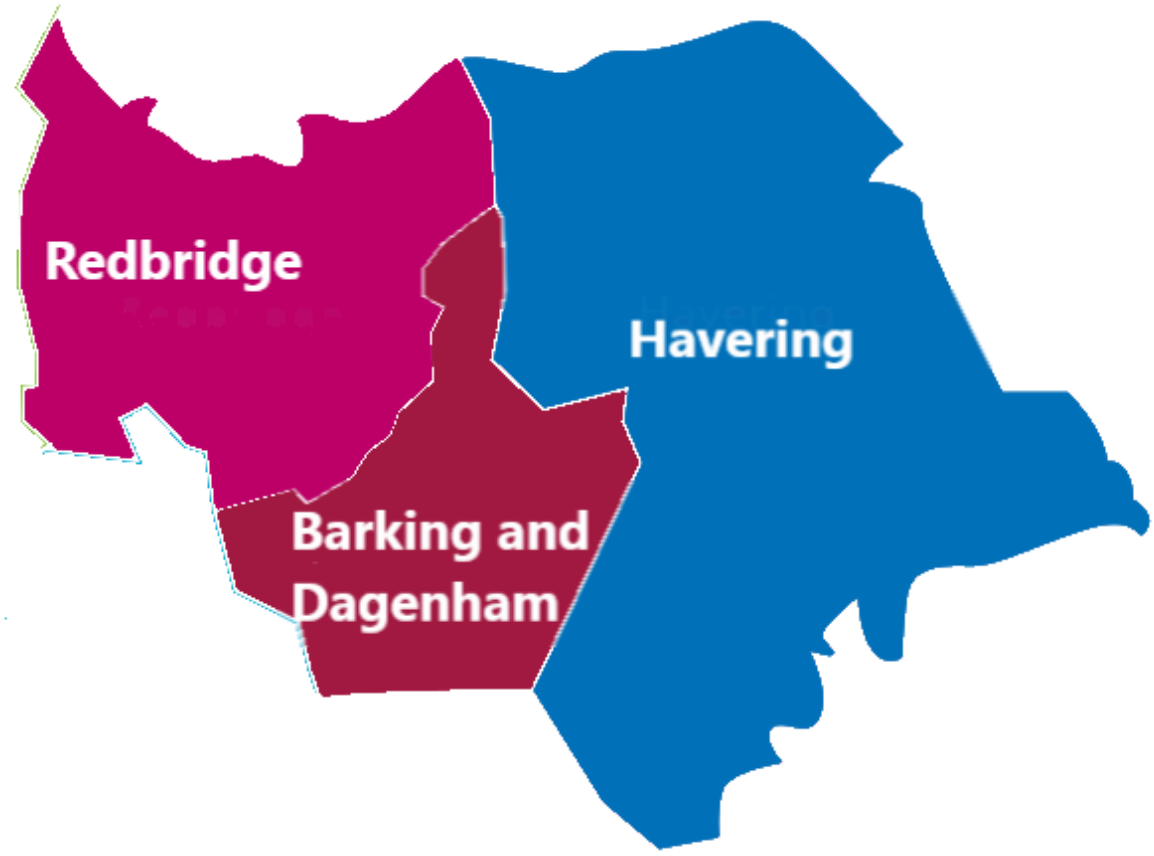
Barking & Dagenham, Havering and Redbridge Joint Strategic Needs Assessment 2020

Executive Summary and Recommendations



The **BHR JSNA 2020** is a first attempt at creating a single view of the challenges facing the partners represented at the BHR Integrated Care Partnership Board (ICPB) 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.

The differences between the three boroughs e.g. in terms of population structure, diversity, levels of disadvantage etc. are marked and are explored in the detail of the JSNA profiles. Nevertheless, the major challenges faced by the health and social care system are similar in all three boroughs and it is these overarching issues that are summarised here.

There has been significant **population growth** in all three boroughs in recent years. Even greater growth, equivalent to the population of another borough, is predicted in the next 20 years. Population increases will be particularly high in areas identified for largescale house building including Barking Riverside, Rainham, Romford and Ilford. New developments may have a significantly different (e.g. younger) demographic than the existing community. Otherwise, the existing population is projected to age; the very elderly cohort, with the most complex health and social care needs will see the greatest growth.

