Barking & Dagenham

Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 13 September 2022 - 6:00 pm
Council Chamber, Town Hall, Barking

Date of publication: 5th September 2022

Fiona Taylor
Acting Chief Executive

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Membership

Cllr Maureen Worby (Chair)	LBBD (Cabinet Member for Adult Social Care and Health Integration)
Dr Jagan John (Deputy Chair)	NHS North East London Clinical Commissioning Group
Elaine Allegretti	LBBD (Strategic Director, Children and Adults)
Matthew Cole	LBBD (Director of Public Health)
Louise Jackson	Metropolitan Police
Cllr Syed Ghani	LBBD (Cabinet Member for Enforcement and Community Safety)
Kathryn Halford	Barking Havering & Redbridge University NHS Hospitals Trust
Cllr Jane Jones	LBBD (Cabinet Member for Children's Social Care and Disabilities)
Cllr Elizabeth Kangethe	LBBD (Cabinet Member for Educational Attainment and School Improvement)
Sharon Morrow	NHS North East London Clinical Commissioning Group
Elspeth Paisley	BD Collective (Lifeline Community Resources)
Nathan Singleton	Healthwatch - Lifeline Projects Ltd.
Melody Williams	North East London NHS Foundation Trust

Standing Invited Guests

Cllr Paul Robinson	LBBD (Chair, Health Scrutiny Committee)
Narinder Dail	London Fire Brigade
Anju Ahluwalia	Independent Chair of the B&D Local Safeguarding Adults Board
Vacant	London Ambulance Service
Vacant	NHS England London Region

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting on 14 June 2022 (Pages 3 - 8)**

4. **Covid-19 Update in the Borough (Pages 9 - 17)**

5. **Monkey Pox Update (Pages 19 - 21)**

6. **Childhood Immunisations Report (Pages 23 - 30)**

7. **Integrated Care System Place Arrangements (Pages 31 - 55)**

8. **Pharmaceutical Needs Assessment (Pages 57 - 188)**

9. **Joint Strategic Needs Assessment (Pages 189 - 361)**

10. **Barking and Dagenham Place Partnership bid to NEL Integrated Care System for health inequalities funding in FY22/23 (Pages 363 - 374)**

11. **Barking and Dagenham Better Care Fund Plan (Pages 375 - 464)**

12. **Proposed Community Diagnostic Centre at Barking Community Hospital (Pages 465 - 472)**

13. **Forward Plan (Pages 473 - 479)**

14. **Any other public items which the Chair decides are urgent**

15. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

Private Business

The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

16. **Any other confidential or exempt items which the Chair decides are urgent**

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Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

Participation and Engagement

- To collaboratively build the foundations, platforms and networks that enable greater participation by:
  - Building capacity in and with the social sector to improve cross-sector collaboration
  - Developing opportunities to meaningfully participate across the Borough to improve individual agency and social networks
  - Facilitating democratic participation to create a more engaged, trusted and responsive democracy
- To design relational practices into the Council's activity and to focus that activity on the root causes of poverty and deprivation by:
  - Embedding our participatory principles across the Council's activity
  - Focusing our participatory activity on some of the root causes of poverty

Prevention, Independence and Resilience

- Working together with partners to deliver improved outcomes for children, families and adults
- Providing safe, innovative, strength-based and sustainable practice in all preventative and statutory services
- Every child gets the best start in life
- All children can attend and achieve in inclusive, good quality local schools
- More young people are supported to achieve success in adulthood through higher, further education and access to employment
- More children and young people in care find permanent, safe and stable homes
- All care leavers can access a good, enhanced local offer that meets their health, education, housing and employment needs
- Young people and vulnerable adults are safeguarded in the context of their families, peers, schools and communities

- Our children, young people, and their communities' benefit from a whole systems approach to tackling the impact of knife crime
- Zero tolerance to domestic abuse drives local action that tackles underlying causes, challenges perpetrators and empowers survivors
- All residents with a disability can access from birth, transition to, and in adulthood support that is seamless, personalised and enables them to thrive and contribute to their communities. Families with children who have Special Educational Needs or Disabilities (SEND) can access a good local offer in their communities that enables them independence and to live their lives to the full
- Children, young people and adults can better access social, emotional and mental wellbeing support - including loneliness reduction - in their communities
- All vulnerable adults are supported to access good quality, sustainable care that enables safety, independence, choice and control
- All vulnerable older people can access timely, purposeful integrated care in their communities that helps keep them safe and independent for longer, and in their own homes
- Effective use of public health interventions to reduce health inequalities

Inclusive Growth

- Homes: For local people and other working Londoners
- Jobs: A thriving and inclusive local economy
- Places: Aspirational and resilient places
- Environment: Becoming the green capital of the capital

Well Run Organisation

- Delivers value for money for the taxpayer
- Employs capable and values-driven staff, demonstrating excellent people management
- Enables democratic participation, works relationally and is transparent
- Puts the customer at the heart of what it does
- Is equipped and has the capability to deliver its vision

MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 14 June 2022
(6:00 - 8:10 pm)

Present: Cllr Maureen Worby (Chair), Dr Jagan John (Deputy Chair), Elaine Allegretti, Matthew Cole, Cllr Syed Ghani, Cllr Jane Jones, Cllr Elizabeth Kangethe, Sharon Morrow, Elspeth Paisley, Nathan Singleton, Melody Williams and Kathryn Halford

Also Present: Cllr Paul Robinson

1. Apologies for Absence

No apologies were received.

2. Declaration of Members' Interests

The Director of Integrated Care (DIC) at North East London Foundation Trust (NELFT) declared an interest in relation to Item 56, Adult Emergency Duty Team Service.

The Representative from Healthwatch declared an interest in relation to Item 60, Award of Contract for Provision of Barking and Dagenham Healthwatch to Lifeline Community Projects.

The Chair did not rule that these were disqualifying interests.

3. Minutes (15 March 2022)

The minutes of the meeting held on 15 March 2022 were confirmed as correct.

4. Covid-19 update in the Borough

The LBBD Director of Public Health (DPH) updated the Board. There had been an increase in cases and the Omicron variant remained the most prominent. However there had not been an increase in hospital admissions.

The DPH added that testing had largely ceased outside of care homes and hospitals and, therefore, it was likely that recorded numbers understated the true rate of infections. The DPH clarified that the Government had no plans to reinstate mandatory testing.

The Board noted the update.

5. Adult Emergency Duty Team Service

The Board were asked by LBBD's Director of Operation and Strategy (DOS) to consider renewing the proposed contract with NELFT for the Adult Emergency Duty Team Service. The Council had a duty under the Care Act 2014 and the Mental Health Act 1982 in relation to the assessment of an individual's care needs.

In addition to Barking and Dagenham, the contract would also include Havering, Redbridge and Waltham Forest and the contracted cost of providing the service would be split between all four borough councils. The DOS added that it was a partnership arrangement under Section 75 of the NHS Act 2006.

The DOS explained that, as it was a single service contract, the highly specialised nature of the service, complexity of the needs of the boroughs and high user satisfaction, the service was not placed out to tender. Therefore, the DOS requested the Board also agree to waive Rule 28.5 of the Contract Regulations to allow for a direct award and confirmed senior officers within the contract and procurement sections had been consulted and that the proposal was compliant.

The DOS highlighted the contract was for the amount of £2,126,921.00 for which Barking and Dagenham Council's share would be £531,742.75. The contract would commence on 1 April 2022 and terminate on 31 March 2025.

In response to questioning, the DOS explained that it was an out of hours service that focused on adults and that whilst there was some crossover with the NHS Crisis Service, the Crisis service's role differed as it treated adolescents and children and made initial assessments whereas the Adult Emergency Duty Team Service often worked with other parties.

The Board **resolved** to

(i) Agree to the Section 75 agreement between NELFT and the London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, to deliver the Adult Emergency Duty Team service on behalf of Barking and Dagenham for three years from 1 April 2022 to 31 March 2025; and

(ii) Agree to waive Rule 28.5 of the Council's Contract Rules to give approval for direct award and for the commission of the emergency care provider on the basis that these were personalised services under Rule 5.1(d) of the Contract Rules.

6. The Integrated Care System Local Borough Partnership Governance Proposal

LBBD's Interim Consultant in Public Health (ICPH) updated the Committee on the Integrated Care System (ICS).

Following the passing of the Health and Social Care Act 2022, the ICS would be established from 1 July 2022. The purpose of the act was to promote a more equal partnership between the NHS, providers, commissioners, local authorities and other local partners. There would be two key bodies; an Integrated Care Board and an Integrated Care Partnership.

A Shadow Partnership Board (SPB) will be established to oversee the introduction of the ICS and would aim:

- To work in partnership to improve health and wellbeing and reduce inequalities;

- To set a local system vision and strategy;
- To develop the Place Based Partnership Plan for B&D ('PBP Plan');
- To provide system wide accountability for the delivery and performance of the PBP plan;
- To review and assess new and revised models of care and to achieve agreed outcomes;
- To develop and deliver a framework of community engagement;
- To provide direction and oversee progress to the life course workstreams (adults, and children and young people);
- To provide a forum to share insight and intelligence into local quality matters, identify opportunities for improvement and identify concerns and risk to quality
- To have oversight of how resources are utilised at place to inform discussions on how best to use money across the system;
- To support the ICS to deliver against its strategic priorities;
- To develop the formal Place Based Partnership governance at place for 1 April 2023

The ICPH then took the Board through the proposals which would see the establishment of an Integrated Care Board (ICB) Sub-Committee by June 2022. Over the next ten months it was envisaged that, in consultation with external stakeholders, appointment to key roles would take place and there would be clarification on the nomination of the person to lead it, the functions presently held by North East London Clinical Commissioning Group (NELCCG) and the number of sub-groups and the scope thereof.

The Chair noted that guidance was still outstanding on the SPB. The Chair also reiterated her concern in relation to balance and accountability noting that the large number of clinical specialists could result in the side-lining of other stakeholders. However, the Chair stated her support for collaboration and the proposal in principle.

The DIC at NELFT explained that the membership of the new bodies will be reviewed after a year and a substructure would be placed below the boards which would feed back to the main board.
The DPH clarified that the arrangements would be in shadow form until 31st March 2023 to enable adjustments to be made and that it will not be formally implemented until 1st April 2023.

The Board agreed to the proposal in principle but requested that the issues raised be addressed in future updates.

7. Place Partnership Lead - ICS Place Based Partnership

The DPH advised the Board on the arrangements that where in place to appoint the Place Partnership Lead.

The appointee would be responsible for the delivery of the shared plan and outcomes for the place based and working arrangements with local partners. The suitable candidate would be appointed subject to Barking and Dagenham Council and ICB agreeing to the appointment.

A white paper was published in February and the consultations have since

concluded however no guidelines have been published. Therefore, the imposition of the ICS will result in process and practices being adjusted based on experience and feedback so will evolve as a result. The Chair stated that the Council could nominate persons for the partnership lead, however it would have to bear in mind what is envisaged for the role.

The Board noted the report.

8. Barking and Dagenham Place Partnership bid to NEL Integrated Care System for health inequalities funding in FY22/23

The LBBD Director of Public Health (DOS) updated the Board. North East London Health and Care Partnership (NEL) had been given £6.6 million by the Government to address health inequalities and had focused on place based approaches. Circa £500,000 had been allocated to support leadership, partnership working and capacity building and circa £600,000 for specific programmes on deprivation, specific programmes. The bids and programmes were required to comply with the NHS operating plan.

The bids had been prepared and were to be submitted on 17 June, with NEL announcing the outcome on 27 June and implementation beginning on 11 July 2022.

The Board **resolved** to approve the proposal subject to any objections being raised offline.

9. Award of contract for Provision of Barking and Dagenham Healthwatch to Lifeline Community Projects

In September 2021 the Board agreed to delegate to the Interim Chief Executive, in consultation with the Chair, the awarding of the contract for the provision of Barking and Dagenham Healthwatch subject to the Board being updated on the award. Lifeline Community Projects was awarded the contract following a competitive tender. LBBD Head of Commissioning - Disabilities (HCD) explained that the contract awarding process involved two local residents with specialist knowledge of services in the borough and that they were part of the evaluation process for the award.

The contract was for three years with an option to extend the contract by one year. The contract can be extended twice so the maximum term would be five years.

The Healthwatch Representative noted that one of the challenges they faced was raising Healthwatch's profile with the public. The Chair noted that it was not initially clear what Healthwatch's role in the ICS would be when the Board discussed the matter in September 2021. The Chair requested that the Council health commissioners discuss with Healthwatch their role in the ICS and that this be added to Healthwatch's obligations when the formal decision letter is sent.

The Board noted the update and **resolved** to agree to ratify the contract decision.

10. Update on LBBD's Early Help Strategy and Best Chance Family Hubs

The LBBD Head of Commissioning- Childrens' (HCC) updated the Board on the

changes relating to the directives from the Government in relation to family development hubs and early help strategy. The newly established Department of Levelling Up, Housing and Communities (DLHC) had joined with the Department to Education (DOE) as well as the Department of Health and Social Care (DHSC) in drawing up the directives. The HSC stressed that that was not just the responsibility of local authorities and would be delivered by numerous stakeholders. This would make delivery challenging and the timescales over the next two years would be tight.

The number of required outcomes had been increased from six to twelve. The Government had also aligned the Supporting Families programme with the new Family Hub and Start for Life. In addition to this, it was anticipated that the DLHC will be carrying out an assurance visit, most likely in July, in relation to the early help strategy.

The DLHC had stated that the Council must report on ten formal outcomes and the performance data relating to each stakeholder must be collectively reported. The Council had been given two years to implement the mechanisms to collectively report performance data.

The family hubs were intended to provide services for families with children and young people up to the age of 19, or 25 in the case of disability or special educational needs. The HCC explained that family hubs had three principles:

- Access: a simple point of access for help and support;
- Connection: service professionals work together to ensure close coordination among services and seamless transfer between them; and
- Relationships: building on family strengths.

The HCC added that the proposal must include digital as well as physical provisions and disclosed that Barking and Dagenham Council was one of 75 local authorities eligible for ‘Start for Life’ and ‘Family Hub Network’ funding. However, it had not been disclosed how much funding the Council would receive, though the HCC stated that it would be a formula based on population. Local authorities were expected to continue to fund existing requirements.

The plan would entail the establishment of three hub networks within the borough with hubs for the north, west and east. Schools would be part of the network as well as community hubs. Services would be integrated and would include:

- Family Navigators;
- Health Visitors;
- Targeted Early Help;
- Parenting Programmes;
- Parental Support;
- Peri-Natal Mental Health Support;
- Domestic Abuse Support;
- Substance Misuse; and
- Youth Services;

The Board praised the proposals however noted that there did not appear to be input from the voluntary sector. The Board also highlighted that a significant

proportion of the Borough's population lived in digital poverty and thus the plan should factor this in. The Board also emphasised that Barking and Dagenham's needs differed from neighbouring boroughs and that it was important that partner organisations tailored their approach.

The Board noted the update.

11. Forward Plan

The Board noted the Forward Plan.

HEALTH AND WELLBEING BOARD

13 September 2022

Title:	**Covid-19 update in the Borough**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Richard Johnston Performance & Intelligence Analyst	**Contact Details:** E-mail: Richard.johnston@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary:

The Board will be presented with the latest information regarding the Covid-19 situation in the borough, including the geographic and demographic spread of the virus, the latest mortality figures and progress made with the vaccination programme.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1. Review and provide feedback on the presentation.

Reason(s)

Keeping the Health and Wellbeing Board informed of the current Covid-19 situation in the borough.

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Coronavirus (COVID-19) Situation Report for the Health and Wellbeing Board

Barking & Dagenham

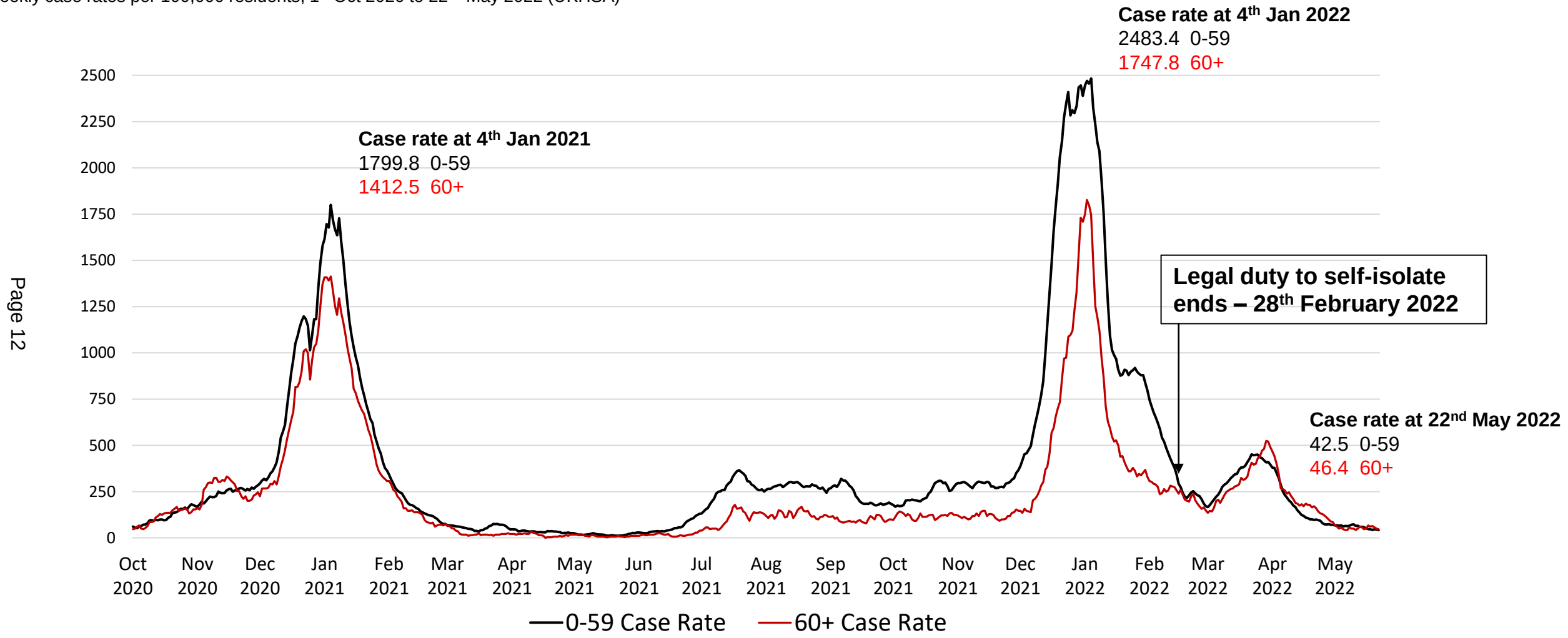
14th June 2022

one borough; one community; no one left behind

Covid-19 Cases in Barking and Dagenham

Positive cases

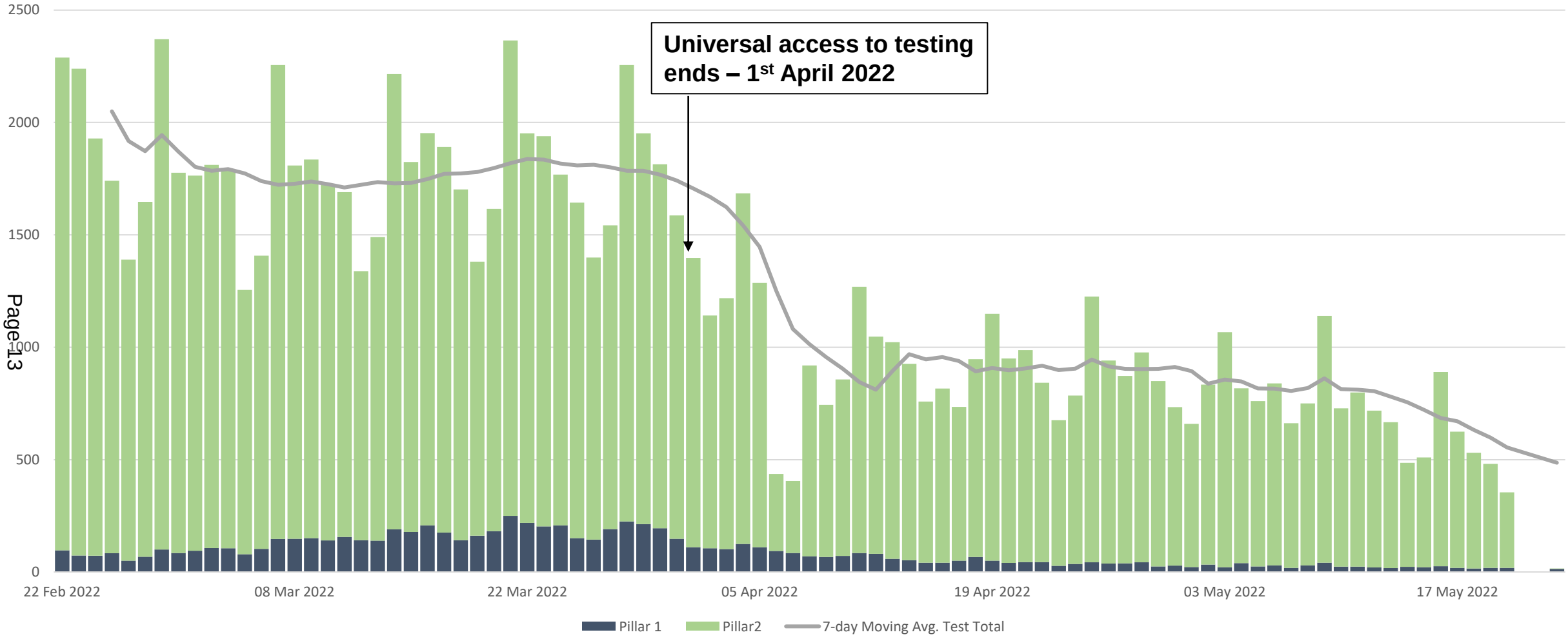
Weekly case rates per 100,000 residents, 1st Oct 2020 to 22nd May 2022 (UKHSA)



Covid-19 Testing in Barking and Dagenham

Residents tested for COVID-19

To 22nd May 2022 (UKHSA), 4 most recent days are provisional

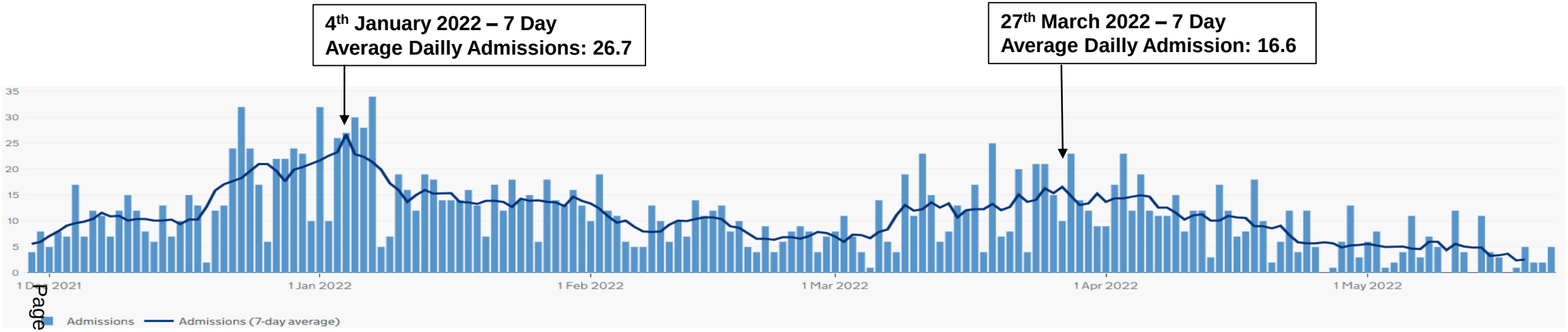


Barking & Dagenham

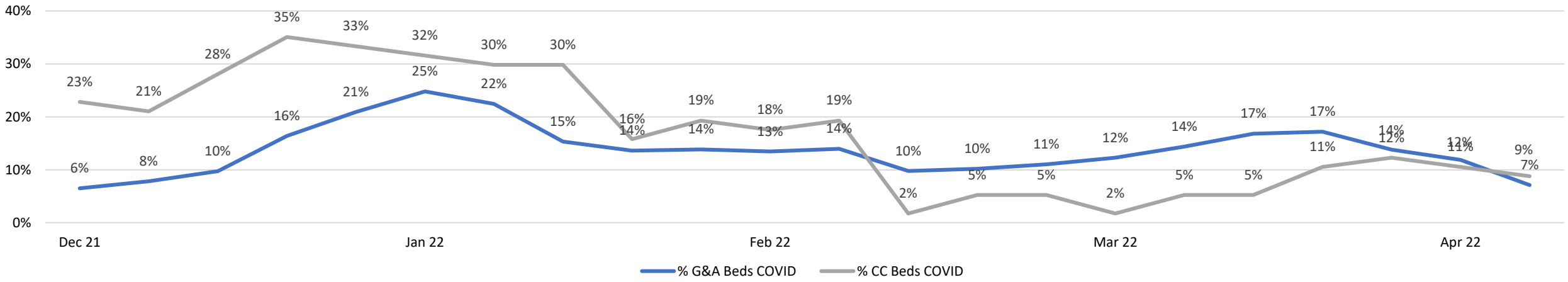
Covid-19 Hospitalisations in Barking and Dagenham

