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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 27 November 2019	Town Hall

Members: 16, Quorum: 6

BOARD MEMBERS:

Elected Members:	Cllr Robert Benham Cllr Jason Frost (Chairman) Cllr Damian White Cllr Nisha Patel
Officers of the Council:	Andrew Blake-Herbert, Chief Executive Barbara Nicholls, Director of Adult Services Mark Ansell, Interim Director of Public Health Robert South, Director of Children's Services
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) Ceri Jacob, Managing Director, BHR CCGs Steve Rubery. Director of Commissioning & Performance, BHR CCGs
Other Organisations:	Anne-Marie Dean, Executive Chairman, Healthwatch Havering Jacqui Van Rossum, Executive Director Integrated Care, NELFT Fiona Peskett, Director of Provider Alliances, BHRUT James Moore, Head of Delivery, NHS England

For information about the meeting please contact:
Luke Phimister 01708 434619
luke.phimister@onesource.co.uk

What is the Health and Wellbeing Board?

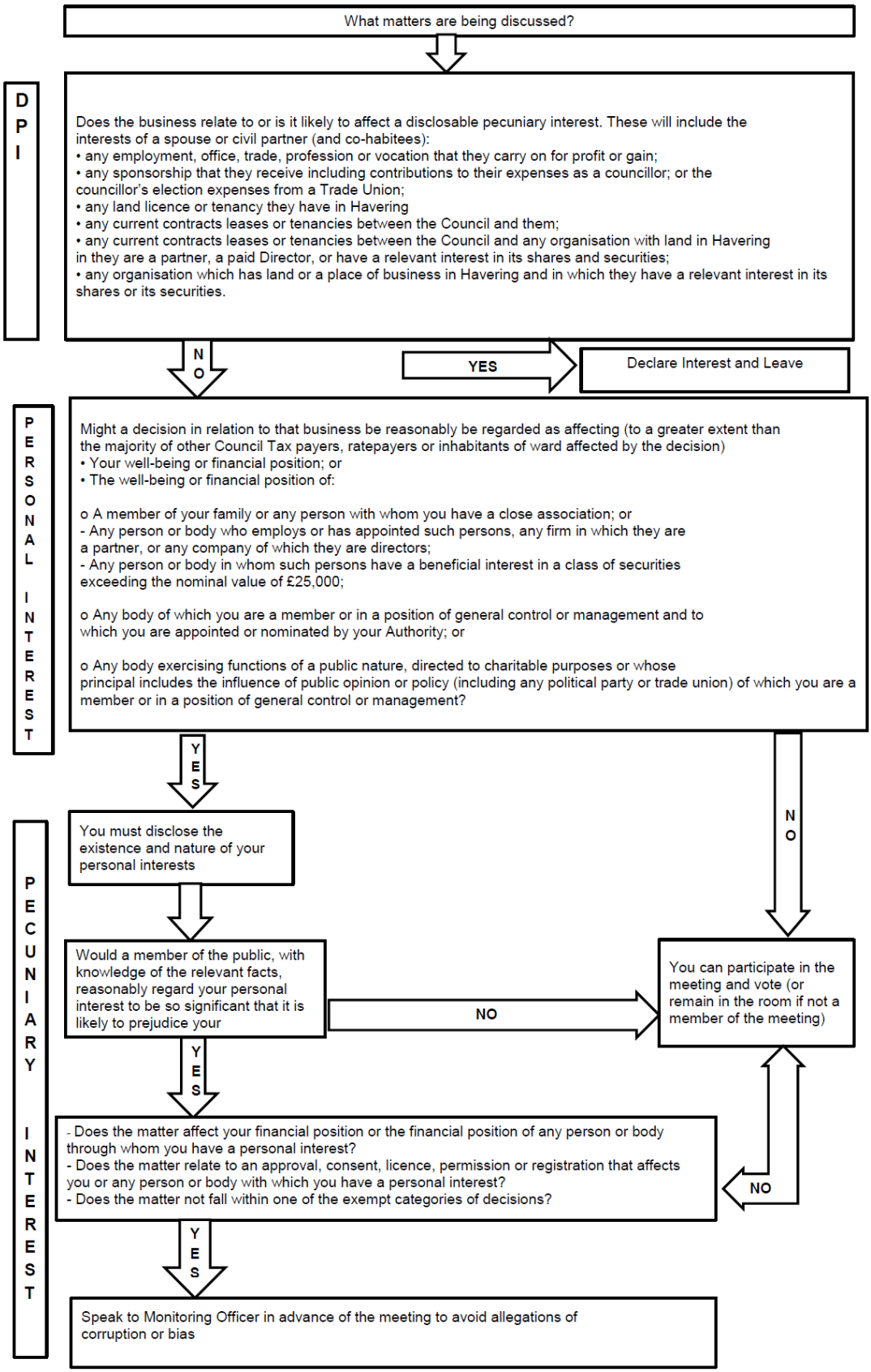
Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information

DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF



AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2 APOLOGIES FOR ABSENCE

(If any) – receive

3 DISCLOSURE OF INTERESTS

Members are invited to disclose any interest in any of the items on the agenda at this point of the meeting.

Members may still disclose any interest in any item at any time prior to the consideration of the matter.

4 MINUTES AND ACTION LOG (Pages 1 - 8)

To approve as a correct record the minutes of the Committee held on 25th September 2019 and to authorise the Chairman to sign them.

Action log is also attached.

5 LOCAL AREA CO-ORDINATION (Pages 9 - 22)

Report and cover sheet attached.

6 COMPENDIUM CONNECTORS MODULE: SOCIAL PRESCRIBING (Pages 23 - 30)

Report and cover sheet attached.

7 TOBACCO HARM REDUCTION DRAFT STRATEGY (Pages 31 - 42)

Report and cover sheet attached.

8 ANY OTHER BUSINESS

9 DATE OF NEXT MEETING

The next meeting will take place on 21st January 2020.

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Town Hall
25 September 2019 (1.00pm - 2.30 pm)

Present

Elected Members: Councillors Jason Frost (Chairman), Robert Benham and Nisha Patel.

Officers of the Council: Barbara Nicholls, Director of Adult Services, Mark Ansell, Joint Director of Public Health, Robert South, Director of Children's Services.

