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HEALTH & WELLBEING BOARD SUPPLEMENTARY AGENDA

29 January 2025

The following report is attached for consideration and is submitted with the agreement of the Chairman as an urgent matter pursuant to Section 100B (4) of the Local Government Act 1972

7 PRIORITIES FOR A REFRESHED JLHWS (Pages 3 - 18)

Zena Smith
Head of Committee & Election Services

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Suggested Priorities for a refreshed Joint Local Health and Wellbeing Strategy

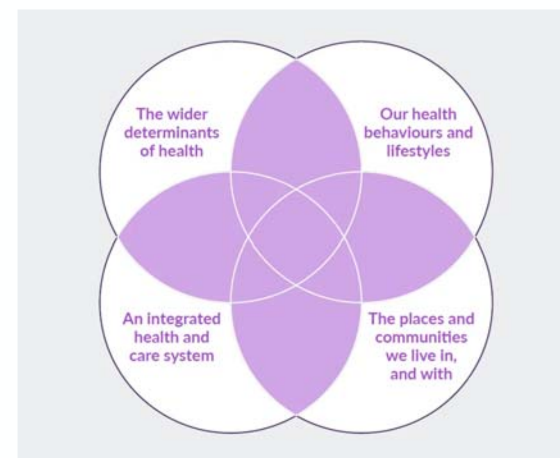
Presentation to Havering Health and Wellbeing Board

29 Jan 2025

Mark Ansell, Director of Public Health

Principles to consider when deciding on priorities

- Consider the life course approach and the 4 pillars underpinning population health
- With particular focus on the long term and wider determinants - to complement but not duplicate HPBPB
- Also avoid duplication of priorities held by other partnerships
- Have a manageable number of priorities
- Ensure there is a forum and staff resources to develop detailed implementation plans
- Any others?



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	Recommendations from Happy Health Lives		Plus recommendations from Adults Delivery Board
1	adolescents' mental health and wellbeing strategy	10	Increase cancer survival*
2	early intervention to improve school readiness	11	Improve identification and diagnosis of CVD and risk factors *
3	reduce self-harming among young people	12	Improve management and monitoring of LTCs*
4	improve transition from child-focused to adult services *	13	Support people with MH problems to live fulfilling, meaningful and healthy lives
5	reduce inequalities in educational outcomes	14	Reduce waiting times for planned care*
	Recommendations from current JHWS	15	Same day access to urgent care/improved experience ED*
6	Improve employment and wage levels to reduce poverty **	16	Use PHM to reduce need for / cost of care packages and improve outcomes achieved where necessary*
7	Reduce homelessness and harm caused	17	Empower older people to live independently
8	Reduce obesity and harm caused	18	Improve uptake of adult immunisations *
9	Reduce tobacco harm including from vapeing	19	Improve diagnosis and support of dementia
		20	People are supported in last stages of life*

- Primarily about improvement of health and care services and therefore within HPBPB remit?

** Also addressed by economic development / regeneration partnerships

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	wider determinants	lifestyles and behaviours	communities we live in	high quality health and care services
start well	1,2,5,6,7, 8, 9	1, 8, 9	1, 2, 3, 5, 8, 9	1, 2, 3,4, 5, 8
live well	6, 7, 8, 9	6, 7, 8, 9	6, 7, 8, 9	6, 7, 8, 9
age well	13, 17	13	13, 17, 19	12, 13, 17, 19
die well				17

NEL Integrated Care Strategy in a nutshell

Partners in NEL have agreed a collective ambition underpinned by a set of design principles for improving health, wellbeing and equity.

To achieve our ambition, partners are clear that a radical new approach to how we work as a system is needed. Through broad engagement including with our health and wellbeing boards, place based partnerships and provider collaboratives we have identified six cross-cutting themes which will be key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

We know that our people are key to delivering these new ways of working and the success of all aspects of this strategy. This is why supporting, developing and retaining our workforce, as well as increasing local employment opportunities is one of our four system priorities identified for this strategy.

Stakeholders across the partnership have agreed to focus together on four priorities as a system. There are of course a range of other areas that we will continue to collaborate on, however, we will ensure there is a particular focus on our system priorities and have been working with partners to consider how all parts of our system can support improvements in quality and outcomes and reduce health inequalities in these areas.

