LONDON BOROUGH OF HAVERING EQUALITY ANALYSIS

HEALTH AND WELLBEING STRATEGY

SCOPE OF PROPOSAL

1. What is the scope and intended outcomes of the activity being assessed; in terms of both the Council's organisation and staffing, and services to the community?

1 (a) Organisation and Staffing

The Health and Wellbeing Strategy is an overarching document that reflects on recent changes in legislation and builds on existing plans to improve the health and wellbeing for local residents, including employees who live locally.

The main objectives of the strategy are to:

- Raise public awareness and understanding of health and risks to health
- Reduce health inequalities, and
- Improve health outcomes and quality of life

Underpinning the strategy is our recognition that people in Havering should be well informed and in control of decisions affecting them, and our ambition to empower them to be as healthy and independent as possible for as long as possible.

The strategy will also:

- Drive and inform the development of commissioning within local areas, and
- Improve partnership working and increase coordination between Health and Social Care services.

The strategy and its corresponding Action Plans will ensure that the health of all residents improves and those with the worst health benefit the most.

1 (b) Services to the Community

The Health and Wellbeing Strategy reflects on recent changes in legislation and builds on existing plans to improve the health and wellbeing for local residents, including employees who live locally.

The main objectives of the strategy are to:

- Raise public awareness and understanding of health and risks to health;
- Reduce health inequalities, and
- Improve health outcomes and quality of life.

The Health and Wellbeing Strategy is informed by the 2011/12 Joint Strategic Needs Assessment (JSNA). The JSNA is a statement of population needs and assets in Havering, based on a collection of datasets and information. The JSNA takes a population based approach, so would consider all of Havering's population including Havering staff members who live and/or work locally.

The priorities identified in the Health and Wellbeing Strategy are drawn from the 2011/12 JSNA and are consistent with the areas flagged as 'high risk', 'red risk' or poor performance areas in the three relevant outcome frameworks: the Public Health Outcomes Framework, the NHS Outcomes Framework, and the Adult Social Care Outcomes Framework. For further information, please refer to *Appendix 1 (Outcomes Framework Performance)*.

The eight key priority areas are:

1) Early help for vulnerable people in the community
2) Dementia – improved identification and support
3) Early detection of cancer
4) Tackling obesity
5) Frail elderly – more integrated care
6) Focusing on vulnerable/high risk children
7) Reducing avoidable hospital admissions
8) Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

In addition, the strategy aims to tackle health inequalities and improve information and community engagement. Underpinning the strategy is also our recognition that people should be in control of decisions affecting them, be informed and take personal responsibility such as self-care, use of direct payments, etc.

Our plans will ensure that the health of all residents improves and those with the worst health benefit the most.

PEOPLE AFFECTED

2. Which individuals and groups are likely to be affected by the activity?

2 (a) Staff Individuals and Groups

The strategy aims to improve the health and wellbeing of local residents, including staff members who live locally (currently, over 70% of the workforce).

For further information, please refer to 2(b).

2 (b) Community Individuals and Groups

The aim of this strategy is to ensure that the health and wellbeing of all residents improves and those with the worst health benefit the most. Amongst the groups that would benefit the most would be vulnerable adults and children at high risk, older people, service users with Dementia, and people who have or are at risk of cancer.

For further information, please refer to Table 2 in point 5(b).

DATA AND INFORMATION

3. What data/information do you have about the people with 'protected characteristics' *(age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation)* or **other socio-economic disadvantage** *(e.g. disabled and part-time workers, low income and/or lone parents (mothers and fathers), looked-after children, other vulnerable children, families and adults)* **among these individuals and groups? What information do you have about how they will be affected by the activity? Will you be seeking further information in order to assess the equalities impact of the activity? How is this information being used to influence decisions on the activity?**

3 (a) Staff

Over 70% of LBH staff members live in Havering and are considered as part of the community. For further information, please refer to 3(b).

3 (b) Community

When developing the Health and Wellbeing Strategy, we have taken into account Havering's 2012 demographic and socio-economic profile as well as the 2011/12 JSNA findings.

Some of the major trends in the Borough are:

- It is estimated that around 236,100 people currently live in Havering. Havering's population is predicted to rise up to: 246,900 people by 2016 and 267,600 people by 2026.
- Of Havering's population, 52% are female and 48% are male. The percentage of women in Havering is slightly above the average for London (50%) and England (51%). The greater number of females than males in Havering's population may in part be explained by the longer life expectancy of females.
- The Borough predominately has a white population and the ethnic minority population is 11.4%. This percentage is well below the London average and slightly below the average for England. The school census reported that nearly 23% of school pupils in Havering were from non-White ethnic

groups in 2011, with the most common ethnic group being Black or Black British (9%).

