A Needs Assessment to inform the Regeneration of Purfleet and a new Integrated Healthy Living Centre

A Thurrock Joint Strategic Needs Assessment (JSNA) Product

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Foreword

The health and wellbeing experienced by our population does not happen by chance. Moreover, it is a product of a complex multi-factorial influences including underlying socio-economic variables such as poverty, education, crime, housing and employment; social and community variables such as aspiration, community cohesion and community resilience, lifestyle choices and access to high quality health and wellbeing services.

In 1971 Tudor-Heart published a paper describing the ‘inverse care law’. Tudor-Heart’s premise was simple; that the populations with the greatest health needs end up with the poorest quality health services. Regrettably, 44 years later, in 2015, the complex interplay of influences on wellbeing described above still combine in Thurrock to confirm their premise.

This report examines the health and wellbeing needs of the population Purfleet and the surrounding area of South Ockendon. Analyses contained within it highlight the significant health and wellbeing challenges faced by residents living these areas compared to both other parts of our borough and to England in general. However such differences shouldn’t be viewed as inevitability. Coordinated action must be taken now by the NHS, Thurrock Council, our voluntary and community sector and the community themselves to address the underlying factors that lead these health inequalities.

Thurrock Council is committed to a major regeneration programme in Purfleet. This creates a once in a lifetime opportunity to create an environment that improves the wider determinants of health such as housing, crime, air quality and employment, creates more cohesive and sustainable communities, and helps people live healthier lives. Furthermore all partner agencies that make up the Thurrock Joint Health and Wellbeing Board are committed to improving and joining up local health and care services for our residents. This is a core theme in our new Health and Wellbeing Strategy. Finally, Thurrock Council for Voluntary Services and the many community and voluntary organisations that they represent are committed to improving community wellbeing, and many of our residents have shown huge enthusiasm to engage and support this new agenda.

This report has been commissioned on behalf of all of these key stakeholders. It examines in detail the health and wellbeing needs of the population of Purfleet and South Ockendon, including the wider determinants of health, lifestyle factors, and the current quality of health and social care. Its recommendations in part 1C and II aim to be the starting point in a conversation for design of a new integrated health and wellbeing in Purfleet and more widely, for the exciting regeneration plans we have for the area.

History suggests that breaking health inequity is notoriously difficult, however if we seize this opportunity, I believe that in Thurrock we have a chance to ensure that the conclusions of Tutor-Heart are not perpetuated for another 44 years.

Ian Wake
Director of Public Health
PART 1A: WHAT ARE THE NEEDS OF OUR POPULATION? ........................................................................ 15

2. DEMOGRAPHY ................................................................................................................................. 15

2.1. Age and Sex distribution of the current population ................................................................. 15

2.2. Ethnicity breakdown ..................................................................................................................... 17

2.3. Fertility Rate .................................................................................................................................. 18

2.4. Pensioners living alone .................................................................................................................. 19

2.5. Population Projections .................................................................................................................. 20

2.6. How can the new Purfleet Integrated Healthy Living Centre help? ........................................... 21

3. WIDER DETERMINANTS OF HEALTH ......................................................................................... 22

3.1. Deprivation .................................................................................................................................... 22

3.1.1. How does deprivation impact on health? .............................................................................. 22

3.1.2. Deprivation in South Ockendon Locality .............................................................................. 23

3.1.3. How can the new Purfleet Integrated Healthy Living Centre help? ...................................... 24

3.2. Housing ....................................................................................................................................... 24

3.2.1. How does poor housing impact on health? ........................................................................... 24

3.2.2. Persons per household ............................................................................................................ 25

3.2.3. Overcrowded households ...................................................................................................... 25

3.2.4. Households with Central Heating .......................................................................................... 26

3.2.5. Needs of residents living in South Ockendon Locality Council Homes ................................. 27

3.2.6. Future known housing developments .................................................................................... 28

3.2.7. How can the new Purfleet Integrated Healthy Living Centre help? ...................................... 28

3.3. Employment .................................................................................................................................. 29

3.3.1. How does employment impact on health? ............................................................................ 29

3.3.2. Residents residing in Council properties .............................................................................. 29

3.3.3. Benefits Claimants ................................................................................................................ 30

3.3.4. How can the new Purfleet Integrated Healthy Living Centre help? ...................................... 32

3.4. Education and Skills ..................................................................................................................... 33

3.4.1. How do Education and Skills impact on health? .................................................................. 33

3.4.2. Good Level of Development ................................................................................................. 33

3.4.3. Residents with no qualifications ........................................................................................... 34

3.4.4. Digital Skills ............................................................................................................................ 35

3.4.5. How can the new Purfleet Integrated Healthy Living Centre help? ...................................... 35
4. Health Lifestyle Behaviour .................................................................................................................. 42
   4.1. Breastfeeding .................................................................................................................................. 42
   4.1.1. How does Breastfeeding impact on health? ............................................................................... 42
   4.1.2. Breastfeeding Prevalence ........................................................................................................ 42
   4.1.3. How can the new Purfleet Integrated Healthy Living Centre help? ...................................... 43
   4.2. Smoking ........................................................................................................................................... 44
   4.2.1. How does Smoking impact on health? ..................................................................................... 44
   4.2.2. The financial impact of smoking ............................................................................................... 44
   4.2.3. Smoking Prevalence .................................................................................................................. 45
   4.2.4. Use of current commissioned stop smoking services .............................................................. 46
   4.2.5. How can the new Purfleet Integrated Healthy Living Centre help? ...................................... 48
   4.3. Obesity ............................................................................................................................................ 49
   4.3.1. How does Obesity impact on health? .......................................................................................... 49
   4.3.2. Child Obesity Prevalence ........................................................................................................ 49
   4.3.3. Adult Obesity Prevalence .......................................................................................................... 51
   4.3.4. Use of Current Services ............................................................................................................ 51
   4.3.5. How can the new Purfleet Integrated Healthy Living Centre help? ...................................... 52
   4.4. Substance Misuse ............................................................................................................................. 53
   4.4.1. How does substance misuse impact on health? ....................................................................... 53
   4.4.2. Prevalence .................................................................................................................................... 54
   4.4.3. Current Service .......................................................................................................................... 55
6. Long Term Conditions ..............................................................................................................69

6.1. Long Term Conditions in Purfleet ......................................................................................69

6.2. Non-diagnosed Long Term Conditions ..............................................................................70

6.3. Quality outcomes framework (QOF) ..................................................................................71

6.4. Clinical Management of Patients with Hypertension .......................................................72

6.5. Clinical Management of Patients with Heart Failure (HF) and Atrial Fibrillation (AF) ....75

6.5.1. Absolute numbers of AF and HF patients requiring Clinical Review .........................78

6.5.2. Emergency Admissions for AF and HF .......................................................................78

6.5.3. Summary of HF and AF Care .......................................................................................79

6.6. Clinical Management of Stroke, Transient Ischaemic Attack (TIA) ............................79

6.6.1. Stroke Hub ..................................................................................................................81

6.6.2. Avoidable Stroke admissions ......................................................................................81

6.6.3. Stroke care summary ...................................................................................................82

6.7. Clinical Management of Patients with Diabetes ..............................................................82

6.7.1. Absolute numbers of patients not receiving diabetes clinical management interventions recommended by QOF ..............................................................................................................85
PART 1B: WHAT DO WE CURRENTLY HAVE?

6.7.2. Emergency admissions For Diabetes ................................................................. 85
6.7.3. Community Diabetes Team .............................................................................. 86
6.7.4. Summary of Diabetes care .............................................................................. 86
6.8. Care of patients with Respiratory Disease ............................................................ 87
   6.8.1. Absolute numbers of patients not receiving COPD and Asthma clinical management interventions recommended by QOF ......................................................... 89
   6.8.2. Emergency Admissions for COPD ................................................................ 89
   6.8.3. The NELFT COPD team .............................................................................. 90
   6.8.4. Summary of respiratory care ....................................................................... 90
7. Mental Health ........................................................................................................ 91
   7.1. Prevalence of mental ill-health ........................................................................ 91
   7.1.1. Recorded Prevalence of Depression ............................................................. 91
   7.1.2. Recorded Prevalence of Schizophrenia, Bipolar Affective Disorder and other Psychoses ................................................................. 92
   7.2. Use of Current Services .................................................................................. 92
   7.2.1. Children and Young People ...................................................................... 92
   7.2.2. Adults ......................................................................................................... 93
   7.2.3. Patient Views ............................................................................................. 94
   7.3. Clinical Management of Patients with Mental Ill-Health in Primary Care ......... 94
   7.4. Mental Ill-health and Co-Morbidities .............................................................. 96
   7.5. Mental Health and Wellbeing Summary ........................................................... 98

PART 1B: WHAT DO WE CURRENTLY HAVE? ................................................................ 99

8. General Practice ................................................................................................... 99
   8.1. Facilities and Services .................................................................................. 99
   8.1.1. Workforce .................................................................................................. 101
   8.1.2. Workforce .................................................................................................. 101
   8.2. Pharmacies .................................................................................................... 104
   8.3. Dentists .......................................................................................................... 106
   8.3.1. Current Service ........................................................................................ 106
   8.3.2. Use of Current Service .............................................................................. 106
   8.4. Opticians ........................................................................................................ 107
   8.5. 0-5 services .................................................................................................... 107
   8.6. Primary Care ‘Out of Hours’ service ............................................................... 108
   8.6.1. Current Service Provision ....................................................................... 108
   8.6.2. Use of Current Service .............................................................................. 108
9. Secondary Care .................................................................................................... 111
PART 1C: WHAT SHOULD AN INTEGRATED HEALTHY LIVING CENTRE IN PURFLEET CONTAIN?

11. Recommendations for services to be included in the Purfleet Integrated Healthy Living Centre

12. Wider Determinants of Health

12.1. Staffing Alternatives

12.2. The Primary Care Receptionist

12.3. The GP Assistant / Clinical Personal Assistant

12.4. The Primary Care Pharmacist

12.5. The Nurse Practitioner

12.6. Wellbeing worker

12.7. Physio-therapist

12.8. Physician Assistant

12.9. Paramedic

12.10. Promoting Self-Care and Management

12.11. Modelling the impact of including additional staff in the Purfleet Primary Care Model – A scenario modelling exercise


12.4. Minor Ailments Clinic
12.5. Long Term Conditions Clinics

12.6. Diagnostics

12.6.1. Blood Test facility

12.6.2. Other potential diagnostics

12.7. Outpatient Clinics

PART 2: CONSIDERATIONS FOR THE WIDER REGENERATION PROGRAMME

13. Travel

13.1. Promote Active Travel

13.2. Provide effective road design and traffic management systems

14. Place

14.1. Mitigate poor air quality

14.2. Provide good quality green and open spaces

14.3. Provision of homes built to Lifetime Homes and London Space Standards

15. Economic

15.1. Provision of opportunities for employment

16. Lifestyle

16.1. Facilitate healthy choices

16.2. Promote Breast Feeding

16.3. Impact on smoking prevalence

Appendix 1 - References

Appendix 2 – Assumptions for Stroke model

Appendix 3 – Enfield minor ailments scheme, patient leaflet

Appendix 4 – Timetable Purfleet Childrens centre

Figure 1: Proposed masterplan of the Purfleet regeneration programme

Figure 2: Influences on health and wellbeing

Figure 3: Purfleet Primary Care Registered Population by Age and Sex, October 2015

Figure 4: South Ockendon Locality Population by Age and Sex, October 2015

Figure 5: % people stating their ethnicity as from a BME group, 2011

Figure 6: Proportion of pensioners living alone, 2011

Figure 7: IMD score by ward, 2015

Figure 8: Average number of persons per household for SO Locality wards, Thurrock and England, 2011

Figure 9: Percentage of households with an occupancy rating of -1 or less, 2011

Figure 10: Proportion of households with central heating, 2011

Figure 11: Average monthly benefits claimants who have been claiming for longer than 12 months, 2012/13
Figure 12: Proportion of working aged adults claiming a benefit in South Ockendon Locality wards, Thurrock and England, 2015 ................................................................. 31
Figure 13: Rate of ESA claimants for South Ockendon Locality wards and Thurrock, 2015 ................................................................. 32
Figure 14: Proportion of pupils from Purfleet primary schools achieving a Good Level of Development, 2015, compared to Thurrock and England .................................................................................................................. 34
Figure 15: Proportion of residents with no qualifications in Purfleet wards, Thurrock and England, 2011 .................................... 34
Figure 16: Air Quality Management Areas in Thurrock, 2015 .................................................................................................................. 37
Figure 17: Proportion of households with no access to a car or van by ward, 2011 ................................................................. 40
Figure 18: Proportion of infants that are totally or partially breastfed in Purfleet and Thurrock, 2014-15 .......... 43
Figure 19: Proportion of infants that are totally or partially breastfed in South Ockendon Locality and Thurrock, 2014-15 ............................................................................ 43
Figure 20: Estimated prevalence of smoking in adults aged 18+ ............................................................................................... 45
Figure 21: QOF recorded smoking prevalence, patients aged 15+ 2014/15 ................................................................. 45
Figure 22: % of patients recorded as smokers setting a quit date through an NHS stop smoking service, 2014/15 .......................................................................................................... 46
Figure 23: % of smokers successfully quitting at four weeks through an NHS stop smoking service in 2014/15 ................................................................. 48
Figure 24: Childhood Obesity Prevalence at Reception .............................................................................................................. 49
Figure 25: Childhood Obesity Prevalence at Year 6 .................................................................................................................. 50
Figure 26: Modeled Obesity Prevalence by ward, 2006-2008 .................................................................................................. 51
Figure 27: Referrals to Vitality Weight Management Service in 2014/15 ................................................................................ 52
Figure 28: Modeled estimates of binge drinking, 2006-2008 ................................................................................................ 54
Figure 29: Hospital admissions for alcohol-attributable conditions, 2008/9 - 2012/13 .......................................................... 55
Figure 30: Rates of new STIs by LSOA in Thurrock (GUM diagnoses only): 2014 ................................................................. 58
Figure 31: Prevalence of diagnosed HIV in 15 to 59 year olds (per 1,000) by MSOA: 2014 ................................................................. 58
Figure 32: Teenage Pregnancy Prevalence by quintile – 2011-13 .......................................................................................... 59
Figure 33: Uptake of LARC in South Ockendon Locality GPs, 2013 ....................................................................................... 60
Figure 34: Proportion of people in ‘bad’ or ‘very bad’ health, 2011 ...................................................................................... 62
Figure 35: Proportion of respondents with a long-standing health condition, 2015 ................................................................. 63
Figure 36: Life expectancy at birth for males in Thurrock, 2008-2012 .................................................................................... 63
Figure 37: Life expectancy at birth for females in Thurrock, 2008-2012 .................................................................................. 64
Figure 38: Premature Mortality in South Ockendon Locality, 2008-2012 ............................................................................. 65
Figure 39: Vaccination Coverage - 2 year olds with 1 dose of MMR, August 2013-2014 .......................................................... 66
Figure 40: Vaccination Coverage - 5 year olds with 2 doses of MMR, August 2013-2014 .......................................................... 66
Figure 41: Breast Cancer Screening, June 2015 .................................................................................................................. 67
Figure 42: Bowel Cancer Screening, June 2015 .................................................................................................................. 67
Figure 43: Cervical Cancer Screening, June 2015 .................................................................................................................... 68
Figure 44 - Recorded prevalence of Long Term Conditions in South Ockendon, Thurrock and England in 2013-14 .................................................................................................................. 69
Figure 45: Diagnosed and non-diagnosed Hypertension in Purfleet ........................................................................................... 70
Figure 46 Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions .......................................................................................................................... 72
Figure 47: QOF indicators for Hypertension care 2013/14 – BP <= 150/90 mmHg ................................................................. 73
Figure 48: QOF indicators for Hypertension care 2013/14 – New patients with a CV risk assessment of 20% or more treated with Statins .......................................................................................................................... 74
Figure 49: % Hypertension Patients receiving Physical Activity Assessment and Lifestyle advice 2013/14
Figure 50: QOF indicators for HF and AF – Aveley Medical Centre
Figure 51: QOF indicators for HF and AF – Purfleet Care Centre
Figure 52: QOF indicators for HF and AF – St Clements Health Centre
Figure 53: Emergency admissions for Heart Failure
Figure 54: QOF Indicators for Stroke and TIA care – Aveley Medical Centre
Figure 55: QOF indicators for Stroke and TIA – Purfleet Care Centre
Figure 56 QOF Indicators for Stroke and TIA care – St Clements Health Centre
Figure 57: QOF Indicators for Diabetes Care – Aveley Medical Centre
Figure 58: QOF Indicators for Diabetes Care – Purfleet Care Centre
Figure 59: QOF Indicators for Diabetes Care – St Clements Health Centre
Figure 60: Emergency Admissions for Diabetes
Figure 61: QOF Indicators for Respiratory Disease – Aveley Medical Centre
Figure 62: QOF Indicators for Respiratory Disease – Purfleet Care Centre
Figure 63: QOF Indicators for Respiratory Disease – St Clements Health Centre
Figure 64: Rate of Emergency admissions for COPD
Figure 65: Depression Prevalence for the South Ockendon Locality practices, 2014/15
Figure 66: Prevalence of Schizophrenia, Bi-polar disorder and other psychoses for South Ockendon Locality Practices, 2014/15
Figure 67: Proportion of patients on QOF Depression register referred to IAPT, 2014/15
Figure 68: Clinical Management for mental health, depression and dementia care, Aveley Medical Centre
Figure 69: Clinical Management for mental health, depression and dementia care, Purfleet Care Centre
Figure 70: Clinical Management for mental health, depression and dementia care, St Clements Health Centre
Figure 71: Modelled estimate of patients with 3 or more LTCs – South Ockendon Locality GPs
Figure 72: Modelled estimate of patients with a LTC and depression – South Ockendon Locality GPs
Figure 73: South Ockendon Locality GP Practices
Figure 74: GP Practice list size: FTE GP, 2014/15
Figure 75: Association between deprivation and ratio of patients: FTE GP, 2014/15
Figure 76: Ratio of Patients: FTE Practice Nurse 2014/15
Figure 77: Pharmacies per 100,000 population in South Ockendon Locality, 2014
Figure 78: Patients aged 3-5 years attending dentists for Band 1 Urgent Treatment, 2014-15
Figure 79: Patients aged 3-5 years attending dentists for Band 2 Treatment, 2014-15
Figure 80: Awareness of GP out of hours service 2014-15
Figure 81: Contact rate with OOH service 2014-15
Figure 82: Proportion of Outpatient attendances and population for purfleet practices
Figure 83: Patients accessing Outpatients Services by age
Figure 84: Top 15 specialties for Outpatient attendances
Figure 85: Top 10 procedures performed in Outpatients
Figure 86: Top 10 procedures performed in Outpatients
Figure 87: A&E Attendance rate
Figure 88: Average cost per A&E attendance
Figure 89: % who attend A&E who are admitted to hospital
Figure 90: Number of A&E attendances by Time of Day and HRG Investigation
Figure 91: Number of Investigations in Normal Hours
Figure 92: Number of Investigations Out of Hours................................................................. 120
Figure 93: A&E attendances and costs by HRG category..................................................... 121
Figure 94: % patients receiving no investigation and no significant treatment .................. 122
Figure 95: Top 10 reasons for attending A&E – by condition ............................................ 123
Figure 96: Top 10 Investigations performed in A&E............................................................... 123
Figure 97: Emergency Admission Rates............................................................................. 124
Figure 98: Top 10 Diagnoses for non-elective admissions.................................................. 124
Figure 99: Top 10 Primary treatments for Non-elective admissionsSource:SUS .................. 125
Figure 100: Primary Reason for accessing ASC packages ................................................ 127
Figure 101: Service type accessed..................................................................................... 129
Figure 102: Top 10 service packages accessed.................................................................. 129
Figure 103......................................................................................................................... 135

Table 1: Purfleet and South Ockendon Locality GP registered populations, October 2015 .......... 15
Table 2: Mid-2014 ward estimates, South Ockendon Locality area wards .......................... 17
Table 3: Estimated Population Projections to 2026 - Purfleet Primary Care Population ...... 20
Table 4: Estimated Population Projections to 2026 - South Ockendon Locality Population .... 21
Table 5: Health needs for those in Council accommodation in South Ockendon locality wards, 2015 .... 27
Table 6: Future known housing builds (outside of the Purfleet regeneration), by 2021 ........... 28
Table 7: Economic activity for those in Council-owned properties from Purfleet wards, 2015 .... 29
Table 8: Primary Condition experienced by ESA Claimants, May 2015 ............................. 32
Table 9: Number and rate of crime in South Ockendon Locality wards, 2014-15 .................. 38
Table 10: Estimated number of undiagnosed cases by GP and condition ......................... 71
Table 11: Absolute numbers of AF and HF patients requiring clinical review ..................... 78
Table 12: Stroke TIA Patients not receiving recommended clinical interventions .................. 81
Table 13: Stroke Avoidable Admissions in Purfleet.............................................................. 82
Table 14: Patients on QOF Diabetes registers not receiving clinical interventions ............... 85
Table 15: Absolute numbers of patients on COPD and Asthma QOF registers who did not receive clinical management interventions .................................................. 89
Table 16: Findings from CQC Patient Survey for SEPT, 2015 ............................................ 94
Table 17: Information on the South Ockendon Locality GP practices ................................. 100
Table 18: Number of FTE GPs required to meet various patient ratios .............................. 102
Table 19: Opportunity for savings by moving A&E attendances that could be dealt with elsewhere into a primary care setting ........................................................................ 121
Table 20: Starting Assumptions for discussion .................................................................. 139
Table 21: staffing suggestion – model output for 2019 ....................................................... 140
Table 22: Staffing Suggestion – Model Output for 2025 .................................................... 140
1. Introduction and Background

Thurrock Council have committed to a large regeneration programme to completely transform Purfleet, creating a new town centre which will provide up to 2,366 new homes, local shops, new school and health care facilities, open access to the River Thames, and an exciting Film, Television and Media development creating up to 2,000 new jobs. The regeneration of Purfleet was kick-started in 2010 by the High House Production Park development, which is now home to the Royal Opera House Production Workshop, Backstage Centre (National Academy Creative and Cultural), and Artists’ Studios, and soon to be opened Royal Opera House Costume Store and production facility. A draft master plan of the development is shown below, with the proposed location of the new Health Centre highlighted.

Figure 1: Proposed Master Plan of the Purfleet Regeneration Programme

Source: Thurrock Council

The future vision for health and social care in Thurrock is to provide more integrated services, and a more holistic population health approach to the way in which we commission services. A Needs Assessment report was produced by the authors in November 2015 to inform requirements for a new Integrated Healthy Living Centre in Tilbury, which has now been successfully endorsed and adopted by the Council and CCG Estates Group as a foundation for production of this new type of health and social care facility.
Following on from this, this report was requested by NHS Thurrock CCG and Thurrock Council to assess the health and wellbeing needs of the population of Purfleet, examine the quality of the current primary care provision and then define a ‘blue print’ for this new Integrated Healthy Living Centre which would include an enhanced primary care facility together with wellbeing services and potentially other clinical and social services traditionally provided in alternative settings.

The report is divided into four sections.

- Part 1A considers in detail, the health and wellbeing needs of the populations of Purfleet and the wider South Ockendon locality area
- Part 1B describes the current level of service provision and how it is being used
- Part 1C sets out recommendations and a ‘blue print’ for the new Integrated Healthy Living Centre to address the current and future needs of the community
- Part II provides recommendations to demonstrate how the whole regeneration programme can benefit health and wellbeing

The authors hope that this report will provide a useful starting point for those tasked with establishing the new facility and involved in the wider regeneration programme.

Influences on health and wellbeing can be thought of as a chain of events as shown below. The report has been structured to mirror this.

**Figure 2: Influences on health and wellbeing**
PART 1A: WHAT ARE THE NEEDS OF OUR POPULATION?

2. DEMOGRAPHY

For the purposes of this report, the population referred to as the “Purfleet Primary Care Population” covers the GP registers for Purfleet Care Centre, St Clements Health Centre and Aveley Medical Centre. The population referred to as the “South Ockendon Locality” population covers the GP registers for the seven practices listed below. Two populations have been used throughout the report to reflect that whilst Primary Care services in the new Centre might just be used by the Purfleet population, other health and social care services may be accessed by a wider population.**

2.1. Age and Sex distribution of the current population

The table below outlines the seven GP practice populations that will be used throughout the report by males and females.

Table 1: Purfleet and South Ockendon Locality GP registered populations, October 2015

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Practice Code</th>
<th>Area</th>
<th>Practice Population (October 2015)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purfleet Care Centre</td>
<td>Y00033</td>
<td>Purfleet</td>
<td>5,689</td>
<td>2,816</td>
<td>2,873</td>
</tr>
<tr>
<td>St Clements Health Centre</td>
<td>Y00999</td>
<td>West Thurrock</td>
<td>3,811</td>
<td>1,874</td>
<td>1,937</td>
</tr>
<tr>
<td>Aveley Medical Centre</td>
<td>F81010</td>
<td>Aveley</td>
<td>11,936</td>
<td>5,961</td>
<td>5,975</td>
</tr>
<tr>
<td>Total Purfleet Primary Care Population</td>
<td></td>
<td></td>
<td>21,436</td>
<td>10,651</td>
<td>10,785</td>
</tr>
<tr>
<td>Belhus Medical Practice</td>
<td>F81669</td>
<td>South Ockendon</td>
<td>4,834</td>
<td>2,322</td>
<td>2,512</td>
</tr>
<tr>
<td>Sancta Maria Medical Centre</td>
<td>F81197</td>
<td>South Ockendon</td>
<td>2,570</td>
<td>1,271</td>
<td>1,299</td>
</tr>
<tr>
<td>Dr Yasin</td>
<td>F81632</td>
<td>Ockendon</td>
<td>3,723</td>
<td>1,829</td>
<td>1,894</td>
</tr>
<tr>
<td>Pear Tree Surgery</td>
<td>F81134</td>
<td>Ockendon</td>
<td>7,273</td>
<td>3,608</td>
<td>3,665</td>
</tr>
<tr>
<td>Total South Ockendon Locality Population</td>
<td></td>
<td></td>
<td>39,836</td>
<td>19,681</td>
<td>20,155</td>
</tr>
</tbody>
</table>

Source: HSCIC
The two population pyramids below depict the two populations referred to throughout the report. It can be seen that the Purfleet Primary Care Registered Population especially, has a larger proportion of children aged 0-9 years, a smaller proportion of teenagers and young adults; but then a larger proportion of adults aged 25-44 years and a smaller proportion of older adults than the Thurrock average. This pattern is also mirrored across the South Ockendon Locality area, although it is slightly less pronounced. [Figure 1 and Figure 2]

Figure 3: Purfleet Primary Care Registered Population by Age and Sex, October 2015

Source: HSCIC
When comparing these data to the population estimates of the four administrative wards that cover South Ockendon Locality (West Thurrock and South Stifford, Aveley and Uplands, Belhus and Ockendon) the GP registers have a slightly lower number registered – 39,836, than the 2014 ward estimates which show a combined total of 42,137. The population estimates may be different as patients living in these ward areas may choose to register at GPs in other nearby wards.