Havering Clinical Commissioning Group: Dr Atul Aggarwal Chair of Havering Clinical Commissioning Group, Maurice Sanomiiv Clinical Director Havering Clinical Commissioning Group and Sharon Morrow Chief Operating Officer Barking and Dagenham Clinical Commissioning Group

Other Organisations: Anne-Marie Dean, Executive Chairman, Healthwatch Havering and Mark Scott, East London Health & Care Partnership. Fiona Peskett, Director of Provider Alliances BHRUT

Also Present: Elaine Greenway, Public Health Consultant, Jordanna Hamberger and Jeremy Kidd Barking, Havering and Redbridge Clinical Commissioning Group:

The Chairman reminded Members of the action to be taken in an emergency.

27 **APOLOGIES FOR ABSENCE**

Apologies were received for the absence of Councillor Damian White, London Borough of Havering; Andrew Blake-Herbert, Chief Executive, London Borough of Havering; Jacqui Van Rossum, Executive Director Integrated Care (London) North East London Foundation Trust and James Moore, Head of Delivery, Improvement and Transformation NHS England.

28 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

29 **MINUTES, ACTION LOG AND INDICATOR SET**

The minutes of the meeting of the Board held on 24 July 2019 were agreed as a correct record and signed by the Chairman.
The following items were noted in respect of the action log:

10 – Members will be presented with feedback from the consultation on the draft strategy at a workshop session – see agenda item 5

11 – AA advised that Engagement with local people is part of the PCN development plan and they will receive some funding to support this.

12 –AA advised HWB members about details of the selection process for the appointment of an accountable Clinical Director of the Primary Care Networks: The Network Contract Directed Enhanced Service, Guidance for 2019/20 in England – May 2019, set out the following guidance around appointment of Clinical Directors (page 6):

Appointment of Clinical Director
It will be the responsibility of the PCN to agree who their Clinical Director will be. The selection process will be for the PCN to determine but may include:

- Election - nomination and voting;
- Mutual agreement between the members;
- Selection – via application and interview for example; or
- Rotation within a fixed term (this could equally apply against the above processes).

The Clinical Director is to be agreed by the PCN by 15 May 2019 and their name submitted to the commissioner as part of the Network Contract DES registration timetable.

The Primary Care Networks themselves were responsible for the recruitment to the Clinical Director role, as per the guidance.

Source: https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-guidance-2019-20-v2.pdf

-
- 13 – AA advised that a briefing about Primary Care Networks would be provided as part of Agenda item 7.

Members received the Health and Wellbeing Board indicator set which provided an overview of the health of residents and the quality of care services available to them.

30 **HEALTH AND WELLBEING STRATEGY CONSULTATION**

The report before the Board updated members on consultation update of the Health and Wellbeing Board Strategy.

Members noted that Health and Wellbeing Board members attended two workshop sessions to consider priorities for a new Health and Wellbeing Strategy for 2019/20 – 2023/24 which led to a draft strategy being produced. The Board agreed that a public consultation should take place over the

summer to seek the views of organisations and local residents. All Health and Wellbeing Board members agreed to promote the consultation to their employees, volunteers and clients.

The consultation was subsequently launched on 1 August 2019 and closed on 28 August. The online version was published on Citizen Space, a web-based consultation tool. 218 responses were received.

The Board would be attending a further workshop session to consider feedback from the consultation and agree the priorities for the final version of the strategy.

Members agreed that, following the workshop session when feedback from the consultation would be considered and the priorities for the final version of the strategy agreed, Chairman's action may be taken to approve final versions of

(a) the consultation report, and
(b) the Health and Wellbeing Board Strategy 2019/20 – 2023/24

31 HEALTHWATCH ANNUAL REPORT

The Board received The Healthwatch Havering Annual Report which provided a summary of the work of Healthwatch Havering over the last year. The Chairman of Healthwatch Havering explained that although they co-ordinated with neighbouring Healthwatch organisations, their priorities differed. The Chairman recognised the challenges faced by Barking, Havering and Redbridge University NHS Trust and their cooperation to converse openly and share information with Healthwatch.

Highlights throughout the last year included:

- Over 600 service users, carers and relatives contributed by sharing their views and concerns
- Over 590 users followed Healthwatch Havering on Twitter and there had been more than 2,100 people who had visited the website
- 25 Enter and View reports on Hospitals, GPs' Nursing and Residential Homes
- Working with other organisations the service had attended over 110 meetings
- Made 111 recommendations for service improvement

In response to a question relating to Right care, Right place, Right time and GP feedback, it was confirmed to members that feedback had been received and that in time the recommendations would feed down in to the Primary Care Networks.

It was agreed that the improvements that Healthwatch Havering had given to GPs be made available to other groups.

The Board **noted** the Annual Report.

32 PRIMARY CARE TRANSFORMATION PROGRAMME

The report before the Board detailed an update on the Primary Care Transformation Board.

Following the establishment of the three respective Primary Care Strategies for Barking & Dagenham, Redbridge and Havering in May 2016 the BHR Primary Care Transformation Programme Board had been established to oversee implementation of the strategy.

With the coming together of the seven North East London CCGs to form the North East London Commissioning Alliance (NELCA) the system had now moved to a single Primary Care Strategy, which was approved by the BHR CCGs Joint Committee and the BHR Health & Care Cabinet in June 2019.

Following a transformation programme workshop in March 2019 the presentation attached to the report summarized the key elements of the North East London Primary Care Strategy and also set out the draft refreshed BHR Transformation Programme Plan.

The report also highlighted the aspirations for the Primary Care Transformation which included providing accessible, co-ordinated and pro-active care.

The priorities, activities, governance and delivery arrangements of BHR were noted from within the report.

Members noted that there was one federation per borough and that at times they came together to form one collective group to see if there was work that could be carried out cross-borough. It was also confirmed that the federations were a membership organisation.

Members voiced concerns regarding the possible exclusion of elderly residents who did not have mobile devices nor had no access to a phone network as to how they could engage with services. It was felt that the over 50s forum could be a good starting point for engagement with older residents.

The report also highlighted the priorities and activities for 2019/20 and in response to a question Members were advised that all Clinical Director posts had been appointed to.

The Board **noted** the contents of the report.

33 NHS LONG TERM PLAN UPDATE

The report before the Board summarised the East London Health and Care Partnership's development of a response to the NHS Long Term Plan.

The report detailed the background of the Long Term Plan and detailed how the North East London Plan would engage with it. The report also detailed the contents of the response document and concluded with timelines and key dates going forward.

Members noted that once the draft was submitted the Board would be asked for further comments in October. At the same time NHS England would respond with feedback on the draft version which would allow amendments and an update before final submission in November.

Members also noted that engagement event was due to take place on 16 October which would allow further engagement with partners in reviewing the first draft. The event would also provide an initial opening for discussion on how the plan moved from a planning stage to an implementation stage.

The Board **noted** the contents of the report.

