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

London Borough of Havering

V 4.0 2020

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Executive Summary

The BHR JSNA 2020 is a first attempt at creating a single view of the challenges facing the partners represented at the BHR ICPB if they are to improve the health and wellbeing of people resident in the three boroughs and their experience of the health and social care system.

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

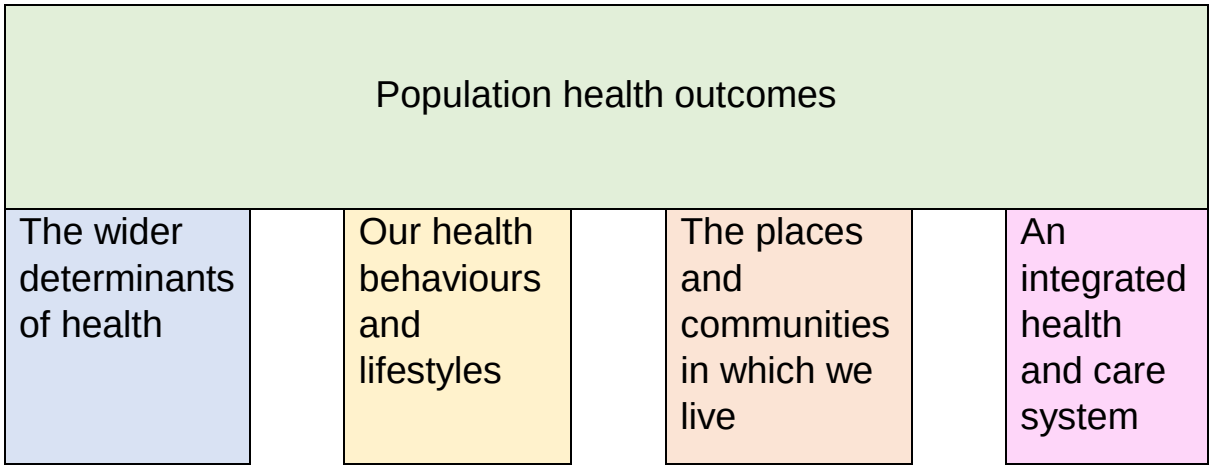
Population growth has affected all the three boroughs in recent years. Further very significant growth, equivalent to the population of another borough, is predicted in the next 20 years. Population increase will be particularly high in areas identified for significant house building including Barking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

Health outcomes in BHR - Life expectancy has increased steadily over the last few decades but more recently the rate of improvement has slowed if not stopped entirely and much of the additional years of life achieved are marred by ill-health and dependency on health and social care services. Moreover, there are marked inequalities in health outcomes between communities and population groups.

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

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

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



The lead agency for local action regarding the first three pillars will be Councils working with partners at borough level. NHS agencies have the opportunity to maximise the potential health benefits of relevant plans via participation in each borough's **Health and Wellbeing Board**[2]. In addition to the crucial impact on the health of future residents, these plans will afford the opportunity to tackle some of the problems facing the health and social care system e.g. plans for **regeneration** could deliver a step change in the quality of local primary care facilities and offer key worker housing to attract hard to recruit health and social care professionals to live and work in BHR. The JSNA also highlights opportunities for health and social care services to contribute directly to improve the life chances of local residents e.g. by fulfilling their role as **'anchor institutions'** at the centre of the local community and economy.

Various international studies suggest that health and social care services contribute about 25% to the overall health of the population and immense benefit to individual patients. However, existing models of care are failing to deliver further improvements in population health and are struggling to cope with the challenge of demographic change, with much more to come.

In these circumstances far greater emphasis must be placed on **prevention** in its widest sense.

Addressing the **wider determinants of health** e.g. by improving educational attainment, employment opportunities or enabling someone to live in a safe secure home undoubtedly prevents physical and mental ill-health in the longer term. Similarly, recognition that exposure to Adverse Childhood Experiences **(ACEs)**

[1] Kings Fund 2018 A vision for population health – towards a healthier future https://www.kingsfund.org.uk/publications/vision-population-health

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

increases the risk of a range of negative outcomes in later life opens up another approach to prevention

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

Smoking has become far less common than previously and is increasingly limited to disadvantaged communities and specific population groups (e.g. people with SMI) where our efforts should now be focused. More recently, **vaping** has helped many more people to stop smoking and partners should actively encourage this trend.

But in working with residents to promote healthier **lifestyles and behaviours** we must recognise that our day-to-day decisions are shaped by how and where we live. 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, CVD, cancers and MSK problems. Obesity will not be solved by simple advice to eat more healthily; we need to employ **a whole system approach** using all the levers available to assist residents to get a better balance between calories consumed and energy expended.

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

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

Happily, most children are born in good health. Nonetheless, maternity and **health visiting services** offer essential support to all parents at a time that inevitably brings new and sometimes significant challenges. In addition, they can identify those families that are struggling enabling **early intervention** e.g. to ensure children are ready to learn by school age.

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

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

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

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 ACEs. In most circumstances, it remains in the best interest of the child that they remain under the care of their parents with additional support. However, for some CYP, the best option is that they be taken into care. 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.

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

One in four adults experience **mental illness** and the total harm to health is comparable to that caused by cancers or CVD. Hence, it is right that the NHS is now committed to giving mental health parity of esteem with physical health. As with physical ill health; the burden of disease shows marked inequalities and there are significant opportunities to **prevent** mental illness throughout the life course. The impact of the wider determinants on mental health is particularly marked. Factors like

debt, unemployment, homelessness, relationship breakdown and social isolation predispose to mental illness. Action to address the wider determinants can aid recovery but people with mental health issues, particularly serious mental illness are much less likely to be have stable accommodation or be in work. A coordinated, proactive approach on the part of multiple agencies is necessary. People in the **criminal justice system** and **street homeless** have particularly complex problems often including concurrent mental illness and drug and alcohol dependency. A relatively small number of patients live with **serious mental illness**. Priorities for action include a timely and effective response to **crisis** and action to reduce the **gap in life expectancy** between people with SMI and the population as a whole. A far bigger number of people are living with a common mental health condition. The ongoing development of **IAPT** has greatly increased the provision of talking therapies but further work is needed to increase uptake and achieve outcomes comparable to the best. At the same time; action is needed to increase the capacity and capability of **primary care** to better support the bulk of people living with mental health problems. Alongside improvements in care, action is needed to tackle stigma; build resilience and improve awareness of effective self-help options.

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

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

This illustrates a more general observation that the number of people known to have a range of long term conditions (**LTCs**) is considerably lower than expected indicating that a large number of cases remain undiagnosed and untreated. Hence our approach to the identification of residents with or at risk of a range of LTCs needs to be improved; making more of NHS health checks; complemented by community based, opportunistic interventions to engage people who don't normally attend their GP and ensuring that GPs regularly check patients with one condition for other LTCs – as they tend to share the same risk factors.

There is also strong evidence suggesting that a proportion of people with an LTC diagnosis miss out of one or more interventions that would reduce their risk of disease

progression. Further improvement in the management of common LTCs is necessary to maximise the benefits of **secondary prevention**.

A small but growing proportion of residents live with **multiple LTCs**. Existing services struggle to meet their complex needs and as a result they frequently attend A&E and/or have unplanned hospital admissions. Although small in number, a disproportionate amount of resource is expended achieving less than satisfactory outcomes.

Similarly, **frail, older people** are at high risk of admission to hospital. Admission can lead to a rapid decline in physical abilities, equivalent to a year's additional age for each day of admission. Such deterioration can very quickly make a return home impossible.

The current model of care resulting in large numbers of A&E attendances and unplanned admissions in response to both relatively minor complaints and regular crises, some of them avoidable, is not improving population health outcomes, gives patients a poorer experience of care and is increasingly unviable financially given the significant and recurrent **financial deficit** affecting the BHR health and social care system.

A significantly different approach to organisation and delivery of health and social care is required.

We need to make better use of information to inform **population health management** as well as the clinical management of the individual patient. Stratification of the population by life stage and complexity of need will improve the planning and delivery of services for specific patient cohorts:

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

In each case, the precise interventions and delivery mechanisms will vary through the life course and in response to social factors. The NHS Long Term sets out a very clear path for regarding 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 focusing less on deficits and what they need by way of services and more on what they can do and the **assets** available to them including family and wider social networks. The role of health and social care being to provide any additional support and / or aids necessary, for a limited period, to return them to their former level of functioning and independence.

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

But better management of complex patients will not of itself improve health outcomes and achieve a sustainable balance between the needs of a growing and ageing population and the capacity and capability of local health and social care services.

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

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

Equally, health professionals and public will need to recognise the impact of personal circumstances and place on health and look beyond health care for more effective ways of improving wellbeing. Strong links between general practice, other statutory services such as housing and the Department of Work Pensions, the community and voluntary sector within the locality should be are an essential element of locality working. The development of an effective **social prescribing** function; whereby patients are actively encouraged to access other forms of support will maximise the likelihood of success e.g. with 1:1 support from a care navigator. Partners and the community itself will also need to consider the assets available relative to needs and

how any gaps may be filled[4]. Approaches such as **local area coordination** are needed to strengthen the capacity of communities to identify and support vulnerable people 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 out of 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 but rather are shaped by the place which they live; prevailing cultural norms, their previous experiences and aspirations for the future. A focus solely on the 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 and reducing social isolation amongst older people.

[4] 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. Introduction

This family of profiles was produced at the request of the Barking, Havering and Redbridge Integrated Care Partnership Board (ICPB). The BHR ICPB brings together elected members, clinicians and officers from the three Health and Wellbeing Boards coterminous with the developing Barking Havering and Redbridge Integrated Care System (ICS).

Health and Wellbeing Boards have a duty to conduct a Joint Strategic Needs Assessment (JSNA) describing the current and future health, care and wellbeing needs of the local community to inform local decision-making.

Profiles have been produced for each of the three constituent boroughs and contain data regarding the 11 localities within the ICS.

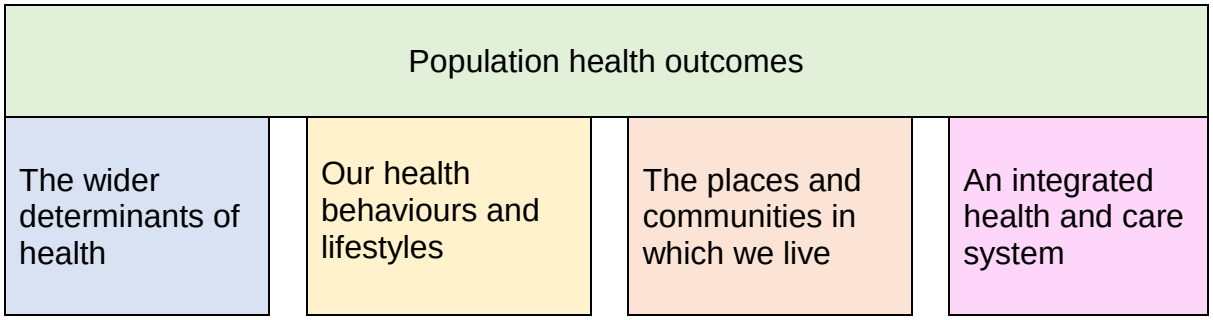
The process followed in developing the profiles is summarised here. They are a first attempt at producing a JSNA in a consistent way across the developing BHR ICS. An interactive, on-line product will be available in the near future.

Suggestions as to how the next iteration of the BHR JSNA can be further improved would be welcomed and should be sent here

NB. These profiles are designed to complement not replace existing borough based JSNA products.

Structure of the BHR JSNA profiles

The health of the population reflects the interaction of a variety of different factors. The framework for population health developed by the Kings Fund describes these factors in terms of four pillars underpinning health outcomes.



Various studies suggest that health and care services contribute about 25% to the overall health of the population. Therefore, any approach to maximise good health must address all four pillars or miss significant benefits to local residents and the opportunity to mitigate ever-increasing demand for health and social care services.

The JSNA profiles replicate the four pillars; a brief description of the local population is followed by a description of health outcomes in the area and a commentary regarding each of the four pillars. Each element of the report is accompanied by a dashboard containing a small number of relevant metrics. The commentary provides an interpretation of the data presented and suggests high-level priorities for action.

The commentaries regarding the first three pillars are unique to the individual borough profile as the lead agency for relevant plans and policies is likely to be the Council working at borough level. NHS partners in the ICPB have the opportunity to influence these plans to maximise the potential value to health via participation in borough level Health and Wellbeing Boards.

The commentary regarding the integrated care system is common to all three profiles as all partners are agreed that the overall approach to the development of integrated health and social care services will be agreed at BHR level and implemented at locality level.

Data are provided at locality level; Public Health Teams will engage with professionals leading the development of locality working in the coming year to agree a commentary regarding need at locality level and priorities for action.

2. The Population

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

2.1 Population Size & Growth

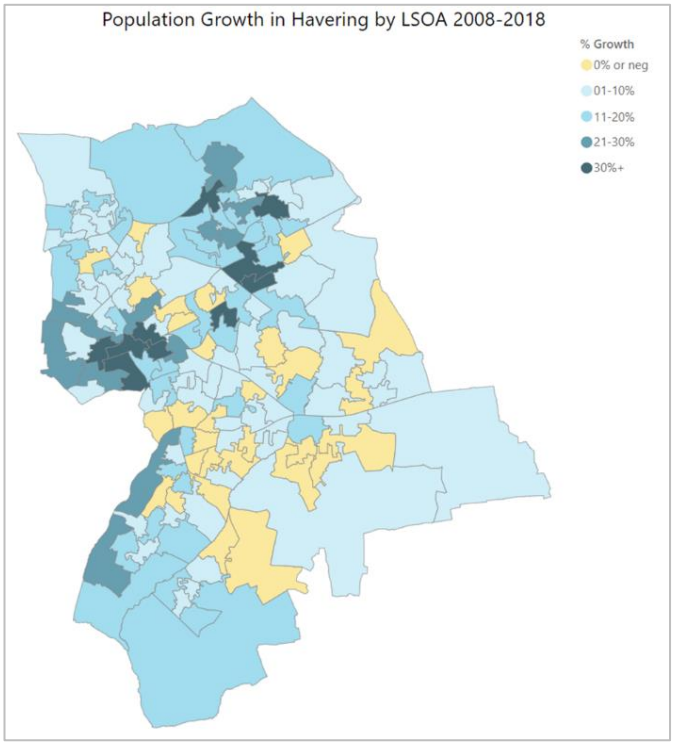
The resident population of Havering in 2018 was estimated to be 258K.

The population registered with a Havering GP in 2019 is 281K. The Havering GP registered population is 33.4% of the total patients registered with a BHRCCGs' GP.

Figure 1: Population Growth by LSOA Havering 2008-2018

The population resident in Havering increased by 26K (11%) in the ten years from 2008.

The rate of population growth has varied within the borough being highest in Romford and Brooklands and much lower in Emerson Park.



Data Source: ONS 2018 Mid-Year Pop Estimates

Further significant population growth is predicted with the population of Havering projected to grow by 41K (16%) from 258K in 2018 to 299K in 2030.

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.[5]

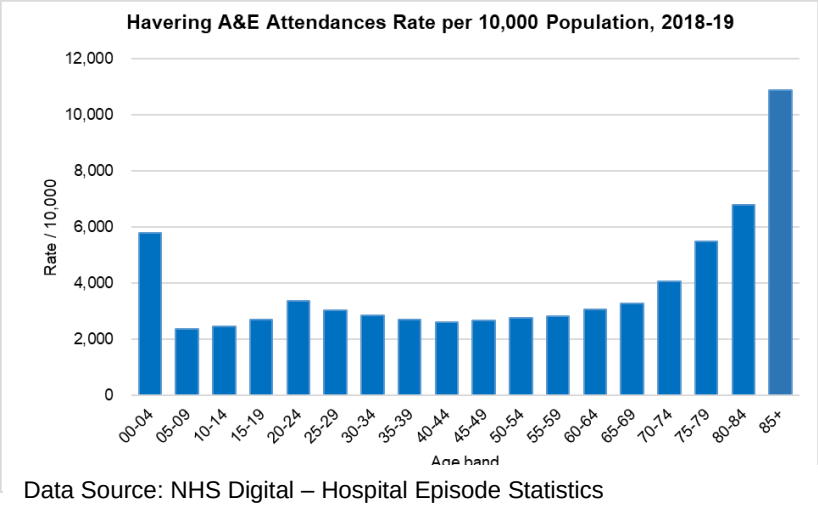
[5] https://www.london.gov.uk/what-we-do/planning/london-plan/new-london-plan/draft-new-london-plan/chapter-4-housing/policy-h1-increasing-housing-supply

2.2 Age Structure

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

Figure 2. Havering A&E Attendance, 2018-19

The use of health services typically exhibits a 'j' shaped curve with much higher use in the first weeks of life and later in old age. For example, people aged 85 and older are 4 times more likely to attend A&E and 11 times more likely to have an unplanned admission than adults aged 25 – 64.

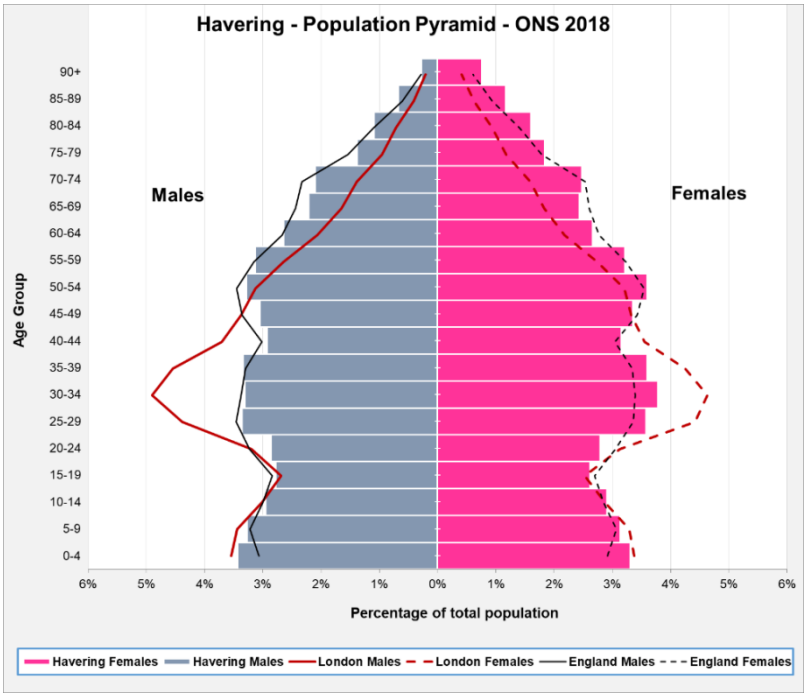


Data Source: NHS Digital – Hospital Episode Statistics

Figure 3. Havering Population Estimates 2018

The population of Havering is relatively old in comparison with the rest of London and the BHR ICS. Nearly half of the 16000 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 e.g. the number of people aged 85 and above living in Havering will increase by 2.4K (31%) from 7.6K in 2018 to 9.9K by 2030.



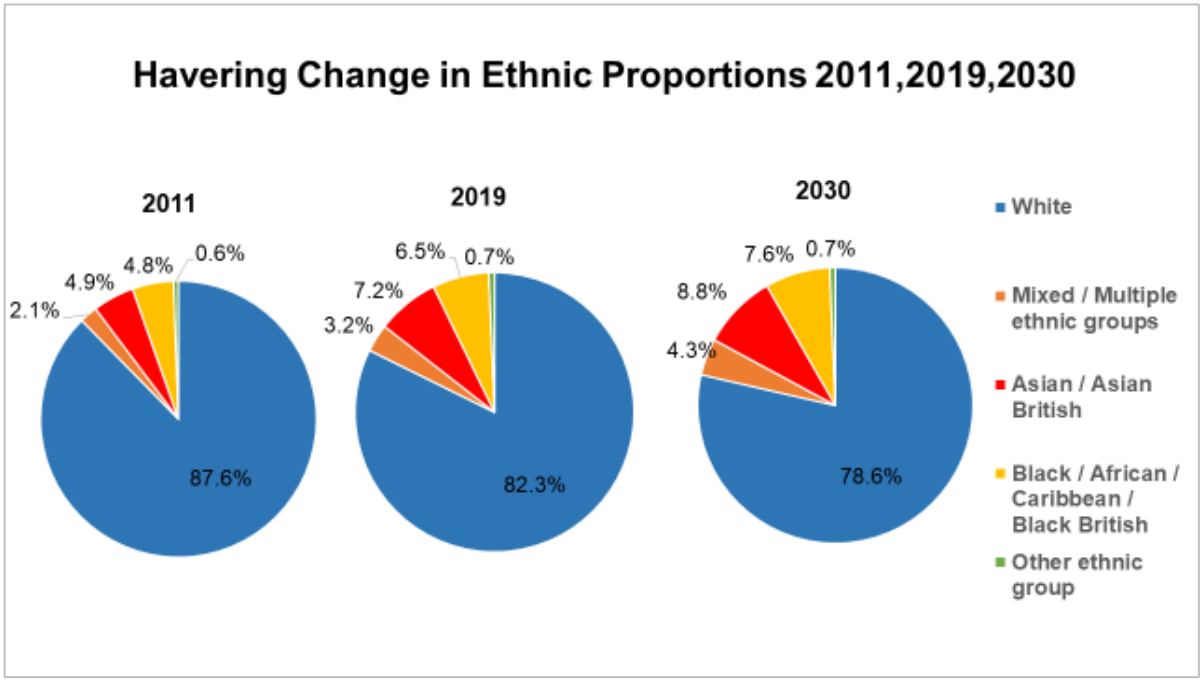
Data Source: ONS Mid-Year Population Estimates 2018

Overall impact of demographic change: If age specific rates of attendance remain unchanged; the demographic change described above will result in a 21% increase in unplanned hospital admissions of Havering residents by 2030.

2.3 Ethnicity

Ethnicity Influences health outcomes via multiple routes e.g. 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 much 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.[6]

Figure 4. Havering change in ethnic populations, 2011-2030



Data Source: ONS Mid-Year Population Estimates 2018

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 78.6% identifying as White; and 76% as White British.

Further increases in diversity are likely.

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

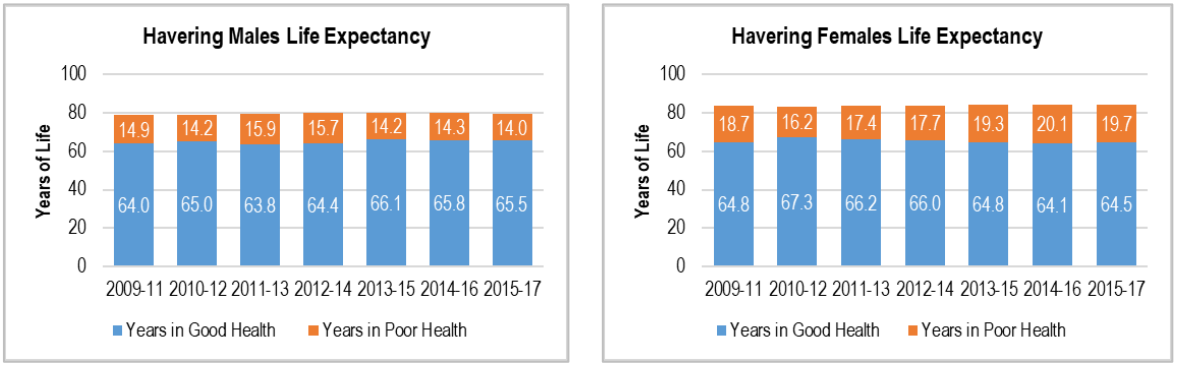
3. Population Health Outcomes

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

Life expectancy in Havering is similar to the national average. As is the case nationally, life expectancy has increased steadily over recent decades but more recently, the rate of improvement has slowed if not stopped entirely.

