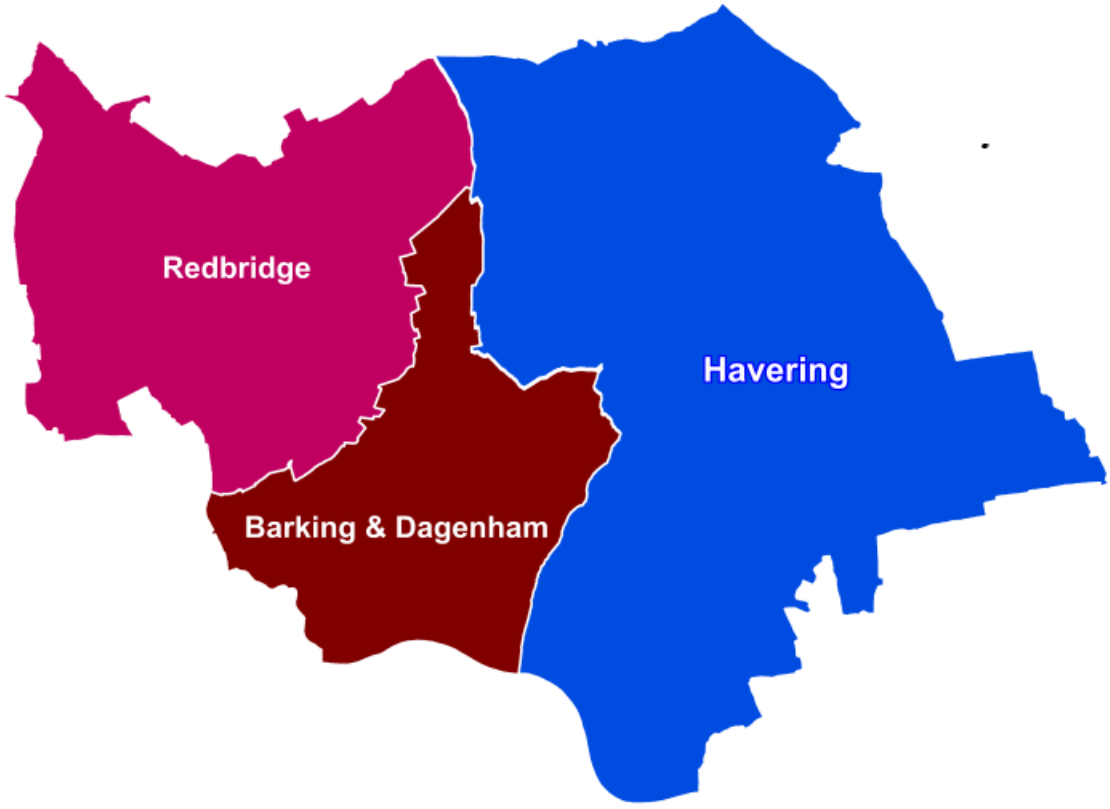
Barking & Dagenham, Havering and Redbridge Joint Strategic Needs Assessment Profiles

London Borough of Havering



September 2022

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Executive Summary

Introduction

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

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

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

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

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

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

The population of BHR

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

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

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

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

Current health outcomes of BHR residents

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

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

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

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

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

Achieving better health and narrowing inequalities.

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

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

Pillar 1: The wider determinants of health

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

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

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

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

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

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

Pillar 2: The places and communities we live in

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

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

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

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

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

Pillar 3: Lifestyles and behaviours

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

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

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

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

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

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

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

Pillar 4: The integrated health and social care system

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

Antenatal and maternity services

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

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

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

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

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

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

Health and care for children and young people

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adult mental health services

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

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

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

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

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

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

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

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

Cancer services

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

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

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

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

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

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

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

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

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

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

Long term conditions

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

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

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

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

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

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

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

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

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

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

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

Older people and frailty services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Urgent and unplanned care

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

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

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

Pillar 4: Planned (non-urgent) care

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

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

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

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

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

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

Population Health Management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The Havering Population

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

1.1 Population Size & Growth

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

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

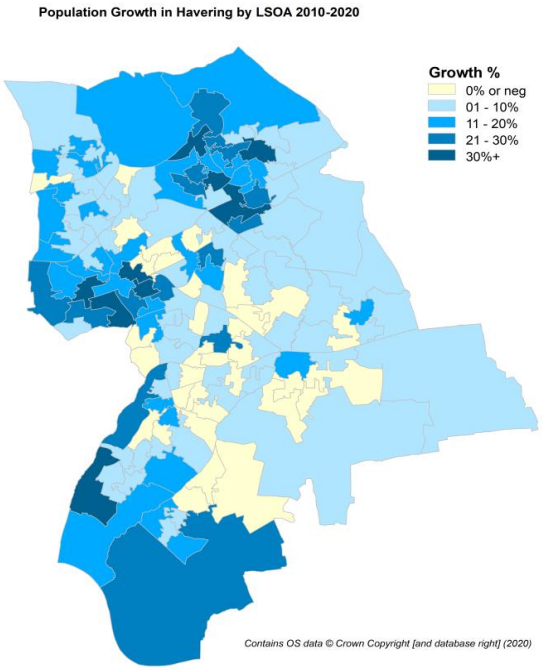
The population resident in Havering is estimated to have increased by 24K (10%) in the ten years from 2010.

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

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

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

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



Data Source: ONS 2020 Mid-Year Pop Estimates

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

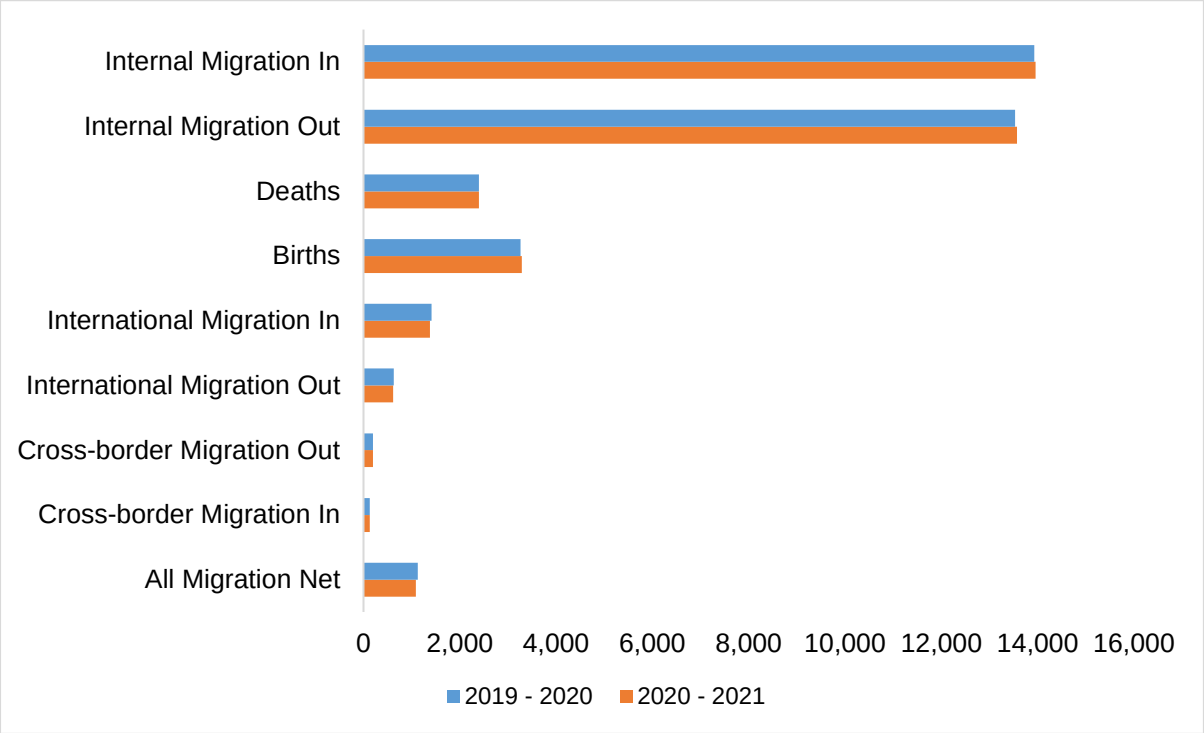
Rate of population change in Havering before the COVID-19 pandemic (2019-2020) is similar to population changes during the pandemic (2020-2021) (Fig. 2). It has been noted that nationally internal and cross-border migration may have reduced in 2020 for reasons such as difficulties in travelling to different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

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

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

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

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



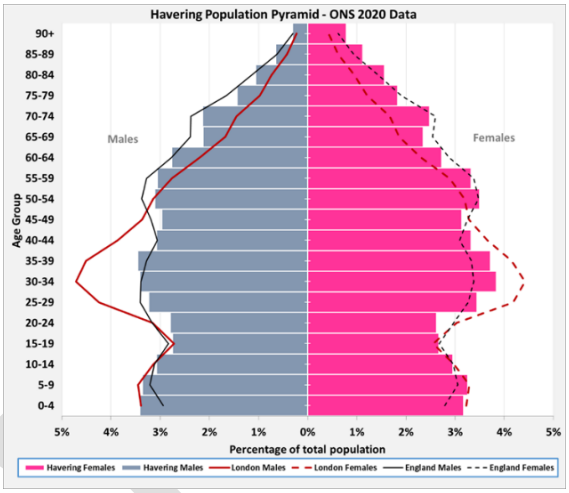
Data Source: ONS subnational population projections for England: 2018-based

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

1.3 Age Structure

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

Figure 3. Havering Population Estimates 2020



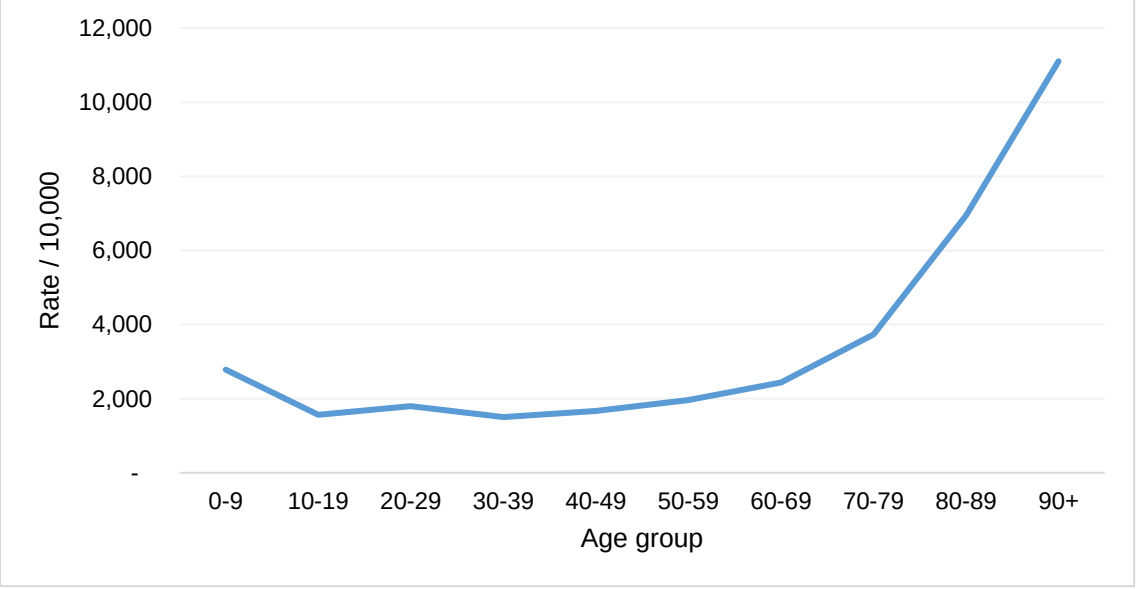
Data Source: ONS Mid-Year Population Estimates 2020

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

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

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

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



Source: NHS Digital

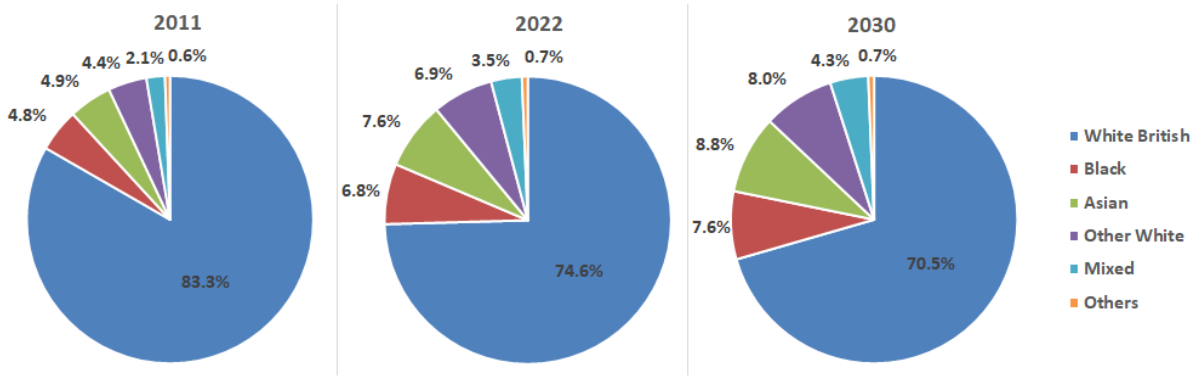
1.4 Ethnicity

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

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

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

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



Data Source: GLA Ethnic Projections

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

2. Current health outcomes of Havering residents

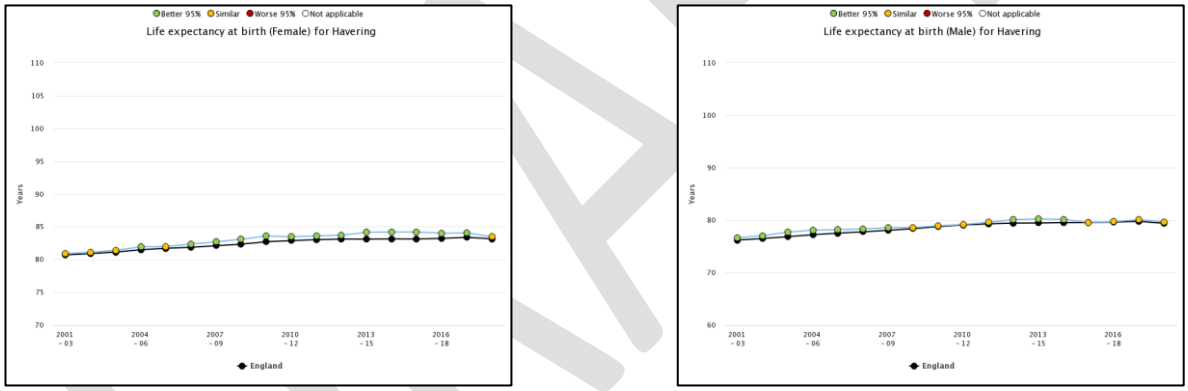
**Indicators and data used in this section can be accessed by clicking here.*

2.1 Life Expectancy

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

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

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



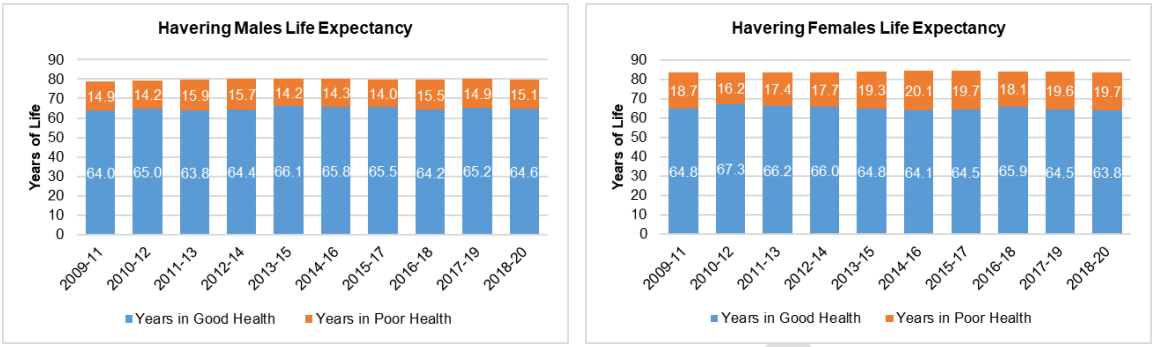
Source: PHE Fingertips

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

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

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

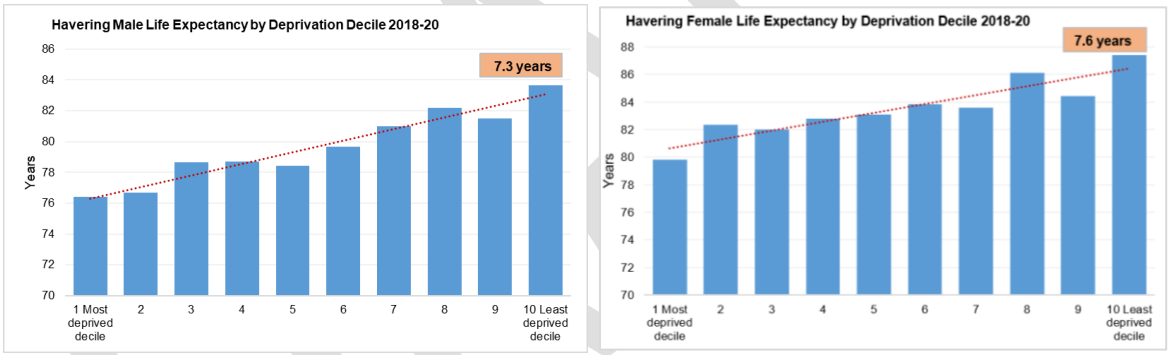
Figures 8 & 9: Havering Life expectancy 2009-11 to 2018-20



Source: Public Health England

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

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



Source: Office for Health Improvement & Disparities - Fingertips

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

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

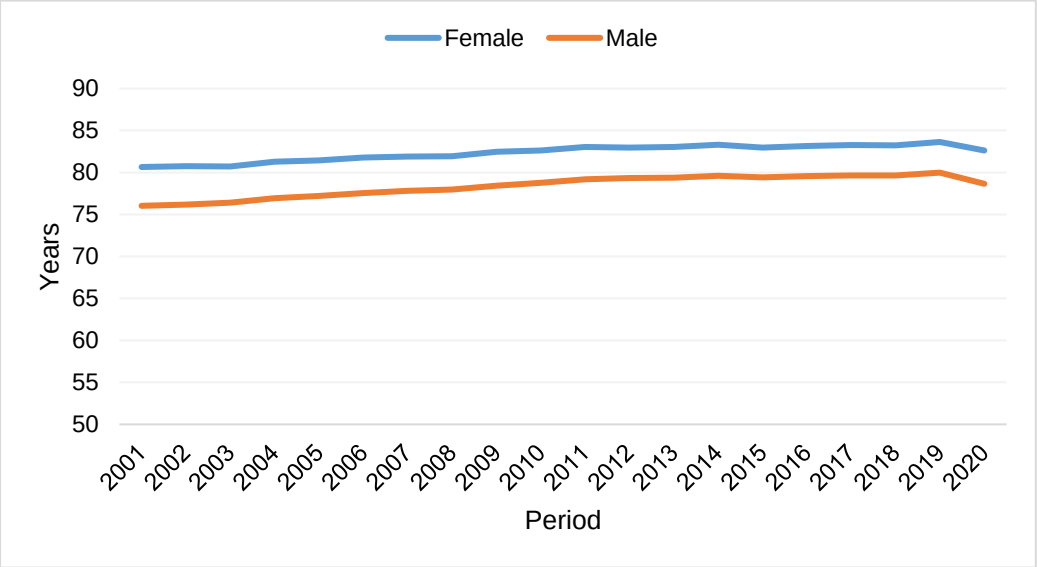
National impacts

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

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

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

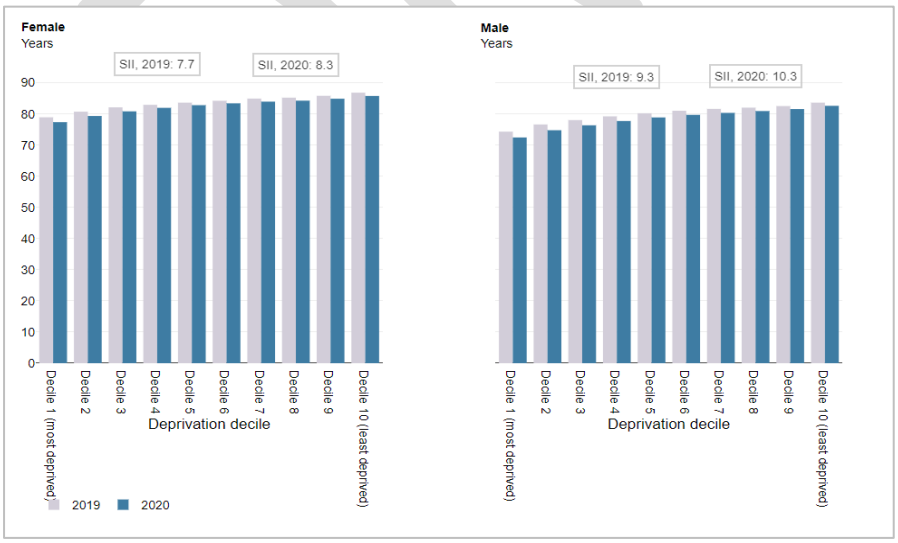
Figure 12. Life expectancy at birth, by sex, England 1981 to 2020



Source**:** Office for National Statistics

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

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



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

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

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

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

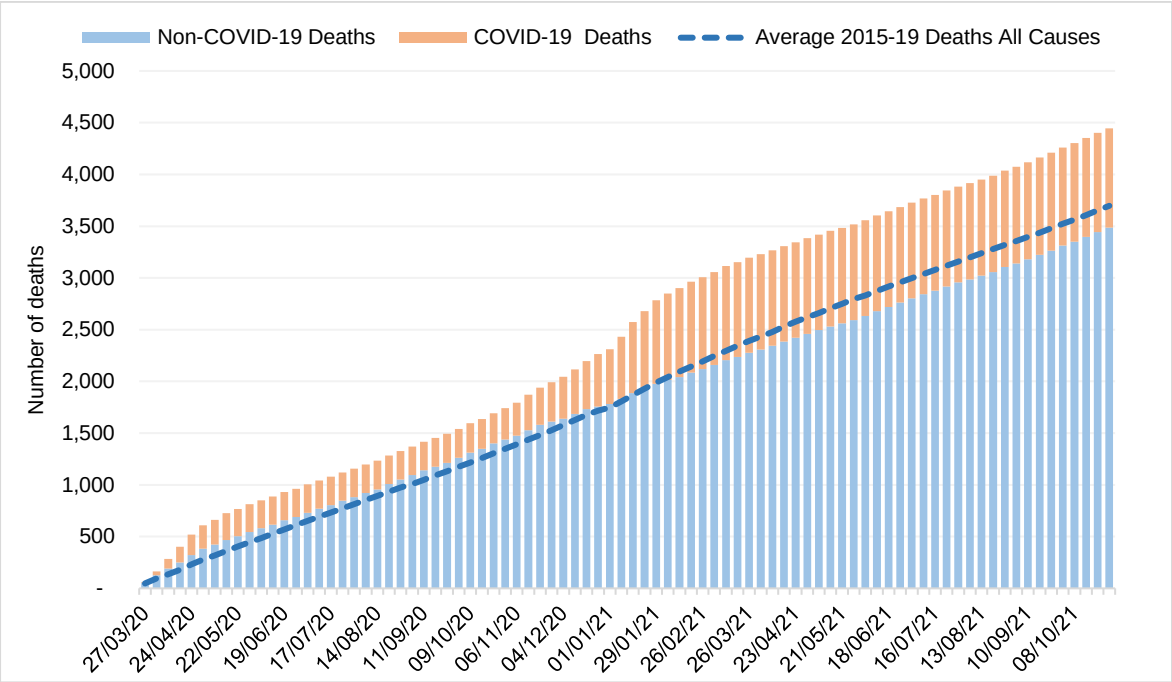
Local impacts

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

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

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

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



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

Source: ONS Deaths Register

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

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

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

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

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

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

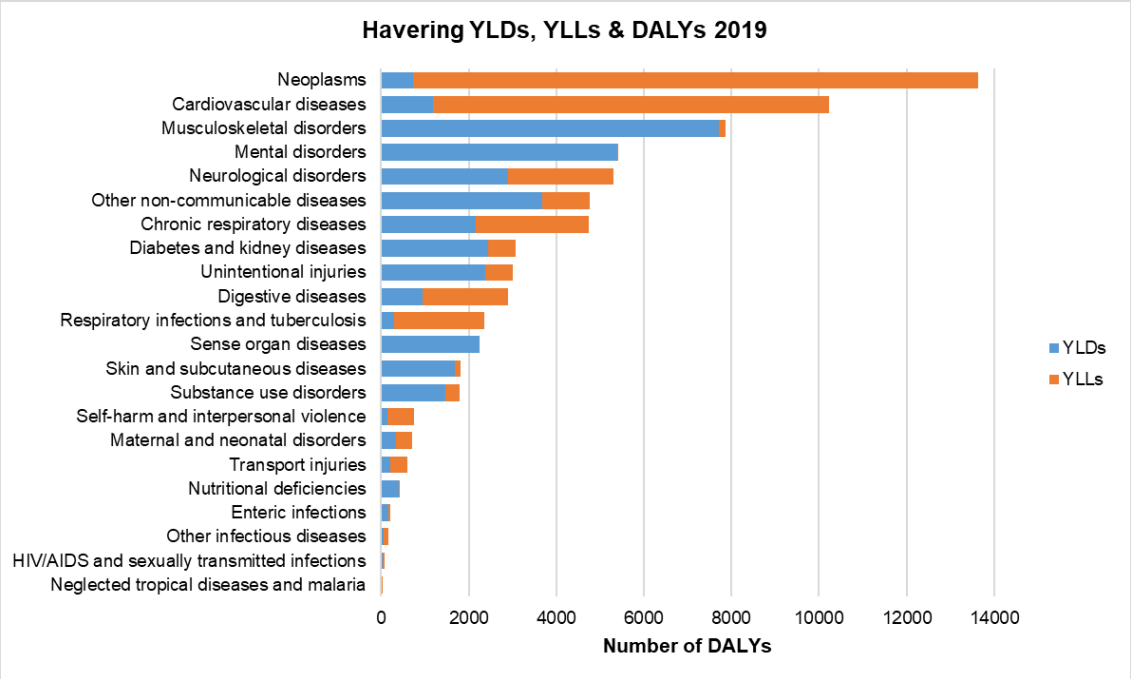
Recommendation 1: *All partners should participate in borough level H&WBs and take the opportunity to ensure there are robust plans in place regarding all four pillars of the population health model.*

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

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

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

Figure 15. Havering YLDs, YLLs & DALYs, 2019



Data Source: Global Burden of Disease, 2019

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

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

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

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

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

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

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

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

3. Pillar 1: The wider determinants of health

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

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

3.1 Income

Income affects health in a variety ways:

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

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

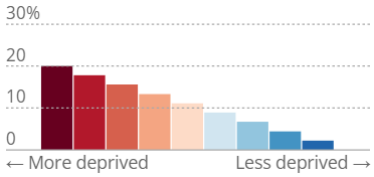
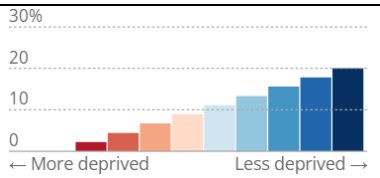
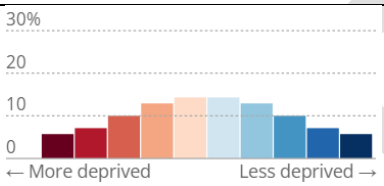
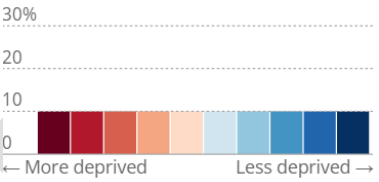
Although average pay may be modest by London standards, the proportion of adults in Havering that are income deprived[16] (10.8%) is below the national average (12.9%) and is the 8th lowest of the 32 London boroughs.

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

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

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

Table 1: ONS income deprivation profiles

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

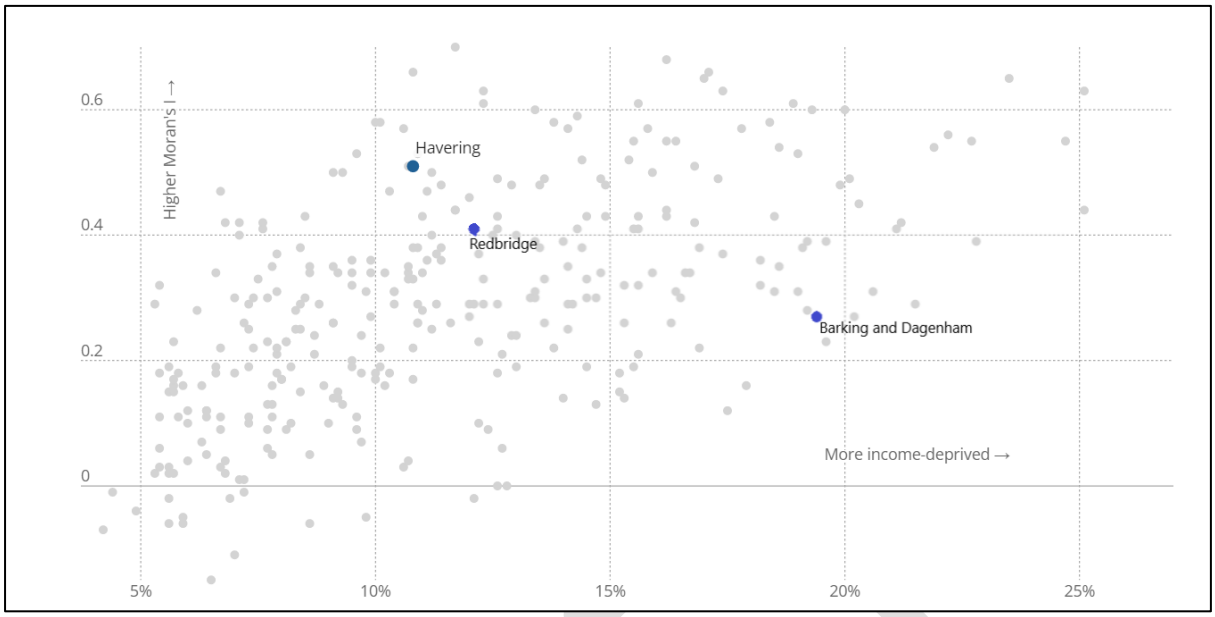
Source: Exploring local income deprivation (ons.gov.uk)

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

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

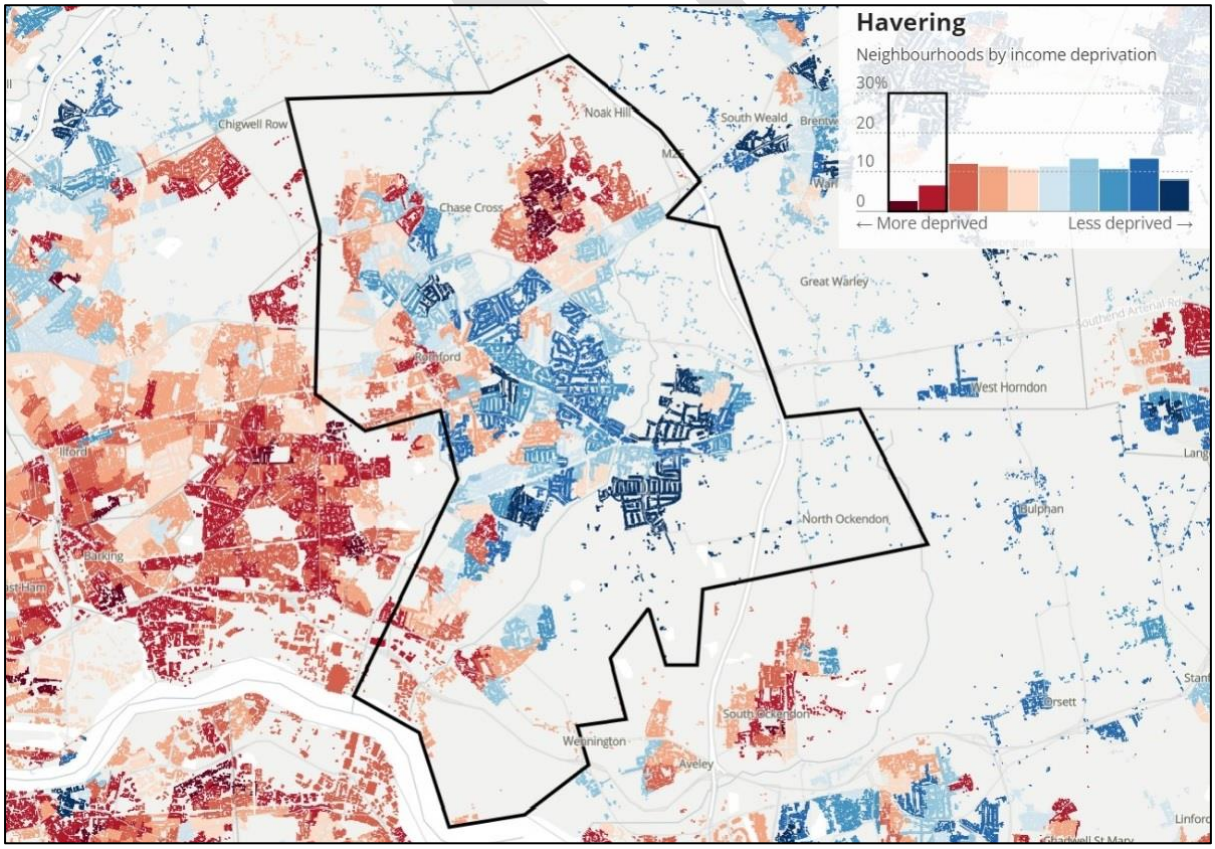
ONS use a metric called Moran's I to quantify the extent to which neighbourhoods with higher levels of income deprivation are clustered together or alternatively, distributed evenly throughout a local authority. Generally, there is an association such that authorities with high levels of overall income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

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



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

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



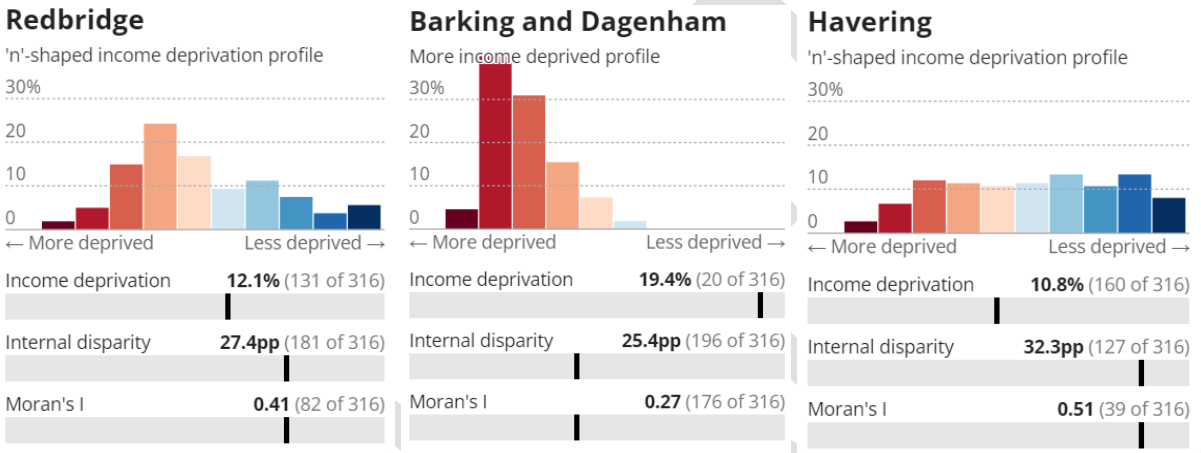
Source: Exploring local income deprivation (ons.gov.uk)

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

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

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

Figure 18 Distribution of Income Disadvantage in the three BHR Boroughs



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

3.2 Work

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

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

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

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

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

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

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

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

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

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

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

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

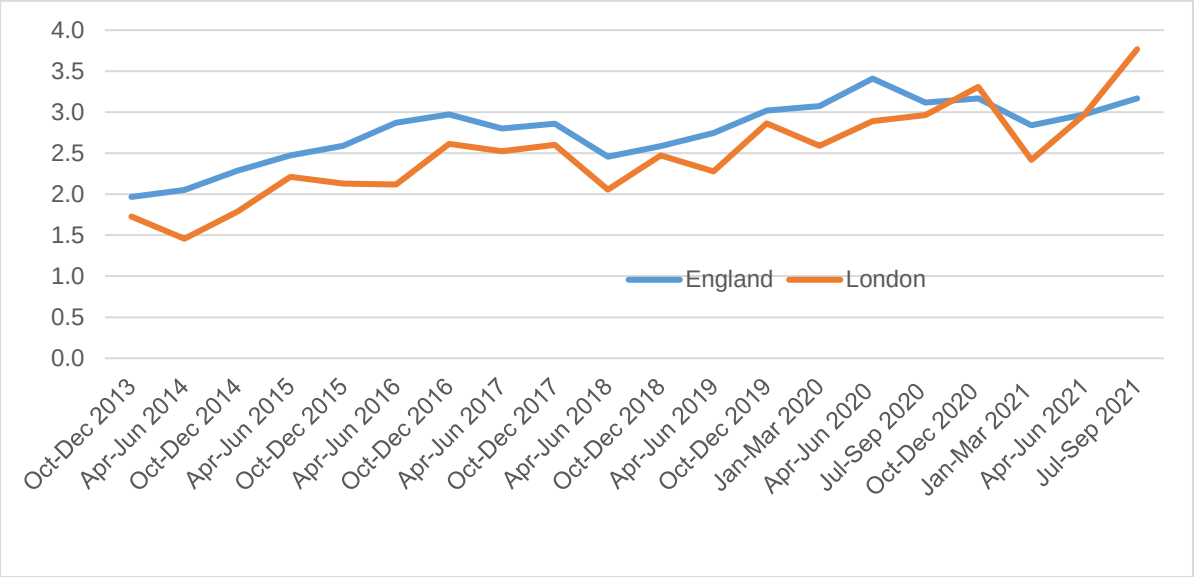
Good work is better for health than bad work - work that involves adverse physical conditions, exposure to hazards, a lack of control and unwanted job insecurity.

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

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

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

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



Source: ONS Labour Force Survey

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

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

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

Source: Public Health England Health & Work Infographics

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

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

3.3 Impact of the pandemic

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

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

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

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

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

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

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

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

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

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

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

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

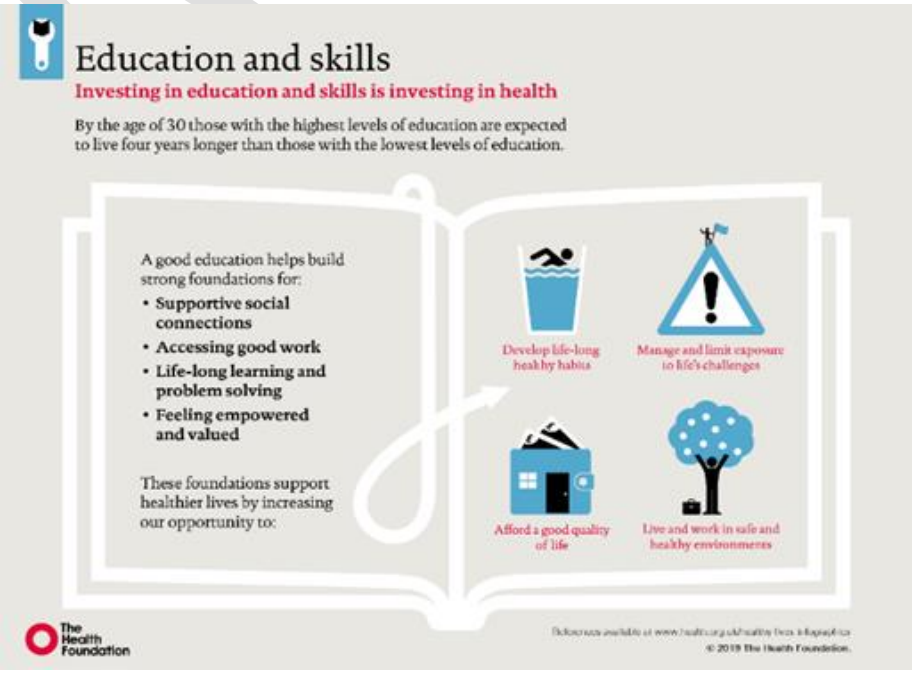
***Recommendation 6**: Consider the impact of working from home on the existing workplace health offer to employees and advice provided to local businesses.*

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

3.4 Educational Attainment

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

Figure 20. Impact of Education on Health Outcomes



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

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

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

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

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

3.5 Housing

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

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

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

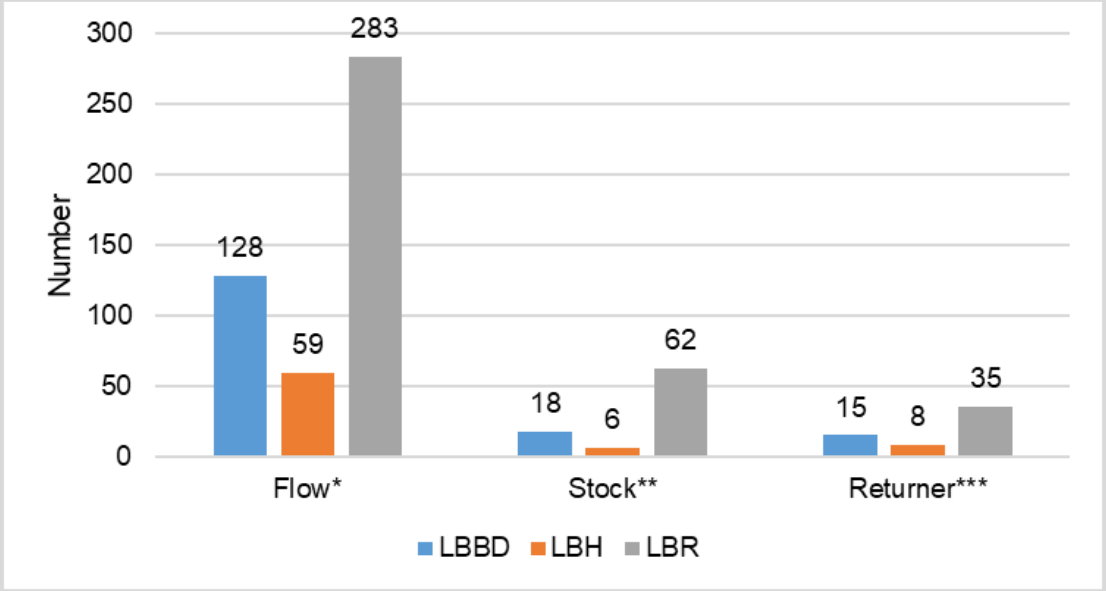
Hence, high quality, affordable housing is a key element in ensuring the health and wellbeing of the population.