Hospital admissions testing positive for COVID-19

To w/e 19th May 2022 (NHS), 4 most recent days are provisional

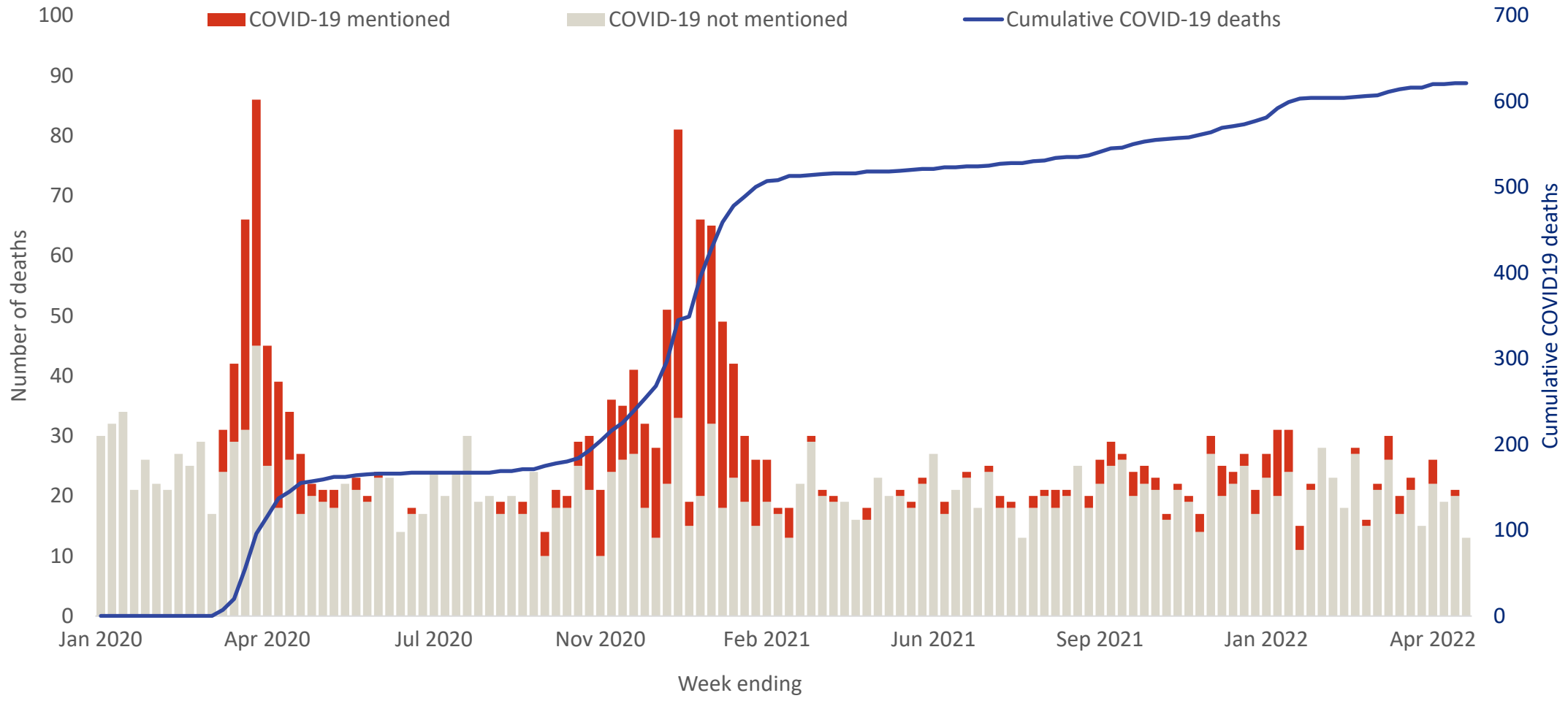


% BHRUT Hospital Bed Occupancy testing positive for COVID-19



Covid-19 Mortality in Barking and Dagenham

Trend in deaths that occurred from w/e 6th March 2022 to w/e 13th May 2022

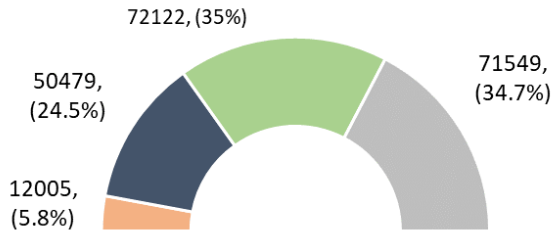


Barking & Dagenham

Vaccination

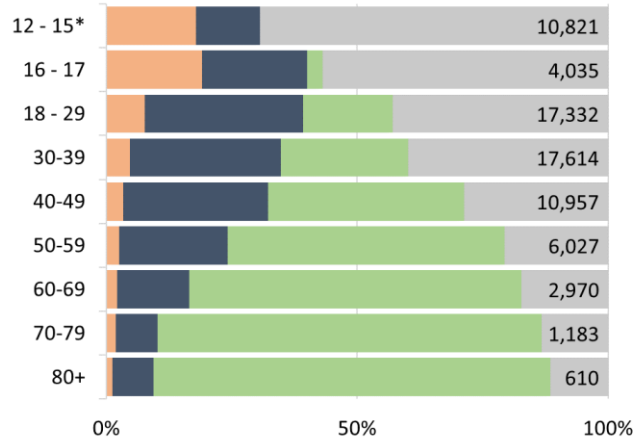
- The pace of vaccination delivery in the borough has slowed since our last meeting and is, for certain doses, slower than the rate of increase in the borough's NHS registered population.
- First dose vaccine coverage has increased marginally, but the percentage of borough residents aged 16 and above that have received a second or third dose has decreased slightly.
- Since the previous Health and Wellbeing board, the number of NHS registered residents aged 16 or above rose by 3,298, of which 1,469 have received at least 1 dose of the vaccine. This means the number of unvaccinated residents has risen from 59,022 to 60,581, of which, 10,790 are aged 50 or above.
- Dose 1 vaccination coverage has risen in residents aged 5-11 and 12-15 since our last meeting. As of 16th May, these groups are now 30.4% and 3.3% vaccinated respectively.
- Abbey ward still has the highest number and percentage of unvaccinated residents, followed by Gascoigne. The gap between the vaccination rates in these wards and the boroughs most vaccinated ward has narrowed slightly since the previous board meeting.
- The proportion of unvaccinated pregnant women in the borough is unchanged from our last meeting at 42%, this remains the highest proportion in North East London.

Latest vaccination uptake, people aged 12+ (16/05/2022)



Data source: UKHSA

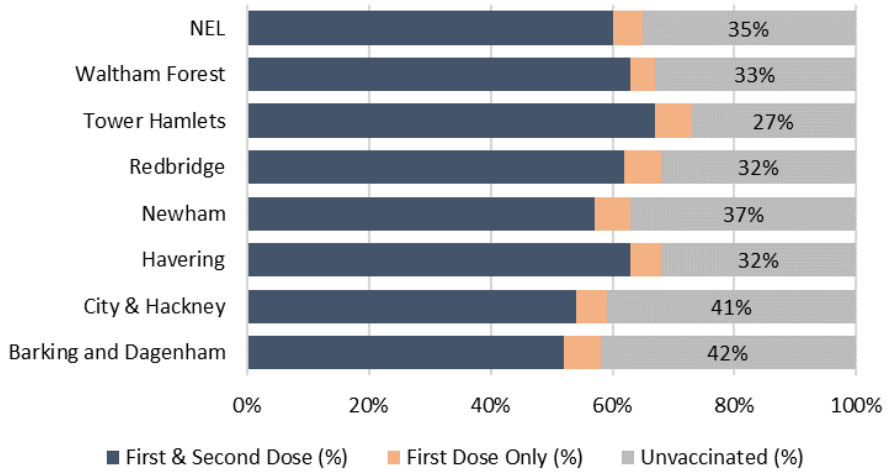
Vaccination uptake by age group (16/05/2022)



*Includes a small number of residents who have had more than one dose. The large majority of this age group are currently only expected to have one dose.

Data source: UKHSA

Vaccination uptake in pregnant women, NEL (12/05/2022)



Data source: North East London Clinical Commissioning Group

Dose 1 Dose 2 Dose 3 Unvaccinated

Barking & Dagenham

Covid-19 in London, 7 days to 19th May and hospitalisations as at 15th May 2022

Case rate

Weekly case rate (per 100,000)
- > 1000
- 600 - 1000
- 400 - 599
- 200 - 399
- < 200

Case rate change

7-day change in weekly case rate
- >100% increase
- 51 to 100% increase
- 10 to 50% increase
- Under 10% change
- 10 to 50% reduction
- 51 to 100% reduction

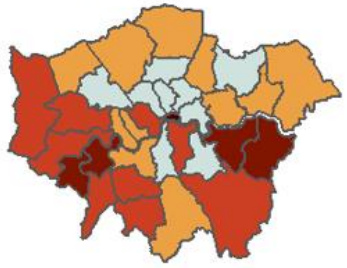
Positivity

Weekly percentage positive
- >10%
- 7.51% - 10%
- 4% - 7.5%
- < 4%

Tests

Daily average individuals tested per 100,000
- 240+
- 200
- 160
- 120
- 80
- 40

Weekly mortality



Weekly mortality rate (per 100,000)
- >= 3
- 2- <3
- 1- <2
- 0.5- <1
- < 0.5

Hospitalisations*

Weekly average hospital admissions
- 15
- 10
- 5
- 0

Produced by Outbreak Surveillance Team, UKHSA
Contains National Statistics data © Crown copyright and database right 2021
*Hospitalisation data shown for different time period, see figure heading
Use caution interpreting data after April 1st 2022 which is affected by reduced community testing data (Pillar 2). See Data sources section for detail

- In the week to 19th May, the all-age case rate in all London boroughs decreased. All boroughs now have all-age case rates below 100 cases per 100k residents and are rag rated green. The London average rate fell to 72.7 cases per 100k residents.
- The City of London's all age case rate rose by 118% to 219.4 cases per 100k residents.
- At the 19th May 2022, Barking and Dagenham has the second lowest all-age case rate in London with 44.4 cases per 100k. Redbridge has the lowest rate of 43.2 cases.
- Half of London's boroughs saw their 60+ case rate rise over the week to 19th May. Despite the rises, all but 4 boroughs have 60+ cases rates below 100 cases per 100k residents and are rag rated green. The largest increase was in the City of London, which saw its rate double to 87.7 cases.
- Barking and Dagenham's rate increased over the week from 42.8 cases per 100k residents to 53.3 cases; a 25% rise.
- Barking and Dagenham's PCR positivity rate rose from 1.7% to 2.9% over the week to rise just higher than the London average rat of 2.8%.
- The average PCR test rate in the capital is 95.5 per 100k residents. Barking and Dagenham remains below the average with a rate of 62.8, the lowest rate in the capital.
- Hospitalisations are lowest in the North East and South West boroughs of London.

Case rates, 7-day change, weekly mortality rate, weekly positivity, and 7-day moving daily average testing rates by Local Authority are for the period 13th May to 19th May.

Barking & Dagenham

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HEALTH AND WELLBEING BOARD

13 September 2022

Title:	**Monkeypox Update**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Matthew Cole, Director of Public Health.	**Contact Details:** E-mail: matthew.cole@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary:

Monkeypox is a rare infectious disease, usually associated with travel to west and central Africa. Since May 2022 we have been seeing an unusual number of cases increasing within the UK. However, the overall risk to the UK population remains low.

The national monkeypox epidemiological overview is available on the gov.uk website which includes a breakdown of cases by region and upper tier local authority by residence: https://www.gov.uk/government/publications/monkeypox-outbreak-epidemiological-overview

Monkeypox is a viral infection, spread by close contact with someone with the virus. Monkeypox can be passed on from person to person through:

- any close physical contact with monkeypox blisters or scabs (including during sexual contact, kissing, cuddling or holding hands)
- touching clothing, bedding or towels used by someone with monkeypox
- the coughs or sneezes of a person with monkeypox when they're close to you
- Anyone can get monkeypox, but currently most cases are in men who are gay, bisexual or have sex with men.
- As the virus spreads through close contact, we are advising these groups to be alert to any unusual rashes or lesions on any part of their body, especially their genitalia

At the beginning of May three incident / clusters of confirmed monkeypox cases were identified in the UK. A national Incident Management Team was stood up from 10th of May 2022 and became an enhanced incident on 15th of May. A London Coordination Incident Management Team began on 17thof May 2022.

- Incident #1 – Single confirmed case in returned traveller from Nigeria to London, onset symptoms 28th of April 2022.

- Incident #2 - Family of three. 2 confirmed cases, 1 probable. First onset 11th of April 2022. No known link to first incident; source remains unidentified.

- Incident #3 – Since 15th of May confirmed cases resident in London has been identified with onset of symptoms for some cases going back into April. The vast majority of the confirmed cases are known to be male with most being gay, bisexual or other men who have sex with men (GBMSM).

At the time of writing the total number of confirmed and highly probable cases in London is 2,240 with a change of 90 confirmed and highly probable cases in the last 7 days from 18th of August 2022. There is currently a small number of confirmed female cases in Incident #3. This number includes cisgender and transgender women and information, where known, does not indicate wider community transmission. The confirmed and highly probable cases in Barking and Dagenham were 12.

There were 238 confirmed and highly probable cases unassigned a to a local authority as no patient postcode was available, of these 45 were missing a local authority in the last 7 days. Confirmed and highly probable cases residing outside of London but being followed up by UKSHA not in London are not included.

The London Coronavirus Response Cell (LCRC) has been rebranded as the London Coordination and Response Cell to allow for a pan-London response. UKHSA have been working with British HIV Association/British Association for Sexual Health and HIV, Terrence Higgins Trust, and other stakeholders in Sexual Health Services (SHS) have been engaged both to inform Genito Urinary practitioners and for input into communications and health protection measures.

Based on recent data, the highest proportion of cases are in London. The outbreak Level is defined as level 2 which is defined as transmission within a defined sub-population, currently GBMSM connected by sexual networks. The route of transmission has been primarily reported as through close or sexual contact. The virus has been detected in air and environmental samples in the hospital room of infected patients, However, there are no confirmed instances of airborne transmission. The ongoing risk to the general public is considered low and most confirmed cases are mild.

Confirmed case isolation is mainly in the home setting with admission to specialist units if required. Contact tracing and contact management actions are reflected as per published contact tracing matrix guidance.

LCRC are completing risk assessments with all confirmed cases and backward contact tracing is in place, aiming to identify potential chains of transmission. All high-risk contacts are followed up by LCRC and all non-complex/ high risk contacts are being managed through a national contact management service.

Post-exposure vaccination is offered to high risk identified contacts and pre-exposure vaccination is now available in London for individuals at highest risk. Information regarding vaccination can be accessed here:

- Monkeypox outbreak: vaccination strategy - GOV.UK (www.gov.uk)
- Smallpox and monkeypox: the green book, chapter 29 - GOV.UK (www.gov.uk)

There has been a national briefing and information has been cascaded to local authorities, primary care and sexual health services highlighting the situation, along with

recommendations for testing, isolation, infection control practices, vaccination and public health management and the need to prioritise working with established community and sexual health networks.

Recommendation(s)
The Health and Wellbeing Board is recommended to:

1. Note the outbreak management steps being taken in London and that the ongoing risk to the general public is considered low and most confirmed cases are mild.

Reason(s)

Local Authority statutory responsibility.– Health Protection (LA powers) Regulations 2010 and Health Protection (part 2A orders) Regulations 2010. Director of Public Health has a statutory responsibility to ensure effective arrangements are in place for communicable disease control with local authorities and others (UKSHA,NHS Trusts, Private sector, GPs etc)

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HEALTH AND WELLBEING BOARD

13 September 2022

Title:	**Childhood Immunisations Report**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Author: Yaccub Enum, Public Health Principal	**Contact Details:** E-mail: yaccub.enum@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary:

Coverage of childhood immunisations in the borough is well below the 95% WHO target, particularly MMR. Uptake of seasonal influenza vaccinations were also very low last year. As we emerge from the COVID-19 pandemic with physical interactions returning to pre-pandemic levels and more relaxed infection prevention and control practices, there is increased risk of outbreaks of seasonal flu and other vaccine preventable illness like measles.

This report highlights what is being done at different levels to help increase uptake of immunisations and minimise the risk of outbreaks.

Recommendation(s)

1. The Health and Wellbeing Board is recommended to review and provide feedback on the report.
2. A multi-agency approach is needed involving the NHS, local authority, schools, community and faith groups, working with residents, to increase uptake of immunisations.
3. The enhanced infection prevention and control (IPC) measures implemented in various settings during the pandemic need to be maintained in the coming months to minimise the risk of outbreaks. This includes ensuring adequate IPC support to high risk settings like care homes and education settings.

Reason(s)

Immunisation is a simple and effective way of protecting children from serious illnesses. As well as helping protect individuals, it also protects the broader community by minimising the spread of infections.

The Director of Public Health has a statutory responsibility under the Health Protection (LA powers) Regulations 2010 and Health Protection (part 2A orders) Regulations 2010 to ensure effective arrangements are in place for communicable disease control with local

authorities and others including the NHS. Keeping the Health and Wellbeing Board informed of the current immunisation and vaccination situation in the borough helps the Board have oversight of these arrangements.

1. Introduction and Background

1.1 The UK is considered by the World Health Organization (WHO) to be polio-free, with low-risk for polio transmission due to the high level of vaccine coverage across the population. However, coverage for childhood vaccines has decreased nationally and especially in parts of London over the past few years. Childhood immunisations rates in London are below the WHO's target of 95%, with lower uptake in areas of high deprivation and for some ethnicities. This perpetuates existing inequalities.

1.2 Earlier this year, genetically related polio virus was found in sewage samples, which suggests that it is likely there has been some spread between closely linked individuals in North and East London. So far, the virus has only been detected in sewage samples and no associated cases of paralysis have been reported. There are ongoing investigations to establish if any community transmission is occurring. Even though the risk to the public is very low, vaccine-derived poliovirus has the potential to spread, particularly in communities where vaccine uptake is lower.

1.3 There is a need, therefore, for immediate and long-term actions to improve overall immunisation uptake and reduce inequalities. The report provides an update on the current picture of immunisations in Barking and Dagenham, and actions being taken to improve uptake. It will cover childhood immunisations, seasonal influenza and COVID-19 vaccinations.

2. Proposal and Issues

2.1 Where are we now?

Childhood immunisation coverage

Table 1 shows childhood immunisations in Barking and Dagenham, London and England. Coverage in the borough is generally below London and England averages, apart from the 6-in-1 vaccine (DTaP/IPV/Hib/Hep B) where our coverage is similar to London.

Table 1: Childhood immunisation coverage

	Barking & Dagenham				London	England
	2021/22				2021/22	2021/22
Vaccine	Q1	Q2	Q3	Q4	Q4	Q4
12 Month DTaP/IPV/Hib/Hep B	83.4%	84.8%	83.8%	87.0%	87.1%	91.9%
2-year MMR dose 1	74.2%	75.2%	78.2%	77.5%	80.7%	89.7%
5-year MMR dose 2	69.9%	67.9%	68.6%	67.7%	74.8%	85.9%
5-year DTaP/IPV Booster	68.1%	66.6%	67.3%	67.4%	72.8%	84.6%

School-aged vaccination uptake

As set out in Table 2, uptake of school-aged vaccination is generally higher in Barking and Dagenham compared to both London and England, with the exception of the tetanus, diphtheria and polio (Td/IPV) vaccine where uptake is below England.

Table 2: School-aged vaccination uptake – September 2020 to August 2021

Vaccine	Barking & Dagenham	London	England
Td/IPV	78.3%	71.7%	83.3%
Men ACWY	77.9%	71.1%	76.5%
HPV1 Girls	88.4%	71.0%	76.7%
HPV2 Girls	83.5%	33.7%	60.6%
HPV1 Boys	84.9%	67.0%	71.0%
HPV2 Boys	79.5%	32.2%	54.7%

Seasonal influenza vaccine uptake

Last year's uptake of the seasonal influenza vaccine was very low in all cohorts (see Table 3), well below the national ambitions. The lowest ambition was to achieve 70% uptake for 2-3 year olds and school-aged children.

Table 3: Seasonal influenza vaccine uptake – 2021/22

GP patients			
Cohort	Barking & Dagenham	London	England
2-year olds	36.9%	40.9%	48.7%
3-year olds	38.8%	42.3%	51.4%
65 and over	70.2%	70.8%	82.3%
Under 65 at risk	44.6%	42.5%	52.9%
50-64-year olds	38.5%	38.0%	52.5%
Pregnant	29.1%	30.2%	37.9%
School-aged children			
Reception	58.6%	52.2%	56.9%
Year 1	54.9%	52.5%	58.9%
Year 2	52.6%	52.1%	58.8%
Year 3	55.2%	50.9%	58.0%
Year 4	46.5%	49.9%	57.3%
Year 5	51.9%	48.3%	56.2%
Year 6	49.0%	47.1%	55.8%
Year 7	38.7%	41.4%	48.5%
Year 8	42.5%	38.0%	45.8%
Year 9	35.1%	34.1%	42.2%
Year 10	34.0%	33.6%	42.0%
Year 11	27.0%	28.9%	38.9%

COVID-19 vaccine

Uptake of the COVID-19 vaccination reduces with age, with children and young people having the lowest uptake. As at 15 August 2022, only 30% of 12-15 year-olds and 4.9% of 5-11 year-olds in the borough had been vaccinated, compared to 40.4% and 8.5% respectively in London. This low uptake may be a reflection of parents' (both vaccinated and unvaccinated parents) mistrust of the COVID-19 vaccination for children.

2.2 **What is being done to improve uptake?**

Response to poliovirus detection

A London Region Polio Vaccination Urgent Response Management Group has been convened to provide system leadership and to support collaboration on actions to protect public health by implementing control measures to prevent any possible transmission of poliovirus.

Actions underway include GP Practices contacting parents of children aged under 5 in London who are not up to date with their polio vaccinations to invite them to get protected. Immunisation Coordinators have been providing support to practices with this work. System partners are supporting this effort by sharing communications, particularly to those communities with low vaccine coverage. Materials such as a template letter to send to parents who have previously declined immunisations and communications assets have been shared with partners. Child Health Information Service (CHIS) have also provided details of children who are not registered with a GP practice and have incomplete polio immunisations with health visiting and school nursing services to support with getting these children registered with a GP practice and up to date with immunisations.

A polio booster campaign for children aged 1 to 9 years has recently been launched in London, with City and Hackney and Waltham Forest being prioritised in NEL due to poliovirus detection in these areas. All 1 to 9-year olds are to be offered a polio vaccination by 26 September. The Integrated Care Board (previously CCG) is working with local partners to develop delivery plans. Delivery across a range of providers and locations including primary care, Covid Vaccination Centres, School Aged Vaccination providers as well as outreach provision for communities with low vaccine coverage is being explored. Local intelligence and links with the voluntary and community sector will underpin much of this work. NHS England are progressing developments with enablers to support the programme, such as data flows, communications and engagement, financing, workforce and training.

Initial indications in Barking and Dagenham are that practices would be best placed to deliver this programme for younger children – either as part of 1 year old or the pre-school booster programme.

With approximately 30,000 children in Barking and Dagenham in the 1-9 year age range, this is potentially a big programme of work. Consideration will need to be given to other providers supporting delivery. There are risks and issues including vaccine supply, ordering logistics, storage of vaccine, workforce and workload implications.

Measles communications campaign

Between February and March 2022, a national MMR communications campaign was launched to encourage parents of children aged 1-5 years to come forward for their child's vaccination and to boost parents' confidence in getting their children vaccinated. Local partners supported with the dissemination of these messages.

A follow up campaign had been planned to take place this summer, but this has been delayed until mid-September due to prioritisation of the polio response.

School Immunisation Programmes

Provisional uptake figures for HPV, Men ACWY and the school leavers booster indicate that uptake for the academic year 2021/22 has decreased compared to previous years. This trend has also been seen across London and England. School Aged Immunisation Providers have reported poorer engagement and support from schools this year and vaccination programmes have been impacted by the 12-15-year-old COVID-19 vaccination programme being delivered in schools. Furthermore, issues previously reported, such as high numbers of non-returned consent forms and parental declines also persist and affect the ability to meet vaccine uptake targets.

Vaccination UK have developed an improvement plan to increase uptake which includes actions such as contacting parents of children with overdue vaccinations and/or refusals to invite them to community-based catch-up clinics being held over the summer. Vaccination UK have also been working closely with the Council to improve engagement with schools, promote walk-in catch-up clinics by displaying posters in public spaces such as libraries and GP practices and sharing promotional material via social media channels. Vaccination UK have also planned health promotion sessions for pupils in year 7 to provide information on the immunisation programmes provided in school and to provide engagement opportunities in advance of delivery. Communications materials are being produced in most commonly spoken languages in the borough and using local intelligence to best align service delivery to meet local needs.

Where a child has missed offers of vaccination, there remains an evergreen offer with parents able to change their minds and access the offer at a later date.

Seasonal influenza immunisation

London Flu Operational Delivery Group meetings resumed in April to provide strategic and operational support to planning for the upcoming influenza vaccination programme. The initial focus was on lessons learned and strategic direction. Workstream-specific workshops took place with local stakeholders over the summer to support the sharing of lessons learned and recommendations for the upcoming flu season. These workshops covered health inequalities, and flu vaccination for health and care workers, 2- and 3-year olds, under 65 at risk, and school-aged children.

Integration and alignment with the Covid vaccination programme and planning for effective delivery has been considered in more recent London Flu Operational Delivery Group meetings. Workstream leads and Integrated Care Boards (ICBs) have submitted their plans for review and comment. Vaccination UK have also completed flu plans in preparation for child flu vaccination programme delivery.

In July 2022, flu vaccination programme eligibility was extended to include 50-64-year olds and secondary school-aged children focusing on years 7, 8 and 9, with any remaining vaccine to be offered to years 10 and 11, subject to vaccine availability. As School Aged Immunisation Providers are also being considered to support the Polio booster campaign response, these additional asks within finite capacity will undoubtedly pose a continuing challenge for the delivery of school immunisation programmes for academic year 2022/23. Therefore, support from local stakeholders will be needed, especially in terms of helping with communications and engagement with schools.