Table 2: Mid-2014 ward estimates, South Ockendon Locality area wards

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Resident Population (2014)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Thurrock and South Stifford</td>
<td>12,411</td>
<td>6,288</td>
<td>6,123</td>
</tr>
<tr>
<td>Aveley and Uplands</td>
<td>9,267</td>
<td>4,574</td>
<td>4,693</td>
</tr>
<tr>
<td>Belhus</td>
<td>10,079</td>
<td>4,991</td>
<td>5,088</td>
</tr>
<tr>
<td>Ockendon</td>
<td>10,380</td>
<td>5,102</td>
<td>5,278</td>
</tr>
</tbody>
</table>

Source: ONS

2.2. Ethnicity breakdown

Data from the 2011 Census indicates that of the four South Ockendon Locality wards, West Thurrock and South Stifford has the highest proportion of residents that are from a BME group (25.0%). The other three wards within the Locality have proportions of BME residents that are closer to the Thurrock average of 14.1%.
2.3. Fertility Rate

Of the four South Ockendon Locality wards, West Thurrock and South Stifford has the highest fertility rate per 1,000 women aged 15-44 years (95.1). This is amongst the highest in the borough. The remaining Locality wards have similar rates to the Thurrock average of 71.1 per 1,000. This can be seen in the figure below.
2.4. Pensioners living alone

Although the Purfleet and South Ockendon populations are relatively young, it is important to note that the older populations can be more vulnerable – particularly those who live alone. The figure below depicts the proportion of pensioners in each ward that live alone, and it can be seen that the South Ockendon Locality has several of the wards with the highest proportions of these (in Aveley and Uplands, 38.8% of pensioners live alone and 38.0% of those who live in Ockendon, compared to the Thurrock average of 31.9%).

Loneliness and isolation can have a number of adverse impacts on physical and mental health, and services should ensure they are tailored effectively to target older people who live alone to reduce their risk of experiencing adverse health.
Figure 6: Proportion of pensioners living alone, 2011

2.5. Population Projections

As with national and borough populations, the populations of Purfleet and the wider South Ockendon Locality are set to increase in coming years, even irrespective of the planned regeneration programme. The two tables below show the modelled estimated population growth for both the Purfleet Primary Care and South Ockendon Locality populations to 2026, with and without the expected Purfleet Regeneration programme. These show that the Purfleet Primary Care population would increase by 2,466 residents in the next ten years before the planned Purfleet Regeneration, due to other housing developments and growth in the area. Factoring in the planned Regeneration programme, this would lead to an expected increase of 8,531 residents. The South Ockendon Locality would increase by 4,144 residents in ten years without the Purfleet Regeneration, and by 10,209 residents factoring this in.

Table 3: Estimated Population Projections to 2026 - Purfleet Primary Care Population

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Thurrock % change</td>
<td>1.03</td>
<td>1.02</td>
<td>1.07</td>
<td>1.00</td>
<td>1.05</td>
<td>1.04</td>
<td>0.97</td>
<td>0.96</td>
<td>0.95</td>
<td>0.89</td>
<td>0.94</td>
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<tr>
<td>Purfleet population without the regeneration</td>
<td>21,436</td>
<td>21658</td>
<td>21880</td>
<td>22114</td>
<td>22336</td>
<td>22571</td>
<td>22806</td>
<td>23028</td>
<td>23250</td>
<td>23471</td>
<td>23680</td>
<td>23902</td>
</tr>
<tr>
<td>Additional residents without the regeneration</td>
<td>222</td>
<td>444</td>
<td>678</td>
<td>900</td>
<td>1,135</td>
<td>1,370</td>
<td>1,592</td>
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<td>2,035</td>
<td>2,244</td>
<td>2,466</td>
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<td>Purfleet population with the regeneration</td>
<td>21,436</td>
<td>21658</td>
<td>21880</td>
<td>22114</td>
<td>22336</td>
<td>22571</td>
<td>24133</td>
<td>25286</td>
<td>26447</td>
<td>27616</td>
<td>28780</td>
<td>29967</td>
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<tr>
<td>Additional residents with the regeneration</td>
<td>222</td>
<td>444</td>
<td>678</td>
<td>900</td>
<td>1,135</td>
<td>2,697</td>
<td>3,850</td>
<td>5,011</td>
<td>6,180</td>
<td>7,344</td>
<td>8,531</td>
<td></td>
</tr>
</tbody>
</table>

Source: HSCIC, ONS and Thurrock Council
Table 4: Estimated Population Projections to 2026 - South Ockendon Locality Population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
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<tbody>
<tr>
<td>Thurrock % change</td>
<td>1.03</td>
<td>1.02</td>
<td>1.07</td>
<td>1.00</td>
<td>1.05</td>
<td>1.04</td>
<td>0.97</td>
<td>0.96</td>
<td>0.95</td>
<td>0.89</td>
<td>0.94</td>
<td></td>
</tr>
<tr>
<td>WT population without</td>
<td>36,025</td>
<td>36398</td>
<td>36770</td>
<td>37165</td>
<td>37538</td>
<td>37933</td>
<td>38327</td>
<td>38700</td>
<td>39073</td>
<td>39446</td>
<td>39796</td>
<td>40169</td>
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<tr>
<td>the regeneration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional residents</td>
<td>373</td>
<td>745</td>
<td>1,140</td>
<td>1,513</td>
<td>1,908</td>
<td>2,302</td>
<td>2,675</td>
<td>3,048</td>
<td>3,421</td>
<td>3,771</td>
<td>4,144</td>
<td></td>
</tr>
<tr>
<td>without the regeneration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>WT population with the</td>
<td>36,025</td>
<td>36398</td>
<td>36770</td>
<td>37165</td>
<td>37538</td>
<td>37933</td>
<td>39655</td>
<td>40958</td>
<td>42270</td>
<td>43591</td>
<td>44896</td>
<td>46234</td>
</tr>
<tr>
<td>regeneration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional residents</td>
<td>373</td>
<td>745</td>
<td>1,140</td>
<td>1,513</td>
<td>1,908</td>
<td>3,630</td>
<td>4,933</td>
<td>6,245</td>
<td>7,566</td>
<td>8,871</td>
<td>10,209</td>
<td></td>
</tr>
<tr>
<td>with the regeneration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: HSCIC, ONS and Thurrock Council

The assumptions used in calculating these projections are listed below:

1) The Purfleet regeneration will provide 2,366 homes by 2026. (Source: Thurrock Council)

2) 531 of these homes will be delivered in phase 1 - completion date by 2021.

3) Assumed that an equal proportion of the outstanding 1,835 homes will be built every year between 2022-2026 (367 per year)

4) ONS Projected Growth Estimates are also applied to account for growth within the area that is outside of the Purfleet regeneration project.

5) An average of 2.5 residents per house was used.

2.6. How can the new Purfleet Integrated Healthy Living Centre help?

The above information indicates that Purfleet and its surrounding areas have a larger population of young children and young adults and a relatively high fertility rate compared to other parts of the borough, meaning there are large numbers of young families. It should also be considered that whilst there may be smaller numbers of older people, a higher proportion of them are likely to live alone than the Thurrock average. Whilst the planned regeneration programme and incoming migration particularly from outer London boroughs may change the demographic profile of the area, it is important to ensure that it provides a range of services to support children and their families to stay healthy – particularly those such as immunisations, breastfeeding support, parenting and sexual health services. It should also work very closely with the existing Purfleet Children’s Centre who already accommodate some of these services, and be able to flexibly accommodate this future population increase. The larger proportion of older adults that may live alone highlights the importance of including a community element to this facility to reduce isolation and encourage inclusion, and ensure they can access the support required.
3. WIDER DETERMINANTS OF HEALTH

This section has been completed for the population of the South Ockendon locality; however the majority of the information can be seen at ward levels in order to display variance between Purfleet residents and neighbouring residents. The Purfleet regeneration site is circled in blue on all maps for clarity.

3.1. Deprivation

3.1.1. How does deprivation impact on health?

Deprivation is directly linked to life expectancy and the length of disability free life. This essentially means that those living in poorer areas not only die sooner, but also they will spend more of their shorter lives with a disability. The consequences of poverty, higher levels of harmful behaviour and lower levels of protective behaviour are seen most clearly in the distribution of illnesses and health status. When compared to those living in more affluent communities, populations living in areas of high deprivation statistically have:

- higher levels of mental illness
- increased likelihood of developing a long-term condition, particularly chronic respiratory conditions, cardiovascular disease and arthritis
- a higher prevalence of unhealthy lifestyle behaviours such as obesity, physical inactivity and smoking

Children living in areas of high deprivation:

- Experience a higher risk of infant mortality
- Are at higher risk of acute illnesses requiring hospital admission
- May be more likely to experience emotional and behavioural problems
- Are less likely to maintain a healthy weight
- Are more likely to experience problems with oral health
- Are more likely to achieve lower levels of educational attainment

In addition, young people growing up in areas of high deprivation:

- Are more likely to conceive and become teenage parents
- Are more likely to enter the youth justice system
- Are more likely to smoke
- Are at higher risk of becoming NEET
- May experience lower earnings and poorer qualifications in adulthood

This will impact accordingly on the use of health services - the inverse care law states that the availability of good medical care tends to vary inversely with the need for it in the population served. Research by Mercer & Watt (2007) found that access to care generally took longer, and satisfaction with access was significantly lower in the most deprived areas. Patients in the most deprived areas had more problems to discuss (especially psychosocial), yet clinical encounter length was generally shorter. GP stress was higher and patient enablement was lower in encounters dealing with psychosocial problems in the most deprived areas. Variation in patient enablement between GPs was related to both GP empathy and severity of deprivation. There is also the added complication of the larger demand on primary, secondary and community care due to the higher likelihood of patients exhibiting unhealthy lifestyle behaviours and earlier onset of long-term conditions.
3.1.2. Deprivation in South Ockendon Locality

According to the Index of Multiple Deprivation 2015, the Locality of South Ockendon contains some of the Lower Super Output Areas (LSOAs) which are within the two most deprived quintiles within Thurrock. South Ockendon also contains one of the most deprived LSOAs in the country – LSOA 006A is amongst the 10% most deprived in England. This LSOA contains Grangewaters outdoor centre and Buckles Lane, which has a large Gypsy and Roma Travellers (GRT) site that is home to approximately 1,000 residents. It is well-documented that GRT communities are more at risk of:

- Reduced access to primary care services
- Higher rates of perinatal and infant mortality
- A reduced life expectancy – approximately 10 years less than the rest of the population
- Lower educational attainment and reduced school attendance
- Increased levels of stress and anxiety
- Increased risk of conditions such as asthma or cystic fibrosis

There are a number of recommendations in the Thurrock Children and Young People’s JSNA (published March 2015) which aim to improve awareness of the health inequalities experienced by this population group and address some of the determinants of health. As some of these residents may access the new Integrated Healthy Living Centre for wider health services, it is important that services are aware of these inequalities and act to reduce them.

Figure 7: IMD score by ward, 2015

Source: Department for Communities and Local Government
3.1.3. How can the new Purfleet Integrated Healthy Living Centre help?
The information above indicates that patients living in parts of the South Ockendon Locality area are already at statistically significantly greater risk of receiving poorer quality care that is unlikely to meet their needs. The personnel employed in the new Health Facility will have a key role in both treating current needs, but in anticipating future needs to avoid costly service use at a later date. Employment of a multi-skilled workforce in the Health Facility will enable patient needs to be assessed holistically, look to reduce stress/workload of GPs by filtering out inappropriate consultations (e.g. those that could be met by a pharmacist), and should aid the addressing of some of the poorer outcomes experienced by patients in deprived areas - e.g. public health preventative services should support people to maintain healthy lifestyle behaviours, a targeted sexual health service should help reduce potential numbers of unplanned pregnancies and teenage parents, co-location of IAPT mental health services could support children who might be at risk of emotional/behavioural problems etc. There is also a role for the Health Facility to host some of the wider community services that can support the place-based outcomes – e.g. inclusion of an area to enable further education and learning opportunities would support people to improve their skills and lead to a greater likelihood of employment, thereby reducing the likelihood of health problems associated with unemployment (see later section on Employment for further detail). The multi-faceted approach of this facility will also improve inter-agency working relationships and ensure each professional is in a position to be able to advice/guide the person to the best avenue to meet their needs.

3.2. Housing

3.2.1. How does poor housing impact on health?
Housing is a massive driver of health inequalities – generally speaking, older people, children and those with long-term conditions are at greater risk of adverse health due to poor housing conditions. There is a large body of evidence to indicate that poor housing can impact on the following health conditions:

- **Respiratory problems** – this is particularly linked to residents living in cold homes and houses with mould, although is also associated with general overcrowding. (Research suggests that around 1 in 18 dwellings in England have appreciable dampness or mould.) This can lead to increased development of conditions such as asthma and bronchitis, and worsening of existing respiratory conditions. In addition, insufficient ventilation in houses can lead to increased indoor pollutants such as radon, carbon monoxide and nitrogen dioxide.

- **Circulatory problems** – cold homes are linked to an increased risk of hypertension and cardiovascular disease. Excess Winter Deaths due to circulatory diseases are estimated to be between 40-50% (Marmot Review Team, 2011).

- **Mental Health** – increased exposure to noise due to poor home insulation can result in increased stress and anxiety levels, and also lead to an increased risk of ischemic heart disease. Stress can also be exacerbated by feeling of overcrowding or fuel poverty. Depression and feelings of isolation could also develop as people feel they cannot escape their situation.

- **Falls and accidents** – poor quality housing leads to an increased number of falls, due to an increased number of trip hazards or poor quality furnishings.

- **Mortality rates** – The Marmot Review Team (2011) found that residents who live in the coldest homes have a 20% greater risk of Excess Winter Deaths than those in the warmest homes, simply due to their houses being colder. The risk factors for respiratory problems might also contribute to a rise in mortality rates. It is also known that mortality rates increase during extreme hot weather;
and although there is not conclusive evidence to link housing quality to this, it should be ensured that houses are adequately ventilated to reduce this risk.

The Memorandum of Understanding (2014) signed by a range of health, social care and local government organisations recognises that the right home environment can:

- Delay or reduce the need for primary care and social care interventions
- Prevent hospital admissions and readmissions
- Enable timely discharges from hospital
- Enable rapid recovery from ill-health or planned admissions

### 3.2.2. Persons per household

The average number of persons per household for three of the four South Ockendon Locality wards is below the Thurrock average of 2.52 but all are higher than the national average of 2.36. Belhus ward has the highest average number of persons per household out of the four South Ockendon Locality wards, with 2.52 persons per household, and Ockendon has the lowest (2.39 persons per household). West Thurrock and South Stifford ward is in the middle (2.47 persons per household). [Figure 8]

![Figure 8: Average number of persons per household for SO Locality wards, Thurrock and England, 2011](source: Census 2011)

### 3.2.3. Overcrowded households

A household can be classified to be overcrowded if it has fewer bedrooms than the notional number recommended by the bedroom standard (a recommended notional number of bedrooms for each household, based on the size of the household, age, sex, marital status and relationship among members of the household). An occupancy rating of -1 or less could indicate overcrowding within a household. In all four SO Locality wards, there are a higher proportion of households with an occupancy rating of -1 or fewer than the national average of 4.64%. West Thurrock and South Stifford has the highest percentage of
households with an occupancy rating of -1 or less, with 8.69% of households having at least one fewer rooms than required. Both West Thurrock and South Stifford, and Belhus have higher proportions than the Thurrock average of 5.42%. [Figure 9]

Figure 9 Percentage of households with an occupancy rating of -1 or less, 2011

![Percentage of households with an occupancy rating of -1 or less, 2011](image)

Source: Census 2011

Taking the above two statistics together, it indicates that for the ward of West Thurrock and South Stifford, whilst the average number of persons per household is lower than the Thurrock average, nearly 9% of the households in that ward can be classified as being overcrowded. This indicates that some of the overcrowded households may have an OR of 2 or even less.

3.2.4. Households with Central Heating

The map overleaf depicts variance in households that have central heating in Thurrock. It can be seen that wards to the west of Thurrock have some of the lowest proportions of households with central heating. Only 93.5% of West Thurrock and South Stifford households have central heating, whereas the Thurrock average is significantly higher at 97.5%
3.2.5. Needs of residents living in South Ockendon Locality Council Homes

Some residents who are living in Council accommodation have particular health needs. The table overleaf outlines these for residents in the four South Ockendon Locality area wards. It can be seen that of the Council’s 3,987 tenants, 248 declare themselves to have health needs, which equates to 6.22%. This proportion is higher in the West Thurrock and South Stifford ward, where 62/647 residents have a health need – equating to 9.58%. The most common type of need in the South Ockendon Locality is Low Mobility, which accounts for 43.55% of the specialist needs recorded (108/248 residents).
Table 5: Health needs for those in Council accommodation in South Ockendon locality wards, 2015

<table>
<thead>
<tr>
<th>Need/Ward</th>
<th>West Thurrock and South Stifford</th>
<th>Aveley and Uplands</th>
<th>Belhus</th>
<th>Ockendon</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents who have a health need</td>
<td>62</td>
<td>69</td>
<td>61</td>
<td>56</td>
<td>248</td>
</tr>
<tr>
<td>Hearing</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>18</td>
<td>63</td>
</tr>
<tr>
<td>Low Mobility</td>
<td>30</td>
<td>36</td>
<td>20</td>
<td>22</td>
<td>108</td>
</tr>
<tr>
<td>Mobility - Wheelchair</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Speech Impairment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Substance Misuse - Alcohol</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Visual Impairment</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>No health needs</td>
<td>585</td>
<td>791</td>
<td>1267</td>
<td>1096</td>
<td>3739</td>
</tr>
<tr>
<td>Grand Total</td>
<td>647</td>
<td>860</td>
<td>1328</td>
<td>1152</td>
<td>3987</td>
</tr>
</tbody>
</table>

Source: Housing Team, Thurrock Council

3.2.6. Future known housing developments

There are some other known future housing developments in progress within the South Ockendon Locality area outside of the Purfleet regeneration programme. Below are details of the known housing builds likely to be completed by 2021:

Table 6: Future known housing builds (outside of the Purfleet regeneration), by 2021

<table>
<thead>
<tr>
<th>Area</th>
<th>Developments</th>
<th>Dwelling Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Thurrock and South Stifford</td>
<td>12</td>
<td>1854</td>
</tr>
<tr>
<td>Aveley and Uplands</td>
<td>5</td>
<td>367</td>
</tr>
<tr>
<td>Ockendon or Belhus</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Housing Team, Thurrock Council

3.2.7. How can the new Purfleet Integrated Healthy Living Centre help?

From the above it can be seen that West Thurrock & South Stifford ward in particular has needs in terms of overcrowding, housing with potentially poor quality heating, and a higher proportion of its Council tenants with known health conditions. Services should be designed to support those in overcrowded households, providing targeted advice and assistance to potentially help overcrowded families in social rented housing move into the private sector or access relevant small capital grants to improve their homes. Part of the health centre could be designated for this purpose, and could also provide a base to share information through training and briefing to other front line services. Advice should be available to residents regarding their needs and options for housing adaptations, potentially reducing falls and resulting in savings to the future healthcare bill. (See Part 1C and Part 2 of this document for recommendations and a detailed specification of future provision).
The wider re-generation of the area will also include more housing, a proportion of which will have to be affordable housing which will all help too.

3.3. Employment

3.3.1. How does employment impact on health?
There is a well-established link between employment and health – in general, having a job is better for health than having no job. Research by the UCL Institute of Health Equity (2015) have cited four ways in which work can however have an adverse effect on health: through adverse physical conditions of work; adverse psychosocial conditions at work; poor pay or insufficient hours; and temporary work, insecurity, and the risk of redundancy or job loss.

Negative health impacts from unemployment and worklessness include:

- Higher mortality rates – evidence summarised by the World Health Organisation found that, even after allowing for other factors, unemployed people and their families suffer a substantially increased risk of premature death
- Increased use of medical services – including higher numbers of medical consultations, increased consumption of medication, and higher hospital admission rates
- Higher rates of depression and anxiety – Catalano et al (2011) found that unemployment is associated with a 15-30% increase in the reported symptoms of depression and anxiety
- Increased substance use and abuse – Catalano et al (2011) found that unemployment is associated with a doubling of alcohol intake
- Worse general health
- Increased risk of cardiovascular disease.

3.3.2. Residents residing in Council properties
The table overleaf shows the economic status of surveyed residents who live in Council-owned properties in South Ockendon Locality area wards. Of the residents surveyed for their economic status, 266 out of 739 in SO Locality were not working, which is 36.0%. The proportion for West Thurrock and South Stifford is similar to this (35.4% - 69/195 residents); however Aveley and Uplands has a higher proportion of retirees than those not working (50.8% of Aveley and Uplands surveyed residents were retired [101/199 residents], compared to 22.6% being out of work [45/199 residents]).
Table 7: Economic activity for those in Council-owned properties from Purfleet wards, 2015

<table>
<thead>
<tr>
<th>Ward</th>
<th>West Thurrock and South Stifford</th>
<th>Aveley and Uplands</th>
<th>Belhus</th>
<th>Ockendon</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents who were surveyed</td>
<td>195</td>
<td>199</td>
<td>209</td>
<td>136</td>
<td>739</td>
</tr>
<tr>
<td>Working Full Time</td>
<td>37</td>
<td>38</td>
<td>34</td>
<td>26</td>
<td>135</td>
</tr>
<tr>
<td>Not Working</td>
<td>69</td>
<td>45</td>
<td>96</td>
<td>56</td>
<td>266</td>
</tr>
<tr>
<td>Working Part Time</td>
<td>23</td>
<td>13</td>
<td>21</td>
<td>15</td>
<td>72</td>
</tr>
<tr>
<td>Retired</td>
<td>58</td>
<td>101</td>
<td>58</td>
<td>37</td>
<td>254</td>
</tr>
<tr>
<td>Unknown</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Not Surveyed</td>
<td>452</td>
<td>661</td>
<td>1119</td>
<td>1016</td>
<td>3248</td>
</tr>
<tr>
<td>Grand Total</td>
<td>647</td>
<td>860</td>
<td>1328</td>
<td>1152</td>
<td>3987</td>
</tr>
</tbody>
</table>

Source: Housing Team, Thurrock Council

3.3.3. Benefits Claimants

Data collected on those who have claimed benefits for longer than 12 months can be used as an estimate for long term unemployment. The map below shows this for 2012/13 for all Thurrock wards, and it can be seen that three of the four SO Locality wards appear to have high rates of unemployment compared to the Thurrock average. The ward of West Thurrock and South Stifford has a rate of 12.4 per 1,000 working aged adults, compared to the Thurrock average of 10.4 per 1,000. Belhus has an even higher rate – 19.1 per 1,000 population.

