Public Document Pack

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD AGENDA

| 1.00 pm | Wednesday 21 September 2022 | Council Chamber - Town Hall |
|---|---|---|

Members: 20, Quorum: 6

**BOARD MEMBERS:**

| | |
|---|---|
| Elected Members: | Cllr Gillian Ford<br>Cllr Oscar Ford<br>Cllr Paul McGeary<br>Cllr Ray Morgon, Leader of the Council |
| Officers of the Council: | Andrew Blake-Herbert, Chief Executive<br>Barbara Nicholls, Director of Adult Services<br>Mark Ansell, Interim Director of Public Health |
| Havering Clinical Commissioning Group: | Dr Narinderjit Kullar, Havering Clinical Care Director<br>Ceri Jacob, BHR CCG |
| Other Organisations: | Anne-Marie Dean, Healthwatch Havering |

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

***Under the Committee Procedure Rules within the Council's Constitution the Chairman of the meeting may exercise the powers conferred upon the Mayor in relation to the conduct of full Council meetings. As such, should any member of the public interrupt proceedings, the Chairman will warn the person concerned. If they continue to interrupt, the Chairman will order their removal from the meeting room and may adjourn the meeting while this takes place.***

***Excessive noise and talking should also be kept to a minimum whilst the meeting is in progress in order that the scheduled business may proceed as planned.***

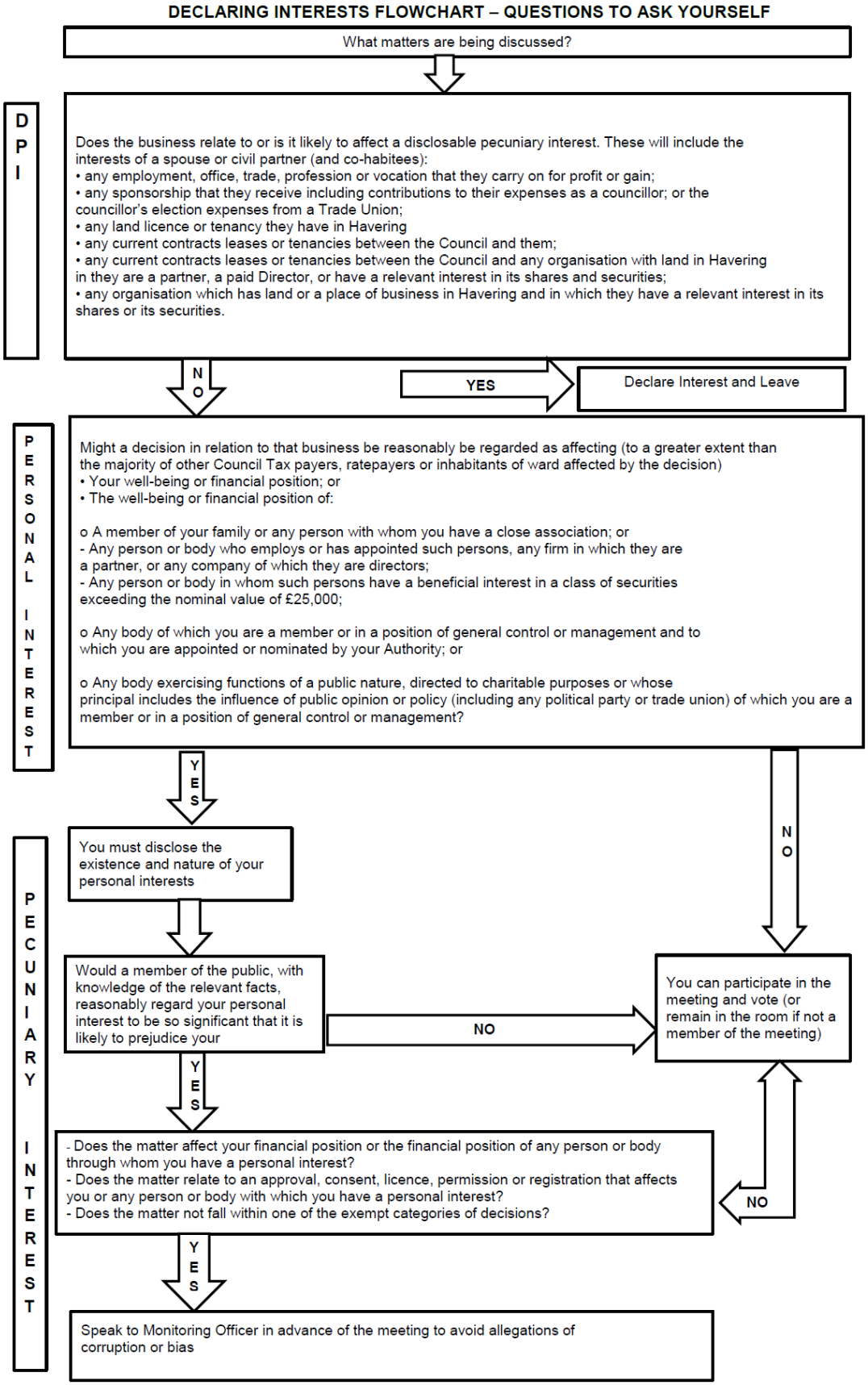
**What is the Health and Wellbeing Board?**

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
What matters are being discussed?
DPI
Does the business relate to or is it likely to affect a disclosable pecuniary interest. These will include the interests of a spouse or civil partner (and co-habitees):
• any employment, office, trade, profession or vocation that they carry on for profit or gain;
• any sponsorship that they receive including contributions to their expenses as a councillor; or the councillor's election expenses from a Trade Union;
• any land licence or tenancy they have in Havering
• any current contracts leases or tenancies between the Council and them;
• any current contracts leases or tenancies between the Council and any organisation with land in Havering in they are a partner, a paid Director, or have a relevant interest in its shares and securities;
• any organisation which has land or a place of business in Havering and in which they have a relevant interest in its shares or its securities.
NO
YES
Declare Interest and Leave
PERSONAL INTEREST
Might a decision in relation to that business be reasonably be regarded as affecting (to a greater extent than the majority of other Council Tax payers, ratepayers or inhabitants of ward affected by the decision)
• Your well-being or financial position; or
• The well-being or financial position of:
o A member of your family or any person with whom you have a close association; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors;
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
o Any body of which you are a member or in a position of general control or management and to which you are appointed or nominated by your Authority; or
o Any body exercising functions of a public nature, directed to charitable purposes or whose principal includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management?
YES
NO
PECUNIARY INTEREST
You must disclose the existence and nature of your personal interests
Would a member of the public, with knowledge of the relevant facts, reasonably regard your personal interest to be so significant that it is likely to prejudice your
NO
You can participate in the meeting and vote (or remain in the room if not a member of the meeting)
YES
- Does the matter affect your financial position or the financial position of any person or body through whom you have a personal interest?
- Does the matter relate to an approval, consent, licence, permission or registration that affects you or any person or body with which you have a personal interest?
- Does the matter not fall within one of the exempt categories of decisions?
NO
YES
Speak to Monitoring Officer in advance of the meeting to avoid allegations of corruption or bias

## 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** (Pages 1 - 2)

To approve as a correct record the minutes of the Committee held on 23rd March 2022 and to authorise the Chairman to sign them.

**5 MATTERS ARISING**

To consider the Board's Action Log

**6 ICS UPDATE** (Pages 3 - 10)

Report and appendix attached

**7 BCF** (Pages 11 - 52)

Report and appendix attached

**8 JSNA** (Pages 53 - 224)

Report and appendix attached

**9 PNA** (Pages 225 - 338)

Report and appendix attached

**10 JHWS REFRESH PROPOSAL** (Pages 339 - 346)

Report and appendix attached

**11 DATE OF NEXT MEETING**

**Zena Smith**
**Democratic and Election Services Manager**

**MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD**
**Zoom**
**23 March 2022 (1.05 - 1.50 pm)**

**Present:**

**Elected Members:** Councillors Jason Frost (Chairman) and Nisha Patel

**Officers of the Council:** Andrew Blake-Herbert (Chief Executive), Barbara Nicholls (Director of Adult Services) and Mark Ansell (Interim Director of Public Health)

**Havering Clinical Commissioning Group:** Dr Atul Aggarwal (Chair, Havering Clinical Commissioning Group (CCG))

**Healthwatch:** Anne-Marie Dean (Healthwatch Havering)

11 **CHAIRMAN'S ANNOUNCEMENTS**

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

12 **APOLOGIES FOR ABSENCE**

Apologies were received from Cllr D White, Cllr R Benham and Robert South

13 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest

14 **MINUTES**

The minutes were agreed and were signed as the Chairman as a correct record

15 **MATTERS ARISING**

No matters arose

16 **UPDATE ON INTEGRATED CARE SYSTEM**

The Board was presented with an update on the Integrated care System.

Members noted there had been delays due to the COVID-19 and plans were still needed to go to central government. Members noted there had been a recruitment drive for statutory roles within the Integrated care Board)

ICB with a constitution for the ICB being prepared for the start of July 2022. Members noted that the ICB would fall under NHS England alongside the ICP and ICS Executive Committees.

The Board noted the report.

17 **DATE OF NEXT MEETING**

Members noted the next meeting would be held on 29th June 2022.

**Chairman**

# Havering Place Based Partnership

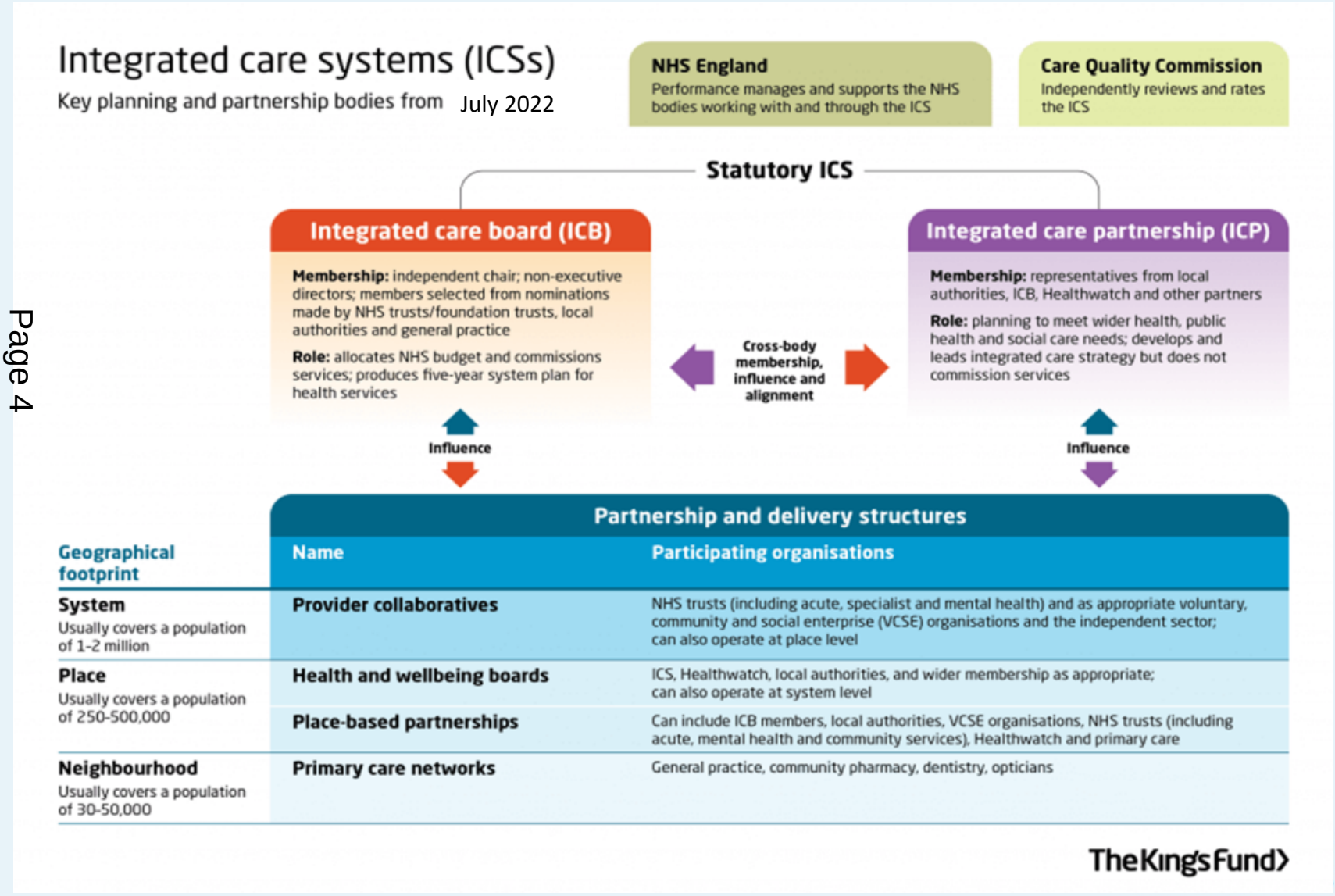









# Integrated Care Systems



# Key functions of a place based partnership

- Understanding and working with communities
  - Developing  an in depth knowledge of local needs
  - Connecting with communities
- Joining up and coordinating services around people's needs
  - Jointly planning and coordinating services
  - Driving service transformation
- Addressing social and economic factors that influence health and well being
  - Collectively focusing on wider determinants of health
  - Mobilising local communities and building community leadership
- Supporting quality and sustainability of local services
  - Making best use of financial resources
  - Supporting local workforce development
  - Driving improvement through local oversight of quality and performance

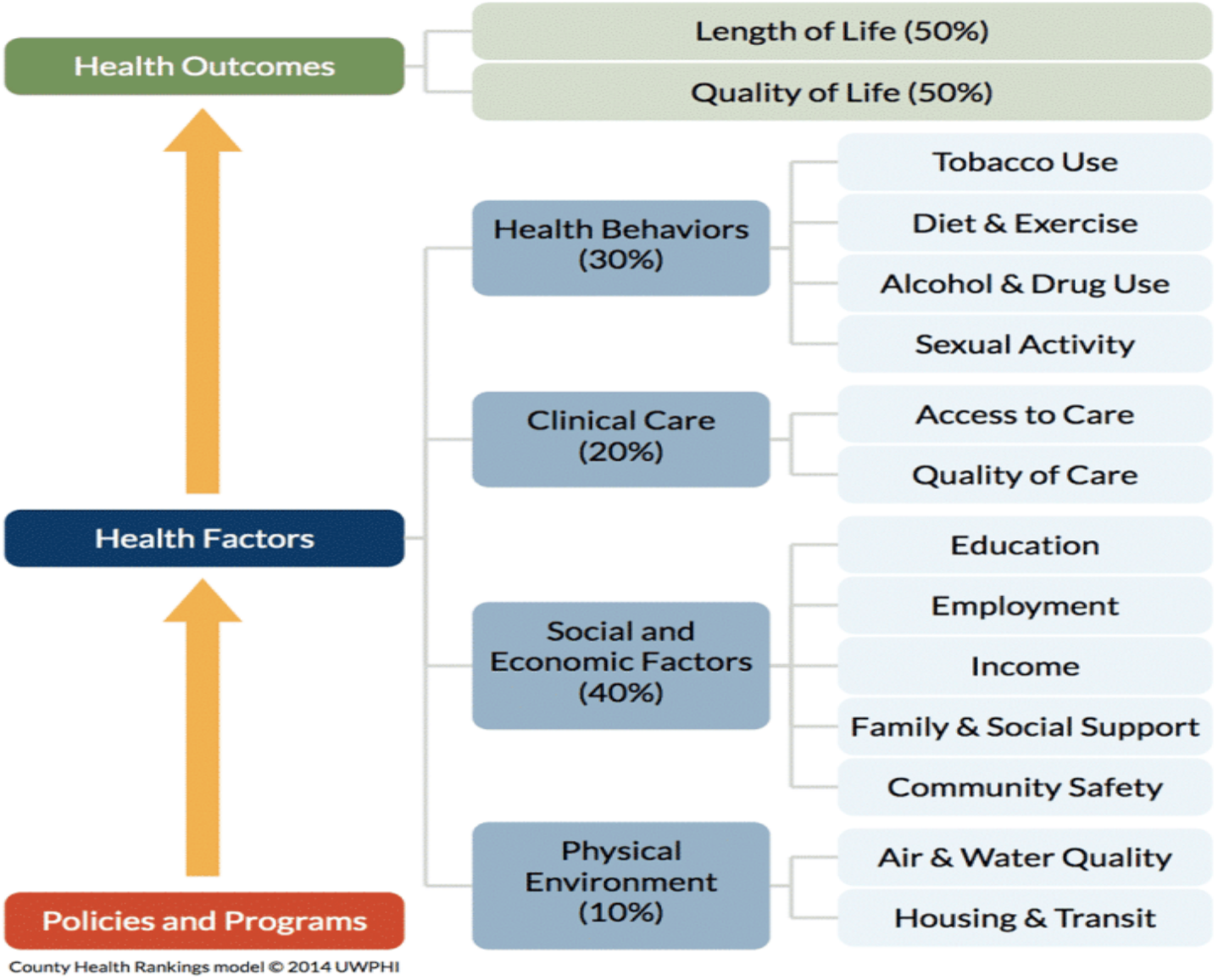
**These functions are where there is greatest potential to add value over and above the contributions of individual organisations or entire systems.**

# Wider Determinants of Health

If we get the best clinical care possible e.g. 100% efficiency. We will still only be affecting 20% of someone's life



The 80% happens outside traditional clinical settings



# Havering PbP – Priority Programmes on a page

**The infographic below illustrates the key priorities being taken forward by the Havering Place based Partnership currently within the resource available. There are a number of wider priorities that have been identified for us to progress once resource is more clear:**

## Aligning Social Prescribing

Progressing Care Connectors Pilot and aligning social prescribing work around Harold Hill Health Centre, including opportunities to build a local network and design training programmes

## Designing a new approach to Quality

Workshop held in July to design the local approach to Quality in Havering. Working group being established to take this forward.

## New approach to engagement

Designing a new approach to ongoing engagement with local people and staff that will embed experience based design in transformation.

## Joined up data/insights/ PHM

Joined up data and insights, supported by strong Information Governance and enabled by IT.


**The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health by:**

## Addressing health inequalities

Tacking Health Inequalities and embedding prevention through a Population Health Management Approach, informed by local insights. Current key projects include:

- AF
- Mental Health
- Health Checks
- HTN
- MSK (BHR)
- Diabetes
- Healthy Havering Approach
- Community Chest funding targeted on local need
- Virtual clinics LTC support

## Leadership / workforce development

Leadership sessions with key partners, Setting up c o workforce development and projects with frontline staff

## Winter keeping people at home

Joined up community led approach to admission avoidance

## One Estate

## Cost of Livcing

Local partners working together around fuel poverty and cost of living

## Clinical and care leadership

Engaging with wider clinical and care Workforce

# PROPOSED governance arrangements post July 2022 PHASE 1


Partnership Workstreams – Health Inequalities – LAC – Prevention – (more added one partnership develops) Elements of BHR work to be place based – Enabling Finance, Digital, Contracts

# Havering PbP Matrix Team – Core Leads

| Area | Lead | Role title |
|---|---|---|
| **Place Lead** | Andrew Blake-Herbert | Chief Executive, LBH |
| **Place Director** | Luke Burton | Director of Place based Partnership development |
| **Place Clinical Care Lead** | Dr Kullar | Clinical Care Director |
| **Lead Member for Health** | Cllr Gillian Ford | Lead member for Health, Havering Council |
| **Communications** | Jackie McMillan | BHR Head of Comms and Engagement |
| **Engagement** | Annie Robertson | Senior Engagement and Community Communications Manager (BHR) |
| **PMO** | Matt Henry | Programme Manager / PMO |
| | Shibbir Ahmed | Project Support |
| | Jenny King | Project Support |
| | VACANT | Senior Commissioning Manager (LBH) |
| | Sandy Foskett | Commissioning Manager (LBH) |
| | Emily Plane | Head of Strategy and System Development – BHR |
| | Judith Smy | Business Manager |
| **Quality Leads** | Sandra Moore | Head of Quality |
| | Rosie Eadon | Havering Quality Lead |
| **CVS lead** | Paul Rose | Chair of Havering Compact |
| **Finance** | Julia Summers | Head of CCG finance |
| **Estates** | Carolyn BotField / Dean Musk | Director of Estates / Head of Estates and Capital Programmes |
| **Analytics (BI)** | tbc | |
| **Digital** | tbc | |

This page is intentionally left blank

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | BCF plans 21/22 and 22/23 |
| **Board Lead:** | Barbara Nicholls |
| **Report Author and contact details:** | John Green 07392782206 |

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

| | |
|---|---|
| ☐ | The wider determinants of health<br>• Increase employment of people with health problems or disabilities<br>• Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.<br>• Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system. |
| ☐ | Lifestyles and behaviours<br>• The prevention of obesity<br>• Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups<br>• Strengthen early years providers, schools and colleges as health improving settings |
| ☐ | The communities and places we live in<br>• Realising the benefits of regeneration for the health of local residents and the health and social care services available to them<br>• Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem. |
| ☒ | Local health and social care services<br>• Development of integrated health, housing and social care services at locality level. |
| ☒ | BHR Integrated Care Partnership Board Transformation Board<br>• Older people and frailty and end of life<br>• Long term conditions<br>• Children and young people<br>• Mental health<br>• Planned Care<br>Cancer<br>Primary Care<br>Accident and Emergency Delivery Board<br>Transforming Care Programme Board |

Havering
LONDON BOROUGH

| SUMMARY |
| --- |
| The BCF plans for 21/22 and 22/23 need ratification and sign off by the Health and Wellbeing board. Sign off for 21/22 has been delayed by the constraints on the board meeting in person because of the COVID pandemic. The late issue of the planning guidance and templates from the NHS has also delayed plans. The 22/23 documents for example were only issued in July 2022, despite the plan covering the period April 22 to March 23. |
| **RECOMMENDATIONS** |
| That the board approve and sign off the plans to meet the requirements for release of BCF funds. The plans will subsequently be submitted for approval by NHSE. |
| **REPORT DETAIL** |
| The narrative plans, as has been the case for the past 4 years, are joint BHR plans reflecting the close working partnership between the 3 boroughs and the ICS. The finance template and performance reports are Havering specific. For the first time, there is a 'demand and capacity' template, which will not be subject to approval by the NHS. It is an attempt to understand the demand on Reablement and voluntary sector services that support people leaving the hospital and the capacity in place to support a smooth transition home. The planning templates will be supplied as supporting documents. |
| **IMPLICATIONS AND RISKS** |
| Without sign off of the BCF plans the funding that supports many of the ASC and health activities in the borough will not be forthcoming. |
| **BACKGROUND PAPERS** |
| BCF planning template 21/22<br>BCF planning template 22/23 |

# Barking & Dagenham Place, Havering Place & Redbridge Place

# Joint Better Care Fund Plan 2022-23

London Borough of Barking & Dagenham
London Borough of Havering
London Borough of Redbridge
NHS North East London

# Contents

## SECTION HEADINGS

# BHR Better Care Fund Plan 2022-23

This joint plan (the BHR BCF plan) covers the following Health & Wellbeing Board areas:

- Barking & Dagenham
- Havering
- Redbridge

The following organisations have signed off the plan:

- London Borough of Barking & Dagenham
- London Borough of Havering
- London Borough of Redbridge
- NHS North East London

These organisations are part of the North East London Integrated Care System with our other partners that includes:

- Barking, Havering & Redbridge University Hospital Trust (BHRUT)
- Barts University Hospital Trust (Barts)
- North East London Foundation Trust (NELFT)
- Primary Care Networks
- Emergency Services
- Commissioned services health and social care provider reps
- Patient and Service User reps
- VCS organisations

**Summary of National Conditions**

Our BHR BCF plan sets out how we will meet these requirements.

| National Conditions | | Covered in Sections |
|---|---|---|
| 1 | **Jointly agreed plan between local health and social care commissioners, signed off by the HWBs** - or delegated authority if there is no HWB board. Reports will all go to the respective borough HWBs informing them of the plan. Plans should set out a joined-up approach to integrated, person-centred services across local health, care, housing and wider public services. They should include arrangements for joint commissioning, and an agreed approach for embedding the current discharge policy in relation to how BCF funding will support this. | Sections 1, 2, 3 &4 |
| 2 | **NHS contribution to adult social care to be maintained in line with the uplift to ICB minimum contribution** | BHR Expenditure Templates |
| 3 | **Invest in NHS-commissioned out-of-hospital services**<br>Narrative plans should set out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it.<br>Expenditure plans should show the schemes that are being commissioned from BCF funding sources to support this objective. | BHR Expenditure Templates<br><br>Sections 2,3,5 & 6 |
| 4 | **National condition 4: Implementing the BCF policy objectives**<br><br>National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:<br><br>• Enable people to stay well, safe and independent at home for longer.<br>• Provide the right care in the right place at the right time. | BHR Expenditure Templates - Metric Tab<br><br>Section 3 |

*All detail and data contained within this plan was correct at the time of submission.

# Executive Summary

**Our Joint Priorities**

Across the Barking & Dagenham, Havering and Redbridge Better Care Fund plan for 2022-23, we have agreed the following priorities:

**Enable people to stay well, safe and independent at home for longer - Targeted Out-of-Hospital Care**

- **To support people with higher care needs to get as great a level of independence as possible**
- **To support people to remain well in the community - maximise their independence and reduce admissions**

**Provide the right care in the right place at the right time**

- **To support safe and timely discharge from hospital and support a home first approach**

**Market Stabilisation**

- **To support the stabilisation of the care market and Winter pressures**

These priorities are key to deliver the ambitions of the BCF programme and deliver the standard and quality of health and care services to meet the needs of our residents.

**Key Changes to the 21/22 BCF plan**

1. The development of a Single Point of Access (SPA). This is now in place and has developed into the *Integrated Discharge Hub* (IDH), combining the Discharge Coordination Unit and the Hospital Discharge Service into a single integrated service. The IDH supports pathways 1-3 for both in-borough and out of borough residents. The service supports the three Places.

2. The *Home First* model of care has been rolled out with senior therapists, rehab assistants and trusted assessors and professional care support working across health and social care. The offer is in all boroughs at varying levels based on need and demand. The service is jointly commissioned with the NHS funding therapy services and the both parties funding reablement care.

3. NHS North East London continue to fund the first four weeks of Discharge to Assess (D2a) Nursing Placements for B&D, Havering and Redbridge places. The system also piloted "Block" D2a nursing beds (28) over three sites with a wraparound therapy team (Physiotherapy/Occupational Therapy) that has supported 30% of local residents to return home, who would not have done so in a straight assessment only placement. This has continued into 22/23.

4. To reduce the rate of admissions where individuals could be supported better in the community through anticipatory care and admission avoidance, NHS North East London have commissioned a community UCR (Urgent Care Response) service across the three places, providing 2-hour crisis response at home service operating 8am to 8pm 7 days a week at a minimum, and using the model in line with national guidance. By the Q4 2021/22 the service was overperforming against the local operating plan target of 70% of people to be seen within 2 hours of referral. For 22/23 the system has also increased the rapid response service for end of life care via the expansion of the hospice 24-hour helpline with additional nursing capacity and a pilot for over-night rapid response nursing as an alternative care pathway.

5. The borough has a Place Based Partnership (PBP) board and is developing a programme of work at each Place. NHS NEL and the boroughs will be working in collaboration to integrate various transformation programmes at Place including older people and frailty and long-term conditions.

6. B&D has been a 3rd wave pilot site for the national Population Health Management (PHM) programme The borough identified a priority cohort using integrated data and analytics as the foundation to drive system transformation The partnership is taking a PDSA approach to trial interventions with local residents to support the development of an anticipatory care model of care for the future. Learning from B&D will be used a blue print to action PHM and anticipatory care in Havering and Redbridge.

7. The impacts of COVID on the care market – financial sustainability, workforce issues and service delivery moving away from building based to more virtual services.

8. Increase in care needs and complexity of conditions due to restrictions in accessing primary care services and people now requiring a higher level of care when entering the system.

9. The impact of COVID on our vulnerable residents with long-term health conditions and BAME communities.

## Section 1: Governance (National Condition 1)

**1. BHR BCF Governance & Ambitions**

Our overarching vision for the Barking and Dagenham, Havering and Redbridge joint plan is to:

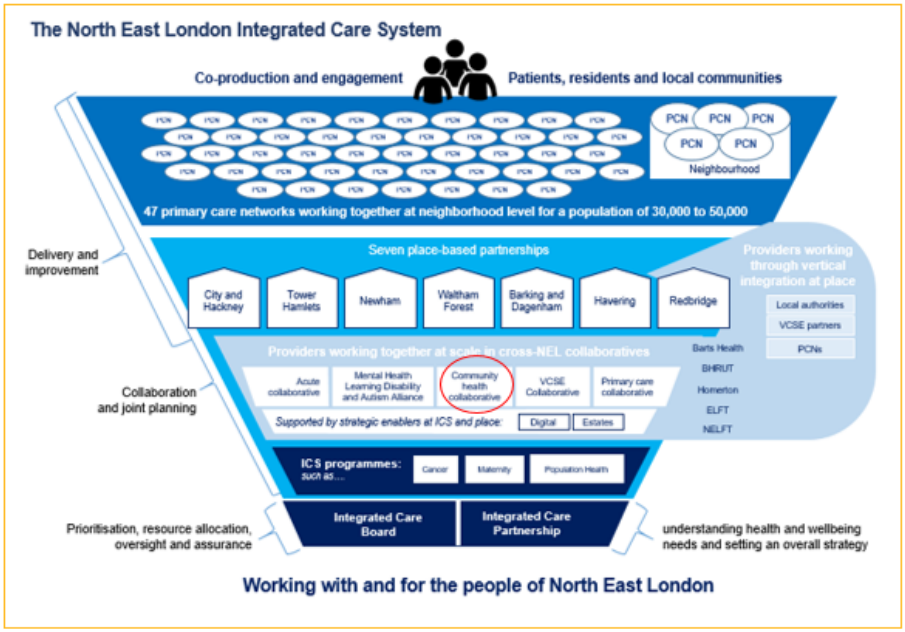
***'Accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high-quality health and wellbeing services.'***

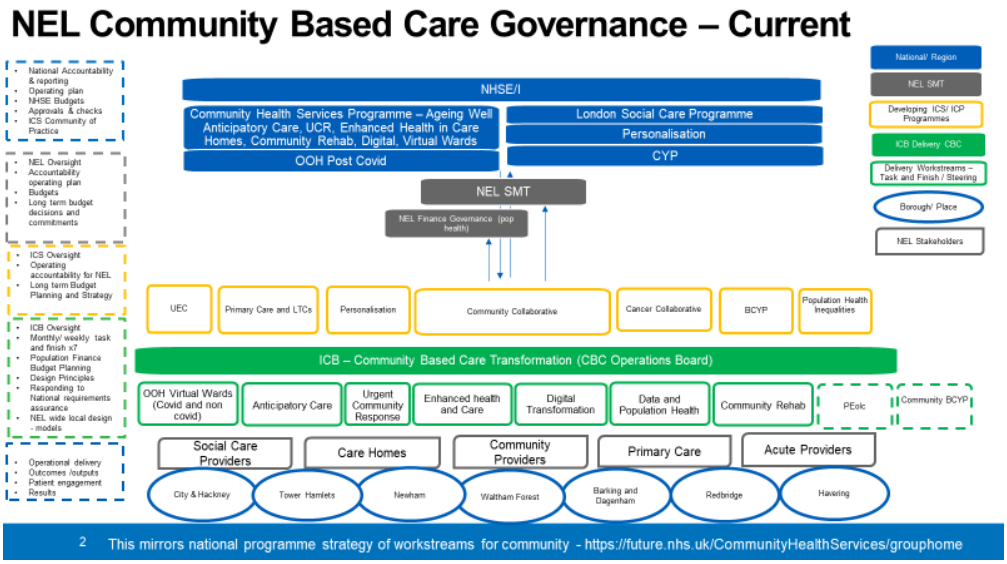
- **Create an environment that encourages and facilitates healthy and independent lifestyles** by enabling and empowering people to live healthily, to access preventive care, to feel part of their local community, to live independently for as long as possible and to manage their own health and wellbeing

- **Organise care around the individual's needs**, involving and empowering them, integrating across agencies, with a single point of access, and providing locally where possible. It will meet best practice quality standards and provide value for money.

- **Ensure organisations work collaboratively**, sharing data where appropriate, and maximise effective use of scarce/specialist resources (e.g. economies of scale).

- **Remove artificial barriers that impede the seamless delivery of care**, bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.






**Joint BHR S75 Agreement and Joint Working**

Overall strategic oversight of partnership working between the Partners is vested in the respective Borough Health and Wellbeing Boards.

The Partners have agreed that the BHR Joint Commissioning Board (JCB) will be responsible for the review of performance and oversight of the partnership agreement. The JCB is a working group of representatives of Barking and Dagenham, Havering and Redbridge Councils, NHS North East London and Place. At least one member from each of the Partners has individual delegated responsibility from their host organisation to make decisions which enable the JCB to carry out its duties and functions. In addition, each partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

The BCF programme of schemes are governed through our Joint Commissioning Board, the JCB provides the strategic direction of the development and application of the Better Care Fund across BHR Places. From our BCF 2017-19 plan we developed a joint BHR S75 with the BHR LAs and CCGs (now NHS North East London), which was completed and signed back in July 2018 and is refreshed annually. This sets out the foundation to strengthen the work across the partners to deliver health and care services across the BHR region using the BCF as a key lever for support integration where this brings efficiencies of quality and sustainability. The S75 sets out three 'BCF aligned pooled funds' for each HWB area and Place, and in addition incorporates the option of utilising a fourth 'pot' to facilitate joint pooled commissioning arrangements between partners and across Places.

The JCB consists of representation between the Barking and Dagenham, Havering and Redbridge Local Authorities, and NHS North East London. The chair alternates between NHS North East London and local authorities with representation consisting of the respective DASSs, DPHs, NHS North East London Leadership, finance representatives and Commissioner Leads as members of the Board. A *BCF Executive group* oversee the delivery of the BCF work in including planning, development and monitor spend and performance. A BCF Operations & Finance group supports the work of the BCF Executive Group including developing reports, reviews, finance templates and developing the submission annually. It is exploring opportunities for further development in relation to integrated services and joint commissioning opportunities. We will review the role of the JCB as the Place Based Partnerships develop over the coming year and whether any changes to governance arrangements are required.

**Jointly Agreed Plan Approval**

Below sets out the key officers from each organisation responsible for plan sign off and the dates of the Health & Wellbeing Boards for plan agreement.

| **Barking & Dagenham** | |
|---|---|
| **Chair of the HWB** | Cllr Maureen Worby, Cabinet Member for Social Care & Health Integration |
| **DASS** | Elaine Allegretti, Strategic Director for Children's & Adults |
| **Section 151 Officer** | Philip Gregory, Director of Finance |
| **Date of HWB Agreement** | 13 September 2022 |

| Havering | |
|---|---|
| **Chair of the HWB** | Councillor Gillian Ford, Lead member for Adults Social Care & Health |
| **DASS** | Barbara Nicholls, Director Adult Social Care & Health |
| **Section 151 Officer** | Dave Mcnamara, Director of Finance |
| **Date of HWB Agreement** | 21 Sept 2022 |

| Redbridge | |
|---|---|
| **Chair of the HWB** | Cllr Mark Santos, Cabinet Member for Adult Social Care & Health |
| **DASS** | Adrian Loades, Corporate Director of People |
| **Section 151 Officer** | Maria Christofi, Corporate Director of Resources |
| **Date of HWB Agreement** | Either 12th of September or 21st of November 2022 |

| NHS NEL | |
|---|---|
| **Accountable Officer** | Zina Etheridge, CEO NHS North East London |
| **Finance Director** | Henry Black, Chief Finance and Performance Officer - NHS North East London |
| **Senior Responsible Officer** | Place Directors NHS North East London - Sharon Morrow (Barking & Dagenham Place), Luke Burton (Havering Place) and Tracy Rubery (Redbridge Place) |

# Section 2: Approach to Integration

**1. Summary**

An integrated care system (ICS) is one that brings together local health and care organisations and the voluntary sector to deliver the 'triple integration' of primary and specialist health care, physical and mental health services and health with social care. Redbridge, Havering & Barking & Dagenham Place Based Partnerships serve a population of around 780,500 people.

Key objectives of an ICS are to (a) shift care from the hospital to the community where it is appropriate to do so, (b) provide place-based care through more proactive and integrated care across the NHS, social care and the voluntary sector at a neighbourhood level and (c) provide person-centred care by breaking down traditional barriers between organisations and the functions within them, placing a greater focus on the delivery of better outcomes for local people.

Pathway redesign and service model development across BHR places has primarily been delivered through a number of BHR system transformation programmes. These the Urgent and Emergency Care Board- led by the acute trust; a Discharge Working Improvement Working Group (DIWG) - chaired by local authority and NHS community services directors which reviews and manages flow in and out-of-hospital and the BHR Older Peoples and Frailty Transformation Board which is led by NHS North East London. The Joint Commissioning Board (JCB) consisting of BHR LAs and NHS North East London functions at a more strategic level where a range of collaborative commissioning and transformation initiatives are developed and negotiated, which includes the BCF. Commissioners across the three boroughs are also working together on a number of themed programmes and service developments.

Primary Care Networks (PCNs) are one of the key building blocks and the focus of integrated care delivery. PCNs are groups of general practices and social and community care providers that serve areas with populations of about 30,000-50,000 people (although can be larger), and aim to provide person-centred, community-based care through multi-disciplinary teams (MDTs). The formation of PCNs was directed by the NHS Long Term Plan in 2019.

**Integration Approaches, Joint Commissioning and transformation approaches**

Barking and Dagenham, Havering and Redbridge boroughs and the local NHS (formerly BHR CCGs) have worked collaboratively at a sub-regional level (BHR) prior to the inauguration of the Integrated Care Board and ICS. BHR Integrated Care Partnership has also developed over a number of years. This work and COVID has brought the NHS and boroughs into a much more collaborative relationship across the three borough areas.

With the move to Place, the focus will be on that borough level, however not losing the collaborative work across outer north East London that has developed over the previous years. The Place Based Partnerships have agreed to continue to collaborate on transformation where this makes sense and will be reviewing how this will operate as the Place Based Partnerships develop.

**Embedding Integration - Joint and Collaborative Commissioning and transformation**

Our vision is to accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge Places and deliver sustainable provision of high- quality health and wellbeing services. This plan sets out a clear determination that the BHR places will move increasingly towards that vision with a new model of care, building upon the history and experience we have together to meet the challenges of increasing demand, demographic change and financial constraint. We have defined, and agreed, a series of themes. Each of them is important to the BHR health & care system and all are central to the Better Care Fund. The plan overall is expected to deliver against the key requirements as set out in the National Guidance and Policy Framework, including the High Impact Change Model, market capacity and sustainability, supporting the acute hospitals' 'flow' and ensuring that social care services are protected wherever possible, which in turns supports the whole health and care system. The system is working together to achieve the following aims:

- To enable and empower people to live a healthy lifestyle, have access to preventative care, to feel part of their local community, to live independently for as long as possible, to manage their own health and wellbeing, which creates an environment that encourages and facilitates healthy and independent lifestyles.

- Where care and support is organised around the individual's needs, involves and empowers the service user/resident, is integrated between agencies, with a single point of access, is provided locally where possible, meets best practice quality standards and provides value for money.

- In which organisations share data where appropriate, work collaboratively with other agencies and make more effective use of scarce resources (e.g., economies of scale).

- Where organisational barriers that impede the seamless delivery of care are removed, bringing together not only health but social care, but a range of other services that are critical to supporting our population to live healthy lives.

Through working in partnership, the local authorities, NHS partners, primary care and the VCS have an ambitious transformation agenda for older people and those who are frail. Through the integration of health and social care, streamlining pathways around the person and by supporting older people to be healthy; preventing hospital admission (both in the community and at the hospital front door), supporting safe effective discharge, preventing people in care homes from being hospitalised and enabling a good end of life experience in a person preferred place of death - we can enable people to be safe and well in community settings.

Having invested in the development of our locality models, bringing greater levels of integration and co-location of teams, we are developing this further with the creation of borough partnership boards which will go live in September 2022 to take a greater role in the commissioning and transforming the provision of services. Increasingly this will draw in the wider range of services than our current community models deliver, such as housing, general practice, voluntary sector services, social care providers and so on.

Improving outcomes for frail and older people is a priority for the BHR places. The planning and delivery of a transformation plan to achieve this has been co-ordinated through a BHR system wide transformation programme for older people and those who are frail. This was established in June 2018 with the aim of improving quality and patient outcomes and ensuring that services are as efficient as possible and integrated around the patient.

The transformation programme provides programme support to the delivery of the BCF outcomes. A number of system workstreams are in place have been established reporting to a transformation board to take forward service transformation through collaboration and shape the BCF plans.

The Older People and Frailty Transformation Programme brought all the work together to describe the entirety of the transformation programme across a pathway of care, the investment requirement to enhance capacity on primary/community care and savings opportunities resultant from a reduction in avoidable hospital activity. It was intended that transformation would be delivered over 3 years – the first year focused on building the foundation, moving to full scale transformation in year 2 and delivery through an ICS in year 3. The Board is planning a refresh of the strategic approach in 2022/23.

The partnership approach involves NHS North East London, NHS provider trusts and Local Authorities across the three boroughs, Havering, Barking and Dagenham and Redbridge. As part of the governance structure a Joint Commissioning Board has been formed to take opportunities for joint commissioning and transformation. Many initiatives and objectives are shared and delivered, and the strategic goals of prevention, integration and partnerships and personalisation resonate across all organisations. The partnership has been in place in various forms over some time and, through lessons learned from the three authorities and through demographic and demand profiling, has developed a localised model for delivery of services based upon Primary Care Network partnerships established within the borough.

**Place Based Partnerships**

Each borough has now established a Partnership Board that brings system partners including primary care, social care, NHS providers, the voluntary sector, Health Watch, the ICB and the local authority. The partnership has identified early priorities and will need to continue to develop aligned with the model of delegation that is ultimately agreed. The Joint Health and Wellbeing strategy and many organisational cross overs and governance groups set out the already established partnership approach between the Havering and system partners. The membership of the Redbridge Borough Partnership is similar to that of Havering. The Redbridge partnership has agreed its governance arrangements and identified three priority areas (Children's Health, Adult Mental Health and the health impact of overcrowding) which it will use to develop the working of the partnership as well as improving outcomes for residents. The Partnership is undertaking a series of developmental workshops in addition to its regular meetings in order to establish future ways of working. Progress is reported to the HWB at its regular meetings.

Redbridge is also developing its Borough partnership approach and priorities and been undertaking a range of workshops to develop this. Progress is reported to the HWB at its regular meetings.

The B&D Partnership Board will be supported by a programme structure that supports delivery across separate pathways of care for children and adults. This will allow the place to respond to local needs and priorities across the borough and include a wide range of relevant partners to develop solutions. The place based partnership aims to leverage the collaborative expertise to influence

system working across NEL and unlock barriers to the delivery of improvements in B&D. The ability to make informed decisions around health and care will support the partnership in tackling wider issues around inequalities.

**Borough Partnerships Visions**


**Locality Models**

Community heath and/or social care services operate on a 'locality model basis'. The localities have populations within them of a size that are largely equal populations though with potentially different needs. The move to a localities model has to be designed so that end users get better services. The concept means that the response to local needs will deliver more value for the residents in that area, because services are aligned with those local needs.

**Primary Care Networks**

BHR has a number of Primary Care Networks (PCNs) operating as part of a wider joint approach to primary care across north-east London. As part of the localities model, we will explore the establishment of 'community hubs' within each borough which will aim to co-locate a number of health and care services including GP and community nursing walk-in clinics, health and wellbeing programmes, employment support, housing support, healthy living prevention activities, and education services for adults and children. GP Federations are at borough level and are a key platform to expand the benefits of PCNs and enable further joint commissioning and economies of scale at both a borough level and across BHR places. They are a key part of the changing way health and care services are working together to support people in community settings.

**Direct Enhanced Services provided by PCNs**

| Direct Enhanced Service | Service Outline | Workforce Service Support |
|---|---|---|
| **Structured Medication Reviews** | • Aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines)<br>• Can identify medicines that could be stopped or need a dosage change, or new medicines that are needed.<br>• Can lead to a reduction in adverse events. | Clinical Pharmacist |
| **Enhanced health in care homes** | • Access to consistent, named GP and wider primary care services<br>• Medicines review<br>• Hydration and nutrition support<br>• Access to out-o-f hours / urgent care when needed | Clinical Pharmacist<br>Community Paramedic |

| Direct Enhanced Service | Service Outline | Workforce Service Support |
|---|---|---|
| **Anticipatory care with community services** | • Thinking ahead and understanding the health needs of individual people<br>• Knowing how to use services better<br>• Helps people make choices about their future care. Those with LTCs or chronic health problems can benefit from having an Anticipatory Care Plan. | Social Prescriber<br>Clinical Pharmacist<br>Physician Associate<br>Community Paramedic<br>PCN Physiotherapists |
| **Personalised care** | • Care tailored to the needs of people and what matters to them<br>• Prevention embedded<br>• Personal Health budgets<br>• Shared decision making | Social Prescriber<br>Clinical Pharmacist<br>Physician Associate<br>Community Paramedic<br>PCN Physiotherapists |
| **Inequalities** | Reducing inequalities between patients in access to, and outcomes from, healthcare services and in securing those services that are provided in an integrated way where this might reduce health inequalities | Social Prescriber<br>Clinical Pharmacist<br>Physician Associate |

# Section 3: BHR BCF Scheme Summary Overview

**1. Summary**

This section provides a summary preview of our schemes for the BCF 2022-23. Since the impact of COVID many of our services have had to adapt and amend their delivery models and Place Based Partnerships are now looking at these services going forward and how revised or new models need to be designed and implemented. This is particularly linked to hospital discharge, the sustainability of homecare, residential care, the care workforce and our prevention and early intervention offer.

**2. Schemes & Metrics**

**BCF National Metrics**

| | |
|---|---|
| **Metric 1:** | Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population |
| **Metric 2:** | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services |
| **Metric 3:** | Unplanned hospitalisation for chronic ambulatory care sensitive conditions |
| **Metric 4:** | Discharge to usual place of residence |

**Other Related Metrics**

Many of our services contained within the BCF plan also deliver to a wide range of other outcome measure under ASCOF and NHSOF, such as those supporting carers. For example:

**ASCOF Related Domains**

1. Enhancing quality of life for people with care and support needs
2. Delaying and reducing the need for care and support
3. Ensuring people have a positive experience of care and support
4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

**Example ASCOF indicators include:**

- 1D. Carer-reported quality of life
- 1I: The proportion of people who have as much social contact as they would like.
- 3D. Proportion of people who use services and carers who find it easy to find information about support
- 4B. Proportion of people who use services who say that those services have made them feel safe and secure

**PHOF Related Domains**

1. Improving the wider determinants of health: Improvements against wider factors which affect health and wellbeing and health inequalities

2. Health improvement: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
3. Health protection: The population's health is protected from major incidents and other threats, whilst reducing health inequalities
4. Healthcare public health and preventing premature mortality: Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

**NHSOF Related Domains**

1. Enhancing quality of life for people with long-term conditions
2. Helping people to recover from episodes of ill health or following injury
3. Ensuring that people have a positive experience of care

**BCF Priorities and Schemes**

Our plan priority schemes for 2022-23 are set out below. The scheme types are those models and/or services that will deliver the priority scheme ambitions.

| | BCF Policy Objectives and Scheme Names | SCHEME TYPES* |
|---|---|---|
| 1 | **Enable people to stay well, safe and independent at home for longer.** | • **Population Health Management Pilots**<br>• **Anticipatory Care**<br>• **Personalised Care and asset-based commissioning**<br>• **Rapid Response**<br>• **Telecare**<br>• **Community Based Equipment**<br>• **Carers services**<br>• **Carer advice and support**<br>• **Carers respite**<br>• **DFG Related schemes** |
| 2 | **Provide the right care in the right place at the right time.** | • **Bed based intermediate Care Services**<br>• **Reablement in a person's own home**<br>• **Residential Placements**<br>• **Home Care or Domiciliary Care**<br>• **Housing Related Schemes**<br>• **Low level support for simple hospital discharges**<br>• **Integrated care planning and navigation**<br>• **IMHA** |
| 3 | **Market Stabilisation & COVID Recovery** | • **Provider uplifts**<br>• **Fee increase**<br>• **Winter pressures**<br>• **Post Covid Recovery**<br>• **Workforce** |

*The scheme types often deliver in more than one priority schemes area to delivery care services in a variety of ways. For example, DFG monies can be used to support hospital discharge and community support and independence in the community.

**Scheme Delivery & Management**

BCF Scheme delivery will be overseen by the BHR BCF Executive Group and BCF Operations & Finance group which ultimately reporting into our Joint Commissioning Board. Progress reports on the health and care models delivery and spend will be presented to the Executive group. However, Commissioners from all three boroughs and the NEL ICB work closely together on a regular basis in relation to discharge models, system changes, and transformational and commissioning work. Our s75 agreement sets out the governance for these groups.

**Approach to Risk**

All partners are facing great financial pressures in the life of this plan and continuing to work to addressing ongoing sustainability. Partners to continue to be responsible for overspends on their respective budgets within the BCF. COVID and increased demand

across all client groups placed a significant risk on the health and care system and financial landscape across BHR. This is impacting our NHS, social care and provider workforce. Within the local authority, social work and brokerage teams are often severely stretched to meet caseloads and demand and key workforce areas are struggling to meet the demand, for example the number of therapists available at a regional and national level. The system is working to mitigate these workforce issues with agency usage, the new BHR Academy and new apprenticeships through Care City, but these longer-term solutions will take a while to trickle through and mitigate these risks.

Further governance detail to Risk is set out in our joint BHR BCF s75 agreement. A detailed **Risk Log** can be found in **Appendix 1.**

# Section 4: Implementing BCF Policy Objectives

## Enable People to stay well, safe and independent at home for longer

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with very occasional admissions to acute hospital settings when necessary. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local health system would quickly become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

**Admission Avoidance**
The key local service for Rapid Response intervention (Community Treatment Team) was comprehensively reviewed in 2021-22. This indicated that with increased demand throughout the day, a larger response team was required and particularly telephone triage capacity. This has led to a considerable investment (£1.2m FYE from Ageing Well) to increase nurses and allied health professionals to meet the new two-hour urgent care response.

**Anticipatory Care (AC)**
By supporting people differently in the community, including tackling the wider determinants of health, we can prevent some individual's needs escalating or address them in the community rather than in acute services. BHR Places are at varying stages with both Population Health Management and Anticipatory Care. Barking and Dagenham Place are actioning a whole Place level PHM pilot in 22/23 and have identified pre-frail and long-term condition as two key cohorts to focus on. This has led to a PDSA approach with a PCN to test proof on concept for targeted interventions on a small scale. The work has included engagement with the local residents and collaboration with voluntary and community organisations. The outcome from this work will inform a future model of AC with an MDT at PCN level. Learning from the pilot will used to inform the development of AC across both outer and inner NEL.

**Homecare & Double Handed Care**
Barking and Dagenham have a homecare framework in place which operates on a locality model ensuring our domiciliary care function can support hospital discharge as well as keeping our residents in their own homes and in the community for as long as possible. Throughout 2022-23 our framework providers are working with partners to support discharge pilots that are outlined at other points in this narrative.

The Redbridge Homecare Framework model is a locality-based model with lead providers, back-up and specialist providers for children, LD and mental health. This enables areas to provide improved personalised care for service users to reduce hospital admission; position the market to deliver an enhanced health and social care home care service that reflects our integrated community care service and deliver improved efficiencies and reduce the need for long-term higher needs care.

In Havering a long established 'Active Homecare Framework' based on a Dynamic Purchasing system has established a set of providers that have passed high quality criteria where relationships are based on long term partnership. It has reduced the need for spot contracting to less than 10% from 50% before the framework was established. Recently the market has joined up in an association model, which is now operating its own forums with the LA as a partner. Continuously improving dialogue has led to initiatives and high quality partnership working.

**Supporting people to remain independent at home, including strengths-based approaches and person-centred care**
Improving the quality of people's lives and reducing the years of disability and illness will increase the length of time people can continue to live independent lives and reduce the need for and dependence on health and social care services. Retaining a level of

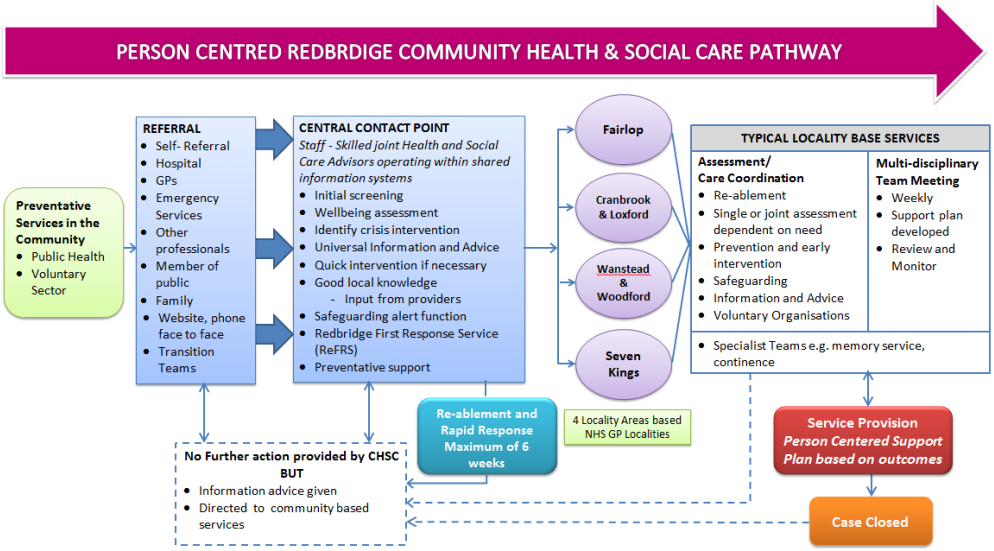
independence supports both psychical and mental health through empowering and maintaining those close community links within a familiar environment.

Supporting people in their own homes is an important part of ensuring that people retain their independence. The retention of links to family and community, in places where they are familiar, results in better health and wellbeing outcomes, as well as reducing the need for costly residential care.

Urgent Care Rapid (UCR) Response is the key approach to supporting people who are at risk of presenting at the emergency department and potentially being admitted to an acute setting. UCR will assess a patient within two hours if required and provide nursing, AHP and medic input (and prescribing) in the persons home. This is for three days.

**Strength-based Model**

The Redbridge First Contact team use 'People Matter - Three Conversations' as the default model of social care across all localities in the borough replacing the traditional 'formal' based assessment model. By putting the person at the centre of the conversation as the best placed person to understand their needs, it uses a conversational approach with the person to find out what is really important to them; what they would like to achieve and how they can best maintain their independence, health and wellbeing for as long as possible. By using this approach people feel their lives are improved and has led to a significant reduction in the number of long-term support packages. It supports the promotion of choice, independence and personalised care - through the use of Direct Payments, Self-directed support and complements personalised health budgets. The personalisation agenda will form part of a key workstream for LA commissioners going forward.




B&D have adopted a strengths-based approach as their social work practice model supported by a delivery model and framework which sets out Care and Support Services' intent over the next three years to develop and introduce a 7 strength and asset-based approach that informs our professional and management practice: and organisational culture across adult services. It will be reflected in our service structures and commissioning intentions; our partnership approaches; and most importantly our engagement and relationships with communities and the Third Sector going forwards. The framework represents a fundamental change to how we engage with each other within Care and Support and the Council; and across the whole system with health and social care stakeholders and partners; and fundamentally with the Third Sector and with residents and communities, and how we support community led new and improved ways of working that will deliver greater community resilience and better outcomes.

Modern 21st century social work and social care in B&D seeks to move away from Care Management and a 'deficit' model, away from 'problems and issues' and how professionals can 'solve' this. Instead, we want to improve practice and support better outcomes through true collaboration with people and communities who use services and those who care for and about them. To drive this forward, we recognise that to maximise empowerment and outcomes for and with people and communities the whole system needs to change, moving from a system built around the assumption that formal services are always the solution, and recognising we are partners in a wider system of relationships and support networks. In B&D, our strength is that we are an ethnically and culturally diverse workforce and population. We do however face significant challenges. On average, communities have less access to resources than the national average. At the same time the population in is growing faster than in any other area in the UK. By moving to a strengths and asset-based model we will seek to be bold, build on our diversity and the knowledge and experience in our communities; and deliver shared community and organisational benefits.

Havering are encouraging the use of all available assets is essential in ensuring that public services continue to support those most vulnerable in our communities. Almost every activity, engagement, communication and discussion between actual and potential service users and their carers, and those who are part of the social care and health system should look to utilise and enhance available assets and abilities as, at least, an implicit aspect of the conversation.

This approach is enshrined in Havering's 'Better Living' approach, whereby social care practice looks to have conversations with service users that first look to find their own or community assets that can address the problems faced without creating a dependency on statutory services. To provide the infrastructure that supports this approach services are commissioned that are complementary. The system we want should support people staying fit and well and keep people out of long-term care as much as possible through interventions that are designed to facilitate people to live as independent a life as possible.

We will use data and establish systems that provide evidence to ensure an understanding of preventative models and to inform where future investment will be best placed. It is important that public health and commissioners work together where there are needs for data and evidence bases to support the delivery of improved health and well-being. Getting to grips with Population Health management is critical to ensure the best outcomes for people over the medium and longer term.

**Mental Health & Carers Support**

Mental health is a key area that has been impacted upon by the pandemic and a number of local providers are commissioned to provide befriending to reduce social isolation for service users and their carers, therefore complimenting and supporting the more clinically based models of care for mental health.

As part of long-established BCF schemes, the BHR boroughs commission employment support for people with mental health needs and a Carers Support Service. The latter service is commissioned from a voluntary sector organisation and delivered in a variety of health and community settings. The service also helps to lead the delivery of the joint health and social care Carers Strategy.

We continue to implement its duties as outlined in the Care Act 2014, through promoting wellbeing, prevention, advice and information on care services, and providing strengths-based person-centred care - including support for Carers. Our Carers offer is being reviewed in order to explore ways in which we can provide better support to carers and reduce incidents of carer breakdown. Through working with our providers and carers themselves, we will be able to co-produce an improved model to ensure more flexible support is available when needed. B&D has developed a new Carers Charter to improve services and support to carers in the Borough.

Redbridge is developing a Carer Friendly Borough by aiming to support carers better through meeting the following strategic priorities:

- Identification and recognition: Support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset in designing local care provision and in planning individual care packages.
- Realising and releasing potential: Support people with caring responsibilities to fulfil their educational and employment potential.
- A life alongside caring: Ensure that support for both carers and those they care for is personalised, enabling them to have a family and community life.
- Supporting carers to stay healthy: Support carers to remain mentally and physically well.
- Supporting young carers: Protect children and young people from inappropriate caring roles and ensure they have the support they need to learn, develop and experience positive childhoods.

Havering has invested BCF in re-commissioning its dedicated carers service and works directly with the provider, integrating the service as an important part of Havering's wider preventative offer.

**Community Provision**

Redbridge LA has a long-established history of working closely with its VCS partners by commissioning and contracting many prevention and early intervention services with VCS providers who are highly experienced in meeting the needs of our diverse community. They provide lower-level cost effective provision, such as our Falls Prevention model provided by Age UK which is now looking to be replicated across the other LAs. Our CVS has been instrumental in both development and delivery of our social prescribing models. In addition, as part of the NHS long-term plan, NHS NEL have been developing their role and commissioning of the VCS over the last year. The VCS are key partners - being key contributors into boards, steering and task and finish groups. This has been particularly the case with the older people and frailty agenda, where a number of new developments will be funded via the BCF, and the VCS have been key in driving these agendas forward. This includes care home trusted assessors to support patients

to be assessed for a care home place in hospital for more rapid discharge; funding additional care navigators to enhance supported discharge and the expansion of Redbridge Falls prevention classes as part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

Community, social connections and having a voice in local decisions are all factors that make a vital contribution to health and wellbeing. These community determinants of health build resilience and can help buffer against disease and influence health-related behaviour. Involving and empowering local communities, and particularly disadvantaged groups, is central to local and national strategies in England for both promoting health and wellbeing and reducing health inequalities. All communities have assets that can contribute to the positive health and wellbeing of residents, including the skills, knowledge, social competence and commitment of individuals, and local community and voluntary groups and associations (both formal and informal

There has been an increased focus on community resilience and social isolation both locally and nationally in the last few years, leading to the rise in practices such as social prescribing. Social prescribing involves GPs, nurses and other health professionals referring patients to non-medical services, typically provided by voluntary and community sector organisations, including, for example, volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and physical activities.

For example, in Redbridge:

- Voluntary Sector: The Borough commissions a number of voluntary sector organisations to support prevention and early intervention including befriending and support for carers to help reduce social isolation. Work to look at future models are being undertaken to understand how needs have changed and can provide an improved more appropriate numbers of services.
- Redbridge Social Prescribing: The Borough and NEL ICB commission a social prescribing service which reaches 42 GP surgeries, the service supports people with low level mental health problems, type 2 diabetes or who were socially isolated with a Health and Wellbeing buddy.
- Day Opportunities: These services, provided both directly by the Borough, and by external agencies promote independence, improve quality of life, and support individuals to socialise and play an active part in their community and provide vital breaks and support for carers of those with LD & MH disabilities. A key feature of developing services going forward is to build in a progression throughout all stages from transition level onwards, to help reduce reliance on (where possible) on high-need care services and promote better life skills for services users and carers.

In Havering, the voluntary and community sector is an important part of the market. Extensive engagement with both commissioned and non-commissioned voluntary sector services co-produced a set of outcomes important in the Havering context. We will work with providers to ensure outcomes are delivered. We will look to integrate the services with the wider system where necessary. The required outcomes include:

- High quality information and advice
- Ensuring people are supported in their journey from hospital to home
- Low level support in the community for vulnerable people that prevents escalation to statutory services

However, the process also identified three other outcomes that are particularly important in the Havering context:

- Social inclusion – informed by the identification of social isolation as a major driver for demand in Havering.
- Carers of all ages are supported in their role – informed by the demographic of Havering and the identification in the 2011 census of 25,000 carers within the borough. The Carers Strategy identifies more detailed outcomes for the voluntary sector to respond to.
- Development of self-sustaining peer support networks – responding to the need for the community to use all its assets to provide support to people.

A further development has been the introduction of community hubs that are designed to provide support to communities, linking them with voluntary sector services and to other preventative initiatives such as Local Area Coordinators.

Within B&D, our front door service, Community Solutions continues to provide essential frontline support to mitigate hardship for residents with specific concerns and support requirements such as finance, debt, rent, benefits, housing and employment. Community Solutions are also commissioned to provide the Borough's social prescribing service.

We have an increasingly vibrant voluntary sector which is an essential part of our Care and Support Provider market and provides a number of our key services such as Carers Support, Handyman service and the Home, Settle and Support service. Through the BD Collective there are now a number of groups which bring together Care and Support staff and VCS colleagues:

- Re-imagining Adult Social Care
- Early Help
- Joining the dots

Alongside the development of Community Hubs and neighbourhood networks in the Borough, these groups offer an opportunity moving forward for professionals from both sectors to come together and better support our residents and work up ideas collaboratively. Social isolation is a key priority and has played a focus for all partners in 2022 onwards.

**Local Area Coordination**

Local Area Coordination is an essential part of Havering's approach to preventative and personalised services. It is a model of supporting people that is embedded in the community. Local Area Coordinators work within a population of around 12,000 people. They get to know the people and local assets in the area. They are based in the community and work on the basis of introductions. If a person has something they want to change, their Local Area Coordinator will walk alongside them to help them achieve it. Local Area Coordination is a strengths-based approach that focuses on the strengths of the individual and the capacity they have and the contribution they can make, reconnecting people into their community. The service is being actively rolled out as a partnership initiative.

Local Area Coordinators form trusting relationships with people and look at all aspects of their lives, focusing on what is good and motivating people to be in control, building their capacity to take control of their life. Local Area Coordination is actively delivering good outcomes, working with people in the community who face a range of challenges including mental health, issues related to debt, housing or feeling isolated. Building community resilience and linking support with local community assets is central to the aims of Local Area Coordination.

We are piloting this approach in Havering and although management of the team sits within the Council structure, Local Area Coordination will support outcomes from all public sector partners and therefore the pilot is jointly funded by a range of partners and from the BCF. An evaluation of the service is being developed and, when it has been operational for a sufficient amount of time, evidence will allow partners to make informed decisions about rolling out the service across Havering. Our ambition is that the LAC offer is expanded to cover the whole borough.

**Personalisation**

Havering is committed to increasing the scope and scale of personalisation and the infrastructure that supports it. There are many issues to be understood, solutions identified and implemented through a programme of change in partnership with service users and their parents/ carers. To build a solid infrastructure for a sustainable system, the activities and approaches needed include:

- Engagement and inclusion of those who are potential and current recipients of self-directed support so that they can shape the model moving forward
- Clear and specific commitment at a leadership level
- Engagement with the market – outlining the drive toward personalisation and the implications, which will include:
    - The opportunities for developing services designed to meet the needs of individual budget holders.
    - Micro commissioning and the need for growth in personal assistants and/or micro commissioned services that meet particular needs
    - Review of levels of payment to direct payment budget holders
- A culture developed across the system that understands and appreciates the power of personalisation, promoting the thinking that is needed to move from the perception of dependent service users and patients to empowered ones
- Use of external information and learning to promote ways of developing personalised services
- Committing to making processes as easy as possible to access and purchase services
- A proportionate and explicit approach to risk around safeguarding and quality within the context of directly commissioned services
- Draw on cross borough initiatives where they are supportive of market development, quality etc.
- Communicate and work with providers to develop the range of services and the support needed to respond to the demand generated for such services
- Have a clear and documented policy framework as the basis for design and decision making
- Clear set of outcome-based measures ensuring movement towards increasingly personalised services for users
- Commissioning services to allow them to be flexible and responsive to individual and family needs

B&D is currently undertaking a direct payment reviews project to ensure that service users have the support available to them in their role as an employer and that they have a Personal Assistant or other service that meets their needs. The Borough's direct

payment support service, run by Vibrance, is working closely with social workers to ensure that service users have the right advice and support when they are thinking about choosing a direct payment and can help a service user to find and employ a PA and put the right documentation in place. This service is being used across adults and children's services and the wider project is also reviewing processes and training needs to support the Care and Support workforce.

**Integrated Community Equipment Service**

Redbridge is the commissioning lead for the Integrated Community Equipment Service (ICES) with its partner - Havering, BHRUT (acute provider), NELFT community health services and the NEL ICB and implemented through a S75 agreement using one equipment provider commissioned via a framework arrangement. The service has just been re-tendered for a new contract and includes sharing management costs and a recycle equipment pool across all partners. This does not currently include B&D who are part of a pan-London community equipment arrangement.

**Assistive Technology**

Havering invests significantly in Assistive Technology, helping people to stay at home as independently as possible. Whilst current offers support people it is also our intention to look at innovative solutions as they develop to look to use the most effective solutions available. There is also interest in virtual reality providing the opportunity for remote monitoring and identification of need without the need for face to face personal interactions.

Redbridge currently has a transformation workstream around its approach and investment in assistive technology. It has been working on a app called 'Multi-me' which enables and supports people with LD to networks with services, carers and friends in relation to their care and needs.

**Care Technology**

B&D have recently procured an Innovation Partner for the management and delivery of an all-age Care Technology solution our residents. This service will deliver in three key areas:

- Innovation and development of technological or digital services to residents which complement their own support and networks. This will also include flexibility and future projects based around arising technology throughout the contract
- Facilitate a cultural change by establishing and embedding a 'Technology First' approach within Care and Support services to include a Care Technology learning and development programme.
- Manage and deliver the service to embed an innovative new operating model for leveraging care technologies and data to support better outcomes in care and support and deliver significant financial benefits. This will include a flexible proactive and reactive response-based service pertinent to both support planning and the immediate welfare of our residents.

This service will move away from the traditional reactive models of assistive technology centred around a conventional monitoring and response alert-based service, to digitally transformed health and social care systems and services centred around technology to achieve better outcomes for residents, fully harnessing the role of the wider community and support networks. This will mean embracing the full suite of technological advancement available now and throughout the contract term ranging from artificial intelligence and machine learning to augmented and virtual realities to offer a truly personalised experience for our residents.

The move to digital represents a huge expansion in the range and depth of available devices and data. Backed up by increased stability and reliability leading to enhanced accuracy and visibility that delivers informed choices for care recipients, their families, caregivers and the wider health and care system. A particular focus will be given to tech-enabled hospital discharge, commencing late summer / early autumn.

LBBD's new Care Technology service represents a significant step for the system's wider digital transformation journey however, there is significant scope to expand the offer, both in terms of the user groups who can access the service and the types of technology available to support them. A Digital Transformation Strategy for Care and Support is currently being developed which will set out our wider ambitions around innovation, our use of data-insights and our commitment to a technology-first culture with service provision and in support of the wider integration agenda.

## Provide the right care in the right place at the right time

**1. Summary**

All of our priorities above are designed to provide a range of services and supporting outcomes to meets the needs and demand of patients, service users and carers within the flow of the health and care system and support the maintenance of people to stay, well

and supported within community and home settings – only needing acute settings when necessary. Therefore, our BCF monies are targeted towards our priorities in supporting this flow. This is as set out in schemes and expenditure plans.

We work towards embedding key improvement outcomes around, independence, support and mental health and care within service design and to ensure we meet the national outcome frameworks of the NHS, Adult Social Care Outcomes Framework (ASCOF) and PHOF.

Key to supporting hospital discharge is partnership working between social care and our acute providers BHRUT & Barts, and community health provider NELFT - in developing discharge policies and processes around flow out of hospital in the community and home. Key to this is the Discharge Improvement Working group where engagement was vital to ensure that the new discharge models of our SPA (Integrated Discharge Hub), D2A and Home First can be implanted and delivered. Joint system working groups are in place to ensure that these are being constantly monitored and refined between all partners.

**Winter Pressures Support across BHR**

Although the Winter Pressures is contained within the BCF (and not subject to ring-fencing) we will use the monies across BHR to support key services and capacity to ensure patient flow through discharge planning, and to ensure there is sufficient capacity to support move on from hospital to other care services (with our Brokerage teams) to fund extra residential placements (residential/nursing care/extra care/supported living); homecare packages; home, settle and support service and reablement (our default offer pathway for hospital services). Further detail is set out in the BHR individual expenditure plans.

**2. Models of Care**

Social care continues to support getting people out of hospital. This approach however of investing to support discharge has led at times to localised market capacity issues and budget pressure (overspends). Greater use of residential care and residential with nursing care places across the boroughs might destabilise those markets locally or push prices up for Local Authorities but there is opportunity to work together to minimise any impact.

Barking & Dagenham, Havering and Redbridge are adjacent boroughs/places in outer north east London. We share a single major acute provider, Barking Havering and Redbridge University Trust, and a large community and mental health Trust, NELFT NHS Foundation Trust. This creates a natural alignment for health and local authority partners and places to work together to achieve the best outcomes for the whole population

**Hospital Discharge Policy**

All three boroughs/place have used the BCF to work to support discharges and improve outcomes for our residents when they come out of hospital.

We have worked across all discharge pathways to improve the experience and outcomes for our residents and also to support the local acute hospital system with the demand increases for their bed base. Internally within the health system the BCF has supported the creation of community-based discharge team which has driven care decisions into the community rather than keeping them based in a hospital setting. Developing a single point of access SPA (now called the Integrated Discharge Hub – IDH) for discharges across BHR places, streamlining discharge processes and giving local authorities a greater degree of management over care packages from their start. Key to the success of the IDH is the trusted assessor model which situates trusted assessors of care needs on the hospital wards to increase the efficiency of assessments for placements across care settings.

The BCF is crucial in supporting our pathway 0 offer with respect to providing people support in their home at point of discharge. This includes our home settle and support service provided by the British Red Cross. This is a particular example of joint commissioning; the service being jointly commissioned by all three boroughs and NHS NEL.

Pathway one is supported through the home first pilot which has been referenced above alongside the BCF supporting general crisis intervention from our homecare agencies. In the B&D Crisis Intervention is our free service provided for a period of up to 6 weeks at point of discharge. Social care in the community, including a DOLs assessments are also supported through the BCF to ensure that we have the capacity to meet the demand from hospital discharges. Similarly, for Havering & Redbridge we use reablement as our default offer for this pathway and also Home First sits within these providers. These dedicated reablement services have been modelled around home first principles and is fundamental to ensuring the flow from hospital is maintained.

**Pathway 2 and 3** are supported through our jointly commissioned discharge pathways include the discharge to assess pathway referenced earlier. This pathway places individuals into nursing home beds that have a rehabilitation team supporting the residents for a six-week period. The aim is that these residents will then be able to have their long-term care package reduced after the six-

week period. The pathway works with contracted nursing home beds which also eases the discharge process as for those who are eligible for the pathway there are pre-arranged beds available. This initiative, piloted in Havering, was evaluated and has been effective in improving outcomes and cost effectiveness. The scheme has been extended to B&D and Redbridge in 22/23 with a total of 28 beds available with therapy support.

The BCF supports a wide range of other services in B&D that support discharges that are safe and effective. This includes our community treatment team and social care capacity and a Blitz Cleaning and decluttering service provided by the ILA, a voluntary sector organisation. Redbridge also provides a service to help those who hoard to enable them to be able to live safely and return home with care. Havering ensures that its commissioned voluntary sector services are joined up with reablement and 'home settle and support' discharge pathways to enable connection with appropriate services depending on needs.

While Barking & Dagenham and Havering have BHRUT as the one main acute provider, Redbridge also has Barts Health NHS Trust (Barts) in addition to BHRUT through Whipps Cross University Hospital, situated in the north west of Redbridge serving approximately one third of the population and is the provider of choice for a number of residents due to access with Redbridge ICB commissioning services with Barts. Therefore, the LA works very closely with both acute providers in supporting its discharge process. Home First is Redbridge will be moving into its next phase which will include developing this with Barts.

The narrative below for our key priorities provides an overview and highlight of the key models of health and care, and key services delivering our ambitions within our BCF plan for 2022-23. This not an exhaustive list of every service provided by every borough and ICB as many of these are the same across the patch, but an illustration of the key components working across BHR. Full details of what is funded is provided within the individual **Planning Expenditure templates**.

The interface between hospital and the community is vitally important in the relationship between health and social care, both for the individual and for the organisations concerned.

The ICS subsystem partners, as the pandemic eases over the next 18 months, must return to its relentless focus on avoiding admissions to the acute hospitals and supporting the reduction in pandemic induced backlogs in care. This will require understanding of vulnerability and early responses to issues without creating dependency. Imaginative approaches to reablement prior to hospitalisation, continued focus on assistive technology, high quality homecare, personalisation of services will all contribute to sustaining people in the community rather than escalating to acute or long-term care.

**Developing Discharge Options**

Over the past 12 months, there have been a number of key developments around discharge. These are:

- **Discharge to Assess:** Particularly piloting targeted care homes with a wrap-around therapy team, has shown outcomes to support 23% of the patients to be discharged home.

- **Home First:** Each borough now has a Home First approach including a therapy team, reablement care and access to equipment. Havering now have Home First as the default model for discharge:
  Reablement / Crisis Intervention
  Homecare
  Residential and Nursing Care

- **Trusted Assessor (TA):** The TA model has really supported the range of discharges required during the pandemic to care homes including discharge to assess, designated provision and alternative rehab stepdown. The service will be sustainably funding from Q3 with two assessors to work across BHR.

When people do go into hospital and come out with a new or on-going need for support there is a need for a quick and effective response, putting in place all the necessary support mechanisms that will re-able and rehabilitate the person back to independent living as soon as possible. We are committed to the principles of 'Discharge to Assess', the idea of getting people out of the acute setting as soon as they are medically fit, ideally back home, where prompt assessment of needs leads to support in place quickly, in whatever form necessary, to enhance chances of rehabilitation and independence. There are a significant number of dependencies on this happening effectively.

- Understanding as soon as possible the point at which clinical need in an acute setting ends, so that the person is identified as ready to go home

- Once this point is understood the rapid transportation home of the person with required support in place (be that equipment or support from a therapist, care worker or an adjustment to the home environment)
- Getting the right assessment of need for the person, recognising that the assessment will be different if done:
    - At the point of crisis in hospital
    - Immediately after the person gets home
    - After a period of reablement and/ or rehabilitation at home.
- Other influencing factors will be whether the assessment is a joint one, with multi-disciplinary input and whether there is a full understanding and application of the principles of personalisation, developing support plans that focus on outcomes.
- How quickly, from the point of return home, the application of high quality reablement and/ or rehabilitation is put in place
- The quality and intelligence applied in determining need for home care
- The messages that are given to the person concerned around dependency and the ability to get them back to independence
- The family response to the situation
- The ability of informal carers to take responsibility for meeting the needs of the person they are caring for
- The quality and appropriateness of the housing situation of the person concerned

All these dependencies, and others, play out in deciding whether or to what extent and how quickly the person might be capable of being fully independent. If the services do not coordinate, the likelihood of recovery being sustainable for the person concerned will be diminished.

Where commissioned services are part of this, they need to be enabled to play their part in contributing to the desired outcome. This needs to be considered in the design of such services, ensuring that integration is designed as an end to end process and not as an individual, segregated service. Commissioners and providers from different organisations must continue to join up where possible to design across the end to end process, with the benefit to the end user in mind, and not in silos with the achievement of narrow targets as the measure of success.

Our strategic approach will look to approach things from this perspective and our system design will actively avoid the development of solutions in isolation of partners crucial to the design of an effective end to end process.

One unintended consequence of the nationally prescribed Hospital Discharge Policy, with its 'Trusted Assessor' element is that the borough is seeing far too many patients discharged into care home settings, who then stay there permanently. Whilst on paper it makes complete sense for any assessment of long term need to take place out of the hospital setting, without the right community offer in place (such as access to rehabilitation), the consequence for the patient can be catastrophic, in that they further decondition, become institutionalised and remain in that care home permanently. As a system, we need to review our investments to refocus on keeping people out of hospital in the first place, but where they do have to be admitted, that there are the right services to pull patients back out into community settings not care homes

BHRUT are currently refreshing their Clinical Strategy, and patients and partner organisations are being widely consulted. BHRUT recognise that central to the refresh, is that it must look more outward and play its part in supporting the right health outcomes for people in out of hospital settings.

**Integrated Discharge Hub**

A key priority across and health and social care was the development a robust and sustainable discharge unit across BHR. The BHR health and social care discharge teams have been brought together under the management of NELFT as a single team that will manage all hospital discharges for pathways 2-3. The operating model was embedded in 21/22 and the service became a formal Integrated Discharge Hub in July 2022 servicing both health and social care.

In 2021/22 external support was sourced to support the system to review discharge approaches. The outcome report has been used to further support understanding and developing services and pathways in 2022/23 alongside the 100-day challenge for the end of September 2022, to address any gaps against the 10 standards to deliver a good discharge offer. Additionally, a series of system wide workshops commenced in July to identify themes and issues for the local system and then prioritise into quick (for winter 22/23), medium- and long-term plans to address these.

All partners have used the BCF to support the integrated commissioning across hospital discharge pathways. The discharge to assess pathway and the home first pathway are both supported by the BCF and commissioned across the local authority and the ICB. Both pathways seek to increase the efficiency of discharges from our acute settings while improving the longer-term outcomes of our patients. The home first pathway uses therapist support to carry out discharge assessments at home where a more accurate package of care can be put in place. This also encourages home as being a default discharge setting.

The discharge to assess pathway sees residents discharged into a named nursing home which has a rehabilitation team wrapped around the nursing homes normal service. This increases the chances of a decrease in long term care needs. The ICB and Local Authority are commissioning 8 beds for the discharge to assess pathway with a rehabilitation team to support these beds. The aim is to improve discharge outcomes in the long term for these residents.

**Home First**

Whilst the home first pilot in Havering described above initiated a different approach, this is now being rolled out, adapted to meet local needs in B&D and Redbridge.

B&D is currently undertaking a number of hospital discharge pilots which are seeking to improve the hospital discharge pathway for our residents. Therefore, many of these are also focused on supporting our residents to remain at home and with a great level of independence. Chiefly is the Home First pathway pilot which is seeking to ensure that as default the first choice for discharge is back home. This pilot then puts in place a more accurate care package that has been assessed in the home of the resident. This aim is that these residents will be more able to remain at home with an accurate care package suited to their needs. With this more accurate care package there will also be a reduction in readmission to hospital.

Redbridge has also expanded its Home First model which is embedded into our Reablement service. Redbridge hosts the Occupational Therapists for both Barking & Dagenham and Redbridge.

**Rehabilitation**

NHS North East London continue to commission from NELFT a range of rehabilitation services. There are 61 community rehab beds available to support discharge with rehab and step down. 27 stroke specialist rehab beds are also commissioned to offer step down rehab from the acute stroke wards. Hybrid models working with care homes to offer step down from hospital and rehab beds have also been developed.

The Intensive Rehab Service (IRS) continues to offer 21-day intensive rehab at home post discharge. Longer term rehab is then continued via integrated care teams in the community. Stroke and Neuro rehab is offered with an Early Supported Discharge team at BHRUT and Community Rehab Services offer slow stream rehab.

28 Discharge to Assess block booked across are available across the 3 places and delivered over 3 care home sites. 30% of patients who went through the block booked bed base with a wraparound rehab team are returning home.

**Reablement**

Redbridge recommissioned and implemented its default Reablement offer with NELFT for hospital inpatient discharge services across both its acute providers - BHRUT and Barts, as well as actively encouraging referrals from community teams. Built into our existing 'Community Health & Social Care Service' S75 agreement where MDTs are co-located within our four locality areas. This provides a platform for the Redbridge Reablement Service (RRS) to deliver a preventative element through the health and adult social care pathway and to proactively interface with the operational service, building on our integrated partnership model which will continue to shape the service in line with service needs. This new default offer is provided using a Trusted Assessor model with our provider and will support discharge and provides a quality service to ensure we maximise the goals and outcomes that service users can achieve reduce the need for long-term care packages and enabling to still be at three months after receiving support. We doubled our investment from £700k to over £1.4m a year to deliver a higher quality outcome focussed Reablement service with increased capacity.

Havering's commissioned service provided by Essex Cares Limited has been in place since 2019 and is a fundamental part of Havering's preventative offer. Demand on the service has exceeded what was expected when the service was commissioned. This has been exacerbated by the pandemic, but demand continues to be at unprecedented levels. If the demand continues the system as a whole will have to consider how the service, which supports hospital flow and allows for delivery of home first principles and outcomes, can be funded. It is a significant challenge but in terms of quality, the service is providing very positive outcomes, which presents at the same time an opportunity for the system to come together to design and deliver a highly effective reablement model that links in with all other aspects of the preventative model. A key priority for health and social care from here on forward is to focus on how reablement services can be funded and tilt towards admission avoidance, in collaboration with CTT, LAS and utilising technological opportunities (such as virtual reality) to stop patients being admitted in the first place.

**Crisis Intervention**

B&D currently implements a crisis intervention model in which homecare agencies provide support to residents for the first six weeks after discharge into the community to support individuals to live independently at home and prevent re-admission to hospital. We are currently reviewing whether we implement a commissioned reablement approach with stakeholders from across the partnership. We have worked with Care City, an innovation centre for healthy ageing and regeneration in North East London, to support us to research and review international and national reablement models to inform our thinking and we are currently developing an options appraisal in order to pilot a reablement approach in 2022/23.

**Home, Settle & Support**

The BHR British Red Cross Home, Settle and Support service commissioned by the local authorities and the ICB has continued to support residents on their arrival home from hospital. The service primarily supports residents who live on their own and a large proportion of the people accessing the service have been 70-89 years old. The main goals of the service are to help people feel more safe and secure when they get home from hospital, reduce their anxiety, and increase their ability to manage day to day things when they get home. The British Red Cross staff and volunteers have picked up medication, delivered shopping and signposted residents to onward services during the pandemic. The service has helped residents feel safe when they get home and has often been delivered remotely or in a COVID-19 secure way, again to reduce the risk of transmission.

**Accommodation Based Care**

We offer a range of specialist accommodation options, including supported living and extra care, and the shared lives programme. Supported living accommodation is commissioned for people assessed as requiring a supported living environment, including people living with or recovering from mental illness or crisis, people with a learning disability, physical disability, at risk of domestic violence, homelessness and for care leavers. Supported living is similar to extra care provision although rather than being based in sheltered housing schemes it tends to be based in shared housing/accommodation. It can also include floating support services where people live independently and receive external support. This housing related support is predominantly provided by registered social landlords that in some cases also provide care to those individuals.

Extra care services provide an alternative approach/model to traditional home care services in people's own homes and to residential and nursing care placements. The transitional service also provides opportunities to individuals who require a higher level of care following hospital discharge to convalesce before returning home when their require level of care improves.

Housing designed to meet needs of individuals and their parents/carers will delay and prevent the need for care. It is essential, therefore, that the dialogue between Housing and commissioning is an active one to ensure provision is responsive to community needs.

Social care for various groups requires a property element that is, however, more diverse than general housing. The designs vary depending on what service is being provided. A supported living facility for people with learning disabilities will differ from a residential home for older people. It is often the case that the market will provide properties and have care linked to the property that they own. Whilst this has advantages it also means it is difficult to change providers if similar property is not available. In other cases, property is owned by different agencies from the care provider, creating complications with compatible timelines and strategic objectives of different organisations. Over a period of time, if the Council has none of these properties and do not control where they are based, it can cause problems with finding provisions and costs can escalate.

Where this has happened, or is happening, the issue will be articulated and possibilities around providing Council owned properties or working with other providers to ascertain interests in providing property assets needs to be brought to decision makers attention, jointly from Housing and Social Care.

Property as a means of responding to people's needs, with social care attached in some form, means the two are inextricably linked. This needs a joined-up response formulated that both protects the financial interest of the council but also means people are in the right places and localities to meet their needs.

Within B&D we are currently piloting some extra care assessment flats. These flats are designed to support hospital discharge for those over 55 who have lower level care needs and need time and support to establish a longer-term housing arrangement or who may be interested in extra care longer-term. If the commissioned assessment flats are successful, we will make this a long-term arrangement to support discharge.

As part of its out-of-hospital transition provision Redbridge also operate a number of step-down beds for people being discharge for hospital before going home where people can stay for up to 2 weeks. There are 7 in total across two sites.

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with very occasional admissions to acute hospital settings when necessary. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local health system would quickly become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

## Market Stabilisation

**Care Market**

Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures. The impact of COIVD has been significant in de-stabilising a number of key care markets – Residential, Homecare and the voluntary sector. This is due to a number of factors:

- Workforce issues relating to care staff leaving the sector to work in other areas where pay is higher. This is proving a huge area of concern for Homecare agencies reducing their ability and capacity to deliver high-quality safe care for people at home and take on new packages.
- An increase in the complexity of care needed in people being discharged from hospital including the need for double-handed care packages, larger care packages with more hours and more care packages for younger older adults - exacerbated by the shortage in workforce.
- Carer breakdowns due to people being looked after at home as a result of building-based services not being open and operating more restricted services. Also, the increased number of hidden carers due to the impact of the pandemic on people heath.
- However, on the flip side, as people have returned to work and are less able to care for relatives as home, we are now seeing an increase in demand again for care services such as Homecare.
- Increase of insurance costs to providers as a result of the increased risk the COIVD pandemic brought with it.
- Voluntary sector providers unable to deliver building-based care and moving towards more virtual models and losing people as they are being cared for at home, as building based services were closed and the increase on the number of hidden carers as a result income generated from this.

Demand for services is predicted to continue to rise across almost all conditions and service user groups across BHR especially in Havering with older people. Demand for services, even though demand management initiatives have been introduced, are therefore likely to rise. Care services are largely people based and it therefore follows that the number of people we will need to provide care in future is likely to increase. This is already manifesting itself in markets like the home care market where across the country the deficit in recruitment is causing shortages in provision. This has had a direct knock on effect on transfers of care from hospital and the challenges around ensuring quality of service. All boroughs are continuing to respond to this by ensuring that investment in the system is targeted where it can make most impact.

Within B&D we are seeing an increase in the acuity and number of placements within nursing and residential care and homecare, throughout 2022/23 there have been times when the residential care market has been full within the borough.

Additionally, the B&D Mental Health service continues to see rising demand with many new referrals considered to be COVID-related. The service is aware of a high number of hospital admissions relating to ill mental health (up by 1/3). Especially young people up to the age of 24 are affected and those who had been discharged from Mental Health services and had remained well in the community for several years. This continues to have an impact on the Services provided by our health colleagues in NELFT and in the longer term will impact on activity levels in our Social Care service. Additionally, the Disabilities service is witnessing significant demand with caseloads above acceptable levels, particularly in young people with disabilities. There are a number of drivers for this additional demand namely that the pandemic has put families under enormous pressure over a prolonged period of time. Additionally, we have seen a rise in families from neighbouring boroughs moving to B&D, with children with complex Learning Disability presentations.

Equipment and Adaptations is being closely monitored due to an increase in demand. This is thought to be a combination of package and placement increases and equipment market pressures due to the combined impacts of COVID and Brexit.

The challenges of COVID have proved to be many and on-going as services and staff responded rapidly to ensure people continue to receive care and support and that new demand is met. Despite the challenges faced, the overall performance of social care was largely maintained.

There are of course other aspects to maintaining a sustainable market. Dialogue with providers is a key element of the strategic approach in this area. The dialogue, through provider forums, through a web portal and through co-production exercises, will be a key factor in the overall strategic approach. It is not only engagement but the tenor of the discussions that are had that is important. The commitment is to operate from an assumption that the Council and providers have a shared objective; to provide high quality services to vulnerable people in a cost-effective way.

BHR as a subsystem is now taking forward joint work on developing an approach for local suppliers to position themselves to bid for procurement opportunities to deliver and supply to Council and NHS services. There is also the development and launch of the BHR health and social care academy (launched in September), to address workforce shortages in the NHS and social care, as well as create opportunities for local people to start and develop their careers in the local care system, including maximising apprenticeships.

The care market has been taking part in the Fair Cost of Care Exercise over the first half of 2022-23 and engagement with the care market has been key in supporting this. The Fair cost of care is important in supporting sustainability within our care market, however there will be key challenges in meeting any identified cost.

**BHR Place Challenges**

BHR faces a number of system challenges. Given the high population, the impact of COVID within the area, the long-term health conditions and complexity of population challenges, we can identify the following:

1. Our rapidly increasing and changing population profile means we need a new approach to preventing ill health, targeting people who are more likely to require health and social care in the future.

2. Social care in particular faces a number of challenges including necessary steps to stabilise the local market and related inflationary pressures, alongside demand pressures. The impact of COIVD has been significant in de-stabilising a number o key care markets – Residential, Homecare and the voluntary sector. This will only become more acute with the increase in the National Living Wage / London Living Wage, as well as inflationary uplift.

3. Resources required per head increase with age therefore any new service model and resource allocation must be appropriately designed to address these challenges given that Havering has one of the oldest populations in the country, as well as a Redbridge receiving a low allocation per head within the BCF.

4. The BHR system has significant challenges to tackle including poor health and inequalities, care and quality and financial sustainability. We have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs and in some cases poor health outcomes. Demand is expected to be highest in more deprived localities.

5. Barking and Dagenham is the 3rd most deprived area nationally with both a prevalence of long-term conditions, below average life expectancy alongside an increasing population specific and marked increases in key groups; an example is a projected increase in Older People over the next 20 years.

6. Redbridge has an increasing prevalence of long-term conditions in an ageing population and the combined effect of this and demographic is projected to result in an increased demand for hospital care of with more elective admissions and emergency admissions, plus an additional increase in demand for long term social care by 2030 if the model of care does not change.

7. Havering has the oldest resident population in London and has seen a large inflow of children. It is estimated to have one of the highest rates of serious physical disabilities among London boroughs and one of the largest proportions of the population in the country with dementia and it is estimated that around half of people living with dementia are as yet undiagnosed.

8. Patients have often found it challenging to access the right service, in the right place, at the right time. Our acute provider has seen significant improvement in emergency flow, staff engagement and financial performance, however, broader system wide partnership is needed to address longstanding access issues, including increasing A&E attendances, admissions and waiting times for elective care. Whilst discharge and LOS have vastly improved, the system needs to embed learning and good practice and review and develop services to maximise flow.

9. Primary care also faces significant challenges with a large proportion of GPs nearing retirement age, difficulty in attracting new talent and increasing demand.

10. External inflationary pressures impact significantly on social care providers and currently inflation is rising, and it is uncertain whether and for how long these inflationary pressures will continue. To meet the local authority obligation to keep the market sustainable the local authority has to listen and respond to the care market. At some point, however the two priorities, to sustain the care market and to protect local authority budgets, could become incompatible. This needs to be part of the system wide understanding of pressures and not seen as a local authority issue alone.

## Section 5: Supporting Unpaid Carers

The pandemic clearly brought into the forefront the issues faced by carers. In addition, it also created an increase in the number of unpaid carers and hidden family carers - highlighting an already underrepresented cohort of people. However, while some of those caring may have since reduced since lockdown eased and service users and their families allow social care services to provide home services and day centres re-open it provided clear evidence of the needs for carers to receive support and wellbeing.

Given the increase of people needing care as we live longer, less people who are less able to self-fund and the complexity of long-term health needs (including LD & MH), the demand and pressure on the health and care system will increase. Therefore, supporting all carers where identified is essential to help manage demand, support those being cared for and provide essential support for carers to reduce and minimise carer breakdown.

The new ONS Census 2021 data releases on Carers will also provide a clearer picture across the individual places and NEL ICB of how this has really changed since 2011.

Across the system we are looking at this in a number of ways:

- BHR Carers Group
- Improved Carers advice, support and MH services
- Targeted and increased identification of unpaid carers through front door services and in speaking with family members and services users
- Promoting services for understanding who carers are and what support they can get
- Carers Forums
- Promoting service benefits on carers for using services such as reablement and implementing a progression model for people with LD to develop independency skills rather than dependency throughout their life
- Closer working with local community and faith groups
- Through the re-commissioning of services, build into services as core work around the identification and support of unpaid carers

We continue to implement its duties as outlined in the Care Act 2014, through promoting wellbeing, prevention, advice and information on care services, and providing strengths-based person-centred care - including support for Carers. Our Carers offer is being reviewed in order to explore ways in which we can provide better support to carers and reduce incidents of carer breakdown. Through working with our providers and carers themselves, we will be able to co-produce an improved model to ensure more flexible support is available when needed.

Redbridge is developing a Carer Friendly Borough by aiming to support carers better through meeting the following strategic priorities:

- Identification and recognition: Support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset in designing local care provision and in planning individual care packages.
- Realising and releasing potential: Support people with caring responsibilities to fulfil their educational and employment potential.
- A life alongside caring: Ensure that support for both carers and those they care for is personalised, enabling them to have a family and community life.
- Supporting carers to stay healthy: Support carers to remain mentally and physically well.

- Supporting young carers: Protect children and young people from inappropriate caring roles and ensure they have the support they need to learn, develop and experience positive childhoods.
- Refreshing our All age Carers Strategy
- Within Redbridge our Disability Charter sets out a number of core principles to support service users and carers with all disabilities to being involved within our Commissioning process – from co-production, contract tendering and contract monitoring.

In addition to this, Barking and Dagenham have developed a Carers Charter for 2022-2025 and associated Action Plan, which acts as a framework for the delivery and development of services, working practices, identification and support of unpaid or informal carers in the borough, through a partnership approach.

The Carers Charter comprises a series of "I" statements that have been co-produced with carers in the borough alongside key stakeholders from health, social care and the community and voluntary sector.

The Carers Charter supports participation and engagement with residents and partners. The outcomes defined in the "I" statements of the Carers Charter and Action Plan will enable carers and their loved ones to thrive and live independent and healthy lives. This is accomplished through joint working across the partnership and bringing carers to the forefront of service delivery. Building on existing partnerships with health and the community and voluntary sector, the Charter will work towards developing effective pathways with partners to identify 'hidden carers'. Hidden carers are those who do not recognise themselves as a carer or are not known to services as providing an informal, unpaid, caring role.

Alongside the Carers Charter, Barking and Dagenham continues to commission the Barking and Dagenham Carers Hub.

Havering Council commission the Havering Carers Hub to provide support to unpaid carers in the borough. This is an established service, which promotes carer-focused activities and partnership working with other agencies and partners, such as Health, to ensure unpaid carers are identified and supported. If the Carers Hub identify a carer who is in need of respite, they refer them for a carer's assessment to understand their needs. The Council, Health and Carers Hub are also working together to develop ways to identify unknown 'hidden carers' to ensure everyone who needs support can access it.

Beyond the assessment to identify carers needs, the Carers Hub also offer network groups (and days out) for carers in Havering who want to get involved. They provide activities for the cared for person to give their carer a break and offer a range of activities on their site including training workshops for carers, Informal Advocacy, emotional support individually or in a group, peer support groups, social activities, telephone support and online digital forums (for those who cannot get out). In addition Carers Hub have developed relationships with providers offering specialist support which unpaid carers can access, including the BCF funded services provided by the Alzheimer's Society, MIND and Havering Association for Disabilities (HAD). Carers receive a seasonal newsletter with upcoming events and relevant important information.

Monthly 'coffee mornings' are held in Romford for carers to meet up face-to-face with often specific topics or themes with a space to exchange experiences and provide support to each other. Coming out of the pandemic, meeting up has been valued by carers to not only network with each other, but also provide a balance of socialising and a couple of hours away from their caring duties. As a Council, we use this as a mechanism to engage with carers, for example, in July the Council attended part of the coffee morning to present the creation of our new Carers Strategy and gain input from the carers themselves – as part of the co-production process.

The strategy is being revised and refreshed, with wider stakeholders input, to improve the offer for unpaid carers in Havering. The strategy will focus on improving the key priority areas identified in partnership with carers, including:

- information accessibility and availability (e.g. financial or legal advice but also awareness of events being held),
- improvement in the quality and accessibility of the carers assessment to produce meaningful outcomes,
- improved communication with the Integrated Care System to ensure smooth discharge pathways,
- a focus on GP accessibility and awareness of carer roles
- more short-term respite activities.

In addition Carers' Voice (a group of carers that meet regularly with professionals) is being relaunched after a hiatus caused by the pandemic. Carers Voice provides an opportunity for carers to have their opinions heard, get involved in the development of local services and represent the wider carer population. Carers Voice can directly influence Council policy and commissioning activity and will be a partner in the development of the carers' strategy.

# Section 6: Disabled Facilities Grant (DFG) & Wider Services

**1. Summary**

Statutory Disabled Facility Grants (DFG) will continue to be delivered via the Better Care Fund which significantly contributes towards helping older and vulnerable homeowners remain in their properties; this meets one of the key aims of the BCF to prevent people from being admitted into hospital or residential care.

The boroughs have a significant population of elderly residents (over 65), particularly Havering, and as such have seen a steady increase in the demand for disabled facility grants. As a system there has been an increasingly joined up approach across health, social care and housing to help deliver adaptations to support people remaining in their own homes.

Traditionally disabled facility grants pay for a range of adaptations to people homes, including Level Access Showers, Ramps, Stairlifts and extensions to provide ground floor bedrooms and bathrooms. However, we are aware that the incorporation of the DFG within the Better Care Fund is to encourage the Council and ICB to think strategically about the use of home aids/adaptations and the use of technologies to support people in their own homes.

Within B&D, work is ongoing between Care and Support, Housing, Community Solutions, Inclusive Growth, Landlord Services, Adaptations team and Be First, our regeneration company on the future of sheltered housing, extra care, bungalow provision, site regeneration, referral processes and adaptations across Council, private and housing association housing. Housing are also involved in hospital discharge where issues arise.

Redbridge People services are working closely with Housing colleagues with those people who experience mental health, addiction homelessness and those with other long-term conditions – including LD and physical disabilities. This includes feeding into the Local Plan and housing strategies.

**2. BHR Area DFGs**

**Barking & Dagenham**
Home adaptations and assisted living enable disabled, vulnerable and older people to maintain their quality of life and improve their ability for independent living and self-care in their home. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs. In Barking and Dagenham, adaptations are designed to meet both current and anticipated needs, thus avoiding the need for more costly interventions e.g., high-cost packages of care /nursing home accommodation.

The local authority offers financial help for adapting homes within the Borough through the use of the Disabled Facilities Grant (DFG), with the aim of supporting residents with disabilities to improve their health and wellbeing by addressing problems with unsuitable homes that do not meet their needs and therefore maximising independence. The DFG can help to prevent or delay the need for care and support, both of which are central themes of the Care Act 2014.

Within Barking and Dagenham, a Disabled Facility Grant can be awarded to residents who have a disability and also live in a privately owned property, a privately rented property or a housing association property. The resident must have the intention of living in the property for a minimum of five years. In order to receive a DFG, the resident must have had an assessment from an Occupational Therapist. Once an assessment has taken place and the Occupational Therapist has made their recommendations it will progress to the Adaptations Panel for agreement. In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System) and will recommend other works, working with colleagues throughout the system, to reduce hazards like cold homes, and trips and falls and refer to other services such as the Handypersons Scheme.

In April 2022, the Council's Cabinet approved a new Aids and Adaptations Policy. The Policy was produced in collaboration with Foundations in order to use the potential flexibilities set out within the Regulatory Reform Order (Housing Assistance) Order 2002. The publication of this Policy allowed Barking and Dagenham to enact six new additional grants to the current mandatory Grant usage - these are summarised in the table below. This includes a non means test for anything under £15,000 and some innovative Grants tailored for individuals with more specific needs. We are of the understanding that the Sensory Needs Grant is the first of its kind in the country. The Policy also enables us to designate funding towards four specific social care projects aimed at private

residents, including spend towards care and assisted technology, minor adaptations, Handypersons and an OT assessment project. The Policy enables more residents with disabilities to stay in their own home, in an environment that is better adapted to meet their needs and improve their health and wellbeing.

| Discretionary Grant | Grant Amount | Means-Tested | Purpose |
|---|---|---|---|
| Adaptations Grant | £15,000 | No | uses the same criteria as the mandatory DFG but is **not** subject to a means-test |
| Top-Up Grant | £15,000 | Yes | where the initial means-tested grant is insufficient to cover the full cost of the works |
| Safe & Well Grant | £5,000 | No | enable property clearances and essential property repairs |
| Relocation Grant | £10,000 | Yes | support residents to move to more suitable accommodation where it is not possible to adapt their current home |
| Sensory Needs Assistance | £2,500 | No | make homes "friendly" where the disabled person has dementia, other cognitive impairment, sensory disability or a recognised long term behavioural condition. |
| Professional Fees Grant | £2,500 | Yes | pay for professional fees if the works are unable to proceed and thus unable to be paid under the mandatory DFGs |

**Havering**

Havering Council has an overarching vision that is focused around the Borough's Cleaner & Safer, Prouder, Together and Value for Money strategic themes. By embracing both statutory and discretionary powers that are available to us via the Regulatory Reform Order 2002 the Authority aims to improve the health and well-being of residents (both adults and children) by helping them maintain independence, whilst having a focus on preventative work which will contribute to improving the quality of life of our vulnerable residents.

We will continue to drive up the visibility and take up of the Disabled Facilities Grant (DFG) to applicable residents. We work across social work teams in both Children's and Adults departments, with our Local Area Coordinators, departmental colleagues in Housing, Health, Environment and Public Protection. We also work with housing associations, their tenants, homeowners, private tenants and/or landlords who are able to apply directly.

In Havering the responsibility for the DFG sits within the Strategic Commissioning function which strengthens our understanding of the end user need and demand. We are able to plan, review and analyse demand for services and provisions as well as offer signposting to the DFG as part of a suite of services, available through a variety of providers including the voluntary sector. Through the analysis of demand, we are able to align commissioned and non-commissioned services and identify opportunities for expansion, for example we plan to review the Handyperson Scheme and the use of Assistive Technology (AT).

We provide advice, information and support on repairs, maintenance, adaptations of properties across the Borough and offer a health-based framework of assistance to vulnerable groups and households including those with long term health conditions. Whilst it is recognised that it is the homeowner's responsibility to maintain their own properties the Council will target limited resources to support vulnerable adults and children who are not able to achieve this themselves and will support families to provide safe and effective care to enable vulnerable loved ones to remain at home.

In addition to the mandatory DFG Havering offer a discretionary Housing Assistance Grant, this includes:

- DFG top up - top up of mandatory DFG which exceeds grant limit.
- Discretionary adaptation assistance - financial assistance for those who fail the mandatory means test.
- Moving on assistance - financial assistance to move to a more suitable accommodation.
- Hospital discharge assistance – to prevent delayed transfers of care associated with housing disrepair or access issues.
- Safe warm and well - to provide a safe and warm house for older and disabled people to promote health, wellbeing and independence.
- Dementia aids, adaptations and assisted technology - to enable people with a diagnosis of dementia manage their surroundings and retain their independence.

- Sanctuary Scheme - to provide occupiers at risk of domestic abuse with improved security.

The BCF enables us to aim to reduce delayed transfers of care, minimise avoidable hospital admission, and facilitate early or timely discharge from hospital by tackling housing related matters. We support vulnerable households to ensure they are able to heat their homes at reasonable cost and assist disabled people with adaptations to facilitate their movement in and around their home thereby improving their quality of life.

Havering Council's DFG plan for 2022-23 includes a programme of digitalisation, expansion and promotion. The first steps will be to expand the use of the recently procured Dynamic Purchasing System (DPS), a review of end to end processes and recruitment of additional staff (Technical Officer and DFG Officer). These activities will provide a more robust foundation from which we can expand the reach of the service whilst also seeking more innovative, preventive and personalised applications of the funding.

**Redbridge**
Home adaptations and assisted living technology enable disabled and vulnerable people to maintain their quality of life and continue independent living in their home environment. Adaptations can also reduce health and social care costs, help to reduce the risk of injury from falls, enable faster discharge from hospital, delay admission to residential care and reduce care costs. In Redbridge adaptations are carried out using the BCF funded Disabled Facilities Grant (DFG) in a variety of ways.

As well as the mandatory DFG (as detailed in the Housing Grants, Construction & Regeneration Act 1996, subsequent amendments and the associated 2002 RRO), Redbridge offers a discretionary DFG to top up mandatory works where the cost exceeds the maximum mandatory allowance of £30k. This allows us to ensure that adaptations are designed to meet both current and anticipated needs, thus reducing the need for hospital stays and residential care. The discretionary DFG is particularly relevant for children's cases as adaptations need to be designed to meet the ongoing complex needs of a growing child and their family.

In some cases, it is not possible to adapt the current home of a disabled resident. This could be because of the size, layout or planning restrictions in place. In such instances Redbridge also offers a Relocation Grant to assist with the cost of moving to a more suitable property.

In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using the parameters of the Housing Health and Safety Rating System) and will recommend other works to reduce hazards like cold homes, and trips and falls. These works are then carried out using other funding set aside for Home Repairs Grants. Alternatively, a referral may be made to the Redbridge Handyperson Scheme for minor repairs.

We also fund our Handyperson Scheme using DFG funding through the BCF. Priority is given to residents about to be discharged from hospital where they need help with moving furniture, fitting of key safes, home security and minor adaptations.

Redbridge has recently carried out a review of the Home Repairs and Disabled Adaptations Policy to improve the provision of adaptations and repairs for vulnerable residents. We have looked to reduce processing times wherever possible and provide a more comprehensive service to our residents. Proposed changes include:

- An alternative non means tested grant to the current mandatory grant for smaller adaptations, including equipment.
- Provision for fast tracking cases to assist residents requiring end of life care at home.
- A wider scope of adaptations for various conditions such as dementia and MND.
- An increase in available discretionary grants to allow for significant increases in the costs of building materials post pandemic.
- Partnership working with colleagues in Adult Social Care to develop the use of assistive technology for vulnerable residents.

## Section 7: BHR BCF Finance Summary

- Refer to individual Planning Templates.

## Section 8: Equality & Health Inequalities

## Equality and health inequalities

### 1. Summary

Our BCF draws together a range of strategies and policies which have, in their development been subject to an assessment of their impact upon key groups within our population. In addition, the BCF is driven by national policy, designed to positively impact upon both the health and social care system and importantly, upon individuals improved health, self-care and wellbeing, seeking to address inequalities and improve outcomes informed by our Joint Strategic Needs Assessments.

All reports to our Health & Wellbeing Boards are required to consider the implications of the protected characteristics under the Equalities Act and similarly as part of our work in understanding demand and need of our populations, we ensure that we undertake Equalities Impact Assessments when undertaking to design and commission services and these will be subject to ongoing review to consider the EIA implications. Within Redbridge our Disability Charter sets out a number of core principles to support service users and carers with all disabilities to being involved within our Commissioning process – from co-production, contract tendering and contract monitoring.

The three boroughs have distinctive populations: Barking and Dagenham has a younger and ethnically diverse population which is the third most deprived in the country; Havering an older, largely white population; and Redbridge an ethnically diverse, majority Asian, median income population. The section below highlights key data on local areas.

### 3. Local Area Summary

Details about each borough profiles can be found on the respective websites with their Joint Strategic Needs Assessments (JSNA). As stated, all detail and data contained within this plan was correct at the time of submission.

**Barking & Dagenham**

https://www.lbbd.gov.uk/joint-strategic-needs-assessment-jsna

**Havering**

https://www.haveringdata.net/joint-strategic-needs-assessment/

**Redbridge**

http://moderngov.redbridge.gov.uk/documents/s128909/LBR%20JSNA%202022%20HWBB%20submission.pdf

**What has changed since our last plan?**
There are two cohorts of patients/residents that will be presenting needs to both health and social care going forward. Firstly, People affected by Long-COVID with respiratory and mobility issues. This is not age defined and is requiring some targeted interventions from local services. There is an increase in care and support needs for those who are below 65 years old which is part of the changing face of health and social care in a post COVID-19 era. This increasing level of demand of the younger cohort is presenting as an issue in a market where the registrations of care providers are, in the vast majority, for over 65s.

Secondly, many older people have been more negatively impacted by the pandemic than other groups. With self-isolating and shielding services are starting to see people who have decondition both physically causing mobility problems and mentally with depression and increased impacts of dementia causing more severe behaviour problems. This is also had a marked impact on informal carers and their ability to cope.

**What are we doing to make difference and address this imbalance?**
Throughout the COVID pandemic and over 2021-22 the BHR health and social care system have been working in tandem through integrated commissioning and joint decision making. This joint working, which is enabled by the BCF, is a different approach from the past 5 years and will pay dividends in the outcomes for our residents across BHR. Removing silo working across local authority boundaries and providing equitable acute and community services can reduce the risk of inequalities increasing across our system. A joint BHR JSNA is produced and supports the future demand management and planning of services across the patch. Close working

with colleagues from Public Health and housing is crucial to understanding the changing needs and impact of wider determinants on both our current and future populations.