The additional years of life achieved in recent decades are impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services.

Figures 5 & 6. Havering Life expectancy 2009-11 to 2015-17

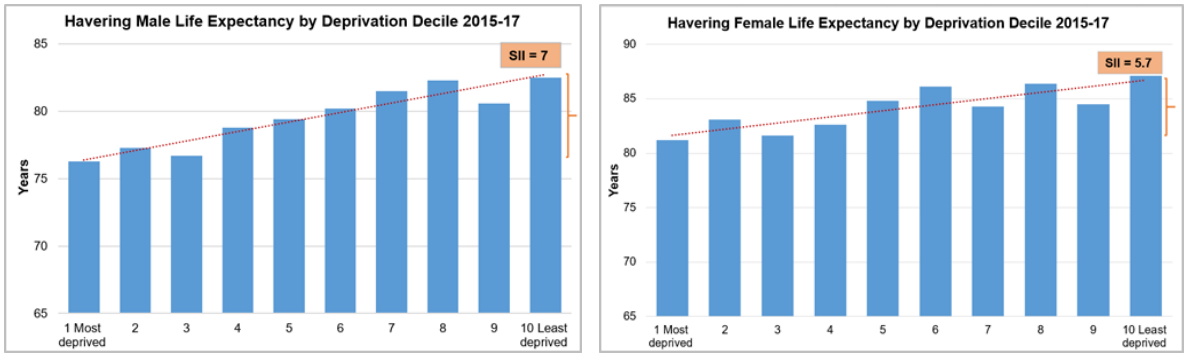


Source: Public Health England

There is a significant social gradient in life expectancy such that residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (7 years for men and 5.7 years for women) than peers in the least deprived decile.[7]

As well as lower life expectancy, people living in disadvantage have proportionally less healthy life expectancy than less disadvantaged peers.

Figures 7 & 8. Havering Life expectancy by Deprivation Decile, 2015-17



Source: Public Health England

Communities elsewhere in England and abroad achieve much better health outcomes than those seen in Havering i.e. residents enjoy longer life expectancy and a greater proportion of that longer life is lived in good health.

[7] Slope Index of Inequality Index (SII) is interpreted as number of years. The SII is a measure of the social gradient in an indicator - it represents the absolute difference across the social gradient from most to least deprived.

This is not because they benefit from significantly better health and social care services – although this maybe the case. Rather it is because they enjoy more favourable social-economic conditions and live in communities and environments that better support health and the adoption of healthy lifestyles.

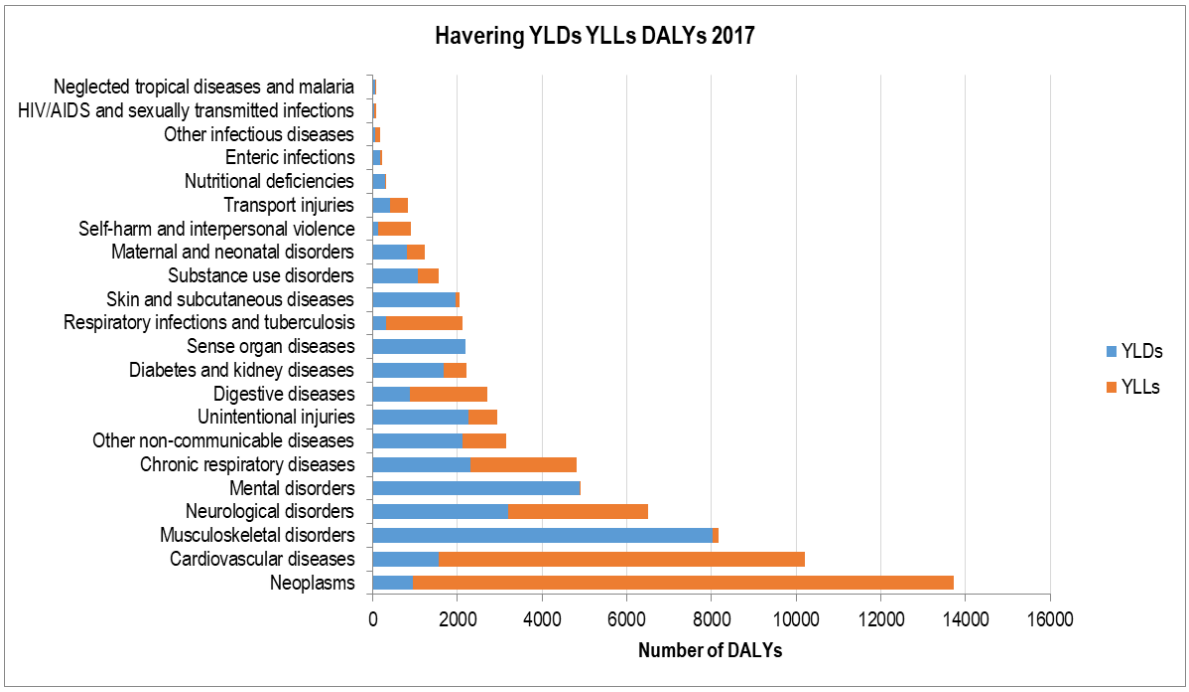
Therefore, to achieve our aspiration of better health for all we must create the conditions that support good health as well as improving care services. Robust plans regarding all four pillars of population health are essential. This is the business of a wide variety of statutory agencies; private enterprise 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.*

DALYs (Disability Adjusted Life Years) are a means of combining premature death and years of life lived with disability into a single measure of harm to population health. Such analysis demonstrates that:

- the harm, measured in terms of DALYs, caused by conditions resulting in disability (49.8%) is similar to that caused by conditions resulting in early death (50.2%).
- the conditions resulting in disability (e.g. back pain, migraines and mental ill health) are different to those causing the majority of premature deaths (cancers, cardiovascular disease, COPD etc.).

Figure 9: Havering YLDs, YLLs & DALYs, 2017



Data Source: Global Burden of Disease, 2017

Health services have traditionally focused on life expectancy as a measure of progress. Whereas this is enormously important, it serves to underplay the harm caused by illness and disability experienced during life for example because of musculoskeletal, neurological and mental health disorders.

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

4. The Wider Determinants of Health

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

4.1 Income and work

The wider determinants of health e.g. income, employment, education and housing, are the most important drivers of health/ill-health. Income impacts on health in a variety ways:

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

Median annual household income in Havering (£36.7K) is well above that for England (£30.6K) – but below the London figure (£39.1K). Although incomes in Havering are not particularly high for London, the proportion of adults that are income deprived[8] is relatively low. Nonetheless more than 1 in 10 adults in LBH are income deprived.

Figure 10: IMD Scores 2019 London Boroughs

[8] 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).

Work is good for physical and mental health, in part due to the association with higher income. Rates of employment in Havering (76.1%) are higher than the London (74.2%) and England (75.6%) average.

The proportion of working age adults in Havering who are economic inactive (19.0%) is correspondingly lower than the London (21.9%) and national averages (21.3%). However, 4800 Havering residents are economically inactive and want a job.

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

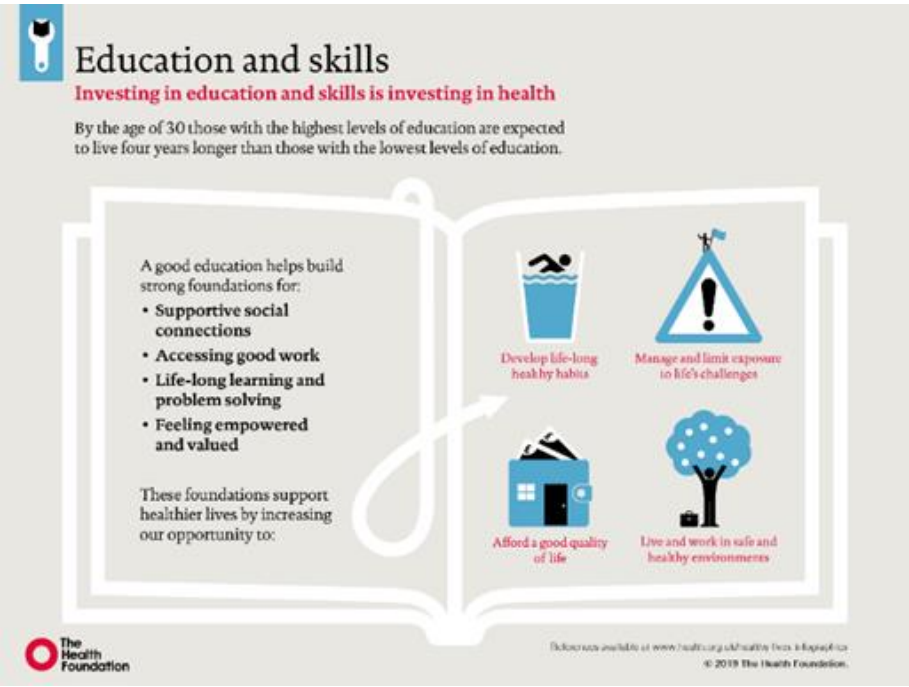
Just under 50% of working age adults resident in Havering are employed in management or professional roles - similar to the national average but below the average for London, which is closer to 60%.

After retail (17.9%), the health and social care sector (16.7%) is the biggest source of employment in Havering, nonetheless the BHR health and social care system struggles to recruit to many professional roles resulting in vacancies and the use of locum staff at increased cost.

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

4.2 Educational Attainment

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



Adult education attainment in Havering is modest – 48% of working age adults have ‘A’ level or higher qualifications compared with 66% for London and 58% for the

country as a whole. This may translate into lower parental expectations for the next generation.

4.3 Housing

The impacts of poor housing are many and varied, affecting physical and mental health at all life stages. A well-housed population helps to reduce and delay demand for NHS services and allow patients to go home from hospital as soon as they are fit to do so.

Appropriate housing adaptions and/or access to supported housing options can enable vulnerable residents to live independently for longer and facilitate timely discharge from hospital.

Cold homes, whether due to poor design, inability to pay for heating or a combination of the two, contribute to excess winter mortality.

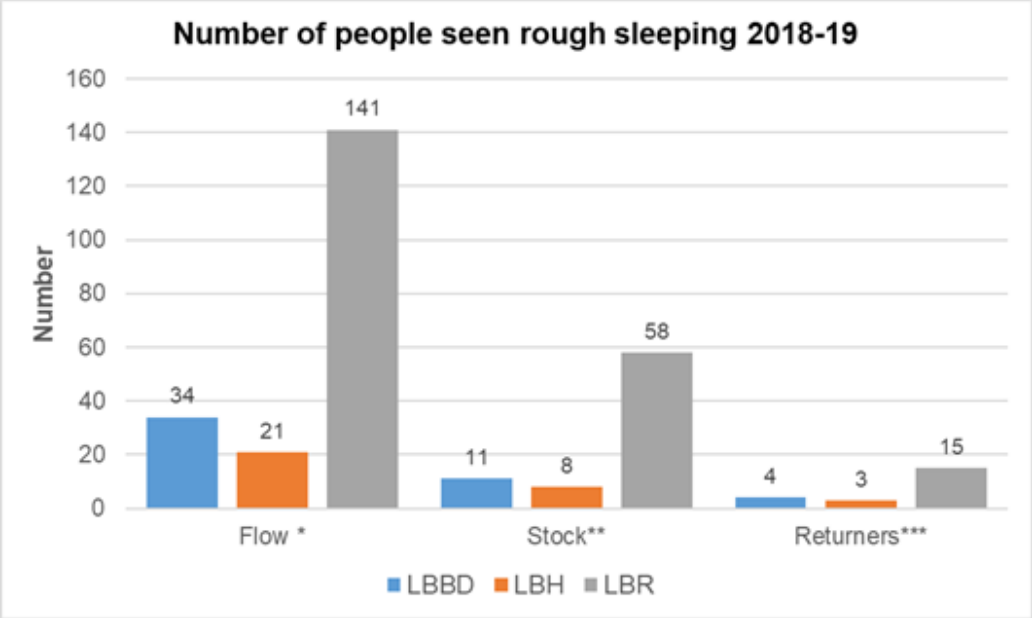
Houses in multiple occupation (HMO) are a part of the privately rented sector that causes particular concern given the inherent additional risks of overcrowding and consequent impact on safety and health. The number of HMOs in Havering is increasing albeit from a low base.

Under supply and unaffordability contribute to homelessness; planned housing growth provides an opportunity to tackle both – as it is 1,254 households are currently homeless and in temporary accommodation.

The health impact of street homelessness cannot be underestimated: the average age of a homeless man at death is 47 years; the figure for women is even lower at only 43

years[9]. Hence the increase in the number of new rough sleepers recorded in 2018/19 is of enormous concern. [10]

Figure 11: Rough Sleeping 2018-19



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.

***Recommendation 3**: Work together to mitigate the worst harms of street homelessness and help those affected with the ultimate aim of enabling them to maintain suitable permanent accommodation.*

[9] 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/
[10] Chain Annual Report: Outer Boroughs April 2018 – March 2019 https://data.london.gov.uk/dataset/chain-reports

NB. **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

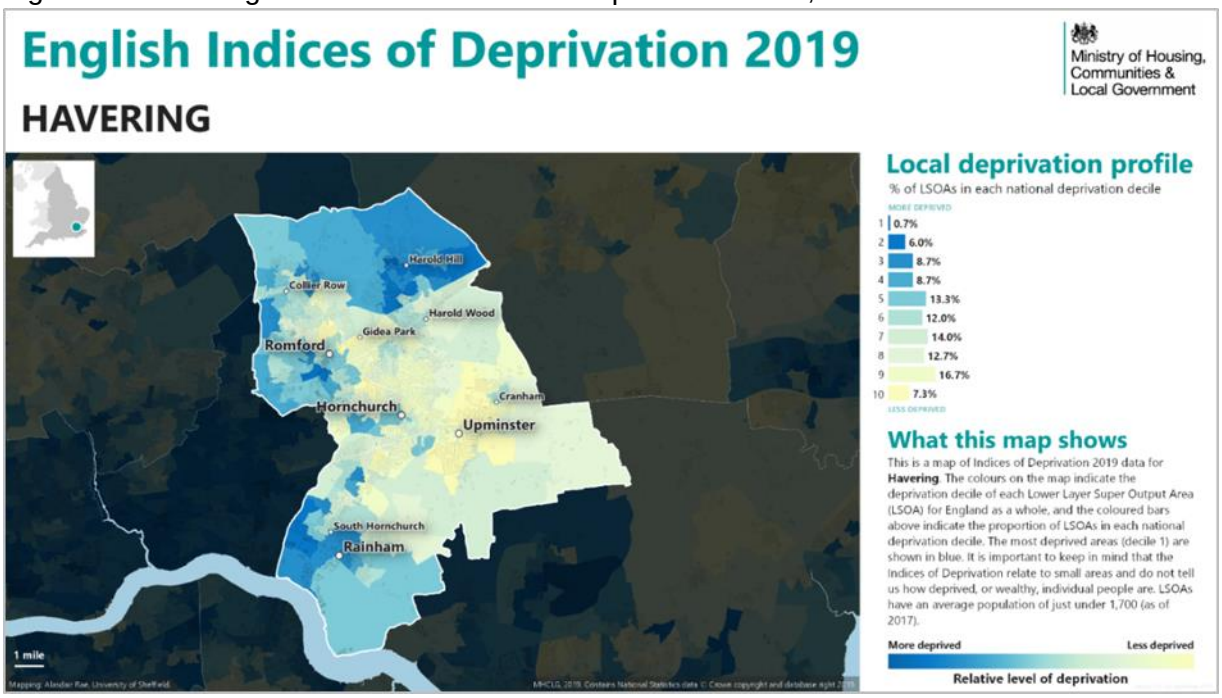
Source: Public Health England Health & Work Infographics

Recommendation 4: *Ensure Councils / NHS providers work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure employment.*

4.4 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.

Figure 12: Havering % of LSOAs in national deprivation decile, 2019.



Source: Ministry of Housing Communities & Local Government

The strong association between levels of disadvantage and life expectancy (see Figures 7 & 8) 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 5: *Encourage health and social care professionals and patients / residents to consider the extent to which problems with employment, poverty, housing etc. are the underlying cause and / or exacerbate a presenting health issue and therefore might benefit from social prescribing[11] in addition to or instead of the tradition medical response.*

Recommendation 6: *Develop social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options, as well as an effective signposting function and bring together NHS, council and CVS stakeholders.*

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[12]' 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 strengthen 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.

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

- Provide an exemplary work place health scheme to employees and help local SMEs to improve the offer to their workforce.
- Routinely consider the potential for additional 'social value' when procuring goods and services; and how bids from local businesses can be facilitated

Recommendation 7: *Encourage councils, NHS providers, colleges etc. to become 'anchor institutions' within the BHR patch maximising the contribution they make to the local community over and above the direct provision of services.*

5. Our Health Behaviours and Lifestyles

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

Our health 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 risks of associated with poor diet, physical inactivity and obesity; and the use of a drugs and alcohol.

Figure 13: Risk Factors and Percentage Contribution to DALYs as Measured by Population Attributable Fraction (PAF), BHR, 2017. [13]

Risk Factor	Barking & Dagenham (PAF%)	Havering (PAF%)	Redbridge (PAF%)
Tobacco	10.57	11.79	9.18
Dietary risks	7.37	8.56	7.52
Alcohol use	3.82	3.59	3.82
Child and maternal malnutrition	3.09	1.51	2.23
Drug use	2.51	1.76	2.26
Low physical activity	0.95	1.20	1.01
Unsafe sex	0.46	0.32	0.40
Childhood maltreatment	0.34	0.25	0.35
Intimate partner violence	0.20	0.15	0.21
Unsafe water, sanitation, and handwashing	0.04	0.03	0.03
High body-mass index	6.24	7.48	6.87
High fasting plasma glucose	5.82	7.05	6.29
High systolic blood pressure	5.74	6.90	6.04
High LDL cholesterol	3.24	3.79	3.30
Impaired kidney function	1.20	1.47	1.36
Low bone mineral density	0.51	0.70	0.60
Occupational risks	3.94	3.90	3.19
Air pollution	2.84	3.11	2.61
Other environmental risks	0.47	0.45	0.36

	Behavioural
	Environmental/Occupational
	Metabolic

Data Source: Global Burden of Disease, 2017

Smoking remains a massive cause of premature mortality and ill health (Figure 13). Although smoking has been in decline since the 1950s, 30K (15%) adults in Havering continue to smoke.

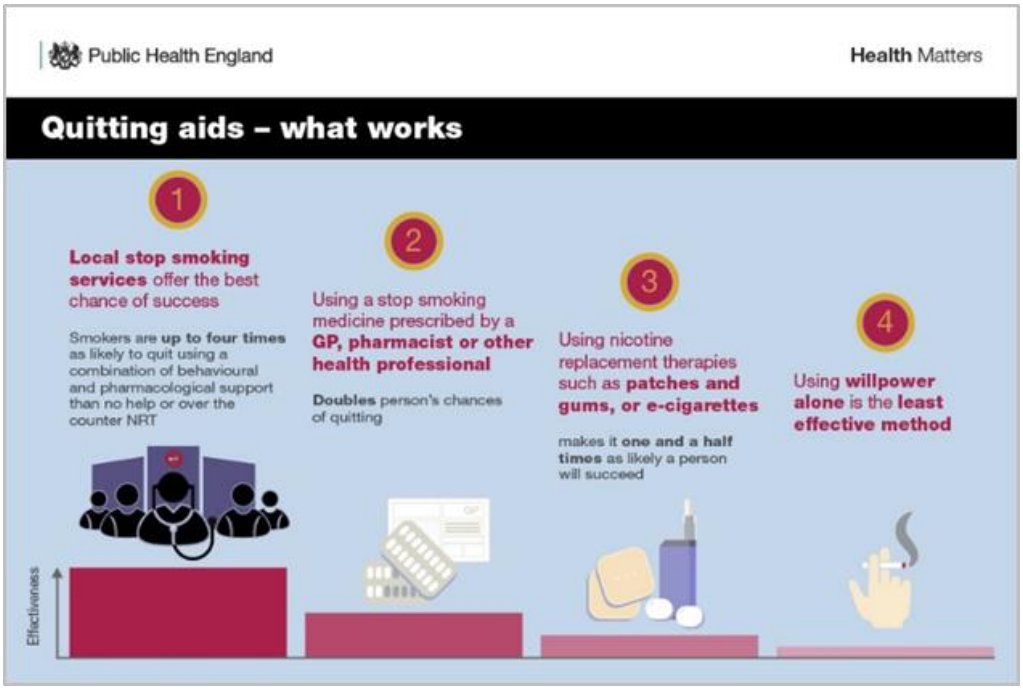
The prevalence of smoking and hence the harm caused displays a marked social gradient with much higher rates in communities and population groups living in disadvantage e.g. Havering residents in the routine and manual occupations group are 3 x more likely to be smokers as compared to all other groups. Smoking is also

[13] 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. World Health Organisation

particularly high amongst people with serious mental illness. Differences in smoking prevalence are the immediate cause of a significant proportion of health inequalities.

Recommendation 8: *Focus additional efforts in disadvantaged communities and / or cohorts known to have high prevalence of smoking e.g. people with mental health problems*.

The majority of smokers want to quit and significant numbers try to quit each year. The chances of success are increased if the individual makes use of counselling support **and** pharmaceutical aids.



Recommendation 9*: Ensure that smokers who wish to quit can continue to access counselling support and pharmaceutical aids, including prescription only medication where clinically indicated.*

Smoking prevalence has reduced noticeably in recent years as significant numbers switch to vaping. PHE estimate that vaping is 95% less harmful than continuing to smoke.

Recommendation 10*: Actively promote vaping as a safer alternative to continuing to smoke.*

Smoking prevalence is much lower amongst young people than adults suggesting that the Government's aspiration for a smoke free society by 2030 is achievable given the active support of all.

