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

Health and Wellbeing Board

The meeting will be held at **10.30 am – 12:30pm** on **31 July 2020**

Virtual My-Teams meeting

Membership:

Councillor Halden (Chair), Councillor Mayes, Councillor Gledhill and Councillor Fish
Corporate Director of Adults, Housing and Health * (Roger Harris)
Corporate Director of Children's Services * (Sheila Murphy – Corporate Director for Children's Services)
Director of Public Health* (Ian Wake)
Interim Deputy Accountable Officer: Thurrock NHS Clinical Commissioning Group* (Mark Tebbs)
Chief Operating Officer HealthWatch Thurrock * (Kim James)
Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board (Dr Kallil)
Executive Nurse: Thurrock NHS Clinical Commissioning Group (Jane Foster-Taylor)
Director – Place (Andy Millard, Interim Director for Place)
Director level Executive, NHS England Midlands and East of England Region (Ann Radmore)
Chair Thurrock Community Safety Partnership Board / Director – Environment and Highways (Julie Rogers)
Adult Safeguarding Partnership senior representative (Jane Foster-Taylor, Thurrock CCG)
Chair Thurrock Local Safeguarding Children's Partnership or their senior representative (Revolving Chair - currently Jane Foster-Taylor)
Integrated Care Director Thurrock, North East London Foundation Trust (NELFT) (Tania Sitch)
Executive member, Basildon and Thurrock Hospitals University Foundation Trust (Andrew Pike / Preeti Sud)
Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Nigel Leonard)
Chief Executive Thurrock CVS (Kristina Jackson)
HM Prison and Probation Service (Karen Grinney)
Interim Joint AO for Mid and South Essex CCGs (Anthony Mckeever)

Agenda

Open to Public and Press

Members are provided with papers to support this agenda item

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Members are provided with papers to support this agenda item

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Members are provided with papers to support this agenda item

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The forward work programme is provided for member's consideration

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - AHH Directorate by sending an email to DKristiansen@thurrock.gov.uk

Agenda published on: **23 July 2020**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

↓

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

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

Public Minutes of the meeting of the Health and Wellbeing Board held on 31 January 2020 10.30am-12.30pm

Present:	Councillor Susan Little (Chair) Councillor Tony Fish Roger Harris, Corporate Director of Adults, Housing and Health and Interim Director of Children's Services Kim James, Chief Operating Officer, Healthwatch Thurrock Nigel Leonard, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) Ian Wake, Director of Public Health Preeti Sud, Executive Member of Basildon and Thurrock Hospitals University Foundation Trust Julie Rogers, Chair Thurrock Community Safety Partnership Board/Director of Environment and Highways Trevor Hitchcock, Lay Member Patient Participation – Thurrock NHS Clinical Commissioning Group Nicola Martin, HM Prison and Probation Service
Apologies:	Councillor Robert Gledhill Mandy Ansell, Accountable Officer, Thurrock NHS Clinical Commissioning Group Kristina Jackson, Chief executive Thurrock CVS Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust (NELFT)
Did not attend:	Dr Anand Deshpande, Chair of Thurrock CCG Dr Anjan Bose, Clinical Representative, Thurrock CCG Tom Abell, deputy Chief executive and Chief Transformation Officer Basildon and Thurrock university Hospitals Foundation Trust Andrew Pike, Executive Member Basildon and Thurrock Hospitals University Trust Jane Foster-Taylor, Executive Nurse Thurrock NHS Clinical Commissioning Group
Representation:	Tania Sitch was represented by Rita Thakaria, Assistant Director Community & Crisis Care. NELFT

1. Welcome and Introduction

Apologies were noted. Cllr Little confirmed that this was her third meeting as Chair of the Health and Wellbeing Board. The Chair invited Nicola Martin to introduce herself and describe her role within HM Prison and Probation Service. The Chair acknowledge that this was the final meeting for Trevor Hitchcock, Lay-member for Thurrock Clinical Commissioning Group and thanked Trevor for his contributions as a Board member.

2. Minutes

The minutes of the Health and Wellbeing Board meeting held on 20 September 2019 were approved as a correct record.

3. Urgent Items

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

The Chair asked Ian Wake, Director of Public Health to update members on the Novel Coronavirus. Key points included:

- The risk to UK had been raised from low to moderate. There had been 2 Cases within the UK. 83 Britons and 27 foreign nationals were flying back to UK on the day of the meeting.
- The Fatality rate was currently 2% on current advice people most at risk were the elderly or those with existing underlying conditions.
- It is important to ensure that our messages are proportionate. Members were reassured that the situation will remain under careful review with daily briefings taking place with Public Health England and other key stakeholders.
- Members were advised that the CCG and health colleagues have been undertaking emergency planning and that robust information gathering and monitoring continued to take place.

4. Declaration of Interests

There were no declarations of interest.

5. Mid & South Essex Health & Care Partnership 5-Year Strategy

This item was presented by Jo Cripps, Interim Programme Director, Mid & South Essex Health & Care Partnership. Key points included:

- The STP was now being referred to as the Mid and South Essex Health and Care Partnership.
- The Mid and South Essex Health and Care Partnership has worked with partners across the system and informed by

those partners to create a five year strategy that reflects local Health and Wellbeing Strategies

- The Strategy sets out commitments provided in the NHS Long Term Plan and how we are intending to deliver them.
- HealthWatch Thurrock engaged members of the public to ensure there has been substantial residential engagement which has informed the Strategy.
- Public Health has provided a population profile which has been fed into the Strategy, including the wider determinants of health and wellbeing.
- An Outcomes framework will be developed with Public Health to ensure progress can be monitored over time.
- A key aim of the Strategy is to reduce health inequalities, supporting people to make healthy choices and lifestyles.

Members were provided with an update on the partnership more generally which included:

- The Partnership remains committed to becoming Integrated Care System by April 2021.
- Provides more autonomy and will be supported by further investment.
- A population health strategy has been developed
- A workforce Strategy is currently being developed
- Implementation of shared care records will be introduced and:
- Chair Mike Thorne has identified two priorities and is keen to engage partners at future Summit meetings to identify:
    - Cancer outcomes
    - Support for aging population

During discussions the following points were made:

- An independent accountable officer has not been appointed. Partners have been notified that no appointment was made. This means there is no change at the moment.
- Concerns were raised about potential impact on Thurrock particularly regarding finances and decision making. Members were reassured that Thurrock is recognised by the Health and Care Partnership as leading on this work. Reassurance was also provided that the Strategy aims to reflect local places and their plans.
- Members were updated about the third meeting of the Thurrock Integrated Care Partnership meeting which took place on 30 January 2020, demonstrating a sustained and strong commitment across partnership agencies to continue to work together in Thurrock.
- A consultation document is to be published on CCG Merger.
- A virtual panel of 1500 people across mid and south Essex has been established. Virtual surveys will be run every six to eight weeks. First survey will be focussed on outpatients.

Members reassured that there are opportunities for the public and partners to provide views on health and care services.

- Information sharing challenge – different systems. There is no requirement for organisations to adopt a new system but members were reassured that connectors are being purchased to enable different systems to link. There will be direct agreements in place between organisations over the next couple of months for sharing information.
- BTUH remains committed to continuing to focus on place level. BTUH will continue to work with individual locations while engaging the wider health and care partnership.

RESOLVED: The Health and Wellbeing Board members agreed the draft 5-year Strategy and Delivery Plan.

6. Sexual Violence and Abuse Joint Strategic Needs Assessment

This item was presented by Maria Payne, Strategic Lead – Public Health and Sareena Gill- Dosanjh, Public Health Programme Manager. Key points included:

- There is a need to expand knowledge of sexual violence and abuse.
- Recommendations made within the JSNA include:
  - Improving the quantity of the data,
  - Co-ordinating practice,
  - Prevention of sexual violence and abuse with school based approaches and
  - Improve access to services and strategic oversight of sexual violence and abuse.
- A dedicated sexual violence and abuse partnership group is to be established, which will include survivors of sexual abuse.
- It can be difficult for survivors to navigate the services available and there are a wide range of organisations providing these services including Local Authority, Home Office, CCG, NHS England, Ministry of Justice, Police, and Social Care.
- The JSNA identified that there have been inconsistencies in where/how data is recorded/reported.
- A Thurrock Sexual Violence and Abuse Summit will be held in March and will provide an opportunity to establish the best way of taking forward recommendations made in the JSNA.

During discussions the following points were made:

- Members requested contact details for reporting sexual violence and abuse is included within the Children's Health Passport.
- Schools will be holding mandatory sex and relationships lessons for students from September 2020.
- A communications strategy will be developed and ensure that key messages are coordinated and aim to reduce the stigma of sexual violence and abuse.

- Members considered professionals and how they are managing and supporting individuals. Members acknowledged the importance of ensuring professionals receive support to manage emotional impact of supporting people that have been subjected to sexual violence and abuse
- The Chair encouraged members to attend summit in March at Orsett Hall.

RESOLVED: The Board endorsed and approved the report for publication. The Board also supported the Thurrock Sexual Violence and Abuse summit.

7. Ofsted Inspection of Local Authority Children's Services (ILACS)

This item was presented by Sheila Murphy, (Interim) Director of Children's Social Care and Early Help. Key points included:

- ILACs were introduced by Ofsted 2018. System major inspection once every three years and focussed annual visits and Joint Area Targeted Inspections which engages wider partners as well as the council.
- ILACs took place in November (comprising 2 weeks on sight activity and one week off sight activity. The comprehensive and thorough inspection was as a result of the service previously being assessed as Requiring Improvement).
- Prior to visit from Ofsted over 150 documents loaded onto the Ofsted system for consideration. Four inspectors were involved over two weeks who were supported by additional two inspectors for two days.
- Key for Ofsted is impact on outcomes for children. Intense work undertaken by social workers and wider children's services colleagues. Feedback from staff suggested that Inspectors were friendly and approachable.

During discussions the following points were made:

- Members welcomed the improved Ofsted Inspection outcome rating of Good and acknowledged the efforts made by staff across the service and beyond.
- Members noted that Ofsted did not find it necessary to liaise with other partners of the council due to the quality of evidence that was provided which demonstrated improved outcomes for children and young people.
- Members were advised that the initial health assessments with the Clinical Commissioning Groups to be further discussed at Brighter Futures Children's Partnership Board.

RESOLVED: Members noted the outcome of the Ofsted report.

8. Costed Mental Health Delivery Plan

This item was presented by Mark Tebbs, Mid & South Essex Sustainability and Transformation Partnership Director of Adult Mental Health Commissioning and and Dr Rajan Mohile. Key points included:

- The Mental Health Strategy is an ambitious mental health programme.
- A Costed Delivery Plan was devised to bring together different work streams focussing on addressing mental health, which required a large collaborative effort of all partners across the system.
- The transformation of mental health provision requires a whole system approach involving all partners including Councils, Social Care, Clinicians, Clinical Professionals and Voluntary Providers.
- £30 million to be invested over the next 5 years focusing on developing an Integrated Primary and Community Care Plans model, reflecting the NHS 5 year Plan.

During discussions the following points were made:

- Members acknowledged that Thurrock has played a key role in driving this work forward.
- Members were encouraged that mental health service provision is being developed as a system within Thurrock and across the Health and Care Partnership.
- Members acknowledged the importance of recognising the contribution of wider partners as well as specialist services in supporting people experiencing a wide range of mental health challenges.

RESOLVED: The Board agreed and supported the delivery Plan.

9. An Integrated Approach to Children's Partnership Working and Governance across Thurrock

This item was presented by Teresa Salami-Oru, Assistant Director – Consultant in Public Health. Key points included:

- The Memorandum of Understanding provides a governance framework in Thurrock and was developed through engagement at a Stakeholder event. This has been signed off at the Brighter Futures Children's Partnership Board.

Members welcomed the MOU and the engagement of partners committing to providing an integrated approach to Governance across Thurrock

RESOLVED: The Board endorsed the Memorandum of Understanding.

10. Integrated Commissioning Executive Minutes as part of oversight of Better Care Fund

RESOLVED: The Board agreed the minutes from the Integrated Commissioning Executive meeting held on 31 October 2019. Thurrock

CVS declared an interest by advising members that By Your Side is a Thurrock CVS Project.

The meeting finished at 12:25pm.

CHAIR……..

DATE……

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31 July 2020	ITEM: 5
Thurrock Health and Wellbeing Board	
Annual Report of the Director of Public Health, 2019/20: Serious Youth Violence and Vulnerability	
Wards and communities affected: All wards	
Accountable Director: Ian Wake, Director of Public Health	
Report Author: Ian Wake, Director of Public Health	

Executive Summary

It is a statutory duty of the Director of Public Health to prepare an independent report on the health and wellbeing of the local population each year. Annual Public Health Reports (APHRs) can comprise of a high level overview of the health of the population, but more usually considers and discusses a specific health issue or considers the health of a specific population group in greater depth. Last year's APHR focused on improving older people's health through housing. The 2019/20 report considers the issue of Violence and Vulnerability in young people and how a public health approach can be used to improve outcomes for our residents.

1. RECOMMENDATIONS

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

1.2 That Health and Wellbeing Board consider how the findings and recommendations contained within the report can best be implemented and used to influence broader council strategy in this area.

2. Introduction and Background

2.1 This report introduces the Annual Report of the Director of Public Health 2019/20.

2.2 The NHS Act 2006 places a statutory legal duty on the Director of Public Health of each top tier local authority to produce comprise of a high level overview of the health of the population, but more usually considers and discusses a specific health issue or considers the health of a specific population group in greater depth.

2.3 An Annual Public Health Report (APHR) can. APHRs have a wide audience including officers, elected members, local NHS partners, the third sector and members of the community, and the chosen topic should therefore be of value to multiple stakeholders.

2.4 Following discussion with a wide range stakeholders across and beyond the council, the Director of Public Health selected the topic of ***Violence and Vulnerability*** with a focus on the impact of urban street gangs for 2019/20 report.

2.5 Serious youth and gang violence including knife and gun crime and its links to the illegal drugs market and 'county lines' has regularly been featured in the news over the past 12 months. Whilst crime has fallen rapidly over the last 20 years, some types of serious violent crime including homicides, knife and gun crime recorded by the police have shown increases since late 2014 in virtually all police force areas in England. Street robbery has also risen sharply since 2016. These increases have been accompanied by a shift towards younger victims and perpetrators.

2.6 Although the consequences of violence have a serious and long-lasting negative impact on health, violence in itself is not inevitable and can be prevented. Interventions can not only prevent individuals from developing a propensity for violence but also can improve educational outcomes, employment prospects and long-term health outcomes.

2.7 However, the published evidence base suggests a number of issues are hampering an effective response including silo'd working between agencies, the targeting and exploitation of vulnerable young people by gangs and school exclusion. Conversely evidence also details a range of interventions and approaches that have been shown to be effective in preventing youth violence and addressing youth vulnerability.

3. Issues, Options and Analysis

3.1 The *Public Health Approach* to tackling serious violence and gang related activity has been reported in the media as an effective response, with the intervention in Glasgow often cited as being successful in significantly reducing knife related violence. A public health approach can be characterised as containing the following:

- It adopts is a whole population, whole systems approach involving multiple stakeholders and datasets.
- It conceptualises violence as a communicable disease that if not addressed 'infects' and spreads outwards within defined communities, but which also can be 'treated' through prevention, intervention and recovery.
- Through using data and intelligence, it defines and monitors the problem to understand the 'who', 'what', 'where' and 'how' associated with it.
- It identifies the risk and protective factors, seeking to minimise the former and strengthen the latter.
- It develops and tests prevention strategies and then ensures widespread adoption through coordinated multi-agency action.

3.2 The APHR 2019/20 uses this methodology as a framework through which to understand the issue of Violence and Vulnerability in Thurrock and to propose multi-agency action to address it.

3.3 The 2019/20 APHR considers the following issues in the detail in the context of a *public health approach to tacking youth violence and vulnerability:*

- Chapter 2 discusses the nature and trends of youth violence at Thurrock and Greater Essex level.
- Chapter 3 discusses the nature and impact of gangs and gang culture in Thurrock
- Chapter 4 discusses the nature and impact of County Lines activity
- Chapter 5 considers the issue of illicit drugs and their connection to youth and gang violence. It also examines the effectiveness of local addiction treatment services
- Chapter 6 considers the risk factors (or vulnerabilities) linked to youth violence and gang culture, both from the published evidence base and by undertaking analyses of Thurrock datasets
- Chapter 7 considers the factors shown to be protective against serious youth violence and gang membership
- Chapter 8 summarises the published evidence base on what has been shown to work in preventing serious youth violence and gang membership
- Chapter 9 critically analyses current service provision in Thurrock against the published evidence and undertakes a 'gap analysis' to identify areas where current provision could be improved

3.4 Chapter 10 draws conclusions from the findings of chapters 1-9 and makes 33 specific recommendations on strategic action to address the issue of serious youth violence and gang membership in Thurrock including proposing a high level new strategic integrated model.

3.5 The recommendations are grouped into four key areas of focus:

- Surveillance and improve data integration
- Primary prevention: 'inoculating' the population to protect them from violence
- Secondary prevention: intervening earlier to support young people most at risk of involvement in serious youth violence or gangs
- Tertiary prevention: intervention with perpetrators and victims of serious youth violence or gang membership to reduce further harm.

4. Reasons for Recommendation

4.1 The report fulfils a statutory duty of the Director of Public Health. The specific recommendations contained within the report arise from a detailed analysis of local and national data and the published evidence base and seek to improve the lives and outcomes of some of our most vulnerable residents.

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

5.1 A wide range of stakeholders were consulted and contributed to the report. These are set out in the acknowledgements section of the main report. Additionally the findings of the report were discussed at the Essex Violence and Vulnerability Operations Group and Thurrock Violence and Vulnerability Board before the report was finalised, allowing further input of stakeholders into the recommendations.

5.2 Annual Public Health Reports are presented at a wide range of different stakeholder forums. This report will also be presented at CGS O&S Committee, Health and Wellbeing Overview and Scrutiny Committee, Thurrock Health and Wellbeing Board, NHS Thurrock Clinical Commissioning Group Board, Cabinet and Full Council.

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

6.1 The report makes clear recommendations on the four areas set out in 3.5. These have implications for services across the council including public health, children's and adults' social care, education and youth services, youth offending, community development, place and community safety. They also have implications for wider stakeholders including the NHS and police.

7. Implications

7.1 Financial

Implications verified by: Mike Jones, Strategic Lead, Corporate Finance

Implementing the recommendations contained within the report in full are likely to result in additional costs. The report was written and finalised pre the COVID-19 epidemic and at time of completion, some financial resource had been earmarked to support implementation. Since March 2020, as a result of COVID-19 the council's financial situation has deteriorated and some of the recommendations may not be affordable in the short term.

7.2 Legal

Implications verified by: Judith Knight Interim Deputy Head of Legal (Social Care and Education)

There are no legal implications. The report has been prepared in accordance with the statutory duties of the Director of Public Health although publication has been delayed slightly due to the COVID-19 epidemic.

7.3 Diversity and Equality

Implications verified by: Natalie Smith Strategic Lead: Community Development and Equalities

Violence and vulnerability is not equally distributed across the population of Thurrock and the report highlights a series of inequality faced by some communities and groups of residents due to violence and vulnerabilities. The recommendations set out within the report seek to address these inequalities, providing targeted and increased support to those most impacted. As such, the report seeks to address and narrow health inequalities caused by violence and vulnerability.

8. Background papers used in preparing the report
Detailed references are given in the main report

9. Appendices to this report

- Report of the Director of Public Health, 2019/20.

Report Author:

Ian Wake, Director of Public Health. iwake@thurrock.gov.uk

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Youth Violence and Vulnerability: *The Crime Paradox and a Public Health Response*

Annual Report of the Director of Public Health 2019/20

Author: Ian Wake, Director of Public Health, Thurrock Council

thurrock.gov.uk

"When a flower doesn't bloom, fix the environment in which the flower grows, not just the flower"

Alexander den Heur

Acknowledgements

The author would like to thank and acknowledge the following people who have assisted in developing this Annual Public Health Report

Harinder Bharma: Public Health Information Analyst, Thurrock Council

Beth Capps: Senior Public Health Programme Manager, Thurrock Council

Michelle Cunningham: Thurrock Community Safety Partnership Manager

Samantha Grant: Project Manager, Essex Violence and Vulnerability Unit, Office of the Police and Fire Commissioner, Essex.

Phil Gregory: Senior Public Health Programme Manager: Health Informatics, Thurrock Council

Mark Johnson: Head of Informatics, Essex Police

Naintara Khosla: Consultant, Children's Contextual Safeguarding

Michele Lucas: Assistant Director, Education and Skills

Kev Malone, Public Health Programme Manager, Thurrock Council

Mandy Moore: Interim Strategic Lead - Business Intelligence, Thurrock Council

Jason Read: Youth Offending Service Manager, Thurrock Council

Wajid Shafiq: CEO, Xantura Ltd

Elozona Umeh: Senior Public Health Programme Manager: Thurrock Council

Foreword

*** INSERT FORWARD

Ian Wake
Director of Public Health

*** INSERT FORWARD

Cllr. James Halden
Cabinet Portfolio Holder: Children's and Adults' Social Care

*** INSERT FORWARD

Cllr. Allen Mayes
Cabinet Portfolio Holder: Health and Air Quality

Contents

Chapter 1: Introduction

Violent crimes, such as murders and gun and knife crime, account for around one per cent of all crime; but the impact of them on society is huge in terms of lives and communities destroyed. Youth violence, particularly related to knife and gang crime has frequently been subject of media attention over the past five years. Whilst crime has fallen rapidly over the last 20 years, some types of serious violent crime including homicides, knife and gun crime recorded by the police have shown increases since late 2016. These increases have been accompanied by a shift towards younger victims and perpetrators.[1]

Knife and gun crime increases have been linked to street crime and the illegal drugs market; particularly crack cocaine and heroin. *County Lines* is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more areas within the UK using dedicated mobile phone lines or other form of 'deal line'. The gangs exploit children and vulnerable adults to move and store drugs and money using coercion, intimidation, violence and weapons.[1]

Serious violent crime and Class A drug supply connected to street gangs has a devastating impact on the lives of the individuals, families and communities affected. Street and organised crime gangs operating the *County Lines* model target the most vulnerable young people and adults through a grooming process and then trap and exploit them through threats or actual experience of serious physical, psychological and sexual violence.[2]

Although the consequences of violence have a serious and long-lasting negative impact on health,[3] violence in itself is not inevitable and can be prevented.[4] [5] Interventions can not only prevent individuals from developing a propensity for violence but also can improve educational outcomes, employment prospects and long-term health outcomes.[6]

However, the published evidence base suggests a number of issues are hampering an effective response: Silo'd working between agencies has been identified as an issue where Community Safety Partnerships and the police drive enforcement, but Local Community Safeguarding Boards take responsibility for safeguarding responses; young people and vulnerable adults exploited by gangs often straddle the responsibilities of both of these statutory responses in that they are both offenders and victims.[7] Furthermore, local child safeguarding responses have historically focused on responding to abuse within families and may not be adequately geared to responding to the issue of exploitation of children and young people by gangs. The trafficking of young people by gangs within the UK means that young people arrested on suspicion of possession of drugs with intent to supply are usually released pending further investigation and sent back to their home area which is usually not the same location of their arrest, hampering effective response from local children's social care teams.

The targeting and exploitation of young people who have been excluded from secondary school is a major feature in the profile of 'county lines' and gang exploitation. School exclusion, whether being placed on a reduced time table, putting in place home schooling arrangements or placing young people in a Pupil Referral Unit has been shown to increase their vulnerability to child criminal exploitation and gang involvement.

Published evidence also highlights the need for an increased focus on activities that prevent young people and vulnerable adults becoming involved in serious violence and gang culture. Whilst there is a reasonably strong evidence base relating to effective prevention, national evidence suggests that there is inadequate 'upstream' provision and that thresholds of intervention are set too high; in short, we are waiting until young people get arrested for serious crime before intervening.

The *Public Health Approach* to tackling serious violence

In 2019, the then Home Secretary – Savid Javid announced a new legal duty on public bodies including the police, local authorities, the NHS, education and youth offending services to adopt a *Public Health Approach* to tackling serious youth violence. In addition, the government announced its intention to amend the Crime and Disorder Act to ensure that serious violence is an explicit priority for Community Safety Partnerships including a legal duty to have a strategy in place to tackle violent crime.

> *An approach that seeks to improve the health and safety of all individuals by addressing underlying risk factors that increase the likelihood that an individual will become a victim or perpetrator of violence.*
>
> *By definition, public health aims to provide the maximum benefit for the largest number of people. Programmes for prevention of violence based on the public health approach are designed to expose a broad segment of a population to prevention measures and to reduce and prevent violence at population level*

The *Public Health Approach* has been recognised as an effective response to serious youth violence, with the interventions in Glasgow often cited in the media as being successful in significantly reducing knife related violence. Box A shows The World Health Organisation definition of a public health approach to reducing serious violence.[8]

The Public Health Approaches can recognised by the following characteristics:

- It adopts is a whole population, whole systems approach involving multiple stakeholders and datasets.

- It conceptualises violence as a communicable disease that if not addressed 'infects' and spreads outwards within defined communities, but which also can be 'treated' through prevention, intervention and recovery.

- Through using data and intelligence, it defines and monitors the problem to understand the 'who', 'what', 'where' and 'how' associated with it.

- It identifies the risk and protective factors, seeking to minimise the former and strengthen the latter.

- It develops and tests prevention strategies and then ensures widespread adoption through coordinated multi-agency action.

- It implements at scale, effective and promising interventions whilst continuing to monitor their effects, impact and cost-effectiveness. (Figure X)

Figure 1.1: A Public Health Approach to Tackling Serious Violence

Source: WHO, 2017

Scope of this report

This report focuses on the issue of serious youth violence and urban street gang activity using the *Public Health Approach* methodology to identify and address the vulnerabilities of the young people concerned. For the purposes of this report 'young people' generally refers to the population of Thurrock aged 10-24 unless otherwise specified as our intelligence suggests that it this is this group of youth that are most likely to become involved in serious violence and gangs. However, prevention activity with younger children is also discussed. The following issues are considered by this report:

- Serious youth violence against the person including assault, serious assault, actual bodily harm, grievous bodily harm, stabbing/knife crime and gun crime and street robbery.
- Urban street gangs including gang related violent crime and drug related crime
- Local drugs markets
- County Lines
- Child criminal exploitation through gangs

The following issues (although important) fall outside the scope of this report as they have been subject to other Joint Strategic Needs Assessments:

- Domestic and sexual violence where not associated with gang activity

In this report we aim to answer the following five key questions:

1. What is the nature, extent and trends in serious youth violence, gang related activity and drug related crime in Thurrock?

2. What is the nature, extent and trends in vulnerabilities within the population of young people involved in or at risk of involvement in serious violence and gang related activity?

3. What are the risk and protective factors relating to involvement in serious youth violence and gang involvement?

4. What has been shown to been shown to be effective in the published evidence base in preventing and reducing serious youth violence and gang related activity and the harms caused by both?

5. How effective is our current multi-agency response to the above three issues and what additional actions need to occur to further disrupt and prevent serious youth violence and gang related activity and the harms that they cause?

How this report is structured

Chapter 2 discusses the nature and trends of youth violence at Thurrock and Greater Essex level.

Chapter 3 discusses the nature and impact of gangs and gang culture in Thurrock

Chapter 4 discusses the nature and impact of County Lines activity

Chapter 5 considers the issue of illicit drugs and their connection to youth and gang violence. It also examines the effectiveness of local addiction treatment services

Chapter 6 considers the risk factors (or vulnerabilities) linked to youth violence and gang culture, both from the published evidence base and by undertaking analyses of Thurrock datasets

Chapter 7 considers the factors shown to be protective against serious youth violence and gang membership

Chapter 8 summarises the published evidence base on what has been shown to work in preventing serious youth violence and gang membership

Chapter 9 critically analyses current service provision in Thurrock against the published evidence and undertakes a 'gap analysis' to identify areas where current provision could be improved

Chapter 10 draws conclusions from the findings of chapters 1-9 and makes recommendations on strategic action to address the issue of serious youth violence and gang membership in Thurrock including proposing a high level new strategic integrated model.

Chapter 2: Youth Violence

Key Findings

Whilst overall rates of crime have fallen over the last 25 years, rates of recorded crimes of violence in Thurrock, Southend and Essex have risen sharply since 2013. Rates of reported crimes of violence with injury and weapons offences where the victim was aged 10-24 in Thurrock rose from 2015/16, peaking in 2016/17 but have since dropped back slightly. Ambulance data suggests that call outs to young people aged 10-24 for assault and stabbing/gunshot wounds have fallen from 2014-15 to 2018-19 but call outs for assault with serious injury have risen. However, Youth Offending Service Records indicate that violence against the person offences and weapons offences committed by young people in Thurrock have risen sharply since 2013-14 to a peak in 2016-17 and fallen back only slightly.

Thurrock has the second highest rate of recorded violence with injury offences against young people aged 10-24 in Essex and the fourth highest rate of ambulance call outs to young people because of violence. Where the suspect was identified, just over half of all suspects were also aged 10-24. The majority of victims and suspects were the same sex, with just over 63% of recorded violent incidents being male on male and a further 23% being female on female.

Violence with injury offences are not uniformly distributed across either Essex or Thurrock. Only 35.6% of wards in Essex had one or more reported incidents of violence against young people recorded in the last two years with a small number of 16 wards (2.4%) having high (>14) numbers of reported incidents of violence. The most violent wards in terms of number of reported incidents against young people aged 10-24 in Thurrock over the last two years were Grays Riverside, Stanford-le-Hope West, West Thurrock and South Stifford, Aveley and Uplands, and Tilbury St. Chads with nine or more recorded incidents. Where the suspect was recorded as aged 10-24, the majority (80%) lived in Thurrock with 20% recorded as living in an area outside Essex.

All deprivation indices at ward level are a very poor predictor of violence and weapons crime. Conversely, previous history of violence at ward level is a very strong predictor of the likelihood of future violence. 100% of wards across Essex with six or more ambulance call outs in 2016-17 to 2017-18 for a stabbing/knife/weapons injury had at least one ambulance call out for the same injuries in 2018-19. Similarly, over 70% of wards with three to five ambulance call outs for these injuries in the previous two years had at least one ambulance call out in the subsequent year. These data could be used to predict the geographical location of future youth violence and better target enforcement and prevention activity and we predict that there is a 70% chance of at least one ambulance call out for a knife/stabbing or gunshot injury in 2019/20 in East Tilbury ward, Chadwell St. Mary Ward, Stanford East and Corringham Town ward and Tilbury St. Chads ward.

The majority (82.7%) of young people who access Thurrock Youth Offending Service because of violence against the person offences do not re-offend. This suggests YOS has a high degree of success in terms of preventing future offending. However there is a small cohort (18%) who commit two or more violence against the person or robbery offences and a very small cohort (3.3%) who commit three or more offences. Our data suggests that this small cohort of offenders committing multiple offences also commit offences relating to supply of class A drugs and could also be more likely to be involved in organised gang activity.

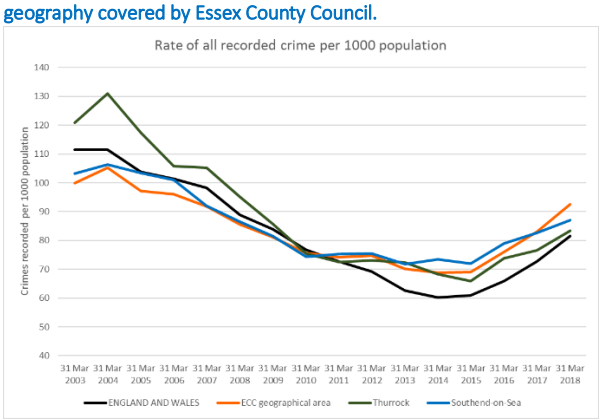
Introduction

In this chapter, we examine the issue of serious youth violence and its public health impact on the perpetrator, victim and wider communities.

We discuss trends in serious youth violence using police reported crime datasets, ambulance service data and undertake detailed analyses of data held by the Thurrock Youth Offending Service (YOS).

Recorded crime in England and Wales and Essex fell significantly since 2003 to 2014, although in the last four years has seen this trend begin to reverse. (Figure 2.1).

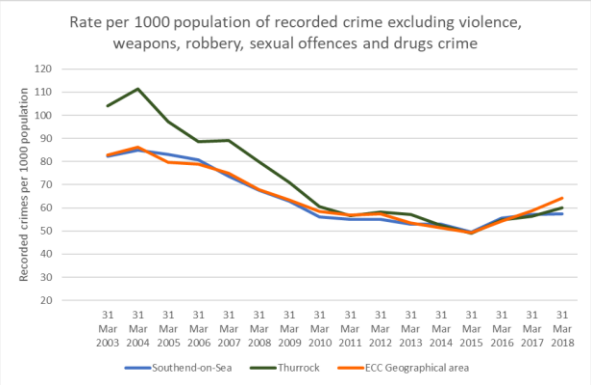
Figure 2.1: Rate of all recorded crime per 1000 population, England and Wales, Thurrock, Southend-on-Sea and the geography covered by Essex County Council.



Whilst the dramatic decrease in recorded crime is welcome, the more recent increase can be attributed to rises in certain

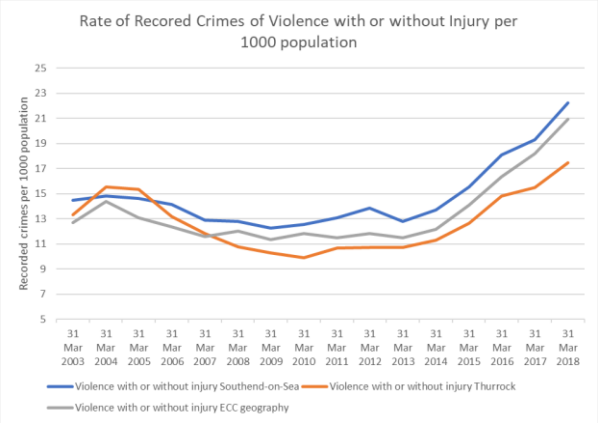
types of offences, particularly violence and sexual offences. Figure 2.2 shows the trend in recorded crime where violent crime, robbery against the person, weapons offences sexual offences and drugs offences are excluded.

Figure 2.2: Rate of crime excluding violence, sexual offences, weapons offences, robbery against the person



Conversely, figure 2.3 shows the trend in rate of recorded violent crime per 1000 population which has increased significantly from 2013 onwards.

Figure 2.3: Rate of recorded crimes of violence with or without injury per 1000 population, Thurrock, Southend-on-Sea, ECC geographical area



Estimating the absolute number of incidents of serious youth violence is difficult. There are three potential sources of data: police records on reported crime, ambulance service data on call outs for violent incidents and youth offending service for young people charged with violent assaults. Each has its advantages and limitations and will be discussed in turn.

Police Data on Reported Crime

Trends and Incidence of Reported *Violence with Injury* and *Possession of Weapons* Offences

Figures 2.4 and 2.5 (overleaf) show the trend in absolute numbers of *Violence with Injury* and *Possession of Weapons* offences in Thurrock and Greater Essex from 2015/16 to 2018/19

We analysed an anonymised dataset provided by Essex Police on reported crime. The dataset provided records of reported crimes recorded as *Violence with Injury*, *Possession of Weapons Offences*, *Rape, Other Sexual Offences, Trafficking of Drugs and Possession of Drugs* between the fiscal years of 2015-15 and 2018-19. The data set also provided details of location of reported offence down to ward level, sex and 'ethnic appearance' of the suspect and victim, whether or not the victim was aged between 10 and 24 and whether or not the suspect was aged under 25. Crucially, unlike the Ambulance Data Set (discussed later) a field was provided that allowed us to exclude crimes committed in a domestic setting (which although important, fall outside the agreed scope of this report).

We also excluded records of crimes relating to rape and sexual violence as it was not possible to determine whether or not they related to gangs and as such could largely fall outside the scope of this report. This provided a total number of records (crimes reported) of 11,446.

Caveats on the dataset and analyses we have conducted:

As with all datasets that we analysed for this report, the police data also has limitations. We believe that the analyses undertaken using this dataset are likely to *underestimate significantly* the true incidence and prevalence of serious youth violence for two reasons:

Firstly not all incidents of youth violence will be reported to the police. Young people involved in gang related violence may be unwilling to report it both due to fear of reprisals from other gang members and because they may be involved in criminal activity themselves.

Secondly, the age of the victim is poorly recorded within the dataset with 4198 (36.7%) of the original 11,446 having no record Because of this, we have had to also exclude all of these records from our analyses. This exclusion has meant that drugs offences recorded at Thurrock level are so low in number that we have not been able to undertake useful analysis on this type of crime using the police dataset. However we have analysed the remaining records for the crime categories of *Violence with Injury* and *Possessions of Weapons* offences.

Finally, for the majority of crimes recorded in the dataset, a suspect is not recorded, presumably because the police were unable to identify one. As such, analyses of data on suspects only represents a relatively small cohort of the offenders who perpetrated the crimes recorded. We are unable to say with certainty that this sample is representative of the overall population of perpetrators.

Figure 2.4

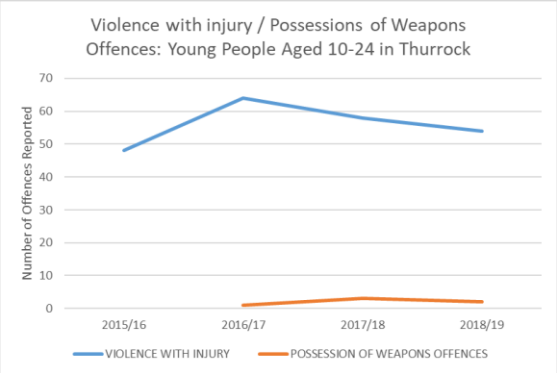
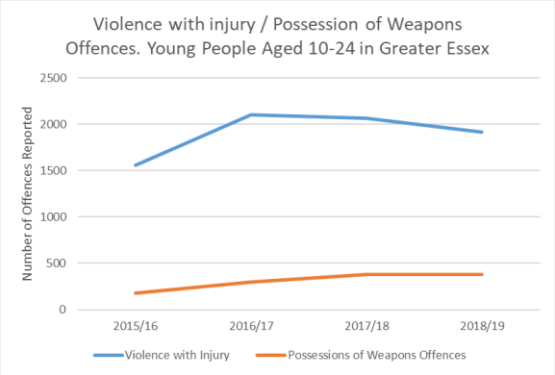


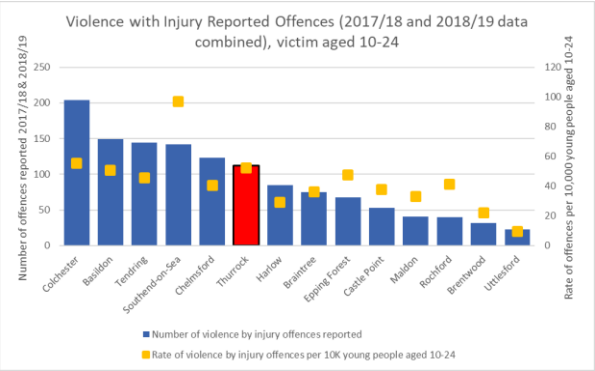
Figure 2.5



Although different in scale, both charts show a similar trend with a rise to a peak in 2016/17 of *Violence with Injury* followed by a slowly decreasing trend in subsequent years. The trend for *Possession of Weapons* offences in Thurrock shows a different trend to Greater Essex with numbers falling from 2017/18 whilst Essex remains static. However due to the numbers of records we have had to exclude because of lack of victim age data recorded, the absolute numbers of records analysed for Thurrock is very small.

Figure 2.6 compares the absolute numbers of *Violence with Injury* offences reported to Essex Police in each district, combining the last two fiscal years of data available where the victim was aged 10-24. As reported earlier, incidents that occurred in a domestic setting have been excluded. Because the population of young people aged 10-24 is not evenly distributed across Essex, we have also presented this data as a rate per 10,000 young people living in each district.

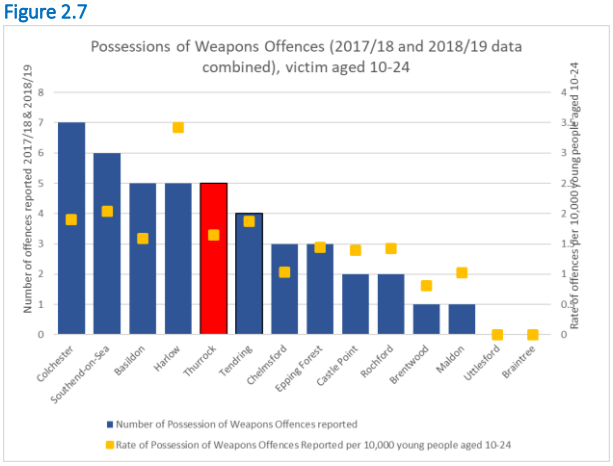
Figure 2.6



In terms of absolute numbers of *Violence with Injury* incidents reported by young people, Thurrock ranks sixth out of 14 districts in Essex. However when rate of reporting per 10,000 young people living in each district is considered, Thurrock has the second highest rate of reported incidents in Essex. It is unclear from the data the extent to which this is caused by a genuinely higher underlying incidence of violence against young people, or because of a greater willingness to report violence compared to young people in other districts.

Figure 2.7 shows similar absolute numbers and rates of reporting of *Possession of Weapons* offences.

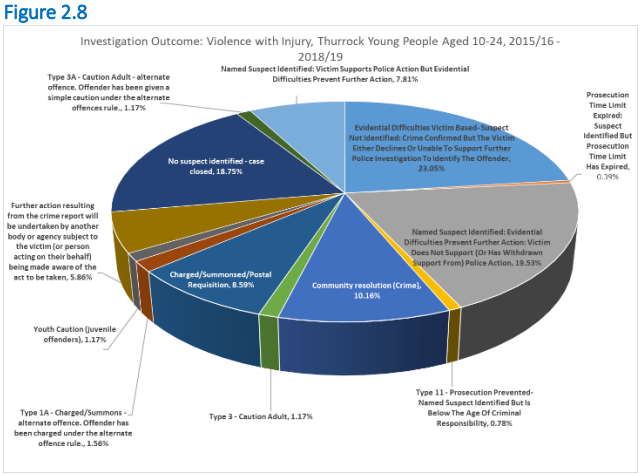
Figure 2.7



Thurrock is ranked the fifth highest district in Essex in terms of both absolute numbers and rate per 10,000 young people aged 10-24 for reported *Possession of Weapons* offences.

Figure 2.8 shows the recorded investigation outcome for reported offences for Violence with Injury against young people in Thurrock aged 10-24 between 2015/16 and 2018/19.

Figure 2.8



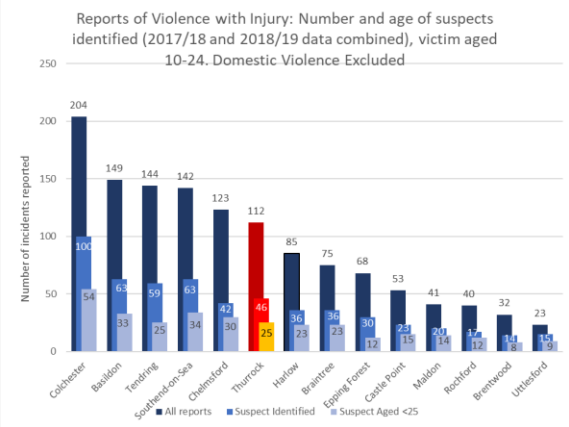
Only 8.59% of reported offences resulted in a formal charge/summons or postal requisition. The main reasons for this were an inability to identify a suspect, the victim withdrawing support for the police action, a community resolution, and further action being taken by another body or agency. Assuming all reports are genuine, this suggests

that the vast majority of offenders who commit violence with injury offences against young people in Thurrock will never face conviction.

Individuals recorded as suspects for involvement in *Violence with Injury Offences.*

Figure 2.9 shows the number of incidents of *violence with injury* and number where the suspect's details appear in the dataset and where the suspect is also under 25 by district in Essex. These data are likely to be a combination of the underlying incidence of violence where both the suspect and victim is aged under 25, the willingness of victims to report violence incidents to the police and the police's ability to identify a suspect. Thurrock ranks seventh out of 16 district areas in Essex for number of suspects identified in 2017/18 and 2018/19.

Figure 2.9



Of the 112 incidents of *Violence with Injury* reported to Essex police (excluding domestic incidents) in 2017/18 and 2018/19 where the victim was under 25, 46 records (41.1%) had details of an identified suspect and of these, 25 records (54.3%) show that the suspect was also aged under 25. This suggests that only just over half of incidents of violence against young people in the borough are committed by other young people under the age of 25.

Sex of suspects and victims of violent crime with injury

Tables 2.1 and 2.2 show the recorded sex and ethnic appearance of victims and suspects recorded in the police records from 2015/16 to 2018/19 for Thurrock and Greater Essex. Records with no suspect recorded were excluded from this analysis.

Table 2.1: Sex of Suspects and Victims in Thurrock

		SUSPECTS ↓	
		Male	Female
VICTIMS →	Male	63.16%	3.51%
	Female	10.53%	22.81%

Table 2.2: Sex of Suspects and Victims in Greater Essex

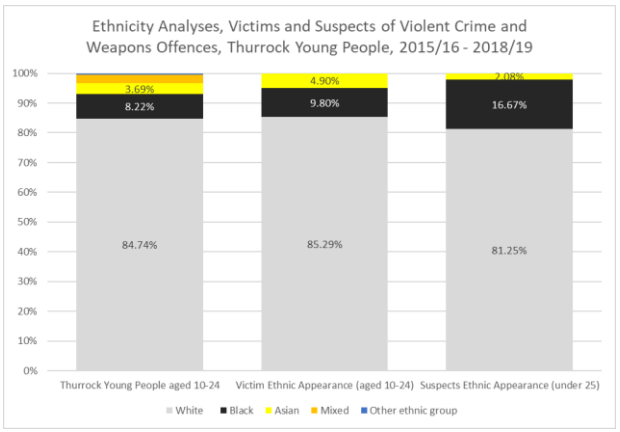
		SUSPECTS ↓	
		Male	Female
VICTIMS →	Male	58.70%	5.60%
	Female	11.65%	24.04%

The majority of reported incidents of *violence with injury* in both Thurrock and Greater Essex has the sex of both the victim and suspect as *male* but with a greater percentage in Thurrock than Essex. The next most common category is where both the victim suspect is female. Incidents of male violence against females makes up circa 11% of records in both Thurrock and Greater Essex and incidents of female suspects committing violence against male victims is rare.

Ethnicity of suspects and victims of violent crime with injury

We analysed the recorded 'ethnic appearance' fields within the police data for victims aged 10-24 and suspects aged under 25 for incidents of *violence with injury* reported in Thurrock between 2015-16 and 2018/19. (Figure 2.10)

Figure 2.10



The ethnicity structure of the cohort of victims reporting crimes of *violence with injury* in Thurrock is broadly in line with ethnicity structure within the general population of young people aged 10-24 in the borough. However, within the cohort of suspects, black young people are over-represented with approximately double the proportion of black suspects compared to the general population. The reasons for this are unclear from the data and are likely to be complex. It is worth noting that 'mixed race' was not recorded in the police data which may over-inflate the numbers of young people recorded as having a black ethnic appearance.

Location of suspects in relation to victims

The police dataset records the district in which the suspect resides. We analysed the dataset to determine whether suspects were likely to live in the same district as victims. This provides a sense of whether suspects are committing violence within their own district or travelling across or into Essex from other districts to commit violent acts against young people.

Table 2.3 (overleaf) shows this location analyses for records containing suspects aged 25+ and table 2.4 shows the same analyses for records containing suspects aged under 25.

Each row shows the percentage of incidents of violence with injury committed in that district in Essex committed by

suspects who live in every district in Essex and outside of the county. The last two full fiscal years of data that were provided (2017/18 and 2018/19 are combined). Boxes where the location of the crime and the location of the suspect are the same are highlighted in red.

Table 2.3: Location of *Violence with Injury* reported crimes and Address of Suspects (Victims aged 10-24, Suspects aged 25+) 2017-18 and 2018-19 Combined Data

	SUSPECTS' (aged 25+) LOCATION ↓↓															
CRIME LOCATION (Victim aged 10-24) ↓	Basildon	Braintree	Brentwood	Castle Point	Chelmsford	Colchester	Epping Forest	Harlow	Maldon	Rochford	Southend-on-Sea	Tendring	Thurrock	Uttlesford	Area outside Essex	**CRIME TOTALS**
Basildon	80.00%									3.33%			10.00%		6.67%	100%
Braintree		76.92%							7.69%						15.38%	100%
Brentwood			83.33%												16.67%	100%
Castle Point				87.50%							12.50%				0.00%	100%
Chelmsford					91.67%										8.33%	100%
Colchester				2.17%		91.30%						2.17%			4.35%	100%
Epping Forest							83.33%								16.67%	100%
Harlow								100.00%							0.00%	100%
Maldon		33.33%							50.00%						16.67%	100%
Rochford				20.00%	20.00%					60.00%					0.00%	100%
Southend-on-Sea											93.10%				6.90%	100%
Tendring		3.03%				3.03%						87.88%			6.06%	100%
Thurrock													100.00%		0.00%	100%
Uttlesford		20.00%			20.00%									60.00%	0.00%	100%

Table 2.4: Location of *Violence with Injury* reported crimes and Address of Suspects (Victims aged 10-24, Suspects aged under 25) 2017-18 and 2018-19 Combined Data

	SUSPECTS' (aged under 25) LOCATION ↓↓															
CRIME LOCATION (Victim aged 10-24) ↓	Basildon	Braintree	Brentwood	Castle Point	Chelmsford	Colchester	Epping Forest	Harlow	Maldon	Rochford	Southend-on-Sea	Tendring	Thurrock	Uttlesford	Area outside Essex	**CRIME TOTALS**
Basildon	96.97%				3.03%											100%
Braintree		91.30%				4.35%					4.35%					100%
Brentwood			62.50%												37.50%	100%
Castle Point	6.67%			93.33%												100%
Chelmsford		3.33%		3.33%	80.00%				6.67%				3.33%		3.33%	100%
Colchester		5.66%				81.13%						11.32%			1.89%	100%
Epping Forest							83.33%								16.67%	100%
Harlow							4.35%	78.26%							17.39%	100%
Maldon									92.86%						7.14%	100%
Rochford										66.67%	33.33%					100%
Southend-on-Sea				2.94%						2.94%	91.18%				2.94%	100%
Tendring						4.00%						84.00%			12.00%	100%
Thurrock													80.00%		20.00%	100%
Uttlesford														88.89%	11.11%	100%

Both tables show that the majority of records with a recorded suspect show that suspect also lived in the district that they were suspect of committing the crime in. This suggests a low level of mobility of suspects when committing violent incidents. Interestingly, unlike many other districts has a lower proportion of suspects aged under 25 (80%) who also live within the borough that they committed the crime, whilst conversely 100% of suspects aged 25+ lived within Thurrock. 20% of reported incidents of *violence with* injury where the suspect was aged under 25 had records of suspects living outside Essex. This may reflect anecdotal evidence that young people are travelling into the borough from the Metropolitan Police area to commit violence against other young people.

Ward level analyses on police dataset

The police dataset contained details of the ward in which the reported incident occurred. We analysed this dataset using records from 2017-18 and 2018-19 across greater Essex, excluding domestic violence incidents.

Figures C shows the distribution of reported incidents for *Violence with Injury* at ward level, by local authority and with Thurrock wards highlighted. Figure D shows the same data but only highlighting wards with seven or more reported incidents of *Violence with Injury*.

Figure 2.11: Number of incidents reported for *Violence with Injury* by Ward across Greater Essex 2017-18 and 2018-19

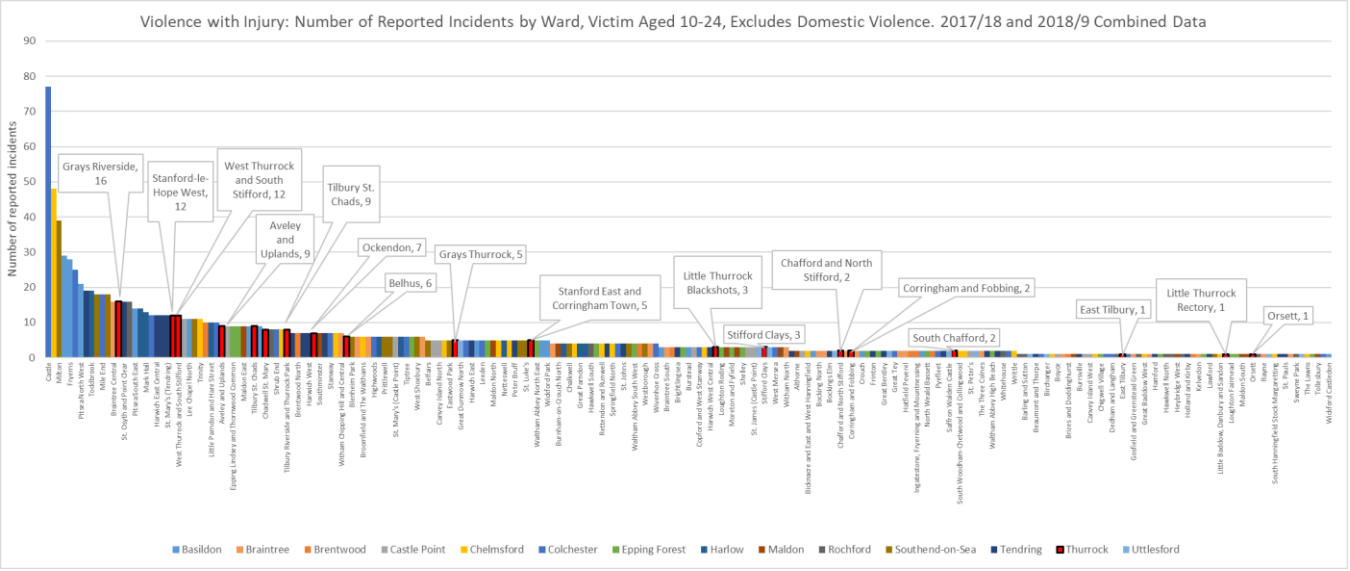
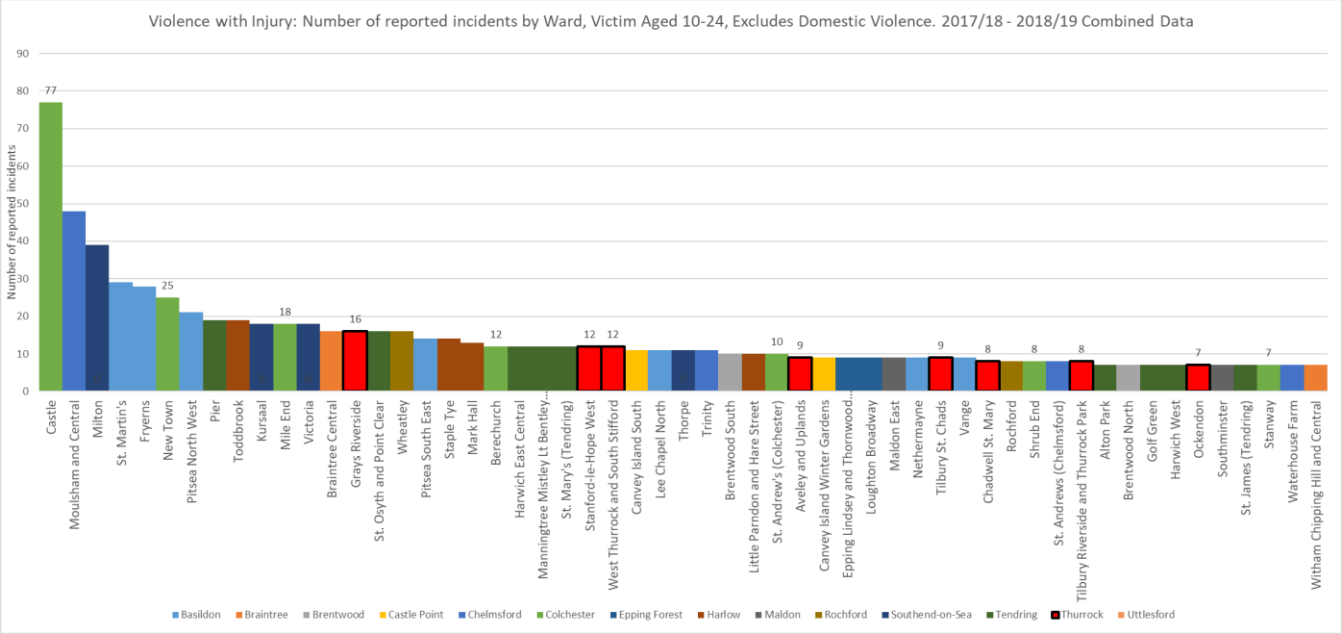


Figure 2.12: Number of incidents reported for *Violence with Injury* by Ward across Greater Essex 2017-18 and 2018-19 (Wards with seven or more incidents)



The ward with by far the highest number of reported incidents of *violence with injury* against young people aged 10-24 in the last two years in Greater Essex is *Castle Ward* in Colchester. *Grays Riverside* is the ward in Thurrock with the highest number of reported incidents with 16 in the last two years. It is ranked 14th highest out of 665 number of wards in Greater Essex. Thurrock has eight wards with seven or more reported incidents of *violence with injury: Grays Riverside, Stanford-le-Hope-West; West Thurrock and South Stifford; Aveley and Uplands; Tilbury St. Chads; Chadwell St. Mary; Tilbury Riverside and Thurrock Park; and Ockendon.*

Figures E and F show similar analyses but only with records where a suspect has been identified who was under 25.As such, these figures show confirmed incidents of youth-on-youth serious violence. Because many records have no suspect data figure E and F show analyses across the longer time period of 2015-16 to 2018-19 Figure F shows only wards where there were five or more reported incidents. All but one wards with five or more reported incidents of *violence with injury* where the suspect was also under 25 were in the Tilbury and Chadwell locality of the borough.

Figures C-E shows that reporting of *violence with injury* is concentrated to specific geographical locations in Essex. In total, 237 of 665 wards (35.6%) in Greater Essex had one or more reported incidents of *Violence with Injury* where the victim was aged 10-24 and only 103 (15.4%) had five or more incidents reported in the last full fiscal years for which we have data. This intelligence has implications for better targeting of both future enforcement and possibly prevention activity.

Figure 2.13

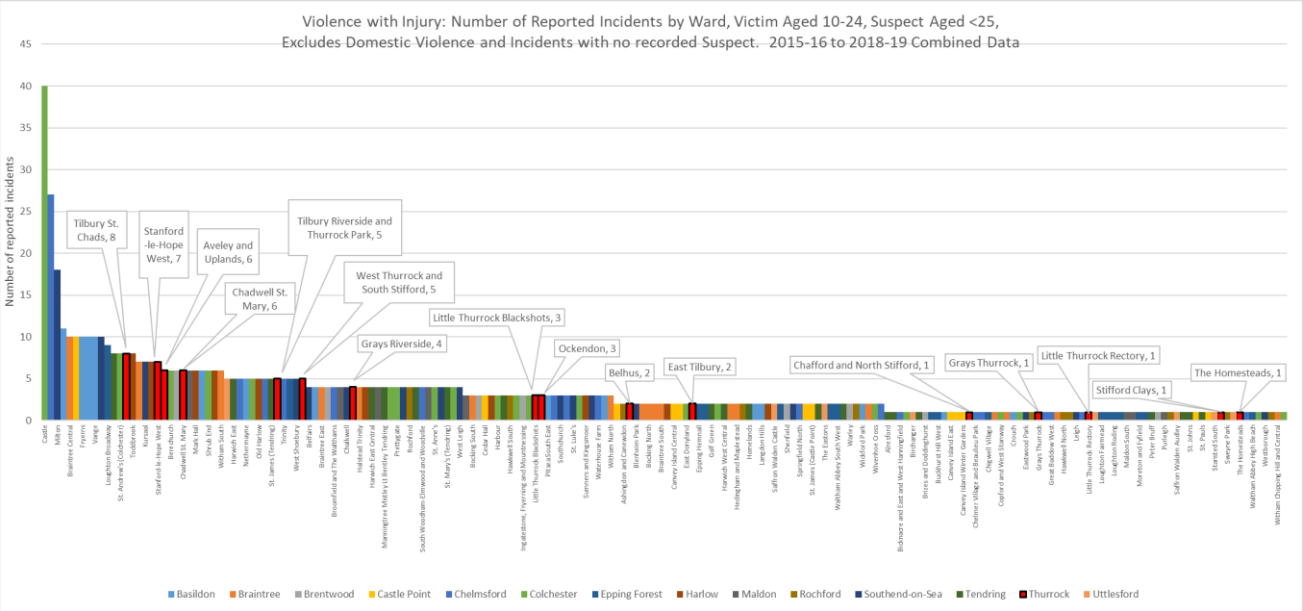
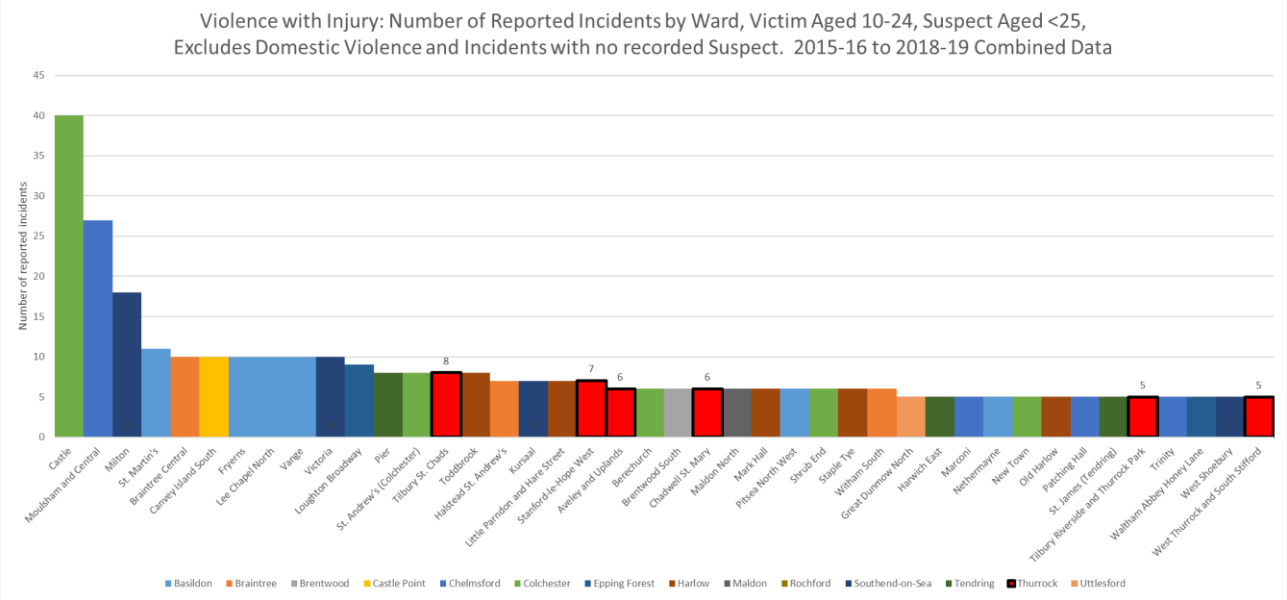


Figure 2.14



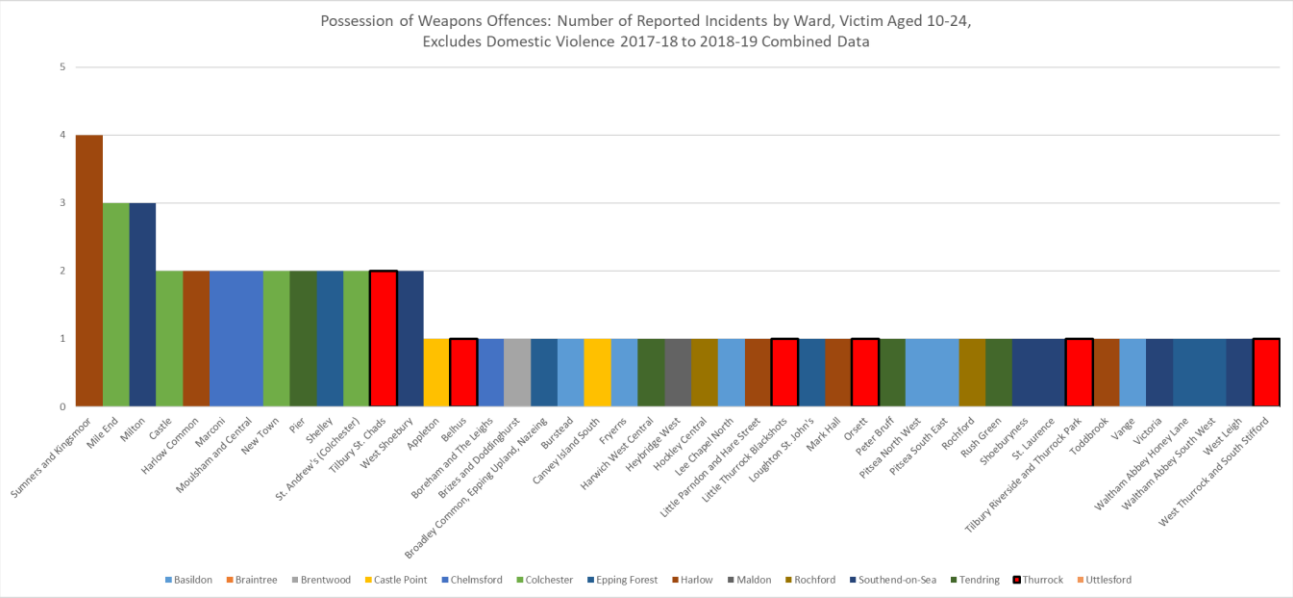
Distribution of Possession of Weapons Offences

If reporting of *violence with injury* offences can be said to be relatively localised to specific wards in the county, *possession of weapons offences* is extremely localised. Figure 2.15 shows the number of incidents of *possession of weapons offences* across Greater Essex in 2017-18 and 2018-19 where the victim was aged 10-24. In total, 63 separate reported incidents were recorded across only 33 of the 655 wards (4.96% of all wards). Again, this intelligence could be used to target enforcement and potentially secondary prevention activity.

Thurrock had six wards where *Possession of Weapons Offences* were reported in 2017/18 – 2018/19: *Tilbury St. Chads; Belhus; Little Thurrock and Blackshots; Orsett; Tilbury Riverside and Thurrock Park; and West Thurrock and South Stifford.*

Analyses of records where a suspect under 25 was recorded has not been included as the number of records were too small to make the analyses meaningful.

Figure 2.15



Ambulance Data

The Essex Ambulance Service provided their dataset from 2014/15 to 2018/19 for ambulance call outs for patients experiencing injury due to violence. Ambulance data included the age of the patient and the location at ward level of the call out. The recording of ward provides a highest level of geographical granularity on where violent incidents may be occurring in Essex. We analysed the subset of this dataset relating to patients aged 10-24. Injuries caused by violence were categorised into those caused by assault, those caused by serious assault with injury and those caused by a gunshot/knife or other stabbing. We excluded all records relating to sexual assault, where the injury was self-inflicted or where we were not able to determine from the data whether or not the assault was sexual or the injury was self-inflicted. Unlike the police data, the Ambulance dataset is more likely to give an accurate picture of need, both because it will not suffer from an unwillingness to report the incident, and because the age of the patient is very well recorded, meaning that we have been able to identify accurately patients who were in the age group 10-24.

Caveats on the dataset and analyses we have conducted

The ambulance dataset does however contains limitations when considering youth violence.

Firstly, the dataset is concerned only with victims of violence who sustain injuries serious enough for an ambulance to be called. As such it is likely to *under-estimate* the overall numbers of young people who are victims of violent attack in the population.

Secondly, the dataset does not record any information on the perpetrators of violence and as such we cannot determine whether or not the perpetrators were also young people. As such it is likely to also include many incidents relating to domestic violence which whilst important are beyond the scope of this report. In that sense, it is highly likely to *over-estimate* the scale of youth violence that this report concerns itself with in its agreed scope.

Trends in ambulance call outs for young people who have been victims of violence

Figures 2.16 and 2.17 show the trend in absolute numbers of ambulance call outs for assault, assault with serious injury and stabbing/knife/gunshot wounds in young people aged 10-24 between 2014/15 and 2018/19 in Greater Essex and Thurrock.

Figure 2.16

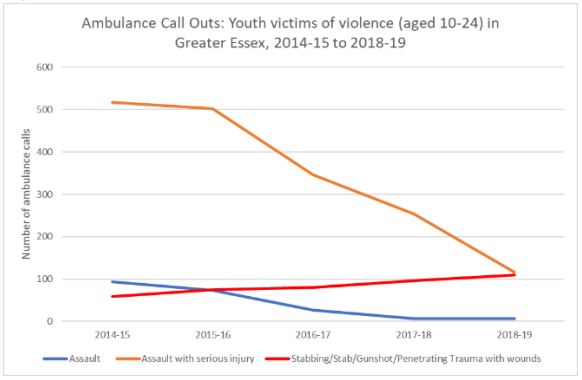
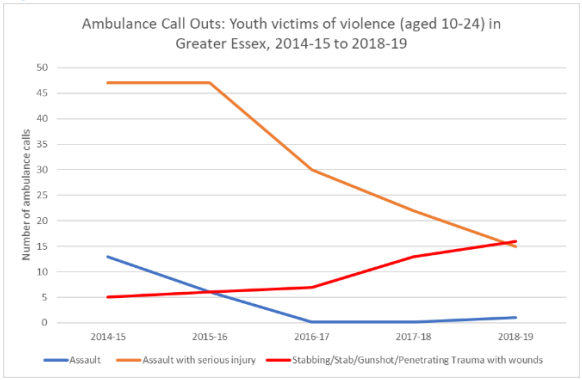


Figure 2.17



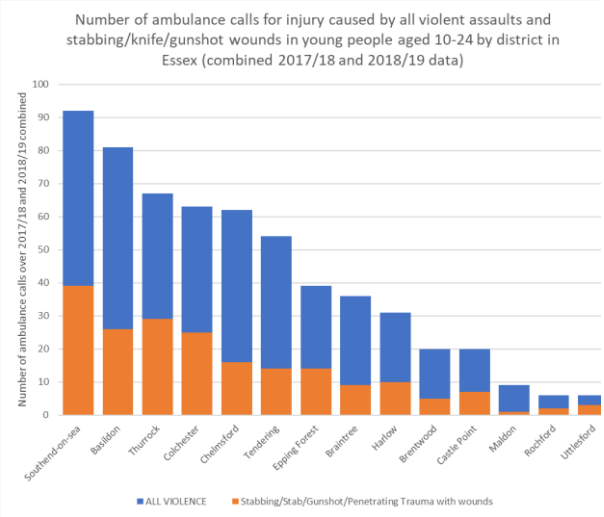
Both graphs show a similar pattern; ambulance call outs for assaults/assault with serious injury have a downward trend whilst ambulance call outs for knife/stabbing/gunshot wounds have risen sharply, particularly over the last three years in Thurrock.

Ambulance Callouts by District

Figure 2.18 shows the total number of ambulance call outs for all violence (excluding self-inflicted/sexual violence) and knife/stabbing/gunshot wounds by district across greater Essex in 2017/18 and 2018/19 for patients aged 10-24.

Thurrock had the third highest numbers of ambulance call outs for violence and the second highest number of ambulance call outs for stabbing/knife/gunshot wounds in Essex over the last two years of recorded data.

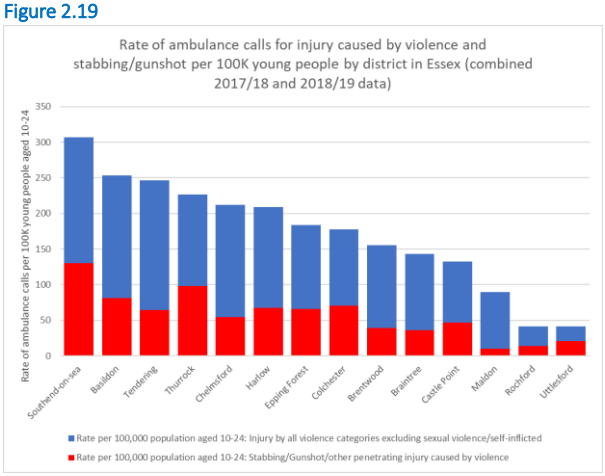
Figure 2.18



However, we know that the population of young people in Essex is not evenly distributed across the county. In order to control for this, we calculated the rates ambulance call outs for injuries caused by all violence (excluding sexual violence) and injuries caused by stabbing/knife/gunshot wounds per 100,000 young people aged 10 to 24 living in each district in Greater Essex. (Figure 2.19). These data give an indication of the *risk* that a young person aged 18-24 has of experiencing a violent attack requiring an ambulance in different geographies across Essex.

The rate of ambulance call outs for injuries caused by violence per 100K young people aged 10-24 in Thurrock is the fourth highest in Essex, and for ambulance conveyances for stab/knife/gunshot wounds, is the second highest in Essex.

Figure 2.19



Ambulance Call-Outs for Violence by Ward

We analysed ambulance data at ward level for assault/assault with serious injury and stabbing/knife/gunshot wounds for young people, combining the five years of data between 2014/15 and 2018/19 both in absolute numbers and as a rate per 1000 population of young people aged 10-24 in each ward.

Figures 2.20 and 2.21 show absolute numbers of ambulance call outs for violence by ward for all wards in Essex and the wards with the highest numbers of call outs (8 or more calls). Thurrock wards are shown in red with a black border.

