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 **19 October 2023**

Council Chamber, CO3 Building, Civic Offices, New Road, Grays, Essex, RM17 6SL.

Membership:

Councillors George Coxshall (Chair), Barry Johnson, Elizabeth Rigby and Sue Shinnick

Ian Wake, Executive Director of Adults, Housing and Health
Jo Broadbent, Director of Public Health
Rita Thakaria, Partnership Director (NELFT / EPUT / Thurrock Council)
Sheila Murphy, Executive Director of Children's Services
Michael Dineen
Anthony McKeever, Executive Lead Mid and South Essex Health and Care Partnership & Joint Accountable Officer for its 5 CCGs
Aleksandra Mecan, NHS MID AND SOUTH ESSEX IC
Margaret Allen, MSE
Jeff Banks, Director of Strategic Partnerships
Michelle Stapleton, Executive Member, Basildon and Thurrock Hospitals University Foundation Trust
Fiona Ryan
Hannah Coffey, Deputy Chief Executive, Mid and South Essex NHS Foundation Trust
Kim James, Chief Operating Officer, Healthwatch Thurrock
Mark Tebbs, Thurrock CVS
Jim Nicholson, Chair of the Adult Safeguarding Partnership or their senior representative
Chair of the Adult Safeguarding Partnership or Senior Representative, Thurrock Local Safeguarding Children's Partnership or their Senior Representative
Gill Burns, Director level representation of Thurrock, North East London Foundation Trust (NELFT)
Alexandra Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
B J Harrington, Essex Police

Agenda

Open to Public and Press

		Page
1	**Apologies for Absence**	
2	**Minutes of 31 August meeting and Action and Decision log**	**5 - 16**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 31 August 2023.

To review action and decision log.

3 Urgent Items

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

4 Declaration of Interests

5 Virtual items for consideration

1. As part of managing and prioritising Health and Wellbeing Board time we consider items for Board's information virtually.
2. Secretariat have not been notified of any items to be circulated and considered virtually following today's meeting.
3. Members are asked to highlight any reports that they would like the Board to be aware of and these can be circulated outside of the meeting.

6	**Thurrock Integrated Sexual Health Needs Assessment**	**17 - 154**

A covering report and copy of the Sexual Health Needs Assessment is included within member's papers.

7	**Southend, Essex and Thurrock (SET) LeDeR Annual Report 22/23.**	**155 - 196**

A covering report and copy of the LeDeR Annual Report 22/23 is provided within member's papers.

8	**A Health in All Policies approach to Place Shaping**	**197 - 282**

A covering report and supporting appendices (A Health in All Policies Approach to place-shaping: Delivering on Thurrock's Health and Wellbeing Strategy (2022-2026) and Executive Summary) is included within member's papers.

9	**Health and Wellbeing Strategy in focus Domain 6 - Community Safety**	**283 - 308**

Queries regarding this Agenda or notification of apologies:

Please contact Claire Dixon, Business Support Officer & Darren Kristiansen, Business Manager by sending an email to claire.dixon@thurrock.gov.uk or dkristiansen@thurrock.gov.uk

Agenda published on: **11 October 2023**

This page is intentionally left blank

Information for members of the public and councillors

Access to Information and Meetings

Advice Regarding Public Attendance at Meetings:

Following changes to government advice there is no longer a requirement for public attendees to book seats in advance of a committee meeting. All public attendees are expected to comply with the following points when physically attending a committee meeting:

1. If you are feeling ill or have tested positive for Covid and are isolating you should remain at home, the meeting will be webcast and you can attend in that way.

2. You are recommended to wear a face covering (where able) when attending the meeting and moving around the council offices to reduce any chance of infection. Removal of any face covering would be advisable when speaking publically at the meeting.

3. Hand sanitiser will also be available at the entrance for your use.

Whilst the Council encourages all who are eligible to have vaccination and this is important in reducing risks around COVID-19, around 1 in 3 people with COVID-19 do not have any symptoms. This means they could be spreading the virus without knowing it. In line with government guidance testing twice a week increases the chances of detecting COVID-19 when you are infectious but aren't displaying symptoms, helping to make sure you do not spread COVID-19. Rapid lateral flow testing is available for free to anybody. To find out more about testing please visit https://www.nhs.uk/conditions/coronavirus-covid-19/testing/regular-rapid-coronavirus-tests-if-you-do-not-have-symptoms/

Members of the public have the right to see the agenda, which will be published no later than 5 working days before the meeting, and minutes once they are published.

Recording of meetings

This meeting will be live streamed and recorded with the video recording being published via the Council's online webcast channel: www.thurrock.gov.uk/webcast

If you have any queries regarding this, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

Guidelines on filming, photography, recording and use of social media at council and committee meetings

The council welcomes the filming, photography, recording and use of social media at council and committee meetings as a means of reporting on its proceedings because it helps to make the council more transparent and accountable to its local communities.

Thurrock Council Wi-Fi

Wi-Fi is available throughout the Civic Offices. You can access Wi-Fi on your device by simply turning on the Wi-Fi on your laptop, Smartphone or tablet.

- You should connect to TBC-CIVIC
- Enter the password **Thurrock** to connect to/join the Wi-Fi network.
- A Terms & Conditions page should appear and you have to accept these before you can begin using Wi-Fi. Some devices require you to access your browser to bring up the Terms & Conditions page, which you must accept.

The ICT department can offer support for council owned devices only.

Evacuation Procedures

In the case of an emergency, you should evacuate the building using the nearest available exit and congregate at the assembly point at Kings Walk.

How to view this agenda on a tablet device

You can view the agenda on your iPad, Android Device or Blackberry Playbook with the free modern.gov app.

Members of the Council should ensure that their device is sufficiently charged, although a limited number of charging points will be available in Members Services.

To view any “exempt” information that may be included on the agenda for this meeting, Councillors should:

- Access the modern.gov app
- Enter your username and password

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

↓

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

↓

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

Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 31 August 2023 11.00am-1.00pm

Present:
Councillor G Coxshall (Chair)
Jo Broadbent, Director of Public Health
Margaret Allen, Deputy Thurrock Alliance Director
Romi Bose, Transformation and Engagement Lead, Thurrock Alliance
Rita Thakaria, Partnership Director, Thurrock Council, EPUT and NELFT
Michele Lucas, Assistant Director for Education and Learning
Fiona Ryan, Managing Director, Mid and South Essex NHS Foundation Trust
Sharon Hall, Northeast London Foundation Trust (NELFT)
Mark Tebbs, Chief Executive, CVS
Jenny Barnett, Chief Superintendent, Essex Police

Apologies:
Councillor Johnson
Councillor Shinnick
Councillor Rigby
Ian Wake, Corporate Director for Adults, Housing and Health
Sheila Murphy, Corporate Director for Children's Services
Michael Dineen, Assistant Director for Counter Fraud and Community Safety
Jim Nicolson, Adult Safeguarding Board
Aleksandra Mecan, Thurrock Alliance Director
Jeff Banks, Director of Strategic Partnerships, Mid and South Essex Integrated Care System
Michelle Stapleton, Integrated Care Pathway Director, Mid and South Essex NHS Foundation Trust
Kim James, Chief Operating Officer, Healthwatch Thurrock
Gill Burns, Director of Children's Services, Northeast London Foundation Trust (NELFT)
Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Hannah Coffey, Acting Chief Executive, Mid and South Essex NHS Foundation Trust
BJ Harrington, Chief Constable, Essex Police

Guests:
Maria Payne, Thurrock Council
Alfred Bandakpara-Taylor, Mid and South Essex Integrated Care System
Daniel Jones, Thurrock Council
Ceri Armstrong, Thurrock Council

1. Welcome, Introduction and Apologies

Colleagues were welcomed and apologies were noted. Michele Lucas attended on behalf of Sheila Murphy, Margaret Allen and Romi Bose provided representation from the Thurrock Alliance and Sharon Hall attended on behalf of Gill Burns.

2. Minutes / Action Log

The minutes of the Health and Wellbeing Board meeting held on 27 July 2023 were approved as a correct record.

The action and decision log were considered and updated accordingly.

3. Urgent Items

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

4. Declaration of Interests

There were no declarations of interest.

5. Virtual items for consideration

There were no items to be considered by the Board outside of the meeting.

6. Action log follow up – NHS Weight Management Services

This item was introduced by Margaret Allen, Thurrock Alliance. Key points included:

- Tier two weight management provision consists of a 12 week programme which includes an exercise programme, healthy eating guidance, portion control and healthy lifestyle support. The Stanford-Le-Hope and Aveley, South Ockendon and Purfleet (ASOP) initiatives are broadly based on tier two provision. Evaluation of this provision commenced in June 2023 and will report after six months (November) and then a year (June 2024).
- The rate of tier two programme uptake has seen an increase for men, up from 10% in 2022/23 to 14% in the first quarter of 2023/24. A GP incentive scheme is also helping to increase the uptake of these services.
- Tier three weight management services incorporate psychological support for those who have already completed a tier two programme – this support lasts for 12 months. The first 12 weeks is a curriculum-based programme of classes dealing with a wide range of weight-related issues and is based on Cognitive Behavioural Therapy.

- In September 2021, the Binge Eating Behaviour (BEB) service was commissioned as binge eating has been identified as one of the main causes of people dropping out of weight management provision, with up to 30% of attendees not completing the courses.
- On completion of the BEB 12 week course, the individual is immediately enrolled on the tier three programme. The dropout rate from tier three is significantly reduced and the weight loss experienced is proportionately greater and is maintained for longer.
- In addition, there are digital weight management programmes available however there are limitations as it is reliant on access to digital platforms.
- Drug therapies are also available in Thurrock which is a two year programme and is offered as an alternative to tier four bariatric surgery.

During discussions, the following points were made:

- Members recognised obesity is a multifaceted issue, with weight management services being commissioned in different places.
- A Weight Management Group has been established for Thurrock, along with a Child Weight Management Working Group.
- The service specification for tier three services is due to be refreshed and self-referral to these services considered. Furthermore, the sequential process of weight management programmes is being reviewed as often moving through these programmes creates a sense of failure for the individual on their weight loss journey.
- A human learning system and personalised approach would be more beneficial to weight management services. For example, if a tier three programme would be more suitable to an individual, however they have not completed a tier two programme, then a tier three offer should be made available.
- Members raised concerns regarding the process of GP referrals to weight management programmes as there are often challenges in obtaining an appointment. However, colleagues were reassured the referral can be made via the GP practice, for example via a social prescriber. Furthermore, tier two services are available for self-referral and details of these are on the Council's website.
- It was recognised a human learning system approach is needed to understand why those signed up to programmes may not attend as this is often due to a multitude of reasons.

Decision: Members noted the update on Weight Management provision in Thurrock.

7. Southend, Essex and Thurrock (SET) All-Age Mental Health Strategy 2023-2028

This item was introduced by Maria Payne, Thurrock Council and Alfred Bandakpara-Taylor, Mid and South Essex Integrated Care System. Key points included:

- Partners across Southend, Essex and Thurrock (SET) have developed an All-Age Mental Health Strategy which has been underpinned by population need and existing national guidance.
- The work on this Strategy has been ongoing throughout the last year, led by an external consultancy company (Tricordant) and is in alignment with priorities from a range of organisational strategies.
- A significant challenge of the previous 2017 Strategy was its implementation therefore system partners are determined to develop effective mechanisms for ensuring implementation of the Strategy whilst recognising most of the delivery will continue to be at local Place level (Alliances).
- In Thurrock, the Mental Health Transformation Board and Integrated Emotional Wellbeing Partnership will be pivotal mechanisms for ensuring local delivery, alongside the clinical strategies developed by the borough's Primary Care Networks (PCNs).
- Partners have developed proposals for a SET All-Age Mental Health Strategy Implementation Group (SIG) focussed on overseeing a limited range of key strategic issues around overall Strategy delivery and SET system development, with partners sharing leadership of individual workstreams as appropriate. It will build on the existing informal working arrangements established for oversight of the Strategy development itself.
- The SIG will have oversight and monitor the overall SET Mental Health Strategy, including the delivery of SET-level outcomes for specialist services such as eating disorders and perinatal mental health. The membership will include senior representatives from the core partners.
- The Strategy has been endorsed by EPUT and MSE ICB Executive Boards, as well as the other two ICBs in Essex and the Essex Health and Wellbeing Board.

During discussions, the following points were made:

- It was noted the data used to underpin the Strategy is from 2020 as this was the most recent data source.
- Members raised concerns that the Strategy does not make specific reference to those with Special Education Needs (SEN) or Looked After Children as many children within these cohorts struggle with their mental health.

- Colleagues were reassured partners will link in with the work on the Brighter Futures Strategy as part of reporting and monitoring against specific deliverables. The transition period between children's and adults service provision will also be included.
- Quantifiable and measurable KPIs were discussed, along with ensuring qualitative statements are included as part of holding organisations to account. Responsibilities are currently being developed, for example Alliance responsibilities and those of wider partners such as the NHS. It was recognised the SIG will not directly hold responsibility.
- It was noted some initial priorities have been identified as part of delivery of the Strategy, including EPUT contracting and the inclusion of those suffering with serious mental illness within the PCN clinical strategies.

Decision: Members completed the following:

- **Agreed to adopt the draft Southend, Essex, and Thurrock Mental Health strategy in the appendix, which has been developed jointly with health and care partners across the geography of greater Essex.**
- **Agreed that Thurrock will be part of a Southend, Essex and Thurrock (SET)-wide Strategy Implementation Group to support and coordinate collaborative working across partners to implement the strategy.**

8. Initial Health Assessments (IHA)

This item was introduced by Daniel Jones, Thurrock Council. Key points included:

- The report provides an update on Initial Health Assessment (IHA) performance. The target is that 90% of children entering care receive their IHA appointment within 20 working days of entering care. This target is not currently met.
- Additional capacity (funded by the ICB) has been helpful in improving performance where children are placed within the Northeast London Foundation Trust (NELFT) area, however it has not addressed the issues which are also faced in other areas of the country. For example, nationally there is a shortage of paediatricians and no clear national workforce plan.
- The report includes evidence that when additional appointments (funded by the ICB) are available, performance improves, however, where these additional appointments are not available, demand exceeds supply.
- Demand can be variable and for this quarter the demand for IHA's for Thurrock was exceptionally high as 30 children entered care that month, 22 of whom required an IHA. They were placed both in and out of area.

- It is important to note that NELFT and Council colleagues work collaboratively to track and monitor all Thurrock children on a weekly basis via an IHA portal. The ICB is also invited and will attend these meetings, when required.
- Given the performance issues, incremental targets may be useful in the region of 60-70% and then 80-90%.

During discussions, the following points were made:

- Members noted that concerns regarding IHA targets were raised last year at the Corporate Parenting Committee, however the target is still not being met.
- Colleagues were advised only one Local Authority within the Eastern Region is currently working above a 70% target, with Essex's performance currently below 30%. Targets across the country are often different due to differing pressure points, for example, asylum seeking children presenting in Thurrock can create a sudden demand therefore impacting on performance.
- There is a need to understand if Thurrock's IHAs target has been missed by a few days or if this is considerably longer.
- It was recognised consideration has been given to using a mix skilled workforce to complete IHAs, however there are safeguarding issues which would need to be addressed for this to be reviewed further.
- Members discussed the segmented funding for IHAs and for the ICB to prioritise this workstream as the temporary increase in capacity did improve performance. However, further difficulties were raised as the previous service provider is no longer completing IHAs therefore organisations are struggling to cover provision.
- A whole system approach was discussed including a wider joint needs assessment across partners due to the multiple providers involved and differing levels of need.
- Members noted ICB engagement, however colleagues from the Children and Young People's department need to be included going forward as they are the commissioners for the services.

Action: Margaret Allen to provide Daniel Jones with the details of the relevant ICB colleagues from the Children and Young People's department.

Decision: A joint needs assessment containing clear ICB funding specifications was endorsed by the Board.

Action: Daniel Jones to provide the Chair with details of other Local Authorities with a IHA target of 70%.

Decision: Members completed the following:

- **Noted the positive impact of the additional capacity provided by the ICB to NELFT.**
- **Noted the further steps being taken to improve performance.**
- **Agreed to the target being adjusted to 70% IHA referrals on time with a stretch target of 90% on the basis of the information requested by the Chair.**

9. Tobacco Control Strategy

This item was introduced by Jo Broadbent, Thurrock Council. Key points included:

- The previous Tobacco Control Strategy for Thurrock expired in 2021 and following this, a Joint Strategic Needs Assessment (JSNA) was conducted.
- The Tobacco Control JSNA made recommendations for reducing smoking and smoking related harm in the borough. The recommendations have been reflected in the current Strategy document, which aims to provide strategic direction for the continuing work to reduce smoking and tobacco related harm in Thurrock, with a focus on inequalities.
- Thurrock has a similar smoking rate to that of England:
    - Thurrock: 12.6%
    - England: 13%
    - East of England: 12.9%
- This data is the result of a new methodology for measuring smoking prevalence and the confidence interval is quite wide, so the true prevalence in Thurrock could be between 9.5 and 15.6. The government has set a national ambition to achieve ≤5% by 2030.
- The Strategy focuses on groups that suffer disproportionately from smoking, including place based inequalities and certain cohorts within the wider population. For example, routine and manual workers, those with long-term mental health conditions and substance misuse issues are all disproportionately affected by smoking.
- The rate of smoking during pregnancy, particularly at the time of delivery is higher in Thurrock than the national average of 9.1% and the regional average of 8.5%.
- There are four priority workstreams outlined within the Strategy – prevention, smoke free environments (expanding zones within the in public realm), help smokers to quit and communication, evaluation, and adaptation.
- Smoking cessation models are based on a holistic treatment plan to align with core services such as maternity.

- This model is based on evidence relating to the success rate of smokers who come through the Thurrock Stop Smoking Service and the best way to increase quits in each higher-risk group.
- This Strategy will require action from a variety of stakeholders as part of embedding smoking reduction widely, with targeted services within the eight most deprived wards.
- A delivery plan will support the Strategy and progress will be monitored against this by the Strategy Coordinator.

During discussions, the following points were made:

- Members welcomed the Strategy as is builds on the comprehensive recommendations of the JSNA.
- It was recognised vaping does not heavily feature within the Strategy as the focus is on tobacco, however illicit vaping products are being targeted by Trading Standards.
- The message regarding vaping is challenging as for adults who smoke, vaping can help them to quit and is included within the smoking cessation offer. However, for those who do not smoke, vaping is discouraged.

- Members noted vaping is often viewed as more socially acceptable by children and young people whereby they believe it is better to vape than to smoke. Communications and messaging are therefore important, particularly across schools as messaging differs depending on the target audience.

Decision: Members noted the contents of the report and agreed to the
publication of the Tobacco Control Strategy 2023-2028 on the Council
website.

10. Health and Wellbeing Strategy - Domain 3 in focus: Person Led Health and Care

This item was introduced by Ceri Armstrong, Thurrock Council. Key points included:

- The aim for Domain 3 is for better outcomes for individuals, that take place close to home and make the best use of health and care resources. This is intrinsically linked with several chapters of the Better Care Together Thurrock: The Case for Further Change Strategy as there is a focus shift from process to people, including empowering of staff and culture changes.
- Goal 3A focuses on the development of more integrated adult health and care services in Thurrock. The progress for year one is outlined below:

    - Four Human Learning Systems ‘learning cycles’ have been established and are at different stages. A ‘learning’ report has been commissioned to understand the learning that needs to become embedded;
    - Governance arrangements for the Better Care Together Thurrock - The Case for Further Change, including Chapter 10 have been established;
    - The development and delivery of a ‘devolution agreement’ between the ICB and Thurrock Integrated Care Alliance, has not yet been agreed due to ongoing restructuring within the ICB.
- The commitments and ambitions for year two (2023/24) are as follows:
    - Implement recommendations following the completion of a learning report, and deliver an ongoing series of ‘learning experiments’ as part of embedding HLS throughout the Directorate;
    - Delivery of an integrated ‘Complex Cases Team’ ‘test and learn’ pilot including Mental Health, Substance Misuse;
    - Adult Social Care, Psychology and Housing – testing the development of an integrated approach to ‘complex’ cases and identifying learning which will result in system change and improved outcomes for the most complex of individuals;
    - Review of Thurrock’s Better Care Fund – ensuring that the Fund and Plan mirror Thurrock’s Integrated Care Strategy and support its implementation.
- Goal 3B relates to improving the Primary Care Response that includes timely access, a reduced variation between practices and access to a range of professionals. The progress for year one is outlined below:
    - As of end of March 2023, Thurrock has a total of 68.76 full time equivalent ARRS staff in PCNs in 12 different roles;
    - As of August 2023, two GP Fellows are working in practices and another three are to be onboarded by the end of September;
    - All four PCNs in Thurrock have a clinical strategy and these are undergoing sign off by the various governance routes.
- The commitments and ambitions for year two (2023/24) were outlined and included the following:
    - Development work has started to create Integrated Neighbourhood Teams in each PCN area (there is a possibility these will be renamed Integrated Locality Teams).

      These Teams will incorporate additional professions and will provide an improved offer to residents. Support will be provided to PCNs to move to the new model of the next three years.

- Goal 3C relates to the delivery of a Single Workforce Locality Model which works across organisational boundaries to provide an integrated and seamless response. The progress for year one is outlined below:
    - Four integrated locality networks have been established and are at different stages of development;
    - A 'blended roles' experiment for Wellbeing Teams has been scoped and has been identified as a year two commitment;
    - Work is ongoing to establish a delivery plan for the delivery of a Single Workforce Locality Model. Housing Teams are now operating at a locality and place level.
- The commitments and ambitions for year two (2023/24) were outlined and included the following:
    - Embed locality networks as a way of working - ensuring that they align or integrate with the developing PCN Integrated Neighbourhood Teams;
    - Development of an integrated approach to keeping people out of hospital, hospital discharge, and prevention of readmission;
    - Continue to develop and implement a Single Workforce Locality Model – with ongoing experiments via HLS and the implementation of change following learning from those experiments.
- Goal 3D relates to the delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual. The progress for year one is outlined below:
    - Work is ongoing to establish an Integrated Locality Based Commissioning Board - a grant fund (focused on Health Inequalities) is initially being established in Tilbury and Chadwell. Grants will be launched in September with the local community voting for them in a participatory budgeting approach;
    - A new integrated Commissioning Strategy has been outlined and is in the process of being developed;
    - A review of the Better Care Fund Plan has been carried out through the offer of support from NHS England. The results of this will be used to develop and improve the BCF.
- The commitments and ambitions for year two (2023/24) were outlined and included the following:
    - Agreement of a proposed engagement framework, development of actions to inform a community leadership model – which will include the scoping of a Locality Commissioning Board;
    - Development of an Integrated Commissioning Strategy with year one commitments identified and delivered;
    - Better Care Fund refreshed to reflect recommendation from the review.

During discussions, the following points were made:

- Members welcomed the domain update and colleagues were thanked for their ongoing work to drive this forward.

  Action: Ceri Armstrong to complete the monitoring framework for Domain 3 and circulate to the Board.

- It was noted that on 27 September, a third development workshop with PCNs will be held as part of the ongoing work to establish Integrated Neighbourhood Teams.

  Action: Integrated Neighbourhood Teams to be added to the forward planner for the December Health and Wellbeing Board.

- There is a national programme regarding the access to Primary Care as part of providing better access to residents. For Thurrock, 27 GP practices have been stratified into three groups – five requiring intensive support to improve access, and then the remaining practices categorised into intermediate and light touch support. The aim is to move from an operational focus to a more strategic approach and will be a GP led offer.

  Action: Margaret Allen to provide an indicative time frame for when PCN Clinical Strategies will be approved and published and the PCN funding for Children and Young People's services.

- Members discussed the complexity of the domain as there are multiple layers to achieving the commitments and reiterated the importance of blended working roles as part of upskilling and training the workforce.
- Members recognised the challenges related to commissioning cycles and the need for a joint commissioning approach as part of reducing transactional process costs. The voluntary sector welcomed early dialogue regarding commissioning models and the draft structure of the commissioning framework.

  Decision: Members noted year one achievements and agreed the year two commitments.

The meeting finished at 12:56pm.

CHAIR……..

DATE……

This page is intentionally left blank

19 October 2023	**ITEM: 6**
Health and Wellbeing Board	
Thurrock Integrated Sexual Health Needs Assessment	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Dr Jo Broadbent, Director of Public Health	
Accountable Assistant Director: Andrea Clement, Assistant Director of Public Health	
Accountable Director: Dr Jo Broadbent, Director of Public Health	
This report is Internal	

Executive Summary

Local authorities have, since 1 April 2013, been responsible for improving the health of their local population and for public health services including most sexual health services. The Secretary of State continues to have overall responsibility for improving health, but Regulations made under Section 6C of the NHS Act 2006 require local authorities to take steps in exercise of their public health functions, or aspects of the Secretary of State's public health functions[1]. Regulation 6 requires local authorities to provide or make arrangements to secure the provision of open access sexual health services in their area, specifically:

- Comprehensive sexual health services including most contraceptive services and all prescribing costs but excluding GP additionally provided contraception.
- Sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing.
- Specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, colleges, and pharmacies.

The sexual health service contract was extended for 1 year and is due to expire on 31st March 2024. Public Health have been granted delegated authority to procure a new sexual health service and in order to do this an Integrated Sexual Health Needs Assessment (ISH NA) was completed. This document sets out the key findings and recommendations from the ISH NA.

[1] See commonslibrary.parliament.uk-briefings

1. Recommendation(s)

1.1 That Health and Wellbeing Board note the contents of and agree to the publication of the Thurrock Integrated Sexual Health Needs Assessment 2023 on the Council website.

2. Introduction and Background

2.1 This needs assessment has been brought to Health and Wellbeing Board at the request of the Director of Public Health to obtain approval to publish the needs assessment on the Council website.

2.2 Good sexual health enables healthy relationships, planned pregnancies, and prevention of disease. It is important for all individuals throughout their life course and contributes to maintaining and improving population health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

2.3 According to The Office for Health Improvement and Disparities (OHID) (2023) sexual health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, young people, and people from ethnic minority backgrounds. Similarly, HIV infection in the UK disproportionately affects gay, bisexual and other MSM, and black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

2.4 Sexual Health services can be accessed throughout the country by anyone in need. Therefore, it is vital that services in Thurrock are comparable to those elsewhere ensuring a high standard of care for those living in or visiting the borough.

2.5 In order to inform the re-procurement process, the Public Health Team has completed a Sexual Health Needs Assessment with a view to addressing the following. These are explored further in the full document attached as Appendix 1:

- Condom distribution.
- Late diagnosis HIV and treatment.
- New and emerging threats/issues.
- STI testing and prevention including opportunistic chlamydia testing.
- Contraception including long-acting reversible contraception (LARC).
- Service engagement with stakeholders.
- Accessibility of services.
- Reducing Teenage pregnancy and repeat terminations.
- Engagement with GPs and Pharmacies.
- Increasing Hepatitis testing.

- To seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems (HLS) co-design approach throughout the life span of the contract.

2.6 The ISH NA has been reviewed by the Public Health Leadership Team and Adults, and Housing and Health Directorate Management Team (DMT) and comments incorporated into the document.

2.7 The Integrated Sexual Health Needs Assessment was completed using a mixed methodology including:

- Quantitative analysis from national datasets
- Qualitative insight from interviews with professionals
- Qualitative insight from service users
- Review of national and local policy/strategies
- Literature search of evidence including Relationship and Sex Education (RSE), deprivation, cross charging, virtual clinics, commissioning, LARC, HIV, STIs and emerging threats

A summary of the key findings and recommendations is given below.

2.8 Findings (The Service):

- The Orsett site is difficult to get to and to navigate.
- The service is appointment only with no drop in provision.
- The service is not open late enough to encourage service users to attend, the building does not have a welcoming environment. The “spoke” clinics are not open.
- Staff don’t appear to be trauma informed.
- Limited focus on inclusivity.
- Online service appears to work well however there is a risk of over ordering tests.

Summary of Recommendations:

- To review the hub and spoke model of provision.
- To ensure clinics are accessible and reach into areas with high deprivation or need.
- To review the use of drop in and outreach services.
- To ensure appropriate training for all staff.

2.9 Findings (Engagement)

- External services find referral into sexual health can be difficult.
- The service is not well known or represented in Thurrock.
- There appears little experience or training in how to talk to people with learning disabilities or autism.
- The sexual health service has no outreach offer.

- There appears too little in place for the growing aging population requiring services.

Summary of Recommendations:

- Services need to be more visible and have a comprehensive communication strategy.
- Services need to engage the community and key stakeholders.
- Services need to ensure age-appropriate communications and engagement.

2.10 Findings (Contraception)

- GP prescribed LARC rates are low in Thurrock.
- Males attending the specialist contraceptive service in Thurrock had increased between 2017-2019. In 2019 44 per 1,000 males attended specialist contraceptive services, compared to 18 per 1,000 across CIPFA neighbours and 20 per 1,000 in England.
- Under 18 conception rates have decreased in Thurrock however the rate of abortions and repeat abortions has increased.
- The rate of under-25 females attending specialist contraceptive services in Thurrock has remained almost consistent since 2017, with a peak in 2019 at 118 per 1,000. The current rate of 90 per 1,000 in 2021 is an increase of 79 per 1,000 in 2020.
- Unplanned pregnancies are more likely to result in abortion, or if the pregnancy is continued, more likely to result in adverse health and life outcomes for the mother and child.

Summary of Recommendations:

- Reduce unwanted pregnancies by improving education and engagement for young people.
- Increase RSE provision throughout Thurrock.
- Increase engagement with stakeholders offering LARC.
- To increase offer of LARC in the service for all those eligible.

2.11 Findings (Chlamydia)

- Chlamydia detection rates in Thurrock are some of the lowest among the CIPFA neighbours' group, with screening rates being only 10% of the 15-24 year old population in 2021. Decreasing from 15% in 2017.
- Nationally areas with the highest detection rates also have the highest screening rates.
- A shorter period of infection will reduce an individual's chance of developing complications and reduce the time when someone is at risk of passing the infection on.
- There may be lack of understanding regarding the risks if not getting tested and getting treatment early throughout Thurrock.

Summary of Recommendations

- Provider to continue to monitor chlamydia testing.
- Provider to increase offer of chlamydia testing in Thurrock.
- Services to increase communication and engagement to increase awareness of chlamydia.

2.12 Findings (HIV)

- Lower rates of HIV testing accepted in Thurrock especially amongst women.
- Repeat testing in gay, bisexual, and other MSM compares well to England averages.
- Late diagnosis of HIV has increased.

Recommendation (HIV):

- Services to raise awareness of HIV risk especially amongst women.
- Provider to continue to monitor repeat testing in high-risk groups and to ensure those at risk are retested.

2.13 Following the findings of this needs assessment, an updated service specification has been developed detailing what the expectation will be for the new Integrated Sexual Health Service. Many of the recommendations above will be actioned through the service re-commissioning process. In addition, areas for immediate action (eg workforce training gaps) are under discussion with the incumbent service provider.

3. Issues, Options and Analysis of Options

3.1 The final draft version of the needs assessment was completed in August 2023 and was subsequently approved by the Public Health Leadership Team, the Adults, Childrens Directorate Management Team and Housing and Health Directorate Management Team.

3.2 **Option 1: Approve the final version of the Thurrock integrated Sexual Health Needs Assessment for publication.**

3.3 The board will note the contents of the Thurrock Integrated Sexual Health Needs Assessment and provide their signoff for publication of this needs assessment on the Council website. The needs assessment has provided direction for the service specification development which will inform the commissioning of a new sexual health service for Thurrock.

3.4 **Option 2: Provide conditional approval for the Thurrock Sexual Health Needs Assessment**

3.5 The board would note the contents of the needs assessment but request a review of content of the document.
Based on the understanding that these amendments would be carried out, conditional signoff for publication of this strategy would be provided.

3.6 **Option 3: Reject the final version of the Thurrock Sexual Health Needs Assessment**

3.7 The board would note the content of the needs assessment but reject the document in its entirety and request a new needs assessment be undertaken based on specific recommendations.

4. Reasons for Recommendation

4.1 Option 1 is recommended. In providing final signoff on the needs assessment the public health team and partners will be able to publish the Integrated Needs Assessment. The procurement went live on the tender portal on the 18th September 2023.

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

5.1 This needs assessment has been reviewed and approved in its final form by Public Health Leadership Team, Childrens DMT and Adults Health and Housing DMT.

5.2 Engagement sessions on service requirements have been held with key stakeholders and have formed part of the qualitative element of the needs assessment.

5.3 Service users have been consulted via an online and paper survey to solicit views on future service delivery. 119 responses were received and have informed the new scope of the sexual health service to including innovative delivery approaches.

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

6.1 The findings of the ISH NA have led to the design of the Integrated Sexual Health Service Specification (ISH SS) which aligns with Thurrock's Improvement and Recovery Plan 2022 to be a more streamlined and financially sustainable organisation.

6.2 The findings and recommendations within the ISH NA leading to the development of the ISH SS have aligned with strategic theme of the IRP to be a focused, cost-effective, sustainable, and co-designed approach to service provision which is delivered in partnership with residents and other key partners, with collaboration across multi-disciplinary teams.

7. Implications

7.1 **Financial**

Implications verified by: **Bradley Herbert**

Senior Management Accountant

Although procuring a new long-term Sexual Health Service Contract will have significant financial implications for the local authority, the proposed financial envelope for the service falls within the current available funding in the Public Health budget and within our best insight on the likely Public Health Grant level over the lifetime of the contract.

Once the procurement exercise is completed, the cost of the new contract will form part for of the 2024/25 Public Health budget setting process. With the planning of the budget, and the Public Health business plan, there is an inflationary element allowed for to reflect additional costs. The submitted tenders will be evaluated against this budget to give an informed view of the contract cost.

7.2 **Legal**

Implications verified by: **Kevin Malloy**

Team Leader Contracts – Legal Services

Following issue by the Council of a s114 notice, the Council must ensure that its resources are not used for non-essential spending. The contracts at issue here are all essential and the provision of them a statutory duty. In procuring the services outlined, the Council must observe the obligations upon it outlined in national legislation and in its internal procurement rules. The proposed procurement approach should fulfil these requirements but Officers are recommended to keep Legal Services fully informed as they progress through the procurements to ensure compliance.

Procuring a new contract for 2024/25 would be permissible under current contract conditions and Public Contracts Regulations.

Failure to have any contract in place for 2024/25 would likely see the Council breach its duty to provide a service specified in statute.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager – Community Development Team

The Sexual Health service is universal but will be specifically contracted to consider and provide for the needs of higher-need, higher-risk and vulnerable groups with regard to sexual health. These needs will be outlined in the

forthcoming needs assessment and the Service Specification. The model of delivery will need to take account of accessibility for our diverse community.

The contract will seek to maximise the Social Value from the contract and will seek to incentivise a Human Learning System approach by the Provider to ensuring the needs of high-need groups are understood and met.

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

Services and models of delivery need to ensure they are accessible to all ensuring that barriers to accessing health are mitigated, Covid-19 saw the transition to online services for many health settings and whilst this has proven to be very successful it cannot be the only mode of interface with service users. The Office for National Statistics (ONS) (2020) revealed 5% of the adult population of Great Britain had not used the internet in the 3 months prior to the survey and 16% of the population did not use a smartphone for private use.

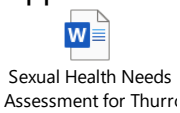
The mode of delivery must also reflect changing working patterns, rural living and access via public and private transport. There will need to be a variety of clinics available including, walk in, booking, out of office hours, sit and wait and online. These will be developed in the Service Specification.

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):

All reference points have been listed from page 115 with the Sexual Health Needs Assessment for Thurrock

9. Appendices to the report

Appendix 1: Integrated Sexual Health Needs Assessment for Thurrock



Report Author:

Rebecca Lawrence

Senior Programme Manager Public Health

Public Health

V4.0

SEXUAL HEALTH NEEDS ASSESSMENT FOR THURROCK

2023 – Thurrock Public Health Team

Contents

Contributors:

Rebecca Lawrence – Senior Programme Manager Public Health.....	Lead Author
Wassim Fattahi-Negro – Senior Programme Manager Public Health.....	Data Lead
Harinder Bhamra – Programme Manager Public Health.....	Data Support
Katie Powers – Health Improvement Officer Public Health.....	Contributor
Juliet Brabben – Health Improvement Officer Public Health.....	Contributor
Helen Forster – Strategic Lead Public Health.....	Contributor
Andrea Clement – Assistant Director Public Health.....	Contributor
Dr Jo Broadbent – Director Public Health.....	Contributor
Emma Sanford – Strategic Lead Public Health.....	Contributor
Gemma Louth – Business Support Officer.....	Contributor

Glossary

ACE Adverse childhood experience

ART anti-retroviral therapy

ASC Adult Social Care

ASOP Aveley, South Ockendon and Purfleet

CGL Change Grow Live

CIPFA Chartered Institute of Public Finance and Accountancy

CLA children looked after

CSW commercial sex worker

DHSC Department of Health and Social Care

DPH Director Public Health

EHC emergency hormonal contraception

GBMSM Gay, bisexual, men who have sex with men

GP General Practitioners

GUMCAD Genitourinary Medicine Clinic Activity Data

HIV human immunodeficiency virus

HLS human learning systems

HP Health Protection

IAPT Improving access to psychological therapies

ICB Integrated Care Board

ICP Integrated Care Partnership

ICS Integrated Care System

IVT Inclusion Visions Thurrock

LARC long-acting reversable contraception

LGBTQQIP2SA lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, two spirited and asexual

LGV Lymphogranuloma

Mpox Monkeypox

NEET not in education, employment, or training

OHID Office for Health Improvement and Disparities

OI opportunistic infection

PC Primary Care

PH Public Health

PrEP Pre exposure prophylaxis

RSE Relationship and sex education

SEND Special Educational Needs and Disabilities

SERIC South Essex Rape and Incest Centre

SH Sexual Health

SHS Sexual Health Services

SLA service level agreement

SPH Solutions for Public Health

SRS sexual and reproductive Health

SRHS sexual and reproductive health services

STI sexually transmitted infection

TC Thurrock Council

THT Terrance Higgins Trust

TLS Thurrock Lifestyle Solutions

UASC Unaccompanied asylum-seeking children

UKHSA United Kingdom Health Security Agency

Executive Summary

This Sexual Health Needs Assessment is a comprehensive evaluation of sexual health, exploring the needs of people living in Thurrock who have accessed or who would benefit from accessing sexual and reproductive health services. It also reviews evidence about how services can effectively engage with under-represented groups and recent approaches to models of care to deliver sexual and reproductive health services to populations. This will be supported by qualitative and quantitative data collected to identify areas of good practice and gaps in the service provision to inform the co-design and future commissioning model.

Good sexual health enables healthy relationships, planned pregnancies, and prevention of disease. It is important for all individuals throughout their life course and contributes to maintaining and improving population health.

Thurrock is a unitary authority area with borough status in the county of Essex. It is part of the London commuter belt and an area of regeneration within the Thames Gateway redevelopment zone. Thurrock has a diverse population that is increasing by over 10% every decade.

Thurrock is in the south of Essex and lies to the east of London on the north bank of the river Thames. Thurrock is divided in to four localities (Primary Care Networks PCNs): Aveley and South Ockendon (ASOP); Grays; Stanford-le-Hope (SLH); and Tilbury and Chadwell (T&C). PCNs are groups of GP practices working closely together with other healthcare staff and organisations to provide more joined up care to local communities.

Based on the 2021 census data, the population of Thurrock was recorded as 176,000. However, as of May 2023, the number of patients registered as Thurrock patients was 185,247, which exceeds the estimated population of the borough. The available data indicates that 181,790 registered patients have a primary address in Thurrock, while an additional 3,457 patients reside outside the borough.

Thurrock Public Health within the local authority and along with members and partners of the Health and Wellbeing Board have endeavoured through the research and delivery of this document to consider options to improve the sexual health outcomes of the local population, these include further supporting groups considered either vulnerable or at risk.

This report includes nationally and locally collected quantitative data about the level of need and type of services required to support people with their sexual health needs. The report also draws on qualitative information gathered from stakeholders about where local services are working well, and where there are barriers to support that some people have experienced. In addition, how service providers and agencies work together, and the gaps in provision for some population cohorts, particularly those with co-occurring conditions or complex needs are explored.

The assessment process involved in collecting and reviewing data from various sources included a mixture of open-source data and health records made available to health professionals. Findings and data were analysed to identify the key sexual health issues affecting the population, the prevalence of sexually transmitted infections (STIs), contraceptive use, sexual behavioural patterns, and the availability and accessibility of sexual health services. The findings, insights and observations will then feed into the development of an

evidence-based strategy linking into interventions to effectively address the sexual health needs of Thurrock's local population.

The author used a mixed methods study combining quantitative and qualitative data collection and analysis in one study. Integrating both these methods helps to gain a more complete picture of need than a standalone quantitative or qualitative study.

Thurrock Council commissioned Solutions for Public Health to inform the qualitative element of the stakeholder engagement piece of the Sexual Health Needs Assessment (SHNA).

The sexual health service commissioned by Thurrock Council is currently extended into its sixth year. The current contract expires in 2024 and a retender will commence in September 2023. To inform the re-procurement process, the Public Health Team has completed this Sexual Health Needs Assessment with a view to identifying the gaps and barriers to accessing the sexual health service and to consider ways in which to encourage engagement, particularly for the services below:

- Condom distribution.
- Late diagnosis HIV and treatment.
- New and emerging threats/issues.
- STI testing and prevention including opportunistic chlamydia testing.
- Contraception including long-acting reversible contraception (LARC).
- Service engagement and communication with stakeholders.
- Accessibility of services.
- Reducing Teenage pregnancy (with a focus on relationship and sex education (RSE).
- To seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems (HLS) co-design approach.

The qualitative elements of the recommendations are supplied by: Thurrock Council Sexual Health Needs Assessment: Stakeholder engagement report 2023 produced by Solutions for Public Health (see appendix 1).

Findings and Recommendations

Figure 1:

Topic	Findings	Relevant Section	Recommendation
Access to services	• The site of services in Orsett Hospital is based at the back of an old building which isn't easily accessible • Service is appointment only. • Spoke clinics are not open. • There is limited inclusivity. • There is limited RSE provision by specialist services. • There is limited promotion of the service. • No community sexual health service for young people. • Opening hours are restrictive.	Pages 18 / 22/ 39 / 48	• The Provider and commissioner review the use of drop in or same day clinic appointments. • The Provider to further promote additional clinics (which have now been reinstated). • RSE to be a focus of commissioning. • RSE to be promoted to improve engagement. • The Provider and commissioner to attend meetings including Head teacher and CEO, Mace, MASH, MARIC where required to ensure sexual health access is highlighted. • The Provider to develop a communication plan • The Provider to move away from one central clinic. • The Commissioner review young people's sexual health services as part of commissioning process. • The Provider to promote inclusivity and to provide specialist clinics where necessary. • The Commissioner and Provider to review the clinic use of family hubs and women's hubs where possible. • The Provider to strengthen links with child exploitation team. • The Provider to promote the use of the hub clinic in Thurrock. • The Provider to ensure signposting to the clinic is in the main hospital. • The Provider to review the use of the buzzer access system to the clinic. • The Provider to review the opening hours with feedback from service users.
Service model	• Limited joint working with pharmacies and GPs. • Access within setting is restricted. • Service is difficult to engage.	Pages 13 / 115	• The Provider to adopt a whole systems approach to look at how commissioners and sexual health services link in with GPs, community pharmacy, probation, people in secure settings, drug, and alcohol services, • The Provider to adopt a whole system approach to those who support people who have experienced sexual violence and domestic abuse such as the refuge and SERIC.

	• The service doesn't allow chaperones supporting vulnerable people in the service. • The sexual health service no longer in reach into services where young people with LD lived to teach the support workers how to support them and talk about their bodies. • The service is clinical without a focus on inclusivity. • Cervical screening is not offered.		• The commissioners and Provider must attend meetings relevant to their work, included but not limited to Brighter Futures, Multi Agency Child exploitation (MACE), and CEO and head teacher's forum. • The commissioners and Providers should ensure they are well represented throughout Thurrock to increase their profile in the community, ensuring that stakeholders are aware of how to refer into services. • The commissioners and providers need to work together to ensure that the HLS model is embedded and work closely with other service providers and the community to build an integrated system in Thurrock. • The Provider to look at alternative sites such as Grindr, Scruff or Taimi may enhance profile. • The commissioner and Provider to ensure LD and chaperones entering the service of the expectation and rationale for seeing the service user alone for initial contact • The commissioner and Provider to ensure that dual trained clinician appointments are advertised throughout Thurrock. • The commissioners to review process for cervical screening (currently GP).
Joint Working	• Lack of integrated working within Thurrock. • Lack of integrated working with neighbouring services. • Lack of awareness of sexual health services in Thurrock. • Lack of visibility in specialist meetings (including MACE, headteachers forum and Primary Care).	Pages 102 / 103 / 115	• The Provider to improve joint working of services across Essex and neighbours to ensure equity of services and ease of access for service users. • Thurrock LGBTQQIP2SA residents will go to Chelmsford Pride as there isn't one in Thurrock, Providers need to be visible at this and other related events. • The Provider to develop joint working between sexual health services and the Child exploitation and missing team. • The Provider to develop an integrated systems approach to governance and the planning of services. • The Provider to improve networking and engagement with other services such as the drug and alcohol team. • The Commissioners and Provider to improve partnerships from both a strategic and operational perspective.

			• The development of a Sexual Health Strategy for Thurrock could be the catalyst to improve partnership work.
Training and Education	• RSE is recognised as an important first step into engagement with sexual health services and good relationship and sexual health care. • Schools are not aware of current offer. • The current contract focuses on a small element of training the trainers regarding sexual health. • There are no 1-1 sessions available in schools. • Staff don't appear to be trauma informed.	Pages 6 / 18 / 19 / 22 / 23 / 25 / 33 / 39 / 41 / 42 / 46 / 47 / 48 / 50 / 51 / 56 / 58 / 59 / 60 / 64 / 65 / 84 / 91 / 94 / 104 / 106 / 107 / 115 / 122 / 125 / 126 / 127	• The Provider should ensure staff receive training to support development of communication skills with different groups e.g., to become trauma informed, appropriately support people attending psychosexual and sexual assault, and communication with people with a learning disability. • The Provider must inform schools about service changes and the benefits of taking up staff training by the provider to ensure all schools are aware and become engaged. • The commissioner and Provider should attend CEO and headteacher forums to ensure education colleagues are aware of training offered and improve take up of offer. • For commissioners to review the RSE element of the sexual health contract. • The Provider to improve promotion in schools and colleges and drop in and assemblies to promote this would enhance access. • The Provider to deliver specialist education and training to deliver to ensure high quality provision.
STI Testing & Diagnosis	• The STI diagnosis rate has declined in Thurrock since 2017, and it is unclear how vulnerable groups are affected by the decline in diagnoses. • In the most recent data (2021), the diagnosis rate in Thurrock is lower than CIPFA neighbours but similar to East of England; the testing rate is lower than both CIPFA	Pages 6 / 19 / 20 / 29 / 32 / 49 / 50 / 76 / 77-80	• The Provider must continue to review and evaluate data recording to improve recording and reporting of protected characteristics to gain a better understanding of potential inequities in Sexual Health outcomes across Thurrock including older age STIs. • The Provider should develop an Action Plan to increase uptake of STI testing to reduce the burden of undiagnosed infection in Thurrock, including: ○ Increasing awareness of the need for regular STI testing among vulnerable groups and those at higher risk. ○ Increasing referrals from other services. • The Provider, working in collaboration with OHID, UKHSA and the commissioner must monitor and respond to new and emerging threats such as Mgen and drug resistant infections.

Page 34	neighbours and East of England; with a corresponding positivity rate that is similar to CIPFA but higher than East of England. • The CIPFA neighbours with the highest diagnosis rates also have high testing rates. • Qualitative feedback from stakeholders and residents suggested that a high proportion of Thurrock residents were not aware of Thurrock sexual health services, and that other professionals were not clear how to refer into the service.		
Chlamydia	• Chlamydia detection rates in Thurrock are some of the lowest among the CIPFA neighbours' group, with screening rates being only 10% of the 15–24-year-old population in 2021. The areas with the highest detection rates also have the highest screening rates.	Pages 6 / 18 / 20 / 32 / 34 / 35 / 37 / 40 / 52 / 55 / 57 / 78-80 / 82 / 84 / 118-119	• The Provider should develop an Action Plan to increase awareness and uptake of chlamydia screening among male and female 15–24-year-olds, to reduce the burden of undiagnosed infection in Thurrock.

HIV Page 35	• Since 2018, fewer new sexual health service attendees in Thurrock accept an HIV test than is typical across East of England or among CIPFA neighbours. The gap is greater for women. • Repeat testing in gay, bisexual, and other MSM compares well to England averages. In comparison to CIPFA neighbours, Thurrock is at the higher end of the range. • Thurrock's HIV prevalence rate is similar to the England average at 2.4 per 1,000 between 15-59 years, but late diagnoses have increased since 2026-28 across both England and Thurrock.	Pages 6 / 13 / 17-20 / 22 / 23 / 38 / 40 / 50 / 52 / 55 / 56 / 60 / 84 / 88 / 89 / 91 / 92 / 94-103 / 116-119	• The Provider must continue to closely monitor HIV testing vs HIV late diagnosis rates in Thurrock population and learn from HIV late diagnosis events through retrospective look backs to identify missed opportunities and a pro-active Human Learning System approach. • The Provider should develop an action plan to: ○ Increase HIV testing among new attendees, especially women. ○ Reduce late presentation for HIV testing. ○ Increase uptake of PrEP among those who have been identified as being able to benefit.
Hepatitis	There may be an under-identification of hepatitis C in Thurrock due to a lower-than-average proportion of injecting drug users being engaged in treatment. Referrals between sexual health and substance misuse services and joint working	Pages 41 / 55 / 102-104 / 116-118	The Provider should consider how to: • Increase engagement of injecting drug users in drug treatment and ensure uptake of hepatitis C testing. • Strengthen joint working between sexual health and substance misuse services.

	may increase uptake by those at risk.		
Conception and Abortion Page 36	• Under 18 conception rates have decreased since 2017 in line with national and regional trends. • Whilst the abortion rate in Thurrock has increased since 2017 and in 2021 was 22 per 1000 females; the percentage of U18 conceptions leading to abortion has remained stable, albeit higher than national, regional and CIPFA comparators. • The rate of repeat abortions in Thurrock has increased since 2017.	Pages 13 / 14 / 17 / 20 / 21 / 31 / 32 / 34 / 60-64 / 74 / 116 / 120 / 124 / 125	• The Provider should review the accessibility of contraception services across Thurrock and surrounding geographies to ensure that good quality contraception services are accessible at a time and place that is convenient for the service user. • The Provider to ensure consistent education and advice on the preferred method of contraception is available to service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing. • Thurrock PH team to conduct further analysis into why the rate of repeat abortions is increasing and the groups most at risk with the aim to identify appropriate preventative actions. The Provider, commissioner, and associated services to develop an action plan for focusing on groups most at risk of unplanned conception and/or abortion such as sex workers or those with addiction.
LARC	There are lower levels of LARC activity in Primary Care.	Pages 6 / 18 / 20 / 21 / 25 / 37 / 46 / 50 / 52 / 58 / 64-71 / 74 / 91 / 116 / 124 / 125	• The Provider must ensure the continued collection of data around LARC recovery rate following the pandemic, teenage pregnancy, repeat abortions, to respond better to those needs. • The Provider must work collaboratively with pharmacies delivering contraceptive services and monitor impacts of over-the-counter contraceptive pill availability. • The Provider must strengthen joint working between sexual health and Primary Care and support them to increase their skill base where necessary.

1. Introduction

Good sexual health enables healthy relationships, planned pregnancies, and prevention of disease. It is important for all individuals throughout their life course and contributes to maintaining and improving population health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

Sexual health is a fundamental aspect of overall health and well-being and addressing sexual health needs is critical in reducing health inequalities and improving the quality of life of individuals and communities.

Sexual ill health is not equally distributed across the population, with some geographical areas and population groups experiencing disproportionate levels of poor sexual health. Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions, and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups. Similarly, Human Immunodeficiency Virus (HIV) infection in the UK disproportionately affects MSM and Black Africans. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their decisions and ability to access services. (Office for Health Improvement and Disparities, 2023).

Assessing the sexual health needs of Thurrock service users is a continuous process for the public health team at Thurrock Council. This includes reviewing population level data and service usage, and comparing this with the views of service users, the public, and other key partners across the system.

The sexual health service will play a key role in delivering preventative interventions that will enable people to make informed decisions about relationships, planning a pregnancy, contraception, sex, and sexual health, building personal resilience, and promoting healthy choices.

An integrated sexual health service model aims to improve sexual health by providing non-judgmental and confidential services through open access, where most of the sexual health and contraceptive needs can be met on site, often by one health professional, in services with extended opening hours (evenings after 6pm and weekends), and locations that are accessible by public transport. STI self-tests kits are available to test for most common STIs, the kits can be ordered through the online portal and are delivered discreetly to a chosen address with the results available in a few days.

Changes in attitudes, sexual practices, and behaviour continue to evolve and naturally impact upon the way sexual and reproductive health services are delivered. Thurrock is dedicated to ensuring that sexual and reproductive health services are a public health priority, and that the local population can access high quality, confidential services that meet their needs.

The needs assessment outlines the expectation for delivering an integrated sexual health service in Thurrock and the current provision against expected outcomes.

Methodology

The author used a mixed methods study combining quantitative and qualitative data collection and analysis in one study. Individually, these approaches can answer different questions, so combining them can provide more in-depth findings.

Mixed methods research combines elements of quantitative and qualitative research to answer research questions. Mixed methods can help to gain a more complete picture than a standalone quantitative or qualitative study, as it integrates benefits of both methods.

Quantitative research methods are useful for gathering hard data to measure, validate and inform crucial decisions. Qualitative research is the process of gathering descriptive data. Rather than numerical data and hard facts, which result from quantitative research, qualitative research deals with more subjective topics like views, attitudes, and motivations. It seeks to answer *why* people believe certain things or act in certain ways.

The benefits to using mixed methods research include:

- combining quantitative and qualitative approaches can balance out the limitations of each method.
- it can provide stronger evidence and more confidence in your findings.
- it can give you more granular results than each individual method.

Drawbacks include:

- it can be more complex to carry out.
- it may require more expertise to collect and analyse data, and to interpret the results, than using one method would.
- combining different methods requires extra resources, such as time and money.

The methods of information gathering used for this HNA included:

1. A document review of publications about the current national and local strategic position concerning sexual and reproductive health services.
2. A literature search of evidence about how services can effectively engage with under-represented groups.
3. A further literature search conducted by the North East Essex Foundation Trust (NELFT) library to further explore sexual and reproductive health, including deprivation, abortion, young people and vulnerable groups (see appendix 2).
4. Qualitative information about the barriers, enablers, and gaps in service provision in Thurrock gathered from semi-structured interviews with 14 professionals.
5. Quantitative data is data represented numerically, including anything that can be counted, measured, or given a numerical value.
6. Quantitative data was explored from various sources included (but not limited to) Fingertips, Census 2021, The Office of National Statistics (ONS), and the Genitourinary

Medicine Clinic Activity Database (GUMCAD). This was used to explore correlations between local, regional, and national testing, treatment, and diagnosis rates.

7. A survey of the general population, including those who have used services, focussing on awareness and experiences of services.

To understand how the current services were provided to people in need of sexual health services in Thurrock, a range of key stakeholders were contacted by the council and asked if they were willing to share their views and experiences in a brief interview with Solutions for Public Health (SPH). A set of questions was drafted and agreed (see Appendix 1); these covered:

- How services were provided.
- Barriers and enablers to delivering the services.
- Service risks.
- Service gaps.
- The impact of the pandemic.
- Suggestions for improving services to residents.

Representatives from the following organisations and teams were invited for interview:

- Commissioners of sexual health services.
- East of England regional sexual health lead.
- Sexual health services providers:
    - Provide.
    - Brook.
    - Terrence Higgins Trust.
- Psychological therapies providing psychosocial support.
- Drug and alcohol services for adults and young people.
- School nursing service.
- Youth offending service.
- Child exploitation and missing team.
- South Essex Rape and Incest Centre (SERIC) rape and sexual abuse specialist service.
- Thurrock lifestyle solutions – providing most of the disability services for Thurrock Council.
- GP with an interest in sexual and reproductive health.

A total of 13 stakeholders and one commissioner were interviewed.

To gather the views of both service users and non-service users a survey was developed and distributed to Thurrock residents (Appendix 1). Questions covered demographic information about the responder (gender, sexuality, ethnic group, age band, resident ward, and any disability), awareness of individual services, use of individual services including location, satisfaction with staff and their support (e.g., treatment and advice giving) and whether they would recommend the service to family and friends.

The survey was distributed online via social media by Thurrock Council and the provider. In total, 119 surveys were completed, returned, and analysed.

One hundred and nineteen surveys were returned and analysed. The geographical spread and demographic range of respondents appeared representative overall, but relatively few young people responded. Thirteen (11%) were aged 20 – 29, and there were no respondents younger than age 20. Less than half (38%, n=45) of survey respondents had used services and 62% (n=74) had not. Of the 45 who had used a service, 62% said they had used services at Orsett Hospital, eight had accessed the walk-in clinic in Grays, Tilbury, or Corringham Health Centres and ten people had gone to a GP, had a telephone appointment or postal test. Forty-two service users and 69 non-service users went on to answer further questions about their experience.

A literature search was conducted by SPH to identify publications describing guidance, best practice, evaluations, or case studies about how sexual health services can effectively engage with under-represented groups. This included evidence about interventions aimed at improving engagement of sexual health services with under-represented groups. Searches were conducted between March and May 2023 using an internet-based search engine (Google) and the TRIP database. Evidence about engagement with or uptake of sexual health services was sought. No specific definition for under-represented groups was used, instead evidence was sought relating to engagement with groups that were described by the authors as under-represented, under-served, hard to reach, socially disadvantaged or in need of, but less likely to access sexual health services. The most recent guidance or evidence identified was prioritised. Additional studies and documents cited in the publications identified by the searches were followed-up.

A further literature search was completed by the NELFT library and Knowledge Services on behalf of the author. Evidence searches: [PH Bulletin] Evidence on Sexual Health Needs Assessment SN40868. Stephen Reid. (7th March 2023). ILFORD, UK: NELFT Library and Knowledge Service (Appendix 2).

Sources searched included:

British Pregnancy Advisory Service.

Faculty of Sexual & Reproductive Healthcare.

Local Government Association (LGA).

NICE Guidance.

Public Health England (PHE).

The Faculty of Sexual & Reproductive Healthcare.

UK Health Security Agency (UKHSA).

Office for Health Improvement and Disparities (OHID).

Nice Guidelines.

FSRH website.

Local Government Website.

Databases searched included:

Embase, HMIC, Medline, Social Policy and Practice, TRIP Medical Database.

2. National and Local Policy/Guidance

National Policy

Sexual health is an important area of public health and affects individuals throughout the life-course – from pre-conception to those living with sexually transmitted illnesses (STIs) later in life. This chapter describes the national and local approaches to sexual health.

Poor sexual health can lead to serious personal long-term health consequences for individuals. As Ian Green, Chief Executive of the Terrence Higgins Trust, stated,

“Sexual health is an issue for most people, but there are clear groups that are disproportionately affected.”

The last full sexual health strategy ‘A framework for Sexual Health Improvement in England’[1] was published by the Department of Health and Social Care (DHSC) in 2013 following the Health and Social Care Act 2012 and subsequent transfer of public health responsibilities to local authorities. The strategy focusses on the following objectives:

- Building knowledge and resilience among young people.
- Improving sexual health outcomes for young adults.
- Ensuring all adults have access to high quality services and information.
- Supporting people to remain healthy as they age.
- Prioritisation of prevention.
- Reducing rates of STIs among people of all ages.
- Reducing onward transmission of and avoidable deaths from HIV.
- Reducing unwanted pregnancies among women of fertile age.
- Continuing to reduce the rate of U16 and U18 conceptions.
- Counselling for all women requesting an abortion.

The stated ambitions resulting from meeting these objectives were to:

- Improve the sexual health of the whole population to remove inequalities and improve sexual health outcomes.
- Build an open and honest culture where everyone can make informed and responsible choices about relationships and sex.
- Recognise that sexual ill health can affect all parts of society.

Since the strategy was produced a decade ago a range of recent reports have outlined some of the challenges facing sexual and reproductive health services in England and include recommendations about future service provision. These include:

[1] Department of Health. A Framework of Health Improvement in England. 2013.

- Report of the inquiry by the House of Commons Health and Social Care Select Committee into sexual health (2019)[2].
- A report by the Local Government Association and English HIV and Sexual Health Commissioners Group (EHSHCG) Breaking Point: securing the future sexual health services (2022)[3].
- A report by British Association for Sexual Health and HIV and the Terence Higgins Trust 'Sexually Transmitted infections in England: The state of the Nation (2020)[4].
- The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK: Women's lives, women's rights: Strengthening access to contraception beyond the pandemic (2020)[5].
- The 'Hatfield vision: A framework to improve women and girls' reproductive health outcomes' (2022) published by the Faculty of Sexual Health[6].

The House of Commons Health and Social Care Select Committee held an inquiry about sexual health services published in 2019[2]. The inquiry identified several priority areas which a new national strategy should address, this included:

- Ease of access to services.
- Provision of services to meet the needs of vulnerable populations.
- Access to cervical screening.
- Testing for the full range of sexually transmitted infections.
- Access to long-acting reversible contraception (LARC).
- Access to pre-exposure prophylaxis (PrEP) for those at risk of contracting HIV.
- Preventative interventions within all aspects of sexual health.

The House of Commons report in 2019 claimed the impact of STIs is greatest in young people. Among those aged 15 to 24, men were twice and women six times as likely to be diagnosed with an STI than their counterparts aged 25 to 59.7 Men who have sex with men (MSM) are also disproportionately affected by STIs. In 2017, 84% of syphilis diagnoses and 64% of gonorrhoea diagnoses in men were in MSM. Over half of those diagnosed with HIV in the UK in 2017 were gay or bisexual men.

In addition, the inquiry asked that the government strongly supported participation of students in Relationships and Sex Education sessions in schools.

According to the House of Commons Health and Social Care Committee, there are also disparities in the impact of STIs on minority ethnic groups. The rates of gonorrhoea and chlamydia in people from ethnic minority backgrounds are three times that of the general population, and the rate of the STI Trichomoniasis is eight times higher. Minority communities constitute 14% of the UK population but have a burden of late HIV diagnoses of 52% and 40% for people accessing HIV services. Although rates of HIV are declining in MSM overall, this is

[2] House of Commons Health and Social Care Committee. 'Sexual Health: Fourteenth report of session 2017-2019'. HC1419. June 2019.
[3] LGA and EHSHCG. 'Breaking Point: securing the future sexual health services'. 2022.
[4] BASHH and THT. 'Sexually transmitted diseases in England: The state of the nation'. 2020.
[5] All Party Parliamentary Group on Sexual and Reproductive Health in the UK. 'Women's lives, women's rights: Strengthening access to contraception beyond the pandemic'. 2020.
[6] Faculty of Sexual and Reproductive Health. 'The Hatfield vision: A framework to improve women and girls' reproductive health outcomes'. 2022.

not the case in all communities. The situation is worse for women, with80% of women living with HIV being from ethnic minority backgrounds, and 62% are of African heritage. In Thurrock the second highest ethnic group is black African/Caribbean/other black and whilst overall attendance at the sexual health services in Thurrock is predominantly female (70%), the split for females accessing the service for HIV concerns is nearly 55%. Service provision must take this into account when planning delivery.

Following the Health and Social Care bill in 2013; Local Authorities have had the commissioning responsibility for sexual health and certain reproductive health services. Responsibilities for commissioning different areas of sexual and reproductive health services are spread across Integrated Care Boards (ICBs), and NHS England.

Since 2013, local authorities have been primarily responsible for sexual health services in England. Sexual health services are paid for by a ring-fenced public health grant – funded by the national Government. There is no doubt that sexual health services are under intense pressure financially. The public health grant to local councils used to fund the sexual health services was reduced by over £1bn (24%) between 2016/17 and 20/21. Across England, spending on STI testing, contraception and treatment decreased by almost 17% between 2015/16 and 2020/21, as local councils adapted to these reductions.

In 2013, commissioning arrangements for sexual, reproductive health and HIV were introduced as part of the implementation of the Health and Social Care Act 2012 and were further detailed in 'The Local Authorities (Public Health Functions and entry to Premises by Local Healthwatch Representatives) Regulations 2013'. Move forward to 2022 and sexual and reproductive health services are commissioned by local councils to meet the needs of the local population, including:

- Contraception.
- STI testing and treatment.
- Sexual health aspects of psychosexual counselling.
- Sexual health specialist services.
- HIV social care.
- Wider support for teenage parents.

The Select Committee Inquiry noted that fragmentation of commissioning following the organisational changes in 2013 has meant that workforce planning, development and training has suffered with a subsequent impact on the number of likely of future specialists in sexual health. Figure 2 shows the commissioning responsibility for different elements of sexual health services. Appendix 4 describes the footprint and relevant responsibilities of LA/ICB/PCNs

Figure 2: Organisational responsibility for commissioning sexual and reproductive health services:

ICBs/ICPs	NHS England	Local Authorities
Most abortion services.	Basic contraception under the GP contract.	Contraceptive services and all prescribing costs including LARCS in GPs.
Gynaecology, including use of contraception for non-contraceptive purposes such as heavy bleeding.	HIV treatment and care.	STI testing and treatment including Chlamydia screening and HIV testing.
Permanent contraception (vasectomy and sterilisation.	STI testing and treatment under GP contract.	Specialist services: young people's sexual health, teenage pregnancy, services in schools, colleges.
Non-sexual health elements of psychosexual services.	Cervical screening.	HIV prevention.
	HPV programme.	Sexual health aspects of psychosexual counselling.
	Sexual assault referral centres.	Sexual health service in pharmacies.
	Specialist foetal medicine services.	Health promotion of sexual health services.
	Sexual health elements of prison health services.	Outreach.

Source: Health and Social Care Select Committee: Sexual health- fourteenth report of session 2017-19[2]

Unless appropriate commissioning arrangements are in place people must access different providers and settings for different aspects of their sexual and reproductive health, for example someone may be diagnosed with HIV at a sexual health clinic but will then receive medication and treatment including blood tests from an HIV specialist clinic which may not be co-located.

The increased use of smart phone dating apps, the rise in Chemsex (sexual activity while under the influence of stimulant drugs) where sexual encounters typically between gay, bisexual, and other men who have sex with men (GBMSM) are combined with taking drugs and the increased awareness of sexual health services have been suggested as the main drivers for the increase in demand for services (LGA, 2022). However, there is a lack of up-to-date research on why these trends have emerged. Another report by the British Association for Sexual Health and HIV and the Terence Higgins Trust called 'Sexually transmitted infections in England: The state of the nation' (2020)[4] outlined how despite declines in some STIs such as genital warts, others such as syphilis and gonorrhoea have increased by 165% and 249% respectively between 2010 to 2020. They also report how people from some ethnic minority communities and GBMSM are among those disproportionately impacted by STIs and that the current available research does not provide an understanding of the inequalities in sexual health and the impact of structural inequalities of STIs. The authors make the point that is there's a lack of sexual health champions speaking out about STIs and the lack of these voices, as well as visibility in the wider media, creates a barrier in the fight against STI stigma.

The LGA and EHSHCG[3] report outlines the problems across councils providing equitable access to contraception with women finding it harder to access the method they need. LARC fittings and removal have been particularly affected with services reporting a drop in access amongst young people, black women as well as women and girls from Asian and other ethnic

minority groups. This was also outlined in the 'All Party Parliamentary Group report on Sexual and Reproductive Health: Women's Lives, Women's Rights: Strengthening access to contraception beyond the pandemic' (2020). Although LARC waiting lists rose during the Covid-19 pandemic in Thurrock, additional services were funded to respond to this need. Although LARC waiting lists rose during the Covid-19 pandemic in Thurrock, additional services were funded to respond to this need. Increased use and access to contraception leads to a decrease in unintended pregnancies and although most will have a positive outcome, women are more likely to present late for antenatal care, more likely to experience postnatal depression and their babies more likely to experience low birth weight, mental health problems and poor health outcomes. Babies born to women under 20, years of age, the age group at highest risk of unintended pregnancy, also have higher rates of stillbirths, higher rates of infant mortality and low birth weight[5]. Around 45% of pregnancies and 33% of births in England are unplanned or associated with feelings of ambivalence. Overall, there has been a 60% decline in teenage pregnancies between 2007 and 2019, however there is a 7-fold difference in rates between LAs. In 2019 there were 16.7 teenage pregnancies per 1000 women under 18 years of age and of those 53% ended in abortion.

Responsibility for access to contraception is split across ICB/ICPs, NHS England and LAs (Table 1). This can lead to people having to engage with more than one service and could lead to confusion and disengagement. This can lead to people having to engage with more than one service and could lead to confusion and disengagement.

Another example where commissioning has led to fragmented delivery of services includes when women who attend a specialist service for contraception or an STI screen and are not able to access a cervical screen even though they are due for a test and staff are trained to take the sample. This is because cervical screening is commissioned by NHS England and is not a commissioning requirement of LAs. This results in either a lost opportunity to take a cervical sample from someone who may not go to her GP for the test, or a second unnecessary appointment made for an intimate examination the woman must undergo. This is in the context of a 20 year low in the uptake of cervical screening[5].

In 2022 the FRSH published the 'Hatfield vision: A framework to improve women and girls' reproductive health outcomes' setting out an ambition for 2030 that by this time 'reproductive health inequalities will have significantly improved for all women and girls, enabling them to live well and pursue their ambitions in every aspect of their lives'. There are 16 goals and 10 actions to tackle health disparities. The goals and actions are set out in appendix 5.

Overall, there is clearly significant focus from both Governmental and non-Governmental organisations to start to address the challenges of delivering a sustainable holistic comprehensive sexual and reproductive health services, however it is yet to be seen whether the resources and leadership required to make these changes will be available to ensure this is effective.

The 5 reports referenced here[2,3,4,5,6] call for a long-term vision for sexual and reproductive health in England and the urgent need for a national sexual health strategy. To provide sustainable holistic sexual and reproductive health services each of the reports have specific recommendations. Headline strategic priority areas that need to be addressed include:

- The DHSC working with local authorities, NHS England with input from providers and community groups should provide clarity on the future models of co-commissioning of sexual health services ensuring transparency and accountability.

- Commissioners, services, and the independent sector working with communities should co-design services and interventions that meet the sexual and reproductive health needs of all people, including underserved and unheard groups.
- With the increasing complexity of the needs of people using sexual health services there should be a greater emphasis on building relationships between services and settings (e.g., mental health, drugs and alcohol, violence against women and girls) and partnership working where feasible.
- There should be adequate long-term funding to cover increased cost pressures and investment in sexual and reproductive health services.
- There should be a drive to maximise the potential of statutory relationship sex and health education to equip young people with an understanding of fertility and contraception and ease access to services.
- A clear programme to re-establish training and development for both the current and future sexual health workforce should be a core requirement in commissioning and provision arrangements.
- Research about sexual and reproductive health inequality and impact on underserved and unheard groups and the systematic collection of data to support this.

Two strategies have recently been published by the Government and a third is expected soon. The 2 strategies are:

- Towards zero: Action plan towards ending HIV transmission, AIDS and HIV deaths in England 2022-2025[7].
- Women's health strategy for England[8].

The third document a National Sexual and Reproductive Health Action Plan has yet to be published. It is unclear yet how the 3 strategies will relate to each other.

Towards zero: Action plan towards ending HIV transmission, AIDS, and HIV deaths in England 2022-2025 [7].

The action plan sets out a commitment to reduce new HIV transmissions to zero by 2030 and outlines the actions required for the 3 years from 2022 to 2025[7].

The total number of people newly diagnosed with HIV decreased from 5,790 in 2014 to 3,770 in 2019. Of those new diagnoses 2,860 (76%) were first diagnosed in England and 905(24%) people were first diagnosed elsewhere.

In 2019, around £96,300 people were living with HIV in England and of those an estimated 18,200 (19%) had transmissible levels of virus. Estimates by the UKSHA suggest of these 18,200, around 5,900 (33%) were undiagnosed, 3,890 (21%) were diagnosed but not referred to specialist HIV care or retained in care, 1,630 (9%) attended for care but were not receiving treatment, and 2,110 people (12%) were on treatment but not virally supressed. The remaining 4,600 (25%) had attended for care but were missing evidence of viral suppression.

[7] Department of Health and Social Care. 'Towards Zero Action plan towards ending HIV transmission, AIDS and HIV related deaths in England 2022-2025'. 2021.

A range of objectives and actions from the strategy and are summarised below. The HIV independent commission published a report in 2020[9] with recommendations that informed the action plan. Appendix 5 shows how the recommendations from the HIV commission map to the objectives in the action plan.

The action plan has 3 specific objectives to reduce mortality and morbidity rates due to HIV. These are:

1. to reduce the number of people first diagnosed in England from 2,860 in 2019, to under 600 in 2025.
2. to reduce the number of people diagnosed with AIDS within 3 months of HIV diagnosis from 219 to under 110.
3. to reduce deaths from HIV/AIDS in England from 230 in 2019 to under 115.

There are 4 overall objectives:

1. Ensure equitable access and uptake of HIV prevention programmes by:
    a. Investing 3.5 million to deliver a National HIV Prevention programme over 2021 to 2024.
    b. Testing at least 20,000 people at higher risk of HIV during the annual National HIV Testing Week.
    c. Develop a plan and invest driving innovation in HIV PrEP delivery to improve access for key groups particularly in settings outside sexual and reproductive health services.
2. Scale up HIV testing in line with National Guidelines by:
    a. Working across clinical and professional communities to reduce missed opportunities for HIV testing and late diagnosis.
    b. Scale up capacity and capability for effective partner notification for people diagnosed with HIV.
3. Optimise rapid access to treatment, retention in care by:
    a. Reducing the people newly diagnosed with HIV who are not promptly referred to care.
    b. Support people living with HIV to increase the number of people retained in care and receiving effective treatment with innovative care models and support for complex needs.
4. Improving quality of life for people living with HIV and addressing stigma by:
    a. Enhancing training of the health and care workforce and drawing on innovation on public awareness and health promotion.

Women's Health Strategy for England

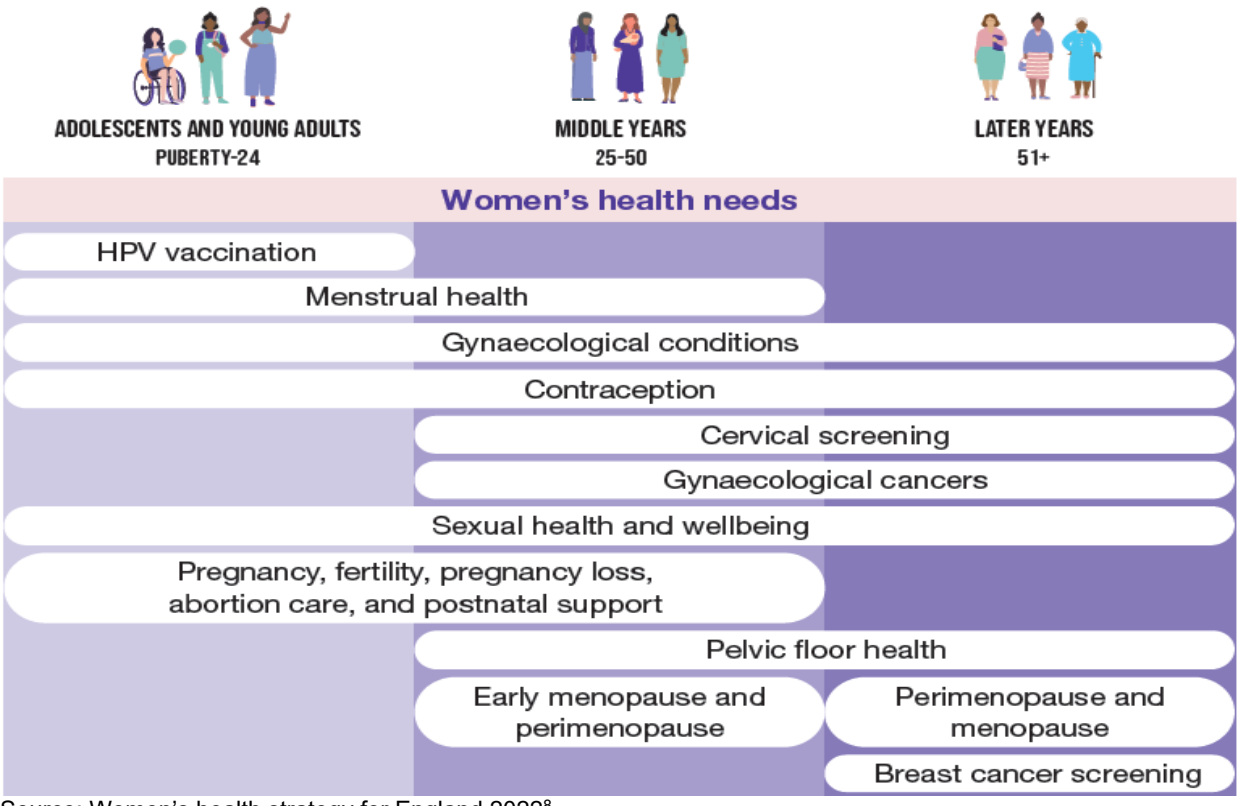
In August 2022 the Government published a strategy for women's health, including sexual and reproductive health[8]. The rationale for the strategy was that women spend a significantly greater proportion of their lives in ill health and disability compared to men and whilst women make up 51% of the population, the health and care system has historically been designed by men for men. It has resulted in women having to move from service to service to have

[8] Department of Health and Social Care. 'Women's Health Strategy for England'. 2022.
[9] HIV Commission. 'How England will end new cases of HIV: The HIV Commission final report and recommendations. 2020.

reproductive health needs met and they can struggle to access basic services such as contraception. The call for evidence for the inquiry resulted in nearly 100,000 responses and from this a 6-point plan aims to improve the way in which the health system engages and listens to girls and women over the next 10 years. This will be based on a life course approach and the ambitions include:

1. Ensuring women and girls are listened to and their concerns taken seriously at every stage of their journey.
2. Women and girls reporting better experiences of procedures and are well informed about the care they can expect for example conversations on pain relief before and intrauterine device is fitted or being offered a chaperone for intimate examinations. Disparities in experiences of services and procedures are reduced especially for women from under-served and seldom heard groups.
3. Personalised care and shared decision making embedded in all areas of women's health.
4. More research into women's experiences of health and care.
5. Increased leadership, accountability and representation of women and women's health expertise in all forums where decisions are made in the health and care system.

Figure 3: Women's reproductive and sexual health needs across the life course[8]



Source: Women's health strategy for England 2022[8]

Innovation and collaborative delivery of women's health services will be an important way to improve access and experience for women. Women's health hubs and similar models of 'one stop clinics' have been created in areas including Liverpool, Manchester, Sheffield, Hampshire, and Hackney. The models provide integrated women's health services at primary and community care level where services are centred on women's needs and reflect the life course approach rather than being organised by individual condition or issue. Hub models

can incorporate management of contraception, heavy menstrual bleeding, cervical screening, menopause, and other aspects of women's health care. A key aim would be to improve access to the full range of contraceptive methods in particular LARC. Public Health England (PHE) assessed the return on investment of contraception and estimated that the public sector had a return of £9 for every £1 invested[10].

To measure whether the strategy is making a difference a new reproductive health experiences survey will be commissioned every 2 years. This will gather data on women's experiences across all areas of reproductive health and include, menstrual health, contraception, pregnancy planning and menopause.

Core20PLUS5

An approach to reducing healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people (see appendix 3). Whilst not directly affecting the commissioning of sexual health services core20plus5 focusses on health inequalities and deprivation, sexual health is disproportionately affected scoio economic factors including deprivation.

Local Policy

The Health and Wellbeing Board published a strategy for the local community, presenting the Board's Vision for health and wellbeing in Thurrock for 2022-26. The Board's Vision of Levelling the Playing Field aims to tackle the many causes of poor health that are not level across Thurrock. These include individuals' health risk behaviours such as smoking and the quality of clinical care that people receive, but the greatest influences on overall community health are wider determinants of health. These include high-quality education, access to employment and other opportunities, warm and safe homes, access to green spaces and leisure, strong and resilient communities, and effective public protection. Thurrock experiences an unlevel playing field in each of these areas and the Health and Wellbeing Strategy aims to level up those inequities.

The strategy sets out goals and action across six broad domains that influence the determinants of health:

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

[10] Public Health England. 'Contraceptive services: estimating the return on investment'. August 2018.

Human Learning Systems

Thurrock Council are exploring a Human Learning Systems (HLS) approach to integrated working. This way of working continuously explores the complex reality of how outcomes that matter to a person might be achieved in their unique life context. The Human Learning System approach has been described in 'Better Together Thurrock: the case for further change 2022-2026'[11] (BTT). This is a collective plan to transform improve and integrate health care and third sector services to improve people's wellbeing. The key messages for the SHNA within BTT are:

- **Chapter 4.4 The Impact of Thurrock's Approach and System "Ask"**

"Encourage culture change in providers – moving from competition to cooperation in the pursuit of best outcomes."