Figure 21. Impact of Housing on Health and Wellbeing

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

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

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



Data Source: London Datastore

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

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

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

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

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

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

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

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

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

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

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

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

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

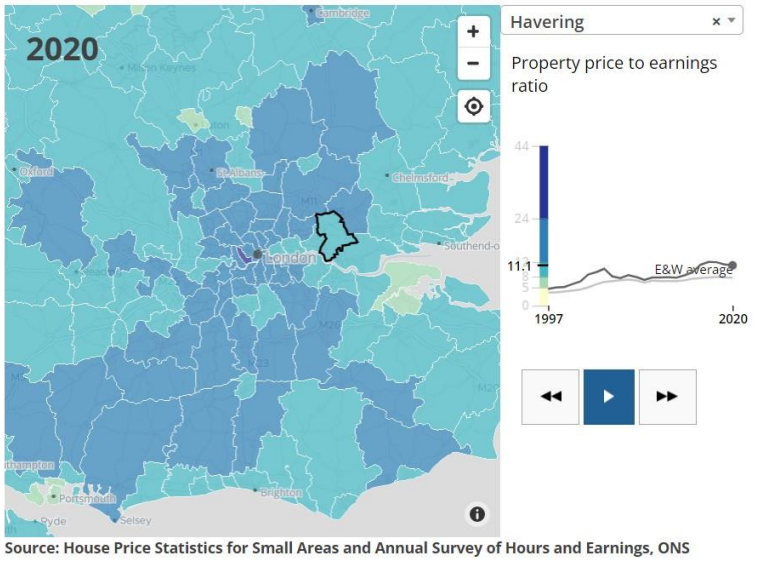
[33] DCLG 2006 A Decent Home: Definition and guidance for implementation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7812/138355.pdf

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

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

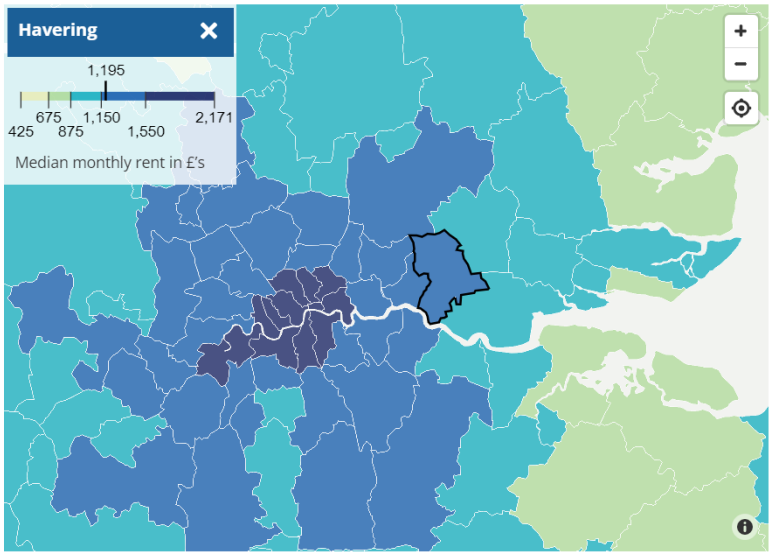
***Recommendation 8**: The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.*

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



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

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



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

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

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

Impact of the pandemic on housing

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

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

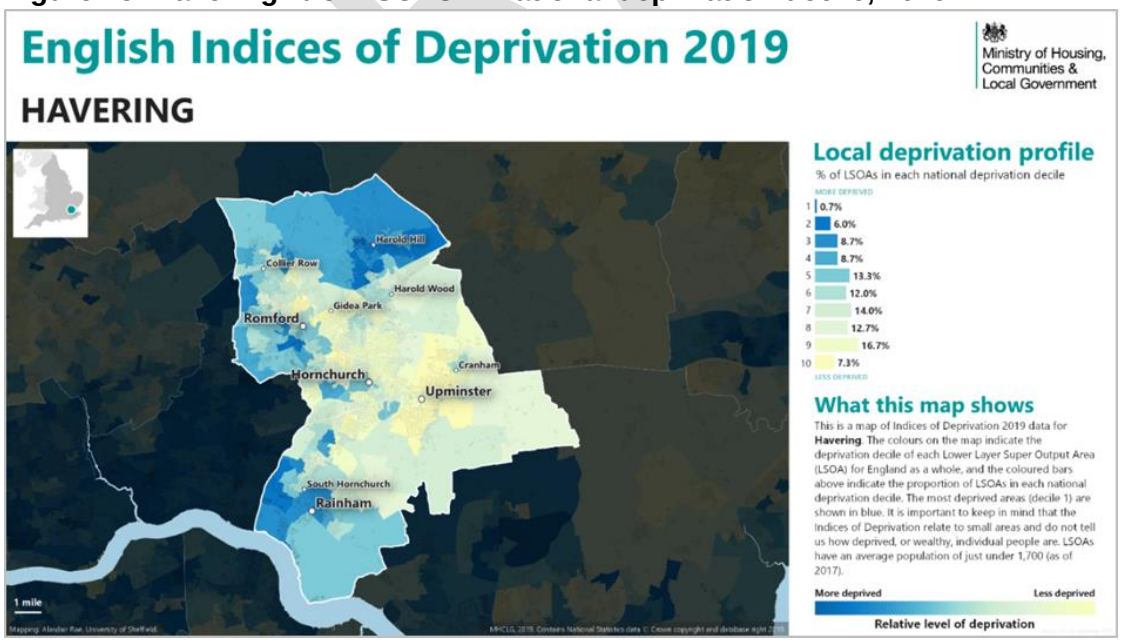
A range of measures including the furlough scheme, mortgage holidays and a halt on evictions of renters were implemented to mitigate the impact of the pandemic on housing and rates of homelessness in the short term. The longer-term impacts are unclear at this time, but those groups most vulnerable to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

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

3.6 Overall Disadvantage

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

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



Source: Ministry of Housing Communities & Local Government

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

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

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

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

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

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

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

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

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

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

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

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

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

3.7 Impact of the Pandemic

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

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

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

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

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

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

4. Pillar 2: Lifestyles and Behaviours

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

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

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

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

Behavioural	
Environmental / Occupational	
Metabolic	

Data Source: Global Burden of Disease, 2019

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

4.1 Smoking

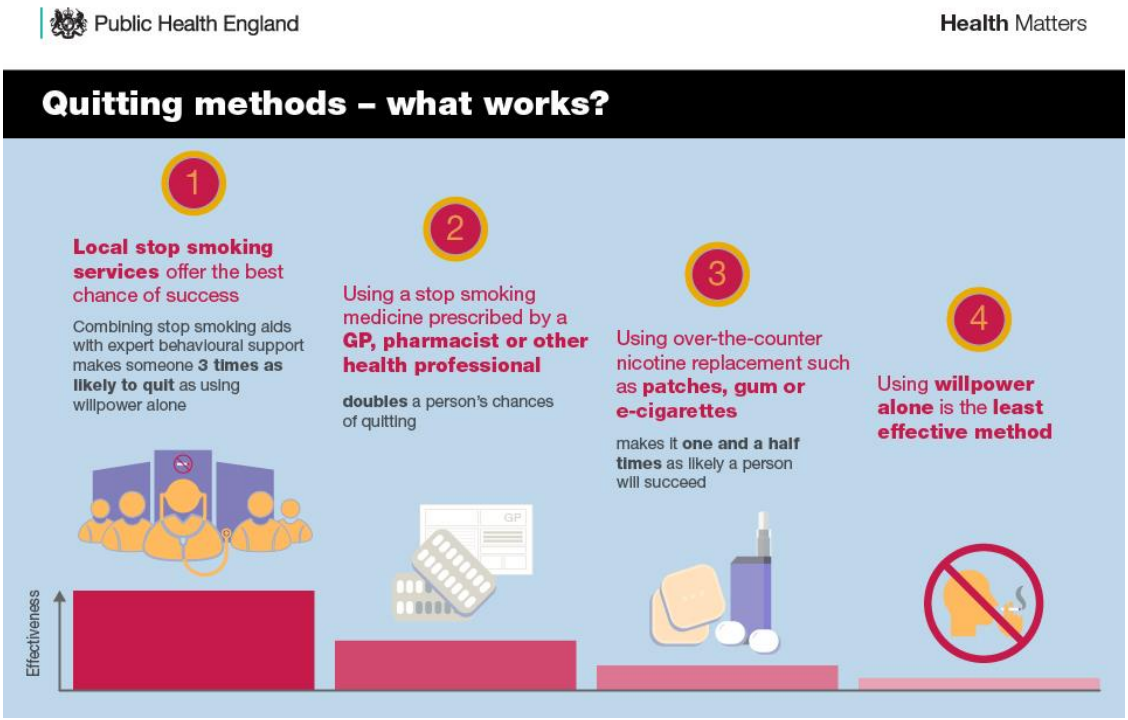
Smoking remains the leading preventable cause of premature mortality and ill health (Fig. 26). Although smoking has been in decline since the 1950s, as of 2019, over 26K (13%) adults in Havering continue to smoke.

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

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

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

Figure 27. Aids to Quitting Smoking



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

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

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

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

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

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

4.2 Diet

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

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

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

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

4.3 Physical Activity

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

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

4.4 Increasing Levels of Obesity

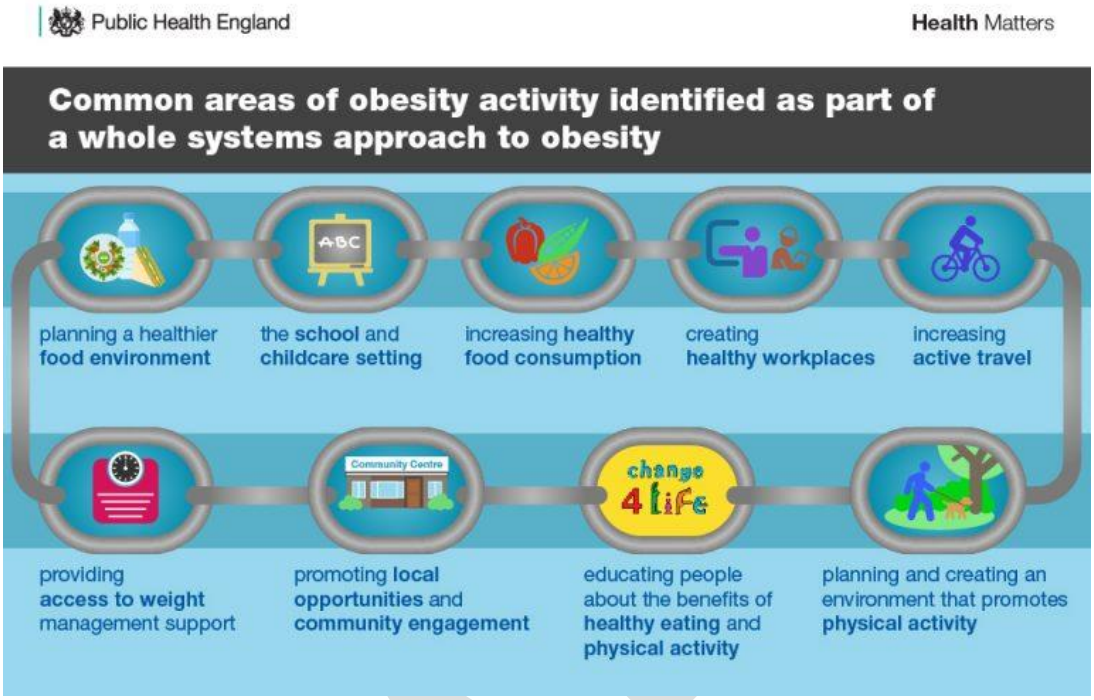
The changing balance between diet, in terms of energy consumed, and physical activity (energy expended) underpins the steady growth in levels of **obesity**. The proportion of adults in Havering living with overweight or obesity (67%) in 2019/20 was significantly higher than the London (56%) and national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

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

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

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

Figure 28. Whole Systems Approach to Obesity Reduction

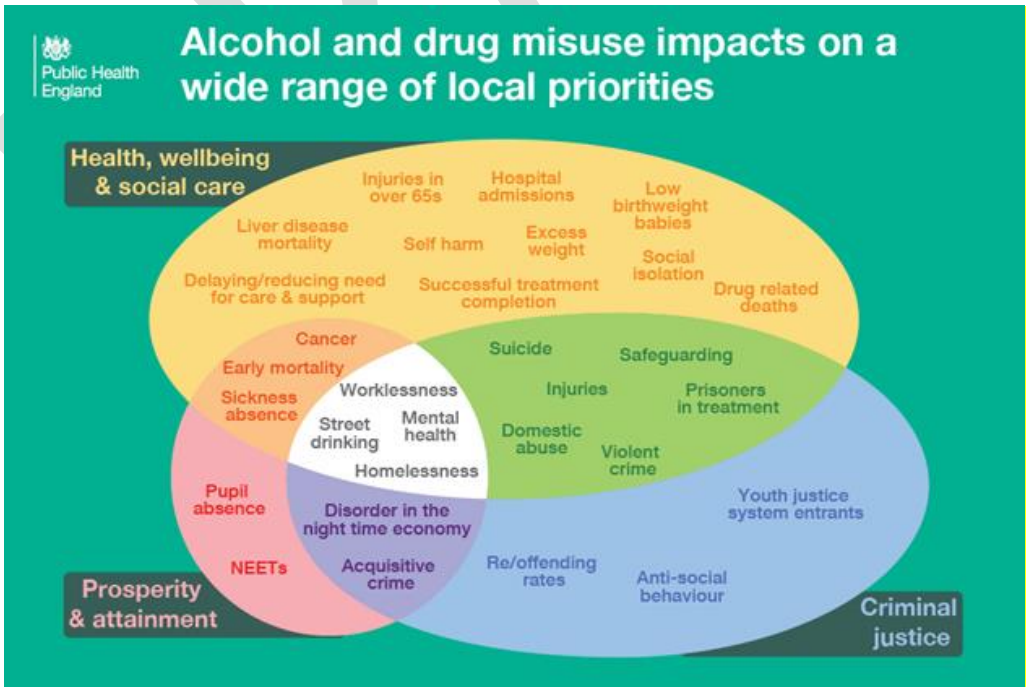


See Section 6.2 for analysis of childhood obesity.

4.5 Alcohol and Drug Misuse

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

Figure 29. Impacts of Alcohol and Drug Misuse



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

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

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

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

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

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

Recommendation 18: *Partners should work to:*

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

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

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

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

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

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

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

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

Figure 30. Community Health Assets

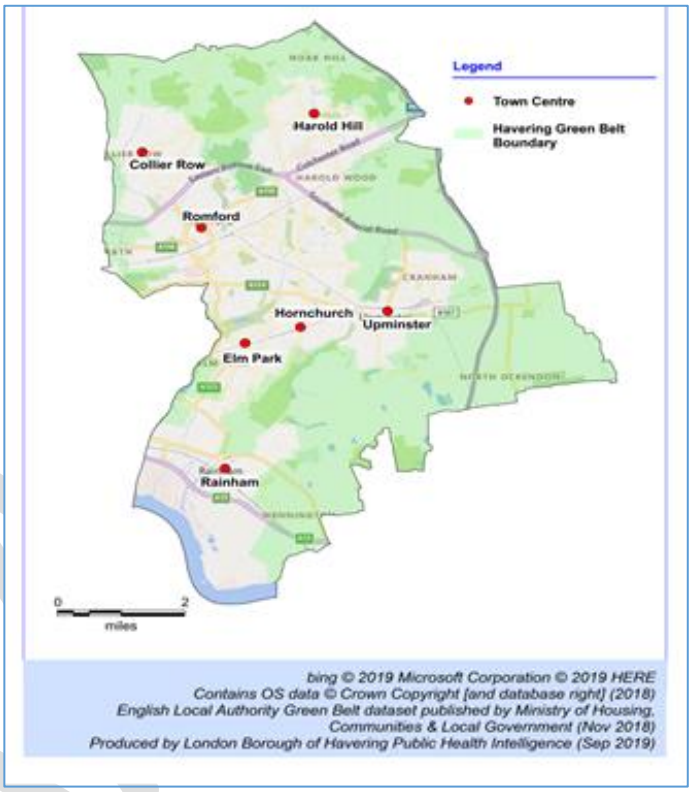
[57] Understanding the health effects of climate change - UK Health Security Agency (blog.gov.uk) https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/

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

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

5.1 Havering – a pen portrait

Figure 31. Havering Green Belt and Urban Areas



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

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

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

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

5.2 Climate Change

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

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

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

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

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

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

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

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

5.3 Air Pollution

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

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

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

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

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

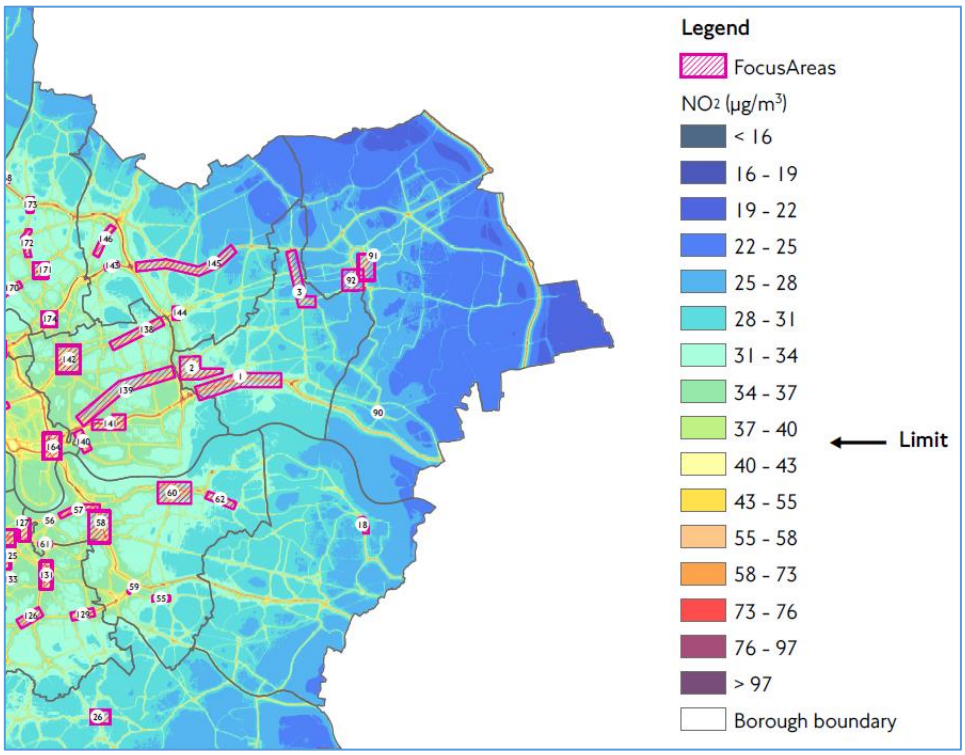
The main pollutants of concern are nitrogen dioxide (NO2) and particulate matter (PM) produced by traffic, heating, and burning of solid fuels.

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

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

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

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



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

Source: GLA Air Quality Team[66].

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

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

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

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

5.4 Travel and Transport Infrastructure

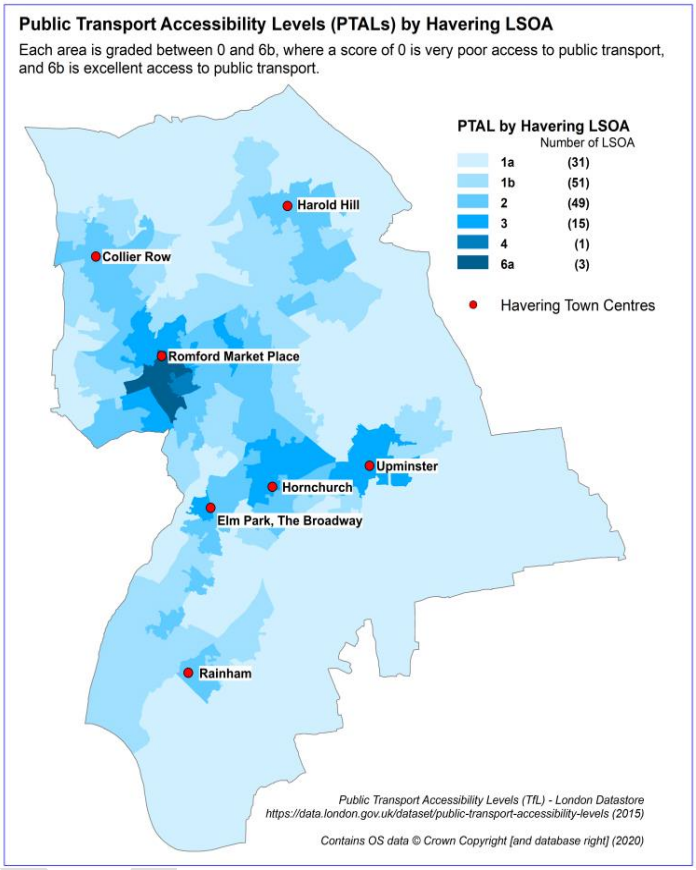
Encouraging residents to switch to public transport or active transport options i.e. walking and cycling will be a crucial element in plans to tackle air pollution and climate change.

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

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

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

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



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

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

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

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

2021	109.0	96.8	83.5	74.7

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

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

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

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

Source: ONS 2011 Census: Key Statistics for local authorities in England and Wales

Recommendation 22: *Partners should ensure that health and social care services are as accessible as possible by public and active transport options and encourage staff and users to leave their car at home when using public services as far as this is practicable.*

Pre-pandemic, only 0.1% of adults in Havering cycled for travel purposes at least three times per week, significantly below the England and London averages, 2.3% and 4.1% respectively.

An environment that makes the resident feel safe is essential if they are to choose active transport options particularly cycling.

Havering currently has 3 School Streets[73]. These are initiatives where roads surrounding schools are closed to motor traffic at drop-off and pick-up times. This makes journeys safer and easier encouraging children to walk or cycle to school, reducing car trips and improve air quality[74].

Havering has about 40km[75] of cycle routes that are either London Cycle Network or 'Greenways' routes'.

Overall, and in common with a number of outer London boroughs, Havering has a relatively poorly developed **active travel infrastructure.** The London Healthy Streets Scorecard[76] assesses boroughs against 5 measures designed to influence modal shift towards active transport including school streets and protected cycling.

[73] http://schoolstreets.org.uk/
[74] https://www.london.gov.uk/press-releases/mayoral/school-streets-improve-air-quality
[75] LBH transport team estimate 2021
[76] https://www.healthystreetsscorecard.london/results/

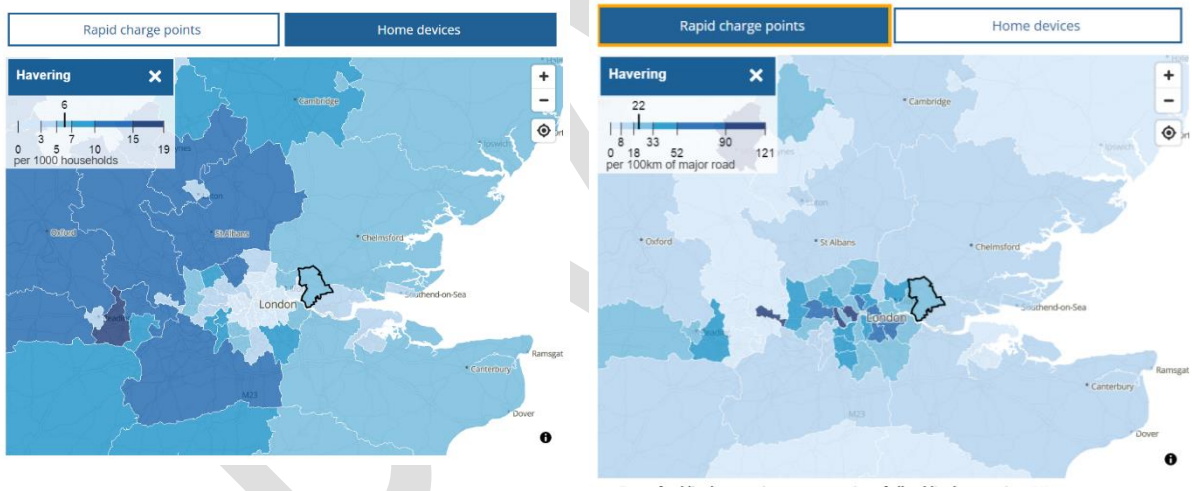
Havering scored 1.75 out of 10 in 2021, the 32nd lowest of the 33 London local authorities.

Recommendation 23: *The Local Authority to work with partners to expand the active transport infrastructure in the borough. The health and social care system to advise residents of the health benefits of active travel whenever the opportunity arises.*

Pending a significant improvement in public and active transport infrastructure, cleaner forms of private transport e.g. car clubs and electric vehicles (EVs) may yield more rapid improvements in air quality.

The sale of new vehicles reliant on fossil fuels is set to end in the UK by 2030 and over half of younger drivers say they are likely to switch to electric in the next decade[77]. The initial cost of electric vehicles remains the biggest barrier to switching to EVs and currently ownership is more common in areas with the highest disposable income. Difficulties recharging electric cars –"range anxiety" - is cited as another key factor against switching from conventional fuels.

Figure 34: Provision of public rapid charge points per 100km of motorway (October 2021) and home devices installed per 1,000 households (2013 to July 2021), UK



Source: ZapMap Logo , Department for Transport, and Office for National Statistics

Currently the public rapid **charging network** tends to be most developed in some inner London boroughs whereas home charging devices are more common in the Home Counties and more affluent rural communities. However, neither is remotely adequate given the Climate Change Committee estimates 325,000 public charging points will be needed to support a fleet of 23.2 million electric cars across the UK by 2032. Currently there are 26,000 for 460,000 plug-in cars (Fig. 34). Massive expansion of charging points is essential.

[77] https://www.ons.gov.uk/economy/environmentalaccounts/articles/overhalfofyoungerdriverslikelytoswitchtoelectricinnextdecade/2021-10-25

Recommendation 24: *All partners to facilitate the shift to electric vehicles including their own fleet.*

66% of Havering's surface area is classified as green cover[78] - parks, green spaces, gardens, woodlands, rivers and wetlands, as well street trees and green roofs. The second highest proportion of any London borough and significantly higher than the London average (approximate 50%).

5.5 Green Infrastructure

Green infrastructure is an important asset (Fig. 35) as it serves to: -

- promote healthier living, providing spaces for physical activity and relaxation
- cool the city and absorb storm water to lessen the impacts of climate change
- filter pollutants to improve air and water quality
- make streets clean, comfortable and more attractive to encourage walking and cycling
- store carbon in soils and woodlands
- create better quality and better-connected habitats to improve biodiversity and ecological resilience

Figure 35: Green Cover, BHR boroughs

Source: GLA Environment Team

Although green space is relatively accessible in Havering, the majority of residents will spend most of their time in more urban environments. As such, the street scene and the offer on our local High Street may be a more important asset or risk to good health.

[78] https://data.london.gov.uk/dataset/green-and-blue-cover

The RSPH reports 'Health on **the High Street'**[79] and Health on the High Street: Running on Empty[80] investigated the relationship between local high streets and health. A healthy high street can provide the public with healthy choices, support community cohesion and social interaction, promote access to health services and do much to support individual wellbeing. The health promoting assets identified included libraries, pubs, greengrocers, gyms, pharmacists and GP surgeries.

Equally, high streets also facilitate activities that can have a detrimental effect on our health, particularly if provided in excess and in communities with greater vulnerability e.g. betting shops, tanning parlours, payday lenders and fast food outlets. Empty shop units are also unhealthy and undermine high streets as a destination. The distribution of assets and risks varies markedly with harms tendering to cluster in disadvantaged areas. The RSPH created a league table of 146 high streets across London[81]. Havering had examples of both unhealthy and healthy high streets with Rainham ranked 10 and Hornchurch 145 where 1 was the least healthy and 146 the most.

The authors noted that planning and licensing legislation did not necessarily prioritise health and wellbeing as it should, and Government was asked to provide Councils with stronger powers to restrict the spread of unhealthy outlets, particularly in areas with a high density. In the absence of further powers, Councils were encouraged to

- introduce planning restrictions within 400 metres of schools (as part of the whole system approach to reducing obesity (see section 4);
- set differential rent classes for tenants based on how health promoting their business is;
- give business rates relief for businesses that try to improve the public's health e.g. by selling e-cigarettes but not cigarettes
- work with vap shops to ensure staff can sign post to stop smoking services
- work with betting shops and pay day loan providers so staff can sign post customers with debt problems to sources of support.

Recommendation 25: *Councils to make use of the powers available to create a healthier offer on our high streets, prioritising disadvantaged areas with the unhealthiest offer, and taking into consideration the views of the local community.*

[79] https://www.rsph.org.uk/static/uploaded/b6f04bb8-013a-45d6-9bf3d7e201a59a5b.pdf
[80] https://www.rsph.org.uk/static/uploaded/dbdbb8e5-4375-4143-a3bb7c6455f398de.pdf
[81] https://www.rsph.org.uk/our-work/campaigns/health-on-the-high-street/2018/london/league-table.html

The wider environment, as well as the service offer available, affects the extent to which high streets support good health. TfL's 2014 transport action plan[82] identified 10 indicators of a healthy **street environment** (Fig. 36).

Figure 36: Indicators of a healthy street environment

Source: Lucy Saunders in *improving the health of Londoners*, TfL 2014

These indicators directly benefit health e.g. by promoting physical activity or by reducing exposure to air pollution and noise; but also serve to make high streets more attractive and safe places to spend time. In turn, this increases the opportunity for social interaction, which is good for mental wellbeing and the likelihood of residents spending money, thereby benefiting local businesses.

The report noted that whereas most streets will have one or two positive characteristics, it often takes multiple positive characteristics to achieve a significant change in the number of people (enjoying) spending time on the street. Hence, regeneration, driven by largescale house building, may afford the most realistic means to achieve a step change in the street scene and its benefit for current and future residents.

5.6 Economic Regeneration

Access to good quality housing is an important determinant of population health (see section 3). An increase in housing stock is necessary given anticipated population

[82] https://content.tfl.gov.uk/improving-the-health-of-londoners-transport-action-plan.pdf

growth (see section 2) and to maintain affordability (see section 3). As well as increasing the housing stock, **regeneration** is an opportunity to build in the physical infrastructure that will underpin healthy communities in the future e.g. green space, active travel infrastructure, healthy street environment, digital connectivity, etc.

Recommendation 26: *Ensure plans and policies shaping regeneration and housing growth e.g. borough level Local Plans serve to build healthier communities not simply additional housing. A formal health impact assessment of the Local Plan may help in this regard.*

The London Plan requires significant house building in all boroughs – the new housing target for Havering is 18,750 additional homes in the period 2019/20 – 2028/29. About half of this new housing is expected to be on relatively small plots and hence could be distributed throughout the borough, but Rainham and Romford are identified as opportunity areas suitable for larger developments.

Rainham, together with Barking Riverside (Barking & Dagenham), is part of the London Riverside opportunity area with a collective housing target of 26,500 new homes and 16,000 new jobs[83]. Barking Riverside is a Healthy New Town demonstrator site, embedding design principles unpinning the promotion of health and wellbeing and securing high quality health and care services[84].

Recommendation 27*: Boroughs, working with developers, should put in place processes to share learning from the healthy new town project at Barking Riverside*.

Residents now and in the future will have a range of needs – and these will change over time. In developing our regeneration plans, we must aim to build communities that accommodate the needs of all, including young people living care, residents with physical and mental health problems and older people affected by frailty. The right housing, in some cases coupled with the right support and care, will serve to maximise wellbeing and independence.

Recommendation 28*: Ensure that the housing needs of residents with specific needs e.g. relating to frailty, mental illness, physical and learning disabilities etc. are an integral part of plans for housing growth and regeneration.*

Appropriately qualified and experienced professionals are essential to the effective functioning of public services (health and social care, but also schools and colleges etc). Staff shortages are already a problem affecting quality of care and increasing the cost of service provision (see section 6). This can only worsen as the population grows, unless local providers succeed in recruiting the next generation of professionals. The opportunity to buy or rent high quality, affordable housing could be part of a wider package BHR may offer to attract professionals into the patch e.g. high performing schools, easy access to green space, safe and welcoming communities etc..

[83] https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas/london-riverside
[84] https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/

Recommendation 29: *Consider if / how key worker housing might be made available to attract hard to recruit health and social care professionals into the BHR patch.*

Recommendation 30*: Building on regeneration plans in the three boroughs; develop an effective approach to promote the benefits of living in Barking, Havering and Redbridge as part of collective effort to fill hard to recruit health and social care vacancies.*

5.7 Crime & Safer Neighbourhoods

Crime, particularly violent crime, impacts negatively on the health of victims and the wider community. **Fear of crime** and antisocial behaviour has wider effects, deterring residents from using assets in the community and reducing social interaction.

Whereas a significant proportion of violent crime is within the home, knife crime, by or against vulnerable adolescents, is the cause of massive public concern and contributes disproportionately to fear of crime. Some serious violence is gang related. In addition, gangs exploit young people and vulnerable adults in a variety of other ways resulting in serious and long lasting harm to life chances.

Alcohol is a more commonly encountered driver of violent crime and crime figures are inflated by the borough's night-time economy which draws people in from adjacent boroughs.

Local action to reduce crime and the harm caused is coordinated by the Havering Community Safety Partnership (HCSP). The Local Authority, on behalf of the HCSP, undertakes an annual CSP Strategic Assessment. The high-level findings and key themes from the 2021 assessment were as follows:-

- Overall, rates of crime in Havering remain relatively low.
- Total notifiable offences (TNO) in the 12 month period Oct 2020 to Sept 2021 were 16,785, a rate of 64.8 per 1,000 residents, well below the average for London (85.7) and England and Wales (81.8). Total notifiable offences were down 4% reduction on 2019/20 and 12% on 2018/19.
- Domestic abuse was the most reported category of crime locally accounting for 41% of crimes in 20/21. Women and girls were disproportionally impacted and report low confidence in the criminal justice system and support networks overall.
- Violence against person was the second highest reported crime category during 20/21. Nonetheless, Havering was the 24th safest borough in London regarding violence.
- There was one homicide in Havering, the lowest number of any borough in London.

A relatively small proportion of (repeat) offenders, many of whom struggle with drug dependency, account for a high proportion of solved crimes. A holistic support package, involving a range of partners including drug treatment services, mental

health services, housing services etc., may be effective in reducing reoffending and the harm caused to these individuals, their families and the wider community.

The level of anti-social behaviour (ASB) dropped dramatically from 9,885 incidences in 19/20 to 1,026 in 20/21 due to the stay at home orders in place for long periods. The level of ASB is low in Havering compared to London.

Knife crime is particular concern across London due to the increasing number of offences year on year from 2015/16 to 2019/20. The council has a strategy to reduce the incidence of violence and knife crime. It is expected that new statutory duties will be placed on councils to work with partners in the coming year to implement a public health approach to the reduction of knife crime as has been successfully employed in Scotland. Guidance about In-Hospital Violence Reduction Services has been published[85]. The approach has been piloted elsewhere in the NEL ICS but not BHRUHT.

Health and social care services have a significant contribution to make, as part of a comprehensive multi-agency response to identify and protect the vulnerable from violence in all forms and crime more generally.

***Recommendation 31**: Health and Social Care Partners should participate in Community Safety Partnerships and contribute to the delivery of agreed plans and strategies.*

5.8 Digital Connectivity

The pandemic demonstrated the importance of **digital connectivity:** e.g. in allowing a proportion of the population to work from home; children to participate in education while restrictions on face-to-face learning were in force; families to keep in contact with loved ones via zoom; and patients to access health care advice.

However, it was equally clear that some of the population were excluded due to unaffordability and/ or lack of skills. This will remain an important barrier for many as we recover from the pandemic e.g. online applications are the usual means of accessing state benefits and job opportunities and digital competence is often a pre-requisite to access education and skills development. Residents with sensory and physical disabilities may be particularly at risk of digital exclusion[86].

***Recommendation 32**: The partnership must consider the needs of digitally excluded communities whenever it seeks to improve access to service by digital means.*

5.9 Social Networks & Social Infrastructure

Social networks with family, friends, work colleagues, neighbours etc can mitigate some of life's challenges and setbacks e.g. ill-health, relationship

[85] Violence Reduction Programme London - In-Hospital Violence Reduction Services: A Guide to Effective Implementation, March 2022

[86] https://www.lloydsbank.com/assets/media/pdfs/banking_with_us/whats-happening/lb-consumer-digital-index-2020-report.pdf

breakdown, job loss, experience of crime etc. Some groups and communities may be less likely to have strong networks and hence less resilient.

New housing developments or areas with a high level of population churn (see section 1) as a result of having more rental property, particularly HMOs, are likely to have a higher proportion of residents with weaker social networks.

In addition, new residents may be slow to (re-)engage with universal health services e.g. general practice and health visiting for families with young children. As a result, such groups may make greater use of A&E and other walk in services (see also section 6.2).

ONS[87] have identify three distinct cohorts as being more likely to self-report loneliness:

- Widowed older homeowners living alone with long-term health conditions.
- Unmarried, middle-agers with long-term health conditions.
- Younger renters with little trust and sense of belonging to their area.

Such social isolation is a risk factor for mental illness particularly in older residents.

Social prescribers working in GP practices, and local area coordinators are well placed to assist individual residents to build social networks.

At community level, Havering Council has established community hubs in Harold Hill and Rainham, the borough's most disadvantaged communities, along with a virtual hub. The community hubs are designed with the community, with the intention of improving access to statutory services and support from the VCS.

The expectation is that timelier provision of advice and support, closer to home, will help stop problems escalating to crisis point. As such, community hubs shift the focus towards prevention and away from more costly and intrusive intervention by statutory services in response to a significant deterioration or crisis. To this end, the hubs provide an information service across the wider determinants of health including debt, housing, work, education as well as health and social care services and access to immediate support including a community food shop, access to computers and the internet alongside training and skills opportunities. Community hubs complement the 1:1 support provided by local area coordinators to individual residents.

***Recommendation 33**: Partners, working with the community, should agree the need for action and how best to go about strengthening social networks and community capacity, prioritising areas with new housing developments, high population churn and significant disadvantage.*

At different points in 2020 and 2021, non-pharmaceutical interventions (NPIs) of varying severity were imposed to control the spread of disease. At times, a large proportion of the population were required to stay at home and forgo all but essential activities.

[87] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10

A variety of harms to the physical and mental health of residents have been reported subsequently e.g. increased levels of obesity and sedentary behaviour (see section 4) and poorer mental health (see section 6).

The Government signposted a return to normality in COVID-19 Response: Living with COVID-19[88]. However, there is considerable evidence that residents have not returned to pre-pandemic patterns of work and leisure. Google's mobility data[89] shows how resident activity in various sectors has changed compared to their pre-pandemic baseline.

Table 4: Percentage change in visits to stated settings compared with pre-pandemic baseline, Feb 15th 2022

	Greater London	LBBD	LBH	LBR
Retail and recreation	-29%	-15%	-10%	-22%
Supermarket and pharmacy	-15%	-14%	-7%	-9%
Parks	-22%	+43%	-12%	-34%
Public transport	-40%	-33%	-35%	-44%
workplaces	-47%	-45%	-41%	-53%
Residential	+12%	+8%	+10%	+10%

Source: COVID-19 Community mobility reports

Visits to retail and recreation, use of public transport and attendance at workplaces are still well below pre-pandemic levels. However, the effects are less marked in suburban areas like Havering than in central London probably because fewer residents are commuting into central London. Nevertheless, they do make some use of local infrastructure while working from home.