To support vaccination of our under-served residents, Barking and Dagenham place team are commissioning housebound flu Local Improvement Scheme (LIS) for 2022/23. Practices have been asked to sign up to provide this service and there is a good response from practices. This LIS has been successful in previous years with 73% of housebound patients receiving their influenza vaccine via this route in 2021/22.

In line with Making Every Contact Count (MECC) a housebound visit for an influenza vaccination also includes other checks, such as those for Atrial Fibrillation, blood pressure monitoring and dementia checks.

By offering late evening and weekend appointments it is hoped to make the vaccine more accessible to those who previously felt unable to take time out of their work day to go and have the vaccine.

The Barking and Dagenham place team will review data on a weekly basis focusing on PCNs and practice level delivery to ascertain reasons for low uptake, then troubleshoot any concerns. Practices in the bottom 5% within Barking and Dagenham will be asked to develop an improvement plan.

As part of monitoring uptake the Barking and Dagenham place team will continue to monitor ICB, London and National trends to ensure that we are not under delivering in particular cohorts and ensure there is a proactive response to addressing concerns.

Our Public Health team has organised regular meetings with UK Health Security Agency (UKHSA), Adult Social Care and other Council departments to share learning and troubleshoot any issues.

<u>BCG/SCID Screening Pilot</u>

From September 2020 neonatal BCG became a targeted vaccination programme provided to those who have an increased risk of coming into contact with tuberculosis. Because this vaccination is no longer offered universally, this brings London in line with the rest of England. In Barking and Dagenham vaccination is provided in community-based locations by NELFT.

Eligibility is determined using the question:
Does your baby, the baby's mother, father, grandparents or anyone who lives with you come from a country with a high rate of TB?

A national evaluative pilot to test babies for SCID (severe combined immune deficiency) went live in September 2021. SCID is an extremely rare condition and

babies who test positive should not be given live vaccines, which includes BCG. The test is a bloodspot taken at day 5 of life by community midwives. A baby who tests positive for SCID will not be offered a BCG or other live vaccine.

Hepatitis B

A standard operating procedure is in place to manage situations where there is a deviation from the Hepatitis B immunisation programme for babies born to hepatitis B positive mothers and therefore at risk of developing hepatitis B infection. North east London Child Health Information Services (CHIS) are instrumental in the follow up with practices where vaccination has been delayed. Delays in vaccination of more than 2 weeks are considered an incident and are reported as such.

Programme challenges include primary care capacity, parental hesitancy and declines, even following conversations with clinicians on the risks associated with the baby not receiving vaccination, and families abroad for prolonged periods. Support is sought from ICB colleagues where situations are more complex or require safeguarding input. All incidents are managed by a clinical team within the Public Health department at NHS England, London Region.

COVID-19 phase 5 autumn campaign

An autumn campaign for Covid-19 vaccination starts on 5 September 2022. It will focus on offering a further dose of COVID-19 vaccination to over 50 year olds, those who are clinically vulnerable and health and care workers. The two previous Local Vaccination Sites (LVS) at Parsloes Surgery and Vicarage Field Shopping Centre are no longer available as sites. With this in mind four sites are in the process of being assured to deliver the autumn campaign. These sites, along with Kry-Ba pharmacy, running from St Martins Church in Dagenham will be offering vaccinations.

The co-administration of COVID-19 and influenza vaccines is hoped to increase uptake across cohorts as patients will only need to attend one appointment.

Working with residents

As part of an NHS quality improvement initiative, Together First CIC (Barking and Dagenham GP Federation) have been exploring opportunities to enable local children to have the best start in life. Local parents, representatives from Barking and Dagenham toddler groups, and community groups with a reach to local parents have been engaged via two workshops designed to understand the following:

- Parents' barriers/concerns at accessing immunisations for their children
- Current experience
- What we don't know
- Suggestions to overcome the identified barriers/concerns
- What could work
- What is required to get there
- What we could test collectively

The qualitative evidence gained from those workshops will be used to pilot some different approaches in Autumn 2023. These will include building trust and understanding across a small number of local community-based toddler groups.

The viability of using local family hubs, community venues and pop-up clinics in areas of high deprivation and low uptake as vaccination delivery sites is being explored.

3. Risks

Issue	Risks	Mitigation
Delivery of flu vaccination from Mid-September	Workforce and clinic space being used for the Polio booster vaccine	Careful planning of sites and workforce being used for Polio rollout.
	Delay in start of vaccinations due to vaccine supply	Orders being placed early by practices to determine supply and demand needs.
Increasing uptake	Flu – people becoming unwell and requiring urgent care placing more pressure on the system. Polio – outbreak of polio within the borough impacting on pressures on urgent care and secondary care. COVID-19 – up surge of cases in the borough.	Linking with all local partners to ensure that vaccinations are publicised with the appropriate information and accessing local community groups to raise awareness.
Polio information leaflets	Current back order of polio leaflets meaning that leaflets cannot be given to the public. This in terms could mean that people do not come forward for their vaccine.	Escalate to NHS London Region.
Polio vaccination distribution	At present only GP practices can order the polio vaccine.	Careful planning of sites being used for Polio vaccines. Escalation to NHS London to see if amendments can be made to allow other sites to order vaccine or ability to transfer to another site.

Public Background Papers Used in the Preparation of the Report: None

List of Appendices: None

HEALTH AND WELLBEING BOARD

13th September 2022

Title:	Integrated Care System (ICS) Place Arrangements
Report of the Director of Public Health	
Open Report	**Update**
Wards Affected:	**Key Decision: No**
Report Author: Jane Leaman, Interim Consultant in Public Health Jess Waithe, Interim Public Health Specialist	**Contact Details:** jane.leaman@lbbd.gov.uk jess.waithe@lbbd.gov.uk
Lead Officer: Matthew Cole, Director of Public Health	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director Childrens and Adults	

Summary:

This paper is intended to provide an update on the current progress in developing the Barking and Dagenham Place-based Partnership and Integrated Care Board (ICB) Subcommittee, along with any future milestones. It also provides information about the guidance for Health and Well Being Boards in consultation until 17th September 2022 and guidance on the new Integrated Care Strategy.

Recommendation(s)

The Health and Wellbeing Board is recommended to note:

(i) The establishment of the Barking and Dagenham Place-based Partnership and ICB subcommittee

(ii) The appointment of the Place Based Partnership Lead and update on other appointments

(iii) The consultation guidance on the future role of the Health and Well Being Board

(iv) The milestones to achieve finalised arrangements for April 2023

(v) The guidance for the new Integrated Care Strategy

Reason(s)

The Health and Wellbeing Board maintains a key role in providing a strong focus on establishing a sense of place; instilling a mechanism for joint working and improving wellbeing of their local population and setting strategic direction to improve health and wellbeing.

Introduction and Background

1.1 Following Royal Assent of the Health and Social Care Act (2022), the ICS across England was established from July 1st 2022.

1.2 ICSs intend to promote equal partnership between the NHS, providers, commissioners, local authorities, and other local partners in a geographical area to collectively plan health and care services to meet local population need. ICSs are made up of two key bodies at system level– an 'Integrated Care Board' and an 'Integrated Care Partnership' (ICP) (see Appendix A for more details of governance arrangements).

1.3 In addition to the two governing bodies, there are three other core components of the ICS system: Place-based Partnerships, five Provider Collaboratives from the NEL footprint (Acute, Mental health, Learning Disabilities and Autism; Community; VCSE and Primary Care), and the Primary Care Networks.

1.4 The focus for the new system is Place and the vision for Place will focus on improving the health and wellbeing outcomes for the population, preventing ill health, and addressing health inequalities.

1.5 The ICB is expected to delegate NHS decision making functions and budgets (expected to happen in April 2023) to this place-based level to a ICB Subcommittee and local systems are free to develop their own wider partnership arrangements. This will provide wider expertise to inform the overall strategic vision and plan to address locally agreed priorities.

1.6 What is undertaken at system or place should be guided by the principle of subsidiarity, with decisions taken as close to local communities as possible and at a larger scale where there are demonstrable benefits or where co-ordination across places adds value.

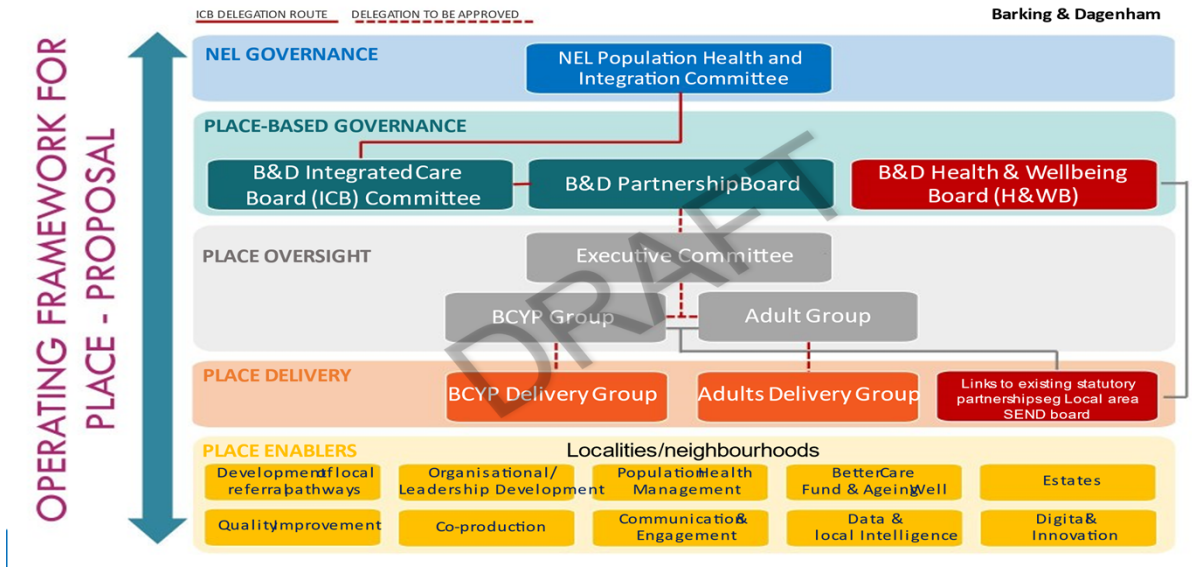
1.7 Recent updates are as follows:

- In June a proposal was presented to the Board to create the ICB place committee to run alongside as 'committees in common' with the Place- based Partnership
- Fiona Taylor, Acting Chief Executive LBBD has been nominated as the Place-based Partnership Lead
- Consultation guidance has been published on the role of HWBs in the new system including their role in developing the Integrated Care Partnerships' (ICP) Integrated Care Strategy
- Guidance has also been published on the development of the Integrated Care Strategy

2. Place- Based Partnership Governance Model

1.8 From 1st July 2022 the previous B&D Delivery Group (DG) transitioned to become a shadow place-based partnership board (PbPB) within the North East London (NEL) ICS. An ICB Subcommittee has also been established for local decision making on ICB functions and will operate with the place-based partnership, working together with common agendas and papers. However, there may be decisions which only the committee can make, and in those circumstances, there will be a 'Part A' and 'Part B' to the agenda.

1.9 The following diagram provides a draft structure:



1.10 **The role of the shadow PbPB includes:**

- To work in partnership to improve health and wellbeing and reduce inequalities.
- To set a local system vision and strategy
- To develop the Place Based Partnership Plan for Barking & Dagenham, ('PBP Plan')
- To provide system wide accountability for the delivery and performance of the PBP plan
- To review and assess new and revised models of care that better serve the population of Barking and Dagenham, and to achieve agreed outcomes
- To develop and deliver a framework of community engagement
- To provide direction and oversee progress to the life course workstreams (adults, and children and young people)
- To provide a forum to share insight and intelligence into local quality matters, identify opportunities for improvement and identify concerns and risk to quality
- To have oversight of how resources are utilised at place to inform discussions on how best to use money across the system
- To support the ICS to deliver against its strategic priorities
- To develop the formal Place Based Partnership governance at place for 1st April 2023

1.11 **The role of the ICB Subcommittee:**

- Exercise delegated functions at place (still to be confirmed)
- Make decisions, authorised by the ICB in relation to them regarding local objectives and priorities
- Support collaborative arrangements- including the development of the 'place-based plan'
- Support ICB with aims and ambitions re joint plans and strategies
- Prioritise delivery against strategic priorities of the ICS
- Support discharge of statutory functions- supporting the core purposes of the ICS
- Improve outcomes
- Tackle inequalities
- Enhance productivity and value for money
- Support broader social/economic development

1.12 Whilst the shadow PbPB and had an inaugural meeting on the 28th July, the first meeting of the committees in common will be on 29th September. They will act in shadow form for a 9-month shadow period during which we can evaluate the functioning of the arrangements. During this period they will be jointly chaired by Cllr Worby and Dr Shanika Sharma, GP Principal, Trainer and Dermatology GPSI, The White House & Green House Surgery, Castleton Road Health Centre and Clinical Director, Network West One PCN.

1.13 This shadow period will allow for development and finalisation of the formal place-based governance system and agreement on delegations and financial arrangements– nationally, regionally, and locally. Locally the future aspiration is for the alignment of the Health and Wellbeing Board (HWB) with the ICB Subcommittee.

3. Key Milestones to 1st April 2023

August 2022	Development of 'Joint Partnership Office' and appointment to Borough Partnership development and support roles
December 2022	• Clinical Care and Leadership Model agreed and recruited • Integrated Care Strategy produced by ICP
By/on 1st April 2023	• Formalisation of Place Based Partnership and ICB arrangements including Subgroups to the Partnership Board for example: CYP & Adults Boards; Quality forum • Delegation of functions and budgets to ICB subcommittees • Agreement on Outcomes Framework and publication of the Health and Wellbeing Strategy and Plan at Place • Establishment of delivery functions e.g.: o Integrated Partnership Office o Executive Group o Ex CCG functions – finance, contracting etc • Agreement on the relationships with BHR TB, NEL TBs and Provider Collaboratives

4. Development Workshop

1.14 The ICB facilitated a workshop with Partnership Board members on 8 July 2022 to discuss the ingredients for successful place-based partnerships and priorities in Barking and Dagenham, facilitated by Gareth Fitzgerald, National Consortium Lead for the place development programme sponsored by NHS England and the Local Government Association. This was the first of a series of workshops that were being rolled out across places in NEL and provided an opportunity to meet Charlotte Pomeroy, Chief Participation and Place Officer, NHS North East London.

1.15 Participants acknowledged that:

- System working in Barking and Dagenham had previously been operating within the BHR sub-system
- There are high levels of deprivation prevalent across the whole borough
- The borough has very high levels of population growth and population churn
- There is historic under-funding across NHS and Local Government
- Partners are tackling significant workforce challenges – including GPs, therapists, social care
- There is an opportunity to further draw in the strengths of the community and VCSE sector

1.16 Alongside the milestones highlighted above (3) the following participants in the workshop identified the following development priorities for the next 9 months:

- Develop a summary map of existing services and resources across the place and neighbourhoods
- Address IG / data sharing issues
- Develop a plan for addressing population growth including new care models
- Make time for cohesive development of these activities and some creative work around the future care models – including wider primary care and the VCSE sector
- Bring together the various estates plans and opportunities into an estates strategy for the Place (community diagnostic centre, community hubs)
- Develop the evidence base around inequalities in outcomes, services, and access
- Clarify potential financial arrangements between ICB and Place
- Develop a plan for identification and development of local community leaders and citizen empowerment
- Develop an associated communications and engagement plan

5. Role and Purpose of Health and Wellbeing Boards

1.17 Health and Wellbeing Boards remain a committee of the local authority, and provide a forum where political, clinical, professional and community leaders from across the care and health system come together to:

- Improve the health and wellbeing of their local population
- Look to reduce health inequalities and
- Be responsible for promoting greater integration and partnership between the NHS, public health and local government.

2. Health and Wellbeing Board Consultation Guidance (published 29th July)

2.1 The Health and Care Act 2022 has not fundamentally changed the required members of a HWB, other than requiring a representative from ICBs, rather than clinical commissioning groups (CCGs) and looks to enable greater integration between partners across the health (including physical and mental health) and social care sector).This includes collaboration between partners who can address the wider determinants of health by:

- Removing barriers to data-sharing
- Enabling joint decision-making and greater collaboration within the NHS, between trusts, and between the NHS and other systems partners – in particular local authorities, based on the principle of subsidiarity

2.2 Health and Wellbeing Boards will continue to:

- Provide a strong focus on establishing a sense of place
- Instil a mechanism for joint working and improving wellbeing of their local population
- Set strategic direction to improve health and wellbeing
- Exist as set out in section 194 of the Health and Social Care Act 2021 (including section 75 arrangement, request for information) and will include a representative from each relevant ICB
- Have responsibility for assessing the health and wellbeing needs of the area and publishing a JSNA, PNA and the JLHWS which should directly inform the development of joint commissioning arrangements in the local area, and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans.

2.3 As leaders of place, local authorities will have an essential role with the NHS to plan and deliver integrated care services, and can act on social, economic and environmental factors that influence people's health and wellbeing.

2.4 Decisions affecting planning, commissioning, operational co-ordination, and the use of resources in the health and care system will happen across a number of forums including ICPs and HWBs.

2.5 NHS England must also – in exercising any functions in arranging for the provision of health services in relation to the area of a responsible local authority – have regard to the relevant JSNAs and JLHWSs.

3. Key Changes to Health and Wellbeing Boards role in the Integrated Care Strategy (NEL NHS)

1. HWBs and ICPs need to work collaboratively in the preparation of the system-wide Integrated Care Strategy (see point 6 below) that will tackle those challenges that are best dealt with at a system level – for example, workforce planning or data and intelligence sharing. And be in involvement in agreeing strategic priorities.
2. Alongside the JLHWSs, the Integrated Care Strategy should be the set direction for the system as a whole.
3. It has been proposed that 2022 to 2023 will be a transition period, proving an opportunity to refresh and develop their integrated care strategy. But to influence the first 5-year joint forward plans (which are to be published before the next financial year and refreshed annually), the Integrated Care Partnership would have to publish an initial strategy by December 2022.
4. DHSC has committed to reviewing, and if necessary, refreshing this guidance in June 2023 following the first cycle of joint 5-year forward plans and integrated care strategies in 2022 to 2023.
5. ICPs should use the insight and data held by HWBs (including JSNAs) in developing the Integrated Care Strategy, identifying where the assessed needs within the JSNA can be met by local authorities, ICBs or NHS England in exercising their functions.
6. The Integrated Care Strategy is for the whole population (covering all ages) and it must, among other requirements, consider whether their needs could be met more effectively by using integration arrangements under section 75 of the National Health Service Act 2006.
7. When they receive the Integrated Care Strategy, HWBs must consider whether to revise their Joint Local Health and Well Being Strategy (JLHWS).

4. Other Proposed Changes

- The functions and duties that previously rested with CCGs have been conferred on ICBs – therefore, HWBs will continue the relationships and accountability they had with CCGs with ICBs, including:
  - forward plans (formerly commissioning plans),
  - annual reports and
  - performance assessments
- The 5-year joint forward plan produced by the ICB must have regard to the Integrated Care Strategy and must set out any steps on how the ICB proposes to implement any JLHWS priorities that relates to the ICB area
- HWBs will receive a copy of an ICB joint capital resource plan outlining their planned capital resource use, to align local priorities, and provide consistency with strategic aims and plans

- Every ICB that is within the HWB's area will be represented on the HWB
- Care Quality Commission (CQC) reviews of integrated care systems will assess the provision of NHS care, public health and adult social care within the ICB area and produce a report. They will consider:
  - How well the ICBs, local authorities and CQC-registered providers discharge their functions in relation to the provision of care
  - The functioning of the system, which will include the role of the ICP
- If ICPs and HWB are geographically coterminous – they can be brought together

5. Engagement in Consultation

5.1 DHSC is engage with all sectors in the development of this guidance and have included the areas below which they welcomed feedback on (the consultation closes on 16th September and the Public health team is leading the consultation with partners and HWB members):

- What examples can you provide of how HWBs are reacting to the introduction of ICBs or ICPs brought about by the Health and Care Act 2022?
- Are there any issues you are encountering with the introduction of ICBs or ICPs that are affecting HWBs?
- Are there new ways of working emerging that you would be happy to share as best practice?
- How are HWBs working to join up to ensure that they are part of discussions around implementation of the proposals in the integration white paper?
- We acknowledge the great work the LGA do in supporting HWBs and the resources they provide. In the final guidance we would like to provide examples in the form of diagrams and so on outlining the different structures and scenarios HWBs operate within, and would welcome examples or case studies
- Does this guidance provide the information you need? Are there any gaps?

6. Developing an Integrated Care Strategy

6.1 The Health and Care Act 2022 amends the Local Government and Public Involvement in Health Act 2007 and requires ICPs to write an integrated care strategy to set out how the assessed needs (from the JSNAs) can be met through the exercise of the functions of the integrated care board, partner local authorities or NHS England (NHSE).

6.2 Guidance was published on 29th July 2022 for integrated care partnerships on the preparation of integrated care strategies and guidance will be reviewed by June 2023.

6.3 The integrated care strategy should set the direction of the system across the area of the integrated care board and integrated care partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life.

6.4 The integrated care strategy is an opportunity to work with a wide range of people, communities and organisations to develop evidence-based system-wide priorities that will improve the public's health and wellbeing and reduce health inequalities.

6.5 When the integrated care partnership receives a new joint strategic needs assessment, from a health and wellbeing board, it must consider refreshing the integrated care strategy.

6.6 Integrated care partnerships should ensure that the integrated care strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not replace or supersede the priorities that are best done locally through the joint local health and wellbeing strategies.

6.7 The Care Quality Commission's reviews will assess how the integrated care strategy is used to inform the commissioning and provision of quality and safe services across all partners, within the integrated care system, and that this is a credible strategy for its population.

7. Mandatory Implications

7.1 Joint Strategic Needs Assessment

The JSNA will inform the Plan at Place and agreed outcomes framework.

7.2 Health and Wellbeing Strategy

The Joint Local Health and Well Being Strategy was renamed on 1st July and remains a key responsibility of the HWBB. It will be the key document identifying partnership outcomes and inform service priorities to address the health needs of people living in Barking and Dagenham. NHS NEL are required to use JLHWBS to inform its Integrated Care Strategy.

7.3 Financial Implications

Completed by Isaac Mogaji – Finance Business Partner:

This report is largely for information of the Health and Wellbeing Board and seeks to provide an update on the current progress in developing the Barking and Dagenham Place-based Partnership and Integrated Care Board (ICB) Subcommittee. It also **provides** guidance on the new Integrated Care Strategy. As such, there are no obvious financial implications of the report.

7.4 Legal Implications

Completed by Dr. Paul Field- Principal Governance Lawyer and Sarah Dawkins, Barrister Consultant for Adult Social Care Law:

The Health and Care Bill received Royal Assent and became an Act of Parliament on 28 April 2022. It enacts the most significant health legislation in a decade into law. Section 26 of the Act makes provision for Integrated Care Partnerships and amends the Local Government and Public Involvement in Health Act 2007 so that the

integrated care board and all upper-tier local authorities that fall within the area of the integrated care board must establish an integrated care partnership. This creates a joint committee of these bodies made under the new section inserted in the Act. The partnership must include members appointed by the integrated care board and each relevant local authority. The integrated care partnership may determine its own procedures and appoint other members.

As set out in the report, the establishment of a Place-based Partnership Board (PbPB) to work up a relationship with the ICB Subcommittee for a 9-months shadow arrangement. At the time of writing, guidance to local authorities on governance arrangements has yet to be published by the Secretary of State. However, the action proposed will be a proper commencement stage in establishing the place- based partnership board by enabling linkages and communications to take root while preparation is in hand to establish a permanent foundation in accordance with the statutory requirements for Integrated Care Partnerships. At this stage the shadow arrangement will not be taking actionable or binding decisions. Accordingly, there are no external adverse legal implications that appear to arise from the recommended course within the report.

Public Background Papers Used in the Preparation of the Report:

See Appendix B.

List of Appendices:

Appendix A - Core components of ICS governance arrangements

Appendix B – Useful guidance documents and publications

APPENDIX A:

CORE COMPONENTS OF ICS GOVERNANCE ARRANGEMENTS AND EXPECTATIONS

Core component	Expectation
Integrated care partnership (ICP) *statutory*	• Each ICS area will have an ICP (a committee, not a body) at system level established by the ICB and relevant local authorities as equal partners and bringing together organisations and representatives concerned with improving the care, health and wellbeing of the population. • The ICP to have a specific responsibility to develop an integrated care strategy. • Each ICB will need to align its constitution and governance with the ICP.
Integrated care board *statutory*	• ICBs will be established as new statutory organisations, to lead integration within the NHS. • The ICB will have a unitary board, responsible for ensuring the body plays its role in achieving the four purposes • Minimum requirements for board membership will be set in legislation. We have set further minimum expectations for board membership. • Each board will be required to establish an audit committee and remuneration committee • All ICBs will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for other committees and groups to advise and feed into the board, and to exercise functions delegated by the board.
Integrated Care Board Subcommittee	• Each Place will have an Integrated Care Board Subcommittee which will be responsible for delegated functions from the ICB (see above) which will include managing the delegated NHS budget and arranging for the provision of health services in the place area
Place-based partnerships	• Place-based partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or community
Provider, community, primary care and mental health collaboratives (may be at sub system, system or supra-system level)	• Collaboratives will agree specific objectives with one ormore ICBs, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved. • The ICB and collaboratives must define their working relationship, including participation in committees via partner members and any other local arrangements, to facilitate the contribution of the provider collaborative to agreed ICB objectives.