Figure 2.21

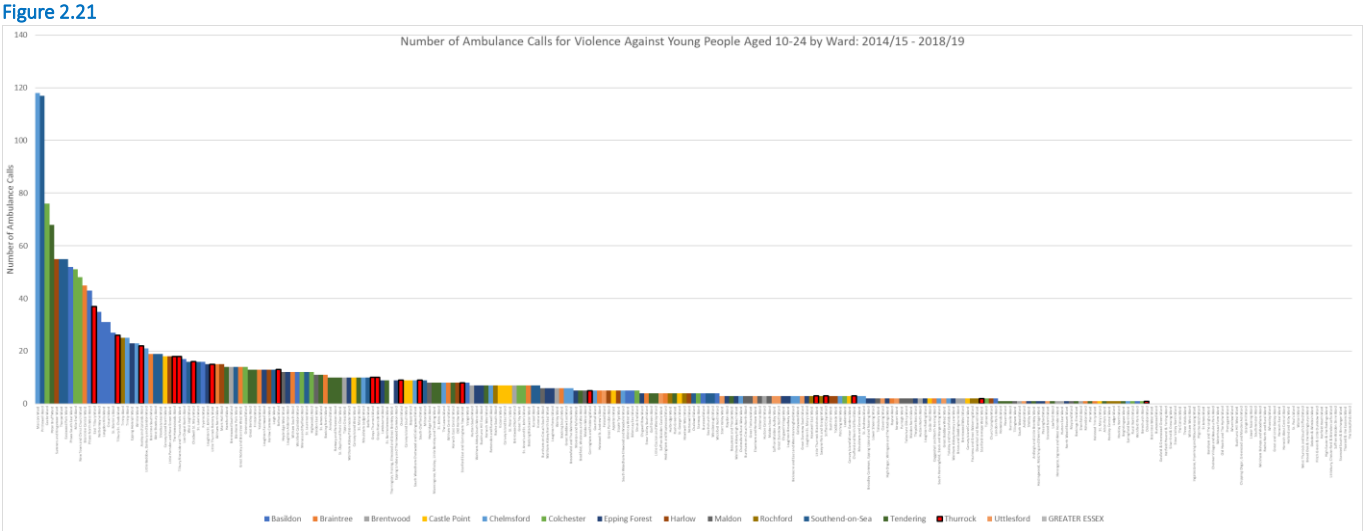
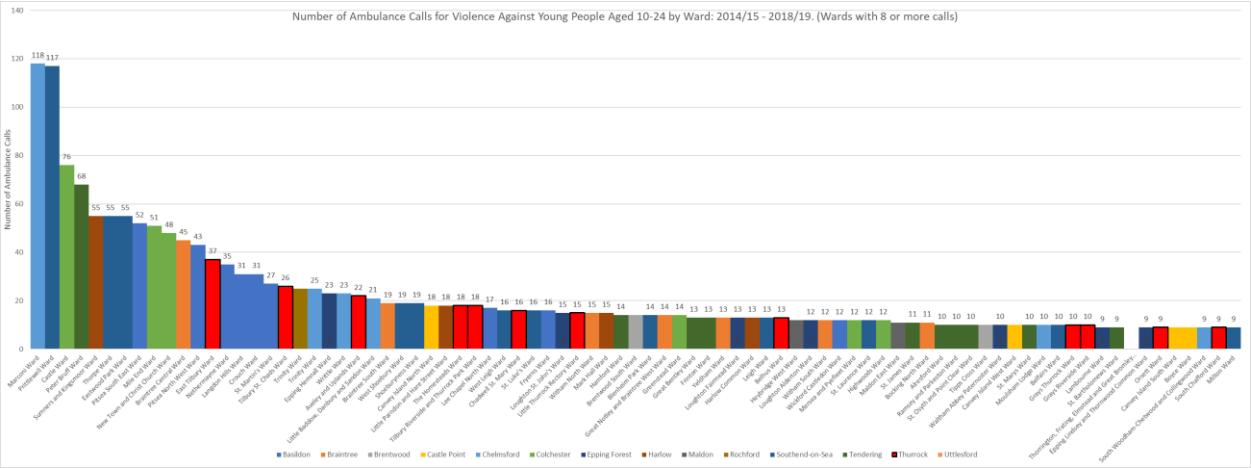


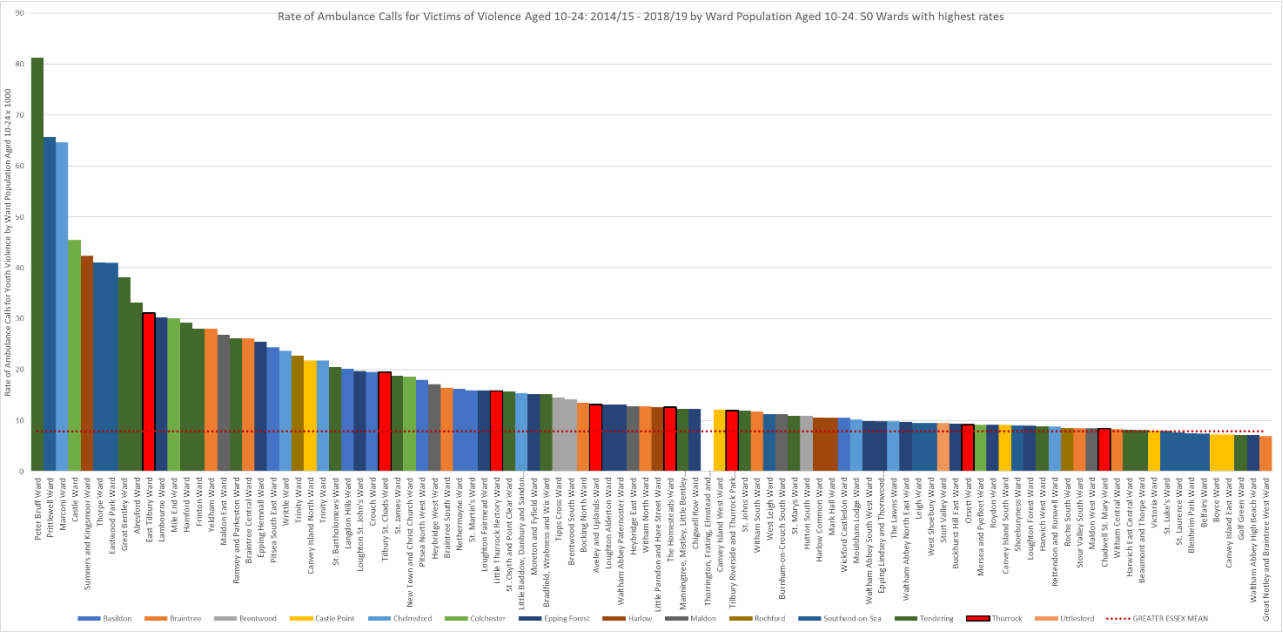
Figure 2.22



Ambulance call outs for injuries caused by violence in young people are not evenly distributed across wards in Essex. Of the 279 wards in Essex, 42 (15.1%) received no ambulance call outs for injuries caused by violence in young people in the last five years. Conversely, there were 118 ambulance call outs in the ward with the highest level of ambulance use (Marconi). In Thurrock, East Tilbury received the most ambulance call outs for injuries caused by violence in young people aged 10-24 over the last five years, followed by Tilbury St. Chads and Aveley and Uplands ranking them 13th, 18th and 23rd respectively across Essex for ambulance call outs for victims of youth violence. These data have implications for targeting of both future enforcement and prevention activity.

We also calculated the rate of ambulance call outs for victims of violence aged 10-24 per 1000 young people resident in each ward. This analyses attempts to control for the fact the population of young people is not distributed evenly between wards, and aims to calculate the *risk* a young person aged 10-24 living in each ward has of requiring an ambulance due to injury caused by violence. However some caution needs to be attached to this analyses as young people may not be victims of violence in the ward that they live. Figure 2.23 shows this analyses for the 50 wards with the highest rate of ambulance call outs for violence in young people aged 10-24 per 1000 young people resident in that ward. Eight wards in Thurrock have rates of ambulance call outs for violence greater than the Essex mean: *East Tilbury, Tilbury St. Chads, Little Thurrock and Rectory, Aveley and Uplands, The Homesteads, Tilbury Riverside and Thurrock Park, Orsett, and Chadwell St. Mary's.*

Figure 2.23



Figures 2.24 and 2.25 (overleaf) show the rate of ambulance call outs for stab/knife/gunshot injuries by ward in patients aged 10-24 per 1000 young people aged 10-24 living in each ward between 2014/15 and 2018/19. Figure A shows an even greater clustering of ambulance call outs for stab/knife/gunshot wounds compared to all injuries caused by violence. Of the 279 wards in Essex, 139

(49.8%) received no ambulance call outs for stab/knife/gunshot wounds in young people aged 10-24 between 2014/15 and 2018/19. Conversely, the ward with the highest rate of callouts (Peter Bruff ward in Tendering) had a rate 19 times that of the lowest.

Figure 2.24

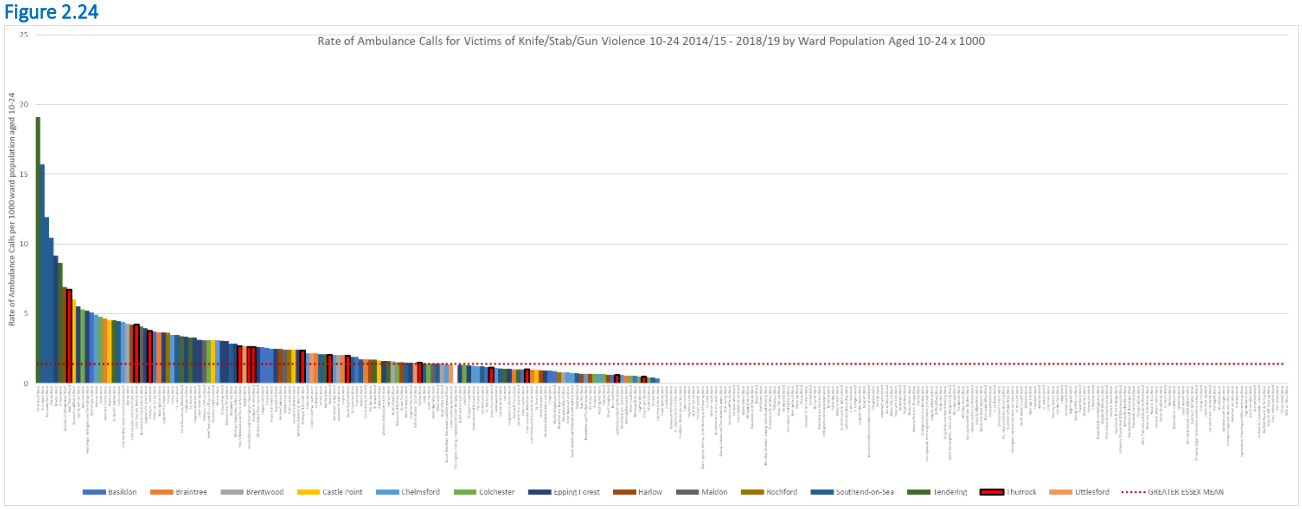
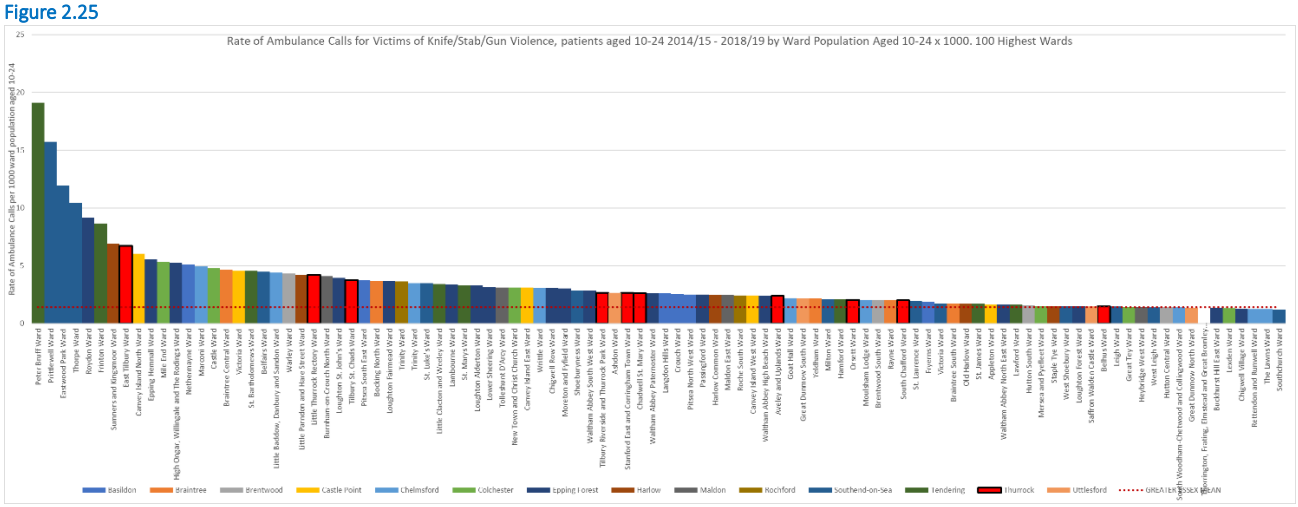


Figure 2.25



Thurrock had 10 wards with rates of ambulance call outs for stab/knife/gunshot wound injuries in patients aged 10-24 above the Essex mean. These were: *East Tilbury, Little Thurrock and Rectory; Tilbury St. Chads, Tilbury Riverside and Thurrock Park, Stanford East and Corringham Town, Chadwell St. Mary, Aveley and Uplands, Orsett, South Chafford, and Belhus*.

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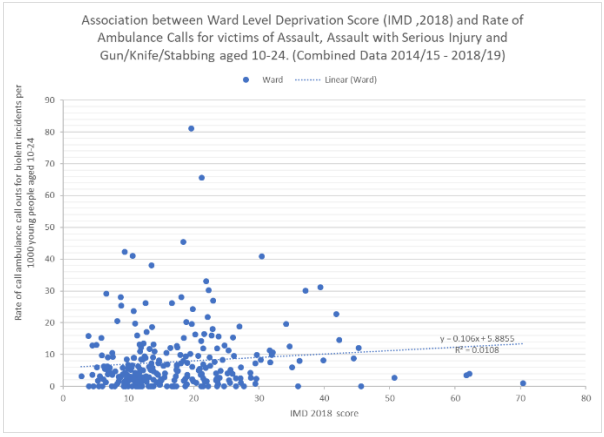
Predicting future incidents of youth violence that require an ambulance call out.

As the previous sections have demonstrated, ambulance call outs for youth violence are not evenly distributed but clustered in specific wards. We can use these patterns to predict future incidents of youth violence that require an ambulance.

We examined the association between rates and numbers of ambulance call outs for youth violence and deprivation at ward level using ward level Index of Multiple Deprivation (IMD 2018) and Index of Childhood Deprivation (IDAC 2018) for all violent incidents and stab/knife/gunshot injuries but found no significant association, suggesting the overall deprivation of the ward is a very poor predictor of levels of violence. (For example, figure 2.26)

Figure 2.26



However, we found that the number of ambulance call outs for stab/knife/gunshot wound injuries in the previous two years in youth (aged 10-24) at ward level was a strong predictor of ambulance call outs for the same injuries in the

subsequent year. This is shown in figure X. The greater the number of ambulance call outs in the previous two years, the greater the risk of a call out in the subsequent year. For example, as figure 2.27 shows, 100% of wards with six or more ambulance call outs for stab/knife/gunshot wound injuries in the previous two years received two or more ambulance call outs for the same injuries in the subsequent year. Similarly 72% of wards that received three to five call outs in the previous two years received at least one call out in the subsequent year.

We can use these data to predict future ambulance call outs for knife/stab/gunshot injuries in the future. This prediction may be useful as a means of targeting future prevention and enforcement activity at ward level.

Figure 2.27

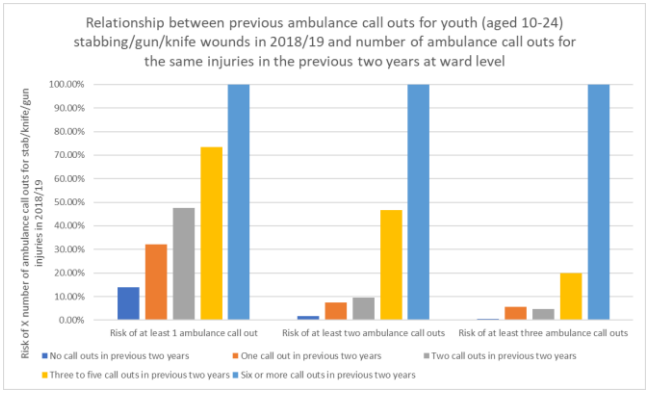
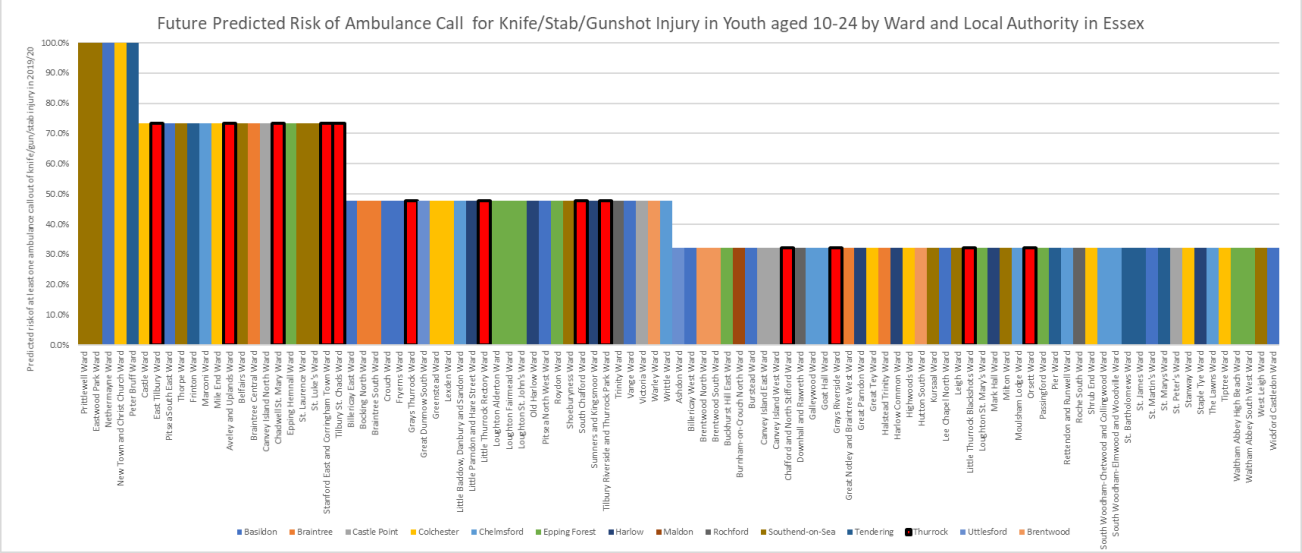


Figure 2.28 demonstrates this by using historical data to predict the risk of at least one ambulance call out for a young person aged 10-24 for a knife/stab/gunshot injury in 2019/20. Wards with a risk of 30% of greater are shown.

Thurrock wards are shown in red with a black boarder.

Figure 2.28



Thurrock has five wards with a predicted risk of 70% of at least one ambulance call out for a knife/stab/gunshot wound in 2019/20. These are *East Tilbury, Aveley and Uplands, Chadwell St.Mary, Tilbury St. Chads, and Stamford East and Corringham Town.*

A further four wards have almost a 50% predictive risk of at least one ambulance call out in 2019/20: *Grays Thurrock; Little Thurrock Rectory; South Chafford; and Tilbury Riverside and Thurrock Park.*

This intelligence can be used to target prevention and enforcement activity more effectively.

Youth Offending Service Data

We analysed the dataset held by the Thurrock Youth Offending Service for the years 2014/15 to 2018/19. We can be confident that the records contained within this dataset pertain to young people (aged <18) guilty of the offences described. However the data is likely to under-estimate the total level of offending in Thurrock as it relates only to young people who have been caught and entered the criminal justice system.

In order to reduce the number of offence categories, we grouped offenses recorded in categories shown in Table 2.5 overleaf.

Figure 2.29 (overleaf) shows the number of each category of offence dealt with by the Thurrock YOS between 2014-15 and 2018-19. Total offending across all categories has risen considerable from 2014-15 to 2018-19 with a slight reduction in 2017-18. Robbery against the individual (likely to be largely street based robbery) shows the fastest increase, with no offences dealt with by the YOS in 2014-15 compared to 84 in 2018-19.

Knife/blade/firearm/offensive weapons offences have also risen sharply since 2013-14 although fell back slightly in 2018-19. (figure 2.30 overleaf)

Table 2.5

APHR Category	Crimes included
Robbery	All robbery / attempted robbery/ conspiracy to commit robbery against the person. (Excluded all other types of theft including burglary, shoplifting, vehicle/cycle theft)
Violence Against the Person – Common Assault	All common assault categories including attempted assault
Violence Against the Person – Serious Assault	Assault / attempted assault by beating, battery, assault of a police officer, assault resulting in actual bodily harm.
Violence Against the Person – GBH	All actual or attempted acts of violence causing grievous bodily harm. Wounding with intent (section 18)
Violence Against the Person – Knife/Blade/Firearm/Offensive Weapon	All offences relating to possessing and/or threatening an individual with a knife, blade, offensive weapon or fire arm
Violence Against the Person – Other	Resisting Arrest and other offensive relating to obstructing a police officer. Using violence to gain entry to a premises. False imprisonment. Interfering with a motor vehicle with the intent of endangering life.

Figure 2.29

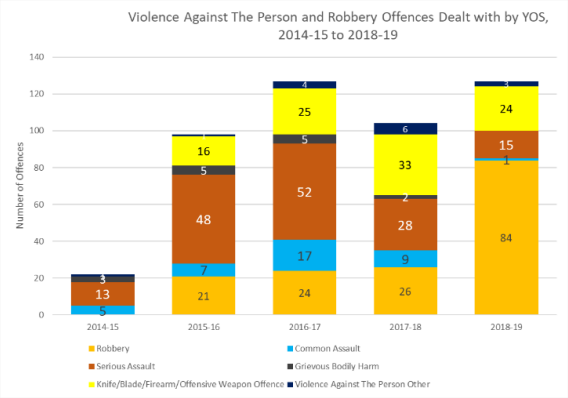
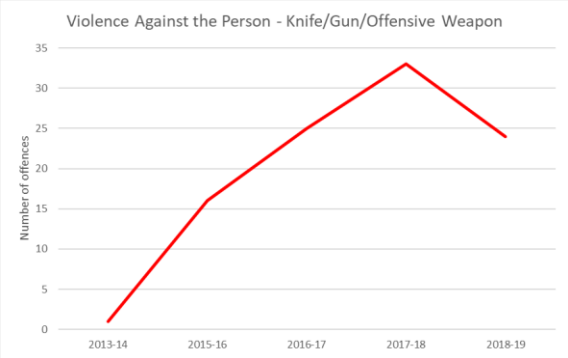
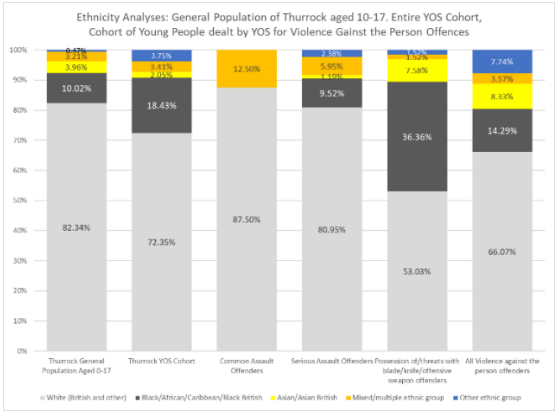


Figure 2.30



We conducted ethnicity analyses of the cohorts of young people accessing the Thurrock YOS because of different categories of violent offences in 2013-14 to 2018-19. This is shown in figure 2.31 and compares these cohorts to the entire cohort of young people the accessed YOS and the ethnicity breakdown of the Thurrock general population aged 10 to 17.

Figure 2.31

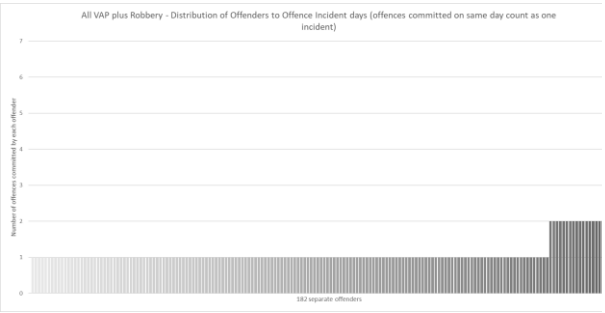


The ethnicity analyses highlights differences in the ethnic makeup of the different cohorts. Young people accessing YOS due to committing *Common Assault* offences are more likely that the entire YOS cohort of the general population of Thurrock to be white or mixed ethnic group. Conversely those accessing YOS because of *Offensive Weapons* offences are disproportionally Asian and particularly Black compared to both the entire YOS cohort and general population of Thurrock aged 10-17. Over all categories of violence against the person, non-white young people are disproportionally over-represented. The reasons behind this are unclear and likely to be complex but could include differences in arrest/conviction rates between different ethnic groups or an underlying difference in the proportions of young people from different ethnic groups committing different types of violent crime. An entire range of differing risk factors faced by different ethnic groups could in turn be driving this phenomenon and the data may have implications for how best to target prevention activity.

Single vs Repeat Offenders

We wished to explore how many offences for youth violence and robbery were committed by the same offender. Figure 2.32 (overleaf) shows the distribution of offenders to offences for all violence against the person categories of offence plus robbery.

Figure 2.32



Over the five years analysed within the YOS dataset, 220 offences for all categories of *violence against the person* plus robber were committed by 182 separate young people. As such, the majority of young people accessing the YOS (82.7%) committed only one violence against the person or robbery offence over five years. This would suggest that the YOS was successful in the majority of cases of offenders in preventing repeat offending behaviour for this type of crime, although this doesn't account for previous offenders who don't get caught for subsequent offences. 18% of young people were referred to YOS for two offences for violence against the person/robbery and 3.3% for three or more offences of this nature.

We conducted similar analyses for the sub categories of *Knife/Gun/Offensive weapon* and *Serious Assault* (figures 2.33 and 2.34)

Figure 2.33

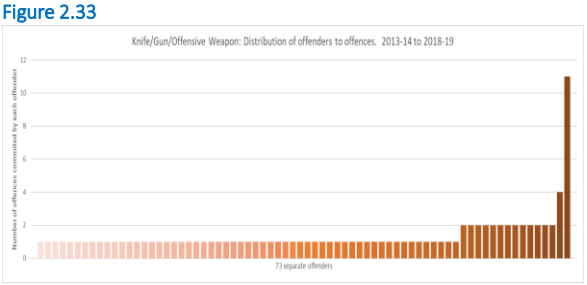
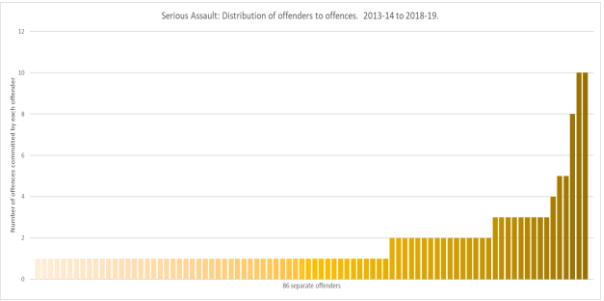


Figure 2.34



In both categories of *Knife/Gun/Offensive Weapon* and *Serious Assault*, once again the majority of offenders (79.4% and 65.1% respectively) committed only one offence. However for *serious assault* there is a larger cohort of young people committing multiple offences despite YOS intervention.

Association with other crime

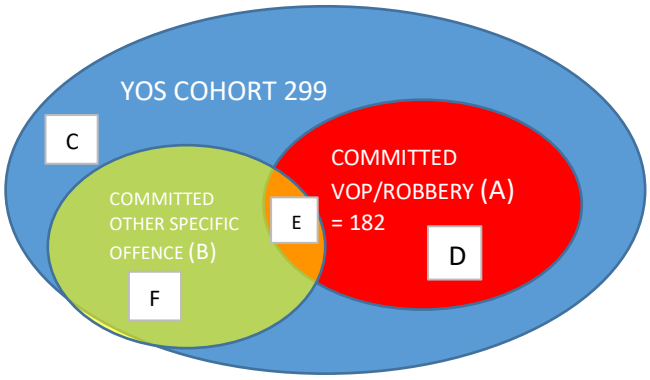
We wished to explore the relationship between committing all sub-categories of *Violence Against the Person/Robbery* and committing other types of crime amongst the YOS cohort. This can be represented by Venn Diagram 1. In total over the years 2013-14 to 2018-19, the YOS worked with 299 separate offenders (Large blue oval). Of those, 182 committed at least one *Violence against the Person/Robbery* category of offence (Red oval – A).

The section of the Red Oval (D) represents the number of young people in the cohort who committed a Violence against the Person/Robbery offence (any category) but not another type of offence. Similarly, the proportion of the green circle (F) represents the numbers of young people who committed other specific types of offences (given in table X) but not one in the *Violence Against The Person/Robbery* categories.

The Overlap between the Green and Red Ovals (E) represents the numbers of young people who committed both other categories of crime and *Violence Against the Person/Robbery*.

The section of the blue oval 'C' represents the YOS cohort who committed neither the specific offence represented by the green oval B nor *Violence Against The Person/Robbery*.

Venn diagram 1



We calculated Odds Ratios to show the level of increased likelihood that committing a range of other types of offence has on committing a *Violence Against the Person/Robbery Offence*. We did this using the remainder of the YOS cohort group (C) as a control. An Odds Ratio of 2 would signify that committing another type of offence means that the offender was twice as likely as the remainder of the YOS cohort to commit a *Violence Against the Person/Robbery* offence.

The results of this analyses are shown in table 2.6 (overleaf).

Table 2.6

Specific other offence committed (Green Oval B)	Total Number of YOS Offenders Committing this category of offence (Number Green Oval B)	Number of YOS offenders also committing VOP/Robbery (Overlap E)	Number of YOS Offenders Committing this offence who did not commite VOP/Robbery (Section F of green oval)	% of offenders committing this offence ALSO committing VOP ROBBERY	Number of Offenders committing VOP/Robbery but not this specific other offence (Section D of red oval)	Number of YOS Cohort who did not commit either VOP/Robbery nor this specific offence (Section of blue oval C)	**Odds Ratio** (Increased risk of committing VOP/Robbery if committed this offence)	95% Confidence Interval	p value
SUPPLY OF A CLASS B DRUG	9	8	1	88.90%	174	116	5.33	0.658 to 43.21	0.12
BREACH OF BAIL	10	8	2	80%	174	115	2.64	0.55 to 12.67	0.2241
POSSESSION OF A CLASS A DRUG	10	7	3	70%	175	114	1.52	0.3851 to 5.99	0.55
SUPPLY OF A CLASS A DRUG	10	7	3	70%	175	114	1.2	0.571 to 2.534	0.63
POSSESSION OF CLASS B DRUG	47	32	15	68.09%	150	102	1.45	0.75 to 2.82	0.27
CRIMINAL DAMAGE	63	41	22	65.08%	141	95	1.26	0.70 to 2.24	0.441
BREACH OF STATUTORY ORDER	34	22	12	64.70%	160	105	0.98	0.45 to 2.12	0.961
PUBLIC ORDER	30	18	12	60%	164	105	0.96	0.44 to 2.08	0.96
BREACH OF CONDITIONAL DISCHARGE	6	3	3	50%	179	114	0.66	0.13 to 3.30	0.61
BURGLARY	16	8	8	50%	174	109	0.63	0.23 to 1.72	0.365
THEFT AND HANDLING STOLEN GOODS	65	31	34	47.70%	151	83	0.501	0.288 to 0.873	0.0148
MOTORING OFFENCES	35	11	24	31.40%	171	93	0.2493	0.1169 to 0.53	0.0003

Table 2.6 shows a high degree of 'overlap' between some other types of offence category and committing *Violence Against The Person/Robbery* amongst the YOS cohort of young people. 88.9%, 80%, 70% and 70% of young people committed offences of Supplying Class B drugs, Breach of Bail, Possession of Class A drugs and Supplying Class A drugs respectively also committed VOP/Robbery offences. It is worth noting that which offence preceded the other cannot be determined from this analyses. The Odds Ratios signify that those young people who committed Possession and Supply of Class A and B drugs offences, those committing criminal damage and those who breached bail were all at greater risk than the rest of the YOS cohort of committing *violence against the person/robbery* offences, although none of the Odds Ratios were statistically significant at 95% confidence, largely because the relatively small numbers of young people involved in both category of offence meant there was insufficient statistical power to the calculation.

Two statistically significant odds ratios were identified, shown in green. Young people committing theft/handling stolen goods and motoring offences were 50% and 24.9% less likely than the entire YOS cohort of also committing *Violence Against the Person/Robbery* offences.

We also calculated odds ratios using the entire population of young people aged 10-17 in Thurrock as the control group rather than the rest of the YOS cohort of young people. The results are shown in Table 2.7 and are striking and all statistically significant at 95% confidence.

Table 2.7

Specific other offence committed	Odds Ratio. (Increased risk of also committing VOP/Robbery compared to the Thurrock General Population aged 10-17)	95% Confidence Interval	p value
SUPPLY OF A CLASS B DRUG	1674.97	211.19 to 13300	<0.0001
BREACH OF BAIL	1489.75	185.33 to 11975.	<0.0001
POSSESSION OF A CLASS A DRUG	432	110.8 to 1684.27	<0.0001
SUPPLY OF A CLASS A DRUG	432	110.8 to 1684.27	<0.0001
POSSESSION OF CLASS B DRUG	460.63	244.36 to 868.30	<0.0001
CRIMINAL DAMAGE	427.99	248.47 to 737.20	<0.0001
BREACH OF STATUTORY ORDER	371.15	180.60 to 762.75	<0.0001
PUBLIC ORDER	296.26	140.45 to 264.92	<0.0001
BREACH OF CONDITIONAL DISCHARGE	181.01	36.28 to 902.87	<0.0001
BURGLARY	186.18	69.09 to 501.68	<0.0001
THEFT AND HANDLING STOLEN GOODS	195.48	117.09 to 323.36	<0.0001
MOTORING OFFENCES	86.79	41.85 to 179.97	<0.001

Young people referred to YOS for the other specific offence categories listed in table 2.7 are between 86.8 and 1675 times more likely to also commit *Violence Against the Person/Robbery* offences suggesting that violence secondary prevention activity needs to be targeted at the entire YOS cohort.

Desistence Analyses

YOS record whether each young person has any of 18 risk factors that make desisting from future offending less likely. We analysed the cohort of young people who had been referred to YOS for all categories of *Violence Against the Person* crimes plus robbery. Figure 2.35 shows the results of the analyses for the sub-categories of *Common Assault, Serious Assault and GBH*. Figure 3.36 shows the results for *Robbery and Knife/Blade/Firearm/Offensive Weapon Offences* showing the percentage of offenders in each crime category with each desistence risk factor.

What is striking in the spider diagrams in figure 2.35 and 3.36 is the shapes produced across all crime categories are very similar, suggesting the most common risk factors against desistence from future offending (present in >50% of offenders) for all *Violence Against the Person* and *Robbery* crime categories for the cohort of young people that the Thurrock YOS works with are:

- *Emotional Development and Mental Health*
- *Features of Lifestyle*
- *Learning, Education, Training and Employment*
- *Parenting, Care and Supervision*
- *Substance Misuse*
- *Thinking and Behaviour*

Emotional Development and Mental Health is also a risk in a lower proportion of young people who committed *Robbery* or *Knife/Blade/Firearm/offensive weapon* offences compared to common or serious assault.

The high proportion of young people in the cohort committing violence against the person/robbery offences with the above six risk factors suggests future prevention activity needs to be targeted at addressing these six issues. It is worth noting that the six risk factors relate to both individual, family and wider societal drivers of wellbeing, suggesting future prevention activity requires a multi-agency, multi-systemic and coordinated approach.

One additional risk factor doesn't follow the same pattern across all offence sub-categories; *Resilience and Goals*. 100% of young people who committed GBH had this risk factor whilst it was present only in very low numbers of young people who committed other types of violent crime/robbery.

Figure 2.35

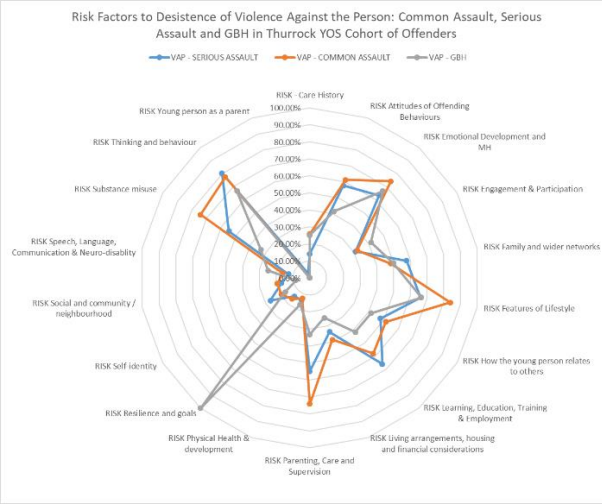
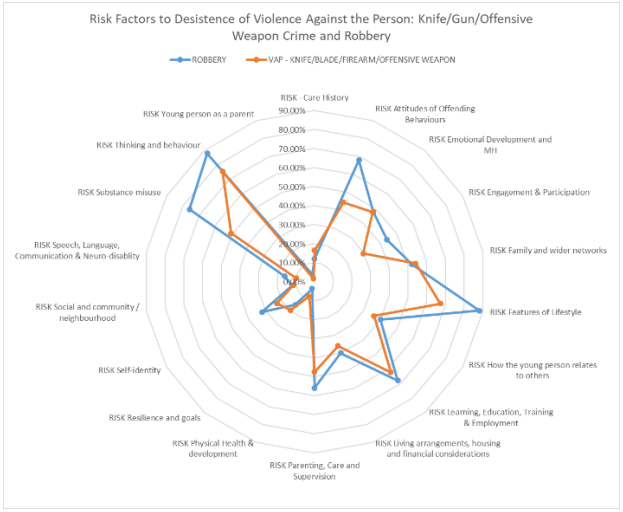


Figure 2.36



Chapter 3: Gang Culture in Thurrock

Key Findings

Evidence suggests serious consequences for both young people who join gangs and their wider communities. Gang membership is strongly associated with risk of both committing and being a victim of serious violence, school exclusion, difficulty gaining meaningful employment, criminal activity including drug dealing, robbery and sexual offences, drug/alcohol dependency and serious mental ill-health.

The numbers of young people becoming involved in gangs in Thurrock remains relatively small as a proportion of our population of the total population but has increased significantly year on year since 2016/17. Black young people are significantly over-represented in the cohort of young people known to be gang nominals in Thurrock. The reasons for this are likely to be complex and not entirely understood but may have implications for the targeting of future prevention activity. The age at which young people become involved in gangs is also reducing year on year over the past three years within the borough.

Gang related activity in Thurrock is centred around the geographical areas of Grays, Chafford Hundred and Purfleet, with three gangs known as C17 (Grays), C100 (Chafford) and P19 (Purfleet) operating. There is evidence of association between established London gangs and gang activity in Thurrock and this could be one explanation for the over-representation of black young people in Thurrock gangs.

Introduction

This chapter examines the issue of youth gangs and gang culture in Thurrock.

Although there is no standard definition of what constitutes a gang, the Centre for Social Justice in 2009 offered a practical description which incorporates five key criteria[9] shown in box 3.1

Box 3.1

Definition of a youth gang

Gangs are a relatively durable, predominantly street-based group of young people who:

- See themselves and are seen by others as a discernible group.
- Engage in criminal activity and violence
- Identify with or lay claim over territory
- Have an identifying structural feature
- Are in conflict with other, similar gangs

Youth gangs are not a new social problem and have been reported in literature since the 19th Century, but the last 15 years British society has seen an increase in gang culture and its associated violence. Evidence suggests that up to 6% of 10-19 year olds in the UK self-report belonging to a gang. [10]

Impact of Gang Membership

The consequences of joining a gang are potentially very serious, both for the youth involved and for their wider communities.

Violence

The frequency with which someone commits serious and violent acts typically increases whilst they are gang members compared with periods before and after gang involvement. Adolescents who are in a gang commit many more serious and violent offences than non- gang affiliated young people.[11] [12] One UK Study found that 90% of male gang members (aged 18 to 34) had been involved in violence in the past five years with 80% reporting at least three violent incidents. Compared with non-gang members, they were more likely to have perpetrated violence, been a victim of violence and fear future victimisation.[13]

Frequent association with other gang members encourages and reinforces violent responses to situations and retaliation against others. This in turn elevates the risk of violent victimisation in gangs.[14] [15]

Exclusion

The majority of gang members either self-exclude (truant) or have been officially excluded from school[16] and are likely to be spending large amounts of time unsupervised on the streets. Gang members subsequently have little, if any, qualifications and are unlikely to gain meaningful employment. This in turn makes criminal activities such as drug dealing appear an attractive alternative.

Involvement in crime and delinquency

Gang involvement encourages more active participation in delinquency and criminal activity. Research suggests that gang members tend to be engaged in a wide range of criminal activities: drug dealing, robbery, assault and rape.[17]Drug use, drug trafficking and violence, and in turn increases the risk to gang members of violence, arrest, conviction and incarceration. [18] [19] These effects of gang involvement also bring disorder to the life course in a cumulative pattern of negative outcomes including school dropout, teenage parenthood and unstable employment

which becomes particularly severe when the young person remains an active member of the gang for several years. [12] [18]

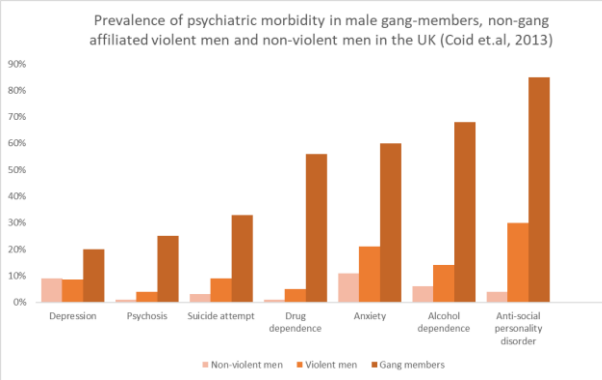
Poor mental health

There is a bi-directional relationship between poor mental health and gang membership. Poor mental health makes young people more vulnerable to joining gangs[20], whilst gang membership can have an adverse effect on mental wellbeing. [13] [21] [22] Exposure to violence and other trauma associated with gang membership damages mental health. Gang members may be under extreme pressure to suppress feelings of fear and anxiety to avoid being ostracised by the gang. [23] Similarly substance misuse often associated with gang membership can further damage mental health. [24]

Long-term exposure to violence associated with gangs has been linked to a range of psychological problems including depression, anxiety, behavioural problems and post-traumatic stress disorder (PTSD).[25] [26] [27]

Analyses of health screening initiatives with young people (aged 10-18) found that at the point of arrest almost 40% of those who were gang members had signs of severe behavioural problems before the age of 12 compared with 13% of youth justice entrants.[28] Around a quarter had a suspected mental health diagnosis and over a quarter were suffering sleeping or eating problems (compared with less than 10% for general entrants). A study of older males (aged 18 to 34) found that those who were gang members had significantly higher levels of mental illness than both men in the general population and non-gang affiliated violent men. (Figure 3.1)[13]

Figure 3.1



Community impact

Fear of crime and gangs are immediate, daily experiences for many people who live in neighbourhoods where gangs are most prevalent[29]Negative impacts of gangs on communities include economic loss including loss of property values, neighbourhood businesses and tax revenue; weakened informal social-control mechanisms; and the exodus of families from gang-ridden neighbourhoods resulting in a downward spiral of neighbourhood decline.[30]

Gangs may also intimidate non-gang members of the community who witness gang related crime making it difficult for law enforcement to maintain order in gang-impacted areas. [31]

Gang Activity in Thurrock

Thurrock's close proximity and good transport links to London and its comparatively cheaper rent has made it vulnerable to significant displacement of gang associated children and adults from the capital into the borough. Thurrock Council's Gang Related Violence Group monitors gang activity within the borough. Figure 3.2 shows the numbers of new referrals, gang nominal managed and gang nominal removed for the group's monitoring data for the years 2016/17 to 2018/19. It shows increasing numbers of new nominal referred and total nominal managed year on year and a decreasing number of gang nominal removed from the register suggesting that gang activity in the borough has increased. In total, there has been a 33% increase in nominals identified and monitored by the Gang Related Violence Operational Group in 2018/19 compared to 2017/18. This fits with previous trends of increasing knife crime and violence discussed in the previous chapter.

Figure 3.2

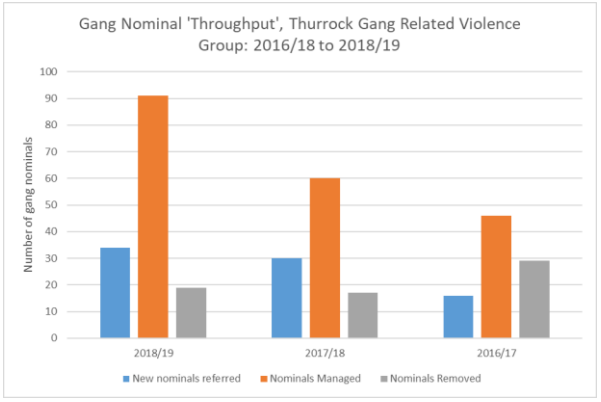
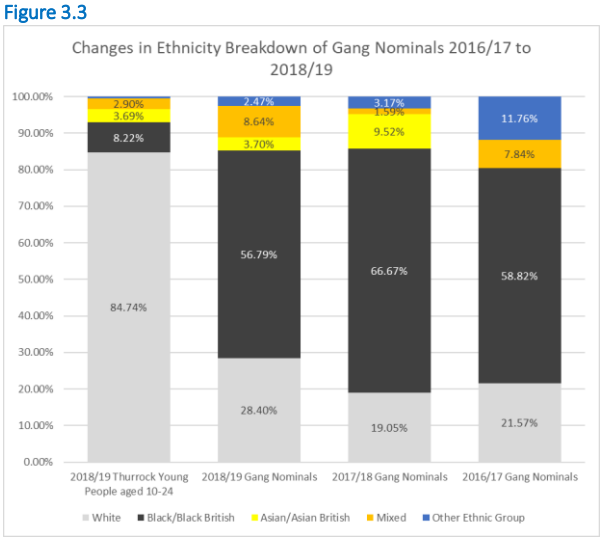


Figure 3.3 shows changes in the ethnicity of gang nominals managed through the Gang Related Violence Group between the years 2016/17 and 2018/19 together with the modelled ethnicity of the population of Thurrock young people aged 10-24.

Figure 3.3



Black/Black British young people are significantly over represented in the population of gang nominals in Thurrock

when compared to the general population of Thurrock young people aged 10-24. This mirrors previously presented data in Chapter 2 on ethnicity breakdown and violent offenders. The reasons for this are unclear but one possible explanation could include the migration of black gang involved young people into the borough from London. Overrepresentation of young black youth in Thurrock gangs also has implications for how future prevention work may need to be focused. However the data shows that the over-representation has become less pronounced when comparing 2018/19 data to 2016/17 data suggesting that greater numbers of white young people are becoming involved in gangs in Thurrock.

Figure 3.4

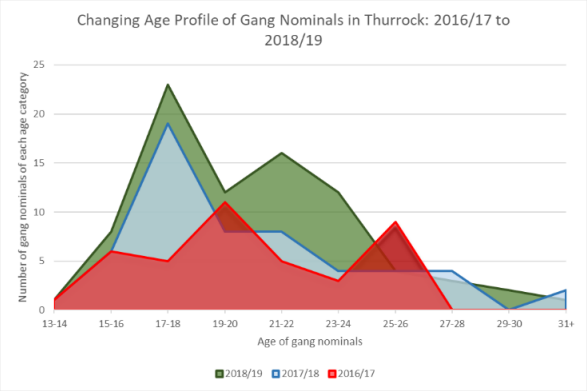


Figure 3.4 shows the age profile of gang nominals monitored through the Thurrock Gang Related Violence Group for the years 2016/17 to 2018/19.

Whilst the larger 'green' plot area of 2018/19 reflects the increasing number of gang nominals being monitored, it also suggests that the age of gang nominals is also getting younger with large increases in the 17-18 age category between 2016/17 and 2018/19 and reductions in gang members over 24. Numbers of gang nominals under the age of 15 is minimal suggesting that future prevention activity aimed dissuading young people from joining gangs, needs to be targeted at the age group under 16

Figures 3.5 and 3.6 show the approximate home area of each of the gang nominals identified and monitored by the Thurrock Council Gang Related Violence Group for 2016/17 and 2018/19. Figure B also shows the name of the gang that the nominal is believed to belong to.

The public health conceptualisation of violence as a communicable disease that 'spreads' from index cases is clearly demonstrated in these two maps. The number of gang nominals increases from a few index cases over three years, particularly in Purfleet, Chafford, Grays and South Ockendon which are the four areas where the majority gang nominals now reside.

Figure 3.5: Approximate Address of Gang Nominals 2016/17

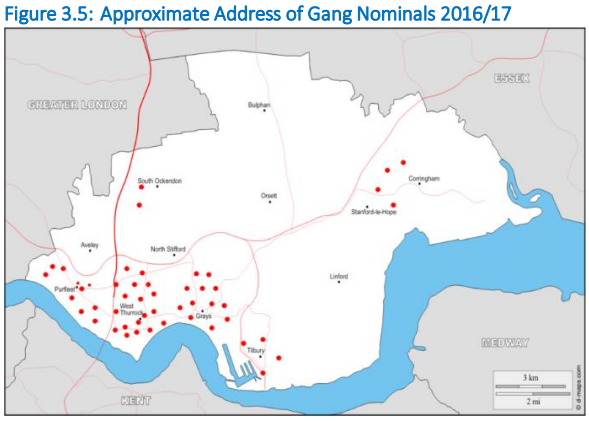


Figure 3.6: Approximate Address of Gang Nominals 2018/19

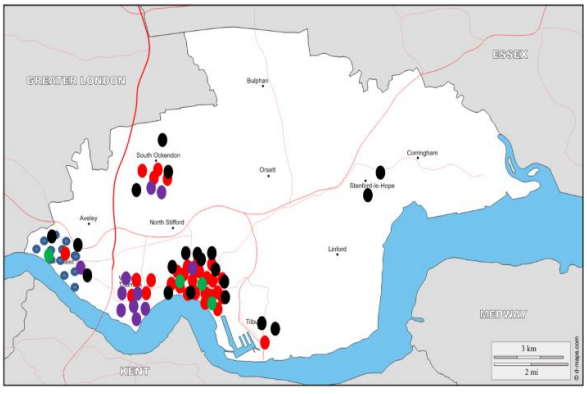
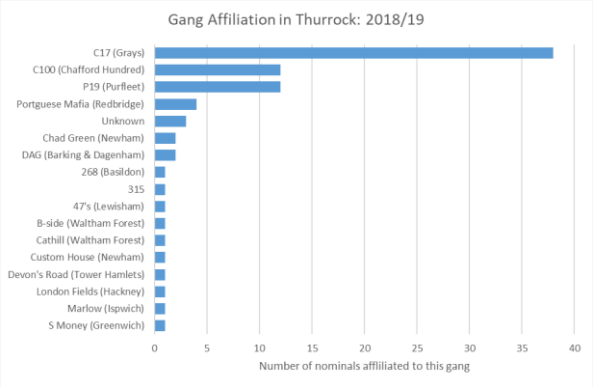


Figure 3.7 shows the affiliation of nominals to gangs in Thurrock.

Figure 3.7



Three main Thurrock gangs operate: C17/7 in Grays, C100 in Chafford Hundred and P19 in Purfleet. Figure C also shows ongoing location of gang affiliates linked to London gangs being located in Thurrock. These gang nominals then align themselves with a Thurrock based gang. Consequently, gangs like C17/7 have members from various London gangs who would not normally associate with each other in their originating borough. It is believed that the purpose of this arrangement is to maximise earning potential from the existing drugs trade and to be associated with the emerging 'drill music' scene.

Chapter 4: County Lines

Key Findings

County Lines is a term used to describe gangs and organised criminal networks who export drugs into one or more locations within the UK using a dedicated mobile phone line. They systematically exploit children and vulnerable adults whom they use to move, store and sell class A drugs (largely crack-cocaine and heroin) using a threats of violence, making such exploitation a form of modern day slavery. County lines gangs recruit victims through a process of grooming that involves identifying young people with existing vulnerabilities and exploiting them. County Lines activity is associated with increasing availability and prevalence of cocaine and crack-cocaine use.

The grooming process typically follows a three stage process of *targeting, testing* and then *trapping* the young person, the final stage involving debt bondage, threats or experience of extreme physical, psychological or sexual violence. Victims may be transported hundreds of miles from their home borough and forced to work in trap houses dealing drugs.

Historical approaches to child safeguarding that are designed to protect against child abuse in domestic settings have been shown to be inadequate in the face of the County Lines threat which crosses multiple disciplines including the police, probation, youth offending teams, education and adults/children's social care, and because lines often cross multiple geographical agency boundaries. Young people exploited through County Lines activity are both perpetrators of serious crime and victims of exploitation, but strategic oversight of enforcement/community safety and wellbeing/vulnerability and safeguarding have historically sat in separate multiagency forums. As County Lines are a relatively new phenomenon, child criminal exploitation has not been historically assessed or recorded on local authority Children's Social Care systems.

Where prevention activity is undertaken, national research reports that it is often undertaken too far 'down-stream' once children and young people have been exploited; thresholds for accessing statutory children's social care and youth offending services are set too high. Children's Social Care practitioners report that historical interpretation of child protection policies did not allow them to accept cases on the sole basis of debt enslavement or entrapment and there was a tendency of statutory safeguarding agencies to view young people's behaviour when being criminally exploited, as a sign of criminality or lifestyle choice rather than as evidence of a vulnerable child in need of protection.

Accurately ascertaining the extent of County Lines activity in Essex and Thurrock is difficult due to their covert nature and recent emergence. Data from the National Referral Mechanism set up to monitor the extent of modern day slavery suggests a sharp increase in under 18 referrals from 2014 to 2018/19 although absolute numbers remain low. Intelligence from Essex police suggest that 20 County Lines are known to be operating in Essex of which three operate in the West Essex Local Police Area which encompasses Thurrock.

Introduction

County Lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move and store the drugs and money and will often use coercion, intimidation, violence (including sexual violence) and weapons.[Error! Bookmark not defined.]

The National Crime Agency[32] describe a typical *County Lines* methodology as having the following components shown in Box A.

Box A: Components of County Lines

1. A group or gang (usually made up of young males) establishes a network between an urban hub and county location, into which drugs (primarily heroin and crack cocaine) are supplied.
2. A branded mobile phone line is established in the market, to which orders are placed by introduced customers. The line will commonly (but not exclusively) be controlled by a third party, remote from the market.
3. The gang exploits young or vulnerable persons, to achieve the storage and/or supply of drugs, movement of cash proceeds and to secure the use of dwellings from which drugs are supplied (commonly referred to as cuckooing).
4. The group or individuals exploited by the gang regularly travel between the urban hub and the county or coastal market to replenish stock and deliver cash.
5. The gang is inclined to use intimidation, violence and

County lines gangs recruit victims through a process of grooming that involves identifying young people with existing vulnerabilities and exploiting them. County Lines activity is associated with increasing availability and prevalence of cocaine and crack-cocaine use.

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The National Crime Agency have published three reports that provide an insight into the nature and scale of county lines. [32] [33] [34] The latest suggests that there are over 2000 individual deal line numbers in the UK, linked to approximately 1000 branded county lines. The Children's Commissioner for England in 2018 warned that up to 50,000 young people could be affected based on the National Crime Agency's estimation that as many as 50 children can be involved in any single county line. [35]Although demand for and supply of drugs underpins county lines offending, exploitation remains integral to the business model. Offenders continue to recruit, transport and exploit individuals including children to carry out low-level criminal activity essential to their operation.

Drugs supplied

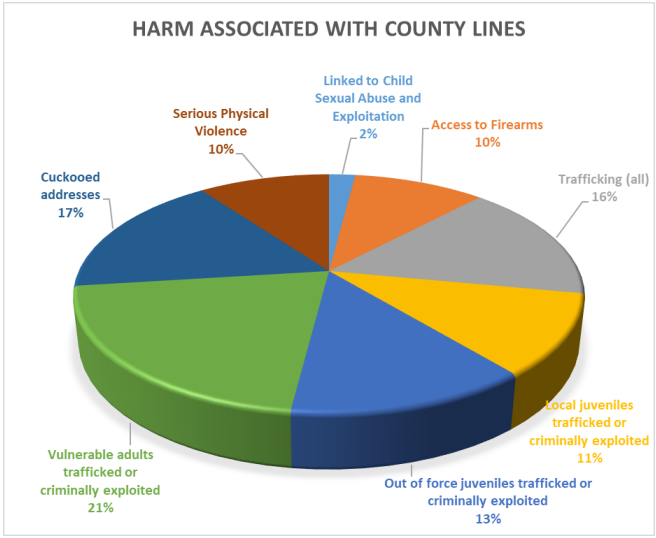
Heroin and crack cocaine remain the drugs most commonly supplied through county lines. Cannabis is generally not supplied through County Lines. Offenders use mass marketing text messages to advertise the supply and availability of drugs and offer free samples (particularly of crack cocaine) in exchange for the contact details of potential customers in order to expand their customer base and increase the number of addicts in the local population.[34]

The County Lines model has revolutionised the supply chain for Class A drugs in recent years. Establishment of a drugs supply business in a new year presents inherent risks for criminals, not least the threat of violence from rival suppliers, and enforcement by the police. By forcing exploited children and vulnerable adults to 'run' the substances for them free of charge, criminal gangs are able to both maximise profits and minimise risks to themselves. The model also allows a minimal number of 'middle men' between the international criminal cartels who import the drugs and the end user, meaning that the quality of the product is high allowing the gang to undercut existing drug suppliers and capture the market.[2]

Vulnerabilities and Harm

The County Lines business model thrives on the exploitation of vulnerable adults and children to deliver drugs and money in what could be described as a type of modern day slavery. The National Crime Agency identified eight main areas of harm caused to children and vulnerable adults exploited through County Lines gangs (Figure 4.1)

Figure 4.1



Source: NCA, December 2018

The National Referral Mechanism (NRM) was established by government to identify, monitor and refer potential victims of modern slavery and ensuring they receive the appropriate support. Data from the NRM on individuals exploited through the County Lines model suggest that the majority

of victims are aged between 15 and 17. Individuals within this age group are likely to be targeted as they provide the level of criminal capability required by the offending model, but remain easier to control, exploit and reward than adults. Adult victims of exploitation by county lines gangs are most frequently vulnerable due to an existing drug addiction and often have extensive criminal histories, generally in low-level offending such as shop lifting related to their drug addiction. Mental health conditions such as depression, anxiety and psychosis, and learning and development disorders are often identified in adult victims of exploitation in county Lines activity. [34]

Recruitment of victims

The recruitment of victims can be explained through a three stage process:

1. Targeting
2. Testing
3. Trapping

Figure 4.2 taken from the Children's Society Report into Child Criminal Exploitation and County Lines[Error! Bookmark not defined.] demonstrates the process

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Figure 4.2

Source: Children's Society, 2018

The first two stages of recruiting victims exploited by county lines gangs is a process of *grooming*. In the first *targeting* phase, gang members build a relationship with the victim that they then go on to exploit. Children displaying vulnerabilities such as poverty, family breakdown, intervention by social care especially looked after children, being excluded from mainstream education or truancy are most frequently targeted by county lines offenders. In some areas middle class children have also been targeted where the gang can identify a vulnerability. The initial targeting phase typically involves the gang member making initial contact and providing something that the victim wants or needs. This can be material things such as phones or trainers that have perceived status, money, or a relationship/emotional support acting as a replacement "family" that is often absent.

Gangs also targeted young people through on-line grooming, opening advertising monetary benefit on social media to becoming involved. Gangs also produce *drill music* videos which are published on YouTube and portray a glamourous lifestyle offered by gang membership as a mechanism to recruit victims.

In the second *testing* phase, the gang seeks to ascertain whether the victim is 'trustworthy' and does not pose a risk to the wider organisation. Victims are often asked to undertake 'minor tasks' which then escalate rapidly in terms of their demand and risk. In the testing phase, the victim is often asked to hold something of value for a period of time such as drugs, cash or weapons. Unbeknown to the victim, the gang then arranges for these to be robbed, placing the victim in 'debt bondage' to the gang.

In the final *trapped* phase, the victim is forced to work for the gang under threat or experience of extreme physical, sexual and psychological violence in return for being unable to pay the debt. Victims are required to traffic drugs/money around the county which may involve having to 'plug' or 'stuff' packages anally or vaginally within their own bodies. A major feature of the county lines model is the movement or trafficking of young people, often over hundreds of miles from urban hubs to rural locations to operate the line. Young people are forced to work in 'trap houses' controlled

by the gang for the purposes of selling drugs, either rented through sites like AirBnB or taken over from vulnerable adults (a process known as 'cuckooing'). The young person is left isolated and prevented from accessing education, family contacts and appointments. Threats may be made to the victims' families and victims may be compelled to groom younger siblings.

Problems with current statutory agency responses to exploitation through county lines

The Violence and Vulnerability Unit which is funded jointly by the Home Office and Mayor of London's Office for Police and Crime (MOPAC) published a national summary and guide to emerging best practice on county lines in May 2018 based on extensive interviews with practitioners and managers and the findings of 70 locality reviews and local three strategic frameworks on county lines activity and the exploitation of young people through them.[36] It identified a range of commonly repeated issues and concerns in the context of partnership working, the criminal justice system, schools and colleges, early help and intervention, and financial exploitation.

Partnership working

The issue of County Lines and gang activity does not fit neatly into historical partnership work programmes or structures that have been set up in local areas. It crosses multiple disciplines and agency accountabilities including the police, probation, youth offending teams, education, adults' and children's social care, adults and children's safeguarding boards, the NHS and public health. This allows gangs to exploit these differences and service gaps to target vulnerable populations with relatively ease and impunity, exacerbated by the fact that county lines run across large geographies not coterminous with the geographical footprints of individual statutory services.

Criminal justice response: common issues

When young people exploited through county lines are arrested by the police for possession of drugs or possession of drugs with intent to supply, they are often released pending further investigation and returned to their home area which may be different to the geography that they were arrested in. Police reported struggling to get emergency children's social care duty teams to engage with the young person, resulting in them being returned home with a drug debt to the gang and inadequate engagement of services.

Nationally Youth Offending Team staff reported inadequate court sentences being given to young people arrested with large quantities of drugs, and young people being sentenced only for possession in cases where the drugs were clearly not for personal use, but held with intent to supply. This sends a message to young people that the consequences of drug dealing were minimal compared to the severe potential consequences of being disloyal to their gang.

There was a persistent call from YOT practitioners that government should change the law to make the grooming of young people in this context illegal and for it to incur stiff penalties. Staff felt older gang members were operating in urban areas to recruit young people with little fear of the legal consequences.

A common concern was that young people were coming to the attention of YOTs at crisis point when their criminal behaviour was entrenched because service access thresholds were set too high and there is inadequate early intervention provision. This was underpinned by a common theme of reported increases in antisocial behaviour (ASB) which is not being challenged. This lack of ASB interventions was linked to a lack of proactive/early intervention youth services and outreach work.

Schools and colleges: common issues

The targeting of pupils excluded from mainstream education is a major feature of county lines. The report suggested an increasing trend in exclusions for a wider range of behaviours and a lack of evidence for effective reintegration into education of pupils who had been excluded even when this is temporary. The exclusion of young people from full time education, whether by placing them on reduced time tables, placing them in home schooling arrangements or removing them to Pupil Referral Units (PRUs) exacerbates their vulnerability and increases the risk of them being targeted by gangs for exploitation. PRUs in particular were highlighted as recruiting grounds for county lines gangs.

Early intervention and help: common issues

There was a common call for more outreach and positive activities for young people arising from the realisation that a reduction in these services has left a vacuum into which gangs are moving. The reviews also highlighted inadequate recording of and response to risks highlighted through conversations between front line youth staff and young people, for example being bought trainers or phones by gang members.

When young people become involved in 'county lines', offering diversion away from these activities will inevitably need to involve their entire family. This can be particularly complex when money from county lines activity is used for paying household bills in cases where families have few resources. The report identified that some parents were struggling to maintain boundaries at home, especially if substance users themselves and that some young people are being brought up in a home environment where crime is normalised. The need for parenting programmes that provide practical support to parents was highlighted.

Adult and child safeguarding: common issues

Like YOT thresholds, the review highlighted that thresholds set by Adult and Children Safeguarding teams for a statutory intervention were often too high. 'Cuckooing' is a

common feature of county lines activity where the home of a vulnerable adult is taken over by the gang from which to sell drugs. However, if the adult is said to have capacity to make their own decisions (and is not suffering from a recognisable/diagnosed mental health condition or learning disability) services felt they could not or would not take further steps unless to move to eviction proceedings.

There was a growing view that this issue of capacity needed to be re-examined in cases of 'cuckooing' and that legislation covering 'coercive control' could be used when deciding what powers or tools could be employed to safeguard vulnerable adults.

Housing support services were felt to have been reduced and whilst in the past gangs would be deterred by professionals' regular visits to properties, it was reported that gangs now felt able to control properties with impunity.

The safeguarding of children and young people involved in county lines was felt to be challenging as statutory safeguarding systems were designed to protect children within a domestic setting not county lines context. Children's social care practitioners reported that the interpretation of current child protection policy does not allow workers to accept cases on the sole basis of debt enslavement and entrapment. In consequence, referrals to agencies where young people were showing signs of involvement in criminal exploitation are often not accepted and there was a need to re-examine what constitutes 'neglect' for this cohort of young people.

Furthermore the evidence review identified a tendency of statutory safeguarding agencies to view (particularly in the case of boys), young people's behaviour as a sign of criminality or lifestyle choice rather than as evidence of a vulnerable child who needs protection from exploitation.

There has been a call for a new type of power to manage/protect young people caught up in 'county lines': an urgent need to explore a type of *Child Criminal Exploitation Protection Order*.

Financial Exploitation

There is evidence that there is a new dimension of financial exploitation where young people have their bank accounts controlled for the purpose of laundering money earnt by the gang from drug dealing. The report identified reports from the reviews that large sums of money being deposited into children's bank accounts had alerted agencies to the presence of gangs in children's lives. This highlights the need to undertake prevention strategies that work with financial institutions and police fraud services.

Local Intelligence on County Lines Activity

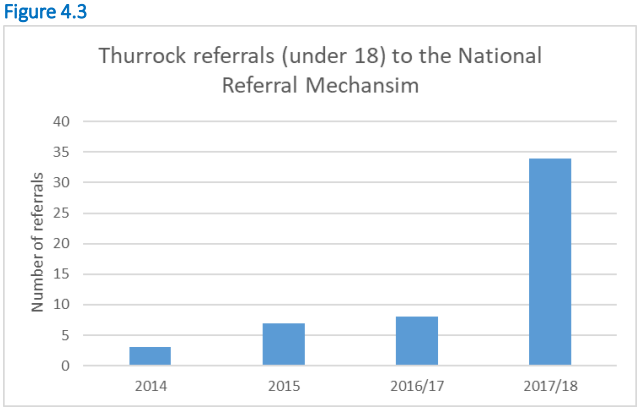
The emerging and covert nature of County Lines activity and the fact that recording of Child Criminal Exploitation is relatively recent makes accurately ascertaining the true extent and impact of County Lines locally difficult. However, there are a couple of sources of intelligence:

National Referral Mechanism (NRM) Data

The National Referral Mechanism (NRM) is a process set up the central government to identify and support victims of modern day slavery trafficking in the UK and also the mechanism through which the *Modern Slavery and Human Trafficking Unit (MSHTU)* collects data about victims. As such, victims of child criminal exploitation through County Lines would be eligible for referral to the NRM, although referrals would also encompass other forms of modern day slavery (for example, domestic servitude). This information aims to help build a clearer picture about the scope of human trafficking gin the UK. A range of 'first responder' agencies can refer both adults and children/young people aged under 18 to the NRM. These include UK Police forces, local authorities, Home Office Immigration enforcement and a number of third sector organisations specialist in safeguarding adults and children, e.g. Barnardo's and the Salvation Army.

Figure 4.3 shows a rapid increase in the number of under 18 referrals to the NRM from Thurrock between 2014 and 2017/18. In 2017/18, 11 of the 34 referrals were for criminal exploitation and nine of these related to exploitation for drug dealing, suggesting an increasing issue of child criminal exploitation due to County Lines activity in Thurrock.

Figure 4.3



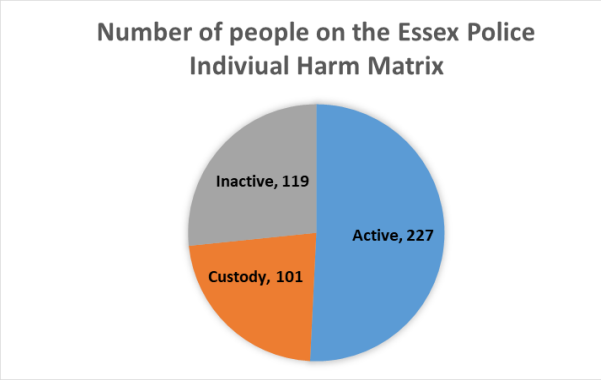
Essex Police Gangs and County Lines Thematic Assessment

In 2018-19, Essex Police published a thematic assessment on Gangs and County Lines activity[37]. Essex Police maintain an *Individual Harm Matrix* that is a list of individuals who meet the following criteria:

- The person shows a level of loyalty to a gang or county line
- The person has links to Essex within the last six months.
- The person is not part of an Essex Organised Crime Group
- The person is a willing participant (not a victim or vulnerable person).

Figure 4.4 shows the number of people on the Individual Harm Matrix in 2018/19.

Figure 4.4



Police Intelligence suggests that the 227 active individuals represent 58 different gangs and 49 different County Lines. Their average age was 23. The Matrix scores gangs and county lines on drugs and violence to allow analysts to produce tables showing those groups potentially posing the greatest risk in Essex. It is maintained by the Essex Police Gangs and County Lines Analysts and takes information from two key places:

- The Essex Individual Harm Matrix (scoring on violence and/or drugs)
- Athena Intelligence about gangs or county lines

The thematic assessment suggests that 20 county lines are operating Essex, three of which operate in the West Local Policing Area which encompasses Thurrock. These are ranked 7th, 10th, and 11th in terms of overall harm of all county lines operating in Essex.

Chapter 5: Illicit Drugs and their connection to youth and gang violence

Key Findings

There is a rising trend in opiate and crack cocaine use in those aged between 15 and 64 in Thurrock between 2010/11 and 2016/17. The estimated number of crack cocaine users in Thurrock has more than doubled over the past five years and this increase and that for the estimated numbers of users of both crack cocaine and opiates is statistically significant. Estimated number of young people aged 15-24 in Thurrock using crack cocaine also rose sharply between 2010/11 and 2016/17 with estimated numbers in 2016/17 being more than twice those of 2010/11, however numbers of opiate users in this age group have fallen slightly and numbers of dual users remain similar to 2010/11 baseline. The reasons behind the increase in crack cocaine use are unclear but one explanation could be increased availability through County Lines activity.

There has been a significant drop in the number of service users accessing the service for drug treatment in the age group 18 to 29 since a peak in 2015/16. The reasons for this are unclear but do not relate to a lack of treatment places being available. A reduction in numbers of residents accessing treatment coupled with an increase in the prevalence of crack-cocaine use amongst the population has a resulted in a significant drop in the proportion of both opiate and crack cocaine users in treatment. The public health consequences of a rising prevalence of crack cocaine use in Thurrock and a drop of the proportion of users in treatment are serious, both for the users themselves and more widely for the community. Crack cocaine use significantly increases the risk of serious physical and mental health conditions and is associated with increased crime. This drop in the 'reach' of drug and alcohol treatment services into the cohort of residents who are users warrants further investigation and action to reverse the trend.

The association between drug use and crime is complex and multi-directional. There is evidence that crime leads to drug use, drug use leads to crime and that both crime and drug use have other common causes including wider socio-familial factors. Thurrock Youth Offending Service (YOS) data suggests a rising trend in young people committing Class A drugs related offences in Thurrock both in terms of possession and supply although the absolute numbers remain small. Black young men are very significantly over-represented in the cohort of offenders dealt with by Thurrock YOS for offences relating to the supply of Class A drugs. The reasons for this are unclear and likely to be complex, but this cohort also tend to differ from the majority of young people who access YOS in the sense that they have multiple records of repeat offending. Further work is required to understand and implement a more effective approach with this cohort to assist and deter them from reoffending.

Introduction

This chapter discusses illegal drug misuse in Thurrock and its connection to youth and gang violence. The previous chapter highlighted the intrinsic connection of County Lines activity with the illegal drug trade. This chapter includes analyses of the estimated prevalence of drug use and the success of our drug treatment services.

Prevalence of drug users in Thurrock

The illicit nature of drug taking makes it difficult to estimate accurately the number of drug users in Thurrock particularly in young people. We do however have Public Health England commissioned synthetic estimates, produced by Liverpool John Moores University[38] for the estimated number of opiate, crack cocaine and dual opiate/crack cocaine users in our local population. The modelled prevalence of these two specific drugs are useful as they are the ones most associated with gangs, violence and County Lines activity.

The modelled estimates are derived by identifying from the published evidence base, the population factors linked to an increased risk of drug taking and local drug and alcohol service data and then applying them through statistical models to local populations. However the estimated numbers of users produced through the modelling have wide confidence intervals (the range of estimated values that the model is 95% confident that the true figure lies within).

Figures 5.1 to 5.3 show the estimated number of opiate, crack cocaine and dual crack cocaine and opiate users aged 15-64 in Thurrock from 2010/11 to 2016/17 respectively. Note that no modelled figures were produced for 2016/16.

Each graph shows an increasing trend in the prevalence of drug users in Thurrock. Whilst the increase is not statistically significant for opiate users, Figures Y and Z show statistically significantly greater prevalence of crack cocaine and crack cocaine/opiate users in 2016/17 compared to 2010/11 baselines.

Figure 5.1

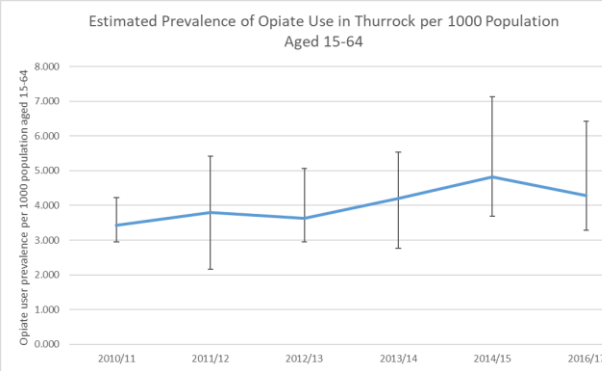


Figure 5.2

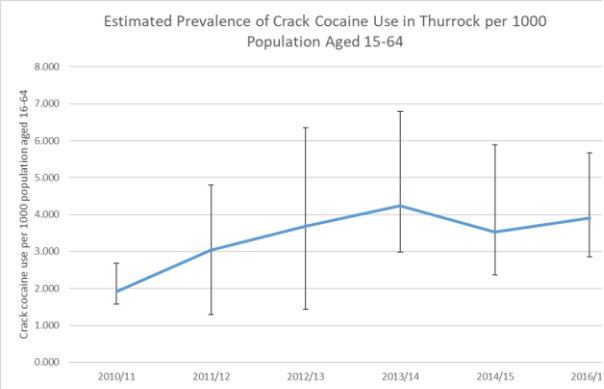
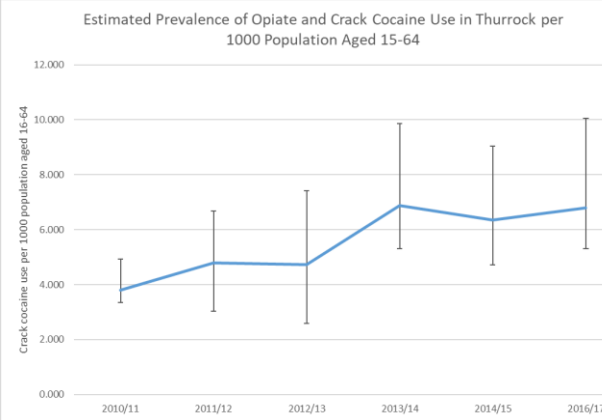


Figure 5.3



Figures 5.4 to 5.6 show the absolute estimated numbers of opiate, crack cocaine and dual Opiate/Crack Cocaine users in Thurrock respectively, from 2010/11 to 2016/17 (note no data was produced for 2015/16.