- **Chapter 10.6.1 – Adopting a Different Commissioning Model**

"Adopting the principles of HLS set out in Chapter 2 and developing a people-led health and care system means developing a very different model of commissioning. Providers must be able to provide flexible, bespoke support that responds to an individual's specific circumstances. Commissioning must operate differently to enable this to take place and the following describes how this will be achieved."

- **Chapter 10.6.2 – Recognising the Flexible Trusting Relationships are Key to Delivering 'Human' Solutions:**

"Establishing a commissioning model that enables this to occur by promoting 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."

This is an ongoing plan, and it is important to know which aspects of the HLS approach are being incorporated in the current Sexual Health Service provision. The HNA analysis of stakeholder views and the Thurrock resident survey conducted by Solutions for Public Health has informed the mapping of sexual health services against the HLS approach and these results are set out in the discussion and recommendations section.

Thurrock Council have a vision about how the integration of health, wellbeing and care for Thurrock residents will work in the future. (SPH,2022). This is a move away from a centralised, deficit driven approach with prescriptive interventions, to a way of working that recognises the uniqueness of each resident, the importance of co-designing solutions that meet their needs, based on the strengths and assets of the individual, their family and friends, the wider community, and the system. This aligns with Thurrock's Health and Care Transformation Programme[12].

The range of people and organisations involved in creating outcomes for residents is typically beyond the management control of a single person or organisation. When a resident comes to the attention of one of many health and social care services in Thurrock, the professional

[11] Thurrock Council. 'Better Together Thurrock: the case for further change 2022-2026. 2022.
[12] Thurrock Council. 'Better Together Thurrock: the case for further change 2022-2026. 2022.

may identify a range of needs that can be met by other services in addition to their own. What follows can be a winding path for the resident of repeating the same information to multiple professionals who do not always appear to talk to one another, have different criteria for the access to their service and may not be able to offer support until other actions by other organisations are completed. In the meantime, the outcome of most importance to the resident is lost amongst the various services offering prescribed interventions may not be what the resident needs.[13]

Acknowledgment that each resident is complex and unique, and the current arrangement of services may not meet their needs, leads to the search for a different strategy.

This way of working continuously explores the complex reality of how the outcomes that matter to each person might be achieved in their unique life context. The three elements of the HLS approach are:

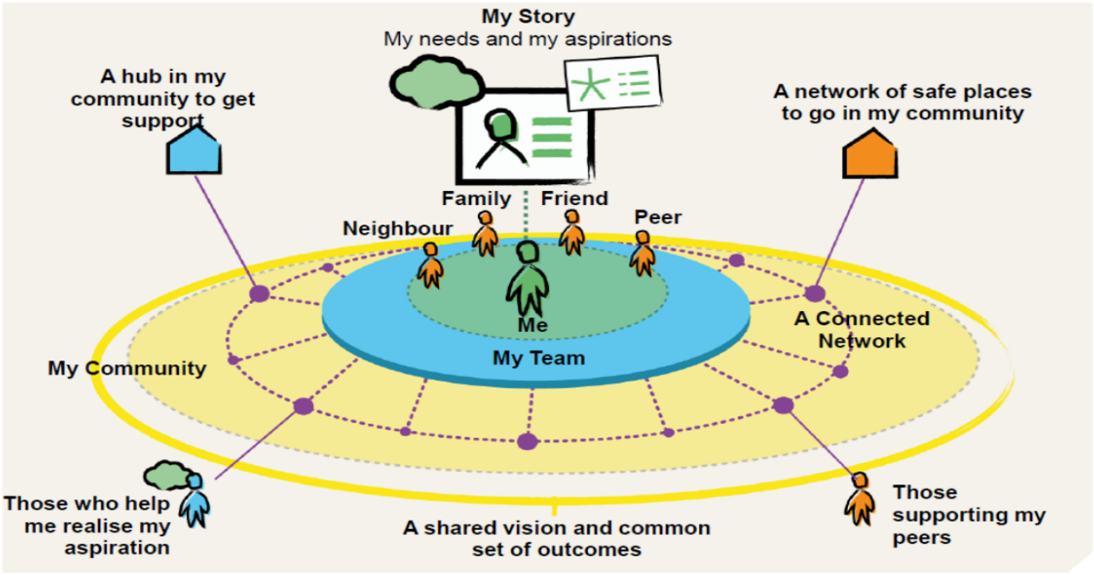
- The **capacity to respond to human variation** - recognising that individual strengths and needs are most effectively met by bespoke solutions that staff are empowered to provide.
- The **ability of the system and services to evolve and change** using continuous process of learning and adaptation. Interventions can be tweaked depending on circumstances with a recognition that 'what works today may not work for other individuals or the same individual in the future.
- The **ability to shape the chaotic system through collaboration and influencing**. Outcomes in response to interventions cannot be reliably predicted in chaotic human systems. However, building relationship, increasing visibility and emotionally intelligent engagement with residents, is helpful in shaping how residents and services relate to one another. This will have an impact on outcomes.

The sought-after outcomes for the individual and the community from this approach are represented in the figure below. The individual can voice the things that matter to them most, services are co-produced around a common vision and the existing strengths and assets within the community are harnessed.

[13] Solutions for Public Health. 'Integrated substance misuse needs assessment for Thurrock'. 2022.

Figure 4: The aim of the Human Learning System (HLS) approach:

Source: Plymouth City Council Alliance for people with complex needs- Alliance Specification 2018



The human learning systems approach has been described in 'Better care together: the case for further change 2022-2026' which is a collective plan to transform, improve and integrate, health, care and third sector services aimed at Thurrock's adults and older people to improve their wellbeing. In addition, the Health and Wellbeing strategy (2022-2026) aiming to tackle the causes of poor health unequally experienced by people across the population of Thurrock, and the Brighter futures Children's Partnership Strategy (2021-2026) focussed on the health and wellbeing of young people to the age of 19, underpin their vision with principles aligned to the human learning systems approach.

The plan to transform and integrate, health, care and third sector services is underway with the development of the first integrated medical centre (hub) based around Stanford le Hope and Corringham PCN footprint (Solutions for Public Health, 2022). Further hubs are being developed around the other three Thurrock PCN footprints. These hubs will be the basis of single locality networks with teams from health, care and third sector organisations building relationships, collaborating and co-designing single integrated solutions with residents rather than referring on or signposting elsewhere. Where specialist advice is required, staff from small teams will be allocated to each integrated locality network rather than being fully embedded. The key elements of this approach are:

- Staff are empowered to co-design solutions together with residents.
- The solutions are coordinated and timely with a focus of what matters to the residents.
- Staff are encouraged to develop a learning culture around what works and does not work.
- For people with the most complex challenges single integrated care plans will be developed.

In terms of the sexual health services, this would be a great opportunity to base staff at each of the hubs which will ensure the opportunity for effective relationship building between staff from different agencies. It will also be a venue where people who attend the hub may be more likely to talk to staff but who would not have attended a clinic. In this way it may be possible

to engage with harder to reach groups and shift the perception of support for sexual health services in a positive direction.

According to the stakeholder engagement conducted by Solutions for Public Health (appendix 1) as part of this needs assessment, overall, currently the way sexual health services in Thurrock are provided reflects the fragmented commissioning approach set out by the Government in 2013 and the local integrated service specification developed in 2017. The organisation 'Provide' deliver sexual health services across the whole of Essex and have a separate contract with Thurrock. The Essex and Thurrock contracts differ in funding and KPIs resulting in services that are essentially separate with little commonality on a day-to-day operational level.

3. Thurrock Overview and Demographics

Figure 5:

Key findings:

- **Overall levels of deprivation in Thurrock are lower than the national average according to the Indices of Deprivation (2019), but some areas of Thurrock are among the 20% most deprived in England.**
- **More than one in five children under 16 years-old in Thurrock are growing up in poverty (21.2%), this is higher than the national rate (20.1%).**
- **Sexual health and consequently sexual ill health is not equally distributed within the population.**
- **Nationally abortion rates increase as levels of deprivation increase.**
- **The 60+ year age group currently account for 19% of the Thurrock population and nationally there is a rise in STI diagnosis in this age group however there is low attendance rates at sexual health services in the 50 year plus age groups.**
- **The largest ethnic group in Thurrock is White British (65%, Census 2021).**
- **Nationally the population rates of STI diagnoses remains highest among people of Black ethnicity (2021).**
- **The highest attendance at the sexual health service in Thurrock are black ethnic followed by mixed ethnic groups.**
- **According to the Office for National Statistics, 91% of adult residents in Thurrock identify as Straight or Heterosexual.**
- **Gay, bisexual and MSM are among the groups of people most likely to be affected by STIs however in 2021 the total number MSM HIV diagnosis was less than. heterosexual men.**
- **Sexual Health Services appear to work in silos.**

Recommendations:

- **Sexual health services to raise awareness for MSM on how STIs are prevented, transmitted, diagnosed, and treated.**
- **Sexual health services to create a safe and comfortable environment in which gay, bisexual and MSM can discuss their needs.**

- **Sexual health services should make every contact count to ensure that wherever service users access help the services can offer the correct information and advice, also ensuring that online access is appropriate and accessible.**
- **To encourage ongoing collaboration with local partners and ensure an HLS approach in the design and delivery of sexual health promotion and interventions.**
- **Sexual health services to promote that MSM have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.**
- **The Provider must ensure clear pathways into services**
- **Commissioners and Provider must work to enhance local data recording and collecting procedures to inform understanding regarding the uptake and usage of the Sexual Health service by CLA and Care Leavers, and this must highlight gaps in provision and relevant adaptations.**
- **The sexual health service should work in a way that ensures age-appropriate information is available to young people in care either through the local offer website or the NHS App.**
- **The Provider must work in collaboration to address the unmet need for CLA, those with learning difficulties, mental health, MSM and marginalised groups and those at higher risk of exploitation.**

Thurrock is in the south of Essex and lies to the east of London on the north bank of the river Thames. Thurrock is divided in to four localities (Primary Care Networks PCNs): Aveley, South Ockendon and Purfleet (ASOP); Grays; Stanford-le-Hope (SLH); and Tilbury and Chadwell (T&C). PCNs are groups of GP practices working closely together with other healthcare staff and organisations to provide more joined up care to local communities.

Within Thurrock there are 20 electoral wards which vary significantly by geographical area, with Orsett ward being the biggest and Chafford the smallest. Some wards like Orsett cover a larger area, predominantly rural, whilst others cover significantly smaller urban areas.

Overall levels of deprivation in Thurrock are lower than the national average according to the Indices of Deprivation (2019), but some areas of Thurrock are among the 20% most deprived in England. Chadwell St Mary, Tilbury and South Ockendon have the highest level of deprivation in Thurrock whilst South Chafford has the lowest.

Based on the 2021 census data, the population of Thurrock was recorded as 176,000. However, as of May 2023, the number of patients registered as Thurrock patients was 185,247, which exceeds the estimated population of the borough. The available data indicates that 181,790 registered patients have a primary address in Thurrock, while an additional 3,457 patients reside outside the borough.

The number of Thurrock residents residing across each PCN show that Grays has the highest concentration of registered patients with 34% of the total population, followed by 26% in ASOP; 25% in SLH; and 15% in T&C. (SystmOne GP Primary Care data – March 2023)

Regarding the age group of zero to nineteen years old, the ONS Census 21 data shows that there are 45,159 residents within this category. However, the number of registered patients in

the same age group is approximately 49,197, which accounts for around 27% of the registered patient population.

Figure 16 highlights the age groups within each PCN. All PCNS except SLH have a higher proportion of 0–19-year-olds. However, SLH has the highest proportion of 60+ year olds at 26% compared to an average of 16% in the other three PCNs.

Figure 6:

Age group	ASOP PCN	GRAYS PCN	STANFORD-LE-HOPE PCN	TILBURY AND CHADWELL PCN	Total
0-9	15%	13%	11%	15%	13%
10-19	14%	14%	12%	16%	14%
20-29	12%	12%	11%	12%	12%
30-39	17%	16%	14%	15%	16%
40-49	15%	15%	13%	13%	14%
50-59	12%	13%	14%	12%	13%
60-69	8%	8%	11%	8%	9%
70-79	5%	6%	10%	5%	6%
80-89	2%	2%	4%	3%	3%
90-99	0%	1%	1%	1%	1%
100-109	0%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The gender split (where recorded) shows an almost equal number (50%) of males to females in the overall population, across all age groups.

Sexual health and consequently sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, young people, and people from ethnic minority backgrounds. According to PHE,[14] (now OHID) in most aspects of sexual and reproductive health variations in outcomes are evident between and within local areas and populations or communities. Some of these differences have a clear relationship with social and health inequalities; and may be impacted by differences in behaviour, social networks, and risk exposures. Others may indicate geographic variation in local populations' demographics or in access to, and use of sexual and reproductive health services, or in the availability and provision of interventions. Therefore, understanding the population and deprivation within Thurrock is vital to the planning of services and interventions.

[14] Public Health England. "Variation in outcomes in sexual and reproductive health in England". 2019.

When considering socio–economic status, rates of new STI diagnosis are shown to be consistently higher in more deprived populations (as measured by the Index of Multiple Deprivation [IMD])[15]. The rates of chlamydia, genital warts, genital herpes, gonorrhoea, and syphilis and all STIs are highest in most deprived areas and lowest in least deprived areas as measured using Index of Multiple Deprivation quintiles.[16]

Nationally abortion rates increase as levels of deprivation increase. The rate in the most deprived decile (decile 1) was 26.1 per 1000 in 2019, this is over twice the rate in the least deprived decile (decile 10) of 12.0 per 1000.[17] The trend of abortion rates increasing in areas of increased deprivation remains consistent when abortion data is studied at both regional and national level.

Gender/Age

The 60+ year age group currently account for 19% of the Thurrock population, with the highest rates in SLH at 25%. Whilst the 60 + year age group is relatively small recent figures from UKHSA have revealed that the number of over-65s who caught common STIs rose from 2,280 in 2017 to 2,748 in 2019, an increase of 20 per cent. Indeed, a 2019 report by then PHE, stated that at that stage the rates of STIs in older age groups were increasing, with the largest proportional increase in gonorrhoea and chlamydia seen in people aged over 65, however attendance at sexual health clinic decreases rapidly for those over 50 years.

Approximately 30% of Thurrock's population are in the 30-49 age bracket, our largest population followed closely by the 0-19 age groups at 27% [figure 7]. The corresponding figures by area are 32% and 28% in ASOP, 31% and 27% in Grays, 26% and 23% in Stanford le-hope, and 28% and 30% in Tilbury and Chadwell.

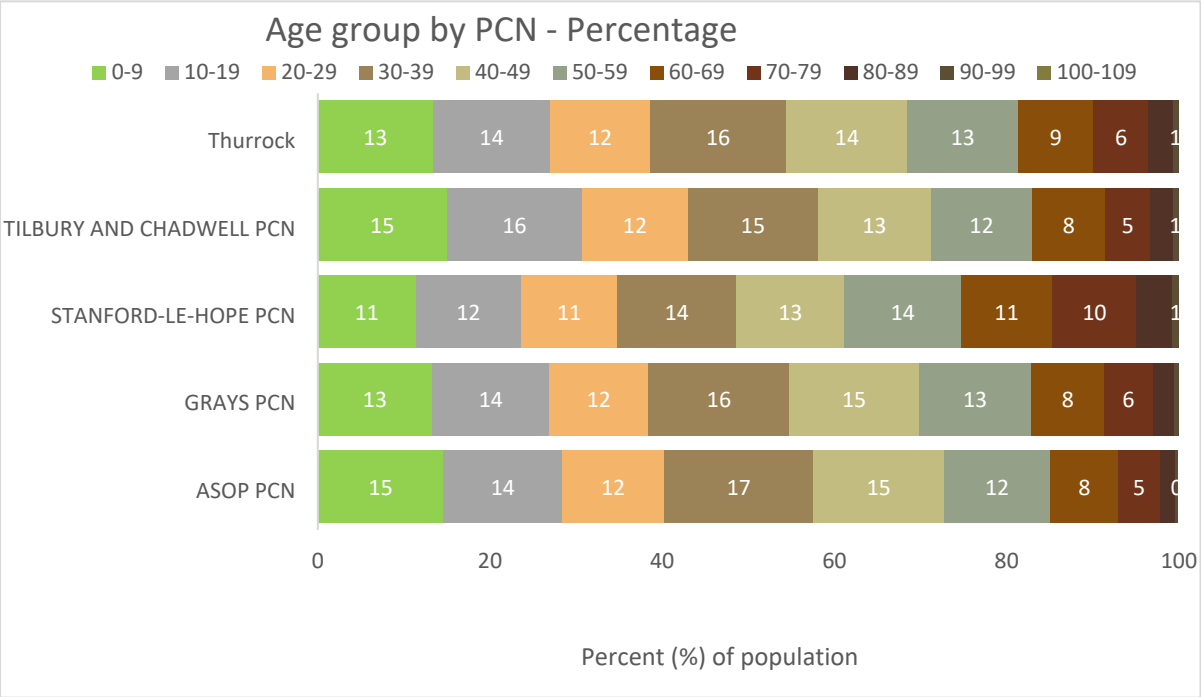
The population distribution in Stanford Le-Hope stands out as being skewed slightly more towards older populations compared to other areas of Thurrock.

[15] Examining the role of socioeconomic deprivation in ethnic differences in sexually transmitted infection diagnosis rates in England: evidence from surveillance data M Furegato 1, Y Chen 2, H Mohammed 1, C H Mercer 2, E J Savage 1, G Hughes 1

[16] Public Health England. "Health Matters: preventing STIs". Guidance. 2019.

[17] Department for Health and Social Care. "Abortion statistics for England and Wales: 2019". 2021.

Figure 7 Age Group by PCN:



A scoping review of twelve international studies by Ezhova et al.[18] on barriers to older adults seeking sexual health advice and treatment found that older people were less likely to disclose concerns and seek help around their sexual health owing to various cultural and social factors, in particular stigma and embarrassment attached to older age sexuality. Healthcare providers were also reluctant to initiate conversations and administer tests to this cohort, suggesting that without their needs being recognised, older people may represent a hidden patient group in sexual healthcare and related policy and campaigns. This review concluded that greater efforts need to be made by healthcare providers to recognise sexuality in older age by creating opportunities and spaces for more conversations (Ezhova).

An article in the Lancet Healthy Longevity by US based Steckenrider[19] also supported the idea of normalising sexual health conversations amongst older adults, attributing increases of sexual activity and STIs in over 65s to an aging global population who also had increased access to drugs and devices for sexual function and online dating for seniors. This age cohort may not have received as much sex and relationship education when they were younger. (Steckenrider).

Teenage pregnancy is both a cause and consequence of health and education inequalities. Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes.[20] Recent data shows that babies born to mothers in England and Wales under 20 years had a 30% higher rate of stillbirth than average, and a 60% higher rate of infant mortality than average. Rates of low birthweight in younger mothers were 30% higher than average,

[18] Ezhova et al. *Barriers to older adults seeking sexual health advice and treatment: A scoping review*. International Journal of Nursing Studies. 2020. Vol 107

[19] Steckenrider, J. *Sexual activity of older adults: let's talk about it*. Lancet Healthy Longevity. 2023

[20] Wellings, K; et al. *The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3).* Lancet. 2013. vol 382.

and this inequality is increasing.[21] Children born to teenage mothers have a 63% higher risk of living in poverty. Mothers under 20 have a 30% higher risk of poor mental health 2 years after giving birth.[22]

Babies born to mothers under the age of 20 are more likely to experience stillbirth, infant mortality, low birthweight, and an upbringing in poverty. Their mothers are also at greater risk of experiencing poor mental health after giving birth.[23] Child poverty and unemployment are most strongly associated with under-18 conception rates at an area level whilst free school meals eligibility, persistent school absence by age 14, poorer than expected academic progress between ages 11 and 14 and being looked after or a care leaver are the strongest associated risk factors at an individual level. First sex before 16, experience of sexual abuse or exploitation, alcohol, and experience of a previous pregnancy are also other associated risk factors for teenage pregnancy.[24]

Young people are more likely to be diagnosed with an STI, among heterosexuals attending sexual health services, most chlamydia and gonorrhoea diagnoses were in people aged 15 to 24 years. Whilst among heterosexuals aged 15 to 24 years, men are three and a half and women seven times more likely to be diagnosed with an STI, than their counterparts aged 25 to 64 years.[25]

Ethnicity

The largest ethnic group in Thurrock is White British (65%, Census 2021). This predominant representation has reduced from 85% since the 2011 Census. As per the 2021 census, the 'Black African/Caribbean/Other Black' ethnic group is the second largest ethnic group of Thurrock residents at 12%, as is the 'Other White' at also 12%. The highest attendance rates at the sexual health services are amongst black ethnic groups followed by mixed ethnic groups (see local provision data).

Figure 17 highlights that the most ethnically diverse PCNs are Grays and ASOP, both of which have a higher rate of ethnic groups who are not classified as British or Mixed British. Grays rate of patients, who are not British or Mixed British, is approximately 52% and in ASOP these ethnic groups account for 48%. This data is obtained from the Primary GP system for Thurrock registered patients (SystmOne, March 2023). [26]

[21] Office for National Statistics. "Live births, stillbirths and linked infant deaths: birthweight by age of mother, numbers and rates, 2016". 2018

[22] Teenage Pregnancy Unit. 'Long-term consequences of teenage births for parents and their children'. Research Briefing. 2004.

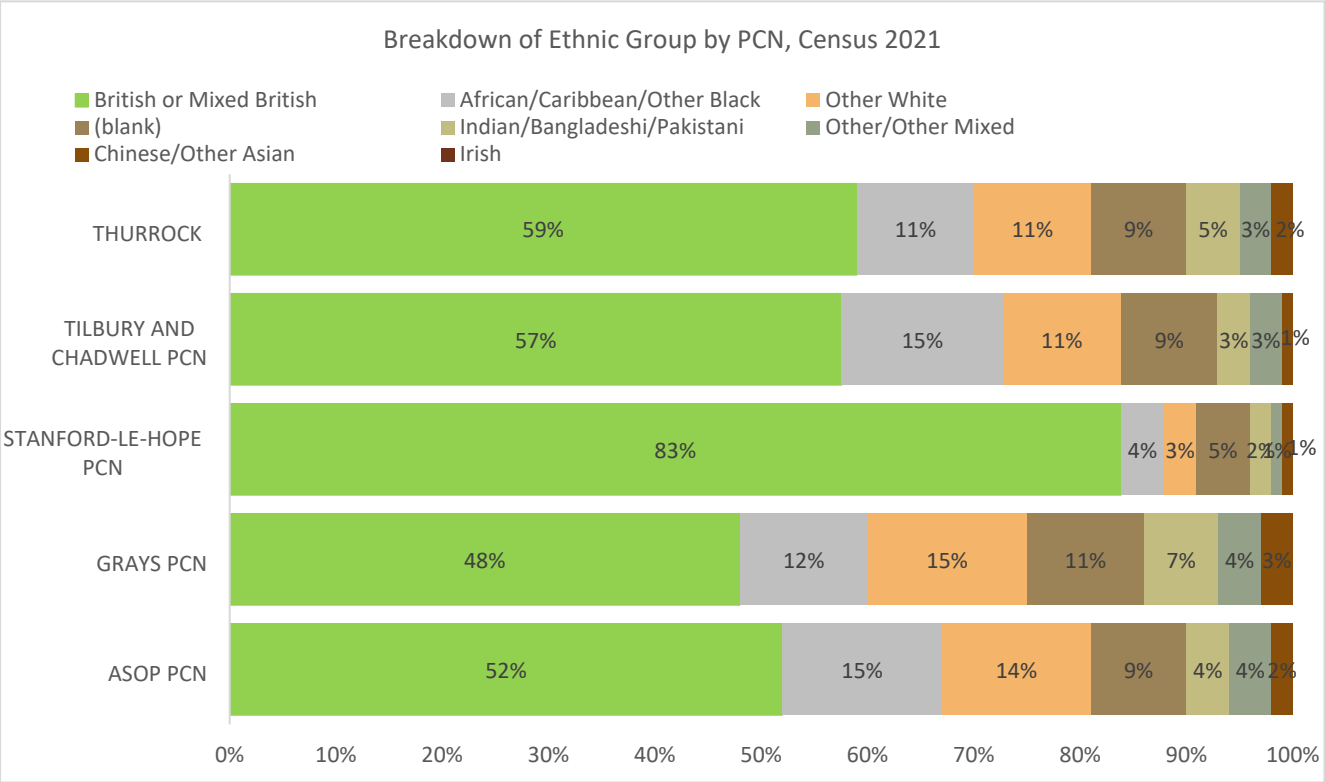
[23] HM Government. 'Child Poverty Strategy: 2014 to 2017'. 2014.

[24] Public Health England. 'Variation in outcomes in sexual and reproductive health in England: a toolkit to explore inequalities at a local level'. 2021.

[25] Public Health England. "Variation in outcomes in sexual and reproductive health in England". 2019.

[26] SystmOne data March 2023 – denominator only includes where Ethnicity was recorded on patient record

Figure 8 Ethnicity by PCN:

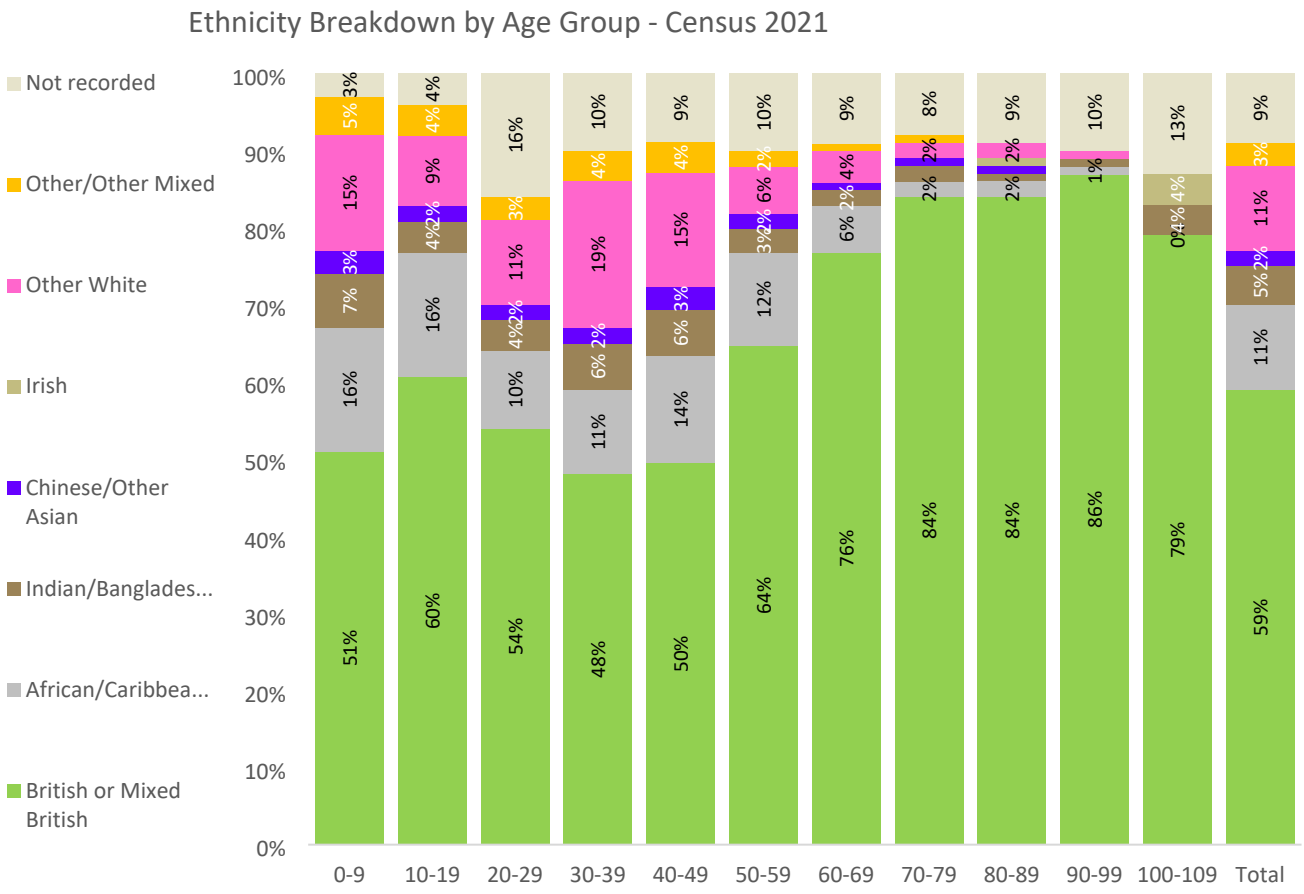


Research conducted through the Health Protection Research Unit (HPRU) on blood-borne and sexually transmitted infections in 2017 to 2018 found, when compared to all other ethnic groups, there were no unique clinical or behavioural factors explaining the disproportionately high rates of STI diagnoses among people of Black Caribbean ethnicity; this ethnic disparity in STIs is likely influenced by underlying socioeconomic factors and the role they play in the structural determinants of the health of this community. Of all ethnic groups nationally, the population rates of STI diagnoses remains highest among people of Black ethnicity in 2021, but this varied amongst Black ethnic groups. In 2021, people of Black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea, herpes, and trichomoniasis, while people of Black African ethnicity had relatively lower rates than other ethnic groups. [27]

Figure 18 demonstrates that our most ethnically diverse populations in Thurrock are in age groups 20 to 59. This diversity then decreases as age increases to the point that on the chart the different groups are barely visible.

[27] UK Health Security Agency. "Sexually transmitted infections and screening for chlamydia in England: 2021 report". 2022

Figure 9 Ethnicity by Age Group:



Faith customs, traditions and societal expectations will undoubtedly influence the acceptability of sexual and reproductive health services, making it even more important for communities and individuals to be informed about options available to them so that they can make an informed decision about the choices that best align with their beliefs and values.

In Thurrock half of the residents describe themselves as Christian (52%), with a considerable percentage having no religion (35%), and a growing percentage of Muslims (5%).

It is observed that among the younger age groups such as those between the ages of 16 and 34 a larger percentage describe themselves as having no religion (44%).

Figure 10:

Religion	0- 15	16 to 24	25 to 34	35 to 49	50 to 64	65 and over	Total
Christian	43%	41%	42%	50%	61%	76%	52%
No religion	41%	46%	43%	34%	29%	16%	35%
Not answered	6%	5%	6%	5%	5%	5%	5%
Muslim	8%	5%	6%	6%	2%	1%	5%
Hindu	1%	1%	2%	2%	1%	1%	1%
Sikh	1%	1%	1%	2%	1%	1%	1%
Other religion	0%	1%	1%	1%	1%	0%	1%
Buddhist	0%	0%	0%	1%	0%	0%	0%
Jewish	0%	0%	0%	0%	0%	0%	0%

One qualitative study[28] into the views, attitudes and experiences of South Asian women concerning sexual health services in the UK found important barriers to access and entry. This included limited knowledge on the local provision of services (specialist and primary care), stigma and shame, and concerns about confidentiality. Overall women from this community felt it difficult to discuss their sexual health with anyone and were often met with judgement and a lack of joined up working from clinicians and community-based services. The authors recommended that service providers should collaborate with community-based organisations to ensure that services are discrete, confidential, and culturally appropriate.

Black and other women of colour in BPAS' report on LARC experienced racist stereotypes around sexuality, promiscuity, young parenthood, and pain thresholds, which impacted on the care and comfort they received from services. A lack of appropriate and relatable imagery in health promotion marketing also created barriers to accessing and using LARC for this group of women. Preliminary recommendations for LARC provision from this report promoted person and rights centred LARC services. This involves working to ensure that LARC provision and removal is legitimate, non-discriminatory, and equitable through challenging assumptions, norms, and stereotypes. It should be recognised that there is no universal one size fits all solution to sexual and reproductive health services. Resources should support safe spaces, conversations, and information sharing so that fully informed consent can be made (BPAS).

Inevitably a younger population would also benefit from an enhanced service which prevents and educates around teenage pregnancies, and accessing SRH services for contraception, as well as any STI prevention screening such as Chlamydia, Gonorrhoea, and Syphilis.

Sexual Orientation and Gender Identity

According to the Office for National Statistics, 91% of adult residents in Thurrock identify as Straight or Heterosexual; and one in fifty identify as Gay/Lesbian or Bisexual (2%). 94% of

[28] Kiridaran, Vaishali; Chawla, Mehar; Bailey, Julia V. ") Views, attitudes and experiences of South Asian women concerning sexual health services in the UK: a qualitative study". *The European Journal of Contraception & Reproductive Health Care*. (2022). 27:5, 418-423.

adult residents identify their gender the same as sex registered at birth. Figure 20 shows the sexual orientation and sexual orientation declared in Thurrock

Figure 11:

Sexual Orientation	Count	%
Straight or Heterosexual	124683	91%
Not answered	8954	7%
Gay or Lesbian	1259	1%
Bisexual	1095	1%
Pansexual	300	0.2%
Asexual	35	0.03%
Queer	7	0.01%
All other sexual orientations	30	0.02%

ONS Definitions and guidance on gender identity and sexual orientation: Guidance for questions on sex, gender identity and sexual orientation for the 2019 Census Rehearsal for the 2021 Census - Office for National Statistics

Gay, bisexual and MSM are among the groups of people most likely to be affected by STIs. According to Public Health England's toolkit for exploring inequalities in sexual and reproductive health, MSM accounted for 81% of syphilis cases,66% of gonorrhoea cases and 41% of new HIV diagnoses in 2019. Although HIV diagnosis rates have been declining amongst this cohort, they still account for the largest proportion of HIV cases diagnosed. (HIV: Annual data tables -Gov.UK 2021). MSM accounted for the highest share of HIV diagnosed in 2019 and 2021, compared to heterosexual men and heterosexual women. However, in 2021 the total number MSM HIV diagnosis was less than heterosexual men and women combined. HIV diagnosed were also more than three times more likely to be diagnosed with an acute bacterial STI than those who are HIV-negative or of unknown HIV status.

Public Health England identified four priorities in its evidence-based resource for professionals on STIs amongst gay, bisexual and MSM. This included raising awareness for MSM on how STIs are prevented, transmitted, diagnosed, and treated. Men who are HIV-negative or of unknown HIV status could benefit from increased knowledge around STIs.

The second priority was for services to be able to create a safe and comfortable environment in which gay, bisexual and MSM can discuss their needs. This means ensuring services are equipped to provide non-judgemental, confidential, professional, and empathetic approaches to sexual health care.

Thirdly, services should be provided in alternative and innovative ways, and strategies should be developed to facilitate targeted, appropriate, accessible, culturally sensitive, and inclusive access for gay, bisexual and MSM. This includes making every contact count to ensure that wherever service uses access help the services can offer the correct information and advice, also ensuring that online access is appropriate and accessible.

The final priority was to encourage ongoing collaboration with local partners and ensure the involvement of community members in the design and delivery of sexual health promotion and interventions (Public Health England).

The NICE sexual health quality standard QS178 advises that MSM have repeat testing every 3 months if they are at increased risk of sexually transmitted infections. This is to ensure any diagnoses of STIs are identified as soon as possible and further transmission prevented (NICE).

It is important to consider the diverse nature of sexual health service users as their needs will vary considerably and not all STI prevention and contraception methods will be beneficial or acceptable to all individuals. Some groups of people will experience barriers in accessing healthcare so extra measures should be taken by healthcare providers and commissioners to enable access for these groups. A single service is not likely to meet everyone's needs, so networks of services with clear pathways into them are important.

NICE guidance states that barriers to services can be reduced by emphasising confidentiality, empathy and a non-judgemental approach, offering access to professional translating and interpretation services, making sure staff understand that services are free and available to everyone without refusing anyone, supporting people to attend appointments and engage with treatments, and by providing outreach activities (NICE).

The use of online testing has become more popular, and benefits include not having to visit a sexual health service in person, not having to take time off work and maintaining anonymity. However, Roy et al. (2020)[29] explored service providers, user experiences and perspectives on behavioural interventions to reduce sexual behaviour risks and found some people were concerned about the use of automated methods to triage them into services. The study included heterosexual young people and MSM and found that they were all generally accepting of sexual health interventions for STIs, however, service users held some concerns about the potential use of automated triage methods and whether the way they were set up (e.g., algorithm design) might result in unfair restricted access to sexual health services for some people depending on the answers they submitted.

Vulnerable and Higher Risk Populations

Higher risk populations include but may not be limited to transgender and gender diverse populations, MSM and GBMSM, older people, intravenous drug users, - Learning disability, commercial sex workers, people who have sex whilst using chemicals, people from other countries with higher prevalence of STIs, people with multiple partners and intravenous drug users.

Sexual behaviour and the way in which sexual behaviour is practiced may lead to negative consequences. However, the definition of a sexual behaviour as risky varies with regards to culture, gender, age, and the threshold. Sexual behaviour is not limited to sexual intercourse and therefore education aimed specifically at target groups is necessary to ensure people are making informed decisions regarding their wellbeing and sexual good health. Open access to services with no fear of recrimination or labelling and assured anonymity must be at the forefront of sexual health services to ensure there is equity of access for all.

Not everyone in a high-risk category will see themselves as higher risk and therefore may not access services. In 2020, the Terence Higgins Trust reported that the sexual activity of older people remains taboo in many areas of society. There is a tendency to desexualise people

[29] Roy, A; et al. *Healthcare provider and service user perspectives on STI risk reduction interventions for young people and MSM in the UK*. Sexually Transmitted Infections. 2020. 96(1): 26-32.

once they reach a certain age, resulting in a reluctance among many health professionals to openly discuss sexual health with older service users, stating that:

"We are seeing increasing rates of STIs reported among older people, although numbers are still much lower than younger age groups. Between 2017 and 2018 the largest proportional increases of gonorrhoea and chlamydia were reported in people 65 years and older (gonorrhoea up 42%, from 236 to 336; and chlamydia up 24%, from 416 to 517)."[30]

Whilst one of the current key performance indicators for the local service is to provide information on the number of young adults opportunistically tested for chlamydia there is no current request to report on older adults receiving testing and treatment and this needs to be addressed locally.

Public Health England (now UKHSA and OHID) confirmed that between 2017 and 2018 sexually transmitted infections in England rose by 5%. Virtually every age group saw a rise in most infections, but gonorrhoea and chlamydia saw the biggest proportional increase in people over 65. This may be in part to divorce rates later in life are increasing and more older people are entering new relationships, they might not feel they are at risk due to their age or may not feel comfortable entering sexual health services due to the perceived stigma of doing so.

Similarly, the proportion of new HIV diagnoses reported in the over 50s has increased from 13% in 2009 to 21% in 2018, and the rate of late diagnoses continues to be highest in this age group (58% in 50-64 years; 64% in 65+).[31]

UKHSA's report Sexually Transmitted Infections and Screening for chlamydia in England (2022) stated that,

"Of all ethnic groups, the population rates of STI diagnoses remained highest among people of Black ethnicity in 2021, but this varied amongst Black ethnic groups. In 2021, people of Black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea, herpes, and trichomoniasis, while people of Black African ethnicity had relatively lower rates than other ethnic groups"

The report also evidenced that between 2012 and 2019 the number of bacterial STI diagnoses among GBMSM increased persistently before dropping in 2020 and whilst increased testing and targeting may have played a role in the increase it could also be attributed to continued risky behaviours within this group. It is widely speculated that the use of dating apps has led to an increase in the incidence of sexually transmitted infections (STIs); among MSM and heterosexual populations, particularly in young adults. Indeed, there have been a few studies into the impact and role of dating sites and apps and links to increasing prevalence of STIs. Research has found that finding sexual partners through geosocial networks and dating apps enables users to have a greater number of sexual partners with increased turnover, consequently decreasing safe sexual practices and increasing the chance of contracting STIs. However, research is currently limited within this area.[32]

[30] Terrence Higgins Trust "It's time to face the taboo around older people having sex". 2020.
[31] UK Health Security Agency. "HIV: annual data tables". 2022
[32] Local Government Association and English HIV and Sexual Health Commissioners Group. "Breaking Point: securing the future of sexual health services". 2022.

The World Health Organisation reported in 2019 that dating apps and sexual health stigma are driving a surge in STIs and untreatable strains daily. Service providers need to use these platforms to promote safer sex and online testing.

It is important that people from high-risk groups are regularly screened for infections and, on some occasions, may have more in-depth testing depending on the circumstances.

Vaccinations are offered to some people in high-risk groups and their partners. These can include vaccination against Hepatitis A, Hepatitis B and Human Papilloma virus (HPV)

Children Looked After

According to the Local Authority Interactive Tool there was a rate of 66 Children Looked After (CLA) per 10,000 children aged under 18 in Thurrock on the 31 March 2021, which is equivalent to 298 CLA. In comparison, the rate of CLA in the East of England was 49 CLA/10,000 children, amongst statistical neighbours it was 65 CLA/10,000, and in England it was 67CLA/10,000 children.

The number of 0 to 19 year-olds in Thurrock is expected to pass 50,500 by 2037, and may increase further as a result of the local economic growth. The proportion of children under 15 years-old is highest in Tilbury, Chafford, North Stifford, West Thurrock and parts of Ockendon.

Children and young people looked after (CLA), and Care Leavers are a particularly vulnerable group with potentially greater health and social needs than their peers. CLA have long been viewed as one of the most vulnerable populations in society, facing inequalities in health, education and social factors that are harmful to their health and wellbeing outcomes, and ultimately their life potential and fulfilment. Evidence shows that certain Adverse Childhood Experiences (ACEs) are commonly linked to children entering the care system and increase the chances of poor health outcomes later in life. ACE include:

- verbal, physical, and sexual abuse.
- emotional and physical neglect.
- household challenges, including:
    - mental illness.
    - domestic violence.
    - problem drug and alcohol use.
    - parental incarceration.
    - parental separation.

Both chronic stress and increased health damaging behaviour which relieves this stress such as smoking, substance abuse and sexual risk-taking, can be associated with poor physiological development and experience of multiple ACEs. As a result, there are some children who, for a variety of reasons, are unable to live with their parent/s. In such circumstances, children, or young people, may either enter care through voluntary means or through a court order which enables the local authority to take on corporate parenting responsibilities to safeguard them. These children then become Children Looked After (CLA).

Care Leavers (CLs) are young people who have been cared for by the Local Authority and are on a path to transition into adulthood towards independent living with the option of accessing the support of the Local Authority care leaving services until age 25.

Nationally, the prevalence of CLA has been increasing year on year. Although Thurrock has had a larger number of children in care than comparator local authorities, this has now stabilised from 2018 and is currently in line with national and comparator local authorities. The CLA cohort includes children with special educational needs and disability (SEND) and Unaccompanied Asylum-Seeking Children (UASC). There were 298 CLA as of 31 March 2021. This is equivalent to a rate of 66 CLA per 10,000 children under the age of 18, which is similar to England and our Statistical Neighbours (SN) but higher than the regional average. As at March 2022, unpublished data shows the number of CLA were 295 equating to a rate of 65 per 10,000 population.

According to The Health and Wellbeing of Children Looked After Needs Assessment (2022)[33] The rate of children in care in Thurrock declined between 2016 and 2019, from 81 CLA per 10,000 children under the age of 18 in 2016 to 67 CLA per 10,000 in 2020 and has remained stable since. At the end of March 2021, 286 Care Leavers (compared to 254 in March 2020), including those 16-18 being supported, were receiving an Aftercare Service. This is a slight increase from March 2019, but this is largely dependent on the age of children in care.

From August 2020 to February 2021 during international COVID-19 restrictions, there had been a reduced number of UASC, but that trend reversed to reach as high as 33 UASC by September 2021. The number of UASC who were open at the end of each month has increased since September 2021, equating to 11% of the total CLA cohort. This is above the Thurrock ceiling of 0.07% and the allocated number of 31 UASC. There has been a reduction in this number since March 2022 (Thurrock Council Children Looked After Monthly Profile, 2022).

In Thurrock over half of children in care are male – 62% compared to 38% female. A larger proportion of Children Looked After are between the ages of 12 and 16 (44%) with the second largest group being the 5–11-year-olds (24%). There is a strong positive association between ward level deprivation and the rate of CLA in each ward in Thurrock with children living in the most deprived area of Thurrock being 4.3 times more likely to be taken into care than those living in the least deprived area of the borough. (Thurrock Council Children Looked After Monthly Profile, 2022)

A key finding in the needs assessment was a gap in the knowledge of the extent of sexual health need in CLA and Care Leavers. The recommendations were:

- commissioners and provider must work to enhance local data recording and collecting procedures to inform understanding regarding the uptake and usage of the Sexual Health service by CLA and Care Leavers, and this must highlight gaps in provision and relevant adaptations.
- The sexual health service should work in a way that ensures age-appropriate information is available to young people in care either through the local offer website or the NHS App.
- This must be considered within the next procurement of the Sexual Health Service.

[33] Thurrock Council. 'The Health and Wellbeing of Children Looked After: a health needs assessment for Thurrock'. 2022

Homeless Population

The Department for Levelling Up, Housing and Communities (DLUHC) (formerly the Ministry of Housing, Communities and Local Government) records local authority level statutory homelessness data. According to this, between April and June 2021 there were 184 households in Thurrock owed a homelessness prevention or relief duty. This included 89 households (a rate of 1.31/1000 households) threatened with homelessness within 56 days (prevention duty owed) and 95 households (a rate of 1.47/1000 households) which were homeless (relief duty owed). [34]

The Thurrock housing-strategy-2022-2027 aligns with other key council strategies including the Thurrock health-and-well-being-strategy-2022-2026 (health and well-being strategy 2022-2026), Better Care Together Thurrock Further Case for Change (adult health and care) Brighter Futures Strategy (children and young people's health and care). With a focus on integration, the housing strategy has reframed the approach to support households interacting with the council, to move away from dealing with issues in isolation by disconnected teams, to develop a strengths-based 'whole person' approach. This connects the wider system of adult social care, children's services, public health, NHS teams, voluntary and faith sector, and other assets within the community.

The Housing Strategy 2022-2027 also incorporates the previously developed Homelessness Prevention and Rough Sleeping Strategy (2020-2025)

There are four strategic priorities focussed on health and wellbeing, partnership and collaboration provision and accessibility and customer excellence. The Housing Strategy 2022-2027 aims to:

- Redefine and simplify pathways for vulnerable households to access health and wellbeing services across the borough, especially in relation to mental health.
- Increase awareness of the physical impact of homelessness and work with partners to improve access to primary care services for those experiencing rough sleeping.
- Explore opportunities to deliver improved services to armed forces veterans who are homeless or at risk of homelessness.
- Review and revise the existing joint protocol for supporting those at risk of homelessness because of fleeing domestic and sexual abuse.

The housing services are provided to adults, including young care leavers. The advice and support cover tenancy management, problems with anti-social behaviour, safeguarding, sheltered housing, hostels, and temporary accommodation. The team carry out homeless assessments, rent collection, leasehold management, repairs, and resettlement support to applicants.

A recent report cited in Your Thurrock (2023)[35] claimed that homelessness has increased by 20% due to the increase in rent and the lifting of the eviction ban (in place throughout the Covid-19 pandemic). This may not be sustained once the backlog from the pandemic has eased however homelessness may increase the risk factor of contracting or passing on STIs

[34] Department for Levelling Up, Housing and Communities. 'Statutory homelessness in England: April to June 2021'. *Official Statistics*. 2021.

[35] Your Thurrock. *Homelessness rises by a 'shocking' 20 per cent in Thurrock*. 13 January 2023.

due to several factors. It may lead to increased commercial sex work and a lack of willingness to engage with services due to the stigma attached to both homelessness and sex work.

Homelessness, as outlined by the NCFE, is defined as "not having a home". Whilst this includes those with nowhere to stay who are living on the street, it also includes many individuals who have a roof over their head.[36]

You count as homeless if you are:

- Staying with friends or family.
- Staying in a hostel, night shelter or B&B.
- Squatting (because you have no legal right to stay).
- At risk of domestic abuse.
- Experiencing violence in your home.
- Living in poor conditions which affect your health.
- Separated from your family because you do not have a place to live together.

The above factors can increase the individual's vulnerability and therefore their risk of contracting STIs as well as other mental and physical health issues especially amongst younger populations. According to the LGA (2017)[37] the risk is higher for several reasons, they may come under pressure to exchange sex for food, shelter, drugs and money, they may lack relationship and independent living skills, formal support and struggle to access services and are more likely to have experienced trauma, abuse and other adverse experiences.

Gypsy/Traveller Population

Thurrock Council manages two English and one Irish socially rented (authorised) Traveller sites which are situated within Aveley, North Stifford and Grays. Each site consists of 21-22 residential caravan pitches according to the DLUHC's Count of Traveller Caravans which was last taken in July 2021.

At this point in time the total count of authorised caravans in Thurrock (with planning permission) amounted to 200 (81 socially rented and 119 private). There were a further 33 unauthorised caravans (without planning permission) on Traveller's own land. This totalled 233 caravans in Thurrock in July 2021. The national dataset includes traditional and non-traditional traveller groups but excludes show people's caravans [38]. The precise number of caravan occupants is not collected in the caravan count but indicates that the local population of travellers extends beyond the managed sites. According to Thurrock's Traveller Liaison service each managed site houses just over 100 people which is broadly in line with the 2011 census which reported 308 people in Thurrock with Gypsy or Irish traveller ethnicity.

There is a further showman site with an estimated population of over 2000 people in Buckles Lane. This site is privately owned and divided into sub yards within the main site. Many of the plots on the site do not have permission and therefore accessing exact data is difficult. Initially the site was for travelling showman however the Buckles Lane Accommodation Assessment

[36] NCFE. *Homelessness the causes and the risks*. 2021.
[37] Local Government Association. "The Impact of Homelessness on Health: a guide for local authorities". 2017.
[38] Department for Levelling Up, Housing and Communities. 'Traveller caravan count: July 2021'. *Official Statistics.* 2021.

Report in 2018 claimed that it has a growing population of non-travelling showmen on the site and this continues to grow.

Generally, the majority of Travelling Show people yards are privately owned and managed. These result from individuals or families buying areas of land and then obtaining planning permission to live on them. Households can also rent plots on existing private yards – often owned and managed by the Showmen's Guild.

Romany Gypsy, Roma, and Irish Traveller communities are known to face some of the starkest inequalities in healthcare access and outcomes amongst the UK population, including when compared with other minority ethnic groups. The reasons for these poor health outcomes are complex, but include the impact of discrimination and stigmatisation, the complicated nature of health systems and the effects of wider social determinants of health. According to a 2022 briefing on health inequalities[39], Romany and Traveller people face life expectancies between ten and 25 years shorter than the general population. Romany and Traveller people experience significantly higher prevalence of long-term illness, health problems or disabilities, which limit daily activities or work. The health of a Romany or Traveller person in their 60s is comparable to an average White British person in their 80s.

There are several factors that contribute to poor health outcomes among Gypsy, Roma and Traveller communities. These relate to structural inequalities, social exclusion, and barriers to healthcare services. Key issues include:

- Chronic exclusion across the wider determinants of health.
- Invisibility in mainstream datasets, meaning needs aren't identified within services.
- Lack of trust in services because of fear of and experiences of discrimination.
- Wrongful registration refusal in primary care.
- Digital exclusion and lack of accessible information.
- Inequalities in access to healthcare waiting lists for nomadic populations.
- Inequalities in mental health and access to mental healthcare.
- A failure within services to account for premature onset of typically age-related conditions.

There is no 'one size fits all' approach, but as commissioning should be evidence and needs-based, services provided in an area should reflect the epidemiological profile and the level of need in the local population, however access remains a crucial issue for socially excluded groups, especially for primary care as the system gatekeeper. The role of the 'trusted individual' is invaluable to enable the 'bridge-building' and navigating work carried out by health and voluntary sector organisations working with excluded, high-need clients, in Thurrock there has been success in promoting and uptake of childhood and adult immunisations by using a hyper local model supported by the traveller liaison teams who are well known, trusted, and respected in the community. The use of trusted individuals would enable sexual health services to outreach into hard-to-reach environments and could encourage better engagement in the community.[40]

[39] Friends, Families & Travellers. 'Briefing: Health inequalities experienced by Gypsy, Roma and Traveller communities'. October 2022.

[40] Gill, Paramjit et al. 'Improving access to health care for Gypsies and Travellers, homeless people and sex workers: An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards'. September 2013

Multi-disciplinary working should be encouraged from the beginning of clinical training, by stressing social inclusion aspects in formal education, as well as through secondments or volunteering. There is a need to systematically capture and share examples of good practice and success stories, as there are strong examples of creative and effective provision of services. Building capacity in the community is a valuable element of working with excluded groups, as it simultaneously engages these communities, and creates social and human capital as well as skills. Outreach work is often the first, most important step in re-connecting the system with the user.

Adults with Learning Disabilities

In 2020 approximately 2.4% of Thurrock's population age 18-64 were estimated to have a learning disability in Thurrock and for the population over 65 years of age this was about 2.1%. The proportion of people with learning disabilities is expected to remain broadly the same over the next twenty years, however, as the total population is expected to grow, so will the actual number of people with learning disabilities. Between 2022 and 2025 an additional 70 people aged 18-64 and 23 people age 65+ are expected to join the local cohort of people with learning, totalling an estimated 3271 people age 18+ with a learning disability in 2025.

Women with intellectual disabilities are often not visible in social research and policy and have experienced a history of denied reproductive freedom, forced sterilisation, and exclusion from information about sexual health, consent, and relationships (Wiseman and Ferrie, 2020)[41]. Their limited agency, choice, and information for making decisions diminishes their rights and places them at a greater risk of poor sexual health and wellbeing and sexual violence.

Wiseman and Ferrie (2020) recommend lifelong commensurate and accessible information and education for women with intellectual disabilities, to enable them to make informed decisions around their sexual health and wellbeing (P. a. Wiseman).

The British Pregnancy Advisory Service (BPAS)'s report into the use of LARC[42] also found that disabled people and those with mental health issues often found their autonomy was undermined, for example, clinicians assuming they knew best rather than taking on board the users' preferences (BPAS).

The Faculty of Sexual and Reproductive Healthcare (FSRH) guidance[43] states that appropriate arrangements should be in place to enable patients with special needs to access SRH services without undue delay. This includes people with communication difficulties and physical or learning difficulties. Sex workers, victims of sexual assault and young people including those in the care systems are also categorised as having special sexual health needs in this guidance (FSRH).

The qualitative study conducted by Solutions for Public Health found that certain services advocates had been discouraged from attending clinic appointments with the service user which may prevent the service users voice being heard.

---

[41] Wiseman, P and Ferrie, J. 'Reproductive (In)Justice and Inequality in the Lives of Women with Intellectual Disabilities in Scotland'. *Scandinavian Journal of Disability Research*. 2020. 22(1):318-329.

[42] British Pregnancy Advisory Service. 'Long-Acting Reversible Contraception in the UK'. 2021.

[43] Faculty of Sexual and Reproductive Healthcare. 'Service Standard for Sexual and Reproductive Healthcare'. 2022.

The NICE quality standard [QS129] on contraception states in its equality and diversity considerations that women with learning disabilities or cognitive impairment may have limited contraception options, in which case contraceptive services should make it clear to the women concerned why certain methods cannot be used (NICE).

According to Mencap (2016)[44] many people with a learning disability say that relationships are important to them. But only 3% of people with a learning disability live as a couple, compared to 70% of the general adult population. Many people with a learning disability would like to pursue intimate or sexual relationships, but they face multiple barriers to developing such relationships. These include (but not limited to)

- Meeting people is more difficult and social isolation is common.
- People are not receiving adequate relationships and sex education to give them the skills and knowledge to have healthy and fulfilling friendships and relationships, and to understand and explore their own sexuality.
- There is often a lack of privacy which restricts opportunities to explore and understand sexuality.
- The balance between risk and rights.

People who receive good relationships and sex education usually have better sexual knowledge, better sexual health, and reduced vulnerability to sexual abuse. The need to ensure that sexual health services are available to the whole population is vital. This may be with outreach clinics into specialist services, specific RSE training in Special Educational Needs and Disabilities (SEND) schools, training for health and social care staff and engaging with the community to understand what their needs are.

Adults with Physical Disabilities

The number of adults aged 18-64 and living with a physical disability is expected to increase in upcoming years, although the proportion of the population affected by physical disability will remain broadly the same in 2025 as in 2020. Having a physical disability doesn't change a person's sexuality or desire to express it. In fact, the World Health Organization says sexuality is a basic need and aspect of being human that cannot be separated from other aspects of life.

A physical disability is any condition that permanently prevents normal body movement or control.

Compared to the non-disabled community, people with disabilities are three times more likely to experience violence and sexual abuse.[45] Why would this be? For starters, there are a lot of negative assumptions toward people with disabilities. They often feel devalued, isolated from their community, and as if they are expected to comply with caregivers. Because they are more likely to be perceived as powerless and physically helpless (depending on their condition), people with disabilities usually have fewer opportunities to learn their sexual likes and dislikes, or to set emotional boundaries with an intimate partner. Research from the Baylor College of Medicine (cited by Perez, S.) found that when instances of violent sexual encounters occur, people with disabilities are more likely to perceive it as "their only choice."

[44] Mencap. 'Sexuality and Relationships Vision Statement'. 2016.
[45] Perez, Stephanie. "How Unhealthy Relationships Impact the Disabled Community". *One Love*.

The Equality Act 2010 prohibited discrimination against disabled people, however, according to the National Disability Strategy many disabled people still feel the stigma of being disabled; this can lead to them feeling hesitant or fearful about disclosing their disability or asking for help. The strategy[46] estimated that 1 in 5 people were disabled therefore estimating there may be over 35,000 people with a disability in Thurrock.

According to the National Disability Strategy, it has been found that when commuting just a quarter of train stations have step-free access between all platforms. When shopping or getting about, 2 in 5 disabled people had experienced difficulties shopping around for products or services, with reported barriers including a lack of appropriate facilities (16%), difficulty using public transport (15%), and difficulty moving around premises (13%). When accessing public services online, when tested in September 2020, the websites of nine of the 10 most populated English county councils did not meet accessibility standards. Access to services must be considered in the specification to ensure that the service is inclusive and accessible to all. Engagement has shown that some service users would prefer to travel Barking or Basildon as it is an easier commute.

If a disability impairs a person's physical ability to engage in a regular sex life, or makes them lack confidence, they may feel worried about having sex.

According to Aruma (2019 the ability to have 'traditional' sex can depend upon someone's disability, however, sex is not black and white – there are many ways to express sexual feelings such as kissing, touching, massaging, and other activities.

Ensuring all people are informed about sex education and have access to resources is of utmost importance. Learning about consent, STIs, contraception, pregnancy, and safe sex is all a part of this education. People with a disability need to be provided with a comfortable environment to talk openly about their experiences. They must be able to access services with ease and comfort via both personal and public transport, Services must be designed and located to accommodate access for all and there must be specialist clinicians that can discuss all matters of sexual health including disabilities and have resources available to share with individuals.

Adults with Mental Health Conditions

In 2020 19% of adults aged 18-64 (20,227 people) in Thurrock were reported as having a common mental health disorder, which was equivalent to 19% of this age group. There were also 12,327 people who were reported as being a survivor of childhood sexual abuse (12%), and 7693 people (7%) with two or more psychiatric disorders. These three indicators individually accounted for the three largest proportions of mental health disorders in Thurrock in 2020 and each of them are expected to increase by 5% between 2020 and 2025.

Other mental health disorders will also see similar growth of around 5% in this time frame, although they affect a smaller proportion of people (individually, between 0-4% of the population age 18-64).

[46] Secretary of State for Work and Pensions. "National Disability Strategy". 2021.

According to Ayelegne, Gebeyehu and Mulatie (2021)[47] people with severe mental health disorders are more likely to engage in high-risk sexual behaviours. As a result of these high-risk behaviours, they might contract sexually transmitted infections and become pregnant unintentionally. Despite the high burden of this problem, very little is known about the association between mental disorders and high-risk sexual behaviours.

High-risk sexual behaviour is an act that increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancy. It includes risky behaviours such as having multiple sexual partners, a history of unprotected sex/ failure to use condoms or intermittent use, exchanging money for sex, performing sexual intercourse while under the influence of alcohol. These behaviours in turn can increase the likelihood of both contracting and passing on STI's.

It is also important to recognise the effect of having or suspecting an STI can have on a person's mental wellbeing. In a survey conducted by Superdrug and cited by Paton, N (2022)[48] of 2000 sexually active people across the UK above the age of 18 more than a third of men (34%) said that a diagnosis of a sexually transmitted infection (STI) would have a negative effect on their mental health. 91% agreed an STI diagnosis would negatively affect their mental health, relationships, social life, love life, general confidence, and even their career.

Half of those polled admitted they wouldn't even feel comfortable speaking to their long-term partner about STIs.

Nearly two-thirds (63%) said they wouldn't feel comfortable speaking to their friends and 90% said the same about their parents or siblings.

There must be robust inter agency communication and integration between specialist services to ensure that people at risk (including those with mental health conditions) are able to access services.

[47] Ayelegne, Gebeyehu, Daniel & Mulatie, Missaye. "Risky sexual behaviour and its associated factors among patients with severe mental disorder in University of Gondar Comprehensive Specialized Hospital". *BMC Psychiatry.* (2021) v.21.

[48] Paton, Nic. "Third of men would find STI diagnosis damaging to mental health". 7 November 2022. *Personnel Today*.

4. Local Provision

Figure 12: Key Findings and Recommendations for Local Provision:

Key Findings:

- **The service sees an average of 15,422 appointments/record of engagements per year.**
- **Many appointments will be for more than one reason (testing and treatment) (testing and advice).**
- **Whilst there has been an increase in the over 65 population this has not been replicated in service attendance.**
- **The highest rates of attendance are amongst the White (72%) and Black (17%) ethnic groups.**
- **The young people's service delivered by Brook have not extended their contract and no longer provide services.**
- **RSE provision is limited.**
- **THT are providing additional support to the contract including engagement with professionals and outreach sessions.**
- **Satellite (spoke) clinics are limited, and one is closed.**
- **Related services are unsure of how to refer into sexual health.**
- **There is a limited visibility of sexual health services in Thurrock.**

Recommendations:

- **Sexual health services to advertise and communicate the offer of the clinic in Tilbury to increase use and awareness.**
- **Provider to review the accessibility of services across Thurrock and surrounding geographies to ensure that good quality services are accessible at a time and place that is convenient for the service user.**
- **Sexual health services to ensure consistent education and advice is available to all service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing.**
- **Sexual health and associated services to develop an action plan for communication and engagement with stakeholders.**

A service review by Thurrock Council in 2021 reported that since the contract started on 1 April 2018, Provide have successfully introduced several service delivery and other operational changes including a staff consultation, a series of subcontracting arrangements, implementation of a triage process, a central booking system, launch of a new electronic C-Card condom distribution scheme and the 'Test at Home' STI testing service. The contract was initially awarded for a 3-year term with the option to extend for a further 2 years. A Deed of Variation was signed by both parties to make the following variations to the contract:

- a 2-year extension until 31 March 2023 (which has now been extended for a further period).
- inclusion of the provision of a HIV Pre-Exposure Prophylaxis (PrEP) service which became a mandatory requirement in November 2020.
- a change to subcontracting arrangements, enabling Provide to subcontract LARC beyond Primary Care.

There are four subcontracted service providers (Healthy Living Partnership, Brook, Terrence Higgins Trust, and Primary Care) delivering community-based services to schools, young people and some underserved groups such as the lesbian, gay, bisexual, queer, questioning, intersex, pansexual, two-spirited and asexual (LGBTQQIP2SAQ) community. Some GP practices deliver contraceptive services including LARC fitting and removal. From April 1st, 2023, Brook withdrew their contract, and the Terence Higgins Trust has taken on the training of professionals to deliver Relationship and sex education in agreement with Essex Public Health.

Providers

The current provider information was informed by Solutions for Public Health as part of the stakeholder engagement element of the needs assessment. The full report can be found in appendix 1.

Current Provision

Provide

Provide Community Interest Company (CIC) are commissioned to deliver the Thurrock Integrated Sexual Health contract. The contract commenced on 1 April 2018. The contract has been extended and is due to end on 31 March 2023.

Orsett is the main hospital consultant led sexual health service in Thurrock offering STI screening, LARC and coil fittings and removal, support for people requiring complex care and a range of advice and support for people with sexual health needs from age 13 years onwards. Although satellite clinics have in the past been available at Tilbury and Corringham these are currently restricted.

Services across Essex including Thurrock are delivered by Provide and share the same InForm system to gather data. Data for each of the services is fed into the Key Performance Indicators which are different for each council. Provide report KPIs quarterly to each council.

The two faculty trainers in the Thurrock service can deliver training to external colleagues such as local GPs which was considered a strength of the service. The Orsett hospital service is open from 8am to 8pm Monday to Friday to improve accessibility for the working population. There is also access to a service for Thurrock residents on Saturdays.

There are two satellite services to deliver sexual health interventions at a locality setting, however the satellite clinic at Corringham does not currently offer any services due to limitations of staffing and equipment. The clinic at Tilbury was closed during Covid but is now operational.

Since the start of the contract (April 2023) Provide have seen 2043 residents, of these appointments 1790 were face to face with 253 being virtual. There were a further 334 follow up visits with only 5 of these being virtual. Of those seen 31.9% were male and just over 68% female. 59% of those attending were white British with the next frequent category being black or black British at 14%. Irish were the fewest with less than 0.3% attendance and Chinese slightly more at 0.5%. Asian British (Pakistani) Asian British (other) and Asian British (Indian) collectively only represented 3% of the overall attendance. This supports the National picture that attendance is lower for people from ethnic minority backgrounds.

60% of those seen reported identified as heterosexual; 1.3%, bisexual; 2.9% gay; and only 0.25% lesbian, however a further 35% were either not asked or declined to answer.

Non LARC contraception 179 appointments including condoms, contraception pill, injection, patches rings and diaphragm and emergency contraception. A further 41 IUS were fitted and 40 removed, 30 hormonal implants were fitted and 43 removed. In April and May 39 and 40% respectively of females attending for contraception were given LARC.

In clinic an average of 15% of those tested for chlamydia, gonorrhoea, syphilis, and HIV tested positive (there were no HIV positive results). In April 78% of those tested were positive for Herpes and in May 41%.

Data from Thurrock Sexual Health Service 2018-2022 – Provide CIC.

This analysis of service user data will illustrate the SHS use/demand between April 2018 to December 2022. The data will primarily focus on the activity levels across the SHS (appointments/engagement with SHS) to reflect the demand of the services. The data will also highlight the number of patients using the SHS, particularly those who have actually attended the appointments and/or used the SHS.

Patient Status/Annual trend

Between 2018 to 2022, the total number of appointments or SHS engagement has been recorded at 77,111 which is an average of 15,422 appointments/record of engagements per year. The number of appointments attended was recorded at 57,019, which is an average of 11,404 a year (74%).

Figure 13:

Year 2021 showed the highest use of/engagement with a SHS, equating to approximately 23%. The average number of appointments/engagement with an SHS pre-covid was 19% (2018/2019), and post-Covid (2021/22) the average was 22%.

Appointments/-Engagement with SHS	2018	2019	2020	2021	2022	Total
Attended	10004	10895	11349	14250	10521	57019
Cancelled By Patient	1881	2952	2368	2785	2827	12813
DNA	1595	1869	757	1218	1411	6850
Booked	30	12	108	96	49	295
Could Not Wait	46	8	8	22	50	134
Grand Total	**13556**	**15736**	**14590**	**18371**	**14858**	**77111**

The number of patients that have had an appointment/engagement with a SHS over this time was recorded as 22,882 which averages at 6,385 patients per year. Of these 22,882 patients, 20,178 have attended which is an average of 5,524 patients (88%), a small number have been booked but deferred for treatment or further testing. This equates to the likelihood of a patient attending a SHS/engaging with a SHS at an average of 2.1 times.

Figure 14:

Patients	2018	2019	2020	2021	2022	Total
Attended	6585	6375	4653	5165	4842	20178
Cancelled By Patient	1468	2257	1776	1988	1954	8019
DNA	1343	1555	664	1014	1115	4957
Booked	30	12	105	94	48	282
Could Not Wait	46	8	8	22	50	134
Grand Total	**7468**	**7800**	**5374**	**5712**	**5572**	**22882**

The data shows a higher demand of service use (attended/appointments booked) prior to the pandemic in 2020. During the pandemic, demand and use of sexual health clinics decreased as expected, and between 2021-2022, service demand/use has begun to increase as services resume to pre-pandemic years. Though during this recovery period, many patients are shown to have cancelled their appointments or were unable to wait at the clinic, indicating a potential resource, service provision issues or unmet expectation. Between 2018 to 2021, Thurrock's population grew from 172,525 in 2018 to approximately 176,000 (Census 2021) - a 2% increase. This could also be a contributory factor where the growth in the population is in excess of the SHS provision and resource.

Age/Ethnicity of attendees

This section only includes those 'attended' or 'booked'.

There were 20,228 patients who attended or booked an appointment at an SHS between 2018 to 2022. This equates to a rate of 115 SHS users per 1,000 Thurrock's population.

Figure 8 illustrates that of the 20,228 patients who has used a SHS service, the highest rate against the Thurrock population was amongst the Black ethnic group at a rate of 163 per 1,000, followed by 130 per 1,000 from the Mixed ethnic group; 107 per 1,000 from the White ethnic group; 61 per 1,000 in Asian ethnic group; and 47 per 1,000 from Other ethnic group. This data provides an insight as to what rate of the Thurrock population have attended or made use of a SHS.

Figure 15:

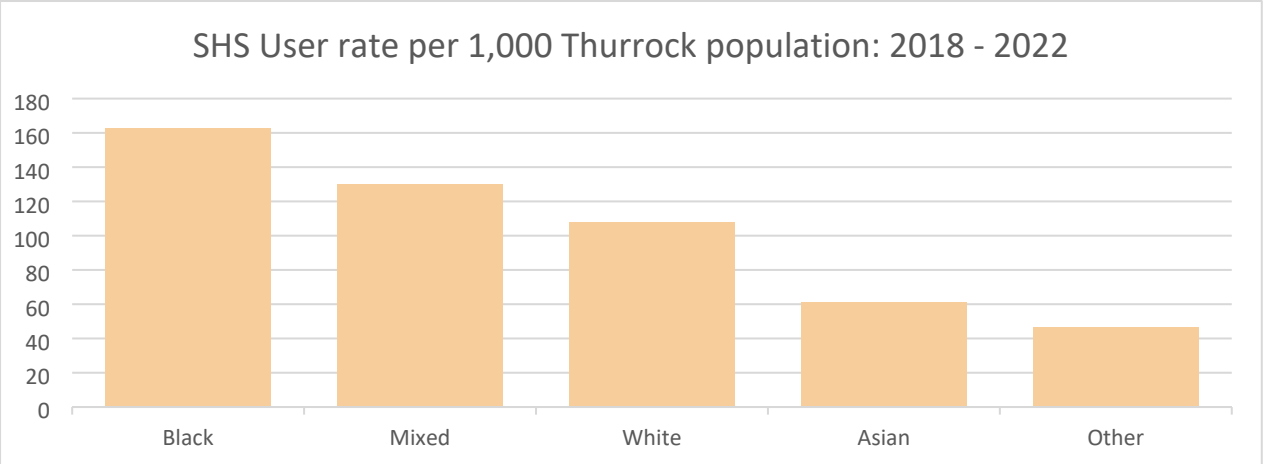


Figure 16 highlights that rate per 1,000 of service users within each age band and ethnic group. The highest use of SHS is amongst the Black and Mixed ethnic groups between the ages of 21 to 35 years; and the White ethnic group between 21 to 25 years of age. SHS use and engagement decreases from 50+ years, and SHS use and engagement is low amongst the under 15s.

Figure 16:

Service attendee rate /1,000 per age group	Asian	Black	Mixed	Other	U/K	White	Grand Total
11 - 15	2	5	13	5	216	21	17
16 - 20	54	189	252	28	263	278	256
21 - 25	155	542	476	142	265	435	441
26 - 30	172	511	488	102	315	332	351
31 - 35	124	449	383	80	323	230	252
36 - 40	108	354	227	81	289	181	202
41 - 45	85	241	230	89	355	127	149
46 - 50	52	162	192	27	330	92	105
51 - 55	42	94	148	36	361	61	70
56 - 60	24	47	81	29	369	39	41
61 - 65	9	33	57	11	357	20	21
66 - 70	11	5	0	0	250	13	13
70+	0	4	0	0	375	4	4
No Age	0	0	0	0	0	1	0
Total	61	163	130	47	285	107	115

Reasons for attendance (includes up to March 2023)

The following tables highlight the reasons for attendance at a sexual health clinic. However, it should be noted that there are overlaps in the reasons for attendance. For example, where someone has been recorded under ‘STI’, they may also have been recorded under ‘pregnant’ and/or ‘IUD removal’ and/or advice given. Another example is someone recorded under ‘Infection’ may also be recorded under ‘pregnant’, ‘STI’ and/or ‘treatment’.

Due to data quality, it is not possible to breakdown each reason individually and avoid duplication. However, the data presented in the tables gives an estimation of the key reasons for attendance amongst the sexual health clinics.

In each category, with the exception of screening, all patients have repeatedly visited a sexual health clinic, hence the elevated activity figures. This could be potentially due to recurrence of infections, a primary test followed by follow up testing, routine testing of a patient with an ongoing STI and other reasons where a patient needs to visit the clinic more than once.

Figure 17:

Reason	No. of Patients attended	No. of times patient attended	Average number of attendances per patient
Test	15162	27775	1.8
Advice	6030	14968	2.5
Infections	5270	9413	1.8
Treatment	5079	9254	1.8
STI	3126	5765	1.8
Contraceptive/ Reproductive/Pregnancy	2533	3412	1.3
Screening	30	33	1.1

Testing and advice appear to feature as the main reasons for attendance. The average number of attendances per patient for 'testing' is approximately two times, and for 'advice' 3 times.

Figure 18 shows the STIs for which most patients have been tested and/or treated.

Gonorrhoea and Chlamydia are showing as the STIs for which patients are testing or treated for, though it should be noted that other STIs are also included in the general STI related care such as warts, HIV (if necessary), Syphilis, and or Trichomonas Vaginalis.

Figure 18:

STI/Infection	No. of Patients attended	No. of times patient attended	Average number of attendances per patient
Gonorrhoea	10152	17638	0.6
Chlamydia	10575	18859	1.8
Hepatitis	2408	3825	1.6
Herpes	193	312	1.6
Pelvic Inflammatory Disease (PID)	79	80	1.0

In Thurrock, the STIs with the relatively higher prevalence are Chlamydia (diagnosis rate 209/100,000 all ages), Gonorrhoea (43 per 100,000 all ages) and PID admissions (229 per 100,000 15-54 years). The average number of attendances per patient for Chlamydia in Thurrock is approximately two times, and for Gonorrhoea and PID it is an average of one appointment/engagement.

Hepatitis and Herpes have a higher average of attendance patient (2 times). The rate of Herpes in Thurrock is 34 per 100,000 and ranks as the 4th highest STI in Thurrock as of 2021, hence, this higher average number of attendances per patient is expected. There is no latest prevalence data available for hepatitis in Thurrock.

Brook

Until April 2023 Brook was subcontracted by Provide to work with schools and other services for children and young people delivering training for staff, relationship, and sexual health education for students and 1 to 1 support through the My Life programme. Referrals to the My Life service were made primarily from teachers, school nurses and social care and the Brook Education and Wellbeing specialists would offer sessions tailored to the young person to support them around sexual health and relationships as well as address unhealthy attitudes and build resilience and self-esteem. Brook delivered a service from Thurrock Health Centre in Grays and if necessary, referrals were made to local sexual health services in Orsett if there were concerns about STIs or pregnancy. Education and training sessions with staff in other services such as Wize Up! have helped those services support their service users. In the last year of the contract Brook offered 60 sessions split evenly between RSE training and school assemblies, the RSE training engaged 72 professionals, however only 4 assemblies were accepted, delivering to a total of 1,310 students.

Terrence Higgins Trust

The Terrence Higgins Trust is subcontracted by Provide and provides community outreach for those at risk of HIV and training for professionals. The THT are subcontracted by Provide to deliver 12 professional or community-based education and training sessions about sexual health and specifically about HIV, per year. These sessions are delivered on site for example they have visited Inclusions Vision Thurrock to deliver an HIV awareness session to staff. Sessions can be attended by any staff offering services such as those involved with housing and homeless, mental health and probation. THT also offer in house testing monthly from Grays Health Centre for HIV and syphilis. At the testing appointment they can also offer advice about wider sexual health concerns and signpost or refer to other services. Community engagement in the form of outreach events with health promotion stands and information about how to access services alongside engagement with groups or community leaders to support the cascade of information. THT have taken on some of the role delivered by Brook in secondary schools.

In the last year of the contract THT delivered training to 39 professionals, ran 33 outreach sessions reaching 621 people and a further 108 awareness sessions were held posted on:

- Grindr.
- Gaydar.
- Squirt.
- Facebook.
- Instagram.

Throughout the year THT ran 4 community engagement sessions and engaged with 232 people. They also distributed 2152 condoms.

School Nursing

The School Nurse Service is not part of the sexual health contract with the Local Authority. It provides a range of services, including sexual health advice and support for school age children in the form of a school drop-in service to secondary schools around every two weeks. There is also an e-drop-in service whereby children can scan a QR code, complete a form

which is submitted to the service, and someone contacts them within 24 hours. They can also contact the service through their website. Support offered can include providing preventative advice, carrying out assessments for condoms, chlamydia testing and treatment, providing the morning after pill, referrals to the sexual health clinic, supporting teenage mothers and those who are pregnant. School nurses meet with GPs regularly, and have input to social workers, looked after children, the vulnerable and at risk and can refer into the multi-agency safeguarding hub (MASH). There is also a risk management group for children being exploited and missing and a plan is put in place for these young people to cover their needs.

Whilst this is the current position the following changes will be in place from September 2023:

- School health will only provide advice and signpost to the current provider. Therefore, direct support will not be available from NELFT e.g., for assessments for condom, chlamydia testing, providing the morning after pill etc.
- Only e-drop-ins, no more face-to-face drop ins.
- Collaborative working with partner agencies will continue.

Psychosexual Service

Inclusion Improving Access to Psychological Therapies Thurrock (Inclusion IAPT) is provided by Inclusion which is part of Midlands Partnership NHS Foundation Trust. Inclusion IAPT offer a gateway for adults across Thurrock to access talking therapies for common mental health difficulties, this includes a psychosexual service who employ one whole time equivalent of psychosexual therapy resource.

South Essex Rape and Incest Centre (SERIC)

Rape and sexual abuse specialists

The SERIC service is funded by the Police and Crime Commissioner and is in place to support people who have experienced rape and sexual abuse through 1 to 1 counselling; provision of Independent Sexual Violence Advisors to support people engaged with the criminal justice system; advocates to support people with other difficulties such as housing problems or dealing with debt and family support workers who work with families and children. SERIC make referrals to Thurrock sexual health service when concerns around STIs, pregnancy and the need for long term contraception arise.

Child exploitation and missing team in Thurrock Council

This team focuses on missing people and those vulnerable to exploitation from adolescence to young adulthood (around 13 to 25 years). A weekly missing children's panel meets to discuss cases when any issues of sexual exploitation are raised. For vulnerable exploited individuals the team try and link with each of the services they will need support from. This could be drugs and alcohol, mental health, or sexual health services in addition to social care.

Wize up!

Young people's drug and alcohol services (delivered by Change Grow Live)

This substance misuse service works with young people who have been affected by parental substance misuse and/or are misusing substances themselves. Generally, services work with young people to age 18 when they transition to adult services unless their needs are such that they need the greater level of support offered by the young people's service. As part of their initial assessment young people are asked questions about sexual health. If a need is identified sexual health advice is offered in-house and if there is a concern about STIs or pregnancy, then people are signposted to Thurrock Sexual Health Services. Staff have completed the training by Brook so they can assess young people for the C-card scheme to access free condoms. Although sexual health support has not been commissioned as part of the Wize Up! service staff are keen to offer a more holistic approach to support the young person.

Thurrock adult drug and alcohol services

(Delivered by Midlands Partnership Foundation Trust (MPFT)

As part of the initial assessment for adults accessing the drug and alcohol services questions about sexual health are asked. Many people put themselves at risk of contracting an STI or becoming pregnant whilst taking drugs and alcohol and this cohort of residents are likely to have a higher proportion of unplanned pregnancies compared to the general population. Currently the service is only able to sign-post individuals to the Thurrock Sexual Health Services and cannot offer support directly to service users.

Thurrock Lifestyle Solutions (TLS)

Providing disability services for Thurrock residents (delivered by Choice and Control)

Thurrock Lifestyle Solutions provides the physical and learning disability services for Thurrock residents. It is typically young people with learning disabilities who have most need for support around sexual health. This could be relationship and sexual health advice, support to access contraception, testing for STIs and unplanned pregnancy concerns. TLS provide the sexual health advice and will accompany someone to a clinic or other appointment to ensure the person understands the process and provides the information required by staff.

Youth offending service

The youth offending team become involved with a young person up to the age of 18 if they are arrested by the police, are charged with a crime involving a court appearance or are convicted of a crime and given a sentence. The Team has a specialist Gangs and Child Exploitation Worker, who works alongside Children's Social Care. Young people have an initial assessment which includes questions about sexual health.

