information
Improving lifestyle risk management through Motivational Interview – training for Primary Care	Community-Generated Inequalities Solutions - Reference & Investment Board Pilot
Workplace Health Champions to provide smoking cessation to employees and referral to NHS health checks	Improving access to health services for Thurrock's Gypsy, Roma, Traveller and Showman communities
Enhancing safeguarding, health, and mental wellbeing for vulnerable young people and young parents	Improving access to health services for Thurrock's homeless communities
Health & Digital Literacy	Open Dialogue training to support people with SMI

Table Three: Health inequality bids for delivery in 22/23 and 23/24.

Annual Public Health Reports 2022 – Improving Quality of Care for Cardiovascular Disease

15.9. Directors of Public Health in England have a statutory duty to write an Annual Public Health Report (APHR) to demonstrate the state of health within their communities.

15.10. The 2022 APHR focuses on quality of care for Cardiovascular Disease (CVD) since 2016. Improving CVD outcomes is important to the health of the population in Thurrock because:

- CVD is the main clinical cause of premature mortality, with 1 in 4 premature deaths (<75) in the UK being due to CVD;
- CVD is the main clinical driver of health inequalities – premature mortality from CVD is higher in more deprived groups, and people living with Severe Mental Illness (SMI) and Learning Disability;
- Focusing on CVD prevention provides the greatest potential to reduce health inequalities and reduce premature mortality in Thurrock;
- Thurrock has the second highest premature (<75) CVD mortality rate in Mid and South Essex Integrated Care System;
- For mortality attributable to socio-economic inequality, CVD is the greatest contributor in Thurrock, accounting for 35% of excess deaths;
- For people living with SMI, Thurrock has the second highest premature CVD mortality rate in England.

15.11. The report found that measurable improvements has been made in the quality of primary care for CVD, but that further improvements could still be made. Recommendations will be taken forward through the Better Care Together Thurrock (BCTT) working group on Population Health and Inequalities. Actions fall into three categories covering workforce, service targeting to maximise impact on CVD outcomes and enhancing the LTC service model, and include:

- Continued quality improvement in primary care services for CVD;

- Embedding a more holistic, co-produced approach to long term conditions care;
- A focus on reducing inequalities in CVD outcomes, particularly for people from a minority ethnic background, people with serious mental illness and people with learning disabilities.

16. Health Protection

16.1. Until recently health protection activities have been largely undertaken by specialist public health professionals at regional and national level. However, the COVID-19 pandemic highlighted the need to maintain expertise at the local level that can mobilise additional capacity as required. The local function will cover the breadth of Health Protection incidents including public health responses to all infectious diseases, non-communicable threats to health (such as flooding), Emergency Planning and Response, plus preventative activity such as infection prevention and control, and immunisations.

Continued impact of COVID-19

16.2. The COVID-19 pandemic and its effects continue to have an impact across the health and care system, with Public Health and Adult Social Care (ASC) activity both affected. The pandemic highlighted the need for specialist Health Protection roles within the Council and a senior manager was employed in Public Health to fill this role.

16.3. This role will cover the breadth of Health Protection action required of Local Authorities (LAs), including LA public health responses to: all infectious diseases, non-communicable threats to health, Emergency Planning and Response, plus preventative activity such as infection prevention and control, and immunisations. The pandemic legislation has been replaced with “living with Covid-19 guidance” and as the country moves into endemic status it has become possible to respond to the virus in a similar way to other existing respiratory viruses.

16.4. The Local Authority continues to work closely with Health colleagues to ensure that outbreaks in care homes are managed effectively and efficiently.

