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

Health and Wellbeing Board

The meeting will be held at **10.30 am** on **28 October 2022**

Committee Room 2, Civic Offices, CO3 Building, New Road, Grays, Essex, RM17 6SL.

Membership:

Elected members

- Cllr D Huelin (Chair),
- Cllr B Johnson, Cllr S Ralph, Cllr S Liddiard, Cllr S Muldowney

Elected member substitutions as agreed at Full Council on 29 June 2022 comprise:
- Cllr Carter
- Cllr Halden

Wider membership
- Corporate Director of Adults, Housing and Health * (Ian Wake) – Interim Arrangements. Les Billingham Director ASC
- Corporate Director of Children's Services * (Sheila Murphy)
- Director of Public Health* (Jo Broadbent)
- Executive Lead Mid and South Essex Health and Care Partnership & Joint Accountable Officer for its 5 CCGs (Anthony McKeever)*
- NHS Thurrock Alliance Director (Interim), MSE ICP (Stephen Porter)
- Chief Operating Officer HealthWatch Thurrock * (Kim James)
- Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board (Dr Anil Kallil)
- Chair Thurrock Community Safety Partnership Board / Director Public Realm (Julie Rogers)
- Chair of the Adult Safeguarding Partnership or their senior representative (Jim Nicholson)
- Thurrock Local Safeguarding Children's Partnership or their senior representative (Sheila Murphy)
- Director level representation of Thurrock, North East London Foundation Trust (NELFT) (Gill Burns)
- Partnership Director, Thurrock Council, NELFT and EPUT (Rita Thakaria)
- Executive member, (Mid and South Essex NHS Foundation Trust) Hannah Coffey / Michelle Stapleton)
- Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Alex Green)
- Thurrock CVS (representative to be confirmed)
- Managing Director Fiona Ryan. Basildon & Thurrock University Hospital Trust
- Essex Police (Jenny Barnett CH/SUPT 42081127

Agenda

Open to Public and Press

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: **20 October 2022**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 5 August 2022 10.30am-12.30pm

Present:
Councillor Huelin (Chair)
Councillor Johnson
Councillor Liddiard
Councillor Ralph
Councillor Muldowney
Ian Wake, Corporate Director for Adults, Housing and Health
Jo Broadbent, Director of Public Health
Sheila Murphy, Corporate Director for Children's Services
Stephen Porter, Interim Director, Thurrock Alliance
Terry Fisher, Temporary Chief Inspector, Essex Police
Jim Nicholson, Adult Safeguarding Board
Fiona Ryan, Acting Managing Director, Mid and South Essex NHS Foundation Trust

Apologies:
Julie Rogers, Chair Thurrock Community Safety Partnership Board / Director of Public Realm
Claire Panniker, Chief Executive, Mid and South Essex NHS Foundation Trust
Rita Thakaria, Partnership Director, Adults Health and Social Care (Thurrock Council/EPUT/NELFT)
Gill Burns, Director of Children's Services, Director, North East London Foundation Trust (NELFT)
Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Andrew Pike, Executive Member, Mid and South Essex NHS Foundation Trust
Michelle Stapleton, Interim Director of Operations, Mid and South Essex NHS Foundation Trust
Hannah Coffey, Executive Member, Mid and South Essex NHS Foundation Trust
Kristina Jackson, Chief Executive, Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Anthony McKeever, Chief Executive of the Mid and South Essex Integrated Care Board
Dr Anil Kallil, Mid and South Essex Integrated Care System
Stephen Mayo, Director of Nursing – Patient Experience, Mid and South Essex Integrated Care System
Karen Grinney, HM Prison and Probation Service

Guests:
Ewelina Sorbjan, Thurrock Council
Ryan Farmer, Thurrock Council

Elozona Umeh, Thurrock Council
Catherine Wilson, Thurrock Council
Allison Hall, Thurrock Council

1. Welcome, Introduction and Apologies

Colleagues were welcomed and apologies were noted.

2. Urgent Items

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

3. Declaration of Interests

There were no declarations of interest.

4. Minutes / Action Log

The minutes of the Health and Wellbeing Board meeting held on 24 June 2022 were approved as a correct record.

Members reviewed the action and decision log and this was updated accordingly.

5. Housing Strategy

This item was presented by Ewelina Sorbjan and Ryan Farmer, Thurrock Council. Key points included:

- The Housing Strategy addresses the range of tenures available in Thurrock -
  social housing, owner-occupiers, and the private rental sector. The Strategy
  considers housing need and services in the borough and the barriers residents may face with accessing safe and secure accommodation.
- Two other critical documents for the Housing service have been developed alongside the Housing Strategy 2022-2027 which provide supporting and supplementary information. These are:
  - The Housing Asset Management Strategy 2022-2027, which outlines the council's approach to managing, maintaining, and investing in Housing assets to ensure that properties provide attractive, good quality council owned homes for current and future residents;
  - The Housing Resident Engagement Strategy 2022-2027 which sets the aims and ambitions of the Housing service in improving its interaction and communication with those who live in and around Thurrock Council's homes and neighbourhoods.
- The Housing Strategy closely aligns with the Health and Wellbeing Strategy and the aims and principles of the Better Care Together Thurrock – The Case for Further Change
- Housing and health are intrinsically linked as access to a safe, secure, stable, warm, and affordable home will provide residents with a solid foundation upon which they can better protect their health and support their wellbeing. If a home is lacking any of these factors, it will have a detrimental impact on the household.

- The Local Authority recognises that affordability not only relates to rent and service changes, but also being able to run and maintain a home.
- The aims of the Housing Strategy 2022-2027 are:
    - To deliver a supportive Housing service based on a person-centred approach;
    - To meet Housing need by identifying and providing the right homes and preventing homelessness;
    - To protect resident safety by improving standards in private homes and within Council stock as well as strengthening links with community safety colleagues to tackle domestic violence;
    - To strengthen community engagement and empowerment by improving satisfaction with the Housing service.
- These aims have been developed in consultation with a broad range of stakeholders and discussions have been held at Committee meetings and Community Forums. For example, the Housing Strategy was presented to Cabinet on 13 July 2022 and was subsequently approved.
- In addition to meeting statutory duties, it is the ambition that the Housing Strategy is both flexible and adaptable to residents' needs.

During discussions the following points were made:

- Board members welcomed the Strategy and its ambitions and principles, including its resident-led approach. The Strategy has been developed through partnership working across key stakeholders such as health and social care.
- The engagement process outlined in the Strategy was also welcomed, particularly the attendance at some Community Forums. Following discussions, Housing colleagues subsequently received an invite to the Chadwell St Mary Community Forum.
- Overcrowding and limited access to gardens was raised a concern as well the perception of out of borough placements causing a disadvantage to Thurrock residents. Members were reassured there is a clear Housing Allocations Policy which includes key criteria such as the need to meet a local connection. However, the private housing market allows free movement of people and there is no single dataset that captures the movement of individuals and families into the borough.
- It was noted there is a demand for both smaller and larger properties within the borough, however, these are limited within the Local Authority's own housing stock therefore considerations need to be given to working with other housing providers.
- Colleagues are linked into the ongoing work relating to the Local Plan, particularly in relation to the need to deliver approximately 500 new social homes within the borough and the spatial requirements of these, including communal gardens and green space. The Housing Strategy is also aligned to Domain 5 of the Health and Wellbeing Strategy.
- Members considered the benefits of future proofing homes for future possible care needs as part of enabling residents to be cared for within their own home.
- The subjectivity of affordable housing and the current financial concerns regarding the cost-of-living crisis, rising inflation and the local financial position were discussed. There is a need to integrate

funding across the system including housing, adult social care, and health to reduce failure demand and ensure an integrated, person-led solution. External funding is to be considered, for example asset acquisition and borrowing from the Housing Revenue Account (HRA).

- Affordability of rents and service charges are governed by statutory definitions therefore the Local Authority is compliant with these and that any increase will be in line with national policy and the benefit cap.
- As part of implementing the Strategy, it was agreed that consideration needs to be given to the development of affordable housing within the borough and to meet increasing and varied demand.

Action Ryan Farmer

RESOLVED: Members noted and commented on the following:

- **The vision, aims, objectives and actions outlined in the Housing Strategy 2022-2027;**
- **The aims, objectives and actions outlined in the Housing Asset Management Strategy 2022-2027 and Housing Resident Engagement Strategy 2022-2027.**

6. Children Looked After (CLA) Needs Assessment

This item was introduced by Elozona Umeh, Thurrock Council. Key points included:

- Children and young people looked after (CLA) and care leavers are a particularly vulnerable group with greater health and social needs than their peers.
- The aim of the report sought to further the understanding of the health and wellbeing needs of CLA, engage with CLA to capture their lived experiences, including experiences of foster carers and professionals working with CLA.
- An overall summary of the local and national context for CLA is provided within the report as well as the risks and protective factors that predispose or prevent children from being taken into care or help stabilise them whilst in care. This includes safeguarding and health inequality challenges.
- The report aligns with several supporting strategies, including the Health and Wellbeing Strategy (Domains 1 and 4), the Brighter Futures Strategy and Working Together to Safeguard Children.
- As of 31 March 2021, there were 301 CLA within the borough which is equivalent to a rate of 66 CLA per 10,000 children under the age of 18. This is similar to England and Thurrock's Statistical Neighbours; however, it is higher than the regional average.
- There is a strong positive association between ward level deprivation and the
  rate of CLA in each ward in Thurrock. Children living in the most deprived
  area of Thurrock are 4.3 times more likely to be taken into care than those
  living in the least deprived area of the borough.
- The report highlights the need for secure and stable placements, and it was reported that 9% of CLA in Thurrock had experienced at least once placement change. Furthermore, 3% had experienced at least

one school move and 77% had experienced at least one in change in social worker.

- The Thurrock fostering recruitment campaign seeks to increase stable and local placements, however, recruitment of local foster carers is a national challenge.
- All CLA in Thurrock in 2019 were offered the opportunity to take part in the engagement exercise for the report. This exercise resulted in a response rate of 22% (66 of the 2019 CLA cohort), and 19 foster carers and 15 professionals.
- The majority of CLAs involved responded positively, with responses relating to having a safe, secure and strong relationship with foster carers and being involved in the decision-making process of their placements.
- However, the following concerns were raised by participants, including:
    - The high turnover of social workers and the issue of continuity;
    - Delays in the completion of initial health assessments;
    - More support for foster carers in accessing information and services relating to mental health issues and other health care needs, such as sexual health services, dental checks, and immunisations;
    - The advocacy service needs to be strengthened and requires further facilitation.
- It was recognised there is also a gap in the voices of care leavers in relation to their experience of transition and that there is a need to ensure mental health information is used for transition planning.
- The report proposed actions and recommendations, including targeted prevention and support services for those with an increased vulnerability of becoming looked after through exposure to a variety of factors, including domestic violence, mental health issues and substance misuse.
- The report is due to be presented at the Local Safeguarding Children's Partnership and the CLA Steering Group where an action plan will be developed in conjunction with the recommendations.

During discussions the following points were made:

- It was noted the report was initially drafted before the pandemic therefore it required updating due to the time that had lapsed and the changing stakeholders. Colleagues were thanked for their contributions.
- Members discussed the concerns outlined within the report, particularly some negative experiences of foster carers regarding a lack of communication and inconsistent relationships with social workers. It was recognised Thurrock is not an outlier for social worker retention as the Local Authority offers a good salary, training, and case management rates.
- Colleagues were advised there is a Social Worker Retention Programme within Children's Services and work is ongoing in this area. The importance of attracting and retaining good social workers and foster carers was reiterated as CLAs would experience significant challenges without them.
- Members noted there is a dedicated newsletter for foster carers which acts as an information sharing platform.

- Members were advised the Annual Foster Carer Event is due to take place in September / October 2022 and is the first event since the pandemic. Further events have been arranged to improve bonding and relationships between CLAs and their carers, including activity days at Grangewaters. These events are also opportunities to build CLA and foster carer support groups.
- Colleagues noted that some foster carers are more engaged than others in the CLA and foster carer community and access to technology was suggested as a barrier to engagement. It was recognised more exploratory work is required to identify the barriers to wider engagement with peer support groups.
- Members agreed a more holistic approach is required which encompasses system wide services, collaboration, and commissioning, particularly in relation to the transition of CLA to adult services.
- As part of this system wide approach and following an Ofsted recommendation, members requested a joint report with health colleagues at the next Health and Wellbeing Board. The report needs to outline the current challenges in completing these assessments within the statutory timeframe and how this can be improved.

  Action: Secretariat to add initial health assessments to the forward planner for the Health and Wellbeing Board.

- Members were reassured that the timelessness of initial health assessments are being monitored by NELFT and the appropriate action is being taken.
- Members agreed that the recommendations within the report surrounding the initial health assessments require strengthening and nuancing to reflect the statutory nature of these.

  Decision: The recommendations in relation to initial health assessments are to be strengthened prior to publication of the report.

RESOLVED: The Board completed the following:

- **Considered, commented, and endorsed the Children Looked After Needs Assessment for Thurrock;**
- **Approve publication of this needs assessment in line with other Joint Strategic Needs Assessments for Thurrock;**
- **Supported the delivery of its recommendations through the Thurrock robust areas of work for CLA**

7. Essex Southend and Thurrock Dementia Strategy refresh

This item was introduced by Catherine Wilson and Allison Hall, Thurrock Council. Key points included:

- In 2017, as a response to feedback about needing better joined up services
  for people with dementia and their carers, an overarching joint health and
  social care Southend, Essex and Thurrock Dementia Strategy was agreed by

all partners. The Strategy came to an end during the pandemic which caused delays in the initial consultation period for the refreshed document.

- Following consultation across the wider Essex area, the following nine priorities were agreed:
    1. Prevention;
    2. Support for unpaid carers;
    3. Reducing the risks of crisis;
    4. A knowledgeable and skilled workforce;
    5. Access to the right information and advice;
    6. Diagnosis and support;
    7. Living well with dementia in the community;
    8. Living well in long-term care;
    9. Appropriate end of life care
- Whilst the Local Authority is committed to working with all partners across Essex to improve the lives of people with dementia and their carers, a Thurrock specific implementation/action plan will be developed to ensure a local strategic approach.
- As part of developing the implementation / action plan, a more in-depth engagement process will be conducted within Thurrock to ensure defined actions are developed against the wider priorities and commitments.
- Once the Thurrock implementation / action plan has been drafted, partners will have the opportunity to comment and review; the report will be considered through the appropriate governance structures, including the Health and Wellbeing Board prior to publication in late 2022. Progress against the priorities will also be reported at future Health and Wellbeing Board meetings.
- The approach outlined within the refreshed Strategy was recently endorsed by the Adult, Housing and Health Leadership Team, with the caveat of information relating to hypertension being included within the document.

During discussions the following points were made:

- Members welcomed the practice of working across the Alliance footprint but also the development of a local implementation plan to ensure priorities are shaped by Thurrock patients and carers with a lived experience of dementia.
- It was recognised that capacity and funding are challenges to the delivery of the Strategy as Thurrock has a high number of residents with dementia.
  These risks will be mitigated as much as possible, and members were reassured of the good working relationships with the voluntary sector, including the Alzheimer's Society. In addition, current service provision focuses on providing support as early as possible to keep patients well and within their home and local community.
- Colleagues were advised that Healthwatch Thurrock will lead on the comprehensive consultation as part of the implementation plan development.
- Members discussed public awareness around the causes and symptoms of dementia, particularly the lack of knowledge around lifestyle choices. Dementia is an all-encompassing illness and effects both the older and young generations. It was recognised further work

regarding dementia friendly communities is needed and more awareness raising around the causes of dementia.

- It was noted the Strategy recognises the different levels of support required at various stages of the illness, and that maintaining independence is key.
- The Board welcomed the Guardian Angel initiative and partnership working with local businesses to help them connect with customers and to support those with dementia to stay safe whilst maintaining their independence.

RESOLVED: Members of the Board completed the following:

- **Agreed the draft priorities and commitments contained in the refreshed Essex, Southend, and Thurrock Dementia Strategy;**
- **Agree the next steps in the development of a Thurrock Implementation/Action Plan.**

8. Virtual items for members' consideration

This item was introduced by the Chair of the Board. Key points included:

- There are two items for members to consider virtually: the LeDeR Annual Report 2019-20 update and the Pharmaceutical Needs Assessment (PNA).
- A briefing note and updated LeDeR annual report provided by Rebekah Bailie will be circulated to members shortly.
- Sign-off of the final PNA was previously delegated by the Health and Welling Board to the Director for Public Health and the PNA Steering Group. The final PNA will be circulated virtually to the Health and Wellbeing Board during September before publication, which needs to be completed by 1st October.

RESOLVED: Members agreed to virtually review and comment on the LeDeR Annual Report 2019-20 update and the Pharmaceutical Needs Assessment (PNA).

9. Work Plan

Members were encouraged to contract the Board secretariat (Darren Kristiansen and Claire Quinn) in relation to future items for Board's consideration.

The meeting finished at 12:19pm.

CHAIR……..

DATE……

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Action number	Date Action Initiated	Agenda item	Action / Decision Details	Action owner	Action/ Decision	Relevant timescales	Action status	Update
1	24/06/22	Health and Wellbeing Board Annual review of Terms of Reference (ToR)	**Secretariat to liaise with the Chair of the Board to plan the sequencing of the themes for each meeting.**	Darren Kristiansen	Action	ASAP	Open	
2	24/06/22	Health and Wellbeing Board Annual review of Terms of Reference (ToR)	**Members agreed the changes to the Terms of Reference as outlined within the report and subject to member's approval will be reflected in the Terms of Reference.**	All	**Decision**	24/06/22	Open	
3	24/06/22	Better Care Together Thurrock - The Case for Further Change	**Members approved the Better Care Together Thurrock – The Case for Further Change as the delivery mechanism for delivery of goals one and three of Thurrock's new Health and Wellbeing Strategy.**	All	**Decision**	24/06/22	Open	
4	24/06/22	Health and Wellbeing Strategy	**Secretariat to liaise with the Chair to arrange bespoke information sharing sessions for staff as required.**	Darren Kristiansen	Action	Ongoing	Open	
5	24/06/22	Health and Wellbeing Strategy	**Members of the Board completed the following:** **• Reviewed, commented on, and approved the final draft Strategy at Appendix 1, considering the proposed Domains and Goals;** **• Reviewed, commented on, and approved the formats of the Accessible and EasyRead versions of the Strategy, and the Consultation Report (appendices 2-4);** **• Reviewed, commented on and approved the plan to launch the Strategy as per the Communications Plan (Appendix 5).**	All	**Decision**	24/06/22	Open	

30 October 2022	**ITEM: 5 and 6**
Health & Wellbeing Board	
Thurrock Health and Wellbeing Strategy 2022-26 Update	
Wards and communities affected: All	**Key Decision:** None
Report of: Jo Broadbent, Director of Public Health	
Accountable Director: Jo Broadbent, Director of Public Health	

Executive Summary

This paper presents an update on Domains 1 and 6 of the Thurrock Health & Wellbeing Strategy (HWBS) 2022-26 and asks the Board to consider and comment on the plans for delivering the Goals in these Domains.

1. Recommendation(s)

1.1 The Board is asked to:

- Consider and comment on the plans for delivering the Goals of the HWBS in Domain 1 – Healthier for Longer and Domain 6 – Community Safety

2. Introduction and Background

2.1 The Health & Wellbeing Board (HWBB) has a statutory duty to produce a HWBS. The HWBS is a whole system plan for health & wellbeing and a means to engage all partners in the wellbeing agenda, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and wellbeing of residents.

2.2 Thurrock agreed its first HWBS in 2013. The current HWBS was launched in July 2022 and can be accessed here: https://www.thurrock.gov.uk/health-and-well-being-strategy/health-and-well-being-strategy-2022-2026

2.3 Proposals for the HWBS were developed by multi-agency stakeholders including Thurrock Council ADs and Subject Matter Experts from across the system. The HWBB considered the proposals for the HWBS at its meeting in July 2021, including the Vision, the 6 Domain structure, and plans to engage with the wider public. A twelve week consultation exercise took place October-December 2021 and the attached Strategy document has been further developed to reflect engagement outcomes.

3. Overview of the Refreshed HWBS 2022-26

3.1. The Vision for the Strategy is *Levelling the Playing Field* and tackling inequalities is reflected throughout. Proposals to level the playing field have been developed based

around six areas of people's lives, which we refer to as Domains, that cover the wider determinants of health and impact on people's health and wellbeing. These are:

1. Staying Healthier for Longer
2. Building Strong & Cohesive Communities
3. Person-Led Health & Care
4. Opportunity for All
5. Housing & the Environment
6. Community Safety

3.2. Through engagement with residents and stakeholders, 3-4 priority Goals have been identified for each Domain, with public feedback leading refinements of these Goals in the attached final draft. These set out specific actions to improve outcomes and specifically level the playing field and address inequalities.

3.3. Delivery of the ambitions within the Goals is underpinned by a number of key topic-specific strategies (such as the Housing Strategy, Better Care Together Thurrock Strategy etc), plus the Local Plan and the Backing Thurrock Economic Growth Strategy. Content proposals in the HWBS have been agreed with leads for these other strategic plans.

4. Consultation outcomes

4.1 A Consultation Report for the Strategy is provided on the website, which details how Goals were refined to reflect consultation outcomes. Over 750 comments were received through a short 'user friendly' questionnaire developed in conjunction with the CVS and Healthwatch, which sought the public's views on the six Domains that have been proposed for the refreshed Strategy. In excess of 300 residents or professionals involved in the planning, commissioning or delivery or health and care services provided feedback on strategy consultation proposals through community and professional forums and meetings. This resulted in over 1,300 individual comments on the proposals.

5. Governance

5.1. The HWBB agreed that in order to keep an oversight of delivery of the aims of the strategy, it would receive an update on each Domain annually. In the first year of delivery of the Strategy, the update will consist of an outline of the plans for each Domain and milestones for delivery.

5.2. An overview of the plans for the following Domains are appended to this report:

- Domain 1 – Staying Healthier for Longer (Appendix 1)
- Domain 6 – Community Safety (Appendix 2)

6. Reasons for Recommendation

6.1. The HWBB has a collective statutory duty to produce a HWBS. It is one of two highest level statutory strategic documents for the Local Authority and system partners, the other being the Local Plan. The statutory status of the document means that the new Integrated Care Board (ICB) must have regard to it when planning their own strategy.

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

7.1. The proposals in this paper reflect substantial consultation with professionals and the public as detailed above and in the full Consultation Report.

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

8.1. The HWBS is one of three highest Place Shaping strategic documents for the Local Authority and system partners, the other being the Local Plan and Backing Thurrock Economic Development plan, with specific synergies between the three strategies being highlighted. It is a whole system plan for health & wellbeing and a means to engage all partners in the wellbeing agenda, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and wellbeing of residents.

8.2. In order to support delivery of the Council's Vision, the 6 Domains of the HWBS Strategy each relate to one of the Council's key priorities of People, Place and Prosperity, as outlined in the attached Strategy.

9. Implications (Replicated from the June 2022 paper on the HWBS)

9.1 **Financial**

Implications verified by: **Mike Jones**

Strategic Lead – Corporate Finance

The cost associated with the strategy refresh will be delivered within existing budgets or agreed through existing Council and partner agencies governance finance arrangements.

9.2 **Legal**

Implications verified by: **Lindsey Marks - Deputy Head of Law**

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.

9.3 **Diversity and Equality**

Implications verified by: **Becky Lee**

Community Development and Equalities Team

Implications have not changed since previous approval provided in July 2021.
The aim of the strategy is to improve the health and wellbeing of the population of Thurrock and reduce health and wellbeing inequalities. A community equality impact assessment (CEIA) will underpin the strategy and mitigate the risk of disproportionate negative impact for protected groups. This approach will ensure the strategy itself and implementation supports delivery of the council's equality objectives while maintaining compliance with the Equality Act 2010 and Public Sector Equality Duty.

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

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. The focus of the strategy is to broadly focus on addressing inequalities in Thurrock.

8. Appendices to the report

Appendix 1 – Staying Healthier for Longer (Domain 1)
Appendix 2 –Community Safety (Domain 6)

Report Authors: Dr Jo Broadbent, Director of Public Health
Darren Kristiansen, Business Manager AHH, Secretary to HWB

Thurrock Health And Wellbeing Strategy 2022-2026

Levelling the Playing Field in Thurrock

Created through the partnership of Thurrock Health and Wellbeing Board

Introduction and overview report to Thurrock Health and Wellbeing Board

Domain 1, Healthier for Longer

Domain 1 Healthier for Longer

Domain Aims and Ambitions

To improve the prevention, identification and management of physical and mental health conditions, to ensure people live as long as possible in good health.

What we want to achieve

This domain focuses on supporting individuals to stay as healthy as they can and to live as long as possible in good health. There is considerable scope to improve both length and quality of life across Thurrock and to reduce variations between different groups in the community.

We want the differences in health and life expectancy between communities across Thurrock to be reduced, through improving promotion of good health, prevention of poor health and quality of care for long term health conditions.

How this Domain levels the playing field

This will Level the Playing Field by:

- Reducing the smoking rate in Thurrock, with a focus on wards that are more deprived.
- Reducing the proportion of people in Thurrock who are overweight or obese, including children.
- Reducing the healthy life expectancy gap between communities in Thurrock.
- Reducing premature mortality, which particularly affects those in more deprived circumstances and those living with serious mental illness

Domain Goals

- **1A Reduce smoking and obesity in Thurrock**
- **1B Work together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock**
- **1C Continue to enhance identification and management of Long Term Conditions**

Goal 1A. Work with Communities to reduce smoking and obesity in Thurrock

What we want to achieve

Reduce overall rates of smoking and obesity in Thurrock and reduce the gap between those in the most and least deprived circumstances. We aim to achieve the national SmokeFree ambition of 5% smoking prevalence by 2030 in all community groups to reduce smoking-related ill health overall and reduce health inequalities. We aim to achieve a year on year reduction of 0.5% in the proportion of overweight or obese children and adults to reduce obesity-related ill health and reduce health inequalities.

Some key challenges

Smoking: –

- Smoking is the largest single modifiable factor contributing to health inequalities, accounting for half the difference in life expectancy between the most and least deprived communities.
- Thurrock has one of the highest smoking prevalence rates in England at 17.5% (vs 13.9% England avg.), with over half of all smokers living in the eight most deprived wards in Thurrock[3].
- Smoking rates are known to be higher in more deprived communities (20-22%), Routine and Manual workers (27%); People with a long term mental health condition (28%); LGBTQ+ individuals (25-27% - national data).

Obesity: –

- >70% of adults are overweight or obese in Thurrock, and Thurrock is in the worst quartile for obesity rates across all ages, inactivity and diet.
- Childhood obesity is significantly worse in Thurrock than England (24% in Year 6 vs 20%[5]), and is associated with deprivation, BAME ethnicity and living in urban areas.
- There is a high correlation between obesity and poorer health outcomes. Obesity is linked to nutrition and physical activity, but also factors such as unemployment, low educational attainment, housing tenure and environment[4].

Goal 1A. Work with Communities to reduce smoking and obesity in Thurrock

How we will achieve this Goal

Reducing the proportion of people in Thurrock who smoke and reducing the difference between community groups, supporting an achievement of the government's ambition to reduce smoking prevalence to 5% or less by 2030: -

•Development of a **Whole System Tobacco Control Plan** for Thurrock, including recommendations made in the Tobacco Control JSNA:

Prevention - preventing people from becoming addicted to smoking by preventing smoking by young people and localised prevention campaigns targeting high prevalence communities and children and young people across the borough.

Treatment – supporting increasing numbers of smokers to quit through provision of stop smoking services focusing on high prevalence communities including the 8 most deprived wards in Thurrock and people with mental health conditions, and harm reduction.

Enforcement - delivering a robust local enforcement approach through Trading Standards and Smoke Free policies.

What will we do differently under this strategy?

- Use social marketing insight and trusted organisations to reach high prevalence communities
- Focus on the 8 most deprived Wards which contribute over half of all smokers
- Implement an integrated Making Every Contact Count offer across all partnership services
- Spread the learning from high-performing services with higher quit rates
- Work with Maternity and Mental Health services to tailor support for these high need groups
- Work with community and organisations to reach under-represented groups within the stop smoking service such as minority ethnic groups and make reasonable adjustments to services for people with learning disability and other needs
- Continue to enhance the enforcement offer regarding illegal tobacco

Goal 1A. Work with Communities to reduce smoking and obesity in Thurrock

How we will achieve this Goal

Reducing the proportion of Reception, Year 6 children and adults in Thurrock who are obese and reducing the variation between community groups: –

- Refresh and implementation of the Thurrock **Whole System Obesity Strategy** including:
  - Evaluation of the previous strategy to inform the refreshed strategy
  - Stakeholder engagement to co-produce a shared vision and actions that tackle overweight and obesity
  - Implement a life course approach to supporting healthy weight and reducing obesity.

What will we do differently under this strategy?

- Incorporate learning and address gaps from the previous strategy, including; strengthening governance arrangements and partnership working across the system.
- Focus on reducing inequalities within groups disproportionally affected by overweight and obesity
- Ensure a greater focus on addressing food insecurity and the current cost-of-living crisis on nutrition and health outcomes within our population
- Prioritise interventions in pregnancy and the early years, including; maternal obesity, breastfeeding, the early diet of infants and maximising opportunities for young children to be active

Goal 1B. Work together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock

What we want to achieve

Build on recent improvements in identification and holistic management of long-term mental health conditions, including addressing gaps in mental health and addiction services, providing seamless holistic support across the totality of needs impacted by poor mental health and addiction.

Some key challenges

Improving population mental health is complex and requires action beyond health services. Unmet need across the mental health agenda is broad and variable, requiring personalised, holistic and flexible solutions:

- Keeping people mentally healthy – An increased focus on promoting good mental health and resilience requires a broad approach
- Enhancing identification of mental ill health - This includes: generalised access to depression screening in Primary Care; screening in high-risk groups or groups who may be less likely to have their needs recognised and met e.g. men, people with LTCs, people with learning disability, younger and older adults, unpaid Carers, certain minority ethnic groups, LGBTQ+ people; building screening into specific services e.g. survivors of violence and abuse, maternity, homelessness
- Access to Dual Diagnosis - Support for those experiencing complex and inter-linked needs covering across substance misuse, mental health & learning disability
- Addressing the impact of challenges in wider determinants (such as housing, employment) at the same time as managing mental ill health
- Addressing links between poor physical & mental health - Higher smoking rates are seen among people with SMI. In Thurrock, 44% of patients recorded as having depression and SMI smoke. This contributes to a higher premature mortality rate among people with an SMI Transitions from young people to adult to older adult stages & services could be more seamless, especially for Secondary Care
- Unmet need exists in relation to drug & alcohol misuse including inter-generational affects, challenges exist in reaching and engaging individuals who could benefit with treatment, and the combined impact of wider determinants of health

Goal 1B. Work together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock

How we will achieve this Goal

Ensuring promoting positive mental health is considered in all domains of the Health & Wellbeing Strategy. This ranges from, for example, access to green spaces to trauma-informed mental health support built into in Community Safety pathways.

What will we do differently under this strategy?

- Transforming mental healthcare through a new Integrated Primary and Community Care (IPCC) Mental Health model, and Children & Adolescent Mental Health Services (CAMHS) for children and young people
- Case finding for common mental illnesses in Primary Care - Improving depression diagnosis in Primary Care by including embedding screening tools in Primary Care systems together with electronic Improving Access to Psychological Therapies (IAPT) referral and encompassing depression screening as part of the NHS Health Check.
- Co-producing with service users and families a new substance misuse model, integrated with wider services such as mental health and housing
- Addressing unmet need in relation to drug & alcohol misuse, including inter-generational affects and the impact on wider determinants of health
- Reviewing the provision available for those in a mental health crisis needing emergency care

Goal 1C Continue to enhance the identification and management of Long Term Conditions (LTCs) to improve physical and mental health outcomes for all

What we want to achieve

Identify a greater number of residents who are living with long term health conditions, and ensure that their treatment is optimised, in order to prevent health emergencies such as strokes, hospital admissions and development of mental illness associated with an LTC.

Some key challenges

- CVD causes the highest levels of premature mortality: 1 in 4 premature deaths (before age 75) in the UK are due to CVD and it is the leading contributor to health inequalities. Analysis of local data shows that for mortality attributable to socio-economic inequality, CVD is also the greatest contributor in Thurrock, accounting for 35% of excess deaths.
- Long term mental ill health is associated with poorer physical health outcomes and can impact on wider determinants of health such as employment. People with depression may be more at risk of developing other LTCs, and those with physical LTCs may be more at risk of becoming depressed. Early identification and subsequent management of depression would delay and reduce the need for higher level interventions later on.
- High numbers of individuals are living with long term health conditions that they are unaware of. It is estimated that two thirds of residents of Thurrock with Coronary Heart Disease (8,431) are undiagnosed, leading to an increased risk of hospitalisation. For high blood pressure, the number of residents who are undiagnosed is around one third (11,409). It is estimated that over 500 hospital admissions per year could be avoided by improved diagnosis.