Figure 11: Average monthly benefits claimants who have been claiming for longer than 12 months, 2012/13

Source: Local Health
Data from May 2015 indicates that 3,620 adults aged between 16-64 years from the four South Ockendon Locality wards were claiming at least one benefit. The figure below depicts the proportion of adults aged 16-64 years from these wards who claim a benefit compared to the Thurrock and England average, and it can be seen that three of the four wards have higher proportions claiming a benefit than the Thurrock and England averages of 11.15% and 11.80% respectively. Within the locality, Belhus has the highest proportion, with 16.91% of working aged adults claiming at least one benefit; and West Thurrock and South Stifford has the lowest proportion – 10.40%. (Figure 12)

When looking at Employment Support Allowance claimants, three out of the four South Ockendon Locality wards have higher rates of those aged 16-64 years claiming ESA than the Thurrock average of 45.99 per 1,000. Belhus has the highest rate of claimants, with a rate of 74.30 per 1,000, whilst West Thurrock and South Stifford has the lowest rate in the Locality (38.56 per 1,000) which is also below the Thurrock average. (Figure 13)

Figure 12: Proportion of working aged adults claiming a benefit in South Ockendon Locality wards, Thurrock and England, 2015

Source: NOMIS and ONS small area population estimates 2014
When looking at the conditions experienced by ESA claimants, it can be seen that the highest proportion claim for a mental health condition (45.0% in South Ockendon Locality and 44.0% in Thurrock). However in Belhus this is even higher - half of the ESA Claimants have mental health conditions. In Aveley and Uplands, nearly a fifth of claimants (19.7%) experience musculo-skeletal conditions which is higher than the Locality and Thurrock averages. [Table 8]

Table 8: Primary Condition experienced by ESA Claimants, May 2015

<table>
<thead>
<tr>
<th>Item</th>
<th>South Ockendon Locality</th>
<th>Aveley and Uplands</th>
<th>Belhus</th>
<th>Ockendon</th>
<th>West Thurrock and South Stifford</th>
<th>Thurrock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental</td>
<td>45.0%</td>
<td>41.0%</td>
<td>50.0%</td>
<td>41.9%</td>
<td>45.5%</td>
<td>44.0%</td>
</tr>
<tr>
<td>Nervous system</td>
<td>5.8%</td>
<td>6.6%</td>
<td>5.1%</td>
<td>7.0%</td>
<td>4.5%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Respiratory / Circulatory</td>
<td>6.4%</td>
<td>4.9%</td>
<td>6.1%</td>
<td>7.0%</td>
<td>7.6%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>17.7%</td>
<td>19.7%</td>
<td>16.3%</td>
<td>17.4%</td>
<td>18.2%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Injury / Poisoning</td>
<td>5.8%</td>
<td>6.6%</td>
<td>5.1%</td>
<td>5.8%</td>
<td>6.1%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Other</td>
<td>19.3%</td>
<td>21.3%</td>
<td>17.3%</td>
<td>20.9%</td>
<td>18.2%</td>
<td>19.9%</td>
</tr>
</tbody>
</table>

Source: NOMIS

3.3.4. How can the new Purfleet Integrated Healthy Living Centre help?

The information above shows that three of the four wards in the Locality area have high levels of long term unemployment and high proportions of their working aged adults who are claiming a benefit of some sort, including employment support allowance. Whilst benefits claimants are not necessarily an indicator of worklessness, it can highlight an issue of low incomes which are requiring supplementation by a benefit, or a
health condition which means a person is unable or less able to work. This could indicate that there are a large number of people not currently receiving the support required to get back into work, or that people may not fully understand the benefits system and therefore could mean people are not accessing the right benefits for their needs. The new health facility should look to support those looking to improve their employment prospects, via offering advice and information to remove employment barriers and signposting to other relevant services. This means patients can be assessed in a more holistic way and also have direct access to relevant support and information.

3.4. Education and Skills

3.4.1. How do Education and Skills impact on health?
Numerous outcomes in adult life are influenced by their early years. The quality of a child’s early life experience is shaped by a number of factors, including socio-economic status, access to high-quality early education and care, and the influence of ‘good parenting’ (Ofsted, 2014). Research cited by the Department for Education (2011) found that vocabulary at age 5 is the best predictor of later social mobility for children from deprived backgrounds – those who start school as confident speakers with good language skills are more likely to become successful learners and achieve in life. Educational attainment throughout school is lower in deprived areas, and this can affect future life chances – young people with fewer qualifications are more likely not to be in education, employment or training (NEET) after leaving school and find it more difficult to secure employment as they get older. They may also have had poor childhood health or not had the support to fully comprehend the consequences of poor lifestyle behaviour choices (such as smoking).

Having few or no qualifications can make it more difficult to move into work and increase the likelihood of obtaining a lower paid or unsecure job. This could then lead to the adverse health impacts cited in the section above on unemployment. Digital skills are becoming more and more important in today’s society, with many services and employment opportunities accessed online. This is also true of health services, with resources such as NHS Choices becoming more frequently used, as well as social networking, learning opportunities and other forms of communication. Those who are digitally excluded could be at risk of isolation and potentially find it harder to engage with services.

3.4.2. Good Level of Development
Pupil attainment by the age of five can be measured by the achievement of a “Good Level of Development” (GLD) at the Early Years Foundation Stage (EYFS). All bar two of the South Ockendon Locality schools exceeded the national average of 66%, with the exception of Aveley Primary and Somers Heath Primary. At 73%, the Thurrock average for GLD was higher than the national average, and three of the Locality schools exceeded this value also. (Figure 14)
3.4.3. Residents with no qualifications

According to Census data, three of the four South Ockendon Locality wards have higher proportions of their residents aged 16+ with no qualifications than both the Thurrock and England averages. West Thurrock and South Stifford is the only ward in the Locality that has a lower proportion of residents aged 16+ with no qualifications than both averages (20.30%, compared to 26.45% in Thurrock and 22.46% in England). [Figure 15]

Figure 15: Proportion of residents with no qualifications in Purfleet wards, Thurrock and England, 2011

Source: Census 2011
3.4.4. Digital Skills

Go ON UK has combined various sources research into the use and experience of digital services within all UK local authorities into a combined indicator to estimate whether an area is at risk of “digital exclusion”. Whilst the below statistics are only available at a Thurrock level, it is worth considering that some of these outcomes may be worse in parts of South Ockendon Locality, given the higher proportion of residents with no qualifications and higher deprivation levels than the Thurrock average.

The quintile values shown are for the UK (quintile 1 = worst 20%, quintile 5 = best 20%).

In Thurrock:

- 8.9% of households do not receive broadband speeds of at least 2MBps (National Quintile 4)
- 4.6% of adults have never been online (National Quintile 5)
- 76% of adults have all 5 Basic Digital Skills (National Quintile 3)
- 34% of adults have used all 5 Basic Digital Skills in the last 3 months (National Quintile 1)
- The Combined Digital Indicator estimates Thurrock to be at “Low” risk of digital exclusion

Source: Go ON UK Digital Exclusion Heat map, 2015

3.4.5. How can the new Purfleet Integrated Healthy Living Centre help?

The data above highlights that the majority of schools in the locality exceed the national average for pupils achieving a Good Level of Development.Whilst many of the services operating from the current Purfleet Children’s Centre already aim to improve the health of those aged 0-5 years, the new Integrated Healthy Living Centre should look to reinforce this, supporting breastfeeding uptake, uptake of childhood immunisations, parenting programmes and to potentially host services that support children to maintain a healthy weight in order to continually maintain the high standard of GLD achievement.

The consequences of West Thurrock and South Stifford ward having higher proportions of adult residents with no qualifications than the Thurrock or national averages could result in residents experiencing the negative health impacts described above. This could then impact on uptake of unhealthy lifestyle behaviours (e.g. smoking). The new Health Facility should look to support residents in improving their education and skills, potentially by providing a local hub for employers and learners to access high quality relevant training, hosting Adult Community Learning sessions, promoting volunteering opportunities and Time Banking. There is also the potential to incorporate the emerging Purfleet Community Hub services into this Integrated Health Facility, which also aim to improve education and skills for residents.

The data above shows that whilst Thurrock as a whole is at low risk of digital exclusion, only 34% of adults have used the five basic digital skills in the last 3 months. This is likely to be worse in parts of the South Ockendon Locality, as affordability has been cited in national research as a barrier to using digital services in areas with low incomes. The new Health Facility has an opportunity here to support residents in accessing online services which could lead to numerous benefits to health – access to health information online can provide people with reassurance or confidence about their own health or health of others, potentially reducing the number and length of GP consultations. It would also empower people to better manage their own health and gain a better understanding of the different resources available to support them, as well as facilitating the process of booking GP appointments or ordering repeat prescriptions where required.
Engaging and training residents in using digital skills and accessing services may also reduce the risk of isolation and empower them with current skills and knowledge to positively impact on employment opportunities.

3.5. Air Quality

3.5.1. How does air quality impact on health?

There is substantial evidence that air pollution has adverse effects on health. Adverse health effects from short and long term exposure to air pollution range from premature deaths caused by heart and lung disease to worsening of asthmatic conditions, and can lead to reduced quality of life and increased costs of hospital admissions. Research by the World Health Organisation’s International Agency for Research on Cancer (IARC) in 2013 concluded that outdoor air pollution is carcinogenic, with the particulate matter component of air pollution most closely associated with increased cancer incidence, especially cancer of the lung. An association was observed between outdoor air pollution and increase in cancer of the urinary tract/bladder. In their briefing, Natural England (2012) found that green spaces provide micro climates that aid particulate removal for cleaner air helping to reduce respiratory conditions.

3.5.2. Air Quality in South Ockendon Locality

Thurrock as a whole has pockets of very poor air quality. As of October 2015, Thurrock had 16 declared Air Quality Management Areas (AQMAs) and a further two pending declaration. An AQMA must result in a robust Air Quality Action Plan to specifically look at interventions in those areas to reduce levels of pollutants to acceptable levels. The majority of these AQMAs are declared for exceeding NO$_2$, although four are also declared for exceeding PM$_{10}$. Thurrock’s AQMAs can be seen in the map below – it shows that almost all of the areas fall within the South Ockendon Locality area. Recent work for the Integrated Air Quality and Health Strategy (2015) includes some proposals to address these, which look at:

- Prioritisation of activities/interventions based on air quality/health and level of deprivation
- Declaration and revocation criteria for AQMAs
- Clean air zone policy position
- Transport interventions
- Development management policies

Thurrock Council is in the unique position of having recently developed an air quality model for the Borough and has in-house expertise to run this model, meaning that robust monitoring and forecasting for air quality readings can be undertaken.

The figure below shows the locations of Thurrock’s Air Quality Management Areas. The numbers next to each area signify the number allocated to each area by Thurrock Council.
3.5.3. How can the new Purfleet Integrated Healthy Living Centre help?

Whilst the new Health Facility alone is unlikely to be able to mitigate the impacts from the poor air quality in Purfleet, it can participate in and support wider initiatives being led by the Council to both reduce emissions and exposure. For example, the facility could support patient education of the adverse effects of poor air quality, and potentially operate an AirAlert-type service to contact those particularly vulnerable to the adverse impacts (e.g. those with long-term conditions) on days when levels are predicted to be higher and advising them to take measures to modify their exposure (e.g. amend their physical activity routine). It can also support staff and patients with travel plans which encourage active travel and reduce reliance on cars.

3.6. Crime

3.6.1. How does Crime impact on health?

Research by Bellis et al (2012) found the following consequences of crime on health:

- Physical injury – potentially leading to disabilities or disfigurement, or in the case of sexual assault, pregnancy or disease
- Relationship difficulties – reduced trust, intimacy and increased isolation
- Self-harm and suicide – particularly stemming from youth violence and bullying
- Post-traumatic stress/anxiety or aggression
- Disruption to eating or sleeping patterns
- Increase in alcohol or drug misuse as a form of self-medication or coping mechanism
- Reduction of physical exercise in parks and public places – leading to a higher level of inactivity amongst the population and an increase in the associated long-term conditions.

Indirect links with health were also found, with crime potentially impacting on educational or professional attainment and victims of violence potentially needing to leave their homes.

There is also a large economic cost associated with the effects of crime on health – Bellis et al (2012) indicated that violence is estimated to cost the NHS £2.9 billion every year, with the total cost to society being estimated at £29.9 billion each year.

### 3.6.2. Crime in South Ockendon Locality

Data on reported crimes from September 2014 – August 2015 shows that there were 5,800 crimes reported to the police within the South Ockendon Locality area. This equates to 137.8 crimes per 1,000 residents (based on 2013 ward population estimates). The table below outlines the distribution of crimes across the locality, and it can be seen that West Thurrock and South Stifford has the highest crime rate in the locality (236.2 per 1,000) and Belhus has the lowest crime rate (86.1). [Table 9]

<table>
<thead>
<tr>
<th>South Ockendon Locality Total</th>
<th>Aveley and Uplands</th>
<th>Belhus</th>
<th>Ockendon</th>
<th>West Thurrock and South Stifford</th>
<th>THURROCK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of crimes</td>
<td>5,800</td>
<td>863</td>
<td>862</td>
<td>1,144</td>
<td>2,931</td>
</tr>
<tr>
<td>Number of residents</td>
<td>42,075</td>
<td>9,267</td>
<td>10,017</td>
<td>10,380</td>
<td>12,411</td>
</tr>
<tr>
<td>Crimes per 1,000 residents</td>
<td>137.8</td>
<td>93.1</td>
<td>86.1</td>
<td>110.2</td>
<td>236.2</td>
</tr>
</tbody>
</table>

Source: UKCrimeStats.com

The most common types of crime in South Ockendon Locality were:

- Anti-Social Behaviour (30.0% of offences)
- Violent Crime (14.9%)
- Shoplifting (12.5%)

Whilst not quantified here, domestic violence has been identified by the Thurrock Community Safety Partnership as a priority type of crime. Confidential data indicates that South Ockendon and Purfleet are among the ‘hotspots’ in Thurrock for domestic violence.
3.6.3. How can the new Purfleet Integrated Healthy Living Centre help?

The data above shows that there is a higher rate of crime in parts of the South Ockendon Locality area than the Thurrock average – the crime rate in West Thurrock and South Stifford is more than double the average rate for Thurrock. Services operated from the new Purfleet Health Facility could look to both reduce the health impacts felt by victims or potential victims, and affect some of the known risk factors for committing crime, thereby contributing to a crime reduction. Hosting services such as specialist domestic abuse and sexual violence services, sexual health services and IAPT would bring together existing services that currently support victims of crime and promote better cross-service relationships as well as supporting a more holistic approach to assessing needs as a whole. This is of particular importance as the Thurrock Community Safety Partnership has identified Purfleet and South Ockendon as hotspots for domestic violence. The Health Facility could also contribute to a reduction in crime by hosting lifestyle services aiming to promote health and reduce likelihood of perpetrating crime – such as drug/alcohol misuse (as many crimes are committed under the influence of a substance), or services aiming to promote good mental wellbeing (as many potential perpetrators have mental health issues themselves). Opportunities for the wider Purfleet Regeneration Programme to support a reduction in crimes and the impacts of crime are detailed in a further section of the document.

3.7. Access to Transport

3.7.1. How does accessing services impact on health?

Being able to access services means people are more likely to be feel better connected within their community and improve choice and therefore encourage them to feel more empowered. Conversely, those who have reduced access to services have a reduced choice and could by that “forced hand” result in poor quality of care because they have no other option. This could have a number of longer term impacts to both physical and mental health – the feeling of being “trapped” can have a negative impact on mental health and wellbeing, and also potentially lead to a greater risk of isolation if there are limited opportunities to interact with others.

3.7.2. Accessibility in South Ockendon Locality

Access to a car or van is a measure of accessibility to services. It can be seen from the map below that this access varies across Thurrock and even within South Ockendon Locality – in Aveley and Uplands only 19.8% of residents do not have access to a car or van, but this increases to 25.8% in Belhus. The Thurrock average is 20.1% and South Ockendon Locality average is 22.9%.
3.7.3. How can the new Purfleet Integrated Healthy Living Centre help?

The fact that a quarter of households in some parts of the Locality area do not have access to a car or van means that they are likely to rely heavily on public transport to access locations further afield and high use of local facilities. The danger is that if the current facilities/services are not meeting the needs of the population and they are less able to access services elsewhere, there is a risk that residents may become more isolated, or access inadequate provision and therefore potentially compound issues in the future. This presents a strong case for providing a wide range of different health and other community services from the new Health Facility, as residents can plan their journeys to one destination and have many of their needs met there, rather than having to make several different journeys. This includes provision of outpatient, community and mental health services within the new Integrated Healthy Living Centre. It can also encourage social inclusion, which may be particularly important for certain community groups. The work of the Local Area Coordinators has been instrumental to date in terms of helping to increase social cohesion, enable residents to feel informed about their available options, and ultimately support people to help each other thereby reducing the demand on statutory services. Reserving a portion of the new Health Facility for drop in use by the Local Area Coordinator for Purfleet would have numerous benefits to health: it would improve inter-agency working and knowledge of available services/resources to communicate to residents, it would raise the profile of isolation as a health issue by locating a service designed to reduce this alongside health services, and would assist the LAC in identifying people who would benefit from their support. This may be particularly important considering data presented earlier in the document which shows that parts of the Locality have a high proportion of pensioners who are living on their own.
3.8. **Summary of Needs: Wider Determinants of Health**

The information in the above section tells us that:

- Parts of the Locality are amongst the most deprived in Thurrock, meaning patients living there are statistically at risk of receiving poorer quality care.
- Parts of the Locality have high numbers of overcrowded households and homes without central heating, which could lead to poorer health outcomes.
- Parts of the Locality have a higher proportion of working aged adults who are unemployed or claim benefits, which highlights an issue of low income – again leading to poorer health outcomes.
- Whilst the Locality children are generally achieving good levels of educational attainment at age 5, many of the adults, particularly in the ward of West Thurrock and South Stifford, do not have any qualifications at all.
- Many of the residents, particularly those in more deprived areas, may be less confident in using Digital Skills to access information.
- Many of the residents will live in or close to an area of poorer air quality, impacting on a variety of health outcomes.
- Parts of the Locality have very high crime rates.
- Around a quarter of residents in some parts of the Locality do not have access to a car or van, therefore relying on public transport to access services.
4. Health Lifestyle Behaviour

This section has been written to reflect both the Purfleet Primary Care population and the wider South Ockendon Locality population. On the maps the site of the Purfleet Regeneration is ringed in blue.

4.1. Breastfeeding

4.1.1. How does Breastfeeding impact on health?
There has been significant reliable evidence produced over recent years to show that breastfeeding is a major contributor to public health and has an important role to play in reducing health inequalities even in the industrialised countries of the world. Breast milk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life; additionally there is evidence that the longer the duration of breastfeeding, the greater the health benefits in later life. According to a review undertaken by the World Health Organisation in 2007, the available evidence suggests that breastfeeding has long term benefits such as lower blood pressure and lower total cholesterol for breastfed subjects, as well as a reduced prevalence of overweight/obesity and type 2 diabetes and better success in intelligence tests. Another review looked at evidence for health outcomes for breastfeeding mothers, and found lactation to be associated with reduced risk for type 2 diabetes, breast and ovarian cancer. Early cessation of breastfeeding or not breastfeeding was associated with an increased risk of maternal postpartum depression.

4.1.2. Breastfeeding Prevalence

Looking at prevalence of infants who have been totally or partially breastfed in Thurrock in 2014-15, it can be seen that prevalence ranges from 49.45%-43.73% throughout the year. Between the three Purfleet Primary Care GPs, there is a wide range – Aveley Medical Centre has the lowest prevalence for all four quarters, with the lowest being 21.62% in quarter four, and Purfleet Care Centre has the highest, with a peak of 74.29% in quarter one. This wide range between practices that are geographical neighbours may merit further investigation. Taking an average of the South Ockendon Locality GPs, it can be seen that South Ockendon Locality practices are similar to the Thurrock average for all quarters.
4.1.3. How can the new Purfleet Integrated Healthy Living Centre help?

The data indicates that the prevalence of breastfeeding at 6-8 weeks in Purfleet women varies widely between neighbouring practices. This is concerning, as the evidence above outlines the many benefits breastfeeding can bring both to the child and the mother. There are currently a range of services being offered around South Ockendon Locality area and BTUH which support mothers to breastfeed – it would be beneficial if the new Health Facility could support coordination of these, and perhaps host some of the breastfeeding support groups and training sessions already running by providers in other locations. As breastfeeding has a traditionally lower uptake amongst low income mothers and also those who left school
at an early age, it is important that the Purfleet Integrated Healthy Living Centre undertakes targeted activities to improve access to breastfeeding support and raise awareness of breastfeeding benefits amongst these women. This could have benefits to future prevalence of long term conditions, including post-partum depression, and therefore reduce demand on the health service.

4.2. Smoking

4.2.1. How does Smoking impact on health?

Adults
There is a large body of evidence to demonstrate the causal links between smoking and a number of diseases, including cancers, circulatory and respiratory conditions, diabetes and rheumatoid arthritis. About 70% of the lung cancer burden can be attributed to smoking alone. Second-hand smoke has been proven to cause lung cancer in non-smoking adults. Smokeless tobacco (also called oral tobacco, chewing tobacco or snuff) causes oral, oesophageal and pancreatic cancer. Smoking has also been shown to diminish general health status and have other adverse effects on the body, such as causing inflammation and impairing immune function. It is ultimately responsible for a large number of premature deaths every year.

Children
Child and adolescent smoking causes serious risks to respiratory health both in the short and long term. Children who smoke are two to six times more susceptible to coughs and increased phlegm, wheeziness and shortness of breath than those who do not smoke. They are also more likely to continue smoking during their adult lives and have a lower chance of quitting. Smokers who start smoking at an early age have a higher risk of developing lung cancer or heart disease. In addition, there are enormous economic costs to society associated with smoking. Research by Action on Smoking and Health (ASH) estimated that smoking costs the UK economy £13.1 billion per year, including £2 billion in direct treatment costs to the NHS. (Action on Smoking and Health, 2014) Children and young people are also more susceptible to the effects of passive smoking, particularly if there is a parent at home who smokes. They are at higher risk of respiratory infections, asthma, bacterial meningitis and cot death.

Smoking in pregnancy
Smoking during pregnancy can cause serious pregnancy-related health problems, complications during labour and an increased risk of miscarriage, premature birth, still birth low birth-weight and sudden unexpected death in infancy. It has been found to increase the risk of infant mortality by 40% (National Institute for Health and Clinical Excellence, 2010). Evidence has shown that smoking prevalence during pregnancy is much higher among lower socioeconomic groups (Gray, et al., 2009) and teenage mothers.

4.2.2. The financial impact of smoking

According to the ASH Ready Reckoner 2014, the cost to the NHS of current and ex-smokers who require care as a result of smoking-related illnesses is £303,000 per year in the ward of West Thurrock and South Stifford alone, and £1,157,000 in the South Ockendon Locality area. The annual cost to Adult Social Care in terms of future care costs due to smoking is a further £105,000 per annum in West Thurrock and South Stifford, and £401,600 in the South Ockendon Locality area.
4.2.3. Smoking Prevalence

Smoking prevalence can be ascertained from two ways – by estimates based on survey data, or by recording of smoking status from GP registers. The latest ward level smoking survey estimates show the South Ockendon Locality wards (outlined in light blue on the below map) to have smoking prevalence similar to the Thurrock average. Prevalence estimates within the Locality range from 19.6% in West Thurrock and South Stifford to 21.2% in Belhus.

**Figure 20: Estimated prevalence of smoking in adults aged 18+**

![Estimated Smoking Prevalence at ward level, 2012](image)

Source: Integrated Household Survey

Figure 21 shows the smoking prevalence recorded at GP practice population level for those aged 15+ for Thurrock with the South Ockendon Locality GP practices shown in red.

**Figure 21: QOF recorded smoking prevalence, patients aged 15+ 2014/15**
In total there were 6,747 smokers aged 15+ recorded in the seven South Ockendon Locality Practices which gives an overall 15+ smoking prevalence for South Ockendon Locality of 23.0%. This is significantly greater than Thurrock’s overall prevalence of 20.3%, and also greater than the ward-level estimate presented above. However these figures are likely to be an under-estimate of the true prevalence of smoking in Thurrock, partly because the smoking status of patients is generally not recorded for all patient records at GP practice level, and secondly because some smokers may be reluctant to admit that they smoke to NHS health professionals.

4.2.4. Use of current commissioned stop smoking services

The public health team commission Vitality to provide a stop smoking service in Thurrock. Within South Ockendon Locality area, Vitality run an outreach clinic on Thursday afternoons at South Ockendon Hub. They also work with eight pharmacies within the SO Locality area, including Dave’s Chemist in Purfleet. Populations identified in red.
Figure 22 shows the percentage of smokers setting a quit date in 2014/15 through an NHS stop smoking service for each GP practice in Thurrock, with the seven South Ockendon Locality practice populations identified in red.
National research suggests that 75% of current smokers wish to quit. Despite this and the high prevalence of smoking in parts of the Locality area, GPs and other front line health professionals are sometimes failing to identify and refer sufficient numbers of smokers to NHS stop smoking services. Out of the 6,747 patients aged 15+ recorded as smokers in the locality area of South Ockendon, 443 (6.6%) set a quit date through an NHS commissioned stop smoking service. The Sancta Maria Medical Centre, Pear Tree and Belhus Medical practices have significantly better proportions of recorded smokers who are setting a quit date than the Thurrock average.

Figure 23 shows the percentage of patients recorded as smokers aged 15+ who successfully quit smoking at four weeks through an NHS stop smoking service in 2014/15.
In general, the South Ockendon Locality GP practices are performing better than the Thurrock average for successful four week quits, with 244 out of the 6,747 smokers successfully quitting smoking with an NHS stop smoking service, equating to 3.61% of those recorded as smokers. Dr Bellworthy has the second-highest four week quit rate in Thurrock, with 5.90% of its smokers quitting smoking. National research suggests that 9% of smokers who quit for four weeks manage to quit smoking permanently. Applying this to the South Ockendon Locality population would mean that NHS stop smoking services are reducing the number of smokers by 22.

4.2.5. How can the new Purfleet Integrated Healthy Living Centre help?

The above critique on the impact of current smoking cessation programmes in South Ockendon highlights that there are some GPs currently performing better than the Thurrock average. However, it is important to remember that differences in smoking prevalence’s between affluent and deprived communities has been calculated to account for up to half of all health inequality outcomes, meaning that efforts must be made to ensure that there needs to be a continued additional focus on assisting smokers in high prevalence areas to quit. The new Health Facility must incorporate an evidence-based smoking cessation service, which should work closely with long term condition management services, mental health services and GPs to identify those who smoke and support them to quit, as it is known that smoking either causes or exacerbates a number of long term conditions, and its’ addictive qualities can make it more difficult for those with mental health conditions to quit. A concerted effort must be made by all front line staff to identify and refer smokers into stop smoking services. All professionals working in the new Health Facility should also undertake Making Every Contact Count (MECC) training to enable them to identify and support smokers.
4.3. **Obesity**

4.3.1. **How does Obesity impact on health?**

The increasing prevalence of obesity amongst adults and children is a major public health challenge both nationally and internationally. There is a large body of evidence to indicate that being overweight or obese can increase the risk of developing a range of other health problems such as coronary heart disease (CHD), type 2 diabetes, some cancers, and stroke and reduce life expectancy. The consequences of obesity are not limited to the direct impact on health. Overweight and obesity also have adverse social consequences through discrimination, social exclusion and loss of or lower earnings, and adverse consequences on the wider economy. There are numerous factors for obesity, as it is a very complex condition. Some of the known inequalities in obesity prevalence include:

- **Age** - prevalence of overweight and obesity generally increases with age, although there is a decline in prevalence among those aged 75 years and over.
- **Income** - those living in low income households have the highest prevalence of obesity and those living in high income households have the lowest. These differences are particularly marked among women: women living in the lowest income households have double the prevalence of obesity (31%) compared to those living in the highest income households (15%)
- **Ethnicity** – there is some ethnic variation: women from Black African groups appear to have the highest prevalence of obesity and men from Chinese and Bangladeshi groups have the lowest
- **Poor diet** – those who are malnourished in early years have a higher risk of obesity in later life
- **Household** – having family members who are obese or overweight can increase the risk of obesity or overweight
- **Mental health issues** – having a mental health condition can lead to different behaviour choices that can lead to overweight or obesity.