We recognise that a well-functioning system that is able to meet the challenges of today and of future years is built on sound foundations. Our strategy therefore also includes an outline of our plans for how we will transform our enabling infrastructure to support better outcomes and a more sustainable system. This includes some of the elements of our new financial strategy which will be fundamental to the delivery of greater value as well as a shift in focus 'upstream'.

Critically we are committed to a relentless focus on equity as a system, embedding it in all that we do.

Our integrated care partnership's ambition is to
"Work with and for all the people of north east London
to create meaningful improvements in health, wellbeing and equity."

- Improve quality & outcomes
- Deepen collaboration
- Create value
- Secure greater equity

6 Crosscutting Themes underpinning our new ICS approach

- Tackling **Health Inequalities**
- Greater focus on **Prevention**
- Holistic and **Personalised** Care
- **Co-production** with local people
- Creating a **High Trust Environment** that supports integration and collaboration
- Operating as a **Learning System** driven by research and innovation

4 System Priorities for improving quality and outcomes, and tackling health inequalities

- Babies, Children & Young People
- Long Term Conditions
- Mental Health
- Local employment and workforce

Securing the foundations of our system

Improving our **physical** and **digital infrastructure**
Maximising **value** through collective financial stewardship, investing in prevention and innovation, and improving sustainability
Embedding **equity**

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Next steps

Within next fortnight, Board members are asked to

- **Confirm / amend principles in Slide 2**
- **Confirm / amend priorities suggested for inclusion in Slide 4**

We will draft a version of the JLHWS for consideration at our next meeting with the intention of going to public consultation in Q1 of 25/26.

Live well: Cancers

Key Findings	Recommendations	Responsible Organisation (s)	Monitoring
• A very high percentage and number of the **cancers of the lung, colon and rectum were diagnosed at late stages** (3 and 4) in 2019-21 and a high percentage of the cancers of oesophagus, pancreas, stomach and oral cavity are diagnosed at late stages.	To improve early diagnosis through further improving screening coverage, raising awareness of cancers with highest numbers of late diagnosis among the residents (lung, colorectal, upper GI, prostate), working with GPs to review opportunities for early detection and appropriate referrals, and strengthening diagnostic capacity including the use of the RDC (rapid diagnostic clinic) and targeted lung health check.	Havering Cancer Leadership Group working with NELCA (Lead: Ameesh Patel, Tha Han)	Quarterly updates on • Cancer screening • Progress on TLHC 6-montly update on • GP referrals for 2WW and conversion • RDC data for Havering patients (if available) • Cancer awareness work in Havering by NELCA
• **Mortality rate from all cancers** in Havering (238.0) in 2022 was **higher than London average** (226.8). • Mortality rate (45) from **lung cancer** in Havering is higher than both London average (39) and England (42.8) in 2020-22 period. • Mortality rate from breast cancer, prostate cancer and oesophageal cancer in Havering were significantly higher than London averages. • **Under 75 mortality rate from cancers** (119.7) in Havering in 2022-22 3 year-range is **higher than London average** (111.4). Under 75 mortality rate of colorectal cancer in Havering in 2020-22 period (12.8) was higher than both London (10.6) and England averages (11.9).			

Live well: Long Term Conditions 1

Key Findings	Recommendations	Responsible Organisation (s)	Monitoring
• 7.9% of Havering residents (17,141 residents) were recorded to have diabetes. It is estimated that **5,265 residents could be having diabetes without knowing it.** • Around **14,000 residents currently do not know they have hypertension** and cannot stop the consequences. • Atrial fibrillation detection and management has led to reduction in stroke admissions. Despite the prevalence of older population, Hospital admissions from stroke in Havering in 2022/23 was 120.5 per 100,000 (300 in number from 365 in 19/20) which was lower than 168.36 in England.	To strengthen the community infrastructure and awareness to improve the detection of hypertension, obesity, atrial fibrillation and prediabetes and to use transformation and innovation (which includes digital health/medical technologies) to speed up diagnosis and management of LTCs.	ICB, LTC Group (Farah Elahi)	6-monthly progress updates • AF stats* • NDPP data • Relevant progress update (*weakness in data qly) Annual report on new diagnoses • HTN • Diabetes