APPENDIX B:

USEFUL GUIDANCE DOCUMENTS AND PUBLICATIONS

- LGA/NHS, “Thriving places”
  https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

- The King’s Fund, “Developing place-based partnerships”
  https://www.kingsfund.org.uk/sites/default/files/2021-04/developing-place-based-partnerships.pdf

- The Kings Fund “Health and Care Bill- our work on the legislative agenda for health and care reform”
  https://www.kingsfund.org.uk/topics/health-and-care-bill

- NHS, “Interim guidance on the functions and governance of the integrated care board”
  Report template - NHSI website (england.nhs.uk)

- Building strong integrated care systems everywhere ICS implementation guidance on effective clinical and care professional leadership
  B0664-ics-clinical-and-care-professional-leadership.pdf (england.nhs.uk)

- Interim guidance on the functions and governance of the Integrated Care Board. Statutory CCG functions to be conferred on ICBs
- https://nhsproviders.org/media/692060/nhs-providers-next-day-briefing-integrated-care-board-governance.pdf

- Health and wellbeing boards: draft guidance for engagement
  https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement

- Get in on the Act: Health and Care Act 2022
  https://www.local.gov.uk/publications/get-act-health-and-care-act-2022

- Guidance on preparing an Integrated Care Strategy
  https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

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Update on the development of our Integrated Care System

Barking & Dagenham

Health and Wellbeing Board

13th September 2022

one borough; one community; no one left behind

Key Milestones

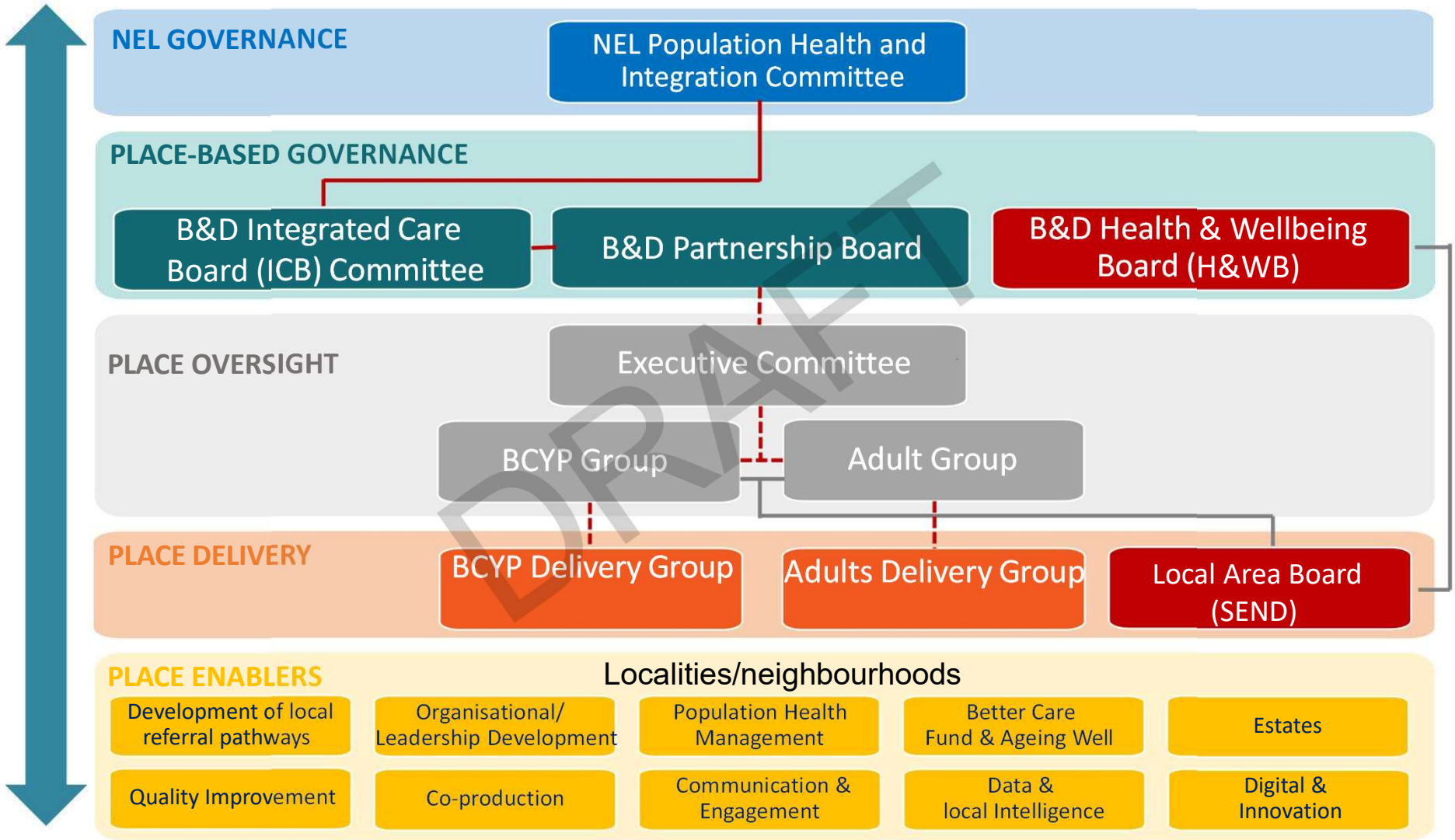
June 2022	• Establishment of the ICB Subcommittee and Partnership Board agreed by the HWB (14th June 2022)
	• Joint Strategic Needs Assessment refresh published
	• Recruitment to ICB Place lead roles:
	  • Clinical/Care Director
	  • Place Leadership role
	  • NEL Clinical and Care Professional Leadership roles
	  • System lead (Director of Place) - outstanding
	  • Clinical Director
	  • Finance Director

July 2022	• ICB and Partnership Board arrangements agreed by NEL • Place Lead role agreed by NEL • 9-month shadow arrangement for the Place Based Partnership begins • Population Health Management Pilot ends • Refreshed Joint Strategic Needs Assessment published
August 2022	Development of 'Joint Partnership Office' and appointment to Borough Partnership development and support roles
December 2022	Clinical Care and Leadership Model agreed and recruited
By/on 1st April 2023	• Formalisation of Place Based Partnership and ICB arrangementsincluding Subgroups to the Partnership Board for example: CYP & Adults Boards; Quality forum • Delegation of functions and budgets to ICB subcommittees • Agreement on Outcomes Framework and publication of the Health and Wellbeing Strategy and Plan at Place • Establishment of delivery functions e.g.: • Integrated Partnership Office • Executive Group • Ex CCG functions – finance, contracting etc • Agreement on the relationships with BHR TB, NEL TBs and Provider Collaboratives

OPERATING FRAMEWORK FOR PLACE - PROPOSAL

ICB DELEGATION ROUTE DELEGATION TO BE APPROVED

Barking & Dagenham



Building place teams in north east London

The place leadership team

- Place partnership lead: responsible for providing overall executive leadership, enabling and challenging partners to combine their expertise and resources to drive meaningful improvements to health, wellbeing, and equity;
- Clinical or care director: responsible for ensuring that the partnership and its plans are supported by broad clinical and care professional leadership; and
- Director of delivery: responsible for driving delivery of the partnership's operational and transformation priorities, as a full-time and dedicated role working on behalf of all partners.

The core place team…

A team working full-time in each place and line managed by the director of delivery, with deep local knowledge and close local relationships.

From NHS NEL:

- a senior manager to lead on planning, delivery, and partnership development, with an additional supporting manger;
- business management and administrative support; and
- additional programme and delivery support, distributed according to need.

Our aspiration is to build larger integrated core teams with colleagues from across multiple partners, where these don't yet exist.

… and the extended place team

This includes NHS NEL colleagues line managed within NEL-wide teams where place is a critical dimension to their work – so who need to spend time in that place and also feel part of an extended place team.

This matrix includes colleagues from:

commissioning and transformation teams;

- the communications and engagement teams;
- the governance team;
- the finance, performance, quality, and safety teams… and many others.

appointed under development

New Roles Within the System

Title and Appointed Person	Role
NEL ICB Chief Executive Officer designate- **Zina Etheridge**	To lead the North East London Health and Care Partnership (ICP). WJ1
Place Based Partnership Lead- **Fiona Taylor**, LBBD WJ0	To convene partners around a common agenda, holding overall accountability for delivery at place and ensuring full co-production with residents and service users. Accountable for the delivery of the shared plan and outcomes for the place, working with local partners (e.g., an individual with a dual role across health and care or an individual lead for a 'place board').
Place Delivery Director- **Sharon Morrow** (acting), NEL ICB	Senior delivery role working with and on behalf of residents, service users, and partners.
Clinical and Care Director- **Dr Rami Hara**	Co-ordination of clinical and care professional leadership into the place-based partnership. Facilitation of clinical and care professional engagement in support of local transformation and quality priorities and ensuring local clinical and care professional input to NEL-wide strategies.
Cllr Worby, Elected Member, LBBD **Dr Shanika Sharma**, PCN Director	Joint Chairs for both B&D Partnership Board and ICB Place Sub Committee

Still to be filled:

- Integrated Partnership Office roles i.e. Head of Borough Partnerships Planning and Delivery and Borough Partnership Business Manager
- NEL Clinical and Care Professional Leadership roles e.g. Primary Care Development Lead
- Finance Director

Slide 5

WJ0 Is this correct or have I confused roles?
Waithe Jess, 2022-08-11T13:38:27.912

WJ1 Is there anything else briefly to add?
Waithe Jess, 2022-08-11T13:59:24.702

Role of the HWBB – Consultation Guidance Background

Health and Wellbeing Boards will continue to:

- provide a strong focus on establishing a sense of place
- instil a mechanism for joint working and improving wellbeing of their local population
- set strategic direction to improve health and wellbeing

- The **Health and Care Act 2022**, looks to enable greater integration between partners across the health (which includes physical and mental health) and social care sector. This includes collaboration between partners who can address the wider determinants of health by:
  - removing barriers to data-sharing
  - enabling joint decision-making and greater collaboration within the NHS, between trusts, and between the NHS and other systems partners – in particular local authorities

Based on the principle of subsidiarity.

- **As leaders of place**, local authorities will have an essential role with the NHS to plan and deliver integrated care services, and have the ability to act on social, economic and environmental factors that influence people's health and wellbeing.

Role and purpose of Health and Wellbeing Boards

Health and Wellbeing Boards remain a **committee of the local authority**, and provide a forum where political, clinical, professional and community leaders from across the care and health system come together to:

- improve the health and wellbeing of their local population,
- look to reduce health inequalities and
- be responsible for promoting greater integration and partnership between the NHS, public health and local government.

- Decisions affecting **planning, commissioning, operational co-ordination, and the use of resources** in the health and care system will happen across a number of forums including ICPs and HWBs.
- HWB will continue to exist as set out in **section 194 of the Health and Social Care Act 2021** (including section 75 arrangement, request for information) and will include a representative from each relevant ICB.
- And sections **116 and 116A of the Local Government and Public Involvement in Health Act 2007** relating to JSNAs and JSNAs (ie the statutory guidance on JSNAs and JLHWBS remains unchanged).
- HWB will continue to have responsibility for assessing the health and wellbeing needs of the area and publishing a **joint strategic needs assessment** (JSNA) and **the joint LOCAL health and wellbeing strategy** (JLHWS) which should directly inform the development of joint commissioning arrangements in the local area, and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans. And develop a **Pharmaceutical Needs Assessment** (PNA) for their area
- NHS England must also – in exercising any functions in arranging for the provision of health services in relation to the area of a responsible local authority – **have regard to the relevant JSNAs and JLHWSs**.
- The Health and Care Act 2022 has not fundamentally changed the required **members of a HWB**, other than requiring a representative from ICBs, rather than clinical commissioning groups (CCGs)

Changes:
Health and Wellbeing Board role in Integrated Care Strategy (NHS NEL System wide)

- HWBs and ICPs need to work collaboratively in the preparation of the system-wide Integrated Care Strategy that will tackle those challenges that are best dealt with at a system level – for example, workforce planning or data and intelligence sharing. And be in involvement in agreeing strategic priorities
- Alongside the JLHWSs, the Integrated Care Strategy should be the set direction for the system as a whole.
- ICPs should use the insight and data held by HWBs (including JSNAs) in developing the Integrated Care Strategy, identifying where the assessed needs within the JSNA can be met by local authorities, ICBs or NHS England in exercising their functions
- The Integrated Care Strategy is for the whole population (covering all ages) and it must, among other requirements, consider whether their needs could be met more effectively by using integration arrangements under section 75 of the National Health Service Act 2006
- When they receive the Integrated Care Strategy, HWBs must consider whether to revise their Joint Local Health and Well Being Strategy (JLHWS)
- Transitional period during 2022 – 2023 – initial strategy December 2022 (to influence the first 5 year forward plan – published by 1st April with annual refresh)

Other areas covered in guidance

- The functions and duties that previously rested with CCGs have been conferred on ICBs – therefore, HWBs will **continue the relationships and accountability they had with CCGs** with ICBs, including :
  - forward plans (formerly commissioning plans),
  - annual reports and
  - performance assessments
- The **5-year joint forward plan** produced by the ICB must have regard to the Integrated Care Strategy and must set out any steps on how the ICB proposes to implement any JLHWS priorities that relates to the ICB area.
- HWBs will receive a copy of an ICB **joint capital resource plan** outlining their planned capital resource use, in order to align local priorities, and provide consistency with strategic aims and plans
- Every ICB that is within the HWB's area will be **represented on the HWB**
- **Care Quality Commission (CQC)** reviews of integrated care systems will assess the provision of NHS care, public health and adult social care within the ICB area and produce a report. They will consider:
  - how well the ICBs, local authorities and CQC-registered providers discharge their functions in relation to the provision of care
  - the functioning of the system as a whole, which will include the role of the ICP
- If ICPs and HWB are geographically coterminous – they can be brought together

Development of an Integrated Care Strategy

- The Health and Care Act 2022 requires ICPs to write an integrated care strategy to set out how the assessed needs (from the JSNAs) can be met through the exercise of the functions of the integrated care board, partner local authorities or NHS England (NHSE).
- Guidance was published on 29th July 2022 for integrated care partnerships on the preparation of integrated care strategies.
- The integrated care strategy should:
  - set the direction of the system across the area of the integrated care board and integrated care partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life.
  - Provide an opportunity to work with a wide range of people, communities and organisations to develop evidence-based system-wide priorities that will improve the public's health and wellbeing and reduce health inequalities.
- Integrated care partnerships should ensure that the integrated care strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not replace or supersede the priorities that are best done locally through the joint local health and wellbeing strategies.
- The Care Quality Commission's reviews will assess how the integrated care strategy is used to inform the commissioning and provision of quality and safe services across all partners, within the integrated care system, and that this is a credible strategy for its population
- The guidance will be reviewed by June 2023

https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

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HEALTH AND WELLBEING BOARD

13th September 2022

Title:	**Pharmaceutical Needs Assessment**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: all	**Key Decision: Yes**
Report Author: Jane Leaman, Consultant in Public Health (Interim) Ashlee Mulimba, Healthy Dialogues (organisation commissioned to undertake the PNA)	**Contact Details:** jane.leaman@lbbd.gov.uk ashlee@healthydialogues.co.uk
Lead Officer: Matthew Cole, Director of Public Health	
Accountable Strategic Leadership Director: Elaine Allegretti, Strategic Director Childrens and Adults	

Summary:

Section 128A of the National Health Service Act 2006 (NHS Act 2006) requires each Health and Wellbeing Board to assess the need for pharmaceutical services in its area and to publish a statement of its assessment, called a pharmaceutical needs assessment (PNA).

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, as amended (the 2013 regulations) set out the minimum information that must be contained within a pharmaceutical needs assessment and outline the process that must be followed in its development.

The purpose of the PNA is to:

- Inform local plans for the commissioning of specific and specialised pharmaceutical services
- Support the decision-making process for applications for new pharmacies or changes of pharmacy premises undertaken by NHS England

The PNA assesses whether the current provision of pharmacies and the commissioned services they provide meet the needs of the LBBD residents and whether there are any gaps between 1st October 2022 to 30th September 2025.

The process included a 60-day consultation with key stakeholders and the community.

Findings:

- LBBD is well served in relation to the number and location of pharmacies, with:
  - 39 community pharmacies
  - one dispensing appliance contractor
- There are a further seven community pharmacies within a mile of LBBDs border.
- There is good access to essential, advanced, enhanced and other NHS pharmaceutical services for the residents of LBBD with no gaps in the current and future provision of these services identified
- Additionally, no services were identified that would secure improvements or better access to pharmaceutical services if provided, either now or in the future

Recommendation(s)

The Health and Wellbeing Board is recommended to agree the publication of the Pharmaceutical Needs Assessment for Barking and Dagenham.

Reason(s)

The Health and Wellbeing Board has a statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for their population – a Pharmaceutical Needs Assessment (PNA) (NHS Pharmaceutical regulations 2013).

1. Introduction and Background

The PNA is a statutory document required to be produced by every local authority's Health and Wellbeing Board every three years. The PNA assesses the pharmacy needs of the local population and informs the strategic development and commissioning of community pharmacy services to help meet the needs of the local individual population.

2. Proposal and Issues

The Health and Wellbeing Board is recommended to agree the publication of the Pharmaceutical Needs Assessment for Barking and Dagenham.

3 Consultation

A 60-day consultation with key stakeholders and the community was undertaken.

4 Mandatory Implications

This PNA will support and align with other strategic documents, such as the Joint Strategic Needs Assessment and Health and Wellbeing Strategy.

4.1 Financial Implications

Implications completed by Isaac Mogaji – Finance Business Partner:

This report is largely for information and seeks the Health and Wellbeing Board to agree the publication of the Pharmaceutical Needs Assessment for Barking and Dagenham. As such, there is no obvious financial implications of the report.

The cost implications of any contract award to produce the publication would need to be addressed under a separate procurement report.

4.2 Legal Implications

Implications completed by- Dr. Paul Feild Principal Governance Lawyer:

As set out in the main body of the report maintaining a local pharmaceutical plan is a duty placed on the HWB by the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

NHS community pharmaceutical services in England are provided through the National Health Service Commissioning Board and the local plans outlining the needs and availability of NHS community pharmaceutical services in an area, which are known as Pharmaceutical Needs Assessments are developed, maintained and updated by local authority Health and Wellbeing Boards. Consideration of this report is a necessary function of the HWB's statutory responsibilities.

Public Background Papers Used in the Preparation of the Report:

None.

List of Appendices:

Appendix A - Barking and Dagenham 2022-2025.pdf

Appendix B - LBBD PNA HWB Update.pptx

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LONDON BOROUGH OF BARKING AND DAGENHAM

PHARMACEUTICAL NEEDS ASSESSMENT 2022

Executive Summary

Introduction

Local pharmacies are a frontline healthcare resource located within the heart of communities often from the community they serve. They provide prescription medications, health promotion, signposting, retail health and care products. They can be the first point of contact for patients seeking medical information or advice, and for some the only contact with a healthcare professional.

Each Health and Wellbeing Board (HWB) has a statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for their population. This is called the Pharmaceutical Needs Assessment (PNA). The purpose of the PNA is to:

- inform local plans for the commissioning of specific and specialised pharmaceutical services
- to support the decision-making process for applications for new pharmacies or changes of pharmacy premises undertaken by NHS England

This PNA was conducted at a time of substantial change within the health and social care landscape as the North East London Health and Care Partnership is being created in response to the NHS Long Term Plan. This includes an increased use and acknowledgement of community pharmacies within newly developed primary care networks, ensuring greater opportunities for patient engagement.

There are 39 community pharmacies and one dispensing appliance contractor located within the London Borough of Barking and Dagenham. The PNA provides an overview of the health and wellbeing needs of Barking and Dagenham population, including patients' and public's views of their pharmacy services. It assesses whether the current provision of pharmacies and the commissioned services they provide meet the needs of the Barking and Dagenham residents and whether there are any gaps, either now or within the lifetime of this document, 1st October 2022 to 30th September 2025. It assesses current and future provision with respect to:

- Necessary Services, i.e., current accessibility of pharmacies and their provision of Essential Services
- Other Relevant Services including Advanced and Enhanced Pharmacy Services commissioned by NHS England and Other NHS Services Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group, or the London Borough of Barking and Dagenham.

These are outlined in Appendix D. The development of new pharmacy services in relation to the local implementation of place-based partnerships is outside the scope of this PNA.

Key findings are outlined below.

Findings

Key demographics and health needs of Barking and Dagenham

Barking and Dagenham is an urban local authority situated in outer, Northeast London. It has an estimated 217,384 residents. Its population is set to increase by 3% by 2025 due to its high birth rate and new developments underway in the Barking Riverside area.

The London Borough of Barking and Dagenham has highest proportion of young people in London and the highest birth rate in London. Nearly half of the population are from BAME groups, a quarter of the population are Asian.

There are pockets of high deprivation within Barking and Dagenham, most notably in the north of Heath, and Thames where deprivation is highest at LSOA level. The impact of COVID-19 affected those from more deprived areas and from BAME communities the most.

Barking and Dagenham have the lowest life expectancy figures in London and the lowest healthy life expectancy for males and the third lowest for females (PHE, Public Health Profiles, 2022).

In terms of lifestyle factors, there are several areas of concern (PHE, Local Health Indicators, 2021):

- 18.1% of adults smoke, substantially higher than regional and national figures
- 65.5% of adults are overweight or obese, the third highest rate in London
- 31.9% of adults are inactive, the third highest rate in London
- There is a high proportion of opiate and/or crack cocaine users who are not receiving treatment
- Chlamydia detection rates are higher than national figures
- 44.7% of Year 6 children are obese, the highest rate in London

There are several population health and wellbeing needs that were identified (PHE, Local Health Indicators, 2021):

- Nearly a quarter of adults have a common mental illness
- Premature mortality for cancers, stroke, coronary heart diseases and respiratory diseases are high
- Rates of premature births, low birth weight, still births and maternal obesity are among the highest in London. 1% of births are to teenage mothers, the highest rate in London.
- Excess winter deaths, loneliness and isolation, and frailty are areas of concern among the older population.

A comprehensive overview of the demographics and health and wellbeing needs of Barking and Dagenham residents is presented in Chapter 4.

Key findings from patient and public engagement

A community survey was disseminated across Barking and Dagenham, Havering and Redbridge. 364 people responded to tell us how they use their pharmacy and their views on specific ‘necessary’ pharmacy services, 40 of whom were from Barking and Dagenham.

The most stated reasons people used their chosen pharmacy were that they were happy with their overall service, the good location and staff are friendly. Most stated they prefer to use their pharmacies during weekdays and during normal working hours.

There were no significant differences between groups in terms of their use, reasons for their chosen pharmacy and expectations in their local pharmacy provision. These findings are presented in Chapter 5.

Health and Wellbeing Board Statements on Service Provision

The Health and Wellbeing Board has assessed whether the current and future pharmacy provision meets the health and wellbeing needs of the Barking and Dagenham population. It has also determined whether there are any gaps in the provision of pharmaceutical service either now or within the lifetime of this document, 1st October 2022 to 30th September 2025. This is presented in Chapter 6.

The London Borough of Barking and Dagenham is well served in relation to the number and location of pharmacies. The Health and Wellbeing Board has concluded that there is good access to essential, advanced, enhanced and other NHS pharmaceutical services for the residents of Barking and Dagenham with no gaps in the current and future provision of these services identified, and no needs for improvements or better access. See Chapter 7 for a full summary of the Health and Wellbeing conclusions on pharmacy services.

Contents

Chapter 1- Introduction

Purpose of the Pharmaceutical Needs Assessment

1.1 Local pharmacies play a pivotal role in Barking and Dagenham working in the centre of communities and providing quality healthcare to local individuals, families and carers. They can be patients' and the public's first point of contact and, for some, their only contact with a healthcare professional.

1.2 The Pharmaceutical Needs Assessment (PNA) identifies the key health needs of the local population and how those needs are being fulfilled, or could be fulfilled, by pharmaceutical services in different parts of the borough. The purpose of the PNA is to:

- Support the 'market entry' decision making process (undertaken by NHS England) in relation to applications for new pharmacies or changes of pharmacy premises.
- Inform commissioning of enhanced services from pharmacies by NHS England, and the commissioning of services from pharmacies by the local authority and other local commissioners, for example Clinical Commissioning Groups (CCGs).

1.3 This document can also be used to:

- Assist the Health and Wellbeing Board (HWB) to work with providers to target services to the areas where they are needed and limit duplication of services in areas where provision is good.
- Inform interested parties of the pharmaceutical needs in the borough and enable work on planning, developing and delivery of pharmaceutical services for the population.

Legislative background

1.4 From 2006, NHS Primary Care Trusts had a statutory responsibility to assess the pharmaceutical needs for their area and publish a statement of their first assessment and of any revised assessment.

1.5 With the abolition of Primary Care Trusts and the creation of Clinical Commissioning Groups in 2013, Public Health functions were transferred to local authorities. Health and Wellbeing Boards were introduced and hosted by local authorities to bring together Commissioners of Health Services (CCGs), Public Health, Adult Social Care, Children's services and Healthwatch.

1.6 The Health and Social Care Act of 2012 gave a responsibility to Health and Wellbeing Boards for developing and updating Joint Strategic Needs Assessments and Pharmaceutical Needs Assessments.

1.7 This PNA covers the period between 1st October 2022 and 30th September 2025. It must be produced and published by 1st October 2022. The Health and Wellbeing Board are also required to revise the PNA publication if they deem there to be significant changes in pharmaceutical services before 30th September 2025.