- Around 23% of the population in Havering is aged 0-19. This percentage is roughly average for England (14%). Just below 18% of the population are aged 65 and over. This percentage is above the average for London (11.5%) and for England (16.5%).
- 17.5% of Havering's working age population have identified themselves as being disabled. 4% of people in Havering are claiming Disability Living Allowance, over 2% of which receive the Higher Rate Mobility award. Just below 18% of older people in Havering are claiming Attendance Allowance, 53% of whom receive Higher Rate award. Nearly 4% of people in Havering are claiming Incapacity Benefits, 77% of whom have been Incapacity Benefits claimants for five or more years.
- Over three quarters (76%) of Havering's population stated that they are Christian, followed by 13% with no religion and just below 8% who preferred no to state their religion. Other religions in the borough are: Hindu (0.77%), Sikh (0.42%), Buddhist (0.18), Muslim (0.8%), Jewish (0.5%). Just below 40% of people with no religion are White British or White other.
- There are pockets of deprivation in Havering, with two small areas (an area in Gooshays and an area in South Hornchurch) falling into the 10% most deprived areas in England, and 11 small areas in Havering falling into the 20% most deprived areas in England. Overall, Gooshays remains the most deprived ward in Havering.
- Female life expectancy in Havering (83.4) remains higher than male life expectancy (78.8), which is in line with the national trends. Longer life expectancies may result in increased burden of disease if extended survival is accompanied by longer average period of morbidity.
- Female disability free life expectancy in Havering (65.6) is higher than male disability free life expectancy (63.4). However, disability free life expectancy rates are slightly higher than London and national trends.
- There is a 4.2 year difference in the life expectancy of women living in the most advantaged and disadvantaged parts of the borough. The inequality in male life expectancy is 6.9 years.
- Population ageing and increases in the older old (ages over 80) is contributing to increases in diseases, and in mortality and hospitalisations resulting from illnesses of the frail elderly e.g. pneumonia and bronchitis.
- Due to the older age profile of the borough, relatively large numbers of residents live with long term health conditions including cardiovascular disease (heart attack, stroke, heart failure etc), respiratory disease (emphysema, bronchitis etc), dementia and osteoporosis (which increases the risk of serious fractures due to falls). The likelihood of most if not all of these conditions increases with age. Thus the number of people needing support from health and social care services will increase as the population continues to grow and age.

- There are new illness patterns among the population relating to ethnicity (e.g. increased sickle cell anaemia), sexual orientation (e.g. higher rates of breast cancer amongst gay women) and other equality groups.
- Many people are diagnosed with cancer each year and short term survival is poor. Large sections of the population have lifestyles and behaviours such as smoking, obesity, poor diet and harmful alcohol consumption that increase the risk of long term conditions and cancer.
- Health services are the top priority for local people in making the Borough a nice place to live, followed by the level of crime and clean streets.

The priorities in the Health and Wellbeing Strategy are drawn by the 2011/12 Joint Strategic Needs Assessment (JSNA). The JSNA is a statement of population needs and assets in Havering, based on a collection of datasets and information. The JSNA takes a population based approach, so would consider all of Havering's population including Havering staff members who live and/or work locally.

The 2011/12 JSNA includes:

1) JSNA chapters on specific topics: CVD, dementia, cancer, domestic violence, obesity, smoking, breastfeeding, demographics, vulnerable adults and older people, vulnerable children and younger people and keeping people out of hospital.
2) JSNA datasets on Havering Data Intelligence Hub: a range of datasets about the health and wellbeing of Havering residents.

Table 1: Main findings from the 2011/12 JSNA

Priorities	Evidence
Early help for vulnerable people to live independently for longer	- There are currently estimated to be 39,000 Havering residents with one or more long term conditions. Demographic change will result in still greater numbers. - Nationally, those with long term conditions are the most intensive users, accounting for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. - 1,200 older people in Havering have particularly complex health and social care needs. Around 900 of this group account for 38% of all emergency bed days. - The prevalence of long term conditions varies in the same way as life expectancy with poorer health outcomes in more disadvantaged areas. - The number of people recorded as having long term conditions on GP disease registers is significantly below the number expected, given the results of national population surveys. This suggests that many people with long term conditions remain undiagnosed and are therefore not benefitting from treatments which could improve their wellbeing and slow disease progression.

Priorities	Evidence
Improved identification and support for people with Dementia	- It is currently predicted that there are approximately 3,101 people with dementia in Havering, although this is predicted to rise by more than 50% in the next 20 years as the population ages still further. However, most recent records indicate that there are approximately 1,015 patients registered with NHS Outer North East London as having some form of dementia, thereby resulting in an estimated under-diagnosis of around 65%. - At any one time, about a quarter of all inpatients at Queens' Hospital have dementia, often un-diagnosed, complicating their management and discharge planning and resulting in longer lengths of stay. - The bulk of care for dementia patients, particularly for the undiagnosed, is provided by family and friends. In 2001, more than 1 in 10 Havering residents identified themselves as a carer; the highest proportion of any borough in London. The majority of care tends to be provided by a spouse or partner, meaning that they are often elderly and experience poor health themselves.
Early detection of cancer	- About 1200 local residents (1 in every 200) are diagnosed with some form of cancer each year and more than 600 die of the disease. - More than 40% of all cancer cases are attributable to avoidable risk factors. - Cancer survival is a particular priority locally as short term (one year after diagnosis) cancer survival in Havering (64.2%) has not improved in recent years and is now significantly worse than the England average (66.5%). - If survival rates for breast, colorectal and lung cancer could be improved to the level achieved in the best performing PCTs in the country, 61 deaths would be avoided in Havering each year.
Tackling obesity	- There are proportionally more obese adults in Havering (26%) than in London (21%) or England (24%) as a whole. - 1 in 5 children in Havering are obese by age 11 which is similar to the national average. 12% are obese by age 5 which is significantly higher than the national average of 10%. - Obesity rates are particularly high in Harold Hill and South Hornchurch. - Most people in Havering are not getting enough physical activity to benefit their health, and many struggle to eat healthily. - High rates of breast feeding are associated with lower levels of obesity, but rates of breastfeeding in Havering are very low.
Better integrated care for the 'frail elderly' population	Currently, 36% of Havering's population are aged 50+ (85,999 people), of which 21% are of retirement age (60+ females, 65+ males; 49,122 people). Women of retirement age are almost twice as many (17,372 people) than men of retirement age (31,750 people).