Goal 1C Continue to enhance the identification and management of Long Term Conditions (LTCs) to improve physical and mental health outcomes for all

How we will achieve this Goal

Continuing with improvements in identification and management of LTCs in Primary Care and other healthcare settings through implementation of Better Care Together Thurrock – The Case for Further Change Strategy. This includes both physical health conditions such as cardiovascular disease (CVD) and common mental health conditions such as depression.

What will we do differently under this strategy?

- Co-develop a Case Finding Strategy covering hypertension, Atrial Fibrillation (AF), and depression in conjunction with clinical leaders within Primary and Community Care, identifying revised screening protocols and target group, and using digital solutions and integrated data to support Primary and Community Care improve case finding.
- Embedding hypertension, AF and depression screening within the work of front-line health and care professionals and within the community to improve detection and early diagnosis.
- Using Population Health Management (PHM) approaches using clinical data systems to identify missed opportunities to improve patient care, using holistic approaches to supporting people with multiple health and care needs
- Incentivising clinical quality improvement in Primary Care beyond national standards (for example improving QoF indicators) to ensure that groups that experience an uneven playing field get the same quality of care as others.
- Ensuring access to joint clinical and social care to improve health outcomes for individuals with multiple needs, including support for self-care and health coaching
- Innovating beyond traditional models of healthcare planning and delivery such as co-production with the Community & Voluntary sector, building community-led approaches to wellbeing.
- Use of digital solutions and preventative data-based approaches such as Population Health Management.to support Primary and Community Care to improve long term conditions management and see performance data and patients requiring review in real time.
- Establishing four new Integrated Medical & Wellbeing Centres (IMWCs) that will host Primary Care Network (PCN) LTC Management Clinics that can deliver an integrated ‘one stop shop’ for residents with multiple LTCs

Domain 1 Healthier for Longer
Key deliverables, commitments and milestones
Year One (July 2022 - June 2023)

Goal 1A - Work with Communities to reduce smoking and obesity in Thurrock

- Complete a Joint Strategic Needs Assessments for the Local Plan
- Co-produce Whole System Tobacco Control and Obesity strategies with the community and stakeholders
- Reduction in the proportion of people who smoke and reduce the variation between community groups by 2026
- Slow the increase in obesity rates for Year R and Year 6 children, and adults by 2026

Goal 1B Work together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock

- Complete a Substance Misuse Health Needs Assessment
- Launch of multi-disciplinary Complex Care team pilot for those with mental health & other challenges to support them to remain in Council housing stock
- Redesigned depression diagnosis-wellbeing calls pathway in place in GP practices
- All young people transitioning to Adult Mental Health Services have a Joint Care Plan in place

Goal 1C Continue to enhance the identification and management of Long Term Conditions (LTCs) to improve physical and mental health outcomes for all

- Piloting of health outreach sessions towards inclusion health groups (Traveller & Showmen and Homeless)
- Launch of the first IMWC in Corringham
- Improve quality of care for LTCs e.g., increase in the number of people with high blood pressure whose care meets national standards
- Increase in the proportion of people who have their LTC diagnosed and treated
- Increase in the percentage of individuals with Severe Mental Illness receiving a Physical Health Check

Thurrock Health And Wellbeing Strategy 2022-2026

Levelling the Playing Field in Thurrock

Created through the partnership of Thurrock Health and Wellbeing Board

Introduction and overview report to Thurrock Health and Wellbeing Board

Domain 6, Community Safety

Domain 6 Community Safety

Domain Aims and Ambitions

To ensure that Thurrock is a place where people feel and are safe to live, socialise, work and visit. We will also ensure that victims/survivors of crime are able to access support to cope and recover from their experiences, should they need it.

What we want to achieve

We know that certain groups are more likely to be the victims of crime, including; women and girls, children and young people, the elderly and those with learning difficulties and disabilities. Crimes disproportionally affecting these groups include but are not limited to domestic violence and abuse, sexual violence and abuse, hate crime, fraud, scams and cuckooing, as well as other forms of abuse and exploitation.

We want Thurrock to be a place where people feel and are safe, whether this is in the community, schools, workplaces or within homes. We want to prevent and safeguard the most vulnerable in our society from being victims of crime, abuse and exploitation. In the tragic instances where this does occur, we want to ensure that victims/survivors are able to access appropriate support to cope and recover from their experiences.

How this Domain levels the playing field

This will Level the Playing Field by:

- Reducing the number of victims locally, and therefore preventing the physical and mental impacts they might have otherwise experienced
- Preventing those who already experience vulnerabilities from facing further inequalities
- Ensuring victims/survivors are supported to cope and recover from their experiences and are able to live safe, happy, healthy and fulfilling lives.
- Improving the health (both physical and mental) of perpetrators

Domain Goals

- **6A We want all children to live safely in their communities**
- **6B Work in partnership to reduce local levels of crime and opportunities for crime to take place**
- **6C Improve the local response to supporting victims/survivors of abuse and exploitation to improve their health and wellbeing**
- **6D Protect residents from being the victims of crime, with a focus on those with increased risk of experiencing exploitation and abuse**

Goal 6A. We want all children to live safely in their communities

What we want to achieve

All children in Thurrock are able to feel safe and be safe in their communities.

Some key challenges

High rates of crimes, including violent crimes, are observed amongst young people locally. We are now seeing young people with a more entrenched pattern of offending and a greater degree of complexity and risk. Particular concerns include:

- Thurrock has the second highest rate of recorded violence with injury offences against young people aged 10-24 in Essex and the 4th highest rate of ambulance call outs to young people because of violence.
- Recent years have seen an increase in gang activity within the borough. There has been an increase in the ‘County Lines’ model of offending as well as the development of Thurrock based gangs involved in the supply of drugs. This is further exacerbated by the relocation of gang nominals into Thurrock by other local authorities.
- The increasing use of knives and offensive weapons.
- Gangs taking over the homes of vulnerable people and using them as a base of drug dealing, also known as ‘cuckooing’.

The outcome of these challenges is:

- The significant demand placed on the local system, including Health, Social Care, Police and the Criminal Justice System.
- The exploitation of residents, particularly those who are already vulnerable, is further exacerbating conditions and inequalities they may already be facing.

Goal 6A. We want all children to live safely in their communities

How we will achieve this Goal

This priority will primarily be achieved through facilitating a coordinated strategic approach to tackling Serious Youth Violence and Vulnerability. This includes delivery of the Brighter Futures Strategy's Strategic Priority 3 '*Enable all children to live safely in their communities, with a Focus on Youth Justice*' and implementation of the recommendations from the 2019 Annual Public Health Report 'Youth Violence and Vulnerability'.

The ambitions of Strategic Priority 3 are to:

- Further develop insight to identify the most at-risk children and families and intervene early with tailored intervention packages.
- Deliver targeted and tailored primary prevention for populations with greater need.
- Intervene early with tailored secondary prevention to reduce the harms of exposure to violence and violence risk behaviours.
- Provide tertiary prevention for perpetrators and victims of violence to reduce further harm

Further to this we will:

- Continue to tackle exploitation by Organised Crime Groups (i.e., gang related activity) including the use of offensive weapons and support young people and vulnerable people at risk of being exploited by gangs (including cuckooing)

What will we do differently under this strategy?

- Implement a Public Health approach to Youth Violence and Vulnerability – for example developing integrated data insight to identify the most at-risk children and families and intervene early with tailored intervention packages

- Ensure a multi-agency approach to tacking Child Sexual Exploitation and ensuring all possible actions are taken to protect victims. This will include the implementation of a Contextual Safeguarding approach across the Thurrock Partnerships

Goal 6B. Work in partnership to reduce local levels of crime and opportunities for crime to take place

What we want to achieve

We want to ensure that everybody in Thurrock is able to feel safe and be safe, resulting in fewer victims of crime.

Some key challenges

It is becoming increasingly difficult to protect residents and ensure they are able to feel safe at all times, with reasons including:

- The use of technology is making to easier for people to engage in criminal activities online and for victims, particularly the vulnerable to be targeted. A higher proportion of adults reported having become more worried about fraud than about crime in general during the pandemic (16% and 10% respectively).
- Children and young people are at increased risk of experiencing extra-familial risks and harm (i.e., harm outside of their home) and concerning and harmful sexual behaviours.
- Due to limited resources, it is not always possible to have a police or authority presence across the borough at all times.

The outcome of these challenges is that:

- Residents who have a high perception of fear are likely to experience negative impacts such as poorer mental health, social isolation and lack of willingness to engage in health improving activities outdoors.
- Harmful behaviours that are not addressed via early intervention can lead to more serious severe consequences for perpetrators and potential victims.
- We must continuously adapt our approaches to protecting and safeguarding residents, particularly those with additional vulnerabilities such as children and vulnerable adults.

Goal 6B. Work in partnership to reduce local levels of crime and opportunities for crime to take place

How we will achieve this Goal

The priority will be achieved via strong multi-agency collaborative working between a range of partnerships including the Community Safety Partnership, Thurrock Local Safeguarding Children's Partnership and the Thurrock Safeguarding Adults Board.

We will also incorporate community safety and crime reduction approaches such as 'Designing Out Crime' and 'Secure by Design' within the council's Housing Strategy and the Local Plan, both of which are currently in development. By implementing such approaches, we will reduce the vulnerability of people and property to crime by reducing opportunities that might be provided inadvertently by the built environment.

Specific aims for this priority include:

- Working in partnership, including with communities, to strengthen local approaches to reducing crime and opportunities for crime to occur e.g., through appropriate use of CCTV, lighting and isolated areas.
- Strengthening local approaches to reducing crime through addressing the drivers of violence and early intervention with those displaying harmful behaviours, particularly harmful sexual behaviours.
- Implementing a Contextual Safeguarding Approach across the Thurrock Partnership in order to keep children and young people, and vulnerable adults safe and disrupt criminal activity and exploitation.
- Implementing approaches to reduce perpetrator offending, with a targeted focus on scams, modern slavery, adult sexual exploitation, cuckooing and hate crime.
- Consulting with residents in order to address locations of concern and increase public perceptions of safety. We will promote the appropriate processes for residents to report their concerns, review alternative channels where applicable and consider the role of guardianship within the community.

What will we do differently under this strategy?

- We will adopt and adhere to the Home Office's new Serious Violence Duty which requires local authorities to work in partnership with key organisations to formulate an evidence-based analysis of the problems associated with serious violence in a local area, and then produce and implement a strategy detailing how they will respond to these particular issues. It is anticipated that this will be adopted through a countywide approach.
- Establish a Combatting Drugs Partnership for Thurrock, to be the multi-agency forum that is accountable for delivering the outcomes contained within the National Combating Drugs Outcomes Framework.

Goal 6C. Improve the local response to supporting victim/survivors of abuse and exploitation to improve their health and wellbeing

What we want to achieve

Victims/survivors who have experienced abuse or exploitation are offered timely access to appropriate support and services to help them cope and recover from their experiences.

Some key challenges

A recent needs assessment has provided insight into challenges faced by local victims/survivors:

- The majority of abuse and exploitation is largely hidden, with many victims/survivors feeling unable to seek support, essentially suffering in silence.
- Whilst personal choice might be a factor, barriers to accessing support to cope and recover exist and include fear of stigma, poor responses to disclosures or attempts to seek help and lack of awareness of local support and services.
- Disclosures of sexual abuse were often not met with appropriate responses by professionals and other sources e.g., friends and family.
- Victims/survivors value a holistic offer of support to help them cope and recover, often requiring access to multiple services. However, the way in which the current system is set up does not easily permit such an approach and can often lead to fragmented provision and silo working. They are also often required to tell their story multiple times to professionals across different agencies which is often traumatic.

The outcome of these challenges is that:

- Unresolved trauma can increase risks later in life. Victims/survivors who do not access support to cope and recover are likely to experience poor physical and mental health outcomes, thus potentially impacting many areas of their lives including housing, relationships, making unhealthy lifestyle choices and often requiring more extensive support later in life.
- Victims/survivors who are not safeguarded and supported might also be at risk of facing additional violence and abuse, leading to further physical and mental harm and in some tragic cases, can lead to loss of life through homicide or suicide.
- The landscape of service provision can be difficult for victims/survivors to navigate, particularly when they are at a point of crisis, which can hinder or prevent them accessing support.

Goal 6C. Improve the local response to supporting victim/survivors of abuse and exploitation to improve their health and wellbeing

How we will achieve this Goal

The key delivery mechanisms for this priority are the Thurrock Violence Against Women Strategic Action plan and implementing the recommendations from the 2020 Sexual Violence and Abuse Joint Strategic Needs Assessment. This will include:

- Working in partnership to enhance holistic approaches to supporting victims/survivors cope and recover from their experiences, including physical and mental health outcomes. This offer should include a clear pathway and offer of support that is strengths based and led by the needs of the victim/survivor.
- Consulting with victims/survivors of abuse and exploitation to understand the barriers and facilitators to accessing support to inform local service provision.
- Upskilling the workforce to identify victims/survivors of abuse or exploitation and respond appropriately to disclosures.

What will we do differently under this strategy?

- Design strengths-based services based on the needs and experiences of victims/survivors, leading to improved Domestic Abuse and Sexual Violence and Abuse services based on the findings from engagement with local victims/survivors
- The SETDAB Board, Thurrock Council, Southend Council and Essex County Council's 'discovery project' will look in-depth across the three geographical areas to understand what it is like for a victim to navigate the domestic abuse support system, including their experiences, what support is on offer and what the barriers to access this might be
- Working with LSCP and NSPCC, develop a harmful sexual behaviours framework for Children & Young People in Thurrock
- Working with NHSEI and local partners, implement a supportive screening service for survivors of sexual abuse

Goal 6D. Protect residents from being victims of crime, with a focus on those with increased risk of experiencing exploitation and abuse

What we want to achieve

Fewer Thurrock residents are the victims of abuse and exploitation.

Some key challenges

- The rate of sexual offences recorded in Thurrock is increasing and at a rate faster than the corresponding population group; 2021 saw a 36% increase in reported sexual offences compared to the previous year.

- We know that certain groups are disproportionately at higher risk of being experiencing exploitation and abuse, particularly women and girls. Recent data for sexual offences in Thurrock reported to Essex Police in 2021 identified that 82% of victims were female (13% were male and 5% had no gender recorded).

- Concerns are also noted regarding young people displaying harmful sexual behaviors and committing sexual offences. The highest number of reported offenders of sexual offences locally are aged 11-15 and 37% of victims were aged 11-20 at the age of reporting. Locally, there are particular concerns regarding domestic violence. In 2020/21 domestic violence was related to 35% of all violence against the person crimes in Thurrock and equates to 6,199 reported crimes. Over a quarter of reported sexual offences in 2021 were also linked to domestic abuse.

- For many victims/survivors, the perpetrator is often a person close to them (e.g., partner, ex-partner or family member). This often creates barriers for the victim/survivor to flee or seek help and often abuse and exploitation occurs over extended periods. Those from ethnic minorities, older people and those with disabilities are also likely to face additional barriers.

- The increasing use and accessibility of technology is making it easier for perpetrators to exploit victims online.

- Vulnerable young people who receive support from Social Care can be particularly vulnerable to exploitation once they reach the age of discharge from Children's Social Care.

The outcome of these challenges is that:

- Local residents are unfortunately victims of abuse and exploitation, with particular concerns noted for that of a domestic and/or sexual nature. Certain population groups are disproportionately affected by crimes and may face additional barriers to reporting and/or receiving support.
- Some young people who have previously been known to Children's Social Care are later reaching Adult Social Care following experiences of exploitation, particularly sexual exploitation and often at a point of crisis. It is important that we bridge the gap between Children's and Adult's Social Care for our residents who are particularly vulnerable to exploitation.

Goal 6D. Protect residents from being victims of crime, with a focus on those with increased risk of experiencing exploitation and abuse

How we will achieve this Goal

This will be achieved via delivery actions within the Thurrock Violence Against Women and Girls (VAWG) Strategic Action Plan & the delivery of the Thurrock Safeguarding Adults Board 'Transitions Plan'. We will:

- Ensure a dedicated focus on safeguarding vulnerable groups and those with increased likelihood of being the victims of crime and exploitation. We will implement approaches to reduce perpetrator offending, with a targeted focus on scams, modern slavery, adults' sexual exploitation and hate crime

- Provide strong local leadership to transform the way we tackle Violence Against Women and Girls, with a key focus on domestic violence and abuse and sexual violence and abuse. We must ensure we have strong, strategic, multi-agency approaches to tacking domestic violence/abuse and sexual violence/abuse. This approach must include prevention, addressing concerning behaviour, supporting victims/survivors and working with perpetrators to reduce reoffending

- Whilst national and local strategies have a focus on women and girls, due to the disproportionate nature of crimes committed against them, both strategies recognise that men and boys are also affected by these crimes. The Government is expected to update the current 'Men and boys' Position Paper' later this year, which will continue to be reflected within the Thurrock VAWG Strategy. Thurrock's support services for all VAWG crimes are available to any victim or survivor, irrespective of their sex/gender.

What will we do differently under this strategy?

- Implement the Minerva project, responding to identified geographical areas with increased risk of crime against women and girls
- Link with Council-wide work to deliver a more individualised transition of vulnerable young people from children's to adult services including those transitioning from children's to adult social care support

Domain 6, Community Safety
Key deliverables, commitments and milestones
Year One (July 2022 - June 2023)

Goal 6A - We want all children to live safely in their communities

- Develop a Serious Youth Violence Strategy
- Increase in identified gang nominals or children being exploited by gangs engaging in identified interventions under the gang related forum prevention key performance indicators
- Reduction in school exclusions as a result of knife crime
- Decrease the percentage of YOS cohort of offenders who have reoffended

Goal 6B - Work in partnership to reduce local levels of crime and opportunities for crime to take place

- Establish a Combatting Drugs Partnership for Thurrock
- Complete a Joint Local Needs Assessment for Drugs

Goal 6C - Improve the local response to supporting victim/survivors of abuse and exploitation to improve their health and wellbeing

- Completion of the SETDAB Board, Thurrock Council, Southend Council and Essex County Council's 'discovery project'
- Develop a harmful sexual behaviours framework for Children & Young People in Thurrock

Goal 6D - Protect residents from being victims of crime, with a focus on those with increased risk of experiencing exploitation and abuse

- Launch of an animated sexual violence awareness e learning training for professionals
- Refresh of the Violence Against Women and Girls Strategy including the Minerva project
- Reduction in the number of vulnerable people aged 16-25 who enter the system at a point of crisis by 2026

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28 October 2022	ITEM: 7
Health and Well-Being Board	
The Better Care Fund Plan 2022/23	
Wards and communities affected: All	**Key Decision:** Not Applicable
Report of: Les Billingham, Interim Director of Adults Social Care, and Stephen Porter, Interim Alliance Director, Mid and South Essex Integrated Care Board	
Accountable Assistant Director: to be confirmed	
Accountable Director: Les Billingham, Acting Director of Adult Social Services	
This report is public	

Executive Summary

Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75 Agreement between the Council and NHS, was approved in 2015. The arrangement has allowed the creation of a pooled fund, to be operated in line with the terms of the Plan and the Agreement, to promote the integration of care and support services. The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home.

The planning requirements for the Better Care Fund Plan for 2022/23 were published by NHS England on 19 July 2022 with a deadline for submission of 26 September 2022. The combination of the short timeframe and the summer holiday did not allow the presentation of the Plan to the Board prior to submission. The Plan has been submitted, and scrutiny by NHS England is underway, with approval letters expected by 30 November 2022.

The Better Care Fund Plan 2022/23 has been developed to reflect the new strategy for adult services – Better Care Together Thurrock – The Case for Further Change 2022-26. A programme of reviews has commenced which will ensure that all services commissioned fully reflect the new strategy, as well as meeting the National Conditions, and demonstrating best value for money.

1. Recommendation(s)

1.1 The Board is asked to approve the Better Care Fund Plan for 2022/23.

2. Introduction and Background

2.1 Thurrock's initial Better Care Fund Plan, and Section 75 Agreement between the Council and the then NHS Thurrock Clinical Commissioning Group, was approved in 2015. The Agreement allowed the creation of a pooled fund, to be operated in line with the terms of the Agreement, to promote the integration of care and support services.

2.2 The Host Partner is the Partner responsible for:

- holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;
- providing the financial administrative systems for the Pooled Fund.

2.3 The pooled fund is overseen by the Thurrock Integrated Care Alliance made up of officers from the Council and NHS Mid and South Essex Integrated Care Board (NHS MSE ICB). The Alliance receives regular reports on expenditure, quality and activity. The Alliance reports, as required, on the performance of the Fund to the Health and Wellbeing Board, as well as Cabinet and the NHS MSE ICB.

2.4 The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home. Despite 2021/22 being another year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Plan Scorecard were met by year-end.

2.5 The planning requirements for The Better Care Fund Plan for 2022/23 were published by NHS England on 19 July 2022. With the help of colleagues from across Adults, Housing and Health, and the NHS, the Plan was drafted and submitted to NHS England with the agreement of the parties, and the endorsement of the Essex County Council Commissioners, by the deadline of 26 September 2022.

2.6 In the view the short timescale over the summer holidays, and the Board's schedule of meetings, it was not possible to convene a meeting to seek approval from the Board before the submission deadline. NHS England agreed to the proposal that the Board would be asked to approve the Plan, following its submission, at its meeting on 28 October 2022.

2.7 The Better Care Fund Plan for 2022/23 has been developed to reflect and implement the new Strategy for Adults: Better Care Together Thurrock – the case for further change 2022-26. A review programme has now commenced which will seek to align each service within the Better Care Fund Plan with the new strategy, while also ensuring it meets the National Conditions set by NHS England and ensuring best value for money.

3. Issues, Options and Analysis of Options

Value of the Better Care Fund

3.1 The value of Thurrock's Better Care Fund for 2022/23 has been increased to £51.068mn from £50.804m in 2021/22. The Fund consists of a mandatory minimum amount, and additional contributions agreed locally by the Council and NHS MSE ICB. The mandated minimum amount for NHS MSE ICB in 2022/23 is £12.755m. In 2022/23 the Fund includes a £17.122m contribution from the NHS MSE ICB, £5.569m from the Improved Better Care Fund grant and £27.058m contribution from the Council.

3.2 In future years, as part of preparations for the Better Care Fund, the Council and NHS MSE ICB will need to agree how much they are adding to the Fund over and above the mandated amount.

Focus of the Fund

3.3 The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or a residential home. The schemes chosen for the Fund reflected this focus. The future plans are likely to continue this focus, and also will include elements that are population wide including initiatives linked to preventing, reducing and delaying the need for health and social care intervention.

3.4 In June 2022 the Health and Wellbeing Board approved Better Care Together Thurrock – The Case for Further Change as the delivery mechanism for delivery of Goals 1 and 3 of Thurrock's new Health and Wellbeing Strategy. Accordingly the new strategy will form the foundation of the new Better Care Fund Plan. To achieve this a programme to review each service in the Better Care Fund is now underway. These reviews will be completed by March 2023 at which point all services resourced under the Better Care Fund Plan will be appropriately aligned to the new strategy, as well assured as meeting the national conditions, and providing best value for money.

3.5 Despite 2021/22 being a further year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Plan Scorecard were met by year-end. In particular the 2021/22 BCF Plan Scorecard shows:

- There were 157 new permanent admissions to residential/nursing care for people 65+ in the year, which equates to 651.5 per 100,000 population. This is 21 under target (87.2 per 100,000 population).
- In Quarter 4, 82 out of 90 discharges from hospital for people 65+ into re-ablement/rehabilitation were at home 91 days later, which equates to 91.1%. This is 4.8% above target.

The following non BCF indicators should also be noted:

- There were 17,470 non-elective admissions in 2021/22. This is a 12% increase compared to the same period last year (increase of 1,892). However, the low numbers of non-elective admissions last year was due to the impact of Covid. Compared to the same period in 19/20, this is a 5% reduction (reduction of 986).

- 678 patients in 2021/22 had stays in hospital lasting longer than 21 days. This is a 38% increase compared to the same period last year (increase of 188). However, the low numbers of long stay patients last year was due to the impact of Covid. Compared to the same period in 19/20, this is a 15% reduction (reduction of 116)
- 9,899 Thurrock patients 65+ attended any A&E department in the year-to-date. This is a 7% increase compared to the same period last year (increase of 672). However, the low numbers of A&E attendances last year was due to the impact of Covid. Compared to the same period in 19/20, this is a 22% reduction (reduction of 2,798).

Section 75 Agreement

3.6 Thurrock has had a Better Care Fund Plan and associated Section 75 Agreement in place since 2015-16. To date, the requirement has been to produce a yearly plan although the requirement was set aside during the first year of the COVID pandemic. The NHS England Planning requirements for 2022/23 stipulate that the section 75 agreement for 2022/23 is to be signed and in place by 31 December 2022.

3.7 Cabinet agreed in July 2021 (Decision: 110575) to give delegated authority to the Corporate Director of Adults, Housing and Health, in consultation with the Cabinet Member for Adults and Communities, to agree annual Section 75 Agreements and Better Care Fund plans and proposals for applicable periods as required, effective from 2021/22. The Agreement is subject to the Council's annual budget setting arrangements, and any changes to the Section 75 can be made with agreement of both parties – Thurrock Council and NHS MSE ICB.

3.8 The Plan submitted on 26 September 2022 was signed off by Thurrock Council, the NHS MSE ICB, and endorsed by the Essex County Council Commissioner. When the Plan has been approved by the Board, and assured by NHS England, the necessary delegated authority will be requested and the Agreement will be executed.

Overspends and Underspends in the Better Care Fund

3.9 The Section 75 Agreement sets out arrangements for overspends and underspends to the Fund. The arrangements will continue and mean that any expenditure over and above the value of the Fund will be the responsibility of either the Council or NHS MSE ICB depending on whether the expenditure is incurred on social care functions or health functions. Arrangements for monitoring expenditure and managing any overspend in an individual scheme are set out in detail within the Section 75 Agreement. Underspends will stay within the Pooled Fund unless otherwise agreed by both parties.

Governance

3.10 The Council continues to be the host for the pooled Fund. The management of the pooled Fund includes regular oversight by both the Council and NHS MSE ICB through the Thurrock Integrated Commissioning Alliance. The Alliance reports to the Health and Wellbeing Board who receive the meeting

minutes at each Board meeting. A Pooled Fund Manager exists to provide regular reports covering performance, finance and risk.

Contracting arrangements

3.11 The Council, as host of the Fund and under the terms of the Section 75 Agreement, enters into contracts with third party providers – largely NHS providers. The standard NHS contract is used for these services with the Council becoming an equal commissioning partner.

The Annual Governance Statement

3.12 This Statement sets out how the Council and NHS MSE ICB are, through effective governance arrangements, complying with the responsibilities set out within the Better Care Fund Section 75 Agreement for Thurrock, and the extant Better Care Fund guidance . The Statement is appended to this report.

Policy and Planning for 2022/23

3.13 The Department of Health and Social Care published the 2022-23 Better Care Fund Policy Framework on 19 July 2022. The Policy Framework sets out four national conditions that all BCF plans must meet to be approved. These are:

1. A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
2. NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
3. Invest in NHS commissioned out-of-hospital services.
4. Implementing the BCF policy objectives.

3.14 National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:

i. Enable people to stay well, safe and independent at home for longer.
ii. Provide the right care in the right place at the right time.

3.15 For both objectives, the Plan should describe:

• The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.
• How BCF funded services will support delivery of the objective.

In addition to this, areas are asked to develop plans that outline expected capacity and demand for intermediate care services in the area, covering demand for both services to support people to stay at home (including admissions avoidance) and hospital discharge pathways 0–3 inclusive, or equivalent, for quarters 3 and 4 of 2022-23 across health and social care. This should cover both:

• BCF funded activity
• non BCF funded activity.

4. Reasons for Recommendation

4.1 Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

4.2 The NHS England Planning requirements for 2022/23 stipulate that the Better Care Fund Plan 2022/23 must be agreed by the Board.

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

5.1 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services, as required under the terms of the Health and Social Care Act 2012, was held in September and October 2014.

5.2 There has also been extensive consultation on the new strategy for adults - Better Care Together Thurrock – The Case for Further Change - which forms the foundation of the plan.

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

6.1 A key aim of the Better Care Fund is to reduce emergency admissions, which brings within it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services. This will contribute to the priority of 'Improve Health and Wellbeing' and the vision set out within the refreshed Health and Wellbeing Strategy.

6.2 Achieving closer integration and improved outcomes for patients, services users and carers is also seen to be a significant way of managing demand for health and social care services, and so manage financial pressures on both the NHS MSE ICB and the Council.

7. Implications

7.1 Financial

Implications verified by: Jo Freeman
Finance Manager for Management Accounts

The Better Care Fund consists of contributions from the Council and NHS MSE ICB and are included in the body of this report. The mandated amount consists of £12.755m from NHS MSE ICB.

Additional contributions have been confirmed and the value of the pool is £51.068m. The nature of the expenditure is an agreed ring-fenced fund. Financial risk is therefore minimised and governed by the terms set out in the Agreement. Paragraph 3.9 refers. The Fund will be accounted for in accordance with the relevant legislation and regulations, and the agreement between the Local Authority and NHS MSE ICB.

Financial monitoring arrangements are in place, ensuring that auditing requirements are met, as well as disclosure in the financial statements.

7.2 **Legal**

Implications verified by: **click this box once and type name of the officer who has verified the implications**

click this box once and type the job title of the officer who has verified the implications

This report outlines the arrangements for a Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group. The Council and the NHS Thurrock Clinical Commissioning Group can pursuant to regulations made by the Secretary of State as provided by Sec 75 of the National Health Service Act 2006 enter into prescribed arrangements in relation to the exercise of prescribed functions of NHS bodies and prescribed health related functions of local authorities. This arrangement can include establishment and maintenance of a pooled fund made up of contributions by one or more NHS bodies and one or more local authorities out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health related functions of the local authority. Legal Services is available to provide advice on any specific issues arising from this report.

7.3 **Diversity and Equality**

Implications verified by: Roxanne Scanlon
Community Engagement and Project Monitoring Officer

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and social care services. The commissioning plans developed to realise this vision will be developed with due regard to the equality and diversity considerations.

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

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):

- Better Care Fund policy framework 2022-23, Published 19 July 2022 Available via the following link: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023/2022-to-2023-better-care-fund-policy-framework

- Better Care Fund planning requirements 2022-23, Published 19 July 2022 Available via the following link: https://www.england.nhs.uk/wp-content/uploads/2022/07/B1296-Better-Care-Fund-planning-requirements-2022-23.pdf

9. **Appendices to the report**

- The Thurrock Better Care Fund Plan (comprising Planning template, Narrative template and Capacity and Demand template) for 2022-23.
- The Annual Governance Statement 2021/22

Report Author:

Christopher Smith
Programme Manager
Adults, Housing and Health

99Cover

Health and Wellbeing Board(s)

Thurrock

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Thurrock Integrated Care Alliance comprising Thurrock Council, Healthwatch Thurrock, Thurrock CVS, Essex Partnership University NHS Foundation Trust, NELFT NHS Foundation Trust, Mid and South Essex NHS Foundation Trust, and Mid and South Essex Health and Care Partnership.

How have you gone about involving these stakeholders?