It's probable that the pandemic will result in a permanent change in work patterns, with an increase in the proportion of residents that regularly work from home. Employers will need to consider the implications of WFH on the health and safety of employees.

***Recommendation 34**: Partners to consider and respond to the needs of employees who, post-pandemic, routinely work from home to ensure their physical and mental health.*

Outside of work, people who were particularly hard hit by the pandemic or who were thought to be particularly at risk e.g. residents who were asked to shield, may require more time and / or reassurances before they fully re-engage with the community. Until then, they will remain more isolated than otherwise would be the case despite the huge reduction in the risk of severe illness achieved through vaccination.

[88] https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19
[89] COVID-19 Community Mobility Reports (google.com)

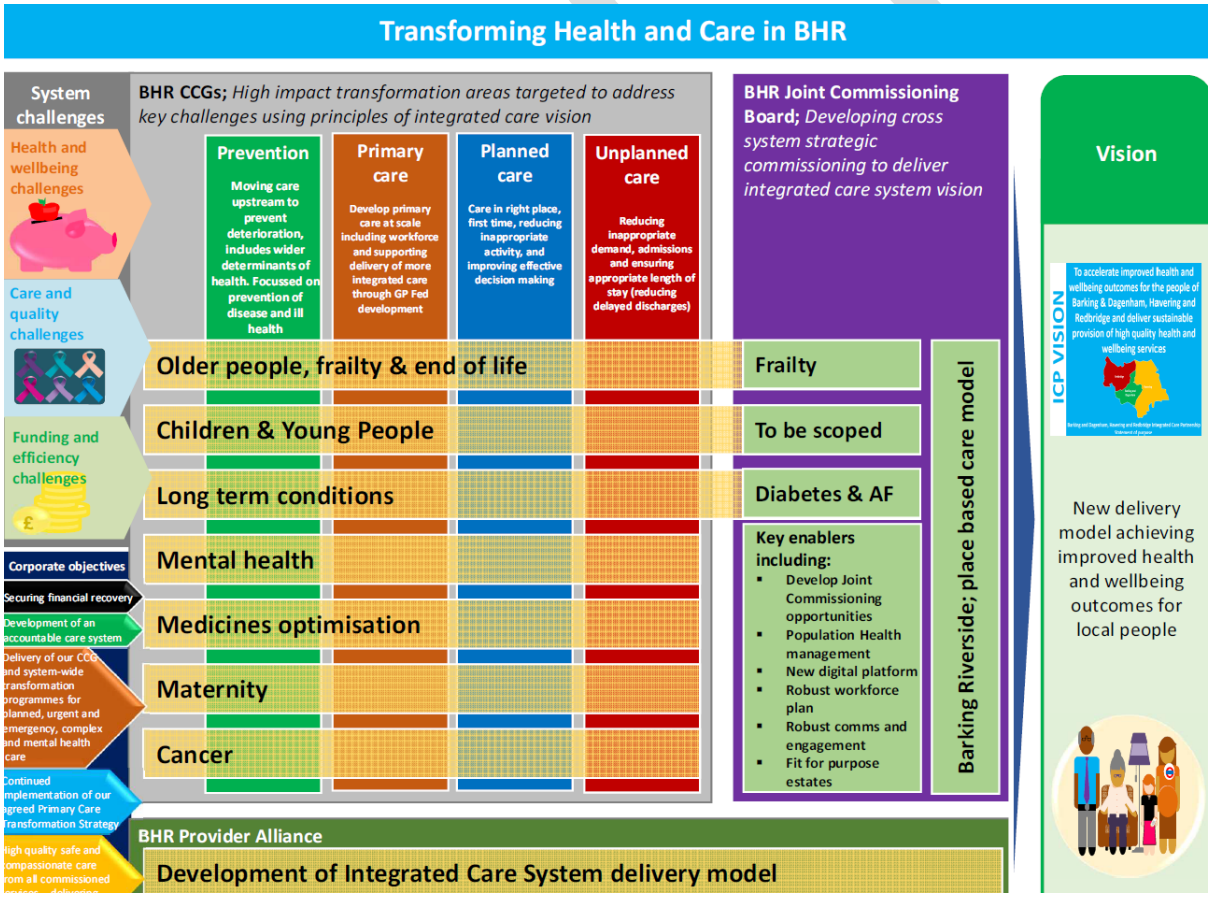
***Recommendation 35**: Partners should work to reassure the great majority of residents who may have shielded during the pandemic that vaccination, and antivirals for some patient groups, offer excellent protection against serious illness and hence the harms of continuing to 'self-shield' outweigh the benefits to physical and mental health to be gained from re-entering their community.*

6. Pillar 4: Integrated Health & Social Care

The recent health and social care reforms recognise the importance of place and communities play in determining health outcomes. Borough partnerships, bring together decision makers from across the health and social care system, with representatives of the community and voluntary sector to ensure the adoption of a population health management approach. The system as a whole will continue to work to ensure that patients can access excellent treatment and care when needed, but equally all partners will seek to tackle the causes of ill-health and shape the place we live in to improve health and reduce inequalities.

A number of transformation boards have been established to lead the redesign and integration of health and social care services locally (Fig. 37).

Figure 37. Plan for Transformation of Health and Care in BHR



The JSNA considers each in turn, following a life course approach beginning with maternity and ending with end of life care.

6.1 Antenatal and Maternity

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

Fertility and birth rates

There were about 11,300 live births to women resident in the three BHR boroughs in 2019. The fertility rate in Barking & Dagenham (82.6/1000 women aged 15-44), Redbridge (73.4) and Havering (68.0) is significantly higher than the London (62.9) and national averages (64.2). Fertility rates in Barking & Dagenham and Redbridge have been at similarly high levels for the last decade. Rates in Havering appear to have now plateaued having increased steadily over the last decade.

Notwithstanding any further changes in fertility rates, the number of pregnancies in all three BHR boroughs is likely to increase further in line with increases in the number of residents of childbearing age.

About 8,200 babies are born at Queens Hospital, making it one of the largest single-site maternity units in the country. Nonetheless, a significant number of women resident in BHR, particularly women living in the west of Redbridge and Barking & Dagenham have their babies in maternity units elsewhere in inner northeast London.

Given these patient flows across local health system boundaries, it makes sense to plan maternity services across a bigger footprint. The East London Local Maternity System (ELLMS)[90], a collaboration of maternity service providers, commissioners, voluntary organisations and service users, fulfils this function ensuring there is adequate capacity across the whole of the NEL ICS and all providers deliver similarly high quality care.

Maternity care

Women can choose to give birth at home, in midwife-led units, or in labour wards. The latter are more suited to the needs of higher risk mothers. The proportion of complex pregnancies is higher in more disadvantaged areas (e.g. Barking & Dagenham) and has increased more widely because of increases in maternal obesity and related gestational diabetes. Given that the Queens Unit is more or less at capacity, there is a need to develop midwife-led care options to free up hospital capacity for higher risk mothers.

Antenatal booking is recommended by 10 weeks of pregnancy[91]. This is an opportunity to gather the information needed to support a healthy pregnancy. Women booking after 20 weeks are considered a higher risk as the opportunity for early screening to identify risk factors such as infectious and inherited diseases has passed. Data from the Maternity Services Dataset (MSDS) for 2018/19 shows that across BHR 6,290 women (51.1%) had their booking appointment with a midwife within 10 completed weeks of their pregnancy. Less than half of Barking and Dagenham and Redbridge pregnant women had a 10-week booking, similar to the London average. The rate of early booking in Havering was higher but nonetheless 4 in 10 pregnant women in Havering did not have a midwife appointment within 10 weeks (Table 5).

[90] http://www.myhealth.london.nhs.uk/maternity/east-london/
[91] Antenatal care for uncomplicated pregnancies | Guidance | NICE

Anxieties about utilising health services during the pandemic may have further increased rates of late presentation.

Table 5: Midwive appointment within 10 weeks

Area	Number of women who had an appointment booked within 10 weeks of their pregancy	10 week bookings as a % of the total number of pregnancy bookings in the period
LBBD	1,865	47.6%
LBH	2,055	58.6%
LBR	2,370	48.5%
London	57,400	47.8%
England	377,235	57.8%

Source: Maternity Services Dataset (MSDS) v1.5

COVID-19 vaccines are strongly recommended in pregnancy. Vaccination is the best way to protect against the known risks of COVID-19 in pregnancy for both women and babies, including admission of the woman to intensive care and premature birth of the baby[92]. However only a minority of women and their babies were fully protected (Table 6).

Table 6: COVID-19 vaccine status of pregnant women October 2021

Area	Uptake of two vaccines	Declined	No invite coded
LBBD	28	4	36
LBH	43	3	17
LBR	40	6	25

The great majority of pregnancies result in the live birth of a healthy baby. However, a small number end in stillbirth[93] or neonatal death[94]. Saving Babies Lives[95] provides detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. BHR CCGs are on track to achieve a 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025 (Table 7).

[92] https://www.rcog.org.uk/guidance/coronavirus-covid-19-pregnancy-and-women-s-health/vaccination/covid-19-vaccines-pregnancy-and-breastfeeding-faqs/

[93] Stillbirth is a baby born after 24 weeks completed gestation and which did not at, any time, breathe or show signs of life

[94] Neonatal death is defined as deaths at under 28 days

[95] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

Table 7. Number and rate (per 1,000) of stillbirths and neonatal deaths in BHR in 2020

Borough	Total births	Stillbirths (rate per 1,000)	Neonatal deaths*
LBBD	3,406	20 (5.8)	12
LBH	3,116	7 (2.2)	5
LBR	4,343	27 (6.2)	7
LONDON	111,688	485 (4.3)	285
ENGLAND	585,195	2,231 (3.8)	1,674

*Data for neonatal deaths is for 2019
Source: Total births and still births: ONS – Births in England and Wales: 2020
Neonatal deaths: Child and infant mortality statistics QMI (2019)

Inequalities in outcomes for mothers and babies

Low birth weight is associated with an increased risk of infant mortality, developmental problems in childhood and poorer health in later life. Some low birth weight babies will be preterm births. The risk factors for low birth weight, whether born prematurely or at full term, include smoking while pregnant; substance and alcohol misuse; pregnancy health and nutrition; pregnancy-related complications; and a mother's young age[96]. Rates of low birth weight are similar to the national average in Barking & Dagenham and Redbridge and better (lower) in Havering.

Smoking is a risk factor for stillbirth and neonatal death. The proportion of mothers known to be smokers at the time of delivery in Barking & Dagenham (7.6%), Havering (6.7%) and Redbridge (3.4%) is significantly lower than the national average (9.6%). Rates in Barking & Dagenham and Havering having improved significantly in recent years; however, they are considerably higher than the London average (4.6%).

The experience of childbirth is a uniquely personal event with potentially long-term impacts on mother and baby and their developing relationship (Table 8). Hence, service user choice and experience of care are particularly important aspects of overall quality of care. The CQC undertakes surveys of mothers across the country. Feedback from women attending Queens is broadly similar to the national average.

Table 8: The experience people receive care and treatment at BHRUHT Maternity services in 2020.

Aspect of care	Patient response	Compared with other trusts
LABOUR AND BIRTH	8.7/10	About the same
STAFF	8.4/10	About the same
CARE IN HOSPITAL AFTER THE BIRTH	7.8/10	About the same

Source: https://www.cqc.org.uk/provider/RF4/survey/5

The pandemic resulted in reduced face-to-face support pre and post-natal to parents negatively affecting experience of pregnancy and childbirth.

[96] https://www.nuffieldtrust.org.uk/resource/low-birth-weight

The benefits of breastfeeding are clear[97] and yet rates of breastfeeding across BHR are variable; Redbridge mothers (81%) are more likely to initiate breastfeeding than the England average (74.5%); rates in Barking & Dagenham (73.6%) are similar to the England average whereas rates in Havering are significantly lower (59.7%). Action is required by many partners to make breastfeeding the norm, particularly in Havering.

Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Antenatal and maternity care provides an opportunity to identify and support. The rate of recorded incidents and offences is higher in Barking & Dagenham but thousands of households are affected in all three boroughs. It has been reported that domestic violence has also risen during the pandemic, particularly during the periods of lockdown (Table 9).

Table 9: Domestic abuse incidents and offences

	LBBD		LBH		LBR	
	Count	Rate/ 1000	Count	Rate/ 1000	Count	Rate/ 1000
Offences	3,395	16.5	2,560	10.2	3,121	10.4
Incidents	5,460	26.5	4,393	17.5	5,019	16.7

Source: MOPAC Domestic and Sexual Violence Dashboard

The vision for maternity services nationally is set out in the Better Births report[98]. In response, the ELLMS has developed identified the priorities set out below to provide women with personalisation, safety and choice, and access to specialist care whenever needed.

Recommendation 36: *Enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led CoC, initially prioritising those identified as most vulnerable and high risk.*

Recommendation 37: *Strengthen personalised care and choice; increase the proportion of women with a personalised care plan, initially prioritising disadvantaged and vulnerable women, whilst offering all women information and choice on place of birth.*

Recommendation 38: *Continuously improve maternal safety including: by full implementation of the second version of the Saving Babies' Lives Care Bundle; and by working with Public Health to help expectant mothers to stop smoking to meet the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths, and intrapartum brain injury by 2025.*

Recommendation 39: *Improved quality of postnatal care for all women including enhanced support to vulnerable women (e.g., perinatal mental health, drug and substance misuse) and focusing on infant feeding.*

Recommendation 40: *Improve access to domestic violence support to all women accessing maternity services through the introduction of an early support and referral scheme for identified victims*

[97] https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/
[98] https://www.england.nhs.uk/ourwork/futurenhs/mat-review/

Achievement of these priorities will be enabled by action to:

- Improve data monitoring and hence the quality and accuracy of available maternity metrics
- Grow and further develop a sustainable workforce
- Improved system working whereby maternity services, particularly ante- and post-natally, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies.

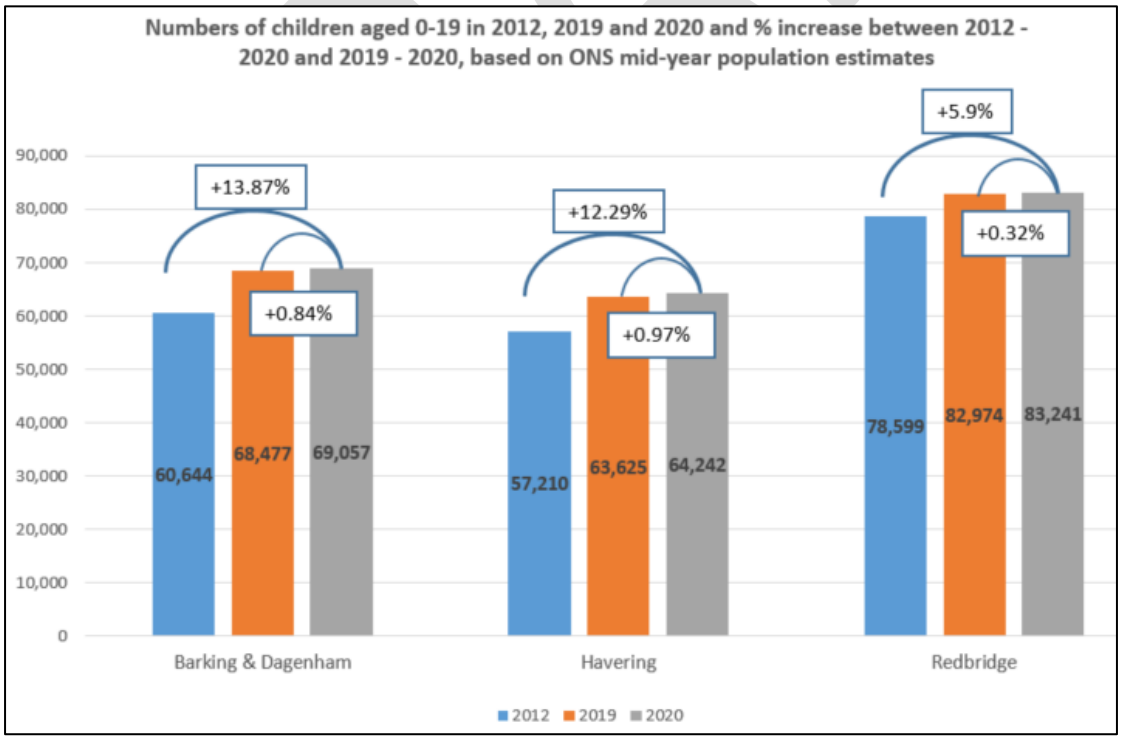
6.2 Children and young people

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

The children and young people of BHR

The number of children and young people (CYP) aged 0-19 years in the three BHR boroughs has increased significantly in recent years. Barking & Dagenham and Redbridge are very young boroughs – with a high proportion of children and young people (32.2% and 27.2% of the resident population respectively) (Fig. 38). Havering has a smaller proportion of CYP aged 0-19 years (24.6%), but has experienced a similar rate of growth in recent years, requiring existing services to expand rapidly to meet increasing demand.

Figure 38: Number of children aged 0-19 and % increase 2012 - 2020



Recommendation 41: *Commissioners / providers should regularly review universal services e.g. health visiting, community paediatrics, therapies etc. to ensure capacity is adequate given the pace and scale of change in the CYP population in recent years.*

Barking & Dagenham and Redbridge are ethnically diverse and similar to London as a whole in this regard. Roughly, ¼ of Barking & Dagenham residents are Black/Black British and another ¼ are Asian/Asian British; about ½ of Redbridge residents are Asian. Havering is less diverse with about ¾ of the population white British. Nonetheless, Havering is becoming more diverse, particularly its younger residents.

Recommendation 42: *The children and young people population is more diverse than the population as a whole and becoming more diverse. All partners should ensure that consideration of culture and language is integral to the development of all services and particularly services for CYP.*

The growth in child numbers is driven by the relatively high fertility rate in all three boroughs and by families with children moving into the patch from elsewhere. Changes in housing benefit and the relative affordability of housing in the three boroughs relative to elsewhere in London may be responsible. The movement of CYP from inner to outer London boroughs may serve to increase the complexity of need as well as the number of CYP in recipient boroughs.

Health and wellbeing outcomes of children and young people in BHR

The death of a child is thankfully a relatively rare event. The risk of death is greatest in the first year of life often linked to prematurity and / or congenital problems. Infant mortality rates for the period 2018-2020 were similar to the national average in all three boroughs; 2.3 /1,000 in Havering, 2.8 in Redbridge and 3.9 in Barking & Dagenham [99].

The Barking and Dagenham, Havering and Redbridge Child Death Overview Panel (BHR CDOP) undertakes a robust review of every child death to identify patterns and trends over time regarding cause of death and opportunities to prevent future deaths e.g. by improvements in health care services or public health action.

Recommendation 43: *Lessons learned through the Child Death Review process should be shared at least annually with commissioners and providers of maternity and children's services to inform decisions regarding priorities for action.*

Wider determinants of health and children and young people

Barking & Dagenham is the most **disadvantaged** London borough, and 5th most deprived upper tier local authority in England[100]. Havering and Redbridge have lower

[99] PHE Fingertips (2021) https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133228/pat/6/par/E12000007/ati/302/are/E09000016/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

[100] UK Government (2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/834001/File_11_-_IoD2019_Local_Authority_District_Summaries__upper-tier__.xlsx

levels of disadvantage. The proportion of children affected by income deprivation varies from 23.8% in Barking & Dagenham (13.1K children) to 16.0% in Havering (7.7K) and 13.7% in Redbridge (9.3K).

Disadvantaged families were the most severely impacted by the pandemic, exacerbating existing inequalities.

Falls in income has also led to increased levels of food insecurity. Over the course of the pandemic, 5 million people in the UK living in households with children under 18 have experienced food insecurity. 1.8 million of these experienced food insecurity solely due to the lack of supply of food in shops, leaving 3.2 million people (11% of households) suffering from food insecurity due to other issues such as loss of income or isolation. This is double the level of food insecurity among households with children reported by the Food Standards Agency in 2018 (5.7%).

The experience of **poverty** in childhood has significant and long lasting effects and is associated with poorer outcomes regarding all aspects of life including health. Disadvantaged families, who spend a greater proportion of their income on food and heating, are likely to be most affected by the current cost of living crisis.

Homelessness directly impacts on the health of children and young people e.g. children in temporary accommodation have poorer social networks and higher rates of mental health problems. In addition, homelessness can interfere with a child's studies further affecting their life chances in the longer term. Rates of family homelessness in all three BHR boroughs (Barking & Dagenham, 5.4/1000 households, n=426; Havering 2.5/1000, n= 256; Redbridge 3.4 /1000, n=381) are higher than the national average (1.7/1000).

Free preschool education and childcare is available to all children from age 3 and to disadvantaged and / or children with additional needs from age 2. The scheme is designed to provide additional support to those most in need. However, take up of places for 2-year old children is incomplete in all three boroughs, but particularly in Redbridge and Havering (LBBD, 76%; Havering, 54%; Redbridge, 45% in 2021). The take-up of 3-4 year old places is better in all three boroughs (Barking & Dagenham 84%; Redbridge in 90%; Havering in 89%). Uptake for both 2 and 3-4 year olds was a few percentage points better pre-pandemic[101].

Recommendation 44: *Ensure opportunities to maximise awareness and uptake of free preschool education and childcare are taken e.g. via regular contacts with health professionals including midwifery, health visiting and with general practice and Local Authority Early Help teams/Children's Centres.*

Childcare providers were asked to continue to take the children of key workers and from vulnerable families during lockdowns. However, during the first lockdown, only a third of childcare providers remained open nationally[102].

[101] Data Source: https://explore-education-statistics.service.gov.uk/find-statistics/education-provision-children-under-5/2021

[102] Economics Observatory (2020). How has the Covid-19 Crisis affected preschool childcare? https://www.economicsobservatory.com/how-has-covid-19-crisis-affected-pre-school-childcare

Ofsted have found that the pandemic significantly impacted the learning and development of children whose participation in early years education was interrupted by repeated lockdowns[103]. They were particularly concerned about children's personal, social and emotional development. Some children had returned less confident and more anxious. In some cases, children had also become less independent, for example returning to their setting using dummies or back in nappies having previously been toilet trained.

Separate assessments are undertaken in early years settings and by health visitors (using ASQ3[104]) at age 2 – 2 ½ years. These reviews provide the opportunity to assess a child's physical, social and emotional needs, identify any potential issues or developmental delays and enable support to be provided as early as possible. Undertaking these assessments together or sharing results can help health and early years professionals arrive at a shared understanding of a child's needs and how they might best be addressed. Analysis of anonymised, aggregate data would provide a better understanding of the needs of young children as a whole to inform the planning of specific interventions and check that the capacity of relevant services e.g. Speech and Language Therapy is adequate.

Recommendation 45: *Maximise uptake and face-to-face delivery of the 5 mandated health and development checks for children aged 0- 5. Increase joint assessments by early years settings and health visitors at age 2 – 2 ½ yrs.*

Recommendation 46: *Ensure that anonymised aggregate data from the ASQ3 are available to inform health service planning and interventions to improve school readiness.*

School readiness is measured at the end of the Reception year to determine the level of development in 4-5 year olds against the Early Years Foundation Stage (EYFS) learning goals. The last available data[105] (2018-19) showed that at the end of reception year, the majority of children in all three boroughs were assessed as having a good level of development. The proportion in Barking & Dagenham (72.4%) and Havering (71.7%) was similar to the England average (71.8%); the proportion in Redbridge (75.6%) was significantly better. Nonetheless, somewhere around 1000 children in each borough were already lagging behind their peers.

Children in receipt of free school meals were more likely not to achieve a good level of development particularly in Havering.

[103] Ofsted (2020). Covid-19 Series: Briefing on Early Years , October 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933836/COVID-19_series_briefing_on_early_years_October_2020.pdf

[104] https://agesandstages.com/products-pricing/asq3/

[105] The Early Years Foundation Stage Profile results in England for 2019-2020 and 2020-2021 were both cancelled as a result of school closures during Covid lockdowns.

In addition, fewer boys than girls achieved a good level of development. The gap is highest in Barking & Dagenham (14.9 percentage points difference), but significant in Redbridge and Havering (11.0% and 11.1% respectively).

Recommendation 47: *Partners should work together to improve the proportion of children achieving at least the expected level across all learning goals, and a good level of development. Consider additional action to reduce inequalities associated with gender and disadvantage.*

Educational attainment is a good predictor of a range of outcomes including income, employment and health. **GCSE attainment** in 2019/20, as measured in terms of average attainment 8 score, was similar to the national average (50.2 mean score) in Barking & Dagenham (50.1) and significantly better than national in Redbridge (56.0) and Havering (52.2). Equivalent scores for children in receipt of free school meals were lower, particularly in Havering (34).

Despite the best efforts of teachers and parents, school closures during the pandemic harmed learning, with disadvantaged children most affected, exacerbating existing inequalities.

Recommendation 48*: As part of their anchor institution role, health and care providers should contribute to wider efforts to build aspiration and educational achievement particularly in disadvantaged and / or otherwise vulnerable groups e.g. through outreach to schools and career fairs; offering workplace experience; apprenticeships; career paths from less skilled, lower paid roles into better paid, professional health and social care roles etc.*

Employment is fundamentally good for health. Rates of youth unemployment across BHR are low with 4.2% of 16-17 years olds in Barking & Dagenham Not in Education, Employment or Training or whose activity is not known (NEET); 2.9% in Havering and 3.1% in Redbridge.

Behaviour and Lifestyle

In some respects, the current generation of children and young people are living more healthily than preceding ones.

Less than 5% of under 15 year olds have used cannabis in the previous month – similar (Havering) or better (Barking & Dagenham and Redbridge) than the national average. About 1% of 15 year olds reported using **drugs** other than cannabis, similar to the national average[106].

The prevalence of **smoking** among young people, when the great majority of adults started smoking, has fallen faster and further than for adults. Rates of smoking

[106] Source: What About YOUth (WAY) survey, 2014/15

amongst 15 year olds in all 3 BHR boroughs (Barking & Dagenham 5.6%, Havering 5.8%, Redbridge 3.4%) are lower than the national average (8.2%).

Childhood obesity has not improved in the same way. In the past, obesity and Type 2 diabetes were associated with middle age. Now 1 in 10 children are obese by the age 5, rising to 1 in 5 by age 11 at Year 6. Obesity is already a significant contributor to death and disability and the harm caused can only increase as more people are overweight and obese for more of their life. Help to individual families with obese children is only part of the action required; a whole systems approach is needed to create places and communities that assist residents to maintain a healthy body weight throughout life.

> ***Recommendation 49:*** *Boroughs to lead a whole system approach to obesity; health and care partners to offer Tier 2 and Tier 3 weight management services for CYP and their families.*

Communities and places for children and young people

Children and to a lesser extent young people have narrower horizons than adults; spending a large proportion of their time in the family home and / or educational settings.

During the pandemic, and particularly during lockdown, young peoples' community contracted still further so that for many, engagement with friends was largely online and **digital connectivity** was essential. Steps were taken to support the digitally excluded but nonetheless it is clear that the learning of disadvantaged CYP was harder hit than that of more affluent peers.

Prior to the pandemic, concern was frequently expressed regarding the effects of prolonged screen time and social media use on the health and wellbeing of CYP including the potential for cyberbullying, lack of sleep and reduced physical activity. The then Chief Medical Officer concluded there was no clear scientific consensus regarding the overall balance of pros and cons but adopting the precautionary principle issued guidance for parents and carers[107].

> ***Recommendation 50:*** *Ensure that programmes to improve digital connectivity are supported by associated education and awareness of the health impacts of cyberbullying and screen addiction.*

The Mayor of London offers award schemes to encourage early years settings (Healthy Early Years London (HEYL)) and schools (Healthy Schools London (HSL)) to review and improve the extent to which their culture and environment support good health. Settings in all 3 boroughs currently participate. Throughout the pandemic, schools and early years settings have continued to engage in the schemes, with several achieving bronze, silver or gold awards throughout this period.

[107]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777026/UK_CMO_commentary_on_screentime_and_social_media_map_of_reviews.pdf

Recommendation 51: *Encourage and support early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the relevant HEYL/HSL scheme or similar.*

Schools also provide a place of safety for our most vulnerable young people. **Exclusion** from school is indicative of poor education attainment. Moreover, excluded CYP are particularly vulnerable to exploitation in all its forms. An increased risk of involvement in serious youth violence, as victim or perpetrator, has been suggested if not universally accepted[108].

Recommendation 52: *Health and care partners should work with schools to provide support to pupils at risk of exclusion.*

The family home is the most important community for a child. A secure and loving family is the single best predictor of subsequent life chances.

Equally, there is extensive evidence regarding the impact of negative factors experienced within the family home during childhood on later life. **'Adverse childhood experiences'** (ACEs) is one way of describing these negative factors.

UK studies[109] have suggested a simple dose/ response relationship between the number of ACEs experienced and the number and type of risky health behaviours engaged in, the social and community impact and impact on use of services as a result of these risky behaviours (Table 10).

Table 10: Likelihood of children with 4 or more ACEs engaging in risky behaviours and the impact on services by the consequences of those behaviours.

Health and wellbeing behaviours	Social and community impact	Impact on services
Those with 4 ACEs + are:		
2x more likely to have a poor diet	2x more likely to binge drink	2.1 x more likely to have visited their GP in the last 12 months
3x more likely to smoke	7x more likely to be involved in recent violence	2.2 x more likely to have visited A&E in the last 12 months
5x more likely to have had sex under 16 years	11x more likely to have been incarcerated	2.5 x more likely to have stayed a night in hospital
6x more likely to have been pregnant or got someone accidently pregnant under 18	11x more likely to have used heroin or crack	6.6 x more likely to have been diagnosed with an STD

[108] https://www.tes.com/news/we-need-reality-check-about-exclusions
[109] Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population

An appreciation of ACEs affords new opportunities to improve health and interrupt the transmission of a variety of negative outcomes from one generation to the next by: -

- **Preventing exposure to ACEs** in the first place e.g. help re. parental attachment; parenting skills courses; resilience building; education and awareness raising re. sex and relationships; drug and alcohol etc. in schools and colleges; anti bullying interventions etc.
- **Early intervention** - effective safeguarding arrangements, identification and effective family focused treatment of parental MH and drug and alcohol problems; support for victims of DV;
- **Mitigation** in support those affected – trauma aware services; CAMHs, YOS

Health and care partners in Barking & Dagenham are working with the Early Intervention Foundation to explore how multi-agency working including family interventions and targeted support for vulnerable cohorts, can improve emotional wellbeing and mental health and better protect children from harm.

Recommendation 53: *Put in place processes to share learning between boroughs, and between health and care partners about how to improve emotional wellbeing and mental health and better protect children from harm, including the joint working between EIF and* Barking & Dagenham*.*

Adolescence entails young people gaining greater independence and taking more risks. Nonetheless **safeguarding adolescents** from significant and long-term harm must be a priority for all partners.

Teenage parents have poorer outcomes e.g. in terms of educational attainment, employment and earning power than peers who have children later in life. Their offspring are more likely to be raised in poverty with impacts on their life chances – hence teen pregnancy serves to transmit disadvantage from one generation to the next.

Table 11: Teenage conceptions, abortions, births, BHR boroughs, 2020

	LBBD	LBH	LBR	London	England
Under 18 conceptions - rate/1000 ♀<18 yrs and (count)	16.1 (66)	15.5 (69)	7.6 (42)	9.8	13
Under 18 conceptions leading to abortion (%)	55%	44%	45%	63%	53%
Under 18 births - rate/1000 ♀<18yrs and (count)	4.9 (20)	2.9 (13)	2.4 (13)	2.5	3.8

Source: OHID Fingertips

Rates of teen conceptions and births in the BHR boroughs are similar to if not better than the national average (Table 11). Nonetheless, a significant number of young women conceive and thereafter choose to terminate or take their pregnancy to term.

Teen parents and their children benefit from support to develop parenting skills and maximise educational attainment, employability and earning potential.

Recommendation 54: *Health, social care and education to periodically review their joint approach to prevent unplanned pregnancy and support teenage parents.*

Both Barking & Dagenham and Redbridge had a rate of first time entrants to the **youth justice system** significantly higher than England. The rate for Havering was significantly lower (better). However, the rates of youth justice custodial sentences and overall youth proven offending rates were significantly worse (higher) in all three boroughs than England. In England, 72% of children in the youth justice system were assessed as having mental health concerns, some were unrecognised and / or inadequately managed [110].

Serious youth violence has resulted in the deaths of young people in each of the BHR boroughs. In some instances, violence is gang related. Criminal gangs may also involve vulnerable young people in the supply of drugs in 'county lines' operations. Young people are also at risk of sexual exploitation from individuals, organised groups and other young people. Still others may be at risk of involvement in religious or politically inspired hate crime. Alongside a vigorous criminal justice response, a public health approach is recommended to tackle serious youth violence[111].

A Public Health approach has 6 broad criteria:

- It is focused on a defined population
- It is established with and for communities
- It is not constrained by organisational or professional boundaries
- It is focused on generating long term, as well as short term, solutions
- It is based on data and intelligence
- It is rooted in evidence of effective practice

The same principles could equally be applied to develop comprehensive, evidence-based solutions to other complex threats to young people.

Recommendation 55: *Health and care partners must actively contribute to collective efforts to reduce serious youth violence and gateways to youth crime; as part of comprehensive efforts to minimise exposure to adverse childhood experiences.*

Integrated health and care system for children and young people

Immunisation is often cited as the single most cost-effective health intervention[112] and yet vaccine coverage has been falling for some time whilst cases of vaccine preventable disease, notably measles, have increased. Coverage is below the WHO target of 95% in all 3 BHR boroughs, as such we cannot be assured that herd immunity will prevent community outbreaks (Table 12). Anti-vaccination messages have not helped but the National Audit Office suggest that more prosaic problems such as the

[110] Gov.UK (2021). https://www.gov.uk/government/statistics/youth-justice-statistics-2019-to-2020
[111] https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence
[112] https://www.parliament.uk/documents/post/postpn314.pdf

way healthcare professionals remind parents to vaccinate their children and difficulty accessing vaccination services at a convenient time and location may be equally to blame[113].

Table 12. Percentage uptake of primary vaccinations by age 5 years in 2020-21 compared to pre-pandemic levels 2018-19 by local authority

Borough	Year	DTaP/IPV /Hib	DTaP/IPV booster	MMR1	MMR2	Hib/MenC
LBBD	18-19	93.8	72.0	92.1	73.3	90.4
	20-21	92.5	69.0	89.6	69.8	87.9
LBH	18-19	96.7	82.2	95.1	83.9	94.2
	20-21	96.0	79.2	93.8	79.7	92.9
LBR	18-19	91.8	69.0	89.9	71.5	87.1
	20-21	90.7	70.1	88.4	71.5	86.3

Recommendation 56: *Review the delivery of childhood immunisation in BHR and develop plans to increase uptake to levels necessary to achieve herd immunity.*

Notwithstanding the benefits of vaccination, all children will at some point experience ill health. In most cases, it is relatively mild and self-limiting. However, very large numbers of children and young people attend emergency departments each year.

Emergency departments (A&E) are for potentially life threatening illnesses or accidents that require immediate, intensive treatment. Long waits at A&E are a common occurrence. Triage to identify patients who need immediate care minimises the impact on treatment outcomes but nonetheless long waits result in poor experience of care. Even more so when young children are involved.

Rates of attendance at A&E by children and young people resident in BHR are below the national average. Nonetheless, there were nearly 12K A&E attendances with babies aged under 1, 30K for children aged 0-4 and almost 70K by CYP aged under 18 years in the year prior to the pandemic[114] (Fig. 39).

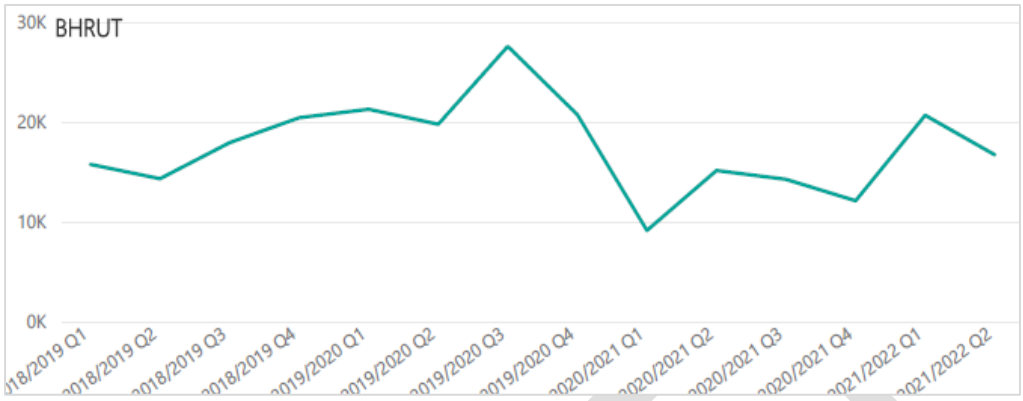
During lockdown, attendances of CYP at A&E dropped significantly before returning to usual levels when controls were relaxed. There is no substantive evidence of additional harm to children themselves from this change in service use, suggesting that the CYP who needed emergency care continued to receive it and that normally, a proportion of A&E attendances are for self-limiting conditions or problems that could equally well be managed by urgent[115], primary or community care services.

[113] https://www.nao.org.uk/wp-content/uploads/2019/08/Investigation-into-pre-school-vaccinations-Summary.pdf

[114] https://fingertips.phe.org.uk/indicator-list/view/iYi2ex7my0#page/1/gid/1/ati/402/iid/90809/age/28/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

[115] Urgent: An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC).

Figure 39. A&E attendances by patients aged under 18 years old resident at BHRUT, Q1 2018-19 to Q2 2021-22



Source: NHS Digital

***Recommendation 57**: Health and care partners, Early Years settings, children's centres, the VCS and parents' representatives to work together to understand how best to meet the health care needs of families with children, improving patient experience and making best use of limited A&E capacity.*

Health visitors have a unique opportunity to engage with all young children and their families in the family home. The 5 mandated checks are a chance to identify families who need more support e.g. to manage minor illness and injury; to achieve a healthy body weight, be school ready, or to prevent abuse and neglect. As such, health visitors contribute to improving health, educational achievement and safeguarding. Delivery of the 5 mandated checks pre-pandemic across BHR was variable[116] (Table 13).

Table 13. Delivery of 5 mandated checks 2019-2020

Area	Antenatal	New birth	6-8 weeks	1yr (by 15mths)	2 – 2 ½ yrs
LBBD	1,621	95.8%	75.9%	78.0%	74.5%
LBH	83	95.1%	20.1%	91.6%	85.4%
LBR	227	89.8%	61.4%	50.7%	39.5%
England	N/A	86.8%	85.1%	83.6%	78.6%

Source: DHSC

Delivery during the pandemic was further disrupted, as health visitors were redeployed to care of patients with COVID-19 and later to support vaccination efforts. Virtual contact substituted for face to face at times and parents undertook some checks themselves. Hence, it is likely that children with problems will not have been picked up as early as would otherwise have been the case.

[116] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011902/Annual_Health_Visitor_Statistical_Release_2019_2020_Aug_2020_update__1_.ods

***Recommendation 58**: Providers to prioritise mandated early years checks as part of wider efforts to recover from the impacts of Covid*

A number of important **long-term conditions** can begin in childhood. **Asthma** is the most common. Effective management can minimise both the frequency of severe attacks and the day-to-day distress and inconvenience of poorly controlled asthma, which in turn affects school attendance and participation in physical activity. Rates of hospital admission for asthma for CYP under 19 years of age in 20/21 were similar to national average (74/100,000) in Havering (89/100,000) and Redbridge (87/100,000) and significantly higher (105/100,000) in LBBD. However, young people have died from asthma in all three boroughs in recent years and the BHR system has developed a detailed improvement plan in response to a Regulation 28 Letter[117] from the local coroner following the Inquest into one of these deaths.

***Recommendation 59:** All partners to prioritise and consider how best to implement plans developed to improve asthma care in BHR.*

About 1 in 10 CYP have a common **mental health** disorder (CMHD). Estimated rates in Barking & Dagenham (10.3%) are higher than the national average (9.2%) whereas rates in Havering (9%) and Redbridge (9%) are similar. In total, about 11K CYP in BHR aged 5 -16 are estimated to have a CMHD.

Conduct disorders (severe and persistent behavioural problems) are the most common CMHD; affecting 5% of children aged 5-10 increasing to 7% in secondary school years. Conduct disorders are twice as likely to be experienced by boys/young men then girls/women[118].

Increasing CAMHS support is a priority in the NHS. The immediate target is to increase access to at least 35% of those with a diagnosable condition. Hence alongside the challenge of increasing CAMHS capacity, there is an equally pressing need to engage and maximise the contribution of non-NHS support e.g. counselling commissioned by schools and / or the CVS; improve the ability of universal services including schools and parents to support CYP with mental health problems and build greater resilience amongst CYP themselves.