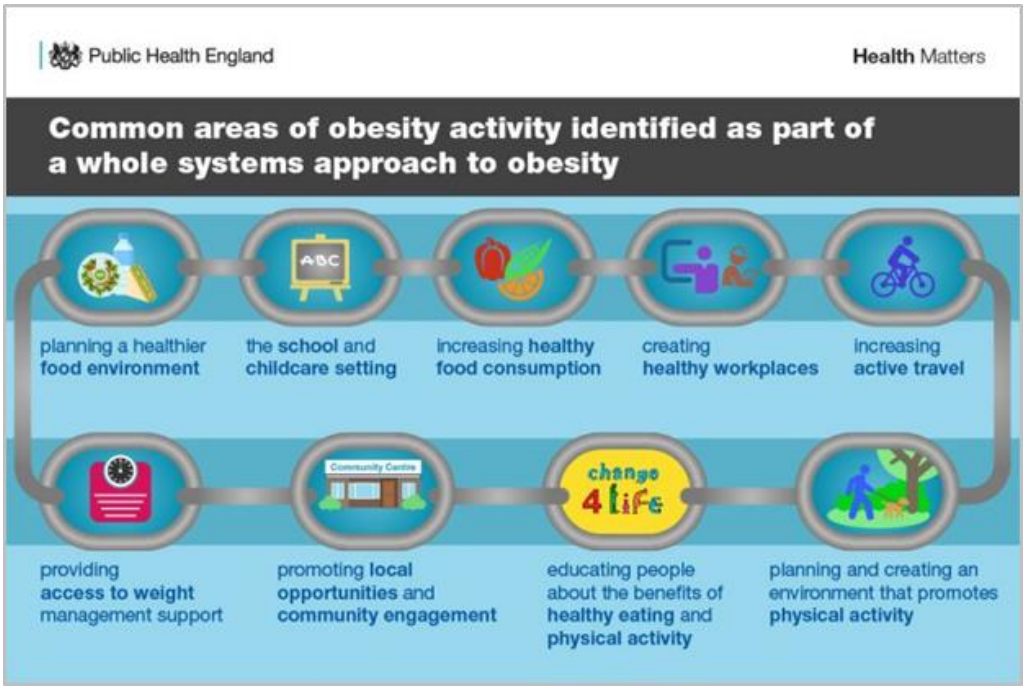
Recommendation 11: *Contribute towards the aspiration of a smoke free society by 2030 e.g. by continuing the de-normalisation of smoking in public spaces and homes; minimising the recruitment of new smokers through work with schools, rigorous enforcement of age related sales regulations and minimising access to cheap smuggled or counterfeit tobacco.*

The total harm associated with an **unhealthy diet** (e.g. low intake of whole grains, fruits, nuts and vegetables and high intake of processed meats) is similar in scale to the harm caused by smoking, in part because so many people eat unhealthily in one way or another e.g. less than half of adults in Havering consume the recommended 5 portions of fruit and veg on a usual day.

A **sedentary lifestyle** results in a lesser but nonetheless very significant burden of ill health. More than one in five adults resident in Havering are physically inactive.

The changing balance between diet, in terms of energy consumed, and physical activity (energy expended) underpins the steady growth in levels of **obesity**. In line with national average, seven out of ten adults in Havering are obese or overweight. Obesity results in a separate and rapidly growing burden of disease.

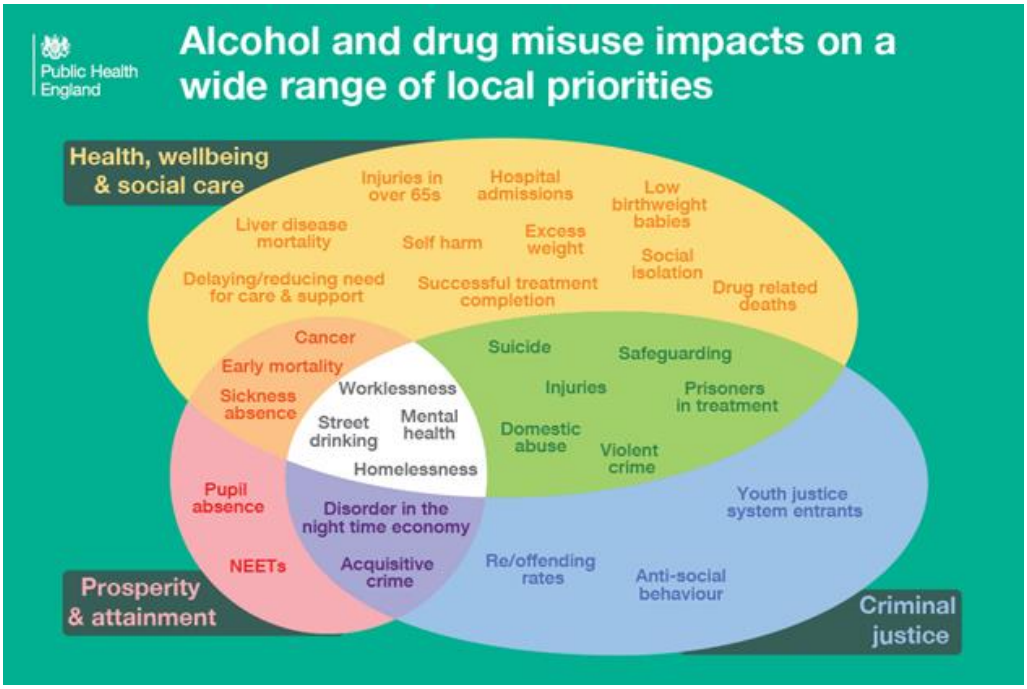
The increase in the prevalence of obesity is the product of many interlinked factors. As a result, there is no single silver bullet; rather partners must commit to maintaining a 'whole system approach' over the long term[14].



Recommendation 12*: Ensure that there is a comprehensive whole system approach to tackling obesity across BHR as a whole.*

[14] https://publichealthmatters.blog.gov.uk/2019/07/25/health-matters-whole-systems-approach-to-obesity/

The use of **alcohol and drugs** also results in significant harm.



A relatively small proportion of residents (circa 1% of adults or 2.2.K) are dependent on alcohol

A smaller number (circa 0.5% or 0.9K) use opiates and / or crack cocaine.

Both groups are at very significant risk of harm as individuals. Their problems 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.

A much larger group run a more modest but nonetheless significant risk of harm as a result of drinking more than recommended – 14% (28K) of adults in Havering binge drink and 21% (42K) drink more than 14 units over the course of a week[15].

Recommendation 13: *Partners should work to:*

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

[15] https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938133118/pat/6/par/E12000007/ati/102/are/E09000016

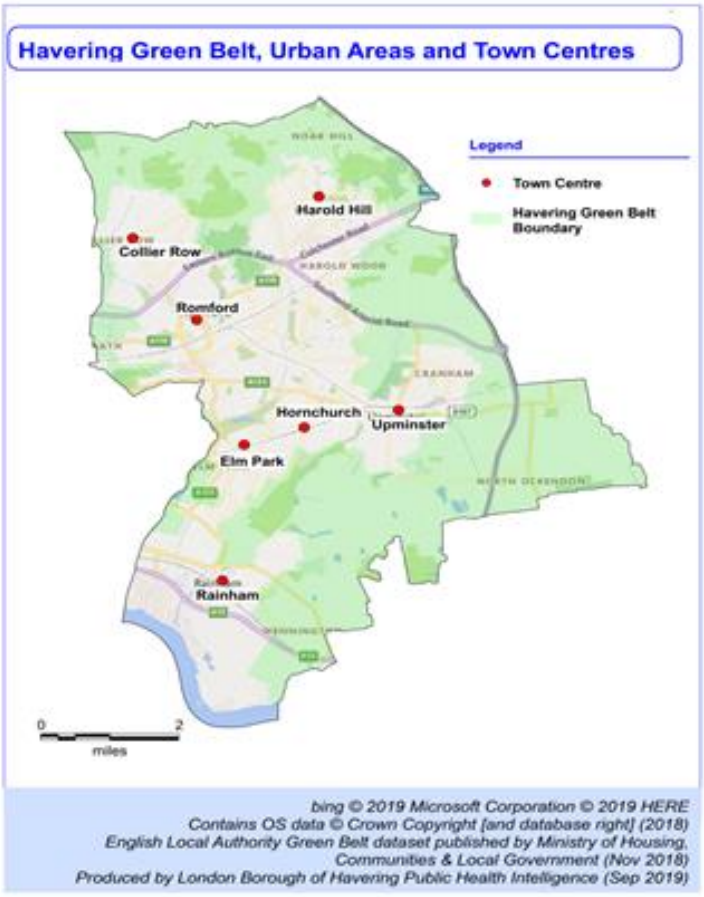
6. The Places and Communities in Which We Live.

There is now increasing recognition of the key role that **places and communities** play in our health. Our local environment is an important influence on our health behaviours, while there is strong evidence of the impact of social relationships and community networks, particularly on mental health.

LB 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, which together with Havering are served by the BHR Integrated Care System.

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. The district level centres are highly variable – and include examples of both healthy and unhealthy high streets[16].

Figure 14. Havering Green Belt and Urban Areas



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.

Air quality in Havering is better than the London average but worse than England. It is estimated that 6.1% of deaths are attributable to particulate air pollution[17].

[16] https://www.rsph.org.uk/our-work/campaigns/health-on-the-high-street.html
[17] Source: https://fingertips.phe.org.uk/

***Recommendation 14**: Work together to minimise the direct contribution of health and social are services to air pollution; put in place the infrastructure / encourage residents to switch to electric vehicles and public transport, or better still, walk and cycle, choosing routes that minimise their exposure to pollutants.*

Health care facilities, community centres, libraries, children's centres etc. are important community assets. Such services also increase footfall and hence contribute to the viability of adjacent commercial premises. Prolonged austerity has made it increasingly difficult to maintain community infrastructure.

***Recommendation 15**: Assess the strengths and weaknesses of the overall public estate at locality level and consider the development of shared community hubs providing a range of statutory services, including health and social care, where this allows the maintenance / improvement of services.*

Havering has changed relatively slowly over the last several decades but the London Plan requires significant house building in all boroughs – the new housing target for Havering is 18750 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 large developments.

Rainham, together with Barking Riverside (LBBD), is part of the London Riverside opportunity area with a collective housing target of 26,500 new homes and 16000 new jobs[18]. Barking Riverside is a Healthy New Town demonstrator site embedding design

[18] https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas/london-riverside

principles unpinning the promotion of health and wellbeing and securing high quality health and care services[19].

Recommendation 16: *Ensure plans and policies shaping regeneration and housing growth e.g. borough level Local Plans serve to build healthier communities not simply additional housing. A formal health impact assessment of the Local Plan may help in this regard.*

Recommendation 17*: Put in place processes to share learning from the healthy new town project at Barking Riverside*.

Recommendation 18*: Ensure that the housing needs of residents with specific needs e.g. relating to frailty, mental illness, physical and learning disabilities etc. are an integral part of plans for housing growth and regeneration.*

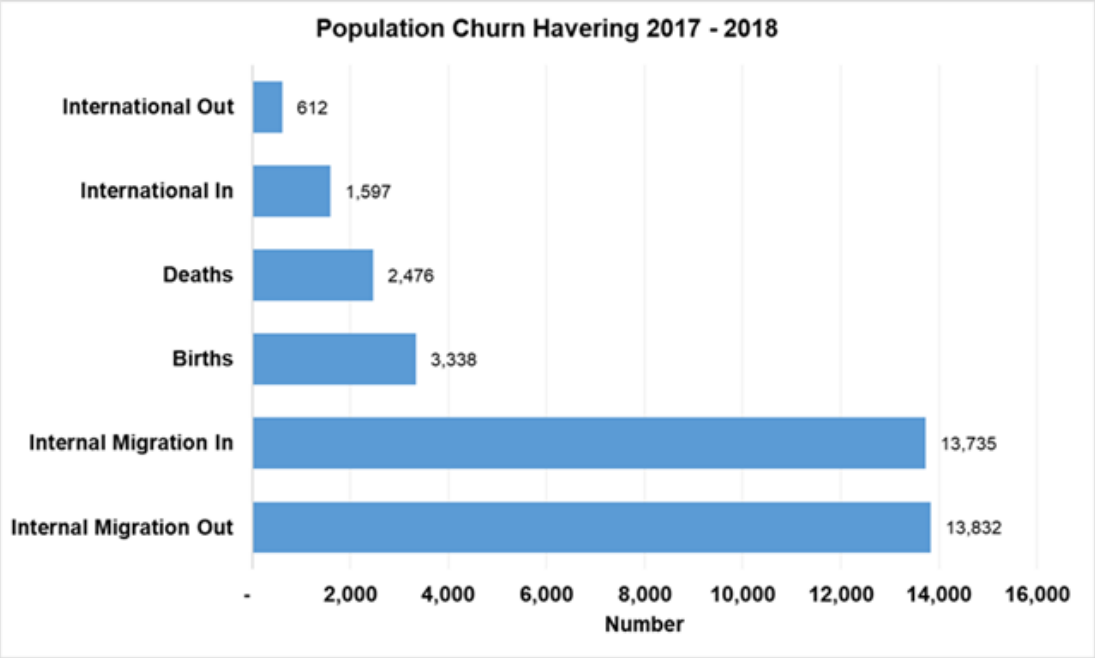
Recommendation 19: *Consider if / how key worker housing might be made available to attract hard to recruit health and social care professionals into the BHR patch.*

Recommendation 20*: Building on regeneration plans in the three boroughs; develop an effective approach to promote the benefits of living in Barking, Havering and Redbridge as part of collective effort to fill hard to recruit health and social care vacancies.*

House building is one of the factors driving population growth described in section 2. The population growth figure is the net result of internal factors (the balance between births and deaths) and the flow of residents into and out of the borough. As such simple measures of population growth fail to capture the scale of population churn. High rates of population churn may weaken social networks making individuals and families less resilient to life's inevitable setbacks including ill-health.

[19] https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/

Figure 15. Havering Population Churn, 2017-2018



Data Source: ONS Mid-Year Population Estimates

***Recommendation 21**: Consider the need for / design of additional support to build social networks and community capacity particularly in areas identified for very large housing development and / or population churn.*

A significant and increasing proportion of residents live in single person households. This has implications for the number and type of housing required. It may also be a marker of social isolation bearing in mind the profiles of people ONS identify as being at particular risk from loneliness:[20]

- 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.

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

See Recommendation 6: re. Social prescribing

Crime and fear of crime, particularly violent crime, impacts negatively on the health of victims and the wider community. A significant proportion of violent crime is within the home, but knife crime, by or against vulnerable adolescents is a cause of massive public concern. Some serious violence is gang related; and 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

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

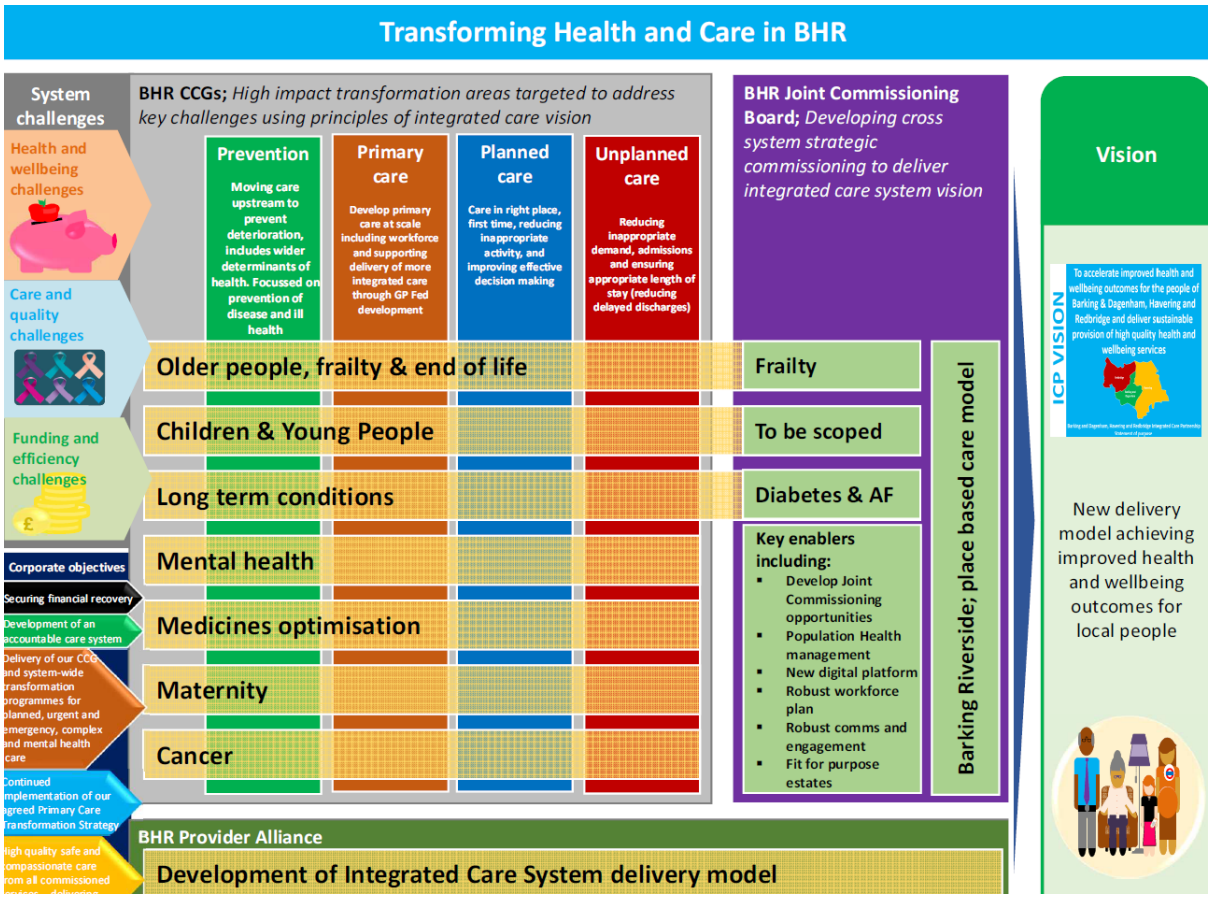
people in from adjacent boroughs. Health and social care services have a significant contribution to make, as part of a comprehensive multi-agency response to identify and protect the vulnerable from violence in all forms.

***Recommendation 22**: Ensure that the health and social care system contributes fully to efforts to tackle violence in all its forms but particularly with regard to domestic violence and the protection of vulnerable adolescents.*

NB. Local action to reduce crime and the harm caused is coordinated by the Havering Community Safety Partnership. CSPs have a statutory requirement to conduct a strategic assessment of crime, disorder, and substance misuse and community safety issues (see here). It is also the key background document used in the development of the Havering CSP Partnership Plan (see here).

7. Integrated Health & Social Care

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



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

7.1 Maternity

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

There were about 11,600 live births to women resident in the three BHR boroughs in 2018. The fertility rate in LBBD (82.6/1000 women aged 15-44), LBR (73.4) and LBH (68.0) is significantly higher than the London (62.9) and national average (64.2). Fertility rates in LBBD and LBR have been at similarly high levels for the last decade. Rates in LBH also 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 LBR and LBBD have their babies in maternity units elsewhere in inner northeast London.

Given such 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)[21], a collaboration of maternity service providers and stakeholders, commissioners, voluntary organisations and service users fulfils this function ensuring there is adequate capacity across the whole of the NEL STP area and all providers deliver similarly high quality 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. LBBD) 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.

The great majority of pregnancies result in the live birth of a healthy baby. However, a small number end in stillbirth or neonatal death. Barking and Dagenham and Havering have a higher rate of stillbirths, but have a lower rate of neonatal deaths. Redbridge conversely has a lower rate of stillbirths and a higher rate of neonatal deaths. Overall, BHR CCGs are on the agreed trajectory for a 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025.

[21] http://www.myhealth.london.nhs.uk/maternity/east-london/

Table 1. Number and rate of stillbirths and neonatal deaths in BHR in 2017

Borough	Total births	Stillbirths*	Neonatal deaths**	Rate*** of stillbirth and neonatal deaths
LBBD	3894	24	7	8
LBH	3416	21	3	7
LBR	4719	12	16	5.9

Source: BHR CCG

*Stillbirth is a baby born after 24 weeks completed gestation and which did not at, any time, breathe or show signs of life
**Neonatal death is defined as deaths at under 28 days
***/ 1000 total live and stillbirths

Smoking is a risk factor for stillbirth and neonatal death. The proportion of women smoking at time of delivery (SATOD) in LBBD (7.8%), LBH (7.2%) and LBR (3.5%) is significantly lower than the national average (10.8%). Rates in LBBD and LBH having improved significantly in recent years.

The experience of childbirth is a uniquely personal event with potentially long-term impacts on mother and baby and their developing relationship. 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 in February 2018 was broadly similar to the national average.

Table 2: The experience people receive care and treatment at BHRUHT Maternity services in 2018.

Aspect of care	Patient response	Compared with other trusts
Labour and birth	8.9/10	About the same
Staff	8.7/10	About the same
Care in hospital after the birth	8.0/10	About the same

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

The benefits of breastfeeding are clear[22] and yet rates of breastfeeding across BHR are variable; LBR mothers (81%) are more likely to initiate breastfeeding than the England average (74.5%); rates in LBBD (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.

The vision for maternity services nationally is set out in the Better Births report[23]. 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 23: *Enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led continuity of carer initially prioritising those identified as most vulnerable and high risk.*

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

Recommendation 24: *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 25: *Continuously improve maternal safety including by full implementation of the second version of the Saving Babies' Lives Care Bundle and work with Public Health to help expectant mothers to stop smoking to meet the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths and intrapartum brain injury by 2025.*

Recommendation 26*: 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.*

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.

7.2 Children & Young People

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

7.2.1 Population

The number of children and young people in the three BHR boroughs has increased significantly in recent years (see Appendix 2). LBBD and LBR are very young boroughs – with a very high proportion of children and young people. LBH has a smaller proportion of CYP but has experienced the greatest relative change in recent years.

The proportion of BAME CYP in LBH has increased in recent years and will continue to do so but LBBD and LBR are much more diverse and representative of London as a whole in this regard (see Appendix 2).

The growth in child numbers has been driven by the relatively high fertility rate in all three boroughs and by children moving into the patch from elsewhere (see data links below). Changes in housing benefit and the relative affordability of housing in the three boroughs relative to elsewhere in London may be responsible. Irrespective of the cause, 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.[24]

Recommendation 27: *The Transformation Board should consider a rolling programme of reviews to ensure that the overall capacity of universal services e.g. health visiting, community paediatrics, therapies, Speech and Language etc. within BHR is adequate given the pace and scale of change in the CYP population in recent years.*

7.2.2 Health and Wellbeing Outcomes

There are relatively few population-level health outcome measures for CYP available at local authority level other than mortality rates.

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 in LBBD are similar to the national average; rates in LBH and LBR are significantly better than the England average. A total of 101 infant deaths were recorded across the 3 boroughs in the 3 years 2015-2017. Child mortality rates (from age 1 – 17 years) are similar to the national average in LBBD and LBH but higher than the England average in Redbridge. A total of 74 deaths were recorded in the period 2015-2017. The small number of deaths at borough level each year precludes further statistical analysis to identify potential issues of concern. However, a three borough Child Death Review process has been implemented from 1st October 2019 providing the means of systematically identifying opportunities to prevent future deaths e.g. by improvements in health care services or public health action.

[24] Havering data source: https://www.haveringdata.net/wp-content/uploads/jsna/this_is_havering/201819_Havering-Demographic-Profile-v4_2.pdf

Recommendation 28: *The Maternity and CYP Transformation boards should receive and formally respond to the BHR CDR annual report each year.*

7.2.3 Wider determinants of health

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. LBBD is the most disadvantaged London borough. LBH and LBR have lower levels of disadvantage overall, focused in smaller areas. The proportion of children in low income families varies in a similar fashion from 22.5% in LBBD (13K children) to 16.5% in LBH (8K) and 14.7% in LBR (9K).

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. Hence the scheme is designed to provide additional support to those most in need but take up is incomplete and many children do not benefit as a result. The take-up of funded early education places by eligible 2 year-old children in 2018 was higher in LBBD (78%) than LBR (57%) or LBH (56%). The take-up of 3-4 year old places across the three boroughs is more evenly spread at 86% in LBBD, 95% in LBR and 93% in LBH."