16.5. The Clinical Hub that was set up at the start of the pandemic continues to ensure care homes and health settings are supported with managing communicable diseases and whilst the meetings have reduced, they remain a focal point for decision making and discussion. The protocol had been updated throughout the pandemic and remains in place today focusing on enhanced action should homes enter outbreak status. This includes:

- A requirement for all patients discharged from hospital back to care homes to have been tested and received a negative COVID-19 test result;
- Immediate rapid COVID-19 testing for one or more cases in care homes;
- Immediate COVID-19 testing for homes with two or more cases;

- Specialist Public Health advice for all care homes, domiciliary care and extra care settings at local level;
- Twice weekly contact by ASC to all care homes, extra care, and domiciliary care workers;
- Twice weekly meetings with ASC and Public Health to discuss system pressures;
- Monthly meetings with Mid and South Essex Integrated Care Board (ICB) and Integrated Care Partnership (ICP) colleagues;
- Monthly meetings with providers throughout ICB;
- Enhanced restrictions if more than two members of staff affected in care homes;
- The development of a local Memorandum of Understanding with UK Health Security Agency (UKHSA) colleagues;
- The multi-agency Care Home Hub continues to meet monthly to manage exposures and outbreaks and to discuss system pressures.

16.6. Since the start of the pandemic the Council has worked closely with external care homes, domiciliary home care and supported accommodation providers to make sure they felt supported throughout and have remained up to date on outbreak management protocols and relevant government guidance and this continues. Regular virtual meetings have continued with providers to maintain relationships and to continue to in partnership for the benefit of service users.

16.7. In 2021/22, Thurrock Public Health Team successfully bid for national funding for Covid Vaccine Champions to help increase the lower-than-average COVID-19 vaccine uptake in the borough. This funding is being used to give support and detailed advice on safety and efficacy of the vaccine to hesitant residents, or those who struggled to access the vaccine, through dedicated partnership work with the Essex Partnership University NHS Foundation Trust (EPUT), Community Health Champions hosted by Thurrock Community and Voluntary Services (CVS), and local organisations.

16.8. Between April and October 2022, 4,973 people, most of whom had previously not taken up the vaccination offer, have received a COVID-19 vaccination at EPUT bus locations and at pop-up clinics in the borough since the Community Health Champions began working with residents in April 2022. Feedback shows that a majority attended as they had reached the decision that it was time for them to get vaccinated, with younger people also likely to get vaccinated for travel reasons. The Champions are also promoting the Mid and South Essex ICS Do Your Bit winter campaign, which covers COVID-19 and flu vaccination, and other health and wellbeing messages for the winter months.

16.9. The Champions identify Community Connectors in areas of low vaccine uptake, and to make contacts with groups and businesses, and encourage people to attend for vaccination. The Champions are helping to promote the vaccine offer across the system, which includes sites operated by Primary Care Networks (PCNs) (including the Grays PCN offer, which is open to all Thurrock residents, and Stifford Clays which offers both booster and the evergreen offer for all aged 5+). There are also community pharmacies

offering appointment only booster vaccination. EPUT ran a dedicated appointment only children's vaccination clinic at the Alastair Farquharson Centre at Thurrock Community Hospital in October half term and Pets as Therapy dogs were funded for this clinic.

16.10. A thorough information and communications campaign, supported by CVS and the Council Communications Team, has been a core part of the programme. This has included:

- Council communications, newsletters and social media promotion;
- Video blogging and a supporting social media campaign including local residents and experts has been prepared and will be launched this month;
- Door to Door delivery of flyers for the bus and pop-up locations ensures that residents in low uptake areas get a monthly reminder of the vaccination offer locally;
- Posters translated into 12 community languages identified by Champions are produced each month and shared in the community by Champions and teams such as libraries and GP practices.
- Infographic on vaccine uptake is updated monthly on the Stronger Together vaccination platform;
- An end of programme showcase event planned for 2023 to highlight learning from the programme that could be applied to other health outreach situations.

16.11. The Local Authority's thanks go to all volunteers and to the voluntary sector which supported communities through this difficult period. CVS has since developed the Our Road programme as a legacy from the pandemic with the aim of embedding wider community led support across Thurrock.

