

Thurrock Health And Wellbeing Strategy

2022-2026

Levelling the Playing Field
in Thurrock



Created through the partnership of Thurrock Health and Wellbeing Board



Year 2 report to Thurrock Health and Wellbeing Board
Domain 1, Healthier for Longer

Domain 1 Healthier for Longer

Domain Aims and Ambitions

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

What we want to achieve

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

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

How this Domain levels the playing field

This will Level the Playing Field by:

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

Domain Goals

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

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



What we want to achieve

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

Some key challenges

Smoking: –

- Smoking is the largest single modifiable factor contributing to health inequalities, accounting for half the difference in life expectancy between the most and least deprived communities.
- Thurrock has one of the highest smoking prevalence rates in England at 17.5% (vs 13.9% England avg.), with over half of all smokers living in the eight most deprived wards in Thurrock³.
- Smoking rates are known to be higher in more deprived communities (20-22%), Routine and Manual workers (27%); People with a long term mental health condition (28%); LGBTQ+ individuals (25-27% - national data).

Obesity: –

- >70% of adults are overweight or obese in Thurrock, and Thurrock is in the worst quartile for obesity rates across all ages, inactivity and diet.
- Childhood obesity is significantly worse in Thurrock than England (24% in Year 6 vs 20%⁵), and is associated with deprivation, BAME ethnicity and living in urban areas.
- There is a high correlation between obesity and poorer health outcomes. Obesity is linked to nutrition and physical activity, but also factors such as unemployment, low educational attainment, housing tenure and environment⁴.

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



How we will achieve this Goal

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

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

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

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

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

What will we do differently under this strategy?

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

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



How we will achieve this Goal

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

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

What will we do differently under this strategy?

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

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



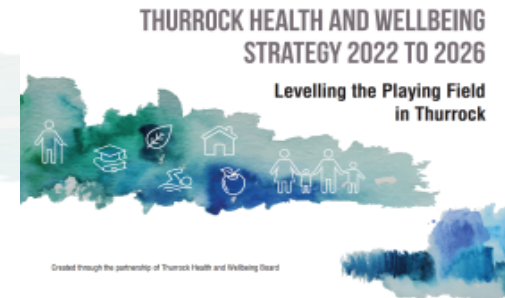
Reporting against our commitments for year 1.

What we said we would do	Progress made
Complete a Joint Strategic Needs Assessments for the Local Plan	Health in All Policies Place Shaping report under consultation. Final version will be brought to HWB Board in December as part of Domain 5 update
Co-produce Whole System Tobacco Control and Obesity strategies with the community and stakeholders	Tobacco Control JSNA complete (See Here) and Strategy final draft under consultation. Implementation Plan to be developed. Obesity strategic approach being reviewed with system leaders from Primary Care, MSE ICS and Thurrock Council. MSE Weight Management Group established to enhance weight management pathways.
Reduction in the proportion of people who smoke and reduce the variation between community groups by 2026	Targeting of smoking cessation support in place in line with JSNA: targeting smoking cessation support to 8 most deprived Wards; embedding smoking cessation in clinical pathways.
Slow the increase in obesity rates for Year R and Year 6 children, and adults by 2026	Obesity strategic approach being reviewed with system leaders from Primary Care, MSE ICS and Thurrock Council. Weight Management for children & families - Taskforce established and service to be included in Healthy Families service re-procurement in 2023/24.

Our commitments and ambitions for Year Two – 2023/24

- Implement Thurrock Tobacco Control Strategy
- Revised weight management pathway in place across Local Authority and NHS services
- Commission enhanced children & families weight management service
- Health in All Policies Place Shaping report findings included in revised Thurrock Local Plan

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



What we want to achieve

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

Some key challenges

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

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



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

How we will achieve this Goal

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

What will we do differently under this strategy?

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

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



Reporting against our commitments for year 1.

What we said we would do	Progress made
Complete a Substance Misuse Health Needs Assessment	Health Needs Assessment completed (See Here). Findings are informing the drug and alcohol misuse service specification for service re-procurement during 2023/24.
Launch of multi-disciplinary Complex Care team pilot for those with mental health & other challenges to support them to remain in Council housing stock	Multi-disciplinary Complex Care team pilot underway, with both specialist Mental Health and Substance Misuse outreach support. Substance Misuse elements of the service will be delivered on an ongoing basis through the service re-procurement.
Redesigned depression diagnosis-wellbeing calls pathway in place in GP practices	Wellbeing calls pathway in place for individuals with a new diagnosis
All young people transitioning to Adult Mental Health Services have a Joint Care Plan in place	Service transition policy in place

Our commitments and ambitions for Year Two – 2023/24

- Substance Misuse Service recommissioning completed for new integrated all age service
- Complex Care Team Assertive Outreach for substance misuse function commissioned as part of core service
- Dual diagnosis pathway for substance misuse and mental health review under way
- Mental health diagnoses in CVD conditions reviewed as part of Case Finding Strategy development

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



What we want to achieve

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

Some key challenges

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



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

How we will achieve this Goal

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

What will we do differently under this strategy?

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

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



Reporting against our commitments for year 1.