Priorities	Evidence
	Some of these people have long term conditions or support needs: - Nearly 15,000 older residents are estimated to be unable to manage at least one self care task on their own, and more than 18,000 are estimated to be unable to manage at least one domestic task on their own (e.g. shopping, washing etc). - It is estimated that 3,760 older people have depression, which is predicted to increase to 4,146 by 2020. - 16,300 older Havering are estimated to be living along, which is predicted to increase to 17,948 by 2020. - More than 1,100 residents are registered as being blind or partially sighted in Havering. - There are around 140 excess winter deaths annually among Havering residents, many of whom are vulnerable older people - More than 1,200 Havering residents are admitted to hospital annually as a result of a fall. - St Francis' hospice end of life care services were used nearly 19,000 times by Havering residents in 2010/11 and demand for services is increasing. - In 2011, there were approximately 560 users of learning disability services in Havering (of all ages), of which around 70 were aged 60+. - It is estimated that 3,760 people aged 65+ in Havering have depression**.** This is estimated to increase to 3,925 by 2015 and 4,146 by 2020. - It is estimated that around 3,050 older people in Havering have dementia, which is predicted to rise to 4,691 by 2030. - There are estimated to be 5,276 older residents with diabetes. - Recent research estimates there to be 39,000 Havering residents with one or more long term conditions. Of these, the number of older people (age 65+) in Havering with long term conditions is estimated at 18,600 where 1,200 older people have particularly complex health and social care needs. Around 900 of these 1,200 people account for 38% of all emergency bed days. - The Indices of Multiple Deprivation for Older People 2010 (IDAOPI) show that in 10.1% of small areas in Havering, older people are within the 20% most deprived nationally (15 small areas across the Borough) and in 1.3% of small areas in Havering, older people are within the 10% most deprived nationally (2 small areas across the Borough). - It is estimated that 16,300 Havering residents aged 65+ are living alone in 2012. This is predicted to increase to 17,948 older people living alone by 2020. Older people living alone can be an indicator of social isolation and may require more support from health and social care services. - It is estimated that in 2012, 4,752 Havering residents aged 65+ are providing unpaid care. It is estimated that this will rise to 5,005 by 2015.

Priorities	Evidence
Better integrated care for vulnerable children (high risk children)	A number of factors may indicate increased vulnerability: - Disadvantage - 20% of children live in poverty; two small areas of Havering falling into the 10% most deprived areas in England (an area in Gooshays and an area in South Hornchurch), and 11 small areas in Havering falling into the 20% most deprived areas in England. - Child protection issues - there are lower numbers of children on child protection plans or in the care of the Council, than many areas of London, but high numbers of referrals to children's social care which do not meet child protection thresholds (avg. 66%). - Family issues - of the 30,000 families in Havering; about 400 are categorised as 'families with multiple complex needs' and over 2000 are 'barely coping '. Of the 400 that are 'families with multiple complex needs', a significant proportion will reach a level of need where they require expensive specialist or statutory services. - Lone-parent families - 27% of children in Havering live in lone-parent families. - Looked after children - There were 183 looked after children in Havering in 2011/12, equating to 36 looked after children for every 10,000 population aged under 18 years. In 2011/12, 80.4% of looked after children were White British, with White and Black Caribbean (4.7%) and other mixed backgrounds (3.9%) representing the second and third largest ethnic groups. There are significantly more male children in care in Havering than female – in 2011/12 61.4% of looked after children were male, compared to 38.6% female children. - Teenage conceptions and sexual health – rates of conception among teenage girls (under 18 years) remain lower than the average for both England and London but have not improved in recent years and therefore the advantage over England has decreased overtime. The rate of conceptions among girls aged under 16 years is higher than that in England as a whole and the needs of this very vulnerable group is a priority. There is an established link between deprivation and young pregnancies. Wards that have higher rates of teenage pregnancies are also the wards that generally have higher rates of deprivation and poverty: Gooshays, Rainham, Wennington, Heaton, Havering Park, and South Hornchurch. - Not in Education, Employment or Training (NEET) - the % of 16-19 year olds NEET is lower than national or London averages. - Learning disabilities – current projections suggest an overall increase of 7.5% across all categories of learning difficulties and disabilities by 2017. The most common categories of learning difficulties and disabilities are: Moderate Learning Disability (30%); Behaviour, Emotional & Social Difficulties (19%); Speech, Language and Communication Needs (17%). - Mental health - In 2009, 1,959 (5.8%) of children in Havering were reported as having conduct disorders. 1,249 (3.7%) had emotional