The foundation of this Better Care Fund plan is our new strategy for health and well-being for adults, 'Better Care Together Thurrock – The Case for Further Change', approved by Thurrock Health and Well-Being Board on 24 June 2022 Agenda for Health and Wellbeing Board on Friday, 24th June, 2022, 10.30 am | Thurrock Council and Thurrock Council Cabinet at its meeting on 13 July 2022. This strategy, that sets out a hugely ambitious and collective plan to radically transform, improve and integrate health, care, housing, and third sector services, is an approach aimed at the borough's adult population and designed to improve their wellbeing. The strategy sits under the refreshed Thurrock Joint Health and Wellbeing Strategy as it is responsible for delivering or contributing to the delivery of its high-level goals and objectives related to transformation and integration of health, care, wellbeing and housing services. The Strategy has been developed through a process led by the Council's Corporate Director of Adults, Housing and Health, extensive consultation and collaboration with NHS, housing, adult social care and third sector partners, and more broadly through resident engagement.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

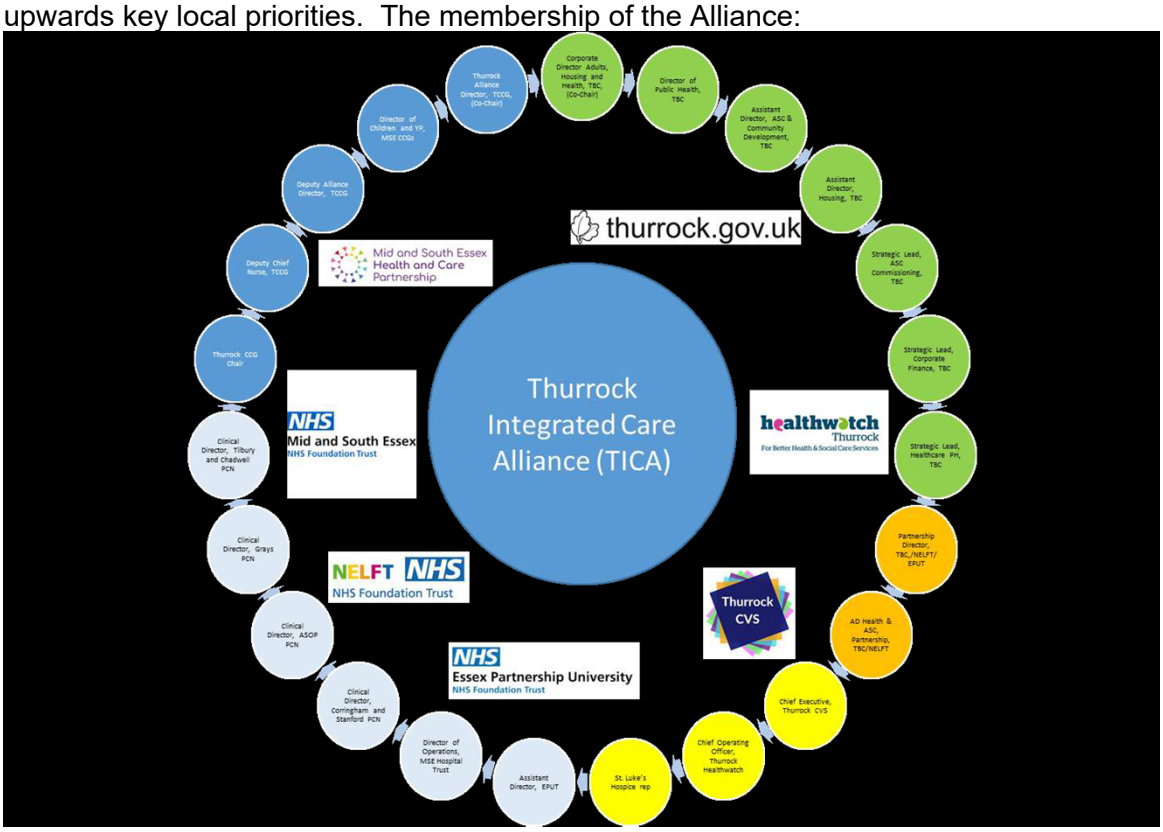
The focus of the Better Care Fund to date has been reshaped by our new strategy for adults: Better Care Together Thurrock - The Case for Further Change 2022 - 26. www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026
The schemes chosen for the Fund reflect this focus. The future plans are likely to continue this focus, and will include elements that are population wide including initiatives linked to preventing, reducing and delaying the need for health and social care intervention.
Priorities for 2022/23 include a focused review of all our schemes with a view to ensuring they closely reflect our new strategy and also:

- Continue to have maximum impact
- Reflect the changes in patterns of health and care needs which have resulted from the pandemic
- Reflect the needs of our communities in the face of unprecedented demand for health and social care services, and significantly reducing resources in real terms.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

HWBBs across Mid and South Essex have reviewed their functions in the light of legislation on Integrated Care Systems. In Thurrock the review addressed the future governance functions, and the delivery of improved health outcomes through 'Better Care Together Thurrock - The Case for Further Change'.
Accordingly, revised Terms of Reference for the Health and Well-Being Board were approved at its meeting on 24 June 2022: Report Template (thurrock.gov.uk)
The review also specified how the governance arrangements required between 'place' (Thurrock), and the ICS should operate – including potential areas of conduct, overlap and responsibility. This will shape the devolution and delegation agreement between the ICB and Thurrock Integrated Care Alliance (TICA).
The current governance arrangements continue to include:
- a single Thurrock Integrated Care Alliance with strategic oversight of the health and care transformation agenda - including the Better Care Fund (the plan is synonymous with the transformation agenda), the commissioning agenda and acting as the financial delivery mechanism for health and care integration
- a finance group reporting to the Alliance which has responsibility for financial monitoring and oversight of the BCF and other system level financial modelling, integration of health and care budgets, and identification of system-level savings which could inform issues such as risk and reward in an alliance contract
- a Better Care Together Thurrock Operations Delivery Board sits under the Partnership with responsibility for the delivery of the transformation programme
- to support integrated working at locality level, a Locality Working Programme Board - which oversees a combined strategic programme of integrated health and care at locality level. This includes scaling up across the Primary Care Networks' mixed skill workforce, Wellbeing Teams, and Community Led Support Teams
- four Locality Delivery Groups where clinicians, Adult Social Care professionals and other front line staff can refine individual locality integrated models. Locality Groups have a key function in driving the priorities of the Alliance by identifying and communicating upwards key local priorities. The membership of the Alliance:



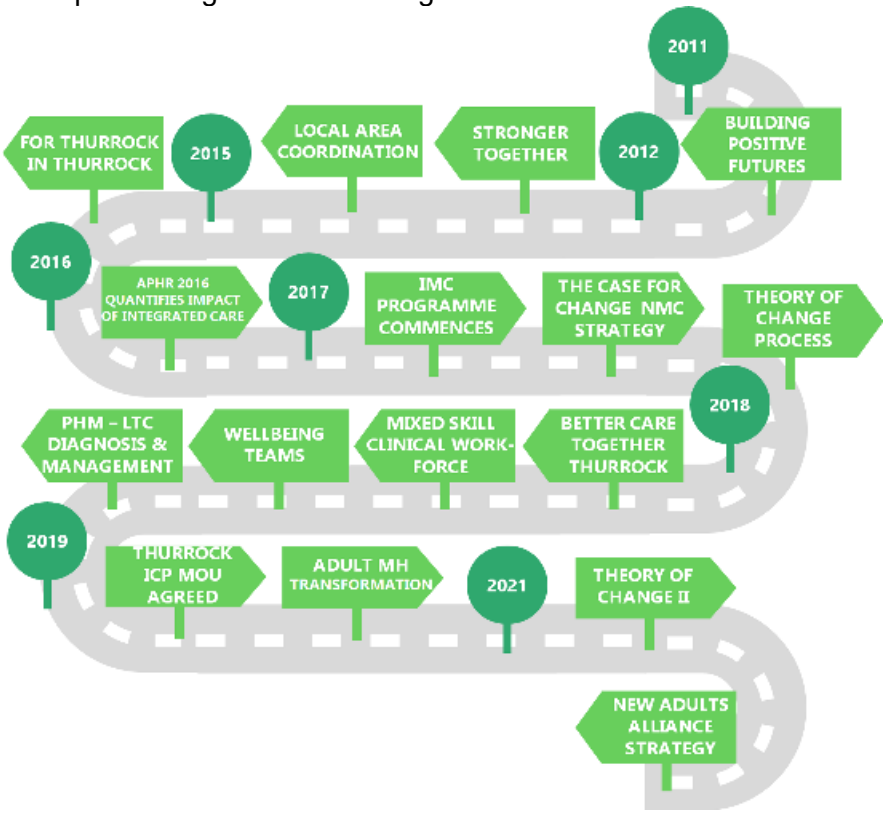
Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning

- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from

The BCF plan for Thurrock is collaborative and is focused on an integrated approach. The whole system works together to deliver the priorities within our plan ensuring the right support at the right time and the right place. As a system we have developed a joint strategic approach through our Case For Further Change narrative that focuses on an individual, their place in their own community, and a response to that person through either community strengths or commissioned services that meet the needs of that individual. We are adopting a human learning systems approach which further supports the already very mature collaborative working of our local systems. This approach will enable a fundamental change to how we commission based on continual learning and understanding the impact of system behaviour. All partners and providers will work in this way as we move forward and the BCF will support this approach as an already positive example of integration. This diagram illustrates Thurrock's transformation journey:



In section 2.2 of the Strategy Better Care Together Thurrock we describe how people have different strengths and skills and face different challenges that they respond to in a myriad of different ways. Challenges such as obesity, diabetes, mental ill health or homelessness are caused by a tangled web of different interdependent causes. The systems designed to respond to these challenges are complicated and are not necessarily designed to deliver the outcomes people want – they often deliver interventions in silo and have traditionally applied a 'one size fits all' approach to an issue. We need to commission a learning environment to constantly test, embed and refine. Our workforce needs to be empowered and given permission to test new approaches and report what works and critically where things don't work or stop working. We need to capture and use data and intelligence in a different way to support learning including qualitative data and residents' stories. We need to bring different professionals together to reflect regularly and share learning.
There are no changes planned to the BCF services commissioned this year as they remain focused on high quality discharge and support for individuals to remain at home wherever possible.

The Thurrock approach to collaborative and joint commissioning is set out in section 10.2 of our new strategy for adult care. Adopting the principles of Human Learning Systems and developing a people-led health and care system means developing a very different model of commissioning. Providers will be able to provide flexible, bespoke support that responds to an individual's specific circumstances.

This commissioning model will promote providers who:

- Build effective and meaningful relationships with those they serve;
- Understand and respond to the unique strengths and needs contained by each person; and
- Act collaboratively with others to deliver what is required by the person.

Service specifications, contract management and market development have been remodelled to be consistent with these new conditions, and types of partnership.

Commissioning for complexity for the bespoke and varied outcomes of individuals means:

- The ability to pool commissioning budgets across different service areas (and organisations);
- Commissioning of integrated contracts and specifications that span different functions – e.g. Adult Social Care, Mental Health, Housing;
- Enabling flexibility within contracts to enable providers to have the freedom and autonomy to use resource as required to deliver on outcomes;
- Expecting providers to collaborate in order to provide integrated functions and solutions – or for providers to potentially be asked to provide a broader set of functions on the behalf of a number of commissioning partners;
- Enabling providers to 'buy in' support that they do not directly provide – for example through an Individual Service Fund type approach; and
- Adopting success indicators that are based upon whether people are achieving the outcomes they have identified as being important to them.

Communities of Practice are being established across Thurrock – aligned with each Primary Care Network (PCN) area. User-led CoPs are charged with agreeing priorities, designing strategies and solutions to meet those priorities and ensuring local intelligence feeds into all decision-making processes from a neighbourhood to a system wide scale.

With budgets aligned to localities, and pooled across different functions, the aim is to get to a point where resources can be shifted to communities and to CoPs (becoming Community Investment Boards), with communities having a direct say in how resources are used.

The market in Thurrock is being developed to enable providers to respond to intelligence gathered through the new model of engagement, and to be able to reflect the principles of Human Learning Systems. This includes supporting smaller grass roots providers as well as existing providers to deliver an offer bespoke to the individual. The marketplace must also develop to encompass less traditional provision – including that which the community itself can offer.

2022-23.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach, and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Our Thurrock BCF Plan delivers the requirements of the national condition 4 to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

The schemes within the BCF deliver the preventative aspects of the objectives, and the ability to provide the right care at the right time in the right place.

The BCF plan enables the local health and care system to ensure support is available for early detection of health needs and, through voluntary sector provision, support and sign posting for families.

Throughout the last 2 years the collective responses from the system have developed further really positive working relationships across health and care in Thurrock. Daily meetings support the understanding of the system and enable speedy responses to challenges across the locality.

Within Thurrock we work closely with providers who are always willing to try and increase capacity to enable timely discharge or prevent hospital admission. This year our internal reablement service have been very challenged due to high levels of referral and some of our external providers have responded by offering reablement. Residential provision is also responsive to the system pressures and providers are willing to work with health and social care partners to support discharge and return home for individuals. We provide responsive community support enabling higher levels of health need to be supported at home.

Thurrock First is our single point of access across community health, mental health and adult social care. The service consists of a team manager who is a qualified social worker, two senior co-ordinators, 17 Thurrock First Advisors who take telephone calls, a Community Psychiatric Nurse, a Mental Health Act Assessment Coordinator plus casual bank staff. It aims to reduce, prevent and delay the need for more significant care by intervening early and works closely with the Urgent Care Response Team (URCT) who can be mobilised to attend residents' houses where they are in crisis.

Early discharge planning and preadmission discharge planning continues to work well to enable timely discharge from hospital. Thurrock have very minimal delayed discharges due to the responsive Hospital Social Work Team who continue to provide 7 day a week working and are based at Basildon and Thurrock Hospital. Our effective approach to hospital discharge planning is described on page 128 of our Strategy Better Care Together Thurrock.

Systems to monitor patient flow continue to develop though our Mede Analytics facility which allows us to analyse activity, supporting our understanding and development of positive integrated responses.

The Home First approach is key, and we have a system wide task and finish group to support the approach. In Thurrock we ensure wherever possible that people are able to return home with the same supports in place and with reablement available.

We continue to invest in domiciliary care to build sufficient capacity and reduce the likelihood of people waiting for care. The provision of intermediate care beds at Collins house again support timely discharge. We have a Home from Hospital Service, 'By Your Side' which ensures people's homes are ready for them when they come out of hospital.

We are focused on a place-based response in Thurrock and through our Better Care Together agenda we have multi-disciplinary responses through our PCN's and community health and social care teams. Our Community Led Support (Social Work) Teams and Local Area Co-ordinators work in an integrated way with health to ensure the right support is available.

The High Impact Change Model self assessment process has been integral to improved discharge planning. The attached report remains a true reflection of the system:

BCF Q4 19-20.xlsx

Thurrock has developed, and is developing, a range of initiatives to support independence. This includes greatly enhancing the offer we make to our older residents and other groups who cannot be supported in general needs housing. It means ensuring genuine accommodation choices that meet the aspirations of our residents for their later life, and high quality intermediate care and supported living facilities when residents need them.

There are many gains from a programme of new housing specifically designed for older adults: manageable, accessible, warm homes with low running costs and bringing a lower risk falls and accidental injury, will enable individuals to maintain their independence, see income go further, and avoid unnecessary admissions to hospital and care homes. For many older people, purpose-built accommodation also brings a social life that protects against isolation and loneliness. And, for some, it also means releasing capital to make life easier in retirement. Examples include our HAPPI housing schemes [HAPPI - Design - Topics - Resources - Housing LIN] in South Ockendon - Bruyns Court, and Beaconsfield Place which opened this spring in Tilbury.

Following a summit with private developers Thurrock has made a commitment that if developers will work with the Council to improve the quality of housing for older people, the Council will offer a range of help including:

- Providing profiles of the housing needs of older people in Thurrock's communities
- Engaging with local people so that they understand the benefits of specialised housing for older people
- Flexibility in relation to planning requirements, for example, parking if the site is well served by access to local facilities and transport
- Exploring the potential for joint ventures with private sector developers
- A one-stop service to facilitate scheme discussions at any point, not just at the pre-planning application stage.

There is also a multiagency panel, reporting to Thurrock's Health and Wellbeing Board, that considers the health and well-being implications of major planning applications and provides advice and guidance on the health, social care and community impacts of proposed new developments.

Thurrock is also developing the Whiteacre / Dilkes Wood site in South Ockendon to provide a range of homes for older people needing care: from small easy to maintain flats designed for frail elderly people, to retirement living for those who wish to downsize to a care ready environment, including potentially a mix of one and two bedroom dwellings for rent. The project aims to provide social care and nursing care in a specialised setting of 45 self-contained dwellings with associated care facilities (lounges, restaurant, treatment rooms, laundry etc.). In addition to the permanent homes on site, the 30 self-contained studios for intermediate care will widen the housing and care offer locally, so that we can more readily avoid admissions by offering a home from home, and step up/step down care for those who need it.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Thurrock is currently refreshing the Carers Strategy, undertaking detailed consultation regarding carers' experiences. There is an excellent carers Information Advice and Support service in Thurrock, together with a short breaks service funded through our external purchasing budget which sits within the BCF. Carers services are offered through our internal Friendship Club, as well as sitting services and residential respite which are all funded through the budgets within the BCF. Direct payments and individual budgets are offered to ensure there are a range of options and choice for carers. Outcomes for carers are improving and the new Better Care Together Thurrock strategy, which will be a joint health and social care approach, will give additional direction and will be framed within a human learning system approach to ensure it is coproduced and responsive.

We know early identification and support is imperative in improving the physical and mental well-being outcomes of carers. The Carers Information, Advice and Support Service carries out a whole host of activities during Carers Week/Carers Rights day and throughout the year to increase the number of people identifying as a carer. As a result of this activity, we have seen a significant increase in the number of carers coming forward – largely self-identifying as having mental health issues as a result of caring through the pandemic (in quarter 1 2022/23 the service identified twice as many carers compared to the same quarter in the years leading up to the pandemic). Carers Officers have also started to be part of the locality Test and Learn project – we hope after we have we have trialled this approach that the service will move to delivering in a place based way. This will aid both the identification and support to carers within the communities in which they live.

Disabled Facilities Grant (DFG) and wider services

Transformation of the DFG services continues with a greater understanding and promotion of health equality. It is acknowledged that there is a primary focus to support people through home adaptations via the mandatory grant; recognising the home environment can have a considerable bearing on people's safety, independence and overall health and wellbeing. It is also recognised that an integrated and holistic approach across health, social care and housing is essential to not only realise the benefits of accessible housing, but also achieve an understanding of, and subsequent approach to, meeting an individual's needs and the needs of the wider community in which they live.

The Council has completed a review of the DFG service and implemented a strength-based approach to service delivery, which has greatly enhanced the support available for the residents of Thurrock. Our approach has improved awareness and accessibility, with a newly introduced pathway meaning DGF applicants can do more for themselves with self-service, which provides significant benefits for all. The service is now hosted alongside the Occupational Therapy Service within Adult Social Care. This has enabled the DFG service to be more accessible and complement integrated approaches already established across health, social care and housing, such as the integrated first point of contact service, placed based support services across health, social care and housing, and the established Integrated Community Equipment Service

The Council has recently implemented its new DFG RRO policy, initiating phase two of the intended transformation of the DFG Service. This includes greater opportunities to support wider services within health, social care and housing, especially where there is a recognised crossover with DFG services in supporting individuals to remain in their home and meet their wider housing needs. Furthermore, the Council can now provide additional support by virtue of the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002, which enables the Council to provide Thurrock residents with financial assistance from a range of discretionary grants. The council is drafting a communication strategy to inform residents and key stakeholders across social care, housing and health services to promote and encourage the uptake of additional support the DFG service intends to provide residents.

Examples include:

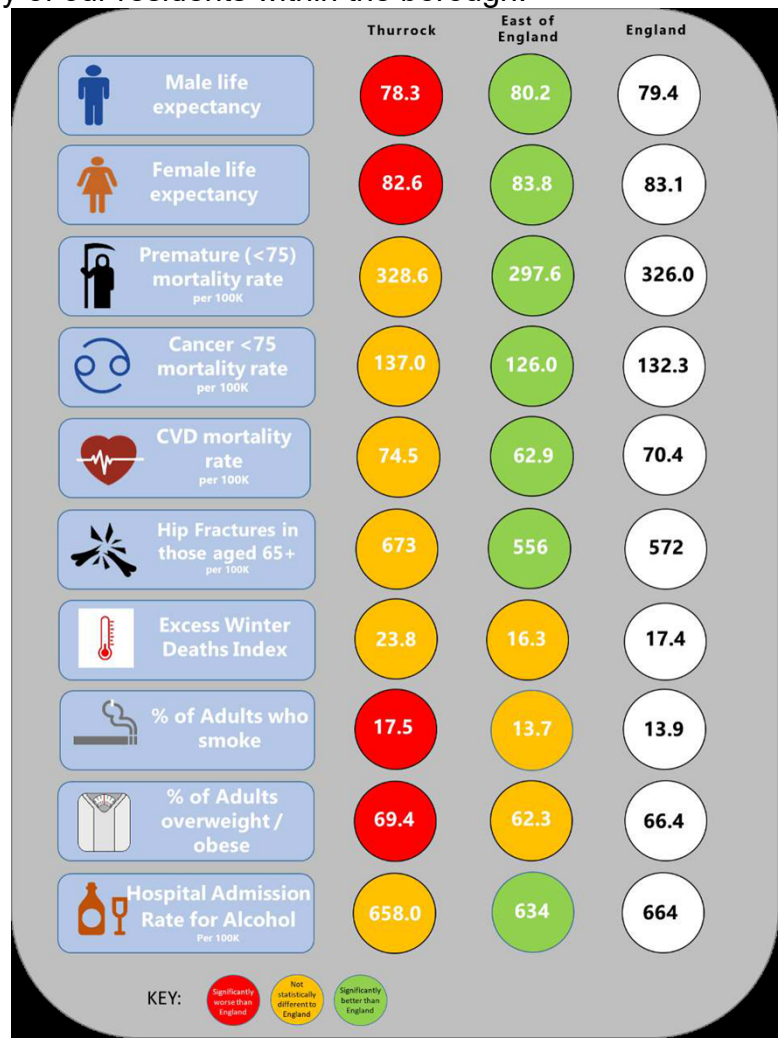
- 'top up' to a mandatory grant and / or to fund unforeseen works
- adaptations for a child's second home where the parents live separately
- adaptations for a child / young person in foster care
- adaptations for an adult supported in "shared lives" or similar supported living scheme
- assist a disabled person or their family to move to more suitable accommodation
- dispense financial assessment for works below £5000
- facilitate timely discharge from hospital or other non-residential settings (individual and schemes)
- avoid unnecessary hospital admission or other non-residential settings
- facilitate fast track adaptations for end of life / life limiting conditions
- improve accommodation of a nature that supports residents in supported living and step down / rehabilitation services, or in need of interim support
- provide non-fixed solutions, including, but not limited to TEC and ICES
- explore and provide innovative housing solutions / schemes for a range of client groups, such as dementia, autism etc (purpose built housing solutions)
- support safe / warm homes initiatives
- support complementary services in meeting an individual's wider housing needs
- support handyman / minor adaptations schemes

The DFG service will strive to make a greater contribution to the Better Care Fund, Thurrock Integrated Care Alliance transformation programme, and the Better Care Together Thurrock strategy, where further opportunities and strategic development for DFG can be explored.

to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Equality and health inequalities

Health inequalities remain a significant issue in Thurrock with our more deprived populations suffering lower levels of both total life expectancy and the numbers of years of their life that they can expect to live without disability.
There is clear health inequity between both total life expectancy and disability free life expectancy linked to deprivation, with both measures increasing as deprivation decreases. Only the least deprived 35% of our population are likely to reach retirement age before reaching the end of disability free life.
Thurrock has the third worse Mortality Attributable to Socioeconomic Inequality (MASI) index in Mid and South Essex with 2,522 deaths being attributable to socio-economic causes between 2003 and 2018.
Thurrock's main cause of death due to socio-economic inequality in cardio-vascular disease. This differs from Mid and South Essex where cancer is the most common cause of death driven by socio-economic inequality.
Thurrock's population is generally less healthy than that of the East of England and England. This reflects the higher levels of deprivation and health inequalities faced by many of our residents within the borough.



The more flexible way in which Integrated Care Systems will in future allocate resources presents an opportunity to distribute funding in a fairer and more equitable way to address the higher health needs of Thurrock residents compared to more affluent communities within our local system.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

The prevailing ethos of our approach remains to ensure all individuals and communities have a health and care system that is equitable and designed around their specific requirements. For example, ensuring that the system looks to deliver a broad range of solutions that meet the outcomes most important to the individual. The focus on shifting the system upstream by redesigning it around principles relating to early intervention and prevention ensures that significantly more activity takes place within the community. This in itself will not only reduce health inequalities, but increase the health and wellbeing of the population. The approach is whole-population meaning that all protected characteristics (Equalities Act 2010) will benefit from the principles of redesign. Thurrock has the third worse Mortality Attributable to Socioeconomic Inequality in Mid and South Essex, with 2,522 deaths being attributable to socio-economic causes between 2003 and 2018. Thurrock's main cause of death due to socio-economic inequality is cardio-vascular disease. The Alliance will support integration at PCN level by ensuring that future enhanced non-core services are commissioned on PCN footprint. This will encourage greater integration of PCN member practices and will drive standardisation of care and reduce health inequality
Development of the BCF plan is aligned with the MSE ICS approach to ensuring the national Core20Plus5 priorities are considered within local schemes addressing digital exclusion, data quality and accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes.

Hi Stocktake Q2 Aug22 V0.1SM P...

Detailed work has been undertaken by the Council and Alliance partners to increase COVID vaccine uptake, with community health champions in place along with community vaccine buses.
Due to complexities in regional demographics across Thurrock, in the development of our aligned BCF plan, the Equalities Impact Assessments are managed at a scheme level. In principle, there are no expected implications for any one section of the community, but inevitably when any process or access route to services changes, there may be an impact that is unintended. Therefore, all changes will be aligned with our Public Sector Equality Duty and subject to ongoing review to consider the EIA implications.
As a collection of initiatives, there will also be a review to ensure that the cumulative effect of changes has not, or does not unduly, affect any one cohort of people.

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Better Care Fund – Annual Governance Statement 2021-2022

1. Introduction

1.1 The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Thurrock pursuant to the Care Act 2014.

1.2 NHS Mid and South Essex Integrated Care Board has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Thurrock.

1.3 The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the national conditions and local objectives as set out within the Better Care Fund Plan. It is a requirement of the Better Care Fund that the NHS MSE ICB and the Council establish a pooled fund for this purpose.

1.4 Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions (as set out within the Council's Constitution) and prescribed NHS functions.

1.5 This Statement sets out how the Council and NHS MSE ICB are, through effective governance arrangements, complying with the responsibilities set out within the Better Care Fund Section 75 Agreement for Thurrock, and the applicable Better Care Fund Guidance[1].

2. Governance Arrangements

2.1 Governance of the Better Care Fund is through the Thurrock Integrated Care Alliance (TICA). Membership of the TICA includes:

NHS MSE ICB

- Interim Alliance Director
- Chief Finance Officer
- Director of Commissioning

Thurrock Council

- Corporate Director of Adults, Housing and Health
- Director of Finance and Information Technology
- Strategic Lead for Commissioning and Procurement
- Director of Adult Social Care and Community Development

[1] https://www.england.nhs.uk/wp-content/uploads/2021/09/B0898-300921-Better-Care-Fund-Planning-Requirements.pdf

2.2 The TICA and the BCF Delivery Group, meets monthly to:

- Provide strategic direction on the schemes contained within the BCF;
- Receive financial and activity information;
- Review the operation of the section 75 Agreement;
- Review risks monthly and agreed annually a risk assessment;
- Review and agree annually revised schedules as necessary; and
- Request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Pooled Fund.

2.3 The TICA is a sub-group of the Health and Wellbeing Board, and as such, minutes of its meeting are considered by the Board at each of its meetings.

2.4 Governance arrangements are reviewed on an annual basis as part of the development of, and approval arrangements for, the Better Care Fund Plan and Section 75 Agreement. This includes a review of the TICA Terms of Reference.

3. Performance Arrangements

3.1 The TICA, assisted by the BCF Delivery Group, is accountable for a performance scorecard and report. The scorecard is the main performance monitoring tool for the Better Care Fund.

3.2 The scorecard is reported to the TICA, assisted by the BCF Delivery Group, on a monthly basis with a more detailed report considered on a quarterly basis. An expanded report is be considered at the end of the year and also mid-year.

3.3 Performance arrangements and the scorecard supporting the delivery of the Better Care Fund are reviewed on an annual basis.

4. Financial Arrangements

4.1 Financial monitoring takes place on a monthly basis with a report jointly prepared by the NHS MSE ICB and Thurrock Council's BCF finance lead.

4.2 Monthly monitoring arrangements allow for any underspends to be identified and for decisions to be made about how any underspends should be allocated.

4.3 Whilst the pooled fund is set at a defined amount, any risk of overspend in any area will require a remedial action plan to be produced and presented.

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5. Risk Management Arrangements

5.1 The Better Care Fund Plan contains a risk register that identifies the top ten risks.

5.2 Risks are reviewed by the TICA, assisted by the BCF Delivery Group, on a monthly basis.

6. Review of Effectiveness

6.1 The robustness of the governance arrangements for the Better Care Fund, as set out within this document and as contained within the section 75 Agreement, are considered on an annual basis – with any necessary changes being made as they arise. The review of effectiveness was undertaken with specific reference to the 2021/22 Better Care Fund: Policy Framework and the associated Planning Guidance.

6.2 The review of the governance arrangements for the Better Care Fund 2022/23 will be considered and agreed by the TICA, assisted by the BCF Delivery Group, as part of the process for formulating the Better Care Fund Plan 2022/23, and reported to the Health and Wellbeing Board for approval.

7 Annual Review

7.1 The Section 75 Agreement contains a requirement for an annual review of the operation of the agreement, the Pooled Fund and the provision of Services, within 3 Months of the end of each financial year. The TICA can agree alternative arrangements, including alternative frequencies.

7.2 The planning process will encompass the review of operation of the agreement, the Pooled Fund and the provision of services. In addition, in 2022/23, the review will take account of the newly approved strategy Better Care Together Thurrock – The Case for Further Change as the delivery mechanism for delivery of Goals 1 and 3 of Thurrock's new Health and Wellbeing Strategy.

7.3 A Task and Finish Group has been constituted to undertake the review of performance of services and has developed a set of funding criteria for the Better Care Fund Plan which includes:

- Funding available for one-off investments;
- Deciding whether the funding of investments made in previous year(s) should continue;
- Helping to identify whether any further spend can be freed up for investing or using differently.

The outcome of the review of the provision of services, and the funding recommendations for the 2023/24 Better Care Fund Plan, and subsequent years, will be presented to the Health and Well-Being Board.

8. Approved

Les Billllngham
Interim Director of Adults, Social Care
Thurrock Council

Stephen Porter
Interim Alliance Director
NHS Mid and South Essex Inegrated Care Board

Date:

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28 October 2022	ITEM: 8
Health and Wellbeing Board	
Performance Report on Initial Health Assessments for Looked After Children	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Dan Jones – Strategic Lead Children Looked After	
Accountable Assistant Director: Janet Simon – Assistant Director Children's Social Care and Early Help	
Accountable Director: Sheila Murphy – Corporate Director of Children's Services	
This report is Public	

Executive Summary

This report is to update Members of the Corporate Parenting Committee on actions taken by Children's Social Care and Health colleagues to address the timeliness of Initial Assessments for Children who are Looked After. This update report is in response to the Committee's request from the meeting held on the 19 July 2022 and is focussed on Initial Health Assessment Performance.

1. Recommendation(s)

1.1 Those members are aware of the work that has taken place, and areas for improvement in completing Initial Health Assessments and note the work that is being undertaken to ensure improving performance.

2. Introduction and Background

2.1 When a child becomes looked after by Thurrock Council there is a duty under the Care Planning, Placement and Case Review (England) Regulations 2010 to undertake an assessment of their health needs within 28 days of accommodation. This is referred to as the Initial Health Assessment and must be carried out by a registered medical practitioner who is ideally a paediatrician. The Initial Health Assessment (IHA) identifies existing health problems and deficits in previous healthcare and provides a baseline for managing the child's future health needs.

2.2 Joint work with partners in Health is required to complete these assessments. There are clear arrangements in place with local Health partners, Referrals for

IHA should be completed within 5 working days of becoming looked after and sent to Health. The IHA appointment will then be arranged, the child seen and assessed within 28 days (20 working days) of entering care and a subsequent report sent to the local authority.

2.3 The timely completion of IHA's is an improvement area for Thurrock Council that was identified in our last full Ofsted inspection in 2019. Since then, considerable work has been undertaken to ensure our processes are clear and there is a weekly joint scrutiny meeting which considers and discusses all children who are due an IHA including any barriers and how to overcome these. This has continued consistently through-out the Covid-19 pandemic. Despite this high level of oversight, meeting the above timescales presents a number of issues for health and social care.

3. Issues, Options and Analysis of Options

3.1 The local authority, through its Corporate Parenting responsibilities, has a duty to promote the welfare of Looked after Children, including those who are eligible, and those children placed in pre-adoptive placements. This includes promoting the child's physical, emotional and mental health.

3.2 Every Looked After Child needs to have an up-to-date health assessment so that a health care plan can be developed to reflect the child's health needs and be included as part of the child's overall Care Plan.

3.3 Health assessments are a statutory requirement and should be carried out within 28 days of entering care and then at a minimum of:

- 6-monthly intervals for babies and children under 5 years of age; and
- Annually for those aged 5 years and over.