What we said we would do	Progress made
Piloting of health outreach sessions towards inclusion health groups (Traveller & Showmen and Homeless)	A programme of outreach sessions in place across all Traveller and Showmen sites in Thurrock, involving public health, primary care and specialist Liaison staff. Soup Kitchen outreach in development.
Launch of the first IMWC in Corringham	IMWC in Corringham operational and hosting a range of NHS and wider wellbeing services.
Improve quality of care for LTCs e.g., increase in the number of people with high blood pressure whose care meets national standards	Cardiovascular Disease Local Enhanced Service (CVD LES) in place in primary care, building on improvements in previous years. National data for 2022/23 shows that quality of primary care for CVD in Thurrock is among the best in England. The Thurrock CVD quality improvement programme has been presented to national NHSE and DHSC CVD Clinical Leads.
Increase in the proportion of people who have their LTC diagnosed and treated	Hypertension detection programmes underway in Primary care. LTC Case Finding Strategy in development with primary and community care clinicians. Hypertension diagnosis rates in Thurrock (as a % of estimated prevalence) increased since 2019/20, despite the pandemic, and is the highest in Mid & South Essex ICS.
Increase in the percentage of individuals with Severe Mental Illness receiving a Physical Health Check	General increase since 2018/19 at 19%, followed by 43% in 2019/20. Pandemic year 2020/21 reduced to 17%, but upward trend since 2021/22 at 59% and currently 61% in 2022/23.

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

THURROCK HEALTH AND WELLBEING
STRATEGY 2022 TO 2026

Levelling the Playing Field
in Thurrock



Our commitments and ambitions for Year Two – 2023/24

- LTC Case Finding Strategy co-produced between Thurrock primary care, clinicians and public health
- CVD primary care quality improvement programme agreed with MSE ICS
- MSE ICS Population Health Improvement Board (PHIB) health inequalities initiatives implemented in Thurrock, including physical and mental health, and an all age approach

Domain 1 Reporting against the Monitoring Framework



Indicator	Delivery/Monitoring	Outcome Term	Progress report	Direction of Travel
Goal 1A: Work with communities to reduce smoking and obesity in Thurrock				
Tobacco Control Strategy for Thurrock in place and being delivered	By Thurrock Public Health Team	Short	Tobacco Control Strategy for Thurrock in place and being delivered – the final draft of the Tobacco Control Strategy will be completed by mid-June 2023.	Following sign-off a delivery plan will be agreed with all relevant partners and stakeholders.
Smoking Prevalence in Adults	Via Tobacco Control Strategy	Medium	13% (2021).	Decrease from 14% in 2020, and from 2017 to 2019 at 18%. Current prevalence of 13% is same as England average.
Smoking attributable mortality	Via Tobacco Control Strategy	Long	262 per 100,000 (DSR) 2017-2019	Decreasing from 300 per 100,000 in 2013-15 to 285 per 100,000 in 2015-17 to currently 262 per 100,000 in 2017-19. Thurrock rate is higher than England rate for 2017-19, and is the third highest against CIPFA neighbours.
Whole System Obesity Strategy for Thurrock in place and being delivered	By Thurrock Obesity Alliance	Short	A Child Weight Management Taskforce set up to increase referrals to services	NCMP due to be completed next month; Currently approximately 95% of Reception and Year Six pupils had their weight measures; an indication of direction of travel for children weight can be ascertained next month upon completion of programme.
Percentage of adults overweight or obese	Via Whole System Obesity Strategy	Medium	70% (2021/22).	Decrease from 2020/21 at 76%. Prior to 2020/21 the trend was consistent between 2015/16 to 2019/20 at 66-70%. Adult obesity across England has been consistently lower than Thurrock since 2015/16.
Proportion of children in year R and year 6 that are a healthy weight increases	Via Whole System Obesity Strategy	Long	YR - 76% / Y6 - 57% (2021/22).	YR - 76% / Y6 - 57% (2021/22). Trends are consistent with 2018/19 and 2019/20 healthy weight percentages for both YR and Y6. Data from 2020/21 is not comparable due to pandemic year as only a 10% representative sample was done. 2021/22 Healthy weight for Y6 was 3% higher nationally than Thurrock.
Goal 1B: Work together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock				
A plan is in place for rollout of the From harm to hope strategy in Thurrock	Via the SET Drug & Alcohol Partnership	Short	A plan is in place for rollout of the From harm to hope strategy in Thurrock.	Thurrock is a member of the Southend, Essex, Thurrock Drug and Alcohol Partnership, the members of whom are tasked with delivering on the ambitions of From Harm to Hope via the National Combating Drugs Outcome Framework. Locally, Thurrock continues to facilitate treatment and recovery for substance misuse via its commissioned substance misuse providers.
All Young People transitioning to Adult Mental Health Services have a Joint Care Plan in place	Via the Mental Health Performance Board	Medium	TBC	Service transition policy is in place.
Proportionate diagnosis of depression	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Long	70% of expected prevalence diagnosed (2021/22).	Upward trend since data has been collected.. This trend is similar to national averages though the England recorded prevalences since 2017/18 to-date have been slightly higher than Thurrock.
Goal 1C: Continue to enhance identification and management of Long Term Conditions to improve physical and mental health outcomes for all				
Percentage of individuals with Severe Mental Illness receiving a Physical Health Check	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Short	61% (2022/23).	General increase since 2018/19 at 19%, followed by 43% in 2019/20. Pandemic year 2020/21 reduced to 17%, but upward trend since 2021/22 at 59% and currently 61% in 2022/23.
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Medium	69% (2021/22).	Indicators were not measured over pandemic year 2020/21 therefore not comparable to previous year. QOF 2019/20 showed 69% for this indicator. Prior to 2019/20, this particular indicator was not measured.
Proportionate diagnosis of hypertension	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Long	59% of expected prevalence diagnosed (2021/22).	Diagnosis of hypertension has (with the exception of 2020/21, which was affected by COVID-19 restrictions) increased annually in Thurrock from 1,321 in 2016/17 to 2,567 in 2021/22..