Life expectancy has improved steadily over the last few decades but more recently the **rate of improvement has slowed** if not stopped entirely and much of the additional years of life achieved are marred by ill-health and dependency on health and social care services. Moreover, there are **marked inequalities** in health outcomes between communities and population groups. The conditions causing most premature mortality are different to those causing the bulk of ill-health and disability.

Attaining good health for all is not in the sole gift of health and social care services. The health of future generations will be determined by the extent to which they:

- are born into loving, secure families and enter school ready to learn;
- are encouraged to aim high and achieve the best they can in school, further and higher education; to attain the qualifications and skills that will equip them for later life
- gain good employment that pays enough to enable them to participate fully in their community
- have safe, secure housing that adapts to their needs as they change through life
- live in communities that:
    - make healthier choices the easy and obvious choice
    - offer support and encouragement throughout life but particularly in times of need, including periods of physical and mental ill health and in old age
- and finally have access to high quality health and social care services proportionate to their needs.

To emphasise the many factors affecting health outcomes, the JSNA describes the needs of the BHR population in terms of **'four pillars of population health'**[1].

Population health outcomes			
The wider determinants of health	Our health behaviours and lifestyles	The places and communities in which we live	An integrated health and care system

Various studies suggest that health and social care services contribute about 25% to the overall health of the population and immense benefit to individual patients. Nonetheless, existing models of care are failing to deliver further improvements in population health and are struggling to cope with the challenge of demographic change, with much more to come. In these circumstances far greater emphasis must be placed on **prevention** in its widest sense; extending beyond traditional approaches addressing harmful lifestyles and behaviours to shape the places and communities in which we live and address the fundamental determinants of health.

Addressing the **wider determinants of health** e.g. by improving educational attainment, employment opportunities or access to a safe secure home is undoubtedly the most effective means of securing good physical and mental health in the long term.

The JSNA highlights opportunities for health and social care services to contribute directly to improve the life chances of local residents as a whole e.g. by fulfilling their role as **'anchor institutions'** at the centre of the local community and economy; as well highlighting the need to help particularly vulnerable groups e.g. patients with physical and mental illness to gain or maintain employment and a home.

The **places and communities** in which we live affects our health in a variety of ways. Currently living in cities inevitably increases exposure to **air pollution**, which causes significant harm to health. Local partners can minimise their direct contribution to air pollution; put in place the infrastructure to enable residents to switch to electric vehicles and public transport or better still walk and cycle, choosing routes that minimise their exposure to pollutants.

Plans for **regeneration** offer a unique opportunity to design in health, giving current and future residents better access to green space and community assets that build social networks and community cohesion. In addition, these plans are a means to tackle some of the problems facing the health and social care system e.g. they could deliver a step change in the quality of community and primary care facilities or provide

[1] Buck et al. A vision for population health: Towards a healthier future. Kings Fund 2018

key worker housing to attract hard to recruit health and social care professionals to live and work in BHR.

In working with residents to promote healthier **lifestyles and behaviours,** we must recognise that our day-to-day decisions are shaped by how and where we live. **Smoking** has become far less common than previously and is increasingly limited to disadvantaged communities and specific population groups (e.g. people with serious mental illness) where efforts should now be focused. More recently, **vapeing** has helped many more people to stop smoking and partners should actively encourage this trend.

However, 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, CVD, cancers and MSK problems. Obesity will not be solved by simple advice to eat more healthily; 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.

The lead agency for local action regarding the first three pillars will be Councils working with partners at borough level. NHS agencies have the opportunity to maximise the potential health benefits of relevant plans via participation in each borough's **Health and Wellbeing Board**[2].

The analysis of the challenges facing the local **health and social care system**[3] is structured around the life course.