Priorities	Evidence
	disorders.
Reducing avoidable hospital admissions	**Emergency admissions** account for nearly two thirds of hospital bed days in England and are costly compared to other types of care. - In Havering, there were 21,214 emergency admissions in 2010/11. - Rates of emergency hospital admission in Havering are significantly lower (better) than the average for England (89.0) and London but are increasing. - A and E attendances in Havering are significantly below the national average and lowest for any borough in London. Attendance rates have also declined in recent years. **Ambulatory Care Sensitive (ACS) admissions** are a subset of all emergency admissions caused by 1 of 19 conditions that are considered to be manageable in the community i.e. without the need for hospital admission. Nationally, ACS admissions account for 1 in 6 of all emergency admissions. - In Havering during 2010/11, ACS conditions accounted for 4.9% of all hospital admissions and 15.5% of emergency hospital admissions in 2010/11. This equates to 6,728 admissions due to ACS conditions. - The main health conditions responsible for ACS admissions are chronic obstructive pulmonary disease (16.5% of all ACS conditions), influenza and pneumonia (15.1%) and dehydration and gastroenteritis (11.3%). - There are wide variations between Havering GP practices in avoidable hospital admissions, ranging from 7 per 1000 population to 32 per 1000 population. - There are pockets across the Borough with high rates of avoidable hospital admissions, however there is a cluster of high rates around Brooklands and Romford Town as well as some areas within Rainham and Wennington, Heaton, South Hornchurch and Harold Wood. - Benchmarking exercises suggest that reductions of about 20% in such admissions are possible. **Readmission rates** in Havering have risen more than 4% over the last 10 years in line with national trends. However, when emergency re-admissions are analysed by age, Havering has consistently had a significantly higher (worse) percentage of older people (aged 75+) who are re-admitted to hospital in an emergency within 28 days of discharge, compared with England. - In 2009/10, there were 2329 readmissions within 1 month of discharge for Havering residents, representing 12.1% of all patients discharged that year, compared with a national average of 11.4%. 52% of those with a long term health condition in Havering feel they have had enough support from local services or organisations in managing their condition (England 55%; London 52%).

Priorities	Evidence
Improving quality of health services to ensure that patient experience and long-term health outcomes are the best they can be	The Government has made explicit that quality of care is a national priority for the NHS and defines quality as having three dimensions. These are: • **Clinical effectiveness** – good quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes • **Patient safety** – good quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety • **Patient experience** – good quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. Organisational integrity has been identified as a fourth explicit local priority for Havering, in recognition of the serious quality and patient safety concerns that have emerged from the care provided by some of our providers. Recent Care Quality Commission (CQC) reports have identified specific concerns with our major acute care provider, BHRUT. In Havering, the two main service 'provider' organisations are Barking, Havering and Redbridge University Hospital Trust (BHRUT) for acute hospital services and North East London NHS Foundation Trust (NELFT) for community (such as district nursing) and mental health services (such as specialist help for people with acute mental health conditions). Community and mental health services are provided in clinics, hospitals and in people's own homes. In 2011, following a number of warning notices being issued to BHRUT, as well as unannounced inspections during 2010/11 and feedback from patients and the public on poor quality care, the CQC investigated the quality of care provided at the Trust and found some key areas for urgent improvement around quality and safety, particularly at Queens Hospital in Romford. Concerns were particularly raised around maternity services, A&E services, patient experience and the handling of patient complaints, as well as serious workforce and governance issues. BHRUT has begun to deliver some improvements following the CQC report, and in 2012 the CQC acknowledged that improvements have taken place in the management, culture and working practices of the Trust but that more still needed to be done. All CQC restrictions that were placed on BHRUT following identification of the quality and patient safety issues have now been lifted. BHRUT in partnership with health commissioners are working on a clinical strategy to continue to address all quality, patient experience and financial issues to ensure they are a sustainable organisation with the capability of delivering high quality patient care. Healthwatch will be the new organisation created to ensure that the voice of local patients of health and social care services and the wider community

Priorities	Evidence
	are heard on the Health and Wellbeing Board. The Council is responsible for commissioning Healthwatch and to ensure it engages with local people on the issues that matter to them about health and that this is used to affect health and social care service improvement.

CONSULTATION

4. If no data and information is available about the groups likely to be affected by the activity, how would you inform your EA? Will you be considering carrying out some consultation to inform your EA?

4 (a) Staff

A number of consultation exercises involving key stakeholders were carried out during the draft of the Health and Wellbeing Strategy.