1.8 A draft PNA must be put out for consultation for a minimum of 60 days prior to its publication. The 2013 Regulations list those persons and organisations that the HWB must consult, which include:

- Any relevant local pharmaceutical committee (LPC) for the HWB area
- Any local medical committee (LMC) for the HWB area
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area
- Any local Healthwatch organisation for the HWB area, and any other patient, consumer and community group, which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area
- Any NHS Trust or NHS Foundation Trust in the HWB area
- NHS England
- Any neighbouring Health and Wellbeing board.

1.9 The NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013 and the Department of Health Information Pack for Local Authorities and Health and Wellbeing Boards[1] provide guidance on the requirements that should be contained in the PNA publication and the process to be followed to develop the publication. The development and publication of this PNA has been carried out in accordance with these Regulations and associated guidance.

Minimum requirements of the PNA

1.10 As outlined in the 2013 regulations, this PNA must include a statement of the following:

- **Necessary Services – Current Provision:** services currently being provided which are regarded to be "necessary to meet the need for pharmaceutical services in the area". This includes services provided in the borough as well as those in neighbouring boroughs.
- **Necessary Services – Gaps in Provision:** services not currently being provided which are regarded by the HWB to be necessary "in order to meet a current need for pharmaceutical services".
- **Other Relevant Services – Current Provision:** services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have "secured improvements or better access to pharmaceutical services".
- **Improvements and Better Access – Gaps in Provision:** services *not* currently provided, but which the HWB considers would "secure improvements, or better access to pharmaceutical services" if provided.
- **Other Services**: any services provided or arranged by the local authority, NHS England, the CCG, an NHS trust or an NHS foundation trust which affects the need for

pharmaceutical services in its area or where future provision would secure improvement, or better access to pharmaceutical services specified type, in its area.

1.11 Additionally, the PNA must include a map showing the premises where pharmaceutical services are provided and an explanation of how the assessment was made.

Circumstances under which the PNA is to be revised or updated

1.12 It is important that the PNA reflects changes that affect the need for pharmaceutical services in Barking and Dagenham. Where the HWB becomes aware that a change may require the PNA to be updated, then a decision to revise the PNA will be made.

1.13 Not all changes in a population or an area will result in a change to the need for pharmaceutical services. However, where these changes do require a review of pharmaceutical services, the HWB will issue supplementary statements to update the PNA.

1.14 The PNA will be updated every three years.

Chapter 2 - Strategic Context

2.1 This section summarises a few of the key policies, strategies and reports which contribute to our understanding of the strategic context for England's community pharmacy services at a national, regional and local level. Since PNAs were last updated in 2018, there have been significant changes to the wider health and social care landscape and to society. This includes but is not limited to the publication of the NHS Long Term Plan, the introduction of the Community Pharmacy Contractual Framework, a greater focus on integrated care, and the significant impact of the COVID-19 pandemic.

National context

Department of Health and Social Care Policy Paper - Integration and Innovation: working together to improve health and social care for all[1]

2.2 In recent years, the health and social care system has adapted and evolved to face a variety of challenges. With the population growing, people living longer, but also suffering from more long-term health conditions, and challenges from the COVID-19 pandemic, there is a greater need for the health and social care system to work together to provide high quality care. This paper sets out the legislative proposals for the Health and Care Bill which capture the learnings from the pandemic.

2.3 **Working together to integrate care:** The NHS and local authorities will be given a duty to collaborate and work with each other. Measures will be brought forward to bring about Integrated Care Systems (ICSs) which will be compromised of an ICS Health and Care partnership, and an ICS NHS Body. The ICS NHS Body will be responsible for the day to day running of the ICS, whilst the ICS Health and Care Partnership will bring together systems to support integration and development which plan to address the system's health, public health, and social care needs. A key responsibility for these systems will be to support place-based working i.e., working amongst NHS, local government, community health including community pharmacy, voluntary and charity services. The ICS will align geographically to a local authority boundary, and the Better Care Fund plan (BCF) will provide a tool for agreeing priorities.

2.4 **Reducing bureaucracy:** The legislation will aim to remove barriers that prevent people from working together and put pragmatism at the heart of the system. The NHS should be free to make decisions without the involvement of the Competition and Markets Authority (CMA).

[1] Department of Health & Social Care. Policy paper: Integration and innovation: working together to improve health and social care for all (updated February 2021). Available at: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version#executive-summary

With a more flexible approach, the NHS and local authorities will be able to meet the current future health and care challenges by avoiding bureaucracy.

2.5 **Improving accountability and enhancing public confidence:** The public largely see the NHS as a single organisation, and the same should happen at a national level. By bringing together NHS England, and NHS Improvement together, organisations will come together to provide unified leadership. These measures will support the Secretary of State to mandate structured decisions and enable the NHS to be supported by the government. With any significant service changes, these measures will ensure a greater accountability with the power for ministers to determine service reconfigurations earlier in the process.

The NHS Long Term Plan (2019)[2]

2.6 As health needs change, society develops, and medicine advances, the NHS must ensure that it is continually moving forward to meet these demands. **The NHS Long Term Plan (2019)** (NHS LTP) introduces a new service model for the 21st century and includes action on preventative healthcare and reducing health inequalities, progress on care quality and outcomes, exploring workforce planning, developing digitally-enabled care, and driving value for money.

2.7 More specifically, pharmacies will play an essential role in delivering the NHS LTP. £4.5 billion of new investment will fund expanded community multidisciplinary teams aligned with the new primary care networks (PCNs). These teams will work together to provide the best care for patients and will include pharmacists, district nurses, allied health professionals, GPs, dementia workers, and community geriatricians. Furthermore, the NHS LTP stipulates that as part of the workforce implementation plan, and with the goal of improving efficiency within community health, along with an increase in the number of GPs, the range of other roles will also increase, including community and clinical pharmacists, and pharmacy technicians.

2.8 Research indicates that around 10% of elderly patients end up in hospital due to preventable medicine related issues and up to 50% of patients do not take their medication as intended. PCN funding will therefore be put towards expanding the number of clinical pharmacists working within general practices and care homes, and the NHS will work with the government to ensure greater use and acknowledgement of community pharmacists' skills and better utilisation of opportunities for patient engagement. As part of preventative healthcare and reducing health inequalities, community pharmacists will support patients to take their medicines as intended, reduce waste, and promote self-care.

2.9 Within PCNs, community pharmacists will play a crucial role in supporting people with high-risk conditions such as atrial fibrillation (AF) and cardiovascular disease (CVD). The NHS will support community pharmacists to case-find, e.g., hypertension case-finding. Pharmacists within PCNs will undertake a range of medicine reviews, including educating patients on the

[2] NHS. *The NHS Long Term Plan* (2019). https://www.longtermplan.nhs.uk/

correct use of inhalers and supporting patients to reduce the use of short-acting bronchodilator inhalers and to switch to clinically appropriate, smart inhalers.

2.10 In order to provide the most efficient service, and as part of developing digitally-enabled care, more people will have access to digital options. The NHS app will enable patients to manage their own health needs and be directed to appropriate services, including being prescribed medication that can be collected from their nearest pharmacy.

Health Equity in England: Marmot review 10 years on[3]

2.11 This document summarises the developments in particular areas that have an increasing importance for equity. These include:

- Give every child the best start in life by increasing funding in earlier life and ensuring that adequate funding is available in areas with higher deprivation.
- Improve the availability and quality of early years' services.
- Enable children, young people and adults to maximise their capabilities by investing in preventative services to reduce school exclusions.
- Restore per-pupil funding for secondary schools and in particular in 6th form and further education.
- Reduce in-work poverty by increasing the national minimum wage.
- Increase number of post-school apprenticeships and support in-work training.
- Put health equity and well-being at the heart of local, regional and national economic planning.
- Invest in the development of economic, social and cultural resources in the most deprived communities.

We explore these in the context of Barking and Dagenham in Chapter 4.

Public Health England (PHE)[4] Strategy 2020-2025[5]

2.12 PHE exists to protect and improve the nation's health and wellbeing and reduce health inequalities. Priorities include creating a smoke-free society by 2030, healthier diets, healthier weight, cleaner air, better mental health, best start in life, effective responses to major incidents, reduced risk from antimicrobial resistance, predictive prevention, enhanced data and surveillance capabilities, and a new national science campus.

[3] Institute of Health Equity. *Health Equity in England: The Marmot Review 10 Years On* (2020). https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-executive-summary.pdf

[4] As of October 2021, PHE ceased to exist. Responsibilities formally undertaken by PHE are now the responsibility of OHID, UKHSA and NHS England.

[5] Public Health England Strategy 2020-2025 (2019). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831562/PHE_Strategy_2020-25.pdf

2.13 PHE produced a briefing: 'Pharmacy teams – seizing opportunities for addressing health inequalities.[6] The briefing highlights the unique role that pharmacy teams can play in helping to address health inequalities. It suggests ways for making the most of pharmacy teams' potential to work with local community and faith leaders, reach out to under-served communities and those with the poorest health outcomes, and to take on a health inequalities leadership role. It also sets out recommendations for system leaders, commissioners, and community pharmacy teams themselves.

Community Pharmacy Contractual Framework (CPCF) 2019/20-2023/24[7]

2.14 The CPCF is an agreement between the Department of Health and Social Care (DHSC), NHSE&I and the Pharmaceutical Services Negotiating Committee (PSNC) and describes a vision for how community pharmacy will support delivery of the NHS Long Term Plan. The CPCF highlights and develops the role of pharmacies in urgent care, common illnesses, and prevention. It aims to "develop and implement the new range of services that we are seeking to deliver in community pharmacy", making greater use of Community Pharmacists' clinical skills and opportunities to engage patients. The deal:

- Through its contractual framework, commits almost £13 billion to community pharmacy, with a commitment to spend £2.592 billion over 5 years.
- Prioritises quality - The Pharmacy Quality Scheme (PQS) is designed to reward pharmacies for delivering quality criteria in clinical effectiveness, patient safety and patient experience.
- Confirms community pharmacy's future as an integral part of the NHS, delivering clinical services as a full partner in local primary care network (PCNs).
- Underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme.
- Includes new services such as the NHS Community Pharmacist Consultation Service (CPCS), which connects patients who have a minor illness with a community pharmacy, taking pressure off GP services and hospitals by ensuring patients turn to pharmacies first for low-acuity conditions and support with their general health.
- Continues to promote medicines safety and optimisation, and the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community.
- Through the Healthy Living Pharmacy (HLP) framework, requires community pharmacies to have trained health champions in place to deliver interventions such as smoking cessation and weight management, provide wellbeing and self-care advice, and signpost people to other relevant services.

2.15 NB: this framework is covers the period of 2019/20-2023/24 and not the full lifetime of this PNA. The impact of the changes to the role of pharmacies in supporting the health and

[6] Public Health England. Pharmacy teams – seizing opportunities for addressing health inequalities (September 2021). https://psnc.org.uk/wp-content/uploads/2021/09/Pharmacy-teams-seizing-opportunities-for-addresssing-health-inequalities.pdf

[7] Community Pharmacy Contractual Framework (2019). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819601/cpcf-2019-to-2024.pdf

wellbeing needs of Barking and Dagenham residents will be considered by the HWB when it is published in 2024.

Pharmacy Integration Fund (PhIF)[8]

2.16 The PhIF and PCN Testbed programme will be used to test a range of additional prevention and detection services, which if found to be effective and best delivered by a community pharmacy, could (with appropriate training) be mainstreamed within the CPCF over the course of the settlement period. Workstreams supported by the PhIF Programme include:

- GP referral pathway to the NHS CPCS.
- Hypertension Case-Finding Pilot - A model for detecting undiagnosed cardiovascular disease (CVD) in community pharmacy and referral to treatment within PCNs.
- Smoking Cessation Transfer of Care Pilot – hospital inpatients (including antenatal patients) will be able to continue their stop smoking journey within community pharmacy upon discharge.
- Exploring the routine monitoring and supply of contraception (including some long-acting reversible contraceptives) in community pharmacy.
- Palliative Care and end of life medicines supply service building on the experience of the COVID-19 pandemic.
- Structured medication reviews in PCNs for people with a learning disability, autism, or both, linked with the STOMP programme.
- Workforce development for pharmacy professionals in collaboration with Health Education England (HEE), e.g., medicines optimisation in care homes; primary care pharmacy educational pathway; leadership; integrated urgent care; independent prescribing; enhanced clinical examination skills.

Regional Context

London Community Pharmacy: Our offer to London – Pharmacy Strategy 2020[9]

2.17 This document was developed jointly by London's local pharmaceutical committees (LPCs), supported by NHS England and NHS Improvement – London region. It presents a service offer to PCNs, local authorities and other health, social care and public health stakeholders, and the people of London. In summary, the offer from London Community Pharmacy is to:

- Expand the range of clinical services
- Increase the range of – and access to – wellness services
- Develop community pharmacy as a social asset – working to increase the social capital of our communities
- Integrate community pharmacy into primary care networks
- Provide strong leadership within integrated care partnerships

[8] NHS Pharmacy Integration Programme. https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/

[9] London LPCs and NHSE&I. *London Community Pharmacy: Our offer to London. Pharmacy Strategy* (2020). https://psnc.org.uk/pharmacylondon/wp-content/uploads/sites/112/2020/09/Offer-to-London.pdf

The Health and Care Vision for London (2019)[10]

2.18 In partnership with Public Health England, NHS, Mayor of London, and London Councils, the vision states a shared ambition to make London the healthiest global city; by making commitments in 10 key areas. The key focus areas are to:

1. reduce childhood obesity
2. improve the emotional wellbeing of children and young Londoners
3. improve mental health and progress towards zero suicides
4. improve air quality
5. improve tobacco control and reduce smoking
6. reduce the prevalence and the impact of violence
7. improve the health of homeless people
8. improve services and prevention for HIV and other STIs
9. support Londoners with dementia to live well
10. improve care and support at the end of life.

North East London Health and Care Partnership (NEL HCP)[11]

2.19 Integrated Care Systems (ICSs) are partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. An ICS exists to improve the health and care of all residents, preventing illness, tackling variation in care and delivering seamless services while getting maximum impact for every pound. The collective strength of these organisations works together to address their residents' biggest health challenges, many exacerbated by COVID-19.

2.20 NEL HCP is the North East London ICS, which brings together NHS organisations, local authorities, and community organisations to support local people to live healthier and happier lives. NEL HCP has started responding to the NHS LTP. It is made up of the following London Councils: Barking & Dagenham, Redbridge, Havering, City and Hackney, Newham, Tower Hamlets, and Waltham Forest; and one CCG, five NHS Trusts (three acute and two community), and 286 GP practices.

Local context

Barking and Dagenham Health and Wellbeing Strategy 2019-2023[12]

2.21 Health and Wellbeing Boards are required to produce Health and Wellbeing Strategies to set out how partners will meet local health needs, improve outcomes, and reduce health inequalities within the borough.

[10] The London Vision (2019). https://www.healthylondon.org/wp-content/uploads/2019/09/London-Vision-short-summary-1.pdf

[11] North East London Health and Care Partnership website: https://www.eastlondonhcp.nhs.uk

[12] Barking and Dagenham Health and Wellbeing Strategy (2019). https://www.lbbd.gov.uk/sites/default/files/attachments/Joint-Health-and-Wellbeing-Strategy-2019-2023.pdf

2.22 Health and Wellbeing Boards are required to produce Health and Wellbeing Strategies to set out how partners will meet local health needs, improve outcomes, and reduce health inequalities within the borough.

2.23 The Barking and Dagenham Health and Wellbeing strategy sets out plans to address gaps and health inequalities, and to achieve realistic and measurable improvements in the health and wellbeing of the residents by 2023. The Joint Strategic Needs Assessment (2017) (JSNA) was used to inform the three key priorities as set out by the health and wellbeing board of Barking & Dagenham:

- **The best start in life:** In the UK, Barking and Dagenham has the highest proportion of residents aged between 0-4. Barking & Dagenham pledge several ways to ensure that all children under the age of 8 have the best start. This includes: resilience building within the first 7 years; seeking alternative community solutions earlier and reserving statutory and specialist services for the most vulnerable children; safeguarding vulnerable children; focusing on supporting communities where there is the potential for the largest impact; co-producing and designing services with residents and children; taking a family based approach to reduce the impact of challenges on children and young people; understanding the factors driving adversities in partnerships, having honest conversations around child development with residents; and providing peer to peer networks to support families.
- **Early diagnosis and intervention:** Barking and Dagenham have the highest rates of deaths from cancer considered preventable in London, and the third highest prevalence of chronic obstructive pulmonary disease (COPD) in London, with the second highest rates of emergency COPD related hospital admissions. The borough also has the third highest proportion of late HIV diagnosis within London. Several pledges have been set to focus on earlier interventions and prevention methods, such as the use of social prescribing to reduce the demand on specialist services, working together with residents and the community to design services for their needs, and having open conversations with residents regarding their health.
- **Building resilience:** The residents of Barking and Dagenham face several inequalities and adversities. Building resilience and coping with change can help the residents to thrive within their communities. The strategy outlines some ways to help the residents of Barking and Dagenham build resilience by ensuring a family-based approach is taken to deal with domestic abuse and violence, child sexual exploitation, and working through a peer-to-peer support model to engage with survivors of domestic violence & abuse, child sexual exploitation and serious crime. Additionally aiming to ensure more people are employed or entering higher education, improve physical and mental wellbeing, and helping older residents to age well with dignity and independence.

Annual Public Health Report for Barking and Dagenham 2020-2021. The impact from COVID-19[13]:

2.24 The annual public health report for Barking and Dagenham highlighted some of the inequalities faced by local residents, particularly in relation to the impact of the COVID-19 pandemic. The findings include:

- A high proportion of Black, Asian and Minority Ethnic (BAME) identifying residents living in older cohabitating households compared to White residents.
- A direct impact of COVID-19 on the residents of Barking and Dagenham, for example, the average age at admission for over 65's was seven years lower in those from a Black African and Black Other background, compared to the White British population.
- Bangladeshi men were 4x more affected than women in terms of mortality.
- Indirect impact of COVID-19 included a double in rate of moderate to severe depression in adults between March and June 2020, and increased levels of stress in younger adults from BAME backgrounds.
- 35% of households with low incomes did not have enough devices to access online learning.
- Obesity was thought to have worsened during the lockdown. The significant time spent at home, reduced activity levels.
- Children living in poorer housing, or with special needs or mental health issues have been particularly affected by the harmful effects of the pandemic.

[13] Annual Public Health Report for Barking and Dagenham 2020-21. The Impact from COVID-19. https://www.lbbd.gov.uk/sites/default/files/attachments/LBBD%20Equality%20Challenges%20in%20Barking%20and%20Dagenham%20Report%202021%20summary.pdf

Chapter 3 - The development of the PNA

3.1 This PNA has been developed using a range of information sources to describe and identify population needs and current service provision from the network of community pharmacies (see Table 3.1). This includes:

- Nationally published data
- The Barking and Dagenham Joint Strategic Needs Assessment
- Local policies and strategies such as the Joint Health and Wellbeing Strategy
- A survey to Barking and Dagenham pharmacy providers
- A survey to the patients and public of Barking and Dagenham, Havering and Redbridge
- Local Authority and BHR CCG commissioners

Table 3.1 PNA 2022-25 data sources

Health need and priorities	• National benchmarking ward and borough-level data from Public Health England[14] • London Borough of Barking and Dagenham Joint Strategic Needs Assessment[15] • A range of GLA demographic data sets • Synthesis from a range of national datasets and statistics
Current Pharmaceutical Services	• Commissioning data held by the NHS England • Commissioning data held by London Borough of Barking and Dagenham • Commissioning data held by North East London CCG • Questionnaire to community pharmacy providers
Views from community pharmacy contractors	• Questionnaire to community pharmacy providers and follow-up interviews
Patients and the Public	• Patient and public survey

3.2 These data have been combined to describe the Barking and Dagenham population, current and future health needs and how pharmaceutical services can be used to support the Health and Wellbeing Board (HWB) to improve the health and wellbeing of our population.

3.3 This PNA was published for public consultation between the 31st January to 4th April 2022. All comments received and the steering group responses to those comments were summarised in the consultation report in Appendix D.

[14] Public Health England (2021) Public Health Profiles: https://fingertips.phe.org.uk/
[15] BHR JSNA profile: LB Barking and Dagenham 2020

Methodological considerations

Geographical Coverage

For the purposes of the PNA the geographical localities of Barking and Dagenham is presented as electoral wards to summarise demographic and health need. Barking and Dagenham has 17 in total, these are illustrated in figure 3.1.

Figure 3.1 London Borough of Barking and Dagenham Electoral Wards

3.4 Provision and choice of pharmacies is determined by using 1 mile radius from the centre of the postcode of each pharmacy. This is approximately a 20-minute walk from the outer perimeter of the buffer zone created. The 1-mile radius approach illustrates where there is pharmacy coverage and areas without coverage (for example, see Figure 6.1).

3.5 In addition, 20-minutes travel time by public transport is also considered as being a reasonable measure to identify variation and choice. Where the population are within 1-mile of a pharmacy or can reach a pharmacy within 20-minutes travel time by public transport then the pharmacy provision is considered 'good'.

3.6 Where areas of no coverage are identified, other factors are taken into consideration to establish if there is a need. Factors include population density, whether the areas are populated (e.g., Green Belt areas), travel time by public transport, patient demand for services (such as needle exchange) and dispensing outside normal working hours. These instances have all been stated in the relevant sections of the report.

Patient and Public Survey

3.7 Patient and public engagement in the form of a survey was undertaken to understand how people use their pharmacies, what they use them for and their views of the pharmacy provision. 364 Barking and Dagenham, Havering and Redbridge residents and workers responded to the survey, their views were explored, including detailed analysis of the Protected Characteristics. The findings from the survey are presented in Chapter 5 of this PNA.

Pharmacy Contractor Survey

3.8 The contractor survey was sent all to the community pharmacies within Barking and Dagenham and 34 pharmacies responded. The results from this survey are referred to throughout this document.

Governance and Steering Group

3.9 The development of the PNA was advised by a Steering group whose membership included representation from:

- Public Health teams in London Borough of Barking and Dagenham, the London Borough of Havering and the London Borough of Redbridge
- North East London Clinical Commissioning Group
- North East London Local Pharmaceutical Committee (LPC)
- Healthwatch Barking and Dagenham, Healthwatch Havering and Healthwatch Redbridge.

The membership and Terms of Reference of the Steering Group is described in Appendix A.

Regulatory consultation process and outcomes

3.10 The PNA for 2022-25 was published for statutory consultation on the 24th of January 2022 for 60 days. All comments were drafted into a consultation report for the steering group (Appendix D) and have been considered and incorporated into the final PNA report to be published before 1st October 2022.

Chapter 4 - Demographics and Health Needs

4.1 This chapter presents an overview of health and wellbeing in Barking and Dagenham, particularly the areas likely to impact on needs for community pharmacy services. It includes an analysis of the latest Barking and Dagenham population and inequalities projections.

4.2 The analysis of health needs and population changes are outlined in five sub-sections of this chapter and are guided by the Barking and Dagenham JSNA[16] priority areas. These are:

- Barking and Dagenham demographic characteristics
- Wider determinants of health
- Our health behaviours and lifestyles
- The places and communities in which we live
- An integrated health and care system

4.3 All the maps that follow present the proportion of the population in relation to different factors such as population density, deprivation, and obesity. They are displayed in gradients, where the lower the marker, the lighter the colour. The gradients are illustrated in the legends attached to each map.

Barking and Dagenham Demographic Characteristics

Population size and density

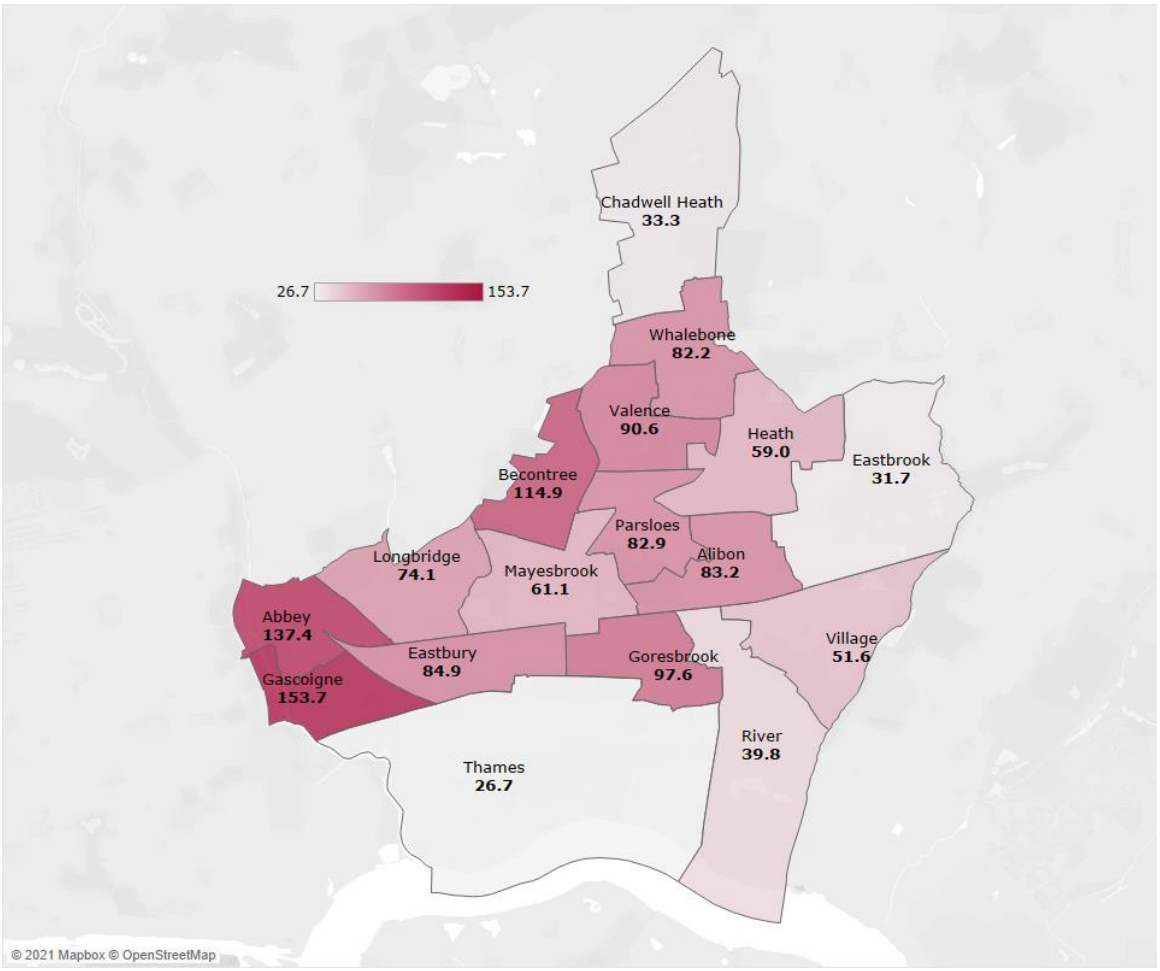
4.4 The London Borough of Barking and Dagenham is a North East London Borough situated in Outer London. It borders Havering, Newham, Bexley, Greenwich, and Redbridge. Barking and Dagenham has a number of local centres and two main town centres, these are Barking Town Centre and Dagenham Heathway, the largest being Barking Town Centre.