Population growth results in additional pressure on all services. The problem is particularly acute for **maternity services**, which have finite capacity and are already close to that limit. Social disadvantage and increases in levels of maternal obesity result in a significant number of complex pregnancies. Therefore, in addition to action to improve further maternal and infant outcomes, action is needed to create additional capacity for low risk, midwife led deliveries in the community so hospital capacity can be focused on higher risk pregnancies.

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. In addition, they can identify those families that are struggling, thereby enabling **early intervention** e.g. to ensure children are ready to learn by school age or to build parental confidence regarding the management of minor childhood illness and injury.

[2] To facilitate this, the JSNA comes in three variants; each presenting a bespoke analysis for one of the constituent boroughs within the BHR system regarding the wider determinants, lifestyle related behaviours and health related aspects of place and community.

[3] The JSNA commentary provides a single analysis regarding the whole BHR health and social care system as overarching priorities and policy will be agreed for the system as a whole. In addition, data are provided at borough and locality level to inform decisions regarding how BHR policy will be implemented locally.

A small proportion of children are born with or develop significant and lifelong problems. Children with **Special Education Needs and Disability** (SEND) may need support from health, social care and education professionals. The most common type of need is mild to moderate learning disability followed by speech, language and communication needs. The needs of a subset of children are captured in an **Education, Health and Care Plan** (EHCP). Autistic Spectrum Disorder is the most common primary need identified in EHCPs. Recent changes in legislation and understandable increases in parental expectations have combined to make SEND an area of financial concern to local government. 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. Greater cooperation between boroughs may enable the creation of more specialist capacity, closer to home and at lower cost.

The mental health of children and young people (CYP) is a significant and growing concern. **Children and Adolescent Mental Health Services** (CAMHS) capacity is increasing significantly in response but even so, only a minority of CYP 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 CYP with mental health problems 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 CYP and give their parents, teachers, social workers etc. the skills and knowledge to identify and help CYP with mental health problems.

Exposure **to Adverse Childhood Experiences** (ACEs) greatly increases the risk of poor physical and mental health in later life, as well as a variety of other negative outcomes for the individual and wider society. Action to minimise exposure to ACEs and early intervene early to minimise harm when they occur must be a part of any holistic approach to prevention.

The **safeguarding** of CYP must be a priority for all partners. 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 CYP, the best option is that they be taken into care. **Looked after children** (LAC) are likely to 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 should extend beyond timely access to excellent treatment and care to include support in the longer term with housing and opportunities to gain employment e.g. in health and social care services.

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.

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 disease shows marked inequalities and there are significant opportunities to **prevent** mental illness throughout the life course. 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 be 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 **street homeless** have particularly complex problems often including concurrent mental illness and drug and alcohol dependency. A relatively small number of patients live with **serious mental illness**. 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 **IAPT** has greatly increased the provision of talking therapies but further work is needed to increase uptake 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. Alongside improvements in care, action is needed to tackle stigma; build resilience and improve awareness of effective self-help options.

Cancers, with CVD, remains the big killer. A significant proportion of all cases are caused by avoidable risk factors like smoking, obesity and alcohol and hence are essentially preventable. **Early detection** remains the key to improving survival. Further effort is needed to increase public awareness of the early signs and symptoms of cancer and increase participation in screening programmes. Additional capacity, dependent on both more equipment and professional staff, is needed to facilitate **timely diagnosis and 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.

Many people are at increased risk of developing **cardiovascular disease** (CVD) due to a combination of lifestyle and physiological risks factors. A significant proportion do not know they are at high risk of heart attacks and stroke. This despite the fact that **NHS health checks** are regularly offered to residents to identify this very risk.

This illustrates a more general observation that the number of people known to have a range of **long term conditions** (LTCs) is considerably lower than expected indicating that a large number of cases remain **undiagnosed and untreated**. Hence our approach to the identification of residents with or at risk of a range of LTCs needs to be improved; making more of NHS health checks; complemented by

community based, opportunistic interventions to engage people who don't normally attend their GP and ensuring that GPs regularly check patients with one condition for other LTCs – as they tend to share the same risk factors.

There is also strong evidence suggesting that a proportion of people with an LTC diagnosis miss out of one or more interventions that would reduce their risk of disease progression. Further improvement in the management of common LTCs is necessary to maximise the benefits of **secondary prevention**.