Live well: Long Term Conditions 2

Key Findings	Recommendations	Responsible Organisation (s)	Monitoring
Hospital admissions from uncontrolled LTC overall in Havering was about England average but previously it has been better than England average. e.g., Hospital admissions rate for diabetes in 2023 was 218.00 per 100,000. The **number of admissions** 577 was **an increase** from 385 in 2020. Long-COVID: **L**ong COVID - the results of surveys carried out by Healthwatch Havering, working with Public Health Havering, NELFT, Havering North PCN and others, show that there is a need for support for those affected by Long COVID. Patients can be referred to the NELFT Long COVID clinic where clinically indicated but the opportunity for setting up Peer Support Groups is being explored.	To review and improve where necessary the current approach to the delivery and monitoring of long-term conditions (e.g., diabetes, long-covid) to ensure access to effective care, self-management and peer support.	ICB, LTC group (Farah Elahi)	6-monthly updates on the LTC outcomes data • Hospital admissions from diabetes, MI, chronic respiratory, stroke (trend, standardised rate and benchmarking if possible) • ACSC admissions • Annual key QOF indicators

Live well: Mental Health

Key Findings	Recommendations	Responsible Organisation (s)	Monitoring
• In 2023/24, the number of adults who are registered to a GP practice in Havering and have depression or anxiety disorder is 17% (49,665). • According to GP records, 0.8% of the Havering adult population (2,073) have a SMI.	• Support individuals with mental health conditions to live, fulfilling, meaningful and healthy lives, and ensure equitable access to mental health services, and doing so in a timely manner to prevent deterioration of mental health to crisis presentations	Place Community MH Board (Rebecca Cooper)	6-monthly Progress Update • Crisis café milestones • Talking Therapies outcomes and waiting times data • Havering use of Mental health Direct • Plus annual data Physical health checks and employment

Live well: Planned Care, Urgent and Emergency

Key Findings	Recommendations	Responsible Organisation (s)	Monitoring
• Waiting time for planned care has even more prolonged due to the pandemic and the backlog. • In 2012, among those aged 45 and over more than 10% have osteoarthritis of hip and 18% osteoarthritis of knee in Havering. • In 2012, 9% of the population has long-term back problem in Havering.	To support implementation of plans developed by the BHR Planned Care Transformation Board to reduce waiting times for planned care.	Planned Care Group Lead TBC – NEL wide	Quarterly updates • Waiting list (total, subdivisions TBC by clinical leads)
• A&E attendance and emergency hospital admissions continue to increase. • Demand on unplanned care takes resources away from planned care. • In terms of ethnicity among those who attended A&E in 2023/24, the rate varies by ethnicity. • Hospital admissions from Ambulatory Care Sensitive Conditions (ACSCs) overall in Havering (89.9/100,000) was about England average (91.9) but previously it has been better than England average.	To Enable same day access to urgent care in the community whenever possible, and, if a visit the Emergency Department is needed, to provide a positive experience	ICB UEC Group (Kirsty Boettcher)	Quarterly updates • Progress on Integrated Neighbourhood Teams • Data on ED and UTC use broken down by age group, sex and ethnicity against the background pop. • Progress on engagement with LAS and BHR • Joy App data (Alt Care Pathway)

Live well and Age Well: Social Care

Key Findings	Recommendations	Responsible Organisation (s)	Monitoring
• 1,368 residents age 18-64 were receiving the support of Havering Adult Social Care. 733 were male and 635 were female. Altogether they were receiving 2,043 care packages. Both the demand and complexity are rising. • As of April 2024, **30 residents in mental health residential or nursing placements** and 136 **residents** were under residential or nursing **learning disability placement**s. More than 320 clients with LD or MH were in direct payment and around 250 were receiving supported living and 84 were receiving Homecare placement. • Average **residential home placement cost has risen by +£167 per wee**k than in 2022-23, and **supported living by +£200 per week**. (due to the higher complexity of need and other factors) • 4,483 residents age 65+ were receiving the support of Havering Adult Social Care. Only 1,504 were male and 2,979 were female. Altogether they were receiving 6,655 care packages from LBH-ASC. • In 2021/22, 282 residents of age 65+ were admitted permanently to residential or nursing care homes. This was the third highest number in London and equivalent to a rate of 606 per 100,000 **permanent admissions to care homes which is significantly above the London rate of 401 and England rate** of 539 per 100,000 over 65+ population. • Among people over 65 who needs a placement (3,160), most were under **homecare** placements (1,697), which has the lowest cost per	Population health management (PHM) approach is used to identify the avoidable risk factors for learning disability and other care packages; and to recommend most effective mental health and physical support interventions, including the use of technology for better and efficient care.	Andrew Sykes, Tom Fowler, Laura Neilson, Tha Han	6-monthly progress updates and share findings