There are also environmental influences that can impact on behavioural choices (such as amount of physical activity undertaken or diet) which can lead to overweight or obesity.

4.3.2. **Child Obesity Prevalence**

In order to provide as robust an indicator as possible at small area level, Public Health England aggregate three years of data from the National Child Measurement Programme and produce estimates of obesity and excess weight prevalence in Reception and Year 6-aged children. The two graphs below show data for each ward in Thurrock for Reception and Year 6-aged children respectively. It can be seen that for Reception-aged children, there are no South Ockendon Locality area wards that have a significantly different obesity prevalence to the Thurrock average (9.5%). The average prevalence for the South Ockendon Locality wards for obesity in Reception-aged children is 10.3%. [Figure 24]

_Figure 24: Childhood Obesity Prevalence at Reception_
Regarding Year 6 children, the data shows a wider variance within the South Ockendon Locality wards. Belhus has a significantly higher prevalence of obese children than the Thurrock average (29.0% compared to 21.0%), whereas Ockendon has a significantly lower prevalence of obese children (12.6%).

Figure 25: Childhood Obesity Prevalence at Year 6
4.3.3. Adult Obesity Prevalence

Adult obesity levels can be estimated using survey data. Ward-level adult obesity prevalence estimates for those aged 16+ estimate that the South Ockendon Locality has an obesity prevalence of 28.9%. This is above the England and Thurrock estimates from that survey data (24.1% for England and 28.1% for Thurrock). Of the four wards within SO Locality, Belhus has the highest obesity prevalence (30.2%) and a rate that is statistically significantly greater than Thurrock’s overall prevalence.

Figure 26: Modelled Obesity Prevalence by ward, 2006-2008

Source: Local Health

4.3.4. Use of Current Services

Vitality run a weight management programme from various areas of Thurrock which is open to those in Purfleet and South Ockendon areas.

The Public Health team also fund some community initiatives via grants, including:

- Tai Chi 4 Health – a weight management programmes across Thurrock. Whilst there is not currently a programme running in the South Ockendon locality area, this will run if there is sufficient demand
- Cookery Classes/Weight Loss support – cookery classes take place at Purfleet Children’s Centre, but the weight loss support element runs from the clinic in Grays.
- Nutritional therapy/counselling – this is available to all Thurrock residents but the premises is based in Grays.
- Mini-Kickers – a sports programme for nursery-aged children has taken place at various different Children’s Centres around the borough; however none local to Purfleet purchased the programme to continue on.
Data from Vitality indicates that for 2014-15, there were 135 referrals for their weight management service from people registered with South Ockendon Locality or St Clements Health Centre GPs. When looking at the referrals against the number of people recorded on QOF Obesity registers in 2014/15, the referral rate per 1,000 patients varies between practices. The Sancta Maria Medical Centre has the lowest rate of referrals from their list of obese patients (8.35 per 1,000) whilst St Clements Health Centre had the highest (95.24 per 1,000). It is recommended that further work is undertaken to explore the reasons for this variation. When compared to the Thurrock average, it can be seen that the overall Thurrock rate is fairly low (37.56 per 1,000) and that the majority of the locality GPs have similar or higher referral rates. This can be seen in the figure below. [Figure 27]

Figure 27: Referrals to Vitality Weight Management Service in 2014/15

Source: Vitality and QOF

Vitality state that their current weight management programme is fairly well attended, and higher than other parts of Thurrock such as Tilbury.

4.3.5. How can the new Purfleet Integrated Healthy Living Centre help?
The information above shows that there is variation across the locality area, both in terms of obesity prevalence and usage of commissioned weight management services. The new Health Centre has a role in hosting and coordinating these services, and providing accurate advice regarding healthy choices (particularly targeted towards low income families to help them to live well) and the adverse consequences of overweight and obesity in both children and adults. There is also the need for the promotion of NHS Health Checks and breastfeeding in early detection of associated diseases and prevention of compounding factors. The Facility can also look towards addressing some of the determinants of obesity, including hosting IAPT services and working closely with them to address underlying mental health issues associated with eating or physical activity behaviours. The “digital hub” portion of the Health Facility would also support people to access healthy choices information directly, signpost to relevant services and improve general
health education. All health professionals would be MECC trained to enable them to identify and support individuals at risk of becoming overweight or obese. Opportunities for the wider Purfleet Regeneration Programme to support people maintain a healthy weight, are detailed in a further section of the document.

4.4. **Substance Misuse**

4.4.1. **How does substance misuse impact on health?**

Substance misuse has a number of adverse effects on health: cardiovascular disease, mental health problems, liver disease and lung damage can all be caused or impacted upon by an individual’s use of certain drugs. In particular, the prevalence of co-existing mental health and substance use problems (termed ‘dual diagnosis’) may affect between 30 and 70 percent of those presenting to health and social care settings. Not only does substance misuse cause physical and mental ill health, it can also cause homelessness, poverty and crime. They are associated with other social and physical problems that influence misuse, such as unemployment, low self-esteem, perceived failure, relationship problems and psychological problems.

**Children and Young People**

The risk to children of substance misuse can come from their own use of drugs/alcohol, or parental use within the family home. The risk-harm profile identifies 10 key items to gauge the vulnerability of young people entering specialist substance misuse services – they are more likely to be NEET, have contracted an STI, have a child, be in contact with the youth justice system, be receiving benefits by the time they are 18, and half as likely to be in full-time employment. The vulnerabilities are:
- Opiate and/or crack user
- Alcohol users
- Using 2 or more substances
- Began using main problem substance under 15
- No Fixed Abode/ unsettled housing
- Not in education, employment or training
- Involved in self harm
- Involved in offending
- Pregnant and/or parent
- Looked after child

Children of parental users can be at risk in terms of:
- Access to drugs or drugs paraphernalia within the home, e.g. tablets, needles etc.
- Violence in the home
- Exposure to a number of strangers within the home
- Neglect of their own needs, potentially resulting in poorer health and educational attainment and poor mental health
Unborn children
Substance use during pregnancy may result in premature birth, low birth weight and potential chemical dependence for the child when s/he is born such as Foetal Alcohol Spectrum Disorder.

4.4.2. Prevalence
Modelled estimates of the population aged 16+ years that binge drink estimate that South Ockendon Locality has some of the highest proportions of those who binge drink in Thurrock. Whilst the Thurrock average is 18.4%, the modelling suggests that 22.4% of Aveley and Uplands residents and 21.4% of West Thurrock and South Stifford residents binge drink. However due to the small sample size from each ward, the confidence intervals are fairly wide and no wards are statistically significantly different to each other.

Figure 28: Modelled estimates of binge drinking, 2006-2008

Source: Public Health England

Data showing hospital admissions for alcohol-attributable conditions shows that South Ockendon locality also has some of the wards with the highest admission ratios in Thurrock – although they are not the same two wards shown above to have the highest binge drinking prevalence. Whilst Thurrock has an average standard admission ratio of 85.2, which is lower than the England ratio of 100, parts of the borough have slightly higher ratios, with Belhus having the highest ratio in South Ockendon locality (105.7), followed by Ockendon (100.6). Displaying this data as standardised admission ratios highlights that areas with higher ratios than 100 have higher than expected admission rates.
4.4.3. Current Service

The Adults substance misuse service is provided by *Addaction* who also coordinate needle exchange services. The needle and syringe exchange programme is an important public health service that reduces risks and harm to injecting drug users and the general public by ensuring injecting users have free access to clean needles and safe disposal of used needles, ensuring they are not discarded in public. The services are commissioned by pharmacy and non-pharmacy providers. Four pharmacies within the South Ockendon locality area provide needle and syringe services. The supervised consumption service is commissioned by the Drug and Alcohol Action Team (DAAT) and provides drug users with the support to reduce harm and manage their treatment programme. The programme aims to improve the service user’s outcomes as well as divert these opiates from surfacing on streets. Six pharmacies within the South Ockendon Locality area provide supervised consumption services. Dave’s Chemist in Purfleet provides both of these services. Whilst the group therapy and key work sessions are run from Grays, clients from Purfleet are still able to access them and would be refunded any travel tickets.

For alcohol treatment, residents need to attend the service based in Grays. Satellite services have been held out of Purfleet Children’s Centre on a needs-basis in previous years, but creating access to a provision in the locality would be of benefit to the residents that were not able to get to Grays with ease. IBA can continue to be provided via GP surgeries where appropriate. In addition, *Addaction*, in partnership with Alcohol Concern, have trained housing officers, Local Area Coordinators and social workers (adults) in alcohol IBA. Feedback on this training has been positive with staff reporting the confidence to engage with clients/residents regarding alcohol IBA and refer or signpost to *Addaction* for treatment where appropriate.
Wize Up provides the young people’s substance misuse service. Whilst the provider accesses the schools in that area for some of their work, they also attend the homes of young people or the local Children’s Centre. This is targeted work for young people open to the service, plus preventative work including IBA at PSHE events or off-timetable (drop-down) days.

4.4.4. How can the new Purfleet Integrated Healthy Living Centre help?
The data above shows that parts of the South Ockendon Locality area may have issues with either binge drinking or higher rates of hospital admissions for alcohol-attributable conditions. Whilst the locality area is relatively well-served in terms of needle exchange and supervised consumption provision, the new Health Facility may have a role in terms systematic identification of people who are drinking alcohol at hazardous and harmful levels, and treatment services for those dependent on alcohol. It could also to address some of the vulnerabilities to young people likely to misuse substances highlighted above – e.g. wider community services hosted within the Facility could support those with No Fixed Abode/unsettled housing or at risk of becoming NEET. Specialist sexual health services would support those who are pregnant and collocated IAPT services would identify those who self-harm or potentially those at risk of self-harming. Colocation of IAPT would also consolidate the relationship between substance misuse and mental health services, and enable closer working between professionals.

4.5. Sexual Health and Teenage Pregnancy

4.5.1. How does poor sexual health further impact on health?
Relationships and sexual practices can be influenced by a number of factors, including:
- Social norms
- Peer pressure
- Religious beliefs
- Culture
- Confidence and self-esteem
- Substance misuse
- Coercion and abuse

Risky sexual behaviour impacts on health services and the wider community in a number of ways. Untreated STIs can facilitate HIV transmission and increase susceptibility to HIV. Late diagnosis of STIs and HIV also make them more costly to treat, with gonorrhoea becoming particularly difficult as it can quickly develop resistance to antibiotics. Unintended pregnancies can also lead to abortions, which can in turn have detrimental effects both in terms of mental health and future fertility, potentially resulting in more costly interventions for future planned pregnancies. There are also impacts to health in dealing with the consequences of rape or sexual assault, which can be substantial and have a long lasting duration.

4.5.2. How does Teenage Pregnancy impact on health?

Unwanted teenage pregnancy is a major underlying driver of health inequalities. Teenage mothers are at greater risk of experiencing a range of poor outcomes, which include:
• Being less likely to finish their education, and more likely to bring up their child alone and in poverty
• Experiencing an infant mortality rate that is 60 per cent higher than for babies born to older mothers
• Experiencing a rate of post-natal depression that is three times that experienced by older mothers and a higher risk of poor mental health for three years after the birth

Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life. Sons of teenage mothers are more likely to be imprisoned when compared to their peers born to older mothers.

A number of risk factors have been identified to be associated with teenage pregnancy:
• Living in a deprived area
• Limited knowledge of or access to contraception and sexual health advice
• Family structure – children living in care or those from lone parent backgrounds may be more likely to become teenage parents. Additionally, those whose mothers were teenage parents are also more likely to become teenage parents.
• Educational attainment - on average, deprived wards with poor levels of educational attainment have under-18 conception rates twice as high as similarly deprived wards with better levels of educational attainment (Department for Education and Skills, 2006).
• Disengagement from school – the Department for Education and Skills found that among the most deprived 20% of local authorities, areas with higher rates of absenteeism have higher under-18 conception rates.
• Participation in early and risky behaviours – including early onset of sexual activity, and substance misuse
• Mental health problems – particularly self-esteem and confidence levels, which can impact on their choices
• Some ethnic groups are more likely to experience teenage pregnancy than others – however it is unclear whether this is an independent factor.

Children of teenage parents are much more likely to become teenage parents themselves, meaning that if not addressed; teenage pregnancy perpetuates health inequality between generations.

4.5.3. Sexual Health in Purfleet/South Ockendon
Small numbers of new diagnoses of sexually transmitted infections (STIs) in certain areas mean it is difficult to see a lot of variation at LSOA level. Looking at the figure below, it can be seen that there are two LSOAs that do have higher rates of new STIs than the rest of Thurrock, and both of these are in the South Ockendon Locality area.
Rates of diagnosed HIV in 15-59 year olds vary across the borough. Whilst Thurrock has a similar diagnosed HIV prevalence to England (2.1 per 1,000 compared to the national average of 2.2 per 1,000), there are some areas which have higher rates. Three of the four MSOAs in the South Ockendon Locality area have rates that are at or above the Thurrock average, with the area corresponding to West Thurrock and South Stifford appearing to have the highest rate in Thurrock.
4.5.4. Teenage Pregnancy in Purfleet/South Ockendon

Data on the rates of under-18 conceptions is released at ward level for aggregated 3 year periods. The latest data is for 2011-13, and it can be seen from the map below that under-18 conceptions within the three of the four wards within the South Ockendon Locality are in the second-highest quintile in Thurrock.

Figure 32: Teenage Pregnancy Prevalence by quintile – 2011-13

Thurrock as a whole has a rate of under 18 conceptions that is statistically significantly greater than England’s.

HES (Hospital Episode Statistics) data indicates that in 2014, 1.7% of deliveries were to mothers aged under 18 years in both Aveley and Uplands and Belhus, 1.6% in Ockendon and 0.9% in West Thurrock and South Stifford. This is similar to the national proportion of 1.5%.

4.5.5. Current Services

Thurrock Council’s Public Health team commission an Integrated Sexual Health Service comprising of:

- Access to full integrated contraceptive and family planning clinic, located in Orsett and Grays
- Postal Chlamydia Screening Kits
- Contraception through C-Card scheme
- Education based health service, i.e. Delay speakeasy and Go Girls
- Primary Care Contract which include management/delivery of Emergency Hormonal Contraceptive, C-Card, Chlamydia Screening, LARC – offered within General Practice and pharmacy
Primary Care Contracts
The intention of the Public Health team is to increase LARC as well as other forms of contraception to reduce unwanted pregnancy and reduce abortion rates (cost to CCG). Going forward sexual health will be looking at a hub model whereby there will be outreach clinics based at areas of high prevalence whilst still maintaining open access but targeted services to fit specific need. Although no GP practices in South Ockendon Locality have opted to contract with Public Health to deliver sexual health services, three pharmacies have signed up:
- Boots (Chlamydia and EHIC)
- Dips Chemist (EHIC)
- South Road Pharmacy/Longthorns (unknown)
Work is in process to encourage more sign ups to this contract via streamlining the current contract, as well as potentially signing up to the HIV self-sampling contract which are kits accessible to all.

The latest information known on use of LARC indicates that there is a lower rate of uptake in women aged 15-49 years in South Ockendon Locality GPs than the Thurrock average of 23 per 1,000 – uptake ranged from 2 per 1,000 (Sancta Maria Health Centre) to 16 per 1,000 (Pear Tree Surgery). This is also a lower rate than the national average of 33 per 1,000. Considering the data displayed earlier in the document that highlights three of the four wards in the Locality to have teenage pregnancy rates in the second highest quintile, and the knowledge that no GP practices in the Locality are currently offering this, there might be a need to promote this in the new facility.

Figure 33: Uptake of LARC in South Ockendon Locality GPs, 2013

Source: MSD

4.5.6. How can the new Purfleet Integrated Healthy Living Centre help?
The information shown above highlights that there are parts of South Ockendon Locality with poorer sexual health than the rest of Thurrock; one MSOA has the highest prevalence of HIV in the borough. Whilst
teenage pregnancy in the locality is not the worst in Thurrock; three of the four wards are in the second worst quintile; and yet the current clinic services are based in Grays and Orsett. The area does have three pharmacies signed up to deliver the Primary Care Contract; however it would be advantageous if the new Purfleet Integrated Healthy Living Centre would also sign up to deliver the services listed in the Public Health Primary Care Contract, whilst also providing advice and guidance on wider sexual health and pregnancy issues, and signposting to other existing services already offering support such as Children’s Centres, Social Care services, School Nurses and Parenting Services. The Health Facility will also look to mitigate some of the risk factors for teenage pregnancy and poor sexual health – such as specialist substance misuse support and co-location of IAPT mental health services, and also via wider community services provide guidance towards housing options, supporting teenage parents to access further education options or employment opportunities. By taking a more holistic view of the determinants and factors, this should result in a longer term benefit to health (in terms of reduced STI incidences, unplanned pregnancies and the accompanying consequences) both in terms of costs and resources.
5. Epidemiology

5.1. Self-reported Health

The 2011 Census asked people to report on their own perceived views of their health and wellbeing. Of the four South Ockendon Locality wards, Belhus and Ockendon have significantly higher proportions of people who rate their health as ‘bad’ or ‘very bad’ (6.4% and 6.5%) than the Thurrock average of 4.7%. West Thurrock and South Stifford has a significantly lower proportion than the Thurrock average (3.5%).

Figure 34: Proportion of people in ‘bad’ or ‘very bad’ health, 2011

Source: Local Health/ONS

Residents are also asked about their health in the GP Patient Survey. In the 2015 release, it can be seen that there is some variation at practice level for those who consider themselves to have a long-standing health condition. However it should be noted that due to the relatively low sample size, the confidence intervals are fairly wide. St Clements Health Centre and the Sancta Maria Medical Centre have 47% of patients with a long term condition, whilst Pear Tree Surgery has 58% of its patients with a long term condition.
5.2. Life Expectancy

5.2.1. Males

Data for 2008-2012 shows that the life expectancy at birth for males in Thurrock is varied. South Ockendon Locality has one of the wards with the lowest life expectancy in Thurrock (West Thurrock and South Stifford has a life expectancy of 76.4 years, compared to the Thurrock average of 79.1 years and England average of 78.9 years).

Source: Local Health
5.2.2. Females

The data for female life expectancy indicates that the life expectancy for the South Ockendon Locality wards are all statistically similar to the Thurrock average of 82.6 years, with West Thurrock and South Stifford ward having a female life expectancy of 84 years. All four wards are statistically similar to the England average of 82.8 years.

Figure 37: Life expectancy at birth for females in Thurrock, 2008-2012

Source: Local Health

5.2.3. Premature Mortality

Premature mortality rates in South Ockendon Locality are significantly higher than the England average for all causes under 75 years. The standardised mortality rate for mortality due to all causes for those aged under 75 years is 114.2 (SMR for England is 100). When looking at some of the key causes of death, SMRs for three of the main causes (cancer, all circulatory disease and coronary heart disease) are also above the England average, with SMRs of 125.1, 147.1 and 147.7 respectively. When comparing to the Thurrock SMRs, Thurrock’s highest SMR is 112.9 (for all circulatory diseases under 75 years).
This may be partly explained by the fact that our cancer screening coverage in Purfleet practices is lower than the Thurrock average, as well as reduced primary care capacity to identify and manage patients (this is explored further in the sections below).

5.3. Immunisations and Screening

This section contains data relating to the three Purfleet Primary Care practices, reflecting the fact that the new Integrated Healthy Living Centre’s immunisation and screening services would be offered to some of these registered populations.

5.3.1. Childhood Immunisations

There are a number of immunisation programmes tailored towards children. One of the most high-profile of these is the MMR (Measles, Mumps and Rubella) vaccine – doses for which are routinely given by ages 2 and 5. The figures below show the population vaccination coverage for the Purfleet Primary Care Population between August 2013 and 2014 for 2 year olds and 5 year olds. It can be seen that of the three practices, the Purfleet Care Centre has the lowest coverage for 2 year olds (89.90%) and that St Clements Health Centre and Aveley Medical Centre have similar coverage rates of 94.90% and 95.00% respectively, both of which are higher than the Thurrock average (93.30%). For 5 year olds, St Clements Health Centre has the highest coverage rate (98.80%) whilst Aveley Medical Centre has the lowest coverage rate (89.40%), which is lower than the Thurrock average of 90.80%.
5.3.2. Cancer Screening

Cancer screening data is available for three types of cancer – breast, bowel and cervical. The latest GP practice level data shows that the three GP practices forming the ‘Purfleet Primary Care Population’ have lower screening coverage for all three programmes than the Thurrock average. For Breast and Bowel
Cancer screening, Aveley Medical Centre has the highest coverage rates (58.5% and 49.3% respectively) but has the lowest coverage rate for Cervical screening (66%). The Thurrock average for each of the programmes is 64.9%, 53.9% and 73.2%.

**Figure 41: Breast Cancer Screening, June 2015**

Source: Open Exeter

**Figure 42: Bowel Cancer Screening, June 2015**

Source: Open Exeter
5.3.3. Summary of Immunisations and Screening

Immunisations for MMR across the three Purfleet practices are almost all higher than the Thurrock average; however, the Thurrock average as a whole still falls short of the 95% target recommended by the World Health Organisation to promote ‘herd immunity’. Performance of the three cancer screening programmes indicates that a lower proportion of eligible Purfleet residents are being screened than the Thurrock average; yet it can be seen that residents who live here have a higher premature mortality rate due to cancer than Thurrock and England. The new Integrated Healthy Living Centre should look to promote good uptake of immunisation and screening programmes via:

- Use of patient reminder and recall systems
- High quality patient education and information resources in a variety of formats to ensure access to all community groups
- Maintenance of staff knowledge and awareness with regard to immunisations and screening to ensure accurate and consistent advice is provided to patients
- Partnership working (e.g. with the Purfleet Children’s Centre) to promote and deliver these programmes
6. Long Term Conditions

Data presented in this section relates to that reported by the three Purfleet GP Practices in their 2014/15 QOF (Quality Outcomes Framework) returns. These are the practices for which the new healthy living facility would be providing primary care.

6.1. Long Term Conditions in Purfleet

In 1948 when the NHS was founded, almost half of the population died before their 65th birthday. In 2015 this figure dropped to 18%. However, although living longer, our population are increasingly doing so with long term conditions. Spend on patients with long-term conditions accounts for over 70% of the entire NHS budget. Effective management of long term conditions is absolutely vital in order to prevent patients’ health, wellbeing and independence from deteriorating and to prevent them being admitted to hospital or requiring social care packages.

Figure 44 shows the prevalence of the most common long term conditions in Purfleet, Thurrock and England using GP QOF data. This estimates prevalence from the number of patients on GP disease registers who have already been diagnosed as having a long term condition.

**Figure 44 - Recorded prevalence of Long Term Conditions in South Ockendon, Thurrock and England in 2013-14**

Source: QOF, 2014-15

Purfleet has a lesser percentage of patients known to be living with almost all of the conditions compared to Thurrock and England. This may be due to underlying levels of disease and/or inadequate early diagnosis within Primary Care.
6.2. Non-diagnosed Long Term Conditions

ERPHO (Eastern Region Public Health Observatory) produced modelled expected estimates of disease prevalence for certain long term conditions in GP practice populations based on the best published evidence and considering differences in demography and other risk factors known about a GP practice population. By comparing the variation between these modelled prevalence figures and the LTC prevalence in figure 30 of patients already diagnosed we can estimate numbers of patients within a given practice population who are living with a long term condition that is not diagnosed, and therefore the completeness of GP long term condition QOF registers. A register that is significantly incomplete suggests poor case finding of patients with long term conditions, meaning that there may be a significant proportion of patients on a GP’s list have a long term condition and that are not being managed or treated. ERPHO generated estimated prevalence for Hypertension, Diabetes, Stroke, Atrial Fibrillation and COPD. When comparing the modelled estimates for each practice to the observed prevalence, for each condition, the condition with the largest gap between observed and the modelled estimate was Hypertension. The figure below shows the total estimated prevalence of hypertension by Purfleet GP, broken down by the diagnosed/observed prevalence and the estimated undiagnosed prevalence generated by the ERPHO estimates. It can be seen that Aveley Medical Centre has the highest difference between observed and estimated prevalence of Hypertension (11.24%), and Purfleet Care Centre has the smallest difference (5.36%); although they still have the lowest prevalence of Hypertension in Purfleet. Aveley Medical Centre has the highest estimated total prevalence of Hypertension (25.36%). [Figure 45]

Figure 45: Diagnosed and non-diagnosed Hypertension in Purfleet


Using this it has been possible to calculate an estimate of how many cases may not be diagnosed. This can be seen in the table below by GP and condition. We have also indicated where the observed levels are higher than expected. This could mean that diagnosis rates are good, or that diagnostic protocols have not
been followed and the wrong people are on the register. An audit of diagnostic procedures is needed to
asses this.