The focus on personalised responses to people suffering from experience of inequalities has given insight into the problems faced and the development of responses to them. The clearest example is the development of local area coordination, where people are 'walked with' to understand the scope and scale of their problems before jointly devising solutions to change lives. Case studies are illustrating how complex people's lives are and are not necessarily solved by an isolated service intervention, such as responding to something identified, for example, as a 'hoarding' issue if in fact the issue is a result of another more deep-rooted problem. Clearing a house without responding to the root cause of the problem will lead to a repetition rather than a solution. The efficacy of this approach has been recognised and funded, through the BCF, by system partners. Although this is an example the wider philosophy across the partnership is that people's needs are to be understood and their assets used to devise tailored solutions that are sustainable. The thrust of our commissioning and operational approaches is compatible with this thinking. For those with protected characteristics this approach will identify the issues they face and deal with them in a personalised way.

Engagement with our service users, carers and providers and local community groups is a key component of understanding the issues at both a service delivery level and grass roots level – the lived experience. Feedback and consultation with our communities is a cornerstone that is and will be embedded in our commissioning work. For example, we know that within Redbridge the Bangladeshi community was particular impacted by the COVID pandemic. By listening to our local community, we are beginning to understand the reasons behind this (such a lifestyle and dietary choices) and therefore provide the targeted support to mitigate the impact of this happening again.

Our public health teams are working closely alongside national initiatives such as NHS Core20Plus5 and the work across BHR on inequalities will be heavily influenced by the health disparities white paper (2022).

## Section 9: Stakeholder Engagement

**1. Summary**

Providing and delivering services in the current climate is challenging and we know that we cannot work in isolation. To maximum the opportunities for achieving the best outcomes for those who use our services, we need to work with and engage those same people in the design and development of services for the future. With an increasing population and growing demand for services, it is essential that service providers and stakeholders work together to ensure that there is maximum benefit for every service commissioned in achieving the best outcomes possible.

Through this we will:

- Ensure all people have an equal opportunity to have their voices heard by increasing the accessibility of consultation and engagement activity
- Measure the impact of consultation on service development, commissioning and provision to ensure that it has a genuine influence
- Ensure that good quality, timely feedback is provided to consultees so that they know how their views have made a difference
- Improve communication between, and increase collaboration by, partners on engagement activity to make best use of limited resources
- Increase community engagement skills among Adult Care, Health and Wellbeing's workforce to improve the quality of consultation and engagement activity

**2. Engagement Activity**

Both the LAs and ICB constantly undertake a wide range of engagement activities throughout the year. These form part of the Commissioning Cycle and partnership work, market development and engagement and contract and provider relationship work. The work delivered by the BCF fund is a key theme throughout our engagement activities. The section below outlines some of the key area activities.

Over the last few years the BHR places have been working with Care Providers Voice to engage our social care providers supporting them to access peer support and voice their thoughts and opinions at forums and strategic meetings across the footprint.

In B&D there have been local community engagement sessions to support the Population Health Management approach, the get direct resident feedback. This has support targeted pilot interventions with a small cohort of residents with health needs.

NHS NEL has also consulted falls support groups and other local resident groups in the development of a Falls Strategy across the three places.

**Service User & Carers**

Barking and Dagenham commissioned the British Red Cross to a undertake piece of research to understand the experience of residents who have gone through each of the four overarching hospital discharge pathways (0-3) as outlined in national guidance. We wanted to understand the experience of residents who go through hospital discharge and use this feedback to improve pathways, support, communication and information and advice. The BRC undertook 16 interviews of Barking and Dagenham residents. The findings and action plan are now being progressed through the Integrated Discharge Hub, Operational teams and the system and enable us to have a baseline to which we can measure the impact of our pathways and pilots as we will repeat the interviews again in 6-12 months time. This methodology is now being replicated across Adult Social Care in order that the voice of the resident drives forward service improvements. An example of an area for improvement included welfare calls within social care/PCNs for residents with no family and friends to help them navigate the system post discharge.

Within B&D the Provider Quality and Improvement Team ring round a random pool of recipients of care and support each month services to understand their experience and any areas for improvement or feedback.

The new Barking and Dagenham Carers Charter engaged over 100 carers, as well as carer groups and system stakeholders between February and August 2021 to develop the Charter's key principles and to inform the action plan. This was signed off at Cabinet and the Health and Wellbeing Board in January 2022.

Redbridge constantly engages both service users and carers. We have recently updated out Carers offers and engaged our Carers Service to lead on the engagement for us. During our commissioning work we are now embedding service users as part of the commissioning workstream work from beginning to end – service design through to procurement. Our Quality Assurance teamwork with service users to discuss their care and quality of care and feed this back to contacts and safeguarding and locality social work teams where necessary. This ensures that we are providing a consistent quality of care across providers.

In Havering homecare recipients are contacted directly to understand their experience of care and this is now established as a corporate indicator reported to councillors. 'Carers Voice' was a group that met regularly but was inhibited as a result of the pandemic but is looking to be re-energised giving a voice for carers that feeds into the Carers Partnership Board, the delivery mechanism for our carers strategy.

**Provider Engagement**

- Older People and Frailty Transformation Board (OPF): The board is system wide and oversees and directs the older people and frailty transformation, the contribution to the Integrated Sustainability Plan to reduce pressures on the system and the developing Ageing Well agenda.
- Operational Working Groups (OWG) for the OPF Transformation including acute frailty, Falls, End of Life, discharge improvement working group, prevention. These OWGs sit under the transformation board and deal with the detail of developing business cases to transform services and then mobilise, operationalise and monitor the progress and impact
- Care Provider Forum - established during the pandemic to support providers to manage outbreaks to developing good practice across services. The forum has both care home and community care providers and continues to develop and support services.
- Redbridge hold a number of provider forums throughout the year for service providers and partners to provide updates and listen to issues and share ideas on delivery services.
- B&D have monthly provider forums with care homes and home care providers to share good practice, information and support for providers.
- The BCF has been used to support discharge pathway pilots, which have been developed with providers and partners across health and social care. Particularly important has been the contribution of therapy services in the development of community-based discharge services.
- The large care market in Havering has put significant pressure on both the market and the local authority's relationship with it through the pandemic. However, the response has included extensive communications, information guidance and support and increased communication directly to the market through meeting technology and an online communications hub. This has led to a much closer and improved relationship with the market and has enabled an understanding of issues faced by all sections

of the community served by the care market. It has led to a range of initiatives and responses and has meant that stakeholder engagement has been an ongoing and active part of all the developments and initiatives outlined within this plan.

The British Red Cross Psychosocial and Mental Health Team provide group reflective practice and clinical supervision to partners across frontline sectors to support their work. The British Red Cross have been undertaking sessions with providers particularly focusing on Covid-19, to support social care staff who have faced very tough and challenging times since March 2020.

A peer review of the Adult Social Care provision across Barking and Dagenham was used to engage providers and service users directly in understanding service improvements and where the strengths and weaknesses of the provider market and local authority provision lay. This is now being built into longer-term service delivery and planning.

**Voluntary Sector Engagement**

BHR ICBs have been developing the role and commissioning of the VCS over the last year. The VCS are now key players in the transformation agendas being key contributors into boards, steering and task and finish groups. The Barking and Dagenham Collective are a member of the Place Based Partnership within Barking and Dagenham and their network, experience and expertise will be integral to the development of the Place Based Partnership priorities within Barking and Dagenham. This has been particularly the case with the older people and frailty agenda, where a number of new developments will be funded via the BCF and the VCS has been key in driving this forward. This includes care home trusted assessors to support patients to be assessed for a care home place in hospital for more rapid discharge, funding additional care navigators to enhance supported discharge and the expansion of Falls prevention classes as part of a strategic approach to falls prevention approach across primary, community, secondary care and the VCS.

The VCS are commissioned to deliver a number of services including the home from hospital and carers support service and front door services within the local authority are signposting service users to VCS services and support as part of their discharge and social prescribing work.

The Reconnections pilot ended in December 2021. This was a two year pilot in Barking and Dagenham and Havering, joint funded by Independent Age, the two local authorities and the ICBs. The service supported over-65s who felt isolated and disconnected from their local community. Although the pilot's first year ran during the pandemic, they reconfigured their service in order to provide support to older people in a COVID secure way. This included weekly phone calls with a volunteer and support to residents to access and use digital technology to connect with loved ones, undertake shopping and listen to their favourite music. They also encouraged wellbeing walks, step challenges and dog walks. They did virtual coffee mornings, online cook-a-long's and friendly postcards sent through the post. Volunteers supported hundreds of residents across the two Boroughs and the pilot received high rates of satisfaction. In addition to the Reconnections pilot, BD Connect, a group set up to support residents in Barking and Dagenham during the first Lockdown undertook befriending phone calls and social prescribing referrals were made to the group where loneliness or isolation was a factor from GPs.

It is recognised that social isolation remains a significant issue within Barking and Dagenham and the VCS, through the BD Collective and Participatory City, have been running design workshops in the Spring and Summer to develop longer-term approaches to social isolation in Barking and Dagenham. Some seed funding has been provided to progress community-based initiatives and Better Care Fund money has been earmarked to take forward innovative approaches in 22/23 and 23/24. A further update will be provided in the next BCF planning round.

Within Redbridge we are currently undertaking a review of our VCS services with a view to developing a new model to better understand the needs of communities and how these have changed over the past few years and also how providers have developed services and seen needs change to adapt their services throughout the COVID period. This is key to our prevention and early intervention model. This also includes our external Day Opportunities providers. There has also been a strong VCS within Redbridge although this has been impacted by COVID.

In Havering, voluntary sector services have been re-commissioned, enabled by BCF funding. The focus of this voluntary sector commissioning has been on achieving particular outcomes including sustaining carers in their roles and looking to minimise social isolation and develop peer support groups for those facing particular issues. There is a tailored approach to support for those facing issues, for example carers of people with dementia will face different issues to carers of people with learning disabilities. Those facing physical disability will face different problems to those facing mental health issues. The range of organisations commissioned reflects the different issues faced and the specific needs of different groups.

Representatives of the voluntary sector join up with the local authority and the ICB to communicate about issues and initiatives that the voluntary sector can respond to at a regular 'compact' meeting. This has enabled the VCS to be intrinsically involved in the development of the borough partnership, where the VCS has established a more joined up means of engaging with the partnership and providing the particular insights they can bring.

**Clinical Engagement**
Primary care, the acute trust and community trust continue to be involved as a system in the development of services through operational working groups, transformation boards and other task groups as stated above. Each transformation area has ICB clinical directors allocated to drive the agenda forward and link to primary care and PCNs.

**Patient or Service Users Groups**
Operational Working Groups (OPF) have patient involvement links which maybe actioned through a patient (and or carer reference group), patient reps on the working group or wider consultation through Age UK and or other forums. Healthwatch's across BHR also engage patient and service user representatives and each of the Borough Healthwatch's provided important reviews of the impacts of COVID across patient, service user, family and provider groups which were used to improve COVID pathways and services. The outcome of the Havering and Barking and Dagenham commissioned patient experience work with British Red Cross will be used to improve and/or redesign pathways across BHR in relation to hospital discharge.

**BHR Leadership Health & Wellbeing Boards**
The local Health and Wellbeing Board provides system leadership for our health and care economy, including overseeing the implementation of each areas Health & Wellbeing Strategy and how we work to reduce health inequalities. The Redbridge Our 'Caring for Redbridge: Strategic Commissioning Framework for People' is the Redbridge LA strategic plan that provides an overview of our vision, ambitions and aims for the commissioning of services. Our Redbridge CVS have been a key member of the HWB since its inception and represent the views of VCS in Redbridge. This provides the opportunity to ensure that our voluntary sector partners, who we work closely with, are engaged alongside other system leaders in health and social care programmes and services across the borough.

We have also engaged through the ICP Board, JCB and Health and Wellbeing Boards for sign-off.

## Section 10: Links to other Plans

**BHR Area Key Strategies & Plans**

- Annual Public Health Reports
- Barts Plans
- BHR End of Life Strategy
- BHRUT Clinical Strategy
- Transformation Nous work on ED @ bhrut
- Discharge strategy
- Falls Strategy
- Health & Wellbeing Strategy's
- PHM work in B&D
- NEl End of Life strategy
- JSNAs
- Market Position Statements
- Older People and Frailty Business Case
- Prevention Strategy
- Primary Care Plans
- Redbridge Commissioning Framework
- Redbridge Disability Charter
- Redbridge Good Practice Commissioning Charter (Draft)
- Urgent Care

**Websites:**

www.lbbd.gov.uk
www.havering.gov.uk
www.redbridge.gov.uk
www.northeastlondon.icb.nhs.uk/
www.nelft.nhs.uk
www.bhruthospitals.nhs.uk
www.bartshealth.nhs.uk

## APPENDIX 1

**BCF Risk Log**

| | IDENTIFIED RISK | RISK MITIGATION | LIKELIHOOD | IMPACT | RISK SCORE | RAG |
|---|---|---|---|---|---|---|
| **1.** | Demographic and need demand - increasing numbers of Older People (over 85s and over 65s), people with long term conditions, low number of healthy life years, deprivation etc. raise specific challenges.<br><br>Complexity of conditions and increase in children and young people with LD transiting in adulthood<br><br>These budget pressures sit alongside corporate financial pressures faced by the partners | Investment in prevention and managing demand and use of the social care grant to support and protect social care, pending solutions to longer term funding solutions to social care funding. Best use of existing community capital and signposting.<br><br>Encouragement of population to take responsibility for their own health, self-management<br><br>Upstream preventative / early intervention investment<br><br>Better planning and management of the Transition process for CYP<br><br>Working with Public Health teams through a Population Health Management approach | 4 | 4 | High | |
| **2.** | Costs and benefits fall unevenly across the system and inequitably to the investing partner for areas of change | • Review and transparency of impact and outcomes achieved.<br>• Affordability to be a determinant of further steps.<br>• Risk share remains an option for consideration.<br>• Protection of social care services and consideration of pooled budgets.<br>• Ongoing monitoring of impacts. | 4 | 3 | Medium | |
| **3.** | Resources locked into current contracts/ activity cannot be effectively unlocked to support activity where positive evidence of improved outcomes are drawn. | Engagement across commissioners and providers with service contracts having sufficient flexibility to allow for adjustments, contract review schedules are considered through governance alongside activity. Effective contract management and the right level of governance. | 2 | 2 | Medium | |
| **4.** | Three borough complexity slows progress because of differing democratic leadership, priorities and indeed financial values into specific /shared schemes | We have mitigated the challenge posed by taking an iterative approach to our deepening the reach of the BCF plan and improved governance and working relationships across the Place Based Partnerships and NEL ICS. COVID was a cornerstone in demonstrating the necessity of working together to support the system under a period if extreme pressure. | 2 | 3 | Low | |

| | IDENTIFIED RISK | RISK MITIGATION | LIKELIHOOD | IMPACT | RISK SCORE | RAG |
|---|---|---|---|---|---|---|
| | | Integrated Care System is responsible for ensuring these tensions are understood and managed. Ensuring effective information and clarity of decision points. | | | | |
| **5.** | Elections at both a local level result in changes to administration(s) and policy direction. | 'Watching brief' on policy and guidance changes | 1 | 2 | Low | |
| **6.** | Budgetary deficits across health and care system | Monitoring of demand and costs in relation to funding to be closely monitored and any remedial action to be agreed and implemented where necessary. | 5 | 5 | High | |
| **7.** | Commissioning capacity and staffing resources | Improving joint and or lead commissioning across BHR will seek to reduce the burden of individual organisational activity, alongside our intention through the BCF plan to achieve a greater level of integration and available resource utilisation. | 3 | 2 | Medium | |
| **8.** | Service demand continues to increase for social care | Review of prevention and early interventions services to provide earlier intervention, passporting to alternative, community and universal services is expected to improve management of demand.<br><br>Utilising new data sets from ONS in relation to the recent Census and refreshed JSNAs | 4 | 4 | High | |
| **9.** | Increasing costs faced by service providers, insurance, wages increases and workforce issues | BHR commissioners to work closely together and with partners to help stabilise the current market and develop a joint protocol around provider concerns and failure - adjusting rates where it can (if available) and taking a proactive approach to managing demand.<br><br>Use all available initiatives such as Skill for Care funding to support workforce issues. | 5 | 5 | High | |
| **10.** | Fair Cost of Care Exercise early indications are that home care and care home rates might need to rise significantly. It is still unclear how this is to be fully funded but it could threaten | Work with other local authorities and DHSC to understand how this is to be mitigated | 5 | 5 | High | |

| IDENTIFIED RISK | | RISK MITIGATION | LIKELIHOOD | IMPACT | RISK SCORE | RAG |
|---|---|---|---|---|---|---|
| | financial sustainability of Local Authorities if government funding is insufficient. | | | | | |

This page is intentionally left blank

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | BHR JSNA 2022 |
| **Board Lead:** | Mark Ansell |
| **Report Author and contact details:** | Anthony Wakhisi<br>Anthony.wakhisi@havering.gov.uk |

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

| | |
|---|---|
| ☐ | The wider determinants of health<br>• Increase employment of people with health problems or disabilities<br>• Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.<br>• Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system. |
| ☐ | Lifestyles and behaviours<br>• The prevention of obesity<br>• Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups<br>• Strengthen early years providers, schools and colleges as health improving settings |
| ☐ | The communities and places we live in<br>• Realising the benefits of regeneration for the health of local residents and the health and social care services available to them<br>• Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem. |
| ☐ | Local health and social care services<br>• Development of integrated health, housing and social care services at locality level. |
| | BHR Integrated Care Partnership &Transformation Boards<br>• Older people and frailty and end of life<br>• Long term conditions<br>• Children and young people<br>• Mental health<br>• Planned Care<br>Cancer<br>Primary Care<br>Accident and Emergency Delivery Board<br>Transforming Care Programme Board |

Havering
LONDON BOROUGH

## SUMMARY

This report provides a summary of the recently completed BHR 2022 Joint Strategic Needs Assessment (JSNA) carried out jointly by the Havering, Barking and Dagenham and Redbridge Public Health teams.

This is the second iteration of the BHR JSNA document following a successful collaborative approach taken by the three local authorities in 2020, which culminated in the production of a modern, easy to use and detailed JSNA that is complemented with an online tool to facilitate both the interrogation and further exploration of useful data, reports, and maps by interested stakeholders.

The report also includes a proposal on the production of future JSNAs for HWBBs consideration. This is a less burdensome approach which entails dropping publication of detailed borough editions of the JSNA but retaining the summary document, illustrated with infographics capturing key statistics and a set of recommendations agreed with the various transformation boards whilst further enhancing the online platform.

The HWB is requested to consider and advise on if the suggested alternative approach might adequately meet its needs and thereby allow PH teams to redirect their limited capacity to supporting their respective borough partnerships and the development of population health management within the ICS.

## RECOMMENDATIONS

The HWB approve the BHR JSNA 2022 report and feedback on the proposed approach to future JSNA production.

## REPORT DETAIL

### 1 Introduction and Background

1.1 The Health and Social Care Act 2012 amends the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

1.2 In the Act, the Government sets out a vision for the leadership and delivery of public services, where decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports the principle of local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs.

1.3 Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board. The responsibility falls on the health and wellbeing board as a whole.

1.4 JSNAs are assessments of the current and future health and social care needs of the local community. Such needs could be met by the local authority, CCGs, or the NHS boards. JSNAs are produced by health and wellbeing boards and are unique to each local area.

1.5 The JSNA provides a single, agreed view of priorities at place level and provide crucial insight to shape the Joint Health and Wellbeing Strategy of the borough. Health and care partners must have regard to the JSNA and JHWS.

1.6 H&WBs can agree to work together and the three BHR H&WBs collaborated on a JSNA for the first time in 2020 and also commissioned an online tool to enable users to explore the data themselves.

1.7 The published JSNAs are complemented by an online tool called Local Insight that allows detailed interrogation of data referred to in the JSNA along with a package of analytical reports that can be downloaded by the public and made use of.

**2. BHR JSNA 2022**

2.1 The pandemic slowed delivery of the current edition and limited engagement with new stakeholders e.g. PCNs. As a result, the 2022 edition is very similar to its predecessor in form and content. Efforts have been made to highlight the impacts of the COVID-19 pandemic as they are currently understood.

2.2 The BHR JSNA 2022 report including an executive summary and list of recommendations is included as part of this briefing package.

2.3 The JSNA will also be shared with each of the borough partnerships, both to inform their thinking regarding priorities for action but also to seek feedback as to how the JSNA can be improved.

2.4 A considerably larger number of datasets, organised under the 4 pillars scheme, are now available via the Local Insight tool.

## 3. Future development of the BHR JSNA

3.1 The rationale for a BHR JSNA was twofold:

- Firstly, it was a means of making the best of limited public health analytical capacity and it continues to deliver in this respect.
- And secondly, a common approach assisted transformation boards that were leading much of the redesign of health and care services across BHR.

3.2 The production of the detailed borough specific versions of the JSNA has proved very time consuming at a time when PH teams would wish to also contribute to the practical application of population health management.

3.3 The JSNA is based on aggregate data that are in the public domain. This allows for a wider variety of comparators to be used and for trends to be mapped in a consistent fashion over time. As such, the JSNA can be used to identify the overall needs of population and high level priorities for action e.g. to be addressed in the Joint Health and Wellbeing Strategies of each borough

.

3.4 However, none of the underlying data is available at the level of individual patient / resident and development of the JSNA is happening separate to thinking about the intelligence needed to underpin operational aspects of population health management.

3.5 A proposal for HWB consideration is a less burdensome approach which entails dropping publication of detailed borough editions of the JSNA but continue to produce the summary document, illustrated with infographics capturing key statistics and a set of recommendations agreed with the various transformation boards whilst further enhancing the online platform.

This would continue to provide an overview of the needs of the three boroughs and recommendations for action, with supporting data sets that could be explored and downloaded as desired but significantly reduce the effort entailed.

The HWBBs are requested to consider and advise on if the suggested alternative approach might adequately meet its needs and thereby allow PH teams to redirect their limited capacity to supporting their respective borough partnerships and the development of population health management within the ICS.

## IMPLICATIONS AND RISKS

JSNA is a statutory requirement and failing to deliver it would result in breaches in local Public Health authorities' duties, including the respective Health and Wellbeing boards.

## BACKGROUND PAPERS

Link to most recent BHR JSNA profiles:

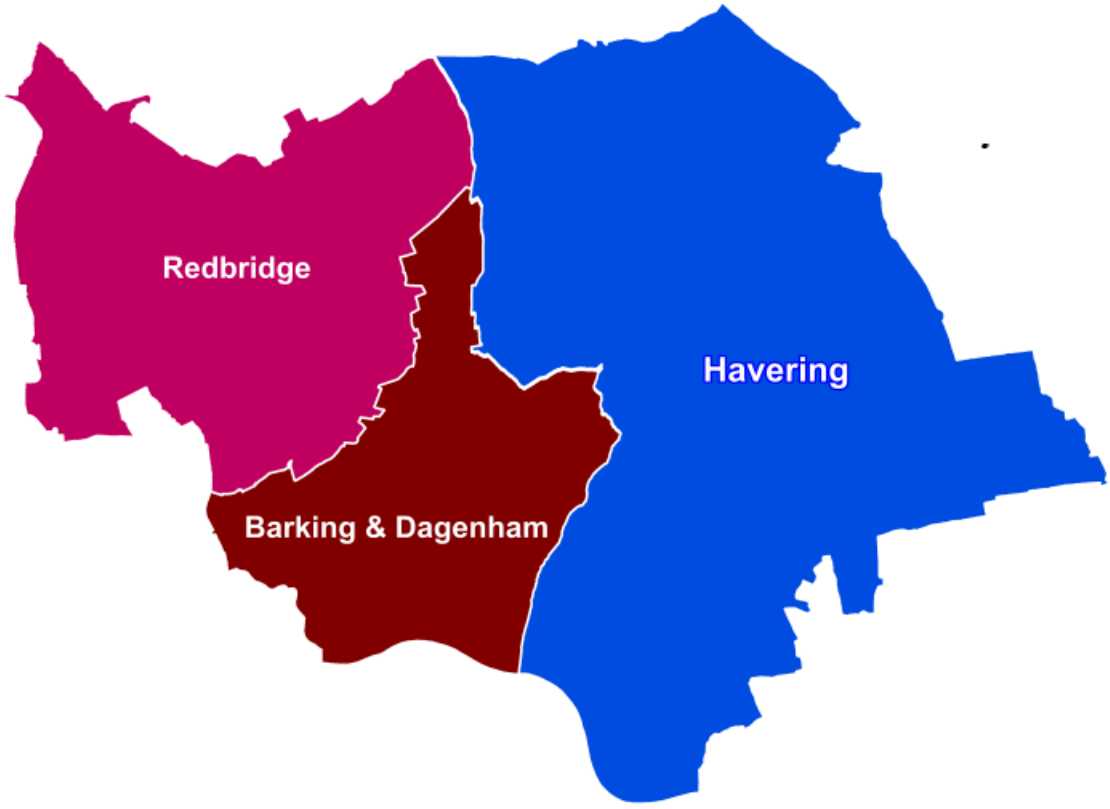
https://bhrjsna.communityinsight.org/custom_pages?view_page=43

Link to BHR online insight tool:

https://bhrjsna.communityinsight.org/map/

# Barking & Dagenham, Havering and Redbridge Joint Strategic Needs Assessment Profiles

# London Borough of Havering




**September 2022**

**Table of Contents**



DRAFT

DRAFT

# Executive Summary

## Introduction

The BHR JSNA 2022 provides a single view of the challenges facing the partners represented at the Barking, Havering and Redbridge Integrated Care Partnership (BHR ICP), if they are to improve the health and wellbeing of people resident in the three boroughs and their experience of the health and social care system post pandemic.

The differences between the three boroughs, e.g. in terms of population structure, diversity, levels of disadvantage etc. are marked. These differences are explored in the detail of this JSNA[1]. Nonetheless, the major challenges faced by the health and social care system are similar in all three boroughs and these overarching issues are highlighted here in this Executive Summary.

Since publication of the 1st edition of the BHR JSNA in 2020, further progress has been made in establishing Integrated Care Systems (ICS) who are charged with implementing population health management[2] (PHM). This means providing intelligence led, high quality health and social care services alongside proactively addressing the factors that pre-dispose to ill health. These factors may cause ill health at the level of the individual resident, but can also lead to health inequalities between groups and communities at population level.

The BHR JSNA is consistent with PHM, describing the factors shaping health outcomes for the population in terms of the 'four pillars of population health'[3]. These are shown in the chart below, with an estimate of their relative contribution to health outcomes (%)[4].

| Population health outcomes | | | |
|---|---|---|---|
| The wider determinants of health (40%) | The places and communities we live in (10%) | Our health behaviours and lifestyles (30%) | Integrated health and care services (20%) |

[1] A variety of datasets relevant to each of the four pillars are available at https://bhrjsna.communityinsight.org/. The site allows users to explore the data through interactive maps and download reports and individual datasets.
[2] NHS England 2022. Population Health and the Population Health Management Programme https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm/
[3] Kings Fund 2018 A vision for population health: towards a healthier future https://www.kingsfund.org.uk/publications/vision-population-health
[4] University of Wisconsin 2022. County Health Rankings Model https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

## The population of BHR

All things being equal, the size and age structure of the population served are the most direct drivers of need for health and care services.

The population of all three BHR boroughs has grown in recent years to 778K[5]. Further **significant growth** (another 120K) is predicted over the next 20 years, more than half of it in Barking and Dagenham; but all three boroughs have areas identified for large-scale redevelopment i.e. in addition to Barking Riverside in Barking & Dagenham; Rainham and Romford in Havering and Ilford in Redbridge.

The type and quantity of health and care services varies with age and is generally higher in the early years and very much higher in old age. Barking & Dagenham and Havering are very different from one another in terms of age structure, with Redbridge somewhere in between. Barking & Dagenham is relatively young (32% aged 0-19) compared to Havering (24%). Havering has a much higher proportion of older people (23% aged 60 and above) compared to Barking & Dagenham (13%). The populations of all three boroughs are projected to age; the **very elderly** cohort, with the most complex health and social care needs will see the greatest growth.

The pandemic illustrated the need for culturally appropriate services, developed through co-design with the communities served and action on racism and discrimination. The three boroughs are very different to one another in terms of ethnic composition. As is the case for London as a whole, a majority of Redbridge (67%) and Barking & Dagenham (55%) residents are from **ethnic minority groups.** Havering (19%) is more similar to England as a whole (15%) in this regard but is become more diverse, particularly its younger residents.

## Current health outcomes of BHR residents

Life expectancy in Havering and Redbridge is similar to the national average but is significantly lower in Barking & Dagenham. In common with England as a whole, improvement in life expectancy across BHR has **stalled in recent years and actually declined during the pandemic.**

The additional years of life that have been gained over the last couple of decades are often **marred by physical and mental ill-health and a degree of dependency** on health and care services.

[5] Current population estimates based on the 2011 census will be superseded by data from the 2021 census in the next iteration of this JSNA



DRAFT

Moreover, there are marked **inequalities** in health outcomes between communities and population groups reflecting a direct causal association between increasing disadvantage and poorer health outcomes.

Overall, existing models of treatment and care are failing to deliver further improvements in health outcomes or narrow health inequalities. Services are struggling to cope with the demands of a growing and ageing population, with much more to come. **Population health management (PHM)** focuses on prevention and early intervention to address the causes of ill health, rather than just responding to problems when they become severe enough for patients to seek care. It is therefore essential if we are to improve outcomes and ensure the long term financial viability of health and care services.

## Achieving better health and narrowing inequalities.

It is implicit from our model of population health that for future generations to have equal opportunity to enjoy a long and healthy life, action is needed to ensure that they:

- are born into loving families with the means to adequately support them through childhood and that they enter school ready to learn;
- are encouraged to aim high and achieve the best they can in education; to attain the qualifications and skills that will equip them for later life
- gain good employment that pays enough to enable them to fully participate in their community
- have secure, affordable housing that adapts to their needs as they change through life
- live in places / communities that:
    - make healthier choices the easy and obvious choice
    - minimise the risk posed by communicable disease and environmental threats to health
    - are safe and feel safe
    - offer support and encouragement throughout life but particularly in times of need, including periods of poor physical and mental health and later in old age
- have access to high quality health and social care services, appropriate and proportionate to their needs

## Pillar 1: The wider determinants of health

Addressing the wider determinants of health, e.g. by improving income, employment opportunities, educational attainment, high quality affordable housing etc. will have the greatest impact on physical and mental health of an individual and the population as

a whole in the long term. Inequalities regarding the wider determinants of health are the underlying cause of the great majority of health inequalities.

Barking & Dagenham ranked 22nd most deprived out of 312 local authorities in England, Redbridge 173rd and Havering 180th. 54% of Barking & Dagenham residents live in areas ranked in the **most deprived quintile**[6] in England. The figure for Havering and Redbridge is 7.6% and 3.3% respectively.

Health and care providers can **directly improve the life chances** of local residents e.g. by **creating routes into employment** for people who struggle to gain a foothold in the job market due to lack of formal qualifications; physical and learning disabilities; long term or recurrent physical and mental health problems or criminal justice issues. Similarly, they can work together to **assist individuals with complex problems** to remain in safe, secure housing and avoid the catastrophic consequences of street **homelessness**.

Health and care agencies can also work to ensure that more of their budgets are spent locally e.g. by recruiting more staff locally particularly from disadvantaged areas and communities, and by procuring more goods and services from local small to medium enterprises. In so doing, they act as **'anchor institutions'** at the centre of the local community and economy.

What is increasingly described as a cost of living crisis will push more residents into poverty. Those on low incomes, who spend a greater proportion of their income on food and heating, will be hit hardest. As it is, nearly 1 in 5 residents in Barking & Dagenham are **income deprived** and more than 1 in 10 in both Redbridge and Havering. Statutory partners must work together to do all they can to support families through what will be a still more difficult period e.g. ensure families are in receipt of all benefits available; target any discretionary funding or discounts to those in most need and enable communities, by working with community and voluntary sector partners, to assist fellow residents.

## Pillar 2: The places and communities we live in

**Supporting and enabling communities** to remedy their own problems can mitigate inequalities to some degree and assist residents for who statutory services may otherwise fail to engage or effectively support. Programmes such as local area coordination may help engage the most vulnerable residents and assist them to develop solutions to their problems. Social prescribers can sign post a wider group to resources and support available in the community. Statutory services need to work with voluntary and community sector partners to grow community capacity and ensure that statutory services are appropriate and accessible.

[6] Communities in the most deprived quintile are identified as a priority in Core20plus5 – NHSE's approach to tackling health inequalities https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

The physical environment in which we live also affects our health in many ways. Access to green space benefits physical and mental health. Good public transport provides access to jobs, retail and leisure opportunities and health and care services. Conversely, car usage reduces physical activity and increases **air pollution**, which causes significant harm to health. Partners in the ICS should seek to minimise their direct contribution to air pollution and encourage residents to use public transport when accessing services, or better still, walk or cycle, choosing routes that minimise their exposure to pollutants. However, the poor public transport infrastructure in parts of BHR is likely to result in continuing reliance on the private car and partners should also consider how to encourage a switch to electric vehicles (EV) within their own transport fleet as well as facilitating EV use amongst the public. Action to reduce air pollution is consistent with the overwhelming priority to avoid catastrophic **climate change**. Partners in the ICS should hold each other to account for the delivery of ambitious plans in this regard.

The **regeneration** underway or planned in all three boroughs is a significant opportunity to improve the health of current and future residents. The incorporation of **health impact assessment** into the planning process (and many other decision making processes) can ensure that health benefit is maximised. Through regeneration we must aim to create healthy communities, with all the necessary facilities, as well as much needed high quality, affordable housing. Regeneration can also provide well paid, high skilled jobs for local people while construction proceeds.

Regeneration may also provide an opportunity to tackle some of the problems facing the health and social care system e.g. by improving the quality of local primary care facilities or offering key worker housing to attract hard to recruit health and social care professionals to live and work in BHR.

## Pillar 3: Lifestyles and behaviours

Lifestyles and behaviours have a huge impact on health outcomes – second only to the wider determinants pillar.

**Most of us** will have a least one behaviour that increases our risk of ill health e.g. 2/3$^{rds}$ of adults are overweight or obese, and 1/4 are obese; 2/5$^{ths}$ of adults drink at levels that put them at higher risk of alcohol-related harm.

Some individuals will have multiple risks that compound one another and have a profound impact on physical and mental health over the life course. Lifestyle related **risk factors cluster in disadvantaged communities** and amongst vulnerable groups and hence are the immediate cause of a significant proportion of health inequalities.

In the case of **alcohol and drug dependency**, the harm caused extends to affect family and the wider community.

**Smoking** has become far less common, but 1 in 10 adults continue to smoke. The prevalence of smoking is higher in disadvantaged communities and specific population groups (e.g. people with SMI) where smoking cessation support should be focused. The majority of smokers wish to quit but most try without **pharmaceutical aids and behavioural support**, which together can triple the likelihood of a successful quit attempt. More recently, **vaping** has helped many more people to stop smoking and partners should actively encourage this trend, as it is far less risky than smoking, for those who are not ready to quit outright.

As the example of smoking cessation demonstrates, input from **lifestyle support** services does not guarantee success. Many individuals will make multiple attempts to change behaviour before they succeed, and some will subsequently relapse. Nonetheless, there is robust evidence that the right support provided in the right way increases rates of success, and is **very cost effective**, in part due to the massive cost to the public purse caused by behaviour related risks to health.

In working with residents to promote healthier lifestyles and behaviours we must also recognise that our day-to-day decisions are shaped by how and where we live. The best example of this being **obesity**. For an increasingly high proportion of residents, obesity begins in childhood and will continue throughout life, greatly increasing their lifetime risk of a range of conditions including diabetes, cardiovascular disease (CVD), cancers and musculo-skeletal (MSK) problems. Obesity will not be solved by simple advice to eat more healthily or weight management services, although both have their place. We need to employ **a whole system approach** using all the levers available to assist residents to get a better balance between calories consumed and energy expended.

## Pillar 4: The integrated health and social care system

The last of the four pillars underpinning good population health outcomes is a high quality, **integrated health and social care system** that provides easily accessible and effective care, proportionate to the needs of the population. The pandemic has demonstrated the value of **designing services with the community served** and that outreach via the VCS or other trusted intermediaries may be necessary to overcome barriers to access and meet the greater needs of disadvantaged communities and vulnerable groups. The following commentary about the health and care is structured around the various transformation boards guiding the development of services for BHR residents.

### *Antenatal and maternity services*

Fertility rates in all three BHR boroughs are above the national average, markedly so in Redbridge and Barking and Dagenham. Some local women deliver their babies in maternity units elsewhere in inner northeast London, rather than their designated

unit. Due to these flows, it makes sense that **maternity services** are planned across the NEL footprint. The East London Local Maternity System (ELLMS) priorities are to provide women with personalisation, safety and choice, and access to specialist care whenever needed.

Women with **complex pregnancies** who would benefit from delivery on hospital labour wards have become more common because of social disadvantage, increasing levels of maternal obesity and gestational diabetes. Midwife led care options are expanding so there is sufficient hospital capacity for higher risk mothers.

Tragically, a small proportion of pregnancies will end in **stillbirth or neonatal death**. Work is underway to minimise such events and the BHR patch is on track to halve stillbirth, neonatal and maternal deaths and brain injury by 2025. This includes action to increase the proportion of women who book for antenatal care early in their pregnancy. Those who book their first maternity appointment before their 10th week is particularly low in Barking and Dagenham and Redbridge and further action to reduce the proportion of women who smoke in pregnancy.

The experience of childbirth is a uniquely personal event with potentially long-term impacts on mother and baby and their developing relationship. Feedback from women attending Queens pre-pandemic was similar to the national average. But face to face contact with midwives was much reduced during the pandemic, as were opportunities for participation by partners.

Pregnant women are at significantly higher risk of poor outcomes from COVID-19. Evidence regarding the safety and effectiveness of covid vaccination in reducing that risk is compelling. However, a significant proportion of pregnant women remain **unvaccinated**.

## *Health and care for children and young people*

Barking and Dagenham and Redbridge are young boroughs. Havering has an older demographic. Nonetheless, Havering has seen a significant increase in numbers of children and young people recently. Therefore, **the capacity of health and care services for children and young people is an issue** in all three boroughs.

Happily, **most children are born in good health**. Nonetheless, maternity and health visiting services offer essential support to all parents at a time that inevitably brings new and sometimes significant challenges. Provision in the community, alongside other family-orientated services provided by Councils and Voluntary & Community Sector organisations (VCS), can help introduce new parents to the full range of support available.

**Health visitors** provide a series of checks through the early years and are ideally placed to identify those families that are struggling, enabling **early intervention** to

avoid problems escalating e.g. by identifying a child who is at risk of not being school ready.

All children at some point will experience ill health. In most cases, it is relatively mild and self-limiting. However, young children in BHR are **more likely to attend A&E** than the national average. Understanding why this is and developing an effective response should be a priority.

**Vaccines are safe and effective**. Anti-vaccination messages to the contrary during the pandemic are unhelpful, but uptake of childhood vaccination has been falling for some time. Better systems to remind parents and greater choice of venue and timing would likely increase uptake.

A number of long-term physical health conditions can begin in childhood. **Asthma** is the most common. Effective management can minimise day-to-day distress and inconvenience associated with poorly controlled asthma, minimising the frequency of severe attacks and preventing deaths. However, young people have died from asthma in all three boroughs in recent years and the system has developed a detailed improvement plan to remedy identified weaknesses.

While 90% of diabetes cases are type 1, type 2 diabetes is increasing in prevalence due to **increases in childhood obesity**.

The mental health of children and young people is a significant and growing concern. **Child and Adolescent Mental Health Services** (**CAMHS)** capacity is increasing significantly in response, but even so, only a minority of the 1 in 10 children and young people with a diagnosable condition will be under the care of specialist services at any point in time. Further effort is needed to improve the capability of GPs to support them and engage services commissioned by schools to make the most of overall capacity and ensure that cases are escalated when needed. In addition, there is a need to build the resilience of our children and young people and give their parents, teachers, social workers etc. the skills and knowledge to identify and help them cope with mental health issues.

Successful **transition** from children's to adult services is crucial to accommodate the changing needs of young people over time. Moreover, their eligibility for services and the team providing their care is also likely to change. Thorough and early planning is essential.

A proportion of children are born with, or develop, significant and lifelong problems. More than 1 in 10 children with **Special Education Needs and Disability** (**SEND**) may need support from health, social care and education professionals to learn. The most common type of need is mild to moderate learning disability followed by speech, language and communication needs. The needs of a growing cohort of children are captured in an **Education, Health and Care Plan** (**EHCP**). Autistic Spectrum Disorder is the most common primary need identified in EHCPs. Development and delivery of EHCPs can involve contributions from schools, children's social care and NHS services (e.g. therapies, community paediatrics, CAMHs etc.).

Changes in legislation have combined to significantly increase demand (and parental dissatisfaction) and put pressure on services and budgets. Some children with particular needs have to be bussed long distances, at great expense, to specialist provision or in exceptional cases are in residential placements out of borough. Cooperation across the ICS is needed to grow capacity as a whole and fill gaps in some specialist provision, allowing support to be provided closer to home and at lower cost.

Safeguarding must be a priority for all partners. Early identification and intervention protects the child in the short term and reduces the likelihood of poor outcomes in later life associated with multiple Adverse Childhood Experiences. In most circumstances, it remains in the best interest of the child that they remain under the care of their parents with additional support. However, for some children and young people (CYP), the best option is that they be taken into care. All **looked after children** (**LAC**) will have had complex and difficult childhoods; many will have mental health problems; often coupled with poor educational attainment; their long-term life chances are significantly poorer than the norm. Support to LAC from all partners should extend beyond timely access to excellent treatment and care to include support with housing and opportunities to gain employment e.g. in health and social care services.

Exposure to **Adverse Childhood Experiences (ACEs)** increases the risk of a range of negative outcomes in later life. Conversely, creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help children reach their full potential. To this end, the needs of the child should be central to the thinking of all agencies working with families affected by serious mental illness, substance misuse, domestic violence, suicide, criminality, homelessness etc.

The experience of poverty in childhood has significant and long lasting effects and is associated with poorer outcomes in all aspects of life including health. The proportion of children affected by income deprivation is highest in Barking & Dagenham, but many thousands of children are affected in all three boroughs. All partners in the ICS should redouble their efforts to increase participation in schemes designed to support families on low income e.g. Healthy Start, free early years provision and free school meals, which is far from complete.

Children and young people have been hard hit by the pandemic, or rather the steps taken to protect more vulnerable sections of the community from COVID-19, as children were at low risk of serious illness themselves.

Although there was provision for the children of key workers and vulnerable families, most children were unable to attend preschool or school for extensive periods. Despite the best efforts of teachers and parents, it is likely that learning was affected, with disadvantaged children being most affected, further increasing existing inequalities in learning achievement.

Lockdowns also deprived children of social interaction and may have increased exposure to ACEs in the home e.g. domestic violence. Such factors, coupled with

anxiety regarding the pandemic itself, may account for reported lower mental wellbeing and higher rates of referral into CAMHs.

Disruption to education and health visiting may have delayed the identification of children at risk of abuse and neglect. Impacts on social care may have affected the protection offered to known vulnerable children. These factors, together with the additional pressures on households during lockdown, may explain the increase in the number and / or severity of presentations reported by children's social care.

Delays in diagnosis and treatment during the pandemic, resulting in prolonged suffering and poorer outcomes are a recurrent theme in the health and care chapter of the JSNA. The potential for harm may be particularly acute in childhood if delayed intervention prolongs and exacerbates impacts on a child's development and learning with potentially life-long impacts.

## *Adult mental health services*

One in four adults experience mental illness and the total harm to health is comparable to that caused by cancers or CVD. Hence, it is right that the NHS is now committed to giving mental health **parity of esteem** with physical health.

As with physical ill health; the burden of mental ill health shows marked inequalities and there are significant opportunities to prevent mental illness throughout the life course e.g. by reducing exposure to ACEs. The impact of the **wider determinants** on mental health is particularly marked. Factors like debt, unemployment, homelessness, relationship breakdown and social isolation predispose to mental illness. Action to address the wider determinants can aid recovery but people with mental health issues, particularly serious mental illness, are much less likely to have stable accommodation or be in work. A coordinated, proactive approach on the part of multiple agencies is necessary.

People in the criminal justice system and rough sleepers have particularly complex problems often including concurrent mental illness and drug & alcohol dependency.

A relatively small number of patients live with **serious mental illness (SMI)**. Priorities for action include a timely and effective response to **crisis** and action to reduce the **gap in life expectancy** between people with SMI and the population as a whole.

A far bigger number of people are living with a common mental health condition. The ongoing development of **Improving Access to Psychological Therapies** (**IAPT)** has greatly increased the provision of talking therapies, but further work is needed to increase uptake, especially among groups who are less likely to seek help and achieve outcomes comparable to the best.

At the same time, action is needed to increase the capacity and capability of **primary care** to better support the bulk of people living with mental health problems. This includes promoting mental wellbeing, identifying those groups at greater risk of poor mental health and less likely to seek help, and promoting better physical health of patients living with serious mental health.

Alongside improvements in care, action is needed within **communities to tackle stigma**; build resilience and improve awareness of effective self-help options. It is important to increase public understanding of mental health; when and how to seek help, and how to recognise and intervene when others experience a mental health problem. This includes a greater awareness amongst frontline staff/volunteers in both clinical and non-clinical settings who may be in contact with individuals experiencing unemployment, debt, homelessness and relationship breakdown.

Despite concerns about a risk in suicide during the pandemic, early indications from real time suicide surveillance systems have not shown a significant increase in suicides comparing pre and post lockdown periods. However, periods of financial recession are known to impact suicide which is a concern in the current climate of increasing costs and in the event of an economic downturn.

## *Cancer services*

Cancer, with cardiovascular disease, remains the **big killer.** Cancers account for a quarter of all years of life lost.

1 in 2 people will be diagnosed with cancer in their lifetime. More than 3,200 people in BHR are diagnosed each year. 46% of cases are in Havering due to its older age profile. More than half of all cases are cancer of the breast, prostate, lung or bowel.

Just under 4 in 10 cases are caused by avoidable risk factors like smoking, obesity and alcohol and hence are **essentially preventable**.

**Survival** has increased steadily in all three BHR boroughs but lags behind the national average.

**Early detection** remains the key to improving survival. But about 1 in 5 cases of cancer in BHR are first diagnosed during an emergency presentation when disease is more likely to have progressed and hence prognosis is poorer. Only about 50% of cases are identified at stage 1 and 2 (early); a long way from the ambition stated in the NHS Long Term Plan of 75% by 2028.

Participation in cancer **screening programmes** is incomplete and displays a clear social gradient contributing to health inequalities.

Further effort is needed to increase participation in screening programmes and raise public and professional awareness of the early signs and symptoms of cancer.

**Additional capacity**, dependent on both more equipment and professional staff, is needed to facilitate timely diagnosis and subsequent treatment.

As survival improves – and the incidence of disease increases with population ageing – more people are **living with and beyond cancer**; sometimes with significant ongoing health problems associated with treatments received.

Disruption to screening programmes during the pandemic and public anxiety about attending health care services, despite potentially having suspicious signs and symptoms, is likely to lead to more late diagnoses and poorer survival.

## *Long term conditions*

As previously stated, life expectancy has increased in recent decades, but most of the additional years of life gained are marred by some degree of ill health or disability. Much of it is due to a variety of **long term conditions (LTCs)** including cardiovascular disease (CVD), diabetes, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD) and musculo-skeletal (MSK) conditions.

Many people are at increased risk of CVD due to a combination of **lifestyle** (e.g. smoking, obesity, alcohol use) and **physiological risks factors** (e.g. high blood pressure and cholesterol levels). As with many LTCs, the prevalence of CVD demonstrates a strong social gradient and very clear **inequalities.**

Treatment and / or lifestyle change can significantly reduce that risk and **prevent potentially life changing heart attacks and strokes**. However, many people will experience few or no obvious symptoms and as a result disease remains undetected and untreated until they experience an event that may kill or cause permanent disability. The proportion of undiagnosed cases tends to be higher in disadvantaged communities, further exacerbating health inequalities.

CVD is representative of a number of LTCs that show significant **under-diagnosis**.

All adults aged 40-74 should be invited for an **NHS Health Check** once every 5 years to assess their risk of CVD until and unless a problem is detected. It's estimated that for every 6 to 10 NHS Health Checks completed, one person is identified as being at high risk of CVD. Uptake varies considerably but can be improved by adopting a more robust invitation process and providing checks at convenient times and locations.

Some communities and population groups are less likely to make time for such a check but may be engaged through opportunistic community or work based interventions.

Some risk factors are common to several LTCs. As a result, someone with one LTC is more likely to develop another and GPs should regularly check patients being treated for one condition for others.

As well as under-diagnosis, there is strong evidence that a proportion of people with a known LTC **miss out on interventions** that would reduce their risk of disease progression. Further improvement in the management of common LTCs is necessary to maximise the benefits. This includes **pharmaceutical treatment** but also participation in **lifestyle change programmes** commissioned by local government and the NHS.

A small but growing proportion of residents live with several LTCs, also known as **multi-morbidity.** Individuals affected by multi-morbidity are also at substantially increased risk of poor mental health. Existing services struggle to meet their complex needs and as a result they frequently attend A&E and/or have unplanned hospital admissions. Although small in number, a disproportionate amount of resource is expended achieving less than satisfactory outcomes.

The diagnosis and management of LTCs was significantly disrupted during the pandemic. Residents were put off seeking help due to fear of infection; access to general practice was curtailed, face-to-face appointments were done virtually and diagnostic investigations delayed. Pending a successful recovery, it is likely that residents will experience otherwise avoidable harm.

It seems increasingly likely that another legacy of the pandemic will effectively be a new LTC in the form of **long COVID**. Symptoms vary widely, including fatigue, shortness of breath, muscle ache and difficulty concentrating. In addition, extended absence from work may increase the risk of unemployment, debt, relationship problems etc. ONS estimated 1.9% of the population self-reported long COVID in October 2021 (before the recent and largest wave of infection associated with the omicron variant). Most individuals can self-manage but a dedicated service has been established at King Georges Hospital to assess and provide a programme of physical and psychological therapy for those with greater needs. Prior hospitalisation with acute COVID-19 has been linked to a higher risk of severe and prolonged symptoms and subsequent diagnosis of new and significant health problems including respiratory disease, diabetes, CVD, CKD and liver disease.

## *Older people and frailty services*

Older people experience more ill health and have greater need for health and social care than other age groups. Consequently, ongoing population ageing will pose a growing challenge to health and social care services.

Greater focus on **prevention** is needed at every stage of the life, including in old age, to improve quality of life for older residents and delay the point at which ill-health results in significant loss of independence and reliance on health and care services. Prevention in old age can take many forms.

Older people are at very much higher risk of serious illness and death because of COVID-19. Vaccination reduces that risk, but immunity wanes quickly and boosters are needed when the incidence of coronavirus infection is high to minimise harm and

pressure on the health and care system. As we slowly move out of the pandemic, the frequency of boosters is still linked to successive waves of infection but in time these will settle and **COVID vaccination** may be offered in advance of winter when other respiratory illnesses peak.

Pre-pandemic, death rates were 20% higher amongst residents aged 85 and above during winter. The bulk of **excess winter deaths** are from dementia, CVD and respiratory conditions, some linked to flu. Pre-pandemic, uptake of **seasonal flu** vaccination by BHR residents aged 65 and above was below the national target and had been in slow decline. To further efforts to maximise uptake of vaccination, the wider partnership should work together to identify and support residents vulnerable to cold weather due to poor housing and low income. This is particularly relevant given the recent huge increase in energy costs which can only add to the 1 in 10 households affected by **fuel poverty**.

People can feel lonely at any stage of life, but the experience is most severe among older people. Action to **tackle social isolation** improves wellbeing and reduces the burden on health and social care services and as such is cost-effective.

An **early diagnosis of dementia** helps someone to benefit from available treatments, make the best of their abilities and live independently for longer. However, between a ⅓ and a ½ of BHR residents with dementia are undiagnosed.

A ⅓ of people over 65, and ½ of people over 80, fall at least once a year. Falls are the number one precipitating factor for loss of independence and admission into long-term care. **A comprehensive approach to falls** includes action to prevent falls; detect and manage osteoporosis; and to support residents after a fragility fracture.

Falls, social isolation and cognitive impairment are a few of the potentially preventable or modifiable risk factors that contribute to the development of **frailty**. Frailty is a particular state of health experienced by a significant minority of older people (25-50% of those 85 and older) such that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing. A **comprehensive approach to frailty** includes prevention, as described above, but also the systematic identification and ongoing targeted support to people living with moderate frailty by community based multidisciplinary teams. Early identification and support is designed to limit further progression and respond urgently to crises to prevent unwarranted hospital admissions.

The mental health of older people is as important at physical health but may be overlooked. **Depression** is the commonest mental health condition, with higher rates among care home residents and after bereavement. Many people with dementia are also depressed, but may struggle to express themselves making diagnosis more difficult. It is important that people are able to access mental health services appropriate for their needs, irrespective of age. Use of **IAPT** appears particularly low amongst this age group.

Hospital admission can lead to a rapid decline in physical abilities, equivalent to a year's additional age for each day of admission. Such deterioration can very quickly make a return home impossible. There is strong evidence that **reablement** services after admission can improve function, independence and the likelihood of a successful return home.

Research suggests that most people would prefer to stay in their own home rather than to move into residential care. **Domiciliary care** enables some residents with very significant care needs to remain at home. Nonetheless, **residential care** homes provide an essential service for some of our most vulnerable residents. Whilst in care, they remain vulnerable individuals often with complex multi-morbidity and frailty requiring ongoing assessment and proactive management to minimise crises and avoid hospital admission. Adoption of the **enhanced health in care homes** model is designed to ensure that all care home residents receive consistently high quality, proactive care.

Few people would choose to die in hospital and yet more than half of all older people in BHR do so. The proportion of people dying in hospital in all three boroughs are significantly higher (worse) than England average. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. Care Home Support, a rapid response team and 24-hour support line are being implemented and the palliative care capacity is being increased to improve the quality of the **end-of-life care**.

The protection afforded to residents of care homes will be a key consideration for the review of the national response to the pandemic. It's clear from local experience that care home management and staff worked unceasingly to protect residents while continuing to meet their care needs. Nonetheless there were outbreaks and some residents became seriously ill and died before the roll out of vaccination. In addition, measures enacted to protect against the spread of infection, as set out in national guidance, served to separate residents from loved ones for long periods. The families affected suffered themselves and report residents deteriorated more rapidly as a consequence.

While enhanced **infection, prevention and control measures** are still in place, some of the most intrusive elements of guidance to care homes have been relaxed. Cases of infection amongst staff and residents continue but rarely result in serious illness while vaccination continues to provide effective protection.

Care homes will continue to be high risk settings with regard to COVID-19 for several years to come; requiring ongoing support from the UK Health Security Agency (UKHSA) and local authorities, and not least from NHS partners providing **booster vaccinations** and timely access to **antivirals** for those eligible. The pandemic has demonstrated that **care homes and domicillary care are essential**

**elements of the health and care system** and neglect for any one part has consequences for the whole.

## *Urgent and unplanned care*

BHRUHT is often full to capacity, with long waits in A&E, ambulances queueing and patients unable to be admitted until someone else is discharged. Whereas previously this would have only happened in the depths of winter, it has become a regular occurrence year round.

Work is underway under the auspices of the BHR Urgent and Emergency Care Transformation Board to create alternatives to A&E attendance. Further action will be needed to ensure that patients and clinicians use these new services as intended.

Perhaps more importantly, the JSNA identifies many opportunities to avoid the crises that trigger attendances at A&E and the need for unplanned hospital admissions. For example, by tackling the risk factors for disease; through better identification and management of long term conditions to prevent disease progression; and by better coordinated and intensive support of a relatively small number of patients with very complex problems that make disproportionate use of services.

## *Pillar 4: Planned (non-urgent) care*

A huge variety of care is provided on a planned basis, including diagnostic investigations, specialist assessment and then treatment, including surgery. Much of this is traditionally provided in acute hospitals through outpatient clinics.

The number of people waiting for care, and the duration of that wait, was growing before the pandemic hit and has grown greatly since as services stopped entirely and then returned with reduced capacity.

The BHR Planned Care Transformation Board aims to ensure that patients are seen in the right place, at the right time, by the right healthcare professional. In doing so it will save patients' time, improve their experience of care and ensure clinical time and resources are utilised effectively to reduce waste in the system.

- Closer working between hospital consultants and GPs, and improved access to diagnostic tests will increase the scope for managing patients in primary care.
- Alternatives to traditional hospital based services are being developed.
- Digital options will reduce the need to travel to hospital and improve sharing of information between clinician and patient.
- Where appropriate, routine appointments to confirm nothing is wrong will be replaced with the opportunity for the patient to initiate follow up when they have concerns.

- Improved information and support will leave patients better informed and more able to self-care.

Just as COVID-19 has exacerbated existing inequalities in other parts of life, access to elective treatment fell further in the most socioeconomically deprived areas of England between January 2020 and July 2021 than in less deprived areas. Hence plans for the recovery of planned care need to consider and provide for the greater need for care in disadvantaged communities.

## *Population Health Management*

There is a recurrent theme through the JSNA and particularly the section regarding integrated health and care. A different approach is required to the organisation and delivery of health and social care.

We need to make better use of information to inform how we plan and deliver services for the population as a whole, as well as the clinical management of individual patients. Stratification of the population by life stage and complexity of need will improve the planning and delivery of services for specific patient cohorts:

- **People who are generally well**: who will benefit from primary prevention interventions to maintain good health; with more intensive support where people are currently well but at risk of developing LTCs.
- **People with long term conditions**: who in addition to the primary prevention interventions above, will benefit from early identification and treatment of LTCs, personalised care planning, self-management support, medicine management and secondary prevention services.
- **Older people with complex needs or frailty**: who in addition to the interventions above would benefit from a case management approach offering integrated, holistic, personalised, co-ordinated care with a high degree of continuity.

In each case, the precise interventions and delivery mechanisms will vary through the life course and in response to social factors.

The NHS Long Term Plan sets out a very clear path for the care of people with the most complex needs. It pledges to end the distinction between primary care and community services. Rather, it envisages a new model, delivered within **localities** by general practices acting together as **Primary Care Networks (PCNs), with community teams, social care, hospitals and the voluntary sector working together** to help people with the most complex needs, to stay well, better manage their own conditions and live independently at home for longer.

At times of crisis, a new NHS offer of **urgent community response and recovery support** will act as a single point of access for people requiring urgent care in the community; provide support within two hours of a crisis and a two-day referral for **reablement** care after discharge.

**Residents in care homes,** some of the most vulnerable patients, will benefit from guaranteed NHS support providing timely access to out of hours support and end of life care when needed.

The extension of **personalisation** from social care to health care services will see the whole package of care brought together in a care and support plan reflecting the needs and assets, values, goals and preferences of the individual.

Development of personalised care plans is an opportunity to reset the relationship between professional and client. It will focus less on deficits and what services they need and more on what they can do and the **assets** available to them, including family and wider social networks. The role of health and social care is to provide any additional support and / or aids necessary, for a limited period, to return them to their former level of functioning and independence.

Developing the multidisciplinary and multiagency team necessary to deliver this new model of care for complex patients will be an immediate and significant challenge for emerging locality teams. The teams will involve non-professional peer support and voluntary sector input in addition to professional and statutory health and care staff.

But better management of complex patients will not in itself improve health outcomes nor achieve a sustainable balance between the needs of a growing and ageing population and the capacity and capability of local health and social care services.

Greater capacity will be needed in the community if the far larger group of residents with, or at risk of, LTCs are all to be identified and thereafter managed in line with best practice. More can be made of **community pharmacy**. The introduction of **new professional groups** e.g. clinical pharmacists and physician assistants, to complement GPs and practice nurses will help. As will better coordination and collaboration between practices working within PCNs; facilitated by improvements to **premises** and **IT**.

Innovative methods will be needed to identify residents who are at risk of disease who currently don't engage with general practice. The use of wearable technology will enable people to better understand and take more control over the management of their health.

Equally, health professionals and public will need to recognise the impact of personal circumstances and place on health and look beyond health care for more effective ways of improving wellbeing. Strong links between general practice, other statutory services such as housing and the Department of Work Pensions, the community and voluntary sector within the locality should be an essential element of locality working. The development of an effective **social prescribing** function, whereby patients are

actively encouraged to access other forms of support, will maximise the likelihood of success e.g. with 1:1 support from a care navigator. Partners and the community itself will also need to consider the assets available relative to needs and how any gaps may be filled[7]. Approaches such as **local area coordination** are needed to strengthen the capacity of communities to identify and support our most vulnerable residents and hence reduce pressure on statutory services.

The switch to a more **preventative** approach will not be achieved by health and social care services alone. Currently many thousands of residents miss potentially lifesaving interventions, such as immunisation and cancer screening, or turn down the opportunity to have a NHS Health Check. Others will delay seeking help when they notice changes to their body that subsequently turn out to early signs of cancer.

We can, and must, seek to improve knowledge and awareness e.g. the 'be clear on cancer' campaign and remove any barriers to engagement by offering screening and health checks outside of traditional working hours or in the workplace.

However, people's decisions about engagement with health services and more widely regarding behaviours that impact on health are not made in isolation. Instead, they are shaped by the place which they live; prevailing cultural norms, their previous experiences and aspirations for the future. A focus solely on health and social care is not enough. We come back to the message underpinning this JSNA – that we cannot achieve significant improvement in health outcomes and a reduction in health inequalities without **tackling all four pillars of the population health model**.

Although not the lead agency, the health and social care system should give equal priority to the direct contribution it can make to tackling the wider determinants of health, throughout the life course e.g.

- by minimising exposure to and the harm caused by adverse childhood experiences;
- improving income and aspiration by creating apprenticeship opportunities for CYP in disadvantaged communities;
- helping people with physical and mental health problems into work or a secure home;
- reducing social isolation amongst older people.

[7] The current JSNA currently describes the need for health and social care services at BHR and borough level. Data are provided at locality level and in the coming year, Public Health Services intend to work with developing locality teams to identify priorities for each.

# 1. The Havering Population

**Indicators and data used in this section can be accessed by clicking here*

## 1.1 Population Size & Growth

The resident population of Havering in 2020 was estimated to be 261K.

The population registered with a Havering GP in 2021 is 283K. The Havering GP registered population is 33% of the total patients registered with a GP in the 3 BHR boroughs.

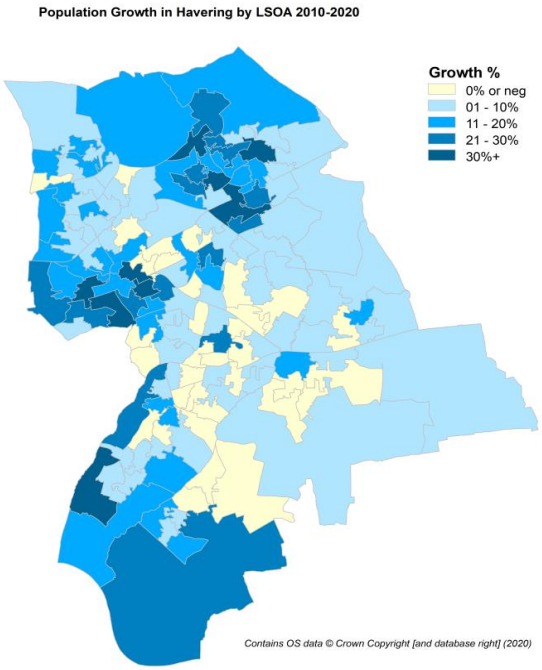
The population resident in Havering is estimated to have increased by 24K (10%) in the ten years from 2010.

Over the same period, population growth varied at ward level from almost 20% in Brooklands (18%) to 0% in Emerson Park (Fig. 1).

Further significant population growth is likely with the population of Havering projected to grow by another 15K (5.6%) from 266K in 2022 to 281K in the ten years to 2032.

As has occurred in recent past, the rate of population growth in the future will vary from area to area – given housing targets in the London Plan the greatest growth is likely to be in Rainham and Romford.[8]

**Figure 1. Population Growth in Havering by LSOA 2010-2020**




Data Source: ONS 2020 Mid-Year Pop Estimates

## 1.2 Local and National Impacts of COVID-19 Pandemic on Population Changes

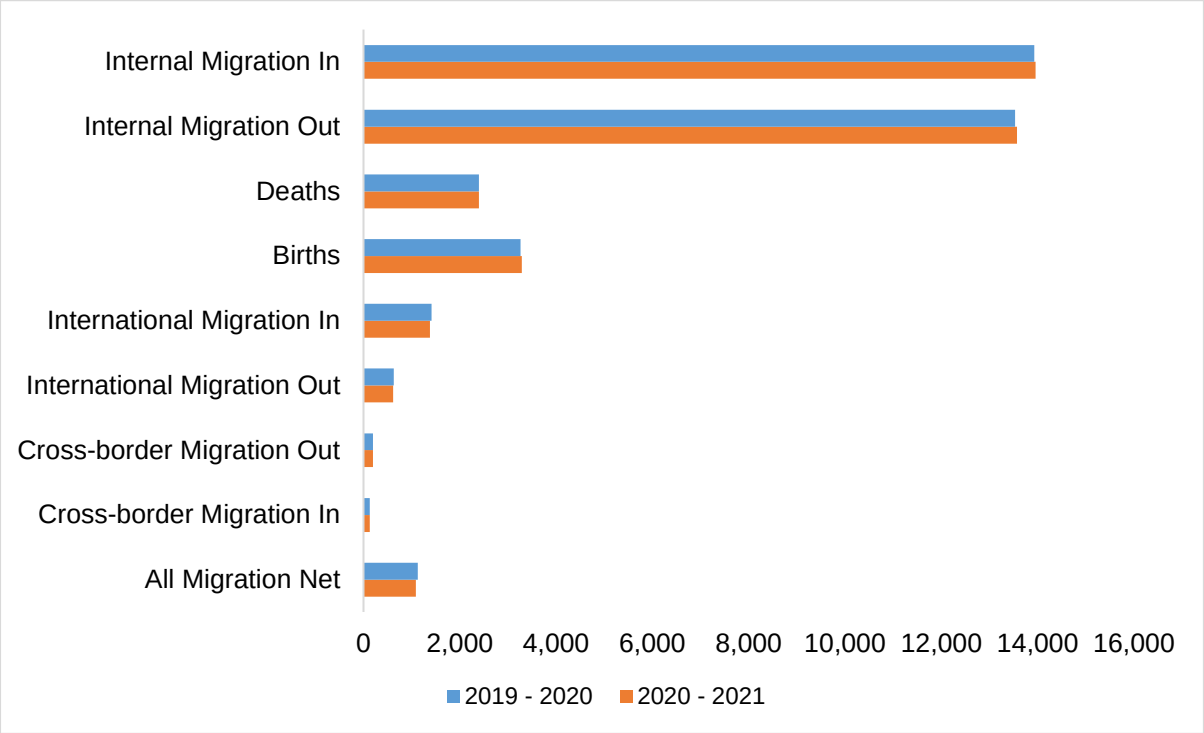
Rate of population change in Havering before the COVID-19 pandemic (2019-2020) is similar to population changes during the pandemic (2020-2021) (Fig. 2). It has been noted that nationally internal and cross-border migration may have reduced in 2020 for reasons such as difficulties in travelling to different areas, changing personal circumstances, reduced job opportunities and an increase in people working from home[9]. However, local data does not indicate any significant changes.

[8] https://www.london.gov.uk/what-we-do/planning/london-plan/new-london-plan/draft-new-london-plan/chapter-4-housing/policy-h1-increasing-housing-supply

[9] Office of National Statistics 2021. What could impact the impact of COVID-10 be on UK demography? Available at: https://blog.ons.gov.uk/2020/12/07/what-could-the-impact-of-covid-19-be-on-uk-demography/

Since March 2020, there have been significant national changes in international migration and mobility as well as a fall in the number of visa application issued for work and study to non-EU nationals[10]. This may explain the reduction in the rates of international migration into and out of Havering between 2019-2020 and 2020-2021.

**Figure 2. Population Churn Estimates for 2019-2020 and 2020 - 2021**



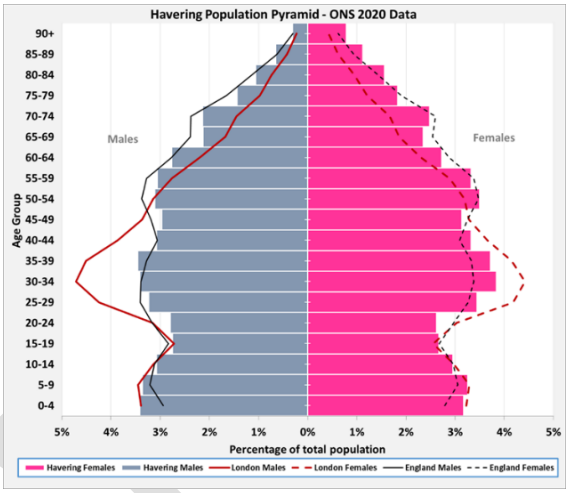

Data Source: ONS subnational population projections for England: 2018-based

[10] Office of National Statistics 2020. International migration and mobility: what's changed since the coronavirus pandemic. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/articles/internationalmigrationandmobilitywhatschangedsincethecoronaviruspandemic/2020-11-26

## 1.3 Age Structure

After population size, age structure is the biggest single determinant of need for health and social care services.

**Figure 3. Havering Population Estimates 2020**



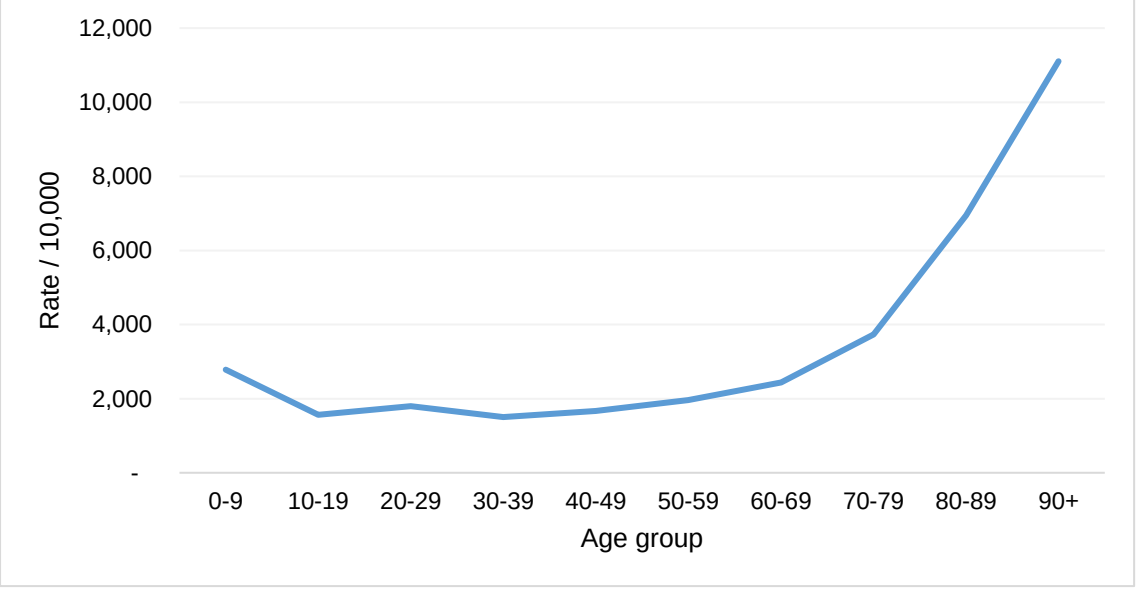

Data Source: ONS Mid-Year Population Estimates 2020

The population of Havering is relatively old in comparison with the rest of London (Fig. 3) and the BHR ICS. Nearly half (46.9%) of the 16K people aged 85 and older living in BHR live in Havering.

As well as growing, the age profile of the Havering population is also projected to change with proportionally greater growth amongst older age groups. For example,the number of people aged 85 and above living in Havering is expected to increase by 2.4K (32%) from 7.5K in 2020 to 9.9K by 2030.

The use of health services typically exhibits a 'j' shaped curve with much higher use in the first weeks of life and again later in old age (Fig. 4). For example, people aged 80-89 are 4 times more likely to attend A&E than adults aged 40-49 years. Utilisation of health and social care services is likely to be proportionally higher in Havering due to its relatively old population (see **Section 6.6 Older People & Frailty**).

**Figure 4. BHRUT Hospitals A&E Attendance rate based on BHR CCG Population 2019-20**




Source: NHS Digital

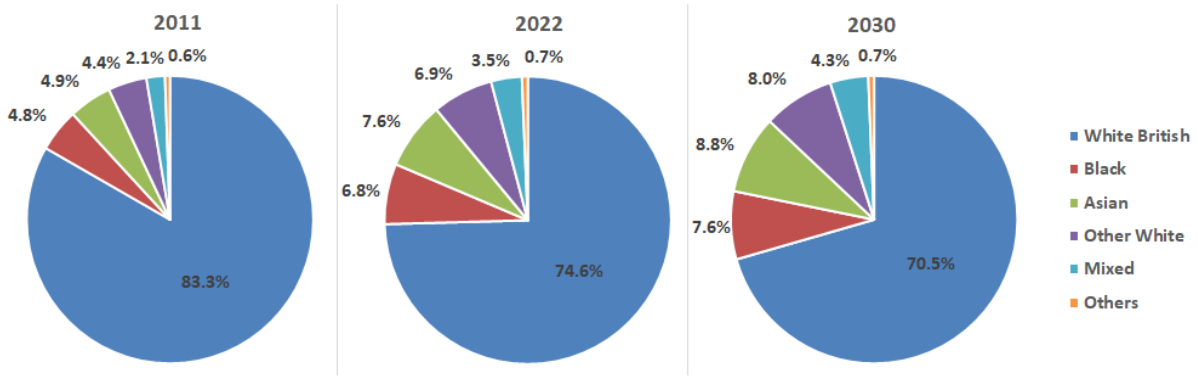
## 1.4 Ethnicity

Ethnicity influences health outcomes via multiple routes. For example experiences of discrimination and exclusion, as well as the fear of such negative incidents, can have

a significant impact on mental and physical health. Health-related practices, including healthcare-seeking behaviours, also vary between ethnic groups. Just as importantly, there are marked ethnic differences regarding the wider determinants of health. Taken together these factors result in a complex picture such that some minority ethnic groups appear to have better health status than the White British population and some much worse; with the pattern differing with life stage, disease and risk factor. Hence, it is difficult and potentially misleading to make generalisations. Nonetheless some groups, notably individuals identifying as Gypsy or Irish Traveller, and to a lesser extent those identifying as Bangladeshi, Pakistani or Irish, stand out as having poor health across a range of indicators.[11]

Diversity has increased in the recent past. Nonetheless, Havering remains more similar to England as a whole than London in terms of ethnic diversity with 74.6% identifying as White British (Fig. 5). Further increases in diversity are likely.

**Figure 5: Havering change in ethnic populations, 2011-2030**




Data Source: GLA Ethnic Projections

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

# 2. Current health outcomes of Havering residents

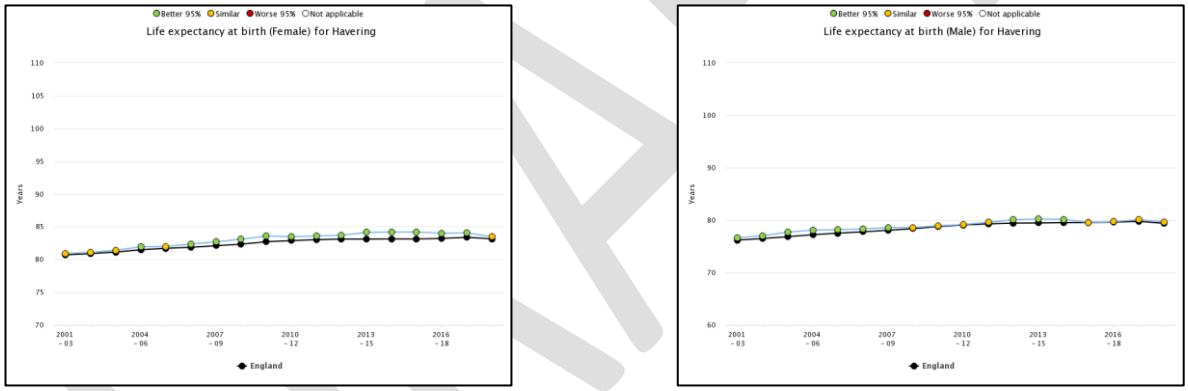
**Indicators and data used in this section can be accessed by clicking here.*

## 2.1 Life Expectancy

As is the case nationally, life expectancy at birth in Havering has increased steadily over recent decades but the rate of improvement has slowed markedly since 2000 (Figs. 6 & 7). Life expectancy continued to increase, albeit slowly, until 2020.

The most recent data available at borough level, aggregated for the period 2018-2020, shows that life expectancy in Havering actually reduced for both men (by 0.4yrs to 79.7yrs) and women (by 0.6yrs to 83.5 yrs) (Figs. 8 & 9). However, it remains similar to national averages, which also experienced a similar downturn, most likely as a result of the Covid-19 pandemic.

**Figures 6 & 7: Female & Male Life Expectancy at Birth Havering 2001-03 to 2018 -2020**



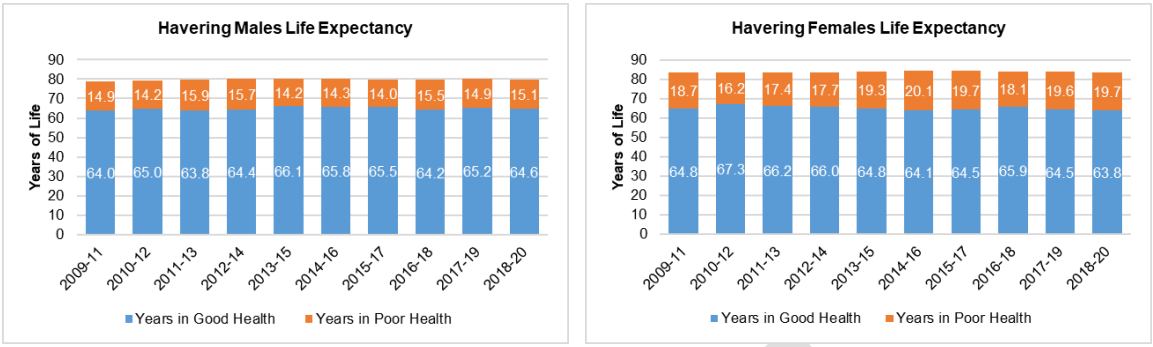

Source: PHE Fingertips

The impact of the pandemic is only partially captured in this period and a further reduction in life expectancy is likely when data for 2021 are included in borough level estimates (further analysis of life expectancy during pandemic at national and regional level is provided later in this section).

The pandemic is also likely to leave a legacy of persistent ill-health and disability. A summary of our early understanding of Long COVID is provided as section 6.5 and the implications for mental health in section 6.3.

This additional burden of ill-health will further emphasise the trend established before the pandemic whereby a significant proportion of life expectancy (19% for men and 23% for women) is impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services.

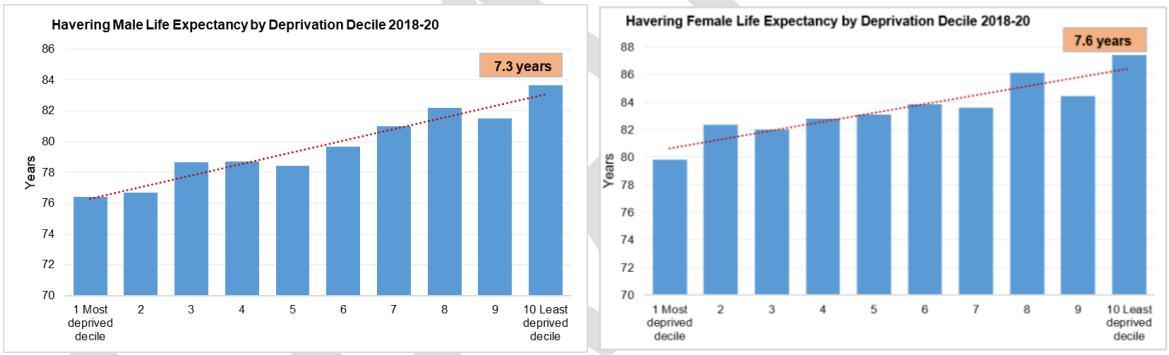
**Figures 8 & 9: Havering Life expectancy 2009-11 to 2018-20**




Source: Public Health England

Residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (7.3 years for males and 7.6 years for females) than peers in the least deprived decile (Figures 10 & 11). The inequality in life expectancy for both men and women widened as compared to 2017-19 (0.4 for men and 0.6 for women).

**Figures 10 & 11. Havering Life expectancy at birth by Deprivation, 2018-20**




Source: Office for Health Improvement & Disparities - Fingertips

As well as lower life expectancy, national evidence shows people living in disadvantage have proportionally less healthy life expectancy than less disadvantaged peers.[12]

## 2.2 Impacts of COVID-19 pandemic on life expectancy and death rates

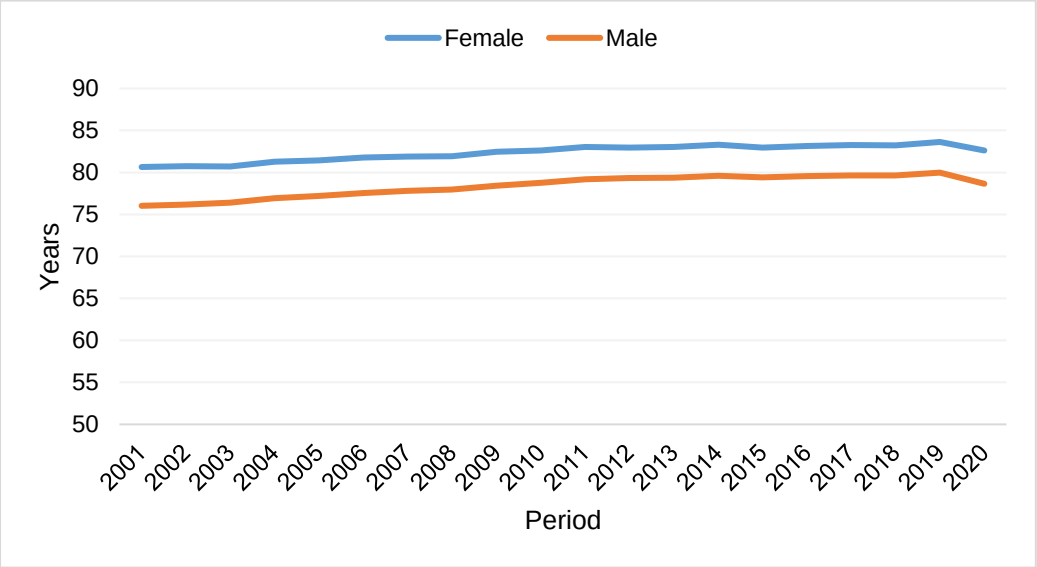
### National impacts

The COVID-19 pandemic has had both direct and indirect impacts on life expectancy. Direct impacts include deaths from COVID-19 and indirect impacts include higher rates of otherwise avoidable deaths due to late presentation and/or impaired access to healthcare. The very high level of excess deaths due to the pandemic caused life expectancy in England to fall in 2020, by 1.3 years for males and 0.9 years for females

[12] Life expectancy and healthy life expectancy at birth by deprivation - The Health Foundation

[13] (Fig. 12). This was the lowest life expectancy since 2011 for males and females. Regional data show that London experienced a still larger fall in life expectancy between 2019 and 2020 for both males (2.5 years) and females (1.6 years).

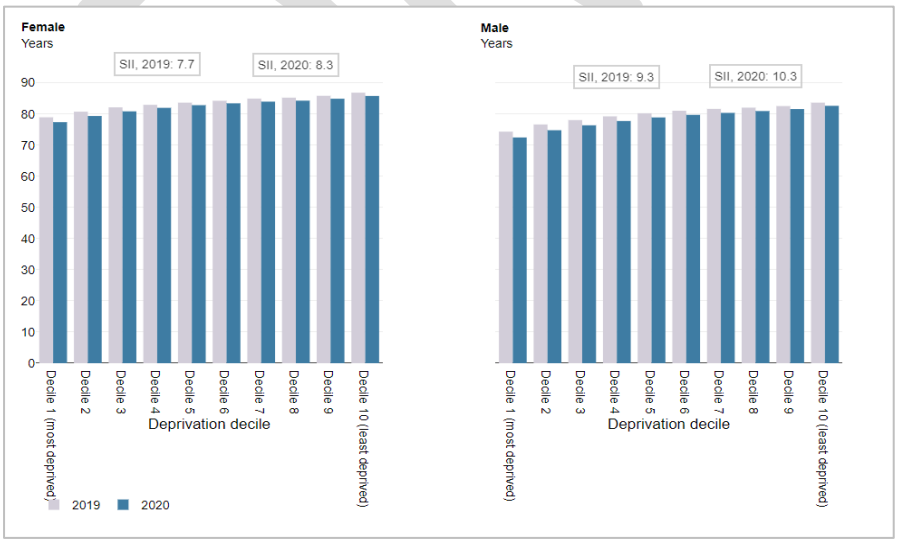
**Figure 12. Life expectancy at birth, by sex, England 1981 to 2020**




Source**:** Office for National Statistics

The COVID-19 pandemic has further increased inequalities across England, with the largest fall in life expectancy seen in the most deprived areas (Fig. 13). The inequality in male life expectancy between the most and least deprived deciles of England was 10.3 years in 2020, 1 year larger than in 2019. For females, the gap was 8.3 years in 2020, 0.6 years larger than in 2019.

**Figure 13. Life expectancy by Deprivation Decile, England, 2019 and 2020**




Source: PHE Wider Impacts of COVID-19 on Health (WICH) tool

[13] Public Health England, Health Profile for England 2021. Found at: https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html#summary-5---life-expectancy (accessed 11 November 2021)

Similarly, the pandemic has replicated pre-existing inequalities between different ethnic groups. After adjusting for a number of different confounders, men of Black ethnic background were 2.0 times more likely to die with COVID-19 than White males and females 1.4 times more likely. Males of Bangladeshi, Pakistani and Indian ethnic background also had a significantly higher risk of death (1.5 and 1.6 times respectively) than White males.[14]

The cause of these inequalities are complex and in part reflect underlying inequalities in the wider determinants of health. In addition, a suspicion of statutory services, including the NHS and greater levels of hesitancy regarding vaccination have been implicated.[7]

### Local impacts

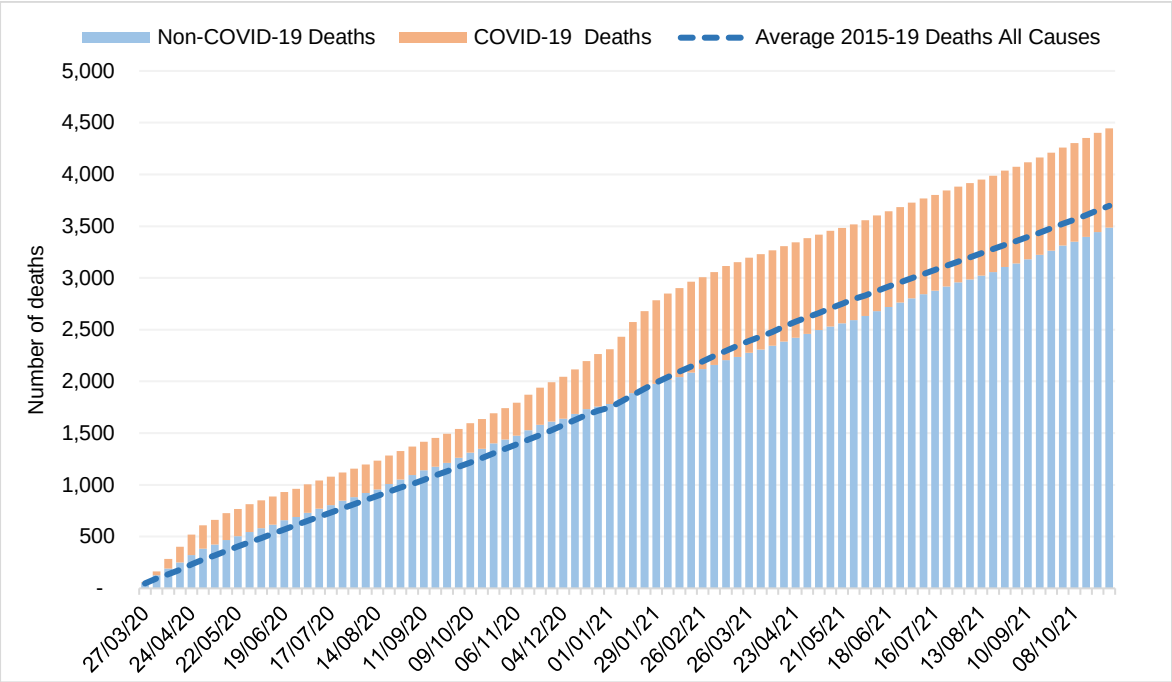
Due to small numbers, life expectancy at borough level is calculated based on a rolling three year period, currently 2018-2020. As such, the majority of the time period predates the pandemic. Nonetheless, life expectancy fell by 0.4yrs to 79.7yrs for men and by 0.6yrs to 83.5 yrs for women. The size of the fall is likely to grow further as the period of analysis shifts to include the second year of the pandemic.

Figure 14 shows the cumulative number of deaths of Havering residents from March 2020, when the first death with coronavirus was registered, through to October 2021. Two distinct periods of excess mortality are evident, the first in April – May 2020 following the first wave of the original Wuhan variant, followed by another in January to February 2021 associated with the second wave caused by the Alpha (Kent) variant. Over the 18 month period as a whole, there were nearly 1,000 deaths where COVID-19 was recorded as a contributory factor and the total number of deaths from any cause was 20% higher than the average in the preceding 5 years.

DRAFT

[14] Disparities in the risk and outcomes of COVID-19 (publishing.service.gov.uk)

**Figure 14. LB Havering, Weekly Cumulative Number of Registered Deaths in 2020-21 and the average over 2015-19**




| | |
|---|---|
| Total registered deaths from March 2020 to October 2021 | 4,445 |
| Total Average 2015-19 Deaths All Causes / Expected Deaths | 3,697 |
| Total Excess Deaths | 748 |
| Total COVID-19 related deaths | 960 |
| Total Non-COVID-19 deaths | 3,485 |

Source: ONS Deaths Register

Deaths from COVID-19 have diminished but not stopped entirely as the protection afforded by vaccination was rolled out to more and more of the population from December 2020 onwards.

Higher rates of death from other causes such as cancers and cardiovascular disease are likely to continue as health and social care services recover from the cumulative impact of the pandemic.

The huge recovery challenge faced by the health and social care system should not obscure the fact that, prior to the pandemic, communities elsewhere in England and abroad achieved much better health outcomes than those seen in Havering. In other words, residents enjoy longer life expectancy and a greater proportion of that longer life is lived in good health.

This is not necessarily because residents of Havering benefit from significantly better health and social care services than other boroughs – although this may be a contributory factor. Rather it is because they enjoy overall more favourable social-economic conditions and live in communities and environments that better support health and the adoption of healthy lifestyles.

Therefore, to achieve our aspiration of reducing inequalities and better health for all, we must create the conditions that support good health as well as improving care services. Robust plans regarding all four pillars of population health are essential, taking into account the impacts of the COVID-19 pandemic.

This is the business of a wide variety of statutory agencies; private enterprise and communities themselves operating locally, nationally and internationally. Borough level Health and Wellbeing Boards (H&WBs) offer a forum for partners to challenge the robustness of relevant local plans as a whole and ensure the health and social care system makes a full contribution, as set out in the recommendations made in subsequent sections.

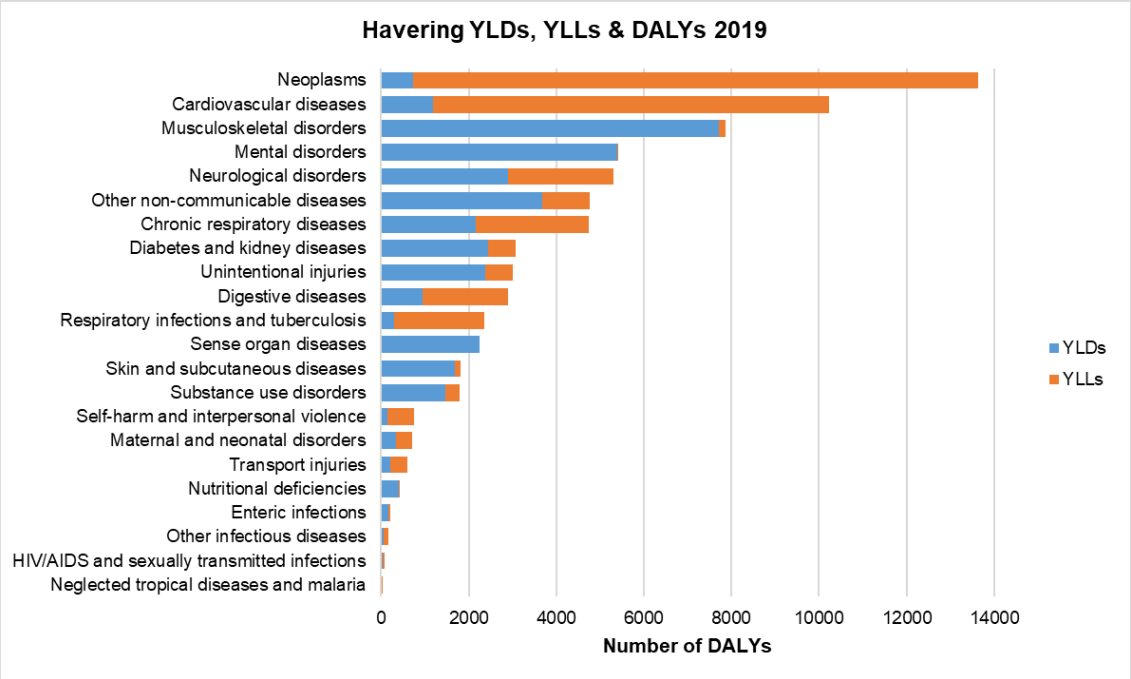
***Recommendation 1:*** *All partners should participate in borough level H&WBs and take the opportunity to ensure there are robust plans in place regarding all four pillars of the population health model.*

Life expectancy and other measures based on death rates highlight diseases that result in early death. Considerable harm to health is also caused by diseases that primarily result in prolonged illness and disability.

DALYs (Disability Adjusted Life Years) are a means of combining years of life lost (YLLs) due to premature death and the years of healthy life lost due to disability (YLDs) into a single measure of harm to population health (Fig. 15).

Pre-pandemic, neoplasms (cancers) and cardiovascular diseases (e.g. heart attack and stroke) caused the greatest loss of good health as measured in DALYs, largely due to premature mortality. Musculoskeletal conditions and mental health disorders caused the next greatest loss of DALYS but as a result of years of healthy life lost to disability.

**Figure 15. Havering YLDs, YLLs & DALYs, 2019**



Data Source: Global Burden of Disease, 2019

***Recommendation 2:*** *Plans regarding integrated health and social care services (pillar 4) should give the same priority to conditions resulting in ill health and disability as for conditions causing premature death.*

In the same vein, as we come out of the pandemic, we must remember that as well as the large number of lives lost, many survivors of COVID-19 infection will face persistent ill-health and disability as a result of Long COVID (see Section 7.5).

The opportunity to reduce the harm caused by premature death and long-term illness through improved prevention and treatment and care is discussed in sections 3 and 6.5 respectively. Prevention and treatment are equally important and both must be at the heart of the developing integrated care system.

***Recommendation 3:*** *All partners within the developing integrated care system must give prevention and treatment equal priority if they are to succeed in improving health, narrow inequalities and provide high quality, affordable health and social care services.*

The health and social care system will face a massive recovery challenge as the pandemic recedes. This is explored in some detail in section 6.5.

Simply reinstating traditional models of care will not suffice. The health outcomes achieved for residents pre-pandemic lagged behind the best and varied such that some communities and population groups experienced significant and persistent inequalities. Much of the ill health seen was both predictable and preventable.

As such, the case for a partnership of NHS, local authority and voluntary sector bodies, working together to deliver integrated health and social care services, informed by a population health management approach, is stronger than ever.

***Recommendation 4*** *Plans regarding the recovery of health and social care services from the pandemic are essential but must not divert from the commitment to adopt a population health management approach that seeks to prevent ill health and pre-empt crises by the timely, proactive offer of support, care and effective treatments to an empowered and informed population.*

# 3. Pillar 1: The wider determinants of health

**Indicators and data used in this section can be accessed by clicking here*

The wider determinants of health e.g. income, employment, education, housing etc. are the most important drivers of health/ill-health at population level. They are the fundamental cause (the 'causes of the causes') of health outcomes, and health inequalities will continue so long as significant social inequalities persist.

## 3.1 Income

Income affects health in a variety ways:

- living on a low income is stressful and directly impacts on physical and mental health
- an adequate income enables us to buy health-improving goods and participate more fully in society
- low income is associated with unhealthy behaviours (See section 4)

Median gross weekly pay of people **living** in Havering (£705pw) is below the London average (£728pw) but significantly higher than the England average (£613pw). However, earnings of people who **work in Havering** (£614; who may or may not actually live in the borough) are very similar to the England average. This suggests that residents who work outside the borough e.g. commute into central London, attract a higher rate of pay than peers who work locally.[15]

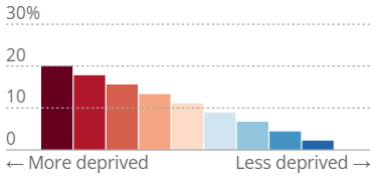
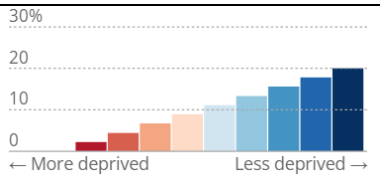
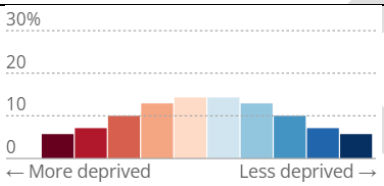
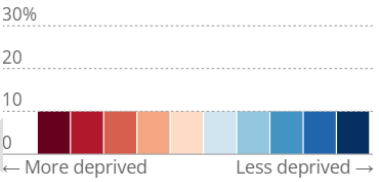
Although average pay may be modest by London standards, the proportion of adults in Havering that are income deprived[16] (10.8%) is below the national average (12.9%) and is the 8th lowest of the 32 London boroughs.

ONS has grouped local authorities into four distinct income deprivation profiles according to the distribution of deprivation within them (see Table 1 below). Havering has an 'n' shaped profile with more neighbourhoods with close to average levels of income deprivation.

[15] ONS (2021) Annual survey of hours and earnings – residence analysis. https://www.nomisweb.co.uk/reports/lmp/la/1946157270/report.aspx?#tabempocc

[16] IMD - Income Deprivation - score - measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people who are out-of-work, and those who are in work but who have low earnings (and who satisfy the respective means test).

**Table 1: ONS income deprivation profiles**

| Income deprivation profile | Distribution graphic | Text description | Examples |
|---|---|---|---|
| More income deprived |  | More neighbourhoods towards the deprived end of the scale | Barking and Dagenham, Newham, Waltham Forest, Hackney, Tower Hamlets |
| Less income deprived |  | More neighbourhoods towards the least deprived end of the scale | Brentwood, Bromley, Kingston upon Thames, Richmond upon Thames |
| 'n' shaped profile |  | More neighbourhoods with close to average levels of income deprivation | Havering, Redbridge, Barnet, Harrow |
| Flat profile |  | Similar % of neighbourhoods at all levels of income deprivation | Basildon, Southend, Bexley, Merton, Croydon |

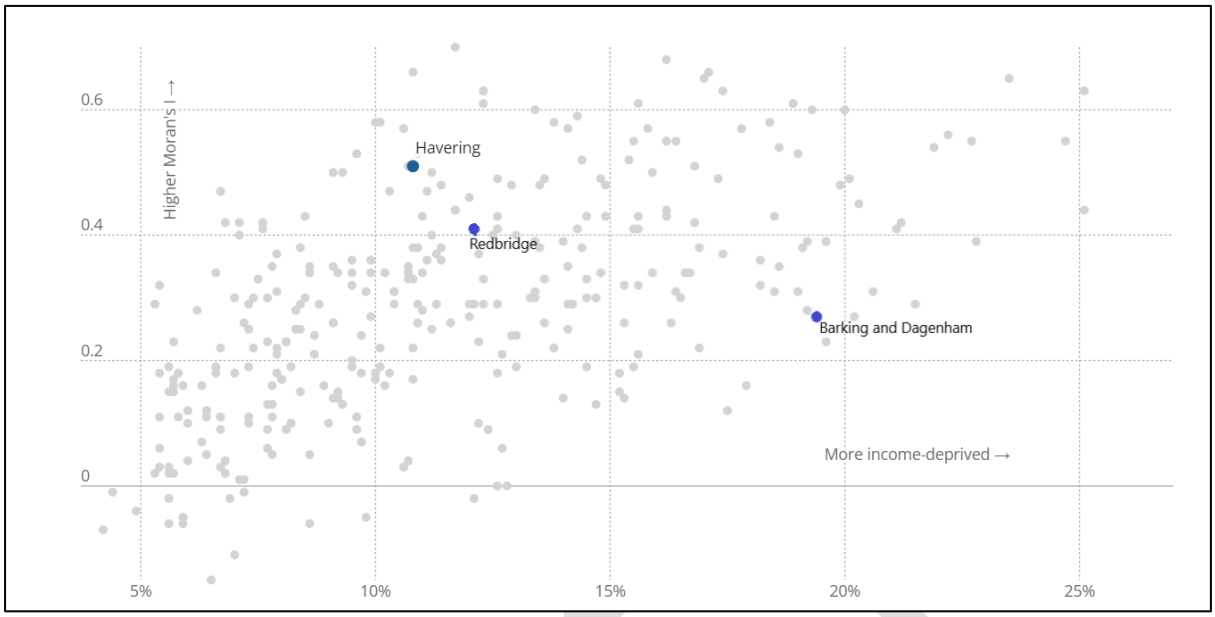
Source: Exploring local income deprivation (ons.gov.uk)

Nonetheless, 27,000 adults resident in the borough are income deprived overall, and there is significant variation across Havering.

In the least deprived neighbourhood in Havering, 1.6% of people are estimated to be income-deprived. In the most deprived neighbourhood, 33.9% of people are estimated to be income-deprived. The gap between these two figures, the internal disparity in income deprivation, is 32.3 percentage points in Havering. Generally, the local authorities in England with the greatest internal disparity (around 50%) have the highest levels of income deprivation overall. Local authorities with the smallest internal disparities, around 15%, tend to be rural, high income, and non-coastal.

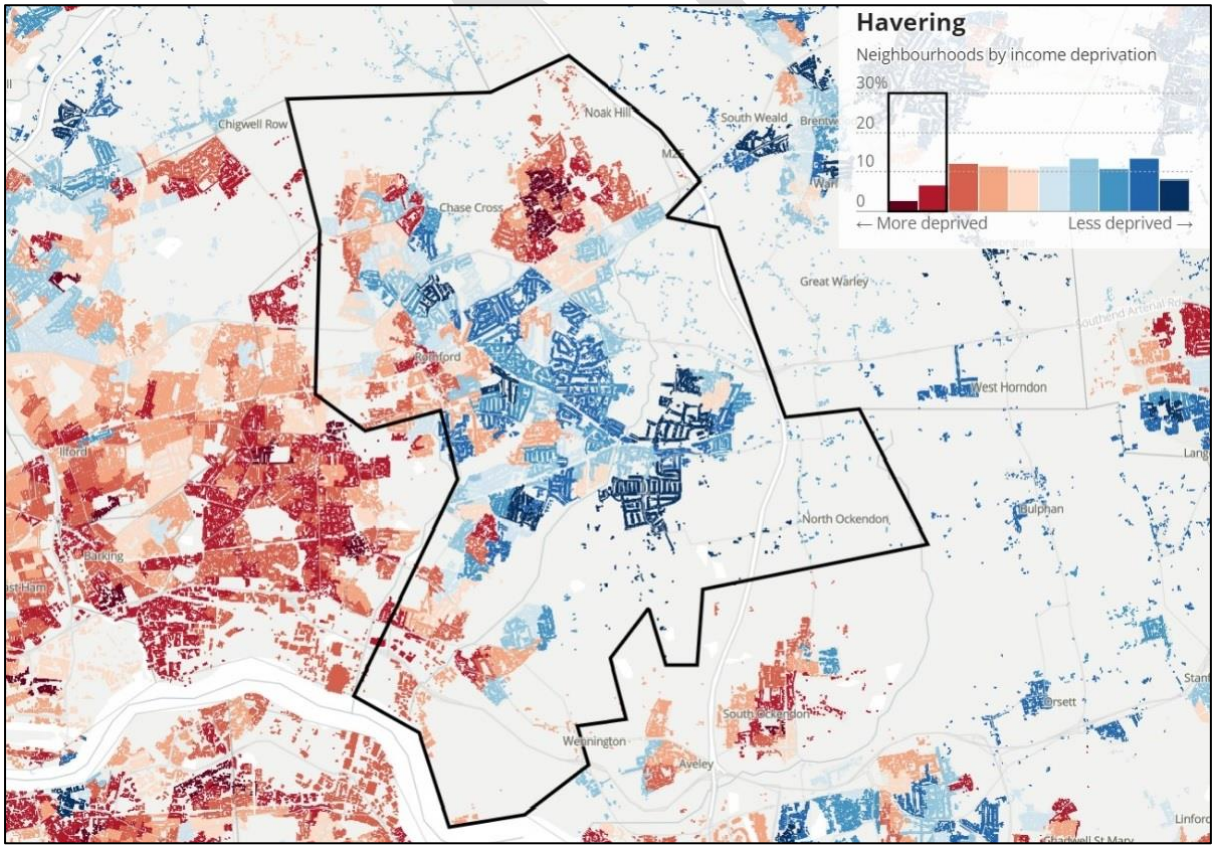
ONS use a metric called Moran's I to quantify the extent to which neighbourhoods with higher levels of income deprivation are clustered together or alternatively, distributed evenly throughout a local authority. Generally, there is an association such that authorities with high levels of overall income deprivation have a high Moran's I (around 0.6) whereas areas with low levels of income deprivation have a low Moran's I (around 0) (Fig. 16). Havering bucks this association to some extent in that it has a relatively high Moran's I (0.5), although levels of income deprivation are relatively modest overall. The majority of residents experiencing income deprivation live in defined areas - largely in the north and along the western edge of the borough (Fig. 17).

**Figure 16. Income deprivation by Moran's I, English local authorities, 2019**




Source: Exploring local income deprivation (ons.gov.uk)

**Figure 17. Distribution of income deprivation at neighbourhood level, Havering, 2019**



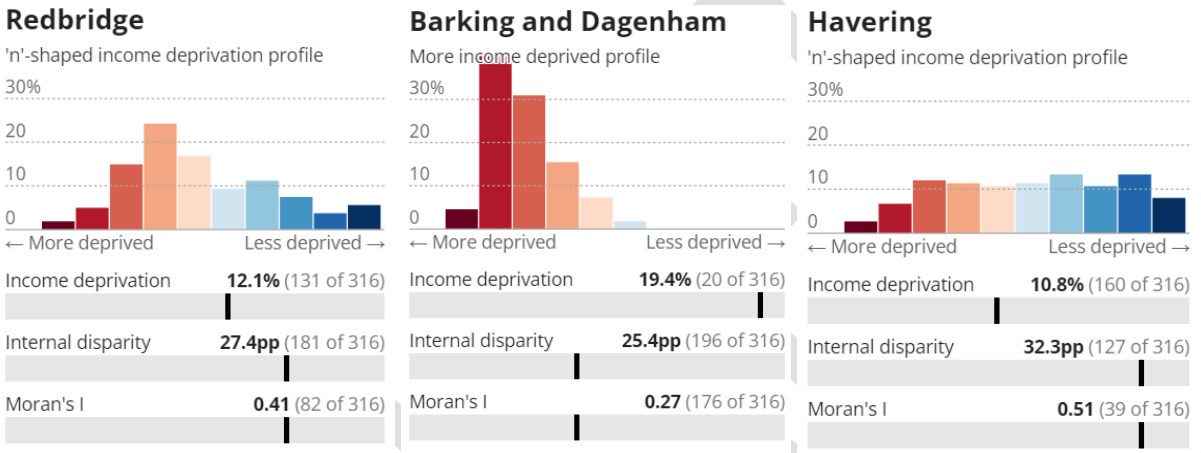

Source: Exploring local income deprivation (ons.gov.uk)

To avoid inequitable access to services, and reduce inequality in life outcomes, including health inequalities, decision makers must ensure that resources and service

provision are married to the level of need at locality, if not sub-locality level, consistent with the principle of 'proportionate universalism'[17] advocated by Marmot et al[18].

The extent and distribution of income disadvantage is very different in each of the three BHR boroughs (Fig. 18). In the case of Havering, relatively small areas in the north and along the western boundary of the borough have significantly greater need and will need proportionally greater resources.

**Figure 18 Distribution of Income Disadvantage in the three BHR Boroughs**




Source: Exploring local income deprivation (ons.gov.uk)

## 3.2 Work

Work is of itself good for physical and mental health, and further benefits wellbeing through its association with higher income.

Rates of employment in Havering (79.8%) are higher than the London (74.5%) and England (75.1%) average.

Job density[19] in Havering (0.60) is below the London (0.99) and England averages (0.85). Given overall rates of employment are high, this would suggest that a significant proportion of residents commute out of borough to work, and may gain a higher rate of pay in doing so.

About 7,200 of the working age population in Havering is unemployed (5.2%), less than the London average (6.0%) and higher than the England figure (4.7).

A much bigger proportion (17% - 27,500) of working age residents are economically inactive[20] for a variety of reasons including being a student, retirement, caring responsibilities and sickness. As with unemployment, this is a lower percentage than

[17] Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are universally available and able to respond to the level of presenting need in the area / community served.
[18] See LGA summary of the Marmot review into health inequalities in England and the role of local government in tackling the social determinants of health inequalities.
https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives
[19] Job density is the ratio of total jobs to population aged 16-64
[20] Economically Inactive: the section of the working age population that is not in employment or actively seeking employment.

reported for London (20.5%) and England 20.9%. However, a relatively large proportion of economically inactive residents (28%, n = 7,900) nonetheless want a job.

Excluding NHS Trusts and the Council, Havering has few large employers - the majority of local businesses are small to medium enterprises (SMEs).

49% of working age adults resident in Havering are employed in management or professional roles - similar to the national average (50%) but well below the average for London (62%).

Conversely, Havering residents are over-represented in administrative and secretarial roles and skilled trades, collectively accounting for 25.4% of the working population, compared with the England (19.2%) and London averages (15.6%).