A small but growing proportion of residents live with **multiple LTCs**. 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.

Similarly, **frail, older people** are at high risk of admission to 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.

Taken as a whole, the current model of health care results in large numbers of A&E attendances and unplanned hospital admissions in response to both relatively minor complaints and more significant crises. In both cases, many of these contacts are avoidable. More significantly, the current model is failing to improve population health outcomes; gives patients a poor experience of care and is unviable financially. A significantly different approach to organisation and delivery of health and social care is required.

We need to make better use of information to inform **population health management** as well as the clinical management of the individual patient. 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 this cohort 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 sets out a very clear path for the redesign of services. 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 focusing less on deficits and what they need by way of services 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 being 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; involving non-professional peer support and voluntary sector input in addition to professional and statutory health and care staff will be an immediate and significant challenge for emerging locality teams.

But better management of complex patients will not of itself improve health outcomes and 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 if the far bigger group of residents with or at risk of a LTCs are all to be identified and thereafter managed in line with best practice. 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 DWP, the community and voluntary sector within the locality should be are 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[4]. Approaches such as **local area coordination** may strengthen the capacity of communities to identify and support vulnerable people and hence reduce pressure on statutory services.

Currently, many thousands of residents miss potentially lifesaving interventions such as immunisation, cancer screening or NHS health checks. Others will delay seeking help when they notice changes to their body that subsequently turn out to the early signs of cancer. Continued action is needed to improve knowledge and awareness e.g. the 'be clear on cancer' campaign and remove any barriers to engagement e.g. by offering screening and health checks outside of working hours or in the workplace.

However, people's decisions about engagement with health services and more widely regarding behaviours that affect health are not made in isolation but rather are shaped by the place where they live; prevailing cultural norms, their previous experiences and aspirations for the future.

The development of locality-based health and social care services is an opportunity to adopt a holistic approach to prevention that seeks to address **all four pillars of the population health model** throughout the life course e.g. by minimising exposure to and the harm caused by adverse childhood experiences; identifying and intervening with children at risk of arriving at school ill-equipped to learn; raising aspiration and incomes by creating apprenticeship opportunities for young people in disadvantaged communities and LAC; helping people with physical and mental health problems into work or to maintain a safe, secure home; reducing social isolation amongst older people etc.

[4] The 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.

Recommendations

From section 3. Population Health Outcomes

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

From section 4. The wider determinants of health

Recommendation 3*: 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.*
Recommendation 4: *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.*
Recommendation 5: *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[5] in addition to or instead of the tradition medical response.*
Recommendation 6: *Develop 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.*
Recommendation 7: *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.*

From Section 5. Our Health Behaviours and Lifestyles

Recommendation 8: *Focus additional efforts in disadvantaged communities and / or cohorts known to have high prevalence of smoking e.g. people with mental health problems*.
Recommendation 9*: Ensure that smokers who wish to quit can continue to access counselling support and pharmaceutical aids, including prescription only medication where clinically indicated.*

[5] https://www.kingsfund.org.uk/publications/social-prescribing

***Recommendation 10**: Actively promote vaping as a safer alternative to continuing to smoke.*
***Recommendation 11:** 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.*
***Recommendation 12**: Ensure that there is a comprehensive whole system approach to tackling obesity across BHR as a whole.*
***Recommendation 13:** Partners should work to:* • *increase participation in drug and alcohol treatment, particularly the latter.* • *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.*

From Section 6. The Places and Communities in which we live

***Recommendation 14**: Work together to minimise the direct contribution of health and social are services to air pollution; put in place the infrastructure / encourage residents to switch to electric vehicles and public transport, or better still, walk and cycle, choosing routes that minimise their exposure to pollutants.*
***Recommendation 15**: Assess the strengths and weaknesses of the overall public estate at locality level and consider the development of shared community hubs providing a range of statutory services, including health and social care, where this allows the maintenance / improvement of services.*
***Recommendation 16:** 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.*
***Recommendation 17**: Put in place processes to share learning from the healthy new town project at Barking Riverside*.
***Recommendation 18**: 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.*
***Recommendation 19:** 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 20**: 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.*

***Recommendation 21**: Consider the need for / design of additional support to build social networks and community capacity particularly in areas identified for very large housing development and / or population churn.*
***Recommendation 6:** Develop 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.*
***Recommendation 22**: Ensure that the health and social care system contributes fully to efforts to tackle violence in all its forms but particularly with regard to domestic violence and the protection of vulnerable adolescents.*

From Section 7. Integrated Health and Social Care

Maternity Services (recommendations need renumbering!)