Figure 5.4

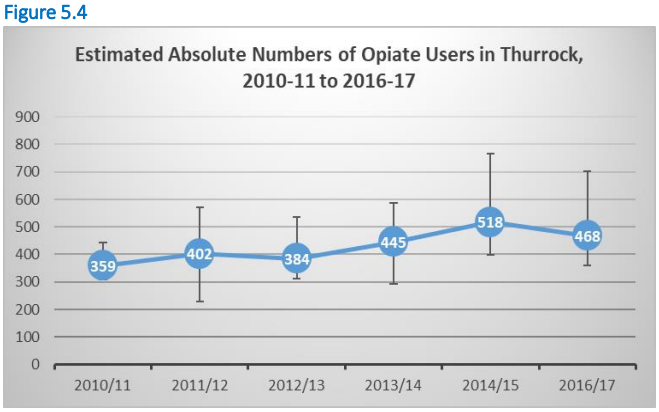


Figure 5.5

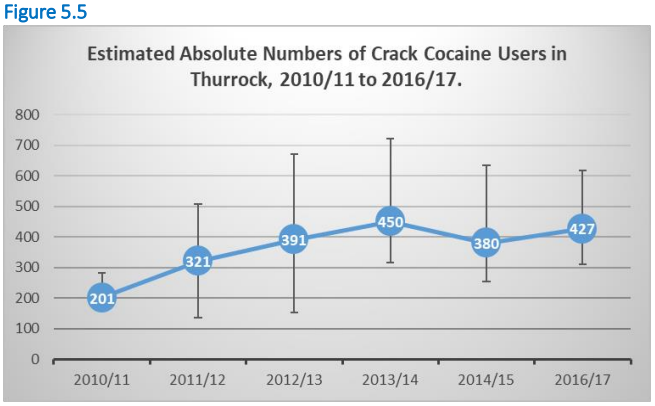
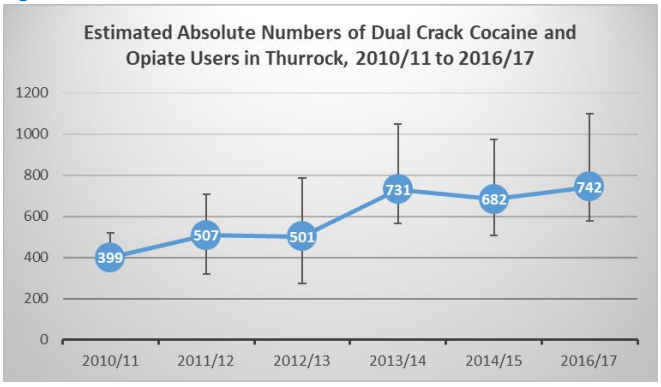


Figure 5.6



Figures 5.3 to 5.6 highlight the scale of the increase in users of opiates and crack cocaine in Thurrock over the last seven years. The absolute number of crack cocaine users is estimated to have more than doubled and the increase is statistically significant despite the wide confidence intervals of the modelling methodology. The number of residents using both crack cocaine and opiates has increased by 86%.

The local increase mirrors national trends. PHE found a statistically significant increase in the number of crack cocaine users in England between 2011/12 and 2016/17 and a 19% increase in the number of adults starting treatment for crack cocaine between 2015/16 and 2017/18.[39]

Prevalence estimates by age

Figures 5.7 and 5.8 (overleaf) show the estimated prevalence and estimated absolute of opiate and crack cocaine users in

Thurrock aged 15-24 between 2010/11 and 2016/17. (No modelled data is available for 2015/16).

Figure 5.7

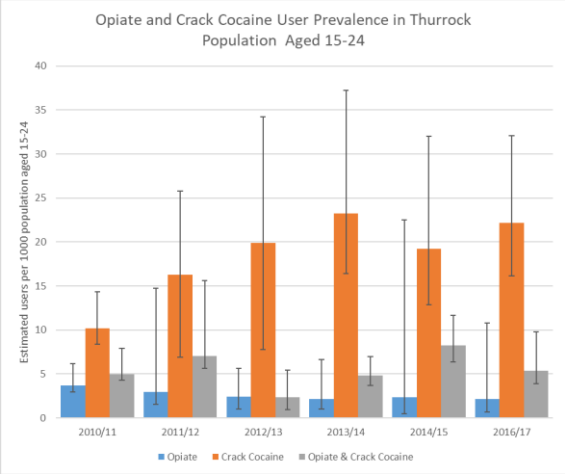
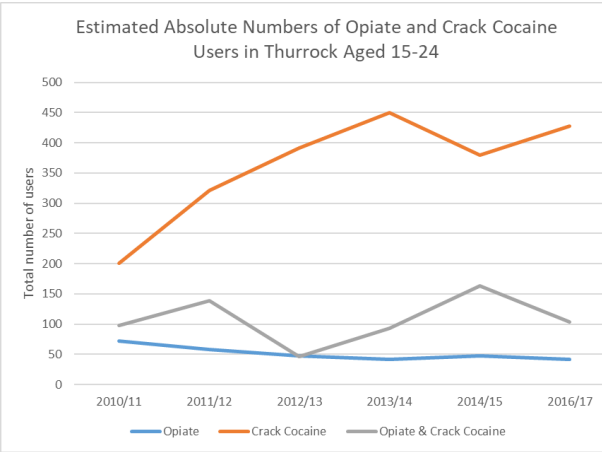


Figure 5.8



Whilst prevalence and overall numbers of young people have fallen, both prevalence and overall numbers of young people using crack cocaine has risen and the rate and numbers is statistically significantly greater in 2013/14 and 2016/17 compared to 2010/11 baseline. The drop in prevalence and numbers of crack cocaine users in 2014/15 compared to 2013/14 corresponds with an increase in use of both drugs in 2014/15 although this trend appears to have reversed again in 2016/17.

Impacts of drug misuse

The reasons behind these increases are unclear, but one explanation could be an increased availability of crack cocaine in Thurrock through County Lines or other drug dealing activity, as discussed in Chapter 3. Qualitative research by PHE identified that crack sales in the UK were being increased through aggressive marketing of the drug by dealers, particularly to existing heroin users.[39]

The public health impacts increasing numbers of crack cocaine and opiate users are serious. Addiction to crack cocaine and heroin has a devastating impact on an individual, their family and the wider community and places additional financial and operation burdens on public services.

Crack cocaine

Crack cocaine is a strong stimulant and one of the most destructive drugs on the market and can cause dependence within the first few uses. One of the problems with crack cocaine is that the effects last a very short time whilst leaving the user with intense cravings for more of the drug. Within fifteen minutes the addict needs to smoke another rock of the drug.

The stimulant effects of crack cocaine places severe stresses on the heart, vascular system increasing the risk of arrhythmias, myocardial infarction (heart attack) and cardiomyopathy and strokes.[40] [41] [42] Smoking crack cocaine damages the lungs causing a range of pulmonary conditions and can cause pulmonary failure[43] and causes neurological damage to the brain including cerebral atrophy[44] and seizures[45] [46] [47]

Psychologically the crack user becomes paranoid, defensive, confused and depressed. Crack cocaine use is strongly associated with psychiatric comorbidities including personality disorders,[48] [49] [50] post-traumatic stress disorder[51] [52] and depressive disorders. [53] [54]

Heroin

Heroin in the most commonly abused opiate. Repeated heroin use changes the physical structure (13) and physiology of the brain, creating long-term imbalances in neuronal and hormonal systems that are not easily reversed. [55] [56] The brain's white matter deteriorates in heroin users negatively impacting on decision making abilities and responses to stress.[57] [58] [59] Heroin also produces profound degrees of tolerance and physical dependency meaning that the user needs to take more and more of the drug to achieve the same effect and experiences very unpleasant physical withdrawal symptoms if drug taking is stopped or reduced abruptly. Chronic heroin use results in *heroin use disorder*; a chronic, relapsing disease characterised by uncontrollable drug-seeking, no matter what the consequences.[60]

No matter how they ingest the drug, chronic heroin users experience a variety of medical complications including insomnia, constipation, lung complications including pneumonia and tuberculosis, depression and anti-social personality disorder. Medical consequences of chronic injection of the drug include scarred or collapsed veins, bacterial infection in the blood vessels. Sharing of needles increases the risk of blood-borne virus infection including hepatitis B and C and HIV.[61]

The link between drugs and crime

There is undeniably a strong association between illicit drug use and criminal activity which is consistent across much of the empirical literature. However this association is also

complex and non-universal and various researchers have argued over its causal direction and association with other possible causal factors [62]

Drug use leads to crime

A number of researchers have suggested that psychopharmacological, economic motivation and systemic theory may cause drug users to commit crime.

Psychopharmacological theory asserts that the intoxicating effect of drugs makes users more likely to commit crime.[63] For example, one study identified that 34% of police detainees were under the influence of an illegal drug whilst they committed the offence and other found that 52.8% of robberies were committed by offenders who were already intoxicated through drugs with a further 5.7% suffering withdrawal effects.[64]

The economic motivation theory asserts that drug users are compelled to commit crime in order to fund their drug habit, with many studies concluding this phenomenon particularly in relation to property crime, shoplifting and street robbery. [65] [66] [67]

Systemic theory suggests that the offender's engagement in the illegal drugs market exposes them to other offenders including organised crime gangs and these associations increase their risk of becoming involved in crime themselves.[68]

Crime leads to drug use

Some researchers have suggested that offenders are more likely to become illegal drug users. Thus, individuals who are deviant are more likely to be involved or choose social situations where drug use condoned or encouraged. This theory may arise when deviant individuals use drugs to self-medicate or to provide and excuse to commit deviant or criminal acts or that income from criminal acts providing additional income enables the offender to purchase drugs. [62]

Crime and drug use have another common cause

This third theory suggests that crime and drug use are not causally linked to each other but share another causal variable. Researchers have suggested that a range of both social and family circumstances appear to be influences on young people's risk of becoming involved in both crime and drug use. When risk factors for both outweigh protective factors, a young person is more likely to both become involved in crime and take illegal drugs. [69] [70] (See Chapters 6 and 7 for further discussion on risk and protective factors).

In reality, all of the above theories may be correct or hold true for different sections of the population, although the economic motivation theory whereby the offender is motivated to commit crime to fund a drug addiction where other economic means are lacking probably has the strongest research base behind it.

Youth Offending Service Data

As discussed in Chapter 2, Thurrock Council's Youth Offending Service (YOS) records data on all crimes committed by young people that they work with. All the young people have had some form of statutory outcome, either pre-court or through the courts. As such we can assume that in every case, they have been convicted of the crime and/or admitted guilt.

We categorised all drugs related offences recorded by the youth service into four categories;

1. Supply (including attempt to supply or possession with intent to supply) of a Class A drug
2. Supply (including attempt to supply or possession with intent to supply) of a Class B drug
3. Possession of a Class A drug
4. Possession of Class B drug

Class A drugs are of interest because crack cocaine and heroin are most strongly associated with gang violence and county lines activity. Cannabis is also of interest as the evidence base and local analyses on risk factors (Chapter 6) identified availability of/exposure to cannabis as a risk factor for a young person becoming involved in serious youth violence and gangs.

Figures 5.9 and 5.10 show the number of recorded offences on the YOS database for possession and supply of Class A and Class B drugs between 2014/15 and 2018/19

Figure 5.9

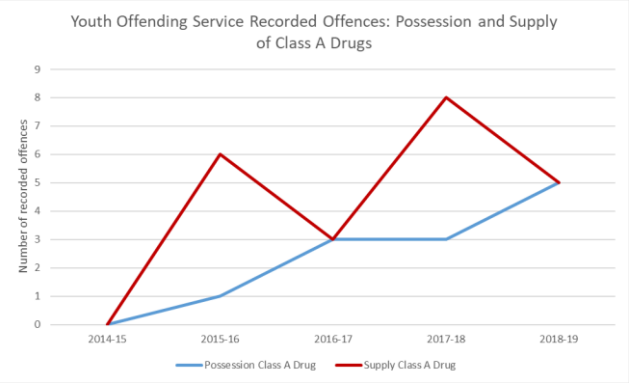
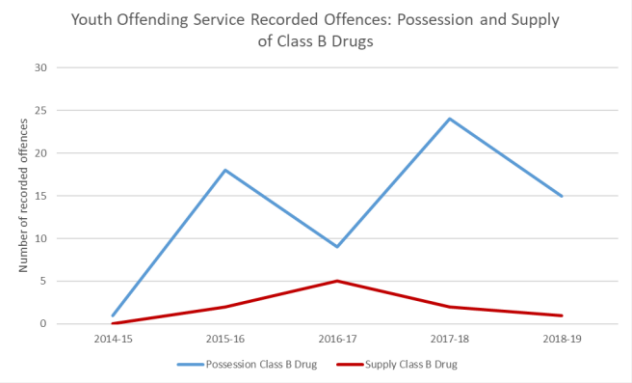


Figure 5.10



There has been an increasing trend in offences recorded on the YOS database for both possession and supply of class A drugs although the overall number of offences remains relatively small. This corresponds with the increasing trend in opiate and crack cocaine users aged 15-24 in Thurrock over the same period.

For class B drugs (likely to be overwhelmingly cannabis), there has also been an increasing trend in possession offences but offences for supply remain very low.

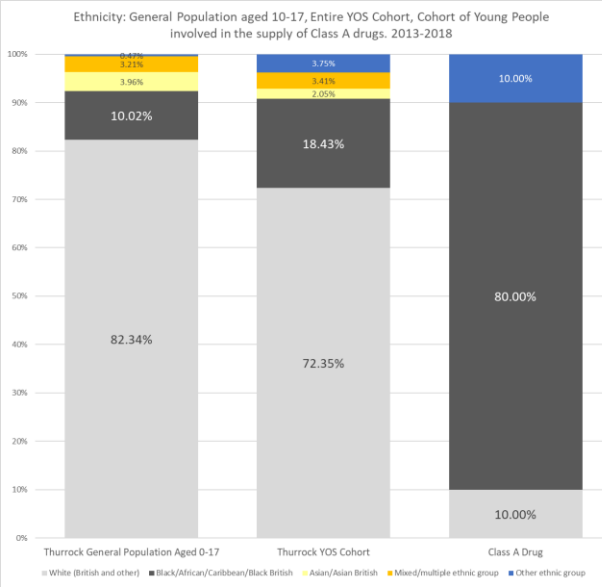
The vast majority of offenders were male with females only committing four drugs recorded offences over the past five years.

Connection between youth violence, gangs and drugs.

Without a single linked data set between YOS, drug treatment services and police data it is difficult to analyse definitively the connection between drugs offences recorded by YOS and youth violence/gang involvement. However, given that supply of crack cocaine and heroin is strongly associated with gang involvement and violence we undertook a detailed analyses of youth offenders involved in the supply of class A drugs.

In total only 10 offenders were responsible for the 22 offences recorded on the YOS database which we categorised as 'Supply of Class A'. All were male with an mean age of 16.3 and a median age of 16 years old. We conducted a detailed analysis of the ethnicity of the cohort of offenders involved in the supply of class A drugs that the YOS worked with. (Figure A)

Figure 5.11



Black African/Caribbean and Black British males are heavily over represented in this cohort of offenders, with 80% belonging to this ethnic group compared with 18.4% in the entire cohort of young people that YOS has worked with over the last five years and just 10% of the Thurrock population of young people. The reasons behind this are unclear.

All ten offenders had committed multiple offences with the mean number of recorded offences being 6.8 and the median being 7. This offending pattern is greater than that of all recorded offenders on the YOS data base where the mean number offences committed was 3.55 and the median was 2. 70% of the cohort this cohort were also recorded as having committed one or more violence against the person offences.

In an attempt to better understand the offending behaviour and success of the response of the criminal justice system to it for these 10 offenders, we created ten offending histories which map each offence committed and the intervention made by the system in response in chronological order. The 'x' (horizontal) axis shows the numbers of days elapsed since the first offence was committed. These are shown in figures 5.12 to 5.21 overleaf. It is worth remembering that these histories represent only offences dealt with through YOS. Each offender may have committed other offences that we do not know about and are therefore not recorded.

Figure 5.12

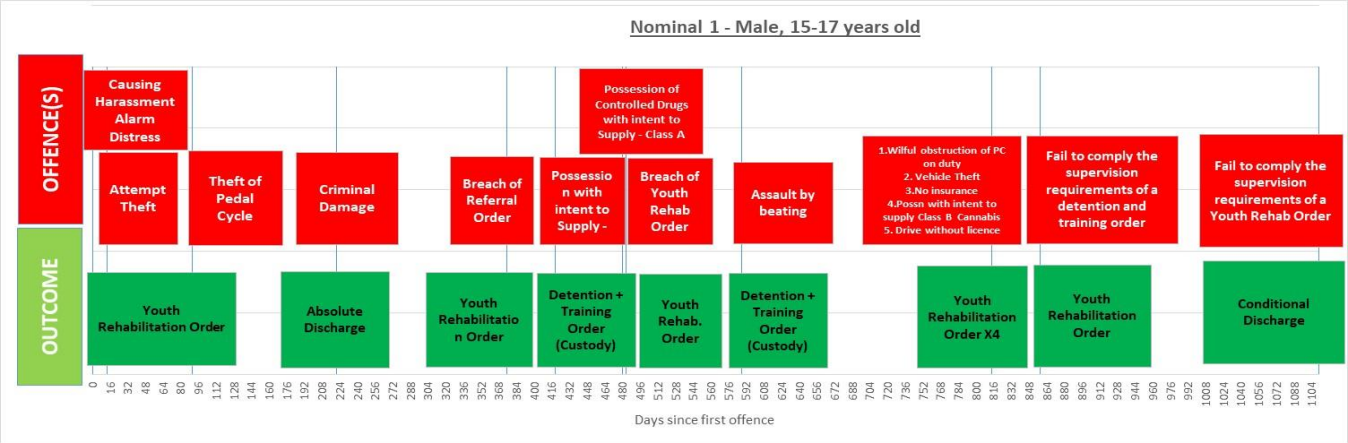


Figure 5.13

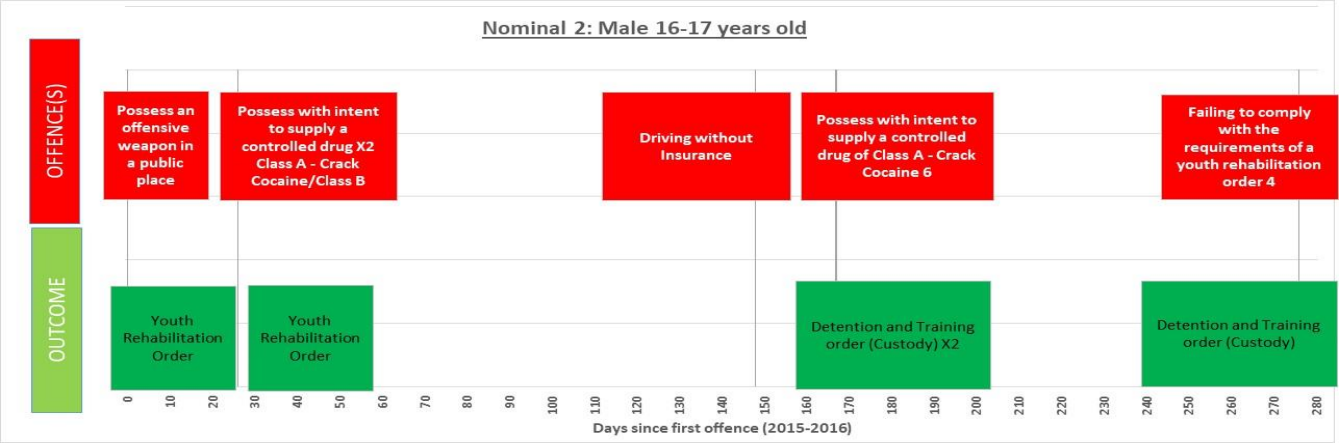


Figure 5.14

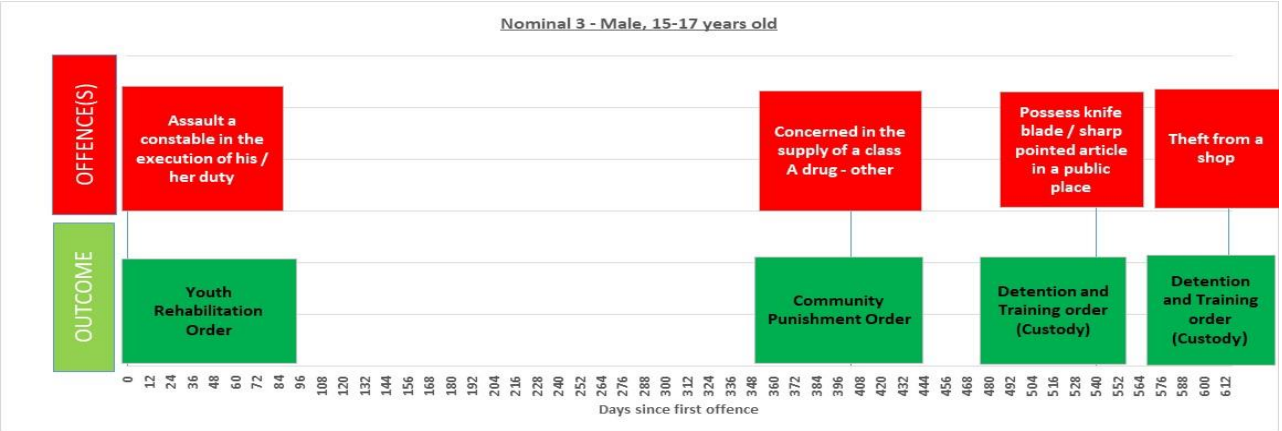


Figure 5.15

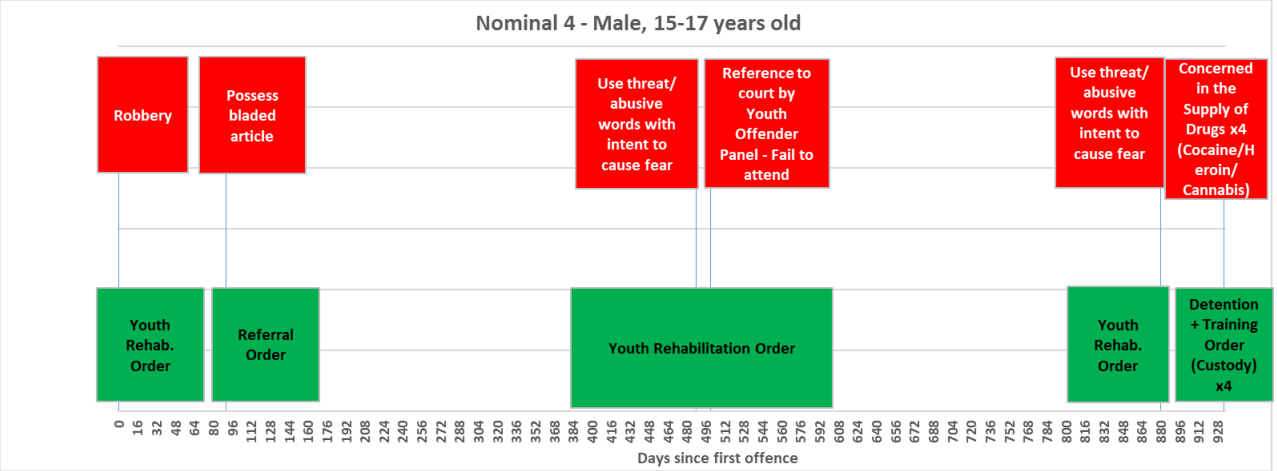


Figure 5.16

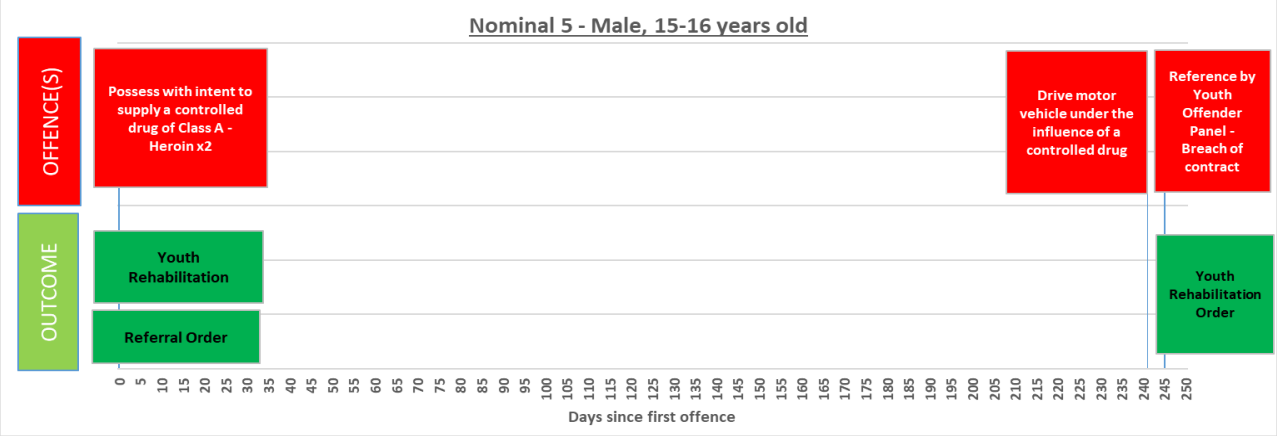


Figure 5.17

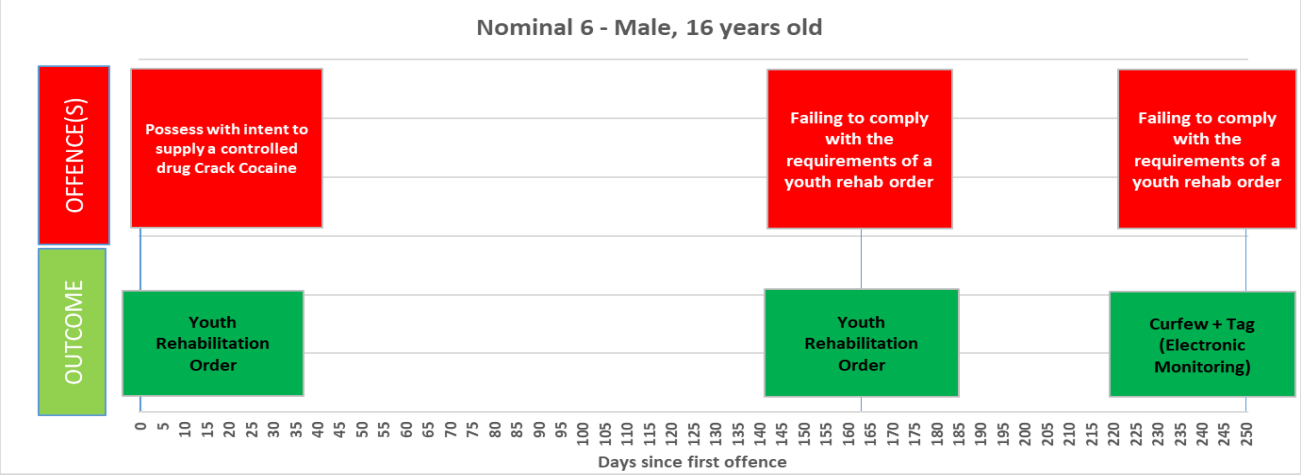


Figure 5.18

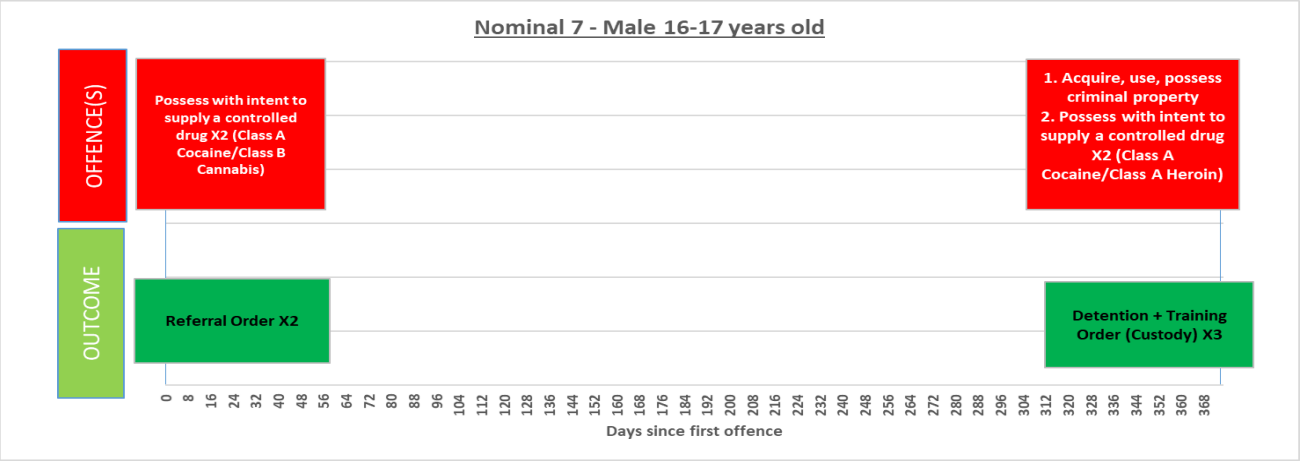


Figure 5.19

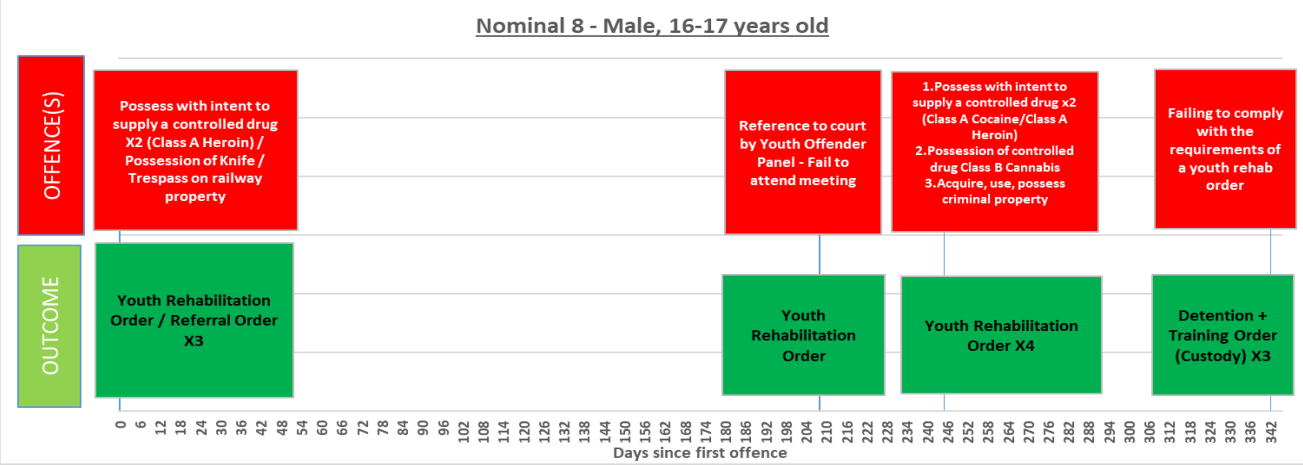


Figure 5.20

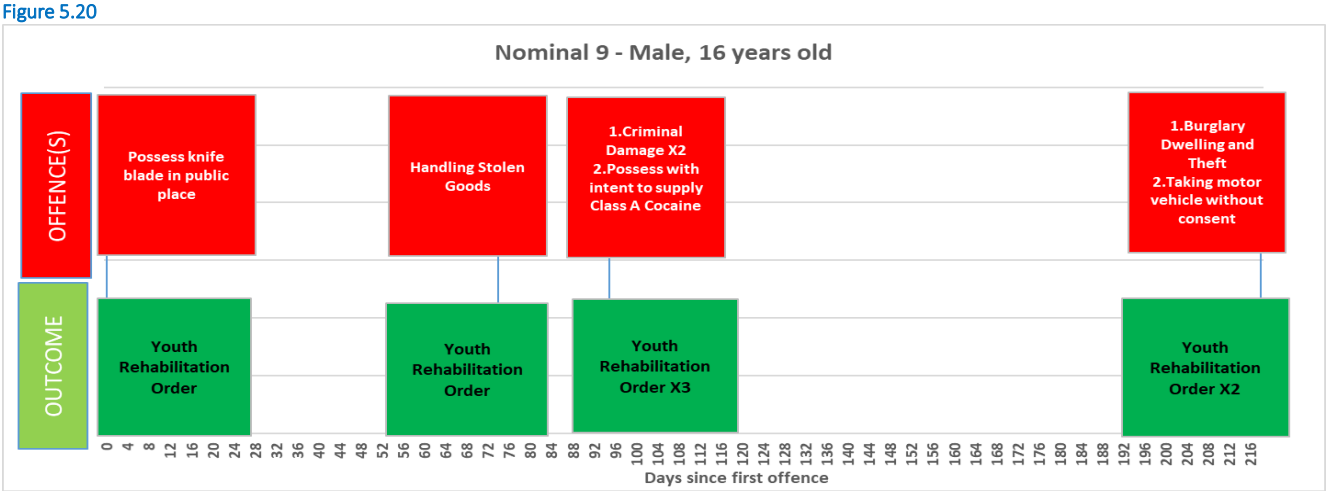
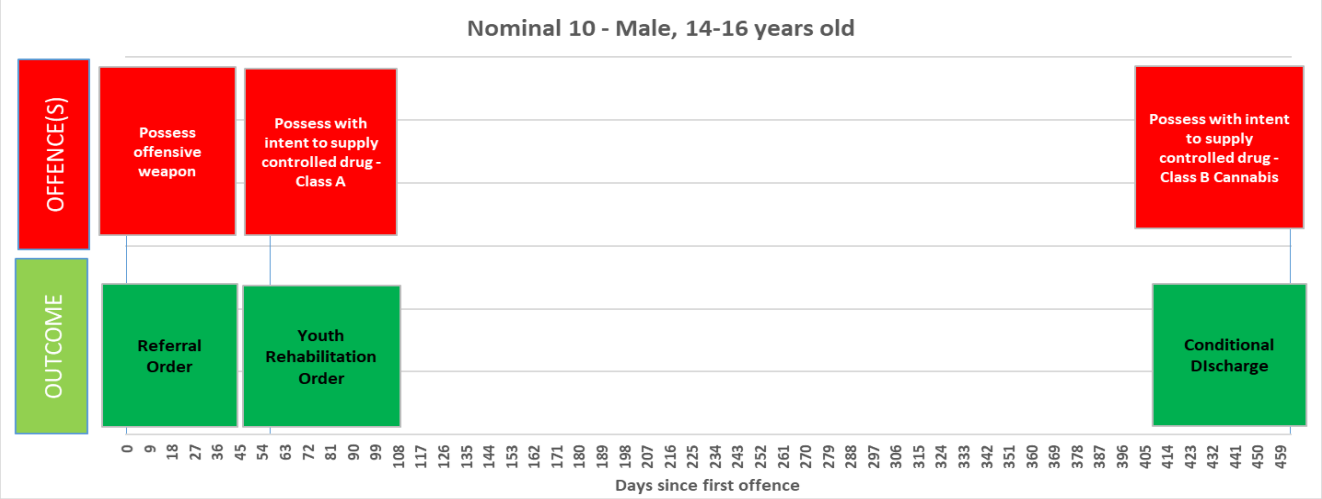


Figure 5.21



What is striking when reading these ten offending histories is that the system interventions have largely been unsuccessful in changing offending behaviour. Youth rehabilitation orders are the most common outcome listed and yet repeatedly this cohort of offenders go on to commit other offences, often serious and also including failure to comply with the original rehabilitation order.

The persistent offending behaviour differentiates them from most young people who commit offences in Thurrock and are dealt with by the Thurrock YOS. Over the entirety of the cohort that YOS has worked with in the past five years; 59.2% of young people did not reoffend and another 4.3% only offended one more time.

Drug Addiction Treatment Services in Thurrock

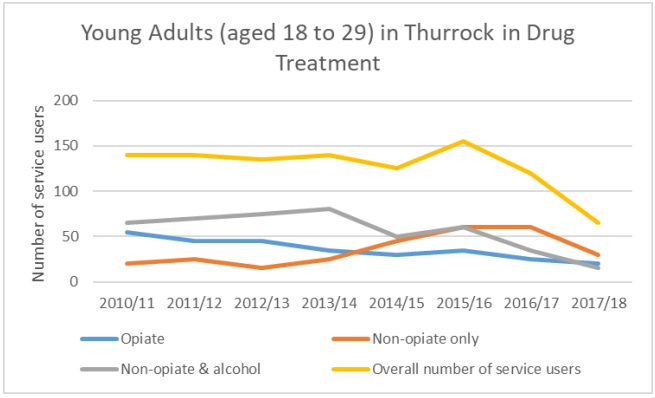
Drug treatment services in Thurrock are commissioned by Thurrock Council from the Public Health Grant and provided by *Inclusion Thurrock* for adults (aged 18+) and *CGL Wise Up* for Children and Young People. As such, the cohort residents that this report discussed (young people aged 11 to 25) are seen by both providers.

Data for adults in drug treatment in Thurrock was analysed from the National Drug Treatment Monitoring System (NDTMS). This categories adults into three age bands; 18-29, 30-39 and 40-64.

Young adults in treatment

Figure 5.22 shows the numbers of young adults (aged 18-29 in treatment for drug problems in Thurrock from 2010/11 to 2017-18, for opiates, non-opiates only, no opiates and alcohol and overall.

Figure 5.22



There has been a significant drop in the number of service users accessing the service for drug treatment in the age group 18 to 29 since a peak in 2015/16. The reasons for this are unclear as treatment places are available for any young adult that wishes to access the service. Regrettably the 18-29 age banding used by NTDMS does not correspond with the 15-25 age band used by Liverpool John Moores University to produce drug user prevalence estimates and so a direct comparison between trends in drug use prevalence and treatment is not possible for different age groups in Thurrock. However, it is worth noting that the rise in estimated prevalence of crack cocaine use in the 15-25 year old age group does not correspond with the trend in treatment access for non-opiate drugs in the 18-29 year old age group. This could mean that there are more young adults that remain untreated for non-opiate addiction than in previous years.

Figure 5.23 demonstrates the 'reach' of drug treatment services into the drug using population by showing the percentage of estimated of drug users in treatment. All ages between 15 and 64 are shown due to restrictions that differing age bands between prevalence estimates and treatment services place on more granular analyses.

For the all age cohort of residents, it can be seen that there a downward trend in the estimated percentage of drug users in treatment for opiate, crack cocaine and dual use

opiate/crack cocaine between 2011/12 and 2016/17. This mirrors a trend nationally and in Essex, the East of England although figures for the percentage of drug users in Thurrock are lower than national and regional figures and similar to Essex (data not shown on graph). The drop in crack cocaine users in treatment is particularly large (from just under 55% in 2010/11 to just under 25% in 2016/17). Again, the reasons for this drop are unclear and do not reflect any change in commissioning practice suggesting a genuine drop in demand. This could reflect a change in demographic profile or other factors in the lives of crack cocaine users. It is however worrying from a public health point of view, meaning that there are a greater proportion of untreated drug users risking their own health and possibly harming their families and wider society.

Figure 5.23

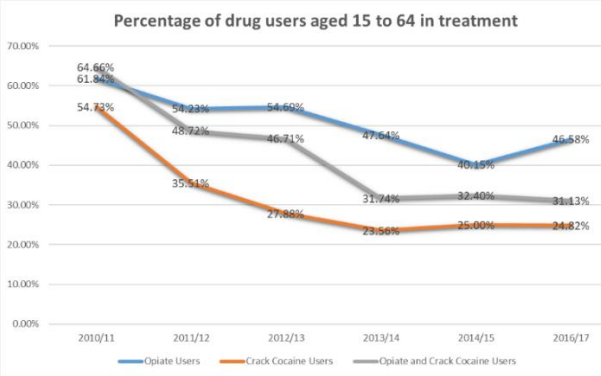
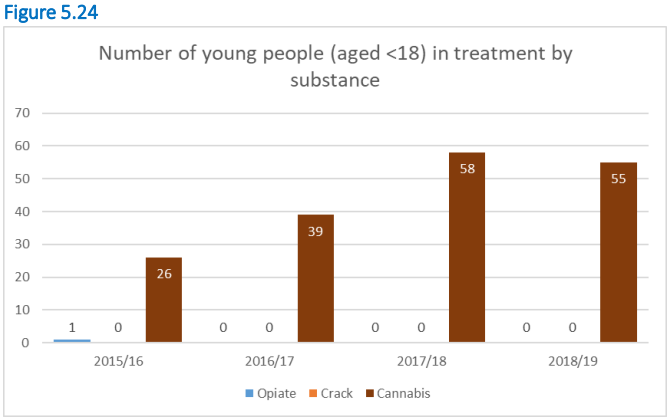


Figure 5.24 shows the numbers of young people (aged under 18) accessing the Thurrock Young People's drug treatment service from 2015/16 to 2018/19

Figure 5.24



Unlike young adults (aged 18-29) the trend in access of young people under the age of 18 is increasing (albeit with a slight reduction from 2017/18 to 2018/19. With the exception of a single opiate user in 2015/16 all drug treatment for those aged under 18 was for cannabis. This would suggest either that the estimated prevalence and absolute numbers of opiate and crack cocaine users in the 15-25 age group relate mainly to young people over the age of 18 and/or that they are not accessing treatment.

We do not have estimated prevalence models for cannabis use so we are unable to ascertain the 'reach' of commissioned young people's drug treatment services into the population of young people using cannabis. The rising trend in treatment access could suggest a rising underlying prevalence in cannabis use, and/or are greater willingness of young people using cannabis to seek help.

Although sometimes portrayed by some in the media as a less 'innocuous' drug, cannabis use in young people remains highly concerning in public health terms, particularly as there is national evidence base that the strength of street cannabis has increased significantly over the past decade and is now often the highly potent 'skunk' form.

Chapter 6: Risk Factors (Vulnerabilities) for Violence and Gang Involvement in Young People

Key Findings

The published evidence base suggests a range of risk factors that are associated with youth violence and gang membership. These can be grouped under five categories of Individual, Family, School, Peer Group and Community. Different risk factors are important at different ages. The largest group of risk factors most strongly associated with youth violence fall in the 'individual category' and include cognitive-behavioural issues such as aggression, conduct disorder, running away and truancy, anti-social behaviour, low self-esteem and high psychopathic features. Disrupted family and poor family supervision, low commitment to school/school exclusion and poor relationships with peers/delinquent peers were also identified as strong risk factors for youth violence. Highly associated risk factors for gang membership include anger/aggression traits, low academic achievement, learning disability, association with delinquent/gang involved peers, living in a neighbourhood with many troubled use and cannabis availability within the neighbourhood. There is increasing evidence that social media is associated with youth violence and gang membership including the use of 'drill music' videos to glamorise gang lifestyle/drug dealing and violence, live broadcasting of violence and anti-police messages. Evidence suggests that the issue is largely hidden from adults who are often unaware what their children are viewing.

An associated risk factor cannot be claimed to be 'causal'. Despite often being cited by the media and politicians as a risk, poverty and deprivation are very poor predictors of crime in general and youth violence in particular both from national and local data. Whilst the majority of criminals come from deprived backgrounds, the vast majority of the population who live in deprived communities do not commit crime or violent crime. This is known as 'the crime paradox'. Longitudinal research demonstrated two causal variables for serious youth offending:

1. Exposure to a criminogenic environment which encompassed unsupervised time in city centre or other locations with low levels of social cohesion, and exposure to peers already involved in crime.
2. Developing an individual crime personality which encompassed low scores on standardised morality inventories and low scores on standardised self-control inventories.

Youth that scored highly on these two variables from both deprived and affluent backgrounds are much more likely to become prolific youth offenders whilst those who did not from both deprived and affluent backgrounds were not. The risk factors identified from the published evidence base can be mapped onto these two causal variables to explain the crime paradox.

Analyses using Thurrock's linked dataset provided by Xantura identified the following five risk factors as being the most significant associated and predictive factors for serious youth violence:

1. Previous Criminality or exposure to family/peers who commit crime
2. Substance Misuse, particularly availability of / use of drugs by others within the neighbourhood
3. Family dysfunction
4. Individual behavioural/cognitive factors including conduct disorder, aggression and troublesome behaviour
5. Being expelled or excluded from school or mainstream education.

Thurrock has high rates of fixed term Primary School exclusions compared to England but very low rates of fixed term secondary school exclusions. Rates of permanent primary and secondary school exclusions are generally in-line with England. There is a high variability of exclusion rates between different schools, with fixed term exclusion rates at the Pupil Referral Unit being exceptionally high. Further work to understand and address this variation is required. There may be opportunities to share best practice between schools to reduce exclusion rates.

Introduction

This chapter discusses the published evidence base on factors that increase the risk of young people committing violence and/or becoming involved in gangs. It is based on an evidence review commissioned by the Home Office[70] together with other published evidence. The Chapter also contains analyses on specific risk factors faced by Thurrock young people and their impact on increasing the risk of youth violence and gang membership.

A risk factor is defined as a variable that can usefully predict an increase in the likelihood that a young person will become involved in serious youth violence or gangs. It is important to remember that a predictive factor does not necessarily mean that the factor is *causal* in the development of violent behaviour or gang membership; simply that it is a reliable predictor of increased risk. For example, it cannot be said that low academic attainment *causes* a young person to become violent, simply that young people with low academic attainment are more likely to be

represented in the cohort of young people who participate in serious youth violence. Risk factors are grouped into five categories:

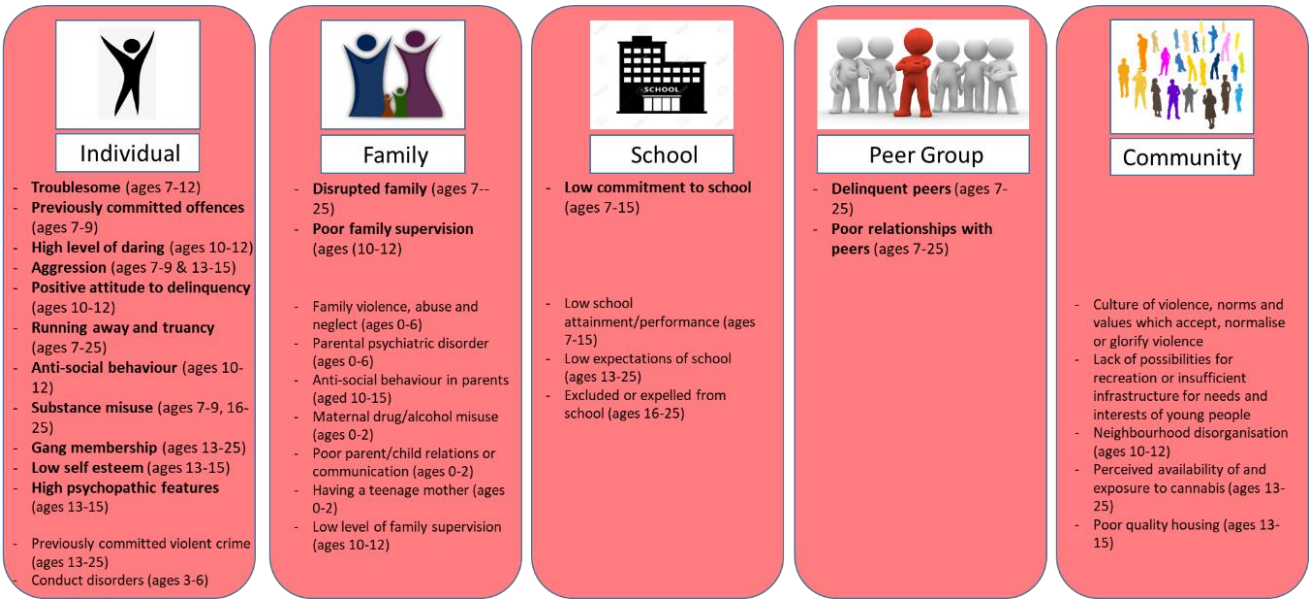
1) Individual
2) Family
3) School
4) Peer Group
5) Community/Society

Risk factors have a cumulative effect; that is, the greater the number of risk factors experienced by the youth, the greater the likelihood of involvement in youth violence or gang membership. For example, one study found that youth in Seattle possessing seven or more risk factors were 13 times more likely to join a gang compared to youth with one risk factor. [71]

Youth Violence

Figure 6.1 summarises the evidence base[72] [73] [74] [75] [76] [77] [78] [79] [80] [81] [82] [83] [84] [85]on risk factors for youth violence. Youth violence was defined as violence committed in a community or public space by a young person aged 25 or under. The factors with the strongest predictive value (a correlation coefficient greater than 0.3 and/or odds ratio greater than 2.5) are shown in bold.

Figure 6.1: Risk Factors for Serious Youth Violence



Across the majority of age categories, individual factors consistently represent the best predictors of youth violence. In particular, attributes such as aggression, risk taking and high psychopathic features such as a lack of guilt and high level of daring are strongly associated with risk of violent behaviour. Running away from home/truancy, misuse of drugs and committing previous criminal acts are also strongly correlated with serious violence.

Family related risk factors tend to be important in younger age groups but generally have a lower predictive value of serious violence, particularly as children age. The exception is 'living in a disrupted family' which was usually defined as the frequency with which children's primary care giver changes, which was an important risk factor up to age 25.

Peer related factors amongst young people aged 7 and above are also consistently found to be a strong predictor of youth violence. Factors predominantly relate to levels of peer delinquency, commitment to delinquent peers and poor relationships with peers.

School based factors also tended to have a lower positive predictive value than individual and peer based factors but included exclusion from school and low academic attainment.

Community and society factors generally have a lower level of predictive value for serious youth violence, however neighbourhood disorganisation, poor quality housing provision and available of/exposure to cannabis have been found to be associated.

Gang Involvement

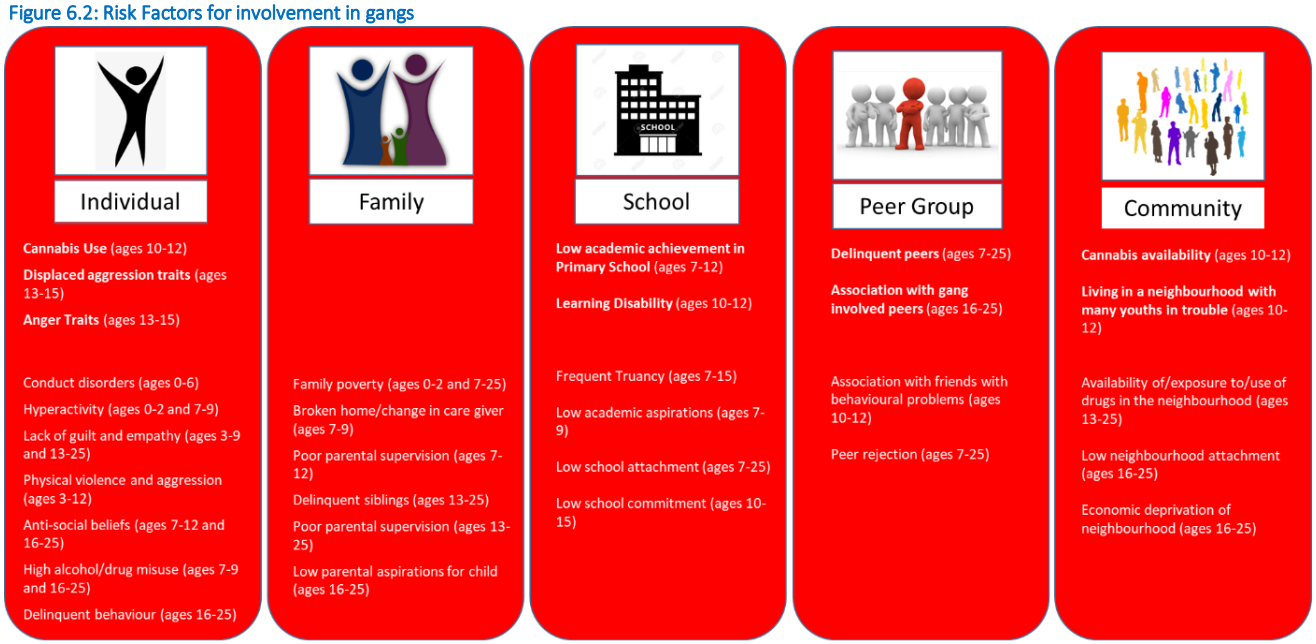
A gang was defined in the evidence search as 'a relatively durable, predominantly street-based group of young people who:

- See themselves (and are seen by others as a discernible group)
- Engage in criminal activity and violence and may;

- Lay claim over territory (this is not necessarily geographical territory but can include an illegal economy territory);
- Have some form of identifying structural feature;
- Be in conflict with other, similar gangs'

Far fewer studies have investigated risk factors associated with gang involvement compared to those that have investigated serious youth violence. Figure 6.2 summarises the evidence base [77 81 83 86 87 88 89 90]on risk factors of gang involvement by young people aged 25 and under. The strongest predictive factors (a correlation coefficient greater than 0.3 and/or odds ratio greater than 2.5) are again shown first in bold.

Figure 6.2: Risk Factors for involvement in gangs



As with studies investigating risk factors for serious youth violence, *individual factors* are often cited as the best predictors of gang membership. Attitudinal factors (particularly) aggression and anger traits are strong predictors together with anti-social beliefs and lack of guilt and empathy. Cannabis use at age 10-12 is the strongest behavioural predictive factor, although other behaviours including conduct disorder, physical violence and aggression and delinquent behaviour have also shown to be associated.

Family factors have been found to have a lower predictive value on gang involvement compared to individual factors but include family poverty, attitudes of parents including pro-violent attitudes and low aspiration for children, delinquent siblings, and changes in care givers.

Much like youth violence, school-based factors are generally associated with poor academic attainment, low commitment to school and truancy. One study identified that children with learning disabilities were particularly vulnerable to gang involvement.[77]

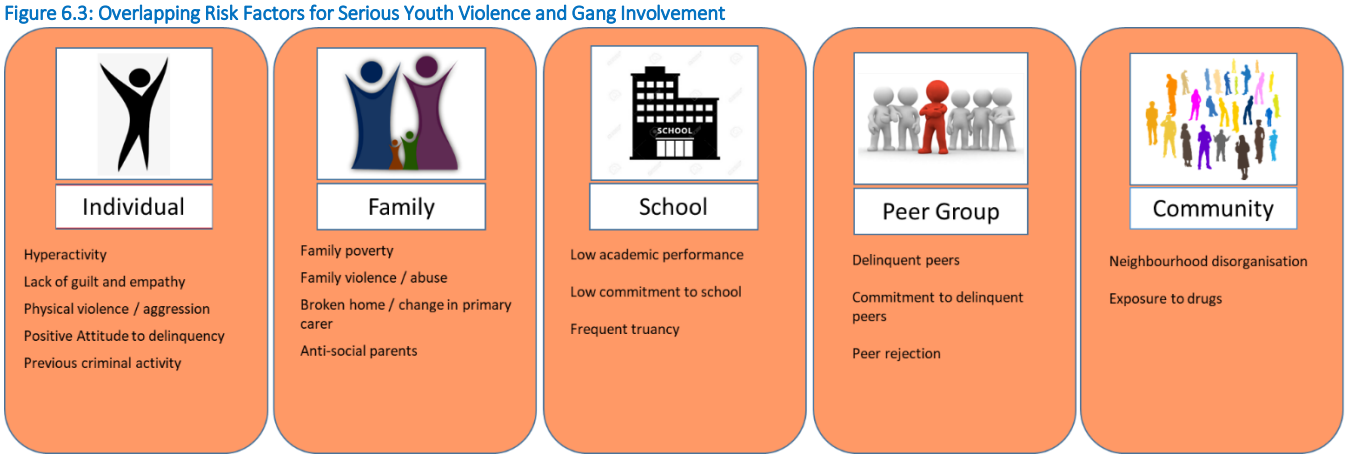
Peer relations have been found to be strongly correlated with gang membership. Both a connection with peers associated with problem behaviours and a commitment to delinquent peers are found to predict gang involvement.

While community/society factors are often included in studies of gang involvement, the majority of studies found a relatively weak association. Availability of cannabis and living in a neighbourhood where many other youths are in trouble were the only two risk factors with strong associations.

Overlapping risk factors

Figure 6.3 (overleaf) shows risk factors that have been identified for both serious youth violence and gang involvement. It is worth noting that not all risk factors shown were identified as strong predictors (i.e. a correlation coefficient greater than 0.3 and/or odds ratio greater than 2.5) for both gang involvement and serious youth violence

Figure 6.3: Overlapping Risk Factors for Serious Youth Violence and Gang Involvement



Social Media

Much has been written in the press about the link between social media and youth violence and gangs.[91] [92]

There is significant anecdotal evidence from law enforcement and youth offending professionals in the UK and US that disputes on social media can fuel and escalate youth violence, and of the link between 'Drill' music videos being used to glamorise gang membership, gang violence and material gain from drug dealing through gangs. However, the relatively recent emergence of this phenomenon means that robust published evidence on the topic is minimal. Dame Glenys Stacey, HM Chief Inspector of Probation in her 2017 report on UK Youth Offending Services concluded that in 25% of cases examined in her thematic inspection, there was a social-media component to the main offence, although the form varied widely. She reported gangs' use of social media to appeal to new members, stake their territory, and issue challenges and engage in provocation with other gangs.[93]

Researchers at University College London conducted a six-month analysis of the social media platforms *Twitter, YouTube, SnapChat, Instagram* and *Periscope*, together with focus groups and interviews with 20 front line professionals and an international review of the literature.[94] They made a number of concerning discoveries about the negative impact of social media on young people's risk for violence and gang membership including:

Anti-police. Social media content frequently depicted police officers in a negative and derogatory light which could lead to anger and resentment, and increased likelihood to commit crime and an increased difficulty for the police to be seen as legitimate

Music videos raising tension. 'Drill music' videos (a genre of rap music that originated in Chicago) were popular and often depicted displays of young people holding weapons, remarks about recent incidents of violence, explicit threats to stab or shoot specific individuals or groups and acted as a call to violence. Many examples were also identified of young people using social media to video and post themselves 'trespassing' onto other gang territory, stealing property associated with rival groups or taunting individuals or rival gangs.

Live broadcasting of violence. Numerous episodes of acts of serious violence being uploaded to social media were identified that led to further reprisals in real life and enhanced the fear and status of individual gangs and gang members.

A growing issue that is hidden from adults. Because social media is commonly perceived to be hidden from adults, a virtual 'free-for-all' space has emerged in which a minority of young people share various forms of material that both displays and incites serious violence in real life unchecked. The explosion in smart phone use and social media and the reported little oversight that parents and teachers have of children's use of it make this an unregulated and harmful space which can be accessed by millions of young people. Many professionals described current e-safety training as either non-existent or narrowly focused on online chat rooms and as such out of date.

School Exclusion

Much has been written in the media about the connection between being excluded from school and youth violence/gang membership.

There is significant evidence of an association between both fixed term or permanent exclusion and becoming either a victim or perpetrator of crime. One study found that 63% and 42% of prisoners stated that they had been temporarily or permanently excluded from school respectively.[95] Of 16 and 17 year old young offenders receiving a custodial

sentence in 2014, 39% had been permanently excluded from school prior to sentence.[96]

The 2019 Timpson Review on School Exclusion in the UK, commissioned by the Secretary of State for Education[97] found that parents, schools and other front line professionals highlighted that exclusion increased other risk factors a child may have of being drawn into crime and suggested that children who have been excluded may face additional vulnerability for exploitation by gangs, with gang membership temporarily fulfilling a sense of belonging that they crave after being asked to leave their school community. OfSted has also highlighted in its research into how London schools are dealing with knife crime that *"gangs know that once children have been excluded, they are much more vulnerable and easier to groom. Gangs are taking advantage of this by, for example, getting children to take a knife into school or break another rule which gets them permanently excluded."*[96]

However, evidence on a *causal link* between school exclusion and crime is minimal and complex. A study by the Ministry of Justice, which found that 85% of young knife possession offenders who had offended prior to the end of Key Stage 4 had received at least one fixed period exclusion from school at some point, and that 20% had received a permanent school exclusion. However it also reported that there was an approximate 50/50 split between those whose first exclusion was prior to the offence, and those who were excluded at some point after the offence. As such, existing criminal behaviour could be the cause not the result of school exclusion for some young people.[98]

Other risk factors already highlighted in this chapter may also be the underlying cause of both school exclusion and serious youth violence or gang membership. The OfSted report into knife crime amongst pupils in London found that the common denominator of pupils found carrying bladed objects into school was their vulnerability, whether that is poverty, abuse neglect, troubled families, or other factors that may lead to exclusion.Error! Bookmark not defined.

Despite the lack of hard evidence that school exclusion is a *causal* factor leading children into serious crime or gang membership, the risk factors associated with exclusion need to be minimised. Being in education, whatever form that takes is likely to be a protective factor for children against violence and gang membership. One study found that 83% of young knife crime offenders were persistently absent from education in at least one of the five years prior to the offence they had committed.[98] Similarly, the prevalence of special educational needs (SEN) among the young offender population is striking; almost half of those young people sentenced to less than 12 months in custody in 2014 were recorded as having SEN without a statement and 28% were recorded as having SEN with a statement.[99] The Timpson Review highlights the need for schools to adopt a *public health approach* to crime by working with other agencies in partnership to minimise exclusion and the impacts of exclusion where it is unavoidable, minimising other risk factors and strengthening protective factors.

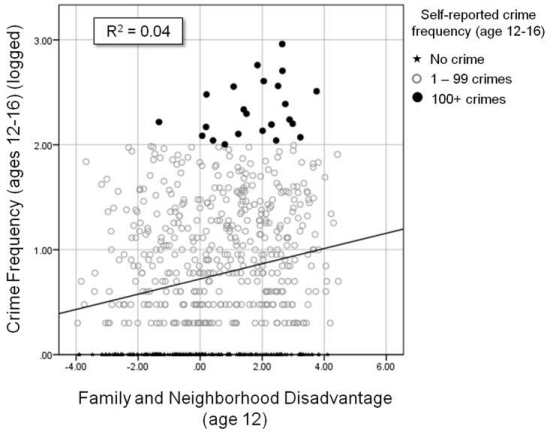
Causal Factors

As stated at the start of this chapter, whilst the risk factors identified can act as *predictors* for involvement in youth violence or gang involvement, it can not necessarily be claimed that they are *causal factors*. For example, whilst we may observe that young people who commit serious violent crime may be more likely to have experienced a disrupted family and misused drugs, we also observe that many young people with substance misuse problems or who come from broken homes do not commit youth violence.

The difference between association and causality in this context can perhaps be best demonstrated by the link between poverty and crime. Poverty and coming from a disadvantaged background is often cited by politicians and in the media as being causal to youth offending because without question, the vast the majority of young people who are persistent offenders and enter the youth criminal justice system come from socially disadvantaged backgrounds. However, it is equally true that the vast majority of young people who come from socially disadvantaged backgrounds never commit criminal offences and that social disadvantage in and of itself is a poor predictor of future criminality leading some researchers to question whether a causal relationship exists at all. This has been labelled by criminologists as *the crime paradox*.[100] [101] [102] [103] [104]

A study by researchers at Cambridge University[105] aimed to investigate this paradox using the Peterborough Adolescent and Young Adult Development (PADS+) Study, a longitudinal study that followed a random sample of 716 young people who were living in Peterborough since they were 12 in 2002, through adolescence into young adulthood in 2015. Across the entire cohort, their research identified only a very weak link (R^2 = 0.04) between members of this cohort of young people who went on to be prolific offenders (committing more than 100 crimes) and family/neighbourhood disadvantage. (Figure 6.4).

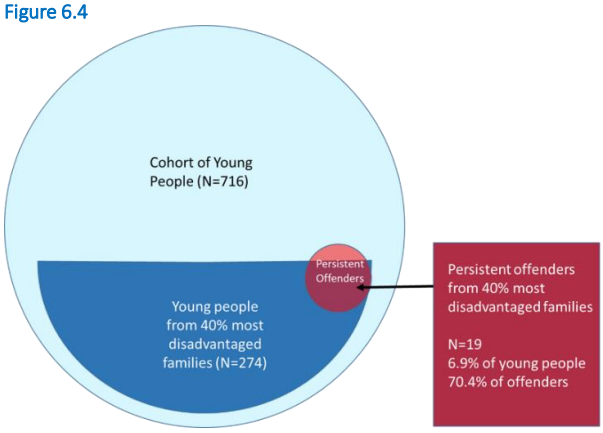
Figure 6.4



The vast majority (93%) of the 274 young people in the 40% most disadvantaged didn't go on to become persistent offenders however, the PADS+ study equally identified that 19 of the 27 (70.4%) of young people who became

persistent offenders were from the 40% most disadvantaged in the cohort. The *crime paradox* is demonstrated in figure B.

Figure 6.4



From detailed analyses of the cohort, the researchers identified two variables that seem to be causal factors in persistent and prolific offending:

1. Being exposed to a criminogenic environment which was a composite measure of two factors:

- Exposure time spent in unstructured and unsupervised peer-oriented activities in local city centres or other locations with poor collective efficacy, i.e. without strong social norms around community cohesion and positive social values
- Having peers who had an existing propensity to involvement in crime

2. Developing an individual crime propensity. This was defined as scoring highly on an index made up of standardised scores on personal morality and levels of personal self-control.

The study found a strong relationship between scoring highly on these two measures and persistent offending behaviour in young people and also demonstrated that the relationship between these two measures and persistent criminal offending was strong in young people from all levels of family disadvantage within the overall cohort.

They therefore concluded it is being exposed to a criminogenic environment (unstructured peer activity in locations with low social cohesion/contact with peers with existing crime involvement) and individual crime propensity (morality/self-control) that were the causal factors in persistent youth crime involvement and not social disadvantage per se. They also concluded that the reason that most persistent offenders come from disadvantaged backgrounds could be explained by the fact that they have a higher likelihood of developing a high crime propensity and/or being exposed to criminogenic environments.

It is worth remembering that the Cambridge study had as its outcome variable all persistent offending as opposed to serious youth violence or gang involvement. However applying its findings to the risk factors identified previously, figure 6,5 attempts to show how the previously identified risk factors for serious youth violence may contribute to being exposed to the two causal factors identified in the research of *Being Exposed to a Criminogenic Environment* and *Developing an Individual Crime Propensity* and their composite measures. The risk factors identified as the strongest (a correlation coefficient greater than 0.3 and/or odds ratio greater than 2.5) are shown in bold.

Figure 6.5: Relationship between Risk Factors for Serious Youth Violence and Causal Factors for persistent youth offending.

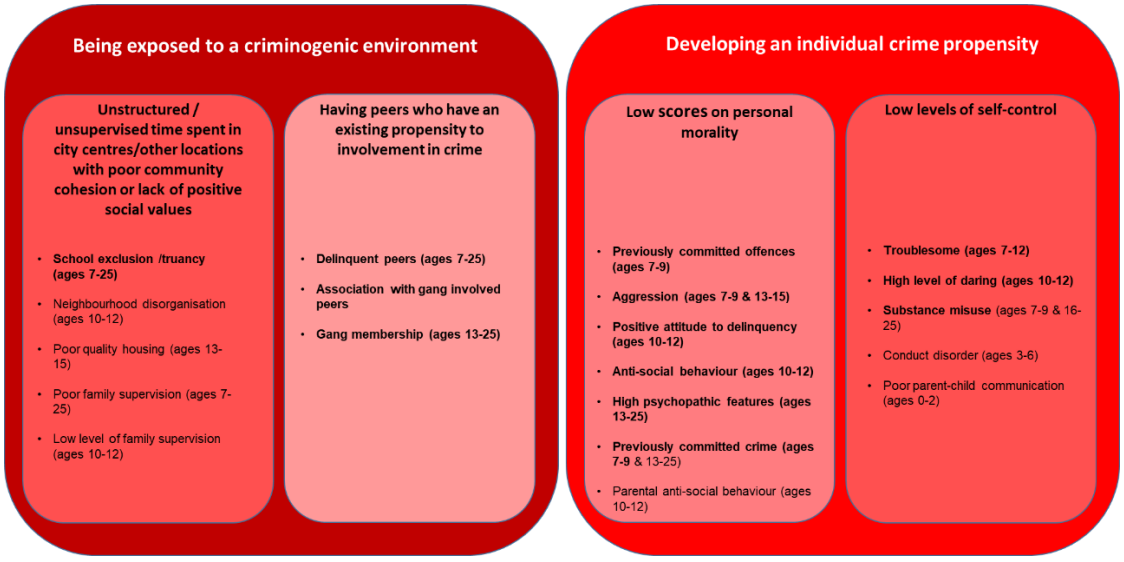
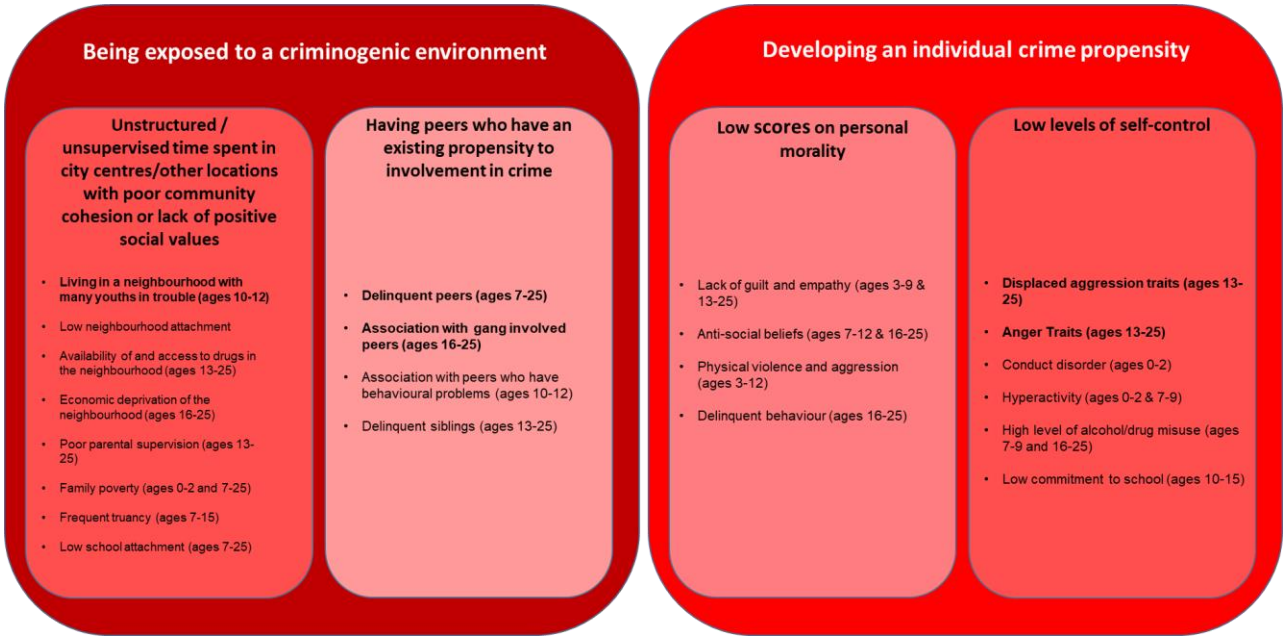


Figure 6.6 (overleaf) suggests how the previously identified risk factors for gang involvement may be linked to the two identified causal factors and their composite measures for persistent youth offending. The strongest risk factors (a correlation coefficient greater than 0.3 and/or odds ratio greater than 2.5) are shown in bold.

Figure 6.6: Association of risk factors for gang involvement with causal factors for persistent youth offending.



Analysis of Risk Factors faced by Thurrock Young People and their impact on prevalence of violence and gang membership.

Xantura has been commissioned by Thurrock Council to create and maintain a linked dataset of different data held on young people and their families. The linked dataset currently joins the following datasets at resident level:

- Youth Offending
- Chronology
- Children's Social Care case notes
- Anti-social behaviour victims data
- Missing persons
- School attendance and exclusions
- Domestic Violence
- Child Safeguarding datasets including Children In Need, Child Protection, CLA, EH
- EDUPRU
- Child missing education
- Benefits data
- Debt including tenancy, council tax, housing benefits over payment.

To date, the main use of the Xantura linked data is to provide a *single view* of an individual child and their parents that displays information from multiple datasets for front line children's social care professionals. However, the system that Xantura has created also provides opportunities to use linked data to ascertain the impact that the risk factors identified in this chapter have had on the likelihood that a young person will commit violent crime or become involved in gangs (the *Outcome Variables* we seek to prevent in the future).

Ascertaining and quantifying the impact that various different risk factors (vulnerabilities) in our own population have on likelihood of involvement in the outcome variables of future violence or gangs creates allows us to identify the most significant vulnerabilities in young people at Thurrock level associated with youth violence and gang involvement.

This in turn opens up the exciting possibility of building a predictive model that could identify the cohorts of young people most at risk of future gang memberships or violent behaviour and provide the opportunity to target tailored prevention interventions at specific young people to reduce their risk. We have therefore worked closely with Xantura to analyse the impact that specific vulnerabilities have had on violent behaviour and gang membership within the population of young people living in Thurrock.

Unfortunately because police data is not currently included within the Xantura linked dataset we have been unable to use arrest/police caution/charge as an outcome variable within these analyses. We have therefore defined the outcome variables that we are interested in preventing from the YOS dataset using the crime categories discussed in Chapter 2 (table 2.5) and shown in figure 6.7. We have considered four outcomes over two levels: All Target Offence Outcomes (TOO); Violence Against The Person Offences; Gang Involvement; and Supply of Class A and B drugs. The limitation of using YOS data is that we are only able to define the outcome in terms of a young person's involvement in YOS and may miss young people who have

been involved in serious youth violence or gangs who have not come to the attention of our YOS service.

Figure 6.7 – Outcome Variables we are interested in preventing

In undertaking this analyses, Xantura considered both category data (values recorded in specific fields in each dataset) and undertook *contextual text* analyses to identify risk factors that appeared in 'free text' notes within each dataset.

Violence Against the Person Risk Factors

Xantura undertook three types of analyses against the outcome variable of *Violence Against the Person* offences dealt with by YOS:

- Risk factors present in young people before committing *Violence Against the Person*
- Correlation of risk factors with *Violence Against the Person* over time
- Predictive factors for *Violence Against the person*

Each will be discussed in turn.

Risk Factors Present Prior to Thurrock Young People Committing *Violence Against the Person* offences.