Table 10: Estimated number of undiagnosed cases by GP and condition

<table>
<thead>
<tr>
<th></th>
<th>Hypertension</th>
<th>CHD</th>
<th>AF</th>
<th>COPD</th>
<th>Stroke</th>
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<td>Total For Purfleet</td>
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<td>267</td>
<td>147</td>
<td>94</td>
<td>71</td>
</tr>
</tbody>
</table>


*Note – we have not calculated this for diabetes because the model is so out of date.

We estimate that in Purfleet practices there are 1866 patients who have Hypertension, 267 who have CHD
and 147 with Atrial Fibrillation who are not diagnosed and thus not treated. Without good quality primary
care and education on self-care these conditions will only worsen and result in high cost activity in
secondary care and increased need of Social Care packages.

Evidence suggests (see QOF section below) that offering patients with LTC good quality care does reduce
levels of non-elective activity for these conditions.

6.3. Quality outcomes framework (QOF)

QOF records certain quality of care information on how patients who are diagnosed with diseases are
treated in primary care. It was set up as an incentive system and GP practices get paid for the percentage
of their “diseased population” that they offer certain tests, medication reviews and treatments for. The
indicators are based on evidence of good quality care for the conditions.

There has been much debate over recent years whether QOF actually achieves good outcomes for patients
in terms of reducing the risk of major events requiring hospitalisation. However a study published in the
BMJ this year showed that nationally the introduction of QOF was in fact associated with a decrease in
emergency admissions for these incentivised conditions. They also state that:

“Contemporaneous health service changes seem unlikely to have caused the sharp change
in the trajectory of incentivised ACSC admissions immediately after the introduction of the
Quality and Outcomes Framework. The decrease seems larger than would be expected
from the changes in the process measures that were incentivised, suggesting that the pay
for performance scheme may have had impacts on quality of care beyond the directly
incentivised activities.” (Harrison et. al., 2014).
Figure 46 shows the findings from their research.

**Figure 46 Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions**

We can therefore use QOF scores as a proxy for quality of care for patients with Long-Term Conditions. These are shown in the figures below.

**Note:** All figures are for 2014/15 and labels are shortened versions of the full QOF indicator. A list of the full QOF indicators is available [http://qofportal.uk/qof-read-codes/clinical-domain/](http://qofportal.uk/qof-read-codes/clinical-domain/)

The radar charts show a global view of how practices LTC patients are being managed. Generally the larger the drawn area (blue line with points) the better that practice is at managing the condition as a whole. They also show where conditions may be well managed in one area and not in others.

### 6.4. Clinical Management of Patients with Hypertension

We estimate that there are 4,386 patients with hypertension in Purfleet, including 1,866 who are not yet diagnosed.

Of those who are diagnosed the QOF tells us about the quality of their care and how well managed their condition is in general. Specifically for Hypertension it looks at the control of patients’ Blood Pressure, and treatment with statins for patients with a CVD risk score of 20% or higher. These indicators are aimed at reducing the risk of patients suffering from a CVD event in the future.
Source: QOF 2014/15

Figure 47 shows that for all three practices around 80% of patients with Hypertension have kept their Blood Pressure under control in the preceding 12 months.

In the Purfleet care centre and St Clements Health Centre all patients (excluding exceptions) with a CV risk score of 20% or over are treated with statins, 50% of the patients in St Clements have, however been exception reported. No patients in the Aveley Medical Centre were treated, the denominator used for this practice was zero suggesting that no patients had a risk of 20% or higher; unfortunately the QOF data for this year no longer includes the indicator which tells us how many patients have been risk assessed. [Figure 48]

Unfortunately QOF no longer tells us about physical activity assessments and interventions for patients diagnosed with hypertension. However Figure 49 shows these indicators for the 2013/14 year.
Figure 48: QOF indicators for Hypertension care 2013/14 – New patients with a CV risk assessment of 20% or more treated with Statins

New Hypertension patients, age 30-74, with CV risk assessment >=20% treated w. statins

Source: QOF 2014/15

Figure 49: % Hypertension Patients receiving Physical Activity Assessment and Lifestyle advice 2013/14

<table>
<thead>
<tr>
<th>Medical Centre</th>
<th>Physical Activity Assessment</th>
<th>Inactive: Brief Intervention</th>
<th>Lifestyle Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aveley Medical Centre</td>
<td>79.50%</td>
<td>82.60%</td>
<td>68.00%</td>
</tr>
<tr>
<td>Purfleet Care Centre</td>
<td>68.90%</td>
<td>92.90%</td>
<td>95.30%</td>
</tr>
<tr>
<td>St Clements Medical Centre</td>
<td>46.40%</td>
<td>72.80%</td>
<td>90.70%</td>
</tr>
</tbody>
</table>

Source: QOF 2013/14
6.5. Clinical Management of Patients with Heart Failure (HF) and Atrial Fibrillation (AF)

We estimate that there are 339 patients with AF in Purfleet, including 147 who are not yet diagnosed. And 107 patients are currently diagnosed with HF.

Of those who are diagnosed the QOF tells us about the quality of their care and how well managed their condition is in general. Specifically for AF and HF it looks at treatment with specific drugs, and for AF the inclusion of a CHADS2 score (with appropriate treatment). All of these indicators are aimed at reducing the risk of patients suffering from a further CVD event in the future. Care should be taken in interpreting some of the figures below, as absolute numbers of patients requiring each clinical intervention are relatively small.

Figure 50: QOF indicators for HF and AF – Aveley Medical Centre

Source: QOF 2014/15

Figure 50 shows that patients registered with Aveley Medical Centre who are on the HF disease register are generally well treated. 91% of patients have had their diagnosis confirmed appropriately, using an ECG or specialist assessment. Additionally 100% of patients (excluding exceptions) with LVD are being treated with an Ace Inhibitor or ARB. However, only 75% of AF patients (excluding exceptions) with a CHADS 2 score of greater than one are being treated with anti-coagulant therapy.
Figure 51: QOF indicators for HF and AF – Purfleet Care Centre

Source: QOF 2014/15
Figure 51 shows clinical management of AF and HF patients registered with the Purfleet Care Centre. Care should be taken when interpreting Figure 50 as the absolute numbers on both AF and HF registers 23 and 14 respectively and so their disease registers are very small. All patients on both the AF and Heart Failure register who are not exception reported are receiving excellent clinical management of AF and Heart Failure, with 100% of patients receiving appropriate clinical management on all metrics. However there were 2 out of 7 persons exception reported for the CHADS 2 greater than one indicator.

Figure 52: QOF indicators for HF and AF – St Clements Health Centre

Source: QOF 2014/15

Figure 52 shows that patients who have not been exception reported and are on the AF and HF disease registers at the St Clements Health Centre receive excellent clinical management of AF and Heart Failure, with 100% of patients receiving appropriate clinical management on all metrics. However this is based on small register sizes (15 and 11 respectively) and there is a high level of exception reporting on two metrics; patients with a CHAD2 score >1 treated with an anti-coagulant four out of nine patients exception reported), and patients with HF their diagnosis confirmed by ECG or specialist assessment (three out of ten patients exception reported). For these two metrics only 56% and 70% of patients respectively are receiving appropriate clinical management although again the absolute numbers of patients is relatively small. The reasons for exception reporting remain unclear and could include good clinical reasons. However this level of exception reporting could warrant further investigation as these patients are potentially at significant increased risk of more serious cardio-vascular events.
6.5.1. Absolute numbers of AF and HF patients requiring Clinical Review

Table 11: Absolute numbers of AF and HF patients requiring clinical review

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Patients with a CHAD2 score&gt;1 not anticoagulated nor excepted</th>
<th>Patients with a CHAD2 score =1 not on anti-platelet therapy nor accepted</th>
<th>Patients with a diagnosis of heart failure not confirmed by an ECG or by specialist assessment 3 months before or 12 months after entering on to the register</th>
<th>Patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, not currently treated with an ACE-I or ARB, but not currently treated with a beta-blocker licensed for heart failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aveley Medical Centre</td>
<td>17</td>
<td>1</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Purfleet Care Centre</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St Clements Health Centre</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Purfleet</td>
<td>17</td>
<td>1</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

6.5.2. Emergency Admissions for AF and HF

Aveley Medical Centre had an Emergency admission rate for AF of 175 per 1,000 registered patients in 2014/15. Purfleet care centre and St Clements Health Centre had none (Source: analyses performed by the PH team, Data Source: SUS). This may be partially explained by the number of patients with a CHADs 2 score of more than one who are not receiving anti-coagulations.

Emergency admission rates for Heart Failure are lower than the Thurrock average (488 per 1,000 registered patients). St Clements Health Centre had the highest rate out of the three in 2014/15 (273 per 1,000) and the Purfleet care centre had the lowest (214 per 1,000). [Figure 53].

Figure 53: Emergency admissions for Heart Failure
6.5.3. Summary of HF and AF Care
There is some variation in clinical management of HF and AF between different GP practices in Purfleet, although absolute numbers of patients not receiving clinical interventions recommended by NIC, nor exception reported are relatively low. Review shows the total number of patients on each of the five clinical intervention metrics in the radar diagrams that are not receiving an appropriate clinical intervention and have not been exception reported.

6.6. Clinical Management of Stroke, Transient Ischaemic Attack (TIA)

In 2014/15 in Purfleet, 256 patients were recorded on GP registers with a stroke or TIA. Of those who are diagnosed the QOF tells us about the quality of their care and how well managed their condition is in general. Specifically for Stroke and TIA it looks at keeping blood pressure within a healthy range in order to reduce the risk of further strokes and other CVD events, and treatments with anti-platelets, anti-coagulants and aspirin, flu vaccination is also included.

Figure 54: QOF Indicators for Stroke and TIA care – Aveley Medical Centre

Stroke and TIA patients registered at the Aveley Medical Centre who are not exception reported appear to receive a reasonable level of clinical management. 75% of the patients on this register have their BP under the recommended levels, 80% are taking an anti-platelet or anti-coagulant, 83% of new patients are referred for further investigation (this indicator is based on only 10 patients, 4 of whom are exception reported), and 98% received flu vaccination. [Figure 54]
Stroke and TIA patients registered at the **Purfleet Care Centre** (n=27) seem to be receiving excellent levels of clinical management with almost all of them receiving all recommended clinical interventions. (Note that no patients are eligible for the referral for further investigation indicator).

Clinical management of stroke/TIA is generally good for patients (n=18) who are not exception recorded at **St Clements Health Centre**. With all patients who are not exception recorded receiving all recommended interventions and 75% of them have their BP under the recommended levels. However, there are 40-50%
exceptions reported on some of the indicators. There may be very good clinical reasons for this, however it may be worth further investigation to ensure that this small number of patients are in fact being managed appropriately. Table shows the absolute numbers of patients not exception reported and not receiving each of the four recommended clinical interventions for each practice in Purfleet. Practices should identify and review these patients in order to reduce their risk of further serious cardio-vascular events.

Table 12: Stroke TIA Patients not receiving recommended clinical interventions

<table>
<thead>
<tr>
<th>STIA patients in whom the last blood pressure reading (measured in the preceding 12 months) was greater than 150/90 mmHg</th>
<th>Non-haemorrhagic stroke patients and those with a history of TIA, with no record of an anti-platelet agent, or an anti-coagulant is being taken, nor exception reported</th>
<th>Patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have no record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA</th>
<th>STIA patients not immunised against flu nor exception reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aveley Medical Centre</td>
<td>55</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>Purfleet Care Centre</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St Clements Health Centre</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Purfleet</td>
<td>61</td>
<td>28</td>
<td>5</td>
</tr>
</tbody>
</table>

6.6.1. Stroke Hub

The stroke Hub is a post stroke rehabilitation service. The overall outcome of the service is to enhance a patient’s quality of life, improve their physical health and optimise their social and psychological well-being by ensuring comprehensive and timely rehabilitation and long term support is available and provided for individuals, who have experiences a stroke and their carers.

6.6.2. Avoidable Stroke admissions

Modelling work by one of the authors in 2013 (model for Essex, Southend and Thurrock) looked at the impacts of detection of Hypertension, CHD and AF on emergency admissions for Stroke. The model included improving detection rates and also what would happen if all GP practices improved care quality on 6 QOF indicators. The model output for each GP practice how many strokes would be saved, the cost to the NHS of those strokes and the cost to Social Care.

The assumptions are detailed in Appendices 2 and the outputs for Purfleet are detailed below.
Table 13: Stroke Avoidable Admissions in Purfleet

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions Annually</th>
<th>Avoided</th>
<th>NHS Saving (non-elective admission only)</th>
<th>Social Care Saving</th>
<th>Individual Saving (Self Funded SC proportion)</th>
<th>NET Saving</th>
<th>System saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>YR 1</td>
<td>18</td>
<td>4</td>
<td>£39,600</td>
<td>£25,814</td>
<td>£6,461</td>
<td>£71,875</td>
<td>£65,413</td>
</tr>
<tr>
<td>YR 2</td>
<td>18</td>
<td>4</td>
<td>£41,617</td>
<td>£71,012</td>
<td>£17,775</td>
<td>£130,404</td>
<td>£112,629</td>
</tr>
<tr>
<td>YR 3</td>
<td>18</td>
<td>4</td>
<td>£43,234</td>
<td>£111,602</td>
<td>£27,936</td>
<td>£182,772</td>
<td>£154,837</td>
</tr>
<tr>
<td>YR 4</td>
<td>18</td>
<td>4</td>
<td>£44,818</td>
<td>£148,033</td>
<td>£37,055</td>
<td>£229,906</td>
<td>£192,852</td>
</tr>
<tr>
<td>YR 5</td>
<td>18</td>
<td>4</td>
<td>£46,343</td>
<td>£180,871</td>
<td>£45,274</td>
<td>£272,489</td>
<td>£227,214</td>
</tr>
<tr>
<td>Total over</td>
<td>92</td>
<td>20</td>
<td>£215,612</td>
<td>£537,333</td>
<td>£134,501</td>
<td>£887,446</td>
<td>£752,945</td>
</tr>
</tbody>
</table>

So if all else remained the same, given the assumptions in appendix 2, by increasing the detection rates of CHD and hypertension to 95% over 5 years, and improving the six quality of care indicators up to the level of the worst performing practice in the top quintile nationally over 5 years. We could save 4 admissions due to stroke in Purfleet patients per year. Over a period of 5 years these admissions would have cost approximately £215K to the NHS.

Additionally the estimated social care cost of these strokes over 5 years would have been approximately £500K (split between SC and individual funding – figures provided based on Essex split and are not applicable to Thurrock).

To prevent these strokes the new health facility, therefore, needs to have the ability to diagnose and offer good quality of care to patients who are hypertensive, and/or suffer from other CVD conditions. Additional benefits would be a reduction in patients developing conditions such as Diabetes.

6.6.3. Stroke care summary
Clinical management of stroke in Purfleet is variable with patients registered at the Purfleet care centre receiving the best levels of care.

Clinical management in the Aveley Medical centre could be improved across the indicators and in St Clements Blood Pressure levels in patients could be improved and some work could be undertaken to investigate the appropriateness of exception reporting levels.

6.7. Clinical Management of Patients with Diabetes

972 people in Purfleet were on Diabetes Disease registers. Of those the QOF tells us about the quality of their care and how well managed their condition is in general. Specifically for Diabetes it looks at keeping HbA1c, blood pressure and cholesterol within a healthy range, as well as testing and treatment for albuminuria, foot examination and risk classification, dietary reviews, referrals to education programmes, flu coverage. These care indicators are used to monitor, manage and prevent some of the complications of Diabetes including: Diabetic Coma and Ketoacidosis, limb amputations, and blindness.
Figure 57: QOF Indicators for Diabetes Care – Aveley Medical Centre

![Radar Diagram for Aveley Medical Centre]

Figure 58: QOF Indicators for Diabetes Care – Purfleet Care Centre

![Radar Diagram for Purfleet Care Centre]

Source: QOF 2014/15

The radar Diagrams displaying clinical management of Diabetes in the Aveley Medical Centre (n=663) [
Figure 57] and the Purfleet Care Centre (n=187) [Figure 58] are quite similar in appearance. With most interventions having room for improvement. Aveley appears to have higher levels of exception reporting than Purfleet.

There are high numbers of people with Diabetes in these two practices who;

- do not have their BP, cholesterol, or HbA1c below recommended levels,
- diagnoses of nephropathy or micro-albinuria are not appropriately treated (or exception reported)
- do not have a record of a foot examination and risk classification
- Have not been referred to an education programme
- Have not had a flu vaccination (although a majority of these are exception reported)

Figure 59: QOF Indicators for Diabetes Care – St Clements Health Centre

Source: QOF 2014/15
6.7.1. Absolute numbers of patients not receiving diabetes clinical management interventions recommended by QOF

Table 14: Patients on QOF Diabetes registers not receiving clinical interventions

<table>
<thead>
<tr>
<th>Patients on the diabetes register, in whom the last IFCC-HbA1c was more than 59 mmol/mol in the preceding 12 months and had not been exception reported</th>
<th>Patients with diabetes, on the register, whose last measured total cholesterol (measured in the preceding 12 months) was more than 150/90 mmHg and had not been exception reported</th>
<th>Patients on the diabetes register without a record of a foot examination in the previous 12 months that included a risk classification, nor exception reported</th>
<th>Newly diagnosed patients with diabetes not referred to a structured diabetes education programme nor exception reported</th>
<th>Patients on the diabetes register not immunised against flu nor exception reported</th>
<th>Patients on the diabetes register, with a diagnosis of nephropathy (clinical proteinuria) or microalbuminuria who are not currently treated with an ACE-I (or ARBs) nor exception reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aveley Medical Centre</td>
<td>155</td>
<td>164</td>
<td>221</td>
<td>19</td>
<td>618</td>
</tr>
<tr>
<td>Purfleet Care Centre</td>
<td>73</td>
<td>62</td>
<td>55</td>
<td>50</td>
<td>180</td>
</tr>
<tr>
<td>St Clements Health Centre</td>
<td>50</td>
<td>18</td>
<td>19</td>
<td>0</td>
<td>115</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>278</strong></td>
<td><strong>244</strong></td>
<td><strong>295</strong></td>
<td><strong>69</strong></td>
<td><strong>913</strong></td>
</tr>
</tbody>
</table>

Table 14 shows the absolute numbers of patients on each GP practice’s diabetes QOF register who did not receive a successful clinical intervention to control their diabetes as recommended by QOF. In total the three GP practices failed to achieve the 2630 clinical interventions/management required.

6.7.2. Emergency admissions For Diabetes

Rates of Emergency admissions for Diabetes in the three Purfleet practices are higher than the Thurrock Average (123 per 1,000 registered patients, Shown as a red line). Rates in the Aveley Medical Centre are of particular concern (408 per 1,000) (Figure 60). This could in part be explained by the fact that in total the three GP practices failed to achieve the 2630 clinical interventions/management required on QOF. A large proportion of these were attributable to Aveley Medical Centre

Table 14).

Figure 60: Emergency Admissions for Diabetes
6.7.3. Community Diabetes Team

NHS North East London Community Foundation Trust (NELFT) is commissioned by NHS Thurrock CCG to provide a Community Diabetes Service. This is a multi-disciplinary team offering support to patients with diabetes, with the intention of increasing the quality of life and delivering cash releasing savings through reduction in avoidable secondary care activity for diabetes. The service specification states that they should contribute to improving the performance on the following biometrics:

- HbA1C outcomes in line with QOF
- Cholesterol below 5m/mol

6.7.4. Summary of Diabetes care

Prevalence of diabetes in Purfleet practices is high; ranging from 4.5% to 7.2% of each of the three GP practice’s over-all lists of patients aged 17+.

However, management of Diabetes is variable between and within Purfleet practices. When exceptions are excluded, clinical management in Aveley and St Clements appears to be fair, however when exceptions are included levels are not dissimilar to those of the Purfleet Medical Centre. The clinical management of diabetes could be improved across all areas, in total the three GP practices failed to achieve 2630 clinical interventions/management required. 819 of these were for not treating those with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria not treated with an ACE-I (or ARBs). This may be having a negative impact on levels of emergency admissions for Diabetes.

A new health facility needs to ensure that patients with diabetes are appropriately diagnosed and managed. There is a strong evidence base in terms of patient education programmes for diabetes and these should be available at the new Integrated Healthy Living Centre as part of any diabetes community management offer.
6.8. Care of patients with Respiratory Disease

In 2014/15 around 379 people in Purfleet had a diagnosis of COPD (we don’t estimate there to be a large amount who are not diagnosed), and 1156 are diagnosed with Asthma.

The QOF tells us about the quality of their care and how well managed their condition is in general. Specifically for respiratory disease it looks at COPD patients having flu vaccination, FEV1 recorded, assessment using MRC dyspnoea score and its results, and confirmation of the diagnosis using spirometry test. For Asthma it looks at measures of variability /reversibility, review, and smoking records. These care indicators are used to monitor, manage and prevent some exacerbations of the conditions which can result in unplanned care activity.

Figure 61: QOF Indicators for Respiratory Disease – Aveley Medical Centre

Source: QOF 2014/15

Figure 62: QOF Indicators for Respiratory Disease – Purfleet Care Centre
When exceptions are excluded the clinical management of COPD and Asthma across Purfleet practices is good (Although with room for improvement). Exceptions include:

**Asthma reviews** in the Purfleet Medical Centre; only 46% of Asthma patients received one of these.

Exception reporting rates are having a large impact on the outcomes across many of the indicators in the Aveley Medical Centre and on two of the COPD indicators at the St Clements Care Centre. Specifically confirmation of a diagnosis using spirometry and having a flu vaccination.

### 6.8.1. Absolute numbers of patients not receiving COPD and Asthma clinical management interventions recommended by QOF

Table 15 shows the absolute numbers of patients on the COPD and Asthma QOF disease registers in the three Purfleet practices who did not receive the clinical management interventions recommended by QOF.

In 2014/15, the three GP practices failed to undertake a total of 327 clinical management interventions with patients on their COPD and asthma disease registers.

Table 15: Absolute numbers of patients on COPD and Asthma QOF registers who did not receive clinical management interventions
6.8.2. Emergency Admissions for COPD

The three Purfleet practices all have higher emergency admissions rates for COPD than Thurrock as a whole (108 per 1,000 registered patients). Of particular concern is the rate in St Clements Health Centre. These high rates could be partially explained by the reduced quality of clinical management of COPD.
6.8.3. The NELFT COPD team

The NELFT COPD team is a pro-active service which provided pulmonary rehab, stop smoking services, and other services to pro-actively manage COPD patients with an MRC score of 3 or more with the aims of avoiding unplanned activity in secondary care, and when admissions do occur facilitate fast discharge back into a community setting.

The south west Essex respiratory review led by one of the authors demonstrated a negative association between referrals into this service and unplanned care admission rates for COPD suggesting that practices who referred a greater proportion of patients with COPD with an MRC score of 3 or more were likely to have lower levels of unplanned care admissions. The referral rate of COPD patients into the community respiratory team explained 29% of the variation in unplanned care admission rates for COPD between practice populations, suggesting that the team is effective at managing patients with serious COPD and reducing the likelihood of an avoidable admission to hospital.

6.8.4. Summary of respiratory care

Care of respiratory conditions (when exceptions are excluded) is fair with a few exceptions. In some cases exception reporting is having a large impact on figures and a review of this is recommended.

If these conditions are not well managed they can result in repeated secondary care activity. Therefore we would recommend that the new health facility ensure that Asthma and COPD patients are getting reviewed regularly and are being managed in line with the QOF recommendations.
7. Mental Health

7.1. Prevalence of mental ill-health

The prevalence of mental ill-health in the community can be assessed in part through demand from a given population for mental health treatment. QOF requires GP practices to place patients on registers for depression or more serious mental ill-health such as schizophrenia, bi-polar disorder or other psychoses.

7.1.1. Recorded Prevalence of Depression

Depression prevalence can be assessed by reviewing the GP QOF register data. Data from 2014/15 indicates that all seven of the South Ockendon Locality practices have a lower recorded prevalence of depression than the Thurrock average (6.65%), with Aveley Medical Centre having the highest prevalence (6.10%) and Sancta Maria Medical Centre having the lowest (2.39%).

There is also a measure to reflect new diagnoses of depression each year. For 2014/15, six out of the seven GP practices were below the Thurrock average (1.14%) with Belhus Medical Practice slightly over with 1.27%. Both of these indicators can be seen on the figure below.

Figure 65: Depression Prevalence for the South Ockendon Locality practices, 2014/15

Source: QOF 2014/15

Given levels of deprivation in the area, one would expect the actual prevalence in the area to be higher than the Thurrock average. That recorded levels are actually lower suggests that not all people suffering from depression are being identified. Non-identification could be due to a number of factors including:

1) Patients not presenting (typical of disadvantaged areas)
2) Under-doctoring / lack of appointments for patients who may not feel it is worth continuing to try to get an appointment due to their depression.
3) Lack of training or awareness for health professionals to be able to identify symptoms and diagnose.
4) Missed opportunities to diagnose – when patients may present with other long term conditions (see section 8.4).

7.1.2. Recorded Prevalence of Schizophrenia, Bipolar Affective Disorder and other Psychoses

Data from 2014/15 indicates that three of the seven South Ockendon Locality GP practices have prevalence above the Thurrock average (0.75%), with Belhus Medical Practice having the highest prevalence of 0.91% and Sancta Maria Medical Centre having the lowest at 0.55%.

Figure 66: Prevalence of Schizophrenia, Bi-polar disorder and other psychoses for South Ockendon Locality Practices, 2014/15

Source: QOF 2014/15

7.2. Use of Current Services

7.2.1. Children and Young People
Mental health services for children and young people are provided by North East London Foundation Trust (NELFT) across Essex, Southend and Thurrock. NELFT commenced their contract in November 2015 and their service aims to focus on early intervention to prevent, reduce or delay more specialist interventions later on.
7.2.2. Adults

NHS Thurrock CCG has recently commissioned South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) to provide a new service called *Inclusion in Thurrock* which will provide a range of therapies through the national Improved Access to Psychological Therapies (IAPT) programme and an innovative Recovery and Wellbeing College where patients can learn the skills to rebuild their lives following a period of mental ill-health. Many of the people teaching recovery techniques at this college will themselves have gone through a bout of mental ill health, thus giving practical and proven tips to aid recovery from personal experience. Patients can be referred by their GP or can self-refer.