GPs

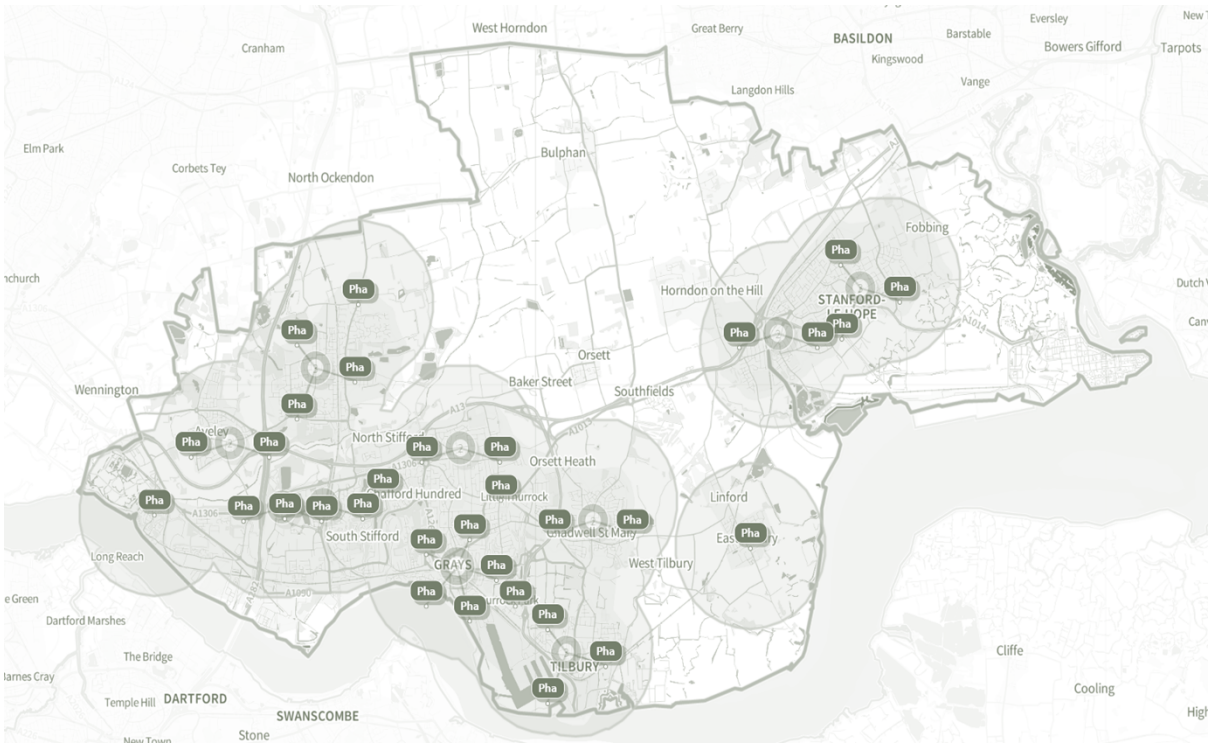
Provide managed the Service Level Agreements (SLAs) for GPs for LARC however this is now managed by the council Public Health team. People accessing services via the GP route are low and this may affect the number of service users waiting for the specialist services intervention. GPs can offer contraception (including emergency contraception) or tests and

treatments for STIs. Advice, information, and tests are free, but there may be a charge for prescriptions causing confusion.

Pharmacies

Pharmacies may be contracted by a variety of commissioners including Local Authority, NHSE and ICS's. Pharmacies in Thurrock providing emergency hormonal contraception (EHC) are contracted directly by the council. Last year only ten pharmacies delivered against the contract supplying 27 prescriptions of EHC, however this service is currently suspended awaiting contract renewal with TC and pharmacies. Figure 13 shows the potential coverage of services if all pharmacies signed up to provide enhanced sexual health services. A location list of all pharmacies in Thurrock is in appendix 6.

Figure 19:



SHAPE Place Atlas - exported on Thursday, April 13, 2023

5. Reproductive Health Data

Teenage pregnancy Framework

The Teenage Pregnancy Prevention Framework was published in 2018 (Public Health England), with the aim to help local areas assess their teenage pregnancy prevention programmes to prevent unplanned pregnancies and support young people to develop healthy relationships. As a key area of the specification, the lead provider is required to follow the framework to assess how improvements can be made and implemented to reduce teenage pregnancy rates.

The provision of integrated sexual health services is supported by current accredited training programmes and guidance from relevant professional bodies including:

- Faculty of Sexual and Reproductive Healthcare (FSRH).
- British Association for Sexual Health and HIV (BASHH).
- British HIV Association (BHIVA).
- Medical Foundation for HIV and Sexual Health (MEDFASH).
- Royal College of Obstetrics and Gynaecology (RCOG).
- National Institute for Health and Care Excellence (NICE).
- Department of Health & Social Care (DHSC).
- UKSHA, and the Office for Health Improvement and Disparities (OHID).

Conception data is collected via the statutory notifications of all births and abortions which are published quarterly by the Office of National Statistics. Data are supplied quarterly with a full annual dataset including district data. There is a 14-month lag whilst the data is processed, checked, and published.

Conceptions and Abortions

Figure 20:

Key Points:

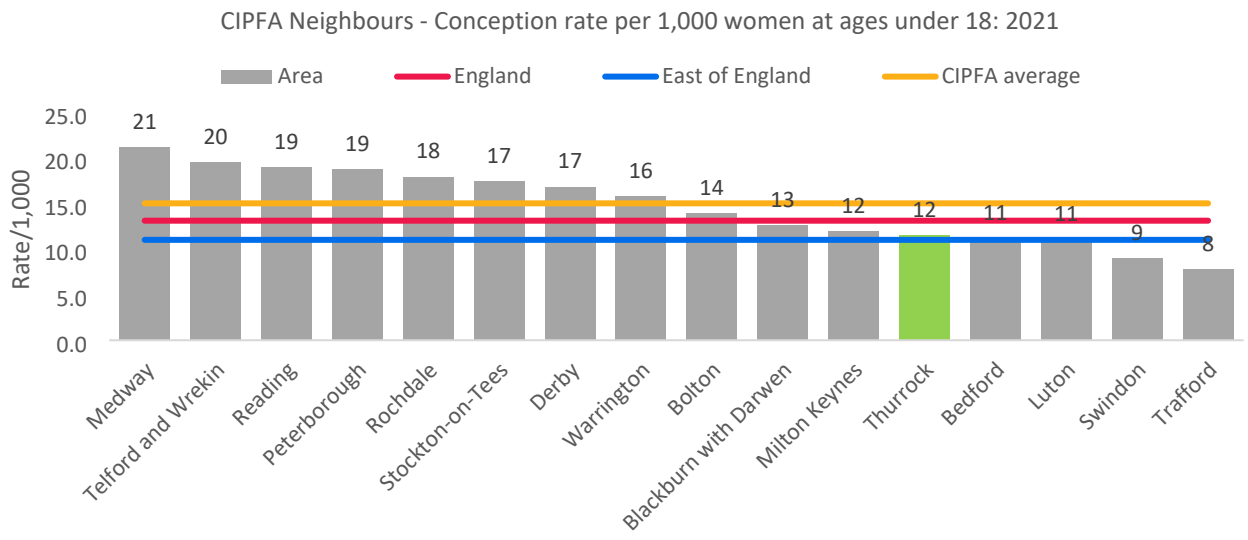
- **Under 18 conception rates have decreased since 2017 in line with national and regional trends.**
- **Whilst the abortion rate in Thurrock has increased since 2017 and in 2021 was 22 per 1000 females; the percentage of U18 conceptions leading to abortion has remained stable, albeit higher than national, regional and CIPFA comparators.**
- **The rate of repeat abortions in Thurrock has increased since 2017.**

Recommendations:

- **Sexual health services to review the accessibility of contraception services across Thurrock and surrounding geographies to ensure that good quality contraception services are accessible at a time and place that is convenient for the service user.**
- **Sexual health services to ensure consistent education and advice on the preferred method of contraception is available to service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing.**
- **Thurrock PH team to conduct further analysis into why the rate of repeat abortions is increasing and the groups most at risk with the aim to identify appropriate preventative actions.**
- **Sexual health and associated services to develop an action plan for focusing on groups most at risk of unplanned conception and/or abortion such as sex workers or those with addiction.**

Figure 21 below shows conception rates among females aged under 18 and figure 23 shows the abortion rates among females aged under 18 and over 25. Under-18 conceptions rates per 1000 females, including those aged 15-17 years, have decreased since 2017 in Thurrock. This downward trend has also been reflected in England, East of England region (EoE), and Thurrock's CIPFA neighbours.

Figure 21 Under 18 Conception rate/1000 – Thurrock/CIPFA 2021:



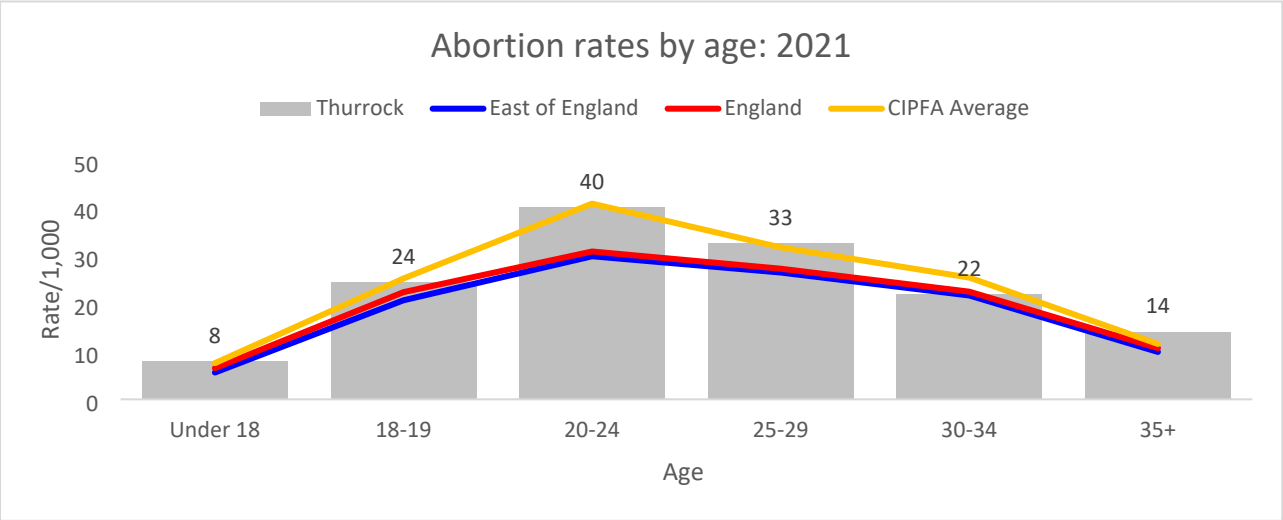
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023 -Office for National Statistics (ONS)

Thurrock's under-18 conception rate for 2021 is low in comparison to most of its CIPFA neighbours but level with the regional average for 2021. Between a range of 8 per 1,000 females to as high as 21 per 1,000 females, Thurrock's rate of 12 per 1,000 is relatively low compared to its statistically similar local authorities, however it is not statistically significantly different from its CIPFA neighbours, EoE or England.

Abortion Rates

The total abortion rate amongst 15–44-year-olds in Thurrock has steadily increased since 2017, currently at 22 per 1,000 females in 2021. This is the same rate across CIPFA neighbours in 2021. Both Thurrock and its CIPFA neighbours are higher than the England rate (19 per 1,000) and East of England (18 per 1,000). Thurrock and its CIPFA neighbours' abortion rates for 2021 are statistically significantly higher than England and East of England.

Figure 22: illustrates the rate of abortions in 2021 for females under 18, 18-34 years, and 35-44 years of age. The denominator for each age band is the total number of females within that age band.



Source: Office for Health Improvement and Disparities. National Abortion Statistics England and Wales 2021 (Updated May 2023). www.gov.uk

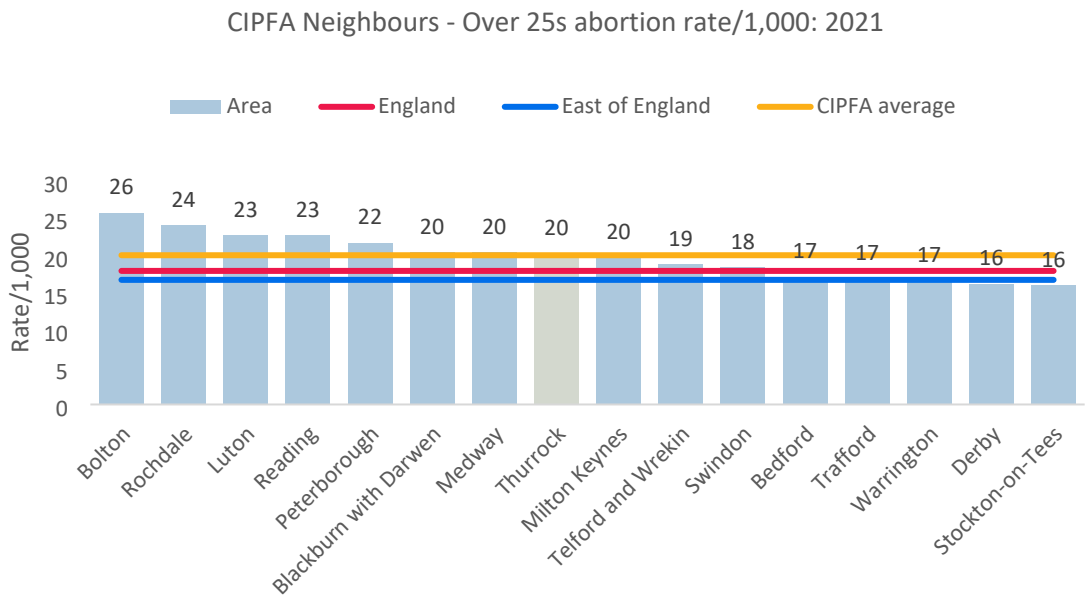
Across all areas, the peak ages for abortions are between 20-29 years of age, with Thurrock and it's CIPFA neighbours showing the highest rates in these age groups.

The Under-18 abortion rates per 1000 females follows a similar trend to decreasing conception rates since 2017. In 2021, in comparison to its CIPFA neighbours (ranging from 5 to 11 abortions per 1,000), Thurrock featured in the middle at a rate of 8 per 1000 females, though is not statistically significantly different to its CIPFA neighbours.

In contrast to the under-18 decreasing conception and abortion rates, the percentage of conceptions leading to an abortion amongst under-18s is showing a consistent and stable trend. This stable trend is also seen nationally, regionally and amongst our CIPFA neighbours, however the percentage of U18 conceptions leading to abortion are consistently higher in Thurrock in comparison.

Abortions in the over-25 age group has shown a steady increase between 2017 and 2021 in Thurrock, which is the same trend seen nationally, regionally and across CIPFA neighbours (see Figure 23).

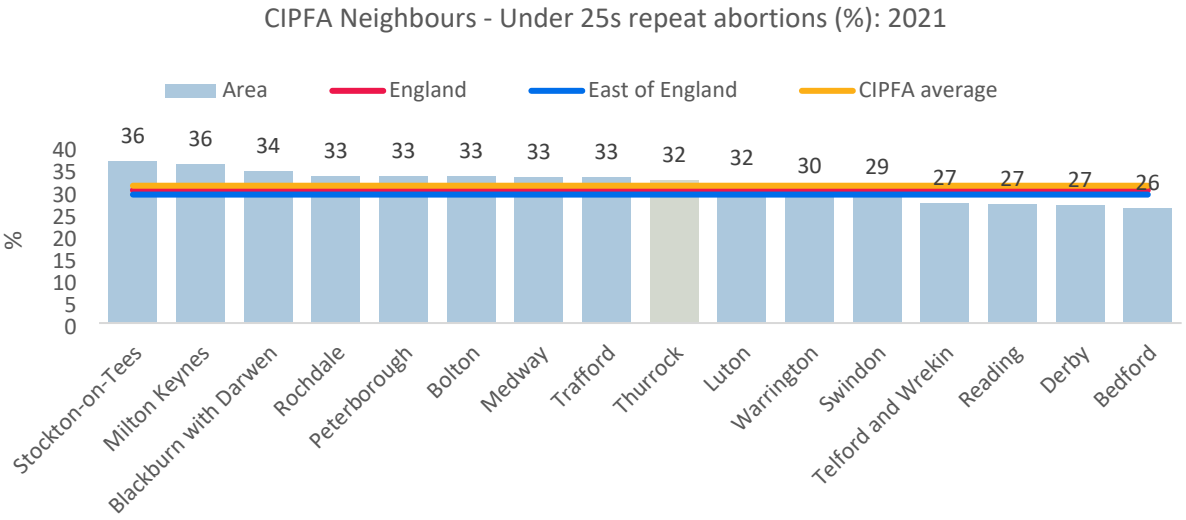
Figure 23: Rate of abortions in the over-25 years (2017-2021) – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities, Department of Health and Social Care based on data from abortion clinics

Repeat abortions in under-25s have also increased across Thurrock, England, East of England, and CIPFA neighbours. Though Thurrock rates remain higher each year, and peak in 2020, Thurrock is not statistically different to its CIPFA neighbours. (See figure 24).

Figure 24: Under 25 Percentage of repeat abortions – Thurrock/CIPFA neighbours - 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023 - Department of Health and Social Care based on data from abortion clinics

The rate of abortions under 10 weeks remains lower for Thurrock each year in comparison to national, regional and CIPFA averages since 2017 though this has increased year on year to 2021.

In summary, conception, and abortion (termination) rates are decreasing amongst the under-18s in Thurrock, apart from the percentage of conceptions leading to abortion which has remained consistent between 53% to 68% in the previous 5 years. Conversely the rate of

abortions in the over 25 years, repeat abortions under 25 years, and abortions under 10 weeks' gestation is increasing in Thurrock. Women living in the most deprived areas are more than twice as likely to have abortions than women living in the least deprived areas. The rate in the most deprived decile is 27.5 per 1,000 women, compared to 12.6 per 1,000 women for women living in the least deprived areas.[49] There are many factors affecting both conception and abortion, there may be a lack of access to high quality reproductive and sexual health training, there may be an inability to access the specialist service due to location, there may be higher levels of commercial sex work or addiction in Thurrock.

Abortion rates are an indicator of a lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality. Services and advisory clinics must be accessible in the most deprived areas, schools, and areas of high young person footfall to ensure the population in Thurrock has equal access to specialist services.

Abortion is available without parental consent (even under the age of 16). The earlier the pregnancy is detected if abortion is required or wanted the more choices the person has as to what procedure is available to them.

Contraception

Figure 25:

Key Points:

Post pandemic the waiting time for LARC had increased.

Marie Stopes were commissioned to provide additional support to address the backlog which has now ceased.

- **The rate of males attending specialist contraceptive services increased from 2017 to 2019. In 2019, in Thurrock, 44 per 1,000 males attended specialist contraceptive services, compared to 18 per 1,000 across CIPFA neighbours and 20 per 1,000 in England in the same year.**

Recommendations:

- **Thurrock PH team, in collaboration with the sexual health service to conduct further analysis with primary care to understand why GP prescribed LARC rates continue to be low.**
- **Sexual health services to develop an action plan to work with primary care to ensure that barriers and challenges to providing LARC in primary care (identified through further analysis) are overcome.**

Contraception refers to a method or device that prevents pregnancy. As an essential component of sexual and reproductive healthcare, contraception gives people autonomy over their reproductive health, and lives, by enabling them to decide if, or when, they would like to become pregnant.

[49] Office for Health Improvement and Disparities. “Abortion Statistics, England and Wales: 2021”. 2023.

Types of contraception range from short-term barrier methods, such as the male or female condom, to long-acting methods, such as the Intra-Uterine Device (or IUD), which can prevent pregnancy for up to 12 years. There are also permanent methods of contraception include tubal ligation and vasectomy, which are minor surgical procedures for people who do not want to have children in the future. The decision to use contraception especially those that may not be successfully reversed should be made with full knowledge and education including benefits and risks of each procedure and other methods available.

Long-Acting Reversible Contraception (LARC)

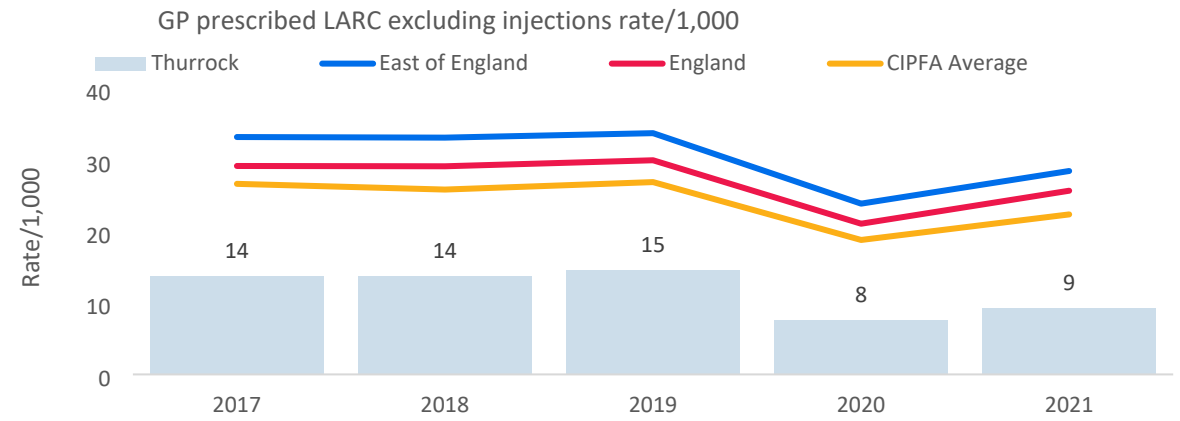
One form of contraception is long-acting reversible contraception (LARC). There are several types of LARC including intrauterine device (IUD), hormonal coil or intra uterine system (IUS), contraceptive injection, and hormonal implant. LARC does not prevent the transmission of sexually transmitted diseases like a condom does and therefore education regarding risk and behaviour should be part of the assessment when discussing LARC. LARC can be accessed for free on prescription but must be fitted by trained, specialist services including GPs, practice nurses, specialist sexual health services and young people services.

Long-acting reversible contraception (LARC) methods such as contraceptive injections, implants, the intra-uterine system (IUS), or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than other methods. The following charts show the crude rate of GP prescribed LARC per 1,000 service user female population aged 15-44 years in Thurrock. It is based on prescriptions of contraceptive injections, implants, IUS, and IUD.

The waiting list for Long-Acting Reversible Contraception (LARC) has previously been a concern in Thurrock, action was taken to address this successfully but due to funding there has been a significant increase in the waiting times in the last two months. GP prescribed LARC remains low throughout the borough which has an ongoing affect to the specialist services. Further investigation is required to understand the hesitancy to deliver services by the GPs.

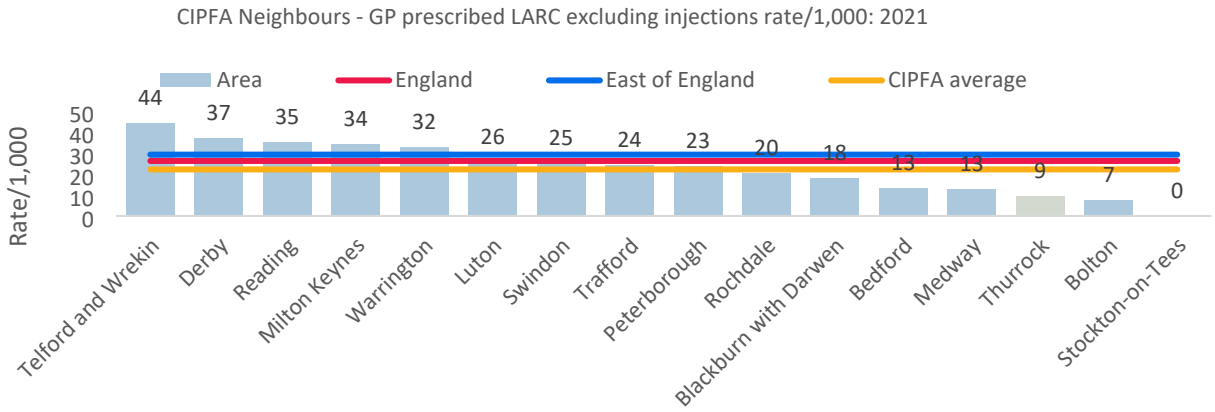
GP prescribed LARC has been almost consistent since 2017, between 14-15 per 1,000, followed by decrease to 8 per 1,000 in 2020 and then 9 per 1,000 in 2021. These rates remain much lower than England and CIPFA neighbour averages since 2017. This puts additional pressure on the specialist services to ensure the need is met. The latter two range between 22 to 29 per 1000, though the trend across all three remain consistent – stable to 2019, followed by an almost 50% decrease between 2019 to 2020. The 2021 rates indicate a potential upward trend, but this cannot be verified without more current data. Across CIPFA neighbours, Thurrock features as one of the local authorities with the lowest rates for GPs prescribing LARC to women in 2021, this may be due to a lack of engagement with the current providers or lack of training and confidence in providing the services and required further investigation (see figures 26 and 27).

Figure 26: GP prescribed LARC per 1,000 All ages (2017-2021)– Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

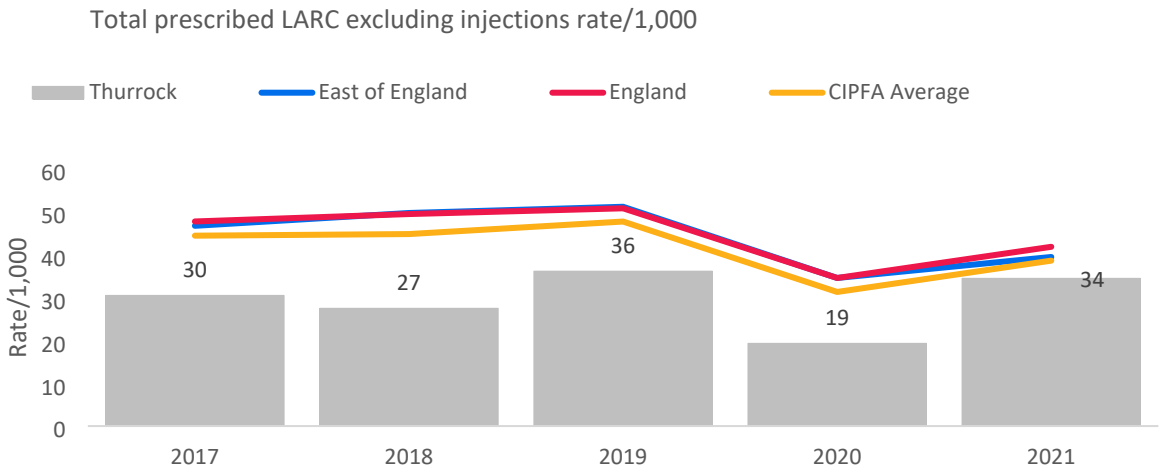
Figure 27: GP prescribed LARC per 1,000 All ages – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

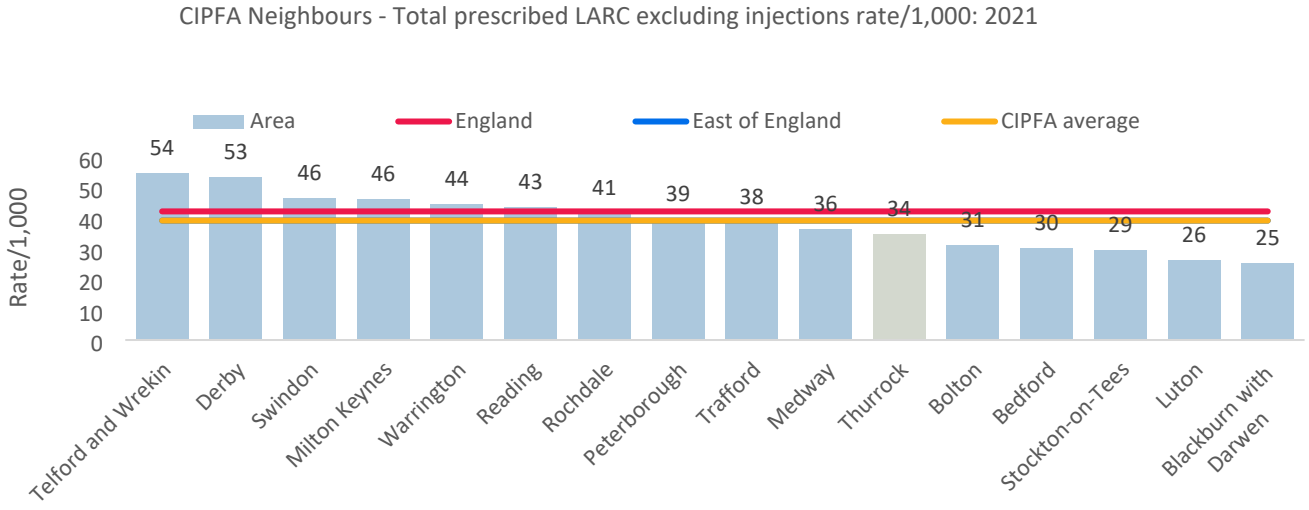
The rate of total LARC being prescribed that excludes injections has also remained lower in Thurrock over the reporting period in comparison to England, regional and CIPFA neighbours. Thurrock has one of the lowest rates across its comparative neighbours in 2021 (see figures 28 and 29).

Figure 28: Total prescribed LARC excluding injections rate/1,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023:

Figure 29: Total prescribed LARC excluding injections rate/1,000 – Thurrock/CIPFA neighbours 2021



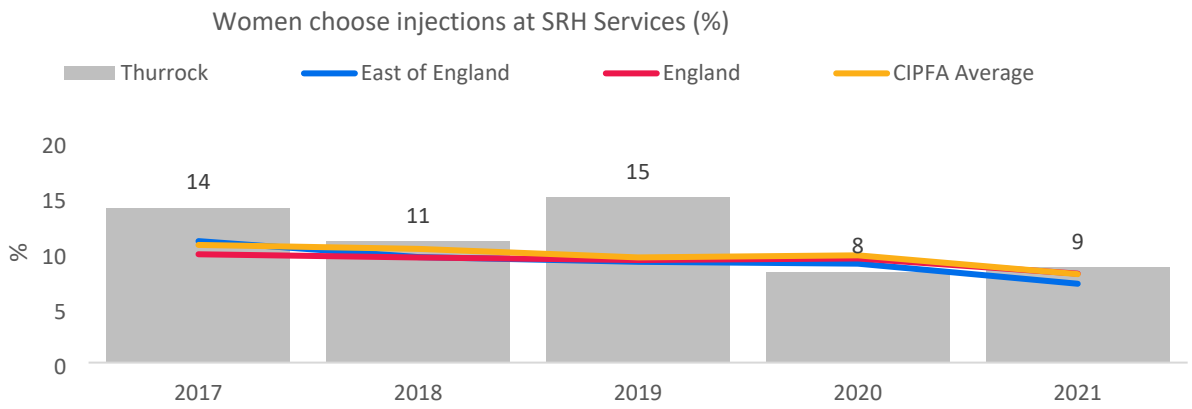
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Sexual and Reproductive Health services

Sexual and Reproductive Health (SRH) services in England include family planning services, community contraception clinics, integrated Genitourinary Medicine (GUM) and SRH services, and young people's services. They provide a range of services including, but not exclusively, contraception provision and advice.

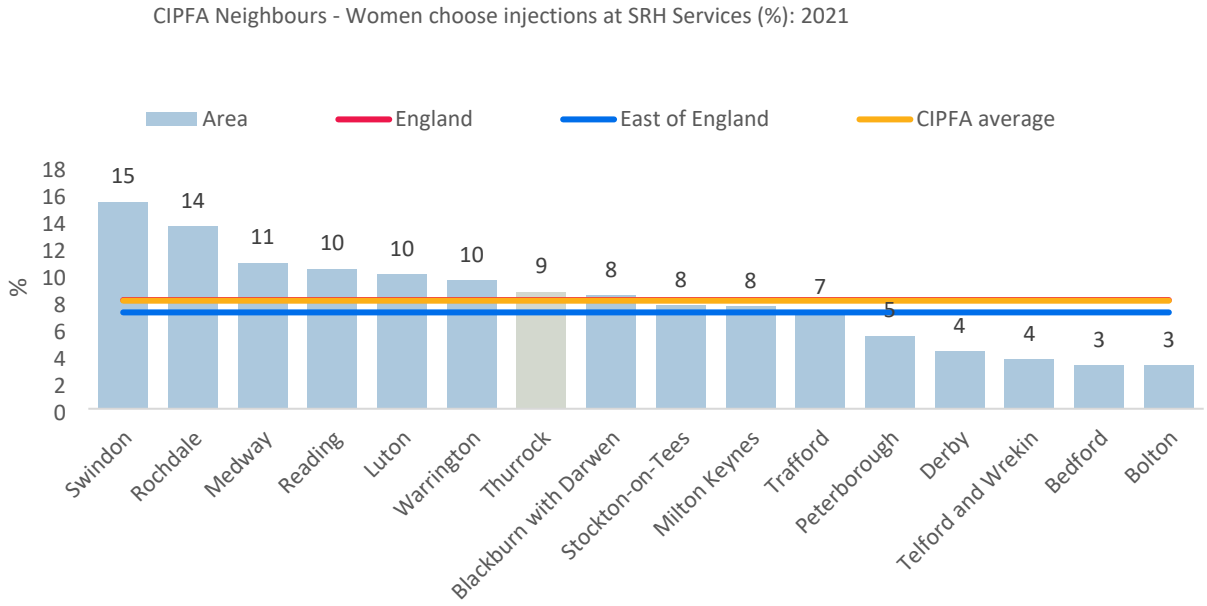
Figure 30 shows a decrease in women choosing contraceptive injections at sexual and reproductive health (SRH) services across Thurrock, England, and CIPFA neighbours between 2017 to 2021. However, Thurrock figures have generally remained higher than their geographic comparators (see figures 30-.43).

Figure 30: Percent of women choosing injections at SRH Services (2017-2021) - Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

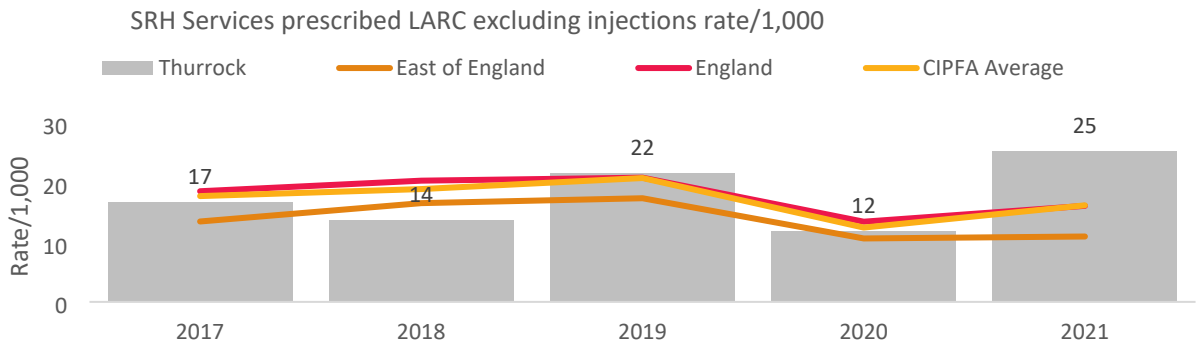
Figure 31: Percent of women choosing injections at SRH Services (%) - Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

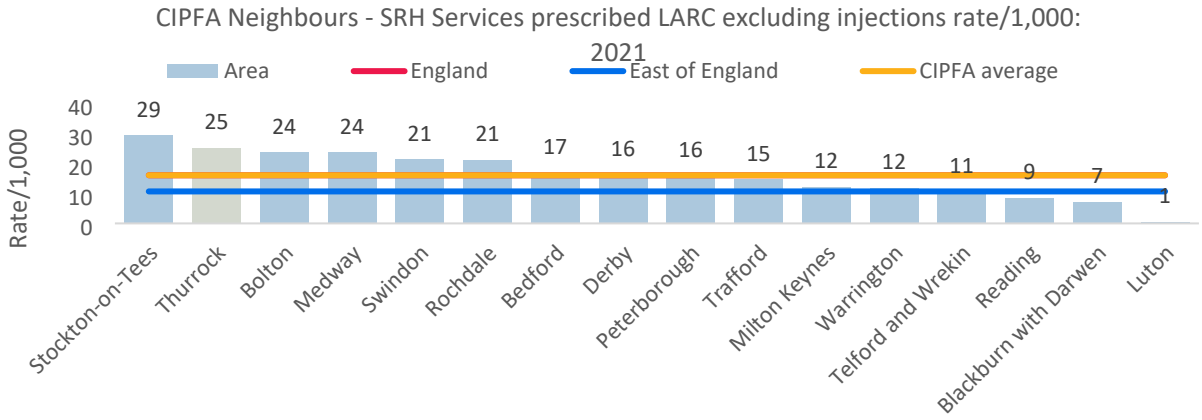
LARC (excluding injections) prescribed by SRH services has fluctuated across Thurrock between 2017 and 2021, whereas across England, East of England, and CIPFA neighbours there was a gradual increase between 2017 to 2019, followed by a sharp decrease in 2020. Thurrock currently has the highest uptake of SRH prescribed LARC in 2021.

Figure 32: SRH Services prescribed LARC excluding injections rate/1,000 (2017-2021) – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

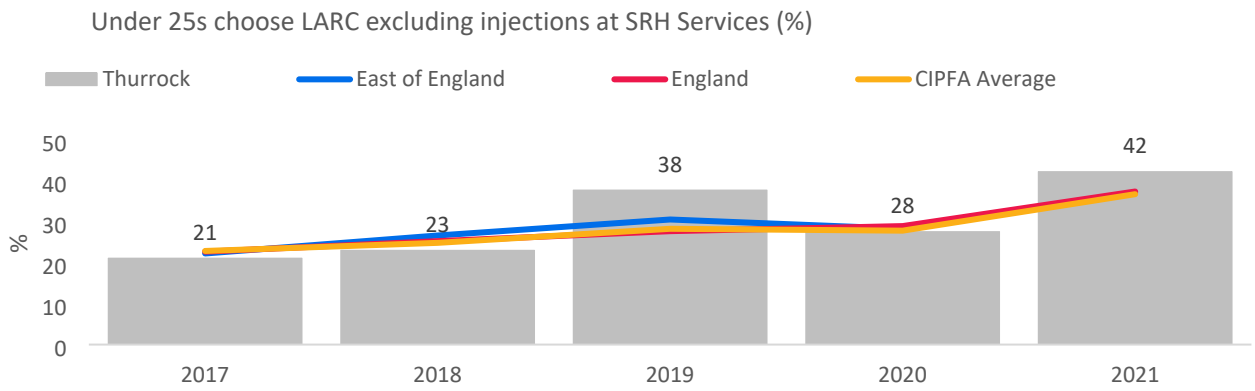
Figure 33: SRH Services prescribed LARC excluding injections rate/1,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

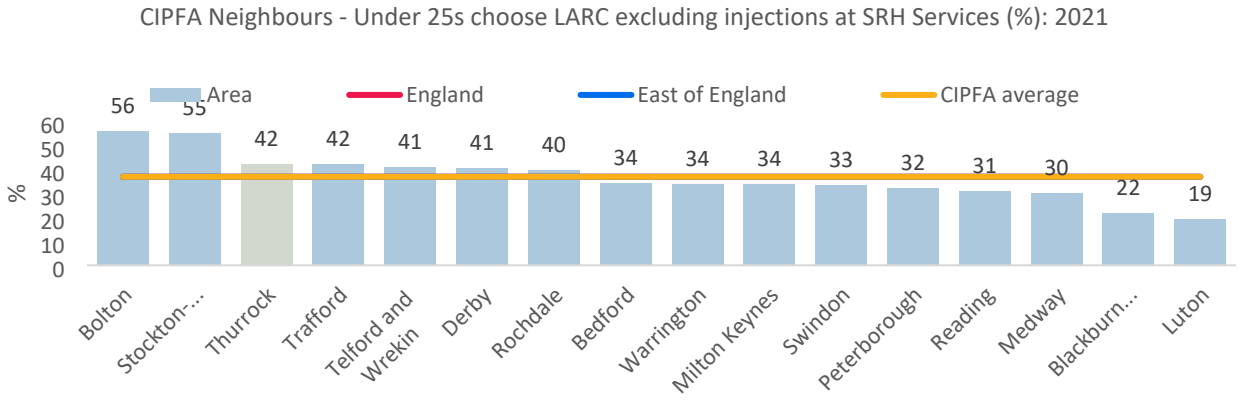
Since 2017 there has been an increase in females in Thurrock choosing LARC (excluding injections) at SRH services. The under 25s choosing LARC has increased from 21% in 2017 to 42% in 2021. The over 25s choosing LARC has increased from 39% in 2017 and currently peaking at 61% in 2021. Thurrock had the highest uptake of LARC excluding injections at SRH services in 2021 and currently features in at the higher end of the range across CIPFA neighbours in 2021.

Figure 34: Under 25s choose LARC excluding injections at SRH Services (%) - Thurrock/England/EoE/CIPFA:



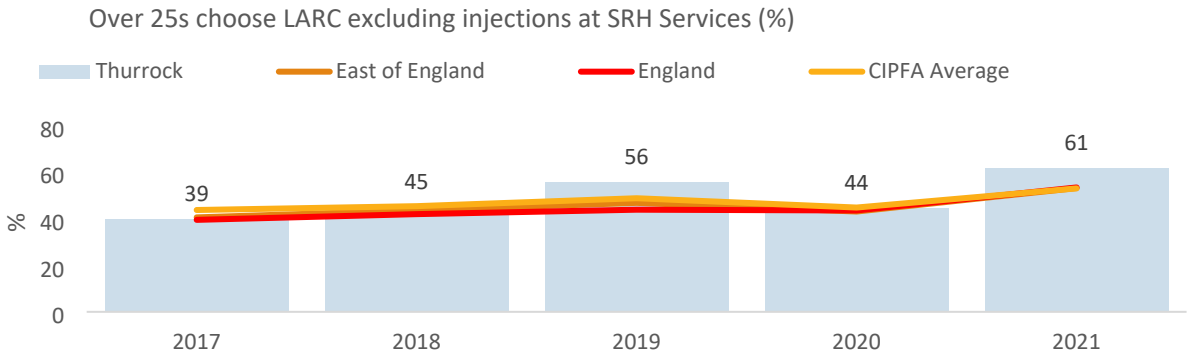
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 35: Under 25s choose LARC excluding injections at SRH Services (%) - Thurrock/CIPFA neighbours 2021:



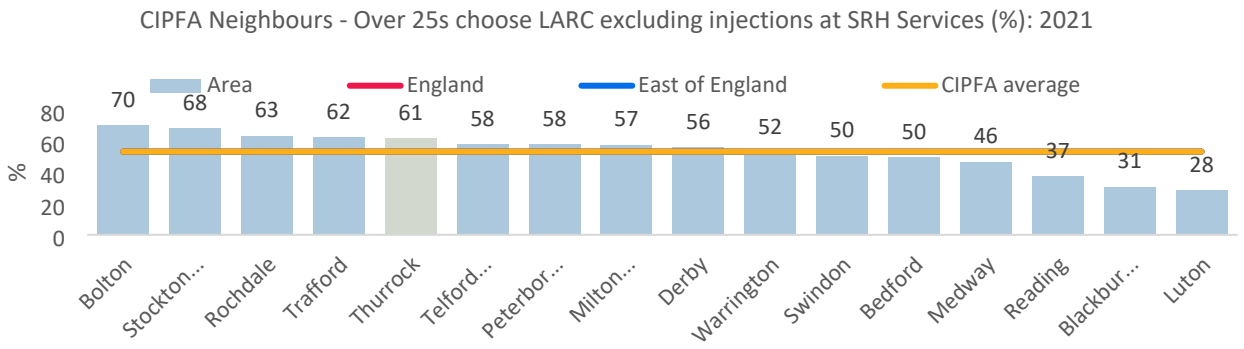
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 36: Over-25s choosing LARC excluding injections at SRH Services (%) - 2017-2021 Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

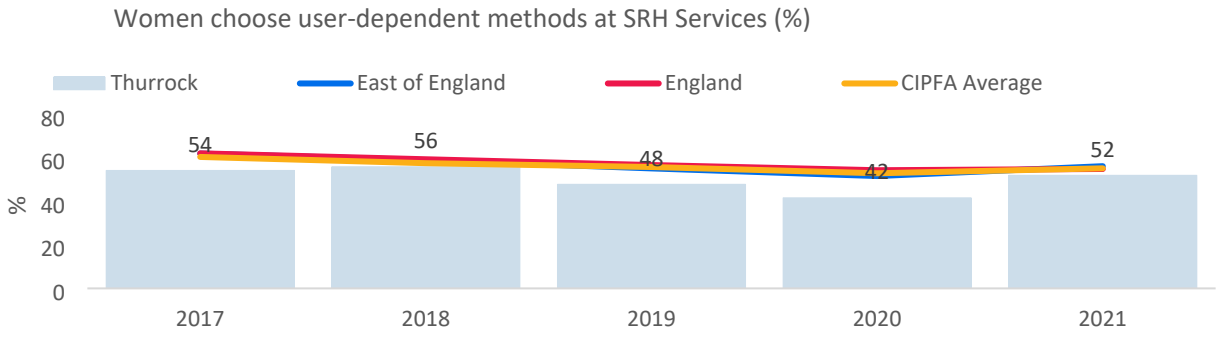
Figure 37: Over-25s choose LARC excluding injections at SRH Services (%) – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

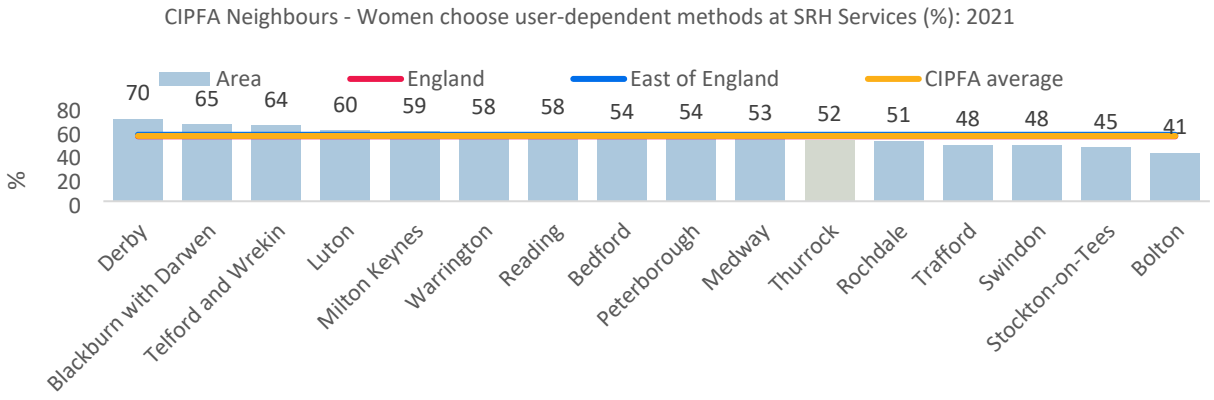
The percentage of women choosing user-dependent methods at SRH services is showing a downward shift between 2017 to 2020, followed by an increase in 2021. The percentage uptake in 2021 for user-dependent methods has remained higher for women than those choosing injections at SRH services.

Figure 38: Women choose user-dependent methods at SRH Services (%) –. Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 39: Women choose user-dependent methods at SRH Services (%) – Thurrock/CIPFA neighbours 2021:

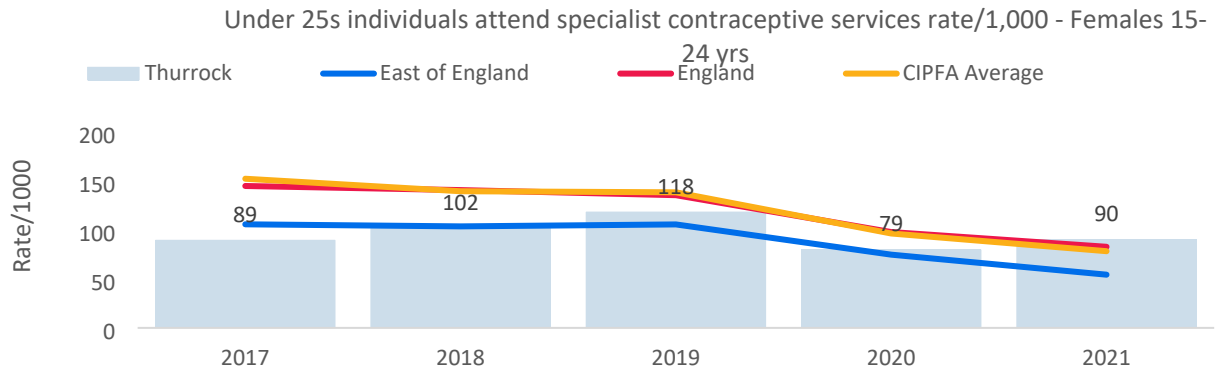


Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

The rate of under-25 females attending specialist contraceptive services has remained almost consistent since 2017, with a peak in 2019 at 118 per 1,000. The current rate of 90 per 1,000 in 2021 is an increase of 79 per 1,000 in 2020. There is a downward trend illustrated since 2019 across England, East of England, and CIPFA neighbours, and Thurrock rates have been lower than its geographical comparators during the reporting period.

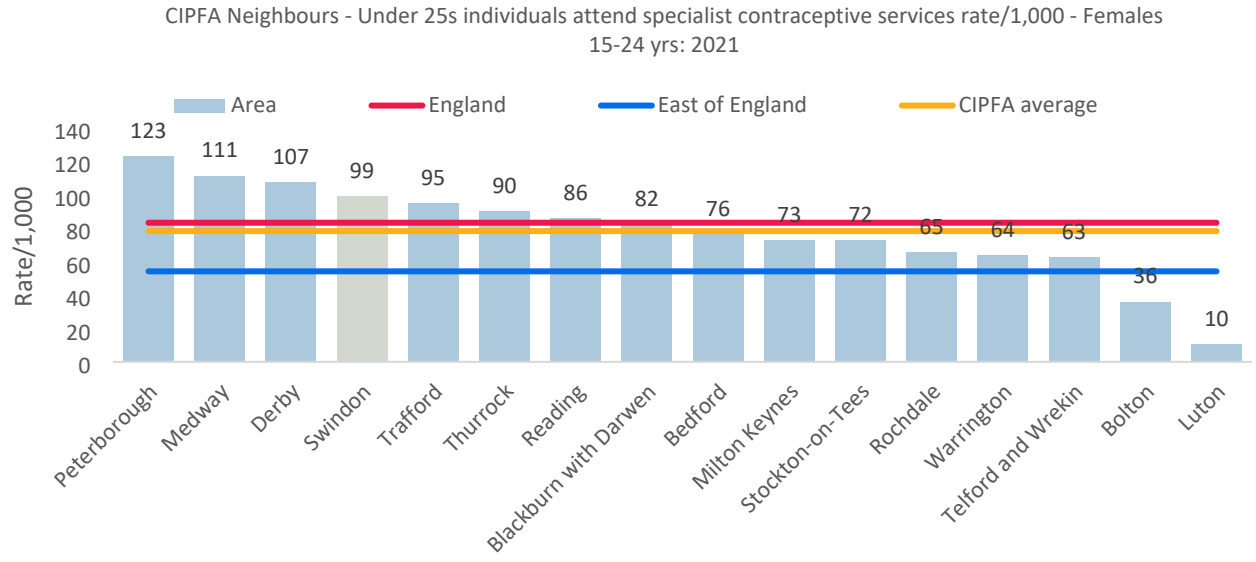
In comparison, the rate of males attending specialist contraceptive services is showing an increase between 2017 to 2019. The highest rate in Thurrock is in 2019 with 44 per 1,000 males attending specialist contraceptive services, compared to 18 per 1,000 across CIPFA neighbours and 20 per 1,000 in England in the same year. This indicates that prior to Covid-19, Thurrock was potentially successful in reaching out to under-25 males and encouraging them to attend specialist contraceptive services, there may be an aspect of better reporting at this time and whilst numbers did reduce during the Covid-19 pandemic they have begun to rise again

Figure 40: Under-25 individuals attend specialist contraceptive services rate/1,000 females (2017-2021) – Thurrock/England/EoE/CIPFA:



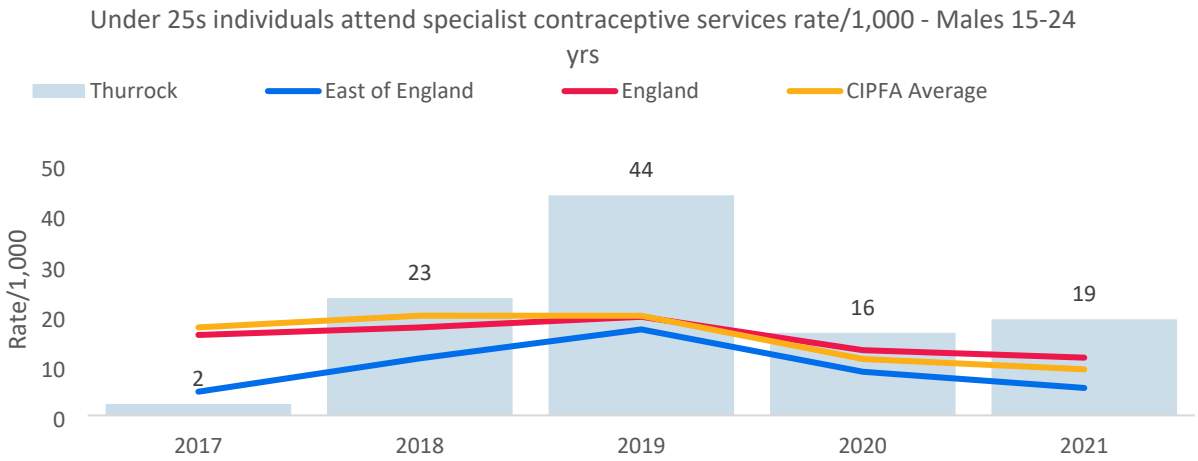
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 41: Under 25s individuals attend specialist contraceptive services rate/1,000 females – Thurrock/CIPFA neighbours 2021:



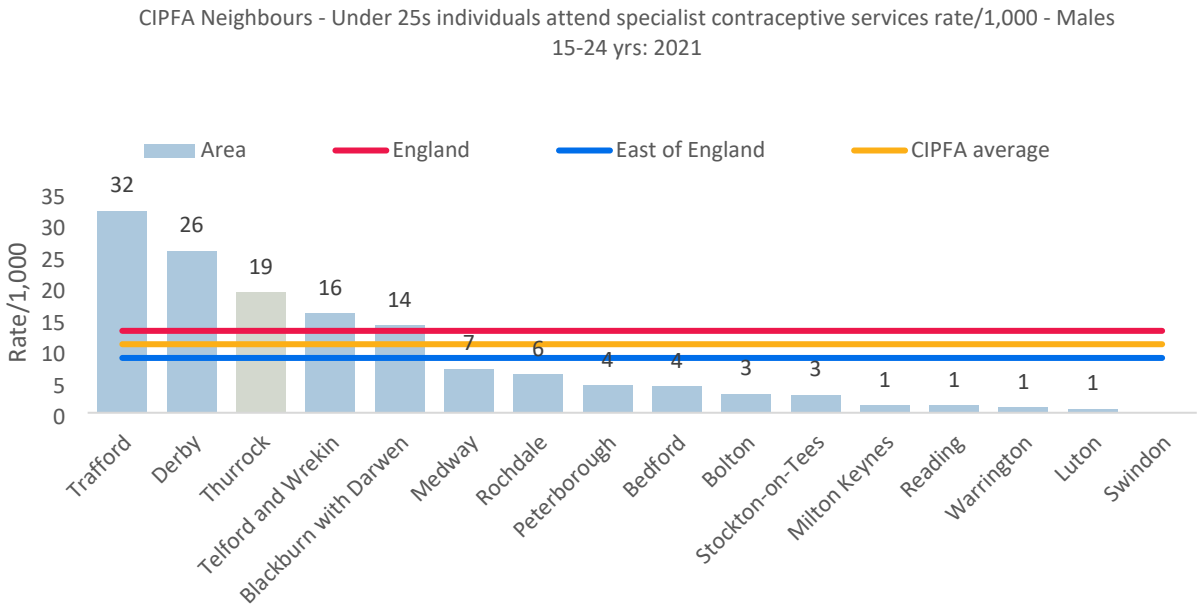
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 42: Under-25s individuals attend specialist contraceptive services rate/1,000 males (2017-2021) – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023 -

Figure 43: Under-25s individuals attend specialist contraceptive services rate/1,000 males – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

The charts show is that there is a decrease in women choosing injections at specialist sexual health services, this may be as their GP or pharmacist is more accessible at times convenient to them. There is an increase in all women choosing long-acting contraception (except injection) and fewer young females are attending specialist contraceptive services. Whilst young male attendance is higher in Thurrock than its CIPFA neighbours and the east of England it has also reduced.

Generally, across all indicators measuring SRH service/LARC, 2021 figures are showing an increase from 2020 rates and percentages. This can potentially be interpreted as 2020 being an anomaly due to the pandemic, and from 2021, the use of SRH services and contraception services could begin to increase.

It is essential that woman have choice and control over their reproduction to ensure that pregnancies are wanted and planned. This allows the health of the woman to be optimised prior to conception and throughout the pregnancy and those that do not want to have children can effectively prevent becoming pregnant. If younger female attendance declines the risk of unwanted pregnancy and people living with undetected STIs that may affect their reproductive system later increases. It is vital that both women and men continue to access services to ensure that appropriate contraception is available and that they are supported to develop healthy relationships for their physical and emotional wellbeing.

According to PHEs publication, Health Matters: reproductive health and pregnancy planning (2018) effective contraception and planning for pregnancy means that women and men stay healthy throughout their life. The publication also states that a planned pregnancy is likely to be a healthier one, with unplanned ones having adverse health impacts for mother, baby, and children in later life.

In summary, the conception rate in U18s in Thurrock is decreasing in line with national trends, however the abortion rate is remaining stable, and in the over 25s, the rate of abortions is increasing as is the rate of repeat abortions.

We know that abortion rates are an indicator of a lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method. We also know that in terms of contraception in Thurrock, prescribed LARC rates remain low compared to the national picture, particularly GP prescribed LARC. As LARC methods are highly effective, this means that a higher proportion of the Thurrock population, compared to other areas, is using other, less reliable forms of contraception or no contraception at all, and this means that a larger proportion of our local population is at greater risk of unplanned pregnancies.

Unplanned pregnancies are more likely to result in abortion, or if the pregnancy is continued, more likely to result in adverse health and life outcomes for the mother and child. If Thurrock sees greater unplanned pregnancies this will therefore have the knock-on effect of adversely affecting the health and wellbeing of the Thurrock population and result in increased need for other services to address these issues in the future.

To be able to address this, Thurrock sexual health services and associated services need to be better able to identify and encourage women of childbearing age to choose LARC as their method of contraception, and then be able to provide this service in a location and at times preferred by the individual. We know from the stakeholder engagement exercise that access to the existing sexual health clinic can be difficult for young people due to location, opening times and a lack of public transport links so there is a need to explore alternative locations for this service and / or greater provision through GPs for example, where we know that LARC provision is low in Thurrock, or through other providers.

6. Sexually Transmitted Infections (STIs)

Figure 44:

Key Findings:

People are most at risk of STIs if they are involved in high rates of condomless sex with multiple partners or frequently change partners.

People may be reluctant to access services because they do not know about them, they may have physical or learning disabilities, language barriers, learning difficulties, or stigma.

Reducing the risk of people getting and transmitting STIs is paramount to improving the sexual health of the population.

Recommendations:

An action plan should be developed to include (but not limited to):

- **Signposting and ensuring local pathways into service.**
- **Communication Plan including advertising of services, locations, online and non-clinical settings.**
- **Emphasising confidentiality, empathy, and a non-judgemental approach.**
- **Making sure stakeholders and the community understand that services are free and available to everyone regardless of where they live (or are from), and they do not refuse access to someone who is entitled to the service.**

People are most at risk of STIs if they are involved in high rates of condomless sex with multiple partners or frequently change partners. There may be more people practising these behaviours in some groups than others, but this does not mean that everyone in the group is necessarily at higher risk. For example, gay, bisexual, and other men who have sex with men are a higher risk group for STIs and HIV, but this does not mean that every person in that group is at higher risk. However, it does mean that attention needs to be given to ensure that the service is able to accommodate all groups and to be aware of the risks and mitigations required.

Some people find it more difficult to access sexual health services because of the location of services (most services are in urban rather than rural settings) or because they do not know that they are eligible for free services (for example, some refugees or asylum seekers may not know this). Others may find it difficult to access services because they do not know about them, physical accessibility issues, language barriers, learning difficulties, or stigma.[50]

Reducing the risk of people getting and transmitting STIs is paramount to improving the sexual health of the population. The National Institute for Health and Care Excellence (NICE), 2022 stated that accessing sexual health services should include ensuring that:

[50] NICE (2022)

- Everyone is signposted to, and can access, the care they need
- Local pathways are in place to link people, including underserved communities, to the best possible care.
- Details of the network are kept up to date and all staff understand what each service offers.
- Determine the most appropriate settings for services and interventions in consultation with groups with greater sexual health or access needs.
- Include online and non-clinical settings.
- Barriers to services for groups with greater sexual health or access needs should be mitigated by:
- Emphasising confidentiality, empathy, and a non-judgemental approach.
- Offering access to a professional translator or interpreter instead of waiting for the person to ask, to ensure they are fully able to communicate and to understand the discussion.
    - Making sure staff understand that services are free and available to everyone regardless of where they live (or are from), and they do not refuse access to someone who is entitled to the service.
    - Supporting people to attend appointments and engage with treatment.
    - Providing outreach activities.
    - Consider guidance on making services more welcoming and inclusive, such as the Department of Health and Social Care's 'You're welcome' quality criteria or UK Health Security Agency's (previously Public Health England) Inclusion health: applying all our health.

How well the service meets these requirements can be seen in detail in the findings and recommendations.

Testing and Diagnosis

Figure 45

Key Points:

- **The STI diagnosis rate has declined in Thurrock since 2017, and it is unclear how vulnerable groups are affected by the decline in diagnoses.**
- **In the most recent data (2021), the diagnosis rate in Thurrock is lower than CIPFA neighbours but similar to East of England; the testing rate is lower than both CIPFA neighbours and East of England; with a corresponding positivity rate that is similar to CIPFA but higher than East of England.**
- **The CIPFA neighbours with the highest diagnosis rates also have high testing rates.**
- **Qualitative feedback from stakeholders and residents suggested that a high proportion of Thurrock residents were not aware of Thurrock sexual health services, and that other professionals were not clear how to refer into the service.**

Recommendations:

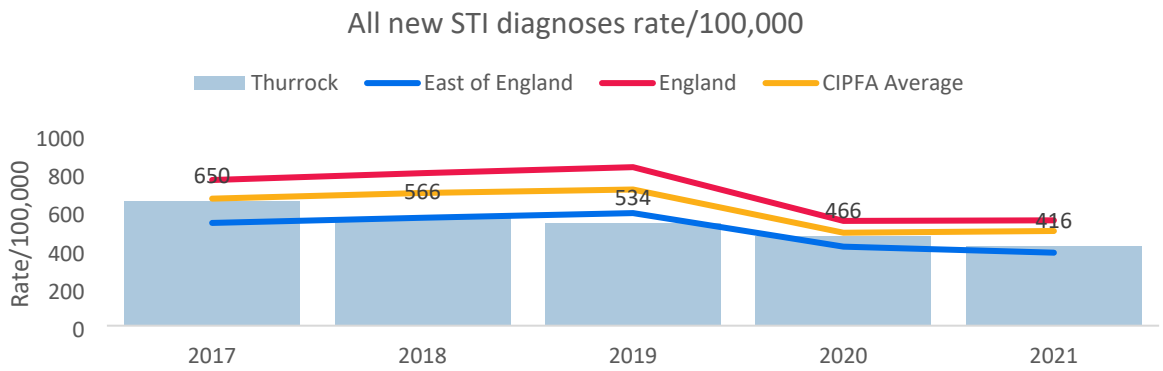
- **The Provider must continue to review and evaluate data recording to improve recording and reporting of protected characteristics to gain a better understanding of potential inequities in Sexual Health outcomes across Thurrock including older age STIs.**
- **Services should develop an Action Plan to increase uptake of STI testing to reduce the burden of undiagnosed infection in Thurrock, including:**

- **Increasing awareness of the need for regular STI testing among vulnerable groups and those at higher risk.**
- **Increasing referrals from other services.**

- **The Provider, working in collaboration with OHID, UKHSA and the commissioner must monitor and respond to new and emerging threats such as Mgen and drug resistant infections.**

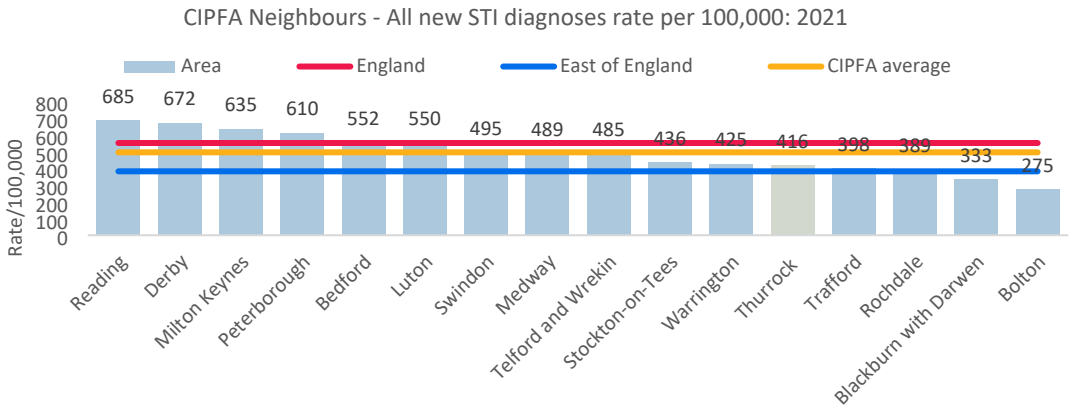
STI diagnosis rate has generally decreased in Thurrock since 2017, which is a trend illustrated across England, East of England, and CIPFA neighbours since 2019. Thurrock STI diagnosis rates remain lower than England and CIPFA neighbours, and in 2021, Thurrock features in the bottom five comparable local authorities for low STI diagnosis rates (see figures 46 – 52).

Figure 46: All new STI diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 47: All new STI diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



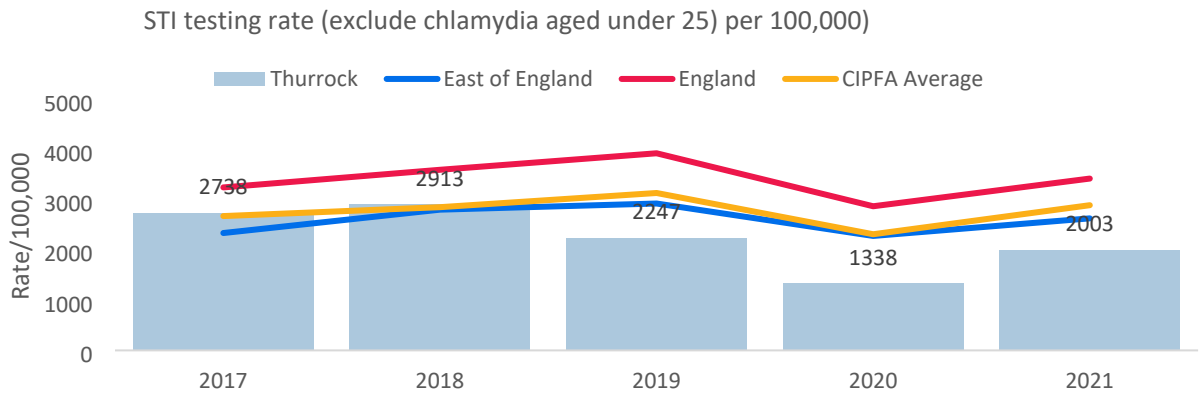
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Testing rates in Thurrock decreased from 2,913 per 100,000 in 2018 to 1,338 in 2020, followed by a small increase in 2021 to 2,003 per 100,000. Nationally, and across the region and Thurrock's CIPFA neighbours, the trend was somewhat similar where 2020 showed the lowest testing rates followed by an upward trend witnessed in 2021. However, Thurrock rates have

consistently remained lower than its geographical comparators since 2018. This may be due in part to a reduction of need and availability due to the pandemic.

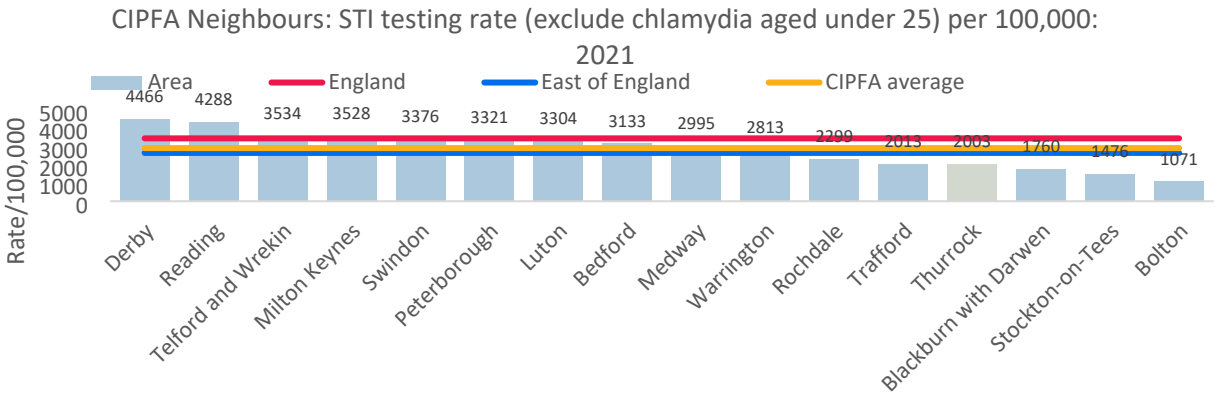
In 2021, Thurrock's testing rate is 4th lowest across the CIPFA neighbours.

Figure 48: STI testing rate (excluding Chlamydia under 25)/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

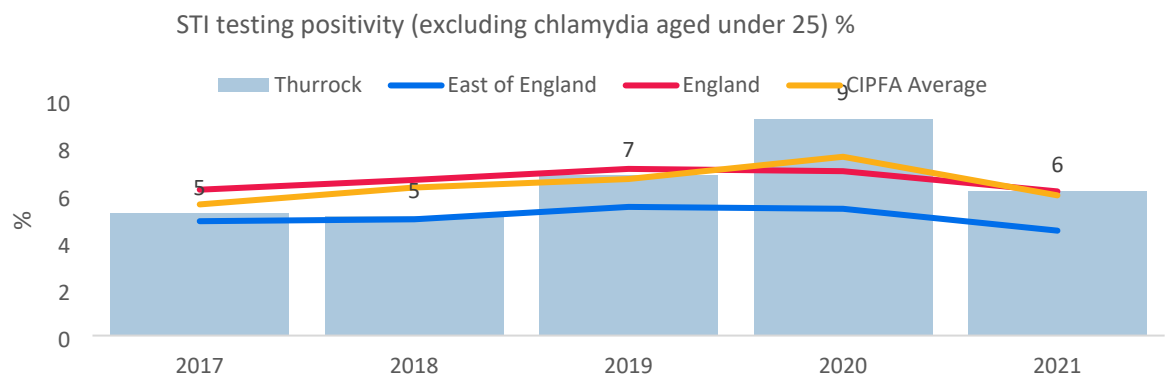
Figure 49: STI testing rate (excluding Chlamydia under 25)/100,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

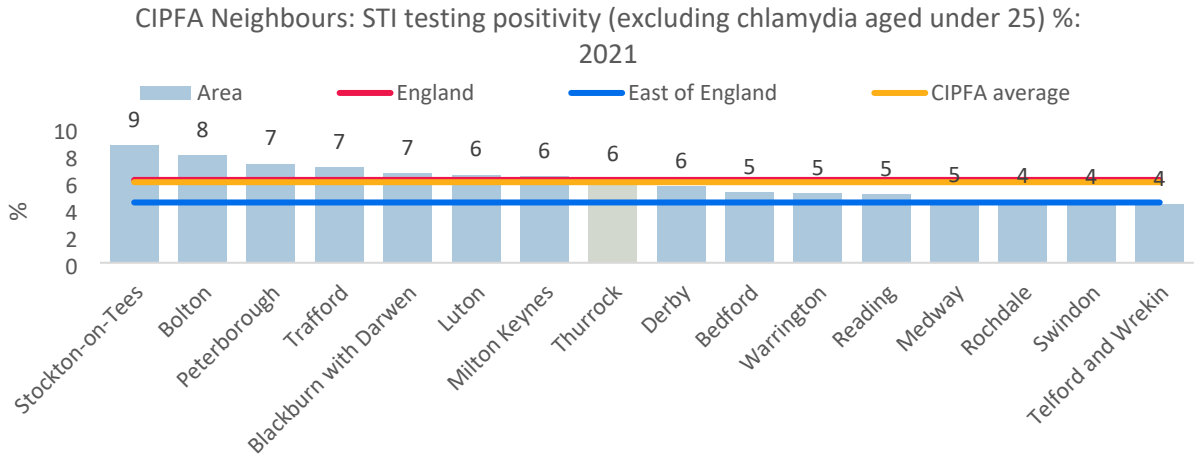
Conversely, with decreasing testing rates since 2018, the percentage positivity has steadily increased between 2018 to 2020. Testing positivity has consistently been higher than the regional average and was higher than the England and CIPFA figures between 2019 and 2020. This may be due to service users engaging when they know they have been at risk or have symptoms rather than testing as a precaution. It may be difficult to ascertain if this trend has continued due to the pandemic.

Figure 50: STI testing positivity (excluding Chlamydia under 25)/100,000 – Thurrock/England/EoE/CIPFA:



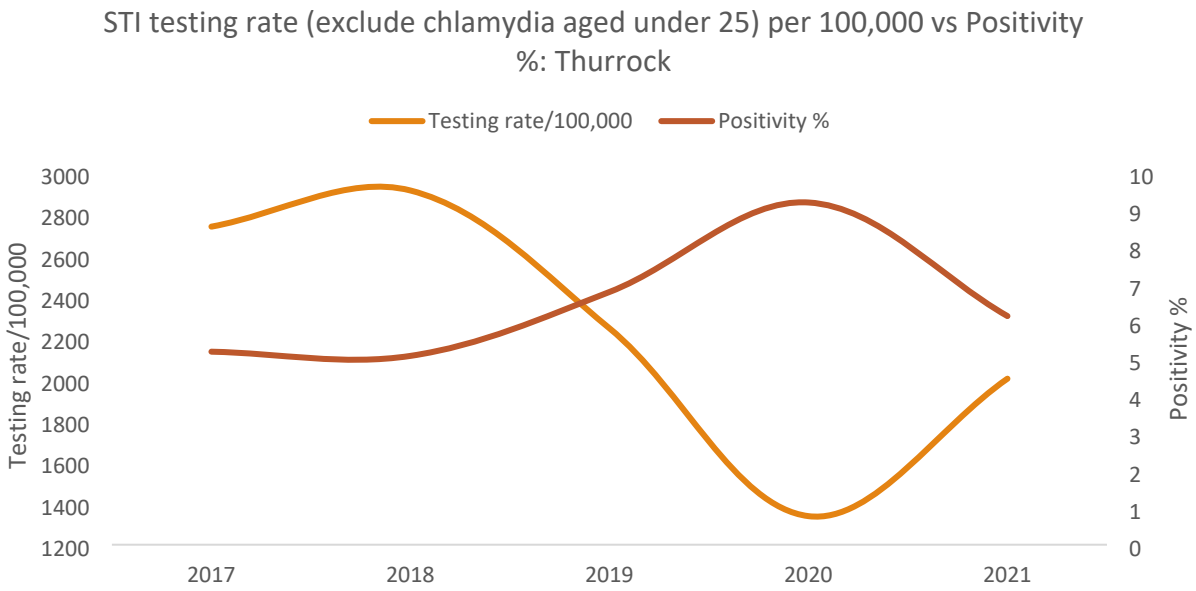
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 51: STI testing positivity (excluding Chlamydia under 25)/100,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 52: STI testing rate vs Positivity (excluding Chlamydia under 25)/100,000 – Thurrock:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

- New STI diagnosis rate has declined steadily in Thurrock from 2017.
- Thurrock is in the bottom 5 out of 15 CIPFA neighbours for new STI diagnoses.
- STI testing rates (excl chlamydia) in Thurrock have been consistently lower than England, EoE, and CIPFA neighbours since 2018.
- In 2021, Thurrock was fourth from bottom among 15 CIPFA neighbours for STI testing rates (excluding chlamydia), significantly below England, EoE, and CIPFA averages
- STI test positivity rates in Thurrock had been increasing steadily to a peak in 2020 before decreasing to 2021. Positivity rates are currently higher than the regional average and similar to England and CIPFA neighbours.
- Between 2018 and 2020, the STI testing rate in Thurrock declined as the positivity rate increased, with both being the same in 2019. In 2021, testing rate increased in contrast to a declining positivity rate.

STIs remain prevalent and are increasing in several populations. Appropriate STI diagnosis is crucial to prevent the transmission and sequelae of untreated infection. STIs remain prevalent and a major burden of morbidity and mortality, impacting on quality of life, reproductive and child health, and national and individual economies. Failure to detect and treat STIs can lead to fertility problems, cancer, and higher risk of contracting further sexually transmitted diseases, including facilitating the sexual transmission of human immunodeficiency virus (HIV).

Some STIs may be difficult to detect, for example chlamydia in the early stages often has limited or no symptoms. Without detection, STIs can be transmitted to one or multiple partners. Increasing testing rates is therefore key to increasing diagnosis rates and reducing the burden of undiagnosed infections in Thurrock.

Regular screening for STIs and HIV, on at least an annual basis, is essential to maintain good sexual health for everyone having condomless sex with new or casual partners. In addition:

- women, and other people with a womb and ovaries, aged under 25 years who are sexually active should have a chlamydia test after having sex with a new partner or annually.
- gay, bisexual, and other men who have sex with men should have tests for HIV and STIs annually or every 3 months if having condomless sex with new or casual partners.

This information must be acted upon by the providers of sexual and reproductive health in Thurrock to ensure that testing, education, and condoms are available throughout the Borough and not just in certain wards or locations.

Chlamydia

Figure 53:

Key Points

- **Chlamydia detection rates in Thurrock are some of the lowest among the CIPFA neighbours' group, with screening rates being only 10% of the 15–24-year-old population in 2021. The areas with the highest detection rates also have the highest screening rates.**

Recommendations

- **Services should develop an Action Plan to increase awareness and uptake of chlamydia screening among male and female 15–24-year-olds, to reduce the burden of undiagnosed infection in Thurrock.**

Chlamydia screening and diagnosis

Chlamydia is the most common bacterial STI in England. By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection. A shorter period of infection will reduce an individual's chance of developing complications and reduce the time when someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population.

The National Chlamydia Screening Programme (NCSP) recommends that all sexually active under 25-year-old men and women be tested for chlamydia annually or on change of sexual partner (whichever is more frequent). Chlamydia is the most commonly tested-for STI in Thurrock, with 10,576 individuals having had Chlamydia screening since 2017 (service uptake data provided by Provide, 2023).

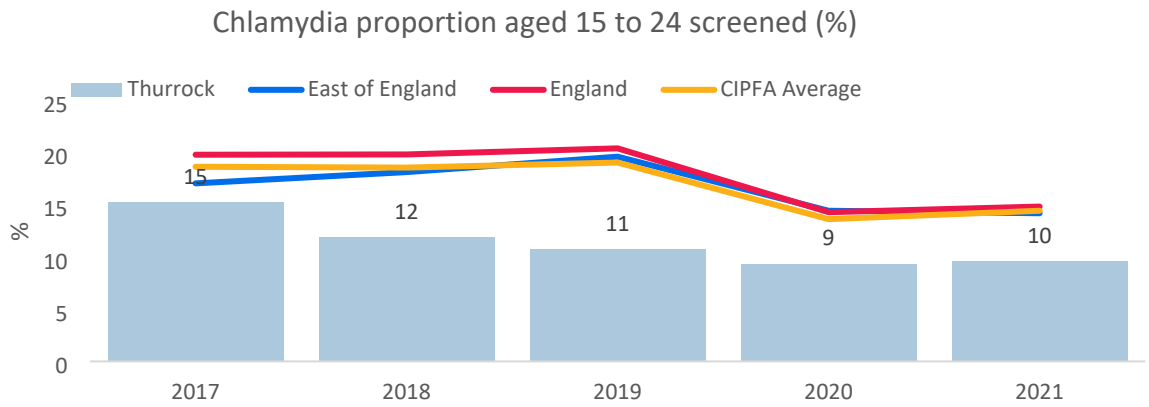
Figure 55 shows the rate of chlamydia detection per 100,000 young people aged 15 to 24. This is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission onto others. An increased detection rate is indicative of increased control activity: detection rate is not a measure of morbidity.