Figures 6.8 and 6.9 show the risk factors (vulnerabilities) already present in young people aged 15-18 and 10-14 respectively who have been dealt with by YOS for offences in the *Violence Against The Person* category.

Figure 6.8

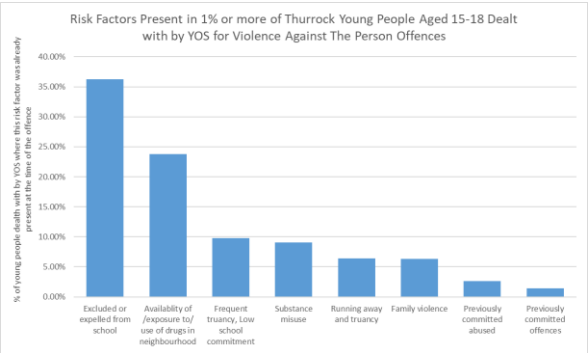
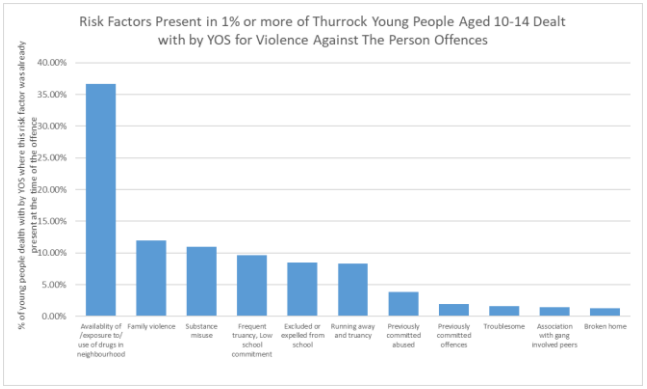


Figure 6.9



For 15-18 year olds, the most common vulnerabilities present at the time of committing violence against the person offences related to school absence: *Being Excluded or expelled from school; Frequent Truancy, low school commitment*, and drugs: *Availability of, exposure to drugs in the neighbourhood;* and *Substance Misuse*.

For 10-14 year olds, the most common vulnerability present at time of committing violence against the person offences was *Availability of/exposure to drug use in the neighbourhood. Family Violence, Substance Misuse, Frequent Truancy/Low school commitment, Being Expelled or excluded from school, running away and truancy* were also present in a significant minority of young people committing violence against the person.

Individual risk factors such as conduct disorders and hyperactivity were recorded in very low numbers of young people dealt with by YOS for violence against the person offences despite the fact they were identified as strong risk factors in the evidence base. However, this may simply reflect that the datasets used in the Xantura analyses were not likely to record conduct disorders or hyperactivity comprehensively.

Correlation between risk factors and *Violence Against the Person* offences over time.

Xantura correlated the numbers of *Violence Against the Person* offences dealt with by YOS with the numbers of young people recorded as having the different risk factors (vulnerabilities) identified within this report at quarterly time periods. Pearson R^2 co-efficients were calculated for each risk factor against the outcome variable of *Violence Against the Person* offences.

Pearson R^2 coefficients calculate how strongly the risk factor (vulnerability) is associated with *Violence Against the Person* offences over time, i.e. to what extent do numbers of violence against the person incidents increase when numbers of young people with a specific risk factor increases. A Pearson R^2 coefficient can range from -1 to +1. The larger the number, the more strongly the risk factor is associated with *Violence Against the Person* offences. A R^2 of >0.5 signifies a strong association. A negative R2 would suggest that the risk factor is *protective* against *Violence Against the Person* offences.

Table 6.1 shows the results of these analyses.

Table 6.1

APHR category	Aged 5 to 9	Aged 10 to 14	Aged 15-18	Max Correlation
Frequenct truancy, Low school commitment	0.37	0.75	0.84	0.84
Previous criminal activity	0.45	0.84	0.79	0.84
Availability of /exposure to/ use of drugs in neighbourhood	0.55	0.8	0.77	0.8
Running away and truancy	0.33	0.74	0.77	0.77
Previously committed violent crime	0.47	0.77	0.76	0.77
Excluded or expelled from school	0.54	0.75	0.69	0.75
Previously committed offences	0.52	0.72	0.65	0.72
Conduct disorders	0.43	0.55	0.61	0.61
Family violence	0.45	0.5	0.61	0.61
Association with gang involved peers	0.26	0.63	0.54	0.63
Poor parental supervision	0.63	0.58	0.58	0.63
Troublesome	0.4	0.5	0.59	0.59
Family poverty	0.19	0.33	0.59	0.59
Disrupted family	0.54	0.52	0.58	0.58
Substance misuse	0.49	0.46	0.55	0.55
Drug-alcohol misuse	0.35	0.19	0.29	0.35
Hyperactivity	0.27	0.26	0.43	0.43
Peer rejection	0.14	0.19	0.46	0.46
Broken home	0.33	0.19	0.24	0.33

Risk factors (vulnerabilities) related to lack of school attendance (frequent truancy, running away, excluded or expelled from school); previous criminal activity (previously committed violent crime, previously committed other offences, association with gang related peers); and availability of/exposure to drugs in the neighbourhood are most strongly associated with *Violence Against the Person* offences over time. Family issues including family violence, family poverty and poor parental supervision is also strongly associated in older age groups. These factors all link with the causal factors identified earlier in this Chapter of *being exposed to a criminogenic environment.*

Predictive Risk Factors in Thurrock

Examining the risk factors already present in young people known to YOS due to *violence against the person* offences or correlations between vulnerabilities and *violence against the* person offences over time does not on its own allow us to predict risk. For example, although figure 6.8 demonstrates that 36% of young people known to YOS for *violence against the person* offences had been excluded from school we cannot confidently state that being excluded from school predicts violence unless we also consider the sizes of the population of young people in Thurrock who have been excluded from school who do not go on to commit violence and the population of Thurrock who commit violence who have not been excluded from school.

In order to calculate the risk that an individual risk factor or vulnerability has on future violence we calculated Odds ratios for the risk factors identified from the Xantura dataset and evidence base. By examining the numbers of young people with a specific risk factor (vulnerability) who do and do not commit *violence against the person* offences and comparing these cohorts with the numbers of young people without the same risk factor who do and do not commit violence, the Odds ratio allows us calculate how much more likely a young person is to commit a *violence against the person* offence if they have an existing risk factor or vulnerability. As such an Odds Ratio of 2 for a given risk factor X means that young people who have experienced risk factor X are twice as likely as young people without risk factor X to commit *violence against the person* offences.

Table 6.2

RISK FACTOR (Vulnerability)	Odds Ratio (CI)	p-value
Previously committed violent crime	326.33 (262.42, 405.80)	0.00
Availability of / exposure to / use of drugs in neighbourhood	203.50 (166.98, 248.02)	0.00
Committing theft or handling stolen goods	95.44 (75.92, 119.98)	0.00
Conduct Disorders	41.98 (34.46, 51.13)	0.00
Previous criminal activity	29.83 (24.96, 35.67)	0.00
Association with gang involved peers	13.08 (10.99, 15.55)	0.00
Troublesome	9.64 (7.72, 12.02)	0.00
Previously committed offences	7.75 (6.55, 9.16)	0.00
Family Stress	7.70 (4.00, 14.82)	0.00
Substance misuse	6.40 (5.08, 8.05)	0.00
Family dysfunction	5.10 (3.10, 8.38)	0.00
Excluded or expelled from school	4.57 (3.87, 5.41)	0.00
Abuse or Neglect	2.01 (1.17, 3.43)	0.01

The odds ratios in table 6.2 suggest four sets of risk factors are highly predictive of future serious youth violence.

Firstly *previous criminality* significantly increases risk of a young person accessing YOS for *violence against the person* offences. Previously committing violent crime; theft or handling stolen goods; previous criminal activity; and previously committed offences, makes a young person 326, 95, 30 and 7.8 times respectively more likely to commit future violent crime compared to young people who did not have a recorded history of criminality. Association with gang involved peers makes a Thurrock young person over 13 times more likely to access YOS for *violence against the person* offences compared to young people not associated with gangs. These four variables are closely associated with the suggested *causal* variables suggested earlier in this chapter of both '*being exposed to a criminogenic environment*' and '*developing an individual crime propensity*'.

Secondly substance misuse, *particularly the availability of / exposure to / use of drugs* in the neighbourhood, and to a lesser extent a history of *substance misuse* increased the risk of youth violence by 203.5 and 4.16 times respectively compared to Thurrock young people who did not have these risk factors. The difference in risk between drugs in the neighbourhood and individual substance misuse is interesting as it could suggest that there is something else about neighbourhoods with drug use, rather than simply drug use itself that is substantially increasing risk of youth violence. Living in a neighbourhood with high levels of drug use could be associated with the suggested causal variable of *being exposed to a criminogenic environment* and its two sub-variables of '*unstructured time spent in city centre or other locations with poor levels of social cohesion*' and '*having peers who have an existing propensity to crime*'. As discussed in Chapter 5, drug misuse itself may increase risk of crime by lowering inhibitions, linking this risk factor to one of the other two sub-variables – *low levels of self-control* in the second suggested causal variable of *developing an individual crime propensity*.

Thirdly, *family dysfunction* and *family stress* increase the risk of involvement in youth violence by 5.1 and 7.7 times that of Thurrock young people without this vulnerability. This again could be said to increase risk of both suggested causal variables: *being exposed to a criminogenic environment* through lack of supervision or other family members' involvement in crime, and *developing an individual crime propensity* through poorer quality of parenting.

Fourthly *individual cognitive and behavioural* factors including a record of *conduct disorders* and being *troublesome* makes a Thurrock young person 42 and almost 10 times respectively more likely to commit *serious youth violence* offences. Both of these risk factors could be said to be associated with one of the suggested causal variables: *developing an individual crime propensity* and its two sub-variables: *low levels of self-control,* and *low levels of personal-morality*.

A final fifth factor of *being expelled or excluded from school* was identified. Young people who have been subject to temporary or permanent school exclusion in Thurrock are 4.6 times more likely than those who have not, to access YOS for *violence against the person* offences. Whilst school exclusion itself has a lower predictive value than some of the other vulnerabilities, it is worth noting that analyses presented earlier in this chapter found it to be both the most highly correlated vulnerability with youth violence over time, and the most common existing vulnerability in those young people who access YOS because they had committed *violence against the person* offences. it is also highly correlated with youth violence School exclusion is likely to substantially increase the risk of a Thurrock young person encountering the suggested causal variable of *being exposed to a criminogenic environment* both because they may be more likely to spend time in unstructured environments, and because they may be at increased risk of being groomed by gangs, exposing them to peers with an existing propensity to crime involvement.

Some care should be taken when interpreting odds ratios of single risk factors. Many young people are likely to have multiple risk factors and what is not clear at this stage is how these risk factors or vulnerabilities may interact. The next stage of analyses would be to build a logical regression model that calculates how each individual risk factor interacts with the others in order to develop an over-all risk score of a young person with multiple risks.

Risk factors (vulnerabilities) for Gang Membership

We asked Xantura to similar analyses on their Thurrock linked dataset for the outcome variable of *Accessing YOS due to Gang Membership* as we did for *violence against the person* offences. However analyses was hampered by low data volumes and a lack of recording of date of first involvement in gangs, meaning it was not possible to calculate predictive odds ratios or ascertain percentages of young people who had existing risk factors prior to gang membership.

We were able to correlate both risk factors identified in the evidence base and general risk factors identified by Xantura over time with gang membership. The results of these analyses are shown in tables 6.3 and 6.4

Table 6.3: Correlation of numbers vulnerabilities from the evidence base in Thurrock young people with gang membership over time

APHR category	Aged 10 to 14	Aged 15 to 18	Aged 19 and above	Maximum Correlation
Excluded or expelled from school	0.97	0.28	0.38	0.97
Frequent truancy & low school commitment	0.96	0.3	0.4	0.96
Poor parental supervision	0.96	0.26	0.36	0.96
Running away and truancy	0.96	0.3	0.41	0.96
Disrupted family	0.95	0.31	0.42	0.95
Availability of / exposure to / use of drugs in the neighbourhood	0.72	0.78	0.93	0.93
Troublesome	0.29	0.54	0.88	0.88
Previously committed offences	0.86	0.59	0.67	0.86
Previously committed violent crime	0.74	0.68	0.77	0.77
Previous criminal activity	0.45	0.61	0.7	0.7
Substance misuse	0.54	0.36	0.68	0.68
Association with gang involved peers	0.14	0.6	0.1	0.6
Broken home	0.14	0.6	0.1	0.6
Conduct disorders	0.03	0.43	0.52	0.52
Family violence	0.15	0.33	0.37	0.37

Table 6.4: Correlation of numbers of general vulnerabilities in Xantura with Thurrock gang membership over time.

APHR category	Aged 10 to 14	Aged 15 to 18	Aged 19 and above	Maximum Correlation
School exclusion	0.97	0.28	0.39	0.97
Missing. Education.	0.97	0.3	0.41	0.97
Theft and handling stolen goods	0.97	0.48	0.61	0.97
Missing person.	0.96	0.31	0.42	0.96
Neglect	0.96	0.26	0.36	0.96
Family dysfunction	0.95	0.32	0.42	0.95
Public Order offence	0.94	0.63	0.63	0.94
Vehicle theft	0.91	0.26	0.36	0.91
Possession of a class B drug	0.87	0.37	0.59	0.87
Criminal damage	0.46	0.62	0.72	0.72
Previous abuse	0.14	0.6	0.1	0.6
Robbery	0.24	0.52	0.59	0.59
Prison history	0.18	0.54	0.05	0.54
Domestic violence	0.15	0.37	0.42	0.42
Knife/blade/firearm/offensive weapons offence	0.3	0.26	0.15	0.52
Emotional abuse	0.1	0.14	0.16	0.37

Correlations above 0.5 could be said to be the most significant. The same predictive risk variables identified in the analyses on *violence against the person* offences feature in above analyses on risk of gang membership:

- *Exclusion from education* including permanent or temporary school exclusion and frequent truancy;
- *Criminality* including previous criminal activity, association with gang related peers, robbery, vehicle theft;
- *Substance misuse,* particularly exposure to drugs in the neighbourhood;
- *Family dysfunction* including poor parental supervision, broken home, neglect, emotional abuse and
- *Individual Behaviour or Cognitive issues* including *troublesome, conduct disorders*

Further exploration of vulnerabilities identified

Thurrock School Exclusion Data

Our analyses have shown that being excluded from school is a predictive risk factor for future youth violence. The Department for Education and Skills publishes data on rate of fixed term and permanent exclusion per 100 pupils on the school role for primary and secondary schools in each local authority in England on an annual basis.

Figures 6.10 and 6.11 show rate of Primary School Fixed Term and Permanent Exclusions per 100 pupils on the school roll for each top tier local authority area in England for the last year of data available (2017/18). Figures 6.12 and 6.13 show the same rates for secondary schools in 2017/18.

Thurrock's performance is shown by the 'red' bar on each graph Thurrock has a rate of both fixed-term and permanent Primary School exclusions at that is greater than England's and in the fourth and worst quintile of performance nationally. Conversely, Thurrock had one of the lowest rates of secondary fixed-term exclusions in England in 2017/18 and rates of secondary permanent exclusions largely in-line with the England me

Figure 6.10

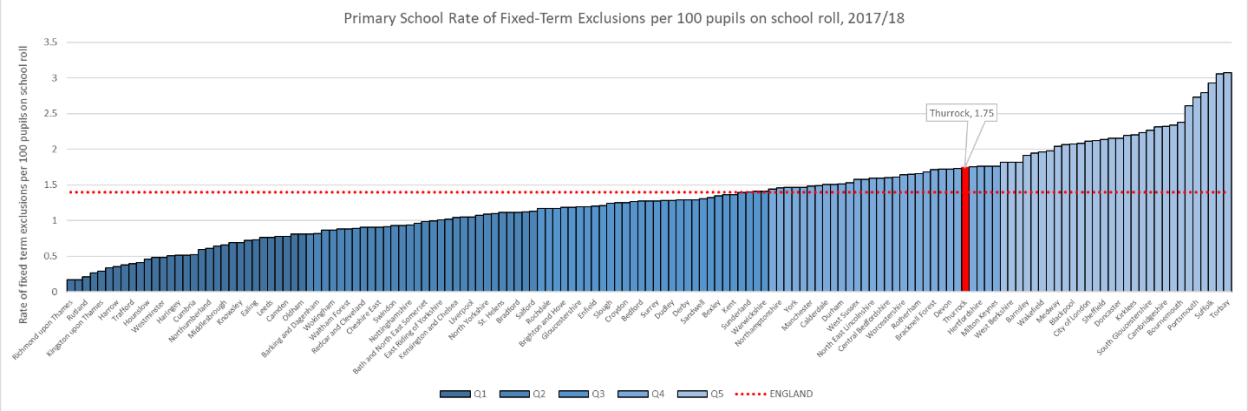


Figure 6.11

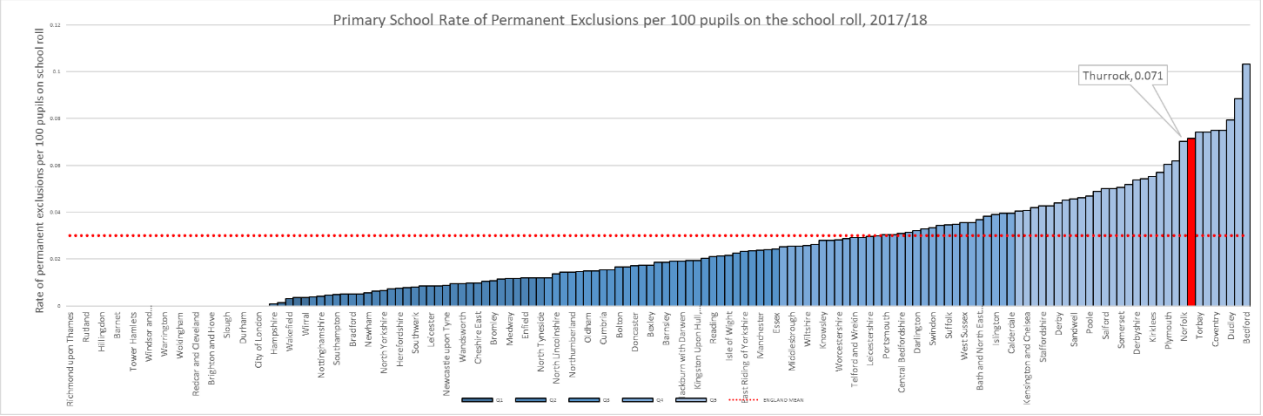


Figure 6.12

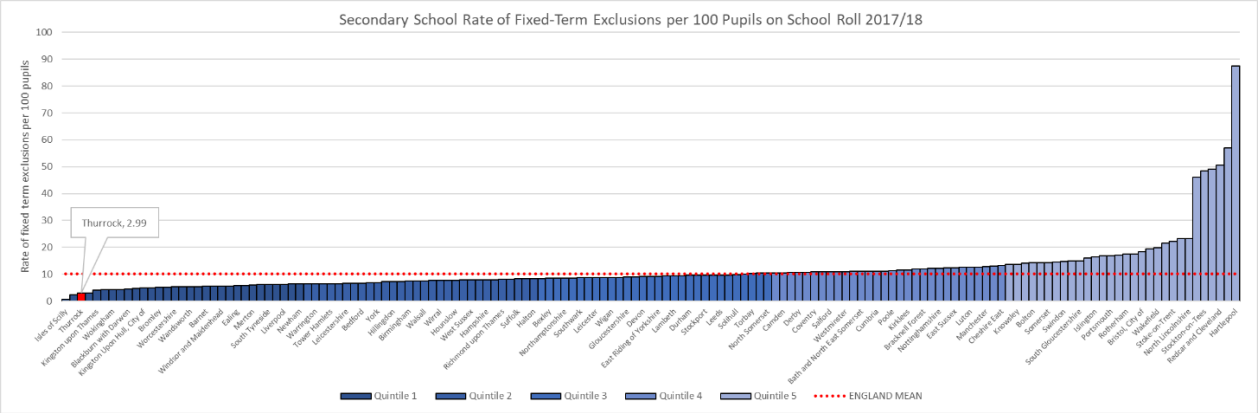
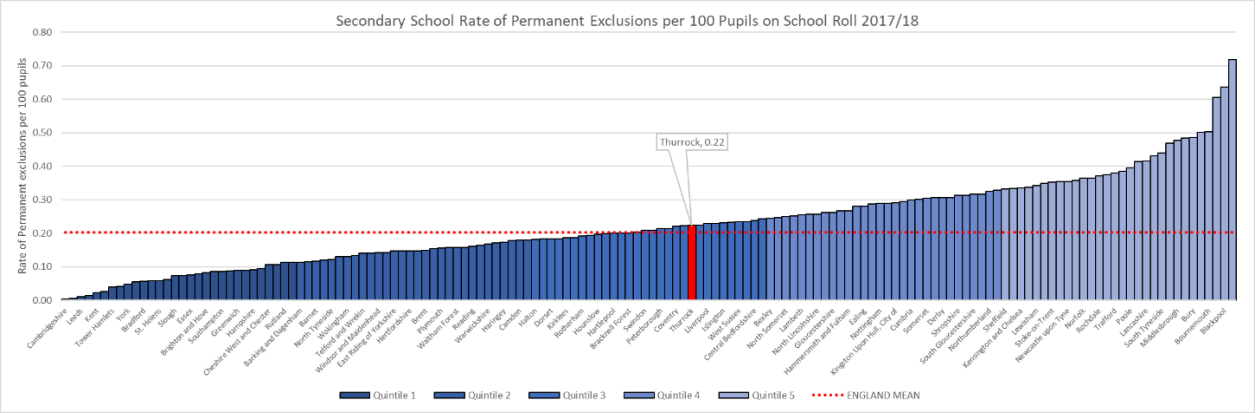


Figure 6.13



Exclusion Rates at School Level within Thurrock.

In order to drill down further into the data we calculated the rates of fixed-term and permanent exclusions per 100 pupils at individual school level for Thurrock Primary and Secondary schools. Because total numbers of school exclusions at school level are low and vary between individual years we used calculated a mean rate over the last three fiscal years (2015/16, 2016/17 and 2017/18). Figures 6.14-6.16 show these analyses. A Thurrock 3-year mean rate and the England mean rate for 2017/18 is also shown.

Figure 6.14

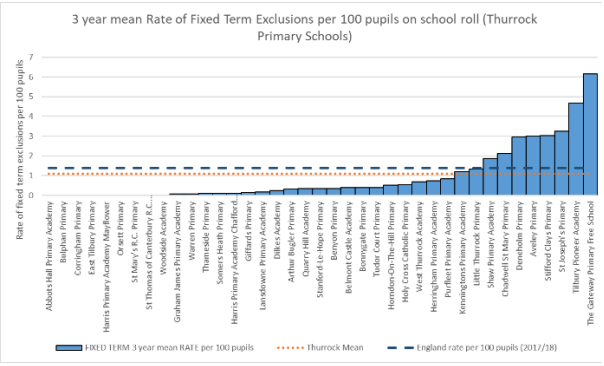


Figure 6.15

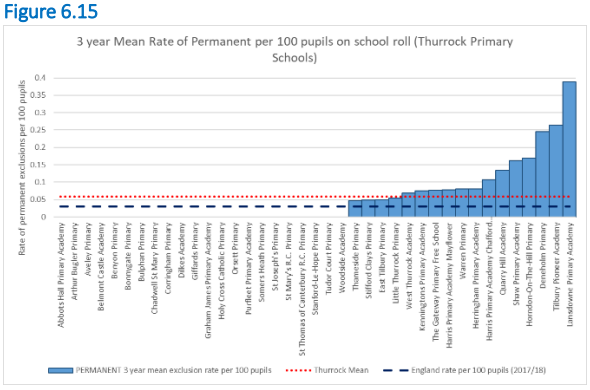


Figure 6.16

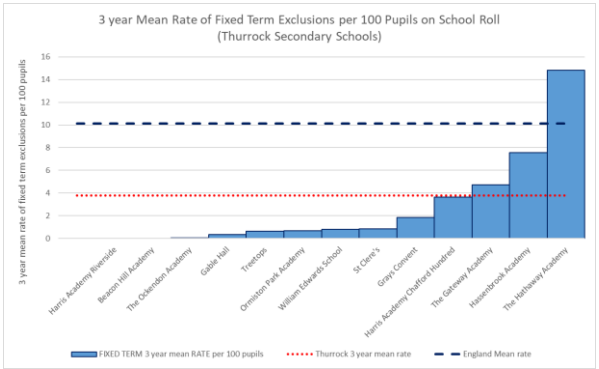
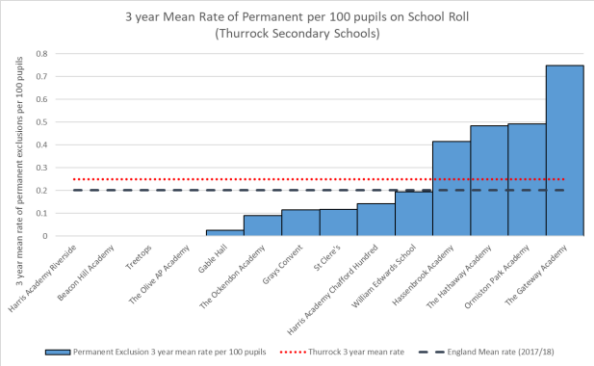


Figure 6.17



All four graphs show a significant variation in school exclusion rates between schools in Thurrock. For primary schools there over a six-fold variation in fixed term exclusions and almost a four-fold variation in permanent exclusion rates, with a significant minority of schools having a rate of exclusion significantly greater than the England mean. For secondary schools there is a fifteen-fold variation in fixed-term exclusion rates between schools and over a seven-fold variation in rates of permanent exclusions.

The Olive Academy is a Pupil Referral Unit in Thurrock that is likely to receive pupils who have been permanently excluded from Thurrock secondary schools Its rates of exclusion are not shown on figures C and D but have been calculated. Whilst no pupils were permanently excluded from The Olive Academy in the three years ending 2017/18, its rate of temporary exclusion was 194 exclusions per 100 pupils. This is 48.5 times greater than the Thurrock mean and is cause for concern.

Given the strong link between exclusion and serious youth violence, further work to understand and address the high rates of fixed term exclusion at Primary school level and at the Olive Academy is required. The high level of variation between exclusion rates of different schools within Thurrock also warrants further investigation. One explanation could be differences in the level of other behavioural risk factors between school populations, however there may also be an opportunity to spread best practice between different schools.

Chapter 7: Protective factors against serious youth violence and gang involvement

Key Findings

The published evidence base identifies a series of protective factors that may act as a 'buffer' between the prevalence of a risk factor and the onset of youth violence. A preventative factor is a predictor of reduced risk but may not be causal in preventing youth violence. The evidence base on preventative factors is less comprehensive than that on risk factors for youth violence. Evidence on prevention of gang membership is particularly sparse.

Factors that have been shown to be associated with reduced risk of youth violence include positive/prosocial attitudes, low levels of impulsivity, belief in 'the moral order', being female, family factors including good family management, stable family structure and infrequent parent-child conflict, academic attainment and low levels of economic deprivation.

There is some evidence that high social skills, personal moral beliefs, high levels of empathy, moderate levels of parental monitoring, a sense of belonging at school and a perception of fairness from teachers, interaction with pro-social peers, and neighbourhood support including neighbourhood safety and participation in/availability of community groups/assets and clubs could be protective against gang membership.

Introduction

This chapter explores the protective factors against serious youth violence and gang involvement that have been identified from the published evidence base.

Research on risk factors for youth violence and gang involvement has promoted discussion and investigation into factors that may provide a 'buffer' between the presence of risk factors and the onset of and involvement in youth violence and gang involvement. A protective factor is defined as *"attributes, characteristics or elements that decrease the likelihood that violence will be perpetrated"*. [106]They are variables that can usefully predict a decrease in the likelihood that a young person will become involved in serious youth violence or gangs. It is important to remember that a predictive factor does not necessarily mean that the factor is *causal* in the protection against violent behaviour or gang membership; simply that it is a reliable predictor of decreased risk (although it is possible that they could be). For example, it cannot be said that infrequent parent-child conflict is the *cause* a young person avoiding violence; simply that young people with less frequent conflicts with their parents are less likely to be represented in the cohort of young people who are convicted for violent offences.

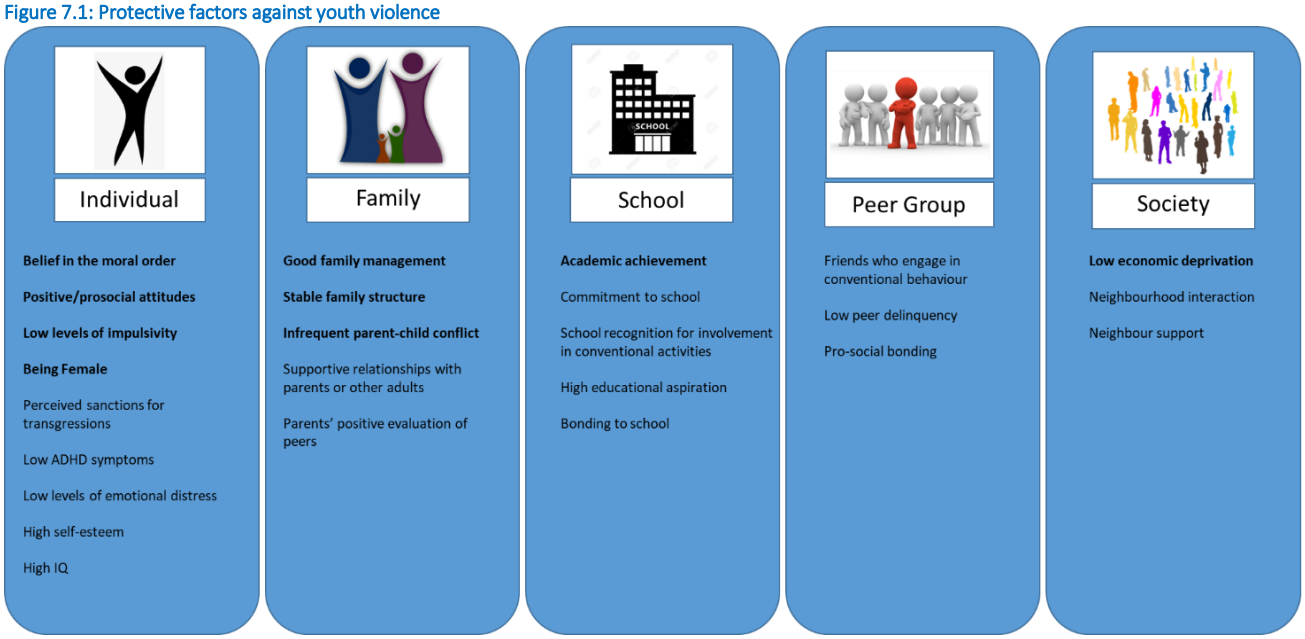
Like risk factors, preventative factors can be grouped into five categories:

1) Individual
2) Family
3) School
4) Peer Group
5) Community/Society

Youth Violence

Figure 7.1 summarises the evidence base on protective factors against perpetrating youth violence. [74 75 107 108 109 110 111 112]. The strongest protective factors an odds ratio less than 0.3) are shown in bold

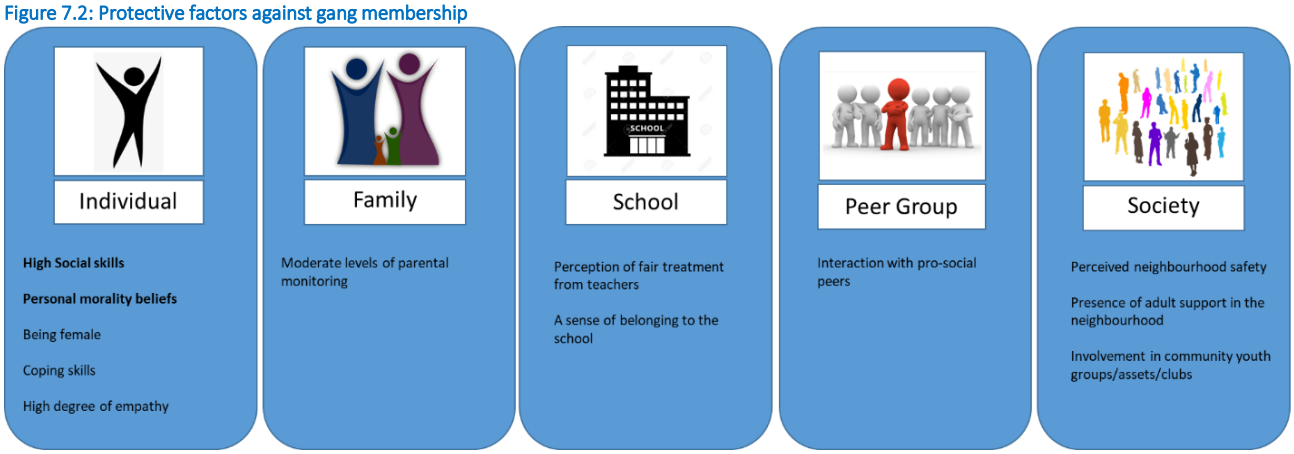
Figure 7.1: Protective factors against youth violence



Gang membership

There is a paucity of published evidence base exists on factors shown to be associated with a reduced risk of gang membership. In general, the factors that prevent young people from joining gangs are less well-understood.[113] The results of the evidence base[114] [115] [116] [117] [118] The protective factors against gang membership identified from the literature available are summarised in figure 7.2.

Figure 7.2: Protective factors against gang membership



Chapter 8: Prevention and Early Intervention Evidence Base

Key Findings

Youth violence is not inevitable and can be prevented. Although the emerging issue of youth violence has meant that the evidence base in some areas is stronger than others, there are a wide range of evidence based strategies and interventions that have shown have a positive effect, both on strengthening preventative factors and reducing risk factors, and on violence as an outcome itself. The strongest evidence base relates to addressing individual and familial risk factors.

The evidence base can be grouped into interventions that support eight strategic actions.

1. **Promoting family environments that support healthy family development:** Promoting supportive family environments has some of the most promising evidence base. The family environment plays a key role in shaping youth's physical emotional, social and behavioural health and if unstable, stressful, without structure or supervision, will contribute to risk factors for violent behaviour and aggression. There is good evidence that early childhood visiting programmes and parenting skill and family relationship programmes can be highly effective.

2. **Providing quality education early in life** improves children's cognitive and socio-emotional development, increases the probability that children will experiencing a safe, nurturing environment, improves academic success and reduces the likelihood of behavioural problems linked to violence such as aggression and crime. The *Healthy Child Programme* in England has a strong evidence base in terms of early year education for 0 to 5s. Additional educational support programmes for children aged 5 to 7 targeted at those with developmental needs have shown positive outcomes in terms of reducing risk factors for violence in later life.

3. **Strengthening youth's communication, empathy, problem solving and emotional intelligence skills** has a strong evidence base and programmes that support skills development have been shown to be effective in improving emotional regulation and impulse control and reducing youth violence perpetration and victimisation. Universal classroom behaviour management programmes such as *Incredible Years Teacher Classroom Management, PATHS Elementary Curriculum* and *The Good Behaviour Game* have RCT level evidence that demonstrates improved pro-social behaviour, improved emotional self-regulation, improved social competency and reduced aggression. Some selective skills based programmes aimed at children with additional needs show similar impact.

4. **Connecting youth to adults and activity that role model positive behaviour** is a strategic action with emerging and promising evidence base particularly when targeted at individuals with an increased number of existing risk factors. Relationships to caring adults over and above parents or primary care givers can influence young people's behavioural choices and reduce their risk in involvement in crime and violence. Mentoring programmes show positive outcomes in systematic reviews and meta-analyses for improvement in behavioural, social, emotional and academic domains. After-school programmes show mixed evidence of effectiveness, probably because of the high variability between the programme models, duration, structure and participants but some specific after-school programmes evaluate positively.

5. **Addressing the wider determinants of serious youth violence and gang membership** including *modifying the built and social environment* to 'design out crime', reducing the concentration of retail outlets selling alcohol in high crime areas, street outreach and community development and strategic action to address the harm caused by social media and its impact of glamorising violence and violent behaviours have some evidence base of effectiveness. Similarly, there is emerging evidence of the effectiveness of reducing and preventing school exclusions which was highlighted a strongly associated risk factor for youth violence in Thurrock.

6. **Intervene early to reduce harms of exposure to violence and violence risk behaviours.** Many young people who engage in violence as teens and young adults have histories of childhood conduct problems, aggression, violence, delinquency and criminal behaviour and a range of known risk factors for violence including substance misuse, academic problems, association with deviant peers and dysfunctional home environments. *Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)* has been shown to be highly effective at treating post-traumatic stress disorder and depression, improving behaviour for victims of serious violence. *Level 5 Pathways Triple P* parenting programme has strong evidence in reducing risk of future parental abuse and improving their children's lives. 'Whole system' family-peer-environmental therapeutic approaches such as *Multi-Systemic therapy* and *Functional Family Therapy* have strong evidence of effectiveness in improving the behaviour and life-chances of young people who have already committed serious youth violence and preventing future violence.

7. **Preventing Gang Membership and Crime Caused by Gangs** is perhaps the strategic action with the weakest evidence base with little that demonstrates conclusive effectiveness on reducing the likelihood of gang membership as an outcome. Approaches aimed at helping gang involved youth exit gangs have centred on *opportunities provision*. *Pulling Levers approaches* including *Gang Injunctions* that seek to actively disrupt gang activity through coordinated law enforcement and community action have been shown to be effective in reducing gang related crime.

8. **Law enforcement** whilst largely a 'downstream' response to violence has been shown to be effective in some areas of prevention. There is some evidence that highly targeted stop and search activity which focuses on suspects with the highest probability of criminal behaviour has a small but positive impact on the prevalence of violent crime and weapons offences. Law enforcement is also an important component of the *Pulling Levers* approach including gang injunctions discussed in strategic action 7.

Introduction

This chapter discusses and summarises the published evidence base on approaches that have been shown to be effective in preventing young people from engaging in serious violence and gang membership.

Programmes that seek to prevent serious youth violence and gang membership can be thought of using different categories:

Primary Prevention programmes aim to prevent violence or gang membership before they occur by reducing risk factors promote protective factors discussed in Chapters 5 and 6.

Secondary/Tertiary Prevention programmes take place after violence or gang membership occurs and aim to reduce prevent the short/long term harms caused by violence or gang membership including helping young people exit gangs.

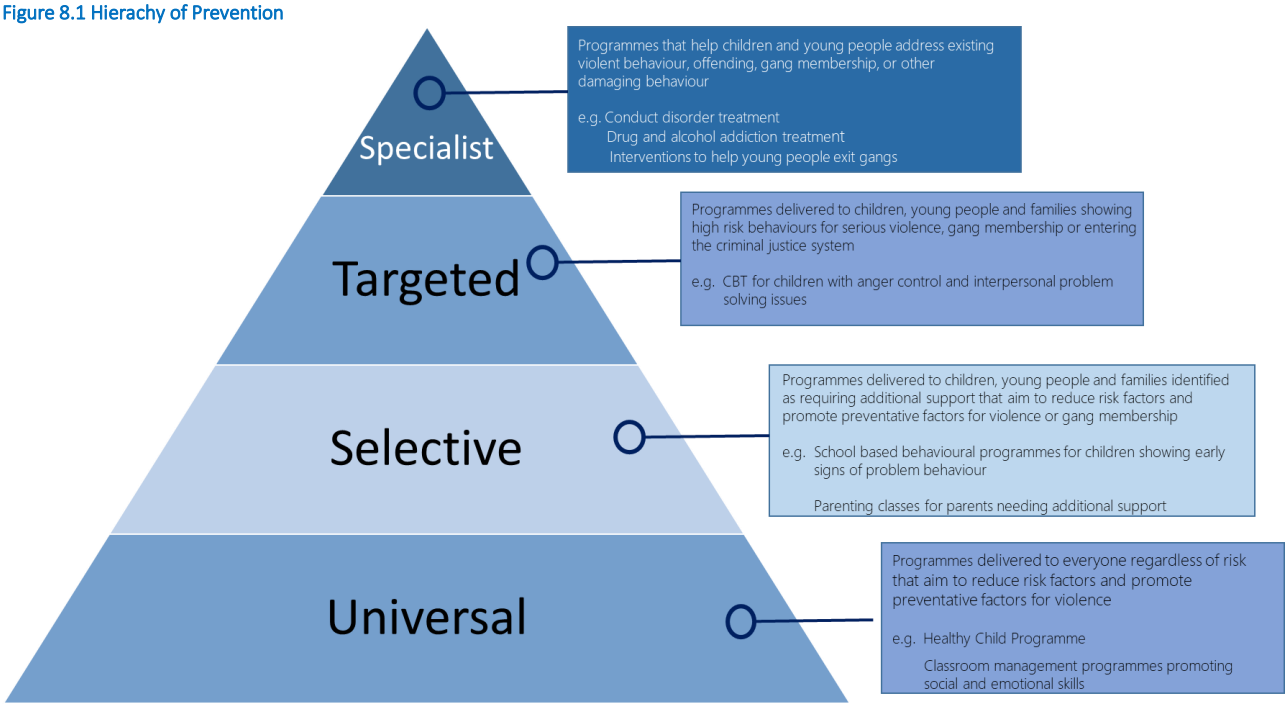
Universal prevention programmes are administered to an entire defined population regardless of risk of violence and aim to reduce risk factors and promote protective factors linked to violence or gang membership.

Targeted prevention programmes are administered only to populations already identified at high risk of or already involved with violence/gang membership.

Hierarchy of prevention

Prevention programmes can be thought of as a hierarchy as shown in figure 8.1

Figure 8.1 Hierachy of Prevention



What works in the prevention of youth violence?

Youth violence can be prevented. Overall, there is good evidence that early intervention programmes can work to prevent violence. There are a wide range of strategies that can be employed to the reduce risk factors and promote protective factors discussed in Chapters 5 and 6. 11 different systematic reviews have found that early interventions were effective in reducing violent behaviour [119] [120] [121] [122] [123] [124] [125] [126] [127] [128] [129] with the most recent review by Cambridge University demonstrated that prevention initiatives can reduce aggression by around 25% [121] and a review by Vries et.al. (2015) found an average decrease of 13% in criminal behaviour amongst high-risk young people.[129]

Most of the evidence base comes from interventions at the individual and relationship level, which aim to prevent behavioural problems which mirrors the fact that the majority of risk factors discussed in Chapter 5 operate at an individual level.

The following five strategic actions (adapted from the US Center for Disease Control's comprehensive technical packing on preventing youth violence and associated risk behaviours)[134] have good evidence on prevention:

1. Promote family environments that support healthy development
2. Provide quality education early in life
3. Strengthen Youth's communication, empathy, problem solving, conflict resolution and emotional intelligence skills

4. Connect youth to adults and activity that role model positive behaviour
5. Intervene early to reduce harms of exposure to violence and violence risk behaviours

Each will be discussed in turn.

1. Promote family environments that support healthy development.

Across all of the major reviews of global evidence, promoting supportive family environments was identified to be one of the key approaches with the most promising evidence base. The family environment plays a key role in shaping youth's physical, emotional, social and behavioural health and this influence extends from early childhood through late adolescence and beyond.[130] Family environments that are unstable, stressful, lack structure and supervision, have poor relationships and communication or use either too harsh or too limited discipline contribute to risk factors for violent behaviour including poor problem skills and aggression. [131] [132] [133]

There are a number of approaches that can help families create and sustain supportive, nurturing and structured environments at every stage of a young person's development.

1a. Early Childhood Home visiting programmes provide information, support to care givers, training in child development and wider wellbeing support to parents. They are generally targeted at populations identified as having additional needs, making them *selective* in the hierarchy of prevention. *The Family Nurse Partnership* is a home-visiting programme for young mothers expecting their first child delivered by highly trained nurses or midwives. It aims to improve pregnancy health and behaviours, improve child development and improve economic self-sufficiency of parents by helping them plan for their own and baby's future. Mothers enrol on the programme early in their pregnancy and receive weekly visits before and for the first six weeks after the birth of their baby, during which they learn about their child's health and development and receive support on their own well-being.

Evidence from the USA demonstrated fewer behavioural problems and by the age of 15, fewer arrests and convictions in children who had participated in the programme compared to those who did not[134]. However robust UK evaluation found no significant benefit of the Family Nurse Partnership over the first two years' of the child's life compared with usual provision through the *Healthy Child Programme (see next section).*[135] Further longer term evaluative studies for the UK programme are awaited.

1b. Parenting skill and family relationship programmes

These programmes teach communication, problem-solving and behaviour monitoring and management skills to parents. They can be delivered either to individual families or through groups.

The quality of inter-parental relationships, particularly how parents communicate and relate to each other has a primary influence on children's mental health and future life chances including a wide range of key risk factors for violence including poor academic achievement, aggression towards peers, behaviour/conduct problems, anti-social behaviour, low self-esteem and greater child-parent conflict[136]

Psycho-educative/skills based group programmes from the US such as *Happy Families, Happy Kids* and *Couples Enhancement Training* that aim to reduce couple/parental relationship stress in intact parental relationships have been found to be effective in improving inter-parental relationships and hence reduce risk factors highlighted above.[137] [138] Similarly skills based training for separated couples that aims to reduce conflict such as *The Collaborative Project* and *Children in the Middle* have shown a similar effect.[139] [140]

Family Foundations is a group-based programme for couples expecting their first child, delivered any time during the mother's pregnancy. It is delivered by male and female co-facilitators with a QCF-level 6 qualification in a helping profession. Parents attend five weekly sessions where they learn strategies for enhancing their communication, conflict resolution and sharing of child care duties, and return for four more weekly sessions two to six months after the baby is born. The programme has been found to have evidence of a long –term positive impact on pro-social behaviour and reduced parent/parent and parent/child psychological and physical violence, and reduced externalising of problems in children.[141] [142]

Multiple systematic reviews have demonstrated the benefit of improving parenting skills on reducing risk factors and increasing protective factors for youth violence. [131] [143] [144]

Evaluation of *The Incredible Years Preschool Programme* showed a reduction in both the frequency and particularly the severity of disruptive behaviour in children.[145] The programme comprised of 20 weekly group sessions for parents aimed at emphasising positive rather than negative interactions between parents and children aged 3 to 6 years old, hence addressing the risk factors of conduct disorder aged (3-6), troublesome (aged 7-12), aggression (aged 7-15) and poor parent/child communication (ages 0-2).

Triple P – Positive Parenting Programme (Levels 3 and 4) combines a mass-media campaign with both consultations with primary carers to improve parenting practices and intensive support to parents with children at risk of behaviour problems aged 0 to 12. Groups of parents attend one to four small group sessions delivered by a trained facilitator (level 3) or sessions delivered over 8 weeks delivered by a trained clinical psychologist (level 4) where they learn strategies for improving their child's competencies and discouraging unwanted behaviour such as aggression.. The programme has been shown to be cost effective at reducing violence and improving child behaviour, parenting skills and increased self-efficacy. [146] [147]

Strengthening Families Programme 10-14 is a parenting and family strengthening programme for families with children aged between 10 and 14. It can be implemented as a

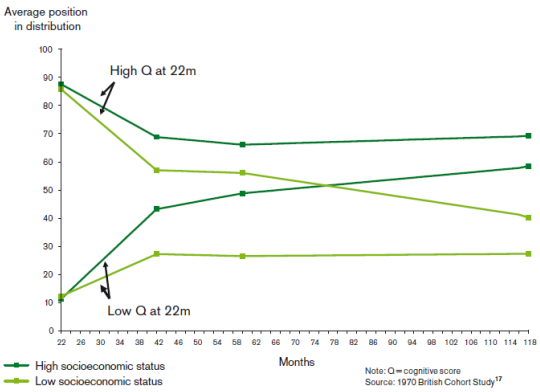
universal or selective programme targeted at high-risk adolescence. The programme consists of seven weekly sessions lasting two hours. During the sessions, families learn how to communicate effectively as well as specific skills such as parental limit setting and child resistance to peer pressure. RCT evidence demonstrates that on four year follow up young people who were involved in the programme had lower levels of aggression and hostility, reduced aggressive and destructive conduct and lower rates of polysubstance use.[148] [149]

2. Provide Quality Education Early in Life

High quality early years education improves children's cognitive and socio-emotional development and increases the probability that children will experience an environment that is safe and nurturing. It improves the likelihood of long term academic success and reduces the rate of behavioural problems, aggression and crime. [150] [151] Early childhood education that includes parental engagement can strengthen youth outcomes, family involvement in children's future education and parenting practices and attitudes. [152] [153]

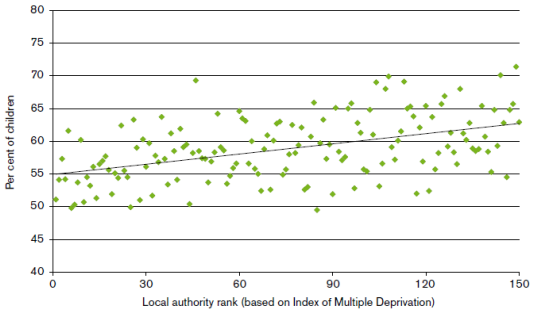
We know that need for early childhood education is not distributed evenly across society and is often positively associated with deprivation. Professor Michael Marmot in his report *Fair Society, Healthy Lives*[154] demonstrated in figure 8.2 that children within initial high cognitive ability relative to their peers at 22 months but who grow up in low socio-economic environments saw their relative position worsen year on year, whilst children with low cognitive ability at the age of 22 months but who grew up on high socio-economic environments saw their relative position improve year on year. By the age of 10, the former group had relatively lower cognitive ability than the latter group.

Figure 8.2: Inequality in early cognitive development in the 1970s British Cohort Study, ages 22 months to 10 years.



Similarly we know that across the UK, the percentage of children achieving a good level of development at age five is negatively associated with the rank of deprivation of the population served by their local authority. (Figure Y)

Figure Y: Percentage of children achieving a good level of development at age five by local authority



As such, high quality education early in life needs to be delivered with universal proportionalism; both a level of universal support and additional support to higher need communities. Pre-school enrichment programmes which improve educational achievement and self-esteem are associated with less violence in later life. Social development programmes to reduce aggressive and anti-social behaviour try to improve social skills with peers and promote cooperative behaviour by teaching young people to manage anger, resolve conflict and solve social problems. These are most effective if delivered in a pre-school or school setting to populations most likely to benefit.[155] [156] Evidence from the US on early-years education programmes such as *Child Parent Centres* and *Early Head Start* found that children/young people who participated in them had significantly lower rates of juvenile arrest and arrests for violence and lower rates of conviction and prison incarceration for violent offences. [157] [158]

The Perry Preschool Programme from the US is one of the universal early years' programme that has shown a direct impact on reducing youth violence as a long-term outcome measure. The programme provided high quality preschool education and home visits to 3 and 4 year old African American children living in poverty and assessed as at high risk of school failure. A preschool was provided each week day morning for 2.5 hour sessions by qualified teaching staff who also undertook 1.5 hour weekly home visits. On follow up of participants up to the age of 40, the programme found decreases in all types of violence including murder and robbery. [159]

In England, the *Healthy Child Programme* is a universal programme that commences during pregnancy and supports children until the age of 18. The first five years are led by Health Visitors with support from midwives and wider health professionals. Although the programme is universal, it provides a greater intensity of support to those with greater need.

Doodle Den is a literacy support after-school programme for children between the ages of 5 and 7. It is delivered in primary school, community centres or libraries and aims to support children to participate fully in education, address delays, and to improve educational outcomes. Each programme provides 15 places to children who would benefit from additional literacy support and encompasses a combination of modalities of literacy instruction including

phonics, sight vocabulary, shared and independent reading, writing and comprehension. An RCT showed a statistically significant positive impact on a number of child development outcomes including improved behaviour and concentration in class and improved reading and literacy skills.[160]

Let's Play in Tandem is a school readiness programme for children aged three living in socially disadvantaged communities. It aims to improve children's cognitive development and self-regulation. The programme runs for 12 months and is typically delivered through children's centres. Each family is assigned a project worker who visits the family in their home each week for 90-120 minutes to deliver a programme to develop pre-reading and numerical skills and promote vocabulary and general knowledge. The project worker also teaches the parents how to prompt and provide instructions to their child. One of the key aims of the programme is to focus on school readiness, and to improve the child's numeracy and communication skills. An RCT concluded that the programme was successful at improving early years' education in pre-reading, numeracy, writing, vocabulary and personal/social skills and that it improved inhibitory control of the children.[161]

3. Strengthen Youth's communication, empathy, problem solving, conflict resolution and emotional intelligence skills

Chapter 5 highlighted that children and young people with low levels of self-control, high levels of aggression or conduct disorder and low levels of empathy are at increased risk of violence. Programmes that seek to develop skills in effective communication, problem-solving, conflict resolution, impulse control and emotional regulation and management can help reduce both youth violence perpetration and victimisation. [162] [163] [164]

Programmes can either be *universal* and incorporated into the school curriculum, or *selective / targeted* depending on the level of skills deficiency identified or severity of the delinquent behaviour that the programme seeks to address.

3a. Universal Skills Based Programmes

Multiple systematic reviews of various universal school based programmes have demonstrated beneficial impact on youth's skills and behaviours including delinquency, aggression, bullying perpetration and violence. [163] [165]

Incredible Years Teacher Classroom Management programme is a universal classroom management programme for teachers of children between the ages of four and eight. It improves teacher competencies in supporting children in the classroom and developing children's social, emotional and problem solving skills together with specific strategies on behaviour management. RCT evidence shows that it improved child negative behaviour, improved child compliance, improved prosocial behaviour, improved emotional self-regulation and improved social competency in children.[166] [167] [168]

PATHS Elementary Curriculum is a comprehensive programme for promoting emotional and social competencies and reducing aggression and behaviour problems in junior school children whilst simultaneously enhancing the educational process in the classroom. The curriculum is designed to be used by teachers and provides systematic, developmentally based lessons, materials and instructions for teaching their pupils emotional literacy, self-control, social competence, positive peer relations and interpersonal problem solving skills. A key objective of promoting these developmental skills is to prevent or reduce behavioural and emotional problems. A cluster RCT study of 1,675 pupils in 56 junior schools found educed aggressive behaviour and reduced impulsivity/ADHD in children who had received the intervention. [169] A further five year follow up RCT found that children who had benefited from the intervention had statistically significantly lower prevalence of contacts with the police compared to those who had not. [170]

Positive Action is a universal, school-based social and emotional learning programme delivered to children between the ages of 4 and 15. Sessions are taught through the curriculum, covering six core topics of self-concept, positive actions for the body and mind, positive actions for getting along with others, positive actions for managing yourself, positive actions for self-improvement and positive actions for being honest with yourself and others. Sessions are direct instruction from lesson plans in teachers' manuals which include activities such as role-play, discussion, poems, music, puppets, games, radio plays and journaling. Two separate RCT trials concluded a range of statistically significant benefits in violence risk reduction including reduced serious violence-related behaviours and reduced prevalence of substance misuse. [171] [172]

The Good Behaviour Game (GBG) is a universal preventative programme delivered by a teacher to a class of primacy school students, normally between 15 and 30 children and normally lasts between 10 and 45 minutes. It is a behaviour management strategy that is designed to encourage prosocial behaviour and reduce disruptive behaviour. Teachers initiate GBG by dividing children into small teams that are balanced for gender and child temperament. Teams are awarded points for good behaviour, according to basic classroom rules which are reviewed in class. Short games are played weekly. The programme is underpinned by life course and social field theory which states that improving the way teachers socialise children in classrooms will result in improved social adaption of the children in the classroom social field. The theory predicts that this early-improved social adaptation will lead to better adaptation in other social fields over the life course. Two RCTs have concluded positive outcomes for violence risk reduction including reduced aggressive and anti-social behaviour in class, reduced anti-social behaviour at 14 year follow up and reduced alcohol abuse and dependence at 3,6 and 14 year follow up. [173] [174]

3b. Selective Skills Based Programmes

Selective skills based programmes target additional support at young people and their families with greater or specific needs.

Helping the Non-Compliant Child is a programme of up to 12 sessions delivered by a psychologist or social worker for parents who are having difficulty managing the behaviour of a child between the ages of three and eight. The practitioner works individually with the parents and their child. The programme teaches a range of effective strategies for managing noncompliant child behaviour and seeks to improve the child's ability to regulate his or her behaviour, reduce anti-social behaviour and improve relationships with other children. An RCT concluded that children treated through the programme reduced symptoms of ADHD and improved conduct, whilst parents improved parenting practice and gained parenting satisfaction.[175]

Incredible Years Dinosaur School Child Training is a group-based programme for children with behaviour difficulties aged between four and eight. The programme teaches children self-regulation and problem solving skills in small groups. Children are taught to identify and recognise emotions in self and others and helped to develop emotional literacy, to problem solve and respond appropriately to social interactions with peers and adults. Parents and teachers are updated on session goals and asked to help reinforce target behaviours. Three separate RCT studies concluded positive effects including improved behaviour in both home and school and improved social competence with peers. [176] [177]

Treatment Foster Care Oregon Adolescent (TFCO) is a team based intervention available in the UK that works with young people in foster care, their foster carer, birth family, school, and move-on placement. It usually lasts for 9-12 months. The programme aims to increase a young person's social, emotional and relational skills and therefore reduce the need for more challenging and anti-social behaviours. Trained foster carers deliver the TFCO model directly to young people in their everyday interactions. All young people also follow an age appropriate behavioural incentive programme and receive weekly skills coaching sessions. A Birth Family Coach works with the young person's birth family to help them learn and implement the TFCO parenting programme. Tis helps to improve their own skills as parents and improve the quality of the contact that they have with their child, increasing the likelihood of the young person being returned home. A number of studies have concluded reduction in risk factors for violence including a reduction in the number of days running away from placements, reduced rates of criminal referrals and reduced rates of delinquent behaviour.[178] [179]

4. Connect youth to adults and activity that role model positive behaviour

Young people's risk for violence can be buffered through strong connections to caring adults other than parents and involvement that help them develop and apply new skills. Relationships to caring adults over and above parents or primary care givers can influence young people's behavioural choices and reduce their risk in involvement in crime and violence. [180] [181] Within the prevention hierarchy they are most often *selective* (aimed at populations at risk) or *targeted* (aimed at individuals with high risk behaviour) although could be delivered universally.

Mentoring programmes show positive outcomes in systematic reviews and meta-analyses for improvement in behavioural, social, emotional and academic domains. The *Big Brothers Big Sisters of America* (BBBS) is the oldest and best known example of a one-to-one mentoring programme implemented in community and school settings in the US. An evaluation found positive impacts in a number of risk behaviours including mentees being 46% less likely to have initiated illegal drugs and 32% less likely to have engaged in a physical fight. Other benefits included stronger academic competence and improvement in parental trust.[182] [183]

After-school programmes show mixed evidence of effectiveness, probably because of the high variability between the programme models, duration, structure and participants. [184] One of the most effective is the *Los Angeles' Better Educated Students for Tomorrow (LA BEST)* programme. A rigorous longitudinal evaluation of LA-BEST found significant positive outcomes on academic achievement and reduction in arrests for youth crime and violence, especially among those students who attended for at least 10 days per month.[185]

Another good example of best practice is the *After School Matters (ASM)* programme which offers apprenticeship experiences in technology, science, communication, the arts and sports to high-school students in Chicago Public Schools. A rigorous RCT of the programme across 10 schools in predominately lower income areas found that participating young people missed fewer days of school, had higher self-regulation, a more positive attitudes and were less likely to sell drugs or participate in gang activity than youths in the control group.[186]

5. Intervene early to reduce harms of exposure to violence and violence risk behaviours

Many young people who engage in violence as teens and young adults have histories of childhood conduct problems, aggression, violence, delinquency and criminal behaviour.[187] [188] [189] These youths often have other known risk factors for violence including substance misuse, academic problems, association with deviant peers and home environments characterised by disruption, conflict, violence and other family problems. [190] [191] Justice responses made in isolation such as incarceration have limited effect on youths' future criminal behaviour. The Children's Society in their 2019 report on Child Criminal Exploitation[Error! Bookmark not defined.] noted that:

> *"Responses are almost always reactive not preventative. Professionals report that many children come to attention of statutory agencies when exploitation is already present and*

criminal groups are controlling them to deliver drugs. Typically law enforcement takes precedence over safeguarding responses."

and further concluded that thresholds for intervention by Youth Offending Services were generally set too high noting that typically Council Children Services Departments wait until a young person offends before providing an intervention.

Approaches that seek to address high risk behaviours such as violence, delinquency and early offending have the potential to interrupt the continuation and escalation to more serious violent offending. [192] [193]

Approaches in this area can be categorised into those that lessen the harms caused by exposure to violence, and those that aim to intervene to treat problem behaviour to prevent future violence or further involvement in violence. Within the prevention hierarchy, they are be categorised as either *targeted* or *specialist* prevention.

Treatment to lessen the harms caused by exposure to violence.

Therapeutic treatment can mitigate the behavioural and health consequences of witnessing or experiencing violence in the home and community and other adverse childhood experiences.[194] [195] Treatment aims to help youth process traumatic exposures, manage trauma-related distress and develop effective coping strategies and skills.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a therapeutic intervention for children and families who have been exposed to a traumatic event. Children and their parents attend between 12 and 18 sessions where they learn cognitive strategies for managing negative emotions and beliefs stemming from highly distressing and/or abusive experiences. It is delivered by a mental health professional with a QCF7/8 level qualification. Rigorous RCT evidence suggests that it is highly effective at treating Post Traumatic Stress Disorder and depression, improving behaviour, improving parenting practices and improving psychological functioning. [196] [197] [198]

Treatment to prevent problem behaviour and further involvement in violence

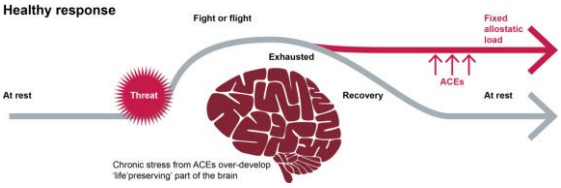
Interventions that seek to address problem behaviour and its causes and prevent future violence or escalation in violent behaviour have been shown to be effective. These approaches develop youths' social and problem-solving skills, provide therapeutic services to address behavioural and emotional issues, offer families therapeutic services to reduce conflict, improvement communication and enhance parental or school ability to supervise and manage problem behaviour in young people or in the case of parents, to address their own violent behaviour.[192] [193]

Early identification and support for neuro-disability including Traumatic Brain Injury (TBI)

Evidence from a range of international studies have demonstrated a consistently high incidence of neurodevelopmental impairment (including TBI) among young people in contact with the Youth Justice System.[199] Research suggests that Adverse Childhood Experiences (ACEs) such as physical and emotional abuse or neglect, sexual or domestic violence, or parental drug/alcohol abuse, mental illness or loss/bereavement can have long term psychological and neuro-biological negative impacts.

Learning how to cope with adversity is an important part of healthy child development. When there is a threat, the body responds by activating a variety of physiological responses, including increases in heart rate, blood pressure, and stress hormones such as cortisol producing what is called collectively as allostatic load. Protective relationships and a supportive environment protect the child from the impact of this biologically and psychologically. However when strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without adult support, stress becomes toxic, as excessive cortisol disrupts developing brain circuits and the allostatic load remains fixed at a higher level than baseline (19) as shown in figure 8.3

Figure 8.3: Biological Impact of ACE-related stressors and trauma related response



There is clear evidence that a prolonged increase in allostatic load caused by ACEs neurodevelopmental impairment, neuro-disability as the brain of the child develops. Neurodevelopmental impairments are expressed through a wide range of symptoms including deficits in reasoning, thinking and perception, lack of impulse control, expression of emotion, formation of positive relationships, and expression of challenging behaviour (all identified as individual risk factors for violence in Chapter 5).

Research suggests the 'tipping point' for this process is experience of four or more ACEs with young people in this cohort being 14 times more likely to become a victim of violence, 15 time more likely to become a perpetrator of violence and 20 times more likely to be incarcerated at some time in their lives[200].

Young people at risk of perpetrating anti-social and violent behaviour could be identified earlier if assessed for underlying cognitive and emotional needs and support and intervention to address these and their underlying causes could be provided.

Level 5 Pathways Triple P is a targeted programme for parents who have difficulty regulating their emotions and as a result are considered at risk of physically or emotionally harming their children (aged 16 or younger). It is delivered over five 1-2 hour sessions in a variety of settings including the home, clinic or community centre. It aims to improve

children's mental health and wellbeing, prevent maltreatment and prevent crime, violence and anti-social behaviour. Three RCTs concluded a reduction in potential for parental child abuse, improved parental confidence and involvement, reduced parental over reactivity and blame and improved child quality of life.[201] [202] [203]

Multi-systemic therapy involves trained therapists working with high risk adolescents who have a history of anti-social behaviour and experience of the criminal justice system. Unlike traditional approaches which concentrate purely on the thoughts and feelings of the individual, MST directly both interpersonal (e.g. cognitive) and systemic (i.e. family, peer and school) factors known to be associated with adolescent anti-social behaviour. Moreover, because different combinations of these factors are relevant for different adolescents, MST interventions and individualised and highly flexible. MST has been shown to be highly effective in reducing violent offending. Evidence suggests that approach can reduce offending by a third compared to standard psychological therapy.[204]

Functional Family Therapy (FFT) is targeted at young people between the aged of 10 and 18 involved in serious anti-social behaviour and/or substance misuse. The young person is typically referred into FFT through the youth justice system at the time of a conviction. The young person and his or her parents than attend between eight to 30 weekly sessions to learn strategies for improving family functioning and addressing the young person's behaviour. Two RCTs have identified positive outcomes in risk factors for violence; reduced recidivism and reduced cannabis use.[205] [206]

Hospital Based Programmes access young people attending A&E or who are admitted to hospital due to violence related injury. They comprise of brief psychological interventions, referral to specialist services including mentoring and youth services and are based on the premise that interaction in A&E with a young person attending because of violence presents a unique 'teachable moment' where youth involved in violence or gang culture may be amenable to receive other interventions that may deliver desistence. The programmes also provide a valuable source of intelligence for law enforcement. There is some evidence of positive results of these programmes where trialled on a reduction in hospital attendances and admissions for violence where there are strong arrangements between acute trusts, crime reduction partnerships and the police for sharing anonymised data on ED attendances for violent crime.[207] [208]

Preventing Gang Membership and Crime caused by Gangs

There is little robust published evidence base (randomised control trials) of interventions that can definitively conclude effectiveness at preventing gang membership and further research is urgently needed in this area of practice.

A systematic review into provision for preventing youth gang involvement for children and young people aged 7-16 in the UK in 2008 concluded that there were *no randomised control trials or quasi-randomised controlled trials of the effectiveness of opportunities for gang prevention.*[209]

Upstream prevention

Upstream prevention activity aims to reduce the risk factors that may lead to young people becoming involved in gangs or intervene to actively dissuade gang membership in youth people. They can be delivered either universally (i.e. to all young people) or in a selective way (targeted at cohorts of young people at increased risk of gang membership).

A systematic review conducted on upstream prevention programmes that focused on dissuading young people from joining gangs found only six robust studies out of an initial search of 3,850 that could be included. Studies included two universal and four targeted approaches. It concluded a small positive impact across the pooled data of a statistically significant odds ratio of 1.26 (i.e. young people receiving the interventions were 26% less likely to join a gang). However, four of the six studies individually failed to conclude a statistically significant positive impact and the authors concluded that the evidence on gang prevention programmes was too weak to claim whether or not the programmes were effective[210].

Despite the lack of robust studies where gang membership prevention was a specific outcome, it is worth noting that many of the risk factors identified from the evidence for youth gang involvement in Chapter 6 mirror those for serious youth violence. As such, it could be argued that many of the evidence based prevention programmes discussed in section 1 to 5 previously in this chapter may also have a positive impact in reducing the risk of gang membership.

Downstream prevention

Downstream prevention activity aims to assist young people to exit gangs and disrupt gang related activity, harm and violence.

Opportunities Provision is a gang prevention strategy derived from research that concluded that young people join gangs as a means of fulfilling economic needs due to exclusion from the labour market and lack of socio-economic opportunity and mobility.[211] [212] *Opportunities Provision* provides tutoring, supplementary education, job training and preparation, job development and other programmes designed to increase economic or educational opportunities available to gang involved youth. Some studies have indicated the potential effectiveness of *opportunities provision*. One 1996 survey of past and current gang members found that 49.1% felt job training and employment programmes were effective in preventing gang membership.[213] Other studies have concluded that *opportunities provision* is most effective when administered within late childhood and early adolescence as this corresponds to a time when parental supervision decreases, youth typically begin involvement in gangs and are most receptive to prevention programmes. [214] [215]

The Pulling Levers Strategy for gang disruption has been experimented by a number of American police departments. Pioneered in Boston to halt serious gang violence, it can be summarised by selecting a specific crime problem such as gang related homicide; convening an inter-agency working group of law enforcement, health and care practitioners and community representatives; framing a response to offenders that uses a varying menu of law enforcement sanctions to dissuade offenders from continuing to offend; focusing health/care/community resources on targeted offenders to match law enforcement activity; and directly communicating to the target group of offenders why they are receiving this special attention.

A meta-analysis of 10 studies relating to the *pulling levers* approach concluded that nine of the 10 reported statistically significant drops in offending although none of the studies were of high quality in that they included a control group.[216] As such, the effect they report could simply be regression towards the mean (the research bias that shows that often situations improve/resolve on their own without or despite intervention).

The *Comprehensive Gang Model* featuring targeted and group-based social interventions offering support and help alongside enhanced enforcement activity against gangs and individuals, provision of social opportunities for at risk youth, and community mobilisation involving agencies and citizens is an example of the *Pulling Levers Strategy*[217]. It is currently the favoured intervention in the US and more recently the UK. This model was a key point of reference in the development of *Operation Ceasefire* developed in Boston and has been described as a 'focused deterrence strategy, harnessing a multitude of different agencies plus resources from within the community itself. [218]A modified version of the model has been adopted in Glasgow and Manchester. However a systematic review of 17 such *comprehensive gang model* programmes found that whilst eight showed positive results on crime reduction, none of the effects achieved statistical significance.[219]

Gang Injunctions are a specific example of the *Pulling Levers* intervention. The Police and Crime Act (2009) authorises law enforcement agencies to apply to a County Court for an injunction if they can demonstrate that on the balance a probability:

- An individual is involved in or has encouraged gang-related violence or drug dealing activity, and
- A gang injunction is necessary to prevent such activity or protect the individual from harm.

Gang injunctions give a range of statutory powers to authorities including to disrupt the movement of gang members, limit association and communication between gang individuals and compel gang members to participate in rehabilitative activities on threat of further arrest and more serious sanction.

A 2017 study examining four Merseyside gangs over a 36 month period found a drop of 70% in individual offending amongst gang members and a 60% drop in victimisation of gang members compared to the pre-injunction period. Comparison between gangs with and without injunctions found a downward trend in gang offending in the injunction served gangs that was not observed in the comparator gangs over the same time period.[220]

Addressing the wider-determinants of serious youth violence and gang membership

Serious youth violence and gang membership does not occur in a vacuum. Chapter 5 highlighted a range of socio-economic, community and environmental risk factors including poverty, adverse childhood experiences such as neglect and abuse, neighbourhood disorganisation, lack of community infrastructure, school exclusion, poor quality housing and access to/perceived availability of cannabis. Chapter 5 also proposed causal factors for prolific youth offending that included unstructured time spent in locations with poor community cohesion or lack of positive social values.

In section *** we highlighted research that demonstrated how experience of adverse childhood experiences can permanently alter the allostatic load on the developing brains of children and young people causing permanent neuro-disability that in turn increases the risk of many of the individual risk factors identified in Chapter 5 such as aggression, high level of daring, low self-esteem and poor impulse control.

Some of the interventions discussed earlier in this chapter can help to address the wider determinants of serious youth violence, for example early years education and parenting support will improve educational outcomes and life chances. Similarly action to improve family dynamics and relationships may reduce the likelihood of adverse childhood experience like neglect and violence.

In the remainder of this chapter we examine the evidence base for addressing other wider determinants of violence and creating systemic change to improve the environment that young people grow up in.

Modifying the physical and social environment

Approaches to prevent youth violence and crime by enhancing and maintaining the built environment could include increasing lighting, improving accessibility to social spaces, increasing security, creating green space and developing meaningful community activity for young people. Evidence suggests that areas in which these approaches are trialled see a reduction in reduced arrests and an overall reduction in violent crime compared to areas that remain undeveloped.[221] [222]

A systematic review of *Crime Prevention Through Environmental Design* standards in the US that promoted design of the built environment based on increased positive personal interactions, enhanced visibility, access to green

spaces and improved housing quality found decreases in gun assault, violent crime, youth homicide, and disorderly conduct as well as beneficial impacts on residents' perception of crime, stress, community pride and physical health.[223] [224] [225] [226] [227] [228]

Reduce the concentration of outlets selling alcohol

Systematic review and meta-analyses show that alcohol control policies including restrictions on the concentration of outlets selling alcohol, licencing regulations and hours and days of sale can reduce risk factors associated with youth violence and other health conditions.[229] [230] One US study found a significant reduction in ambulance pickups of youth for violent injuries compared to a control community following alcohol control policies being implemented. [231] Other international research studies demonstrate the efficacy of alcohol sale restriction on murder, physical assault and violent crime. [232] [233] [234]

Street outreach and community development

Interventions in this category use outreach or community development workers to connect with residents, youth and gang members to mediate conflict, promote norms of non-violence and connect violent offenders or gang members with support that may prevent further offending. There is some evidence from the US of its efficacy. Evaluation of Chicago's *Cure Violence* outreach programme implemented in seven communities found significant reductions in aggravated batteries and assaults and shootings in half of the implementation communities. Evaluation of Baltimore's *Safe Streets* programme in four neighbourhoods found significant reductions in nonfatal shootings in all areas and significant reductions in murder in two implementation areas compared to comparator communities without the intervention.[235] [236]

Intervention to address the harm caused by social media

In Chapter 5 we discussed the emerging evidence on the link between social media and youth violence and gang membership. The evidence base on how to address this effectively is extremely limited. Researchers from University College Birmingham in their *Catch 22* research report on social media and youth violence[94] suggest three approaches:

Prevention: Providing resources and training on social media to parents and front line professionals that will enable them to better engage with young people and understand the risks posed by the largely unregulated social media space

Intervention. Recent research in Chicago has provided some evidence on how effective use of social media proactively by youth outreach workers is pre-empting and preventing serious incidents of face-to-face youth violence. Youth workers use social media platforms to monitor increased tension between high-risk individuals and groups and then intervene proactively to reduce tension.[237]

Suppression. Active monitoring of social media content by law enforcement authorities with a view to requiring social media platforms to take down damaging content.

Reducing school exclusions and minimising impact when they occur

In Chapter 5 we explored the association between school exclusion and violent crime and gang membership in young people and highlighted evidence that being excluded from school can increase other risk factors.