17. Health Improvement

Thurrock Healthy Lifestyle Service

17.1. Thurrock Healthy Lifestyle Service (THLS), in partnership with Primary Care, has now resumed (post-COVID-19) provision of cardiovascular disease (CVD) risk assessments for the eligible 40-74 year old population. A schedule of refresher training for GP practice staff has been provided, although provision is still not yet back to pre-pandemic levels.

17.2. The programme remains an important tool for CVD outcome improvement. By identifying people at risk of CVD, appropriate interventions and support can be provided to improve their health and lower their risk of cardiovascular related illness.

17.3. THLS has continued to provide a virtual stop smoking service over the telephone with good long-term outcomes identified at six months. Clients respond positively with the remote service, as this provides flexibility for the service user at times that are convenient to them.

Tobacco

17.4. In addition to the smoking cessation service run by Thurrock Healthy Lifestyle Service (THLS), there are alternative treatment elements including Allen Carr Easyway – a cognitive behavioural therapy-based treatment that uses no nicotine replacement therapy.

17.5. Referrals for smoking cessation from partner agencies declined during the pandemic due to restrictions on face-to-face provision; alcohol and drug treatment services only saw the most clinically vulnerable clients, mental health referrals declined and maternity services at Basildon and Thurrock University Hospital (BTUH) experienced dramatic staff reductions, meaning the stop smoking specialist midwives were redeployed to the delivery wards. All treatment providers have been instructed to reinstate CO validation when delivering face-to-face stop smoking support.

17.6. Enforcement work in partnership with trading standards has continued following its pandemic affected reinstatement. Test purchasing and the use of tobacco detection dogs are once again disrupting the unscrupulous traders that operate in Thurrock, including the organised crime groups that supply the illicit tobacco markets and often have links to drug supply chains and modern-day slavery.

17.7. A refreshed whole system Tobacco Control Strategy is currently in production and is expected to be published in early 2023. Alongside this Strategy, the Tobacco Control Alliance will be relaunched locally. This will allow all relevant stakeholders to come together to shape the delivery of the Strategy and to inform the development of future approaches to reducing tobacco-related harm.

Alcohol and Drugs

17.8. The young people's substance misuse treatment service has now reintroduced its face-to-face offer, whilst maintaining the option of a digital contact. With schools returning to full time status, referrals have increased to pre-pandemic levels. Multi-agency working and safeguarding support has continued throughout the pandemic. The complexity of need has risen, with an ongoing need for partnership working with colleagues in mental health, social care, and youth justice.

17.9. The Adult Treatment Service has also returned to a face-to-face service, whilst maintaining the option of a digital contact. The complexity of cases seen by the service is increasing, with a greater need for multi-disciplinary support. Additional funding from the Joint Combating Drugs Unit has been made available to supplement existing treatment and recovery options.

17.10. Following its suspension due to COVID-19 restrictions, the Alcohol Liaison Service at BTUH has now been reinstated.

17.11. The Local Authority has continued to work across a pan-Essex footprint on drug market mapping with fellow commissioners, treatment services and enforcement agencies to ensure partners remain responsive to the rapidly changing illicit drugs market during the pandemic, working to disrupt the supply, reduce the demand and increase the number of people seeking treatment.

17.12. In line with national guidance, a new Combatting Drugs Partnership (CDP) has been launched. Meeting on a regular basis, the CDP will bring together partners from the Police, Public Health, Probation, the NHS, alongside members of the Community Safety Partnership, with a view to delivering on the national Drugs Strategy. A Substance Misuse and Alcohol Health Needs Assessment has been completed during 2022 and this will inform both the CDP and future service delivery.

Sexual Health

17.13. The Thurrock Integrated Sexual Health Service, delivered by Provide Community Interest Company (CIC) continues to provide sexual health and contraception services to Thurrock residents. The service now provides both a face-to face and a virtual offer.

17.14. Increased HIV testing and early diagnosis, and increased screening for Chlamydia will be priorities over the next 12 months. A Sexual Health Needs Assessment will be completed over the same period to inform future service needs.