***Recommendation 60:** CYP and MH transformation Boards should work to: -*

- *Increase CAMHS capacity and strengthen links with other providers*
- *Develop the capacity and capability of professionals in universal services including health visiting, school nursing general practice and schools to support children with mental health problems and their families*
- *Support children and their families to be more resilient*

[117] https://www.inquest.org.uk/faqs/prevention-of-future-death-reports#:~:text=After%20an%20inquest%2C%20the%20Coroner,preventative%20action%20is%20not%20taken.
[118] Green et al 2005

Self-harm is a particular indicator of emotional distress and is associated with a higher risk of suicide[119]. Rates of hospital admission for self-harm in all 3 BHR boroughs are less than half the national average. Amongst 10-24 year olds, rates of hospital admissions as a result of self-harm per 100,000 are 166 in Havering, 136.2 in Barking & Dagenham and 126.2 in Redbridge, However, hospital admission captures only a small proportion of cases. Data about attendances at A&E would give a better measure of the incidence of self-harm. Systems to follow up people attending A&E with self-harm are an element of robust suicide prevention plans.

Recommendation 61: *ICS partners to:-*

i) consider how best to report attendances for self-harm in CYP;

ii) ensure that NICE guidance for psychosocial assessment after hospital attendance for self harm is implemented.

Children with Special Education Needs and Disabilities (SEND)

SEND comprise a wide variety of problems that affect a child or young person's ability to learn. As a result, children with SEND need extra support, which can include help to take part in usual class activities or help communicating with others, through to a special learning programme and help with physical and personal care.

More than 1 in 10 children and young people have SEND; reported rates in Barking & Dagenham (14.5%) Havering (11.0%) and Redbridge (11.8%) are lower than the England average (14.4%)[120].

Delivery of the required help can involve contributions from schools, children's social care and NHS services (e.g. therapies, community paediatrics, CAMHs etc.). Complex care is captured in an Education Health Care Plan specifying the support needs of individual young people up to the age of 25 to achieve what they want in their life. The percentage of CYP aged 0-25 with statements of SEN or an EHC Plan varies across the patch - Barking & Dagenham 1.6%, Havering 1.6%%, Redbridge 1.8%; but in all cases, rates are similar to or less than the average for London (1.8%) and England (1.9%). In total, just under 4000 children and young people in BHR have an EHCP or statement.

The complex needs of small numbers of CYP cannot be met locally necessitating, in some cases, long journeys to specialist facilities and / or residential care. Greater collaboration across BHR or NEL as a whole may enable partners to meet the needs of more CYP closer to home.

[119] Repetition of self-harm and suicide following self-harm in children and adolescents: findings from the Multicentre Study of Self-harm in England, Hawton, K., Bergen H., et al, Jnl of child Psychology and psychiatry April 2012.

[120] DfE Jan 2019 All Schools : number of pupils with special educational needs, based on where the pupil attends school https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814246/SEN_2019_Local_Authority_tables.xlsx

Recommendation 62: *CYP transformation board to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews and options for Pan BHR commissioning to facilitate best use of scarce clinical resources and enable provision of care closer to home.*

Safeguarding children and young people

Neglect, physical abuse, exposure to domestic violence, parental drug and alcohol dependency and mental illness can result in immediate harm to children. In addition, and as discussed above, exposure to Adverse Childhood Experience (ACEs) is linked a range of significant negative outcomes in later life.

Safeguarding requires the active cooperation of a variety of partners. Borough level arrangements have been augmented by the addition of BHR wide collaboration developed and agreed by the Director of Childrens Services (DCS) for each borough, the Nursing Director for BHR CCGs and the lead for the Metropolitan Police Service.

Universal services like health visiting, early years services, nurseries and schools play a vital role in safeguarding children. Reduced contact during the pandemic may have delayed the identification of at risk children thereby prolonging abuse and neglect. Such delays may have contributed to the increase in the number and severity of children protection cases reported post pandemic.

Recommendation 63: *All partners must participate in safeguarding arrangements and ensure all staff working within the ICS are clear on thresholds and pathways for raising and acting on safeguarding concerns.*

The primary purpose of child protection arrangements are to protect children from further harm; in many instances, and following detailed assessment, this will entail remaining in the family home with appropriate support. Depending on the specific needs and strengths of the individual child and their family, child protection arrangements can be stepped up (or down) from child in need, to child protection or the child may be taken into the care of the Council.

Rates for all forms of safeguarding are generally similar or lower than the national average in Havering and Redbridge but higher in Barking & Dagenham as would expect given the higher rates of disadvantage. Irrespective of the precise rates, significant numbers of children are subject to some form of child protection in all three boroughs.

Outcomes for looked after children such as educational attainment and mental and physical health tend to be poorer than those of children in the general population[121]. Subsequent life chances are also poorer and health and care partners should consider how they can assist care experienced children beyond their statutory duties e.g. by

[121] https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children/#heading-top

giving them priority to opportunities like apprenticeships and work experience that might lead to secure well paid employment.

Recommendation 64: *Health and care partners to consider how they can support care experienced young people into employment as part of their wider 'anchor institution' role.*

6.3 Adult Mental Health

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

Prevalence and risk factors

The great majority of people will experience problems with their mental wellbeing at some point in their lives.

The modelled prevalence of common mental health disorders (any type of depression or anxiety) for adults in Havering (15.9%) and Redbridge (17.7%) is similar to the national average (16.9%), but significantly higher in Barking & Dagenham (22.4%). As such, there are likely to be more than 108K people with a common mental health problem living in the three BHR boroughs at any point in time.

The GP recorded prevalence of depression for adults in each of the three boroughs is below the national average, which may indicate unidentified need, particularly in Barking & Dagenham and Redbridge where recorded prevalence is lowest. Nonetheless, almost 52K people across BHR are known to have depression.

A smaller number of the adult population have a severe mental illness (SMI) including schizophrenia, bipolar affective disorder and other psychoses. Rates of SMI are lower than the national average in all three boroughs – nevertheless more than 6,800 people have a SMI.

Poor mental health disproportionately affects those who experience disadvantage in all its forms e.g. with regard to the wider determinants, levels of social support, experience of abusive relationships and discrimination[122].

People from ethnic minority communities are less likely to engage with mental health services other than at a time of crisis. People of African/Caribbean descent are over-represented at all levels of the psychiatric process; in particular they are more likely to be treated as inpatients, be sectioned or access mental health services via a criminal justice system pathway[123].

Mental health problems are more common among people who are lesbian, gay, bisexual, trans, intersex, queer or questioning (LGBTIQ+)[124].

Studies suggest that the rate of mental health problems in people with a learning disability is double that of the general population[125].

Compared with the general population, common mental health conditions are over twice as high among people who experience homelessness, and psychosis is up to 15 times as high[126]. Many people who sleep rough have co-occurring mental ill health and substance misuse needs, combined with physical health needs and past experience of significant trauma.

[122] PHE Guidance: Wellbeing and mental health: Applying All Our Health Updated 28 August 2019
[123] https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities
[124] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-lgbtiq-people
[125] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/mental-health
[126] https://publichealthmatters.blog.gov.uk/2019/09/30/health-matters-rough-sleeping/

As many as nine out of ten people in prison have a mental health, drug or alcohol problem[127]. 50% of mental health problems are established by age 14 and 75% by age 24[128]. Subsequent life stages or events may be associated with further risk.

It is estimated that between 1.3K and 2.7K of women in BHR experience adjustment disorders and distress in the perinatal period. Between 4-6% of pregnant women experience post-traumatic stress disorder as a result of traumatic events during labour or childbirth[129]. Perinatal disorders are associated with increased risk of psychological and developmental disturbances in children[130].

1 in 5 of older people living in the community and 40% of older people living in care homes are affected by depression[131].

Prevalence of recorded dementia in BHR is two-thirds of that in England; almost 5K of registered patients have dementia. Evidence suggests that up to 40% of all cases of dementia are linked to modifiable lifestyle factors, but just a third of UK adults think it is possible for people to reduce their risk. Women are less likely than men to think it's possible (30% compared to 37%)[132]. Smoking is one of the biggest risk factors and can double individual risk[133].

Harm caused by mental illness

People with severe mental illness die on average 10 - 20 years sooner than the general population[134]. Cardiovascular disease, respiratory illness and cancers are the main causes of the observed gap in life expectancy, in part due to the very high prevalence of smoking (and heavier smoking) amongst people with mental health problems[135,136]. Over 1,700 people across BHR are recorded as smokers with SMI. Some of the drugs used to treat SMI can cause obesity and thus increase cardiovascular risk[137].

Deaths from mental illness represent only a small element of the harm caused. In total, mental health problems are estimated to cause about 10% of all health lost to disability (YLD) and 5% of all health lost to disability and premature death (DALYs) [138].

[127] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[128] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.
[129] Dekel S, Stuebe C, Dishy G. Childbirth induced posttraumatic stress syndrome: A systematic review of prevalence and risk factors.Frontiers in Psychology. 2017;https://doi.org/10.3389/fpsyg.2017.00560
[130] Steain, A et al (2014) *Effects of perinatal mental disorders on the fetus and child*
[131] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[132] Alzheimer's Research UK *Public attitudes towards dementia*
[133] National Government (2018) *Dementia: applying all our health*
[134] Hayes JF, Marston L, Walters K, King MB, Osborn DPJ. (2017) Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000–2014. The British Journal of Psychiatry Jul 2017, bjp.bp.117.202606; DOI: 10.1192/bjp.bp.117.202606
[135] Kings Fund (2014) *Smoking and severe mental ill health*
[136] ASH (2019) *Factsheet: Smoking and Mental Health*
[137] NHS England (2019) Achieving more for people with severe mental illness
[138] JSNA Chapter 3 Population Health Outcomes

The impact of the pandemic on mental health

Anecdotally, BHR local authorities, local NHS agencies, and partner organisations such as schools and the voluntary sector have observed that not only are the pre-existing inequalities in mental health widening, but there are new mental health challenges emerging, fuelled by the experiences of living through a pandemic.

A national study observed that depression and anxiety levels were greatest during lockdowns, reducing when lockdowns were eased, although symptoms increased over Christmas 2021 and on a par with levels during lockdown at the start of 2021. This was driven by concerns about catching Covid-19, as well as concerns about finance. Working age adults were twice as likely to report concerns as older adults.[139] Further common causes for worry were being separated from friends and family, being unable to cope with uncertainty, how the mental health of one's own children will be affected by the pandemic, and making one's existing mental health problems worse.[140]

People have been using a wide range of strategies to cope, including walking, spending time in green spaces, and staying connected with others. Some people reported resorting to potentially harmful ways of coping, including increased alcohol consumption (19%), substance misuse, and over-eating (36%), putting their mental and physical health at greater risk.

Use and outcomes of local mental health services

The rate of referral to Talking Therapies (IAPT) across BHR boroughs is similar to the national average, which is a marked improvement compared to that described in the 2019 JSNA, when this was about half the national average. However, there are disparities across the borough, with lowest referral rates in B&D. The rate of people who achieved a reliable improvement is also similar to the national average, which again is an improvement.

The proportion of people in contact with adult mental health services in all 3 BHR boroughs is below the national average – in Q2 2019/20, 10,230 patients in BHR were in contact with services.

Rates of mental health admissions to hospital across BHR are lower than the national average. In total, there were 135 mental health hospital admissions in 2019/20.

The rate of people subject to the Mental Health Act in Q2 2019/20 was lower in Havering compared to England; rates in Redbridge and Barking & Dagenham were similar. In total 240 people were subject to the Mental Health Act across BHR during the quarter. It is unknown how many are repeat episodes.

The proportion of patients in concurrent contact with mental health services for substance misuse in Barking & Dagenham is similar to the national average but much lower in Havering and Redbridge.

The percentage of people in contact with mental health services with a diagnosis or provisional diagnosis recorded during Q2 2019/2020 was far below the averages for London (21.9%) and England (30%); Barking & Dagenham 8.9%, Havering 8.6%,

[139] UCL *Covid-19 Social Sudy*
[140] The Mental Health Foundation (2021) *Coronavirus: Mental Health in the Pandemic*

Redbridge 7.3%. There is some disparity between expected levels of mental health disorders and levels known to health services, particularly in Barking & Dagenham. This may reflect a reticence on the part of local residents to seek help and / or the need for a more systematic approach to the identification of people with mental health problems.

Issues with mental wellbeing are an almost universal experience at some point in life. Self-help information and aids have been brought together by the NHS under the 'Every Mind Matters' banner, providing useful advice about how to cope with low level mental health issues.

Recommendation 65: *Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.*

Recommendation 66*: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience, including by making use of 'Every Mind Matters' resources and self-help aids; giving particular consideration to groups who appear less likely to seek help such as LGBTIQ+ and ethnic minority residents, and older people.*

Poverty, unemployment, homelessness, relationship breakdown etc. predispose to mental health problems. With additional training, public facing staff in a wide range of services and in the community can encourage people experiencing disadvantage and personal problems to seek help, as well as identify and intervene where there is risk of suicide.

Recommendation 67*: Promote the Making Every Contact Counts (MECC) approach by providing training to front facing staff across the wider partnership to promote awareness of mental health issues including stigma, suicide prevention and the benefits of Talking Therapies.*

Talking Therapies (IAPT) are an effective means of helping the thousands of people living with common mental health services.

Recommendation 68*: Improve understanding of public perceptions of Talking Therapies and barriers to access and use the insight gained to improve how IAPT is promoted and delivered to maximise participation and successful completion.*

At any one time, only a small proportion of people with common mental health problems are under the care of specialist mental health services. General practice cares for the majority of patients with common mental health problems. GPs also care for groups known to be at higher risk of mental health problems such as LGBTIQ+ people, older people, people with LTCs and people with learning disabilities.

***Recommendation 69**: Continue to develop the capacity and capability of primary care to manage patients with common mental disorders and integrate consideration of mental health into the management of other care groups known to be at high risk of mental health problems.*

Care and support of people with mental health issues requires a joined up approach across the NHS, Councils (social care and housing), other statutory agencies such as DWP, and community and voluntary groups. Support to access services and strengthen social networks can benefit people with or at risk of mental illness. Local area coordination, social prescribers and health champions can assist with this.

***Recommendation 70**: Develop partnerships between primary care, specialist mental health services, other statutory services and the VCS at locality level to provide holistic support addressing the wider determinants as well as health and social care needs of people with mental health problems. An effective social prescribing function will assist patients to engage with relevant support.*

People with co-occurring substance misuse and mental health conditions have a heightened risk of other health problems and early death but are often excluded from services.[141] People in the criminal justice system and the street homeless have particularly complex social issues and are at high risk of both substance misuse and mental health problems. Effective care requires specialist input for both problems. Concurrent contact with mental health services for drug and alcohol misuse is much lower in Redbridge and Havering, compared to England.

***Recommendation 71:** Improve and increase joint working between mental health services and drug and alcohol services to improve outcomes for patients with co-occurring substance/alcohol misuse and mental health conditions.*

***Recommendation 72:** Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.*

***Recommendation 73:** Review arrangements for those in contact with the criminal justice system, including ex-prisoners and their access to mental health services, and mental health service provision for offenders served with community orders, particularly for those subject to Alcohol Treatment Orders and Drug Rehabilitation Requirements*

Following changes in national policy, this JSNA has discontinued indicators reporting the Care Programme approach that were previously used to describe quality outcomes for service users. They werereplaced with indicators describing 72-hour follow up for all adult patients discharged from inpatient care, as per NHSE and NHSI recommendations.[142] Patients followed up within 72 hours of discharge from

[141] PHE (2017) *Better care for people with co-occurring mental health and alcohol/drug use conditions*
[142] NHS England and NHS Improvement (2021) *position statement*

adult acute beds in Barking & Dagenham (80%) and Havering (87%) is higher than the national average (77%), but lower in Redbridge (70%). In the 6 month period to March 2021, 95 patients were not followed up within 72 hours across BHR. The national standard is 80%, with the evidence base showing that there is an increased risk of patients dying by suicide on days 2-3 following discharge from inpatient services.[143]

Recommendation 74: *MH services should audit re-admissions to identify the underlying causes of re-admission and whether improvements could be made as part of planned discharge, and ongoing treatment and support (including support from local authority housing teams).*

Rates of employment for people with severe mental illness (SMI) are lower than for any other group of health conditions. The benefits of being in employment include an income and a greater sense of purpose and wellbeing, while for the health system there is an overall reduction in the use of primary and secondary mental health services, leading to improved efficiency and savings[144].

Recommendation 75: *Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.*

The BHR system has relatively few inpatient mental health beds in comparison with other London areas. As reported in the 2019 JSNA, patients requiring admission had to be placed out of area. Further work is needed to understand whether the care provided to those in crisis is sufficient, given the size and complexity of the population now served and the prospect of further population growth. A 2019 audit of patients occupying inpatient beds has indicated that around a quarter were not previously known to mental health services.

Recommendation 76: *Review the management of patients in crisis ensuring there is adequate place of safety provision given population growth and increasing complexity of needs. Investigate where interventions might have previously prevented escalation to crisis and use the lessons learned to improve mental healthcare.*

The reasons for the mortality gap between people with SMI and the population as a whole are complex. One of the more obvious contributory factors is the very high prevalence of smoking for people with SMI. New approaches to assist people with SMI to adopt healthier lifestyles are needed to maximise the benefits of annual health checks for people with SMI.

[143] https://mentalhealthwatch.rcpsych.ac.uk/indicators/proportion-of-patients-discharged-from-adult-acute-beds-followed-up-within-72-hours

[144] https://www.england.nhs.uk/mental-health/case-studies/severe-mental-illness-smi-case-studies/individual-placement-and-support-offers-route-to-employment-for-people-with-severe-mental-health-conditions/

Recommendation 77: *Improve the management of physical health of patients with SMI; ensure all get an annual health check and, through joining up initiatives across the system, improve effectiveness of support available to assist with lifestyle change, starting with smoking.*

Preventing Suicide

Whilst rates of suicide across BHR are lower than the national rate, it remains the case that many suicides are preventable. The risks of suicide are increased when an individual has been previously bereaved by a suicide, has a history of self-harm, or a history of mental ill health, especially if there is co-existing substance misuse.

Despite concerns about a rise in suicide during the pandemic, early indications from real time suicide surveillance systems have not shown a significant increase in suicides when comparing pre and post lockdown periods. However these are provisional figures and further monitoring is essential. Periods of financial recession are known to impact suicide rates, which is a concern in the event of an economic downturn or increases in the costs of living, and the subsequent impact on employment and financial stressors such as unmanageable debt[145].

Outside of the pandemic, rates of suicide and self-harm in under 24 year olds in England have been steadily increasing over the last decade.[146] It is suggested that around half of people who die by suicide have previously self-harmed. Reported rates of self-harm across BHR are lower than England, with 460 people admitted to hospital for intentional self-harm. However, the majority of self-harm is known to occur in the community and does not lead to hospital attendance.[147]

Recommendation 78: *Ensure there are comprehensive strategies/plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.*

Recommendation 79: *Monitor suicides in real time to identify trends and use the insight to inform preventative action as needed.*

[145] HM Government (2021) *Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives*
[146] ONS (2021) *Suicides in England and Wales*
[147] ONS (2021) *Suicides in England and Wales*

6.4 Cancer

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

Cancer incidence and prevalence

Cancer is the cause of enormous harm to health – accounting for 26 % of all years of life lost across BHR[148]. 1 in 2 people will be diagnosed with cancer in their lifetime. Adjusting for differences in age structure; the incidence of all cancers in Barking & Dagenham and Havering is similar to the national average; the incidence of cancers in Redbridge is significantly lower (better) than the national average.

Overall, more than 3,500 people in BHR are diagnosed with cancer each year (Fig. 40).

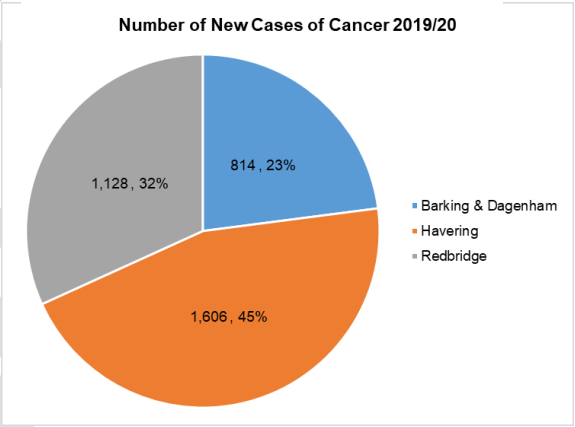
Cancer Lifetime Risk

Source: Cancer Research UK

More than half of new cases are cancer of the breast, prostate, lung or bowel.

The incidence of cancer increases steeply with age, peaking in the 85 to 89 age group (Fig. 41). As a result, Havering, with its older population has a higher number of cases than other BHR boroughs. The number of cancer cases in all three boroughs will increase as the population grow and ages.

Figure 40. New Cases of Cancer across BHR 2019-20



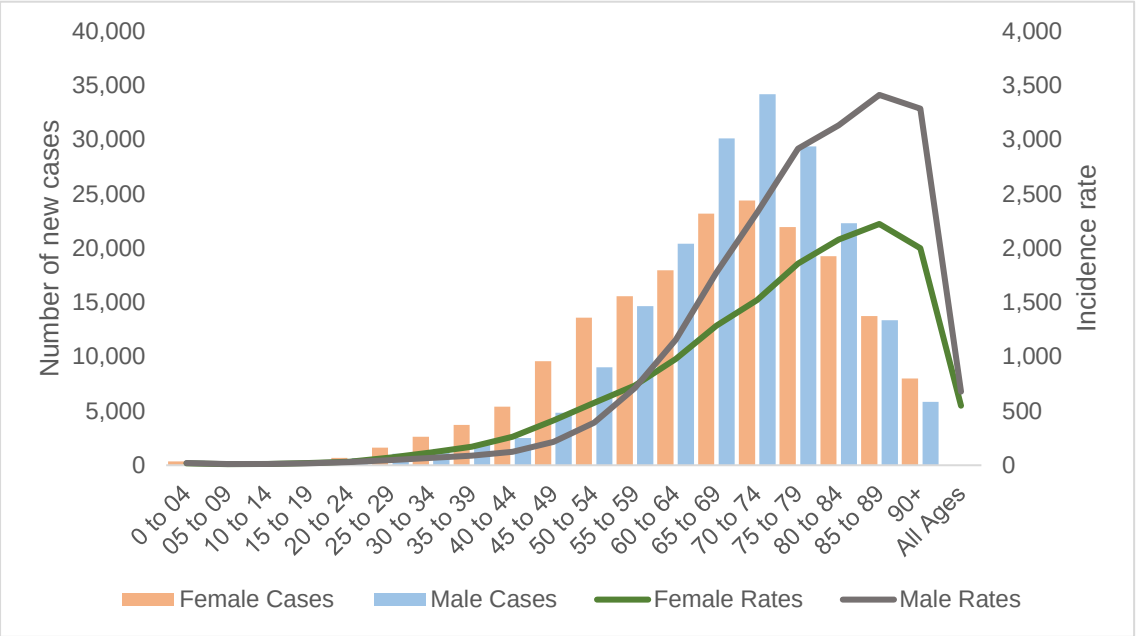
More than 16,000 people locally are living with and beyond cancer (prevalence), almost half are resident in Havering. The number of people living with cancer will increase in line with increases in incidence and as survival continues to improve[149].

According to Cancer Research UK Incidence rates are strongly related to age for all cancers combined, with the highest incidence rates being in older people. In the UK in 2016-2018, on average each year more than a third (36%) of new cases were in people aged 75 and over.

[148] http://www.healthdata.org/gbd

[149] https://public.tableau.com/profile/transforming.cancer.services.for.london#!/vizhome/LondonCancerPrevalenceDashboard2017/PrevalenceDashboard

Figure 41 : Average Number of New Cases Per Year and Age-Specific Incidence Rates per 100,000 Population, UK



Source: Cancer Research UK

There is significant scope to reduce the burden of disease as around 4 in 10 cases are preventable.

Lifestyle factors to prevent cancer

Smoking remains the largest preventable cause responsible for 15% of cases followed by excess weight[150].

NB. Action to tackle lifestyle related risk factors are discussed in section 4.

Preventable cases

Source: Cancer Research UK

Vaccination against the Human Papilloma Virus (HPV) greatly reduces the risk of developing cervical cancer in later life. In 2020-21, coverage in BHR boroughs outperformed the national average (Table 14). Nonetheless, more than 800 girls aged 13-14 yearsin the three boroughs were not protected.

Table 14: Population Vaccination Coverage – HPV Vaccination Coverage (for one dose)

AREA	12-13 FEMALE	13-14 FEMALE**	12-13 MALE
LBBD	88.4%	83.5%	84.9%
LBH	91.9%	86.7%	85.6%
LBR	87.5%	79.2%	83.9%
ENGLAND	76.7%	60.6%	71.0%

Source: PHE Fingertips 2020-21

** Two doses

[150] Brown KF, Rumgay H, Dunlop C, et al. The fraction of cancer attributable to known risk factors in England, Wales, Scotland, Northern Ireland, and the UK overall in 2015. BJ of Cancer 2018

Recommendation 80: *Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.*

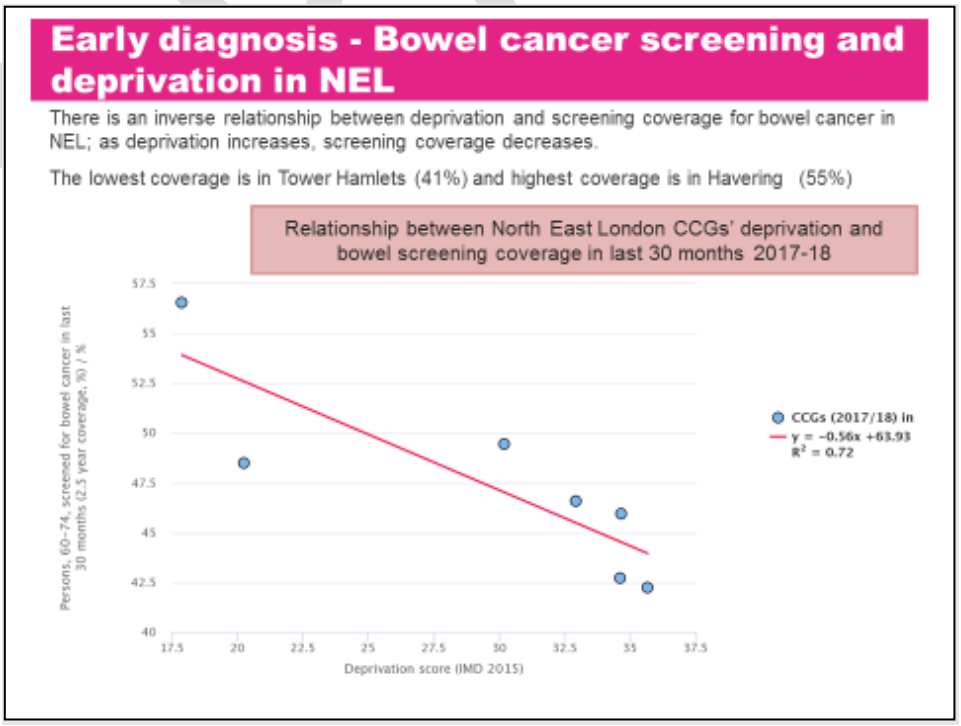
Surviving cancer

Survival varies significantly depending on site of the cancer. For example, and with regard to the common cancers, survival varies from more than 95% at 1 year for breast cancer to about 30% for lung cancer[151]. In all cases, 1-year survival is significantly better when cancer is diagnosed early.

One year survival has increased steadily in all three BHR boroughs, e.g. for Barking & Dagenham residents, from 54.2% in 2002 to 69.7% in 2017. However, survival in all BHR boroughs has consistently lagged behind the national average – now 73.3%, particularly in Barking & Dagenham at 69.7%.

For some cancers, screening offers a means of identifying cancers before any signs of disease are evident, increasing the likelihood of successful treatment. Screening coverage for the three national screening programmes (bowel, breast and cervical) is lower than England in Barking & Dagenham and Redbridge. Coverage for breast and cervical screening is higher in Havering than the national average but coverage of bowel screening is significantly lower. There is a strong correlation between levels of disadvantage and screening coverage uptake (Fig. 42). Hence, coverage in Havering is higher than that achieved in any other borough in NEL for all three screening programmes[152].

Figure 42. Relationship between early cancer diagnosis and deprivation in NEL



Source: Healthy London - Inequalities Toolkit

[151] https://www.cancerresearchuk.org/health-professional/cancer-statistics/survival

[152] https://www.healthylondon.org/resource/cancer-inequalities-toolkit/north-central-london-snapshot/

Cancer screening programmes and early diagnosis

Irrespective of the precise uptake, many hundreds of eligible BHR residents do not participate in cancer screening programmes each year (Table 15). Coverage is expected to have dropped further during the pandemic.

Table 15: Cancer screening coverage 2021

	CERVICAL (25-49)	CERVICAL (50-64)	BREAST	BOWEL
LBBD	65.0%	71.2%	54.5%	54.3%
LBH	71.4%	76.3%	75.9%	66.5%
LBR	58.6%	72.5%	61.7%	59.0%
LONDON	59.1%	70.9%	55.2%	59.3%
ENGLAND	68.0%	74.7%	64.1%	65.2%

Source: NHS Digital via PHE Fingertips.

The national cancer screening programmes were the subject of a review[153] by Prof Sir Mike Richards who recommended fundamental change in terms of accountability for screening programmes which are currently split between multiple organisations. The changes recommended included: improvements in IT to facilitate better call and recall; more rapid adoption of improved screening methods; and approaches that better fit with peoples' busy lives, including improved access to cervical screening appointments. In addition, proactive outreach is required to engage some population groups e.g. residents who are not registered with a GP. Otherwise screening programmes are likely to increase health inequalities.

***Recommendation 81**: Continue to work to increase uptake of: cervical screening by offering extended hours in general practice; bowel screening with the roll out of FIT[154] testing for diagnosing colorectal cancer; and breast screening*

Recommendation 82: *Undertake a deep dive/equity audit to understand which populations are not taking up screening and support a programme of community engagement working with those identified as less likely to participate in screening programmes to increase uptake.*

In addition to the established national cancer screening programmes, BHR CCGs are a pilot site for the SUMMIT Study, run by University College London Hospitals NHS Foundation Trust (UCLH) and UCL (University College London). The study aims to recruit 25,000 people aged 50-77 in north and east London, who are at higher risk of lung cancer, to take part in early screening. If a patient is eligible, they will be invited to have a low dose CT scan and provide a blood sample which will support the development of a blood test by GRAIL (a U.S. healthcare company focused on the early detection of cancer) to detect multiple types of deadly cancers, including in the lung.

[153] https://www.england.nhs.uk/wp-content/uploads/2019/02/report-of-the-independent-review-of-adult-screening-programme-in-england.pdf

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

Where no screening programme exists, early diagnosis relies on people being aware of the risk and seeking help when they notice changes to their body and thereafter, their GP promptly referring patients with suspicious signs and symptoms for relevant investigations. However, referring without adequate cause can result in unnecessary anxiety to patients and overburden finite diagnostic capacity so that the investigation of patients with more concerning symptoms is delayed.

There is significant variation among general practices in Barking & Dagenham, Havering and Redbridge regarding the rate of two week wait referrals made (where cancer is suspected) and the proportion that subsequently result in a diagnosis of cancer (Fig. 43).

Figure 43: Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals). Five years combined data.

Lower | Similar | Higher | Not compared

Recent trends: – Could not be calculated | No significant change | Increasing | Decreasing

New cancer cases treated resulting from a Two Week Wait referral (Detection rate: % of all new cancer cases treated). Five years combined data. (Persons, All ages) 2016/17 - 20/21

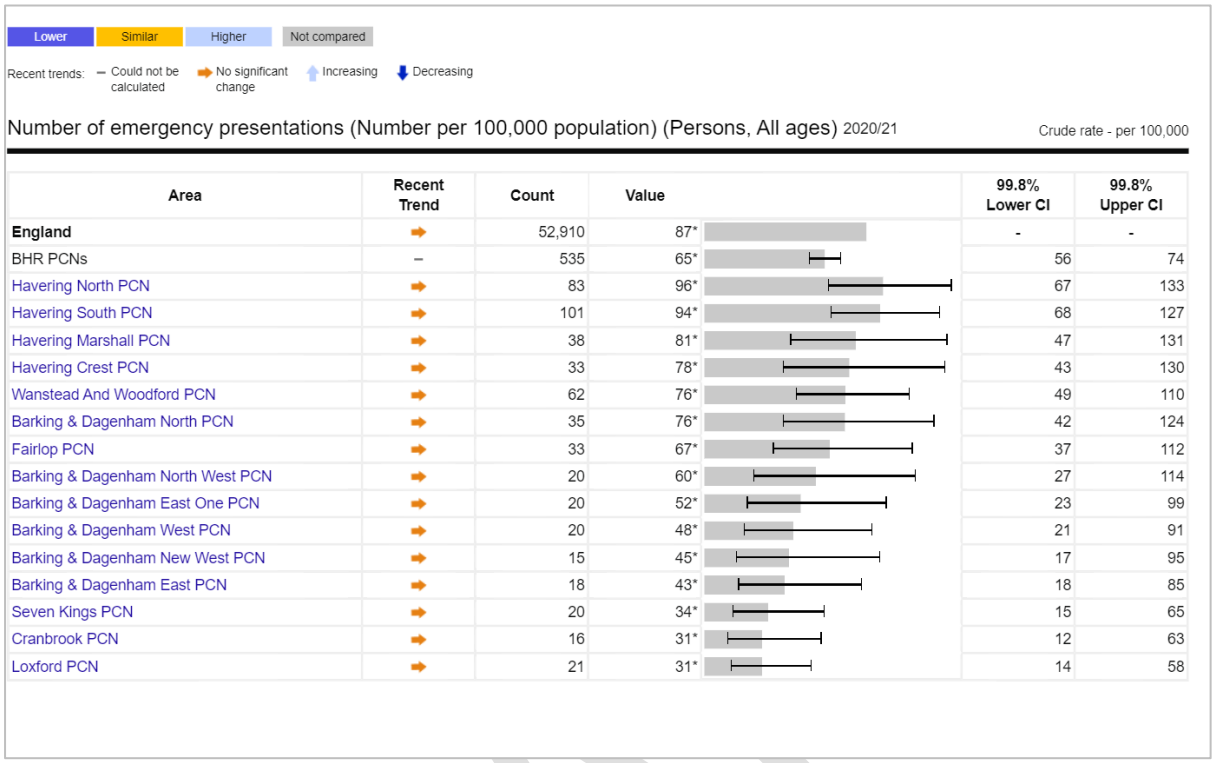
Proportion - %

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	–	727,917	52.9	-	-
BHR PCNs	–	7,896	55.8*	54.5	57.1
Cranbrook PCN	–	355	59.3*	53.0	65.3
Havering South PCN	–	1,727	59.1*	56.2	61.8
Barking & Dagenham West PCN	–	314	57.7*	51.1	64.1
Havering Marshall PCN	–	662	57.3*	52.8	61.7
Havering Crest PCN	–	607	57.1*	52.4	61.7
Fairlop PCN	–	443	56.1*	50.6	61.4
Loxford PCN	–	320	55.9*	49.5	62.2
Havering North PCN	–	1,022	55.9*	52.3	59.5
Barking & Dagenham North PCN	–	395	55.6*	49.8	61.2
Barking & Dagenham East One PCN	–	340	54.3*	48.1	60.4
Barking & Dagenham North West PCN	–	246	53.1*	46.0	60.2
Barking & Dagenham New West PCN	–	136	52.1*	42.6	61.4
Seven Kings PCN	–	364	51.3*	45.5	57.0
Wanstead And Woodford PCN	–	800	51.2*	47.3	55.1
Barking & Dagenham East PCN	–	165	48.1*	39.9	56.4

Source: PHE Fingertips

The diagnosis of cancer cases in A&E or following an emergency admission may indicate that the disease has already progressed to being an acute problem before it is identified. On average, cases identified as an emergency have a poorer prognosis than cases identified elsewhere. Just under 1 in 5 cases of cancer in BHR are first diagnosed following an emergency presentation (Fig. 44)..

Figure 44: Number of emergency cancer presentations (Number per 100,000 population)



Lower | Similar | Higher | Not compared

Recent trends: – Could not be calculated | No significant change | Increasing | Decreasing

Number of emergency presentations (Number per 100,000 population) (Persons, All ages) 2020/21 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	99.8% Lower CI	99.8% Upper CI
England	➡	52,910	87*	-	-
BHR PCNs	–	535	65*	56	74
Havering North PCN	➡	83	96*	67	133
Havering South PCN	➡	101	94*	68	127
Havering Marshall PCN	➡	38	81*	47	131
Havering Crest PCN	➡	33	78*	43	130
Wanstead And Woodford PCN	➡	62	76*	49	110
Barking & Dagenham North PCN	➡	35	76*	42	124
Fairlop PCN	➡	33	67*	37	112
Barking & Dagenham North West PCN	➡	20	60*	27	114
Barking & Dagenham East One PCN	➡	20	52*	23	99
Barking & Dagenham West PCN	➡	20	48*	21	91
Barking & Dagenham New West PCN	➡	15	45*	17	95
Barking & Dagenham East PCN	➡	18	43*	18	85
Seven Kings PCN	➡	20	34*	15	65
Cranbrook PCN	➡	16	31*	12	63
Loxford PCN	➡	21	31*	14	58

Source: PHE Fingertips

The percentage of cancers detected at stage 1 and 2 (early) in Havering is lower (worse) than other BHR boroughs and the current national average. The rate in all boroughs (about 50%) is a long way from the ambition stated in the NHS Long Term Plan that by 2028, the NHS will diagnose 75% of cancers at stage 1 or 2. It is still too early to tell the impact of Covid on late presentation. The latest available data is 2019, as shown on the dashboard (Appendix 8) but percentages are not reported due to issues with denominator.

Recommendation 83: *To undertake an audit to assess the impact of Covid-19 on Cancer screening and service delivery including emergency presentations post-pandemic*

Recommendation 84: *Continue efforts to raise awareness of signs and symptoms of cancer with the public and healthcare professionals.*

The timeliness of diagnosis and initiation of effective treatment are important measures of services quality. A variety of waiting time standards have been established to drive improvements in the delivery of cancer care.

Lack of capacity, both equipment and staff, remains the limiting factor slowing the improvement of cancer diagnosis and treatment. The NHS Long Term Plan commits to the roll-out of new Rapid Diagnostic Centres (RDCs) that will bring together modernised kit, expertise and cutting edge innovation to achieve earlier diagnosis,

with improved patient experience, for all patients with cancer symptoms or suspicious results. Separate to this investment in facilities; action will be needed to remedy shortages in key professions e.g. pathologists, radiologists, gastroenterologists (and other endoscopists).

Recommendation 85: *Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)*[155]

Recommendation 86*: Implement the national optimal cancer pathways*[156]*.*

More people than ever are living with and beyond cancer. In parallel with improvements in survival has come greater recognition that quality of life outcomes are just as important. Quality of life measurement is being introduced to improve understanding of the impact of cancer and its treatment and how well people are living after treatment. In addition, action is underway to provide personalised care and support – putting patients more in control of their recovery.

The personalised approach is also being applied to follow-up so that people can be reassured of effective ongoing cancer surveillance, but require fewer face-to-face appointments, with rapid access to support, advice and interventions with the most appropriate clinicians when needed.

Further work is underway to improve the provision of services to manage the consequences of treatment, which cause poor quality of life and are often under-recognised. These include psychological difficulties, fatigue, pain, or bowel, bladder and sexual problems.

Recommendation 87: *Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways*[157] *for prostrate, breast and bowel cancer patients.*

Recommendation 88: *Work towards a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long-Term Condition.*

NB. Continued collaboration with third sector partners is key and there are many large and well-established charities working in cancer – in particular Cancer Research UK which supports earlier diagnosis, and Macmillan Cancer Support provides support to people living with and beyond cancer.

[155] https://www.england.nhs.uk/cancer/early-diagnosis/
[156] http://uklcc.org.uk/wp-content/uploads/2019/10/01-UKLCC-Pathways-Matter-Report-Final.pdf
[157] https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf

6.5 Long Term Conditions

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

What are Long Term Conditions?

Long-term conditions, also known as chronic conditions, are those health conditions that require ongoing treatment or management over a period of years or decades. They may not be able to be cured or reversed but can be controlled with the use of medication and therapies (NHS England).

As described in *Section 3*, despite recent increases in life expectancy, most of the additional years of life gained over recent decades are affected by ill health or disability. A significant proportion of this ill health is the result of long-term conditions (LTCs) and they contribute substantially to health inequalities by ethnicity and deprivation in England.

LTCs can affect almost every part of the body and often people may be dealing with more than one LTC at a time (Table 16). Many LTCs may cause few symptoms initially, whilst increasing the risk of serious acute events long-term, such as heart attack or strokes, which can lead to premature death or long-term disability. This may mean that people are less likely to seek help at an early stage of their condition and LTCs may remain undiagnosed and unmanaged.

Table 16. Long term conditions

Common Long-Term Conditions:	
cardiovascular disease (CVD)	hypertension
heart failure	chronic kidney disease (CKD)
atrial fibrillation (AF)	diabetes
chronic obstructive pulmonary disease (COPD)	asthma

Prevention and ensuring early detection, diagnosis and treatment of LTCs are equally important.

Many LTCs are associated with lifestyle related risk factors such as poor diet, smoking and low levels of physical activity. Some LTCs are also linked to environmental exposures e.g. the risk of chronic obstructive pulmonary disease (COPD) and asthma are increased by regular exposure to poor air quality. The prevalence of lifestyle and environmental risk factors tend to be higher in disadvantaged communities and are the immediate cause of significant inequalities evident regarding many LTCs.