In February 2012, a development workshop was held to discuss health and wellbeing in Havering and inform the strategy. The workshop included partners from public health, the local authority, Councillors and GP commissioners.

The objectives for the workshop were, as follows:

- Identify high level needs in Havering PCT
- Develop top line priorities and outcomes
- Commence engagement with stakeholders

Two main themes were identified at the development workshop as being crucial to improving the health and wellbeing of the population, and the quality of services commissioned for them.

Theme 1: Prevention - Keeping people healthy; early identification of people at risk; early intervention to maintain and improve wellbeing

Theme 2: Supporting those most at risk

At the health and wellbeing workshop it was agreed that there were a number of areas relating to health and wellbeing which are particularly important in Havering and which partners need to focus further actions on. These areas were informed by the 2011/12 JSNA:

1) Early help for vulnerable people in the community
2) Dementia – improved identification and support
3) Early detection of cancer
4) Tackling obesity
5) Frail elderly – more integrated care
6) Focusing on vulnerable/high risk children
7) Reducing avoidable hospital admissions

The priorities identified in the workshop were drawn from the 2011/12 JSNA and were consistent with the areas flagged as ‘high risk’, ‘red risk’ or poor performance areas in the three relevant outcome frameworks: the Public Health Outcomes Framework, the NHS Outcomes Framework, and the Adult Social Care Outcomes Framework

In addition, staff members from Havering Council and NHS Outer North East London (Havering) were consulted as part of the JSNA consultation earlier in the year.

4 (b) Community

The Joint Health and Wellbeing strategy is directly informed by the priorities identified by the Joint Strategic Needs Assessment. The evidence base for the strategy priorities was therefore built on a range of consultation groups for the JSNA chapters. These groups were identified as being affected by and having an interest in the topics considered by the chapters. This included community groups and third sector organisations representing service users.

Consultees on the JSNA chapters included:

- The Obesity Forum (Obesity Chapter)
- The Dementia Implementation Group (Dementia Chapter)
- The Children's Trust (Obesity, Domestic Violence and Breastfeeding Chapters)
- Breastfeeding Stakeholders (Breastfeeding Chapter)
- The Children's South Partnership (Domestic Violence Chapter)
- The ONEL Cardiovascular Network (CVD Chapter)
- Council Heads of Service (All Chapters)
- Havering Public Health Team (All Chapters)
- Smoking cessation stakeholders (Smoking Chapter)
- The Domestic Violence Forum (Domestic Violence Chapter)
- Havering Cancer Locality Group (Cancer Chapter)

The chapters also contain a section on "local views" to reflect community/service user views. Further information is available at the JSNA page.

As the key priorities in the Health and Wellbeing Strategy were based on the evidence coming from the 2011/12 JSNA chapters which were broadly consulted with both internal and external stakeholders a further formal consultation was not required.

In March 2012, a workshop was held with partners of the shadow Health and Wellbeing Board, which included clinical commissioners (GPs), local authority and health commissioners, elected members and other agencies with an interest in improving the health and wellbeing of local people. The workshop focused on key issues emerging from the JSNA. It also looked at the indicators contained within the three national outcomes frameworks for the NHS, public health and social care, and identified where Havering's performance was above or below the national average against these measures. From this session, the key priorities for the Health and Wellbeing Strategy emerged and were subsequently agreed at the next Health and Wellbeing Board meeting. Further to this, stakeholder engagement took place through the Integrated Care Strategy to test priorities for health and social care, most recently in June 2012.

A summary of the strategy, providing an overview of the themes, priorities and outcomes, was however made available for public comment on the Council's website from September 2012. All responses will be considered and implemented in the final draft of the strategy.

LIKELY IMPACT

5. Based on the collected data and information, what will be the likely impact of the activity on individuals and groups with protected characteristics or other socio-economic disadvantage?

5 (a) Staff

Please refer to Table 2 below.

5 (b) Community

Please refer to Table 2 below.

Table 2: Likely impact on people with protected characteristics and other disadvantaged groups

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
Early help for vulnerable people to live independently for longer	The work coming from this priority will primarily target and benefit vulnerable adults who are more likely to be: women, older people, people with physical, sensory, hearing and/or learning disabilities, people with mental health needs, people with long-term illnesses, as well as other disadvantaged groups such as: victims of domestic violence and abuse (usually women), lone parents (usually women), people on low income, single people and carers. Historically LGBT communities, certain BME groups (Gypsy, Roma and Irish Travellers, non-English speakers, refugees and asylum seekers) and people from certain religious groups (e.g. Muslim) are more likely to face barriers when accessing services and/or information about services, hence, are more likely to be disadvantaged and vulnerable. Evidence also suggests that members of these groups are also more likely to be subject to discrimination, harassment and victimisation. The Health and Wellbeing Strategy recognises that vulnerable people have specific needs and wherever possible will consider and address these in its corresponding Action Plan.
Improved identification and support for people with dementia	The work coming from this priority will potentially benefit everyone as dementia can affect people of any age. However, evidence suggests that the majority of people with dementia in Havering are predominantly white, older (70+), and that there are considerably more female dementia cases than male. People with learning disabilities are also more likely to develop dementia compared to the general population, with a significantly increased risk for people with Down's syndrome and at an earlier age. There is also evidence suggesting that people from disadvantaged groups such as older people who live alone, carers and people who live on low incomes and in deprived areas are more likely to develop dementia. It is estimated that there are a small number of people in Havering with