Recommendation 29: *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.*

Separate **assessments** are undertaken in early years settings and by health visitors (ASQ3) at age 2 – 2 ½ years providing an opportunity to identify individual children needing additional support to maximise the likelihood they will subsequently enter school ready to learn. 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. Data regarding the proportion of children receiving an ASQ3 review is shown below in the section regarding health visiting services (Table 3). Currently NELFT is unable to share the data collected in an anonymised, aggregate form. Sharing this information would assist with the design of interventions to enable universal services to better support the needs of children and improve our understanding of the need for specialist services e.g. Speech and Language Therapy.

***Recommendation 30**: Increase joint assessments by early years settings and health visitors; ensure that anonymised aggregate data from 2 – 2 ½ year checks undertaken using the ASQ3 are available to inform health service planning and interventions to improve school readiness. HV to implement a failsafe follow up procedure to capture all children eligible for the 2 year offer*

At the end of reception year, the majority of children are assessed as having **a good level of development**. The proportion in LBBD (71.3%) and LBH (71.5) is similar to the England average (71.5%). The proportion in LBR (75%) is significantly better. Nonetheless, somewhere around 1000 children in each borough are already lagging behind their peers by this time. Children in receipt of free school meals are more likely to not achieve a good level of development particularly in LBH.

***Recommendation 31:** Use data from 2-2 ½ year checks to identify population groups and or communities at greater risk of being non-school ready and the reasons why; to inform the development and targeting of evidence based interventions to enable parents and child care staff to support children back on to a trajectory towards school readiness. Use the same data set to ensure that there is adequate provision for children with more significant problems requiring timely assessment and care from relevant specialist health care services.*

GCSE Attainment – as measured in terms of average attainment 8 score is similar to the national average (46.7) in LBBD (46.8) and LBH (47.0) and significantly better in LBR (53.4). Equivalent scores for children in receipt of free school meals are lower, particularly in LBH (34%).

***Recommendation 32**: As part of a comprehensive approach to building greater aspiration and education achievement particularly in disadvantaged and / or otherwise vulnerable groups - consider the potential contribution of health and social care providers e.g. outreach to schools and career fairs; workplace experience; apprenticeships; career paths from less skilled lower paid roles into better paid, professional health and social care roles etc.*

Employment – As discussed in section 5, employment is fundamentally good for health. Rates of youth unemployment across BHR are relatively low with 4.2% of 16-17 years olds in LBBD Not in Education, Employment or Training (n = 240); 3.5% in LBH (n= 200) and 3.7% in LBR (n=280).

For Recommendation see 32 above

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 (LBBD, 5.4/1000 households, n=426; LBH

2.5/1000, n= 256; LBR 3.4 /1000, n=381) are higher than the national average (1.7/1000).

7.2.4 Behaviour and Lifestyle

In some respects, the current generation of children and young people are living more healthily than preceding ones. Most notably, the prevalence of **smoking** among young people, when the great majority of adults start smoking, has fallen faster and further than for adults. Rates of smoking amongst 15 year olds in all 3 BHR boroughs (LBBD 5.6%, LBH 5.8%, LBR 3.4%) are lower than the national average (8.2%).[25]

The same survey found that less than 5% of under 15 year olds had used cannabis in the previous month – similar (LBH) or better (LBBD and LBR) than the national average and about 1% of 15 year olds in BHR reported using drugs other than cannabis, similar to the national average.

Concerns have been raised about the impact of screen and social media use on the health and wellbeing e.g. cyberbullying and lack of sleep impacting on mental health. The 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[26].

The one lifestyle related risk factor that is unequivocally going in the wrong direction and as such represents a significant threat to the health of the population is **childhood obesity**. Previously obesity was associated with middle age. Now 1 in 10 children are obese by the age 5, rising to 1 in 5 by age 11. Type 2 diabetes is now a disease of childhood and very large numbers of residents will run the increased risk cancers, CVD, MSK etc. associated with excess weight for many more years of life. There is no single silver bullet. As stated in Section 5, careful and rigorous implementation of a 'whole system' approach, coupled with advocacy for further action by central Government offers a potential solution in the long term.

For Recommendation see 32 above

7.2.5 Community and place

NB. See wider issues considered in Section 7.

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.

The Mayor of London offers award schemes to encourage early years settings (Health Early Years London) and schools (Healthy Schools London) to review and improve the extent to which their culture and environment support health. Settings in all 3 boroughs currently participate.

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

[26] United Kingdom Chief Medical Officers' commentary on 'Screen-based activities and children and young people's mental health and psychosocial wellbeing: a systematic map of reviews'

Recommendation 33: *Encourage early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the relevant Mayor for London scheme or similar.*

More fundamentally, schools can 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 and an increased risk of involvement in serious youth violence – as victim or perpetrator has been suggested if not universally accepted[27].

Recommendation 34: *Work with schools to provide better support to pupils at risk of exclusion.*

The family home is by far the most important community for any child. A secure and loving family is the single best predictor of subsequent life chances and one that other agencies struggle to replicate. Nonetheless there is extensive evidence regarding the impact of negative factors experienced within the family home during childhood on later life. **'Adverse childhood experiences'** is one way of describing these negative factors.

UK studies[28] have suggested a simple dose/ response relationship between the number of ACEs experienced and:

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

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

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

- **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

LBBD is currently working with the Early Intervention Foundation to better protect children from harm.

Recommendation 35: *Put in place mechanisms to share learning from joint working between EIF and LBBD. Ensure that the outcomes from the multi-agency working around Emotional Wellbeing and Mental Health (including family interventions and targeted support for vulnerable cohorts) are taken forward.*

Safeguarding vulnerable adolescents from harm must be a priority for all partners. The threat may come in many forms. Serious youth violence is a major concern resulting 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.[29]

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 36: *Adopt a public health approach to tackling serious youth violence.*

Youth offending – young people in contact with the criminal justice system are small in number but are at very high risk of poor outcomes in later life. The rates of first time entrants to the youth justice system vary across the BHR patch. They are highest in

[29] https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence

LBBD (528/100,000, n=119); significantly higher than the national average (292/100,000). Whereas rates in LBH (260/100,000, n = 60) and LBR (228/100,000, n=71) are significantly lower than the England average. A significant proportion have significant mental health problems that maybe unrecognised and / or inadequately managed.

Teenage parents have poorer **o**utcomes 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. Teen parents and their children benefit from support to develop parenting skills and maximise educational attainment, employability and earning potential.

7.2.6 Integrated health and social care system for CYP

Immunisation - Vaccines are often cited as the most cost-effective health intervention[30] and yet uptake is falling and cases of vaccine preventable disease notably measles are on the increase. Anti-vaccination messages are certainly unhelpful but the National Audit Office suggest that more prosaic problems such as the way healthcare professionals remind parents to vaccinate their children and difficulty access vaccination services at a convenient time and location may be to blame[31].

Recommendation 37: *Review the delivery of childhood immunisation in BHR with the aim of increasing uptake to levels necessary to achieve herd immunity.*

Health visitors have a unique opportunity to engage with all children and their families in the family home. The current 4,5,6, model of service delivery strikes a balance between universal health checks for all and targeted support to more vulnerable families; with a particular focus on 6 high impact areas.

Delivery of the 5 mandated checks across BHR is variable, As a result opportunities to offer advice about issues of concern and identify families needing additional support are missed.

Table 3. Delivery of 5 mandated checks Q4 2018/19

Area	Antenatal	New birth	6-8 weeks	1yr (by 15mths)	2 – 2 ½ yrs ASQ
LBBD	353	N/A	80.3%	70.6%	N/A
LBH	94	98%	14.4%	88.3%	83.6%
LBR	99	85.9%	68.4%	50.4%	41.8%
England	N/A	87.5%	85.9%	84.4%	92.5%

Recommendation 38: Work to improve delivery of mandated checks.

[30] https://www.parliament.uk/documents/post/postpn314.pdf
[31] https://www.nao.org.uk/wp-content/uploads/2019/08/Investigation-into-pre-school-vaccinations-Summary.pdf

Also see recommendations 30 & 31

7.2.7 Safeguarding vulnerable CYP

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 recently been augmented by the addition of BHR wide collaboration developed and agreed by the DCS for each borough, the Nursing Director for BHR CCGs and the lead for the MPS.

Recommendation 39: *The CYP Transformation Board should support the development of joint working in support of better safeguarding as requested.*

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 LBH and LBR but higher in LBBD 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, but given their experiences this isn't unexpected[32].

Subsequent life chances are also poorer and the wider health and social care system should consider how they can assist LAC beyond their statutory duties e.g. by offering a variety of job opportunities giving LAC the opportunity to find 'good' employment.

See recommendations 30, 31, 32, 36 and 39

7.2.8 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.

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

About 1 in 10 children and young people have SEND; reported rates in LBBD (14.1%) LBH (9.9%) and LBR (11.6%) are lower than the England average (14.9%).[33]

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 proportion of CYP with an EHCP or statement locally is lower than (LBBD 2.7%, LBH 2.7%, LBR 2.6%) than the national average (3.1%). In total, just under 4000 children and young people in BHR have an EHCP or statement.

The needs of small numbers of CYP cannot be met locally necessitating 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.

Recommendation 40: *CYP transformation board to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews to better direct resources and options on Pan BHR commissioning to facilitate best use of scarce clinical resources.*

7.2.9 Mental health problems in CYP

About 1 in 10 CYP have a common mental health disorder. Estimated rates in LBBD (10.3%) are higher than the national average (9.2%) whereas rates in LBH (9%) and LBR (9%) are similar to the England average. In total circa 11K children 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[34].

Actual data (as opposed to estimated) on mental health needs is only known for children with an EHCP. Children with social, emotional and mental health needs identified as a primary need on their EHCP, as a percentage of all school-age children, is higher in LBBD (2.7%) than the national average (2.4%); rates in LBH (1.2%) and LBR (1.9%) are significantly lower.

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

[33] 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

[34] Green et al 2005

including schools and parents to support CYP with mental health problems and build greater resilience amongst CYP themselves.

Recommendation 41: *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*

Self-harm is a particular indicator of emotional distress and is associated with a higher risk of suicide[35]. Rates of hospital admission for self-harm in all 3 BHR boroughs are less than half the national average. 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.

See Recommendation 45 & 46

7.2.10 Physical health of CYP

All children will at some point experience ill health. In most cases, it is relatively mild and self-limiting. However, about 42000 children aged 0-4 and living in BHR attended A&E in 2017/18. The rate of A&E attendance for young children was significantly higher than the national average in all 3 BHR boroughs. Improving the management of minor illness and injuries is a high impact area for health visiting services.

Recommendation 42: *Consider how health visiting, children centres and other early years providers can work together to strengthen the ability of parents to manage minor childhood illness and injury (and their confidence to do so).*

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 impacts school attendance and participation in physical activity. Rates of hospital admission for asthma vary significantly between the 3 BHR boroughs from higher than the national average (186/100,000) in LBR (226/100,000), similar in LBBD (215/100,000) to significantly lower in LBH (91/100,000). However, young people have died from asthma in all three boroughs in recent years and the system has developed

[35] 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.

a detailed improvement plan in response to a Regulation 28 Letter from the local coroner following the inquest into one of these deaths.

Recommendation 43: *Implement the existing plans developed to improve asthma care in BHR.*

7.3 Adult Mental Health

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

7.3.1 Prevalence and risk factors

The great majority of people will experience problems with their mental wellbeing at some point; a 2018 survey of stress levels in the UK found that 74% of respondents reported in the past year feeling 'so stressed that they had been overwhelmed or unable to cope'[36]. A smaller but very significant proportion of people will have a diagnosable mental health problem.

Mental health is important at every stage of life; specific concerns about other life stages are considered in the relevant chapters about maternity care, children and young people and older people.

The modelled prevalence of common mental health disorders (any type of depression or anxiety) for adults in LBH and LBR is similar to the national average, but significantly higher in LBBD. Based on these estimates, there are likely to be nearly 108K people with a common mental health problem living in the three BHR boroughs.

The GP recorded prevalence of depression in each of the three boroughs is below the national average, with around 40K people across BHR known to have depression.

A smaller number 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 6500 people have an SMI.

The wider determinants of mental health conditions include: poverty/disadvantage (including factors such as debt, unemployment and housing), level of social support and relationships (including family/childhood, couple relationships and community), and discrimination (based on age, ethnicity and sexual orientation)[37].

People from BAME 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.

People who are lesbian, gay, bisexual and trans (LGBT) have increased levels of common mental health problems.

Studies suggest that the rate of mental health problems in people with a learning disability is double that of the general population[38].

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[39]. Many people who sleep rough have co-occurring mental ill health

[36] mentalhealth.org.uk/statistics/mental-health-statistics-stress
[37] PHE Guidance: Wellbeing and mental health: Applying All Our Health Updated 28 August 2019
[38] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/mental-health
[39] https://publichealthmatters.blog.gov.uk/2019/09/30/health-matters-rough-sleeping/

and substance misuse needs, combined with physical health needs and past experience of significant trauma.

7.3.2 Harm caused by mental illness

Suicide rates in LBBD and LBR are below the national average; rates in LBH are similar. Whilst suicide is a rare event including amongst people with mental illness, nevertheless 130 deaths were reported in BHR in the three-year period 2016-18.

People with severe mental illness die on average 10 - 20 years sooner than the general population[40]. 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 amongst people with mental health problems[41].

Deaths from mental illness capture 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).

7.3.3 Use and outcomes of local mental health services

The rate of referral to IAPT (Talking Therapies) in the three BHR boroughs is only about half the national average. Similarly, the rate of people subsequently entering and completing IAPT treatment is below the national average[42].

The proportion of people in contact with adult mental health services in all 3 BHR boroughs is below the national average – in Q4 2018/19, 10400 patients in BHR were in contact with services.

The rate of mental health admissions to hospital in LBH is lower than the national average; rates in LBBD and LBR are similar. In total, there were 375 mental health hospital admissions in Q4 2018/19.

The rate of people subject to the Mental Health Act in LBH is lower than England; rates in LBR and LBBD are similar.

The Care Programme Approach (CPA[43]) is offered to people with SMI, at risk of suicide, self-neglect, substance misuse, history of violence/self-harm etc. People on CPA have a care coordinator and care plan taking into account a broad range of considerations, including physical health, housing, and employment. The rate of people with a Care Programme Approach (CPA) is similar (LBH and LBR) or higher (LBBD) than the national average in BHR. About 80% of people on CPA in LBH and LBBD are in settled accommodation, falling to 50% in LBR. Fewer than 1 in 10 people on CPA in BHR are in employment[44].

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[40] 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

[41] Kings Fund (2014) *Smoking and severe mental ill health*

[42] https://fingertips.phe.org.uk

[43] Recent guidance has been published that suggest future changes to the CPA approach. Detail awaited.

[44] https://fingertips.phe.org.uk/

The proportion of patients in concurrent contact with mental health services for drug misuse is similar (LBBD) or lower than the national average (LBH and LBR).

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 and PHE under the 'Every Mind Matters' banner, providing useful advice about how to cope with low level mental health issues.

There is some disparity between expected levels of mental health disorders and levels known to health services, particularly in LBBD. 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.

Recommendation 44: *Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.*

Recommendation 45*: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience e.g. by making use of 'Every Mind Matters' resources and self-help aids giving particular consideration to groups who appear less likely to seek help e.g. LGBT and BAME residents.*

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 46*: 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. By 2020, 22% of people with CMH are expected to be accessing Talking Therapies each year. New approaches e.g. online Talking Therapies are being introduced but uptake in BHR is currently far below the national aspiration.

Recommendation 47*: Improve understanding of public perceptions of Talking Therapies and how it be can promoted and delivered to maximise participation and successful completion and thereafter improve the promotion and delivery of Talking Therapies based on this insight.*

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 LGBT people, older people, people with LTCs and people with learning disabilities.

***Recommendation 48**: 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. Social prescribers can assist in this regard.

***Recommendation 49**: 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 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. Locally, the percentage of people receiving treatment for substance misuse and in concurrent contact from mental health services is lower than England as a whole. Services should work together in accordance with NICE guidelines, using CPAs where appropriate to treat this vulnerable group.

***Recommendation 50:** Improve and increase joint working between mental health services and drug and alcohol services, including use of the CPA where appropriate, to improve outcomes for patients with dual diagnosis.*

***Recommendation 51:** - Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.*

***Recommendation 52:** 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

The CQC has highlighted that mental health service patients with a CPA report better outcomes, but also that there are systematic differences between Trusts in how CPA policy is applied. Nationally there has been a declining trend in the percentage of adults with a CPA in mental health services. Locally, a significant proportion of people on CPA are not in settled accommodation and very few are in employment.

***Recommendation 53**: MH services should consider whether more people might benefit from a CPA and where a CPA is in place, work to improve the proportion in settled accommodation and in employment.*

***Recommendation 54:** MH services; social care and housing should consider the scope to further improve the proportion of patients on the CPA in settled accommodation.*

***Recommendation 55:** 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. Over the past year, patients requiring admission have had to be placed out of area although in most recent weeks, these numbers have reduced. 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 56**: 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.

Recommendation 57: *Improve the management of physical health of patients with SMI; ensure all get an annual health check and improve effectiveness of support available to assist with lifestyle change – starting with smoking.*

Whilst rates of suicide across BHR are either similar or 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. The NHS Long Term Plan includes commitments to provide bereavement support to family and friends following bereavement by suicide and the new Thrive London early notification scheme offers a means of identifying the bereaved quickly.

Recommendation 58*: Ensure there are comprehensive plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.*

7.4 Cancer

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

Cancer is the cause of enormous harm to health – accounting for 26 % of all years of life lost across BHR.[45] 1 in 2 people will be diagnosed with cancer in their lifetime. Adjusting for differences in age structure; the incidence of all cancers in LBBD and LBH is similar to the national average; the incidence of cancers in LBR is significantly lower (better) than the national average.

Nonetheless, more than 3,200 people in BHR are diagnosed with cancer each year.

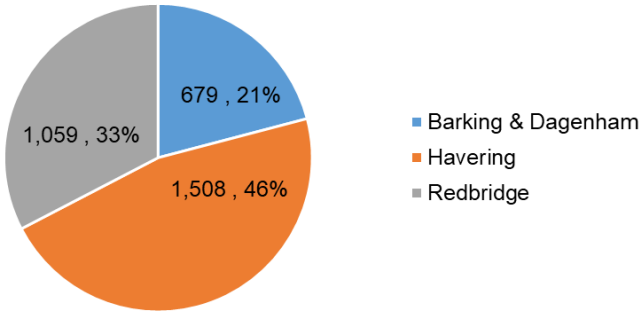
Cancer Lifetime Risk

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. As a result, Havering, with its older population has a higher number of cases than other BHR boroughs.

Number of New Cases of Cancer 2016/17



Source: Public Health England

The number of cancer cases in all three boroughs will increase as the population ages. More than 16,000 people locally are living with and beyond cancer (prevalence), almost half are resident in LBH. The number of people living with cancer will increase in line with increases in incidence and as survival continues to improve[46].

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

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

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

Smoking remains the largest preventable cause responsible for 15% of cases followed by excess weight[47].

Preventable cases

Source: Cancer Research UK

NB. Action to tackle lifestyle related risk factors are discussed in section 6.

Vaccination against the Human Papilloma Virus (HPV) greatly reduces the risk of developing cervical cancer in later life. In 2017/18, coverage in BHR boroughs was comparable to the national average. Nonetheless, more than 600 13-14 year old girls in the three boroughs were not protected. HPV vaccination will be offered to boys as well as girls for the first time this year.

Recommendation 59: *Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.*

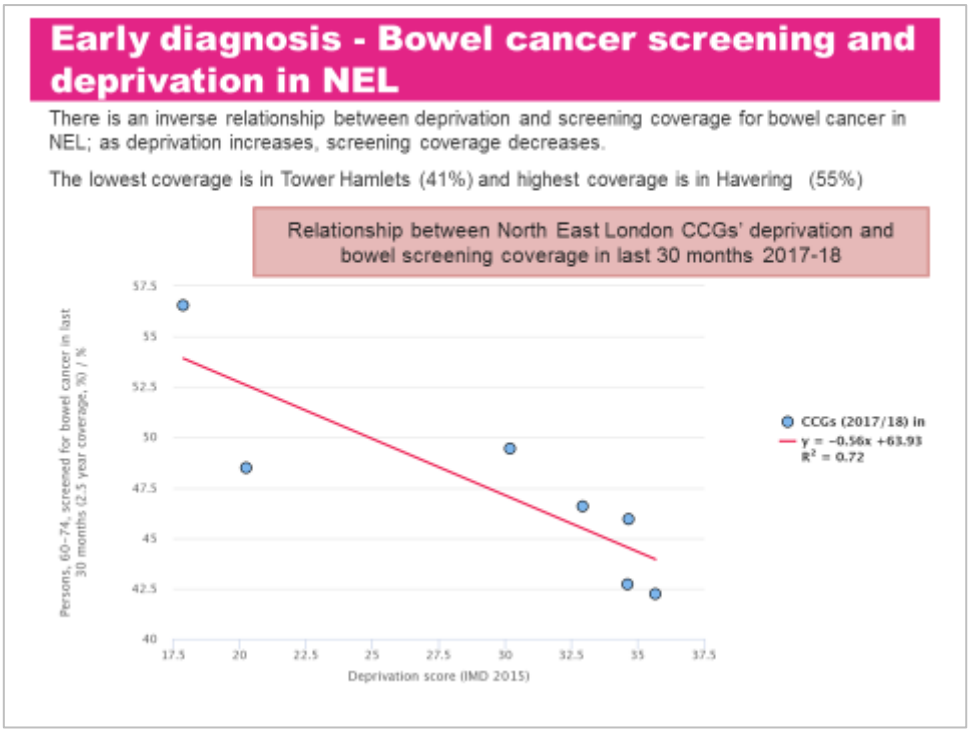
Survival varies significantly depending on site. For example, and with regard to the common cancers, survival varies from more than 95% at 1 year for breast cancer to about 30% for lung cancer[48].

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 LBBD residents from 55% in 2001 to 68% in 2016. However, survival in all BHR boroughs has consistently lagged behind the national average – now 72.8%, particularly in LBBD.

For some cancers, screening affords 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 LBB&D and LBR. Coverage for breast and cervical screening is higher in LBH than the national average but coverage of bowel screening is significantly lower. There is a strong correlation between levels of disadvantage and screening coverage. Hence, coverage in LBH is higher than that achieved in any other borough in NEL for all three screening programmes[49].

[47] 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
[48] https://www.cancerresearchuk.org/health-professional/cancer-statistics/survival
[49] https://www.healthylondon.org/resource/cancer-inequalities-toolkit/north-central-london-snapshot/



Source: Healthy London - Inequalities Toolkit

Irrespective of the precise uptake, many hundreds of eligible BHR residents do not participate in cancer screening programmes each year.

The national cancer screening programmes have recently been the subject of a review[50] by Prof Sir Mike Richards who has recommended fundamental change in terms of accountability for screening programmes – currently split between multiple organisations; 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, 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.

***Recommendation 60**: - Continue to work to increase uptake of cervical screening by offering extended hours in general practice and bowel screening with the roll out of FIT[51] testing for diagnosing colorectal cancer.*

[50] https://www.england.nhs.uk/wp-content/uploads/2019/02/report-of-the-independent-review-of-adult-screening-programme-in-england.pdf
[51] 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.

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.

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.