Age Well (1)

Key Findings	Recommendations	Organisations	Monitoring
The prevalence of **osteoporosis** among those 50 years and over in Havering in 2022/23 (0.9%) was **higher than London** average (0.61%). In 2022/23, there were 255 hip fractures in people aged 65 and over in Havering. This is a rate of 508.4 per 100,000 which is similar to London average (502.32 per 100,000).The rate of hip fractures in people aged 65 and over was higher among **women** (61[illegible].0 per 100,000) than men (330.0 per 100,000). (need more info to prevent locally.)	To empower older people to live independently in their own homes with appropriate care and support and to facilitate social connectivity by: • Developing a multidisciplinary approach around PCNs • Raising the importance of social connectivity, nutrition, physical activity, polypharmacy, and falls prevention • Frailty prevention and intervention incl. St George's hub • Prevention of first time falls and better use of technology for prevention • Reablement pathways and innovate around earlier intervention	Ageing Well subgroup (Kirsty Boettcher) Social prescribers group? Live Well Havering Partnership group	6-monthly updates • Frailty unit milestones and activities • Falls and fractures data (6M or Annual), falls conveyances Annual • Emergency admissions, readmissions and length of stay data for older people • The proportion of older people living at home 6 months following hospital discharge
• Havering has around **8,061 residents who were recorded to be frail.** Someone with moderate frailty has three times risk of urgent care utilisation, death and care home admission than another who is not frail. • The estimated number of people in Havering aged 65 and over **unable to manage at least one activity on their own** is estimated to be 9,408 (19,478 per 100,000) - the **highest** in London (alongside Bexley).			
Flu vaccine coverage (65+) 2023/24 – 72.7% (**below England average** 77.8%); Shingles vaccine coverage 57.4% (2022/23) – better than England	Build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu, covid, pneumococcal and zoster vaccines.	PCNs/ Havering Health	6-monthly updates

Age Well (2)

Key Findings	Recommendations	Responsible Organisation (s)	Monitoring
• There are an **estimated 3,121 people with Dementia in Havering**. In 2024, the number of people **diagnosed is 1,757.** Havering's diagnosis rate is currently **56.3%**, which is below both London and England rates. • (A further 335 people need to be diagnosed to meet the national diagnosis target of 67%.)	To maintain efforts to further increase the completeness of dementia diagnosis, and improve access to the information and support for patients and their families.	Havering Dementia Operational Working Group working with NELFT and Admiral nurses (Kirsty Boettcher)	Quarterly updates: (Dementia strategy implementation) • Meet national diagnosis target of 66.7% (NHSE)

Die Well

Key Findings	**Recommendations**	**Responsible Organisation (s)**	**Monitoring**
• At Saint Francis Hospice in Havering, in 2024, 61% of the service users were related to cancer, and 39% were with dementia, frailty, COPD, heart failure, Parkinson’s disease and other neurological conditions. 85.7% were White, 5.09% Asian, 3.77 Black and 5.47% were others. 2,000 people were cared for in the past year, of which 1,238 were at home, in hospital and in care homes. • The percentages of people dying at hospitals across all age groups were significantly lower than London averages. In addition, the percentages of people dying at home across all ages were marginally lower than London averages in 2022. Nonetheless, the percentages of the residents dying at care homes across all ages were significantly higher than London average. • The percentages of those who died at hospices for age groups under 75 years were higher than London and England averages. Nonetheless, people had made decision to be in the hospice for their place of choice for death. • Urgent Care Plan being set up for EOLC. Also working with community pharmacies.	People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people, and place	EOL Group (Kirsty B, Jan S, Tes Smith)	6-monthly or Annual updates • Place of death data • Percentage of older people (age TBC) who die within 7 days of an emergency hospital admission

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