Screening

The percentage of 15–24-year-olds screened for Chlamydia in Thurrock in 2017 was 15%, and this has steadily decreased to 10% in 2021. England, EoE and CIPFA neighbours' percentages have consistently remained higher than Thurrock since 2017 though their rates have also been decreasing over the last five years. The highest recorded rates across

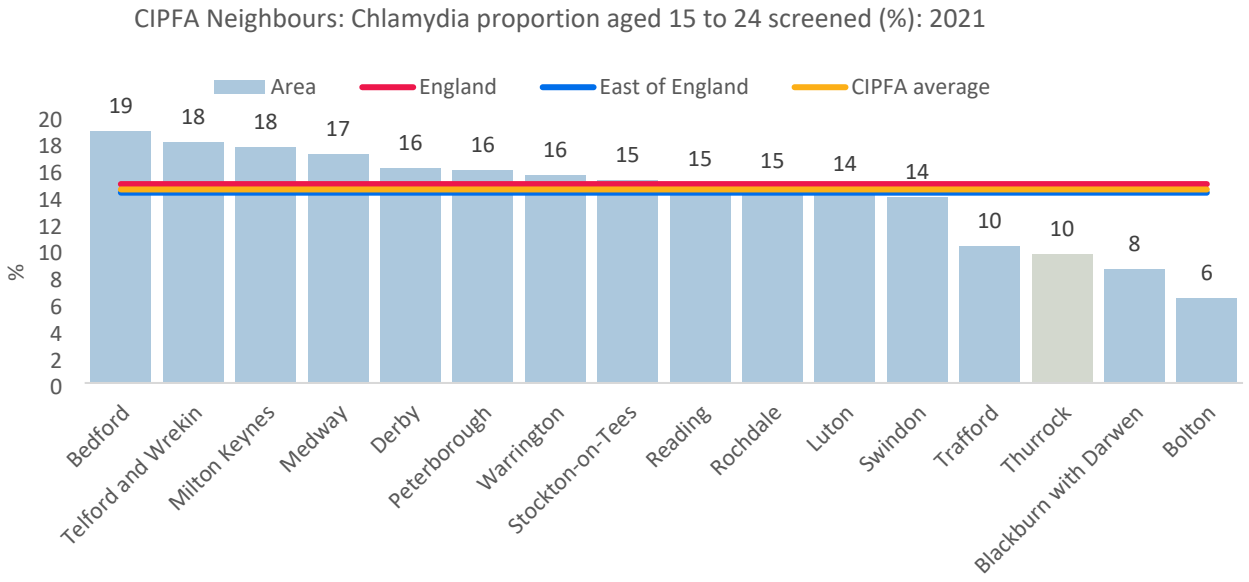
England, EoE, and CIPFA neighbours was in 2019 at approximately 20%. In comparison to its CIPFA neighbours, Thurrock features as one of the lowest performing local authorities after Blackburn and Bolton (see figures 54 – 58).

Figure 54: Proportion aged 15 to 24 screened for chlamydia – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 55; Proportion aged 15 to 24 screened for chlamydia – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

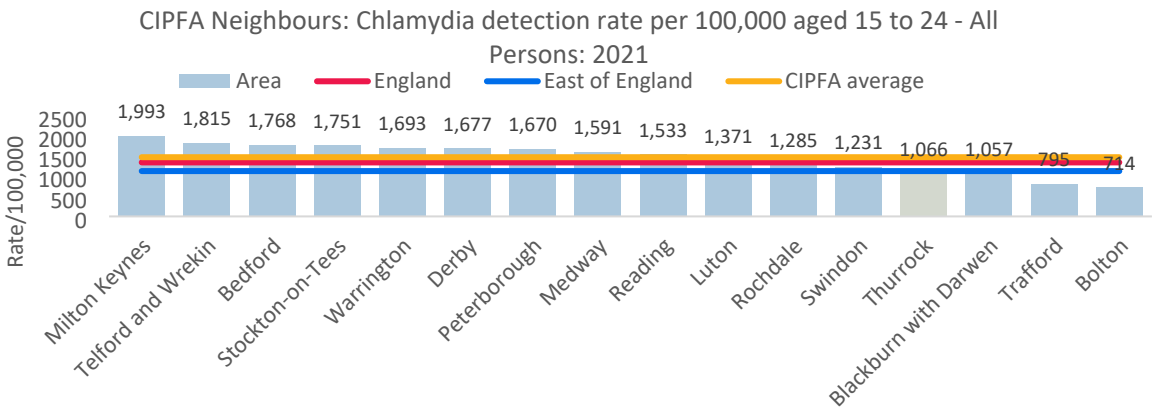
Detection

The chart below shows the chlamydia detection rate amongst under 25-year-olds for males and females respectively in Thurrock compared to the average for your chosen comparison group. This is a measure of chlamydia control activities.

The detection rate for Chlamydia amongst 15–24-year-olds has been lower for males than females between 2017 to 2021. Since 2020, the detection rates for 15–24-year-old males in Thurrock, England, EoE, and CIPFA neighbours have shown similar rates. However, the rates

for chlamydia detection in females in Thurrock have consistently remained much lower than England and CIPFA neighbours.

Figure 56: Chlamydia detection rate for all persons aged 15 to 24 per 100,000 population – Thurrock/England:



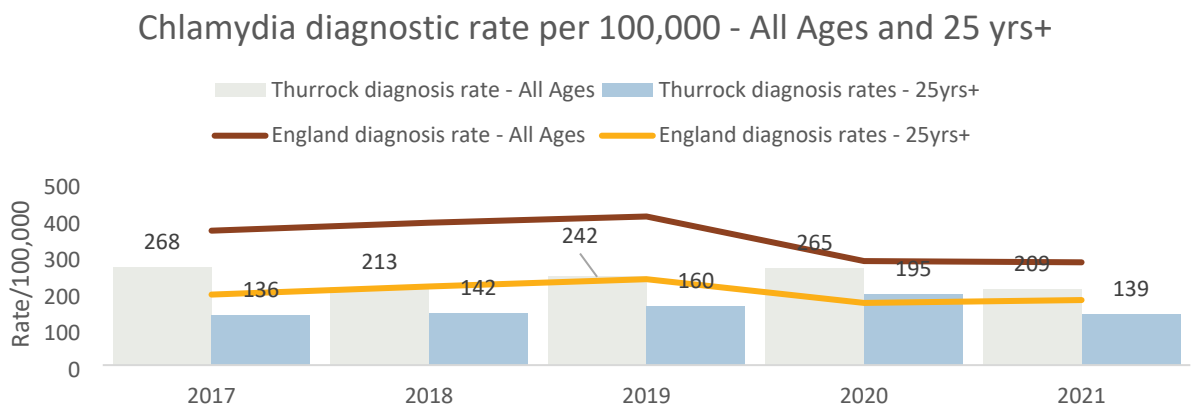
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Diagnosis

The below chart shows the rate of all chlamydia diagnoses among people of all ages, as well as people aged 25 years and above specifically, accessing sexual health services, per 100,000 population.

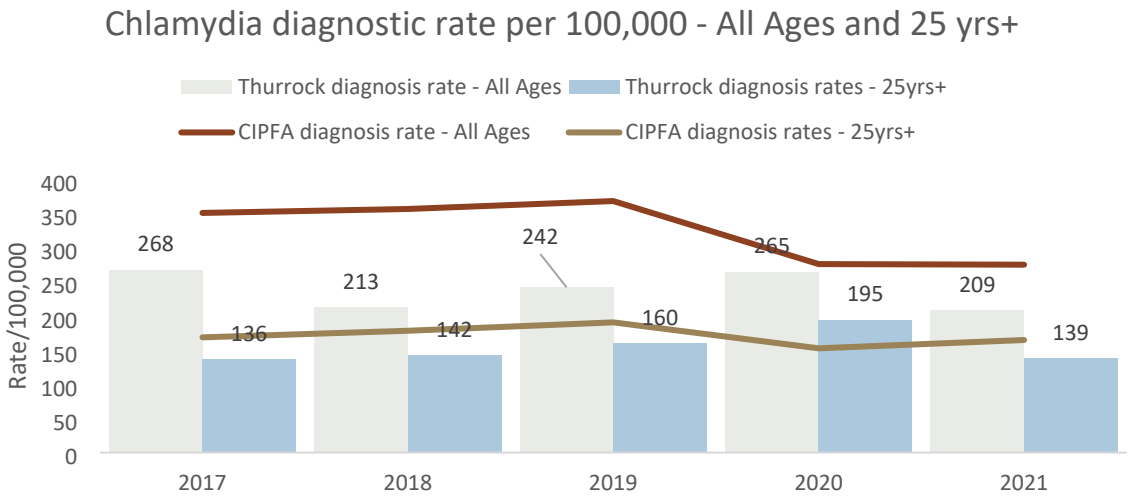
The rate of people of all ages and in those aged 25 years and over, accessing sexual health services leading to a diagnosis of chlamydia in Thurrock, had been steadily increasing since 2017, followed by a decrease in 2021. The England and CIPFA rates for all ages being diagnosed with Chlamydia has remained above Thurrock levels since 2017. This was also the trend for 25 years and over, except for 2020, where Thurrock recorded a slightly higher diagnosis rate than England and CIPFA neighbours.

Figure 57: Chlamydia diagnosis rate among all ages per 100,000 population & Chlamydia diagnoses rate per 100,000 population aged 25 years and over – Thurrock/England:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 58: Chlamydia diagnosis rate among all ages/100,000 population & Chlamydia diagnoses rate/100,000 population aged 25 years and over – Thurrock/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

The percentage of 15–24-year-olds screened for Chlamydia in Thurrock has been steadily decreasing since 2017. This is significant as Thurrock is the third lowest performing LA for Chlamydia screening amongst CIPFA neighbours. The detection rate for Chlamydia amongst 15–24-year-olds in Thurrock in lower for males than females, this may be due to a lack of symptoms leading to a lack of urgency to be tested as a precaution. Rates for chlamydia detection in females in Thurrock have consistently remained much lower than England and CIPFA neighbours. The all-ages Chlamydia diagnosis rate in Thurrock has consistently been below England and CIPFA neighbours. Thurrock briefly out-performed England and CIPFA neighbours for over-25 Chlamydia diagnoses in 2020, this may be as a result of testing during the beginning of the pandemic, though this has now reverted to being lower in 2021.

Chlamydia can be cured with antibiotics from a health care provider. However, if chlamydia is left untreated, it can cause permanent damage. The risk of getting other STIs, like gonorrhoea or HIV, increases and in males, untreated chlamydia can lead to sterility (inability to make sperm). In women, untreated chlamydia can cause pelvic inflammatory disease (PID), ectopic pregnancy and infertility.

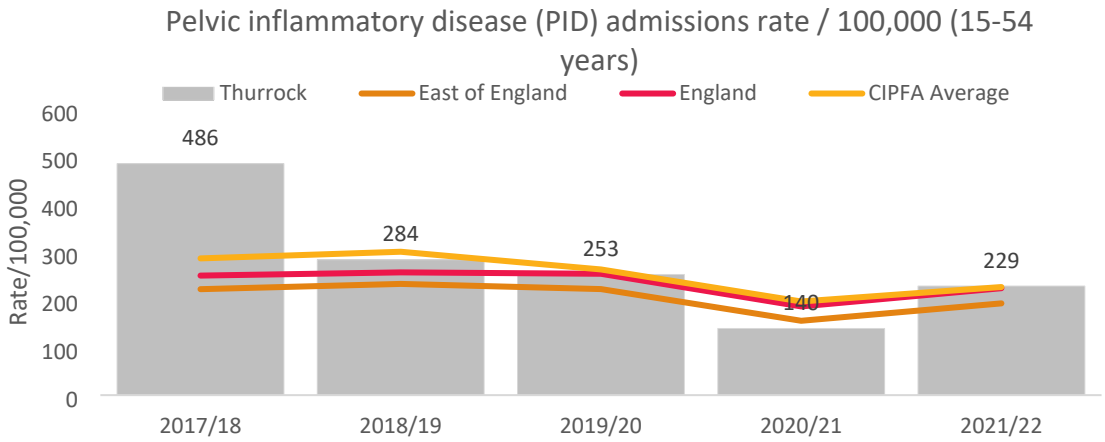
Women may be more willing to seek testing for chlamydia due to health risks associated with the STI in later life, however there may be lack of understanding regarding the risks if not getting tested and getting treatment early throughout Thurrock. The Provider should develop an action plan to improve communication, education and, engagement regarding the risks and consequences of contracting chlamydia and how people can mitigate this.

Without treatment chlamydia can persist for years in both men and women and this increases the risk of further complications. This can result in late-stage chlamydia spreading to the cervix, eyes, throat, and testicular tubes causing swelling and pain.

Pelvic inflammatory disease (PID)[51]

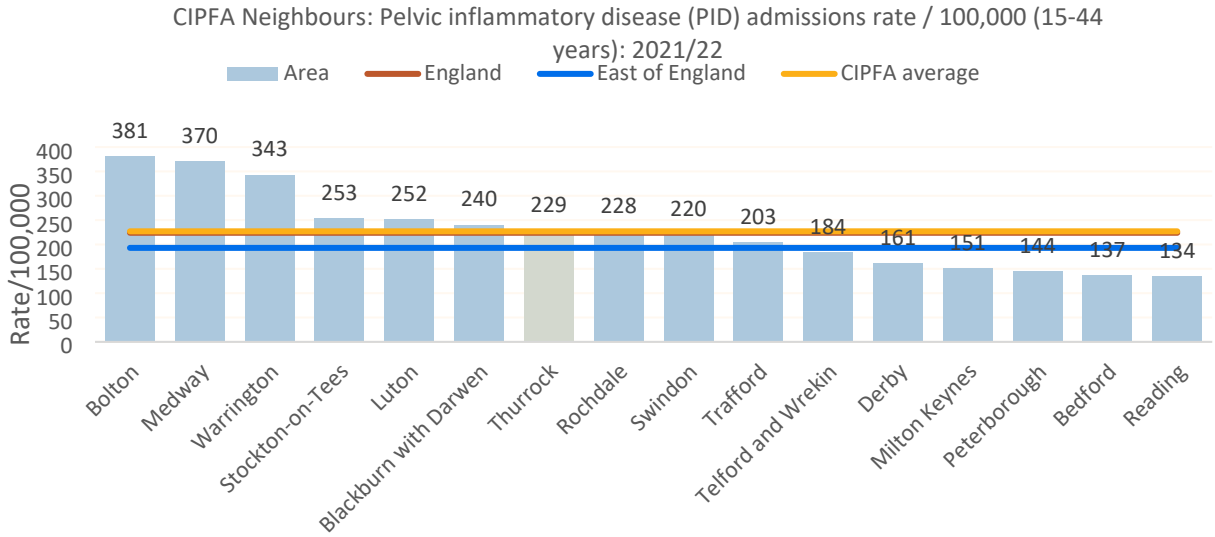
Pelvic inflammatory disease (PID) is a clinical syndrome referring to infection and inflammation of the upper female genital tract, which may lead to serious complications such as ectopic pregnancy, tubal factor infertility, and chronic pelvic pain. Chlamydial infection and other sexually transmitted infections are major causes of this condition. This indicator should be examined alongside the chlamydia screening and chlamydia diagnoses indicators. It is anticipated that high chlamydia screening coverage should lead to increased chlamydia diagnoses which, assuming successfully treated, should lead to a decrease in PID (see figures 59 – 60).

Figure 59: Rate of pelvic inflammatory disease (PID) admissions/100,000 female population aged 15-44 – Thurrock/England/EoE/CIPFA:



Source: LG Inform - Office for Health Improvement and Disparities

Figure 60: Rate of pelvic inflammatory disease (PID) admissions/100,000 female population aged 15-44 – Thurrock/CIPFA neighbours – 2021/22:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

[51] Office for Health Improvement and Disparities. 'Sexual and Reproductive Health Profiles, Rate of pelvic inflammatory disease (PID) admissions per 100,000 female population aged 15-44'. 2022.

Following higher rates of PID in 2017/18 (486 per 100,000), Thurrock rates have reduced significantly from 2017/18 to 2020/21 (486 per 100,000 to 140 per 100,000, respectively). This reduction between 2017/18 to 2020/21 is statistically significant. England, EoE, and CIPFA neighbours showed a steady trend of PID between 2017/18 to 2020/21, though the most recent rate of 2020/21 is almost 50% less than 2017/18, this may be due to increased awareness and engagement regarding PID Currently, Thurrock compares favourably against its CIPFA neighbours, featuring as one of the lower rates of PID per 100,000 in 2020/21.

Gonorrhoea

Figure 61:

Key Points:

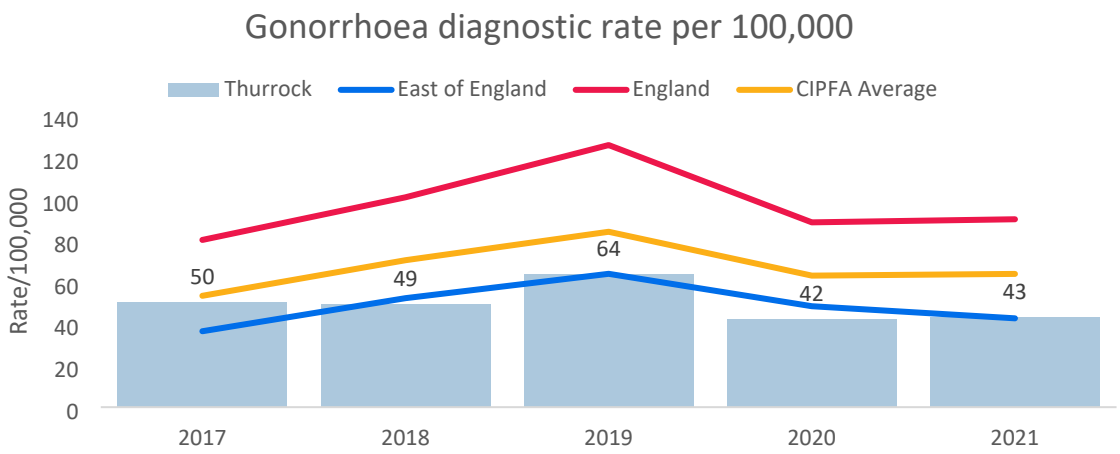
- **Gonorrhoea diagnosis rates in Thurrock have been lower than England and its CIPFA neighbours since 2018.**
- **There is a higher positivity test within older cohorts who may not access treatment services due to their age, stigma, or lack of knowledge regarding the risks and transmission of STIs.**
- **Gonorrhoea is the second most commonly tested-for STI in Thurrock, with 10,151 individuals being tested since 2017.**
- **Gonorrhoea is becoming increasingly resistant to antibiotics.**

Recommendations:

- **Services should develop an Action Plan to increase awareness and uptake of gonorrhoea screening among older service users, to reduce the burden of undiagnosed infection in Thurrock.**

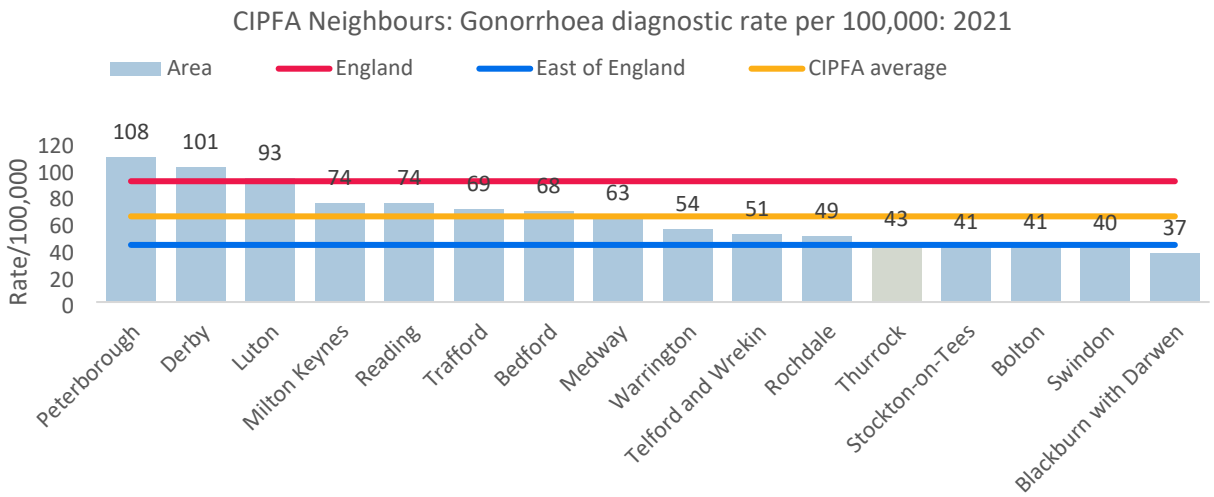
Gonorrhoea causes avoidable sexual and reproductive ill-health. Untreated Gonorrhoea can lead to complications such as long-term pelvic pain, pelvic inflammatory disease, ectopic pregnancy, and infertility in women. Prevalence is highest amongst young adults, black Caribbean people, and men who have sex with men (MSM). It is used as a marker for rates of unsafe sexual activity because the majority of cases are diagnosed in sexual health clinics, and consequently the number of cases may be a measure of access to STI treatment. Infections with gonorrhoea are also more likely than chlamydia to result in symptoms. The following charts show the rate of gonorrhoea diagnoses per 100,000 population (see figures 62 and 63).

Figure 62: Gonorrhoea diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 63: Gonorrhoea diagnostic rate per 100,000 (2021) – Thurrock/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Gonorrhoea diagnosis rates in Thurrock have been lower than England and its CIPFA neighbours since 2018. The current 2021 rate for Thurrock is 43 per 100,000 which is almost consistent with 2020 at 42 per 100,000, but a big decrease from 2019 where the rate was 64 per 100,000. This trend of rates peaking in 2019 is also evident across England and CIPFA neighbours. Currently in 2021, Thurrock is towards the lower end of diagnosis rates in comparison to CIPFA neighbours. There is a higher positivity test within older cohorts who may not access treatment services due to their age, stigma, or lack of knowledge regarding the risks and transmission of STIs. Gonorrhoea is the second most commonly tested-for STI in Thurrock, with 10,151 individuals being tested since 2017.

Recent surveillance published by The United Kingdom Health Security Agency (UKHSA) in June 2023[52] shows that gonorrhoea diagnoses increased last year and stated that people aged between 15-24 years remain the most likely to be diagnosed with sexually transmitted infections:

- Gonorrhoea diagnoses increased to 82,592 in 2022, an increase of 50.3% compared to 2021 (54,961) and 16.1% compared to 2019 (prior to the COVID-19 pandemic) – this is the highest number of diagnoses in any one year since records began in 1918.

Gonorrhoea is becoming increasingly resistant to antibiotics and at risk of becoming untreatable in the future, making it vital that people test early and diagnose the infection so that they can prevent passing it on.

Syphilis

Figure 64:

Key findings:

- **Syphilis is a bacterial infection easily treated with antibiotics.**
- **Syphilis rates are increasing nationally**
- **Men who have sex with men are disproportionately affected.**
- **There is an increased risk of HIV transmission for those infected with syphilis.**
- **Thurrock rates of infection are lower than England and CIPFA neighbours.**
- **The increase may be attributed to increased testing.**
- **scale of the increase in diagnoses strongly suggests that there is more transmission of STIs within the population**.

Recommendations:

- **Services should develop an Action Plan to increase awareness and uptake of screening among men who have sex with men, to reduce the burden of undiagnosed infection in Thurrock.**

Syphilis is a bacterial disease, which, if left untreated, can have very serious complications; however, it is easily treated with antibiotics. While anyone can contract syphilis, it disproportionately affects men who have sex with men (MSM), and high rates of syphilis are associated with risky behaviour and socioeconomic deprivation.[53] Those who are infected with syphilis are at increased risk of HIV transmission as well.[54]

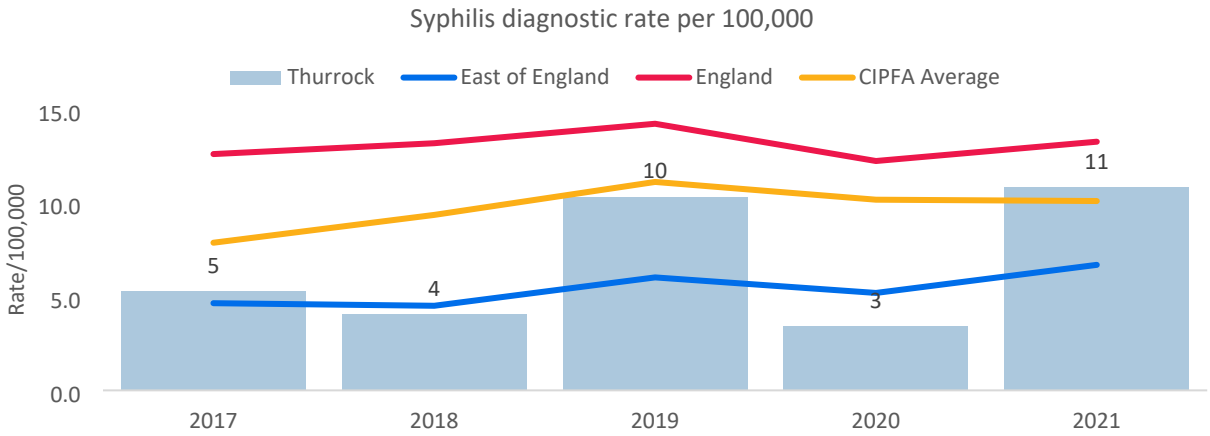
The charts below show the diagnosis rates of syphilis for people of all ages per 100,000 population (see figures 65 – 66).

The diagnosis rate for Syphilis in Thurrock has increased from 5 per 100,000 in 2017 to 11 per 100,000 in 2021, but rates do fluctuate year to year due to low absolute numbers. Thurrock

[52] UKHSA. 'Sexually transmitted infections and screening for chlamydia in England: 2022 report'. *Official Statistics*. 2023.
[53] Public Health England. "Tracking the syphilis epidemic in England: 2010 to 2019: an update on progress towards the Syphilis Action Plan prevention priorities". 2021.
[54] Public Health England. "Addressing the increase in syphilis in England: PHE Action Plan". 2019.

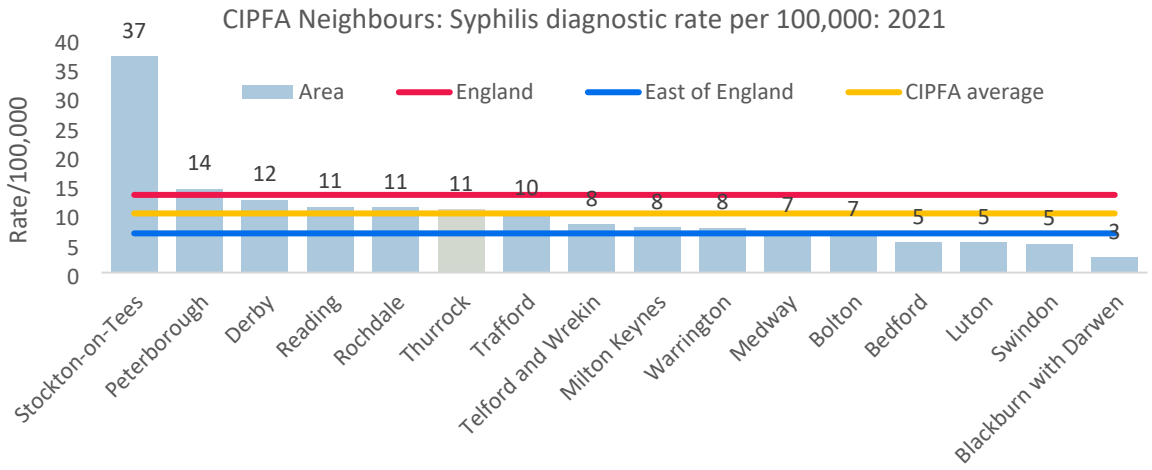
rates have consistently remained lower than England and CIPFA neighbours' rates over the reporting five-year period. Thurrock rates are similar to its CIPFA neighbours in 2021.

Figure 65: Syphilis diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 66: Syphilis diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Syphilis is caused by bacteria. It is an infection that spreads easily through anal, vaginal, and oral sex and can seriously damage your heart, brain, and nervous system. It is easy to treat and cure with antibiotics. The stages of syphilis can be found in appendix 7.

Having syphilis can also increase the likelihood of contracting or passing on HIV. Untreated syphilis will not go away on its own.

In 2019 Thurrock with 11 other local authorities across the East of England partnered with OHID (Public Health England at the time) and the Terence Higgins Trust to launch a media campaign aimed at raising awareness of the rise in syphilis. The campaign was primarily aimed at (but not restricted to) gay, bisexual and men who have sex with men (MSM) as this group represented 75% of the 301 syphilis cases diagnosed in 2017. It may account for the high positive test rate during this time.

UKHSA surveillance in June 2023[55] shows that syphilis diagnoses increased last year and stated that people aged between 15-24 years remain the most likely to be diagnosed with sexually transmitted infections:

- Infectious syphilis diagnoses increased to 8,692 in 2022, up 15.2% compared to 2021 (7,543) and 8.1% compared to 2019 – this is the largest annual number since 1948.

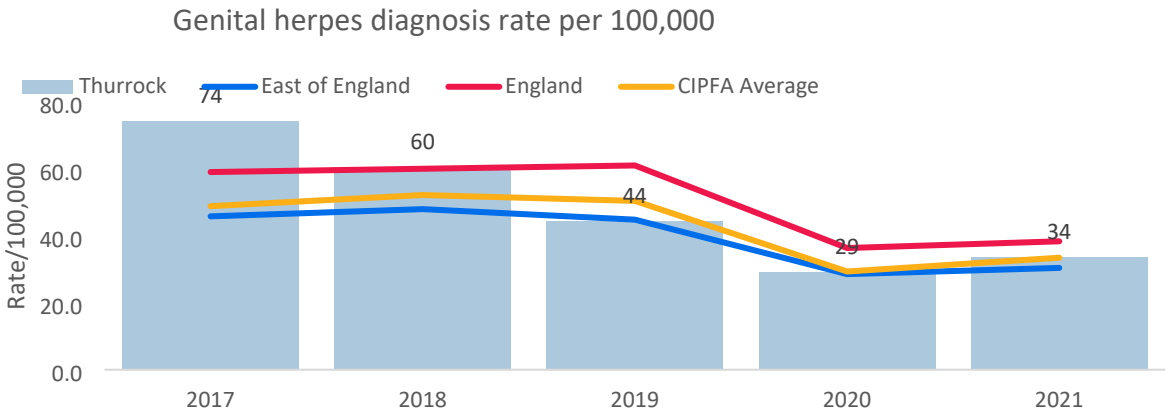
While the increase in gonorrhoea and syphilis diagnoses will in part be due to increases in testing, the scale of the increase in diagnoses strongly suggests that there is more transmission of STIs within the population.

Genital Herpes

Herpes is a long-term condition caused by the herpes simplex virus. There is no treatment for herpes, but medications can reduce the duration and frequency of herpes outbreaks.

The genital herpes diagnosis rate in Thurrock has decreased rapidly between 2017 (74 per 100,000) to 2020 (29 per 100,000). In 2021 the diagnosis rate was measured at 34 per 100,000. England and CIPFA neighbours followed a similar downward trend though between 2017 to 2019 the diagnosis rates remained consistent between 50-60 per 100,000. In 2021, Thurrock showed a lower diagnosis rate than CIPFA neighbours and England (see figures 67 -68).

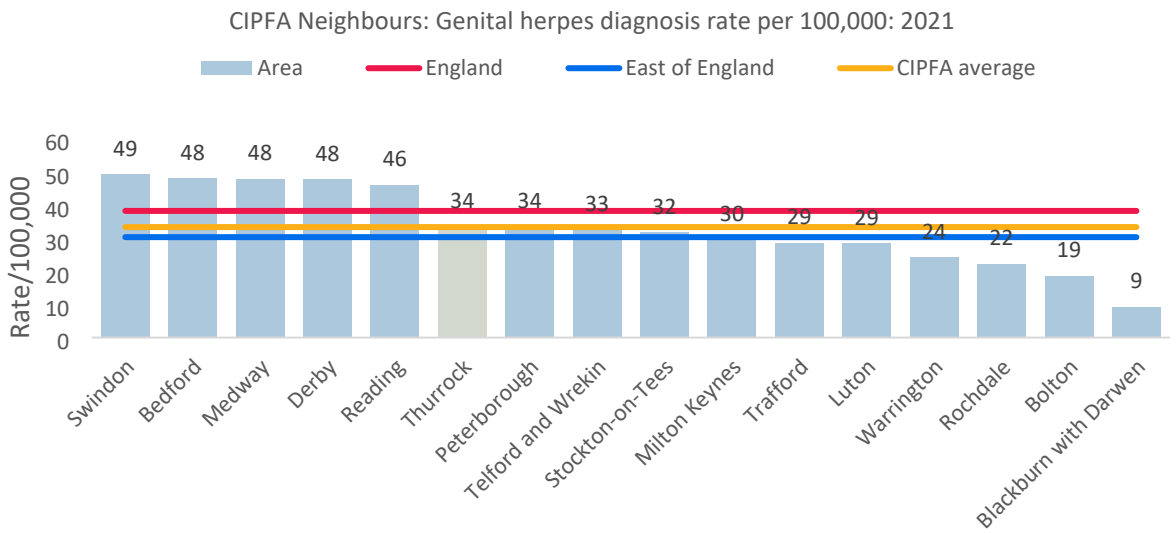
Figure 67: Genital herpes diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

[55] UKHSA. 'Sexually transmitted infections and screening for chlamydia in England: 2022 report'. *Official Statistics*. 2023.

Figure 68: Genital herpes diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Herpes remains in the body for life, lying dormant in nerves between outbreaks. It can reactivate at any time however subsequent active outbreaks are usually less severe. Anti-viral treatments can help prevent outbreaks and reduce symptoms. LARC and other forms of contraception do not offer protection from genital herpes however the use of condoms can reduce the risk of transmission. The ability to reduce the infection rate for the population through education regarding sexual good health is vital as prevention is key with genital herpes. Sexual Health Services need to be available at the right time and in the right location to encourage all potential service users to access testing and treatment.

Genital Warts and Human Papillomavirus (HPV) Vaccination

Figure 69:

Key Findings:

Thurrock has above the East of England and England vaccination rate for HPV for females aged 12-13 years.

The HPV vaccine has only been available to boys since 2019.

The HPV vaccine is also offered to men (up to and including 45 years old) who have sex with men, some trans men and trans women, sex workers and people living with HIV.

Recommendations:

Providers to work with schools and immunisation colleagues to raise awareness of the risk of not vaccinating for HPV for boys and girls.

Providers to ensure that those accessing the service under the age of 25 or those at risk including (but not limited to) MSM, transgender women (if not previously treated) are offered the HPV vaccine.

Engagement with the community to ensure people are aware of signs and symptoms of genital warts and how to access treatment.

Genital warts are causes by strains of the HPV virus and can be very uncomfortable but can be treated. HPV is the name for a group of viruses that includes more than 100 types. More than 40 types of HPV can be passed through sexual contact. The types that infect the genital area are called genital HPV. HPV itself has no symptoms, so many people may have HPV without knowing it. HPV usually goes away without causing any problems. In 9 in 10 cases, HPV is cleared within 2 years.
In England, Scotland and Wales, cervical screening (previously called a 'smear test') looks for high-risk HPV first. This is called HPV primary screening is a way of testing the sample of cells taken at your cervical screening (smear test) appointment. It tests for a virus called high-risk human papillomavirus (HPV) that can cause cervical cell changes to develop into cervical cancer.

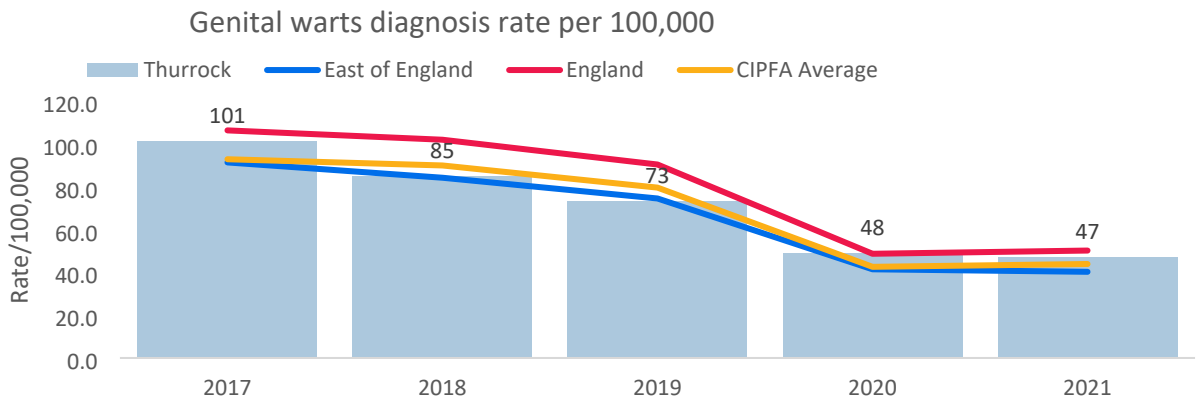
The HPV vaccine protects against four strains of HPV that can cause cancer and prevents genital warts. The HPV vaccine is offered to 12- to 13-year-old girls and boys in England protects against genital warts and some cancers (such as cervical cancer and anal cancer), however until 2019 only girls were offered the HPV vaccine.

The HPV vaccine is also offered to men (up to and including 45 years old) who have sex with men, some trans men and trans women, sex workers and people living with HIV.

The 2020/21 HPV vaccination coverage for 12–13-year-old females is 85.2%, which is higher than the East of England (71.8%) and England (76.7%), but still below the target of 90% coverage and the trend has been declining in recent years. In 2019/20, the England coverage of the HPV vaccine dropped very sharply, but Thurrock did not experience the same dramatic drop and coverage remained steady during the Covid-19 pandemic. Genital warts diagnosis in Thurrock has also decreased from 101 per 100,000 in 2017 to 47 per 100,000 in 2021. This downward trend was also illustrated across England and CIPFA neighbours. Any decrease in genital wart diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination[56] (see figures 70 and 71).

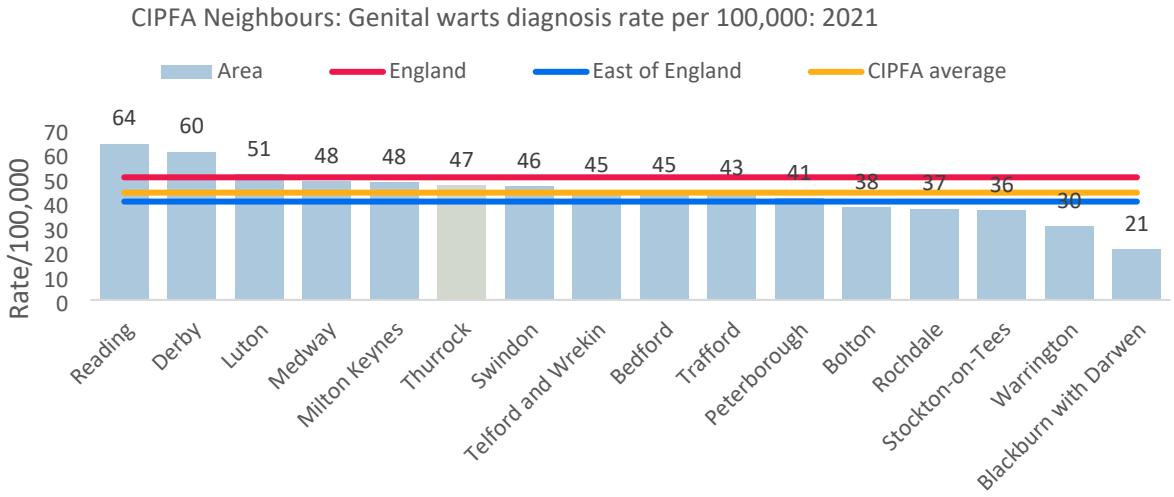
[56] UK Health Security Agency. "Spotlight on sexually transmitted infections in the East of England: 2021 data". 2023.

Figure 70: Genital warts diagnosis rate/100,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 71: Genital warts diagnosis rate/100,000 – Thurrock/ CIPFA neighbours - 2021



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

During sex, HPV is passed on when someone's skin touches another person's warts (which will not be visible if they are inside the rectum or vagina) This can be through genital contact, sharing sex toys, (very rarely) through oral sex. In extremely rare cases a mother can pass HPV to her baby during birth.

Using an external or internal condom reduces the risk of passing on warts – but only if the condom covers the skin where the wart virus is. Other forms of contraception do not offer any protection from transmission of genital warts.

Warts can be treated in a variety of ways including, freezing, topical creams and laser treatment, the earlier they are diagnosed, and the sooner treatment is started the more successful it will be. Genital warts are not always visible or painful and therefore may be passed on without knowing, the more sexual partners the greater the risk especially if practicing unprotected sex. Regular check-ups are important for early detections and treatment and to prevent the spread of genital warts.

Clinics need to be available in Thurrock to encourage regular check-ups in the same way that people may access a health check.

Human Immunodeficiency Virus (HIV) and Pre-Exposure Prophylaxis (PrEP)

Figure 72:

Key Points

- **Since 2018, fewer new sexual health service attendees in Thurrock accept an HIV test than is typical across East of England or among CIPFA neighbours. The gap is greater for women.**
- **Repeat testing in gay, bisexual, and other MSM compares well to England averages. In comparison to CIPFA neighbours, Thurrock is at the higher end of the range.**
- **Thurrock's HIV prevalence rate is similar to the England average at 2.4 per 1,000 between 15-59 years, but late diagnoses have increased since 2016-18 across both England and Thurrock.**

Recommendations

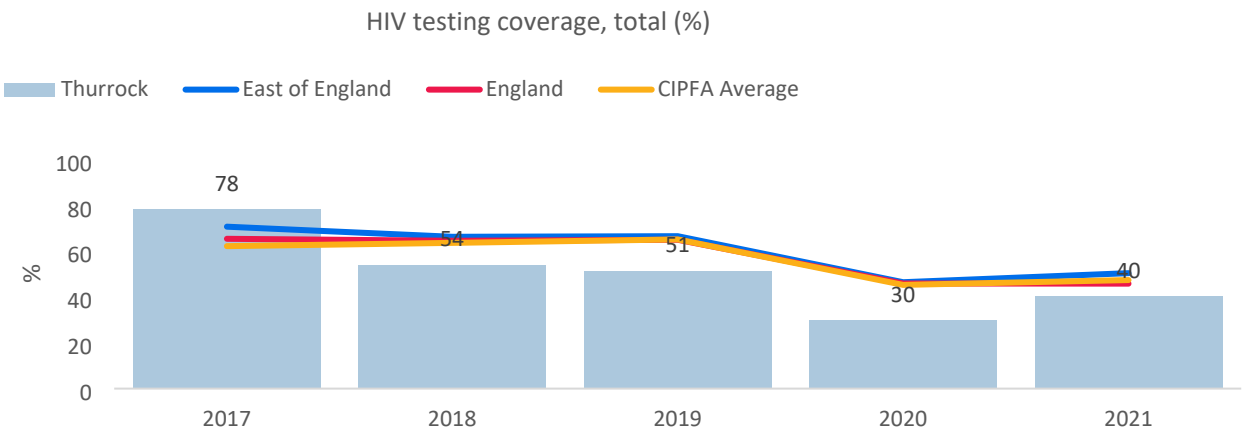
- **The Provider must continue to closely monitor HIV testing vs HIV late diagnosis rates in the Thurrock population and learn from HIV late diagnosis events through retrospective look backs to identify missed opportunities and a pro-active Human Learning System approach**.
- **Services should develop an action plan to:**
    - **Increase HIV testing among new attendees, especially women.**
    - **Reduce late presentation for HIV testing.**
    - **Increase uptake of PrEP among those who have been identified as being able to benefit.**
    - **Increase education to reduce the stigma of HIV.**

HIV screening

The following charts show the level of HIV testing coverage in Thurrock among all persons and among men and women specifically. Testing coverage is the proportion of new sexual health service attendees in whom a HIV test was accepted. Values are shown in quantiles of your chosen comparison group. All data is taken from PHE Fingertips.

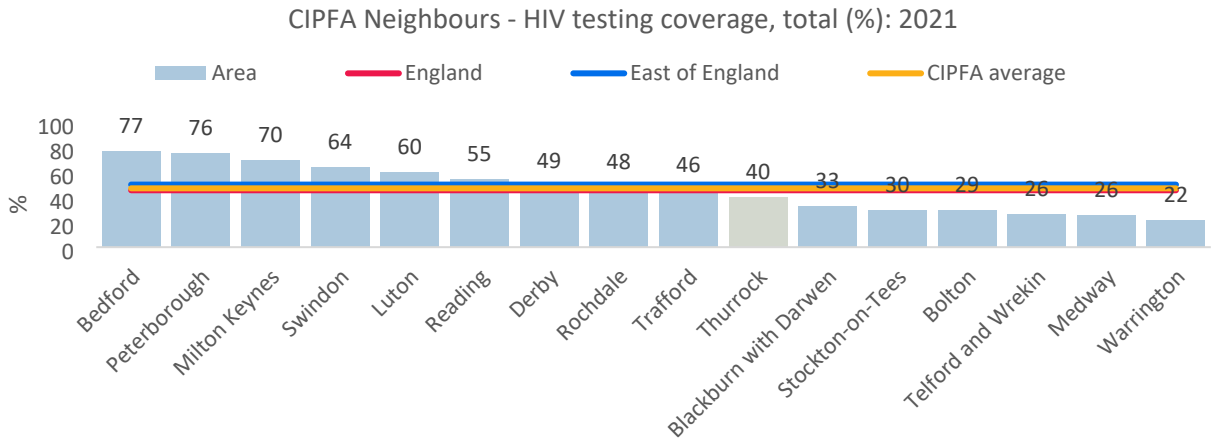
In Thurrock, 78% of new sexual health service attendees accepted an HIV test in 2017. This gradually decreased to an average of 53% over 2018 and 2019. This was followed by a further decrease to 30% in 2020. Year 2021 saw a 10% increase from 2020 to 40% coverage of HIV testing. Men's testing coverage was measured at 65% compared to women's coverage of 30%. Since 2018, Thurrock's HIV testing coverage has been lower than England and CIPFA neighbours, which are currently showing a coverage of 46% and 47% in 2021, respectively. England and CIPFA neighbours have also illustrated a gradual decline in testing coverage since 2017. This may be due to the syphilis awareness programme run in Thurrock, which was aimed at MSM, gay and bisexual residents who may also have been appropriate for HIV testing (see figures 73 – 79).

Figure 73: HIV Testing Coverage all persons – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 74: HIV Testing Coverage all persons – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

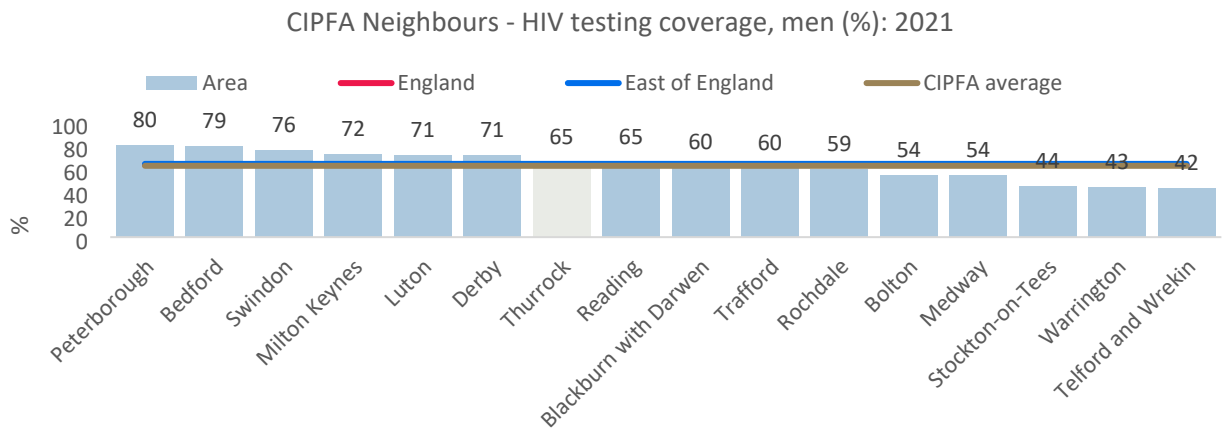
Men's testing coverage has followed a similar and closer trend to England and CIPFA neighbours' – a gradual decline since 2017, as has women's HIV testing coverage. The women's testing coverage was much lower than England and CIPFA neighbours' testing coverage. Men's testing coverage between 2017 to 2021 has reduced by 20%, but women's testing coverage has fallen by nearly 40% over the same period in Thurrock. The women's testing coverage in England and CIPFA reduced by an average of 12% between 2017 to 2021 which highlights that HIV testing amongst women in Thurrock has shown a more significant reduction than women across England and our comparable local authorities.

A study conducted by Columbia University Vagelos College of Physicians and Surgeons highlighted that women are underrepresented in HIV prevention and PrEP services.[57] They were less likely to receive adequate HIV screening compared to men. They were also less likely to receive any documentation of HIV prevention discussion. Considering this and that

[57] Yumori, Caitlin, et al. "Women are less likely to be tested for HIV or offered PrEP at time of STI diagnosis". *Sexually Transmitted Diseases*. (2021). 48(1) pg. 32-36.

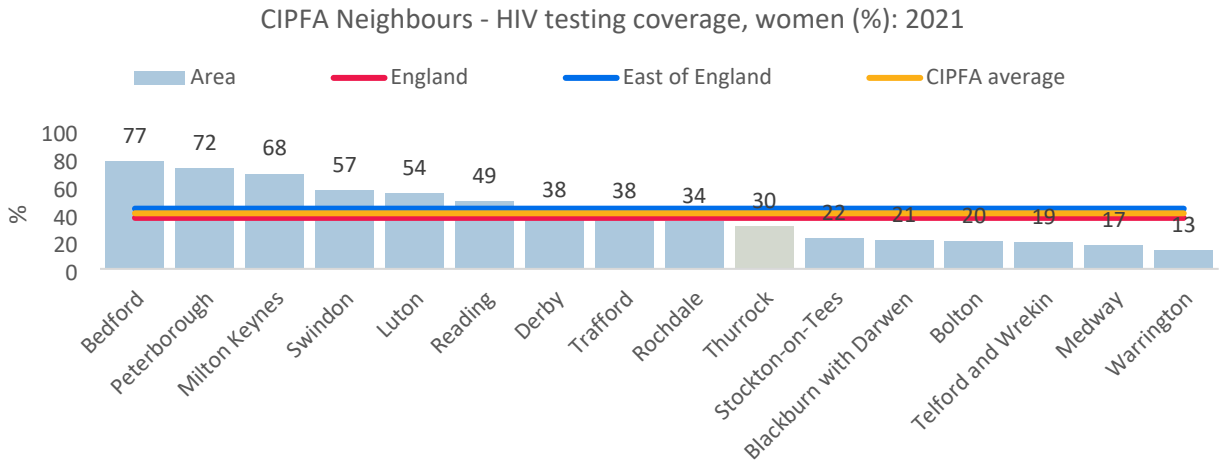
nearly one third of women live with HIV[58] in the UK, it is important for Thurrock to increase HIV testing amongst women.

Figure 75: HIV testing coverage men - Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 76: HIV testing coverage women - Thurrock/CIPFA neighbours 2021

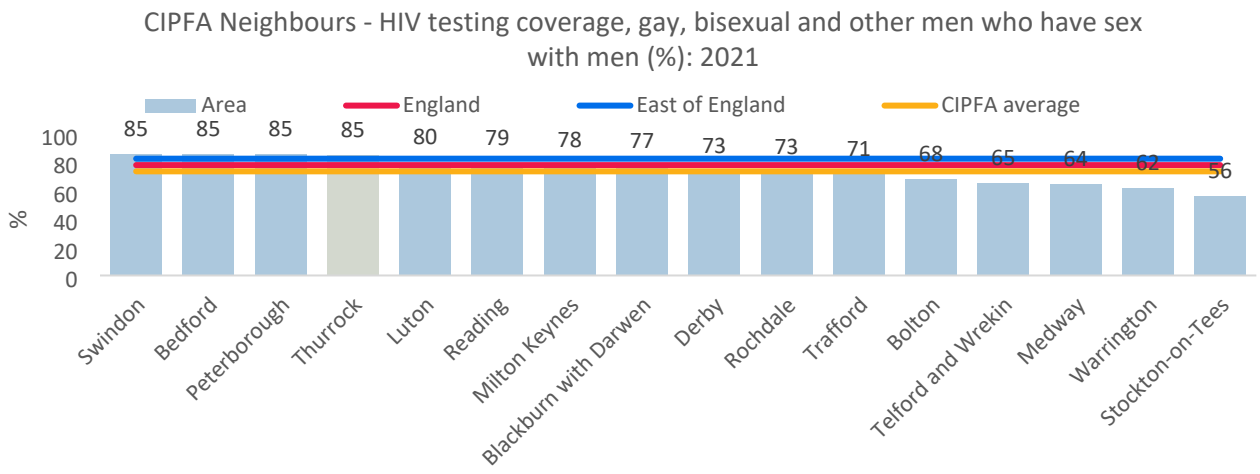


Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

There is a high percentage of HIV testing coverage in gay, bisexual, and other MSM across Thurrock as well as England and CIPFA neighbours – between 79 to 91% over the previous five years. The latest 2021 testing coverage is 85%. Thurrock features in the top 5 CIPFA neighbours with the highest testing coverage in 2021.

[58] Terrence Higgins Trust. "Women and HIV: Invisible No Longer". 2018.

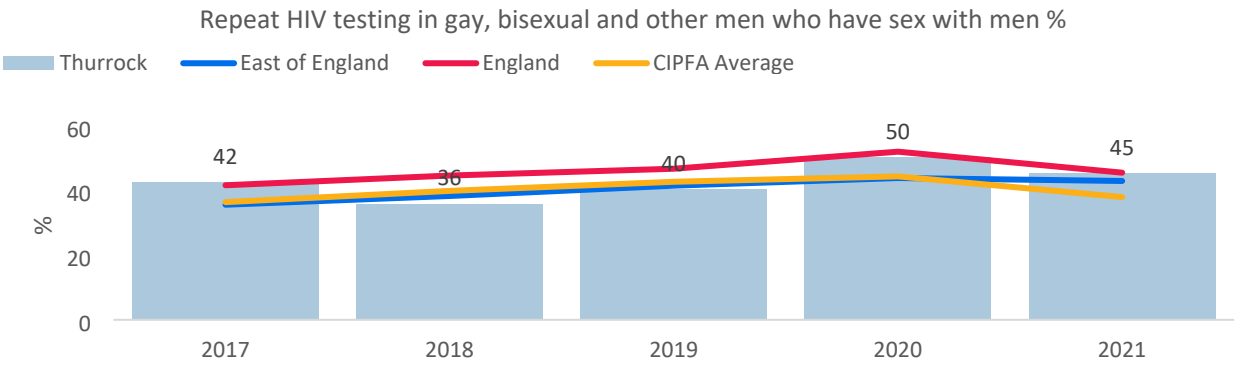
Figure 77: HIV Testing Coverage Gay, Bisexual and other Men who have sex with Men (MSM) – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

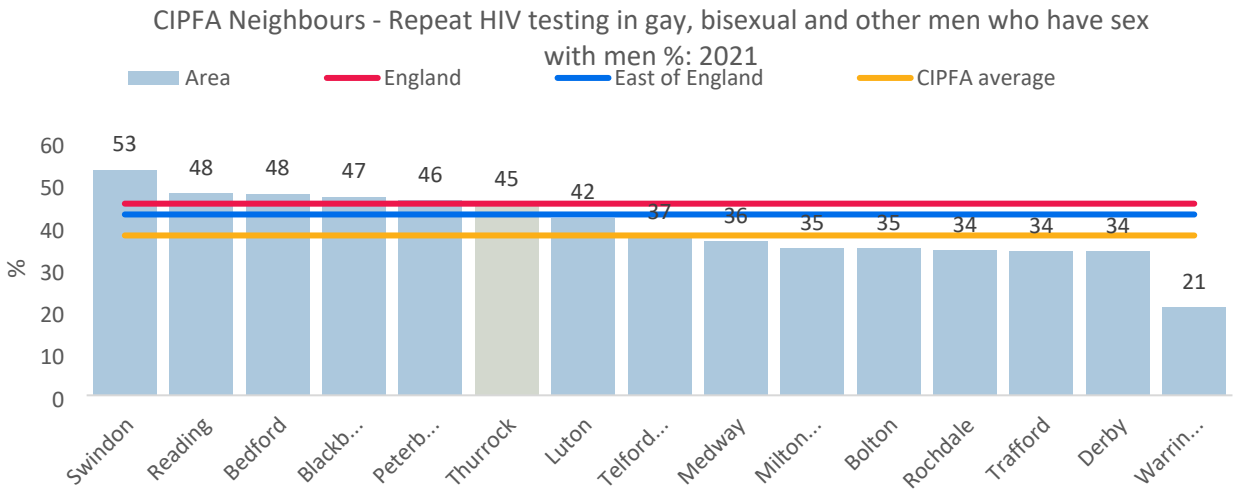
Repeat testing in gay, bisexual, and other MSM has ranged between 43% to 45% since 2017, which is similar to England and CIPFA neighbours. In comparison to CIPFA neighbours, Thurrock is on the higher end of repeat testing percentage. Testing should be in place for those at risk not based on ethnicity or gender.

Figure 78: Repeat HIV Testing Coverage Gay, Bisexual and other Men who have sex with Men (MSM) – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 79: Repeat HIV Testing Coverage Gay, Bisexual and other Men who have sex with Men (MSM) – Thurrock/CIPFA neighbours – 2021:

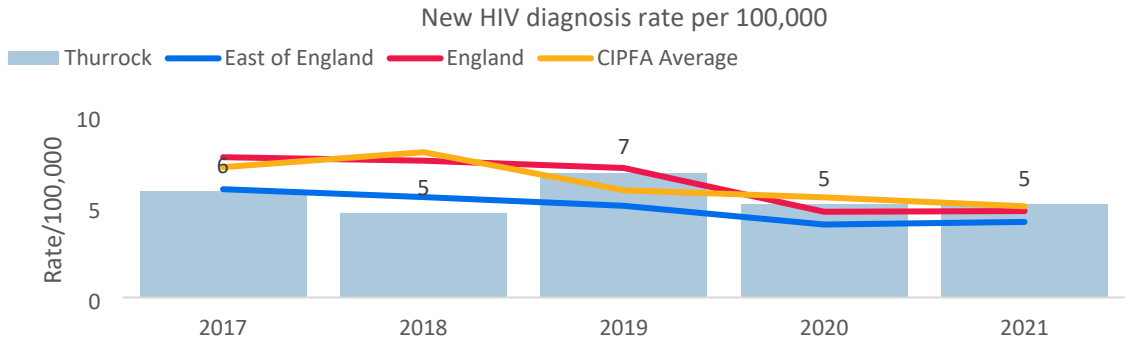


Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

HIV Diagnosis

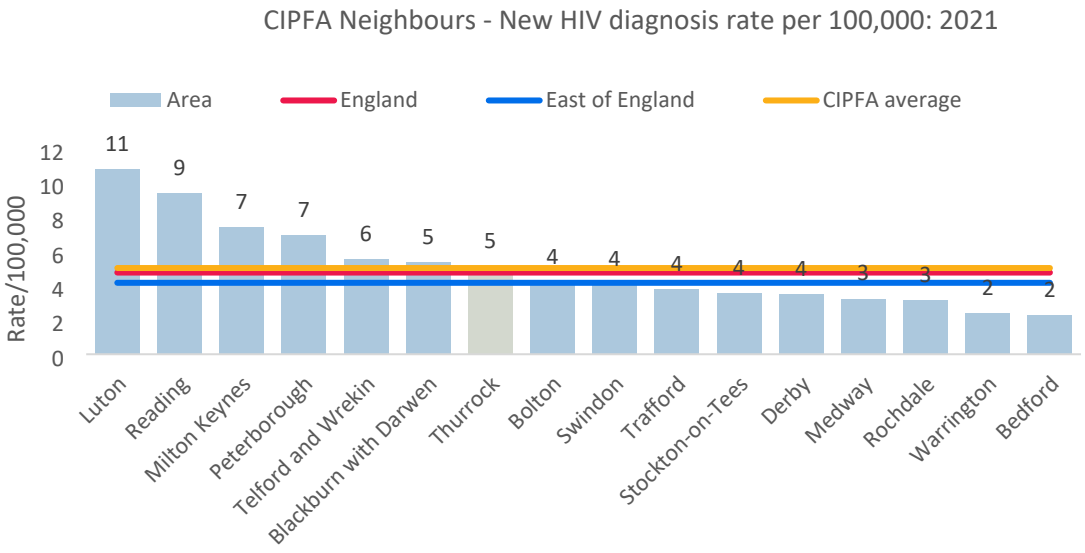
HIV diagnosis rates amongst 15+ year olds, who accepted a HIV test at a specialist sexual health service in Thurrock has remained steady between 2017 to 2021. This trend is also mirrored across England and CIPFA neighbours (see figures 80 – 85).

Figure 80: HIV Diagnosis rate/100,000 – Thurrock/England/EoE//CIPFA:



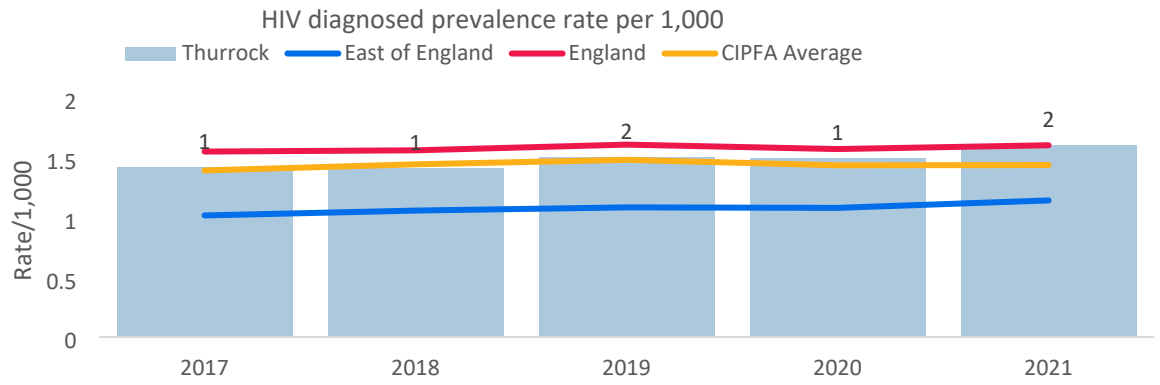
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 81: HIV Diagnosis rate/100,000 – Thurrock/CIPFA neighbours 2021:



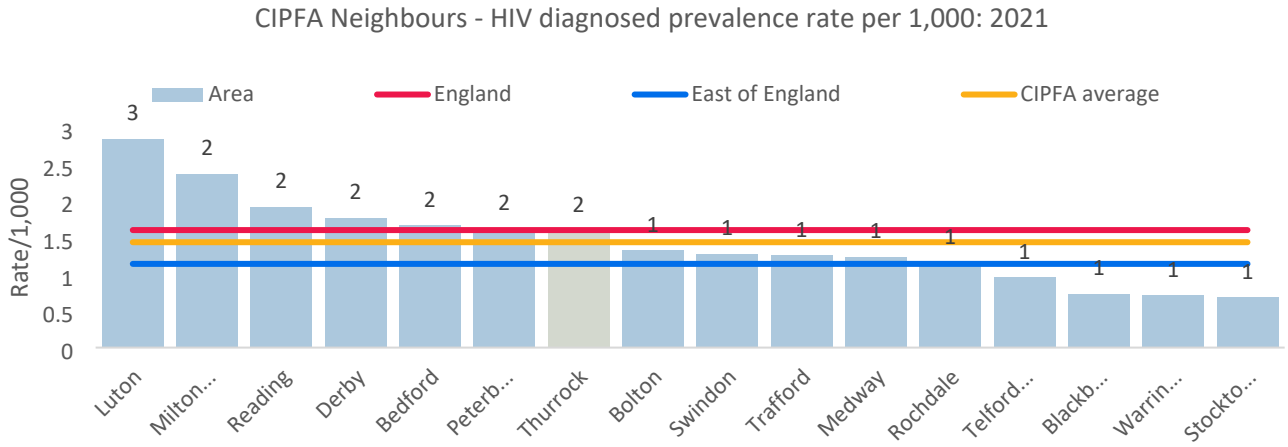
Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 82: HIV diagnosed prevalence rate/1,000 – Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

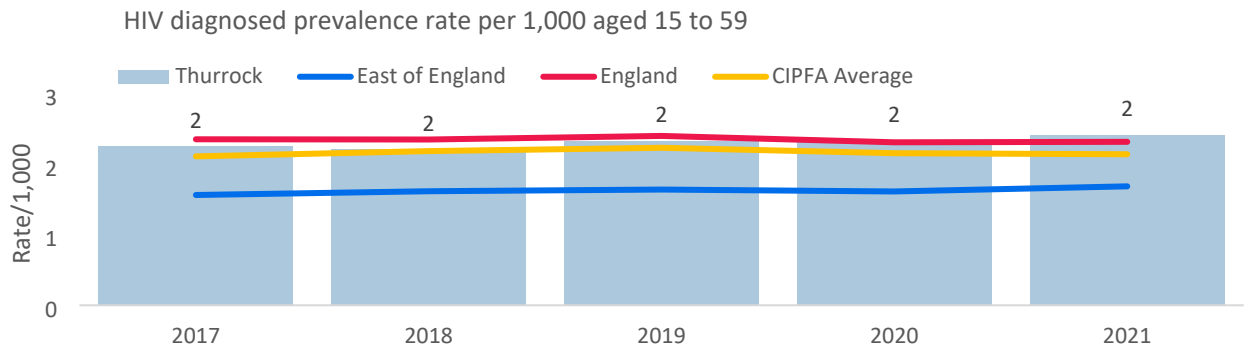
Figure 83: HIV diagnosed prevalence rate/1,000 – Thurrock/CIPFA neighbours 2021:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

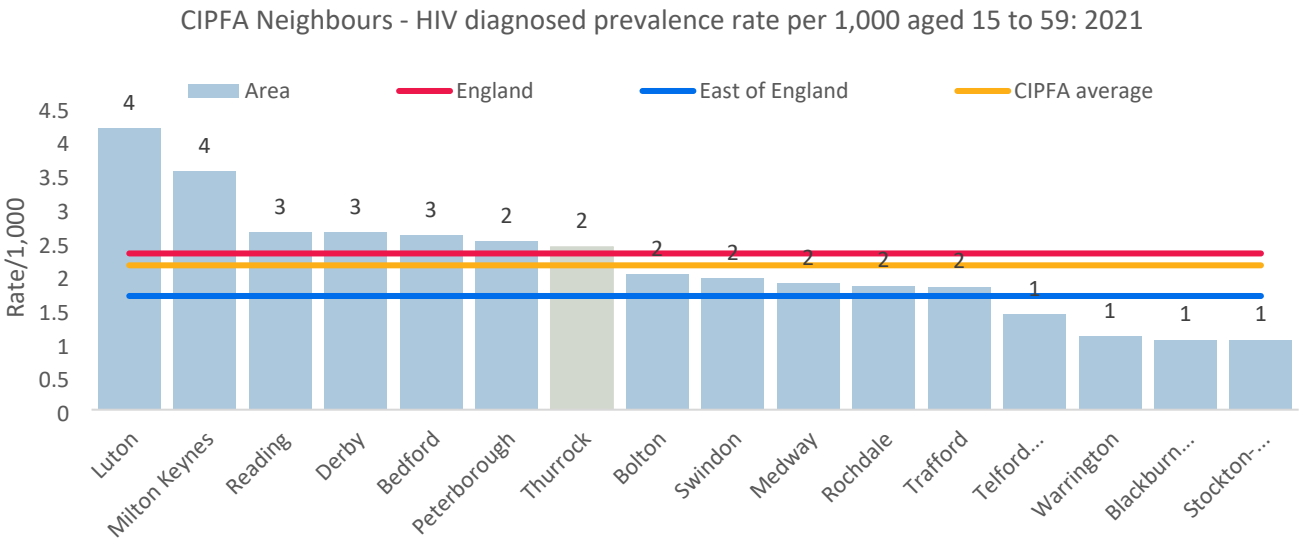
The prevalence rate amongst every 1000 people aged 15-59 years has remained consistent in Thurrock between 2017 to 2021 (fig 84). Currently Thurrock is showing its highest prevalence rate of 2.4 per 1,000 between 15-59 years diagnosed. Thurrock rates are currently higher than EoE and CIPFA neighbours' rates. The Provider and Commissioner need to understand why the prevalence is high and work to reduce this.

Figure 84: HIV diagnosed prevalence rate per 1,000 at ages 15 to 59 - Thurrock/England/EoE/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 85: HIV diagnosed prevalence rate per 1,000 at ages 15 to 59 - Thurrock/CIPFA neighbours 2021:

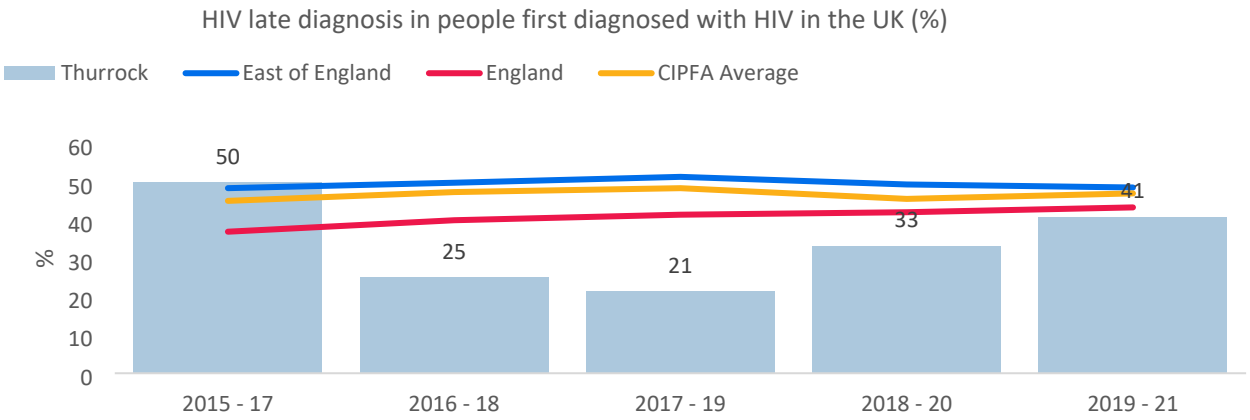


Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Late diagnosis is where a person tests positive for HIV after the virus has already started to damage their immune system. CD4 cell count is an indicator of immune function in service users living with HIV. CD4 cells are a type of white blood cell, called T cells, that move throughout your body to find and destroy bacteria, viruses, and other invading germs If the person is diagnosed when their CD4 count has dropped below 350 (or it reaches this point within three months of diagnosis) this is considered a late diagnosis.

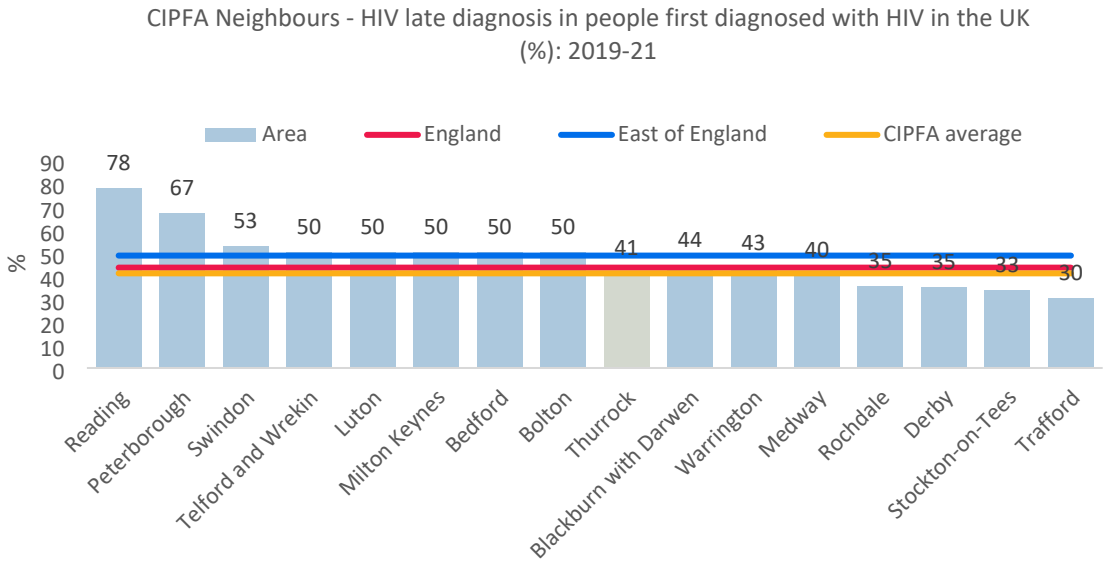
The rate of late diagnosis has also shown a slight increase in Thurrock between 2015-17 to 2019-21, During this period, England and CIPFA rates for late diagnosis has also gradually increased until 2020, followed by a drop in 2021. This could be due to several factors including (but not limited to) the Covid-19 pandemic. People may have been worried about coming forward towards the end of this time due to national restrictions of movement and concerns they may be penalised for doing so. People may have felt they had not been taking as many risks and therefore felt they did not require intervention and testing (See figures 86 and 87).

Figure 86: HIV late diagnosis aged 15 or above – Thurrock/England/CIPFA:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Figure 87: HIV late diagnosis aged 15 or above – Thurrock/CIPFA neighbours 2019-21:



Source: Office for Health Improvement and Disparities. Public health profiles. 2023 https://fingertips.phe.org.uk © Crown copyright 2023

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a 10-fold risk of death compared to those diagnosed

promptly. When diagnosed late the outcomes for those with HIV infection are significantly worse and the health costs are significantly worse.

PrEP (pre-exposure prophylaxis) is a drug that people at risk of HIV can take to prevent them contracting HIV in the event of exposure. PrEP can reduce your chance of getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

In 2021, 3.5% (143 out of 4,090) of HIV-negative people accessing specialist Sexual Health Services in Thurrock were defined as having PrEP need. Among these, 55.2% (79 out of 143) initiated or continued PrEP The 3.5% identified as having a PrEP need in Thurrock in 2021 is like its CIPFA neighbours at 4%, but lower than England's 7%.

When HIV diagnosis and treatment are delayed, HIV continues to replicate. This can negatively impact the infected individual's health and increase the risk of transmitting the virus to others therefore early detection and treatment is vital for the health of the individual and any partners they have in the future.

Hepatitis

Figure 88:

Key Points

- **There may be an under-identification of hepatitis C in Thurrock due to a lower-than-average proportion of injecting drug users being engaged in treatment compared to the England average. Referrals between sexual health and substance misuse services and joint working may increase uptake by those at risk.**

Recommendations

- **Services should consider how to:**
    - **Increase engagement of injecting drug users in drug treatment and ensure uptake of hepatitis C testing.**
    - **Strengthen joint working between sexual health and substance misuse services.**

Hepatitis B and C are viral infections that affect the liver and are passed on through blood, semen, and vaginal fluids. UKHSA (2021) estimated that 206,000 people were living with a chronic hepatitis B infection in England and 92,900 people were living with hepatitis C infection in the UK.[59] Rates of Hepatitis C decreased by approximately 37% between 2015 and 2020 with many of the positive cases associated with injecting drug users.[60] In response to this 100% of service users in structured drug and alcohol service treatment are offered testing for Hepatitis C. However, the Diagnostic Outcomes Monitoring Executive Summary (DOMES), 2022[61] estimated that 79.2% of opioid users and 69.2 of non-opioid users were not engaged in treatment in Thurrock compared to the England average of 53.7% and 47% respectively, therefore several high-risk residents may not be offered testing or treatment.

[59] UK Health Security Agency. *Don't forget to check for hep- testing and treatment for hepatitis*. 18 May 2023.
[60] UK Health Security Agency. "Hepatitis C in England 2022: Working to eliminate hepatitis C as a public health problem". Full data report to end of December 2020. 2022.
[61] NDTMS. "Diagnostic Outcomes Monitoring Executive Summary Report for Thurrock". Q4 2021/22.

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

Most cases of hepatitis B are in migrants who have acquired infection overseas in endemic countries prior to arrival in the UK. Communities at higher risk of getting hepatitis B in the UK include people who inject drugs, gay, bisexual and men who have sex with men who are having sex with multiple partners, sex workers and people detained in prisons or immigration detention centres (UKHSA, 2023). To date this year 4.2% of service users have identified as gay or bisexual (compared to 2% of Thurrock residents in the 2021 Census; however 7% did not answer this question so the true prevalence could be higher), however 35% have either declined to give the information or not stated their sexuality when entering treatment or testing, this does not however cover men who identify as heterosexual but who have sex with men. There are no prisons or immigration centres in Thurrock and only one commercial sex establishment however this does not mean that there are no risk factors as associated with these groups.

Many people who have hepatitis are unaware they have the infection, because the viruses can be symptomless, therefore pro-active testing for those at risk is vital to ensure appropriate treatment and reduction of onward transmission and should be done as part of a regular routine sexual health check-up.[62] Referrals between sexual health and substance misuse service and joint working may increase uptake of testing by those at risk, the needs assessment engagement has shown that this needs to be strengthened.

Although not common, hepatitis C can also be transmitted through sexual activity. Having a sexually transmitted infection, having sex with multiple partners, and engaging in anal sex appear to increase a person's risk for hepatitis C. MSM with multiple sex partners who are coinfected with HCV and HIV have been shown to transmit hepatitis C.[63]

Early diagnosis and treatment for hepatitis can prevent progression to serious liver disease, and for hepatitis C, treatment can clear the virus. Hepatitis B infections can be prevented by having the hepatitis B vaccination. If left untreated chronic or long-term hepatitis can cause liver failure, which stops the liver working properly, and increases the risk of liver cancer. 93.2% of children in Thurrock were fully vaccinated against Hepatitis B by the age of two, this is slightly above the National average.

Transmission of hepatitis A virus can occur from any sexual activity with an infected person and is not limited to faecal-oral contact. People who are sexually active are considered at risk for hepatitis A if they are MSM, live with or are having sex with an infected person, or inject drugs.

Vaccination is the most effective means of preventing hepatitis A transmission among people at risk for infection. Someone with hepatitis A is most infectious two weeks before jaundice

[62] Centers for Disease Control and Prevention. "CDC Recommendations for Hepatitis C Screening Among Adults". Morbidity and Mortality Weekly Reports. April 10th, 2020.
[63] Centers for Disease Control and Prevention. "Sexual Transmission and Viral Hepatitis". September 21st, 2020.

appears. Although not as effective as vaccination risk may be reduced by avoiding sex that involves contact with faeces and using a latex barrier for genital, digital or oral sexual contact.[64]

Hepatitis D is a liver infection caused by the hepatitis D virus. Hepatitis D is not as common as A, B or C and only occurs in people who are also infected with the hepatitis B virus as it needs the hepatitis B virus to survive. Hepatitis D is spread when blood or other body fluids from a person infected with the virus enters the body of someone who is not infected. Hepatitis D can be an acute, short-term infection or become a long-term, chronic infection. Hepatitis D can cause severe symptoms and serious illness that can lead to life-long liver damage and even death. There is no vaccine to prevent hepatitis D however, prevention of hepatitis B with hepatitis B vaccine will help protect against it.[65]

Vaccination for hepatitis B and A and testing and treatments for hepatitis B and C are free and can be accessed via GP, sexual health services or home sampling. Completing a course of vaccination offers long term protection against hepatitis B infections. We do not have data for those attending pharmacies for testing however hepatitis B vaccine is given as part of the 6 in 1 vaccination given to children as routine, data is collected at 1 year and 2 years of age with coverage of 91.7% and 93.2% respectively (Fingertips, 2023). There is no vaccination for hepatitis C, but it can be cured with effective treatments. However, it is important to be aware that completing treatment for Hep C will not prevent reinfection.

In the current contract year, 2.77% of service users attending the sexual health clinic were tested for hepatitis A, B and C, and 0% were positive. Whilst the figure is low only those at risk are currently tested for hepatitis and due to the routine vaccination of children there will be a smaller percentage of the population thought to be at risk, however consideration should be given to testing all those at higher risk as routine.

Emerging Threats – Shigella, Lymphogranuloma and Mpox

Figure 89:

Key Findings:

There are three recognised emerging threats: Shigella, Lymphogranuloma and Mpox.
Men who have sex with men, gay or bisexual are most at risk.
Whilst all three can be treated shigella sonnei is becoming resistant to treatment.
There is a vaccination for mpox.