***Recommendation 61**: 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 62**: Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)[52]*

***Recommendation 63**: Implement the national optimal cancer pathways[53].*

[52] https://www.england.nhs.uk/cancer/early-diagnosis/
[53] http://uklcc.org.uk/wp-content/uploads/2019/10/01-UKLCC-Pathways-Matter-Report-Final.pdf

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 64: *Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways*[54] *for prostrate, breast and bowel cancer patients.*

Recommendation 65: *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.

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

7.5 Long Term Conditions

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

As described in Section 4, most of the additional years of life gained in recent decades as life expectancy has increased are affected by ill-health resulting in poorer wellbeing and some degree of dependency on health and social care services. A significant proportion of this ill-health is the result of long-term conditions.

Long Term Conditions are those that cannot, at present, be cured, but people living with these conditions can be supported to maintain a good quality of life.

Source: NHS England

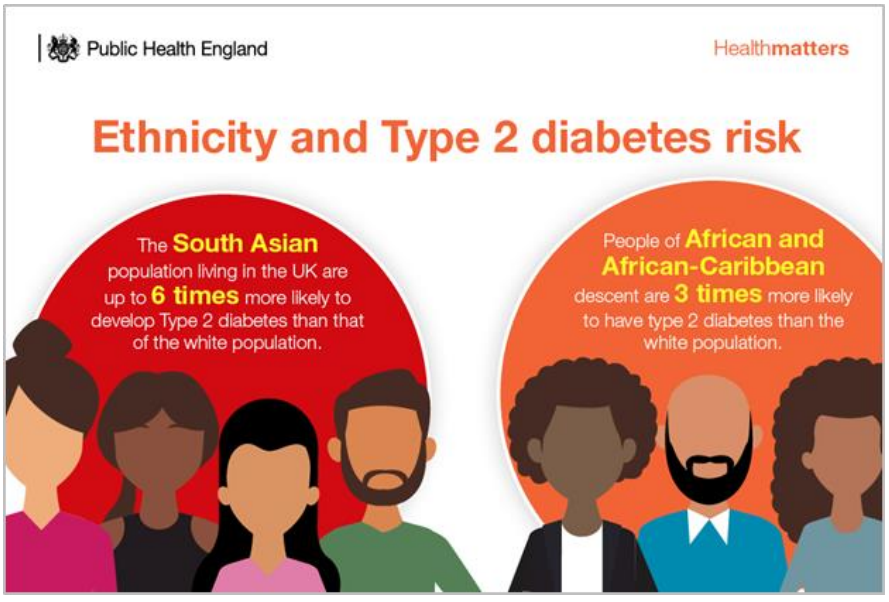
LTCs can affect most if not all of the bodies systems and are often interlinked. The harm caused may be insidious; causing few symptoms whilst paving the way for an acute event such as a heart attack or stroke carrying the risk of sudden death or significant and persistent disability. As a result, people are less likely to seek help and problems may remain undiagnosed and unmanaged.

Common LTCs

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

The risk of developing an LTC increases with age. As a result, LTCs have become more prevalent as the population has aged and further increases are likely in the absence of effective prevention.

The risk of disease may vary with ethnicity e.g. Asian and African persons are at a relatively higher risk of developing diabetes as compared to the white population Diabetes



The risk of developing LTCs is only partly determined by non-modifiable factors like age and ethnicity; a significant proportion is modifiable. An estimated 50% to 80% of CVD cases are caused by modifiable and preventable risk factors[55] including:

- smoking
- obesity
- hypertension
- high cholesterol
- harmful drinking
- poor diet
- physical inactivity

Disadvantaged communities are at higher risk of developed LTCs than more advantaged peers of similar age. For example, Type 2 diabetes is 60% more common among individuals in the most deprived quintile compared with those in the least deprived quintile in England[56] and premature death rates from CVD in the most deprived 10% of the population are almost twice as high as rates in the least deprived 10%. A very large proportion of this difference is due to differences in the prevalence of modifiable risk factors, particularly smoking.

Primary prevention to reduce the prevalence of modifiable risk factors must be a significant component of the overall response to LTCS.

NB. See section 5 about harmful behaviours.

NHS health checks are an opportunity to identify people with or at high risk of CVD and related conditions including diabetes, hypertension and CKD. PHE estimate that for every 6 to 10 NHS Health Checks, one person is identified as being at high risk of CVD.

[55] https://publichealthmatters.blog.gov.uk/2018/01/24/health-matters-nhs-health-check-a-world-leading-cvd-prevention-programme/

[56] https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/health-matters-preventing-type-2-diabetes

The potential benefit of NHS health checks is only partially realised as a proportion of eligible patients are not offered and / or do not attend for a check.

Table 5. Offer and uptake of NHS Health Checks Q1 2015/16 – Q1 2019/20

	LBBD	LBH	LBR	London	England
People invited for an NHS Health	89.1	71.1	86.0	80.7	74.9
People receiving an NHS Health	49.6	30.1	42.2	38.9	35.5

Source: Public Health England

Recommendation 66**:** *Councils to work with PCNs and individual GP practices to increase the offer and uptake of NHS health checks.*

A proportion of patients may not respond to the offer of a health check in general practice e.g. due to other commitments and / or being unappreciative of the potential benefits given they feel fine in themselves.

Recommendation 67: *Consider if / how novel approaches to opportunistic screening in the community might serve to engage an additional cohort of patients who do not take up the offer of a health check.*

Health checks provide an opportunity to encourage people to tackle lifestyle related risk factors and connect them with sources of support that might assist them to achieve change reflecting their needs and preferences.

Recommendation 68: *Increase range of support options available to assist patients found to be at high risk of CVD to achieve behaviour change. Collate all available support in a resource to facilitate planning following delivery of health checks.*

Healthier You: NHS Diabetes Prevention Programme 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 with nondiabetic hyperglycaemia (NDH) and are therefore at high risk for progression to Type 2 diabetes 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 9 months. There are at least 13 sessions, lasting between 1 and 2 hours, and at least 16 hours of contact time. Each session covers topics geared towards the Programme'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[57]. 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.

Recommendation 69: *Maximise participation by eligible patients resident in BHR in the NDPP*

The differences in demography and levels of disadvantage across BHR result in different patterns of LTC in each of the 3 boroughs.

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.

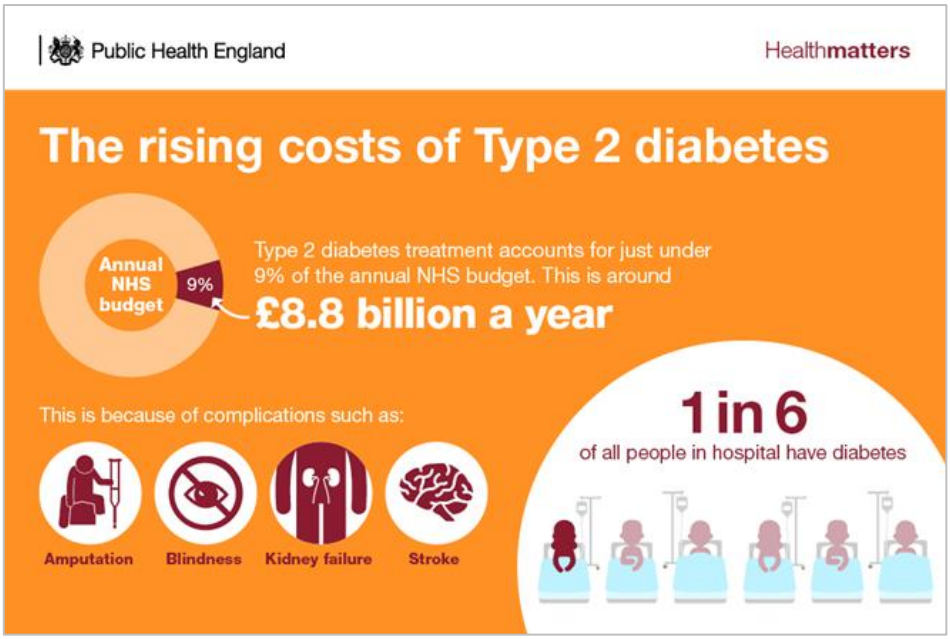
Moreover, of those that do have a diagnosis, many do not receive all the treatments that would benefit them – hence the risk of disease progression is not slowed or prevented as much as possible. As a result a valuable opportunity for **secondary prevention** is missed.

The situation regarding diabetes is typical of many LTCs.

The harm to residents is very great. Locally diabetes is responsible for 1.6% of all YLL, 4.4% of YLD and 3.1% of all DALYs.

Nationally, about 9% of the total NHS budget is spent on the treatment of diabetes and the complications arising.

[57] https://preventing-diabetes.co.uk/london/locations/



About 1 in 6 of the people with diabetes in BHR do not know they have the condition – about 10,000 undiagnosed cases across the three boroughs.

And of the 49,000 people in BHR known to have diabetes, two thirds received all 8 care processes in LBBD and less than a half in LBH and LBR[58].

Diabetes care in LBBD improved significantly following the implementation of targeted quality improvement scheme agreed by B&DCCG and constituent practices.

BHR CCGs are seeking to offer all patients diagnosed with an LTC with a consistence holistic 'First response' that: -

- Understands their health, psycho-social aspects and ability / willingness and to manage their condition (activation)
- Generates a co-designed plan supported by coaching conversation (understanding drivers for change in the person and level of support they require to achieve their own goals)
- Supports people with appropriate information for them to manage their heath / well-being

Recommendation 70: *Improve the diagnosis and management of LTCS; consider the approach employed to improve diabetes care in LBBD. Given the common risk factors for a number of LTCs, patients with an existing condition should be checked regularly for other LTCs*

Diagnosing and caring for people with a single LTC is a significant challenge given the numbers involved. However, an increasing proportion of people have multiple

[58] https://fingertips.phe.org.uk/profile/diabetes-ft/

problems causing significant loss of function and a greatly increased risk of crisis and unplanned hospital admission.

A recent analysis by BHR CCGs identified nearly 24000 patients with 2 LTCs, more than 12000 with 4 LTCs and more than 400 with 6 LTCs.

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

Tertiary prevention to maximise quality of life and independence for patients with complex comorbidities, that result in significant disability is the final challenge requiring the coordinated input from a number of different health and social care professionals to maximise quality of life and minimise the requirement for unplanned hospital admission.

Recommendation 71: *Agree system wide arrangements for the management of complex, unstable multi-morbidity including*

- *An approach to population segmentation to identify the appropriate cohort of patients*
- *Consistent community provision across BHR and common pathways between primary, community and secondary care; social care and the voluntary sector Agreement and clarity of roles, enabling professionals to work at the top of their license*
- *Processes to facilitate multidisciplinary working e.g. opportunity to review complex cases by a MDT*

7.6 Older People & Frailty

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

Older people experience more ill health and have greater need for health and social care than other age groups. It follows that improvements in the care of older people are likely to yield greater benefit, faster to the health and social care system than actions regarding other patient cohorts.

There are large numbers of older people in all three BHR boroughs and every locality. However, the population of LBH is significantly older such that nearly half of the 16000 BHR residents aged 85 and above live in Havering.

Female **life expectancy** at age 65 in LBBD (20.5 yrs) is worse the national average (21.2 yrs) but significantly higher in LBH (21.6) and LBR (21.8). Male life expectancy at age 65 in LBR (19.3) is similar to the national average (19.0) but it is significantly lower in both LBBD (17.4) and LBH (18.5).

Healthy life expectancy at age 65 is similar to the national average for both men and women in all three BHR boroughs.

People in Redbridge live longer than peers in the other two BHR boroughs, whereas people in Barking and Dagenham have a shorter life expectancy but live a greater proportion of their life in (apparent) good health. This is consistent with the observation made in Section 4 that additional years of life added to life expectancy are often characterised by some degree of ill health and dependency on health and social care services. The priority must be to increase healthy life expectancy, with a greater focus on the **prevention** of ill health at every stage of the life including in old age.

Nationally, there are 21% more deaths during the winter months. The proportion of **excess winter deaths** is lower in LBBD (15.7%) and similar in LBR (20.4%) and LBH (24.5%). In total, there were 350 additional deaths across BHR in the winter of 2016/17. The bulk of excess winter deaths result from an increase in deaths from respiratory conditions, some linked to flu; dementia and CVD[59].

Flu vaccination coverage of patients aged 65 and older is below the national target of 75% in all three BHR boroughs and has been in slow decline over the last decade[60].

PHE estimate that 1 in 10 excess winter deaths are directly attributable to fuel poverty[61]. More than 1 in 10 households in BHR are affected by **fuel poverty** ranging from 9.9% in LBH to 13.7% in LBR[62].

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 in old age include the loss of a loved one, an estimated 35K BHR

[59] ONS Excess winter mortality in England and Wales: 2017 to 2018 (provisional) and 2016 to 2017 (final).
[60] Source: https://fingertips.phe.org.uk
[61] Public Health England & UCL Institute of Health Equity (2014) Local action on health inequalities: Fuel poverty and cold home-related health problems.
[62] Source https://fingertips.phe.org.uk

residents aged 65 and above live alone[63]; 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[64].

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 their own home for longer[65]. The prevalence of diagnosed dementia in patients aged 65 and above in LBH (4.4%) and LBR (4.4%) is similar to the national average (4.3%). Rates in LBBD (3.8%) are significantly lower. In all three BHR boroughs, only about 2/3rds of cases have been diagnosed.

Recommendation 72: *Maintain efforts to further increase the completeness of dementia diagnosis and the information and support available to patients and their families*

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.[66] Falls are the number one precipitating factor for 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 2017/18.

Hip fracture is a particularly serious consequence of falls - 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 all three BHR boroughs; more than 650 were recorded in 2017/18.

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[67] 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 focus 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

[63] Source poppi.org.uk
[64]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
[65] https://www.scie.org.uk/dementia/symptoms/diagnosis/early-diagnosis.asp
[66] https://publichealthmatters.blog.gov.uk/2014/07/17/the-human-cost-of-falls/
[67] https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

- 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 73: *Ensure the BHR Falls prevention pathway currently in development is consistent with national guidance and effectively implemented.*

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, smoking, and vision problems.

Recommendation 74: *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.*

Frailty is a particular state of health experienced by a significant minority of older people - around 10% of people aged over 65 live with frailty, rising to 25- 50% of over 85s. Being frail can mean that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing e.g. 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 isn't frail.

A comprehensive approach to minimise the harm caused by frailty[68] 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.

[68] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

Recommendation 75: *Ensure that patients at risk of frailty are systematically identified; effectively supported to stay well; and receive urgent additional help in times of crisis.*

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. All three boroughs perform better than the national average in terms of the % of people aged 65 and over who were still at home 91 days after discharge from hospital.

Recommendation 76: *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 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 6. Care home beds, number and rate / 100 people aged 75+, 2018

Area	Number	Rate
LBBD	726	7.7
LBH	1858	8.2
LBR	1366	7.9
London		7.6
England		10.1

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 77: *Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.*

End of Life 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 LBH is similar to the national average but rates in LBBD and LBR are significantly higher (worse). 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 is addressing this challenge across three boroughs.

Recommendation 78: *Strengthen end of life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.*

List of acronyms

Acronym	Meaning	Further information
ACEs	Adverse Childhood Experiences	
ASQ3	Ages and Stages Questionnaire Third Edition	Used to assess child development
BHR	Barking Havering and Redbridge Health and Social Care System	
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	
CAMHS	Children and Adolescent Mental Health Services	
CDR	Child Death Review	
CMO	Chief Medical Officer	
COPD	Chronic Obstructive Pulmonary Disease	
CPA	Community Programme Approach	
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	
DALYs	Disability Life Adjusted Years	Combine years of life lost to premature death and years of life lived with disability into a single measure
DWP	Department of Work and Pensions	
EHCP	Education, Health and Care Plan	
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	
EL STP	East London Sustainability and Transformation Partnership	A partnership of health and social care commissioners and providers (including those in BHR) covering 8 boroughs and the city of London
EoLC	End Of Life Care	

Acronym	Meaning	Further information
FIT	Faecal Immunochemical Test	A test to identify people at increased risk of bowel cancer
HMO	Houses in Multiple Occupation	
H&WB	Health and Wellbeing Board	
IAPT	Improving Access To Psychological Therapies	‘talking therapies’
ICS	Integrated Care System	
ICPB	Integrated Care Partnership Board	
IMD	Index of Multiple Deprivation	
JSNA	Joint Strategic Needs Assessment	
LAC	Looked After Children	
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
LGBT	Lesbian, Gay, Bisexual, Trans	
LTC	Long Term Condition	
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	
PAF	Population Attributable Fraction	
PCN	Primary Care Network	
PHE	Public Health England	
SATOD	Smoking At Time Of Delivery	A measure of smoking prevalence amongst pregnant women
SEND	Special Education Needs and Disability	
SMEs	Small and Medium Sized Enterprises	
SMI	Serious Mental Illness	
VCS	Voluntary and Community Sector	
YLD	Years Lived with Disability	
YLL	Years of Life Lost	

Acknowledgements

This first edition of a JSNA for the developing BHR health and social care system has been a collective effort on the part of many individuals, coordinated by the Public Health Information Leads for each of three boroughs. A number of analysts have contributed to its development. Other officers have facilitated discussions with relevant Transformation Boards. We, the Directors of Public Health for each of the boroughs, would like to thank everyone for their efforts, and apologise for anyone inadvertently omitted from the list below.

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Gladys Xavier, Director of Public Health, LBR

Anthony Wakhisi, Principal Public Health Specialist, LBH

Wassim Fattahi-Negro, Principal Manager Performance & Intelligence, LBBD

Soumya-Kanti Chatterjee, Business Intelligence - Public Health Lead, LBR

Mark Holder, Senior Public Health Analyst, LBH

Bianca Hossain, Senior Intelligence and Analysis Officer, LBBD

Alex McLellan, Principal Public Health Analyst, LBH

Hasna Begum, Public Health Analyst, LBH

Katherine Kavanagh, Cancer Commissioning Manager

Usman Khan, Consultant in Public Health, LBBD

Elaine Greenway, Consultant in Public Health, LBH

Deborah Redknapp, Public Health Principal, LBH

Ikenna Obianwa, Public Health Manager, LBR

Appendix 1: BHR JSNA Process

1 Background

1.1 To support the BHR ICP fulfil its functions, BHR Public Health teams worked jointly to produce a new product 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[69] 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:
    - Older people and frailty
    - Children and young people
    - Long term conditions
    - Mental health

[69] 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.

6 Timelines

Activity	Responsible	June 2019	July 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
JSNA scoping exercise	BHR PHI Leads							
Consultation with service leads and agreeing on JSNA indicators	BHR PHI Leads							
Project proposal with delivery plan presented to ICPB	DPH							
Data analysis	BHR PHI Leads							
Commentary by service leads	BHR Consultants and Transformation Leads							

Activity	Responsible	June 2019	July 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019
Compilation of final reports	Lead Author & PHI Leads							
Submission of final reports to ICP Board	BHR JSNA DPH Lead						26/11/19	
ICP Board Meeting								04/12/19
BHR JSNA Interactive Version	Barking & Dagenham Public Health							

Appendix 2: Population & Health Outcomes

Click Chapter 2, 3 or 7.2 to return to respective chapters

BHR Joint Strategic Needs Assessment 2019
London Borough of Havering
Population & Health Outcomes
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
Resident Population	1	Percentage of resident population aged 0 - 4 years		17,370	6.7	9.2	7.5	7.7	6.9	6.0		
	2	Percentage of resident population aged 5 - 9 years	2018	16,510	6.4	9.1	7.1	7.4	6.7	6.3		
	3	Percentage of resident population aged 10-19 years	2018	29,007	11.3	13.9	12.6	12.5	11.1	11.4		
	4	Percentage of resident population aged 20-64 years	2018	148,487	57.6	58.5	60.2	58.9	63.4	58		
	5	Percentage of resident population aged 65-74 years	2018	23,764	9.2	5.0	6.7	7.1	6.5	10		
	6	Percentage of resident population aged 75-84 years	2018	15,240	5.9	2.9	4.0	4.3	3.8	6		
	7	Percentage of resident population aged 85+ years	2018	7,432	2.9	1.4	1.8	2.1	1.6	2.4		
	8	Total resident population	2018	257,810								
GP Registered Population	9	Percentage of GP population aged 0 - 4 years	2019	17,597	6.3	8.1	6.9	7.1	5.9	5.5		
	10	Percentage of GP population aged 5 - 9 years	2019	17,620	6.3	8.6	7.1	7.3	6.1	6.0		
	11	Percentage of GP population aged 10-19 years	2019	31,179	11.1	14.1	12.1	12.4	10.7	11.1		
	12	Percentage of GP population aged 20-64 years	2019	164,519	58.6	60.9	61.7	60.7	66.5	60.0		
	13	Percentage of GP population aged 65-74 years	2019	25,814	9.2	4.7	6.2	6.9	6.0	9.5		
	14	Percentage of GP population aged 75-84 years	2019	16,335	5.8	2.5	3.6	4.1	3.5	5.6		
	15	Percentage of GP population aged 85+ years	2019	7,756	2.8	1.1	1.6	1.9	1.4	2.3		
	16	Total GP population	2019	280,820								
Ethnic Population	17	Percentage White British	2019	197,040	76.5	36.3	25.9	45.5	39.4			
	18	Percentage Black	2019	16,430	6.4	23.0	8.3	11.7	13.4			
	19	Percentage Asian	2019	16,450	6.4	21.1	47.6	26.7	18.4			
	20	Percentage Other White	2019	16,260	6.3	11.7	9.6	9.1	17.5			
	21	Percentage Mixed	2019	8,010	3.1	5.0	4.6	4.2	5.6			
	22	Percentage Others	2019	3,310	1.3	2.8	4.0	2.8	5.6			
Hrealth Outcomes	23	Life expectancy at birth (Males)	2015-17		79.6	77.8	81.0		80.5	79.6	74.2	83.2
	24	Life expectancy at birth (Females)	2015-17		84.2	82.1	84.3		84.3	83.1	79.5	86.5
	25	Healthy Life Expectancy at birth (Males)	2015-17		65.5	62.8	63.7		63.9	63.4	54.7	69.8
	26	Healthy Life Expectancy at birth (Females)	2015-17		64.5	62.3	63.0		64.6	63.8	53.5	71.6

Data Sources:
Indicators: 1-8 - ONS Population Estimates 2018. Indicators 9-16 NHS Digital 2019. Indicators 17-22 GLA Ethnic Population Projections 2019. Indicators 23-26 Public Health England

Appendix 3: Wider Determinants Dashboard

To return to chapter 4: Wider Determinants - Click Here

BHR Joint Strategic Needs Assessment 2019

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			36670.0	29420.0	36670.0	-	39110.0	30600.0		
2	Gross Weekly Pay for Full Time Workers (£)	2018			642.0	571.5	633.2	-	670.8	574.9	422.1	919.2
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		26,766	10.8	19.4	12.1	13.6	13.8	12.9	25.1	2.9
5	Proportion of residents aged 16 - 64 in employment	2019		121,300	76.1	69.0	68.7	71.1	74.2	75.6	59.2	87.8
6	Proportion of residents aged 16 - 64 in management / professional roles	2019		60,200	46.9	33.6	49.8	44.5	57.5	47.2	74.2	15.6
7	Proportion of residents 16-64 who are economically inactive	2018/18		30,300	19.0	26.8	26.6	24.2	21.9	21.1	34.4	8.6
8	Proportion of residents 16-64 who are economically inactive and want a job	2018/19		4,800	15.8	16.2	20.4	18.0	20.8	20.5	6.9	53.2
9	Jobs Density Ratio for population 16-64	2017			0.64	0.49	0.50	0.54	1.02	0.87	0.41	1.25
10	Proportion of residents by level of education - NVQ 4 & Above	2018		48,000	30.0	33.0	46.2	37.4	53.1	39.0	10.6	100.0
11	Proportion of residents by level of education - No Qualifications	2018		14,000	8.8	8.2	8.4	8.5	6.6	7.6	20.4	1.5
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	17.2	14.9	3.4	40.1	0.0
14	Number of households on waiting list	2019		1,981	1981.0	4856.0	-	-	-	-	-	-
15	Proportion of homes that are not 'Decent Homes'	2015		16,083	15.7	17.5	16.3	16.4	16.4	19.6	50.7	11.9
16	Proportion of Households experiencing Fuel Poverty	2016		8,123	8.0	11.6	11.3	10.2	10.0	11.1	17.0	4.9
17	Rate of verifiable Houses of Multiple Occupation (HMOs) to dwellings (%)	2011		139	0.1	0.2	0.0	0.1	0.4	0.4	6.1	0.0
18	Estimated rate of HMOs to dwellings including the verifiable HMOs (%)	2011		150	0.2	0.4	6.4	2.5	4.7	1.9	14.7	0.0
19	Number of people seen rough sleeping in the year	2018/19		32	32.0	49.0	214.0	295.0	-	-	-	-

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, 12, 13, 17, 18 - 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 - ONS Jobs Density, NOMIS - https://www.nomisweb.co.uk/. 14 - Borough Housing Departments. 15 - 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.