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	dementia who are from BME backgrounds which is representative of the demographic profile of Havering. However, with the increase of the BME communities in Havering, the potential impact on BME communities needs to be further explored. Although uncommon, dementia can also affect younger people, and their needs will differ from the older age group. It is estimated that there are currently 61 cases of early on-set dementia in Havering. There are currently gaps in data about potential relationships between dementia and sexual orientation or gender reassignment. However, the work coming from this priority will aim at engaging people from all protected characteristics, including religion, sexual orientation and transgender.
Early detection of cancer	The work coming from this priority will potentially benefit all as cancer can affect anyone, regardless of their age, gender, race, etc. However, evidence suggests that high numbers of Havering residents are diagnosed with and die from cancer each year due in part to the older population. These numbers will increase even further as the population continues to get older. Prostate, lung and bowel cancer are the most common cancers in men, whereas breast, bowel, and lung cancer are the most common cancers in women, with gay women being more likely to develop breast cancer than other women. Evidence also suggests that mortality rates of people from disadvantaged groups (people on low incomes, people living in deprived areas, etc) are much higher. There are currently gaps in data about potential relationships between cancer and: race, pregnancy, sexual orientation and gender reassignment.
Tackling obesity	The work coming from this priority will primarily target and benefit people that are (or are more likely to be) clinically obese. Certain individuals or sections of the community who are more likely to be obese include the children of obese parents or whose mother was obese during pregnancy, some people with physical and learning disabilities, older people. People with some specific learning difficulties are more susceptible to obesity. Certain physical disabilities may also increase the risk of obesity due to restrictions on physical activity. Certain ethnic groups including Black African and Black Caribbean women and South Asian populations are more at risk of the metabolic complications of excess body fat and so a lower obesity ‘cut off’ (BMI 28 kg/m2) is applicable. It is also worth noting that the risk of obesity and ethnicity may be confounded by deprivation. Rates of overweight and obesity in total are higher for men however the proportion of adults of each gender in the obese or morbidly obese category is the same. Evidence suggests that disadvantaged groups (people living on low income and in deprived areas) are less likely to live healthy lives. In addition, the built environment can have an impact on levels of obesity. For instance,

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	people living in urban areas with poor access to green spaces and sports facilities are at higher risk of obesity. This priority will partly focus on children and young people who are overweight or obese as they are much more likely to become obese adults with the increased health risks this entails. They may also experience harm during childhood or teenage years. Pre-existing asthma may be harder to control. Musculo-skeletal problems may reduce their ability to take part in sports or active play. Obese children and young people are more likely to suffer from low self esteem and be bullied, and this can cause them to take time off school which can have negative impacts on their education. Rates of childhood and teenage obesity are higher in deprived areas than in more affluent neighbourhoods. As there is clear evidence that children whose mother was obese during pregnancy are more likely to become overweight, the strategy will ensure that women who are pregnant or trying for a baby are supported to achieve a healthy weight before or after the birth. No strong evidence suggests that there is a relationship between obesity and protected characteristics such as sexual orientation, transgender or religion.
Better integrated care for the 'frail elderly' population	The demographic trends show that Havering's aging population will continue to increase steadily which would increase demand on health and social care services. The work coming from this priority will primarily target and benefit older and frail people who are more likely to have multiple disabilities (physical, sensory, hearing, learning, as well as mental health needs) and long-term illnesses. Evidence also shows that older people are more likely to be living alone, in poor conditions and/or in deprived areas. The prevalence of long term conditions varies in the same way as does life expectancy with poorer health outcomes in more disadvantaged areas. Evidence shows that older women and widows (particularly from some religious groups such as Muslim) are more likely to be frail than older men, older women are also more likely to be frail older carers. There is also evidence that older LGBT people/couples who are isolated from their families due to their 'coming out' at a later stage of their lives are at a higher risk of becoming frail. These groups of frail older people are also more likely to become victims of domestic violence, homophobic and hate crimes and abuse. Social isolation among older people is another important public health issue that is associated with poor outcomes such as increased mortality and increased susceptibility to dementia. The Health and Wellbeing Strategy recognises the current service model is both ineffective and expensive in terms of the outcomes achieved for older and frail people, and that a more coordinated and customer-care approach between health and social care services is required. The strategy will address this issue in its corresponding Action Plan. In addition, a separate Havering's Integrated Care strategy will be developed to bring together all existing provision based around prevention