4.5 Greater London Authority estimates that the population of Barking and Dagenham is 217,384 in 2022 (Housing-led population projections).

4.6 The borough's population density is comparable to the London average (57.9 vs 56.2 - per hectare respectively) with the most densely populated wards being the western wards of Gascoigne and Abbey (see Figure 4.1).

[16] BHR JSNA profile: LB Barking and Dagenham 2019-20

Figure 4.1: Population Density of Barking and Dagenham per hectare by Ward, 2022 estimates



Source: GLA, Land Area, and Population Density

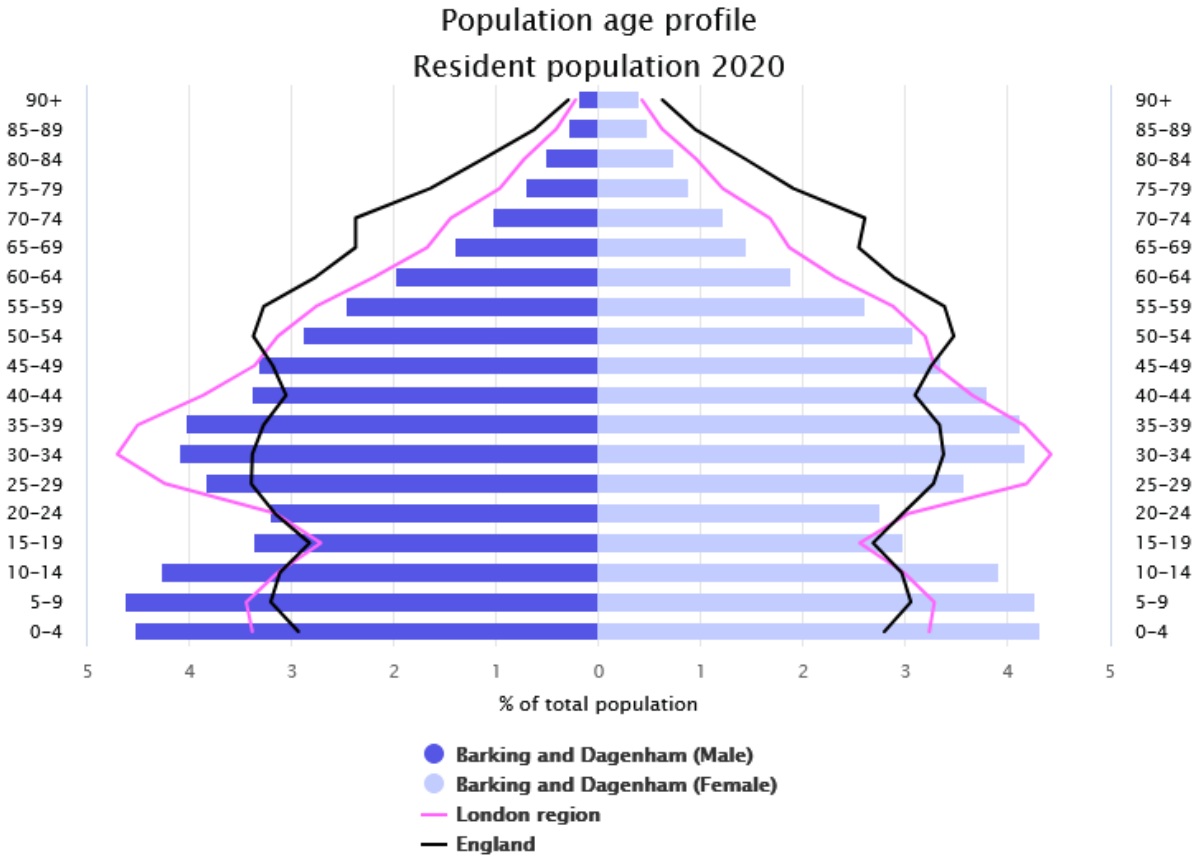
Age and Gender Structure

4.7 According to 2020 mid-year estimates Barking and Dagenham has a comparatively young population; in fact, it has the highest proportion of children and young people in the country. 27.3% of the population is aged between **0-15 years**.

4.8 The proportion of **working age population** is slightly lower than that of the rest of London. 63.4% of the population are age between 16 and 64, compared to 73.6% for all of London.

4.9 9.73% of Barking and Dagenham residents are **aged 65 and over**. This is lower than London overall (12.5%). Figure 4.2 presents a breakdown of the age and gender of Barking and Dagenham residents (ONS 2020 Mid-Year Estimates).

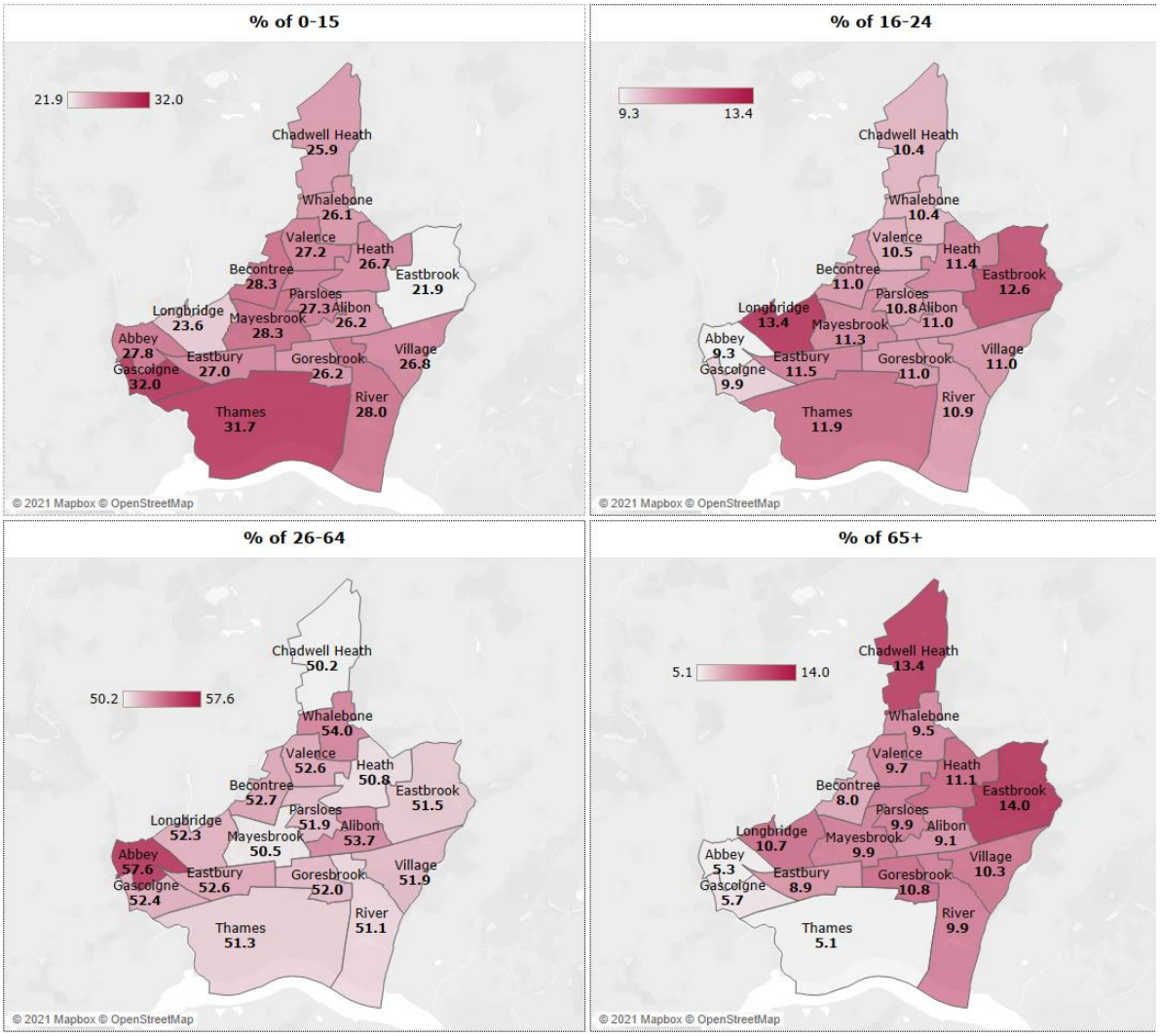
Figure 4.2: Proportion of resident population by age-band and gender, Mid-year 2020 estimates for Barking and Dagenham



Source: PHE, Local Authority Health Profiles, 2022

4.10 The south-western wards of Gascoigne and Thames have the highest representation of the 0-15 population, while Eastbrook in the north-west and Chadwell South, the most northern ward, have the highest representation of those aged 65+ (see figure 4.3).

Figure 4.3 Population Age Groups by Ward, 2019 mid-year estimates



Source: PHE, Local Authority Health Profiles, 2018

Ethnicity and diversity

4.11 Areas where diversity is higher correlate with areas of higher levels of deprivation and poorer health. Pharmacy staff often reflect the social and ethnic backgrounds of the community they serve making them approachable to those who may not choose to access other health care services. [17]

4.12 NICE Guidance[18] highlights that community pharmacies can impact on health inequalities in several ways. For example, they recommend that community pharmacists take into consideration how a patient's personal factors may impact on the service they receive. Personal factors would include, but are not limited to, gender, identity, ethnicity, faith, culture,

[17] NICE guideline (2018) Community pharmacies: promoting health and wellbeing [NG102]
[18] NICE guideline (2018) Community pharmacies: promoting health and wellbeing [NG102]

or any disability. It also recommends that community pharmacists make use of any additional languages staff members may have.

4.13 Nearly half (49%) of the Barking and Dagenham resident population are from **BAME groups.** One in four residents identify as Asian and 17% are Black (Table 4.1).

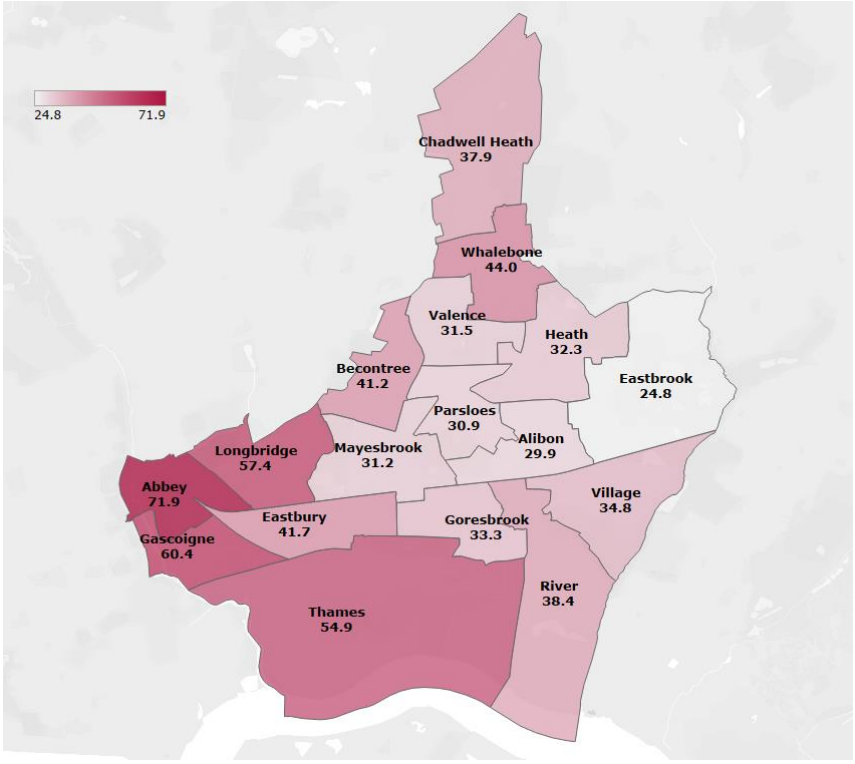
Table 4.1 Ethnicity population breakdown for Barking and Dagenham, London and England and Wales

Area	White	Asian	Black	Mixed/ Other
Barking and Dagenham	50.9%	25.2%	16.8%	7.0%
London	59.2%	18.4%	11.9%	10.6%
United Kingdom	85.9%	7.3%	3.3%	3.5%

Source: UK Data Service, Annual Population Survey, 2019

4.14 The highest representation of the Black, Asian and Minority Ethnic population is in the western wards of the borough, particularly Abbey, Gascoigne, and Thames (see Figure 4.4).

Figure 4.4: Percentage of black and ethnic minority groups by wards in Barking and Dagenham, 2011

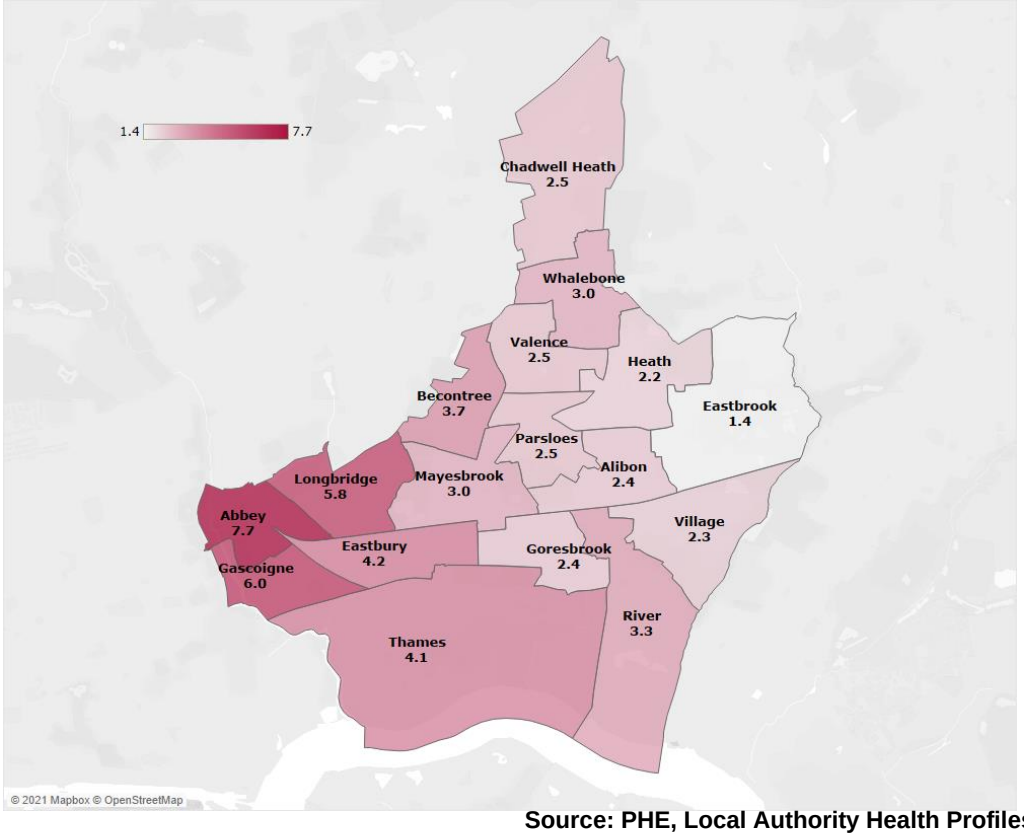


Source: ONS Census, 2011

4.15 18.7% of the borough's residents who are aged 3+ state their main language is not English (2011 census). This is likely to increase significantly due to levels of international migration.

4.16 Figure 4.5 shows a breakdown of the population who **do not speak English well or at all**. As with the BME data, the wards with the greatest population of residents not proficient in English are Abbey, Gascoigne, and Thames. Please note, this map is created from 2011 census data.

Figure 4.5: Percentage of people that cannot speak English well or at all by Ward in Barking and Dagenham in 2019



Source: PHE, Local Authority Health Profiles, 2021

4.17 2011 data shows that Lithuanian, Bengali and Urdu are the most spoken languages in the borough after English (Table 4.2).

Table 4.2: Proportion of languages spoken in Barking and Dagenham

Language	Percentage
English	81.3%
Lithuanian	2.3%
Bengali	2.0%
Urdu	1.7%
Polish	1.0%
Panjabi	0.9%
Albanian	0.8%
Portuguese	0.8%

French	0.7%
Romanian	0.7%

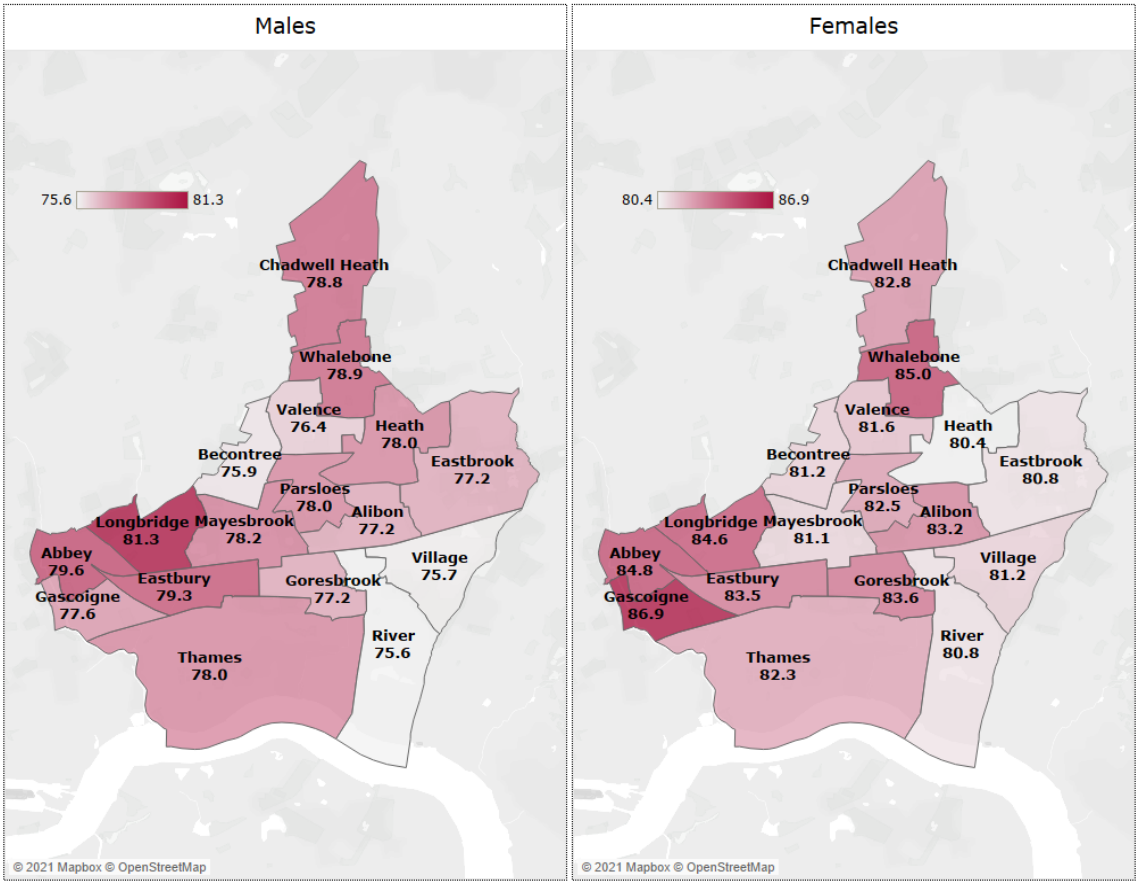
Source: ONS Census, 2011 Population Health Outcomes

4.18 **Life expectancy at birth** is the average number of years a person would expect to live based on contemporary mortality rates. For males in Barking and Dagenham this is 78.1, and 82.3 years for females (2017-19 figures). This is lower than national figures for both males and females at 79.8 and 83.4 years, respectively. Barking and Dagenham have the lowest life expectancy figures in London (PHE 2021).

4.19 The variation in life expectancy across Barking and Dagenham is low. The **inequality in life expectancy at birth**, which is the measure of the absolute difference in life expectancy between the most and least deprived areas, shows a 2.9-year life expectancy gap for men and a 3.2-year gap for women between those who live in the most deprived areas and the least deprived areas in 2017-19. In terms of national comparators, Barking and Dagenham are within the lowest quintile for differences in life expectancy (PHE, 2021). This means that they have comparatively low inequality in life expectancy at birth.

4.20 A breakdown of life expectancy figures at a ward level is presented in Figure 4.6. River has the lowest life expectancy among males, while Heath has the lowest among females.

Figure 4.6: Life expectancy at birth for Males and Females in Barking and Dagenham, 2015 to 2019

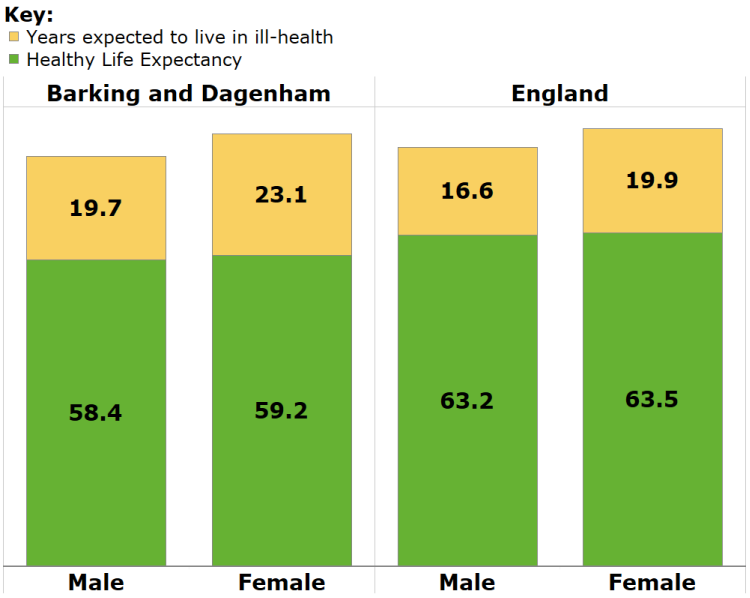


Source: PHE, Local Authority Health Profiles, 2021

4.21 **Healthy life expectancy** at birth is the average number of years an individual should expect to live in good health considering age-specific mortality rates and prevalence for good health for their area.

4.22 The healthy life expectancy for both males and females are also significantly lower than national figures. They are also the lowest in London for males and third lowest in London for females. Males have a healthy life expectancy of 58.4 years and females have a healthy life expectancy of 59.2 years (2017-19). The England healthy life expectancy for men is 63.2 and 63.5 for women. These figures indicate that males living in Barking and Dagenham could live with ill health for 19.7 years and females for 23.1 years, three years more than the England average (see figure 4.7).

Figure 4.7: Life expectancy and Healthy life expectancy in years for males and females in Barking and Dagenham, 2017-2019



Source: PHE, Public Health Profiles, 2021

Wider Determinants of Health

4.23 There are a range of social, economic, and environmental factors that impact on an individual's health behaviours, choices, goals and ultimately, health outcomes and life expectancy. These include factors deprivation, housing, education, and employment. Barking and Dagenham Joint Health and Wellbeing Strategy[19] acknowledges the need to influence these wider determinants of health to improve health and wellbeing outcomes of its residents. We will explore each of these in this section.

4.24 Community pharmacies are typically well-placed within communities that are most likely to experience health inequalities. Often, they are the only healthcare facility located in an area of deprivation. Additionally, 'underserved' communities, such as those who are homeless or sleeping rough, people who misuse drugs or alcohol may be more likely to go to a community

[19] Barking and Dagenham Joint Health and Wellbeing Strategy 2019-2023

pharmacy than a GP or another primary care service[20]. They also play a role as a community asset for people who are experiencing violence or abuse. They provide a safe place where people can get information and support and make calls for help.

4.25 Pharmacies have the potential to play a vital role in improving the health of deprived communities by offering convenient and equitable access to health improvement services. All registered pharmacists must complete the CPPE e-learning on Health Inequalities and pass the accompanying e-assessment. This will enable them to develop the appropriate knowledge and skills required to take action to tackle health inequalities at a local and community level with the individuals they serve.