Appendix 4: Health Behaviour & Lifestyle Dashboard

To return to chapter 5: Health Behaviour & Lifestyle - Click Here

BHR Joint Strategic Needs Assessment 2019

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	2017/18		305	71.2	64.4	56.4	64.3	55.9	62.0	74.4	46.5
2	Percentage of physically inactive adults	2017/18		109	22.4	33.6	25.7	27.1	22.0	22.2	37.1	11.2
3	Smoking Prevalence (% of adult population) (APS)	2018		30,008	15.0	22.4	13.2	16.2	13.9	14.4	26.1	5.9
4	Smoking prevalence in adults (age 18-64 years) - gap between current smokers in routine and manual occupations and other occupations (Odds Ratio)	2018			3.2	1.3	1.9		2.2	2.5	5.3	1.0
5	Percentage of adults drinking over 14 units of alcohol a week	2011-14			20.9	12.9	14.8		21.6	25.7	31.9	3.6
6	Percentage of adults binge drinking on heaviest drinking day	2011-14			14.2	7.3	5.9		13.2	16.5		
7	Percentage of dependent drinkers	2014/15		2,189	1.1	1.5	1.0		1.4	1.4	3.9	0.6
8	Percentage of dependent drug users (All in Opiate treatment)	2017/18		250	0.3	0.6	0.4	0.4	0.5	0.7	0.7	0.7
9	Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2017/18			44.7	43.9	52.6		54.1	54.8	40.7	65.9

Data Source: Indicators 1-7, 9 - Public Health England: https://fingertips.phe.org.uk/ , Indicator 8 - NDTMS: https://www.ndtms.net/

Appendix 5: Maternity Dashboard

To return to chapter 6: Maternity - Click Here

BHR Joint Strategic Needs Assessment 2019

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	Number & percentage of mothers known to be smokers at the time of delivery	2017/18	↓	228	7.2	7.8	3.5	6.0	5.0	10.8	25.7	1.6
2	Number of live births	2018		3,307								
3	Number and percentage of stillbirths	2015-17		54	5.3	5.9	3.1	4.6	4.9	4.3	6.8	2.6
4	General Fertility Rate (per1,000 women age 15-44)	2018		3,395	68.0	82.6	73.4	74.4	62.9	64.2	41.6	86.5
5	Low Birth Weight Births (% term babies)	2017	→	83	2.7	3.8	3.9	3.5	3.0	2.8	5.3	1.6

Data Source: Indicators 1, 2, 5 - PHE. Indicators 2 & 4 - ONS

Appendix 6: Children & Young People Dashboard

To return to chapter 7.2 Children & Young People - Click Here

BHR Joint Strategic Needs Assessment 2019

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	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Havering		Barking & Dagenham	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Number and percentage of pupils with Special Educational Needs (SEN) based on where the pupil attends school	2019		4,005	9.9	14.1	11.6	12.0	14.6	14.9	9.9	20.5
2	Number and percentage of children and young people with EHC Plan (Denominator Age 0-25 ONS 2018)	2019		1,534	1.9	1.8	2.0	1.9	2.1	2.0		
3	Number and percentage of children (Age 5-15) with EHC Plan (Denominator Age 5-15 ONS 2018)	2019		1,024	3.0	2.7	3.2	3.0	3.4	3.3		
4	Number of primary school pupils with EHCP (local data)	2019		573								
5	Number of secondary school pupils with EHCP (local data)	2019		526								
6	Number and percentage SEND pupils resident and educated in Borough (Local data)	2018/19		3,616	10.1							
8	Estimated prevalence of common mental disorders in children & young people: Age 5-16	2015		3,149	9.0	10.3	9.0	9.4	9.3	9.2	7.0	11.0
9	Percentage of school pupils with social, emotional and mental health needs (school age)	2018		485	1.2	2.7	1.9	1.9	2.4	2.4	1.2	4.3
10	Hospital admissions as a result of self harm (Age 10-24)	2017/18		50	117.0	116.9	133.1	119.8	209.1	421.2	116.9	1009.6
11	Hospital admissions for asthma (under 19 years)	2016/17		54	90.5	215.3	226.0	183.1	188.1	186.4	82.5	511.7
12	Hospital admissions diabetes (under 19 years)	2016/17		37	63.0	37.1	45.1	47.4	46.8	55.1	27.4	121.6
13	Number of children with a Child Protection Plan and rate per 10,000 children at 31st March 18	2017/18		215	37.9	51.0	38.1	42.2	39.2	45.0		
14	Number of Looked after Children and rate per 10,000 children at 31st March 2018	2017/18		250	44.0	65.0	29.0	45.1	49.0	64.0	23.0	185.0
15	Number of Children in Need and rate per 10,000 children at 31st March 18	2017/18		2,273	401.1	345.5	298.7	343.4	360.1	338.5		
16	Number and percentage of looked after children in Youth Offending system (local data)	2019		13	21.0							
17	Number of 2 year olds taking up offer of free nursery care (local data)	2018/19		1,215								
18	Number and percentage of unauthorised school absence sessions	2017/18		131,437	1.1	1.6	1.2	1.3	1.3	1.4		
19	Rate of teenage pregnancy (under 18 year olds - rate/1,000)	2017	↓	89	21.0	25.1	12.4	18.8	16.4	17.8	6.1	43.8
20	Deliveries to teenage mothers (under 18 year olds - rate/1,000)	2017/18	↓	26	0.8	0.7	0.3	0.6	0.4	0.7	0.2	2.1
21	Under 18s abortion rate (under 18 year olds - rate/1,000)	2017	→	51	12.1	12.4	6.1	9.8	9.2	8.4	2.4	15.4
22	Income deprivation affecting Children (under 16) (%)	2015		7,710	16.0	23.8	13.7	17.6	18.2	17.1	3.2	32.7
23	Percentage of children achieving a good level of development at the end of reception	2017/18	↑	2,368	71.5	71.3	75.0	72.8	73.8	71.5	63.9	81.3
24	Pupil Absence: Overall absence rate for enrolments who are persistent absentees (%)	2017/18		211,932	17.7	17.4	16.5	17.2	17.5	18.5	21.5	12.4
25	GCSE Achievement (5A*-C inc. English & Maths) (%)	2017/18		1,878	67.7	60.0	74.4	68.5	67.7	59.1	41.9	93.3
26	Proportion of 16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2019		298	5.2	5.3	3.6	4.6	4.8	5.5	14.3	1.6
27	Percentage of children with excess weight (including obesity) (Reception Year)	2017/18	→	774	24.4	25.6	21.5	23.7	21.8	22.4	29.6	13.9
28	Percentage of children with excess weight (including obesity) (Year 6)	2017/18	↑	1,053	37.3	44.5	40.2	40.8	37.7	34.3	44.5	21.7
29	Breastfeeding prevalence at 6-8 weeks after birth (%)	2017/18		1,120			0.9			42.7		
30	Low Birth Weight Births (% term babies)	2017	→	83	2.7	3.8	3.9	3.5	3.0	2.8	5.3	1.6

Data Sources: *Indicators 1,2,3,18,- Department of Education. Indicators 8,9,10,12,13, 19-30 - PHE. Indicators 4,5,6,17,18 - Local Data. Indicator 16 - https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2017-to-2018.Indicators 14,15 - https://www.gov.uk/government/collections/statistics-children-in-need*

Appendix 7: Adult Mental Health

To return to chapter 7.3: Adult Mental Health - Click Here

BHR Joint Strategic Needs Assessment 2019

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)	2017/18	↑	15,702	7.7	6.3	5.5	6.4	7.1	9.9	3.2	15.6
3	Rate of SMI (All Ages) (QOF)	2017/18	↑	1,935	0.7	0.8	0.9	0.8	1.1	0.9	0.4	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	2018		485	1.2	2.7	1.9	2.0	2.4	2.4	4.3	1.2
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	2017/18			18.9	17.7	19.2		21.2	20.0	18.0	21.2
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+	2017/18			45.4	41.7	46.7		41.4	46.0	34.3	54.4
13	Access to IAPT services: people entering IAPT (month) as % estimated to have anxiety\depression	Jun 2019	↓	360	17.5	16.8	19.2	18.0		18.8	8.6	27.7
14	APT reliable improvement: % of people in IAPT (quarter) who achieved reliable improvement (18+)	Q1 19/20		430	72.9	68.2	71.3	71.1		72.0	45.0	82.2
15	Percentage of social care users who suffer depression and anxiety	2017/18			48.9	58.1	49.5		55.8	54.5	43.6	65.8
16	Dementia: QOF prevalence (all ages) Number and % of patients with dementia against total GP patients	2017/18	↑	2,024	0.7	0.4	0.6	0.5	0.5	0.8	0.0	63.1
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	2017/18	↓	10	17.6	28.6	14.5	20.0	76.0	84.7	14.5	187.6
19	Proportion of people (18-74) in contact with secondary mental health services	2014/15		5,074	3.0	3.9	3.1	3.2	4.7	5.4	2.7	14.5
20	Number and age standardised mortality rate from suicide per 100,000 population (Persons)	2016-18		51	7.8	5.1	7.1	6.7	8.1	9.6	5.1	19.5
21	Number and directly age standardised rates for emergency hospital admissions for intentional self harm	2017/18		196	77.4	65.5	55.1	66.4	83.6	185.5	50.6	466.5
22	Mental Health service users on Care Programme Approach (CPA)	Q4 18/19	↓	740	19.7	25.3	21.9	22.1	17.8	14.7	0.2	48.7
23	Stable and appropriate accommodation - % of people on CPA	Q4 18/19	↓	485	80.2	77.1	49.3	68.2	63.9	58.5	0.0	88.7
24	CPA Adults in Employment	Q4 18/19	↑	55	9.1	7.6	4.9	7.1	7.7	9.1	0.0	31.9

Data Sources:
Indicators: 1-24 - Public Health England (PHE)

Appendix 8: Cancer Dashboard

To return to chapter 7.4: Cancers - Click Here

BHR Joint Strategic Needs Assessment 2019

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)	2016/17	↑	1,508	548.6	307.0	340.5	402.2	347.9	520.8	209.0	758.0
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)	2017		162	69.1	60.9	51.8	61.0	60.7	68.4		
5	Incidence lung cancer (Age standardised rate per 100,000)	2017		175	75.1	91.6	48.2	68.6	74.0	77.0		
6	Incidence prostate cancer (Age standardised rate per 100,000)	2017		251	239.5	231.4	209.2	226.3	183.0	173.1		
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 (%)	2016			72.0	68.0	71.4			72.8	67.7	77.4
9	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2017/18	↓	15,093	54.7	41.4	46.6	48.9	48.9	57.3	36.4	66.9
10	Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2017/18	→	9,581	55.1	40.5	45.9	48.6	46.0	56.1	33.1	65.9
11	Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2017/18	↑	22,761	56.6	42.7	48.5	50.9	50.3	59.6	37.9	69.0
12	Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2017/18	↑	14,092	56.4	40.6	47.2	49.8	47.5	57.7	34.9	67.3
13	Breast screening uptake (%)	2018	↓	21,529	78.4	67.0	70.7	72.9	69.3	74.9	56.3	84.6
14	Cervical screening uptake (%)	2017/18	↓	52,505	72.8	67.5	64.2	67.9	65.2	71.7	52.2	82.2
15	Percentage of cancers detected at stage 1 and 2	2017		521	48.6	52.9	52.3	50.8	52.7	52.2	36.8	60.0
16	Percentage of cancers diagnosed through emergency presentation	2017/18 Q2 – 2018/19 Q1			17.2	18.1	18.7			18.8		
17	Premature mortality from all cancers (rate per 100,000)	2015-17		892	143.1	157.0	106.7		123.6	134.6	91.3	194.5
18	Premature mortality from lung cancer (rate per 100,000)	2015-17		190	30.6	37.4	18.6	27.6	27.8	31.1	14.9	62.2
19	Premature mortality from breast cancer (rate per 100,000)	2015-17		80	24.2	20.0	27.1		20.1	20.6	12.5	32.9
20	Premature mortality from colorectal cancer (rate per 100,000)	2015-17		93	14.9	12.9	9.8		10.9	12.0	6.3	17.4
21	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
22	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
23	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
24	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- Transforming Cancer Services Team for London, Cancer Metrics Pack, Feb 2019, 17-25 PHE

Appendix 9: Long Term Conditions Dashboard

To return to chapter 7.5: Long Term Conditions - Click Here

BHR Joint Strategic Needs Assessment 2019

London Borough of Havering

Population Health Pillar: HSC - Long Term Conditions

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	Diabetes: QOF prevalence (Age 17+) (%)	2017/18		15,092	6.8	8.0	8.7	7.8	6.5	6.8		
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)	2015/16 - 17/18		40	9.3	7.0	6.1		7.3	8.0	2.2	20.5
4	Percentage of LTCs reporting that they have received all or some of the support they need	2017/18		798	46.5	49.1	46.8	47.2	52.1	55.0		
5	Coronary Heart Disease: QOF prevalence (All Ages) (%)	2017/18		7,352	2.6	1.8	2.4	2.3	2.0	3.1		
6	Coronary Heart Disease: Estimated prevalence (Age 55-79) (%)	2015			8.7	9.6	7.6			7.9		
7	Emergency hospital admissions for coronary heart disease, standardised admission ratio	2013/14 - 17/18		2,974	92.0	119.3	122.5		96.0	100.0	55.1	188.2
8	Coronary Heart Disease: Mortality Under 75 (DSR per 100,000)	2015-17		244	39.6	48.1	41.2		38.5	38.7	19.4	83.3
9	COPD: QOF prevalence (All Ages) (%)	2017/18		4,797	1.7	1.5	0.8	1.3	1.1	1.9		
10	COPD: Estimated prevalence (All Ages) (%)	2015			2.8	2.4	1.9			3.0		
11	COPD: Emergency hospital admissions standardised admission ratio	2013/14 - 17/18		2,980	102.2	175.2	73.5		96.8	100.0	36.4	226.1
12	COPD: Mortality (DSR per 100,000)	2015-17		414	54.7	84.2	40.3		47.7	52.7	27.4	103.5
13	Hypertension: QOF prevalence (All Ages) (%)	2017/18		38,358	13.8	11.4	11.7	12.4	11.0	13.9		
14	Diagnosed Hypertension: Estimated prevalence (%)	2015			22.8	19.0	16.3			20.8		
15	Hypertension: Emergency Admissions (Require HES data)											
16	Hypertension: Mortality Under 75 (Require PCMD)											
17	Under 75 mortality rate from respiratory conditions considered to be preventable (DSR per 100,000)	2015-17		92	15.1	32.0	9.4		16.2	18.9	7.5	46.4
18	Stroke QOF Prevalence (All Ages)	2017/18		4,217	1.5	0.9	1.0	1.2	1.1	1.8		
19	Emergency hospital admissions for stroke, standardised admission ratio	2013/14 - 17/18		1,861	93.4	106.1	95.2		103.8	100.0	64.7	151.3
20	Stroke - Under 75 Mortality (DSR per 100,000)	2015-17		65	10.4	20.0	14.6		13.5	13.1	7.3	22.1
21	Learning Disability QOF Prevalence (All Ages) (%)	2017/18		947	0.3	0.4	0.4	0.4	0.4	0.5		
22	Learning Disability: Completed Health checks (%)	2017/18		4,217	1.5	0.9	1.0	1.2	1.1	1.8		

Data Source: Public Health England (PHE) & NHS Digital

Appendix 10: Older People & Frailty Dashboard

To return to chapter 7.6: Older People & Frailty - Click Here

BHR Joint Strategic Needs Assessment 2019

London Borough of Havering

Population Health Pillar: HSC - Older People & Frailty

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	Life expectancy at 65 (Years) - Females	2015-17			21.6	20.5	21.8		21.9	21.1	18.7	24.1
2	Life expectancy at 65 (Years) - Males	2015-17			18.5	17.4	19.3		19.0	19.0	16.1	22.1
3	Healthy life expectancy at 65 (Years) - Females	2015-17			11.3	9.4	10.9		10.8	10.9	6.8	17.8
4	Healthy life expectancy at 65 (Years) - Males	2015-17			11.4	12.0	8.7		10.1	10.4	6.3	15.7
5	Disability-free life expectancy at 65 (Years) - Females	2015-17			9.3	8.1	10.3		10.3	9.8	6.3	16.0
6	Disability-free life expectancy at 65 (Years) - Males	2015-17			10.2	9.7	9.9		10.3	9.9	5.2	13.5
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)	2017/18		901	1759.1	1727.5	1831.2		2319.3	2170.4	1352.0	3329.0
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)	2017/18		313	594.2	595.0	545.7		515.0	577.8	377.0	797.0
13	Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital	2017/18	↑	240	88.0	94.0	97.0	93.3	87.0	83.0	50.0	100.0
14	Percentage of deaths that occur in hospital (ages 65-74)	2017	↓	187	50.8	58.3	57.9	54.8	53.7	48.7	39.0	70.5
15	Percentage of deaths that occur in hospital (ages 75-84)	2017	↓	348	51.9	58.6	64.3	57.3	55.7	49.7	38.5	65.9
16	Percentage of deaths that occur in hospital (ages 85+)	2017	↓	521	46.6	55.9	54.9	51.0	51.0	42.8	27.2	60.3
17	Rate of permanent admissions to residential and nursing care homes (ages 65+, per 100,000)	2017/18	→	242	521.3	702.2	285.7	470.7	406.2	585.6	204.0	1513.0

Data Source: Public Health England (PHE) & NHS Digital

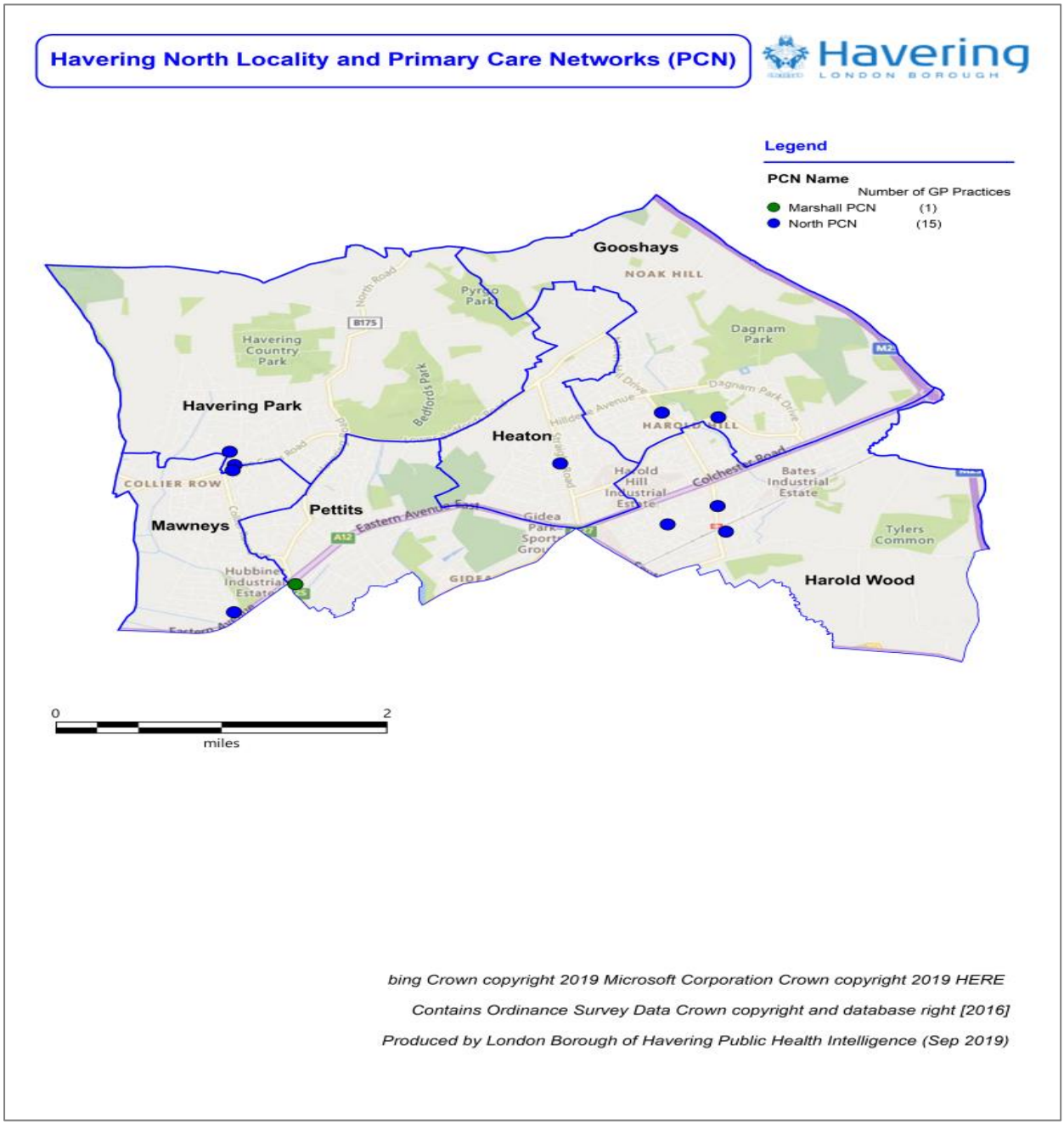
Appendix 11: Localities Data

London Borough of Havering (LBH) – North Locality

1. Places and Communities

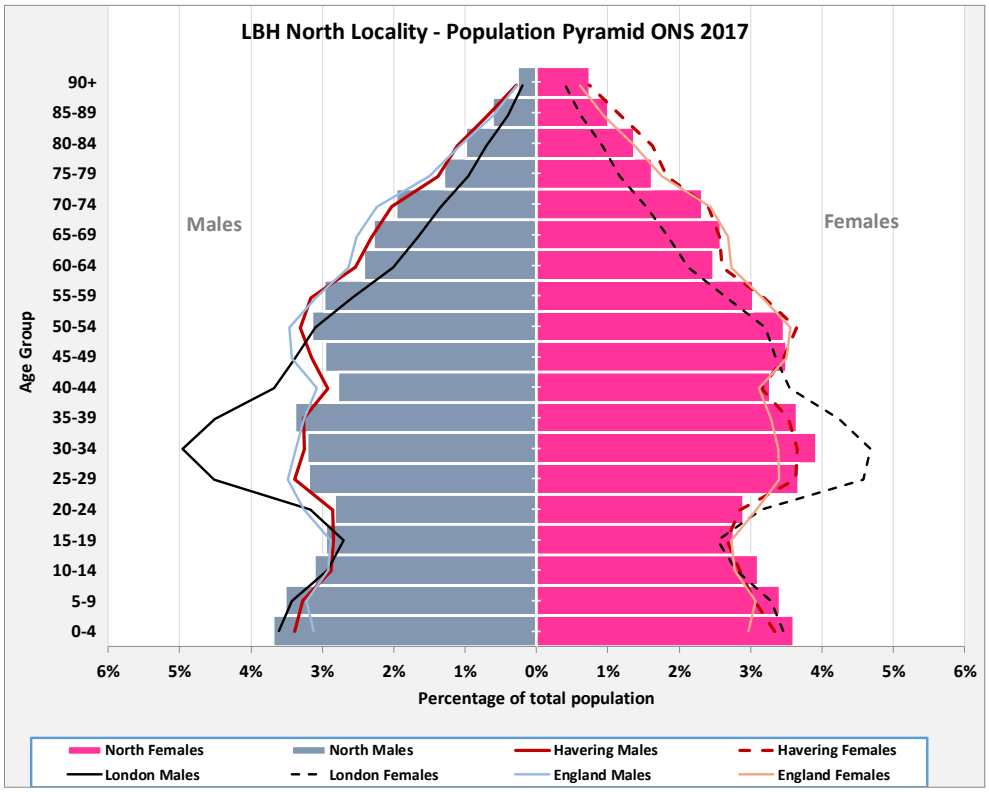
1.1 Havering north locality map

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 - 2017

Age Band (Years)	Female	Male	Totals
0-4	3,119	3,198	6,317
5-9	2,957	3,053	6,010
10-14	2,692	2,695	5,387
15-19	2,396	2,557	4,953
20-24	2,510	2,449	4,959
25-29	3,185	2,764	5,949
30-34	3,402	2,781	6,183
35-39	3,163	2,930	6,093
40-44	2,843	2,408	5,251
45-49	3,035	2,567	5,602
50-54	3,005	2,721	5,726
55-59	2,633	2,574	5,207
60-64	2,152	2,096	4,248
65-69	2,236	1,974	4,210
70-74	2,011	1,702	3,713
75-79	1,399	1,121	2,520
80-84	1,183	854	2,037
85-89	868	530	1,398
90+	644	232	876
Totals	45,433	41,206	86,639