Recommendations:

- **The Provider and commissioner must work closely with UKHSA and OHID colleagues to monitor emerging threats in Thurrock and Nationally**
- **Services should develop an action plan to:**
    - **Increase awareness of emerging threats to target audiences.**
    - **Increase communication of emerging threats throughout Thurrock.**
    - **Increase education regarding emerging threats.**

[64] Terrence Higgins Trust. *Hepatitis A*. 9 December 2021.
[65] NHS Online. *Hepatitis*. 23 August 2023.

Shigella Spp.

Shigella spp. are bacterial enteric pathogens transmitted through faecal-oral contact, which can cause dysentery. Whilst diagnoses of shigellosis are often associated with exposure to contaminated food or water during travel to endemic countries, shigellosis is increasingly acquired domestically in England, mainly among men who have sex with men via direct oral-anal contact, oral sex after anal sex or play, including fingering and use of sex toys.

The previous Shigella Health Protection Report[66] described a reduction in the number of reported Shigella spp. diagnoses overall in 2020, likely due to the impact of coronavirus (COVID-19) related control measures, reduced international travel, limited domestic travel and social distancing.

Whilst the number of sexually transmitted Shigella spp. diagnoses reported in England by quarter 2 (Q2) 2022[67] had not yet reached pre-COVID-19 pandemic levels, reported, diagnoses among presumptive MSM increased from 67 to 152 between Q3 2021 and Q2 2022 indicating transmission has increased following the lifting of restrictions. London continued to account for most Shigella spp. diagnoses reported in the 12-month period between Q3 2021 and Q2 2022.

From Q3 2021 onwards, there was a substantial increase in Shigella sonnei diagnoses from the very low levels reported during the COVID-19 lockdown period, with 56 diagnoses reported in Q2 2022, in addition to increased reporting of Shigella flexneri diagnoses – this increase was driven by the return in late 2021 of a Shigella sonnei outbreak strain which had since become extensively drug-resistant.

Lymphogranuloma

Lymphogranuloma Venereum (LGV) is a type of chlamydia bacteria that attacks the lymph nodes. LGV is very rarely seen in heterosexual men and women in the UK, but cases are being seen among gay and bisexual men. Antibiotics cure LGV with no lasting effects if the infection is treated early enough however, left untreated, LGV can cause lasting damage to the rectum that may require surgery.

There have also been increases nationally in less frequently reported STIs such as lymphogranuloma venereum (LGV) (82.8%, from 570 in 2021 to 1,042 in 2022). There is evidence of a rebound in sexual mixing among GBMSM between 2020 and 2021, and this is likely to have contributed to the rise in STIs within this population in 2022.[68]

Mpox

Mpox (or monkeypox) is an illness caused by the monkeypox virus. It is a viral infection which can spread between people and occasionally from the environment to people via things and surfaces that have been touched by a person with mpox.

---

[66] UKHSA Research and Analysis: Sexually Transmitted Shigella spp. In England: Data update to quarter 2 2022. Updated 28 September 2022

[67] UK Health Security Agency. "Sexually transmitted Shigella spp. in England: data up to quarter 2, 2022". 2022.

[68] UK Health Security Agency. "Sexually transmitted infections and screening for chlamydia in England: 2022 report". 2023.

Mpox is spread from person-to-person through close contact with someone who is infected with the monkeypox virus. Close contact includes being face-to-face, skin-to-skin, mouth-to-mouth, or mouth-to-skin contact. During the global outbreak that began in 2022, the virus mostly spread through sexual contact. Detection of cases of mpox infection, acquired within the UK, were confirmed in England from 6 May 2022. The outbreak has mainly been in gay, bisexual, and other men who have sex with men without documented history of travel to endemic countries.[69]

UKHSA modelling, found evidence of transmission of mpox before symptoms are identified (pre-symptomatic transmission). Researchers estimated that more than half (53%) of transmission occurred up to four days before symptoms were developed or were recognised, with an average incubation period of between 7-8 days.

Whilst the symptoms are generally mild, for those who are immunosuppressed, an mpox infection can be associated with more severe symptoms. There is a vaccine for mpox, and those eligible for the vaccine include gay, bisexual, or other men who have sex with men who have multiple sexual partners, participate in group sex or attend sex on premises venues. Staff who work in these premises are also eligible.[70]

7. Primary Prevention

Relationship and Sex Education (RSE)

The Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019, made under sections 34 and 35 of the Children and Social Work Act 2017, make Relationships Education compulsory for all pupils receiving primary education and Relationships and Sex Education (RSE) compulsory for all pupils receiving secondary education. The regulations also make Health Education compulsory in all schools except independent schools. Personal, Social, Health and Economic Education (PSHE) continues to be compulsory in independent schools.

Schools are free to determine how to deliver the RSE agenda, in the context of a broad and balanced curriculum. Effective teaching in these subjects will ensure that core knowledge is broken down into units of manageable size and communicated clearly to pupils, in a carefully sequenced way, within a planned programme or lessons. Teaching will include sufficient well-chosen opportunities and contexts for pupils to embed new knowledge so that it can be used confidently in real life situations.[71]

There is good international evidence[72] that relationships and sex education, particularly when linked to contraceptive services, can have a positive impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates.

---

[69] Sinka, Katy. "One year on: 7 things we've learnt about mpox". *UHKSA*. 2023.
[70] UK Health Security Agency. "Mpox (monkeypox) outbreak: epidemiological overview". 2 March 2023.
[71] Department for Education. "Relationships Education, Relationships and Sex Education (RSE) and Health Education Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers". 2019.
[72] Wellings, K, et al. "The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)". *Lancet* (2013) 382: 1807–1816.

This measure lays the foundations for universal prevention - equipping all children and young people to make safe, well-informed decisions about relationships, pregnancy, and sexual health. It also signals a fantastic opportunity for councils to work closely with schools and parents in their local areas to ensure high quality RSE gives children and young people age-appropriate knowledge and information on contraception, safe sex, and healthy relationships.

A comprehensive RSE delivery package could help to reduce the stigma associated with attending sexual health services and could through education, access and training reduce teenage and unwanted pregnancy. The Provider needs to work collaboratively with school nurses and stakeholders to ensure that high quality RSE is delivered to meet the needs of the population of Thurrock.

Stakeholder attendance at professional training to deliver RSE is low in Thurrock and feedback from Terrance Higgins Trust (and previously Brook) have found increasing attendance to be difficult, however stakeholders state they are unsure of how to access services. Increased collaboration and communication may close this gap and Providers should attend relevant meetings with Headteachers to ensure the service is visible.

Condom Distribution

Condoms are the only contraception that can prevent the transmission of STIs and reduce the number of unwanted pregnancies. Easily accessible condoms to young people and at-risk adults are an important intervention to protect health and reduce unwanted pregnancies. Condom distribution within educational settings and locations that target young people can provide a good introduction to wider sexual and reproductive health services.

Condom distribution schemes (CDS) need to be targeted so that they are available for local populations who are at increased risk of contracting a STI. For young people, multi-component schemes including condoms, lubricant, and information and/or training are recommended. Condom provision should include reliable information about sexual and reproductive health and clear pathways into services should be available.[73]

Provide have an eC-card app which can be accessed throughout Essex (excluding Southend). The app is available to everyone aged 16-24 years of age and enables young people to discretely collect free condoms and lubricant from a convenient pickup point. To access the service people must download the application, watch 3 short videos, and answer a simple questionnaire they are then given a unique QR code which they scan on arrival at their pickup point. People under 16 or that require additional support are signposted to the Thurrock Sexual Health help centre for advice and either face to face or virtual support.

Future provision of sexual health services should include a comprehensive offer providing condoms, lubrication, information, and advice throughout Thurrock.

8. Engagement

Solutions for Public Health (SPH) was commissioned to provide the qualitative data about the level of need and type of services required to support people requiring sexual health services.

[73] NICE. “Sexually transmitted infections: condom distribution schemes”. *NICE Guideline [NG68]*. 2017.

The report also draws on qualitative information gathered from stakeholders about where local services are working well, and where there are barriers to support that some people experience. In addition, how service providers and agencies work together, and the gaps in provision for some population cohorts, particularly those with co-occurring conditions or complex needs are explored.

The key objectives for the engagement were agreed with Thurrock Council following contract award:

1. To present qualitative data concerning service needs and provision, to inform the recommissioning of local sexual health services. The focus is on organisations in contact with people with sexual health problems, and how services support the needs of the residents in Thurrock.
2. To identify gaps in the local service provision, including consideration of those who do not engage with services, and seeks to identify any barriers and potential solutions to lack of engagement.
3. To provide a literature review relevant to the subject matter and to include National and Local policy and structure.
4. To seek to identify any areas of quality improvement that might lend themselves to a Human Learning Systems (HLS) co-design approach.

The full document can be found in Appendix 1.

9. Future Service Provision

This Health Needs Assessment will inform future commissioning and strategy for Sexual Health in Thurrock. The below recommendations will be useful to develop a strategic ambition for sexual health in Thurrock, this should include aspirations for services and system wide approaches to prevention, early identification, and treatment of sexual health issues. These strategic ambitions will be realised over the long term, however there are some opportunities in the short to medium term to improve services and partnerships to deliver improvements in population sexual health.

10. Key Findings and Recommendations

Access to service and Service Model

Figure 90:

Topic	Findings	Relevant Section	Recommendation
Access to services	• The site of services in Orsett Hospital is based at the back of an old building which isn't easily accessible. • Service is appointment only. • Spoke clinics are not open. • There is limited inclusivity. • There is limited RSE provision from specialist services. • There is limited promotion of the service. • No community sexual health service for young people. • Opening hours are restrictive.	Pages 18 / 22/ 39 / 48	• The Provider and commissioner to review the use of drop in or same day clinic appointments. • The Provider to promote hub clinics. • RSE to be a focus of commissioning. • The Provider and commissioner to attend meetings including Head teacher and CEO, Mace, MASH, MARIC where required to ensure sexual health access is highlighted. • The Provider to develop a communication/promotion plan. • The Provider to move away from one central clinic. • The Provider to promote inclusivity and to provide specialist clinics where necessary. • The Provider and commissioner to review the clinic use of family hubs and women's hubs where possible. • The Provider to strengthen links with child exploitation team. • The Provider to promote the use of the hub clinic in Thurrock. • The Provider to ensure signposting to the clinic is in the main hospital. • The Provider to review the use of the buzzer access system to the clinic. • The Provider to review the opening hours with feedback from service users.
Service model	• Limited joint working with pharmacies and GPs. • Access within setting is restricted. • Service is difficult to engage.	Pages 13 / 115	• The Provider to adopt a whole systems approach to look at how commissioners and sexual health services link in with GPs, community pharmacy, probation, people in secure settings, drug, and alcohol services. • The Provider to adopt a whole system approach to those who support people who have experienced sexual violence and domestic abuse such as the refuge and SERIC. • The Provider should review the access to the service on arrival at the hospital.

Page 134	• The service doesn't allow chaperones supporting vulnerable people in the service. • The sexual health service no longer in reach into services where young people with LD lived to teach the support workers how to support them and talk about their bodies. • The service is clinical without a focus on inclusivity. • Cervical screening is not offered.		• The Commissioner and Provider for sexual health services must be more visible to key stakeholders. • The Commissioner and Providers must attend meetings relevant to their work, included but not limited to Brighter Futures, Multi Agency Child exploitation (MACE), and CEO and head teacher's forum. • The Commissioner and Providers should ensure they are well represented throughout Thurrock to increase their profile in the community, ensuring that stakeholders are aware of how to refer into services. • The Commissioner and providers need to work together to ensure that the HLS model is embedded and work closely with other service providers and the community to build an integrated system in Thurrock. • The Provider to look at alternative sites such as Grindr, Scruff or Taimi to enhance profile. • The Commissioner and Provider to ensure LD and chaperones entering the service of the expectation and rationale for seeing the service user alone for initial contact. • The Commissioner and Provider to ensure that dual trained clinician appointments are advertised throughout Thurrock. • The Commissioner to review process for cervical screening (currently GP).
Joint Working	• Lack of integrated working within Thurrock. • Lack of integrated working with neighbouring services. • Lack of awareness of sexual health services in Thurrock. • Lack of visibility in specialist meetings (including MACE, headteachers forum and Primary Care).	Pages 102 / 103 / 115	• The Provider to improve joint working of services across Essex and neighbours to ensure equity of services and ease of access for service users. • Thurrock LGBTQQIP2SA residents will go to Chelmsford Pride as there isn't one in Thurrock, so providers need to be visible at this and other related events. • The Provider to develop joint working between sexual health services and the Child exploitation and missing team. • The Commissioner and Provider to develop more integrated system approaches to governance and the planning of sexual health services. • The Provider to improve networking and engagement with other services such as the drug and alcohol team. • The Commissioner and Provider to improve partnerships from both a strategic and operational perspective.

			• The development of a Sexual Health Strategy for Thurrock could be the catalyst to improve partnership work.
Training and Education	• RSE is recognised as an important first step into engagement with sexual health services and good relationship and sexual health care. • Schools are not aware of current offer. • The current contract focuses on a small element of training the trainers regarding sexual health. • There are no 1-1 sessions available in schools. • Staff don't appear to be trauma informed.	Pages 6 / 18 / 19 / 22 / 23 / 25 / 33 / 39 / 41 / 42 / 46 / 47 / 48 / 50 / 51 / 56 / 58 / 59 / 60 / 64 / 65 / 84 / 91 / 94 / 104 / 106 / 107 / 115 / 122 / 125 / 126 / 127	• Sexual Health staff should receive training to support development of communication skills with different groups e.g., to become trauma informed, appropriately support people attending psychosexual and sexual assault, and communication with people with a learning disability. • The Provider must inform schools about service changes and the benefits of taking up staff training by the provider to ensure all schools are aware and become engaged. • The Commissioner and Provider should attend CEO and headteacher forums to ensure education colleagues are aware of training offered and improve take up of offer. • The Commissioner to review the RSE element of the sexual health contract. • The Provider to promote access to services for students referred by the school and related services. • The Provider to deliver specialist education and training to deliver RSE to ensure high quality provision.

Improving Diagnosis of New STIs

Figure 91:

Topic	Key Findings	Relevant Section	Recommendations
STI Testing & Diagnosis	• The STI diagnosis rate has declined in Thurrock since 2017, and it is unclear how vulnerable groups are affected by the decline in diagnoses. • In the most recent data (2021), the diagnosis rate in Thurrock is lower than CIPFA neighbours but similar to East of England; the testing rate is lower than both CIPFA neighbours and East of England; with a corresponding positivity rate that is similar to CIPFA but higher than East of England. • The CIPFA neighbours with the highest diagnosis rates also have high testing rates. • Qualitative feedback from stakeholders and residents suggested that a high proportion of Thurrock residents were not aware of Thurrock sexual health services, and that other professionals were not clear how to refer into the service.	Pages 6 / 19 / 20 / 29 / 32 / 49 / 50 / 76 / 77-80	• The Provider must continue to review and evaluate data recording to improve recording and reporting of protected characteristics to gain a better understanding of potential inequities in Sexual Health outcomes across Thurrock including older age STIs. • The Provider should develop an Action Plan to increase uptake of STI testing to reduce the burden of undiagnosed infection in Thurrock, including: ○ Increasing awareness of the need for regular STI testing among vulnerable groups and those at higher risk ○ Increasing referrals from other services. • The Provider, working in collaboration with OHID, UKHSA and the commissioner must monitor and respond to new and emerging threats such as Mgen and drug resistant infections.
Chlamydia	• Chlamydia detection rates in Thurrock are some of the lowest among the CIPFA neighbours' group, with screening rates being only 10% of the 15–24-year-old population in 2021. The areas with the highest detection rates also have the highest screening rates.	Pages 6 / 18 / 20 / 32 / 34 / 35 / 37 / 40 / 52 / 55 / 57 / 78-80 / 82 / 84 / 118-119	The Provider should develop an Action Plan to increase awareness and uptake of chlamydia screening among male and female 15–24-year-olds, to reduce the burden of undiagnosed infection in Thurrock.

HIV	• Since 2018, fewer new sexual health service attendees in Thurrock accept an HIV test than is typical across East of England or among CIPFA neighbours. The gap is greater for women. • Repeat testing in gay, bisexual, and other MSM compares well to England averages. In comparison to CIPFA neighbours, Thurrock is at the higher end of the range. • Thurrock's HIV prevalence rate is similar to the England average at 2.4 per 1,000 between 15-59 years, but late diagnoses have increased since 2026-28 across both England and Thurrock.	Pages 6 / 13 / 17-20 / 22 / 23 / 38 / 40 / 50 / 52 / 55 / 56 / 60 / 84 / 88 / 89 / 91 / 92 / 94-103 / 116-119	• The Provider must continue to closely monitor HIV testing vs HIV late diagnosis rates in Thurrock population and learn from HIV late diagnosis events through retrospective look backs to identify missed opportunities and a pro-active Human Learning System approach. • The Provider should develop an action plan to: ○ Increase HIV testing among new attendees, especially women. ○ Reduce late presentation for HIV testing. ○ Increase uptake of PrEP among those who have been identified as being able to benefit.
Hepatitis	There may be an under-identification of hepatitis C in Thurrock due to a lower-than-average proportion of injecting drug users being engaged in treatment. Referrals between sexual health and substance misuse services and joint working may increase uptake by those at risk.	Pages 41 / 55 / 102-104 / 116-118	• The Provider should consider how to: • Increase engagement of injecting drug users in drug treatment and ensure uptake of hepatitis C testing. • Strengthen joint working between sexual health and substance misuse services.

Contraception, Conception, and Abortion

Figure 92

Topic	Key Findings	Relevant Section	Recommendations
Conception and Abortion	• Under 18 conception rates have decreased since 2017 in line with national and regional trends. • Whilst the abortion rate in Thurrock has increased since 2017 and in 2021 was 22 per 1000 females; the percentage of U18 conceptions leading to abortion has remained stable, albeit higher than national, regional and CIPFA comparators. • The rate of repeat abortions in Thurrock has increased since 2017.	Pages 13 / 14 / 17 / 20 / 21 / 31 / 32 / 34 / 60-64 / 74 / 116 / 120 / 124 / 125	• The Provider must review the accessibility of contraception services across Thurrock and surrounding geographies to ensure that good quality contraception services are accessible at a time and place that is convenient for the service user. • The Provider must ensure consistent education and advice on the preferred method of contraception is available to service users through a range of formats, utilising a range of existing services as appropriate such as primary care and school nursing. • Thurrock PH team to conduct further analysis into why the rate of repeat abortions is increasing and the groups most at risk with the aim to identify appropriate preventative actions. • The Commissioner, Provider, and associated services to develop an action plan for focusing on groups most at risk of unplanned conception and/or abortion such as sex workers or those with addiction.
LARC	There are lower levels of LARC activity in Primary Care	Pages 6 / 18 / 20 / 21 / 25 / 37 / 46 / 50 / 52 / 58 / 64-71 / 74 / 91 / 116 / 124 / 125	• The Provider must ensure the continued collection of data around LARC recovery rate following the pandemic, teenage pregnancy, repeat abortions, to respond better to those needs. • The Provider must work collaboratively with pharmacies delivering contraceptive services and monitor impacts of over-the-counter contraceptive pill availability. • The Commissioner and Provider must strengthen joint working between sexual health and Primary Care and support them to increase their skill base where necessary.

11. Conclusion

Stakeholders on the whole described Thurrock Sexual Health Services as a competent effective service for people who accessed it. However overall professionals working in and around the service have described several ways that the service is not meeting the needs of the Thurrock population.

There are accessibility issues regarding the main site which are exacerbated due to there being no “spoke” sexual health clinics in Thurrock.

Stakeholders repeatedly mentioned that people were likely to go elsewhere for sexual health services due to better access and friendlier more approachable up to date staff and settings.

A clear theme was the lack of joint working or even informal networking with any other teams that would form the basis of a relationship and information sharing.

There is a need to expand the RSE element of the service and to build relationships either with community groups or schools. RSE is not a mandated function of the sexual health service or contract however the development of a comprehensive package to schools and community settings could form a vital part of the prevention work required to reduce STIs and unwanted pregnancy.

Whilst the sexual health service is currently delivering all the key performance indicators (KPIs) to the expected level this needs assessment has demonstrated that many of the aspects of the service that need to be reviewed in a new service model cannot be counted or numerated. A new service needs to be integrated into the wider community, the service leads need to be central to education, primary care, and stakeholder meetings.

Acknowledgements

To Solutions for Public Health for the comprehensive qualitative element of this needs assessment and for providing the overarching policy literature review.

We are incredibly grateful to everyone who gave up their time to engage with us on this. As part of our continuous engagement, we would like to ask for any comments on this needs assessment to be sent to our Public Health email: publichealthsi@thurrock.gov.uk

References

All Party Parliamentary Group on Sexual and Reproductive Health in the UK. “Women’s lives, women’s rights: Strenthening access to contraception beyond the pandemic.” 2020.

Ayelegne Gebeyehu, Daniel and Missaye Mulatie. “Risky sexual behavior and its associated factors among patients with severe mental disorder in University of Gondar Comprehensive Specialized Hospital.” *BMC Psyshiatry* (2021): v.21.

BPAS. “Long-acting reversible contraception in the UK.” May 2021. *British Pregnancy Advisory Service.* <https://www.bpas.org/media/3477/larc-report-final-laid-up.pdf>.

Centers for Disease Control and Prevention. “CDC Recommendations for Hepatitis C Screening Among Adults.” Morbidity and Mortality Weekly Report. April 10th, 2020.

Centres for Disease Control and Prevention. “Sexual Transmission and Viral Hepatitis.” September 21st, 2020.

Department for Education. “Relationships Education, Relationships and Sex Education (RSE) and Health Education Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers.” 2019.

Department for Health and Social Care. “Abortion statistics for England and Wales: 2019.” 2021.

Department of Health. “A Framework for Sexual Health Improvement in England.” 2013.

Department of Health and Social Care. “Towards Zero Action plan towards ending HIV transmission, AIDS and HIV related deaths in England 2022-2025.” 2021.

—. “Women’s Health Strategy for England.” 2022.

Ezhova, I et al. “Barriers to older adults seeking sexual health advice and treatment: A scoping review.” *International Journal of Nursing Studies, Volume 107* (2020): https://doi.org/10.1016/j.ijnurstu.2020.103566.

Faculty of Sexual and Reproductive Health. “The Hatfield vision: A framework to improve women and girls’ reproductive health outcomes.” 2022.

Friends, Families & Travellers. “Briefing: Health inequalities experienced by Gypsy, Roma and Traveller communities.” October 2022.

FSRH. “Service Standard for Sexual and Reproductive Healthcare.” 2022. *The Faculty of Sexual & Reproductive Healthcare.* <https://www.fsrh.org/standards-and-guidance/documents/service-standard-for-sexual-reproductive-healthcare-october/>.

Gill, Paramjit, et al. “Improving access to health care for Gypsies and Travellers, homeless people and sex workers: An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards.” Sptember 2013.

HM Government. “Child Poverty Strategy: 2014 to 2017.” 2014.

House of Commons Health and Social Care Committee. “Sexual Health: Fourteenth report of session 2017-2019.” HC1419. June 2019.

Kiridaran, Vaishali, Mehar Chawla and Julia V. Bailey. “Views, attitudes and experiences of South Asian women concerning sexual health services in the UK: a qualitative study.”

The European Journal of Contraception & Reproductive Health Care (2022): v27:5, pg418-4.

Local Governmant Association and English HIV and Sexual Health Commissioners Group. “Breaking Point: securing the future sexual health services.” 2022.

Local Government Association. “The Impact of Homelessness on Health: a guide for local authorities.” 2017.

Mencap. “Sexuality and Relationships Vision Statement.” 2016.

NCFE. *Homelessness the causes and the risks*. 2021.

NDTMS. “Diagnostic Outcomes Monitoring Executive Summary Report for Thurrock.” Q4 2021/22.

NHS Online. *Hepatitis*. 23 August 2022.

NICE. *Contraception: Quality standard [QS129]*. 8 September 2016. <https://www.nice.org.uk/guidance/qs129>.

—. *Reducing sexually transmitted infections: NICE guideline NG221*. 15 June 2022. <https://www.nice.org.uk/guidance/ng221>.

—. “Sexual health: Quality standard [QS178].” 5 February 2019. *NICE.* <https://www.nice.org.uk/guidance/qs178/chapter/Quality-statement-6-Partner-notification>.

—. “Sexually transmitted infections: condom distribution schemes.” NICE guideline [NG68]. 2017.

Office for Health Improvement and Disparities. “Abortion statistics, England and Wales: 2021.” 2023.

Office for National Statistics. “Live births, stillbirths and linked infant deaths: birthweight by age of mother, numbers and rates, 2016.” 2018.

Paton, Nic. “Third of men would find STI diagnosis damaging to mental health.” 7 November 2022. *Personnel Today.*

Perez, Stephanie. “How Unhealthy Relationships Impact the Disabled Community.” n.d. *One Love.*

Public Health England. “Health Matters: preventing STIs.” Guidance. 2019.

—. “Sexually transmitted infections: promoting the sexual health and wellbeing of gay, bisexual and other men who have sex with men.” September 2021. *Public Health England.* <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1021121/HPRU1_MSM_PHE_UCL_Report__1_.pdf>.

—. “Tracking the syphilis epidemic in England: 2010 to 2019: an update on progress towards the Syphilis Action Plan prevention priorities.” 2021.

—. “Variation in outcomes in sexual and reproductive health in England.” 2019.

—. “Variation in outcomes in sexual and reproductive health in England.” 2019.

—. “Variation in outcomes in sexual and reproductive health in England: a toolkit to explore inequalities at a local level.” May 2021. *Public Health England.* <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984393/SRH_variation_in_outcomes_toolkit_May_2021.pdf>.

Roy, A et al. “Healthcare provider and service user perspectives on STI risk reduction interventions for young people and MSM in the UK.” *Sexually Transmitted Infections* (2020): 96(1) pgs. 26-32.

Secretary of State for Work and Pensions. “National Disability Strategy.” 2021.

Sinka, Katy. “One year on: 7 things we’ve learnt about mpox.” 2023.

Solutions for Public Health. “Integrated substance misuse needs assessment for Thurrock.” 2022.

Steckenrider, J. “Sexual activity of older adults let's talk about it.” *The Lancet Healthy Longevity* (2023): e96-e97 https://doi.org/10.1016/S2666-7568(23)00003-X.

Teenage Pregnancy Unit. “Long-term consequences of teenage births for parents and their children.” Research Briefing. 2004.

Terrence Higgins Trust. *Hepatitis A*. 9 December 2021.

—. “It’s time to face the taboo around older people having sex.” 2020.

—. “Women and HIV: Invisible No Longer.” 2018.

Thurrock Council. “Better Together Thurrock - the case for further change 2022-2026.” 2022.

—. “The Health and Wellbeing of Children Looked After: a health needs assessment for Thurrock.” 2022.

—. “Thurrock Health and Wellbeing Strategy 2022 to 2026.” 2022.

UK Health Security Agency. *Don't forget to check for hep- testing and treatment for hepatitis*. 18 May 2023.

—. “Hepatitis C in England 2022: Working to eliminate hepatitis C as a public health problem.” Full data report to end of December 2020. 2022.

—. “HIV: annual data tables.” 2022.

—. “Mpox (monkeypox) outbreak: epidemiological overview.” 2 March 2023.

—. “Sexually transmitted infections and screening for chlamydia in England: 2021 report.” 2022.

—. “Sexually transmitted infections and screening for chlamydia in England: 2022 report.” Official Statistics. 2023.

—. “Sexually transmitted Shigella spp. in England: data up to quarter 2, 2022.” 2022.

UKHSA. “Sexually transmitted infections and screening for chlamydia in England: 2022 report.” Official Statistics. 2023.

Wellings, K and et al. “The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3).” *Lancet* (2013): vol. 382.

Wellings, K et al. “The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3).” *Lancet* (2013): 382: 1807–1816.

Wiseman, P and Ferrie, J. “Reproductive (In)Justice and Inequality in the Lives of Women with Intellectual Disabilities in Scotland.” *Scandinavian Journal of Disability Research, Volume 22, Issue 1* (2020): 318-329 https://doi.org/10.16993/sjdr.677.

Wiseman, Phillippa and Jo Ferrie. “Reproductive (In)Justice and Inequality in the Lives of Women with Intellectual Disabilities in Scotland.” *Scandinavian Journal of Disability Research* (2020): 22(1) pgs. 318-329.

Your Thurrock. *Homelessness rises by a ‘shocking’ 20 per cent in Thurrock*. 13 January 2023.

Yumori, Caitlin, et al. “Women are less likely to be tested for HIV or offered PrEP at time of STI diagnosis.” *Sexually Transmitted Diseases* (2021): 48(1) pg.32-36.

Papers of Interest

Towards Zero: the HIV Action Plan for England 2022-2025

Sexual and reproductive health and HIV: applying All Our Health

A Framework for Sexual Health

Syphilis Action Plan

Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)

hiv-sexual-and-reproductive-health-2014

promoting-the-health-and-wellbeing-of-gay-bisexual-and-other-men-who-have-sex-with-men

public-health-services-non-mandatory-contracts-and-guidance-published

commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities

sexual-and-reproductive-health-and-hiv-applying-all-our-health

sexual-health-commissioning-local-government-

NICE Sexual Health Quality Standard (QS178)

Further Reading

Acceptability of remote prescribing and postal delivery services for contraceptive pills and treatment of uncomplicated Chlamydia trachomatis

Access to healthcare for street sex workers in the UK: perspectives and best practice guidance from a national cross-sectional survey of frontline workers

Access to, usage and clinical outcomes of, online postal sexually transmitted infection services: a scoping review https://pubmed.ncbi.nlm.nih.gov/32380261/

Barriers to older adults seeking sexual health advice and treatment: A scoping review.

Changes in the prevalence and profile of users of contraception in Britain 2000-2010: Evidence from two National Surveys of Sexual Attitudes and Lifestyles

Expanding choice through online contraception: a theory of change to inform service development and evaluation https://srh.bmj.com/content/46/2/108

Healthcare provider and service user perspectives on STI risk reduction interventions for young people and MSM in the UK https://sti.bmj.com/content/96/1/26

Department of Health and Social Care. Health and Social Care Act 2012 Available http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted [accessed June 2021]

Department of Health and Social Care. Abortion Statistics, England and Wales: 2019. Available from: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019.

Hughes G, Field N. The epidemiology of sexually transmitted infections in the UK: impact of behaviour, services and interventions. 2015;10(1):35-51.

Appendices

Appendix 1 - Full Report Solutions for Public Health

Thurrock Sexual HNA - engagement report.

Appendix 2 - Literature Review

A literature review was conducted by The North East London NHS Foundation Trust on behalf of Public Health Thurrock. [PH Bulletin] Evidence on Sexual Health Needs Assessment SN40868. Stephen Reid. (7th March 2023). ILFORD, UK: NELFT Library and Knowledge Service

Sources searched British Pregnancy Advisory Service (1) Faculty of Sexual & Reproductive Healthcare (1) Local Government Association (LGA) (2) NICE Guidance (1) Public Health England (PHE) (2) The Faculty of Sexual & Reproductive Healthcare (2) UK Health Security Agency (UKHSA) (1)

Date range used (5 years, 10 years): 2020 - 2023 Limits used (gender, article/study type, etc.): English language; adults Search terms and notes (full search strategy for database searches below):

Searches were carried out in a range of databases: Embase, HMIC, Medline, Social Policy, and Practice. In addition, the researcher searched NICE guidance, TRIP, Google Scholar, gov.uk, the FSRH website, the Service user Experience Library and the Local Government Association website.

The search terms used varied according to the source. For some of the individual sites, simple searches for "sexual health" and then "reproductive health" were used. For Google Scholar and for TRIP, the terms used were ("sexual health" or "reproductive health") AND (commissioning or policy or procure or provide or provision). The searches in Embase, HMIC, Medline and Social Policy and Practice expanded upon these terms to include database specific subject headings.

Appendix 3 - Commissioning Responsibilities

The Responsibilities of Local Authorities, Integrated Care Boards, and Primary Care Networks

- **Integrated care systems (ICSs)** are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. An ICS is made up of an Integrated Care Board (ICB); integrated Care Partnership (ICP); Local authorities; Alliances; and Provider Collaboratives.
- The organisations that make up the Mid and South Essex Integrated Care System are: Mid and South Essex Integrated Care Board and Three upper tier local authorities: Essex County Council, Southend-on-Sea City Council (unitary), Thurrock Council (unitary)

- **Integrated Care Board (ICB)** - A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget**,** and arranging for the provision of health services in the ICS area. NHS Mid and South Essex Integrated Care Board (ICB) is responsible for deciding how the NHS budget for mid and south Essex is spent. It is also responsible for developing a plan to improve people's health, deliver higher quality care and better value for money.
- **ICP** - A statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally. Integrated Care Partnerships (ICPs) are committees that bring the NHS together with other key partners like local authorities to develop a strategy to enable the ICS to improve health and wellbeing in its area.
- **PCNS –** Primary Care Networks: PCNs are groups of GP practices within a Local Authority (e.g., Thurrock) working closely together with other healthcare staff and organisations to provide more joined up care to local communities. Thurrock is divided in to 4 PCNs.

Appendix 4 - Core20PLUS5

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health, many of which may affect either risk factors or engagement with sexual health services:

Income.

Employment.

Education.

Health.

Crime.

Barrier to housing and services.

Living environment.

PLUS

PLUS population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

The plus population may also be within the core group, this group may have difficulty accessing sexual health services due to fear, stigma, restrictions, and ability to travel and may benefit form a hyper local service.

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5 (adult)

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

1. Maternity

Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

2. Severe mental illness (SMI)

Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. Chronic respiratory disease

A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. Early cancer diagnosis 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

5 (children)

The five areas of focus are part of wider actions for Integrated Care Board and Integrated Care Partnerships to achieve system change and improve care for children and young people. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve aims.

1. Asthma Address over reliance on reliever medications; and decrease the number of asthma attacks.

2. Diabetes Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

3. Epilepsy Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

4. Oral health Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.

5. Mental health Improve access rates to children and young people's mental health services for 0–17-year-olds, for certain ethnic groups, age, gender, and deprivation.

Appendix 5 - Hatfield Model to Tackle Health Disparities

The 16 Goals to tackle reproductive health disparities.

Ability to choose if and when to have children Access and standards of contraceptive care:

Goal 1. The proportion of pregnancies which are unplanned, unintended and/or ambivalent is reduced to less than 30% of all pregnancies by 2030 to ensure positive physical and mental health outcomes for women and children.

Goal 2. The gap between rates of unplanned, unintended and/or ambivalent pregnancies in disadvantaged areas as compared to those in advantaged areas is halved by 2030.

Access and standards of contraceptive care:

Goal 3. Integrated Care Systems (ICS), local authorities and providers promote the fulfilment of SRH rights including offering women and girls the full range of contraceptive methods in the location of their choosing, with quick access to local general practice and specialist services when needed.

Goal 4. Face-to-face and remote contraceptive consultations are patient-centred, with users feeling able to openly discuss their preferences, participating in decision-making effectively, as well as being informed about possible side effects and how to deal with them as per FSRH Quality Standards.

Goal 5. Enhanced access to contraceptive care, addressing the needs of all those who are the least well-served, with a particular focus on populations that experience the worst inequalities such as, but not limited to, women and girls living with disabilities, from low socio-economic backgrounds, from Asian and ethnic minority groups, black women/girls and women/girls of colour.

Goal 6. Access to Long-Acting Reversible Contraception (LARC) is made equitable across ICS geographies and demographics.

Goal 7. By 2025, free oral emergency contraception is available and funded in all community pharmacies across England, including to under 25s.

Goal 8. ICS should ensure that all methods of contraception are discussed with women during pregnancy and, where possible, their method of choice should be initiated prior to discharge from maternity services. Rapid follow-up pathways for LARC should be in place when needed.

Access to preconception care:

Goal 9. All women are offered comprehensive preconception care when they attend their contraception appointments in general practice, specialist SRH and community gynaecology services.

Access to menstrual health support:

Goal 10. Women and girls have access to a practitioner who is able to provide support, diagnosis and treatment for their menstrual health including pain, heavy bleeding and premenstrual mood disturbance at their general practice, specialist SRH services and community gynaecology services.

Goal 11. Women and girls have universal access to free menstrual products within health services and schools.

Access and standards of abortion care:

Goal 12. As per NICE guidance, all women and girls seeking abortion have access to a choice of method (medical or surgical), including the option to self-refer directly to a service, as well as access to the full range of contraceptive methods. Access to menopause care Maternal health outcomes in black women and women of colour

Access to cervical screening:

Goal 13. Each local authority area meets the national NHS Cervical Screening Programme target of 80% coverage by 2025.

Access to information:

Goal 14. Every woman is able to access a practitioner in their local area, such as a member of their primary care health team, who is able to provide menopause care, support them to manage symptoms and choose appropriate treatment if required.

Maternal health outcomes in black women and women of colour:

Goal 15. By 2030, widespread reproductive health disparities, particularly in maternal health outcomes, experienced by black women and women of colour as well as women and girls from Asian and minority ethnic groups, are significantly reduced.

Goal 16. Information is easily available to support women and girls in making decisions about their own reproductive health, ranging from signs and symptoms of gynaecological cancers to where to access support and care, regardless of age, ethnicity, language, disability, postcode, socioeconomic status, levels of literacy or religious belief. 8

Priority actions to tackle reproductive health disparities Workforce

Realising the 2030 Ambition and achieving the Goals will require priority action on:

Action 1. Community SRH specialty training posts are fully funded, with one new fully funded specialty training post per Health Education England region for the next three years, to provide local leadership, training and governance to the SRH workforce and services.

Action 2. The primary care workforce is adequately resourced to provide LARC fittings, removals and training. Local contracts should fully cover the costs of provision, training and maintaining access to this essential service.

Action 3. Service specifications for specialist SRH services are designed to include training requirements in their contracts. Commissioning.

Action 4. The NHS and ICS are mandated to collaboratively commission SRH with local authorities, and contracts with care providers require them to adhere to nationally recognised quality standards such as FSRH's Standards for Sexual and Reproductive Healthcare Services. Accountability.

Action 5. A National Clinical Director for women's reproductive health or a National Specialty Adviser in SRH, or similar, is appointed, who would hold accountability for the commissioning and outcomes of women's reproductive health.

Action 6. A women's health lead, with accountability for reproductive health, is appointed in every ICS Board to ensure that holistic women's reproductive health is prioritised in ICS strategies. Realising the 2030 Ambition and achieving the Goals will require priority action on: 10 Data and information.

Action 7. A national digital service platform is developed for SRH, which will serve as a one-stop point of access for the public and will support the maintenance of access to essential SRH care operating seamlessly with existing regional / local digital offers.

Action 8. The London Measure of Unplanned Pregnancy is introduced as the standard national measure of unplanned pregnancy.

Action 9. The Department of Education signposts teachers to reliable and evidence-based information on issues across the breadth of SRH, to support effective implementation of statutory relationships and sex education guidance. Health promotion.

Action 10. Providers are well-resourced to ensure that service staff use every contact with patients and the public to promote positive SRH and wellbeing in accordance with Making Every Contact Count principle.

Faculty of Sexual and Reproductive Healthcare Hatfield Vision: A Framework to Improve Women and Girls' Reproductive Health Outcomes (July 2022)

Appendix 6 - Thurrock Pharmacies

Figure 93:

Code	Name	Address	Postcode
FA736	Allcures Pharmacy	62 High Street, Grays	RM17 6NA
FF646	Allcures Pharmacy	Allcures House, Arisdale Avenue, South Ockendon	RM15 5TT
FG775	Allcures Pharmacy	Unit 1, Stanford House, Princess Margaret Road, East Tilbury	RM18 8YP
FGW47	Allcures Pharmacy	16 Kings Parade, Stanford-Le-Hope	SS17 0HP
FQV22	Allcures Pharmacy	19 Lampits Hill, Corringham, Stanford-Le-Hope	SS17 9AA
FKK05	Allcures Plc	Purfleet Care Centre, Tank Hill Road, Purfleet	RM19 1SX
FNT96	Armada Pharmacies Ltd	1 Drake House, Drake Road, Chafford Hundred	RM16 6RX
FFP86	Asda Pharmacy	Thurrock Park Way, Tilbury	RM18 7HJ
FHF78	Boots	2 St Chads Road, Tilbury	RM18 8LB
FKD78	Boots	74/75 Thurrock Lakeside, Shopping Centre, West Thurrock, Grays	RM20 2ZG
FMX69	Boots	35-43 High Street, Grays	RM17 6NB
FNC41	Boots	1B Junction Retail Park, Western Avenue, Thurrock	RM20 3LP
FQ578	Boots	83-85 St. John's Way, Corringham, Stanford-Le-Hope	SS17 7NA
FQQ40	Boots	17 Derwent Parade, South Ockendon	RM15 5EF
FPW42	Dips Chemist	12 Defoe Parade, Chadwell St. Mary	RM16 4QR
FQK60	Dock Pharmacy	128 Dock Road, Tilbury	RM18 7BJ
FDN49	Essex Pharmacy	2 Civic Square, Tilbury	RM18 8AD
FT060	Hassengate Pharmacy	Southend Road, Stanford-Le-Hope	SS17 0PH
FNT35	Hemants Chemists	10 Derwent Parade, South Ockendon	RM15 5EE
FD776	LloydsPharmacy	Burghley Road, Chafford Hundred	RM16 6QQ
FLQ07	LloydsPharmacy	31 Lodge Lane, Grays	RM17 5RY
FTK09	Ohms Pharmacy	32 High Street, Aveley	RM15 4AD

FW514	Riverview Pharmacy	22 River View, Chadwell St. Mary, Grays	RM16 4BJ
FKL83	South Road Pharmacy	1 South Road, South Ockendon	RM15 6NU
FW449	Steve's Chemist	36 Bridge Road, Grays	RM17 6BU
FX248	Stifford Pharmacy	16 Crammavill Street, Stifford Clays, Grays	RM16 2BD
FJ599	Tesco in-Store Pharmacy	Tesco Store (Instore Phcy), Cygnet View, West Thurrock	RM20 1TX
FA673	Unicare Pharmacy	22 St Johns Way, Stanford-Le-Hope, Corringham	SS17 7LJ
FMM25	Unicare Pharmacy	34 East Thurrock Road, Grays	RM17 6SP
FQG23	Unicare Pharmacy	89 Orsett Road, Grays	RM17 5HH
FCJ06	Vision Pharmacy	11 Crammavill Street, Stifford Clays, Grays	RM16 2AP
FM809	Well	22 High Street, Aveley	RM15 4AD

Appendix 7 - Stages of Syphilis

Syphilis can be described in three stages, primary, secondary and tertiary each of these stages has symptoms specific to them.

First stage (primary syphilis)

- Ten days to three months after you become infected a painless sore (called a ‘chancre’) may appear where the infection is. This is usually on the penis or vagina, in the mouth or around the rectum. Some people get several sores.
- Glands in your neck, groin or armpits may swell.
- The sores are very infectious. They heal after about two to eight weeks and disappear.

Second stage (secondary syphilis)

- A few weeks after the sore disappears you may get:
- a blotchy rash on your body, often on the palms of your hands or soles of your feet.
- patchy hair loss.
- white patches in your mouth.
- growths like genital warts appearing near the anus and also near the vulva.
- The rash and growths are infectious.
- You might also feel ill, with a fever or headache, and swollen glands, and suffer weight loss.

Third or late stage (tertiary syphilis)

- Syphilis can go on to cause serious damage to your heart, brain, bones and nervous system, years later. This damage can be life-threatening.
- You could experience stroke, blindness, heart problems, dementia and loss of co-ordination.
- It can still be treated at this stage, but it might not be possible to repair damage that has been done.

If stage one is not treated it may advance to secondary or stage 2 syphilis. Between stage 2 and 3 you can't see or feel any signs or symptoms of syphilis. The disease becomes latent, which means hidden. It can still be passed on during this time for up to two years.

This page is intentionally left blank

19 October 2023	**ITEM: 7**

Health and Wellbeing Board

Southend, Essex and Thurrock (SET) LeDeR Annual Report 22/23.

Wards and communities affected:	**Key Decision:**
This report covers the whole of Southend, Essex and Thurrock.	Non-Key Decision For Information.

Report of: Andrew Graham, Learning Disability Health Equality Commissioner For Adults, Southend, Essex and Thurrock Learning Disability / Autism Health Equality Team.

This report is public.

Executive Summary

To inform the Health and Wellbeing Board of the learning from LD deaths in the year 22/23.

To seek support for the development of a further 3-year LeDeR plan and to refresh the current 2021-24 plan.

1. Recommendation(s)

1.1 To note the LeDeR End of Year report and associated documents.

1.2 To seek support for the development of a further 3-year LeDeR plan and to refresh the current 2021-24 plan.

2. Introduction and Background

2.1 The LeDeR programme reviews all deaths of people with learning disability and autistic people whose deaths are notified and seeks to identify improvements to health and social care which could prevent premature deaths and deliver equity of access to services, so that people now alive with learning disability and/ or autism can live long and good quality lives.

2.2 In 2022/23 113 people with Learning Disability and / or Autism died (7 children/young people) in Southend, Essex and Thurrock (SET). The median average age at death for adults across SET in 2022/23 was 57. This is a reduction on the average age of death in the 2021/22 report, which we are monitoring.

2.3 We believe that we are still seeing the impact of Covid 19 on our notifications and across health provision. One explanation for the reduction in the average age at death is that some of the oldest adults died during the pandemic who might otherwise have died in 22/23. For example, there are only 113 death notifications this year. This is the same number as the number of adult's deaths notified to LeDeR in 2020/21 that were over 60. Then in 2021/22 there were 69 deaths notified to LeDeR of people over 60.

2.4 The SET LeDeR programme is committed to maintaining good performance in the Key Performance Indicators (KPIs). The programme is also in compliance with the revised LeDeR policy in terms of team structure and approach.

2.5 Themes arising from recommendations in the 22/23 report confirms findings from previous years and highlights additional items to explore. These recommendations are either already being explored by existing workstreams or will be actioned this financial year.

2.6 Pneumonia and aspiration pneumonia remains the main direct causes of death for people with learning disability in SET. This is not the same for the rest of the population.

2.7 One of the main areas of integration and progress in 22/23 continues to be early aging and frailty in people with learning disability. Specialist LD Health services are working with partners to implement change and are increasingly involving relevant mainstream health services.

2.8 The SET LeDeR 3 year deliverable plan should be noted as all organisations will need to drive implementation. This plan is monitored by the SET LeDeR Steering Group and is due to be reviewed this year as it comes to an end on 31st March 2024. We would like your support to create a new 3-year deliverable plan.

2.9 Within the report 13 key recommendations were made based on the themes identified. These include highlighting the importance of prevention, awareness of LeDeR, care pathways, advocacy, end of life planning and primary care.

3. Issues, Options and Analysis of Options

3.1 There are no options associated with this report.

4. Reasons for Recommendation

4.1 Noting the LeDeR End of Year report and associated documents is very important to be aware of the learning from people experience of care throughout their life and at their death. It also highlights key recommendations to make improvement moving forward.

4.2 Supporting the development of a further 3-year LeDeR plan by refreshing the current 2021-24 plan will give us the opportunity to embed the latest learning of LeDeR, target specific change and continue to reduce health inequalities for people with Learning Disabilities and / or Autistic people.

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

5.1 Not applicable.

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

6.1 Not applicable.

7. Implications

7.1 Financial

Not applicable.

7.2 Legal

Not Applicable.

7.3 Diversity and Equality

A Community Equality Impact Assessment has not been completed for this paper as this is a discussion paper updating on the SET LeDeR Annual Report for 22/23.

However, it is important to note the work of the Southend, Essex and Thurrock Learning Disability and Autism Health Equality Team and in particular the LeDeR Programme is designed to positively impact people with a Learning Disability and / or Autistic people by:

- Identifying and reducing health inequalities and promoting access to healthcare as well as appropriate support.
- Being mindful of how those with protected characteristics may experience care and support differently throughout their lives as well as deaths and capturing learning.
- Working towards closing the gap between the life expectancy of those with Learning Disabilities and / or Autism in comparison to the general population.

7.4 Other implications

Not Applicable.

8. Background papers used in preparing the report

- SET LeDeR Annual Report 22/23.

SET LeDeR Annual Report V2_3 - Final.pc

- SET LeDeR Annual Report Summary Slides 22/23.

22_23 SET LeDeR Annual Report Summ

- Current SET LeDeR 3 year deliverable plan (2021 – 2024).

LeDeR 3 Year Deliverable Plan - Eas

- SET LeDeR Annual Report 22/23 Thurrock Specific Insights.

SET LeDeR Annual Report 22_23 Thurroc

9. Appendices to the report

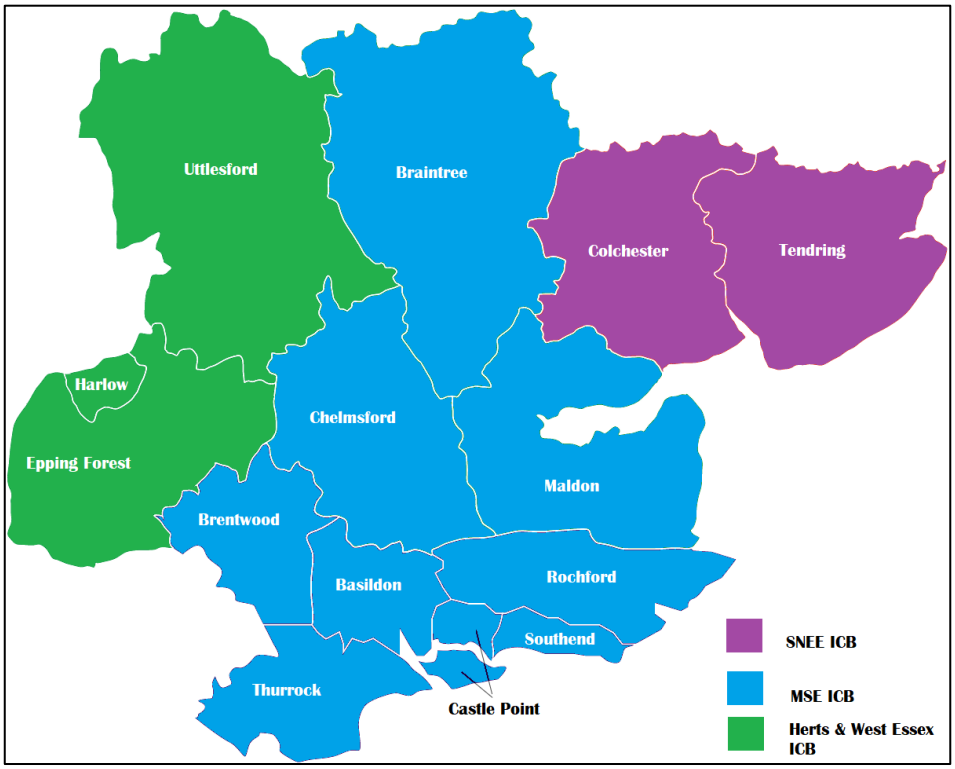
- Appendix 1: Southend, Essex and Thurrock (LeDeR) Annual Report 2022 - 2023

Report Author:

Andrew Graham, Learning Disability Health Equality Commissioner For Adults, Southend, Essex and Thurrock Learning Disability / Autism Health Equality Team.

Southend, Essex and Thurrock (LeDeR) Annual Report 2022 - 2023

Learning from lives and deaths – People with a learning disability and autistic people



Version 2.3: August 2023

Contents

Foreword

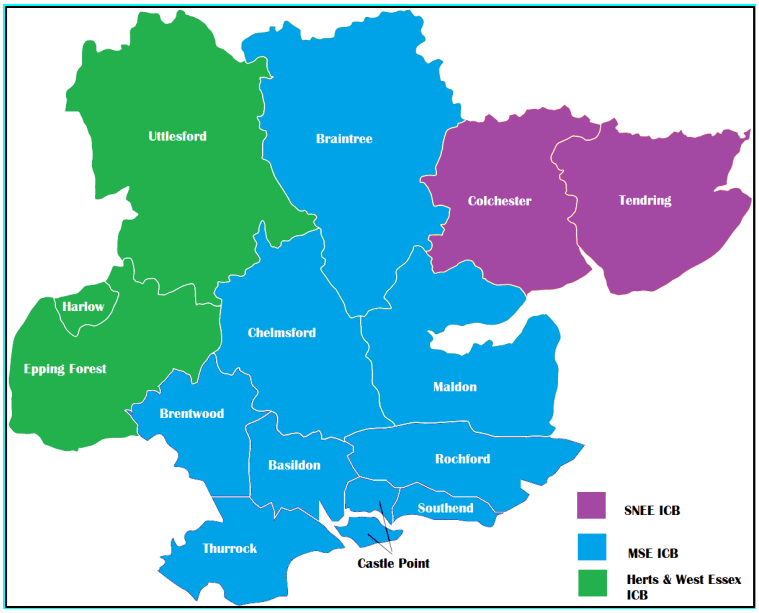
We welcome readers to the Southend, Essex and Thurrock (SET) LeDeR annual report for 2022-23. This report talks about the lives and deaths of people who lived in SET.

With the introduction of Integrated Care Boards (ICBs) from 1st July 2022, there are now three NHS boards working across SET;

Mid and South Essex (MSE)

Suffolk and North East Essex (SNEE)

Herts and West Essex (HWE)



Together as partners, we are committed to delivering the ambition set out in the Learning Disability and Autism NHS Long Term Plan to reduce health inequalities.

Throughout the report, we will sometimes split our information into three ICB areas to make it clear when we are talking about something which applies across all of SET, or whether there are differences across the County.

Since the last report, we have a shared Senior Reviewer working across SET and Suffolk, which has also helped us identify themes or concerns that are common across both counties

Throughout SET, we continue to work in partnership and remain committed to take the learning from LeDeR reviews, turning them into actions, and demonstrating change. This report will show the difference the programme has made to local people and their families and should give assurance of the ongoing commitment to service improvement.

The SET Transforming Care Partnership was set up do deliver the vision set out in Building the Right Support:

"Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with dignity and respect." (Department of Health and Social Care (2022) available at Building the Right Support Action Plan - GOV.UK (www.gov.uk)

The SET partnership Board continues to work across the three integrated care organisations and three Local Authorities which cover the County of Essex

Everyone's Essex sets out 5 commitments to Health for promoting health, care and wellbeing:

Healthy Lifestyles; promoting independence; place-based working (local partnerships); support for carers; levelling up health (Everyone's Essex: our plan for levelling up the county 2021-2025 available at Everyone's Essex: our plan for levelling up the county 2021 to 2025: Foreword from Kevin Bentley | Essex County Council)

Essex county Council published their 4 year strategy for disability in April 2023:

Essex_County_Council_Disability_Strategy_-_Meaningful_Lives_Matter.pdf

Essex County Council have an Ageing Well Programme

Ageing Well Programme

The 5 year all age autism strategy runs from 2020-2025:

All-age-autism-strategy-EasyRead-2020-2025.pdf (snapcharity.org)

The Relevant Strategies for Southend City Council are Ageing Well and Caring Well:

Ageing Well Strategy for Southend-on-Sea Borough Council 2022-2027
Caring Well Strategy for Southend-on-Sea Borough Council 2022-2027

Thurrock's Health and Wellbeing Strategy sets priorities for reducing inequalities in health and well-being, and for improving the health and well-being of the people of Thurrock:

Health and well-being strategy 2022-2026 | Health and well-being strategy | Thurrock Council

This Report will be made available in an Easy Read Format after having been approved by all relevant boards and adopted and published by MSE ICB

Acknowledgements

A special thanks to the LeDeR reviewers, health and social care providers, carers and families who have been central to supporting the LeDeR process and delivering the programme.

We acknowledge the ongoing support of Krishna Ramkhelawon Southend's Director of Public Health, who chairs the LeDeR steering group for SET.

We thank the dedicated members of the three LeDeR Quality Panels for their commitment, contribution and continued passion for improvement for people with a learning disability and autistic people.

We acknowledge our Health and Well Being Boards, the Learning Disability Health Equalities Board and the SET partnership for our ongoing governance and oversight arrangements, and a joint commitment for learning from the lives and deaths of people with a learning disability and autistic people.

We are grateful to the people from all agencies who make the notifications, our dedicated team of reviewers who work hard to make sure each review is carried out to the highest standard possible with the information available; we thank the family members and carers of people who have died for sharing the histories of their loved ones, and the Learning Disability Liaison Nurses for their dedicated input over the years.

We thank Rebekah Bailie at Essex County Council for laying the firm foundations of LeDeR in SET, and the wider Health Equalities Team at Essex County Council, the ongoing support from Essex Family Carers Network, our Suffolk and Hertfordshire colleagues, and LeDeR colleagues across the region for a commitment to collaborative working for better outcomes.

We remember Phil Brown, who transformed lives, and the people whose lives and deaths we have had the privilege to review and learn from, and in commitment to them we continue to strive for improvement across all aspects of health and care.

Executive Summary

The deaths of 113 people with learning disability and/or Autism were notified across SET between April 2022 and March 2023. This is a very similar number to the previous year when 116 deaths were notified. Since January 2022, the scope of LeDeR has been broadened to include reviews for people with Autism only (without a Learning Disability) and we are starting to see notifications for this group of people.

The average age of death has gone down somewhat this year, which we are monitoring. We believe that we are still seeing the impact of Covid-19 on our notifications and across health provision.

We remain compliant with the revised LeDeR policy in terms of team structure, and since January 2023 have shared a Senior Reviewer with Suffolk to achieve efficiencies and share learning.

We are committed to maintaining good performance in respect of allocation and completion KPIs and the expected split between initial and focused reviews. Although 2022-23 has been a challenging year in terms of staffing in the team, we have remained sighted on achieving the required number of completions in a timely manner whilst improving quality across reviews.

We have a 3-year deliverable plan which identifies where we need to a) prevent ill health b) improve management of health and c) remove inequalities and this reflects the commitment of all organisations, including public health. This is monitored by the LeDeR Steering group and is due to be reviewed this year.

Introduction

The aim of the Learning from Lives and Deaths (LeDeR) Programme is to reduce the health inequalities faced by people who have a learning disability.

The LeDeR programme to date has reported on deaths of people with learning disabilities aged 4 and above. The new LeDeR policy has brought the inclusion of those with a diagnosis of autism (aged 18 and over) into the programme from January 2022.

When somebody with a learning disability or autism dies, and their death is notified to LeDeR, we carry out a review of all aspects of the care and support they received – this might be Primary Care (from their GP Practice), care in Hospital, care and support from paid providers, or from family, or specialist services.

By reviewing all aspects of care and support, we are looking to improve quality by learning from what went well and making recommendations for change where things could have been better, to improve health outcomes for other people with learning disability and/or autism.

The LeDeR programme works alongside other quality improvement measures currently in place to reform services and improve health outcomes for people with a learning disability. If other reviews and enquiry processes need to take place, such as hospital structured judgement reviews (SJRs), serious incident reviews, safeguarding investigations, police investigations or a Coroner's report, the LeDeR review should be done after these are completed, so we can include the learning from their findings in our summaries.

The programme started in Essex in 2017. At that time, there were two things we wanted to see to show how LeDeR was making a difference:

1. We wanted the number of deaths notified to LeDeR to increase every year, as more people became aware of the programme, so that opportunities to learn were not missed
2. We wanted to see the average age of death of people with a learning disability increase, "to close the gap" as we knew that on average people with learning disability were dying up to 20+ years younger than the general population

We still want these things. However, the impact of Covid-19 throughout 2020 and 2021 had a significant impact on the numbers of deaths reported and the average age at death, and this is still seen across 2022 and 2023. Also, while we still have a steady increase in notifications for people with a learning disability, we have had very few for autistic people who didn't also have a learning disability.

It will take more time before we are confident that we are getting all the notifications we should, and we start to see an impact on the average age of death. However, in the meantime, this annual report provides an update on the achievements of the three Integrated Care Boards (ICBs) and Southend Essex and Thurrock (SET) Local Authorities and transforming care partnerships, and the changes already being seen.

The report will also report on the LeDeR learning from demographic data from notifications and reviews. It will provide an update on our progress since last year's report and then describe what we have learned from the reviews undertaken during this reporting year.

This report will also outline the governance arrangements for LeDeR across SET, and how partners are working together to promote improved outcomes and experiences for people with a learning disability and autistic people.

We will make the report available in 'easy read' format later in the year.

Involvement of people with a learning disability, experts by experience and families/carers

Across the SET footprint, there are many opportunities for people with Learning Disability and/or autism to be involved in the delivery of the programme. All Focussed reviews are overseen by a Quality Panel which is supported by an expert by experience from Essex Carer's Network. There is also Family carer representation on the LeDeR Steering Group, which monitors all recommendations and actions from reviews, and also the SET Partnership board.

The Learning Disability Health Equalities Board has maintained involvement from people with Learning Disability and Autism, but we recognise that there have been significant changes in ways of working, and this has potentially made it more difficult for people to be meaningfully engaged. This was due to changes in the ways we work which were the result of fewer face to face and more online meetings due to covid restrictions, plus the loss of some key personnel in Essex.

As a result, the Health Equalities team are recruiting associate commissioners with a Learning Disability plus dedicated support for them in the workplace, to ensure the voice of people with Learning disability does not become lost. We also have recruited a commissioner dedicated to Autism, as we are anticipating an increase in the number of "Autism only" reviews in 2023/24.

Delivery of the Programme

The LeDeR programme for SET is hosted by Essex County Council for the 7 Clinical Commissioning Groups (CCGs) in partnership with the three Local Authorities. This arrangement has continued under the newly formed ICBs in place of the old CCGs, and the SET reviewers are employed by Essex County Council. At the end of March 2023, the review team consisted of a Senior Reviewer covering both SET and Suffolk, one part time (0.6) permanent reviewer. This impacted on the capacity of the team to deliver the reviews in a timely way, although we were able to use the resource of some independent contracted reviewers. Since then, we have had a part time reviewer (0.6) return from a year's secondment, and we have recruited two additional part time reviewers (0.6 and 0.4), as well as a new commissioner who will be the SET LeDeR Local Area Contact (LAC) , freeing up additional time from the Senior Reviewer. We are also recruiting into a co-ordination and admin position to support all aspects of LeDeR.

We are monitoring the number of notifications being made to ensure that we now have sufficient capacity to deliver as many reviews as possible within the 6 months target.

Due to the historically lower numbers of notifications made in Suffolk County, the Senior Reviewer role is shared across SET and Suffolk, and two LD nurses are employed on a bank basis, with the Support of the Suffolk LAC and administrative support.

Governance arrangements

LeDeR is integral to the NHS 10 Year Plan, published in 2019, with the aim of improving the lives of people with learning disabilities nationally.

The Senior Responsible Officer Role is held by Nick Presmeg on behalf of Southend, Essex and Thurrock.

The Deputy Responsible Officer Role is held by Jeff Banks on behalf of Southend, Essex and Thurrock.

The ICB Chief Nurse is the Lead for the LeDeR programme in Mid and South Essex, and North East Essex and Herts. In West Essex, the ICB Lead is the Director of Strategy.

SET LeDeR Steering group – chaired by Southend's Director Of Public Health

This group has representation from senior leadership across Health and Social Care systems with the authority to affect change.

This group will review its original terms of reference in 2023 but will remain the key driver for change across all systems and be sighted on all reviews completed.

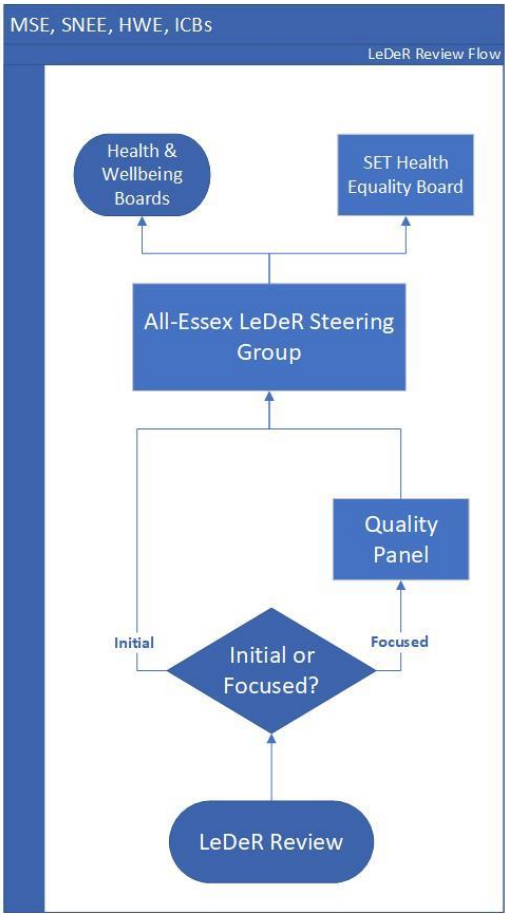
The Three Quality Panels

These groups convene separately for reviews from the MSE, NEE or WE areas. They are attended by an Expert by Experience from Essex Family Carers, with representation across the ICBs, Local Authorities, and the Learning Disability Specialist Health provider (ELDP – Essex Learning Disability Partnership). We are able to learn from practitioners who can help unpick anything tricky to understand or give a perspective on certain decisions.

In 2022/23 there were a number of changes to key personnel associated with the formation of the new ICBs, and so in 2023/24 we wish to identify a lead or leads across the three areas as a specialist to support reviews for people of any ethnic, racial or religious minority background.

We will also be investigating how we can involve colleagues from the Ambulance Trust to contribute to identified Quality Panels.

The image below represents how each group is involved in the Governance and oversight of LeDeR in SET.



Performance against national targets

The new LeDeR policy launched in March 2021 set out a plan for a 'lighter touch' initial review and it was expected that approximately 1/3 of reviews notified would move into the second focused review stage. Those focused reviews are guided by the reviewer and agreed by the Local Area Contact. The criteria for a focused review are:

- if it is believed there will be significant learning,
- when the family have requested a focused review,
- when the person has a diagnosis of Autism only,
- when the person is from a minority ethnic, racial, or religious background.

The key quality improvement measures which we continue to monitor across SET:

- 100% reviews to be completed within 6 months of notification (except where reviews are placed on hold for permitted reasons)
- At least 35% of reviews to be a focused review.
- Continued improvements to the quality of reviews to identify local learning.
- Progression of identified learning in a timely manner.

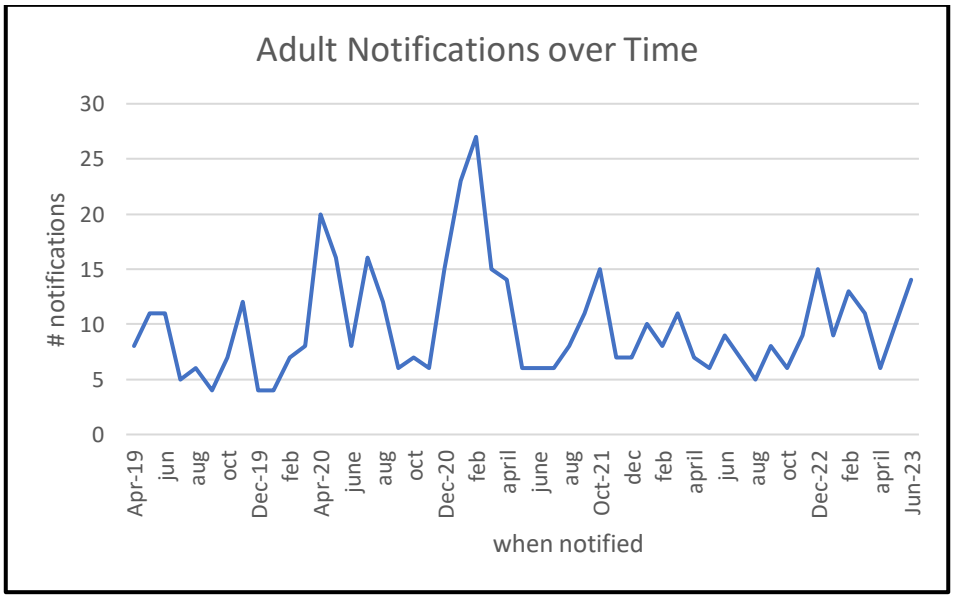
Our People, Performance, Themes and Trends

The data we are using

In this report, there are two sets of data we refer to.

The first is the set of **notifications.** This is the number of deaths notified to us at LeDeR in the year 22/23, meaning from 1st April 2022 to the 31st March 2023.

Since most notifications are made close to the day when the person died, this data is helpful for us to understand some of the trends around deaths as they occur. For example, this graphic:



is a clear indication of the impact on Covid-19, when notifications were at their highest, but also shows the impact of Winter on health.

Looking at notifications helps us to understand any changes on a year-by-year basis.

The second set of data we use is **completed reviews.** This would normally be for the same time period, from 1st April 2022 to 31st March 2023, but this year NHSE decided to extend the period by 10 weeks, as there was a problem in the online system which meant reviews could not be completed for a time, which meant there may not have been enough completed reviews to provide good data. We have decided for this report to mirror NHSE, so that our data will be in line with the National Annual report when it is published later this year. This does mean that our WE and NEE data covers a slightly different date range than the data being used in the HWE and SNEE reports, so there are slightly different numbers used in those areas. I will make it clear whether the data in the report relates to

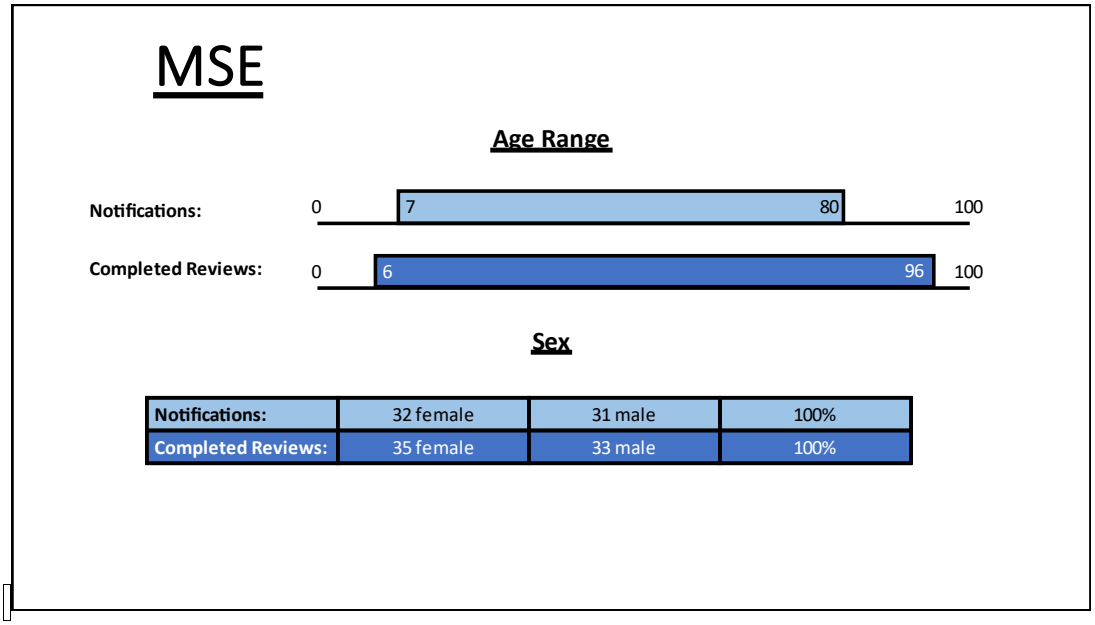
notifications in the year, which will nearly all be for people who died in that year, or completed reviews, some of which may be more than a year old.

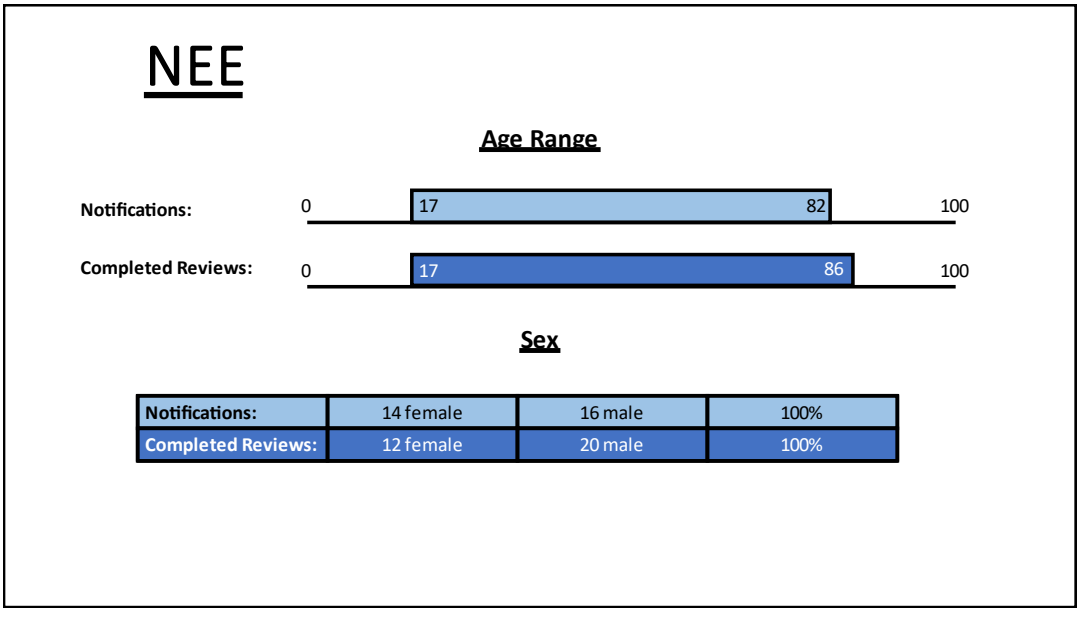
Notifications 2022-23

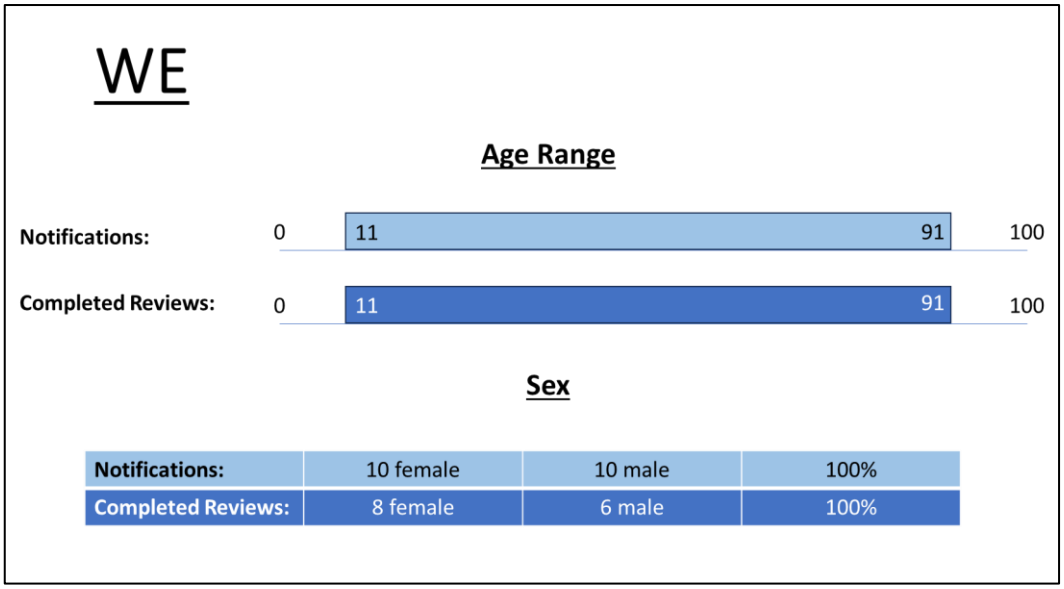
In 2022/23 we received a total of 113 notifications which included 7 child death notifications.

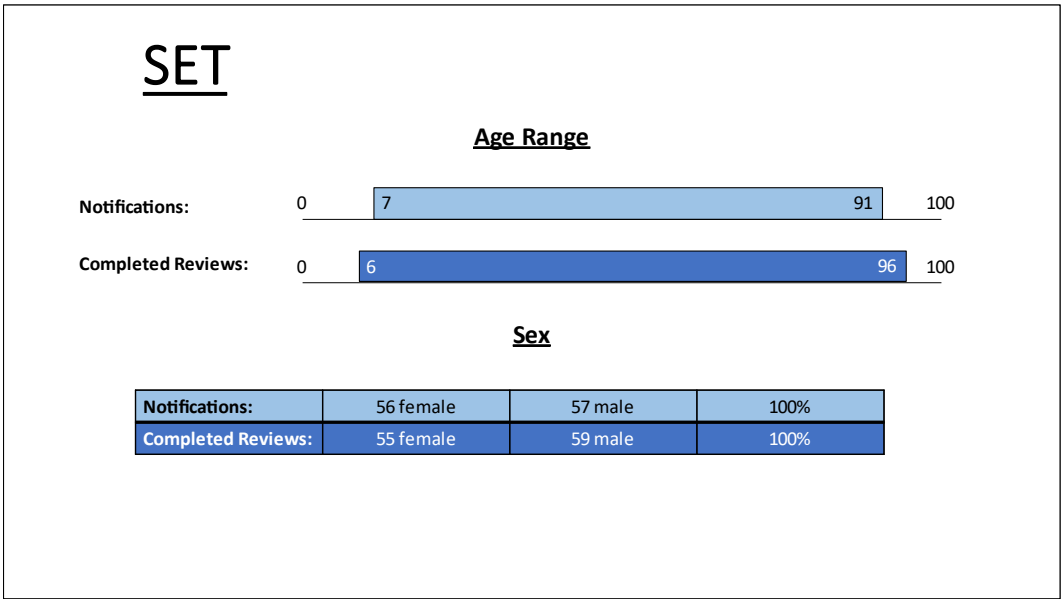
ICB	*April*	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*January*	*February*	*March*	*Total*
MSE	4	4	7	5	3	3	3	3	9	5	6	11	63
WE	1	3	0	2	0	1	2	1	1	1	5	3	20
NEE	2	3	2	1	1	3	1	6	4	3	3	2	30
Essex total	7	10	9	8	4	7	6	10	14	8	14	16	113

Below is a comparison between notifications and completed reviews:









The number and nature of **completed reviews** in a year are broadly similar to the number of notifications, but they provide better data, as we know more about what happened once a review has been completed, and a number of reviews which were **notified** in 22/23 are not yet completed. The age range of completed reviews is broader than that of reviews notified in year by 6 years

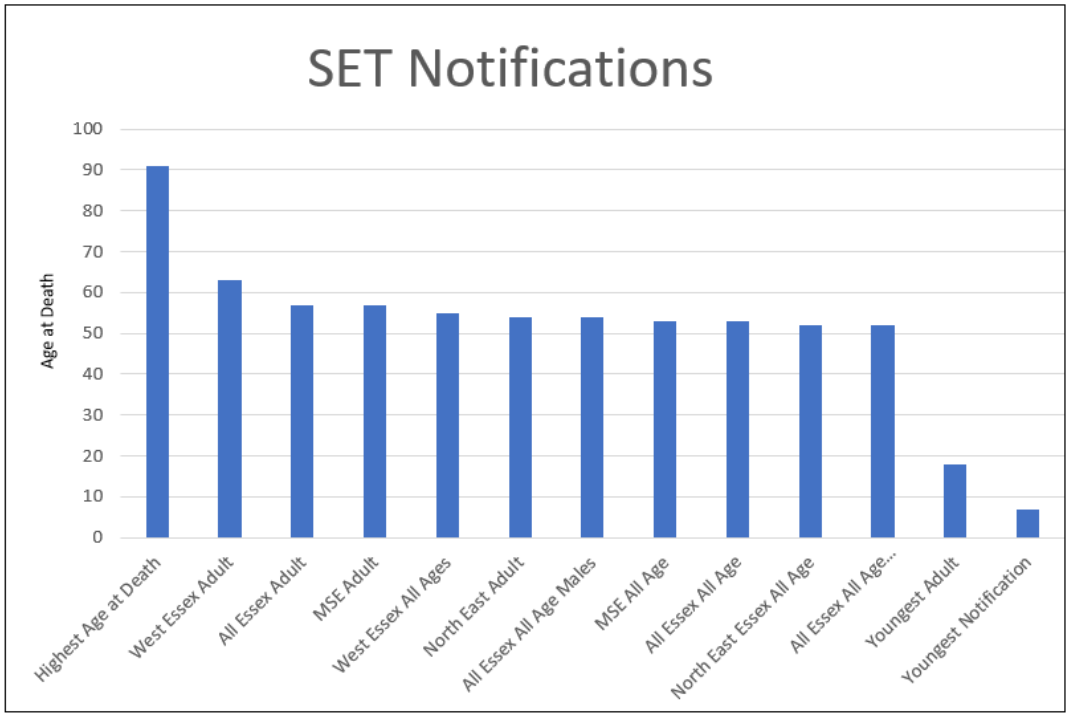
Age at death by notification

The King's College National LeDeR report 2021 leder-main-report-hyperlinked.pdf (kcl.ac.uk) highlighted that the median age at death was 61 for males and 60 for females based on notifications. Males with a Learning Disability died 22 years earlier than in the general population and females died 26 years younger than the general population.

Notifications in 22/23 for Essex show a drop in average age of death overall.

Last year the median average age of death was 65.5 years. This year we have broken down the average ages by sex and by ICB area.