Deprivation

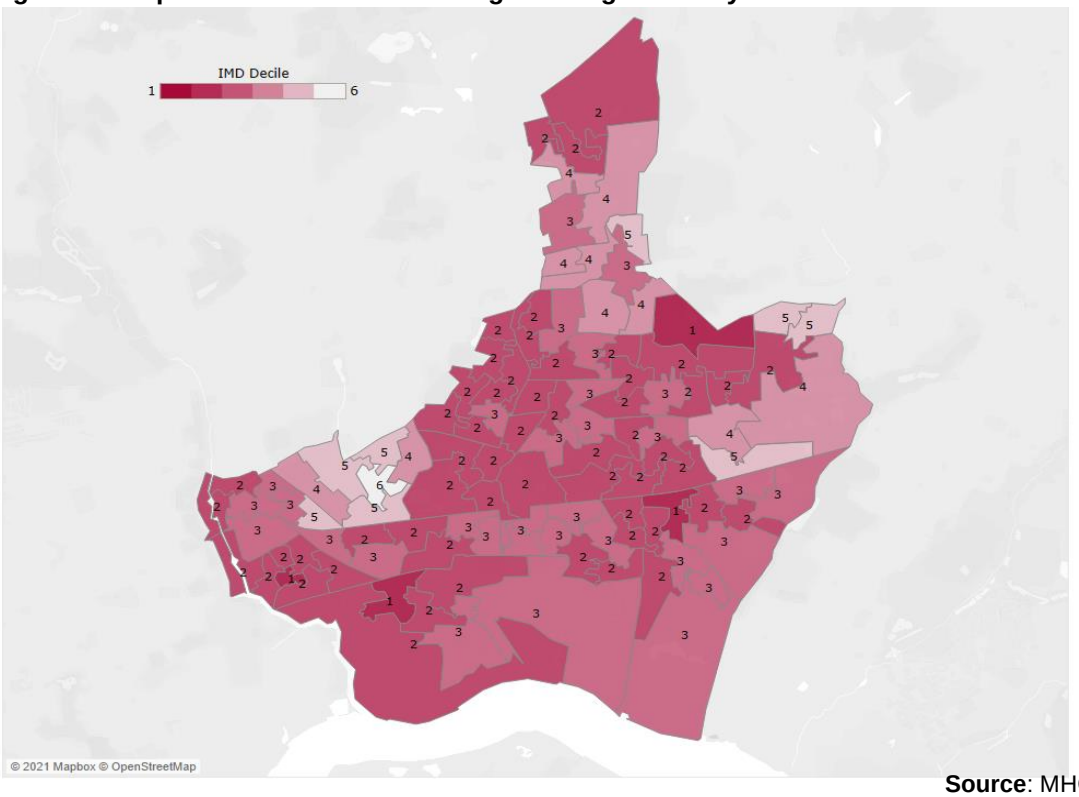
4.26 Access to community pharmacy services in communities where there is high deprivation is important in addressing health inequalities. IMD deciles enable a comparison of deprivation in neighbourhoods across England. A decile of one, for instance, means, that the neighbourhood is among the most deprived 10% of neighbourhoods nationally (out of a total of 32,844 neighbourhoods in England).

4.27 Barking and Dagenham has 110 neighbourhoods (LSOAs). The borough's overall average IMD decile figure is 2.7 compared to the national one of 5.5. This means that Barking and Dagenham is considerably more deprived compared to England as a whole.

4.28 Figure 4.8 shows deprivation deciles at LSOA level, highlighting that there are high levels of deprivation in Barking and Dagenham, with several areas having deprivation levels that falls within the highest in the nation. 60 of the boroughs 100 LSOAs are among the most deprived 20% in all of England.

[20] NICE guideline (2018) Community pharmacies: promoting health and wellbeing [NG102]

Figure 4.8 Deprivation deciles in Barking and Dagenham by LSOA in 2019



Source: MHCLG, 2019

4.29 Employment is one of the domains that determine index of multiple deprivation scores. In 2019/20, 71.1% people of the working age population of the borough were **in employment**. This is lower than the London and England rate at 75.1 and 76.2% respectively (Annual Population Survey, 2020).

4.30 The **COVID-19** pandemic has highlighted the impact of deprivation on health risks and health outcomes. COVID-19 morbidity and mortality has been more pronounced in more deprived areas and in those from ethnic minority groups who experience more social inequalities such as income, housing, education, employment, and conditions of work.

4.31 Nationally, the people who have suffered the worst outcomes from COVID-19 have been older, of black or Asian heritage and have underlying health conditions such as obesity of diabetes[21]. In Barking and Dagenham, COVID-19 case analysis showed that there was an over-representation of Bangladeshi, Pakistani, Indian, Other Asian, Other Black, and Other ethnic groups in particular who have tested positive for COVID-19.

4.32 The proportion of hospital admissions due to COVID-19 were higher amongst White British, Bangladeshi or Pakistani, and Other Ethnic groups relative to their composition of the

[21] PHE (2020). Beyond the data: Understanding the impact of COVID-19 on BAME groups.

population. The high representation of White British may be due to the older population being predominantly white[22].

4.33 As part of the Pharmacy Quality Scheme guidance for 2021/22 pharmacists must complete and action plan to actively promote COVID-19 vaccinations, particularly in Black, Asian and minority ethnic and low uptake communities. [23]

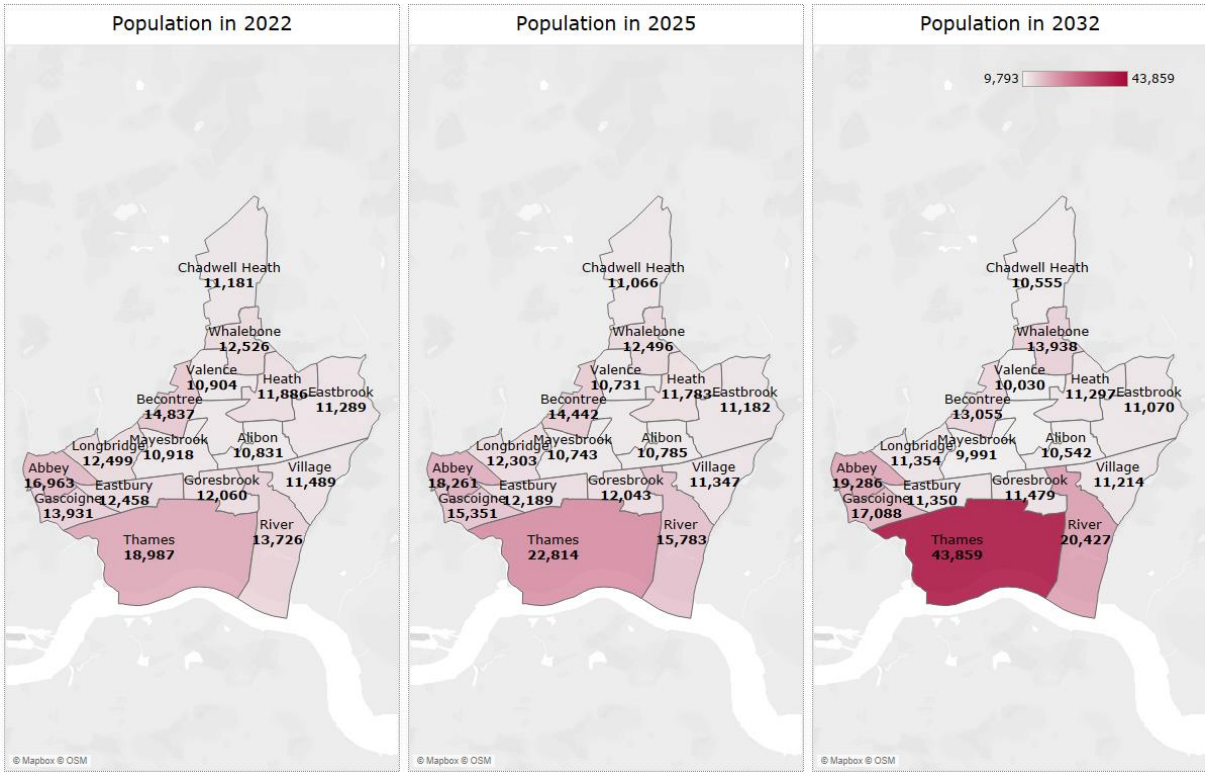
Regeneration Population Growth

4.34 Barking and Dagenham is an area designated as a national priority for urban regeneration. The target for Barking and Dagenham is 22,640 additional homes between 2019/20 and 2028/29. The majority of this development is located in Barking Riverside. A key feature of the District Centre is a proposed Health and Wellbeing hub combining a new leisure centre with pool together with health and community facilities. A new health facility would be provided as part of the new development to service.

4.35 The population of the borough is expected to increase by 3% between 2022 and 2025 (the lifetime of this PNA) to 223,986 (See Table 4.3).

4.36 Between 2022 and 2032 it is expected to increase substantially by 21.8% to 273,369 residents (GLA, Housing-led population projections – Identified Capacity Scenario, 2021). These figures are based on mid-year population estimates and assumptions such as births, deaths, and migration.

Figure 4.9: Population Change by Ward – 2022, 2025 and 2032



[22] Annual Director of Public Health Report 2020/21: Equality Challenges in Barking and Dagenham.
[23] Pharmacy Quality Scheme Guidance 2021/22

Source: GLA, Housing-led population projections – Identified Capacity Scenario, 2021

4.37 The wards with the highest anticipated population increases are Thames, River and Gascoigne. Thames ward's population is expected to more than double in size between 2022 and 2032 (from 18,976 to 43,859 residents) (see Table 4.3).

Table 4.3: **Projected population increase by ward between 2022 - 2032**

Name	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Abbey	0.0%	3.1%	6.1%	7.6%	9.3%	11.1%	13.0%	15.0%	14.4%	14.0%	13.7%
Alibon	0.0%	0.2%	-0.3%	-0.4%	-0.8%	-0.7%	-0.5%	-0.6%	-1.4%	-2.1%	-2.7%
Becontree	0.0%	-0.6%	-1.1%	-2.7%	-4.3%	-5.7%	-6.8%	-7.9%	-9.5%	-10.9%	-12.0%
Chadwell Heath	0.0%	-0.3%	-0.7%	-1.0%	-1.7%	-2.2%	-2.4%	-2.3%	-3.6%	-4.7%	-5.6%
Eastbrook	0.0%	-0.3%	-0.8%	-0.9%	-1.1%	-1.1%	-1.1%	-1.0%	-1.4%	-1.7%	-1.9%
Eastbury	0.0%	-0.5%	-1.0%	-2.2%	-3.2%	-3.9%	-4.7%	-5.2%	-6.7%	-7.9%	-8.9%
Gascoigne	0.0%	4.1%	8.0%	10.2%	12.4%	14.7%	17.2%	19.9%	20.6%	21.6%	22.7%
Goresbrook	0.0%	0.1%	0.1%	-0.1%	-0.4%	-0.6%	-0.9%	-1.1%	-2.5%	-3.7%	-4.8%
Heath	0.0%	0.1%	-0.3%	-0.9%	-1.5%	-2.0%	-2.3%	-2.4%	-3.4%	-4.3%	-5.0%
Longbridge	0.0%	-0.1%	-0.6%	-1.6%	-2.5%	-3.4%	-4.2%	-5.1%	-6.6%	-8.1%	-9.2%
Mayesbrook	0.0%	-0.1%	-0.6%	-1.6%	-2.6%	-3.3%	-4.0%	-4.6%	-6.1%	-7.4%	-8.5%
Parsloes	0.0%	-0.2%	-0.7%	-2.1%	-3.4%	-4.7%	-5.8%	-6.7%	-8.0%	-9.2%	-10.1%
River	0.0%	4.3%	8.4%	15.0%	22.7%	30.6%	38.4%	46.3%	47.1%	48.0%	48.8%
Thames	0.0%	6.7%	13.0%	20.2%	28.6%	37.0%	45.4%	53.9%	79.5%	105.3%	131.0%
Valence	0.0%	0.0%	-0.7%	-1.6%	-2.4%	-3.3%	-4.1%	-4.8%	-6.1%	-7.3%	-8.0%
Village	0.0%	-0.6%	-1.5%	-1.2%	-0.9%	-0.3%	0.6%	1.4%	-0.1%	-1.4%	-2.4%
Whalebone	0.0%	0.0%	-0.2%	-0.2%	-0.1%	0.1%	0.3%	0.8%	4.1%	7.6%	11.3%
Borough Total	0.0%	1.2%	2.2%	3.0%	4.1%	5.2%	6.5%	7.9%	9.5%	11.3%	13.3%

Source: GLA, Housing-led population projections – Identified Capacity Scenario, 2021

4.38 This growth is being driven by the high fertility rate in the population of Barking and Dagenham and by the urban regeneration. Population increases will most likely increase due to demand for community pharmacy services, this will be considered in Chapter 6 where we look at the capacity of the current pharmacy provision.

Our health behaviours and lifestyles

4.39 Health-related behaviours such as smoking, drinking alcohol to excess, being physical inactive and having a poor diet can significantly impact on health outcomes.

4.40 Community pharmacies are mandated to provide the Healthy Living Pharmacy framework. This ensures that they are providing a broad range of health promotion interventions designed to meet local need. The framework includes supporting the delivery of community health promoting interventions, by for example, engaging public health campaigns and rolling out locally commissioned initiatives such as stop smoking services, sexual health services and dementia friends.

4.41 As an essential service, pharmacies participate in up to six national health campaigns at the request of NHS England and NHS Improvement. The first mandated health campaign of 2021/22 was the COVID-19 vaccination campaign to inform the public about the vaccine and encourage people to take it up when it is offered to them.

4.42 In addition, pharmacies are required to signpost people to other health and social care providers and provide brief advice where appropriate.

4.43 This section of the chapter explores different health behaviours and lifestyles that impact the health of the Barking and Dagenham population that pharmacies can support people with.

Smoking

4.44 Smoking is the leading cause for preventable death in the world. 18.1% of adults surveyed in Barking and Dagenham smoke. This is a substantially higher rate than London and England where 12.9% and 13.9% smoke, respectively.

Dietary risks

4.45 **Obesity** is recognised as a major determinant of premature mortality and avoidable ill health. It increases the risk of a range of diseases including certain cancers, high blood pressure and type 2 diabetes[24] and increases the risk of death from COVID-19 by 40- 90%[25]. In 2019/20, 65.5% of adults are overweight or obese in Barking and Dagenham.

4.46 This proportion is substantially higher than London rate 55.7%, the fourth highest London. It is also slightly higher than the England rate where 62.8% of adults are overweight or obese (PHE, 2021).

Low physical activity

4.47 Just over one-half of adults (53.9%) residing in the borough in 2019/20 are considered **physically active**, meaning they engage in at least 150 minutes of moderate physical activity per week (PHE, 2021). People who are physically active reduce their chances of cardiovascular disease, coronary heart disease and stroke. Physical activity also decreases the risk of obesity, diabetes, osteoporosis, and some cancers and can improve mental health mental health.

4.48 Barking and Dagenham have the third highest proportion of **physical inactive** adults. 31.9% of Barking and Dagenham adults are inactive (2019/20 data), meaning they are doing less than 30 minutes a week. This is significantly higher than regional national figures. 23.8% of Londoners and 22.9% of England residents are physically inactive (PHE, 2021).

Alcohol use

4.49 **Alcohol consumption** contributes to morbidity and mortality from a diverse range of conditions. 6.2 per 100,000 deaths were wholly caused by alcohol consumption in Barking

[24] Public Health England (2017). Guidance: Health matters: obesity and the food environment.

[25] Public Health England. Excess weight and covid-19. Jul 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903770/PHE_insight_Excess_weight_and_COVID-19.pdf.

and Dagenham in 2017-19. This is lower than London and national figures of 7.9 and 10.9 respectively (PHE 2021).

4.50 There were 592 admission episodes for Barking and Dagenham residents where alcohol was the main reason for admission in 2019/20. This equates to 373 per 100,000 hospital admissions. This is significantly lower than national figures at 519 per 100,000 and lower than London at 416 per 100,000 (PHE 2021).

4.51 The rate of **Binge drinking** in Barking and Dagenham is lower to that of the rest of England. 12.9% of adults binge drink on their highest drinking day (2015-18), lower than national and regional figures of 15.4% and 14.6% respectively (Health Survey for England, 2021).

Substance misuse

4.52 Substance misuse is defined as intoxication or regular excessive consumption and/or dependence on psychoactive substances. It can lead to mental health problems such as depression or suicides, adverse experiences, and behaviours such as truancy, exclusion from school and social and legal problems such as homelessness, time in care and serious or frequent offending.

4.53 Pharmacies can provide support for people with substance misuse problems through needle and syringe services; supervised consumption of medicines to treat addiction, e.g., methadone; Hepatitis testing and Hepatitis B and C vaccination; HIV testing; provision of naloxone to drug users for use in emergency overdose situations.

4.54 771 Barking and Dagenham residents are receiving treatment at specialist **drug misuse** services (2017/18 figures, PHE 2021). 64.2% of opiates and/or crack cocaine users are not in treatment (2018/19 figures, PHE 2021) This is significantly higher than the national proportion of 52.1%.

Unsafe Sex

4.55 Barking and Dagenham have a high **Sexually Transmitted Infection** (STI) testing rate, for example, in 2019 7,704 residents (under 25 years) were tested. Despite this, in 2019 941 per 100,000 Barking and Dagenham residents were diagnosed with an STI (excluding Chlamydia), this is similar to national figures (830 per 100,00) and one of the lowest in London where 1,683 per 100,000 tested positive with a STI (PHE, 2021).

4.56 **Chlamydia** figures, however, are quite high in comparison to national figures. In 2019, chlamydia was detected in 423 15- to 24-year-olds (equating to 1,606 per 100,000 population). In England the rate at 1,420 per 100,000 population (PHE, 2021).

4.57 The latest figures show that there are 713 residents (15- to 59- year-olds) in Barking and Dagenham diagnosed with **HIV**. This equates to 5.49 per 100,000 people. This is significantly higher than the national rates at 2.39, although lower than the regional figure at 5.60 per 100,000 population. 86.7% of those newly diagnosed with HIV start antiretroviral therapy with 91 days of diagnosis (2017-19 figures) and 92.5% achieve virological success meaning they have achieved an undetectable viral load in 2019 (PHE, 2020).

Air pollution

4.58 **Air quality** is of concern in Barking and Dagenham. Particulate matter contributes to mortality, particularly cardiopulmonary mortality. Like most of London, Barking and Dagenham is within the worst quintile for proportion fine particulate matter within the air. In 2019, 6.8% of mortality in Barking and Dagenham is attributed to particulate air pollution. This is higher than London and England at 6.4% and 5.1% respectively (PHE, 2021).

Violence against women and girls

4.59 Violence against women and girls in London is increasing. 1 in every 10 crimes recorded by the Metropolitan Police being **domestic abuse** related. In Barking and Dagenham, the prevalence rate of reported domestic abuse is high. In 2017/18 there were 23 incidents of domestic abuse reported for every 1000 population and there were over 1700 referrals to children's social care for domestic abuse alone. There were also 390 referrals for other forms of violence against women and girls such as female genital mutilation, forced marriage, stalking, sexual abuse and sexual exploitation[26].

Community Safety

4.60 London Borough of Barking and Dagenham Community Safety Partnership Plan[27] outlines how partner agencies will work collaboratively to ensure that Barking and Dagenham is a safer place to live, work and visit. It's key priorities address:

- anti-social behaviour
- burglary
- non-domestic abuse violence with injury
- serious youth violence and knife crime

An Integrated Health and Care System

4.61 Barking and Dagenham, Havering and Redbridge CCGs have established a number of transformation boards to redesign and integration of health and social care services locally[28]. These are focused on different stages of the life course, as well as mental health, cancer and long-term conditions. We will explore each of these individually in this section of the PNA.

Maternity

4.62 Barking and Dagenham has the **highest birth rate** in London. In 2019, there were 117,897 births in Barking and Dagenham, this equates to a birth rate of 77.5 per 1,000 females aged 15 to 44 years. The national birth rate was 57.7 per 1000 females (ONS, 2021).

4.63 There are a few areas of concern in child and maternal health in Barking and Dagenham. For example, the **stillbirth rate** is the second highest in London. There were 69 stillbirths in 2017-

[26] London Borough of Barking and Dagenham (2018). Ending violence against women and girls: A gender-informed strategy to tackle domestic and sexual violence 2018-2022

[27] London Borough of Barking and Dagenham Community Safety Partnership Plan 2019-2022: Annual Refresh 2021.

[28] BHR JSNA profile: LB Barking and Dagenham 2019-20

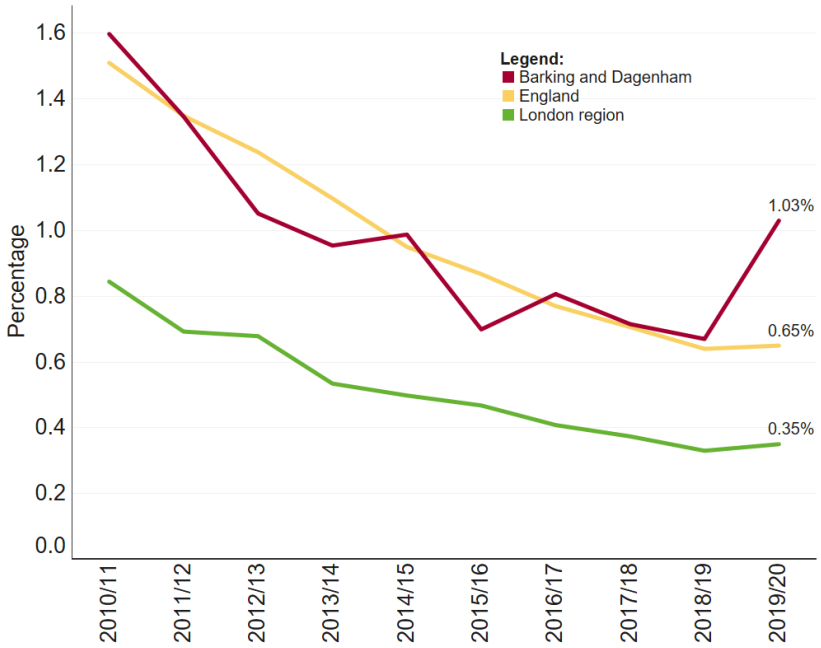
19, equating to a rate of 6.2 per 1,000 births in 2017-19. The national rate is 4.0 per 1,000 stillbirths (ONS, 2021).

4.64 The rate of **premature births** is also among the highest in England and the third highest in London. 89.3 per 1,000 births were premature (before 37 gestation), this is a total of 1,036 in 2016-18 (ONS, 2021).

4.65 Barking and Dagenham has the highest rate of **teenage mothers** in London. Teenage mothers are of a higher risk of postnatal depression and poor mental health. Children born to teenage mothers have higher risk of infant mortality and low birthweight. The rate of births to teenage mothers had been reducing in recent years, in-line with national figures, however increased substantially in 2019/20 (Figure 4.10).

4.66 One percent of births in Barking and Dagenham were to teenage mothers in 2019/20. The England and London rate are 0.7% and 0.4% respectively (HES, 2021).

Figure 4.10: Percentage of Deliveries where the mother is aged under 18 years, 2010/11 to 2019/20



Source: PHE, Local Health Indicators, 2021

4.67 **Folic acid** before and in the first 4 weeks of pregnancy is very important for the development of a healthy foetus, it can significantly reduce the risk of neural tube defects, such as spina bifida. 18.7% of Barking and Dagenham expectant mothers took folic acid supplements before their pregnancy in 2019/20. This is the third lowest in London and substantially lower than national figures where 27.3% expectant mothers took folic acid supplements before their pregnancy (Maternity Services Dataset, 2021).

4.68 Barking and Dagenham also has the highest rate of **obesity in early pregnancy**. Excess weight or obesity can lead to increased risk of a number of issues for both mother and baby, including diabetes, miscarriage and maternal death for the mother and foetal death, stillbirth, congenital abnormality for the baby. More than a quarter (27.4%) of mothers were obese in 2018/19, this is higher than London and England with 17.8% and 22.1% respectively (Maternity Services Dataset, 2021).

4.69 Nearly three quarters (73.6%) of new mothers gave their babies **breast milk** in their first 48 hours in 2016/17. This is similar to national figures of 74.5% (NHS England, 2018).

Children and young people

4.70 Barking and Dagenham has the highest proportion of children and young people in the country and due to the high birth rate the young population is growing. In this section we explore the wider determinants of health in children, health behaviours and health outcomes that are of concern in Barking and Dagenham.

Wider determinants of Health for children

4.71 Strong **educational attainment** in childhood is linked to better health outcomes and better access to work opportunities and higher income. In Barking and Dagenham, the proportion of children reaching a good level of development or reaching expected standards are in-line with national figures at most Key Stages. At some stages Barking and Dagenham are doing better than national comparators. For example, 16- and 17-years olds were in Education or training (LAIT, 2021), higher than the national proportion of 93%. In 2021 82.8% of 19-year-olds have achieved a level 2 qualification in Barking and Dagenham, nationally the figure is 81.3%.

4.72 **School absences** are lower than national comparators, particularly in children who have been looked after. 3.5% of school absences are from children who have been looked after, whereas nationally 5.1% of absences are of children who have been looked after in 2019 (LAIT, 2021).

4.73 Since March 2020 children's development has been disrupted by national and local lockdowns, leading to breaks in their education, inequalities in online education and lack of social contact. This may result in long-term impact on educational outcomes and their physical, mental, and emotional wellbeing. Information on the actual impact has not yet been quantified.

4.74 Childhood poverty is high in Havering. Children living in poverty are at more exposed to a range of risks that can impact on their mental health. In 2019/20 13,032 (22.5%) children are living in **absolute low-income families**. The highest in London. Nationally 15.6% of children are living in absolute low-income families.