Whole System Obesity and Weight Management

17.15. A refreshed Whole Systems Obesity Strategy is currently being developed. An evaluation of the 2018-2021 strategy has been undertaken to critically reflect on the whole systems approach of the previous Strategy and consider opportunities for addressing gaps and strengthening activities. This refresh will serve as an opportunity for all stakeholders to refocus their attention on obesity and co-produce a shared vision and actions that tackle obesity. Plans are currently being developed to hold a stakeholder workshop early 2023 to facilitate this co-production process. The refreshed Strategy will also include the latest data, legislation, and best practice. The Strategy will be developed to ensure it is relevant in the new post-pandemic landscape and reflects the current cost-of-living crisis. It is anticipated to be launched Spring 2023.

17.16. The Public Health Team has recently launched a new work programme dedicated to improving uptake of the Healthy Start Scheme. Healthy Start is a UK-wide scheme providing a nutritional safety net to those who are 10+ weeks pregnant and children under 4 in low-income families in receipt of

qualifying income-related benefits. Recent data indicates just 59% of eligible residents in Thurrock are utilising the scheme.

Approaches include; a dedicated communications and marketing campaign to raise awareness and encourage uptake of the scheme, calling on key stakeholders (including local processionals, charities, voluntary organisations, and retailers) to promote the scheme to residents and ensuring information is accessible online and within community settings.

17.17. Public Health and the Council's Communications Team have been working together to remove the advertising of High Fat, Sugar and Salt (HFSS) products within the Council's advertising space. Food and the environment will be an important feature within the new Strategy. The aim is for healthy food choices to be a simpler and easier task, particularly considering the current cost-of-living crisis. It is likely that HFSS advertising will likely be an integral part of this and therefore the Council is keen to lead by example and not promote advertising of such products.

17.18. A Tier Two Weight Management Service for children launched in March 2022 as part of recovery from the impacts of the COVID-19 pandemic. BeeZee Bodies has been commissioned to provide a progressive engagement model for child weight management that consists of three interventions to families with children age between 5-12 years old. The three tiered approach includes; a self-lead online tool, one-to-one extended brief intervention and Tier Two Digital Weight Management support. This service aims to put in place a programme that works holistically with families to help them make positive changes to their nutrition and physical activity. Longer term solutions for the provision of children's weight management services are currently being explored.

Mental Health Improvement - Suicide Prevention and Postvention Support

17.19. The Local Authority continues to play a vital role in coordinating and delivering programmes of work which aim to prevent deaths by suicide.
Thurrock residents have benefited from work programmes that have been funded from dedicated NHS (wave three) funding which are being rolled out in partnership across the Mid and South Essex footprint. Key successes to highlight from the last year have included:

- Continued delivery of grant funding towards Turning Corners football club enabling them to increase their support towards improving mental wellbeing of their attendees. This has been profiled in a 'Moments That Matter' video, which is available to view here: Moments that Matter Turning Corners - YouTube;
- Further dissemination of grant funding towards more organisations addressing risk factors for suicide;
- Publication of a self-harm prevention and management toolkit for professionals, which is available here: Adult Self-harm Management Toolkit NHSE - Mid and South Essex Integrated Care System (ics.nhs.uk)

- Continued development of the Wellbeing Calls pathway for patients newly-diagnosed with depression or newly-prescribed anti-depressants which sees Thurrock patients offered a series of weekly phone calls from Thurrock and Brentwood MIND for a period of approximately six weeks;
- Continued roll out of suicide prevention training via the bespoke website launched last year: Suicide Prevention - Homepage - #TalkSuicide Essex (letstalkaboutsuicideessex.co.uk). The Public Health Team undertook an evaluation of attendees at Suicide Prevention courses over 2021/22 and found an overwhelmingly positive response, indicating community interest in improving knowledge and awareness on this topic;
- The rollout of a near-Real Time Suicide Surveillance System by Essex Police which captures information on suspected suicides in Southend Essex and Thurrock on a monthly basis. This is enabling a much quicker response to emerging local trends than historically relying on coroner-reported information and is now being shared with relevant professionals on a regular basis to inform planning.