The 2019 Timpson Review commissioned by the Department for Education set out a range of evidence based recommendations to prevent unnecessary exclusion and the harms that can be caused by them. It highlighted four key drivers:

- Differences in leadership at school level which leads to an unacceptable level of variation in exclusion policy and practice
- Variation in systems, capability and capacity between schools to manage poor behaviour
- Perverse incentives at system level that can discourage schools from taking responsibility for the needs of children they wish to exclude
- Lack of safeguards that protect children against informal exclusion and off-rolling together with inadequate safeguarding responses to the wellbeing of children receiving multiple periods of exclusion.

The review makes a number of recommendations to reduce avoidable exclusions and the harm caused by excluding children including:

- Consistent guidelines to address variation in practice between schools
- Strengthened partnership working and data sharing between all schools, local authorities, local health partners to take collective responsibility for collecting and reviewing data on excluded pupil needs and for planning and funding local alternative provision and services that intervene early for children at risk of exclusion
- Additional support to the school workforce to ensure that have the knowledge and skills needed to better manage behaviour and meet wider pupil needs and address risk factors including dedicated senior leads for mental health
- Strengthening Alternative Provision and additional support for at risk children including creation of school 'internal inclusion units; nurture pogrammes; approaches to strengthen the engagement and advocacy skills of parents; creating inclusive environments for BME children who are at higher risk of exclusion including mentoring and role models; proactive use of AP as an early intervention delivered in mainstream schools and through off-site placements including comprehensive holistic six week assessment of the educational, behavioural and social needs of young people who are excludedRi

Enforcement – Stop and Search

Police stop and search practice either to deter or detect remains a controversial and political topic. The statutory power to stop and search is an investigative tool used to allay or confirm a police officer's suspicions, short of arrest. It requires reasonable suspicion on the part of the officer conducting the search that a crime may have been committed. Non-statutory stop and search allows officers to search individuals on a voluntary basis.

One distinction that can be drawn is between reactive and proactive stop and search. Put simply, reactive stop and search responds to suspicious circumstances either reported or witnessed, whilst proactive stop and search actively seeks out potential suspects in situations where an offence is likely to occur. Evidence suggests that these two approaches to stop and search are underpinned by different policing aims. Reactive stop and search aims to detect incriminating evidence, and therefore makes greater use of statutory search powers which require reasonable suspicion. In contrast, proactive stop and search aims to deter people from offending and involves carrying out a large number of searches in order to communicate the likelihood of detection.[238]

Table 8.1 taken from an evaluation of police practice in Scotland describes the two approaches based on force data.[238]

Table 8.1: Reactive and proactive stop and search: Key Indicators

Indicator	Reactive (Detection)	Proactive (Deterrence)
Search rates	Lower search rates, due to greater use of reasonable suspicion.	Higher search rates in order to communicate the likelihood of detection and strength of the deterrent effect
Search power	Greater use of statutory powers and reasonable suspicion, in order to detect	Greater use of non-statutory stop and search. Allows officers to increase search rates without reasonable suspicion.
Reason for search	Higher proportion of drugs searches, due to the prevalence of drugs and reasonably clear grounds for suspicion.	Searches target crimes associated with younger populations. High proportion of offensive weapons and alcohol searches.
Age-profile	Searches follow the standard age-distribution of offending	Searches directed towards young people over and above the standard age-distribution of offending
Detection rate	Higher detection rates, due to use of reasonable suspicion (19%)[1]	Lower detection rates, due to limited use or lack of reasonable suspicion. (9%)[1]

Does stop and search reduce crime and deter people from offending?

Evidence on the efficacy of stop and search in deterring violent crime is equivocal. Proponents draw on existing literature that concludes that 'the perceived likelihood or certainty of being caught must be reasonably strong to deter crime'.[239] [240] It is also worth noting that widespread use of stop and search as a deterrent has featured in successful approaches to reducing knife crime in the UK, for example in Glasgow.[241]

Whilst there is limited robust evidence to suggest a *direct* association between the use of stop and search and offending levels, it should be noted that deterrent effects of individual interventions are notoriously difficult to untangle, as stop and search almost always employed as one in a range of different interventions to deter crime.[238] Some researchers point to 'highly consistent evidence' to suggest that stop and search '*causes reductions in weapons violence and homicide*'[242] whilst others point to the methodological difficulties of the evidence base that typically applies causal reasoning after the event[243] and highlight the dangers of the approach in damaging relationships between communities targeted and the police.[244]

Some recent research from the US has suggested a small but significant effect of stop and search of suspects with the highest probability of criminal behaviour on the prevalence of violent crime, drugs offences and weapons offences, with an approximate two month time lag.[245] [246] An analyses of the impact of stop and search over a ten-year period between 2004 and 2014 in London quantified a small but statistically significant impact of increased stop and search on all susceptible crime and drugs offences (-0.32% and -1.85% respectively) for each 10% increase in stop and search activity), and a weak statistically significant impact on week-on-week but not month-on-month violent crime. However no statistically significant impact was found on robbery, theft, criminal damage or non-domestic violent crime). [247]

[1] Data taken from study[238] on stop and search across Scottish Police forces in 2010.

Chapter 9: A Gap Analysis of Current Provision in Thurrock against the Published Evidence Base

Key Findings

We conducted a gap analysis to critically analyse our current provision on preventing youth violence against the eight strategic actions identified in the evidence base and discussed the previous chapter. Our findings were as follows.

1. **Promoting family environments that support healthy family development:** Thurrock has a comprehensive and evidence based offer on Promoting Family Environments that support healthy development and Thurrock's offer in this category is almost entirely supported by high quality evidenced based studies. Thurrock provision goes over and above the current evidence base, providing a range of targeted provision for families with significant additional needs particularly around parenting. Provision is delivered in an integrated way through Brighter Futures programme with selective and targeted provision directed at families identified as having additional needs either through Brighter Futures universal work for example, health visitor checks or as a result of direct referral from Children's Social Care. There is evidence of effectiveness of the programme in terms of improved outcomes for families, reduced levels of risk factors and reduced demand on children's social care services.

2. **Providing quality education early in life**: Thurrock has invested heavily into early years education through Brighter Futures funding provided through the Education and Skills and Children's Social Care Divisions of the council and from the Public Health Grant. Current provision is comprehensive and in line of published evidence of best practice both for the universal offer and selective support given to children with additional needs. Our current services are likely to be reducing risk factors and vulnerabilities for future youth violence including aggression, development and education attachment. The programme is delivered in an integrated way through Brighter Futures. Outcomes data show the programme is having a positive effect. Despite having levels of child deprivation and hence need significantly worse than England's, Thurrock's outcomes are statistically significantly better than England's on all major indicators; the only local authority within our CIPFA comparator group to achieve this.

3. **Strengthening youth's communication, empathy, problem solving and emotional intelligence skills:** Thurrock's current provision on skills development does not currently mirror recommendations in evidence base which recommends universal classroom based programmes to help young people to develop skills and additional selective skills development programmes with children who need additional support. The new *Schools' Wellbeing Service* has great potential to fill this gap and help individual schools in the borough develop curriculum activity that supports young people to improve skills in communication, empathy, problem solving, conflict resolution and emotional intelligence but the service is at an early stage. The school nursing element of the Healthy Families service is also well placed to support this programme but is believed that most of its focus is with individual children rather than wider universal programmes. A new OfStEd framework that focusses on a more rounded curriculum should also support both services to develop skills based classroom and selective provision. A more comprehensive universal and targeted skills based offer in schools would improve classroom behaviour, reduce risk factors for violence and could support a reduction in the need for fixed term exclusions, which have been identified as having a strong association with youth violence in Thurrock young people.

   A range of additional skills based development programmes are on offer through INSPIRE Although of high quality, they are generally highly selective for example TCHC only works with NEETS and careers advice is only available to a relatively small number of children that each school who purchases the service selects. As such, their reach into the general population of Thurrock young people is limited and their primary focus is also often based around employment and careers. INSPIRE front line staff report that the effectiveness of their work is often compromised by underlying unmet mental ill-health need in the young people whom they work with. Access to EWMHS for 1:1 therapy is not adequate for underlying need both in terms of waiting times and minimum threshold requirements. Better integration of adolescent mental health provision as part of an integrated youth offer is required to maximise the effectiveness of INSPIRE's offer.

4. **Connecting youth to adults and activity that role model positive behaviour**: The evidence base suggests that universal youth work provision to create meaningful out of school activity, and mentoring programmes for young people show promise in reducing risk factors for serious youth violence and gang membership. Thurrock's current provision is of high quality but inadequate in its scope and coverage. There is no youth provision whatsoever in Grays and limited provision in other parts of the borough operating only one evening a week. New mentoring programmes are available but are highly targeted and will only be accessible by a small proportion of young people who could benefit. The council needs to prioritise new or future investment to expand the provision of universal youth services across the borough, particularly in Grays and to expand the provision of mentoring programmes so that significantly more young people could benefit.

Key Findings (continued)

5. Addressing the wider determinants of serious youth violence and gang membership: There are currently some gaps in local provision against this strategic action. Whilst universal provision on improving the built environment is operating effective at a strategic level for major future planning/regeneration programmes such as the Purfleet Regeneration Programme and Grays Town Centre redevelopment, there is less evidence of a strong connection on how local intelligence on serious violent crime feeds into a drives regeneration action. The evidence base highlights the success of action to limit the concentration of retail outlets selling alcohol in geographical areas with a high prevalence of violent crime but there is little evidence that this is happening locally or that crime intelligence is being considered as part of licensing decisions. The council needs to use its intelligence in a more proactive way to inform services that address wider determinants of health.

   Drug and alcohol treatment services for both young people aged under 18 and adults are considered high quality and waiting times for treatment remain short. However the proportion of drug users in treatment has fallen year on year from 2014/15 driven largely by a steady increase in prevalence of crack-cocaine use as discussed in Chapter 5.This is a worrying trend meaning an increase in the numbers of residents in Thurrock with untreated crack-cocaine use. This is turn may reflect an increase in County Lines activity within the borough. The Council's new Addictions Strategy should undertake further analyses to understand issue and action to increase the proportion of users in treatment

   The relationship between social and youth violence is discussed in Chapter 6 but there is little evidence of a comprehensive strategy in Thurrock to addressing harm caused to young people by social media in the context of violence, either at a universal level in terms of education of parents or a more targeted level in terms of monitoring social media platforms to gain intelligence or action to disrupt harmful social media content and targeted outreach interventions based on intelligence gained. A more strategic local approach to addressing the harms caused by social media needs to be developed.

6. Intervene early to reduce harms of exposure to violence and violence risk behaviours: Thurrock has a wide range of selective/targeted provision aimed at addressing violent behaviour in young people and reducing the likelihood of future violence. The Prevention and Support Service (PASS) and youth work service in A&E are in line with published evidence base although the latter is currently only funded as a pilot from the Essex Police, Fire and Crime Commissioner and requires mainstream funding to become sustainable. A range of additional innovative programmes including Holiday Activity Programmes, the Goodman Project and Power undertake targeted work with high risk young people. These programmes need to be evaluated to assess impact and success. Thurrock YOS is evidence based, high quality and achieves good outcomes in general for young people who have committed crime with the majority of young people who access the service prevented from re-offending. However Chapter 2 identified a small cohort of young people who access YOS multiple times for violence against the person offences and robbery. This cohort often also commit drugs offences and current YOS interventions appear unsuccessful at delivering crime desistence for this group. Further work is required to understand the reasons behind this and develop new approaches.

   The current mental health offer provided to Thurrock via the EWMHS service is commissioned separately and is not well integrated with other programmes. Front line professionals highlighted that thresholds to access EWMHS services are set too high and waiting times are too long. Current EWMHS mental health provision when provided focuses largely on the individual and does not offer the more holistic specialist support recommended in the evidence base such as multi-systemic therapy or family functional therapy that seeks to address wider problems in the family and environment of the young person. Trauma focused CBT also recommended in the evidence base for victims of serious youth violence is also offered. As such, current provision in this area is too individually focused and fragmented. A new single integrated model for treatment of young people involved violence is required that treats children in young people in the wider context of issues within their family and environment.

   A new single integrated and more holistic offer for treating youth violence is required that works further 'upstream' with youth at high risk of committing violent offences, integrates mental health and the other range of interventions and treats the individual in the context of their environment.

7. Preventing Gang Membership and Crime Caused by Gangs: The published evidence base is weak in this area. The SoS+ programme is funded as a pilot and only operates within the Olive Academy. The Knife Crime Awareness programme operates through YOS and as such is only available to those young people who have been arrested for weapons offences. Current provision is therefore largely re-active when targeted at young people who are members of gangs. A wider *Opportunities Provision* approach is required to increase the likelihood of young people exiting gangs together with increased reach of programmes aimed to dissuading and diverting young people from gang involvement.

8. Enforce the law to disrupt and deter violent offenders and crime connected with gangs: Thurrock is making use of targeted stop and search activity based on intelligence led policing activity. Gang Injunctions are in place and have been shown to be successful. Current enforcement activity is in-line with the published evidence base.

Introduction

This Chapter examines the current provision in Thurrock to prevent and reduce serious youth violence and gang membership. It critiques the likely effectiveness against the evidence base discussed in Chapter 7 and makes recommendations for future provision moving forward. It also describes current governance arrangements relating to the Violence and Vulnerability agenda.

Eight strategic actions to prevent serious youth violence and gang membership.

The evidence base in Chapter 7 can be grouped into eight strategic actions shown to be effective in preventing and reducing serious youth violence and gang membership:

1. Promote family environments that support healthy development
2. Provide quality education early in life
3. Strengthen Youth's communication, empathy, problem solving, conflict resolution and emotional intelligence skills
4. Connect youth to adults and activity that role model positive behaviour
5. Intervene early to reduce harms of exposure to violence and violence risk behaviours
6. Address the wider determinants of violence and gangs
7. Prevent gang membership and crime caused by gangs
8. Enforce the law to disrupt and deter violent offenders and crime connected with gangs.

A summary of the evidence base against these eight strategic actions is shown in figure 9.1, which also highlights whether the evidence based activity is *universal* (aimed at the entire population); *selective* (provided only populations with additional need or increased risk); *targeted* (aimed only at individuals with additional needs or risk); or *specialist* (programmes that seek to address existing violent or other damaging behaviour in young people).

Figure 9.1

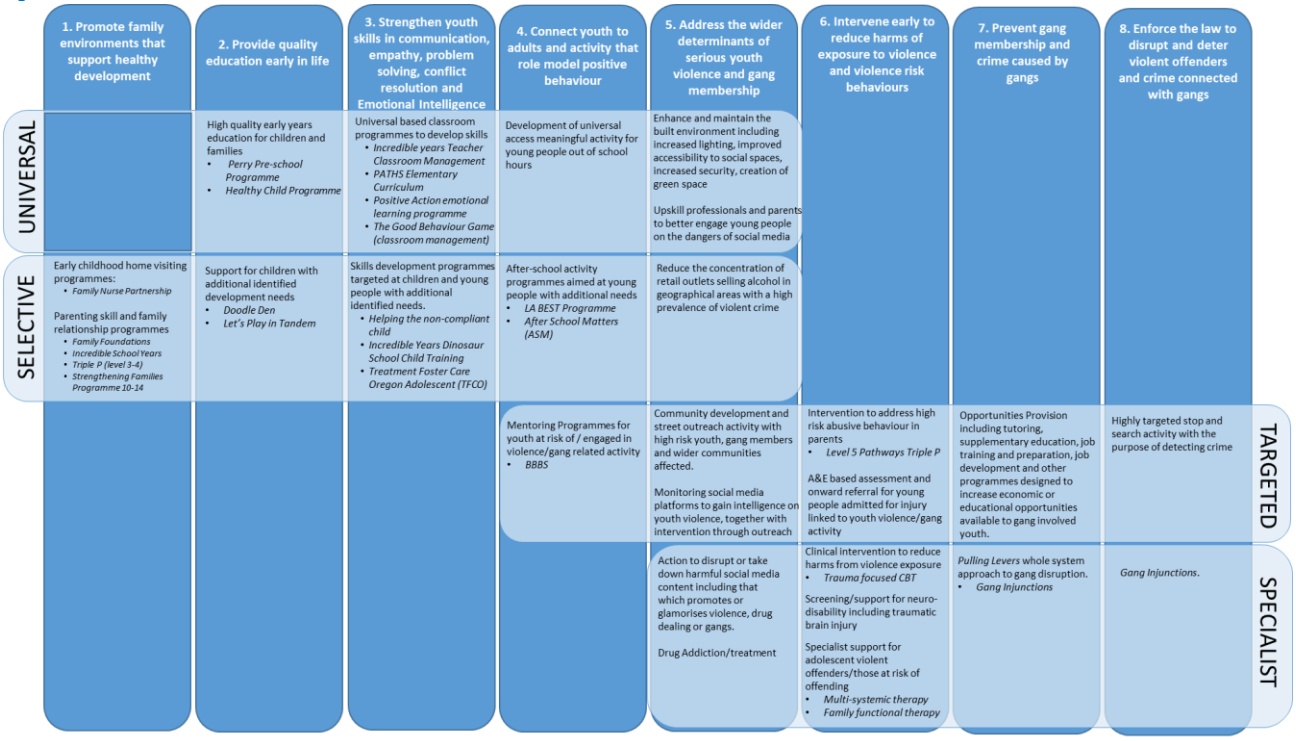
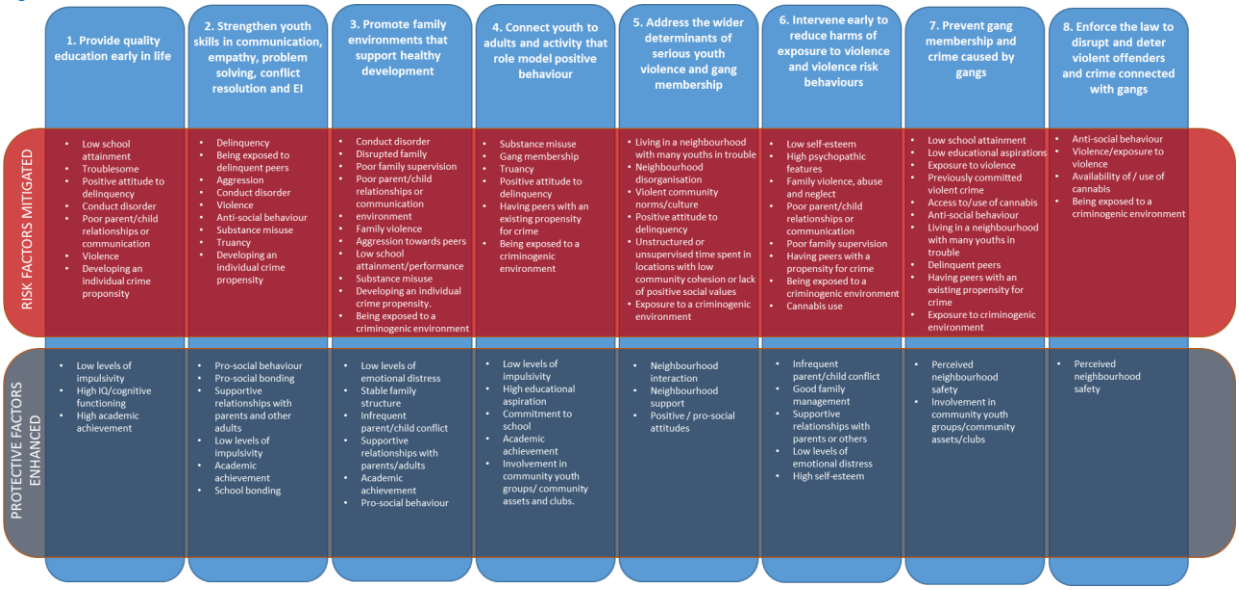


Figure 9.2 highlights the risk and protective factors that each strategic action aims to reduce or strengthen.

Figure 9.2



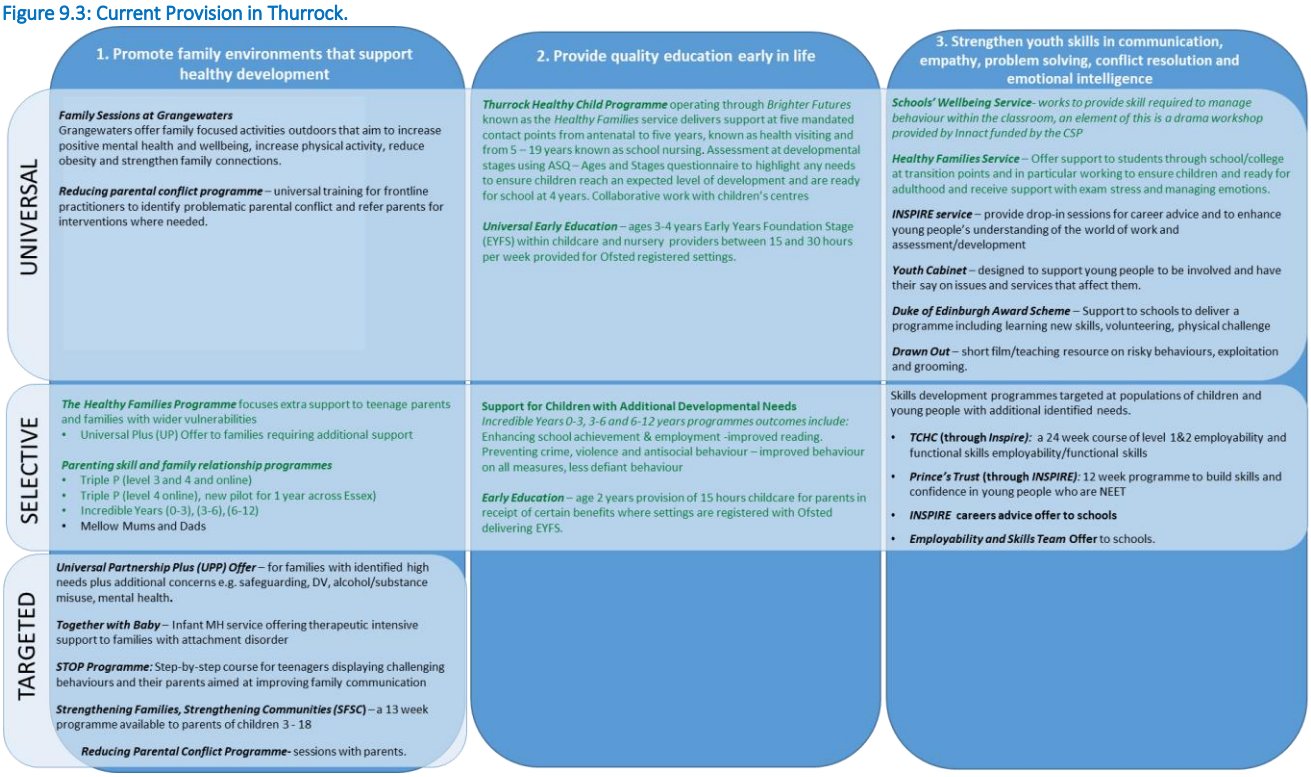
Current provision against strategic actions 1-3:

Figure 9.3 gives a summary of current provision for the first three strategic actions:

- 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.

Interventions that mirror evidence of best practice set out in the previous chapter are shown in green. Interventions not supported by published evidence base are shown in black. It is important to remember that serious youth violence is an emerging issue and as such, the published evidence base is not that well developed. As such, it should not be inferred that because an approach is not supported by a published paper, it does not have value or is not effective; simply that it is important to ensure that it is well evaluated. A public health approach to tackling serious violence should be about testing new and innovative ways of working and scaling up those that show a positive effect.

Figure 9.3: Current Provision in Thurrock.



1. Promote family environments that support healthy development

Universal Provision

Grangewaters offer a range of family focussed activities outdoors that aim to promote positive mental health and wellbeing, increase physical activity, reduce obesity and strengthen family connections.

A universal training programme is available for all frontline practitioners to help identify problematic parental conflict and refer parents for interventions where needed.

Selective Provision

The council commissions or delivers provision in line with published evidence of best practice.

The Healthy Families Programme is delivered through the Brighter Futures Healthy families Service delivered by North East Foundation Trust (NELFT). It is an early intervention and prevention public health programme for children and families. The Universal plus element of provision identifies vulnerable families, provides, delivers and co-ordinates evidence based packages of additional care, including maternal mental health & wellbeing, parenting issues, families at risk of poor outcomes and children with additional health needs in a targeted way. Additional contact points and support are put in place. Universal Plus includes intensive parenting support and interventions for vulnerable parents that have been shown to improve their outcomes and that of their children.

Parenting Programmes in Thurrock are commissioned by Children's Services and offered on to families identified as needing additional support. A range of accredited and evidence-based parenting programmes are available and in addition a limited number of one-to-one interventions. Current capacity meets demand.

Programmes include:

Incredible Years Programme is delivered in Children's Centres. The model used focuses on strengthening parenting competencies and fostering parent involvement in children's school experiences, to promote children's academic, social and emotional skills and reduce conduct problems. This is available to parents of children and young people between the ages of 0 and 12 with specific programmes aimed at different age groups including a baby and toddler programme, pre-school programme and school age children (aged 6-12). Each programme consists of two-hour weekly group sessions over 12-13 weeks, where parents learn strategies for interacting positively with their child and discouraging unwanted behaviour.

National published evidence for this programme's impact specifies it achieves positive outcomes for families including: enhancing school achievement and enjoyment; improved reading; preventing anti-social behaviour, crime and violence; and improved child behaviour.

Triple P (level 3) – Triple P is an evidence based tool for frontline staff to use in their everyday practice. This is not a commissioned offer however, the provider is expected to have staff trained in this programme. Upon assessment, a decision is made on whether this programme is the most suitable for the family at the time. When used the teenage programme (aimed at parents of children aged 12 – 16) is delivered focussing on addressing behavioural difficulties within this age group and improving family communication problems receives specified intensive sessions to improve their parenting practices.

Outcomes measured using the Outcome star and de-escalation of cases model as above.

Mellow Mums or mellow Dad is a programme designed to support families with children aged 0 to 5 who are experiencing complex relational and attachment issues. It is delivered over 14 weekly 4.5 hour sessions. It works to create and understanding how previous experiences may impact on parenting relationships. The programme consists of using a mixture of reflective and practical techniques to allow parents to address their personal challenges and the challenges they face with their children.

Outcomes measured using the Outcome star and de-escalation of cases model as above. Other outcomes measured include improvement in parental mental health and child behaviour.

An emerging offer of *Triple P (Level 4)* known as the Triple P online parenting programme has been commissioned by Essex CCGs and Essex County Council for a 12 month pilot across Southend, Essex and Thurrock and delivered by Triple P as a digital offer. It is a stand-alone web-based intervention (equivalent to Level 4 Triple P) designed to promote positive parenting practices and teach parents the application of principles to specific situations. There are three elements to this offer;

i) 0 – 12 year - It is a broad-based parenting intervention delivered online for parents of children up to 12 years. It involves eight (1-hour) online modules that parents complete independently.

ii) Teen Triple P – 10 – 16 - It is a broad-based parenting intervention delivered online for parents of teens aged up to 16 years. It comprises six (1-hour) online modules that parents complete independently.

iii) Triple P - Stepping Stones- this is a service is specifically for families with CYP with ASD and on the autistic spectrum. The service also provides mentoring support through e learning.

The *Triple P Online* programme focuses on families with pre-adolescent children, children who present with diagnosed (or undiagnosed) developmental challenges. The stepping stone element works to manage and prevent mild to moderate behavioural challenges for families already within the care of specialists to address developmental needs.

The Step-by-Step course is available for parents with pre-teen or teenagers (10-16 year olds). The course aims to improve family communication through learning how to really listen and de-code what your pre-teen/teenager is really saying or needing. As your pre-teen/teenager is developing and changing, this course aims to increase knowledge on effective behaviour management skills which will increase parental knowledge and confidence.

Targeted Provision

The following programmes are only available to families referred through Children's Services – PASS and Social care. This includes those children that have a plan as a Child In Need (CIN), a Child Protection (CP) plan or in some rare cases at the point of care proceedings. Outcome measures follow requirements of the programme licence:

Universal Partnership Plus (UPP) offer from Healthy Families Service is available where there are identified health needs plus additional concerns, such as safeguarding, domestic abuse, alcohol/substance misuse, mental health problems, or poor physical health. The UPP offer provides ongoing support from health visiting team plus a range of local services within the Brighter Futures offer, working together to deal with more complex issues over a period of time. These include services from the children's centres and other community services including charities

Together with Baby-Infant Mental Health Service commissioned by the CCG pan Essex, provided by EPUT and supported by the Parent Infant Foundation (PIP UK) offering highly therapeutic intensive support to families with attachment disorders to support healthy parent infant attachment. It supports families where parent mental health problems or substance abuse has prevented them from forming a secure parent infant attachment.

Strengthening Families Strengthening Communities (SFSC) is targeted at parents, step-parents, grandparents and other family members (who may be under a Special Guardianship Order) of children and young people aged 3 to 18. The Thurrock SFSC forms part of a government programme of evaluation in 2012 (The Parenting Early Intervention Programme – PEIP) which are evidenced as programmes to deliver successful outcomes. The aims are carefully assessed and aligned to the local needs and correlated to the success of existing and previous parenting programmes in Thurrock. The offer includes an initial visit with parents prior to attending any of the group sessions to assess family needs. About half of sessions are delivered as a group at Children's Centres which is the primary location for service delivery.

The broader outcomes measured follow the fidelity of the programmes which are termed *outcome stars* assessed at the beginning and end of the programme. *Outcome starts* include measures on: physical health; wellbeing; meeting emotional needs; keeping children safe; social networks; education and learning; boundaries and behaviours; family routine; home and money; and progress to work. Evaluation shows a positive shift on *outcome starts* between the beginning and end of the programme. In addition, across all of the programmes there have been 23% of cases that have de-escalated or closed to social care following intervention during the last 12 months suggesting the programme is effective in reducing demand on children's social care services.

STOP programme – This is a 10 week programme, is aimed at parents of teenagers displaying challenging behaviours. Referral is through open cases within social care or PASS and presenting issues include school attendance, relationships with parents and gang affiliation or vulnerability to this. More referrals are being received where there is gang involvement or vulnerability with incidences of young people aged just 12 reported as 'running' drugs. The STOP Programme also gives information on key parental concerns for this age group such as drugs, drink, sexual health and aggression in young people. This course is mindful of parents/carers needs and emotions as well as the teenagers. This course also offers a session on Exploitation and County Lines/ Gangs delivered by YOS.

Outcomes measured using the Outcome star and de-escalation of cases model as above.

The *Reducing Parental conflict (RPC)* programme is focussed on persistent unresolved conflict which affects the health and wellbeing of the child. Funding has been awarded from DWP to develop a strategic response and facilitate the training of professionals across the Brighter Futures partnership to be able to recognise parental conflict and support families with this. The second component to this is joining up with Essex in a regional agreement to offer 100 places on the RPC programme for parents over next 2 years. This programme is delivered by the Tavistock and Portman NHS trust.

Analysis of current provision and gaps

Thurrock has a comprehensive and evidence based offer on *Promoting Family Environments that support healthy development.* The published evidence base only contains interventions that are *selective* and Thurrock's offer in this category is almost entirely supported by high quality evidenced based studies.

Thurrock provision goes over and above the current evidence base, providing a range of targeted provision for families with significant additional needs particularly around parenting.

Provision is delivered in an integrated way through *Brighter Futures* programme with selective and targeted provision directed at families identified as having additional needs either through Brighter Futures universal work for example, health visitor checks or as a result of direct referral from Children's Social Care. There is evidence of effectiveness of the programme in terms of improved outcomes for families, reduced levels of risk factors and reduced demand on children's social care services. However, we identified a need to strengthen integrated commissioning arrangements, and evidence that

2. Provide quality education early in life

Universal Provision

The Thurrock Healthy Child Programme is delivered through the *Brighter Futures Healthy families Service* and is an early intervention and prevention public health programme for children and families that follows published evidence of best practice. The Healthy Child Programme's universal reach provides an invaluable opportunity to identify and provide evidence-based interventions for families that are in need of additional support and children that are at risk of poor outcomes including those families with varying levels of vulnerability.

The universal offer within the service is offered to all families. There are currently five mandated contact points, with a health visitor led service for the 0-5 pathway and within the school nurse led service for the 5-19 part of the pathway. Delivery takes place in a variety of locations including the home, health clinics, Children's Centres, community venues, schools and colleges. Evidence suggests that universal prevention such as health visiting; school nursing and childcare have a significant impact on reducing demand for early intervention services. They place a crucial role in identifying children and supporting families that are struggling and need early intervention support and they prevent early issues from turning into more serious problems.

Universal Early Education provides free childcare for parents or carers of children aged 3-4 in/from OfSted registered nurseries/childminders. The Early Years Foundation Stage curriculum is delivered.

Selective Provision

Support for Children who with additional developmental needs is available through the *Brighter Futures Healthy Families* service. Health visitors assess expected development through the 2½ year check to highlight children who have areas of development below what is expected. Appropriate additional support and interventions are put in place ahead of the child starting school at four years to improve development.

Early Education and aged 2 scheme offers free childcare for parents of two year olds whose parents or carers are on low income and can include nurseries, childminders and other providers who are OfSted registered and deliver the Early Years Foundation Stage curriculum (EYFS).

Analysis of current provision and gaps

Thurrock has invested heavily into early years education through *Brighter Futures* funding provided through the Education and Skills and Children's Social Care Divisions of the council and from the Public Health Grant. Current provision is comprehensive and in line of published evidence of best practice both for the universal offer and selective support given to children with additional needs. Our current services are likely to be reducing risk factors and vulnerabilities for future youth violence including aggression, development and education attachment. The programme is delivered in an integrated way through *Brighter Futures*.

Outcomes data show the programme is having a positive effect. Despite having levels of child deprivation and hence need significantly worse than England's, Thurrock is the only local authority in its CIPFA comparator group of local authorities with the most similar demographic populations to have performance scores on all major Early Years' Key Performance Indicators statistically significantly better the England's. (Table 9.1) Furthermore, Thurrock's Early Years' performance ranks within the top five local authorities in every indicator, the top three in four the eight indicators and first in two of the indicators.

Table 9.1

LOCAL AUTHORITY CIPFA COMPARATOR GROUP	Proportion of New Birth Visits completed within 14 days	Proportion of infants receiveing 6 to 8 week review	Proportion of children receiving 12 week review	Proportion of children receiveing 2-2.5 year review	Proportion of children aged 2-2.5 years receiving ASQ-3 as part of health review	Good level of development achived at 2- 2.5 years	Good level of development achieved at end of year R	% children achieving expected level in communication and language skills at the end of year R
Thurrock	**90.0%**	**97.4%**	**94.0%**	**87.3%**	**98.8%**	**88.2%**	**73.7%**	**82.6%**
Thurrock RANK	**5th out of 16**	**2nd out of 16**	**1st out of 16**	**5th out of 16**	**5th out of 16**	**3rd out of 16**	**1st out of 16**	**5th out of 16**
Bedford	79.7%	76.2%	90.7%	77.5%	100.0%	83.6%	69.1%	81.0%
Bolton	92.2%	94.1%	92.6%	95.5%	96.5%	66.4%	67.3%	76.1%
Calderdale	84.3%	82.2%	90.6%	84.5%	94.8%	No data	70.5%	83.6%
Coventry	89.1%	97.2%	92.5%	86.7%	88.9%	78.4%	69.0%	77.5%
Derby UA	85.7%	98.9%	93.7%	89.8%	93.5%	86.6%	70.7%	79.2%
Medway UA	84.6%	88.0%	87.8%	75.9%	100.0%	No data	73.5%	83.4%
Milton Keynes	86.1%	91.3%	85.0%	79.7%	98.5%	82.2%	73.3%	82.2%
Peterborough	88.7%	82.3%	93.4%	78.1%	No data	71.5%	67.0%	78.2%
Reading	93.3%	89.4%	84.0%	75.3%	92.8%	91.0%	69.2%	79.1%
Rochdale	98.2%	94.8%	83.0%	64.8%	No data	66.4%	66.0%	75.4%
Stockton on Tees	82.6%	88.0%	93.1%	85.7%	86.6%	No data	73.7%	84.4%
Swindon	72.7%	87.2%	21.6%	71.2%	97.4%	88.2%	71.2%	81.8%
Telford and Wreken	89.4%	91.6%	82.5%	72.1%	97.6%	67.1%	71.3%	81.6%
Trafford	96.5%	95.2%	90.7%	92.0%	100.0%	No data	74.7%	85.5%
Warrington	89.1%	95.1%	91.5%	88.6%	99.6%	89.6%	73.6%	81.7%

Statistically significantly better performance than the England mean
Performance statistically similar to the England mean
Performance is statistically signifantly worse than the England mean

3. Strengthen youth skills in communication, empathy, problem solving, conflict resolution and emotional intelligence

Universal Provision

Thurrock School Mental Wellbeing Service – is a new programme of support offered to all schools to help them improve mental resilience and reduce risk factors to mental ill-health amongst their pupils. Dedicated workers aligned to clusters of schools undertake an individual school assessment and develops and delivers a joint action plan. Support can include curriculum development, policy development and direct delivery of programmes within the classroom. An element of this universal offer to schools works to provide skill required to manage their behaviour in class. Innact delivers assembly, video and drama sessions for children in schools. This is aimed at working with pupil at risk of being excluded using drama to communicate how to manage their behaviour and self-awareness.

The Healthy Families Service employ school nursing staff who offer support to students through school/college at transition points and in particular working to ensure children and ready for adulthood and receive support with exam stress and managing emotions

Thurrock Youth Cabinet – is designed to support young people to be fully involved in having their say about the issues that affect young people and the services that are provided for them. The programme provides consultation opportunities for services to gain feedback from young people and for the views of young people to be heard. Elected members are part of the British youth council attending conventions throughout the year in addition to the annual youth sitting. The Youth Cabinet deliver an annual youth conference which all schools in the borough attend offering the opportunity to debate issues that have arisen via the national Make your Mark campaign.

Duke of Edinburgh Award Scheme is a youth award programme supporting schools and colleges to deliver all sections of the Bronze, Silver and Gold awards including learning a new skill, volunteering, physical challenge and an expedition, in addition to operating open centres that encourage those who wish to enrol outside of their school.

INSPIRE Service Careers advice drop in sessions at Inspire Youth Hub are offered on an open access basis and provide sessions to enhance young people's understanding of the world of work focusing on identification of strengths and self-assessment, career learning, psychometric testing; understanding emotional intelligence and skills needed to excel in the modern workplace.

Drawn Out. A short film available to schools that provides a message of hope to those caught up or stuck in negative situations that have the potential to place them in very risky situations to be exploited, groomed etc. it looks at the reality of street life, gang life and associated violence and how easy it is to get drawn in.

Selective Provision

Thurrock Council's *INSPIRE* service run a number of programmes available to some young people in the Borough:

Schools based careers advice offer is available for individual schools to purchase, which provides one to one assessment and individual careers advice to secondary school pupils, usually to year 9 pupils. The offer varies between schools and is dependent on what each school decides to purchase but includes sessions on aspirations, finances, apprentices and routes to university and other higher education. Generally the level of provision purchased means only a few pupils from each school receive the offer. The council's *Employability and Skills Team* link closely with *INSPIRE* to work with schools to arrange work experience for young people and to organise employment skills development programmes like *Thurrock's Next Top Boss*.

TCHC (Level 1 and 2) employability and functional skills programme is commissioned by INSPIRE and run from their Grays hub offering a 24 week course programme in maths, literacy and confidence building linked to careers advice and development of a careers plan. The programme is open to young people who are NEET (not in education, employment or training).

The Prince's Trust programme is also offered through INSPIRE and aims to build confidence in young people who are NEET. Evaluation suggests positive outcomes include increased confidence, improved relationships with parents, improved mental health and a reduction in homelessness risk.

Analysis of Current Provision and Gaps, and Recommendations

The published evidence base recommends universal classroom based programmes to help young people to develop skills and additional selective skills development programmes with children who need additional support. This perhaps the strategic action with the strongest level of published evidence based of effectiveness.

Thurrock's current provision on skills development does not currently mirror recommendations in evidence base. The Schools' Wellbeing Service has great potential to fill this gap and help individual schools in the borough develop curriculum activity that supports young people to improve skills in communication, empathy, problem solving, conflict resolution and emotional intelligence but the service is at an early stage.

The school nursing element of the *Healthy Families* service is also well placed to support this programme but is believed that most of its focus is with individual children rather than wider universal programmes.

A new OfSted framework that focusses on a more rounded curriculum should also support both services to develop skills based classroom and selective provision.

A range of additional skills based development programmes are on offer through INSPIRE including the traded careers advice service to schools and the Duke of Edinburgh, Princes Trust, TCHC and Youth Cabinet. Although of high quality, they are generally highly selective for example TCHC only works with NEETS and careers advice is only available to a relatively small number of children that each school who purchases the service selects. As such, their reach into the general population of Thurrock young people is limited. Their primary focus is also often based around employment and careers.

INSPIRE front line staff report that the effectiveness of their work is often compromised by underlying unmet mental ill-health need in the young people whom they work with. Access to EWMHS for 1:1 therapy is not adequate for underlying need both in terms of waiting times and minimum threshold requirements. Better integration of adolescent mental health provision as part of an integrated youth offer is required to maximise the effectiveness of INSPIRE's offer.

A more comprehensive universal and targeted skills based offer in schools would improve classroom behaviour, reduce risk factors for violence and could support a reduction in the need for fixed term exclusions, which have been identified as having a strong association with youth violence in Thurrock young people.

Summary of Gaps Identified

- A lack of a comprehensive universal and targeted skills based offer in schools that builds youth skills in communication, empathy, problem solving, conflict resolution and emotional intelligence. The new Schools Based Wellbeing Service provides a strong opportunity to be the delivery mechanism to achieve this but needs to concentrate on ensuring curriculum development and targeted programmes based on the evidence base for example:
  - Incredible years Teacher Classroom Management
  - PATHS Elementary Curriculum
  - Positive Action emotional learning programme
  - The Good Behaviour Game (classroom management)
- Thurrock Council Education and Public Health divisions should identify and share models of best practice across all schools using mechanisms like *The Head Teachers' Forum*
- The current EWMHS clinical care pathways and commissioning model are not sufficiently integrated into other skills based assets. Issues of access and treatment thresholds into EWMHS are limiting the efficacy of other programmes due to untreated underlying mental health problems in young people.

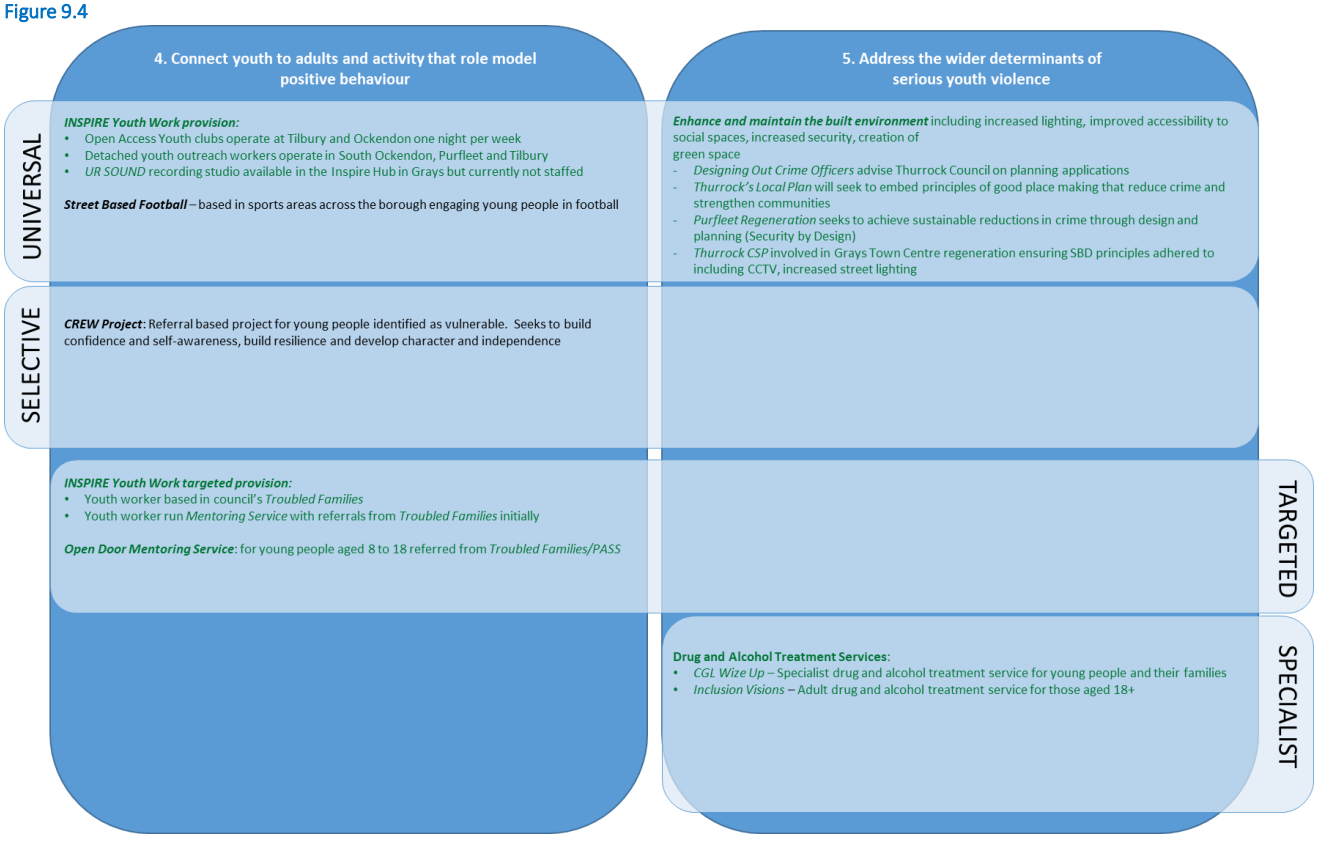
Current provision against strategic actions 4-5:

Figure 9.4 gives a summary of current provision against strategic actions four and five:

4. Connect youth to adults and activity that role model positive behaviour
5. Address the wider determinants of serious youth violence

Activity supported by the published evidence base is shown in green.

Figure 9.4



4. Connect youth to adults and activity that role model positive behaviour

The evidence base highlights the importance of universal youth work provision to create meaningful activity for young people out of school hours. Mentoring approaches for young people requiring additional support are also highlighted as showing promise in reducing risk factors for youth violence.

Universal Provision

Youth work provision forms part of the council's INSPIRE service and offers open access youth centres and detached youth workers in parts of the borough, providing informal educational opportunities that:

- Explore issues that affect young people
- Support them to build effective networks within the wider community
- Provide opportunities to develop skills
- Build positive relationships
- Explore issues and concerns

The youth work team consists of 12 posts comprising of qualified youth workers, youth support workers and apprentices. Provision includes *youth groups* operating one night a week in Tilbury and South Ockendon for 9-14 year olds and 14-18 year olds. In addition, *detached youth workers* operate in parts of South Ockendon, Tilbury and Purfleet with the aim of engaging and supporting young people within the community and connecting them to other community assets and groups.

There is currently no universal youth work provision in Grays although there are plans to deliver this when vacant posts

Summary of Gaps Identified

- Lack of provision of universal and targeted youth service provision across the borough, prioritising Grays where there is currently no provision
    - Lack of adequate provision of mentoring programmes for young people so that they are available to significantly greater numbers with a broader focus rather than simply on careers advice.

Selective Provision

CREW project is a referral based project for vulnerable young people to raise confidence and self-awareness, builds resilience and character and supports the development of independence.

Targeted Provision

Mentoring: All youth workers are trained in mentoring skills and a mentoring programme is due to commence imminently. Referrals to the programme will be from the Troubled Families (PASS) programme initially and referral criteria will be reviewed based on demand.

Mentoring is also is commissioned by Thurrock Children's Services and delivered by Open Door, aimed at children and young people aged 8-18 years. Mentoring is delivered by professionally qualified staff. The majority of referrals are from social care and schools with some from PASS. Referral reasons include young people identified at risk of exposure to gang criminality, exploitation or online grooming.

The provider (Open Door) also delivers an intensive mentoring programme funded outside of the scope of this for young people who are frequently missing, many of whom will likely have been drawn into gangs. This adds value as the project is externally funded through and independently sourced grant.

The *Employability and Skills Team* offer mentoring to four schools: Gable Hall, St. Clairs, Harris Academy and Ockendon for year 8 students. Schools typically select their most disengaged students.

Analysis of Current Provision and Gaps, and Recommendations

The evidence base suggests that universal youth work provision to create meaningful out of school activity, and mentoring programmes for young people show promise in reducing risk factors for serious youth violence and gang membership.

Thurrock's current provision is of high quality but inadequate in its scope and coverage. There is no youth provision whatsoever in Grays and limited provision in other parts of the borough operating only one evening a week.

New mentoring programmes are available but are highly targeted and will only be accessible by a small proportion of young people who could benefit.

5. Address the wider determinants of youth violence

The evidence base highlights approaches that maintain and enhance the built environment including increased lighting, improved accessibility to social spaces, increased security and the creation of green space. It also highlights action to upskill professionals and young people on the dangers of social media and proactive monitoring of social media platforms to gain intelligence from/action to take down or disrupt harmful social media content. Programmes to treat drug addiction in young people are also highlighted.

Universal provision

Designing Out Crime Officers (DOCOs) have training and experience of advising on safety and security, are independent in their advice and have further access to more specialist resources where required (ref – NPPF). Essex Police have DOCOs in place and are actively involved in advising Thurrock on planning applications as members of the Health and Planning Advisory Group, a sub-group of the Thurrock Health and Well-being Board.

Building considerations for crime and safety into the Local Plan and regeneration schemes is key. This should use relevant guidance materials and best practice (such as Secured by Design and the National Design Guide).

In Thurrock, the emerging local plan is in development and will seek to embed principles of good place-making that encourage active frontages, natural surveillance and reasons to utilise public spaces. It will also seek to protect and improve community facilities to strengthen support networks within communities, ensure a high quality natural and built environment to give a sense of pride and ownership, and design the public realm to encourage positive social behaviour such as play, relaxation, and leisure.

The Thurrock design guide (a part of local plan policy) is used as a starting point for regeneration schemes.

The Grays Town Centre Framework requires public safety to be addressed in new schemes recognising that perceptions of crime are a key reason why people do not use the town centre. The Community Safety Partnership has been involved in consultations to inform the approach for the town centre and they will be further consulted, as well as SBD (Secure by Design), as schemes develop. In schemes such as the underpass, crime and safety have been written in to the specifications including requirements for lighting, CCTV, views in and out of the spaces, designing out hiding places and shadow areas, and creating informal surveillance.

In the Purfleet Regeneration Centre Programme, part of the pre-development process will be to consult with SBD. This will seek to achieve sustainable reductions in crime through design and other approaches to reduce the demand on Police authorities and help people live in a safer society."

Selective and Targeted Provision

There is no evidence on work in these areas.

Specialist Provision

Drug and Alcohol Treatment Services for young people (aged up to 18) are commissioned from the Public Health Grant and provided by *CGL Wise Up*. The service offers specialist support to children and young people in Thurrock under the age of 18 and their families to help young people cut down or stop using alcohol or drugs, including new psychoactive substances. The offer includes; specialist one-to-one sessions, support for young people affected by the hidden harm of parental substance misuses, access to counselling, advice and information for parents and carers and support to access other health and lifestyle support alcohol and drug preventative messages and brief advice delivered in schools and community settings by the young person's substance misuse service.

Drug and Alcohol Treatment Services for young people aged 18+ are provided by *Inclusion Visions*. The service supports people to facilitate change in their lives through motivation and providing evidence-based interventions. Support may include; one-to-one and/or group work, psychological support, substitute prescribing, community or residential detoxification and/or rehabilitation, needle exchange services and health and lifestyle support.

Analysis of Current Provision and Gaps, and Recommendations

There are currently some gaps in local provision against this strategic action. Whilst universal provision on improving the built environment is operating effective at a strategic level for major future planning/regeneration programmes such as the Purfleet Regeneration Programme and Grays Town Centre redevelopment, there is less evidence of a strong connection on how local intelligence on serious violent crime feeds into a drives regeneration action.

The evidence base highlights the success of action to limit the concentration of retail outlets selling alcohol in geographical areas with a high prevalence of violent crime but there we are unclear as to the extent to which is happening locally or that crime intelligence is being routinely considered as part of licencing decisions.

The role that social media plays in relationship to youth violence is discussed in Chapter 5 but there is little evidence of a comprehensive strategy in Thurrock to addressing harm caused to young people by social media in the context of violence, either at a universal level in terms of education of parents or a more targeted level in terms of monitoring social media platforms to gain intelligence or action to disrupt harmful social media content and targeted outreach interventions based on intelligence gained.

Drug and alcohol treatment services for both young people aged under 18 and adults are considered high quality and waiting times for treatment remain short. However the proportion of drug users in treatment has fallen year on year from 2014/15 driven largely by a steady increase in prevalence of crack-cocaine use. (See Chapter 5). This is a worrying trend meaning an increase in the numbers of residents in Thurrock with untreated crack-cocaine use. This is turn may reflect an increase in County Lines activity within the borough.

Summary of gaps identified

- A need for Thurrock Community Safety Partnership to improve links with the Planning and Regeneration Teams to ensure that live crime data shapes the work programme of regeneration activity. A single mechanism based around Contextual Safeguarding should be developed where data from all agencies is shared which shapes planning and regeneration activity.
- A need to limit the concentration of licenced premises in geographical areas with a high incidence of violent crime
- Further analysis and action to understand and address the falling proportion of crack-cocaine users in treatment. This should be included in the development of a new council Addictions Strategy.

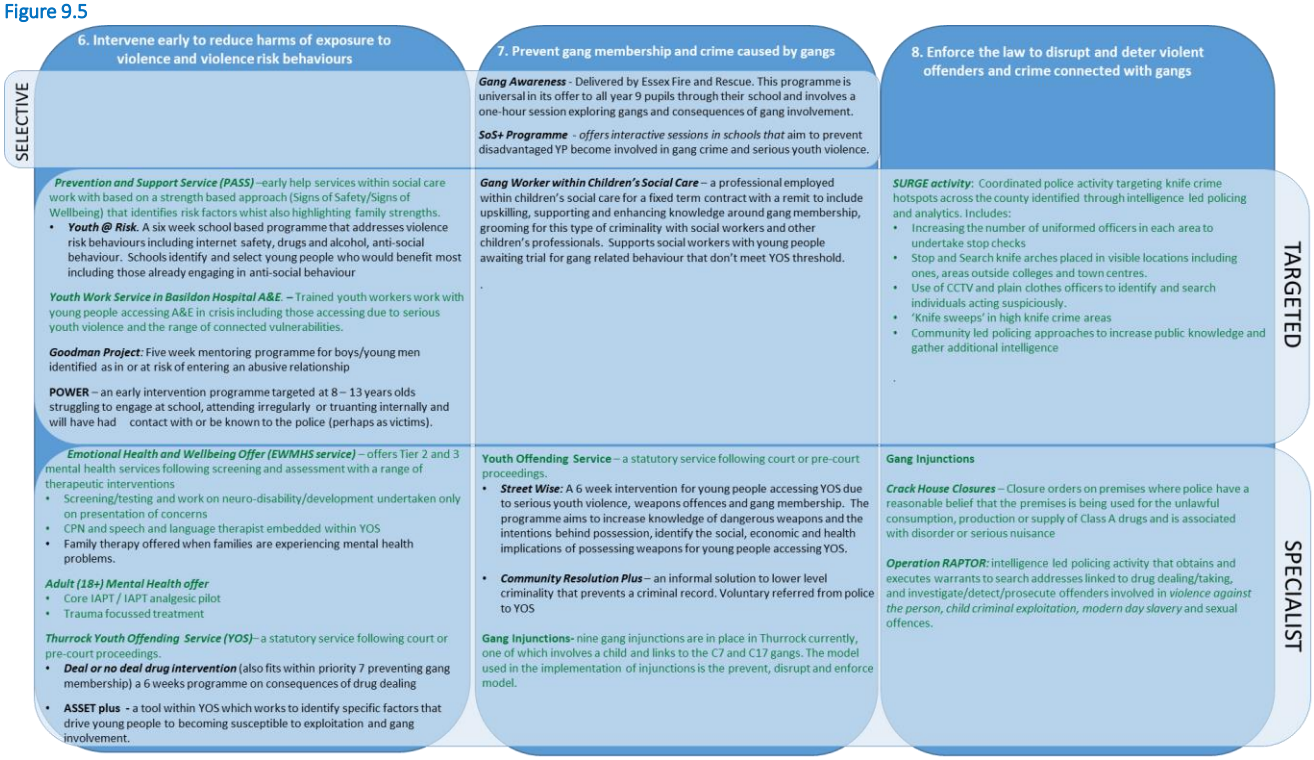
Current provision against strategic actions 6 to 8:

Figure 9.5 gives a summary of current provision against strategic actions six, seven and eight:

6. Intervene early to reduce harms of exposure to violence and violence risk behaviours
7. Prevent gang membership and crime caused by gangs
8. Enforce the law to disrupt and deter violent offenders and crime connected with gangs

Activity supported by the published evidence base is shown in green.

Figure 9.5



6. Intervene early to reduce harms of exposure to violence and violence risk behaviours

The evidence base references action in the targeted category including A&E based assessment and onward referral of young people linked to youth violence/gang activity, and the Level 5 Triple P parenting programme for parents at high risk of abusive behaviour towards their children.

In the specialist category, the evidence base highlights clinical programmes that help young people who have experienced violence deal with trauma, screening and support for neurodisability/development problems and specialist support for youths who are violent offenders including multi-systemic therapy and family functional therapy.

Selective Provision / Targeted Provision

Holiday Activity Programme is selective and targeted for different participants with the intention of preventing escalation and diverting young people from criminality. This referral based project service forms part of the Thurrock youth offer. Referrals come from the Youth Offending Team (YOT), Prevention and Support Service (PASS), Social Care, and Schools. It offers diversionary activities to those deemed vulnerable or at risk in terms of engaging in violent behaviours or have been exposed to violence, antisocial behaviours or behavioural difficulties highlighted at school. There are varying referral reasons, not all attendees are there for the same reasons or behaviours. The sessions are delivered in a group every school holiday and give participants the opportunity to engage with a team of professional youth workers who are able to constructively challenge behaviours, emotions and reactions.

Prevention and Support Service (PASS). Thurrock's PASS is a tier two service which supports CYP and families with additional needs that do not meet the criteria for a statutory service. Staff groups include Social Work, Youth Offending, Mental Health, Youth Service, and a wide range of Children Centre staff.

The PASS service initiates work with young people by completing a comprehensive assessment, based on a strength based approach (Signs of Safety/Signs of Wellbeing), this allows for a holistic assessment which will identify any risk factors whilst also highlighting the strengths within a family/child. In relation to children exposed to serious youth violence and vulnerability, a child exploitation risk assessment is completed to ensure appropriate interventions are actioned.

PASS work on an evidence based approach to preventing child criminal and sexual exploitation. The team work collaboratively with a focus on partner agency working with a *Team Around the Family Approach*. This promotes a contextual safeguarding/support to the children and family to ensure support is proportionate, appropriate and relevant, meeting the requirements and needs of the family/child.

Youth @ Risk is a programme run by the PASS Team and youth workers within schools and funded through the community safety partnership. Schools select young people to attend, most often young people showing signs of anti-social behaviour or already engaging in these behaviours. The programme is delivered over a six week period and works to address risky behaviours. The programme also works to support children at risk of CSE and addresses topics such as internet safety and substance misuse. The aim is to prevent young people from engaging in these risky behaviours and leading to involvement in youth violence and criminality.

Youth Work Service in Basildon Hospital A&E. Trained youth workers work with young people accessing A&E in crisis including those accessing due to serious youth violence and the range of connected vulnerabilities. The service is based on the premise that when a young person accesses A&E they are usually in crisis and this provides a unique 'teachable moment' when they are most likely to be receptive to help. The service has been funded as a pilot by the Essex Police, Fire and Crime Commissioner as part of the countywide pilot and is provided by Essex County Council. Youth workers develop a shared action plan with the young people involved. Work can continue over a period of weeks or months and includes onward referral to statutory services and community organisations.

The Goodman Project is a five week male mentoring programme for boys and young men (aged 13 – 18 years) who are at risk of entering into abusive relationships in the future and/or are at current risk within an abusive relationship. It can be delivered on either a group work or 1:1 basis, depending on need. The areas covered include:

- Making relationships work
- Relationships in a digital world
- Confidence
- Manners and respect
- Consequences
- Healthy relationships

The project looks to educate young people about the value of respect and the characteristics of healthy and unhealthy relationships. Equipping them with the necessary skills to develop and maintain healthy relationships, recognise how to break up in an appropriate way when necessary and maintaining appropriate open lines of communication.

POWER is an early intervention project working across Southend, Essex and Thurrock. POWER practitioners offer direct support to children and young people aged 8-13 struggling to engage at school, attending irregularly or truanting internally and will have had contact with or be known to the police (perhaps as victims). They also work to support children, young people and their parents towards developing ways of coping with challenging situations at home, at school and in their local communities. POWER also seeks to support schools to develop effective methods to enable children and young people to be successful in school.

A referral is needed and can be from the following,

- Police (through a multi-agency panel) panel
- Education services
- Pupil Referral Units (PRUs) Primary
- Secondary and special schools
- Others by consultation

Once a referral is assessed and accepted, an allocated case worker will develop and agree a plan with parent and young person and a minimum of six (6) sessions are required administered.

Specialist Provision

Emotional Health and Wellbeing Offer (EWMHS Service)

The EWMHS service delivered by NELFT is an integrated Tier 2 and 3 mental health service that delivers mental health services for children and young people aged 5-18 years with a mental health need across Essex including Thurrock.

There are two referral pathways – Single Point of Access (triage of need happens here) and A & E Crisis Response - crisis assessment is completed. Referral can be from professionals (medical, educational, community etc), young people, parents/carers, schools. The EWMHS is a selective and specialist service for young people aged 5-18 years.

Mental Health & Emotional Wellbeing practitioners are trained in different interventions across the work streams, children are assigned a practitioner depending on need. A team is based in Thurrock at the Grays hub. Where there is a requirement for group or individual sessions is to be delivered off site, these happen across locations including family/carers homes, school, coffee shop or where most convenient for the young person.

Intervention timelines vary, group interventions lasts between 6 – 8 weeks and individual interventions following the length identified within the care package provided.

Single point of access –. once a referal is made, a triage and assessment process occur.

- Routine Assessment – referral with concerns for emotional and mental wellbeing and need for interventions. Following triage, asesssment is offered within 12 weeks of referal.
- Urgent Assessment – Referals where an underling risk of harm has been, arrangements are made for the referal to be attended to within 10 working days

- Emergency Response – referrals with an imminent threat to life is refered to the crisis team. Assessment happens within 4 hours

As children are waiting for assessment, other services can be offered e.g. Universal or community (vountary sector, parenting support, early help, etc.) The single point of access also provide clinical advice to referrers as needed.

Following triage and identification of need, treatment is offered. There are four core workstreams/pathway to treatment;

- Behaviourial Conduct
- Complex Cases
- Anxiety and Mood
- Neurodevelopmental (children with morbidity)

Once a case is assigned to a workstream, the following is expected:

- Care plan development and identified interventions – these commence within 18 weeks of referral. This is also a national target. If cases get worse there is an avenue to fast track where the need presents.
- Interventions administered (a range of this exists)– This may be brief or long term depending on need
- Outcomes are tracked based on the intervention administered as well as individual achievements
- Link to other services where appropriate.

A EWHMS Community Psychiatric Nurse and speech and language therapist is embededd within the Youth Offending Service (YOS) to work with young offenders with mental health issues and/or neuro-development problems.

EWHMS also offers family therapy where families are experiencing mental health problems, although the evidence based multi-systemic therapy and family functional family is not currently provided.

Adult (18+) mental health offer relating to youth violence

IAPT provides a core offer of provision of therapies to patients with a common mental health problem. This is mandated by NHS England and has a number of targets around waiting times, access and recovery rates. An innovative pilot aiming to provide specialist IAPT treatment to those addicted to legal opioid medications is currently underway. A pharmacist has been recruited to review and treat patients referred through the pathway; IAPT therapists are providing psychological support where needed.

Trauma-focussed treatment is commissioned by NHS Thurrock CCG for victims/survivors aged 18+ who have experienced violence and subsequent trauma at any time in their lives.

Thurrock Youth Offending Service (YOS) is a multi-agency partnership that sits within the Children and Family Services department of Thurrock Council. The partnership comprises of statutory partners; the Local Authority, Essex Police, the National Probation Service, the local CRC providers and Health, each of whom (apart from the CRC) have a duty placed upon them by the Crime and Disorder Act 1998 to secure youth justice services appropriate for their area. The partnership maintains strong links with education at a strategic level through senior level engagement. Most services and interventions are delivered by the youth workers and officers with the YOS 'in house', substance misuse and mental health support is provided by specialist services.

To be eligible for the YOS a young person has been arrested and sentenced by the courts, programmes are also available via an 'out of court disposal' route. This is an arrangement between YOS and police where minor offences are committed and liaison happens to determine consequences – this enables young people become diverted from the court system. An example of where this route may be used in the instance of preventing gang membership could be where the circumstances of the arrest are in relation to young people arrested at a 'trap house' for drug dealing where it becomes evident they are being exploited by gangs. This most often occurs in a 'County Lines' scenario where young people are exploited by gangs to transport or deal drugs between counties out of bigger towns and cities to more rural locations.

Most of the interventions are delivered in house at the YOS based in Corringham. Where a need for drug and alcohol or other specialist services are identified, appropriate referrals are made. The length of the programme is determined by the nature of the court order and length of sentence and can range from 1 month to approximately 3 years.

The overarching outcome within the YOS is to prevent re-offending, the service have core KPIs to measure success;

- Reduce first time entrance to youth justice system
- Prevent reoffending
- Reduce use of custody

The YOS uses a management tool recommended by the Youth Justice Board called Asset Plus intervention. Asset Plus has been designed to provide a holistic end-to-end assessment and intervention plan, allowing one record to follow a young person throughout their time in youth justice system. The tools within the assessment framework look to identify specific factors that drive young people to becoming susceptible to exploitation and gang involvement. In this way the tool acts a targeted prevention intervention in itself. The tool is not exclusively to prevent gang membership and criminality but this is a component. It can be used for all youth offenders to manage their time with the YOS. Subsequently a multi-agency approach is used to address these factors. The YOS works towards a trauma informed model with all YOS staff being trauma trained.

- Thurrock Asset Plus contains a range of elements:
- Offending behaviour
- Drug and alcohol use
- Sexual health
- Career guidance, education and employment

- Gang and knife crime
- Family restoration

Deal or no deal drug intervention is a six week programme delivered by YOS that explores the young offender's attitudes towards drug dealing, the consequences of dealing and how the skills required to deal drugs could be effectively and positively channelled to better use. The young people accessing this intervention have usually been arrested for 'possession with intent to supply' and are often victims of being groomed for criminality by gangs. The sessions are delivered on a one-to-one basis; group work is identified to be very challenging for young people at risk of or being groomed for gang membership as tensions exist between groups and so this is generally avoided to safeguard young people and the facilitators. The intervention aims to prevent young people from becoming further involved with drug dealing, gang membership and criminality.

Analysis of Current Provision and Gaps, and Recommendations

Thurrock has a wide range of selective/targeted provision aimed at addressing violent behaviour in young people and reducing the likelihood of future violence. The Prevention and Support Service (PASS) and youth work service in A&E are in line with published evidence base although the latter is currently only funded as a pilot from the Essex Police, Fire and Crime Commissioner and requires mainstream funding to become sustainable.

A range of additional innovative programmes including Holiday Activity Programmes, the Goodman Project and Power undertake targeted work with high risk young people. These programmes need to be evaluated to assess impact and success.

Thurrock YOS is evidence based, high quality and achieves good outcomes in general for young people who have committed crime with the majority of young people who access the service prevented from re-offending. However Chapter 2 identified a small cohort of young people who access YOS multiple times for violence against the person offences and robbery. This cohort often also commit drugs offences and current YOS interventions appear unsuccessful at delivering crime desistence for this group. Further work is required to understand the reasons behind this and develop new approaches.

The current mental health offer provided to Thurrock via the EWMHS service is commissioned separately and is not well integrated with other programmes. In the development of this report, many front line professionals highlighted that thresholds to access EWMHS services are set too high and waiting times are too long. Current EWMHS mental health provision when provided focuses largely on the individual and does not offer the more holistic specialist support recommended in the evidence base such as multi-systemic therapy or family functional therapy that seeks to address wider problems in the family and environment of the young person. Trauma focused CBT also recommended in the evidence base for victims of serious youth violence is also offered.

As such, current provision in this area is too individually focused and fragmented. A new single integrated model for treatment of young people involved violence is required that treats children in young people in the wider context of issues within their family and environment.

Many professionals consulted in the course of developing this report believe the current offer in this area is too far down stream with thresholds set too high and largely only a 'statutory' response available once young people have committed serious offences. A new strengths based integrated offer to work with young people at risk of serious violence before they offend is required.

Summary of gaps identified

- Mainstream funding to allow the Youth Work Service in A&E to continue
- Trauma based CBT to support young people who have experienced serious violence
- A single integrated and more holistic model for treating youth violence that:
  - Brings together the current range of distinct interventions
  - Has a threshold of access below that required by YOS, i.e. before young people have committed serious violent offences.
  - Integrates EWMHS
  - Provides a more holistic and less individually focussed approach adopting evidence based interventions such as Multi-Systemic Therapy and Family Focussed Therapy
- Further analyses and work to develop interventions to address offending behaviour in cohort of young people who repeatedly commit violence against the person/drugs offences

7. Prevent gang membership and crime caused by gangs

The published evidence base on this strategic action is relatively weak, with few robust studies showing positive evaluation of interventions that reduce risk of gang membership. *Opportunities Provision* where education, job training and other programmes designed to increase economic opportunity as seen as the most promising approaches. The *Pulling Levers* approach discussed in Chapter 7 where a whole system multi-agency approach is used to disrupt gangs has the best evidence base on curtailing harm caused by gang activity, with gang injunctions being one evidence based example of this approach.

Selective Provision

Gang Awareness - Delivered by Essex Fire and Rescue. This programme is universal in its offer to all year 9 pupils through their school and involves a one-hour session exploring gangs and consequences of gang involvement. It has also been offered to South Essex College for older pupils.

SoS+ Programme is an intervention that has been delivered by the St. Giles' Trust as a pilot using funding from the Violence and Vulnerability Programme established by the Police, Fire and Crime Commissioner (PFCC) and partners across Essex. The programme funds projects to reduce the risk of young and vulnerable people being groomed into a life of crime and help those affected by gangs to take the steps to leave. Funding is not yet secured for this to continue.

This programme includes one-to-one mentoring sessions alongside group sessions looking at the psychological impact of prison; it has been delivered to 20 young people at the Olive Academy, Pupil Referral Unit (PRU). Interactive sessions are offered in the school with practical tools for the young people attending to benefit from. The programme also includes an element of intervention with parents and significant adults for the young person to equip them with skills to initiate difficult conversations. It is a selective prevention programme delivered to those within the PRU only at this stage although it is intended to be a targeted programme if it were to continue with individuals identified as being at risk through social care involvement, disclosure from the young person and intelligence gathered from the professional involved in their care and education, they may be children with a Child Protection Plan or a Child in Need Plan.

Targeted Provision

Gang Worker within Children's Social Care is a professional employed within Children's Social Care for a fixed term 12 month contract with a remit to include upskilling, supporting and enhancing knowledge around gang membership, grooming for this type of criminality with social workers and other children's professionals. This role is not a front line professional with children and young people but supports those who do have this role. Children who may have been arrested can wait up to a year for the case to reach court dependent upon the complexity. In nearly all cases these children would be subject to statutory intervention from children's social care and would not be eligible for youth offending services until a court orders this. The Gang Lead can support social care with interventions and approaches to support young people with the aim of preventing further criminality and gang involvement.

Youth Offending Service (see also previous section)
Streetwise Knife Crime Awareness interventions is a 6 week in-house programme that case workers within YOS complete directly with young people on a 1-2-1 basis. It is works with young people who have been involved with weapons in any way and this includes through gang membership and for young people identified as being groomed by gangs for criminal exploitation. They will be young people in the criminal justice system with the aim to prevent further gang activity and criminality, to disrupt gang activity and divert the young person away from the gang. The sessions aim to create awareness of dangerous weapons and the intentions behind possession, identify the social, economic and health implications of possessing weapons, develop skills in conflict resolution, self-control and positive decision making and identify strategies and ways to highlight and reduce weapon crime. Each weekly session has specified aims and outcomes expected to be met or delivered on.

Analysis of Current Provision and Gaps, and Recommendations

The published evidence base is weak in this area. The SoS+ programme is funded as a pilot and only operates within the Olive Academy. The Knife Crime Awareness programme operates through YOS and as such is only available to those young people who have been arrested for weapons offences. Current provision is therefore largely re-active when targeted at young people who are members of gangs.

Summary of gaps identified

- Wider provision of programmes aimed at dissuading young people form gang membership
- A more proactive *Opportunities Provision* approach to assist young people exit gangs

8. Enforce the law to disrupt and deter violent offenders and crime connected with gangs

Targeted Provision

Increased Police Activity in SURGE areas: Essex Police have a programme of targeted stop and search, and enforcement in identified 'hotspot' locations led by a dedicated Chief Inspector. A dedicated team of intelligence officers and analysts identify geographical areas of high knife crime and individuals of interest who are known knife carriers/offenders. Funding has been made available to increase the number of officers to undertake targeted enforcement work including stop and search checks. Knife arches have been located at visible locations in including train stations, areas outside colleges and in town centres where there is an existing high prevalence of knife crime. CCTV is also used in SURGE operations and alongside plain clothed officers, is used to identify people who appear to avoid the highly visible police presence or knife arch. These individuals are spoken to, and if suspicion is raised, may be subject to a search.

The SURGE teams also undertake 'knife sweeps' to locate 'stash weapons and drugs' placed regularly in certain locations, often frequently used public spaces such as in bushes in parks and near to leisure centres. Officers also engage with members of the public, discussing the issue of knives and serious violent crime and visit locations where children and young people congregate including fast food

restaurants and cinemas in order to education them about knife crime, child criminal exploitation and serious violence, gaining further intelligence in through these discussions.

Specialist Provision

Operation RAPTOR: Dedicated police offers in 'Operation Raptor' teams use a number of methods to combat serious violence. Led by intelligence they will patrol areas in plain clothes which have a high incidence of violence, drug dealing and where intelligence tells them high harm is likely or anticipated. During the patrols they will use Stop and Search powers against known drug suppliers and those suspected to be engaging in drug supply. They will also stop and speak to children and young people whom they believe may be being coerced or exploited by Gangs and County Lines.

Raptor teams organise intelligence led operations in which they obtain and execute warrants to search premises in hotspot areas, or where intelligence suggests drug dealing is taking place. Searches of these premises and any persons on the premises believed to be involved in the supply of drugs (or possibly possession) are undertaken. The team also investigate the offences of *Possession with intent to Supply, Human Trafficking and Modern day Slavery,* and *Child Criminal Exploitation*. They might also encounter *Violence against the Person* offences and sometimes sexual offences have been perpetrated against some of the people involved.