3.4 Local Authorities and local Health partners should have arrangements in place to support the completion of 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 area. Where children are looked after due to being remanded in custody, heath assessments are undertaken by the unit in which they are remanded. These children are included in the figures presented but sit outside of the usual health arrangements

3.5 The Local Authority should always advise health colleagues when a child is initially accommodated and there should be effective communication and understanding between each other as part of being able to promote children's wellbeing.

3.6 In the first quarter of the financial year 2022/23**, 16** children became looked after. **13** Children were pending an IHA at the 31 March 2022 totalling **29** children due an IHA.

- **22 Children** received an Initial Health Assessment

- **4** Children became looked after, after the 6th May meaning the IHA's were due outside of the first quarter
- **1** Child was looked after for less than 28 days
- **3** Children had overdue IHA's pending at the end of the first quarter

3.7 Of the **16** children who became looked after in Q1:

- 6 received an IHA by the end of Q1.
- 7 children were placed within Thurrock
- 9 were placed outside of Thurrock
- 14 were placed within 20 miles of their home address
- 4 were UASC
- The children were placed in the following areas:
  - Thurrock
  - Redbridge
  - Essex
  - Luton
  - Milton Keynes
  - Havering

3.8 The majority of children entering care receive Initial Health Assessments though these are not completed on time. Where a child does not receive an IHA, there are clear reasons. The table below identifies the completion dates and delay reasons for the IHAs (Initial Health Assessments) for the 16 children entering Thurrock's Care during Q1:

#	Date entering care	Date IHA completed	Notes/Delay reasons:
1	05/04/22	22/08/22	First appointment offered 23rd June, and then cancelled as an interpreter was unavailable – re-booked for 22nd Aug 2022
2	11/04/22	-	IHA refused by child
3	13/04/22	10/08/22	3 IHA appointments offered, first was missed due to child's anxieties, 2nd due to the paediatrician being ill. IHA completed on third attempt.
4	20/04/22	09/06/22	First Appointment offered out of time.
5	21/04/22	13/06/22	First Appointment offered out of time
6	21/04/22	-	In care for less than 28 days
7	22/04/22	20/05/22	IHA completed in time
8	27/04/22	28/04/22	IHA at YOI
9	27/04/22	27/06/22	First Appointment offered out of time.
10	05/05/22	30/06/22	First Appointment offered out of time
11	12/05/22	06/06/22	IHA completed in time

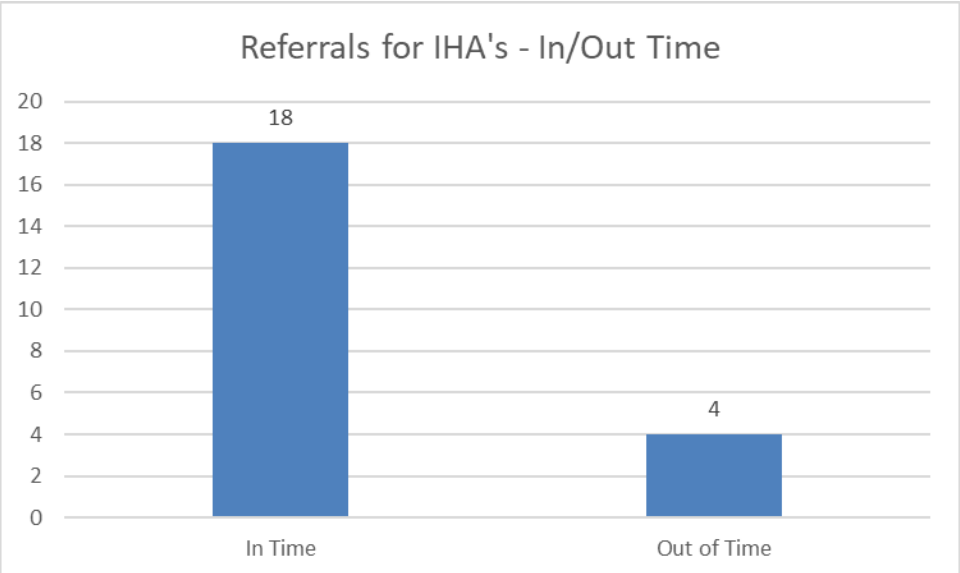
12	27/05/22	10/08/22	Parents did not consent to IHA initially. Appointment further delayed due to the paediatrician being ill. Completed on third appointment
13	17/06/22	-	First appointment for these sibs was 14th July. This was missed due carers refusal to attend at very short notice. Next appointment not available until September 2022
14	17/06/22	-	
15	17/06/22	-	
16	23/06/22	08/08/22	First appointment delayed as carer and child on holiday

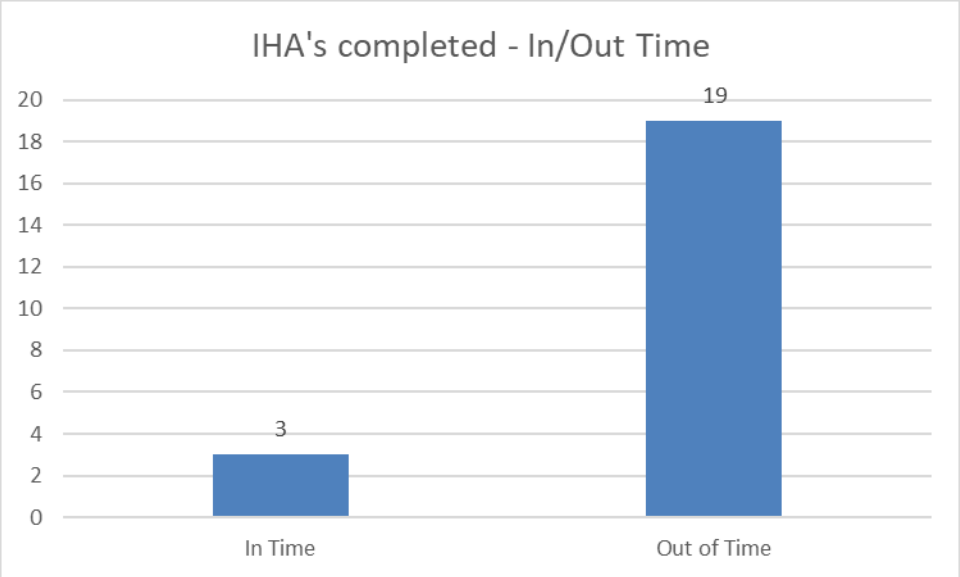
3.9 Most children are referred for their Initial Health assessment within the 5 working day referral window. Referrals are tracked weekly to ensure children receive an IHA even when this occurs out of timescales.

3.10 Timeliness of IHAs remain a key area of focus with weekly oversight from Senior Managers in Health and Children's Social Care. Two performance measures inform the data and success in children having an initial health assessment in time:

- Whether the referral for an initial health assessment is made by the local authority within 5 working days
- An initial health assessment takes place within 20 working days of a child entering into care.

3.11 In the first quarter of 22/23 for those **22** children who received IHA, referrals to health were largely made within timescales. Pressures continue in IHA in completion of IHA's within 20 working days from referral, as follows





3.12 The timeliness for children placed outside of the local health area remains a challenge and where possible, children are brought back to our local health service for their IHA to avoid delay.

3.13 Once the referral is completed and accepted by health, an appointment is arranged, a report written by the Paediatrician and, finally, sent to Children's Social Care. The date the IHA assessment is physically completed is the date recorded for this measure. However, in order for this to be formally recorded as complete the report needs to be received by the local authority.

3.14 Initial Health Assessments remain a priority focus area for improvement for both Children's Social Care and Health partners. Progress continues to be reviewed weekly. The following are routes to improve performance:

- Service Manager oversight and managing weekly review meetings to ensure referrals are completed on time identify any barriers or themes to ensure they are addressed
- The local Health provider (NELFT) has increased the resources to create more appointments for IHA's to provide improved capacity for children placed in the local area
- Prioritising of IHA appointments with social workers leading on and ensuring children attend appointments and that carers understand that this is a priority to ensure children's health needs are met
- Health Colleagues are reviewing the escalation pathway so there is quicker resolution where children are placed in other areas
- The Multi-Agency CLA Steering Group continues to track performance monthly to escalate strategic issues

4. Reasons for Recommendation

4.1 Members of the Committee are aware of Statutory Duty to complete Initial Assessments for all children and young people who come into care and how we are meeting these duties.

4.2 Members of the Committee are aware of the issues and steps being taken to improve these

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

5.1 Consultation with NELFT in preparing this report

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

6.1 None

7. Implications

7.1 Financial

Implications verified by: **Michelle Hall**
Senior Management Accountant
MICHall@thurrock.gov.uk

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)
JUKnight@thurrock.gov.uk

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 for the health assessment by the child's first review, and for a written report of the health assessment to be provided as soon as soon as reasonably practicable.

7.3 Diversity and Equality

Implications verified by: **Rebecca Lee**

Team Manager - Community Development and Equalities

The Service is committed to practice, which promotes **equality, diversity and inclusion**, and will carry out its duties in accordance with the Equality Act 2010, **Public Sector Equality Duty and** related Codes of Practice and Anti-discriminatory policy. The service recognises that a range of communities and groups of people may have experienced obstruction or the impact of prejudice when accessing services including Social Care and Health services. Both Services are committed to support all children in the care of Thurrock Council to access Initial Health assessments, individual arrangements are made where required to meet needs and address individual concerns

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

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

- None

Report Author:

Dan Jones
Strategic Lead - Children Looked After
Children's Services

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28 October 2022	ITEM: 9
Health & Wellbeing Board	
Annual Public Health Report 2022	
Wards and communities affected: All	**Key Decision:** None
Report of: Jo Broadbent, Director of Public Health	
Accountable Director: Jo Broadbent, Director of Public Health	
This report is Public	

Executive Summary

This paper presents the following report: Reducing the Impact of Cardiovascular Disease in Thurrock, Annual Report of the Director of Public Health, 2022.

1. Recommendation(s)

1.1 That Members note the contents of the Annual Public Health Report 2022 and approve its publication.

2. Introduction and Background

2.1 Directors of Public Health in England have a statutory duty to write an Annual Public Health Report (APHR) to demonstrate the state of health within their communities. The Association of Directors of Public Health describes the core purpose of the Director of Public Health as independent advocate for the health of the population and system leadership for its improvement and protection. The DPH Annual Report is an important vehicle for providing advocacy and recommendations on population health to both professionals and public.

2.2 The APHR can focus on any topic of key relevance to improving the public's health, and in recent years, topics of focus have included Youth Violence & Vulnerability and Improving Older People's Health Through Housing. Previous reports can be found here https://www.thurrock.gov.uk/public-health/other-public-health-reports .

3. Overview

3.1. The attached APHR 2022 is a follow-up to the APHR 2016, which explored the sustainability of health and social care systems in Thurrock, with particular reference to Long Term Conditions (LTCs) amongst adult residents. The 2022 report demonstrates the progress that has been made in terms of LTC care as a result of the recommendations in that report. It also makes recommendations to the wider Thurrock health and care system to further improve LTC outcomes, looking through the lens of improving outcomes for cardiovascular disease (CVD).

3.2. The recommendations will be taken forward through the Better Care Together Thurrock (BCTT) working group on Population Health and Inequalities, chaired by the DPH. Actions will include:

- Continued quality improvement in primary care services for CVD
- Embedding a more holistic, co-produced approach to long term conditions care
- A focus on reducing inequalities in CVD outcomes, particularly for people from a minority ethnic background, people with serious mental illness and people with learning disabilities.

4. Reasons for Recommendation

4.1. Directors of Public Health in England have a statutory duty to write an Annual Public Health Report to report on the state of health within their communities.

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

5.1 This report is being presented to Health Overview & Scrutiny, the Health & Wellbeing Board and the Cabinet. It has also been shared for comment with Thurrock Integrated Care Alliance (TICA).

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

6.1 This report adds further detail and granularity to the aims of the Health & Wellbeing Strategy to Level the Playing Field and reduce inequalities in Thurrock, specifically the aims of Domain 1 – Staying Healthier for Longer. This includes a specific Goal to –
Continue to enhance identification and management of Long Term Conditions (LTCs) to improve physical and mental health

6.2 The report also sets out some specific actions to support the Better Care Together Thurrock adult health and care strategy, in particular Chapter 6 – Improved Health & Wellbeing through Population Health Management. This sets specific Goals as follows –
The Public Health Team will co-design with PCN, NELFT and EPUT clinical leaders, a more detailed case-finding strategy setting out revised protocols for hypertension, AF and depression, targets, training requirements and required resources

We will embed lifestyle modification services, social prescribing and ASC support within the multi-morbidity care models, ensuring that they are holistic, can respond to the individual context of residents including addressing wider determinants of health, self-care and in-depth motivational interviewing, creating a new blended coach role

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead – Corporate Finance

Expenditure relating to the provision of public health services is contained within the ring-fence of the public health grant.

The report will influence transformation of NHS and public health services and will be used as part of the basis for the allocation of the funding and will be contained within the overall allocation. This will be addressed as part of the medium term financially planning for the public health service.

7.2 Legal

Implications verified by: **Gina Clarke**

Corporate Governance Lawyer & Deputy Monitoring Officer

This report fulfils the statutory obligation of the Director of Public Health to produce an Annual Public Health Report on the health of the population in the Council's area. The content and the structure of the report is a matter to be determined locally. However, the Council has a statutory duty to publish the Annual Public Health Report.

7.3 Diversity and Equality

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The report makes a number of recommendations aimed at reducing health inequalities from LTCs, including inequalities in service access, condition diagnosis and quality of care, all of which contribute to inequalities in outcomes. Community groups identified as experiencing such inequalities

include minority ethnic groups, people living in deprived areas, people living with serious mental illness or learning disability.

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

This report aims to influence activity in the local NHS, particularly primary care and will be used to support TICA in NHS service quality improvement.

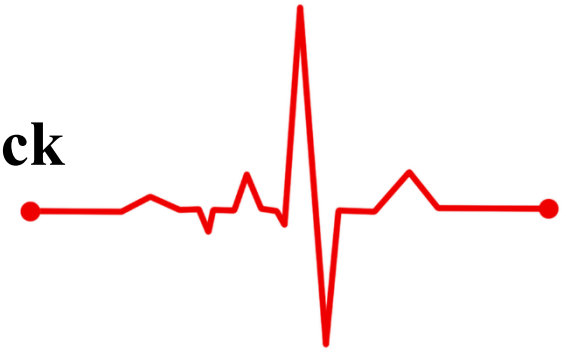
Report Author: Dr Jo Broadbent, Director of Public Health

Appendices:

1 Executive Summary
2 Reducing the Impact of Cardiovascular Disease in Thurrock, Annual Report of the Director of Public Health, 2022; Full Report

Reducing the Impact of Cardiovascular Disease in Thurrock

Annual Report of the Director of Public Health, 2022



Thurrock Public Health

Reducing the Impact of Cardiovascular Disease in Thurrock

Annual Report of the Director of Public Health, 2022

AUTHORS:

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Monica Scrobotovici, Senior Population Health Management Programme Manager

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Rita Thakaria, Partnership Director, Adults Health and Social Care

To read this document in other formats please contact PublicHealth@Thurrock.gov.uk

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Reducing the Impact of Cardiovascular Disease in Thurrock

Annual Report of the Director of Public Health, 2022

Foreword

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Annual Report of the Director of Public Health, 2022

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Reducing the Impact of Cardiovascular Disease in Thurrock

Annual Report of the Director of Public Health, 2022

Executive Summary

The 2016 Annual Public Health Report for Thurrock[1] explored the sustainability of health and social care systems in Thurrock, with particular reference to Long Term Conditions (LTCs) amongst adult residents. A number of issues were highlighted, including variable access to primary care, differences in the quality of care between practices, and associated impacts on patients and consequent hospital admissions. The report made a series of recommendations to increase the effectiveness and cost-effectiveness of care in Thurrock across a range of health conditions. Much has changed since 2016, both proactively in terms of national health policy and local health systems, and reactively as a consequence of the Covid-19 pandemic. This report reviews progress since then for one of the LTC clusters outlined in the 2016 report: Cardiovascular Disease (CVD).

Why focus on Cardiovascular Disease?

Of all the disease groups, CVD causes the highest levels of premature mortality: 1 in 4 premature deaths (before age 75) in the UK are due to CVD and it is the leading contributor to health inequalities[2]. Analysis of local data shows that for mortality attributable to socio-economic inequality, CVD is also the greatest contributor in Thurrock, accounting for 35% of excess deaths[3]. Yet if risks are detected and managed in line with NICE guidance, focusing on CVD provides the greatest potential to reduce health inequalities and reduce premature mortality. As outlined by the World Health Organisation (WHO), the key behavioural risk factors for CVD are smoking, unhealthy diet/obesity, lack of physical activity, and harmful use of alcohol[4], all risks which can be ameliorated with support and appropriate policies.

What has changed since 2016?

Both national and local drivers of CVD care have developed since 2016. The NHS Long Term Plan, published in 2019, set out a range of goals for reducing the number of strokes and heart attacks and reducing the inequalities associated with CVD by 2029, with a particular focus on high blood pressure (hypertension).

Improvements in clinical pathways for CVD in Thurrock have been seen since 2016. However, part-suspension of QOF during the pandemic has made it difficult to make direct comparisons with the findings of the 2016 report. (Moreover, exact comparison with the 2016 report is not appropriate due to nationally driven organisational change in primary care with the establishment of Primary Care Networks). Measurable quality improvements do include:

- Whilst it is not possible to attribute success to individual initiatives, overall analysis does show that numbers of diagnoses for hypertension across Thurrock have increased from 1,321 in 2016/17 to 2,567 in 2021/22. There is still a gap between current register numbers for cases of hypertension and the national target that 80% of expected cases be detected by 2029, but the gap is smaller in Thurrock than in other areas of MSE. When it comes to treatment of patients on the hypertension register, all four Thurrock PCNs are working beyond the national target for those aged over 80, and close to target for those below 80, and again are achieving higher rates of treatment to target than neighbours in MSE.
- There have also been improvements locally in the treatment of patients with atrial fibrillation, where Thurrock is already exceeding the national target, though when it comes to detection there is still a gap (of around 260 cases) between the current recorded prevalence and national target.

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- There is still a significant gap between expected and diagnosed prevalence of high cholesterol, with fewer than one third of the expected numbers having a formal diagnosis but the quality of care for those on Coronary Heart Disease (CHD) registers is high.

Key Findings and Recommendations

More detail on each of the findings, references and recommendations can be found in the full report.

	Key Findings	Recommendations
1	Most of Mid and South Essex is in the quartile in England with the most patients per GP, and the situation is worst in Thurrock, with 2,296 patients per GP (increased from 2,110 per GP in 2016), which is the third highest list size per GP in England.	Thurrock Integrated Care Alliance (TICA) should work with Mid and South Essex ICS to prioritise support for new models of working and additional workforce capacity to practices within Thurrock PCNs, to avoid increasing health inequalities associated with access and quality in primary care.
2	The COVID-19 pandemic has exposed and worsened health inequalities. It has had adverse effects on people's physical and mental health, and on demand and access to health and care services, including prevention and management of CVD.	Refresh the focus on primary prevention of CVD post-COVID-19, including: • Tobacco control • Reducing obesity • Focusing on healthy behaviours in early years
3	The development of Integrated Medical and Wellbeing Centres (IMWCs) is an opportunity to deliver: • More personalised, proactive care, with a more collaborative and flexible approach • An integrated service bringing together health, wellbeing and social care services in multi-disciplinary LTCs teams.	Promote personalised, collaborative and holistic care planning, for example the House of Care using an evidence-based model, alongside instigating long term condition specialists and multi-disciplinary working within the IMWCs. New models of working should include maximising potential for risk behaviour services to target support to patients, including those at higher risk of CVD, through joint working within the new IMWC model.
4	The evidence base shows that: • Focusing on the processes and tools of transformation is not sufficient when seeking a shift to co-production • Goals linked to the patient's starting point will be more successful	In designing new holistic care models, TICA should specifically consider: • That transformation programmes need to be built around how to achieve cultural shifts in practice • The benefits of health goals being contextualised within the patient's life and personal priorities

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	• The Patient Activation Measure (PAM) can assist in segmenting and prioritising patients with multi-morbidities and/or complex needs for care-coordination and support • Health Coaching can support outcome improvement through motivational techniques and focusing on the individual's starting point	• Adopting the Patient Activation Measure (PAM) • Training a range of staff in primary care, integrated teams in Health Coaching, prioritising patients identified through PAMs at the lowest levels of engagement
5	Whilst it is not possible to attribute success to individual initiatives, joint working between public health and primary care, such as Stretch QOF, have produced measurable improvements in quality of care for hypertension, CHD and atrial fibrillation since 2016.	Continue to strengthen the links between public health and primary care, using data to inform improvements. Use Stretch-QOF and other approaches to promote case-finding and a strengths-based approach to improving outcomes, taking into account multi-morbidities, to promote holistic management of LTCs.
6.1	Case studies of best practice consistently demonstrate the potential for the wider community health and care workforce to contribute to CVD prevention and diagnosis.	In seeking further improvements in care for specific CVD conditions (and other LTCs), services should consider developing Community and Allied Health Professional roles (e.g. Podiatrists, Physiotherapists, Community Social Care roles) and considering how broader roles might enhance LTC services for patients.
6.2	Given the high quality of primary care for those on CVD registers in Thurrock, the greatest improvements in population health through improving CVD outcomes are likely to be gained by a focus on reducing gaps in diagnosis.	Implement systematic and targeted case finding for atrial fibrillation, CHD and hypertension, including targeting over 65s, those who are housebound, those with higher BMIs.
6.3	Evidence suggests that the NHS Health Checks programme needs to be more targeted in order to increase uptake in those with most to benefit – which includes people living in more deprived areas and/or those from BME groups at the younger age limit.	Target NHS Health Checks for people at the younger age limit in groups known to be at higher and earlier CVD risk. This includes those in certain minority ethnic groups, smokers and people on obesity registers, as well as residents in areas of higher deprivation.
6.4	Thurrock has the second highest premature mortality rate in England due to CVD in people living with SMI in	Maximise uptake and associated follow-up of physical health checks for people living with SMI and who have a learning disability.

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	2018-20. Heart disease is the second highest cause of death amongst people with a learning disability. Despite, this follow-up of risks identified during physical health checks is low – for example, fewer than 1/3 of those with SMI having high cholesterol were followed up in primary care in 2021/22.	

Conclusions

Assessing the impact of initiatives put in place since 2016 to improve CVD outcomes is hampered by the impact of the COVID-19 pandemic on implementation, changes in access to primary care, the primary care workforce and data-capture, but there is evidence of measurable improvement in the quality of care for CVD in Thurrock since 2016. Given the impact of the pandemic, however, on widening inequalities, the case for improved identification and management of CVD is even more pressing.

The most recent Marmot review[5] stresses the need to re-focus on prevention in order to reduce the inequalities exacerbated by COVID-19. Given the high rates of smoking and obesity in Thurrock, increased identification and improved management of cardiovascular conditions will not alone address the inequalities currently associated with CVD in the borough; prioritising wider action to increase access to healthy foods, provide support for individuals to manage their weight, increase physical activity and reduce smoking is required. In addition, opportunities to identify those at increased risk of CVD, through NHS Health Checks and other case finding programmes, need to be targeted in areas of higher deprivation and for population groups with most to gain.

There have been some positive changes in primary care staffing since the 2016 report, but these are set against local and national concerns about ongoing workforce pressures, and Thurrock remains significantly under-doctored. The first IMWC to open has been in Corringham, where innovative practice in obesity can already be found. However, in Thurrock there is greater need in Tilbury & Chadwell and in ASOP, both in terms of constraints on primary care capacity and greater levels of patient need. These areas should therefore be prioritised for additional workforce capacity and adoption of new models of care, in order to avoid widening health inequalities further.

Despite the challenges of workforce pressures and the pandemic, there have already been improvements through initiatives implemented and developed since the 2016 report, notably the use of public health data to support practices, Stretch-QOF, and generation of additional workforce capacity with new roles in primary care.

Looking through the lens of CVD care, this report makes further recommendations on how holistic care activity could be directed to support different patient groups. The literature on changing models of care is clear that care for people with multiple needs requires to become more personalised, more coordinated and more collaborative if patients are to be engaged in optimising their health, and if both demand on the

system and health inequalities are to be reduced. This means, for example, that Stretch QOF needs to be more holistic, focused on patient outcomes overall rather than individual disease targets. However, a shift towards more collaborative, co-produced care requires fundamental shifts in culture, investment in staff (for example training) as well as time to embed. Achieving this at the same time as seeking to reduce variation between and within PCNs and manage workforce constraints is a significant challenge. Time, training and opportunities for co-production and shared reflection on cultural change, in addition to continued collaboration between public health and primary care to understand the data driving and measuring this work, are needed to support this shift.

Long Term Conditions covered in this report

- Hypertension (High blood pressure)
- Atrial fibrillation (a heart rhythm problem, characterised by a rapid, irregular heartbeat)
- Raised cholesterol (Coronary Heart Disease; CHD)
- Familial hypercholesterolaemia
- People who have had a stroke or TIA (transient ischaemic attack, also known as a mini-stroke)
- Diabetes – CVD related risk only (people with diabetes are at increased risk of CVD and a range of other complications)

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1. Introduction

The 2016 Annual Public Health Report for Thurrock[1] explored the sustainability of health and social care systems in Thurrock, with particular reference to Long Term Conditions (LTCs) amongst adult residents. The report, which was extensive, highlighted a number of issues including variable access to primary care across the Borough, differences in the quality of care between practices (affecting both the detection and management of LTCs), and associated impacts on patients, their health status and consequent hospital admissions. The report made a series of recommendations to increase the effectiveness and cost-effectiveness of care in Thurrock. These included:

- A new model for Primary Care to address under-doctoring (lower than average ratio of GPs to residents), especially in the Tilbury and Chadwell area
- Mechanisms to case-find and diagnose patients
- Recommendations to reduce avoidable demand on secondary (hospital and community specialist) care
- Support to improve the management of LTCs in primary care

Much has changed since 2016, both proactively in terms of national policy and local health developments, and reactively as a consequence of the COVID-19 pandemic. The 2016 report examined the identification and management of a wide range of LTCs and disease groups. This report, the 2022 Annual Public Health Report for Thurrock, considers progress in improving LTC care through the recommendations of that report by reviewing one of the LTC clusters outlined in the 2016 report: Cardiovascular Diseases (CVD). Of all the disease groups, CVD causes the highest levels of premature mortality and health inequalities, and detecting and treating CVD, in accordance with NICE guidance, has the greatest potential to reduce health inequalities and reduce premature mortality.

One in four premature deaths (death before the age of 75) in the UK are due to cardiovascular disease, and it is the leading clinical contributor to health inequalities. However, if risks are correctly

What is Cardiovascular Disease?

Cardiovascular disease (CVD) is a set of conditions that affect the heart or blood vessels. They include, most commonly:

- Coronary heart disease
- Heart attack
- Heart failure
- Stroke

People with certain Long Term Conditions (LTCs), including atrial fibrillation, high blood pressure, and raised cholesterol, are at higher risk of ill-health or death from CVD, but this is reduced if these conditions are identified and treated. The risk of developing these conditions increases with age, for people with a family history of heart disease, people with Diabetes, and for people from south Asian, Black African or African Caribbean backgrounds. However, healthy behaviours and effective treatment reduce the risk of acquiring these long-term conditions.

Reducing health risk behaviours– not smoking, maintaining a healthy weight and diet, being physically active, and moderate alcohol consumption – reduces the risk of developing these conditions in the first place.

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Why focus on CVD risks?

One in every 20 people with untreated high blood pressure will have a stroke in the next three years

One in every two people with untreated Atrial fibrillation will have a stroke in the next three years.

BUT

For every 1% increase in patients identified and registered as at risk, 65 strokes could be prevented over 3 years.

identified and managed, CVD is also the most preventable cause of premature mortality. As set out by the World Health Organisation (WHO), the key behavioural risk factors for CVD are smoking, unhealthy diet/obesity, lack of physical activity, and harmful use of alcohol, all risks which can be ameliorated with support and appropriate policies. The 2017 Global Burden of Disease study[6] found that whilst there have been reductions in smoking rates over the last 30 years, England is in the worst performing group of the 22 countries studied for levels of physical activity, Body Mass Index (BMI – an indicator of healthy weight) and diet.

After outlining the population of interest, this report first provides an overview of national and local contextual changes since 2016: those originating from national policy, and those arising due to the pandemic. It then briefly outlines the findings of the 2016 report relating to primary care workforce, and to prevalence and admissions due to CVD. Next it considers the impact of the 2016 report through summarising current data on CVD along with data on health inequalities in Thurrock, and initiatives on CVD put in place after the 2016 report. A literature review (presented here in summary but full text available) then sets out additional areas for potential improvement in the detection and management of CVD LTCs. The report concludes with a range of recommendations for building on the 2016 report and further improving CVD prevention and management locally.

2. Why Focus on Cardiovascular Disease?

With a rate of 74.5 per 100,000 residents, Thurrock has a higher rate of premature (ie under age 75) mortality from cardiovascular diseases than the East of England (62.9/100,000) and England (70.4/100,000) (PHE, 2017-19 data). In 2020, CVD accounted for 18.5% of deaths in Thurrock in 2020 and 13.8% of deaths in those aged under 75. CVD is also the most significant contributor to mortality attributable to socio-economic inequality in Thurrock, accounting for 35% of excess deaths[7].

However, much CVD is preventable, and as outlined below there are significant opportunities to save lives, improve quality of life for patients, and reduce health inequalities associated with poor CVD outcomes. The national ambition, set out in the NHS Long Term Plan in 2019 and further detailed by Public Health England[8], is to prevent 150,000 CVD events (in England) over the 10 years to 2029, through increased detection of risk factors and a higher quality approach to the management of CVD conditions. Locally, if the health of adult Thurrock residents were typical of that in the national population, this would translate to preventing 370 CVD events by 2029 (equivalent to 1.1% of non-elective CVD admissions per year). However, as rates of mortality and morbidity in Thurrock from CVD are already higher than nationally, this should be very much a minimum target.

Addressing CVD requires a multi-layered approach that can be best conceptualised as a pyramid (see Figure 1). At the base are universal actions also termed 'primary prevention' (e.g. local and national policies such as easy access to affordable fruit and vegetables), then actions that promote and sustain healthy behaviours (such as support to stop smoking). Further up the pyramid is increased activity to identify risk factors and early diagnosis of CVD LTCs, some of which needs to be targeted to groups or areas where prevalence is higher than average, and finally the smallest number of people require effective clinical management of LTCs and secondary prevention to prevent adverse outcomes. When opportunities for primary prevention are maximised, fewer people need complex and costly clinical intervention, as shown in the 2022 report from the Thurrock Integrated Care Alliance: Better Care Together Thurrock: The Case for Further Change[9]. That strategy (BCTT Strategy) includes analysis of the extent of avoidable admissions and associated costs from increased CVD prevention, and sets out in more detail the plan to transform and integrate adult health, care and third sector services across the district. This APHR report complements that BCTT report by focusing on the actions taken since 2016 to reduce the burden associated with CVD in Thurrock and the changes in healthcare since then, and the potential for further action, with the aim of reducing the health inequalities associated with CVD in Thurrock.