The health and social care (20.5%) sector, wholesale and retail trades (16.9%), administration (9.6%), construction (8.4%) and transportation (8.4%) are the largest sources of employment for Havering residents.[21]

Recent and ongoing changes to the retail sector in favour of online sales and fewer administrative roles as automation and AI reduce staffing levels may alter established patterns of employment and require the acquisition of new skills and expertise.

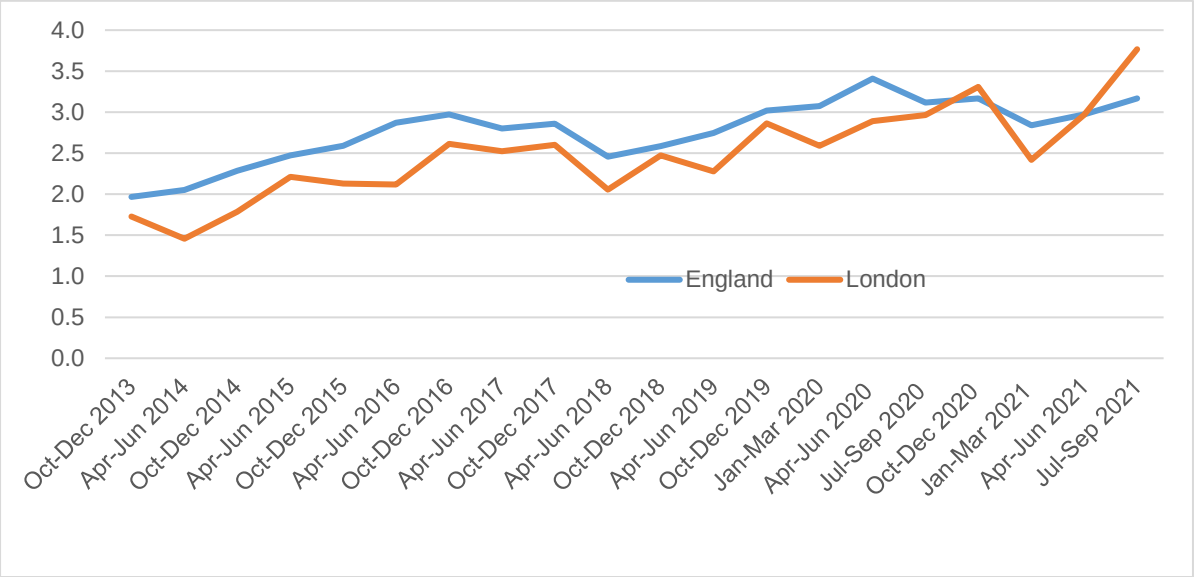
Good work is better for health than bad work - work that involves adverse physical conditions, exposure to hazards, a lack of control and unwanted job insecurity.

Atypical employment including zero hours contracts (ZHCs), short-hour contracts and various self-employment options within the gig economy, as well as more established models including part-time employment, temporary positions and agency work have been the cause of much concern over the past decade, in part regarding the rights to which such workers are entitled to and whether they are being consistently upheld. The lack of certainty around income has been raised particularly in relation to ZHCs.[22]

[21] https://www.nomisweb.co.uk/reports/lmp/la/1946157270/report.aspx?c1=2013265927&c2=2092957699#tabempunemp

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772215/Resolution_Foundation_-_Atypical_approaches_-_Options_to_support_workers_with_insecure_incomes.pdf

**Figure 19 - Percentage of people in employment on a zero-hours contract**




Source: ONS Labour Force Survey

A small (4% in London) but growing proportion of workers are on ZHCs (Fig. 19). This rises to about 10% amongst the youngest workers (16-24). Rates are generally higher for women than men, and non-UK residents than UK residents. For some, ZHCs offer valuable flexibility but a quarter of people on ZHCs say they are under- employed i.e. want to work more hours, four times more than peers employed on other forms of contract.[23]

**People with poor health and / or disability are at particular risk of disadvantage in all its forms** e.g. people living with a long-term condition, mental illness or mental and physical disability, are more likely to be living on a low income, be unemployed or in unsuitable housing putting them at additional risk of further decline. Effective action to address such problems can improve health and wellbeing and hence reduce the need for health and social care.

- 60% of people with LTC are in employment.
- 43% of people reporting a mental illness are in employment
- 74% of the general population are in employment

Source: Public Health England Health & Work Infographics

***Recommendation 5:*** *Ensure Councils / NHS providers work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure employment.*

[23] EMP17: Labour Force Survey: zero-hours contracts data tables https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/emp17peopleinemploymentonzerohourscontracts

## 3.3 Impact of the pandemic

The response to the pandemic affected employment in a variety of ways e.g.

- a number of lockdowns were imposed
- working from home where possible was recommended for long periods
- various social distancing measures were introduced to reduce close contact between staff and between staff and customers

At the same time, Government introduced measures to protect businesses and their employees including the Coronavirus Job Retention Scheme (aka furlough) and the Self-Employment Income Support Scheme.

Nonetheless, the various non-pharmaceutical interventions employed to control the spread of infection affected the economy as a whole and hit some sectors disproportionately e.g. hospitality, personal services and leisure.

Unsurprisingly, the proportion of residents claiming out of work benefits increased during the pandemic but rates have since begun to decline. Overall, the available evidence suggests that the UK labour market continues to recover from the pandemic. However, rates of self-employment have not recovered at the same rate and workers from ethnic minority groups, young workers, low paid workers and disabled workers, have been most impacted economically.[24,25]

Thus, the pandemic has tended to hit communities and groups already experiencing inequalities with regard to work. As such, health and social care partners should redouble their efforts to support these priority groups into employment, including providing opportunities to enter the health and social care professions and enable local SMEs to tender to provide services (see recommendations 3 and 4).

Residents' occupation affected their risk of infection and hence serious illness and death[26]. The reasons are complex and difficult to disentangle at the level of specific occupations[27], but it clear that those who were able to work at home were at less risk of exposure than peers who could not.

During the first lockdown, nearly half of all workers worked from home (wfh) (49%). Lower earners, frontline workers, and men were less likely to be able to work from home[28]. Over a third of working adults (36%) report having worked from home at least once in the past seven days during the last two weeks of January 2022[29] and 'wfh' is likely to persist in full or as part of hybrid working arrangements for the longer term.

---

[24] The Health Foundation (2021) Unequal pandemic, fairer recovery
[25] Research Briefing - Coronavirus: Impact on the labour market https://commonslibrary.parliament.uk/research-briefings/cbp-8898/
[26] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020
[27] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965094/s1100-covid-19-risk-by-occupation-workplace.pdf
[28] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichjobscanbedonefromhome/2020-07-21
[29] Homeworking and spending during the coronavirus (COVID-19) pandemic, Great Britain - Office for National Statistics (ons.gov.uk)

Separate from COVID-19 related affects, working from home has both positive and negative impacts for health and wellbeing at an individual and population level.

On the plus side, working from home can offer greater autonomy and flexibility. Coupled with the time freed up by not commuting to work, workers may be able to achieve a better fit with caring responsibilities and leisure interests.

On the other hand, working from home can entail working in a poorly designed or completely unsuitable workstation with increased risk of back pain, headaches or eyestrain. Individuals who work from home are likely to have fewer social interactions and the line between work and personal life may become blurred posing a risk to mental health in the longer term. In addition, the removal of the daily commute can result in lost physical activity if not replaced with other alternatives.

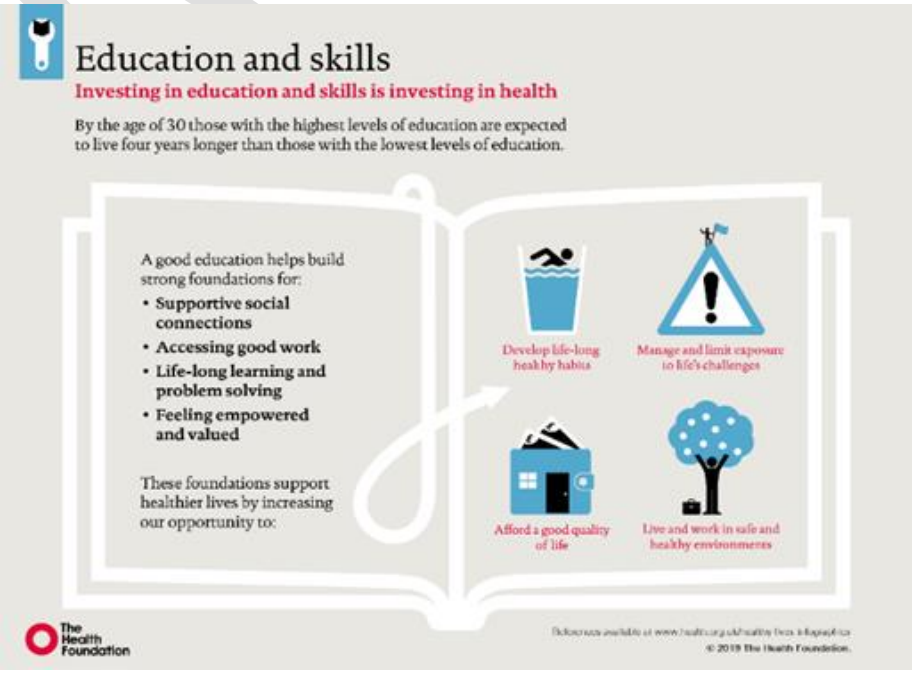
***Recommendation 6**: Consider the impact of working from home on the existing workplace health offer to employees and advice provided to local businesses.*

Despite the provision of isolation payments, various studies have suggested that lack of job security and the non-availability of sick pay for some, e.g. those in the gig economy or on zero hour contracts - and the low rate of statutory sick pay for some on more traditional contracts has militated against full compliance with isolation contributing to enduring prevalence in some disadvantaged communities[30].

## 3.4 Educational Attainment

Educational attainment is strongly linked with health outcomes (Fig. 20). The impact on health reflects associations with health-related behaviours as well as quality of work, income etc.

**Figure 20. Impact of Education on Health Outcomes**




[30]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/983665/S1212_Places_of_enduring_prevalence.pdf

Adult education attainment in Havering is modest – 56% of working age adults have 'A' level or higher qualifications compared with 71% for London and 61% for the country as a whole.

This may translate into lower parental expectations for the next generation. See section 6.2 for a discussion about the educational attainment of children and young people.

More immediately, lack of higher-level qualifications may limit the opportunity for residents to compete for higher paid jobs and / or secure employment in new roles and sectors, which may be necessary if opportunities in retail and administration continue to shrink.

Health and social care partners should consider how they can provide opportunities for entry into the caring professions for residents with the required commitment and aptitude but limited formal qualifications.

## 3.5 Housing

The impact of homelessness on health and wellbeing outcomes, particularly street homelessness (also known as rough sleeping), can be profound.

Poor housing in all its forms affects a much larger group, harming physical and mental health, at all life stages (Fig. 21).

Furthermore, high housing costs put pressure on the household budgets of the many who are on moderate as well as low incomes.

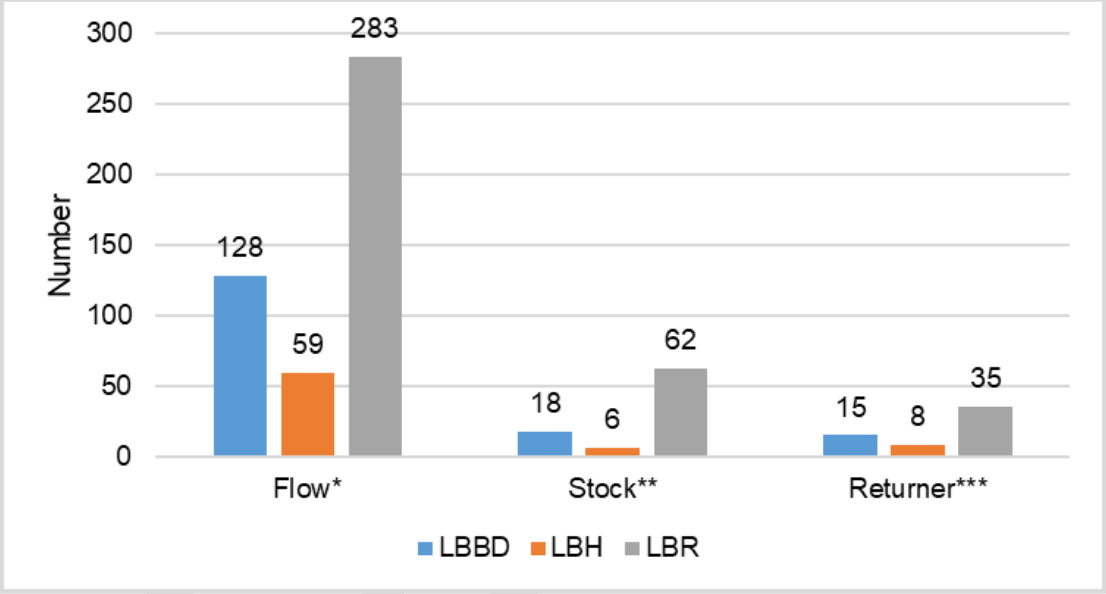
Hence, high quality, affordable housing is a key element in ensuring the health and wellbeing of the population.


**Figure 21. Impact of Housing on Health and Wellbeing**

The health impact of street homelessness cannot be over stated: the average age of a homeless man at death is 47 years; the figure for women is even lower at only 43 years[31]. Hence the continued increase in the number of new rough sleepers recorded between 2018/19 (21) and 2020/21 (59) is of enormous concern (Fig. 22).[32] Rough sleepers often have complex physical and mental health issues, including drug and alcohol dependency. Action regarding housing issues is more likely to succeed as part of a comprehensive, well-coordinated package of support delivered with health and social care partners.

***Recommendation 7**: Partners must work together to mitigate the worst harms of street homelessness and help those affected with the ultimate aim of enabling them to maintain suitable permanent accommodation.*

**Figure 22: Number of people seen rough sleeping, 2020-21**




Data Source: London Datastore

*Flow – people who had never been seen rough sleeping prior to 2018/19 i.e. new rough sleepers
**Stock – people who were also seen rough sleeping the previous year
***Returners – people who had been seen rough sleeping in the past but not during the previous year.

Appropriate housing adaptions and/or access to supported housing options can enable vulnerable residents to maintain their independence and facilitate timely discharge from hospital. Conversely, poor housing can increase the risk of poor health and potentially life changing accidents.

[31] Thomas, B. (2011) Homelessness: A silent killer - A research briefing on mortality amongst homeless people. London: Crisis. https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/health-and-wellbeing/homelessness-a-silent-killer-2011/
[32] Chain Annual Report: Outer Boroughs April 2020 – March 2021 https://data.london.gov.uk/dataset/chain-reports

Very few homes in Havering fail the decent homes standard [33] (n = 69, less than 0.1% of homes).

Cold homes, whether due to poor design, inability to pay for heating or a combination of the two, contribute to excess winter mortality. The proportion of households in fuel poverty in Havering (13.2%) is similar to the national average (13.5%) and better than the average for London (15.2%). Nonetheless, more than 1 in 8 households are affected and this figure can only increase given the very significant energy price rises planned for 22/23.

Houses in multiple occupation (HMO) are a part of the privately rented sector that causes particular concern, given the inherent additional risks of overcrowding and consequent impact on safety and health. Only a small proportion (0.25%, n = 267) of dwellings in Havering are verified HMOs, much lower than the national (2.17%) and London (4.88%) figures but the number is increasing.

Under-supply of housing and unaffordability contribute to homelessness. Planned housing growth, as detailed in the Local Plan[34], provides an opportunity to tackle both – as more than 900 households are currently homeless and in temporary accommodation.

Around 73% of Havering population are homeowners, proportionally higher than the London (50%) and national (65%) averages.

The average house price in Havering is 11.08 times average earnings. Houses in Havering have become significantly less affordable over the last decade and are less affordable than the national average (7.8x). Nonetheless, homes in Havering remain more affordable than in many other London boroughs (Fig. 23).

Nationally, privately owned and social rental housing is becoming more common, particularly among young and lower income households and may become the norm for a growing proportion of the population unless the supply of affordable homes is significantly increased.

As with home prices, the cost of renting in Havering is significantly higher than the national average, but below the average for London as a whole, which is skewed by the much higher prices in inner London boroughs (Fig. 24).

The cost of housing is a very significant charge on all household incomes. Saving for a deposit, on top of the cost of rental, may be too much for some, reducing the opportunity for more residents to buy and increasing the need for rental properties that meet the needs of individuals and families, throughout the life course.

Recruitment of health and social care professionals is a significant problem in the BHR health economy. As with many younger adults, they may struggle to meet the cost of housing, whether rental or ownership. Significant regeneration is ongoing in all three BHR boroughs. The wider partnership should consider the opportunities afforded by

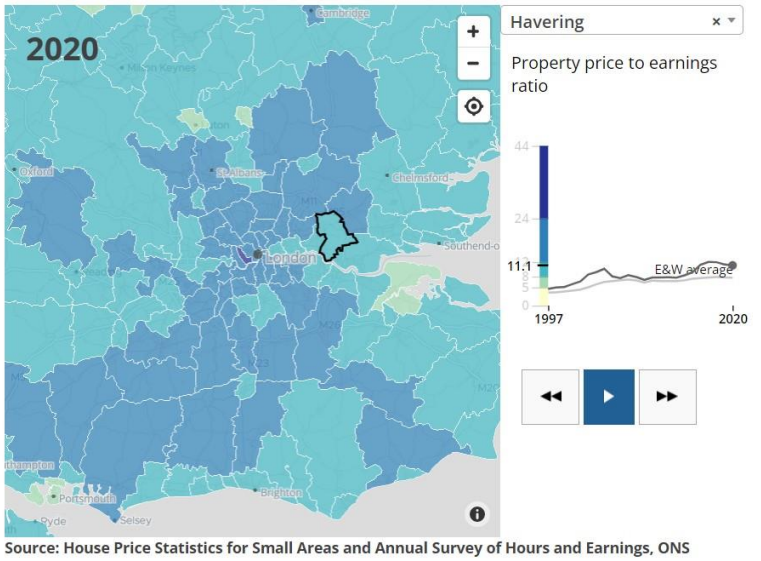
[33] DCLG 2006 A Decent Home: Definition and guidance for implementation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7812/138355.pdf

[34] Havering Local Plan 2016-2031 Havering Local Plan | The London Borough Of Havering

regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.

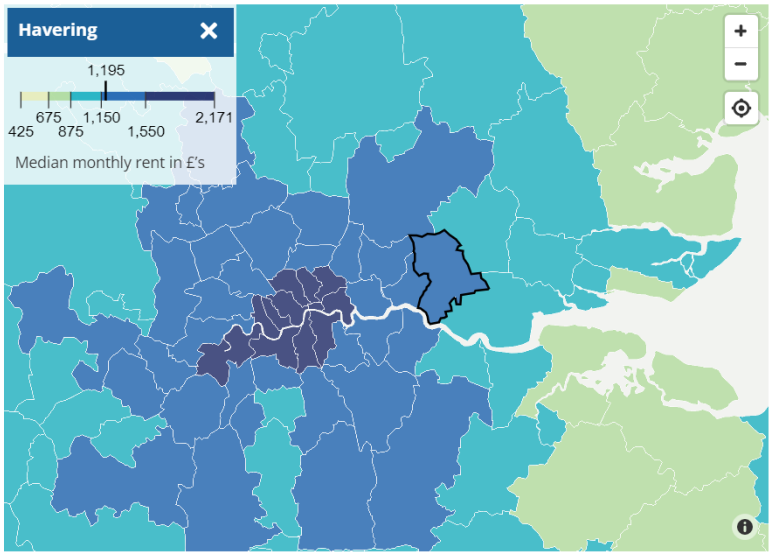
***Recommendation 8**: The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.*

**Figure 23 - Housing affordability ratio by local authority district, England and Wales, 1997 to 2020** [35]




Source: House Price Statistics for Small Areas and Annual Survey of Hours and Earnings, ONS

**Figure 24: Median monthly rental price, by local authority, all categories, 1st October 2020 – 30th September 2021** [36]




Source: Valuation Office Agency – Lettings Information Database, Office for National Statistics

35 https://www.ons.gov.uk/peoplepopulationandcommunity/housing/bulletins/housingaffordabilityinenglandandwales/latest#local-authority-analysis

36 https://www.ons.gov.uk/peoplepopulationandcommunity/housing/bulletins/privaterentalmarketsummarystatisticsinengland/october2020toseptember2021#local-authority-analysis

### Impact of the pandemic on housing

The pandemic affected housing in a variety of ways, and housing affected the course of the pandemic, for example transmission of the virus amongst overcrowded homes or houses of multiple occupation.

Attempts were made to provide all rough sleepers with shelter during the first year of the pandemic, but street sleeping has resumed subsequently. Nonetheless, it is possible that the links made with services during this period may ultimately help find more permanent solutions for some of the hardest to reach.

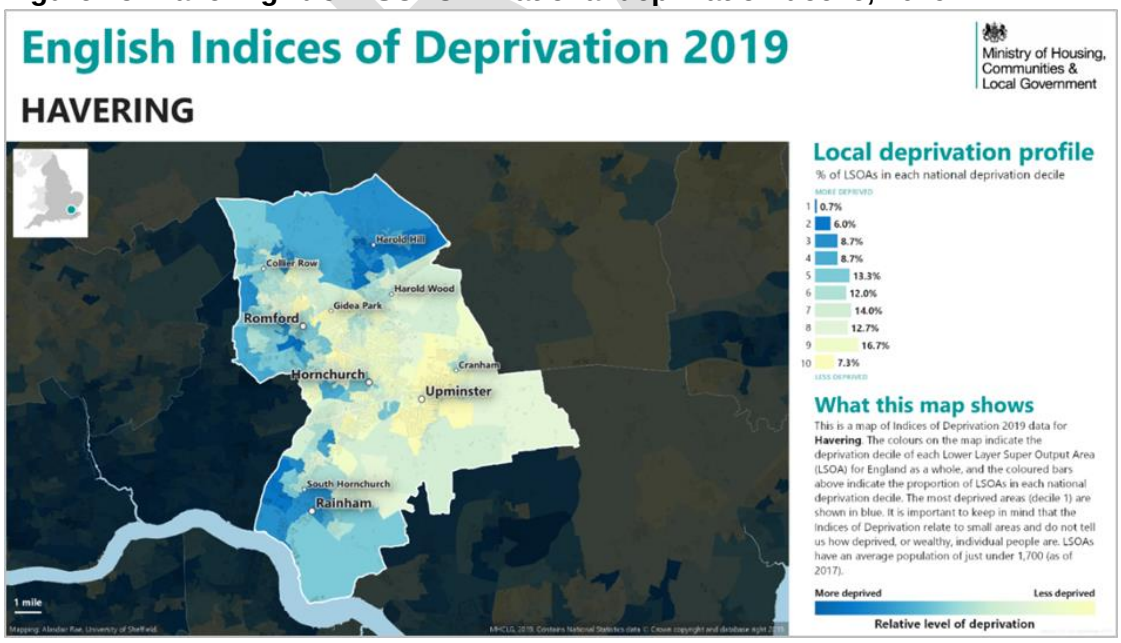
A range of measures including the furlough scheme, mortgage holidays and a halt on evictions of renters were implemented to mitigate the impact of the pandemic on housing and rates of homelessness in the short term. The longer-term impacts are unclear at this time, but those groups most vulnerable to inequality are again likely to be worst hit.

Housing problems, relating to poor-quality, affordability and overcrowding have been associated with an increased risk of coronavirus infection and severe disease[37].

## 3.6 Overall Disadvantage

The **Index of Multiple Deprivation (IMD**) combines many different facets of disadvantage into a single measure. Levels of disadvantage for Havering as a whole are modest but vary significantly within the borough with pockets of significant disadvantage in Harold Hill, Rainham and parts of Romford (Fig. 25).

**Figure 25: Havering % of LSOAs in national deprivation decile, 2019[38].**




Source: Ministry of Housing Communities & Local Government

[37] The Health Foundation (2021). Unequal Pandemic, Fairer Recovery https://reader.health.org.uk/unequal-pandemic-fairer-recovery/changes-in-the-wider-determinants-of-health

[38] The Indices of Deprivation are typically updated every 3 to 4 years, but the dates of publication for future Indices have not yet been scheduled.

The strong association between levels of disadvantage and life expectancy (see Figures 10 &11) is evidence that the wider determinants are the most important driver of whether we are healthy or not.

At local level, the levers to affect the socio-economic determinants of health tend to lie with councils rather than the NHS.

Health and wellbeing boards give NHS partners the opportunity to ensure that local plans regarding tackling poverty, employment opportunities, educational attainment, housing etc. are robust, focused on reducing inequality and those groups most vulnerable to poor health and wellbeing. However, the health and social care system also has a direct role to play in tackling disadvantage.

Residents living with physical and mental illness are at greater risk of disadvantage in all its forms, worsening their wellbeing still further. Effective action to support people with health problems into work or stable accommodation can improve health and reduce demand on health and social care services.

***Recommendation 9:*** *Encourage health and social care professionals and patients / residents to consider the extent to which problems with employment, poverty, housing etc. are the underlying cause and / or exacerbate a presenting health issue and therefore might benefit from social prescribing[39] in addition to or instead of the tradition medical response.*

***Recommendation 10:*** *Strengthen social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options as well as an effective signposting function and bring together NHS, council and CVS stakeholders.*

In addition, NHS agencies and Councils have the opportunity to directly impact on the wider determinants to the benefit of local people e.g. by spending a greater proportion of their budget (BHR CCGs' annual budget is circa £1bn) with local businesses. To this end, they should view themselves as 'anchor institutions[40]' and consciously seek to maximise the contribution they make to the local community over and above the direct provision of services e.g. by:

- Further strengthening links (e.g. through work experience, apprenticeships, bursaries etc.) between the health and social care system and local schools and colleges to increase the numbers of young people who aspire to and train towards a relevant career, prioritising more disadvantaged groups and hard to recruit to professions.
- Providing an exemplary work place health scheme to employees and help local SMEs to improve the offer to their workforce.
- Routinely considering the potential for additional 'social value' when procuring goods and services; and how bids from local businesses can be facilitated

[39] https://www.kingsfund.org.uk/publications/social-prescribing
[40] https://www.health.org.uk/newsletter-feature/the-nhs-as-an-anchor

***Recommendation 9:*** *Encourage councils, NHS providers, colleges etc. to become 'anchor institutions' within the BHR patch maximising the contribution they make to the local community over and above the direct provision of services.*

***Recommendation 10:*** *Encourage all partners to adopt a Health in All Policies approach that takes into consideration health and wellbeing impacts in decision-making, including on the social determinants of health to maximise the wellbeing of residents.*

## 3.7 Impact of the Pandemic

Nationally, as well as locally, people living in areas of higher deprivation and minority ethnic groups have experienced higher rates of Covid-19 disease and death[41].

Uptake for the Covid-19 vaccine is also lowest amongst those living in the most deprived areas and in Black and other minority ethnic groups[42].

In addition to statutory intervention, health champions and partners from the voluntary and community sector (VCS) have been instrumental in supporting vulnerable and disadvantaged residents in the local response to Covid-19.

***Recommendation 11:*** *Strengthen community resilience through continued partnership with the VSC. This includes building upon and mapping existing VCS capabilities, identifying gaps in community support and providing opportunities for skills development.*

DRAFT

[41] ONS (2020) Deaths involving Covid-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020 Deaths involving COVID-19 by local area and socioeconomic deprivation - Office for National Statistics (ons.gov.uk)

[42] Havering London Borough (2021) Coronavirus in Havering Coronavirus in Havering – Week 45, ending 12 November 2021 | The London Borough Of Havering

# 4. Pillar 2: Lifestyles and Behaviours

**Indicators and data used in this section can be accessed by clicking here*

Our behaviours and lifestyles are the second most important driver of health after the wider determinants. The greatest harm to health results from smoking; the interrelated risk factors associated with poor diet, physical inactivity and obesity; and the use of drugs and alcohol.

**Figure 26: Risk factors and percentage contribution to DALYs as measured by Population Attributable Fraction (PAF), BHR, 2019.[43]**

| Risk Factor | Havering | Barking & Dagenham | Redbridge | London | England |
|---|---|---|---|---|---|
| Tobacco | 13.25% | 12.65% | 10.86% | 11.72% | 14.06% |
| High fasting plasma glucose | 8.81% | 7.58% | 7.82% | 7.93% | 8.96% |
| High body-mass index | 7.72% | 6.6% | 7.38% | 8.11% | 8.73% |
| Dietary risks | 7.29% | 6.59% | 6.25% | 6.12% | 7.47% |
| High systolic blood pressure | 6.53% | 5.70% | 5.64% | 5.63% | 7.05% |
| Alcohol use | 4.26% | 4.72% | 4.67% | 5.51% | 4.76% |
| High LDL cholesterol | 3.68% | 3.44% | 3.16% | 3.02% | 3.84% |
| Occupational risks | 3.54% | 3.49% | 2.68% | 2.81% | 3.27% |
| Non-optimal temperature | 2.29% | 2.01% | 1.74% | 1.71% | 2.18% |
| Air pollution | 2.15% | 2.22% | 2.02% | 1.92% | 1.72% |
| Kidney dysfunction | 1.69% | 1.41% | 1.57% | 1.43% | 1.74% |
| Drug use | 1.56% | 2.33% | 2.02% | 2.47% | 1.92% |
| Child and maternal malnutrition | 1.24% | 2.44% | 2.08% | 2.00% | 1.50% |
| Low physical activity | 1.15% | 0.89% | 0.97% | 1.00% | 1.21% |
| Low bone mineral density | 1.03% | 0.75% | 0.89% | 0.79% | 1.00% |
| Childhood sexual abuse and bullying | 0.46% | 0.59% | 0.63% | 0.63% | 0.49% |
| Other environmental risks | 0.39% | 0.38% | 0.30% | 0.30% | 0.36% |
| Unsafe sex | 0.25% | 0.45% | 0.36% | 0.46% | 0.32% |
| Intimate partner violence | 0.23% | 0.29% | 0.30% | 0.30% | 0.22% |
| Unsafe water, sanitation, and handwashing | 0.04% | 0.04% | 0.04% | 0.03% | 0.04% |

| | |
|---|---|
| Behavioural | |
| Environmental / Occupational | |
| Metabolic | |

Data Source: Global Burden of Disease, 2019

[43] The contribution of a risk factor to a disease or a death is quantified using the population attributable fraction (PAF). PAF is the proportional reduction in population disease or mortality that would occur if exposure to a risk factor were reduced to an alternative ideal exposure scenario (e.g. no tobacco use). Many diseases are caused by multiple risk factors, and individual risk factors may interact in their impact on overall risk of disease. As a result, PAFs for individual risk factors often overlap and add up to more than 100 percent.
Global Burden of Disease (GBD 2019) | Institute for Health Metrics and Evaluation (healthdata.org)

## 4.1 Smoking

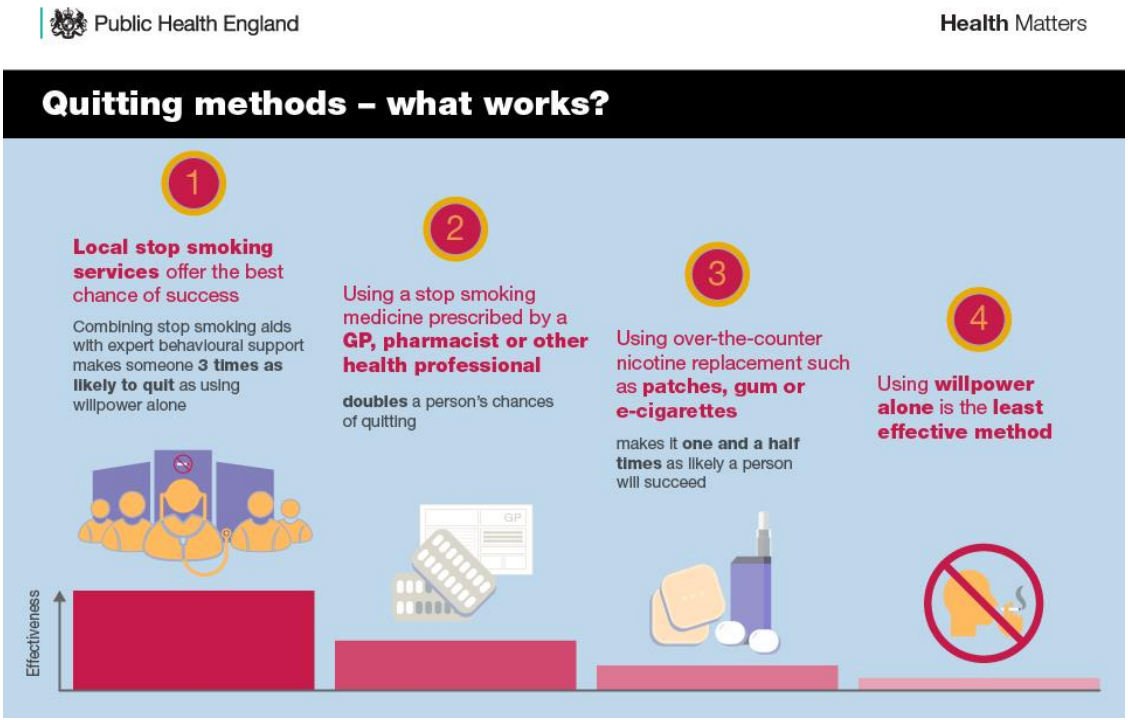
**Smoking** remains the leading preventable cause of premature mortality and ill health (Fig. 26). Although smoking has been in decline since the 1950s, as of 2019, over 26K (13%) adults in Havering continue to smoke.

The prevalence of smoking, and hence the harm caused, displays a marked social gradient, with much higher rates in communities and population groups living in disadvantage. In 2019, the proportion of Havering residents in routine and manual occupations identifying as current smokers (20.7%) was 1.8x higher than those in other occupations. Smoking is also particularly high amongst people with serious mental illness and smoking rates increase with the severity of mental illness.[44] Differences in smoking prevalence are the immediate cause of a significant proportion of health inequalities.

***Recommendation 12:*** *Focus additional efforts in disadvantaged communities and / or cohorts known to have high prevalence of smoking e.g. people with mental ill health*.

The majority of smokers want to quit and significant numbers try to quit each year. However, most try to do so unaided, which is the least effective method. The chances of successfully quitting are increased by up to 3x if the individual makes use of face-to-face counselling support **and** pharmaceutical aids (Fig. 27).[45]

**Figure 27. Aids to Quitting Smoking**




[44] UKHSA Health Matters: Smoking and mental health. 2020
[45] PHE Health matters: stopping smoking – what works?, 2019

***Recommendation 13**: Ensure that smokers who wish to quit can access face-to-face counselling support and pharmaceutical aids, including prescription only medication where clinically indicated.*

E-cigarettes (vapes) are the most commonly used quit aid among smokers in England. The OHID maintain that vaping regulated nicotine products have a small fraction of the risks of smoking, and there is growing evidence of their effectiveness in supporting smokers to quit.[46]

***Recommendation 14**: Actively promote e-cigarettes to smokers as an effective quitting aid and a safer alternative to continuing to smoke.*

Over the last decade, the largest fall in smoking prevalence has been among 18-24 year-olds.[47] The majority of smokers will have already begun smoking by the time they reach this age range, which suggests that the Government's aspiration for a smoke free society by 2030 is achievable given the active support of all.

***Recommendation 15:** Contribute towards the aspiration of a smoke free society by 2030 e.g. by continuing the de-normalisation of smoking in public spaces and homes; minimising the recruitment of new smokers through work with schools, rigorous enforcement of age-related sales regulations and minimising access to cheap smuggled or counterfeit tobacco.*

## 4.2 Diet

The total harm associated with an **unhealthy diet** (e.g. high intake of saturated fat, salt, free sugars, and processed meats; and low intake of whole grains, fruits, vegetables, legumes, oily fish and fibre) is similar in scale to the harm caused by smoking, in part because so many people eat unhealthily in one way or another. In 2019/20, almost half of adults in Havering failed to consume the recommended 5 portions of fruit and vegetables on a usual day.

The socioeconomic impacts of the COVID-19 pandemic (see section 5 for further details) have left more people across England food insecure than before the pandemic. It is estimated that a fifth of households cut down or skipped meals since the pandemic started, with households with children more likely than other households to reduce meal sizes or skip meals due to not having enough money. Households with lower financial or food security were also more likely to have poorer diets than other households.[48]

***Recommendation 16:** Actively promote existing food and financial support mechanisms to low income households and households with children e.g. Havering Community Hub food pantry, free school meals, school holiday meal scheme, Healthy Start scheme etc.*

[46] Office for Health Improvement and Disparities (OHID) Smoking and tobacco: applying All Our Health, 2021
[47] ONS, Adult smoking habits in the UK: 2019
[48] PHE, National Diet and Nutrition Survey: Diet, nutrition and physical activity in 2020 - A follow up study during COVID-19, 2021

## 4.3 Physical Activity

A **sedentary lifestyle** results in a lesser but nonetheless very significant burden of ill health. In the period May 2020-21, more than one in three (37.8%) adults (aged 16+) in Havering were physically inactive, significantly more than the national average. The number of physically inactive adults in Havering increased by around 7.6%, in comparison to the previous 12 months, as a result of the national and tiered restrictions introduced to counter the coronavirus pandemic.[49]

Existing inequalities in physical activity levels have widened nationally as a result of the COVID-19 pandemic, with women, young people aged 16-34, over 75s, people living with disability or long-term health conditions, and those from BAME backgrounds disproportionately negatively affected.[50]

## 4.4 Increasing Levels of Obesity

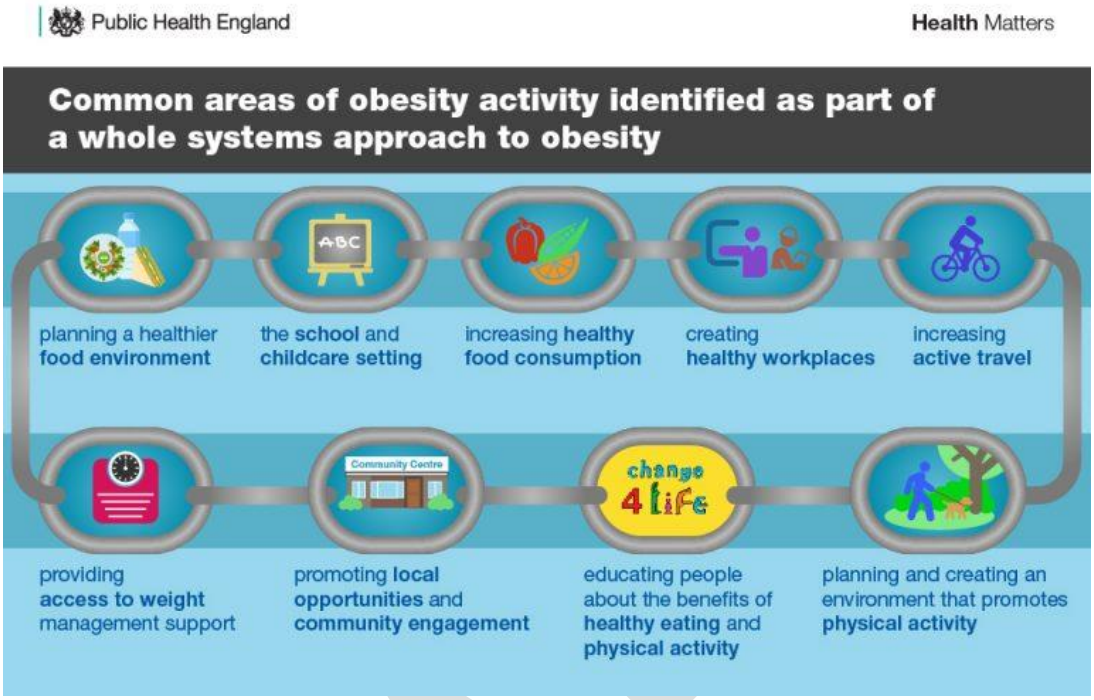
The changing balance between diet, in terms of energy consumed, and physical activity (energy expended) underpins the steady growth in levels of **obesity**. The proportion of adults in Havering living with overweight or obesity (67%) in 2019/20 was significantly higher than the London (56%) and national (63%) averages. People with learning disabilities and those living in social disadvantage are more likely to experience obesity than the rest of the population[51]. Obesity results in a separate and rapidly growing burden of disease and thus exacerbates the other health inequalities experienced by these groups.

The increase in the prevalence of obesity is the product of many interlinked factors. As a result, there is no single silver bullet; rather partners must commit to maintaining a 'whole system approach' over the long term.[52]

***Recommendation 17**: Ensure that there is a comprehensive whole system approach to tackling obesity across BHR as a whole with additional efforts aimed at supporting groups known to have higher prevalence of obesity.*

[49] Sport England Active Lives data tables May 2020-21
[50] Sport England Active Lives Adult Survey May 2020-21 Report
[51] PHE Obesity and weight management for people with learning disabilities: guidance. 2020
[52] UKHSA, Health Matters: Whole systems approach to obesity, 2019

**Figure 28. Whole Systems Approach to Obesity Reduction**

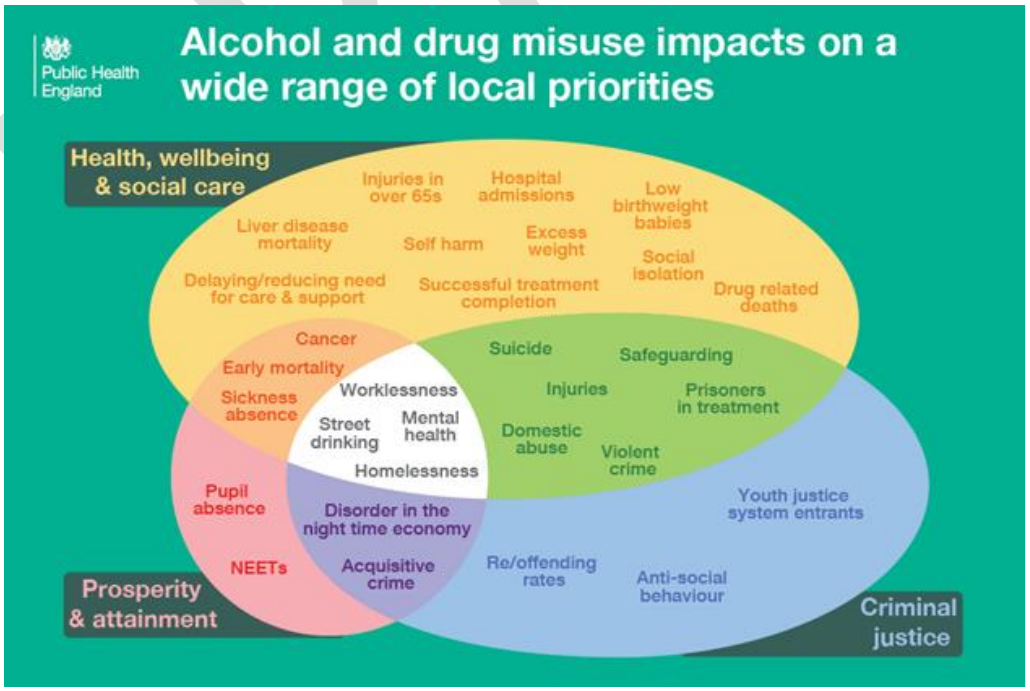



See Section 6.2 for analysis of childhood obesity.

## 4.5 Alcohol and Drug Misuse

The use of **alcohol and drugs** also results in significant harm (Fig. 29).

**Figure 29. Impacts of Alcohol and Drug Misuse**




In 2019/20, a relatively small proportion of adults in Havering were dependent on alcohol (circa 1.1% or 2.2K).

A smaller number of adults in Havering (circa 0.12% or 233) were using opiates and / or crack cocaine in 2019. The age-standardised mortality rates for deaths related to drug poisoning and drug misuse in Havering between 2018-20 were significantly lower than rates across England.[53] However despite this, the number of drug-related deaths in England rose to its highest on record in 2020, with approximately half of all drug poisoning deaths involving an opiate.[54]

Theproblems/issues experienced by those people who misuse drugs and/or alcohol are often complex, including additional mental health issues; with knock on effects on family and wider society.

Whereas a good proportion of people engaging with services successfully complete treatment, the proportion of residents with a drug and/ or alcohol problem in treatment is relatively low - around 6.4% of opiate users successfully completed drug treatment in 2019. Furthermore, 84% of adults dependent on alcohol in 2019/20 were not in contact with alcohol treatment services.

A much larger group run a more modest, but nonetheless significant risk of harm as a result of drinking more than recommended.I In the period 2015-18, one in five adults in Havering were drinking more than 14 units of alcohol over the course of a week, the level at which it is likely to cause some harm[55].

Before the COVID-19 pandemic, there was an increase in alcohol-related hospital admissions and deaths across England, but the pandemic seems to have further accelerated these trends. From May 2020 onwards, there have been significant and sustained increases in the rates of unplanned admissions for alcoholic liver disease and total alcohol-specific deaths, with a large proportion (33%) of deaths occurring in the most deprived group.[56]

***Recommendation 18:*** *Partners should work to:*

- *increase participation in drug and alcohol treatment, particularly the latter, with additional efforts aimed at supporting those who are more socially deprived*
- *improve the offer to people with drink and drug dependency and additional mental health problems*
- *effectively support people with drink and drug problems who are street homeless*
- *reduce and prevent harm to children and families arising from parental drink and drug problems.*

[53] ONS. Drug-related deaths by local authority, England and Wales. 2021
[54] ONS. Deaths related to drug poisoning in England and Wales: 2020 registrations. 2021
[55] https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938133118/pat/6/par/E12000007/ati/102/are/E09000016
[56] PHE Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary. 2021

# 5. Pillar 3: The Places and Communities in Which We Live.

Climate change already poses a risk to the wellbeing of current residents and is an existential threat to humanity if left unchecked[57]. It is fundamentally a consequence of how we live. Shifting to a sustainable future will require changes at all levels including within local communities e.g. how we as individuals travel from place to place; how our homes are built and heated etc.

The places and communities we live in affect health and wellbeing in many other ways, for both good and ill.

The local environment is an important influence on our health behaviours. Access to green space encourages physical activity and is good for mental wellbeing, whereas a high density of fast food outlets may increase the consumption of energy rich food and contribute to obesity levels. Air pollution is a pervasive threat to good health particularly in urban areas.

A range of physical assets contributes to health including early years and youth provision, sports facilities, schools and colleges, community centres, libraries, children's centres etc (Fig. 30). They not only benefit users but also increase footfall and hence contribute to the viability of adjacent businesses.

The capacity of individual residents, their families and of the wider community as a whole is perhaps its greatest asset e.g. there is strong evidence about the protective effects of social relationships and community networks, particularly on mental wellbeing[58].

**Figure 30. Community Health Assets**

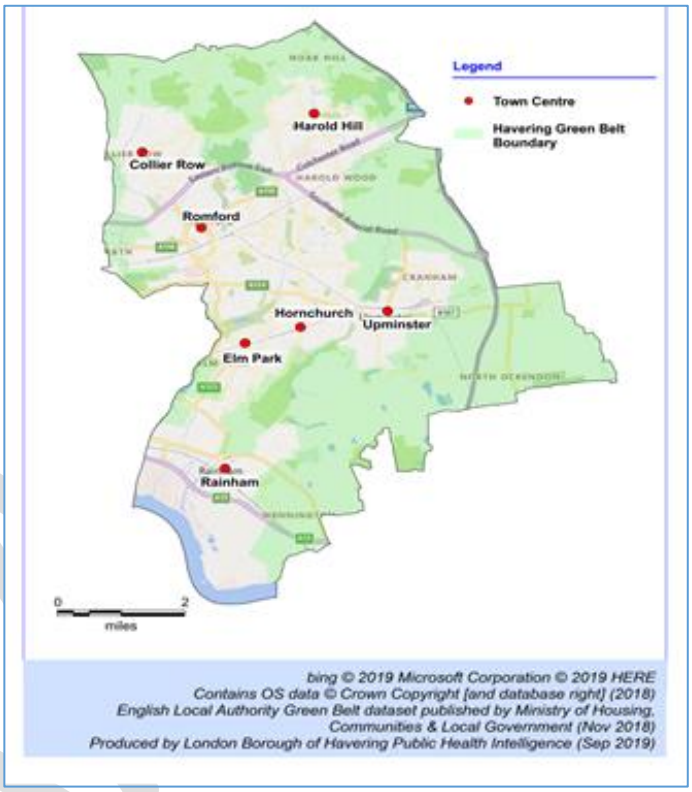

[57] Understanding the health effects of climate change - UK Health Security Agency (blog.gov.uk) https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/

[58] The Marmot Review 10 years on. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf

Therefore, strengthening our communities and creating environments that promote healthier choices and protect residents from harm is a significant opportunity to improve health and reduce inequalities in health.

## 5.1 Havering – a pen portrait

**Figure 31. Havering Green Belt and Urban Areas**




The London Borough of Havering is in the north east of London, bordered to the south by the Thames, to the east and north by the M25 and Essex, and to the west by the LBs of Barking and Dagenham and Redbridge.

Havering comprises a number of discrete town centres with their own unique identity, character and community assets. Romford is a metropolitan centre with a large retail offer and substantial night-time economy (Fig. 31). The district level centres are highly variable – and include examples of both healthy and unhealthy high streets[59].

Havering is less densely populated than many other London boroughs and a large proportion of land is designated as green belt.

Public transport links into London are good and will improve further when the Elizabeth Line opens; but north-south connections within the borough are poorer. As a result, private car usage is high, contributing to poor air quality and reducing opportunities to be physically activity.

## 5.2 Climate Change

**Climate change** is both an immediate risk to the health and wellbeing of residents and an existential threat to humanity in the longer term if left unchecked. Already we face increasingly frequent and extreme weather events, including prolonged heatwaves and flooding[60].

In England, during the summer of 2020, there were 3 periods, totalling 20 days that met Public Health England's **heatwave** definition. The total cumulative all-cause excess mortality over this period was 2,556 deaths. Just under 9 in 10 of deaths were people aged 65 and above, and 1 in 2 were aged 85 or older. About 20% of deaths were in London consistent with the 'urban heat island' effect whereby cities

[59] https://www.rsph.org.uk/our-work/campaigns/health-on-the-high-street.html
[60] Understanding the health effects of climate change - UK Health Security Agency (blog.gov.uk) https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/

tend to be hotter than surrounding rural areas. Mortality was significantly greater than that experienced in previous summers, raising the possibility that the concurrent risks of COVID-19 and heatwaves may amplify the harm caused by either alone[61].

Deaths from **flooding** in the UK are thankfully very infrequent. Nonetheless, there are long term negative impacts on the mental health of people whose lives are affected by flooding. Havering experienced a major flood event on 15 and 16 August 2020 when one month's rainfall fell across the borough over 36 hours. Flooding was reported at over 70 locations and a similar number of properties were inundated. A subsequent investigation found the primary cause of the flooding to be the sheer volume and intensity of rainfall experienced, outstripping the capacity of the surface water sewer infrastructure[62]. Such extreme weather events will become more common as climate change proceeds.

Bloomberg Associates in collaboration[63] with the GLA have produced London-wide climate risk maps showing the risk posed by excess heat, flood and overall climate risk. The risk is generally higher in inner London boroughs and in Havering is higher in Romford and around Harold Hill and Harold Wood.

***Recommendation 19**: Partners should collaborate to reduce greenhouse emissions and mitigate the harms caused, ensuring that climate change is considered in every policy and decision.*

Cities consume 78% of world's energy and produce more than 60% of greenhouse gas emissions[64], with transport and buildings among the largest contributors. Cutting emissions will reduce the impact of climate change in the long term and improve air quality in the short term.

## 5.3 Air Pollution

**Air pollution** is a huge public health problem now; 6% of all deaths in Havering are attributable to air pollution, higher than the national average (5.1%) but lower than the figure for London as a whole (6.4%).

Long-term exposure to air pollution reduces life expectancy, mainly due to its contribution to cardiovascular and respiratory diseases and lung cancer, but it is also linked to dementia, cognitive decline and early life effects.

Some people will also experience immediate effects during episodes of particularly poor air quality, with reduced lung function and exacerbations of asthma contributing to an increase in respiratory and cardiovascular hospital admissions. In December 2020, a London Coroner concluded that Ella Adoo-Kissi-Debrah died, aged nine in 2013, from a combination of acute respiratory failure, severe asthma and air pollution

[61] Heatwave mortality monitoring report: 2020 - GOV.UK (www.gov.uk)
[62] Havering Section 19 Flood Investigation Report 2021
[63] https://gisportal.london.gov.uk/portal/apps/webappviewer/index.html?id=7322196111894840b5e9bae464478167
[64] https://www.un.org/en/climatechange/climate-solutions/cities-pollution

exposure. The first time that air pollution had been listed as a medical cause on a death certificate in the UK.

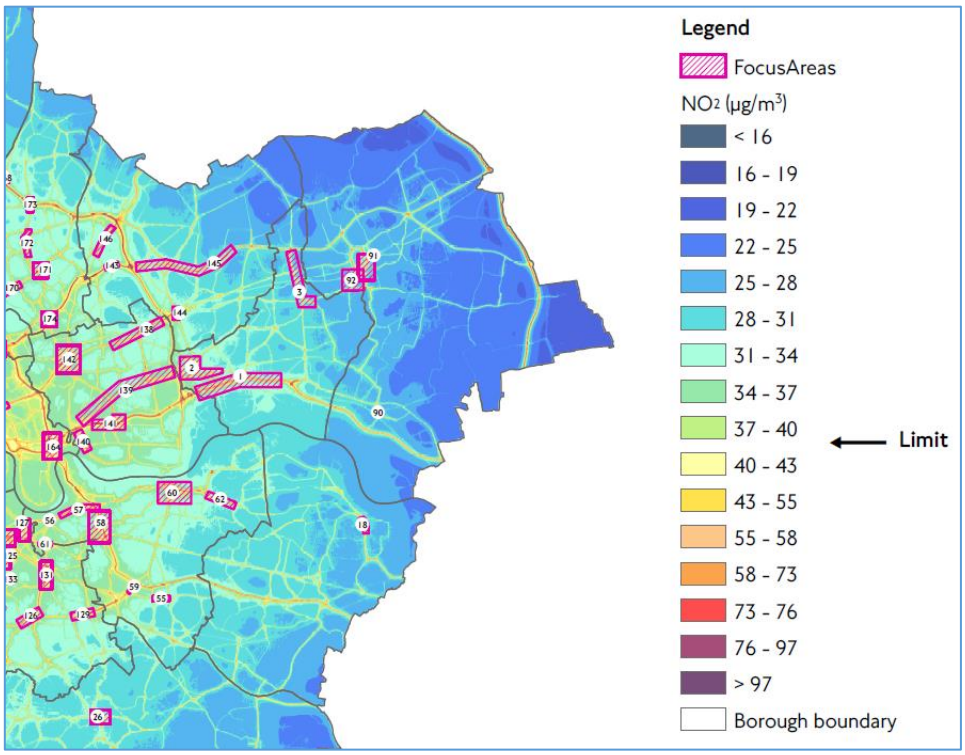
The main pollutants of concern are nitrogen dioxide (NO2) and particulate matter (PM) produced by traffic, heating, and burning of solid fuels.

Air quality in Havering is generally better than the London average but significantly worse than the national average. The background annual average concentration of fine particulate matter in Havering is 8.2 µg $m^{-3}$ compared with London and England averages of 8.9 and 6.9 respectively; reflecting the borough's position on the periphery of the capital and it's largely suburban character.

Local authorities have a statutory responsibility in Local Air Quality Management (LAQM). They must declare an Air Quality Management Area (AQMA) anywhere where the national air quality objectives will not be achieved. Havering, like much of London has designated AQMAs. Local authorities designating their boroughs as AQMAs must produce an Air Quality Action Plan (AQAP) set out how local authorities, working with other agencies, will use their powers to meet the air quality objectives. The Havering AQAP and annual progress reports are publically available[65].

In addition, the Greater London Authority has identified 187 Air Quality Focus Areas that not only exceed the national air quality objective but also have high levels of footfall. Two locations in Romford are listed (Fig. 32).

**Figure 32. Air Quality Focus Areas in the three 'BHR' boroughs**




[65] https://www.havering.gov.uk/downloads/download/507/air_quality_reports

Source: GLA Air Quality Team[66].

The pandemic demonstrated that poor air quality is not inevitable. During the spring 2020 lockdown, NO2 decreased by 59% in London[67]. More modest but nonetheless hugely beneficial improvements are attainable as recovery from the pandemic progresses e.g. by encouraging individuals to use public transport, and the adoption of cleaner fuels for transport, heating and manufacturing.

***Recommendation 20**: Partners should collaborate to reduce air pollution, risks and health inequalities and ensure the impact on air pollution is considered in every relevant decision.*

In parallel with action to reduce air pollution, residents can, if appropriately informed, take action to reduce their personal exposure. Nationally, the Daily Air Quality Index (DAQI)[68] offers information on levels of air pollution and provides recommended actions and health advice. In London, the Mayor's air quality alerts system[69] advises Londoners on days where air pollution is elevated e.g. by sending warning emails to signed-up stakeholders. Similarly, subscribers to the airTEXT[70] system receive a text message, call or voicemail whenever moderate or high levels of pollution are expected. Such alerts enable residents to determine what steps they should take given the expected level of pollution. For example, taking a different route/mode of transport to work, keeping their medication with them or not exercising outside on certain days.

***Recommendation 21**: Partners should collaborate to raise public understanding and awareness of current local levels of air pollution – the 'air pollution forecast' and encourage residents to adjust their behaviour accordingly, taking into account any health problems that might put them or their family at particular risk.*

## 5.4 Travel and Transport Infrastructure

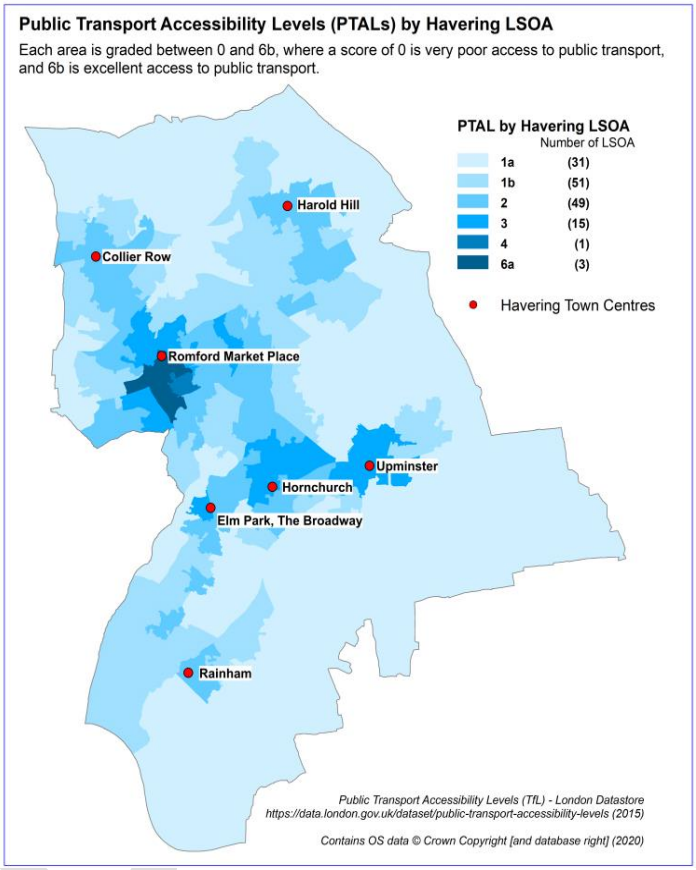
Encouraging residents to switch to public transport or active transport options i.e. walking and cycling will be a crucial element in plans to tackle air pollution and climate change.

Many people could incorporate some form of **active travel** with public transport in the course of a longer journey or commute which would serve to reduce air pollution and provide the individual, who may otherwise be in a largely sedentary occupation with beneficial physical activity. However, pre-pandemic only 14% of adults in Havering residents walked three or more times per week for travel purposes, the lowest proportion in any London borough and well below the London average 22%[71].

[66] https://data.london.gov.uk/dataset/laei-2013-london-focus-areas
[67] Latest lockdown had less impact on UK air pollution levels than the first, new analysis shows - News and events, University of York
[68] What is the Daily Air Quality Index? - Defra, UK
[69] https://www.london.gov.uk/what-we-do/environment/pollution-and-air-quality/monitoring-and-predicting-air-pollution
[70] https://www.airtext.info/
[71] Source: https://fingertips.phe.org.uk/

Although Havering has good public transport links into central London, the **public transport infrastructure** within the borough links is relatively poor, with the great majority of LSOAs in the borough having a PTAL score of 2 or below[72] (Fig. 33). As a result, residents tend to drive to work or closer to major transport nodes within the borough before making their onward journey into central London. Improvement of the public transport infrastructure within the borough, provided by TfL would seem to be a pre-requisite if more Havering residents are to leave their car at home more often.

**Figure 33: Public Transport Accessibility Levels (PTALs) for LSOAs in Havering**




There has been a very modest reduction in **car ownership** in recent years (Table 2) but rates of ownership in Havering remain high with about 110 cars per 100 households in the borough.

**Table 2: Cars registered per 100 households: 2019, 2020 and 2021**

| Borough | Havering | Redbridge | Barking & Dagenham | Greater London Average |
|---|---|---|---|---|
| 2019 | 110.7 | 97.2 | 82.1 | 75.7 |
| 2020 | 109.5 | 96.6 | 82.0 | 75.1 |

[72] https://data.london.gov.uk/dataset/public-transport-accessibility-levels

| | | | | |
|---|---|---|---|---|
| 2021 | 109.0 | 96.8 | 83.5 | 74.7 |

Sources: Vehicle licensing statistics: 2018, 2019 and 2020 report
Households data from ONS. Household projections for England; Principal projection. Table 406: Household projections, mid-2001 to mid-2041

However, car ownership is not universal. About 1 in 4 households in Havering do not have access to a car; with higher rates amongst older people and disadvantaged communities who are most likely to make use of public services in general and health and social care in particular (Table 3).

**Table 3: % of households with no cars or vans; 2011**

| Area | England | London | Barking & Dagenham | Havering | Redbridge |
|---|---|---|---|---|---|
| % of households | 25.8 | 41.6 | 39.6 | 23.0 | 27.9 |

Source: ONS 2011 Census: Key Statistics for local authorities in England and Wales

***Recommendation 22:*** *Partners should ensure that health and social care services are as accessible as possible by public and active transport options and encourage staff and users to leave their car at home when using public services as far as this is practicable.*

Pre-pandemic, only 0.1% of adults in Havering cycled for travel purposes at least three times per week, significantly below the England and London averages, 2.3% and 4.1% respectively.

An environment that makes the resident feel safe is essential if they are to choose active transport options particularly cycling.

Havering currently has 3 School Streets[73]. These are initiatives where roads surrounding schools are closed to motor traffic at drop-off and pick-up times. This makes journeys safer and easier encouraging children to walk or cycle to school, reducing car trips and improve air quality[74].

Havering has about 40km[75] of cycle routes that are either London Cycle Network or 'Greenways' routes'.

Overall, and in common with a number of outer London boroughs, Havering has a relatively poorly developed **active travel infrastructure.** The London Healthy Streets Scorecard[76] assesses boroughs against 5 measures designed to influence modal shift towards active transport including school streets and protected cycling.

[73] http://schoolstreets.org.uk/
[74] https://www.london.gov.uk/press-releases/mayoral/school-streets-improve-air-quality
[75] LBH transport team estimate 2021
[76] https://www.healthystreetsscorecard.london/results/

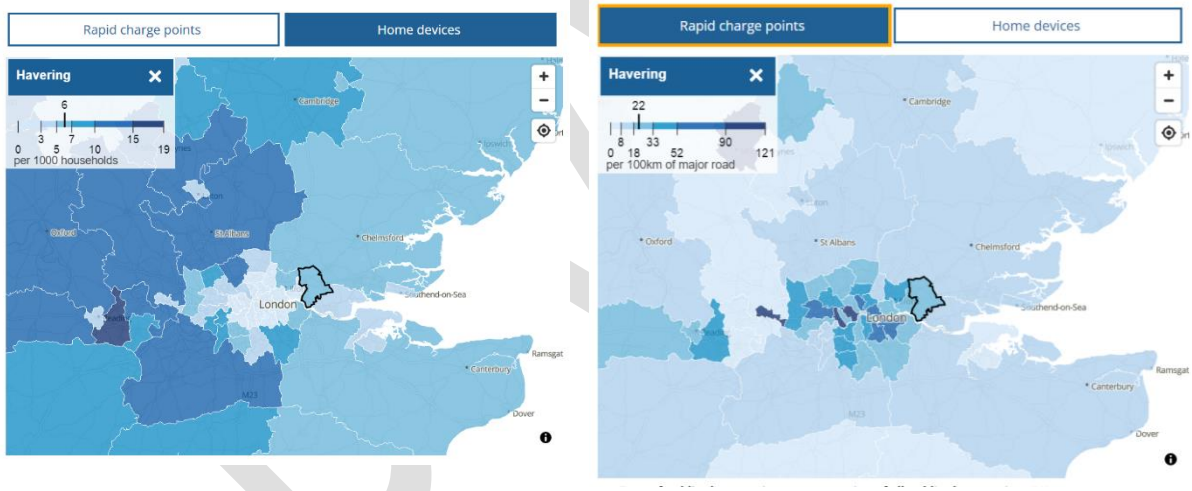
Havering scored 1.75 out of 10 in 2021, the 32nd lowest of the 33 London local authorities.

***Recommendation 23:*** *The Local Authority to work with partners to expand the active transport infrastructure in the borough. The health and social care system to advise residents of the health benefits of active travel whenever the opportunity arises.*

Pending a significant improvement in public and active transport infrastructure, cleaner forms of private transport e.g. car clubs and electric vehicles (EVs) may yield more rapid improvements in air quality.

The sale of new vehicles reliant on fossil fuels is set to end in the UK by 2030 and over half of younger drivers say they are likely to switch to electric in the next decade[77]. The initial cost of electric vehicles remains the biggest barrier to switching to EVs and currently ownership is more common in areas with the highest disposable income. Difficulties recharging electric cars –"range anxiety" - is cited as another key factor against switching from conventional fuels.

**Figure 34: Provision of public rapid charge points per 100km of motorway (October 2021) and home devices installed per 1,000 households (2013 to July 2021), UK**




Source: ZapMap Logo , Department for Transport, and Office for National Statistics

Currently the public rapid **charging network** tends to be most developed in some inner London boroughs whereas home charging devices are more common in the Home Counties and more affluent rural communities. However, neither is remotely adequate given the Climate Change Committee estimates 325,000 public charging points will be needed to support a fleet of 23.2 million electric cars across the UK by 2032. Currently there are 26,000 for 460,000 plug-in cars (Fig. 34). Massive expansion of charging points is essential.

[77] https://www.ons.gov.uk/economy/environmentalaccounts/articles/overhalfofyoungerdriverslikelytoswitchtoelectricinnextdecade/2021-10-25

***Recommendation 24:*** *All partners to facilitate the shift to electric vehicles including their own fleet.*

66% of Havering's surface area is classified as green cover[78] - parks, green spaces, gardens, woodlands, rivers and wetlands, as well street trees and green roofs. The second highest proportion of any London borough and significantly higher than the London average (approximate 50%).

## 5.5 Green Infrastructure

**Green infrastructure** is an important asset (Fig. 35) as it serves to: -

- promote healthier living, providing spaces for physical activity and relaxation
- cool the city and absorb storm water to lessen the impacts of climate change
- filter pollutants to improve air and water quality
- make streets clean, comfortable and more attractive to encourage walking and cycling
- store carbon in soils and woodlands
- create better quality and better-connected habitats to improve biodiversity and ecological resilience

**Figure 35: Green Cover, BHR boroughs**


Source: GLA Environment Team

Although green space is relatively accessible in Havering, the majority of residents will spend most of their time in more urban environments. As such, the street scene and the offer on our local High Street may be a more important asset or risk to good health.

[78] https://data.london.gov.uk/dataset/green-and-blue-cover

The RSPH reports 'Health on **the High Street'**[79] and Health on the High Street: Running on Empty[80] investigated the relationship between local high streets and health. A healthy high street can provide the public with healthy choices, support community cohesion and social interaction, promote access to health services and do much to support individual wellbeing. The health promoting assets identified included libraries, pubs, greengrocers, gyms, pharmacists and GP surgeries.

Equally, high streets also facilitate activities that can have a detrimental effect on our health, particularly if provided in excess and in communities with greater vulnerability e.g. betting shops, tanning parlours, payday lenders and fast food outlets. Empty shop units are also unhealthy and undermine high streets as a destination. The distribution of assets and risks varies markedly with harms tendering to cluster in disadvantaged areas. The RSPH created a league table of 146 high streets across London[81]. Havering had examples of both unhealthy and healthy high streets with Rainham ranked 10 and Hornchurch 145 where 1 was the least healthy and 146 the most.

The authors noted that planning and licensing legislation did not necessarily prioritise health and wellbeing as it should, and Government was asked to provide Councils with stronger powers to restrict the spread of unhealthy outlets, particularly in areas with a high density. In the absence of further powers, Councils were encouraged to

- introduce planning restrictions within 400 metres of schools (as part of the whole system approach to reducing obesity (see section 4);
- set differential rent classes for tenants based on how health promoting their business is;
- give business rates relief for businesses that try to improve the public's health e.g. by selling e-cigarettes but not cigarettes
- work with vap shops to ensure staff can sign post to stop smoking services
- work with betting shops and pay day loan providers so staff can sign post customers with debt problems to sources of support.

***Recommendation 25:*** *Councils to make use of the powers available to create a healthier offer on our high streets, prioritising disadvantaged areas with the unhealthiest offer, and taking into consideration the views of the local community.*

[79] https://www.rsph.org.uk/static/uploaded/b6f04bb8-013a-45d6-9bf3d7e201a59a5b.pdf
[80] https://www.rsph.org.uk/static/uploaded/dbdbb8e5-4375-4143-a3bb7c6455f398de.pdf
[81] https://www.rsph.org.uk/our-work/campaigns/health-on-the-high-street/2018/london/league-table.html

The wider environment, as well as the service offer available, affects the extent to which high streets support good health. TfL's 2014 transport action plan[82] identified 10 indicators of a healthy **street environment** (Fig. 36).

**Figure 36: Indicators of a healthy street environment**


Source: Lucy Saunders in *improving the health of Londoners*, TfL 2014

These indicators directly benefit health e.g. by promoting physical activity or by reducing exposure to air pollution and noise; but also serve to make high streets more attractive and safe places to spend time. In turn, this increases the opportunity for social interaction, which is good for mental wellbeing and the likelihood of residents spending money, thereby benefiting local businesses.

The report noted that whereas most streets will have one or two positive characteristics, it often takes multiple positive characteristics to achieve a significant change in the number of people (enjoying) spending time on the street. Hence, regeneration, driven by largescale house building, may afford the most realistic means to achieve a step change in the street scene and its benefit for current and future residents.

## 5.6 Economic Regeneration

Access to good quality housing is an important determinant of population health (see section 3). An increase in housing stock is necessary given anticipated population

[82] https://content.tfl.gov.uk/improving-the-health-of-londoners-transport-action-plan.pdf

growth (see section 2) and to maintain affordability (see section 3). As well as increasing the housing stock, **regeneration** is an opportunity to build in the physical infrastructure that will underpin healthy communities in the future e.g. green space, active travel infrastructure, healthy street environment, digital connectivity, etc.

***Recommendation 26:*** *Ensure plans and policies shaping regeneration and housing growth e.g. borough level Local Plans serve to build healthier communities not simply additional housing. A formal health impact assessment of the Local Plan may help in this regard.*

The London Plan requires significant house building in all boroughs – the new housing target for Havering is 18,750 additional homes in the period 2019/20 – 2028/29. About half of this new housing is expected to be on relatively small plots and hence could be distributed throughout the borough, but Rainham and Romford are identified as opportunity areas suitable for larger developments.

Rainham, together with Barking Riverside ( Barking & Dagenham), is part of the London Riverside opportunity area with a collective housing target of 26,500 new homes and 16,000 new jobs[83]. Barking Riverside is a Healthy New Town demonstrator site, embedding design principles unpinning the promotion of health and wellbeing and securing high quality health and care services[84].

***Recommendation 27****: Boroughs, working with developers, should put in place processes to share learning from the healthy new town project at Barking Riverside*.

Residents now and in the future will have a range of needs – and these will change over time. In developing our regeneration plans, we must aim to build communities that accommodate the needs of all, including young people living care, residents with physical and mental health problems and older people affected by frailty. The right housing, in some cases coupled with the right support and care, will serve to maximise wellbeing and independence.

***Recommendation 28****: Ensure that the housing needs of residents with specific needs e.g. relating to frailty, mental illness, physical and learning disabilities etc. are an integral part of plans for housing growth and regeneration.*

Appropriately qualified and experienced professionals are essential to the effective functioning of public services (health and social care, but also schools and colleges etc). Staff shortages are already a problem affecting quality of care and increasing the cost of service provision (see section 6). This can only worsen as the population grows, unless local providers succeed in recruiting the next generation of professionals. The opportunity to buy or rent high quality, affordable housing could be part of a wider package BHR may offer to attract professionals into the patch e.g. high performing schools, easy access to green space, safe and welcoming communities etc..

[83] https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas/london-riverside
[84] https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/

***Recommendation 29:*** *Consider if / how key worker housing might be made available to attract hard to recruit health and social care professionals into the BHR patch.*

***Recommendation 30****: Building on regeneration plans in the three boroughs; develop an effective approach to promote the benefits of living in Barking, Havering and Redbridge as part of collective effort to fill hard to recruit health and social care vacancies.*

## 5.7 Crime & Safer Neighbourhoods

**Crime**, particularly violent crime, impacts negatively on the health of victims and the wider community. **Fear of crime** and antisocial behaviour has wider effects, deterring residents from using assets in the community and reducing social interaction.

Whereas a significant proportion of violent crime is within the home, knife crime, by or against vulnerable adolescents, is the cause of massive public concern and contributes disproportionately to fear of crime. Some serious violence is gang related. In addition, gangs exploit young people and vulnerable adults in a variety of other ways resulting in serious and long lasting harm to life chances.

Alcohol is a more commonly encountered driver of violent crime and crime figures are inflated by the borough's night-time economy which draws people in from adjacent boroughs.

Local action to reduce crime and the harm caused is coordinated by the Havering Community Safety Partnership (HCSP). The Local Authority, on behalf of the HCSP, undertakes an annual CSP Strategic Assessment. The high-level findings and key themes from the 2021 assessment were as follows:-

- Overall, rates of crime in Havering remain relatively low.
- Total notifiable offences (TNO) in the 12 month period Oct 2020 to Sept 2021 were 16,785, a rate of 64.8 per 1,000 residents, well below the average for London (85.7) and England and Wales (81.8). Total notifiable offences were down 4% reduction on 2019/20 and 12% on 2018/19.
- Domestic abuse was the most reported category of crime locally accounting for 41% of crimes in 20/21. Women and girls were disproportionally impacted and report low confidence in the criminal justice system and support networks overall.
- Violence against person was the second highest reported crime category during 20/21. Nonetheless, Havering was the 24$^{th}$ safest borough in London regarding violence.
- There was one homicide in Havering, the lowest number of any borough in London.

A relatively small proportion of (repeat) offenders, many of whom struggle with drug dependency, account for a high proportion of solved crimes. A holistic support package, involving a range of partners including drug treatment services, mental

health services, housing services etc., may be effective in reducing reoffending and the harm caused to these individuals, their families and the wider community.

The level of anti-social behaviour (ASB) dropped dramatically from 9,885 incidences in 19/20 to 1,026 in 20/21 due to the stay at home orders in place for long periods. The level of ASB is low in Havering compared to London.

Knife crime is particular concern across London due to the increasing number of offences year on year from 2015/16 to 2019/20. The council has a strategy to reduce the incidence of violence and knife crime. It is expected that new statutory duties will be placed on councils to work with partners in the coming year to implement a public health approach to the reduction of knife crime as has been successfully employed in Scotland. Guidance about In-Hospital Violence Reduction Services has been published[85]. The approach has been piloted elsewhere in the NEL ICS but not BHRUHT.

Health and social care services have a significant contribution to make, as part of a comprehensive multi-agency response to identify and protect the vulnerable from violence in all forms and crime more generally.

***Recommendation 31**: Health and Social Care Partners should participate in Community Safety Partnerships and contribute to the delivery of agreed plans and strategies.*

## 5.8 Digital Connectivity

The pandemic demonstrated the importance of **digital connectivity:** e.g. in allowing a proportion of the population to work from home; children to participate in education while restrictions on face-to-face learning were in force; families to keep in contact with loved ones via zoom; and patients to access health care advice.

However, it was equally clear that some of the population were excluded due to unaffordability and/ or lack of skills. This will remain an important barrier for many as we recover from the pandemic e.g. online applications are the usual means of accessing state benefits and job opportunities and digital competence is often a pre-requisite to access education and skills development. Residents with sensory and physical disabilities may be particularly at risk of digital exclusion[86].

***Recommendation 32**: The partnership must consider the needs of digitally excluded communities whenever it seeks to improve access to service by digital means.*

## 5.9 Social Networks & Social Infrastructure

**Social networks** with family, friends, work colleagues, neighbours etc can mitigate some of life's challenges and setbacks e.g. ill-health, relationship

[85] Violence Reduction Programme London - In-Hospital Violence Reduction Services: A Guide to Effective Implementation, March 2022

[86] https://www.lloydsbank.com/assets/media/pdfs/banking_with_us/whats-happening/lb-consumer-digital-index-2020-report.pdf

breakdown, job loss, experience of crime etc. Some groups and communities may be less likely to have strong networks and hence less resilient.

New housing developments or areas with a high level of population churn (see section 1) as a result of having more rental property, particularly HMOs, are likely to have a higher proportion of residents with weaker social networks.

In addition, new residents may be slow to (re-)engage with universal health services e.g. general practice and health visiting for families with young children. As a result, such groups may make greater use of A&E and other walk in services (see also section 6.2).

ONS[87] have identify three distinct cohorts as being more likely to self-report loneliness:

- Widowed older homeowners living alone with long-term health conditions.
- Unmarried, middle-agers with long-term health conditions.
- Younger renters with little trust and sense of belonging to their area.

Such social isolation is a risk factor for mental illness particularly in older residents.

Social prescribers working in GP practices, and local area coordinators are well placed to assist individual residents to build social networks.

At community level, Havering Council has established community hubs in Harold Hill and Rainham, the borough's most disadvantaged communities, along with a virtual hub. The community hubs are designed with the community, with the intention of improving access to statutory services and support from the VCS.

The expectation is that timelier provision of advice and support, closer to home, will help stop problems escalating to crisis point. As such, community hubs shift the focus towards prevention and away from more costly and intrusive intervention by statutory services in response to a significant deterioration or crisis. To this end, the hubs provide an information service across the wider determinants of health including debt, housing, work, education as well as health and social care services and access to immediate support including a community food shop, access to computers and the internet alongside training and skills opportunities. Community hubs complement the 1:1 support provided by local area coordinators to individual residents.

***Recommendation 33**: Partners, working with the community, should agree the need for action and how best to go about strengthening social networks and community capacity, prioritising areas with new housing developments, high population churn and significant disadvantage.*

At different points in 2020 and 2021, non-pharmaceutical interventions (NPIs) of varying severity were imposed to control the spread of disease. At times, a large proportion of the population were required to stay at home and forgo all but essential activities.

[87] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10

A variety of harms to the physical and mental health of residents have been reported subsequently e.g. increased levels of obesity and sedentary behaviour (see section 4) and poorer mental health (see section 6).

The Government signposted a return to normality in COVID-19 Response: Living with COVID-19[88]. However, there is considerable evidence that residents have not returned to pre-pandemic patterns of work and leisure. Google's mobility data[89] shows how resident activity in various sectors has changed compared to their pre-pandemic baseline.

**Table 4: Percentage change in visits to stated settings compared with pre-pandemic baseline, Feb 15th 2022**

| | Greater London | LBBD | LBH | LBR |
|---|---|---|---|---|
| Retail and recreation | -29% | -15% | -10% | -22% |
| Supermarket and pharmacy | -15% | -14% | -7% | -9% |
| Parks | -22% | +43% | -12% | -34% |
| Public transport | -40% | -33% | -35% | -44% |
| workplaces | -47% | -45% | -41% | -53% |
| Residential | +12% | +8% | +10% | +10% |

Source: COVID-19 Community mobility reports

Visits to retail and recreation, use of public transport and attendance at workplaces are still well below pre-pandemic levels. However, the effects are less marked in suburban areas like Havering than in central London probably because fewer residents are commuting into central London. Nevertheless, they do make some use of local infrastructure while working from home.

It's probable that the pandemic will result in a permanent change in work patterns, with an increase in the proportion of residents that regularly work from home. Employers will need to consider the implications of WFH on the health and safety of employees.

***Recommendation 34**: Partners to consider and respond to the needs of employees who, post-pandemic, routinely work from home to ensure their physical and mental health.*

Outside of work, people who were particularly hard hit by the pandemic or who were thought to be particularly at risk e.g. residents who were asked to shield, may require more time and / or reassurances before they fully re-engage with the community. Until then, they will remain more isolated than otherwise would be the case despite the huge reduction in the risk of severe illness achieved through vaccination.

[88] https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19
[89] COVID-19 Community Mobility Reports (google.com)

***Recommendation 35**: Partners should work to reassure the great majority of residents who may have shielded during the pandemic that vaccination, and antivirals for some patient groups, offer excellent protection against serious illness and hence the harms of continuing to 'self-shield' outweigh the benefits to physical and mental health to be gained from re-entering their community.*

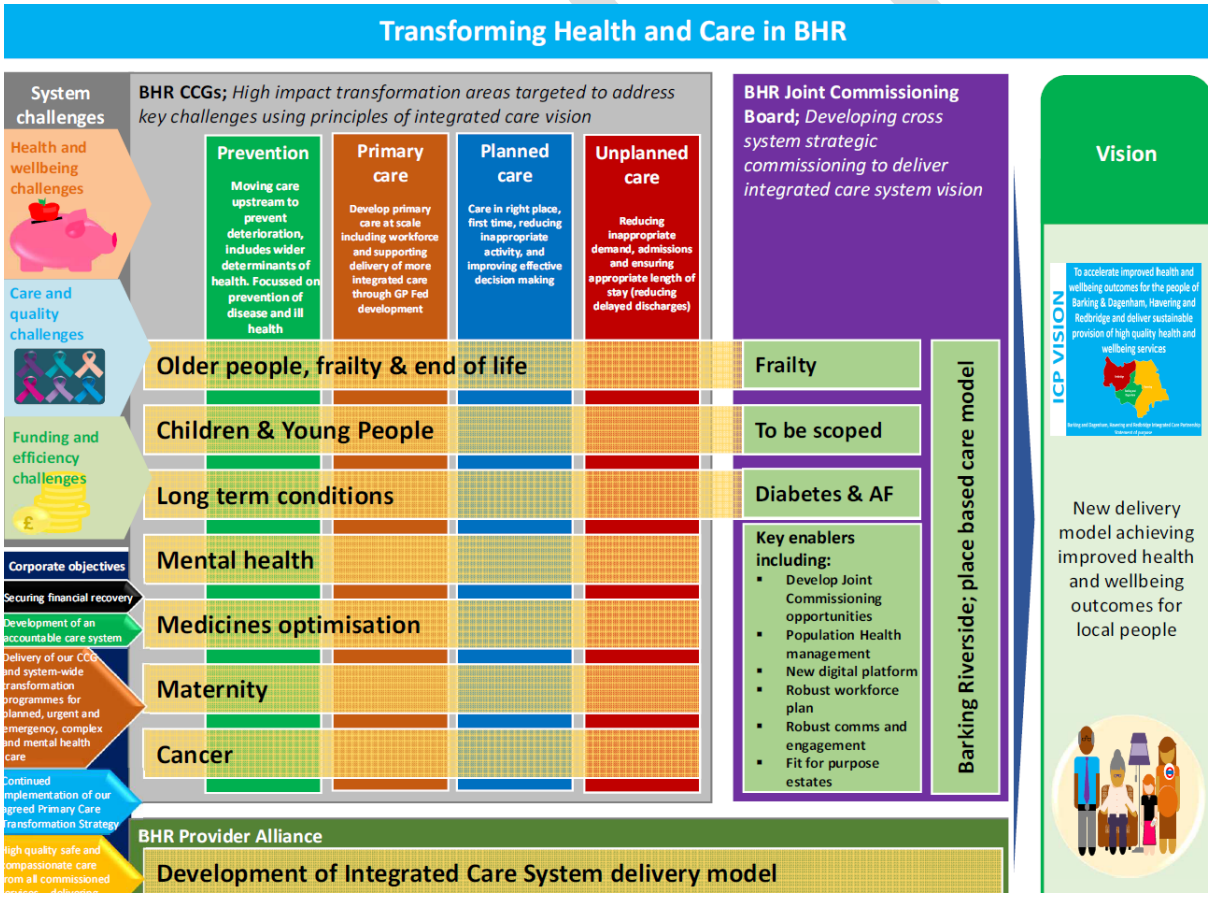
DRAFT

# 6. Pillar 4: Integrated Health & Social Care

The recent health and social care reforms recognise the importance of place and communities play in determining health outcomes. Borough partnerships, bring together decision makers from across the health and social care system, with representatives of the community and voluntary sector to ensure the adoption of a population health management approach. The system as a whole will continue to work to ensure that patients can access excellent treatment and care when needed, but equally all partners will seek to tackle the causes of ill-health and shape the place we live in to improve health and reduce inequalities.

A number of transformation boards have been established to lead the redesign and integration of health and social care services locally (Fig. 37).

**Figure 37. Plan for Transformation of Health and Care in BHR**




The JSNA considers each in turn, following a life course approach beginning with maternity and ending with end of life care.

## 6.1 Antenatal and Maternity

**Indicators and data used in this section can be accessed by clicking here*

**Fertility and birth rates**

There were about 11,300 live births to women resident in the three BHR boroughs in 2019. The fertility rate in Barking & Dagenham (82.6/1000 women aged 15-44), Redbridge (73.4) and Havering (68.0) is significantly higher than the London (62.9) and national averages (64.2). Fertility rates in Barking & Dagenham and Redbridge have been at similarly high levels for the last decade. Rates in Havering appear to have now plateaued having increased steadily over the last decade.

Notwithstanding any further changes in fertility rates, the number of pregnancies in all three BHR boroughs is likely to increase further in line with increases in the number of residents of childbearing age.

About 8,200 babies are born at Queens Hospital, making it one of the largest single-site maternity units in the country. Nonetheless, a significant number of women resident in BHR, particularly women living in the west of Redbridge and Barking & Dagenham have their babies in maternity units elsewhere in inner northeast London.

Given these patient flows across local health system boundaries, it makes sense to plan maternity services across a bigger footprint. The East London Local Maternity System (ELLMS)[90], a collaboration of maternity service providers, commissioners, voluntary organisations and service users, fulfils this function ensuring there is adequate capacity across the whole of the NEL ICS and all providers deliver similarly high quality care.

**Maternity care**

Women can choose to give birth at home, in midwife-led units, or in labour wards. The latter are more suited to the needs of higher risk mothers. The proportion of complex pregnancies is higher in more disadvantaged areas (e.g. Barking & Dagenham) and has increased more widely because of increases in maternal obesity and related gestational diabetes. Given that the Queens Unit is more or less at capacity, there is a need to develop midwife-led care options to free up hospital capacity for higher risk mothers.

Antenatal booking is recommended by 10 weeks of pregnancy[91]. This is an opportunity to gather the information needed to support a healthy pregnancy. Women booking after 20 weeks are considered a higher risk as the opportunity for early screening to identify risk factors such as infectious and inherited diseases has passed. Data from the Maternity Services Dataset (MSDS) for 2018/19 shows that across BHR 6,290 women (51.1%) had their booking appointment with a midwife within 10 completed weeks of their pregnancy. Less than half of Barking and Dagenham and Redbridge pregnant women had a 10-week booking, similar to the London average. The rate of early booking in Havering was higher but nonetheless 4 in 10 pregnant women in Havering did not have a midwife appointment within 10 weeks (Table 5).

[90] http://www.myhealth.london.nhs.uk/maternity/east-london/
[91] Antenatal care for uncomplicated pregnancies | Guidance | NICE

Anxieties about utilising health services during the pandemic may have further increased rates of late presentation.

**Table 5: Midwive appointment within 10 weeks**

| Area | Number of women who had an appointment booked within 10 weeks of their pregancy | 10 week bookings as a % of the total number of pregnancy bookings in the period |
|---|---|---|
| LBBD | 1,865 | 47.6% |
| LBH | 2,055 | 58.6% |
| LBR | 2,370 | 48.5% |
| London | 57,400 | 47.8% |
| England | 377,235 | 57.8% |

Source: Maternity Services Dataset (MSDS) v1.5

COVID-19 vaccines are strongly recommended in pregnancy. Vaccination is the best way to protect against the known risks of COVID-19 in pregnancy for both women and babies, including admission of the woman to intensive care and premature birth of the baby[92]. However only a minority of women and their babies were fully protected (Table 6).

**Table 6: COVID-19 vaccine status of pregnant women October 2021**

| Area | Uptake of two vaccines | Declined | No invite coded |
|---|---|---|---|
| LBBD | 28 | 4 | 36 |
| LBH | 43 | 3 | 17 |
| LBR | 40 | 6 | 25 |

The great majority of pregnancies result in the live birth of a healthy baby. However, a small number end in stillbirth[93] or neonatal death[94]. Saving Babies Lives[95] provides detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. BHR CCGs are on track to achieve a 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025 (Table 7).

[92] https://www.rcog.org.uk/guidance/coronavirus-covid-19-pregnancy-and-women-s-health/vaccination/covid-19-vaccines-pregnancy-and-breastfeeding-faqs/

[93] Stillbirth is a baby born after 24 weeks completed gestation and which did not at, any time, breathe or show signs of life

[94] Neonatal death is defined as deaths at under 28 days

[95] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

**Table 7. Number and rate (per 1,000) of stillbirths and neonatal deaths in BHR in 2020**

| Borough | Total births | Stillbirths (rate per 1,000) | Neonatal deaths* |
|---|---|---|---|
| **LBBD** | 3,406 | 20 (5.8) | 12 |
| **LBH** | 3,116 | 7 (2.2) | 5 |
| **LBR** | 4,343 | 27 (6.2) | 7 |
| **LONDON** | 111,688 | 485 (4.3) | 285 |
| **ENGLAND** | 585,195 | 2,231 (3.8) | 1,674 |

*Data for neonatal deaths is for 2019
Source: Total births and still births: ONS – Births in England and Wales: 2020
Neonatal deaths: Child and infant mortality statistics QMI (2019)

**Inequalities in outcomes for mothers and babies**

Low birth weight is associated with an increased risk of infant mortality, developmental problems in childhood and poorer health in later life. Some low birth weight babies will be preterm births. The risk factors for low birth weight, whether born prematurely or at full term, include smoking while pregnant; substance and alcohol misuse; pregnancy health and nutrition; pregnancy-related complications; and a mother's young age[96]. Rates of low birth weight are similar to the national average in Barking & Dagenham and Redbridge and better (lower) in Havering.

Smoking is a risk factor for stillbirth and neonatal death. The proportion of mothers known to be smokers at the time of delivery in Barking & Dagenham (7.6%), Havering (6.7%) and Redbridge (3.4%) is significantly lower than the national average (9.6%). Rates in Barking & Dagenham and Havering having improved significantly in recent years; however, they are considerably higher than the London average (4.6%).

The experience of childbirth is a uniquely personal event with potentially long-term impacts on mother and baby and their developing relationship (Table 8). Hence, service user choice and experience of care are particularly important aspects of overall quality of care. The CQC undertakes surveys of mothers across the country. Feedback from women attending Queens is broadly similar to the national average.

**Table 8: The experience people receive care and treatment at BHRUHT Maternity services in 2020.**

| Aspect of care | Patient response | Compared with other trusts |
|---|---|---|
| **LABOUR AND BIRTH** | 8.7/10 | About the same |
| **STAFF** | 8.4/10 | About the same |
| **CARE IN HOSPITAL AFTER THE BIRTH** | 7.8/10 | About the same |

Source: https://www.cqc.org.uk/provider/RF4/survey/5

The pandemic resulted in reduced face-to-face support pre and post-natal to parents negatively affecting experience of pregnancy and childbirth.

[96] https://www.nuffieldtrust.org.uk/resource/low-birth-weight

The benefits of breastfeeding are clear[97] and yet rates of breastfeeding across BHR are variable; Redbridge mothers (81%) are more likely to initiate breastfeeding than the England average (74.5%); rates in Barking & Dagenham (73.6%) are similar to the England average whereas rates in Havering are significantly lower (59.7%). Action is required by many partners to make breastfeeding the norm, particularly in Havering.

Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Antenatal and maternity care provides an opportunity to identify and support. The rate of recorded incidents and offences is higher in Barking & Dagenham but thousands of households are affected in all three boroughs. It has been reported that domestic violence has also risen during the pandemic, particularly during the periods of lockdown (Table 9).

**Table 9: Domestic abuse incidents and offences**

| | LBBD | | LBH | | LBR | |
|---|---|---|---|---|---|---|
| | Count | Rate/ 1000 | Count | Rate/ 1000 | Count | Rate/ 1000 |
| Offences | 3,395 | 16.5 | 2,560 | 10.2 | 3,121 | 10.4 |
| Incidents | 5,460 | 26.5 | 4,393 | 17.5 | 5,019 | 16.7 |

Source: MOPAC Domestic and Sexual Violence Dashboard

The vision for maternity services nationally is set out in the Better Births report[98]. In response, the ELLMS has developed identified the priorities set out below to provide women with personalisation, safety and choice, and access to specialist care whenever needed.

***Recommendation 36:*** *Enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led CoC, initially prioritising those identified as most vulnerable and high risk.*

***Recommendation 37:*** *Strengthen personalised care and choice; increase the proportion of women with a personalised care plan, initially prioritising disadvantaged and vulnerable women, whilst offering all women information and choice on place of birth.*

***Recommendation 38:*** *Continuously improve maternal safety including: by full implementation of the second version of the Saving Babies' Lives Care Bundle; and by working with Public Health to help expectant mothers to stop smoking to meet the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths, and intrapartum brain injury by 2025.*

***Recommendation 39:*** *Improved quality of postnatal care for all women including enhanced support to vulnerable women (e.g., perinatal mental health, drug and substance misuse) and focusing on infant feeding.*

***Recommendation 40:*** *Improve access to domestic violence support to all women accessing maternity services through the introduction of an early support and referral scheme for identified victims*

[97] https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/
[98] https://www.england.nhs.uk/ourwork/futurenhs/mat-review/

Achievement of these priorities will be enabled by action to:

- Improve data monitoring and hence the quality and accuracy of available maternity metrics
- Grow and further develop a sustainable workforce
- Improved system working whereby maternity services, particularly ante- and post-natally, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies.

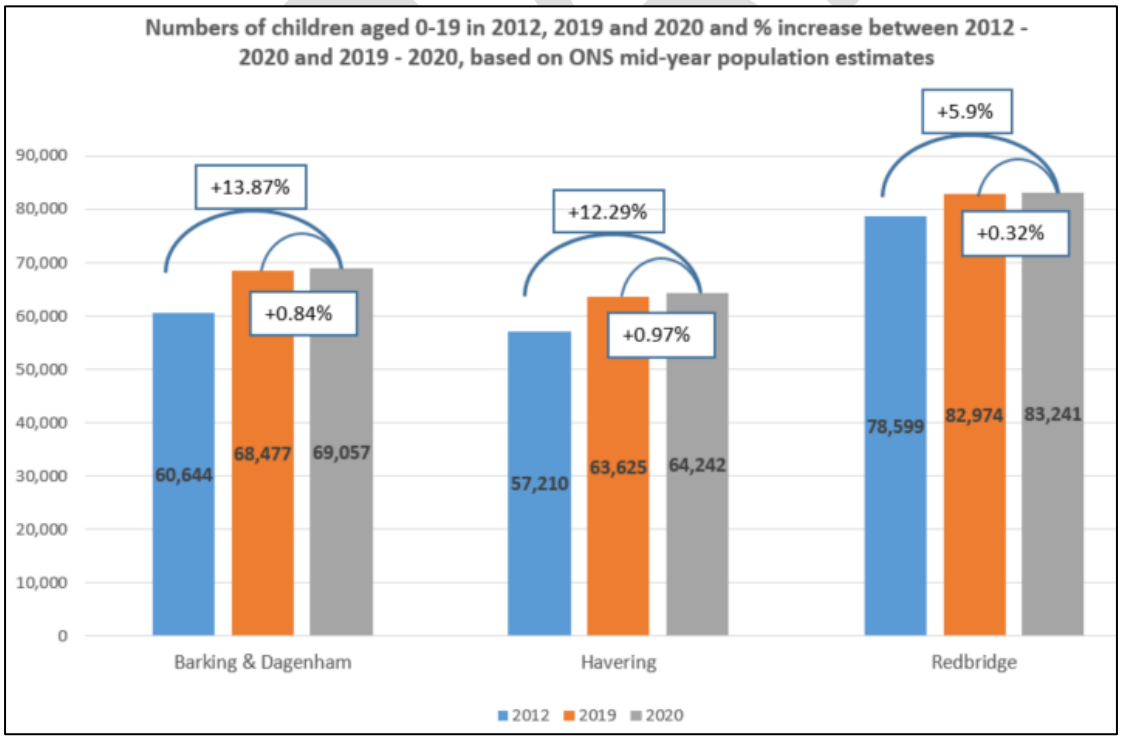
## 6.2 Children and young people

**Indicators and data used in this section can be accessed by clicking here*

### The children and young people of BHR

The number of children and young people (CYP) aged 0-19 years in the three BHR boroughs has increased significantly in recent years. Barking & Dagenham and Redbridge are very young boroughs – with a high proportion of children and young people (32.2% and 27.2% of the resident population respectively) (Fig. 38). Havering has a smaller proportion of CYP aged 0-19 years (24.6%), but has experienced a similar rate of growth in recent years, requiring existing services to expand rapidly to meet increasing demand.

**Figure 38: Number of children aged 0-19 and % increase 2012 - 2020**




***Recommendation 41:*** *Commissioners / providers should regularly review universal services e.g. health visiting, community paediatrics, therapies etc. to ensure capacity is adequate given the pace and scale of change in the CYP population in recent years.*

Barking & Dagenham and Redbridge are ethnically diverse and similar to London as a whole in this regard. Roughly, ¼ of Barking & Dagenham residents are Black/Black British and another ¼ are Asian/Asian British; about ½ of Redbridge residents are Asian. Havering is less diverse with about ¾ of the population white British. Nonetheless, Havering is becoming more diverse, particularly its younger residents.

***Recommendation 42:*** *The children and young people population is more diverse than the population as a whole and becoming more diverse. All partners should ensure that consideration of culture and language is integral to the development of all services and particularly services for CYP.*

The growth in child numbers is driven by the relatively high fertility rate in all three boroughs and by families with children moving into the patch from elsewhere. Changes in housing benefit and the relative affordability of housing in the three boroughs relative to elsewhere in London may be responsible. The movement of CYP from inner to outer London boroughs may serve to increase the complexity of need as well as the number of CYP in recipient boroughs.

## Health and wellbeing outcomes of children and young people in BHR

The death of a child is thankfully a relatively rare event. The risk of death is greatest in the first year of life often linked to prematurity and / or congenital problems. Infant mortality rates for the period 2018-2020 were similar to the national average in all three boroughs; 2.3 /1,000 in Havering, 2.8 in Redbridge and 3.9 in Barking & Dagenham [99].

The Barking and Dagenham, Havering and Redbridge Child Death Overview Panel (BHR CDOP) undertakes a robust review of every child death to identify patterns and trends over time regarding cause of death and opportunities to prevent future deaths e.g. by improvements in health care services or public health action.

***Recommendation 43:*** *Lessons learned through the Child Death Review process should be shared at least annually with commissioners and providers of maternity and children's services to inform decisions regarding priorities for action.*

## Wider determinants of health and children and young people

Barking & Dagenham is the most **disadvantaged** London borough, and 5th most deprived upper tier local authority in England[100]. Havering and Redbridge have lower

[99] PHE Fingertips (2021) https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133228/pat/6/par/E12000007/ati/302/are/E09000016/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

[100] UK Government (2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/834001/File_11_-_IoD2019_Local_Authority_District_Summaries__upper-tier__.xlsx

levels of disadvantage. The proportion of children affected by income deprivation varies from 23.8% in Barking & Dagenham (13.1K children) to 16.0% in Havering (7.7K) and 13.7% in Redbridge (9.3K).

Disadvantaged families were the most severely impacted by the pandemic, exacerbating existing inequalities.

Falls in income has also led to increased levels of food insecurity. Over the course of the pandemic, 5 million people in the UK living in households with children under 18 have experienced food insecurity. 1.8 million of these experienced food insecurity solely due to the lack of supply of food in shops, leaving 3.2 million people (11% of households) suffering from food insecurity due to other issues such as loss of income or isolation. This is double the level of food insecurity among households with children reported by the Food Standards Agency in 2018 (5.7%).

The experience of **poverty** in childhood has significant and long lasting effects and is associated with poorer outcomes regarding all aspects of life including health. Disadvantaged families, who spend a greater proportion of their income on food and heating, are likely to be most affected by the current cost of living crisis.

**Homelessness** directly impacts on the health of children and young people e.g. children in temporary accommodation have poorer social networks and higher rates of mental health problems. In addition, homelessness can interfere with a child's studies further affecting their life chances in the longer term. Rates of family homelessness in all three BHR boroughs (Barking & Dagenham, 5.4/1000 households, n=426; Havering 2.5/1000, n= 256; Redbridge 3.4 /1000, n=381) are higher than the national average (1.7/1000).

**Free preschool education and childcare** is available to all children from age 3 and to disadvantaged and / or children with additional needs from age 2. The scheme is designed to provide additional support to those most in need. However, take up of places for 2-year old children is incomplete in all three boroughs, but particularly in Redbridge and Havering (LBBD, 76%; Havering, 54%; Redbridge, 45% in 2021). The take-up of 3-4 year old places is better in all three boroughs ( Barking & Dagenham 84%; Redbridge in 90%; Havering in 89%). Uptake for both 2 and 3-4 year olds was a few percentage points better pre-pandemic[101].

***Recommendation 44:*** *Ensure opportunities to maximise awareness and uptake of free preschool education and childcare are taken e.g. via regular contacts with health professionals including midwifery, health visiting and with general practice and Local Authority Early Help teams/Children's Centres.*

Childcare providers were asked to continue to take the children of key workers and from vulnerable families during lockdowns. However, during the first lockdown, only a third of childcare providers remained open nationally[102].

[101] Data Source: https://explore-education-statistics.service.gov.uk/find-statistics/education-provision-children-under-5/2021

[102] Economics Observatory (2020). How has the Covid-19 Crisis affected preschool childcare? https://www.economicsobservatory.com/how-has-covid-19-crisis-affected-pre-school-childcare

Ofsted have found that the pandemic significantly impacted the learning and development of children whose participation in early years education was interrupted by repeated lockdowns[103]. They were particularly concerned about children's personal, social and emotional development. Some children had returned less confident and more anxious. In some cases, children had also become less independent, for example returning to their setting using dummies or back in nappies having previously been toilet trained.

Separate assessments are undertaken in early years settings and by health visitors (using ASQ3[104]) at age 2 – 2 ½ years. These reviews provide the opportunity to assess a child's physical, social and emotional needs, identify any potential issues or developmental delays and enable support to be provided as early as possible. Undertaking these assessments together or sharing results can help health and early years professionals arrive at a shared understanding of a child's needs and how they might best be addressed. Analysis of anonymised, aggregate data would provide a better understanding of the needs of young children as a whole to inform the planning of specific interventions and check that the capacity of relevant services e.g. Speech and Language Therapy is adequate.

***Recommendation 45:*** *Maximise uptake and face-to-face delivery of the 5 mandated health and development checks for children aged 0- 5. Increase joint assessments by early years settings and health visitors at age 2 – 2 ½ yrs.*

***Recommendation 46:*** *Ensure that anonymised aggregate data from the ASQ3 are available to inform health service planning and interventions to improve school readiness.*

**School readiness** is measured at the end of the Reception year to determine the level of development in 4-5 year olds against the Early Years Foundation Stage (EYFS) learning goals. The last available data[105] (2018-19) showed that at the end of reception year, the majority of children in all three boroughs were assessed as having a good level of development. The proportion in Barking & Dagenham (72.4%) and Havering (71.7%) was similar to the England average (71.8%); the proportion in Redbridge (75.6%) was significantly better. Nonetheless, somewhere around 1000 children in each borough were already lagging behind their peers.

Children in receipt of free school meals were more likely not to achieve a good level of development particularly in Havering.

[103] Ofsted (2020). Covid-19 Series: Briefing on Early Years , October 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933836/COVID-19_series_briefing_on_early_years_October_2020.pdf

[104] https://agesandstages.com/products-pricing/asq3/

[105] The Early Years Foundation Stage Profile results in England for 2019-2020 and 2020-2021 were both cancelled as a result of school closures during Covid lockdowns.

In addition, fewer boys than girls achieved a good level of development. The gap is highest in Barking & Dagenham (14.9 percentage points difference), but significant in Redbridge and Havering (11.0% and 11.1% respectively).

> ***Recommendation 47:*** *Partners should work together to improve the proportion of children achieving at least the expected level across all learning goals, and a good level of development. Consider additional action to reduce inequalities associated with gender and disadvantage.*

Educational attainment is a good predictor of a range of outcomes including income, employment and health. **GCSE attainment** in 2019/20, as measured in terms of average attainment 8 score, was similar to the national average (50.2 mean score) in Barking & Dagenham (50.1) and significantly better than national in Redbridge (56.0) and Havering (52.2). Equivalent scores for children in receipt of free school meals were lower, particularly in Havering (34).

Despite the best efforts of teachers and parents, school closures during the pandemic harmed learning, with disadvantaged children most affected, exacerbating existing inequalities.

> ***Recommendation 48****: As part of their anchor institution role, health and care providers should contribute to wider efforts to build aspiration and educational achievement particularly in disadvantaged and / or otherwise vulnerable groups e.g. through outreach to schools and career fairs; offering workplace experience; apprenticeships; career paths from less skilled, lower paid roles into better paid, professional health and social care roles etc.*

**Employment** is fundamentally good for health. Rates of youth unemployment across BHR are low with 4.2% of 16-17 years olds in Barking & Dagenham Not in Education, Employment or Training or whose activity is not known (NEET); 2.9% in Havering and 3.1% in Redbridge.

## Behaviour and Lifestyle

In some respects, the current generation of children and young people are living more healthily than preceding ones.

Less than 5% of under 15 year olds have used cannabis in the previous month – similar (Havering) or better (Barking & Dagenham and Redbridge) than the national average. About 1% of 15 year olds reported using **drugs** other than cannabis, similar to the national average[106].

The prevalence of **smoking** among young people, when the great majority of adults started smoking, has fallen faster and further than for adults. Rates of smoking

[106] Source: What About YOUth (WAY) survey, 2014/15

amongst 15 year olds in all 3 BHR boroughs (Barking & Dagenham 5.6%, Havering 5.8%, Redbridge 3.4%) are lower than the national average (8.2%).

**Childhood obesity** has not improved in the same way. In the past, obesity and Type 2 diabetes were associated with middle age. Now 1 in 10 children are obese by the age 5, rising to 1 in 5 by age 11 at Year 6. Obesity is already a significant contributor to death and disability and the harm caused can only increase as more people are overweight and obese for more of their life. Help to individual families with obese children is only part of the action required; a whole systems approach is needed to create places and communities that assist residents to maintain a healthy body weight throughout life.

> ***Recommendation 49:*** *Boroughs to lead a whole system approach to obesity; health and care partners to offer Tier 2 and Tier 3 weight management services for CYP and their families.*

## Communities and places for children and young people

Children and to a lesser extent young people have narrower horizons than adults; spending a large proportion of their time in the family home and / or educational settings.

During the pandemic, and particularly during lockdown, young peoples' community contracted still further so that for many, engagement with friends was largely online and **digital connectivity** was essential. Steps were taken to support the digitally excluded but nonetheless it is clear that the learning of disadvantaged CYP was harder hit than that of more affluent peers.

Prior to the pandemic, concern was frequently expressed regarding the effects of prolonged screen time and social media use on the health and wellbeing of CYP including the potential for cyberbullying, lack of sleep and reduced physical activity. The then Chief Medical Officer concluded there was no clear scientific consensus regarding the overall balance of pros and cons but adopting the precautionary principle issued guidance for parents and carers[107].

> ***Recommendation 50:*** *Ensure that programmes to improve digital connectivity are supported by associated education and awareness of the health impacts of cyberbullying and screen addiction.*

The Mayor of London offers award schemes to encourage early years settings (Healthy Early Years London (HEYL)) and schools (Healthy Schools London (HSL)) to review and improve the extent to which their culture and environment support good health. Settings in all 3 boroughs currently participate. Throughout the pandemic, schools and early years settings have continued to engage in the schemes, with several achieving bronze, silver or gold awards throughout this period.

[107]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777026/UK_CMO_commentary_on_screentime_and_social_media_map_of_reviews.pdf

***Recommendation 51:*** *Encourage and support early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the relevant HEYL/HSL scheme or similar.*

Schools also provide a place of safety for our most vulnerable young people. **Exclusion** from school is indicative of poor education attainment. Moreover, excluded CYP are particularly vulnerable to exploitation in all its forms. An increased risk of involvement in serious youth violence, as victim or perpetrator, has been suggested if not universally accepted[108].

***Recommendation 52:*** *Health and care partners should work with schools to provide support to pupils at risk of exclusion.*

The family home is the most important community for a child. A secure and loving family is the single best predictor of subsequent life chances.

Equally, there is extensive evidence regarding the impact of negative factors experienced within the family home during childhood on later life. **'Adverse childhood experiences'** (ACEs) is one way of describing these negative factors.

UK studies[109] have suggested a simple dose/ response relationship between the number of ACEs experienced and the number and type of risky health behaviours engaged in, the social and community impact and impact on use of services as a result of these risky behaviours (Table 10).