Some of this work will involve repatriating High Risk Missing Persons (generally children and young people) to their host local authority and ensuring safeguarding arrangements are in place. The team also attempts to safeguard individuals whose properties have been 'cuckoo'ed', working with them over the medium term to attempt to ensure this does not occur again and offering support.

'Crack House Closures'. Essex Police look to impose closure orders on any premises where there is a reasonable belief that the premises is involved in the production or supply of Class A drugs
'Crack House Closures') and is associated with disorder or serious nuisance. The closure order can be extended to a maximum of six months.

Analysis of Current Provision and Gaps, and Recommendations

Thurrock is making use of targeted stop and search activity based on intelligence led policing activity. Gang Injunctions are in place and have been shown to be successful. Current enforcement activity is in-line with the published evidence base.

Chapter 10 Conclusions, Recommendations and Future Action

Introduction

In this chapter we bring together all of the analyses of the previous nine chapters and propose recommendations to address the issue of serious youth violence and vulnerability in Thurrock.

In Chapter 1 we introduced the concept of the *Public Health Approach* to serious youth violence and vulnerability and the idea that it can be conceptualised as a communicable disease that if not addressed 'infects' and spreads outwards within defined communities, but which also can be diagnosed through screening, studied using epidemiological surveillance techniques, treated through early intervention and recovery and against which communities can be 'immunised' by reducing their risk factors and strengthening protective factors.

We return to this conceptualisation in this final chapter. Recommendations using a p*ublic health approach* to address the issue of serious youth violence and vulnerability can be segmented into four categories shown in figure 10.1:

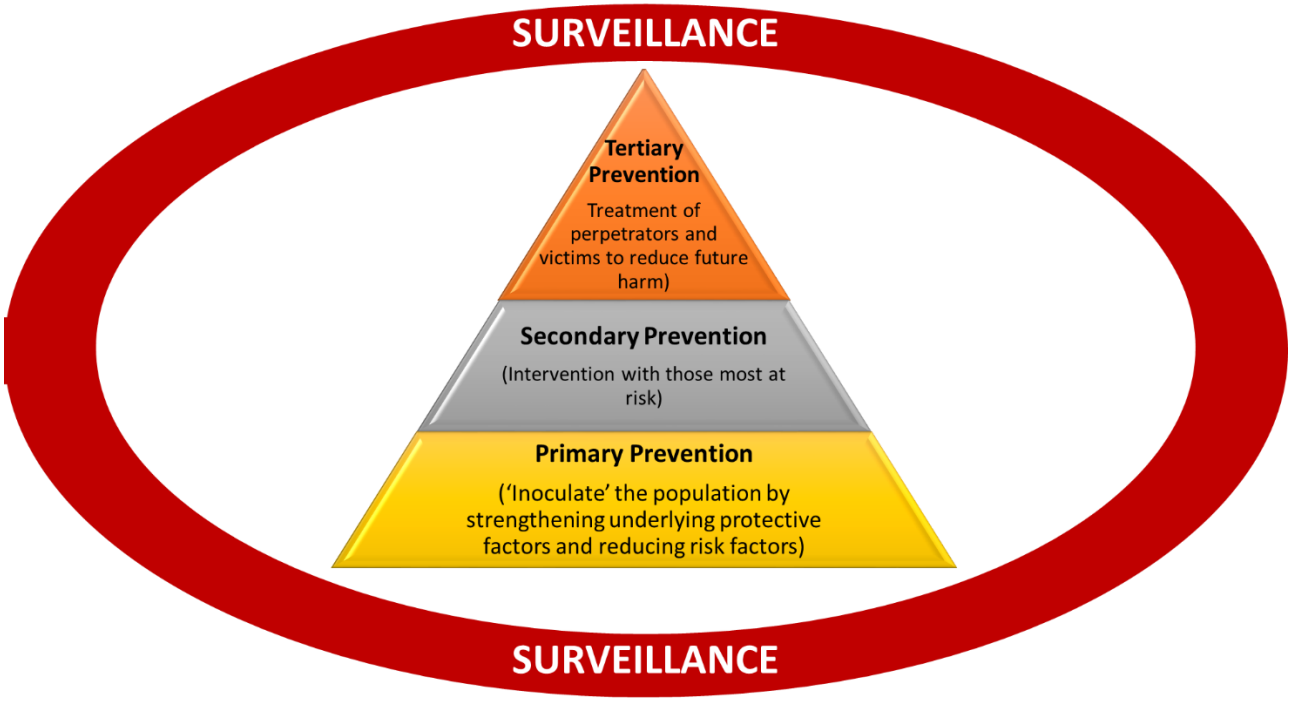
1. Surveillance: Action to understand and monitor the problem at a population level including the effectiveness of a whole system approach.

2. Primary Prevention: Action to 'inoculate' the wider communication against the risk of becoming either a victim or perpetrator of serious violence.

3. Secondary Prevention: Intervention with those with existing risk factors to mitigate risk

4. Tertiary Prevention: 'Treatment' of perpetrators and victims of violence to reduce further harm.

Figure 10.1



1. Surveillance

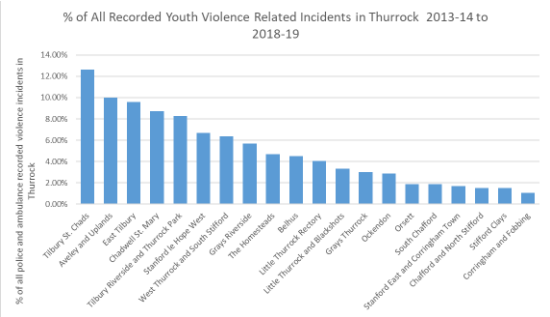
When police, ambulance and youth offending service datasets are analysed, serious youth violence and gang membership have risen significantly in Thurrock since 2013 although the limitations of each dataset on estimating the true extent of youth violence and gang membership mean that the estimated numbers vary.

Violence, injury caused by violence and gang membership is not distributed evenly across either the borough or more widely across the county and remains concentrated within specific wards. Thurrock has the second highest rate of recorded violence with injury offences in Essex with the majority of suspected perpetrators also living in the borough.

Indices of ward deprivation are a very poor predictor of violence both at Thurrock and Essex level and it is too simplistic to say that poverty is the underlying cause of violence. Whilst the majority of offenders are likely to come from deprived backgrounds, the vast majority of deprived populations never commit violent offences.

Conversely, the historical prevalence of violence at ward level is a very strong predictor of the likelihood of future violence. Violence begets violence and geographical patterns of violence and gang membership can be shown to repeat and spread outwards between years as increasing numbers of young people within a locality become 'infected'. Combining police data on reported violent crime against young people where the perpetrator was also under 25 with ambulance call outs for violent incidents where the victim was aged 10-24 for the last five years, we can see a wide variation in youth related violence between wards in the borough. This analyses should be used to prioritise targeted prevention activity (see section 3).

Figure 10.2



Datasets relating to youth violence and vulnerability are dispersed between a number of different agencies including Essex Police, Essex Ambulance Service, NHS Providers and Thurrock Council. A children's linked data set operating through the Xantura system integrates a range of different individual council service data but is currently used largely as an operational tool to provide a 'single view' of data to front line children's social care professionals. It does not however include police or ambulance datasets and only has limited health data within it. We have demonstrated through work undertaken in producing this report that the power this system has the ability to also be harnessed to provide predictive risk modelling capabilities that could allow us to identify the most at risk children and families and intervene earlier with tailored prevention packages.

As such it remains an untapped asset that could be use to join up a wider range of relevant crime and health datasets with those held by the council, to offer more proactive and holistic response, particularly to young people at risk of becoming victims or perpetrators of violent crime and/or of gang involvement.

Recommendations: Surveillance

Rec #	Issue to be addressed	Recommendation
1.1	Inadequate commissioning of strategic surveillance capability	Thurrock Council Transformation Corporate Programme should work with all key stakeholders to commission Xantura to deliver a single programme of strategic analyses that answers key corporate questions/responds to corporate strategic needs, rather than the current 'piecemeal' approach of commissioning of different pieces of individual analyses by different council services.
1.2	Inadequate linking of datasets and intelligence between crime, health and local authority	Thurrock Council Public Health and Transformation Corporate Programme Team should work with Xantura, Essex Police, Essex Ambulance Service and MSE Hospital to facilitate a regular flow of Police, Ambulance and A&E data into the Xantura system
1.3	Need to develop analyses in this report into a predictive risk model	Thurrock Council's Public Health Team should work with Xantura to develop the analyses on initial risk factors contained within this report into a predictive risk model for youth violence and (if possible) gang involvement
1.4	Need to use predictive analytics to deliver more proactive, tailored multi-agency preventative response	Following development of a predictive risk model, Xantura should work with other relevant council services to provide relevant risk profiling information to allow tailored preventative packages and more effective multi-agency response to young people at risk of becoming victims or perpetrators of violent crime and/or of gang membership
1.5	Need for effective multi-agency strategic oversight of trends in youth violence and vulnerability and effectiveness of response	Thurrock Council's Violence and Vulnerability Board should receive and review quarterly monitoring information from Xantura on trends in youth violence and gang involvement and impact of future prevention activity in order to receive assurance on effectiveness of prevention, and to inform future strategic action on prevention of serious youth violence and gang related activity. Public Health should work with other key stakeholders to design and agree a *surveillance monitoring dashboard*.
1.6	Current prevention activity inadequately targeted at geographies of greatest need	Analyses contained within this report on variation of youth violence at ward level should be used to target and prioritise prevention activity (where appropriate) at ward and school level (see next sections) including any immediate investment

2. Primary Prevention ('inoculate the population against violence')

Analyses in this report demonstrates a comprehensive, integrated and high performing *Early Years* and *Family/Parenting Support* offer through our Brighter Futures Programme that is both evidence based and delivering some of the best outcomes for children and families in the country. This is perhaps one of the most important programmes of preventative activity that the local authority and health partners can undertake to deliver long-term protection against violence and vulnerability and it should be celebrated and continued to be resourced. Over time, as the cohort of children and families accessing this offer age, protective factors will be strengthened and risk factors reduced in a large cohort of Thurrock young people.

Although the over-all programme outcomes are positive, there is a complex range of parenting programmes available and in general there is scope to strengthen and integrate commissioning arrangements of *Brighter Futures* and evaluation of individual elements. The AD Public Health is leading a process with all stakeholders to develop a single Children's Services Strategy to drive the next phase of transformation. A stakeholder workshop has already been undertaken and a shared vision developed. This work needs to explicit reference and reflect the findings and recommendations within this report. We also identified evidence that a strategic commissioning approach to Brighter Futures parenting programmes is not replicated across all tiers of need resulting in lower tier provision being used to meet higher need along with a lack of provision to meet specialist needs. The planned recommissioning of parenting provision should be expanded to provide a strategic multi agency review of the parenting support required and the resource available across all tiers. This should be used to ensure that an evidenced based offer is available across the spectrum of need. This will bring together the existing range of provision and support targeted planning, building on existing good practice

There is a strong evidence base that skills based training that addresses cognitive and behavioural risks including aggression, conduct disorder and lack of empathy prevents future youth violence. Our analyses also highlighted these risks as one of the five key risk factors within Thurrock young people driving violent behaviour. Whilst the skills based offer provided by INSPIRE is of high quality, once again its reach is limited to a small number of Thurrock young people and its traded school offer is generally limited to careers advice rather than wider skills based training.

There is a need to develop a more comprehensive classroom based skills offer on improving behaviour, reducing aggression and strengthening emotional intelligence in our young people. A new more holistic OfSted framework should support this and there is probably best practice within some schools within the borough that could be shared more widely. The new Schools Based Wellbeing Service are ideally placed to build this capacity within the Thurrock school curriculum and should ensure that what is developed is based on programmes that have already been shown to be the most effective.

For teenagers in Thurrock, the INSPIRE service offer is undoubtedly of high quality but has insufficient reach and scope. Whilst there is a growing evidence base on the positive impact that both generic and targeted youth service out of school provision can have on diverting young people away from violence, provision is currently limited to Tilbury, Ockendon and Purfleet and is inadequate in terms of its reach. After school meaningful youth activity directly positively impacts one of the four causal risk factors suggested in this report that explain *the crime paradox; being exposed to a criminogenic environment through unstructured time spent unsupervised in neighbourhoods with poor community cohesion.* However some wards with higher prevalence of youth violence such as Aveley and Uplands, Stanford-le-hope West, West Thurrock and South Stifford, and Grays Riverside have limited or no youth clubs or detached youth work

Recommendations: Primary Prevention

REC #	Issue to be addressed	Recommendation
2.1	Continued success of Early Years offer, with selective provision better targeted and tailored to populations with greater need	Thurrock Council should continue to commission the current model of Early Years and Family/Parenting Support through Brighter Futures. The new Brighter Futures strategy being developed by Public Health should explicitly reference youth violence and vulnerability prevention and the role that the suite of services play in universal and selective prevention.
2.2		The Xantura predictive model (when developed) should be used to better target tailored prevention packages (particularly selective prevention) available through Brighter Futures at children and families most at risk

Recommendations: Primary Prevention (continued)

REC #	Issue to be addressed	Recommendation
2.3	Continued success of Early Years offer, with selective provision better targeted and tailored to populations with greater need	Brighter Futures commissioners should strengthen commissioning arrangements into a single integrated function that includes a review of parenting programmes and robust evaluation of the impact of individual interventions
2.4	Inadequate comprehensive schools based skills offer despite strong evidence base.	The School Based Wellbeing Service in conjunction with the *Brighter Futures Healthy Schools Service* and Thurrock schools/academy groups should seek to develop a comprehensive curriculum skills based offer focusing on improving communication, improving classroom behaviour, problem solving, strengthening emotional intelligence, reducing aggression and strengthening impulse control in conjunction with Thurrock schools based on evidence based programmes such as: - *Incredible Years Teacher Classroom Management* - *PATHS Elementary Curriculum* - *Positive Action Emotional Learning Programme* - *The Good Behaviour Game*
2.5		Thurrock Council Education Division in conjunction with Thurrock Schools/Academy Groups should seek to share best practice on skills based learning between all schools through existing mechanisms such as the Head Teachers' Forums.
2.6	Inadequate reach of generic youth services to provide meaningful after-school activity for young people, despite emerging evidence base and link to locally determined risk factor	Thurrock Council should prioritise future new investment in expanding the reach of the generic youth service offer, prioritising areas where there is currently no or inadequate levels of provision and higher prevalence of youth violence for example: Aveley and Uplands, Grays, Chafford
2.7	INSPIRE skills based offer, although of high quality, is to funded at a supply level to meet need/demand and could be broadened from careers focus	Thurrock Council and Thurrock Schools/Academy Trusts should prioritise future new investment in expanding the reach and breadth of INSPIRE generic skills based offer to allow a greater number of young people to benefit. INSPIRE should consider broadening the scope of the traded offer to schools from careers advice to include skills development on improving communication, problem solving, strengthening emotional intelligence, conflict resolution and impulse control.
2.8	Efficacy of INSPIRE skills based offer is compromised through young people being unable to access timely 1:1 talking therapy to address mental health problems	NHS Thurrock CCG/MSE CCGs Joint Committee in partnership with Thurrock Children's Services Commissioners and Public Health should seek to re-design and recommission the EWMHS care pathways to better integrate 1:1 talking therapies into other community assets providing Primary Prevention activity, for example INSPIRE

Secondary Prevention (Intervene earlier with those most at risk)

It is perhaps in the area of earlier intervention with those who have significant numbers of vulnerabilities that in-turn lead to serious youth violence and/or gang membership where there is most scope for an improved local strategic response.

In short, and in line with many other areas of the UK as highlighted in earlier chapters of this report, in Thurrock current thresholds for intervention with those at serious risk of becoming perpetrators (and perhaps to a lesser extent) victims of violent crime are set too high. Our focus is too heavily skewed downstream to tertiary prevention with inadequate secondary prevention activity. There is insufficient secondary prevention activity and we wait until young people get arrested for a violent offence before intervening. This is a huge missed opportunity.

In line with many other areas of the country, when we do intervene, there is too great a disconnect between different agencies; a weighting towards criminal justice and a

complex array of discrete interventions but a lack of a single holistic assessment and tailored, coordinated multi-agency response. Furthermore provision currently consists of a series of interventions which, whilst may be of merit, are insufficiently coordinated, have multiple referral pathways for access, may be delivered in parallel and are often focused on individual cognitive or behavioural factors. Neighbourhood disorganisation, and particularly living in a neighbourhood with access to drugs/drug dealing was highlighted in both the published evidence base and in analyses undertaken through the Xantura dataset as a key driver of youth violence in Thurrock. Conversely, our current response perhaps focuses too much on individual risk factor and behaviour without adequately considering the context in which the young person lives.

In line with findings by Ofsted, there is a need to strengthen the operational coordination of information and alignment of systems to monitor the needs and impact of work with vulnerable adolescents and children including alignment of wider support such as employment, training, education, homelessness advice, drug and alcohol addiction and mental health treatment services. Young people at high risk of or beginning their journey of violent offending are likely to have experienced a range of adverse childhood experiences and will likely have a number of vulnerabilities that need addressing in parallel.

That is not to say that nothing is being done in Thurrock or that what is currently being delivered lacks value. Children's Services have commissioned a consultant in contextual safeguarding to review existing provision and make recommendations and we have worked closely with her in producing this report. There are also some models of good practice such as basing a gangs lead within social care, that go some way to joining up provision, however more needs to be done particularly in 'joining the dots' to create a coordinated and holistic response.

There is a need to share intelligence from multiple agencies on young people that they have individual concerns about, regularly in multi-disciplinary panels to build up a comprehensive picture of need/risk. Where risk was assessed to meet statutory thresholds for intervention, a referral could be made to Children's Social Care. Where a young person was identified as having a series of significant risk factors that were under the threshold for statutory intervention but where a coordinated response from multiple agencies could assist in reducing risk, referral to a new integrated support team would be made.

A Multi-Agency Child Exploitation Panel currently exists in Thurrock and this could be expanded in scope and potentially number to be locality based and focussed on evidenced and data based information sharing that will support all agencies to understand in-depth risk and community based threats. In time, these multi-agency panels could in time be supported by Xantura predictive risk analyses modelling work referenced in recommendations 1.3 and 1.4.

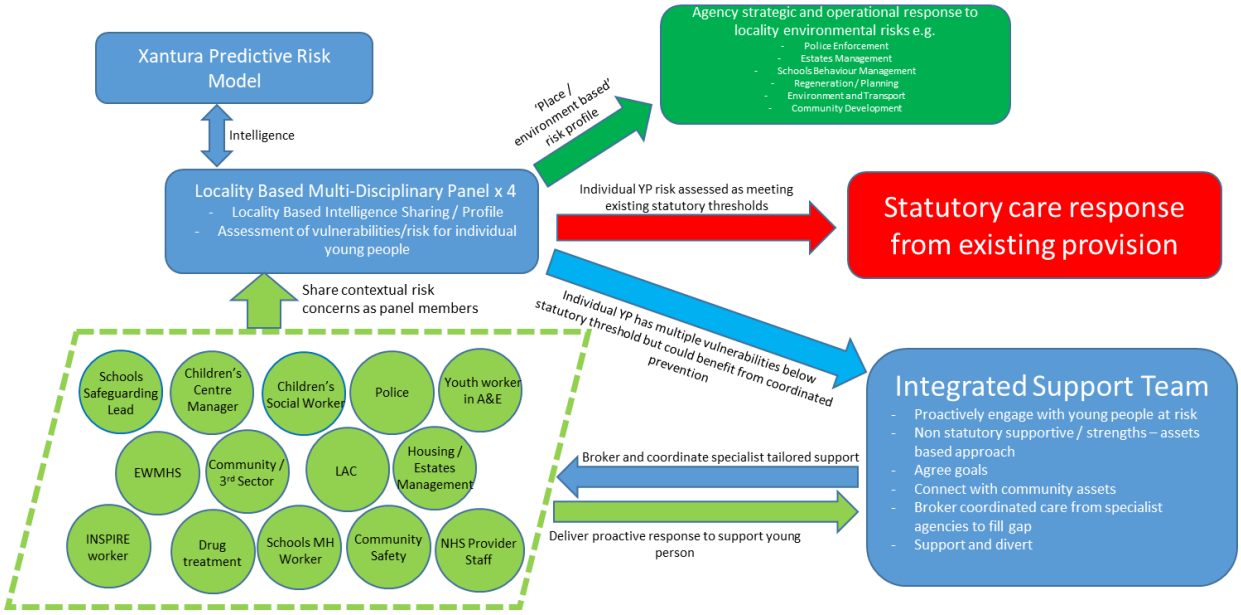
Locality based shared intelligence on 'place based' environmental risks e.g. drug dealing, bullying, anti-social behaviour could also be used to direct rapid operational interventions from a range of stakeholders to reduce place based environmental risks, e.g. police enforcement activity, action within schools or estates management. In addition it could be used more strategically to inform commissioning of future services, community development/asset building work or the work of planning and regeneration and environment functions to improve the built environment.

We recommend the creation of a new integrated support team to receive referrals of each multi-agency panel of young people with risk below the statutory threshold for intervention but where proactive multi-agency support would assist in reducing vulnerabilities and risk. They would act upon shared intelligence from each multiagency panel and seek to engage directly and proactively with vulnerable young people and their families to divert them away from exploitation and youth violence. This service should work on the 'strengths/asset' based approach successfully employed by Thurrock Adult Social Care through the *Better Care Together Thurrock* transformation programme; a Local Area Coordination/Community Led Solutions approach to vulnerable young people / families. The team would also be responsible for care coordination of a tailored package of support where required to enhance the strengths based approach and to connect young people with more meaningful community activity.

Key to this multi-agency model of working is the responsiveness to education issues, ensuring that there are appropriate activities to provide alternatives for young people who are not able to attend or are excluded from school. Mental health support could be available through either a funded dedicated specialist post within the team and/or through a more integrated care pathway with EWMHS.

Figure 10.3 shows a high level graphical representation of what an improved service offer may look like:

Figure 10.3



Other Secondary Prevention Conclusions

In line with recommendations made in the report of the Contextual Safeguarding Consultant, there is a need to implement a programme of training for front line health and care staff in the emerging issue of contextual safeguarding, child criminal exploitation and county lines.

There is also a need to address variation in school exclusions across the borough. Whilst Thurrock has one of the lowest rates of secondary school fixed-term exclusions in England and a permanent exclusion rate in line with the national mean, the borough's primary schools have a fixed-term and permanent exclusion rates are in the second worst and worst quintiles of national performance respectively. Moreover, there is a four and six fold variation in primary school fixed and permanent exclusion rates and a 14 and seven fold variation in secondary fixed term and permanent exclusion rates at school level respectively. This will undoubtedly reflect in part differences in demographic intake and need between school populations, but may also suggestion variation in exclusion practice and policy at school level. Exclusion from education was highlighted both in the national evidence base as a risk factor, and could be a driver for the suggested causal factor of time spent in unsupervised locations. It was also one of the five risk factors linked to youth violence and gang membership identified from the Xantura analyses.

Fixed and permanent exclusions are not the only mechanism by which children and young people detach from education; poor attendance and truancy could also be underlying programmes. The *Power programme offers direct support to children and young people struggling to* engage at school, attending irregularly or truanting internally and will have had contact with or be known to the police (perhaps as victims). They also work to support children, young people and their parents towards developing ways of coping with challenging situations at home, at school and in their local communities. POWER also seeks to support schools to develop effective methods to enable children and young people to be successful in school. We have been unable to access robust evaluation of the impact of this programme, and if not completed, this would be worth undertaking. The proposed model above could be one mechanism to intervene more proactively with repeated school absence, and monitoring could take place within the Locality Based Multi-disciplinary panels with proactive engagement with parents and young people undertaken by the Integrated Support Team or existing resources within schools. During the development of this report, one head teacher suggested than any child with an attendance below 75% needed to be flagged and followed up as a risk.

Drug and alcohol treatment services, whilst high performing in terms of access and treatment success indicators have shown a decrease in 'population reach' corresponding to an increase in crack-cocaine use at population level. This is concerning as it suggests that fewer residents with class A drug addiction are coming forward for treatment. There is a clear association between drugs and violent crime/gang membership in both the evidence base and in local analyses from Xantura. Further analyses is needed to understand and address the issue.

There is an emerging evidence base on the positive impact of mentoring approaches with young people with existing risk factors for violence. Thurrock has a low level of provision in this area which is highly targeted suggesting that supply is inadequate for need. Future investment should be prioritised at expanding the reach of these services.

Finally social media has been linked to both youth violence and gang membership both in the national evidence base and through local intelligence but there is little strategic or coordinated action to address this risk.

Recommendations: Secondary Prevention

REC #	Issue to be addressed	Recommendation
3.1	Intelligence on young people with multiple vulnerabilities that make them at high risk of becoming victims or perpetrators of violence not shared in a timely fashion between partner agencies in a single forum and risk assessed on the basis of concerns from all stakeholders	Create locality based multi-disciplinary panels that meet regularly where all intelligence can be shared 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
3.2		Public Health to ensure Xantura Predictive Risk Model (when developed) is used to support the work of the multi-disciplinary panels
3.3	Inadequate place (locality) based understanding of environmental and organisational risk e.g. school based bullying, drug dealing, anti-social behaviour and coordinated timely action to address	Locality based multi-disciplinary panels should collate environmental risks to create a locality based risk profile and relevant agencies should undertake rapid operational action to reduce and mitigate risks for example enforcement activity, community development, estates management. Action to swiftly address identified drug availability/dealing within neighbourhoods should be prioritised as this was identified in Xantura analyses as a local risk factor strongly associated with youth violence.
3.4	Inadequate link between place (locality) based identified environmental risk and strategic action to improve the built environment to reduce existing risk factors such as crime	Locality risk profiles should be used 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,
3.5	Risk assessment of young people who may be above thresholds for statutory social care service is not informed by intelligence from a sufficient number of agencies	Multi-disciplinary panels to assess risk of individual young people using intelligence from all panel members and refer young people above the threshold for a statutory service to Children's Social Care
3.6	Inadequate and uncoordinated service provision for young people with multiple risk factors who do not meet threshold for statutory service	Thurrock Council should prioritise future investment to create a new Integrated Support team to receive referrals from multi-disciplinary panel from young people with multiple risk factors but below threshold for statutory service.
		New Integrated Support Team should be based on the strengths/assets approach successfully used by Adult Social Care and will be responsible for: • Proactively engaging with young people at risk and (where appropriate) their family/peers • Agree goals with young people • Connect young people with community assets that help them achieve their goals • Support and divert young people away from crime and gang membership • Broker coordinated care from specialist agencies where necessary to address unmet needs
3.7	An inadequate provision of mentoring provision for young people with existing vulnerabilities and risk factors for violence is very highly targeted and not meeting need, despite emerging evidence base of effectiveness in violence prevention	Thurrock Council should prioritise new investment in developing and expanding reach of current mentoring provision so that an increased number of young people at risk of violence can benefit. Effectiveness of current and future mentoring should be evaluated robustly using Xantura

Recommendations: Secondary Prevention (continued)

REC #	Issue to be addressed	Recommendation
3.8	High variation in fixed-term and permanent exclusion rates between primary and secondary schools, and high overall rate of primary fixed-term and permanent exclusions are likely to be increasing risk of youth violence and gang involvement. Very high rates of fixed term exclusions in the PRU are of particular concern. This was identified as a key risk factor in the Xantura analyses.	The AD Education and Skills with support from Public Health should undertake further analyses to understand variation, particularly very high rates at the PRU and develop a strategy to address these.
3.9		Education and Skills Division in association with Head Teachers and Academy Trusts should facilitate sharing of best practice on reducing exclusions between schools.
3.10	Lack of systematic mechanism to provide assurance that children and young people who are absent from education are monitored and followed up.	Education and Skills Division in association with Public Health should undertake a robust evaluation of the *Power Programme* to ascertain impact and effectiveness (if not already completed)
		Children and young people with school attendance below 75% should be flagged at the Locality Based Multi-Disciplinary panel with proactive follow up initiated where appropriate
3.10	Adult drug treatment services are treating a decreasing proportion of crack-cocaine users at a time when prevalence is increasing meaning more residents are living with untreated crack-cocaine addiction	The Director of Public Health should undertake further analyses of the issue and develop strategic action plans to improve the situation through the new Thurrock Addictions Strategy in 2020/21
3.11	The national evidence base and local intelligence suggests a link between harmful social media content and use and the glamorisation of youth violence and gang membership. There is a lack of coordinated strategic action to address this.	The Violence and Vulnerability Board should commission further work to develop a Thurrock multi-agency strategic response to addressing harms caused by social media

3. Tertiary Prevention: 'Treatment' of perpetrators and victims of violence to reduce further harm

Tertiary prevention seeks to deliver interventions that 'treat' victims and perpetrators of serious youth violence with a view to minimising harm caused by the violence and preventing future violence and the harm caused by it. Thurrock has a range of provision in this terms of this strategic action including the Prevention and support Service (PASS) that run a *Youth @ Risk* programme, *Goodman* mentoring programme for boys/young men who are abusive in relationships.

The Youth Offending Service is of high quality with low rates of reoffending amongst the overall cohort that it works with. The service offer a range of tertiary prevention programmes including a *Deal or no Deal drug intervention* for young people involved in drug related crime, *Street Wise* six week intervention for young people arrested for serious youth violence including weapons offences and gang involvement, and uses an ASSET plus tool which seeks to identify specific factors that drive young people into becoming susceptible to exploitation and gang involvement. A children's social care worker is embedded within YOS.

We have been unable to identify robust evaluation on the impact of each of the specific interventions delivered by PASS and YOS and further work to evaluate this is desirable. We also identified a small cohort of young people within YOS who are repeat offenders and for whom the current service is less successful at achieving desistance from crime. This group is characterised by violence, drug supply and weapons offences, and is over-represented by black young men. The reasons why YOS are less successful at diverting this cohort away from future serious offending is unclear and beyond the scope of this work but warrants further investigation and the piloting of new approaches.

The EWMHS service sits largely separately to other tertiary prevention activity although there has been recent moves to integrate a CPN and speech and language therapist within the YOS service. The service offers a range of CBT but we were unable to ascertain whether this included NICE recommended Trauma focussed CBT for victims of serious youth violence, gang involvement in line with NICE guidelines.

The *Level 5 Triple P* parenting programme is the only evidenced based initiative shown to address and reduce abusive behaviour in parents, but this is not available in Thurrock. Brighter Futures should consider commissioning/delivering this.

For young people who are perpetrators of serious youth violence or involved in gangs, the service is currently not offering multi-systemic therapy of family functional therapy that seeks to treat individuals in the context of environmental, peer group and familial risk, although this is best practice from the published evidence base. As such, there is a risk that the current service offer is too individually focussed and efficacy of treatment will be compromised.

There is a need to develop a much more holistic an integrated tertiary prevention offer between YOS and PASS, with EWMHS fully integrated within it and delivering evidence based programmes that seek to treat the individual in the context of their wider environment. The current threshold for prevention remains too high, as YOS programmes are only available to young people who have been arrested for violent offences

A youth service offer, delivered by Essex County Council and funded by the Essex V&V Board has been operating in Basildon Hospital A&E in line with evidence of best practice, although at time of writing, on-going funding for this service in 2020/21 has not been secured. Early outcome data from the service has been positive but there is a need to continue funding this service in 2020/21 to allow a full evaluation to be undertaken.

Enforcement activity in Thurrock and more widely in Essex is in line with evidence of best practice, being highly intelligence led with focussed stop and search activity. Nine gang injunctions are place in Thurrock, and again this approach is well supported by published evidence. The Violence and Vulnerability Board may wish to consider piloting an *Opportunities Provision* approach which provides education, skills, employment and other support to gang involved youth as a mechanism to persuade them from exiting gangs, although robust evidence of the effectiveness of this is not currently available. As such, any future programme would need to be well evaluated.

Recommendations: Tertiary Prevention

REC #	Issue to be addressed	Recommendation
4.1	Trauma focussed CBT is not currently available for young people aged under 18 in EWHMS who are victims of serious violence, despite this being evidence of best practice	NHS CCG / Brighter Futures / MSE Joint CCG Committee should ensure that Trauma-focussed CBT is available within the service offer of a re-commissioned EWMHS
4.2	A range of individual initiatives are available through PASS and YOS that may well have considerable merit, but robust evaluation is not currently available	Thurrock Violence and Vulnerability Board in conjunction with the relevant service managers and support from Public Health and Xantura, should seek to evaluate all current tertiary prevention programmes including *Deal or No Deal, Goodman, Holiday Activity* and *Youth @ Risk* to determine effectiveness of impact
4.3	Lack of integrated tertiary prevention model with EWMHS provision largely provided separately, programmes focused too narrowly on individual/behavioural factors and threshold for intervention currently set at a level that requires a young person to be arrested for an offence before some interventions are available	NHS CCG / Brighter Futures / MSE Joint CCG Committee should recommission EMHWS to ensure integrated provision with other tertiary prevention programmes. New commissioning model should seek to ensure service offer is in line with evidence of best practice, for and includes for example: - Multi-systemic Therapy/ Family Focussed Therapy
4.4		Thurrock Violence and Vulnerability Board in conjunction with Brighter Futures should future evaluation of current offer, and develop a more integrated an holistic model with a greater focus on addressing familial, school, environment risk.
4.6	Current service offer lacks evidence based parenting intervention for parents at high risk of abusive relationships with their children	Brighter Futures should review current service offer and commission an appropriate intervention such as *Level 5 – Triple P*
4.7	There is a cohort of young people accessing YOS who are committing multiple violence / drugs offences and for whom current interventions appear to be unsuccessful in terms of future desistence.	YOS should undertake further work to understand this issue and pilot and evaluate new approaches where appropriate
4.8	A&E based youth service in line with evidence of best practice but lacks evaluation data or on-going funding.	Essex V&V unit and/or Essex County, Thurrock and Southend Councils should seek to continue funding for this service in 2020/21 to allow an evaluation of impact to be undertaken

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31st July 2020	ITEM: 6
Health & Wellbeing Board	
Adult Mental Health Service Transformation Update	
Wards and communities affected: All	**Key Decision:** No
Report of: Maria Payne, Strategic Lead for Public Mental Health & Adult Mental Health System Transformation Catherine Wilson, Strategic Lead for Commissioning & Procurement Jane Itangata, Associate Director of Mental Health Commissioning, NHS Thurrock CCG	
Accountable Assistant Director: Les Billingham, Adult Social Care	
Accountable Director: Roger Harris, Corporate Director, Adults, Housing and Health / Ian Wake – Director of Public Health Mark Tebbs, Deputy Accountable Officer NHS Thurrock CCG	
This report is Public	

Executive Summary

A report by the Director of Public Health which aimed to triangulate learning from three previous reports (the Mental Health Joint Strategic Needs Assessment, LGA Peer Review and Healthwatch Research) and propose strategic action on transforming the local adult mental health treatment system was agreed at the September 2018 Thurrock Joint Health and Wellbeing Board and March 2019 Cabinet. The report collated learning from each of the reports and set out five priority areas for action to improve local mental health services:

1. Address the issue of under-diagnosis of mental health problems
2. Improve access to timely treatment
3. Develop a new model for Common Mental Health Disorders
4. Develop a new *Enhanced Treatment Model* for people with serious mental ill-health conditions
5. Integrate commissioning and develop a single common outcomes framework supported with improved commissioning intelligence.

The purpose of this report is to:

- Provide an update on some of the progress made since this initial report was produced
- At a high level, consider the impacts that COVID-19 has had on mental health transformative activity
- Profiling some of the work that has been undertaken during the lockdown period so far to help Thurrock residents maintain good mental health and wellbeing
- Detailing the next steps and priorities for future mental health transformation

Recommendations

- **Health and Wellbeing Board notes the progress made with relation to adult mental health system transformation**

- **Health and Wellbeing Board endorses the next steps as detailed in the paper**

- **Agrees to establish a member led body to receive progress reports on the development of the joint mental health transformation plan.**

1 Introduction

1.1 A report by the Director of Public Health which aimed to triangulate learning from three previous reports (the Mental Health Joint Strategic Needs Assessment, LGA Peer Review and Healthwatch Research) and propose strategic action on transforming the local adult mental health treatment system was agreed at the September 2018 Thurrock Joint Health and Wellbeing Board and March 2019 Cabinet. The report collated learning from each of the reports and set out five priority areas for action to improve local mental health services:

1. Address the issue of under-diagnosis of mental health problems
2. Improve access to timely treatment
3. Develop a new model for Common Mental Health Disorders
4. Develop a new *Enhanced Treatment Model* for people with serious mental ill-health conditions
5. Integrate commissioning and develop a single common outcomes framework supported with improved commissioning intelligence.

1.2 This paper is structured as follows:

- Section 2 provides a high-level update on progress made against each of these themes
- Section 3 discusses the impact that COVID-19 has had on mental health transformation plans
- Section 4 sets out the future priorities for mental health transformation

2 Transformation Progress to date

Address the issue of under-diagnosis of mental health problems

2.1 The previous report highlighted a stark gap between the number of patients in Thurrock diagnosed with Depression, and the number likely to have it as modelled by Public Health England. The data estimated that only 59.5% of the population likely to have depression had been diagnosed. The report also described a four-fold variation in GP Practice Depression QOF register completeness ranging from 24% through to fully complete. As of March 2020, the data indicated that 62.5% of those with depression have been diagnosed – it is likely that the programmes referenced below contributed towards identifying more patients with depression.

2.2 Since this report was completed, a depression screening protocol has been developed in Systm One, and implemented in three pilot GP practices. This is in place for patients on the Diabetes QOF register attending a review, and guides clinicians to ask the validated PHQ-9 questions and prompt an automated referral to IAPT if required. NELFT Clinical Health Psychology Service has also been using this protocol for their Diabetes patients. Data indicates that 2,039 screens were undertaken using this protocol in 2019/20, and 454 for April-June 2020. 98 referrals have been made to IAPT via this route between April 2019-June 2020.

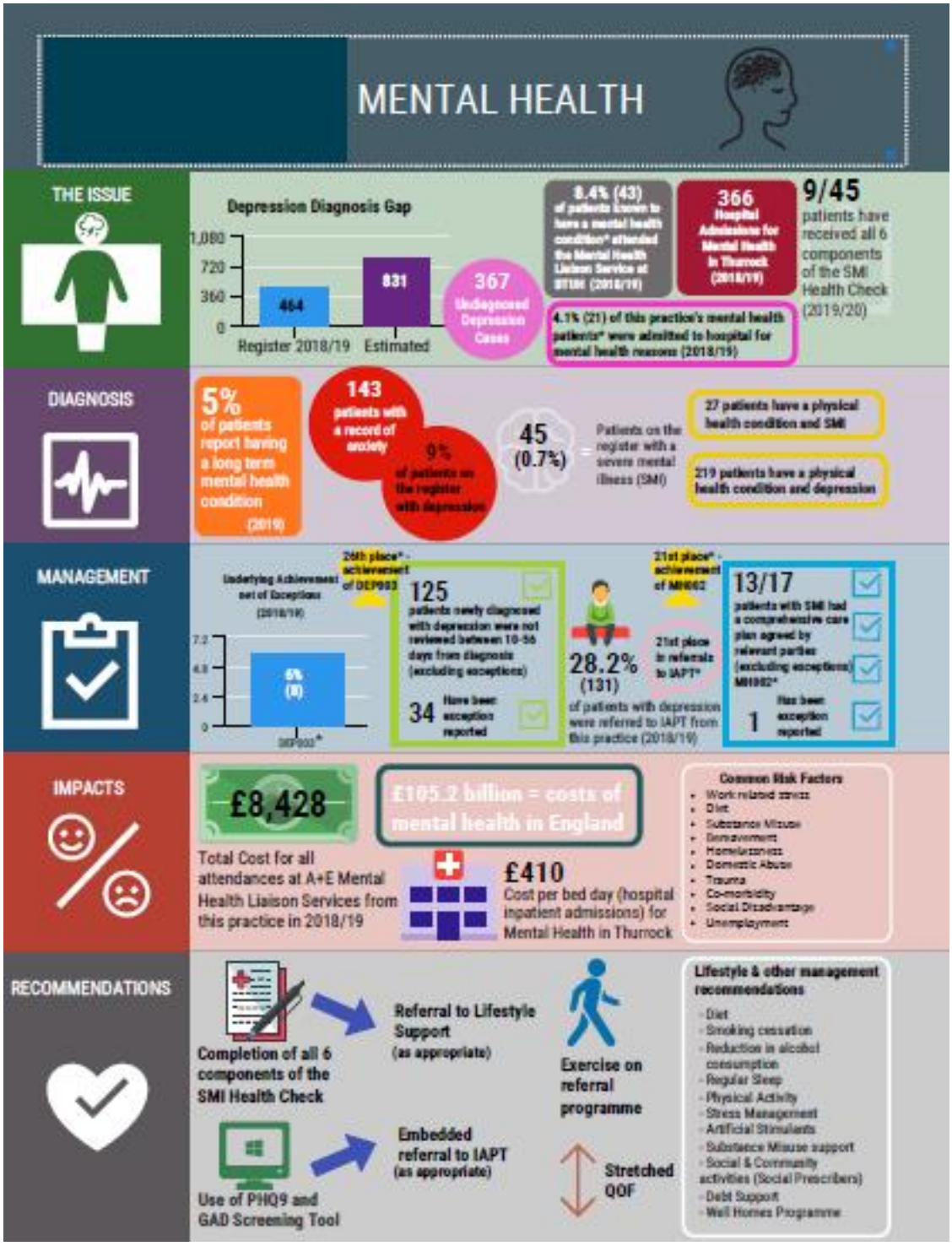
2.3 Thurrock Healthy Lifestyle Service also embedded a short form of depression and anxiety screening into their NHS Health Check. Data indicates that 3,865 short-form screens were undertaken in 2019/20, and of the 195 who met the threshold for IAPT referral, 34 referrals were made. This programme ceased at the end of March as face-to-face Health Check delivery was suspended, but will be resumed when NHS Health Checks restart.

2.4 There has been a noticeable increase in the communications both nationally and locally around mental health. Thurrock Council's Communications team have extensively promoted a number of national programmes such as World Mental Health Day on 10th October. Public Health England's Every Mind Matters platform was also promoted at this time; this is a digital offer which enables people to create a personalised action plan recommending a set of self-care actions to deal with stress, boost mood, improve sleep and feel in control. Statistics provided by the Council's Communications team showed that the social media posts for that campaign alone resulted in 22,555 impressions and that 117,835 individuals were reached – i.e. would have seen the posts via the Council's Facebook or Twitter pages.

2.5 Over the last year there has been a large amount of work on improving the quality of information held on GP systems. The Public Health team paid for an external company called Interface Clinical Services (ICS) to look at GPs records of patients with long term conditions, and run some other searches to identify patients who might have long term conditions but not be 'coded' as such. This exercise was conducted in 20 practices and included Depression and Serious Mental Illness registers. The analyses potentially identified over 1,000 patients known to these practices who might have Depression but are not coded as such, and over 400 potential SMI patients. However only 47 of the Depression patients and 8 of the SMI patients were subsequently added

– this could be because the search criteria weren't quite right, or that the practices did not have capacity to review all of the records to check if they should be added. There may be the possibility going forward to employ dedicated resource to look at this further.

2.6 The Public Health teams' three Healthcare Public Health Improvement Managers developed a specialist Mental Health Profile Card for every GP practice, and took these out to GP practices during their winter 2019 practice visits. These contained data on mental health diagnoses and treatment of mental health conditions, usage of emergency mental health care services and general recommendations for practices to follow. A sample card can be seen below.



Feedback gathered from practices indicated that they found it interesting to see data on the diagnosis and management of their patients in primary care, and the financial costs of their patients using emergency care. These cards triggered wider conversations around increasing IAPT referrals, using wider primary care roles such as clinical pharmacists, and future use of the electronic depression screening protocol. It is hoped to incorporate this into the future plans for integrated primary care and community mental health care transformation (see section 2.18).

Improving Access to Mental Health Treatment

2.7 The previous report highlighted a large amount of variation in the experience of patients accessing mental health treatment, both in primary and secondary care settings. In addition, large numbers of patients were attending A&E when in mental health crisis, as they did not have any other alternative support mechanism. Difficulties in accessing mental health treatment was also identified as an issue in the LGA Peer Review, which specifically cited that "*GP referral is building unnecessary delays into the system"* [with regard to secondary care mental health services].

2.8 The Public Health's team 'Stretched QOF' programme has incentivised Thurrock GP practices to treat all patients eligible for clinical interventions under the Quality Outcomes Framework (as GPs only receive a national incentive to treat around 70% of eligible patients). Clinical reviews for newly-diagnosed depression patients were included within this incentivisation programme. Between July 2018-March 2019, GPs claimed for 125 patients, and in 2019/20 GPs claimed for 90 patients (this will have been impacted on by COVID-19 where patients may not have attended reviews). These patients may not otherwise have received these reviews.

2.9 MPFT - Inclusion Thurrock (the IAPT and Recovery College provider), provides talking therapies for people experiencing depression, anxiety and other common mental health problems as well as support and treatment for those who have had experienced trauma, offering a range of treatment options available which are tailored to individual needs. Therapists have also been trained to provide help for those who may have long term health conditions such as diabetes, chronic pain, COPD, fibromyalgia or fatigues that can leave you feeling low in mood. The service also has therapists able to provide evidence-based treatment for trauma and help cope with adjustment following a hospital stay.

Inclusion Thurrock had always ensured that therapists were set up for agile working, using laptops and remote access to systems. The transition to remote working from home was relatively seamless, with the biggest transition being the switch to working over the telephone rather than face to face.

Currently, all therapists are working with patients via telephony, video-consultation and an enhanced digital offer. Referrals had reduced significantly during lock-down but are now steadily returning to near pre-COVID19 levels. The waiting lists have been managed down and patients who are unable to undertake remote treatments, a prioritisation process has been developed to ensure they are in treatment as soon as some face to face appointments are made available. The MSE system has agreed to plan for a 20% increase in demand for IAPT services.

2.10 In September 2019, the Housing Solutions team employed a Senior Mental Health practitioner on secondment from EPUT for one year. The worker was employed to upskill staff across the Housing directorate in mental health awareness, but also to undertake specialist mental health assessments to help inform decisions on housing allocation. Between September-May 2020, the worker has received 173 referrals from

fellow housing colleagues, anti-social behaviour officers and mental health professionals. Requests are to:

- undertake specialist mental health assessments
- provide specialist mental health advice
- undertake a welfare check
- ascertain secondary mental health care information on specific clients

The worker has also been providing information and advice to Housing staff on wider health and wellbeing support options via the compilation and cascading of a services directory. This has improved cohesion between housing and mental health services, and improved knowledge of Housing staff.

2.11 On 1st April 2020, the new 24-7 mental health crisis response service launched across Mid and South Essex, offering immediate and specialist support to adults and older people experiencing mental health crisis. Callers who dial 111 and select option 2 are then connected to trained staff at EPUT who provide timely and appropriate support and advice. GPs, Police, Ambulance each have dedicated direct lines into the EPUT Contact Centre to enable access to mental health support. Social Care services have also been provided with a dedicated Professionals' direct line. All are actively utilising these lines. As part of this clinical pathway three Sanctuaries have been set up across the footprint, with one run by Thurrock and Brentwood MIND. The sanctuaries offer a non-clinical service and also deliver an Outreach Programme to ensure people are supported to access the right solutions to their presenting needs e.g. Advocacy, Housing, IAPT, Substance Misuse services, Peer Mentoring and Support, Bereavement Counselling etc. The sanctuary is currently operating via telephony and video-consult due to lockdown restrictions. It is likely face to face support will be restored in early 2021. The Thurrock and Brentwood MIND Sanctuary has supported 61 patients (April- June 2020) with issues such as anxiety (both COVID and non-COVID), suicidal thoughts and social isolation.

Developing New Models of Care

2.12 The previous report highlighted that existing models of mental health treatment were too clinical and not sufficiently person centred or holistic to encompass the wider determinants of health. This was also particularly highlighted within the LGA Peer Review findings. It was also highlighted that the current service offer is seen as too reactive, waiting for patients to hit mental health crisis before services are available and with insufficient focus on early identification and intervention to prevent patients with SMI entering crisis.

2.13 Individuals with Personality Disorders were profiled in the previous report as a key group requiring improved care. A pilot evidence-based programme called STEPPS (Systems Training for Emotional Predictability and Problem Solving) was run between September-March 2020 for adults with Emotionally Unstable Personality Disorder (EUPD). It involved 21 weekly 2 hour group sessions and it was co facilitated by professionals from EPUT and Inclusion Thurrock working in partnership. The aim of the programme is help participants learn to identify warning signs and use new skills to

prevent them from getting to a crisis point. By keeping a record over time, participants develop an awareness of their progression in managing their emotional intensity. Five participants completed all sessions, and reported improved understanding of their condition and an ability to 'reconstruct' unhelpful thoughts and behaviours. Due to the positive outcome of the pilot the CCG will be exploring mainstreaming this service as part of the Integrated Primary and Community Care Mental Health offer for the PCNs to improve access and choice to treatment for service users with EUPD.

2.14 Thurrock Council commissioned an external provider (Frontline Training Group) to deliver a Personality Disorder training course to staff between May-October 2019. 83 staff members attended, the majority from Adult Social Care frontline roles. Feedback from attendees was that this course was beneficial in increasing understanding of Personality Disorder and useful to roles.

2.15 A new service to support those with serious mental ill-health to access paid employment was launched in October 2019 on the back of a successful national Transformation bid. IPS (Individual Placement and Support) is being delivered in partnership between EPUT, Inclusion Thurrock and Thurrock & Brentwood MIND. This replaces the element of World of Work which supported those with mental health needs with employment.

2.16 The previous report referred to the Open Dialogue holistic strengths based approach to treating people with psychosis. 12 staff in EPUT and Thurrock and Brentwood MIND attended four residential training sessions during 2019, and the service went live at the start of 2020. Arrangements had been made for Thurrock's team to participate in the national randomised control trial to ensure it would be evaluated effectively. However, this programme was suspended at the start of April due to COVID-19.

2.17 The Mental Health Floating Support Service was recommissioned in 2019 to deliver individual support to a range of people with mental health challenges. The service provides support to enable people to live as independently as possible in the community supporting them to maintain their tenancies and accommodation helping with budget planning paying bills and rent. The service also delivers advice and support to people with mental health challenges who are homeless or at risk of being homeless helping to liaise with the Council's Housing Directorate. It is a very well used service, which adds to the holistic mental health offer in Thurrock.

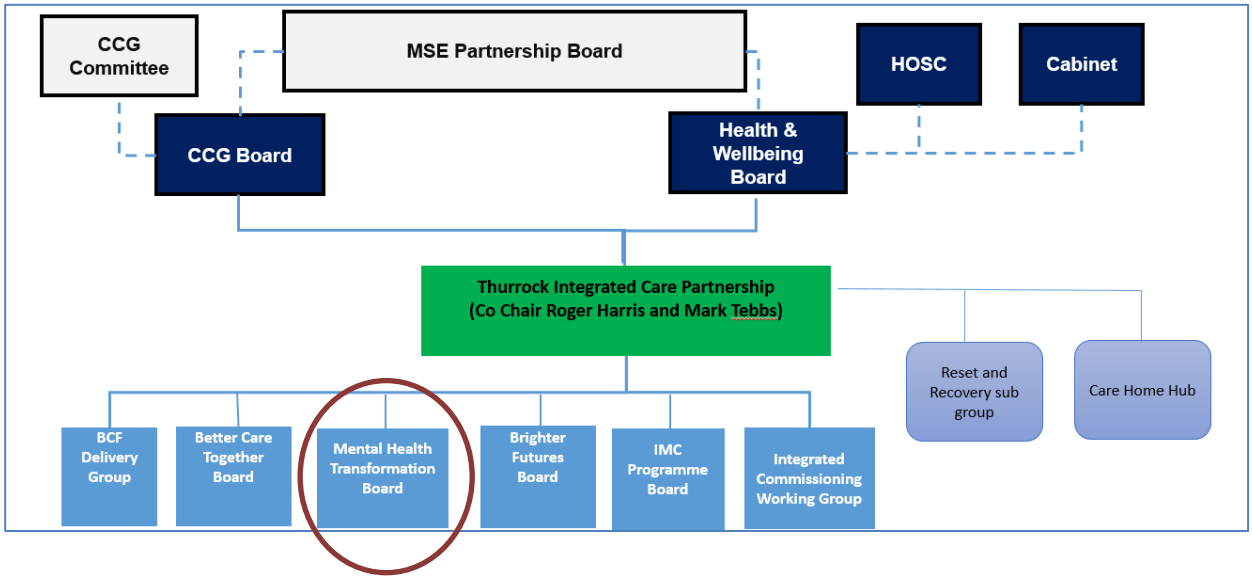
2.18 One of the key deliverables of the NHS Long Term Plan for Mental Health is providing seamless mental health treatment and support between primary care and secondary care mental health through an integrated service offer for the developing Primary Care Networks. This will improve timely access to the right type of support for presenting needs by the appropriate person or team, reducing fragmentation of service delivery between organisations and integrating elements of physical and mental health together. This also aligns with the changes to Adult Social Care provision and the new Community Led Support teams, which will ensure there is a strengths-based community asset focus to mental health support; and supports recommendations raised in the LGA Peer Review around developing person-centred, outcome-focussed services This work is most advanced for the Aveley, South Ockendon and Purfleet

(ASOP) PCN but has paused due to COVID-19; however it is due to restart later in July with a view for the service offer being implemented in Q4 of 2020-21.

Improved integration with partners

2.19 In July 2019, Thurrock's Health and Wellbeing Board pledged to sign the Prevention Concordat for Better Mental Health. This is a national pledge that we are taking a prevention-focussed approach to improving the public's mental health, with emphasis on actions that impact on the wider determinants of mental health and wellbeing. By having our submission accepted, it was a national "announcement" that our work programme and priorities are dedicated towards this as well as transforming service provision, and that they are delivered in partnership by the relevant agencies sitting on the Board.

2.20 The previous report and LGA Peer Review highlighted a complex governance structure in which mental health decisions were taken in different forums and sometimes seen as separate to other health and social care issues. The Thurrock Mental Health Transformation Board has now been established, and comprises of partners across local authority, CCG, provider trusts and third sector organisations. This has a reporting line into the Thurrock Integrated Care Partnership, and will also receive updates from relevant Mid & South Essex mental health groups.



3 Impact of COVID on previous transformation plans

3.1 The arrival of COVID-19 in March 2020 had a number of impacts on our planned transformation activities. Our front-line clinicians have prioritised delivery of care, meaning that non-urgent developmental service activities were ceased. Additionally, our mental health services have had to deliver care in different ways, which had increased demands on staff. During the first quarter of 2020/21, CCGs and mental health trusts were asked to prioritise delivery against certain service areas as dictated by letters from Simon Stevens and Claire Murdoch. Simon Stevens' priorities for the initial 6 weeks are set out below:

- *For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.*
- *Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.*
- *Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.*
- *Ensure enhanced psychological support is available for all NHS staff who need it.*

Claire Murdoch's letter placed emphasis on the delivery of the NHS Long Term Plan for Mental Health Priorities for transformation which includes an enhanced offer of support for people with Severe Mental Illness (SMI).
A Thurrock Mental Health Recovery and Restoration group has been meeting every two weeks since April to:

- Develop and implement a plan in response to Simon Steven's letter;
- Explore the changes in service delivery by each provider;
- Understand the mental health needs presenting in the system;
- Assess the impact of COVID19 on demand for mental health services;
- Analyse available intelligence and evidence base to define a framework to project the anticipated surge in demand for mental health services in response to the COVID 19 crisis. This work is now linked with wider STP deliverables for mental health.
- Establish a baseline on which to reset 'business as usual' and inform the IPCCMH transformation programme.

The requirements of the Simon Steven's letter have been completed and the group is evolving to take forward and complete development and implementation of the Integrated Primary & Community Care Mental Health transformation programme.

3.2 Some of the planned transformative activities which have been delayed include:

- Plans to develop and roll out a training programme to primary care staff focussing on identification and treatment of mental ill-health
- Implementation of the Integrated Primary and Community Mental Health service offer in Aveley, South Ockendon and Purfleet (ASOP) locality in 2020-21
- Development of the At Risk Mental State (ARMS) service and interface to the Early Intervention in Psychosis service.
- Development of the next phase of the Analgesic IAPT and Psychosexual IAPT pathways as part of the IPCCMH transformation programme.
- Continuation and evaluation of the Open Dialogue pilot
- Expansion of the depression screening programme
- Development of the next phase of the Mental Health Crisis Sanctuaries to support more people with sub-crisis needs and deliver Out of Hours substance misuse support in collaboration with existing community substance misuse services such as Inclusion Visions in Thurrock.

- Delivery of elements of the Mid and South Essex Suicide Prevention programme

3.3 Whilst the full impact of COVID-19 on the mental health of Thurrock's population is as yet unknown, local data on presentations to services indicates that fewer individuals have been accessing mental health services during the period of lockdown – although this is starting to increase now. This has been consistent with national findings, and it is anticipated that there is an amount of suppressed mental health need during the lockdown period. As referred to above, a more extensive piece of work will be undertaken later this year to look back at what impact COVID-19 is likely to have had on the mental health and wellbeing of our population, and what we may expect to see in the future as a result. This will incorporate findings from national research on anticipated changes in population need, local data profiling both need and service usage during the lockdown period and apply estimates from research to our population data to consider future need and demand. It will also look at the roles played by Thurrock Coronavirus Community Action and other partner agencies who will have supported those with poor mental health outside of a traditional service setting, and consider how we can continue to build on these strengths.

4 Priorities and next steps

4.1 Although we are by no means back to 'normal', now is the time to begin making plans to reset, restart and recover mental health transformation plans, as well as continue with initiatives mentioned in section 2. Although the Thurrock Mental Health Transformation Board has not met since January due to COVID, it is due to meet in July and determine the main priorities. These will include work areas listed below.

Revisiting existing transformation plans

4.2 These are work programmes listed in section 3.2 above which had been delayed due to COVID-19:

- **Training programme to primary care staff focussing on identification and treatment of mental ill-health.** This was also a political priority; however is dependent on both capacity and funding, so is likely to be delayed until 2021.
- **Implementation of the Integrated Primary and Community Mental Health model in Aveley, South Ockendon and Purfleet (ASOP) locality.** It is hoped this can progress towards completion by Q4 20-2021, with focus on the remaining localities after that.
- **Continuation and evaluation of the Open Dialogue pilot.** This was paused due to COVID and it is unknown when it can restart, locally or within the national trial.
- **Expansion of the depression screening programme**. This is dependent on GP practices undertaking more routine reviews of patients with long term conditions; as such it is likely this will be delayed until later in 2020/21.
- **Development of the next phase of the Mental Health Crisis Sanctuaries to support more people with sub-crisis needs and deliver Out of Hours substance misuse support in collaboration with existing community substance misuse services such as Inclusion Visions in Thurrock.**

- **Delivery of elements of the Mid and South Essex Suicide Prevention programme**. The suicide prevention work programme has been redeveloped in order to allow the third sector/community fund element to occur first, and primary care elements to occur towards the end of 2020/21.

Other future priority work areas

4.3 The above refers to work areas which were substantially underway before being impacted upon; however there are other pieces of work which have been identified to require future focus, including:

- **Understanding the impact of COVID-19 on the mental health of Thurrock's population.** This is the piece of work referenced above in section 3.3, which aims to bring together information on population need and impact on mental health due to COVID, with service presentation data (including non-clinical mental health provision) to estimate what future mental health needs might look like and support modelling of future demand on services. This piece of work is going to be very complex.
- **Wider review of employment support for those with mental health needs.** As mentioned above, the IPS service did go live in October 2019 to support those with severe mental illness into paid employment, but there is a wider need to explore if other provision might be needed, particularly following the impact of COVID-19.
- **Developing service provision for those identified to have an At Risk Mental State (ARMS).** This should link in with the existing Early Intervention in Psychosis service which is currently delivered by EPUT, Inclusion Thurrock and Thurrock and Brentwood MIND.
- **Addressing inequalities in mental health.** It is well-documented that certain population groups are both at risk of poorer mental health, and less likely to seek help. Work to explore the likely gaps in Thurrock and develop appropriate solutions to meet needs must recommence, particularly as COVID-19 is likely to have had a disproportionate impact on many of these groups.
- **Better consolidation of treatment and support options for those with common mental health disorders.** Section 2 of this report profiles initiatives such as Stretched QOF and the expansion of the IAPT service to support those identified to have CMHDs, but more work is required to develop varied pathways for CMHD patients which also consider elements such as physical activity and prescribing.
- **Ensuring appropriate support for those with mental health needs is incorporated into other work programmes**. There are a number of existing non mental health-specific work programmes where support for those with mental ill-health should be incorporated. These include the Council's Single View of Debt programme, the work programme resulting from the 2020 Sexual Violence JSNA, and the ongoing work programme relating to the Homelessness Prevention Strategy.
- **Continued focus on coproduction** – work started earlier in 2020 with Enable East to consider a framework to adopt in all areas; but more needs to be done to develop this approach consistently
- **Finalising a mental health outcomes framework** – this should shift focus from individual contract and provider process/input KPIs to single system wide outcome measures, and give a broader indication of the mental health and wellbeing of the Thurrock adult population. This will also align to the MSE Population Health

Management Strategy and corresponding outcomes framework which are also under development.

4.4 Currently Thurrock's social work and social care mental health services are provided through a Section 75 Agreement between Thurrock Council and Essex Partnership University NHS Foundation Trust (EPUT), under section 75 of the NHS Act 2006. This section of the NHS Act allows Local Authorities to delegate their statutory duties under the Care Act 2014 and transfer funding to an NHS body. The agreement ensures that the principles of integrated working and service delivery within the Care Act 2014 are followed. The Section 75 Agreement has been in place since 2002 and it is considered by Adult Social Care, the CCG and EPUT that the agreement needs to be revised to be more aligned towards the strength based, enabling and early intervention model that is being delivered through the transformation agenda and the Better Care Together work. There are concerns shared across Adult Social Care, the CCG and EPUT that the current model of delivery is medically based and therefore does not lend itself to wellbeing and holistic approach. A huge amount of very positive work has been undertaken by EPUT to raise the profile of social work and EPUT is a partner in all of the Better Care Together work, they recognise the success of the Community Led Support approach to social work and the need for social workers to be at the heart of their communities.

The Section 75 Agreement encompasses the secondment agreement for Thurrock's social care staff to work within EPUT, and has been in place for a number of years. This was originally designed to ensure a seamless service for users / carers and a fully integrated health and care mental health offer. The Council has worked hard with EPUT to ensure that the social care voice is fully heard and there is a clear joint ownership of the management and service delivery.

The Council now feels it is time to have a fundamental review of this arrangement in light of the lessons learnt from the Care Act, our wider transformation programme and the need to ensure there is a stronger management oversight.

As a result we want to jointly consider the viability of the following options:

Option 1: the transfer of all Thurrock Council social work staff back to Thurrock Council.

Option 2: the TUPE of all the social care staff over to be fully employed by EPUT.

Option 3: the establishment of a Joint Manager between EPUT and Thurrock Council reporting into a Joint Management Board to oversee the operations of the Thurrock-based services.

Option 4: to accelerate the integration of mental health staff into the newly-developing teams.

The key priority is to explore the options, in partnership, for the future delivery of social work within mental health to ensure that it is at the heart of our transformation across mental health and wider adult social care. To ensure that social care services within

mental health are at the heart of the transformation it is recommended that the post of a joint manager across EPUT and Thurrock Council is created to support delivery and establishment of the longer term agreement. This is a priority to be achieved by April 2021.

4.5 An integrated commissioning approach across health and social care is essential to deliver improve and maintain such wide ranging mental health developments. It is clear through our Better Care Together work in Thurrock that there needs to be an approach to commissioning that is strength and place based. A key priority is to ensure that commissioners, providers and experts by experience work together to develop a single common outcomes framework supported with improved commissioning intelligence (as mentioned in section 4.3). The Commissioning and contracting sub-group of the Thurrock Integrated Care Partnership will support the agenda within mental health together with the wider market development.

4.6 Transition from children's to adult services is another key priority for mental health. The current Children and Young Person's Community Mental Health provision is the Emotional Well Being and Mental Health Service (EWMHS) delivered by NELFT. Transitions has remained a key issue and to support more effective joint working the Preparing For Adulthood Strategy has been developed through a partnership approach. The first key priority for the coming year is the re-procurement of the EWMH's service; this is an Essex, Southend and Thurrock joint procurement with the 7 CCG's. We are clear that the service to be delivered in Thurrock will be based on local need and that the procurement will recognise this. We want the service to be accessible and responsive working in partnership across social care, education and health. The second priority is to ensure that transition is a major focus of the service response and we will want our Providers to work closely together to ensure young people are supported into adult services where they are needed. We will continue to work closely with Health with regard to specialist in patient care and support to ensure that when required it meets the needs of our young people.

Reasons for Recommendation

5.1 This report gives an overview of progress against planned transformation and an indication of future work programmes which will continue to improve mental health outcomes for Thurrock residents.

6 Consultation (including Overview and Scrutiny, if applicable)

6.1 This report is a progress update against the previous transformation plans. It was discussed with partners at the Mental Health Transformation Board on 15th July.

7 Implications

7.1 Financial

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

The report outlines progress made against existing mental health priorities, and sets out new ones to consider. If agreed, the creation of a new joint manager position between EPUT and Thurrock Council will require funding. Individual business cases will need to be presented for new work streams which require additional funding.

7.2 **Legal**

Implications verified by: Lindsey Marks (Deputy Head of Law)

The continued transformation of Mental Health Services in Thurrock will ensured the continued delivery of the duties outlined in the Mental Health Act 1983 (Amended 2007) and the Care Act 2014.

7.3 **Diversity and Equality**

Implications verified by: Roxanne Scanlon Community Engagement and Project Monitoring Officer

Residents with mental ill health are at significantly greater risk of experiencing health inequalities and this is set to have increased due to COVID-19. The continued programme of transformation work set out in this report will help to address this issue.

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

- Adult Mental Health Transformation report as presented to Cabinet, March 2019

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31 July 2020	ITEM: 8
Health and Wellbeing Board	
Thurrock Health and Wellbeing Strategy refresh – Post COVID-19	
Wards and communities affected: All	**Key Decision:** Key
Report of: Roger Harris – Corporate Director for Adults Housing and Health	
Accountable Head of Service: Roger Harris, Corporate Director Adults Housing and Health	
Accountable Director: Roger Harris, Corporate Director Adults Housing and Health Ian Wake Director for Public Health	
This report is Public	

1. Introduction and Background

1.1 Section 194 of the Health and Social Care Act 2012 requires Thurrock Council to establish a Health and Wellbeing Board. The Health and Wellbeing Board is the primary partnership body in Thurrock that is responsible for creating and overseeing Thurrock's Statutory Health and Wellbeing Strategy.

1.2 The Health and Wellbeing Strategy identifies priorities for reducing inequalities in health and wellbeing and improving the health and wellbeing of the local population. The Strategies are prepared jointly by the Council and CCG and owned by Health and Wellbeing Boards who are then responsible for overseeing their delivery.

1.3 The second and current Strategy was launched in July 2016 and its lifespan was extended from 3 to 5 years. This was because the action necessary on the wider determinants of health, which supports the achievement of good health and wellbeing for all Thurrock people is reflected in the current strategy, which take some time to impact on the life chances of the population.

1.4 Since the Strategy's launch in 2016 there have been nationally driven changes made to local health structures and the creation of the Mid and South Essex Health and Care Partnership and further development of Integrated Care Systems. Further evidence has emerged on the wider determinants of health and wellbeing and potential new priorities cannot be incorporated into the current Strategy Framework. Given the current Strategy was subject to extensive public and partner engagement, the refresh exercise will consider how the framework can be tweaked to incorporate current and future health and care priorities.

1.5 The COVID-19 Pandemic resulted in action has impacted on the planning and delivery of services and future operation models and a refreshed Strategy will take into account the impact of COVID-19, including utilising the positive lessons learned from COVID-19, while addressing some of the potential challenges. We are now also aware of over 4000 people in Thurrock who were required to adopt shielding to reduce the impact of catching the virus. Priorities identified within the refreshed Strategy will need to continue to consider how to tackle health inequalities and provide health and care support to the most vulnerable residents of Thurrock.

2. Recommendation(s)

2.1 It is recommended that Board members:

- Agrees that Thurrock Health and Wellbeing Strategy 2016-2021 is refreshed along the lines of proposals set out within this report.
- Agrees that a task and finish group should be established to drive forward the refresh of the Strategy.
- Considers how the HWB Strategy is resourced post September 2020 to support the delivery of the refresh and continued oversight, engagement, and driving forward of the strategy once the refresh is launched in July 2021.

3. Issues, Options and Analysis of Options

Summary

3.1 The Health and Wellbeing Strategy is live and organic and has been amended to reflect new priorities and reinforced links with programmes that impact on people's the health and wellbeing. However, there is an increasing risk that emerging priorities and programmes being developed cannot be incorporated or reflected within the current strategy framework.

3.2 The Strategy is scheduled to be refreshed in July 2021. However, there have been significant national policy drivers that affect people's health and wellbeing and the planning and commissioning of services provided to support improved outcomes. These include:

- The NHS Long Term Plan, which is already impacting on the future planning, commissioning and provision of services for the residents of Thurrock. This includes the establishment of the Mid and South Essex Health and Care Partnership (previously referred to as the Mid and South Essex Sustainability and Transformation Partnership) and a shift towards planning and commissioning services at the different geographical levels (System (STP), Place (Thurrock CCG and Council) and Neighbourhood /Locality level/Primary Care Network). Subject to the Board's approval the refreshed Health and Wellbeing Strategy will reflect the MOU being considered by members at today's meeting.
- Homelessness regulations introduced in April 2019, placing a duty on local authorities to support residents who are homeless or at risk of homelessness, which impacts on their health and wellbeing. Refreshing the Strategy will provide an opportunity to capture more action on housing that impacts on health and wellbeing including the quality of housing and tackling fuel poverty.
- The Local Plan and how commitments to regeneration and planning - particularly around the potential adverse and positive impacts of the Lower Thames Crossing and the regeneration of Grays Town Centre on the populations health and wellbeing.
- Emerging priorities for specific services including implementing the SEND Written Statement of Action and the emerging Transition Strategy.

3.3 Since the Health and Wellbeing Strategy was launched in July 2016, there has been substantial additional research on areas affecting the health and wellbeing of the population of Thurrock, which cannot be easily reflected in the current Strategy framework. This includes evidence provided by Public Health Joint Strategic Needs Assessments on bespoke subject matters including the sexual violence and abuse JSNA, the Young Person's Substance Misuse needs assessment. A refresh of the

Strategy will facilitate the continued public commitment of working with the Health and Wellbeing Board to make sure the JSNA informs the Health and Wellbeing Strategy[1].

3.4 The refreshed Strategy will reflect lesson's learned from the COVID-19 Pandemic set out below.

4. COVID-19 Pandemic

4.1. The Covid 19 pandemic is different from other disaster recovery scenarios for a number of reasons. The scale, effects and length of time of the emergency created by the pandemic are more far reaching than anything experienced globally since the World Wars of the last century.

4.2 Transformation of the Thurrock Health and Well-being system has been predicated upon a number of key principles, which have been instrumental in our ability to respond quickly and effectively as a system to the pandemic, which will be reflected in the refreshed Health and Wellbeing Strategy:

- **A coherent, shared vision**. This has enabled the whole system to respond as one with no disagreement between partners and a common understanding of what was necessary to achieve results. The refreshed Health and Wellbeing Strategy will reinforce the shared vision for the people of Thurrock that is informed by the people of Thurrock.
- **Outcomes not outputs.** The future performance management systems to focus on collecting data that provides evidence of success in terms that service recipients would identify with. Of course systems and organisations need to measure success. However, these should focus upon outcomes and not on inputs or outputs, such a focus too often drives perverse behaviour that does little or nothing to improve real performance. Performance is also too often inward looking and service focused, rather than recognising that a number of factors contribute towards the achievement of an individual's health and wellbeing, and all of these factors need to push in the same direction. This will be even more important as we move in to a recovery phase, there will be significant challenges to resolve with extreme pressure upon resources; this will require certainty that activity is focused upon achieving the right outcomes with the greatest efficiency. The refreshed Health and Wellbeing Strategy Outcome Framework will reflect the shift to outcome based measures.
- **The importance of technology.** Technology enabled care and support is a work stream already central to transformation in Thurrock. The speed with which technology has been utilised in dealing with the response to Covid suggests that much more could, and should, have been achieved in the health and well-being field to date. There are numerous reasons, human and technical, which have slowed the use of technology in this field. However, as is often the case, the scale of the crisis has forced the issue. This is an area that we need to understand better to ensure that the potential that technology affords us to improve recovery is fully utilised. It will also be important to ensure that the refreshed Health and Wellbeing Strategy considers how future operating models and therefore potential outcomes may be impacted on by technological developments. It will also be important to ensure any challenges that may be created by technological advances are identified and addressed.

[1] As set out on JSNA page of council website

- **Collaboration through strong, trust based partnership arrangements.** Utilising and building on existing relationships has been a major feature of the local response. Creating an agile and collective reaction to the issues as they emerged. The refreshed Health and Wellbeing Strategy will reflect partnership and governance arrangements that have been agreed across the wider health and care system and within and across Thurrock.
- **Flexible and Adaptable Workforce.** The response to the pandemic has shown the ability of and importance of staff across the system to be flexible and adaptable. This will challenge us to remove the divide between health and care and between provider and commissioner. Health and care staff will work in partnership with the third sector and the community and focus on the totality of assets available to them and to the person
- **Asset based/strength based approaches.** At both an individual and at a system level asset based working is another feature of the transformation model in Thurrock. The concept of doing with rather than to sits at the heart of every aspect of our change journey. This has enabled a truly collaborative response to be introduced whereby we have supported communities to take action rather than imposed a service type solution on them. The success of the Thurrock Coronavirus Community Action (TCCA) response, which mobilised volunteers to support the vulnerable and shielded in our communities quickly and effectively, is a strong example of the asset based approach in action. The refreshed Health and Wellbeing Strategy will build on the success of collaborative working with communities and the VCS.
- **Community embedded practice.** Possible the strongest single feature of the Thurrock transformation of health and well-being is the commitment to work within and alongside our communities. The fact that we had already established such a strong community presence, via our Local Area Coordinators, Community Led Support social work teams and our Social Prescribers, amongst others, enabled us to meet the challenge set by the uncertain period that existed between the lockdown and having the structures in place to deal with the consequences. This provides a strong evidence base for the effectiveness of knowing the communities you work alongside, and is another feature that must be further developed to secure successful recovery.

5. How the refreshed Strategy will reflect changes to the NHS operating landscape

5.1 The refreshed Health and Wellbeing Strategy refresh will identify health and wellbeing priorities for the population of Thurrock over a five years period, many of which will be joint partnership priorities across system, place and locality levels.