***Recommendation 40:** Enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led continuity of carer initially prioritising those identified as most vulnerable and high risk.*
***Recommendation 41:** 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 42:** Continuously improve maternal safety including by full implementation of the second version of the Saving Babies' Lives Care Bundle and work 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 43**: 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 ??**: Review the capacity of maternity services with regard to low risk and complex pregnancies to ensure it keeps pace with recent / future population growth. (Additional recommendation)*

Children & Young People

***Recommendation 23:** Undertake a rolling programme of reviews to ensure that the capacity of universal services e.g. health visiting, community paediatrics, therapies, Speech and Language etc. within BHR is adequate given the pace and scale of CYP population growth.*
***Recommendation 24:** The Maternity and CYP Transformation boards should receive and formally respond to the BHR Child Death Review annual report each year.*

Recommendation 25: *Ensure opportunities to maximise awareness and uptake of free preschool education and childcare are taken e.g. via e-red book, regular contacts with health professionals including midwifery, health visiting and with general practice.*
Recommendation 26*: Increase joint assessments by early years settings and health visitors; ensure that anonymised aggregate data from 2 – 2 ½ year checks undertaken using the ASQ3 are available to inform health service planning and interventions to improve school readiness. HV to implement a failsafe follow up procedure to capture all children eligible for the 2 year offer*
Recommendation 27: *Use data from 2-2 ½ year checks to identify population groups and or communities at greater risk of being non-school ready and the reasons why; to inform the development and targeting of evidence based interventions to enable parents and child care staff to support children back on to a trajectory towards school readiness. Use the same data set to ensure that there is adequate provision for children with more significant problems requiring timely assessment and care from relevant specialist health care services.*
Recommendation 28*: As part of a comprehensive approach to building greater aspiration and education achievement particularly in disadvantaged and / or otherwise vulnerable groups - consider the potential contribution of health and social care providers e.g. outreach to schools and career fairs; workplace experience; apprenticeships; career paths from less skilled lower paid roles into better paid, professional health and social care roles etc.*
Recommendation 12*: Ensure that there is a comprehensive whole system approach to tackling (childhood) obesity across BHR as a whole.*
Recommendation 29: *Encourage 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 Mayor for London scheme or similar.*
Recommendation 30: *Work with schools to provide better support to pupils at risk of exclusion.*
Recommendation 31: *Put in place mechanisms to share learning from joint working between EIF and LBBD. Ensure that the outcomes from the multi-agency working around Emotional Wellbeing and Mental Health (including family interventions and targeted support for vulnerable cohorts) are taken forward.*
Recommendation 32: *Adopt a public health approach to tackling serious youth violence.*
Recommendation 33: *Review the delivery of childhood immunisation in BHR with the aim of increasing uptake to levels necessary to achieve herd immunity.*
Recommendation 34: *Work to increase delivery of 0-5 healthy child mandated checks.*
Recommendation 35: *The CYP Transformation Board should support the development of joint working in support of better CYP safeguarding as requested.*
Recommendation 36: *CYP transformation board to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews to better direct resources and options on Pan BHR commissioning to facilitate best use of scarce clinical resources.*

Recommendation 37: *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 to support children with mental health problems and their families* *- support children and their families to be more resilient*
Recommendation 54*: Ensure there are comprehensive 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 38: *Consider how health visiting, children centres and other early years providers can work together to strengthen the ability of parents to manage minor childhood illness and injury (and their confidence to do so).*
Recommendation 39: *Implement the existing plans developed to improve asthma care in BHR.*