Average Age at Death



The median average age at death for adults in Essex in 2022-23 was 57. In West Essex the average median age was a little higher at 63, but this is impacted by the small sample size and two 80+ notifications. In North East Essex the average age is lower at 54, but again this is influenced by the small sample size and two young adult deaths. The average age of death in MSE is 57, in line with the average age overall.

The reasons for this are not fully understood, and contrary to how it may first appear, not all negative. We have a few notifications for the deaths of very young adults who have outlived their initial prognoses, which is to say that they might have been expected to die in childhood, except for the very good care from family and professionals. This has the effect of decreasing our average age at death for adults, but not the average age at death overall.

Another reason we think the average age has gone down is because of the higher numbers of notifications we received during the peak of the covid-19 epidemic, when our average age at death actually increased. We think that some of the oldest adults died during covid, who might otherwise have died in 22/23, and therefore some of the oldest people are “missing” from this year’s numbers.

In the 2020/21 annual report there was 50 notifications for people between 60-69, 52 notifications for people between 70-79, 11 notifications for people above 80 years of age. In

the 2021/22 annual report there was 32 notifications for people between 60-69, 22 notifications for people between 70-79 and 15 notifications for people over 80 years of age.

As you can be seen from the evidence above, we lost a significant number of people above the age of 60 during covid. Especially when we consider that there are only 113 death notifications this year. Which is the same number as the number of adult's deaths that were over 60 when notified to LeDeR in 2020/21. Then in 2021/22 there were 69 people deaths notified of people over 60 which a significant number. It is important to note data shows the significant impact covid 19 had on our older adults with learning disabilities between 2020-2022 and therefore explains the lower average age of death in 2023.

We are determined not to allow the impacts of Covid-19 have a long-term impact on people's health and social care, and we are paying particular attention to some key areas in 23/24 and beyond to hopefully ensure that this is not a downward trend. This includes:

Monitoring uptake of Annual Health checks and completion of a Health Action Plan

Monitoring uptake of screening and vaccination working with Public Health colleagues to reduce un-necessary exclusions, including desensitisation work

Highlighting the importance of face-to-face appointments, especially where the patient is non-verbal or needs support with communication

Highlighting any variations from NICE guidelines, especially where this may result in late detection of cancer or late diagnoses

Working with Provider Quality Innovation to roll out training in key areas to care and support personnel in Essex.

For clarity the average age of death is calculated by omitting any notification under 18 years of age and then determining the average age of death amongst the adult notifications. This helps provide a realistic average age of death within the limitation of a small sample size.

Sex and Gender

During the LeDeR process, some aspects of healthcare we review is specific to the sex of the person who died, for example some of the screening offered.

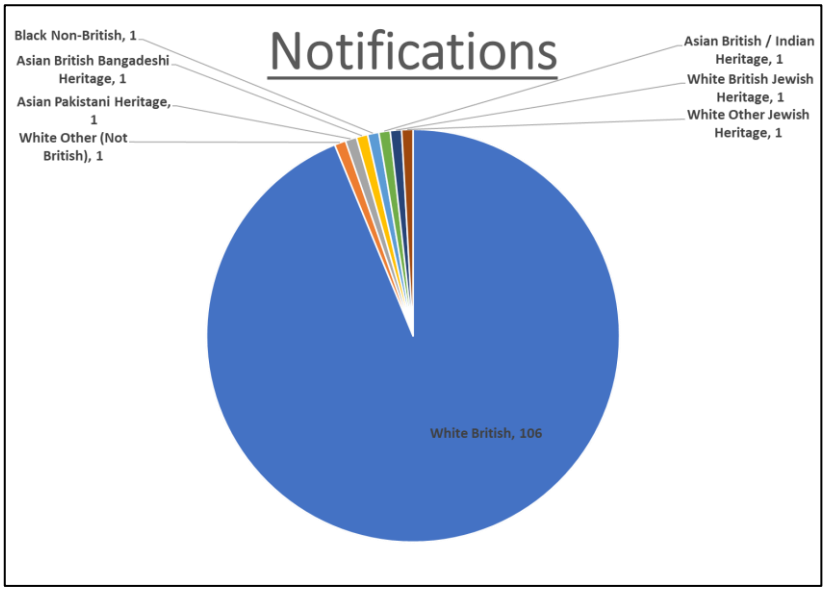
We received very similar number of notifications for women and men (56 female, 57 male), and also completed reviews for a similar number (55 female, 59 male).

We are able to record if a person who died identified as being a different gender to their biological sex, but so far we have not completed a review where that has been noted as the case. As conversations around sex and gender identity are becoming more normalised, we predict that this may change, and also if we start to be notified about more deaths of autistic people.

Ethnicity by completed reviews

The 2019 National LeDeR Report found that people from minority ethnic groups died at disproportionately younger ages than white British people. Nationally, of those who died in childhood (ages 4-17 years), 43% were from minority ethnic groups.

SET has a significantly lower number of deaths in people from minority ethnic backgrounds In 2022/23, only 7 LeDeR reviews were completed for people with a minority ethnic background and the rest were white British.



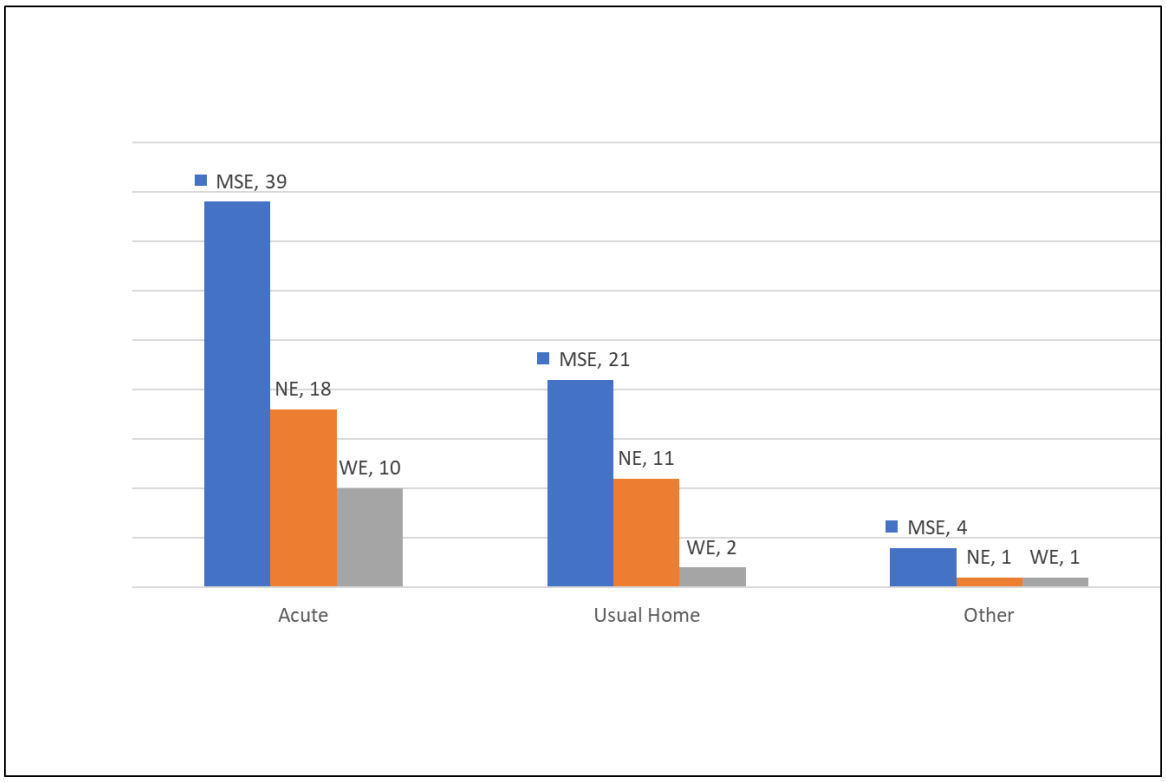
It seems likely that there is under-reporting of deaths across all minority groups. This is concerning, because it suggests that people from all minority ethnic backgrounds are less known to services for people with Learning Disability.

According to the latest 2021 census, the population in SET is predominantly white (90.4%), with non-white minorities representing the remaining 9.6% of the population. Asian people were the largest minority group in SET accounting for 3.7% of the population.

Place of death by notification

Nationally, the proportion of people with learning disabilities dying in hospital was 61% in 2021. We know that many people say that they would prefer to die at home. The NHS Long Term Plan identifies the ambition to avoid emergency admissions, and it is understood that dying at home in familiar surroundings is regarded as a preference by a majority in the general population

Place of Death



In 2022-23, 59% of people whose deaths were notified died in an Acute Hospital. That is the same percentage as last year.

The reviews have highlighted a number of reasons why people are not able to die at home, including:

When care providers do not feel able to take a person back home, as they do not offer the level of care and support the person needs at end of life.

When there is not a clear plan for a person to stay at home to die peacefully, and they are transported to hospital unnecessarily.

When a discharge from hospital is not well planned, and the person does not have the care, medication or equipment they need to remain at home.

We also know from reviews that where palliative care teams/hospice teams are involved at the end of someone's life, there is typically good planning, and care providers and families value this support.

One reason it might appear that more people die in their usual home than actually do, is that some people might classify a place as a "usual home" even if the person had lived there for a very short time, if being placed their effectively ended their previous living

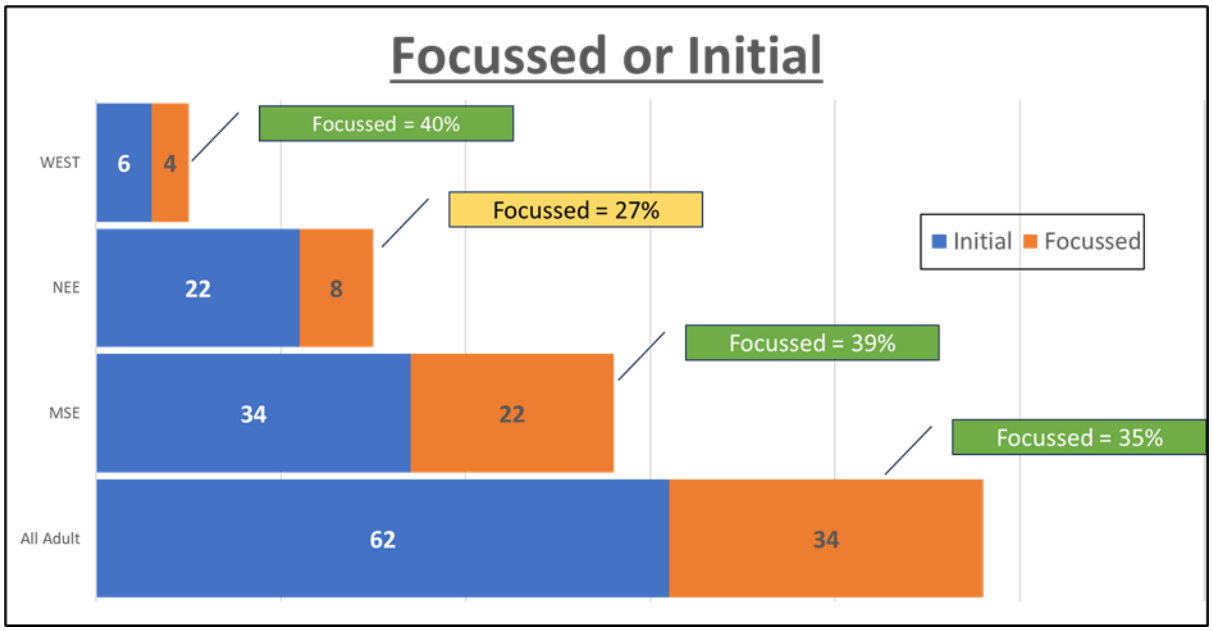
arrangement. The person with the Learning Disability may not have considered it their "usual home" and therefore it is likely that the number of people who died in the place they thought of as home is actually lower than 35.

Completed reviews

In 22/23 we completed:
10 Adult reviews for West Essex
30 Adult reviews for North East Essex
56 Adult reviews for Mid and South Essex

Adult reviews are either completed after the **Initial** review, or are selected for a more in-depth **Focussed** review

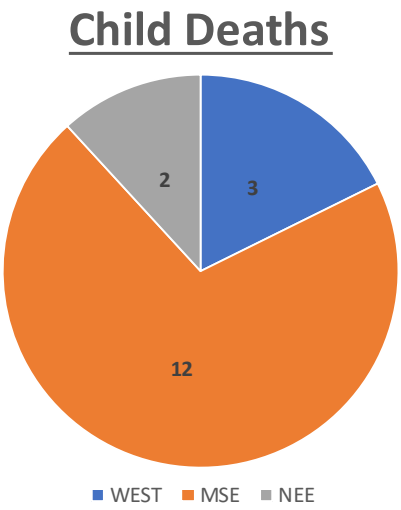
NHSE expects at least 35% of reviews to be focussed, which is in line with what we have done this year. Although the chart below shows that we are a little under 35% for NEE, that will balance out as we sign off the next Focussed reviews for completion in 23/24, which are mainly NEE reviews



The criteria for a focussed review are:

- if it is believed there will be significant or new learning,
- when the family have requested a focussed review,
- when the person has a diagnosis of Autism only,
  when the person is from a minority background.

We also completed 17 reviews of child deaths across the SET.



Total SET Deaths: 17

The child deaths are not reviewed by the LeDeR reviewers, as they are passed to the Child Death Overview Panels (CDOP), who will carry out a thorough inquiry. The Senior Reviewer will attend the CDOP if there is a LeDeR case being discussed and will receive copies of the completed review and will receive a copy of a Form C, which has details of the completed review by CDOP. Relevant learning from the Panel will be reported back to the LeDeR Steering Group.

From 1st July 2023, Child Deaths will no longer be considered under LeDeR, but the information and learning from the Child Death Reviews will be shared with the LeDeR Steering Group and analysed alongside LeDeR Data at a National Level.

Primary causes of death from completed reviews

The cause of death is described in 4 parts on death certificates:

1a disease or condition directly leading to death

1b other disease or condition (if any) leading to 1a

1c other disease or condition (if any) leading to 1b

Part 2 other significant conditions contributing to the death, but not related to the disease or condition causing it.

There are some marked differences in the leading causes of death for the general population and the individuals whose deaths were notified to LeDeR.

The most common causes of deaths in Essex recorded on people's death certificate at 1a as the primary cause of death are set out below in the table, which shows where there were three or more deaths of a single primary cause (listed at 1a on the death certificate) , or

where there were three or more deaths which are strongly related (for example Pneumonia, Community Acquired Pneumonia (CAP), and Hospital Acquired Pneumonia (HAP) are all shown, even though there was only one death recorded as HAP.

Primary Cause of Death	ICD codes		MSE	NEE	HWE	SET
Respiratory Conditions	J00-J99	Aspiration Pneumonia	14	4	1	19
		Bronchopneumonia	2	2		4
		Lower Respiratory Tract Infection/Chest Infection	3	1		4
		Respiratory Failure	2	2	1	5
		Pneumonia	12	4		16
		Hospital Acquired Pneumonia			1	1
		Community Acquired Pneumonia	1	2		3
		Covid-Pneumonia/ Pneumonitis/Covid-19	4		2	6
		Pulmonary Embolism/fibrosis	3			3
		Total Respiratory	**41**	**15**	**5**	**61**
Sepsis/ Septicaemia	A40-A41	Sepsis	2			2
		Urosepsis	1			1
		Septicaemia		1		1
		Septic Shock	1			1
		Total Sepsis	**4**	**1**		**5**
Cardiac/ circulatory system	I00-I99	Congestive heart Disease		1		1
		Congestive Cardiac Failure/ Cardiac Failure/Heart failure	4			4
		Intercerebral Haemorrhage	1			1
		Cardiac Arrest	2	3	1	6
		Obstructive Coronary Artery Disease/Atherosclerosis	1	1		2
		Dilated Cardiomyopathy	1			1
		Myocardial Infarction	1			1
		Myocarditis	1			1
		Other Cardiac	1		2	3
		Total Cardiac	**12**	**5**	**3**	**20**
Neoplasm/ Cancer	C00-D48	Metastatic Cancer	3		1	4
		Neoplasm		1		1
		Cancer of the Bowel	1			1
		Acute Myeloid Leukaemia		1		1
		Carcinomatosis		1		1
		Carcinoma	1		1	2
		Cancer of the Pancreas	1	1		2
		Total Neoplasm/Cancer	**6**	**4**	**2**	**11**
Dementia/ Alzheimer's	F01, F03, G30	Dementia	2	2		4
		Alzheimer's	1	2		3
		Total Dementia/Alzheimer's	**3**	**4**		**7**
Epilepsy	G40	Epilepsy	1			1
		Status Epilepticus	1			1
		Epilepsy Seizure			1	1
		Total Epilepsy			**1**	**3**

This shows that Respiratory conditions are by far the leading primary cause of death for people with a Learning Disability (61) , followed by Cardiac deaths (20), Cancers (11), Dementia (7) Sepsis (5) and Epilepsy (3)

For comparison, if we had reviewed a sample of deaths of people from the general population, we would expect to find the leading cause of death to be Dementia and Alzheimers (around 12 people) , followed by heart diseases (around 10 people) and chronic lower respiratory diseases (around 6 people).

Clearly there is a very great difference in the leading casues of death for people in the general population and people with a learning disability, and this continues to inform the work of the SET Health Equalities team and partners. In particular, there has been a focus on respiratory illness throughout 2022 and into 2023.

For more detail on the causes of death in the general population against the relevant ICD10 codes, the ONS website is helpful:

Deaths registered summary statistics, England and Wales - Office for National Statistics (ons.gov.uk) (accessed June 2023)

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented.

Some deaths resulting from Sepsis, Cancers, Epilepsy and Diseases of the Circulatory or Respiratory system are classified as Avoidable Deaths in adults under 75, which make up the majority of deaths notified and reviews completed.

(for further detail, please see: Avoidable mortality in the UK QMI - Office for National Statistics (ons.gov.uk) accessed July 2023)

Genetic and Long-Term Conditions (LTCs)

The online LeDeR Platform did not collect data about people's genetic or long-term conditions in a uniform way across all reviews until January 2023. This means there is not a full year's data available, however by the time of the next annual report for 23/24, this data will be available.

For this year, we have done a manual count of all genetic and long term conditions mentioned in the reviews, which may not have captured every individual case, but nonetheless this has shown us some interesting trends which we can use to shape our reviews in 23/24, and will provide a useful comparison with the data available next year. We have identified 7 areas where we want to continue to work with agencies to make improvements; these are:

Down's Syndrome

Cerebral Palsy

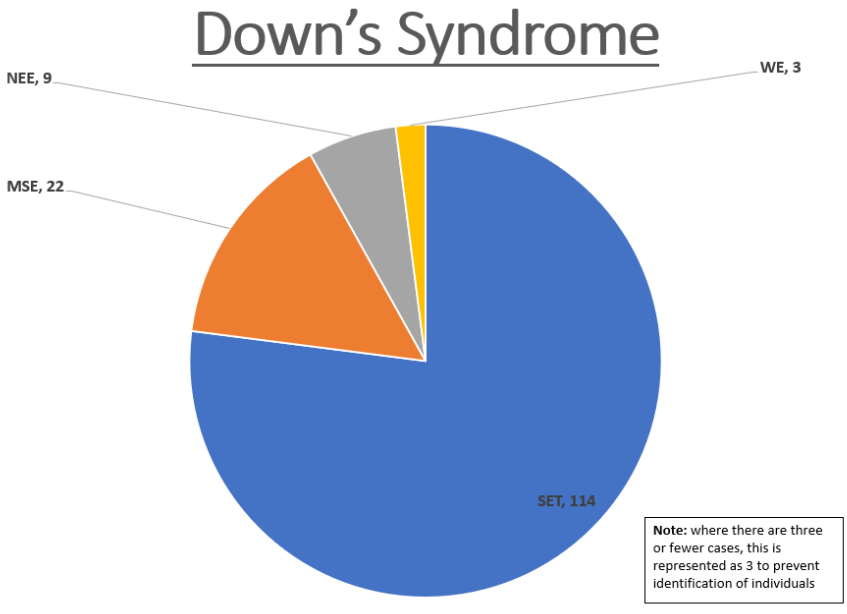
Epilepsy

Scoliosis

Dysphagia and PEG feeding

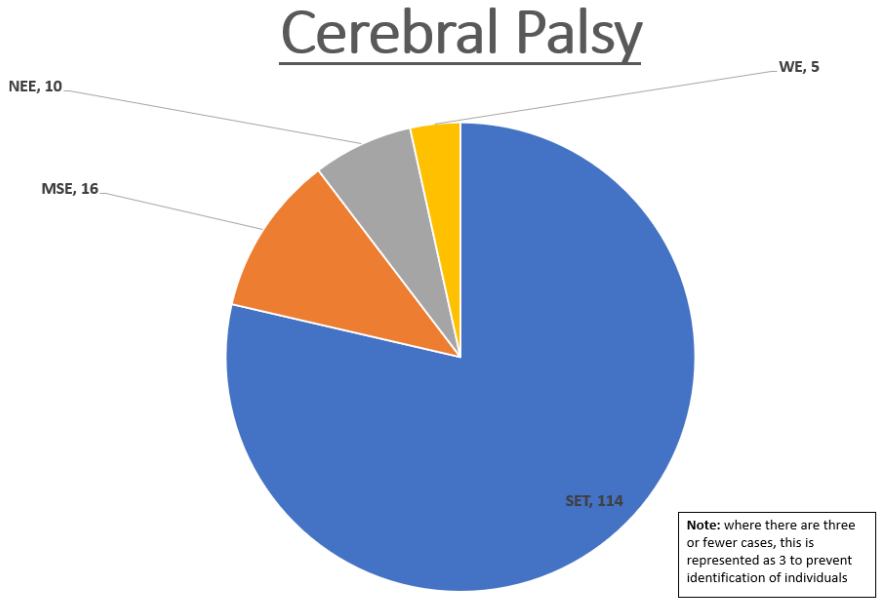
Constipation

Visual impairment

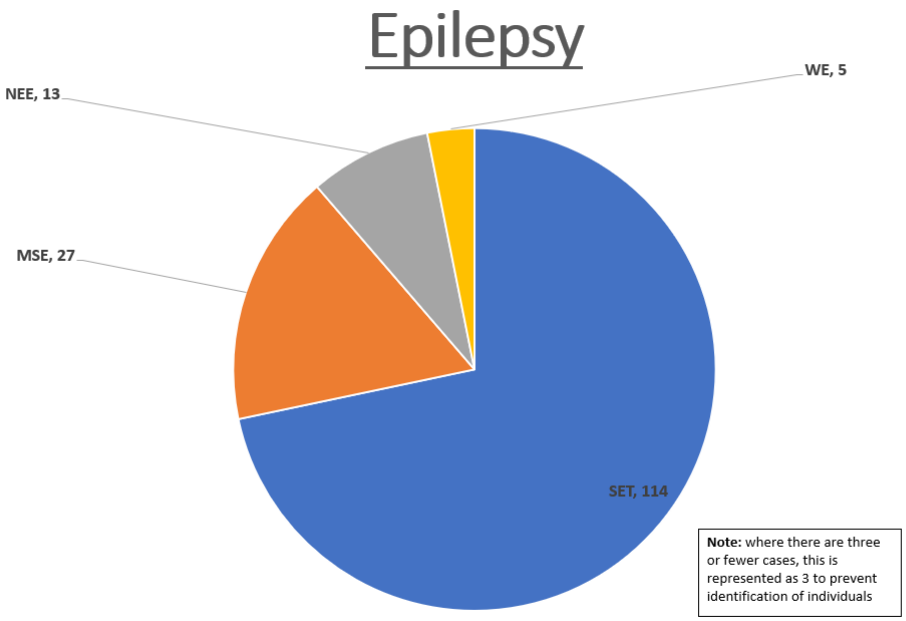


At least 34 (30%) of the completed reviews were for people with Down's syndrome. This genetic condition is associated with some other health conditions, and we should look at what reasonable adjustments we can make across health and social care to improve services for people with Down's syndrome.

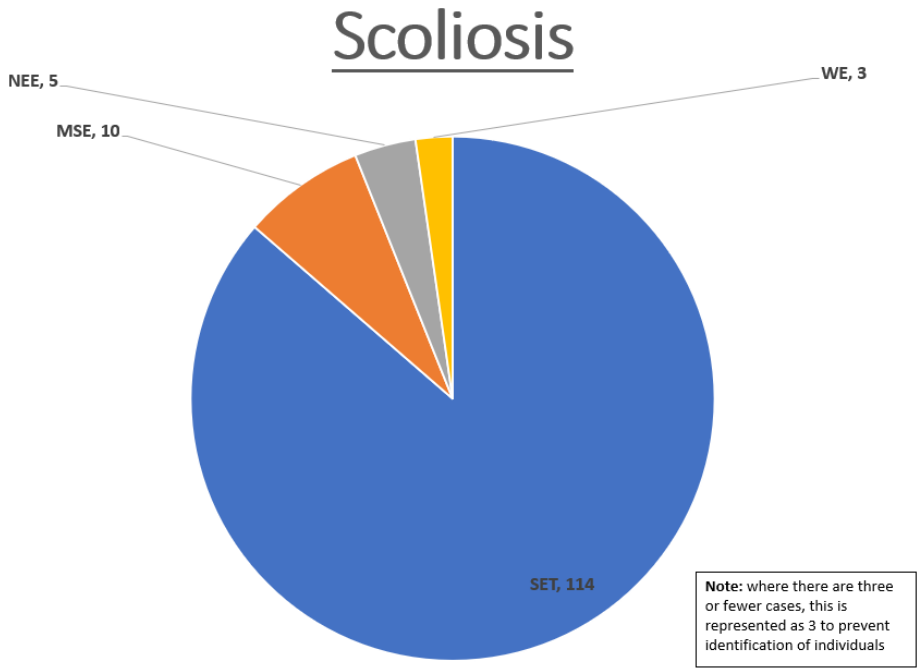
An example of this relates to dementia. Although everyone's health needs are unique, we do know that people with Down's syndrome typically experience symptoms of dementia at a younger age. We need to make sure that care providers are alert to the early symptoms, and that dementia assessment and support services do not exclude people with Down's Syndrome unnecessarily.



At least 31 (27%) of the completed reviews were for people living with Cerebral Palsy. We have noted in reviews that this group are most likely to have different perceptions of the level of their learning disability by professionals, and in particular where a person has communication needs which are not understood.



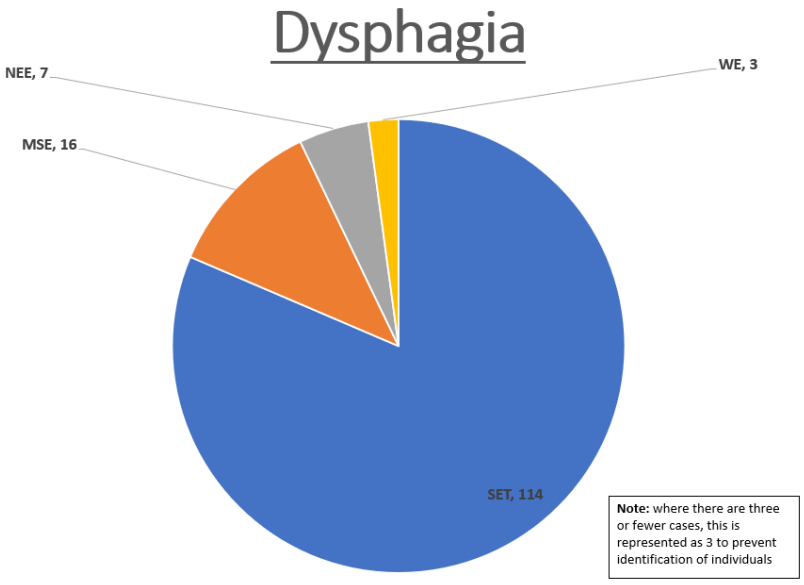
At least 45 (40%) of the completed reviews were for people with epilepsy. Many of those had well-managed epilepsy, managed through medication, with oversight from a Neurologist and or epilepsy nurse. In reviews, we are looking to ensure that care providers are appropriately trained, and that there are emergency plans and risk assessments in place. If someone has a seizure who doesn't have epilepsy, they should be referred to the First Fit clinics and fully assessed.

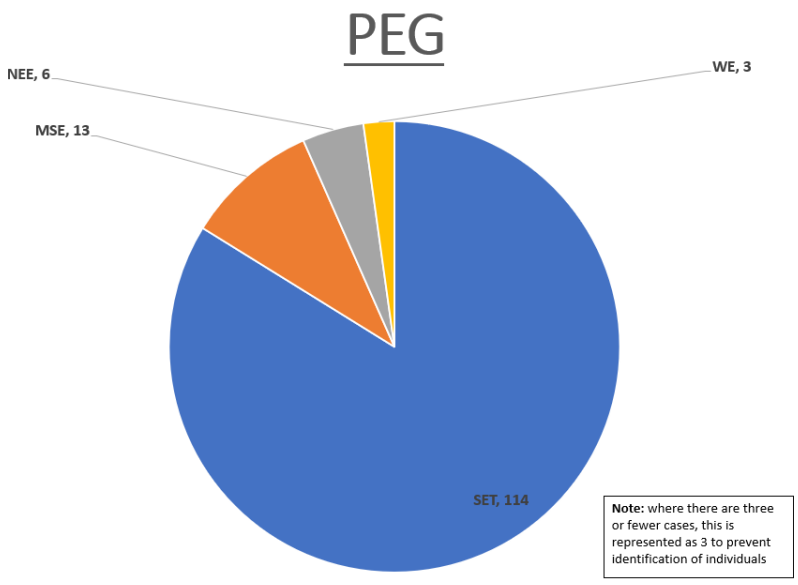


At least 18 (16%) of people had scoliosis, and we think the number could be much higher, as some reviews use different language such as "postural difficulties". Posture is extremely

important to consider when people are eating and drinking, because good posturing can reduce the risk of a person aspirating, and also important to understand how to support people with postural difference to mobilise/keep mobile, as this can also have an impact on their overall health.

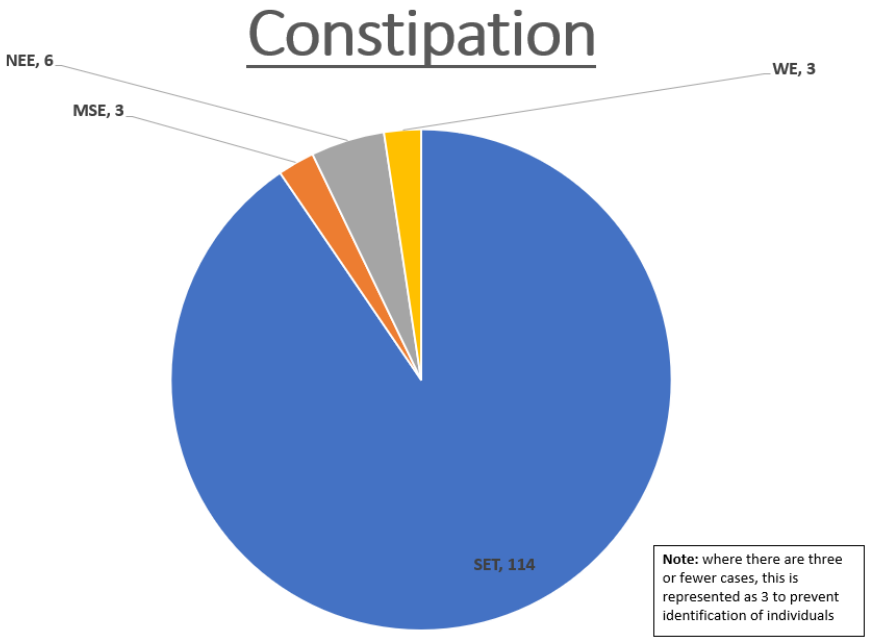
Reviews have shown us the positive influence of Speech and Language Teams (SALT) in training and supporting care providers to encourage good posture for eating and drinking, and there is evidence of good working between SALT, Occupational therapy teams, and equipment services. However, a number of reviews highlight delays in people being able to access equipment which will meet their needs, which creates a risk of health deterioration.





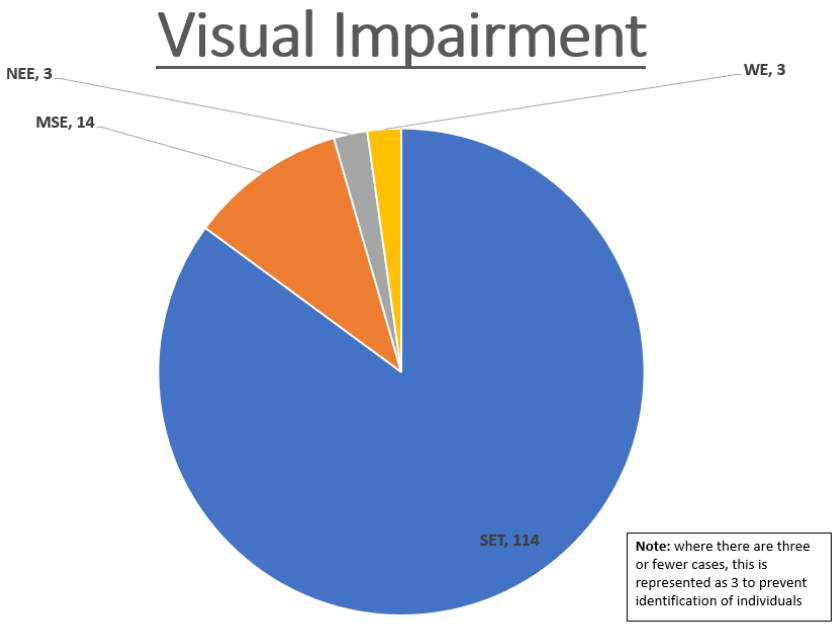
At least 26 (23%) of reviews directly talk about dysphagia, and we think the number of people affected is higher, as some reviews use terms such as swallowing difficulties. 22

reviews were for people who were PEG fed. Dysphagia is a very significant condition given the high numbers of people who die from Aspiration Pneumonia. Again, where SALT teams are involved in a person's care, they are able to support care providers to manage the condition.



12 (10%) of the reviews directly talk about the effects of constipation, and we understand how dangerous this condition can be if unresolved, and how painful. We will ensure all learning from the case of Richard Handley is carried forward into reviews where constipation is a feature.

Richard Handley: 'Gross failures' in constipation death - BBC News (accessed Jun 2023)



20 (17%) of reviews were for people with significant visual impairment. To date, we have not

made many recommendations around improving services for this group of people, and so for 23/24 we will make it a priority to consider how services made reasonable adjustments to accommodate their needs.

DNACPR numbers

Before January 2023, the LeDeR online platform did not routinely capture whether a person had a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation – sometimes called a DNR or DNAR). Again, we have manually counted and captured those reviews where reviewers explicitly state they have seen confirmation that a DNACPR is in place.

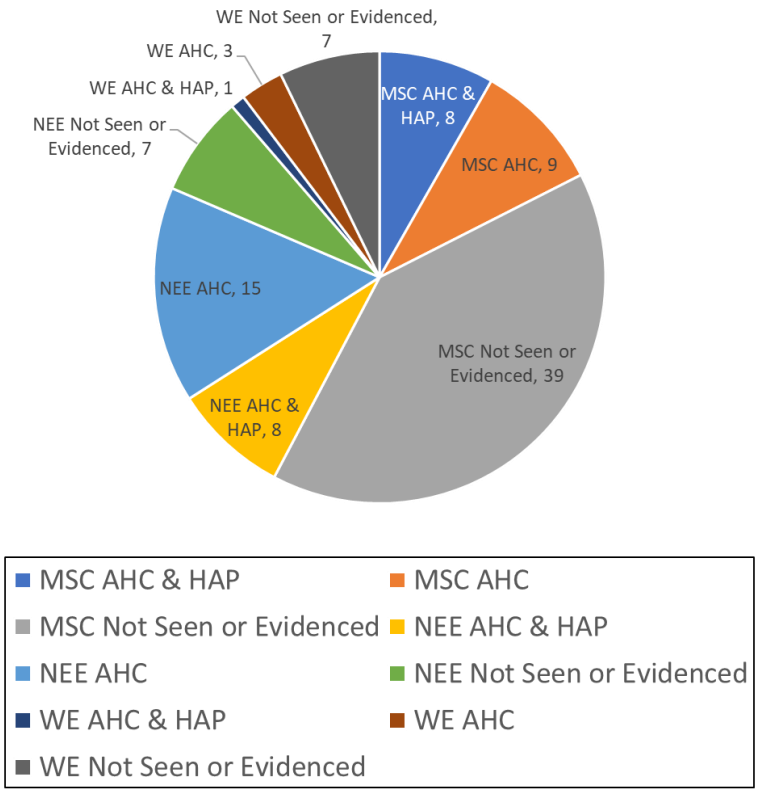
	DNACPR confirmed
MSE	55%
NEE	70%
WE	76%

The majority of reviews did have DNACPRs in place, and as part of the review process we are asked to consider whether they were correctly completed and followed. One area where we have seen improvement is that DNACPR documents sometimes used to cite Learning Disability as a clinical reason not to resuscitate. However, our Learning Disability Liaison Nurses and have been proactive at challenging this, and this is now an infrequent occurrence. We do wish to continue to see improvements in respect of consultation with the person concerned, family, carers, and the involvement of advocates. We want to see better evidence that Capacity Assessments are carried out and clear best interests decisions with rationale where appropriate, and also the involvement of an IMCA (independent Mental Capacity Advocate) especially in hospitals.

Annual Health Checks

For most of 2022/23, the LeDeR system didn't specifically ask for annual health check information to be recorded in initial reviews, although in older reviews, it is often included in the narrative. The Pie-chart below shows only the reviews where the Annual Health Check and/or Health Action Plan has been confirmed by the reviewer – we are confident that in reality a much higher proportion of Annual Health Checks are carried out, and there is targeted work ongoing to improve uptake and quality in this area.

Annual Health Checks & Health Action Plans

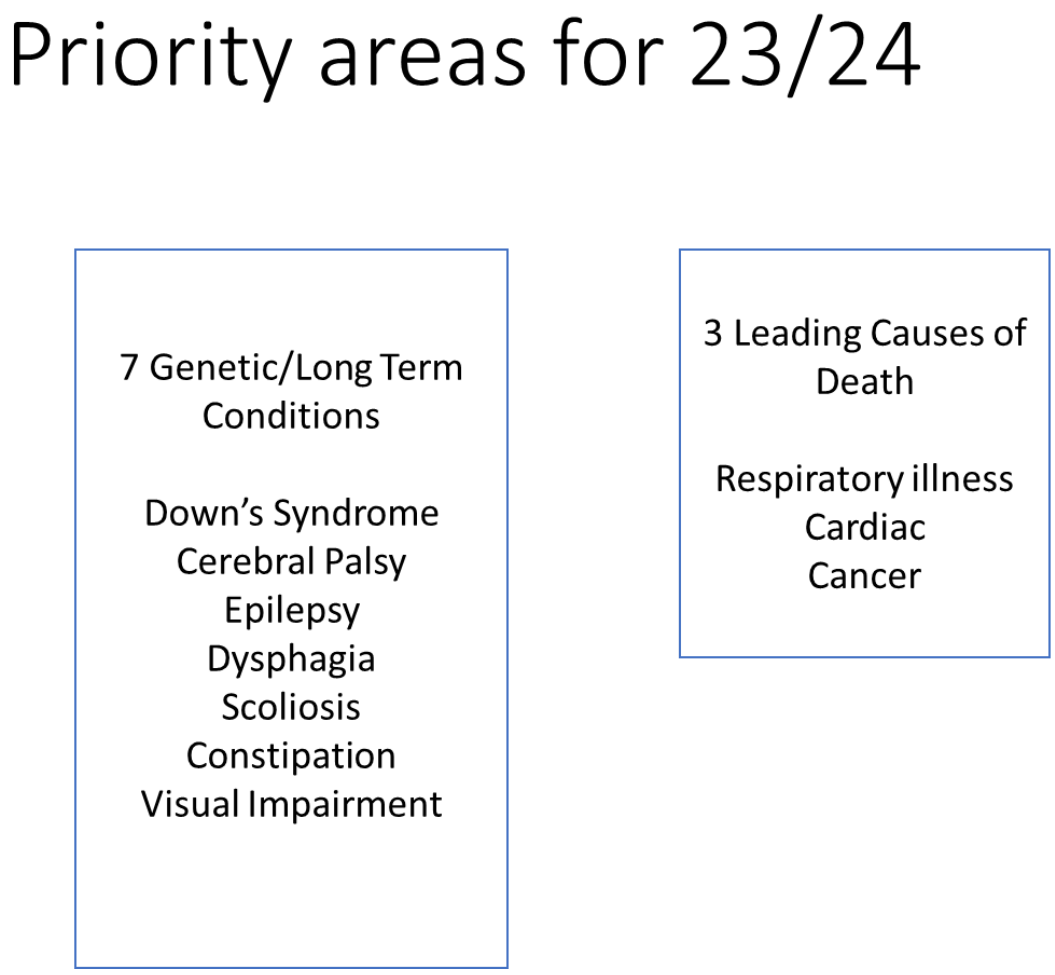


(Note – only those 14+ are eligible to receive an annual health check)

Whilst there is evidence that annual health checks and Health Action Plans are being carried out, there are also concerns raised about the quality of some annual health checks and health action plans, and improving quality is the focus of the Annual Health Check working group. We also secured additional funding from NHSE to support people who had previously missed out on a health check to attend.

Themes and learning from 22-23

Analysis of the leading causes of death and prevalent genetic and long term conditions identifies a “Top Ten” for 2023/34, to better understand the landscape and to identify areas for improvement and reduce the impact of living with these conditions.



There are also a number of consistent themes, and some new emerging themes from 22-23, including the following:

Emerging Themes from 22-23 reviews

- Systemwide need for increased focus on preventative health care
  - Weight management
  - Public health screening uptake
- Lack of advocacy
- Need for transparency around Best Interest Decisions, especially decisions not to treat
- Improved quality of Annual Health Checks, and a clear Health Action Plan
- Missed or late diagnoses
- Oral Health, access to dentistry
- Mental health, access to appropriate services
- Timely and appropriate referrals
- Planning for ageing (people with LD and their carers)
- Lack of clear pathways
- People's histories becoming "lost", family history not considered
- MCAs being carried out appropriately and correctly recorded

Autism Reviews

Although we have been able to carry out a LeDeR Review following the notification of a death of a person with Autism only (no Learning Disability), there have been very few notifications, nationally and locally in SET.

To date we have had three or fewer notifications for an individual with Autism Only. However, we have had a small additional number of notifications where Autism was the primary need, but the person had also been given a diagnosis of a mild Learning Disability. We have also been made aware of an out-of-scope death of an autistic person who did not have a formal diagnosis, which is one of the criteria of eligibility for a LeDeR Review.

In 23/24, we will make sure that every reviewer has access to Autism Training, and work with NHSE to promote LeDeR to Mental health and other professionals and supporters of people with Autism, to encourage in-scope notifications.

Summary Of Recommendations

Our key recommendations based on the themes identified within this report are:

1. **Continue to increase the number of Annual Health Checks that people over 14 with Learning Disabilities receive** to proactively identify any additional support needs they may have.
2. **A Health Action Plan should be created when an Annual Health Check is completed** to improve the health of the individual and prevent / reduce / delay the need for crisis care.
3. **Promote overall awareness of LeDeR** to increase notifications for those who have died who had a Learning Disabilities and / or Autism.
4. **Target awareness of LeDeR to those that work with individuals / communities that are Non-White British** as there is a lack of representation in notifications. Investigate if there is a connection with notifications to access to health care for these groups.
5. **Utilise reasonable adjustments to allow for face to face appointments** for those with a Learning Disability and / or Autism to enable early diagnosis of health issues and cancers.
6. **Continue to support targeted work to address respiratory conditions** that are by far the leading primary cause of death in LeDeR.
7. **Encourage use of Healthcare Passports** to make accessing services as positive as possible and to avoid histories being lost.
8. **There should be increased access to dental services both mainstream and specialist.** To achieve this, we will promote existing oral health training available for provides and unpaid carers. Alongside working with the Meaning Lives Matters Programme and other aligned projects to promote access to dental health across SET.
9. **Plans for ageing should be discussed with individuals and their carers.** To ensure there is a clear plan for a person's future and enhance the opportunity for individuals to die peacefully in their place of choosing. This will be achieved by linking with the Essex County Council Ageing Well Programme and the Southend Ageing Well Strategy. Along with other aligned work across SET.
10. **Support the training of the workforce across SET on Mental Capacity Assessments and promote the use of Mental Capacity Assessments (where appropriate)** along with best practice of how to record them.
11. **Analyse pathways of support for those with Cerebral palsy and /or Down's Syndrome** as a priority these conditions are experienced by a significant number of people whose deaths were notified to us.
12. **Raise awareness of the other most common genetic and long term conditions** that are experienced by those whose deaths were notified to LeDeR as well as how to access appropriate support. This includes Epilepsy, Dysphasia, Scoliosis, Constipation and Visual Impairment.
13. **Promote the importance of advocacy to people with Learning Disabilities and / or Autism across the health and social care system.** Work with commissioners across SET to understand the existing as well as future offer, the eligibility and promote the

use of advocacy. Use of a formal or informal advocate to be flagged in future reviews.

NHS England LeDeR Annual Report

The themes identified in this report mirror a number of the recommendations made in last year's National Report (2021 LeDeR report into the avoidable deaths of people with learning disabilities - King's College London (kcl.ac.uk)). However, this Southend, Essex and Thurrock LeDeR Annual report 22/23 was written and published in advance of the 2022 NHS England LeDeR Annual Report which is due in the Autumn of 2023. Once the national report is published the local themes, trends and findings will be compared against the national context. Any similarities or differences between the national and local report will be reported via governance.

It is also important to note that the period the national report analyses is different to the local report as the national report analyses notifications between 1st January 2022 – 31st December 2022. Whereas the SET LeDeR Annual Report along with the majority other reports within the East of England colleagues has analysed the notifications from April 2022 to March 2023.

Highlights of Progress since Last Annual Report

Aspiration pneumonia conference – having highlighted the prevalence of Aspiration Pneumonia in the Learning Disability Cohort, as a direct result of recommendations from the LeDeR Quality panels, Provider Quality Innovation in partnership with the HE team are presenting an Aspiration Pneumonia conference for learning and sharing good practice – Autumn 2023

Ageing Well Program – is now in its second year which has been driven forward by the Provider Quality Innovation Team in partnership with Essex County Council colleagues.

End Of Life Programme – this is being led by the Provider Quality Innovation and delivered in partnership with Essex Hospices.

Health Equalities team representation on working groups for : Aspiration Pneumonia, Pneumonia, Dementia, Frailty, STOMP oversight group, AHCs

AHCs – having secured funding for additional support for people who had "missed" an annual health check, this project has delivered additional health-checks, and in particular this is shown in the AHC data collected for NEE

Digital Hospital Passports – following recommendations from the LeDeR Quality Panels, MSE Hospitals are working on a digital hospital passport which can be easily updated

Gold Standard review for Autism /Suicide – The Health Equalities team supported the development of a "Gold Standard" approach to this specialist area of reviews, and this has already been shared with SNEE ICB and is available to all reviewers

Care co-ordination and Dynamic Support register and shaping of new ELDP contract – as a result of LeDeR Recommendations, the Essex Learning Disability Partnership (Specialist health) has adapted the provision to include a care-co-ordination role, and in addition the dynamic support register is in place, and key personnel actively involved in LeDeR will be involved in shaping the next contract

ReSPECT is currently being rolled out**.** ReSPECT is a process that supports meaningful conversations between one or more healthcare professionals and people, their carers/family on how they want their future care to be given. The ReSPECT form is a summary of personalised choices for a person's clinical care in the event of an emergency when that person may not have the capacity to express those choices themselves.

The process reflects both patient preferences and clinical judgement, including a recommendation on whether CPR should be attempted if a person's heart and breathing stops. This Supports the DNACPR process and is an excellent opportunity to ensure the wishes and feelings of people with a learning disability and autistic people are captured.

Oliver McGowan Mandatory Training has commenced roll out across the three ICBs. All the LeDeR Team will eventually have received all tiers of the training

Access to sytsm1 – Laptops have been procured to allow the review team access to released flagged GP records, which should assist in the quality and timeliness of reviews being completed.

Report Origin & Endorsements

This Southend, Essex and Thurrock LeDeR Annual report 22/23 was written in accordance with the requirement from the NHS. The report is commissioned by the Learning Disability Health Equality Board and formally signed off by the SET LeDeR Steering Group.

This report is endorsed by the Learning Disability / Autism Health Equality Board which is led by:

Nick Presmeg	(LD HE Board SRO)
Jeff Banks	(LD HE Board Vice SRO)

The report is formally signed off by SET LeDeR Steering Group which is led by:

Krishna Ramkhelawon	(SET LeDeR Steering Group Chair)

This year's report was produced by the SET LeDeR Team, the lead author was:

Suzanna Edey	(SET Senior Reviewer)

Local LeDeR contacts

If you would like any further information on the work that is happening in SET please contact:

Andrew Graham
LeDeR Programme Local Area Contact (LAC)
Email: Andrew.Graham@essex.gov.uk

Suzanna Edey
Senior Reviewer
Email: Suzanna.edey@essex.gov.uk

Appendix 1 case study – Adam

Adam's health started to deteriorate in September 2021 when his mum took him to hospital with pain in his back. She explained to the hospital staff that Adam had a very high pain threshold and that he was in a lot of pain.

They were kept waiting from 10.00pm in the evening, they were told he needed a scan as there was inflammation in his body; they were moved to another area at 4.00 and at 4.45am were told that "they didn't do scans at night" and to go home and see their GP.

Whilst in hospital Adam had been given two doses of Morphine for the pain, but was discharged with no pain relief. Adam's mum felt he had been discriminated against she said that they saw a person with a learning disability, who was overweight and who was difficult to deal with.

No information about Adam's visit to the hospital was received by his GP. Adam's mum said that Adam was angry, that they didn't help him.

Adam would find hospital's stressful due to his autism, he found being kept waiting caused him frustration and anger and this could lead to behaviours which could be seen as challenging.

Mum wrote a letter of complaint as she felt Adam had been discriminated against. She received a reply that said the doctor didn't feel he had discriminated against Adam, but he agreed a letter was not sent to inform doctor of hospital admission to A&E.

Mum took Adam to GP as she felt there was something seriously wrong. At that time, she was supporting her husband who had terminal bowel cancer. The Doctor listened to her and Adam's concerns and arranged an ultrasound. The GP referred him to liver specialist after the ultrasound for a colonoscopy

Staff at (different) hospital were brilliant, they talked to Adam and made him comfortable. They made reasonable adjustments and allowed Adam to have his Phone so he could talk to his mum through-out the procedure. After the procedure the Consultant spoke to Adam's mum and told her that it was likely that Adam had bowel cancer.

Adam was referred for a PET scan, mum spoke about how they really helped Adam through the procedure that she was allowed to be present though from a distance due to Adam being radioactive. Adam was diagnosed with terminal cancer, ring tumours, disease in nodes and liver.

She said that the learning disability liaison nurse was with them at as many hospital appointments as possible. However, the staff all took on board that Adam could exhibit behaviours that could be challenging.

Adam's oncologist was very good. She explained that though Adam's cancer was not curable it was treatable, and that immunotherapy would help. Adam also received good support from his Mental health team.

The hospice become involved in Adam's care and support.

Appointments were usually well managed, as Adam needed that the appointments happened on time. Adam would become angry if he was kept waiting.
Whilst undergoing treatment Adam was supported 24-hour care in his own home. He had a good team of support staff who mum said were more like family.

During this time the care provider business was sold, but Adam was able to keep the staff who had good knowledge of his needs.

Adam's health continued to deteriorate and becoming less aware of the people around him, and there were plans to start him on chemotherapy.

Adam and his mum wanted to arrange for Adam to come home to live. It was important that this happened whilst maintaining the same staff team. There were meetings arranged but no one from social services came and the meetings were cancelled.

All staff around Adam worked to secure a meeting with social services and his support package was changed to ensure he was able to move home to mum's house with support in place. His support staff had been helping mum while the transition was being arranged, they would bring Adam home to visit and would be on call if needed.

By the end of August 2022 Adam moves home with support in place. Mum had arranged GP transfer, hospice support transfer.

When Adam is admitted to hospital Mum stayed with him 24 hours a day. His support staff are with him in the hospital. At first, he is placed on a ward but is moved to a side ward. Adam's mum said the staff were wonderful; she was very clear that this was all staff, inclusive of Porters, catering staff, nurses, and doctors. Adam's mum remembered that Adam didn't like the noise that the drinks trolley made. The woman who pushed it would always apologise to Adam and ask if it was ok to give mum a cup of tea.

Adam's medication was explained to him and even at end of life he was given options about when to take certain medication. When Adam died the nursing staff and Adam's mum prepared his body together.

Adam's mum said that at Adam's funeral there were lots of people from the hospital who had cared for Adam and that it was very special to her that they came.

This review was taken to a focussed review, and subsequently Adam's mum has agreed to be videoed to share her experience and Adam's story, and this will be used as training within the ICB

Appendix 2 – EOY performance Data

ICS	all notifications from sep 2017 to (31/3/23)	% ics split	no (from total notifications) who are CYP	% of child deaths of ICS total deaths	No. awaiting allocation	in progress	% in progress	No. Complete	% complete	percentage of reviews completed as initial	percentage of reviews completed as focussed target >35%	
North East	209	30%	11	5%	2	27	13%	180	86%	75	25	
West	78	11%	10	13%	2	11	14%	65	83%	64	36	
MSE	403	58%	36	9%	10	45	11%	348	86%	67	33	
Total	690		57		14	83		593	86%			

KPI completion within 6 months	Number of adult deaths notifed this year from April 22	Complete within 6 months	complete outside 6 months	in progress and under 6 months old	in progress and over 6 months old	still to allocate	reviews from before April 22 (on hold or DSCRO)	No of child deaths notified this year from April	complete within 6 months	in progress over 6 months old	still to allocate	child reviews on hold from 21-22
NEE	28	3	4	13	6	2	4	2	0	1	0	0
WEST	15	4	1	7	1	2	1	3	0	1	0	0
MSE	60	14	4	26	6	10	5	7	0	3	0	0
Total	103	21	9	46	13	14	10	12	0	5	0	0

This page is intentionally left blank

19 October 2023	**ITEM: 8**
Health and Wellbeing Board	
A Health in All Policies approach to Place Shaping	
Wards and communities affected: Thurrock-wide guidance	**Key Decision:** Non-key
Report of: Karen Balthasar, Public Health Improvement Officer (Wider Determinants), Joanne Ferry, Head of Public Health (Whole Systems Obesity)	
Accountable Assistant Director: Sara Godward, Assistant Director of Public Health	
Accountable Director: Jo Broadbent, Director of Public Health	
This report is Public	

Executive Summary

Where we live, work and socialise plays an important role in our health. Both the built and natural environment make up part of the wider determinants of health and influence people's physical and mental health across the life course and can impact on health inequalities. The quality of the environment can influence many aspects of people's lives, from access to education, employment, healthcare and green and blue spaces to social connections within a neighbourhood, quality and affordability of housing, food production and availability, exposure to air, noise, and light pollution and safe sustainable transport including opportunities for active travel. The planning and management of places can help promote good health, improve access to services and reduce health inequalities. This is what we refer to as 'place shaping,' which can be defined as the 'creative use of powers and influence to promote the general well-being of a community and its residents'. It focuses on shaping an area's distinctive and unique identity and acts as the voice of the entire community.

This guidance document represents our aspirations for healthy place-shaping for existing and future residents, as set out in the Health and Wellbeing Strategy (2022-2026). It is deliberately ambitious to enable us to strive for meaningful change in policy, guidance and practice, recognising that such change can only be achieved intergenerationally. This guidance is aimed at those involved in place-shaping in Thurrock and includes the Place Leadership & Growth Board, Public Health, community development, strategic planners (Local Plan), development management (Planning), housing, transport, highways, regeneration, design, sustainability, leisure and recreation, the community and residents of Thurrock, NHS partners in the ICS, and developers, house builders and project promoters.

It sets out achievable recommendations for delivery in the short, medium and long term, which support the overall vision whilst acknowledging the Council's current financial position.

Commissioner Commentary

Supports the delivery of the Health and Well-being Strategy (2022-2026).

1. Recommendation(s)

1.1 That Health and Wellbeing Board note the contents of and agree to the publication of the 'Health in All Policies approach to Place Shaping' on the Council website.

2. Introduction and Background

2.1 This guidance document has been brought to Health and Wellbeing Board at the request of the Director of Public Health to obtain approval and assent to publish on the Council website.

2.2 This guidance document has primarily been developed to ensure the delivery of the HWB Strategy within the context of the Local Plan and broader place-shaping agenda.

2.3 In Thurrock there are many complex factors that contribute to the widening of health inequalities including a reliance on cars; poor air quality in parts of the Borough; unequal access to green and blue spaces; poor public transport and walking and cycling infrastructure; uneven distribution of affordable healthy food options; and lack of affordable housing.

2.4 Public Health's role is to influence the wider determinants to support a reduction in health inequalities through working in partnership with a range of stakeholders, across a number of systems including housing, local plan, planning and design, regeneration and transport.

2.5 The Health in All Policies (HiAP) approach is central to achieving this collaborative place-based approach which builds on the strengths of Public Health and emphasises the reach and influence of local government's many other functions.

2.6 The 'Framework for creating change' detailed in the full report is synthesised from review of multiple policy and guidance documents from across the planning and health sectors which identified similar themes presented in a variety of ways. The framework encapsulates the key themes related to place-shaping: Neighbourhood Design, Housing, Food Systems, Natural Environments and Transportation Networks.

2.7 Climate change, sustainability and health underpin each of the framework topics, and the interconnectedness of health and climate.

2.8 The report is deliberately ambitious to enable us to strive for meaningful change in policy, guidance and practice, recognising that such change can only be achieved intergenerationally.

3. Issues, Options and Analysis of Options

3.1 The final draft version of the report was completed in July 2023 and was subsequently approved by the Public Health Leadership Team, the Adults, Housing and Health Directorate Management Team, and Place Directorate Management Team.

3.2 The board will note the contents of the Health in All Policies approach to Place Shaping and provide their signoff for publication of this report on the Council website.

4. Reasons for Recommendation

4.1 It is recommended that the Board approve this document. In providing final signoff on the report the public health team and partners will be able to adopt it and work towards the strategic ambitions can begin.

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

5.1 This strategy has been reviewed and approved in its final form by the Public Health Leadership Team and Adults Health and Housing DMT, and Place Directorate Management Team.

5.2 In addition, a representative from key Place Directorate Teams, including Local Plan, Transport, and Housing, reviewed and commented on an earlier draft during a series of socialisation workshops. All feedback was considered and worked into the final version as appropriate.

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

6.1 The implementation of this guidance will supports the delivery of The Thurrock Health and Wellbeing Strategy 2022-26, specifically impacting on Domains 1,5, and 6.

7. Implications

7.1 Financial

Implications verified by: **Bradley Herbert**

Senior Management Accountant

There are no direct financial implications of noting the content of the Health in All Policies approach to Place Shaping and providing approval for its

publication on the Council website. More specific financial implications would be likely to follow from any subsequent delivery plan.

7.2 **Legal**

Implications not received at the time of publication.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The Health in All Policies Approach to Place-shaping Guidance Document aims to support and promote healthy places in Thurrock by highlighting good practice across the Framework topics of Neighbourhood Design, Housing, Food Systems, Natural Environments and Transportation Networks. This approach will be of benefit to all longer term, regardless of protected characteristics (as defined by the Equalities Act 2010). Details about health inequalities, and our role in addressing them, is included in the report. The report references integration of Health Impact Assessment with Community Equality Impact Assessment as recommended practice and recommendation for action.

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

There are no significant identified implications of this report.

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

- Health and Wellbeing Strategy (2022-2026)
- Thurrock Joint Strategic Needs Assessment Whole Systems Obesity (2017)
- Thurrock Active Travel Needs Assessment (2021)

9. Appendices to the report

- Appendix 1: A Health in All Policies Approach to place-shaping: Delivering on Thurrock's Health and Wellbeing Strategy (2022-2026)
- Appendix 2: A Health in All Policies Approach to place-shaping: Executive Summary

Report Author:

Joanne Ferry, Head of Public Health (Whole System Obesity)
Karen Balthasar, Public Health Improvement Officer (Wider Determinants)

This page is intentionally left blank

A **Health in All Policies** approach to place-shaping

Delivering on Thurrock's Health and Wellbeing Strategy 2022 - 2026

Public Health Team, 2023

thurrock.gov.uk

Foreword

An introduction from the Director of Public Health

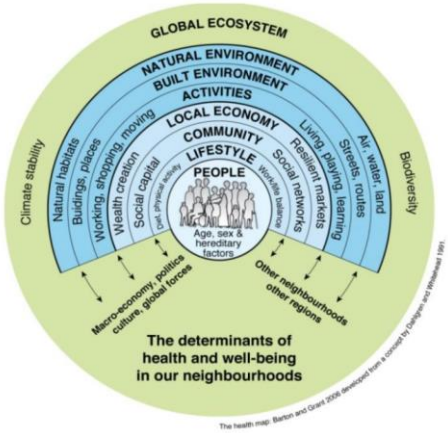
Where we live, work and socialise plays an important role in our health. Both the built and natural environment make up part of the wider determinants of health and influence people's physical and mental health across the life course and can impact on health inequalities. The quality of the environment can influence many aspects of people's lives, from access to education, employment, healthcare and green and blue spaces to social connections within a neighbourhood, quality and affordability of housing, food production and availability, exposure to air, noise, and light pollution and safe sustainable transport including opportunities for active travel. The planning and management of places can help promote good health, improve access to services and reduce health inequalities. This is what we refer to as 'place shaping,' which can be defined as the 'creative use of powers and influence to promote the general well-being of a community and its residents'. It focuses on shaping an area's distinctive and unique identity and acts as the voice of the entire community. (1) (2)

Source: ChangeLab Solutions

The factors that influence our health are multiple and complex. Most of these factors lie outside the health and social care system, with these services only accounting for up to 25% of health outcomes. It has been estimated that socio-economic and physical environments determine approximately 60% of health outcomes. These are known as the wider determinants of health. Focusing on wider determinants is essential for improving population health and wellbeing and reducing inequalities. (3)

The King's Fund highlight the following wider health determinants, all of which are included within Thurrock's Health and Wellbeing Strategy 2022-2026, as being crucial drivers of population health:

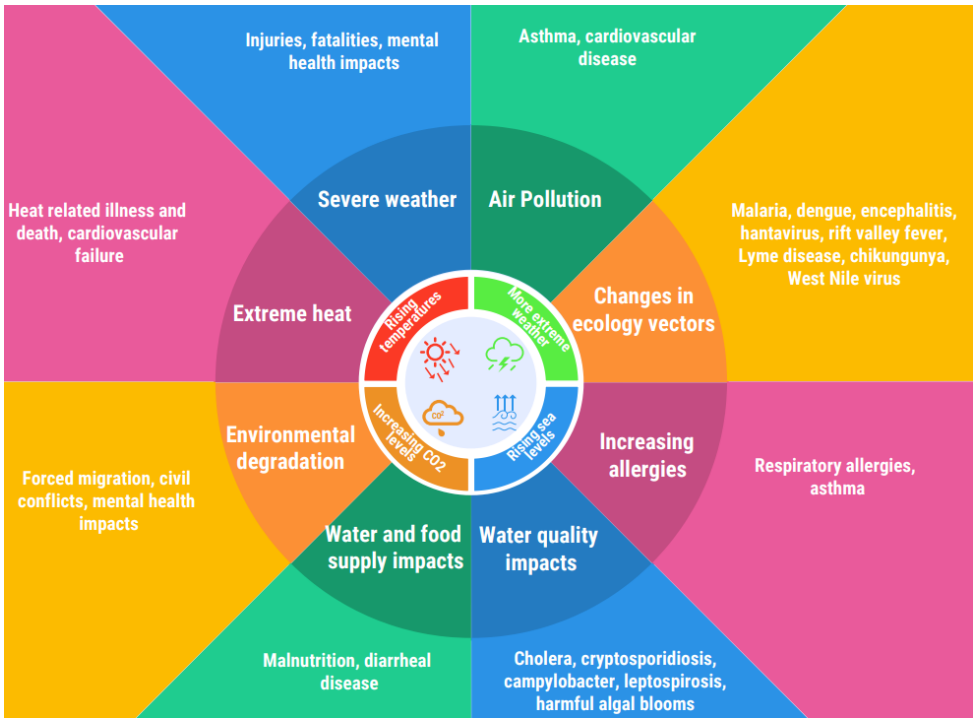
- Spatial planning
- Access to green spaces and leisure
- Transport and active travel
- Built and green environment
- Housing
- Best start in life
- Warmer and safer spaces
- Strong and resilient communities



However, in the public and political debate about how to improve health in the UK, the wider determinants are often left out, underestimated, or misunderstood. People tend to think of health as highly individualistic; it's the food we eat and how much we exercise. But this isn't the case, almost every aspect of our lives impacts our health and ultimately how long we will live. The Health Foundation has recently published a document, 'A matter of life and death: explaining the wider determinants of health in the UK' and an accompanying toolkit, 'How to talk about the building blocks of health' (see suggested reading below). (4), (5). This toolkit sets out how we can frame communications to tell a more powerful story about health inequalities.

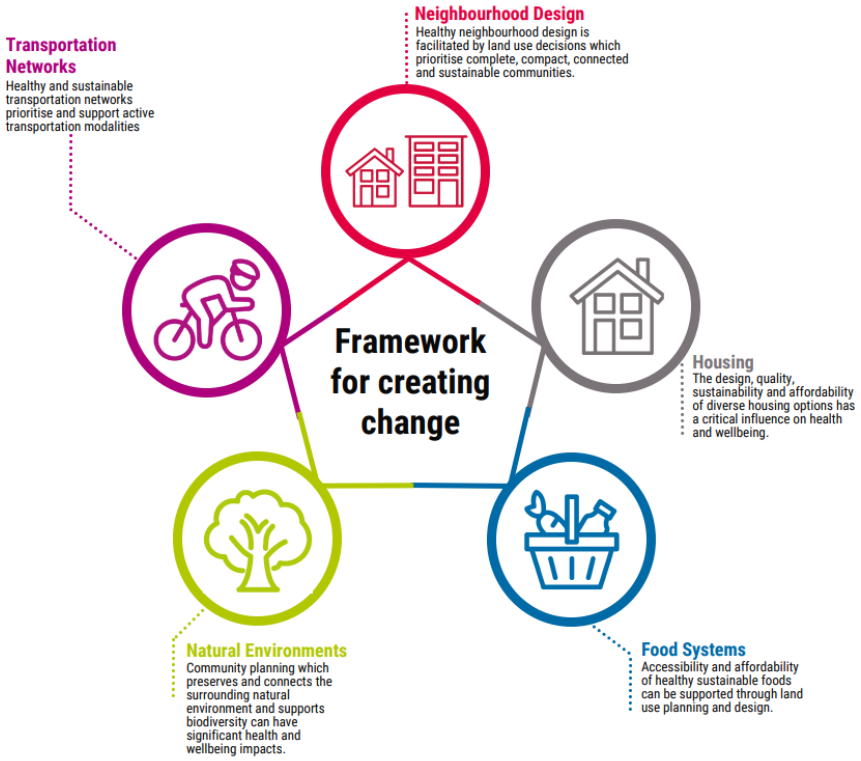
In Thurrock there are many complex factors that contribute to the widening of health inequalities including a reliance on cars; poor air quality in parts of the Borough; unequal access to green and blue spaces; poor public transport and walking and cycling infrastructure; uneven distribution of affordable healthy food options; and lack of affordable housing. Public Health's role is to influence the wider determinants to support a reduction in health inequalities through working in partnership with a range of stakeholders, across a number of systems including housing, local plan, planning and design, regeneration and transport.

The Health in All Policies (HiAP) approach is central to achieving this collaborative place-based approach which builds on the strengths of Public Health and emphasises the reach and influence of local government's many other functions. (6) The 'Framework for creating change' (below) is synthesised from review of multiple policy and guidance documents from across the planning and health sectors which identified similar themes presented in a variety of ways. The framework encapsulates the key themes related to place-shaping: Neighbourhood Design, Housing, Food Systems, Natural Environments and Transportation Networks. The model below represents the areas where design, housing, local plan, planning, regeneration, transport, leisure and recreation, environmental health and communities can have the most impact for health and wellbeing. Climate change, sustainability and health underpin each of the framework topics, the infographic above illustrates the interconnectedness of health and climate. We recognise that there are synergies across and between the five topics contained within the framework and have added relevant evidence, data and guidance under the topic which is most relevant. We have utilised the Framework icons to emphasis where issues are cross-cutting.



Source: Adapted from Merton Council APHR, 2022/23

Framework for creating change



Source: British Columbia Centre for Disease Control. Healthy Built Environment Linkages Toolkit: making the links between design, planning and health, 2018

This report provides an overview of the health and community profile in Thurrock and then presents each of the five framework topics in turn, outlining: key issues, local picture, resident voice, evidence base and recommendations, which should be considered over the short, medium and long-term. ‘Spotlight’ boxes draw attention to specific examples of policy, practice, evidence or local issues across the framework areas, whilst ‘Focus On climate change and sustainability’ boxes highlight the key related issues and opportunities. There is a further reading section at the end of the report.

This guidance document represents our aspirations for healthy place-shaping for existing and future residents, as set out in the Health and Wellbeing Strategy (2022-2026). It is deliberately ambitious to enable us to strive for meaningful change in policy, guidance and practice, recognising that such change can only be achieved intergenerationally. This guidance is aimed at those involved in place-shaping in Thurrock and includes the Place Leadership & Growth Board, Public Health, community development, strategic planners (Local Plan), development management (Planning), housing, transport, highways, regeneration, design, sustainability, leisure and recreation, the community and residents of Thurrock, NHS partners in the ICS, and developers, house builders and project promoters. It sets out achievable recommendations for delivery in the short, medium and long term, which support the overall vision whilst acknowledging the Council’s current financial position.

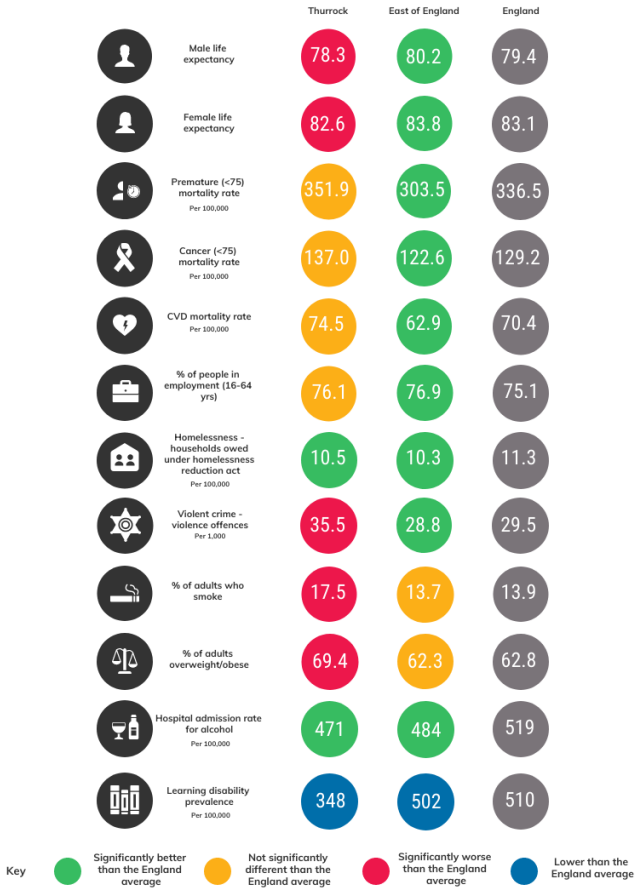
Dr Jo Broadbent
Director of Public Health

Thurrock Overview

Thurrock has a population of 175,000 and is growing. It is a relatively young place, with an average age of 36.9 years old compared to the England average of 40.2 years old. A quarter of residents are aged under 18 years. White British is the most common ethnicity reported by Thurrock residents at 77% of the population. The second largest ethnic group is Black/African/Caribbean and Black British at 9% followed by all other White at 7%. (7) It is estimated that 3,120 people have a learning disability, which accounts for just under 2% of the Thurrock population.

The most recent deprivation scores show that Thurrock has several areas that fall within the 10% most deprived locations in the country, but also some areas that fall within the most affluent in the country.

The more deprived areas are mainly located in and around Tilbury, with further areas in South Ockendon, Grays and areas of Corringham also suffering from higher levels of deprivation. Less deprived areas tend to be found in Thurrock's more rural locations, around South Chafford, and in some areas to the north of Grays. Just under a fifth (18.6%) of children live in poverty, and there is a high percentage of older people living in deprivation[1].

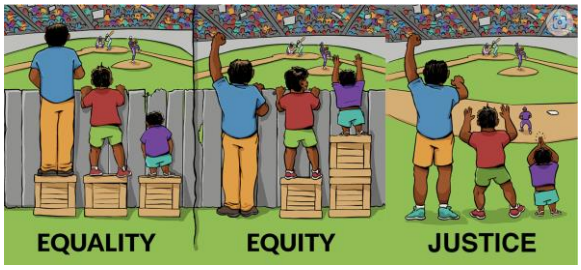


Source: Thurrock Health and Wellbeing Strategy, 2022-2026

There is variation in health outcomes across Thurrock. Life expectancy for both men and women in Thurrock is significantly worse than average for England for both men (78.3 years vs 79.4 years) and women (82.6 years vs 83.1 years). (2). More information about the health and community profile of the Borough can be found in the **Thurrock Health and Wellbeing Strategy 2022-2026.**

Health Inequalities

Health inequalities are unjust, avoidable and unfair systematic disparities between different groups of people. (8) The work of Public Health focuses on narrowing the gap between the most and least advantaged by trying to remove barriers and create equity. Public Health's primary aim is to create an environment which empowers and enables people and communities to achieve wellbeing across all aspects of their lives, while also addressing systematic health inequalities.



Source: Adapted from Interaction Institution for Social Change

[1] The Income Deprivation Affecting Children Index (IDACI) measures the proportion of children 0 to 15 years, living in income deprived families. The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. They are subsets of the Income Deprivation Domain which measures the proportion of the population in an area experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

Levelling the playing field in Thurrock

The Health and Wellbeing Strategy focuses on levelling the playing field in Thurrock:

Smoking and obesity are key drivers of unequal health outcomes. Both smoking and obesity are significantly worse in Thurrock than across England and drive premature deaths from health conditions such as heart disease.

Around two thirds of people with **long term health conditions** such as high blood pressure and mental ill health are not diagnosed and not receiving support. We know that certain communities have higher rates of these conditions including people living in less affluent areas, men, people with learning disability, young people and older adults, unpaid Carers, certain minority ethnic groups, LGBTQ+ people.

People who felt most lonely and disconnected from their local community prior to COVID-19 in the UK now have even higher levels of loneliness. This includes young people, people living alone, those on low incomes, who are out of work, or living with a mental health condition and / or learning disability.

Residents are concerned about the **ease of seeing a GP**, and we know that access and capacity in Primary Care differs across the Borough, and sometimes within the same ward. **Quality of care** also varies for both physical and mental health conditions.

Educational attainment is generally good across Thurrock, but children who are NEET, have SEND, are Children Looked After or In Need, and from some minority ethnic groups do not achieve the same levels as their peers. While overall, 61% of GCSE pupils in Thurrock achieved 9-4 in 2019, only 10% of pupils with three disadvantages did.

The proportion of **adults in employment, the claimant count and the impact of economic growth** varies between communities in Thurrock. Groups that experience inequality in employment include 18–24-year-olds, those living with a physical or learning disability and those with chronic diseases such as serious mental illness and musculoskeletal conditions.

Housing affordability is a major challenge in Thurrock, with over half of households not being able to purchase a home in the Borough.

The **fear and risk of crime** continues to be a challenge for many community groups. The rates of recorded **violent crimes** are higher in Thurrock compared to England and have risen sharply since 2013. The Thurrock Youth Offending Service are seeing young people with a more entrenched pattern of offending and a greater degree of complexity and risk. National data indicates that 1 in 5 working-age women have experienced sexual violence

Source: Thurrock Health and Wellbeing Strategy, 2022-2026

Local Policy Context

The ***Health and Wellbeing Strategy*** 2022-2026 focuses on six broad domains aligned to the Council's corporate priorities of **People**, **Place** and **Prosperity** and aims to address the wider determinants of health. (2) The Domains are:

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

Backing Thurrock is a five-year Economic Strategy focused on supporting economic recovery, resilience and growth. The vision is for Thurrock to recover from the economic impact of the pandemic and return to growth that benefits residents, local businesses and the Borough as a whole. It aims to strengthen and grow the local economy so that it is sustainable and inclusive, making Thurrock a more resilient place and positively contribute to securing the well-being of everyone in the community. The current strategy's roadmap action plan is underpinned by three key goals, namely: enabling economic recovery; building resilience and; a return to growth. **(9)**

A refresh of the Backing Thurrock Economic Growth Strategy is currently being undertaken, with a view to publishing the strategy and action plan by late 2023. In parallel to this the **Green Growth Action Plan** is being developed and aims to align economic growth with carbon reduction in Thurrock's key sectors to help realise the UK's net zero ambitions.

The ***Local Plan*** sets out and helps to shape how land uses and places will change and develop in the future. The Local Plan offers a unique opportunity to systematically address some of the wider determinants of health within the Borough. This includes environmental, living and working conditions and the social and community networks which have been identified by Dalgren and Whitehead (1991) and later by Barton and Grant (2006). (10), (11)

In early 2014 the Council began work on a new Local Plan; the intention is to adopt this by the winter of 2025. It will cover the period up to 2040 and will endeavour to deliver circa 32,000 new homes over the course of its lifetime across five identified strategic character areas and within nine potential growth areas.

Part of this work aims to develop a better understanding of these growth areas and Thurrock as a place. The Local Plan team are developing some placemaking intelligence packs which will be supported by the 'live' Ward level health and wellbeing profile cards which the Public Health Intelligence team are creating.

The ***Thurrock Design Charter*** and ***Design Code*** act together to promote high-quality design in the Borough and provide clear expectations to planning applicants on design requirements for development. The Thurrock Design Charter sets out the vision for the design code, articulated around a series of high-level objectives and aspirational themes that describe the importance of good design for Thurrock and the Council's vision for the quality of local places. The Design Code itself would provide a set of simple, concise, illustrated design requirements that provide specific and detailed parameters for critical aspects of development for the borough. The purpose of the Charter and Code is both to set an aspirational vision for place quality for Thurrock, and give applicants greater certainty around expectations, hence de-risking the planning process and accelerating the delivery of high-quality homes, streets and places for the Thurrock.

Other key documents

Thurrock Climate Change Strategy - In 2019, Thurrock Council declared a Climate emergency. In response to this, the Local Plan team has commissioned Consultants to develop a Climate Change Strategy for Thurrock. This focuses on six key topics, namely: transport; energy; industry; waste; land use and food systems and; buildings and public estates. The Public Health team has fed into the development of this strategy, highlighting that the health of the planet is inextricably linked to human health and wellbeing and that a healthy planet provides us with our most basic needs:

- fertile land for food production
- safe water to drink
- clean air to breathe

Air Quality Strategy - There are currently 18 Air Quality Management Areas (AQMAs) across the Borough. Development of a refreshed Air Quality Strategy will commence in 2023 following submission of the Annual Status Report on air quality. The Council has commissioned consultants to carry out a borough-wide air quality model to provide a full and up-to-date image of the distribution of air pollution in the Borough as well as how that is expected to change over the coming years. This modelling exercise will inform the Air Quality Action Plan, enabling targeting of the areas most in need of improvement.

Thurrock Council Transport Strategy 2013 – 2026 is based on a robust evidence base and feedback from residents and key stakeholders. It sets out the aims, objectives and a series of policies for delivering transport improvements in Thurrock. (12)

Aligned to this strategy is *Thurrock Active Travel Needs Assessment*. This Needs Assessment examines the potential for active travel by exploring how the situation currently looks, identifying local needs, and describing factors that should be addressed. It outlines the actions needed to be taken to ensure Thurrock provides a coordinated and effective approach to delivering the physical infrastructure, information and support that will generate the necessary changes required to increase levels of active travel. Linked to this and driven by central Government *"Local Cycling and Walking Infrastructure Plans (LCWIPs) are used by Local Authorities to identify and prioritise investment for cycling and walking schemes from local funds and relevant national funding streams…"*

The Government has produced guidance for local authorities on preparing Local Cycling and Walking Infrastructure Plans (LCWIPs). These plans are intended to help local transport authorities take a long-term approach to identifying and delivering interventions fit for their own local areas. Local authorities are not required to adopt an LCWIP, but the Government has said that it is "keen that as many areas as possible do so". (13) In Thurrock, the LCWIP has been commissioned and is currently under development.