5.2 The refreshed Health and Wellbeing Strategy will reinforce the Mid and South Essex Partnership MOU that is being considered by members at today's meeting.

5.3 At Mid and South Essex level:

- Digital technology will be used to drive change and ensure systems are inter-operable, including the development of the integrated shared care record would support the identification and treatment of long term conditions across Thurrock.
- The CCG Joint Committee has delegated authority to take decisions collectively on matters relating to areas that are likely impact on the achievement of outcomes within the refreshed Health and Wellbeing Strategy including:
    - Acute hospital services
    - NHS 111 services

- Ambulance services
- Patient transport services
- Acute mental health services

5.4 At place level:

- Thurrock is one of the four Places across the (Mid and South Essex Health and Care Partnership) that have established Integrated Care Partnerships. Political leadership for each ICP will be provided through the relevant Health and Wellbeing Board. For Thurrock, this will be through the Thurrock Integrated Care Partnership arrangements, being considered separately by members at today's meeting. Each ICP will be accountable to the Health and Wellbeing Board for delivery of its locally agreed plan. Each ICP will also have a line of accountability to the System (Partnership Board) for delivery of agreed system transformation, finance, quality and performance priorities.
- The ICP locally agreed plan will reflect appropriate priorities identified through the Health and Wellbeing Strategy refresh.

5.5 At Locality / PCN level

- Action taken at locality and PCN level will be crucial to delivering priorities contained in the refreshed Health and Wellbeing Strategy. PCNs will be responsible for the delivery of locality based healthy lifestyle services (eg. self-care/patient education, smoking cessation, sexual health (spoke services), cervical screening, weight management)
- As set out in the MOU, PCNs will also be responsible for delivering a wider range of services closer to people's homes, which are likely to be aligned with the refreshed Strategy priorities including:
    - Minor operations coordinated across GP practices (eg. lumps and bumps, vasectomy services)
    - Long Term Conditions case-finding programmes including hypertension, AF and depression screening.
    - Delivery of dental care and improved oral health programmes
    - Single, integrated 'one stop shop' clinics for the management of diabetes, cardio-vascular disease and respiratory long-term conditions with input from secondary care consultants.
    - New model of care for Common Mental Health Disorders and some mental health services for patients with SMI including IAPT, Dementia and Psychiatric Nursing
    - Adult Social Care assessment/fieldwork services
    - Social Prescribing
    - The Schools Wellbeing Service (defining a school as a community)
    - Children's Centres – a wide range of services and support for families with young children.

5.6 The refreshed Strategy will identify the health and wellbeing priorities for Thurrock and should be integral part of determining and informing both system and PCN level priorities.

6. Outline approach for refreshing Thurrock's Health and Wellbeing Strategy

Activity completed to date to support the refresh

6.1 A light touch project management approach has been created to support the delivery of the Health and Wellbeing Strategy refresh which includes a broad timeline, setting out

key deliverables and products and identifying key milestones to ensure the refreshed strategy can be launched no later than July 2021. A snapshot of the key milestones is provided at **Annex A**

6.2 An analysis of progress made against current Health and Wellbeing Strategy priorities has been completed. This helps to inform discussions with system partners when considering whether they should continue to be reflected in the refreshed Strategy, ensuring it continues to focus on the areas that matter most.

6.3 A review of recent policy developments and key literature (including JSNAs) has been undertaken and has helped to inform discussions with key partners about future priorities and how the findings of JSNA's and other research will be reflected in their priorities.

6.4 A draft communication strategy has been created and plan will be created to support the identification of key stakeholders, provided at **Annex B**. Following the establishment of a Task and Finish Group a detailed activity engagement plan will be developed to underpin and deliver the communication strategy.

Review of Health and Wellbeing Strategy Framework

6.5 Consideration has been given to how the Health and Wellbeing Strategy's 5 Strategic Goals and Objectives framework, with some slight tweaking, will enable the refreshed strategy to continue to focus on existing Strategy priorities, as well as any emerging and future priorities that impact on people's health and wellbeing.

6.6 A new Framework has been created comprising seven domains which incorporate the current Strategy's 5 Strategic Goals as well as the 25 priorities (otherwise referred to as objectives) that underpin them. The newly created framework provides a wider focus on the key determinants of health and comprises 7 Strategic Domains. Potential priorities are still being established and subject to public and partner consultation.

6.7 The new Framework has been largely welcomed by system partners who have been initially engaged to inform the direction of travel of the refresh. The draft Framework is provided at **Annex C.**

Initial system partner consultation and key findings

6.8 Over the last month feedback has been sought on the current Health and Wellbeing Strategy. from officers across the council and some key system partners, including Thurrock CCG and Thurrock CVS, Some key themes have emerged from feedback received to date:

- The draft Strategy framework has been widely welcomed by system partners to date
- The refreshed Strategy should focus on wider determinants of health particularly around the impact of housing and safety on health and wellbeing
- Governance processes in the refreshed Health and Wellbeing Strategy should be established, building on existing governance arrangements
- The Strategy should be embedded into the day to day work of system partners at all levels
- The refreshed Strategy should reflect lesson's learned from COVID-19
- Resources should be identified to ensure that the Strategy remains on system partner radars and effective oversight can be provided and driven forward.

- Many of the existing priorities should remain in the refreshed Strategy along with additional priorities that have been identified

Looking forward

6.9 In additional to engaging specific partners to understand the future operating landscape and identify priorities to be included in the refreshed Strategy, a Task and Finish Group will be established to help drive forward and inform the refresh exercise by:

- Finalising the refreshed Health and Wellbeing Strategy framework and establishing potential priorities that are agreed by system partners and subject to public consultation.
- Considering and refining the proposed governance structure for providing oversight of and reporting against agreed health and wellbeing strategy priorities.
- Creating a communication activity plan to underpin the Communication Strategy and necessary support materials such as the online and hard copy consultation documents, press releases and promotional material to stimulate interest and engagement in the consultation exercise.
- Supporting the delivery of the public consultation exercise
- Leading the development of the refreshed Strategy which reflects feedback received from the people of Thurrock.

6.10 A public consultation exercise comprising face to face and online activities will be delivered in early 2021.

6.11 A refreshed Health and Wellbeing Strategy will be launched by July 2021.

6. Reasons for Recommendation

6.1 Refreshing the Strategy will:

- Build on the current Strategy and focus more widely on the key determinants of health.
- Continue to comprise priorities that focus on population health management as well as more targeted health and wellbeing priorities.
- Reflect changes in the health landscape and the planning and commissioning of services and support at system and place levels. The refreshed Strategy will support locking in service design and commissioning at Place level and reinforcing the Mid and South Essex system partner MOU
- Address changes in future operational models and approaches and lessons learned from the COVID-19 Pandemic.
- Create a framework that is flexible enough to respond to future health and care challenges, ensuring the five year strategy remains fit for purpose.
- Provide an opportunity to review the outcome framework and agree an approach for monitoring the implementation of the refreshed Strategy and achievement of improved outcomes and key performance indicators; and
- Review and improve Governance arrangements for the Strategy and consider resources necessary to oversee the Strategy, ensuring regular activity and reporting against key deliverables and commitments is maintained.

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

7.1 Initial consultation and engagement has been carried out on the development of the refreshed strategy framework.

7.2 A task and finish group will be established comprising key strategic partners to help drive forward the strategy refresh, described within the timeline at Annex A..

7.3 Communication and engagement activity will be taking place throughout 2020. A formal consultation period, running for approximately 8 weeks, commencing in January 2021.

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

8.1 The Strategy will drive the Council's Health and Wellbeing priorities as set out within the Corporate Plan. It will also act as the Council's 'people' Strategy and make the necessary connections with the 'place' agenda.

9. Implications

9.1 **Financial**

Implications verified by: **Mike Jones**
Strategic Lead – Corporate Finance

9.2 The cost associated with the strategy refresh will be delivered within existing budgets

9.3 **Legal**

Implications verified by:

9.4 The Health and Social Care Act 2012 established a responsibility for Councils and CCGs to jointly prepare Health and Wellbeing Strategies for the local area as defined by the Health and Wellbeing Board.

9.5 **Diversity and Equality**

Implications verified by: **Natalie Smith, Strategic Lead: Community Development and Equalities**

9.6 The aim of the Strategy is to improve the health and wellbeing of the population of Thurrock. Doing so will mean reducing inequalities in health and wellbeing.

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

9.8 The refreshed Health and Wellbeing Strategy will facilitate crime and disorder priorities that relate specifically to health and wellbeing, further strengthening the relationship between the Health and Wellbeing Board and Community Safety Partnership.

10. 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):

- Health and Wellbeing Strategy 2016-2021

Report Author:

Darren Kristiansen
Business Manager AHH Directorate

Annex A

Snapshot of HWB Strategy refresh

Thurrock Health and Wellbeing Strategy Key Timescales and Milestones

The Health and Wellbeing Strategy refresh will comprise the following elements:

* **Analysis of current Strategic Goals and Objectives to determine which current Strategy Objectives should remain in the refreshed Strategy**
* **Consideration of new evidence that has emerged over the last 12 months which includes APHRs, JSNAs, national policy drivers to determine whether there are new challenges and priorities that should be included within the refreshed HWB Strategy**
* **Creation of new HWB Strategy Goals and Objectives Framework**
* **Consultation with Elected members, partners and the public on proposed HWB Strategy Goals and Objectives**
* **Finalising HWB Strategy for 2021-2026 and prepaing and launching refreshed HWB Strategy for Thurrock**

Milestone	Description	Achieved	Owners
Action taken up until 31 July	Review of new evidence provided via JSNAs, APHR, National policies and local strategies completed	Yes	Darren Kristiansen and Claire Quinn AHH BMT
	Analysis of current HWB Strategy Goals and Objectives completed	Yes	
	Framework created for HWB Strategy	Yes	
	Draft communication strategy developed	Yes	
	Broad timescales developed	Yes	
	Informal partner and officer engagement to consider current and refreshed Strategy	Yes	
	Paper developed for consideration by the HWB	Yes	
31-Jul-20	**HWB to consider proposals for HWB Strategy refresh**		

Milestone	Description	Achieved	Owners
	Task and Finish Group established		
July - Beginning of October	All papers relating to HWB Strategy refresh (Proposed Goals and Objectives widely agreed by partners / Comms Strategy finalised and engagement plan developed / publicity and promotional material /online consultation document/ hard copies available in easy read)		Task and Finish Group and AHH BMT
October - December	Governance approval (DB, HWB, CCG Board, Partner Boards, Overview and Scrutiny Committees)		
January 21 - Feb 21	**Public Consultation Period**		
Mar-21	Analysis and report writing for both online and face to face consultation		
April / May 21	Creating final version of the HWB Strategy		
June - July 21	Engaging various governance structures (HOSC / HWB / Cabinet / CCG Board / STP Board) to secure agreement on final strategy		
End July 21	Launch of HWB Strategy 2021 - 2026		

Annex B

Thurrock Health and Wellbeing Strategy Refresh
Communication and Engagement Plan

Background

1. Health and Wellbeing Boards are partnership boards that include the Council, NHS, Voluntary and Community Sector, and local councillors. The Boards are responsible for improving the health and wellbeing and reducing inequalities in health and wellbeing of their local areas. They do this through the setting health and wellbeing priorities which form part of a Health and Wellbeing Strategy.

2. Thurrock agreed its first Health and Wellbeing Strategy in 2013. The second and current Health and Wellbeing Strategy was launched in July 2016. It is a five year Strategy which focusses on preventing poor health and wellbeing from occurring by addressing the wider determinants of health.

Approach to be adopted for refreshing the Strategy.

3. This Health and Wellbeing Strategy refresh will be comprehensive and each element of our approach is set out as part of a suite of five papers created to explain and support it:

    - Paper 1 considers and proposes commencing the refresh now to ensure that a revised Health and Wellbeing Strategy can be launched before the current Strategy concludes in July 2021. The five year Health and Wellbeing Strategy was launched in July 2016.

    - Paper 2 provides an analysis of progress made against **current Health and Wellbeing Strategy priorities to consider whether they should continue to be reflected in the refreshed strategy** ensuring it continues to focus on the areas that matter most.

      This paper also considers how the outcome framework and Key Performance Indicators, created to ensure progress being made with improving outcomes can be measured and reported to the Board, can be reviewed.

    - Paper 3 considers the population and future demographics of the population of Thurrock. A **review of recent policy developments and key literature has also been undertaken as part of informing the potential priorities** for the refreshed Health and Wellbeing Strategy.

    - Paper 4 **considers the Health and Wellbeing Strategy Goals and Objectives framework** and whether proposals to approve slight tweaking to the existing framework will enable the refreshed strategy to continue to focus on existing Strategy priorities as well as any emerging and future priorities that impact on people's health and wellbeing.

    - This paper is the communication and engagement plan which will ensure that the refreshed Strategy is informed by partners and members of the public.

4. The Health and Wellbeing Strategy refresh will be planned and delivered using light touch Project Management approach. As part of providing robust governance and

ensuring key stakeholders can inform the shape and priorities of the refreshed Strategy a Task and Finish Group will be established.

5. The Strategy Refresh will be guided by the Health and Wellbeing Board's vision and key principles. The Board's vision is:

Add years to life and life to years

6. The Health and Wellbeing Board's vision and the work of the Board is guided by a set of key principles:
    - Reducing inequality in health and wellbeing. We want things to get better for everyone but we are also committed to ensuring that the poorest communities enjoy the same levels of opportunity, health and wellbeing as the most affluent.

    - Prevention is better than cure. Rather than waiting for people to need help, we want Thurrock to be a place where people stay well for as long as possible.

    - Empowering people and communities. We don't just want to do things to people, but give people the opportunity to find their own solutions and make healthy choices.

    - Connected services Good health and care services should be organised around the needs of people, not around the needs of organisations.

    - Our commitments will be delivered. We will ensure that commitments are delivered and all partners are accountable.

    - Continually improving service delivery. We will not settle for poor levels of service, continually striving to improve the planning and delivery of local services, ensuring that they meet the needs of the people of Thurrock.

    - Continuing to establish clear links between health and education services, improving accessibility for all. We will make sure that clear links continue to be established between health and education services, improving accessibility.

Engagement of system partners and the population of Thurrock

7. Thurrock's refreshed Strategy will co-created through the active involvement and engagement of local citizens and system partners.

Key Partners

8. The engagement of system partners is essential in helping determine local priorities and how improved outcomes can be achieved through adopting a genuine partnership approach for planning, commissioning and delivery services at the appropriate geographical levels comprising System (Mid and South Essex Health and Care Partnership); Place (Thurrock Clinical Commissioning Group and the Council); and Neighbourhood /Locality levels.

9. **System partners and officials will be engaged in the first instance to inform the development of a Health and Wellbeing Strategy Framework and potential**

priorities. This is because it Important to ensure that the refreshed Health and Wellbeing Strategy provides a framework that:

- Remains evidence based and reflects the priorities of Thurrock residents
- Continues to capture and stimulate action that impacts on the wider determinants of health and wellbeing
- Is flexible enough to respond future emerging challenges and national and local policy developments
- Does not duplicate but holds the system to account

10. Partners will also help to identify possible priorities for the refreshed Health and Wellbeing Strategy which will be subject to consultation with the public.

The public

11. Part of the engagement approach is to ensure Thurrock's citizens understand the important part they have in improving both their own and their community's health and wellbeing as well as helping to identify how health and care services can and should improve.

12. Stakeholders that we intend to engage with as part of the Strategy refresh are provided at **Annex B1**.

13. Communication and engagement activity will be taking place throughout 2020. **A formal consultation period, running for approximately 8 weeks, will take place in early 2021**. Specific, timed communication activity is set out at Annex B2.

14. The questions we are likely to ask as part of consulting the public are:
    - Do you think the Goals are the right ones?
    - Are the priorities identified within each of the Goals the right ones?
    - Do you think there are other health and wellbeing issues that we should consider as part of the Health and Wellbeing Strategy?
    - What action should we take to deliver the priorities?
    - How do you think we should measure whether the Strategy is improving outcomes for the people of Thurrock?

15. We aim to have the refreshed Strategy in place by the end of March 2021.

<u>Key Messages</u>

16. To ensure consistency throughout the consultation exercise key messages will include:
    - We are living longer but not healthier lives
    - A number of the conditions that cause poor health are very preventable
    - A wide range of issues affect health and wellbeing, often referred to as the wider determinants of health, which include housing, education and employment, finances and the environment within which we live and work.
    - All partners and organisations have a role to play in supporting health and wellbeing
    - Individuals themselves have a key role in maintaining their health and wellbeing and using health and care resources wisely
    - We want people to access services at locations and times that are suitable for them
    - People can access health and wellbeing support through a range of non-traditional methods (i.e. pharmacists)

- If more people are kept healthy less people will require expensive hospital services which will free up resources that can then be spent on prevention.

Annex B1

Stakeholder mapping

Stakeholders		Possible methods	Contacts
Elected members	• Leader (HWB member) • Cllr Mayes (PFH Air Quality and Health) • Cllr xxx (PFH Education) • Cllr Little (PFH Children and Adult Social Care and HWB member) • Cllr Fish (HWB member) • Cllr Holloway (Chair of HOSC) • Cllr Johnson (PFH Housing) • Cllr Hullin (PFH Communities)	• HWB • Specific briefings • Meetings	
Council Committees / Strategic Meetings	• Health and Wellbeing Board • Cabinet • HOSC • Director's Board • Council DMTs	• Meetings and papers	
Key Partners	• NELFT • EPUT • CCG • Mid and South Essex Health and Care Partnership • BTUH • Prison and probation service	• Primarily through the Health and Wellbeing Board	
Partner governance	• CCG Board • Mid and South Essex Health and Care Partnership		

Stakeholders		Possible methods	Contacts
VCS Organisations	• Thurrock CVS • Thurrock Health Watch		
	• Service Users	• Letters • Attendance at Forums (described within specific targeted forums)	
The public	• General Public	• Attendance at Community Hubs • Attendance at events • Attendance at locations (i.e hospitals, surgeries) • Attendance at Forums • Consultation portal • Letters (as part of council tax reminders etc, CCG, CVS) • Press release • Twitter • LACs • On the street engagement via Ngage • Partner websites with links to Thurrock Council website	
Specific targeted Forums	• Thurrock Disability Partnership Board • Older People's Parliament • Youth Parliament • Thurrock Asian Association	• Attendance at meetings	
Council Employees		• Attending Directorate Team meetings • Discussions at various staff forums • Chief Executive's Blog • Staff Forums	
Various audiences		• Council Twitter to advertise events / opportunities to provide views on HWB Strategy refresh	

Annex B2

Communication activities and timescales

[The Communication activity plan will be developed by the Task and Finish Group that is to be established

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Current HWB Strategy Goals and Objectives

OALS →	1 OPPORTUNITY FOR ALL	2 HEALTHY SAFER AND ACCESSIBLE ENVIRONMENTS (amended)	3 BETTER EMOTIONAL HEALTH AND WELLBEING	4 QUALITY CARE CENTRED AROUND THE PERSON	5 HEALTHIER FOR LONGER
jectives	1A All children in Thurrock making good educational progress **Michele Lucas**	2A. Create Spaces that make it easy to exercise and be active. Amended from: Create outdoor places that make it easy to exercise and to be active **Grant Greatrex / Andy Millard**	3A. Give parents the support they need **Sue Green**	4A. Create four integrated healthy living centres **Rahul Chaudari / Christopher Smith**	5A. Reduce obesity **Helen Horrocks**
	1B More Thurrock residents in employment, education or training **Michele Lucas**	2B. Develop homes that keep people well and independent **Sean Nethercoat / Keith Andrews / Les Billingham**	3B. Improve children's emotional health and wellbeing **Malcolm Taylor / Helen Farmer**	4B. When services are required, they are organised around the individual **Mark Tebbs**	5B. Reduce the proportion of people who smoke **Kev Malone**
	1C Fewer teenage pregnancies **Sareena Gill**	2C. Build strong, well-connected communities **Les Billingham / Natalie Warren / Kristina Jackson**	3C. Reduce social isolation and loneliness **Les Billingham**	4C. Put people in control of their own care **Catherine Wilson**	5C. Significantly improve the identification and management of long term conditions **Emma Sanford / Mark Tebbs**
	1D Fewer children and adults in poverty **Michele Lucas**	2D. Improve air quality in Thurrock **Dean Page / Mark Gentry**	3D: Improve the Identification and treatment of mental ill-health, particularly in high risk groups. Amended from: Improve the identification and treatment of depression, particularly in high risk groups **Catherine Wilson / Mark Tebbs**	4D. Provide high quality GP and hospital care to Thurrock **Rahul Chaudari / Jane Foster Talyor**	5D. Prevent and treat cancer better **Mark Tebbs**

uture HWB Strategy framework and domains.

nt – Existing objective not been considered with partners to date. Blue Font existing objective that should be included within refreshed strategy based on initial partner feedback. Orange for priorities. Purple font existing objectives to be further considered.

l Domain 1 are Centre he Person on existing HWB goal 4) ute and Community , focussing on e (GPs Pharmacists, Hospital care, NHS.	**Proposed Domain 2 Children and Adult Social Care** (new domain) Focus on Social Care from Birth to Death	**Proposed Domain 3 Healthier for Longer** (building on existing HWB Strategy goal 5) Targeted diagnostic, prevention and intervention (health conditions). Focussing on health conditions and wider health aspects of a person's life	**Proposed Domain 4 Emotional Health and Wellbeing** (building upon existing HWB Strategy goal 3) Focussing on all mental health and LD	**Proposed Domain 5 Wider Determinant of Health – Opportunity for all** (building on existing HWB Strategy Goal 1) Opportunities Education, Training, Volunteering and Employment	**Proposed Domain 6 Wider Determinant of Health – Housing and the Environment** (new domain) Focussing on Housing, environment, local plan, economic development	**Proposed Domain Determinant of He Community Safety Development and Cohesion** (new do Focussing on Domestic exploitation, ASB, safe feeling safe, gangs, cou
ective 4A. Create ted Medical Centres	Current objective 4C. Put people in control of their own care	Current objective 1C. Fewer Teenage Pregnancies	Current objective 3B. Improve Children's Emotional Health and Wellbeing (by providing support for identifying and supporting mental health challenges early)	Current objective 1A. All children in Thurrock making good educational progress	Current objective 2A. Create spaces that make it easier to exercise and be active	APHR Report recomm area 1 surveillance Develop a broader understanding of the impacts of serious yo violence and vulnerab develop interventions challenges Public Heal
ategy priority 4B. Quality care centred around the person ategy priority 4C. People will feel in control of their care tion on Livin Well@Home, Advocacy Service, Personal rect Payments, Shared Lives Service		Current objective 5A. Reduce Obesity	Current objective 3C. Reduce Social Isolation and Loneliness	Current objective 1B. More Thurrock residents in employment, training or education	Current objective 2B. Develop homes that keep people well and independent [Possibly include sheltered housing]	Perpetrator Disruption Safeguarding Partners Strategic Plan) Levi Si Sinden)
ective 4D. Provide GP and hospital rrock Primary Care		Current objective 5B. Reduce the proportion of people who smoke	Current objective 3D. Improve the identification and treatment of mental ill health, particularly in high risk groups	Current objective 2C. Build Strong, well connected communities – to be amended to reflect benefits of COVID	Current objective 2D. Improve air quality in Thurrock	Improve response and for response to sexua ((Adult Safeguarding Partnership Strategic Sinden (Levi Sinden)
nability and ion Partnership	Transitioning to adulthood. (Joe Tynan) Transitional Safeguarding (Adult Safeguarding Partnership Strategic Plan) Levi Sinden (Levi Sinden)	Current objective 5C. Significantly improve the identification and management of long term conditions Health checks for the seriously mentally ill (SMI). SMI have broader HC so could support LTC Maria Payne	*Provide support to people with LD (LD Health-Checks, LTCs)* *Proposed by Ian Stidston*	Current objective 1D Fewer children and adults in poverty *Improve Energy Efficiency and tackle Fuel Poverty and Excess Cold (Dulal Ahmed) (Housing Strategy)* [Can include reference to tackling fuel poverty, the council's single view of debt support – Links to domain 6 energy efficiency		APHR Report recomm area 4 Tertiary prevention – with YOT [Michelle Cu
ategy priority 3A. l be given the y need when they arers	Ensuring completion of initial health assessments for children coming into social care (Joe Tynan)	Existing Strategy Priority 5D. More cancers will be prevented, identified early and treated better.	Provide treatment in the best available setting (virtual or face to face) including utilising Thurrock CVS *Maria Payne*		Existing strategy priority 2A. Create spaces that make it exercise and to be active To include in a safe environment	

ed Domain 1 Care Centre the Person on existing HWB goal 4)	**Proposed Domain 2 Children and Adult Social Care** (new domain)	**Proposed Domain 3 Healthier for Longer** (building on existing HWB Strategy goal 5)	**Proposed Domain 4 Emotional Health and Wellbeing** (building upon existing HWB Strategy goal 3)	**Proposed Domain 5 Wider Determinant of Health – Opportunity for all** (building on existing HWB Strategy Goal 1)	**Proposed Domain 6 Wider Determinant of Health – Housing and the Environment** (new domain)	**Proposed Domain 7 Wide Determinant of Health – Community Safety, Development and Cohesi** (new domain)
cute and Community em , focussing on are (GPs Pharmacists, c) Hospital care, NHS.	Focus on Social Care from Birth to Death	Targeted diagnostic, prevention and intervention (health conditions). Focussing on health conditions and wider health aspects of a person's life	Focussing on all mental health and LD	Opportunities Education, Training, Volunteering and Employment	Focussing on Housing, environment, local plan, economic development	Focussing on Domestic Violence, exploitation, ASB, safe places, fee safe, gangs, count lines
ation of Primary Care	**APHR Report recommendation Theme 3 Secondary prevention intervention those with existing risk factors to mitigate the risk** [to be linked to Domain 7 to perhaps include wider partnership arrangements]	**Increase the proportion of children in Thurrock receiving the recommended immunisations. (Possibly Teresa Salami Oru) Strategy Childhood Immunisation Recovery Plan**	**Providing access to mental health services as part of a wider package of support provided to homeless families and individuals** Ryan Farmer	**APHR Report recommendation area 2 Primary prevention stopping people early years wide generic offer up to 18 from entering into gangs** Education lead	**Well Homes (captures information about people 4000 supported) as whether they smoking and Long Term Health Conditions (Dulal).** Link with Domain 3	
nation of services to provide integrated health and care n their communities on CCG – suggested that some objectives should cross omains to ensure that partnership working continues to be d)		**Current objective 3A. Give parents and carers with the support they need**	**Prevention of suicides in Thurrock** ***Maria Payne*** *This would link into the wider suicide prevention strategy*	New: SEND Written statement of action	**Ensuring properties are of good condition in the private and public sector Housing conditions in the private sector Improved licensing Removal of hazards (statutory responsibility) Dulal Ahmed**	
	Tackling child exploitation. Joe Tynan. (link to proposed priority in domain 5 and APHR report)	**New: Substance misuse** which could support the invididual as well as contribute to outcomes in domain 7	**To create a vibrant local economy, supporting local businesses, to employ local people Luke Tyson**		**Support homelessness prevention and rough sleepers** *Carol Hinevest*	
					Existing Strategy priority 2D. Air quality will be improved.	

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31 July 2020	ITEM: 9
Thurrock Health and Wellbeing Board	
Mid and South Essex Health and Care Partnership Memorandum of Understanding	
Wards and communities affected: All wards	
Accountable Director: Roger Harris, Corporate Director for Adults Housing and Health	

Executive Summary

The purpose of the Memorandum of Understanding (MOU) being considered by members at today's meeting is to formalise and build on our existing partnership arrangements and relationships. The MOU does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

The MOU defines an agreed governance framework that specifies the functions that will be delivered at:

- Locality (ie. Sub-place footprint/Primary Care Network) level.
- Place (ie. The four places linked to respective Health and Wellbeing Boards)
- System (ie. Health & Care Partnership/Mid and South Essex) level

The MoU recognises that accountability for the System and Places would be through Health & Wellbeing Boards, with scrutiny undertaken by Health Overview and Scrutiny Committees, and further acknowledges that the MoU needs also to recognise the role and expectations of NHS regulatory functions.

The MoU shall commence on the date of signature of the Partners. It shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System. It shall thereafter be subject to an annual review of the arrangements by the Partnership Board.

1. RECOMMENDATIONS

1.1 That Health and Wellbeing Board members approve the Memorandum of Understanding

2. Introduction and Background

1.1 Since the creation of the Mid and South Essex Health and Care Partnership, the way system partners work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 1.2 million people living in our area. We have recently published our 5-Year Strategy and Delivery Plan which outlines our vision and ambitions and refreshes our commitment to working together for the benefit of our residents.

1.2 The Mid and South Essex Health and Care Partnership have a number of lines of accountability – to each other, as partners, to our residents and service users and, for

NHS partners, to government through NHS England and NHS Improvement. Through that route, two key expectations for systems have been identified:

- That we will work together to agree and deliver a **coordinated programme of transformational change,** to secure the long-term sustainability, ensure local delivery of the NHS Long Term Plan (LTP) and to support transformation of health and care at System, Place and Locality.
- That we will **collectively manage system performance**, noting that individual organisations retain individual statutory accountabilities.

1.3 The Memorandum of Understanding (MoU) has been created, at Annex A, to strengthen existing joint working arrangements and support our future development. This document is in two parts:

- Memorandum of Understanding – that provides an overview of the Partnership, its vision and priorities, principles for integrated working and a description of the functions at System, Place and Locality/Primary Care Network.
- Ways of working - that provides an overview of the governance arrangements and expectations for mutual accountability and collective agreement.

3. Issues, Options and Analysis

3.1 The MOU provides a commitment across strategic partners to work together and undertake the planning and commissioning of services at the most appropriate geographical level.

4. Reasons for Recommendation

4.1 The MOU provides a commitment across strategic partners to work together and undertake the planning and commissioning of services at the most appropriate geographical level.

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

5.1 The following partners have been engaged and consulted during the development of the MOU:

- Local Authorities and Health and Wellbeing Boards across Essex, Southend and Thurrock
- NHS Commissioners representing Clinical Commissioning Groups across the Mid and South Essex Health and Care Partnership
- NHS Service Providers including NELFT, Essex Partnership University NHS Foundation Trust and East of England Ambulance Trust
- Other key partners including the local Healthwatch service within Thurrock, Southen and Essex and the CVS

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

6.1 The MOU helps to establish roles and responsibilities of local partners and will inform the future planning, commissioning and delivery of health and care services within Thurrock and across the wider Mid and South Essex Health and Care Partnership footprint.

7. Implications

7.1 Financial

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

Any Financial Implications will be subject to organisational governance arrangements.

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7.2 Legal

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

The MoU is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this MoU. It is a formal understanding between all of the Partners who have each entered into this MoU intending to honour all their obligations under it.

7.3 Diversity and Equality

The MOU will ensure that health and care services are planned and commissioned which address inequalities

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

8. Background papers used in preparing the report

N/A

9. Appendices to this report

Annex A	Health and Care Partnership Board MOU agenda item
Annex B	Membership of the Task and Finish Group
Annex C	MOU document

Annex A

PARTNERSHIP BOARD MEETING
10 JUNE 2020

TITLE:	PARTNERSHIP MEMORANDUM OF UNDERSTANDING
AUTHOR:	PROFESSOR MIKE THORNE, INDEPENDENT CHAIR
PRESENTED BY:	PROFESSOR MIKE THORNE, INDEPENDENT CHAIR
FOR:	AGREEMENT

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1. PURPOSE

This paper presents the Partnership Memorandum of Understanding, for agreement by the Mid & South Essex Health & Care Partnership Board.

2. BACKGROUND

Following discussion by the Partnership Board and Chairs' Group, in December 2019, a Governance Task and Finish Group was established, chaired by Alan Tobias, to develop a memorandum of understanding to guide the work of the Health & Care Partnership.

The Task and Finish Group comprised representatives from across the Partnership (see membership at Appendix 1). The group has met three times, with work taking place in between meetings via email correspondence, to work through iterations of a MoU, building on work undertaken in Thurrock, and learning from other systems (Harrogate and West Yorkshire particularly, and other integrated care systems).

A draft of the MoU was considered by the Partnership Chairs' Group when it met in February and comments received through that route have been incorporated. Attached at Appendix 2 is the MoU for agreement of the Board.

3. PRINCIPLES

In developing the MoU, the Task and Finish Group acknowledged:

- The overarching principle was one of subsidiarity in decision-making, which is person-centred and not based around the needs of organisations.
- The statutory responsibilities and accountabilities of individual organisations would remain unchanged, given the Partnership has no power or authority.
- The dual requirements of an ICS (from an NHS perspective) - to have a role in both system oversight/performance, and transformation. This is reflected in the MoU.

4. ISSUES CONSIDERED BY THE TASK & FINISH GROUP

It was acknowledged that, unless and until Integrated Care Systems are given statutory powers, it would not be possible for the Partnership to act as a single entity, with its own discrete decision making powers.
In developing the MoU, the Group recognised the existing position that partnership working and collaboration is currently undertaken without specific authority or delegation of powers from the various partners eg the four "places" or Alliances.

The MoU recognises that accountability for the System and Places would be through Health & Wellbeing Boards, with scrutiny undertaken by Health Overview and Scrutiny Committees, and further acknowledges that the MoU needs also to recognise the role and expectations of NHS regulatory functions.

Partners had differing perspectives on the level of detail the MoU should provide. We have sought to steer a middle path, maintaining flexibility rather than providing definitive descriptions of actions and functions in all areas, particularly as no part of the MoU is legally binding. We have aimed to describe our *intent* to work in partnership.

5. RECOMMENDATIONS

5.1 The Task and Finish Group recommends that the Partnership Board adopts the attached Memorandum of Understanding (MoU).
In so doing, the following steps would be followed:

- 5.1.1 Partnership Board members will recommend the MoU to their respective Board/Governing Body for adoption (a generic cover sheet for Board discussions will be developed to support this), such that by 31 July (Board meeting dates permitting) all statutory partners will have signed the MoU.
- 5.1.2 The MoU will be backed by revised terms of reference for existing system groups outlined in the document (Partnership Board, System Finance Leader Group, Clinical & Professional Forum). These will be presented to the Partnership Board for agreement in due course.
- 5.1.3 ToR will be developed for new groups outlined within the MoU (Transformation Programme Delivery Group, System Leadership Executive Group). These will be presented to the Partnership Board for agreement in due course.
- 5.1.4 This will enable adoption of the MoU from 1 August 2020 and enable us as a Partnership to work together to implement it.

5.2 The Partnership Board records its thanks to Alan Tobias and members of the Task and Finish Group for their support and leadership in developing the MoU.

Annex B

Membership of the Governance Task & Finish Group

Alan Tobias (Chair),
Mike Thorne, Independent Chair, Health & Care Partnership
Ian Wake, Director of Public Health, Thurrock
Viv Barnes, Director of Governance & Performance, Mid-Essex CCG (representing the 5 CCGs)
Nick Spenceley, Non-executive Director, BBCCG
Brinda Sittapah, Company Secretary, Southend Hospital
Lauren McIntyre, Director of Governance, NELFT
Phil Richards, Executive Finance Director & Corporate Secretary, Provide
Nigel Leonard, Executive Director, Strategy & Transformation, EPUT
Nick Faint, Director of Partnerships, Southend Council (handed over to Jacqui Lansley, Director of Integration, Southend Council)
Simon Froud, Director of Locality Delivery, ECC
Jo Cripps, Programme Director, Health & Care Partnership

Mid and South Essex Health and Care Partnership

Attachment C2

Memorandum of Understanding & Ways of Working

Table of Contents

Foreword

Since the creation of our Partnership, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 1.2 million people living in our area. We have recently published our 5-Year Strategy and Delivery Plan which outlines our vision and ambitions and refreshes our commitment to working together for the benefit of our residents.

As a Partnership we have a number of lines of accountability – to each other, as partners, to our residents and service users and, for NHS partners, to government through NHS England and NHS Improvement. Through that route, two key expectations for systems have been identified:

- That we will work together to agree and deliver a **coordinated programme of transformational change,** to secure the long-term sustainability, ensure local delivery of the NHS Long Term Plan (LTP) and to support transformation of health and care at System, Place and Locality.

- That we will **collectively manage system performance**, noting that individual organisations retain individual statutory accountabilities.

The challenge for the Partnership is to manage these expectations while also working together as equal partners. This document sets out how we will do this. We have aimed to:

- Put people at the heart of our approach, and not organisations.
- Honour the principle of subsidiarity
- Be respectful of the statutory functions and accountabilities of individual organisations
- Be as "light touch" as possible, while recognising the requirements placed upon us as outlined above, and that collectively, we are stewards of public services and funding.

We have agreed to develop this Memorandum of Understanding (MoU) to strengthen existing joint working arrangements and support our future development. This document is in two parts:

1. Memorandum of Understanding – that provides an overview of the Partnership, its vision and priorities, principles for integrated working and a description of the functions at System, Place and Locality/Primary Care Network
2. Ways of working - that provides an overview of the governance arrangements and expectations for mutual accountability and collective agreement.

The Covid-19 emergency has accelerated transformational change across the system. We have learned just how much can be done when led from the front line. The emergency has led to even closer working between organisations and sectors at place level and we realise that there is thereby still greater potential for change which is beneficial to all.

While we have made great strides, we know there is a lot more to do. The health and care system will continue to be under significant pressure, and we must address health inequalities. We all agree that

working more closely together at System, Place and Locality level will enable us to tackle these challenges and achieve our ambitions. This MoU demonstrates our clear commitment to do this.

Professor Michael Thorne CBE
Independent Chair
Mid & South Essex Health and Care Partnership

Part 1: Memorandum of Understanding

Overarching Principles:

This MoU:

- Is based on an ethos that the Partnership is a **servant of the people** in Mid and South Essex.
- Seeks to ensure **collective decision-making** to **improve the health and wellbeing of our residents.**
- Has a **central principle of subsidiarity**.
- Commits to **supporting Place** as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services.
- Recognises the **pivotal role of our Health and Wellbeing Boards** in setting joint health and wellbeing strategies to reduce health inequalities.
- Recognises the central role of **Local Authority Health Overview and Scrut**iny arrangements with responsibilities for holding health and care organisations to account and for scrutinizing major service changes
- Recognises the **regulatory functions of the NHS**.

This MoU is **not**:

- A legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this MoU.
- Intended to replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Local Authorities.

1. Parties to the Memorandum

1.1 The members of the Mid and South Essex Health and Care Partnership (the **Partnership**), and parties to this Memorandum of Understanding (MoU), are:

Local Authorities

- Essex County Council* #
- Southend-on-Sea Borough Council #
- Thurrock Council #

NHS Commissioners

- NHS Basildon & Brentwood CCG
- NHS Castle Point & Rochford CCG
- NHS Mid-Essex CCG
- NHS Southend CCG
- NHS Thurrock CCG

NHS Service Providers

- East of England Ambulance Services Trust *
- Essex Partnership University NHS Foundation Trust *
- North East London NHS Foundation Trust *
- Mid & South Essex NHS Foundation Trust
- Provide CIC *

Heath Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other Partners

- Healthwatch Essex*
- Healthwatch Southend
- Healthwatch Thurrock
- Community & Voluntary Sector Network
- University College London Partners (UCLP)*
- Eastern Academic Health Science Network*

* These organisations are also part of neighbouring Integrated Care Systems.

\# The policy agenda and priorities for Local Authorities are set out by democratically elected councilors and cabinet and these are subject to scrutiny alongside management of finance and performance.

1.2 As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this MoU.

1.3 Certain aspects of the MoU are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

Definitions and Interpretation

1, 4 This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

1.5 This MoU shall commence on the date of signature of the Partners. It shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System. It shall thereafter be subject to an annual review of the arrangements by the Partnership Board.

2. Purpose

2.1. The purpose of this MoU is to formalise and build on our existing partnership arrangements and relationships. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.2. The MOU defines an agreed governance framework that specifies the functions that will be delivered at:

- Locality (ie. Sub-place footprint/Primary Care Network) level.
- Place (ie. The four places linked to respective Health and Wellbeing Boards)
- System (ie. Health & Care Partnership/Mid and South Essex) level

2.3. The MoU also outlines how partners will discharge the two key roles for the Integrated Care System, as defined by NHS England and Improvement. These are to;

- Work together to agree and deliver a **coordinated programme of transformational change,** to secure the long-term sustainability of the system, ensure local delivery of the LTP and to support transformation of delivery of health and care at System, Place and Locality.

- **Collectively manage system performance**, including the overall NHS financial and operational performance of the system, noting that individual organisations retain individual (and statutory) accountabilities

2.4. Partners to this MoU recognise that the system needs to move from a transactional model of commissioning /provision to a model of collaboration between health and care providers based on population health outcomes; and to transform healthcare services from a focus purely on treatment to one that also prevents ill health from occurring and has a strengths-based approach.

2.5. Our 5-year Strategy and Delivery Plan has outlined how we will take a Population Health System approach by working together to a common set of health and wellbeing outcomes.

2.6. We wish this MOU to provide pragmatic solutions to integration and partnership working and to avoid adding extra unnecessary layers of governance, bureaucracy or complexity. We aim to avoid creating rigid long term structures that are unable to evolve over time or which undermine the existing governance and statutory responsibilities of our individual organisations.

2.7. The MoU is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this MoU. It is a formal understanding

between all of the Partners who have each entered into this MoU intending to honour all their obligations under it.

2.8. Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the MoU, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

3. Our Vision & Ambitions

3.1 We have worked together to develop a shared vision for health and care services across Mid and South Essex. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

"A health and care partnership working for a better quality of life in a thriving Mid and South Essex, with every resident making informed choices in a strengthened health and care system"

We are committed to supporting:

Healthy Start – helping every child to have the best start in life
- Supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.
- Supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide

Healthy Places – creating environments that support healthy lives.
- creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – spring from participation
- making sure everyone can participate in community life, empowering people to improve their own and their communities' health and wellbeing, and to tackle loneliness and social isolation

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives
- Helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home

- From advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

3.2 Our priorities for improving health outcomes, joining up care locally, and living within our financial means were set out in our 5-year Strategy & Delivery Plan and this MoU should be read in conjunction with the Strategy.

3.3 We have agreed through our 5-Year Strategy that our focus as a partnership should be to **reduce health inequalities** by seeking to shift resources to address the "inverse care law". We will do this by:

4 Principles for integrated working

This MOU, and more widely the way we plan, commission and deliver a Population Health System through an ICS is based on the following principles which all signatories to this MOU agree to:

1. **Prevention.** We will transform services from ones that react to health and care need, to ones that play a proactive part in keeping our residents as healthy and independent for as long as possible. We will intervene earlier to help people remain well. We recognise that this approach is both good for our population's health and wellbeing, and saves money in the longer term.

2. **Partnership.** *Progress occurs at the speed of trust.* We will ensure that future transformation and integration builds upon the strong relationships and partnerships at System, Place and Locality/PCN level and see to protect and nurture these relationships. We will ensure that future partnership arrangements include the widest possible range of stakeholders. As partners, at every level we will act for the benefit of the population we serve, and not for organisational self-interest. We will ensure that our residents are engaged as equal partners in decision making on future transformation activity at the most appropriate level.

3. **Whole Systems Thinking.** We recognise the value of coordinated action across all providers at each level of the system, as the best way to address the health and wellbeing challenges that our residents face. We have developed a single outcomes framework that operates across System, Place and Locality footprints. We seek to define population outcomes based contracts that coordinate action across multiple providers to ensure our system becomes sustainable over the long term.

4. **Strengths and Asset Based Approach.** We believe in a 'strengths and solutions' based approach. We see the individual as a whole person with differing needs and wants, not a passive recipient of "top down" services. We will harness and empower individuals to solve their own problems, with service providers support to 'fill the gaps'. We will leverage existing community and third sector assets in care delivery, connecting individuals with support outside of traditional NHS or Social Care interventions. This strengths based approach to delivering care will generate positive and varied solutions tailored to the wider wellbeing needs of each resident, not a 'one size fits all' option.

5. **Subsidiarity.** We believe in 'building from the bottom up'. We want to plan and deliver care in the heart of our communities. We recognise that PCNs and localities are the building blocks around which integration best occurs. We will devolve planning and delivery down to the lowest possible level where it makes sense to do so. Our starting point for service delivery, transformation and integration will be locality/sub locality level and we will only plan, commission and deliver services over wider geographical footprints where a clear case can be made that this is necessary.

6. **Empowering front line staff to do the right thing.** We believe in 'distributed leadership'; harnessing the creativity and energy of staff. We will move from a transactional model of commissioning to an approach that focuses on outcomes.

7. **Pragmatic Pluralism**. We recognise that across the system and our places there is a considerable heterogeneity of need between populations. We recognise that there are some actions that it makes sense to do once at system level, whilst others that need to be done differently in different places and localities. We will respect this diversity and develop pragmatic solutions that respond to it.

8. **Leverage Health Intelligence and the evidence base.** We recognise the importance of health intelligence and published evidence to fully understand and then best respond to ensure a high quality of care. We will use our JSNA programmes to understand the needs of our residents and improve their outcomes. We will look for opportunities for joint working between the three Public Health teams on shared health intelligence products. We know that different population groups have different care needs and we will use Population Health Management techniques like risk stratification and predictive modelling developed from our integrated health and care record system to identify and segment 'at risk' cohorts in our population and design targeted, tailored and proactive evidence based interventions to keep people well.

9. **Innovation.** Transforming the way we work means trying new and innovative approaches. To make process we will try and test new approaches, evaluating as we go, keeping the best and not admonishing ourselves where we fail and not being afraid to stop things that have not worked.

5. Expected Functions at Locality, Place & System Level

Subsidiarity is our guiding principle as a Partnership and everything we do together aims to ensure this. The following section describes the functions that may be carried out at each level in the system – at locality/PCN level, at Place and at System. The functions listed are not exhaustive. **Annex 4** provides a high level description of the spectrum of relationships between the various sectors and partners, and the functions that will be delivered within each.

Locality / Primary Care Network Level

5.1 Localities are the footprint upon which we can ensure that social care, welfare, advice, physical and mental health services collaborate to provide seamless care and support to residents. To support this approach, 28 Primary Care Networks (PCN) have been formed; these are groups of practices collaborating around populations of 30-50,000 residents.

5.2 We recognise the critical and increasing importance of localities and PCNs and support the principle of *subsidiarity;* that the starting point for planning, transforming and delivering services should be at the most local level practicable.

5.3 We have an aspiration to deliver Community-Led Commissioning/Resource prioritisation. We wish to shift power from organisations to communities, allowing them to drive what is commissioned, what it looks like, and to be part of the decision-making process.

5.4 At **Locality / PCN level** we commit to the following where practicable:

- Forming **locality/PCN based Steering Boards** to manage development and implementation of new models of integrated care within each locality
- Devolving the maximum number of programmes possible to create a coherent and integrated **locality offer**, moving services closer to communities.
- **Empowering front-line staff** to design and deliver a service offer that responds to local need and engages the third sector and residents in the wellbeing agenda.
- Through the **Better Care Fund**, identifying and protecting a local locality budget
- Developing **locality-based commissioning arrangements** where partners agree it makes sense to do so (eg locality/PCN based contracts for long-term condition case finding/management, LES services with GP, voluntary sector services)
- Delivery of locality based **healthy lifestyle services** (eg. self-care/patient education, smoking cessation, sexual health (spoke services), cervical screening, weight management)
- Supporting service delivery with a **mixed skill workforce** including integration of community healthcare, mental health, and social care.
- Delivery of a **wider range of services closer to people's homes**. This may include, but is not limited to:

- Minor operations coordinated across GP practices (eg. lumps and bumps, vasectomy services)
- Phlebotomy services
- Long Term Conditions case-finding programmes including hypertension, AF and depression screening.
- Support for carers
- End of Life care
- Delivery of dental care and improved oral health programmes
- Delivery of MSK services
- Wound Care
- Single, integrated 'one stop shop' clinics for the management of diabetes, cardio-vascular disease and respiratory long-term conditions with input from secondary care consultants.
- New model of care for Common Mental Health Disorders and some mental health services for patients with SMI including IAPT, Dementia and Psychiatric Nursing
- Clinical models including diagnostics (eg. 24 hour blood pressure monitoring) and some secondary care outpatient clinic provision
- Consultant-led integrated primary/secondary care specialist clinical provision (eg. gerontology, community paediatrics, diabetes, neurology/epilepsy, community cardiology)
- Proactive clinical outreach to residential care homes
- Adult Social Care assessment/fieldwork services
- Social Prescribing
- Asset Based Community Development approaches including community assets and community resilience building
- Locality housing and employment support
- The Schools Wellbeing Service (defining a school as a community)
- Children's Centres – a wide range of services and support for families with young children.

Place (Integrated Care Partnership) Level

5.5 We have four defined Places across the system and will form four Integrated Care Partnership Boards with representation from all key local authority, NHS, Healthwatch, and community and voluntary sector stakeholders, aligned to the relevant Health and Wellbeing Board(s). These are:

- An Integrated Care Partnership for **Thurrock** encompassing the geographical footprint of Thurrock Council, Thurrock CCG ,Thurrock Joint Health and Wellbeing Board, Thurrock Healthwatch and Thurrock CVS

- An Integrated Care Partnership for **South East Essex** encompassing the geographical footprint of Southend-on-Sea Borough Council, part of Essex County Council, Castle Point Borough Council, Rochford District Council, Castle Point and Rochford CCG, and Southend CCG, linking to both Southend Health and Wellbeing Board and Essex Health and Wellbeing Board.
- An Integrated Care Partnership covering for **Mid Essex** encompassing the geographical footprint of Mid Essex CCG, Chelmsford City Council, Maldon District Council, Braintree District Council and part of Essex County Council, linking to Essex Health and Wellbeing Board.
- An Integrated Care Partnership for **Basildon and Brentwood** encompassing the geographical footprint of Basildon and Brentwood CCG, Basildon District Council, Brentwood Borough Council, part of Essex County Council and linking to Essex Health and Wellbeing Board.

5.6 The work within each Place will reflect local priorities and relationships, and provide a greater focus on population health management, integration of services around the individual's needs, and a focus on care provided in primary and community settings.

5.7 We recognise *Place* as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services. We also recognise the Kings Fund Research finding that 70% of integration activity occurs at Place or Locality level.

5.8 Appropriate resources will be made available to ensure our places can deliver agreed transformation programmes.

5.9 We acknowledge the pivotal role of Local Authorities in delivering integrated care and population health through their functions to address the wider determinants of health including housing, employment and economic growth, education, planning, regeneration and transport, their role in commissioning of primary and secondary prevention activity from the Public Health Grant, and their responsibility to commission and deliver Adult and Children's Social Care.

5.10 We further recognise the statutory role of the three Health and Wellbeing Boards, with responsibility for joint strategic needs assessments, and setting joint health and wellbeing strategies to reduce health inequalities. The Health and Wellbeing Boards also hold a requirement to approve plans for the Better Care Fund.

5.11 We also acknowledge the key roles of local Healthwatch in representing the views of patients and the community and voluntary sector in delivering wider health and wellbeing programmes.

5.12 Each place will have formal arrangements for engaging with local communities.

5.13 Political leadership for each ICP will be provided through the relevant Health and Wellbeing Board.

5.14 Each ICP will be accountable to the Health and Wellbeing Board for delivery of its locally agreed plan.

5.15 Each ICP will also have a line of accountability to the System (Partnership Board) for delivery of agreed system transformation, finance, quality and performance priorities.

5.16 We recognise the statutory role of Health Overview and Scrutiny Committees., with responsibilities for holding health and care organisations to account and for scrutinizing major service changes. Political scrutiny of proposals and decisions made at all levels of the system will be undertaken through Essex, Thurrock and Southend Health Overview and Scrutiny Committees and Cabinets. For some issues that have system-wide implications a Joint Overview and Scrutiny Committee will be established.

5.17 At each **Integrated Care Partnership** we commit to the following:

- **Developing and leading delivery of an Integrated Care Partnership Population Health Strategy** and outcomes framework aligned to wider Health and Wellbeing Strategies and the agreed system Outcomes Framework.
- Developing a single **ICP Integrated Care Alliance Contract** between all health and care stakeholders including the third sector with arrangements for sharing population health outcome metrics, and (where relevant) budgets and mechanisms to share financial risk and reward.
- **Gathering the views of our residents and engaging them** in re-design of services and commissioning decisions through Healthwatch and other consultation mechanisms.
- **Leading capital regeneration programmes** that impact on health and wellbeing and that are distinct to each ICP geography
- **Integrating planning and regeneration strategic programmes** that impact positively on wellbeing and wider determinants
- Developing and **implementing new models of integrated preventative care** encompassing NHS, adult and children's social care, education, housing, health improvement and prevention, community safety and third sector services/community assets.
- **Where appropriate, integrating Health and Social Care commissioning in a single function, managed through the Better Care Fund** as the financial delivery mechanism for integrated out of hospital health and care services.
- Development and **strategic leadership of local prevention programmes** eg tobacco control, smoking cessation, weight management.
- Delivery of **integrated Frailty Pathways** between hospital, community and primary healthcare, adult social care and the third sector.

- **Discharge planning from secondary to adult social care** including programmes to reduce/eliminate Delayed Transfers of Care
- Delivery of planned care activity including **Continuing Health Care.**

In addition, and depending on the footprint of the ICP, they may also undertake:

- **A Joint Strategic Needs Assessment and Healthcare Public Health Offer** to assess need/demand/supply and drive commissioning priorities
- **Management of integrated contracts / agreements** between providers eg. Section 75
- **Commissioning ICP wide primary prevention services** as appropriate, including local stop smoking, weight management, services that promote physical activity, services that improve nutrition, drug and alcohol treatment services, sexual and reproductive health services, public health nursing
- **Strategic commissioning Adult and Children's Social Care** where provision is borough wide

System (ie. Mid and South Essex) level

5.18 We recognise that there are some tasks and integration activity that it makes sense to do once, at scale, at *System* level for our 1.2m population. We also recognise the planning footprint of Mid and South Essex will become increasingly more important as the geography recognised by NHS England & Improvement for strategic financial and planning activity in their oversight of the NHS Long Term Plan implementation.

5.19 At System level, we commit to:

- Keep up to date our **Strategy & Delivery Plan**
- Agree and monitor a set of high level **population health outcomes** meaningful to the population of Mid and South Essex.
- Plan for and secure the right **workforce.**
- Use **digital technology** to drive change and ensure systems are inter-operable, including the development of the **integrated shared care record.**
- Place **innovation** and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Develop and shape the **strategic capital and estates** plans across Mid and South Essex.
- Develop a shared **information, data, and intelligence function** to drive system-wide change.
- Operate as an Integrated Care System and progressively to build **population health management** capabilities required to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services.
- Manage our **financial resources** within a shared financial framework for the NHS across the constituent CCGs and provider organisations to maximise system-wide efficiencies necessary to manage within the NHS financial control total. (See Annex 1 for organisations subject to the NHS control total)

- **Allocate resources in** line with the need to address health inequalities, re-investing savings in areas where this will have the largest impact for residents.
- Strengthen **strategic planning and commissioning arrangements** for the system.
- Own and resolve **system-wide challenges** (to be agreed between partners) through partnership working.
- Integrate, over time, the **regulatory functions** that have historically sat with NHSE/I as part of a single ICS.

Greater Essex

5.20 It is recognised that some services are planned, commissioned and delivered at the Greater Essex level – for example mental health and learning disability services. Nothing in this MoU seeks to undermine these arrangements.

NHS Region /National

5.21 It is recognised that some specialised NHS services are planned, commissioned and delivered at regional or supra-regional level. Nothing in this MoU seeks to undermine these arrangements.

Part 2: Ways of Working

This section of the document describes in more detail the ways of working and governance groups that exist.

6. Partnership Governance

6.1. The Partnership does not replace or override the authority of the Partners' Boards and Governing Bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

6.2 The Partnership provides a mechanism for collaborative action and common decision-making for issues which are best tackled on a wider scale.

6.3 A schematic of our governance and accountability relationships is provided at **Annex 3** and terms of reference of the Partnership Board, System Leadership Executive, System Finance Leaders Group and Clinical & Professional Forum will be developed separately.

Partnership Board

6.4. A Partnership Board is in place to provide the formal leadership for the Partnership. The Partnership Board is responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to reach collective agreement as Partners which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

6.5. The Partnership Board is made up of the chairs of each organisation (NHS and upper tier Health & Wellbeing Board chairs), the Executive Lead for the Partnership (who is also the Joint Accountable Officer for the 5 CCGs), Chief Executive Officers of NHS provider organisations, lead officers for the three Local Authorities, Place-based leads, representatives from Healthwatch, Public Health, Community and Voluntary Sector organisations and the Local Medical Committee. Over time, membership will evolve to include identified system leaders for specific programmes eg. workforce, quality, performance.

The Partnership Board is independently chaired. It will meet at least 4 times each year in public.

6.6 The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national NHS bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive Group

6.7 The System Leadership Executive (SLE) Group comprises Chief Executive Officers and Accountable Officers of NHS organisations and lead officers from the Local Authorities. It is responsible for:

- Overseeing delivery of the Partnership's strategy, receiving reports from the Transformation Programme Delivery Group on priority programmes and agreeing action to resolve any issues arising.
- Taking advice from the System Finance Leaders Group and the Clinical and Professional Forum as appropriate.
- Regularly reviewing a dashboard of key performance, quality, finance and transformation metrics and taking appropriate action where required.
- Building leadership and collective responsibility for our shared objectives.
- Act as the interface with NHS regulators on system performance and assurance on behalf of the Partnership.

6.8. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

Clinical & Professional Forum

6.9. Clinical and professional leadership is central to all of the work we do. Clinical and professional leadership is built into each of our work programmes and governance groups.

6.10 The purpose of the Clinical & Professional Forum is to drive clinical and professional leadership and provide support, advice, guidance and challenge to the Partnership, and to assist the Partnership in both setting and achieving its stated priorities.

6.11 The Clinical & Professional Forum ensures that the voice of professionals from across the range of partner organisations, drives the development of new models and proposals for the transformation of services. It also takes an overview of system performance on quality.

System Finance Leaders Group

6.12 Financial stewardship is key to the Partnership's work. The purpose of the System Finance Leaders Group is to provide financial support, advice and guidance to the Partnership and to assist the Partnership Board by providing collaborative financial leadership for all programmes.

6.13 The System Finance Leaders Group will develop a system-wide governance framework and work towards the system control total for NHS Partners, support the development of data analytics and financial modelling for the system, ensure financial plans are up to date, and develop a financial investment process to include the operation of an investment advisory group.

Transformation Programme Delivery Group

6.14 Delivery and transformation programmes have been established to enable the Partnership to achieve its agreed priorities. Cross-system programmes are overseen by a central Programme Management Office to ensure a consistent methodology of managing complex programmes.

6.15 Each programme has a Senior Responsible Owner, typically at executive level, and has a structure that builds in clinical and other stakeholder input, representation from each of our four places and each relevant service sector. All programmes will adopt the agreed system Design Principles and Target Operating Model described at **Annex 2**.

6.16 The Transformation Programme Delivery Group will comprise programme leads. It will meet bi-monthly to track progress of agreed priority programmes, manage risk and ensure interdependencies are managed. Programmes will provide regular updates to the System Leadership Executive.

Other governance arrangements between Partners

6.17 The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, providers, local authorities) that support the way it works.

The Joint Committee of Clinical Commissioning Groups

6.18 The five CCGs in Mid and South Essex are continuing to develop closer working arrangements within each of the four Places that make up our Partnership.

6.19 The CCGs established a Joint Committee in 2017, which has delegated authority to take decisions collectively on matters relating to:

- Acute hospital services
- NHS 111 services
- Ambulance services
- Patient transport services
- Acute mental health services

The Joint Committee comprises representatives from each CCG and has one lay member. To make sure that decision making is open and transparent, the Committee meets in public on a bi-monthly basis. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

6.20 The CCGs have commenced work to engage with partners on a formal merger.

6.21 The Joint Committee is a committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the Mid and South Essex programmes of work that have been expressly delegated to it by the CCGs.

Mid & South Essex NHS Foundation Trust

6.22 The three acute hospital trusts in Mid and South Essex have been working closely together for several years and formally merged in April 2020 to become the Mid & South Essex NHS Foundation Trust.

Essex Partnership University NHS Foundation Trust (EPUT)

6.23 EPUT provides adult mental health and learning disability services across mid and south Essex. EPUT also provides Community services in south east Essex. For the purposes of NHS planning, EPUT aligns with the Mid and South Essex footprint. EPUT provides services across three STPs/ICS in Essex and is part of the New Models of Care Provider Collaborative with other mental health trusts for specialist mental health services in the region.

North East London NHS Foundation Trust

6.24 NELFT provide adult community services in south west Essex and children's community services across the footprint and children's mental health services across greater Essex. For the purposes of planning, NELFT aligns with north east London.

Provide CiC

6.25 Provide is a community interest company (social enterprise), providing health and care community services across the East region.

Joint Approach

6.26 NELFT, Provide and EPUT are currently exploring opportunities for joint working, sharing best practice and integration of services to achieve better outcomes for residents. This work is on-going with a view to a potential joint venture contract arrangement. NHS commissioners have indicated that they wish to pursue a single contract with the three providers.

Local Government

6.27 The Partnership includes three upper tier local authorities. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions. At Place level, the district councils of Basildon, Brentwood, Castle Point, Rochford, Rayleigh, Maldon, Chelmsford and Braintree play a key role.

6.28 Within the Partnership, NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

6.29 The four Places have accountability to the upper tier Health and Wellbeing Boards for delivery of locally agreed plans.

6.30 Local Authorities are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime, certain aspects of these arrangements will not apply - most significantly, Local Authority partners would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this MoU, Local Authorities agree to align with the spirit of joint planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councilors will continue to hold the partner organisations accountable through their formal Scrutiny powers. It is recognised that Essex County Council interacts with three ICS' and therefore must take a pragmatic approach to its interactions with each.

Current statutory requirements

6.31 NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of

CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

6.32 NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

6.33 NHS England and NHS Improvement are working more closely together and expect, over time, to merge. This means that NHS regulators will increasingly be taking a joined up approach to regulation of NHS partners, taking a "system first" approach. Our Partnership needs to be able to respond to this while respecting that non-NHS partners have separate lines of accountability.

7. A new model of mutual accountability

7.1. Through this MoU the Partners agree to take a collaborative approach to, and collective responsibility for, managing performance, resources and the totality of population health.

7.2 This MoU has no direct impact on the roles and respective responsibilities of the Partners which all retain their full statutory duties and powers.

7.3 The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on supporting the spread and adoption of innovation and best practice between Partners.

7.4. Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

7.5. System oversight will including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress and areas for improvement;
- Identifying the need for improvement support through education, sharing of best practice and peer review;
- Agreeing the need for more formal action or intervention on behalf of the Partnership; and
- Consideration of regulatory powers or functions.

7.6. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a

coordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

Taking Action

7.7. The SLE will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal support and intervention when needed. These may include:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- the appointment of external support where required; and
- restrictions on access to discretionary funding and financial incentives.

7.8 Where financial performance is not consistent with plan, the System Finance Leaders Group will make recommendations to the SLE on a range of support and, where required, intervention, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- enhanced controls for deployment of transformation/capital funding held at Place

7.9 Mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places require support from the wider Partnership to ensure the effective management of financial and delivery risk.

National NHS Bodies – Support, Oversight and Escalation

7.10 As part of the development of the Partnership and the collaborative working between the Partners under the terms of this MoU, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in Mid and South Essex in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of providers, commissioners and Places in accordance with the terms of this MoU;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, outcomes and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual provider and commissioner partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the SLE and work through the Partnership Board to seek a resolution prior to making an intervention with the Partner.

7.11. To support Partnership development as an Integrated Care System there will be a process of aligning resources from Arms Length Bodies to support delivery and establish an integrated single assurance and regulation approach.

7.12. National capability and capacity will be available to support Mid and South Essex from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

8. Collective Arrangements & Resolving Issues

8.1 We aim to make collective decisions as a partnership, respectful of the statutory obligations of each partner. Our approach to collective decision-making arrangements will follow the principle of subsidiarity and will be in line with our shared values and behaviours. We commit to taking all reasonable steps to reach a mutually acceptable resolution to any issue that arises.

8.2 Both the Partnership Board and SLE have no formal powers delegated by any Partner. However, they will increasingly take on responsibility for coordinating agreements, based on a "Best for Mid and South Essex" basis. The Partnership Board will initially have responsibility for reaching agreement on:

- The objectives of priority work programmes and work streams
- The apportionment of transformation monies from national NHS bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

8.3 The Partnership Board will receive recommendations on the above from the SLE. The SLE will aim to reach agreement by consensus. If agreement cannot be reached, then the matter may be referred to the Partnership Board for wider discussion and resolution.

8.4 In respect of priorities for NHS capital investment or apportionment of transformation funding, if a consensus cannot be reached at the SLE meeting to agree this then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

8.5 The Partners understand any decision about service change that requires consultation will be undertaken in accordance with the relevant statutory obligations of partners.

Issue resolution

8.6 Partners will attempt to resolve in good faith any issues between them in respect of Partnership-related matters, in line with the principles set out in this MoU.

8.7 The Partnership will apply an issue resolution process to resolve any issues which cannot otherwise be agreed through these arrangements.

8.8 Subsidiarity will be the overarching principle when resolving issues. Therefore, where appropriate, Place-based arrangements will be used to resolve any issues which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

8.9. As agreements made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared values and behaviours and come to a mutual agreement through the issue resolution process.

8.10. The key stages of the issue resolution process are

1. The SLE will discuss issues openly and transparently and seek to find resolution to the mutual satisfaction of each of the affected parties. The SLE will take appropriate advice from the System Finance Leaders Group, the Clinical and Professional Forum, Place/Alliances and other relevant groups in pursuit of a resolution.
2. The SLE will come to a majority decision (ie. a majority of eligible Partners participating in the meeting who are affected by the matter under discussion, determined by the scope of applicable issues set out in Annex 1) on how best to resolve the issue through applying the principles of this MoU and taking account of the objectives of the Partnership. SLE will advise the Partners of its decision in writing.
3. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the issue, the matter can be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the issue in accordance with the terms of this MoU.
4. In the unlikely event that the independent facilitator cannot resolve the issue, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the issue in accordance with the terms of this MoU and advise the parties of its decision.

9. Financial Framework

9.1. All Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

9.2. A set of financial principles have been agreed. They confirm that we will:

- aim to live within our means, and develop, for the NHS, system financial governance and risk management arrangements to deliver the system control total.
- develop a Mid and South Essex system efficiency plan in response to the financial challenges we face; and
- develop a shared approach to investment, including the establishment of an Investment Advisory Group
- develop payment and risk share models that support a system response rather than work against it.

9.3. We will collectively manage resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to ensure financial sustainability.

Living within our means and management of risk

9.4. Through this MoU the collective leaders at System level and in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective partners involved.

9.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks at System level and in each Place, leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

NHS Contracting principles

9.6. NHS partners are committed to continuing the adoption of payment models which are better suited to whole system collaborative working and are outcome focused. The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Allocation of Transformation Funds

9.7. The Partners intend that any transformation funds made available to the Partnership will be allocated through collective agreement by the Partnership, in line with agreed priorities. The method of allocation may vary according to agreed priorities – for example, funds may be allocated on an equitable basis in order to address the inverse care law. Any savings accrued through demand management functions will be re-invested where they can have maximum impacts for the population. Decisions will be guided by the Partnership population health management work.

9.8 Funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the partners have agreed that they will deliver the maximum leverage for change and address financial risk.

9.9. The funding provided to Places (through formula agreed by the partners) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all partners that the resource has been deployed to deliver maximum transformational impact, address financial risk, and to meet efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and Partnership Board, and be subject to on-going monitoring and assurance.

9.10. Funding provided to the Programmes will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant partners.

Allocation of ICS capital

9.11. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this MoU.

Allocation of Provider and Commissioner Incentive Funding (Financial Recovery Funding)

9.12. The approach to managing additional funds set out by NHS planning guidance and business rules is not part of this MoU. A common approach to this will be agreed by the Partnership as part of annual financial planning.

10. Variations

10.1. This MoU, including the Schedules, may only be varied by written agreement of all the Partners.

11. Charges and liabilities

11.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this MoU.

11.2. By separate agreement, the Parties have agreed to share specific costs and expenses arising in respect of the Partnership between them in accordance with a "Contributions Schedule", developed by the Partnership and approved by the Partnership Board.

11.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

12. Information Sharing

12.1 The Partners will provide to each other all information that is reasonably required in order to achieve the objectives and take decisions on a "Best for Mid and South Essex" basis.

12.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

13. Confidential Information

13.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorized disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this MoU in accordance with the principles and objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

13.2. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

13.3. The Parties agree to procure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this MoU.

13.4. Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

14. Additional Partners

14.1. If appropriate to achieve the agreed objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this MoU if required.

14.2. The Partners intend that any organisation who is to be a partner to this MoU (including themselves) shall commit to the principles, governance arrangements and ways of working.

15. Signatures

15.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same document.

15.2. The expression "counterpart" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

15.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

Signed: Print:	Position	Organisation	Date
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Schedule 1 - Definitions and Interpretation

1. The headings in this MoU will not affect its interpretation.

2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers*	Councils	NHSE & NHSI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Collective agreement and issue resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
NHS financial framework – risk management	✓	✓		✓		
Financial framework – Allocation of NHS capital and transformation funds	✓	✓		✓		
National and regional support	✓	✓	✓	✓		

*All elements of the financial framework for Mid & South Essex, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs. Provide CIC is a significant provider of NHS services. It is categorised as an 'Other

Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

Annex 2 – Design Principles & Target Operating Model

Design Principle	Description

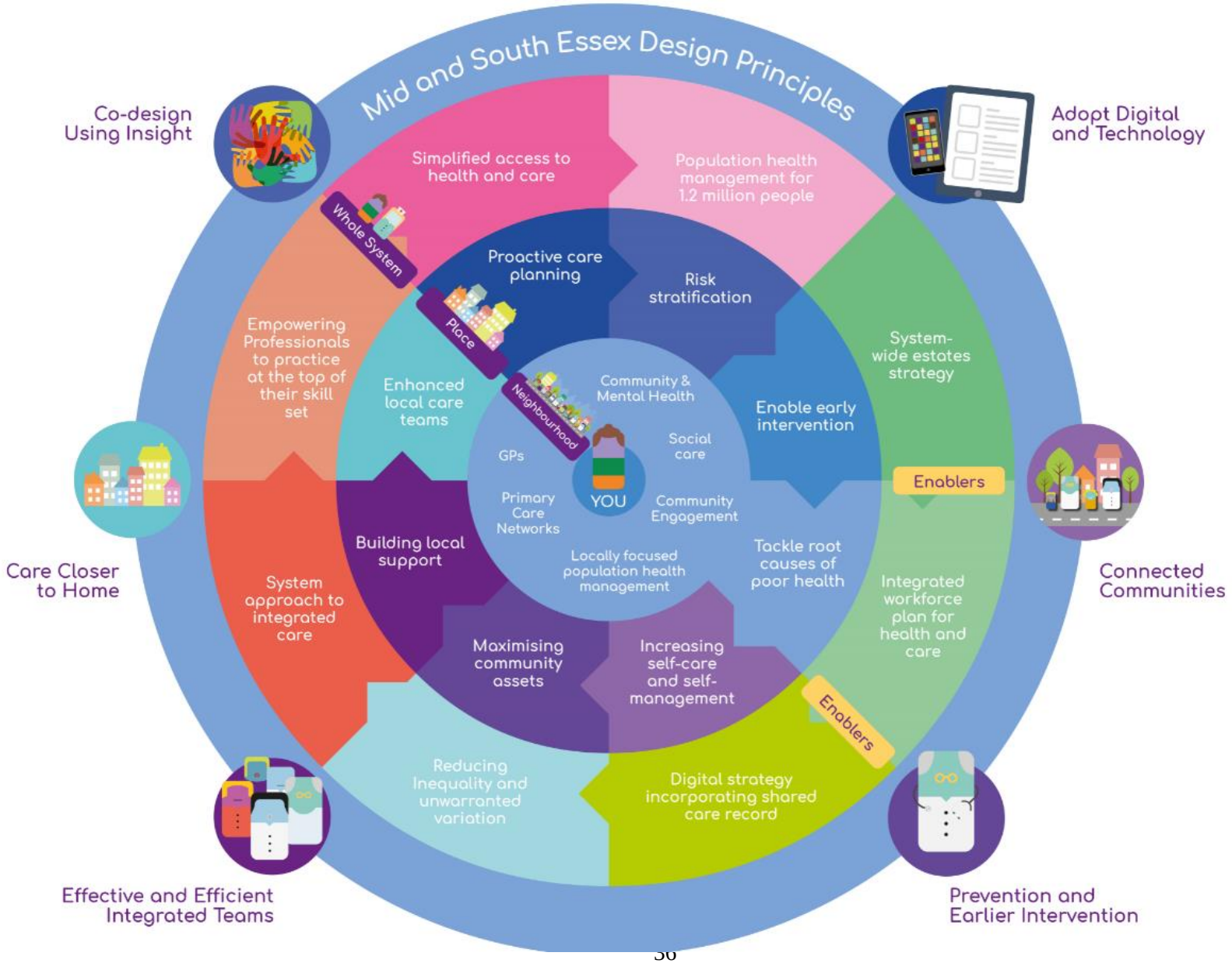
We will co-design with insights and intelligence, putting residents at the centre 	// We will work with our residents and staff to shape services that are focussed on better outcomes, long-term sustainability and continuous improvement driven by a feedback culture.
	// We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity.
	// We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.

We will connect people together, delivering integrated care in the community 	// Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions. // We will ensure different organisations work together, meaning people get the right care more quickly and easily.
We will support people to stay well through prevention, self-care and independence thus building resilient communities 	// A shift from the reactive transactional model currently in place, to a responsive, proactive and sustainable system that focuses on keeping residents well and supports them through all stages of their life. // We will reduce inequalities by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention.