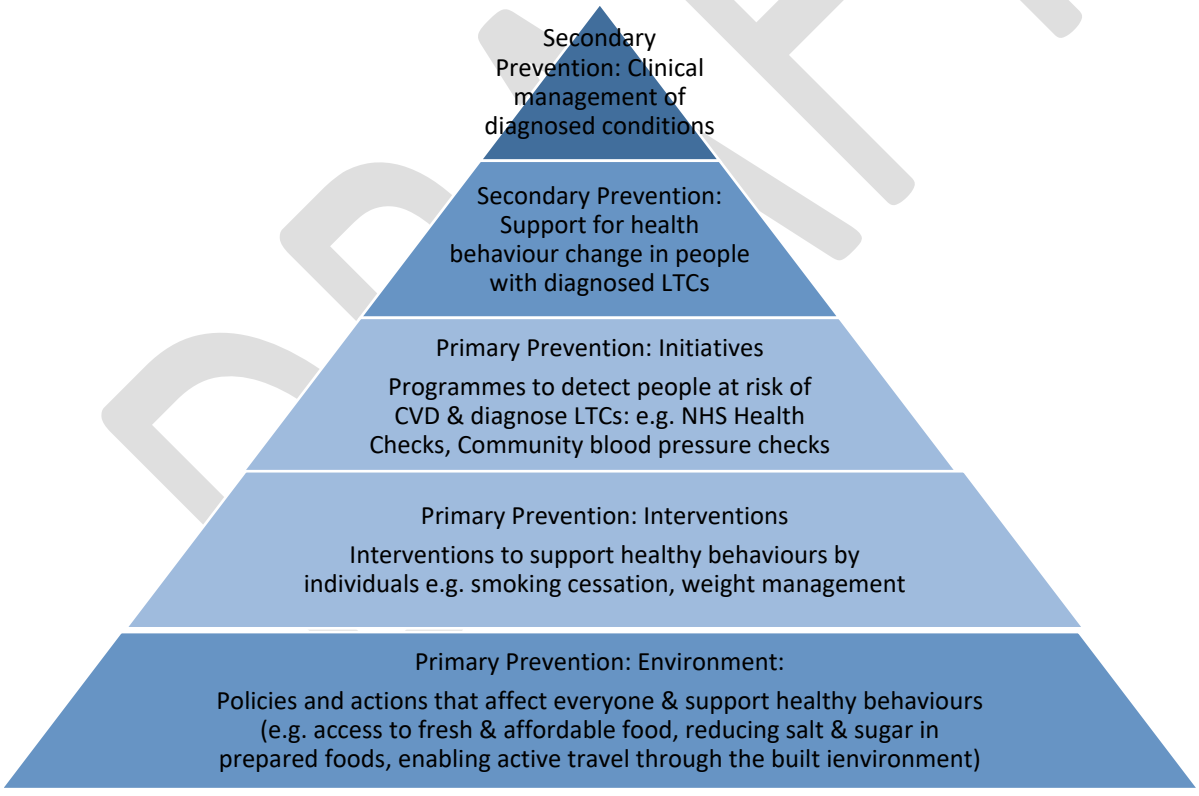

Figure 1: Actions required to reduce the impact of cardiovascular disease

Healthy behaviours are key to both preventing and reducing the risk of cardiovascular conditions (primary prevention), and to limiting the impact of diagnosed CVD conditions (part of secondary prevention). Moreover, risk factors for CVD, and prevalence of CVD conditions, are higher amongst people living in the most deprived areas where residents have poorer access to health care – a situation known as the Inverse Care Law. The 2016 report found evidence of this in Thurrock, with fewer available healthcare appointments per head than in the least deprived parts of the district. However, since then the former Thurrock CCG (whose functions have since July 2022 been subsumed by the Mid & South Essex Integrated Care System: MSE ICS) has taken action to address this by increasing the number of clinicians available in primary care (See section 5.6 for further information).

Figure 2 provides a schematic overview of the categories of patients who may benefit from a more systematic approach to CVD identification management. Patients most at risk of poor health outcomes, but with most to gain, are those with undiagnosed conditions (shown in in red), and those whose conditions are not adequately managed (shown in orange). Our analysis of hospital data in the 2016 APHR – refreshed for this report, is that these patients experience avoidable hospital admissions, along with those patients in the buff circle, whose condition/s are recorded in primary care but whose condition/s are poorly controlled (for example whose blood pressure is not at or below the NICE-recommended minimum levels), and those in the amber circle whose conditions are not only poorly managed but not recorded in primary care records. This focus on improved detection and treatment of risk factors aligns with the goal in the NHS Long Term Plan to prevent 150,000 CVD events nationally by 2029[10].

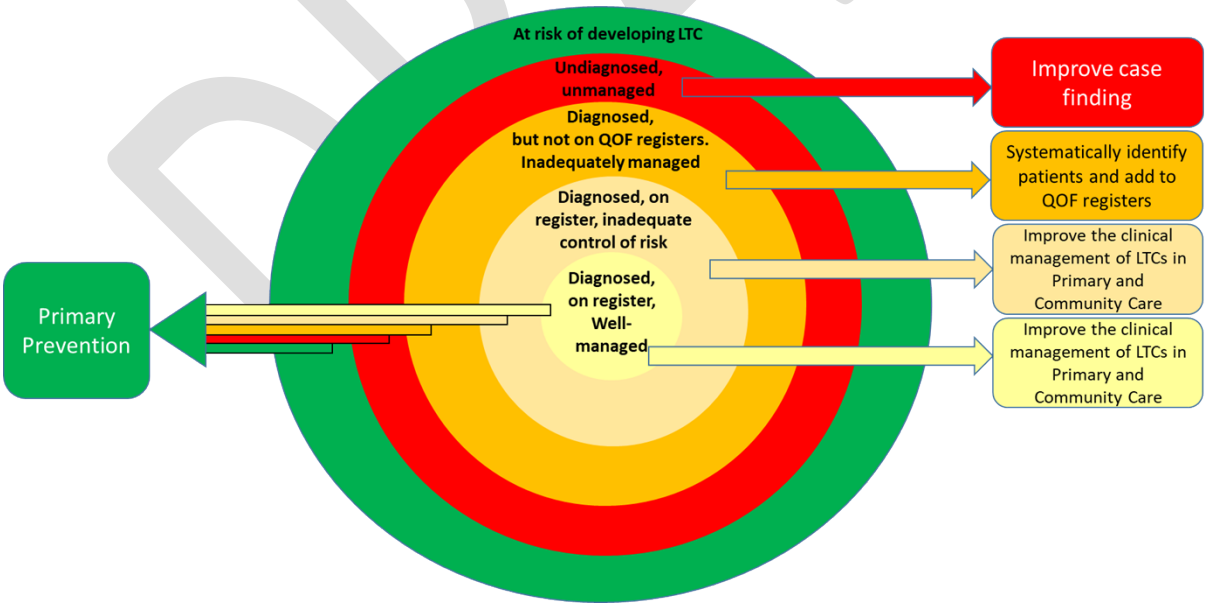

Figure 2: Segmentation of patient groups relating to CVD

Improving outcomes for patients with known or hitherto un-identified CVD risks not only benefits individuals, it also reduces pressures in both primary and secondary care. The majority of adults in Thurrock, as elsewhere, make very limited use of health services.

Analysis for the BCTT[9] has identified that in Thurrock, greater use of health care is associated with age and increased morbidities. In Thurrock, just 1% of the population, typically aged over 65 and with high levels of frailty and/or LTCs, account for 8.8% of the spend on A&E attendances and 26% of the spend on hospital admissions. Moreover, circulatory diseases (including CVD and diabetes) account for the highest proportion of hospital costs compared with other types of disease such as cancers: £5.23M in 2019-20. (This situation is not unique to Thurrock: evidence on healthcare utilisation in England suggests more than a quarter of the population accounts for more than half of all primary and secondary healthcare use[11].) As the 2016 APHR outlined, many of these admissions could be avoided with better identification and management of cardiovascular conditions, as well as through increased identification of those at risk, benefitting both residents and the local health system.

3. Context

3.1 National Policy Changes

Since 2016 there have been significant developments in national healthcare policy, with the publication of the NHS Long Term Plan [2] in January 2019. This acknowledges the challenges facing the health care system in relation to access, the workforce, increasing demand, joined-up care, quality of care and health inequalities, and outlines how these challenges may be addressed locally and nationally. Organisationally it has led to the creation of Integrated Care Systems, which bring together not just healthcare organisations (including hospital Trusts) but Local Authorities and the Voluntary & Community sector at sub-regional level. A system priority for the NHS Long Term Plan is digital transformation, though it should be noted that the pandemic has led to rapid developments in this area, arguably faster than would perhaps have been achieved otherwise.

The NHS Long Term Plan focuses on a number of clinical priorities, two of which are Cardiovascular Disease and Stroke, with the overall goal of preventing 150,000 strokes, heart attacks and dementia cases and reducing the inequalities associated with CVD by 2029. To achieve this, national objectives include:

Cardiovascular Plan

1. Improving the effectiveness of approaches such as the NHS Health Check
2. Supporting people with heart failure and heart valve disease to access increased testing including in primary care
3. Working with partner organisations to increase the number of people who know their AF, high blood pressure and high cholesterol (ABC) status
4. Increasing access to cardiac rehabilitation

5. Improving community first response and defibrillator access
6. Expanding access to testing for familial hypercholesterolaemia to increase identification from 7% to 25%

Stroke Plan

- Prevention through increased identification and support for ABC Increased access and quality of rehabilitation services (including working with partners such as the Stroke Association)

What is your ABC?

Knowing three things:

- If you have atrial fibrillation
- Your Blood pressure
- Your Cholesterol level

Building on these objectives, the National CVD Prevention System Leadership Forum[8] has determined a set of specific ambitions to reach the NHS LTP goal:

- Detection of atrial fibrillation to increase from 79% to 85% of those expected to have the condition; Management (those at high risk of stroke to be anticoagulated) to rise from 84% to 90%.
- Detection of hypertension cases to increase from 57% to 80% of those expected to have the condition; management (treated to target as per NICE) from 56% to 80%.
- Detection of raised cholesterol to increase from 49% to 75% of those expected to have the condition; management of high cholesterol from 35% to 45% (focused first on increasing initiation of statins to people with a ≥20% risk of developing CVD within 10 years).

The local implications of these targets are explored in section 5.4 below.

In order to meet its stated aims, the NHS Long-Term Plan signalled further development and diversity in the primary care workforce, with an expansion of roles in primary care. These include Paramedics, Pharmacists

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Does this report align with other strategies and plans for Thurrock?

Thurrock's Health & Wellbeing Strategy (2022-26) has recently been refreshed. With the vision "Levelling the Playing Field" it endorses a whole systems approach for addressing inter-generational health inequalities and variation in service access and outcomes. A statutory document (which must therefore be taken into account by Mid & South Essex ICS when planning health services locally), it covers 6 domains encompassing health outcomes and wider determinants of health. Priorities include creating the four Integrated Medical Centres (priority 3B), improvements in the identification and holistic management of LTCs (priority 1C) and primary prevention of chronic diseases through reducing smoking, obesity, lack of physical activity and substance misuse (priority 1A).

The Better Care Together Thurrock: Case for Further Change strategy sets out in more detail the plan to transform and integrate adult health, care and third sector services across the district. This strategy endorses the Human Learning Systems (HLS) approach, which recognises the dynamic nature of complex systems like healthcare. It describes how HLS principles, which include co-design and co-production, continuous learning and refinement, supported by quantitative and qualitative data, will be adopted and used to ensure that care is built around outcomes for individuals, not inputs.

Thurrock's Brighter Futures Strategy concerns the wellbeing of children & young people in the district.

(of particular relevance to people with LTCs to support adherence to medication) and Physician Associates (who provide diagnostics under the supervision of a GP, with the aim of freeing up clinical capacity and reducing GP workload). Other roles are more holistic, such as Social Prescribers, and aim to address specific wellbeing and social needs which impact health. Alongside these workforce developments, the Primary Care section of the NHS LTP aims to bring together mental and physical health, focusing on 'person' and 'place', with outpatient clinics brought to the community, and more community teams providing support in the home. This is to be achieved in part through the creation of Primary Care Networks (PCNs). These are informal organisations (i.e. not legal entities) that encourage collaboration between GP Practices, Dentists, Pharmacists and other healthcare providers including mental health.

3.2 Changes to Health & Care Services in Thurrock

Organisationally, Thurrock CCG is now one of four Alliances within Mid & South Essex Integrated Care System (formerly Mid & South Essex HCP), which, alongside Thurrock Health & Wellbeing Board and Thurrock Integrated Care Partnership, make strategic decisions about funding and commissioning of healthcare services.

Locally, GP practices have grouped into four PCNs:

- ASOP: 6 practices with c. 40,000 patients from Aveley, South Ockendon & Purfleet)
- Stanford-le-Hope & Corringham (SLH): 6 practices with c. 33,000 patients
- Tilbury and Chadwell: 5 practices with c.37,000 patients
- Grays: 10 practices with c.73,000 patients

Practices within PCNs are expected to collaborate to make best use of staffing and practice across the PCN and to work together to share good practice and address quality concerns. In 2021, Mid & South Essex HCP published a

new Primary Care Strategy which commits to supporting both the leadership and management within PCNs and the increased collaboration and integration between community services and primary care that the locality focus brought by the introduction of PCNs in the NHS Long Term Plan makes possible. An example is the Integrated Mental Health Team set up in ASOP in 2020, in which mental health specialist staff (employed by EPUT) work alongside primary care staff. This team provides support to people who need more specialist care than can be provided in primary care, but who do not meet the threshold for secondary care services; the team also supports people with severe mental illness to manage their physical health.

Even before the national and MSE strategies were introduced, Thurrock had already made progress in some of these areas. As outlined in chapter 2 of Thurrock CCG's Adult Place Based Strategy[12], Physician Associates and Paramedics were recruited in 2017 to address pressures and quality concerns in Tilbury & Chadwell PCN, and Thurrock CCG took responsibility for primary care planning locally. Thurrock Council had already brought in Local Area Coordinators, providing social support to individuals and communities – for example helping with entitlement to benefits, dealing with debt and money problems, and connecting people to volunteering schemes. The next steps are to build on this progress across all four PCNs locally.

3.3 The COVID-19 Pandemic

This report is concerned with CVD specifically, rather than the impact of the pandemic on the health of Thurrock residents overall. However, it is clear that some common general themes arising from the pandemic will have further exacerbated the gap between health demand and supply, including for the prevention and management of CVD, as follows:

- There have been changes to the way healthcare is provided, and to how patients access support, with growth in 'virtual' appointments; difficulties or perceived difficulties accessing healthcare during lockdowns; and increased waiting lists for secondary care which may in turn impact on demand for primary care. As an example, May 2020 saw the lowest number of primary care appointments provided (53,242) and within this, the lowest proportion of face-to-face appointments (52.5%) and home visits (< 10). It is important to note that whilst the increase in virtual appointments may be positive for many patients, many others are digitally excluded, which risks exacerbating health inequalities associated with age and deprivation. As of autumn 2021, 100% of Thurrock practices responding to the Practice Access Survey were open core hours. However only 42% were providing same day appointments face-to-face against a target of 100%. A fifth of clinicians were still working from home, limiting the availability of face-to-face appointments.

- There have been adverse effects on people's physical and mental health. These include worsening of health due to reduced (or perceived reductions in) access to health care, fear of contracting COVID-19 reducing help-seeking, capacity constraints leading to longer waits for treatment and elective surgery, and Long COVID. The pandemic is also likely to have had an adverse impact on the number of people with long term conditions managed to clinical targets, further widening the health

inequalities associated with CVD. Children are also affected, with NCMP data showing increased rates of obesity amongst children in reception class and year 6.

- In order to ensure that the COVID-19 vaccination programme could be rolled out as fast as possible, Government released General Practice from many of the requirements associated with QOF (primary care Quality Outcomes Framework[1]), firstly to manage capacity during the first part of the pandemic, then to release capacity for the COVID-19 vaccination programme. In practice, this has meant delays to the usual schedule of reviews for people with CVD conditions on the QOF disease registers. In addition, practices were twice directed to suspend locally commissioned services not related to COVID-19, affecting delivery of services such as NHS Health Checks.

- Finally, but significantly, the pressure of meeting the increased demand for healthcare at the same time as having to adapt practice or service delivery on an ongoing basis, has had an impact on the health and wellbeing of healthcare staff.

Most importantly, COVID-19 has exposed and worsened health inequalities. People living in more deprived areas, people with learning disabilities (LD) and people from Black, Asian and other minority ethnic groups have experienced higher mortality from COVID-19. This is related to a variety of factors such as housing conditions, but also in part to the severity and mortality of COVID-19 being increased amongst individuals with diagnosed CVD or risk factors. Research[13] has identified, for example, that amongst people admitted with COVID-19 before November 2020, hypertension was associated with 2.6x higher risk of severe COVID-19 and 2.5x higher odds of mortality, odds were highest for people with coronary heart disease (CHD; 3.6x higher mortality). Severe COVID-19 was associated with smoking and mortality with obesity (odds 1.8x higher and 2.2x higher respectively). (The research also identifies the incidence of acute cardiovascular events and cardiac complications that follow admission with COVID-19.)

The pandemic has also worsened and exposed structural inequalities associated with low income, insecure or low-paid employment, with associated increases in food and fuel poverty. Other factors which contribute to health inequity have also worsened including increased caring responsibilities and domestic abuse[14]. Some COVID-19 impacts are already evident – such as the increase in complexity of illness for patients who did not, or could not, access health care during lockdowns. Other impacts may be yet to emerge, particularly those relating to changing health behaviours, changed economic or family circumstances, and to Long COVID.

RECOMMENDATION: Refresh the focus on primary prevention of CVD post-COVID-19

[1] QOF (Quality Outcomes Framework) is a primary care incentive scheme set up in the mid 2000s to improve the quality of care. QOF targets focus attention on detection of patients with particular risks (e.g. smoking) and improved management of a wide range of long term conditions including those covered in this report.

4. The 2016 Report – a summary of issues relating to CVD

In the 2016 Annual Public Health Report for Thurrock, the authors set out a vision and plans for a sustainable adult and social care system in the Borough. The report outlined a number of challenges within health and care system, considering staffing issues, financial pressures on secondary care, increases in demand for emergency care and the impact of all these on the health of Thurrock residents with long term conditions (including but not restricted to CVD). The report presented a number of ways in which health and care could be improved for Thurrock residents whilst making financial efficiencies. These included a specific focus on the detection and management of long-term conditions including CVD.

4.1 Primary Care Workforce

One of the areas explored in the 2016 report was access to appointments in primary care. In common with many parts of the country, Thurrock experiences 'under-doctoring'- a lower ratio of clinicians to residents than average. Across Thurrock and the UK as a whole, there are variations in the ratio of patients to clinicians, a situation which is often exacerbated in the most deprived areas (an example of the inverse care law in action)[15]. It is important to note that this is not a reflection on individual practices, but a result of the way in which primary care has traditionally been funded, as well as a consequence of staffing pressures resulting from the age profile of GPs and Thurrock's proximity to London. In 2016, Thurrock was the 4th most 'under-doctored' CCG in England, with 2110 patients to every full-time equivalent GP compared with the England average (mean) of 1321, with the practice under most pressure having a ratio over five times that of England. In addition, all but five Thurrock practices in 2016 had a lower ratio of nurses than the England average. As the 2016 report makes clear, the ratio of doctors to patients is not the only factor affecting the availability of appointments. Nonetheless, as the 2016 Thurrock report outlines, difficulty accessing appointments in primary care is associated with increased hospital admission for CHD and Heart Failure, and under-capacity in primary care has impacts not just on patient care but also increases otherwise avoidable clinical exacerbations resulting in pressure elsewhere in the health system. As an example, it was estimated in the 2016 report that every 1% increase in availability of GP appointments would lead to a reduction of 109 emergency admissions for heart failure.

4.2. Prevalence and Management of CVD in Thurrock in 2016

Public Health England (PHE) used a range of data to predict the prevalence rates of long-term conditions at General Practice, and now PCN, level. These could then be compared with the diagnosed rates reported through the QOF framework.

Analysis of QOF data in 2016 (comparing individual practice data from 2014-15 with 2016 PHE estimates) found significant gaps between the reported numbers of patients on disease registers for hypertension, stroke/TIA and CHD and the numbers that would be expected using PHE prevalence estimates (these take into account demographical variations between practices and PCNs). For example, in 2016 hypertension registers were on average 68% complete versus expected prevalence, with significant variation between

practices. Table 1, from the 2016 Report[16], shows the recorded and expected prevalence for certain conditions (the original table included COPD), and the estimated number of patients yet to be diagnosed.

Long Term Condition	Recorded Prevalence (i.e. people already diagnosed)	Estimated Prevalence	Additional Number of Undiagnosed Patients based on the estimated prevalence
Stroke (2016)	1.51%	3.70%	3,540
Hypertension (2016)	14.08%	20.95%	10,983
CHD (2016)	2.78%	7.58%	7,521
Diabetes (2016)	6.3% (17+)	7.9% (16+)	2,109

Table 1: Estimated gap between expected and recorded prevalence of CVD conditions (adapted from the 2016 APHR)

Analysis of QOF data for the 2016 report also suggested concerns around the management and quality of care for many patients diagnosed with CVD conditions. There were significant gaps recorded for the number of patients treated to NICE-recommended clinical thresholds. For example, the number of patients diagnosed with atrial fibrillation with a CHA2DS2-VASc score >1 but not prescribed (or exception-reported) an anti-coagulant was 247. This is significant because 50% of these patients were estimated to be at risk of having a stroke within 3 years.

4.3 Recommendations of the 2016 Report Relating to CVD

The 2016 APHR calculated the number of hospital admissions and A&E attendances that might be avoidable, if Thurrock patients were diagnosed and treated to target, and the potential cost-savings associated with the reduction in admissions, leading to the following recommendations:

- Further investigation of the GP practices with the highest rates of admission for 'ambulatory care sensitive' conditions (angina, congestive heart failure and diabetes), with the implementation of a practice scorecard and facilitating the sharing of best practice.
- Redesign and procurement of a healthy lifestyle service with a focus on those patients with LTCs
- Support for a whole system approach to reduce obesity prevalence
- Implementation of a hypertension case-finding and Clinical Management Improvement Programme
- Treat more heart failure patients with effective medication, with support from the Public Health team via further analyses and the creation of bespoke SystmOne reports.
- Support more patients with effective blood pressure control (e.g. as above)
- Significantly increase primary/community care capacity in Thurrock including better skills mix of staff with GP surgeries
- Expediate building the four Integrated Healthy Living Centres (now Integrated Medical & Wellbeing Centres) in Purfleet, Tilbury & Chadwell, Grays and SLH

DRAFT

5. Thurrock in 2022

5.1 Health Inequalities in Thurrock, 2022

There is variation in health outcomes across Thurrock and between Thurrock and neighbouring areas, driven by broad and complex factors. Health inequalities between populations manifest as differences in life expectancy. In 2020, life expectancy was significantly lower in Thurrock than average across England for both men (78.3 years vs 79.4 years) and women (82.6 years vs 83.1 years), and the lowest in MSE ICS (see Figure 3)

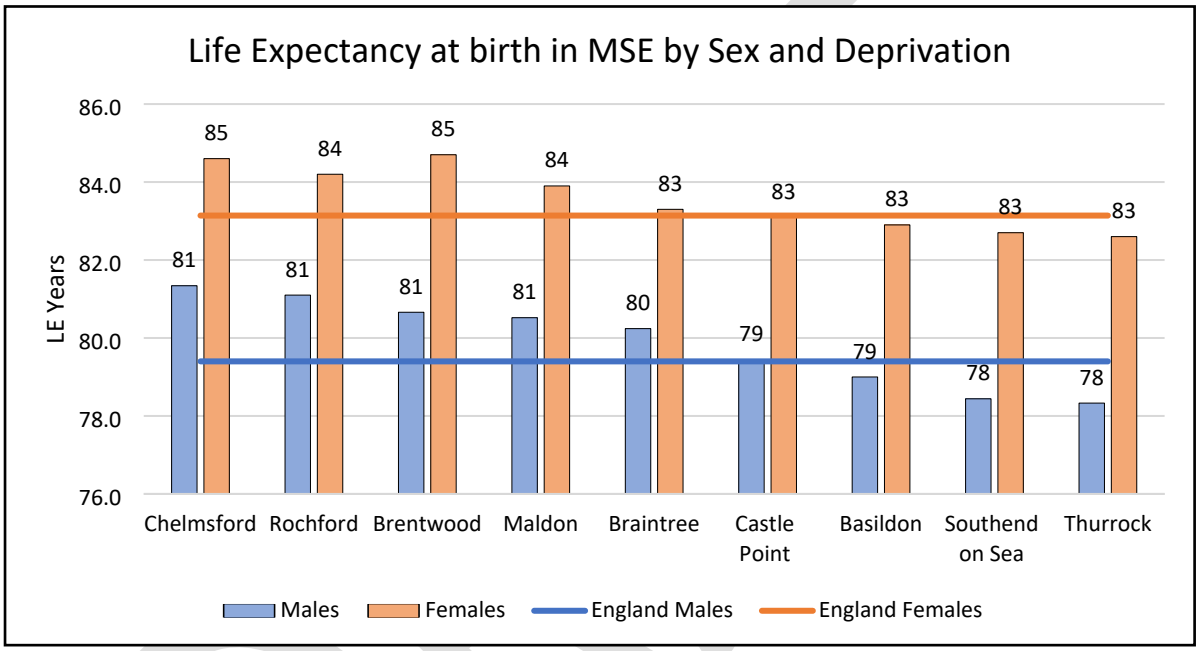


Figure 3 – Life expectancy at birth in MSE ICS at district level (ONS, 2020; Fingertips)

Healthy Life Expectancy (HLE) is how long an individual can expect to live in good health. Variation in HLE is a measure of the health inequity that exists within and between populations. HLE in Thurrock is 63 years for males and 61 years for females, but this hides considerable variation within the local community. Individuals in the least deprived parts of Thurrock can expect to live between 6.4 to 8.7 years longer than those in the most deprived areas. In terms of HLE, people in the most affluent areas of Thurrock experience 8 years more healthy life than those in the most deprived, with women in the most deprived areas experiencing 22 years in poor health.

In terms of socio-economic inequality, Thurrock has a larger proportion of its population clustered around the England average deprivation level than is typical for the country as a whole: around 11% of the Thurrock population live in the 20% least deprived areas nationally, and around 11% live in the 20% most deprived[3]. Overall, local data show that the local authority district of Thurrock has the 3rd worst mortality rate attributable to socioeconomic inequality in Mid & South Essex, with circulatory conditions being the greatest clinical driver[3]. Detailed information about the impact of socio-economic inequality on health in Thurrock can be found in the Thurrock Health & Wellbeing Strategy 2022-26[17].

Figure 4 shows the populations covered by the four PCNs in Thurrock, and their relative deprivation, clearly showing the difference in area-level deprivation for Tilbury & Chadwell and ASOP patients, and those in SLH and Grays.

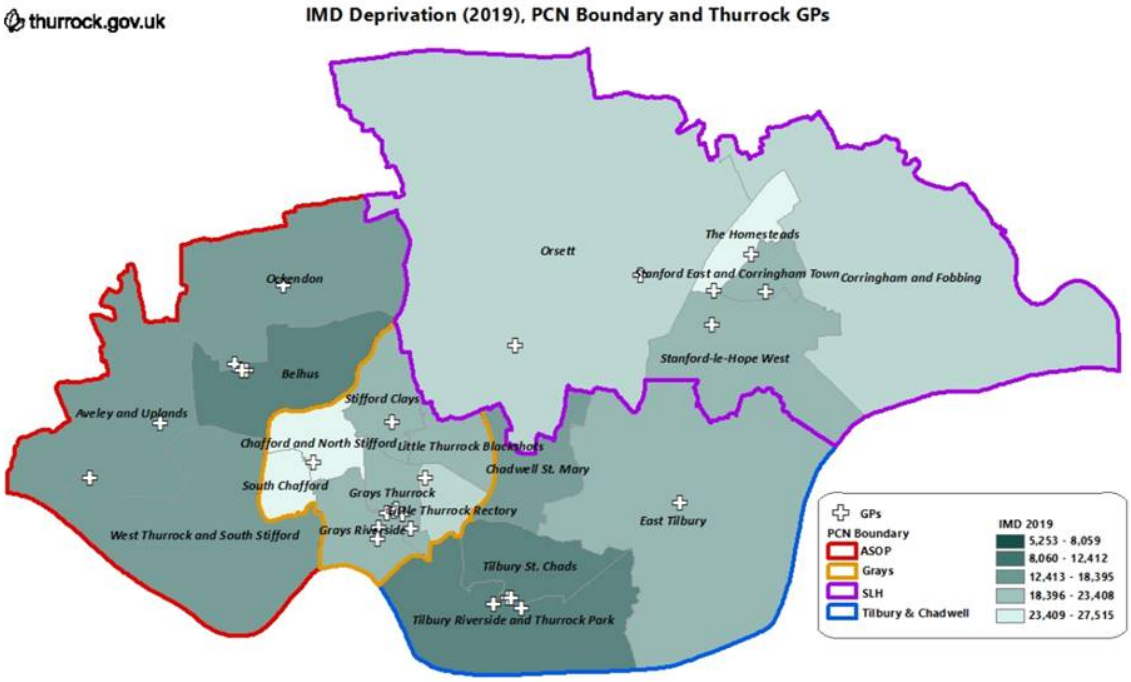


Figure 4: Map of Thurrock District, showing PCN boundaries and IMD 2019 scores. A higher IMD score indicates a higher level of deprivation.

5.2 Prevalence and Management of CVD Risks in Thurrock in 2022

As noted above, QOF reporting found under-diagnosis of CVD and variation in care quality across Thurrock practices in 2016; addressing this variation in quality between practices was a key reason for implementing the initiatives outlined above. The key question, therefore, is what difference this focus and activity has made to the detection and management of CVD conditions in Thurrock. For methodological reasons (including the fact that the earlier report analysed data by practice, but data are now presented by PCN, and the impact of COVID-19 on QOF data collection) direct comparisons are not made with the data in the 2016 report. Available data are used to assess trends, and to explore the situation now for three key areas of focus in the national CVD plan: hypertension, atrial fibrillation and familial hypercholesteremia.

5.3 Prevalence of CVD Conditions

Figure 5 below shows recorded prevalence of diagnosed CVD conditions across the four PCNs for the last period with full QOF data (2019/20 as reporting was paused for some indicators during the COVID-19 pandemic). Given the higher levels of socio-economic deprivation in the areas covered by the ASOP

practices compared to Grays or SLH, true prevalence of CVD LTCs would be expected to be higher. As the comparison in Table 2 shows, the gap between estimated and recorded cases is highest in ASOP, representing a higher proportion of residents undiagnosed and untreated.

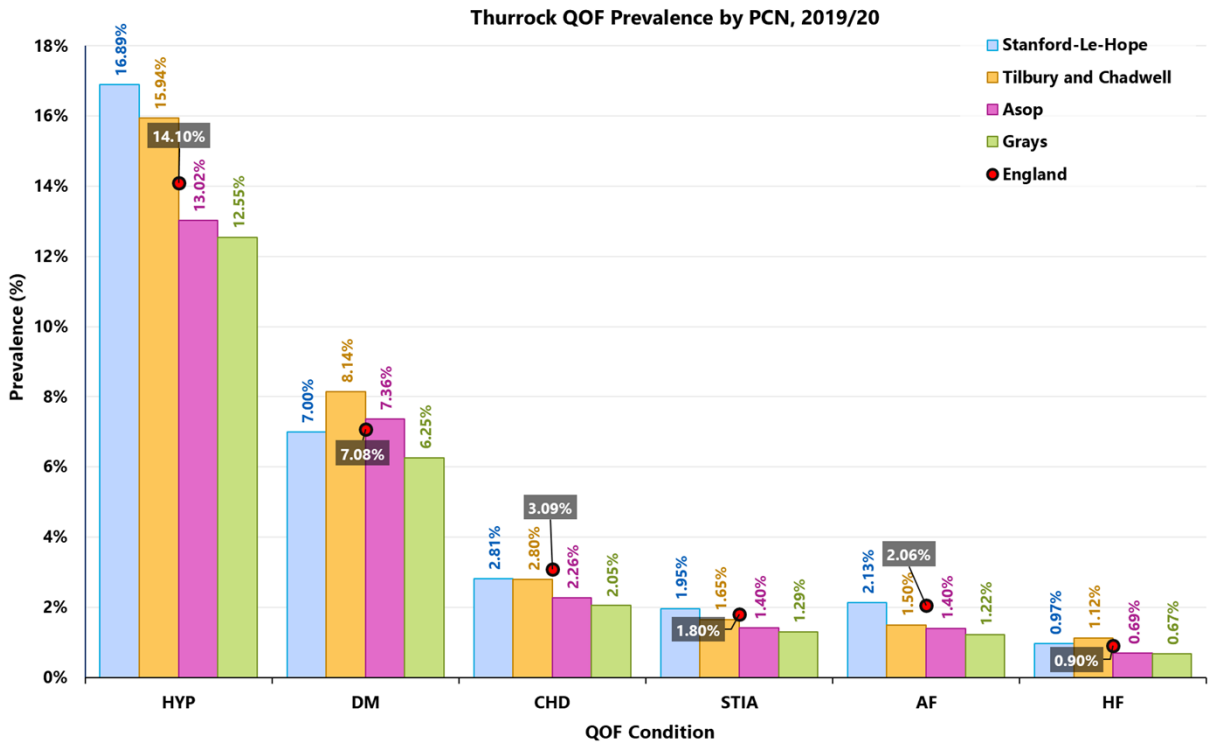


Figure 5: Prevalence of CVD long term conditions by PCN (2019/20 data, the latest available)

PCN	PHE Estimated Prevalence	Recorded PCN Prevalence 19/20
ASOP	20.20%	13.02%
Grays	18.95%	12.55%
SLH	22.32%	16.89%
Tilbury and Chadwell	21.80%	15.95%

Table 2: Estimated Hypertension prevalence by Thurrock PCN (Source PHE)

In all four PCNs, hypertension is the CVD condition with highest recorded prevalence locally. It is also the most common risk condition for CVD mortality and morbidity in England, the most common morbidity across all LTCs amongst patients on primary care disease registers[11], and significantly associated with health

inequalities. However, many residents have more than one CVD condition (with or without other LTCs). Figure 6 provides an illustration of the overlap between CVD conditions.