Appropriate management of established LTCs through medication, lifestyle change and therapies can prevent crises, delay further progression and lead to significant improvements in quality of life. However, inequitable and/or culturally inappropriate models of providing effective interventions can further exacerbate health inequalities.

Who is most at risk from long-term conditions?

Inequalities by age

The risk of developing an LTC increases with age, with 62% of people over 60 years old reporting at least one LTC compared to only 24% of those under 40 years old nationally (*ONS Annual Population Survey*, ONS, 2019). As a result, forecasted increases in the number of older individuals in the population (see Section 1.3) are likely to lead to increases in the number of individuals with LTCs in the absence of more effective prevention.

Inequalities by ethnicity

There are substantial inequalities in the prevalence of LTCs by ethnicity. South Asian groups, in particular Bangladeshi and Pakistani groups, and Black African groups are at higher risk of developing many LTCs and experiencing worse outcomes in comparison to White groups (*Local Action on Health Inequalities*, PHE, 2019).

Inequalities by deprivation

Deprivation is a key risk factor for LTCs. Over half of the gap in life expectancy between the most and least disadvantaged nationally is a result of premature death from preventable LTCs and cancers *(NHS Long-Term Plan, 2020).*

Nationally, on average, individuals living in more disadvantaged areas develop more than one LTC 10-15 years earlier than those in more affluent neighbourhoods, substantially affecting inequalities in quality of life (*NHS Long Term Plan*, NHS England, 2019). Type 2 diabetes is 60% more common among individuals in the most deprived quintile compared with those in the least deprived quintile in England.

Premature death rates from cardiovascular disease (CVD) in the most deprived 10% of the population are almost twice as high as rates in the least deprived 10%. Much of this disparity results from higher rates of preventable risk factors, such as smoking and poor diet, representing an opportunity for effective prevention to reduce health inequalities.

Impact of lifestyle and environmental factors

The risk of developing most LTCs is partly, if not largely determined by modifiable factors. An estimated 50-80% of CVD results from modifiable or preventable factors such as smoking, obesity, poor diet, harmful drinking and low levels of physical activity. This represents an important opportunity for effective prevention at an individual level to have a substantial impact on the prevalence of LTCs.

There are also important environmental exposures that increase the risk of LTCs. These include exposure to air pollution and environments that do not support physical activity and healthy eating (for example, lack of access to green space and over density of fast-food takeaways). Many of these environmental exposures are greatest in areas of high deprivation and make a substantial contribution to health inequalities. Local authorities and other partners in BHR have a key role in addressing these wider determinants of health to prevent LTCs.

What is being done to support those with Long Term Conditions?

Primary prevention of Long-Term Conditions
Primary prevention aims to prevent people developing disease in the first place. Due to the strong link between modifiable lifestyle factors (such as alcohol, smoking and obesity) and long-term conditions; effective, culturally sensitive primary prevention, that reflects the distribution of risk factors within the community can reduce the overall burden of long-term conditions and narrow health inequalities.

NHS Health Checks

NHS Health Checks[158] are an opportunity to identify people with, or at high risk of, CVD and related conditions including diabetes, hypertension and Chronic Kidney Disease (CKD). A Health Check should be offered once every 5 years to everyone aged 40-74 years who does not have a pre-existing LTC. Public Health England estimated that for every 6 to 10 NHS Health Checks completed, one person is identified as being at high risk of CVD. Health checks also provide an opportunity to encourage people to tackle lifestyle related risk factors before they cause ill health and connect them with sources of support that might assist them to achieve change.

A significant proportion of eligible patients are not offered or do not attend their NHS Health Check. Currently, only Barking and Dagenham are achieving above the London average of 49.9% of eligible individuals receiving an NHS Health Check (Table 17). In addition to having the lowest overall health check attendance, Havering also has the most inequitable uptake, with a gap of 7.7 percentage points between the least and most deprived quintiles (Fig. 45).

As stated previously, non-White groups are at greater risk of preventable LTCs. Therefore, and notwithstanding the need to increase uptake in all groups, it is encouraging that, in the period 2012/13-2017/18, Asian groups recorded the highest percentage attendance in all three boroughs, followed by Black groups and White groups (Fig. 46).

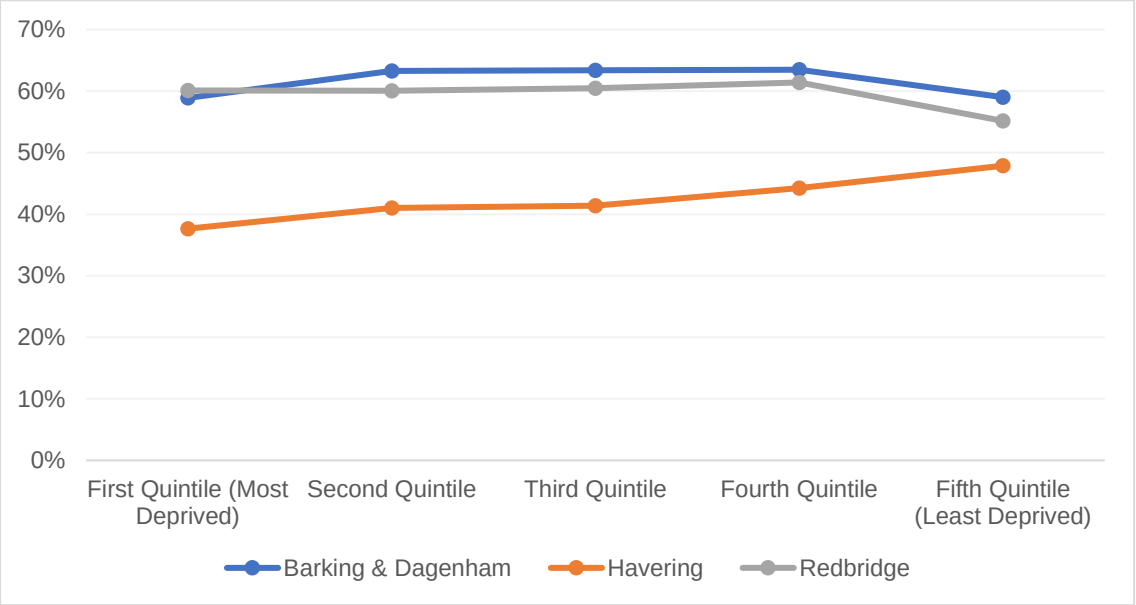
Table 17: Proportion of eligible individuals invited and receiving an NHS Health Check Q1 2016/17 –2020/21 in Barking & Dagenham, Havering and Redbridge

	LBBD *(%)*	**LBH** *(%)*	**LBR** *(%)*	**London***(%)*	**England** *(%)*
% of eligible individuals invited for an NHS Health Check	85.4	71.9	82.1	73.4	71.8
% of eligible individuals receiving an NHS Health Check	53.4	38.0	49.1	49.9	46.5

= below London avg., = similar to London avg., = above London Avg.
Source: OHID Fingertips

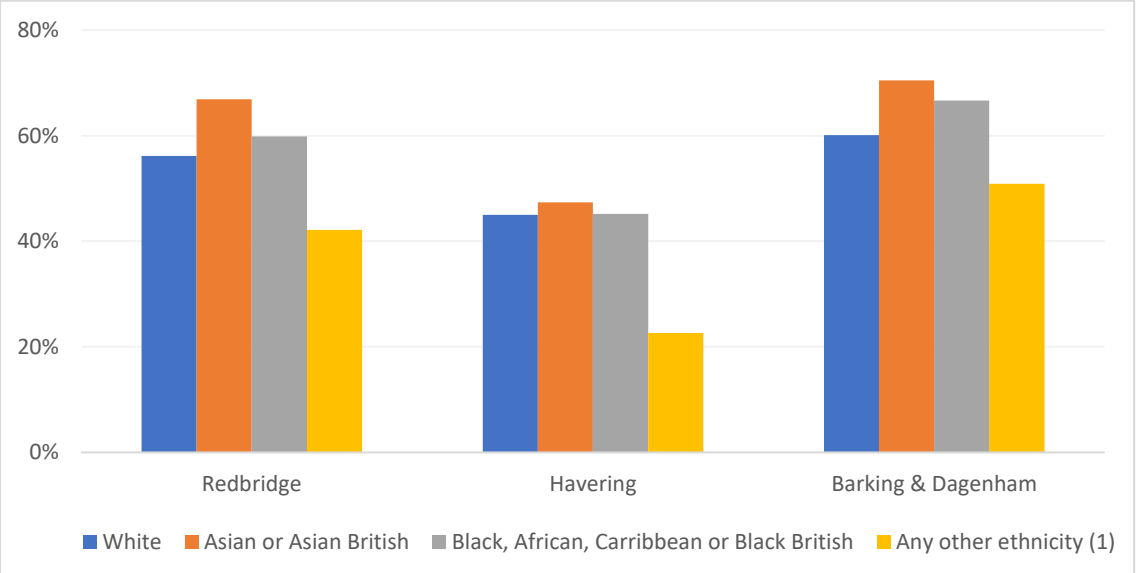
[158] https://www.healthcheck.nhs.uk/

Figure 45: Proportion of individuals attending an NHS Health Check after receiving an invitation by deprivation quintiles within each local authority for the period 2012/13-2017/18.



Source: NHS Digital, Health Check Dashboard

Figure 46: Proportion of individuals attending an NHS Health Check after receiving an invitation within each ethnic group and by local authority from 2012/13-2017/18



(1) "Any other ethnicity" includes those of mixed ethnicity, any other ethnic group and those without recorded ethnicity data)

***Recommendation 89**: BHR should review the care pathway and provision of support for patients found to be at high risk of LTCs following an NHS Health Check (or other identification route) to ensure that:-*

- behaviour change support is effective, high quality and in line with best practice guidelines. This should include reviewing whether support is culturally appropriate for each borough's communities, with a focus on contributing to reductions in health inequalities by ethnicity and deprivation

- treatment is likewise effective, high quality and in line with best practice guidelines.

***Recommendation 90:** Each BHR borough should review the current service delivery model and approach to increasing the offer and uptake of NHS health checks and develop a robust action plan for improvements in uptake, particularly among those at greatest risk of poor health. Key opportunities to explore should include the accessibility of Health Checks appointments by time and geography, the role of PCNs and exploring the potential for delivery of workplace-based programmes.*

***Recommendation 91:** To review the processes for analysis and reporting of key local data on preventative interventions to support local Public Health teams in improving delivery. This should include both the Health Check and National Diabetes Prevention programmes. There should be a focus on improving the granularity of data, both by geography (in particular by Primary Care Networks) and inequalities by ethnicity, deprivation and age, as well as regular reporting of data on invitation, uptake and outcomes.*

Secondary prevention of Long-Term Conditions

Secondary prevention aims to reduce or reverse the negative impacts of LTCs**.** The effects of many LTCs, such as diabetes, may be reversed or prevented through effective secondary prevention and so lead to substantial improvements in quality of life.

For most LTCs there is a significant difference between the proportion of the population expected to have the disease and the number actually diagnosed; as a result many thousands of residents are unaware they have an LTC. Moreover, of those that do have a diagnosis, many do not receive all the treatments that would benefit them.

Healthier You: NHS Diabetes Prevention Programme (NDPP)

The NDPP is based on a strong evidence base that shows supporting people to maintain a healthy weight and be more active, can significantly reduce the risk of developing Type 2 diabetes. Individuals aged 18 years or over at high risk of progressing to Type 2 Diabetes (known as non-diabetic hyperglycaemia) are eligible for referral to the NDPP.

The intervention consists of a series of predominantly group-based sessions delivered in person across a period of at least nine months. There are at least 13 sessions, lasting between one and two hours, and at least 16 hours of contact time. Each session covers topics geared towards the NDPP's main goals of weight reduction and improved glycaemic control through dietary improvements, and increased physical activity and reduction in sedentary behaviour. They are underpinned by behavioural theory and involve the use of behavioural techniques. Sessions are offered in the community at various sites within BHR. In addition, a digital stream offers an alternative service to face-to-face programmes making use of technologies, including wearables and apps.

The NDPP was offered in BHR relatively late and there is a considerable way to go in terms of increasing participation and completion if the potential benefits are to be realised. The harm to residents is very great. Locally, diabetes is responsible for 1.6% of all Years of Life Lost, 4.4% of Years Lived with Disability and 3.1% of all Disability Adjusted Life Years. Nationally, about 9% of the total NHS budget is spent on the treatment of diabetes and the complications arising.

Years of Life Lost (YLL); YLL estimates the number of years of potential life lost due to premature deaths from a condition, based on the average life expectancy of a population.

Years Lived with Disability (YLD); YLD estimates the number of years lived with a disability resulting from a condition.

Disability Adjusted Life Years (DALY); DALYs measure the impact of a condition on both mortality and morbidity. DALYs are calculated through combining the Years of Life Lost (YLL) and Years Lived with Disability (YLD) measures for a condition. One DALY is equivalent to the loss of one year of healthy life.

Recommendation 92: *BHR should review the local approach to maximising participation in the National Diabetes Prevention Programme and develop an action plan for improved uptake and outcomes. This should include actions to ensure that the NDPP is culturally appropriate for the different communities of BHR to reduce inequalities by ethnicity and deprivation.*

Care and Support for those with diabetes

Of the 49,000 people in BHR known to have diabetes, only two-thirds in Barking & Dagenham receive all eight care processes that comprise effective care, falling to less than half in Havering and Redbridge (PHE *Fingertips*).

Recommendation 93: *BHR should review and amend where necessary the current approach to the delivery and monitoring of diabetes care to ensure that all effective care is consistently provided.*

Moreover, around 1 in 6 of BHR residents (n=10,000) expected to have diabetes remain undiagnosed and hence untreated.

***Recommendation 94**: BHR should explore opportunities to expand the target populations for NHS Health Checks and the NDPP beyond the statutory minimum (currently 40-74 years for Health Checks and 35+ for the NDPP) to increase the proportion of people with diabetes that are diagnosed and can be offered effective prevention. In addition, BHR should develop actions to increase uptake by under-served populations (such as homeless residents).*

Tertiary prevention for long term conditions

Tertiary prevention for LTCs refers to efforts to reduce the negative impacts on health and quality of life for those with LTCs and prevent further complications. This is particularly challenging as individuals may have more than one LTCs affecting their lives. Key actions are likely to include supporting people to remain independent and manage their conditions to prevent avoidable negative outcomes such as unplanned hospital admissions.

Effective tertiary prevention can ensure those individuals with one or more LTCs are able to live as long and happy a life as possible and requires close working across many different health and social care organisations.

Of a sample of individuals with LTCs surveyed locally, less than 50% in all three boroughs report that they received all or some of the support they needed, below the national average of 54.9% (Table 18).

One method for assessing the effectiveness of care for those with LTCs is by looking at rates of preventable deaths and surgical procedures locally. With effective tertiary prevention in place, these deaths and procedures should be prevented. From 2017-2019, both Havering and Barking and Dagenham reported a mortality rate from preventable respiratory conditions for those under 75 years above the national and London averages, representing preventable deaths in part from LTCs. From 2016/17-2018/19 all three boroughs also reported a rate of avoidable major lower limb amputations resulting from diabetes above that of the national average (Table 18).

***Recommendation 95:** BHR should review current levels of preventable mortality and surgical procedures linked to LTCs, to understand in detail differences across the three boroughs. A robust action plan should be developed to reduce preventable mortality and procedures.*

Table 18– summary data on avoidable negative health outcomes for individuals with LTCs (taken from Appendix 9: Long Term Conditions dashboard)

Indicator	Period	Count	Havering	Barking & Dagenham	Redbridge	London average	England average
Percentage of individuals with LTCs reporting that they have received all or some of the support they need	2019/ 2020	798	46.5%	49.1%	46.8%	52.1%	54.9%
Under 75 mortality rate from respiratory conditions considered to be preventable (rate per 100,000)	2017-2019	128	20.2	38.2	11.8	17.3	20.0
Major Diabetic lower-limb amputation procedures (rate per 10,000)	2016/17 - 2018/19	40	9.2	10.7	13.3	N/A	8.2

= better than England avg; = similar to England avg; = worse than England avg

Source: PHE Fingertips

Multiple Long-term conditions

An increasing proportion of people are affected by more than one LTC at a time, also known as "multi-morbidity". Due to the added complexity of managing multiple conditions, multi-morbidity has been identified as one of the greatest challenges facing the NHS and social care and has been highlighted in the UK Government's Health and Care White Paper (UK Government, 2021).

More than one in four adults nationally live with two or more LTCs ("Multiple Long Term Conditions – making sense of the evidence" NIHR, 2021). A previous analysis by BHR CCGs in 2019/2020 identified nearly 24,000 patients with 2 LTCs, more than 12,000 with 4 LTCs and more than 400 with 6 LTCs.

Due to the challenge and complexity of managing multiple conditions, individuals affected by multi-morbidity are also at substantially increased risk of poor mental health. One in three patients with multiple LTCs also experiences poor mental health, increasing the chances of individuals with multi-morbidity experiencing both poor physical and mental health outcomes.[159] Table 19 provides the most common range of LTCs experienced by those with six or more conditions as an example of the complexity of issues involved in delivering effective care for these individuals.

[159] "Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study", Salisbury, C. et al, *British Journal of General Practice* 2011; 61 (582): e12-e21. DOI: https://doi.org/10.3399/bjgp11X548929

Table 19: Number of patients across BHR with different combinations of six LTCs concurrently

Combination of LTCs	Number of Patients
Asthma, CHD, CKD,COPD, diabetes, AF	7
Asthma, CHD, CKD,COPD, hypertension, AF	46
CHD, CKD, COPD, diabetes, hypertension, AF	127
Asthma, CHD, CKD, diabetes, hypertension, AF	85
Asthma, CHD, COPD, diabetes, hypertension, AF	104
Asthma, CKD, COPD, diabetes, hypertension, AF	53

Recommendation 96: *BHR should conduct a review of the current provision of prevention and care to those with multiple conditions and develop a robust action plan for improving local care pathways across all three boroughs to reduce levels of preventable ill health, morbidity and mortality.*

Long COVID

Most children, young people and adults who have had an acute COVID-19 infection recover and return to normal health. However, some patients can have symptoms that can last for weeks or even months after recovery from acute illness. Persistent symptoms following a COVID-19 infection is commonly termed 'long COVID' but has also been referred to as 'ongoing symptomatic COVID-19' and 'post-COVID-19 syndrome'[160].

The Office of National Statistics has estimated that 1.2 million people in private households (1.9% of the population) were experiencing self-reported long COVID as of 2nd October 2021[161]. The types and duration of long Covid symptoms vary widely, with the main symptoms being fatigue, shortness of breath, muscle ache and difficulty concentrating[162]. Most individuals with long COVID are able to self-manage their symptoms and will only need generalist assessment, support and rehabilitation.

[160] National Institute for Health and Care Excellence (2020) COVID-19 rapid guideline: managing the long-term effects of COVID-19 (NICE guideline 188). Available at: https://www.nice.org.uk/guidance/ng188

[161] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 4 November 2021. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/latest

[162] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 July 2021. Available at:

However, Greenhalgh et al, estimate that approximately 11% of patients with long COVID will need specialist assessment and management for specific long-term complications[163]. Emerging evidence suggests that these patients were previously hospitalised due to COVID-19, particularly those who were admitted to ICU. More information is needed to understand the emerging needs associated with long COVID. One study found that there were significantly more new diagnoses of respiratory disease, diabetes, major adverse cardiovascular event (MACE), chronic kidney disease and chronic liver disease following hospital admission due to acute COVID-19 infection[164].

Long COVID clinics have been set-up across England, including a clinic in BHRUT based at King George's Hospital[165]. The clinic hosts professionals who provide physical, cognitive and psychological assessments for those referred by their GP for suspected long COVID. The clinic is for those with ongoing symptomatic COVID-19 (4-12 weeks post confirmed or probable infection) or post-COVID syndrome (more than 12 weeks after confirmed or probable infection) and need a programme of physical and/or psychological therapy.

***Recommendation 97**: Consider commissioning of further services for those with long Covid, based on learning from newly commissioned services in BHRUT. These should include dedicated support services and self-management, for example mobile apps, community exercise programmes and peer support groups.*

***Recommendation 98**: Borough partnerships should work with primary care clinicians and directly with the public to raise awareness of long COVID, opportunities for self-care and appropriate referral for specialist assessment*

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1july2021

[163] 'Long Covid': evidence, recommendations and priority research questions. Available at: https://committees.parliament.uk/writtenevidence/12345/pdf/

[164] Ayoubkhani D, Khunti K, Nafilyan V, Maddox T, Humberstone B, Diamond I et al. Post-covid syndrome in individuals admitted to hospital with covid-19: retrospective cohort study *BMJ* 2021; 372 :n693 doi:10.1136/bmj.n693

[165] https://www.england.nhs.uk/2020/12/long-covid-patients-to-get-help-at-more-than-60-clinics/

6.6 Older People & Frailty

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

Life Expectancy and Healthy Life Expectancy

There are large numbers of older people in all three BHR boroughs and every locality. However, the population of Havering is relatively older such that nearly half of the 16,000 BHR residents aged 85 and above live in Havering (Fig. 47).

All things being equal, older people experience more ill health and have greater need for health and social care than other age groups, with the oldest residents having the greatest need. It follows that population ageing (see Section 1.3) will significantly increase the need for health and care services unless we do better in preventing ill-health.

This conclusion is very clearly illustrated by comparisons between life expectancy and healthy life expectancy at age 65.

The 'average' resident approaching retirement will live around 20 more years.

Life expectancy at age 65 for both men and women in Redbridge, and women in Havering is similar to the national average (18.7 years for men and 21.1 years for women) but is lower than the England average for men and women living in Barking & Dagenham and men in Havering. As is the case for the population as a whole, cancers and CVD are the big killers in old age, together with dementia.

However, average **healthy** life expectancy at age 65 is closer to 10 years for both men and women in all BHR boroughs, similar to the England average (10.5 yrs for men and 11.3 yrs for women). The conditions that cause the bulk of ill health for the population as a whole – mental illness, LTCs, MSK also contribute most to the burden of disease in old age – together with dementia.

A greater focus on the **prevention** of ill health throughout life is crucial if we are to improve healthy life expectancy and quality of life in later life and maintain the sustainability of health and care services as the population becomes progressively older.

Further opportunities to prevent ill health and slow progression and minimise crises where it does exist, occur in old age.

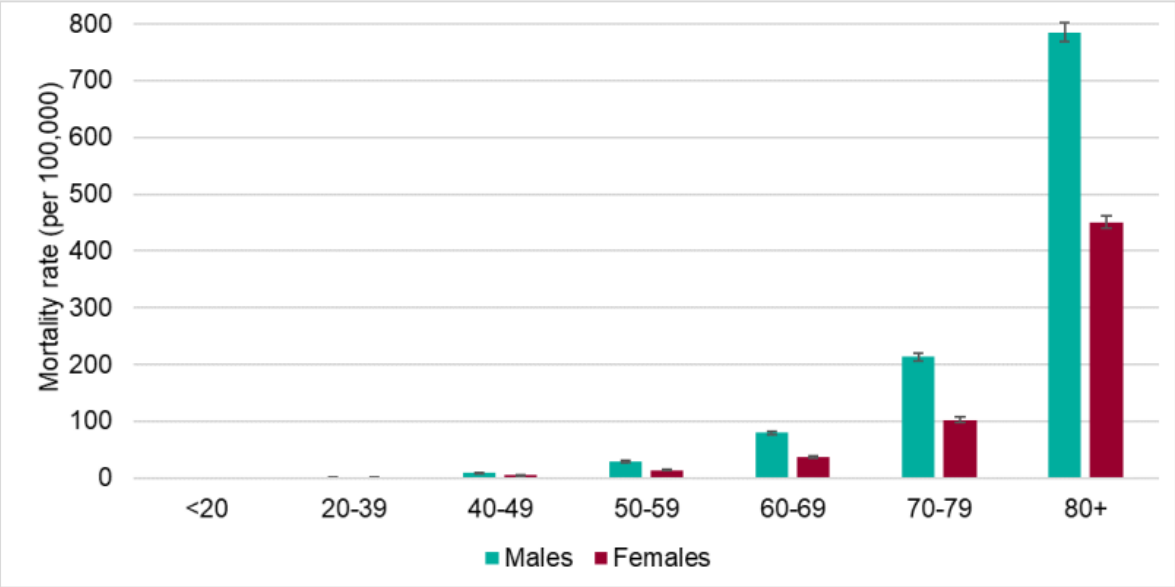
Vaccinations to Prevent Excess Winter Death

As is the case nationally, death rates among BHR residents aged 85 and above are about 20% higher during the winter months. The bulk of **excess winter deaths** result from respiratory conditions, some linked to flu infection; dementia and CVD (heart disease and stroke)[166]. In addition, there have been significant excess deaths due to the Covid-19 pandemic.

[166] ONS Excess winter mortality in England and Wales: 2019 to 2020 (provisional) and 2018 to 2019 (final).

Much of the response to the **pandemic** was designed to protect older residents from harm pending production of an **effective vaccine** as the risk of severe disease and mortality increased steeply with increasing age (Fig. 47).

Figure 47: Crude mortality rates COVID-19 deaths per 100,000 pop by age and sex May 2020



Source: Public Health England

When vaccines were approved, the JCVI recommended roll out in order of descending age so that the most vulnerable were protected first. As immunity wanes over time, further booster doses have and will be required, and are likely to be incorporated into measures taken each year to reduce excess winter deaths and manage winter pressures on the health and social care system[167].

Pre-pandemic, there was strong evidence that **flu vaccination** reduced excess winter deaths among the elderly. The benefit of flu vaccination is likely to be greater still while coronavirus is circulating, as patients with SARS-CoV-2 and influenza virus co-infection are around twice as likely to die[168] as people with SARS-CoV-2 alone[169].

Flu vaccine coverage of patients aged 65 and older in 2020/21 was below the national average (80.9%) in all 3 BHR boroughs. However, uptake was an improvement on that seen pre-pandemic and the minimum national target of 75% was surpassed in Redbridge and Havering for the first time in more than 10 years[170]. Therefore, Covid booster vaccine and flu vaccine work synergistically to reduce illness and death among older people.

Recommendation 99: *Build on the effective partnerships established during the pandemic to maintain and further improve uptake of flu and covid vaccines.*

[167] https://www.bmj.com/content/373/bmj.n1137
[168] Odds ratio 2.27 (95% Confidence Interval 1.23 to 4.19)
[169] Stowe J, Tessier E, Zhao H, et al. Interactions between SARS-CoV-2 and influenza, and the impact of coinfection on disease severity: a test-negative design. Int J Epidemiol2021;50:1124-33. doi:10.1093/ije/dyab081. pmid:3394210
[170] Source: https://fingertips.phe.org.uk

Recommendation 100: *Recognise heightened awareness of the benefits of vaccination amongst older age groups and (re-)check status regarding pneumococcal and zoster vaccines.*

Wider determinants of wellbeing in older age

PHE estimates that 1 in 10 excess winter deaths are directly attributable to fuel poverty[171]. More than 1 in 10 households in BHR are affected by **fuel poverty** ranging from 9% in Havering to 12.7% in Redbridge[172] *(see Section **3.5** re. fuel poverty).*

An early diagnosis of **dementia** can help people take control of their condition; plan for the future; potentially benefit from available treatments and make the best of their abilities. There is strong evidence that an early diagnosis helps someone with dementia to continue to live independently in his or her own home for longer[173]. In 2021, dementia diagnosis rate of Redbridge (63.5%) is the closest to the national target of 66%, whereas that of Havering and B&D trailed significantly at 53% and 58.9% respectively.

Recommendation 101: *Maintain efforts to further increase the completeness of dementia diagnosis, and improve access to the information and support for patients and their families*

Sudden confusion (delirium) can have many causes. Infection e.g. a urinary tract infection is a common cause of confusion in elderly people and people with dementia. Confusion can also result from a variety of medical conditions, drug side effects and head injury. The cause of many cases of delirium can be treated and recurrence prevented. New onset confusion requires urgent investigation and the responsible clinician should talk to someone who knows the person well and knows what has happened to them recently.

UK based surveys show that people can feel **lonely** at any stage of life, but that the experience is most severe among older people. Social networks shrink with retirement and the associated reduction in income may limit social activities. Additional contributory factors for loneliness in old age include: the loss of a loved one (an estimated 35,000 BHR residents aged 65 and above live alone)[174]; health conditions that precipitate disability and loss of mobility; and caring responsibilities. Successful interventions to tackle social isolation reduce the burden on health and social care services; as such, they are typically cost-effective[175].

[171] Public Health England & UCL Institute of Health Equity (2014) Local action on health inequalities: Fuel poverty and cold home-related health problems.
[172] Source https://fingertips.phe.org.uk
[173] https://www.scie.org.uk/dementia/symptoms/diagnosis/early-diagnosis.asp
[174] Source poppi.org.uk
[175] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

Recommendation 102: *Support efforts to tackle social isolation in general, but particularly amongst older residents, as part of wider efforts to improve the mental health of older people.*

There is a high prevalence of **mental health** issues in older people so Comprehensive Geriatric Assessment is not complete without addressing both mood and cognition. Care that looks at a 'whole person' and that is undertaken by a geriatric MDT is the gold standard approach so as not to miss either physical or mental health conditions. **Depression** often co-exists with physical illness or dementia. In addition, the health of an older person can also be adversely impacted by hazardous drinking of alcohol.[176]

The most common mental health condition in older people is depression, affecting 22% of men and 28% of women aged 65 or over, followed by anxiety.[177] 40% of older people who are living in care homes have depression; 30% of older carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience depression than older people who haven't been bereaved.[178]

Older people living with dementia may struggle to express how they are feeling which also increases the difficulty of diagnosis.[179] Dementia can also trigger mental health problems, with estimates suggesting that 20-40% of people living with dementia are depressed.[180]

It is important that older people are able to access services which are appropriate for their needs.[181] A target was set in 2011 to increase the proportion of older people referred to IAPT (Improving Access to Psychological Therapies) services to 12%. However, the proportion of users to the IAPT service who are over 65 has remained stable at or below 7%, despite this age group making up 18% of the population.[182]

Recommendation 103: *Services should be designed so that older people's needs can be met, including mental health and dementia.*

[176] https://academic.oup.com/ageing/article/42/5/598/18032?login=true
[177] Health and Social Care Information Centre (2007). Health Survey for England, 2005: Health of Older People. [online] Available at: http://www.hscic.gov.uk/pubs/hse05olderpeople
[178] Independent Age (2018), Good grief: older people's experiences of bereavement, London: Independent Age. Available at: https://independent-age-assets.s3.eu-west-1.amazonaws.com/s3fs-public/2018-04/Good Grief report.pdf
[179] British Geriatric Society and Royal College of Psychiatrists (2019), Collaborative approaches to treatment: depression among older people living in care homes, London: British Geriatric Society. Available at: https://www.bgs.org.uk/sites/default/files/content/attachment/2018-09-12/Depression%20among%20older%20people%20living%20in%20care%20homes%20report%202018.pdf
[180] Alzhimer's society, 'Depression and dementia'. Available at: https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/depression
[181] x Hamid, Abdul et al (2015), "Comparison of how old age psychiatry and general adult psychiatry services meet the needs of elderly people with functional mental illness: cross-sectional survey", British Journal of Psychiatry, 207 (5), pp. 440-443.
[182] Colins, N., and Corna, L. (2018), 'General practitioner referral of older patients to Improving Access to Psychological Therapies (IAPT): an exploratory qualitative study', BJPsych Bulletin, 42(3). pp. 115-118.

Falls are the most common cause of death from injury in the over 65s. A third of people over 65, and half of people over 80, fall at least once a year.[183] Falls are the number one factor precipitating a person losing independence and going into long-term care.

Age standardised rates of hospital admission for falls for over 65's are better (lower) than the national average in all three BHR boroughs. Nonetheless, close to 2000 admissions were recorded in 2019/20.

Hip fracture is a particularly serious consequence of falls especially among those with osteoporosis, malnutrition, weak muscle strength, sensory impairment and frailty. One in three people with a hip fracture dies within a year. Rates of hospital admission for hip fracture are similar to the national average in Havering and Barking & Dagenham, but better (lower) in Redbridge than the national average. More than 600 were recorded in 2019/20.

Falls are not an inevitable consequence of ageing; the risk of falling and the harm caused can be reduced. The Falls and Fragility Fractures Pathway[184] defines the core components of an optimal service for people who have suffered a fall or are at risk of falls and fragility fractures. The pathway focuses on the three priorities for optimisation:

- Falls prevention
- Detecting and Managing Osteoporosis
- Optimal support after a fragility fracture

Higher value interventions include:

- Targeted case-finding for osteoporosis, frailty and falls risk
- Strength and balance training for those at low to moderate risk of falls
- Multi-factorial intervention for those at higher risk of falls
- Fracture liaison service for those who have had a fragility fracture

Recommendation 104: *Ensure the BHR Falls prevention pathway is consistent with national guidance and equitably implemented according to need.*

Deconditioning - the loss of physical, psychological, and functional capacity due to inactivity – can occur rapidly in older adults, and, among other health impacts, increases the risk of falls. Public Health England found that older people experienced a considerable reduction in strength and balance during the first lockdown, further increasing the risk of falls.

[183] https://publichealthmatters.blog.gov.uk/2014/07/17/the-human-cost-of-falls/
[184] https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

Recommendation 105: *Refer older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitation services.*

Frailty is a particular state of health experienced by a significant minority of older people - around 10% of people aged 65+ years (around 10,500 across BHR in mid-2019) live with frailty, rising to 25- 50% of 85+ years (4,000 to 8,000). Being frail can mean that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing. For example,someone with moderate frailty has three times the annual risk of urgent care utilisation, death and care home admission than an older person of the same age who is not frail.

A comprehensive approach to minimise the harm caused by frailty[185] includes:

- **comprehensive prevention** as described above
- **population-based stratification** to systematically identify people who are living with moderate and severe frailty
- coupled with **targeted support** to help older people living with frailty to stay well and live independently for as long as possible including:-
    - **Community multidisciplinary teams** – focused on the moderate frailty population who are most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.
    - **Urgent Community Response** – crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.

Recommendation 106: *Ensure that patients at risk of frailty are systematically identified, using population health management approach; effectively supported by the local partners to stay well; or receive urgent additional help in times of crisis.*

Falls, social isolation and cognitive impairment are a few of the potentially preventable or modifiable risk factors that contribute to the development of frailty**;** others include alcohol excess; functional impairment, hearing problems, mood problems, nutritional compromise, physical inactivity, polypharmacy[186], smoking, and vision problems.

Recommendation 107: *Ensure that the BHR Older People and Frailty Prevention offer currently under development is comprehensive, addressing socio-economic and behavioural risk factors and the early identification and management of modifiable conditions.*

Over our lifetime we accumulate diagnoses, such that many people experience old age as a state of **multimorbidity**.[187] Efforts to manage multimorbidity can lead to

[185] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

[186] Polypharmacy refers to the use of multiple medications. WHO defines polypharmacy as 'the routine use of five or more medications. This includes over-the-counter, prescription and/or traditional and complementary medicines used by a patient'.

[187] https://www.bgs.org.uk/blog/more-is-less-and-less-is-more-breaking-the-cycle-of-polypharmacy-with-deprescribing

polypharmacy. In some instance, polypharmacy generates yet more prescribing for example when medication is required to manage the side effects of existing drugs or when side effects are wrongly interpreted as new conditions.

Sometimes the complexity is such that the balance between the risks inherent in treatment and the benefits arising can be misplaced so that patients are exposed to harm. Deprescribing, the discontinuation of medications in a systematic and considered manner, can serve to restore the desired balance between benefits and harm. Multidisciplinary teams, including pharmacists and nurse specialists can help. Deprescribing requires a thoughtful explanation to patients and carers. Deprescribing is not about restricting the access of some people to healthcare, but instead an acceptance of the limitations of medicines in some situations. Prescribing fewer drugs is not the same as offering less care.

Recommendation 108: *Ensure that there is a systematic approach of reviewing patients with multimorbidity and frailty that includes a medication review to maximise the benefits of medications and minimise side effects.*

Although essential in some circumstances**, hospital admission** entails significant risks to the continuing independence of older people, as a short period of inactivity can result in a disproportionately large decline in physical ability.

There is strong evidence that provision of **reablement** services after admission improves function and hence independence. Havering and Redbridge perform better than the national average in terms of the percentage of people aged 65 and over who were still at home 91 days after discharge from hospital and Barking & Dagenham is similar to the national average.

Recommendation 109: *Further improve the reablement offer in all three boroughs to maximise the proportion of patients who return home and stay home after admission to hospital.*

Research suggests that, where possible, people prefer to stay in their own home rather than move into **residential care**. The rate of permanent admissions to care homes varies between the three boroughs. Redbridge has the lowest rate, followed by Havering. Both boroughs have rates that are significantly below the England average. Barking and Dagenham has the highest rate in London although this represents a significant improvement on previous years.

Nationally**,** one in seven people aged 85 and above live in a care home. The number of care beds varies significantly between three BHR boroughs.

Table 20. Care home beds, number and rate / 100 people aged 75+, 2021

Area	Number	Rate
LBBD	718	8.0
LBH	1,834	8.0
LBR	1,379	7.7
London	35,435	7.1
England	458,955	9.4

Source: Care Quality Commission (CQC) and Office for National Statistics (ONS)

Many people in care homes are not having their needs assessed and addressed as well as they could be, resulting in unnecessary unplanned and avoidable admissions to hospital. The **Enhanced Health in Care Homes (EHCH)** model is designed to put this right.

> ***Recommendation 110:*** *Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.*

End-of-Life Care (EoLC): Few people would choose to die in hospital and yet more than half of all older people in BHR do so. The proportion of people dying in hospital in all three boroughs are significantly higher (worse) than England average. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. The BHR EoLC workstream aim is to acknowledge a person's wishes and support their end-of-life needs in their preferred place of care and is addressing this challenge across three boroughs. Care Home Support, a rapid response team and 24-hour support line are being implemented and the palliative care capacity is increasing to improve the quality of the end-of-life care.

> ***Recommendation 111:*** *Strengthen end-of-life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.*

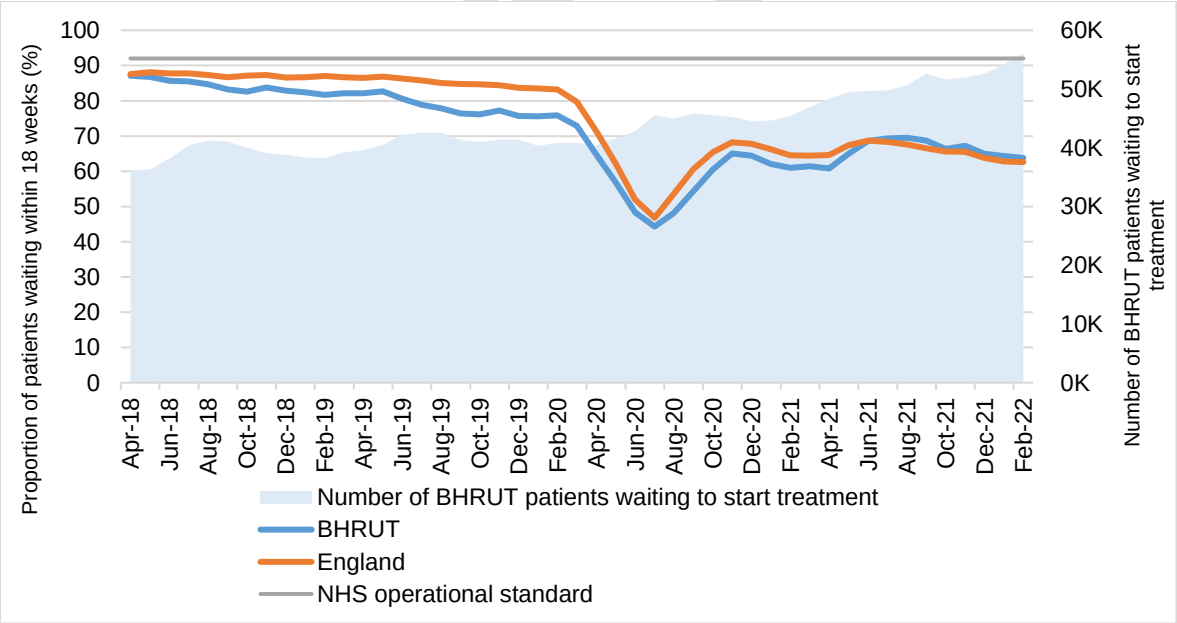
6.7 Planned (non-urgent) Care

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

Non-urgent may suggest a lower priority. However, the people waiting for treatment may be anxious, sometimes in pain, with their quality of life impaired. Hence, waiting times directly affect patient experience and are one of the public's main concerns about the NHS.

The NHS constitution sets a standard that 92% of people waiting for elective (non-urgent) treatment should wait no longer than 18 weeks from their referral to their first treatment. However, waiting times had been worsening for some time prior to the pandemic because of a variety of factors including workforce pressures, financial constraints, and insufficient beds, clinics, and diagnostic services such as imaging (Fig. 48)[188].

Figure 48: Number of Patients waiting to start treatment at BHRUT with Proportion of Patients waiting within 18 weeks April 2018 – February 2022



Data Source: NHS Digital (2022)

As a result, a nationwide work programme had been initiated before the pandemic, led locally by the BHR Planned Care Transformation Board, with the aim of ensuring that patients are seen in the right place, at the right time, by the right healthcare professional, saving patients' time, improving patient experience and ensuring clinical time and resources are utilised effectively to reduce waste in the system.