**Table 10: Likelihood of children with 4 or more ACEs engaging in risky behaviours and the impact on services by the consequences of those behaviours.**

| Health and wellbeing behaviours | Social and community impact | Impact on services |
|---|---|---|
| Those with 4 ACEs + are: | | |
| 2x more likely to have a poor diet | 2x more likely to binge drink | 2.1 x more likely to have visited their GP in the last 12 months |
| 3x more likely to smoke | 7x more likely to be involved in recent violence | 2.2 x more likely to have visited A&E in the last 12 months |
| 5x more likely to have had sex under 16 years | 11x more likely to have been incarcerated | 2.5 x more likely to have stayed a night in hospital |
| 6x more likely to have been pregnant or got someone accidently pregnant under 18 | 11x more likely to have used heroin or crack | 6.6 x more likely to have been diagnosed with an STD |

[108] https://www.tes.com/news/we-need-reality-check-about-exclusions
[109] Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population

An appreciation of ACEs affords new opportunities to improve health and interrupt the transmission of a variety of negative outcomes from one generation to the next by: -

- **Preventing exposure to ACEs** in the first place e.g. help re. parental attachment; parenting skills courses; resilience building; education and awareness raising re. sex and relationships; drug and alcohol etc. in schools and colleges; anti bullying interventions etc.
- **Early intervention** - effective safeguarding arrangements, identification and effective family focused treatment of parental MH and drug and alcohol problems; support for victims of DV;
- **Mitigation** in support those affected – trauma aware services; CAMHs, YOS

Health and care partners in Barking & Dagenham are working with the Early Intervention Foundation to explore how multi-agency working including family interventions and targeted support for vulnerable cohorts, can improve emotional wellbeing and mental health and better protect children from harm.

***Recommendation 53:*** *Put in place processes to share learning between boroughs, and between health and care partners about how to improve emotional wellbeing and mental health and better protect children from harm, including the joint working between EIF and* Barking & Dagenham*.*

Adolescence entails young people gaining greater independence and taking more risks. Nonetheless **safeguarding adolescents** from significant and long-term harm must be a priority for all partners.

**Teenage parents** have poorer outcomes e.g. in terms of educational attainment, employment and earning power than peers who have children later in life. Their offspring are more likely to be raised in poverty with impacts on their life chances – hence teen pregnancy serves to transmit disadvantage from one generation to the next.

**Table 11: Teenage conceptions, abortions, births, BHR boroughs, 2020**

| | LBBD | LBH | LBR | London | England |
|---|---|---|---|---|---|
| Under 18 conceptions - rate/1000 ♀<18 yrs and (count) | 16.1 (66) | 15.5 (69) | 7.6 (42) | 9.8 | 13 |
| Under 18 conceptions leading to abortion (%) | 55% | 44% | 45% | 63% | 53% |
| Under 18 births - rate/1000 ♀<18yrs and (count) | 4.9 (20) | 2.9 (13) | 2.4 (13) | 2.5 | 3.8 |

Source: OHID Fingertips

Rates of teen conceptions and births in the BHR boroughs are similar to if not better than the national average (Table 11). Nonetheless, a significant number of young women conceive and thereafter choose to terminate or take their pregnancy to term.

Teen parents and their children benefit from support to develop parenting skills and maximise educational attainment, employability and earning potential.

***Recommendation 54:*** *Health, social care and education to periodically review their joint approach to prevent unplanned pregnancy and support teenage parents.*

Both Barking & Dagenham and Redbridge had a rate of first time entrants to the **youth justice system** significantly higher than England. The rate for Havering was significantly lower (better). However, the rates of youth justice custodial sentences and overall youth proven offending rates were significantly worse (higher) in all three boroughs than England. In England, 72% of children in the youth justice system were assessed as having mental health concerns, some were unrecognised and / or inadequately managed [110].

**Serious youth violence** has resulted in the deaths of young people in each of the BHR boroughs. In some instances, violence is gang related. Criminal gangs may also involve vulnerable young people in the supply of drugs in 'county lines' operations. Young people are also at risk of sexual exploitation from individuals, organised groups and other young people. Still others may be at risk of involvement in religious or politically inspired hate crime. Alongside a vigorous criminal justice response, a public health approach is recommended to tackle serious youth violence[111].

A Public Health approach has 6 broad criteria:

- It is focused on a defined population
- It is established with and for communities
- It is not constrained by organisational or professional boundaries
- It is focused on generating long term, as well as short term, solutions
- It is based on data and intelligence
- It is rooted in evidence of effective practice

The same principles could equally be applied to develop comprehensive, evidence-based solutions to other complex threats to young people.

***Recommendation 55:*** *Health and care partners must actively contribute to collective efforts to reduce serious youth violence and gateways to youth crime; as part of comprehensive efforts to minimise exposure to adverse childhood experiences.*

## Integrated health and care system for children and young people

**Immunisation** is often cited as the single most cost-effective health intervention[112] and yet vaccine coverage has been falling for some time whilst cases of vaccine preventable disease, notably measles, have increased. Coverage is below the WHO target of 95% in all 3 BHR boroughs, as such we cannot be assured that herd immunity will prevent community outbreaks (Table 12). Anti-vaccination messages have not helped but the National Audit Office suggest that more prosaic problems such as the

[110] Gov.UK (2021). https://www.gov.uk/government/statistics/youth-justice-statistics-2019-to-2020
[111] https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence
[112] https://www.parliament.uk/documents/post/postpn314.pdf

way healthcare professionals remind parents to vaccinate their children and difficulty accessing vaccination services at a convenient time and location may be equally to blame[113].

**Table 12. Percentage uptake of primary vaccinations by age 5 years in 2020-21 compared to pre-pandemic levels 2018-19 by local authority**

| Borough | Year | DTaP/IPV /Hib | DTaP/IPV booster | MMR1 | MMR2 | Hib/MenC |
|---|---|---|---|---|---|---|
| LBBD | 18-19 | 93.8 | 72.0 | 92.1 | 73.3 | 90.4 |
| | 20-21 | 92.5 | 69.0 | 89.6 | 69.8 | 87.9 |
| LBH | 18-19 | 96.7 | 82.2 | 95.1 | 83.9 | 94.2 |
| | 20-21 | 96.0 | 79.2 | 93.8 | 79.7 | 92.9 |
| LBR | 18-19 | 91.8 | 69.0 | 89.9 | 71.5 | 87.1 |
| | 20-21 | 90.7 | 70.1 | 88.4 | 71.5 | 86.3 |

***Recommendation 56:*** *Review the delivery of childhood immunisation in BHR and develop plans to increase uptake to levels necessary to achieve herd immunity.*

Notwithstanding the benefits of vaccination, all children will at some point experience ill health. In most cases, it is relatively mild and self-limiting. However, very large numbers of children and young people attend emergency departments each year.

**Emergency departments** (A&E) are for potentially life threatening illnesses or accidents that require immediate, intensive treatment. Long waits at A&E are a common occurrence. Triage to identify patients who need immediate care minimises the impact on treatment outcomes but nonetheless long waits result in poor experience of care. Even more so when young children are involved.

Rates of attendance at A&E by children and young people resident in BHR are below the national average. Nonetheless, there were nearly 12K A&E attendances with babies aged under 1, 30K for children aged 0-4 and almost 70K by CYP aged under 18 years in the year prior to the pandemic[114] (Fig. 39).

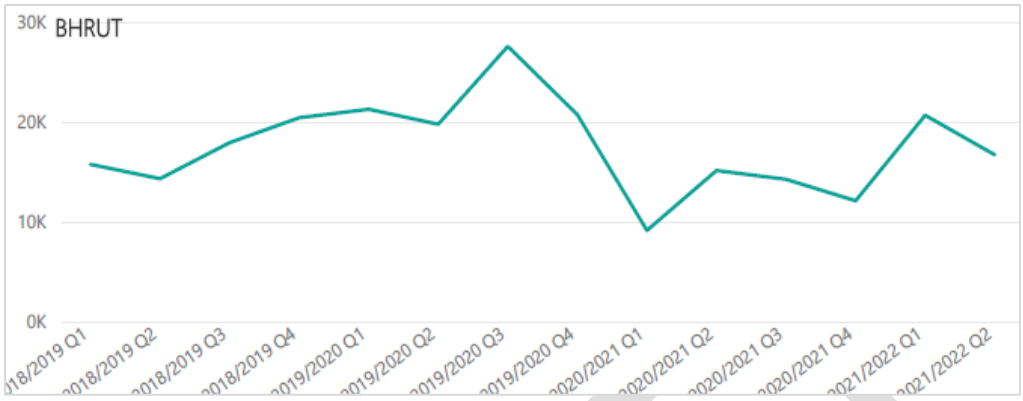
During lockdown, attendances of CYP at A&E dropped significantly before returning to usual levels when controls were relaxed. There is no substantive evidence of additional harm to children themselves from this change in service use, suggesting that the CYP who needed emergency care continued to receive it and that normally, a proportion of A&E attendances are for self-limiting conditions or problems that could equally well be managed by urgent[115], primary or community care services.

[113] https://www.nao.org.uk/wp-content/uploads/2019/08/Investigation-into-pre-school-vaccinations-Summary.pdf

[114] https://fingertips.phe.org.uk/indicator-list/view/iYi2ex7my0#page/1/gid/1/ati/402/iid/90809/age/28/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

[115] Urgent: An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC).

**Figure 39. A&E attendances by patients aged under 18 years old resident at BHRUT, Q1 2018-19 to Q2 2021-22**




Source: NHS Digital

***Recommendation 57**: Health and care partners, Early Years settings, children's centres, the VCS and parents' representatives to work together to understand how best to meet the health care needs of families with children, improving patient experience and making best use of limited A&E capacity.*

**Health visitors** have a unique opportunity to engage with all young children and their families in the family home. The 5 mandated checks are a chance to identify families who need more support e.g. to manage minor illness and injury; to achieve a healthy body weight, be school ready, or to prevent abuse and neglect. As such, health visitors contribute to improving health, educational achievement and safeguarding. Delivery of the 5 mandated checks pre-pandemic across BHR was variable[116] (Table 13).

**Table 13. Delivery of 5 mandated checks 2019-2020**

| Area | Antenatal | New birth | 6-8 weeks | 1yr (by 15mths) | 2 – 2 ½ yrs |
|---|---|---|---|---|---|
| LBBD | 1,621 | 95.8% | 75.9% | 78.0% | 74.5% |
| LBH | 83 | 95.1% | 20.1% | 91.6% | 85.4% |
| LBR | 227 | 89.8% | 61.4% | 50.7% | 39.5% |
| England | N/A | 86.8% | 85.1% | 83.6% | 78.6% |

Source: DHSC

Delivery during the pandemic was further disrupted, as health visitors were redeployed to care of patients with COVID-19 and later to support vaccination efforts. Virtual contact substituted for face to face at times and parents undertook some checks themselves. Hence, it is likely that children with problems will not have been picked up as early as would otherwise have been the case.

[116] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011902/Annual_Health_Visitor_Statistical_Release_2019_2020_Aug_2020_update__1_.ods

***Recommendation 58**: Providers to prioritise mandated early years checks as part of wider efforts to recover from the impacts of Covid*

A number of important **long-term conditions** can begin in childhood. **Asthma** is the most common. Effective management can minimise both the frequency of severe attacks and the day-to-day distress and inconvenience of poorly controlled asthma, which in turn affects school attendance and participation in physical activity. Rates of hospital admission for asthma for CYP under 19 years of age in 20/21 were similar to national average (74/100,000) in Havering (89/100,000) and Redbridge (87/100,000) and significantly higher (105/100,000) in LBBD. However, young people have died from asthma in all three boroughs in recent years and the BHR system has developed a detailed improvement plan in response to a Regulation 28 Letter[117] from the local coroner following the Inquest into one of these deaths.

***Recommendation 59:** All partners to prioritise and consider how best to implement plans developed to improve asthma care in BHR.*

About 1 in 10 CYP have a common **mental health** disorder (CMHD). Estimated rates in Barking & Dagenham (10.3%) are higher than the national average (9.2%) whereas rates in Havering (9%) and Redbridge (9%) are similar. In total, about 11K CYP in BHR aged 5 -16 are estimated to have a CMHD.

Conduct disorders (severe and persistent behavioural problems) are the most common CMHD; affecting 5% of children aged 5-10 increasing to 7% in secondary school years. Conduct disorders are twice as likely to be experienced by boys/young men then girls/women[118].

Increasing CAMHS support is a priority in the NHS. The immediate target is to increase access to at least 35% of those with a diagnosable condition. Hence alongside the challenge of increasing CAMHS capacity, there is an equally pressing need to engage and maximise the contribution of non-NHS support e.g. counselling commissioned by schools and / or the CVS; improve the ability of universal services including schools and parents to support CYP with mental health problems and build greater resilience amongst CYP themselves.

***Recommendation 60:** CYP and MH transformation Boards should work to: -*

- *Increase CAMHS capacity and strengthen links with other providers*
- *Develop the capacity and capability of professionals in universal services including health visiting, school nursing general practice and schools to support children with mental health problems and their families*
- *Support children and their families to be more resilient*

[117] https://www.inquest.org.uk/faqs/prevention-of-future-death-reports#:~:text=After%20an%20inquest%2C%20the%20Coroner,preventative%20action%20is%20not%20taken.
[118] Green et al 2005

Self-harm is a particular indicator of emotional distress and is associated with a higher risk of suicide[119]. Rates of hospital admission for self-harm in all 3 BHR boroughs are less than half the national average. Amongst 10-24 year olds, rates of hospital admissions as a result of self-harm per 100,000 are 166 in Havering, 136.2 in Barking & Dagenham and 126.2 in Redbridge, However, hospital admission captures only a small proportion of cases. Data about attendances at A&E would give a better measure of the incidence of self-harm. Systems to follow up people attending A&E with self-harm are an element of robust suicide prevention plans.

***Recommendation 61:*** *ICS partners to:-*

*i) consider how best to report attendances for self-harm in CYP;*

*ii) ensure that NICE guidance for psychosocial assessment after hospital attendance for self harm is implemented.*

## Children with Special Education Needs and Disabilities (SEND)

SEND comprise a wide variety of problems that affect a child or young person's ability to learn. As a result, children with SEND need extra support, which can include help to take part in usual class activities or help communicating with others, through to a special learning programme and help with physical and personal care.

More than 1 in 10 children and young people have SEND; reported rates in Barking & Dagenham (14.5%) Havering (11.0%) and Redbridge (11.8%) are lower than the England average (14.4%)[120].

Delivery of the required help can involve contributions from schools, children's social care and NHS services (e.g. therapies, community paediatrics, CAMHs etc.). Complex care is captured in an Education Health Care Plan specifying the support needs of individual young people up to the age of 25 to achieve what they want in their life. The percentage of CYP aged 0-25 with statements of SEN or an EHC Plan varies across the patch - Barking & Dagenham 1.6%, Havering 1.6%%, Redbridge 1.8%; but in all cases, rates are similar to or less than the average for London (1.8%) and England (1.9%). In total, just under 4000 children and young people in BHR have an EHCP or statement.

The complex needs of small numbers of CYP cannot be met locally necessitating, in some cases, long journeys to specialist facilities and / or residential care. Greater collaboration across BHR or NEL as a whole may enable partners to meet the needs of more CYP closer to home.

[119] Repetition of self-harm and suicide following self-harm in children and adolescents: findings from the Multicentre Study of Self-harm in England, Hawton, K., Bergen H., et al, Jnl of child Psychology and psychiatry April 2012.

[120] DfE Jan 2019 All Schools : number of pupils with special educational needs, based on where the pupil attends school https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814246/SEN_2019_Local_Authority_tables.xlsx

***Recommendation 62:*** *CYP transformation board to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews and options for Pan BHR commissioning to facilitate best use of scarce clinical resources and enable provision of care closer to home.*

## Safeguarding children and young people

Neglect, physical abuse, exposure to domestic violence, parental drug and alcohol dependency and mental illness can result in immediate harm to children. In addition, and as discussed above, exposure to Adverse Childhood Experience (ACEs) is linked a range of significant negative outcomes in later life.

Safeguarding requires the active cooperation of a variety of partners. Borough level arrangements have been augmented by the addition of BHR wide collaboration developed and agreed by the Director of Childrens Services (DCS) for each borough, the Nursing Director for BHR CCGs and the lead for the Metropolitan Police Service.

Universal services like health visiting, early years services, nurseries and schools play a vital role in safeguarding children. Reduced contact during the pandemic may have delayed the identification of at risk children thereby prolonging abuse and neglect. Such delays may have contributed to the increase in the number and severity of children protection cases reported post pandemic.

***Recommendation 63:*** *All partners must participate in safeguarding arrangements and ensure all staff working within the ICS are clear on thresholds and pathways for raising and acting on safeguarding concerns.*

The primary purpose of child protection arrangements are to protect children from further harm; in many instances, and following detailed assessment, this will entail remaining in the family home with appropriate support. Depending on the specific needs and strengths of the individual child and their family, child protection arrangements can be stepped up (or down) from child in need, to child protection or the child may be taken into the care of the Council.

Rates for all forms of safeguarding are generally similar or lower than the national average in Havering and Redbridge but higher in Barking & Dagenham as would expect given the higher rates of disadvantage. Irrespective of the precise rates, significant numbers of children are subject to some form of child protection in all three boroughs.

Outcomes for looked after children such as educational attainment and mental and physical health tend to be poorer than those of children in the general population[121]. Subsequent life chances are also poorer and health and care partners should consider how they can assist care experienced children beyond their statutory duties e.g. by

[121] https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children/#heading-top

giving them priority to opportunities like apprenticeships and work experience that might lead to secure well paid employment.

***Recommendation 64:*** *Health and care partners to consider how they can support care experienced young people into employment as part of their wider 'anchor institution' role.*

DRAFT

# 6.3 Adult Mental Health

**Indicators and data used in this section can be accessed by clicking here*

**Prevalence and risk factors**

The great majority of people will experience problems with their mental wellbeing at some point in their lives.

The modelled prevalence of common mental health disorders (any type of depression or anxiety) for adults in Havering (15.9%) and Redbridge (17.7%) is similar to the national average (16.9%), but significantly higher in Barking & Dagenham (22.4%). As such, there are likely to be more than 108K people with a common mental health problem living in the three BHR boroughs at any point in time.

The GP recorded prevalence of depression for adults in each of the three boroughs is below the national average, which may indicate unidentified need, particularly in Barking & Dagenham and Redbridge where recorded prevalence is lowest. Nonetheless, almost 52K people across BHR are known to have depression.

A smaller number of the adult population have a severe mental illness (SMI) including schizophrenia, bipolar affective disorder and other psychoses. Rates of SMI are lower than the national average in all three boroughs – nevertheless more than 6,800 people have a SMI.

Poor mental health disproportionately affects those who experience disadvantage in all its forms e.g. with regard to the wider determinants, levels of social support, experience of abusive relationships and discrimination[122].

People from ethnic minority communities are less likely to engage with mental health services other than at a time of crisis. People of African/Caribbean descent are over-represented at all levels of the psychiatric process; in particular they are more likely to be treated as inpatients, be sectioned or access mental health services via a criminal justice system pathway[123].

Mental health problems are more common among people who are lesbian, gay, bisexual, trans, intersex, queer or questioning (LGBTIQ+)[124].

Studies suggest that the rate of mental health problems in people with a learning disability is double that of the general population[125].

Compared with the general population, common mental health conditions are over twice as high among people who experience homelessness, and psychosis is up to 15 times as high[126]. Many people who sleep rough have co-occurring mental ill health and substance misuse needs, combined with physical health needs and past experience of significant trauma.

[122] PHE Guidance: Wellbeing and mental health: Applying All Our Health Updated 28 August 2019
[123] https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities
[124] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-lgbtiq-people
[125] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/mental-health
[126] https://publichealthmatters.blog.gov.uk/2019/09/30/health-matters-rough-sleeping/

As many as nine out of ten people in prison have a mental health, drug or alcohol problem[127]. 50% of mental health problems are established by age 14 and 75% by age 24[128]. Subsequent life stages or events may be associated with further risk.

It is estimated that between 1.3K and 2.7K of women in BHR experience adjustment disorders and distress in the perinatal period. Between 4-6% of pregnant women experience post-traumatic stress disorder as a result of traumatic events during labour or childbirth[129]. Perinatal disorders are associated with increased risk of psychological and developmental disturbances in children[130].

1 in 5 of older people living in the community and 40% of older people living in care homes are affected by depression[131].

Prevalence of recorded dementia in BHR is two-thirds of that in England; almost 5K of registered patients have dementia. Evidence suggests that up to 40% of all cases of dementia are linked to modifiable lifestyle factors, but just a third of UK adults think it is possible for people to reduce their risk. Women are less likely than men to think it's possible (30% compared to 37%)[132]. Smoking is one of the biggest risk factors and can double individual risk[133].

**Harm caused by mental illness**

People with severe mental illness die on average 10 - 20 years sooner than the general population[134]. Cardiovascular disease, respiratory illness and cancers are the main causes of the observed gap in life expectancy, in part due to the very high prevalence of smoking (and heavier smoking) amongst people with mental health problems[135,136]. Over 1,700 people across BHR are recorded as smokers with SMI. Some of the drugs used to treat SMI can cause obesity and thus increase cardiovascular risk[137].

Deaths from mental illness represent only a small element of the harm caused. In total, mental health problems are estimated to cause about 10% of all health lost to disability (YLD) and 5% of all health lost to disability and premature death (DALYs) [138].

[127] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[128] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.
[129] Dekel S, Stuebe C, Dishy G. Childbirth induced posttraumatic stress syndrome: A systematic review of prevalence and risk factors.Frontiers in Psychology. 2017;https://doi.org/10.3389/fpsyg.2017.00560
[130] Steain, A et al (2014) *Effects of perinatal mental disorders on the fetus and child*
[131] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[132] Alzheimer's Research UK *Public attitudes towards dementia*
[133] National Government (2018) *Dementia: applying all our health*
[134] 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
[135] Kings Fund (2014) *Smoking and severe mental ill health*
[136] ASH (2019) *Factsheet: Smoking and Mental Health*
[137] NHS England (2019) Achieving more for people with severe mental illness
[138] JSNA Chapter 3 Population Health Outcomes

## The impact of the pandemic on mental health

Anecdotally, BHR local authorities, local NHS agencies, and partner organisations such as schools and the voluntary sector have observed that not only are the pre-existing inequalities in mental health widening, but there are new mental health challenges emerging, fuelled by the experiences of living through a pandemic.

A national study observed that depression and anxiety levels were greatest during lockdowns, reducing when lockdowns were eased, although symptoms increased over Christmas 2021 and on a par with levels during lockdown at the start of 2021. This was driven by concerns about catching Covid-19, as well as concerns about finance. Working age adults were twice as likely to report concerns as older adults.[139] Further common causes for worry were being separated from friends and family, being unable to cope with uncertainty, how the mental health of one's own children will be affected by the pandemic, and making one's existing mental health problems worse.[140]

People have been using a wide range of strategies to cope, including walking, spending time in green spaces, and staying connected with others. Some people reported resorting to potentially harmful ways of coping, including increased alcohol consumption (19%), substance misuse, and over-eating (36%), putting their mental and physical health at greater risk.

## Use and outcomes of local mental health services

The rate of referral to Talking Therapies (IAPT) across BHR boroughs is similar to the national average, which is a marked improvement compared to that described in the 2019 JSNA, when this was about half the national average. However, there are disparities across the borough, with lowest referral rates in B&D. The rate of people who achieved a reliable improvement is also similar to the national average, which again is an improvement.

The proportion of people in contact with adult mental health services in all 3 BHR boroughs is below the national average – in Q2 2019/20, 10,230 patients in BHR were in contact with services.

Rates of mental health admissions to hospital across BHR are lower than the national average. In total, there were 135 mental health hospital admissions in 2019/20.

The rate of people subject to the Mental Health Act in Q2 2019/20 was lower in Havering compared to England; rates in Redbridge and Barking & Dagenham were similar. In total 240 people were subject to the Mental Health Act across BHR during the quarter. It is unknown how many are repeat episodes.

The proportion of patients in concurrent contact with mental health services for substance misuse in Barking & Dagenham is similar to the national average but much lower in Havering and Redbridge.

The percentage of people in contact with mental health services with a diagnosis or provisional diagnosis recorded during Q2 2019/2020 was far below the averages for London (21.9%) and England (30%); Barking & Dagenham 8.9%, Havering 8.6%,

[139] UCL *Covid-19 Social Sudy*
[140] The Mental Health Foundation (2021) *Coronavirus: Mental Health in the Pandemic*

Redbridge 7.3%. There is some disparity between expected levels of mental health disorders and levels known to health services, particularly in Barking & Dagenham. This may reflect a reticence on the part of local residents to seek help and / or the need for a more systematic approach to the identification of people with mental health problems.

Issues with mental wellbeing are an almost universal experience at some point in life. Self-help information and aids have been brought together by the NHS under the 'Every Mind Matters' banner, providing useful advice about how to cope with low level mental health issues.

***Recommendation 65:*** *Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.*

***Recommendation 66****: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience, including by making use of 'Every Mind Matters' resources and self-help aids; giving particular consideration to groups who appear less likely to seek help such as LGBTIQ+ and ethnic minority residents, and older people.*

Poverty, unemployment, homelessness, relationship breakdown etc. predispose to mental health problems. With additional training, public facing staff in a wide range of services and in the community can encourage people experiencing disadvantage and personal problems to seek help, as well as identify and intervene where there is risk of suicide.

***Recommendation 67****: Promote the Making Every Contact Counts (MECC) approach by providing training to front facing staff across the wider partnership to promote awareness of mental health issues including stigma, suicide prevention and the benefits of Talking Therapies.*

Talking Therapies (IAPT) are an effective means of helping the thousands of people living with common mental health services.

***Recommendation 68****: Improve understanding of public perceptions of Talking Therapies and barriers to access and use the insight gained to improve how IAPT is promoted and delivered to maximise participation and successful completion.*

At any one time, only a small proportion of people with common mental health problems are under the care of specialist mental health services. General practice cares for the majority of patients with common mental health problems. GPs also care for groups known to be at higher risk of mental health problems such as LGBTIQ+ people, older people, people with LTCs and people with learning disabilities.

***Recommendation 69**: Continue to develop the capacity and capability of primary care to manage patients with common mental disorders and integrate consideration of mental health into the management of other care groups known to be at high risk of mental health problems.*

Care and support of people with mental health issues requires a joined up approach across the NHS, Councils (social care and housing), other statutory agencies such as DWP, and community and voluntary groups. Support to access services and strengthen social networks can benefit people with or at risk of mental illness. Local area coordination, social prescribers and health champions can assist with this.

***Recommendation 70**: Develop partnerships between primary care, specialist mental health services, other statutory services and the VCS at locality level to provide holistic support addressing the wider determinants as well as health and social care needs of people with mental health problems. An effective social prescribing function will assist patients to engage with relevant support.*

People with co-occurring substance misuse and mental health conditions have a heightened risk of other health problems and early death but are often excluded from services.[141] People in the criminal justice system and the street homeless have particularly complex social issues and are at high risk of both substance misuse and mental health problems. Effective care requires specialist input for both problems. Concurrent contact with mental health services for drug and alcohol misuse is much lower in Redbridge and Havering, compared to England.

***Recommendation 71:** Improve and increase joint working between mental health services and drug and alcohol services to improve outcomes for patients with co-occurring substance/alcohol misuse and mental health conditions.*

***Recommendation 72:** Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.*

***Recommendation 73:** Review arrangements for those in contact with the criminal justice system, including ex-prisoners and their access to mental health services, and mental health service provision for offenders served with community orders, particularly for those subject to Alcohol Treatment Orders and Drug Rehabilitation Requirements*

Following changes in national policy, this JSNA has discontinued indicators reporting the Care Programme approach that were previously used to describe quality outcomes for service users. They werereplaced with indicators describing 72-hour follow up for all adult patients discharged from inpatient care, as per NHSE and NHSI recommendations.[142] Patients followed up within 72 hours of discharge from

[141] PHE (2017) *Better care for people with co-occurring mental health and alcohol/drug use conditions*
[142] NHS England and NHS Improvement (2021) *position statement*

adult acute beds in Barking & Dagenham (80%) and Havering (87%) is higher than the national average (77%), but lower in Redbridge (70%). In the 6 month period to March 2021, 95 patients were not followed up within 72 hours across BHR. The national standard is 80%, with the evidence base showing that there is an increased risk of patients dying by suicide on days 2-3 following discharge from inpatient services.[143]

***Recommendation 74:*** *MH services should audit re-admissions to identify the underlying causes of re-admission and whether improvements could be made as part of planned discharge, and ongoing treatment and support (including support from local authority housing teams).*

Rates of employment for people with severe mental illness (SMI) are lower than for any other group of health conditions. The benefits of being in employment include an income and a greater sense of purpose and wellbeing, while for the health system there is an overall reduction in the use of primary and secondary mental health services, leading to improved efficiency and savings[144].

***Recommendation 75:*** *Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.*

The BHR system has relatively few inpatient mental health beds in comparison with other London areas. As reported in the 2019 JSNA, patients requiring admission had to be placed out of area. Further work is needed to understand whether the care provided to those in crisis is sufficient, given the size and complexity of the population now served and the prospect of further population growth. A 2019 audit of patients occupying inpatient beds has indicated that around a quarter were not previously known to mental health services.

***Recommendation 76:*** *Review the management of patients in crisis ensuring there is adequate place of safety provision given population growth and increasing complexity of needs. Investigate where interventions might have previously prevented escalation to crisis and use the lessons learned to improve mental healthcare.*

The reasons for the mortality gap between people with SMI and the population as a whole are complex. One of the more obvious contributory factors is the very high prevalence of smoking for people with SMI. New approaches to assist people with SMI to adopt healthier lifestyles are needed to maximise the benefits of annual health checks for people with SMI.

[143] https://mentalhealthwatch.rcpsych.ac.uk/indicators/proportion-of-patients-discharged-from-adult-acute-beds-followed-up-within-72-hours

[144] https://www.england.nhs.uk/mental-health/case-studies/severe-mental-illness-smi-case-studies/individual-placement-and-support-offers-route-to-employment-for-people-with-severe-mental-health-conditions/

***Recommendation 77:*** *Improve the management of physical health of patients with SMI; ensure all get an annual health check and, through joining up initiatives across the system, improve effectiveness of support available to assist with lifestyle change, starting with smoking.*

**Preventing Suicide**

Whilst rates of suicide across BHR are lower than the national rate, it remains the case that many suicides are preventable. The risks of suicide are increased when an individual has been previously bereaved by a suicide, has a history of self-harm, or a history of mental ill health, especially if there is co-existing substance misuse.

Despite concerns about a rise in suicide during the pandemic, early indications from real time suicide surveillance systems have not shown a significant increase in suicides when comparing pre and post lockdown periods. However these are provisional figures and further monitoring is essential. Periods of financial recession are known to impact suicide rates, which is a concern in the event of an economic downturn or increases in the costs of living, and the subsequent impact on employment and financial stressors such as unmanageable debt[145].

Outside of the pandemic, rates of suicide and self-harm in under 24 year olds in England have been steadily increasing over the last decade.[146] It is suggested that around half of people who die by suicide have previously self-harmed. Reported rates of self-harm across BHR are lower than England, with 460 people admitted to hospital for intentional self-harm. However, the majority of self-harm is known to occur in the community and does not lead to hospital attendance.[147]

***Recommendation 78:*** *Ensure there are comprehensive strategies/plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.*

***Recommendation 79:*** *Monitor suicides in real time to identify trends and use the insight to inform preventative action as needed.*

[145] HM Government (2021) *Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives*
[146] ONS (2021) *Suicides in England and Wales*
[147] ONS (2021) *Suicides in England and Wales*

## 6.4 Cancer

**Indicators and data used in this section can be accessed by clicking here*

### Cancer incidence and prevalence

Cancer is the cause of enormous harm to health – accounting for 26 % of all years of life lost across BHR[148]. 1 in 2 people will be diagnosed with cancer in their lifetime. Adjusting for differences in age structure; the incidence of all cancers in Barking & Dagenham and Havering is similar to the national average; the incidence of cancers in Redbridge is significantly lower (better) than the national average.

Overall, more than 3,500 people in BHR are diagnosed with cancer each year (Fig. 40).

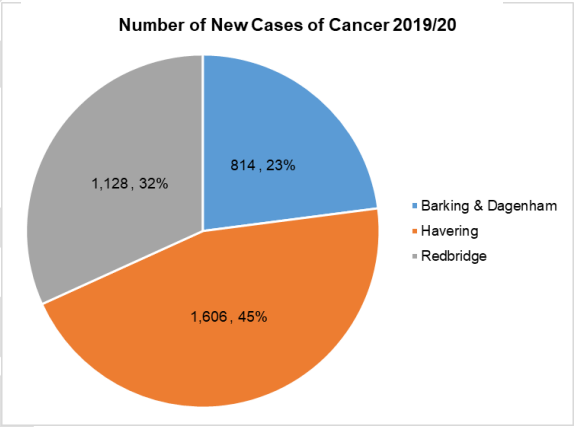
**Cancer Lifetime Risk**


Source: Cancer Research UK

More than half of new cases are cancer of the breast, prostate, lung or bowel.

The incidence of cancer increases steeply with age, peaking in the 85 to 89 age group (Fig. 41). As a result, Havering, with its older population has a higher number of cases than other BHR boroughs. The number of cancer cases in all three boroughs will increase as the population grow and ages.

**Figure 40. New Cases of Cancer across BHR 2019-20**



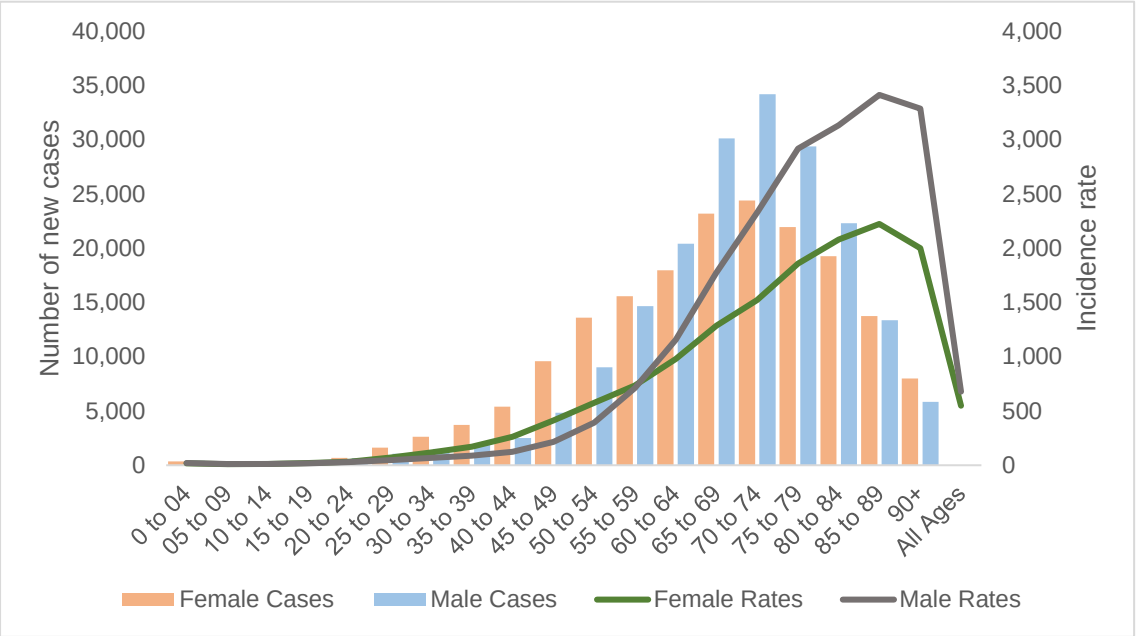

More than 16,000 people locally are living with and beyond cancer (prevalence), almost half are resident in Havering. The number of people living with cancer will increase in line with increases in incidence and as survival continues to improve[149].

According to Cancer Research UK Incidence rates are strongly related to age for all cancers combined, with the highest incidence rates being in older people. In the UK in 2016-2018, on average each year more than a third (36%) of new cases were in people aged 75 and over.

[148] http://www.healthdata.org/gbd

[149] https://public.tableau.com/profile/transforming.cancer.services.for.london#!/vizhome/LondonCancerPrevalenceDashboard2017/PrevalenceDashboard

**Figure 41 : Average Number of New Cases Per Year and Age-Specific Incidence Rates per 100,000 Population, UK**




Source: Cancer Research UK

There is significant scope to reduce the burden of disease as around 4 in 10 cases are preventable.

**Lifestyle factors to prevent cancer**

Smoking remains the largest preventable cause responsible for 15% of cases followed by excess weight[150].

NB. Action to tackle lifestyle related risk factors are discussed in section 4.

**Preventable cases**


Source: Cancer Research UK

Vaccination against the Human Papilloma Virus (HPV) greatly reduces the risk of developing cervical cancer in later life. In 2020-21, coverage in BHR boroughs outperformed the national average (Table 14). Nonetheless, more than 800 girls aged 13-14 yearsin the three boroughs were not protected.

**Table 14: Population Vaccination Coverage – HPV Vaccination Coverage (for one dose)**

| AREA | 12-13 FEMALE | 13-14 FEMALE** | 12-13 MALE |
|---|---|---|---|
| **LBBD** | 88.4% | 83.5% | 84.9% |
| **LBH** | 91.9% | 86.7% | 85.6% |
| **LBR** | 87.5% | 79.2% | 83.9% |
| **ENGLAND** | 76.7% | 60.6% | 71.0% |

Source: PHE Fingertips 2020-21

** Two doses

[150] Brown KF, Rumgay H, Dunlop C, et al. The fraction of cancer attributable to known risk factors in England, Wales, Scotland, Northern Ireland, and the UK overall in 2015. BJ of Cancer 2018

***Recommendation 80:*** *Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.*

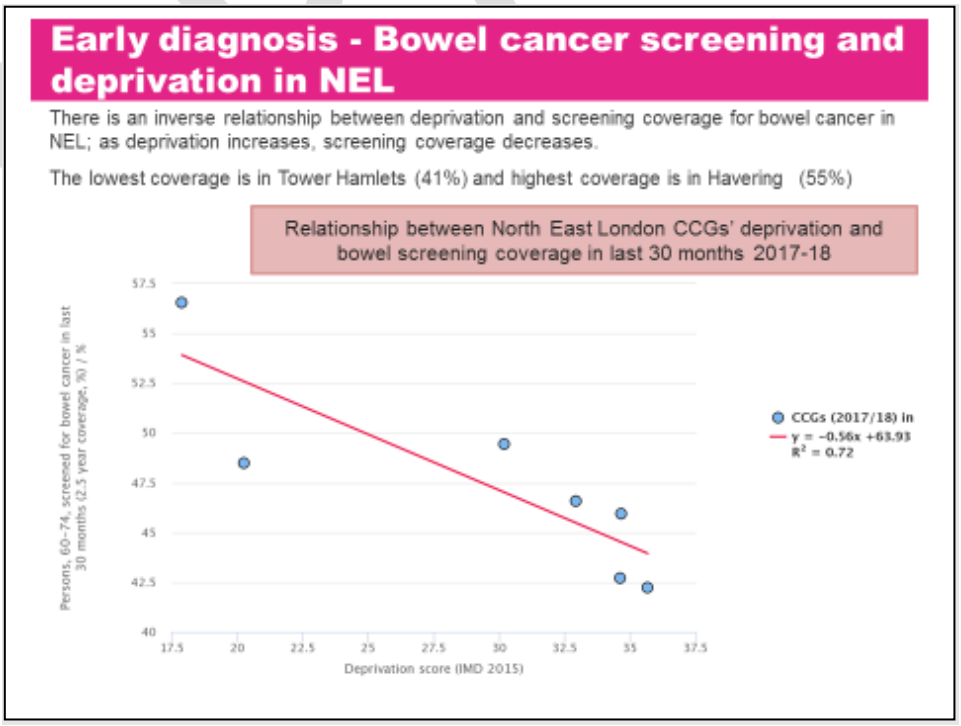
**Surviving cancer**

Survival varies significantly depending on site of the cancer. For example, and with regard to the common cancers, survival varies from more than 95% at 1 year for breast cancer to about 30% for lung cancer[151]. In all cases, 1-year survival is significantly better when cancer is diagnosed early.

One year survival has increased steadily in all three BHR boroughs, e.g. for Barking & Dagenham residents, from 54.2% in 2002 to 69.7% in 2017. However, survival in all BHR boroughs has consistently lagged behind the national average – now 73.3%, particularly in Barking & Dagenham at 69.7%.

For some cancers, screening offers a means of identifying cancers before any signs of disease are evident, increasing the likelihood of successful treatment. Screening coverage for the three national screening programmes (bowel, breast and cervical) is lower than England in Barking & Dagenham and Redbridge. Coverage for breast and cervical screening is higher in Havering than the national average but coverage of bowel screening is significantly lower. There is a strong correlation between levels of disadvantage and screening coverage uptake (Fig. 42). Hence, coverage in Havering is higher than that achieved in any other borough in NEL for all three screening programmes[152].

**Figure 42. Relationship between early cancer diagnosis and deprivation in NEL**




Source: Healthy London - Inequalities Toolkit

[151] https://www.cancerresearchuk.org/health-professional/cancer-statistics/survival

[152] https://www.healthylondon.org/resource/cancer-inequalities-toolkit/north-central-london-snapshot/

**Cancer screening programmes and early diagnosis**

Irrespective of the precise uptake, many hundreds of eligible BHR residents do not participate in cancer screening programmes each year (Table 15). Coverage is expected to have dropped further during the pandemic.

**Table 15: Cancer screening coverage 2021**

| | CERVICAL (25-49) | CERVICAL (50-64) | BREAST | BOWEL |
|---|---|---|---|---|
| **LBBD** | 65.0% | 71.2% | 54.5% | 54.3% |
| **LBH** | 71.4% | 76.3% | 75.9% | 66.5% |
| **LBR** | 58.6% | 72.5% | 61.7% | 59.0% |
| **LONDON** | 59.1% | 70.9% | 55.2% | 59.3% |
| **ENGLAND** | 68.0% | 74.7% | 64.1% | 65.2% |

Source: NHS Digital via PHE Fingertips.

The national cancer screening programmes were the subject of a review[153] by Prof Sir Mike Richards who recommended fundamental change in terms of accountability for screening programmes which are currently split between multiple organisations. The changes recommended included: improvements in IT to facilitate better call and recall; more rapid adoption of improved screening methods; and approaches that better fit with peoples' busy lives, including improved access to cervical screening appointments. In addition, proactive outreach is required to engage some population groups e.g. residents who are not registered with a GP. Otherwise screening programmes are likely to increase health inequalities.

***Recommendation 81**: Continue to work to increase uptake of: cervical screening by offering extended hours in general practice; bowel screening with the roll out of FIT[154] testing for diagnosing colorectal cancer; and breast screening*

**Recommendation 82**: *Undertake a deep dive/equity audit to understand which populations are not taking up screening and support a programme of community engagement working with those identified as less likely to participate in screening programmes to increase uptake.*

In addition to the established national cancer screening programmes, BHR CCGs are a pilot site for the SUMMIT Study, run by University College London Hospitals NHS Foundation Trust (UCLH) and UCL (University College London). The study aims to recruit 25,000 people aged 50-77 in north and east London, who are at higher risk of lung cancer, to take part in early screening. If a patient is eligible, they will be invited to have a low dose CT scan and provide a blood sample which will support the development of a blood test by GRAIL (a U.S. healthcare company focused on the early detection of cancer) to detect multiple types of deadly cancers, including in the lung.

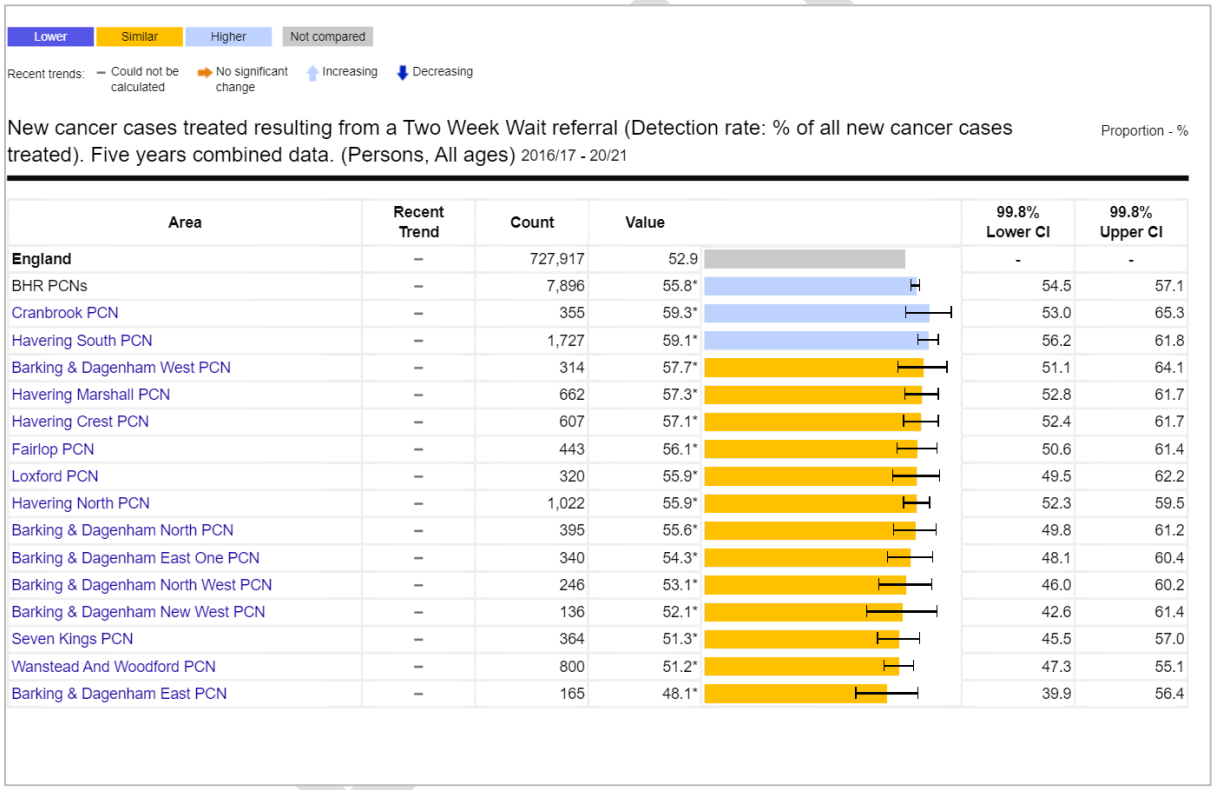
[153] https://www.england.nhs.uk/wp-content/uploads/2019/02/report-of-the-independent-review-of-adult-screening-programme-in-england.pdf

[154] https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/faecal-immunochemical-test-fit#FIT2

Where no screening programme exists, early diagnosis relies on people being aware of the risk and seeking help when they notice changes to their body and thereafter, their GP promptly referring patients with suspicious signs and symptoms for relevant investigations. However, referring without adequate cause can result in unnecessary anxiety to patients and overburden finite diagnostic capacity so that the investigation of patients with more concerning symptoms is delayed.

There is significant variation among general practices in Barking & Dagenham, Havering and Redbridge regarding the rate of two week wait referrals made (where cancer is suspected) and the proportion that subsequently result in a diagnosis of cancer (Fig. 43).

**Figure 43: Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals). Five years combined data.**

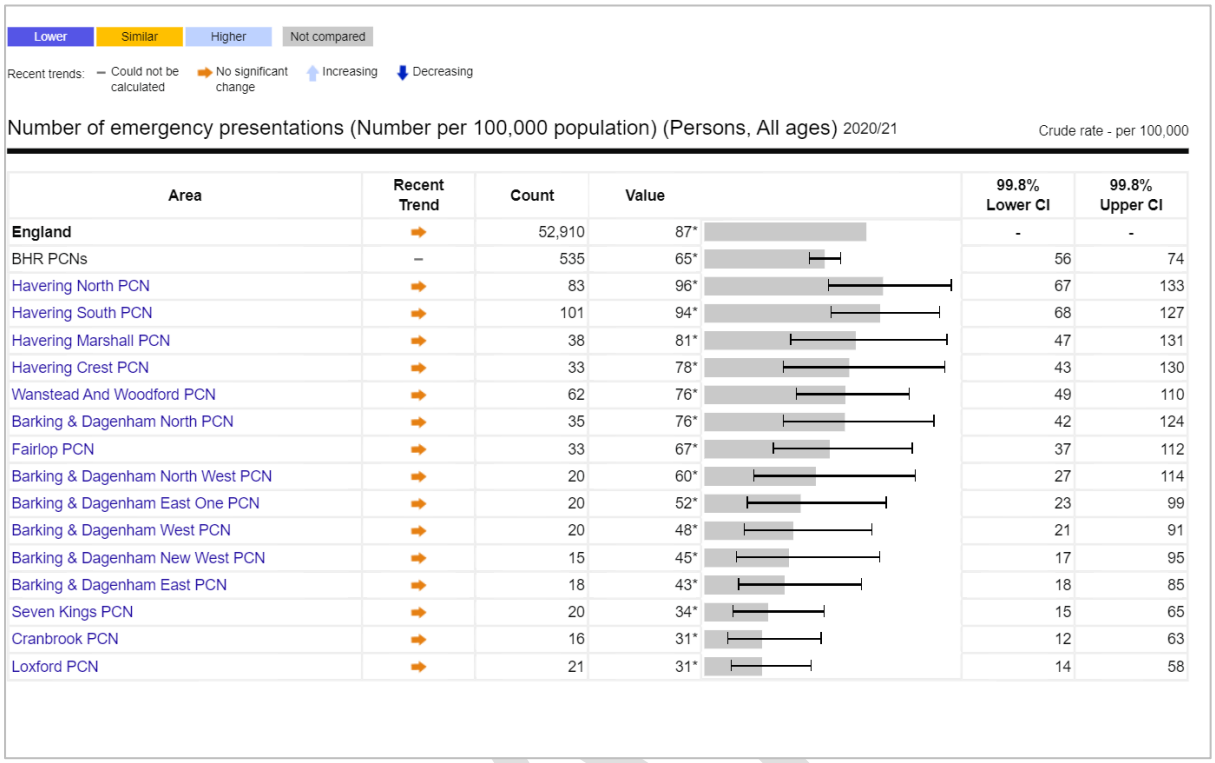



| Area | Recent Trend | Count | Value | 99.8% Lower CI | 99.8% Upper CI |
|---|---|---|---|---|---|
| England | – | 727,917 | 52.9 | - | - |
| BHR PCNs | – | 7,896 | 55.8* | 54.5 | 57.1 |
| Cranbrook PCN | – | 355 | 59.3* | 53.0 | 65.3 |
| Havering South PCN | – | 1,727 | 59.1* | 56.2 | 61.8 |
| Barking & Dagenham West PCN | – | 314 | 57.7* | 51.1 | 64.1 |
| Havering Marshall PCN | – | 662 | 57.3* | 52.8 | 61.7 |
| Havering Crest PCN | – | 607 | 57.1* | 52.4 | 61.7 |
| Fairlop PCN | – | 443 | 56.1* | 50.6 | 61.4 |
| Loxford PCN | – | 320 | 55.9* | 49.5 | 62.2 |
| Havering North PCN | – | 1,022 | 55.9* | 52.3 | 59.5 |
| Barking & Dagenham North PCN | – | 395 | 55.6* | 49.8 | 61.2 |
| Barking & Dagenham East One PCN | – | 340 | 54.3* | 48.1 | 60.4 |
| Barking & Dagenham North West PCN | – | 246 | 53.1* | 46.0 | 60.2 |
| Barking & Dagenham New West PCN | – | 136 | 52.1* | 42.6 | 61.4 |
| Seven Kings PCN | – | 364 | 51.3* | 45.5 | 57.0 |
| Wanstead And Woodford PCN | – | 800 | 51.2* | 47.3 | 55.1 |
| Barking & Dagenham East PCN | – | 165 | 48.1* | 39.9 | 56.4 |

Source: PHE Fingertips

The diagnosis of cancer cases in A&E or following an emergency admission may indicate that the disease has already progressed to being an acute problem before it is identified. On average, cases identified as an emergency have a poorer prognosis than cases identified elsewhere. Just under 1 in 5 cases of cancer in BHR are first diagnosed following an emergency presentation (Fig. 44)..

**Figure 44: Number of emergency cancer presentations (Number per 100,000 population)**



Lower | Similar | Higher | Not compared

Recent trends: – Could not be calculated | No significant change | Increasing | Decreasing

Number of emergency presentations (Number per 100,000 population) (Persons, All ages) 2020/21 — Crude rate - per 100,000

| Area | Recent Trend | Count | Value | 99.8% Lower CI | 99.8% Upper CI |
|---|---|---|---|---|---|
| England | ➡ | 52,910 | 87* | - | - |
| BHR PCNs | – | 535 | 65* | 56 | 74 |
| Havering North PCN | ➡ | 83 | 96* | 67 | 133 |
| Havering South PCN | ➡ | 101 | 94* | 68 | 127 |
| Havering Marshall PCN | ➡ | 38 | 81* | 47 | 131 |
| Havering Crest PCN | ➡ | 33 | 78* | 43 | 130 |
| Wanstead And Woodford PCN | ➡ | 62 | 76* | 49 | 110 |
| Barking & Dagenham North PCN | ➡ | 35 | 76* | 42 | 124 |
| Fairlop PCN | ➡ | 33 | 67* | 37 | 112 |
| Barking & Dagenham North West PCN | ➡ | 20 | 60* | 27 | 114 |
| Barking & Dagenham East One PCN | ➡ | 20 | 52* | 23 | 99 |
| Barking & Dagenham West PCN | ➡ | 20 | 48* | 21 | 91 |
| Barking & Dagenham New West PCN | ➡ | 15 | 45* | 17 | 95 |
| Barking & Dagenham East PCN | ➡ | 18 | 43* | 18 | 85 |
| Seven Kings PCN | ➡ | 20 | 34* | 15 | 65 |
| Cranbrook PCN | ➡ | 16 | 31* | 12 | 63 |
| Loxford PCN | ➡ | 21 | 31* | 14 | 58 |

Source: PHE Fingertips

The percentage of cancers detected at stage 1 and 2 (early) in Havering is lower (worse) than other BHR boroughs and the current national average. The rate in all boroughs (about 50%) is a long way from the ambition stated in the NHS Long Term Plan that by 2028, the NHS will diagnose 75% of cancers at stage 1 or 2. It is still too early to tell the impact of Covid on late presentation. The latest available data is 2019, as shown on the dashboard (Appendix 8) but percentages are not reported due to issues with denominator.

***Recommendation 83:*** *To undertake an audit to assess the impact of Covid-19 on Cancer screening and service delivery including emergency presentations post-pandemic*

***Recommendation 84:*** *Continue efforts to raise awareness of signs and symptoms of cancer with the public and healthcare professionals.*

The timeliness of diagnosis and initiation of effective treatment are important measures of services quality. A variety of waiting time standards have been established to drive improvements in the delivery of cancer care.

Lack of capacity, both equipment and staff, remains the limiting factor slowing the improvement of cancer diagnosis and treatment. The NHS Long Term Plan commits to the roll-out of new Rapid Diagnostic Centres (RDCs) that will bring together modernised kit, expertise and cutting edge innovation to achieve earlier diagnosis,

with improved patient experience, for all patients with cancer symptoms or suspicious results. Separate to this investment in facilities; action will be needed to remedy shortages in key professions e.g. pathologists, radiologists, gastroenterologists (and other endoscopists).

***Recommendation 85:*** *Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)*[155]

***Recommendation 86****: Implement the national optimal cancer pathways*[156]*.*

More people than ever are living with and beyond cancer. In parallel with improvements in survival has come greater recognition that quality of life outcomes are just as important. Quality of life measurement is being introduced to improve understanding of the impact of cancer and its treatment and how well people are living after treatment. In addition, action is underway to provide personalised care and support – putting patients more in control of their recovery.

The personalised approach is also being applied to follow-up so that people can be reassured of effective ongoing cancer surveillance, but require fewer face-to-face appointments, with rapid access to support, advice and interventions with the most appropriate clinicians when needed.

Further work is underway to improve the provision of services to manage the consequences of treatment, which cause poor quality of life and are often under-recognised. These include psychological difficulties, fatigue, pain, or bowel, bladder and sexual problems.

***Recommendation 87:*** *Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways*[157] *for prostrate, breast and bowel cancer patients.*

***Recommendation 88:*** *Work towards a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long-Term Condition.*

NB. Continued collaboration with third sector partners is key and there are many large and well-established charities working in cancer – in particular Cancer Research UK which supports earlier diagnosis, and Macmillan Cancer Support provides support to people living with and beyond cancer.

[155] https://www.england.nhs.uk/cancer/early-diagnosis/
[156] http://uklcc.org.uk/wp-content/uploads/2019/10/01-UKLCC-Pathways-Matter-Report-Final.pdf
[157] https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf

## 6.5 Long Term Conditions

*Indicators and data used in this section can be accessed by clicking here*

### What are Long Term Conditions?

Long-term conditions, also known as chronic conditions, are those health conditions that require ongoing treatment or management over a period of years or decades. They may not be able to be cured or reversed but can be controlled with the use of medication and therapies (NHS England).

As described in *Section 3*, despite recent increases in life expectancy, most of the additional years of life gained over recent decades are affected by ill health or disability. A significant proportion of this ill health is the result of long-term conditions (LTCs) and they contribute substantially to health inequalities by ethnicity and deprivation in England.

LTCs can affect almost every part of the body and often people may be dealing with more than one LTC at a time (Table 16). Many LTCs may cause few symptoms initially, whilst increasing the risk of serious acute events long-term, such as heart attack or strokes, which can lead to premature death or long-term disability. This may mean that people are less likely to seek help at an early stage of their condition and LTCs may remain undiagnosed and unmanaged.

**Table 16. Long term conditions**

| **Common Long-Term Conditions:** | |
|---|---|
| cardiovascular disease (CVD) | hypertension |
| heart failure | chronic kidney disease (CKD) |
| atrial fibrillation (AF) | diabetes |
| chronic obstructive pulmonary disease (COPD) | asthma |

Prevention and ensuring early detection, diagnosis and treatment of LTCs are equally important.

Many LTCs are associated with lifestyle related risk factors such as poor diet, smoking and low levels of physical activity. Some LTCs are also linked to environmental exposures e.g. the risk of chronic obstructive pulmonary disease (COPD) and asthma are increased by regular exposure to poor air quality. The prevalence of lifestyle and environmental risk factors tend to be higher in disadvantaged communities and are the immediate cause of significant inequalities evident regarding many LTCs.

Appropriate management of established LTCs through medication, lifestyle change and therapies can prevent crises, delay further progression and lead to significant improvements in quality of life. However, inequitable and/or culturally inappropriate models of providing effective interventions can further exacerbate health inequalities.

**Who is most at risk from long-term conditions?**

*Inequalities by age*

The risk of developing an LTC increases with age, with 62% of people over 60 years old reporting at least one LTC compared to only 24% of those under 40 years old nationally (*ONS Annual Population Survey*, ONS, 2019). As a result, forecasted increases in the number of older individuals in the population (see Section 1.3) are likely to lead to increases in the number of individuals with LTCs in the absence of more effective prevention.

*Inequalities by ethnicity*

There are substantial inequalities in the prevalence of LTCs by ethnicity. South Asian groups, in particular Bangladeshi and Pakistani groups, and Black African groups are at higher risk of developing many LTCs and experiencing worse outcomes in comparison to White groups (*Local Action on Health Inequalities*, PHE, 2019).

*Inequalities by deprivation*

Deprivation is a key risk factor for LTCs. Over half of the gap in life expectancy between the most and least disadvantaged nationally is a result of premature death from preventable LTCs and cancers *(NHS Long-Term Plan, 2020).*

Nationally, on average, individuals living in more disadvantaged areas develop more than one LTC 10-15 years earlier than those in more affluent neighbourhoods, substantially affecting inequalities in quality of life (*NHS Long Term Plan*, NHS England, 2019). Type 2 diabetes is 60% more common among individuals in the most deprived quintile compared with those in the least deprived quintile in England.

Premature death rates from cardiovascular disease (CVD) in the most deprived 10% of the population are almost twice as high as rates in the least deprived 10%. Much of this disparity results from higher rates of preventable risk factors, such as smoking and poor diet, representing an opportunity for effective prevention to reduce health inequalities.

*Impact of lifestyle and environmental factors*

The risk of developing most LTCs is partly, if not largely determined by modifiable factors. An estimated 50-80% of CVD results from modifiable or preventable factors such as smoking, obesity, poor diet, harmful drinking and low levels of physical activity. This represents an important opportunity for effective prevention at an individual level to have a substantial impact on the prevalence of LTCs.

There are also important environmental exposures that increase the risk of LTCs. These include exposure to air pollution and environments that do not support physical activity and healthy eating (for example, lack of access to green space and over density of fast-food takeaways). Many of these environmental exposures are greatest in areas of high deprivation and make a substantial contribution to health inequalities. Local authorities and other partners in BHR have a key role in addressing these wider determinants of health to prevent LTCs.

## What is being done to support those with Long Term Conditions?

**Primary prevention of Long-Term Conditions**
Primary prevention aims to prevent people developing disease in the first place. Due to the strong link between modifiable lifestyle factors (such as alcohol, smoking and obesity) and long-term conditions; effective, culturally sensitive primary prevention, that reflects the distribution of risk factors within the community can reduce the overall burden of long-term conditions and narrow health inequalities.

### NHS Health Checks

NHS Health Checks[158] are an opportunity to identify people with, or at high risk of, CVD and related conditions including diabetes, hypertension and Chronic Kidney Disease (CKD). A Health Check should be offered once every 5 years to everyone aged 40-74 years who does not have a pre-existing LTC. Public Health England estimated that for every 6 to 10 NHS Health Checks completed, one person is identified as being at high risk of CVD. Health checks also provide an opportunity to encourage people to tackle lifestyle related risk factors before they cause ill health and connect them with sources of support that might assist them to achieve change.

A significant proportion of eligible patients are not offered or do not attend their NHS Health Check. Currently, only Barking and Dagenham are achieving above the London average of 49.9% of eligible individuals receiving an NHS Health Check (Table 17). In addition to having the lowest overall health check attendance, Havering also has the most inequitable uptake, with a gap of 7.7 percentage points between the least and most deprived quintiles (Fig. 45).

As stated previously, non-White groups are at greater risk of preventable LTCs. Therefore, and notwithstanding the need to increase uptake in all groups, it is encouraging that, in the period 2012/13-2017/18, Asian groups recorded the highest percentage attendance in all three boroughs, followed by Black groups and White groups (Fig. 46).

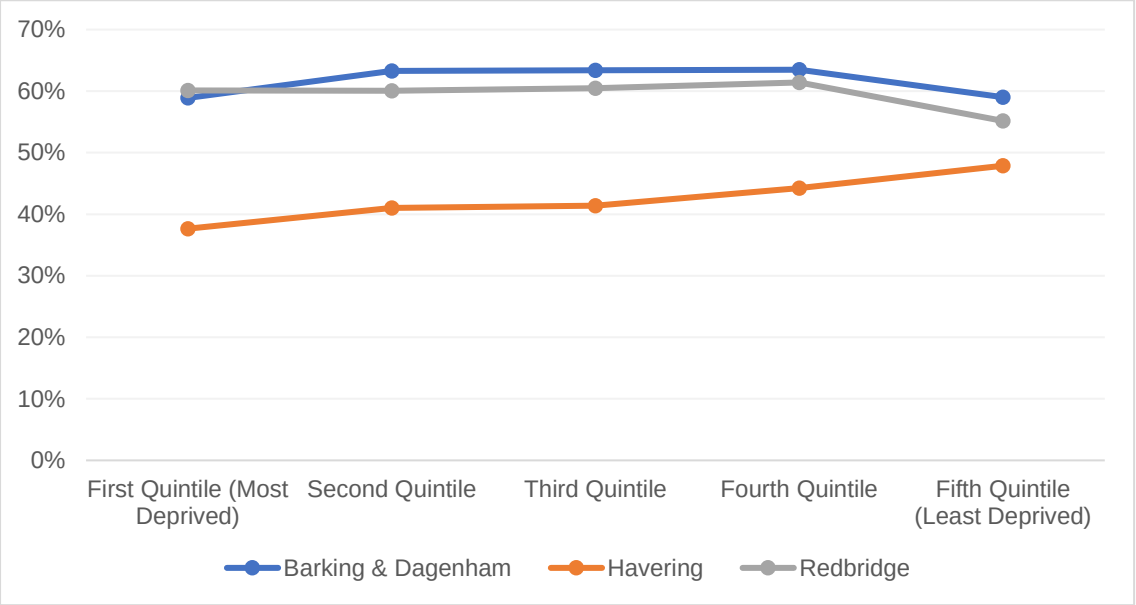
**Table 17: Proportion of eligible individuals invited and receiving an NHS Health Check Q1 2016/17 –2020/21 in Barking & Dagenham, Havering and Redbridge**

| | **LBBD** *(%)* | **LBH** *(%)* | **LBR** *(%)* | **London***(%)* | **England** *(%)* |
|---|---|---|---|---|---|
| % of eligible individuals invited for an NHS Health Check | 85.4 | 71.9 | 82.1 | 73.4 | 71.8 |
| % of eligible individuals receiving an NHS Health Check | 53.4 | 38.0 | 49.1 | 49.9 | 46.5 |

= below London avg., = similar to London avg., = above London Avg.
Source: OHID Fingertips

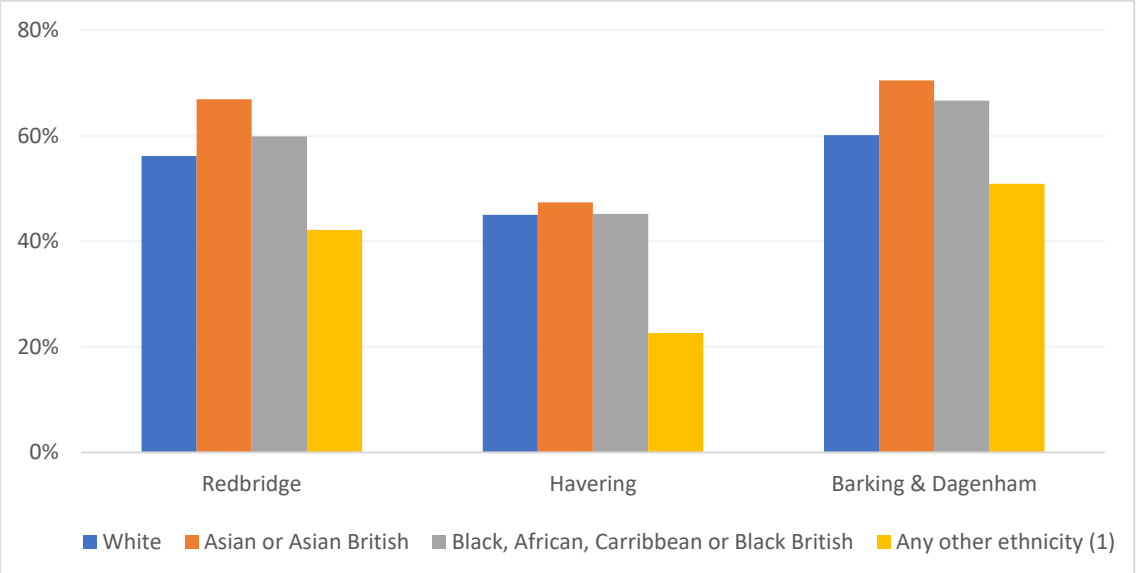
[158] https://www.healthcheck.nhs.uk/

**Figure 45: Proportion of individuals attending an NHS Health Check after receiving an invitation by deprivation quintiles within each local authority for the period 2012/13-2017/18.**




Source: NHS Digital, Health Check Dashboard

**Figure 46: Proportion of individuals attending an NHS Health Check after receiving an invitation within each ethnic group and by local authority from 2012/13-2017/18**




*(1) "Any other ethnicity" includes those of mixed ethnicity, any other ethnic group and those without recorded ethnicity data)*

***Recommendation 89**: BHR should review the care pathway and provision of support for patients found to be at high risk of LTCs following an NHS Health Check (or other identification route) to ensure that:-*

*- behaviour change support is effective, high quality and in line with best practice guidelines. This should include reviewing whether support is culturally appropriate for each borough's communities, with a focus on contributing to reductions in health inequalities by ethnicity and deprivation*

*- treatment is likewise effective, high quality and in line with best practice guidelines.*

***Recommendation 90:** Each BHR borough should review the current service delivery model and approach to increasing the offer and uptake of NHS health checks and develop a robust action plan for improvements in uptake, particularly among those at greatest risk of poor health. Key opportunities to explore should include the accessibility of Health Checks appointments by time and geography, the role of PCNs and exploring the potential for delivery of workplace-based programmes.*

***Recommendation 91:** To review the processes for analysis and reporting of key local data on preventative interventions to support local Public Health teams in improving delivery. This should include both the Health Check and National Diabetes Prevention programmes. There should be a focus on improving the granularity of data, both by geography (in particular by Primary Care Networks) and inequalities by ethnicity, deprivation and age, as well as regular reporting of data on invitation, uptake and outcomes.*

**Secondary prevention of Long-Term Conditions**

Secondary prevention aims to reduce or reverse the negative impacts of LTCs**.** The effects of many LTCs, such as diabetes, may be reversed or prevented through effective secondary prevention and so lead to substantial improvements in quality of life.

For most LTCs there is a significant difference between the proportion of the population expected to have the disease and the number actually diagnosed; as a result many thousands of residents are unaware they have an LTC. Moreover, of those that do have a diagnosis, many do not receive all the treatments that would benefit them.

**Healthier You: NHS Diabetes Prevention Programme (NDPP)**

The NDPP is based on a strong evidence base that shows supporting people to maintain a healthy weight and be more active, can significantly reduce the risk of developing Type 2 diabetes. Individuals aged 18 years or over at high risk of progressing to Type 2 Diabetes (known as non-diabetic hyperglycaemia) are eligible for referral to the NDPP.

The intervention consists of a series of predominantly group-based sessions delivered in person across a period of at least nine months. There are at least 13 sessions, lasting between one and two hours, and at least 16 hours of contact time. Each session covers topics geared towards the NDPP's main goals of weight reduction and improved glycaemic control through dietary improvements, and increased physical activity and reduction in sedentary behaviour. They are underpinned by behavioural theory and involve the use of behavioural techniques. Sessions are offered in the community at various sites within BHR. In addition, a digital stream offers an alternative service to face-to-face programmes making use of technologies, including wearables and apps.

The NDPP was offered in BHR relatively late and there is a considerable way to go in terms of increasing participation and completion if the potential benefits are to be realised. The harm to residents is very great. Locally, diabetes is responsible for 1.6% of all Years of Life Lost, 4.4% of Years Lived with Disability and 3.1% of all Disability Adjusted Life Years. Nationally, about 9% of the total NHS budget is spent on the treatment of diabetes and the complications arising.

**Years of Life Lost (YLL);** YLL estimates the number of years of potential life lost due to premature deaths from a condition, based on the average life expectancy of a population.

**Years Lived with Disability (YLD);** YLD estimates the number of years lived with a disability resulting from a condition.

**Disability Adjusted Life Years (DALY);** DALYs measure the impact of a condition on both mortality and morbidity. DALYs are calculated through combining the Years of Life Lost (YLL) and Years Lived with Disability (YLD) measures for a condition. One DALY is equivalent to the loss of one year of healthy life.

***Recommendation 92:*** *BHR should review the local approach to maximising participation in the National Diabetes Prevention Programme and develop an action plan for improved uptake and outcomes. This should include actions to ensure that the NDPP is culturally appropriate for the different communities of BHR to reduce inequalities by ethnicity and deprivation.*

**Care and Support for those with diabetes**

Of the 49,000 people in BHR known to have diabetes, only two-thirds in Barking & Dagenham receive all eight care processes that comprise effective care, falling to less than half in Havering and Redbridge (PHE *Fingertips*).

***Recommendation 93:*** *BHR should review and amend where necessary the current approach to the delivery and monitoring of diabetes care to ensure that all effective care is consistently provided.*

Moreover, around 1 in 6 of BHR residents (n=10,000) expected to have diabetes remain undiagnosed and hence untreated.

***Recommendation 94**: BHR should explore opportunities to expand the target populations for NHS Health Checks and the NDPP beyond the statutory minimum (currently 40-74 years for Health Checks and 35+ for the NDPP) to increase the proportion of people with diabetes that are diagnosed and can be offered effective prevention. In addition, BHR should develop actions to increase uptake by under-served populations (such as homeless residents).*

**Tertiary prevention for long term conditions**

Tertiary prevention for LTCs refers to efforts to reduce the negative impacts on health and quality of life for those with LTCs and prevent further complications. This is particularly challenging as individuals may have more than one LTCs affecting their lives. Key actions are likely to include supporting people to remain independent and manage their conditions to prevent avoidable negative outcomes such as unplanned hospital admissions.

Effective tertiary prevention can ensure those individuals with one or more LTCs are able to live as long and happy a life as possible and requires close working across many different health and social care organisations.

Of a sample of individuals with LTCs surveyed locally, less than 50% in all three boroughs report that they received all or some of the support they needed, below the national average of 54.9% (Table 18).

One method for assessing the effectiveness of care for those with LTCs is by looking at rates of preventable deaths and surgical procedures locally. With effective tertiary prevention in place, these deaths and procedures should be prevented. From 2017-2019, both Havering and Barking and Dagenham reported a mortality rate from preventable respiratory conditions for those under 75 years above the national and London averages, representing preventable deaths in part from LTCs. From 2016/17-2018/19 all three boroughs also reported a rate of avoidable major lower limb amputations resulting from diabetes above that of the national average (Table 18).

***Recommendation 95:** BHR should review current levels of preventable mortality and surgical procedures linked to LTCs, to understand in detail differences across the three boroughs. A robust action plan should be developed to reduce preventable mortality and procedures.*

DRAFT

**Table 18– summary data on avoidable negative health outcomes for individuals with LTCs (taken from Appendix 9: Long Term Conditions dashboard)**

| Indicator | Period | Count | Havering | Barking & Dagenham | Redbridge | London average | England average |
|---|---|---|---|---|---|---|---|
| Percentage of individuals with LTCs reporting that they have received all or some of the support they need | 2019/ 2020 | 798 | 46.5% | 49.1% | 46.8% | 52.1% | 54.9% |
| Under 75 mortality rate from respiratory conditions considered to be preventable (rate per 100,000) | 2017-2019 | 128 | 20.2 | 38.2 | 11.8 | 17.3 | 20.0 |
| Major Diabetic lower-limb amputation procedures (rate per 10,000) | 2016/17 - 2018/19 | 40 | 9.2 | 10.7 | 13.3 | N/A | 8.2 |

= better than England avg; = similar to England avg; = worse than England avg

Source: PHE Fingertips

### Multiple Long-term conditions

An increasing proportion of people are affected by more than one LTC at a time, also known as "multi-morbidity". Due to the added complexity of managing multiple conditions, multi-morbidity has been identified as one of the greatest challenges facing the NHS and social care and has been highlighted in the UK Government's Health and Care White Paper (UK Government, 2021).

More than one in four adults nationally live with two or more LTCs ("Multiple Long Term Conditions – making sense of the evidence" NIHR, 2021). A previous analysis by BHR CCGs in 2019/2020 identified nearly 24,000 patients with 2 LTCs, more than 12,000 with 4 LTCs and more than 400 with 6 LTCs.

Due to the challenge and complexity of managing multiple conditions, individuals affected by multi-morbidity are also at substantially increased risk of poor mental health. One in three patients with multiple LTCs also experiences poor mental health, increasing the chances of individuals with multi-morbidity experiencing both poor physical and mental health outcomes.[159] Table 19 provides the most common range of LTCs experienced by those with six or more conditions as an example of the complexity of issues involved in delivering effective care for these individuals.

[159] "Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study", Salisbury, C. et al, *British Journal of General Practice* 2011; 61 (582): e12-e21. DOI: https://doi.org/10.3399/bjgp11X548929

**Table 19: Number of patients across BHR with different combinations of six LTCs concurrently**

| Combination of LTCs | Number of Patients |
|---|---|
| Asthma, CHD, CKD,COPD, diabetes, AF | 7 |
| Asthma, CHD, CKD,COPD, hypertension, AF | 46 |
| CHD, CKD, COPD, diabetes, hypertension, AF | 127 |
| Asthma, CHD, CKD, diabetes, hypertension, AF | 85 |
| Asthma, CHD, COPD, diabetes, hypertension, AF | 104 |
| Asthma, CKD, COPD, diabetes, hypertension, AF | 53 |

***Recommendation 96:*** *BHR should conduct a review of the current provision of prevention and care to those with multiple conditions and develop a robust action plan for improving local care pathways across all three boroughs to reduce levels of preventable ill health, morbidity and mortality.*

**Long COVID**

Most children, young people and adults who have had an acute COVID-19 infection recover and return to normal health. However, some patients can have symptoms that can last for weeks or even months after recovery from acute illness. Persistent symptoms following a COVID-19 infection is commonly termed 'long COVID' but has also been referred to as 'ongoing symptomatic COVID-19' and 'post-COVID-19 syndrome'[160].

The Office of National Statistics has estimated that 1.2 million people in private households (1.9% of the population) were experiencing self-reported long COVID as of 2nd October 2021[161]. The types and duration of long Covid symptoms vary widely, with the main symptoms being fatigue, shortness of breath, muscle ache and difficulty concentrating[162]. Most individuals with long COVID are able to self-manage their symptoms and will only need generalist assessment, support and rehabilitation.

[160] National Institute for Health and Care Excellence (2020) COVID-19 rapid guideline: managing the long-term effects of COVID-19 (NICE guideline 188). Available at: https://www.nice.org.uk/guidance/ng188

[161] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 4 November 2021. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/latest

[162] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 July 2021. Available at:

However, Greenhalgh et al, estimate that approximately 11% of patients with long COVID will need specialist assessment and management for specific long-term complications[163]. Emerging evidence suggests that these patients were previously hospitalised due to COVID-19, particularly those who were admitted to ICU. More information is needed to understand the emerging needs associated with long COVID. One study found that there were significantly more new diagnoses of respiratory disease, diabetes, major adverse cardiovascular event (MACE), chronic kidney disease and chronic liver disease following hospital admission due to acute COVID-19 infection[164].

Long COVID clinics have been set-up across England, including a clinic in BHRUT based at King George's Hospital[165]. The clinic hosts professionals who provide physical, cognitive and psychological assessments for those referred by their GP for suspected long COVID. The clinic is for those with ongoing symptomatic COVID-19 (4-12 weeks post confirmed or probable infection) or post-COVID syndrome (more than 12 weeks after confirmed or probable infection) and need a programme of physical and/or psychological therapy.

***Recommendation 97**: Consider commissioning of further services for those with long Covid, based on learning from newly commissioned services in BHRUT. These should include dedicated support services and self-management, for example mobile apps, community exercise programmes and peer support groups.*

***Recommendation 98**: Borough partnerships should work with primary care clinicians and directly with the public to raise awareness of long COVID, opportunities for self-care and appropriate referral for specialist assessment*

DRAFT

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1july2021

[163] 'Long Covid': evidence, recommendations and priority research questions. Available at: https://committees.parliament.uk/writtenevidence/12345/pdf/

[164] Ayoubkhani D, Khunti K, Nafilyan V, Maddox T, Humberstone B, Diamond I et al. Post-covid syndrome in individuals admitted to hospital with covid-19: retrospective cohort study *BMJ* 2021; 372 :n693 doi:10.1136/bmj.n693

[165] https://www.england.nhs.uk/2020/12/long-covid-patients-to-get-help-at-more-than-60-clinics/

## 6.6 Older People & Frailty

**Indicators and data used in this section can be accessed by clicking here*

### Life Expectancy and Healthy Life Expectancy

There are large numbers of older people in all three BHR boroughs and every locality. However, the population of Havering is relatively older such that nearly half of the 16,000 BHR residents aged 85 and above live in Havering (Fig. 47).

All things being equal, older people experience more ill health and have greater need for health and social care than other age groups, with the oldest residents having the greatest need. It follows that population ageing (see Section 1.3) will significantly increase the need for health and care services unless we do better in preventing ill-health.

This conclusion is very clearly illustrated by comparisons between life expectancy and healthy life expectancy at age 65.

The 'average' resident approaching retirement will live around 20 more years.

Life expectancy at age 65 for both men and women in Redbridge, and women in Havering is similar to the national average (18.7 years for men and 21.1 years for women) but is lower than the England average for men and women living in Barking & Dagenham and men in Havering. As is the case for the population as a whole, cancers and CVD are the big killers in old age, together with dementia.

However, average **healthy** life expectancy at age 65 is closer to 10 years for both men and women in all BHR boroughs, similar to the England average (10.5 yrs for men and 11.3 yrs for women). The conditions that cause the bulk of ill health for the population as a whole – mental illness, LTCs, MSK also contribute most to the burden of disease in old age – together with dementia.

A greater focus on the **prevention** of ill health throughout life is crucial if we are to improve healthy life expectancy and quality of life in later life and maintain the sustainability of health and care services as the population becomes progressively older.

Further opportunities to prevent ill health and slow progression and minimise crises where it does exist, occur in old age.

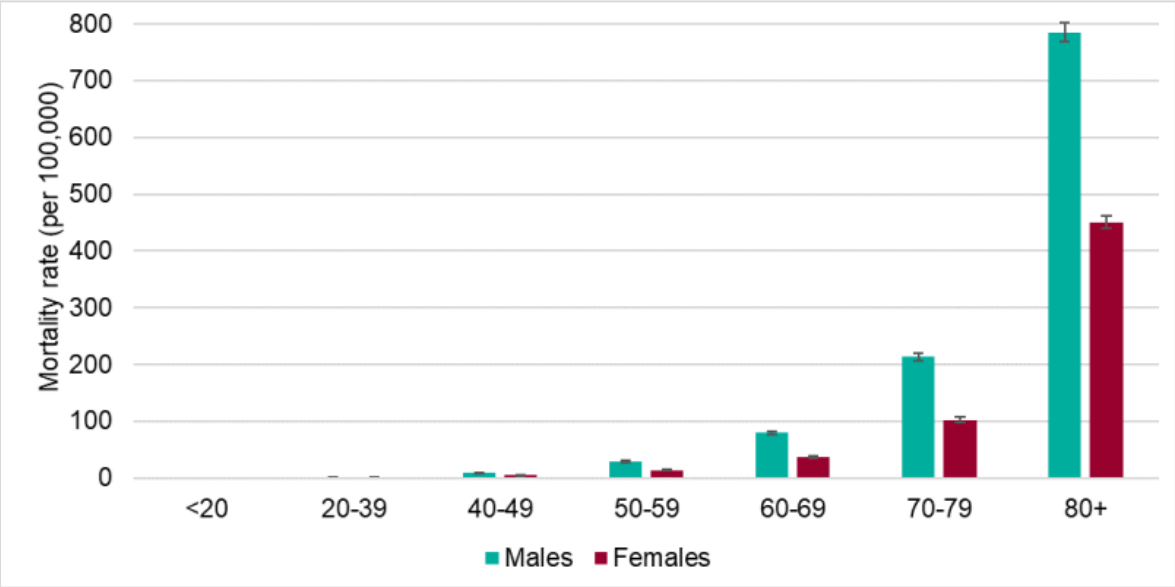
### Vaccinations to Prevent Excess Winter Death

As is the case nationally, death rates among BHR residents aged 85 and above are about 20% higher during the winter months. The bulk of **excess winter deaths** result from respiratory conditions, some linked to flu infection; dementia and CVD (heart disease and stroke)[166]. In addition, there have been significant excess deaths due to the Covid-19 pandemic.

[166] ONS Excess winter mortality in England and Wales: 2019 to 2020 (provisional) and 2018 to 2019 (final).

Much of the response to the **pandemic** was designed to protect older residents from harm pending production of an **effective vaccine** as the risk of severe disease and mortality increased steeply with increasing age (Fig. 47).

**Figure 47: Crude mortality rates COVID-19 deaths per 100,000 pop by age and sex May 2020**




Source: Public Health England

When vaccines were approved, the JCVI recommended roll out in order of descending age so that the most vulnerable were protected first. As immunity wanes over time, further booster doses have and will be required, and are likely to be incorporated into measures taken each year to reduce excess winter deaths and manage winter pressures on the health and social care system[167].

Pre-pandemic, there was strong evidence that **flu vaccination** reduced excess winter deaths among the elderly. The benefit of flu vaccination is likely to be greater still while coronavirus is circulating, as patients with SARS-CoV-2 and influenza virus co-infection are around twice as likely to die[168] as people with SARS-CoV-2 alone[169].

Flu vaccine coverage of patients aged 65 and older in 2020/21 was below the national average (80.9%) in all 3 BHR boroughs. However, uptake was an improvement on that seen pre-pandemic and the minimum national target of 75% was surpassed in Redbridge and Havering for the first time in more than 10 years[170]. Therefore, Covid booster vaccine and flu vaccine work synergistically to reduce illness and death among older people.

***Recommendation 99:*** *Build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu and covid vaccines.*

[167] https://www.bmj.com/content/373/bmj.n1137
[168] Odds ratio 2.27 (95% Confidence Interval 1.23 to 4.19)
[169] Stowe J, Tessier E, Zhao H, et al. Interactions between SARS-CoV-2 and influenza, and the impact of coinfection on disease severity: a test-negative design. Int J Epidemiol2021;50:1124-33. doi:10.1093/ije/dyab081. pmid:3394210
[170] Source: https://fingertips.phe.org.uk

***Recommendation 100:*** *Recognise heightened awareness of the benefits of vaccination amongst older age groups and (re-)check status regarding pneumococcal and zoster vaccines.*

**Wider determinants of wellbeing in older age**

PHE estimates that 1 in 10 excess winter deaths are directly attributable to fuel poverty[171]. More than 1 in 10 households in BHR are affected by **fuel poverty** ranging from 9% in Havering to 12.7% in Redbridge[172] *(see Section **3.5** re. fuel poverty).*

An early diagnosis of **dementia** can help people take control of their condition; plan for the future; potentially benefit from available treatments and make the best of their abilities. There is strong evidence that an early diagnosis helps someone with dementia to continue to live independently in his or her own home for longer[173]. In 2021, dementia diagnosis rate of Redbridge (63.5%) is the closest to the national target of 66%, whereas that of Havering and B&D trailed significantly at 53% and 58.9% respectively.

***Recommendation 101:*** *Maintain efforts to further increase the completeness of dementia diagnosis, and improve access to the information and support for patients and their families*

**Sudden confusion (delirium)** can have many causes. Infection e.g. a urinary tract infection is a common cause of confusion in elderly people and people with dementia. Confusion can also result from a variety of medical conditions, drug side effects and head injury. The cause of many cases of delirium can be treated and recurrence prevented. New onset confusion requires urgent investigation and the responsible clinician should talk to someone who knows the person well and knows what has happened to them recently.

UK based surveys show that people can feel **lonely** at any stage of life, but that the experience is most severe among older people. Social networks shrink with retirement and the associated reduction in income may limit social activities. Additional contributory factors for loneliness in old age include: the loss of a loved one (an estimated 35,000 BHR residents aged 65 and above live alone)[174]; health conditions that precipitate disability and loss of mobility; and caring responsibilities. Successful interventions to tackle social isolation reduce the burden on health and social care services; as such, they are typically cost-effective[175].

[171] Public Health England & UCL Institute of Health Equity (2014) Local action on health inequalities: Fuel poverty and cold home-related health problems.
[172] Source https://fingertips.phe.org.uk
[173] https://www.scie.org.uk/dementia/symptoms/diagnosis/early-diagnosis.asp
[174] Source poppi.org.uk
[175] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

***Recommendation 102:*** *Support efforts to tackle social isolation in general, but particularly amongst older residents, as part of wider efforts to improve the mental health of older people.*

There is a high prevalence of **mental health** issues in older people so Comprehensive Geriatric Assessment is not complete without addressing both mood and cognition. Care that looks at a 'whole person' and that is undertaken by a geriatric MDT is the gold standard approach so as not to miss either physical or mental health conditions. **Depression** often co-exists with physical illness or dementia. In addition, the health of an older person can also be adversely impacted by hazardous drinking of alcohol.[176]

The most common mental health condition in older people is depression, affecting 22% of men and 28% of women aged 65 or over, followed by anxiety.[177] 40% of older people who are living in care homes have depression; 30% of older carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience depression than older people who haven't been bereaved.[178]

Older people living with dementia may struggle to express how they are feeling which also increases the difficulty of diagnosis.[179] Dementia can also trigger mental health problems, with estimates suggesting that 20-40% of people living with dementia are depressed.[180]

It is important that older people are able to access services which are appropriate for their needs.[181] A target was set in 2011 to increase the proportion of older people referred to IAPT (Improving Access to Psychological Therapies) services to 12%. However, the proportion of users to the IAPT service who are over 65 has remained stable at or below 7%, despite this age group making up 18% of the population.[182]

***Recommendation 103:*** *Services should be designed so that older people's needs can be met, including mental health and dementia.*

[176] https://academic.oup.com/ageing/article/42/5/598/18032?login=true
[177] Health and Social Care Information Centre (2007). Health Survey for England, 2005: Health of Older People. [online] Available at: http://www.hscic.gov.uk/pubs/hse05olderpeople
[178] Independent Age (2018), Good grief: older people's experiences of bereavement, London: Independent Age. Available at: https://independent-age-assets.s3.eu-west-1.amazonaws.com/s3fs-public/2018-04/Good Grief report.pdf
[179] British Geriatric Society and Royal College of Psychiatrists (2019), Collaborative approaches to treatment: depression among older people living in care homes, London: British Geriatric Society. Available at: https://www.bgs.org.uk/sites/default/files/content/attachment/2018-09-12/Depression%20among%20older%20people%20living%20in%20care%20homes%20report%202018.pdf
[180] Alzhimer's society, 'Depression and dementia'. Available at: https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/depression
[181] x Hamid, Abdul et al (2015), "Comparison of how old age psychiatry and general adult psychiatry services meet the needs of elderly people with functional mental illness: cross-sectional survey", British Journal of Psychiatry, 207 (5), pp. 440-443.
[182] Colins, N., and Corna, L. (2018), 'General practitioner referral of older patients to Improving Access to Psychological Therapies (IAPT): an exploratory qualitative study', BJPsych Bulletin, 42(3). pp. 115-118.

**Falls** are the most common cause of death from injury in the over 65s. A third of people over 65, and half of people over 80, fall at least once a year.[183] Falls are the number one factor precipitating a person losing independence and going into long-term care.

Age standardised rates of hospital admission for falls for over 65's are better (lower) than the national average in all three BHR boroughs. Nonetheless, close to 2000 admissions were recorded in 2019/20.

**Hip fracture** is a particularly serious consequence of falls especially among those with osteoporosis, malnutrition, weak muscle strength, sensory impairment and frailty. One in three people with a hip fracture dies within a year. Rates of hospital admission for hip fracture are similar to the national average in Havering and Barking & Dagenham, but better (lower) in Redbridge than the national average. More than 600 were recorded in 2019/20.

Falls are not an inevitable consequence of ageing; the risk of falling and the harm caused can be reduced. The Falls and Fragility Fractures Pathway[184] defines the core components of an optimal service for people who have suffered a fall or are at risk of falls and fragility fractures. The pathway focuses on the three priorities for optimisation:

- Falls prevention
- Detecting and Managing Osteoporosis
- Optimal support after a fragility fracture

Higher value interventions include:

- Targeted case-finding for osteoporosis, frailty and falls risk
- Strength and balance training for those at low to moderate risk of falls
- Multi-factorial intervention for those at higher risk of falls
- Fracture liaison service for those who have had a fragility fracture

***Recommendation 104:*** *Ensure the BHR Falls prevention pathway is consistent with national guidance and equitably implemented according to need.*

**Deconditioning** - the loss of physical, psychological, and functional capacity due to inactivity – can occur rapidly in older adults, and, among other health impacts, increases the risk of falls. Public Health England found that older people experienced a considerable reduction in strength and balance during the first lockdown, further increasing the risk of falls.

[183] https://publichealthmatters.blog.gov.uk/2014/07/17/the-human-cost-of-falls/
[184] https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

***Recommendation 105:*** *Refer older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitation services.*

**Frailty** is a particular state of health experienced by a significant minority of older people - around 10% of people aged 65+ years (around 10,500 across BHR in mid-2019) live with frailty, rising to 25- 50% of 85+ years (4,000 to 8,000). Being frail can mean that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing. For example,someone with moderate frailty has three times the annual risk of urgent care utilisation, death and care home admission than an older person of the same age who is not frail.

A comprehensive approach to minimise the harm caused by frailty[185] includes:

- **comprehensive prevention** as described above
- **population-based stratification** to systematically identify people who are living with moderate and severe frailty
- coupled with **targeted support** to help older people living with frailty to stay well and live independently for as long as possible including:-
    - **Community multidisciplinary teams** – focused on the moderate frailty population who are most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.
    - **Urgent Community Response** – crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.

***Recommendation 106:*** *Ensure that patients at risk of frailty are systematically identified, using population health management approach; effectively supported by the local partners to stay well; or receive urgent additional help in times of crisis.*

Falls, social isolation and cognitive impairment are a few of the potentially preventable or modifiable risk factors that contribute to the development of frailty**;** others include alcohol excess; functional impairment, hearing problems, mood problems, nutritional compromise, physical inactivity, polypharmacy[186], smoking, and vision problems.

***Recommendation 107:*** *Ensure that the BHR Older People and Frailty Prevention offer currently under development is comprehensive, addressing socio-economic and behavioural risk factors and the early identification and management of modifiable conditions.*

Over our lifetime we accumulate diagnoses, such that many people experience old age as a state of **multimorbidity**.[187] Efforts to manage multimorbidity can lead to

[185] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

[186] Polypharmacy refers to the use of multiple medications. WHO defines polypharmacy as 'the routine use of five or more medications. This includes over-the-counter, prescription and/or traditional and complementary medicines used by a patient'.

[187] https://www.bgs.org.uk/blog/more-is-less-and-less-is-more-breaking-the-cycle-of-polypharmacy-with-deprescribing

**polypharmacy**. In some instance, polypharmacy generates yet more prescribing for example when medication is required to manage the side effects of existing drugs or when side effects are wrongly interpreted as new conditions.

Sometimes the complexity is such that the balance between the risks inherent in treatment and the benefits arising can be misplaced so that patients are exposed to harm. Deprescribing, the discontinuation of medications in a systematic and considered manner, can serve to restore the desired balance between benefits and harm. Multidisciplinary teams, including pharmacists and nurse specialists can help. Deprescribing requires a thoughtful explanation to patients and carers. Deprescribing is not about restricting the access of some people to healthcare, but instead an acceptance of the limitations of medicines in some situations. Prescribing fewer drugs is not the same as offering less care.

***Recommendation 108:*** *Ensure that there is a systematic approach of reviewing patients with multimorbidity and frailty that includes a medication review to maximise the benefits of medications and minimise side effects.*

Although essential in some circumstances**, hospital admission** entails significant risks to the continuing independence of older people, as a short period of inactivity can result in a disproportionately large decline in physical ability.

There is strong evidence that provision of **reablement** services after admission improves function and hence independence. Havering and Redbridge perform better than the national average in terms of the percentage of people aged 65 and over who were still at home 91 days after discharge from hospital and Barking & Dagenham is similar to the national average.

***Recommendation 109:*** *Further improve the reablement offer in all three boroughs to maximise the proportion of patients who return home and stay home after admission to hospital.*

Research suggests that, where possible, people prefer to stay in their own home rather than move into **residential care**. The rate of permanent admissions to care homes varies between the three boroughs. Redbridge has the lowest rate, followed by Havering. Both boroughs have rates that are significantly below the England average. Barking and Dagenham has the highest rate in London although this represents a significant improvement on previous years.

Nationally**,** one in seven people aged 85 and above live in a care home. The number of care beds varies significantly between three BHR boroughs.

**Table 20. Care home beds, number and rate / 100 people aged 75+, 2021**

| Area | Number | Rate |
|---|---|---|
| LBBD | 718 | 8.0 |
| LBH | 1,834 | 8.0 |
| LBR | 1,379 | 7.7 |
| London | 35,435 | 7.1 |
| England | 458,955 | 9.4 |

Source: Care Quality Commission (CQC) and Office for National Statistics (ONS)

Many people in care homes are not having their needs assessed and addressed as well as they could be, resulting in unnecessary unplanned and avoidable admissions to hospital. The **Enhanced Health in Care Homes (EHCH)** model is designed to put this right.

> ***Recommendation 110:*** *Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.*

**End-of-Life Care (EoLC):** Few people would choose to die in hospital and yet more than half of all older people in BHR do so. The proportion of people dying in hospital in all three boroughs are significantly higher (worse) than England average. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. The BHR EoLC workstream aim is to acknowledge a person's wishes and support their end-of-life needs in their preferred place of care and is addressing this challenge across three boroughs. Care Home Support, a rapid response team and 24-hour support line are being implemented and the palliative care capacity is increasing to improve the quality of the end-of-life care.

> ***Recommendation 111:*** *Strengthen end-of-life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.*

DRAFT

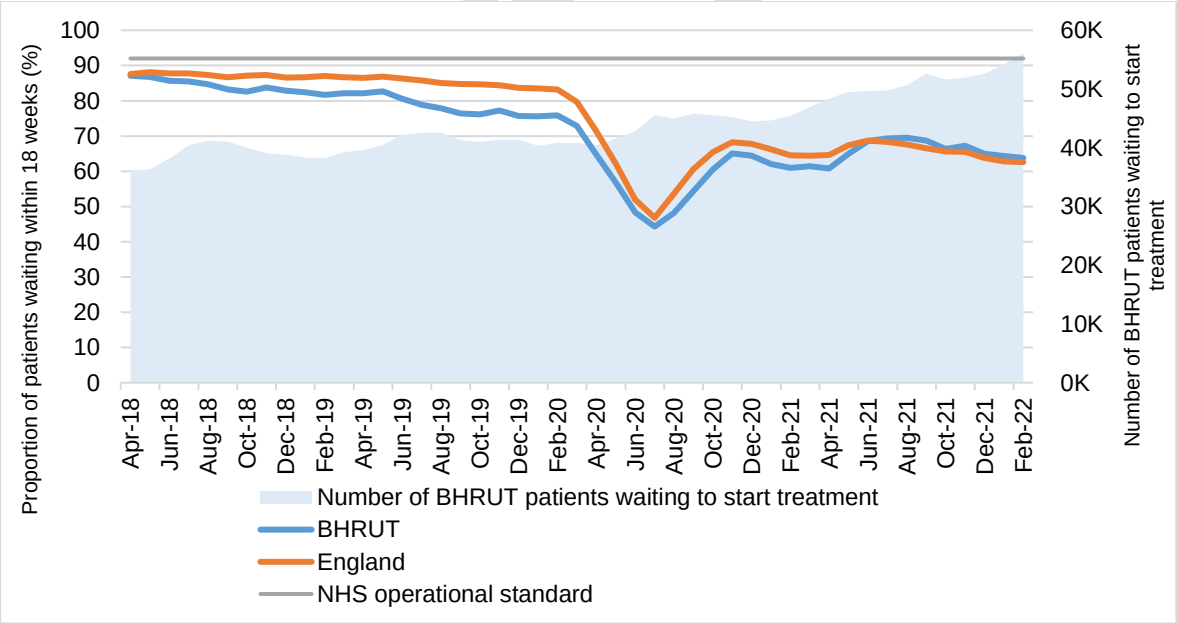
## 6.7 Planned (non-urgent) Care

A variety of care is provided on a planned basis, including diagnostic investigations, specialist assessment and then treatment, including surgery. Much of it is traditionally provided in acute hospitals through outpatient clinics.

Non-urgent may suggest a lower priority. However, the people waiting for treatment may be anxious, sometimes in pain, with their quality of life impaired. Hence, waiting times directly affect patient experience and are one of the public's main concerns about the NHS.

The NHS constitution sets a standard that 92% of people waiting for elective (non-urgent) treatment should wait no longer than 18 weeks from their referral to their first treatment. However, waiting times had been worsening for some time prior to the pandemic because of a variety of factors including workforce pressures, financial constraints, and insufficient beds, clinics, and diagnostic services such as imaging (Fig. 48)[188].

**Figure 48: Number of Patients waiting to start treatment at BHRUT with Proportion of Patients waiting within 18 weeks April 2018 – February 2022**




Data Source: NHS Digital (2022)

As a result, a nationwide work programme had been initiated before the pandemic, led locally by the BHR Planned Care Transformation Board, with the aim of ensuring that patients are seen in the right place, at the right time, by the right healthcare professional, saving patients' time, improving patient experience and ensuring clinical time and resources are utilised effectively to reduce waste in the system.

[188] https://www.nuffieldtrust.org.uk/resource/treatment-waiting-times#background

This work is still more urgent given the scale of the backlog that has accumulated during the pandemic.

During the first wave of the pandemic, planned care was postponed wholesale to free up capacity to treat seriously unwell patients with COVID-19 and reduce the risk of transmission.

As the pandemic progressed, the impact on planned care was somewhat reduced e.g. by the creation of 'green zones' in which elective care was provided to patients known to be coronavirus free after testing and quarantine. However, Infection Prevention and Control (IPC) guidance in place to keep staff and patients as safe as possible continued to reduce elective capacity. Subsequent reviews of IPC guidance by UKHSA[189] have provided further latitude but continue to limit capacity to some degree.

The pandemic also slowed the rate at which new patients were added to waiting lists as some patients chose not to present with problems due to fear of COVID-19. Similarly, the pandemic affected primary care, delaying initial assessment and onward referral. Therefore, it is likely that the number of patients currently waiting for elective care is an underestimate of the true scale of the problem. As residents become more confident and the health and social care system recovers, a surge in unmet need will likely be identified, making things worse before they get better. Hence, the Health Secretary has suggested that waiting lists will continue to grow[190].

Priorities for action by the BHR Planned Care Transformation Board include: -

- The extension of 'Advice and Guidance' services to more specialities, whereby consultants assist GP colleagues to effectively manage patients in primary care or advise immediate referral into specialist services as appropriate.
- Improving GP's access to diagnostics to inform their management of patients in primary care and, coupled with better guidance about the investigations that need be completed before referral, ensuring that the results of all necessary tests are available when the patient is seen for the first time at the outpatient clinic.
- Triage of patients already waiting a first appointment, so that those who don't need to be seen at all can continue to be managed in primary care and those who do need to be seen in hospital are seen in order of clinical priority, by the right professional first time. Such actions will reduce the need for onward referrals between clinics and wasted appointments
- Think Digital First - use of technology to enable care out of hospital e.g. use of video and telephone conferencing and the sharing information between patient and clinician via Patient Knows Best system
- The launch of community minor surgery undertaking an additional 2,000 minor surgery procedures each year
- A new MSK exercise on referral service providing an alternative to surgical treatment for 3,000 patients with chronic pain.

[189] https://www.gov.uk/government/publications/ukhsa-review-into-ipc-guidance
[190] https://www.thetimes.co.uk/article/javid-told-13-million-covid-cases-may-lengthen-nhs-backlog-j38027hk9

- The extension of Patient Initiated Follow Up stopping routine appointments in outpatient clinics that rarely identify a problem, instead allowing the patient to request follow up when they have a concern
- Ensuring patients have access to emotional and wellbeing support all the way through the planned care journey, including during recovery. Such support will be sought from available voluntary sector organisations and other local partners, including social and community care providers
- Patient empowerment to self-care – people are supported and empowered to self-care by easily accessing good quality information and local support.

Just as COVID-19 has exacerbated existing inequalities in other parts of life, access to elective treatment fell further in the most socioeconomically deprived areas of England between January 2020 and July 2021 than in less deprived areas. Hence plans for the recovery of planned care need to consider the greater need for care in disadvantaged communities and whether proactive engagement and outreach is needed to ensure that they are not inadvertently increasing inequalities via the 'inverse care law'.

**Recommendation 112**: Support implementation of plans developed by the BHR Planned Care Transformation Board

DRAFT

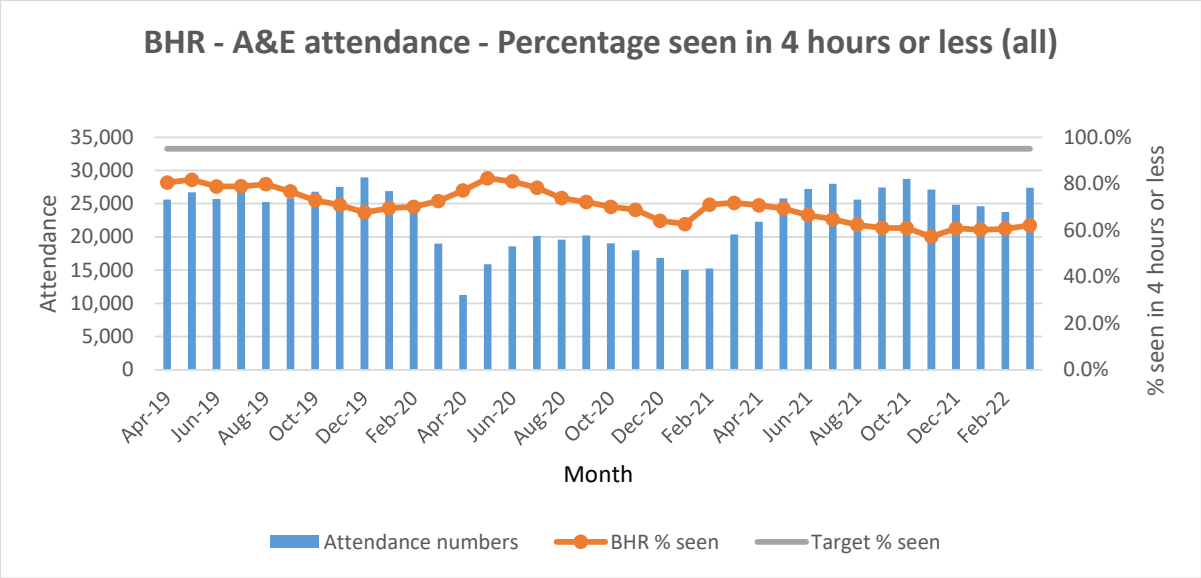
## 6.8 Urgent and Emergency care

Urgent[191] and Emergency Care[192] (UEC) services perform a critical role in keeping the population healthy and the wider health and care system functioning.

Very large numbers of people attend UEC services (Fig. 49). Some, particularly those attending emergency departments (ED), will be conveyed by ambulance services. In some cases, particularly to ED attendance, alternative services offering a faster, more convenient response, at lower cost to the NHS, are available via other urgent care options and /or primary care.

Demand in ED is such that waiting time targets are routinely missed contributing to a poor patient experience.

**Figure 49: BHRUT A&E attendance 2019- 2022**




Source: NHS Digital

A number of the opportunities identified in other chapters of the JSNA will reduce pressure on urgent and emergency care e.g. improved management of LTCs, better identification and care of frail older people, better end of life care, easier access / perceived access to primary care etc.

At the same time, UEC services must themselves change to cope with increasing pressure; to better meet the growing expectations of the population and make best use of opportunities afforded by new technology.

[191] Urgent: An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC).
[192] Emergency: Life threatening illnesses or accidents which require immediate, intensive treatment. Services that should be accessed in an emergency include ambulance (via 999) and emergency departments.

The NHS Long Term Plan[193], published in January 2019, sets out the vision for the future of the NHS as a whole and included the following commitments about urgent and emergency care services which are either in progress or fully implemented locally:

- Providing a 24/7 urgent care service, accessible via NHS 111, which can provide medical advice remotely and refer directly to Urgent Treatment Centres, GP, and other community services, as well as ambulance and hospital services.
- Implementing Same Day Emergency Care (SDEC) services across 100% of type 1 emergency departments[194].
- Focusing efforts to reduce the length of stay for patients in hospital longer than 21 days.
- Working closely with primary and community care services to ensure an integrated, responsive healthcare service helping people stay well longer and receive preventative or primary treatment before it becomes an emergency.

Last year (2021/22) saw still greater pressure on urgent and emergency care, in part due to the pandemic, its effects on other parts of the NHS and how the public in turn responded. A 10 point plan was developed to manage delivery in winter and support recovery across all UEC services[195]. This focused on:

1. Supporting 999 and 111 services.
2. Supporting primary care and community health services to help manage the demand for UEC services.
3. Supporting greater use of urgent treatment centres.
4. Increasing support for children and young people.
5. Using communications to support the public to choose services wisely.
6. Improving in-hospital flow and discharge.
7. Supporting adult and children's mental health needs.
8. Reviewing infection prevention and control measures to ensure a proportionate response.
9. Reviewing staff COVID isolation rules.
10. Ensuring a sustainable workforce.

Locally, action is led and co-ordinated by the BHR Urgent and Emergency Care Transformation Board.

It aims to ensure services meet patients' needs and, where appropriate, provide an alternative to emergency department attendance in order to improve patient experience and waiting times and enable ED to focus on emergency care.

[193] https://www.longtermplan.nhs.uk/
[194] Launched by BHRUHT in July 2021 and estimated to have prevented 268 admissions in 21/22.
[195] https://www.england.nhs.uk/publication/uec-recovery-10-point-action-plan-implementation-guide/

This will be achieved by:

- Establishing Urgent Treatment Centres as the Front Door for urgent care[196]
- Increasing the options for care and advice (for clinicians and patients) as an appropriate alternative to ED referral/ attendance – fully implemented
- Improving ambulance and community pathways and ensuring that these are fully utilised and embedded[197] -
- Developing a more robust, resilient and responsive urgent & emergency care system across BHR in development.

Notwithstanding the ongoing and completed improvements regarding UEC services themselves, they remain under intense pressure. Effective solutions will require action from all parts of the health and care system.

**Recommendation 113**:
Support plans developed by the BHR Urgent Care Transformation Board, and:-

- encourage clinicians and patients to make appropriate use of alternatives to ED referral and attendance, including self care
- support residents to stay well longer and ensure they receive effective preventative and / or primary treatment to minimise the need for urgent and emergency care

[196] Four UTCs successfully implemented across BHR.
[197] A variety of alternative care pathways have been developed giving ambulance crews alternatives to conveying patients to A&E. The Hospital Ambulance Liaison Officers began in November-21 at both the KGH & Queens sites. HALOs review ambulance arrivals and guide/ educate ambulance crews regarding alternative options as appropriate, preventing over 1000 unnecessary A&E attendances. A Physician Response Unit (PRU), a rapid response vehicle staffed by a senior emergency medicine doctor and a emergency ambulance crew, is expected to launch in July 2022 and avoid over 900 A&E attendances a year thereafter.