Thurrock Council Housing Strategy 2022 – 2027 sets Thurrock Council's direction and ambitions for housing support and services for the next five years. Through this strategy, the council aims to provide a housing service that delivers on its targets in a human and empathetic way. It recognises that housing and health are intrinsically linked and its vision aligns with the aims and objectives of Domain 5 of the Health and Wellbeing Strategy. It sets out eight core principles: What is important to you?; right time, right place, high quality; supports health and wellbeing; minimises bureaucracy; local strength-based solutions; doesn't break the law and meets statutory duties; flexible and adaptable; and focuses on partnership working and collaborations. (14)

Active Place Strategy 2020 identifies a clear strategy to develop improved facilities for residents. It seeks to ensure that Thurrock is connected in such a way that residents can be active in their daily lives and that local communities are connected with key physical activity and cultural destinations. The Strategy is based on a suite of documents including Open Space and Play areas study, Indoor and Built Sports Facilities Strategy, Playing Pitch (and outdoor sport) Strategy, and the Active Travel Strategy. A key aspect of the combined Active Place Strategy is to guide infrastructure developers in understanding the wider needs and opportunities across Thurrock when developing new housing and infrastructure projects. This seeks to ensure that as much as possible, a holistic approach to delivering health and wellbeing outcomes is achieved from new development in the Borough. (15) A refresh of this Strategy is expected imminently.

A framework for creating change

Neighbourhood Design

Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.

What is the issue?

Neighbourhoods are places where people live, work, relax, and play and have a sense of belonging. The design of a neighbourhood impacts on the health and well-being of the people living there. Several aspects of neighbourhood design can maximise opportunities for social engagement and active travel. Neighbourhood design influences our day-to-day perceptions, abilities, and decisions and therefore have a significant role in shaping our health behaviours.

Improving neighbourhood character and infrastructure designed to promote cycling, walking and wheeling was found to be associated with numerous positive health outcomes, including increased physical activity levels and improved social engagement among older adults. Furthermore, areas of mixed land use (i.e., neighbourhoods that include green spaces), diverse housing types and high-quality public transport were found to be associated with increased physical activity levels, reduced risk of pedestrian injury and road traffic collisions, and increased social participation of older adults, among other positive health outcomes. (16)

Nineteen per cent of the population of England live in rural areas which make up 85 per cent of the land. Overall, health outcomes are more favourable in rural areas than in urban areas. But broad-brush indicators can mask small pockets of significant deprivation and poor health outcomes. There is an absence of detailed statistical information on health outcomes in rural areas, as national statistics often do not reveal differences within small areas. Rural communities are increasingly older and experience higher levels of multiple or long-term health conditions, higher levels of financial poverty and have greater need of health and care services. (6)

FOCUS ON: Climate change & sustainability

KEY ISSUES	KEY OPPORTUNITIES
Climate change should be the top priority for planning across the UK because the impacts of flooding, overheating and other consequences stand in the way of everything else we want to achieve in terms of the creation of vibrant communities and a sustainable and just society. The damaging outcomes of climate change continue to have the most severe impacts on the most vulnerable and those least able to respond. *Whilst it is important to ensure new development is resilient, there is also a need to address risks to existing building stock since 80% of it will continue to exist in 2050.*	*The core purpose of planning is the creation of healthy, sustainable and resilient places that are fair for everyone. It is not possible to achieve this aim without addressing both climate change mitigation and adaptation. Many of the adverse impacts of climate change, such as extreme heat, flooding or water scarcity, vary spatially but will result in costs to businesses and householders. Solutions to these problems need to be developed locally. There are four shared messages for planners and the wider community:* 1. *Ensure that tackling the climate crisis is at the heart of the vision for the future of our communities, recognising that actions to tackle the climate crisis are also key in creating healthy, ecologically rich, prosperous and beautiful places for us and for future generations* 2. *Recognise how vital planning is to securing that vision through facilitating the extension of renewable energy generation, and strategically, through practical nature-based solutions and design actions that can promote sustainable travel, urban cooling, or natural flood defence.* 3. *Encouraging a wide range of behavioural change, such as enabling people to make personal choices through, for example, the creation of green and walkable streets.* 4. *Building retrofit programmes designed to consider adaptive interventions, ideally alongside energy efficiency or other types of upgrades and improvements. Retrofitting nature-based solutions (such as green roofs and walls) is a good example. Effective siting can provide health benefits, support biodiversity, improve air quality and reduce carbon emissions as well as help manage flood risk and excess heat.* *Source: **TCPA**, 2021 and **ADEPT/Defra**, 2019*

What is the picture locally?

Thurrock is a place of contrasts, some areas are more urban in character, some are suburban, and others are rural. Most people in the Borough live in either urban or suburban neighbourhoods. In 2017/18 only 41% of people aged 16 and over living in Thurrock felt a sense of belonging to the neighbourhood they lived in which is significantly lower than the national average of 60%.

With a growing and ageing population it is important to consider the health and wellbeing needs of older adults (aged 65 and over) now and in the future. It is predicted that by 2035, nearly 3000 residents aged 65+ will be living with dementia, an increase of 75% since 2017. (17)[2] The percentage of older adults who live alone (an indicator of potential isolation) is 31%, similar to England although this varies by Ward with Belhus, Ockendon, Aveley and Uplands, Stifford Clays, West Thurrock and South Stifford, Grays Thurrock, Little Thurrock Rectory; and Tilbury Riverside and Thurrock Park experiencing significantly higher percentages than both Thurrock and England. Changes in demography can present challenges (social cohesion and integration) for place makers but also opportunities (vibrant, inclusive, multigenerational places).

SPOTLIGHT on emerging practice: School Superzones

School Superzones was originally piloted in London, with the aim to protect children and young people's health and promote healthy behaviours using place shaping to implement environmental actions and reduce harmful exposures in the built environment. It is a place-based intervention that creates healthy zones in the immediate vicinity around a primary or secondary school often located within the most deprived wards, or in areas with poor health outcomes. Approximately half of the Superzones in the London pilot boroughs were ranked in the most deprived 30% nationally. Focus is on the conceptual areas detailed in the infographic.

The 18-month pilot explored, tested and developed the Superzone concept in a 400m vicinity around the selected schools. The pilot established six fundamental principles that underpin the Superzones approach:

- Put children and young people at the centre
- Take a flexible approach
- Target the greatest need
- Address multiple issues
- Consider local assets and harms
- Co-produce action plans with partners

Source: School Superzones, ***PHE, TCPA, London Councils,*** *2021*

Feeling safe in the place that you live is an important factor in determining how people view and use local spaces. The percentage of residents who feel safe going out in their local area after dark varies depending on where in the Borough they live. On average, 58% of residents across Thurrock report feeling safe going out after dark. Grays Thurrock is the ward where the lowest proportion of residents' report feeling safe after dark (40%) with the highest percentage of residents living in Orsett (87%). (18) In terms of reported crime, Thurrock experienced high levels of certain types of offences in 2019/20 including violence and sexual offences (406), anti-social behaviour (267), vehicle crime (125) and criminal damage and arson (115). (19)

The quality of the local environment is impacted in part by anti-social behaviour in Thurrock. Examples include littering, nuisance vehicles, vandalism, and drug dealing and use. These factors impact on perceptions among the community of safety and the interest in communities to enjoy their local area. Residents who have a high perception of fear are likely to experience negative impacts such as poorer

[2] It is worth noting that there will be some people with dementia or depression who have not received a formal diagnosis, and therefore, the number could be much higher.

mental health, social isolation and lack of willingness to engage in health improving activities outdoors. (2) The Council has installed solar lights in Koala Park in response to young people's fears about safety. (20)

What do Residents' say?

Resident consultation was undertaken to inform the new Health and Wellbeing Strategy (2022- 2026). Feedback received on priority 6B[3] and how it might be achieved included acknowledging the impact of the fear of crime and the importance of police or authority visibility in addressing the fear of crime. There was a suggestion (a view reinforced by the Housing Overview & Scrutiny Committee) that fear of crime has increased in the Borough with many people scared to go out at night, especially in town centres and estates. Respondents acknowledged the impact of anti-social behaviour on health and wellbeing and the importance of designing out crime in new developments. (21)

Feedback also acknowledged the importance of ensuring that residents are provided with opportunities for sports, leisure, cultural and arts activities as part of supporting their health and wellbeing; particularly if services or facilities are closed or are relocated.

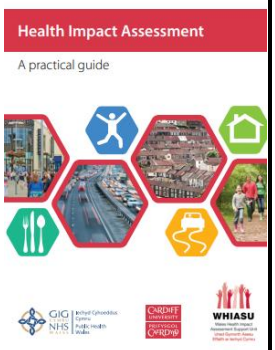
Furthermore, consideration of the importance of creating sustainable, future proofed developments including, for example, the provision of electric charging points was raised by residents. This was reinforced by Housing Overview and Scrutiny Committee. (21)

The Your Place Your Voice (YPYV) events which took place in 2018 as part of the Local Plan consultation process, gathered a range of key themes raised by residents in relation to neighbourhood design. These included the need to:

- Ensure that infrastructure is appropriately phased in relation to new development
- Focus on social infrastructure especially facilities for younger people as a way of reducing crime and antisocial behaviour
- Plan strategically for the provision of health facilities across the Borough and protect essential strategic facilities such as Orsett Hospital (22)

SPOTLIGHT on good practice: Health Impact Assessment

Health Impact Assessment (HIA) is "A systematic, objective and yet flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being. It suggests ways in which opportunities for health gain can be maximised and risks to health minimised."



There are a range of benefits of HIA across three main themes:

- **Health knowledge and action:** Increases awareness across sectors of how decisions may affect health; identifies the connections between health and other policy areas and; co-ordinates action between sectors to improve and protect health
- **Organisational development:** Potentially reduces demand on NHS and social care services by investing in healthy policies, programmes and projects that prevent ill-health; makes the decision-making processes more transparent and; promotes evidence-based planning and decision-making
- **Communities:** Promotes greater equity in health; proposes actions to maximise health benefits and minimise the health risks; involves the communities who will be

[3] Goal 6B: Work in partnership to reduce local levels of crime and opportunities for crime to take place, which will result in fewer victims of crime and make Thurrock a safer place to live

affected by a proposal; supports the development of environments and services that meet local needs and; enhances public/citizen engagement

Whilst there is currently no mandatory/legal requirement for developers to undertake HIA, there is an appetite for it to form an intrinsic part of planning policy, so this is likely to change in the future. The Public Health team are supporting embedding of HIA in response to planning applications in Thurrock. As part of this they are planning to use the Housing and Planning Advisory Group (HPAG) as a mechanism for strengthening a coordinated approach across council services/departments, and in conjunction with the NHS and Essex Police, for responding to planning applications aimed at improving the health outcomes of Thurrock residents.

In parallel to this, as part of our Health in All Policies approach, we are working with the Communities team to integrate Health Impact Assessment into the Community Equality Impact Assessment (CEIA) process. CEIA, like HIA, can assess and identify early on what impacts on communities (positive or unintended) might arise and therefore plan ways to mitigate or enhance outcomes. As a Council we have a legal duty to consider the impact of our policies, strategies, services and functions for the nine protected groups set out in the Equality Act 2010. This integration provides an opportunity to elevate the status of HIA.

Source: ***Wales Health Impact Assessment Support Unit,*** *2012*

What does the guidance say?

There is a plethora of guidance, policy and research focused on the role of public health and health and wellbeing in the planning process as part of place-shaping. The most prominent documents key to place-shaping in terms of neighbourhood design are described below.

The key issues identified include:

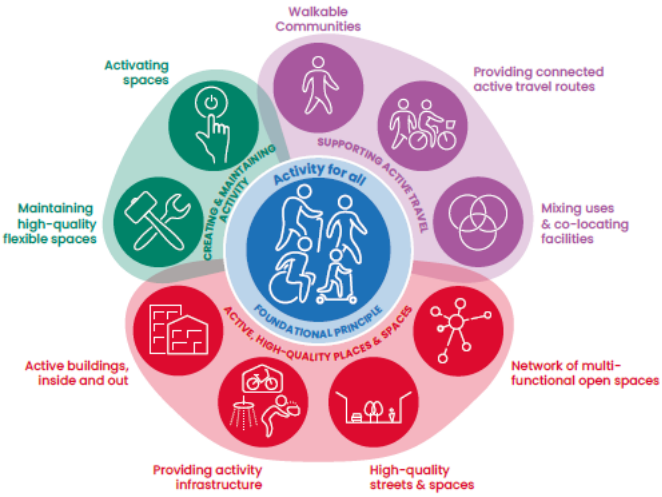
- Enhancing neighbourhood design and character to support community belonging and active lifestyles
- Ensuring that neighbourhoods (existing and new) have a wealth of services and amenities, including green spaces, that are within easy reach
- Enhancing connectivity with safe and effective infrastructure

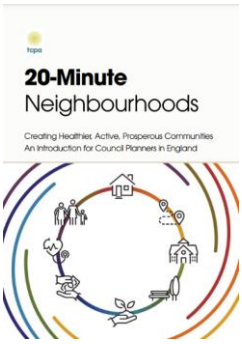
Building for a Healthy Life centres on the concept of creating places that are better for both people and nature. It is underpinned by 12 principles within three overarching headings:

- *Integrated neighbourhoods:* natural connections, active travel, facilities and services and homes for everyone
- *Distinctive places*: making the most of what's there, developing a memorable character, well-designed streets and spaces and wayfinding
- *Streets for all:* healthy streets, cycle and car parking, green/ blue infrastructure and back of pavement, front of house. (23)

Streets for a Healthy Life – A companion guide Building for a Healthy Life (Issue 2) has recently been published. See Selected Further Reading section below.

Active Design – Creating active environments through Planning and Design aims to create places and spaces which encourage people to move more, with more opportunities for everyone to increase their activity levels and lead healthier lives. The design of the places and spaces in which we live, work and play can have a significant impact on how physically active we are — either encouraging people to be more active, or by designing out the need or ability to be active. The guide outlines ten key principles for Active Design and provides useful case studies to illustrate how these principles can be successfully implemented in a variety of contexts. It has been developed with planners, urban designers and developers in mind but is relevant to anyone involved in delivering and managing the built environment.

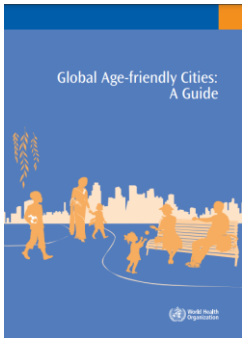




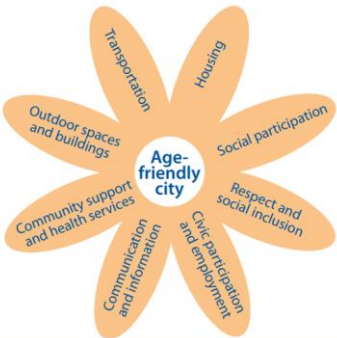
20-minute Neighbourhoods focuses on creating developments which enable residents to access amenities essential to daily living within a short walking or cycling distance. It promotes embedding of mixed-use developments to support this and centres on the liveability of places and spaces. The key features of 20-minute neighbourhoods are:

- Diverse and affordable homes
- Well-connected paths, streets and spaces
- Schools at the heart of communities
- Good green spaces in the right places
- Local food production
- Keeping jobs and money local
- Community health and wellbeing facilities
- A place for all ages (24)

School Streets – Reducing children's exposure to toxic air pollution and road danger is a practical and achievable approach to reduce children's exposure to toxic air pollution. School Streets, where traffic is restricted on roads outside schools at pick-up and drop-off times during term-times, makes it safer and easier for children to walk, scoot and cycle to school and it also encourages active travel, which brings multiple other benefits including reducing traffic and air pollution over a wider area, reducing road danger, and increasing physical activity. Evidence shows that School Streets do not simply displace traffic but reduce it overall. The report documents that high levels of air pollution in urban areas throughout the UK have a devastating impact on children's health which can be severe, long term and even deadly. The UK has a legal requirement to meet air quality limits as soon as possible. Yet achieving legal compliance is insufficient to protect children's health and we need to reduce air pollution throughout all areas as much as possible. (25)



Global age-friendly cities identifies that age-friendly cities encourage active ageing by optimising opportunities for health, participation and security in order to enhance quality of life as people age. An age-friendly city adapts its structures and services to be accessible to and inclusive of older people with varying needs and capacities, across the thematic areas shown in the infographic. (26)



What is the way forward?

The recommendations below will support a generational shift towards healthier places and people.

- The Thurrock Local Plan should ensure that new and existing neighbourhoods are designed or regenerated to accommodate and support the diverse and changing needs of individuals throughout their life course, emphasising the need for safe, accessible, well-connected neighbourhoods and spaces that support community belonging and active lifestyles

- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
    - Building for a Healthy Life
    - Active Design Guide
    - 20-minute Neighbourhoods
    - School Streets

- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and neighbourhood design

- Through cross-Council partnership and community engagement, pilot a place-based approach to improving health and wellbeing outcomes modelled on the London Superzones pilot

- Ensure that the Thurrock Superzones approach is integral to Local Plan policy and Design Strategy

Related indicators from Thurrock's Health and Wellbeing Strategy
1A: Work with communities to reduce smoking and obesity in Thurrock
• *Reducing the proportion of Reception, Year 6 children and adults in Thurrock who are obese and reducing the variation between community*
5D: Regeneration and future developments will seek to improve physical and mental health, reduce expose to air pollution and to build community resilience and reduce antisocial behaviour
• *Local Plan policies and Health Impacts Assessment for major new developments will consider a full range of health and well-being issues including for example, Active Travel and Public transport; access to green and open spaces; air quality; and the food environment* • *All council-led new build schemes will comply with Secured by Design standards* • *All regeneration and developments will increase physical activity, promote mental wellbeing, reduce exposure to air pollution, promote availability of healthy food options, enhance community resilience, and reduce antisocial behaviour*
6B Work in partnership to reduce local levels of crime and opportunities for crime to take place
• *Incorporating crime reduction approaches such as 'Designing Out Crime' and 'Secure by Design' within the council's Housing Strategy and the Local Plan*

- Ensure that a refreshed Health Impact Assessment model is embedded within the Local Plan / Design Strategy, integral to planning culture and mandated in policy

- Use the Housing and Planning Advisory Group (HPAG) as a mechanism for strengthening coordinated responses to planning applications, incorporating Health Impact Assessment principles

- Embody the 'Health in All Policies' approach through integration of Health Impact Assessment with Community Equality Impact Assessment

What is the issue?

Improved housing conditions can save lives, reduce disease, increase quality of life, reduce poverty, help avoid environmental damage and mitigate climate change. (27) The quality and affordability of housing can determine the health status of residents. Decent housing makes a fundamental difference to mental and physical health and wellbeing and can make a critical contribution to the value and effectiveness of the health and care system. It is estimated that 20% of the UK's housing stock does not meet decent home standards and that the cost to the NHS of poor-quality housing is £2.5 billion per annum.

An examination of the evidence on the influence of housing on health revealed that good quality housing (e.g., energy efficiency, housing refurbishment, and removal of home hazards) and affordable housing was associated with a variety of positive health outcomes, including improved social outcomes among older adults and reduced injury among older adults and children. Among vulnerable groups (e.g., substance users, homeless, disabled, LGBTQ+), provision of affordable and suitable housing was associated with improved quality of life, mental health and clinical health-related outcomes. (16), (27)

Source: **World Health Organisation**, 2022

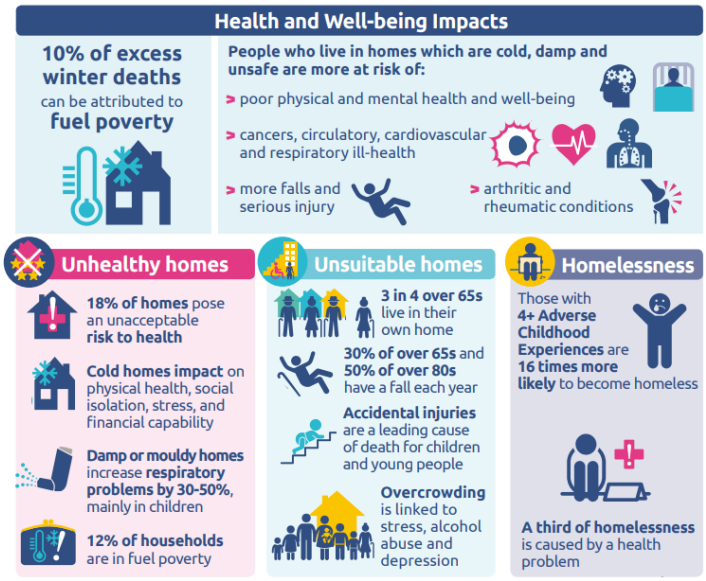
FOCUS ON: Climate change & sustainability	
KEY ISSUES	**KEY OPPORTUNITIES**
*In a recent report **'UK housing: Fit for the future?'** the Climate Change Committee (CCC) warns that the UK's legally-binding climate change targets will not be met without the near-complete elimination of greenhouse gas emissions from UK buildings. The report finds that emissions reductions from the UK's 29 million homes have stalled, while energy use in homes – which accounts for 14% of total UK emissions – increased between 2016 and 2017.* *Efforts to adapt the UK's housing stock to the impacts of the changing climate: for higher average temperatures, flooding and water scarcity, are also lagging far behind what is needed to keep us safe and comfortable, even as these climate change risks grow. Around 4.5 million homes overheat, even in cool summers; 1.8 million people live in areas at significant risk of flooding; and average UK water consumption is higher than in many other European countries. Cost-effective measures to adapt the UK housing stock are not being rolled-out at anywhere near the required level.*	*The technology and knowledge to create high quality, low-carbon and resilient homes exists, but current policies and standards are failing to drive either the scale or the pace of change needed:* • ***Retrofitting existing homes.** Ensuring existing homes are low-carbon and resilient to the changing climate is a major UK infrastructure priority* • ***Building new homes.** New homes should be built to be low-carbon, energy and water efficient, and climate resilient.* *Householders can also make a big difference, even with small changes, the report shows. This includes setting boilers to the correct temperature, installing shading and increasing insulation, which helps to lower people's energy bills and improve the comfort of their homes.* *Source: **Climate Change Committee,** 2019*

Homelessness specifically is complex and often reflects other vulnerabilities or circumstances related to health, justice or social services. Evidence tells us that the health of people experiencing homelessness is significantly worse than that of the general population, and the cost of homelessness experienced by single people to the NHS and social care is considerable. A recent audit found that 41 per cent of homeless people reported a long-term physical health problem and 45 per cent had a diagnosed mental health problem, compared with 28 per cent and 25 per cent, respectively, in the general population. The last conservative estimate (2010) of the healthcare cost associated with this population was £86 million per year. Homelessness often results from a combination of events such as relationship breakdown, debt, adverse experiences in childhood and through ill health. Homelessness and ill health are intrinsically linked and professionals in both sectors have a role to play in tackling the issues together. (28)

What is the picture locally?

The Thurrock Council Housing Strategy (2022-2027) suggests that there is likely to be an undersupply of housing compared to demand. This is one factor in the significant challenges for residents to find and secure suitable accommodation in Thurrock. Demand that exceeds supply contributes to the rising levels of housing unaffordability within Thurrock. In the private rental sector high demand has led to landlords seeking to increase rental costs, whereas in the property market demand has raised asking prices, putting first time buyers under further pressure due to the requirement for larger deposits. This undersupply has also led to fewer homes being developed to allow overcrowded families and those with adult children living at home to move into a property that is the right size for their needs and has also impacted upon the supply of new homes built with adaptability in mind.
Pressures exist not only in the private sector but also within social housing. Demand far outstrips supply for the council's stock and there is a disproportionately small amount of housing association properties within the Borough as an alternative. (14)

There are a number of health inequalities relating to housing which are important to address as part of the Local Plan, Regeneration programmes and Design Strategy. There have been significant changes in the housing market in Thurrock that have led to increased challenges surrounding affordability in the Borough for both residents attempting to find secure accommodation and for the council to fulfil its rehousing duty (29):



Source: Public Health Wales, 2019

- Between 2014 and 2019 the average house price increased by 50%, a greater rise compared to other parts of the East of England. This is exacerbated by the current cost of living crisis and leaves people at increased risk of debt, paying high rental prices and affording only poor-quality housing.
- Approximately 53% of Thurrock households do not meet the affordability requirements to purchase the smallest types of property available on the housing market.
- The average weekly cost to rent in Thurrock has increased over the past five years.
- A significant proportion of people are unable to afford their own homes or privately rent. This puts them at increased risk of home insecurity, increased risk of eviction, increased risk of overcrowding and an increased risk of homelessness.
- In 2021 there were an estimated 630 Houses in Multiple Occupation. (30) (31) [4]

[4] A property is a house in multiple occupation if both of the following apply: at least three tenants live there, forming more than one household and you share toilet, bathroom or kitchen facilities with other tenants

- 9% of households are overcrowded in Thurrock, higher than the national figure (8.7%). (32)[5]
- There are an estimated 13.4% of households experiencing fuel poverty in Thurrock. (33) (34)[6]

Thurrock's 2018 Annual Public Health Report, '**Healthy Housing for the Third Age: Improving Older People's Health Through Housing**' highlights the need to understand the current and projected future health and wellbeing needs of our older residents to ensure our future housing offer keeps them as well and independent as possible. It summarises the current and predicted health and wellbeing needs of our older residents and discusses the implications for the council, health partners and the third sector. More in-depth analysis is presented in the report. (17)

Thurrock has a range of **sheltered housing** options across the Borough for older residents, including homes for social or affordable rent, and shared ownership. Additionally, older residents in Thurrock benefit from affordable, fully accessible council homes such as Beaconsfield Place in Tilbury. This development follows the **'Housing our Ageing Population: Plan for Implementation'** (HAPPI) principles for older people's housing, offering residents independence in a home that can adapt over time to meet changing needs, such as health or mobility problems, with the ongoing support of a sheltered housing officer. (35) This scheme offers residents private communal gardens including an allotment-style space, an outdoor gym, indoor communal room with fully fitted kitchen, mobility scooter storage and ample parking. A community room on the lower floor can also be used to hold activities to benefit residents or for community groups.

Thurrock Well Homes is a scheme to improve the housing conditions and the health and well-being of residents living in privately rented properties. The Well Homes scheme:

- offers help to make homes safer by reducing the risk of ill health or accidents – for example, unsafe stairs or wiring, or providing improvements to your heating system
- puts residents in touch with health and lifestyle services that can improve quality of life – for example, help to stop smoking, health checks, debt advice, housing adaptations (36)

The Council has a duty to ensure that Houses in Multiple Occupation are licensed in accordance with Mandatory Licensing scheme as stipulated by national legislation. The Council also operates an additional licensing scheme covering 11 out of its 20 wards to protect the health and safety of tenants, reduce anti-social behaviour and remove rogue landlords from the private rented sector. Properties in poor condition can be improved via the use of legal enforcement. The council has licensed 222 HMOs over the last four years and suspect there are 212 unlicensed HMOs in 2022/23. These properties house tenants in need of accommodation but are unable to either purchase their own property, rent a whole property or are not applicable for social housing. This can include persons who are either homeless or at risk of being made homeless. Licensing helps reduce the likelihood of illegal evictions which can cost the Council money in taking enforcement action and assisting in rehoming displaced tenants. The subsequent increase in young people renting and migrant workers, has resulted in shared accommodation (HMOs) being a more common form of tenure. These people are often desperate to obtain some form of accommodation in the Borough and therefore accept accommodation below decent standards which pose health and safety risks. These are often the most vulnerable people in our society and can have a debilitating effect on their physical and mental health. (37)

Homelessness is associated with poor health, education and social outcomes, particularly for children and young people. It often results from a combination of events including relationship breakdown, debt, ill health and adverse childhood experiences. (38) **Thurrock Council's Homelessness Prevention and Rough Sleeping Strategy 2020-2025** reported that since the introduction of the Homelessness Reduction Act in

[5] A household is considered to be overcrowded if the property has one or more rooms too few in relation to the number of occupants living there.
[6] A household is fuel poor if they have required fuel costs that are above average, the national median level, and were they to spend that amount, they would be left with a residual income below the official poverty line.

April 2018 Thurrock Council has experienced an increase in the number of households which are homeless or at risk of homelessness. In 2018-19, the first year of the Homelessness Reduction Act, the number of households approaching the Housing Solutions Service increased by 15% compared to the year before. In the months between April and October 2019, the service saw a 41% increase in approaches compared to the same period in 2018-19, and a 53% increase in approaches compared to April to November 2017. (39)

Individuals or families who experience homelessness are sometimes placed in temporary accommodation while more long-term accommodation is found. A major factor currently experienced in Thurrock is the number of households being placed in the Borough by other local authorities, either within temporary accommodation or as a final placement. This impacts upon the availability of accommodation for the council to secure as accommodation for its own residents. (40) In 2020/21, Thurrock had the third highest rate of households in temporary accommodation across the East of England and the fourth highest rate when compared to our CIPFA comparators.[7]

The Homelessness Strategy goes on to emphasise the impact of sexual and domestic abuse on individuals and their families, significantly affecting both physical and emotional health and wellbeing. Those affected will often be deprived of safe, secure and suitable accommodation and will require highly specialised support as a result of the abuse which has been experienced. The Strategy made a recommendation to review and revise the existing joint protocol for supporting those at risk of homelessness as a result of fleeing domestic and sexual abuse. This is further noted in the Health and Wellbeing Strategy. (2), (39)

SPOTLIGHT on local situation: Buckles Lane

Buckles Lane site is one of the largest traveller sites in Europe and is home to over 1,975 people in 828 structures. It is known that there are many people living on the site with a range of health conditions, including: people who fell under the definition of Clinically Extremely Vulnerable during the COVID-19 pandemic; older persons with mobility issues; individuals registered with Long Term Conditions; and a likely greater number whose health conditions are not registered. 77% of the 1,975 residents are not Travelling Show People (TSP) nor Gypsy Travellers but people renting rooms in caravans avoiding the normal utility expense and council tax/business rates liabilities. There are 296 households of TSP at Buckles Lane and 634 units of Non-TSP accommodation with each equating to a household. The number of non-TSP units has increased from 467 in 2018 to 634 in 2021/22. The number of non-TSP units on site have varied with slightly higher figures between these dates. Although the number of plots occupied by TSP at Buckles Lane has slightly decreased since 2018, the number of households of TSP households has increased due to more concealed TSP households. The site is very complex and comes with a number of risks, for example, inadequate water and sewerage facilities and electrical supply issue and overflowing cesspits. In the winter period electric over-loading causes power cuts. The site is over-crowded and mobile homes and caravans are packed tightly into the plots.

In response to the findings of a recent Local Government Ombudsman investigation, the Council made a corporate decision to create a Buckles Lane Working Group, tasked with the following strategic aims:

- Continue to Safeguard all our residents, including those at Buckles Lane.
- Prevent crime & anti-social behaviour linked to the site and pursue those responsible.
- Stop the growth of unlawful development and/or additional housing of caravans and persons residing at Buckles Lane.

Activity to support and improve the site is ongoing across a number of Council teams; the establishment of the new Working Group represents an opportunity to reduce health inequalities

[7] CIPFA comparators are used to compare local authorities with similar characteristics in terms of population and other demographics such as area density.

and improve public health across wider determinants as outlined in Thurrock's Health and Wellbeing Strategy.

Source: Buckles Lane Briefing Report, 2023

What do Residents' say?

The Health and Wellbeing Strategy consultation findings highlighted residents' and committee's (Housing Overview and Scrutiny) views about the need to ensure that all types of housing are of a decent, acceptable standard and the importance of ensuring that maintenance of properties and land is considered alongside repair services. Feedback highlighted the need to address poor housing conditions in Council Stock, recognising that damp has historically been difficult to address. During the engagement and development of this strategy, many residents were concerned that the right types of accommodation were insufficiently available to meet their needs. Affordability was cited as one of the most significant barriers to securing accommodation within Thurrock with growing inflation, increasing household costs and the continuation of welfare reforms placing incomes under pressure. Residents also highlighted difficulties in accessing adapted or adaptable properties in the Borough. (14)

In relation to the provision of safe and suitable accommodation for victims/survivors of domestic violence and/or abuse, feedback acknowledged that housing is one part of the solution alongside action to deliver a single route to reduce the need for victims/survivors to have to repeat their stories and to ensure that individuals are supported to navigate the system when fleeing domestic abuse while maintaining networks of friends and community relationships. (21)

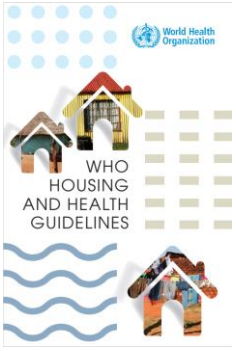
Findings from Your Place, Your Voice events suggested that residents want the council to plan for a range of housing types that address and respond to local needs and priorities. For example, it was noted that there was a specific local need for further older people's housing, and new housing (renting and ownership models) should provide a range of housing types including affordable housing to allow local people to buy and rent in the Borough. (22)

What does the guidance say?

Improved housing conditions can save lives, prevent disease, increase quality of life, reduce poverty, and help mitigate climate change. Housing is becoming increasingly important to health in light of urban growth, ageing populations and climate change.

The key issues identified include:

- Increasing provision of affordable, accessible and diverse housing
- Improving the quality of housing including indoor air quality and reduced noise pollution
- Improving the energy efficiency and climate resiliency of current and future housing stock



WHO Housing and Health Guidelines bring together the most recent evidence to provide practical recommendations to reduce the health burden due to unsafe and substandard housing. Based on newly commissioned systematic reviews, the guidelines provide recommendations relevant to inadequate living space (crowding), low and high indoor temperatures, injury hazards in the home, and accessibility of housing for people with functional impairments. In addition, the guidelines identify and summarise existing WHO guidelines and recommendations related to housing, with respect to water quality, air quality, neighbourhood noise, asbestos, lead, tobacco smoke and radon. The guidelines take a comprehensive, intersectoral perspective on the issue of housing and health and highlight co-benefits of interventions addressing several risk factors at the same time. The Guidelines aim at informing housing policies and regulations at the national, regional and local level and are further relevant in the daily activities of implementing actors who are directly involved in the construction, maintenance and demolition of housing in ways that influence human health and safety. The guidelines therefore emphasize the importance of collaboration between the health and other sectors and joint efforts across all government levels to promote healthy housing. (27)

Better housing is crucial for our health and the COVID-19 recovery suggests that the factors linking housing and health can be broadly described as follows:

Quality and condition: relating to the physical characteristics of homes, such as damp. Studies have linked damp to a number of health problems, including respiratory issues, physical pain, and headaches, particularly affecting children. Quality and condition can also include the suitability of the home, such as whether it would be considered overcrowded for the household living there. Less obvious aspects include whether the home has access to a garden or outside space, an issue brought to the fore during the lockdown. A range of studies have found health benefits to improvements in home quality, for example, a recent longitudinal study found a reduction in hospital admissions following a range of home upgrades.

Stability and security: relating to the extent to which people have control over how long they live in their homes, and how secure they feel. Owner occupiers can typically stay in their home as long as they keep up with payments (if they have any), whereas private renters typically have short tenancy agreements and can be evicted through factors beyond their control at short notice. Housing instability can act as a stressor harming health, while frequent moves can undermine engagement with health, other local services and weaken relationships in the local community.

Affordability: relating to the financial pressure caused by housing payments – both for housing itself and for utilities and maintenance. The effects of poor housing affordability are both direct (causing stress and anxiety, for example) and indirect – particularly through reducing the disposable income that people have available to spend on other things which may promote good health (such as quality food and exercise). Affordability problems can also contribute to overcrowding, as households seek to share the fixed costs of accommodation across more individuals. (41)

The impact of homelessness on health: a guide for local authorities identifies that homelessness is complex and often reflects other vulnerabilities or circumstances related to health, justice or social services. Successful homelessness strategies require all public services to contribute in a way that recognises the personal needs, strengths and assets of every household. The information and ideas in this briefing aim to support local authorities in protecting and improving their population's health and wellbeing, and reducing health inequalities, by tackling homelessness and its causes. To improve health outcomes and reduce health inequalities, local leaders in health and social care systems clearly have a role to play in preventing, reducing and ending homelessness: in systems leadership and in enabling holistic responses that have the voice of people who have experience of homelessness at their heart. (28)

Housing our Ageing Population Panel for Innovation (HAPPI) principles are based on 10 key design criteria. Many are recognisable from good design generally - good light, ventilation, room to move around and good storage - but they have particular relevance to the spectrum of older persons' housing which needs to both offer an attractive alternative to the family home and be able to adapt over time to meet changing needs. (35) They reflect:

- *Space and flexibility*
- *Daylight in the home and in shared spaces*
- *Balconies and outdoor space*
- *Adaptability and 'care ready' design*
- *Positive use of circulation space*
- *Shared facilities and 'hubs'*
- *Plants, trees, and the natural environment*
- *Energy efficiency and sustainable design*
- *Storage for belongings and bicycles*
- *External shared surfaces and 'home zones'*

What is the way forward?

The recommendations below will support a generational shift towards healthier places and people.

- The Thurrock Local Plan and Housing Strategy should be used to enable adequate provision of affordable, accessible and diverse housing across the Borough to meet the needs of an increasingly diverse population, and that existing and future housing stock addresses issues related to indoor air quality, noise pollution, energy efficiency and climate resiliency

- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
    - WHO Housing and Health Guide
    - Better housing is crucial for our health and Covid-19 recovery
    - Impact of homelessness on health – a guide for Local Authorities
    - Housing Ageing Population Panel for Innovation (HAPPI)

- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and housing

- Consider the best approach to understanding the existing living standards and health inequalities at sites housing vulnerable communities in the Borough

Related indicators from Thurrock's Health and Wellbeing Strategy
5A: Reduce homelessness and increase the supply of affordable housing in Thurrock
• *Improve residents' access to a range of affordable new build homes that prioritise providing housing for people with an established connection to the local area* • *Increase supply of good quality social housing for local residents*
5B: Facilitate and encourage maintenance of good quality homes in Thurrock to promote the health of residents, protecting them from hazards such as cold, damp and mould
• *Improving the condition of housing in the public and private sector - for example by increasing use of renewable technologies in council stock* • *Reducing fuel poverty - for example by investment in council housing, accessing Green Homes Grants for improvements in the private sector, and by improving Energy Performance Certificate (EPC) ratings across the Borough* • *Increase access to programmes such as Well Homes to benefit priority groups such as people with LTCs, physical or learning disabilities and mental health needs* • *Reduce the proportion of households in Fuel Poverty*
5C. Provide safe, suitable and stable housing solutions for people who have or who are experiencing domestic abuse / violence and/or sexual abuse / violence
• *Delivering expert advice through a single route to support regarding housing, skills, employment and other needs of people experiencing or who have experienced domestic and/or sexual abuse and/or violence.* • *Improve public awareness of how victims/survivors can seek housing support.* • *Streamlining support offer by combining three funding streams from Thurrock Women's Refuge, the Brighter Futures Programme and Safe Accommodation new burdens fund to create one service provider.*

Food Systems

Accessibility and affordability of healthy sustainable foods can be supported through land use planning and design.

What is the issue?

Local authorities are in a uniquely influential position to lead their communities and local partners to help improve the food environment and reduce inequalities. At the same time, there is potential to diversify the retail offer and help support a more vibrant high street. Many local authorities across England have already taken action, with at least 40 areas having developed policies to restrict the proliferation of excess takeaways and fast-food outlets on the high streets and around schools. (42) Local authority planners can play a vital role by helping to create a policy framework that will support sustainable food systems locally and also by integrating sustainable food into local planning and development decision making. They can enable community food growing through planning policies which support urban food growing by:

- Providing space for growing food within new developments
- Including edible plants and trees in planting schemes in new developments
- Encouraging local groups starting a community food growing space
- Protecting open space under threat from a proposed development
- Using land for food growing on a temporary basis e.g. pending its redevelopment. (43)

The food environment plays an important role in promoting a healthy diet. This is a complex system influenced by a range of factors, including affordability, accessibility and availability. Action is required across the food system to improve health and wellbeing and reduce inequalities across the population. The role of planning in creating healthy and sustainable environments, including the food system, is increasingly being recognised, specifically the need for land for both food growing and retail and encouragement for both commercial and non-commercial food enterprise. Urban food growing was found to be associated with improved attitudes towards healthy eating, increased opportunities for social connectivity and increased opportunities for physical activity. (16) Beyond planning, Councils have a role in procuring food for schools and other services, many manage waste and composting, have a role in local land use, farming and local food growing i.e. allotments, and they therefore have a significant role in shaping the diets of residents and the food available locally. (43)

FOCUS ON: Climate change & sustainability

KEY ISSUES	**KEY OPPORTUNITIES**
Farming and fishing, transport, food processing and waste is responsible for 20-30% of greenhouse gas emissions globally*. In 2019, the Climate Change Committee (CCC) stated that climate change would make it harder for the government to ensure the resilience of the UK's food supply. More frequent weather extremes would cause damage to: crops, livestock and fisheries both in the UK and around the world and farming infrastructure, biodiversity loss adversely affecting productivity. Climate change is likely to result in further volatility in domestic food prices unless the UK adapts. Climate change could lead to a 20% rise in food prices globally by 2050.* *74% of UK councils have declared a climate and nature emergency; acknowledging an urgent crisis and committing to taking steps to address it. However, most are not tackling food in a way needed to achieve net zero, or indeed restore biodiversity, halt deforestation and prevent antimicrobial resistance.*	*Some of the key actions that Councils should focus on include:* • *Finding local solutions to design-out food waste* • *Ensuring planning policy allows local areas to protect and increase land available for growing sustainable food* • *Supporting the normalisation of good diets in the public sector prioritising meals high in good quality, locally sourced fruit and vegetables, low in ultra-processed foods and meat* *Launched at the UN COP26, the Glasgow Food and Climate Declaration is a commitment by local and regional governments to tackle the climate emergency through integrated food policies. More information on signing up to the Declaration is available here.* *Source:* ***Glasgow Food and Climate Declaration****, 2023,* ***Association for Public Service Excellence,*** *2021 and* ***House of Lords Library****, 2022*

What is the picture locally?

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 food environment. (44) One factor that impacts healthy eating behaviour is ease of access (via walking or public transport) to fresh food retailers who supply healthy food options. Walking and public transport accessibility to fresh food retailers varies across different areas of Thurrock. Urban and more densely populated areas such as Grays, Stanford, Tilbury and Ockendon have better access to healthy food retailers than more rural areas. (45)

The volume rather than the distance of fast food outlets appears to be associated with childhood obesity at year 6 (age 10-11). When year 6 data (age 10/11) was analysed with the fast food outlet data, there was a relatively strong relationship with excess weight in children, when considering all of the factors which cause and contribute to obesity. This may be because this age group are typically more independent from parents and carers with more flexibility to travel to/from school and spend pocket money on food items, in addition to this group expressing more readily their preferences for specific foods and the impact of peer pressure from their social group. When looking at this association between fast food outlets and adult obesity, there is no association visible at Thurrock level. This could be affected by the fact that adults often have takeaways delivered to them from outlets in different ward areas to their home residence. (45)

The proportion of the population (aged 16 and over) in Thurrock who eat the recommended 5-a-day of fruit and vegetables on a ‘usual’ day is 51%. This is significantly lower than the regional and national percentages (56.7% and 55.4% respectively). (46) There is a strong association between an area’s Index of Multiple Deprivation (IMD) score and healthy eating; as deprivation increases, healthy eating behaviour decreases. (45) It was considered whether the location of allotments locally in Thurrock might impact on healthy eating behaviours. 27 allotment sites were identified in Thurrock in 2016, with 1011 plots, covering just over 31 hectares of land (0.19 hectares per 1000 population). When plotted against healthy eating behaviour there appears to be limited association between the locations of allotments and the prevalence of healthy eating behaviour, although this is also confounded by the relatively small number of allotments. It is assumed that residents may travel across wards to allotments. The National Society of Allotment and Leisure Gardeners (NSALG) suggests a national standard of 20 allotments per 1,000 households. Thurrock currently has approximately 75% of the NSALG recommended standard. From the perspective of affordability of purchasing food versus growing your own, and supporting people to live a healthy lifestyle, allotments provide the opportunity for physical activity, growing fruit and vegetables for consumption (increasing affordability), and also the social interaction and community benefits that being part of an allotment site provides.

What do Residents’ say?

Residents who participated in the Health and Wellbeing Strategy consultation generally agreed with the goal of preventing ill health due to obesity. Specific suggestions included using social media and other communication activities to reinforce the impact of obesity on an individuals’ wider health and wellbeing; the importance of providing safe, maintained spaces within which people can exercise including green spaces and gyms; influencing the number and locations of fast-food outlets; and the need to target hard to reach groups, working across geographical locations and communities of interest to truly level up prevention.

The views on limiting the number of or influencing the location of takeaway services across the Borough was also raised by residents attending community forums. It was felt that by doing so, this could support people to eat healthier and to halt or slow down the rise in home delivery for fast food which may be creating further challenges. (21)

The impact of the wider food environment was highlighted by the Resource, Place and Delivery Group through describing how health and wellbeing strategy goals can be aligned to the approach for regeneration. For example, creating vegetable gardens as part of regeneration to aid access to fresh fruit and vegetables. (21) Additionally, the Open Space Assessment found that there is a steady demand for the provision of allotment sites and plots across the area and demand outweighs supply. (47)

SPOTLIGHT on emerging practice: Fruit and veg on prescription pilot

"An innovative pilot, thought to be the UK's first large-scale "fruit and veg on prescription" project, has been launched to help tackle health inequalities and food poverty. Alexandra Rose Charity, in partnership with public health teams in the London boroughs of Tower Hamlets and Lambeth, has launched Fruit & Veg on Prescription as part of a £250,000 pilot funded by local authorities and Impact on Urban Health to help tackle health inequality and food poverty.

Trials in the boroughs, which both have high rates of chronic disease, will explore the viability of fruit and veg on prescription as a long-term solution to tackling diet-related ill health and food insecurity. The project launches as food prices continue to soar and fresh food inflation has reached a record 13.3%. Each person will be prescribed Rose Vouchers for Fruit & Veg and will receive up to £8 per week in vouchers, plus £2 per week for each household member. Participants can spend their Rose Vouchers on the fruit and veg of their choice with local retailers and market traders. In Tower Hamlets, they will also be invited to take part in monthly healthy lifestyle group sessions to improve their understanding of nutrition and health.

"So many long and short-term illnesses deteriorate significantly with a poor diet. A healthy diet can often achieve far more than any medicines. Therefore, fruit and veg prescriptions are essential in reversing and preventing many illnesses. When I trained over 40 years ago, Type 2 Diabetes was a disease of the elderly. We are now seeing it in teenagers. Much of it is preventable with a healthy diet and good regular exercise. Fruit and veg should be part of every prescription." - Professor Sir Sam Everington

During the 12-month pilot, Rose Vouchers for Fruit and Veg will be distributed to a target group of 122 residents across both boroughs who are at risk of, or have, conditions such as high blood pressure, diabetes or mental health conditions and are struggling financially. When the pilot is evaluated, it could be rolled out across the UK subject to funding.

Alexandra Rose Charity has also called for the government to implement the recommendations of the National Food Strategy quickly. The strategy, which has been on hold, recommended a "Community Eatwell" programme which recognised the huge potential role of empowered local communities working with primary care to radically change eating habits and health."

Source: PRESS RELEASE: Fruit and Veg on Prescription pilot launched to tackle ill health and food poverty. Posted on 7 November 2022 by Eloise Jarrett

What does the guidance say?

Historically, our towns and cities have been built around the supply and distribution of food. Today, planning can affect the food and farming system in a number of ways. Planners and associated professionals can help to create a more sustainable food and farming system that enables the general population to access healthy, affordable food.

The key issues identified include:

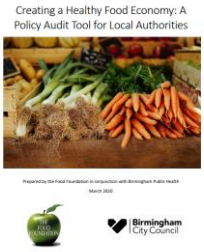
- Protecting and increasing both the number and the diversity of types of food retail outlets
- Creating and protecting food growing spaces in and around the locality
- Making the best use of our land for food and farming

National Food Strategy: An independent review for Government sets out government ambitions and priorities to create a more prosperous agri-food sector that delivers healthier, more home-grown and affordable diets for all, regardless of where people live or their income. It takes a close look at how the food system really works, the damage it is doing to our bodies and our ecosystem, and the interventions we could make to prevent these harms. It considers the characteristics of complex systems and the mechanisms that cause system failures, and sets out a strategy for the future, based not just on rigorous science but on the needs and wishes of ordinary citizens. The National Food Strategy review contains recommendations to address the major issues facing the food system: climate change, biodiversity loss, land use, diet-related disease, health inequality, food security and trade. These are grouped under four main National Food Strategy objectives:

1. Escape the junk food cycle to protect the NHS
2. Reduce diet-related inequality
3. Make the best use of our land
4. Create a long-term shift in our food culture

Transforming the food system will require change at all levels: structural, cultural, local and individual. The Strategy highlights how Local Food Partnerships have already brought together councils and partners from the public sector, voluntary and community groups, and businesses to reduce diet-related ill health and inequality, while supporting a prosperous local food economy. Further work will be undertaken to learn from their approaches and to understand and identify best practice in addressing food affordability and accessibility to healthy food. Defra will work with local authorities and food charities in these priority areas. (48)

Planning sustainable cities for community food growing brings together in one place examples of planning policies around the UK that support community food growing. It is aimed primarily at planning authorities to help them to use food growing as a way of creating healthy communities. The report is structured around the different issues that food growing helps to address, from sustainability to residential amenity via health and wellbeing, green infrastructure, regeneration and many other agendas. In each section, food growing has been woven into planning policies to meet these priorities in local areas and illustrated with examples of growing projects that have also been set up to help meet that particular agenda. The report ends with recommendations, firstly to planners with practical steps on putting these ideas into policy and practice, then more broadly recommendations to local groups about their potential role. **(49)**



Creating a Healthy Food Economy: A Policy Audit Tool for Local Authorities presents an audit tool the Food Foundation created for Birmingham Public Health on the extent to which their existing policies and programmes are creating a healthy food economy in the city. Based on existing evidence they created a conceptual framework showing the outcomes and policy outputs needed for Birmingham to have a 'Healthy Food Economy' and then used this framework to create an audit tool. To complete the audit, they interviewed 18 officials in Birmingham City Council and in a variety of other agencies and settings that have oversight and leadership on the food environment across the city and conducted a desk review of published documents and policies. The audit tool allows local areas to assess where they are making progress on food policy and where further action is needed. Completing the audit can be the first step towards creating a new food policy or strategy. (50)

Hot Food Takeaways: Planning a route to healthier communities is Sustain's guide for Councils which draws on the experience of planning authorities in collecting evidence to support and defend planning policies to restrict new hot food takeaways. Despite there being national targets for obesity reduction, there is only so much local councils can do with their existing powers. The report also calls for a series of actions to be explored on planning, design and licensing to tackle child obesity. These include:

- National Government support for local areas to increase the adoption of planning restrictions and defend existing policies by critiquing evidence regularly submitted by fast food chains.
- Explore the impact of restrictions on the sale of unhealthy food to under 16s before 6pm on school days.
- Reviewing residential space standards to ensure houses have sufficient space for food preparation, cooking, dining and storage.

The report contains recommendations for next steps for local authorities, government, campaigners and organisations. (51)

What is the way forward?

The recommendations below will support a generational shift towards healthier places and people.

- The Thurrock Local Plan should ensure that the number and diversity of food retail outlets and food growing spaces are protected and increased

- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
    - National Food Strategy
    - Planning Sustainable Cities for Community Food Growing
    - Creating a healthy food economy: A policy audit tool for Local Authorities
    - Hot Food Takeaways: Planning a route to healthier communities

Related indicators from Thurrock's Health and Wellbeing Strategy
1A: Work with communities to reduce smoking and obesity in Thurrock
• *Reducing the proportion of Reception, Year 6 children and adults in Thurrock who are obese and reducing the variation between community*
1C: Continue to enhance identification and management of Long-Term Conditions (LTCs) to improve physical and mental health outcomes for all
• *A greater proportion of people will have their LTC diagnosed and treated*
5D: Regeneration and future developments will seek to improve physical and mental health, reduce exposure to air pollution and to build community resilience and reduce antisocial behaviour
• *All regeneration and developments will promote physical & mental wellbeing, reduce exposure to air pollution, promote healthy food options, enhance community resilience, and reduce antisocial behaviour*

- Consider how future Health and Wellbeing Strategies can support the food system as it relates to human health, place-shaping and climate change

- Consider the best approach to assessing progress on food policy and identifying where further action is needed as a first step towards creating a new food policy or strategy. For example, utilising '**Creating a Healthy Food Economy: A Policy Audit Tool for Local Authorities**', which considers as a minimum:
    - Accessibility to affordable and diverse healthy foods
    - Community food growing schemes such as allotments and school growing clubs
    - Density of unhealthy fast-food outlets
    - Addressing rising food poverty
    - Engaging schools and other public institutions in improving the food environment
    - Investment in and protection of local food infrastructure
    - Reducing food waste to support tackling climate change and improving food security

- Create a dialogue with key local stakeholders, including the CVS-led Food Network, to establish the motivation for a Thurrock Food Partnership which brings together partners from the public sector, voluntary and community groups, and businesses to reduce diet-related ill health and food poverty, while supporting a prosperous local food economy

What is the issue?

Contact and exposure to the natural and sustainable environment through provision of good quality open and green spaces, increases physical activity, promotes mental wellbeing, improves health outcomes (e.g., reduces CVD mortality risk) and reduces exposure to air pollution. Furthermore, high quality built and green environments can support net-zero ambitions, promote community resilience and social capital, and reduce antisocial behaviour. (2) In addition, provision of infrastructure to support cycling, walking and wheeling that improves connectedness is associated with increased physical activity and improved social engagement among older adults. (16)

Analysis undertaken by the Office for National Statistics during the COVID-19 pandemic found that people on lower incomes reported greater dissatisfaction with the quality of their green space than those on higher incomes. The study suggested the quality of nearby green space might have affected the way people spent their time during lockdown, including reduced participation in physical activity and increased time spent in sedentary behaviour. (52), (53), (54)

FOCUS ON: Climate change & sustainability

KEY ISSUES	**KEY OPPORTUNITIES**
Our lives and livelihoods depend on our natural environment and the benefits it provides – from timber, food and clean water to pollination, carbon storage and the cultural benefits of landscapes, archaeological sites and wildlife. There are significant risks to this natural capital from the scale and rate of climate change, which may be too much for some natural systems to adapt to. *Changes to ecosystems due to temperature, sea level rise or extreme events, of which the latter are predicted to increase in frequency and severity are already occurring. Where species are unable to move in response to climate change there is a risk they will continue to decline. These issues all impact on the benefits the environment provides and are heightened because the natural environment is already under pressure. Pollution, habitat loss and fragmentation, diseases and invasive non-native species, the continuing drainage of wetlands and the unsustainable use of soil, water and marine resources all reduce the natural resilience of species and ecosystems and their ability to adjust and adapt.* *Green infrastructure is also potentially vulnerable to climate change; for example, a shortage of water could diminish the quality of green spaces and their ability to function as adaptation solutions.*	*Green spaces help to regulate temperature and water flow, reduce noise and air pollution. Nature can also play an important role in adapting our built environment, with nature-based solutions providing urban cooling and flood management as well as a range of other benefits for health, biodiversity, and the attractiveness of places.* *Local authorities can help ensure that natural capital assets in their area and the benefits and services provided by them are protected, valued and used sustainably to deliver a net gain in local natural capital. They also have a role in helping ecosystems adapt, providing new habitats that allow nature to migrate.* Source: **ADEPT**, 2019 & **Defra**, 2018

What is the picture locally?

The natural environment can promote or inhibit opportunities for physical activity. Thurrock has a key challenge in relation to the amount and quality of open space across the area, with deficiencies and shortfalls in terms of quantity, quality and accessibility identified against provision standards. However, the key focus for the Council is to maintain current open space standards wherever possible and on improving existing open space for more multi-purpose outcomes. (15)

The ease at which residents feel they can be active coupled with satisfaction with local parks, playgrounds and open space is crucial to actual physical activity levels. Residents' perceptions of the ease with which

they can exercise outside was lower among those living with a disability than without (69% compared to 75%). This indicates that improvements to accessibility need to be considered in new developments, although improvements have been made since the survey was undertaken in 2016. (18), (45)

Significantly fewer adults are physically active in Thurrock (60%) compared to the regional and national average (66% for both). (55) Fewer than 10% of adults walk for travel at least three times per week and fewer than 1% of adults cycle at least three times a week for travel. Both walking and cycling levels for travel are significantly lower than the East of England and England as a whole. This may be reflective of the cycling environment in Thurrock. (56), (57) Specific data about wheeling is not available for Thurrock.

What do Residents' say?

Feedback from residents as part of the Health and Wellbeing Strategy and Your Place, Your Voice consultations recognised the need to provide, protect and enhance safe, maintained green spaces within which people can exercise and be active. Alongside this, residents wanted to safeguard and maintain the integrity of the green belt land. (22)

A Thurrock resident survey undertaken in 2016 indicated that resident's satisfaction with local parks, playgrounds and open spaces varied across the Borough. The survey found that whilst satisfaction in areas such as The Homesteads and Corringham and Fobbing is relatively high (77% and 66% respectively), satisfaction in areas such as Stifford Clays and East Tilbury is much lower (26% and 24% respectively). Perceptions about how easy Thurrock Council make it to exercise and be physically active in outdoor spaces were also captured within this survey. Eastern areas such as Stanford East and Corringham Town (90%), the Homesteads (87%) and Orsett (85%) were seen as easy whilst Tilbury St Chads, Tilbury Riverside and Thurrock Park have the lowest percentage of residents reporting that they find it easy to be active in outdoor spaces (63% and 49% respectively). (18), (47)

In summary, 26% of respondents are very satisfied with the amount of space for local parks yet only 12% are very satisfied with the quality of that space. Similarly, only 7% of people are very dissatisfied with the amount and availability of outdoor networks but 15% are very dissatisfied with the quality of them. (15)

Residents in Aveley, Bulphan, Corringham, East Tilbury, Horndon-on-the-Hill, Orsett and Stanford-le-Hope highlighted the need for improved infrastructure that supports and enables walking and cycling opportunities. Aligned with this, residents from some of these areas suggested the need to improve opportunities for children to be able to walk to school.

There were strong views on the importance of improving air quality and recognising the impacts of air pollution on health and wellbeing. The CCG Clinical Reference Group provided feedback on the importance of tackling air pollution in Thurrock. The group was concerned about the collective impact of multiple developments including the London Resort and growth of local Ports. Air quality was also major concern raised by Children's Overview and Scrutiny Committee. (21)

Consultation feedback collated for the Alcohol and Substance Misuse Needs Assessment suggested that community activity open to a range of people with vulnerabilities and aimed at directly improving the environment, such as a green space for community projects, as a place to connect for support and health and wellbeing activities would be beneficial. This would bring people together, integrate people more into the community, build confidence and resilience in service users. It is important that when someone stops using a substance which has been their coping mechanism for so long that there is something positive that can fill the gap. (58)

SPOTLIGHT on emerging local good practice: South Essex Estuary Park

The South Essex Estuary (SEE) Park plans include a continuous and accessible coastal path stretching from Tilbury Fort to Shoeburyness, ensuring every home will have easy access to high quality green space, creating new woodlands, restoring marshlands and completing a huge network of natural landscapes. This vision for South Essex to become an extraordinary parkland setting providing an attractive offer for modern living that supports residents, businesses, industry, tourism, and leisure activities.

The park will be a single, unified, regional parkland which will ensure that the natural wonders which abound throughout Essex are all connected as part of the same ecological community. This single park system will address the challenges of providing access to green spaces, improving health and well-being and air quality, mitigating the effects of climate change including flooding, boosting eco-tourism and green job creation, restoring biodiversity and helping the region achieve a net zero carbon footprint.

The park will serve as a standard bearer for place-making ensuring that residents across South Essex have even better access to a diverse range of natural green or blue spaces and get the advantages of all the health and well-being benefits that creates. It will also provide carbon offsetting opportunities for local businesses right on their doorstop. SEE Park will provide 200 km of enhanced continuous coastal paths and create over 550 km of greenways and cycleways. By ensuring a holistic approach to enhancing and maintaining our local green spaces and the ecosystem they sustain, we can help ensure that South Essex is a greener and healthier place for our residents.

Source: ***South Essex 2050****, 2023*

What does the guidance say?

Access to good quality greenspace has a range of positive health outcomes. They can help to promote healthy behaviours, support the development of skills and capabilities and improve social connectedness and gives people a sense of familiarity and belonging.

The key issues identified include:

- Improving access to and engagement with the natural environment for mental health and wellbeing
- Adapting to climate change
- Increasing participation in physical activity
- Reducing exposure to air pollution

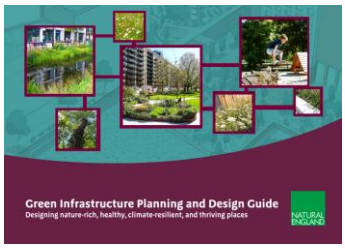
Building with Nature's mission is maximising the benefits that high-quality green infrastructure can deliver for people when it is put at the heart of placemaking. By bringing nature closer to people, we not only build great places for people to live, work and play, but we make development a force for societal good. The purpose of the Wellbeing Standards is to take advantage of the opportunity that development offers to use green infrastructure to support people's mental and physical health and build a sense of belonging and encourage active stewardship.

Spending time in the natural environment – as a resident or a visitor – improves our mental health and feelings of wellbeing. It can reduce stress, fatigue, anxiety and depression. It can help boost immune systems, encourage physical activity and may reduce the risk of chronic diseases such as asthma. It can combat loneliness and bind communities together. For all these reasons, improving access to quality greenspace has the potential to improve health outcomes for the whole population. However, this is particularly true for disadvantaged communities, who appear to accrue an even greater health benefit from living in a greener environment. This means that greenspace also can be an important tool in the ambition to increase healthy life expectancy and narrow the gap between the life chances of the richest and poorest in society. (59)

Improving access to greenspace such as parks, woodland, fields and allotments as well as natural elements including green walls, roofs and incidental vegetation, are increasingly being recognised as an important asset for supporting health and wellbeing. This 'natural capital' can help local authorities address local issues that they face, including improving health and wellbeing, managing health and social care costs, reducing health inequalities, improving social cohesion and taking positive action to address climate change. Evidence shows that living in a greener environment can promote and protect good health, aid in recovery from illness and help with managing poor health. People who have greater exposure to greenspace have a range of more favourable physiological outcomes. Greener environments are also associated with better mental health and wellbeing outcomes including reduced levels of depression, anxiety, and fatigue, and enhanced quality of life for both children and adults. Greenspace can help to bind communities together, reduce loneliness, and mitigate the negative effects of air pollution, excessive noise, heat and flooding. Disadvantaged groups appear to gain a larger health benefit and have reduced socioeconomic-related inequalities in health when living in greener communities, so greenspace and a greener urban environment can also be used as an important tool in the drive to build a fairer society.

This report offers policy, practice and research recommendations for local government and those working in partnership with it. Local authorities play a vital role in:

- providing new, good quality greenspace that is inclusive and equitable
- improving, maintaining and protecting existing greenspace
- increasing green infrastructure within public spaces and promoting healthy streets
- improving transport links, pathways and other means of access to greenspace, and providing imaginative routes linking areas of greenspace for active travel
- creating cost savings - £2.1 billion per year could be saved in health costs if everyone in England had good access to greenspace, due to increased physical activity in those spaces (60)



Green Infrastructure Planning and Design Guide provides evidence based practical guidance on how to plan and design good green infrastructure. It complements the **National Model Design Code** and **National Design Guide** and can be used to help planners and designers develop local design guides and codes with multifunctional green infrastructure at the heart. It will also be useful to landscape architects, urban designers, parks and greenspace managers and neighbourhood planning bodies. Restoring nature is one of the most important things we can do for the long-term health and prosperity of people, wildlife, and our economy. Using the Green Infrastructure Planning and Design Guide can support Government's 25 Year Environment Plan commitment to leave the environment in a better state than it was before and to making greener, healthier, climate resilient, distinctive, and thriving places to live learn work and play. (61)

Using Green Infrastructure to Protect People from Air Pollution summarises the current best practice for how green infrastructure can reduce public exposure to air pollution in the urban environment. The report acknowledges that there is not a 'one size fits all' intervention but the right green infrastructure in the right place can reliably reduce exposure to air pollution. It provides advice and guidance about how to embed green infrastructure into local places focused on different types of roads and considers green roofs and walls and green open spaces, as well as outlining general planting principles and links to further practical considerations. (62)

What is the way forward?

The recommendations below will support a generational shift towards healthier places and people.

- The Thurrock Local Plan, Public Realm, Regeneration and Recreation and Leisure teams should ensure that the natural environment is protected and enhanced to encourage access and engagement in physical activity and mental wellbeing, reduce exposure to air pollution and support adaptation to climate change

- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
    - Building with Nature
    - Improving access to greenspace
    - Green Infrastructure Planning and Design Guide
    - Using Green Infrastructure to protect people from air pollution

Related indicators from Thurrock's Health and Wellbeing Strategy
5D: Regeneration and future developments will seek to improve physical and mental health, reduce expose to air pollution and to build community resilience and reduce antisocial behaviour
• *Local Plan policies and Health Impacts Assessment for major new developments will consider a full range of health and well-being issues including for example, Active Travel and Public transport; access to green and open spaces; air quality; and the food environment* • *All council-led new build schemes will comply with Secured by Design standards* • *All regeneration and developments will increase physical activity, promote mental wellbeing, reduce exposure to air pollution, promote availability of healthy food options, enhance community resilience, and reduce anti-social behaviour*

- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and natural environments

- Consider commissioning **Green Infrastructure Training for local authorities** provided by Building with Nature which is recommended for elected members, directors / heads of public health, heads of place, heads of highways, local lead flood authorities, climate and sustainability leads, and all teams whose work influences green infrastructure provision

Transportation Networks

Healthy and sustainable transportation networks prioritise and support active transportation modalities.

What is the issue?

Transportation plays an important role in supporting daily activities. Active travel (cycling, walking, wheeling and use of public transport) can increase physical activity levels and improve physical and mental wellbeing. Prioritisation of active travel can also reduce over reliance on motorised transport, contributing to improved air quality and a reduction in road injuries. Evidence demonstrates that infrastructure for walking and cycling, installation of traffic calming measures, and public realm improvements (e.g., street lighting) are associated with increased mobility, increased physical activity levels, reduced Body Mass Index (BMI) and reduced risk of injury, among other positive outcomes. Furthermore, the provision of open and green space, high quality public transport and improved air quality is associated with numerous positive health outcomes, including increased physical activity, improved cardiovascular outcomes, and improved social participation. (16)

***** LANGUAGE MATTERS *****

The term 'wheeling' ensures we listen to, engage and better represent people who use wheelchairs and mobility scooters. Always use 'walking and wheeling' together as both represent the action of moving at a pedestrian's pace, whether someone is standing or sitting, walking or wheeling unaided or using any kind of aid to mobility, including walking aids, wheeled aids, personal assistants or support animals.

Transport also plays a key role in facilitating people's access to health services such as GP surgeries, hospitals, dentists and pharmacies. This is particularly important for older people, disabled people and those living in rural areas, as public transport may be their only link to local amenities and services. In addition, transport allows medical professionals to access their workplaces or visit their patients, including emergency services' workers such as paramedics to access people in life threatening situations. Transport allows people to connect and maintain relationships with others, access work opportunities, education or leisure activities, live active lives and to be more autonomous. The impact of transport on wellbeing is also connected to the impact of transport on inequality. (63)

FOCUS ON: Climate change & sustainability

KEY ISSUES	KEY OPPORTUNITIES
Transport is essential, but how we choose to move around has economic, social and environmental consequences. Transport is a key contributor to climate change, responsible for producing 24% of the UK's total greenhouse gas emissions in 2020.	*Decarbonising the transport sector has the potential to make significant improvements to air quality and public health.*
Rail Freight is essential for helping reduce road congestion and carbon emissions. Yet less than five per cent of the UK's freight is transported by rail; this needs to change.	*Moving to electric vehicles alone is not enough to solve climate change. A suite of interventions are needed which tackle emissions across all transportation modes including cars, buses, rail including freight and aviation.*
	Active travel including cycling, walking and wheeling are key to this. Opportunities should focus on improving routes and infrastructure such as more bike storage and parking.
	*Source: Department for Transport, **2021** & **2022***

The quality of a transport system encapsulates a broad range of factors, including journey times, the availability of public transport, reliability and affordability of services as well as consistent active travel infrastructure. Investing in transport is one way we can help address widening health inequalities and reduce the impact of air pollution and climate change. (64) Furthermore, health-promoting transport systems are pro-business and support economic prosperity. They enable optimal travel to work with less congestion, collisions, pollution, and they support a healthier workforce. (65)

Electric vehicles give us cleaner streets making our towns and cities a better place for pedestrians and cyclists. Research has shown that they are better for the environment and emit fewer greenhouse gases and air pollutants than petrol or diesel cars, taking into account their production and electricity generation to keep them running. The major benefit of electric cars is the contribution that they can make towards improving air quality in towns and cities. With no tailpipe, pure electric cars produce no carbon dioxide emissions when driving. This reduces air pollution considerably. In just one year, one electric car on the roads can save an average 1.5 million grams of CO2. That's the equivalent of four return flights from London to Barcelona. (66) However, despite significant early progress, action is needed to go further, faster. The market for battery electric vehicles and the necessary charging infrastructure is growing fast, but the barriers of vehicle price and supply, infrastructure provision, and the consumer experience of using that

infrastructure, need to be addressed. (67) Electrification of vehicles is only part of the solution to tackling air pollution and in fact it is recognised that brake and tyre wear associated with electric vehicles contributes significantly to harmful pollutants (PM2.5). (68) A broader shift to a multi-modal transportation system is required to realise improvements in air quality.

What is the picture locally?

Thurrock's Active Travel Needs Assessment provides an overview of local data for walking and cycling:

- Levels of regular walking in Thurrock are similar to other areas (48% compared to 50% nationally).
- Levels of regular cycling is significantly worse than other areas (1.2% compared to 4.4% nationally).
- Cars are still the most common mode of transport, accounting for 62% of journeys.
- Only about 4% of Thurrock children cycle to school; contrast this with a figure as high as 59% in the Netherlands.

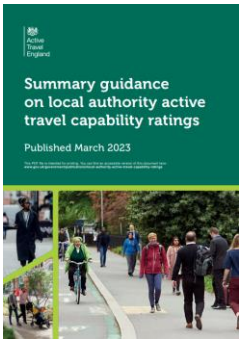
The majority of children within Thurrock live within 30 minutes walking or cycling time to a primary or secondary school, although many are travelling greater distances to schools outside their local catchment and therefore unable to utilise travelling by active means. (13) Evidence suggests that both primary and secondary aged pupils expressed a preference for travelling via walking or cycling modes, but that this did not always match up with their usual method of travel to school. (69)

According to Thurrock's Transport Strategy, there is generally good accessibility by public transport and walking to many services, but poor access to further education and hospitals which could exacerbate low skills and health issues, the latter being a particular concern with the ageing population. There are a number of sections of the interurban road network, both within and around Thurrock, where public transport services leave room for improvement and there is no viable rail option. In such places the option of investing in high quality bus and coach services will be considered, as this is unlikely to require new large-scale infrastructure. (12) Recently, due to strict limits on council spending, a decision was made by Cabinet in March 2023 to end funding subsidies for a number of bus services. This decision will now be reviewed, with the review proposed to take place in Summer 2023. Until the review is completed and a final decision made, the services will continue as normal. It is currently unclear what impact this may have on health and wellbeing although a Community Equality Impact Assessment has been undertaken. (70)

High numbers of Heavy Goods Vehicles (HGVs) and high traffic flows on strategic and local roads adversely impact on local air quality, CO^2 emissions, and congestion. Economic growth could potentially make this worse. Exposure to high levels of air pollution is associated with a variety of adverse health outcomes including increased risk of respiratory conditions, heart disease and lung cancer. More severe impacts affect those who have existing health needs, children, young people and older people who tend to be more susceptible. (71) In Thurrock, the annual mean level of air pollution is higher than the East of England and England averages. Thurrock has the second highest level of annual air pollution compared with both our CIPFA comparators[8] and across the East of England region. All of Thurrock's AQMA's are declared because of an exceedance in NO2 emissions caused by transport.

Thurrock Council have provided strong opposition to the Lower Thames Crossing (LTC) proposals and have made sure that National Highways are in no doubt about our concerns for the impacts their scheme will cause, both in the construction phase and in the longer term as the new crossing goes into operation, and we deal with the significant change to the Borough's landscape and infrastructure which will be brought about by this major scheme. Whilst the scheme may bring a range of strategic connectivity benefits to the UK as a whole, it will negatively affect Thurrock's economy, restrict access and movement around the Borough (creating severance), delay growth, harm the environment, negatively impact health and wellbeing, increase air and noise pollution and offer very limited local benefits. The Council has, and will continue to, advocate for significant changes to the LTC scheme. (72)

[8] CIPFA comparators are used to compare local authorities with similar characteristics in terms of population and other demographics such as area density.



Summary guidance on local authority active travel capacity ratings developed by Active Travel England has been established to drive up standards of active travel infrastructure and support councils to deliver high-quality schemes that enable more people to walk, wheel or cycle for everyday trips. In this first ever review of active travel capability, each local transport authority self-assessed their capabilities and assigned themselves a rating. This was then subjected to a validation process led by Active Travel England. The resulting ratings will be used to guide the allocation of funding and other resources. They focus primarily on three areas: local leadership, plans and delivery record. 'Delivery record' also considers whether authorities require developers of new housing or industrial developments to include good facilities for walking, wheeling and cycling. Thurrock is currently rated one. (73)

Rating	Description
Rating 0	Local leadership for active travel is not obvious, no significant plans are in place, the authority has delivered only lower complexity schemes.
Rating 1	Some local leadership with basic plans and isolated interventions that do not yet obviously form a plan for a network.
Rating 2	Strong local leadership, with clear plans that form the basis of an emerging network with a few elements already in place.
Rating 3	Very strong local leadership, comprehensive plans, and a significant network in place with a growing number of people choosing to walk, wheel and cycle.
Rating 4	Established culture of active travel with successive increases in walking, wheeling and cycling, underpinned by a dense integrated network and highly supportive policies to give more people the choice to walk or cycle.

What do Residents' say?

A range of issues were raised as part of the Health and Wellbeing Strategy and Your Place, Your Voice consultations. It was agreed that transport can be an issue not only due to the movement of vehicles such as HGVs across the Borough but also in terms of accessing appointments. Feedback from attendees at one workshop suggested that the infrequency of public transport coupled with the cost is a borough-wide issue. It can impact on access to hospital and general practice referrals to community-based services. Related to this, residents reported the need to improve the sustainability of transport links and facilities and to consider how people travel across the Borough. Some respondents agreed that access to public transport and active travel may be an important factor for improving air quality and reducing pollution. (21), (22)

Residents in Aveley, Bulphan, Corringham, Horndon-on-the-Hill and Stanford-le-Hope, highlighted the need for improved transport infrastructure, that is safe, promotes improved connectivity, supports better management of HGV vehicle movements especially in the village areas, and addresses the need for improved affordable public transport links. They also highlighted the need for more, and improved walking and cycling routes.

SPOTLIGHT on evidence: What works to increase cycling?

A wide range of factors influence whether or not people walk or cycle, particularly environmental factors such as the design, quality, accessibility and availability of walking and cycling networks. In neighbourhoods where there are accessible, safe walking and cycling routes, studies consistently show communities are walking and cycling more. Areas that have successfully increased levels of walking and cycling have all prioritised people and place first, with cars being a 'guest' in the area. Attributes of successful infrastructure include:

- Routes designed with the continuity of the route in mind
- Routes that are legible and do not depend on signage
- Cyclists are segregated from traffic on busy roads or junctions
- Participatory design at a local level ensures that residents' needs and concerns are addressed

A coherent, convenient and safe network of routes is necessary but not sufficient to bring about change, while campaigns and behaviour change interventions are unlikely to be successful without the infrastructure to support them. An evidence assessment carried out by the Department for Transport identifies a mix of infrastructural improvements/provision, community-wide communications/campaigns, targeted (usually community-level) support and some individually-specific support. The most effective mechanisms for increasing walking and cycling comprise of a complementary package of measures, such as:

- Provision of dedicated cycling lanes (and bicycle parking)
- Personal travel planning (behaviour change)

- Walk/Cycle to workdays
- Cycle-hire/bike-share schemes
- Some school-based interventions
- Cycle maintenance skills training

Source: ***Thurrock Active Transport Needs Assessment,*** *2021*

What does the guidance say?

Increasing cycling and walking can help tackle some of the most challenging issues we face as a society – improving air quality, combatting climate change, improving health and wellbeing, addressing inequalities and tackling congestion on our roads (74).

The key issues identified include:

- Increasing the provision of safe, easily accessible active travel infrastructure (cycling, walking, wheeling)
- Increasing the availability, reliability and affordability of public transport
- Reducing air pollution

How Transport offers a route to better health recognises that a good transport system is essential for a healthy society. The impact of air pollution on health is well-known, but transport affects the health of people across society, in multiple ways. Investing in transport is one way we can help address widening health inequalities and regional disparities in public health. The quality of the transport infrastructure and the adequacy of transport services directly affect health by, for example, enabling active modes of travel (such as cycling and walking) that have health benefits or reducing road accidents and harmful emissions. But wider, indirect impacts on health include enabling people to get to work, school, hospital and fresh food shops, as well as social events and leisure activities – aspects of life that are important for good physical and mental health. The growth in car ownership has revolutionised people's lives in the UK – providing comfort and increasing the geographical scope of employment and social interactions. But these benefits have not been shared equally across society, with access especially low among young adults and low-income families. Car-centric policies can lead to underinvestment in other forms of transport. While cars are likely to remain the best (or only) option for some people, particularly where health conditions can otherwise limit mobility, a lack of public transport alternatives can mean reduced options for people without a car. Consequences of a car-dependent transport system includes:

- Marginalised road users
- Reduced services
- Reshaped built environment
- Access to cars is limited for some groups in society (64)

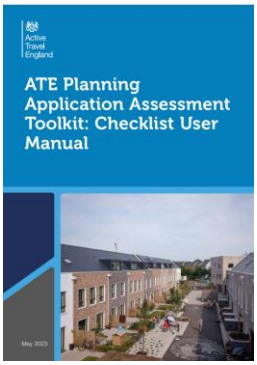
Working Together to Promote Active Travel - A briefing for local authorities has been written for transport planners, others concerned with the built environment, and public health practitioners. It looks at the impact of current transport systems and sets out the many benefits of increasing physical activity through active travel. It suggests that while motorised road transport has a role in supporting the economy, a rebalancing of our travel system is needed. Key considerations when developing a healthy local transport strategy include:

- Physical inactivity directly contributes to 1 in 6 deaths in the UK and costs £7.4 billion a year to business and wider society
- The growth in road transport has been a major factor in reducing levels of physical activity and increasing obesity
- Building walking or cycling into daily routines is the most effective way to increase physical activity
- Short car trips (under 5 miles) are a prime area for switching to active travel and to public transport

This guide suggests a range of practical actions for local authorities, from overall policy to practical implementation. It highlights the importance of community involvement and sets out key steps for transport and public health practitioners. (65)

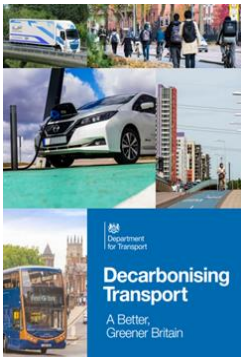
Gear Change A bold vision for cycling and walking sets the ambition for a modal shift towards active travel. The key themes are better streets for cycling and people, cycling at the heart of decision making, empowering and encouraging local authorities and enabling people to cycle and protecting them when they do. At the heart of this vision is the need to achieve:

- Healthier happier and greener communities -
- Safer streets
- Convenient and accessible travel
- Walking and cycling are at the centre of transport decision making (74)



ATE Planning Application Assessment Toolkit: Checklist User Manual has been prepared as a desktop guide for users of the Active Travel England (ATE) Planning Application Assessment Toolkit. It includes brief instructions on how to use the toolkit and is supported by examples. Its purpose is to lead the assessor through the process required to assess planning proposals against existing policy requirements and technical guidance. Users are expected to use their professional judgement in providing an evidence-based recommendation. (75)

Decarbonising Transport: A Better, Greener Britain brings together existing work to reduce emissions across all forms of transport, and for the first time lays out the scale of the additional reductions needed to deliver transport's contribution to legally binding carbon budgets and delivering net zero by 2050. This plan sets out how to deliver those emissions reductions and the associated benefits that will be realised from it across the UK. The strategic priorities are:



1. Accelerating modal shift to public and active transport
2. Decarbonising road transport
3. Decarbonising how we get our goods
4. UK as a hub for green transport technology and innovation
5. Place-based solutions to emissions reduction
6. Reducing carbon in a global economy (67)

What is the way forward?

The recommendations below will support a generational shift towards healthier places and people.