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	and protecting those most at risk.
Better integrated care for vulnerable children	Our vision is for Havering to be a place where all children and young people are valued and safe; feel good about themselves and each other; get the best start to life and enjoy it to the full; have high aspirations and are given every opportunity to achieve their full potential; and are encouraged and supported to contribute positively to their community. We recognise that some children and young people living in Havering are more vulnerable than their peers and are more likely to be at high risk due to a number of factors (see Table 1 above). Therefore, we need to ensure that that such children and young people get adequate support. The work coming from this priority will focus on and benefit vulnerable and high risk children and young people. Some of the groups that we would be focusing on are: – Disabled children and young people, a high proportion of whom are with learning difficulties and have special education needs. – Children and young people who live in poverty. Evidence suggests that families that are most likely to be financially vulnerable are also more likely to have large numbers of children or be lone parents. – Children and young people who are victims of domestic violence and/or who are involved in child protection cases . – Children and young people from 'families with multiple complex needs, including lone-parent families, a significant proportion of whom require specialist or statutory services. Families with multiple complex needs are more likely to be from poorer socio-economic backgrounds. – Children in care who are more likely to be boys between 11 – 15 years. – Children and young people who affected by alcohol and/or substance misuse. – Children with mental health needs. – Young people (16-19 year olds) Not in Education, Employment or Training (NEET). These are more likely to be males than females. – Young people who generally lack confidence accessing sexual health advice, information and services. – Teenage girls (under 18 years) amongst whom rates of conception are higher than the England average. These are statistically more likely to be girls who are from deprived backgrounds. Limited data is available on the protected characteristics. Further work needs to be done to explore the relationships between each of the above factors of vulnerability/high risk and children's/young people's gender, disability, race, religion/belief and socio-economic factors accordingly. Another unexplored factor is vulnerability of LGBT young people (aged 16+). Wherever possible we will consider and address these gaps in the

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	Health and Wellbeing Strategy Action Plans.
Reducing avoidable hospital admissions	Evidence suggests the Ambulatory Care Sensitive (ACS) admissions can be reduced by 20% and this priority will target and potentially benefit everyone whose hospital admission is viewed as 'avoidable'. Although this priority will target and potentially benefit everyone whose hospital admission is viewed as 'avoidable', older people, disabled people and/or people with long-term illnesses are most likely to be subject to hospital (re-)admission. An increasing proportion of older people live alone, many carers are themselves frail older people, and fewer older people can rely on the support of an extended family living nearby. Socially isolated individuals are at risk of depression, self neglect and functional decline which can predispose to a physical health crisis and unplanned hospital admission. The primary reasons for (re-)admission of older people are: Chronic obstructive pulmonary disease (COPD), heart failure and angina, Gastroenteritis and association dehydration, preventable conditions due to the lack of immunisation and other interventions. Children are also more likely to be (re-)admitted to hospital compared to other age groups due to acute conditions or other preventable conditions, where immunisation and other interventions can prevent illness. Both children and older people can benefit from the protection afforded by immunisation. People with different types of disabilities and long-term illnesses (e.g. dementia, cancer) are also very likely to be subject to hospital admission and re-admission due to absence of a more appropriate, community-based, model of care. No strong evidence is suggesting that there is a relationship between hospital (re-)admissions and protected characteristics such as sexual orientation, transgender or religion.
Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be	Targets set shed light on groups that are likely to be impacted by this priority. This priority concerns service improvement and therefore positive impact is expected for all groups, particularly those most in need. Significant positive impact would be expected for pregnancy and maternity service users as a result of targets around improving service quality and patient safety in maternity services at Queens Hospital. Insignificant data was available to deduce whether there was any relationship between the evidence driving the need for this specific service improvement and other protected characteristics such as ethnicity, sexual orientation, transgender or religion. Actions around improving primary medical care in nursing homes and quality of care in community residential settings will positively impact older people accessing these services. Unfortunately insufficient data is available

Priorities	Likely impact on people with protected characteristics and other disadvantaged groups
	to show the ethnic distribution of the populations using these services. Commissioning of Healthwatch, the organisation that will serve as the voice of local patients of health and social care services and the wider community, will facilitate robust performance management of our providers and safe guard all populations, including the protected characteristics. Healthwatch will work to be inclusive across all 9 equality strands and ensure historically underrepresented groups views are considered and fed back into the needs assessment process. A positive impact on hard to reach groups that have historically not been as widely consulted on patient experience will therefore be possible.

6. What is the likely impact on arrangements for safeguarding children and/or safeguarding vulnerable adults?

6 (a) Vulnerable children

Please refer to table 2 above.

6 (b) Vulnerable adults

Please refer to Table 2 above.

PREVENTING DISCRIMINATION

7. If any negative impact is identified, is there a way of eliminating or minimising it to reasonable level? If not, how can the negative impact be justified?

7 (a) Staff

Staff involved in the implementation of the Health and Wellbeing Strategy and corresponding Action Plans will be fully versed on the objectives and expected outcomes of the strategy. They will also be required to:

- be aware of and comply with our duties under the Equality Act 2010 and other relevant legislation
- be sensitive to the different needs and experiences of the communities
- treat people with dignity and respect at all times
- report any discriminatory or inappropriate behaviour and escalate any concerns to their manager or another senior officer, following corporate policies and processes.