17.20. Thurrock Public Health also coordinates the work of the newly reinstated Southend Essex and Thurrock Suicide Prevention Steering Board, which is chaired by the Deputy Police, Fire and Crime Commissioner for Essex. This Board will be responsible for developing a new joint Strategy in 2023 following publication of the national strategy.

17.21. There is a separate programme of work underway to improve the support available to those impacted by a death by suicide (postvention support). This is also being funded by dedicated NHS (wave four) funding across the Mid and South Essex footprint and will be a collaboration between existing and newly commissioned agencies. The service will be operational by the end of the year.

18. Wider determinants of health

18.1. The Council can improve the health and wellbeing of Thurrock residents and reduce inequalities (between Thurrock and other places and within Thurrock itself) and through bringing together the concerted efforts of all our services and partners including the NHS and the third sector. Embedding systematic prevention and early intervention in the work of all benefits residents and services users directly and contributes to the financial sustainability of public sector services in Thurrock.

18.2. The Health and Wellbeing Strategy recognises the importance of the wider determinants of health on preventing ill health and promoting an individual's health and wellbeing: economic growth, housing, place, violence, vulnerability and sexual abuse are explored further below.

Health and Wellbeing Strategy 2022-2026

18.3. The Health and Wellbeing Board (HWBB) has a collective statutory duty to produce a Health and Wellbeing Strategy (HWBS). The HWBS is one of two highest level strategic documents driving place making for the Local Authority and system partners (the other being the Local Plan). The HWBS is a whole system plan for health and wellbeing and should engage all partners in the wellbeing agenda, coordinating strategic thinking of all elements of the Council and all system partners to deliver quantifiable gains in health and wellbeing of residents.

18.4. The refreshed HWBS was agreed by the HWBB and Full Council in June 2022. It can be and can be accessed here: https://www.thurrock.gov.uk/health-and-well-being-strategy/health-and-well-being-strategy-2022-2026 . The HWBB is reviewing plans for and progress against the Goals set out in the Strategy on a rotating basis at its meetings to ensure delivery.

18.5. The Strategy has a Vision of *Levelling the Playing Field* and tackling inequalities is reflected throughout the document. In order to support delivery of the Council's vision, the six domains of the Strategy each relate to one of the Council's key priorities of People, Place and Prosperity as set out in Figure One. The domains will ensure a broad focus on the wider determinants of health that underpin the persistent inequities within Thurrock.

PEOPLE	**PEOPLE**	**PEOPLE**	**PROSPERITY**	**PLACE**	**PEOPLE**
Domain 1 *Health Improvement* Staying Healthier for Longer	Domain 2 *Wider Determinants of Health* Building Strong and Cohesive Communities	Domain 3 *Health and Care Services* Quality Care Centred Around the Person	Domain 4 *Wider Determinants of Health* Opportunity for All	Domain 5 *Wider Determinants of Health* Housing and the Environment	Domain 6 *Wider Determinants of Health* Community Safety

Table Four: Alignment of Domains of HWBS to the Thurrock Vision

18.6. A thorough consultation exercise was undertaken to inform the Strategy and a full Consultation Report has been produced. Proposals for the refreshed HWBS were refined to reflect consultation outcomes, and the changes made in response to community feedback are detailed in the full Consultation Report.

18.7. Over 750 comments were received through a short 'user friendly' questionnaire developed in conjunction with the CVS and Healthwatch, which sought the public's views on the six Domains that have been proposed for the refreshed Strategy. In excess of 300 residents or professionals involved in the planning, commissioning or delivery or health and care services provided feedback on the strategy consultation proposals through community and professional forums and meetings.