- The Local Plan, Transport Vision and Strategy, regeneration programme and Design Charter and Design Codes should be utilised to embed a commitment to accessible and safe transport infrastructure which supports a modal shift to cycling, walking and wheeling, as well as improvements (availability, reliability and affordability) in public transport, as a means to reduce both health inequalities and air pollution

- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
    - Decarbonising Transport: A Better, Greener Britain
    - Gear Change: A bold vision for cycling and walking
    - How transport offers a better route to health
    - Working together to promote active travel: A briefing for Local Authorities

Related indicators from Thurrock's Health and Wellbeing Strategy
1A: Work with communities to reduce smoking and obesity in Thurrock
• *Reducing the proportion of Reception, Year 6 children and adults in Thurrock who are obese and reducing the variation between community*
5D: Regeneration and future developments will seek to improve physical and mental health, reduce exposure to air pollution and to build community resilience and reduce antisocial behaviour
• *Local Plan policies and Health Impacts Assessment for major new developments will consider a full range of health and well-being issues including for example, Active Travel and Public transport; access to green and open spaces; air quality; and the food environment*

- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and transportation networks

- Implement the recommendations of the Thurrock Active Travel Needs Assessment

- Deliver the Thurrock Local Cycling and Walking Infrastructure Plan (LCWIP)

- Identify a Senior Champion for Active Travel within the Council

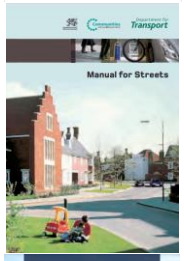
- Building on the existing Cycle Forum, establish a Taskforce for Active Travel which will specifically focus on increasing cycling in the Borough. Membership could include representatives from:

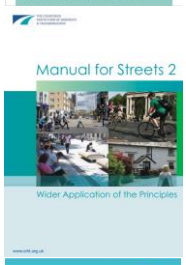
    - Transport
        - Highways maintenance
        - LCWIP
    - Public Health
    - Environmental Health - air quality
    - Cycle safety
    - Leisure and Recreation
    - Climate change & sustainability
    - Communities
    - Communications
    - Planning
    - Local Plan
    - Regeneration
    - Design Team
    - Children's

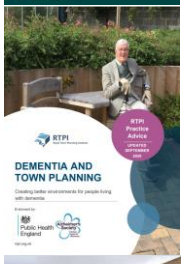
Selected Further Reading

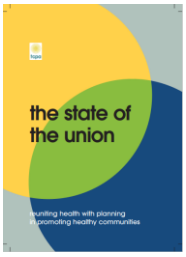
Neighbourhood Design

Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.



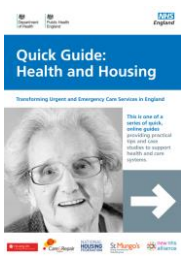


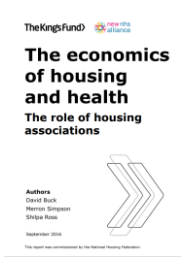


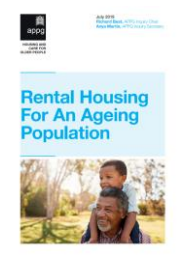


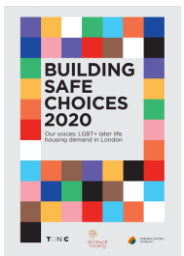
Housing

The design, quality, sustainability, and affordability of diverse housing options has a critical influence on health and well-being



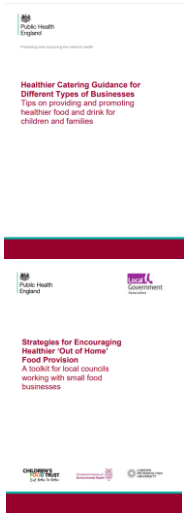


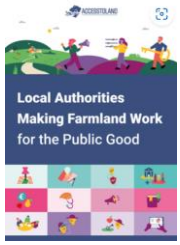


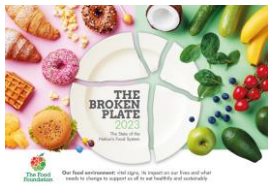


Food Systems

Accessibility and affordability of healthy sustainable foods can be supported through land use planning and design

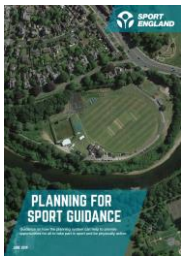






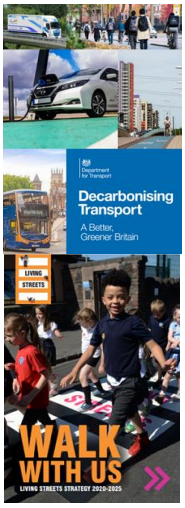
Natural Environments

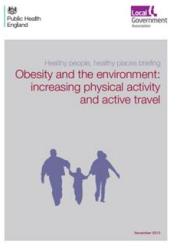
Community planning which preserves and connects the surrounding natural environment and supports biodiversity can have significant health and well-being impacts.

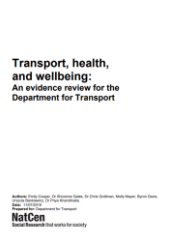


Transportation Networks

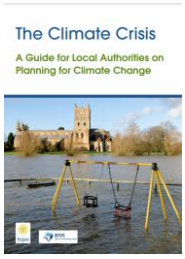
Healthy and sustainable transportation networks prioritise and support active transportation modalities.

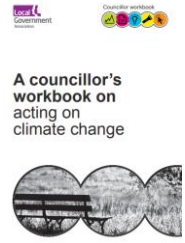


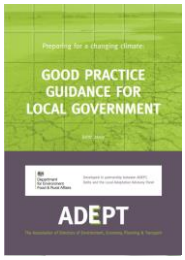


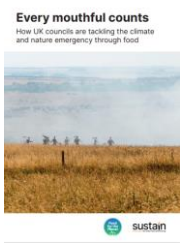


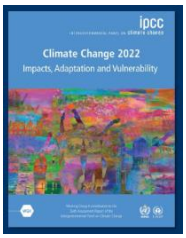
Climate change and sustainability

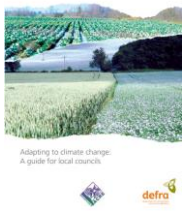




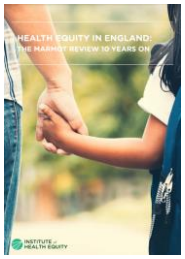


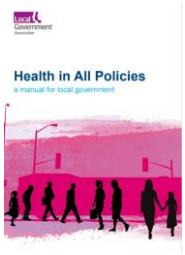






Wider determinants





References

1. **Lyons, M.** *Lyon's Inquiry into Local Government - Place-shaping: a shared ambition for the future of local government .* London : The Stationery Office, 2007.

2. **Thurrock Health and Wellbeing Board - Thurrock Council.** *Thurrock Health and Wellbeing Strategy 2022 to 2026: Levelling the playing field in Thurrock.* s.l. : Thurrock Council, 2022 - 2026.

3. **The King's Fund.** Broader determinants of health: Future trends . *The King's Fund.* [Online] The King's Fund, 2022. https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health.

4. **The Health Foundation.** *A Matter of Life and Death: Explaining the Wider Determinants of Health in the UK.* s.l. : The Health Foundation, 2022.

5. —. *How to talk about the building blocks of health, a toolkit.* s.l. : The Health Foundation, 2022.

6. *Health and wellbeing in rural areas.* **Local Government Association (LGA) and Public Health England (PHE).** s.l. : LGA, 2017.

7. **Office for National Statistics .** Census 2021 . *ONS .* [Online] 2021.

8. **The King's Fund.** What are health inequalities? . *The King's Fund.* [Online] 2022. https://www.kingsfund.org.uk/publications/what-are-health-inequalities.

9. **Thurrock Council.** *Backing Thurrock: A five year strategy for economic recovery, resilience and a return to growth.* 2020.

10. **Dalgren, G,. & Whitehead, M.** *Policies and strategies to promote social equity in health.* Institute for future studies . Stockholm : s.n., 1991.

11. *A health map for the local human habitat.* **Barton, H., & Grant, M.** 6, 2006, The Journal for the Royal Society for the Promotion of Health , Vol. 126, pp. 252-253.

12. **Thurrock Council - Transport and Highways.** *Thurrock Council Transport Strategy 2013 - 2026.* s.l. : Thurrock Council, 2013 - 2026.

13. **Thurrock Council - Public Health.** *Thurrock Active Travel Needs Assessment.* s.l. : Thurrock Council , 2021.

14. **Thurrock Council - Housing Strategy team.** *Thurrock Council Housing Strategy 2022 - 2027.* s.l. : Thurrock Council, 2022 - 2027.

15. **Thurrock Council.** *Thurrock Council Active Place Strategy: Executive Summary.* 2020.

16. **Public Health England (PHE).** *Spatial Planning for Health: An evidence resource for planning and designing healthier places.* London : PHE, 2017.

17. **Thurrock Council - Public Health.** *Annual Report of the Director of Public Health: Healthy Housing for the third age: Improving Older People's Health through housing.* s.l. : Thurrock Council, 2018.

18. **Thurrock Council.** *Thurrock Council Resident Survey .* s.l. : Thurrock Council , 2016 .

19. **Police UK.** Data Downloads. *Data.Police.UK.* [Online] 2019-2020. https://data.police.uk/data/.

20. **Essex Violence and Vulnerability Unit (VVU).** *The VVU Youth Voices Listening Report 2022-2023: Young people's views around youth violence and how safe they feel in their communities.* s.l. : Essex VVU, 2022-2023.

21. **Thurrock Council.** *Thurrock Health and Wellbeing Strategy Refresh Consultation Report 2022.* s.l. : Thurrock Council, 2022.

22. **Thurrock Council - Local Plan Team .** *Your Place, Your Voice Summary Report.* 2018 .

23. **Homes England.** *Building for a Healthy Life: A design toolkit for neighbourhoods, streets, homes and public spaces.* Saffron Walden : Homes England, 2020.

24. **Town and County Planning Association (TCPA).** *20-Minute Neighbourhoods: Creating Healthier, Active, Prosperous Communities - An Introduction for Council Planners in England.* s.l. : TCPA, 2021.

25. **Hopkinson, L., Goodman, A., Sloman, L., Aldred, R. & Thomas A.** *School Streets - Reducing children's exposure to toxic air pollution and road danger.* s.l. : Mums for Lungs, Possible. Inspiring Climate Action, transport for quality of life & Active Travel Academy, 2021.

26. **World Health Organisation (WHO).** *Global age-friendly cities: A guide.* s.l. : WHO, 2007.

27. —. *WHO Housing and Health Guidelines.* s.l. : World Health Organisation, 2018.

28. **Local Governement Association (LGA).** *The Impact of Homelessness on Health: A Guide to Local Authorities.* s.l. : LGA, 2017.

29. **Thurrock Council - Public Health team .** *Housing Affordability Joint Strategic Needs Assessment (JSNA - in production).* s.l. : Thurrock Council .

30. **Thurrock Council.** Houses in multiple occupation: Register of licensed HMOs. *Thurrock.gov.uk.* [Online] 2023. https://www.thurrock.gov.uk/houses-in-multiple-occupation/register-of-licensed-hmos.

31. —. Houses in multiple occupation. *Thurrock.gov.uk.* [Online] 2023. https://www.thurrock.gov.uk/houses-in-multiple-occupation/overview.

32. **Office for Health Improvement and Disparities (OHID).** Local Health: Overcrowded houses. *Local Health.* [Online] Office for National Statistics - ONS Census 2011, 2011. https://www.localhealth.org.uk/#view=map12&c=indicator.

33. **Office for Health Improvement and Disparities.** Local Health: Households in fuel poverty. *Local Health.* [Online] 2020. https://www.localhealth.org.uk/#view=map12&c=indicator.

34. **Department for Business, Energy and Industrial Strategy (BEIS).** Local Health: Households in fuel poverty. *Local Health.* [Online] OHID, 2020. https://www.localhealth.org.uk/#view=map12&c=indicator.

35. **Communities and Local Government, Department of Health & Homes and Communities Agency.** *Housing our Ageing Population Panel for Innovation (HAPPI).* 2009.

36. **Thurrock Council.** Well Homes in Private Housing . *Thurrock.gov.uk .* [Online] 2022. https://www.thurrock.gov.uk/well-homes-in-private-housing/well-homes.

37. **Building Research Establishment (BRE) on behalf of Thurrock Council.** *BRE Client Report: BRE Integrated Dwelling Level Housing Stock Modelling and Database for Thurrock Council.* 2021.

38. **Office for Health Improvement and Disparities .** Public Health Profiles: Indicator Definitions and Supporting Information. *OHID - Public Health Profiles - Fingertips.* [Online] 2022. https://fingertips.phe.org.uk/search/temporary%20accommodation#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/93735/age/-1/sex/-1/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1.

39. **Thurrock Council.** *Thurrock Council Homelessness Prevention and Rough Sleeping Strategy 2020 - 2025.* s.l. : Thurrock Council, 2020 - 2025.

40. **Citizens Advice .** If you're offered housing because you're homeless. *Citizens Advice .* [Online] 2018. https://www.citizensadvice.org.uk/housing/homelessness/getting-homeless-help/if-youre-offered-housing-by-the-council/.

41. **The Health Foundation.** *Better housing is crucial for our health and the COVID-19 recovery.* 2020.

42. **UK Health Security Agency.** Putting healthier food environments at the heart of planning. *UK Health Secutiry Agency - Gov.UK.* [Online] 2018. https://ukhsa.blog.gov.uk/2018/06/29/putting-healthier-food-environments-at-the-heart-of-planning/.

43. **Sustain.** *Good planning for good food - using planning policy for local and sustainable food.* s.l. : Sustain, 2011.

44. **Batterham, R.** *Health inequalities and obesity.* s.l. : Royal College of Physicians, 2020.

45. **Thurrock Council - Public Health.** *Thurrock Joint Strategic Needs Assessment: Whole Systems Obesity.* s.l. : Thurrock Council, 2018.

46. **Office for Health Improvement and Disparities (OHID).** Public Health Profiles - proportion of the population eating the recommended five-a-day on a 'usual' day. *OHID - Public Health Profiles: Fingertips based on the Active Lives Survey, Sport England .* [Online] 2019/20. https://fingertips.phe.org.uk/search/fruit%20and%20veg#page/3/gid/1/pat/6/par/E12000006/ati/402/are/E06000055/iid/93077/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1.

47. **Thurrock Council.** *Open Space Assessment .* 2020.

48. **Dimbleby, H.** *National Food Strategy Independent Review - The Plan.* 2021.

49. **Sustain.** *Planning sustainable cities for community food growing.* 2014.

50. **The Food Foundation & Birmingham City Council.** *Creating a Healthy Food Economy: A Policy Audit Tool for Local Authorities.* 2020.

51. **Sustain.** *Hot Food Takeaways: Planning a route to healthier communities.* 2019.

52. **Thurrock Council - Public Health.** *Rapid Review: Health, Societal and Community Impacts of COVID-19.* s.l. : Thurrock Council, 2021.

53. **Natural England.** *The People and Nature Survey.* s.l. : Natural England, 2020 - updated 2022.

54. **Office for National Statistics (ONS).** *How has lockdown changed our relationship with nature?* s.l. : ONS, 2021.

55. **Office for Health Improvement and Disparities (OHID).** Public Health Profiles: adult physical activity. *OHID - Public Health Profiles - Fingertips.* [Online] OHID based on Active Lives Survey, Sport England, 2020-2021. https://fingertips.phe.org.uk/search/physical%20activity#page/3/gid/8000005/pat/6/par/E12000006/ati/402/are/E06000034/iid/93014/age/298/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0.

56. —. Public Health Profiles - walking for travel. *OHID - Public Health Profiels: Fingertips.* [Online] OHID/Department for Transport based on Active Lives Survey, Sport England, 2019-20. https://fingertips.phe.org.uk/search/walk#page/3/gid/1/pat/6/par/E12000006/ati/402/are/E06000034/iid/93439/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1.

57. —. Public Health Profiles: cycling for travel. *OHID - Public Health Profiles: Fingertips.* [Online] OHID/Department for Transport based on the Active Lives Survey, Sport England, 2019/20. https://fingertips.phe.org.uk/search/cycle#page/3/gid/1/pat/6/par/E12000006/ati/402/are/E06000034/iid/93440/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1.

58. **Thurrock Council - Public Health team.** *Alcohol and Substance Misuse Health Needs Assessment (in production).* s.l. : Thurrock Council , 2023.

59. **Building with Nature.** *Standards Framework (BwN 2.0).* 2022.

60. **Public Health England.** *Improving access to greenspace: A new review for 2020.* s.l. : PHE, 2020.

61. **Natural England.** *Green Infrastructure Planning and Design Guide: Designing nature-rich, healthy, climate resilient and thriving places.* s.l. : Natural England, 2023.

62. **Mayor of London: Greater London Authority.** *Using Green Infrastructure to Protect People from Air Pollution.* s.l. : Greater London Authority, 2019.

63. **NATCEN Social Research on behalf of Department for Transport.** *Transport, Health and Wellbeing: An evidence review for the Department for Transport.* 2019.

64. **The Health Foundation.** *How transport offers a better route to health.* s.l. : The Health Foundation, 2021.

65. **Public Health England.** *Working Together to Promote Active Travel: A briefing for local authorities.* s.l. : PHE, 2016.

66. **EDF Energy.** Benefits of electric cars on the environment. *EDF Energy.* [Online] 2023. https://www.edfenergy.com/energywise/electric-cars-and-environment.

67. **Department for Transport.** *Decarbonising Transport: A Better, Greener Britain.* s.l. : DfT, 2021.

68. **The Organisation for Economic Cooperation and Development (OECD) .** Non-exhaust Particulate Emissions from Road Transport : An Ignored Environmental Policy Challenge. *OECD iLibrary.* [Online] OECD. https://www.oecd-ilibrary.org/sites/4a4dc6ca-en/index.html?itemId=/content/publication/4a4dc6ca-en&_csp_=681d016aff567eeb4efd802d746cdcc4&itemIGO=oecd&itemContentType=book.

69. **Modeshift Stars.** Modeshift Stars Schemes. *Modeshift Stars.* [Online] 2023. https://modeshiftstars.org/.

70. **Thurrock Council.** *Support Services Community Equalities Impact Assessment and Community Impacts Report.* s.l. : Thurrock Council, 2022.

71. **World Health Organisation (WHO).** Health consequences of air pollution on populations . *World Health Organisation.* [Online] WHO, 2019 . https://www.who.int/news/item/15-11-2019-what-are-health-consequences-of-air-pollution-on-populations#:~:text=Exposure%20to%20high%20levels%20of,people%20who%20are%20already%20ill..

72. **Thurrock Council.** *Lower Thames Crossing: Mitigating the negative impacts and maximising the benefits to create a positive legacy for Thurrock.* s.l. : Thurrock Council, 2021.

73. **Active Travel England.** *Summary guidance on local authority active travel capability ratings.* 2023.

74. **Department for Transport (DfT).** *Gear Change: A bold vision for cycling and walking.* London : DfT, 2020.

75. **Active Travel England (ATE).** *ATE Planning Application Assessment Toolkit: Checklist User Manual.* s.l. : ATE, 2023.

Acknowledgements

Authors:

Joanne Ferry – Strategic Lead for Public Health – Place, Environments & Communities (PEC) (interim)

Karen Balthasar – Public Health Improvement Officer (Wider Determinants)

Contributors:

Alec Scragg – Place and Design Manager
Amy Linford – Principal Design Officer
Andrea Clement – Assistant Director of Public Health
Cath Bicknell – NHS Estates - MSE ICB
Chris Seman – Intelligence & Performance Manager (Housing)
Christopher Cooper - Principal Environmental Health Officer - Private Housing and Adaptation Services
Christopher Smith - Programme Manager - Health and Social Care Transformation
Gareth Olive – Principal Officer – Food Environmental Health Food Safety
Gary Crooks – Economic Development Manager – Sustainability
Gerard McCleave – Assistant Director – Economic Growth & Partnerships
Grant Greatrex – Policy Manager – Sport Development
Helen Forster – Strategic Lead – Public Health (Health Improvement)
Helen Horrocks – Strategic Lead for Public Health – Place, Environments & Communities (PEC)
Irina Davis – Principal Planning Officer – Strategic Planning
Jahur Ali – Recreation and Leisure Services Manager
Jo Broadbent – Director of Public Health
Jonathan Keen – Principal Planner – Development Manager
Keith Andrews – Strategic Lead - Housing Development
Kelly Clarke – Public Health Support Officer
Kirsty Paul – Local Plan Manager
Maria Payne – Strategic Lead for Public Health – Public Mental Health & Vulnerable Populations
Mat Kiely – Strategic Lead – Transportation Services
Natalie Smith – Strategic Lead – Community Development
Nav Tung – Strategic Transport Manager
Paul Sallin – Place & Infrastructure Manager
Peter Bond – Air Quality Pollution Officer
Peter Doherty – Strategic Lead – Housing Operations
Peter Reynolds – Environmental Protection and Digital Evidence Manager
Romi Bose – Transformation and Engagement Lead – Thurrock Alliance
Ryan Farmer – Housing Strategy Manager
Sara Godward – Assistant Director of Public Health
Sean Nethercott – Strategic Lead – Strategic Services
Tracey Finn – Senior Transport Planner
Wassim Fattahi-Negro – Senior Public Health Manager – Health Intelligence
Zoe McAden – Senior Planning Officer

For more information about this document, please email: PublicHealth@thurrock.gov.uk

This page is intentionally left blank

A Health in All Policies approach to Place-shaping

Delivering on Thurrock's Health and Wellbeing Strategy 2022 - 2026

Executive Summary

Place, Environment and Communities Team,
Public Health

Joanne Ferry – Strategic Lead Public Health

Karen Balthasar – PH Improvement Officer

Davy Down Riverside Park

July 2023


Elements of a Healthy, Equitable Community
Healthy Workplaces & Quality Jobs
Health & Supportive Services
Safe, Stable, Affordable Housing
Quality Schools
OFFICE
WELLNESS CENTER
Apartments
PUBLIC SCHOOL
Cafe
Salads
Fresh Fruit Smoothies
MARKET DAY
FRESH PRODUCE
Thriving Local Economy
Parks & Community Spaces
Environmental Quality & Sustainability
Access to Healthy Food
Safe, Connected Transportation System
Together, these elements provide cumulative health and equity benefits:
Physical health
Mental health
Economic security
Safety
Community cohesion
Civic engagement

Local Policy Context

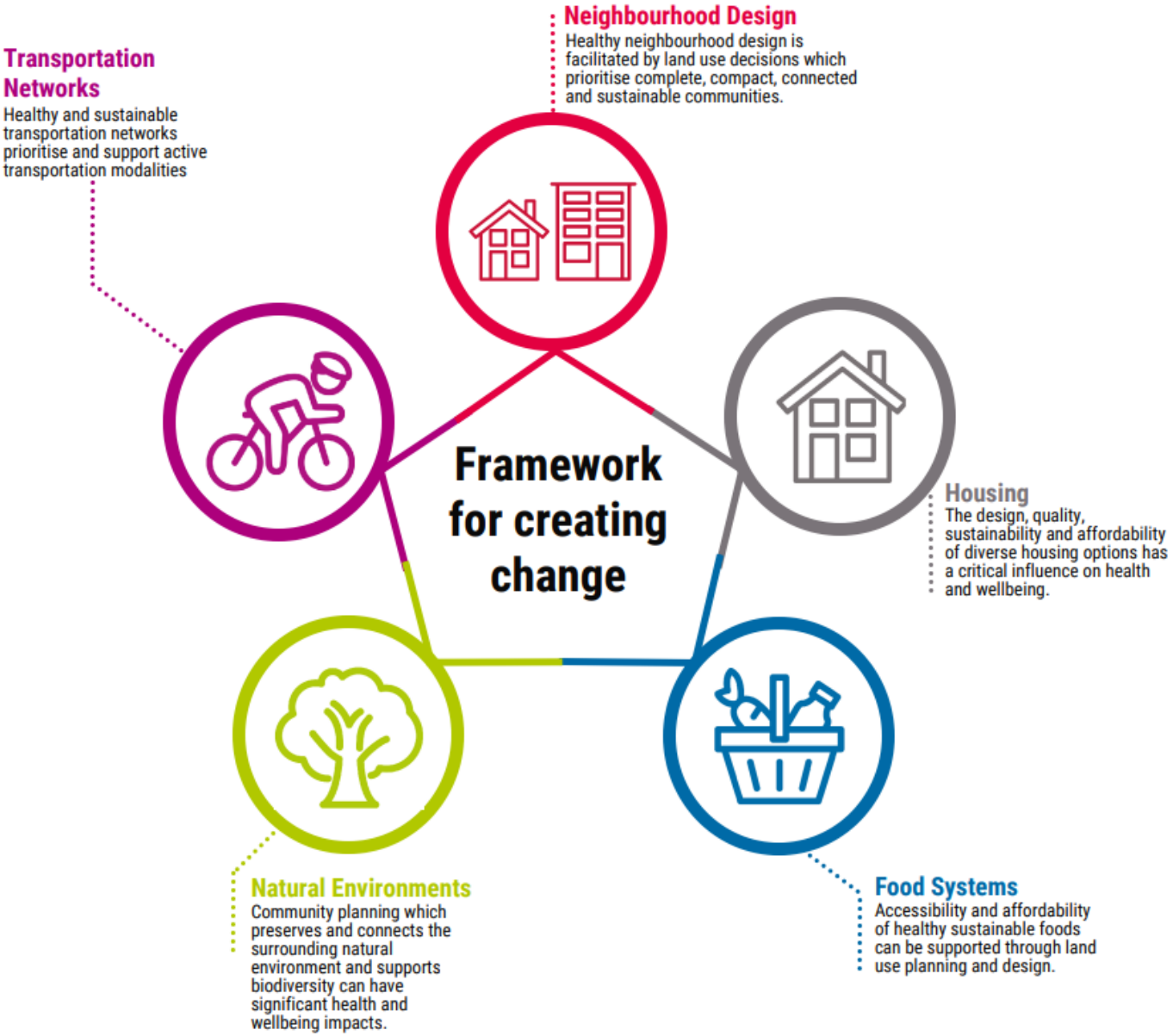
High-level Strategies:

- *Health and Wellbeing Strategy 2022-2026*
- *Backing Thurrock*
- *The Local Plan*

Other key documents:

- *Thurrock Climate Change Strategy*
- *Thurrock Air Quality Action Plan*
- *Thurrock Council Transport Strategy 2013 – 2026*
- *Thurrock Council Housing Strategy 2022 – 2027*

Health and Wellbeing Strategy 6 Domains :
1. Staying Healthier for Longer
2. Building Stronger & Cohesive Communities
3. Person-Led Health & Care
4. Opportunity for All
5. Housing & the Environment
6. Community Safety

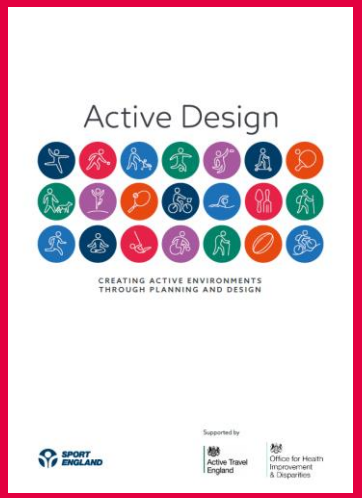


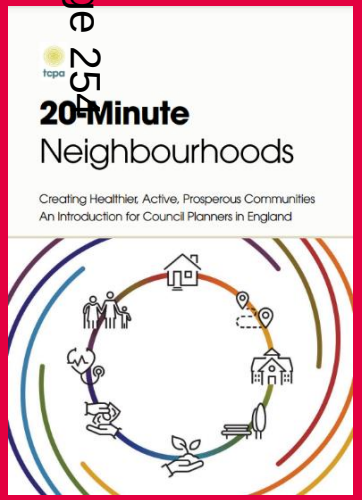
BC Centre for Disease Control. Healthy Built Environment Linkages Toolkit: making the links between design, planning and health, 2018

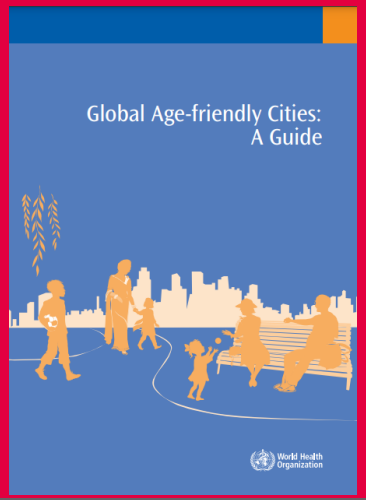
A framework for creating change

Neighbourhood Design

Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.







- Enhancing neighbourhood design and character to support community belonging and active lifestyles
- Ensuring that neighbourhoods (existing and new) have a wealth of services and amenities that are within easy reach
- Enhancing connectivity with safe and effective infrastructure

Neighbourhood Design

Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.

Related indicators from Thurrock's Health and Wellbeing Strategy
1A: Work with communities to reduce smoking and obesity in Thurrock
• *Reducing the proportion of Reception, Year 6 children and adults in Thurrock who are obese and reducing the variation between community*
5D: Regeneration and future developments will seek to improve physical and mental health, reduce expose to air pollution and to build community resilience and reduce antisocial behaviour
• *Local Plan policies and Health Impacts Assessment for major new developments will consider a full range of health and well-being issues including for example, Active Travel and Public transport; access to green and open spaces; air quality; and the food environment* • *All council-led new build schemes will comply with Secured by Design standards* • *All regeneration and developments will increase physical activity, promote mental wellbeing, reduce exposure to air pollution, promote availability of healthy food options, enhance community resilience, and reduce anti-social behaviour*
6B Work in partnership to reduce local levels of crime and opportunities for crime to take place
• *Incorporating crime reduction approaches such as 'Designing Out Crime' and 'Secure by Design' within the council's Housing Strategy and the Local Plan*

Neighbourhood Design

Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.

Resident Voice

Fear of crime has increased – concerns about anti-social behaviours

Importance of sustainable, future-proofed developments

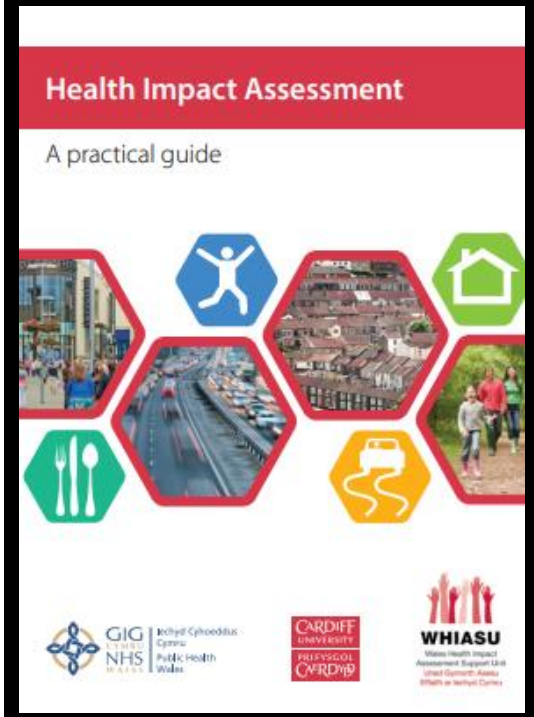
Need for sports, leisure, cultural & arts activities, especially for young people

Neighbourhood Design

Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.

SPOTLIGHT: Health Impact Assessment (HIA)

Health Impact Assessment is “A systematic, objective and yet flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being. It suggests ways in which opportunities for health gain can be maximised and risks to health minimised.”



Benefits of HIA across three themes:

- Health knowledge and action
- Organisational development
- Communities

Neighbourhood Design

Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.

SPOTLIGHT: Superzones

Superzones is a place-based intervention that creates healthy zones in the immediate vicinity around a primary or secondary school often located within the most deprived wards, or in areas with poor health outcomes.

A London pilot established six fundamental principles that underpin the Superzones approach:

- Put children and young people at the centre
- Take a flexible approach
- Target the greatest need
- Address multiple issues
- Consider local assets and harms
- Co-produce action plans with partners

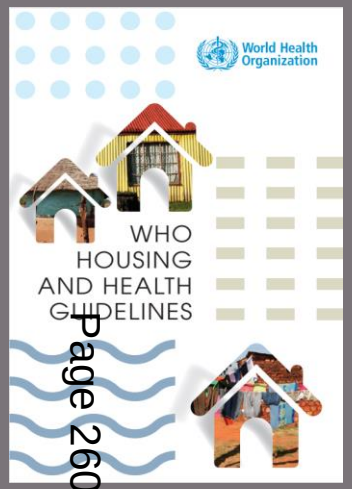
Neighbourhood Design – What is the way forward?

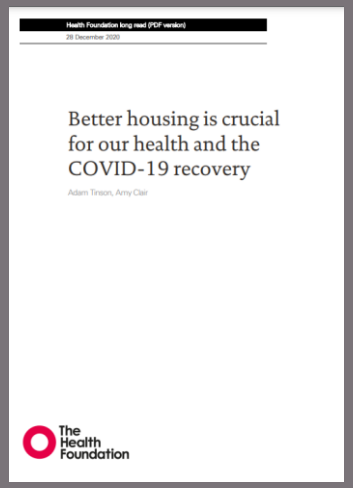
Healthy neighbourhood design is facilitated by land use decisions which prioritise complete, compact and connected and sustainable communities.

- The Thurrock Local Plan should ensure that new and existing neighbourhoods are designed to accommodate and support the diverse and changing needs of individuals throughout their life course, emphasising the need for safe, accessible, well-connected neighbourhoods and spaces that support community belonging and active lifestyles
- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
  - Building for a Healthy Life
  - Active Design Guide
  - 20-minute Neighbourhoods
  - School Streets
- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and neighbourhood design
- Through cross-Council partnership and community engagement, pilot a place-based approach to improving health and wellbeing outcomes modelled on the London Superzones pilot
- Ensure that the Thurrock Superzones approach is integral to Local Plan policy and Design Strategy
- Ensure that a refreshed Health Impact Assessment model is embedded within the Local Plan / Design Strategy, integral to planning culture and mandated in policy
- Use the Housing and Planning Advisory Group (HPAG) as a mechanism for strengthening coordinated responses to planning applications, incorporating Health Impact Assessment principles
- Embody the ‘Health in All Policies’ approach through integration of Health Impact Assessment with Community Equality Impact Assessment

Housing

The design, quality, sustainability, and affordability of diverse housing options has a critical influence on health and well-being.

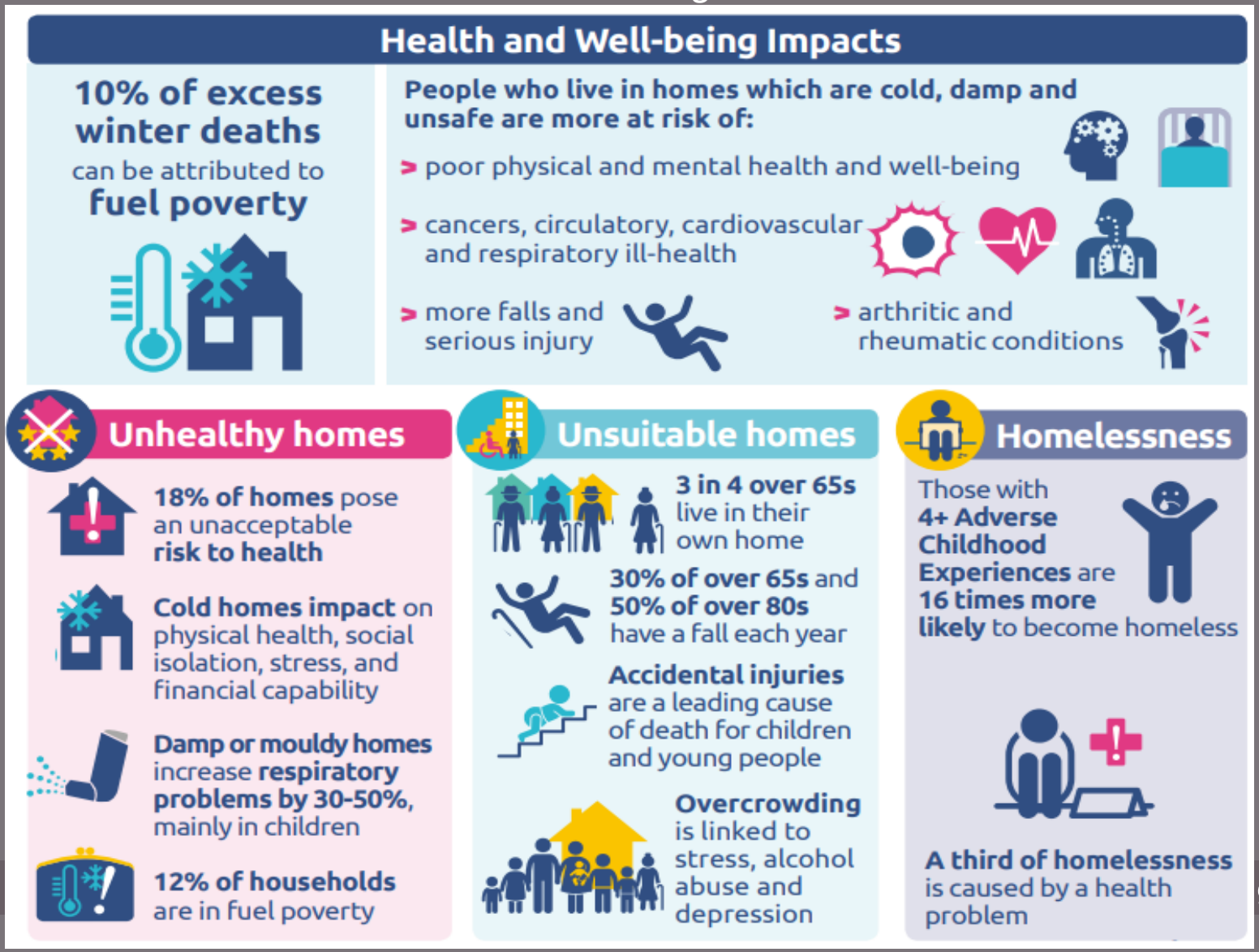




- Increasing provision of affordable, accessible and diverse housing
- Improving the quality of housing, including indoor air quality and reduced noise pollution
- Improving the energy efficiency and climate resiliency of current and future housing stock

Housing

The design, quality, sustainability, and affordability of diverse housing options has a critical influence on health and well-being.



Housing

The design, quality, sustainability, and affordability of diverse housing options has a critical influence on health and well-being.

Related indicators from Thurrock's Health and Wellbeing Strategy
5A: Reduce homelessness and increase the supply of affordable housing in Thurrock
• *Improve residents' access to a range of affordable new build homes that prioritise providing housing for people with an established connection to the local area* • *Increase supply of good quality social housing for local residents*
5B: Facilitate and encourage maintenance of good quality homes in Thurrock to promote the health of residents, protecting them from hazards such as cold, damp and mould
Improving the condition of housing in the public and private sector - for example by increasing use of renewable technologies in council stock *Reducing fuel poverty - for example by investment in council housing, accessing Green Homes Grants for improvements in the private sector, and by improving Energy Performance Certificate (EPC) ratings across the borough* • *Increase access to programmes such as Well Homes to benefit priority groups such as people with LTCs, physical or learning disabilities and mental health needs* • *Reduce the proportion of households in Fuel Poverty*
5C. Provide safe, suitable and stable housing solutions for people who have or who are experiencing domestic abuse / violence and/or sexual abuse / violence
• *Delivering expert advice through a single route to support regarding housing, skills, employment and other needs of people experiencing or who have experienced domestic and/or sexual abuse and/or violence.* • *Improve public awareness of how victims/survivors can seek housing support.* • *Streamlining support offer by combining three funding streams from Thurrock Women's Refuge, the Brighter Futures Programme and Safe Accommodation new burdens fund to create one service provider.*

Housing

The design, quality, sustainability, and affordability of diverse housing options has a critical influence on health and well-being.

Resident Voice

Council should plan for a range of housing types which meet local needs

Importance of ensuring that new housing is affordable

All housing types should be of a decent standard and be well maintained

Housing – What is the way forward?

The design, quality, sustainability, and affordability of diverse housing options has a critical influence on health and well-being.

- The Thurrock Local Plan and Housing Strategy should be used to enable adequate provision of affordable, accessible and diverse housing across the Borough to meet the needs of an increasingly diverse population, and that existing and future housing stock addresses issues related to indoor air quality, noise pollution, energy efficiency and climate resiliency

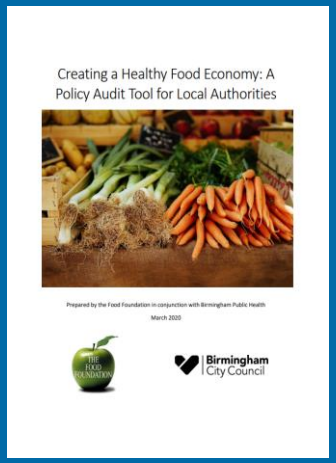
- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
  - WHO Housing and Health Guide
  - Better housing is crucial for our health and Covid-19 recovery
  - Impact of homelessness on health – a guide for Local Authorities
  - Housing Ageing Population Panel for Innovation (HAPPI)

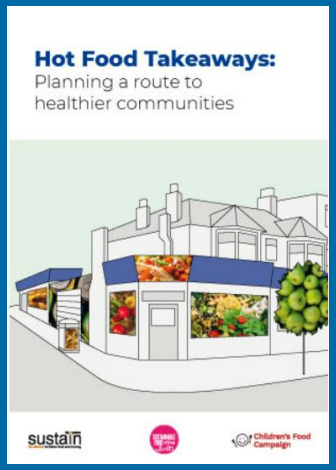
- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and housing

- Consider the best approach to understanding the existing living standards and health inequalities at sites housing vulnerable communities in the Borough

Food Systems

Accessibility and affordability of healthy sustainable foods can be supported through land use planning and design.





- Protecting and increasing both the number and the diversity of types of food retail outlets
- Creating and protecting food growing spaces in and around the locality
- Making the best use of our land for food and farming

Food Systems

Accessibility and affordability of healthy sustainable foods can be supported through land use planning and design.

Related indicators from Thurrock's Health and Wellbeing Strategy
1A: Work with communities to reduce smoking and obesity in Thurrock
• *Reducing the proportion of Reception, Year 6 children and adults in Thurrock who are obese and reducing the variation between community*
1C: Continue to enhance identification and management of Long-Term Conditions (LTCs) to improve physical and mental health outcomes for all
• *A greater proportion of people will have their LTC diagnosed and treated*
5D: Regeneration and future developments will seek to improve physical and mental health, reduce exposure to air pollution and to build community resilience and reduce antisocial behaviour
• *All regeneration and developments will promote physical & mental wellbeing, reduce exposure to air pollution, promote healthy food options, enhance community resilience, and reduce antisocial behaviour*

Food Systems

Accessibility and affordability of healthy sustainable foods can be supported through land use planning and design.

Resident Voice

Role of limiting the number or influencing the location of fast food outlets

Supporting people to eat healthier

Steady demand for the provision of allotment sites and plots across the area which outweighs supply

Food Systems

Accessibility and affordability of healthy sustainable foods can be supported through land use planning and design.

SPOTLIGHT: Fruit & veg on prescription pilot

"An innovative pilot, thought to be the UK's first large-scale "fruit and veg on prescription" project, has been launched to help tackle health inequalities and food poverty. Alexandra Rose Charity, in partnership with public health teams in the London boroughs of Tower Hamlets and Lambeth, has launched Fruit & Veg on Prescription as part of a £250,000 pilot funded by local authorities and Impact on Urban Health to help tackle health inequality and food poverty."

During the 12-month pilot, Rose Vouchers for Fruit and Veg will be distributed to a target group of 122 residents across both boroughs who are at risk of, or have, conditions such as high blood pressure, diabetes or mental health conditions and are struggling financially. When the pilot is evaluated, it could be rolled out across the UK subject to funding.

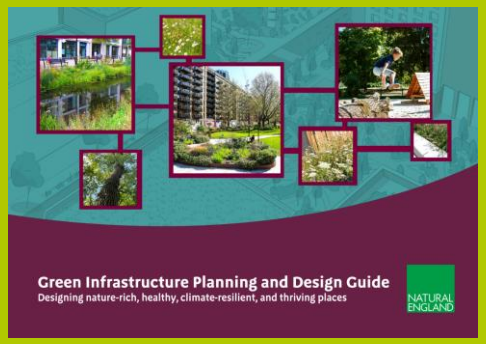
Food Systems – What is the way forward?

Accessibility and affordability of healthy sustainable foods can be supported through land use planning and design.

- The Thurrock Local Plan should ensure that the number and diversity of food retail outlets and food growing spaces are protected and increased
- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
    - National Food Strategy
    - Planning Sustainable Cities for Community Food Growing
    - Creating a healthy food economy: A policy audit tool for Local Authorities
    - Hot Food Takeaways: Planning a route to healthier communities
- Consider how future Health and Wellbeing Strategies can support the food system as it relates to human health, place-shaping and climate change
- Consider the best approach to assessing progress on food policy and identifying where further action is needed as a first step towards creating a new food policy or strategy. For example, utilising '**Creating a Healthy Food Economy: A Policy Audit Tool for Local Authorities**', which considers as a minimum:
    - Accessibility to affordable and diverse healthy foods
    - Community food growing schemes such as allotments and school growing clubs
    - Density of unhealthy fast-food outlets
    - Addressing rising food poverty
    - Engaging schools and other public institutions in improving the food environment
    - Investment in and protection of local food infrastructure
    - Reducing food waste to support tackling climate change and improving food security
- Create a dialogue with key local stakeholders, including the CVS-led Food Network, to establish the motivation for a Thurrock Food Partnership which brings together partners from the public sector, voluntary and community groups, and businesses to reduce diet-related ill health and food poverty, while supporting a prosperous local food economy

Natural Environments

Community planning which preserves and connects the surrounding natural environment & supports biodiversity can have significant health & well-being impacts.



- Improving access to and engagement with the natural environment for mental health and wellbeing
- Adapting to climate change
- Increasing participation in physical activity
- Reducing exposure to air pollution

Natural Environments

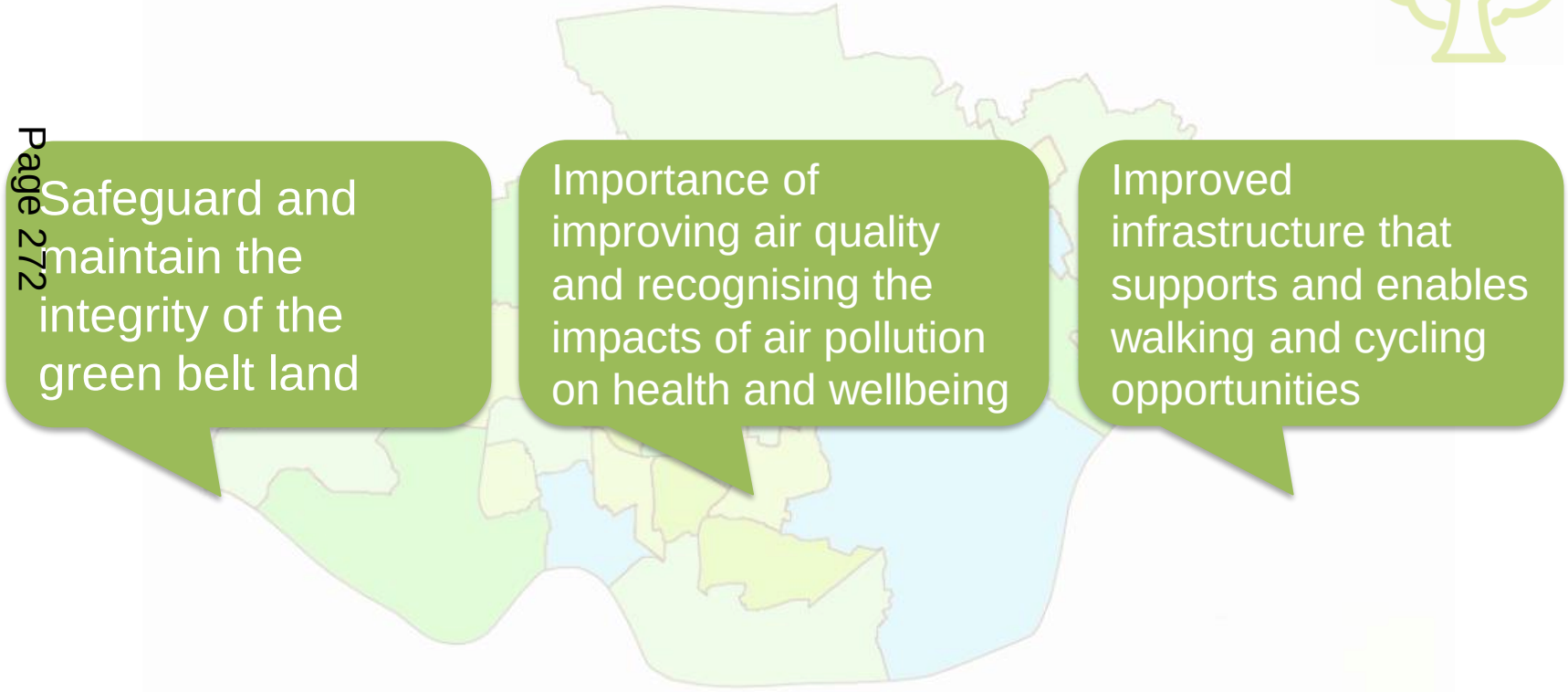
Community planning which preserves and connects the surrounding natural environment & supports biodiversity can have significant health & well-being impacts.

Related indicators from Thurrock's Health and Wellbeing Strategy
5D: Regeneration and future developments will seek to improve physical and mental health, reduce expose to air pollution and to build community resilience and reduce antisocial behaviour
• *Local Plan policies and Health Impacts Assessment for major new developments will consider a full range of health and well-being issues including for example, Active Travel and Public transport; access to green and open spaces; air quality; and the food environment* • *All council-led new build schemes will comply with Secured by Design standards* • *All regeneration and developments will increase physical activity, promote mental wellbeing, reduce exposure to air pollution, promote availability of healthy food options, enhance community resilience, and reduce anti-social behaviour*

Natural Environments

Community planning which preserves and connects the surrounding natural environment & supports biodiversity can have significant health & well-being impacts.

Resident Voice



Safeguard and maintain the integrity of the green belt land

Importance of improving air quality and recognising the impacts of air pollution on health and wellbeing

Improved infrastructure that supports and enables walking and cycling opportunities

Natural Environments

Community planning which preserves and connects the surrounding natural environment & supports biodiversity can have significant health & well-being impacts.

SPOTLIGHT: SEE Park

The South Essex Estuary (SEE) Park plans include a continuous and accessible coastal path stretching from Tilbury Fort to Shoeburyness, ensuring every home will have easy access to high quality green space, creating new woodlands, restoring marshlands and completing a huge network of natural landscapes. This vision for South Essex to become an extraordinary parkland setting providing an attractive offer for modern living that supports residents, businesses, industry, tourism, and leisure activities.

Natural Environments - What is the way forward?

Community planning which preserves and connects the surrounding natural environment & supports biodiversity can have significant health & well-being impacts.

- The Thurrock Local Plan, Public Realm, Regeneration and Recreation and Leisure teams should ensure that the natural environment is protected and enhanced to encourage access and engagement in physical activity and mental wellbeing, reduce exposure to air pollution and support adaptation to climate change

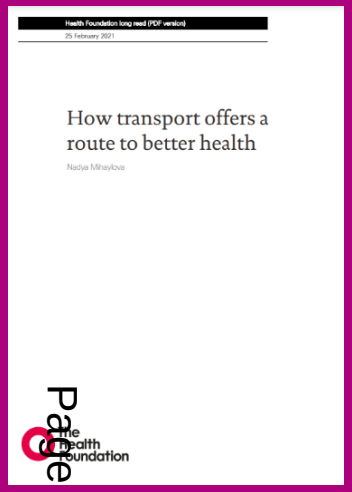
- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
  - Building with Nature
  - Improving access to greenspace
  - Green Infrastructure Planning and Design Guide
  - Using Green Infrastructure to protect people from air pollution

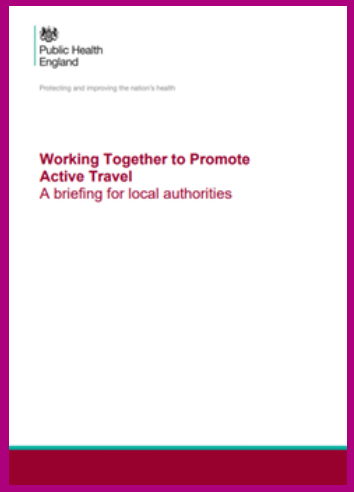
- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and natural environments

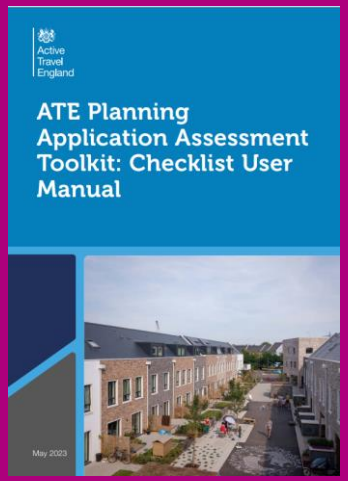
- Consider commissioning **Green Infrastructure Training for local authorities** provided by Building with Nature which is recommended for elected members, directors / heads of public health, heads of place, heads of highways, local lead flood authorities, climate and sustainability leads, and all teams whose work influences green infrastructure provision

Transportation Networks

Healthy and sustainable transportation networks prioritise and support active transportation modalities.







- Increasing the provision of safe, easily accessible active travel infrastructure (cycling, walking, wheeling)
- Increasing the availability, reliability and affordability of public transport
- Reducing air pollution

Transportation Networks

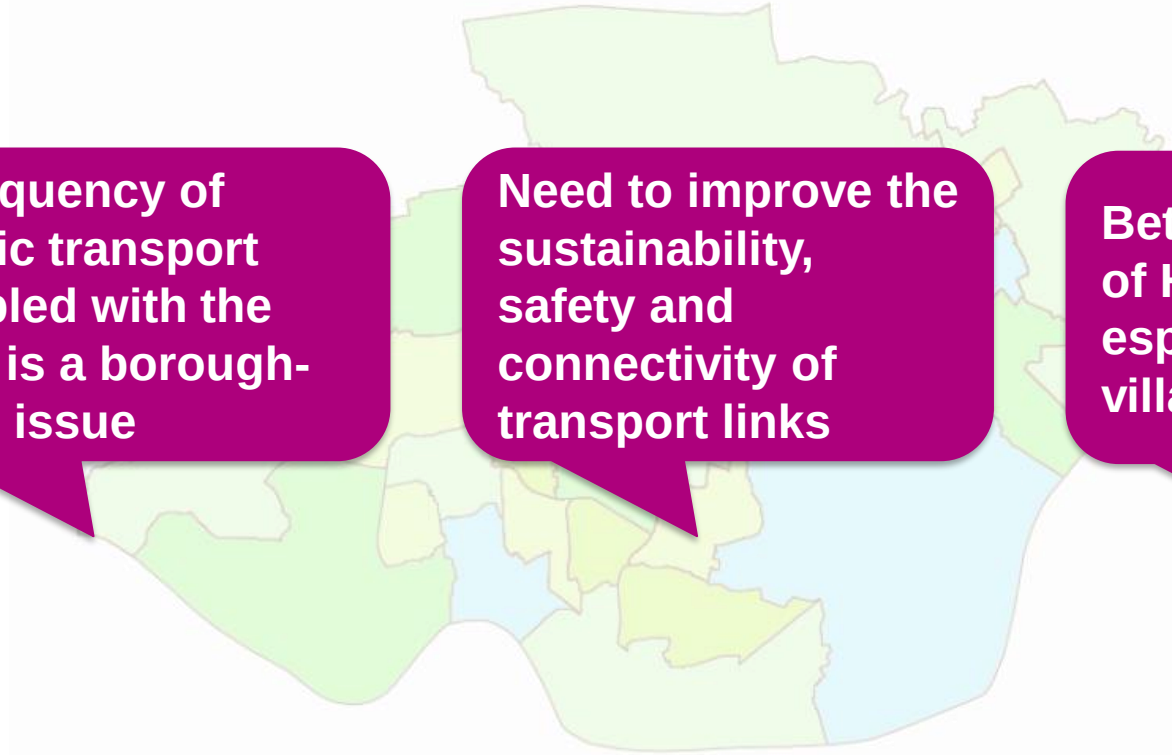
Healthy and sustainable transportation networks prioritise and support active transportation modalities.

Related indicators from Thurrock's Health and Wellbeing Strategy
1A: Work with communities to reduce smoking and obesity in Thurrock
• *Reducing the proportion of Reception, Year 6 children and adults in Thurrock who are obese and reducing the variation between community*
5D: Regeneration and future developments will seek to improve physical and mental health, reduce exposure to air pollution and to build community resilience and reduce antisocial behaviour
• *Local Plan policies and Health Impacts Assessment for major new developments will consider a full range of health and well-being issues including for example, Active Travel and Public transport; access to green and open spaces; air quality; and the food environment*

Transportation Networks

Healthy and sustainable transportation networks prioritise and support active transportation modalities.

Resident Voice



Infrequency of public transport coupled with the cost is a borough-wide issue

Need to improve the sustainability, safety and connectivity of transport links

Better management of HGV movements especially in villages

Transportation Networks

Healthy and sustainable transportation networks prioritise and support active transportation modalities.

SPOTLIGHT: What works to increase cycling?

Areas that have successfully increased levels of walking and cycling have all prioritised people and place first, with cars being a ‘guest’ in the area. Attributes of successful infrastructure include:

- Routes designed with the continuity of the route in mind
- Routes that are legible and do not depend on signage
- Cyclists are segregated from traffic on busy roads or junctions
- Participatory design at a local level ensures that residents’ needs and concerns are addressed

The most effective mechanisms for increasing walking and cycling comprise of a complementary package of measures, such as:

- Provision of dedicated cycling lanes (and bicycle parking)
- Personal travel planning (behaviour change)
- Walk / cycle to work days
- Cycle hire/bike share schemes
- School-based interventions
- Cycle maintenance skills training

Transportation Networks - What is the way forward?

Healthy and sustainable transportation networks prioritise and support active transportation modalities.

- The Local Plan, Transport Vision and Strategy, regeneration programme and Design Charter and Design Codes should be utilised to embed a commitment to accessible and safe transport infrastructure which supports a modal shift to cycling, walking and wheeling, as well as improvements (availability, reliability and affordability) in public transport, as a means to reduce both health inequalities and air pollution

- Integrate into local place-shaping the principles that contribute to a reduction in health inequality as detailed in:
  - Decarbonising Transport: A Better, Greener Britain
  - Gear Change: A bold vision for cycling and walking
  - How transport offers a better route to health
  - Working together to promote active travel: A briefing for Local Authorities

- Implement the Health and Wellbeing Strategy priority actions pertaining to place-shaping and transportation networks

- Implement the recommendations of the Thurrock Active Travel Needs Assessment

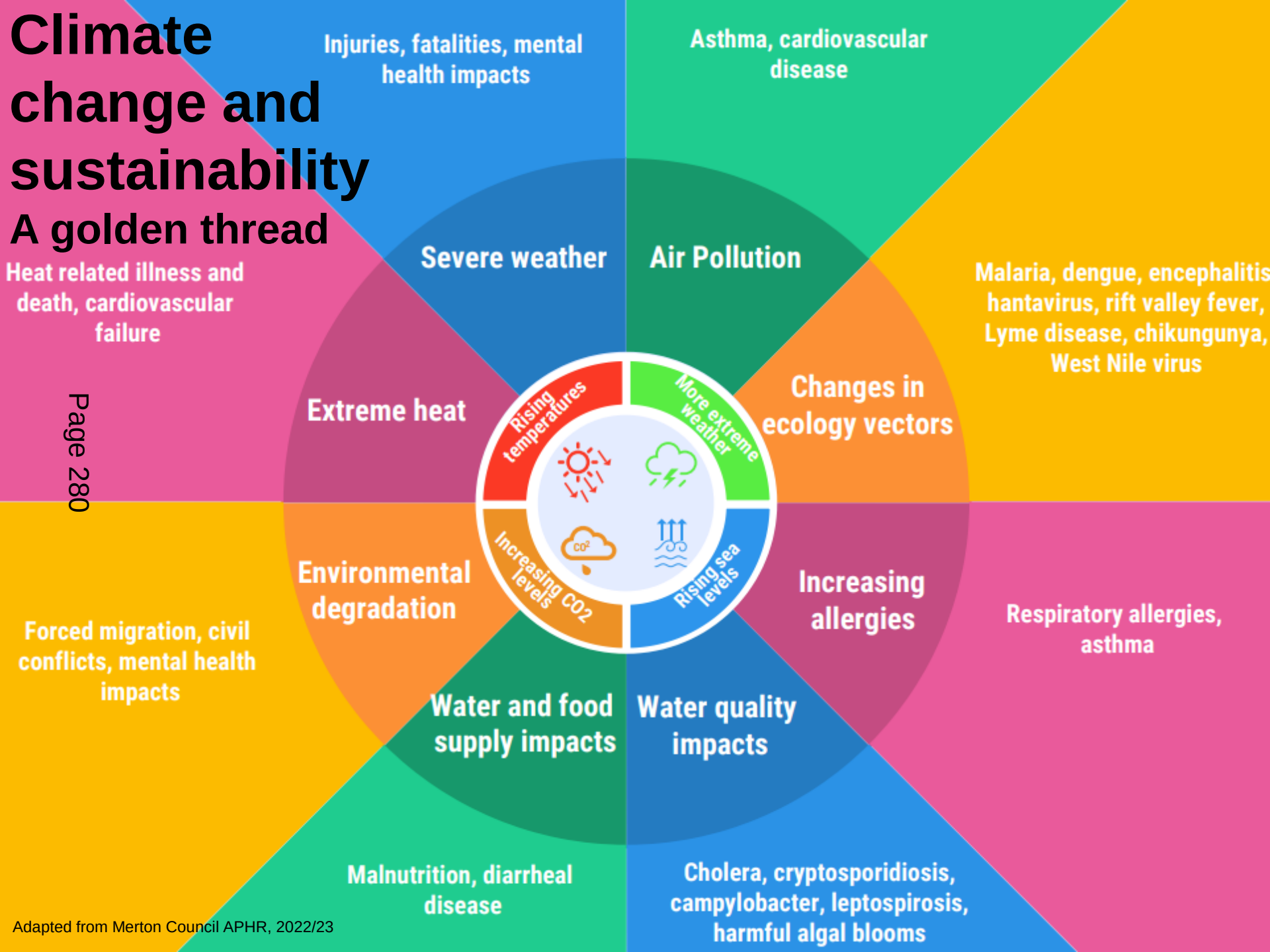
- Deliver the Thurrock Local Cycling and Walking Infrastructure Plan (LCWIP)

- Identify a Senior Champion for Active Travel within the Council

- Building on the existing Cycle Forum, establish a Taskforce for Active Travel which will specifically focus on increasing cycling in the Borough.

Climate change and sustainability

A golden thread



Adapted from Merton Council APHR, 2022/23

Climate Change: summary of key issues

- *The damaging outcomes of climate change continue to have the most severe impacts on the most vulnerable and those least able to respond*

- *Efforts to adapt the UK's housing stock to the impacts of the changing climate: for higher average temperatures, flooding and water scarcity, are lagging far behind what is needed to keep us safe and comfortable, even as these climate change risks grow*

- *Climate change will make it harder for the government to ensure the resilience of the UK's food supply, which will likely result in further volatility in domestic food prices unless the UK adapts*

- *Green infrastructure is potentially vulnerable to climate change; for example, a shortage of water could diminish the quality of green spaces and their ability to function as adaptation solutions (such as urban cooling and flood management)*

- *Transport is a key contributor to climate change, responsible for producing 24% of the UK's total greenhouse gas emissions in 2020.*

thurrock.gov.uk

19 October 2023	**ITEM: 9**

Health and Wellbeing Board

Thurrock Health and Wellbeing Strategy 2022-26 – Overview and annual progress report for Domain 6, Community Safety

Wards and communities affected: All	**Key Decision:** None

Report of: Michael Dineen, Strategic Lead for Counter Fraud & Investigation, Public Realm

Accountable Director: Claire Demmel, Interim Corporate Director Public Realm

Executive Summary

This paper provides an overview of Thurrock Health & Wellbeing Strategy (HWBS) 2022-26 and provides a specific update on progress made with implementing domain 6 of the Strategy, Community Safety.

1. Recommendation(s)

1.1 The Board is asked to:

- Note the overview provided on the complete Health and Wellbeing Strategy.
- Review, comment on and approve progress made against domain six commitments for year one, as previously approved by Board and commitments for year two.

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/strategies/health-and-well-being-strategy

2.3 Proposals for the current 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. Preparatory work with system partners and HWBB Chair identified key influences on Health & Wellbeing and suggested that the HWBS needs to:

- Be high level and strategic
- Be highly ambitious and set out genuinely new plans rather than just describe what has already been done
- Provide a clear narrative that drives the work of all aspects of the local authority, NHS and third sector
- Address resident priorities and be co-designed with residents
- Be place and locality based and take a strengths and assets approach, not focused only on deficits or services

3.2. The HWBB agreed that the Strategy would have a Vision of *Levelling the Playing Field* and tackling inequalities is reflected throughout the Strategy. 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

3.3. 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.

3.4. 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 summary of the consultation exercise is provided below and a full Consultation Report was produced. The refreshed HWBS proposals were refined to reflect consultation outcomes, and the changes made in response to community feedback are detailed in the full Consultation Report.

4.2 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.

4.3 Officers attended Scrutiny Committees, Group meetings and a range of stakeholder meetings to seek feedback. Direct face to face engagement was impacted by COVID-19 but Thurrock CVS and Healthwatch engaged directly with residents and also ran two workshops comprising representatives from several CVS organisations operating in Thurrock.

4.4 The Strategy reflects and addresses key themes arising in feedback which comprised accessibility through IT digital exclusion geographical locations and capacity of services; informing residents by effectively communicating using range of methods, the role of residents and support available to improve their own health and wellbeing; The Environment and managing the impact of housing and commercial developments, providing access to green, open spaces and opportunities for people to remain active and socialise in a safe environment; and Mental Health and the impact of COVID on social isolation and loneliness as well as the link between wider mental ill health and wider determinants.

5. Governance

5.1. The duty to produce the HWBS statutorily falls to the HWBB. Three versions of the Strategy were produced to ensure broad accessibility to the report. These are available on the Council website at Health and well-being strategy 2022-2026 | Health and well-being strategy | Thurrock Council:

- The main Strategy document
- An Accessible version to comply with website publication guidance attached
- An Easy Read version.

5.2. Subsequent to the Strategy being agreed, further work was undertaken to establish appropriate ways of monitoring and reporting progress to the Board. During year one the board was presented with each of the domains which included priorities and commitments for year one. Year two reports will provide Board members with a progress report against those commitments and set out priorities for year two.

6. Domain 6 – Community Safety

6.1. Appendix A provide the Board with a detailed overview of Domain 6, Community Safety.

7. Reasons for Recommendation

7.1. 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

9.1 Financial

Implications verified by: Not sought as provides paper provides an overview of existing strategy, previously provided with implication approval.

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: Not sought as provides paper provides an overview of existing strategy, previously provided with implication approval.

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: Not sought as provides paper provides an overview of existing strategy, previously provided with implication approval.

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. Domain 6, Community Safety. Overview, progress report and commitments for year two.

Report Authors: Michelle Cunningham, Community Safety Partnership Manager
Dr Jo Broadbent, Director for Public Health
Priscilla Bruce-Annan, LSCB Business Manager
Iyobosa Osunde, Head of Social Work Support

This page is intentionally left blank

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 – Year 2

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

Reporting against our commitments for year 1.

What we said we would do	Progress made
Develop a Serious Youth Violence Strategy	This is in response to the implementation of the Serious Violence Duty and requirement to publish a strategy by end Jan 24. Essex Violence and Vulnerability Unit are developing a Greater Essex strategy in response to their strategic needs assessment (high level draft currently) which we will adopt locally.
Increase in identified gang nominals or children being exploited by gangs engaging in identified interventions under the gang related forum prevention key performance indicators	For year ending March 23, 47 nominals monitored by the gang related forum, 19 new referrals and 18 removed. 10 completed Gang intervention/knife prevention programmes. All those aged < 18 received intervention through either YOS or our Young Person's Exploitation Worker. 21 were supported in Employment/Education/Training
Reduction in school exclusions as a result of knife crime	Since inception, our outreach programme supported 154 pupils at risk of exclusion with only two being permanently excluded.
Decrease the percentage of YOS cohort of offenders who have reoffended	The MOJ reoffending data published in June 2022 (YDS 110) indicates that Thurrock's reoffending rate for the yearly cohort was 36.4%. The MOJ reoffending data published in June 2023 (YDS 114) indicates that Thurrock's reoffending rate for the yearly cohort was 37.3% *This indicates a very slight increase over the financial year and will be closely monitored at the Youth Crime Governance Board. The cohort is very small (under 12) and therefore the percentages are likely to fluctuate up and down.*

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

Our commitments and ambitions for Year Two – 2023/24

- Develop a local Thurrock Action Plan in response to the serious Violence Duty and Essex wide strategy aligned to the Health and well Being Strategy to be implemented from April 24.
- The 11-19 Strategy Group review the Violence and Vulnerability agenda to look at solutions in communities and schools.
- The 11-19 Strategy Group Meeting focusses on skills agenda in the borough prioritising access to training, work experience and employment opportunities to vulnerable groups, i.e., YP known to YOT
- Reduce school exclusions: Through Essex Violence and Vulnerability funded projects including outreach support for schools working with young people at risk of permanent exclusion and intensive programmes for those at risk of exploitation and serious violence.
- The work we are undertaking with the Delivering Better Value DfE programme which is looking to support children with additional needs will provide opportunities for additional funding to further imbed outreach provision.
- The Youth Crime Governance Board (YCGB) have reviewed the knife crime protocol for schools and are in the process of finalising before issuing to all schools in the autumn term 2023.

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

Reporting against our commitments for year 1.

What we said we would do	Progress made
Establish a Combatting Drugs Partnership for Thurrock	This has been established as a joint Southend, Essex and Thurrock Drug & Alcohol Partnership (SET DAP), including membership from all 3 Local Authorities, MSE ICS, Essex Police, National Probation Service, OPFCC and Essex Recovery Foundation.
Complete a Joint Local Needs Assessment for Drugs	An Alcohol & Substance Misuse: epidemiological population health needs assessment for Thurrock was completed in August 2022 and is published here . An Outcomes Framework for SET DAP is also being produced to inform local delivery of the National Drugs Strategy.

Our commitments and ambitions for Year Two – 2023/24

- Implement street pastors scheme in Grays to increase presence of trusted adults (in response to feedback from young voices)
- Continue to work in partnership with external agencies, councillors and community, utilising data including crime recording, and ASB reporting to identify emerging criminality/concerns and to implement bespoke problem-solving measures to address. This includes High visibility patrols with police and enforcement officers, pop up engagement events, target hardening measures, and education programmes.
- Re-commission an all-age Substance Misuse Service for Thurrock in line with Human Learning System principles.
- Review the SET DAP Outcomes Framework, to ensure delivery of the National Drugs Strategy at a local level.

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

Reporting against our commitments for year 1.

What we said we would do	Progress made
Completion of the SETDAB Board, Thurrock Council, Southend Council and Essex County Council's 'discovery project'	A mapping exercise assessed the access routes into services, where these may overlap and where there are gaps in provision. A report was commissioned by Essex County Council through an independent research expert to understand the above areas. The final report was published in February 2023
Develop a harmful sexual behaviours framework for Children & Young People in Thurrock	A Harmful Sexual Behaviours Project has been launched across the multi-agency partnership. Following an audit of provision to support children and young people, practitioner training on the Brook Traffic Light Tool has been rolled out to practitioners working with children and young people to understand the issue and to provide appropriate interventions and support.

Our commitments and ambitions for Year Two – 2023/24

- Redesign of services in relation to DA across Essex is being considered and is in early development stage. In order to ensure victims resident in Thurrock have access to services that meet local needs, the service design will be based on a local needs analysis as well as the wider analysis that has been conducted across SET.
- To increase take up of the Brook Traffic Light Tool training to ensure identification of where intervention and support is required. Audit use and impact of the implementation of the Brook Traffic Light Tool.

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. Joined up work with the Local Safeguarding Childrens Partnership (LSCP and Safeguarding Adults Board (SAB) will identify where the transitions process is to be developed and strengthened leading to vulnerable young people experiencing a transition based on need.

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

Reporting against our commitments for year 1.

What we said we would do	Progress made
Launch of an animated sexual violence awareness e learning training for professionals	This training launched in February 2022. To date there are 32 active licences in use indicating the number of users completing the training.
Refresh of the Violence Against Women and Girls Strategy including the Minerva project	Thurrock VAWG strategy was refreshed and was presented at Overview and Scrutiny. Confirmation of funding awaited to launch Minerva project in Corringham, including CCTV, bystander training and self defence
Reduction in the number of vulnerable people aged 16-25 who enter the system at a point of crisis by 2026	The Transition team attends Education Health Care Plans for young people from year 9 to understand young people's needs and provide information and advice on services available in the community with the aim of providing early help to reduce and prevent needs escalating. The team completes care act assessments in line with the Care Act and identify needs and outcomes that will prevent escalation and delay needs from reaching a crisis point. The Team also completes Carers' Assessment to avoid carer breakdowns as well as to support the young people to remain living with their families as long as possible. Ongoing work with stakeholders.

Our commitments and ambitions for Year Two – 2023/24

- Increase the number of completions of the new Sexual Abuse training product and the DA and stalking offer internally and across the wider partnerships.
- To review ASC training plan to ensure safeguarding training is mandatory for provider of services and people working with vulnerable young people and families.
- Ensure improved practice and system change, including increasing inter-agency working and breaking down the barriers for young people.
- Ensure stakeholders including young people and families are represented in transitioning safeguarding arrangements steering group.

Reporting against the monitoring framework

Indicator	Delivery/Monitoring	Outcome Term	Progress Report
Goal 6A: Enable all children to live safely in their communities			
Implement a Serious Youth Violence Strategy including the recommendations of the 2020 Annual Public Health Report & Brighter Futures Strategy SP3	Gang Related Violence Performance Indicators & Brighter Futures Monitoring Framework	Short	Led by Essex VVU, high level strategic needs assessment shared, Strategy to be published end Jan 24 and Local Thurrock Plan implemented from April 24
Achieve a reduction of children being convicted of possession with intent to supply and possession of a bladed article	Gang Related Violence Performance Indicators	Medium	Individuals monitored by the GRV have shown a reduction in conviction for offences of possession with intent to supply and possession of a bladed article from 47% in 2021/2022 0 19% in 2022/2023.
Achieve a decrease in the percentage of Youth Offending Service cohort of offenders who have reoffended after a previously recorded offence	Gang Related Violence Performance Indicators	Long	*The MOJ reoffending data published in June 2022 (YDS 110) indicates that Thurrock's reoffending rate for the yearly cohort was 36.4%* *The MOJ reoffending data published in June 2023 (YDS 114) indicates that Thurrock's reoffending rate for the yearly cohort was 37.3%* *This indicates a very slight increase over the financial year and will be closely monitored at the Youth Crime Governance Board*
Goal 6B: Work in partnership to reduce local levels of crime and opportunities for crime to take place, which will result in fewer victims of crime and make Thurrock a safer place to live			
Developing local practice around contextual safeguarding and reachable moments.	Thurrock Council Children's Social Care & TSAB	Short	Contextual Safeguarding is model used throughout CSC and is embedded in practice. The YOS continue to support young people at the reachable moments particularly when in Custody or at the point of school exclusion.
Training all staff in relevant roles in contextual safeguarding, evidence based parenting programmes and trauma informed youth justice practice.	HR/OD/ Safeguarding Boards	Medium	Contextual Safeguarding reports are produced bi- monthly, that highlights those children most at risk from exploitation, their peer groups, places of interest (hot spots) identified by mapping which triggers multi agency responses for disruption.
A reduction in community-based violence	Community Safety Partnership	Long	For 12 months to July 23 Violence against the person offences, excluding Domestic Abuse offences have reduced by 11%

Reporting against the monitoring framework

Indicator	Delivery/Monitoring	Outcome Term	Progress Report
Goal 6C: Improve the local response to supporting victims/survivors of crimes to improve their health and wellbeing			
Embed the Duty of the Domestic Abuse Act to consult with victims/survivors Action plan developed to implementing the recommendations from the SVA JSNA to consult with victims/survivors	Action Plan Monitored at VAWG Board	Short	Service user and stakeholder engagement has played a key role in the discovery project. Survivor engagement will continue through our service provision in the upcoming needs assessment as required by DA Act.
Undertaking the consultation with victims/survivors/professionals to understand barriers & facilitators	Summary report of quantitative & qualitative feedback from victims/survivors Monitored at VAWG Board	Medium	Following SERICC's support to the largest child exploitation investigation ever undertaken by Essex Police, survivors assisted to develop a new support guide for families and children.
Provide Domestic Abuse and Sexual Violence and Abuse services based on the findings from engagement with local victims/survivors	Summary report of changes to commissioned services Monitored at VAWG Board	Long	O&S Report details changes to commissioned services, available here.

Reporting against the monitoring framework

Indicator	Delivery/Monitoring	Outcome Term	Progress Report
Goal 6D Name: Work in partnership to prevent and deter crime, with a focus on those with increased risk of experiencing crime			
Develop a process and pathways (in consultation with the target population) that will deliver a more individualised transition of vulnerable young people from Children's to Adults Services	Action plan for the development, implementation and review of the new 'Transitions Process' Monitored via TSAB	Short	Progress has been slower than hoped, although it is a priority for both the Safeguarding Adults Board and the Safeguarding Childrens Partnership. We have developed a process and written policy and guidance around this. Before implementation it was agreed that we would scope out and detail all the support available to enable us to develop clear pathways of support. We have a draft of current support available. One of the gaps is around support for those who do not fit into existing pathways i.e., exploitation. These people are very likely to bounce back into the system in the future. We have a meeting on the 10th October to discuss the options and start work on the pathway. To support us with this, we will be inviting frontline practitioners to support us in taking the work forward, by highlighting what is working well in addition to barriers that are preventing support.
Implement the new 'Transitions process' and pathways' across the workforce	'Transitions Process' Action Plan Monitored via TSAB	Medium	TC has a Preparing for Adulthood strategy which was co-produced with partners and the consultation process was led by the User-Led Organisation focusing on all four key action set based on the Preparing for adulthood outcomes. The strategy group meets every three months to review the action set and implementation plan. We know that as young people with SEND move towards adulthood, they experience many changes which can be challenging and we are committed to supporting young people during transition to be at the centre of planning and decision making, to ensure a good transition to adulthood. The main aim of the strategy is for all stakeholders, partners, and organisations to embed it within their practice.
Transition age young people report feeling better supported Achieve a reduction in vulnerable people aged 16-25 who enter the system at a point of crisis	User feedback from case studies and surveys Metric for the reduction is new and may be difficult to capture this information (to be discussed with the Transitions Group) Monitored by TSAB & LSCP	Long	The Transition team attends Education Health Care Plans for young people from year 9 to understand young people's needs and provide information and advice on services available in the community with the aim of providing early help to reduce and prevent needs escalating. The team completes care act assessments in line with the Care Act and identify needs and outcomes that will prevent escalation and delay needs from reaching a crisis point. The Team also completes Carers' Assessment to avoid carer breakdowns as well as to support the young people to remain living with their families as long as possible. Ongoing work with stakeholders

Domain 6, Community Safety
Key deliverables, commitments and milestones
Year Two (July 2023 - June 2024)

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

- Develop a local Thurrock Action Plan in response to the serious Violence Duty and Essex wide strategy aligned to the Health and well Being Strategy to be implemented from April 24.
- The 11-19 Strategy Group review the Violence and Vulnerability agenda to look at solutions in communities and schools.
- The 11-19 Strategy Group Meeting focusses on skills agenda in the borough prioritising access to training, work experience and employment opportunities to vulnerable groups, i.e., YP known to YOT
- Reduce school exclusions: Through Essex Violence and Vulnerability funded projects including outreach support for schools working with young people at risk of permanent exclusion and intensive programmes for those at risk of exploitation and serious violence

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

- Implement street pastors scheme in Grays to increase presence of trusted adults (in response to feedback from young voices)
- Continue to work in partnership with external agencies, councillors and community, utilising data including crime recording, and ASB reporting to identify emerging criminality/concerns and to implement bespoke problem solving measures to address. This includes High visibility patrols with police and enforcement officers, pop up engagement events, target hardening measures, and education programmes.
- Re-commission an all-age Substance Misuse Service for Thurrock in line with Human Learning System principles
- Review the SET DAP Outcomes Framework, in order to ensure delivery of the National Drugs Strategy at a local level

Domain 6, Community Safety
Key deliverables, commitments and milestones
Year Two (July 2023 - June 2024)

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

- To deliver "walk and talk" in our town centres and respond to findings
- System redesign of DA services across Essex is being considered and is in early development stage. The initial model will focus on five key principles: a single point of access for victims/survivors, children and preparators with signposting to the most appropriate services, a whole family approach including the perpetrator where risk assessed as safe to do so, engaging minoritised groups, providing longer term support where appropriate, breaking the cycle through investment in prevention and early intervention with perpetrators

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

- Increase the number of completions of the new Sexual Abuse training product and the DA and stalking offer internally and across the wider partnerships.
- Continue to raise awareness of support services available in the borough through events such as 16 days of activism.
- Explore opportunities to determine if a suite of targeted intervention for females that are at risk of exploitation can be provided.