## List of acronyms

| Acronym | Meaning | Further information |
|---|---|---|
| A&E | Accident and Emergency | Hospital department, also known as ED – Emergency Department |
| ACEs | Adverse Childhood Experiences | Potentially traumatic events that occur in childhood, e.g. violence, abuse, neglect |
| AQAP | Air Quality Action Plan | Mechanism by which local authorities work towards meeting air quality goals |
| AQMA | Air Quality Management Area | A geographical area defined by the local authority which does not meet national air quality standards |
| ASQ3 | Ages and Stages Questionnaire Third Edition | Used to assess child development |
| BHR | Barking Havering and Redbridge Health and Social Care System | Tri-borough partnership in Outer North East London |
| BHR CCGs | Barking Havering and Redbridge Clinical Commissioning Groups | The local commissioner of health care services |
| BHRUHT | Barking Havering and Redbridge University Hospitals Trust | Provider of acute hospital services at Queens and King George Hospital sites. |
| BAME | Black, Asian and Minority Ethnic | Minority ethnic groups includes Gypsy, Roma and Irish Traveller groups |
| CAMHS | Children and Adolescent Mental Health Services | https://www.nelft.nhs.uk/camhs/ |
| CDR | Child Death Review | Process to understand why children die and put in place interventions to protect other children and prevent future deaths |
| CKD | Chronic Kidney Disease | A long term condition in which the kidneys do not function effectively |
| CMO | Chief Medical Officer | The most senior Government advisor on matters relating to health |
| COPD | Chronic Obstructive Pulmonary Disease | A group of lung conditions that cause breathing difficulties |
| CQC | Care Quality Commission | Independent regulator of health and social care |
| CVD | Cardio-Vascular Disease | e.g. heart disease, stroke |
| CYP | Children and Young People | People aged 0 to 25 years |
| DALYs | Disability Life Adjusted Years | Combine years of life lost to premature death and years of life lived with disability into a single measure |
| DAQI | Daily Air Quality Index | DEFRA system to tell people the daily levels of air pollution and recommended actions and health advice |
| DWP | Department of Work and Pensions | Responsible for welfare, pensions and child maintenance policy |
| EHCP | Education, Health and Care Plan | A plan for a child or young person for whom extra support is required beyond that which the school can provide |
| EIF | Early Intervention Foundation | A charity supporting the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes |
| ELLMS | East London Local Maternity System | Collaboration of maternity service providers, stakeholders, commissioners, voluntary organisations and service users |
| EL STP | East London Sustainability and Transformation Partnership | A partnership of health and social care commissioners and providers (including |

DRAFT

| Acronym | Meaning | Further information |
|---|---|---|
| | | those in BHR) covering 8 boroughs and the city of London |
| EoLC | End Of Life Care | Support, comfort and medical care given during the time surrounding death |
| EV | Electric Vehicles | Fully electric, self-charging or plug in hybrid vehicles including cars, vans, buses |
| FIT | Faecal Immunochemical Test | A test to identify people at increased risk of bowel cancer |
| HEYL | Healthy Early Years London | Awards scheme funded by the Mayor of London which supports and recognises achievements in child health, wellbeing and development in early years settings |
| HMO | Houses in Multiple Occupation | A property rented out by at least 3 people who are not from 1 'household' but share facilities such as kitchen and bathroom |
| HSL | Healthy Schools London | Awards programme that will reach out to every London child, working with schools to improve children and young people's wellbeing |
| HWB | Health and Wellbeing Board | A formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government |
| IAPT | Improving Access To Psychological Therapies | 'Talking therapies' services for help to overcome depression and anxiety |
| ICS | Integrated Care System | Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area |
| ICPB | Integrated Care Partnership Board | A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS. |
| IMD | Index of Multiple Deprivation | Widely used datasets to classify the relative deprivation of small areas |
| IPC | Infection Prevention and Control | Practical, evidence-based approach preventing patients and health workers from being harmed by avoidable infections |
| JSNA | Joint Strategic Needs Assessment | Process by which local authorities and ICS assess the current and future health, care and wellbeing needs of the local community to inform decision-making |
| LAC | Looked After Children | A child who has been in the care of their local authority for more than 24 hours |
| LBBD | London Borough of Barking And Dagenham | Commissioner (and provider) of social care and public health services for residents |
| LBH | London Borough of Havering | ditto above |
| LBR | London Borough of Redbridge | ditto above |
| LGBTIQ+ | Lesbian, Gay, Bisexual, Trans, Intersex, Queer or Questioning | An inclusive acronym encompassing all minority sexual and gender identities |

| Acronym | Meaning | Further information |
|---|---|---|
| LTC | Long Term Condition | Chronic diseases or conditions for which there is currently no cure, and which are managed with drugs and other treatment |
| MSK | Musculoskeletal Conditions | e.g. back and neck pain |
| NELFT | North East London Foundation Trust | Provider of mental health and community health care services |
| NDPP | NHS Diabetes Prevention Programme | https://preventing-diabetes.co.uk/ |
| NO2 | Nitrogen Dioxide | Pollutant gas produced durng combustion of fossil fuels |
| OHID | Office for Health Improvement and Disparities | Government department focusing on improving the nation's health and levelling up health disparities |
| PAF | Population Attributable Fraction | The proportion of cases for an outcome of interest that can be attributed to a given risk factor among the entire population |
| PCN | Primary Care Network | Groups of GP practices working together |
| PHE | Public Health England | PHE was replaced by UKHSA and OHID |
| PHM | Population Health Management | An approach that uses data to help health and care systems to improve population health and wellbeing |
| PM | Particulate Matter | Mixture of solid particles and liquid droplets (pollutants) found in the air |
| PTAL | Public Transport Accessibility Levels | Measure of accessibility of a point to the public transport network |
| SATOD | Smoking At Time Of Delivery | A measure of smoking prevalence amongst pregnant women |
| SDEC | Same Day Emergency Care | Provision of same day care for patients who would otherwise be admitted to hospital |
| SEND | Special Education Needs and Disability | A child with a learning difficulty and/or disability that means they require special health and education support |
| SMEs | Small and Medium Sized Enterprises | A company in the UK that has a turnover of less than £25m; fewer than 250 employees and gross assets less than £12.5m |
| SMI | Serious Mental Illness | Someone aged 18 or over who has a diagnosable mental, behavioural or emotional disorder that causes serious impairment |
| UKHSA | UK Health Security Agency | Government department |
| VCS | Voluntary and Community Sector | Not-for-profit, value-driven organisations that are independent of government and constutionally self-governing |
| YLD | Years Lived with Disability | A measure refleting the impact an illness has on quality of life before it resolves or leads to death |
| YLL | Years of Life Lost | A measure of premature mortality that takes into account both the frequency of deaths and the age at which it occurs |

DRAFT

## Acknowledgements

This second edition of a JSNA for the developing BHR health and social care system has been a collective effort on the part of many individuals, coordinated by the Public Health Information Leads for each of three boroughs. A number of analysts have contributed to its development. Other officers have facilitated discussions with relevant Transformation Boards. We, the Directors of Public Health for each of the boroughs, would like to thank everyone for their efforts, and apologise for anyone inadvertently omitted from the list below.

Mark Ansell, Director of Public Health, LBH

Matthew Cole, Director of Public Health, LBBD

Gladys Xavier, Director of Public Health, LBR

Anthony Wakhisi, Principal Public Health Specialist, LBH

Wassim Fattahi-Negro, Principal Manager Performance & Intelligence, LBBD

Soumya-Kanti Chatterjee, Business Intelligence - Public Health Lead, LBR

Mark Holder, Senior Public Health Analyst, LBH

Christopher Wilding, Senior Intelligence and Analysis Officer, LBBD

Thomas Goldrick, Senior Public Health Analyst, LBH

Hasna Begum, Public Health Analyst, LBH

Jane Leaman, Consultant in Public Health, LBBD

Elaine Greenway, Consultant in Public Health, LBH

Louise Dibsdall, Public Health Principal, LBH

Ian Diley, Consultant in Public Health, LBR

Tha Han, Consultant in Public Health, LBH

Osama Mahmoud, Public Health Specialist

Sedina Lewis, Public Health Specialist

Jack Davies, Public Health Specialist

Ratidzo Chinyuku, Public Health Specialist

DRAFT

# Appendix 1: BHR JSNA Process

## 1 Background

1.1 To support the BHR ICP fulfil its functions, BHR Public Health teams worked jointly to the 2021 JSNA whose main focus is to identify priority health and social care needs and related wider determinants that impact on health and wellbeing in a consistent format at locality, borough and ICS level and make recommendations on appropriate interventions.

1.2 This product is to complement not replace the existing borough based JSNAs.

## 2 Governance

2.1 The BHR JSNA process was overseen by the Havering Director of Public Health and was supported by the other two directors.

2.2 The lead director received formal monthly updates during implementation and provided support as necessary. He was also the lead author, a task which included writing some sections and reviewing all drafts.

2.3 BHR Public Health Intelligence (PHI) leads facilitated data collection, analysis, interpretation and presentation of results.

2.4 Public Health Consultants/ service leads in consultation with transformation boards advised on content and were responsible for commentary on results including recommendations.

2.5 BHR PHI leads were responsible for the final report compilation.

## 3 Structure

3.1 The JSNA was structured around the four pillars of population health[198] namely:

i. The wider determinants of health e.g. income, education, housing.
ii. Our health behaviours and lifestyles e.g. smoking, alcohol consumption, diet and exercise.
iii. Places and communities e.g. environment, community networks and support systems, social relationships and culture.
iv. The integrated health and care system with a focus on the 4 priorities of the ICPB:
    - Children and young people
    - Mental health
    - Long term conditions
    - Older people and frailty

[198] https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean



DRAFT

3.2 The JSNA also included sections on demography and population health outcomes.

## 4 Form and Content

4.1 Following several consultations between Public Health Consultants / service leads, PHI leads and transformation boards, indicators for each pillar were agreed. PHI leads facilitated data collation, analysis and presentation for indicators where data was available. The report therefore only includes analysis and commentary for indictors which data could be sourced within the provided timelines.

4.2 It's intended that this product will develop in an iterative manner with BHR PH consulting with stakeholders after publication of each edition to identify opportunities for improvement.

4.3 The initial edition is static but BHR PH are currently working with an external provider to develop an interactive product that will be available to all stakeholders.

## 5 Final Report

The current report includes data analysis and commentary at borough and BHR levels. It includes some data at locality level but without commentary. This is due to time and specialist resource constraints experienced and will be included in the next iteration.

DRAFT

# Appendix 2: Population & Health Outcomes

*Click section 1, 2 or 6.2 to return to respective chapters*

## BHR Joint Strategic Needs Assessment 2022

### London Borough of Havering

### Population & Health Outcomes

**Benchmark: England**

**Compared with Benchmark:** Better | Similar | Worse | Not Compared | Higher | Lower | No Data

| | | Indicator | Period | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Count | Value | Value | Value | Value | Value | Value | Lowest | Highest |
| Resident Population | 1 | Percentage of resident population aged 0 - 4 years | 2020 | 17,167 | 6.6 | 8.8 | 7.3 | 7.5 | 6.6 | 5.7 | 5.7 | 5.7 |
| | 2 | Percentage of resident population aged 5 - 9 years | 2020 | 17,251 | 6.6 | 8.9 | 7.0 | 7.4 | 6.7 | 6.3 | 6.3 | 6.3 |
| | 3 | Percentage of resident population aged 10-19 years | 2020 | 29,824 | 11.4 | 14.5 | 12.9 | 12.9 | 11.4 | 11.6 | 11.6 | 11.6 |
| | 4 | Percentage of resident population aged 20-64 years | 2020 | 149,891 | 57.5 | 58.5 | 59.9 | 58.7 | 63.1 | 58 | 57.9 | 57.9 |
| | 5 | Percentage of resident population aged 65-74 years | 2020 | 23,707 | 9.1 | 5.1 | 7.0 | 7.2 | 6.6 | 10 | 9.9 | 9.9 |
| | 6 | Percentage of resident population aged 75-84 years | 2020 | 15,342 | 5.9 | 2.8 | 4.0 | 4.3 | 3.9 | 6 | 6.1 | 6.1 |
| | 7 | Percentage of resident population aged 85+ years | 2020 | 7,469 | 2.9 | 1.3 | 1.8 | 2.0 | 1.7 | 2.5 | 2.5 | 2.5 |
| | 8 | Total resident population | 2020 | 260,651 | | | | | | | | |
| GP Registered Population | 9 | Percentage of GP population aged 0 - 4 years | 2021 | 16,882 | 6.0 | 7.4 | 6.5 | 6.7 | 5.4 | 5.1 | 5.1 | 5.1 |
| | 10 | Percentage of GP population aged 5 - 9 years | 2021 | 18,131 | 6.4 | 8.4 | 6.9 | 7.3 | 5.8 | 5.8 | 5.8 | 5.9 |
| | 11 | Percentage of GP population aged 10-19 years | 2021 | 32,277 | 11.4 | 14.7 | 12.5 | 12.9 | 10.9 | 11.4 | 11.4 | 11.4 |
| | 12 | Percentage of GP population aged 20-64 years | 2021 | 166,164 | 58.8 | 61.2 | 61.9 | 60.9 | 66.9 | 60.1 | 60.1 | 60.1 |
| | 13 | Percentage of GP population aged 65-74 years | 2021 | 25,658 | 9.1 | 4.8 | 6.4 | 6.9 | 6.1 | 9.5 | 9.4 | 9.5 |
| | 14 | Percentage of GP population aged 75-84 years | 2021 | 16,220 | 5.7 | 2.4 | 3.5 | 4.0 | 3.4 | 5.8 | 5.8 | 5.8 |
| | 15 | Percentage of GP population aged 85+ years | 2021 | 7,315 | 2.6 | 1.1 | 1.5 | 1.8 | 1.4 | 2.3 | 2.3 | 2.3 |
| | 16 | Total GP population | 2021 | 282,647 | | | | | | | | |
| Ethnic Population | 17 | Percentage White British | 2021 | 396,618 | 74.6 | 32.7 | 23.8 | 43.0 | 38.3 | | | |
| | 18 | Percentage Black | 2021 | 36,186 | 6.8 | 23.8 | 8.2 | 12.0 | 13.3 | | | |
| | 19 | Percentage Asian | 2021 | 40,508 | 7.6 | 23.6 | 50.5 | 28.9 | 20.5 | | | |
| | 20 | Percentage Other White | 2021 | 36,566 | 6.9 | 12.5 | 10.0 | 9.6 | 18.0 | | | |
| | 21 | Percentage Mixed | 2021 | 18,504 | 3.5 | 5.2 | 4.6 | 4.4 | 5.8 | | | |
| | 22 | Percentage Others | 2021 | 3,515 | 0.7 | 2.1 | 2.9 | 2.0 | 4.1 | | | |
| Health Outcomes | 23 | Life expectancy at birth (Male) | 2018-2020 | | 79.7 | 77.0 | 80.5 | | 80.3 | 79.4 | 79.4 | 79.4 |
| | 24 | Life expectancy at birth (Female) | 2018-2020 | | 83.5 | 81.7 | 84.6 | | 84.3 | 83.1 | 83.1 | 83.2 |
| | 25 | Healthy Life Expectancy at birth (Male) | 2018-2020 | | 64.6 | 58.1 | 60.6 | | 63.8 | 63.1 | 63.0 | 63.4 |
| | 26 | Healthy Life Expectancy at birth (Female) | 2018-2020 | | 63.8 | 60.1 | 64.0 | | 65.0 | 63.9 | 63.3 | 63.7 |

**Data Sources:**

Indicators: 1-8 - ONS Population Estimates 2020. Indicators 9-16 NHS Digital 2021. Indicators 17-22 GLA Ethnic Population Projections 2021. Indicators 23-26 Public Health England

# Appendix 3: Wider Determinants Dashboard

*To return to section 3: Wider Determinants – Click Here*

## BHR Joint Strategic Needs Assessment 2022

**London Borough of Havering**

**Population Health Pillar: Wider Determinants of Health**

**Benchmark: England**

| Compared with Benchmark: | Better | Similar | Worse | Not Compared | Higher | Lower |
|---|---|---|---|---|---|---|

| Recent Trend: | Data not available | ↑ Increasing getting worse | ↑ Increasing getting better | ↓ Decreasing getting worse | ↓ Decreasing getting better | → No significant Change | ↑ Increasing | ↓ Decreasing |
|---|---|---|---|---|---|---|---|---|

| | Indicator | Period | Recent Trend | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Count | Value | Value | Value | Value | Value | Value | Worst / Lowest | Best / Highest |
| 1 | Median Annual Household Income (£) | 2012/13 | | | £36,670 | £29,420 | £36,670 | | £39,110 | £30,600 | | |
| 2 | Gross Weekly Pay for Full Time Workers (£) | 2020 | | | £690 | £609 | £719 | | £716 | £590 | 454.2 | 893.2 |
| 3 | Index of Multiple Deprivation (IMD) 2019 Rank/Score | 2019 | | | 16.8 | 32.8 | 17.2 | 21.3 | 21.8 | 21.7 | 45.0 | 5.5 |
| 4 | Proportion of residents who are Income Deprived (%) | 2019 | | 26,877 | 10.8% | 19.4% | 12.1% | | | 12.9% | | |
| 5 | Proportion of residents aged 16 - 64 in employment (%) | 2020 | | 128,000 | 77.5% | 67.3% | 74.0% | | 75.3% | 75.7% | | |
| 6 | Proportion of residents aged 16 - 64 in management / professional roles (%) | 2020-21 | | 67,300 | 50.0% | 35.8% | 54.6% | 48.5% | 62.3% | 50.2% | | |
| 7 | Proportion of residents 16-64 who are economically inactive (%) | 2020 | | 31,600 | 19.1% | 25.6% | 24.6% | 23.1% | 19.9% | 20.5% | 12.6% | 30.6% |
| 8 | Proportion of residents 16-64 who are economically inactive and want a job (%) | 2020 | | 8,600 | 27.2% | 26.5% | 19.0% | 23.5% | 25.8% | 22.6% | 9.6% | 53.0% |
| 9 | Jobs Density Ratio for population 16-64 | 2019 | | | 0.61 | 0.50 | 0.49 | | 1.03 | 0.88 | 0.40 | 102.30 |
| 10 | Proportion of residents by level of education - NVQ 4 & Above (%) | 2020 | | 66,300 | 40.2% | 43.7% | 51.5% | 45.7% | 58.5% | 42.8% | | |
| 11 | Proportion of residents by level of education - No Qualifications (%) | 2020 | | 10,800 | 6.5% | 9.2% | 9.3% | 8.4% | 5.1% | 6.2% | | |
| 12 | Number of homeless people/households (rate per 1,000 estimated total households) | 2017/18 | | 330 | 3.2 | 6.5 | 4.4 | 4.6 | 4.2 | 2.4 | 9.4 | 0.2 |
| 13 | Number of people in temporary accommodation (rate per 1,000 estimated total households) | 2017/18 | | 924 | 8.9 | 23.9 | 20.3 | | 14.9 | 3.4 | | |
| 14 | Number of households on waiting list | 2019/20 | | | 1995 | 5350 | 5979 | 13324 | 250992 | 1145501 | | |
| 15 | Proportion of homes that are not 'Decent Homes' (%) | 2018-19 | | 69 | 0.7% | 9.6% | 13.8% | 7.5% | | 4.5% | 37.2% | 0.0% |
| 16 | Proportion of Households experiencing Fuel Poverty (%) | 2019 | | | 13.2% | 22.5% | 15.4% | 16.4% | 15.2% | 13.5% | | |
| 17 | Rate of verifiable Houses of Multiple Occupation (HMOs) to dwellings (%) | 2020 | | 124 | 0.1% | 0.2% | 1.9% | 0.8% | 1.2% | 0.56% | 0.01% | 6.10% |
| 18 | Estimated rate of HMOs to dwellings including the verifiable HMOs (%) | 2020 | | 267 | 0.3% | 0.3% | 3.7% | 1.5% | 4.9% | 2.17% | 0.02% | 16.60% |
| 19 | Number of people seen rough sleeping in the year | 2020 | | 3 | 3 | 10 | 24 | 37 | 714 | 2688 | 242 | 0 |
| 20 | Income deprivation affecting Children (under 16) | 2019 | | | 16.0% | 23.8% | 13.7% | 17.6% | | 17.1% | 32.7% | 3.2% |
| 21 | Child Development at age 5 | 2013/14 | | | 65.4 | 60.0 | 62.8 | | 62.2 | 60.4 | | |
| 21 | Attendance levels from children who are persistently absent from school (%) | 2018/19 | | 3,741 | 10.7% | 11.2% | 9.9% | 10.5% | 10.1% | 10.9% | 3.4% | 16.1% |
| 22 | Average Attainment 8 score (mean - score) | 2019/20 | | 148,285 | 52.20 | 50.10 | 56.00 | | 53.40 | 50.2 | | |
| 23 | 16-17 year olds not in education, employment or training (NEET) or whose activity is not known (%) | 2019 | | 170 | 2.9% | 3.5% | 3.1% | | 4.2% | 5.5% | | |
| 24 | Proportion of economically active population claiming Job Seekers Allowance (%) | 2021 | | 788 | 0.6% | 0.8% | 0.5% | | 0.6% | 0.5% | 1.5% | 0.2% |
| 25 | Claimant count (16+) and claimants as a proportion of residents aged 16-64 (%) | 2021 | | 9,200 | 5.7% | 10.1% | 7.6% | | 7.4% | 5.7% | 10.8% | 2.2% |

**Data Sources**

1: GLA - https://data.london.gov.uk/blog/gla-household-income-estimates/. 2: Annual Survey of Hours and Earnings - https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/previousReleases. 3, 4, 20 - Indices of Multiple Deprivation, MHCLG - https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019. 5 - 8, 10, 11 - Annual Population Survey - https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/. 9, 24, 25 - NOMIS - https://www.nomisweb.co.uk/. 14 - Borough Housing Departments. 12 - Homelessness Statistics DCHLG, https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness15 - Estimated from English Housing Survey , MHCLG - https://www.gov.uk/government/collections/english-housing-survey. 16- Department for Business , Energy and Industrial Strategy - https://www.gov.uk/government/collections/fuel-poverty-statistics. 19 - London Chain Report - https://data.london.gov.uk/dataset/chain-reports 21 - DFE, https://www.gov.uk/government/collections/statistics-pupil-absence 22 - DFE, https://www.gov.uk/government/publications/progress-8-school-performance-measure 23 - DFE, https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures

DRAFT

# Appendix 4: Health Behaviour & Lifestyle Dashboard

*To return to section 4: Health Behaviour & Lifestyle - Click Here*

## BHR Joint Strategic Needs Assessment 2022

### London Borough of Havering

### Population Health Pillar: Health Behaviours & Lifestyles

**Benchmark: England**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Compared with Benchmark:** | Better | Similar | Worse | Not Compared | Higher | Lower | | |
| **Recent Trend:** | Data not available | ↑ Increasing getting worse | ↑ Increasing getting better | ↓ Decreasing getting worse | ↓ Decreasing getting better | → No significant Change | ↑ Increasing | ↓ Decreasing |

| | Indicator | Period | Recent Trend | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Count | Value | Value | Value | Value | Value | Value | Worst / Lowest | Best / Highest |
| | Percentage of adults (aged 18+) classified as overweight or obese (ALS) | 2019/20 | | | 67.3 | 65.5 | 60.6 | | 55.7 | 62.8 | 78.3 | 41.6 |
| | Percentage of physically inactive adults (16+ ALS) | 2020/21 | | | 37.8 | 36.6 | 30.6 | | 26.7 | 27.5 | 27.2 | 27.8 |
| 3 | Smoking Prevalence (% of adult population) (APS) | 2019 | | 26,524 | 13.2 | 18.1 | 13.4 | | 12.9 | 13.9 | 13.6 | 14.1 |
| 4 | Smoking Prevalence (%) in adults in routine and manual occupations (18-64) - current smokers (Persons, 18-64 yrs) APS) | 2019 | | | 20.7 | 24.3 | 22.8 | | 20.7 | 23.2 | 36.8 | 10.3 |
| 5 | Percentage of adults drinking over 14 units of alcohol a week (HSE) | 2015-18 | | | 20.7 | 15.1 | 10.7 | | 20.1 | 22.8 | 41.3 | 7.9 |
| 6 | Smoking prevalence in adults (age 18-64 years) - gap between current smokers in routine and manual occupations and other occupations (APS) | 2019 | | | 1.8 | 1.5 | 1.9 | | 1.9 | 2.5 | 5.7 | 0.7 |
| 7 | Proportion of dependent drinkers not in treatment (%) (Current method) (NDTMS) | 2019/20 | | 1,870 | 84.3 | 85.9 | 85.2 | | 82.0 | 82.2 | 92.3 | 59.5 |
| 8 | Successful completion of drug treatment - % opiate users (NDTMS) | 2019 | | 15 | 6.4 | 6.1 | 8.3 | | 6.7 | 5.6 | 1.6 | 12.2 |
| 9 | Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) (Active Lives, Sport England). | 2019/20 | | | 51.8 | 47.9 | 53.2 | | 55.8 | 55.4 | 41.4 | 67.7 |
| | *Data Source: Indicators 1, 3-9 - Public Health England: Fingertips, 2 - Sport England Active Lives survey* | | | | | | | | | | | |

DRAFT

# Appendix 5: Maternity Dashboard

*To return to section 6.1: Maternity - Click Here*

## BHR Joint Strategic Needs Assessment 2022

### London Borough of Havering

### Population Health Pillar: HSC - Maternity

**Benchmark: England**

| **Compared with Benchmark:** | Better | Similar | Worse | Not Compared | Higher | Lower |
|---|---|---|---|---|---|---|

| **Recent Trend:** | Data not available | ↑ Increasing getting worse | ↑ Increasing getting better | ↓ Decreasing getting worse | ↓ Decreasing getting better | → No significant Change | ↑ Increasing | ↓ Decreasing |
|---|---|---|---|---|---|---|---|---|

| | Indicator | Period | Recent Trend | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Count | Value | Value | Value | Value | Value | Value | Worst / Lowest | Best / Highest |
| | Smoking status at time of delivery | 2020-21 | → | 193 | 6.7% | 7.6% | 3.4% | | 4.6% | 9.6% | 21.4% | 1.8% |
| | Number of live births | 2019 | | 3,186 | | | | | | | | |
| 3 | Stillbirths rate per 1,000 births | 2018-20 | | 38 | 3.9 | 6.0 | 5.8 | | 4.4 | 3.9 | 3.8 | 4.0 |
| 4 | Low Birth Weight of term babies | 2020 | → | 63 | 2.2% | 4.2% | 4.5% | | 3.3% | 2.9% | 4.9% | 1.4% |

*Data Source: Indicators, PHE Fingertips 1 (93085), 3, 4(20101) Indicators 2 ONS*

DRAFT

# Appendix 6: Children & Young People Dashboard

**BHR Joint Strategic Needs Assessment 2022**

**London Borough of Havering**

**Population Health Pillar: HSC - Children & Young People**

**Benchmark: England**

| Compared with Benchmark: | Better | Similar | Worse | Not Compared | Higher | Lower |
|---|---|---|---|---|---|---|
| **Recent Trend:** | Data not available | ↑ Increasing getting worse | ↑ Increasing getting better | ↓ Decreasing getting worse | ↓ Decreasing getting better | → No significant Change |

| | Indicator | Period | Recent Trend | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Count | Value | Value | Value | Value | Value | Value | Lowest | Highest |
| 1 | Pupils with special educational needs (SEN): % of school pupils with special educational needs (School age) | 2018 | | 3,659 | 9.3% | 14.4% | 10.9% | | 14.4% | 14.4% | | |
| 2 | Number and percentage of pupils with Special Educational Needs (SEN) based on where the pupil attends school | 2020-21 | | 4,457 | 11.0% | 14.5% | 11.8% | 12.4% | 15.3% | 15.8% | 11.0% | 21.3% |
| 3 | Number and percentage of children and young people with EHC Plan (Denominator Age 0-25 ONS mid-2020) | 2020-21 | | 1,332 | 1.6% | 1.6% | 1.8% | 1.7% | 1.8% | 1.9% | | |
| 4 | Number and percentage of children (Age 5-15) with EHC Plan (Denominator Age 5-15 ONS 2018) | 2020-21 | | 1,167 | 2.2% | 2.1% | 2.5% | 2.3% | 2.4% | | | |
| 5 | Number of primary school pupils with EHCP - Education, Health and Care Plan (local data) | 2021 | | 605 | | | | | | | | |
| 6 | Number of secondary school pupils with EHCP (local data) | 2021 | | 401 | | | | | | | | |
| 7 | Number and rate SEND pupils resident and educated in Borough (Local data) | 2021 | | | | 92.7 | | | | | | |
| 9 | Estimated number of children and young people with mental disorders - aged 5 to 17 (count) | 2017-18 | | 4,808 | | | | | | | | |
| 10 | Percentage of school pupils with social, emotional and mental health needs (school age) | 2020 | | 693 | 1.7% | 2.5% | 1.9% | | 2.5% | 2.7% | 1.5% | 4.4% |
| 11 | Hospital admissions as a result of self harm (Age 10-24) directly standardised rate per 100,000 | 2019-20 | | 70 | 166.0 | 136.2 | 126.2 | | 191.7 | 439.2 | 203.1 | 1105.4 |
| 12 | Hospital admissions for asthma (under 19 years) - CCG data. Crude rate per 100,000 | 2019-20 | | 95 | 149.8 | 158.8 | 180.9 | | | 158.3 | 48.5 | 376.7 |
| 13 | Hospital admissions diabetes (under 19 years) Crude rate per 100,000 | 2019-20 | | 40 | 63.1 | 22.3 | 36.2 | | | 51.1 | 49.9 | 52.3 |
| 14 | Children on child protection plans: Rate per 10,000 children <18 | 2019/20 | | 142 | 24.3 | 52.7 | 41.7 | 40.1 | 34.9 | 42.8 | 11.5 | 124.3 |
| 15 | Children in Care (number of children looked after at 31st March (including adoption and care leavers) | 2020 | | 230 | 40.0 | 63.0 | 31.0 | | 49.0 | 67.0 | | |
| 16 | The number and rate of children on a Child Protection Plan (CPP) as at 31st March 2020' | 2020 | | 142 | 24.3 | 52.7 | 41.7 | 40.1 | 34.9 | 42.8 | 11.5 | 124.3 |
| 17 | The number and rate of Looked after Children (LAC) as at 31st March 2020 | 2020 | | 232 | 39.8 | 63.3 | 31.1 | 44.0 | 49.3 | 66.6 | 23.0 | 223.0 |
| 18 | The number and rate of Children in Need (CIN) as at 31st March 2020' | 2020 | | 1,737 | 297.6 | 370.1 | 279.4 | 313.8 | 336.7 | 323.7 | 141.9 | 931.5 |
| 19 | The number and rate of children in the youth justice system (10-17 yrs) | 2019-20 | | 107 | 4.4 | 7.4 | 3.9 | | 4.4 | 3.5 | | |
| 20 | Number and percentage of unauthorised school absence sessions | 2018-19 | | 136,633 | 1.1% | 1.8% | 1.2% | 1.4% | 1.3% | 1.4% | 0.0 | 0.0 |
| 21 | Reception: Prevalence of overweight (including obesity) % | 2019/20 | | 480 | 21.6% | 24.6% | 22.3% | | 21.6% | 23.0% | | |
| 22 | Year 6 : Prevalence of overweight (including obesity) % | 2019/20 | | 1,135 | 38.1% | 44.7% | 39.6% | | 44.7% | 35.2% | | |
| 23 | Reception: Prevalence of obesity (including severe obesity) % | 2019/20 | | 225 | 10.1% | 12.9% | 11.2% | | 10.0% | 9.9% | | |
| 24 | Year 6: Prevalence of obesity (including severe obesity) % | 2019/20 | | 710 | 23.8% | 29.0% | 25.0% | | 23.7% | 21.0% | | |
| 25 | Youth offending: first time entrants to the youth justice system, rate per 10,000 | 2018 | | 408 | 183.0 | 377.0 | 280.0 | | 251.0 | 211.0 | | |
| 26 | Youth justice custodial sentences per 10,000 | 2019/20 | | 17 | 2.9 | 3.1 | 2.1 | | 1.5 | 1.0 | | |
| 27 | Youth proven offending rate per 10,000 | 2018/19 | | 53 | 9.0 | 13.7 | 11.2 | | 8.0 | | | |
| 28 | School readiness: percentage of children achieving a good level of development at the end of Reception | 2018/19 | | 2,289 | 71.7% | 72.4% | 75.6% | | 74.1% | 71.8% | | |
| 29 | School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception | 2018/19 | | 2,666 | 83.5% | 80.0% | 83.0% | | 82.6% | 82.2% | | |
| 30 | Hospital admissions due to substance misuse (15-24 years) count and rate per 100,000 | 2017/18 - 19/20 | | 65 | 78.6 | 67.7 | 73.8 | | 55.6 | 84.7 | | |
| 31 | Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review | 2019/20 | | 2,850 | 100.0 | 100.0 | 100.0 | | 91.1 | 92.6 | | |
| 32 | Number and rate (per 10,000) of children and young people accessing NHS funded community mental health services (CAMHS) | 2020/21 | | | | | | | 400.4 | 490.9 | | |
| 33 | Percentage of children in need with statements of SEN or EHC plans | 2019/20 | | | 36.7% | 7.5% | 54.0% | | | 23.4% | | |
| 34 | 16-17 year olds not in education, employment or training (NEET) or whose activity is not known | 2019 | | 170 | 2.9% | 4.2% | 3.1% | | 4.2% | 5.5% | | |

***Data Sources:*** *(Indicators 1,9-12,14,15,21-25,28-31,34 PHE Fingertips) (Indicators 2,3,4,16-19,21,26,27 Gov.uk) (Indicators 5-7, local data) (Indicators 32 NHS Digital) (Indicators 33 LG Inform)*

DRAFT

# Appendix 7: Adult Mental Health Dashboard

## BHR Joint Strategic Needs Assessment 2022

### London Borough of Havering

### Population Health Pillar: Health & Social Care - Mental Health

**Benchmark: England**

| **Compared with Benchmark:** | Better | Similar | Worse | Not Compared | Higher | Lower |
|---|---|---|---|---|---|---|
| **Recent Trend:** | Data not available | ↑ Increasing getting worse | ↑ Increasing getting better | ↓ Decreasing getting worse | ↓ Decreasing getting better | →No significant Change | ↑ Increasing | ↓ Decreasing |

| | Indicator | Period | Recent Trend | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Count | Value | Value | Value | Value | Value | Value | Lowest | Highest |
| 1 | Estimated prevalence of common mental health disorders - Age 16+ | 2017 | | 32,729 | 15.9% | 22.4% | 17.7% | 18.3% | 19.3% | 16.9% | 11.6% | 24.4% |
| 2 | Number and percentage of adults: Depression recorded prevalence - Age 18+ (QOF) | 2019/20 | ↑ | 20,911 | 10.1% | 8.0% | 6.3% | 8.0% | 8.2% | 11.6% | 4.0% | 18.5% |
| 3 | Rate of SMI (All Ages) (QOF) | 2019/20 | → | 1,995 | 0.7% | 0.8% | 0.9% | 0.8% | 1.1% | 0.9% | 0.6% | 1.5% |
| 4 | Adjustment disorders and distress in perinatal period (lower estimate): Estimated number of women | 2017/18 | | 386 | 386 | 443 | 535 | 1364 | 14431 | 73828 | | |
| 5 | Adjustment disorders and distress in perinatal period (upper estimate): Estimated number of women | 2017/18 | | 773 | 773 | 887 | 1070 | 2730 | 28863 | 147656 | | |
| 6 | PTSD in perinatal period: Estimated number of women | 2017/18 | | 77 | 77 | 89 | 107 | 273 | 2886 | 14766 | | |
| 7 | Number and percentage of school pupils with social, emotional and mental health needs | 2020 | ↑ | 693 | 1.7% | 2.5% | 1.9% | 2.1% | 2.5% | 2.7% | 2.7% | 2.7% |
| 8 | Number of children in need due to family stress or dysfunction or absent parenting and rate per 10,000 children under 18 | 2017 | | 259 | 46.6 | 93.6 | 46.8 | 61.7 | 97.9 | 93.8 | 0.0 | 265.9 |
| 9 | Self reported wellbeing - Percentage of people with a high anxiety score | 2019/20 | | | 21.9% | 20.1% | 19.9% | | 22.4% | 21.9% | 14.5% | 29.2% |
| 10 | Number and percentage in concurrent contact with Mental Health Services for drug misuse | 2016/17 | | 23 | 11.7% | 20.0% | 12.9% | 15.6% | 28.5% | 24.3% | 2.8% | 60.7% |
| 11 | Number and percentage in concurrent contact with Mental Health Services for alcohol misuse | 2016/17 | | 9 | 5.8% | 22.0% | 6.7% | 11.4% | 28.1% | 22.7% | 3.3% | 72.5% |
| 12 | Percentage of adult social care users who have as much social contact as they would like - Age18+ | 2019/20 | | 1,280 | 48.3% | 49.5% | 50.5% | 49.5% | 42.9% | 45.9% | 34.3% | 56.6% |
| 13 | Access to IAPT services: people entering IAPT (month) as % estimated to have anxiety\depression | Sep 2019 | ↑ | 365 | 17.8% | 14.7% | 19.4% | 17.6% | | 18.3% | 7.0% | 29.9% |
| 14 | APT reliable improvement: % of people in IAPT (quarter) who achieved reliable improvement (18+) | Q2 2019/20 | → | 445 | 75.4% | 71.3% | 72.6% | 73.3% | | 71.7% | 62.0% | 79.2% |
| 15 | Percentage of social care users who suffer depression and anxiety | 2018/20 | | | 48.7% | 51.9% | 53.7% | | | 50.5% | 38.5% | 63.6% |
| 16 | Dementia: QOF prevalence (all ages) Number and % of patients with dementia against total GP patients | 2019/20 | → | 2,169 | 0.8% | 0.4% | 0.6% | 0.6% | 0.5% | 0.8% | 0.3% | 1.3% |
| 17 | Number and % of adults on GP list recorded as smokers with Serious Mental Illness | 2014/15 | | 570 | 39.4% | 40.2% | 30.4% | 35.7% | 38.9% | 40.5% | 27.2% | 52.3% |
| 18 | Number of hospital admissions for mental health conditions and rate per 100,000 population | 2019/20 | → | 40 | 68.5 | 55.1 | 78.7 | 68.1 | 64.5 | 89.5 | 26.3 | 249.7 |
| 19 | Proportion of people (18-74) in contact with secondary mental health services rate per 100,000 | Q2 2019/20 | → | 3,825 | 1910.0 | 2016.0 | 1498.0 | 1774.3 | 2201.0 | 2381.0 | 1208.0 | 4633.0 |
| 20 | Number and age standardised mortality rate from suicide per 100,000 population (Persons) | 2017/19 | | 47 | 7.2 | 6.1 | 7.1 | | 8.2 | 10.1 | 4.9 | 19.0 |
| 21 | Number and directly age standardised rates for emergency hospital admissions for intentional self harm | 2019/20 | → | 185 | 73.5 | 63.9 | 44.5 | 59.2 | 81.6 | 192.6 | 44.5 | 457.6 |

**Data Sources:**
Indicators: 1-24 - Public Health England (PHE), Indicator 10 and 11 used old values

DRAFT

# Appendix 8: Cancer Dashboard

## BHR Joint Strategic Needs Assessment 2022

### London Borough of Havering

### Population Health Pillar: Health & Social Care - Cancers

**Benchmark: England**

| Compared with Benchmark: | Better | Similar | Worse | Not Compared | Higher | Lower |
|---|---|---|---|---|---|---|

| Recent Trend: | Data not available | ↑ Increasing getting worse | ↑ Increasing getting better | ↓ Decreasing getting worse | ↓ Decreasing getting better | →No significant Change | ↑ Increasing | ↓ Decreasing |
|---|---|---|---|---|---|---|---|---|

| | Indicator | Period | Recent Trend | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Count | Value | Value | Value | Value | Value | Value | Lowest | Highest |
| 1 | New cancer cases (Crude incidence rate: new cases per 100,000) | 2018-19 | | 1,668 | 589.0 | 328.0 | 363.0 | | | 529.0 | 217.0 | 728.0 |
| 2 | All Tumours (Age standardised incidence rate per 100,000) | 2017 | | 1,719 | 727.9 | 744.6 | 630.5 | 694.9 | 653.5 | 713.9 | | |
| 3 | Incidence breast cancer (Age standardised rate per 100,000) | 2017 | | 210 | 160.6 | 181.2 | 161.2 | 165.3 | 164.8 | 166.7 | | |
| 4 | Incidence colorectal cancer (Age standardised rate per 100,000) | 2018 | | 178 | 74.0 | 79.7 | 52.3 | | | 69.0 | | |
| 5 | Incidence lung cancer (Age standardised rate per 100,000) | 2018 | | 177 | 74.4 | 119.5 | 61.8 | | | 75.8 | | |
| 6 | Incidence prostate cancer (Age standardised rate per 100,000) | 2018 | | 368 | 343.3 | 303.5 | 218.7 | | | 204.1 | | |
| 7 | The percentage of patients with cancer, as recorded on practice disease registers | 2017/18 | | 7,512 | 2.7% | 1.4% | 1.7% | 1.9% | 1.8% | 2.7% | 4.2% | 0.9% |
| 8 | Cancer 1 year survival rate (%) | 2017 | | 1,018 | 73.2% | 69.7% | 72.6% | | | 73.3% | | |
| 9 | Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) | 2018-19 | | 15,714 | 56.3% | 42.8% | 48.4% | | 49.2% | 58.0% | | |
| 10 | Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %) | 2018-19 | | 7,999 | 56.5% | 41.7% | 47.9% | | 47.9% | 57.9% | | |
| 11 | Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) | 2019-20 | | 25,554 | 62.0% | 48.6% | 55.1% | | 55.6% | 63.8% | 45.1% | 70.9% |
| 12 | Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %) | 2019-20 | | 11,533 | 63.7% | 50.9% | 55.8% | | 56.8% | 65.8% | 45.9% | 72.5% |
| 13 | Breast screening uptake (%) | 2020 | | 22,037 | 78.7% | 66.4% | 71.8% | | 67.2% | 74.1% | 54.1% | 81.7% |
| 14 | Cancer screening coverage - cervical cancer (aged 25 to 49) | 2020 | | 34,830 | 72.9% | 65.6% | 61.5% | | 61.8% | 70.2% | 46.4% | 80.1% |
| 15 | Cancer screening coverage - cervical cancer (aged 50 to 64) | 2020 | | 18,444 | 77.6% | 72.9% | 74.6% | | 73.2% | 76.1% | 59.2% | 90.6% |
| 16 | Percentage of cancers detected at stage 1 and 2 | 2019 | | 497 | | | | | | | | |
| 17 | Percentage of cancers diagnosed through emergency presentation | 2018 | | 658 | 55.4% | 54.4% | 60.2% | | 56.5% | 55.0% | 47.5% | 76.5% |
| 18 | Premature mortality from all cancers (rate per 100,000) | 2017-19 | | 832 | 130.6 | 147.1 | 102.8 | | 117.4 | 129.2 | 87.4 | 182.4 |
| 19 | Premature mortality from lung cancer (rate per 100,000) | 2017-19 | | 390 | 52.9 | 70.8 | 34.8 | | 48.0 | 53.0 | | |
| 20 | Premature mortality from breast cancer (rate per 100,000) | 2017-19 | | 70 | 20.8 | 19.1 | 20.9 | | 19.6 | 20.0 | 15.6 | 26.1 |
| 21 | Premature mortality from colorectal cancer (rate per 100,000) | 2017-19 | | 69 | 10.8 | 11.4 | 8.3 | | 10.4 | 11.8 | 17.6 | 5.8 |
| 22 | Excess cancer deaths and attributable life years gap; females, compared to England | 2015-17 | | - 30 | 0.0 | 0.4 | -0.4 | | -0.3 | 1.0 | -0.8 | 1.0 |
| 23 | Excess cancer deaths and attributable life years gap in most/least deprived quintile; females within area | 2015-17 | | 22 | 0.8 | 1.3 | -0.1 | | 1.0 | 1.4 | -1.5 | 3.0 |
| 24 | Excess cancer deaths and attributable life years gap; males, compared to England | 2015-17 | | 128 | 0.4 | 0.6 | -0.7 | | -0.3 | 1.0 | -1.0 | 1.0 |
| 25 | Excess cancer deaths and attributable life years gap in most/least deprived quintile; males within area | 2015-17 | | 68 | 1.4 | 0.8 | 0.8 | | 1.3 | 1.6 | -0.8 | 3.2 |

**Data Sources**
Indicators: 1 - Public Health England (PHE), 2-6 NCRAS, 7 - PHE, 8 - NHS Digital, 9-14 PHE, 15 - NHS Digital, 16-25 PHE

# Appendix 9: Long Term Conditions Dashboard

## BHR Joint Strategic Needs Assessment 2022

### London Borough of Havering

**Population Health Pillar: HSC - Long Term Conditions**

**Benchmark: England**

**Compared with Benchmark:** Better | Similar | Worse | Not Compared | Higher | Lower

| | Indicator | Period | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Count | Value | Value | Value | Value | Value | Value | Lowest | Highest |
| 1 | Diabetes: QOF prevalence (Age 17+) (%) | 2019/20 | 16,845 | 7.5% | 8.6% | 9.1% | 8.4% | 6.8% | 7.1% | 3.6% | 11.1% |
| 2 | Diabetes: Estimated prevalence (Age 16+) (%) | 2017 | 18,728 | 8.6% | 9.2% | 10.5% | | | 8.5% | | |
| 3 | Major diabetic lower-limb amputation procedures (Per 10,000) | 2016/17 - 18/19 | 40 | 9.2 | 10.7 | 13.3 | 11.1 | | 8.2 | 27.0 | 3.4 |
| 4 | Percentage of LTCs reporting that they have received all or some of the support they need (%) | 2019/20 | 798 | 46.5% | 49.1% | 46.8% | 47.5% | 52.1% | 54.9% | 46.5% | 61.2% |
| 5 | Coronary Heart Disease: QOF prevalence (All Ages) (%) | 2019/20 | 6,854 | 2.6% | 1.8% | 2.4% | 2.3% | 1.9% | 3.1% | 1.2% | 5.0% |
| 6 | Coronary Heart Disease: Estimated prevalence (Age 55-79) (%) | 2015 | | 8.7% | 9.6% | 7.6% | 8.6% | | 7.9% | 14.8% | 6.7% |
| 7 | Emergency hospital admissions for coronary heart disease, standardised admission ratio | 2019/20 | | 85.9 | 114.0 | 113.6 | 104.5 | | 102.1 | 78.6 | 127.2 |
| 8 | Coronary Heart Disease: Mortality Under 75 (DSR per 100,000) | 2017/19 | 238 | 37.7 | 47.7 | 33.4 | 39.6 | | 37.5 | 108.5 | 16.1 |
| 9 | COPD: QOF prevalence (All Ages) (%) | 2019/20 | 5,033 | 1.8% | 1.5% | 0.8% | 1.4% | | 1.9% | | |
| 10 | COPD: Estimated prevalence (All Ages) (%) | 2015 | | 2.8% | 2.4% | 1.9% | 2.4% | | 3.0% | 4.9% | 1.5% |
| 11 | COPD: Emergency hospital admissions standardised admission ratio | 2019/20 | 530 | 363.0 | 597.0 | 266.0 | 408.7 | | 415.0 | | |
| 12 | COPD: Mortality (DSR per 100,000) | 2017-19 | 429 | 55.1 | 81.8 | 41.8 | 59.6 | | 53.9 | | |
| 13 | Hypertension: QOF prevalence (All Ages) (%) | 2019/20 | 40,668 | 14.4% | 11.3% | 11.7% | 12.5% | 11.0% | 14.1% | 7.4% | 18.9% |
| 14 | Diagnosed Hypertension: Estimated prevalence (%) | 2017 | 54,000 | 26.3% | 20.7% | 22.4% | 23.1% | 21.6% | 26.2% | 15.8% | 32.8% |
| 15 | Hypertension: Mortality Under 75 (Require PCMD) (DSR per 100,000) | 2017-2019 | 15 | 2.7 | 4.6 | 2.1 | 3.1 | 3.8 | 3.0 | 1.2 | 10.8 |
| 16 | Under 75 mortality rate from respiratory conditions considered to be preventable (DSR per 100,000) | 2017-19 | 128 | 20.2 | 38.2 | 11.8 | 23.4 | 17.3 | 20.0 | 44.7 | 6.4 |
| 17 | Stroke QOF Prevalence (All Ages) (%) | 2019/20 | 4,397 | 1.6% | 0.9% | 1.1% | 1.2% | 1.1% | 1.8% | 0.7% | 2.9% |
| 18 | Emergency hospital admissions for stroke, standardised admission ratio | 2019/20 | 365 | 144.0 | 175.1 | 155.2 | 158.1 | | 170.2 | 298.1 | 110.3 |
| 19 | Stroke - Under 75 Mortality (DSR per 100,000) | 2017-19 | 77 | 12.1 | 17.6 | 12.7 | 14.1 | | 12.5 | 24.7 | 6.8 |
| 20 | Learning Disability QOF Prevalence (All Ages) (%) | 2019/20 | 1,051 | 0.4% | 0.5% | 0.4% | 0.4% | 0.4% | 0.5% | 0.2% | 0.8% |
| 21 | Learning Disability: Completed Health checks (%) | 2018/19 | 674 | 73.7% | 66.2% | 61.2% | 67.0% | 58.2% | 52.3% | 3.4% | 87.2% |

*Data Source: Public Health England (PHE) & NHS Digital*

DRAFT

# Appendix 10: Older People & Frailty Dashboard

**BHR Joint Strategic Needs Assessment 2022**

**London Borough of Havering**

**Population Health Pillar: HSC - Older People**

**Benchmark: England**

| Compared with Benchmark: | Better | Similar | Worse | Not Compared | Higher | Lower |
|---|---|---|---|---|---|---|

| | Indicator | Period | Havering | | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Count | Value | Value | Value | Value | Value | Value | Lowest | Highest |
| 1 | Life expectancy at 65 (Years) - Females | 2018-20 | | 21.2 | 19.8 | 22.0 | | 22.0 | 21.1 | 21.1 | 21.2 |
| 2 | Life expectancy at 65 (Years) - Males | 2018-20 | | 18.2 | 16.7 | 19.2 | | 19.2 | 18.7 | 18.7 | 18.7 |
| 3 | Healthy life expectancy at 65 (Years) - Females | 2017-19 | | 10.8 | 8.5 | 12.1 | | 10.0 | 11.1 | 2.4 | 16.7 |
| 4 | Healthy life expectancy at 65 (Years) - Males | 2017-19 | | 10.9 | 8.5 | 8.4 | | 9.7 | 10.6 | 6.1 | 16.0 |
| 5 | Disability-free life expectancy at 65 (Years) - Females | 2017-19 | | 9.8 | 8.6 | 12.1 | | 9.7 | 9.7 | 6.0 | 13.5 |
| 6 | Disability-free life expectancy at 65 (Years) - Males | 2017-19 | | 10.8 | 9.3 | 10.0 | | 10.0 | 9.9 | 7.0 | 15.1 |
| 7 | Emergency hospital admissions due to falls in people aged 65 and over- Females (DSR per 100,000) | 2017/18 | 596 | 1862.2 | 1843.0 | 2097.0 | | 2542.4 | 2453.4 | | |
| 8 | Emergency hospital admissions due to falls in people aged 65 and over- Males (DSR per 100,000) | 2017/18 | 305 | 1588.7 | 1538.0 | 1424.2 | | 1981.5 | 1775.1 | | |
| 9 | Emergency hospital admissions due to falls in people aged 65 and over- Persons (DSR per 100,000) | 2019/20 | 845 | 1623.1 | 1670.4 | 1743.2 | | 2214.7 | 2221.8 | 1325.0 | 3394.0 |
| 10 | Hip fractures in people aged 65 and over- Females (DSR per 100,000) | 2017/18 | 233 | 705.5 | 710.0 | 712.7 | | 611.7 | 697.1 | | |
| 11 | Hip fractures in people aged 65 and over- Males (DSR per 100,000) | 2017/18 | 80 | 414.4 | 409.9 | 294.0 | | 372.3 | 410.7 | | |
| 12 | Hip fractures in people aged 65 and over- Persons (DSR per 100,000) | 2019/20 | 300 | 563.0 | 472.4 | 488.8 | | 472.7 | 571.6 | 326.0 | 912.0 |
| 13 | Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital (%) | 2019/20 | 200 | 89.3 | 85.0 | 92.9 | 89.6 | 83.4 | 82.0 | 42.9 | 96.9 |
| 14 | Emergency readmissions within 30 days of discharge from hospital (%) | 2018/19 | 4,810 | 16.8 | 16.6 | 15.4 | 16.7 | | 14.4 | 11.7 | 17.2 |
| 15 | Delayed transfers of care from hospital, per 100,000 | 2019 | 12 | 6.2 | 5.7 | 5.3 | 5.7 | 6.8 | 10.8 | | |
| 16 | Percentage of deaths that occur in hospital (ages 65-74) | 2019 | 198 | 54.2 | 55.3 | 61.3 | 56.6 | 56.1 | 48.3 | 35.4 | 63.6 |
| 17 | Percentage of deaths that occur in hospital (ages 75-84) | 2019 | 331 | 50.3 | 50.7 | 63.9 | 54.8 | 56.6 | 48.4 | 39.8 | 63.9 |
| 18 | Percentage of deaths that occur in hospital (ages 85+) | 2019 | 501 | 45.7 | 47.4 | 54.6 | 48.7 | 50.7 | 41.4 | 31.7 | 59.0 |
| 19 | Rate of permanent admissions to residential and nursing care homes (ages 65+, per 100,000) | 2019/20 | 295 | 631.6 | 677.5 | 401.5 | 555.3 | 431.3 | 584.0 | 61.0 | 1724.0 |
| 20 | Older People who are Income Deprived (IMD) (%) | 2019 | 6,875 | 11.7 | 26.1 | 19.5 | 17.4 | 20.6 | 14.2 | 5.0 | 43.9 |
| 21 | Excess winter mortality | 2018/19 | 140 | 20.5 | 26.2 | 17.7 | | 13.7 | 14.6 | -20.0 | 210.0 |
| 22 | Population vaccination coverage - Flu (aged 65+) (%) | 2019/20 | 31,302 | 70.0 | 65.0 | 68.0 | | 66.2 | 72.4 | 58.3 | 80.1 |
| 23 | Care home beds per 100 people aged 75+ | 2021 | 1,834 | 8.0 | 8.0 | 7.7 | 7.9 | 7.1 | 9.4 | 2.3 | 17.2 |
| 24 | People invited for an NHS Health Check per year (%) | 2020/21 | 1,630 | 2.3 | 4.5 | 4.5 | 3.7 | 3.6 | 3.1 | | |
| 25 | People receiving an NHS Health Check per year (%) | 2020/21 | 586 | 0.8 | 2.5 | 1.4 | 1.5 | 2.2 | 1.2 | 0.0 | 9.2 |
| 26 | People taking up an NHS Health Check invite per year (%) | 2020/21 | 586 | 36.0 | 56.7 | 30.8 | 39.8 | 62.5 | 39.0 | | |

*Data Source: Public Health England (PHE), NHS Digital and IMD*

DRAFT

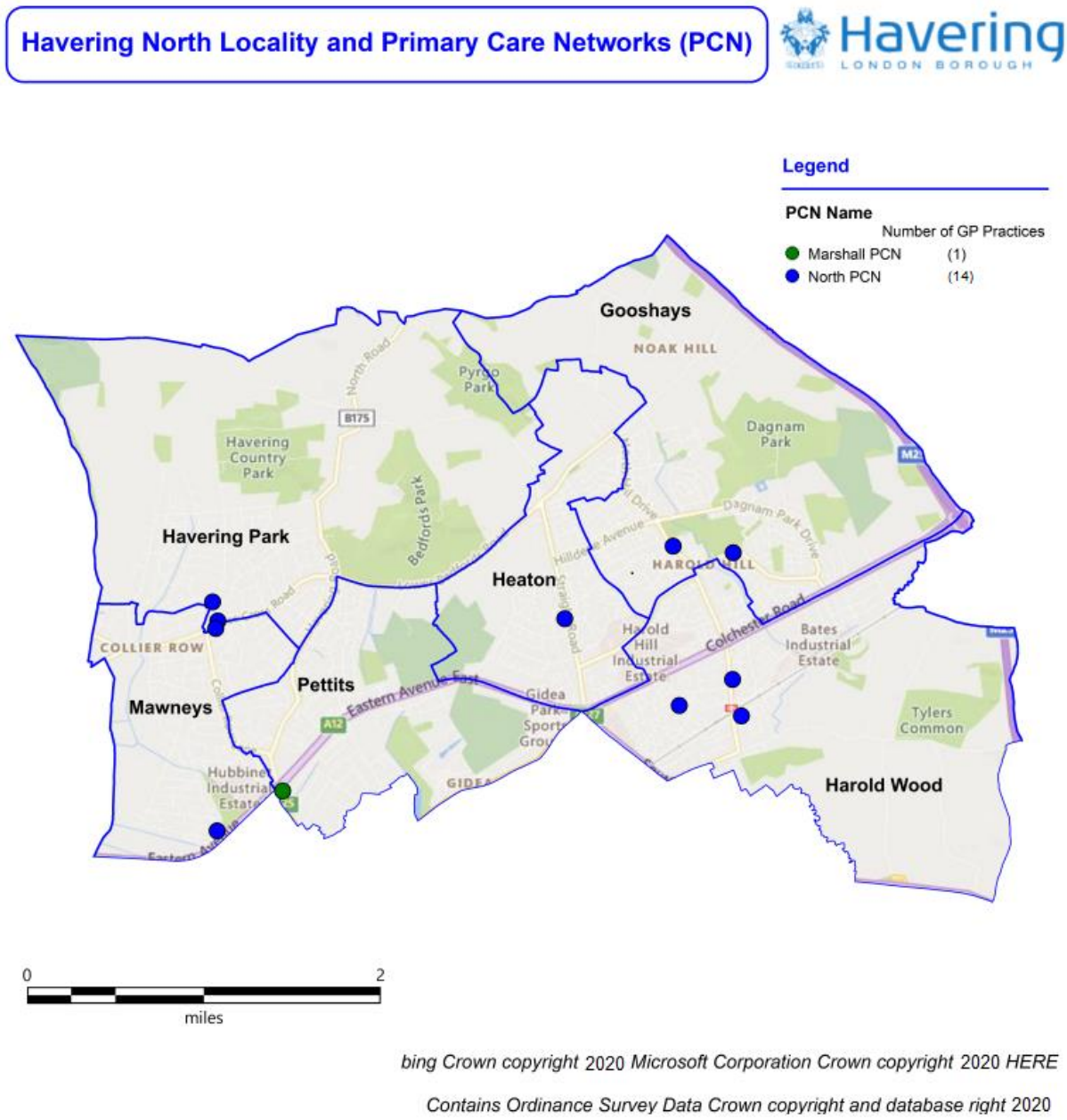
# Appendix 11: Localities Data

## London Borough of Havering (LBH) – North Locality

### 1. Places and Communities

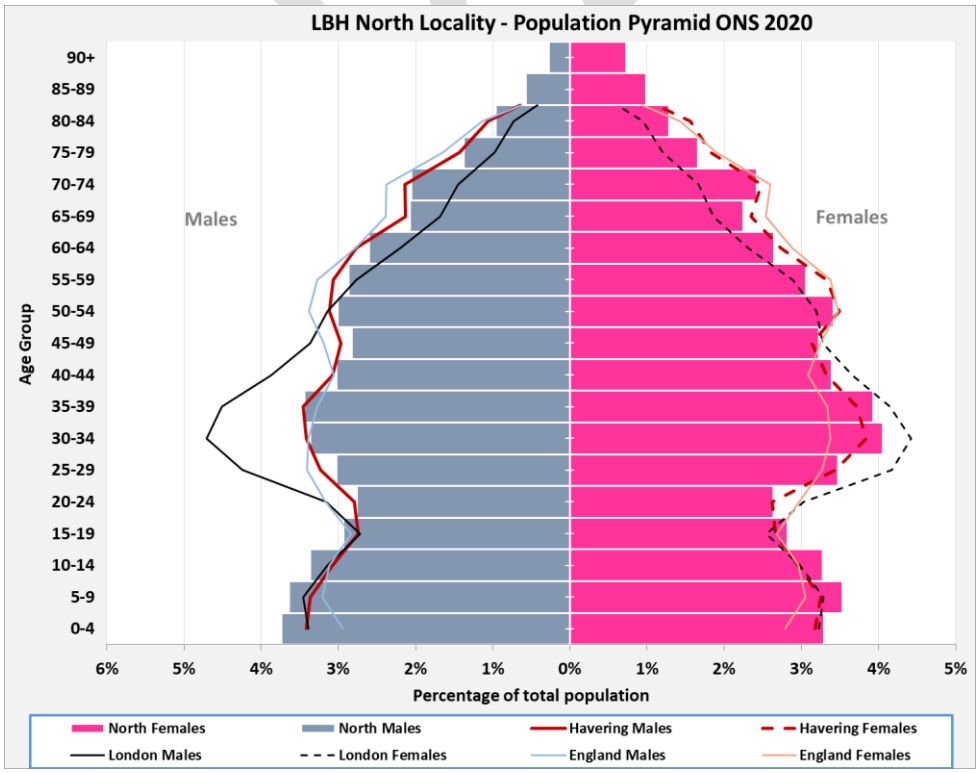
### 1.1 Havering north locality map

Wards include: Gooshays, Harold Wood, Havering Park, Heaton, Mawneys, Pettits



## 1.2 Estimated population of LBH North locality residents by gender and five year age groups - 2020

| Age Band (Years) | Males | Females | Totals |
|---|---|---|---|
| **0-4** | 3,333 | 2,943 | 6,276 |
| **5-9** | 3,246 | 3,157 | 6,403 |
| **10-14** | 3,004 | 2,925 | 5,929 |
| **15-19** | 2,618 | 2,518 | 5,136 |
| **20-24** | 2,465 | 2,356 | 4,821 |
| **25-29** | 2,698 | 3,105 | 5,803 |
| **30-34** | 3,000 | 3,619 | 6,619 |
| **35-39** | 3,067 | 3,507 | 6,574 |
| **40-44** | 2,703 | 3,027 | 5,730 |
| **45-49** | 2,519 | 2,881 | 5,400 |
| **50-54** | 2,685 | 3,048 | 5,733 |
| **55-59** | 2,557 | 2,732 | 5,289 |
| **60-64** | 2,324 | 2,362 | 4,686 |
| **65-69** | 1,849 | 2,011 | 3,860 |
| **70-74** | 1,836 | 2,163 | 3,999 |
| **75-79** | 1,224 | 1,479 | 2,703 |
| **80-84** | 855 | 1,151 | 2,006 |
| **85-89** | 510 | 886 | 1,396 |
| **90+** | 242 | 651 | 893 |
| **Totals** | **42,735** | **46,521** | **89,256** |




Source: ONS 2020 Mid-Year Estimates

## 1.3 LBH PCN Profile - GP population 5 year age groups

| | HAVERING CREST PCN | | | HAVERING MARSHALL PCN | | | HAVERING NORTH PCN | | | HAVERING SOUTH PCN | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Age Band (Years)** | **F** | **M** | **PER** | **F** | **M** | **PER** | **F** | **M** | **PER** | **F** | **M** | **PER** | **Havering Total** |
| **0_4** | 1263 | 1362 | 2625 | 1352 | 1434 | 2786 | 2609 | 2865 | 5474 | 2802 | 2909 | 5711 | 16596 |
| **5_9** | 1383 | 1381 | 2764 | 1417 | 1494 | 2911 | 3036 | 3198 | 6234 | 3179 | 3257 | 6436 | 18345 |
| **10_14** | 1295 | 1282 | 2577 | 1278 | 1351 | 2629 | 2845 | 3003 | 5848 | 2974 | 3161 | 6135 | 17189 |
| **15_19** | 1103 | 1194 | 2297 | 1206 | 1246 | 2452 | 2510 | 2602 | 5112 | 2855 | 2863 | 5718 | 15579 |
| **20_24** | 1131 | 1173 | 2304 | 1243 | 1252 | 2495 | 2481 | 2455 | 4936 | 2885 | 2934 | 5819 | 15554 |
| **25_29** | 1631 | 1436 | 3067 | 1639 | 1432 | 3071 | 2959 | 2772 | 5731 | 3323 | 3367 | 6690 | 18559 |
| **30_34** | 1835 | 1654 | 3489 | 1941 | 1750 | 3691 | 3550 | 3141 | 6691 | 3661 | 3626 | 7287 | 21158 |
| **35_39** | 1662 | 1619 | 3281 | 1807 | 1858 | 3665 | 3637 | 3280 | 6917 | 3845 | 3622 | 7467 | 21330 |
| **40_44** | 1400 | 1540 | 2940 | 1671 | 1631 | 3302 | 3041 | 3156 | 6197 | 3467 | 3419 | 6886 | 19325 |
| **45_49** | 1347 | 1391 | 2738 | 1407 | 1538 | 2945 | 2786 | 2795 | 5581 | 3208 | 3285 | 6493 | 17757 |
| **50_54** | 1392 | 1375 | 2767 | 1535 | 1566 | 3101 | 2862 | 2835 | 5697 | 3614 | 3570 | 7184 | 18749 |
| **55_59** | 1333 | 1363 | 2696 | 1514 | 1506 | 3020 | 2679 | 2657 | 5336 | 3895 | 3704 | 7599 | 18651 |
| **60_64** | 1197 | 1172 | 2369 | 1310 | 1248 | 2558 | 2324 | 2295 | 4619 | 3379 | 3383 | 6762 | 16308 |
| **65_69** | 905 | 894 | 1799 | 1090 | 981 | 2071 | 1786 | 1729 | 3515 | 2730 | 2588 | 5318 | 12703 |
| **70_74** | 857 | 749 | 1606 | 1122 | 981 | 2103 | 1863 | 1628 | 3491 | 2953 | 2601 | 5554 | 12754 |
| **75_79** | 720 | 529 | 1249 | 909 | 789 | 1698 | 1355 | 1040 | 2395 | 2373 | 1893 | 4266 | 9608 |
| **80_84** | 567 | 402 | 969 | 689 | 477 | 1166 | 929 | 717 | 1646 | 1766 | 1241 | 3007 | 6788 |
| **85_89** | 406 | 253 | 659 | 501 | 270 | 771 | 628 | 407 | 1035 | 1325 | 861 | 2186 | 4651 |
| **90_94** | 167 | 100 | 267 | 287 | 152 | 439 | 336 | 159 | 495 | 641 | 333 | 974 | 2175 |
| **95+** | 43 | 22 | 65 | 87 | 27 | 114 | 121 | 36 | 157 | 191 | 61 | 252 | 588 |
| **PCN Total** | **21637** | **20891** | **42528** | **24005** | **22983** | **46988** | **44337** | **42770** | **87107** | **55066** | **52678** | **107744** | **284367** |

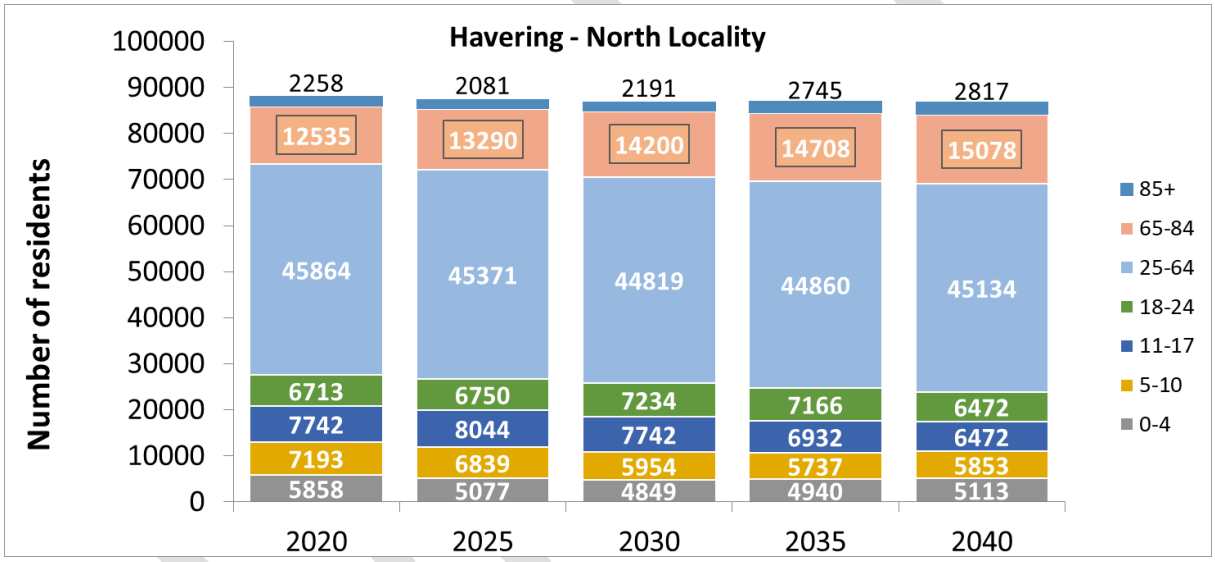
Source: NHS Digital GP Registrations (September 2021)

DRAFT

## 1.4 LBH North Location Population Projections 2020, 2025, 2030, 2035, 2040

| Area | 2020 | 2025 | 2030 | % change | 2035 | % change | 2040 | % change |
|---|---|---|---|---|---|---|---|---|
| North | 88,163 | 87,452 | 86,989 | -1.3 | 87,088 | -1.2 | 86,939 | -1.4 |

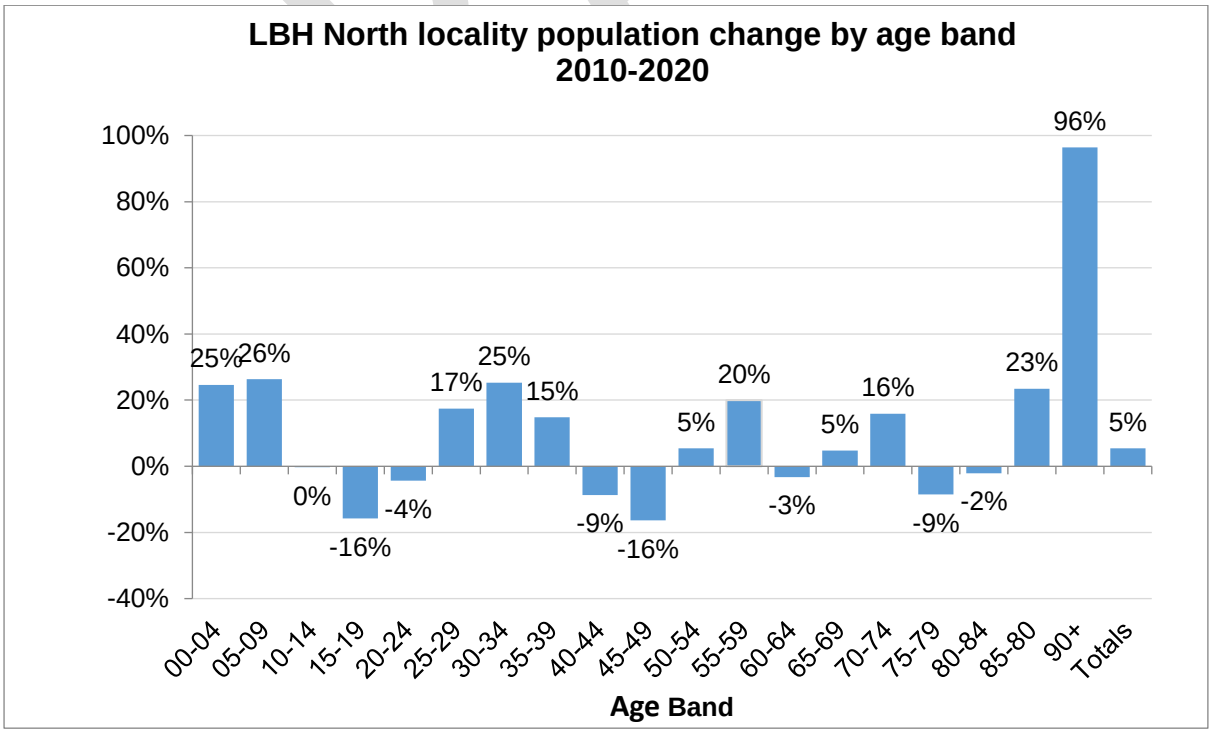
| North | 2020 | 2025 | 2030 | 2035 | 2040 |
|---|---|---|---|---|---|
| 0-4 | 5858 | 5077 | 4849 | 4940 | 5113 |
| 5-10 | 7193 | 6839 | 5954 | 5737 | 5853 |
| 11-17 | 7742 | 8044 | 7742 | 6932 | 6472 |
| 18-24 | 6713 | 6750 | 7234 | 7166 | 6472 |
| 25-64 | 45864 | 45371 | 44819 | 44860 | 45134 |
| 65-84 | 12535 | 13290 | 14200 | 14708 | 15078 |
| 85+ | 2258 | 2081 | 2191 | 2745 | 2817 |
| Total | 88,163 | 87,452 | 86,989 | 87,088 | 86,939 |




Source: GLA Household led population projections using 2020-based Demographic Projections, Ward population projections for London Boroughs 2020-based Scenario Projection: Identified Capacity Scenario

## 1.5 LBH North Locality population change by age band 2010 - 2020

| Age Band | 2010 | 2020 | Change | % |
|---|---|---|---|---|
| **00-04** | 5062 | 6276 | 1214 | 24 |
| **05-09** | 4733 | 6403 | 1670 | 35 |
| **10-14** | 5092 | 5929 | 837 | 16 |
| **15-19** | 5309 | 5136 | -173 | -3 |
| **20-24** | 4631 | 4821 | 190 | 4 |
| **25-29** | 4836 | 5803 | 967 | 20 |
| **30-34** | 4881 | 6619 | 1738 | 36 |
| **35-39** | 5135 | 6574 | 1439 | 28 |
| **40-44** | 5682 | 5730 | 48 | 1 |
| **45-49** | 5599 | 5400 | -199 | -4 |
| **50-54** | 5154 | 5733 | 579 | 11 |
| **55-59** | 4414 | 5289 | 875 | 20 |
| **60-64** | 4906 | 4686 | -220 | -4 |
| **65-69** | 3422 | 3860 | 438 | 13 |
| **70-74** | 2985 | 3999 | 1014 | 34 |
| **75-79** | 2661 | 2703 | 42 | 2 |
| **80-84** | 2105 | 2006 | -99 | -5 |
| **85-89** | 1465 | 1396 | -69 | -5 |
| **90+** | 583 | 893 | 310 | 53 |
| **Total** | 78655 | 89256 | 10601 | 13 |




Source: ONS mid-year population estimates

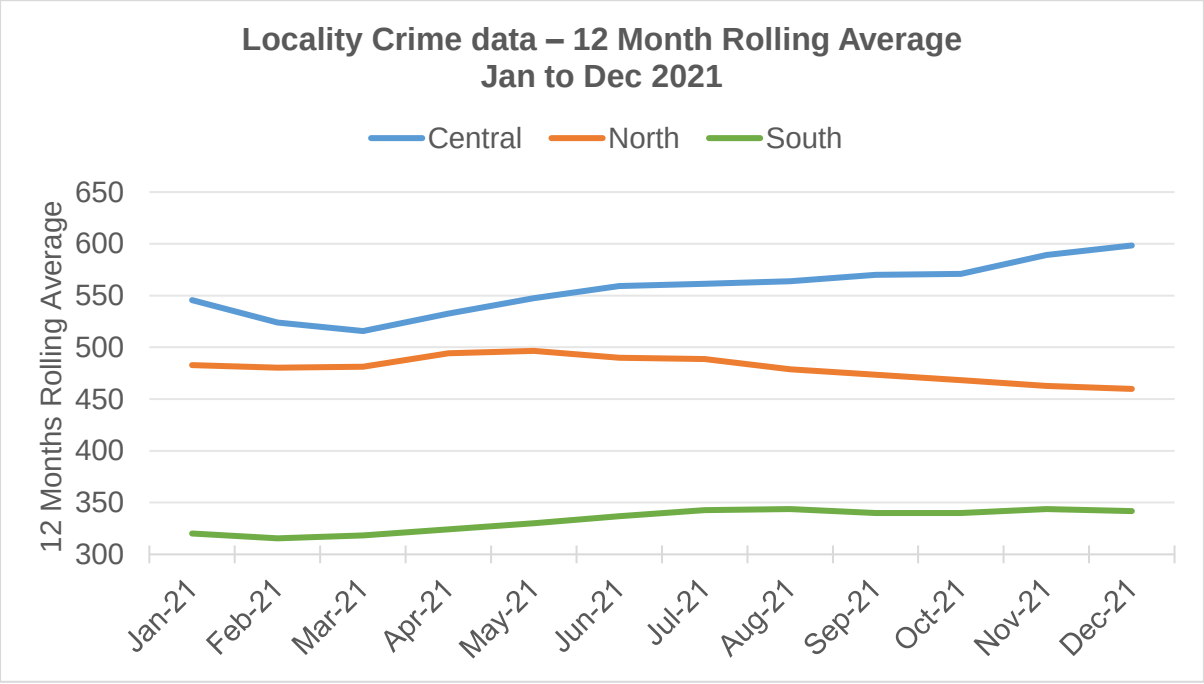
DRAFT

### 1.6 Ethnicity

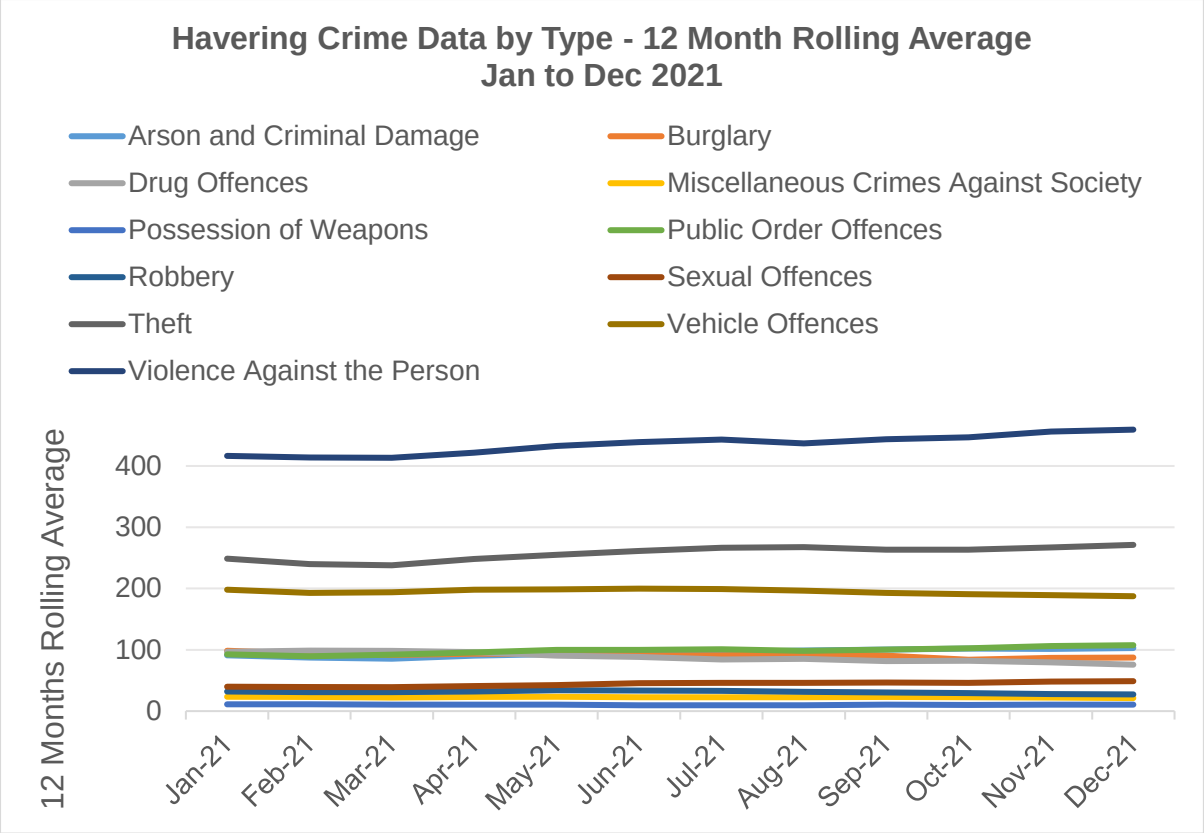
| Ethnic group | Number | % |
|---|---|---|
| British | 66,135 | 83.9 |
| African | 3,143 | 4.0 |
| Indian or British Indian | 1,134 | 1.4 |
| Irish | 785 | 1.0 |
| Caribbean | 1,035 | 1.3 |
| White and Black Caribbean | 677 | 0.9 |
| Pakistani or British Pakistani | 457 | 0.6 |
| Chinese | 395 | 0.5 |
| White and Asian | 349 | 0.4 |
| European mixed | 383 | 0.5 |
| Other | 4,289 | 5.4 |
| Totals | 78,782 | 100 |

Source: Census 2011

### 1.7 Crime data – 12 month rolling average




Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).




Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).

### 1.8 Projected new homes in North Locality

The London Plan 2021 sets a ten year housing target for Havering of 12,850 new homes between 2019/20 and 2028/29 or 1,285 per annum. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

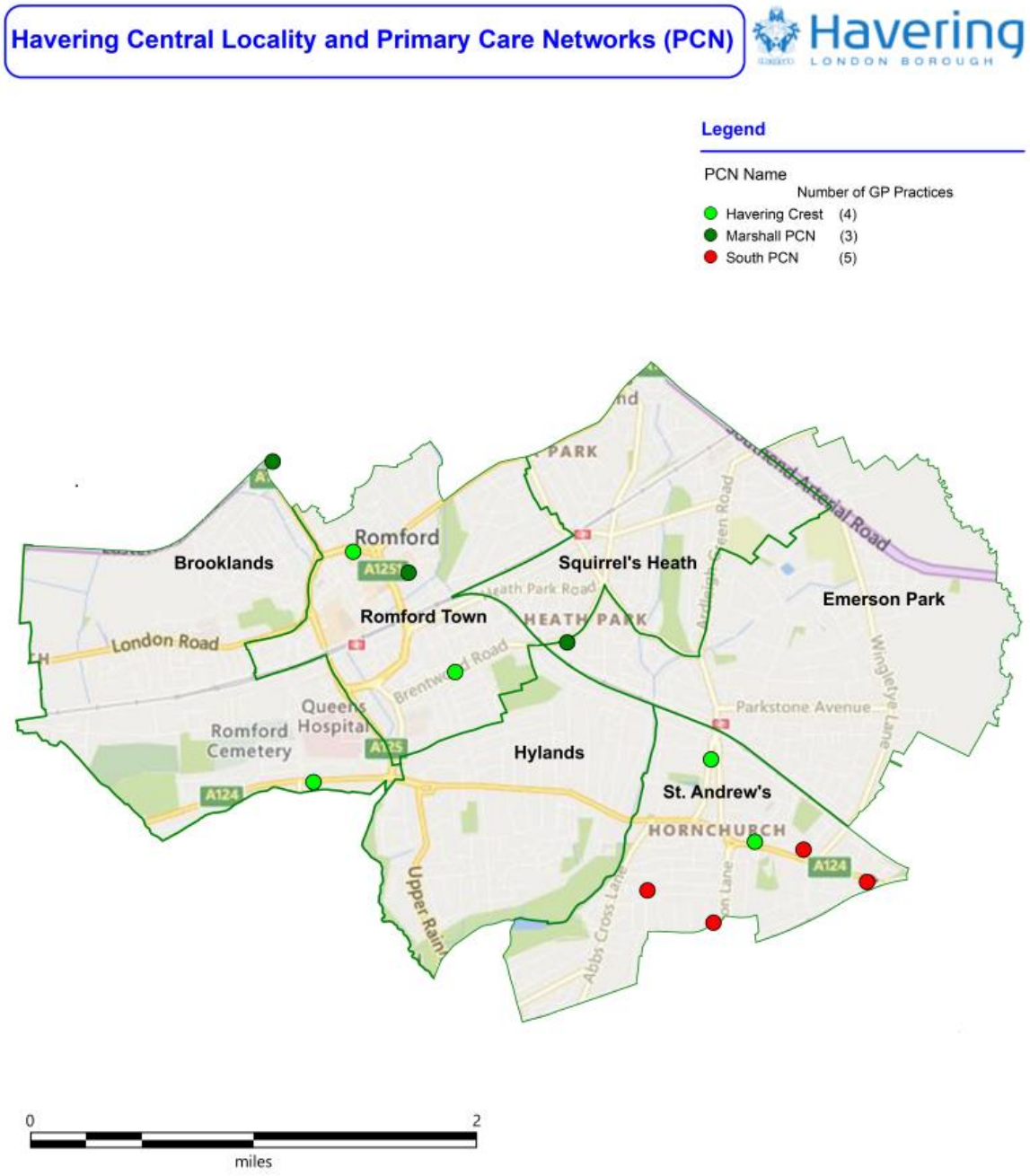
| Locality | Number of houses |
|---|---|
| Central | 4992 |
| North | 717 |
| South | 3702 |
| Total | 9411 |

# London Borough of Havering (LBH) – Central Locality

## 1. Places and Communities

### 1.1 Havering central locality map

Wards include:  Brooklands, Emerson Park, Hylands, Romford Town, St. Andrews, Squirrel's Heath

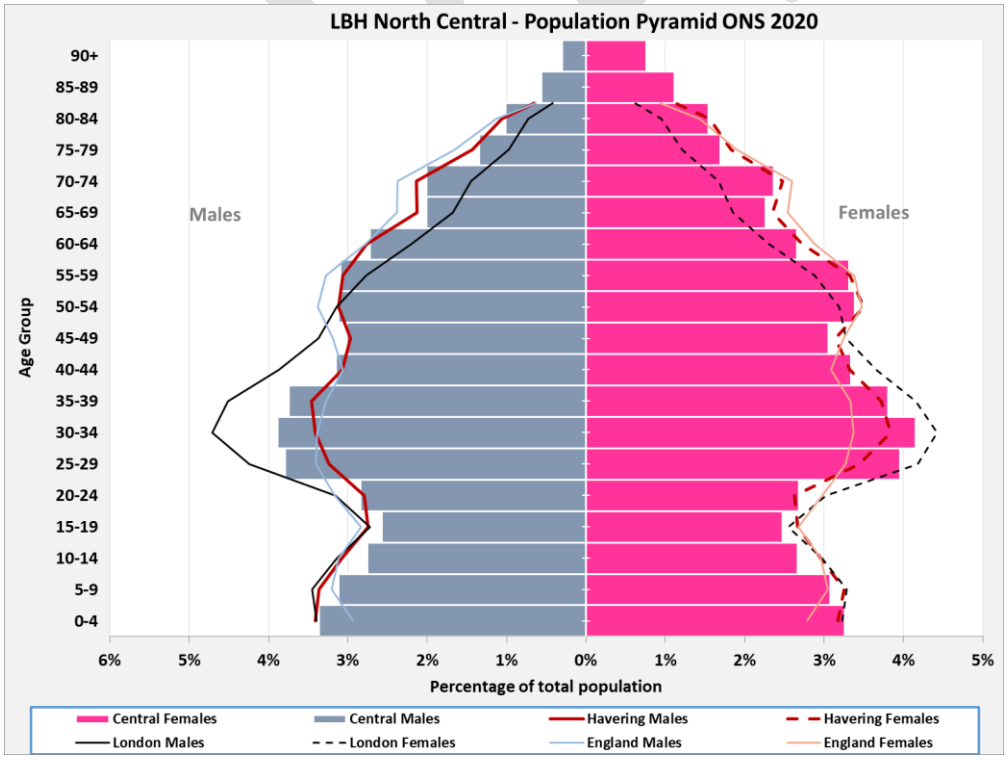



bing Crown copyright 2020 Microsoft Corporation Crown copyright 2020 HERE

Contains Ordinance Survey Data Crown copyright and database right [2020]

## 1.2 Estimated population of LBH Central locality residents by gender and five year age groups – 2020

| Age Band (Years) | Males | Females | Totals |
|---|---|---|---|
| **0-4** | 3,069 | 2,975 | 6,044 |
| **5-9** | 2,845 | 2,813 | 5,658 |
| **10-14** | 2,512 | 2,438 | 4,950 |
| **15-19** | 2,350 | 2,263 | 4,613 |
| **20-24** | 2,595 | 2,447 | 5,042 |
| **25-29** | 3,460 | 3,616 | 7,076 |
| **30-34** | 3,545 | 3,793 | 7,338 |
| **35-39** | 3,419 | 3,473 | 6,892 |
| **40-44** | 2,875 | 3,046 | 5,921 |
| **45-49** | 2,749 | 2,791 | 5,540 |
| **50-54** | 2,848 | 3,092 | 5,940 |
| **55-59** | 2,827 | 3,027 | 5,854 |
| **60-64** | 2,486 | 2,429 | 4,915 |
| **65-69** | 1,837 | 2,064 | 3,901 |
| **70-74** | 1,834 | 2,162 | 3,996 |
| **75-79** | 1,228 | 1,549 | 2,777 |
| **80-84** | 923 | 1,408 | 2,331 |
| **85-89** | 514 | 1,022 | 1,536 |
| **90+** | 275 | 694 | 969 |
| **Totals** | **44,191** | **47,102** | **91,293** |




Source: ONS 2020 Mid-Year Estimates

## 1.3 LBH PCN Profile - GP population 5 year age groups

| | HAVERING CREST PCN | | | HAVERING MARSHALL PCN | | | HAVERING NORTH PCN | | | HAVERING SOUTH PCN | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Age Band (Years)** | **F** | **M** | **PER** | **F** | **M** | **PER** | **F** | **M** | **PER** | **F** | **M** | **PER** | **Havering Total** |
| **0_4** | 1263 | 1362 | 2625 | 1352 | 1434 | 2786 | 2609 | 2865 | 5474 | 2802 | 2909 | 5711 | 16596 |
| **5_9** | 1383 | 1381 | 2764 | 1417 | 1494 | 2911 | 3036 | 3198 | 6234 | 3179 | 3257 | 6436 | 18345 |
| **10_14** | 1295 | 1282 | 2577 | 1278 | 1351 | 2629 | 2845 | 3003 | 5848 | 2974 | 3161 | 6135 | 17189 |
| **15_19** | 1103 | 1194 | 2297 | 1206 | 1246 | 2452 | 2510 | 2602 | 5112 | 2855 | 2863 | 5718 | 15579 |
| **20_24** | 1131 | 1173 | 2304 | 1243 | 1252 | 2495 | 2481 | 2455 | 4936 | 2885 | 2934 | 5819 | 15554 |
| **25_29** | 1631 | 1436 | 3067 | 1639 | 1432 | 3071 | 2959 | 2772 | 5731 | 3323 | 3367 | 6690 | 18559 |
| **30_34** | 1835 | 1654 | 3489 | 1941 | 1750 | 3691 | 3550 | 3141 | 6691 | 3661 | 3626 | 7287 | 21158 |
| **35_39** | 1662 | 1619 | 3281 | 1807 | 1858 | 3665 | 3637 | 3280 | 6917 | 3845 | 3622 | 7467 | 21330 |
| **40_44** | 1400 | 1540 | 2940 | 1671 | 1631 | 3302 | 3041 | 3156 | 6197 | 3467 | 3419 | 6886 | 19325 |
| **45_49** | 1347 | 1391 | 2738 | 1407 | 1538 | 2945 | 2786 | 2795 | 5581 | 3208 | 3285 | 6493 | 17757 |
| **50_54** | 1392 | 1375 | 2767 | 1535 | 1566 | 3101 | 2862 | 2835 | 5697 | 3614 | 3570 | 7184 | 18749 |
| **55_59** | 1333 | 1363 | 2696 | 1514 | 1506 | 3020 | 2679 | 2657 | 5336 | 3895 | 3704 | 7599 | 18651 |
| **60_64** | 1197 | 1172 | 2369 | 1310 | 1248 | 2558 | 2324 | 2295 | 4619 | 3379 | 3383 | 6762 | 16308 |
| **65_69** | 905 | 894 | 1799 | 1090 | 981 | 2071 | 1786 | 1729 | 3515 | 2730 | 2588 | 5318 | 12703 |
| **70_74** | 857 | 749 | 1606 | 1122 | 981 | 2103 | 1863 | 1628 | 3491 | 2953 | 2601 | 5554 | 12754 |
| **75_79** | 720 | 529 | 1249 | 909 | 789 | 1698 | 1355 | 1040 | 2395 | 2373 | 1893 | 4266 | 9608 |
| **80_84** | 567 | 402 | 969 | 689 | 477 | 1166 | 929 | 717 | 1646 | 1766 | 1241 | 3007 | 6788 |
| **85_89** | 406 | 253 | 659 | 501 | 270 | 771 | 628 | 407 | 1035 | 1325 | 861 | 2186 | 4651 |
| **90_94** | 167 | 100 | 267 | 287 | 152 | 439 | 336 | 159 | 495 | 641 | 333 | 974 | 2175 |
| **95+** | 43 | 22 | 65 | 87 | 27 | 114 | 121 | 36 | 157 | 191 | 61 | 252 | 588 |
| **PCN Total** | **21637** | **20891** | **42528** | **24005** | **22983** | **46988** | **44337** | **42770** | **87107** | **55066** | **52678** | **107744** | **284367** |

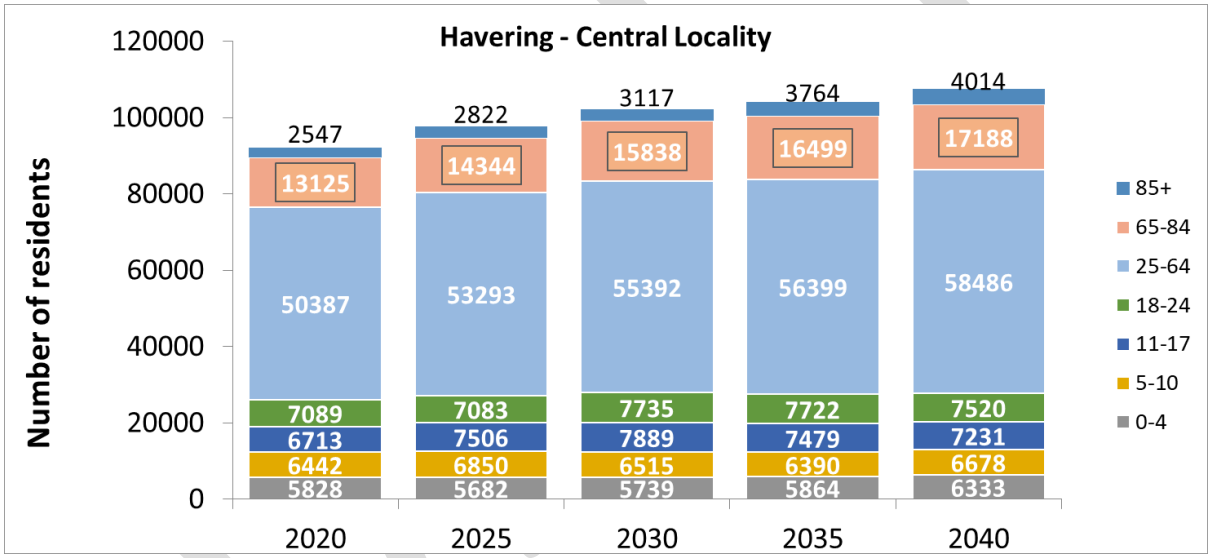
Source: NHS Digital GP Registrations (September 2021)

DRAFT

## 1.4 LBH Central Location Population Projections 2020, 2025, 2030, 2035, 2040

| Area | 2020 | 2025 | 2030 | % change | 2035 | % change | 2040 | % change |
|---|---|---|---|---|---|---|---|---|
| Central | 92,131 | 97,580 | 102,225 | 11.0 | 104,117 | 13.0 | 107,450 | 16.6 |

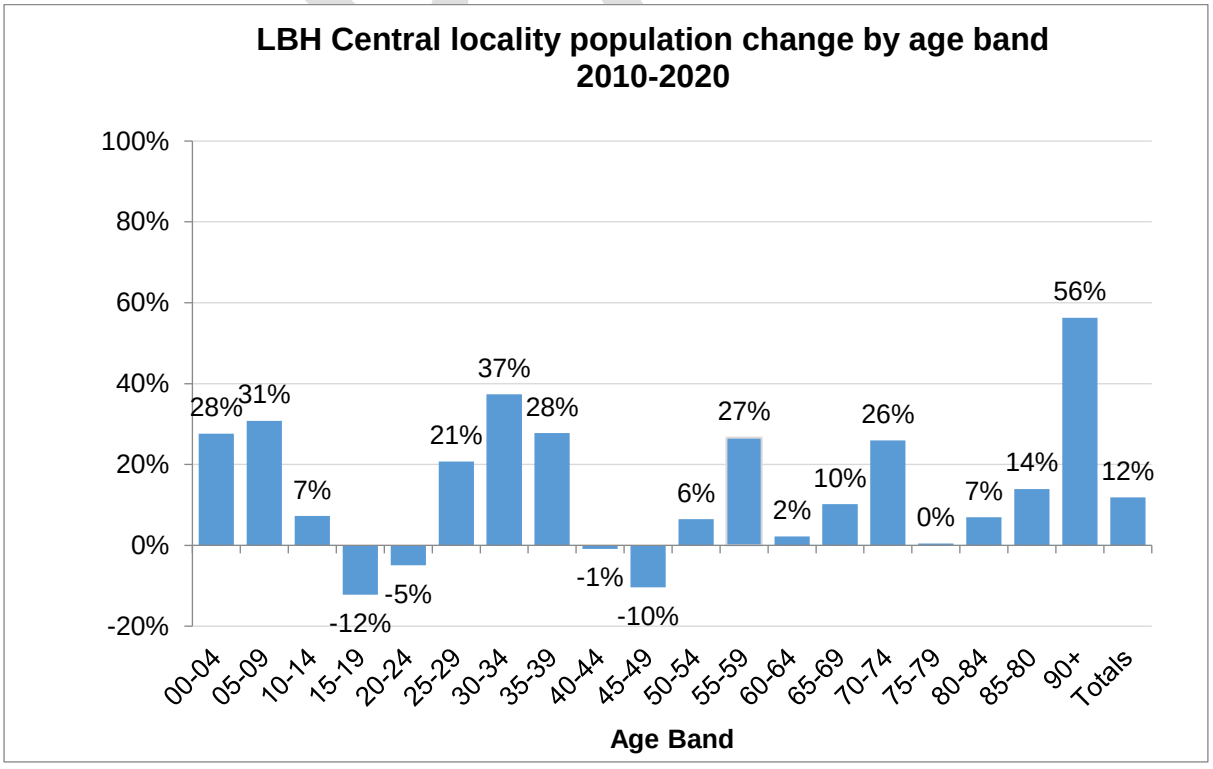
| Central | 2020 | 2025 | 2030 | 2035 | 2040 |
|---|---|---|---|---|---|
| 0-4 | 5828 | 5682 | 5739 | 5864 | 6333 |
| 5-10 | 6442 | 6850 | 6515 | 6390 | 6678 |
| 11-17 | 6713 | 7506 | 7889 | 7479 | 7231 |
| 18-24 | 7089 | 7083 | 7735 | 7722 | 7520 |
| 25-64 | 50387 | 53293 | 55392 | 56399 | 58486 |
| 65-84 | 13125 | 14344 | 15838 | 16499 | 17188 |
| 85+ | 2547 | 2822 | 3117 | 3764 | 4014 |
| Total | 92,131 | 97,580 | 102,225 | 104,117 | 107,450 |




Source: GLA Household led population projections using 2020-based Demographic Projections, Ward population projections for London Boroughs 2020-based Scenario Projection: Identified Capacity Scenario

### 1.5 LBH Central Locality population change by age band 2010 - 2020

| Age Band | 2010 | 2020 | Change | % |
|---|---|---|---|---|
| **00-04** | 4737 | 6044 | 1307 | 28 |
| **05-09** | 4325 | 5658 | 1333 | 31 |
| **10-14** | 4616 | 4950 | 334 | 7 |
| **15-19** | 5256 | 4613 | -643 | -12 |
| **20-24** | 5305 | 5042 | -263 | -5 |
| **25-29** | 5863 | 7076 | 1213 | 21 |
| **30-34** | 5341 | 7338 | 1997 | 37 |
| **35-39** | 5395 | 6892 | 1497 | 28 |
| **40-44** | 5974 | 5921 | -53 | -1 |
| **45-49** | 6183 | 5540 | -643 | -10 |
| **50-54** | 5580 | 5940 | 360 | 6 |
| **55-59** | 4623 | 5854 | 1231 | 27 |
| **60-64** | 4811 | 4915 | 104 | 2 |
| **65-69** | 3539 | 3901 | 362 | 10 |
| **70-74** | 3172 | 3996 | 824 | 26 |
| **75-79** | 2765 | 2777 | 12 | 0 |
| **80-84** | 2180 | 2331 | 151 | 7 |
| **85-89** | 1348 | 1536 | 188 | 14 |
| **90+** | 620 | 969 | 349 | 56 |
| **Total** | 81633 | 91293 | 9660 | 12 |



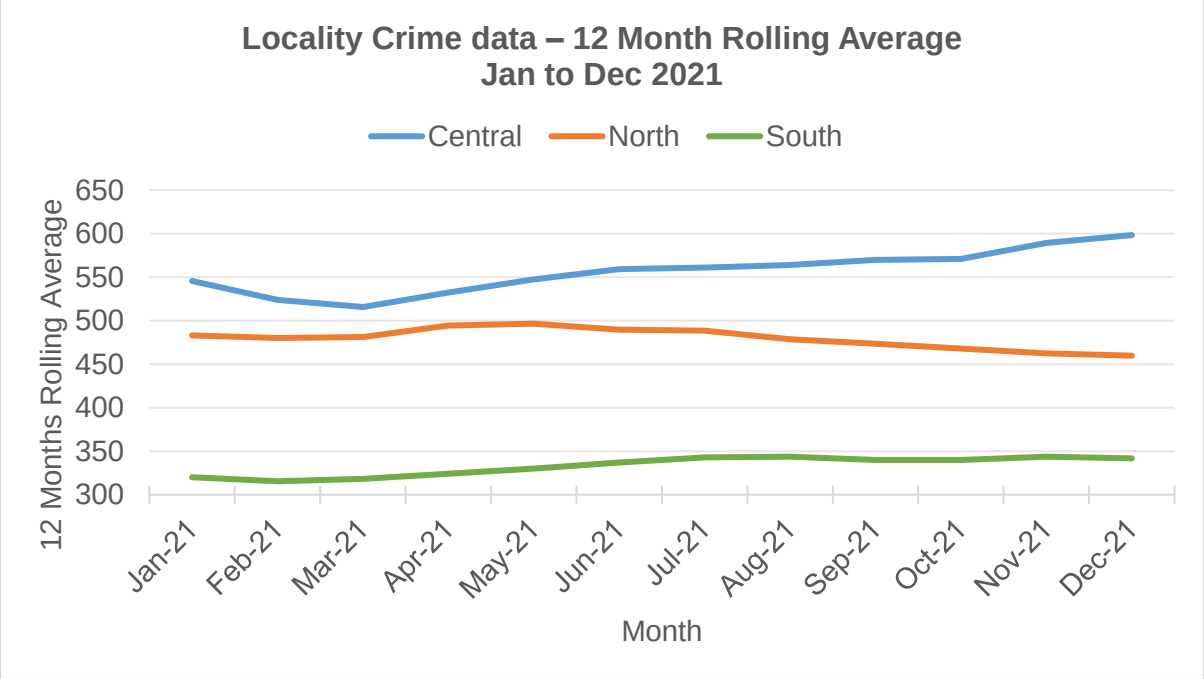

Source: ONS mid-year population estimates

### 1.6 Ethnicity

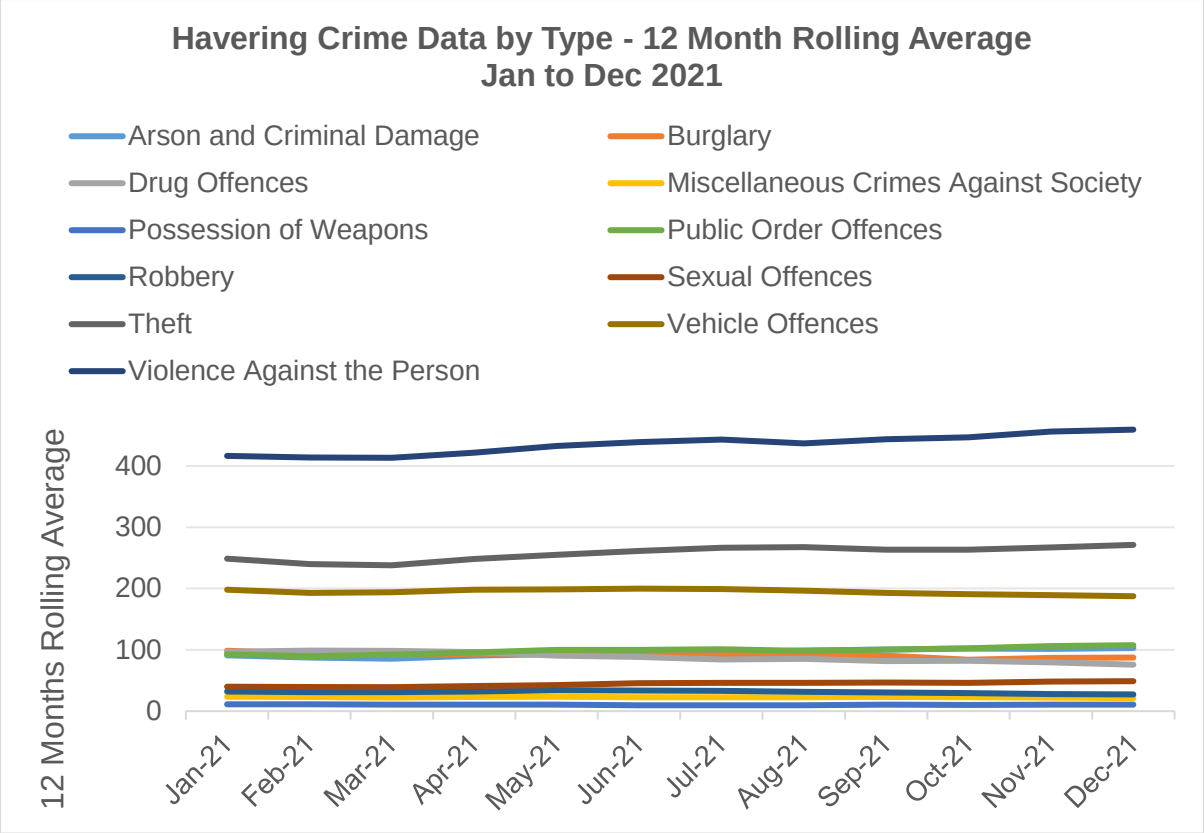
| Ethnic group | Number | % |
|---|---|---|
| British | 66,455 | 80.7 |
| African | 2,184 | 2.7 |
| Indian or British Indian | 2,611 | 3.2 |
| Irish | 1,287 | 1.6 |
| Caribbean | 1,171 | 1.4 |
| White and Black Caribbean | 675 | 0.8 |
| Pakistani or British Pakistani | 758 | 0.9 |
| Chinese | 665 | 0.8 |
| White and Asian | 464 | 0.6 |
| European mixed | 423 | 0.5 |
| Other | 5,642 | 6.9 |
| Totals | 82,335 | 100 |

Source: Census 2011

### 1.7 Crime data – 12 month rolling average




Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).




Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).