Mental Health

Recommendation 40: *Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.*
Recommendation 41*: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience e.g. by making use of 'Every Mind Matters' resources and self-help aids giving particular consideration to groups who appear less likely to seek help e.g. LGBT and BAME residents.*
Recommendation 42*: 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.*
Recommendation 43*: Improve understanding of public perceptions of Talking Therapies and how it be can promoted and delivered to maximise participation and successful completion and thereafter improve the promotion and delivery of Talking Therapies based on this insight.*
Recommendation 44*: 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.*
Recommendation 45*: 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.*

Recommendation 46: *Improve and increase joint working between mental health services and drug and alcohol services, including use of the CPA where appropriate, to improve outcomes for patients with dual diagnosis.*
Recommendation 47: *- Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.*
Recommendation 48: *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*
Recommendation 49*: MH services should consider whether more people might benefit from a CPA and where a CPA is in place, work to improve the proportion in settled accommodation and in employment.*
Recommendation 50: *MH services; social care and housing should consider the scope to further improve the proportion of patients on the CPA in settled accommodation.*
Recommendation 51: *Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.*
Recommendation 52*: 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.*
Recommendation 53: *Improve the management of physical health of patients with SMI; ensure all get an annual health check and improve effectiveness of support available to assist with lifestyle change – starting with smoking.*
Recommendation 54*: Ensure there are comprehensive 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.*

Cancer

Recommendation 56: *Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.*
Recommendation 57*: - Continue to work to increase uptake of cervical screening by offering extended hours in general practice and bowel screening with the roll out of FIT[6] testing for diagnosing colorectal cancer.*
Recommendation 58*: Continue efforts to raise awareness of signs and symptoms of cancer with the public and healthcare professionals.*

[6] https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/faecal-immunochemical-test-fit#FIT2

***Recommendation 59**: Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)*[7]
***Recommendation 60**: Implement the national optimal cancer pathways*
***Recommendation 61:** Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways*[8] *for prostrate, breast and bowel cancer patients.*
***Recommendation 62:** Work towards a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long-Term Condition.*

Long term conditions

***Recommendation 63:** Council to work with PCNs and individual practices to increase the offer and uptake of NHS health checks.*
***Recommendation 64:** Consider if / how novel approaches to opportunistic screening in the community might serve to engage an additional cohort of patients who do not take up the offer of a health check*
***Recommendation 65:** Increase range of support options available to assist patients found to be at high risk of CVD to achieve behaviour change. Collate all available support in a resource to facilitate planning following delivery of health checks.*
***Recommendation 66:** Maximise participation by eligible patients resident in BHR in the NDPP*
***Recommendation 67:** Improve the diagnosis and management of LTCS; consider the approach employed to improve diabetes care in LBBD. Given the common risk factors for a number of LTCs, patients with an existing condition should be checked regularly for other LTCs*
***Recommendation 68:** Agree system wide arrangements for the management of complex, unstable multi-morbidity including* • *An approach to population segmentation to identify the appropriate cohort of patients* • *Consistent community provision across BHR and common pathways between primary, community and secondary care; social care and the voluntary sector Agreement and clarity of roles, enabling professionals to work at the top of their license* • *Processes to facilitate multidisciplinary working e.g. opportunity to review complex cases by a MDT*

[7] https://www.england.nhs.uk/cancer/early-diagnosis/

[8] https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf

Older people and frailty

Recommendation 69: *Maintain efforts to further increase the completeness of dementia diagnosis and the information and support available to patients and their families*
Recommendation 70: *Ensure the BHR Falls prevention pathway currently in development is consistent with national guidance and effectively implemented.*
Recommendation 71: *Ensure that the BHR Older People and Frailty Prevention offer currently in development is comprehensive, addressing socio-economic and behavioural risk factors and the early identification and management of modifiable conditions*
Recommendation 72: *Ensure that patients at risk of frailty are systematically identified; effectively supported to stay well; and receive urgent additional help in times of crisis.*
Recommendation 73: *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.*
Recommendation 74: *Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.*
Recommendation 75: *Strengthen end of life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.*