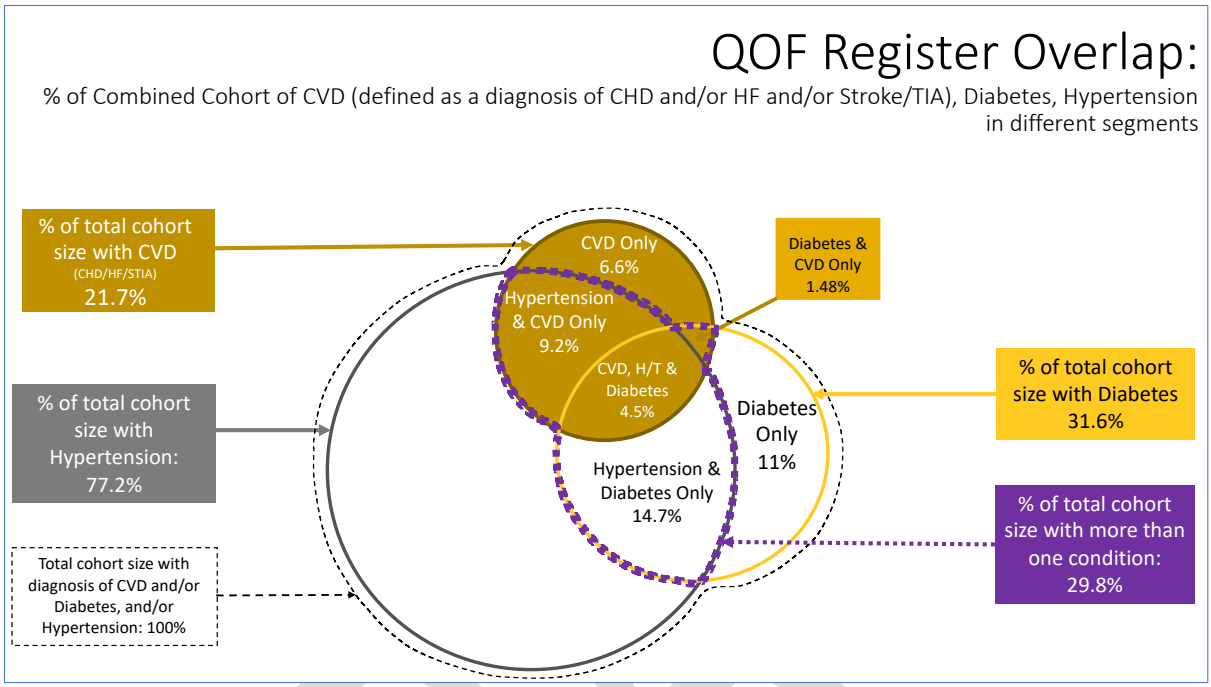


Figure 6: Overlap of recorded CVD conditions for patients on primary care registers

The more conditions a person lives with, the more frequent appointments and interactions they have with health professionals. However, initiatives implemented to improve prevention and management of CVD can lead to improvements for other disease groups (and especially for individuals with multiple LTCs) and inform actions to be taken across health and wellbeing services. In Thurrock, the highest rate of multi-morbidities is found in Tilbury & Chadwell PCN, consistent with higher socio-economic deprivation levels, with 45% of patients on a register having more than one LTC. Using the number of LTCs to signify complexity of health care need, table 3 shows the relative complexity of need in each PCN.

PCN	% of LTC individuals with more than 1	% of LTC individuals with more than 2
Grays PCN	40%	14%
Tilbury and Chadwell PCN	45%	17%
ASOP PCN	39%	14%
Stanford-Le-Hope PCN	42%	15%
Total	41%	15%

Table 3: Patients with multiple Long Term Conditions in Thurrock PCNs

5.4 Measures of quality in the diagnosis and treatment of CVD conditions

PHE calculations show that the expected number of patients on primary care registers by April 2020 increased due to the increase in population. As in 2016, there are gaps between reported and expected prevalence for CVD conditions, as shown in Figure 7.

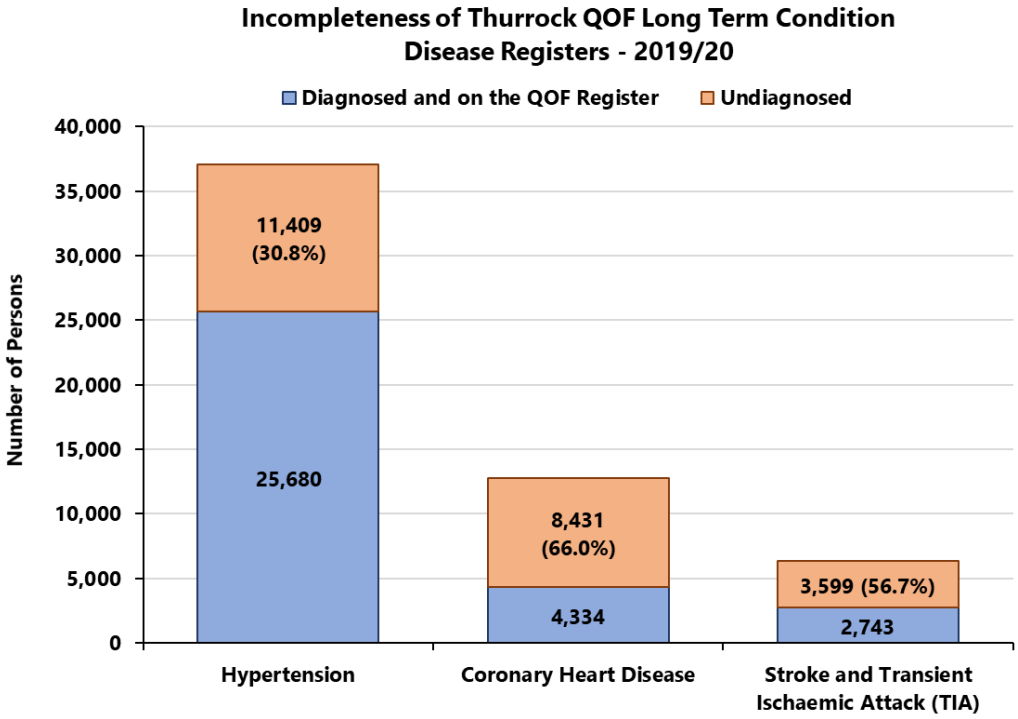


Figure 7: Difference between actual and expected numbers of patients recorded on primary care CVD registers

Further analysis, using 2019/20 data on hospital admissions data and QOF registers has suggested that some patients admitted to hospital due to a LTC or with stroke/TIA were not subsequently added to the relevant register in their practice. This is important because the purpose of primary care registers is to ensure patients with known CVD risks receive the correct treatment, and the analysis suggests an opportunity to improve clinical management for these patients.

Once patients are listed on QOF registers, practices are required each year to treat a set percentage of them to NICE-identified clinical treatment targets in order to attract payment. As with case-finding, there are gaps between the number of people recorded on QOF registers, and the number or percentage of those who are treated to target. Comparison with Thurrock's CIPFA neighbours (areas with similar demographics to Thurrock) does suggest that there are individual indicators where all the CIPFA neighbours struggle to reach target, for example two concerning blood pressure measurement (HYP007 and STIA010), others where most (including Thurrock) succeed, and a limited number where there may be some potential to close the treat to target gap, as for instance with the atrial fibrillation target shown in Figure 8.

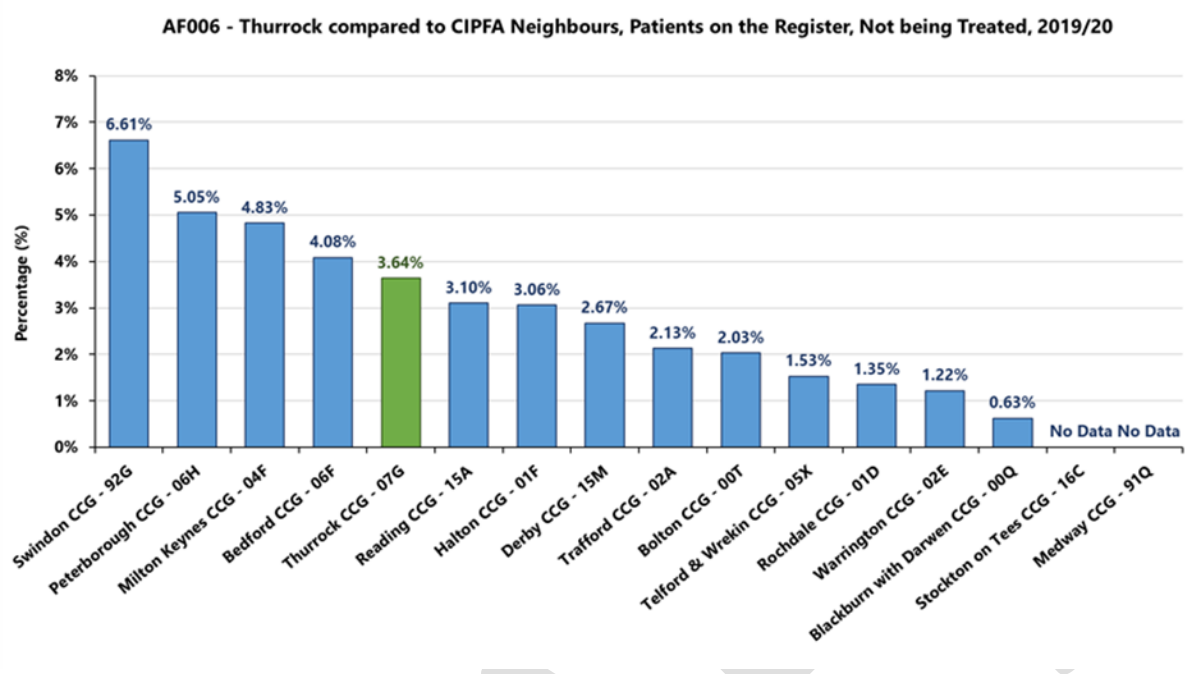


Figure 8: Comparison of Thurrock with similar authorities for the percentage of patients with atrial fibrillation not assessed using the CHA_2DS_2-VASc score

In general, quality of care for those on CVD primary care registers, as measured by QOF, is high and compares favourably to England averages and CIPFA neighbours (see below). This suggests that further improvements in population health are likely to be gained by a focus on reducing the gaps in diagnosis in particular.

Hypertension

Since 2016/17, diagnosis of hypertension has (with the exception of 2020/21, which was likely affected by COVID-19 restrictions) increased annually from 1,321 in 2016/17 to 2,567 in 2021/22. Attribution to individual elements of interventions to increase hypertension case-finding is unclear, but the combined result of measures implemented overall are positive. This is, however, balanced by individuals who leave the register, due either to the higher rates of CVD mortality in Thurrock or to resident mobility out of the area. Adjusting for population increase, this has resulted in a relatively constant estimated register completeness of between 67.6% and 70.0% in the period 2016/17 to 2020/21. Within Thurrock there is some variation present, with the highest underdiagnosis rate in ASOP, and the lowest in SLH.

Without these initiatives, it is likely that the percentage register completeness would have fallen. Population Health Management data shows that in 2019/20, the estimated completeness of hypertension registers was higher in Thurrock than in the other areas of MSE, suggesting that Stretch QOF and detection efforts applied in Thurrock have had an impact on clinical practice, despite the constraints of the pandemic.

There is a national target to reduce the current gap to 20% by 2029. This would require a further increase in case finding of around 650 individuals per year (over and above the 2,567 currently identified annually).

Data from 2020/21 reveals inequalities in blood pressure testing in primary care by age in particular (younger age bands being much less likely to be checked), with some inequality also persisting by sex and ethnicity, but not by deprivation[12]. Analyses also show an inequality in under-diagnosing in certain ethnic groups.

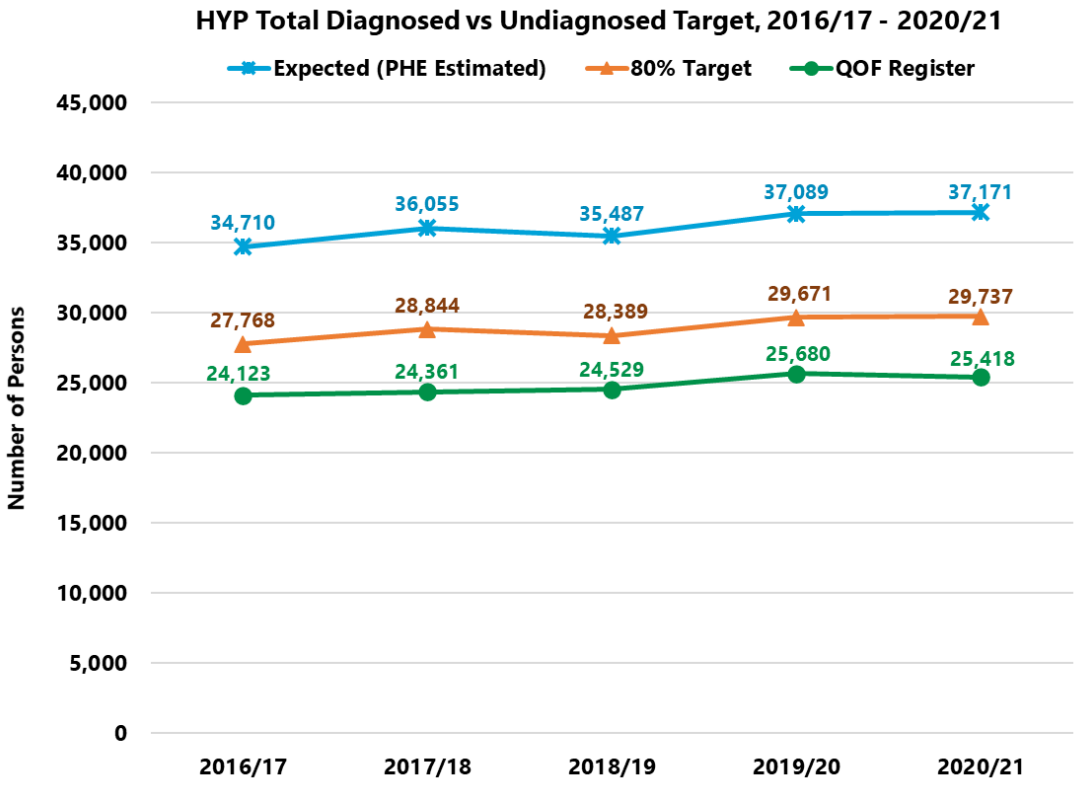


Figure 9: Increases in diagnosed cases of Hypertension between 2016-17 and 2021-2022

For treatment to hypertension targets (a measure of quality of clinical care), all four Thurrock PCNs are working beyond the national target for those aged over 80 (HYP007), and close to target for those under 80 (HYP003), as shown in Figure 10 below. All PCNs are performing better on treatment to target than average for England for both age groups. Similarly, QOF treatment to target indicators were also higher in 2020/21 in Thurrock than other areas of MSE, again suggesting that the combined initiatives in Thurrock have had a positive impact on clinical care.

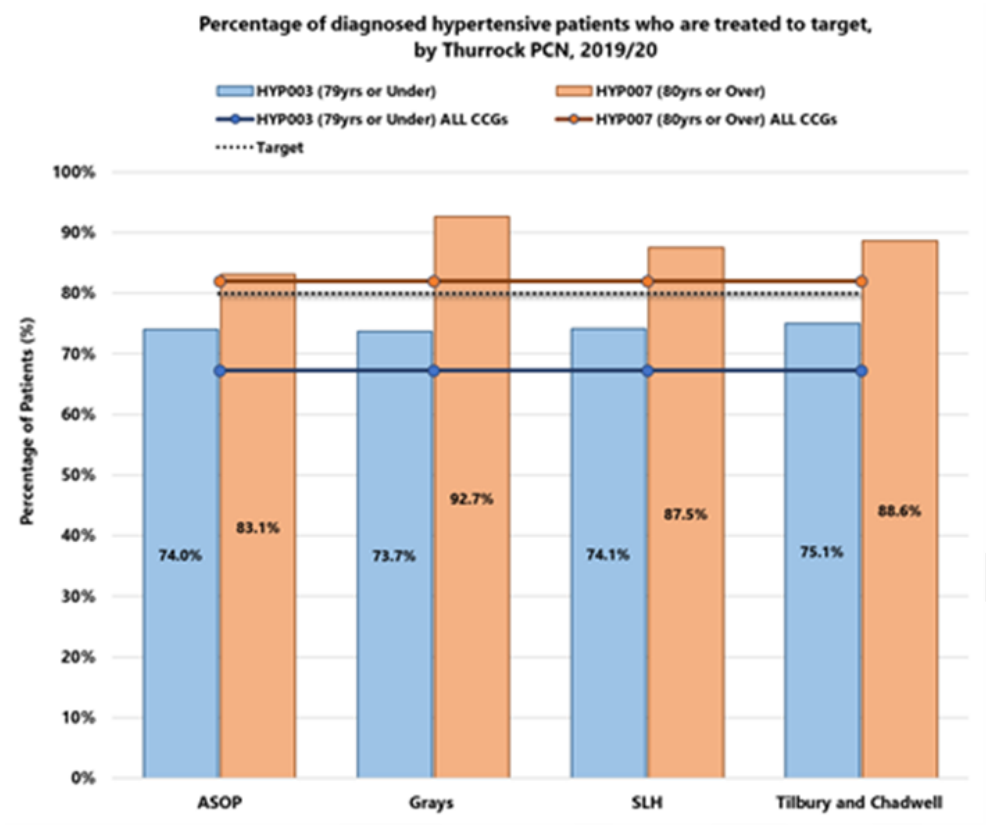


Figure 10 Thurrock patients on the hypertension register being treated to target

Coronary Heart Disease and Hypercholesterolaemia

Total blood cholesterol is an important predictor of CVD events, particularly coronary heart disease. QOF registers for CHD include patients prescribed statins for atherosclerosis, and the national ambition is that 45% of adults aged 40-74 identified as having a significant risk of CHD are treated with statins. In Thurrock in 2016, 36.7% of the estimated prevalence of CHD was diagnosed. Unlike for hypertension, data from 2021/22 suggests that diagnosed prevalence has decreased to 30.7% with an estimated 9,615 residents having undiagnosed CHD. Whilst some of this decrease in detection rate is associated with increase in population, it is likely that factors related to COVID-19 (including access to primary care and the suspension of some QOF measures) will have had an adverse effect in this area.

For those who are on the CHD register, measures of therapeutic treatment and blood pressure management (QOF CHD005, 008, 009; 2019/20) show that Thurrock performs better than average for England and compares favourably to CIPFA neighbours, being the best performer in the group for blood pressure management in CHD.

Around 100 more Thurrock patients with familial hypercholesterolaemia have been identified since the 2016 report. The national target (25% of predicted prevalence range to be detected by 2024), applied to Thurrock is for 225 patients (at the upper end of the predicted range) with the condition to be identified. This target

has already been exceeded. It is important to note that around 50% of men and 30% women with this condition will develop heart disease before the age of 55 so early detection through NHS Health Checks and practice screening could have significant impact on both morbidity and premature mortality.

Atrial fibrillation

One of the concerns in the 2016 report regarding the detection and treatment of atrial fibrillation was the number of patients known assessed as at risk (using CHA2DS2-VASc) but not being treated with anti-coagulants (AF006). The number in 2016 was 247 patients, assessment using 2019/20 data finds that this has reduced, with 182 patients yet to be treated (out of 2,230, allowing for the number locally exempted due to personalised care adjustments). Thurrock is thus already exceeding the national target of 90% in this area and has made improvements in treatment since the 2016 report.

The other national plan target relating to atrial fibrillation is detecting 85% of predicted prevalence. Analysis of local data from 2019-20 suggests that 77% have been identified (are recorded on registers) so far, and around 260 cases are yet to be detected to reach the 85% target.

5.5 Inequalities and CVD

Nationally, premature mortality for all causes (deaths under 75 years) correlates with increasing deprivation, a pattern also found in premature mortality from CVD specifically. Analysis of local data shows that Thurrock has the highest level of premature mortality in MSE ICS, with CVD being the largest underlying clinical cause. For mortality attributable to socio-economic inequality, CVD is the greatest contributor in Thurrock, accounting for 35% of excess deaths[12].

Whilst this report primarily concerns CVD, it is important to note the high health inequalities and lower life expectancy due to CVD associated with serious mental illness (SMI) such as schizophrenia or bipolar disorder, and the often complex interactions for those with multiple physical and mental morbidities[11]. For people with SMI, increased prevalence of smoking, diabetes and obesity contribute to increased risk of CVD and a three-fold excess death rate from CVD in those aged under 75 compared with the general population[18]. In Thurrock, this appears to be particularly acute, with the borough having the second highest premature mortality rate in England due to CVD in people living with SMI in 2018-20[19].

In addition, whilst rates of smoking and drinking are lower for people with learning disabilities than for the general population, other risks – notably poor diet, high rates of obesity, and low levels of physical activity – are higher [2] and heart disease is the second highest cause of death amongst people with a learning disability.

Inequalities exist not just in CVD rates and outcomes between different community groups, but also in CVD diagnosis and quality of care. Primary care data extracted by the Public Health team in 2022 shows that for all CVD conditions, the diagnosis rate in Thurrock for all non-White ethnic groups is lower than for White

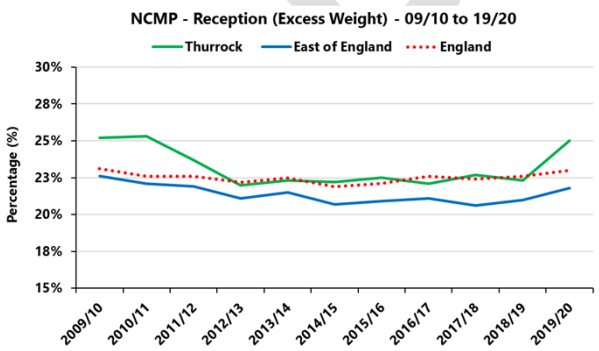
groups, despite the higher prevalence of CVD among certain minority ethnic groups, particularly South Asian and Black Caribbean communities, compared to the general population[20].

5.6 Health Behaviours and Health Inequalities

The behavioural risk factors for CVD are more prevalent in areas of higher deprivation and amongst certain population groups. People living in the most deprived areas of England are known to be 30% more likely to have high blood pressure, and four times more likely to die prematurely from CVD than those in the least deprived areas (pre-COVID).[8] The Global Burden of Disease study identifies that in 2019, tobacco use, high blood pressure and a variety of dietary risks are the greatest cross cutting health risk factors in Thurrock[21]. These are the factors that will have the greatest impact on population health and health inequalities as well as health and social care demand in future. Smoking and obesity are key modifiable risk factors for CVD that are strongly correlated with deprivation. This is borne out locally; estimates from PHE suggest smoking rates are highest in Tilbury & Chadwell PCN (22.0%) and lowest in Grays (16.6%), and at 17.5%, overall smoking prevalence in Thurrock in 2020 is significantly higher than both the England (13.7%) and Essex (13.2%)

averages. In 2022, primary care records indicated that 18.2% of adults in Thurrock were smokers. Rates of adult obesity are also higher, at 69.4% for Thurrock compared with 62.3% for the East of England. QOF data show variations between PCNs for obesity; again this shows the rate as lowest in Grays (9.5%). The highest rate is reported in SLH (11.8%), though this may be an anomaly due to higher quality of QOF reporting; rates in Tilbury & Chadwell and ASOP are both over 10%.

Rates of childhood obesity have also increased. The National Childhood Measurement Programme (NCMP) measures children's weight in reception and year 6. Due to the pandemic, data for 2020-21 is not yet available, but as shown in figure 11, rates of childhood obesity in Thurrock have been consistently higher for Year 6 children than either national or East of England for several years and show a sharp increase for reception children.



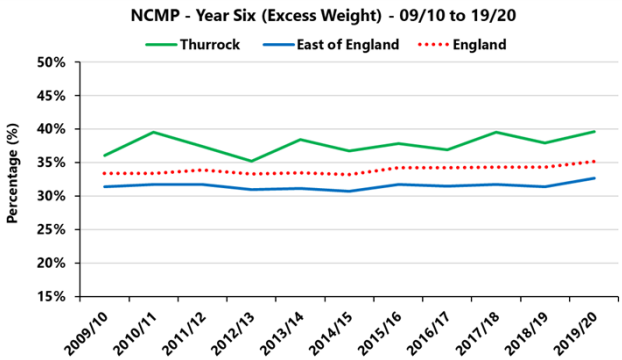


Figure 11: Childhood Obesity in Thurrock (NCMP data)

5.7 NHS Health Checks

Local Authorities are required to commission or provide NHS Health Checks as part of the national programme, which is the only mandated population-level provision for primary prevention, promotion of healthy behaviours, and identification of CVD risks. In Thurrock, NHS Health Checks are provided partly in general practice and partly by the Thurrock Healthy Lifestyles Service (THLS). (Checks are offered every five years to people aged between 40-74 who are not already on CVD registers but may have other LTCs such as asthma). Where CVD risk is found to be high, residents are given lifestyle advice, and referred to their GP for follow-up and clinical management as required (for example prescribing for hypertension or high cholesterol, or referral to the NHS pre-diabetes programme).

Local data, see figure 12 below, shows that of 22,132 health check invites sent in the five years 2016/17-2020/21, 14,016 health checks were conducted (based on 2022 GP registers).

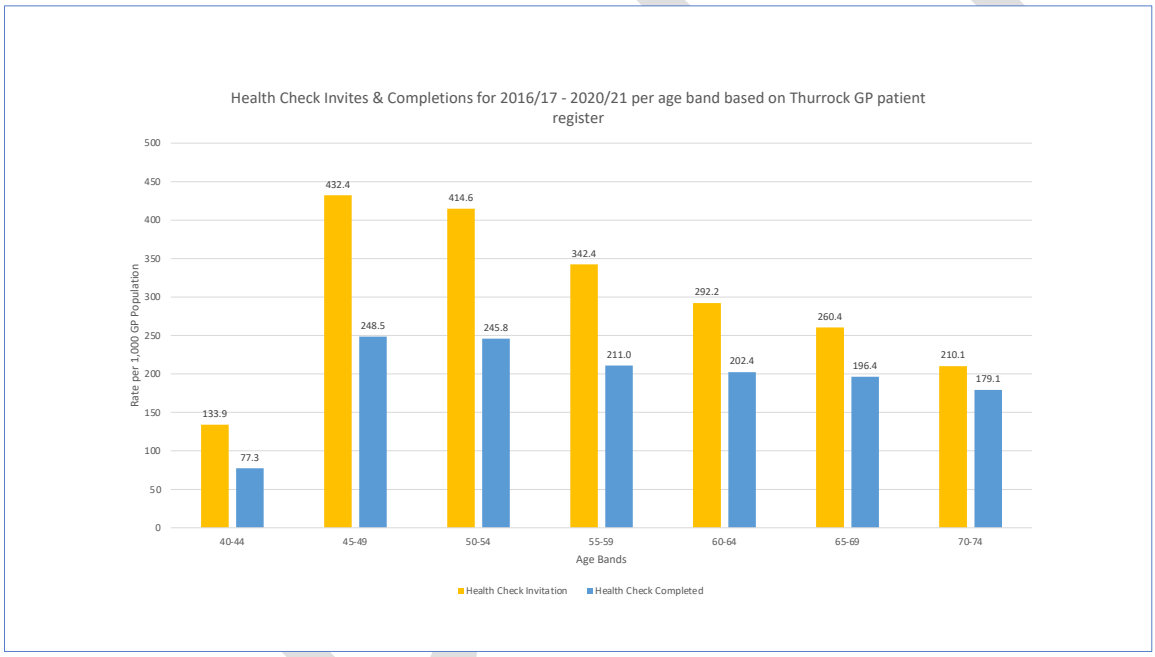


Figure 12 Invitations and Uptake of NHS Health Checks by eligible age band, Thurrock 2016-2021

Completed checks are higher amongst the older age groups, suggesting higher levels of engagement amongst older eligible residents. However, increasing engagement with younger age groups would enable more people to be supported to make changes at an earlier age, with potentially more impact on CVD in the long term.

Nationally, evidence (see summary literature review in section 9 below) suggests that the NHS Health Checks programme needs to be more targeted in order to increase uptake in those with most to benefit – which includes people living in more deprived areas and/or those from BME groups at the younger age limit – in

order to contribute to a reduction in health inequalities. Currently, follow-up for those people identified as having higher CVD risk (for example requiring statins or blood pressure management) is dependent on individuals making contact themselves with their GP practice – a potential barrier.

RECOMMENDATION: Target NHS Health Checks for people at the younger age limit, in groups known to be at higher and earlier CVD risk. This includes those in certain minority ethnic groups, smokers and people on obesity registers, as well as residents in areas of higher deprivation.

5.8 Serious Mental Illness and Learning Disability Health Checks

Patients with a diagnosis of SMI or who have an LD should receive an annual health check covering various aspects of their physical health. Both of these checks differ to the NHS Health Check in that they are completed by different professionals (the PCN Mental Health Practitioners complete the SMI Health Checks and the LD nurses complete the LD Health Checks), and performance/uptake statistics are reported separately. Improving outcomes for people with SMI and LD is a shared responsibility; the checks are commissioned to ensure that the specific needs of these patient groups are identified and can be followed up in primary care and by other appropriate services.

In the case of the SMI Health Checks, there are a number of mandatory components (six), which must all be completed within the 12 month period in order to count as a complete check; along with a number of other components that, whilst they are not mandatory, they are recommended. Performance for the SMI Health Checks has traditionally been viewed as successful in that overall uptake of the check has increased, now 56%, close to the national target of 60% uptake; but less focus has been given to the follow up elements – i.e. the onward referrals/care that is given when a need is identified. This is particularly important for SMI patients, who already suffer from poorer cardiovascular health and subsequently have high rates of premature mortality due to cardiovascular health problems. Analysis of local data from 2021/22 has indicated that, for example, whilst the majority of SMI patients had their BMI recorded and a discussion logged about their weight, a low proportion of them had a record of onward support or advice (only 345/787 or 44% in 2018-20), and this is corroborated by low numbers of referrals received by weight management services following on from these checks. Similarly, out of 1,242 SMI patients eligible for blood lipid (cholesterol) interventions, only 383 had a follow up offer recorded (31%). This therefore could mean that preventative opportunities for early intervention are being missed in this higher risk group. Even within the SMI cohort, there are certain groups who are even less likely to have had the full checks completed, nor the onward interventions undertaken. The MSE ICS Population Health Management (PHM) team identified these to be younger adults (30-39 year olds), and those with an ethnicity record of Asian, Mixed or Unknown.

LD Health Checks also cover a number of questions about cardiovascular health, but the follow up activities/interventions are not routinely reported in the same way. So although it is reported that Thurrock

performs well with LD Health Checks compared to other areas, it is unknown how successful they are in prevention of onset of further cardiovascular complications. A pan-Essex thematic review was undertaken of the LD deaths in 2021-22, and there were a number of recommendations posed relating to changing processes, improving partnership working, staff training and data validation, all of which should contribute towards improved physical health outcomes in the future. In particular the recommendations include:

- Annual Health Checks should be face to face and should cover all items specified so as to be a comprehensive check of physical and mental health, (not just height, weight and blood pressure) including a medication review and a review of any known conditions.
- Annual Health Checks must result in a Health Action Plan which is shared with the adult and anyone supporting them.

A Southend, Essex and Thurrock (SET)-wide LD forum, comprising of representatives from Local Authorities, NHS commissioners, providers and clinicians, is developing a programme of work aligned to delivering on these recommendations. Close working between this SET-level forum and Thurrock colleagues should ensure that prevention initiatives are prioritised and that there is no duplication. The forum colleagues have recently reviewed the paperwork around the LD Health Check for example to ensure the same easy read information is given out to all patients.

RECOMMENDATION: Maximise uptake and associated follow-up of physical health checks for people living with SMI and people who have a learning disability. A targeted approach to SMI physical health checks across younger age groups and lower uptake ethnic groups should be a priority.