### 1.8 Projected new homes in Central Locality

The London Plan 2021 sets a ten year housing target for Havering of 12,850 new homes between 2019/20 and 2028/29 or 1,285 per annum. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

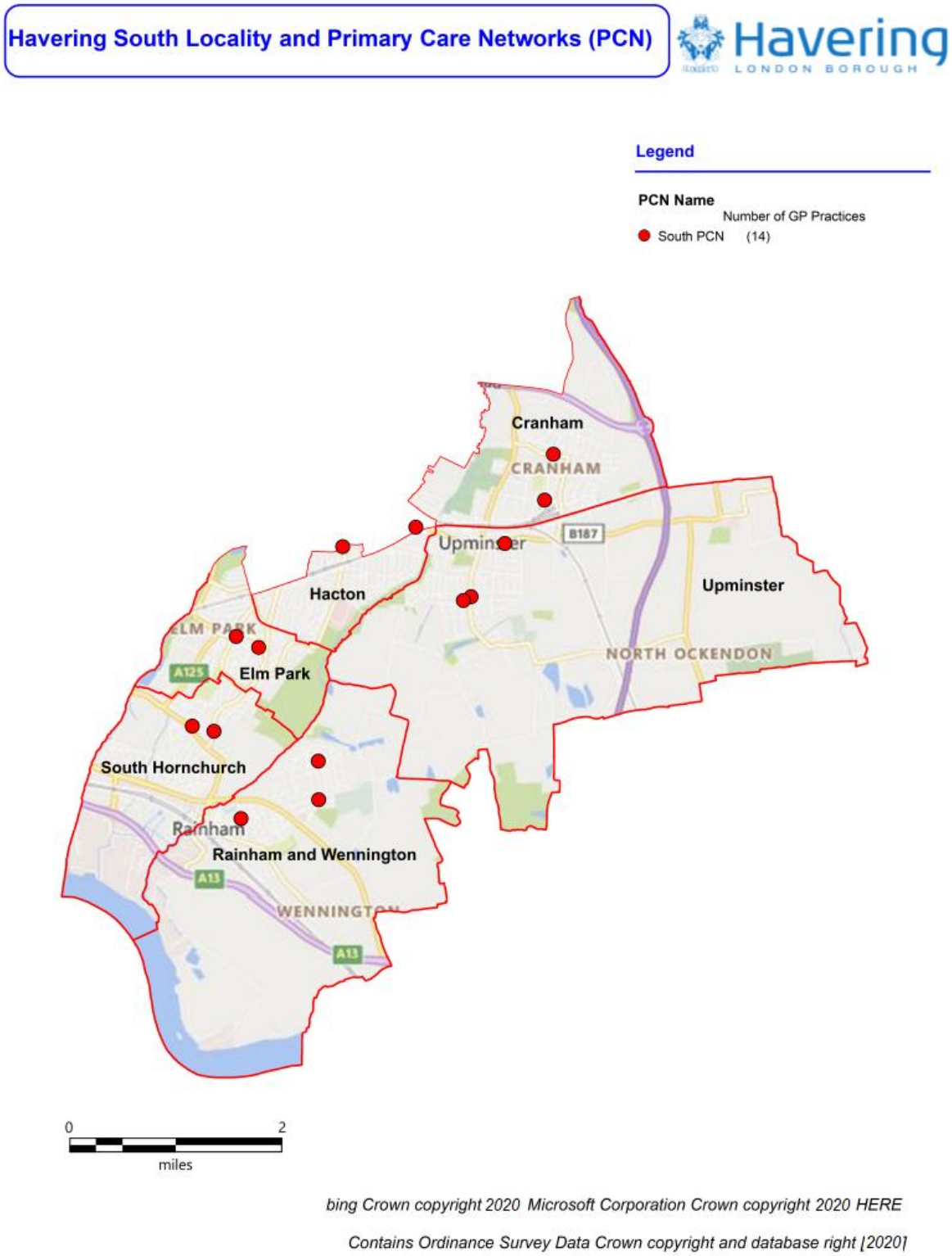
| Locality | Number of houses |
|---|---|
| Central | 4992 |
| North | 717 |
| South | 3702 |
| Total | 9411 |

# London Borough of Havering (LBH) – South Locality

## 1. Places and Communities

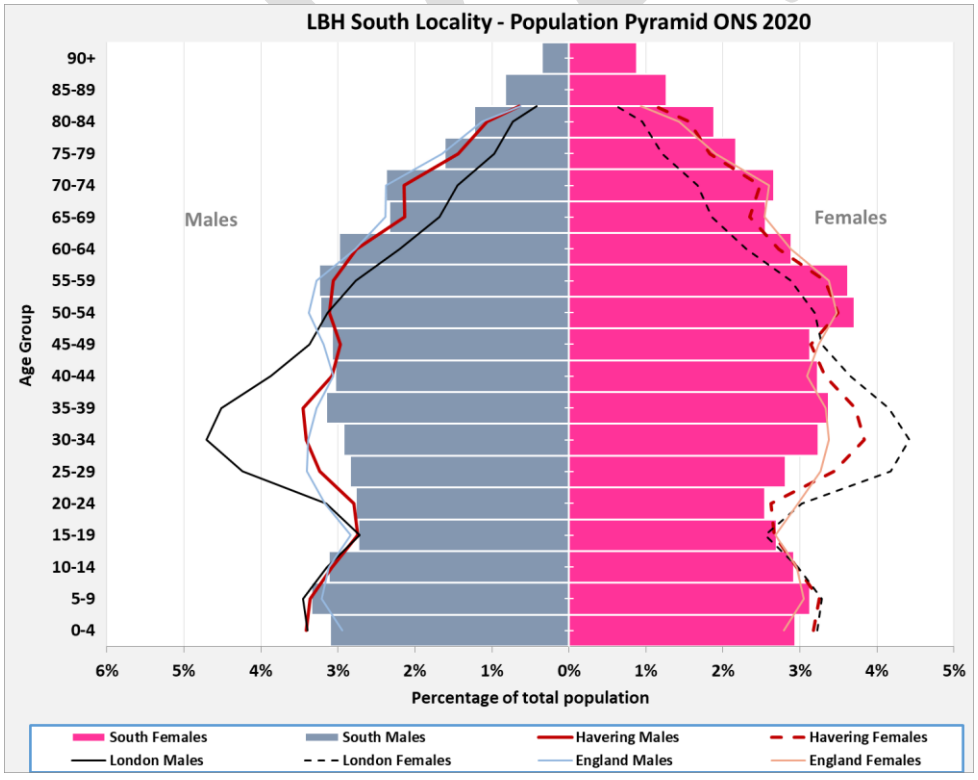
### 1.1 Havering South locality map

Wards include: Cranham, Elm Park, Hacton, Rainham and Wennington, South Hornchurch, Upminster



## 1.2 Estimated population of LBH South locality residents by gender and five year age groups - 2020

| Age Band (Years) | Male | Female | Totals |
|---|---|---|---|
| **0-4** | 2,488 | 2,359 | 4,847 |
| **5-9** | 2,679 | 2,511 | 5,190 |
| **10-14** | 2,498 | 2,342 | 4,840 |
| **15-19** | 2,191 | 2,165 | 4,356 |
| **20-24** | 2,216 | 2,038 | 4,254 |
| **25-29** | 2,275 | 2,253 | 4,528 |
| **30-34** | 2,347 | 2,596 | 4,943 |
| **35-39** | 2,525 | 2,707 | 5,232 |
| **40-44** | 2,434 | 2,592 | 5,026 |
| **45-49** | 2,463 | 2,510 | 4,973 |
| **50-54** | 2,585 | 2,969 | 5,554 |
| **55-59** | 2,598 | 2,903 | 5,501 |
| **60-64** | 2,393 | 2,314 | 4,707 |
| **65-69** | 1,866 | 2,045 | 3,911 |
| **70-74** | 1,902 | 2,138 | 4,040 |
| **75-79** | 1,291 | 1,738 | 3,029 |
| **80-84** | 985 | 1,511 | 2,496 |
| **85-89** | 667 | 1,016 | 1,683 |
| **90+** | 285 | 707 | 992 |
| **Totals** | **38,688** | **41,414** | **80,102** |




Source: ONS 2020 Mid-Year Estimates

## 1.3 LBH PCN Profile - GP population 5 year age groups

| | HAVERING CREST PCN | | | HAVERING MARSHALL PCN | | | HAVERING NORTH PCN | | | HAVERING SOUTH PCN | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Age Band (Years)** | **F** | **M** | **PER** | **F** | **M** | **PER** | **F** | **M** | **PER** | **F** | **M** | **PER** | **Havering Total** |
| **0_4** | 1263 | 1362 | 2625 | 1352 | 1434 | 2786 | 2609 | 2865 | 5474 | 2802 | 2909 | 5711 | 16596 |
| **5_9** | 1383 | 1381 | 2764 | 1417 | 1494 | 2911 | 3036 | 3198 | 6234 | 3179 | 3257 | 6436 | 18345 |
| **10_14** | 1295 | 1282 | 2577 | 1278 | 1351 | 2629 | 2845 | 3003 | 5848 | 2974 | 3161 | 6135 | 17189 |
| **15_19** | 1103 | 1194 | 2297 | 1206 | 1246 | 2452 | 2510 | 2602 | 5112 | 2855 | 2863 | 5718 | 15579 |
| **20_24** | 1131 | 1173 | 2304 | 1243 | 1252 | 2495 | 2481 | 2455 | 4936 | 2885 | 2934 | 5819 | 15554 |
| **25_29** | 1631 | 1436 | 3067 | 1639 | 1432 | 3071 | 2959 | 2772 | 5731 | 3323 | 3367 | 6690 | 18559 |
| **30_34** | 1835 | 1654 | 3489 | 1941 | 1750 | 3691 | 3550 | 3141 | 6691 | 3661 | 3626 | 7287 | 21158 |
| **35_39** | 1662 | 1619 | 3281 | 1807 | 1858 | 3665 | 3637 | 3280 | 6917 | 3845 | 3622 | 7467 | 21330 |
| **40_44** | 1400 | 1540 | 2940 | 1671 | 1631 | 3302 | 3041 | 3156 | 6197 | 3467 | 3419 | 6886 | 19325 |
| **45_49** | 1347 | 1391 | 2738 | 1407 | 1538 | 2945 | 2786 | 2795 | 5581 | 3208 | 3285 | 6493 | 17757 |
| **50_54** | 1392 | 1375 | 2767 | 1535 | 1566 | 3101 | 2862 | 2835 | 5697 | 3614 | 3570 | 7184 | 18749 |
| **55_59** | 1333 | 1363 | 2696 | 1514 | 1506 | 3020 | 2679 | 2657 | 5336 | 3895 | 3704 | 7599 | 18651 |
| **60_64** | 1197 | 1172 | 2369 | 1310 | 1248 | 2558 | 2324 | 2295 | 4619 | 3379 | 3383 | 6762 | 16308 |
| **65_69** | 905 | 894 | 1799 | 1090 | 981 | 2071 | 1786 | 1729 | 3515 | 2730 | 2588 | 5318 | 12703 |
| **70_74** | 857 | 749 | 1606 | 1122 | 981 | 2103 | 1863 | 1628 | 3491 | 2953 | 2601 | 5554 | 12754 |
| **75_79** | 720 | 529 | 1249 | 909 | 789 | 1698 | 1355 | 1040 | 2395 | 2373 | 1893 | 4266 | 9608 |
| **80_84** | 567 | 402 | 969 | 689 | 477 | 1166 | 929 | 717 | 1646 | 1766 | 1241 | 3007 | 6788 |
| **85_89** | 406 | 253 | 659 | 501 | 270 | 771 | 628 | 407 | 1035 | 1325 | 861 | 2186 | 4651 |
| **90_94** | 167 | 100 | 267 | 287 | 152 | 439 | 336 | 159 | 495 | 641 | 333 | 974 | 2175 |
| **95+** | 43 | 22 | 65 | 87 | 27 | 114 | 121 | 36 | 157 | 191 | 61 | 252 | 588 |
| **PCN Total** | **21637** | **20891** | **42528** | **24005** | **22983** | **46988** | **44337** | **42770** | **87107** | **55066** | **52678** | **107744** | **284367** |

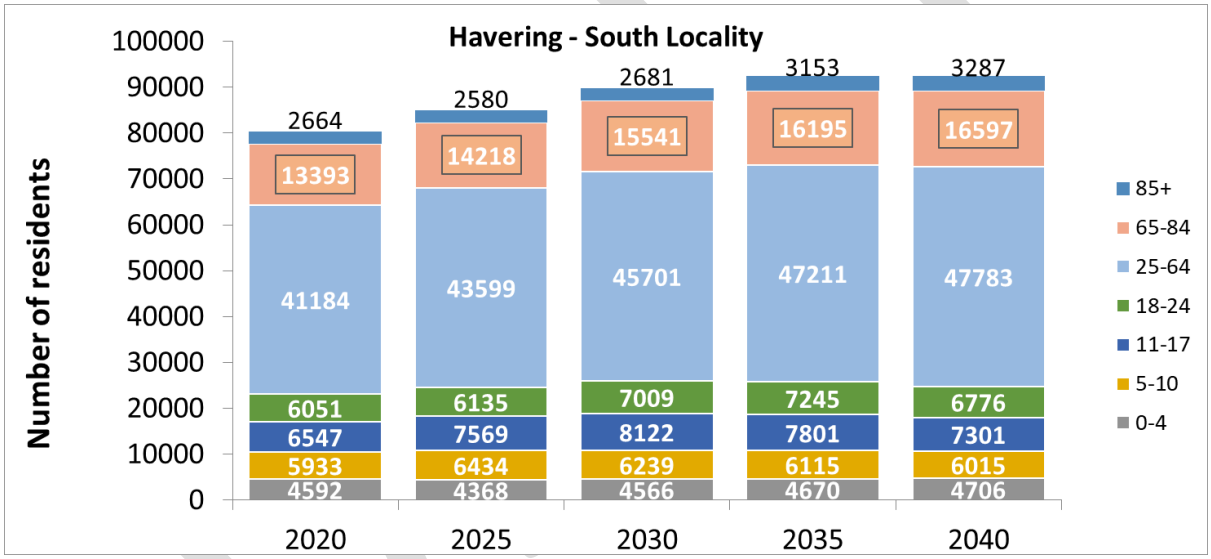
Source: NHS Digital GP Registrations (September 2021)

DRAFT

## 1.4 LBH South Location Population Projections 2020, 2025, 2030, 2035, 2040

| Area | 2020 | 2025 | 2030 | % change | 2035 | % change | 2040 | % change |
|---|---|---|---|---|---|---|---|---|
| South | 80,364 | 84,903 | 89,859 | 11.8 | 92,390 | 15.0 | 92,465 | 15.1 |

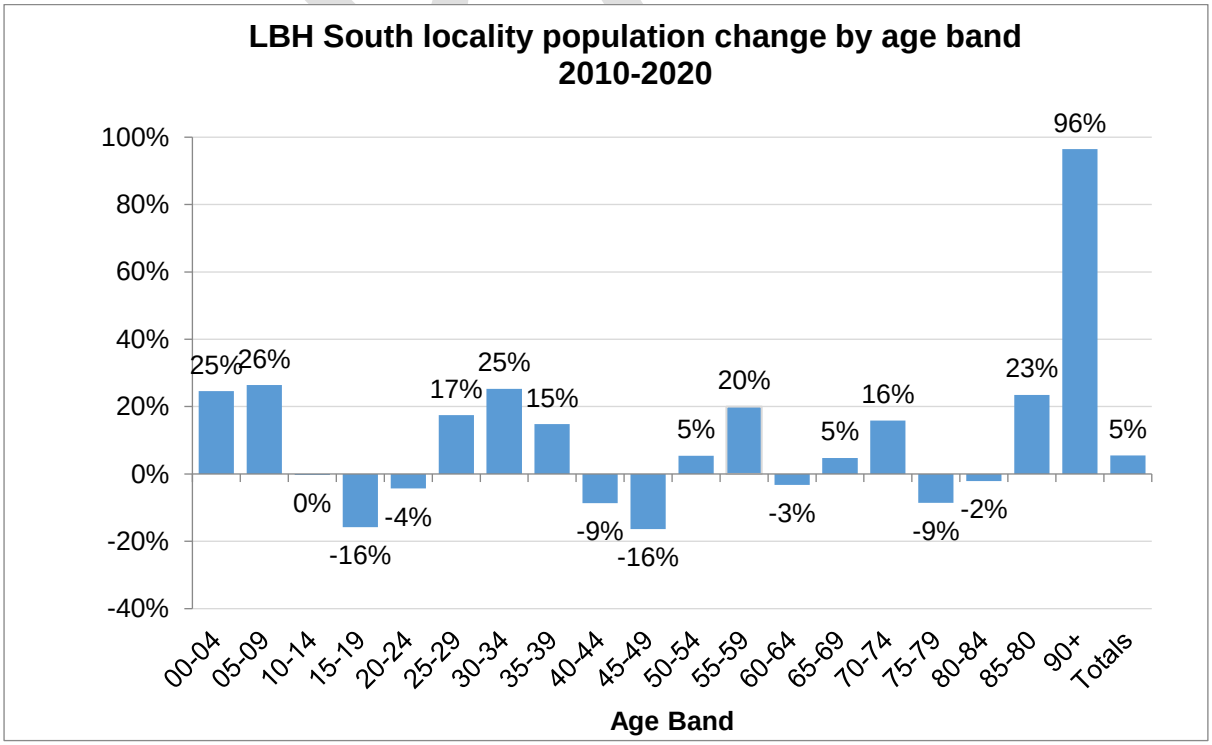
| South | 2020 | 2025 | 2030 | 2035 | 2040 |
|---|---|---|---|---|---|
| 0-4 | 4592 | 4368 | 4566 | 4670 | 4706 |
| 5-10 | 5933 | 6434 | 6239 | 6115 | 6015 |
| 11-17 | 6547 | 7569 | 8122 | 7801 | 7301 |
| 18-24 | 6051 | 6135 | 7009 | 7245 | 6776 |
| 25-64 | 41184 | 43599 | 45701 | 47211 | 47783 |
| 65-84 | 13393 | 14218 | 15541 | 16195 | 16597 |
| 85+ | 2664 | 2580 | 2681 | 3153 | 3287 |
| Total | 80,364 | 84,903 | 89,859 | 92,390 | 92,465 |




Source: GLA Household led population projections using 2020-based Demographic Projections, Ward population projections for London Boroughs 2020-based Scenario Projection: Identified Capacity Scenario

## 1.5 LBH South Locality population change by age band 2010 - 2020

| Age Band | 2010 | 2020 | Change | % |
|---|---|---|---|---|
| **00-04** | 3890 | 4847 | 957 | 25 |
| **05-09** | 4107 | 5190 | 1083 | 26 |
| **10-14** | 4855 | 4840 | -15 | 0 |
| **15-19** | 5174 | 4356 | -818 | -16 |
| **20-24** | 4446 | 4254 | -192 | -4 |
| **25-29** | 3856 | 4528 | 672 | 17 |
| **30-34** | 3946 | 4943 | 997 | 25 |
| **35-39** | 4556 | 5232 | 676 | 15 |
| **40-44** | 5503 | 5026 | -477 | -9 |
| **45-49** | 5944 | 4973 | -971 | -16 |
| **50-54** | 5269 | 5554 | 285 | 5 |
| **55-59** | 4584 | 5501 | 917 | 20 |
| **60-64** | 4866 | 4707 | -159 | -3 |
| **65-69** | 3733 | 3911 | 178 | 5 |
| **70-74** | 3487 | 4040 | 553 | 16 |
| **75-79** | 3312 | 3029 | -283 | -9 |
| **80-84** | 2550 | 2496 | -54 | -2 |
| **85-89** | 1363 | 1683 | 320 | 23 |
| **90+** | 505 | 992 | 487 | 96 |
| **Total** | 75946 | 80102 | 4156 | 5 |



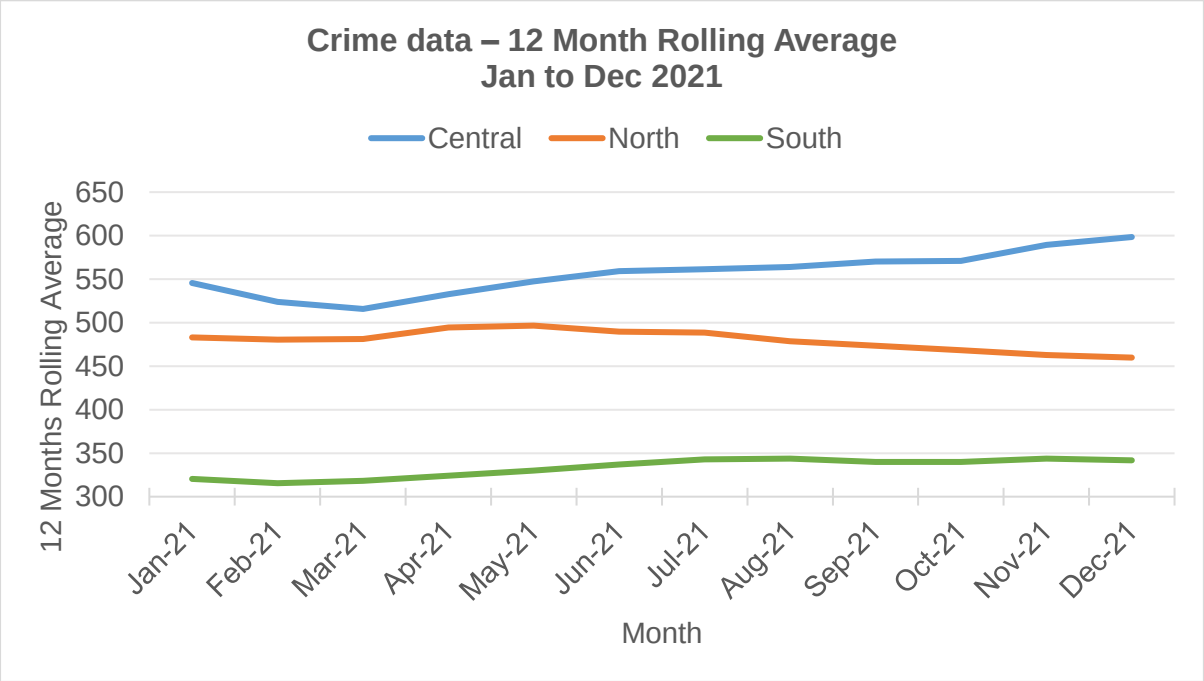

Source: ONS mid-year population estimates

### 1.6 Ethnicity

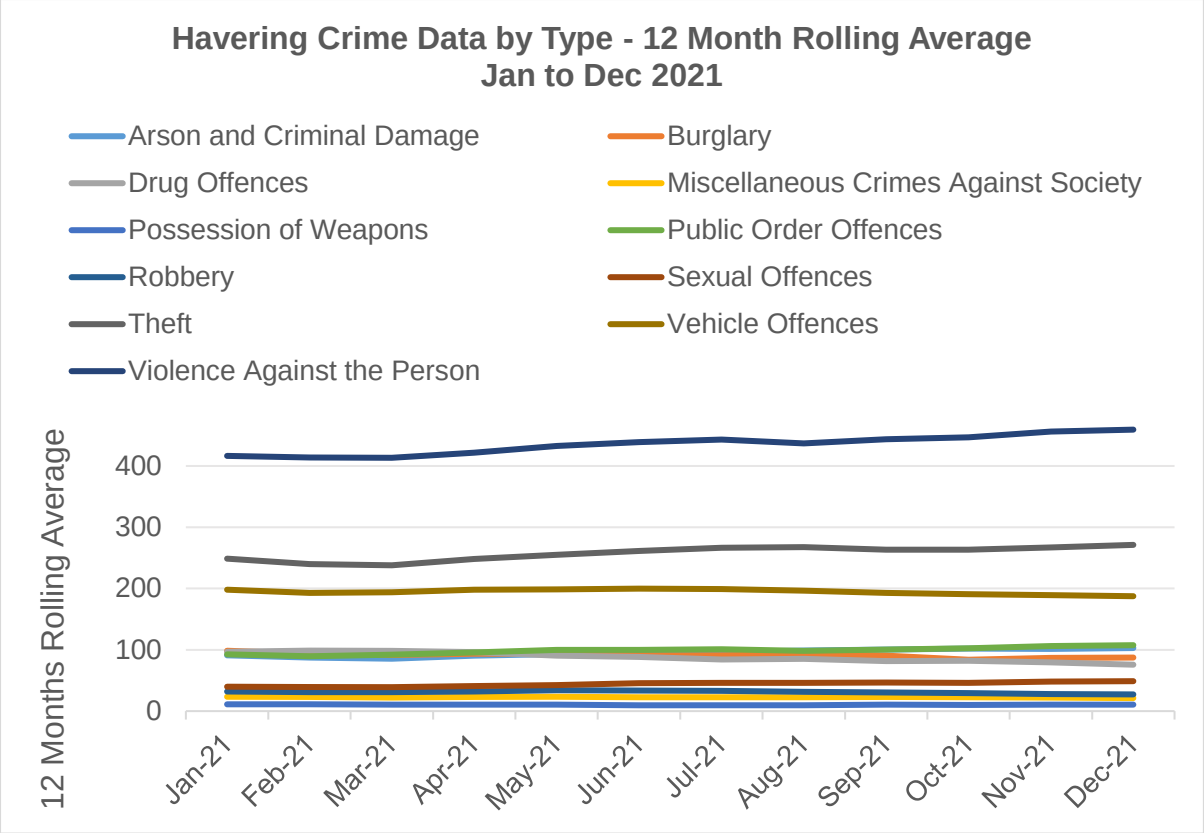
| Ethnic group | Number | % |
|---|---|---|
| British | 66,593 | 87.4 |
| African | 1,991 | 2.6 |
| Indian or British Indian | 1,076 | 1.4 |
| Irish | 970 | 1.3 |
| Caribbean | 602 | 0.8 |
| White and Black Caribbean | 493 | 0.6 |
| Pakistani or British Pakistani | 245 | 0.3 |
| Chinese | 477 | 0.6 |
| White and Asian | 369 | 0.5 |
| European mixed | 228 | 0.3 |
| Other | 3,117 | 4.1 |
| Totals | 76,161 | 100 |

Source: Census 2011

### 1.7 Crime data – 12 month rolling average




Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).




Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).

### 1.8 Projected new homes in South Locality

The London Plan 2021 sets a ten year housing target for Havering of 12,850 new homes between 2019/20 and 2028/29 or 1,285 per annum. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

| Locality | Number of houses |
|---|---|
| Central | 4992 |
| North | 717 |
| South | 3702 |
| Total | 9411 |

The London Plan quotes a housing figure for Havering of 18,750. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

| Locality | Number of houses |
|---|---|
| Central | 4992 |
| North | 717 |
| South | 3702 |
| Total | 9411 |

DRAFT

## BHR Joint Strategic Needs Assessment 2019

### London Borough of Havering

### Locality Dashboard

**Benchmark: England**

| Compared with Benchmark: | Better | Similar | Worse | Not Compared | Higher | Lower |
|---|---|---|---|---|---|---|

| | | Indicator | Period | North | Central | South | Havering | Barking & Dagenham | Redbridge | BHR | London | England | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Value | Value | Value | Value | Value | Value | Value | Value | Value | Lowest | Highest |
| Wider Determinants | 1 | Index of Multiple Deprivation (IMD) 2019 Rank/Score | 2019 | 22.7 | 14.3 | 13.9 | 16.8 | 32.8 | 17.2 | 21.3 | 21.8 | 21.7 | 45.0 | 5.5 |
| | 2 | Proportion of residents who are Income Deprived | 2019 | 14.5 | 9.2 | 9.0 | 10.8 | 19.4 | 12.1 | 13.6 | 13.8 | 12.9 | 25.1 | 2.9 |
| | 3 | Proportion of Households experiencing Fuel Poverty | 2016 | 8.3 | 8.3 | 7.3 | 8.0 | 11.6 | 11.3 | 10.2 | 10.0 | 11.1 | 17.0 | 4.9 |
| | 4 | Healthy Behaviour and Lifestyles: Smoking Prevalence (% of adult population) (APS) ** | 2018 | 16.0 | 15.2 | 15.1 | 15.0 | 22.4 | 13.2 | 16.2 | 13.9 | 14.4 | 26.1 | 5.9 |
| Maternity | 5 | Number of live births | 2018 | 1,229 | 1,211 | 949 | 3307 | 3700 | 4539 | 11546 | 120673 | 625651 | | |
| | 6 | Number and percentage of stillbirths | 2015-17 | 8.9 | 9.7 | 5.1 | 5.3 | 5.9 | 3.1 | 4.6 | 4.9 | 4.3 | 6.8 | 2.6 |
| | 7 | General Fertility Rate (per1,000 women age 15-44)(locality data not available) | 2018 | | | | 68.0 | 82.6 | 73.4 | 74.4 | 62.9 | 64.2 | 41.6 | 86.5 |
| | 8 | Low Birth Weight Births (% term babies) | 2017 | 3.2 | 2.2 | 2.8 | 2.7 | 3.8 | 3.9 | 3.5 | 3.0 | 2.8 | 5.3 | 1.6 |
| Children and Young People | 9 | Number and percentage of pupils with Special Educational Needs (SEN) based on where the pupil attends school | 2019 | 10.3 | 9.1 | 10.8 | 9.9 | 14.1 | 11.6 | 12.0 | 14.6 | 14.9 | 9.9 | 20.5 |
| | 10 | Number of children with a Child Protection Plan and rate per 10,000 children at 31st March 18 | 2017/18 | 47.7 | 15.1 | 25.0 | 37.9 | 51.0 | 38.1 | 42.2 | 39.2 | 45.0 | | |
| | 11 | Number of Looked after Children and rate per 10,000 children at 31st March 2018 | 2017/18 | 42.5 | 22.4 | 32.6 | 44.0 | 65.0 | 29.0 | 45.1 | 49.0 | 64.0 | 23.0 | 185.0 |
| | 12 | Number of Children in Need and rate per 10,000 children at 31st March 18 | 2017/18 | 135.0 | 85.5 | 74.0 | 401.1 | 345.5 | 298.7 | 343.4 | 360.1 | 338.5 | | |
| | 13 | Rate of teenage pregnancy (under 18 year olds - rate/1,000) | 2017 | 32.7 | 19.9 | 18.7 | 21.0 | 25.1 | 12.4 | 18.8 | 16.4 | 17.8 | 6.1 | 43.8 |
| | 14 | GCSE Achievement (5A*-C inc. English & Maths) (%) | 2017/18 | 53.6 | 64.1 | 62.2 | 67.7 | 60.0 | 74.4 | 68.5 | 67.7 | 59.1 | 41.9 | 93.3 |
| | 15 | Percentage of children with excess weight (including obesity) (Reception Year) | 2017/18 | 24.8 | 23.8 | 24.1 | 24.4 | 25.6 | 21.5 | 23.7 | 21.8 | 22.4 | 29.6 | 13.9 |
| | 16 | Percentage of children with excess weight (including obesity) (Year 6) | 2017/18 | 38.9 | 36.3 | 38.0 | 37.3 | 44.5 | 40.2 | 40.8 | 37.7 | 34.3 | 44.5 | 21.7 |
| | 17 | Mental Health: No locality indicators please refer to Borough profiles | | | | | | | | | | | | |
| Cancers | 18 | Incidence breast cancer (Age standardised rate per 100,000) | 2012-16 | 103.9 | 100.0 | 111.3 | 105.1 | 91.7 | 95.7 | 98.6 | 94.7 | 100.0 | 80.7 | 118.9 |
| | 19 | Incidence colorectal cancer (Age standardised rate per 100,000) | 2012-16 | 101.9 | 84.0 | 110.7 | 98.9 | 101.4 | 83.6 | 93.8 | 90.8 | 100.0 | 75.1 | 122.7 |
| | 20 | Incidence lung cancer (Age standardised rate per 100,000) | 2012-16 | 114.0 | 90.7 | 93.2 | 98.9 | 138.1 | 75.9 | 98.5 | 97.4 | 100.0 | 45.8 | 194.7 |
| | 21 | Incidence prostate cancer (Age standardised rate per 100,000) | 2012-16 | 99.9 | 105.9 | 114.0 | 106.9 | 115.1 | 100.7 | 106.2 | 105.5 | 100.0 | 65.3 | 148.3 |
| Long Term Conditions | 22 | Deaths from coronary heart disease, all ages, standardised mortality ratio | 2013-17 | 101.5 | 84.3 | 84.1 | 89.6 | 107.3 | 101.1 | 97.3 | 94.1 | 100.0 | 56.9 | 165.7 |
| | 23 | Deaths from respiratory diseases, all ages, standardised mortality ratio | 2013-17 | 117.2 | 93.7 | 102.9 | 104.4 | 131.2 | 95.1 | 106.5 | 91.5 | 100.0 | 41.8 | 157.9 |
| | 24 | Deaths from stroke, all ages, standardised mortality ratio | 2013-17 | 83.9 | 78.9 | 96.2 | 86.5 | 95.0 | 95.1 | 91.3 | 88.5 | 100.0 | 32.8 | 144.5 |
| | 25 | Emergency hospital admissions for coronary heart disease, standardised admission ratio | 2013/14 - 17/18 | 106.1 | 90.2 | 80.9 | 92.0 | 119.3 | 122.5 | 109.0 | 96.0 | 100.0 | 55.1 | 188.2 |
| | 26 | Emergency hospital admissions for stroke, standardised admission ratio | 2013/14 - 17/18 | 97.8 | 88.7 | 94.0 | 93.4 | 106.1 | 95.2 | 96.7 | 103.8 | 100.0 | 64.7 | 151.3 |
| Older People | 27 | Emergency hospital admissions for hip fracture in persons 65 years and over, standardised admission ratio | 2013/14 - 17/18 | 104.0 | 97.3 | 102.6 | 101.3 | 107.4 | 91.6 | 99.1 | 88.7 | 100.0 | 72.2 | 126.5 |
| | 28 | Older People in Deprivation, English Indices of Deprivation 2015, IDAOPI | 2015 | 17.7 | 12.9 | 10.2 | 13.5 | 27.9 | 21.0 | 19.1 | 22.2 | 16.2 | 6.3 | 49.7 |

***Data Sources:*** *1,2 - IMD 2019, 3,18,19,20,21,22,23,24,25,26,27,28 - Local Health (www.localhealth.org), 4 - http://ash.lelan.co.uk/, 5,7 - ONS, 6,8,13,14,15,16 - PHE Indicators https://fingertips.phe.org.uk 9,10,11,12 - Local data* ** *Please refer to Borough profiles for more indicators*

## Appendix 12: Contact

Anthony Wakhisi
Principal Public Health Specialist
London Borough of Havering
Mercury House, Mercury Gardens, Romford, RM1 3SL

Email: anthony.wakhisi@havering.gov.uk

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | **Havering Pharmaceutical Needs Assessment 2022-25** |
| **Board Lead:** | **Mark Ansell Director of Public Health, LB Havering** |
| **Report Author and contact details:** | **Mark Ansell Director of Public Health, LB Havering** |

**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

Each Health and Wellbeing Board has a statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for their population. This is called the Pharmaceutical Needs Assessment (PNA) (NHS Pharmaceutical Regulations 2013). Each HWB must publish their PNA by the 1st of October 2022.

The main user of the PNA is NHS England who commission community pharmacy services and its prime purpose is to control market entry of new pharmacies to an area over a three year period. If there are significant unplanned changes during that time then the HWB are responsible for publishing supplementary reports as required.

The HWB delegates to the Director of Public Health the responsibility of overseeing the production of the PNA on its behalf. The delivery of the PNA is then coordinated by a steering group who also quality assure the process and any decisions.

The Barking and Dagenham, Havering and Redbridge local authorities collaborated to establish a steering group and commissioned the delivery of their PNAs to Healthy Dialogues through a competitive tender process.

The steering group was properly constituted with membership that consisted of:

- NEL Local Pharmaceutical Committee (LPC)
- LB Havering
- LB Barking and Dagenham
- Redbridge Council
- NEL ICB
- Healthwatch

The steering group was chaired by Redbridge Council, and quorate was met with representation from each council, the LPC and Healthy Dialogues.

The PNA assessed whether the current and future pharmacy provision meets the health and wellbeing needs of the Havering population. It has also determined whether there are any gaps, or need for improvements or better access, in the provision of pharmaceutical service either now or within the lifetime of this document, 1st October 2022 to 30th September 2025.

The London Borough of Havering is well served in relation to the number and location of pharmacies. The PNA has concluded that there is good access to essential, advanced, enhanced and other NHS pharmaceutical services for the residents of Havering with no gaps in the current and future provision of these services identified and no needs for improvements or better access. Additionally, no services were identified that would secure improvements or better access to pharmaceutical services if provided, either now or in the future.

The attached Havering PNA which includes an executive summary has been completed and signed-off by the steering group and NHS England and is now ready for publication.

**RECOMMENDATIONS**

That the members of the Health and Wellbeing Board approve the PNA report so that it can be published before the 1st October 2022.

Havering
LONDON BOROUGH

## REPORT DETAIL

Please see attached PNA 2022-25 report

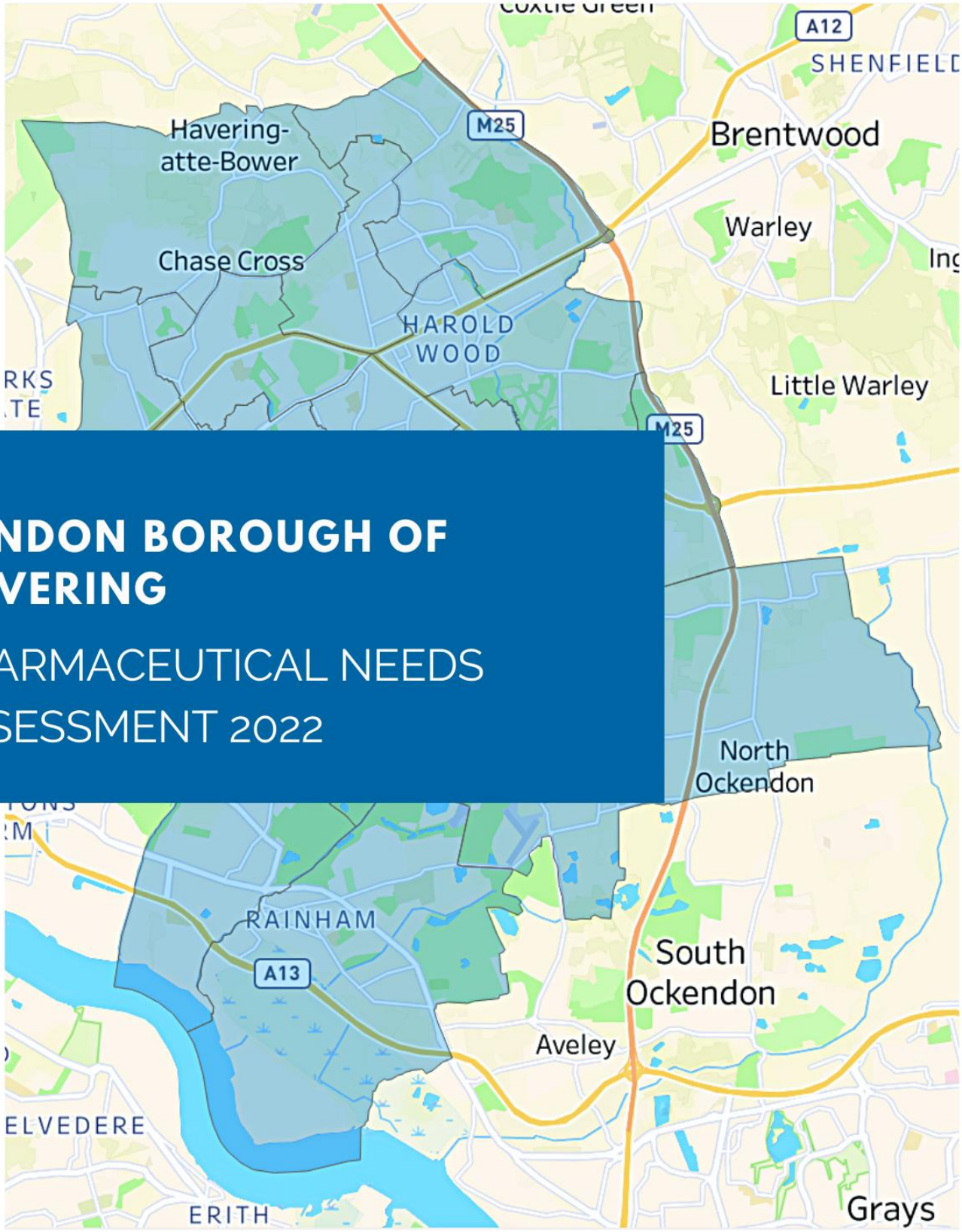
## IMPLICATIONS AND RISKS

Financial implications and risks: None
Legal implications and risks: None
Human resource implications and risks: None
Equalities implications and risks: None

## BACKGROUND PAPERS

None

This page is intentionally left blank




# LONDON BOROUGH OF HAVERING

## PHARMACEUTICAL NEEDS ASSESSMENT 2022

# Executive Summary

## Introduction

Local pharmacies are a frontline healthcare resource located within the heart of communities. They provide prescription medications, health promotion, signposting, retail health and care products. They can be the first point of contact for patients seeking medical information or advice, and for some the only contact with a healthcare professional.

Each Health and Wellbeing Board (HWB) has a statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for their population. This is called the Pharmaceutical Needs Assessment (PNA). The purpose of the PNA is to:

- inform local plans for the commissioning of specific and specialised pharmaceutical services
- to support the decision-making process for applications for new pharmacies or changes of pharmacy premises undertaken by NHS England

This PNA was conducted at a time of substantial change within the health and social care landscape as the North East London Health and Care Partnership is being created in response to the NHS Long Term Plan. This includes an increased use and acknowledgement of community pharmacies within newly developed primary care networks, ensuring greater opportunities for patient engagement.

There are 45 community pharmacies and one dispensing appliance contractor located within the London Borough of Havering. This PNA assesses the health and wellbeing needs of the population, including patients' and the public's views, with respect to:

- Necessary Services, i.e., current pharmacy provision of Essential Services
- Other Relevant Services including Advanced and Enhanced Pharmacy Services commissioned by NHS England and Other NHS Services commissioned by Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group or the London Borough of Barking and Dagenham.

Key findings are outlined below.

## Findings

### Key demographics and health needs of Havering

Havering is an urban local authority situated in outer, Northeast London. It has an estimated 263,354 residents. Its population is set to increase by 2.5% by 2025 due to new developments and regenerations such as the Thames Gateway regeneration and the Regeneration of Romford Town. The London Borough of Havering has highest proportion of older people in London. The most common languages spoken by residents in the borough other than English are Lithuanian, Polish and Punjabi (2011 ONS data).

There are a few areas of concern in Havering health behaviours and lifestyles (PHE, Local Health Indicators, 2021): 13.2% of adults smoke and 29.7% of adults are inactive, 67.3% of Havering adults are overweight or obese (the third highest figure in London) and the rates of dental decay in children and excess weight in Year 6 children is higher than national averages.

Several population health and wellbeing needs were identified (PHE, Local Health Indicators, 2021):

- Cancer is the biggest cause of life expectancy gap in Havering and the incidence of cancers is the fourth highest in London.
- Havering has the fourth highest stroke prevalence in London.
- Premature mortality by respiratory disease is also high in Havering.
- Dementia detection rates are lower than expected prevalence of dementia.

### Key findings from patient and public engagement

A community survey was disseminated across Barking and Dagenham, Havering and Redbridge. 364 people responded (184 of whom were from Havering) to tell us how they use their pharmacy and their views on specific 'necessary' pharmacy services.

The most stated reasons people used their chosen pharmacy were that they were happy with their overall service, the good location and staff are friendly. Most stated they prefer to use their pharmacies during weekdays and during normal working hours, 24% preferred using their pharmacy during the weekend.

There were no significant differences between groups in terms of their use, reasons for their chosen pharmacy and expectations in their local pharmacy provision.

## Health and Wellbeing Board Statements on Service Provision

The Health and Wellbeing Board has assessed whether the current and future pharmacy provision meets the health and wellbeing needs of the Havering population. It has also determined whether there are any gaps, or need for improvements or better access, in the provision of pharmaceutical service either now or within the lifetime of this document, 1st October 2022 to 30th September 2025.

The London Borough of Havering is well served in relation to the number and location of pharmacies. The Health and Wellbeing Board has concluded that there is good access to essential, advanced, enhanced and other NHS pharmaceutical services for the residents of Havering with no gaps in the current and future provision of these services identified and no needs for improvements or better access. Additionally, no services were identified that would secure improvements or better access to pharmaceutical services if provided, either now or in the future.

# Contents

# Chapter 1- Introduction

## Purpose of the Pharmaceutical Needs Assessment

**1.1** Local pharmacies play a pivotal role in Havering working in the centre of communities and providing quality healthcare to local individuals, families and carers. They can be patients' and the public's first point of contact and, for some, their only contact with a healthcare professional. Their distribution is known not to obey inverse care law.

**1.2** The Pharmaceutical Needs Assessment (PNA) identifies the key health needs of the local population and how those needs are being fulfilled, or could be fulfilled, by pharmaceutical services in different parts of the borough. The purpose of the PNA is to:

- Support the 'market entry' decision making process (undertaken by NHS England) in relation to applications for new pharmacies or changes of pharmacy premises.
- Inform commissioning of enhanced services from pharmacies by NHS England, and the commissioning of services from pharmacies by the local authority and other local commissioners, for example Clinical Commissioning Groups (CCGs).

**1.3** This document can also be used to:

- Assist the Health and Wellbeing Board (HWB) to work with providers to target services to the areas where they are needed and limit duplication of services in areas where provision is good.
- Inform interested parties of the pharmaceutical needs in the borough and enable work on planning, developing and delivery of pharmaceutical services for the population.

## Legislative background

**1.4** From 2006, NHS Primary Care Trusts had a statutory responsibility to assess the pharmaceutical needs for their area and publish a statement of their first assessment and of any revised assessment.

**1.5** With the abolition of Primary Care Trusts and the creation of Clinical Commissioning Groups in 2013, Public Health functions were transferred to local authorities. Health and Wellbeing Boards were introduced and hosted by local authorities to bring together Commissioners of Health Services (CCGs), Public Health, Adult Social Care, Children's services and Healthwatch.

**1.6** The Health and Social Care Act of 2012 gave a responsibility to Health and Wellbeing Boards for developing and updating Joint Strategic Needs Assessments and Pharmaceutical Needs Assessments.

**1.7** This PNA covers the period between 1st October 2022 and 30th September 2025. It must be produced and published by 1st October 2022. The Health and Wellbeing Board are also required to revise the PNA publication if they deem there to be significant changes in pharmaceutical services before 30th September 2025.

**1.8** A draft PNA must be put out for consultation for a minimum of 60 days prior to its publication. The 2013 Regulations list those persons and organisations that the HWB must consult, which include:

- Any relevant local pharmaceutical committee (LPC) for the HWB area
- Any local medical committee (LMC) for the HWB area
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area
- Any local Healthwatch organisation for the HWB area, and any other patient, consumer and community group, which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area
- Any NHS Trust or NHS Foundation Trust in the HWB area
- NHS England
- Any neighbouring Health and Wellbeing board.

**1.9** The NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013 and the Department of Health Information Pack for Local Authorities and Health and Wellbeing Boards[1] provide guidance on the requirements that should be contained in the PNA publication and the process to be followed to develop the publication. The development and publication of this PNA has been carried out in accordance with these Regulations and associated guidance.

## Minimum requirements of the PNA

**1.10** As outlined in the 2013 regulations, this PNA must include a statement of the following:

- **Necessary Services – Current Provision:** services currently being provided which are regarded to be "necessary to meet the need for pharmaceutical services in the area". This includes services provided in the borough as well as those in neighbouring boroughs.
- **Necessary Services – Gaps in Provision:** services not currently being provided which are regarded by the HWB to be necessary "in order to meet a current need for pharmaceutical services".
- **Other Relevant Services – Current Provision:** services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have "secured improvements or better access to pharmaceutical services".
- **Improvements and Better Access – Gaps in Provision:** services *not* currently provided, but which the HWB considers would "secure improvements, or better access to pharmaceutical services" if provided.
- **Other Services**: any services provided or arranged by the local authority, NHS England, the CCG, an NHS trust or an NHS foundation trust which affects the need for

pharmaceutical services in its area or where future provision would secure improvement, or better access to pharmaceutical services specified type, in its area.

**1.11** Additionally, the PNA must include a map showing the premises where pharmaceutical services are provided and an explanation of how the assessment was made.

## Circumstances under which the PNA is to be revised or updated

**1.12** It is important that the PNA reflects changes that affect the need for pharmaceutical services in Havering. Where the HWB becomes aware that a change may require the PNA to be updated, then a decision to revise the PNA will be made.

**1.13** Not all changes in a population or an area will result in a change to the need for pharmaceutical services. However, where these changes do require a review of pharmaceutical services, the HWB will issue supplementary statements to update the PNA.

**1.14** The PNA will be updated every three years.

# Chapter 2 - Strategic Context

**2.1** This section summarises a few of the key policies, strategies and reports which contribute to our understanding of the strategic context for England's community pharmacy services at a national, regional and local level. Since PNAs were last updated in 2018, there have been significant changes to the wider health and social care landscape and to society. This includes but is not limited to the publication of the NHS Long Term Plan, the introduction of the Community Pharmacy Contractual Framework, a greater focus on integrated care, and the significant impact of the COVID-19 pandemic.

## National context

### Department of Health and Social Care Policy Paper - Integration and Innovation: working together to improve health and social care for all[1]

**2.2** In recent years, the health and social care system has adapted and evolved to face a variety of challenges. With the population growing, people living longer, but also suffering from more long-term health conditions, and challenges from the COVID-19 pandemic, there is a greater need for the health and social care system to work together to provide high quality care. This paper sets out the legislative proposals for the Health and Care Bill which capture the learnings from the pandemic.

**2.3** **Working together to integrate care:** The NHS and local authorities will be given a duty to collaborate and work with each other. Measures will be brought forward to bring about Integrated Care Systems (ICSs) which will be compromised of an ICS Health and Care partnership, and an ICS NHS Body. The ICS NHS Body will be responsible for the day to day running of the ICS, whilst the ICS Health and Care Partnership will bring together systems to support integration and development which plan to address the system's health, public health, and social care needs. A key responsibility for these systems will be to support place-based working i.e., working amongst NHS, local government, community health including community pharmacy, voluntary and charity services. The ICS will align geographically to a local authority boundary, and the Better Care Fund plan (BCF) will provide a tool for agreeing priorities.

**2.4** **Reducing bureaucracy:** The legislation will aim to remove barriers that prevent people from working together and put pragmatism at the heart of the system. The NHS should be free to make decisions without the involvement of the Competition and Markets Authority (CMA). With a more flexible approach, the NHS and local authorities will be able to meet the current future health and care challenges by avoiding bureaucracy.

[1] Department of Health & Social Care. Policy paper: Integration and innovation: working together to improve health and social care for all (updated February 2021). Available at: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version#executive-summary

**2.5** **Improving accountability and enhancing public confidence:** The public largely see the NHS as a single organisation, and the same should happen at a national level. By bringing together NHS England, and NHS Improvement together, organisations will come together to provide unified leadership. These measures will support the Secretary of State to mandate structured decisions and enable the NHS to be supported by the government. With any significant service changes, these measures will ensure a greater accountability with the power for ministers to determine service reconfigurations earlier in the process.

## The NHS Long Term Plan (2019)[2]

**2.6** As health needs change, society develops, and medicine advances, the NHS must ensure that it is continually moving forward to meet these demands. **The NHS Long Term Plan (2019)** (NHS LTP) introduces a new service model for the 21st century and includes action on preventative healthcare and reducing health inequalities, progress on care quality and outcomes, exploring workforce planning, developing digitally enabled care, and driving value for money.

**2.7** More specifically, pharmacies will play an essential role in delivering the NHS LTP. £4.5 billion of new investment will fund expanded community multidisciplinary teams aligned with the new primary care networks (PCNs). These teams will work together to provide the best care for patients and will include pharmacists, district nurses, allied health professionals, GPs, dementia workers, and community geriatricians. Furthermore, the NHS LTP stipulates that as part of the workforce implementation plan, and with the goal of improving efficiency within community health, along with an increase in the number of GPs, the range of other roles will also increase, including community and clinical pharmacists, and pharmacy technicians. Research indicates that around 10% of elderly patients end up in hospital due to preventable medicine related issues and up to 50% of patients do not take their medication as intended. PCN funding will therefore be put towards expanding the number of clinical pharmacists working within general practices and care homes, and the NHS will work with the government to ensure greater use and acknowledgement of community pharmacists' skills and better utilisation of opportunities for patient engagement. As part of preventative healthcare and reducing health inequalities, community pharmacists will support patients to take their medicines as intended, reduce waste, and promote self-care.

**2.8** Within PCNs, community pharmacists will play a crucial role in supporting people with high-risk conditions such as atrial fibrillation (AF) and cardiovascular disease (CVD). The NHS will support community pharmacists to case-find, e.g., hypertension case-finding. Pharmacists within PCNs will undertake a range of medicine reviews, including educating patients on the correct use of inhalers, and supporting patients to reduce the use of short acting bronchodilator inhalers and to switch to clinically appropriate, smart inhalers.

**2.9** In order to provide the most efficient service, and as part of developing digitally enabled care, more people will have access to digital options. The NHS app will enable patients to

[2] NHS. *The NHS Long Term Plan* (2019). https://www.longtermplan.nhs.uk/

manage their own health needs and be directed to appropriate services, including being prescribed medication that can be collected from their nearest pharmacy.

### Data saves lives: reshaping health and social care with data[3]

**2.10** The NHS Digital Strategy prioritises to make appropriate data sharing the norm across health and care system. This includes

- Delivering shared record with community pharmacies
- Integrated local data system and
- Electronic prescription

### Health Equity in England: Marmot review 10 years on[4]

**2.11** This document summarises the developments in particular areas that have an increasing importance for equity. These include:

- Give every child the best start in life by increasing funding in earlier life and ensuring that adequate funding is available in areas with higher deprivation.
- Improve the availability and quality of early years' services.
- Enable children, young people and adults to maximise their capabilities by investing in preventative services to reduce school exclusions.
- Restore per-pupil funding for secondary schools and in particular in 6th form and further education.
- Reduce in-work poverty by increasing the national minimum wage.
- Increase number of post-school apprenticeships and support in-work training.
- Put health equity and well-being at the heart of local, regional and national economic planning.
- Invest in the development of economic, social and cultural resources in the most deprived communities.

We explore these in the context of Havering in Chapter 4.

### Public Health England (PHE)[5] Strategy 2020-2025[6]

**2.12** PHE exists to protect and improve the nation's health and wellbeing and reduce health inequalities. Priorities include creating a smoke-free society by 2030, healthier diets, healthier weight, cleaner air, better mental health, best start in life, effective responses to major incidents, reduced risk from antimicrobial resistance, predictive prevention, enhanced data and surveillance capabilities, and a new national science campus.

---

[3] https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data-draft/data-saves-lives-reshaping-health-and-social-care-with-data-draft

[4] Institute of Health Equity. *Health Equity in England: The Marmot Review 10 Years On* (2020). https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-executive-summary.pdf

[5] As of October 2021, PHE ceased to exist. Responsibilities formally undertaken by PHE are now the responsibility of OHID, UKHSA and NHS England.

[6] Public Health England Strategy 2020-2025 (2019). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831562/PHE_Strategy_2020-25.pdf

**2.13** PHE produced a briefing: 'Pharmacy teams – seizing opportunities for addressing health inequalities.[7] The briefing highlights the unique role that pharmacy teams can play in helping to address health inequalities. It suggests ways for making the most of pharmacy teams' potential to work with local community and faith leaders, reach out to under-served communities and those with the poorest health outcomes, and to take on a health inequalities leadership role. It also sets out recommendations for system leaders, commissioners and community pharmacy teams themselves.

### Community Pharmacy Contractual Framework (CPCF) 2019/20-2023/24[8]

**2.14** The CPCF is an agreement between the Department of Health and Social Care (DHSC), NHSE&I and the Pharmaceutical Services Negotiating Committee (PSNC) and describes a vision for how community pharmacy will support delivery of the NHS Long Term Plan. The CPCF highlights and develops the role of pharmacies in urgent care, common illnesses, and prevention. It aims to "develop and implement the new range of services that we are seeking to deliver in community pharmacy", making greater use of Community Pharmacists' clinical skills and opportunities to engage patients. The deal:

- Through its contractual framework, commits almost £13 billion to community pharmacy, with a commitment to spend £2.592 billion over 5 years.
- Prioritises quality - The Pharmacy Quality Scheme (PQS) is designed to reward pharmacies for delivering quality criteria in clinical effectiveness, patient safety and patient experience.
- Confirms community pharmacy's future as an integral part of the NHS, delivering clinical services as a full partner in local primary care network (PCNs).
- Underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme.
- Includes new services such as the NHS Community Pharmacist Consultation Service (CPCS), which connects patients who have a minor illness with a community pharmacy, taking pressure off GP services and hospitals by ensuring patients turn to pharmacies first for low-acuity conditions and support with their general health.
- Continues to promote medicines safety and optimisation, and the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community.
- Through the Healthy Living Pharmacy (HLP) framework, requires community pharmacies to have trained health champions in place to deliver interventions such as smoking cessation and weight management, provide wellbeing and self-care advice, and signpost people to other relevant services.

**2.15** NB: this framework is covers the period of 2019/20-2023/24 and not the full lifetime of this PNA. The impact of the changes to the role of pharmacies in supporting the health and wellbeing needs of Havering residents will be considered by the HWB when it is published in 2024.

[7] Public Health England. Pharmacy teams – seizing opportunities for addressing health inequalities (September 2021). https://psnc.org.uk/wp-content/uploads/2021/09/Pharmacy-teams-seizing-opportunities-for-addresssing-health-inequalities.pdf

[8] Community Pharmacy Contractual Framework (2019). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819601/cpcf-2019-to-2024.pdf

### Pharmacy Integration Fund (PhIF)[9]

**2.16** The PhIF and PCN Testbed programme will be used to test a range of additional prevention and detection services, which if found to be effective and best delivered by a community pharmacy, could (with appropriate training) be mainstreamed within the CPCF over the course of the settlement period. Workstreams supported by the PhIF Programme include:

- GP referral pathway to the NHS CPCS.
- Hypertension Case-Finding Pilot - A model for detecting undiagnosed cardiovascular disease (CVD) in community pharmacy and referral to treatment within PCNs.
- Smoking Cessation Transfer of Care Pilot – hospital inpatients (including antenatal patients) will be able to continue their stop smoking journey within community pharmacy upon discharge.
- Exploring the routine monitoring and supply of contraception (including some long-acting reversible contraceptives) in community pharmacy.
- Palliative Care and end of life medicines supply service building on the experience of the COVID-19 pandemic.
- Structured medication reviews in PCNs for people with a learning disability, autism, or both, linked with the STOMP programme.

**2.17** Workforce development for pharmacy professionals in collaboration with Health Education England (HEE), e.g., medicines optimisation in care homes; primary care pharmacy educational pathway; leadership; integrated urgent care; independent prescribing; enhanced clinical examination skills.

## Regional Context

### London Community Pharmacy: Our offer to London – Pharmacy Strategy 2020[10]

**2.18** This document was developed jointly by London's local pharmaceutical committees (LPCs), supported by NHS England and NHS Improvement – London region. It presents a service offer to PCNs, local authorities and other health, social care and public health stakeholders, and the people of London. In summary, the offer from London Community Pharmacy is to:

- Expand the range of clinical services
- Increase the range of – and access to – wellness services
- Develop community pharmacy as a social asset – working to increase the social capital of our communities
- Integrate community pharmacy into primary care networks
- Provide strong leadership within integrated care partnerships

[9] NHS Pharmacy Integration Programme. https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/

[10] London LPCs and NHSE&I. *London Community Pharmacy: Our offer to London. Pharmacy Strategy* (2020). https://psnc.org.uk/pharmacylondon/wp-content/uploads/sites/112/2020/09/Offer-to-London.pdf

### The Health and Care Vision for London (2019)[11]

**2.19** In partnership with Public Health England, NHS, Mayor of London, and London Councils, the vision states a shared ambition to make London the healthiest global city; by making commitments in 10 key areas. The key focus areas are to:

- reduce childhood obesity
- improve the emotional wellbeing of children and young Londoners
- improve mental health and progress towards zero suicides
- improve air quality
- improve tobacco control and reduce smoking
- reduce the prevalence and the impact of violence
- improve the health of homeless people
- improve services and prevention for HIV and other STIs
- support Londoners with dementia to live well
- improve care and support at the end of life.

### North East London Health and Care Partnership (NEL HCP)[12]

**2.20** Integrated Care Systems (ICSs) are partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. An ICS exists to improve the health and care of all residents, preventing illness, tackling variation in care and delivering seamless services while getting maximum impact for every pound. The collective strength of these organisations work together to address their residents' biggest health challenges, many exacerbated by COVID-19.

**2.21** NEL HCP is the North East London ICS, which brings together NHS organisations, local authorities, and community organisations to support local people to live healthier and happier lives. NEL HCP has started responding to the NHS LTP. It is made up of the following London Councils: Barking and Dagenham, Redbridge, Havering, City and Hackney, Newham, Tower Hamlets, and Waltham Forest; and one CCG, five NHS Trusts (three acute and two community), and 286 GP practices.

## Local context

### Havering Health and Wellbeing Strategy 2019-2023[13]

**2.22** Health and Wellbeing Boards are required to produce Health and Wellbeing Strategies to set out how partners will meet local health needs, improve outcomes and reduce health inequalities within the borough.

**2.23** The Havering Health and Wellbeing Strategy (2019/20 – 2023/24) plans to address gaps and health inequalities, and to achieve realistic and measurable improvements in the health and

[11] The London Vision (2019). https://www.healthylondon.org/wp-content/uploads/2019/09/London-Vision-short-summary-1.pdf

[12] North East London Health and Care Partnership website: https://www.eastlondonhcp.nhs.uk

[13] Joint health and wellbeing strategy. Havering wellbeing board. https://www.havering.gov.uk/download/downloads/id/1533/joint_health_and_wellbeing_strategy_201920_%E2%80%93_202324.pdf

wellbeing of the residents of Havering. To assess and identify the potential health and wellbeing issues affecting Havering, the **Havering Joint Strategic Needs Assessment 2020**, NHS partners and Healthwatch were used as sources to set out the priorities for the health and wellbeing strategy in Havering:

- **Assisting people with health problems (back) into work:** to bring together private, public and third sector stakeholders to assist excluded groups into work.
- **Further developing the council/ NHS trusts as anchor institutions:** to aim to build a healthier community and economy.
- **Preventing homelessness at a strategic level:** life expectancy for homeless people is under 50 years.
- **Realising the benefits of regeneration for health and social care services.**
- **Improving support to residents who are likely or are frequent callers to health and social care services:** e.g., guiding people to more effective forms of support such as social prescribing services where health and social care services are not required.
- **Obesity:** 1 in 5 children are overweight, and 2 in 3 adults are obese. This priority will focus on encouraging individuals to make healthier choices by shifting cultural norms, coordinate and sustain action in addressing the obesogenic environment.
- **Reducing tobacco harm:** smoking remains high in many communities but using and encouraging the use of e-cigs provides opportunities to reduce the harm caused by smoking**.**
- **Early years providers, schools and colleges as health improvement settings:** Schools and colleges to build partnerships providing support to CYP where issues such as knife crime and mental health problems are on the rise in children and young people.
- **Development of integrated health and social care services of CYP and adults at locality level:** better community and care to support vulnerable residents.
- At each step, a member of the health and wellbeing board will be appointed to lead on a selected priority.

# Chapter 3 - The Development of the PNA

**3.1** This PNA has been developed using a range of information sources to describe and identify population needs and current service provision from the network of community pharmacies (see Table 3.1). This includes:

- Nationally published data
- The Havering Joint Strategic Needs Assessment
- Local policies and strategies such as the Joint Health and Wellbeing Strategy
- A survey to Havering pharmacy providers
- A survey to the patients and public of Barking and Dagenham, Havering and Redbridge
- Local Authority and BHR CCG commissioners

**Table 3.1 PNA 2022-25 data sources**

| | |
|---|---|
| **Health need and priorities** | • National benchmarking ward and borough-level data from Public Health England[14]<br>• London Borough of Havering Joint Strategic Needs Assessment[15]<br>• A range of GLA demographic data sets<br>• Synthesis from a range of national datasets and statistics |
| **Current Pharmaceutical Services** | • Commissioning data held by the NHS England<br>• Commissioning data held by London Borough of Havering<br>• Commissioning data held by North East London CCG<br>• Questionnaire to community pharmacy providers |
| **Views from community pharmacy contractors** | • Questionnaire to community pharmacy providers and follow-up interviews |
| **Patients and the Public** | • Patient and Public survey |

**3.2** These data have been combined to describe the Havering population, current and future health needs and how pharmaceutical services can be used to support the Health and Wellbeing Board (HWB) to improve the health and wellbeing of our population.

**3.3** This PNA was published for public consultation 24th January to 4th April 2022. All comments were drafted into a consultation report for the steering group and have been considered and incorporated into the final PNA final report.

[14] Public Health England (2021) Public Health Profiles: https://fingertips.phe.org.uk/
[15] BHR JSNA profile: LB Havering 2020

# Methodological considerations

## Geographical Coverage

**3.4** For the purposes of the PNA the geographical localities of Havering is presented as electoral wards to summarise demographic and health need. At the time of producing this PNA, Havering has 18 wards in total, these are illustrated in figure 3.1.

**Figure 3.1 London Borough of Havering Electoral Wards (prior to May 2022)**


**3.5** Please note, that in the lifetime of this PNA new Havering Ward Boundaries will come into place, the changes include an increase from 18 wards to 20 (Figure 3.2).

**Figure 3.2 London Borough of Havering Electoral Wards (from May 2022)**

**3.6** Analysis in this PNA is based on the ward-based structure that is in place prior to May 2022 (Figure 3.1) as it is in-line with available population health needs data and enables us to identify differences at ward level with respect to demography, health needs or service provision.

**3.7** Provision and choice of pharmacies is determined by using 1 mile radius from the centre of the postcode of each pharmacy. This is approximately a 20-minute walk from the outer perimeter of the buffer zone created. The 1-mile radius approach illustrates where there is pharmacy coverage and areas without coverage (for example, see Figure 6.1). In addition, 20-minutes travel time by public transport is also considered as being a reasonable measure to identify variation and choice. Where the population are within 1-mile of a pharmacy or can reach a pharmacy within 20-minutes travel time by public transport then the pharmacy provision is considered 'good'.

**3.8** Where areas of no coverage are identified, other factors are taken into consideration to establish if there is a need. Factors include population density, whether the areas are populated (e.g., Green Belt areas), travel time by public transport, patient demand for services (such as needle exchange) and dispensing outside normal working hours. These instances have all been stated in the relevant sections of the report.

### Patient and Public Survey

**3.9** Patient and public engagement in the form of a survey was undertaken to understand how people use their pharmacies, what they use them for and their views of the pharmacy provision. 364 Barking and Dagenham, Havering and Redbridge residents and workers responded to the survey, their views were explored, including detailed analysis of the Protected Characteristics. The findings from the survey are presented in Chapter 5 of this PNA.

### Pharmacy Contractor Survey

**3.10** The contractor survey was sent to all (44) community pharmacies within Havering and 38 pharmacies responded. The results from this survey are referred to throughout this document.

### Governance and Steering Group

**3.11** The development of the PNA was advised by a Steering group whose membership included representation from:

- Public Health teams in London Borough of Barking and Dagenham, the London Borough of Havering and the London Borough of Redbridge
- North East London Clinical Commissioning Group
- North East London Local Pharmaceutical Committee (LPC)
- Healthwatch Barking and Dagenham, Healthwatch Havering and Healthwatch Redbridge.

The membership and Terms of Reference of the Steering Group is described in Appendix A.

### Regulatory consultation process and outcomes

**3.12** The PNA for 2022-25 will be published for statutory consultation on the 24th of January 2022 for 60 days and will also be open on the Council website for public comment. This PNA was published for public consultation 24th January to 4th April 2022. All comments were drafted into a consultation report for the steering group (Appendix C) and have been considered and incorporated into the final PNA final report.

# Chapter 4 - Demographics and Health Needs

**4.1** This chapter presents an overview of health and wellbeing in Havering, particularly the areas likely to impact on needs for community pharmacy services. It includes an analysis of the latest Havering population and inequalities projections.

**4.1** The analysis of health needs and population changes are outlined in five sub-sections of this chapter and are guided by the Havering JSNA[16] priority areas. These are:

- Havering demographic characteristics
- Wider determinants of health
- Our health behaviours and lifestyles
- The places and communities in which we live
- An integrated health and care system

**4.2** All the maps that follow present the size of population in relation to different factors such as population density, deprivation, and obesity. They are displayed in gradients, where the lower the marker, the lighter the colour. The gradients are illustrated in the legends attached to each map.

## Havering Demographic Characteristics

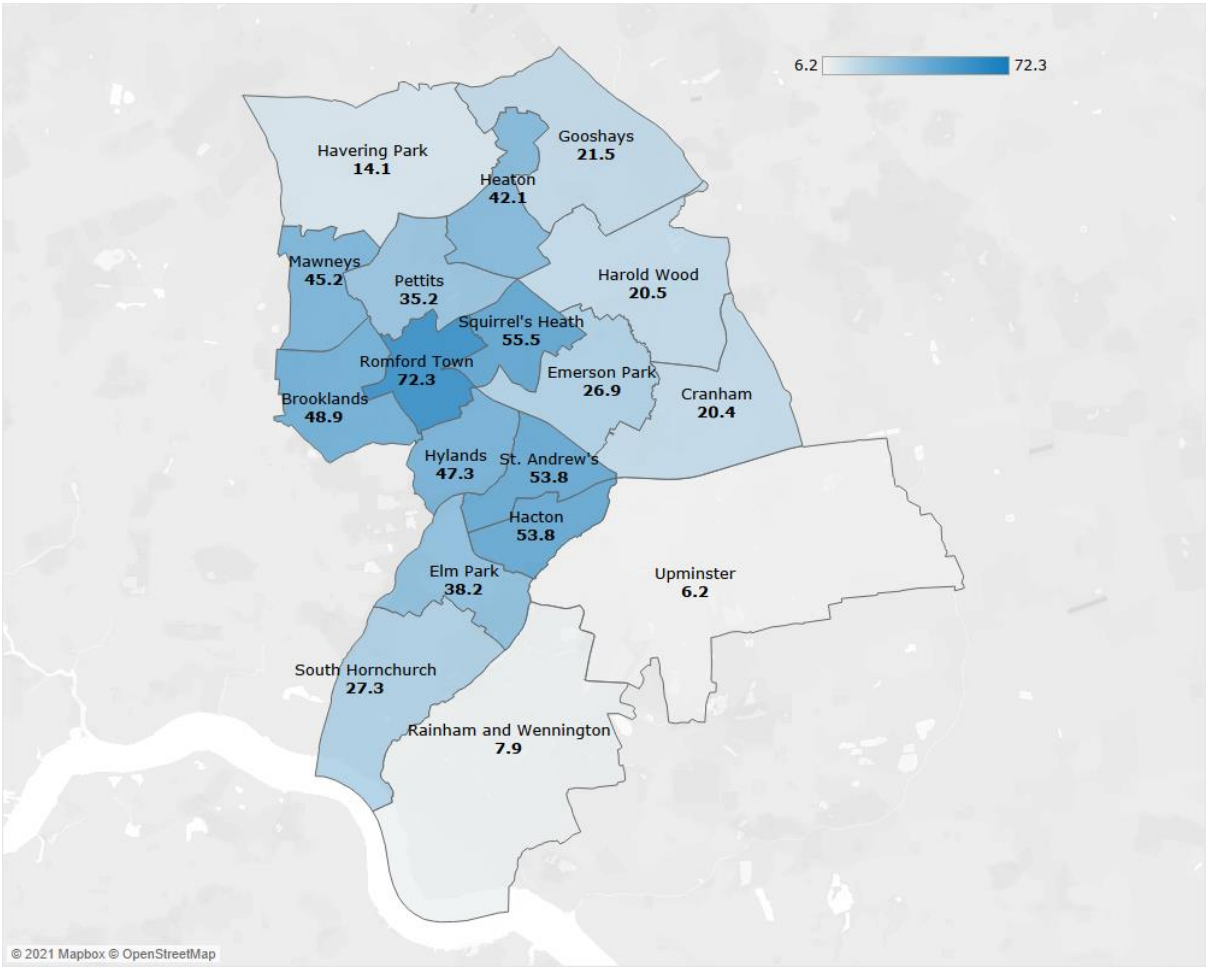
### Population size and density

**4.3** The London Borough of Havering is a North East London Borough situated in Outer London. It borders Barking and Dagenham, Newham, Bexley, Greenwich and Redbridge. Greater London Authority estimates that the population of Havering is 263,354 in 2022 (Housing-led population projections).

**4.4** The borough's population density is much lower than the London average (22.6 vs 56.2 - per hectare respectively) with the most densely populated wards being Romford Town and c. The least densely populated wards are Upminster and Rainham Wennington which is mostly covered by open green spaces (see Figure 4.1).

[16] BHR JSNA profile: LB Havering 2019-20

**Figure 4.1 Population Density of Havering per hectare by Ward, 2022 estimates**



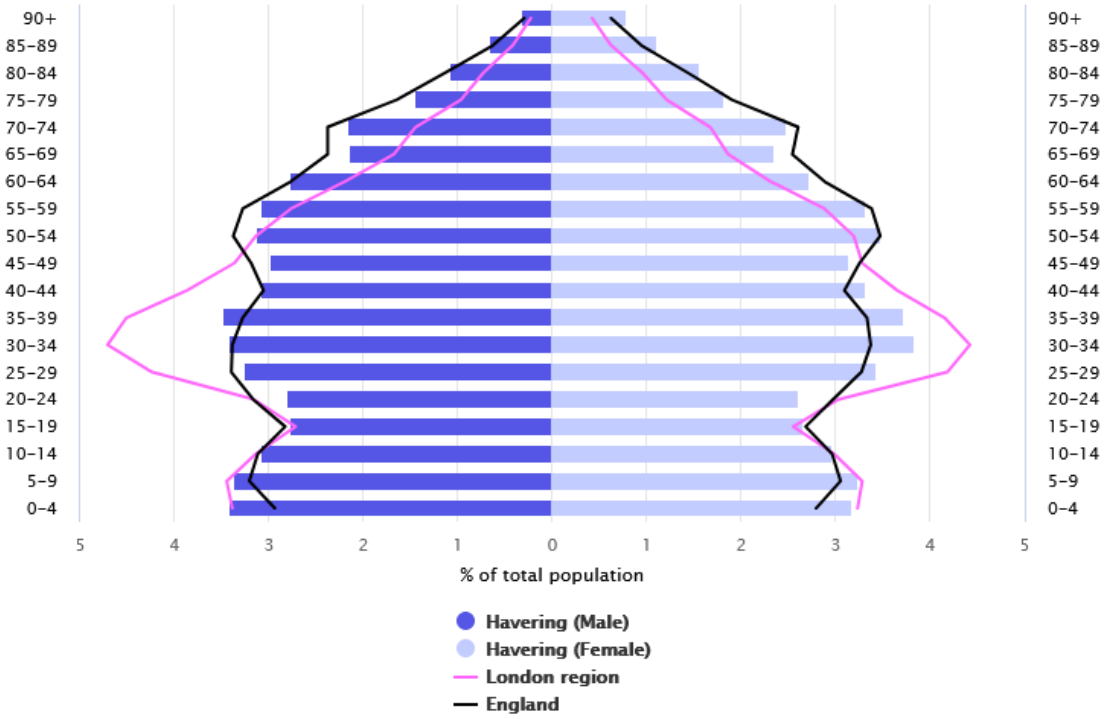

**Source**: GLA, Land Area, and Population Density

## Age and Gender Structure

**4.5** According to 2020 resident population, overall, Havering has a relatively older population. 17.8% of Havering residents (46,518) are **aged 65 and over** (Public Health Outcomes Framework). This is substantially higher than London's overall rate of 12.2%.

**4.6** 19% of the population are aged **less than 15 years**, similar to London and England figures.

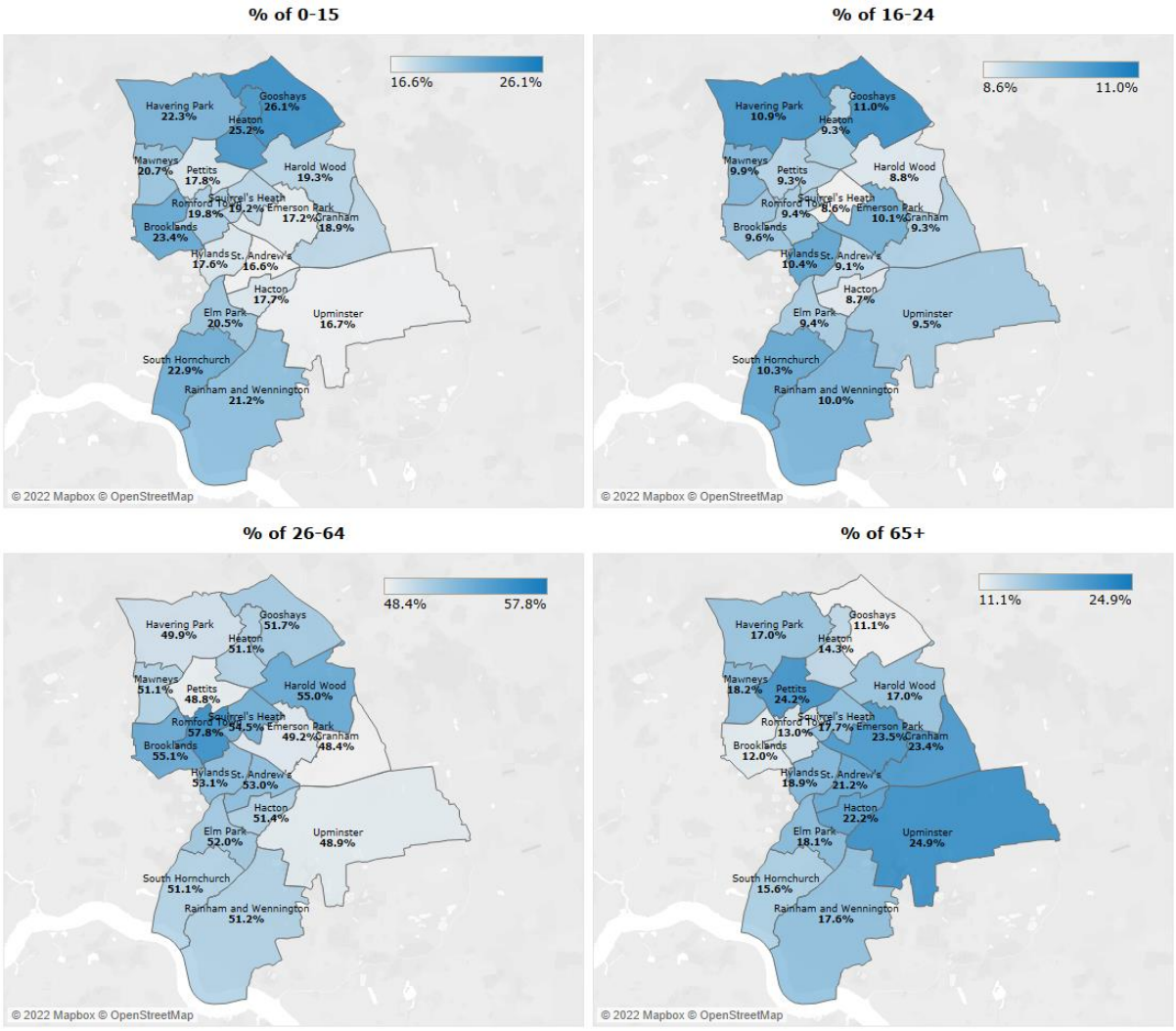
**Figure 4.2: 2020 Proportion of Havering resident population by age-band and gender**




**Source:** PHE, Local Authority Health Profiles, 2022

**4.7** The northern wards of Gooshay and Heaton have the highest representation of the 0-15 population, while Upminster and Pettits, have the highest representation of those aged 65+ (see figure 4.3 below).

**Figure 4.3 Population Age Groups by Ward, 2020 mid-year estimates**




**Source:** ONS, Ward-level population estimates, 2021

## Ethnicity and diversity

**4.8** Areas where diversity is higher correlate with areas of higher levels of deprivation and poorer health. Pharmacy staff often reflect the social and ethnic backgrounds of the community they serve making them approachable to those who may not choose to access other health care services.[17]

**4.9** NICE Guidance[18] highlights that community pharmacies can impact on health inequalities in several ways. For example, they recommend that community pharmacists take into consideration how a patient's personal factors may impact on the service they receive. Personal factors would include, but not limited to, gender, identity, ethnicity, faith, culture, or any disability. It also recommends that community pharmacists make use of any additional languages staff members may have.

[17] NICE guideline (2018) Community pharmacies: promoting health and wellbeing [NG102]
[18] NICE guideline (2018) Community pharmacies: promoting health and wellbeing [NG102]

**4.10** Havering has a small population of residents from **BAME groups** compared to the rest of London (16.2% vs 40.9%). 5.4% of its residents identify as Black while 5.0% are Asian (Table 4.1).

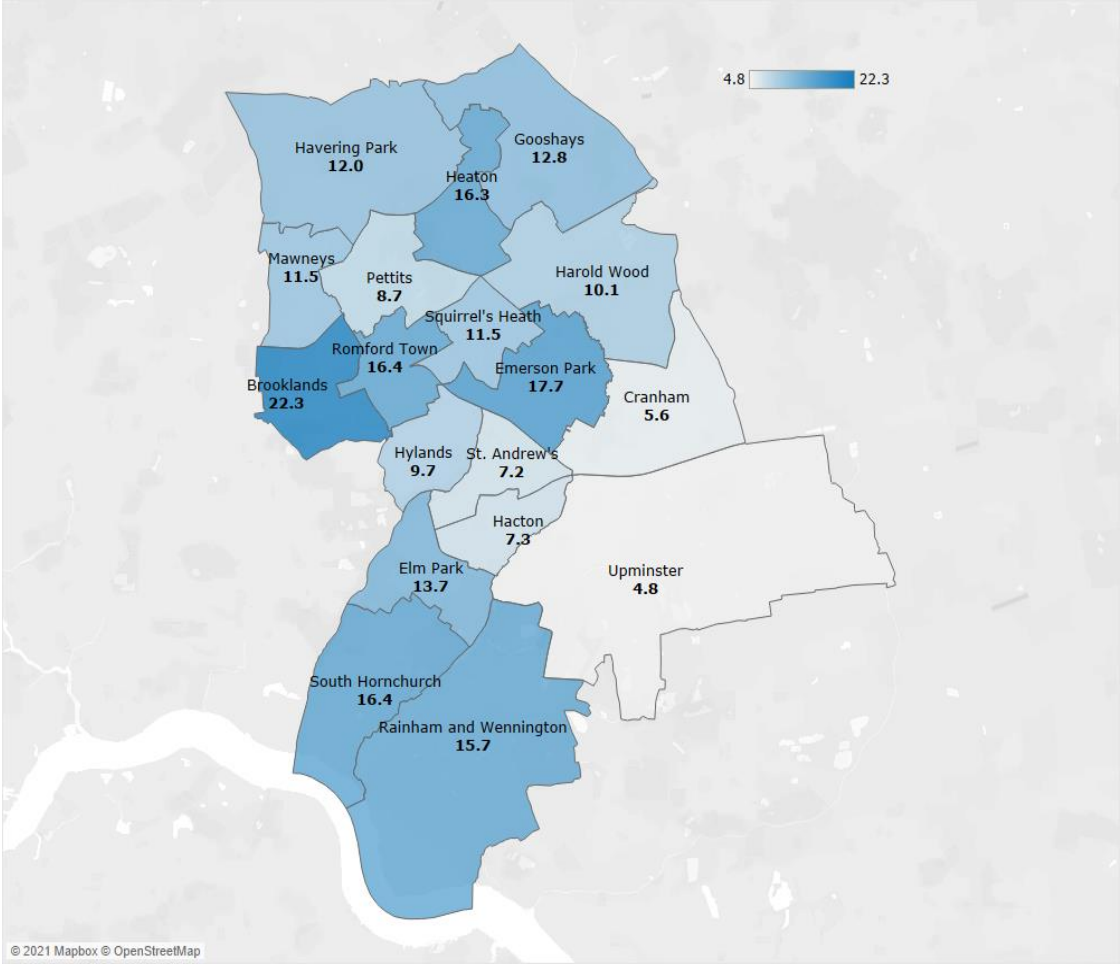
**Table 4.1 Ethnicity population breakdown for Havering, London and England and Wales**

| Area | White | Asian | Black | Mixed/ Other |
|---|---|---|---|---|
| Havering | 83.7% | 5.0% | 5.4% | 5.8% |
| London | 59.2% | 18.4% | 11.9% | 10.6% |
| United Kingdom | 85.9% | 7.3% | 3.3% | 3.5% |

**Source:** UK Data Service, Annual Population Survey, 2019

**4.11** At a ward level, there is great variability in the representation of the Black, Asian and Minority Ethnic populations with Brookside having the highest percentage at 22.3%, and Upminster with the lowest at 4.8% (see Figure 4.4). Please note, this is based on 2011 census data. While it is the most up-to-date census data available, care should be taken in extrapolating this to the current population.

**Figure 4.4: Percentage of black and ethnic minority groups by wards in Havering, 2011**

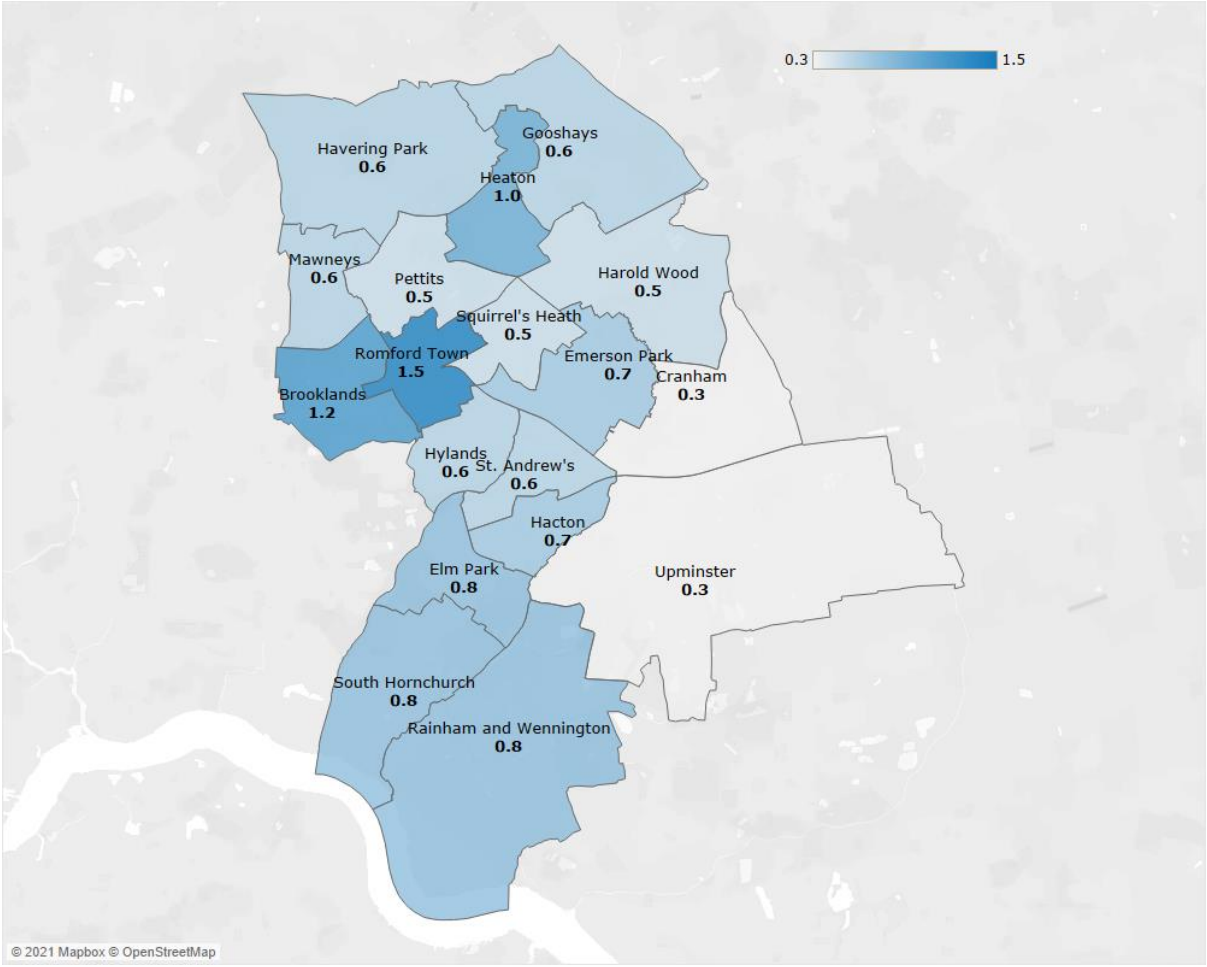



**Source:** ONS Census, 2011

**4.12** 4.6% of the borough's residents who are aged 3+ state their main language is not English (2011 census).

**4.13** Figure 4.5 shows a breakdown of the population who **do not speak English well or at all**. As with the BME data, the ward with the greatest population of residents not proficient is Brookland while that with the least is Upminster. Please note, this map is created from 2011 census data.

**Figure 4.5: Percentage of people that cannot speak English well or at all by Ward in Havering in 2019**




**Source:** PHE, Local Authority Health Profiles, 2021

**4.14** Lithuanian, Polish and Panjabi are the most spoken languages after English (Table 4.2) according to the 2011 census, although these figures may have changed in recent years.

**Table 4.2: Proportion of languages spoken in Havering**

| Language | Percentage |
|---|---|
| English | 95.4% |
| Lithuanian | 0.4% |
| Polish | 0.4% |
| Panjabi | 0.3% |
| Bengali | 0.2% |
| Tagalog/Filipino | 0.2% |
| Turkish | 0.2% |
| Gujarati | 0.2% |
| Urdu | 0.2% |
| Romanian | 0.2% |
| All other Chinese | 0.2% |

**Source:** ONS Census, 2011

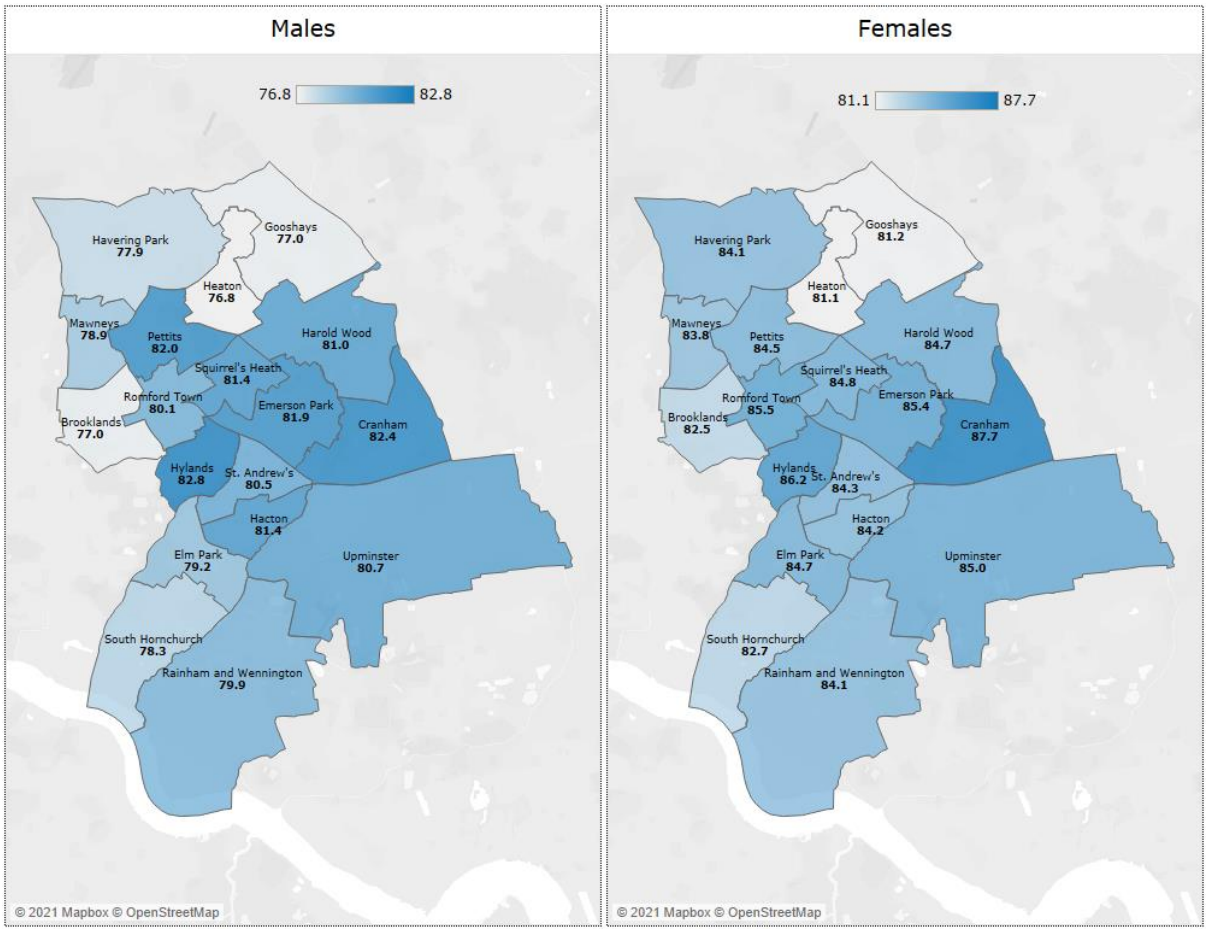
## Population Health Outcomes

**4.15** **Life expectancy at birth** is the average number of years a person would expect to live based on contemporary mortality rates. For males in Havering this is 79.7, and 83.5 years for females (2018-20 figures). This is similar to national figures for males and females at 79.4 and 83.1 years respectively (PHE 2022).

**4.16** The variation in life expectancy across Havering is low. The **inequality in life expectancy at birth**, which is the measure of the absolute difference in life expectancy between the most and least deprived areas, shows a 7.1-year life expectancy gap for men and a 5.6-year gap for women between those who live in the most deprived areas and the least deprived areas (PHE, 2021).

**4.17** A breakdown of life expectancy figures at a ward level is presented in Figures 4.6. Heaton ward has the lowest life expectancy among both males and females.

**Figure 4.6: Life expectancy at birth by Ward in Havering, 2015 to 2019**

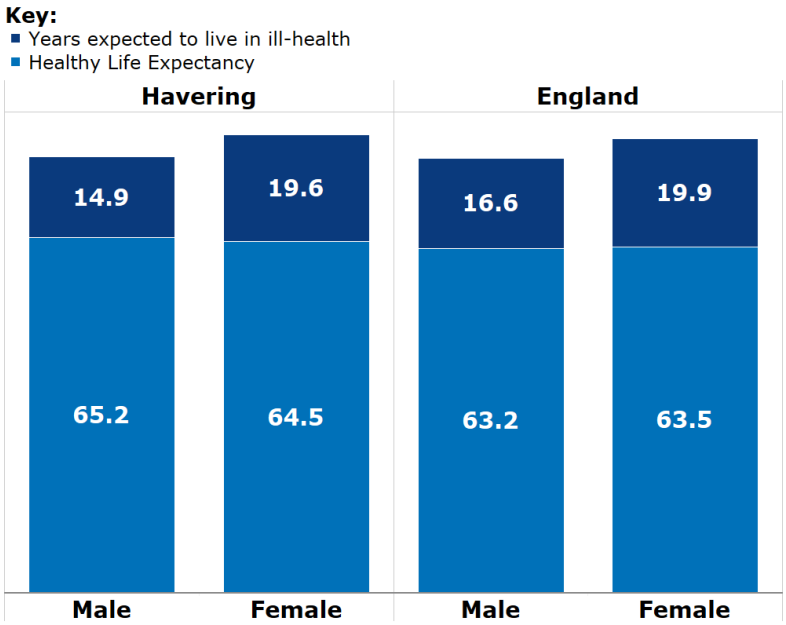



**Source**: PHE, Local Authority Health Profiles, 2021

**4.18** **Healthy life expectancy** at birth is the average number of years an individual should expect to live in good health considering age-specific mortality rates and prevalence for good health for their area.

**4.19** The healthy life expectancy for males and females are also significantly lower than national figures. They are also the lowest in London for males and third lowest in London for females. Males have a healthy life expectancy of 65.2 years and females have a healthy life expectancy of 64.5 years (2017-19). The England healthy life expectancy for men is 63.2 and 63.5 for women. These figures indicate that males living in Havering could live with ill health for 14.9 years and females for 19.6 years (see figure 4.7).

**Figure 4.7 Life expectancy and Healthy life expectancy in years for males and females in Havering, 2017-2019**




**Source:** PHE, Public Health Profiles, 2021

## Wider Determinants of Health

**4.20** There are a range of social, economic, and environmental factors that impact on an individual's health behaviours, choices, goals and ultimately health outcomes and life expectancy. These include factors such deprivation, housing, education, and employment. Havering Joint Health and Wellbeing Strategy[19] acknowledges the need to influence these wider determinants of health to improve health and wellbeing outcomes of its residents.

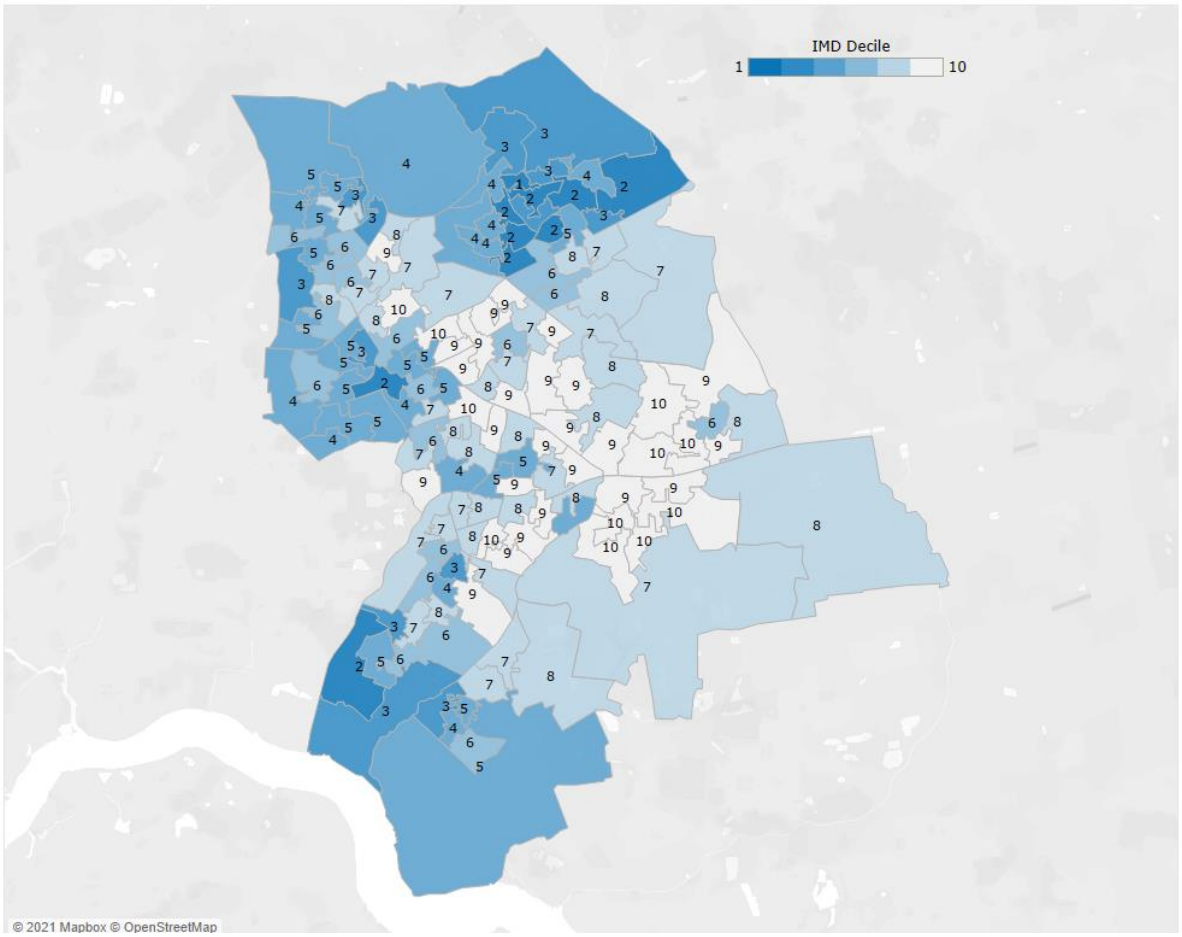
**4.21** Access to community pharmacy services in communities where there is high deprivation is important in addressing health inequalities. Index of Multiple Deprivation (IMD) deciles enable a comparison of deprivation in neighbourhoods across England. A decile of one, for instance, means, that the neighbourhood is among the most deprived 10% of neighbourhoods nationally (out of a total of 32,844 neighbourhoods in England).

**4.22** Havering has 150 neighbourhoods (LSOAs). The borough's overall average IMD decile figure is 6.35 compared to the national one of 5.5. This means that Havering is comparatively less deprived in relation to England as a whole.

**4.23** Figure 4.8 shows deprivation deciles at LSOA level, highlighting that there is great variability in the levels of deprivation in Havering. 11 LSOAs in Havering are among the least deprived 10% in England, while one LSOA is among the most deprived 10% in the country.

[19] Havering Joint Health and Wellbeing Strategy 2019-2023

**Figure 4.8 Deprivation deciles in Havering by LSOA in 2019**




**Source**: MHCLG, 2019

**4.24** Pharmacies have the potential to play a vital role in improving the health of deprived communities by offering convenient and equitable access to health improvement services. Community pharmacies are typically well-placed within communities that are most likely to experience health inequalities[20].

**4.25** In 2019/20 76.4.1% people of the working age population of the borough are in **employment**. This is higher than the London and England rate at 75.1 and 76.2% respectively (Annual Population Survey, 2020).

### *The impact of COVID-19*

**4.26** The impact of **COVID-19** has affected those from more deprived areas and ethnic minority groups the most. Nationally, the people who have suffered the worst outcomes from COVID-19 have been older, of black or Asian heritage and have underlying health conditions such as obesity of diabetes[21].

[20] NICE guideline (2018) Community pharmacies: promoting health and wellbeing [NG102]
[21] PHE (2020). Beyond the data: Understanding the impact of COVID-19 on BAME groups.

**4.27** Over 4 in 10 Black or Black British adults reported feeling hesitant about taking the COVID-19 vaccine. Some of the reported concerns related to side effects, long term health effect and questions on how well the vaccine works[22].

## Our health behaviours and lifestyles

**4.28** Health-related behaviours such as smoking, drinking alcohol to excess, being physical inactive and having a poor diet can significantly impact on health outcomes.

**4.29** Community pharmacies are mandated to provide the Healthy Living Pharmacy framework. This ensures that they are providing a broad range of health promotion interventions designed to meet local need. The framework includes supporting the delivery of community health promoting interventions, by for example, engaging public health campaigns and rolling out locally commissioned initiatives such as stop smoking services, sexual health services and dementia friends.

**4.30** As an essential service, pharmacies participate in up to six national health campaigns at the request of NHS England and NHS Improvement. The first mandated health campaign of 2021/22 was the COVID-19 vaccination campaign to inform the public about the vaccine and encourage people to take it up when it is offered to them.

**4.31** In addition, pharmacies are required to signpost people to other health and social care providers and provide brief advice where appropriate.

**4.32** In this section of the chapter, we explore different health behaviours and lifestyles that impact the health of the Havering population that pharmacies can support people with.

### Smoking

**4.33** Smoking is the leading cause for preventable death in the world. 13.2% of adults surveyed in Havering smoke in 2019. This is slightly higher rate than London and lower than England where 12.9% and 13.9% smoke respectively (Annual Population Survey, 2021).

### Dietary risks

**4.34** Obesity is recognised as a major determinant of premature mortality and avoidable ill health. It increases the risk of a range of diseases including certain cancers, high blood pressure and type 2 diabetes[23] and increases the risk of death from COVID-19 by 40- 90%[24]. In 2019/20, 67.3% of adults are overweight or obese in Havering.

[22] Fenton, K. (2021). COVID-19, Health Inequalities and Recovery. LGA & ADPH Annual Public Health Conference –23 March 2021

23 Public Health England (2017). Guidance: Health matters: obesity and the food environment.

[24] Public Health England. Excess weight and covid-19. Jul 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903770/PHE_insight_Excess_weight_and_COVID-19.pdf.

**4.35** This proportion is substantially higher than London rate 55.7% and the third highest London. It is also slightly higher than the England rate where 62.8% of adults are overweight or obese (PHE, 2021).

### Low physical activity

**4.36** Just over one-half of adults (58.2%) residing in the borough in 2019/20 are considered **physically active**, meaning they engage in at least 150 minutes of moderate physical activity per week (PHE, 2021). People who are physically active reduce their chances of cardiovascular disease, coronary heart disease and stroke. Physical activity also decreases the risk of obesity, diabetes, osteoporosis and some cancers and can improve mental health mental health.

**4.37** Havering have the fifth highest proportion of **physical inactive** adults. 29.7% of Havering adults are inactive (2019/20 data), meaning they are doing less than 30 minutes a week. This is significantly higher than regional national figures. 23.8% of Londoners and 22.9% of England residents are physically inactive (PHE, 2021).

### Alcohol use

**4.38** Alcohol consumption contributes to morbidity and mortality from a diverse range of conditions. 5.4 per 100,000 deaths were wholly caused by alcohol consumption in Havering in 2017-19. This is lower than London and national figures of 7.9 and 10.9 respectively (PHE 2021). It is the fourth lowest rate in London.

**4.39** There were 1,065 admission episodes for Havering residents where alcohol was the main reason for admission in 2019/20. This equates to 437 per 100,000 hospital admissions. This is lower than national figures at 519 per 100,000 but higher than London at 416 per 100,000 (PHE 2021).

**4.40** **Binge drinking** in Havering is similar to that of the rest of England. 14.3% of adults binge drink on their highest drinking day (2015-18), national and regional figures are at 15.4% and 14.6% respectively (Health Survey for England, 2021).

### Substance misuse

**4.41** **Substance misuse** is defined as intoxication or regular excessive consumption and/or dependence on psychoactive substances. It can lead to mental health problems such as depression or suicides, adverse experiences and behaviours such as truancy, exclusion from school and social and legal problems such as homelessness, time in care and serious or frequent offending.

**4.42** An estimated 5.4 per 1,000 residents of Havering are opiates and/or crack cocaine users. This is substantially lower than the estimated prevalence for London and England at 8.9 and 9.3 per 1,000 residents respectively (2018/19 figures, PHE 2021). 453 Redbridge residents are receiving treatment at **specialist drug misuse services** (2017/18 figures, PHE 2021).

**4.43** Community pharmacies are typically well-placed within communities that are most likely to experience health inequalities. ‘Underserved’ communities, such as those who are homeless

or sleeping rough, people who misuse drugs or alcohol may be more likely to go to a community pharmacy than a GP or another primary care service[25].

**4.44** Pharmacies can provide support for people with substance misuse problems through needle and syringe services; supervised consumption of medicines to treat addiction, for example, methadone; Hepatitis testing and Hepatitis B and C vaccination; HIV testing; provision of naloxone to drug users for use in emergency overdose situations.

### Unsafe Sex

**4.45** In 2019 605 per 100,000 Havering residents were diagnosed with a **Sexually Transmitted Infection** (STI), this is similar to national figures (830 per 100,00) the lowest in London where 1,683 per 100,000 tested positive with an STI (PHE, 2021).

**4.46** The latest figures show that there are 316 residents (15- to 59- year-olds) in Havering diagnosed with **HIV**. This equates to 2.12 per 100,000 people. This is lower than the national rates at 2.39 and the second lowest in London (PHE, 2020).

### Influenza Vaccine

**4.47** In 2020/21, less than half (47.9%) of the 'at risk' population received their flu vaccine. 'At risk' people are those who are at greater risk of developing serious complications if they catch the flu. Nationally 53% of the 'at risk' population have received a flu vaccination.

**4.48** 75.7% of the over 65 population and 57.8% of primary school aged children have been vaccinated for the flu in 2020/21. This is lower than the overall proportion of over 65s and primary school aged children vaccinated in England overall (UK Health Security Agency, 2022).

## The places and communities in which we live

### Regeneration Population Growth

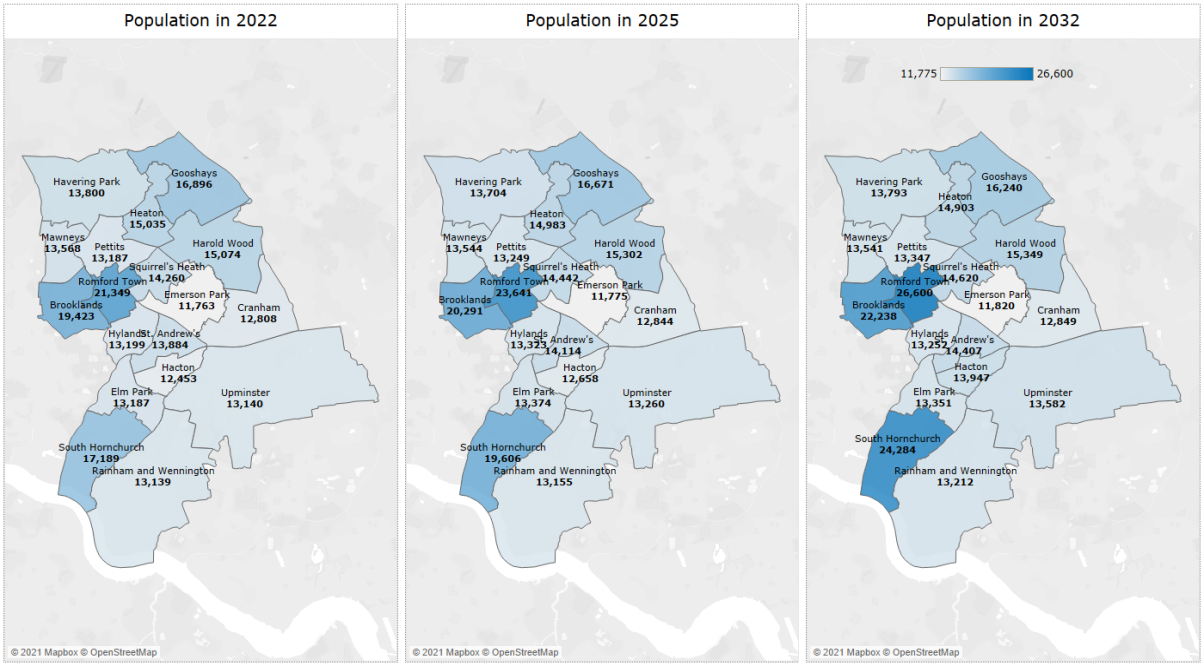
**4.49** Havering is suburban but with large areas of protected open spaces. Its principal town is Romford, a major retail and night-time entertainment centre. Romford also includes other smaller towns such as Hornchurch, Upminster, Collier Row and Rainham.

**4.50** The population of the borough is expected to increase by 2.5% between 2022 and 2025 (the lifetime of this PNA) to 269,934 (See Table 4.3). Between 2022 and 2032 it is expected to increase by 6.8% to 281,336 residents (GLA, Housing-led population projections – Identified Capacity Scenario, 2021). These figures are based on mid-year population estimates and assumptions such as births, deaths, and migration.

**4.51** South Hornchurch, Romford Town and Brooklands are the wards anticipated to have the highest population (Figure 4.9).

[25] NICE guideline (2018) Community pharmacies: promoting health and wellbeing [NG102]

**Figure 4.9: Population Change by Ward – 2022, 2025 and 2032**




**Source**: GLA, Housing-led population projections – Identified Capacity Scenario, 2021

### *Table 4.3: Projected population increase by ward between 2022 - 2032*

| Ward | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Brooklands | 0.0% | 1.6% | 3.0% | 4.5% | 6.3% | 7.9% | 9.7% | 11.4% | 12.5% | 13.6% | 14.5% |
| Cranham | 0.0% | 0.2% | 0.3% | 0.3% | 0.2% | 0.2% | 0.0% | -0.1% | 0.1% | 0.3% | 0.3% |
| Elm Park | 0.0% | 0.8% | 1.3% | 1.4% | 1.4% | 1.4% | 1.4% | 1.2% | 1.3% | 1.4% | 1.2% |
| Emerson Park | 0.0% | 0.0% | -0.1% | 0.1% | 0.0% | -0.2% | 0.0% | 0.0% | 0.3% | 0.4% | 0.5% |
| Gooshays | 0.0% | -0.3% | -0.8% | -1.3% | -2.0% | -2.6% | -3.1% | -3.6% | -3.7% | -3.8% | -3.9% |
| Hacton | 0.0% | 0.4% | 0.8% | 1.6% | 2.8% | 3.9% | 5.0% | 6.1% | 8.1% | 10.1% | 12.0% |
| Harold Wood | 0.0% | 0.7% | 1.3% | 1.5% | 1.4% | 1.4% | 1.2% | 1.2% | 1.5% | 1.7% | 1.8% |
| Havering Park | 0.0% | -0.3% | -0.6% | -0.7% | -1.0% | -1.0% | -1.0% | -1.0% | -0.6% | -0.3% | 0.0% |
| Heaton | 0.0% | -0.1% | -0.3% | -0.3% | -0.6% | -1.0% | -1.0% | -1.2% | -1.0% | -1.0% | -0.9% |
| Hylands | 0.0% | 0.4% | 0.8% | 0.9% | 0.7% | 0.4% | 0.2% | 0.0% | 0.3% | 0.4% | 0.4% |
| Mawneys | 0.0% | 0.2% | -0.1% | -0.2% | -0.2% | -0.2% | -0.4% | -0.5% | -0.2% | -0.1% | -0.2% |
| Pettits | 0.0% | 0.2% | 0.3% | 0.5% | 0.3% | 0.4% | 0.4% | 0.4% | 0.7% | 1.0% | 1.2% |
| Rainham and Wenningt.. | 0.0% | 0.0% | 0.0% | 0.1% | 0.0% | 0.0% | 0.1% | 0.3% | 0.4% | 0.5% | 0.6% |
| Romford Town | 0.0% | 4.2% | 8.2% | 10.7% | 13.7% | 16.8% | 19.7% | 22.9% | 23.7% | 24.2% | 24.6% |
| South Hornchurch | 0.0% | 5.2% | 10.1% | 14.1% | 19.2% | 24.2% | 29.2% | 34.1% | 36.8% | 39.1% | 41.3% |
| Squirrel's Heath | 0.0% | 0.5% | 0.9% | 1.3% | 1.5% | 1.6% | 1.8% | 2.0% | 2.3% | 2.4% | 2.5% |
| St. Andrew's | 0.0% | 0.8% | 1.3% | 1.7% | 2.0% | 2.3% | 2.6% | 3.0% | 3.3% | 3.6% | 3.8% |
| Upminster | 0.0% | 0.3% | 0.6% | 0.9% | 1.2% | 1.5% | 1.9% | 2.3% | 2.8% | 3.1% | 3.4% |
| Borough Total | 0.0% | 1.0% | 1.8% | 2.5% | 3.2% | 3.9% | 4.6% | 5.4% | 6.0% | 6.4% | 6.8% |

**Source: GLA,** Housing-led population projections – Identified Capacity Scenario, 2021

**4.52** South Hornchurch's population is expected to increase by more than 40% between 2022 and 2032 (from 17,189 to 24,284 residents). This is due to the Thames Gateway regeneration that extends to this area.