34 HEALTH PROTECTION FORUM - ANNUAL REPORT 2018/19

The report before the Board detailed the annual report for Havering's Health Protection Forum.

The Havering Health Protection Forum (HPF) supported the Council Director of Public Health in discharging their duty to protect health and prevent threats to health; by contributing to surveillance and challenge of local health protection arrangements.

The annual report reviewed the priority areas identified in the 2017/18 report; summarised the work of the HPF during 2018-19; and outlined the priorities for 2019-20.

The Board **noted** the report and Members were invited to provide any comments to Elaine Greenway.

Chairman

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Health and Wellbeing Board Action Log (following September 2019 Board meeting)

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner		Date for completion	RAG rating	Comments
	25.09.19	Councillor Jason Frost	Elaine Greenway	The Board to meet to consider feedback from the public consultation on the Health and Wellbeing Board draft Strategy, make agreed amendments to the strategy, and the Chairman to approve (a) final version of the strategy and (b) the consultation report.	27 Nov 19		

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Havering
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HEALTH & WELLBEING BOARD

Subject Heading:	Local Area Coordination
Board Lead:	
Report Author and contact details:	Rebecca Smith Rebecca.amy-smith@havering.gov.uk

The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☐ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☐ Theme 4: Quality of services and user experience

SUMMARY

The attached slides and report detail provide information regarding the development of Local Area Coordination in Havering.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the report and presentation.

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REPORT DETAIL

Background

Havering is developing a new way of providing support and services to local people, based in the community, with individuals and communities at its heart. This is through a concept called 'Local Area Coordination'. Local Area Coordination is an evidence based approach which is currently being implemented in 12 authorities across England and Wales.

We know that people can sometimes feel lost and unsure of where they can get support; the system can be difficult to understand, information can be confusing and services may have eligibility criteria that people in need don't meet. Local Area Coordination seeks to change this, and to empower people and communities to support themselves and one another.

Local Area Coordination aims to make sure that vulnerable people are better supported to find local solutions in their community that improve their lives and allow them to be more independent and resilient as a result. On a wider level, it seeks to promote a different way of delivering services out in the community with a more personalised approach and offers an opportunity to transform systems, policies, and processes.

Local Area Coordination focuses on making connections; connecting people who need support to resources and people within their community who can help. Local Area Coordination also focuses on building up the community, and increasing the community's capacity to support one another.

The approach is led by people called Local Area Coordinators. Local Area Coordinators:

- Are recruited by the community; people who live in the local area chose who they would like to have as their Local Area Coordinator
- Live in the local area; understand what it is like to be a Havering resident, know the community and the people who live there
- Are based in community venues so they are easily accessible to people in the areas they work. They work in small areas so that they can really get to know the community, understand it's needs and the people who live there
- Spend time supporting community building and building their local connections, as well as working with individuals
- Work alongside people to identify practical solutions to problems. They also help people to plan or solve problems as a family or with friends where that makes sense to them

- Try to support local or non-service solutions wherever possible and focus on what the person can do for themselves using their skills and experience; as well as the help that friends, family and the local community can provide
- Are highly skilled individuals from a variety of backgrounds, with different skill sets
- Can work with anyone; there are no set criteria for getting support from a Local Area Coordinator

We are working in partnership with Community Catalysts to develop the approach in Havering. Community Catalysts have worked with a number of Local Authorities (both in the UK and overseas) to implement Local Area Coordination and manage the Local Area Coordination network which brings together the 12 areas across the country which are delivering Local Area Coordination.

Outcomes

Independent evaluations of Local Area Coordination in other areas have demonstrated the following outcomes for systems and people:

System outcomes	For people and communities
• Simplified system • Integrated, cross-system collaboration • Shared system wide outcomes Reductions in: • Visits to GP surgery and A&E • Dependence on formal health and social services • Referrals to Mental Health Team & Adult Social Care • Safeguarding concerns, people leaving safeguarding sooner • Evictions and costs to housing • Smoking and alcohol consumption • Dependence on day services • Out of area placements – bringing people home	• Increased informal and valued supportive relationships – reducing isolation • Increasing capacity of families to continue in caring role • Greater confidence in the future • Better knowledge & connection with community • Improved access to information – choice and control, • Better control over own health • Better resourced communities, • Support into volunteering, training and employment, • Preventing crises through early intervention, and supporting people who do not meet statutory eligibility criteria • Improved access to specialist services

Social Return on Investment

Case example - Thurrock Local Area Co-ordination – Social Return on Investment Report by Socialvalue.org reported at £3.65 for every £1 spent

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The aim of Local Area Coordination and the use of coordinators based in the community are to ensure vulnerable people are better supported to find local solutions that enable them to build a 'good life' and are less dependent on other services as a result. The complexity of need met by LAC is high. The majority of people supported were found to have mental health issues of varying degrees and many of the individuals suffer from isolation.

The detailed evaluation of the Thurrock scheme sets out the methodology for measuring the impact of the collective investment on individuals themselves, their families, the wider community and also referrals and access to services such as GP's, social care, housing and mental health services over a 3 year period. The diagram below isolates more tangible expected changes in behaviour against demand for council provision; the following table shows how the 3-year financial benefit has been calculated for the delivery of outcomes to individuals. A small sub-set of benefits for the case for on-going investment were:

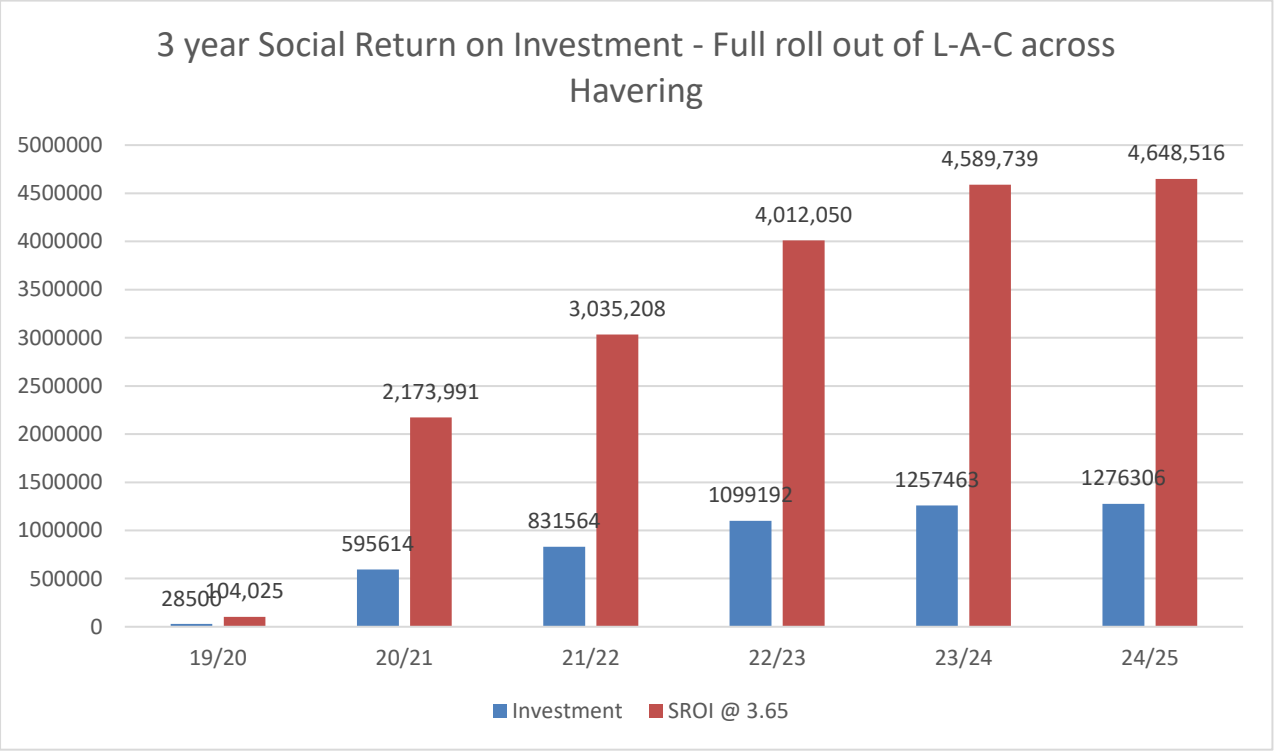
- 203 assessments avoided at a cost of £510 per assessment = £103,530
- 83 people diverted from support for depression and anxiety = £456,417.
- 88 people diverted from traditional day services = £24,534.
- 51 complex evictions avoided = £371,076
- 83 people diverted from Community Health Teams = £127,488
- 37 people supported in mental health crisis with cost avoidance =£1,108m
- 51 people diverted from their GP surgery = £8,384
- 110 avoided ambulance and A&E attendances = £181,789

In total over the 3 year period, the avoidable/avoided costs were estimated to be £2,966,649

Havering Social Return on Investment

Rolling out Local Area Coordination in Havering has been modelled to show the amount of investment required and the potential Social Return on Investment. This is further illustrated in the chart overleaf.

Year	Investment	SROI @ 3.65
19/20	28,500	104,025
20/21	595,614	2,173,991
21/22	831,564	3,035,208
22/23	1,099,192	4,012,050
23/24	1,257,463	4,589,739
24/25	1,276,306	4,648,516



Funding has so far been secured from:

- Adults Social Care
- Public Health
- BHR CCG

Other partners are exploring investment opportunities.

Governance

A Leadership Group has been established to oversee the development of Local Area Coordination in Havering. Membership of this group is composed of key figures from each of the services / organisations which are bought into implementing the approach in Havering. The group has representation from:

- Adult Social Care
- Children's Social Care
- Commissioning
- Public Health
- Housing
- Culture / Libraries
- Community Development
- Community Safety

- Clinical Commissioning Group
- GP Confederation
- North East London NHS Trust
- Metropolitan Police
- Department of Work and Pensions

This Leadership Group meets monthly and is accountable for the success of Local Area Coordination, making decisions on the implementation, and ensuring resources are available to deliver the project effectively.

Co-production

We are working with the community to develop and deliver this approach, and residents themselves will decide what Local Area Coordination will look like in their area. The recruitment of Local Area Coordinators will be citizen led. Community steering groups will be set up in each area in which Local Area Coordination is to be introduced.

Test and Learn Sites

To test the delivery of Local Area Coordination in Havering and to develop an understanding of the kinds of outcomes that can be achieved here, we are developing two test and learn sites in the borough. The intention is to roll out the approach in subsequent sites across the borough using learning from the test sites. The two test areas that have been identified are:

- Harold Hill
- Rainham / South Hornchurch

These areas have been identified for several reasons:

- Stakeholders have identified these areas as priorities due to need, and receptiveness to community based initiatives
- Community hubs are being developed in these areas; Local Area Coordinators will be key facilitators of Community Hubs, and will be introduced to local people and groups through these hubs
- These areas are among the first in which the council's regeneration programme will be delivered

Milestones

The recruitment of Local Area Coordinators for Harold Hill is due to start in December 2019, with the aim of having three Local Area Coordinators in post by March 2020. The recruitment for Rainham / South Hornchurch is due to start in February 2020 with the aim of having a subsequent three Local Area Coordinators in post by May 2020.

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IMPLICATIONS AND RISKS

Doing things differently does cause uncertainty for many stakeholders and therefore there is need for systematic and well planned approaches that involve and communicate effectively with relevant groups.

Capacity is an issue across services and the ability to engage in doing things differently can be impacted. If we do not resource appropriately and fully engage in the project the benefits will not be realised.

Leadership and design are key aspects of successful models and if we do not secure both effectively, this will significantly impact the likely success of the model

BACKGROUND PAPERS

Attached presentation

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Havering
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Local Area Coordination
Health and Wellbeing Board
27th November 2019

Background

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A NEW APPROACH FOR HAVERING

Local Area Coordination is a well-evidenced way to support people of all ages who are dealing with complex situations in their lives. This may include people who are disabled, have mental health needs, are living with a long-term condition or are older.

EMBEDDED IN COMMUNITIES ACROSS HAVERING

We will be recruiting highly skilled people as Local Area Coordinators who will work in small geographical areas and build strong relationships with the people, organisations and businesses in that area.

CONNECTED AND INCLUSIVE COMMUNITIES

Local Area Coordinators help people to draw upon their own strengths and those around them to live the life they want, connected to their community; and build resilient and more welcoming communities.