5.9 Support with Healthy Behaviours

Many residents, both those known to have CVD conditions and therefore requiring support with secondary prevention, or those at greater CVD risk due to lifestyle factors (primary prevention), could benefit from support to manage healthy behaviours. Locally, THLS provides access to Weight Management programmes and support to stop smoking for residents of Thurrock. The 2016 APHR report included a recommendation that the service (at that point known as Vitality) be redesigned and procured with greater focus on lifestyle support for those with established LTCs. Changes were made to service management during 2017-18, including establishing a single point of access, but delivery remains largely as before. Redesign is still required in order to increase focus on delivery to those experiencing the greatest health inequalities - whether related to areas of deprivation or protected characteristics such as people with severe mental illness. Work is however underway to engage and train a wider group of staff such as social prescribers in delivering brief advice to support smoking cessation, but there could be opportunities to target and expand the provision of advice to people with LTCs through providing training to the new primary care roles within the four PCNs. Currently, services are as follows:

- The Stop Smoking service provides access to CBT with and without Nicotine Replacement Therapy or Vaping; it continues to operate as a telephone-based service since the pandemic in response to client demand. Clients can self-refer or be referred by a member of the primary care team including Social Prescribers, Local Area Coordinators and other Council Officers. Thurrock Public Health Team completed a Whole System Tobacco Control JSNA in 2021[22]. This recommended enhanced targeting of smoking cessation support to address inequalities. To address this during 2022-23 one practitioner is providing smoking cessation training and support to staff in GP practices in the 8 most deprived wards (funded through funds provided to help authorities manage and reduce the impact of COVID). MSE ICS Health Inequalities funding will also enable a further practitioner to offer support via employers, targeting those in routine and manual occupations, who have higher rates of smoking nationally.

- Limited support to lose weight for people above certain BMI thresholds is available, on referral from primary care, either via Slimming World or the Exercise on Referral programme with local leisure providers Impulse Leisure. Capacity for enhanced access to free physical activity classes was expanded and diversified (for example including Zumba and Bootcamp) during 2021-22 using central government funding, however this funding stream has not been extended. Support for families with overweight and obese children continues to be offered in 2022/23 through BeeZee Bodies however.

- There is some access to support through the Exercise on Referral programme with Impulse Leisure for residents with diagnosed LTCs needing targeted support to increase their level of physical activity, although this is only available in part of the district and on referral from a clinician.

- There are a range of community and grass-roots physical activity offers and schemes in Thurrock, funded through a variety of routes. Active Thurrock [2] is a community activity network with representatives from Active Essex, Thurrock Council and local organisations within the statutory, voluntary and private sectors. Its recent *Find Your Active* campaign has provided universal encouragement and information about physical activity as we emerge from the COVID-19 pandemic.

- A number of pilots are underway to address obesity locally. These include the Corringham IMWC obesity pilot to deliver a holistic and personalised response to residents at high risk of obesity (see box below) and Active Minds, a pilot between Active Essex and Thurrock & Brentwood MIND to provide service users with free exercise opportunities to increase their confidence and better their physical and mental health. These pilots will be critically evaluated to determine the appropriateness and feasibility of future expansion.

[2] https://www.activeesseximpact.org/thurrock

- An integrated drug and alcohol misuse treatment service for adults is provided by Inclusion Visions Thurrock (IVT), an NHS service which is part of the Midlands Partnership NHS Foundation Trust. The service provides a single point of contact and a range of interventions focussed on the recovery of adults from illicit and other harmful drug and alcohol misuse for residents registered with a Thurrock GP. Access to the service is via referral, self-referral and engagement with outreach initiatives undertaken by IVT. A young person's substance misuse treatment service is provided by Change Grow Live (CGL) Wize up.

Thurrock Public Health Team are leading on refreshing local health risk behaviour support programmes in order to reach their full potential to improve local health outcomes. This will include:

- Public Health will provide strong strategic leadership to engage with stakeholders across the system to reinvigorate the Making Every Contact Count (MECC) programme, incorporating a number of healthy behaviours, including smoking, alcohol, healthy weight and physical activity.

- The forthcoming Whole System Tobacco Control Strategy, based on the Tobacco Control JSNA, will consider both whole population and targeted approaches to reduce inequalities to meet the national smoking rate ambition of 5% by 2030. We already know that minority ethnic communities have been under-represented in the Stop Smoking service over the last 5 years, with 'White British' residents representing 85-92% of service users despite representing 80.9% of the Thurrock population. Targeted groups will include routine and manual workers, people living with mental health problems, and people from minority ethnic groups under-represented in the current service profile.

- Public Health are currently undertaking a refresh of the Thurrock Whole Systems Obesity Strategy, as the previous one is now out of date. The new strategy will have a key focus on reducing obesity related health inequalities, for example through expanding the Healthy Start scheme. Targeted consultation will be undertaken with groups at highest risk to ensure future delivery meets their needs. A review of the commissioning of local weight management and physical activity services will also be undertaken.

- Alongside the commissioning of weight management services, we will implement a 'Health in All Policies' approach to ensure that Whole Systems Obesity is everybody's business. There are also plans to implement a Thurrock pilot similar to the London Superzones programme. We will do this through the Planning for Healthier Places JSNA that is currently in development, which will form a key part of evidence for the Local Plan and influence relevant planning, development, and regeneration decisions.

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5.10 Primary Care Capacity

5.10.1 Appointment Availability

Ease of access to primary care is key to patient engagement and thus to effective management of LTCs. The pandemic led to rapid changes in access to, and availability of primary care. Overall, although there has been an increase in primary care capacity since the 2016 report, there are still significant concerns about the number of GPs in Thurrock- for example, the recent engagement exercise on Thurrock's Health and Wellbeing Strategy 2022-26 identified concerns about access to primary care as a key theme from the engagement[23]. This was also a recurring theme in recent conversations recorded by Thurrock CVS' Community Builders and aligns with national analysis which shows increasing workforce pressures for GPs, especially in areas of deprivation, with 1.4 fewer GPs per 10,000 patients in the most deprived areas than in the least deprived areas and associated risk of widening health inequalities[24]. Whilst the total number of appointments available in Thurrock has increased, with the number of appointments provided April-November 2021 exceeding that in the equivalent period in 2019-20 (pre-pandemic) by 6,791 (1.1%), this is a lower increase than for the other CCGs in Mid & South Essex (source: NHS Digital). Basildon & Brentwood CCG, by comparison, has seen an increase in appointments of 10.5% over the same periods.

Over the last two years there have been changes in the type of appointments offered and the staff providing them. A continued legacy of the pandemic is an ongoing lower proportion of face-to-face and home visits than pre-pandemic, with the proportion of face-to-face appointments provided in Thurrock between April-November 2021 being 26.3% lower than for the same period in 2019. As changes in staff roles and workforce constraints have coincided over the pandemic any perceived impact from changes in appointment type should be viewed with caution. It is known that the change in appointment types has, for instance, led to frustrations for patients having to access general practice via old telephone systems. However it is important to note that for some patients, increased flexibility in appointment types may be positive, enabling people to attend a telephone appointment during the working day; research from The Health Foundation in 2018[25] found that 30% of people with four or more LTCs (out of a list of 36 conditions) were of working age. Shifts in the type of staff providing primary care appointments in Thurrock appear to reflect the expansion of roles within the PCNs. Figure 13 provides an illustration, showing an increase in the number and proportion of appointments offered by nursing and 'other' staff compared with GPs.

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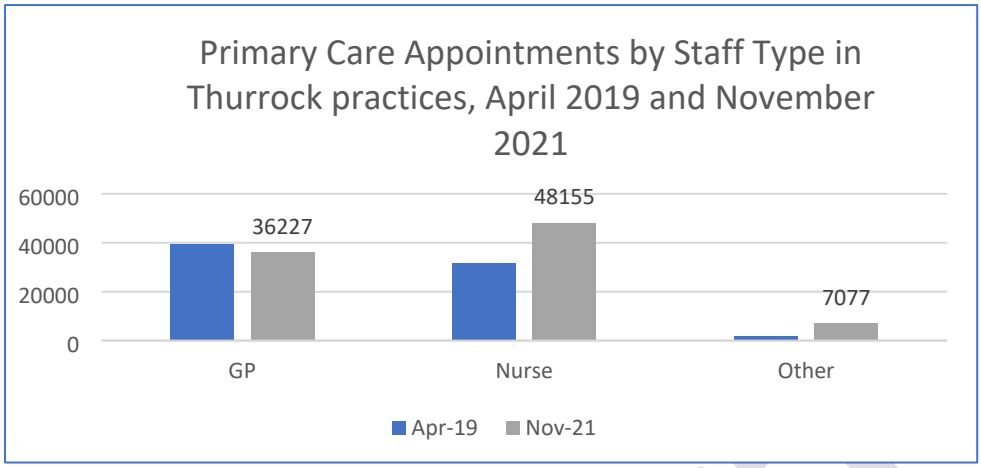

Figure 13: Change in primary care appointments by staff type

Data on types of appointment and type of professionals involved is not available at PCN level, but additional CCG provision in Tilbury & Chadwell since 2016 has improved capacity in that PCN. It is important to note that despite the improvements in Tilbury & Chadwell and the expected increase in additional roles due to the NHS LTP, Thurrock remains significantly 'under-doctored'. Analysis by the Nuffield Trust in April 2022[26] shows that most of Mid and South Essex is in the worst quartile for the number of patients per GP, but that the situation is worst in Thurrock, with 2296 patients per GP (increased from 2110 per GP in 2016), which is the third highest list size per GP in England.

Early analyses by the PHM team suggest that primary care resources are not currently distributed equitably in relation to need, across Thurrock and beyond. Work is being undertaken to look at the impacts of this inequity and to estimate how we would "close the gap" to bring all areas in line with SLH – the PCN which currently has the most generous provision compared to population characteristics.

5.10.2 Skill mix in primary care

The Kings Fund, in their report on Innovative Models of General Practice[27] (which preceded the publication of the NHS Long Term Plan), stress that new roles in primary care should *supplement,* not *substitute*, traditional clinical roles. The 2016 APHR highlighted particular pressures in primary care in the practices that now form Tilbury & Chadwell PCN, which led to additional capacity being commissioned by the CCG. Analysis of the primary care workforce in Thurrock in November 2021 suggests a modest expansion in the number of full-time-equivalent pharmacists employed across the four PCNs (from 4.9 FTE in 2016 to 6.8 in November 2021), but a very limited increase in Allied Health Professionals or paramedics (0.5 and 1.0 respectively across all four PCNs). The largest increase in staffing since 2016 has been in the new role of Physician Associate, the largest number of whom work within Grays PCN. Overall, as shown in Figure 14 below, despite an increase in GPs and substantial reduction in locum doctors, the number of GPs across the four PCNs is lower (by 3.3 FTE) than in 2016.

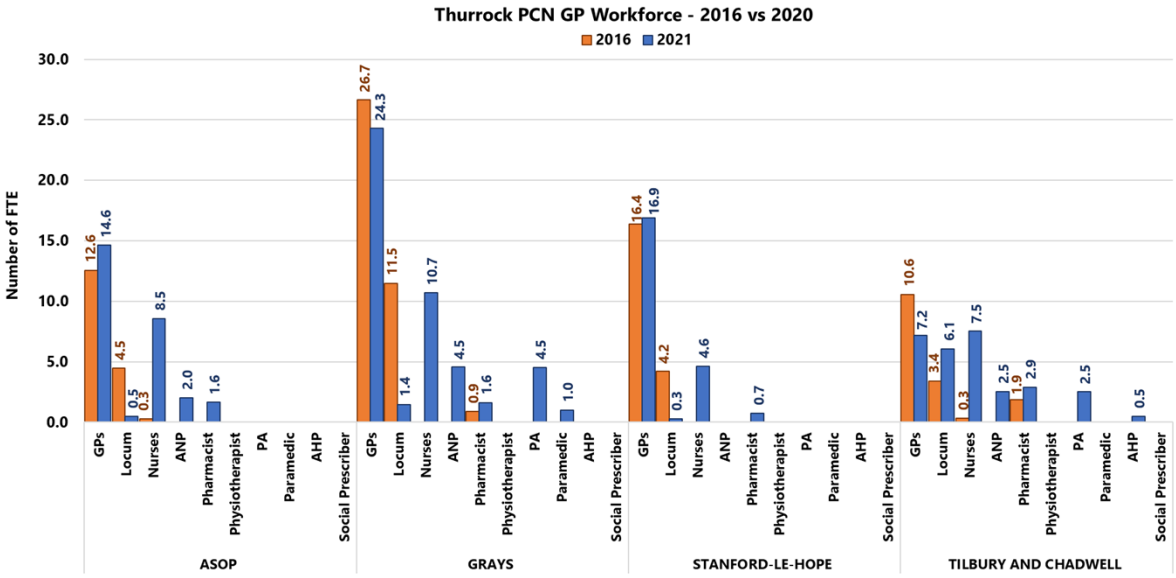

Figure 14: Primary Care workforce in Thurrock by PCN, 2016 to 2021

The published literature (see section 8 below) suggests opportunities for a broader health and care workforce in providing more personalised care in order to address both outcomes and health inequalities associated with CVD. This suggests there is still significant opportunity to increase staffing in the roles outlined in the NHS LTP, in particular Allied Health Professions (AHPs) and Social Prescribers, within all four PCNs, providing that recruitment challenges for AHPs (an outer-London effect) can be overcome. However, whilst the new roles funded through the NHS Long Term Plan provide permanent additional appointment capacity, they are funded on a population basis, not taking account of issues of equity of access or health inequalities, and thus risk perpetuating the inverse care law in Thurrock.

RECOMMENDATION: Thurrock Integrated Care Alliance (TICA) should work with Mid & South Essex ICS to prioritise support for new models of working and additional workforce capacity to practices within Thurrock to avoid increasing health inequalities associated with access and quality in primary care.

5.10.3 Patient views on primary care in Thurrock

The GP Patient Survey provides an annual snapshot of patients' experiences relating to access and quality of GP care. The 2021 survey was sent out in July to 6% of the practice population in Thurrock. Return rates varied across the 27 practices in Thurrock, from 21% to 48% (the national average being 35%). Whilst responses are higher than in the two previous years, it is important to note that the results are based on responses from only 2% of the total GP registered population in Thurrock. Respondents with a positive or negative bias may be more likely to respond, as may higher users of primary care services. However, the

results serve as a snapshot on patient access and highlight issues of concern as well as areas of good practice.

In 2020, the first year of the pandemic, with associated changes to access and delivery of primary care, the survey showed lower satisfaction rates than in 2019 both nationally and in Thurrock. By 2021, patients appear to report improved ease of access, most notably in satisfaction with the type of appointment offered (75% locally and 82% nationally). Ease of access via phone in Thurrock remained much lower than the national average at 55% compared with 68%, but there are plans in the 2022 BCTT strategy for upgrading GP telephony and online systems[28].

The 2021 survey shows that Thurrock patients continue to score their experience of primary care below the national average, with 72% for 'overall experience' compared to 83% nationally (though the lower average score for Thurrock reflects a wide range of individual practice ratings, which range from 27% to 96%). At PCN level, SLH attracts the highest ranking and Tilbury & Chadwell the lowest. Analysis suggests that when a practice performs well or poorly in one area of the survey, this is likely to be indicative of performance (on the survey) overall. That said, whilst ease of use of online services shows a slight downturn both locally and nationally, Tilbury and Chadwell PCN shows as an exception, achieving the highest increase (11% improvement on 2020) across the four PCNs for this item. This is relevant because if the ambitions in the NHS Long Term Plan for reduction in cardiovascular disease and associated reductions in health inequalities are to be realised, additional staff, increased accessibility for patients, and changes in ways of working are essential.

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6. From 2016 to 2022: Progress against the recommendations in the 2016 report

6.1 Integrated Medical Centres

One of the recommendations of the 2016 APHR report was to expediate development of the Integrated Medical & Wellbeing Centres (IMWCs). Four are planned for Thurrock, in Corringham, Grays, Tilbury & Chadwell and Purfleet[3] by 2025. The geographical reach of these centres aligns with those of Thurrock's four PCNs, with some practices relocating into the new IMWCs. The four IMWCs are at different stages of development, with that in Corringham having opened during summer 2022. The timeline and site for Grays IMWC is yet to be determined. Outline business cases are being produced for Purfleet and Tilbury & Chadwell, with the latter expected to be a new build in Civic Square as part of wider regeneration in the town, and with funds confirmed (subject to commercial arrangements) by Thurrock Borough Council. Purfleet IMWC will also be a new build as part of regeneration of the area into a riverside destination by Purfleet Centre Regeneration Limited, for which outline planning consent has been given.

Creation of these IMWCs will be fundamental to the success of the BCTT plans for more integrated care, and aligns with both Mid & South Essex and Thurrock strategic plans. Once developed, these hubs will contribute substantially to effective management of LTCs as each will provide not just a core offer bringing together health, wellbeing and social care services in multi-disciplinary LTCs teams, but also have a specific focus on a particular set of conditions and diseases. Two IMWCs will focus on diabetes and on CVD, with access to co-located diagnostics and cardiology clinics. The expectation is that delivery of health, social and wellbeing services in a person-centred way within IMWCs will improve both efficiency and effectiveness of care for both individuals (for example reducing the need to attend additional hospital appointments) and the health system. The BCTT strategy envisages that THLS services will be aligned within the IMWC clinical model.

Corringham Integrated Medical & Wellbeing Centre Obesity Pilot

This project aims to recognise obesity as a LTC to be addressed through a holistic way of working to address the relapsing nature of this condition that existing time limited models are unable to resolve. The project will use proactive case finding and personalised care planning to focus on clinical factors beyond BMI, plus impact of social and wider determinants of health.

The multi-disciplinary LTC teams are expected to provide co-ordinated care for patients with one or more LTCs, led by the most appropriate clinician for the person (this could for example be a pharmacist, nurse or GPs). Teams will include specialist support for patients with more complex needs (e.g. housebound), mental health support (through IAPT or through NELFT for those with more complex needs), social prescribing/local care coordinators and healthy lifestyle practitioners able to provide health coaching.

[3] For further details see Thurrock Integrated Medical Centres Model of Care, Version 6.0 December 2021

When considering the care that will be provided from IMWCs, it is important to note that evidence on new models of care, such as the Primary Care Home (set out by the Kings Fund[27]) and the House of Care explored in the literature review below, and the Human Learning Systems approach as outlined in the BCTT[29], clearly suggest that more personalised, proactive care requires a shift in mindset as much as it does the implementation of new processes and systems. To be effective, personalised care requires a more collaborative and flexible approach that is community-focused, with patients and clinicians sharing decision-making, aided by continuity of care, coordinated care and associated information flows. This takes time, support and often training to adopt.

RECOMMENDATION: Promote personalised, collaborative and holistic care planning, using an evidence-based model, alongside long term condition specialists and multi-disciplinary working within the IMWCs. Maximise potential for risk behaviour services to target support to patients, including those at higher risk of CVD, through joint working within the new Integrated Medical Centre model.

6.2 Initiatives for increasing detection and management implemented after the 2016 Report

Estimates of identified versus anticipated prevalence could be taken as suggesting that *all* anticipated cases can be detected, diagnosed, and treated. This is unlikely to be the case, for a variety of reasons including onset of other disease and patient choice when it comes to population level screening. However, what is clear is that, although the modelled prevalence is only a guide, identification and management of CVD and health behaviours influencing CVD outcomes can be improved, and that improvements not only benefit patients but introduce efficiencies into the healthcare system, as set out in the 2016 report. As a result of the 2016 report, a number of initiatives were put in place, funded by the Public Health Grant (to Local Authorities) and Better Care Fund (funded by Local Authorities and NHS). However, further work is needed to ensure that the aims of the Better Care Fund align with the priorities set out in the BCTT strategy.

6.2.1 Stretch QOF

Payments through the national QOF scheme are capped (with the cap on what each practice can earn from each indicator varying across indicators), and practices generally achieve the level required to reach maximum payment. In Thurrock, 'Stretch-QOF' was implemented in 2017-18 and applied to a sub-set of individual indicators to support detection and referral for support managing behavioural risk factors (such as smoking) and higher quality management (to established clinical thresholds) for conditions including hypertension, atrial fibrillation, CHD, stroke and diabetes. Stretch QOF in Thurrock uses some of the existing QOF indicators and provides support and equipment, extending the threshold for payment to 100% of those eligible in order to promote and sustain practice beyond the national standard and thereby address inequity

experienced by those not commonly included in activity to meet QOF payments. The scheme has been renewed annually since to reflect priorities and needs of the area.

6.2.2 Long Term Condition Practice Profile Cards

In order to ensure that improvements in primary care are informed by, and reflected in, practice data, from 2017 public health staff devised Practice Profile cards (updated annually) to support quality improvement visits to practices. The profile cards bring together detailed information on a range of health data for each practice including QOF performance, attendances at A&E, and patient experience. Each practice was offered an annual visit; although practices were prioritised for visits according to health needs, these were scheduled according to practice availability and ability to engage in the process. Practice quality visits were disrupted by the pandemic, but the profile cards have been updated and are in the process of being shared. In 2021 additional "deep dive" analyses such as for AF as shown in Figure 15 were also shared. These deep dives will resume shortly. The first one is suggested to be around stroke prevention.

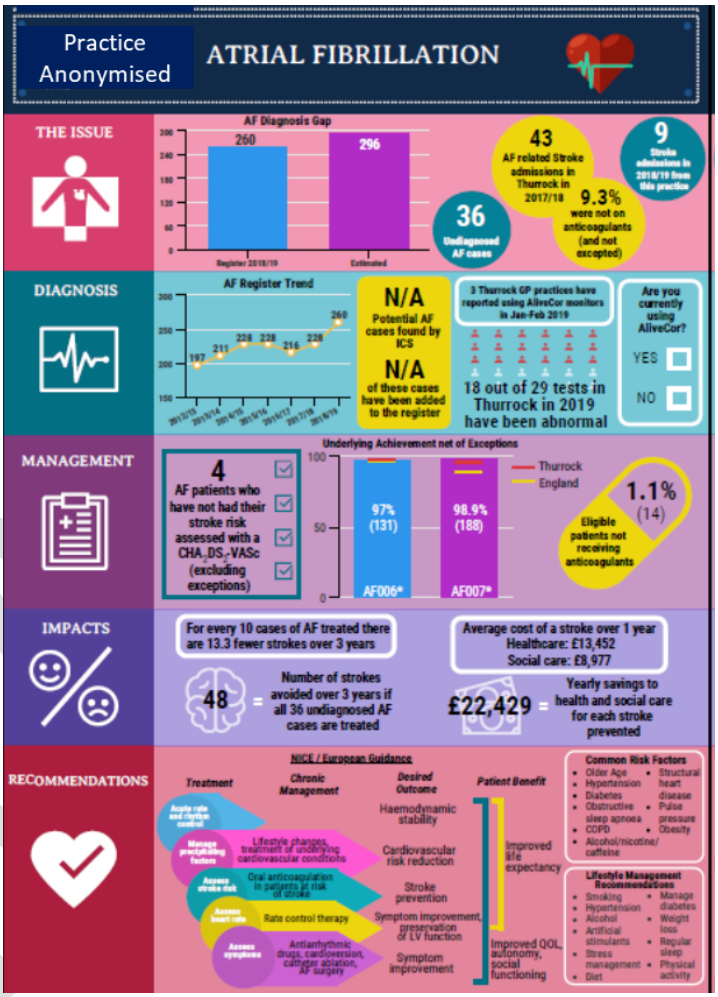

Fig. 15: A sample 'Deep Dive' practice profile card, showing the information typically shared with practices in Thurrock

RECOMMENDATION: Continue to strengthen the links between public health and primary care, using data to inform improvements. Use Stretch-QOF and other approaches to promote case-finding and a strengths-based approach to improving outcomes, taking into account multi-morbidities, to promote holistic management of LTCs.

Given the high quality of primary care for those on CVD registers in Thurrock, the greatest improvements in population health are likely to be gained by a focus on reducing gaps in diagnosis.

6.2.3 Diabetes in dentistry evaluation

Although not a cardiovascular disease in itself, diabetes is a risk factor for CVD. This pilot project is included here as an example of innovative work undertaken in the borough since the 2016 report to improve case-finding that appears replicable if time and resource constraints in dental practices (since amplified by changes due to the pandemic) can be addressed.

There is a known relationship between the prevalence and severity of periodontal (gum) disease and diabetes (and between treatment of periodontal disease and improvements in glycaemic control in diabetes). This suggests an opportunity for screening people attending dental appointments who may be at high risk of having undiagnosed diabetes. To test this, a pilot took place in 2017 with three dental practices in Thurrock- two for 12 months, one for 1 month. Adult patients attending appointments were first offered a diabetes risk survey then risk assessed as part of their dental appointment for periodontal disease. Those with BPE scores (measuring periodontal disease) over 3 were offered a HbA1c test (used for diabetes screening) and referred on to the National Diabetes Prevention Programme (NDPP) if the result was in the pre-diabetic range, or to their GP if in the diabetic range.

Overall, 262 people took part in the pilot, of whom HbA1c results suggested 26 were pre-diabetic and 5 diabetic, with onward referral to NDPP or GP for further investigation as indicated. Surveys of practice staff found that, whilst enthusiastic about the project, time constraints in dental services limited potential to implement it. Analysis suggests that screening is generally cost-effective especially when dental practices target only those patients likely to be at higher risk.

6.2.4 Self-testing of Blood Pressure in GP surgeries and community hubs.

Blood pressure monitors were put into waiting areas in GP surgeries in 2018 and patients encouraged to test themselves and report the result to reception in order to improve case-finding. Despite fewer patients accessing surgeries in person during the pandemic, patients (including those already on hypertension registers) appear to have made use of the testing facility in Tilbury & Chadwell and Grays PCNs, during 2021 in particular. It would be interesting to explore reasons why patients in the other two PCNs have made less use of self-testing, or been less aware of the machines.

This project is distinct from the Blood Pressure at Home project managed by the ICS, which is a national pilot where initially patients meeting certain conditions were given a blood pressure monitor to monitor and better control their blood pressure at home. (Evidence suggests that people who are enabled to check their own blood pressure are also more likely to manage it well.) The criteria have since been relaxed and now anyone for whom their GP feels that this would benefit them can now receive a free blood pressure machine. The total number of Thurrock patients who have been given a device for home testing between March 2021-May 2022 to date is 8817. The expectation is that regular blood pressure readings will be provided to the surgery either through an app or by phoning the practice.

6.3 Summary of progress against 2016 Recommendations

2016 Recommendation	Status in 2021	Comment
… implementation of a practice scorecard and facilitating the sharing of best practice.	Practice profiles (scorecards) and linked quality visits established, though limited for past two years by pandemic pressures on both Public Health and Primary Care. Profiles have been updated in late 2021 to include deep dive on AF.	Practice profiles support delivery of Stretch QOF, which for 2022-23 has been redesigned to focus on a more personalised holistic approach (focusing on achieving collective not single indicators for each individual). Elements of national QOF were suspended twice during the pandemic, interrupting delivery on SQOF over the past two years.
Redesign and procurement of a healthy lifestyle service with a focus on those patients with LTCs	Service now provided in-house (known as Thurrock Healthy Lifestyles Service) with some improvements regarding access, but not redesigned	When capacity allows, the Public Health team are planning an options appraisal for sustainable future delivery of the health improvement services delivered by THLS.
Support for a whole system approach to reduce obesity prevalence	JSNA in 2018 led to a 3-year Whole Systems Obesity strategy including a goal to improve the identification and management of obesity (of particular interest for CVD). Analysis of any impact of 2018 targets and goals is currently underway. Refreshed WSO strategy to be approved during 2022, with a renewed focus on targeting inequalities. Combating Obesity project providing personalised care now underway in Corringham PCN, supported by the MSE ICS	Obesity is associated with poor COVID outcomes. Action plans in the strategy being reviewed and refreshed following COVID-19 pandemic. Lack of face-to-face primary care appointments is likely to have reduced opportunities to record BMI in primary care (and thus to offer brief advice and onward referral). Children and family interventions on obesity reduction are being linked to Family Hub development in Thurrock.

	Population Health Management team.	
Implementation of a hypertension case-finding and Clinical Management Improvement Programme	Hypertension case-finding implemented and additional patients identified between 2017-18 and 2019-20.	Changes in access to surgeries due to the pandemic will have impacted results since 2019-20. The BCTT strategy includes plans to develop a Case Finding Strategy building on gains since 2016.
Treat more heart failure patients with effective medication, with support from the Public Health team via further analyses and the creation of bespoke SystmOne reports.	Stretch QOF implemented in 2018, with practices paid for activity above QOF thresholds up to 100% of target, and reviewed annually since	Stretch QOF for 2022-23 has been redesigned to focus on a more personalised holistic approach (focusing on achieving collective not single indicators for each individual).
Support more patients with effective blood pressure control (e.g. as above)	As above	As above
Significantly increase Primary/Community care capacity in Thurrock including better skills mix of staff with GP surgeries	Limited progress, but enhanced capacity in place in the PCN with most need (Tilbury & Chadwell)	Implementation of wider skill mix as set out in NHS LTP should add further capacity
Expediate building the four Integrated Healthy Living Centres in Purfleet, Tilbury & Chadwell, Grays and SLH	**Corringham IMWC** Building completed during 2022. **Tilbury IMWC**	NELFT lead Thurrock Council lead

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	Outline Business Case under review by NHS. Aim is to have this IMWC completed by 2025. **Purfleet on Thames IMWC** Completion is expected by 2024. **Grays IMWC** The aim is to have Grays IMWC completed by 2025.	Being developed by Purfleet Centre Regeneration Ltd MSEFT lead Timeframe is dependent on the extent to which the existing buildings on the Thurrock Community Hospital site can be repurposed.

In summary, a combination of local developments in the last 5 years have sought to improve case-finding and management of CVD in Thurrock. There has been more success to date in some domains than others. Data from 2019/20 in the key areas provide a benchmark, but the part-suspension of QOF over the last two years has made it difficult to quantify the impact of the pandemic on the management of CVD in primary care, or to make adequate comparisons with the findings of the 2016 report. However, it is known that the pandemic has led to reduced opportunities for primary prevention, reduced access to primary care and a widening of systemic inequalities that may influence health behaviours and health service access, so the targets for detection and management of key CVD conditions remain highly relevant, and progress in these areas is essential if health inequalities are not to be widened further.

Thurrock continues to be under-doctored overall, as reflected in patients' experience of primary care in the borough. Although capacity constraints have eased in Tilbury & Chadwell PCN as a consequence of additional roles being commissioned, the higher levels of complexity in that population still leave a healthcare deficit. It is likely that in the other PCN areas there is still an equity deficit. Further analysis needs to be done to understand this and identify solutions. The additional roles proposed by the NHS LTP and MSE Primary Care strategy could go some way to addressing the ongoing workforce constraints in primary care if implemented in full and if time is given to building teams and organising care according to complexity of need not existing levels of engagement.

Viewed overall, there appears to be a gap between the system-level work underway on holistic approaches to obesity, smoking, development of community assets and integrated care (the IMWCs), and the focus on individual indicators through Stretch QOF. The proposed multi-disciplinary teams within the IMWCs bring opportunities to start closing that gap for people with CVD or at risk of CVD, particularly in ASOP, but only if care is personalised, holistic, coordinated and segmented to provide the most support to those with the

highest needs. Practice quality visits and Time to Learn practice shut-down sessions could be used to identify best performance and promote peer to peer learning opportunities within and across PCNs.

7 Summary Literature Review

This literature review sought to identify evidence for improving both the detection or diagnosis of CVD LTCs, for improving the management and of these LTCs in primary care, and for primary and secondary prevention of CVD risk factors. The review is based largely on evidence identified by searches undertaken by NELFT library, with additional web searching and citation screening. The majority of studies reviewed for this report were UK studies of NHS provision.

The evidence used is a mix of policy documents, primary and secondary research, and case studies used to exemplify policy developments. The literature falls broadly into four subject areas:

- Models of care for primary care (with LTCs used as one of the drivers for change), typically policy papers or evaluations of NHS initiatives;
- Approaches to the management of LTCs: QOF and alternatives, often longitudinal cohort studies;
- Interventions for better management of LTCs and secondary prevention: principally ways of engaging patients in their care, drawn from a mix of research and case studies reported in policy papers; Primary Prevention and case-finding/detection: reviews of NHS Health Checks, reported case studies and research looking specifically at atrial fibrillation and hypertension.

Primary and secondary prevention, and management of conditions, is a wide-ranging area of enquiry in which definitions can vary or be loosely defined across studies (Health Coaching being an example). However, exploration of epistemological differences in models of care, behavioural or person-centred approaches to interventions are beyond the scope of this report. Measures of success also vary widely, from physiological outcomes, to health behaviours and health services use. Much of the evidence relating to primary and secondary prevention is observational case reports and/or relies on self-reports, which may not be generalisable. Very few qualitative studies were found for this report.