[188] https://www.nuffieldtrust.org.uk/resource/treatment-waiting-times#background

This work is still more urgent given the scale of the backlog that has accumulated during the pandemic.

During the first wave of the pandemic, planned care was postponed wholesale to free up capacity to treat seriously unwell patients with COVID-19 and reduce the risk of transmission.

As the pandemic progressed, the impact on planned care was somewhat reduced e.g. by the creation of 'green zones' in which elective care was provided to patients known to be coronavirus free after testing and quarantine. However, Infection Prevention and Control (IPC) guidance in place to keep staff and patients as safe as possible continued to reduce elective capacity. Subsequent reviews of IPC guidance by UKHSA[189] have provided further latitude but continue to limit capacity to some degree.

The pandemic also slowed the rate at which new patients were added to waiting lists as some patients chose not to present with problems due to fear of COVID-19. Similarly, the pandemic affected primary care, delaying initial assessment and onward referral. Therefore, it is likely that the number of patients currently waiting for elective care is an underestimate of the true scale of the problem. As residents become more confident and the health and social care system recovers, a surge in unmet need will likely be identified, making things worse before they get better. Hence, the Health Secretary has suggested that waiting lists will continue to grow[190].

Priorities for action by the BHR Planned Care Transformation Board include: -

- The extension of 'Advice and Guidance' services to more specialities, whereby consultants assist GP colleagues to effectively manage patients in primary care or advise immediate referral into specialist services as appropriate.
- Improving GP's access to diagnostics to inform their management of patients in primary care and, coupled with better guidance about the investigations that need be completed before referral, ensuring that the results of all necessary tests are available when the patient is seen for the first time at the outpatient clinic.
- Triage of patients already waiting a first appointment, so that those who don't need to be seen at all can continue to be managed in primary care and those who do need to be seen in hospital are seen in order of clinical priority, by the right professional first time. Such actions will reduce the need for onward referrals between clinics and wasted appointments
- Think Digital First - use of technology to enable care out of hospital e.g. use of video and telephone conferencing and the sharing information between patient and clinician via Patient Knows Best system
- The launch of community minor surgery undertaking an additional 2,000 minor surgery procedures each year
- A new MSK exercise on referral service providing an alternative to surgical treatment for 3,000 patients with chronic pain.

[189] https://www.gov.uk/government/publications/ukhsa-review-into-ipc-guidance
[190] https://www.thetimes.co.uk/article/javid-told-13-million-covid-cases-may-lengthen-nhs-backlog-j38027hk9

- The extension of Patient Initiated Follow Up stopping routine appointments in outpatient clinics that rarely identify a problem, instead allowing the patient to request follow up when they have a concern
- Ensuring patients have access to emotional and wellbeing support all the way through the planned care journey, including during recovery. Such support will be sought from available voluntary sector organisations and other local partners, including social and community care providers
- Patient empowerment to self-care – people are supported and empowered to self-care by easily accessing good quality information and local support.

Just as COVID-19 has exacerbated existing inequalities in other parts of life, access to elective treatment fell further in the most socioeconomically deprived areas of England between January 2020 and July 2021 than in less deprived areas. Hence plans for the recovery of planned care need to consider the greater need for care in disadvantaged communities and whether proactive engagement and outreach is needed to ensure that they are not inadvertently increasing inequalities via the 'inverse care law'.

Recommendation 112: Support implementation of plans developed by the BHR Planned Care Transformation Board

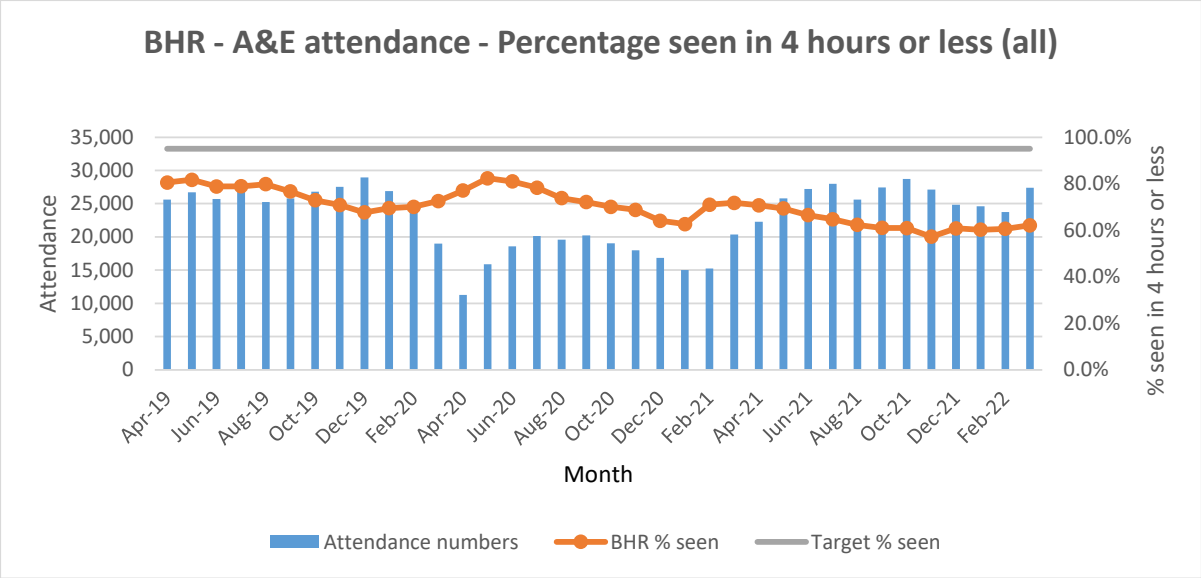
6.8 Urgent and Emergency care

Urgent[191] and Emergency Care[192] (UEC) services perform a critical role in keeping the population healthy and the wider health and care system functioning.

Very large numbers of people attend UEC services (Fig. 49). Some, particularly those attending emergency departments (ED), will be conveyed by ambulance services. In some cases, particularly to ED attendance, alternative services offering a faster, more convenient response, at lower cost to the NHS, are available via other urgent care options and /or primary care.

Demand in ED is such that waiting time targets are routinely missed contributing to a poor patient experience.

Figure 49: BHRUT A&E attendance 2019- 2022



Source: NHS Digital

A number of the opportunities identified in other chapters of the JSNA will reduce pressure on urgent and emergency care e.g. improved management of LTCs, better identification and care of frail older people, better end of life care, easier access / perceived access to primary care etc.

At the same time, UEC services must themselves change to cope with increasing pressure; to better meet the growing expectations of the population and make best use of opportunities afforded by new technology.

[191] Urgent: An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC).
[192] Emergency: Life threatening illnesses or accidents which require immediate, intensive treatment. Services that should be accessed in an emergency include ambulance (via 999) and emergency departments.

The NHS Long Term Plan[193], published in January 2019, sets out the vision for the future of the NHS as a whole and included the following commitments about urgent and emergency care services which are either in progress or fully implemented locally:

- Providing a 24/7 urgent care service, accessible via NHS 111, which can provide medical advice remotely and refer directly to Urgent Treatment Centres, GP, and other community services, as well as ambulance and hospital services.
- Implementing Same Day Emergency Care (SDEC) services across 100% of type 1 emergency departments[194].
- Focusing efforts to reduce the length of stay for patients in hospital longer than 21 days.
- Working closely with primary and community care services to ensure an integrated, responsive healthcare service helping people stay well longer and receive preventative or primary treatment before it becomes an emergency.

Last year (2021/22) saw still greater pressure on urgent and emergency care, in part due to the pandemic, its effects on other parts of the NHS and how the public in turn responded. A 10 point plan was developed to manage delivery in winter and support recovery across all UEC services[195]. This focused on:

1. Supporting 999 and 111 services.
2. Supporting primary care and community health services to help manage the demand for UEC services.
3. Supporting greater use of urgent treatment centres.
4. Increasing support for children and young people.
5. Using communications to support the public to choose services wisely.
6. Improving in-hospital flow and discharge.
7. Supporting adult and children's mental health needs.
8. Reviewing infection prevention and control measures to ensure a proportionate response.
9. Reviewing staff COVID isolation rules.
10. Ensuring a sustainable workforce.

Locally, action is led and co-ordinated by the BHR Urgent and Emergency Care Transformation Board.

It aims to ensure services meet patients' needs and, where appropriate, provide an alternative to emergency department attendance in order to improve patient experience and waiting times and enable ED to focus on emergency care.

[193] https://www.longtermplan.nhs.uk/
[194] Launched by BHRUHT in July 2021 and estimated to have prevented 268 admissions in 21/22.
[195] https://www.england.nhs.uk/publication/uec-recovery-10-point-action-plan-implementation-guide/

This will be achieved by:

- Establishing Urgent Treatment Centres as the Front Door for urgent care[196]
- Increasing the options for care and advice (for clinicians and patients) as an appropriate alternative to ED referral/ attendance – fully implemented
- Improving ambulance and community pathways and ensuring that these are fully utilised and embedded[197] -
- Developing a more robust, resilient and responsive urgent & emergency care system across BHR in development.

Notwithstanding the ongoing and completed improvements regarding UEC services themselves, they remain under intense pressure. Effective solutions will require action from all parts of the health and care system.

Recommendation 113:
Support plans developed by the BHR Urgent Care Transformation Board, and:-

- encourage clinicians and patients to make appropriate use of alternatives to ED referral and attendance, including self care
- support residents to stay well longer and ensure they receive effective preventative and / or primary treatment to minimise the need for urgent and emergency care

[196] Four UTCs successfully implemented across BHR.

[197] A variety of alternative care pathways have been developed giving ambulance crews alternatives to conveying patients to A&E. The Hospital Ambulance Liaison Officers began in November-21 at both the KGH & Queens sites. HALOs review ambulance arrivals and guide/ educate ambulance crews regarding alternative options as appropriate, preventing over 1000 unnecessary A&E attendances. A Physician Response Unit (PRU), a rapid response vehicle staffed by a senior emergency medicine doctor and a emergency ambulance crew, is expected to launch in July 2022 and avoid over 900 A&E attendances a year thereafter.

List of acronyms

Acronym	Meaning	Further information
A&E	Accident and Emergency	Hospital department, also known as ED – Emergency Department
ACEs	Adverse Childhood Experiences	Potentially traumatic events that occur in childhood, e.g. violence, abuse, neglect
AQAP	Air Quality Action Plan	Mechanism by which local authorities work towards meeting air quality goals
AQMA	Air Quality Management Area	A geographical area defined by the local authority which does not meet national air quality standards
ASQ3	Ages and Stages Questionnaire Third Edition	Used to assess child development
BHR	Barking Havering and Redbridge Health and Social Care System	Tri-borough partnership in Outer North East London
BHR CCGs	Barking Havering and Redbridge Clinical Commissioning Groups	The local commissioner of health care services
BHRUHT	Barking Havering and Redbridge University Hospitals Trust	Provider of acute hospital services at Queens and King George Hospital sites.
BAME	Black, Asian and Minority Ethnic	Minority ethnic groups includes Gypsy, Roma and Irish Traveller groups
CAMHS	Children and Adolescent Mental Health Services	https://www.nelft.nhs.uk/camhs/
CDR	Child Death Review	Process to understand why children die and put in place interventions to protect other children and prevent future deaths
CKD	Chronic Kidney Disease	A long term condition in which the kidneys do not function effectively
CMO	Chief Medical Officer	The most senior Government advisor on matters relating to health
COPD	Chronic Obstructive Pulmonary Disease	A group of lung conditions that cause breathing difficulties
CQC	Care Quality Commission	Independent regulator of health and social care
CVD	Cardio-Vascular Disease	e.g. heart disease, stroke
CYP	Children and Young People	People aged 0 to 25 years
DALYs	Disability Life Adjusted Years	Combine years of life lost to premature death and years of life lived with disability into a single measure
DAQI	Daily Air Quality Index	DEFRA system to tell people the daily levels of air pollution and recommended actions and health advice
DWP	Department of Work and Pensions	Responsible for welfare, pensions and child maintenance policy
EHCP	Education, Health and Care Plan	A plan for a child or young person for whom extra support is required beyond that which the school can provide
EIF	Early Intervention Foundation	A charity supporting the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes
ELLMS	East London Local Maternity System	Collaboration of maternity service providers, stakeholders, commissioners, voluntary organisations and service users
EL STP	East London Sustainability and Transformation Partnership	A partnership of health and social care commissioners and providers (including

Acronym	Meaning	Further information
		those in BHR) covering 8 boroughs and the city of London
EoLC	End Of Life Care	Support, comfort and medical care given during the time surrounding death
EV	Electric Vehicles	Fully electric, self-charging or plug in hybrid vehicles including cars, vans, buses
FIT	Faecal Immunochemical Test	A test to identify people at increased risk of bowel cancer
HEYL	Healthy Early Years London	Awards scheme funded by the Mayor of London which supports and recognises achievements in child health, wellbeing and development in early years settings
HMO	Houses in Multiple Occupation	A property rented out by at least 3 people who are not from 1 'household' but share facilities such as kitchen and bathroom
HSL	Healthy Schools London	Awards programme that will reach out to every London child, working with schools to improve children and young people's wellbeing
HWB	Health and Wellbeing Board	A formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government
IAPT	Improving Access To Psychological Therapies	'Talking therapies' services for help to overcome depression and anxiety
ICS	Integrated Care System	Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area
ICPB	Integrated Care Partnership Board	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS.
IMD	Index of Multiple Deprivation	Widely used datasets to classify the relative deprivation of small areas
IPC	Infection Prevention and Control	Practical, evidence-based approach preventing patients and health workers from being harmed by avoidable infections
JSNA	Joint Strategic Needs Assessment	Process by which local authorities and ICS assess the current and future health, care and wellbeing needs of the local community to inform decision-making
LAC	Looked After Children	A child who has been in the care of their local authority for more than 24 hours
LBBD	London Borough of Barking And Dagenham	Commissioner (and provider) of social care and public health services for residents
LBH	London Borough of Havering	ditto above
LBR	London Borough of Redbridge	ditto above
LGBTIQ+	Lesbian, Gay, Bisexual, Trans, Intersex, Queer or Questioning	An inclusive acronym encompassing all minority sexual and gender identities

Acronym	Meaning	Further information
LTC	Long Term Condition	Chronic diseases or conditions for which there is currently no cure, and which are managed with drugs and other treatment
MSK	Musculoskeletal Conditions	e.g. back and neck pain
NELFT	North East London Foundation Trust	Provider of mental health and community health care services
NDPP	NHS Diabetes Prevention Programme	https://preventing-diabetes.co.uk/
NO2	Nitrogen Dioxide	Pollutant gas produced durng combustion of fossil fuels
OHID	Office for Health Improvement and Disparities	Government department focusing on improving the nation's health and levelling up health disparities
PAF	Population Attributable Fraction	The proportion of cases for an outcome of interest that can be attributed to a given risk factor among the entire population
PCN	Primary Care Network	Groups of GP practices working together
PHE	Public Health England	PHE was replaced by UKHSA and OHID
PHM	Population Health Management	An approach that uses data to help health and care systems to improve population health and wellbeing
PM	Particulate Matter	Mixture of solid particles and liquid droplets (pollutants) found in the air
PTAL	Public Transport Accessibility Levels	Measure of accessibility of a point to the public transport network
SATOD	Smoking At Time Of Delivery	A measure of smoking prevalence amongst pregnant women
SDEC	Same Day Emergency Care	Provision of same day care for patients who would otherwise be admitted to hospital
SEND	Special Education Needs and Disability	A child with a learning difficulty and/or disability that means they require special health and education support
SMEs	Small and Medium Sized Enterprises	A company in the UK that has a turnover of less than £25m; fewer than 250 employees and gross assets less than £12.5m
SMI	Serious Mental Illness	Someone aged 18 or over who has a diagnosable mental, behavioural or emotional disorder that causes serious impairment
UKHSA	UK Health Security Agency	Government department
VCS	Voluntary and Community Sector	Not-for-profit, value-driven organisations that are independent of government and constutionally self-governing
YLD	Years Lived with Disability	A measure refleting the impact an illness has on quality of life before it resolves or leads to death
YLL	Years of Life Lost	A measure of premature mortality that takes into account both the frequency of deaths and the age at which it occurs

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Appendix 1: BHR JSNA Process

1 Background

1.1 To support the BHR ICP fulfil its functions, BHR Public Health teams worked jointly to the 2021 JSNA whose main focus is to identify priority health and social care needs and related wider determinants that impact on health and wellbeing in a consistent format at locality, borough and ICS level and make recommendations on appropriate interventions.

1.2 This product is to complement not replace the existing borough based JSNAs.

2 Governance

2.1 The BHR JSNA process was overseen by the Havering Director of Public Health and was supported by the other two directors.

2.2 The lead director received formal monthly updates during implementation and provided support as necessary. He was also the lead author, a task which included writing some sections and reviewing all drafts.

2.3 BHR Public Health Intelligence (PHI) leads facilitated data collection, analysis, interpretation and presentation of results.

2.4 Public Health Consultants/ service leads in consultation with transformation boards advised on content and were responsible for commentary on results including recommendations.

2.5 BHR PHI leads were responsible for the final report compilation.

3 Structure

3.1 The JSNA was structured around the four pillars of population health[198] namely:

i. The wider determinants of health e.g. income, education, housing.
ii. Our health behaviours and lifestyles e.g. smoking, alcohol consumption, diet and exercise.
iii. Places and communities e.g. environment, community networks and support systems, social relationships and culture.
iv. The integrated health and care system with a focus on the 4 priorities of the ICPB:
    - Children and young people
    - Mental health
    - Long term conditions
    - Older people and frailty

[198] https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean

3.2 The JSNA also included sections on demography and population health outcomes.

4 Form and Content

4.1 Following several consultations between Public Health Consultants / service leads, PHI leads and transformation boards, indicators for each pillar were agreed. PHI leads facilitated data collation, analysis and presentation for indicators where data was available. The report therefore only includes analysis and commentary for indictors which data could be sourced within the provided timelines.

4.2 It's intended that this product will develop in an iterative manner with BHR PH consulting with stakeholders after publication of each edition to identify opportunities for improvement.

4.3 The initial edition is static but BHR PH are currently working with an external provider to develop an interactive product that will be available to all stakeholders.

5 Final Report

The current report includes data analysis and commentary at borough and BHR levels. It includes some data at locality level but without commentary. This is due to time and specialist resource constraints experienced and will be included in the next iteration.

Appendix 2: Population & Health Outcomes

Click section 1, 2 or 6.2 to return to respective chapters

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population & Health Outcomes

Benchmark: England

Compared with Benchmark: Better | Similar | Worse | Not Compared | Higher | Lower | No Data

		Indicator	Period	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
Resident Population	1	Percentage of resident population aged 0 - 4 years	2020	17,167	6.6	8.8	7.3	7.5	6.6	5.7	5.7	5.7
	2	Percentage of resident population aged 5 - 9 years	2020	17,251	6.6	8.9	7.0	7.4	6.7	6.3	6.3	6.3
	3	Percentage of resident population aged 10-19 years	2020	29,824	11.4	14.5	12.9	12.9	11.4	11.6	11.6	11.6
	4	Percentage of resident population aged 20-64 years	2020	149,891	57.5	58.5	59.9	58.7	63.1	58	57.9	57.9
	5	Percentage of resident population aged 65-74 years	2020	23,707	9.1	5.1	7.0	7.2	6.6	10	9.9	9.9
	6	Percentage of resident population aged 75-84 years	2020	15,342	5.9	2.8	4.0	4.3	3.9	6	6.1	6.1
	7	Percentage of resident population aged 85+ years	2020	7,469	2.9	1.3	1.8	2.0	1.7	2.5	2.5	2.5
	8	Total resident population	2020	260,651								
GP Registered Population	9	Percentage of GP population aged 0 - 4 years	2021	16,882	6.0	7.4	6.5	6.7	5.4	5.1	5.1	5.1
	10	Percentage of GP population aged 5 - 9 years	2021	18,131	6.4	8.4	6.9	7.3	5.8	5.8	5.8	5.9
	11	Percentage of GP population aged 10-19 years	2021	32,277	11.4	14.7	12.5	12.9	10.9	11.4	11.4	11.4
	12	Percentage of GP population aged 20-64 years	2021	166,164	58.8	61.2	61.9	60.9	66.9	60.1	60.1	60.1
	13	Percentage of GP population aged 65-74 years	2021	25,658	9.1	4.8	6.4	6.9	6.1	9.5	9.4	9.5
	14	Percentage of GP population aged 75-84 years	2021	16,220	5.7	2.4	3.5	4.0	3.4	5.8	5.8	5.8
	15	Percentage of GP population aged 85+ years	2021	7,315	2.6	1.1	1.5	1.8	1.4	2.3	2.3	2.3
	16	Total GP population	2021	282,647								
Ethnic Population	17	Percentage White British	2021	396,618	74.6	32.7	23.8	43.0	38.3			
	18	Percentage Black	2021	36,186	6.8	23.8	8.2	12.0	13.3			
	19	Percentage Asian	2021	40,508	7.6	23.6	50.5	28.9	20.5			
	20	Percentage Other White	2021	36,566	6.9	12.5	10.0	9.6	18.0			
	21	Percentage Mixed	2021	18,504	3.5	5.2	4.6	4.4	5.8			
	22	Percentage Others	2021	3,515	0.7	2.1	2.9	2.0	4.1			
Health Outcomes	23	Life expectancy at birth (Male)	2018-2020		79.7	77.0	80.5		80.3	79.4	79.4	79.4
	24	Life expectancy at birth (Female)	2018-2020		83.5	81.7	84.6		84.3	83.1	83.1	83.2
	25	Healthy Life Expectancy at birth (Male)	2018-2020		64.6	58.1	60.6		63.8	63.1	63.0	63.4
	26	Healthy Life Expectancy at birth (Female)	2018-2020		63.8	60.1	64.0		65.0	63.9	63.3	63.7

Data Sources:

Indicators: 1-8 - ONS Population Estimates 2020. Indicators 9-16 NHS Digital 2021. Indicators 17-22 GLA Ethnic Population Projections 2021. Indicators 23-26 Public Health England

Appendix 3: Wider Determinants Dashboard

To return to section 3: Wider Determinants – Click Here

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: Wider Determinants of Health

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Median Annual Household Income (£)	2012/13			£36,670	£29,420	£36,670		£39,110	£30,600		
2	Gross Weekly Pay for Full Time Workers (£)	2020			£690	£609	£719		£716	£590	454.2	893.2
3	Index of Multiple Deprivation (IMD) 2019 Rank/Score	2019			16.8	32.8	17.2	21.3	21.8	21.7	45.0	5.5
4	Proportion of residents who are Income Deprived (%)	2019		26,877	10.8%	19.4%	12.1%			12.9%		
5	Proportion of residents aged 16 - 64 in employment (%)	2020		128,000	77.5%	67.3%	74.0%		75.3%	75.7%		
6	Proportion of residents aged 16 - 64 in management / professional roles (%)	2020-21		67,300	50.0%	35.8%	54.6%	48.5%	62.3%	50.2%		
7	Proportion of residents 16-64 who are economically inactive (%)	2020		31,600	19.1%	25.6%	24.6%	23.1%	19.9%	20.5%	12.6%	30.6%
8	Proportion of residents 16-64 who are economically inactive and want a job (%)	2020		8,600	27.2%	26.5%	19.0%	23.5%	25.8%	22.6%	9.6%	53.0%
9	Jobs Density Ratio for population 16-64	2019			0.61	0.50	0.49		1.03	0.88	0.40	102.30
10	Proportion of residents by level of education - NVQ 4 & Above (%)	2020		66,300	40.2%	43.7%	51.5%	45.7%	58.5%	42.8%		
11	Proportion of residents by level of education - No Qualifications (%)	2020		10,800	6.5%	9.2%	9.3%	8.4%	5.1%	6.2%		
12	Number of homeless people/households (rate per 1,000 estimated total households)	2017/18		330	3.2	6.5	4.4	4.6	4.2	2.4	9.4	0.2
13	Number of people in temporary accommodation (rate per 1,000 estimated total households)	2017/18		924	8.9	23.9	20.3		14.9	3.4		
14	Number of households on waiting list	2019/20			1995	5350	5979	13324	250992	1145501		
15	Proportion of homes that are not 'Decent Homes' (%)	2018-19		69	0.7%	9.6%	13.8%	7.5%		4.5%	37.2%	0.0%
16	Proportion of Households experiencing Fuel Poverty (%)	2019			13.2%	22.5%	15.4%	16.4%	15.2%	13.5%		
17	Rate of verifiable Houses of Multiple Occupation (HMOs) to dwellings (%)	2020		124	0.1%	0.2%	1.9%	0.8%	1.2%	0.56%	0.01%	6.10%
18	Estimated rate of HMOs to dwellings including the verifiable HMOs (%)	2020		267	0.3%	0.3%	3.7%	1.5%	4.9%	2.17%	0.02%	16.60%
19	Number of people seen rough sleeping in the year	2020		3	3	10	24	37	714	2688	242	0
20	Income deprivation affecting Children (under 16)	2019			16.0%	23.8%	13.7%	17.6%		17.1%	32.7%	3.2%
21	Child Development at age 5	2013/14			65.4	60.0	62.8		62.2	60.4		
21	Attendance levels from children who are persistently absent from school (%)	2018/19		3,741	10.7%	11.2%	9.9%	10.5%	10.1%	10.9%	3.4%	16.1%
22	Average Attainment 8 score (mean - score)	2019/20		148,285	52.20	50.10	56.00		53.40	50.2		
23	16-17 year olds not in education, employment or training (NEET) or whose activity is not known (%)	2019		170	2.9%	3.5%	3.1%		4.2%	5.5%		
24	Proportion of economically active population claiming Job Seekers Allowance (%)	2021		788	0.6%	0.8%	0.5%		0.6%	0.5%	1.5%	0.2%
25	Claimant count (16+) and claimants as a proportion of residents aged 16-64 (%)	2021		9,200	5.7%	10.1%	7.6%		7.4%	5.7%	10.8%	2.2%

Data Sources

1: GLA - https://data.london.gov.uk/blog/gla-household-income-estimates/. 2: Annual Survey of Hours and Earnings - https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/previousReleases. 3, 4, 20 - Indices of Multiple Deprivation, MHCLG - https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019. 5 - 8, 10, 11 - Annual Population Survey - https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/. 9, 24, 25 - NOMIS - https://www.nomisweb.co.uk/. 14 - Borough Housing Departments. 12 - Homelessness Statistics DCHLG, https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness15 - Estimated from English Housing Survey , MHCLG - https://www.gov.uk/government/collections/english-housing-survey. 16- Department for Business , Energy and Industrial Strategy - https://www.gov.uk/government/collections/fuel-poverty-statistics. 19 - London Chain Report - https://data.london.gov.uk/dataset/chain-reports 21 - DFE, https://www.gov.uk/government/collections/statistics-pupil-absence 22 - DFE, https://www.gov.uk/government/publications/progress-8-school-performance-measure 23 - DFE, https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures

Appendix 4: Health Behaviour & Lifestyle Dashboard

To return to section 4: Health Behaviour & Lifestyle - Click Here

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: Health Behaviours & Lifestyles

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower		
Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Percentage of adults (aged 18+) classified as overweight or obese (ALS)	2019/20			67.3	65.5	60.6		55.7	62.8	78.3	41.6
2	Percentage of physically inactive adults (16+ ALS)	2020/21			37.8	36.6	30.6		26.7	27.5	27.2	27.8
3	Smoking Prevalence (% of adult population) (APS)	2019		26,524	13.2	18.1	13.4		12.9	13.9	13.6	14.1
4	Smoking Prevalence (%) in adults in routine and manual occupations (18-64) - current smokers (Persons, 18-64 yrs) APS)	2019			20.7	24.3	22.8		20.7	23.2	36.8	10.3
5	Percentage of adults drinking over 14 units of alcohol a week (HSE)	2015-18			20.7	15.1	10.7		20.1	22.8	41.3	7.9
6	Smoking prevalence in adults (age 18-64 years) - gap between current smokers in routine and manual occupations and other occupations (APS)	2019			1.8	1.5	1.9		1.9	2.5	5.7	0.7
7	Proportion of dependent drinkers not in treatment (%) (Current method) (NDTMS)	2019/20		1,870	84.3	85.9	85.2		82.0	82.2	92.3	59.5
8	Successful completion of drug treatment - % opiate users (NDTMS)	2019		15	6.4	6.1	8.3		6.7	5.6	1.6	12.2
9	Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) (Active Lives, Sport England).	2019/20			51.8	47.9	53.2		55.8	55.4	41.4	67.7
	Data Source: Indicators 1, 3-9 - Public Health England: Fingertips, 2 - Sport England Active Lives survey											

Appendix 5: Maternity Dashboard

To return to section 6.1: Maternity - Click Here

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: HSC - Maternity

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Smoking status at time of delivery	2020-21	→	193	6.7%	7.6%	3.4%		4.6%	9.6%	21.4%	1.8%
2	Number of live births	2019		3,186								
3	Stillbirths rate per 1,000 births	2018-20		38	3.9	6.0	5.8		4.4	3.9	3.8	4.0
4	Low Birth Weight of term babies	2020	→	63	2.2%	4.2%	4.5%		3.3%	2.9%	4.9%	1.4%

Data Source: Indicators, PHE Fingertips 1 (93085), 3, 4(20101) Indicators 2 ONS

Appendix 6: Children & Young People Dashboard

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: HSC - Children & Young People

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower
Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change

	Indicator	Period	Recent Trend	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Pupils with special educational needs (SEN): % of school pupils with special educational needs (School age)	2018		3,659	9.3%	14.4%	10.9%		14.4%	14.4%		
2	Number and percentage of pupils with Special Educational Needs (SEN) based on where the pupil attends school	2020-21		4,457	11.0%	14.5%	11.8%	12.4%	15.3%	15.8%	11.0%	21.3%
3	Number and percentage of children and young people with EHC Plan (Denominator Age 0-25 ONS mid-2020)	2020-21		1,332	1.6%	1.6%	1.8%	1.7%	1.8%	1.9%		
4	Number and percentage of children (Age 5-15) with EHC Plan (Denominator Age 5-15 ONS 2018)	2020-21		1,167	2.2%	2.1%	2.5%	2.3%	2.4%			
5	Number of primary school pupils with EHCP - Education, Health and Care Plan (local data)	2021		605								
6	Number of secondary school pupils with EHCP (local data)	2021		401								
7	Number and rate SEND pupils resident and educated in Borough (Local data)	2021				92.7						
9	Estimated number of children and young people with mental disorders - aged 5 to 17 (count)	2017-18		4,808								
10	Percentage of school pupils with social, emotional and mental health needs (school age)	2020		693	1.7%	2.5%	1.9%		2.5%	2.7%	1.5%	4.4%
11	Hospital admissions as a result of self harm (Age 10-24) directly standardised rate per 100,000	2019-20		70	166.0	136.2	126.2		191.7	439.2	203.1	1105.4
12	Hospital admissions for asthma (under 19 years) - CCG data. Crude rate per 100,000	2019-20		95	149.8	158.8	180.9			158.3	48.5	376.7
13	Hospital admissions diabetes (under 19 years) Crude rate per 100,000	2019-20		40	63.1	22.3	36.2			51.1	49.9	52.3
14	Children on child protection plans: Rate per 10,000 children <18	2019/20		142	24.3	52.7	41.7	40.1	34.9	42.8	11.5	124.3
15	Children in Care (number of children looked after at 31st March (including adoption and care leavers)	2020		230	40.0	63.0	31.0		49.0	67.0		
16	The number and rate of children on a Child Protection Plan (CPP) as at 31st March 2020'	2020		142	24.3	52.7	41.7	40.1	34.9	42.8	11.5	124.3
17	The number and rate of Looked after Children (LAC) as at 31st March 2020	2020		232	39.8	63.3	31.1	44.0	49.3	66.6	23.0	223.0
18	The number and rate of Children in Need (CIN) as at 31st March 2020'	2020		1,737	297.6	370.1	279.4	313.8	336.7	323.7	141.9	931.5
19	The number and rate of children in the youth justice system (10-17 yrs)	2019-20		107	4.4	7.4	3.9		4.4	3.5		
20	Number and percentage of unauthorised school absence sessions	2018-19		136,633	1.1%	1.8%	1.2%	1.4%	1.3%	1.4%	0.0	0.0
21	Reception: Prevalence of overweight (including obesity) %	2019/20		480	21.6%	24.6%	22.3%		21.6%	23.0%		
22	Year 6 : Prevalence of overweight (including obesity) %	2019/20		1,135	38.1%	44.7%	39.6%		44.7%	35.2%		
23	Reception: Prevalence of obesity (including severe obesity) %	2019/20		225	10.1%	12.9%	11.2%		10.0%	9.9%		
24	Year 6: Prevalence of obesity (including severe obesity) %	2019/20		710	23.8%	29.0%	25.0%		23.7%	21.0%		
25	Youth offending: first time entrants to the youth justice system, rate per 10,000	2018		408	183.0	377.0	280.0		251.0	211.0		
26	Youth justice custodial sentences per 10,000	2019/20		17	2.9	3.1	2.1		1.5	1.0		
27	Youth proven offending rate per 10,000	2018/19		53	9.0	13.7	11.2		8.0			
28	School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19		2,289	71.7%	72.4%	75.6%		74.1%	71.8%		
29	School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	2018/19		2,666	83.5%	80.0%	83.0%		82.6%	82.2%		
30	Hospital admissions due to substance misuse (15-24 years) count and rate per 100,000	2017/18 - 19/20		65	78.6	67.7	73.8		55.6	84.7		
31	Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2019/20		2,850	100.0	100.0	100.0		91.1	92.6		
32	Number and rate (per 10,000) of children and young people accessing NHS funded community mental health services (CAMHS)	2020/21							400.4	490.9		
33	Percentage of children in need with statements of SEN or EHC plans	2019/20			36.7%	7.5%	54.0%			23.4%		
34	16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2019		170	2.9%	4.2%	3.1%		4.2%	5.5%		

Data Sources: *(Indicators 1,9-12,14,15,21-25,28-31,34 PHE Fingertips) (Indicators 2,3,4,16-19,21,26,27 Gov.uk) (Indicators 5-7, local data) (Indicators 32 NHS Digital) (Indicators 33 LG Inform)*

Appendix 7: Adult Mental Health Dashboard

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: Health & Social Care - Mental Health

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Estimated prevalence of common mental health disorders - Age 16+	2017		32,729	15.9%	22.4%	17.7%	18.3%	19.3%	16.9%	11.6%	24.4%
2	Number and percentage of adults: Depression recorded prevalence - Age 18+ (QOF)	2019/20	↑	20,911	10.1%	8.0%	6.3%	8.0%	8.2%	11.6%	4.0%	18.5%
3	Rate of SMI (All Ages) (QOF)	2019/20	→	1,995	0.7%	0.8%	0.9%	0.8%	1.1%	0.9%	0.6%	1.5%
4	Adjustment disorders and distress in perinatal period (lower estimate): Estimated number of women	2017/18		386	386	443	535	1364	14431	73828		
5	Adjustment disorders and distress in perinatal period (upper estimate): Estimated number of women	2017/18		773	773	887	1070	2730	28863	147656		
6	PTSD in perinatal period: Estimated number of women	2017/18		77	77	89	107	273	2886	14766		
7	Number and percentage of school pupils with social, emotional and mental health needs	2020	↑	693	1.7%	2.5%	1.9%	2.1%	2.5%	2.7%	2.7%	2.7%
8	Number of children in need due to family stress or dysfunction or absent parenting and rate per 10,000 children under 18	2017		259	46.6	93.6	46.8	61.7	97.9	93.8	0.0	265.9
9	Self reported wellbeing - Percentage of people with a high anxiety score	2019/20			21.9%	20.1%	19.9%		22.4%	21.9%	14.5%	29.2%
10	Number and percentage in concurrent contact with Mental Health Services for drug misuse	2016/17		23	11.7%	20.0%	12.9%	15.6%	28.5%	24.3%	2.8%	60.7%
11	Number and percentage in concurrent contact with Mental Health Services for alcohol misuse	2016/17		9	5.8%	22.0%	6.7%	11.4%	28.1%	22.7%	3.3%	72.5%
12	Percentage of adult social care users who have as much social contact as they would like - Age18+	2019/20		1,280	48.3%	49.5%	50.5%	49.5%	42.9%	45.9%	34.3%	56.6%
13	Access to IAPT services: people entering IAPT (month) as % estimated to have anxiety\depression	Sep 2019	↑	365	17.8%	14.7%	19.4%	17.6%		18.3%	7.0%	29.9%
14	APT reliable improvement: % of people in IAPT (quarter) who achieved reliable improvement (18+)	Q2 2019/20	→	445	75.4%	71.3%	72.6%	73.3%		71.7%	62.0%	79.2%
15	Percentage of social care users who suffer depression and anxiety	2018/20			48.7%	51.9%	53.7%			50.5%	38.5%	63.6%
16	Dementia: QOF prevalence (all ages) Number and % of patients with dementia against total GP patients	2019/20	→	2,169	0.8%	0.4%	0.6%	0.6%	0.5%	0.8%	0.3%	1.3%
17	Number and % of adults on GP list recorded as smokers with Serious Mental Illness	2014/15		570	39.4%	40.2%	30.4%	35.7%	38.9%	40.5%	27.2%	52.3%
18	Number of hospital admissions for mental health conditions and rate per 100,000 population	2019/20	→	40	68.5	55.1	78.7	68.1	64.5	89.5	26.3	249.7
19	Proportion of people (18-74) in contact with secondary mental health services rate per 100,000	Q2 2019/20	→	3,825	1910.0	2016.0	1498.0	1774.3	2201.0	2381.0	1208.0	4633.0
20	Number and age standardised mortality rate from suicide per 100,000 population (Persons)	2017/19		47	7.2	6.1	7.1		8.2	10.1	4.9	19.0
21	Number and directly age standardised rates for emergency hospital admissions for intentional self harm	2019/20	→	185	73.5	63.9	44.5	59.2	81.6	192.6	44.5	457.6

Data Sources:
Indicators: 1-24 - Public Health England (PHE), Indicator 10 and 11 used old values

Appendix 8: Cancer Dashboard

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: Health & Social Care - Cancers

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	New cancer cases (Crude incidence rate: new cases per 100,000)	2018-19		1,668	589.0	328.0	363.0			529.0	217.0	728.0
2	All Tumours (Age standardised incidence rate per 100,000)	2017		1,719	727.9	744.6	630.5	694.9	653.5	713.9		
3	Incidence breast cancer (Age standardised rate per 100,000)	2017		210	160.6	181.2	161.2	165.3	164.8	166.7		
4	Incidence colorectal cancer (Age standardised rate per 100,000)	2018		178	74.0	79.7	52.3			69.0		
5	Incidence lung cancer (Age standardised rate per 100,000)	2018		177	74.4	119.5	61.8			75.8		
6	Incidence prostate cancer (Age standardised rate per 100,000)	2018		368	343.3	303.5	218.7			204.1		
7	The percentage of patients with cancer, as recorded on practice disease registers	2017/18		7,512	2.7%	1.4%	1.7%	1.9%	1.8%	2.7%	4.2%	0.9%
8	Cancer 1 year survival rate (%)	2017		1,018	73.2%	69.7%	72.6%			73.3%		
9	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2018-19		15,714	56.3%	42.8%	48.4%		49.2%	58.0%		
10	Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2018-19		7,999	56.5%	41.7%	47.9%		47.9%	57.9%		
11	Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2019-20		25,554	62.0%	48.6%	55.1%		55.6%	63.8%	45.1%	70.9%
12	Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2019-20		11,533	63.7%	50.9%	55.8%		56.8%	65.8%	45.9%	72.5%
13	Breast screening uptake (%)	2020		22,037	78.7%	66.4%	71.8%		67.2%	74.1%	54.1%	81.7%
14	Cancer screening coverage - cervical cancer (aged 25 to 49)	2020		34,830	72.9%	65.6%	61.5%		61.8%	70.2%	46.4%	80.1%
15	Cancer screening coverage - cervical cancer (aged 50 to 64)	2020		18,444	77.6%	72.9%	74.6%		73.2%	76.1%	59.2%	90.6%
16	Percentage of cancers detected at stage 1 and 2	2019		497								
17	Percentage of cancers diagnosed through emergency presentation	2018		658	55.4%	54.4%	60.2%		56.5%	55.0%	47.5%	76.5%
18	Premature mortality from all cancers (rate per 100,000)	2017-19		832	130.6	147.1	102.8		117.4	129.2	87.4	182.4
19	Premature mortality from lung cancer (rate per 100,000)	2017-19		390	52.9	70.8	34.8		48.0	53.0		
20	Premature mortality from breast cancer (rate per 100,000)	2017-19		70	20.8	19.1	20.9		19.6	20.0	15.6	26.1
21	Premature mortality from colorectal cancer (rate per 100,000)	2017-19		69	10.8	11.4	8.3		10.4	11.8	17.6	5.8
22	Excess cancer deaths and attributable life years gap; females, compared to England	2015-17		- 30	0.0	0.4	-0.4		-0.3	1.0	-0.8	1.0
23	Excess cancer deaths and attributable life years gap in most/least deprived quintile; females within area	2015-17		22	0.8	1.3	-0.1		1.0	1.4	-1.5	3.0
24	Excess cancer deaths and attributable life years gap; males, compared to England	2015-17		128	0.4	0.6	-0.7		-0.3	1.0	-1.0	1.0
25	Excess cancer deaths and attributable life years gap in most/least deprived quintile; males within area	2015-17		68	1.4	0.8	0.8		1.3	1.6	-0.8	3.2