19. Public Health Action on Wider Determinants of Health

HWBS Domain 4 - Opportunity for All
Economic Growth

19.1. A joint strategic needs assessment (JSNA) on Work and Health was published in 2020 and the current Healthier Communities JSNA will inform the development of the Local Plan. The Public Health Team is represented on the Backing Thurrock implementation group and is contributing to the development of the revised Thurrock-wide economic strategy.
It is engaged with the Association of South Essex Local Authorities (ASELA) Anchor and Digital Programmes. It is currently focused on the development of a signposting resource to support Small and Medium-sized Enterprises in improving the Health and Wellbeing of their employees, the training of Health and Wellbeing workplace champions in large employers and establishing community-based groups to promote digital inclusion.

HWBS Domain 5 Housing and the Environment

19.2. Public Health contributed to an assessment of housing affordability for the Housing Strategy. This was to inform the future planning and delivery of affordable housing in Thurrock, including improvements to the existing housing stock.

19.3. The Housing and Public Health Teams are now jointly working to address Fuel Poverty, and this topic will be the focus of the 2023 Annual Public Health Report. Delivering effectively on this will support the levelling up agenda through improving mental health, and reducing ill health associated with poor housing such as respiratory illnesses. This continued close working across teams makes efficient use of combined resources.

19.4. Public Health is also working with officers in Housing and Planning to deliver domain five of the Joint Health and Wellbeing Strategy, which is about “Housing and Environment”.

Place Making

19.5. Public Health continues to have a strong influence on place making in the borough, engaging with Planning, Regeneration, Transport and Sustainability to positively influence the environment in Thurrock to be health promoting. Public Health is strategically involved in the following:

- The Local Plan: The Local Plan represents one of the largest opportunities to influence the health and wellbeing of residents through spatial planning and the built environment.
  The Public Health Team is in the process of finalising a guidance document aimed specifically at informing the evidence base for the Local Plan;
- Health in Planning: The Public Health Team continue to work towards ensuring that relevant planning applications in the borough are assessed for health impacts.

The Team also recently organised Health Impact Assessment training for colleagues across the Council and are looking to develop a new Health in All Policies approach to Health Impact Assessment going forward;

- In addition to the local planning system, the Team is beginning to start work on health and climate change. This includes informing the Climate Change Strategy for the borough;

- Regeneration: The Public Health Team has contributed to the development of bids for the Towns Funds for both Grays and Tilbury, working to ensure that the built environment in these regeneration areas is health-promoting. The Team also provide input into the regeneration of these areas by attending the relevant Boards and through the Health Impact Assessment work that the team undertakes;
- Transport Visioning: Following completion of the Active Travel Needs Assessment, the Public Health Team continue to champion a modal shift to active travel, recognising that this is key to supporting health promoting behaviours and supporting climate change adaptation. This is through working with Transport colleagues as well as through the review of planning applications.

HWBS Domain 6 – Community Safety
Youth Violence and Vulnerability

19.6. The local response to serious youth violence in Thurrock (16-24 year olds) has been structured around the 2019 Annual Public Health Report (APHR) written by the then Director of Public Health (DPH) on youth violence and vulnerability.

The report took a public health approach to addressing youth violence and vulnerability and made 32 recommendations within the following four categories: surveillance; primary prevention; secondary prevention; and tertiary prevention.

19.7. The Thurrock Violence and Vulnerability Board was established under the leadership of the DPH to provide oversight and assurance of the activity of the four work streams in implementing the APHR's recommendations, ensure the work of the Essex wide Violence and Vulnerability unit is being delivered locally and ensure that the voice of communities is part of tackling serious youth violence. The majority of the recommendations in the 2019 report have been delivered and the Action Plan has been reviewed in line with the new Serious Violence Duty. It was felt that it would be appropriate to review the governance for this work to reduce duplication, and it is now being merged with work ongoing through the Community Safety Partnership. Public Health will continue to lead on data-driven surveillance.