Source: ONS 2017 Mid-Year Estimates

1.3 LBH PCN Profile - GP population 5 year age groups

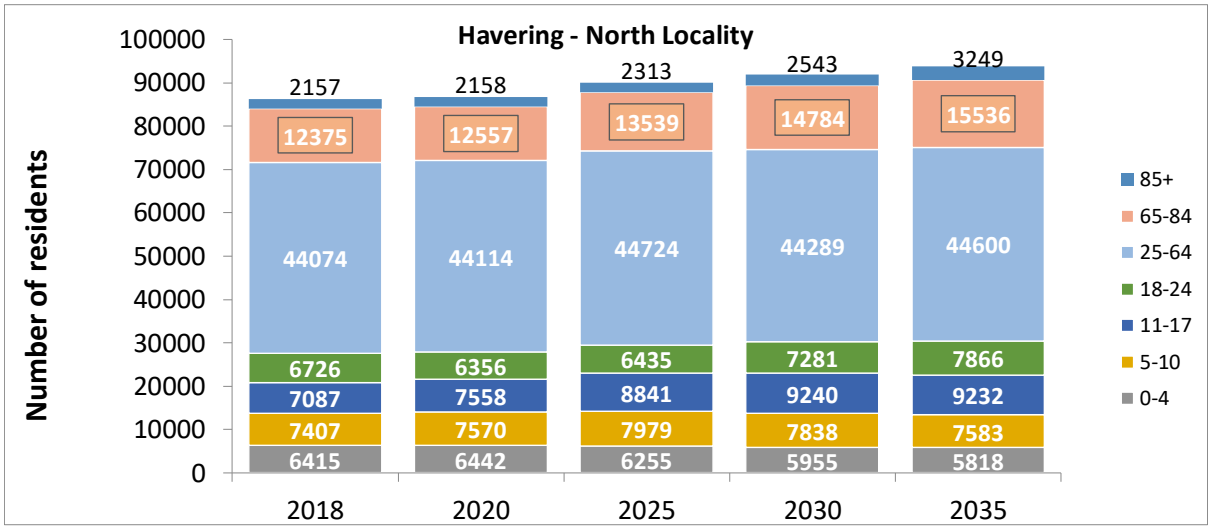
	HAVERING CREST			Marshall PCN			North PCN			South PCN		
AGE BAND (YEARS)	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**
0_4	1380	1456	2836	1410	1534	2944	2820	3031	5851	2966	3001	5967
5_9	1340	1415	2755	1384	1412	2796	2964	3061	6025	2971	3142	6113
10_14	1209	1266	2475	1278	1268	2546	2747	2836	5583	2930	2898	5828
15_19	1063	1136	2199	1153	1197	2350	2360	2487	4847	2730	2804	5534
20_24	1233	1177	2410	1212	1167	2379	2484	2447	4931	2888	2997	5885
25_29	1669	1468	3137	1661	1430	3091	3101	2780	5881	3393	3493	6886
30_34	1835	1652	3487	1859	1626	3485	3573	3065	6638	3757	3563	7320
35_39	1594	1544	3138	1713	1716	3429	3459	3311	6770	3549	3479	7028
40_44	1334	1429	2763	1480	1521	3001	2825	2769	5594	3242	3171	6413
45_49	1386	1361	2747	1404	1520	2924	2828	2815	5643	3386	3346	6732
50_54	1452	1505	2957	1586	1598	3184	2889	2855	5744	3845	3736	7581
55_59	1331	1377	2708	1443	1390	2833	2606	2620	5226	3779	3744	7523
60_64	1114	1136	2250	1240	1173	2413	2122	2207	4329	3113	3144	6257
65_69	908	867	1775	1089	988	2077	1809	1709	3518	2853	2608	5461
70_74	918	764	1682	1174	1050	2224	1897	1619	3516	2970	2614	5584
75_79	714	562	1276	847	664	1511	1249	1025	2274	2260	1711	3971
80_84	643	433	1076	710	493	1203	1003	730	1733	1908	1406	3314
85_89	406	269	675	546	329	875	672	438	1110	1407	851	2258
90_94	177	84	261	282	125	407	425	157	582	668	308	976
95+	76	21	97	78	29	107	143	52	195	199	54	253
Total	**21782**	**20922**	**42704**	**23549**	**22230**	**45779**	**43976**	**42014**	**85990**	**54814**	**52070**	**106884**

Source: NHS Digital GP Registrations (June 2019)

1.4 LBH North Location Population Projections 2020, 2025, 2030, 2035

Area	2018	2020	2025	% change	2030	% change	2035	% change
North	86,241	86,755	90,086	4.5	91,930	6.6	93,884	8.9

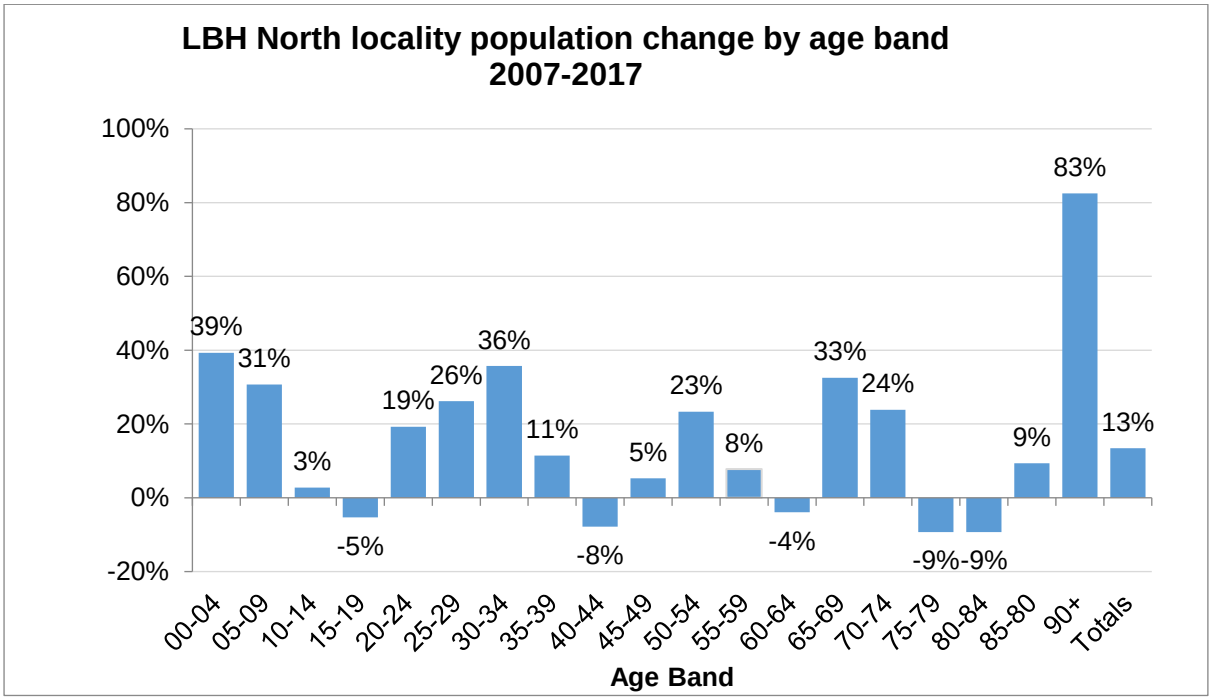
North	2018	2020	2025	2030	2035
0-4	6415	6442	6255	5955	5818
5-10	7407	7570	7979	7838	7583
11-17	7087	7558	8841	9240	9232
18-24	6726	6356	6435	7281	7866
25-64	44074	44114	44724	44289	44600
65-84	12375	12557	13539	14784	15536
85+	2157	2158	2313	2543	3249
Total	86,241	86,755	90,086	91,930	93,884



Source: GLA Household led population projections using 2016 SHLAA

1.5 LBH North Locality population change by age band 2007 - 2017

Age Band	2007	2017	Change	%
00-04	4,534	6,317	1783	39%
05-09	4,598	6,010	1412	31%
10-14	5,243	5,387	144	3%
15-19	5,232	4,953	-279	-5%
20-24	4,159	4,959	800	19%
25-29	4,715	5,949	1234	26%
30-34	4,556	6,183	1627	36%
35-39	5,468	6,093	625	11%
40-44	5,694	5,251	-443	-8%
45-49	5,322	5,602	280	5%
50-54	4,642	5,726	1084	23%
55-59	4,831	5,207	376	8%
60-64	4,422	4,248	-174	-4%
65-69	3,177	4,210	1033	33%
70-74	2,998	3,713	715	24%
75-79	2,778	2,520	-258	-9%
80-84	2,245	2,037	-208	-9%
85-89	1,278	1,398	120	9%
90+	480	876	396	83%
Totals	76,372	86,639	10267	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

Crime	Number of cases			
	Central	North	South	Havering
Non-domestic abuse and violence with injury offences *	672	351	241	1,264
Domestic abuse offences **	821	1067	646	2,534
Knife crime offences ***	147	102	90	339

*rolling 12 months to 1st April 2019
**rolling 12 months to December 2018
***rolling 12 months to 1st July 2019

Source: MOPEC crime dashboards

https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/crime-dashboard

https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/weapon-enabled-crime-dashboard

https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/domestic-and-sexual-violence-dashboard

1.8 Mosaic – Havering Central Locality household segmentation data 2018

Number of households in Central Locality classified by Mosaic groups

Mosaic Group	Totals
A Country Living	182
B Prestige Positions	1433
C City Prosperity	23
D Domestic Success	3909
E Suburban Stability	4042
F Senior Security	4155
G Rural Reality	48
H Aspiring Homemakers	5616
I Urban Cohesion	704
J Rental Hubs	1566
K Modest Traditions	2531
L Transient Renters	624
M Family Basics	6142
N Vintage Value	2334
O Municipal Tenants	1716
U Unclassified	0
Totals	35025

1.9 Projected new homes in South Locality

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.

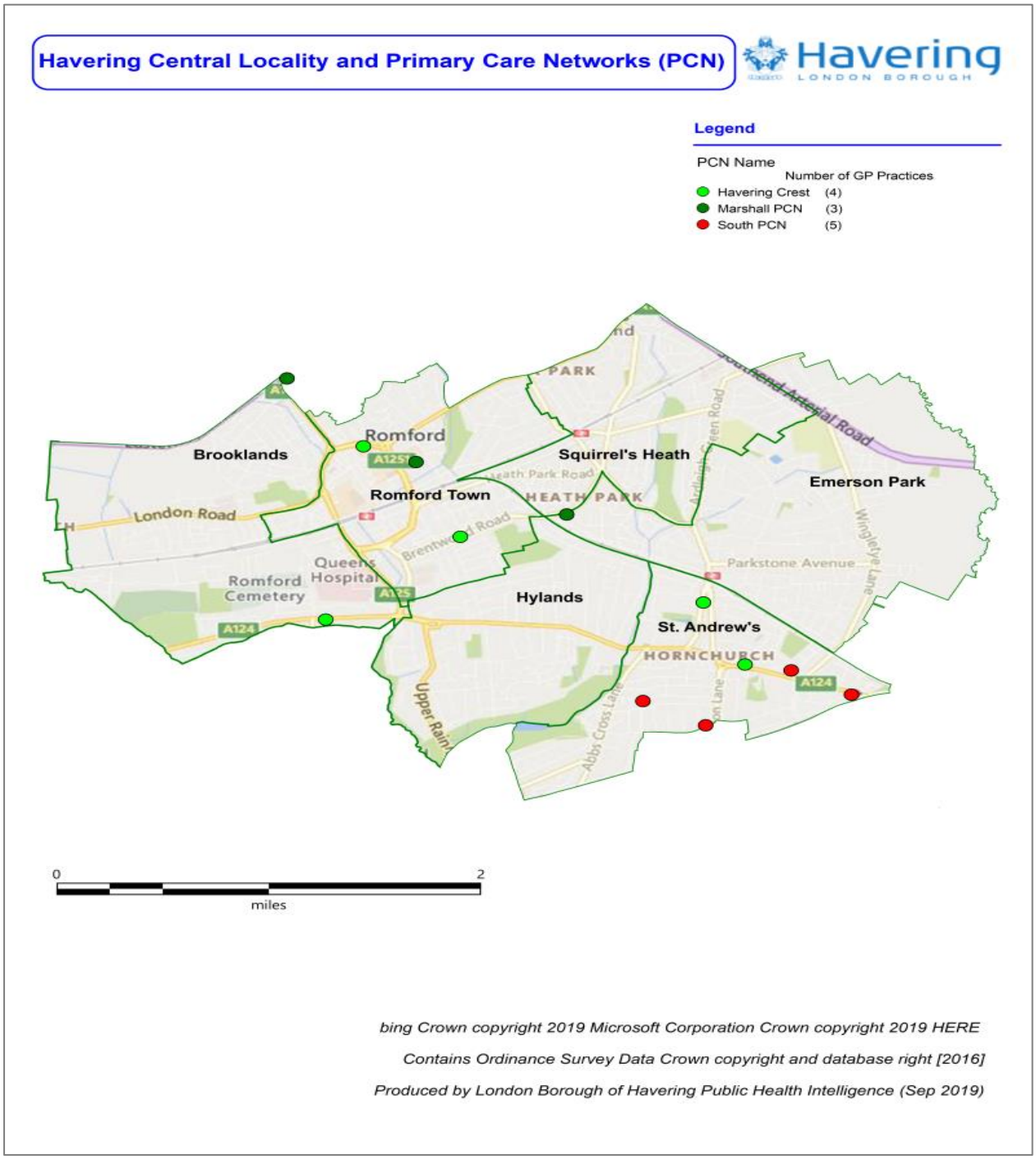
Locality	Number of houses
Central	4992
North	717
South	3702
Total	9411

London Borough of Havering (LBH) – Central Locality

1. Places and Communities

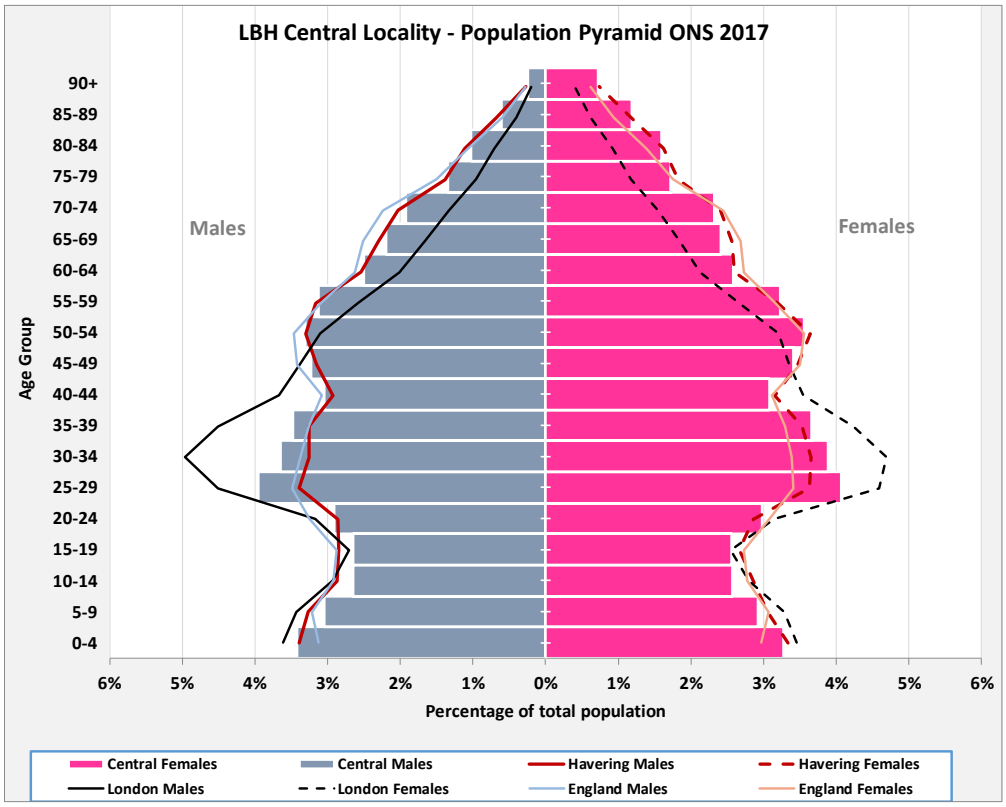
1.1 Havering central locality map

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 - 2017

Age Band (Years)	Female	Male	Totals
0-4	2,943	3,068	6,011
5-9	2,621	2,737	5,358
10-14	2,303	2,378	4,681
15-19	2,302	2,376	4,678
20-24	2,678	2,614	5,292
25-29	3,652	3,552	7,204
30-34	3,488	3,270	6,758
35-39	3,288	3,118	6,406
40-44	2,764	2,734	5,498
45-49	3,059	2,899	5,958
50-54	3,189	2,965	6,154
55-59	2,900	2,805	5,705
60-64	2,315	2,248	4,563
65-69	2,161	1,968	4,129
70-74	2,084	1,727	3,811
75-79	1,542	1,208	2,750
80-84	1,436	926	2,362
85-89	1,068	542	1,610
90+	643	222	865
Totals	46,436	43,357	89,793



Source: ONS 2017 Mid-Year Estimates

1.3 LBH PCN Profile - GP population 5 year age groups

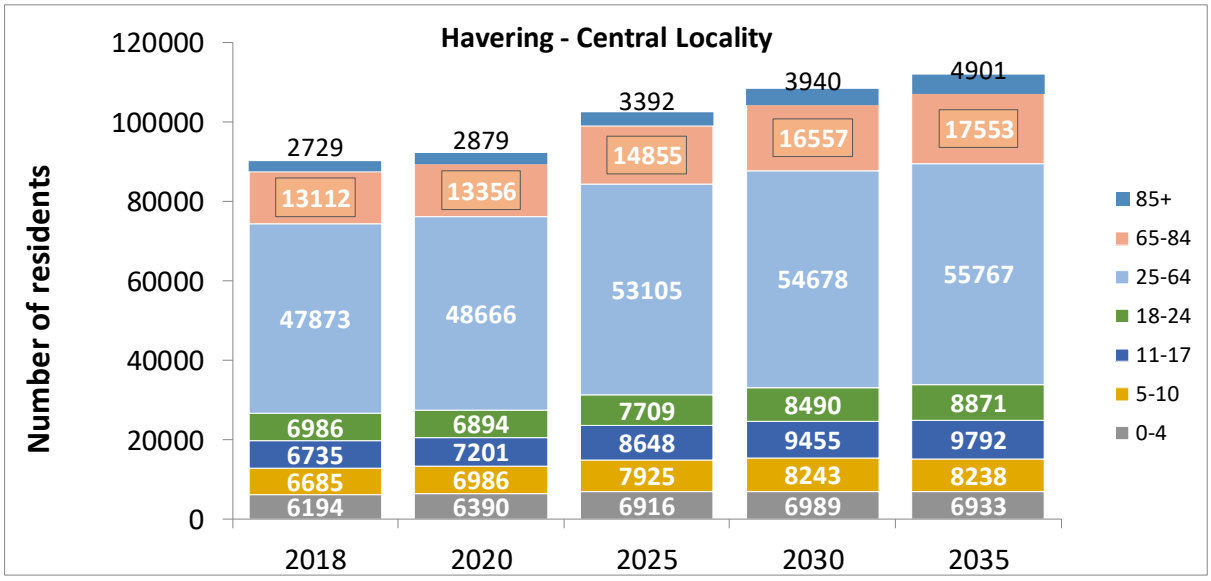
	HAVERING CREST			Marshall PCN			North PCN			South PCN		
AGE BAND (YEARS)	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**
0_4	1380	1456	2836	1410	1534	2944	2820	3031	5851	2966	3001	5967
5_9	1340	1415	2755	1384	1412	2796	2964	3061	6025	2971	3142	6113
10_14	1209	1266	2475	1278	1268	2546	2747	2836	5583	2930	2898	5828
15_19	1063	1136	2199	1153	1197	2350	2360	2487	4847	2730	2804	5534
20_24	1233	1177	2410	1212	1167	2379	2484	2447	4931	2888	2997	5885
25_29	1669	1468	3137	1661	1430	3091	3101	2780	5881	3393	3493	6886
30_34	1835	1652	3487	1859	1626	3485	3573	3065	6638	3757	3563	7320
35_39	1594	1544	3138	1713	1716	3429	3459	3311	6770	3549	3479	7028
40_44	1334	1429	2763	1480	1521	3001	2825	2769	5594	3242	3171	6413
45_49	1386	1361	2747	1404	1520	2924	2828	2815	5643	3386	3346	6732
50_54	1452	1505	2957	1586	1598	3184	2889	2855	5744	3845	3736	7581
55_59	1331	1377	2708	1443	1390	2833	2606	2620	5226	3779	3744	7523
60_64	1114	1136	2250	1240	1173	2413	2122	2207	4329	3113	3144	6257
65_69	908	867	1775	1089	988	2077	1809	1709	3518	2853	2608	5461
70_74	918	764	1682	1174	1050	2224	1897	1619	3516	2970	2614	5584
75_79	714	562	1276	847	664	1511	1249	1025	2274	2260	1711	3971
80_84	643	433	1076	710	493	1203	1003	730	1733	1908	1406	3314
85_89	406	269	675	546	329	875	672	438	1110	1407	851	2258
90_94	177	84	261	282	125	407	425	157	582	668	308	976
95+	76	21	97	78	29	107	143	52	195	199	54	253
Total	**21782**	**20922**	**42704**	**23549**	**22230**	**45779**	**43976**	**42014**	**85990**	**54814**	**52070**	**106884**