Data Sources
Indicators: 1 - Public Health England (PHE), 2-6 NCRAS, 7 - PHE, 8 - NHS Digital, 9-14 PHE, 15 - NHS Digital, 16-25 PHE

Appendix 9: Long Term Conditions Dashboard

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: HSC - Long Term Conditions

Benchmark: England

Compared with Benchmark: Better | Similar | Worse | Not Compared | Higher | Lower

	Indicator	Period	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
			Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Diabetes: QOF prevalence (Age 17+) (%)	2019/20	16,845	7.5%	8.6%	9.1%	8.4%	6.8%	7.1%	3.6%	11.1%
2	Diabetes: Estimated prevalence (Age 16+) (%)	2017	18,728	8.6%	9.2%	10.5%			8.5%		
3	Major diabetic lower-limb amputation procedures (Per 10,000)	2016/17 - 18/19	40	9.2	10.7	13.3	11.1		8.2	27.0	3.4
4	Percentage of LTCs reporting that they have received all or some of the support they need (%)	2019/20	798	46.5%	49.1%	46.8%	47.5%	52.1%	54.9%	46.5%	61.2%
5	Coronary Heart Disease: QOF prevalence (All Ages) (%)	2019/20	6,854	2.6%	1.8%	2.4%	2.3%	1.9%	3.1%	1.2%	5.0%
6	Coronary Heart Disease: Estimated prevalence (Age 55-79) (%)	2015		8.7%	9.6%	7.6%	8.6%		7.9%	14.8%	6.7%
7	Emergency hospital admissions for coronary heart disease, standardised admission ratio	2019/20		85.9	114.0	113.6	104.5		102.1	78.6	127.2
8	Coronary Heart Disease: Mortality Under 75 (DSR per 100,000)	2017/19	238	37.7	47.7	33.4	39.6		37.5	108.5	16.1
9	COPD: QOF prevalence (All Ages) (%)	2019/20	5,033	1.8%	1.5%	0.8%	1.4%		1.9%		
10	COPD: Estimated prevalence (All Ages) (%)	2015		2.8%	2.4%	1.9%	2.4%		3.0%	4.9%	1.5%
11	COPD: Emergency hospital admissions standardised admission ratio	2019/20	530	363.0	597.0	266.0	408.7		415.0		
12	COPD: Mortality (DSR per 100,000)	2017-19	429	55.1	81.8	41.8	59.6		53.9		
13	Hypertension: QOF prevalence (All Ages) (%)	2019/20	40,668	14.4%	11.3%	11.7%	12.5%	11.0%	14.1%	7.4%	18.9%
14	Diagnosed Hypertension: Estimated prevalence (%)	2017	54,000	26.3%	20.7%	22.4%	23.1%	21.6%	26.2%	15.8%	32.8%
15	Hypertension: Mortality Under 75 (Require PCMD) (DSR per 100,000)	2017-2019	15	2.7	4.6	2.1	3.1	3.8	3.0	1.2	10.8
16	Under 75 mortality rate from respiratory conditions considered to be preventable (DSR per 100,000)	2017-19	128	20.2	38.2	11.8	23.4	17.3	20.0	44.7	6.4
17	Stroke QOF Prevalence (All Ages) (%)	2019/20	4,397	1.6%	0.9%	1.1%	1.2%	1.1%	1.8%	0.7%	2.9%
18	Emergency hospital admissions for stroke, standardised admission ratio	2019/20	365	144.0	175.1	155.2	158.1		170.2	298.1	110.3
19	Stroke - Under 75 Mortality (DSR per 100,000)	2017-19	77	12.1	17.6	12.7	14.1		12.5	24.7	6.8
20	Learning Disability QOF Prevalence (All Ages) (%)	2019/20	1,051	0.4%	0.5%	0.4%	0.4%	0.4%	0.5%	0.2%	0.8%
21	Learning Disability: Completed Health checks (%)	2018/19	674	73.7%	66.2%	61.2%	67.0%	58.2%	52.3%	3.4%	87.2%

Data Source: Public Health England (PHE) & NHS Digital

Appendix 10: Older People & Frailty Dashboard

BHR Joint Strategic Needs Assessment 2022

London Borough of Havering

Population Health Pillar: HSC - Older People

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

	Indicator	Period	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
			Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Life expectancy at 65 (Years) - Females	2018-20		21.2	19.8	22.0		22.0	21.1	21.1	21.2
2	Life expectancy at 65 (Years) - Males	2018-20		18.2	16.7	19.2		19.2	18.7	18.7	18.7
3	Healthy life expectancy at 65 (Years) - Females	2017-19		10.8	8.5	12.1		10.0	11.1	2.4	16.7
4	Healthy life expectancy at 65 (Years) - Males	2017-19		10.9	8.5	8.4		9.7	10.6	6.1	16.0
5	Disability-free life expectancy at 65 (Years) - Females	2017-19		9.8	8.6	12.1		9.7	9.7	6.0	13.5
6	Disability-free life expectancy at 65 (Years) - Males	2017-19		10.8	9.3	10.0		10.0	9.9	7.0	15.1
7	Emergency hospital admissions due to falls in people aged 65 and over- Females (DSR per 100,000)	2017/18	596	1862.2	1843.0	2097.0		2542.4	2453.4		
8	Emergency hospital admissions due to falls in people aged 65 and over- Males (DSR per 100,000)	2017/18	305	1588.7	1538.0	1424.2		1981.5	1775.1		
9	Emergency hospital admissions due to falls in people aged 65 and over- Persons (DSR per 100,000)	2019/20	845	1623.1	1670.4	1743.2		2214.7	2221.8	1325.0	3394.0
10	Hip fractures in people aged 65 and over- Females (DSR per 100,000)	2017/18	233	705.5	710.0	712.7		611.7	697.1		
11	Hip fractures in people aged 65 and over- Males (DSR per 100,000)	2017/18	80	414.4	409.9	294.0		372.3	410.7		
12	Hip fractures in people aged 65 and over- Persons (DSR per 100,000)	2019/20	300	563.0	472.4	488.8		472.7	571.6	326.0	912.0
13	Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital (%)	2019/20	200	89.3	85.0	92.9	89.6	83.4	82.0	42.9	96.9
14	Emergency readmissions within 30 days of discharge from hospital (%)	2018/19	4,810	16.8	16.6	15.4	16.7		14.4	11.7	17.2
15	Delayed transfers of care from hospital, per 100,000	2019	12	6.2	5.7	5.3	5.7	6.8	10.8		
16	Percentage of deaths that occur in hospital (ages 65-74)	2019	198	54.2	55.3	61.3	56.6	56.1	48.3	35.4	63.6
17	Percentage of deaths that occur in hospital (ages 75-84)	2019	331	50.3	50.7	63.9	54.8	56.6	48.4	39.8	63.9
18	Percentage of deaths that occur in hospital (ages 85+)	2019	501	45.7	47.4	54.6	48.7	50.7	41.4	31.7	59.0
19	Rate of permanent admissions to residential and nursing care homes (ages 65+, per 100,000)	2019/20	295	631.6	677.5	401.5	555.3	431.3	584.0	61.0	1724.0
20	Older People who are Income Deprived (IMD) (%)	2019	6,875	11.7	26.1	19.5	17.4	20.6	14.2	5.0	43.9
21	Excess winter mortality	2018/19	140	20.5	26.2	17.7		13.7	14.6	-20.0	210.0
22	Population vaccination coverage - Flu (aged 65+) (%)	2019/20	31,302	70.0	65.0	68.0		66.2	72.4	58.3	80.1
23	Care home beds per 100 people aged 75+	2021	1,834	8.0	8.0	7.7	7.9	7.1	9.4	2.3	17.2
24	People invited for an NHS Health Check per year (%)	2020/21	1,630	2.3	4.5	4.5	3.7	3.6	3.1		
25	People receiving an NHS Health Check per year (%)	2020/21	586	0.8	2.5	1.4	1.5	2.2	1.2	0.0	9.2
26	People taking up an NHS Health Check invite per year (%)	2020/21	586	36.0	56.7	30.8	39.8	62.5	39.0		

Data Source: Public Health England (PHE), NHS Digital and IMD

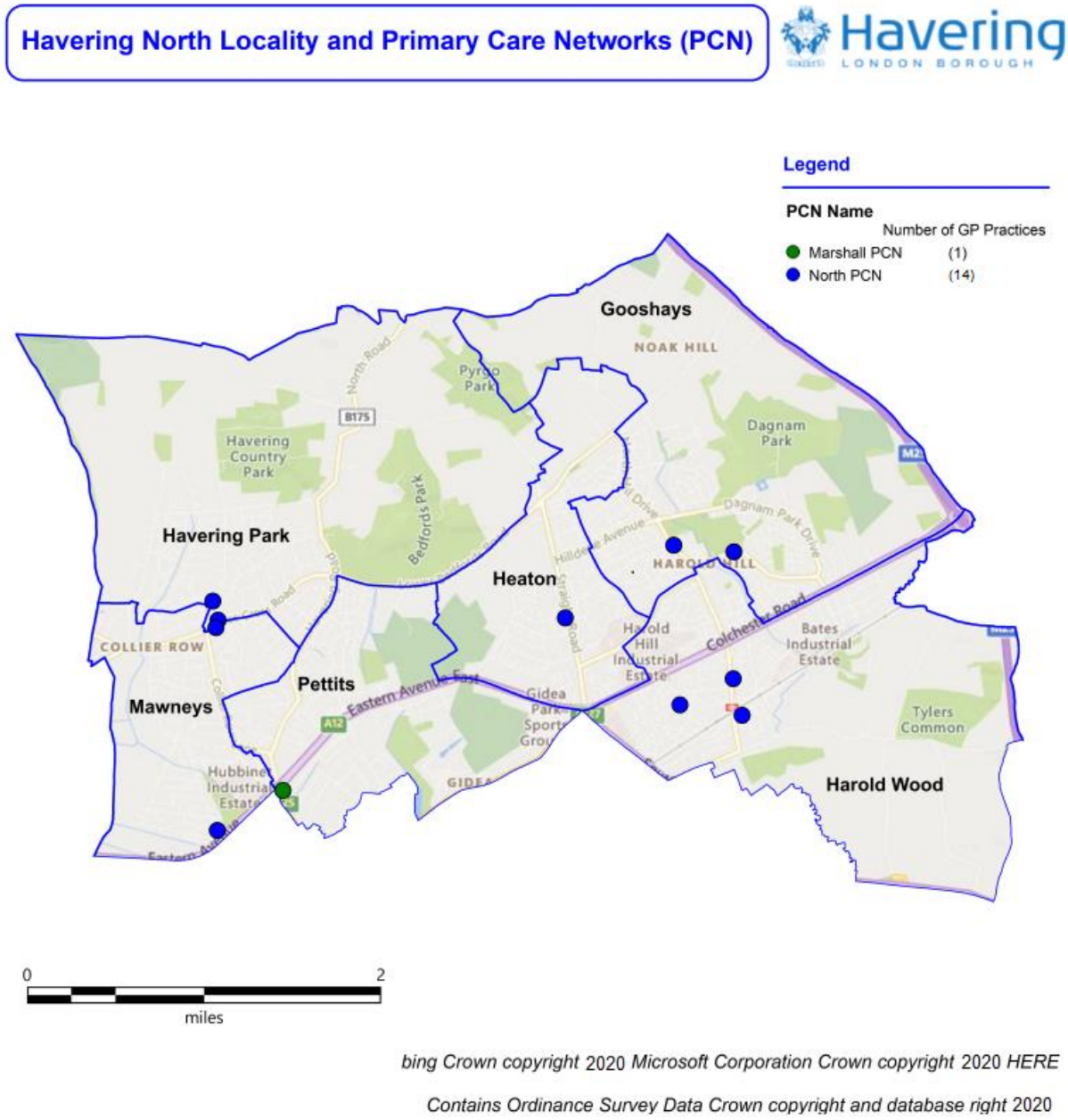
Appendix 11: Localities Data

London Borough of Havering (LBH) – North Locality

1. Places and Communities

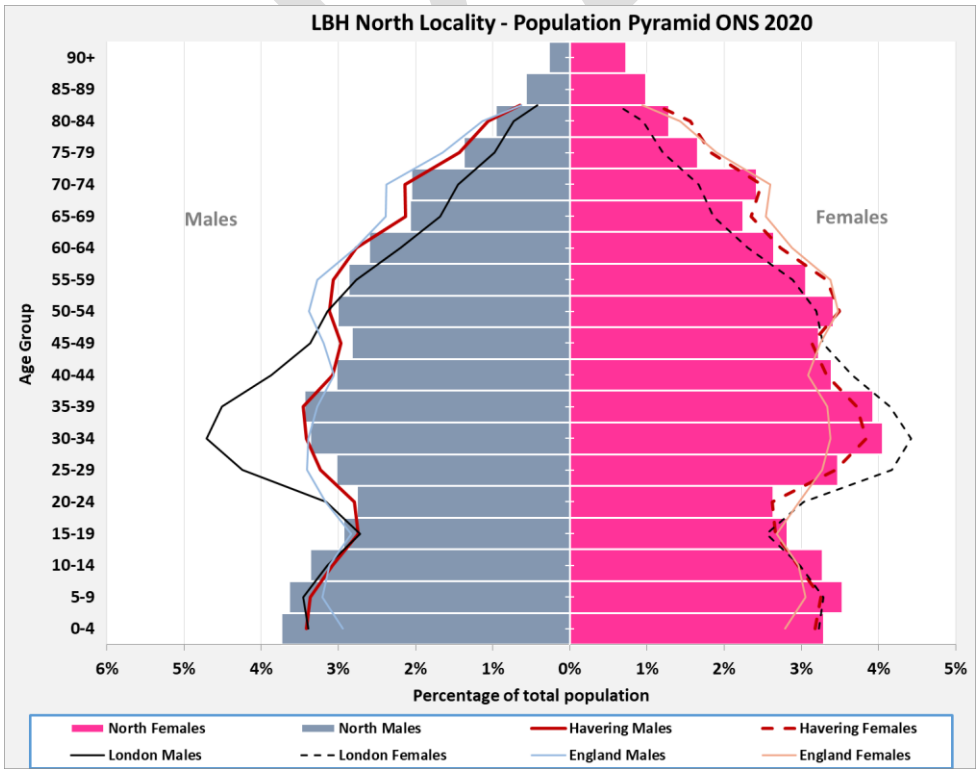
1.1 Havering north locality map

Wards include: Gooshays, Harold Wood, Havering Park, Heaton, Mawneys, Pettits



1.2 Estimated population of LBH North locality residents by gender and five year age groups - 2020

Age Band (Years)	Males	Females	Totals
0-4	3,333	2,943	6,276
5-9	3,246	3,157	6,403
10-14	3,004	2,925	5,929
15-19	2,618	2,518	5,136
20-24	2,465	2,356	4,821
25-29	2,698	3,105	5,803
30-34	3,000	3,619	6,619
35-39	3,067	3,507	6,574
40-44	2,703	3,027	5,730
45-49	2,519	2,881	5,400
50-54	2,685	3,048	5,733
55-59	2,557	2,732	5,289
60-64	2,324	2,362	4,686
65-69	1,849	2,011	3,860
70-74	1,836	2,163	3,999
75-79	1,224	1,479	2,703
80-84	855	1,151	2,006
85-89	510	886	1,396
90+	242	651	893
Totals	**42,735**	**46,521**	**89,256**



Source: ONS 2020 Mid-Year Estimates

1.3 LBH PCN Profile - GP population 5 year age groups

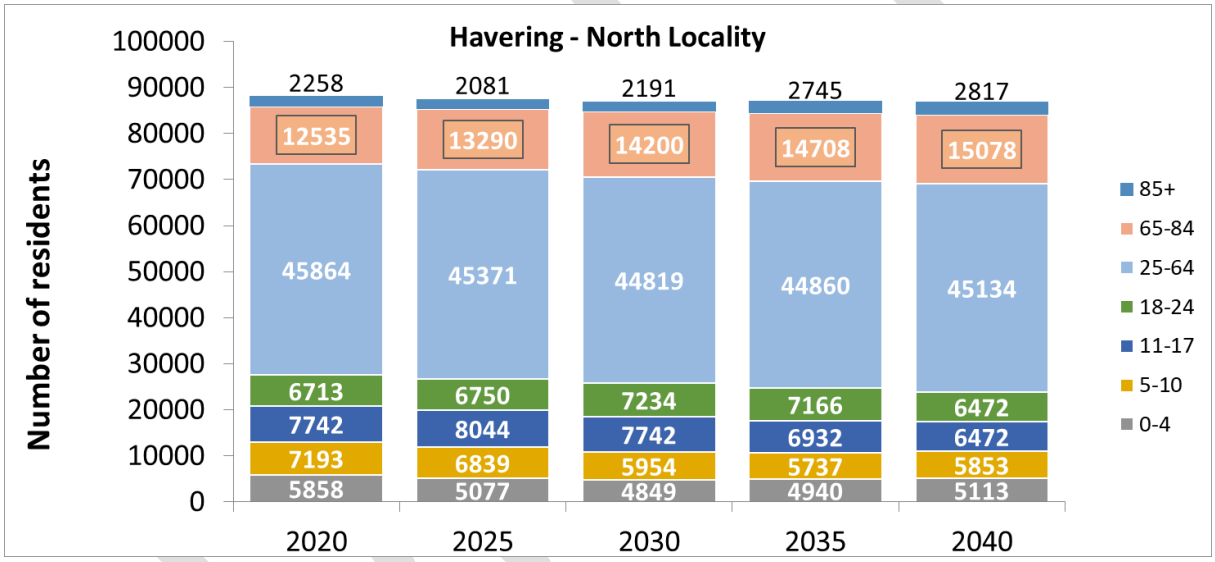
	HAVERING CREST PCN			HAVERING MARSHALL PCN			HAVERING NORTH PCN			HAVERING SOUTH PCN			
Age Band (Years)	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**Havering Total**
0_4	1263	1362	2625	1352	1434	2786	2609	2865	5474	2802	2909	5711	16596
5_9	1383	1381	2764	1417	1494	2911	3036	3198	6234	3179	3257	6436	18345
10_14	1295	1282	2577	1278	1351	2629	2845	3003	5848	2974	3161	6135	17189
15_19	1103	1194	2297	1206	1246	2452	2510	2602	5112	2855	2863	5718	15579
20_24	1131	1173	2304	1243	1252	2495	2481	2455	4936	2885	2934	5819	15554
25_29	1631	1436	3067	1639	1432	3071	2959	2772	5731	3323	3367	6690	18559
30_34	1835	1654	3489	1941	1750	3691	3550	3141	6691	3661	3626	7287	21158
35_39	1662	1619	3281	1807	1858	3665	3637	3280	6917	3845	3622	7467	21330
40_44	1400	1540	2940	1671	1631	3302	3041	3156	6197	3467	3419	6886	19325
45_49	1347	1391	2738	1407	1538	2945	2786	2795	5581	3208	3285	6493	17757
50_54	1392	1375	2767	1535	1566	3101	2862	2835	5697	3614	3570	7184	18749
55_59	1333	1363	2696	1514	1506	3020	2679	2657	5336	3895	3704	7599	18651
60_64	1197	1172	2369	1310	1248	2558	2324	2295	4619	3379	3383	6762	16308
65_69	905	894	1799	1090	981	2071	1786	1729	3515	2730	2588	5318	12703
70_74	857	749	1606	1122	981	2103	1863	1628	3491	2953	2601	5554	12754
75_79	720	529	1249	909	789	1698	1355	1040	2395	2373	1893	4266	9608
80_84	567	402	969	689	477	1166	929	717	1646	1766	1241	3007	6788
85_89	406	253	659	501	270	771	628	407	1035	1325	861	2186	4651
90_94	167	100	267	287	152	439	336	159	495	641	333	974	2175
95+	43	22	65	87	27	114	121	36	157	191	61	252	588
PCN Total	**21637**	**20891**	**42528**	**24005**	**22983**	**46988**	**44337**	**42770**	**87107**	**55066**	**52678**	**107744**	**284367**

Source: NHS Digital GP Registrations (September 2021)

1.4 LBH North Location Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
North	88,163	87,452	86,989	-1.3	87,088	-1.2	86,939	-1.4

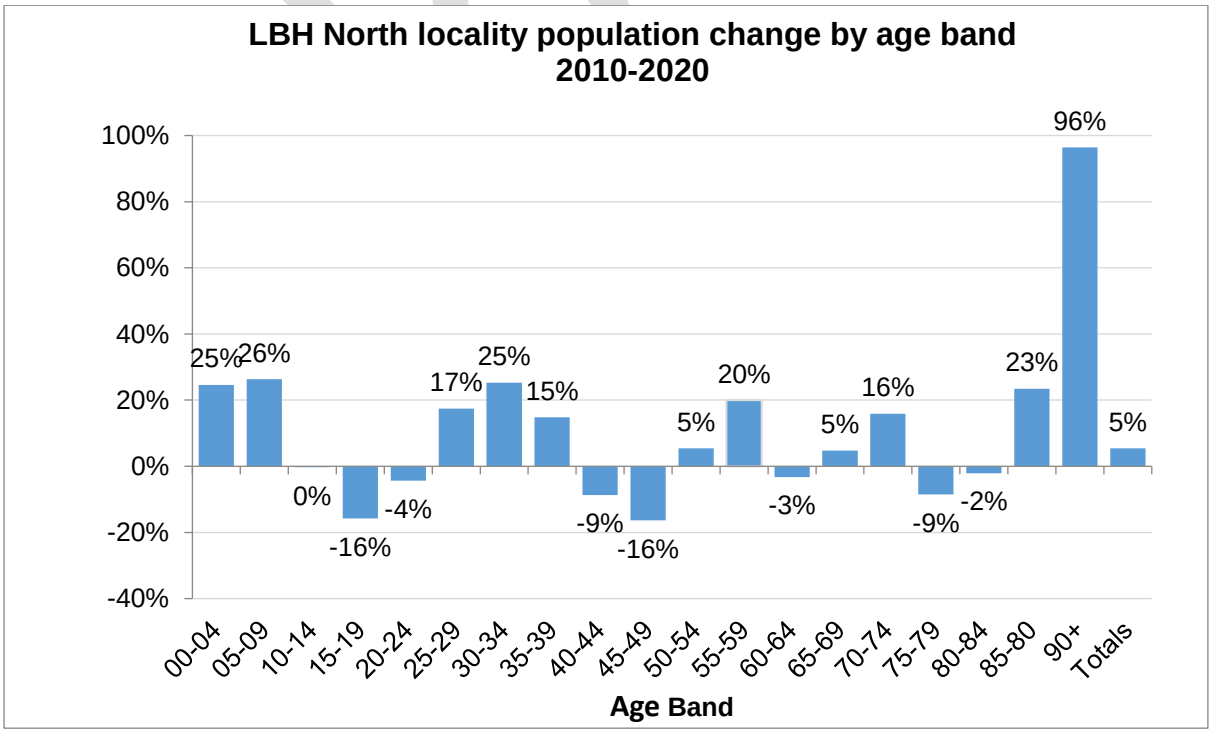
North	2020	2025	2030	2035	2040
0-4	5858	5077	4849	4940	5113
5-10	7193	6839	5954	5737	5853
11-17	7742	8044	7742	6932	6472
18-24	6713	6750	7234	7166	6472
25-64	45864	45371	44819	44860	45134
65-84	12535	13290	14200	14708	15078
85+	2258	2081	2191	2745	2817
Total	88,163	87,452	86,989	87,088	86,939



Source: GLA Household led population projections using 2020-based Demographic Projections, Ward population projections for London Boroughs 2020-based Scenario Projection: Identified Capacity Scenario

1.5 LBH North Locality population change by age band 2010 - 2020

Age Band	2010	2020	Change	%
00-04	5062	6276	1214	24
05-09	4733	6403	1670	35
10-14	5092	5929	837	16
15-19	5309	5136	-173	-3
20-24	4631	4821	190	4
25-29	4836	5803	967	20
30-34	4881	6619	1738	36
35-39	5135	6574	1439	28
40-44	5682	5730	48	1
45-49	5599	5400	-199	-4
50-54	5154	5733	579	11
55-59	4414	5289	875	20
60-64	4906	4686	-220	-4
65-69	3422	3860	438	13
70-74	2985	3999	1014	34
75-79	2661	2703	42	2
80-84	2105	2006	-99	-5
85-89	1465	1396	-69	-5
90+	583	893	310	53
Total	78655	89256	10601	13



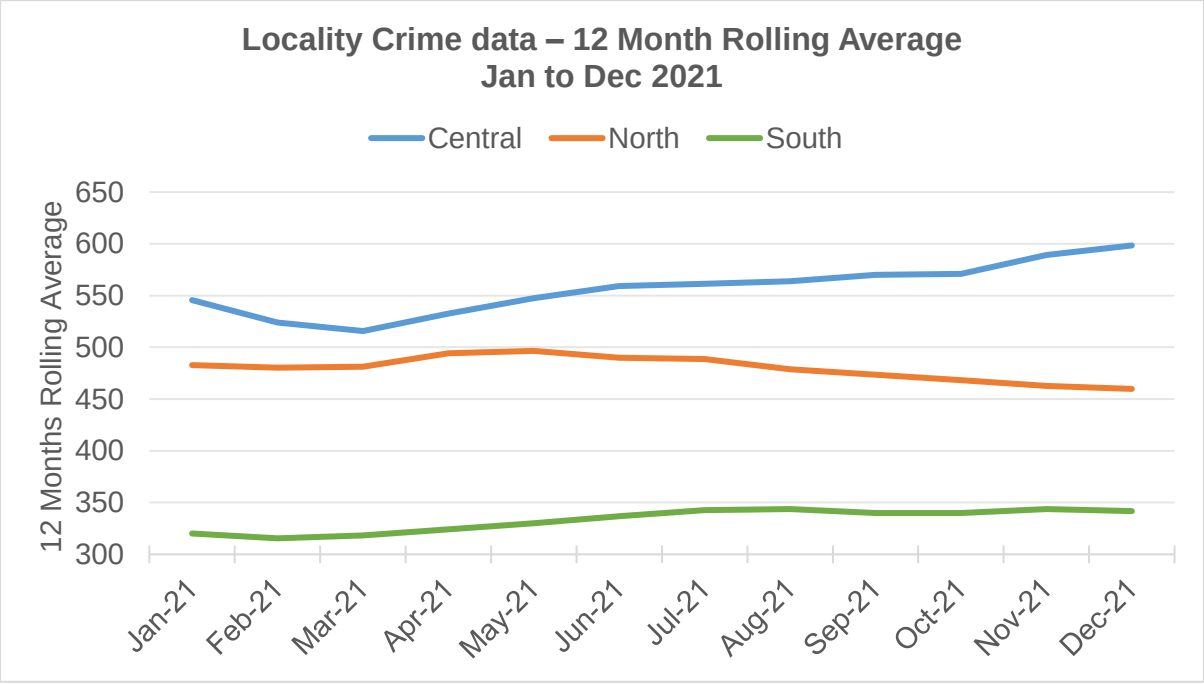
Source: ONS mid-year population estimates

1.6 Ethnicity

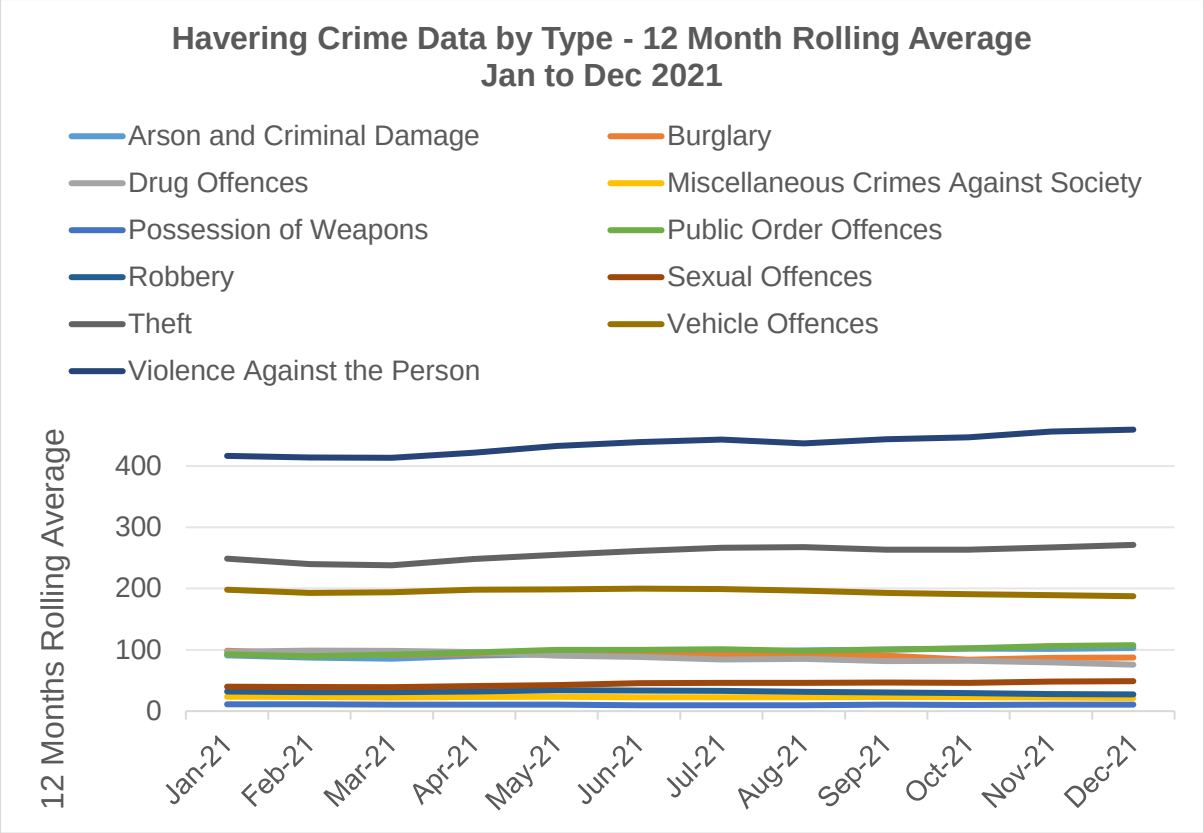
Ethnic group	Number	%
British	66,135	83.9
African	3,143	4.0
Indian or British Indian	1,134	1.4
Irish	785	1.0
Caribbean	1,035	1.3
White and Black Caribbean	677	0.9
Pakistani or British Pakistani	457	0.6
Chinese	395	0.5
White and Asian	349	0.4
European mixed	383	0.5
Other	4,289	5.4
Totals	78,782	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).



Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in North Locality

The London Plan 2021 sets a ten year housing target for Havering of 12,850 new homes between 2019/20 and 2028/29 or 1,285 per annum. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

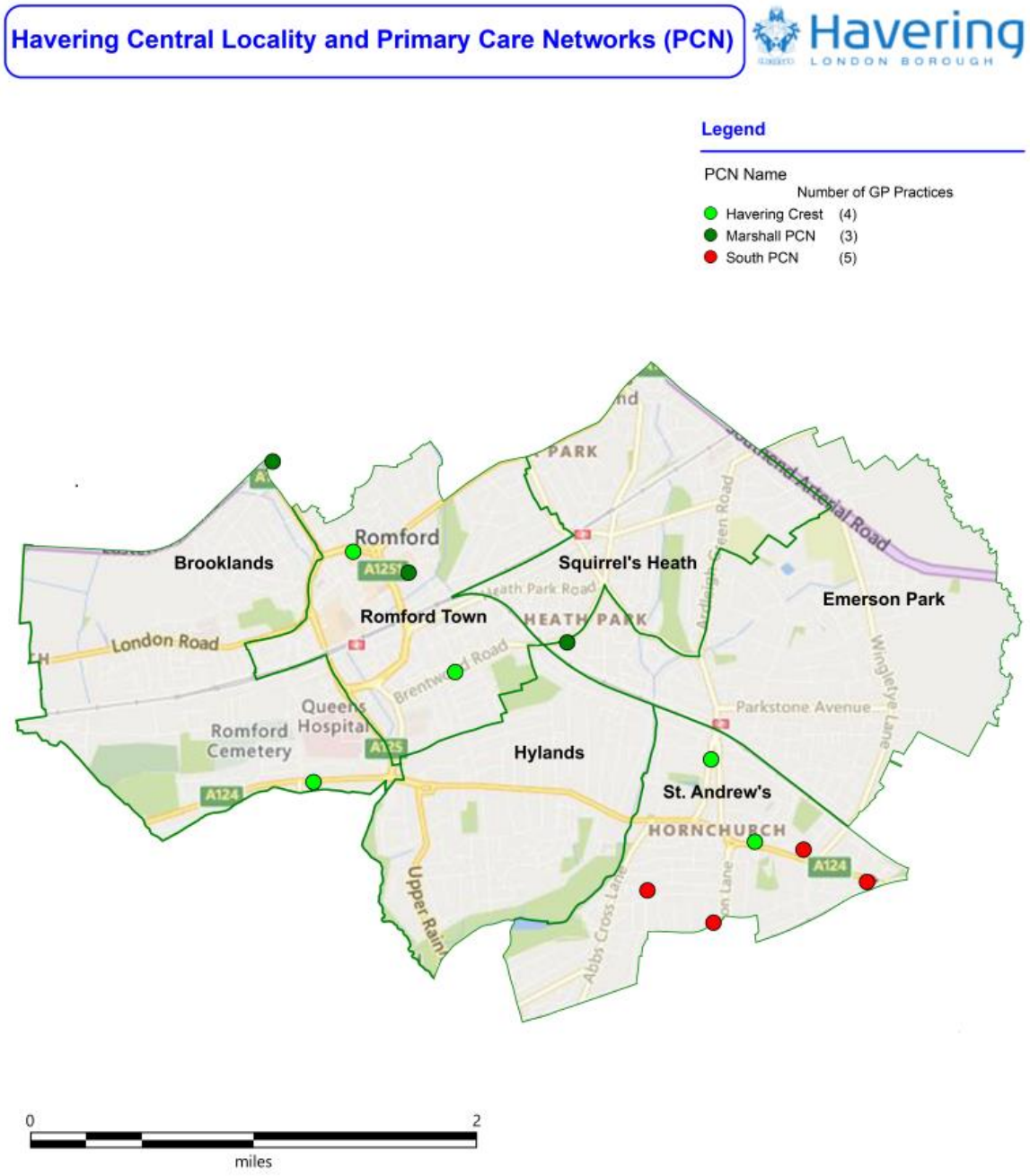
Locality	Number of houses
Central	4992
North	717
South	3702
Total	9411

London Borough of Havering (LBH) – Central Locality

1. Places and Communities

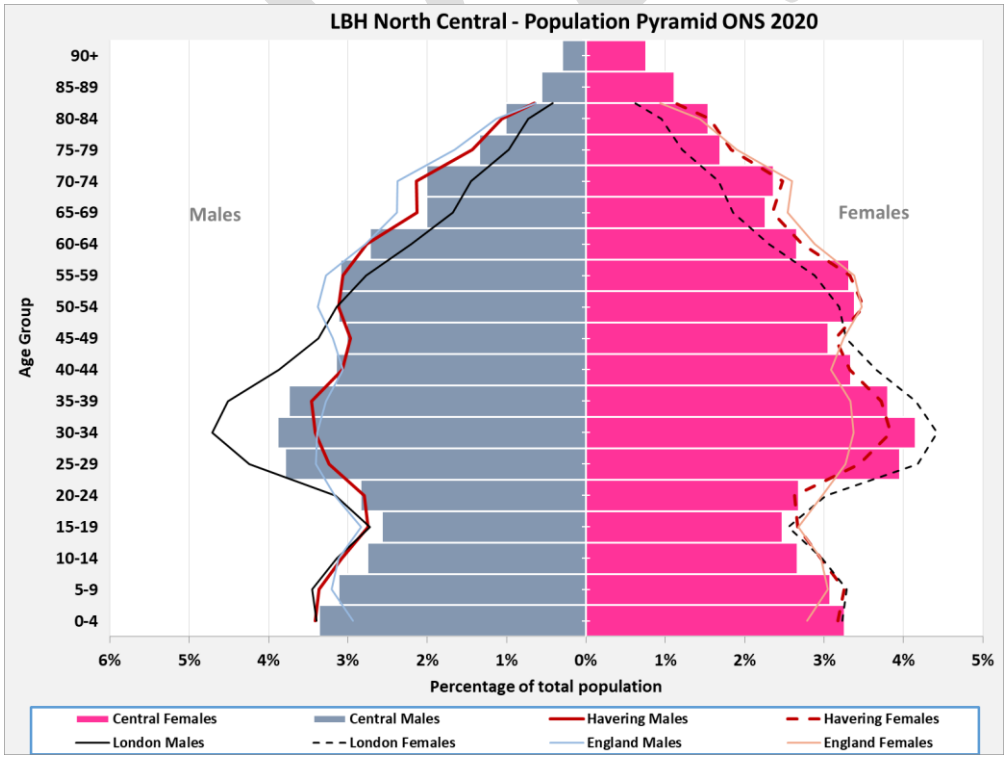
1.1 Havering central locality map

Wards include: Brooklands, Emerson Park, Hylands, Romford Town, St. Andrews, Squirrel's Heath



1.2 Estimated population of LBH Central locality residents by gender and five year age groups – 2020

Age Band (Years)	Males	Females	Totals
0-4	3,069	2,975	6,044
5-9	2,845	2,813	5,658
10-14	2,512	2,438	4,950
15-19	2,350	2,263	4,613
20-24	2,595	2,447	5,042
25-29	3,460	3,616	7,076
30-34	3,545	3,793	7,338
35-39	3,419	3,473	6,892
40-44	2,875	3,046	5,921
45-49	2,749	2,791	5,540
50-54	2,848	3,092	5,940
55-59	2,827	3,027	5,854
60-64	2,486	2,429	4,915
65-69	1,837	2,064	3,901
70-74	1,834	2,162	3,996
75-79	1,228	1,549	2,777
80-84	923	1,408	2,331
85-89	514	1,022	1,536
90+	275	694	969
Totals	**44,191**	**47,102**	**91,293**



Source: ONS 2020 Mid-Year Estimates

1.3 LBH PCN Profile - GP population 5 year age groups

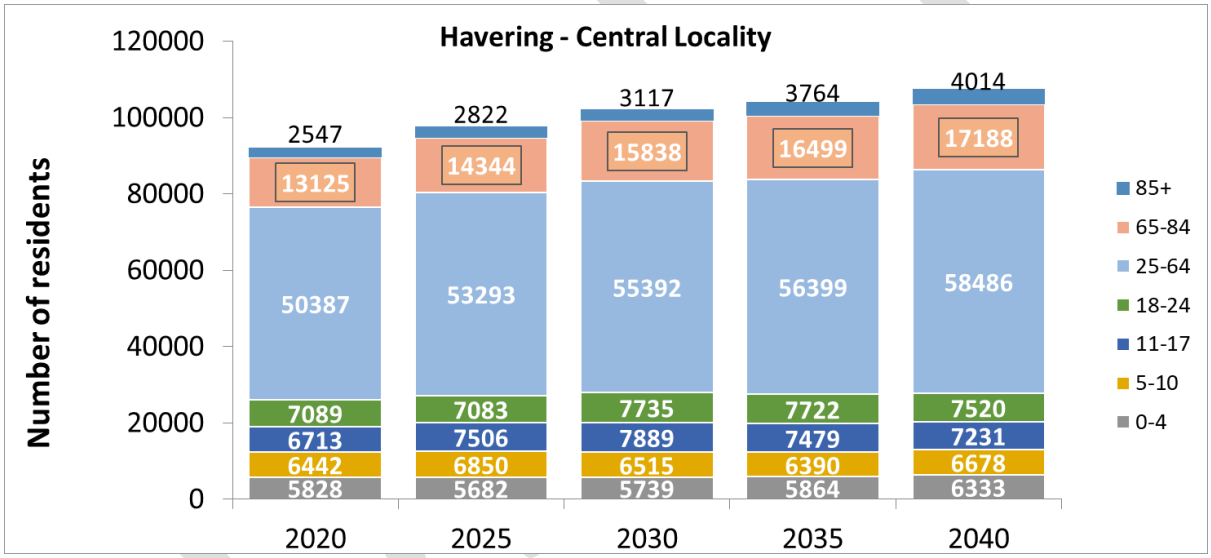
	HAVERING CREST PCN			HAVERING MARSHALL PCN			HAVERING NORTH PCN			HAVERING SOUTH PCN			
Age Band (Years)	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**Havering Total**
0_4	1263	1362	2625	1352	1434	2786	2609	2865	5474	2802	2909	5711	16596
5_9	1383	1381	2764	1417	1494	2911	3036	3198	6234	3179	3257	6436	18345
10_14	1295	1282	2577	1278	1351	2629	2845	3003	5848	2974	3161	6135	17189
15_19	1103	1194	2297	1206	1246	2452	2510	2602	5112	2855	2863	5718	15579
20_24	1131	1173	2304	1243	1252	2495	2481	2455	4936	2885	2934	5819	15554
25_29	1631	1436	3067	1639	1432	3071	2959	2772	5731	3323	3367	6690	18559
30_34	1835	1654	3489	1941	1750	3691	3550	3141	6691	3661	3626	7287	21158
35_39	1662	1619	3281	1807	1858	3665	3637	3280	6917	3845	3622	7467	21330
40_44	1400	1540	2940	1671	1631	3302	3041	3156	6197	3467	3419	6886	19325
45_49	1347	1391	2738	1407	1538	2945	2786	2795	5581	3208	3285	6493	17757
50_54	1392	1375	2767	1535	1566	3101	2862	2835	5697	3614	3570	7184	18749
55_59	1333	1363	2696	1514	1506	3020	2679	2657	5336	3895	3704	7599	18651
60_64	1197	1172	2369	1310	1248	2558	2324	2295	4619	3379	3383	6762	16308
65_69	905	894	1799	1090	981	2071	1786	1729	3515	2730	2588	5318	12703
70_74	857	749	1606	1122	981	2103	1863	1628	3491	2953	2601	5554	12754
75_79	720	529	1249	909	789	1698	1355	1040	2395	2373	1893	4266	9608
80_84	567	402	969	689	477	1166	929	717	1646	1766	1241	3007	6788
85_89	406	253	659	501	270	771	628	407	1035	1325	861	2186	4651
90_94	167	100	267	287	152	439	336	159	495	641	333	974	2175
95+	43	22	65	87	27	114	121	36	157	191	61	252	588
PCN Total	**21637**	**20891**	**42528**	**24005**	**22983**	**46988**	**44337**	**42770**	**87107**	**55066**	**52678**	**107744**	**284367**