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The Three Levels of Local Area Coordination

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Outcomes and impacts evidenced in other areas

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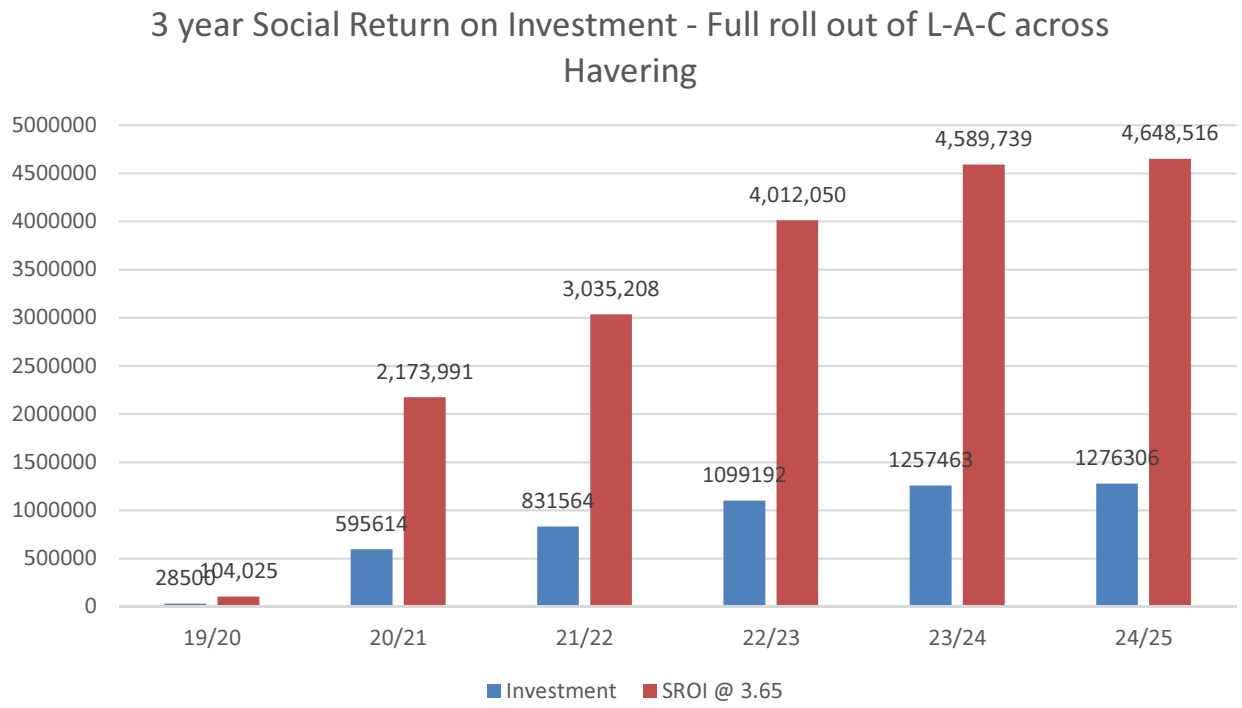
System outcomes	For people and communities
• Simplified system • Integrated, cross-system collaboration • Shared system wide outcomes Reductions in: • Visits to GP surgery and A&E • Dependence on formal health and social services • Referrals to Mental Health Team & Adult Social Care • Safeguarding concerns, people leaving safeguarding sooner • Evictions and costs to housing • Smoking and alcohol consumption • Dependence on day services • Out of area placements – bringing people home	• Increased informal and valued supportive relationships – reducing isolation • Increasing capacity of families to continue in caring role • Greater confidence in the future • Better knowledge & connection with community • Improved access to information – choice and control, • Better control over own health • Better resourced communities, • Support into volunteering, training and employment, • Preventing crises through early intervention, and supporting people who do not meet statutory eligibility criteria • Improved access to specialist services

Social Return on Investment

Rolling out Local Area Coordination in Havering has been modelled to show the amount of investment required and the potential Social Return on Investment.



Delivering Local Area Coordination

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HEALTH & WELLBEING BOARD

Subject Heading:	Havering Volunteer Centre – Compendium Connectors Module
Board Lead:	
Report Author and contact details:	Shelley Hart, Chief Executive Officer Havering Volunteer Centre Community Reach House 32-34 The High Street Romford RM1 1HR

The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy

- ☐ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☐ Theme 4: Quality of services and user experience

SUMMARY

HVC has just been awarded a seed fund from the Mayor of London's team London small grants programme 2019/20 – this fund's aim is to reduce loneliness and social isolation through social prescribing.

The seed funding is to launch the Compendium Connectors social prescribing module within the London borough of Havering with the beneficiaries being those who seek primary medical care and/or who are socially isolated with low level mental health or social needs.

With thanks to the Mayor of London we are able to establish the module but we know the demand for this service in Havering is going to be far greater than this fund allows therefore we are looking to establish a long term plan to be able to effectively roll out a Borough wide sustainable module.

RECOMMENDATIONS

To establish a module that can be rolled out Borough wide ensuring that local needs are met, non-medical related pressures are relieved from NHS services and be an example to other London Boroughs.

REPORT DETAIL

Social prescribing module launch for the London Borough of Havering, as set out in accompanying presentation.

IMPLICATIONS AND RISKS

Demand for service being high whilst establishing the module without prospect of future investment of provisions.

BACKGROUND PAPERS

None

HAVERING VOLUNTEER CENTRE

SOCIAL PRESCRIBING MODULE

HVC IS THE HEART OF THE VOLUNTARY SECTOR

WHAT IS HVC'S VALUE?

$$V_{(VALUE)} = \frac{Q_{(QUALITY)} + S_{(SERVICE)}}{\$_{(COST)}}$$

WHAT IS HAVERING VOLUNTEER CENTRE?

4000 Volunteers

5000+ Referrals

2735 Placed

273 Employed

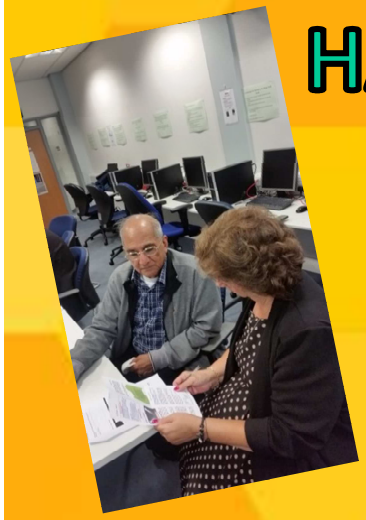
£12,942,020

Social Prescribing

Empowering individuals, building communities

HOW DOES SOCIAL PRESCRIBING WORK?

HVC & SOCIAL PRESCRIBING?