Source: NHS Digital GP Registrations (June 2019)

1.4 LBH Central Location Population Projections 2020, 2025, 2030, 2035

Area	2018	2020	2025	% change	2030	% change	2035	% change
Central	90,314	92,372	102,550	13.6%	108,352	20.0	112,055	24.1

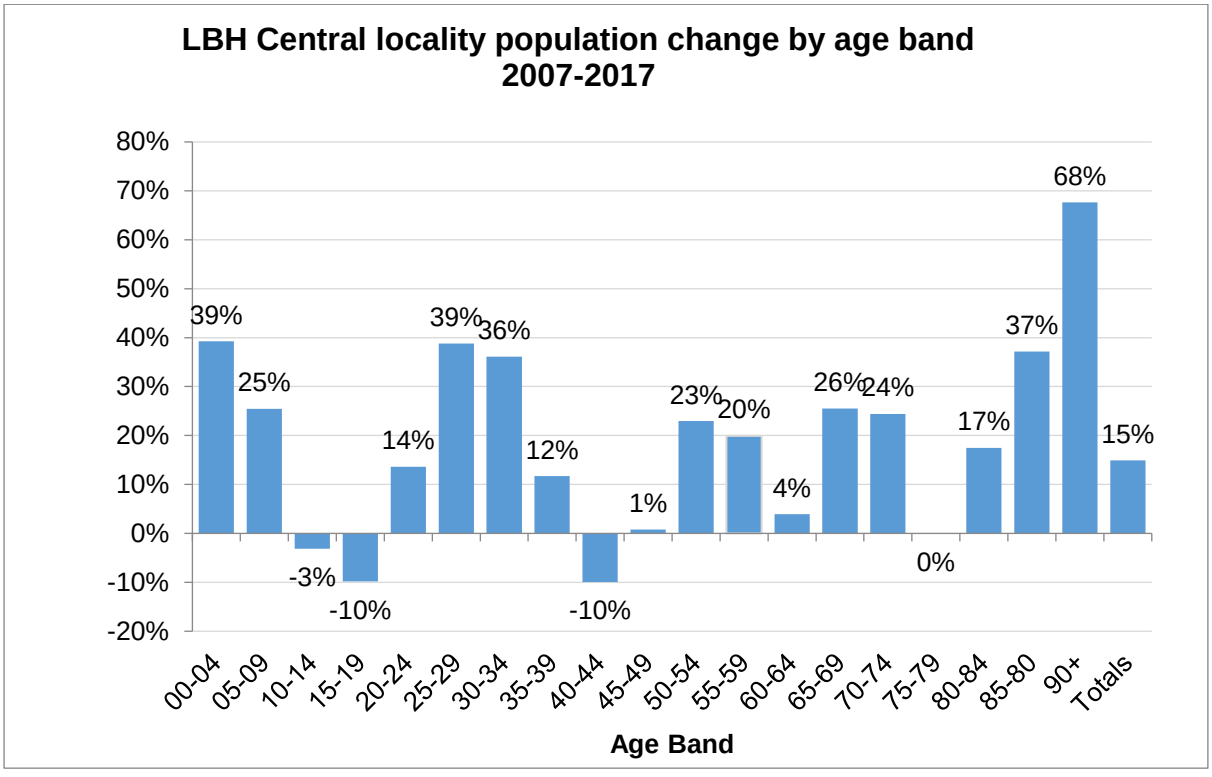
Central	2018	2020	2025	2030	2035
0-4	6194	6390	6916	6989	6933
5-10	6685	6986	7925	8243	8238
11-17	6735	7201	8648	9455	9792
18-24	6986	6894	7709	8490	8871
25-64	47873	48666	53105	54678	55767
65-84	13112	13356	14855	16557	17553
85+	2729	2879	3392	3940	4901
Total	90,314	92,372	102,550	108,352	112,055



Source: GLA Household led population projections using 2016 SHLAA

1.5 LBH Central Locality population change by age band 2007 - 2017

Age Band	2007	2017	Change	%
00-04	4,317	6,011	1,694	39.2%
05-09	4,271	5,358	1,087	25.5%
10-14	4,834	4,681	-153	-3.2%
15-19	5,186	4,678	-508	-9.8%
20-24	4,658	5,292	634	13.6%
25-29	5,190	7,204	2,014	38.8%
30-34	4,964	6,758	1,794	36.1%
35-39	5,735	6,406	671	11.7%
40-44	6,106	5,498	-608	-10.0%
45-49	5,911	5,958	47	0.8%
50-54	5,005	6,154	1,149	23.0%
55-59	4,757	5,705	948	19.9%
60-64	4,390	4,563	173	3.9%
65-69	3,290	4,129	839	25.5%
70-74	3,063	3,811	748	24.4%
75-79	2,754	2,750	-4	-0.1%
80-84	2,011	2,362	351	17.5%
85-89	1,174	1,610	436	37.1%
90+	516	865	349	67.6%
Totals	78,132	89,793	11,661	14.9%



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

Crime	Number of cases			
	Central	North	South	Havering
Non-domestic abuse and violence with injury offences *	672	351	241	1,264
Domestic abuse offences **	821	1067	646	2,534
Knife crime offences ***	147	102	90	339

*rolling 12 months to 1st April 2019
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Source: MOPEC crime dashboards

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1.8 Mosaic – Havering Central Locality household segmentation data 2018

Number of households in Central Locality classified by Mosaic groups

Mosaic Group	Totals
A Country Living	0
B Prestige Positions	3895
C City Prosperity	299
D Domestic Success	7856
E Suburban Stability	3581
F Senior Security	4269
G Rural Reality	0
H Aspiring Homemakers	4194
I Urban Cohesion	2302
J Rental Hubs	7274
K Modest Traditions	419
L Transient Renters	269
M Family Basics	634
N Vintage Value	1528
O Municipal Tenants	1631
U Unclassified	0
Totals	38151

1.9 Projected new homes in South Locality

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.

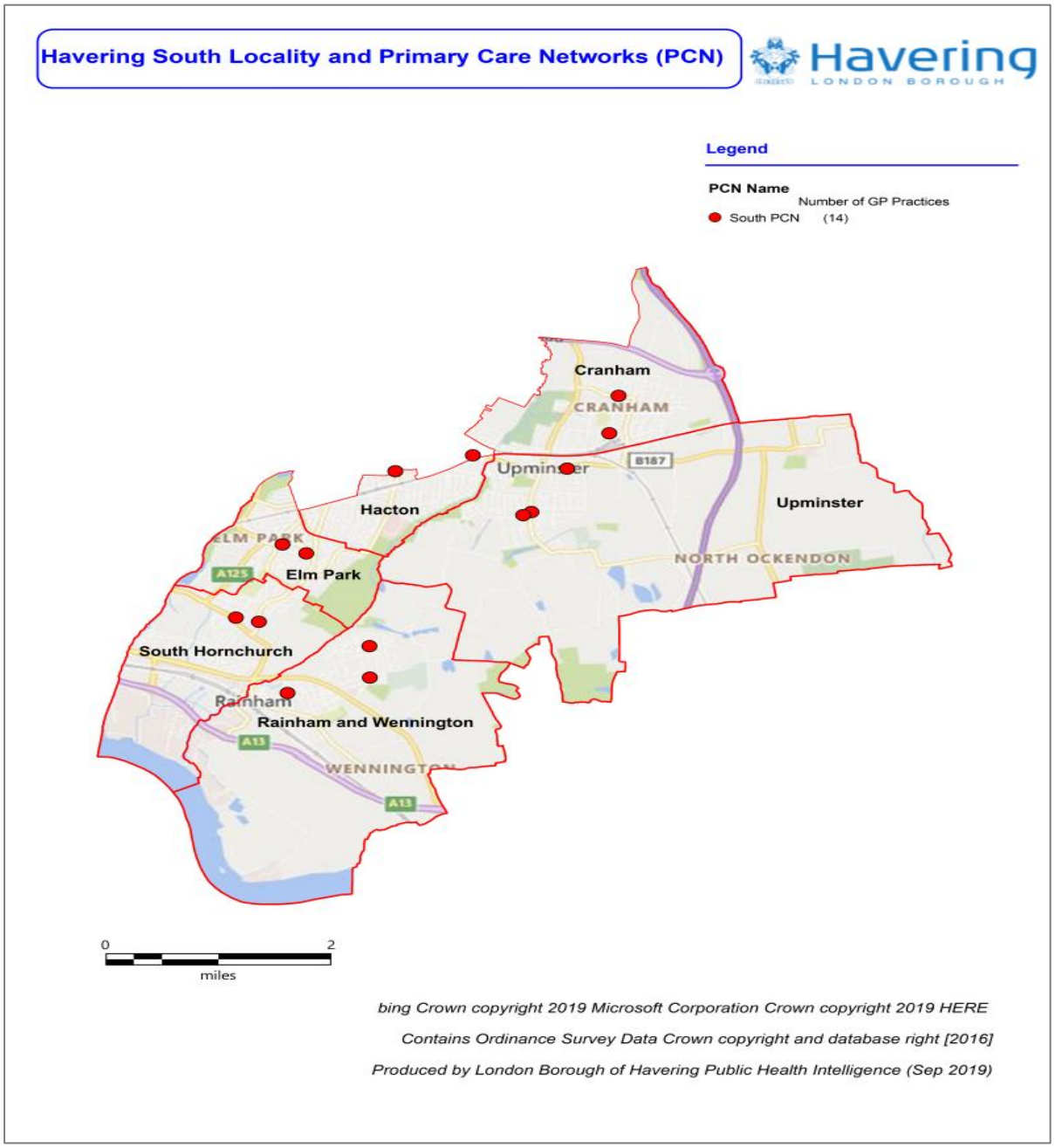
Locality	Number of houses
Central	4992
North	717
South	3702
Total	9411

London Borough of Havering (LBH) – South Locality

1. Places and Communities

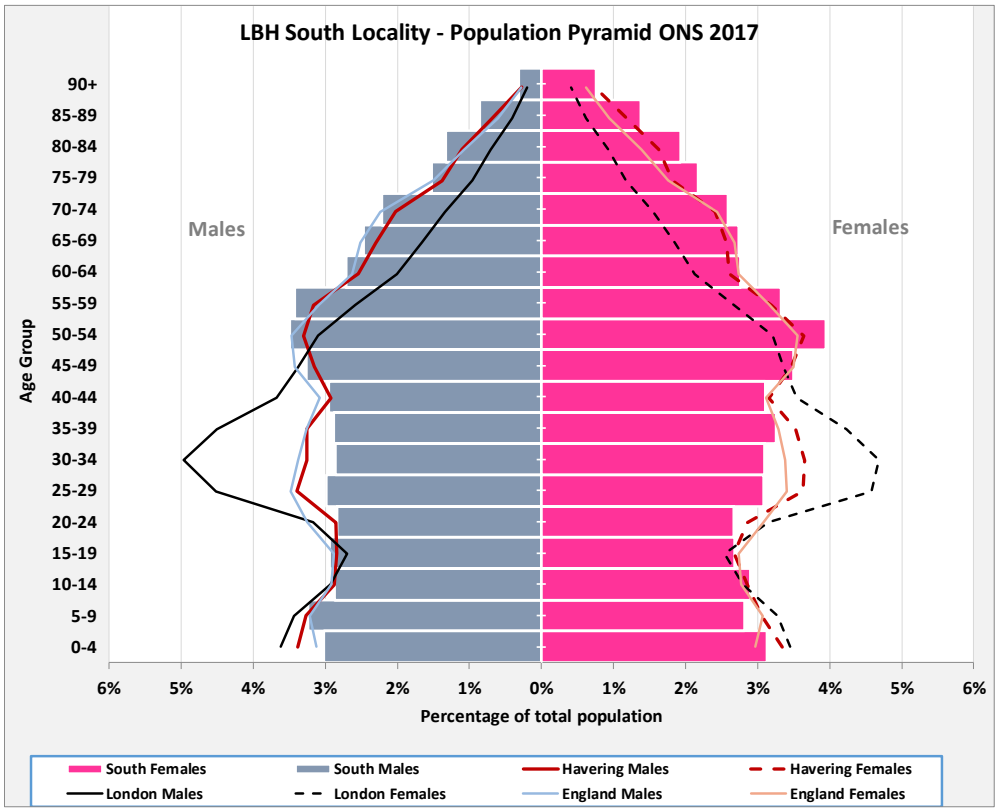
1.1 Havering south locality map

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 - 2017

Age Band (Years)	Female	Male	Totals
0-4	2,491	2,405	4,896
5-9	2,242	2,581	4,823
10-14	2,311	2,286	4,597
15-19	2,135	2,344	4,479
20-24	2,120	2,253	4,373
25-29	2,458	2,372	4,830
30-34	2,465	2,274	4,739
35-39	2,587	2,296	4,883
40-44	2,471	2,349	4,820
45-49	2,785	2,598	5,383
50-54	3,139	2,777	5,916
55-59	2,650	2,724	5,374
60-64	2,197	2,160	4,357
65-69	2,180	1,961	4,141
70-74	2,063	1,762	3,825
75-79	1,731	1,210	2,941
80-84	1,538	1,056	2,594
85-89	1,096	684	1,780
90+	604	252	856
Totals	41,263	38,344	79,607



Source: ONS 2017 Mid-Year Estimates

1.3 LBH PCN Profile - GP population 5 year age groups

	HAVERING CREST			Marshall PCN			North PCN			South PCN		
AGE BAND (YEARS)	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**	**F**	**M**	**PER**
0_4	1380	1456	2836	1410	1534	2944	2820	3031	5851	2966	3001	5967
5_9	1340	1415	2755	1384	1412	2796	2964	3061	6025	2971	3142	6113
10_14	1209	1266	2475	1278	1268	2546	2747	2836	5583	2930	2898	5828
15_19	1063	1136	2199	1153	1197	2350	2360	2487	4847	2730	2804	5534
20_24	1233	1177	2410	1212	1167	2379	2484	2447	4931	2888	2997	5885
25_29	1669	1468	3137	1661	1430	3091	3101	2780	5881	3393	3493	6886
30_34	1835	1652	3487	1859	1626	3485	3573	3065	6638	3757	3563	7320
35_39	1594	1544	3138	1713	1716	3429	3459	3311	6770	3549	3479	7028
40_44	1334	1429	2763	1480	1521	3001	2825	2769	5594	3242	3171	6413
45_49	1386	1361	2747	1404	1520	2924	2828	2815	5643	3386	3346	6732
50_54	1452	1505	2957	1586	1598	3184	2889	2855	5744	3845	3736	7581
55_59	1331	1377	2708	1443	1390	2833	2606	2620	5226	3779	3744	7523
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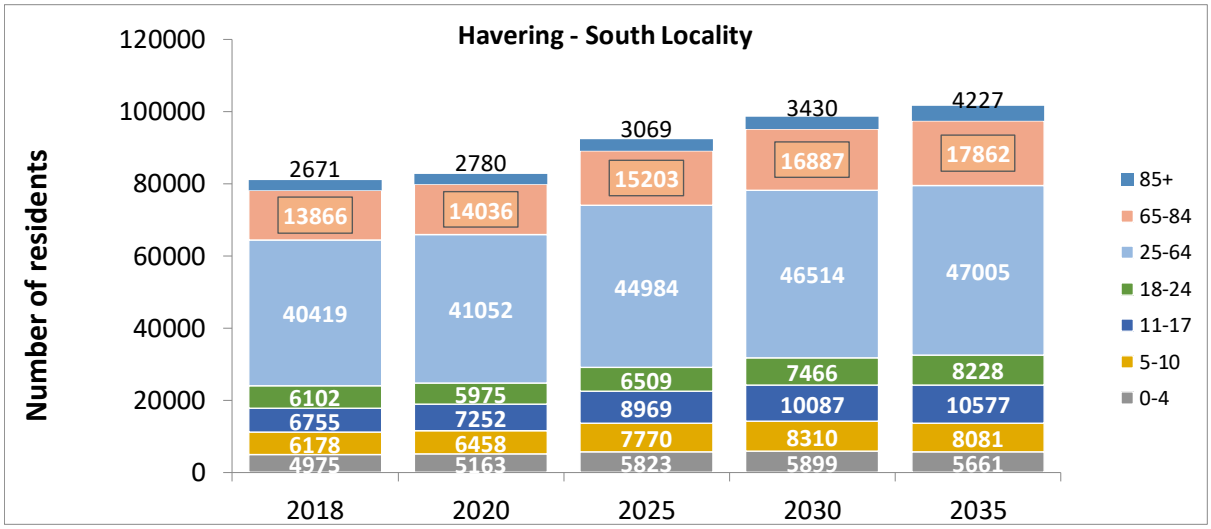
90_94	177	84	261	282	125	407	425	157	582	668	308	976
95+	76	21	97	78	29	107	143	52	195	199	54	253
Total	**21782**	**20922**	**42704**	**23549**	**22230**	**45779**	**43976**	**42014**	**85990**	**54814**	**52070**	**106884**

Source: NHS Digital GP Registrations (June 2019)

1.4 LBH South Location Population Projections 2020, 2025, 2030, 2035

Area	2018	2020	2025	% change	2030	% change	2035	% change
South	80,966	82,716	92,327	14.0	98,593	21.8	101,641	25.5

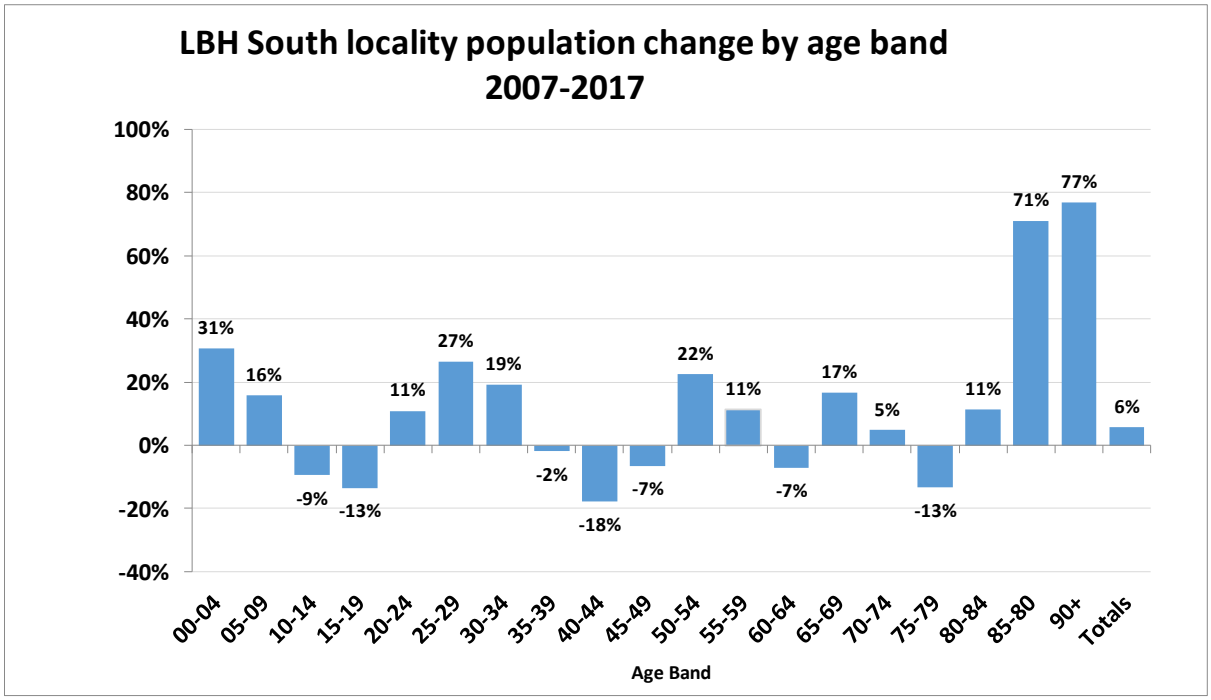
South	2018	2020	2025	2030	2035
0-4	4975	5163	5823	5899	5661
5-10	6178	6458	7770	8310	8081
11-17	6755	7252	8969	10087	10577
18-24	6102	5975	6509	7466	8228
25-64	40419	41052	44984	46514	47005
65-84	13866	14036	15203	16887	17862
85+	2671	2780	3069	3430	4227
Total	80,966	82,716	92,327	98,593	101,641



Source: GLA Household led population projections using 2016 SHLAA

1.5 LBH South Locality population change by age band 2007 - 2017

Age Band	2007	2017	Change	%
00-04	3,747	4,896	1149	31%
05-09	4,165	4,823	658	16%
10-14	5,077	4,597	-480	-9%
15-19	5,177	4,479	-698	-13%
20-24	3,944	4,373	429	11%
25-29	3,818	4,830	1012	27%
30-34	3,974	4,739	765	19%
35-39	4,975	4,883	-92	-2%
40-44	5,862	4,820	-1042	-18%
45-49	5,761	5,383	-378	-7%
50-54	4,830	5,916	1086	22%
55-59	4,823	5,374	551	11%
60-64	4,696	4,357	-339	-7%
65-69	3,545	4,141	596	17%
70-74	3,649	3,825	176	5%
75-79	3,391	2,941	-450	-13%
80-84	2,327	2,594	267	11%
85-89	1,040	1,780	740	71%
90+	484	856	372	77%
Totals	75,285	79,607	4322	6%



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

Crime	Number of cases			
	Central	North	South	Havering
Non-domestic abuse and violence with injury offences *	672	351	241	1,264
Domestic abuse offences **	821	1067	646	2,534
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Source: MOPEC crime dashboards

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https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/domestic-and-sexual-violence-dashboard

1.8 Mosaic – Havering Central Locality household segmentation data 2018

Number of households in Central Locality classified by Mosaic groups

Mosaic Group	Totals
A Country Living	213
B Prestige Positions	3431
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G Rural Reality	33
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I Urban Cohesion	797
J Rental Hubs	1707
K Modest Traditions	1243
L Transient Renters	392
M Family Basics	1687
N Vintage Value	989
O Municipal Tenants	646
U Unclassified	0
Totals	32357

1.9 Projected new homes in South Locality

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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

Anthony Wakhisi
Principal Public Health Specialist
London Borough of Havering
Mercury House, Mercury Gardens, Romford, RM1 3SL

Email: anthony.wakhisi@havering.gov.uk