Whilst the current provider is new, IAPT has been in place in Thurrock for a while. The chart below shows the estimated percentage of patients diagnosed with depression who were referred to IAPT in 2014/15 (South Ockendon Locality GPs highlighted in red).

We would hope to see less variation in referral levels across Thurrock than is apparent here. Two of the practices in the area of interest for this report have referral rates of between 30 and 40%, compared to others that have levels between 50% and 65%.

**Figure 67: Proportion of patients on QOF Depression register referred to IAPT, 2014/15**

![Diagram showing referral rates to IAPT](source: QOF and Thurrock CCG)
7.2.3. Patient Views

In 2015, the CQC conducted patient experience surveys across all mental health trusts in England. They asked people to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question (the higher the score the better). Each trust also received a rating of ‘About the same’, ‘Better’ or ‘Worse’ which compared their performance against other trusts. The table below shows that SEPT patients considered these aspects of their mental health care to be comparable with patients in other trusts in England.

**Table 16: Findings from CQC Patient Survey for SEPT, 2015**

<table>
<thead>
<tr>
<th>Category</th>
<th>Patient Response</th>
<th>Compared with other Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Social Care workers</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Organising Care</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Planning Care</td>
<td>6.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Reviewing Care</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Changes in who people see</td>
<td>5.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Crisis Care</td>
<td>6.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Treatments</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Other areas of life</td>
<td>5.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall views and experiences</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td>Overall experience</td>
<td>7.0</td>
<td>About the same</td>
</tr>
</tbody>
</table>

Source: CQC

7.3. Clinical Management of Patients with Mental Ill-Health in Primary Care

Figures 68–70 show the clinical management of patients with mental ill-health and dementia in the three practices which make up the Purfleet Primary Care population.

**Mental Health** – The quality of clinical management of Mental Health patients in the Aveley Medical centre and St Clements Care centre is generally in line with QOF recommendations. (Only 4 patients on lithium therapy in Aveley so no conclusions drawn).

At the Purfleet care centre only 26% of mental health patients have a comprehensive care plan. (Only 1 patient recorded as being on lithium therapy so no conclusions regarding this).

**Depression** – there is only one depression indicator currently on QOF, this is “New diagnoses being reviewed between 10 and 56 days”. It is important that patients are reviewed to ensure that any medication prescribed is being complied with, and is helping but also to ensure that patients have followed up on any referrals to IAPT or other services. The fact that exception reporting on this is high across the three primary care locations is concerning. It is recommended that a further piece of work is undertaken to understand the reasons why exception reporting is so high.
Dementia – management of Dementia needs to be improved across the board in the Purfleet area, it is particularly concerning for Dementia patients registered with St Clements health centre.

**Figure 68:** Clinical Management for mental health, depression and dementia care, Aveley Medical Centre

**Figure 69:** Clinical Management for mental health, depression and dementia care, Purfleet Care Centre

Source: QOF 2014-15
7.4. Mental Ill-health and Co-Morbidities

A report by the King’s Fund (2014) identified that at least 23.5% of the total population in England are currently living with a Long-Term Condition (LTC). This high prevalence has increased the resource burden in both primary care and secondary care - 50% of all GP appointments, 64% of all outpatient appointments and over 70% of inpatient bed stays have been attributed to LTCs (King’s Fund 2014). In 2008 the King’s Fund estimated that 3.1% of people in England had multi-morbidity (three or more LTCs). Individuals with an LTC are more than twice as likely to suffer from depression as the rest of the population, (National Institute for Health and Clinical Excellence (NICE) 2011). They estimate that 20% of the population in people with an LTC also suffer from depression.

Applying the above national prevalence estimates for multi-morbidities and comorbidity of one LTC + depression indicates there could be 641 people registered within Purfleet/Surrounding Areas GPs with three or more LTCs and 973 people with one LTC + depression. However the true number of cases is likely to be higher than these modelled estimates.
Figure 71: Modelled estimate of patients with 3 or more LTCs – South Ockendon Locality GPs

![Bar chart showing estimated number of people with multimorbidity (three or more LTCs) for different medical centers.](image)

Source: Kings Fund 2008 and QOF 2013-14

Figure 72: Modelled estimate of patients with a LTC and depression – South Ockendon Locality GPs

![Bar chart showing estimated number of people with long term conditions and depression for different medical centers.](image)

Source: NICE 2011 and QOF 2013-14
The Kings Fund research clearly demonstrated that patients with a long term condition and comorbid depression were much more likely to have a greater level of mortality and morbidity and to cost the health and social care system significantly more. It is therefore imperative that this cohort of patients is identified and treated for their depression.

Given that there are only 285 patients diagnosed with depression in Pear tree surgery, 222 in the Purfleet care centre and 219 in the St Clements Health Centre it is apparent that not only are levels of depression generally being non-diagnosed but levels as a co-morbidity are also not being well identified.

7.5. Mental Health and Wellbeing Summary

Throughout this section we saw some recurring themes:

- Depression in the Purfleet practices is not well identified and diagnosed.
- Quality of Care for patients diagnosed with mental ill-health conditions is variable both between and within practices in Purfleet, with too many patients diagnosed with depression, dementia and serious mental ill health not receiving all of the interventions necessary to keep them well.
- Of particular concern are that at the Purfleet care centre only 26% of Mental health patients have a comprehensive care plan, exception reporting for reviewing patients with depression (is this indicative of non-follow up or DNA’s?), and the management of Dementia patients in the St Clements Health Centre.

Conditions that appear to be being managed less well than others include Respiratory conditions, Diabetes and Mental Health, Depression and Dementia. However there is still plenty of room for improvement on all areas.

Evidence shows that offering good quality care does reduce activity in a secondary care setting as well as quality of life for individuals.
PART 1B: WHAT DO WE CURRENTLY HAVE?

8. General Practice

8.1.1. Facilities and Services

The locality area of South Ockendon currently has six GP centres situated in four administrative wards. Two of these also have branch practices (Aveley Medical Centre and Pear Tree Surgery). The map below depicts the locations of these GP premises, plus the St Clements Health Centre which although outside of the locality boundary has a lot of patients registered with it that reside in the Locality area. It can be seen from the map below that the three closest GP practices to the proposed regeneration site are the three referred to in this report as the Purfleet Primary Care Registered population.

Figure 73: South Ockendon Locality GP Practices

Source: Thurrock Council
The table below shows further information on the locality GP Practices.

**Table 17: Information on the South Ockendon Locality GP practices**

<table>
<thead>
<tr>
<th>Practice Code</th>
<th>Premises</th>
<th>Net Internal Area (NIA) M²</th>
<th>Ownership</th>
<th>Rent Type</th>
<th>Hours currently operating including extended hours</th>
<th>No. of rooms/type</th>
</tr>
</thead>
<tbody>
<tr>
<td>F81010</td>
<td>Aveley Medical Centre, 22 High Street, Aveley, RM15 4AD</td>
<td>383</td>
<td>Owned by the Dr</td>
<td>Notional</td>
<td>58.15</td>
<td>3 x consulting rooms, 1 x office, 1 x waiting room</td>
</tr>
<tr>
<td>F81010 (branch)</td>
<td>Bluebell Surgery, South Ockendon Health Centre, Darenth Lane, South Ockendon, RM15 5LP</td>
<td>87</td>
<td>NHS Property Services</td>
<td>40</td>
<td>40</td>
<td>4 x consultation rooms, 1 x office, 1 x reception/dispensary, 1 x waiting room, 3 x toilets</td>
</tr>
<tr>
<td>F81010 Total</td>
<td></td>
<td>470</td>
<td></td>
<td>98.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F81134</td>
<td>Pear Tree Surgery, 4 West Road, South Ockendon, RM15 6PR</td>
<td>349</td>
<td>Owned by the Dr</td>
<td>Notional</td>
<td>56</td>
<td>1 x waiting room, 1 x reception/consultation, 1 x waiting room, 3 x toilets</td>
</tr>
<tr>
<td>F81134 (branch – not depicted on above map)</td>
<td>129 Station Road, West Horndon, CM13 3NB</td>
<td>94</td>
<td>Owned by the Dr</td>
<td>Fixed Cost</td>
<td>22</td>
<td>1 x waiting room, 1 x reception area, 1 x nurses room, 1 x consultation room, 1 x dispansory, 1 x computer room, 1 x office, 2 x toilets</td>
</tr>
<tr>
<td>F81134 Total</td>
<td></td>
<td>443</td>
<td></td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F81197</td>
<td>Dr Bellworthy SV Practice, Sancta Maria Medical Centre, Daiglen Drive, South Ockendon, RM15 5SZ</td>
<td>258</td>
<td>Owned by the Dr</td>
<td>Fixed Cost</td>
<td>53.75</td>
<td>1 x waiting room, 1 x reception, 4 x examination rooms, 1 x waiting room, 3 x consultation rooms, 2 x treatment rooms, 2 x storage rooms, 1 x staff room, 1 x kitchen, 1 x shower room</td>
</tr>
<tr>
<td>F81632</td>
<td>The Health Centre, Darenth Lane, South Ockendon, RM15 5LP</td>
<td>217</td>
<td>NHS Property Services</td>
<td></td>
<td>54.15</td>
<td></td>
</tr>
<tr>
<td>F81669</td>
<td>Belhus Medical Practice, Derry Court, Derry Avenue, South Ockendon, RM15 5LN</td>
<td>375.2</td>
<td>Other</td>
<td>Actual</td>
<td>54.75</td>
<td>1 x waiting room, 1 x reception, 1 x record room, 1 x minor surgery room, 1 x staff room, 3 x storage rooms, 1 x conference room, 1 x nurses room, 5 x consultation rooms</td>
</tr>
<tr>
<td>Y00033</td>
<td>Purfleet Care Centre, Tank Hill Road, Purfleet, RM19 1SX</td>
<td>265</td>
<td>NHS Property Services</td>
<td></td>
<td>55.15</td>
<td></td>
</tr>
<tr>
<td>Y00999</td>
<td>St Clements Health Centre, London Road, West Thurrock, RM20 4AR</td>
<td>346</td>
<td>NHS Property Services</td>
<td></td>
<td>54.15</td>
<td></td>
</tr>
</tbody>
</table>

*Source: NHS England*
8.1.2. Workforce

GPs

The figure below shows each GP practice list size per FTE GP in Thurrock and England for 2014/15 (South Ockendon Locality practices are highlighted in red).

Figure 74: GP Practice list size: FTE GP, 2014/15

The average number of patients cared for by a FTE GP in England is 1391. Thurrock is significantly ‘under doctored’ with the average number of patients per FTE being 2,032 in 2014/15. All but four GP practices have list sizes per FTE GP that are greater than England’s. In parts of the South Ockendon Locality, the ratio is even worse – Dr Yasin has 3,563 patients per FTE GP and St Clements Health Centre has 3,561 patients per FTE GP.

The table below estimates the numbers of GPs required both in the Purfleet Primary Care area and the wider South Ockendon Locality to meet the current patient ratios for Thurrock, England and the ratio recommended in the previous Tilbury Integrated Healthy Living Centre Needs Assessment. This estimates that the Purfleet Primary Care population would need to recruit another 1.41FTE GPs to meet the Thurrock average or another 6.27FTE GPs to meet the England average – and this is irrespective of health needs or future population increases. Across the South Ockendon Locality, there is a bigger gap – another 3.46FTE GPs are needed to meet the Thurrock average or another 12.50FTE GPs to meet the England average.

Source: HSCIC
## Table 18: Number of FTE GPs required to meet various patient ratios

<table>
<thead>
<tr>
<th>Population Size</th>
<th>Current number of FTE GPs</th>
<th>FTE GPs required for Thurrock average (2,032 pts per GP)</th>
<th>FTE GPs required for England average (1,391 pts per GP)</th>
<th>FTE GPs required for Tilbury-recommended ratio (1,300 pts per GP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purfleet Primary Care Population</td>
<td>21,436</td>
<td>9.14</td>
<td>10.55</td>
<td>15.41</td>
</tr>
<tr>
<td>South Ockendon Locality Population</td>
<td>39,836</td>
<td>16.14</td>
<td>19.6</td>
<td>28.64</td>
</tr>
</tbody>
</table>

Source: HSCIC

When looking at patient: GP ratios elsewhere in the country, the highest ratio for any CCG is 2,163 (NHS Swale). Thurrock as a whole was the 4th worst in the country (others below were Luton, Bexley and Swale). [Source: HSCIC]

The figure below shows the association between GP practice population deprivation and ratio of patients: FTE GP in Thurrock (South Ockendon Locality practices highlighted in red).
Figure 75 clearly demonstrates a positive association between practice population deprivation and the ratio of patients: FTE GP. As practice population deprivation is an extremely good proxy measure for overall health need, this suggests that the inverse care law referred to in the Foreword of this document is a potential problem in Thurrock, as practice populations with greater levels of ill-health are more likely to be registered to practices with more patients per FTE GP. Practice deprivation can be used to explain almost 30% of the difference in size of ratio between the practice list size and the number of FTE GPs employed. A practice with fewer GPs for a given number of patients is in turn likely to be able to offer fewer appointments and have less capacity to undertake proactive long term condition management to help keep patients well. Whilst association does not prove causality, the figure above suggests under-doctoring could have an impact on driving health inequalities within Thurrock and demonstrates the need to increase the number of GPs both to the Borough as a whole but also to a greater extent, in our more deprived areas.

**Practice Nurses**

GP practice nurses are a key part of the GP practice clinical workforce and deliver a number of essential clinical interventions to patients including wellbeing programmes such as smoking cessation, cervical screening, immunisations and long term condition management such as diabetes clinics or management of patients with high blood pressure.
The recommended ratio of patients to FTE practice nurse in England is a maximum of 4000:1 although the England average ratio is actually smaller than this at 3729:1.

The figure below shows the ratio of patients: FTE Practice Nurse for the seven South Ockendon Locality areas, together with the England mean ratio.

Figure 76: Ratio of Patients: FTE Practice Nurse 2014/15

Three of the seven practices, Aveley Medical Centre, Sancta Maria Medical Centre and Purfleet Care Centre, are recorded as having no practice nurses in 2014/15 according to the Workforce Census. The ratios of patients: FTE practice nurses in three of the four other practices are all greater than England’s. This is undoubtedly constraining local practices to offer good quality care to patients.

In 2014/15 South Ockendon Locality practices had 3.64FTE Practice nurses to serve 39,836 patients. In order to increase capacity to the recommended ratio of 4000 patients per FTE nurse, the South Ockendon Locality practices would require 9.96FTE nurses, meaning there currently appears to be a deficit of 6.32FTE nurses.

8.2. Pharmacies

The South Ockendon Locality area contains 12 pharmacies which includes one online pharmacy. Five of these are within the ward of West Thurrock and South Stifford, five in Ockendon, and two in Aveley and Uplands. When compared to Thurrock as a whole, Ockendon and West Thurrock and South Stifford wards have a higher density of pharmacies per population size than Thurrock or England (Ockendon has 41.3 pharmacies per 100,000 and West Thurrock and South Stifford has 47.7 pharmacies per 100,000, compared to Thurrock’s average of 23 per 100,000 and England’s average of 22 per 100,000). The density of
Pharmacies in the South Ockendon Locality area is also therefore greater than the Thurrock average (31 per 100,000) despite Belhus having no pharmacies in its ward area.

**Figure 77: Pharmacies per 100,000 population in South Ockendon Locality, 2014**

Pharmacies in South Ockendon Locality provide a range of services to patients, including:

- Diabetes screening
- Respiratory and Lung Check service
- Minor Ailments
- Substance misuse
- Needle Exchange
- Waste Management
- Weight Management
- Social Prescribing
- Gluten Free Products supply and management
- Incontinence products
- Travel Vaccinations
- Well man clinics

They also have the potential to provide services such as NHS Health Checks, Medicines Use Reviews, New Medicines Service and Seasonal Immunisation where commissioned.
8.3. Dentists

8.3.1. Current Service

There are six dentists in the South Ockendon Locality area – two within the ward of West Thurrock and South Stifford, two in South Ockendon and one each in Aveley and Uplands and Belhus.

8.3.2. Use of Current Service

Data is collected by the NHS Business Services Authority on usage of dental services by children aged 3-5 years by ward of residence (not by location of dentist). High usage of band 1 urgent or band 2 treatments may indicate worse oral health in certain areas. In general, there is a lower proportion of patients aged 3-5 years in the South Ockendon Locality wards attending dentists for band 1 urgent treatment than the Thurrock average of 4.6% - Belhus has the highest proportion (4.8%) and Ockendon the lowest (3.8%). There is a little more variation when considering attendances for band 2 treatment (e.g. a filling) – West Thurrock & South Stifford and Aveley & Uplands have visibly higher proportions of children attending than the Thurrock average (18.3% and 17.4% compared to 16.4%). This can be seen in the two figures below.

Figure 78: Patients aged 3-5 years attending dentists for Band 1 Urgent Treatment, 2014-15

Source: NHS Business Services Authority
Figure 79: Patients aged 3-5 years attending dentists for Band 2 Treatment, 2014-15

Source: NHS Business Services Authority

8.4. Opticians
The largest concentration of opticians in the Locality area is within Lakeside Shopping Centre – there are five opticians within the premises:

- Two Boots Opticians
- Vision Express
- Optical Express
- Specsavers

Also within the ward of West Thurrock & South Stifford there is an optician within the Tesco on the Lakeside Retail Park.

South Ockendon has one optician called Earnshaw and Dallow.

8.5. 0-5 services
Residents of Purfleet and the South Ockendon Locality can access breastfeeding support services run by NELFT at South Ockendon Health Centre which are run weekly besides home visits.

Purfleet has one children's centre – Purfleet Children's Centre which is run by 4children. The nearest alternative children's centres are in Aveley and Ockendon. All 3 centres have very similar target groups:

- Children living in workless or low income households
- Children in lone parent families
- Children eligible for the 2 year old entitlement
- BME families (Purfleet)
- Those living in the most deprived LSOAs
- Children who are subject of a CP plan or who are Children in Need (primarily Aveley and Ockendon)
- Those with poor mental health (Purfleet)

The three main priorities for Purfleet Children’s Centre are:

1) **Economic Stability & Raising Aspirations**
   - Increase number of families accessing Self-esteem, Family Learning or Adult Learning Courses in order to support the adults back to work.

2) **Good Level of Development – Supporting Speech & Language & 2 year olds**
   - To support children as identified as needing 2yr funded places to access Early Years support from the Centre.
   - Identifying children with Speech and Language needs to access more effective support.

3) **Healthy Lifestyles – Obesity**
   - To support families in the reach area to access more effective sessions around Healthy Lifestyles in order to contribute to the reduction of obesity rates.

The latest timetable showing the range of groups and services offered at Purfleet Children’s Centre is in appendix 4.

### 8.6. Primary Care ‘Out of Hours’ service

#### 8.6.1. Current Service Provision

Out of hours care is offered by IC24. It can be accessed between the hours of 6.30-8am Monday-Friday, and 24 hours over the weekend. Patients can either ring NHS 111 or visit the premises at Thurrock Community Hospital. Depending on need, patients will either receive a telephone call from a clinician, be invited to visit the premises for an appointment, or receive a home visit.

#### 8.6.2. Use of Current Service

Data from the GP Patient Survey indicates that the Sancta Maria Medical Centre had the highest proportion of patients in the South Ockendon Locality who knew how to contact out of hours services in 2014-15 (74%). The Purfleet Care Centre had the lowest proportion of patients who knew how to contact out of hours services, with only 32% of survey respondents answering yes to this question. This is significantly worse than the Thurrock and England averages (60% and 56% respectively).
St Clements Health Centre had the highest number of patients contacting OOH services with a rate of 157.70 per 1,000. Sancta Maria Medical Centre had the lowest number of patients contacting the OOH services with a rate of 10.51 per 1000 patients, even though this practice had the highest proportion aware of how to contact the service (Figure 81). The average across Thurrock was 76.35 per 1000 patients. There appears to be no relationship between Out of Hours use and inappropriate out of hours A&E use. (See section 10.3 for definition)
Figure 81: Contact rate with OOH service 2014-15

Source: NEL Commissioning Support Unit
9. Secondary Care

9.1. Current Service Provision

Purfleet Residents can currently access three locations for secondary care services:

1) Basildon and Thurrock University Hospital

BTUH hosts the nearest A&E provision as well as a range of other clinics and services. An analysis of catchment areas (ERPHO) showed that this is the hospital most commonly used for A&E by Thurrock residents.

2) Orsett Hospital

Orsett Hospital is open during weekday hours and offers non-acute services for all Thurrock residents including:

- Epilepsy nursing
- Speech and language therapy – adult’s services
- Musculoskeletal physiotherapy

There is a minor injuries unit onsite open 7 days a week which is nurse-led.

3) Thurrock Community Hospital

Thurrock Community Hospital is located in Grays and offers a range of non-acute services accessible by all Thurrock residents, including:

- Continence clinic
- Drop-in phlebotomy service
- Falls clinic
- Paediatric physiotherapy
- Specialist community children’s services
- Speech and Language therapy – children’s service
- Wheelchair service
- Musculoskeletal physiotherapy

9.2. Outpatient Clinics

In 2014/15 there were 20,345 outpatient attendances by Purfleet patients. When considering where these patients were registered, it is roughly in proportion with the registered population at each GP practice. Aveley Medical Centre is slightly over-represented and Purfleet care centre slightly under. However Aveley Medical Centre do have a more elderly population. [Figure 82]
Figure 82: Proportion of Outpatient attendances and population for Purfleet practices

Source: SUS

Figure 83 shows the distribution by age group – it can be seen that usage is fairly high in the 30 – 34 and 65 - 69 year olds. This reflects what we know about the demographics of the three practices.

However the pattern is different for the three different GP practices. In the Aveley medical centre it is the 65 – 69 year olds who are using outpatients more frequently whereas in Purfleet care centre and St Clements Medical centre it is the 30 – 34 year olds.

Figure 83: Patients accessing Outpatients Services by age

Source: SUS
When considering the speciality codes for outpatient attendances, the most common were for trauma and orthopaedics (2556) and ophthalmology (1769). Gynaecology, general surgery and paediatrics were also frequently used. [Figure 84]

Figure 84: Top 15 specialties for Outpatient attendances

For those attendances with a procedure recorded, the most common procedures performed in outpatient services for Purfleet patients can be seen below – the most common is a diagnostic blood test (459 attendances). 296 (65%) of these were coded as routine blood tests. [Figure 85]

Source: SUS
Additionally the majority plain x-rays (44/47) were routine and there was a reasonable number of routine Ultrasound Scan NEC (45) Transvaginal ultrasound (38) and routine injections of therapeutic substances into joints (27). Figure 86 shows the percentage of these that were classified as routine.

**Source:** SUS

**Figure 86:** Top 10 procedures performed in Outpatients
9.2.1. Potential for treatment in Primary Care
Of the 20,345 Outpatient attendances, 14,310 (70%) of these were recorded with a priority code of Routine. When considering the main procedures undertaken during these appointments, it is envisaged that many could be addressed in primary care with the correct resources. This is particularly true for diagnostic tests, which make up the largest volume of procedures for Routine attendances.

9.3. A & E Attendance
Out of the seven GP practices of Purfleet and the Surrounding area, Belhus Medical practice had the highest rate of attendance at A&E, with a rate of 407 per 1,000 patients. Purfleet Care Centre had the lowest rate of attendance with 150 per 1,000 patients. The mean for Thurrock was 357 per 1,000 patients. [Figure 87]

Previous research by one of the report authors found that there are three main factors associated with likelihood of high A&E attendance: deprivation, proximity to A&E service, and dissatisfaction with their local GP. This analysis has not been carried out here, but there may be merit in exploring this further to see if this variation in A&E attendances across the locality of South Ockendon can be explained by any of the above factors.

Figure 87: A&E Attendance rate

The average cost per A&E attendance in Thurrock was £99.12 in 2014/15. Of the seven GP practices of Purfleet and the Surrounding area, five had lower costs per attendance in comparison to the Thurrock average, and two had slightly higher costs (Aveley Medical Centre and Belhus Medical Practice). [Figure 88]

This could be influenced by the variation in the primary care offer received by patients; thus resulting in some patients attending A&E requiring costly treatments/investigations, however this can be seen in more detail within Section 10.3.1 (A&E Attendees that could have been treated elsewhere) It should be noted that
the 2014/15 national reference cost per A&E attendance in England was £132 – indicating that the average costs in South Ockendon Locality and Thurrock were lower than elsewhere in the country.¹

Figure 88: Average cost per A&E attendance

![Graph showing average cost per A&E attendance for different locations in 2014/15.]

Source: Mede Analytics

Figure 89 states that patients from Purfleet and the Surrounding area fall below the Thurrock average of patients admitted to hospital, following their attendance to A&E. This graph shows that compared to the Thurrock average of 17% of patients admitted to hospital, St Clements Health Centre had the highest of admittance with 14% and the lowest is Purfleet Care Centre with 2%.

9.3.1. A&E attendances that could have been treated elsewhere

Attending A&E for clinical conditions that could have been treated in a more local clinical setting are both inconvenient for patients and put additional and unsustainable pressure and cost on the Thurrock health economy. When attending A&E, the clinical complexity (and cost) of a patient’s investigation and treatment is coded into one of 10 categories. Coding for investigation and treatment runs from 0 (no significant investigation/treatment) to 5 (the most clinically serious/complex investigation and treatment). As such HRG coding is a good method of ascertaining the severity of clinical case mix patients attending A&E.