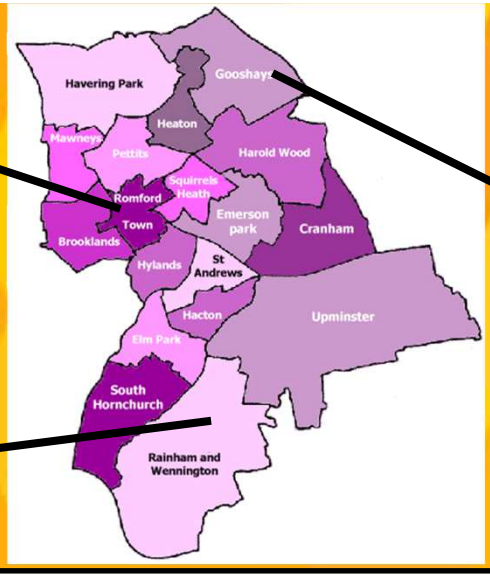


HAVERING VOLUNTEER CENTRE'S COMPENDIUM CONNECTORS

SUPPORTED BY

MAYOR OF LONDON

ROMFORD TOWN



HAROLD HILL

RAINHAM

HAVERING VOLUNTEER CENTRE'S COMPENDIUM CONNECTORS MODULE

SUPPORTED BY

MAYOR OF LONDON

Social Prescribing

Empowering individuals, building communities

CREATING A SOCIALLY CONNECTED HAVERING VIA THE COMPENDIUM CONNECTORS MODULE

HAVERING VOLUNTEER CENTRE'S COMPENDIUM CONNECTORS MODULE

SUPPORTED BY

MAYOR OF LONDON

Working in partnership across Havering to take social prescribing to the next stage and make our borough a model for others.

A community where social prescribing services can be accessed easily by all residents , with provisions being delivered centrally and to a high standard

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HEALTH & WELLBEING BOARD

Subject Heading:	Draft Tobacco Harm Reduction Strategy
Board Lead:	Dr Mark Ansell, Director of Public Health
Report Author and contact details:	Elaine Greenway, Public Health Consultant Elaine.greenway@havering.gov.uk

The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☒ Theme 4: Quality of services and user experience

SUMMARY

The draft tobacco harm reduction strategy is presented to the Board for consideration as (a) an exemplar for how future strategies might be presented to Health and Wellbeing Board, and (b) as an outline approach for reducing prevalence of smoking, as set out in the draft Health and Wellbeing Strategy.

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RECOMMENDATIONS

(a) Exemplar

The draft tobacco harm reduction strategy is presented primarily as an exemplar of content to be included in future strategies that are developed to deliver against the Board's priorities. It is recommended that strategies should:

- **Describe between 4 and 12 key indicators of success**, which could be a combination of long term outcomes (the Tobacco Control Strategy indicators are from the Public Health Outcomes Framework), and shorter/medium term measures (possibly service level). Updates on progress against these indicators should be included in annual reports to the Board
- **Summarise information about the partnership** that will be formed to deliver the strategy
- **Set out approximately four milestones for the year ahead** – these will be included in a dashboard that will be presented to the Board at each meeting. Authors to provide RAG updates for each HWB meeting (and short commentaries in the case of red /amber ratings)

Recommendation 1: The Board is invited to discuss the above, and agree the core content of future strategies that will be developed to deliver the Board's priorities.

(b) Health and Wellbeing Board Priority: Reduce prevalence of smoking in adults

The draft Tobacco Harm Reduction Strategy is also presented as an outline of the approach proposed to reduce prevalence of smoking in adults (and reduce harms of tobacco) which is one of the priorities of the draft Health and Wellbeing Strategy.

Recommendation 2 The Board is asked to agree the tobacco harm reduction strategy approach

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REPORT DETAIL

Further detail included in accompanying document

IMPLICATIONS AND RISKS

Not applicable

BACKGROUND PAPERS

None

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Havering Health and Wellbeing Board

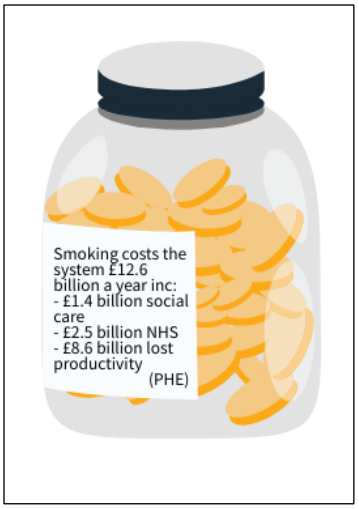
Draft Tobacco Harm Reduction Strategy

2019-23

Introduction

Despite rates having reduced over recent years, smoking remains the biggest cause of preventable deaths and the cause of long term health problems for smokers and those exposed to second-hand smoke. Apart from the obvious impact this has on individuals and families, the harms caused by smoking tobacco place extra pressures on health and social care services, damages the environment, negatively impacts productivity in the workplace, and the trade in illegal cigarettes also fuels criminal activity.

The Health and Wellbeing Board recognises that tackling the problem of smoking requires system-wide changes and action. By making it a Board priority, this shows that individual members are committed to working together and with partners, in the belief that, through concerted and united efforts, it will be possible to create the right conditions for a smokefree generation of healthier and more prosperous residents.



Aim

The aim is for the borough to raise a smokefree generation by

- ✓ achieving a smokefree pregnancy for all, recognising that every child deserves the best start in life
- ✓ stopping children from taking up smoking, as it is mostly in childhood that smoking addictions are formed
- ✓ reducing smoking prevalence in adults, paying particular attention to those groups where smoking rates are highest; benefiting individuals that quit and also lowering prevalence and shifting cultural norms in favour of smoke free living
- ✓ protecting the health of non-smokers, by reducing children and adults exposure to second-hand smoke
- ✓ ensuring parity of esteem for those with mental health conditions

The approach

The following pages set out how tobacco use impacts different groups, and recommends what approaches should be taken. Once the tobacco harm reduction strategy is agreed, a detailed action plan will be developed by a multi-agency steering group, representing Health and Wellbeing partners, and key stakeholder organisations. The group will report to the Health and Wellbeing Board annually.

Indicators of success

The measures below will form the core data set that will be presented to Health and Wellbeing Board as part of an annual progress report. See appendix 1 for more information about why these indicators have been selected. The steering group will add further indicators to those listed below.

- Prevalence of smoking in adults
- Rates of smoking in pregnancy
- Difference in smoking prevalence between disadvantaged communities and borough average.
- Prevalence of smoking among people with serious mental ill health

Steering group membership

- London Borough of Havering: Public Health, Housing, Adult Social Care, Children's Services, Education, Public Protection; Healthy Workplace
- Havering Clinical Commissioning Group
- NELFT: Health Visitors, Mental Health Services, District Nurses, Estates
- BHRUT: Maternity Services, Respiratory/Long Term Conditions, Estates
- Primary Care Networks
- Non HWB partners
    - Community and voluntary sector representatives
    - Fire Service
    - Department for Work and Pensions
    - Substance Misuse Treatment Service

Key Milestones

- A steering group to be formed by January 2020
- The final version of the strategy to be agreed by the steering group , and a comprehensive action plan agreed by March 2020 (further milestones will be described in the action plan)

Further information

The appendix provides additional information on three areas

- the targets proposed for each of the four indicators above
- why people smoke, and
- further information about vaping.