20. Finance

20.1. Table Five, below, indicators the income streams for 22/23 for the ringfenced Public Health Grant:

Income source	Amount (£s)
Public Health Grant 2020/21	-11,887,359
PHG Carry Forward from 20/21	-380,341
OPCC Grant Income	-48,907
NRT Re-charge from NHS Thurrock CCG	-27,000
HRA Recharge (contribution to Well Homes Project)	-45,000
s31 Criminal Justice D&A funding	-214,000
MSE partnership contribution	-218,211
prEP allocation	-23,812
Total Income sources:	**-12,844,630**

21. Conclusions

21.1. This report highlights the comprehensive and high-quality work undertaken across the diverse portfolio of services that are the responsibility of the Cabinet Portfolio Holder for Adults and Health.

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Health and Wellbeing Overview & Scrutiny Committee
Work Programme
2022/2023

Dates of Meetings: 7 June 2022, 1 September 2022, 3 November 2022, 12 January 2023 and 9 March 2023

Topic	Lead Officer	Requested by Officer/Member
7 June 2022		
HealthWatch	Kim James	Members
Thurrock Health and Wellbeing Strategy 2022 - 2026	Jo Broadbent	Officers
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Adult's Integrated Care Strategy	Les Billingham / Ceri Armstrong	Officers
Integrated Community Equipment Service (ICES)	Ian Kennard	Officers
Work Programme	Democratic Services	Officers
1 September 2022		
HealthWatch	Kim James	Members
2021/22 Annual Complaints and Representations Report – Adult Social Care	Lee Henley	Officers
Gray's IMWC Engagement Update (PowerPoint)	Tina Starling and Stephen Porter	Members
Contract for Occupational Therapy and Independent Mobility Assessment Service	Ian Kennard	Officers
Contract to Supply, Install, Maintain & Repair Telecare Equipment	Ian Kennard	Officers
Work Programme	Democratic Services	Officers
3 November 2022		

HealthWatch	Kim James	Members
Annual Public Health Report 2022	Jo Broadbent	Members
Adults, Housing and Health - Fees and Charges Pricing Strategy 2023/24	Catherine Wilson	Officers
Under Doctoring in Thurrock (PowerPoint)	Steve Porter	Members
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Community In-Patient Beds in Mid and South Essex	James Wilson and Andy Vowles	Officers
Transforming Health and Care in Thurrock (PowerPoint)	Tiffany Hemmings	Officers
Request to Consult for the Charging of Assistive Technology Monitoring Service	Ian Kennard	Officers
Service Harmonisation Mid and South Essex ICB	Claire Hankey	Officers
Work Programme	Democratic Services	Officers
12 January 2023		
HealthWatch	Kim James	Members
EPUT Presentation	Rita Thakaria	Members
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Active Travel Needs Assessment	Jo Ferry	Officers
Self-Care in the Context of Living with Long Term Conditions – A Joint Strategic Needs Assessment	Emma Sanford	Officers
Adult Substance Misuse Needs Assessment	Phil Gregory or Helen Forster	Officers
Report of the Cabinet Member for Adults and Health	Cllr Arnold	Members
Work Programme	Democratic Services	Officers
9 March 2023		

HealthWatch	Kim James	Members
Personality Disorders and Complex Needs Report	tbc	Members
Dementia Strategy - Thurrock Implementation Plan –	Sarah Turner	Officers
Integrated Medical Centres Update (PowerPoint)	Tiffany Hemming	Members
Final Market Sustainability Plan	Catherine Wilson	Officers
Domiciliary Care and Unpaid Carer Support	Sarah Turner	Officers
Work Programme	Democratic Services	Officers
Briefing Notes		
Thurrock Safeguarding Adults Board (TSAB) Annual Report 2021/22	Jim Nicholson – 28 November 2022	Officers

Items for 2023/24 Work Programme:

Transforming Health and Care in Thurrock – Ceri Armstrong / Steve Porter
Community Impatient Beds in Mid and South Essex following consultation – James Wilson
Safeguarding Adult Board - Annual Report – Jim Nicholson

Clerk: Jenny Shade
Last Updated: July 2022

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