Of 14,080 A&E attendances from Purfleet/Surrounding Area practices in 2014/15, 11,760) were classified as (for the purpose of payment):

- Emergency Medicine, No Investigation with No Significant Treatment
- Emergency Medicine, category 1 Investigation with category 1-2 Treatment
- Emergency Medicine, category 2 Investigation with category 1 Treatment

Source: Mede Analytics
Category one and two investigations include:

<table>
<thead>
<tr>
<th>Category 1 Investigations</th>
<th>Category 2 Investigations that required Category 1 treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial/capillary blood gas</td>
<td>Arterial/capillary blood gas</td>
</tr>
<tr>
<td>Biochemistry</td>
<td>Bacteriology</td>
</tr>
<tr>
<td>Dental investigation</td>
<td>Biochemistry</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>Blood culture</td>
</tr>
<tr>
<td>None</td>
<td>Cardiac enzymes</td>
</tr>
<tr>
<td>Other</td>
<td>Clotting studies</td>
</tr>
<tr>
<td>Pregnancy test</td>
<td>Cross match blood/group and save serum for later cross match</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td></td>
<td>Haematology</td>
</tr>
<tr>
<td></td>
<td>Histology</td>
</tr>
<tr>
<td></td>
<td>Immunology</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Pregnancy test</td>
</tr>
<tr>
<td></td>
<td>Refraction, orthotic tests and computerised visual fields</td>
</tr>
<tr>
<td></td>
<td>Serology</td>
</tr>
<tr>
<td></td>
<td>Toxicology</td>
</tr>
<tr>
<td></td>
<td>Urinalysis</td>
</tr>
<tr>
<td></td>
<td>X-ray plain film</td>
</tr>
</tbody>
</table>

Figure 90 shows the breakdown of HRG investigation and treatment coding and whether the patient
arrived at A&E within Normal or Out of Hours, for Purfleet/Surrounding Area patients in 2014/15. It shows that the vast majority of patients from Purfleet/Surrounding Area attended A&E for investigations or treatments that were coded in the least clinically serious HRG categories.

Figure 90: Number of A&E attendances by Time of Day and HRG Investigation

![Number of A&E attendances by Time of Day and HRG Investigation and Treatment categories - 2014/15](image)

Source: MEDE

There are similar numbers of attendances for most investigations and treatment categories during the day and night with the exception of those requiring no-significant investigation or treatment. This indicates that most people with these ailments would rather attend A&E / Primary care facility in the daytime (where primary care/Minor Injuries should be an option if the access to these facilities was possible). It is however worth noting that there are almost equivalent numbers in the other two categories of interest in the daytime and night time hours.

This chart also indicates that large numbers of people who are attending A&E for conditions that are neither an accident nor an emergency (–coded as No Investigation with No Significant Treatment) The cost of these attendees can be shown in more detail within the Costing’s Section below.

Figure 91 and Figure 92 show that large numbers of people attending from the HRG "category 1
Investigation with category 1-2 treatment” and “Category 2 investigation with category 1 treatment” are having investigations such as pregnancy tests, ECG, Urinalysis, Blood tests and x-rays.

Figure 91: Number of Investigations in Normal Hours

Figure 92: Number of Investigations Out of Hours
9.3.2. Costing

Attendances at A&E for Purfleet/Surrounding Area patients cost the CCG £1,395,609.60 in 2014/15 (14,080 attendances at an average cost of £99.12 each).

11,760 of the attendances can be broadly categorised as attendances that could have been dealt with in a primary care setting (category 1 Investigation with category 1-2 Treatment/category 2 Investigation with category 1 Treatment/No Investigation with No Treatment) – these alone would have cost the CCG £1,165,651.20, which is 85% of the total A&E spend for Purfleet patients attending A&E.

The cost of these 11,760 patients if treated by GP appointments would be in the region of £540,960 (£46 per appointment), which results in an opportunity to save around £854,649.60.

The cost of £540,960 can also be broken down into Day and Night Time attendees (Table 19) which could subsequently save a further £146,096.00 as this cost would be covered by Out of Hours Provider.

**Table 19: Opportunity for savings by moving A&E attendances that could be dealt with elsewhere into a primary care setting**

<table>
<thead>
<tr>
<th>Time of Attendance</th>
<th>GP Cost</th>
<th>No of Patients</th>
<th>Potential Cost</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Time (08:00 - 17:59)</td>
<td>£46</td>
<td>8584</td>
<td>£394,864.00</td>
<td>Potentially met by Primary Care Provision</td>
</tr>
<tr>
<td>Night Time (18:00 - 07:59)</td>
<td>£46</td>
<td>3176</td>
<td>£146,096.00</td>
<td>Potentially met by Out of Hours Service Provision</td>
</tr>
</tbody>
</table>

The below indicates a more detailed number/costing for the Purfleet/Surrounding Areas patients who attended A&E per Category (Figure 93)

**Figure 93: A&E attendances and costs by HRG category**

Darker=avoidable Source: SUS
On average 39% of patients attending A&E from Purfleet/Surrounding GP practices did not require any investigation or significant treatment. Belhus Medical Practice (42%) had the highest number of patients while the average across Thurrock was 41%.

Figure 94: % patients receiving no investigation and no significant treatment

A similar report was written to assess the need for an integrated healthy living centre for that locality (Tilbury). In that report we were able to compare the diagnoses case mix of patients attending during usual Primary care opening hours and during out of hours times. This however has not been possible in the report due to the number of people from Purfleet attending and leaving with no diagnosis or a diagnosis that is unclassifiable. The findings from the Purfleet report suggested overall similar case mixes both day and night.

9.3.3. Reasons for attending A&E

When analysing why Purfleet/Surrounding patients attended A&E in 2014/15, the most common cause was due to Respiratory conditions (excluding asthma) with 1072 patients, then Soft tissue Inflammation with 916 patients; many of these causes could be seen in Primary care if capacity were available. Also to note that 8358 patients were coded as “Diagnosis unclassifed” and 6848 coded as “None” [Figure 95]
9.3.4. Diagnostic Investigations performed in A&E

When analysing what diagnostic investigations were routinely performed for Purfleet/Surrounding patients in 2014/15, the most common investigation performed was Haematology (2188 patients) followed by X-ray (2054 patients) and clotting studies (669 patients).

It’s also worth noting that from the data it was found that 6528 patients did not require any investigations.
9.4. **Emergency Admissions**

Out of the six Purfleet/surrounding area GP practices, Belhus Medical Practice had the highest rate of emergency admissions, with a Directly Standardised Rate (DSR) of 10,447.28 per 100,000. Pear Tree Surgery had the lowest number of emergency admissions (7,698.69 per 100,000). The Thurrock Average is 8,237.8.

*Figure 97: Emergency Admission Rates*

![Emergency Admissions DSR - 2014/15](image)

**Source:** SUS

When analysing the reasons why Purfleet/Surrounding Area’s patients were admitted to hospital in 2014/15, the most common cause was Sepsis (65 admissions) followed by Urinary Tract Infections (58 admissions) and Acute Lower respiratory infections in individuals with COPD (56 admissions).

*Figure 98: Top 10 Diagnoses for non-elective admissions*

![Top 10 Diagnosis for Purfleet/Surrounding Area - 2014/15](image)

**Source:** SUS
The main primary procedures performed on Purfleet/Surrounding Area’s residents while in hospital were Computed tomography NEC (106) Computed tomography of head (85) and Transthoracic echocardiography (66). This can be seen in the figure below.

Figure 99: Top 10 Primary treatments for Non-elective admissions

![Bar chart showing top 10 primary treatments for Purfleet/Surrounding Area's non-elective admissions in 2014/15. The treatments listed are: Computed tomography NEC, Computed tomography of head, Transthoracic echocardiography, and other procedures with decreasing frequency.]

Source: SUS

9.5. Summary – Secondary Care
In 2014/15 there were 20,345 outpatient attendances by Purfleet patients. The most common specialties were Orthopaedics, Ophthalmology, Gynaecology and Paediatrics. 70% of outpatient attendances were recorded with a priority code of ‘routine’. This provides potential scope to deliver some of these services within an enhanced integrated healthy living centre setting more locally.

In total there were 14,080 A&E attendances from patients registered to the 7 GP practices in the South Ockendon area. In 4 practices rates were above the Thurrock mean. Half of all of these attendances required no significant investigation or treatment and 83% were classified into the three least clinically serious HRG categories. This suggests huge potential to reduce avoidable A&E attendances.

By far the most common diagnosis of patients attending A&E where no investigation or treatment was required was that no diagnosis of illness was made or that the diagnosis ‘was not classifiable’.

Common investigations performed on patients coded into the three least clinically serious categories included urine analysis, electrocardiograms, haematology and X-rays.

Most A&E attendances for the three least clinically severe categories happened during usual GP opening hours, however a large number happened during the hours that a GP practice would usually be closed.
- 15% Cat 1 inc. cat 1-2 treat – GP closed
- 30% cat 2 inc., cat 1 treat – GP closed
- 39% no inc. no treat – GP closed

It is recommended, then, that there is a need to consider urgent care/diagnostics – 24/extended hours to have maximum impact on A&E attendances.

To aid the reduction in the reliance of A&E for non-urgent reasons, more local provision of some of the A&E diagnostic equipment should be considered for inclusion at the new facility, this should in turn deliver a reduction in / more appropriate use of ambulance services.

Out of the seven GP practices in the South Ockendon area, three had directly standardised rate of unplanned care admissions greater than the Thurrock mean, two statistically significantly greater. The most common reasons were; respiratory problems including pneumonia, COPD and asthma, sepsis, lower abdominal pain and urinary tract infections.

Please refer to section 6 for further information on unplanned activity for Long Term Conditions.
10. Adult Social Care

In 2014-15, 1,366 adult social care service packages were provided to 359 residents of Aveley & Uplands, Belhus West Thurrock and South Stifford wards. The packages provided to Aveley & Uplands, Belhus and Purfleet residents made up 15% of the total number of packages provided in Thurrock.

10.1.1. Primary Support Reason

The most common primary support reason for accessing support packages in Aveley & Uplands, Belhus and Purfleet was Physical Support – Personal Care Support, which accounted for 50% of packages. The next most common primary support reasons were Learning Disability Support (17%) and Physical Support - Access and Mobility Only (15%). In Thurrock as a whole there were a wider range of primary support reasons – Physical Support – Personal Care Support was still the most common reason and accounted for a higher proportion of packages (53%). The next most common primary support reasons for Thurrock was Physical Support - Access and Mobility Only (15%) and Learning Disability Support (12%).

Figure 100: Primary Reason for accessing ASC packages

Source: Thurrock Council

It should be noted that 0.07% of primary support reasons for Thurrock were for reasons not used in the areas of interest (Social Support - Substance Misuse Support & Social Support - Support to Carer).
10.1.2. Service Type and Package

The majority of services accessed by Purfleet/Surrounding Area and Thurrock residents were Community Based – 89.53% of Aveley & Uplands, Belhus and Purfleet and 81.93% of Thurrock packages fell into this category. A lower proportion of Aveley & Uplands, Belhus and Purfleet packages related to Residential Services (7.47%) than Thurrock (13.77%).

Figure 101: Service type accessed

The most common service packages accessed by Aveley & Uplands, Belhus and Purfleet residents were Homecare Standard Single Handed (14.6%), Internal Single Handed Homecare (11.2%) and Pendant Alarm (8.1%). Translating this into numbers, 199 service packages were provided to 109 residents in Aveley & Uplands, Belhus and Purfleet for Homecare Standard Single Handed packages in 2014/15.

Source: Thurrock Council
10.1.3. How can the new Purfleet Health Facility help?

The key focus for adult social care is to support people to live as independently as possible and ultimately to reduce emergency admissions to hospital for conditions which could be effectively prevented or managed elsewhere. The data above tells us that residents of Aveley & Uplands, Belhus and Purfleet are already accessing a Community Based Service Type, with three of the top ten service packages relating to Community Based packages. In order to effectively provide for the growing and aging population, the new Purfleet Health Centre will assist with this need, by co-locating health and social care professionals, it should also reduce duplication and increase communication and collaboration, with the shared aim to support Aveley & Uplands, Belhus and Purfleet residents to live independently for longer.
PART 1C: WHAT SHOULD AN INTEGRATED HEALTHY LIVING CENTRE IN PURFLEET CONTAIN?

11. Summary of the needs of Purfleet

In the previous sections of this report we have established the following needs for the populations of Purfleet and the surrounding areas:

Purfleet and its surrounding areas have a larger population of young children and young adults and a relatively high fertility rate compared to other parts of the borough, meaning there are large numbers of young families. Whilst the planned regeneration programme and incoming migration particularly from outer London boroughs may change the demographic profile of the area, it is important to ensure that it provides a range of services to support children and their families to stay healthy – particularly those such as immunisations, breastfeeding support, parenting and sexual health services.

Residents of Purfleet and the surrounding areas are more likely than in other areas of Thurrock to live in conditions of overcrowding, housing with potentially poor quality heating, have known health conditions. They are also more likely to be long-term unemployed, have no qualifications and claim benefits. In addition to this only a small proportion of the population have (or are using) five basic digital skills, making it more difficult for them to find employment. This may be due to a lack of training in these skills, or a financial difficulty to afford digital products.

Around a quarter of residents in the area do not have access to a car or van.

Babies are less likely to be breastfed and children are less likely to receive immunisations if they are resident in South Ockendon compared to the rest of Thurrock and England.

There is a need for good quality, effective lifestyle interventions in the area to address levels of smoking, obesity, and substance misuse (including alcohol). Current services have varying levels of uptake / referrals into.

Sexual Health and levels of HIV are of particular concern in the area; one MSOA has the highest HIV prevalence in Thurrock.

Low levels of cancer screening are apparent in the area, as are high levels of mortality from cancer. It is important that we increase access to cancer screening programmes as early diagnosis is the biggest predictor of 1 year and 5 year survival rates.

There are lower levels of people identified as living with Long Term conditions in the three Purfleet practices than both the Thurrock and England averages. Given the levels of deprivation of the area, and the levels of hospital activity due to these conditions it is likely that this is not a true estimation of the underlying
prevalence and that there is a proportion of people who are living with Long Term Conditions who have not been diagnosed and so are not being treated appropriately.

The clinical management of those patients who have been diagnosed is variable across the three practices. It is noted that this is likely to be contributing to the levels of Emergency admissions for these conditions. Specific concerns are highlighted in the relevant sections, but generally management of patients with Diabetes, and COPD urgently need improving.

Depression is not well identified and diagnosed for patients registered in the Purfleet practices. Additionally once diagnosed with depression or another mental ill-health condition clinical management is not of the quality we would expect with too many patients not receiving all of the interventions necessary to keep them well. Specific concerns are raised in the relevant section.

Although not the worst in Thurrock, Purfleet has a noticeable shortage of GPs and nurses for its population. This is undoubtedly perpetuating the ‘inverse care law’ referred to the Foreword of this report; the population with the greatest health need is receiving some of the worst access to and quality of primary care. We estimate that almost 13 additional FTE GPs are needed to be employed locally to meet the needs of the population at present.

Of the 20,345 Outpatient attendances, 14,310 (70%) of these were recorded with a priority code of Routine. Additionally many of the procedures performed could be addressed in Primary Care if appropriately resourced. This is particularly true for diagnostic tests, which make up the largest volume of procedures for Routine attendances. 70 % of outpatient attendances were recorded with a priority code of ‘routine’. This provides potential scope to deliver some of these services within an enhanced integrated healthy living centre setting more locally.

In total there were 14,080 A&E attendances from patients registered to the seven GP practices in the South Ockendon area. In four of the practices rates were above the Thurrock mean. Half of all of these attendances required no significant investigation or treatment and 83% were classified into the three least clinically serious HRG categories. This suggests huge potential to reduce avoidable A&E attendances.

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Out of the seven GP practices in the South Ockendon area, three had directly standardised rate of unplanned care admissions greater than the Thurrock mean, two statistically significantly greater. The most common reasons were; respiratory problems including pneumonia, COPD and asthma, sepsis, lower abdominal pain and urinary tract infections.
12. Recommendations for services to be included in the Purfleet Integrated Healthy Living Centre

Based on the needs summarised in the last section and throughout this report, the table below provides a ‘blue print’ of recommended services that commissioners should consider ensuring are provided/co-located within any new facility.

Table 20 Recommended services to be provided within the new Healthy Living Centre

12.1. Wider Determinants of Health

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Brief Rationale</th>
<th>Evidence (section number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A benefits, housing, debt advice service</td>
<td>These are all particular issues facing the current population and key drivers of stress and depression. Social issues such as these have been estimated to account for up to 15% of all GP appointment time, even though they have no underlying clinical cause.</td>
<td>3.1, 3.2, 3.3</td>
</tr>
<tr>
<td>Employment advice and job skill based training programmes</td>
<td>Unemployment in Purfleet, particularly in Belhus is high. Having a job is probably the single most health protective factor and moving people from benefits and into work was shown in recent research by Professor Michael Marmot to have a greater impact in reducing health inequalities than any other intervention.</td>
<td>3.3</td>
</tr>
<tr>
<td>Children’s services with a focus on parenting and the 0 to 5.</td>
<td>Children in parts of South Ockendon are less ‘school ready’ than elsewhere in Thurrock or England. Addressing this will have a positive impact on reducing the perpetuation of health inequalities. Breastfeeding uptake also varies widely across the locality. Move of responsibility for commissioning 0-5 services to Thurrock Council provides an opportunity to review the current model and integrate with other services such as the Children’s Centre</td>
<td>3.4, 4.1</td>
</tr>
<tr>
<td>Flexible space for use by the community and voluntary sector including co-location of the Purfleet ‘hub’</td>
<td>Good health and wellbeing is much more than the absence of disease or disability but encompasses social health and community resilience. Loneliness and isolation are key drivers of poor mental and physical health and wellbeing. By providing a range of flexible rooms that can be used by community groups, community resilience can be strengthened and wellbeing increased.</td>
<td>Section 5</td>
</tr>
<tr>
<td>Drop in surgery for the Purfleet Local Area Coordinator</td>
<td>Parts of the locality have high proportions of older people living alone. Local Area Coordinators are designed to connect lonely and vulnerable individuals with the social capital and community assets within their community. They have proved highly successful and popular amongst the communities where they work and could sign post service users/patients to a range of services that will improve their health and wellbeing.</td>
<td>2.4, 3.7</td>
</tr>
</tbody>
</table>
### 12.2. Lifestyles

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Brief Rationale</th>
<th>Evidence (section)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic, integrated lifestyle modification services</td>
<td>Smoking prevalence in Thurrock is extremely high and current commissioned services are having virtually no impact on reducing it. Prevalence of obesity is also extremely high. Research previously conducted locally has suggested that ‘one size does not fit all’ with regard to helping our population improve their lifestyles. A new, flexible and non-judgemental approach is required that encompasses a wide range of different formal and informal community based activities to promote physical activity that appeal to as many different sections of the community. Services are also required to assist people to improve diet, increase cooking skills and offer a range of types of support to help people quit smoking. Front line health, social care and third sector staff and volunteers should be trained to proactively identify and refer patients with poor lifestyles into services that are right for them.</td>
<td>Section 4</td>
</tr>
<tr>
<td>An integrated sexual health service – delivering on the Public Health Primary Care contract.</td>
<td>Access to high quality sexual health and contraceptive services have been shown to be one of the most important interventions to reduce teenage pregnancy. Three of the wards fall in the second worst quintile for this. However of more importance to the population of south Ockendon is education around STI’s and HIV.</td>
<td>4.5</td>
</tr>
<tr>
<td>IAPT/Mental health counselling service</td>
<td>Depression prevalence is high and yet access to talking therapies has traditionally been low (with the exception of the Purfleet care centre), perhaps as a result of no local service provision.</td>
<td>Section 7</td>
</tr>
</tbody>
</table>

### 12.3. Primary Care

Given the information on the current primary care workforce in Purfleet, providing a primary care workforce that is adequate to meet the demands and needs of the population will be challenging. By the time the facility is built 2018/19 we estimate that the registered population size will be around 22336. With the current infrastructure and processes this would mean that we would need 16.06 wte GPs. There are currently only three permanently employed WTE GPs in the area. We either face the challenge of employing a further 13 WTE GPs or find innovative ways of re-distributing a GPs current workload in order that the gap between what is needed and what is currently available is bridged.

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2 Estimated by the Public Health Intelligence team – contact Maria Payne for more details
Ensuring that we have adequate primary care would be expected to have an impact on the areas use of A&E reducing the CCGs costs in this department.

In October 2015 the Primary Care Foundation and NHS alliance published “Making Time in General Practice”³. This report looks at a number of ways that we can free up GP time, leaving them with more time to do the job that they were trained to do and perhaps go some of the way to bridging the gap between the number of GPs that are required and what we can provide. Solutions can be split into two broad categories:

1. Introducing alternative staff (clinical and/or administrative) to take over some of the workload.
2. Introducing an environment to reduce the bureaucratic burden on GPs. This includes information systems, communications etc… While we think that this is important we feel that it is outside the scope of this report and we will look at it separately and make further recommendations.

There is much work to be done nationally on both of these but here we concentrate on what is in the primary care and the CCGs gift to achieve.

12.3.1. Staffing Alternatives

Figure 103 shows the administrative (red) and clinical (blue) staff that could surround GPs in the primary care to reduce the number of required GPs and maximise GP time spent on clinical issues. Below we look at the remit of each of these roles individually and then apply some assumptions to model what effect some of them would have on the number of GPs required to effectively serve the population of Purfleet.

It is important to note here that the staff considered not only reduce the caseload of a GP but also add value and aim to target some of the needs of the population identified in section 9.
12.3.2. The Primary Care Receptionist

In this model the receptionist(s) is key to success. They need to be highly trained individuals who can make a judgement on the best clinician/professional that a patient needs to see. And they need to get this right most of the time to avoid duplicating appointments.

12.3.3. The GP Assistant / Clinical Personal Assistant

This is a AfC band 4 administrative worker trained to support GPs by processing letters coming into the practice. They use a clearly defined and agreed workflow, to carry out delegated work where it is safe to do so, leaving GPs to deal only with letters requiring medical input or oversight. Other actions can involve entering read codes and other data onto the GP system; booking a follow up appointment with a patient; booking follow-up blood tests with patients; or following DNA processes for patients who missed appointments. The GP or other clinicians then have no need to see these letters.

A pilot scheme in Brighton and Hove estimated that this role required around 3 hours of administrative work per 5,000 registered patients and saved each GP in a practice 40 minutes of time per day. Translated into GP appointments for Purfleet, with 16 required GPs this would free up 66 ten-minute appointment slots.

The role is heavily dependent on well-defined processes and workflow, requires training for administrative staff, and a lead GP to provide governance and audit.

The added value of this role is that communications at the practice can be dealt with in a more timely and organised manner. Patients requiring follow-up will be contacted more swiftly, patient records should be more up to date when a health professional does see a patient, and a reduction in the number of times a patient has to make contact with or see anyone at the practice.
12.3.4. The Primary Care Pharmacist

While GPs are in short supply, nationally there is an over-supply of pharmacists. The RCGP and RPS describe pharmacists as a “hidden army” (RCGP, 2015).

The “Making Time in General Practice” report (Primary Care Foundation, 2015), suggests that around 5.5% of GP appointments nationally could be taken care of by a pharmacist or self-care. A pharmacist is able to diagnose and treat minor ailments (see information above on minor ailments scheme).

This role is not necessarily about including a pharmacy on site, as we can see (above) there are already a number of pharmacies in Purfleet, it is about making use of a pharmacists clinical skills to help patients and the over-stretched GP workforce.

“Having a pharmacist a part of the team could make a huge difference both to patients and clinical colleagues. Practice pharmacists can consult with and treat patients directly, relieving GPs of casework and enabling them to focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. As part of the multidisciplinary team, practice pharmacists can advise other professionals about medication resolve problems with prescriptions and reduce prescribing errors. They can work with GPs to resolve day-to-day medicine issues and with practice teams to provide advice on medicines to care homes, as well as visiting patients in their own homes when needed.”

In the modelling work below we consider the role only in terms of reducing a GPs workload in way of a minor ailments clinic, however with further additional capacity the role could also help to improve the quality of care:

- Medicines Reconciliation
- Medication Review (poly-pharmacy / QOF etc.)
- Prescription management (average GP 200 repeat prescriptions per week)
- Prescription safety / concordance
- Chronic disease management (respiratory, cardiovascular and diabetes clinics)

We recommend that the use of practice pharmacists is considered separately in a wider context. An additional pharmacist could be employed using savings generated from the staffing changes.

12.3.5. The Nurse Practitioner

The role of the Nurse Practitioner is already well documented and understood. The “Making Time in General Practice” report suggests that 6.5% of GP appointments nationally could be seen by a nurse practitioner. The impact that this would have on GP requirements in Purfleet is modelled below.

The role would also mean that those patients with more complex clinical needs, who need to see a GP, will get to do so in a timelier manner.

12.3.6. Wellbeing worker

These members of the team act as a care navigator, peer coach, health trainer or befriender. This role could be handled expanding the current Thurrock Local Area Coordinator role.
The “Making Time in General Practice” report suggests that 4% of GP appointments nationally could be handled by a wellbeing worker. Because a wellbeing worker would be considerably cheaper than a GP to handle these “non-clinical” issues it would be possible for them to spend more time with patients on these issues.

12.3.7. Physio-therapist

MSK patients make up to 30% of a GPs caseload. There is a complex referral pathway from this point, typically with a GP referring to a consultant who then either refers to physio-therapist or decides to perform surgery.

At Windermere Health Centre, in the Lake District, a physiotherapist joined the practice team to assess, diagnose and triage MSK patients. During the first three months, 168 GP appointments were freed up and the translation of orthopaedic referral to operation rate increased to 99%. Additionally, the number of steroid injections delivered in the centre rose because the physiotherapist could also do this, generating income for the practice.