For staff members who are local residents, please refer to 7(b).

7 (b) Community

The Health and Wellbeing Strategy is an overarching and strategic document the aim of which is to ensure the health of all residents improves and those with the worst health benefit the most. We do not anticipate any direct negative impact arising from this document but recognise that there are gaps that need to be addressed (refer to Table 2) and, wherever possible, will address these gaps in the corresponding Action Plans.

PROMOTING EQUALITY

8. How will the activity help the Council fulfil its legal duty to advance equality of opportunity in the way services are provided?

8 (a) Staff

Under the Equality Act 2010 the Council has a legal duty (Public Sector Equality Duty) to: eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity; and promote good community relationships.

When carrying out their functions and services, members of staff involved in the implementation of the Health and Wellbeing Strategy and Action Plans are required to pay due regard to the Public Sector Equality Duty and consider the impact on all protected equality groups. This approach will not only ensure compliance with legislation but will also improve health outcomes and quality of life of local residents, particularly those who are vulnerable and at high risk, and equality groups who are historically more likely to face barriers when accessing services and/or information about services.

For staff members who are local residents, please refer to 8(b).

8 (b) Community

The Health and Wellbeing Strategy focuses on two key themes:

- Keeping people healthy: early identification of people at risk and early intervention to maintain and improve wellbeing (Prevention)
- Supporting those most at risk

The first theme is about ensuring that people in Havering are as healthy and independent as possible for as long as possible. We will identify key points in the life course when timely intervention can help our residents on to a healthier track, thereby improving outcomes and reducing the likelihood that they will need more intensive support from the health and social care system at a later date.

The second theme is about better targeting and coordinating the support of health and social care services on those protected groups within the population

who would benefit most from that input either because they are at very high risk or already have the poorest health and wellbeing. High quality, timely, effective, integrated care will improve outcomes and patient experience and maximise value for money.

Cross-cutting themes:

A number of common themes run through all aspects of the strategy:

- Improving the quality of care people receive and their experience of that care
- Being outcome focused and ensuring that improvements in the process of care translate into quantifiable improvements in health and wellbeing outcomes for local residents
- Working to reduce the health inequalities gap between local communities.

The main objectives of the Health and Wellbeing Strategy are:

- Raising public awareness and understanding of health and risks to health
- Reducing health inequalities, and
- Improving health outcomes and quality of life.

Our plans will ensure that the health of all residents improves and those with the worst health benefit the most. We will proactively target, communicate with and engage vulnerable people and those at high risk, and equality groups who are historically more likely to face barriers when accessing services and/or information about services.

By addressing health and wellbeing inequalities and improving people's health outcomes and quality of life, the Health and Wellbeing Strategy will ensure that Council is proactively fulfilling its Public Sector Equality Duty.

SPECIFIC NEEDS

9. What actions will you be taking in order to maximise positive impact and minimise negative impact from the activity?

9 (a) Staff

Please refer to 7(a) and 7(b)

For staff members who are local residents, please refer to 9(b).

9 (b) Community

Our plans will ensure that the health of all residents, including employees living in Havering, improves and those with the worst health benefit the most. We will proactively target, communicate with and engage vulnerable people and those at high risk, and equality groups who are historically more likely to face barriers when accessing services and/or information about services.

MONITORING AND REVIEW

10. Once implemented, how often do you intend to monitor the actual impact of the activity?

10 (a) Staff

The Health and Wellbeing Board, made up of GPs, local councillors, and healthcare professionals, as well as other commissioners of health services and patient involvement networks, will oversee the delivery of the strategy. Within the strategy are our priorities for action and each has a jointly agreed plan for how we will deliver improved outcomes for local people. The strategy will be delivered by partners of the Health and Wellbeing Board (see Appendix A for membership details of the Board). The Board is committed to ensuring that health and social care services in Havering are effective and cost-effective. Plans will be continually reviewed against the best available evidence and amended, where necessary, to ensure that the best possible outcomes are achieved within the resources available.

The metrics we will use to monitor progress regarding each of our priorities have been selected from the national NHS, social care and public health outcomes frameworks where these contain an indicator pertinent to our local priorities. In some instances, where this is not the case or where the national indicator is still in development, a local indicator has been specified. For each indicator, thresholds for adequate, good and excellent progress have been suggested to help the Health and Wellbeing Board and local residents judge performance over time.

Performance against the key actions and indicators set out in this strategy will be monitored and published every six months by the Health and Wellbeing Board, and the strategy will be critically reviewed and revised at the end of the two-year period.

10 (b) Community

Results from the 2011 ‘Your Council, Your Say’ residents survey, carried out by the Council identified health services as the top priority for local people in making the borough a good place to live. It also found that 25.3% of residents class themselves as having a ‘long standing illness or disability’.

SIGN OFF AND PUBLICATION

11. When completed, the Equality Analysis needs to be signed off by the Head of Service. Once signed off, it should be forwarded to the Directorate Equality Analysis Web administrator to publish it on the council's website.

HEAD OF SERVICE **Name:**

Date: **Signature:**