Smoking in pregnancy

Smoking during pregnancy increases the risk of miscarriage, premature birth, low birthweight and stillbirth. Babies born to mothers who smoke are at greater risk of cot death. Secondhand smoke is also harmful during pregnancy.

A specialist stop smoking service works with BHRUT maternity services to provide support to pregnant women and those living in the same household as a pregnant woman, using a Babyclear 1 approach which includes automatic referral to stop smoking services and routine CO monitoring. Babyclear 1 commenced in in 2015, with pump priming from Havering Council and Barking and Dagenham Council. It has contributed to an impressive reduction in smoking rates in pregnant women, from 14.7% in 2011/12 to current rates of 7.3% (in 2018/19). Women who stop smoking by 16 weeks of pregnancy may become a lower risk group (depending on other factors), potentially requiring fewer scans and clinic appointments during antenatal care.

What else should be done: Babyclear 2 should be introduced. This builds on Babyclear 1 to include a further discussion between the midwife and expectant mother on the type of harm being caused to the unborn baby. Where this has been introduced elsewhere conversion rates have increased (those referred to stop smoking service who subsequently stop smoking). The importance of smokefree homes should be reinforced, including in settings where pregnant women are likely to attend. Preconception advice should include the importance of stopping smoking when planning a pregnancy and avoiding secondhand smoke.

Smoking in childhood

Smoking is an addiction which is largely taken up in childhood. As a result many young people become addicted before they fully understand the health risks associated with smoking. The good news is that across England smoking rates in 15 year olds have fallen from 21% in 2004 to 5% in 2018. However, underage sales, the availability of illicit tobacco, and tactics to promote products to children through social media threaten further reductions in the numbers of children smoking. The law prohibits sales of tobacco to under 18s and prohibits virtually all tobacco advertising, however:

- research shows that in 2014, 46% of pupils aged 11 to 15 who were smokers usually bought cigarettes in shops.[1]
- research from the North of England showed that over half of smokers aged 14 to 17 were

Smoking and the environment

- The farming, manufacture and consumption of tobacco threatens the environment by contributing to greenhouse gases and using harmful chemicals that are banned in higher income countries (a)
- Cigarette butts are non-biodegradable and toxic; dangerous to children if ingested and harmful to wildlife (a)
- Approximately 24 tonnes of tobacco waste is produced annually in Havering, of this more than 6 tonnes discarded as street litter (b)

(a)https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2697937/ - (b) ASH Ready Reckoner

[1] 28 NHS Digital. 'Smoking, Drinking and Drug Use Among Young People in England - 2014

offered illicit tobacco, and that buying rates in this age group were higher than among older smokers.[2]

- tobacco companies are using social media to promote products to young people, with one company currently under investigation by the Advertising Standards Authority.

It is worth noting that regular e-cigarette use among young people remain low and almost entirely confined to those who smoke or have quit.[3]

What else should be done: Develop an action plan to raise awareness among children of the harms caused by tobacco, including to the environment. Learning from the North of England's programme, LBH and partners to deliver wider education and media campaigns, change any perceptions of illicit tobacco as "no big deal" and highlight how organised criminal gangs are prospering from its sale. Media campaigns to include messaging to staff and schools, with information about how to report underage sales and sales of illicit tobacco, with follow up enforcement.

Smoking in adulthood

Smoking disproportionately affects the most disadvantaged people, with smokers from poorer backgrounds tending to start young and more likely to become highly addicted.[4] Smoking puts poorer families under significant pressure; in 2015 the ASH poverty calculator illustrated how, across London, 46k households could be brought above the poverty line if they quit smoking. In London, smoking is the number one cause of fatal fires and one of the top three causes of all accidental fires in the home.

The groups where rates of smoking are not falling as fast as the general population include:

- Nationally, around 1 in 5 25-34 year olds smoke (whereas smoking rates among young adults under 25 have fallen the most)
- 1 in 4 people in routine and manual occupations is a smoker (compared to 1 in 10 in managerial and professional occupations)
- People who are unemployed are almost twice as likely to smoke as those in work

It is estimated that local businesses in Havering lose over 50,000 days of productivity every year due to smoking-related sickness. This costs about £4.6m.[5]

A universal telephone/online stop smoking service is available free of charge for adult smokers in Havering. Service users pay for their own nicotine replacement therapy (which is far less expensive than cigarettes). Currently prescription medications are not available in the borough. E-cigarettes are now the most popular stop smoking aid in England.

The NHS Making Every Contact Count approach presents a key opportunity to engage with smokers. However, since the decommissioning of the traditional local NHS stop smoking service, there is still

[2] Smokefree Action factsheet *Smoking: illicit tobacco,* PHE FPH avail http://ash.org.uk/wp-content/uploads/2016/05/Illicit.pdf

[3] https://publichealthmatters.blog.gov.uk/2018/07/03/turning-the-tide-on-tobacco-smoking-in-england-hits-a-new-low/

[4] ASH https://ash.org.uk/media-and-news/press-releases-media-and-news/new-figures-show-each-local-authority-how-many-people-could-be-lifted-out-of-poverty-if-they-quit-smoking/

[5] ASH Ready Reckoner

misunderstanding about the local offer of stop smoking support which is telephone and internet based. There is currently no process for prescription-only medications to be made available when residents use this service. A specialist service is available for pregnant women and those living in the same household as a pregnant woman (described above).

What else should be done: The non-availability of prescription only medications such as Champix is preventing some heavy smokers from achieving a successful quit, and so it is important that a solution be found that makes prescription only medications available for those who need them. Interventions should be targeted towards those groups where smoking rates are highest and where prescription only medications would be most helpful. . Consideration should be given to training the many professional groups who are in contact with populations where there are higher rates of smoking, including the fire service, debt advice workers, social care workers, healthcare professionals and housing professionals. Training should cover harm reduction alternatives such as e-cigarettes. Health and Wellbeing Board members can demonstrate leadership through workplace health programmes that support their respective workforces to stop smoking.