Source: NHS Digital GP Registrations (September 2021)

1.4 LBH Central Location Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
Central	92,131	97,580	102,225	11.0	104,117	13.0	107,450	16.6

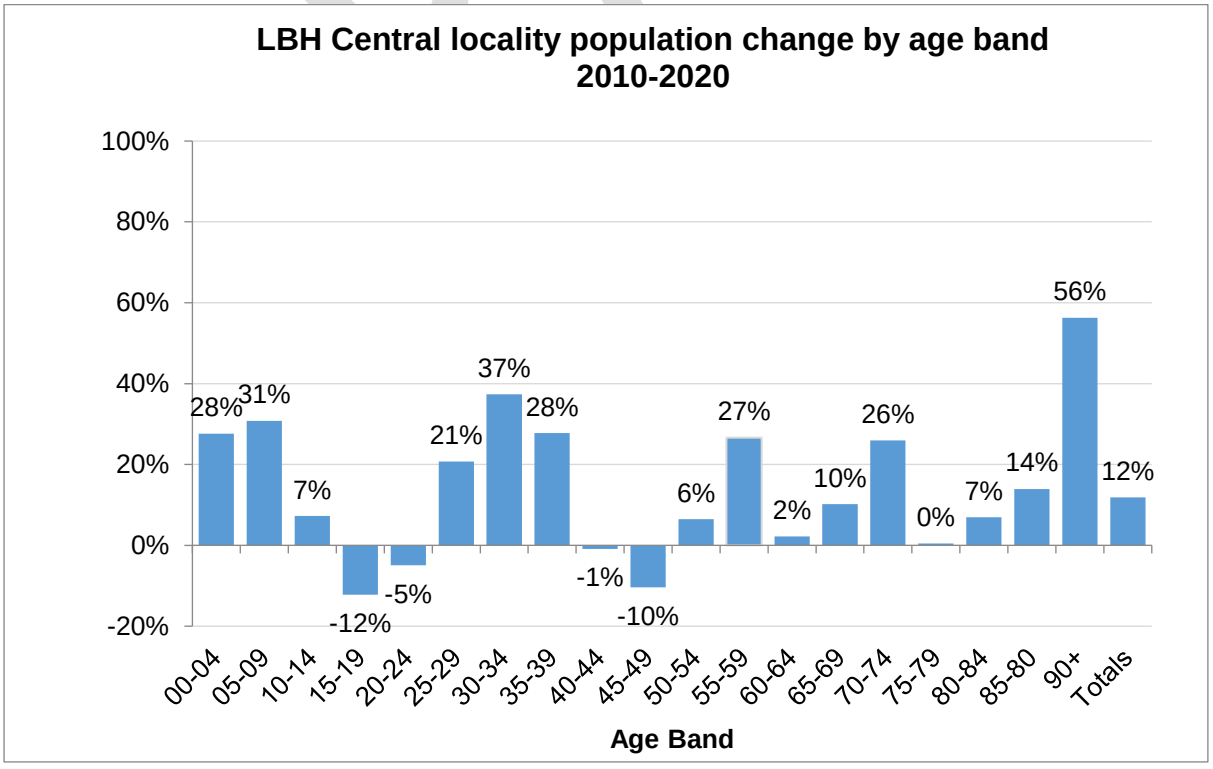
Central	2020	2025	2030	2035	2040
0-4	5828	5682	5739	5864	6333
5-10	6442	6850	6515	6390	6678
11-17	6713	7506	7889	7479	7231
18-24	7089	7083	7735	7722	7520
25-64	50387	53293	55392	56399	58486
65-84	13125	14344	15838	16499	17188
85+	2547	2822	3117	3764	4014
Total	92,131	97,580	102,225	104,117	107,450



Source: GLA Household led population projections using 2020-based Demographic Projections, Ward population projections for London Boroughs 2020-based Scenario Projection: Identified Capacity Scenario

1.5 LBH Central Locality population change by age band 2010 - 2020

Age Band	2010	2020	Change	%
00-04	4737	6044	1307	28
05-09	4325	5658	1333	31
10-14	4616	4950	334	7
15-19	5256	4613	-643	-12
20-24	5305	5042	-263	-5
25-29	5863	7076	1213	21
30-34	5341	7338	1997	37
35-39	5395	6892	1497	28
40-44	5974	5921	-53	-1
45-49	6183	5540	-643	-10
50-54	5580	5940	360	6
55-59	4623	5854	1231	27
60-64	4811	4915	104	2
65-69	3539	3901	362	10
70-74	3172	3996	824	26
75-79	2765	2777	12	0
80-84	2180	2331	151	7
85-89	1348	1536	188	14
90+	620	969	349	56
Total	81633	91293	9660	12



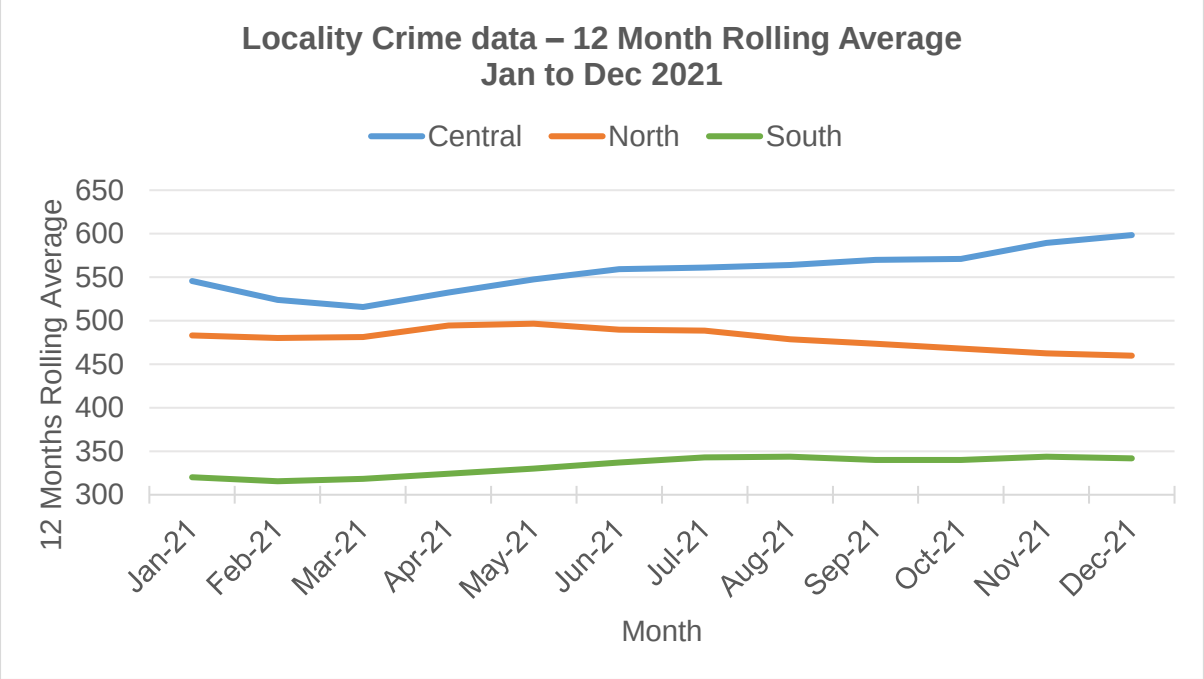
Source: ONS mid-year population estimates

1.6 Ethnicity

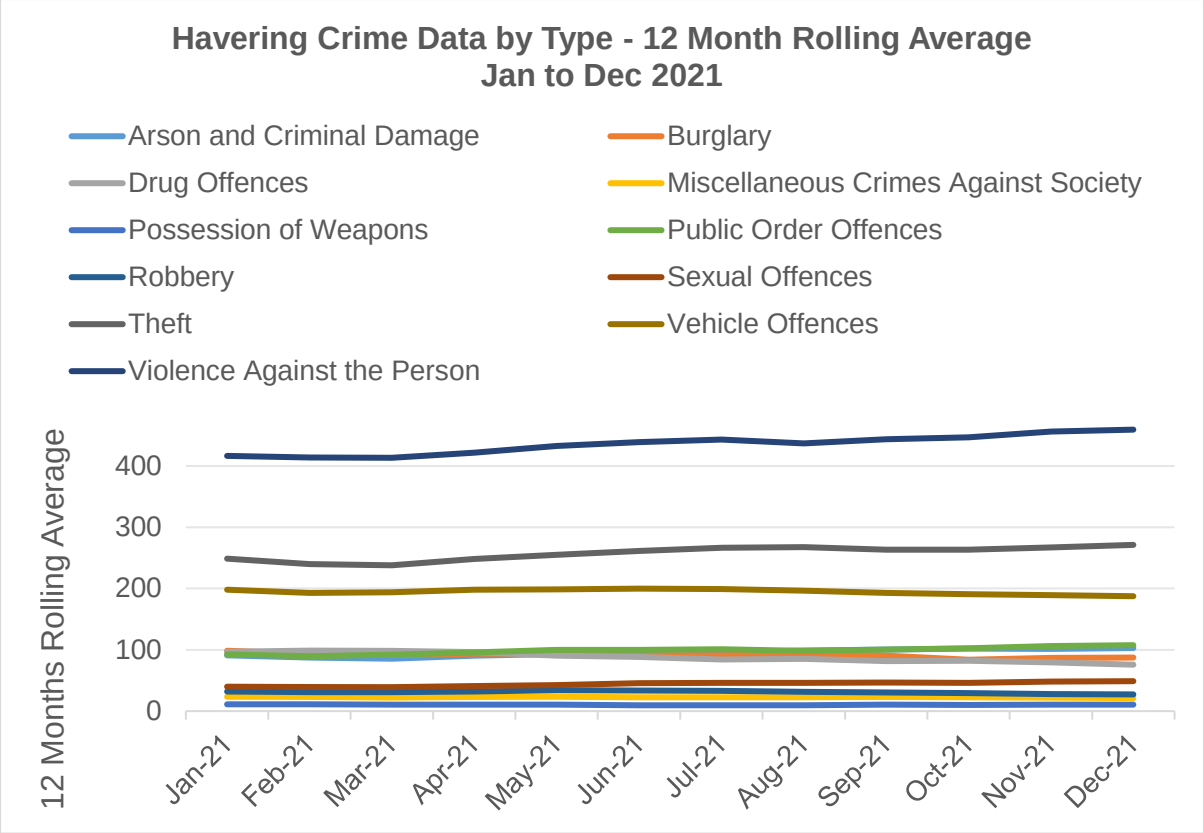
Ethnic group	Number	%
British	66,455	80.7
African	2,184	2.7
Indian or British Indian	2,611	3.2
Irish	1,287	1.6
Caribbean	1,171	1.4
White and Black Caribbean	675	0.8
Pakistani or British Pakistani	758	0.9
Chinese	665	0.8
White and Asian	464	0.6
European mixed	423	0.5
Other	5,642	6.9
Totals	82,335	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).



Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in Central Locality

The London Plan 2021 sets a ten year housing target for Havering of 12,850 new homes between 2019/20 and 2028/29 or 1,285 per annum. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

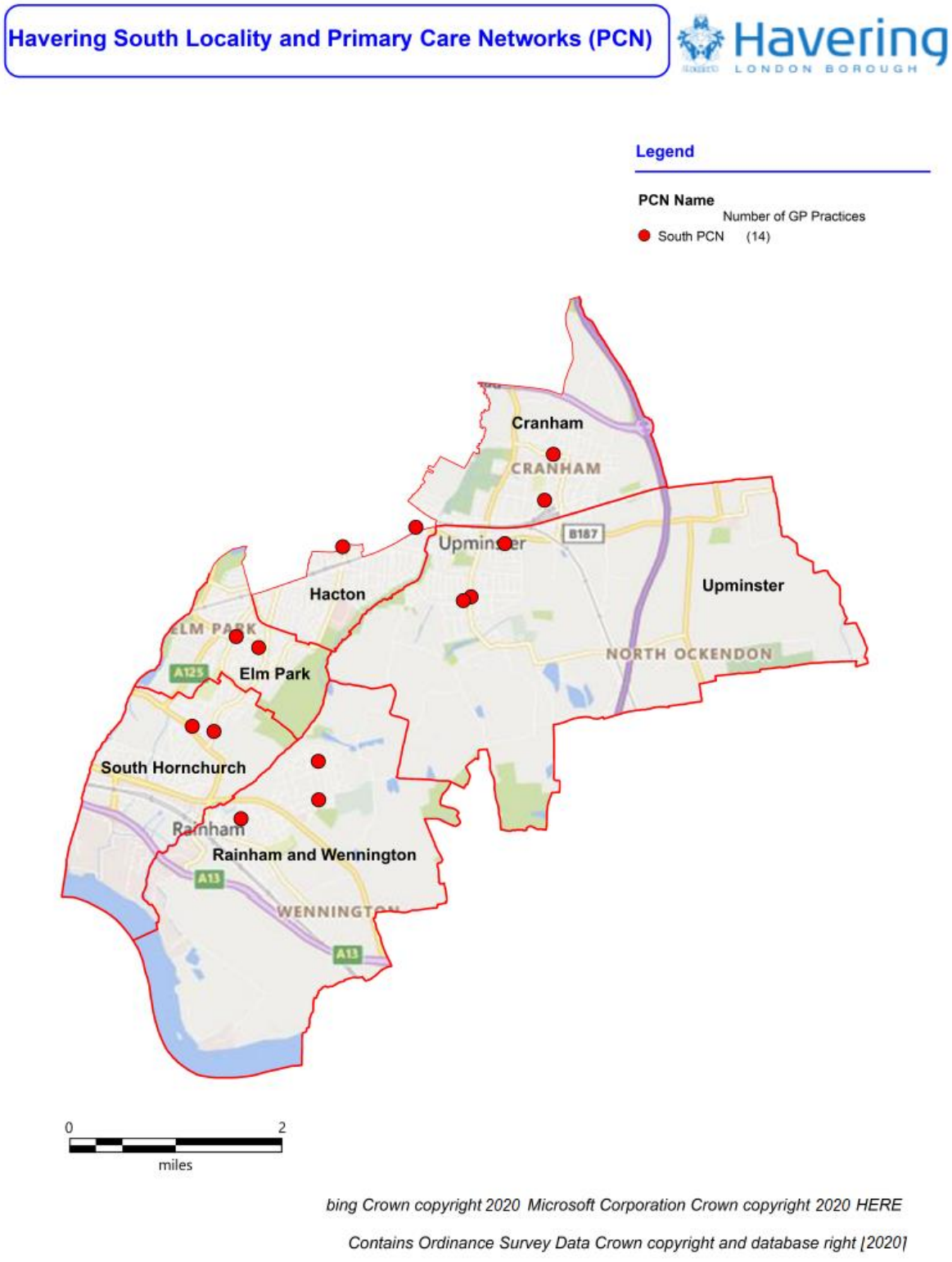
Locality	Number of houses
Central	4992
North	717
South	3702
Total	9411

London Borough of Havering (LBH) – South Locality

1. Places and Communities

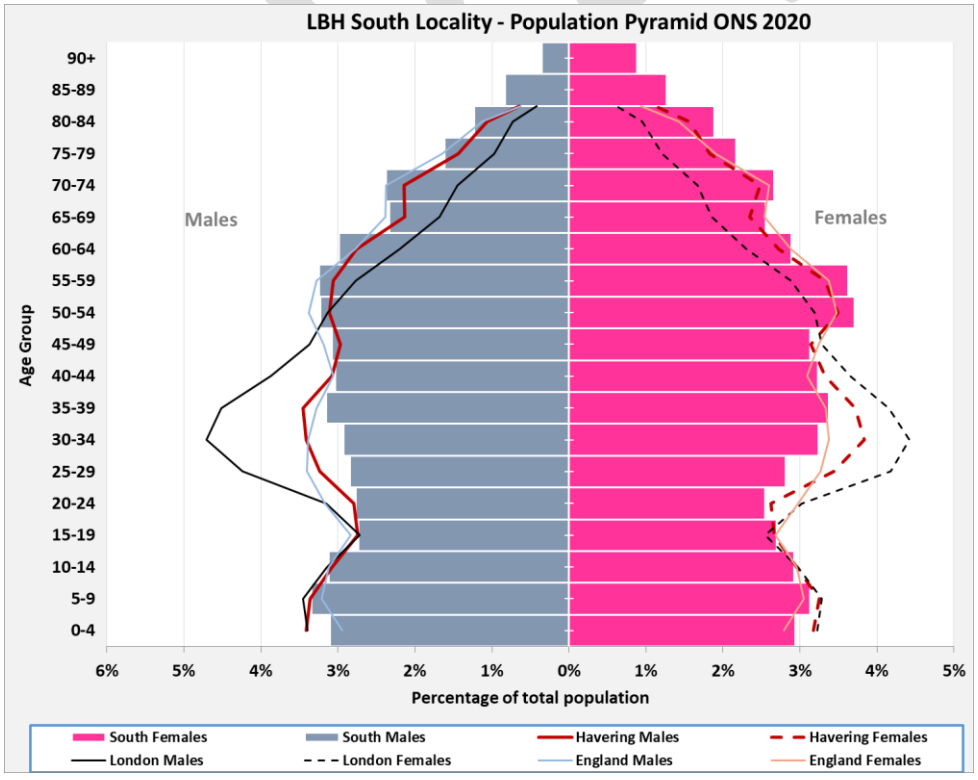
1.1 Havering South locality map

Wards include: Cranham, Elm Park, Hacton, Rainham and Wennington, South Hornchurch, Upminster



1.2 Estimated population of LBH South locality residents by gender and five year age groups - 2020

Age Band (Years)	Male	Female	Totals
0-4	2,488	2,359	4,847
5-9	2,679	2,511	5,190
10-14	2,498	2,342	4,840
15-19	2,191	2,165	4,356
20-24	2,216	2,038	4,254
25-29	2,275	2,253	4,528
30-34	2,347	2,596	4,943
35-39	2,525	2,707	5,232
40-44	2,434	2,592	5,026
45-49	2,463	2,510	4,973
50-54	2,585	2,969	5,554
55-59	2,598	2,903	5,501
60-64	2,393	2,314	4,707
65-69	1,866	2,045	3,911
70-74	1,902	2,138	4,040
75-79	1,291	1,738	3,029
80-84	985	1,511	2,496
85-89	667	1,016	1,683
90+	285	707	992
Totals	**38,688**	**41,414**	**80,102**



Source: ONS 2020 Mid-Year Estimates

1.3 LBH PCN Profile - GP population 5 year age groups

	HAVERING CREST PCN			HAVERING MARSHALL PCN			HAVERING NORTH PCN			HAVERING SOUTH PCN			
Age Band (Years)	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**Havering Total**
0_4	1263	1362	2625	1352	1434	2786	2609	2865	5474	2802	2909	5711	16596
5_9	1383	1381	2764	1417	1494	2911	3036	3198	6234	3179	3257	6436	18345
10_14	1295	1282	2577	1278	1351	2629	2845	3003	5848	2974	3161	6135	17189
15_19	1103	1194	2297	1206	1246	2452	2510	2602	5112	2855	2863	5718	15579
20_24	1131	1173	2304	1243	1252	2495	2481	2455	4936	2885	2934	5819	15554
25_29	1631	1436	3067	1639	1432	3071	2959	2772	5731	3323	3367	6690	18559
30_34	1835	1654	3489	1941	1750	3691	3550	3141	6691	3661	3626	7287	21158
35_39	1662	1619	3281	1807	1858	3665	3637	3280	6917	3845	3622	7467	21330
40_44	1400	1540	2940	1671	1631	3302	3041	3156	6197	3467	3419	6886	19325
45_49	1347	1391	2738	1407	1538	2945	2786	2795	5581	3208	3285	6493	17757
50_54	1392	1375	2767	1535	1566	3101	2862	2835	5697	3614	3570	7184	18749
55_59	1333	1363	2696	1514	1506	3020	2679	2657	5336	3895	3704	7599	18651
60_64	1197	1172	2369	1310	1248	2558	2324	2295	4619	3379	3383	6762	16308
65_69	905	894	1799	1090	981	2071	1786	1729	3515	2730	2588	5318	12703
70_74	857	749	1606	1122	981	2103	1863	1628	3491	2953	2601	5554	12754
75_79	720	529	1249	909	789	1698	1355	1040	2395	2373	1893	4266	9608
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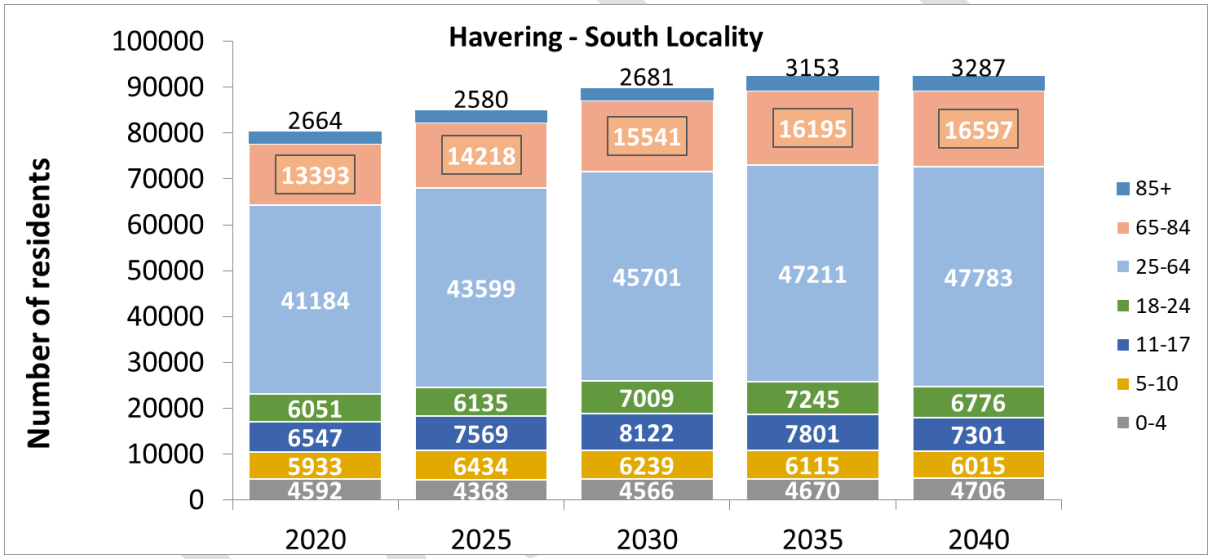
85_89	406	253	659	501	270	771	628	407	1035	1325	861	2186	4651
90_94	167	100	267	287	152	439	336	159	495	641	333	974	2175
95+	43	22	65	87	27	114	121	36	157	191	61	252	588
PCN Total	**21637**	**20891**	**42528**	**24005**	**22983**	**46988**	**44337**	**42770**	**87107**	**55066**	**52678**	**107744**	**284367**

Source: NHS Digital GP Registrations (September 2021)

1.4 LBH South Location Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
South	80,364	84,903	89,859	11.8	92,390	15.0	92,465	15.1

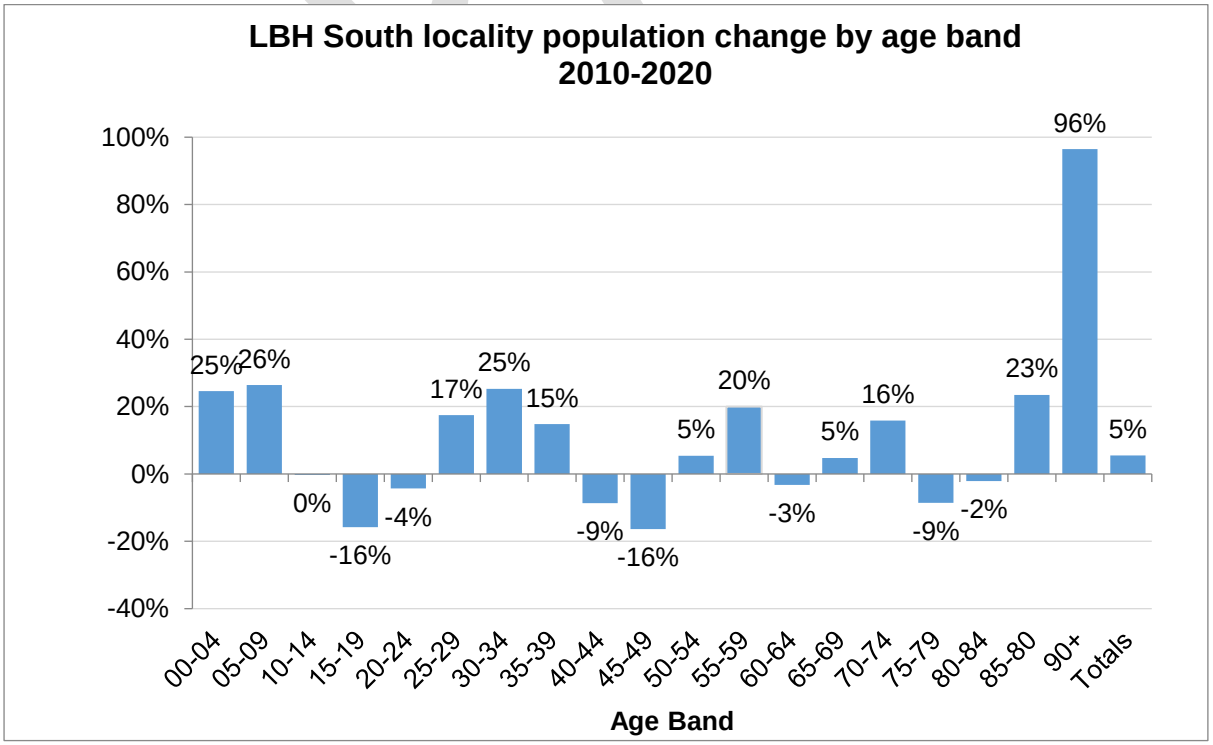
South	2020	2025	2030	2035	2040
0-4	4592	4368	4566	4670	4706
5-10	5933	6434	6239	6115	6015
11-17	6547	7569	8122	7801	7301
18-24	6051	6135	7009	7245	6776
25-64	41184	43599	45701	47211	47783
65-84	13393	14218	15541	16195	16597
85+	2664	2580	2681	3153	3287
Total	80,364	84,903	89,859	92,390	92,465



Source: GLA Household led population projections using 2020-based Demographic Projections, Ward population projections for London Boroughs 2020-based Scenario Projection: Identified Capacity Scenario

1.5 LBH South Locality population change by age band 2010 - 2020

Age Band	2010	2020	Change	%
00-04	3890	4847	957	25
05-09	4107	5190	1083	26
10-14	4855	4840	-15	0
15-19	5174	4356	-818	-16
20-24	4446	4254	-192	-4
25-29	3856	4528	672	17
30-34	3946	4943	997	25
35-39	4556	5232	676	15
40-44	5503	5026	-477	-9
45-49	5944	4973	-971	-16
50-54	5269	5554	285	5
55-59	4584	5501	917	20
60-64	4866	4707	-159	-3
65-69	3733	3911	178	5
70-74	3487	4040	553	16
75-79	3312	3029	-283	-9
80-84	2550	2496	-54	-2
85-89	1363	1683	320	23
90+	505	992	487	96
Total	75946	80102	4156	5



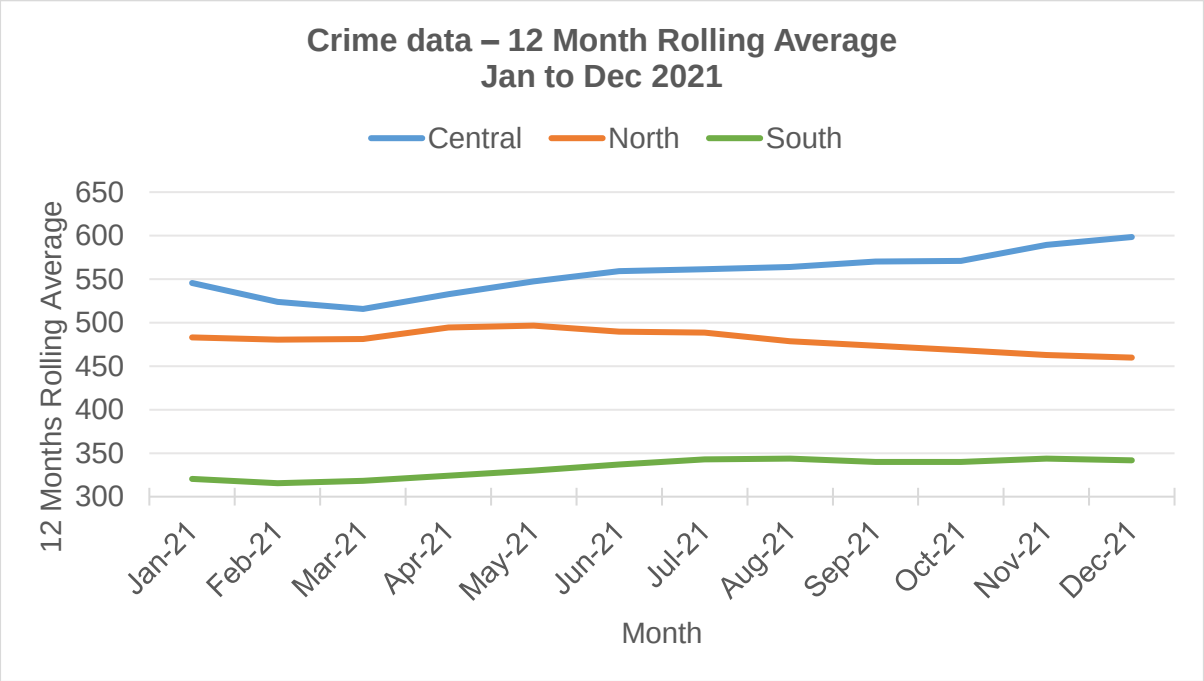
Source: ONS mid-year population estimates

1.6 Ethnicity

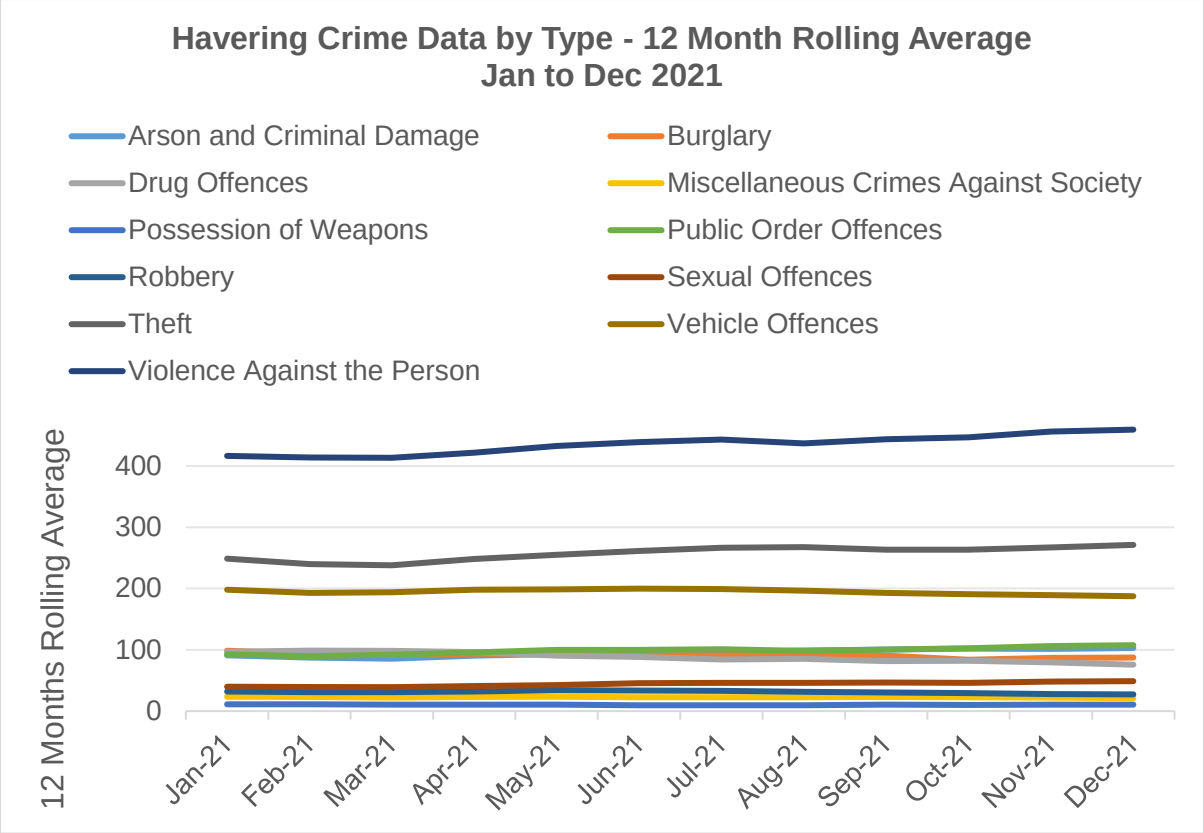
Ethnic group	Number	%
British	66,593	87.4
African	1,991	2.6
Indian or British Indian	1,076	1.4
Irish	970	1.3
Caribbean	602	0.8
White and Black Caribbean	493	0.6
Pakistani or British Pakistani	245	0.3
Chinese	477	0.6
White and Asian	369	0.5
European mixed	228	0.3
Other	3,117	4.1
Totals	76,161	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).



Source: [Recorded Crime: Geographic Breakdown - London Datastore]
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in South Locality

The London Plan 2021 sets a ten year housing target for Havering of 12,850 new homes between 2019/20 and 2028/29 or 1,285 per annum. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

Locality	Number of houses
Central	4992
North	717
South	3702
Total	9411

The London Plan quotes a housing figure for Havering of 18,750. Our local plan quotes a figure of 11,701 homes from 2015-2025. From recent work (February 2019) the planning team supplied ward level housing projections to the GLA for Borough Preferred Population estimates.

These figures gave housing figures for a five year period 2020/21 to 2024/25.

These figures broken down by locality and show the 5 year projection.

Locality	Number of houses
Central	4992
North	717
South	3702
Total	9411

BHR Joint Strategic Needs Assessment 2019

London Borough of Havering

Locality Dashboard

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

		Indicator	Period	North	Central	South	Havering	Barking & Dagenham	Redbridge	BHR	London	England		
				Value	Value	Value	Value	Value	Value	Value	Value	Value	Lowest	Highest
Wider Determinants	1	Index of Multiple Deprivation (IMD) 2019 Rank/Score	2019	22.7	14.3	13.9	16.8	32.8	17.2	21.3	21.8	21.7	45.0	5.5
	2	Proportion of residents who are Income Deprived	2019	14.5	9.2	9.0	10.8	19.4	12.1	13.6	13.8	12.9	25.1	2.9
	3	Proportion of Households experiencing Fuel Poverty	2016	8.3	8.3	7.3	8.0	11.6	11.3	10.2	10.0	11.1	17.0	4.9
	4	Healthy Behaviour and Lifestyles: Smoking Prevalence (% of adult population) (APS) **	2018	16.0	15.2	15.1	15.0	22.4	13.2	16.2	13.9	14.4	26.1	5.9
Maternity	5	Number of live births	2018	1,229	1,211	949	3307	3700	4539	11546	120673	625651		
	6	Number and percentage of stillbirths	2015-17	8.9	9.7	5.1	5.3	5.9	3.1	4.6	4.9	4.3	6.8	2.6
	7	General Fertility Rate (per1,000 women age 15-44)(locality data not available)	2018				68.0	82.6	73.4	74.4	62.9	64.2	41.6	86.5
	8	Low Birth Weight Births (% term babies)	2017	3.2	2.2	2.8	2.7	3.8	3.9	3.5	3.0	2.8	5.3	1.6
Children and Young People	9	Number and percentage of pupils with Special Educational Needs (SEN) based on where the pupil attends school	2019	10.3	9.1	10.8	9.9	14.1	11.6	12.0	14.6	14.9	9.9	20.5
	10	Number of children with a Child Protection Plan and rate per 10,000 children at 31st March 18	2017/18	47.7	15.1	25.0	37.9	51.0	38.1	42.2	39.2	45.0		
	11	Number of Looked after Children and rate per 10,000 children at 31st March 2018	2017/18	42.5	22.4	32.6	44.0	65.0	29.0	45.1	49.0	64.0	23.0	185.0
	12	Number of Children in Need and rate per 10,000 children at 31st March 18	2017/18	135.0	85.5	74.0	401.1	345.5	298.7	343.4	360.1	338.5		
	13	Rate of teenage pregnancy (under 18 year olds - rate/1,000)	2017	32.7	19.9	18.7	21.0	25.1	12.4	18.8	16.4	17.8	6.1	43.8
	14	GCSE Achievement (5A*-C inc. English & Maths) (%)	2017/18	53.6	64.1	62.2	67.7	60.0	74.4	68.5	67.7	59.1	41.9	93.3
	15	Percentage of children with excess weight (including obesity) (Reception Year)	2017/18	24.8	23.8	24.1	24.4	25.6	21.5	23.7	21.8	22.4	29.6	13.9
	16	Percentage of children with excess weight (including obesity) (Year 6)	2017/18	38.9	36.3	38.0	37.3	44.5	40.2	40.8	37.7	34.3	44.5	21.7
	17	Mental Health: No locality indicators please refer to Borough profiles												
Cancers	18	Incidence breast cancer (Age standardised rate per 100,000)	2012-16	103.9	100.0	111.3	105.1	91.7	95.7	98.6	94.7	100.0	80.7	118.9
	19	Incidence colorectal cancer (Age standardised rate per 100,000)	2012-16	101.9	84.0	110.7	98.9	101.4	83.6	93.8	90.8	100.0	75.1	122.7
	20	Incidence lung cancer (Age standardised rate per 100,000)	2012-16	114.0	90.7	93.2	98.9	138.1	75.9	98.5	97.4	100.0	45.8	194.7
	21	Incidence prostate cancer (Age standardised rate per 100,000)	2012-16	99.9	105.9	114.0	106.9	115.1	100.7	106.2	105.5	100.0	65.3	148.3
Long Term Conditions	22	Deaths from coronary heart disease, all ages, standardised mortality ratio	2013-17	101.5	84.3	84.1	89.6	107.3	101.1	97.3	94.1	100.0	56.9	165.7
	23	Deaths from respiratory diseases, all ages, standardised mortality ratio	2013-17	117.2	93.7	102.9	104.4	131.2	95.1	106.5	91.5	100.0	41.8	157.9
	24	Deaths from stroke, all ages, standardised mortality ratio	2013-17	83.9	78.9	96.2	86.5	95.0	95.1	91.3	88.5	100.0	32.8	144.5
	25	Emergency hospital admissions for coronary heart disease, standardised admission ratio	2013/14 - 17/18	106.1	90.2	80.9	92.0	119.3	122.5	109.0	96.0	100.0	55.1	188.2
	26	Emergency hospital admissions for stroke, standardised admission ratio	2013/14 - 17/18	97.8	88.7	94.0	93.4	106.1	95.2	96.7	103.8	100.0	64.7	151.3
Older People	27	Emergency hospital admissions for hip fracture in persons 65 years and over, standardised admission ratio	2013/14 - 17/18	104.0	97.3	102.6	101.3	107.4	91.6	99.1	88.7	100.0	72.2	126.5
	28	Older People in Deprivation, English Indices of Deprivation 2015, IDAOPI	2015	17.7	12.9	10.2	13.5	27.9	21.0	19.1	22.2	16.2	6.3	49.7

Data Sources: *1,2 - IMD 2019, 3,18,19,20,21,22,23,24,25,26,27,28 - Local Health (www.localhealth.org), 4 - http://ash.lelan.co.uk/, 5,7 - ONS, 6,8,13,14,15,16 - PHE Indicators https://fingertips.phe.org.uk 9,10,11,12 - Local data* *** Please refer to Borough profiles for more indicators*

Appendix 12: Contact

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