Management of long-term health conditions itself is a broad topic, covering a wide range of physical and mental health conditions. Much of the research focuses on LTCs generically, or on specific LTCs (notably diabetes, COPD and Mental Health). Arguably, this is as it should be, given the clearly acknowledged requirement in the literature that a shift is needed from managing individual conditions, as required by the QOF to a more holistic approach, as encapsulated in Thurrock's BCTT strategy. Aspirations are clearly expressed, both in terms of potential benefits to patients (improved health outcomes, improved agency leading to better engagement with treatment and adoption of health behaviours), and to health care systems (improved efficiency in primary care and less demand on the system). However, evidence of how long approaches or new systems should be trialled for, or of the practical and cultural factors associated with implementing new systems in primary care and how to address them, is lacking.

Policy papers from the Kings Fund [27], Nuffield Trust [30] and IPPR [31] present the theory for new models of care, clearly articulate the characteristics associated with good care, and provide examples of good practice. But whilst they identify some of the requirements for success (time to build relationships, training, and support in new ways of working – as opposed to new processes – increased skill-mix and so on), they lack detail on *how* to achieve cultural shifts in practice especially when change is to be implemented across an area rather than developed by individual practices which already have a strong drive for innovation. Roberts et al [32], in their report on a new cyclical approach to care and support planning for people with LTCs (the 'Year of Care' approach) which was first tested with patients with diabetes then extended to include people with CVD, articulate the steps in the care planning cycle and emphasise the co-produced nature of this approach. But they are clear that what is required is not new systems but a change in culture from the traditional medical model to a social model of care. The Thurrock BCTT strategy to transform adult health and social care draws heavily on the Human, Learning, Systems (HLS) approach to system transformation[33]. The HLS focus on cultural change and empowering the workforce to adopt a strengths-based approach, a learning culture and act as system stewards, offers opportunities to develop sustainable approaches to delivering holistic care.

Studies by Close et al [34] and Lugo-Palacios[35] et al explored the impact of an alternative, more holistic approach as an alternative to QOF in general practices in the south-west and north-west of England, but were unable to provide evidence of positive effect on health service use, clinical or patient outcomes. However, both were measuring success within a short timeframe, and one experienced difficulties in implementation. Close et al did however identify organisational changes in the participating surgeries that could be beneficial in the longer term, including time-savings and increased informal networks.

A common starting point for the literature on more personalised and holistic care planning for people with LTCs is the recognition that even those patients with multi-morbidities spend a very small proportion of their time with health professionals. Discussions about health goals therefore need to be contextualised within the patient's life, not just the time spent in the surgery.

Several of the studies in a Cochrane review from 2015[36], assessing the effect of personalised care planning, found that whilst results were mixed, factors increasing positive effects included more frequent contact and care from the patients' usual clinician. Several of the studies in that review used Patient-reported Outcome Measures (PROMs). More recently, there has been a shift towards 'Patient Activation', where instead of being *educated and informed by* health professionals (the 'expert patient' model), the patient is *collaborating with* them to identify goals which are personally relevant, and strategies to meet those goals. This approach requires prior assessment of the patients' level of engagement in managing their health needs; as set out by the Health Foundation. (Deeny, et al., 2018). Crucially, they identified associations between level of activation and health service use: out of the 9,348 patients studied, the 13% scoring at the highest level of activation had 38% fewer admissions, 32% fewer A&E attendances, and 18% fewer appointments in primary care. There is potential for bias in the research towards engaged patients (PAMs were assessed by survey with the 9,348 patients studied representing a 25% response rate), but the results are promising. Interestingly, the results also challenge traditional expectations about the association

between deprivation and patient engagement – only half of those scoring at the lowest level were from the most deprived areas. The researchers then identify strategies such as health coaching which can be used to assist patients to move to a higher level of activation. In summary, PAMs appear to offer promise both at an organisational level, for stratifying and prioritising those patients needing most assistance to manage their care, and at an individual level as understanding the patient's starting point informs the work between healthcare provider and patient.

Turning to clinical management of individual LTCs, a number of case studies showcasing innovative approaches to management or secondary prevention are cited by NICE and NHSE. These include incentivising blood pressure management by pharmacists [37], and a Quality Improvement support package for primary care nurses in Cheshire [38]. Most recently, the Academic Health Sciences Network has developed (in collaboration with partners) a set of free, digital Proactive Care Frameworks for stratifying and prioritising patients already on CVD registers in order to optimise management of those most at risk post COVID [39]. The resources include search tools for SystmOne and guidance on the allocation of related tasks within the primary care workforce.

Some good practice examples focus on the development of systems and guidelines within primary care, such as an audit to identify patients at risk of familial hypercholesterolaemia in Kent[40]. Others showcase opportunities for both primary and secondary prevention amongst Allied Health Professionals such as Podiatrists and Physiotherapists, as well as in pharmacies. For example, providing MECC training to AHPs in Newcastle to enable them have more effective conversations about health behaviours [41], and AF screening at community podiatry clinics [42]. What these examples typically demonstrate is the potential for the wider community health and care workforce to contribute to CVD prevention, providing that some additional resource – be that financial, training and/or short-term support – is available to support implementation.

For individual patients, CVD conditions can be managed once diagnosed, but there appear to be gaps when it comes to strategies and programmes aiming to target and identify those at greatest risk of having these conditions. Research and reports of projects for detecting atrial fibrillation and hypertension in particular do suggest opportunities for rolling out programmes in a range of community settings from fire services to community nursing teams visiting housebound patients, but issues of generalisability and transferability will apply so local evaluation would be needed. Higher quality evidence for population screening appears limited and mostly confined to AF (screening being considered cost-effective for those over 65, see for instance Welton et al[43] and Lowres et al [44]). Katsoulis et al [45] and Iyen et al [46] used primary care records in longitudinal cohort studies to explore long-term outcomes for patients on obesity registers. Iyen et al found a small but stable increase in BMI over all groups (mean age 49.5, mean BMI 33.8 kg/m^2) with those in the highest categories of obesity having the highest risk for CVD, heart failure and mortality. Katsoulis et al examined a wider age range and found that younger patients identified as overweight or obese were at significantly higher risk of moving to a higher BMI than older patients, moreover that age was a more important predictor of obesity than ethnicity or deprivation.

More generally, national policy and NICE guidance continues to promote the NHS Health Check for assessing CVD risk in people aged 40-74 and identifying people at greater risk of CVD, but evidence on uptake and impact is at best mixed. Recent systematic reviews of the NHS Health Checks programme present equivocal findings, especially in relation to Health inequalities, but do propose a more targeted approach in delivery going forward.

Adopting healthy behaviours is key to both prevention and management of cardiovascular risks, but many studies suggest mixed or limited effects in initiatives designed to support behaviour change. For those without currently identified CVD risk, the NHS Health Checks programme seeks to promote positive health behaviours and to refer individuals to local support and lifestyle services in order to reduce risks associated with obesity, smoking and low physical activity. However, the success of the programme at engaging those with most to gain and prompting health behaviour change appears limited. That said, there is much variation in the content and delivery of the NHS Health Checks programme across the country, so the generalisability of outcomes from NHS Health Check research needs to be assessed at a local level if targeted approaches are in place.

Once individuals have been identified as at risk, however, some studies have investigated the effect of Health Coaching as an alternative to traditional patient information and education. Although different definitions are in use, the common elements are that coaching applies motivational techniques and is more focused on the patient's starting point – linking therefore to patient activation. (For exploration of the term Health Coaching see NHSE/I technical guidance [47]) Studies of health behaviour change rely typically on self-reporting and are therefore often considered subject to bias, with associated concerns over quality; moreover they are not usually specific to patients with CVD risk. A recent systematic Korean review [48] sought to address these methodological concerns, and pooled results from 15 RCTs of health coaching on health behaviours for adults with established cardiovascular risks, measured using a range of tools specific to each domain (Physical activity, Dietary behaviours, Health responsibility, Stress management and Smoking). Health coaching was provided by a range of staff within and outside healthcare (e.g. dieticians, fitness professionals), all of whom had received training. They identified small but significant effects for health coaching in all areas except smoking (which had the fewest studies). They found that coaching was easily implemented (much of the coaching in the included studies was delivered by telephone), with an 'optimal dose' of 30 or more sessions over a period of 6-12 months.

Conclusions

Whilst acknowledging the early gains in quality of care associated with QOF, the literature over the last five years clearly identifies the limitations of QOF from both a primary care and a patient perspective, turning instead to more holistic models and approaches for managing LTCs and prompting positive health behaviours. However, these are not always clearly defined, or evaluated over the long term; moreover, there is a lack of detail on implementation and addressing problems which could be aided by more qualitative research, particularly when change is required to address quality concerns, rather than generated by motivated innovators.

There are positive initiatives for detection and screening of atrial fibrillation and hypertension, though these may be dependent on resources being available to support implementation. NHS Health Checks may need to be targeted quite specifically in order to increase detection of those at risk and support behaviour change. Studies of patient activation levels and support to increase activation through interventions such as Health Coaching suggest promise for both individuals, primary care providers and health system use overall; however, the literature is also clear that these depend on a cultural shift towards co-production and a more social model of health care.

RECOMMENDATIONS: In designing new holistic care models, Thurrock Integrated Care Alliance should consider learning from the evidence base, and specifically consider:

- That transformation programmes need to be built around *how* to achieve cultural shifts in practice;
- The benefits of health goals being contextualised within the patient's life and personal priorities;
- Adopting the Patient Activation Measure (PAM) to assist in segmenting and prioritising patients with multi-morbidities and/or complex needs for care-coordination and support;

Training a range of staff in primary care, integrated teams and lifestyle services in Health Coaching. Roll-out Health Coaching within multi-disciplinary teams, prioritising patients identified through PAMs at the lowest levels of engagement.

In seeking further improvements in care for specific CVD conditions, services should consider:

- Further developing Community and Allied Health Professional roles (e.g. Podiatrists, Physiotherapists) and considering how broader roles might enhance LTC services for patients e.g. MECC, opportunistic atrial fibrillation and hypertension screening in community clinics
- Implementing systematic and targeted case finding for atrial fibrillation and hypertension, including targeting over 65s, those who are housebound, those with higher BMIs, and those living in more deprived circumstances
- Maximising uptake of NHS Health Checks, targeting higher risk groups such as those at lower ages in higher risk minority ethnic groups

8. Conclusions

The 2016 APHR report highlighted concerns about workforce capacity in primary care, variations in the quality of care and the impact of poor identification and management of CVD and other long-term conditions. It quantified the potential benefits of action on these factors for the health system. Assessing the impact of initiatives put in place to address these concerns is difficult given the impact of the COVID-19

pandemic on implementation, changes in access to primary care, the primary care workforce and data-capture, but where impact is measurable, indicators show an improvement in quality of care for CVD in Thurrock since 2016. Given the impact of the pandemic, however, on widening inequalities, the case for improved identification and management of CVD is even more pressing.

The most recent Marmot review[5] stresses the need to re-focus on prevention in order to reduce the inequalities exacerbated by COVID-19. Given the high rates of smoking and obesity in Thurrock, increased identification and improved management of cardiovascular conditions will not alone address the inequalities currently associated with CVD in the borough; prioritising wider action to increase access to healthy foods, provide support for individuals to manage their weight, increase physical activity and reduce smoking is required. In addition, opportunities to identify those at increased risk of CVD, through NHS Health Checks and other case finding programmes, need to be targeted in areas of higher deprivation and for population groups with most to gain.

There have been some positive changes in primary care staffing since the 2016 report, but these are set against local and national concerns about ongoing workforce pressures, and Thurrock remains significantly under-doctored. The introduction of new roles such as Physician Associates and Social Prescribers is positive, and appears to have increased availability of appointments as well as providing more tailored support in areas such as mental healthcare. However, the funding that supports these roles is population based, not weighted to deprivation, so care should be taken to ensure that such innovations do not inadvertently widen health inequalities between higher performing practices with more capacity, and those facing greater challenge due to higher health needs and workforce pressures. Moreover, learning from these roles must be shared within and between PCNs.

Despite the challenges of workforce pressures and the pandemic, there have already been improvements through initiatives implemented and developed since the 2016 report, notably the use of public health data to support practices, Stretch-QOF, and generation of additional workforce capacity with new roles in primary care. Figure 16 shows how activity could now be directed to support different patient groups.

More generally, the literature on changing models of care and approaches to the management of LTCs is clear that care for people with multi-morbidities needs to become more personalised, more coordinated and more collaborative if patients are to be engaged in optimising their health, and if both demand on the system and health inequalities are to be reduced. This means, for example, that Stretch QOF needs to be more holistic, focused on patient outcomes overall rather than individual disease targets. However, a shift towards more collaborative, co-produced care requires fundamental shifts in culture, investment in staff (for example training) as well as time to embed – as has already been recognised in the BCTT strategy in regard to the adoption of a Human Learning Systems approach. Achieving this at the same time as seeking to reduce variation between and within PCNs and manage workforce constraints is a significant challenge. Review of the literature suggests that the principles underpinning the roles of long-term condition specialists in Thurrock needs to be articulated, understood and shared within and across the four PCNs if the ambitions for patient outcomes and health system savings are to be realised. Time, training and opportunities for co-

production and shared reflection on cultural change, in addition to continued collaboration between public health and primary care to understand the data driving and measuring this work (not least the segmentation of patient groups), are needed to support this shift.

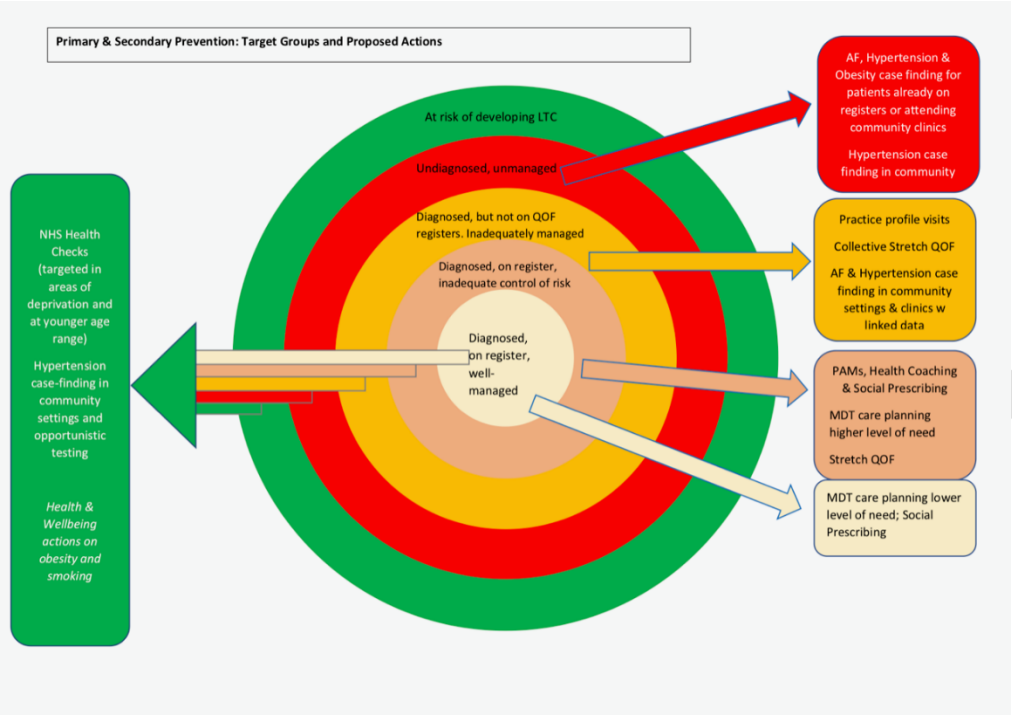

Figure 16: Proposed actions for patient groups to reduce impact of CVD

There is now a national drive for CVD prevention, particularly through improved identification and treatment of hypertension and atrial fibrillation, as part of the NHS Long Term Plan. Over the last 5 or so years, there has been a shift in evidence towards more collaborative and holistic models of care, and greater understanding of how to engage patients in managing their health and associated health behaviour changes (away from the expert patient and educational model) towards, for example, PAMS and Health Coaching, and an increase in innovative projects in the community for identifying those at risk of CVD. This knowledge, together with alignment with the national CVD plan, offer opportunities for both primary and secondary prevention in Thurrock, subject to robust evaluation. Much may rest on the development of the IMWCs for those patients with multi-morbidities and complex health and social care needs, especially those for whom the co-location of community services and mental health services with primary care may improve engagement. The first IMWC to open has been in Corringham, where innovative practice in obesity can already be found. However, in Thurrock there is greater need in Tilbury & Chadwell and in ASOP, both in terms of constraints on primary care capacity and greater levels of patient need. These areas should therefore be prioritised for additional workforce capacity and adoption of new models of care, in order to avoid widening health inequalities further.

9. Recommendations

1. **Thurrock Integrated Care Alliance (TICA) should work with Mid and South Essex ICS to prioritise support for new models of working and additional workforce capacity to practices within Thurrock PCNs, to avoid increasing health inequalities associated with access and quality in primary care.**

2. **Refresh the focus on primary prevention of CVD post-COVID-19.** To reduce inequalities, particularly given the widening of inequalities due to COVID, more resource and effort should be directed to primary prevention as well as addressing wider issues such as debt and fuel poverty
   Thurrock has significantly higher rates of smoking and obesity than average for England; and smoking is the largest single modifiable factor contributing to health inequalities and preventable deaths. Specifically, as set out in Goal 1A of the 2022-2026 Thurrock Health & Wellbeing Strategy:
   - Develop a Whole System Tobacco Control Plan for Thurrock. Through this, reduce the proportion of people in Thurrock who smoke, and the variation between community groups - focusing on residents in areas of higher deprivation and those with severe mental illness, with the aim of reducing smoking prevalence to 5% or less by 2030. Continue to train staff working with people in higher risk groups in smoking cessation.
   - Implement the refreshed Thurrock Whole System Obesity Strategy (to be agreed 2022), again reducing both the proportion of people (children and adults) who are obese and with an increased focus on health disparities, both of place and protected characteristics, with an additional focus on obesity in pregnancy and early years. As part of this strategy, improve the food environment, leveraging positive community influences, to assist people in making healthy food choices and improve the physical environment to promote physical activity. The age profile of Thurrock is younger than the England average, and the risks associated with obesity increase with age. Ensure that the refresh of the Whole System Obesity Strategy identifies and promotes opportunities to identify and manage obesity and low levels of physical activity in younger adults, including during and after pregnancy before the risk of LTCs associated with obesity is exacerbated.
   - Leverage opportunities within the new Family Hubs to implement activities promoting and supporting health behaviours in the early years, especially to reduce high levels of childhood obesity at age 5 and 11 in the district.

3. **Promote personalised, collaborative and holistic care planning, for example the House of Care using an evidence-based model, alongside long term condition specialists and multi-disciplinary working within the IMWCs. New models of working should include maximising potential for risk behaviour services to target support to patients, including those at higher risk of CVD, through joint working within the new Integrated Medical Centre model.**

   The integration of risk behaviour & wellbeing support services with the four IMWCs provides an opportunity to target NHS Health Checks to residents using social care and housing services,

increasing uptake amongst groups who may not currently respond to invitation letters from GP practices.

Similarly, improved access to lifestyle support and coaching for residents attending mental health and community support services, as part of the long-term condition model of care, offers an opportunity to address some of the health inequalities associated with having learning disabilities or poor mental health. This will depend on effective collaboration between IAPT/NELFT, PCN Mental Health and THLS teams to identify patients at highest risk.

Transformation of care should centre around a change in culture from the traditional medical model to a social model of care. This should ideally be co-developed, for example using Human Learning Systems (as outlined in the Better Care Together Thurrock strategy). To support this and the following two recommendations, re-establish the Better Care Together LTC & Inequalities group to steer and support adoption of new ways of working to steer cultural change.

4. **In designing new holistic care models, Thurrock Integrated Care Alliance should consider learning from the evidence base, and specifically consider:**
   - **That transformation programmes need to be built around *how* to achieve cultural shifts in practice**;
     Focusing on the processes and tools of transformation used by innovators is not sufficient when seeking a shift to co-production and towards a more social model of care across all partners in a system.
   - **The benefits of health goals being contextualised within the patient's life and personal priorities**;
     Evidence suggests that goals linked to the *patient's* starting point will be more successful.
   - **Adopting the Patient Activation Measure (PAM)** to assist in segmenting and prioritising patients with multi-morbidities and/or complex needs for care-coordination and support;
     Evidence suggests that using the PAM to determine patients' engagement in managing their conditions can benefit both individual patients (by helping them identify goals which are personally relevant) and health professionals (by determining which patients have the most complex care-coordination needs and would benefit from interventions to help them manage their health condition). As a collaborative tool, PAM differs substantively from patient-reported outcome measures or patient education. Patient activation measures should not be limited to areas of higher health inequality only, as all levels of engagement are found across all socio-economic groups. Use of the PAM has also been recommended in the Mid & South Essex Self-Care JSNA (2021).

- **Training a range of staff in primary care, integrated teams and lifestyle services in Health Coaching.** Roll-out Health Coaching within multi-disciplinary teams, prioritising patients identified through PAMs at the lowest levels of engagement.

  Health Coaching differs from traditional patient information and education as it is based on motivational interviewing approaches, and a collaborative process between patient and professional. Health Coaching can be offered in a range of settings, including by telephone. Evidence suggests Health Coaching can deliver positive changes in health behaviours, especially when targeted at patients identified as having low levels of activation.

  Health Coaching and PAMs are new approaches built on a more collaborative, holistic approach to LTC management. Ensure opportunities to share learning between health coaches and other members of the primary care workforce, informally and at Time to Learn practice shut-downs.

5. **Continue to strengthen the links between public health and primary care, using data to inform improvements. Use Stretch-QOF and other approaches to promote case-finding and a strengths-based approach to improving outcomes, taking into account multi-morbidities, to promote holistic management of LTCs.**

   Given the high quality of primary care for those on CVD registers in Thurrock, the greatest improvements in population health are likely to be gained by a focus on reducing gaps in diagnosis.

   A case finding strategy is, as recommended in the BCTT strategy, is warranted to further build on gains in CVD diagnosis and management since 2016. This should include processes to identify patients diagnosed but not on QOF registers. Holistic approaches should be considered to reduce the risks of siloed practice that could flow from addressing CVD prevention targets in the NHS LTP individually, including for example through implementation of PAMs.

   Practice Profile cards and other data should be provided at practice level within PCNs, to assist PCNs in recognising and addressing variation in practice. These could include a focus on levels of reported Personal Care Adjustments (previously QOF exceptions) to ensure that these do not contribute to health inequalities. Refresh the plan for quality visits to practices in order to prioritise reduction of health inequalities.

   Use practice quality visits and Time to Learn practice shut-down sessions to identify best performance and promote peer to peer learning opportunities within and across PCNs.

6. **In seeking further improvements in care for specific CVD conditions, services should consider:**

- **Developing Community and Allied Health Professional roles (e.g. Podiatrists, Physiotherapists, Community Social Care roles) and considering how broader roles might enhance LTC services for patients** (eg MECC, opportunistic atrial fibrillation and hypertension screening in community clinics.
  As part of the IMWC clinical model, make more use of community roles including AHPs for atrial fibrillation and hypertension case finding in community clinics, as well as new roles in primary care such as Social Prescribers and ARRS roles. Ensure that AHPs, Pharmacists and new primary care roles have received training in MECC and are well informed about access to health coaching and lifestyle support services, and the relevance of these approaches for supporting their patients. The role of Community Pharmacies in CVD prevention warrants further consideration in Thurrock, with the potential contribution of pharmacists to primary and secondary prevention being reflected in future Pharmaceutical Needs Assessments.

- **Implementing systematic and targeted case finding for atrial fibrillation and hypertension, including targeting over 65s, those who are housebound, those with higher BMIs**
  Consider use of portable devices such as AliveCor by community teams, as set out in the Health & Wellbeing Strategy. Ensure that training and support is available to assist with implementation of screening / case finding and that data on patients identified as requiring further investigation can be shared directly with general practice.

- **Targeting NHS Health Checks for people at the younger age limit, in groups known to be at higher and earlier CVD risk. This includes those in certain minority ethnic groups, smokers and people on obesity registers, as well as residents in areas of higher deprivation.**
  Targeting NHS Health Checks as above should build on evidence of how best to engage those groups. Expanding delivery of health checks should include workplaces, collaboration with other community services (e.g. fire service) and a variety of venues and different days and times.

  The principle of Universal Proportionalism which drives the NHS Health Checks programme provides authorities with the freedom to target invitations for checks at those at greater risk, whilst still enabling the general eligible population to access the health check on invitation. THLS should work with PCNs and individual practices, using software currently available to the team, to secure agreement to stratify and target health check invitations using primary care registers. In addition, consider with MSE partners how best to work within the constraints of the NHS Health Checks programme regarding the provision of checks for people working, but not resident in, Thurrock.

- **Maximising uptake and associated follow-up of physical health checks for people living with SMI and who have a learning disability.** A targeted approach to SMI physical health checks across younger age groups and lower uptake ethnic groups should be a priority.

10. References

1. Wake, I.S., E. Payne, M. Clarke, K., *A sustainable Adult Health and Social Care Sytem for Thurrock: The Annual Report of the Director of Public Health*. 2016, Thurrock Council.
2. Fingertips, P., *Health Inequalities: Cardiovascular Disease*.
3. Team, M.S.E.H.P.H.M., *Thurrock Health Inequalities Data Pack*. 2022.
4. *Lancet Global Burden of Disease*. [cited 2022; Available from: https://www.thelancet.com/gbd.
5. Marmot, M., et al., *Build Back Fairer: The COVID-19 Marmot Review. The Pandemic, Socioeconomic and Health Inequalities in England*. 2020, Institute of Health Equity: London.
6. ; Available from: https://www.thelancet.com/gbd.
7. Lewer, D., et al., *Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study*, in *Lancet Public Health*. 2020. p. e33-e41.
8. England, P.H., *Preventing Cardiovascular Disease*. 2019.
9. Alliance, T.I.C., *Chapter 6: Improved Health & Wellbeing through Population Health Management. From reactive to proactive care*, in *Better Care Together Thurrock: The Case for Further Change*. 2022-26.
10. *The NHS Long Term Plan*, N. England, Editor. 2019.
11. Cassell, A.e.a., *The epidemiology of multimorbidity in primary care: a retrospective cohort study.* British Journal of General Practice, 2018. **68**(669).
12. Wake, I., *Transforming Primary Care in Thurrock*. 2022: Thurrock Council.
13. England, P.H., *Summary: An Umbrella Review on Cardiovascular Risk Factors, Cardiovascular Disease and Covid-19*. 2021, Public Health England/University of Liverpool.
14. Association, L.G., *Health Inequalities: Deprivation and Poverty and Covid-19*. 2021.
15. Fisher, R., *'Levelling up' general practice in England*. 2021, The Health Foundation.
16. Wake, I., et al., *The Annual Report of the Director of Public Health: Executive Summary*

A Sustainable Adult Health and Social Care System for Thurrock. 2016.

17. Board, T.H.a.W., *Thurrock Health and Wellbeing Strategy: Levelling the Playing Field in Thurrock*. 2022-26.
18. OHID, *Office for Health Improvement & Disparities: Fingertips Public Health Data*. 2022.
19. *Premature mortality in adults with severe mental illness*, O.f.H.I.a. Disparities, Editor. 2022.
20. Raleigh, V. and J. Holmes, *The health of people from ethnic minority groups in England*. 2021, The Kings Fund.
21. Evaluation, I.f.H.M.a. *GBD Compare/Viz Hub*. Global Burden of Disease Study 2019 [cited 2022; Available from: https://vizhub.healthdata.org/gbd-compare/.
22. Team, T.P.H., *Thurrock Whole System Tobacco Control JSNA*. 2021, Thurrock Council.
23. Team, T.P.H., *Thurrock Health and Wellbeing Strategy Refresh, Consultation Report*. 2022, Thurrock Council.
24. Nussbaum, C.F., J. *Worsening GP shortages in disadvantaged areas likely to widen health inequalities*. 2021; Available from: https://www.cam.ac.uk/research/news/worsening-gp-shortages-in-disadvantaged-areas-likely-to-widen-health-inequalities.

25. Stafford, M., et al., *Understanding the health care needs of people with multiple health conditions*. 2018, The Health Foundation.
26. Trust, N. *General practice: What are the trends in staff numbers working in general practice?* NHS Staffing Tracker 2022 [cited 2022 July 2022]; Available from: https://www.nuffieldtrust.org.uk/nhs-staffing-tracker/general-practice#general-practice.
27. Baird, B., et al., *Innovative models of general practice*. 2018, The Kings Fund.
28. Alliance, T.I.C., *Chapter 5: Transforming Primary Care*, in *Better Care Together Thurrock: The Case for Further Change*. 2022-26.
29. Alliance, T.I.C., *Chapter 2: Our Vision, Aim, Principles and Values*, in *Better Care Together Thurrock: The Case for Further Change*. 2022-26.
30. Kumpunen, S., et al., *Primary Care Home: Evaluating a new model of primary care*. 2017, Nuffield Trust.
31. Thomas, C. and H. Quilter-Pinner, *Realising the neighbourhood NHS: A new deal for primary care in England*. 2020, Institute of Public Policy Research.
32. Roberts, S., et al., *The Year of Care approach: developing a model and delivery programme for care and support planning in long term conditions within general practice.* BMC Fam Pract, 2019. **20**(1): p. 153.
33. *Human Learning Systems*. 2020; Available from: https://www.humanlearning.systems/overview/.
34. Close, J., et al., *Longitudinal evaluation of a countywide alternative to the Quality and Outcomes Framework in UK General Practice aimed at improving Person Centred Coordinated Care.* BMJ Open, 2019. **9**(7): p. e029721.
35. Lugo-Palacios, D.G., Hammond, J., Allen, T. et al, *The Impact of a combinatorial digital and organisational intervention on the management of long-term conditions in UK primary care: a non-randomised evaluation.* BMC Health Service Research, 2019. **19**(159).
36. Coulter, A., et al., *Personalised care planning for adults with chronic or long-term health conditions.* Cochrane Database Syst Rev, 2015(3): p. CD010523.
37. PHE, *Case study: Virtual clinics to improve Blood Pressure in poorly controlled patients*. 2019, Lambeth CCG.
38. PHE, *High blood pressure quality improvement in Cheshire and Merseyside*. 2019, Wirral Council, British Heart Foundation, Sefton Clinical Commissioning Groups.
39. Kearney, M., *The Blood Pressure Optimisation Programme: Doing things differently to prevent heart attacks and strokes at scale*, in *The AHSN Network*. 2022.
40. Group, M.C.C., *Improved identification of familial hypercholesterolaemia (FH) in primary care*. 2015, NICE.
41. NICE, *Behaviour Change: Enabling Allied Health Professionals to have Healthy Conversations*. 2018, Newcastle Upon Tyne Hospitals NHS Foundation Trust.
42. Fisk, M., N. Tuck, and A. Lang. *Podiatrists do prevention: increasing detection of atrial fibrillation with mobile ECG devices in community podiatry. Opportunity for spread and adoption?* [cited 2022; Available from: https://aftoolkit.co.uk/af-detection-in-gstt-podiatry-paper-for-podiatry-now/.

43. Welton, N.J., et al., *Screening strategies for atrial fibrillation: a systematic review and cost-effectiveness analysis.* Health Technol Assess, 2017. **21**(29): p. 1-236.
44. Lowres, N., et al., *Screening to identify unknown atrial fibrillation. A systematic review.* Thromb Haemost, 2013. **110**(2): p. 213-22.
45. Katsoulis, M., *Identifying adults at high-risk for change in weight and BMI in England: a longitudinal, large-scale, population-based cohort study using electronic health records.* The Lancet. Diabetes & Endocrinology, 2021. **9**(10): p. 681-694.
46. Iyen, B., et al., *Long-term body mass index changes in overweight and obese adults and the risk of heart failure, cardiovascular disease and mortality: a cohort study of over 260,000 adults in the UK.* BMC Public Health, 2021. **21**(1): p. 576.
47. England, N., *Health coaching: Implementation and Quality Summary Guide: Technical Annexes*. 2020.
48. An, S. and R. Song, *Effects of health coaching on behavioral modification among adults with cardiovascular risk factors: Systematic review and meta-analysis.* Patient Educ Couns, 2020. **103**(10): p. 2029-2038.

Appendix 1: Literature Review

Identification and management of cardiovascular long-term conditions in primary care

Available from: https://www.thurrock.gov.uk/public-health/other-public-health-reports

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