**4.53** The population of Romford Town is expected to increase by 10.7% in the lifetime of this PNA from 21,349 to 23,641 residents. This is due to the regeneration of the Romford Town centre

that will include a rejuvenation of the market centre and development of town centre apartments.

**4.54** Please note, there will be Ward Boundary changes that will come into effect from May 2022 (see Figure 3.1). These changes include Pettits Ward changing its name to Marshalls and Rise Park, a new ward 'Beam Park', Hylands Ward changing its name to Hylands and Harrow Lodge, and Romford Ward splitting into two, becoming St. Albans and St. Edwards.

**4.55** Population increases will likely increase demand on community pharmacy services, this will be considered in Chapter 6 where we look at the capacity of the current pharmacy provision.

### Air pollution

**4.56** **Air quality** is of concern in Havering. Particulate matter contributes to mortality, particularly cardiopulmonary mortality. Like most of London, Havering is within the worst quintile for proportion fine particulate matter within the air. In 2019, 6% of mortality in Havering is attributed to particulate air pollution. This is similar than London and England at 6.4% and 5.1% respectively (PHE, 2021).

### Violence against women and girls

**4.57** Violence against women and girls in London is increasing. 1 in every 10 crimes recorded by the Metropolitan Police being **domestic abuse** related. More than 50% of female mental health service users have experienced domestic violence. In 2017/18, in Havering there were 2300 incidents of domestic abuse reported to the police[26]. Havering has the fourth lowest rates of hospital admissions for violence (including sexual violence) in 2017/18 to 2019/20 in London at 33 per 100,000 admissions. This is substantially lower than the national rate of 45.8 per 100,000 admissions (HES, 2021).

## An integrated health and care system

**4.58** One of the priorities of the Havering Joint Health and Wellbeing Strategy[27] is the development of integrated health and social care services for children and young people and adults at locally level. The rationale is that the majority of care will be delivered at locality level with integrated team of primary and community health care professionals and social care counterparts working with other statutory partners.

**4.59** This section of the chapter explores the impact on services on:

- Maternity
- Children and young people
- Adult mental health
- Cancer and long-term conditions
- Older people and frailty

[26] London Borough of Havering (2018). Havering Violence Against Women and Girls Strategy 2019-2022
[27] Havering Health and Wellbeing Board Joint Health and Wellbeing Strategy 2019/20 – 2023/24

## Maternity

**4.60** Havering has a relatively high birth rate. In 2019, there were 3,186 births in Havering, this equates to a birth rate of 62.9 per 1,000 females aged 15 to 44 years. The national birth rate was 57.7 per 1000 females (ONS, 2021).

**4.61** Pregnant women in Havering have better early access to maternity care than London overall. Early access to maternity care enables early identification of women who might need more than their usual care and risk factors such as smoking or poor mental health. 58.6% of pregnant women have early access to maternity care, this is similar than the national rate of 57.8% (NHS Digital, 2020).

**4.62** However, there are a few areas of concern in child and maternal health in Havering. For example, the stillbirth rate is one of the highest in London. There were 52 stillbirths in 2017-19, equating to a rate of 5.2 per 1,000 births in 2017-19. The national rate is 4.0 per 1,000 stillbirths (ONS, 2021).

**4.63** Havering has one of highest rates of obesity in early pregnancy in London. Excess weight or obesity can lead to increased risk of several issues for both mother and baby, including diabetes, miscarriage and maternal death for the mother and foetal death, stillbirth, congenital abnormality for the baby. 21.7% of mothers were obese in 2018/19, this is higher than London at 17.8% but similar to England with at 22.1% (Maternity Services Dataset, 2021).

**4.64** Just over half (59.7%) of new mothers gave their babies breast milk in their first 48 hours in 2016/17. This is the lowest recorded figure in London and substantially lower than the England Breastfeeding Initiation rate of 74.5% (NHS England, 2018).

## Children and young people

**4.65** The Joint Health and Wellbeing Strategy[28] highlights a number of priorities relating to children and young people. In this section we explore the wider determinants of health in children, health behaviours and health outcomes that are of concern in Havering.

### *Wider determinants of Health for children*

**4.66** Strong **educational attainment** in childhood is linked to better health outcomes and better access to work opportunities and higher income. In Havering the proportion of children meeting expected standards at key stage 2 in reading, writing and maths are above national and England comparators. In 2019/20, 71.5% of children are meeting these expected standards, whereas 70.7% of London children and 65.3% of children in England overall are meeting expected standards (Department for Education, 2021).

**4.67** **Persistent school absences** in Havering are lower than national comparators. In 2018/19, 8.4% of primary school enrolled children and 13.4% of secondary school enrolled children missed 10% or more school sessions. The national figures are 11.8% and 21.8% for primary and secondary age children respectively (Department of Education, 2020).

[28] Havering Health and wellbeing Board: Joint Health and Wellbeing Strategy 2019/20 – 2023/24.

**4.68** Since March 2020 children's development has been disrupted by national and local lockdowns, leading to breaks in their education, inequalities in online education and lack of social contact. This may result in long-term impact on educational outcomes and their physical, mental, and emotional wellbeing. Information on the actual impact has not yet been quantified.

**4.69** Childhood poverty is high in Havering. Children living in poverty are at more exposed to a range of risks that can impact on their mental health. In 2019/20 13,032 (14.1%) children are living in **absolute low-income families**. Although this is a high proportion of families, it is lower than regional and national proportion of 14.6% and 15.6% respectively.

**4.70** 14.8% of households with dependent children in Havering are owed a duty under the **Homelessness Reduction Act**. This means that they have been identified as homeless by the local authority and the local authority must take reasonable steps to help them to secure accommodation. This equates to 1,557 families in Havering.

### *Health behaviours and health outcomes for children*

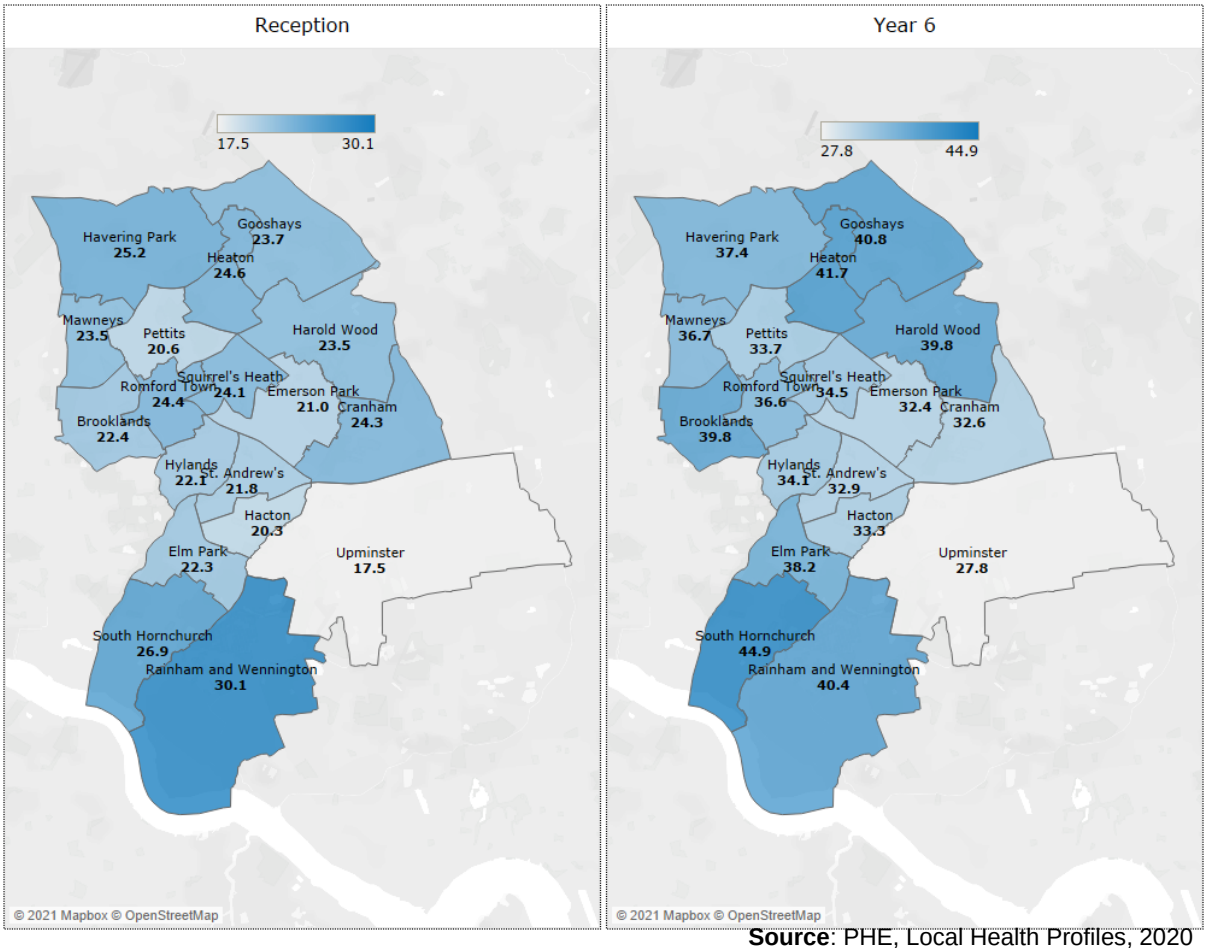
**4.71** **Childhood obesity** is on the rise and can have significant impact on health outcomes. In England, one in 10 children are obese at reception age and one in five Year 6 children are obese. A child who is overweight or obese can have increased blood lipids, glucose intolerance, Type 2 diabetes risk, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

**4.72** The COVID-19 pandemic is likely to have impacted on the number of children who are overweight or obese. The impact of the pandemic and lockdowns meant that routines of the children and their families were disrupted, thus hindering opportunities to maintain healthy lifestyle behaviours.

**4.73** In 2019/20, one in five, or 21.6% of reception age children are overweight or obese in Havering, this is slightly lower than national figures of 23%. However, 38.1% of Year 6 children are overweight or obese, slightly higher than England overall rate of 35.2 (PHE, 2021).

**4.74** At a ward level, Rainham and Wennington and Southchurch have the highest percentage of children who are overweight or obese in Reception, while South Hornchurch and Heaton have the highest representation in Year 6 (see Figure 4.10)

**Figure 4.10: Percentage of children who are overweight or obese by ward.**




**Source**: PHE, Local Health Profiles, 2020

**4.75** **Asthma** is the most common long-term health condition in children in the UK. It is also the one of the most common reasons for emergency hospital admissions in the UK. In 2019/20 there were 85 hospital admissions for asthma for Havering children (under 19 years), this equates to a rate of 138.8 per 100,000 admissions, substantially lower than both London and England rates of 160.7 and 167.6 per 100,000 respectively (HES, 2021).

**4.76** **Dental decay** is a highly preventable condition increased by a high-sugar diet. Nearly one quarter (24.6%) of age-5 children have visual obvious dental decay in Havering in 2018/19; this is lower than regional figures of 27.0% but higher than national figures 23.4% (Dental Public Health Epidemiology Programme for England, 2019).

## Adult mental health

**4.77** **Common mental illnesses** include depression, general anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder. PHE estimates that 32,729 adults, 15.2%, of the Havering population have a common mental illness (based on Adult Psychiatric Morbidity Survey, 2017 data). This is similar to the England estimated prevalence of 16.9%.

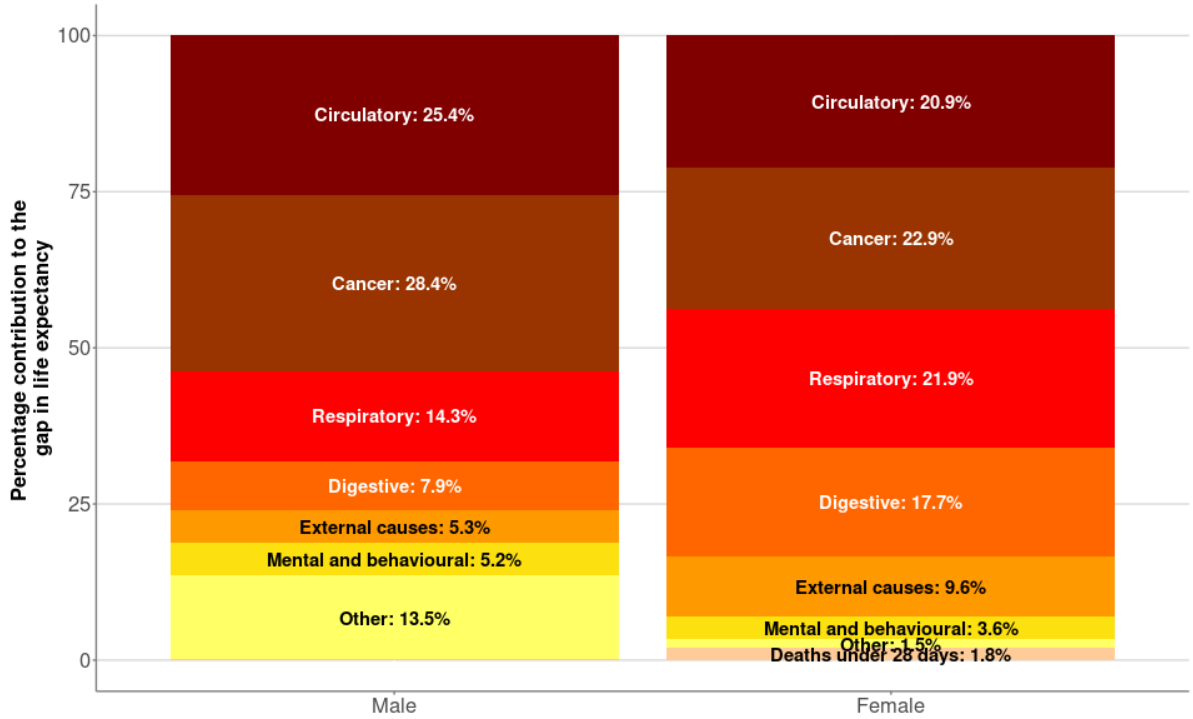
**4.78** 18.3% of Havering patients who have a long-term mental health condition are current smokers (PHE, 2019/20), this is lower than the national rate and a substantial decrease than previous year where rate was 26.6%. Nationally, a quarter (25.8%) of patients who have a long-term mental health condition currently smoke (GP Patient Survey, 2021).

## Cancer and long-term conditions

**4.79** The causes of life expectancy gap between the most deprived and least deprived populations within a borough provides a good indicator on what health conditions have a bigger impact on local populations and where a targeted approach is needed.

**4.80** The stacked bar chart in Figure 4.11 show, for each broad cause of death the percentage contribution that it makes to the overall life expectancy gap in Havering. It highlights cancer as the biggest cause of the differences in life expectancy between deprivation quintiles, accounting for 28.4% of the life expectancy gap in males and 22.9% in females.

**Figure 4.11: Life expectancy gap between the most deprived quintile and least deprived quintile of Havering, by broad cause of death, 2015-17.**




**Source:** Public Health England based on ONS death registration data and mid-year population estimates, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2015

**4.81** This is followed by circulatory diseases which includes heart disease and stroke**.** Circulatory diseases account for 25.4% the male life expectancy gap and 20.9% in the female life expectancy gap. Respiratory diseases are another substantial contributor to the life expectancy gap and account for 14.3% of the gap in men and 21.9% in females.

**4.82** We will look at each of these health classifications and their impact on Havering in more depth.

### *Cancer*

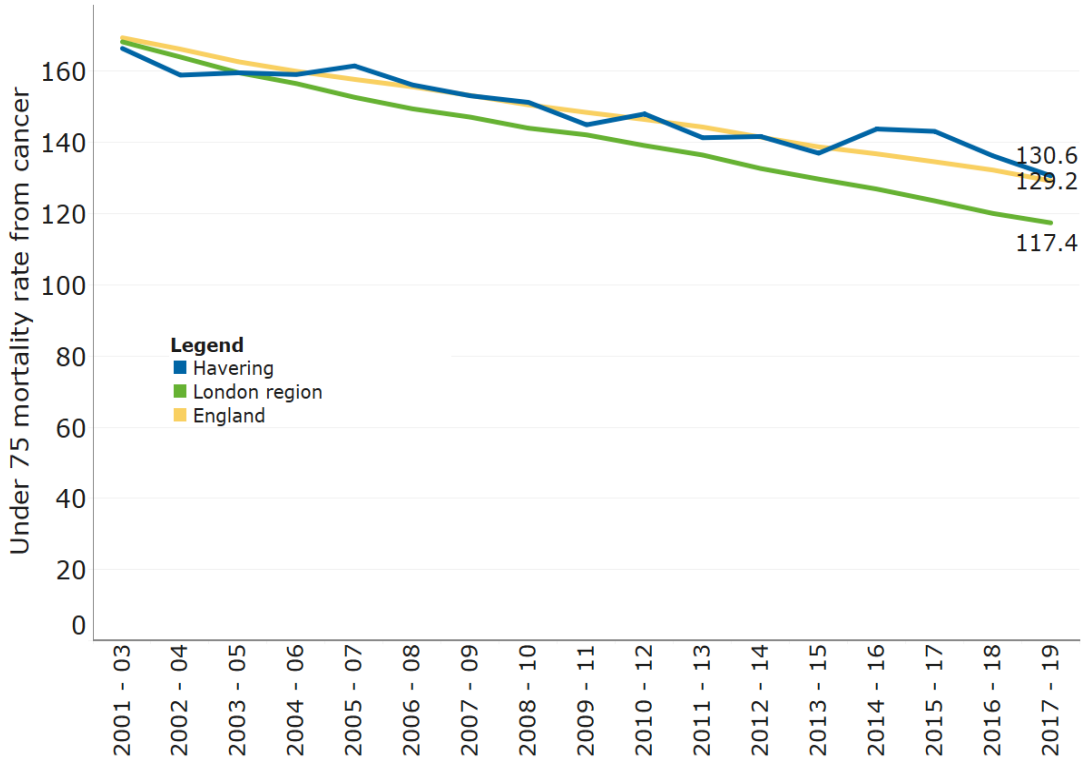
**4.83** Around one in every two people in the UK will get cancer in their lifetime. Pharmacists can play in an important role in the early detection and diagnosis of cancer. Raising awareness through public health campaigns and talking to patients about signs and symptoms of different cancers can result in earlier diagnosis and therefore better treatment options for patients.

**4.84** The incidence of all cancers is high in Havering in comparison to the rest of England. 2014-2018 data shows 103.4 new cases of cancer per 100,000 GP population. This is the forth highest in London and substantially higher than the national rate of 100 new cases per 100,000 population (AV2018 CASREF01, 2020).

**4.85** NHS Havering CCG **screening coverage** for bowel, breast and cervical cancers are high in comparison to England. In fact, the screening coverage for breast cancer for females aged 53-70 years is 78.7%, this is the highest in London. The only exception is bowel cancer screening coverage, where 62.3% of 60–74-year-olds are screened, lower than the national rate of 63.8%, although still the fourth highest rate in London (NHS Cancer Screening Programme, 2021).

**4.86** The **premature mortality rate for cancer** (i.e., under 75 years) for Havering is similar to the national rate although higher than London. Currently 130.6 per 100,000 residents of the borough died prematurely each year from cancer, compared with 129.2 for England and 117.4 for London. This mortality rate, although fluctuating, has generally been on a downward trend since 2001-03 (see Figure 4.12).

**Figure 4.12: Trendline of under 75 mortality rates from cancer for Havering, London and England, 3-year range, 2001/03-2017/19.**



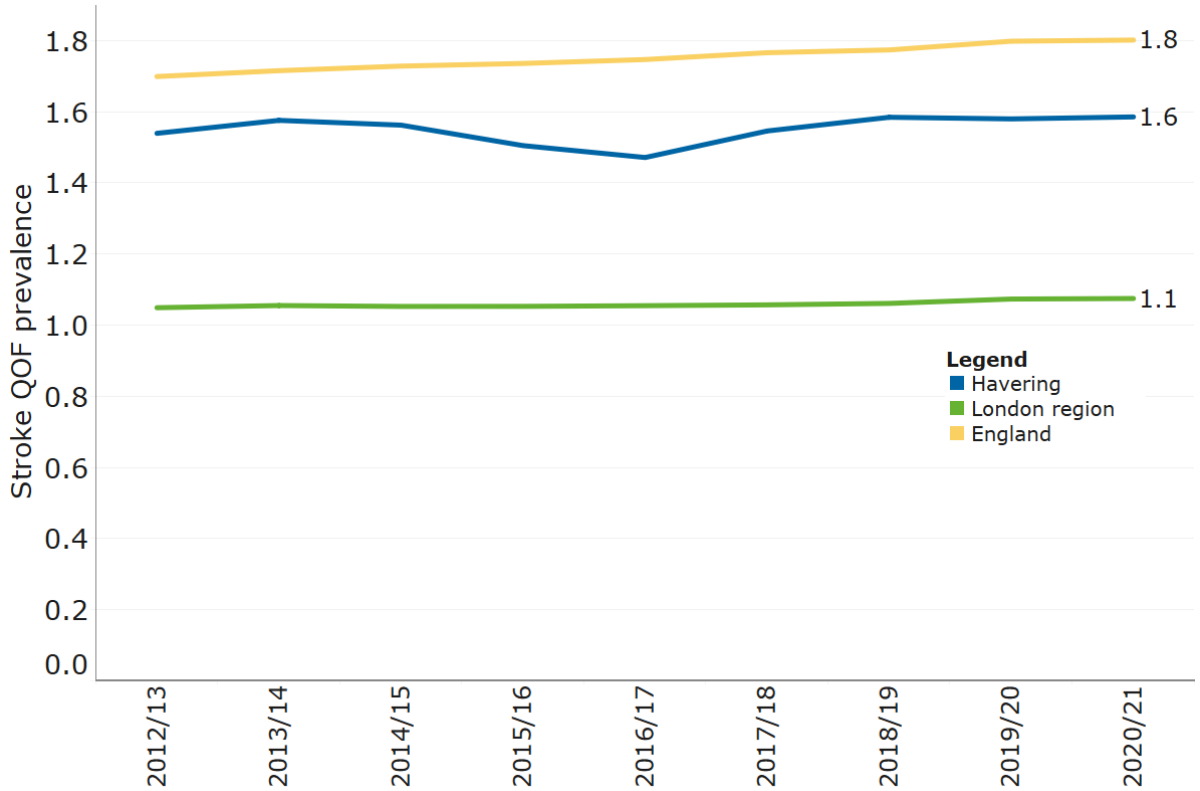

**Source:** PHE, Public Health Profiles, 2021

### *Circulatory Disease*

**4.87** Circulatory diseases such as coronary heart disease and stroke is the second biggest cause of the differences in life expectancy in Havering.

**4.88** Havering has the 2nd highest stroke prevalence in London, although it is a low prevalence in comparison to England overall. 1.6% of the GP registered population in Havering have had stroke or transient ischaemic attack at some point in their lives. A trendline shows that this figure has been steady since 2018/19 (see figure 4.13). The national prevalence is 1.8% of the GP registered population (QOF, 2021).

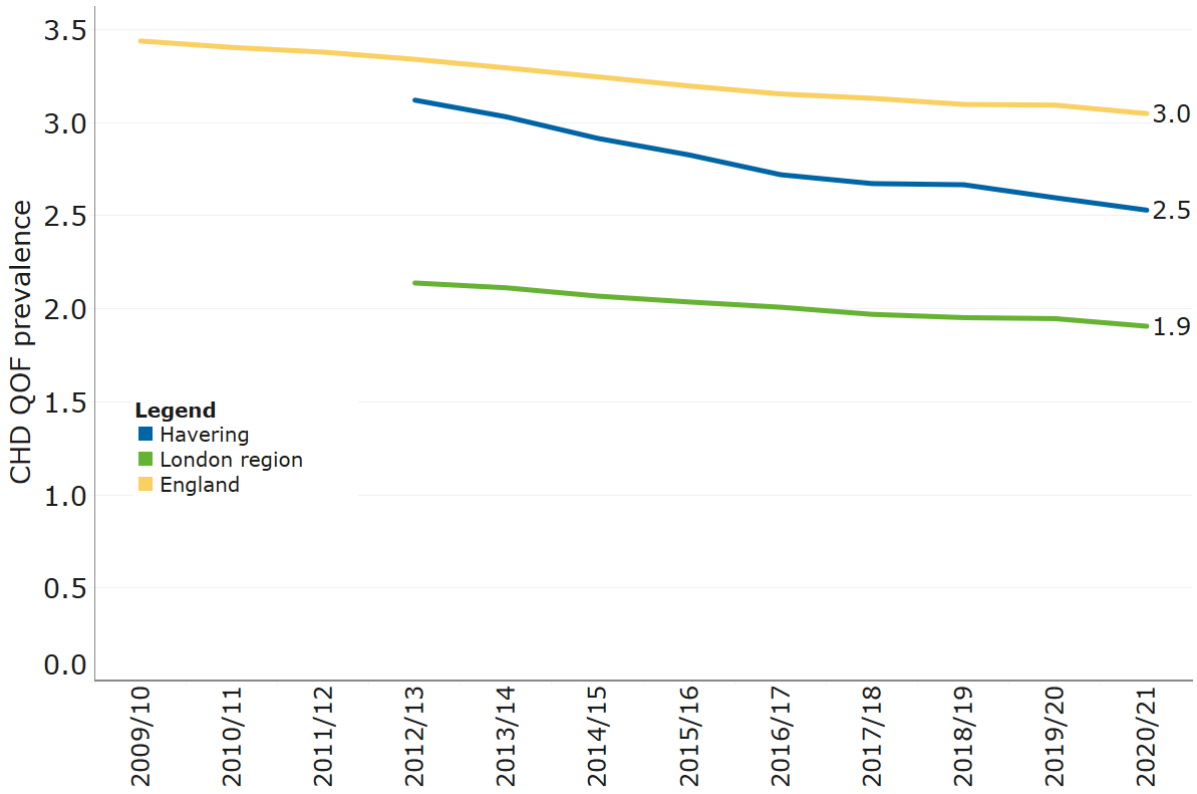
**Figure 4.13: Trendline of Stroke: QOF prevalence (all ages) for Havering, London and England, 3-year range, 2012/13-2020/21.**




**Source**: PHE, Public Health Profiles, 2021

**4.89** In 2020/21, the NHS Havering CCG prevalence rate for coronary heart disease (CHD) is 2.5% of patients. While this was lower than the national prevalence of 3.0% it is the fourth highest in London (QOF, 2021). This figure has been on a downward trend since 2012/13 (see Figure 4.14).

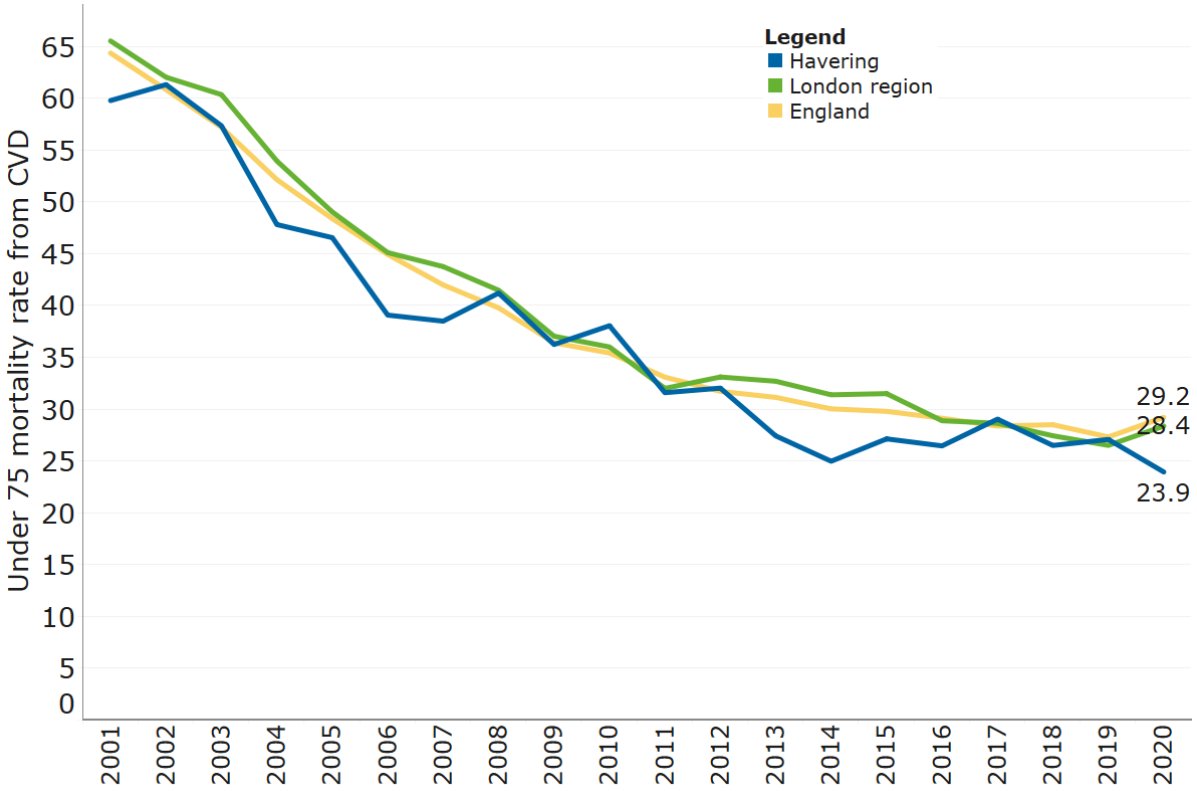
**Figure 4.14: Trendline of CHD: QOF prevalence (all ages) for Havering, London and England, 2009-2021.**




**Source:** PHE, Public Health Profiles, 2021

**4.90** The under 75 mortality rates for cardio-vascular disease considered preventable is 23.9 deaths per 100,000 population. This is substantially lower than the national rate of 29.2 deaths per 100,000 population and one of the lowest in London (Office for Health Improvement and Disparities, 2021). Rates have been reducing over the years (see Figure 4.15) and this is likely due to timelier and high-quality treatment, effective prescribing, and a reduction in the number of smokers.

**Figure 4.15: Under 75 mortality rate per 100,000 from cardiovascular disease considered preventable for Havering, London and England from 2001 to 2020**




**Source:** PHE, Public Health Profiles, 2021

### *Respiratory diseases*

**4.91** **Respiratory disease** is one of the top causes of death in England in under 75s. The under 75 mortality rate by respiratory disease (considered preventable) in Havering is 32.2 per 100,000 population in 2020. This is slightly higher than London and England where the rates are 26.7 and 29.4 respectively (OHID, 2021)

**4.92** One of the major respiratory diseases is **chronic obstructive pulmonary disease** (COPD). Emergency hospital admissions for COPD in Havering is similar to national figures. In 2015/16- 2019/20 there were 101.4 per 100,000 admissions for COPD, the national rate is 100.0 per 100,000 admissions. Helping people to stop smoking is key to reducing COPD and other respiratory diseases (HES, 2021).

## Older people and frailty

**4.93** Havering has the oldest population in London with a median age of approximately 40 years old. Older people are the majority users of healthcare.

**4.94** Pharmacies provide a vital resource in providing consistency in care, supporting older people's medicine adherence, and liaising between other health care practitioners and patients to ensure the patient's optimal pharmaceutical care.

**4.95** In Havering there were 140 excess winter deaths during the winter months in 2019/20, this equates a proportion of 18.4%, similar to the proportion of excess winter deaths in England of 17.4% (ONS, 2021). Excess winter deaths typically affect the older population and those with circulatory, respiratory diseases or dementia.

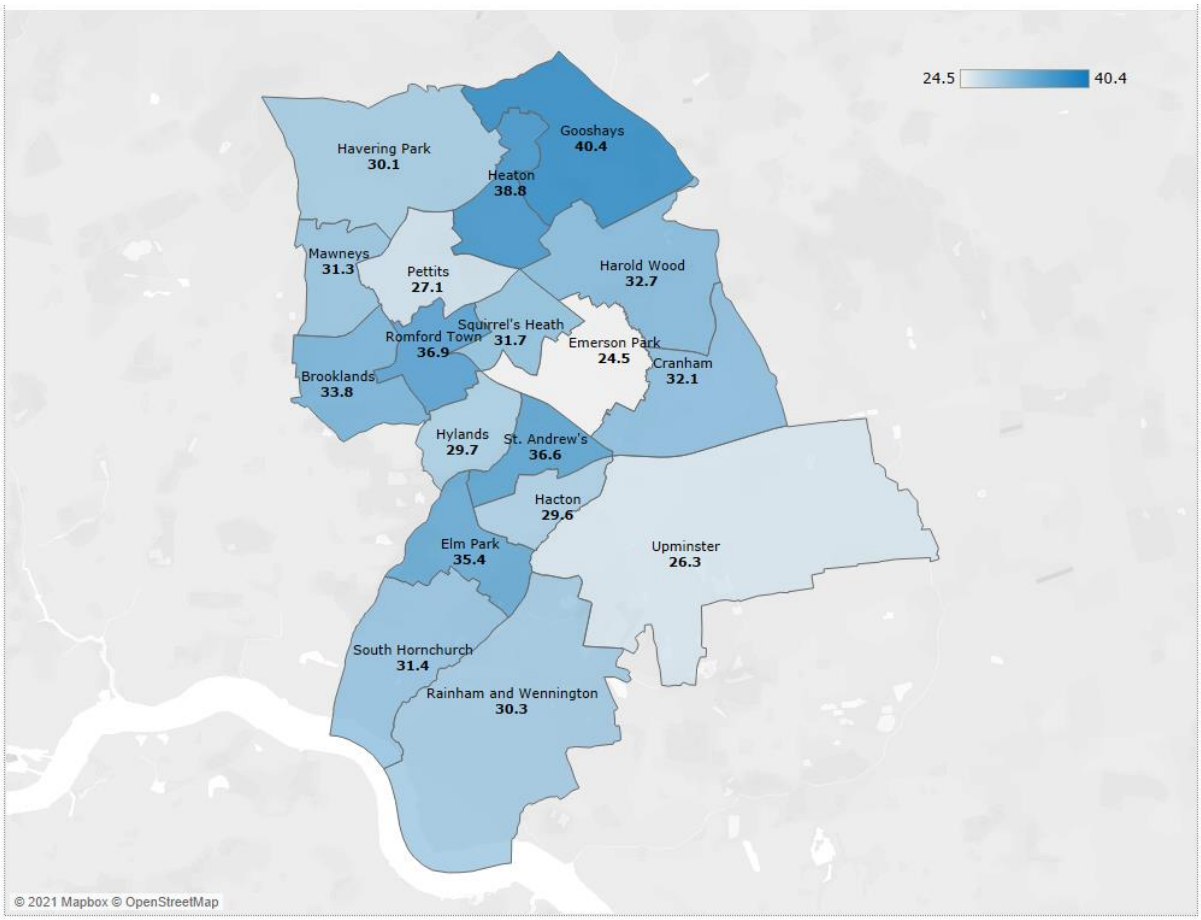
**4.96** Excess winter deaths are also linked to drops in temperature in winter, and fuel poverty hinder resilience to the cold. 9,200 households (9%) were considered to be in fuel poverty in 2018, lower than regional and national figures of 11.4% and 10.3% respectively (Department for Business, Energy and Industrial strategy, 2020).

**4.97** Social isolation and loneliness can impact people of all ages but is more prominent in older adults. It is linked to increased behavioural risk factors, poor mental health as well as morbidity and mortality from acute myocardial infarction and stroke[29]. Adult social care survey explores isolation and loneliness in its analysis. Findings show that in Havering 48.3% of over 65 adult social care users who responded to the survey have as much social contact as they would like. Although this is higher than national figures of 45.9%, it still shows that more than half of older adults in receipt of social care do not have as much social contact as they would like and are likely feeling isolated and lonely (Adult Social Care Survey, 2021).

**4.98** 29.9% of Havering over 65s live alone. Although this is lower than England rate 31.5% figure 4.16 shows that there are wards within Havering where the rates of living alone are high. 40.4% of Gooshays residents live alone (PHE 2021, ONS 2011 Census).

[29] Hakulinen C, Pulkki-Råback L, Virtanen M, et al (2018). Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: UK Biobank cohort study of 479 054 men and women. *Heart*; 104:1536-1542.

**Figure 4.16: Older People living alone in Redbridge by ward, 2011**




**Source:** PHE,Local Authority Health Profiles, 2018

**4.99** Approximately 2,075 people (0.8% of GP registered patients) have dementia in Havering in 2019/20. Early diagnosis is important in enabling people to access the right services and support early and live well with dementia.[30] However, the estimated percentage of people living with dementia who have a formal diagnosis in Havering is 53.0%, significantly lower than the national rates of 61.6% and the lowest in London (NHS Digital, 2021).

**4.100** Falls are a major cause of emergency hospital admissions and loss of independence, disability, or death in older people. 1,623 per 100,000 emergency hospital admissions in 2019/20 were due to falls in people aged 65-79. This is much lower of regional and national rates of 2,215 and 2,222 per 100,000 admissions respectively (HES 2021). Pharmacy services can support people to manage their medicines and signpost them to services that can assist them to live independently and prevent falls and thereby prevent hospital admissions.

[30] Social Care Institute for Excellence (2020) Why early diagnosis of dementia is important.

**4.101** 300 Havering residents (over 65s) had a hip fracture in 2019/20. This equates to a directly standardised rate of 563 per 100,000 population, similar to the national rate of 572 per 100,000 population (HES, 2020).

**4.102** Frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care. It is typically the result of the effects of natural ageing, the outcomes of multiple long-term conditions and a loss of fitness and reserves.

**4.103** It is estimated that 12% of over 65-year-olds are living with moderate frailty. This equates to approximately 5,634 people living with moderate frailty in Havering. Moderate frailty is defined by having at least three or more symptoms from weight-loss, fatigue, weakness in the form of weak grip strength or low energy expenditure[31]. Around 42% of 65-year-olds are known to be pre-frail (having one or two of these symptoms). This equates to around 19,719 pre-fail older people residing in Havering (GLA, Housing-led population projections, 2021).

**4.104** Pharmacists can play a role in assisting people who are frail or at risk of becoming frail. This includes highlighting any concerns with the persons GP or reviewing the patient's medication records and identify medications that could amplify the effects of frailty, increase the patient's fall risk, or escalate cognitive decline.in assisting people who are frail or at risk of becoming frail.

[31] NHS RightCare Frailty Toolkit (2020): https://www.england.nhs.uk/rightcare/products/pathways/frailty/

## Summary of Demographics and Health Needs of Havering

This chapter looks at the overall health and wellbeing of the population of Havering guided by the JSNA priority areas.

***Havering Demographic Characteristics***

The London Borough of Havering is North East London Borough situated in outer London. It has a relatively older population, with the oldest population in London. Upmister and Pettits wards have the highest representation of older people in the borough.

There is great variability in the representation of the Black, Asian and Minority Ethnic populations with Brookside having the highest percentage at 22.3%, and Upminster with the lowest at 4.8%.

Romford Town is the ward with the highest proportion of people who cannot speak English well or at all. Lithuanian, Polish and Panjabi are the languages most spoken after English in Havering. Overall Havering have a higher healthy life expectancy than England.

***Wider determinants of health***

Generally, deprivation is low in Havering. Only one neighbourhood, situated in Heaton Ward is among the most deprived decile in England.

***Our health behaviours and lifestyles***

Smoking is the leading cause of preventable death in the world, 13.2% of adults smoke in Havering, slightly higher than the national rate. 67.3% of Havering adults are overweight or obese, the third highest figure in London. 29.7% of adults are inactive, again, substantially higher than London figures.

Havering adults drink less than comparators and there are fewer residents who are opiates and/or crack cocaine users.

The rates of STIs in general are similar to national figures. The rates of people living with HIV are lower than the national figures.

***The places and communities in which we live***

The population of Havering is set to increase by 2.5% by in the lifetime of this PNA. The highest anticipated increases are in South Hornchurch, Romford Town and Brooklands wards.

***Children and Young people***

Children are doing comparatively well in terms of the wider determinants of health in Havering. However, excess weight in Year 6 children is higher than national figures, as is dental decay.

***Adults***

Cancer is the biggest cause of life expectancy gap in Havering. The incidence of cancers is the fourth highest in London. Havering has the fourth highest stroke prevalence in London. Premature mortality by respiratory disease is high in Havering.

***Older Adults***

Approximately 5,634 people are living with frailty in Havering, although hospital admissions for falls is low. Rates of dementia is lower than expected prevalence of dementia.

# Chapter 5 – Patient and Public Engagement

**5.1** This chapter discusses the results of the patient and public engagement that was carried out in Barking and Dagenham, Havering and Redbridge (BHR) between the period of 1st November 2021 to the 31st of December 2021. Results show feedback by Havering residents then BHR results are explored for differences between protected characteristic groups.

**5.2** A "protected characteristic" means a characteristic listed in section 149(7) of the Equality Act 2010. There are also certain vulnerable groups that experience a higher risk of poverty and social exclusion than the general population. These groups often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment.

**5.3** A community questionnaire was used to engage with residents to understand their use and experience of local pharmacies. This questionnaire was approved for use with the local population by the PNA Steering Group and the communication teams of BHR.

**5.4** The community questionnaire was disseminated via online and social media platforms. Over the period between 1st November 2021 to 31st December 2021, we engaged with 364 residents in BHR. 184 of those responses were from Havering residents, an additional 53 were from residents living in postcodes bordering Havering making a total of 237 responses. This is a small sample size of the population and therefore not a representative sample, therefore, there are limits to the conclusions that can be made from this analysis.

**Online:**

- Residents E-Newsletters
  Across BHR, e-newsletters were sent to 74947 residents from public health communications teams. This was done on multiple occasions.
- VCS community leads
  Across BHR a total of 689 faith and community organisations were contacted by VCS community leads.
- Healthwatch website
  The patient and public engagement survey was accessible on the Havering & Redbridge Healthwatch websites, and survey was available via Havering Healthwatch e-bulletin
- Public health website
  Survey was also accessible via the Havering public health consultations page

**Social media:**

**5.5** BHR public health communications teams disseminated links to the survey using various social media channels multiple times. Social media channels included Twitter, Facebook, Instagram, LinkedIn, and Next Door.

**Other engagement:**

**5.6** Healthy Dialogues also contacted 18 cultural community and faith-based organisations within BHR via email, with a link to the survey to be disseminated to their community groups.

**5.7** This chapter will first look at responses from people from Havering, then will take a deeper look at responses across groups of people from protected characteristics across BHR.

# Pharmacy use by Havering residents

**5.8** We first looked at how and why Havering residents use their pharmacy and what services they would like to see. When asked how **long it takes them to travel to their pharmacy** the top two responses where:

- Between 5-20 minutes: 132 respondents
- 5 minutes: 90 respondents

**5.9** This result was similar across Redbridge and Barking and Dagenham where the top response from residents in both boroughs also indicated that 5-20 minutes of travel was the most popular choice.

**5.10** When analysing the reasons for chosen pharmacy and **why the residents chose their local pharmacy**, the top three responses from Havering residents were:

- **Accessibility:** Good location (178 responses)
- **Patient interaction:** Happy with the overall service provided by the pharmacy (161 responses)
- **Satisfaction with the service:** Short wait for prescriptions (126 responses)

**5.11** This result was similar across Redbridge and Barking and Dagenham where residents chose their pharmacy based on good location, satisfaction with the overall service provided by the pharmacy, and the short waiting times for prescriptions.

**5.12** In comparison to the previous Havering PNA (2018) which had shown that residents of Havering wanted to see more accessible locations for pharmacies, the current PNA shows that overall, residents were felt their pharmacy is in a good and accessible location.

**5.13** 185 comments were left around what **services the residents would like to see** being provided from their local pharmacy that they do not currently provide. When breaking this down further, 50 comments were left by Havering residents. The top two services the Havering residents would like to see within their pharmacies included:

- Blood checks: 19 respondents
- Vaccinations: 14 respondents

**5.14** These results were similar across Redbridge and Barking and Dagenham, where the most popular service the residents of these boroughs would like to see within their pharmacy was also blood checks.

**5.15** These results are also similar to that of the previous Havering PNA (2018), where suggestions around services by residents of Havering also included vaccinations, and blood testing.

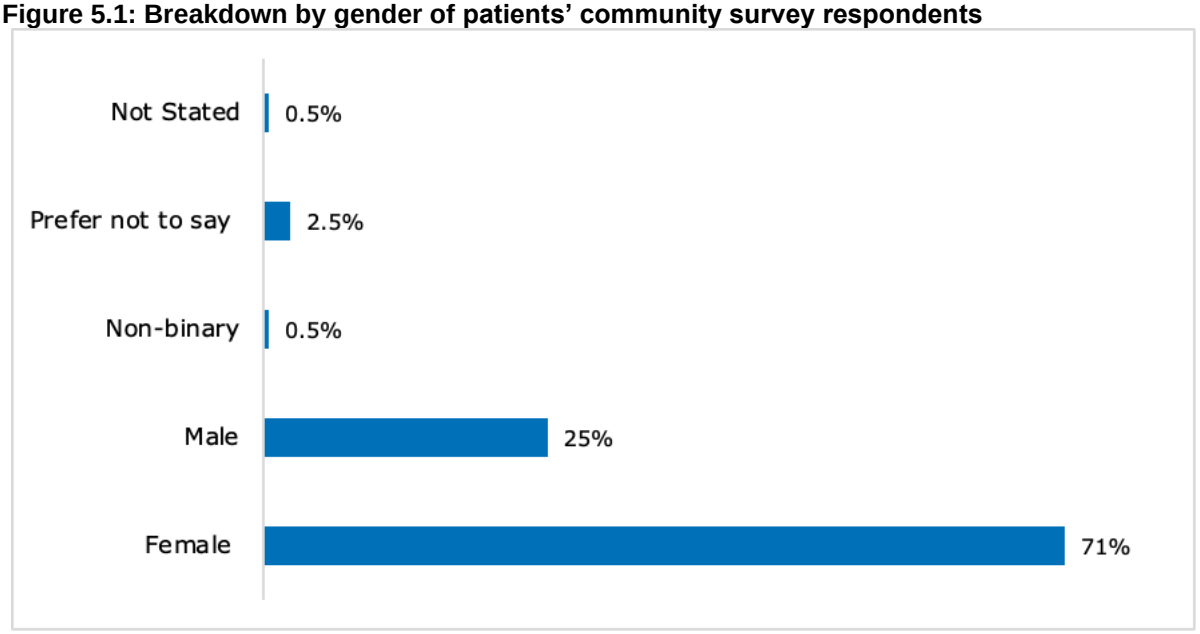
# Barking and Dagenham, Havering and Redbridge combined results and Equalities Impact Assessment

**5.16** The 364 questionnaires responses collated were analysed to better understand the use of community pharmacies by residents of BHR and identify any potential gaps in service provision for the protected characteristics.

## Demographics of the sample population[32]

**5.17** A breakdown of the gender shows that 71% of the respondents were female, 25% were males, 2.5% preferred not to state their gender, 0.5% were non-binary, and 0.5% did not state their gender on the survey (see figure 5.1)

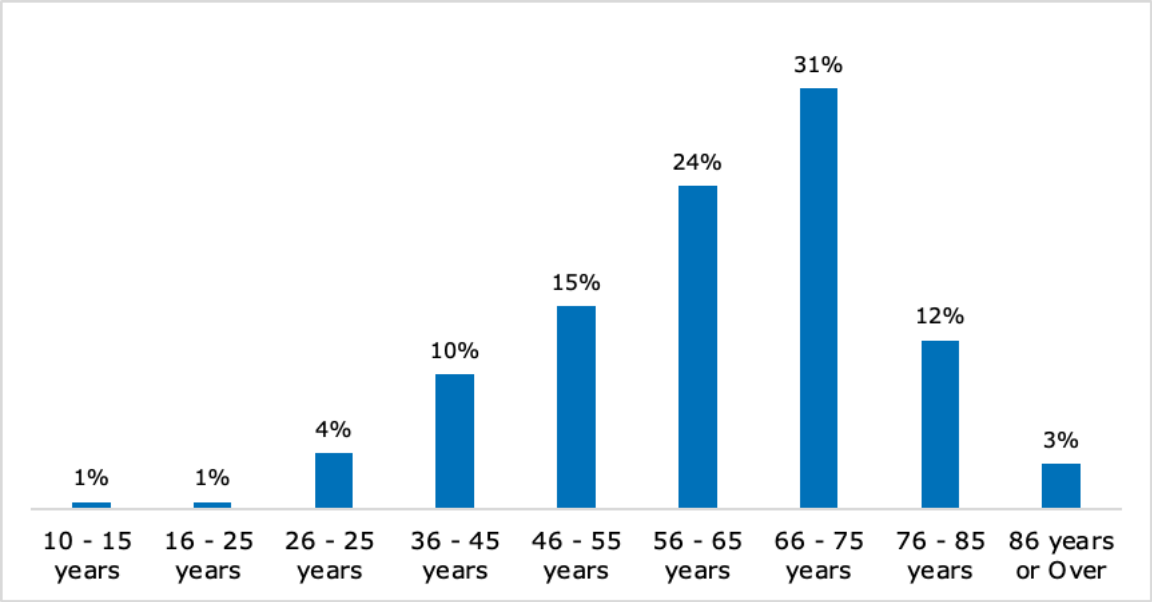
**Figure 5.1: Breakdown by gender of patients' community survey respondents**




[32] NB: The user composition does not reflect the general population because the needs are different by population groups, thereforend the responders would not necessarily represent users or general population.

**5.18** The survey sample represented a wide range of **age** categories, with the highest representation from the 66-75 age group (31%), followed by the 56-65 age group (24%). The least represented group was between the age categories of 10–15-year-olds (1 %) and 16–25-year-olds (1%) (see figure 5.2).

**Figure 5.2: Breakdown by age groups of patients and community survey respondents**




**5.19** Below is the breakdown data from the survey represented the following **ethnic groups** between the period of 1st November 2021, to 31st December 2021 (figure 5.3):

**Figure 5.3: Breakdown of respondent's ethnicities**

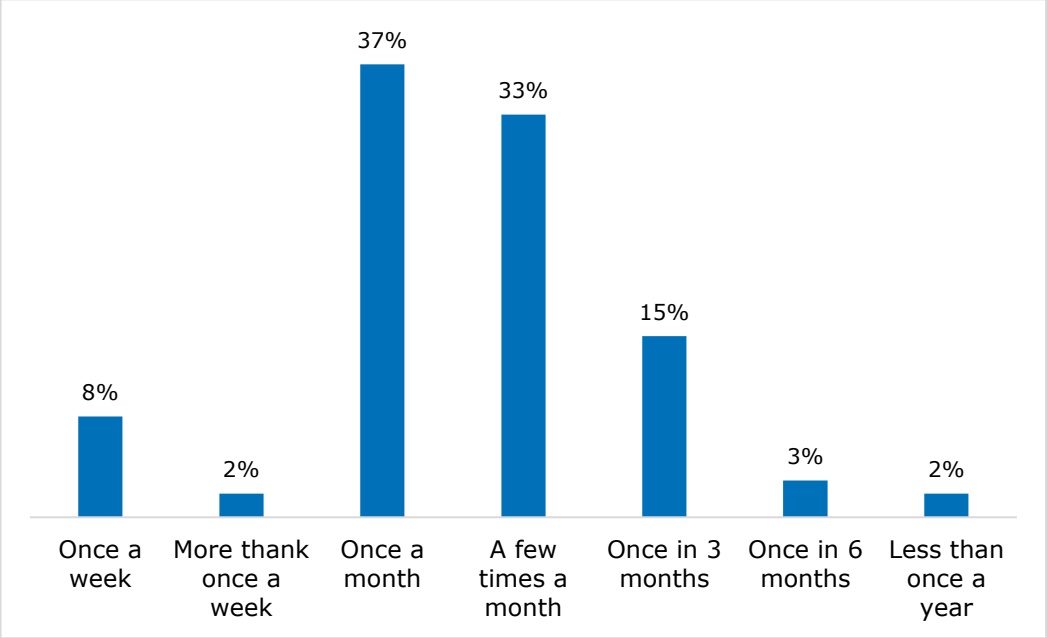
| Ethnicity | Number of respondents |
|---|---|
| **White** (including English, Welsh, Scottish, Northern Irish, British, Irish, Gypsy or Irish Traveller, and other White background) | 317 residents of BHR (87%) |
| **Mixed ethnic groups** (including White and Black Caribbean, White and Black African, White and Asian, any other mixed ethnic background) | 5 residents of BHR (1.4%) |
| **Asian or British Asian** (including Indian, Pakistani, Bangladeshi, Chinese, any other Asian background) | 26 residents of BHR (7%) |
| **Black African, Caribbean or Black British** (including African, Caribbean, any other Black African or Caribbean background) | 11 residents of BHR (3%) |
| **Any other ethnic group** (including Arab) | 1 resident of BHR (0.3%) |
| **Did not state their ethnic background** | 4 residents of BHR (1%) |

**5.20** Please note: the user composition could not reflect the general population because the pharmacy and health needs are different, and therefore the responders would not necessarily represent users or general population.

## Overall use of Pharmacies

**5.21** When asked around **how often they use the pharmacy** around 37% of the BHR residents use the pharmacy monthly, with 33% of residents use the pharmacy a few times in a month, and around 15% using it once in 3 months. Only 8% of residents use the pharmacy weekly, and around 2% more than once a week (figure 5.4).

**Figure 5.4: A breakdown of how often respondents use their pharmacy**




**5.22** The majority (82%) of the respondents indicated that they would prefer to use the pharmacy during the weekday (figure 5.5), with the most popular times being between 9am- 12pm, followed by 2pm- 5pm (see figure 5.6). Note: residents could select multiple responses for this survey question.

**Figure 5.5: Preference of when to use the pharmacy**

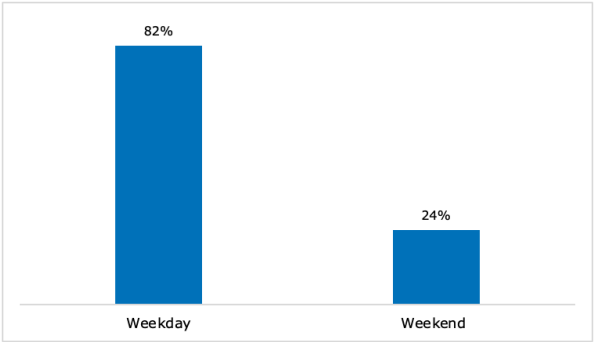
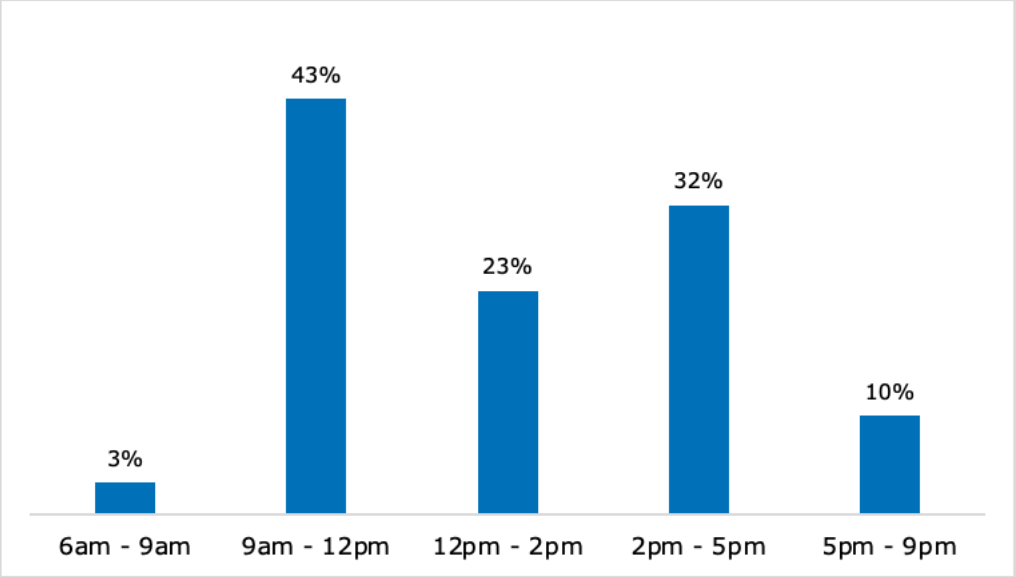


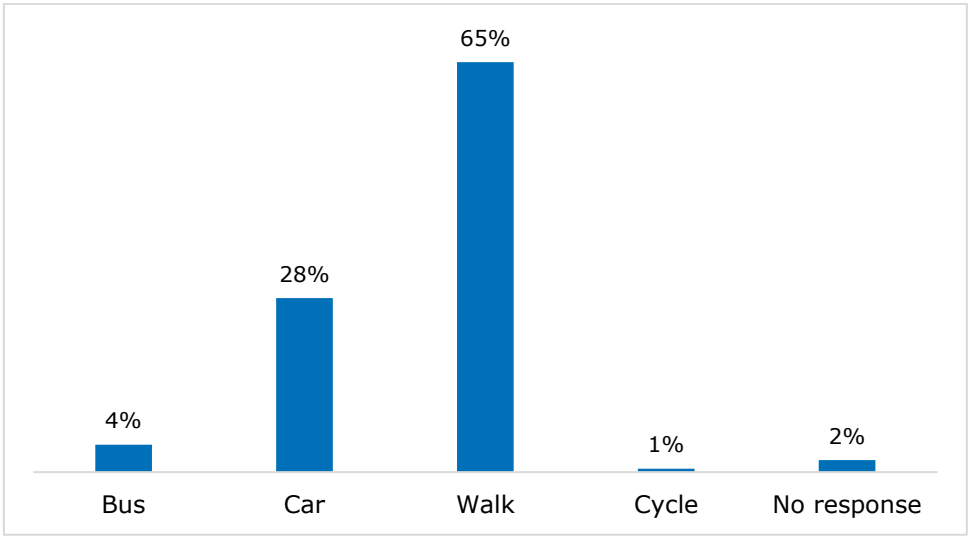
**Figure 5.6: A breakdown of preference for time of day to use the pharmacy (includes weekend and weekday times)**




**5.23** When asked **who they are using the pharmacy for,** 91% of respondents use the pharmacy for themselves, 35% use the pharmacy for their partner/spouse, and 13% use the pharmacy for their children.

When asked around how they usually travel to their pharmacy, the majority of respondents, 65%, walk to their pharmacy. 28% use their car to get to their pharmacy, and 4% take the bus (figure 5.7).

**Figure 5.7: A breakdown of usual travel to pharmacy**



**5.24** Of the 364 responses, 61 residents indicated that they do use an **online pharmacy service.** When asked **what they use their online pharmacy for**, 87% said that they use their online pharmacy to order repeat prescriptions.

**5.25** The survey also asked how the patients and publics **use of pharmacy had changed since the COVID-19 pandemic**. 274 people responded to this question, of whom, 38% (107) felt that their use of the pharmacy had not changed since the start of the pandemic.

**5.26** 230 respondents (63%) left a comment on what they felt **could be improved about their pharmacy.** Of the 230 responses, 82 (35%) residents were very pleased, or had no further recommendations on improving their current pharmacy service.

**5.27** An additional 140 comments were left around how residents felt pharmacy services could be improved. These have been categorised below into the top four recommendations for improvement:

**The top four recommendations for improvement included:**

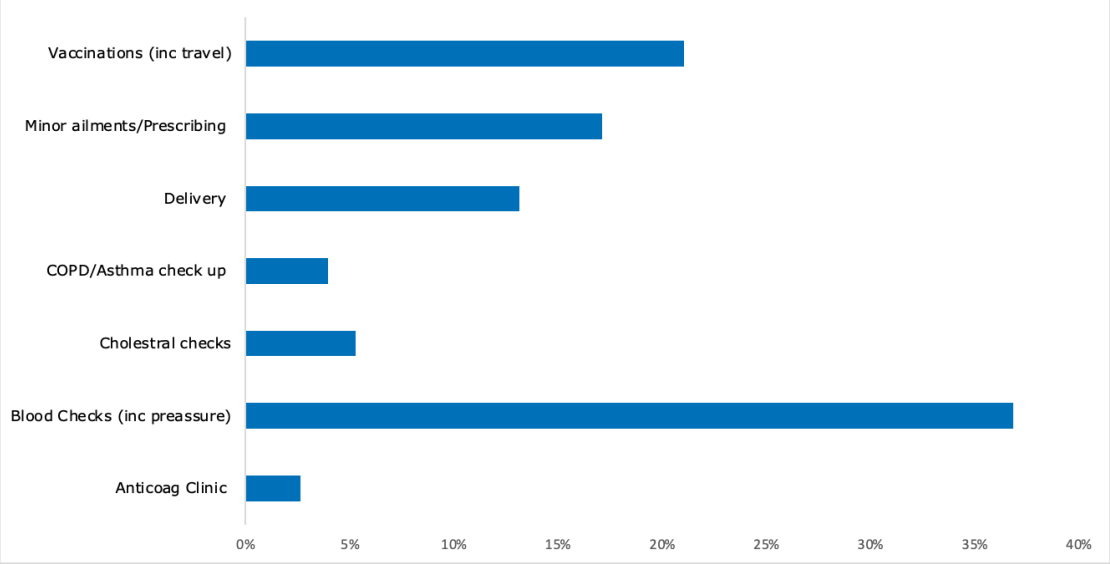
1. Increased opening hours (11%)
2. Staffing, including more staff, and friendlier staff (7%)
3. Accessibility, including parking and disabled access (4%)
4. Better, or more seating inside the pharmacy (3%)

**5.28** Of the 364 respondents, 185 left a comment on how **what services they would like to see available** in their pharmacy (figure 5.8).

**The top five services the public would like to see within their pharmacy were:**

- Blood checks, including blood tests, and pressure checks
- Vaccinations, including travel, COVID-19, flu-jab
- Minor ailments and prescribing
- Delivery service
- Cholesterol checks

**Figure 5.8: Services public would like to see within their pharmacy**




## Protected Characteristics

### Age

**5.29** The current age profile and projections of the borough are discussed in Chapter 4. Pharmacies provide essential services to all age groups such as dispensing, promotion of healthy lifestyles and signposting patients to other healthcare providers. Pharmacies providing services to vulnerable adults and children are required to be aware of the safeguarding guidance and local safeguarding arrangements.

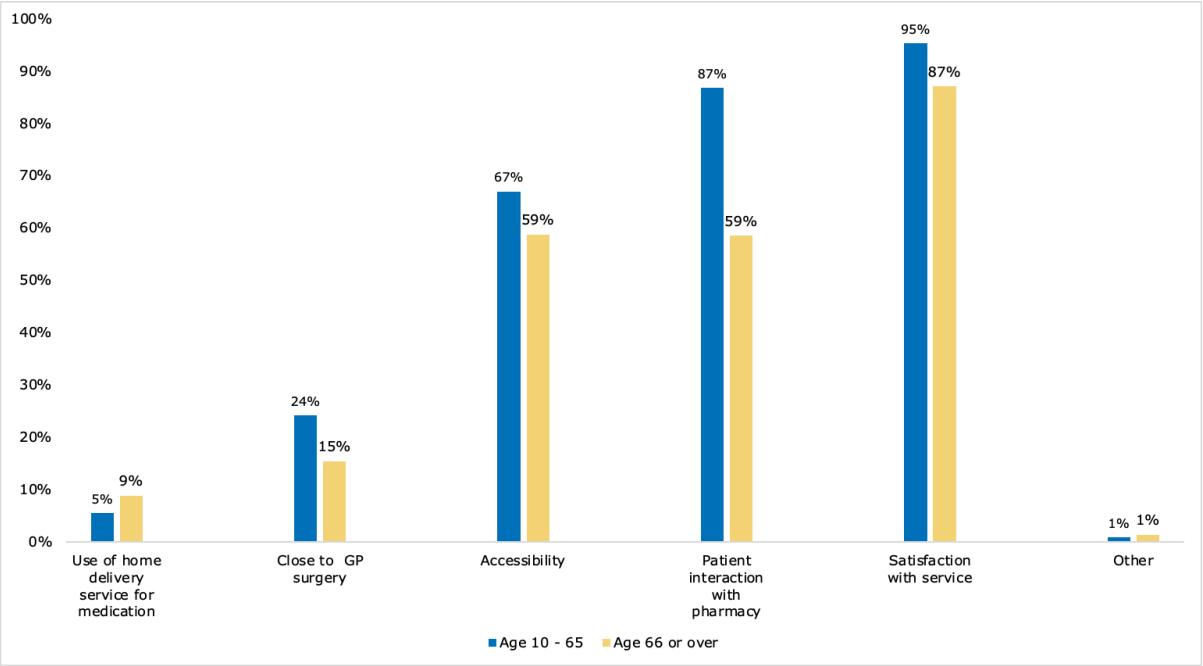
**5.30** To understand any differences, we carried out the analysis by grouping together age groups that are over 66 and compared this with age groups under the age of 65.

**5.31** We analysed the reasons for chosen pharmacy by age groups i.e., under 65's (n= 195) and over 66's (n=169).

**5.32** The use of home delivery service for medication was more prevalent in the over 66's compared to the under 65 age group.

**5.33** When analysing other reasons for chosen pharmacy, the under 65 age categories were more satisfied with the service compared to the over 66 age group. The under 65's also stated that they felt they had better patient-pharmacy interaction, the pharmacy was accessible, and it was closer to their GP surgery. (Figure 5.9)

**Figure 5.9: reasons for chosen pharmacy by age group**




**5.34** There were no differences between the two age categories in terms of which services residents would like to see within their pharmacy. The top three services both age categories would like to see included:

- Blood testing
- Vaccinations
- Blood pressure checks

## Ethnicity

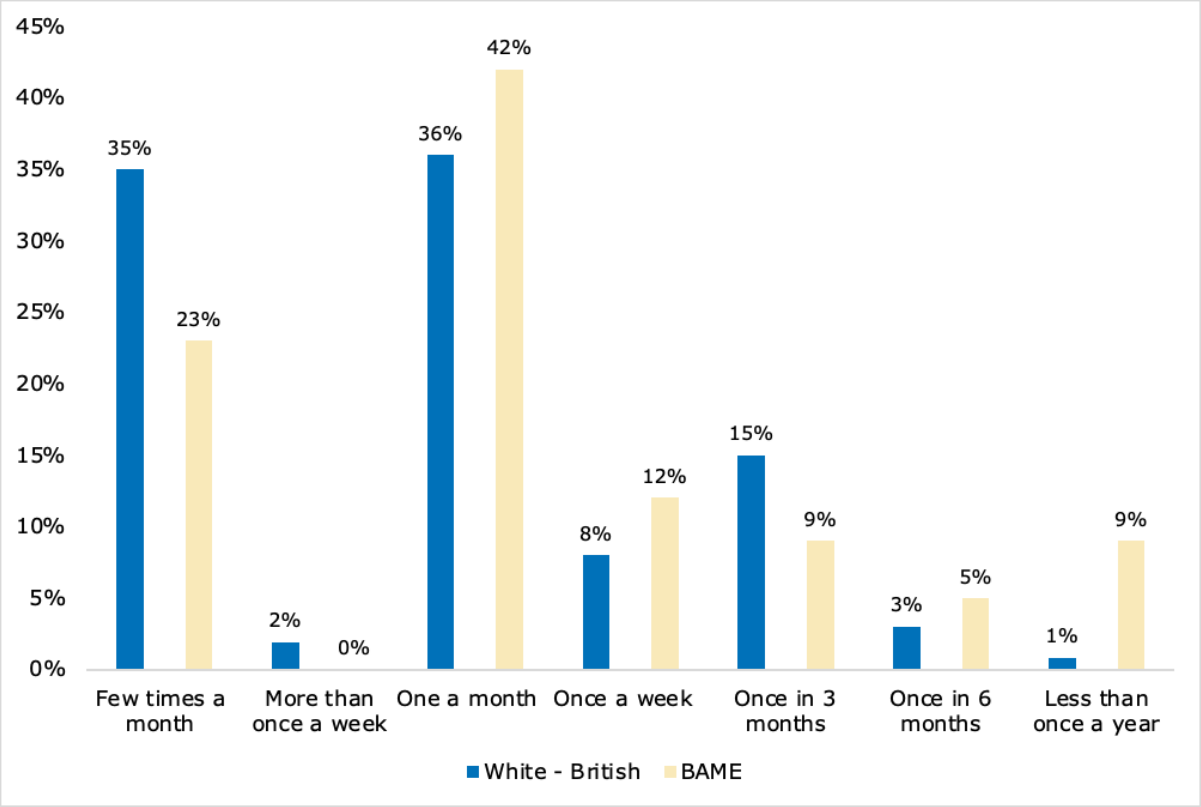
**5.35** Of the respondents, 43 (12%) identifying as being from a Black, Asian and Ethnic minority (BAME) background (breakdown in section 5.9). 317 (87%) respondents identified themselves as White.

**5.36** For the purposes of studying differences in the use and experience of pharmacies, we compared BAME populations with groups identifying as White (including British, Irish, and other White).

**5.37** The majority of the residents used the pharmacy at least once a month, or a few times a month across all ethnic groups.

**5.38** Those from a BAME background were more likely to be using the pharmacy at least once a week, White ethnic residents, are more likely to use the pharmacy at least once a month (figure 5.10).

**Figure 5.10: Breakdown of ethnicity and pharmacy usage**




**5.39** 19 comments were left by the BAME community in relation to what services they would like to see within their pharmacy. This entailed, delivery service including for single mothers, more minor ailments services and blood checks (cholesterol, pressure, blood tests).

**5.40** 162 comments were left by the White ethnic groups around what services they would like to see within their pharmacy. 43% of the respondents were happy with the service that was already being provided. Others that left comments felt their pharmacy could offer blood checks (cholesterol, blood tests), COVID-19 vaccinations and other vaccinations.

## Pregnancy and maternity

**5.41** Five (1%) of the respondents to the community engagement survey were pregnant or breastfeeding. Four of the respondents were aged between 26-35, and one aged between 36-45.

**5.42** Those who were pregnant, or breastfeeding tended to use the pharmacy on the weekday. There was no significant difference in their use of pharmacies in comparison to the rest of the survey population.

**5.43** No comments were left by those who were pregnant or breastfeeding in relation to what services they would like to see within their pharmacy.

**5.44** Reasons for chosen pharmacy included being in a good location, within a 5-minute walk or drive.

**5.45** Though pregnant and breastfeeding respondents made a small representation to the overall survey responses, this could be explained by the fact that the majority of people who completed this survey were aged 66 and over.

## Gender

**5.46** Of the survey respondents, 259 identified themselves as female, 92 as males, 9 preferred not to state, two as non-binary, and two were left blank.

**5.47** The usage of pharmacy showed 38% of the 92 males, used the pharmacy a few times a month, compared to 31% of the 259 females. 49% of females used the pharmacy at least once a month, compared to 30% of males.

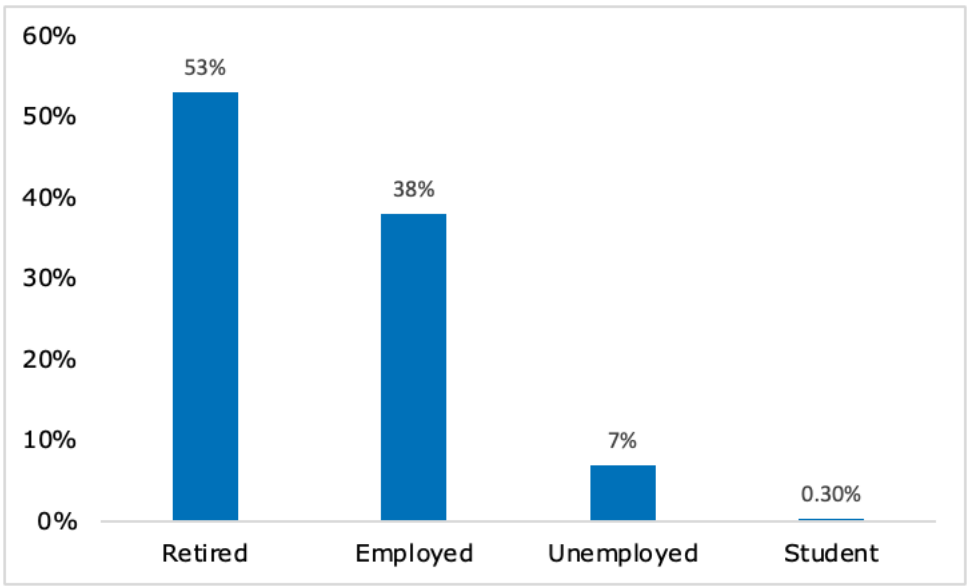
**5.48** Overall, women also tended to use the pharmacies for their children, more than their male counterparts.

**5.49** There were no significant differences in the reasons for chosen pharmacies across the genders.

## Employment Status

**5.50** A breakdown of employment status showed that over half of the survey responses were from retired residents. This was followed by employed (part-time, full-time, self-employed, full-time, and part-time carers). 7% were unemployed, and we received one response from a student (figure 5.11).

**Figure 5.11: Breakdown of employment status**



**5.51** The analysis showed that those working in employment still preferred to use their pharmacy during the weekday over the weekend. However, there were no significant differences across the groups around when they would prefer to use the pharmacy (weekend or weekday).

## Disability

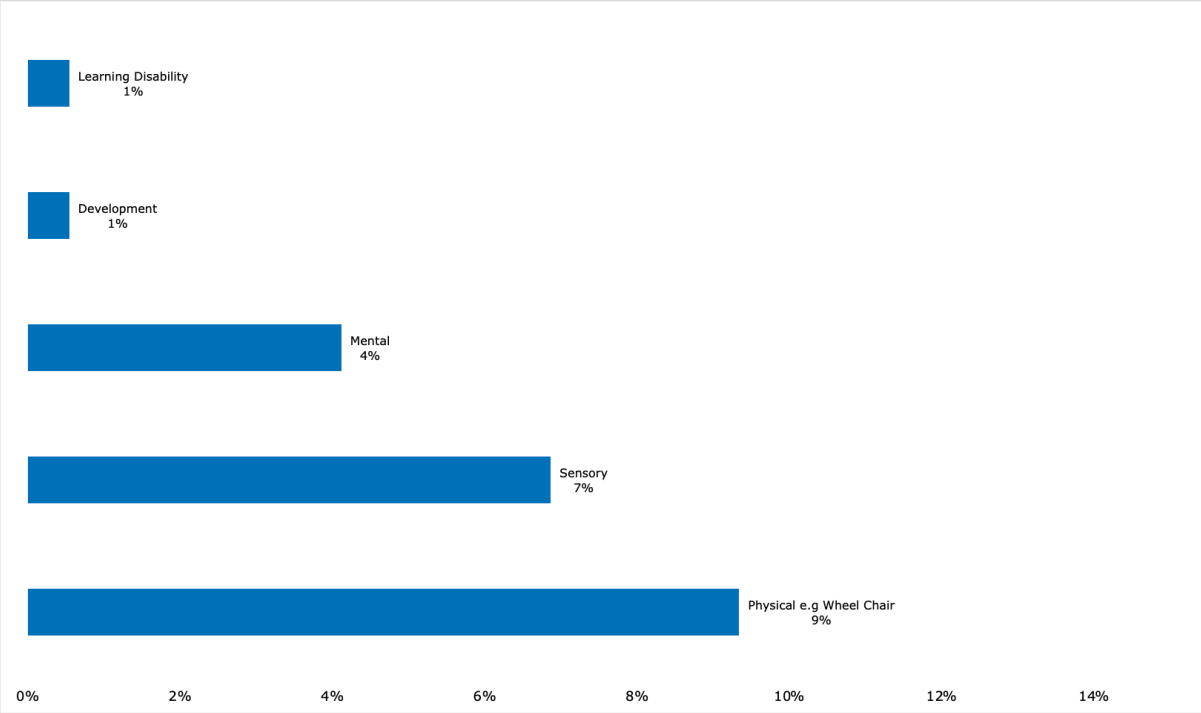
**5.52** All pharmacies must comply with the Disability Discrimination Act 1995. Pharmacy contractors may have assessed the extent to which it would be appropriate to install hearing loops or provide access ramps wide aisles to allow wheelchair access. Accessible information formats are alternatives to printed information, used by blind and partially sighted people, or others with a print impairment.

**5.53** The survey categorised disabilities into five main groups, followed by other:

1. Physical e.g., wheelchair user
2. Mental health issues e.g., bi-polar disorder, schizophrenia, depression
3. Sensory e.g., mild deafness, partially sighted, blindness
4. Learning disabilities e.g., Down Syndrome
5. Developmental e.g., autistic spectrum disorder, dyslexia, dyspraxia
6. Other

**5.54** 112 (31%) respondents answered yes to having a disability (figure 5.12) When asked to state what kind, of which the majority of respondents had a physical disability (9%), followed by sensory (7%), and mental health disability (4%).

**Figure 5.12: Breakdown of the top 5 disabilities**



**5.55** Those who said that they have a disability preferred to use the pharmacy during the weekday over the weekend. Weekdays between 9am – 12pm seemed to be the most popular time for use of pharmacies.

**5.56** 43 residents left comments on how they felt the pharmacy services could be improved for them. Of this, 28 felt very pleased with the service and had no recommendations. The top 3 recommendations included:

1. Better access to pharmacy
2. Home deliveries
3. Opening hours at weekends

**5.57** The top 2 services respondents with a disability would like to see included:

1. Blood checks (blood testing, cholesterol, and pressure)
2. Vaccinations

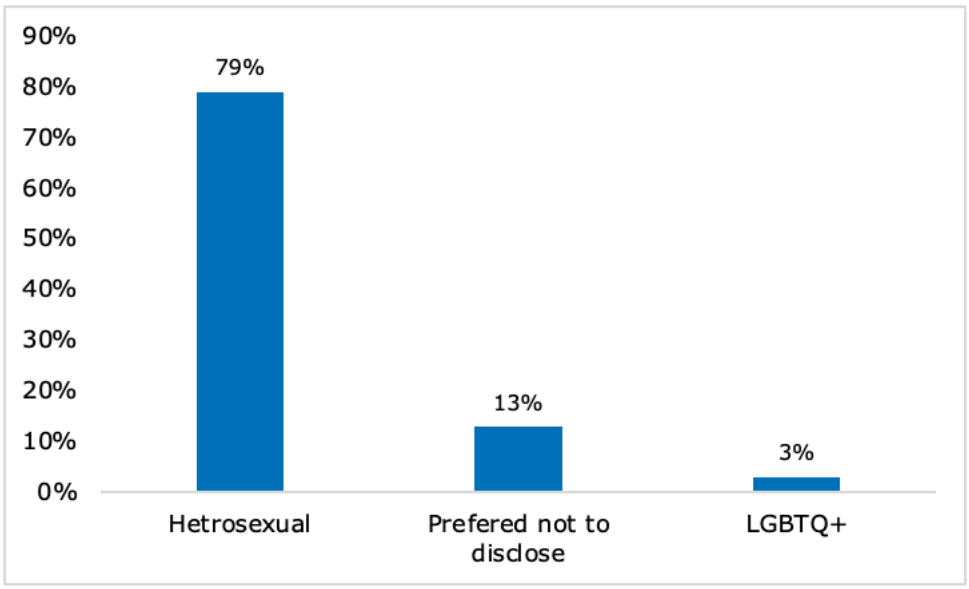
**5.58** No significant differences were identified between the overall responses and this protected characteristic in relation to improvements to the pharmacy, and services residents would like to see within their pharmacy.

## Sexual Orientation

**5.59** Of the total number of respondents, 289 identified as heterosexual, 12 identified as LGBTQ+, and 46 preferred not to disclose (figure 5.13).

**5.60** No significant differences were identified between groups of sexual orientation around the use of pharmacy, and services they would like to see.

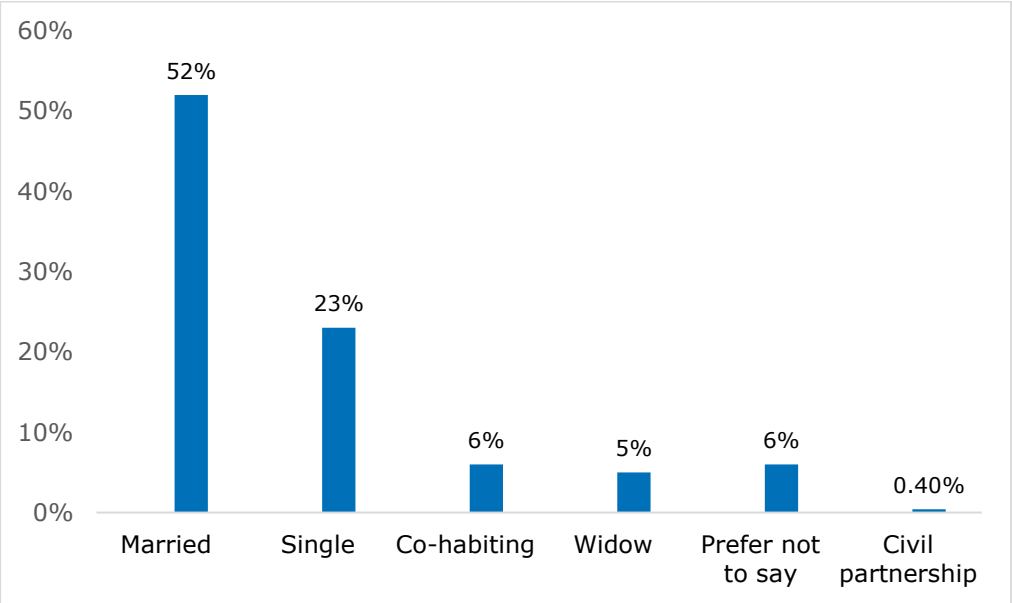
**Figure 5.14: Breakdown of sexual orientation**



## Relationship Status

**5.61** 190 respondents were married, 85 respondents were single, 23 preferred not to disclose their relationship status, 22 were co-habiting, and 5 in a civil partnership (figure 5.14).

**Figure 5.14: Breakdown of relationship status**




**5.62** No differences were found in the use and experience of those who were single and those who were married, co-habiting or in a civil partnership.

### Summary of the Patient and Public Engagement and the Protected Characteristics

Patient and public engagement in the form of a survey was undertaken to understand how people use their pharmacies, what they use them for and their views of the pharmacy provision. It included an exploration of the health needs specific to protected characteristics and vulnerable groups.

Overall, 364 BHR residents and workers responded to the survey, 184 of whom were from Havering. Results showed that residents choose their pharmacy based on overall satisfaction of their pharmacy service, ease of location, and friendly staff.

Most people surveyed used their pharmacy during weekdays and normal working hours. A sizeable proportion (24%) preferred weekend opening.
Overall, people are happy with the pharmacy services they receive in BHR. A small number of survey respondents made some suggestions for improvement. These were mainly around provision of providing simple health check-ups which largely included blood checks (cholesterol, pressure, and testing). Other suggestions included providing vaccinations, including COVID-19 vaccines and travel vaccines flu vaccines.
**Overall, no different needs were identified for people who share protected characteristics.**

# Chapter 6 – Current Provision of Pharmaceutical Services

**6.1** This chapter identifies and maps the current provision of pharmaceutical services in order to assess the adequacy of provision of such services. Information was collected up until April 2022.

**6.2** It assesses of the adequacy of the current provision of necessary services by considering:

- Different types of pharmaceutical service providers
- Geographical distribution and choice of pharmacies, within and outside the borough
- Opening hours
- Dispensing
- Pharmacies that provide essential, advanced, and enhanced services.

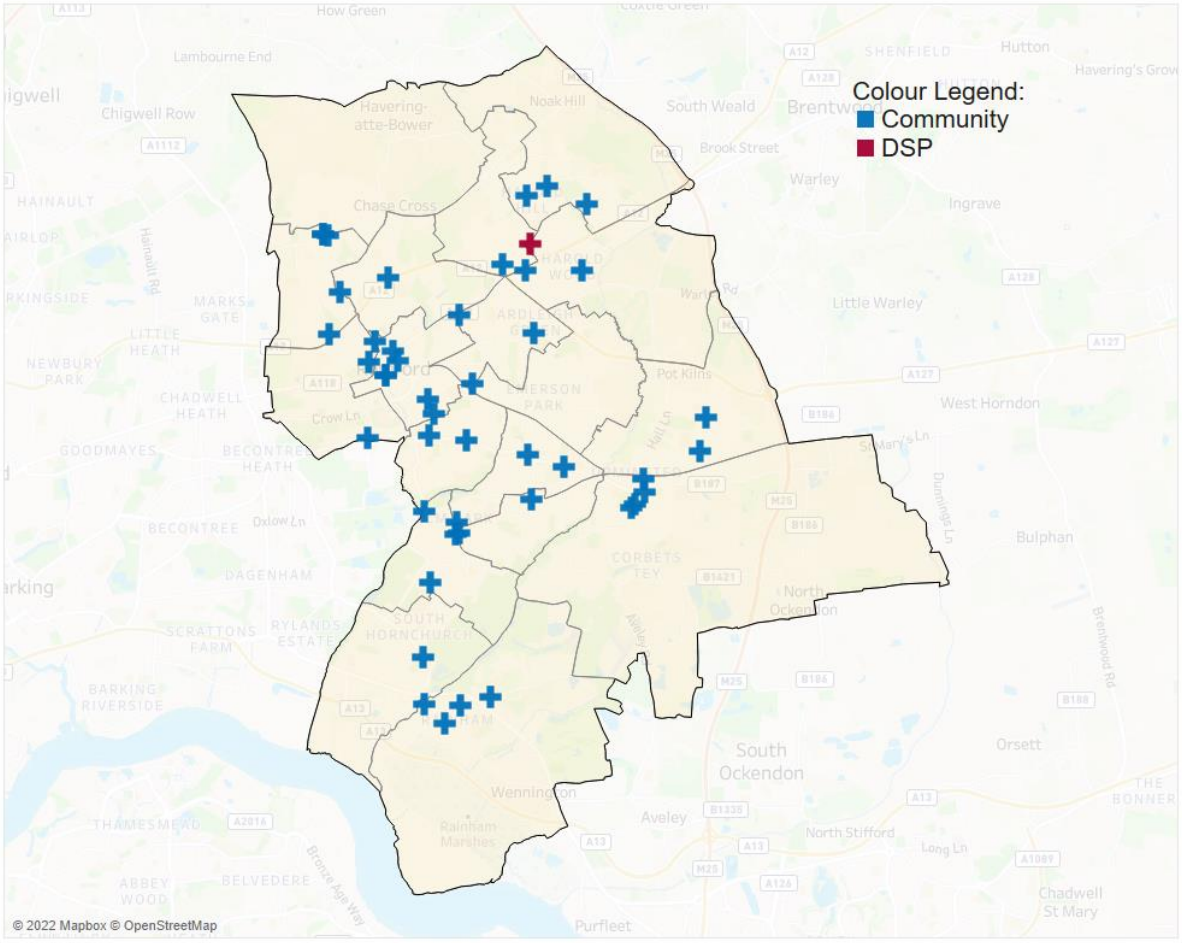
In addition, this chapter also summarises responses to the contractor survey where contractors have indicated willingness to provide a service to address a specific population health and wellbeing need in Havering, if commissioned.

## Pharmaceutical Service Providers

**6.3** As of April 2022, there are 46 pharmacies in Havering that hold NHS contracts; 45 community pharmacies and 1 distance selling pharmacy. They are presented in the map in Figure 6.1 below.

**6.4** All the pharmacy providers in the borough as well as those within 1 mile of its border are also listed in Appendix B.

**Figure 6.1: Map of pharmacies in Havering, April 2022**




**Source: NHS England, 2022**

## Community Pharmacies

**6.5** The 45 community pharmacies in Havering equates to 1.7 community pharmacies per 10,000 residents (based on a 2022 population estimate of 263,354). This ratio is below the London and England averages, both of which stand at 2.2 based on 2014 data (LGA, 2021[33]).

## Distance Selling Pharmacies (DSP)

**6.6** A distance Selling Pharmacy works exclusively at a distance from patients. They include mail order and internet pharmacies that remotely manage patients medicine logistics and distribution. DSPs collect prescriptions and provide them to patients at their homes, care homes or nursing homes. They can also provide a 'click and collect' service.

[33] Local Government Association: LG Inform. Ratio of pharmacies per 10,000 population (Snapshot: 29 November 2014) https://lginform.local.gov.uk/reports/lgastandard?mod-area=E92000001&mod-group=DEFRA2009_OtherUrbanList&mod-metric=3707&mod-type=namedComparisonGroup (Accessed in December 2021).

**6.7** There one DSP in Havering (Ayp Healthcare).

### Dispensing Appliance Contractor (DAC)

**6.8** There are no DACs on the Havering's pharmaceutical list. A DAC is a contractor that specialises in dispensing prescriptions for appliances, including customisation. They cannot dispense prescriptions for drugs.

**6.9** There are no DACs on the Havering's pharmaceutical list. A DAC is a contractor that specialises in dispensing prescriptions for appliances, including customisation. They cannot dispense prescriptions for drugs.

### GP Dispensing practices

**6.10** There are no GP dispensing practices in Havering.

### Local Pharmaceutical services

**6.11** There are no Local Pharmaceutical Service (LPS) contracts within Havering. No area in Havering have been designated as LPS areas.

## Accessibility

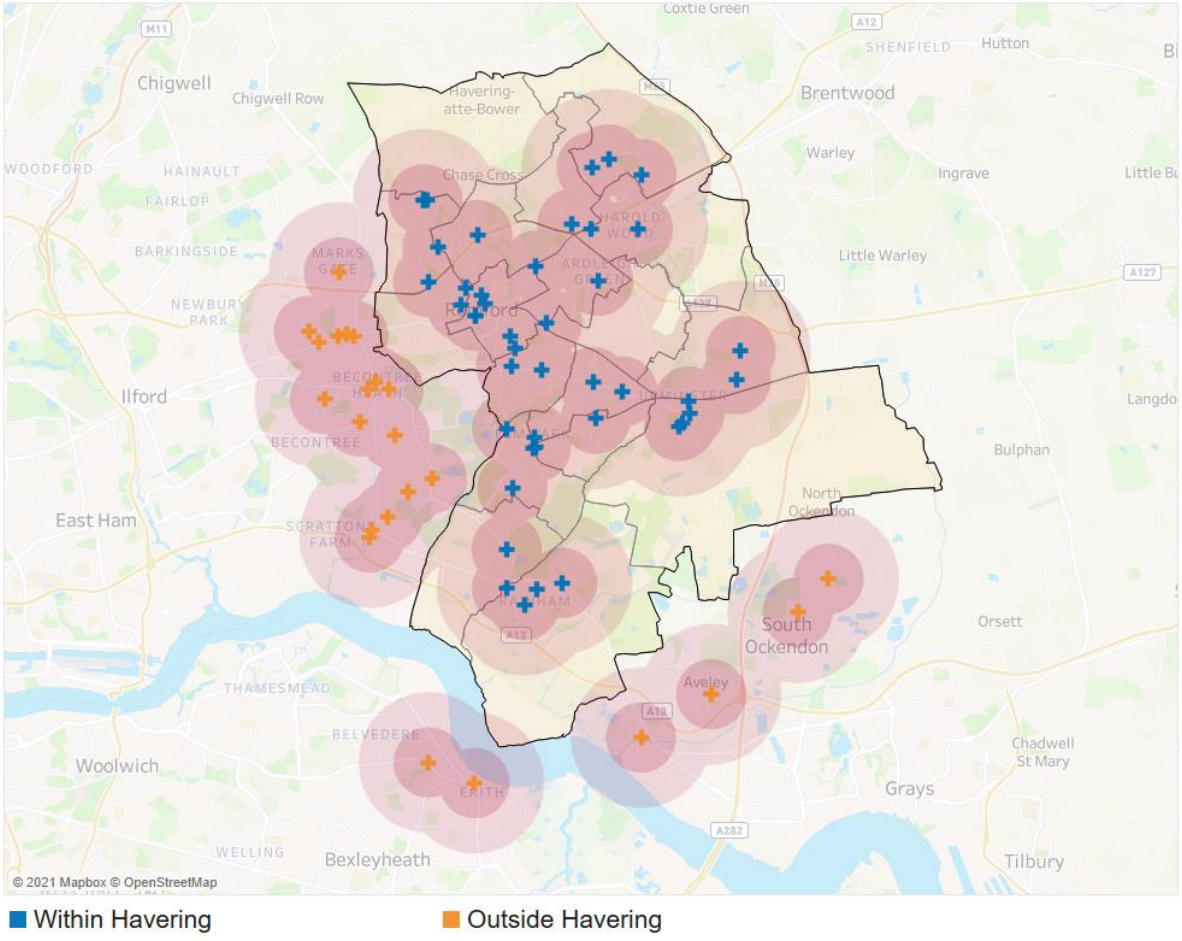
### Distribution and choice

**6.12** The PNA Steering Group agreed that the maximum distance for residents in Havering to access pharmaceutical services, should be no more than 1 mile. This distance equates to about a 20-minute walk.

**6.13** Figure 6.2 below shows the 44 community pharmacies located in Havering as well as an additional 24 that are located in other boroughs but are within 1 mile of Havering's border. A 0.5- and 1-mile radius from each pharmacy's location is shown. These have been included in the pharmacies shown in Figure 6.1 as well as in Appendix B.

**6.14** Figure 6.2 shows that most of the borough is within 1 mile of at least one pharmacy. There are some areas around the borders of Havering that are not within 1 mile of a pharmacy. Therefore, travel distance, population density, distance to travel in relation to GP services and deprivation are also considered.

**Figure 6.2: Distribution of community pharmacies in Havering and within 1 mile of the borough boundaries, with 0.5- and 1-mile coverage**




**Source:** NHS England, 2022

**6.15** The geographical distribution of the pharmacies by electoral ward and the pharmacy to population ratio is shown in Table 7.1. As seen all wards in the borough have at least one pharmacy and there is good distribution of pharmacy by population in most wards.

**Table 7.1: Distribution of community pharmacies by ward**

| Ward | Number of Community Pharmacies | Population Size | Community Pharmacies per 10,000 |
|---|---|---|---|
| Romford Town | 7 | 21,349 | 3.3 |
| Upminster | 4 | 13,140 | 3.0 |
| Rainham and Wennington | 4 | 13,139 | 3.0 |
| St. Andrew's | 3 | 13,884 | 2.2 |
| Gooshays | 3 | 16,896 | 1.8 |
| Elm Park | 3 | 13,187 | 2.3 |
| Harold Wood | 2 | 15,074 | 1.3 |
| Squirrel's Heath | 2 | 14,260 | 1.4 |

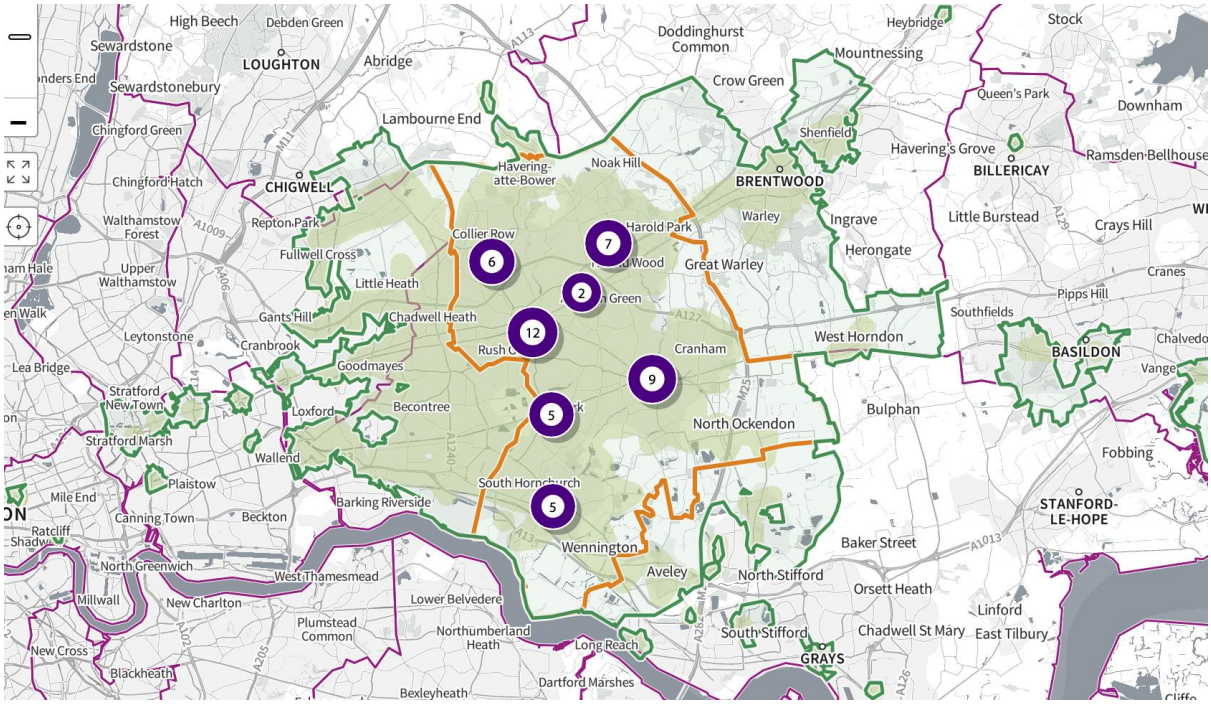
| | | | |
|---|---|---|---|
| Pettits | 2 | 13,187 | 1.5 |
| Mawneys | 2 | 13,568 | 1.5 |
| Hylands | 2 | 13,199 | 1.5 |
| Havering Park | 2 | 13,800 | 1.4 |
| Hacton | 2 | 12,453 | 1.6 |
| Cranham | 2 | 12,808 | 1.6 |
| Brooklands | 2 | 19,423 | 1.0 |
| South Hornchurch | 1 | 17,189 | 0.6 |
| Heaton | 1 | 15,035 | 0.7 |
| Emerson Park | 1 | 11,763 | 0.9 |
| Borough Total | 45 | 263,354 | 1.7 |

**Source:** NHSE & GLA (Housing-led population projections)

**6.16** Additionally, 100% of Havering residents can reach a pharmacy using public transport within 20 minutes from their home, attesting to the accessibility of the pharmacy provision in the borough. A total of 670,419 people in and outside the borough can reach a Havering pharmacy by public transport within 20 minutes (OHID, SHAPE Atlas Tool, 2022).

**6.17** Figure 6.3 presents the coverage of the Havering pharmacies in consideration of public transport, both inside and outside the borough. Coverage is presented in green while the Havering borough border is highlighted in orange.

**Figure 6.3: Areas covered by 20-minute travel time by public transport to a Havering pharmacy from within and outside the borough.**



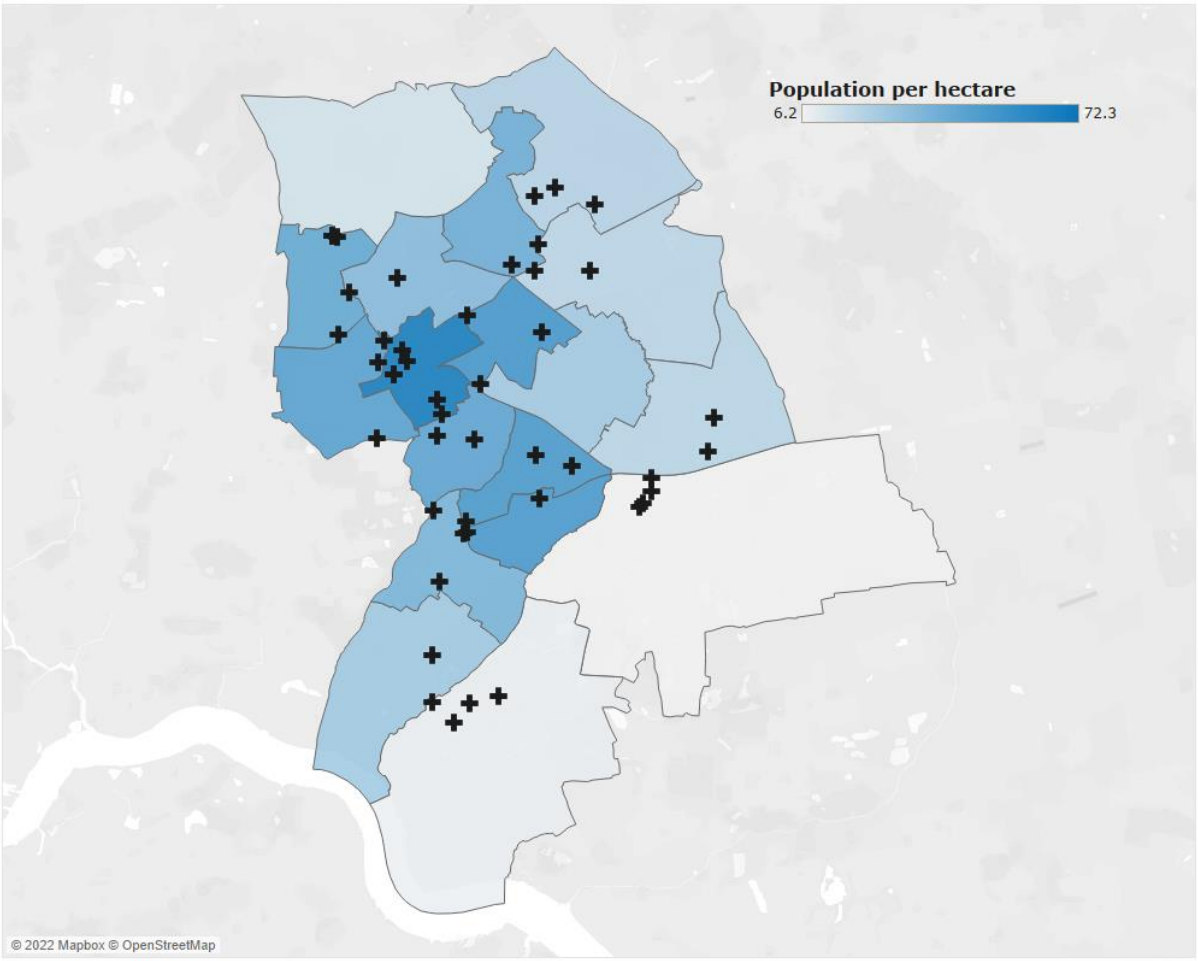

**Source**: OVID, Strategic Health Asset Planning and Evaluation Atlas Tool, 2022

**6.18** Havering tend to fill their prescriptions almost exclusively at local pharmacies. NHSE data shows that in 2020-21, 92% (3,815,162) of items prescribed by GPs in Havering were dispensed by community pharmacies in the borough. 2.2% and 1.6% were dispensed by Barking and Dagenham and Redbridge pharmacies, respectively.

### *Pharmacy Distribution in relation to population density*

**6.19** The population density map below (Figure 6.4) indicates that the community pharmacy premises are predominantly located in areas of highest population density although a small number of pharmacies were identified in areas with comparatively low population densities.

**Figure 6.4: Pharmacy locations in relation to population density by ward in Havering**




**Sources**: GLA (Land Area, and Population Density and NHSE)

**6.20** There are two main areas of regeneration that will impact on population density in the lifetime of this PNA. These are Thames Gateway regeneration in South Hornchurch and the Romford Town Centre regeneration. Both regeneration areas are within accessible distance to pharmacy provision. Pharmacies in Havering have also indicated in the contractor survey that they are willing to deliver additional services.

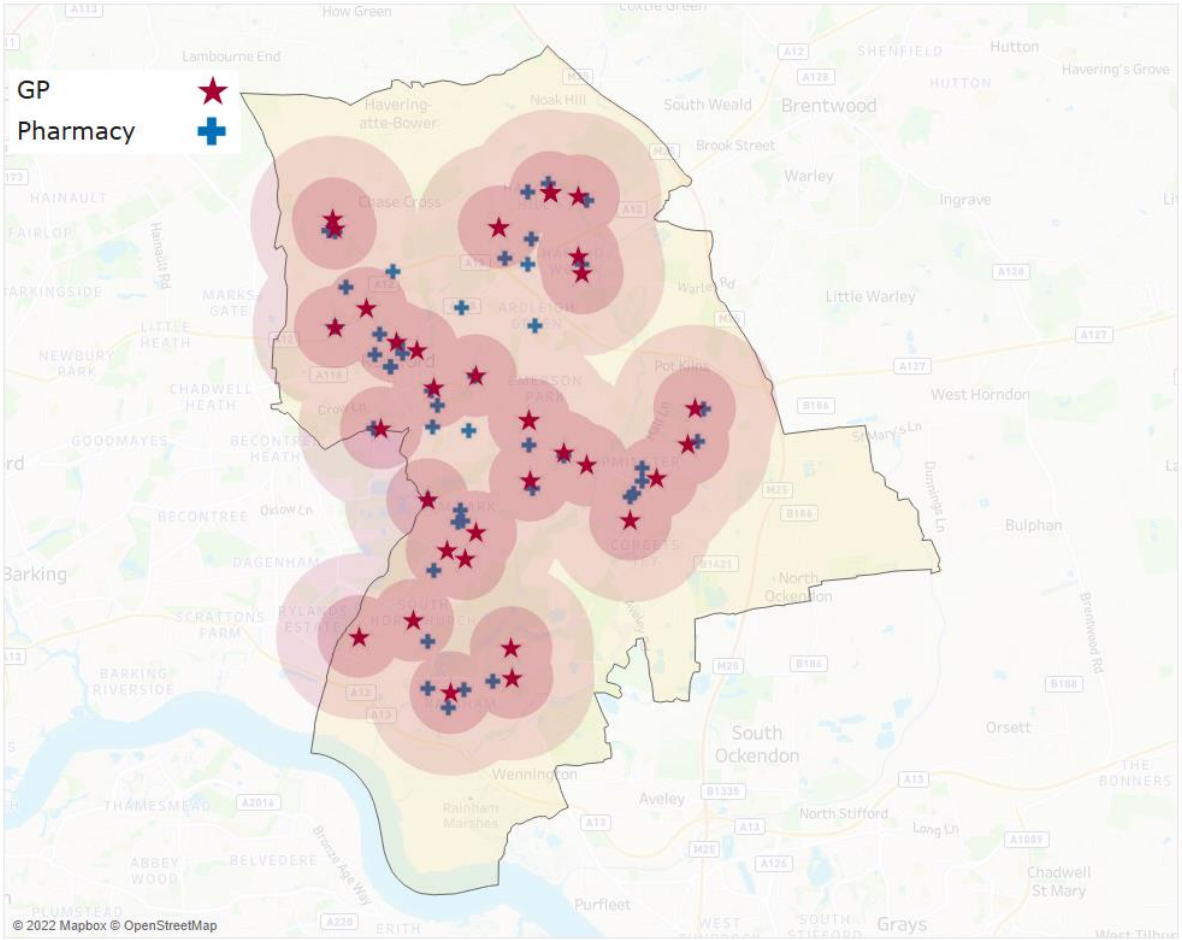
### *Pharmacy Distribution in relation to GP surgeries*

**6.21** As part of the NHS Long Term Plan[34] all general practices were required to be in a primary care network (PCN) by June 2019. Since January 2019 Havering GPs organised themselves into four PCNs within Havering. Altogether there are 45 GP member practices across these PCNs. These are presented in Figure 6.5.

**6.22** Each of these networks have expanded neighbourhood teams which will comprise of a range of healthcare professionals including GPs, district nurses, community geriatricians, Allied Health Professionals, and pharmacists. It is essential that community pharmacies are able to fully engage with the PCNs to maximise service provision for their patients and residents.

**6.23** There is a pharmacy within accessible distance to all GP practices in Havering. Figure 6.5 shows that there is a pharmacy within half a mile of all GP practices in the borough.

**Figure 6.5: GP practices in Havering and their 0.5- and 1-mile coverage, April 2022**




**Source: NHS England, 2022**

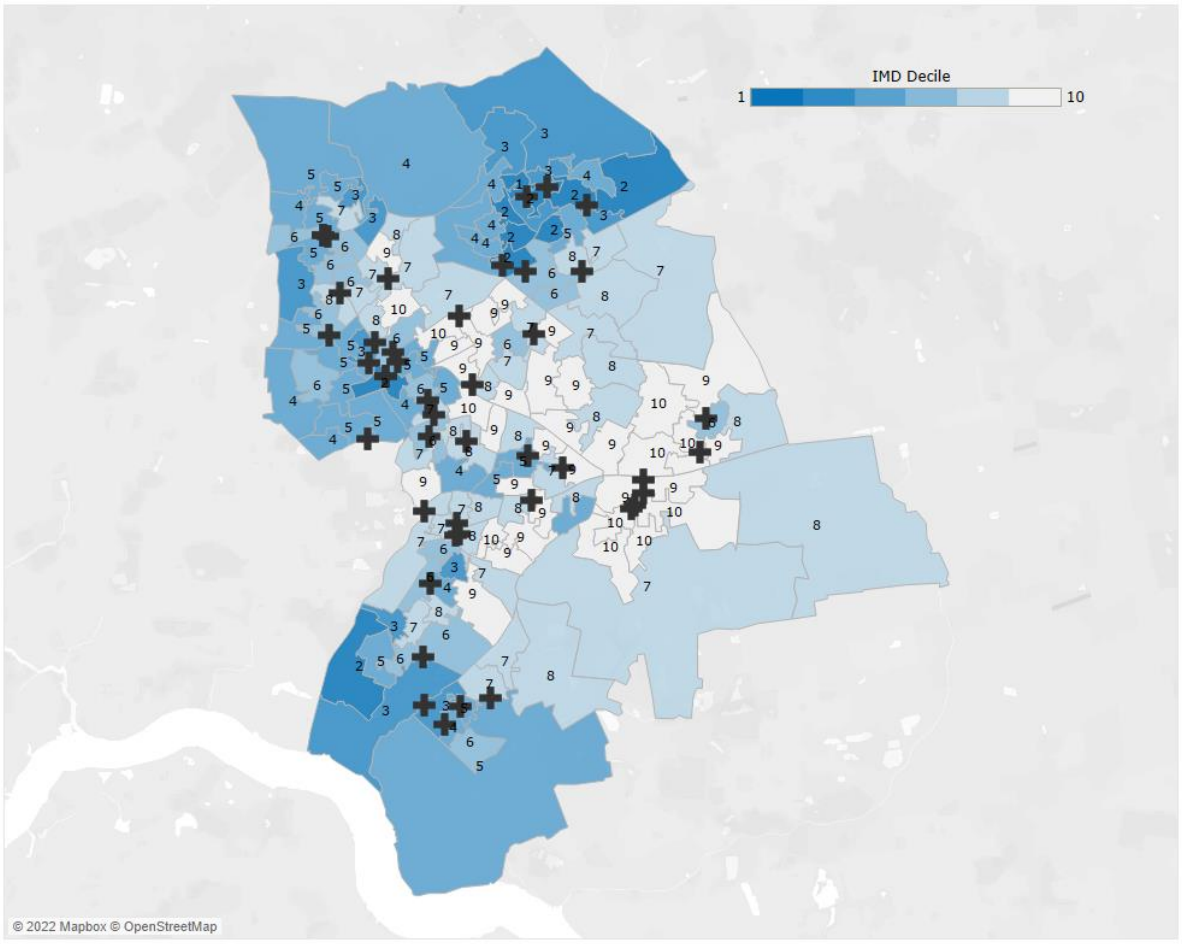
[34] NHS England (2019). The *NHS long term plan*. London, England

**6.24** The Health and Wellbeing Board is not aware of any firm plans for changes in Health and Social Care services within the lifetime of this PNA.