In Betsi Cadwaladr, north Wales, two physiotherapists worked across four practices and in the first six months saw 1525 patients who would normally have seen the GP. Only 23 of these patients required any input from the GP and there was a 12% reduction in secondary care referrals. In addition to freeing up GP time, the reduction in referrals for MSK activity in Purfleet would equate to around £4,100 per year. Fewer patients would also have a need to travel to see consultants at the hospital.

Two systematic reviews of physiotherapy showed that patient costs were lower for primary care clinics than conventional outpatient clinics (Hensher, 1998; Roberts and Stevens, 1997). Overall cost per patient was also lower for primary care clinics than conventional outpatient clinics, but savings were partially offset by increased demand in primary care.

12.3.8. Physician Assistant

There is much debate about this role in GP practice, it is not a well-researched or defined role and training schemes / courses vary in their emphasis. Drenan et al (2014) published a review of the research around the role along with an observational study comparing 6 practices which employed PAs to 6 that did not. Evidence showed that the role is acceptable to patients and that they tended to see patients with same day booked appointments, and worked at the younger end of the population compared to GPs.

No difference was found in rates at which patients returned to surgery within 14 days between patients seeing a GP or a PA. The PA tended to spend longer with a patient but the cost per consultation was £6.22 lower.

Caveats:

- Little thought given to regulation or prescribing rights of role
- Some evidence that higher level of supervision needed
- No research comparing PA and nurse practitioner (possible overlap)
- Short supply so finding may be as difficult as finding a GP, however new places on courses in 2015 announced.
Registration issues?
The "making time in general practice report" suggests that a PA could see around 40 patients per day.

12.3.9. Paramedic
A newer role is the practice-attached paramedic or emergency care practitioner. This role is now being tested in a number of the Multispecialty Community Provider vanguards, including Kent and Derbyshire.

In Whitstable, Kent, a paramedic team is now based in a GP practice. They have their own vehicle with on-board diagnostics and access to electronic patient records. When patients call the surgeries at 8am requesting home visits, GPs screen the calls and refer the most urgent to the paramedics who can make a visit quickly. The less urgent wait until a GP can visit later in the day. In the first five weeks of the pilot in sprint 2015, paramedics were able to see, treat and complete two thirds of patients referred to them. The volume of 999 calls was down 10% over the period.

There is currently not enough evidence to consider this in our calculations but we could re-visit this at a later date.

12.3.10. Promoting Self-Care and Management
Promoting self-care, particularly for patients with long term conditions is a key and often over-looked element of Primary Care and chronic disease management. Condition specific support groups and education programmes that assist patients to develop a better understanding of their condition and lives and cope with symptoms have been shown to improve clinical outcomes and reduce stress. For example programmes that assist patients to develop an understanding of their condition and lives and cope with their symptoms when delivered with both education and practitioner review have been found to reduce hospitalisations in patients with asthma by up to 50% and reduced hospital admissions in patients with COPD by between 13% and 36% depending on disease severity. Such programmes should be provided as part of the Primary Care offer. Use of existing third sector support groups should be maximised.

12.3.11. Modelling the impact of including additional staff in the Purfleet Primary Care Model – A scenario modelling exercise
The model incorporates various pieces of information from above to calculate what is the maximum WTE numbers of each staffing group (where possible) that could be included based on the estimated population for 2018/19 (including regeneration). This is then translated into appointments saved and WTE GPs saved. The recommended number of GPs is re-calculated based on the number of other professionals introduced. Costs and Savings are also considered. An excel spreadsheet accompanies and allows the assumptions on length of consultation, total daily consultation time available, and the % of a GPs workload that could potentially be handled by each professional group.
Table 21: Starting Assumptions for discussion

<table>
<thead>
<tr>
<th>Role</th>
<th>WTE GP time with patients</th>
<th>Length of GP appointment</th>
<th>% GP caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>410.4 minutes</td>
<td>10 minutes</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>410.4 minutes</td>
<td>10 minutes</td>
<td></td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>410.4 minutes</td>
<td>10 minutes</td>
<td>6.50%</td>
</tr>
<tr>
<td>Wellbeing worker</td>
<td>410.4 minutes</td>
<td>30 minutes</td>
<td>4.00%</td>
</tr>
<tr>
<td>Physio-therapist</td>
<td>410.4 minutes</td>
<td>15 minutes</td>
<td>20%</td>
</tr>
<tr>
<td>Physician assistant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number appts per day</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP assistant</td>
<td></td>
<td></td>
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<tr>
<td>2019 registered pop</td>
<td>22262</td>
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</tr>
<tr>
<td>hrs needed per week</td>
<td>13.3572</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in GP time per GP per day</td>
<td>40 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptionist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients in total per day</td>
<td>857.5448</td>
<td></td>
<td></td>
</tr>
<tr>
<td>length per phone call / conversation</td>
<td>3 mins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>length of time able to take appts</td>
<td>410.4 mins</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 22: Staffing Suggestion – Model Output for 2019

<table>
<thead>
<tr>
<th>Role</th>
<th>GP appointments free’d per day</th>
<th>WTE GPs free’d</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7 receptionist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.9 practice pharmacist</td>
<td>36.25</td>
<td>0.88</td>
</tr>
<tr>
<td>1.0 nurse practitioner</td>
<td>42.84</td>
<td>1.04</td>
</tr>
<tr>
<td>1.9 Wellbeing worker</td>
<td>26.36</td>
<td>0.64</td>
</tr>
<tr>
<td>4.8 Physio-therapist</td>
<td>131.82</td>
<td>3.21</td>
</tr>
<tr>
<td>1.0 physician assistant</td>
<td>40.00</td>
<td>0.97</td>
</tr>
<tr>
<td>0.4 GP assistant</td>
<td>4.00</td>
<td>0.10</td>
</tr>
<tr>
<td>14.6 GPs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total reduction in GP appointments: 281.28
Total reduction in WTE GPs required (compared to 16.06): 6.85

Based on the assumptions above the Purfleet practice could include, 0.9 WTE practice pharmacist, 1 WTE nurse practitioner (in addition to 5.6 that will be needed by 2019 to get us in line with the recommended 1 per 4000 registered patients), 1.9 WTE wellbeing workers, 4.8 WTE Physiotherapists, 1 WTE Physician’s Assistant, 0.4 WTE GP Assistant and 9.2 WTE GPs compared to the original estimated 16.06 required WTE GPs we now only need 9.2. We estimate that for patients to be directed to the correct professional a total of 7.7 WTE receptionists should be employed.

12.3.12. Future – Proofing Primary Care 2025 Estimation

The outputs in Table 23 are based on a population size of Purfleet 29,967. This is the projected population (see Demography section).

As discussed the council has an aspiration to build additional new homes. The table below therefore give workforce requirements based on population projections for 2026.

Table 23: Staffing Suggestion – Model Output for 2025

<table>
<thead>
<tr>
<th>Role</th>
<th>GP appointments free’d per day</th>
<th>WTE GPs free’d</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.7 receptionist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 practice pharmacist</td>
<td>48.53</td>
<td>1.18</td>
</tr>
<tr>
<td>1.4 nurse practitioner</td>
<td>57.35</td>
<td>1.40</td>
</tr>
<tr>
<td>2.6 Wellbeing worker</td>
<td>35.29</td>
<td>0.86</td>
</tr>
<tr>
<td>6.5 Physio-therapist</td>
<td>176.47</td>
<td>4.30</td>
</tr>
<tr>
<td>1.0 physician assistant</td>
<td>40.00</td>
<td>0.97</td>
</tr>
<tr>
<td>0.4 GP assistant</td>
<td>4.00</td>
<td>0.10</td>
</tr>
<tr>
<td>12.7 GPs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total reduction in GP appointments: 361.65
Total reduction in WTE GPs required (compared to 16.06): 8.81
12.4. Minor Ailments Clinic

National research indicates that 18% of GP workload is accounted for by minor ailments alone (PAGB, 2009) which is around one hour per day per GP. Whilst nearly 9 out of 10 people often treat minor ailments themselves, the research by PAGB indicates that people often abandon self-care to seek advice within 4-7 days, and this is usually from a GP, who would usually just give a prescription. Treatment of minor ailments costs £2 billion per year to the NHS. The top 10 minor ailments (which incidentally account for 75% of all minor ailments seen) are:

1) Back pain
2) Dermatitis
3) Heartburn and indigestion
4) Nasal congestion
5) Constipation
6) Migraine
7) Cough
8) Ache
9) Sprains and strains
10) Headache

The same report defines some characteristics for self-treaters and those who visit their GP/nurse for advice.

<table>
<thead>
<tr>
<th>Self-treaters are more likely to be:</th>
<th>Those who visit their GP/nurse are more likely to be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Lower earners</td>
</tr>
<tr>
<td>Higher earners</td>
<td>Prescription-exempt</td>
</tr>
<tr>
<td>Older Consumers</td>
<td>Have children</td>
</tr>
<tr>
<td>White British</td>
<td>Prescription Payers</td>
</tr>
<tr>
<td>Full time workers</td>
<td></td>
</tr>
</tbody>
</table>

When pharmacists were asked how much of their working day was spent advising on minor ailments, 59% felt that they were spending approximately the right amount of time, but 34% felt that they were spending too little time on this; inferring that they felt they should have more of their time dedicated to this.

Based on this research, the direction for the future should encourage patients to self-care where appropriate, but where intervention is required, to utilise pharmacy in the first instance. GP’s and nurses should also feel confident in signposting patients to pharmacists. By co-locating a pharmacy within the new healthy living centre in Purfleet, there is a greater opportunity for trust to develop between GPs, nurses and pharmacists, and therefore the greater likelihood for improved patient outcomes. Additionally, for those who are low earners, prescription exempt or with Children could be actively encouraged to seek advice from a pharmacist rather than a GP if the co-located pharmacy could run and publicise a minor ailments scheme. This means that they can supply medicines for certain conditions on the NHS (either with standard prescription charge or for free for those who are exempt). (See Enfield flier Appendix 3).

In Enfield the scheme sees and treats around 600 patients per month.
Research by Baqir et al (2011) investigated what the costs to run a minor ailment scheme were and the potential savings it could generate. Based on a sample of 396 patients who accessed the scheme, they found:

- The cost to run the minor ailment scheme was £1,346 – based on a professional fee of £3.40 per patient.
- If the scheme had not been in place, 58% would have accessed their GP, 0.5% would have accessed A&E, 0.25% would have accessed a health visitor, and 41.1% would have purchased over the counter medicine or done nothing.
- Using the following costs (£36 per GP appointment, £111 per A&E attendance, £11.70 per health visitor appointment and a £2.63 cost for provision of medicine), the authors calculated that the cost saving to the NHS was £6,739.01 for those 396 patients, equating to £17.02 per patient.

Given that we have already made provision above for a practice pharmacist to be included in the facility the professional fee would not be applicable to our situation. Additionally we have already accounted for the pharmacist to see 5.5% of GP appointments some of which may currently be using A&E inappropriately due to the lack of availability of GP appointments.

Should demand become high for the service and there is evidence that it is resulting in reduced demand on A&E then we could consider this in the existing pharmacies around Purfleet. However at this stage we would recommend against doing this to avoid creating a supply led demand for the service.

NHS Thurrock CCG currently do not commission the Minor Ailments Scheme in any pharmacy in the borough. Consideration could be made for other areas.

12.5. Long Term Conditions Clinics

Prevalence of long term conditions in Purfleet is high and clinical management variable and in many cases poor. (See section 7) A long term conditions clinic is an innovative approach to the way practices care for patients with long term conditions (Asthma, Diabetes, Stroke, Hypertension, COPD, and CHD). Patients would be recalled to have their conditions and medications reviewed in a more efficient way. Patients would not need to make repeat visits to see the doctor and practice nurse because they would all work together.

Pro-actively re-calling patients for review gives the practice more control on how they do it logistically. Options could include:

- Call patients as a certain trigger point hits (6 months, 12 months, certain number of repeat prescriptions)
- Have days where the clinic is dedicated to a specific long term condition, giving the option to include an external specialist if needed (e.g. diabetes nurse from elsewhere in Thurrock)
- Call all patients with multiple conditions and see them about all conditions at the same time
The stow health medical centre operated a Long Term Conditions clinic and they have found that reviewing patients in this way represents about 30% of the workload of the entire practice and they are achieving the following objectives:

- allow patients more time with the doctor/nurse team for help and advice on the management of their condition
- give patients more control over the management of their condition
- reduce the need for patients to make multiple visits to the practice to see the nurse and the doctor
- provide a more “joined-up” approach to the care of patients with more than one LTMC
- better allocation of the practice resources so that we have more time for the important stuff like providing good quality health advice for all of our patients (Drenan et. al, 2014)

Given that the quality of care that is currently offered to patients with Long Term Conditions in Purfleet is variable, we strongly suggest that the new centre does include Long Term Condition Clinics. These clinics should aim to identify patients with disease who are not diagnosed and ensure that those who are diagnosed receive best quality evidence based care as per Nice guidelines and QOF. There is strong evidence that since the introduction of QOF emergency admissions for ambulatory care LTCs have fallen. We should expect to see similar in Purfleet populations.

The clinic should plan to be reviewing and supporting patients in the region of the following number. It should be noted that some patients will have co-morbidities and that this list is not exclusive; there may be other conditions (e.g. MSK) that we have not estimated here:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Projected 2019</th>
<th>Projected 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>22336</td>
<td>28780</td>
</tr>
<tr>
<td>COPD*</td>
<td>329 to 431</td>
<td>423 to 555</td>
</tr>
<tr>
<td>Hypertension*</td>
<td>2441 to 5580</td>
<td>3146 to 7189</td>
</tr>
<tr>
<td>Depression</td>
<td>1675</td>
<td>2159</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1259</td>
<td>1623</td>
</tr>
<tr>
<td>Asthma</td>
<td>1056</td>
<td>1361</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>602</td>
<td>776</td>
</tr>
<tr>
<td>Coronary Heart Disease (CHD)</td>
<td>423</td>
<td>545</td>
</tr>
<tr>
<td>Cardiovascular Disease (CVD)</td>
<td>294</td>
<td>379</td>
</tr>
<tr>
<td>Cancer</td>
<td>251</td>
<td>323</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>207</td>
<td>266</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>187</td>
<td>241</td>
</tr>
<tr>
<td>Mental Health Conditions</td>
<td>170</td>
<td>219</td>
</tr>
<tr>
<td>Atrial Fibrillation (AF)</td>
<td>159</td>
<td>205</td>
</tr>
<tr>
<td>Atrial Fibrillation (AF)</td>
<td>159</td>
<td>205</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>93</td>
<td>120</td>
</tr>
<tr>
<td>Peripheral Arterial Disease (PAD)</td>
<td>76</td>
<td>98</td>
</tr>
<tr>
<td>Dementia</td>
<td>74</td>
<td>96</td>
</tr>
</tbody>
</table>

Notes: Populations projections and methodology are explained in the demography section, here we have assumed that the prevalence of disease will remain constant and as is measured by QOF with the exception of COPD and Hypertension (*) which we know are the currently under-diagnosed the most, here we have given a range between the current QOF prevalence and the 2011 modelled prevalence estimate (APHO).
12.6. Diagnostics

12.6.1. Blood Test facility

Outreach services currently operate from Aveley (4.5 hrs per week), Peartree (1.5 hours per week), the Purfleet care centre (1 hour per week), and St Clements medical centre (5 hours per week). In Aveley and Peartree there are 50 and 20 (respectively) patients seen during each and every session (consistently) suggesting that these services are currently operating at capacity. However numbers at the Purfleet care centre range between 20 and 50 per 1 hour session and at St. Clements we are informed that only around 5 patients are seen per 1 hour session. This suggests that resources need to be further investigated and maybe re-distributed.

Additionally there were 459 diagnostic blood tests performed in outpatients and over 2,000 A&E attendances for haematology in 2014/15 suggesting a need for more streamlined phlebotomy services in this area. The CCG are working with BTUH to consolidate the clinic venues and offer longer hours and set days rather than an hour or two here and there, and due to the demand in Purfleet, it is recommended that Purfleet is considered as a venue for longer blood test clinics.

12.6.2. Other potential diagnostics

Information in section 10.3.2 suggests that providing other diagnostic services more locally would reduce A&E attendances. X-ray imaging, ultra-sound, ECGs and urinalysis are recommended.

12.7. Outpatient Clinics

In 2014/15 there were 20,345 outpatient attendances by Purfleet patients. The most common specialities were Trauma and Orthopaedics, Ophthalmology, Gynaecology and Paediatrics. 70% of out-patient attendances were recorded with a priority code of ‘routine’. This provides potential scope to deliver some of these services within an enhanced integrated healthy living centre setting more locally.
PART 2: CONSIDERATIONS FOR THE WIDER REGENERATION PROGRAMME

The wider Purfleet regeneration programme is an immense opportunity to improve the health of existing and future residents, and reduce the existing health inequalities. The final regeneration proposal should be subject to a full robust Health Impact Assessment with the objective of maximising health gain and reducing health inequalities. However, some general mechanisms in which the development can influence health behaviour change include:

13. Travel

13.1. Promote Active Travel
The development should include adequate walking and cycling paths, as well as facilitate access to good quality public transport. This should have an impact on physical activity levels and obesity levels, as well as reduce air pollution and the likelihood of road traffic accidents. This is particularly important in this area, as section 4.3.2 highlights the high proportion of obese Year 6 children in parts of this Locality, and low current uptake of weight management services. Given that around a quarter of local residents do not have use of a car or van this should be welcomed.

13.2. Provide effective road design and traffic management systems
The development should facilitate good traffic flows and sufficient pedestrian/cycle crossings to reduce congestion and promote road safety. However it should discourage commuter traffic to drive through the development to avoid traffic on surrounding roads.

14. Place

14.1. Mitigate poor air quality
The above measures will have some impact on air quality, but there are other opportunities for the development to mitigate the already poor air quality here, such as implementing a new Low Emissions Strategy, using suppliers with more efficient engines in their lorries, and ensuring there is sufficient green infrastructure as buffers as the evidence presented in the JSNA proves that green spaces can improve the impact of air quality on health. (See section 3.5 for analyses of need).

14.2. Provide good quality green and open spaces
There is a plethora of published evidence that demonstrates a link between positive, mental and physical health, physical activity and access to green spaces. (for example, Department for Environment, 2009; Mitchell and Popham, 2008). Design of green spaces that promotes physical activity and their proximity to homes is associated with a 20% long term improvement in physical activity. Natural play environments have also been shown to decrease bullying in children, improve social contact and reduce social isolation. Mass et.al. (2009) found that having green spaces within one km of a home reduced prevalence of diseases such as diabetes, cancer and depression. Green spaces will also help to improve air quality. The
regeneration of Purfleet should take account of this research and ensure that well designed green spaces that promote physical and social activity and located in close proximity to new housing development.

The development could actively encourage and facilitate community schemes such as Neighbourhood Watch which will aid residents to feel connected and safer in their homes, as well as provide good access to all community facilities to ensure they are equally accessible to those with reduced mobility. The development could also look to reduce opportunities for anti-social behaviour by providing adequate lighting and open spaces. Another opportunity is for the development to work with the Council to reduce availability of alcohol, as there is evidence to show that areas with higher densities of alcohol outlets have higher rates of alcohol-related crime. This is particularly important as the crime rate in this area is already much higher than the Thurrock average, and the data above shows a higher-than-average estimate of binge drinking around the proposed regeneration area.

14.3. **Provision of homes built to Lifetime Homes and London Space Standards**

Including some to meet HAPPI standards – this would ensure potential residents have access to good quality housing. The data in section 3.2 indicates that the area has a current problem with overcrowding, lack of houses with central heating and a higher rate of residents on long-term unemployment benefits (therefore indicating low income). Working towards an aim of providing 35% of homes as affordable (in line with the Council’s adopted Core Strategy) would promote choice amongst all resident groups and look to relieve the overcrowding issues experienced by some residents in the area.

Data in section 3.2 also shows that shows a high proportion of older people living alone in the Locality. Whilst there is already a good usage of adult social care services that aim to promote independent living in this area, this development can encourage more people to transition into independent living.

15. **Economic**

15.1. **Provision of opportunities for employment**

Being in employment is perhaps the single biggest protector of good health. It is vital that the new Purfleet regeneration promotes economic wellbeing and increases employment opportunities for local people. Incorporating a space of a range of businesses and facilities within the town regeneration programme, will promote opportunities of local employment and boost the economy of the area. There is also an opportunity to link with the local colleges regarding suitable apprentice schemes to encourage young people into work. This is particularly important in this area, as the data above highlights a higher rate of adults claiming long term unemployment benefit (See section 3.3 for analyses of need).

16. **Lifestyle**

16.1. **Facilitate healthy choices**

Section 4.3 highlighted the issue of obesity as a major public health challenge in both adults and children. The developer should seek to work with Thurrock Council to review opportunities for inclusion of healthy food outlets within the regeneration programme, thereby reducing opportunities to access unhealthy food and look to address the nationally-increasing obesity trend.
16.2. Promote Breast Feeding
Section 4.1 highlighted relatively low rates of breast feeding in Thurrock compared to other areas of England. The development should include somewhere comfortable and private for mothers to nurse their babies.

16.3. Impact on smoking prevalence
Evidence suggests that policy changes (partial smoking ban) and prevention of uptake have a bigger impact on the prevalence of smoking than stop smoking services. Making large areas of the space in the new development non-smoking could reduce the amount of cigarettes smoked per day by employees and visitors reduce passive smoking and help slow down the uptake of smoking by young people who often start as a social activity. This would all have a major impact on the health of the area. Some thought would need to be given on how this would be managed / policed.
Appendix 1 - References


Baqir et al (2011): [http://jpubhealth.oxfordjournals.org/content/33/4/551.long#T2](http://jpubhealth.oxfordjournals.org/content/33/4/551.long#T2)


M J Harisson, M Dusheiko, M Sutton, H, Gravelle, T Doran, M Roland; Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions: controlled longitudinal study, BMJ 2014; 349:g6423

Horta, B. L. e. a., 2007. *Evidence on the long-term effects of breastfeeding*, s.l.: World Health Organisation. [http://www.annfammed.org/content/5/6/503.short](http://www.annfammed.org/content/5/6/503.short)


Making the case for the self-care of minor ailments, August 2009, PAGB


# 17. Appendix 2 – Assumptions for Stroke model

## 1. Insert your aspirations for all GP practices in here

<table>
<thead>
<tr>
<th>% of Underlying prevalent population you wish to find for</th>
<th>YR 1</th>
<th>YR 2</th>
<th>YR 3</th>
<th>YR 4</th>
<th>YR 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>80.00%</td>
<td>85.00%</td>
<td>90.00%</td>
<td>95.00%</td>
<td>95.00%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>75.00%</td>
<td>85.00%</td>
<td>90.00%</td>
<td>95.00%</td>
<td>95.00%</td>
</tr>
<tr>
<td>AF</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

### Aspired QOF outcomes

<table>
<thead>
<tr>
<th></th>
<th>YR1</th>
<th>YR2</th>
<th>YR 3 (default: half way between YR1 and YR5)</th>
<th>YR 4</th>
<th>YR 5 (default: worst perfo</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP 4</td>
<td>89.85</td>
<td>91.06</td>
<td>92.28</td>
<td>93.49</td>
<td>94.70 %</td>
</tr>
<tr>
<td>BP 5</td>
<td>79.43</td>
<td>80.75</td>
<td>82.07</td>
<td>83.38</td>
<td>84.70 %</td>
</tr>
<tr>
<td>CHD 6</td>
<td>90.33</td>
<td>91.27</td>
<td>92.22</td>
<td>93.16</td>
<td>94.10 %</td>
</tr>
<tr>
<td>CHD 9</td>
<td>90.93</td>
<td>92.30</td>
<td>93.67</td>
<td>95.03</td>
<td>96.40 %</td>
</tr>
<tr>
<td>Stroke 6</td>
<td>88.83</td>
<td>91.12</td>
<td>93.42</td>
<td>95.71</td>
<td>98.00 %</td>
</tr>
<tr>
<td>Stroke 12</td>
<td>92.4</td>
<td>92.70</td>
<td>93.00</td>
<td>93.30</td>
<td>93.60 %</td>
</tr>
</tbody>
</table>

### Cost of a Stroke Non-elective admission

- Admission: £3,644
- Ambulance: £2,672.00
- A&e: £737.00

### Social care assumptions

- % stroke admissions result in social care package: 33.00%
- Average cost of a social care package: £18,000
- % self funded: 55.00%

<table>
<thead>
<tr>
<th>1st year savings</th>
<th>50.00% (default: 15% will die yr 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd yr savings</td>
<td>85.00% (default: 15% will die yr 2)</td>
</tr>
<tr>
<td>3rd year savings</td>
<td>72.25% (default another 15% will die)</td>
</tr>
<tr>
<td>4th year savings</td>
<td>61.41% (default another 15% will die)</td>
</tr>
<tr>
<td>5th year savings</td>
<td>52.20% (default another 15% will die)</td>
</tr>
</tbody>
</table>
Appendix 4 – Timetable Purfleet Children’s centre

Opening times for Purfleet Children Centre
Monday to Friday 9.00am – 5.00pm
Diana O’Brien 07833 049477
Sharon Cullen 07920 084251

INTRODUCTION TO CUSTOMER SERVICE
City & Guilds Certificate
2 WEEK COURSE 10.00AM – 2PM
12-16 October 2015 & 19-23 October 2015
Please phone Purfleet Children Centre
01708 863739
To secure a place!

Under Ones Fun – 1.30pm – 2.30pm

We are recruiting for PATCH Parenting courses.
Starting 14th September 2015
If you are interested in this course then please contact us.

Facebook Purfleet Children Centre

Contact us at:
Centurion Way
Purfleet
Essex
RM19 1PF
Essex
01708 863739

SureStart