Smoking and mental health

People with severe mental illness die on average 10 - 20 years sooner than the general population[6]. Smoking is the largest avoidable cause of these premature deaths. Around 40% of adults with SMI smoke.[7]

Historically, traditional stop smoking services, with the focus on 4 week quit targets, have not succeeded in reducing smoking rates in this group. A Havering 2019/20 pilot project "switch to vaping" seeks to reduce the harms caused by tobacco to patients of NELFT mental health services. Initially patients are supported to reduce dependence on tobacco, and there are additional early signs of success, with a few people stopping smoking altogether.

The national Tobacco Control Plan for England set out how all mental health inpatient services sites should be smokefree by 2018, the importance of providing access to training for all health professionals on how to help patients in mental health services to quit smoking, and of changing the smoking culture in mental health settings.

It is worth noting that whilst staff working on inpatient units are protected from secondhand smoke by smokefree legislation, domicillary mental health workers could be more at risk through being exposed to second hand smoke in patients' homes (see section below).

What else should be done: LBH public health, NELFT and CCG to learn lessons from evaluation of the pilot project and, based on the recommendations, either embed the approach permanently, or further test the approach with a second pilot phase. The approach should then be extended into primary care for those patients with SMI who not in contact with mental health teams. See also smokefree places below.

[6] Hayes JF, Marston L, Walters K, King MB, Osborn DPJ. (2017) Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000–2014. The British Journal of Psychiatry Jul 2017, bjp.bp.117.202606; DOI: 10.1192/bjp.bp.117.202606

[7] https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf

Smokefree places

People who are frequently exposed to second-hand smoke are more likely to get the same diseases as smokers, including cancers and heart disease. Older adults are also more at risk of pneumonia.[8] Children are more likely to develop asthma and infections and respiratory disorders including emphysema in later life. [9] [10] There are risks to the health of the unborn baby when pregnant women are exposed to second-hand smoke.

In 2007 smokefree laws were introduced to protect people from the harms of secondhand smoke in enclosed public places, public transport and work vehicles. To further protect children, legislation was extended in 2015 to cover private vehicles carrying children. Despite the legislation, it has been estimated that approximately 2 milllion children in the UK are routinely exposed to secondhand smoke.[11] There are also gaps in the legislation to protect the domicillary workforce.

Smoking in the home is much more common in certain types of housing. While 18% of all people in England live in social housing, among smokers it is almost a third. Smokers in social housing are known to be equally motivated and equally likely to try to quit as smokers living in other types of housing, but they are half as likely to succeed. They are also more likely to be heavily addicted to smoking. It is not known whether more domicillary visits are made to clients who live in rented properties, compared to owner occupiers.

A 2019/20 pilot project is being delivered to identify new parents who did not stop smoking in pregnancy, or have started smoking again. Health visitors, at the new birth visit discuss smoking status, and signpost to the services available, including switching to vaping through taking up discounted vape products. Early findings indicate that some partners of new mothers have continued to smoke throughout the pregnancy and into the early weeks of parenthood.[12]

What else should be done: Develop an action plan for smokefree homes, smokefree estates and raising awareness of smokefree cars. This should include providing more support and targeted interventions to people living in rented accommodation, as well as a strong communications element about the harms of secondhand smoke. There may be opportunities to work more closely with landlords and consideration could be given to designate certain types of housing or new developments as smokefree.

[8] https://bmjopen.bmj.com/content/4/6/e005133
[9] https://www.nhs.uk/live-well/quit-smoking/passive-smoking-protect-your-family-and-friends/
[10] https://ash.org.uk/wp-content/uploads/2019/10/SecondhandSmoke-Home.pdf
[11] Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group of the Royal College of Physicians. London, RCP, 2010.
[12] The majority of people who smoke do so outside of the home.

Appendix: Further information

Indicators

Page 2 sets out four key indicators. Below proposes the Health and Wellbeing Board ambitions for successful delivery of this strategy as measured by the four indicators:

1. Prevalence of smoking in adults is currently 15%, which represents 30.008 people. The ambition is to reduce prevalence to 12% or less, to reflect the national strategy.
2. Rates of smoking in pregnancy are 7.3%, which represents 227 women. The ambition is to reduce rates to 5% or less; better than the national target of 6%.
3. Reduce the inequality gap in smoking prevalence between those in routine and manual occupations, which is currently 3.19. The ambition is to reduce the gap to 2.47 to achieve the current average for England.
4. Reduce prevalence of smoking by people with serious mental ill health which is currently 39.4 (representing 570 people). The ambition is to reduce prevalence initially to 27% or better; 27% is the midpoint between the current prevalence of smoking among people with SMI and the adult population.

Why do people smoke? And why is it so difficult to stop?

Cigarettes contain nicotine, which is highly addictive. Nicotine alters the balance of two chemicals in the brain: dopamine and noradrenaline. When nicotine changes the levels of these chemicals, mood and concentration levels change. The changes happen very quickly; inhaled nicotine immediately rushes to the brain, where it produces feelings of pleasure and reduces stress and anxiety. This nicotine rush can be very enjoyable. But the more someone smokes, the more the brain becomes used to the nicotine, this means that more smoking is required to get the same effect.

When someone stops smoking, the loss of nicotine changes the levels of dopamine and noradrenaline, which can lead to feelings of anxiousness, depression and irritability. The nicotine cravings can be very strong, making it difficult to quit using just willpower.

Vaping

The peak age for vaping is among 35-44 years olds, and around 1 in 8 ex-smokers vape, compared to less than 1% of those who have never smoked. Vaping is not completely risk free, but it is far less harmful than smoking tobacco. PHE states that "there is no situation where it would better for health to continue smoking, rather than switching completely to vaping"

UK media headlines have warned about an outbreak of serious lung disease across the US, which is said to be associated with vaping. Over 1600 cases have been reported, including more than 30 deaths. According to PHE

> "*The US has an estimated 9 million e-cigarette users in the country, but weekly updates on the CDC website make it clear that the group of people affected is very specific. The outbreak appears to be largely among young men: 70% of patients are male and the average age is 24. Almost half (46%) are under 21.*

> *"Dr Dana Meaney-Delman, head of the CDC team investigating the outbreak has reported that "We've narrowed this clearly to THC-containing products that are associated with most patients who are experiencing lung injury. The specific substance or substances we have not identified yet". THC is the main psychoactive component of cannabis and the CDC has said that the products identified are being obtained off the street or from other informal sources (e.g. friends, family members or illicit dealers*).[13]

All UK cigarette products are tightly regulated for quality and safety. It is important to only use UK-regulated e-liquids and never risk vaping home-made or illicit e-liquids, or adding substances, any of which could be harmful.

[13] https://publichealthmatters.blog.gov.uk/2019/10/29/vaping-and-lung-disease-in-the-us-phes-advice/