### *Pharmacy Distribution in relation to Index of Multiple Deprivation*

**6.25** Figure 6.6 illustrates that there is higher number of community pharmacies where there is higher deprivation.

**Figure 6.6: Pharmacy locations in relation to deprivation deciles in Havering, 2022**




**Source: MHCLG & NHSE**

## Opening times

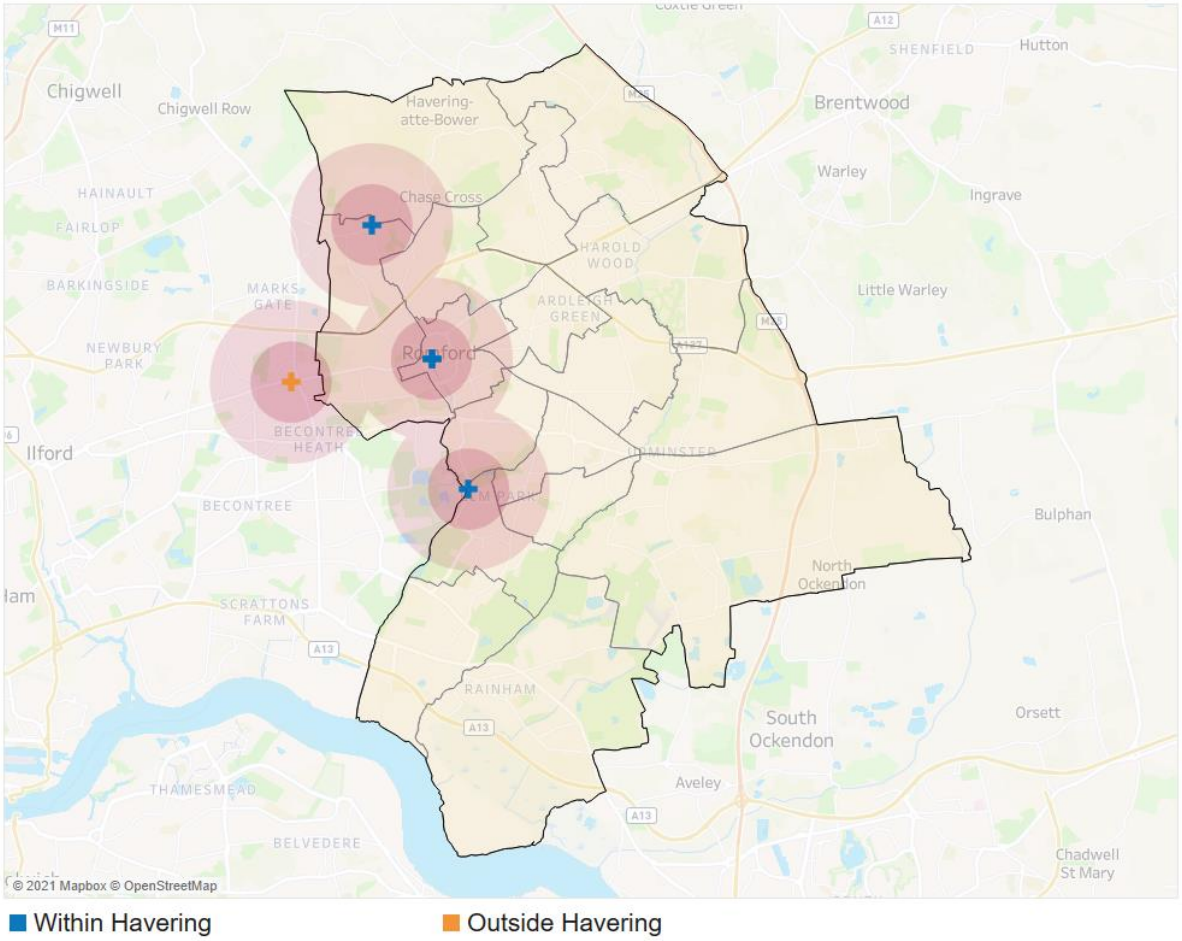
**6.26** Pharmacy contracts with NHS England stipulate the core hours during which each pharmacy must remain open. Historically these have been 40-hour contracts (and some recent 100-hour contracts). A pharmacy may stay open longer than the stipulated core opening hours, these are called supplementary hours.

**6.27** Opening times were obtained from NHS England in April 2022. Additionally, market entry updates to the NHS England pharmaceutical list were reflected on the original list.

### *100-hour pharmacies*

**6.28** NHS England has four 100-hour pharmacies (core hours) on their list for Havering. These are presented in Figure 6.7 and Table 6.3. Two of these pharmacies are within close proximity of each other and therefore indistinguishable on the map. There is one other 100-hour pharmacy which is outside the borough but within 1 mile of its border (Figure 6.7)

**Figure 6.7: 100-hour community pharmacies in Havering and their 0.5- and 1-mile coverage April 2022**




**Source: NHS England, 2022**

**Table 6.3: 100-hour pharmacies in Havering, April 2022**

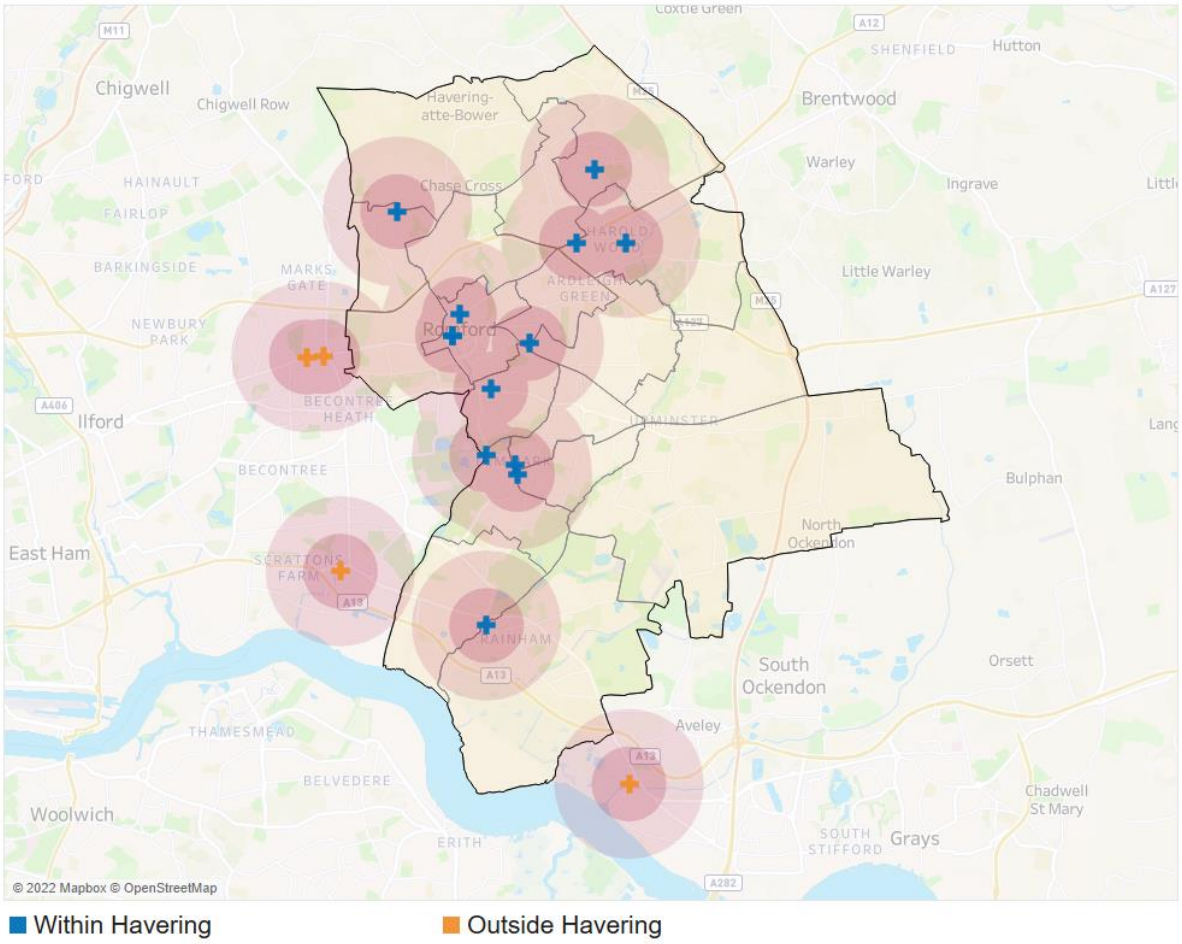
| Pharmacy | Address | Ward |
|---|---|---|
| Boots The Chemist | Unit 7, The Brewery, Waterloo Road, Romford | Romford Town |
| Clockhouse Pharmacy | 5 Clockhouse Lane, Collier Row, Romford | Havering Park |
| Lloyds Pharmacy | 1-15 The Brewery, Waterloo Road, Romford | Romford Town |
| Maylands Pharmacy | 300 Upper Rainham Road, Hornchurch | Elm Park |

**Source: NHS England, 2022**

### *Early morning Opening*

**6.29** Thirteen pharmacies are open before 9 am on weekdays within the borough and another four that are within 1 mile of the borough's border. These are shown in Figure 6.8. Table 6.4 show that there is good coverage of early opening pharmacies in the borough, particularly within areas of higher population density.

**Figure 6.8: Pharmacies that are open before 9am on a weekday and their 0.5- and 1-mile coverage, April 2022**




**Source: NHS England, 2022**

**Table 6.4: Community Pharmacies open before 9am on weekdays in Havering**

| Pharmacy | Address | Ward |
|---|---|---|
| Instore Pharmacy | Tesco Superstore, Bridge Road, Rainham | Rainham and Wennington |
| Lloyds Pharmacy | 1-15 The Brewery, Waterloo Road, Romford | Romford Town |
| Lloyds Pharmacy | 2 Tadworth Parade, Elm Park, Hornchurch | Hacton |
| Instore Pharmacy | Bryant Avenue, Gallows Corner, Romford | Harold Wood |
| Clockhouse Pharmacy | 5 Clockhouse Lane, Collier Row, Romford | Havering Park |
| Day Lewis Pharmacy | Harold Hill Health Centre, Gooshays Dr, Harold Hill, Romford | Gooshays |
| Well Harold Wood - Station Road | 7 Station Road, Harold Wood, Essex | Harold Wood |

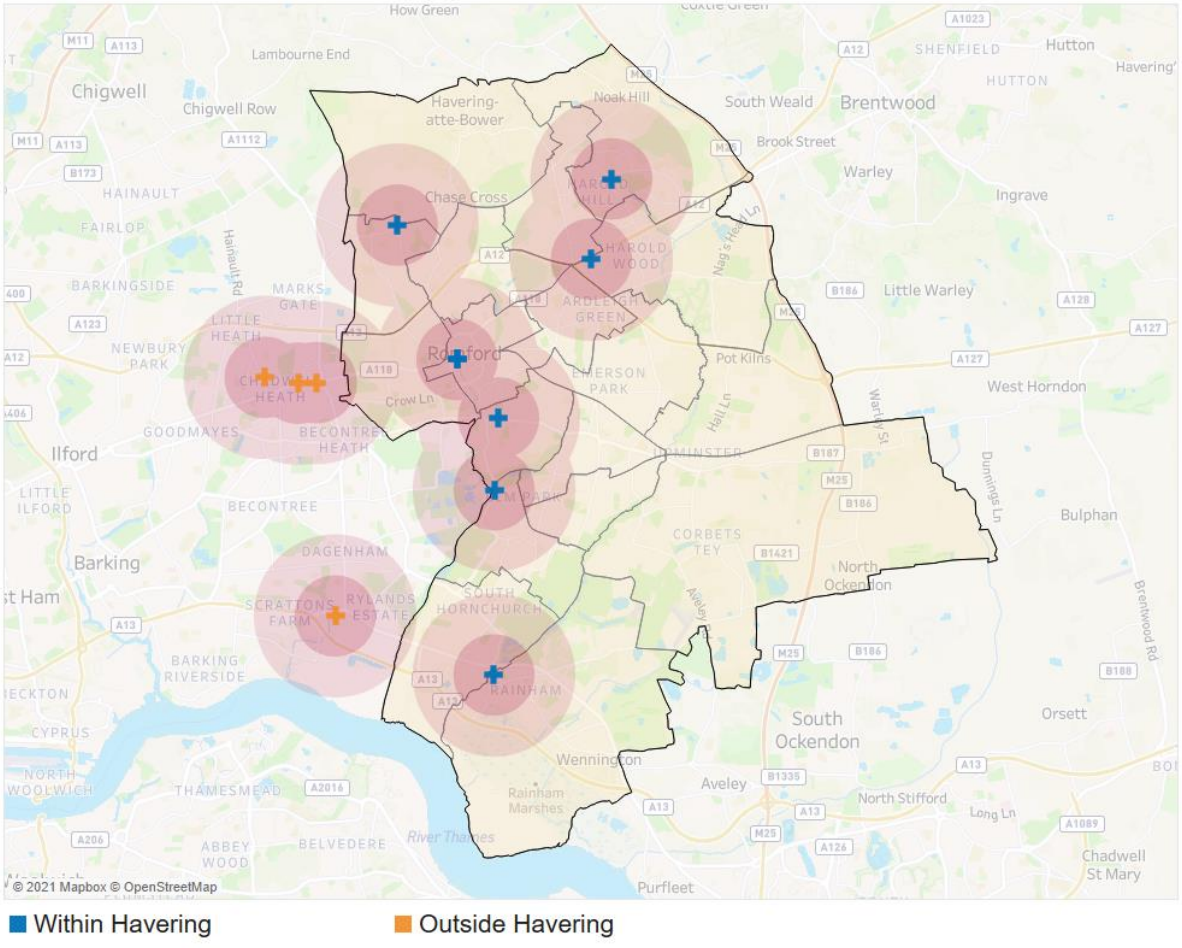
| | | |
|---|---|---|
| Elm Park Pharmacy | 208-212 Elm Park Avenue, Elm Park, Hornchurch | St Andrew's |
| Shadforth Pharmaceutical Co Ltd | 266 Brentwood Road, Romford | Emerson Park |
| Maylands Pharmacy | 300 Upper Rainham Road, , Hornchurch | Elm Park |
| Boots The Chemist | Unit 7, The Brewery, Waterloo Road, Romford | Romford Town |
| Boots The Chemist | Unit 4, 47 Market Place, Romford | Romford Town |
| Instore Pharmacy | Tesco Superstore, 300 Hornchurch Road, Hornchurch | Hylands |

**Source: NHS England, 2022**

### *Late Evening Closure*

**6.30** There are eight pharmacies in the borough that still open after 7 pm on weekdays with four other pharmacies within 1 mile of Havering (see Figure 6.9 and Table 6.5).

**Figure 6.9: Community Pharmacies that are open after 7pm on weekdays and their 0.5- and 1-mile coverage, April 2022**




**Source: NHS England, 2022**

**Table 6.5: Community Pharmacies closing after 7pm on weekdays in Havering**

| Pharmacy | Address | Ward |
|---|---|---|
| Instore Pharmacy | Tesco Superstore, Bridge Road, Rainham | Rainham and Wennington |
| Lloyds Pharmacy | 1-15 The Brewery, Waterloo Road, Romford | Romford Town |
| Instore Pharmacy | Bryant Avenue, Gallows Corner, Romford | Harold Wood |
| Clockhouse Pharmacy | 5 Clockhouse Lane, Collier Row, Romford | Havering Park |
| Day Lewis Pharmacy | Harold Hill Health Centre, Gooshays Dr, Harold Hill, Romford | Gooshays |
| Maylands Pharmacy | 300 Upper Rainham Road, Hornchurch | Elm Park |
| Boots The Chemist | Unit 7, The Brewery, Waterloo Road, Romford | Romford Town |
| Instore Pharmacy | Tesco Superstore, 300 Hornchurch Road, Hornchurch | Hylands |

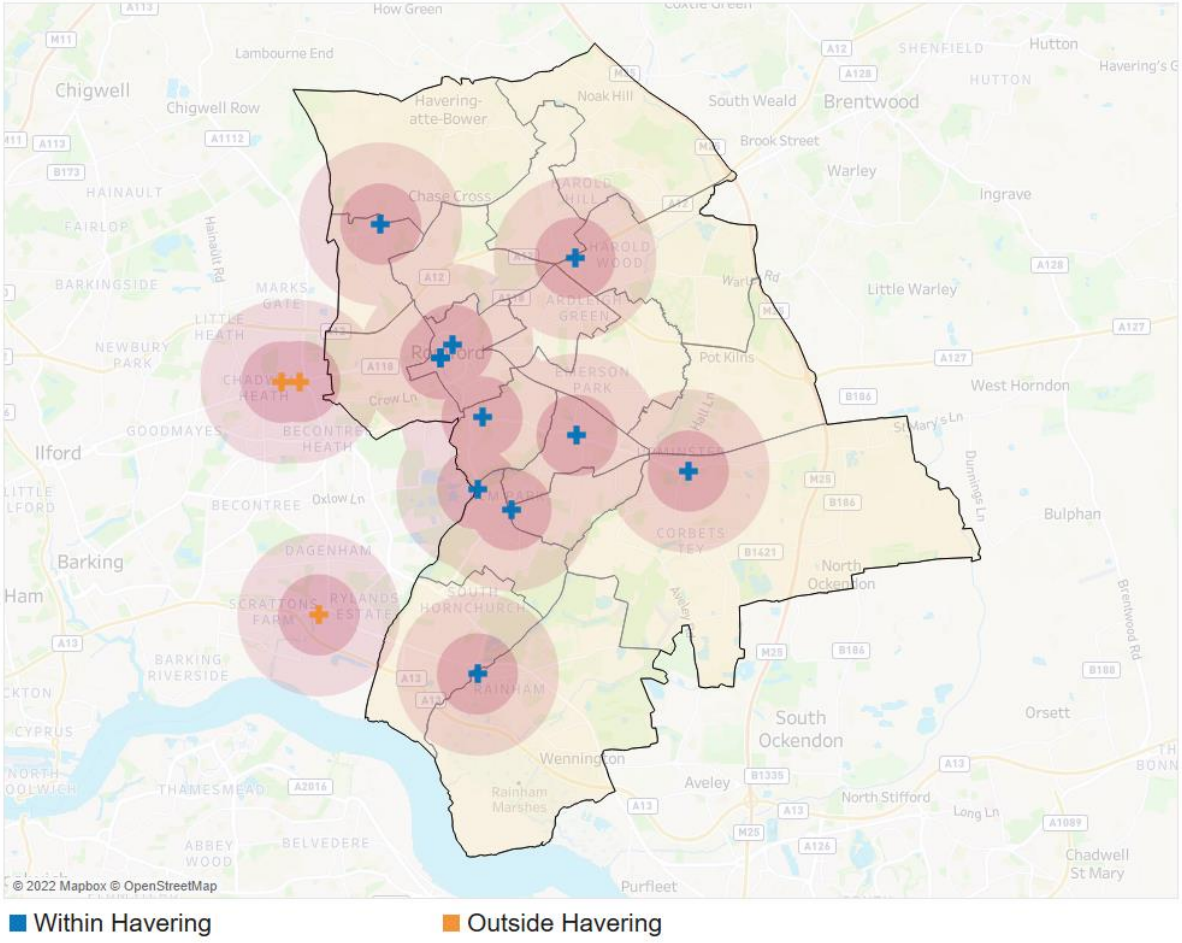
**Source: NHS England, 2022**

**6.31** In terms of travel distance, 100% Havering residents live within 20-minute reach of an early opening and late closing pharmacy by public transport (OHID, SHAPE Atlas Tool, 2021).

### *Saturday Opening*

**6.32** 41 out of the 45 community pharmacies in Havering are open on Saturday. There are another 20 pharmacies near the borough's border that are also open on Saturday (Figure 6.10).

**Figure 6.10 Community Pharmacies open on Saturday and their 0.5- and 1-mile coverage, April 2022**

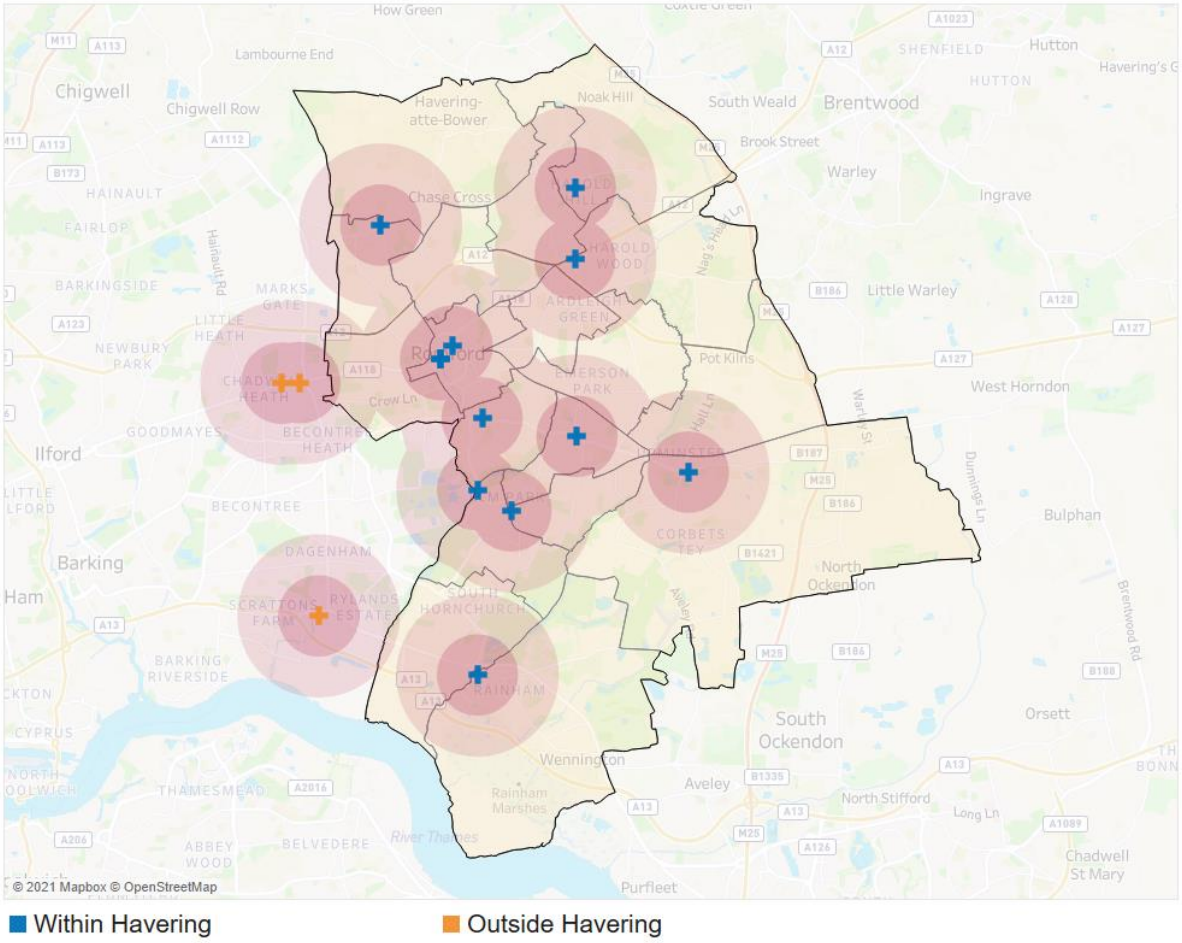



**Source: NHS England, 2022**

### *Sunday Opening*

**6.33** Eleven community pharmacies are open on a Sunday within Havering with another three open in boroughs around Havering within 1 mile of the borough's borders (Figure 6.11, Table 6.6).

**Figure 6.11: Pharmacies open on a Sunday and their 0.5- and I-mile coverage, April 2022**




**Source: NHS England, 2022**

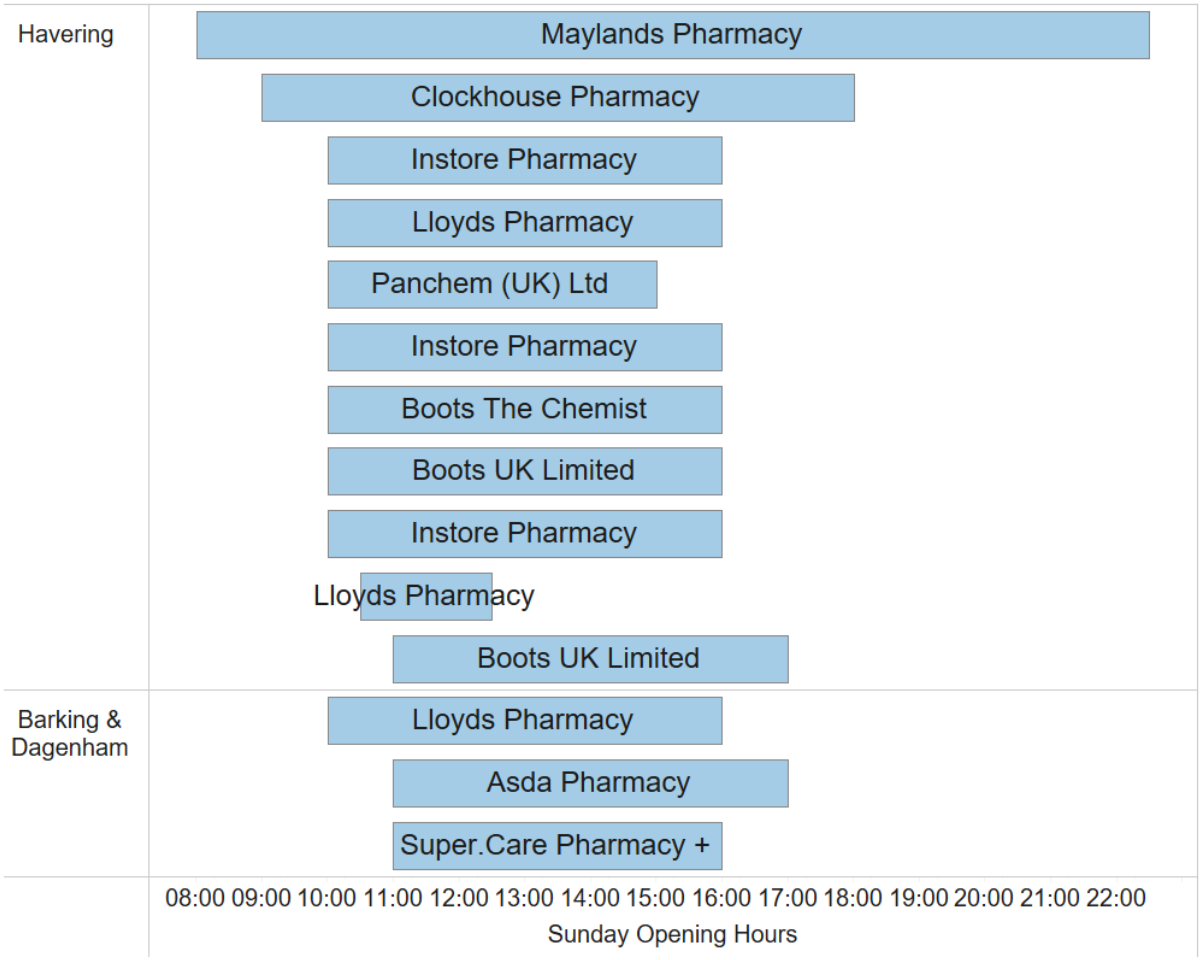
**Table 6.6: Community Pharmacies open on Sunday in Havering, April 2022**

| Pharmacy | Address | Ward |
|---|---|---|
| Instore Pharmacy | Tesco Superstore, Bridge Road, Rainham | Rainham and Wennington |
| Lloyds Pharmacy | 1-15 The Brewery, Waterloo Road, Romford | Romford Town |
| Lloyds Pharmacy | 2 Tadworth Parade, Elm Park, Hornchurch | Hacton |
| Panchem (UK) Ltd | 160 St Marys Lane, Upminster | Upminster |
| Instore Pharmacy | Bryant Avenue, Gallows Corner, Romford | Harold Wood |
| Clockhouse Pharmacy | 5 Clockhouse Lane, Collier Row, Romford | Havering Park |
| Boots UK Limited | 12 The Liberty, Romford, Essex | Romford Town |
| Maylands Pharmacy | 300 Upper Rainham Road, Hornchurch | Elm Park |
| Boots The Chemist | Unit 7, The Brewery, Waterloo Road, Romford | Romford Town |
| Boots UK Limited | 120-126 High Street, Hornchurch | St Andrew's |
| Instore Pharmacy | Tesco Superstore, 300 Hornchurch Road, Hornchurch | Hylands |

**Source: NHS England, 2022**

**6.34** Overall, as shown in Figure 6.12 below, there is a good range of Sunday opening hours offered in Havering. [35]

**Figure 6.12: Opening times of pharmacies on Sundays**




**Source: NHS England, 2022**

**6.35** All but 12,402 residents can reach a Sunday opening Havering pharmacy within 20-minutes if traveling by public transport.

## Essential Services

**6.36** Essential services are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework. All pharmacy contractors required to deliver and comply with the specifications for all essential services, these are:

- Dispensing Medicines
- Dispensing Appliances
- Repeat Dispensing

[35] NB: 'Good' is when the population is able to access their local pharmacy within 20-minutes, a statistic as defined by the Local Government Association: Local Government Association (March 2016). The community pharmacy offer for improving the public's health: a briefing for local government and health and wellbeing boards.

- Clinical governance
- Discharge Medicines Service
- Public Health (Promotion of Healthy Lifestyles)
- Signposting
- Support for self-care
- Disposal of Unwanted Medicines

### Dispensing

**6.37** Havering pharmacies dispense an average of 7,496 items per month (based on NHS Business Services Authority, 2020/21 financial year data). While this is higher than the London average of 5,295 per month and England average at 6,675 per month, there is good distribution and capacity amongst Havering pharmacies to fulfil current and anticipated need in the lifetime of this PNA.

**Summary of the accessibility pharmacy services and of essential services**

Overall, there is good geographical coverage of pharmacies to provide essential services across the borough in both inside normal working hours and outside normal working hours.

## Advanced pharmacy services

**6.38** Advanced services are NHS England commissioned services that community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation, as necessary.

**6.39** As at October 2021, the following services may be provided by pharmacies:

- new medicine service
- community pharmacy seasonal influenza vaccination
- community pharmacist consultation service
- community pharmacy blood pressure service, and
- community pharmacy hepatitis C antibody testing service (currently until 31 March 2022).

**6.40** In early 2022 a stop-smoking service in pharmacies will be introduced for patients who started their stop-smoking journey in hospital.

**6.41** As at October 2021, the community pharmacy COVID-19 lateral flow device distribution service and community pharmacy Covid-19 medicines delivery service are also commissioned to be delivered from community pharmacies. NHS England data was not yet available at the time of publication of this PNA.

**6.42** There are two appliance advanced services that pharmacies and dispensing appliance contractors may choose to provide:

- appliance use reviews, and
- stoma appliance customisation.

**6.43** Medicine Use Reviews is an Advanced Service that was decommissioned on the 31st of March 2021.

## New Medicines Services

**6.44** The New Medicine Service (NMS) supports patients with long-term conditions, who are taking a newly prescribed medicine, to help improve medicines adherence.

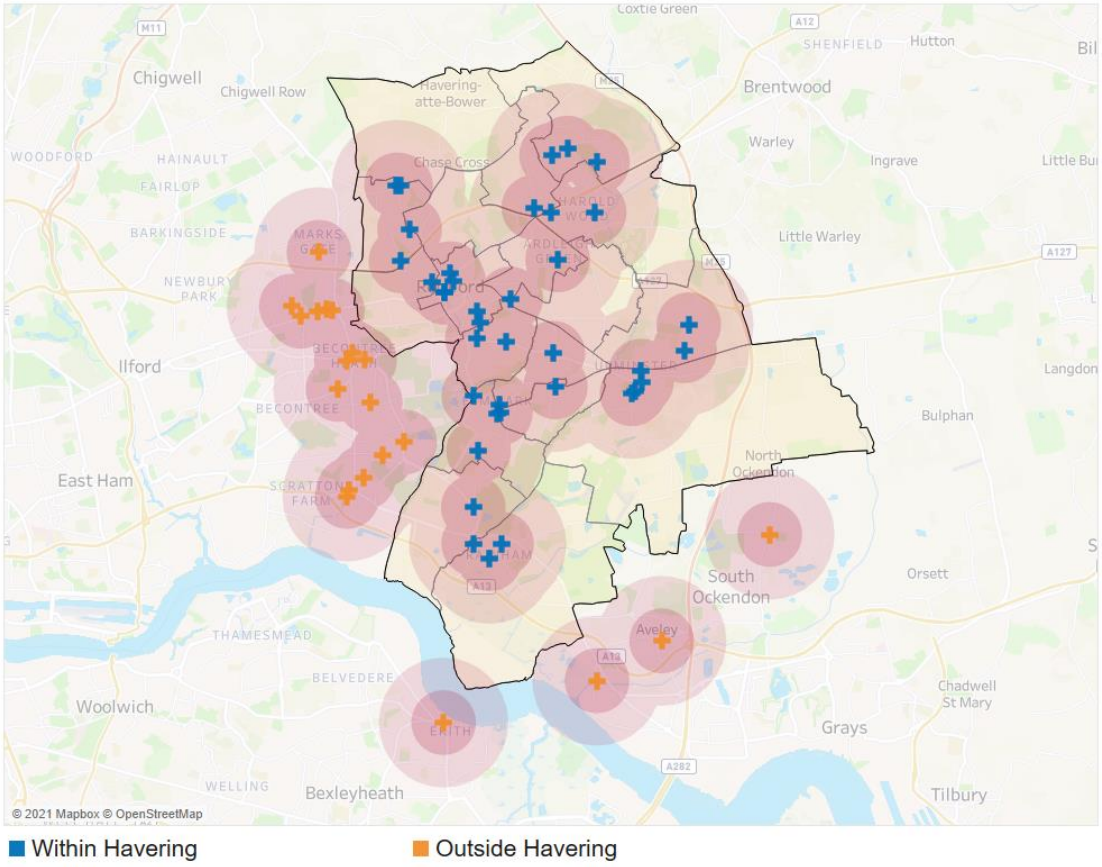
**6.45** This service is designed to improve patients' understanding of a newly prescribed medicine for their long-term condition and help them get the most from the medicine. It aims to improve adherence to new medication, focusing on people with specific conditions

- Asthma and COPD
- Type 2 diabetes
- Antiplatelet or anticoagulation therapy
- Hypertension

**6.46** New Medicines Service can only be provided by pharmacies and is conducted in a private consultation area to ensure patient confidentiality.

**6.47** Thirty-eight pharmacies provided NMS in Havering in 2020/21. An additional 20 pharmacies in bordering boroughs provided NMS. All these pharmacies are shown in Figure 6.13 below

**Figure 6.13: Pharmacies providing NMS and their 0.5- and I-mile coverage, October 2021**




**Source: NHS England, 2021**

**6.48** Table 6.7 below shows NMS provision by ward.

**Table 6.7: Number of NMS provided by Havering pharmacies by ward, 2020/21**

| Ward | Number of Pharmacies | Total Number of NMSs provided | Average NMS per pharmacy |
|---|---|---|---|
| Brooklands | 1 | 39 | 39 |
| Cranham | 2 | 305 | 153 |
| Elm Park | 3 | 380 | 127 |
| Emerson Park | 1 | 54 | 54 |
| Gooshays | 3 | 811 | 270 |
| Hacton | 2 | 172 | 86 |
| Harold Wood | 2 | 385 | 193 |
| Havering Park | 1 | 83 | 83 |
| Heaton | 1 | 167 | 167 |
| Hylands | 2 | 298 | 149 |
| Mawneys | 2 | 118 | 59 |
| Pettits | 1 | 316 | 316 |
| Rainham and Wennington | 3 | 40 | 13 |
| Romford Town | 6 | 274 | 46 |
| South Hornchurch | 1 | 117 | 117 |
| Squirrel's Heath | 1 | 124 | 124 |
| St Andrew's | 2 | 277 | 139 |
| Upminster | 4 | 243 | 61 |
| Borough Total | 38 | 4,203 | 111 |

**Source: NHS England, 2021**

**6.49** NMS is supplied widely across the borough within areas of high density and need, therefore the current provision of the NMS is sufficient to meet the needs of this borough.

## Community pharmacy seasonal influenza vaccination

**6.50** Flu vaccination by injection, commonly known as the "flu jab" is available every year on the NHS to protect certain groups who are at risk of developing potentially serious complications, such as:

- anyone over the age of 65
- pregnant women
- children and adults with an underlying health condition (particularly long-term heart or respiratory disease)
- children and adults with weakened immune systems

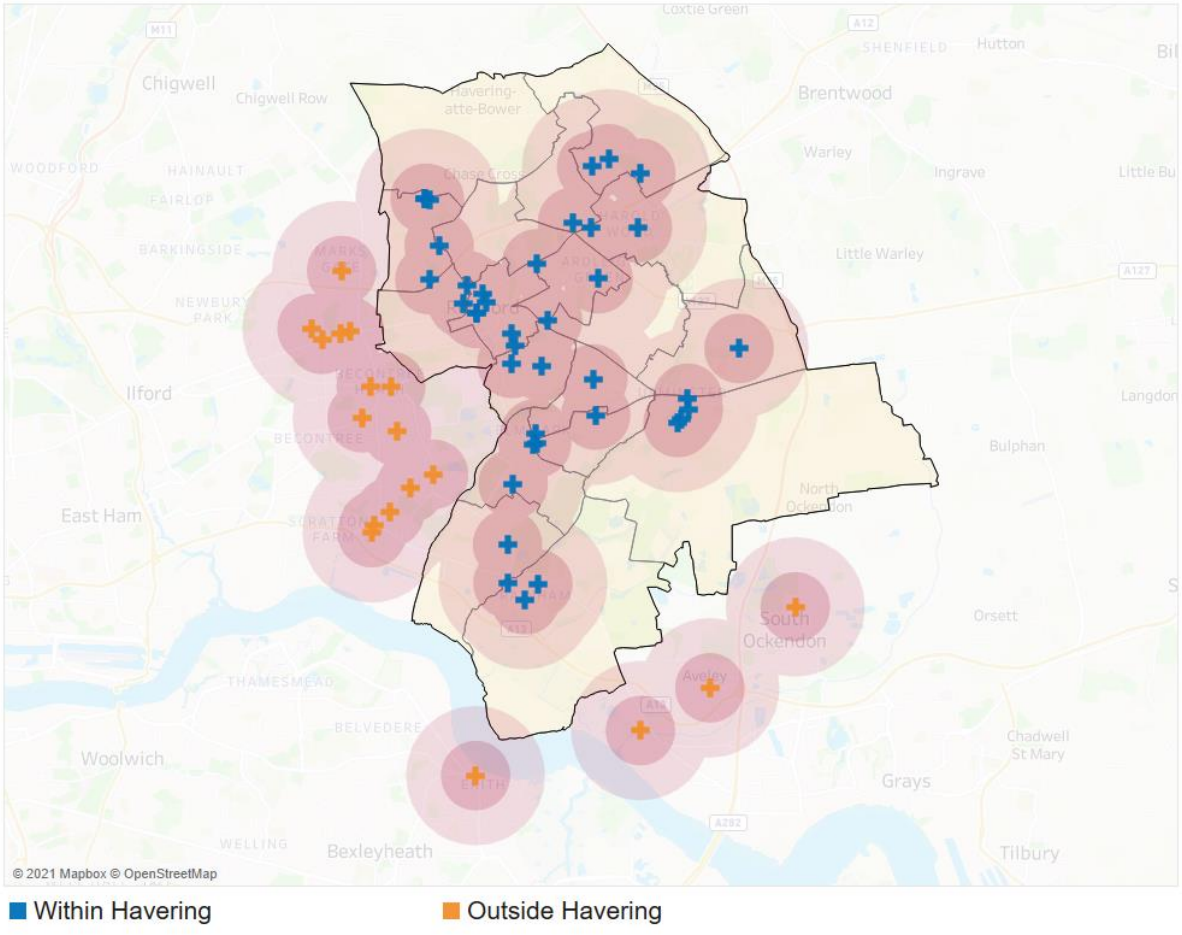
**6.51** GPs currently provide most flu vaccinations and pharmacies can help improve access to this service given their convenient locations, extended opening hours and walk-in service. The National Advanced Flu Service is an advanced service commissioned by NHS England to maximise the uptake of the flu vaccine by those who are ‘at-risk’ due to ill-health or long terms condition.

**6.52** Alongside this, the Advanced Flu Service the NHS England London Region commissions the London Pharmacy Vaccination Service. This can be provided by any pharmacy in London. The aims of the service are to:

- sustain and maximise uptake of flu vaccine in at risk groups by continuing to build the capacity of community pharmacies as an alternative to general practice attendance
- to provide more opportunities and improve convenience for eligible patients to access flu vaccinations

**6.53** A vast majority of community pharmacies in the borough provided flu vaccines (39/45) in Havering in 2020/21. Another 18 outside but bordering the borough provided the service. The distribution of these pharmacies is shown in Figure 6.14 and Table 6.8.

**Figure 6.14: Pharmacies providing Flu vaccination and their 0.5- and I-mile coverage, October 2021**




**Source**: NHS England, 2021

**Table 6.8: Pharmacies that provide Flu Vaccinations in Havering by ward, October 2021**

| Ward | Number of Pharmacies | Ward | Number of Pharmacies |
|---|---|---|---|
| Romford Town | 7 | Harold Wood | 2 |
| Upminster | 4 | Hacton | 2 |
| Rainham and Wennington | 3 | Elm Park | 2 |
| Gooshays | 3 | South Hornchurch | 1 |
| St Andrew's | 2 | Pettits | 1 |
| Squirrel's Heath | 2 | Heaton | 1 |
| Mawneys | 2 | Emerson Park | 1 |
| Hylands | 2 | Cranham | 1 |
| Havering Park | 2 | Brooklands | 1 |

**Source: NHS England, 2021**

**6.54** Overall, there is strong coverage of this service across Havering. Therefore, the current provision Advanced Flu Service is sufficient to meet the needs of this borough.

**6.55** In addition, there is a National Pandemic Flu Service is designed to support GP provision of antiviral medicines during a flu pandemic. An enhanced service specification has been agreed by the PSNC and NHSE&I for pharmacies acting as antiviral collection points. At the point that a flu pandemic is likely, PSNC and NHSE&I will agree funding for provision of the service and the service specification will be released for use by regional NHSE&I teams. This specification will be used to commission community pharmacies to supply antivirals to patients that have had a supply authorised by the National Pandemic Flu Service.

### Community pharmacist consultation service (CPCS)

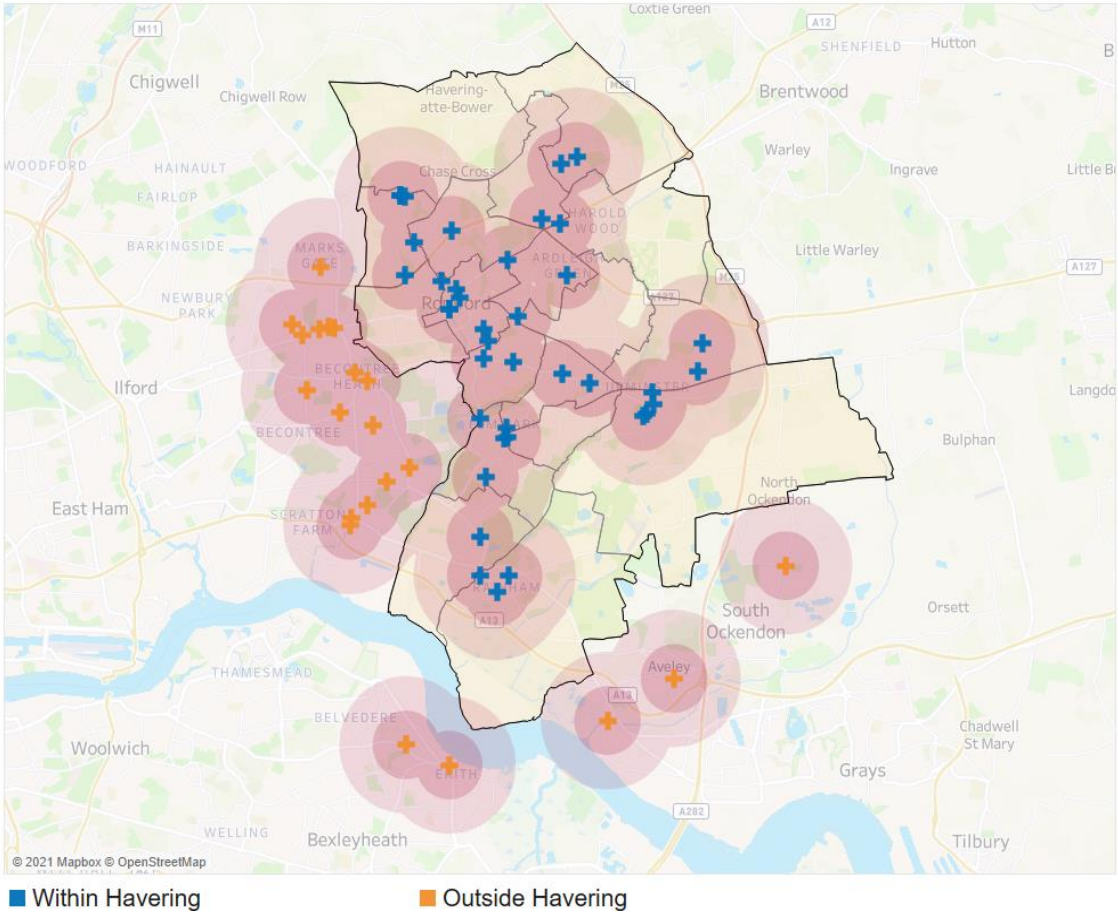
**6.56** The community pharmacist consultation service (CPCS) is a new service provided by pharmacies that was launched in October 2019. The aims of the service are to support the integration of community pharmacy into the urgent care system, and to divert patients with lower acuity conditions or who require urgent prescriptions from the urgent care system and to community pharmacy.

**6.57** It will also offer patients who contact NHS 111 the opportunity to access appropriate urgent care services in a convenient and easily accessible community pharmacy setting on referral from an NHS 111 call advisor and via the NHS 111 Online service.

**6.58** There is strong coverage of CPCS in Havering. A large portion of the community pharmacies (39/45) in the borough provided CPCS in 2020/21. There are an additional 21 pharmacies in neighbouring boroughs that provided the service (Figure 6.15 and Table 6.9).

**6.59** The current provision of CPCS is sufficient to meet the needs of this borough.

**Figure 6.15: Pharmacies providing CPCS and their 0.5- and I-mile coverage, October 2021**




**Source: NHS England, 2021**

**Table 6.9: Pharmacies that provide CPCS in Havering by ward, October 2021**

| Ward Name | Number of Pharmacies | Ward Name | Number of Pharmacies |
|---|---|---|---|
| Romford Town | 7 | Hylands | 2 |
| Upminster | 4 | Havering Park | 2 |
| St Andrew's | 3 | Gooshays | 2 |
| Rainham and Wennington | 3 | Cranham | 2 |
| Elm Park | 3 | South Hornchurch | 1 |
| Squirrel's Heath | 2 | Heaton | 1 |
| Pettits | 2 | Harold Wood | 1 |
| Mawneys | 2 | Hacton | 1 |
| Hylands | 2 | Emerson Park | 1 |

**Source: NHS England, 2021**

## Community pharmacy blood pressure service

**6.60** Community pharmacy blood pressure service is a relatively new service and at the time of publication NHSE does not report any pharmacy in Havering offering this service.

**6.61** 30 respondents to the contractor survey indicated being willing to provide the service if commissioned.

### Community pharmacy hepatitis C antibody testing service

**6.62** NHSE data does not show any pharmacy offering Community pharmacy hepatitis C antibody testing service as of the time of publication.

**6.63** 24 respondents to the contractor survey indicated being willing to provide the service if commissioned.

### Community pharmacy Covid-19 lateral flow device distribution service and community pharmacy Covid-19 medicines

**6.64** As at the time of publication, NHSE data was not yet available for these services. However, these services are stopping at the end of March 2022.

**6.65** Four respondents from the contractor survey indicated that they currently provide COVID-19 vaccinations, while another 25 indicated being willing to provide the service if commissioned.

**6.66** 30 respondents to the survey indicated they currently provide rapid COVID-19 lateral flow test kits and another 7 are willing to provide the kits if commissioned to do so.

### Appliance Use Reviews (AURs)

**6.67** Appliance Use Review (AUR) is another advanced service that community pharmacy and appliance contractors can choose to provide so long as they fulfil certain criteria.

**6.68** AURs can be carried out by, a pharmacist or a specialist nurse either at the contractor's premises or at the patient's home. AURs help patient's to better understand and use their prescribed appliances by:

- Establishing the way the patient uses the appliance and the patient's experience of such use
- Identifying, discussing, and assisting in the resolution of poor or ineffective use of the appliance by the patient
- Advising the patient on the safe and appropriate storage of the appliance
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

**6.69** No pharmacies within or bordering the borough provided this AURs in 2020/21. However, NEL LPC have assure the Health and Wellbeing Board that should the need arise, there would be pharmacies in Havering willing to provide the service. Therefore, no gap is evident in the current provision of this service.

### Stoma Appliance Customisation service (SAC)

**6.70** The SAC service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

**6.71** Currently two pharmacies provided SACs within Havering in 2020/21: Lloyds Pharmacy on Tadworth Parade, Hornchurch (Hacton ward) and Lloyds Pharmacy on Chase Cross Road, Romford (Mawneys ward).

**6.72** Residents can access the SAC service either from non-pharmacy providers within the borough (e.g., community health services) or from dispensing appliance contractors outside of the borough. Therefore, the current provision of SAC service is sufficient to meet the needs of this borough.

### Medicine Use Reviews

**6.73** 43 pharmacies in Havering delivered Medicine Use Reviews (MURs) up until the service contract was decommissioned by NHS England in March 2021. With MURs patients were offered a structured review of their medicine use to help them manage their medicines more effectively. MURS ensured that patients understood how their medicines should be used, why they have been prescribed and identified any problems patients may encounter. Where necessary would provide feedback to the prescriber.

**Summary of the Advanced Pharmacy Services**

It is concluded that there is currently sufficient provision for the following enhanced services to meet the likely needs of residents in Havering:

- new medicine service
- community pharmacy seasonal influenza vaccination
- community pharmacist consultation service
- Community pharmacy blood pressure service, and
- community pharmacy hepatitis C antibody testing service (currently until 31 March 2022).
- Stoma Appliance Customisation service

At the time of data collection for this PNA, no data was available on the following newly commissioned services:

- stop-smoking service in pharmacies for patients who started their stop-smoking journey in hospital
- COVID-19 lateral flow device distribution service and community pharmacy COVID-19 medicines delivery service

Havering pharmacies have indicated their willingness to provide this service, therefore no gap is evident for future access to these advanced services.

No local pharmacies provided Appliance Use Reviews between October 2020 and October 2021. However, Havering pharmacies will be willing to provide them, should the need arise. Therefore, the current provision of the AUR service is sufficient to meet the current and future needs of this borough.

## Enhanced Pharmacy Services

**6.35** There are currently three locally enhanced services commissioned by NHSE&I, the London Region. These are the London Seasonal Influenza Vaccination Service, the Bank Holiday Rota Service, and the COVID-19 Vaccination Service.

### London Seasonal Influenza Vaccination Service

**6.36** In addition to the Advanced Flu Service the NHSE&I commissions the London Seasonal Influenza Vaccination Service. It provides a vaccination service where there may otherwise be gaps and is offered to a wider patient group, including carers, asylum seekers and the homeless and children from 2 to 18 years.

**6.37** They also offer provision for pneumococcal vaccination to eligible cohorts and MenACWY for 18–24-year-olds living permanently or temporarily in London.

**6.38** As at the time of publication, NHSE data was not yet available for these services.

### Bank Holiday Rota Service

**6.39** Community pharmacies are not obliged to open on nominated bank holidays. Since 2020 NHSE&I commission pharmacies to open during bank holidays on a rota basis as an enhanced service. This is to ensure pharmacy services are available during bank holidays and they are accessible to other out of hours providers, thus enabling patients to easily access medication if required.

**6.40** In Havering, this service is provided by two pharmacies: Mim Pharmacy, 118 North Street, Romford, and Britcrown Pharmacy, 5 Balgores Lane, Gidea Park.

### COVID-19 Vaccination Service

**6.74** The aim of this service is to maximise uptake of COVID-19 vaccine by providing vaccination services from accessible pharmacy locations and improving patients' convenience and choice. This service is commissioned as and when required. At the time of the production of this PNA, three pharmacies provide COVID-19 vaccinations in Havering.

## Other NHS Services

**6.75** These are services commissioned by the London Borough of Havering, and Barking and Dagenham, Havering, and Redbridge CCG to fulfil a local population health and wellbeing need. Havering enhanced services are listed below:

**6.76** Local authority commissioned services:

- Needle exchange
- Supervised consumption
- Emergency hormonal contraception

**6.77** Barking and Dagenham, Havering, and Redbridge CCG commissioned services:

- Community anticoagulation service
- End of life care medication provision

The provision of these services is explored below.

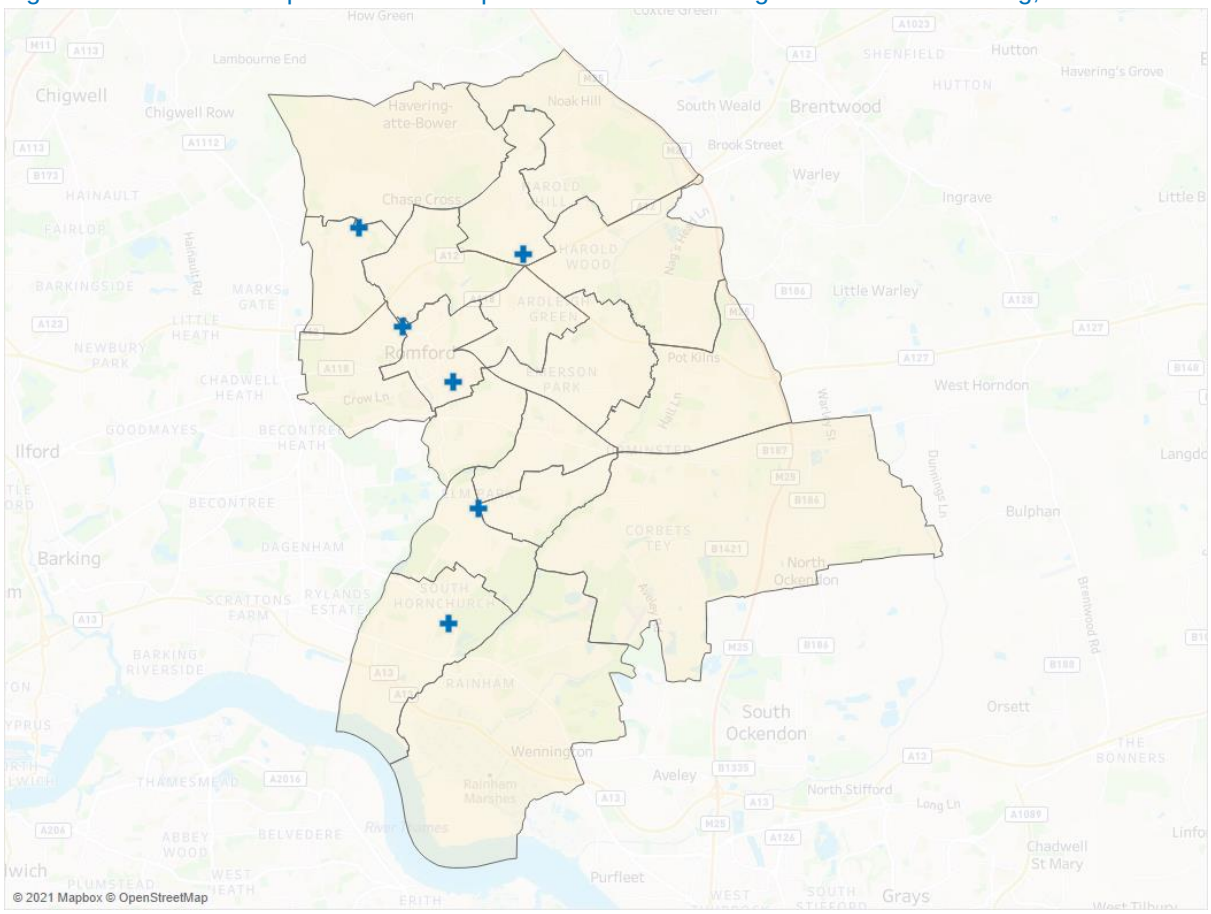
## Needle exchange

**6.78** Needle exchange service in Havering is subcontracted by Change Grow Live, a national health and social care charity. The needle exchange service supplies needles, syringes and other equipment used to prepare and take illicit drugs. The purpose of this services is to reduce the transmission of blood-borne viruses such as hepatitis B and C, and other infections caused by sharing injecting equipment.

**6.79** Needle exchange services also aim to reduce the harm caused by injecting drugs through providing information and advice and acting as a gateway to other services, including drug treatment centres.

**6.80** Six pharmacies offer the needle exchange service. Their locations are shown in Figure 6.16 and Table 6.10

Figure 6.16: Location of pharmacies that provide Needle Exchange Services in Havering, October 2021




**Source:** Change Grow Live, 2021

**Table 6.10: Pharmacies that provide Needle Exchange Services in Havering, October 2021**

| Pharmacy | Address | Ward |
|---|---|---|
| Day Lewis Pharmacy | 113 Rainham Road, Rainham, Essex | South Hornchurch |
| Crescent Pharmacy | 65 Masefield Crescent, Gidea Park, Romford | Heaton |
| Lloyds Pharmacy | 12 Chase Cross Road, Collier Row, Romford | Mawneys |
| Mim Pharmacy Ltd | 118 North Street, Romford | Romford Town |
| Park Lane Pharmacy | Park Lane Pharmacy, 1 Park Lane, Hornchurch | Romford Town |
| Day Lewis Pharmacy | 6 Station Parade, Broadway Elm Park, Hornchurch | Elm Park |

**Source:** Change Grow Live, 2021

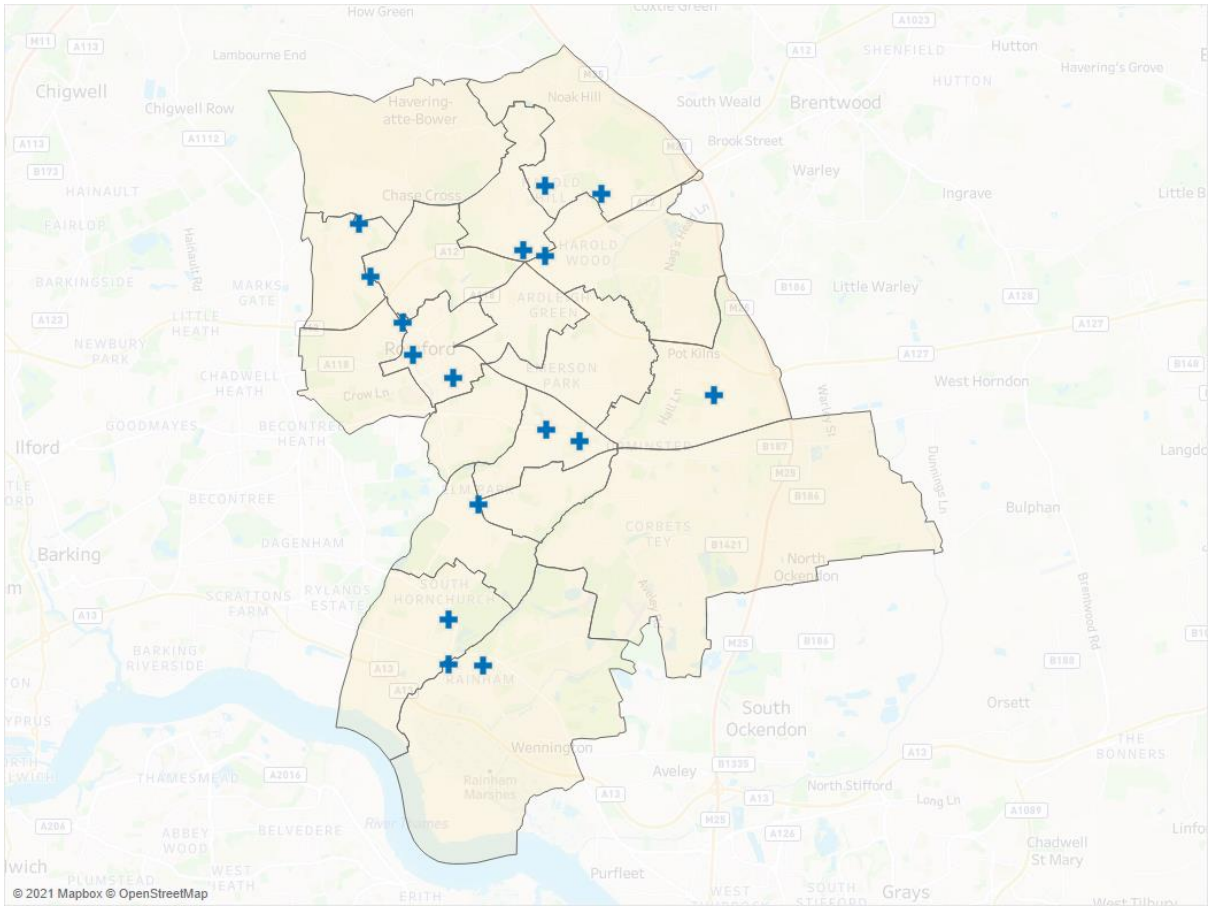
## Supervised consumption

**6.81** The London Borough of Havering commission community pharmacies to provide supervised consumption as part of as part of treatment services for opioid dependency.

**6.82** Supervised consumption of opioid substitution treatment forms a critical element of safe and effective treatment in the community. It reduces risk of overdose and non-compliance with treatment, minimises diversion and enables people being treated for opioid dependency to utilise the benefits of pharmacy intervention around health choices. It is typically used for people who are new to treatment and/or have complex needs.

**6.83** There is good provision of this service in the borough. Sixteen pharmacies have been commissioned to provide supervised consumption services in Havering. These are presented in Figure 6.17 and Table 6.11.

**Figure 6.16: Location of pharmacies that provide Supervised Consumption in Havering, October 2021**




**Source:** London Borough of Havering, 2021

**Table 6.11: Number of Pharmacies that provide Supervised Consumption in Havering by ward, October 2021**

| Ward | Number of Pharmacies | Ward | Number of Pharmacies |
|---|---|---|---|
| Romford Town | 3 | Mawneys | 1 |
| St Andrew's | 2 | Heaton | 1 |
| Rainham and Wennington | 2 | Harold Wood | 1 |
| Gooshays | 2 | Elm Park | 1 |
| South Hornchurch | 1 | Cranham | 1 |
| Pettits | 1 | Pettits | 1 |

**Source:** London Borough of Havering, 2021

## Emergency Hormonal Contraception

**6.84** There are two Emergency Hormonal Contraception services that are delivered through Havering pharmacies. These are:

- Ulipristal acetate 30mg
- Levonorgestrel 1500mcg

**6.85** Both services are Patient Group Direction services that are commissioned by the London Borough of Havering, Barking and Dagenham, Havering and Redbridge CCG, and Barts Health NHS Trust. Community pharmacists must complete mandatory training approved by Train All East, Barts Sexual Health Primary Care Support Team, and access regular commissioner-approved updates.

**6.86** The aim of the emergency contraception is to reduce the number of unwanted pregnancies in Havering, particularly in teenagers and young women. It is for women aged from 13 years to 25 years, within 72 hours following unprotected sexual intercourse or contraceptive method failure with the intention of preventing an unintended pregnancy. Clients who seek this service are also offered advice and guidance on other forms of contraception.

**6.87** Two pharmacies offer this service in Havering: Mim Pharmacy on North Street (Romford Town ward) and Crescent Pharmacy on Masefield Crescent (Heaton ward).

### Community anticoagulation service

**6.88** This service is commissioned by Barking and Dagenham, Havering, and Redbridge CCG to reduce the expected prevalence of atrial fibrillation in Havering.

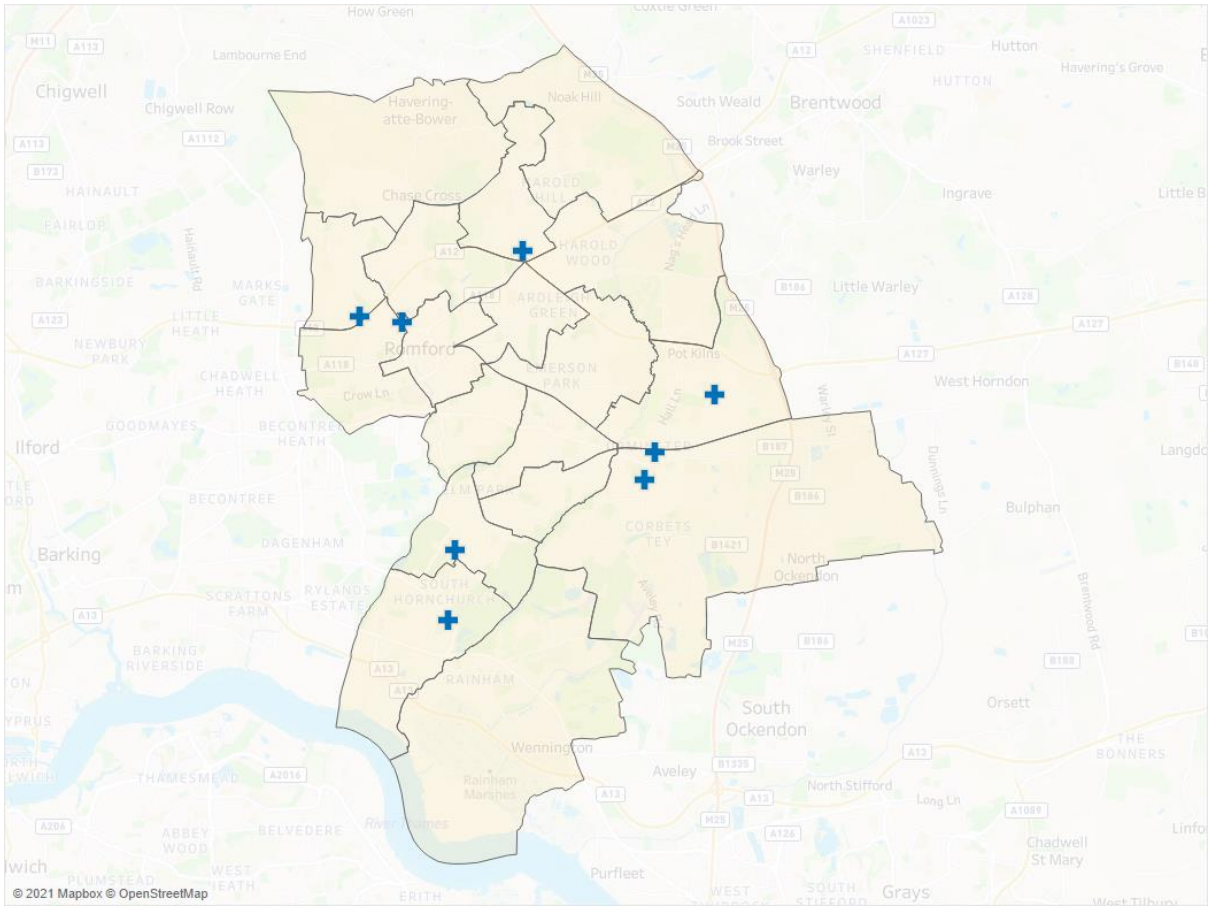
**6.89** The overall aim of this service is to provide on-going monitoring and management of anticoagulation therapy in the community for patients aged 18 and over, who are registered with a GP practice in Havering and Havering CCG, including temporary residents.

**6.90** The provision of the service includes:

- Point of Care Testing
- Organisation and provision of domiciliary service for housebound patients who require anticoagulation monitoring and on-going management.
- Use of Computer Decision Support Software (CDSS) for dosing advice and frequency of testing.
- Prescribing conducted in accordance with the prescribing protocol

**6.91** Eight pharmacies in the borough offer this service. These are presented in Figure 6.17 and Table 6.12

**Figure 6.17: Location of pharmacies that provide anti-coagulation service in Havering, October 2021**




**Source:** London Borough of Havering, 2021

**Table 6.12: Number of Pharmacies that provide Community anticoagulation service in Havering by ward, October 2021**

| Ward | Number of Pharmacies |
|---|---|
| Upminster | 2 |
| South Hornchurch | 1 |
| Romford Town | 1 |
| Mawneys | 1 |
| Heaton | 1 |
| Elm Park | 1 |
| Cranham | 1 |

**Source:** London Borough of Havering, 2021

## End of life care medication provision

**6.92** The aim of the end-of-life care (EoLC) medication is to improve access to medications for patients, carers, and healthcare professional when they are required. This is to ensure that there is no delay to treatment whilst also providing access and choice.

**6.93** Commissioned pharmacies who provide this service maintain a required stock of EoLC medication. Where requested, the pharmacist will provide advice to the healthcare professional regarding the prescribing or dosage of EoLC that should be administered to the patient.

**6.94** Commissioned pharmacies may also opt-in to provide an Out-Of-Hours dispensing service for EoLC medication. These pharmacies would provide EoLC medication when no other commissioned pharmacies are open, namely:

- Mon - Saturday 12 am -7 am
- Sunday 12 am – 9 am

**6.95** The Out-Of-Hour's service is to ensure there is 24 hours 7 days a week availability of medicines for EoLC from community pharmacies across the CCGs three boroughs, Barking and Dagenham, Havering, and Redbridge.

**6.96** No pharmacies in Havering offer EoLC medication only, but the four that offer both EoLC and OOH provision are shown in table below (Table 6.12).

**Table 6.13: Pharmacies providing the EOLC medicines and OOH in Havering**

| Pharmacy | Address | Ward |
|---|---|---|
| Clockhouse Pharmacy | 5 Clockhouse Lane, Collier Row, Romford | Havering Park |
| Crescent Pharmacy | 65 Masefield Crescent, Gidea Park, Romford | Heaton |
| Lloyds Pharmacy | 12 Chase Cross Road, Collier Row, Romford | Mawneys |
| Mim Pharmacy Ltd | 118 North Street, Romford | Romford Town |

**Source:** BHR CCG, 2021

### Summary of enhanced pharmacy services

It is concluded that there is currently sufficient provision for the following enhanced services to meet the likely needs of residents in Havering:

- Needle exchange
- Supervised consumption
- Emergency hormonal contraception
- Community anticoagulation service
- End of life care medication provision

## Contractor survey responses

**6.97** There are some areas of population health and wellbeing need identified in Chapter 4 that pharmacies do not provide specialist support for. The contractor survey identified where pharmacies would be willing to provide additional services to address these needs if commissioned. These are summarised below.

**6.98** The rates of people who smoke in Havering are higher than the national figures. 30 Havering pharmacies stated in the contractor survey they would be willing to provide a stop smoking service if commissioned.

**6.99** A high proportion of Havering adults and Year 6 children are overweight or obese. 30 pharmacies responded that they would be willing to provide a disease specific service for obesity management for children and adults.

**6.100** Premature mortality for respiratory diseases are high in Havering. There are a number of services Havering community pharmacies would be willing to provide if commissioned:

Premature mortality for

- 34 pharmacies were willing to provide a disease specific service for asthma
- 34 pharmacies were willing to provide a disease specific service for COPD

**6.101** Dementia detection rates are low in Havering. 32 pharmacies stated that they were willing to provide an Alzheimer's or Dementia disease specific service if commissioned.

## Communication

**6.102** 2011 data shows that the most common **languages** spoken by residents in the borough other than English are Lithuanian, Polish, and Punjabi.

**6.103** According to the responses to the contractor survey most common languages besides English spoken by pharmacy staff are Hindi, Urdu, and Punjabi. Table 6.14 lists the most common languages spoken by a member of staff in Havering pharmacies. Polish is not reportedly spoken Havering pharmacies.

**Table 6.14: Top 10 languages spoken by a member of staff at the pharmacies in Havering**

| Language | Number of Pharmacies |
|---|---|
| Hindi | 9 |
| Urdu | 7 |
| Punjabi | 6 |
| Gujarati | 3 |
| Italian | 3 |
| Persian | 3 |
| Lithuanian | 2 |
| Turkish | 2 |
| Albanian | 1 |
| Bangladeshi | 1 |

**Source: Havering Contractor Survey, 2021**

**6.104** 29 Havering pharmacies would be willing to provide a Language Access Service if commissioned.

# Chapter 7 - Conclusions

**7.1** This pharmaceutical needs assessment has considered the current provision of pharmaceutical services across Havering in alongside the health needs and demographics of its population.

**7.2** It has assessed whether current provision meets the needs of the population and whether there are any gaps in the provision of pharmaceutical service either now or within the lifetime of this document, 1st October 2022 to 30th September 2025.

**7.3** This chapter will summarise the provision of these services in Havering and its surrounding local authorities.

## Current provision

**7.4** The Havering Health and Wellbeing Board has identified the following services as necessary to this PNA to meet the need for pharmaceutical services:

- Essential services provided at all premises included in the pharmaceutical lists.

**7.5** Other Relevant Services are services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have secured improvements or better access to medicines. The Havering Health and Wellbeing Board has identified the following as Other Relevant Services.

- Good provision of advanced, enhanced, and other NHS services to meet the need of the local population.

### Current access to essential services

**7.6** In assessing the provision of essential services against the needs of the population, the Health and Wellbeing Board considered access (distance, travel time and opening hours) as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

**7.7** To determine the level of access with the borough to pharmaceutical services, the following criteria were considered:

- The ratio of community pharmacies per 10,000 population
- Distance and travel time to pharmacies
- Opening hours of pharmacies
- Proximity of pharmacies to GP practices.

**7.8** There are 1.7 community pharmacies per 10,000 residents in Havering. Though this ratio is lower than the national average of 2.2, as indicated by the contractor survey, the pharmacies have capacity to offer more services.

**7.9** As demonstrated by the maps in Chapter 7, the entirety of borough's population is within 1 mile (or 20 minutes commute) of a pharmacy. Additionally, all GP practices are within 1 mile of a pharmacy.

**7.10** No difference in needs for vulnerable groups or people who share protected characteristics were identified.

**7.11** Considering all this, the residents of the borough are well served in terms of the number and location of pharmacies.

### *Current access to essential services during normal working hours*

**7.12** All pharmacies are open for at least 40 hours each week. There are 45 community pharmacies in the borough, providing good access as determined in the previous section.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of essential services during normal working hours.

### *Current access to essential services outside normal working hours*

**7.13** On weekdays, 13 pharmacies are open before 9am and eight are open after 7pm. These are mapped out on Chapter 7 and show good coverage of services available on weekdays outside normal working hours.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of essential services outside normal working hours.

**7.14** While not all residents can reach the 11 pharmacies that are open on Sundays, all residents can reach 41 of the borough's 45 community pharmacies that are open on Saturday. Considering these pharmacies and those in neighbouring local authorities, as shown in the maps in Chapter 7, there is good accessibility of pharmacies to residents on weekends.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of essential services on Saturdays or Sundays.

## Current access to advanced services

**7.15** The following advanced services are currently available for provision by community pharmacies: new medicine service, community pharmacy seasonal influenza vaccination, community pharmacist consultation service, Community pharmacy blood pressure service, community pharmacy hepatitis C antibody testing service, COVID-19 lateral flow device

distribution service, COVID-19 medicines delivery service, appliance use reviews and stoma appliance customisation.

**7.16** NMS is widely available with 38 pharmacies in the borough providing it.

**7.17** Though majority of flu vaccinations are currently provided by GPs, they are also available from 39 pharmacies in the borough.

**7.18** Thirty-nine of the borough's 45 community pharmacies offer CPCS.

**7.19** Community pharmacy blood pressure service, hepatitis C antibody testing service, COVID-19 lateral flow device distribution and COVID-19 medicines is finishing in March 2022 as it is no longer required.

**7.20** Though there are pharmacies in the borough and its surrounding that dispense appliances, none provided reviews of their usage in the last recorded year (AURs). The LPC has assured the Health and Wellbeing Board that should the need arise, there would be pharmacies willing to provide the AURs in Havering.

**7.21** Stoma Appliance Customisation service is offered by two pharmacies.

**7.22** It is therefore concluded that there is sufficient provision of advanced services to meet the needs of the residents of Havering.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of advanced services.

### Current access to enhanced pharmacy services

**7.23** There are currently three enhanced services commissioned by the London region of NHSE&I. These are the London Seasonal Influenza Vaccination Service, the Bank Holiday Rota Service (provided by two pharmacies) and the COVID-19 Vaccination Service (delivered by three pharmacies). These are commissioned as and when required.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of advanced services.

### Current access to other NHS services

**7.24** Other NHS services are other services commissioned by the London Borough Havering, or the Barking and Dagenham, Havering, and Redbridge Clinical Commissioning Group. Pharmacies are commissioned to deliver these services to fulfil the specific health and wellbeing of the Havering population. Enhanced services include needle exchange, supervised consumption, emergency hormonal contraception, community anticoagulation service and end of life care medication provision.

**7.25** Six pharmacies offer the needle exchange service, 16 offer supervised consumption, emergency hormonal contraception is available from two pharmacies while eight offer anticoagulation services.

**7.26** Three pharmacies offer End of Life Care medicines and its accompanying out-of-hours dispensing service.

**7.27** Overall, there is very good availability of the enhanced services in the borough.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the provision of other NHS services.

# Future Provision

**7.28** The Health and Wellbeing Board has considered the following future developments:

- Forecasted population growth
- Housing Development information
- Regeneration projects
- Changes in the provision of health and social care services
- Other changes to the demand for services

## Future access to essential services

### *Future access to essential services during normal working hours*

**7.29** The Health and Wellbeing Board is not aware of any firm plans for changes in the provision of Health and Social Care services. The HWB is aware of and has considered the proposed new housing developments within Thames Gateway regeneration in South Hornchurch and the Romford Town Centre.

**7.30** The HWB has carefully considered these developments, and other causes of population increases and conclude that pharmacy provision is well placed within Buckinghamshire during the lifetime of this PNA. There is enough choice in pharmacy providers and to support any changing needs of the Havering community.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of essential services during normal working hours.

### *Future access to essential services outside normal working hours*

**7.31** The Health and Wellbeing Board is not aware of any notifications to change the supplementary opening hours for pharmacies at the time of publication.

**7.32** Pharmacy provision outside normal working hours is well placed within locations of planned new dwelling housing developments and projected population increases.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of essential services outside of normal working hours.

### Future access to advanced services

**7.33** Through the contractor survey local pharmacies have indicated that they have capacity for future increases in demand for advanced services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of advanced services.

### Future access to enhanced services

**7.34** These are commissioned as and when required. Through the contractor survey, local pharmacies have indicated that they have capacity for future increases in demand for enhanced services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of enhanced services.

### Future access to other NHS services

**7.35** Through the contractor survey local pharmacies have indicated that they have capacity and future increases in demand for other NHS services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of other NHS services.

## Improvements and better access

### Current and future access to essential services

**7.36** In consideration of population health and wellbeing needs and needs of those who share protected characteristics the PNA did not identify any services, that if provided either now or in future would secure improvements or better access to essential services. Further, there is sufficient capacity to meet any increased future demand.

The Health and Wellbeing Board identified no gaps in essential services that if provided, either now or in the future, would secure improvements or better access to essential services.

### Current and future access to advanced services

**7.37** NMS, CPCS and flu vaccination services are all widely available throughout the borough.

**7.38** There is no data available publicly for the relatively new services namely community pharmacy blood pressure service and hepatitis C antibody testing service but there is sufficient capacity for pharmacies to provide these.

**7.39** There is good availability of SAC provision. SACs and AURs are also offered by hospital and other healthcare providers.

The Health and Wellbeing Board did not identify any gaps in the provision of advanced services at present or in the future, that would secure improvements or better access to advanced services.

### Current and future access to enhanced services

**7.40** These are commissioned as and when required. The PNA did not identify any services, that if provided either now or in future would secure improvements or better access to the enhanced services offered. Through the contractor survey local pharmacies have indicated that they have capacity for future increases in demand for enhanced services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no services that if provided would secure improvements or better access to enhanced services.

### Current and future access to other NHS services

**7.41** There is good provision of services commissioned by Barking and Dagenham, Havering and Redbridge CCG and Havering Council. The PNA did not find any evidence to conclude that these services should be expanded.

The Health and Wellbeing Board identified no gaps, either now or in the future, that if provided would secure improvements or better access to other NHS services in the area.

# Appendix A – Steering group membership and terms of reference

## - BARKING AND DAGENHAM, HAVERING, AND REDBRIDGE PHARMACEUTICAL NEEDS ASSESSMENT STEERING GROUP

**Terms of reference**

### 1. Background

The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only), who wishes to provide NHS Pharmaceutical services, must apply to be on the Pharmaceutical List.

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and subsequent amendments set out the system for market entry. Under the Regulations, Health and Wellbeing Boards are responsible for publishing a Pharmaceutical Needs Assessment (PNA); and NHS England is responsible for considering applications.

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The PNA is used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or to provide additional services. In addition, it will provide an evidence base for future local commissioning intentions.

The Barking and Dagenham, Havering and Redbridge Health and Wellbeing Boards have now initiated the process to refresh the PNAs by 1st April 2021.

### 2. Role

The primary role of the group is to advise and develop structures and processes to support the preparation of a comprehensive, well researched, well considered, and robust PNA, building on expertise from across the local healthcare community; and managed by Healthy Dialogues Ltd.

In addition, the group is responsible for:

- Responding to formal PNA consultations from neighbouring HWBs on behalf of the Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards.

- Establishing arrangements to ensure the appropriate maintenance of the PNA, following publication, in accordance with the Regulations.

## 3. Objectives

- Ensure the new PNA meets the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and its amendments.
- Develop the PNA so that it documents all locally commissioned services, including public health services commissioned; and services commissioned by the CCG/ICS and other NHS organisations as applicable; and provides the evidence base for future local commissioning.
- Agree a project plan and ensure representation of the full range of stakeholders.
- Ensure a stakeholder and communications plan is developed to inform pre-consultation engagement and to ensure that the formal consultation meets the requirements of the Regulations.
- Ensure that the PNA, although it is a separate document, integrates, and aligns with, with both the joint strategic needs assessment and the health and wellbeing strategies of each of the boroughs as well as other key regional and national strategies.
- Ensure that the requirements for the development and content of PNAs are followed, and that the appropriate assessments are undertaken, in accordance with the Regulations. This includes documenting current and future needs for, or improvements and better access to, pharmaceutical services as will be required by the Barking and Dagenham, Havering, and Redbridge populations.
- Approve the framework for the PNA document, including determining the maps which will be included.
- Ensure that the PNA contains sufficient information to inform commissioning of enhanced services, by NHS England; and commissioning of locally commissioned services by the CCG and other local health and social care organisations.
- Ensure a robust, and timely consultation is undertaken in accordance with the Regulations; including formally considering and acting upon consultation responses and overseeing the development of the consultation report for inclusion in the final PNA.
- Consider and document the processes by which the HWB will discharge its responsibilities for maintaining the PNA.
- Comment, on behalf of the Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards, on formal PNA consultations undertaken by neighbouring HWBs
- Advise the HWB, if required, when consulted by NHS England in relation to consolidated applications.

- Document and manage potential and actual conflicts of interest.

## 4. Accountability and reporting

The Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards have delegated responsibility for the development and maintenance of the PNA; and for formally responding to consultations from neighbouring HWBs to the PNA Steering Group

The PNA steering group will be accountable to the Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards and will report on progress on a two-monthly frequency or as required by the Health and Wellbeing Board.

The pre-consultation draft and the final draft PNAs will be presented to the Health and Wellbeing Board for approval.

## 5. Membership

Membership of the group shall be:

| Name | Organisation |
|---|---|
| **Chair: Ian Diley** | **Redbridge Council** |
| Janaka Perera | NEL LPC |
| Wassim Fattahi-Negro | LB Barking and Dagenham |
| Anthony Wakhisi | LB Havering |
| Leaman Jane | LB Barking and Dagenham |
| Ashlee Mulimba | Healthy Dialogues |
| Beattie Sturrock | Redbridge Council |
| Camille Barker | Redbridge Council |
| Emily Plane | BHR CCG |
| Manisha Modhvadia | Healthwatch Barking and Dagenham |
| Ian Buckmaster | Healthwatch Havering |
| Cathy Turland | Healthwatch Redbridge |

An agreed deputy may be used where the named member of the group is unable to attend.

Other staff members / stakeholders may be invited to attend meetings for the purpose of providing advice and/or clarification to the group.

## 6. Quorum

A meeting of the group shall be regarded as quorate where there is one representative from each of the following organisations / professions:

- Chair (or nominated deputy)
- Barking and Dagenham HWB

- Havering HWB
- Redbridge HWB
- LPC
- Healthy Dialogues

## 7. Declaration of Interests

It is important that potential, and actual, conflicts of interest are managed:

- Declaration of interests will be a standing item on each PNA Steering Group agenda.
- A register of interests will be maintained and will be kept under review by the HWB.
- Where a member has a potential or actual conflict of interest for any given agenda item, they will be entitled to participate in the discussion but will not be permitted to be involved in final decision making.

## 8. Frequency of meetings

The group will meet monthly for the lifetime of this project. Meetings may be held, or decisions taken, virtually, where appropriate.

# Appendix B – Pharmacy provision within Havering and within 1 mile of border

| Borough | ODS Code | Pharmacy | Contract Type | Address | Post Code | Early Opening | Late Closing | Open on Saturday | Open on Sunday |
|---|---|---|---|---|---|---|---|---|---|
| Havering | FVE89 | Alliance Pharmacy | Community | 21 Clockhouse Lane, Collier Row, Romford | RM5 3PH | No | No | Yes | No |
| | FKD50 | Ayp Healthcare Ltd | DSP | Unit 9 Guardian Bus Ctr, Farrington Av,Harold Hill, Romford | RM3 8FD | No | No | Yes | Yes |
| | FR092 | Bencrest Chemist | Community | 67/69 Park Lane, Hornchurch | RM11 1BH | No | No | Yes | No |
| | FV092 | Boots The Chemist | Community | Unit 7, The Brewery, Waterloo Road, Romford | RM1 1AU | Yes | Yes | Yes | Yes |
| | FV600 | Boots The Chemist | Community | Unit 4, 47 Market Place, Romford | RM1 3AB | Yes | No | Yes | No |
| | FA737 | Boots UK Limited | Community | 122 Petersfield Avenue, Harold Hill, Romford | RM3 9PH | No | No | Yes | No |
| | FF297 | Boots UK Limited | Community | 12 Farnham Road, Harold Hill, Romford | RM3 8DX | No | No | Yes | No |
| | FGD64 | Boots UK Limited | Community | 12 The Liberty, Romford, Essex | RM1 3RL | No | No | Yes | Yes |
| | FW198 | Boots UK Limited | Community | 205 Station Lane, Hornchurch | RM12 6LL | No | No | Yes | No |
| | FX556 | Boots UK Limited | Community | 120-126 High Street, Hornchurch | RM12 4UL | No | No | Yes | Yes |
| | FXH36 | Boots UK Limited | Community | 57-59 Corbets Tey Road, Upminster, Essex | RM14 2AJ | No | No | Yes | No |
| | FJL00 | Bows Chemist | Community | 329 Upminster Road North, Rainham, Essex | RM13 9JR | No | No | Yes | No |
| | FE805 | Britannia Pharmacy | Community | 36 Corbets Tey Road, Upminster | RM14 2AD | No | No | Yes | No |
| | FDM09 | Britcrown Pharmacy | Community | 31 Upminster Road, Hornchurch, Essex | RM11 3UX | No | No | Yes | No |
| | FGW82 | Britcrown Pharmacy | Community | 5 Balgores Lane, Gidea Park, Romford | RM2 5JR | No | No | Yes | No |

| Borough | ODS Code | Pharmacy | Contract Type | Address | Post Code | Early Opening | Late Closing | Open on Saturday | Open on Sunday |
|---|---|---|---|---|---|---|---|---|---|
| | FTE90 | Chansons Pharmacy | Community | 6 Crown Parade, Upminster Road South, Rainham | RM13 9BD | No | No | Yes | No |
| | FFX17 | Clockhouse Pharmacy | Community | 5 Clockhouse Lane, Collier Row, Romford | RM5 3PH | Yes | Yes | Yes | Yes |
| | FGV99 | Crescent Pharmacy | Community | 65 Masefield Crescent, Gidea Park, Romford | RM3 7PB | No | No | Yes | No |
| | FC513 | Day Lewis Pharmacy | Community | 113 Rainham Road, Rainham, Essex | RM13 7QX | No | No | Yes | No |
| | FEP91 | Day Lewis Pharmacy | Community | 109 Mungo Park Road, Rainham, Essex | RM13 7PP | No | No | No | No |
| | FGA85 | Day Lewis Pharmacy | Community | Harold Hill Health Centre, Gooshays Dr, Harold Hill, Romford | RM3 9LB | Yes | Yes | Yes | No |
| | FLN08 | Day Lewis Pharmacy | Community | 143 Avon Road, Upminster, Essex | RM14 1RQ | No | No | No | No |
| | FQP07 | Day Lewis Pharmacy | Community | 52 Collier Row Lane, Romford | RM5 3BB | No | No | Yes | No |
| | FXW05 | Day Lewis Pharmacy | Community | 6 Station Parade, Broadway Elm Park, Hornchurch | RM12 5AB | No | No | Yes | No |
| | FMD27 | Elm Park Pharmacy | Community | 208-212 Elm Park Avenue, Elm Park, Hornchurch | RM12 4SD | Yes | No | Yes | No |
| | FE051 | Govani Chemists | Community | 87 Front Lane, Upminster, Essex | RM14 1XN | No | No | Yes | No |
| | FPD73 | Govani Chemists | Community | 64 Station Road, Upminster, Essex | RM14 2TD | No | No | Yes | No |
| | FA052 | Instore Pharmacy | Community | Tesco Superstore, Bridge Road, Rainham | RM13 9YZ | Yes | Yes | Yes | Yes |
| | FDT86 | Instore Pharmacy | Community | Bryant Avenue, Gallows Corner, Romford | RM3 0LL | Yes | Yes | Yes | Yes |
| | FYN65 | Instore Pharmacy | Community | Tesco Superstore, 300 Hornchurch Road, Hornchurch | RM11 1PY | Yes | Yes | Yes | Yes |
| | FA111 | Lloyds Pharmacy | Community | 1-15 The Brewery, Waterloo Road, Romford | RM1 1AU | Yes | Yes | Yes | Yes |
| | FCC42 | Lloyds Pharmacy | Community | 2 Tadworth Parade, Elm Park, Hornchurch | RM12 5AS | Yes | No | Yes | Yes |

| Borough | ODS Code | Pharmacy | Contract Type | Address | Post Code | Early Opening | Late Closing | Open on Saturday | Open on Sunday |
|---|---|---|---|---|---|---|---|---|---|
| | FN391 | Lloyds Pharmacy | Community | 12 Chase Cross Road, Collier Row, Romford | RM5 3PR | No | No | No | No |
| | FQV93 | Maylands Pharmacy | Community | 300 Upper Rainham Road, Hornchurch | RM12 4EQ | Yes | Yes | Yes | Yes |
| | FT893 | Mim Pharmacy Ltd | Community | 118 North Street, Romford | RM1 1DL | No | No | Yes | No |
| | FCN97 | Panchem (UK) Ltd | Community | 160 St Marys Lane, Upminster | RM14 3BS | No | No | Yes | Yes |
| | FTV79 | Park Lane Pharmacy | Community | Park Lane Pharmacy, 1 Park Lane, Hornchurch | RM11 1BB | No | No | Yes | No |
| | FRF15 | Pharmacare Chemist | Community | 164 Hornchurch Road, Hornchurch, Essex | RM11 1QH | No | No | Yes | No |
| | FXK72 | Rise Park Pharmacy | Community | 173 Eastern Avenue East, Rise Park, Romford | RM1 4NT | No | No | Yes | No |
| | FKK95 | Rowlands Pharmacy | Community | 3 Fairview Parade, Mawney Road, Romford | RM7 7HH | No | No | Yes | No |
| | FQD98 | Rowlands Pharmacy | Community | 100 Ardleigh Green Road, Hornchurch | RM11 2LG | No | No | No | No |
| | FGD90 | Safedale Pharmacy | Community | 197 Rush Green Road, Romford | RM7 0JR | No | No | Yes | No |
| | FN455 | Shadforth Pharmaceutical Co Ltd | Community | 266 Brentwood Road, Romford | RM2 5SU | Yes | No | Yes | No |
| | FL514 | Well Harold Wood - Station Road | Community | 7 Station Road, Harold Wood, Essex | RM3 0BP | Yes | No | Yes | No |
| | FN123 | Wh Burdess Chemist Ltd | Community | 178 Mawney Road, Romford, Essex | RM7 8BU | No | No | Yes | No |
| | FG050 | Williams Dispensing Chemist | Community | 139A Wennington Road, Rainham, Essex | RM13 9TR | No | No | Yes | No |
| Barking & Dagenham | FH672 | Andrew Bass Pharmacy | Community | 1148 Green Lane, Becontree Heath, Dagenham | RM8 1BP | No | No | Yes | No |
| | FGR47 | Asda Pharmacy | Community | Asda Superstore, Merrielands Crescent, Dagenham | RM9 6SJ | Yes | Yes | Yes | Yes |
| | FKA24 | Britannia Pharmacy | Community | 167- 169 High Road, Chadwell Heath, Romford | RM6 6NL | No | No | Yes | No |

| Borough | ODS Code | Pharmacy | Contract Type | Address | Post Code | Early Opening | Late Closing | Open on Saturday | Open on Sunday |
|---|---|---|---|---|---|---|---|---|---|
| | FQN03 | Britannia Pharmacy | Community | 420 Wood Lane, Dagenham | RM10 7FP | No | No | Yes | No |
| | FKX93 | Day Lewis Chemist | Community | 149 Broad Street, Dagenham | RM10 9HX | No | No | Yes | No |
| | FAP61 | Day Lewis Pharmacy | Community | 2 Royal Parade, Church Street, Dagenham | RM10 9XB | No | No | Yes | No |
| | FRA86 | Day Lewis Pharmacy | Community | 7 Beadles Parade, Rainham Road South, Dagenham | RM10 8YL | No | No | No | No |
| | FCE87 | Fittleworth Medical | DAC | Unit 6A Midas Bus Centre, Wantz Road, Dagenham | RM10 8PS | No | No | Yes | No |
| | FE678 | Kry-Ba Pharmacy | Community | 21 Goresbrook Road, Dagenham, Essex | RM9 6XA | No | No | Yes | No |
| | FRH15 | Lloyds Pharmacy | Community | 97-131 High Road, Chadwell Heath, Essex | RM6 6PA | Yes | Yes | Yes | Yes |
| | FWG54 | Lloyds Pharmacy | Community | 281 Wood Lane, Dagenham | RM8 3NL | No | No | Yes | No |
| | FAR43 | Mastaa-Care Pharmacy Ltd | Community | 26 Whalebone Lane South, Dagenham, Essex | RM8 1BJ | No | No | Yes | No |
| | FY843 | Oxlow Chemist | Community | 217 Oxlow Lane, Dagenham, Essex | RM10 7YA | No | No | Yes | No |
| | FJT17 | Super.Care Pharmacy + | Community | 198-200 High Road, Chadwell Heath, Romford | RM6 6LU | Yes | Yes | Yes | Yes |
| | FFX94 | Valence Pharmacy | Community | 453 Becontree Avenue, Dagenham, Essex | RM8 3UL | No | No | Yes | No |
| | FML56 | Well Chadwell Heath - Rose Lane | Community | 107 Rose Lane, Chadwell Heath, Romford | RM6 5NR | No | No | Yes | No |
| Bexley | FL579 | Harrisons Pharmacy | Community | 1 Town Square, Erith | DA8 1RE | No | No | Yes | No |
| | FA554 | Soka Blackmore Pharmacy | Community | 2 Pembroke Parade, Erith, Kent | DA8 1DB | No | No | Yes | No |
| Redbridge | FYT00 | Cordeve Ltd Dispensing Chemist | Community | 70 Chadwell Heath Lane, Chadwell Heath, Romford | RM6 4NP | No | Yes | Yes | No |
| | FMC24 | Wellbeing Pharmacy | Community | 1207 High Road, Chadwell Heath, Romford | RM6 4AL | No | No | Yes | No |

| Borough | ODS Code | Pharmacy | Contract Type | Address | Post Code | Early Opening | Late Closing | Open on Saturday | Open on Sunday |
|---|---|---|---|---|---|---|---|---|---|
| Thurrock | FF646 | Allcures Pharmacy | Community | Allcures House, Arisdale Avenue, South Ockendon | RM15 5TT | | No | No | No |
| | FKK05 | Allcures Plc | Community | Purfleet Care Centre, Tank Hill Road, Purfleet | RM19 1SX | Yes | No | No | No |
| | FQQ40 | Boots | DSP | 17 Derwent Parade, South Ockendon, Essex | RM15 5EF | Yes | No | Yes | No |
| | FTK09 | Ohms Pharmacy | Community | 32 High Street, Aveley, Essex | RM15 4AD | No | No | Yes | No |
| | FKL83 | South Road Pharmacy | Community | 1 South Road, South Ockendon, Essex | RM15 6NU | No | No | Yes | No |
| | FM809 | Well Aveley - Aveley Mc | Community | 22 High Street, Aveley | RM15 4AD | No | No | No | No |

# Appendix C – Consultation report

The table below presents a summary of the comments received during the statutory 60-day consultation period and the response from the steering group.

| Summary of comments | Response |
|---|---|
| The term 'Adequate' is subjective. | We have reviewed this again and edited the text to acknowledge the lower provision of pharmacies on Sundays (para 6.35) and highlighted that there is good provision overall during the weekend (para 7.14). 'Good' is described in paragraph 3.7. |
| Include information on 'Enhanced' services:<br>- COVID-19<br>- Bank Holiday<br>- Enhanced Flu | This has been included. |
| Services listed as enhanced are locally commissioned services and need to be labelled as such. | This has been amended. |
| Updates to openings/closures of pharmacies, times and names of pharmacies:<br>• FGD90 Asvacare Ltd t/a Safedale Pharmacy at 197 Rush Green, RM7 0JR is missing.<br>• FKD50 – Now opens on Saturdays<br>• FF297 – does not open on Sundays<br>• FGD64 – Does not open before 9am<br>• FX556 - Does not open before 9am<br>• FN391 – Does not open on Saturdays<br>• FQD98 – Does not open on Saturdays | These amendments have been made to reflect updates to pharmacy details. |
| Be clear that we have assessed Improvements or Better Access and included protected characteristics. | This has been included in 'Improvements or better access statement' in chapter 7. |
| Some of the COVID-19 services are stopping at the end of March 2022 and should therefore be noted as such on the PNA. | Text has been amended to reflect this. |
| Urban regeneration:<br>Be clear on what we took into account, i.e. housing, population projections and pharmacy can support capacity. | This has been included in Chapter 6&7. |
| Hypertension Case finding service – now called – Community Pharmacy blood pressure service | This has been amended. |
| Essential services now needs to include DMS. | This is already listed on Pg. 75 |
| The PNA does not mention GPCPS | This is called the Community Pharmacist Consultation Service Which is discussed in chapter 6&7. |
| There should be improved channels of communication including an accessible resource of pharmacies with | These comments have been feedback to the LPC. Pharmacy opening times |

| Summary of comments | Response |
|---|---|
| opening times included – available for GPs and patients to see.<br><br>There should be a map of Supervised consumption and Hepatis C Antibody Testing | can be found on https://www.nhs.uk/service-search/pharmacy/find-a-pharmacy<br><br>A map of supervised consumption is shown within the PNA. Data on Hepatis C Antibody Testing is not yet available for mapping. |
| NEL LPC will support any current contractors in offering services if a need arises as all contractors are keen to do more and are willing to do so as long as a service is commissioned | No action required |
| Update the text to reflect that data on pharmacy numbers, locations and opening times was up to April 2022 | This is updated in chapter 3 and throughout chapter 6. |
| Include narrative on how Healthy Living Pharmacies support health and behaviours in chapter 4.<br><br>Highlight that the framework covers the period up to 2024 and not the lifetime of this PNA. | Narrative on HLP has been included in Paragraph 4.29.<br>A note has been added in para 2.15 to highlight the impact of the next framework will be considered by the Health and Wellbeing Board. |

This page is intentionally left blank

Havering
LONDON BOROUGH

# HEALTH & WELLBEING BOARD

| | |
|---|---|
| **Subject Heading:** | JHWS Refresh Proposal |
| **Board Lead:** | Mark Ansell |
| **Report Author and contact details:** | Parth Pillai 01708433484 |

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

| | |
|---|---|
| ☐ | The wider determinants of health<br>• Increase employment of people with health problems or disabilities<br>• Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.<br>• Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system. |
| ☐ | Lifestyles and behaviours<br>• The prevention of obesity<br>• Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups<br>• Strengthen early years providers, schools and colleges as health improving settings |
| ☐ | The communities and places we live in<br>• Realising the benefits of regeneration for the health of local residents and the health and social care services available to them<br>• Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem. |
| ☐ | Local health and social care services<br>• Development of integrated health, housing and social care services at locality level. |
| ☐ | BHR Integrated Care Partnership Board Transformation Board<br>• Older people and frailty and end of life<br>• Long term conditions<br>• Children and young people<br>• Mental health<br>• Planned Care<br>Cancer<br>Primary Care<br>Accident and Emergency Delivery Board<br>Transforming Care Programme Board |

Havering
LONDON BOROUGH

## SUMMARY

The JHWS refresh proposal document sets out a work programme for the H&WB for the remainder of 22/23 focused on continuing to implement the existing joint health and wellbeing strategy while conducting a review to ensure it remains fit for purpose as recovery from the pandemic proceeds and the Borough Partnership begins to take the lead on improving health and care services as part of new integrated care system arrangements.

## RECOMMENDATIONS

Continuing to implement the priorities identified in the current JHWS (2019-2024) adopting a programme management approach to improve oversight and enable the Board to intervene sooner should obstacles arise.

Clarifying the Board's relationship with the newly established Havering Borough Partnership, which may be better placed to lead the response to a number of priorities identified in the current JHWS.

Preparing to refresh the JHWS to reflect:

- progress made thus far with priorities in the existing strategy, new insight from the JSNA, the continuing impact of the pandemic and new challenges such as the cost of living crisis
- improved access to the views of local care professionals and residents and patients afforded by the Borough Partnership.

## REPORT DETAIL

See attached paper

## IMPLICATIONS AND RISKS

The health of residents and their experience of health and care will not improve as well as it might if the JHWS doesn't identify the right priorities and / or the H&WB doesn't work in a complementary fashion with the Borough Partnership.

## BACKGROUND PAPERS

JHWS 2022-23 Work programme paper

Havering
LONDON BOROUGH

This page is intentionally left blank

Havering
LONDON BOROUGH

# Proposed work programme for Health and Wellbeing Board 2022-2023

## 1. Background

Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which leaders from the local health and care system can work together to improve the health and wellbeing of local people.

Each Health and Wellbeing Board (HWB) has a statutory duty to produce a Joint Health and Wellbeing Strategy (JHWS) setting out its priorities to address the health and wellbeing needs of local residents as captured in its Joint Strategic Needs Assessment (JSNA).

## 2. Recommendations

The Board agrees that its 2022-23 work programme should focus on:

- Continuing to implement the priorities identified in the current JHWS (2019-2024) adopting a programme management approach to improve oversight and enable the Board to intervene sooner should obstacles arise.
- Clarifying the Board's relationship with the newly established Havering Borough Partnership, which may be better placed to lead the response to a number of priorities identified in the current JHWS.
- Preparing to refresh the JHWS.

## 3. Our Existing Priorities

As summarised below, the Havering Joint Health and Wellbeing Strategy (JHWS) 2019-2024 identifies nine cross cutting issues that span the 'four pillars' underpinning good physical and mental health that make a real impact on the lives of local people and require a collaborative effort on the part of all members of the HWB.

**1. The wider determinants of health**
- Increase employment of people with health problems or disabilities
- Develop the Council and NHS Trusts as anchor institutions[1] that consciously seek to maximise the health and wellbeing benefit to residents of everything they do.
- Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system.

**2. The communities and places we live in**
- Realising the benefits of regeneration for the health of local residents and the health and social care services available to them
- Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem.

**3. Lifestyles and behaviours**
- The prevention of obesity
- Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and by vulnerable groups
- Strengthen early years providers, schools and colleges as health improving settings.

**4. Local health and social care services**
- Development of integrated health, housing and social care services at locality level.

## 4. Ensuring delivery of the JHWS

Delivery of the JHWS is a collective responsibility of the HWB comprising Havering Council, North East London Integrated Care Systems (NEL ICS, formerly NEL CCG), Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), North East London NHS Foundation Trust (NELFT), the Voluntary and Community Sector, Healthwatch Havering and Havering Primary Care Networks (PCNs).

When the current JHWS was first adopted, it was agreed that a member of the Health and Wellbeing Board would be identified to act as SRO for each priority. They would receive management and administrative support from their own organisation. Priorities would be distributed between participants to ensure that the burden was shared and the LBH PHS would programme manage delivery of the JHWS as a whole.

The pandemic disrupted adoption of this approach. As a result, leadership of some priorities remains unclear and a programme management approach to the delivery of JHWS as a whole has still to be adopted.

In addition, integrated care systems have been created; resulting in the establishment of the Havering Borough Partnership charged with leading the integration and improvement of health and care services at ‘place’ level. As a result, the Borough Partnership may now be better placed to lead the response to a number of priorities in the JHWS.

The table below suggests the JHWS priorities that would now best sit within the remit of the Borough Partnership. Assuming the HWB agrees, it’s suggested that the HBP

is asked to confirm that it is willing to take ownership of these priorities and report back on progress at least once a year.

For the remainder, an organisational owner on the HWB has been suggested. If agreed, each owner would be expected to identify an appropriate SRO with adequate management and administrative support to enable them to devise and oversee delivery of a joint plan capturing the contribution of all partners within the HWB. All members of the HWB would be expected to contribute where they can add value and as far as their resources allow. LBH PHS will coordinate the programme as a whole ensuring the HWB is kept apprised of the status of each constituent priority through the year. As a minimum, progress regarding each individual priority will be reported to the Health and Wellbeing Board at least once a year.

| Pillar | Priority | Proposed owner or borough partnership lead |
|---|---|---|
| Wider determinants of health | Increase employment of people with health problems or disabilities | NELFT |
| | Develop the Council and NHS Trusts as anchor institutions that consciously seek to maximise the health and wellbeing benefit to residents of everything they do | BHRUHT |
| | Prevent homelessness and minimise the harm caused to those affected, particularly rough sleepers and consequent impacts on the health and social care system | Borough partnership |
| Communities and places we live in | Realising the benefits of regeneration for the health of local residents and the health and social care services available to them | LBH |
| | Targeted multidisciplinary working with people who, because of their life experiences, currently make frequent contact with a range of statutory services that are unable to fully resolve their underlying problem | Borough partnership |
| Lifestyles and behaviours | The prevention of obesity | LBH |
| | Further reduce the prevalence of smoking across the borough and particularly in disadvantaged communities and vulnerable groups | LBH |
| | Strengthen early years providers, schools and colleges as health improving settings | LBH |
| Local health and social care services | Development of integrated health, housing and social care services at locality level. | Borough partnership |

## 5. Refreshing the JHWS

A huge amount has happened since the current JHWS was adopted in 2019, not least the pandemic and the ongoing cost of living crisis. In addition, the NHS has been fundamentally reorganised with the creation of integrated care systems to foster collaboration and the adoption of a more preventative approach.

The variety of risks to the wellbeing of residents, and the renewed commitment of all partners to prevent ill-health and narrow inequalities wherever possible supports continuation of the 'four pillars' approach.

Nonetheless, the Board may wish to consider whether the current basket of priorities requires amendment to better address current risks to health and the opportunities for improvement at this time, taking advantage of the greater access to the views of local health and social care professionals and residents and patients that the development of the Havering Borough Partnership should afford.

If so, a review of the current JHWS could be undertaken in parallel with work to clarify ownership and improve implementation of the existing strategy.

## 6. The Health and Wellbeing Board work programme for 22-23.

Assuming, the HWB is in agreement with the arguments presented above, its work programme for 2022-23 will focus on:

- Continuing to implement the priorities identified in the current JHWS (2019-2024) adopting a programme management approach to improve oversight and enable the Board to intervene sooner should obstacles arise.
- Clarifying the Board's relationship with the newly established Havering Borough Partnership, which may be better placed to lead the response to a number of priorities identified in the current JHWS.
- Preparing to refresh the JHWS to reflect:-
  - progress made with priorities in the existing strategy, new insight from the JSNA, the continuing impact of the pandemic and new challenges such as the cost of living crisis
  - improved access to the views of local care professionals and residents and patients afforded by the Borough Partnership.

## 7. Upcoming Health and Wellbeing Board Meetings

- Wednesday 30th November 2022
- Wednesday 25th January 2023
- Wednesday 29th March 2023