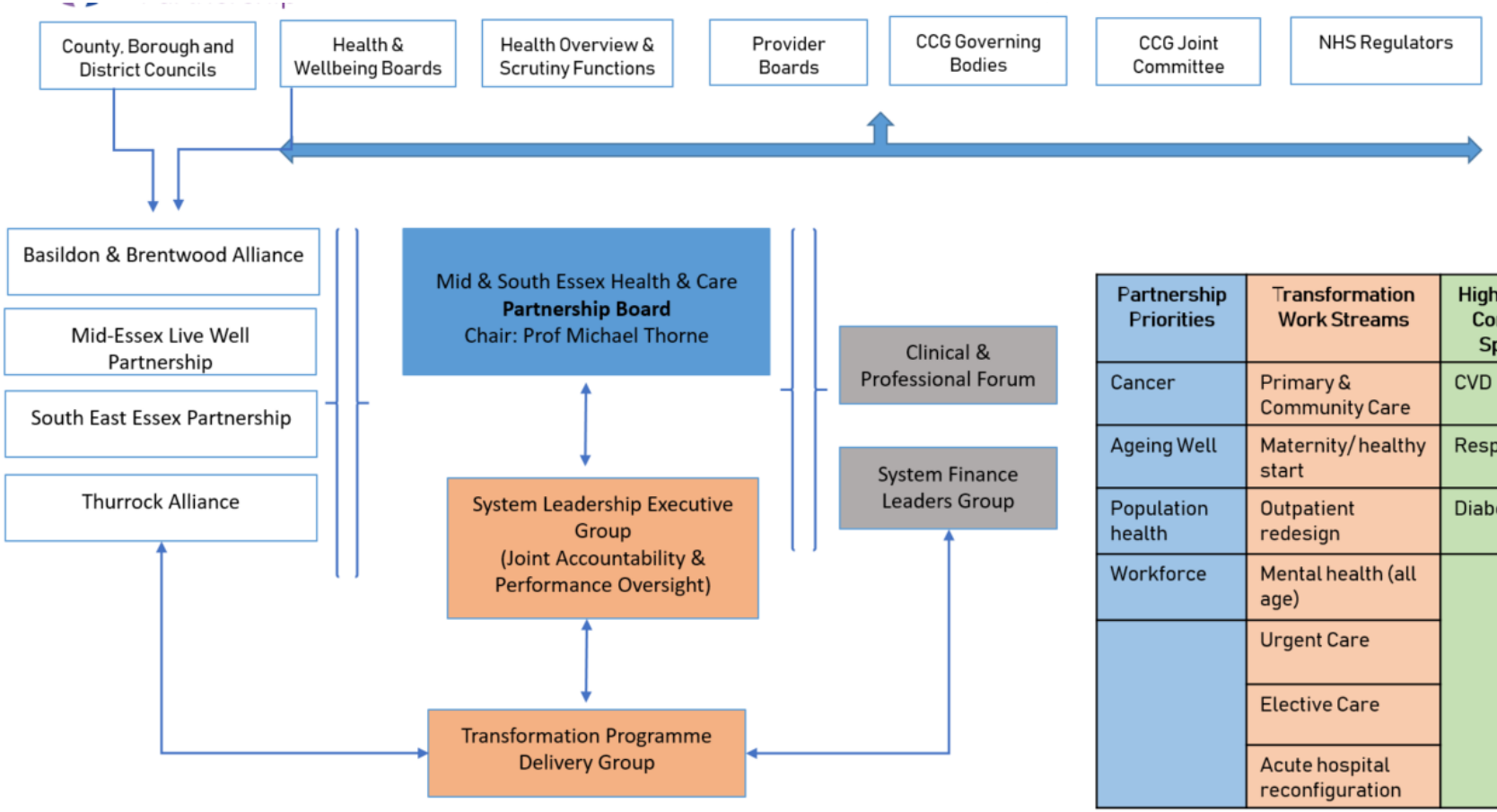
We will adopt digital and technology by default 	// Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions.
	// Other channels will remain available but used only when most appropriate.
	// Staff and residents are supported to adapt to new ways of working and champion innovation.

We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce 	// Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset.
	// Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services.
	// We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.

 We will deliver services as close to the home as possible	// Community based provision of services is the default position, unless necessitated by clinical need. This ensures residents are able to access health, care and wellbeing services in the most appropriate setting for their needs; including online.

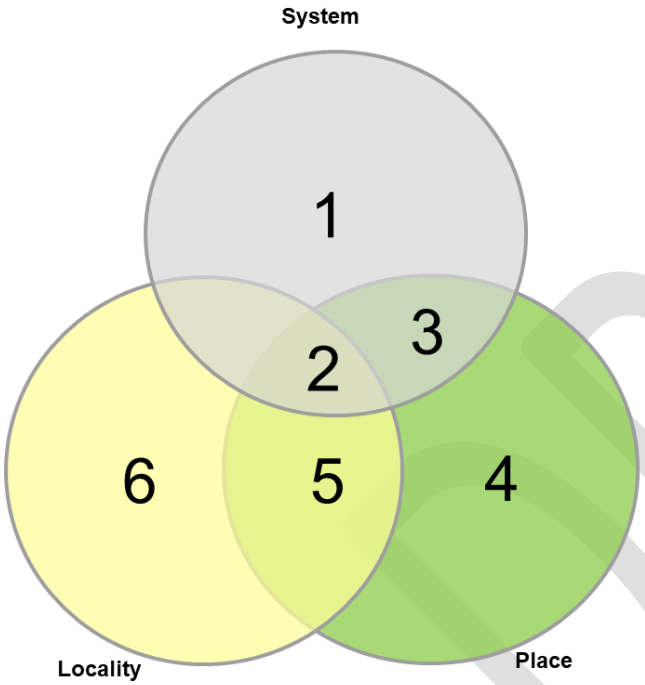

Mid and South Essex Design Principles
Co-design Using Insight
Adopt Digital and Technology
Care Closer to Home
Connected Communities
Effective and Efficient Integrated Teams
Prevention and Earlier Intervention
Simplified access to health and care
Population health management for 1.2 million people
Whole System
Proactive care planning
Risk stratification
Place
Empowering Professionals to practice at the top of their skill set
Enhanced local care teams
Neighbourhood
Community & Mental Health
Social care
GPs
YOU
Primary Care Networks
Community Engagement
Locally focused population health management
System-wide estates strategy
Enable early intervention
Enablers
Building local support
Tackle root causes of poor health
System approach to integrated care
Integrated workforce plan for health and care
Maximising community assets
Increasing self-care and self-management
Enablers
Reducing Inequality and unwarranted variation
Digital strategy incorporating shared care record

Annex 3 – Partnership Overview



Partnership Priorities	Transformation Work Streams	High-Impact Condition Specific	Enabling Programmes
Cancer	Primary & Community Care	CVD	Digital
Ageing Well	Maternity/healthy start	Respiratory	Innovation & Improvement
Population health	Outpatient redesign	Diabetes	Communications & Engagement
Workforce	Mental health (all age)		Estates & Capital
	Urgent Care		Business functions
	Elective Care		
	Acute hospital reconfiguration		

Annex 4 – Spectrum of Relationships



1

Shared vision and purpose for Population Health

System wide health intelligence

Population Health Outcomes Framework

Integrated Data Solution procurement/management

Workforce

Owning and resolving system wide challenges e.g. A&E

NHS Capital Programme

System wide population health activity e.g. Ottawa stop smoking model within hospitals

Single ICS contract for activity that it makes sense to do once at system level:

- Primary Care contracting and performance management
- Secondary Healthcare commissioning across more than one hospital site
- NHS Specialist commissioning
- System wide MH commissioning including inpatients, crisis care, ANLS, suicide prevention, RAID

Strategic oversight of STP Primary Care Strategy

2

Allocation of system wide finance/resources based on need/inequality
Use of integrated data
Local planning/implementation to support system wide priorities

3

Frailty Care pathway
Planned care commissioning
Secondary care implementation of prevention programmes

4

Integrated Care Partnership of all key stakeholder agencies with a single Alliance Contract and outcomes framework aligned to wider Health and Wellbeing Strategies, single capitated budget and mechanisms for risk/reward share between partners

Joint Strategic Needs Assessment to drive commissioning priorities

Engaging resident views in re-design of services through Healthwatch

Capital regeneration programmes that impact on Health and Wellbeing

Developing and strategic oversight of integrated care models

Integrating planning/regeneration and housing functions to impact positively on wellbeing

Integrating Health and Social Care commissioning managed through the BCF as the financial deliver mechanism for integrated out of hospital health and care

Strategic leadership of prevention programmes including Tobacco Control, Whole Systems Obesity, children and young people's wellbeing, public mental health

Management of integrated contracts/agreements between providers e.g. Section 75

Commissioning of lifestyle modification services including smoking cessation, weight management and drug/alcohol treatment

Commissioning planned care including continuing care

Minor Injuries

5

Developing single integrated population outcome based contracts encompassing LTC case finding/clinical management, PH lifestyle services, LESs, NHSE dental, PCN contracts, and provision of MH and community services
Single locality budget within BCF
Devolution of current place based services to locality level e.g. Community Led Solutions
Market development of locality based services

6

Formation of Local Based Steering Boards to manage implementation/delivery
Empowering front line staff in service re-design
Co-commissioning with residents
Implementation of integrated locality contracts care models including lifestyle modification, mixed skill clinical workforce, minor ops, LTC case finding/management, end of life care, wound care, CMHDs, IMC clinical models, proactive outreach to care homes, wellbeing teams, ASC fieldwork, social prescribing, community hubs/development, children's centres, edge of care services, locality housing offices

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31 July 2020	ITEM: 10
Thurrock Health and Wellbeing Board	
Creation of Thurrock Integrated Care Partnership – a sub-group of the Health and Wellbeing Board	
Wards and communities affected: All	**Key Decision:** Yes
Report of: Roger Harris Corporate Director, Adult's Housing and Health and Mark Tebbs Interim Deputy Accountable Officer Thurrock CCG.	
Accountable Head of Service: Roger Harris, Corporate Director Adult's, Housing and Health Directorate	
Accountable Director: Roger Harris, Corporate Director for Adult's Housing and Health Directorate	
This report is Public	

Executive Summary

This paper gives a brief overview of the existing joint working arrangements between partners from health and care across Thurrock, and outlines some proposed changes. It set out partners' conclusions that a single senior forum – the Thurrock Health and Care Partnership - should be established, as a sub-group of the Health and Wellbeing Board, to lead and co-ordinate all relevant partnership working across Thurrock.

The Health and Wellbeing Board scheduled for March was cancelled due to the COVID-19 outbreak. As described in earlier papers considered by members at today's meeting, in response to COVID-19, decisions on services to be stopped, scaled back and indeed created have been taken at pace. To facilitate and support the action that has been taken governance structures have been established.

Since May the TICP has been meeting on a weekly basis to consider system wide action taken to respond to COVID, consider challenges and emerging priorities and understand reset and recovery issues.

1. Recommendation(s)

1.1 The Health and Wellbeing Board is asked to:

- Endorse the Thurrock Integrated Care Partnership Board as a sub-group of the Board
- Comment upon the draft Terms of Reference of the Thurrock Integrated Care Partnership (Appendix 1)
- Agree that minutes of the Thurrock Integrated Care Partnership will be considered by Health and Wellbeing Board members as a standing agenda item. Minutes of recent meetings are provided at Annex B for member's consideration.

2. Introduction and Background

2.1 As Members of the Health and Wellbeing Board will be aware, health and care partners have a long and successful history of partnership working in Thurrock. This has been enabled by: the coterminous arrangements of key statutory bodies (e.g. the Council, Clinical Commissioning Group, Healthwatch and Thurrock CVS); the strength of local relationships; and shared principles and values.

2.2 Some of the achievements of the partnership to date include:

- Establishment of the pooled BCF pooled fund of over £40m.
- Developing and rolling out a new model of care, rooted in a comprehensive case for change
- The development of four Integrated Medical Centres
- Integration of key local services, including establishing joint leadership posts
- Alignment of all partners' planning around four localities.
- Commissioning a Social prescribing service in Thurrock. Social Prescribing supports people with their health and well-being needs. It is available to patients aged 18+ who present to their GP with issues that have a non-clinical underlying cause. Patients may have a social Peed, on-going health condition, regularly attend the GP surgery or are at risk of unplanned admission.
- Expansion of the Local Area Coordinators (LACs) scheme which helps vulnerable people find ways to make a better life. LACs do not provide a formal social care or health service. Instead they ask people "what would make a good life for you?", and help them find how best to lead that life in their local community.

2.3 The extent and nature of this partnership was codified in a comprehensive Memorandum of Understanding that was signed off by the Boards of all local partners, and by the Health and Wellbeing Board, in November 2019.

2.4 In late 2019, the principal health and care partnership forum (the Thurrock Integrated Care Alliance) conducted a review of how it operated. This was prompted by a range of factors, including:

- The emergence of proposals to merge the five CCGs in Mid and South Essex
- The decision to appoint a single Accountable Officer and Executive Team to the five CCGs (as a precursor to potential merger)
- The development of the Mid and South Essex STP, and its evolution into a Health and Care Partnership
- The establishment of Primary Care Networks as key parts of the local NHS 'architecture'
- The need to clarify and streamline partnership working in Thurrock (as existing arrangements had evolved over time)

2.5 Thurrock is part of a wider health and care system: Mid and South Essex Health and Care Partnership. This cover's the 5 CCGs of Thurrock, Basildon / Brentwood, Southend, Mid-Essex and Castlepoint / Richford. This complex health and care partnership arrangement is developing into something called an Integrated Care System (ICS). ICS's will cover every part of the country and seek to ensure improved outcomes where services can be better developed at scale.

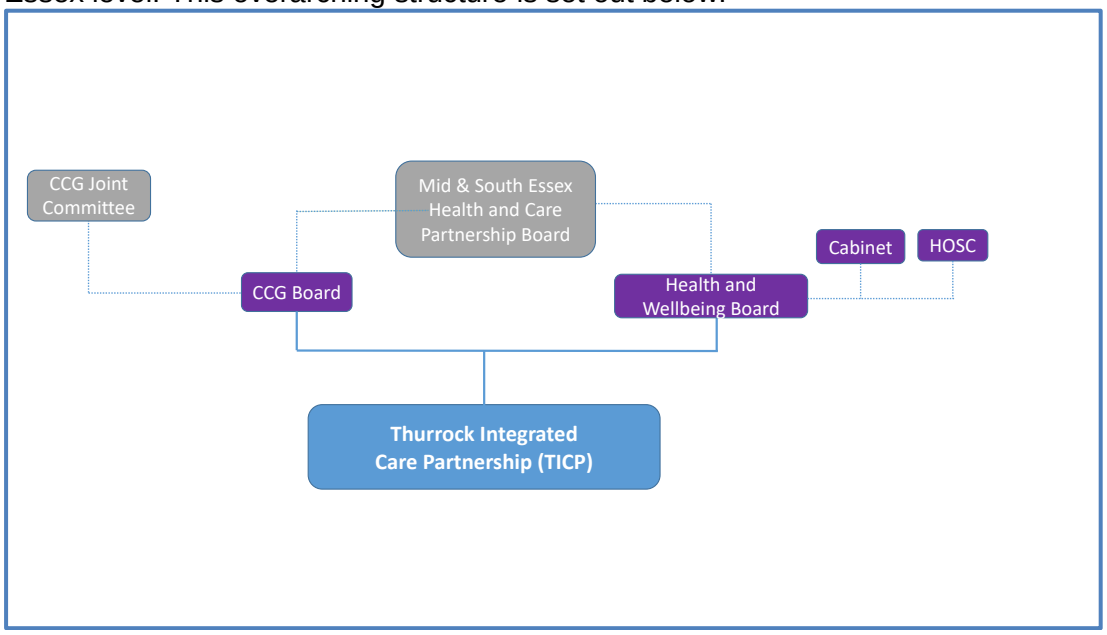
2.6 Partners agreed that in the light of the shifting landscape (especially in the NHS) there was a need to refocus partnership working locally. For some time we have

been working with our partners in the ICS to get the right balance between what is done at place – i.e. Thurrock and what is done at system i.e. Mid and South Essex. Good progress has been made on this and we are hoping that a further Memorandum of Understanding will be agreed soon that states these roles and responsibilities very clearly.

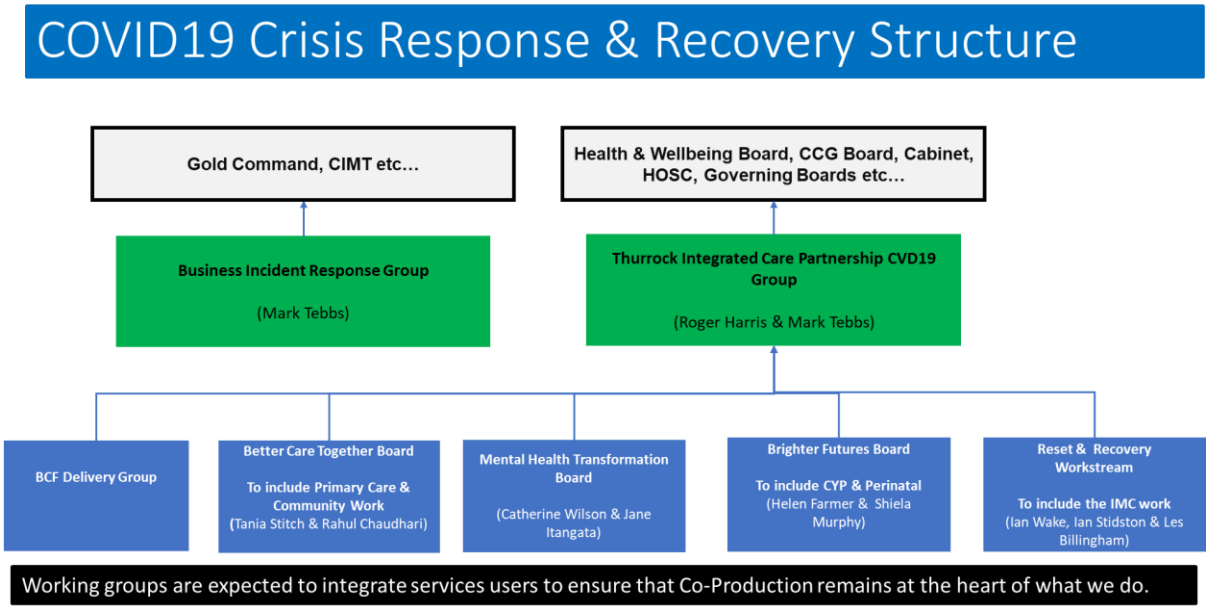
3. Key issues

3.1 In response to the changes outline above, partners have agreed to establish a single all age partnership forum that brings together local leaders. This new group – the Thurrock Integrated Care Partnership – brings together planning for children, young people, adults and older people. It replaces a number of previous groups, including the Thurrock Integrated Care Alliance and the Integrated Commissioning Executive. The draft Terms of Reference for the new group are attached at Appendix 1, which reflects the overall focus of the Partnership and how they have been reviewed in light of COVID-19.

3.2 It is proposed that the TICP has a dual line of accountability: into Thurrock Health and Wellbeing Board and Thurrock CCG Board. Partners also recognise that there are important links into other fora, both within Thurrock Council and at Mid and South Essex level. This overarching structure is set out below:



3.3 As part of reviewing and further defining the Partnership's Terms of Reference to respond to COVID-19 partners have proposed the following structure:



3.4 The TICP brings together all local statutory and third/voluntary sector partners, with senior leaders from:

- Thurrock Council
- Thurrock CCG
- The four Primary Care Networks
- Thurrock Healthwatch
- Thurrock CVS
- Essex Partnership University Trust
- North East London Foundation Trust
- Basildon & Thurrock University Hospitals NHS Foundation Trust

3.5 The key functions of the Thurrock Integrated Care Partnership are to:

- Build on the HWB strategy by developing, setting and agreeing the partnership strategy/priorities and associated outcomes for health, care and wider communities across Thurrock
- Agree the key collaborative work programmes required to deliver the agreed strategy and outcomes
- Oversee the development and deployment of all relevant pooled funds, ensuring they are aligned with the Partnership's strategy
- Develop and oversee the deployment of the Better Care Fund, including developing the annual plan for ratification by the HWB
- Be the focal point for partnership discussions about health, care and related services that are principally controlled in Thurrock
- Be the forum through which Partners influence decision that are taken outside Thurrock (e.g. at Mid & South Essex Health and Care Partnership)
- Review the Partnership's success in delivering the agreed strategy, outcomes and work programmes, intervening as required to address any concerns
- Respond to changes in the operating environment, such as national policy or regulatory requirements
- Develop and agree common decision-making papers for Boards/Council, as required

- Act as champions for the Thurrock Partnership and its strategy, both within and outside organisations

3.6 The TICP is co-chaired by the Interim Deputy Accountable Officer of Thurrock CCG and the Corporate Director of Adults, Housing and Health, Thurrock Council. It is currently meeting on a weekly basis and has established a small number of groups that report into it, each of which leads on priority areas.

4. Reasons for Recommendations

4.1 The recommendations are being made as (a) it is proposed that the TICP has a formal reporting line into the Health and Wellbeing Board (in addition to the Board of Thurrock CCG) and (b) it will be play a significant role in the delivery of the wider Health and Wellbeing Board strategy, which is being refreshed in 2020.

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

5.1 Consultation has taken place with Health and Care system partners

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

6.1 The TICP is being established as a sub-group to the Health and Wellbeing Board and as such will regularly report decisions made to the Board.

7. Implications

7.1 **Financial**

Implications verified by: **Mike Jones**
Strategic Lead – Corporate Finance

As a sub-group of the Health and Wellbeing Board the TICP will monitor and manage the day to day operation of the Better Care Fund.

7.2 **Legal**

Implications verified by:

There are no legal implications involved in setting up the TICP as a sub-group of the Health and Wellbeing Board

7.3 **Diversity and Equality**

Implications verified by: **Natalie Smith Strategic Lead Community Development and Equalities**

The TICP membership will provide consideration to equality and diversity matters when considering both strategic and operational matters

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

Not applicable

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

- None

9. Appendices to the report

- Appendix 1 – Draft Terms of Reference of Thurrock Integrated Care Partnership

Report Authors:

Andy Vowles, RETHINK Partners / Darren Kristiansen Business Manager Adult's Housing and Health

Thurrock Integrated Care Partnership

Terms of Reference

DRAFT

1. INTRODUCTION

This document outlines the purpose and functions of the Thurrock Integrated Care Partnership (TICP). The original TICP terms of references have been amended to enable the TICP to plan the strategic response and recovery during the COVID 19 crisis.

2. BACKGROUND

Partners across Thurrock have a long history of working together to agree and deliver shared outcomes. The approach taken has been inclusive, bringing together commissioners, providers and colleagues from the third/voluntary sector as well as Healthwatch.

In late 2019, following a review of local arrangements, partners agreed to strengthen, further embed and accelerate collaborative arrangements by establishing the Thurrock Integrated Care Partnership.

In March 2020 the national priorities for delivering health and social care services were refocussed to meet the unprecedented challenge due to the international coronavirus pandemic.

The intention is that the TICP partnership will evolve during the coronavirus pandemic to meet the developing challenges presented to health and social care services. The COVID 19 TICP will steer the development of partnership working in Thurrock throughout the coming phases of the COVID 19 crisis. Operating as the key strategic mechanism for all relevant system wide discussions and decisions. It consists of senior officers from all existing partners and – crucially – the leaders of the emerging Primary Care Networks (PCNs). Unlike its predecessor bodies, the TICP brings together into a single forum partnership working for all age groups – children, young people, adults and older people.

3. SCOPE

Reflecting its nature as an ICP, all relevant health, care and related services are considered to be within the broad scope of the group. The group will seek to take decisions, and/or where necessary co-ordinate decision making by other forums such as Board or Cabinet, about relevant services that are primarily governed within Thurrock. In other instances, the Board will wish to influence other parties, for example where services cover a wider geographic footprint such as the Mid and South Essex Health and Care Partnership.

4. ROLE AND RESPONSIBILITIES

The agreed key functions of TICP are to:

- Build on the HWB strategy by developing, setting and agreeing the partnership strategy/priorities and associated outcomes for health and care across Thurrock
- Agree the key collaborative work programmes required to deliver the agreed strategy and outcomes, subject to partners' governance arrangements
- Oversee the development and deployment of all relevant pooled funds, ensuring they are aligned with the Partnership's strategy
- Develop and oversee the deployment of the Better Care Fund, including developing the annual plan for ratification by the HWB
- Ensure the four Integrated Medical Centres (IMCs) are delivered
- Be the operational and strategic focal point which underpins the Health and Wellbeing Board, for partnership discussions about health, care and related services that are principally controlled in Thurrock
- Enable and support the development of the four Thurrock localities
- Be the forum through which Partners influence decisions that are taken outside Thurrock (e.g. at Mid & South Essex Health and Care Partnership)
- Review the Partnership's success in delivering the agreed strategy, outcomes and work programmes, intervening as required to address any concerns
- Respond to changes in the operating environment, such as national policy or regulatory requirements
- Develop and agree common decision-making papers for Boards/Cabinet, as required
- Act as champions for the Thurrock Partnership and its strategy, both within and outside organisations

To ensure that the TICP can meet the challenges presented by the COVID 19 pandemic, the key responsibilities have been increased to include the following:

- Lead on shaping the mechanisms and resources that need to be in place due to the current COVID 19 crisis
- Lead the planning and transition into the next phase and the future following phases of the NHS and local government responses
- Agree which of the beneficial changes that have resulted from the COVID 19 crisis should be 'locked in' to become part of the new operating model for the Thurrock community
- Continue to work in partnership to develop the role of place in Thurrock, defining the responsibilities of how partner organisations work in an integrated way at place in response to the COVID 19 crisis and the recovery.
- Define how the partnership will interface between place and system, agreeing the arrangements of how to align the planning and the monitoring of performance across Thurrock

- Contribute to shaping the relationship between partnership organisations working at Place, PCNs and Locality based services
- Continue to commit to work in partnership to define place-based working through evolving the thinking around the integrated resources including people, processes, finances and systems within achievable constraints
- Plan out the next Phases of maturity of place-based working with reference to those already published for ICS and PCNs

The TICP will be guided by the Thurrock Memorandum of Understanding - "An integrated approach to health and care". This MoU, which has been ratified by all relevant local Boards including the Health and Wellbeing Board, sets out a number of commitments that all partners have agreed to, including to:

- Put the improvement of health and well-being for the people of Thurrock at the forefront of all decision making
- Agree a set of Population Health System Outcomes so that objectives are fully aligned and to support a move away from process measures towards a focus on population outcomes
- Support the principle of subsidiarity – for decisions to be taken at the most local level possible
- Plan together – for example, aligning serve, operational and financial planning
- Change the way services are commissioned and provided to promote collaboration
- Prioritise Prevention –to keep people as healthy and independent as possible for as long as possible
- Develop shared or common models of care that integrate services around the person and reduce fragmentation
- Enable staff to work more flexibly across organisations and settings
- Ensure we have an equal focus on physical and mental health
- Reduce bureaucracy and transactions costs – for example by sharing assets

5. GOVERNANCE

The accountability for TICP is set out in the exhibit below.

The TICP is jointly accountable to Thurrock CCG and the Thurrock Health and Wellbeing Board, with an informal line of accountability to other relevant fora, such as the Cabinet of the Council, the Joint Committee of the five CCGs and the Mid and South Essex Health and Care Partnership Board.

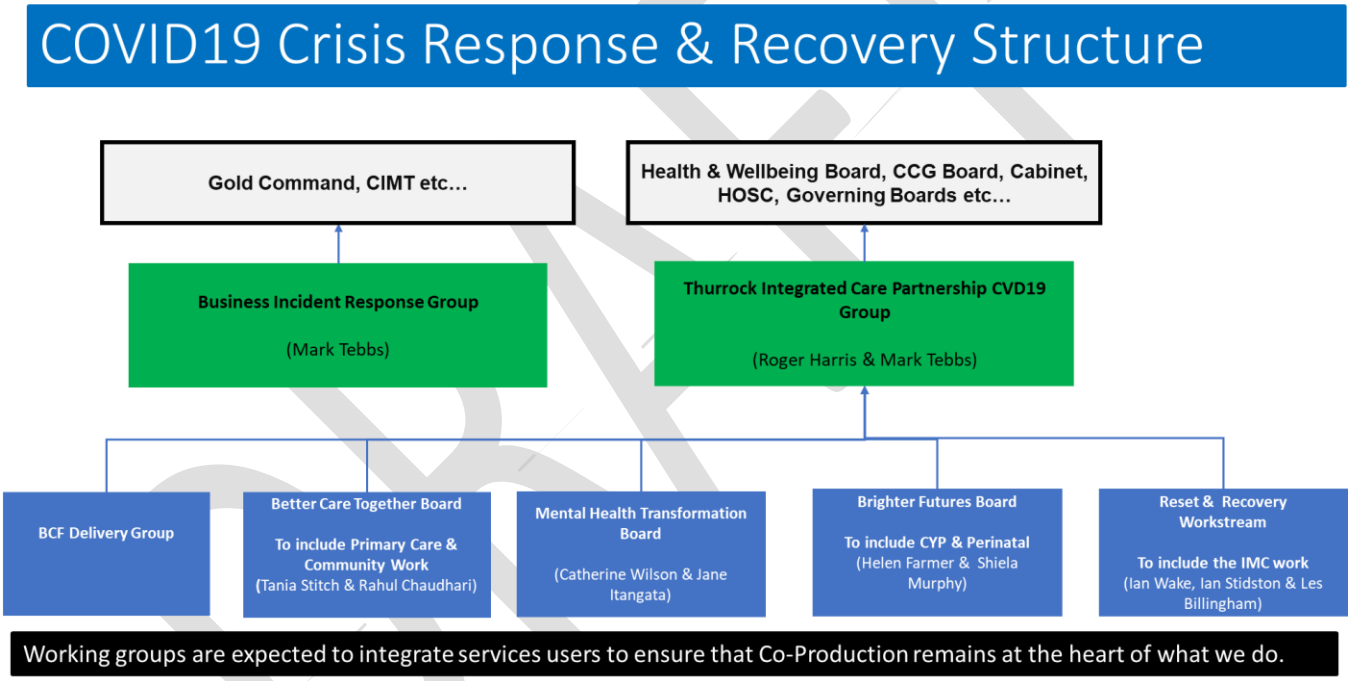
TICP has five key sub-groups, each of which take the lead on priority areas:

- Brighter Futures Partnership, which leads on services for children, young people & Perinatal services. Merit in adjusting the existing TOR & Membership to ensure it can rapidly address emerging needs and priorities due to COVID19 crisis.
- Better Care Together Board, leading on the COVID19 response & recovery implementing the emerging primary care & community model. Merit in adjusting the existing TOR &

Membership to ensure it can rapidly address emerging needs and priorities due to COVID19 crisis.

- The BCF Delivery Group, which prepares the annual plan for, and monitoring of, the Better Care Fund.

- The Mental Health Transformation Board, which focuses on the redesign of mental health services and has strong links with both the localities and Mid & South Essex wide groups. . Merit in adjusting the existing TOR & Membership to ensure it can rapidly address emerging needs and priorities due to COVID19 crisis.
- The Reset & Recovery Workstream will lead on the development and implementation of an integrated health, local authority and social care place based system during the COVID19 response & recovery period. This working group will include the work of the IMC as part of its scope. A TOR & membership will need to be developed to ensure it can rapidly address emerging needs and priorities due to COVID19



Sub groups reporting into the TICP through Highlight Reporting process:

- The COVID19 TICP Sub groups will report the progress of their workstreams into the TICP meeting through a highlight report process by exception.

6. AUTHORITY

The Boards/Cabinet of the relevant statutory bodies have not at this point formally delegated decision making to the TICP, although such a scheme of delegation may be developed in future.

Therefore, the Board draws its authority from the delegated responsibilities of its members as senior leaders across Thurrock.

Members of the Board will work together to secure decisions from the Boards/Cabinet of each partner, as required.

The Board has the authority to establish task & finish groups as it considers appropriate and necessary.

7. MEMBERSHIP

The TICP will continue to bring together all relevant partners locally; its members are as follows:

Member
Roger Harris (Co Chair, Thurrock Council)
Mark Tebbs (Co Chair, Thurrock CCG)
Dr Anil Khallil
Ian Wake Thurrock Council
Catherine Wilson Thurrock Council
Les Billingham Thurrock Council
Sean Clark / Michael Jones Thurrock Council
Rahul Chaudhari Thurrock CCG
Maria Wheeler Thurrock CCG
Sheila Murphy Thurrock Council
Jane Foster-Taylor Thurrock CCG
Ian Stidston Thurrock CCG
Tania Stitch NELFT/Thurrock Council
Brid Johnson NELFT
Nigel Leonard / Sue Waterhouse EPUT
Kim James, Thurrock Health Watch
Kristina Jackson Thurrock CVS
Tom Abell BTUH / Michelle Stapleton BTUH (either to attend as BTUH rep)
Mohammed Munshi PCN (Aveley/Ockendon) Dr Chris Olukanni PCN (Tilbury) Dr Manoj Chandran PCN (Grays) Dr Reg Rehal PCN (Tilbury) Dr Kam Singh PCN (Grays) Dr Manjeet Sharma PCN (Stanford)

Other parties may be requested to attend the Board as required.

8. MEETINGS

The meeting will be chaired on a rotating basis by Mark Tebbs Deputy Accountable Officer of Thurrock CCG, and Roger Harris, Corporate Director of Adults, Housing and Health, Thurrock Council,

The Board will meet every Wednesday weekly. The meeting frequency will be reviewed as we move through the future phases of the COVID 19 Pandemic. Timings should be of sufficient frequency to ensure completion of the objectives and outputs, and can be flexed (increased/decreased) at the discretion of either Chair to accommodate these requirements. The Chair may call extraordinary meetings if required.

Attendance will be via dial-in or video link.

All members will receive copies of papers and minutes of meetings.

To be quorate, at least one of the following: CCG Deputy Accountable Officer (or nominated deputy) or Corporate Director of Adults, Housing and Health, Thurrock Council (or nominated deputy) must be present.

The TICP may invite non-members to attend its meetings as it considers necessary, at the discretion of the Chair.

These meetings are considered private and shall not be open to the public.

It would be expected that in most cases decisions would be reached through consensus. If this is not possible, then this should be escalated initially to Cabinet/Boards (or equivalent) of partner organisations.

9. MINUTES AND ADMINISTRATIVE SUPPORT

Administrative support to the COVID 19 TICP will initially be provided by Adult Housing and Health Directorate Business Management Team, Thurrock Council. The core role is to manage a forward planner to ensure key agenda items are considered when necessary, ensure the agenda and papers are compiled and circulated to members prior to meetings, and to attend to capture key discussions, decisions and actions of meetings.

10. REVIEW

The Terms of Reference will be reviewed as we move through the phases of the COVID 19 Pandemic.

Thurrock Integrated Care Partnership

6 May 2020 9:15 – 10:15am

Teleconference

TICP weekly meeting membership

- Roger Harris (Co Chair, Thurrock Council) / Mark Tebbs (Co-Chair Thurrock CCG)
- Dr Anil Khallil Confirmed
- Ian Wake Thurrock Council
- Les Billingham Thurrock Council
- Rahul Chaudhari Thurrock CCG
- Maria Wheeler Thurrock CCG
- Jane Foster-Taylor Thurrock CCG
- Ian Stidston Thurrock CCG
- Nigel Leonard EPUT
- Tania Sitch NELFT
- Kim James, Thurrock Health Watch
- Kristina Jackson Thurrock CVS

Apologies

- Catherine Wilson Thurrock Council
- Sheila Murphy Director of Children's Services Apologies
- Sean Clark Thurrock Council / Michael Jones Thurrock Council (either to attend as Thurrock Council Finance rep)
- Brid Johnson NELFT – Tania Sitch attended
- Sue Waterhouse EPUT – Nigel Leonard attended attendance

Wider TICP members to remain updated

Tom Abell BTUH / Michelle Stapleton BTUH (either to attend as BTUH rep); Mohammed Munshi PCN (Aveley/Ockendon); Dr Chris Olukanni PCN (Tilbury); Dr Manoj Chandran PCN (Grays); Dr Reg Rehal PCN (Tilbury); Dr Kam Singh PCN (Grays); Dr Manjeet Sharma PCN (Stanford); Jane Itangata Thurrock CCG; Stephen Mayo Thurrock CCG; Helen Farmer Thurrock CCG and Emma Sanford Thurrock Council.

Key discussion points and actions

Introduction

1. The joint Chair's introduced the meeting. The following points were made:

    - Early discussions have taken place and it has been agreed that TICP meetings should restart, recognising that some key partners may not be able to attend at the moment due to other priorities.

    - The TICP will initially consider how to build on lessons learned over the last few weeks and consider how to sequence restarting some of the work that has been paused during the Covid19 Pandemic such as Integrated Medical Centres.

    - It is helpful to ensure the TICP does has oversight of and does not duplicate the work of existing forums including the twice weekly BIRG meeting which focusses on actions required primarily over the next six weeks.

2. Members agreed with the proposal that the TICP will initially be arranged as a short meeting that takes place on a Wednesday morning. Arrangements will be reviewed at the end of May.

   [This has now been amended to reflect the availability of all members. Meetings have therefore been arranged where possible on Wednesdays within the timeframes previously approved by members]

Agenda item 1. TICP Terms of Reference and links with BIRG

3. Members considered TICP revised Terms of Reference. The following points were made

   - Members considered the structure within section 5 and acknowledged that the critical incident decision making structure remains in place over the next few weeks.

   - It was agreed that the TICP focusses on integrated delivery at Place level and the existing structures provide an opportunity to share some of work that Thurrock has been doing via Gold Command Structure, informing decisions taken at system and place levels.

   - Members acknowledged that existing partnership meetings are beginning to recommence. The next Health and Wellbeing Board meeting has been scheduled for 31 July.

   - Members considered the Reset Recovery work stream and agreed that it will be crucial that the group does not duplicate existing governance arrangements. It was agreed this work stream should establish learning from Covid19 and inform the work of existing governance groups. It was agreed that Ian Stidston, Les Billingham, Kristina Jackson and Ian Wake will meet to consider priorities for this work stream and that a draft TOR will be created for the TICP to consider in two weeks.

     Action Ian Wake, Ian Stidston, Les Billingham and Kristina Jackson

Agenda item 2. Lessons learned from COVID

4. Members agreed that placed based working has provided evidence that place is where services can be mobilised quickly and effectively to meet emerging challenges at pace.

5. Members agreed to consider further the lessons learned from COVID further and discuss at next week's meeting.

   Action members and secretariat

6. It was agreed feedback on lessons' learned would be sought from Clinical Directors.

   Action Rahul Chaudari

Agenda item 3. What recovery / reset will look like, how the new world is shaping up

7. The Chair recognised that the TICP considering what recovery and reset looks like will be similar in some cases to those already being considered at BIRG meetings.

8. Members were advised about Simon Steven's letter which sets out next phase of the recovery programme for the NHS. Members were provided with an outline of the key contents of the letter and it was agreed that it would be circulated to members.

   Action Rahul Chaudari / TICP Secretariat
   Complete - circulated with these minutes

9. Members learned about some early work undertaken by CCG colleagues to consider points raised in Simon Steven's letter. The six weeks recovery list considers action needed by Primary Care, Adult Social Care and GPs. This will become the work plan for BIRG and progress made against the work streams identified will be reported to the TICP. It was agreed that this would be circulated to members with the minutes.

   Action Rahul Chaudari / TICP Secretariat

Complete - circulated with these minutes

Agenda item 4. Early Priorities for partnership working

10. The Chair explained that identifying early priorities for partnership working should comprise a stocktake of the current status of partnership projects.

11. It was agreed that a piece of work to be should be undertaken to help identify what has stopped and what needs to be reenergised. Members learned about the regular update report that is provided to the Better Care Together Deliver Group which could be utilised. Roger Harris agreed to discuss further with Nicola Winsor with a view to a report being provided to the TICP for consideration in two weeks.

Action Roger Harris / Nicola Winsor

Agenda item 5. Future meetings and possible video conference arrangements

12. It was agreed that future meetings to be arranged through My Teams and that all members of the TICP will be invited to the meeting.

Action TICP Secretariat

Meeting concluded 10:05am.

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Thurrock Integrated Care Partnership

20 May 2020 3:00pm – 4:00pm

Minutes and action points

Attendees

Roger Harris (Co Chair, Thurrock Council) / Mark Tebbs (Co-Chair Thurrock CCG), Dr Anil Khallil, Sheila Murphy Director of Children's Services, Ian Wake Thurrock Council, Les Billingham Thurrock Council, Sean Clark Thurrock Council, Rahul Chaudhari Thurrock CCG, Maria Wheeler Thurrock CCG, Jane Foster-Taylor Thurrock CCG, Ian Stidston Thurrock CCG, Nigel Leonard EPUT, Tania Sitch NELFT / Brid Johnson NELFT, Kristina Jackson Thurrock CVS, Michelle Stapleton BTUH, Mohammed Munshi PCN (Aveley/Ockendon), Dr Reg Rehal PCN (Tilbury).

Apologies or represented at the meeting

Dr Kam Singh PCN (Grays), Dr Manjeet Sharma PCN (Stanford), Dr Chris Olukanni PCN (Tilbury), Dr Manoj Chandran PCN (Grays), Tom Abell BTUH, Sue Waterhouse EPUT, Catherine Wilson Thurrock Council, Kim James Thurrock Health Watch and Michael Jones Thurrock Council

Agenda Items

Agenda item one. Welcome

1. Mark Tebbs welcomed members to the meeting who agreed with proposals to prioritise the two Covid focussed reporting items on the agenda. Members agreed items not considered at today's meeting.

2. Members welcomed Sheila Murphy, Corporate Director for Children's Services, Thurrock Council to the Partnership as a member as part of ensuring that all age groups are represented on the Partnership. Members also welcomed PCNs attendance at meetings.

Agenda Item two. Minutes of previous meeting (all)

3. The minutes of the meeting of 6 May were approved.

Agenda Item three. Lessons learned from COVID – (all)

Action from previous meeting

4. This item was deferred until the next meeting

Agenda Item four. Early Priorities for partnership working (Roger Harris and Nicola Winsor)

Action from previous meeting

5. This item was deferred until the next meeting

Agenda item five. Reset governance arrangements – PowerPoint slides

6. Mark Tebbs introduced this item and explained that system level reset governance arrangements are being developed in parallel to the work being undertaken by the Reset and Recovery work stream (considered as agenda item 6).

7. The Partnership were advised that a strategic reset group will consider future partnership arrangements at place and system levels including and from Thurrock perspective progressing the MOU. A date for leads on this theme to meet has yet to be set.

8. Operational Reset Group comprises 3 strands:
    - System infrastructure
    - Acute reset and acute services
    - System learning around PCNs community mental health and care homes

9. TICP members are leading on some of the wider system wide reset programme groups.

10. During discussions the following points were made
    - It was noted that some work streams were not included on the proposed structure. However, members acknowledged that the structure is being developed and subject to change.
    - Members noted that the governance structure provides for an overview of all action being taken at system and place levels and that some system groups appear to be focussing on place based priorities. Members recognised that this is work in progress and that further work is needed to agree the approach to reset at both system and place levels.
    - Members noted that three Local Authorities including Thurrock have stated very clearly to NHS the need to reflect and consider Local Health and Wellbeing Boards and the local place based arrangements. Clearly need to work on wider system issues and the new interim single accountable officer has given assurances that place is a key focus in his plans.
    - Members recognised that all places are at different levels and place based solutions need to be bespoke to the need of the local population. Members also acknowledged that there are some system wider responses that can be delivered well including the medical equipment system that have been supporting care homes across the STP, ensuring consistent equipment, with same spec is provided across the STP.
    - Members acknowledged the importance of ensuring the VCS and providers are given the opportunity to inform wider system developments.

Agenda item 6. Reset recovery workstream TOR and 7 Reset Sub-Group update (Kristina Jackson, Les Billingham, Ian Stidston and Ian Wake)
Action from previous meeting

11. Les Billingham introduced this item. It has been widely agreed by partners that the Thurrock Model has stood up well under additional pressure on service provision created by the Covid Pandemic. Les summaries the paper as follows which:
    - Recognises the good work that has been done during the Covid Pandemic.
    - Focusses on two phases. Phase one provides a short term focus on reopening and commencing services that have been stopped, some of them essential for maintaining health and wellbeing. The second aspect of the paper focusses on building on lessons learned over the last few months and future modelling.
    - Provides a set of draft key principles and structured along the lines of a crisis recovery model adopted in other local authority areas.
    - Identifies some of the positive effects of the Covid Pandemic including the local eco system and the changes to community and neighbourly behaviour
    - Sets out the importance of placed based work engaging local communities and developing services at a local footprint. Important to continue to ensure the contribution of placed based planning and delivery of services and the integrity of the local model is protected.

12. During discussions the following points were made:
    - Members approved proposals in the paper that the group:
        - Is set up for six months with a review after four.
        - Remains small, with senior representation from the voluntary sector, Thurrock Council, the CCG, CDs and Providers.
    - Members agreed it is important to ensure all partners are provided with the opportunity to continue to coproduce services and inform the direction of travel. The role of impact assessments will provide an opportunity to identify how action taken affects a wide range of communities across Thurrock.
    - Members also agreed that communities should be engaged and able to inform the direction of travel based on their experiences.

- Members acknowledged that the Covid Pandemic had accelerated some transformation programmes over the last few months including sharing data, digital front door, the use of technology, mobilisation of volunteers and identification of the shielded group has helped to identify the 900 most vulnerable people in Thurrock. All of these developments create potential opportunities.
- Member's learned that from a children's perspective there has been less bureaucracy due to having to adapt to how the council and partners work with vulnerable children. Children's services experienced more concern from some children and families regarding officers visiting their homes and have utilised PPE equipment to do so. The virtual communication progress has been welcomed along with the improvement of the council's ability to get business done. Children's Services will be seeking feedback from families on their experience and will share that with the group.

Action Children's Services

- It was agreed that consideration should be provided to the whole range of experiences and where things had not gone as well as planned.

Agenda item 8. Approval of TOR (all)

13. This item was deferred until the next meeting.

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16 July 2020	**ITEM: 11**
Health and Wellbeing Board	
Initial Health Assessments	
Wards and communities affected: All	**Key Decision:** Non Key
Report of: Sheila Murphy, Corporate Director of Children's Services	
Accountable Head of Service: Joe Tynan, Assistant Director Children's Social Services	
Accountable Director: Sheila Murphy, Corporate Director Children's Services	
This report is public	

Executive Summary

During the Ofsted Inspection in November 2019, Ofsted highlighted the delay in completing timely Initial Health Assessments. Ofsted acknowledged the work between Social Care and Health colleagues to resolve the delay but that the pace of change was too slow and said the Timeliness of initial health assessments when all children come into care needed to improve.

This report is to advise Members of the Board on Thurrock's timeliness of Initial Assessments

1. Recommendation(s)

1.1 That Members of the Board are informed about the efforts made by Health and Children's Services to improve the timeliness of Initial Assessments for Children Looked After.

1.2 Members note the positive progress that has been made and agree that a KPI (of 90%) should be agreed and progress reported to the Board.

2. Introduction and Background

2.1 When a child or young person comes into care, they must have an Initial Health Assessment (IHA). This is a statutory health assessment. The assessment is to be completed within 28 days of the child coming into care. A paediatrician or an appropriately trained medical practitioner completes the assessment.

2.2 The Initial Health Assessment identifies existing health problems and deficits in previous healthcare and provides a baseline for managing the child's future health needs.

2.3 This report sets out the actions taken by Children's Social Care and Health colleagues to address the timeliness of Initial Health Assessments for Children who are Looked After

3. Issues, Options and Analysis of Options

3.1 The Local Authority and Health, through their Corporate Parenting responsibilities, have a duty to promote the welfare including the physical, emotional and mental health of Children who are Looked After, including those who are children placed in pre-adoptive placements.

3.2 Every Child who is Looked After must have an up to date health assessment so that a health care plan can be developed to reflect the child's health needs and contribute to the child's overall Care Plan.

Health assessments are a statutory requirement and must be carried out at a minimum period of:

- 6-monthly for babies and children under 5 years of age; and
- Annually for those aged 5 years and over.

3.3 The Originating and Receiving Clinical Commissioning Group (CCG) should have arrangements in place to support the Local Authority to complete statutory health assessments for Looked After Children within statutory timescales, irrespective of whether the placement of the child is an emergency, short term or in another CCG.

3.4 The Local Authority should always advise the CCG when a child is initially accommodated and request an Initial Health Assessment within 5 working days of a child becoming Looked After. Where there is a change in placement, which will require the involvement of another CCG, the child's Originating CCG, and Receiving CCG should be informed, as well as the child's GP.

3.5 Both the Local Authority and relevant CCG(s) should develop effective communications and understandings between each other as part of being able to promote children's wellbeing. The assessment is to be completed within 28 days (20 working days) of coming into care. A paediatrician or an appropriately trained medical practitioner completes the assessment.

3.6 <u>Before the assessment</u>

Information is sourced from parents, carers, GPs, health visitors and school nurses

3.7 <u>The assessment</u>

The assessment consists of a general discussion about the young person’s health and general well-being. There will be an opportunity for the young person appropriate to their age and understanding to discuss any concerns or worries they may have.

All children and young people need to be present for their health assessment.

Parents and carers will be consulted but older young people where it is deemed appropriate will be offered time to be seen alone.

3.8 During the assessment

Advice and information may be given on:

- Child development
- Height and weight
- Emotional health
- Dental health and oral hygiene
- Vision and hearing
- Immunisations and health promotion
- Substance misuse
- Sexual health and relationships

Appointment times may vary in length, and will often be dependent on need.

3.9 After the assessment

All looked after children are reviewed periodically throughout the year and health needs are reviewed and revised.

3.10 Performance between June 2019 and June 2020

Please see Appendix 1-3

The data demonstrates the improvement in performance in making timely referrals with slight dip in April 2020 impacted on in part by Covid19. The capacity within health services to provide a timely paediatric appointment has been more challenging, particularly at times of higher demand and during Covid19.

3.11 Prior to Ofsted's visit in November 2019, a Review was undertaken of the Initial Health Assessment Process to identify blockages and issues preventing timely assessments and actions to address these:

- The process for arranging an Initial Assessment was complicated and the paperwork difficult to fill in within required timescales.

  Action
  Streamlining of paperwork to arrange Initial Health Assessments.

  Consent for Initial Health Assessments included in the consent for children looked after.

  Flowchart developed in partnership with Health to support staff in arranging medicals.

- Information held by Health and Social Care did not always match

  Action
  A weekly meeting is held involving health and social care to discuss data and

outstanding assessments and referrals and resolve any issues.

Online and live tracking developed and shared with health colleagues.

- Consent to Initial Health Assessment was not always sought at the time the child became looked after.

  Action
  Where a child is accommodated under s20 Children Act 1989 the parent's will consent to their child becoming Looked After. The paperwork for consent to s20 Accommodation has been updated to include consent to;

  - Routine Health Assessments
  - Dental Checks
  - Optician Appointments
  - Emergency Treatment

- Parents sometimes refuse to sign consent for Health Assessment.

  Action
  Where the authority has a legal order which means that they share parental responsibility with the parent, consent is given by the Strategic Lead on behalf of the authority

3.12 The impact of the actions above has been to significantly improve the timeliness of referrals to health services from social care. This had led to the identification of further issues as follows:

- There is a shortage of timely Paediatrician capacity in our local area

- Appointments are not always utilised for another child if there is a cancellation

- Where children are placed outside the local health area difficulties have been experienced with other areas not prioritising the offer of an initial health assessments or have long waiting lists

- Successfully encouraging teenagers aged 16 and over who are accommodated to engage in an initial health assessment can sometimes be challenging and this is an area we are working on to make sure their health needs are assessed

- Where the local authority does not share parental responsibility with the parent they are not able to give consent to the health assessment if the parent refuses until they either gain shared parental responsibility or the parent changes their mind. This is a legal issue and not easily resolved

3.13 There have been discussions with Health partners and there have been some improvement with local capacity. Where children are placed outside of the local authority area there have been recently emerging problems in organising Initial Assessments within timescales. This has been escalated within the CCG and

arrangements made for children to be brought back to Thurrock for their assessments where appropriate**.**

3.14 Additional identified actions;

- Health assessments are regularly discussed and actions identified at the Monthly LAC Health Steering Group.
- Weekly tracking meetings are held to discuss outstanding Initial Health Assessment and referrals from social care.
- Live tracking has been developed to identify timeliness or blockages at each stage of the process of Initial Assessments.
- Clear escalation process are in place where delay is identified
- Cancelled (not required) paediatrician appointments are being used for children waiting for an appointment – a notification process is being agreed
- The process for receipt and upload of the reports once the assessment is completed is being tracked.
- Health have also more recently spot purchased IHA's for young people where they have struggled to meet the need.

3.15 Outcomes

Following the actions identified above being implemented there has been a significant and sustained improvement in the timeliness of referrals for assessments. It should be noted that between April 2020 and May 2020 there was a dip in performance for Initial Health Assessments completed and a dip in April 2020 for referrals. It is believed that this has been contributed to by Covid19.

4. Reasons for Recommendation

4.1 Members of the Board are aware of the Statutory Duty to complete Initial Assessments for all children and young people who come into care and how we are meeting these duties.

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

5.1 Overview and Scrutiny and the Corporate Parenting Committee are aware of the issues and the timeliness of Initial Health Assessments.

5.2 Health colleagues have been consulted in improving the performance in achieving timely initial health assessments.

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

6.1 None

7. Implications

7.1 Financial

Implications verified by: **Michelle Hall**

Management Accountant

There are no financial implications to this report.

7.2 Legal

Implications verified by: **Judith Knight**

Interim Deputy Head of Legal (Social Care and Education)

The Council has general duty to safeguard and promote the welfare of any child that its looks after under Section 22(3) of the Children Act 1989 and it must have regard to the Corporate Parenting Principles in Section 1(1) of the Children and Social Work Act 2017.

The Care Planning, Placement and Case Review (England) Regulations 2010 set out the detailed legal requirements in caring for Looked after Children. The timescales for health are set in regulation 7 which provides for the Council to make arrangements by the child's first review for the health assessment to take place as soon as reasonably practicable.

7.3 Diversity and Equality

Implications verified by: **Rebecca Lee**

Community Development Officer

The Service is committed to practice, which promotes inclusion and diversity, and will carry out its duties in accordance with the Equality Act 2010 and related Codes of Practice and Anti-discriminatory policy.

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

None

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

- None

9. Appendices to the report

- Appendix 1 - Initial Health Assessments completed
- Appendix 2 - Initial Health Assessments completed in 20 working days
- Appendix 3 - Requests made in timescale
- Appendix 4 – Brief report from Health

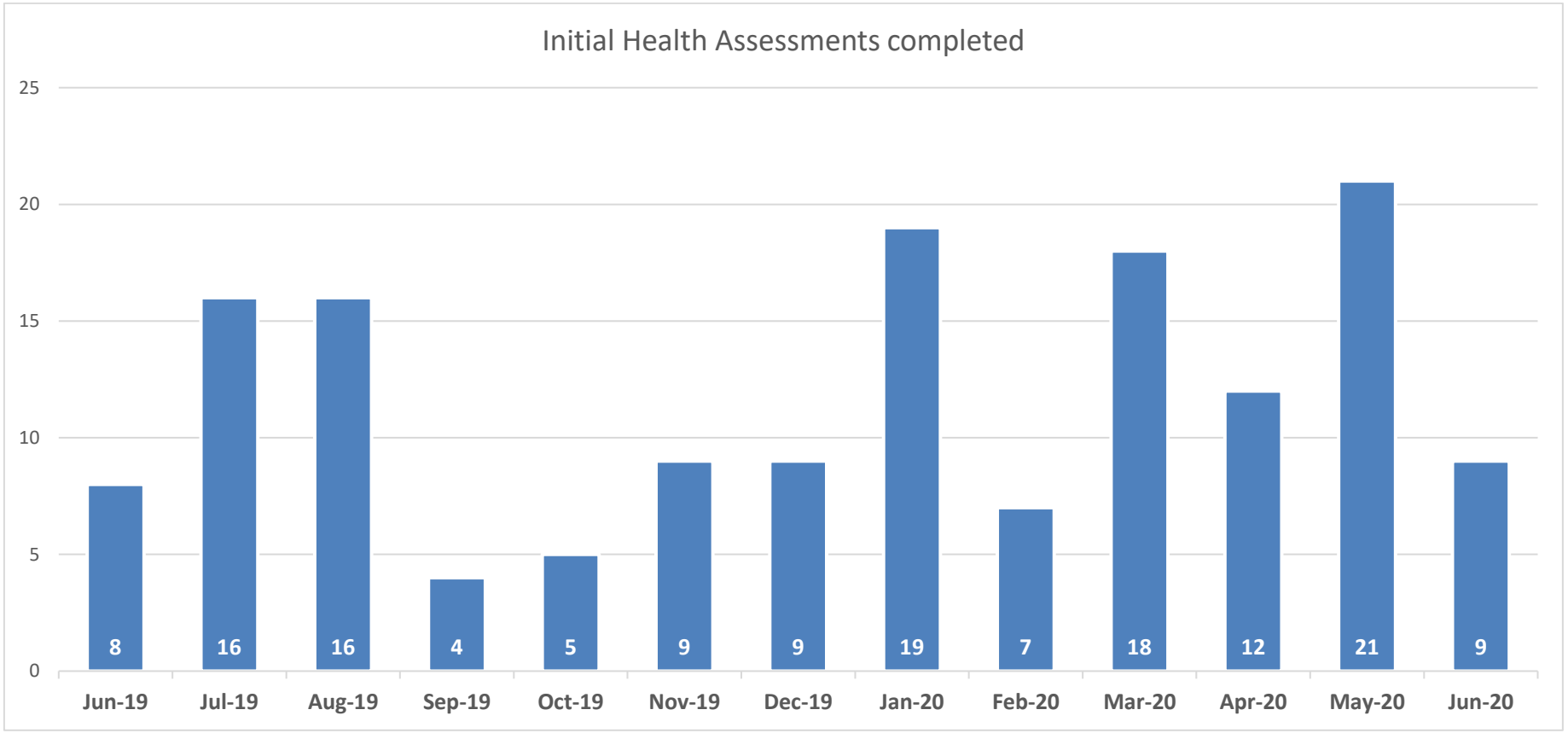
Report Author:

Janet Simon

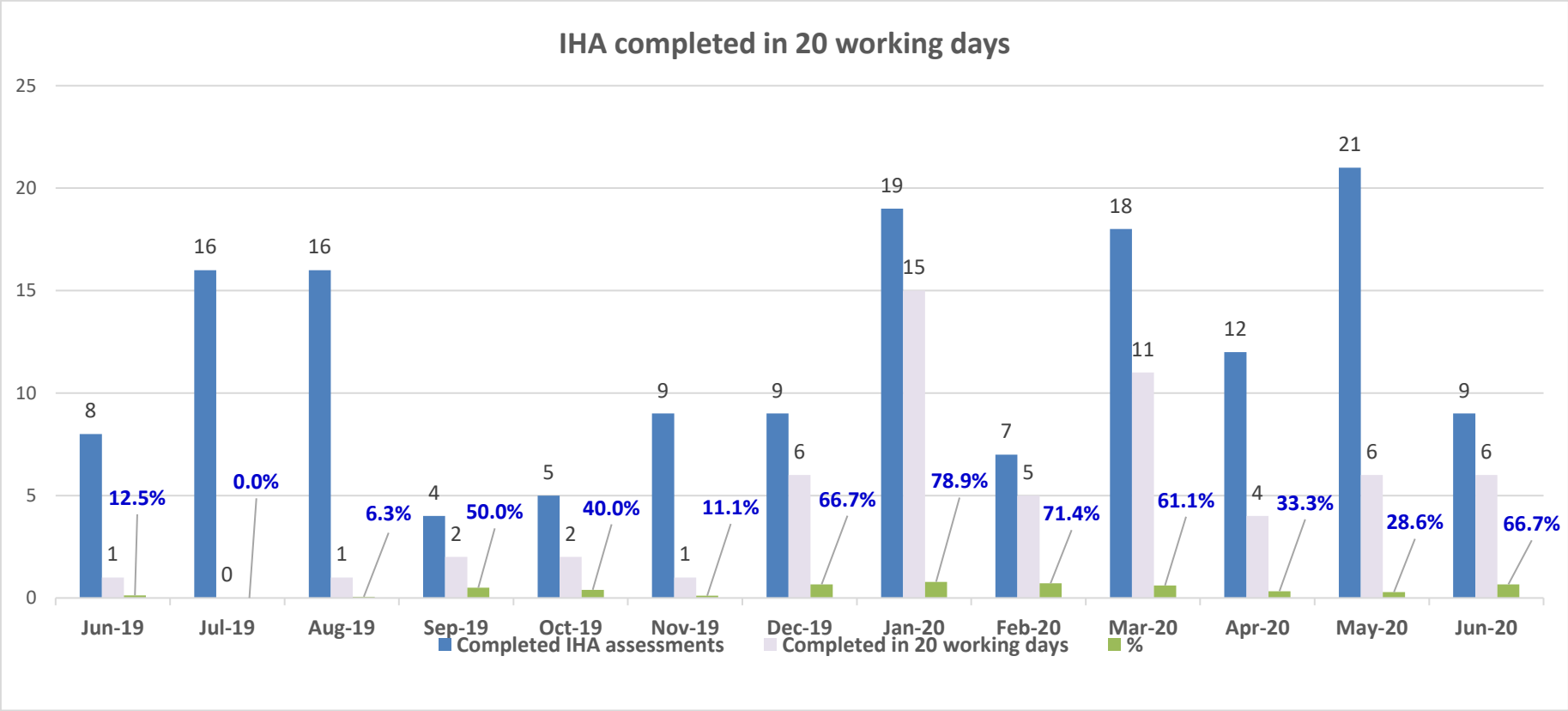
Strategic Lead – Children Looked After

Children's Services

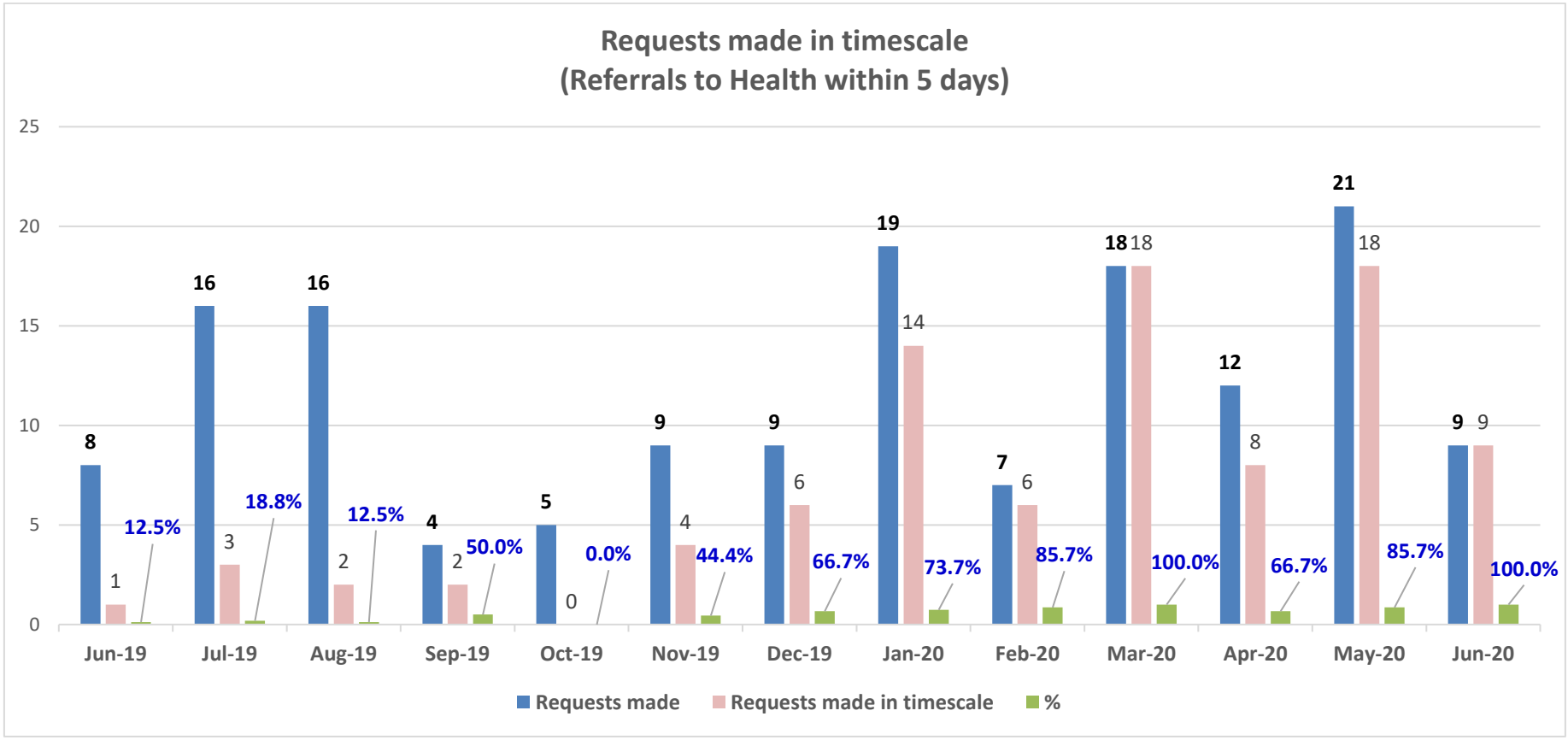
Appendix 1


Initial Health Assessments completed
25
20
15
10
5
0
8
16
16
4
5
9
9
19
7
18
12
21
9
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

Appendix 2


IHA completed in 20 working days
25
20
15
10
5
0
8
1
12.5%
16
0
0.0%
16
1
6.3%
4
2
50.0%
5
2
40.0%
9
1
11.1%
9
6
66.7%
19
15
78.9%
7
5
71.4%
18
11
61.1%
12
4
33.3%
21
6
28.6%
9
6
66.7%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Completed IHA assessments
Completed in 20 working days
%

Appendix 3


Requests made in timescale
(Referrals to Health within 5 days)
25
20
15
10
5
0
8
1
12.5%
16
3
18.8%
16
2
12.5%
4
2
50.0%
5
0
0.0%
9
4
44.4%
9
6
66.7%
19
14
73.7%
7
6
85.7%
18
18
100.0%
12
8
66.7%
21
18
85.7%
9
9
100.0%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Requests made
Requests made in timescale
%

Progress Looked After Children (LAC) Health Report – July 2020.

1.0 Workforce Capacity

1.1 There is currently a vacancy in the CCG Looked After Children Designated Nurse post. Interviews were scheduled for 18th June, however we were unable to appoint into this role. However, within the CCG Safeguarding Team, a member of staff Michael Addo-Boateng has expressed an interest in this role. A development plan has started with Michael, and will be in place for 6 months. In the interim, the Designated Nurse for Safeguarding Children and Michael will work hand in hand, picking up and covering key LAC matters. We will work with health colleagues and partner's agencies to ensure our LAC CYP are safeguarding and prioritised.

1.2 Within South West Essex, North East London Foundation Trust (NELFT) is commissioned by the CCGs (Basildon & Brentwood and Thurrock CCGs) to provide the IHA's (Initial Health Assessment) for Basildon Brentwood and Thurrock.

1.3 The Thurrock NELFT LAC Team Operational Manager was re-deployed due to COVID 19 demands. She returned 13th July. The nursing operation team were not re-deployed and have been business as usual during this time. This makes the team fully staffed/full capacity.

2.0 LAC - COVID 19 – Update

2.1 A decision was made from the onset of COVID19 that services for LAC would continue. Within this time of Covid 19, NELFT have advised that none of their Pediatrician have been redeployed, however one paediatrician was shielding. Each IHA is been risk assessed by the Pediatrician to ensure the best possible way forward for face to face or virtually assessing a LAC CYP. A guidance was produced by the Designated LAC Nurses to support the Pediatrician, discussing the risk and how best to manage it.

2.2 Due to the number of delayed IHAs followed up by the CCG team, it came to the attention of the CCG that a number of Local Authorities (LA) Providers have had their Pediatricians redeployed or have had to isolate due to Covid 19. Subsequently, this has put an extra pressure on a number of Providers to deliver a service that was already depleted before Covid 19 started.

3.0 Health Assessments (HAs)

One of the main problems with HAs are the children placed out of area (OOA). It has come to the CCGs attention that a number of surrounding areas have stated they do not have capacity to undertake Initial Health Assessments (IHA) and Review Health Assessments (RHA) for our OOA children.

3.2 IHA Outstanding

Problems with IHA are historical, so collectively across Essex we are in the early stages of discussing a central data base, which will be used across Southend Essex and Thurrock (SET). There are still capacity challenges to undertake the IHA assessment of Thurrock children and this has been highlighted as a problem across a number of local authorities including Basildon Brentwood and Thurrock. Below information highlights some pieces of work taking place to attempt to resolve this long term challenges.

3.3 Review Health Assessments (RHAs)

RHA'S are completed in house within Thurrock, and there appear not to be any significant concerns in-house. However, there have been concerns expressed around placement of LAC CYP in LAs who do not provide RHA for our CYP placed in their area. This needs to be discussed in house, to ensure a review of all CYP placed in OOA LA provide and deliver HA's to CYP placed from other LA before placement is signed off. To mitigate any risks/delays, these CYP are brought back for RHAs to be completed by NELFT LAC Nursing Team, this again adds unpredicted/unplanned added pressure to our local service/LAC team. As they are also expected to provide these same services to LAC CYP who are placed in Thurrock from other areas.

4.0 Spot Purchasing

Due to the above, the CCG has had to bring in some LAC CYP, Spot purchasing their IHA to minimize the waiting and potential risks, that could be associated with delayed IHA. These have now been completed and details will be shared with the LA this week.

5.0 Commissioners working on a long term solution

5.1 Early stages of discussing a central data base, aim to have one digital solution. The progress for this central data was put on hold due to COVID 19. The aim is to have one digital solution, which would show where a CYP is within the IHA pathway, this will be a live data base and have the ability to trace the child journey from when they come into care. We await another date to be rescheduled for these meetings.

- Collectively across SET, early discussions. COVID 19 Work Steam was developed and is an ongoing process. We are in discussion with Providers on how best to go forwards and bring in new changes to the IHA system and utilizing the knowledge and Skill we have developed in Covid 19 and taking them forward once we exit this very worrying time as the response from the young children regarding the virtual IHA's assessment, have been extremely positive. Bearing in mind some of the dangers and risk of virtual consultations and assessment, these suggestions are being looked into carefully.
- Virtual Initial Health Assessment (IHA) - Data Collection form/Audit – to be collected
- An option paper has also been written and is currently been reviewed. When appropriate this will be shared externally.

6.0 Areas to look into:

- Data on Outstanding IHA, RHA and OOA
- ADOS Assessment Service/Outstanding List
- LAC – SEND Services
- Review Performance LAC Data

End of Report – 13th July 2020

Author

Yvonne Anarfi – Designated Nurse Safeguarding Children

Basildon & Brentwood and Thurrock CCGs

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Meeting Planner

Health and Wellbeing Board

Health and Wellbeing Board Executive Committee

HWB Membership

Leader of the Council* (Cllr Robert Gledhill) Portfolio Holder for Children's and Adult Social Care **(Chair)** (Cllr James Halden), Portfolio Holder for Health (and Air Quality) (Cllr Mayes), Cllr Tony Fish, Corporate Director of Adults, Housing and Health* (Roger Harris) Corporate Director Children's Services*, (Sheila Murphy), Director of Public Health* (Ian Wake), Interim Deputy Accountable Officer: Thurrock NHS Clinical Commissioning Group* (Mark Tebbs), Chief Operating Officer HealthWatch Thurrock * (Kim James), Clinical Representative: Thurrock NHS Clinical Commissioning Group (tbc) Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board (Dr Kalil), Executive Nurse: Thurrock NHS Clinical Commissioning Group (Jane Foster-Taylor), Lay Member Patient Participation: Thurrock NHS Clinical Commissioning Group (To be confirmed), Director – Place (Andy Millard), Director level Executive, NHS England Midlands and East of England Region (Waiting for confirmation) Chair Thurrock Community Safety Partnership Board / Director – Environment and Highways (Julie Rogers), Chair of the Adult Safeguarding Board or their senior representative (Jane Foster-Taylor, Thurrock CCG), Representative Thurrock Local Safeguarding Children's Partnership (Jane Foster-Taylor), Integrated Care Director Thurrock, North East London Foundation Trust (NELFT) (Tania Sitch), Executive member, Basildon and Thurrock Hospitals University Foundation Trust (Andrew Pike/Preeti Sud), Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Nigel Leonard), Chief Executive Thurrock CVS (Kristina Jackson), Senior officer, HM Prison and Probation Service (Karen Grinney), Interim AO for Mid and South Essex joint CCG (Anthony McKeever)

Operation matters regarding Health and Wellbeing Board

- Meetings are organised quarterly on a Friday morning
- One quarter of the whole number of Board Members, provided that in no case shall the quorum of a Committee be less than three
- Meetings must be held in Committee Room 1, unless virtual or Hybrid
- Meetings must be recorded as the Board is a formal committee of the council
- Meetings are public – members of the public can attend and sit in the public area. Any questions from the public must be requested prior to the meeting and will be considered on the discretion of the Chair.

HWB Executive Committee membership

Roger Harris (Chair), Mark Tebbs (Chair), Sheila Murphy, Les Billingham, Jane Foster-Taylor, Kim James, Michele Lucas, Ian Wake, Carol Hinvest, Julie Rogers/Michelle Cunningham, Teresa Salami-Oru

Operation matters regarding Health and Wellbeing Board

- Meetings are arranged by exception
- The Executive Committee helps to determine agenda items for the Health and Wellbeing Board

Meeting	Meeting date and time	Agenda Items	Deadlines
HWB	Friday 31 July	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests 5. Annual Director of Public Health Report violence and vulnerability (Ian Wake) 6. Mental Health Review (Catherine Wilson, Mark Tebbs, Maria Payne, Jane Itangata) **Break** 7. Outbreak Control Plan (Ian Wake) 8. Health and Wellbeing Strategy – a new approach in a post Covid world (Roger Harris, Ian Wake, Mark Tebbs, Darren Kristiansen) 9. Mid and South Essex Health and Care Partnership update to confirm the MOU. (Roger Harris and Mark Tebbs) 10. Creation of Thurrock Integrated Care Partnership – a sub-group of the Health and Wellbeing Board (Mark Tebbs, Ian Wake, Roger Harris) 11. Initial Health Assessments for Looked After Children (Sheila Murphy)	Room booked. Invitations sent to members. Revised invitations sent MyTeams Implication deadline: 15 July Publishing deadline: 23 July Meeting date: 31 July
HWB	October 2020 Draft date: Friday 30 October – 10:30-12:30 May take place on Thursday 29 October Cllr Halden to confirm date – invitation to be sent to members Meeting to be confirmed with members Chairs Brief 9:30 – 10:30	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests 5. Breastfeeding JSNA (Beth Capps) 6. CLA JSNA (Elozona) **Break** 7. 0-5 Wellbeing Programme (Teresa Salami-Oru) 8. Preparing for Adulthood Strategy (Bosa Osunde) 9. Thurrock Health and Wellbeing Strategy refresh (Darren Kristiansen) 10. SEND stretch targets – requested by Cllr Halden (Sheila Murphy/Michele Lucas) 11. Adolescent suicide during lockdown– requested by Cllr Halden (Sheila Murphy/Michele Lucas) 12. Active Place Strategy (Julie Rogers)	to publish papers for implications Need to book Committee Room 1

Meeting	Meeting date and time	Agenda Items	Deadlines
HWB	Draft date Friday 22 January – 10:30 – 12:30 May take place on Thursday 21 January Cllr Halden to confirm date Invitations to be sent to members	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests 5. Health and Wellbeing Strategy refresh **Break**	to publish papers for implications Waiting for Cllr Little to come back regarding dates
HWB	March 2021	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests **Break**	

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