4.75 25 per 1,000 households with dependent children in Barking and Dagenham are owed a duty under the Homelessness Reduction Act. This means that they have been identified as homeless by the local authority and the local authority must take reasonable steps to help them to secure accommodation. This equates to 847 families, the fifth highest in London.

Health behaviours and health outcomes

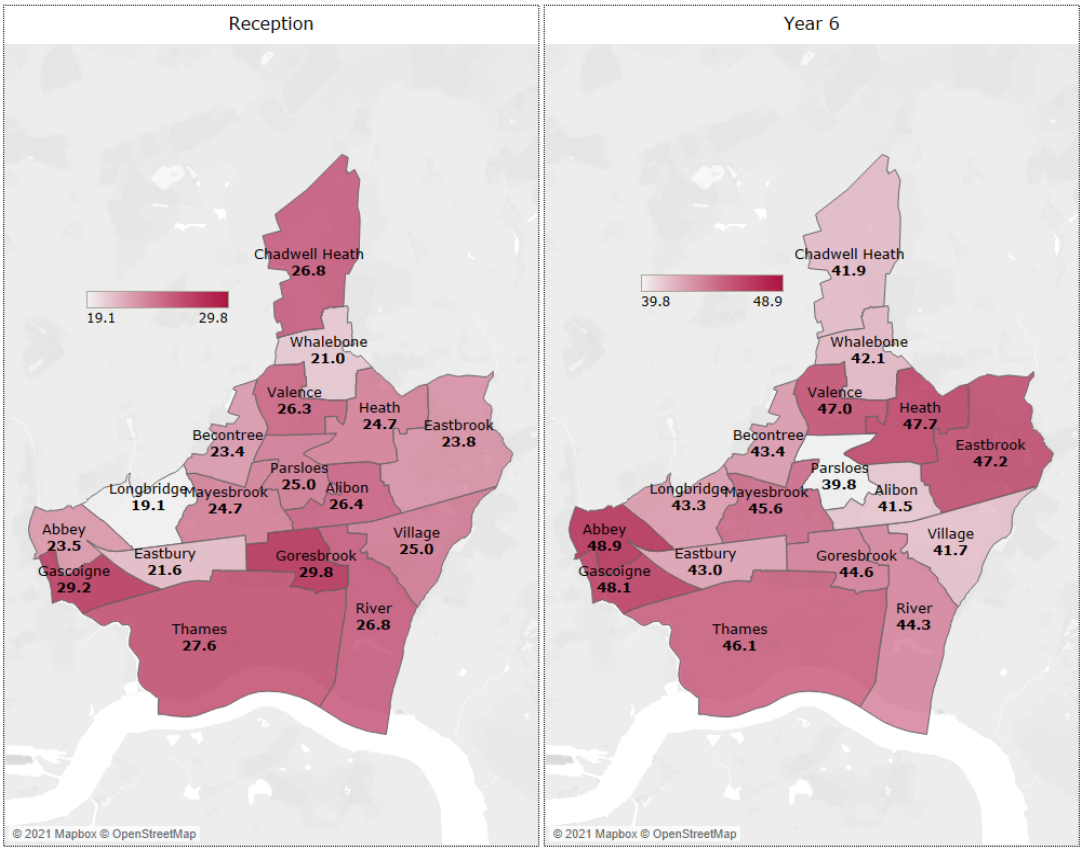
4.76 **Childhood obesity** is on the rise and can have significant impact on health outcomes. In England, one in 10 children are obese at reception age and one in five Year 6 children are obese. A child who is overweight or obese can have increased blood lipids, glucose intolerance, Type 2 diabetes risk, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

4.77 The COVID-19 pandemic is likely to have impacted on the number of children who are overweight or obese. The impact of the pandemic and lockdowns meant that routines of the children and their families were disrupted, thus hindering opportunities to maintain healthy lifestyle behaviours.

4.78 In 2019/20, 12.9% of reception age children are obese in Barking and Dagenham, the second highest rate in London. 44.7% of Year 6 children are obese, the highest rate in London (PHE, 2021).

4.79 At a ward level, Goresbrook and Gascoigne have the highest percentage of children who are overweight or obese in Reception, while Abbey and Gascoigne have the highest representation in Year 6 (see Figure 4.11).

Figure 4.11: Percentage of children who are overweight / obese by ward in Barking and Dagenham, 2017-19



Source: PHE, Local Health Profiles, 2020

4.80 **Asthma** is the most common long-term health condition in children in the UK. It is also the one of the most common reasons for emergency hospital admissions in the UK. In 2019/20 there were 130 hospital admissions for asthma (under 19 years), this equates to a rate of 196.2 per 100,000 admissions, among the highest in England (HES, 2021).

4.81 **Dental decay** is a highly preventable condition increased by a high-sugar diet. Over one quarter (29.5%) of age-5 children have visual obvious dental decay in Barking and Dagenham in 2018/19; this is higher than regional and national figures of 27.0% and 23.4% respectively (Dental Public Health Epidemiology Programme for England, 2019).

Adult mental health

4.82 **Common mental illnesses** include depression, general anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder. PHE estimates that 54,096 adults, 22.4%, of the Barking and Dagenham population have a common mental illness (based on Adult Psychiatric Morbidity Survey, 2017 data). This is significantly higher than England (16.9%).

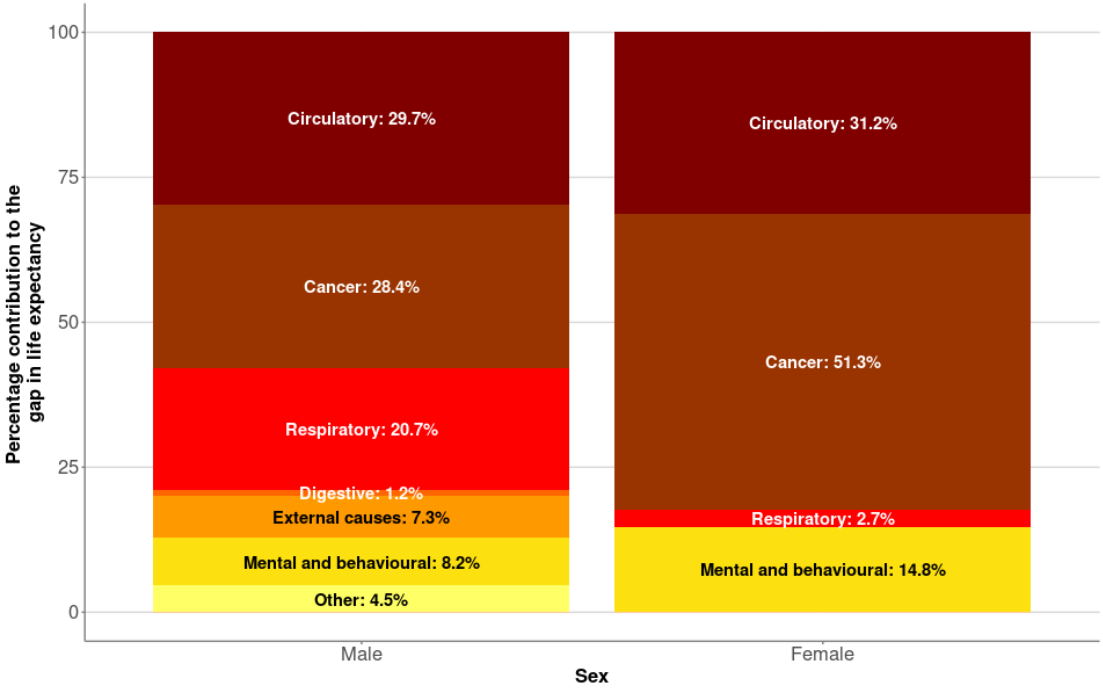
4.83 A third of Barking and Dagenham patients who have a long-term mental health condition (33.6%) are current smokers (PHE, 2019/20). This can substantially impact on their life expectancy and healthy life expectancy. Nationally, a quarter (25.8%) of patients who have a **long-term mental health condition currently smoke** (GP Patient Survey, 2021).

Cancer and long-term conditions

4.84 The causes of life expectancy gap between the most deprived and least deprived populations within a borough provides a good indicator on what health conditions have a bigger impact on local populations and where a targeted approach is needed.

4.85 The scarf chart in Figure 4.12 show, for each broad cause of death the percentage contribution that it makes to the overall life expectancy gap within Barking and Dagenham. It highlights cancer as the biggest cause of the differences in life expectancy between deprivation quintiles, accounting for 28.4% of the life expectancy gap in males and 51.3% in females.

Figure 4.12: Life expectancy gap between the most deprived quintile and least deprived quintile of Barking and Dagenham, by broad cause of death, 2015-17.



Source: Public Health England based on ONS death registration data and mid-year population estimates, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2022

4.86 This is followed by circulatory diseases which includes heart disease and stroke**.** Circulatory diseases account for 29.7% of the male life expectancy gap and 31.2% of the female life expectancy gap. Respiratory diseases are another substantial contributor to the life expectancy gap in men (20.7%).

4.87 We will look at each of these health classifications and their impact on Barking and Dagenham in more depth.

Cancer

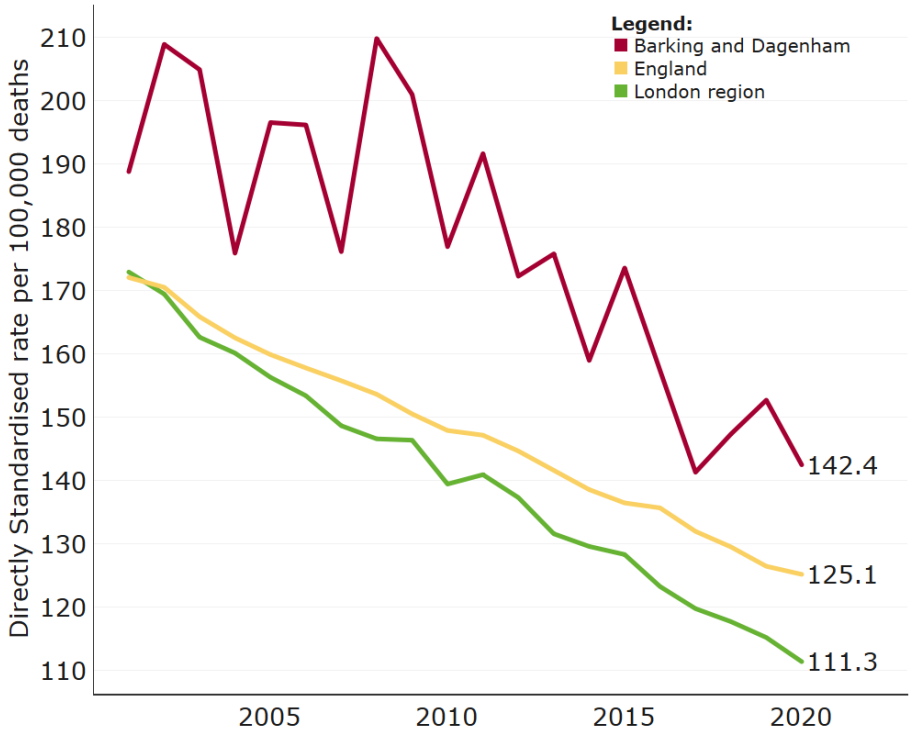
4.88 Pharmacists can play in an important role in the early detection and diagnosis of cancer. Raising awareness through public health campaigns and talking to patients about signs and symptoms of different cancers can result in earlier diagnosis and therefore better treatment options for patients.

4.89 The incidence of all cancers is high in Havering in comparison to the rest of England. 2014-2018 data shows 105.1 new cases of cancer per 100,000 GP population. This is the second highest in London and substantially higher than the national rate of 100 new cases per 100,000 population (AV2018 CASREF01, 2020).

4.90 NHS Barking and Dagenham CCG **screening coverage** for bowel, breast and cervical cancers are low in comparison to England (NHS Cancer Screening Programme, 2021).

4.91 The **premature mortality rate for cancer** (i.e., under 75 years) for Barking and Dagenham is high in comparison to the national rate, and the highest in London. Currently 142.4 per 100,000 residents of the borough died prematurely each year from cancer, compared with 125.1 for England. Premature mortality considered preventable has been on a downward trend over the last decade, however, the borough figures have always been higher than regional and national rates (see Figure 4.13).

Figure 4.13: Under 75 mortality rate from cancer for Barking and Dagenham, London and England from 2001 to 2020



Source: PHE, Local Health Indicators, 2021

Circulatory Disease

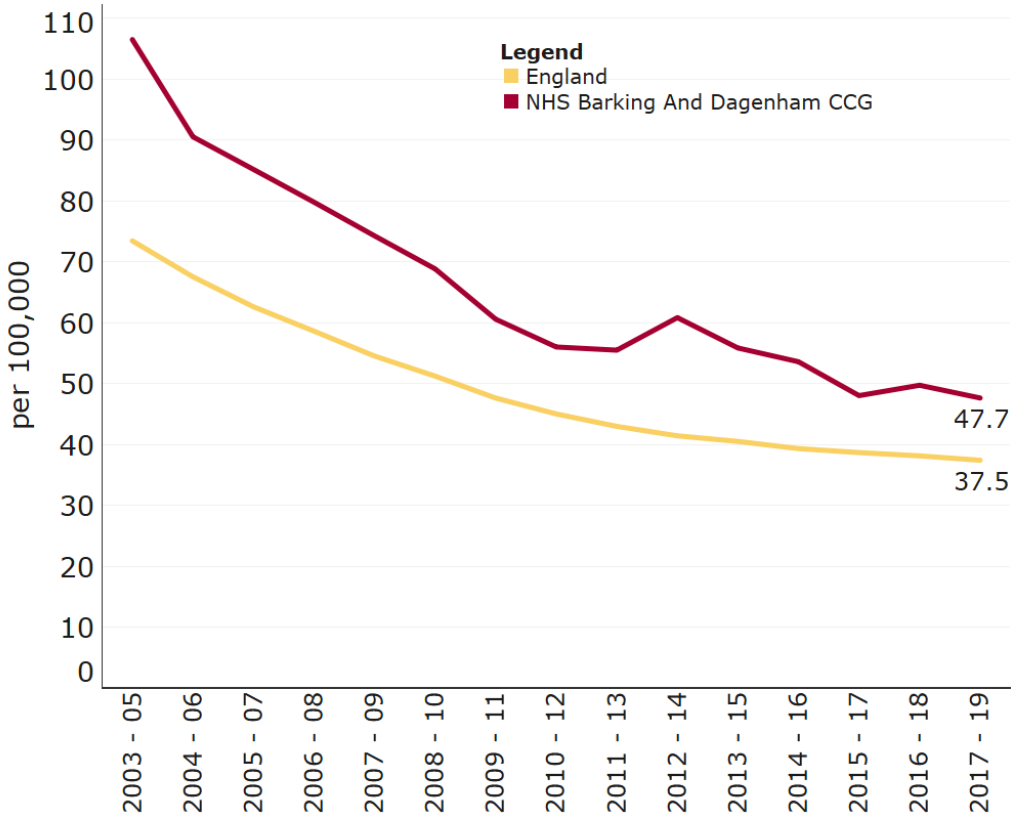
4.92 Circulatory diseases such as coronary heart disease and stroke is the second biggest **cause of the differences in life expectancy** in Barking and Dagenham.

4.93 Barking and Dagenham have the 2nd highest **under 75 stroke mortality** (age standardised) rate, 2017-19. The directly standardised rate for Barking and Dagenham is 17.6 per 100,000 population, substantially higher than the national rate of 12/5 per 100,000 (ONS Mortality Statistics 2020).

4.94 In 2020/21, the NHS Barking and Dagenham CCG prevalence rate for **coronary heart disease** is 1.7% of patients. This was substantially lower than the national prevalence of 3.0% (QOF, 2021).

4.95 However, the under 75 mortality rates for coronary heart disease is the fourth highest in London. The coronary heart disease mortality rate, under 75 years (three-year range) is 47.7 deaths per 100,000 population. This is higher than the national rate of 37.5 deaths per 100,000 population (ONS Mortality Statistics, 2020). Rates have been reducing over the years (see Figure 4.14) and this is likely due to timelier and higher quality treatment, effective prescribing, and a reduction in the number of smokers.

Figure 4.14: Coronary heart disease mortality rates, under 75 years (3-year range) for Barking and Dagenham, and England from 2003 to 2017



Source: PHE, Local Health Indicators, 2021

Respiratory diseases

4.96 **Respiratory disease** is one of the top causes of death in England in under 75s. The under-75 mortality rate by respiratory disease of 61.1 per 100,000 population is substantially higher in Barking and Dagenham than London and England. It is also the highest in London. The London and England rates are 29.9 and 34.2 respectively (PHE, 2020).

4.97 One of the major respiratory diseases is **chronic obstructive pulmonary disease** (COPD). Emergency hospital admissions for COPD is high in Barking and Dagenham. There were 597 per 100,000 admissions for COPD in 2019/20, substantially higher than London and national comparators of 358 and 415 admissions per 100,000 admissions respectively. Helping people to stop smoking is key to reducing COPD and other respiratory diseases (HES, 2021).

Older people and frailty

4.98 Barking and Dagenham has a smaller older population, in comparison to England as a whole. However, community pharmacies can play an important role in the provision of health services and support of older people and those with frailty.

4.99 Older people are the majority users of healthcare. Pharmacies provide a vital resource in providing consistency in care, supporting older people's medicine adherence, and liaising between other health care practitioners and patients to ensure the patient's optimal pharmaceutical care.

4.100 In Barking and Dagenham there were 70 **excess winter deaths** during the winter months in 2019/20, this equates a proportion of 18.2%, similar to the proportion of excess winter deaths in England of 15.1% and a reduction of the proportion of winter deaths in 2018/19 of 25.6% (ONS, 2021). Excess winter deaths typically affect the older population and those with circulatory, respiratory diseases or dementia.

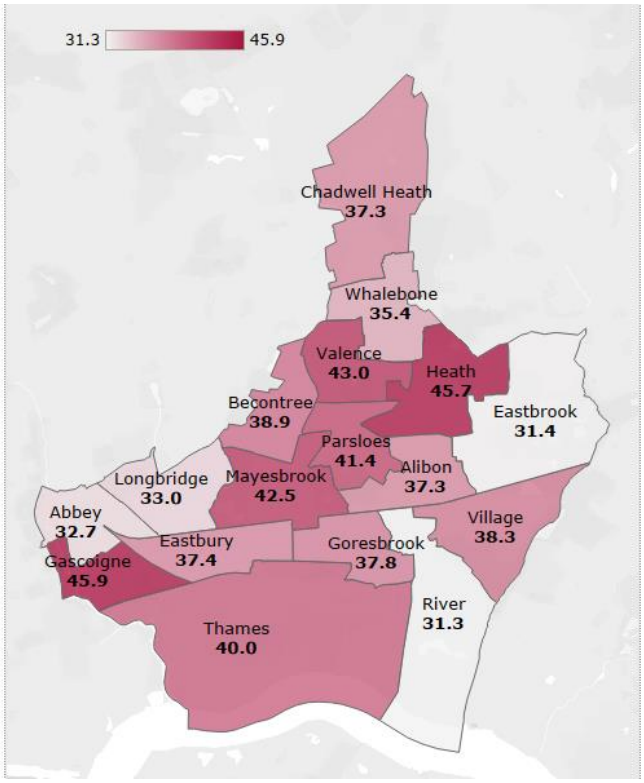
4.101 Excess winter deaths are also linked to drops in temperature in winter, and **fuel poverty** hinder resilience to the cold. 9,008 households (12.3%) were considered to be in fuel poverty in 2018, higher than regional and national figures of 11.4% and 10.3% respectively (Department for Business, Energy, and Industrial Strategy, 2020).

4.102 65% of the over 65 population have been vaccinated for the **flu** in 2019/20. This is much lower than the overall proportion of over 65s who are flu vaccinated in England at 80.9% (UK Health Security Agency, 2021).

4.103 **Social isolation and loneliness** can impact people of all ages but is more prominent in older adults. It is linked to increased behavioural risk factors, poor mental health as well as morbidity and mortality from acute myocardial infarction and stroke29. The 2011 census found that 38% of people over 65 years were living alone in Barking and Dagenham, higher than the national of 31.5%. The wards with the highest proportion of older adults living alone were Gascoigne and Heath (see Figure 4.15).

[29] Hakulinen C, Pulkki-Råback L, Virtanen M, et al (2018). Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: UK Biobank cohort study of 479 054 men and women. *Heart*;104:1536-1542.

Figure 4.15: Older People living alone in Barking and Dagenham by ward, 2011



Source: PHE,Local Authority Health Profiles, 2018

4.104 The adult social care survey explores isolation and loneliness in its analysis. Findings show that in Barking and Dagenham 49.4% of over 65 adult social care users who responded to the survey have as much social contact as they would like. Although this is higher than national figures of 45.9%, it still shows that more than half of older adults in receipt of social care do not have as much social contact as they would like and are likely feeling isolated and lonely (Adult Social Care Survey, 2021).

4.105 Approximately 994 people (0.4% of GP registered patients) have **dementia** in Barking and Dagenham in 2019/20. Early diagnosis is important in enabling people to access the right services and support early and live well with dementia[30]. However, the estimated percentage of people living with dementia who have a formal diagnosis in Barking and Dagenham is 58.9%, significantly lower than the national rates of 61.6% (NHS Digital, 2021).

4.106 **Falls** are a major cause of emergency hospital admissions and loss of independence, disability or death in older people. 1670 per 100,000 emergency admissions for the over 65s in Barking and Dagenham are due to falls. In 2019/20 865 per 100,000 hospital admissions were due to falls in people aged 65-79, this is much lower of regional and national rates of 1154 and 1042 per 100,000 admissions respectively (HES 2021). Pharmacy services can support people to manage their medicines and signpost them to services that can assist them to live independently and prevent falls and thereby prevent hospital admissions.

[30] Social Care Institute for Excellence (2020) Why early diagnosis of dementia is important.

4.107 100 Barking and Dagenham residents (over 65s) had a **hip fracture** in 2019/20. This equates to a directly standardised rate of 472 per 100,000 population, similar to the national rate of 572 per 100,000 population (HES, 2020).

4.108 **Frailty** defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care. It is typically the result of the effects of natural ageing, the outcomes of multiple long-term conditions and a loss of fitness and reserves.

4.109 It is estimated that 12% of over 65-year-olds are living with moderate frailty. This equates to approximately 2,216 people living with moderate frailty in Barking and Dagenham. Moderate frailty is defined by having at least three or more symptoms from weight-loss, fatigue, weakness in the form of weak grip strength or low energy expenditure[31]. Around 42% of 65+-year-olds are known to be pre-frail (having one or two of these symptoms). This equates to around 7,756 pre-fail older people residing in Barking and Dagenham (GLA, Housing-led population projections, 2021).

4.110 Pharmacists can play a role in assisting people who are frail or at risk of becoming frail. This includes highlighting any concerns with the persons GP or reviewing the patient's medication records and identify medications that could amplify the effects of frailty, increase the patient's fall risk, or escalate cognitive decline.

[31] NHS RightCare Frailty Toolkit (2020): https://www.england.nhs.uk/rightcare/products/pathways/frailty/

Summary of Demographics and Health Needs of Barking and Dagenham

This chapter looks at the overall health and wellbeing of the population of Barking and Dagenham guided by the JSNA priority areas.

Barking and Dagenham Demographic Characteristics

The London Borough of Barking and Dagenham is North East London Borough situated in outer London. It has a fairly young population, with the highest proportion of young people in London. Gascoigne and Thames wards have the highest representation of young people in the borough. Nearly half of the population are from BAME groups, a quarter of the population are Asian. Gascoigne, Abbey and Thames have the highest representation of BAME groups.
Barking and Dagenham have the lowest life expectancy figures in London and the lowest healthy life expectancy for males and the third lowest for females.

Wider determinants of health

There are pockets of high deprivation within Barking and Dagenham, most notably in the north of Health, and Thames where deprivation is highest at LSOA level. The impact of COVID-19 affected those from more deprived areas and from BAME communities the most.

The places and communities in which we live

The population of Barking and Dagenham is set to increase by 21.8% by 2031. The highest anticipated increase is in Thames ward where the population is expected to more than double by 2032, due to new developments underway in the Barking Riverside area.

Our health behaviours and lifestyles

Smoking is the leading cause of preventable death in the world, 18.1% of adults smoking in Barking and Dagenham. 65.5% of Barking and Dagenham adults are overweight or obese, the third highest in London, 31.9% of adults are inactive, the third highest in London.
Barking and Dagenham adults binge drink less and alcohol-related hospital admission episodes are lower than comparators. Barking and Dagenham has a high proportion of opiate and/or crack cocaine users who are not receiving treatment.
STI rates are generally low in Barking and Dagenham, except Chlamydia where detection rates are higher than national figures.

An integrated Health and care system

Barking and Dagenham has the highest birth rate in London, including the highest number of babies born to teenage mothers. Rates of premature births, low birth weight, still births and maternal obesity are of concern in Barking and Dagenham.
Children and young people are reaching expected educational standards at most key stages. However, family poverty and homelessness are high in Barking and Dagenham. Childhood obesity, asthma and dental decay are other areas of concern within Barking and Dagenham.
Nearly a quarter (22.4%) of Barking and Dagenham adults have a common mental illness.
Premature mortality for cancers, stroke, coronary heart diseases and respiratory diseases are high in Barking and Dagenham.
While Barking and Dagenham has a relatively low older population, excess winter deaths, loneliness and isolation, and frailty are areas of concern.

Chapter 5 – Patient & Public Engagement

5.1 This chapter discusses the results of the patient and public engagement that was carried out in Barking and Dagenham, Havering & Redbridge (BHR) between the period of 1st November 2021 to the 31st December 2021. Feedback by Redbridge residents is presented, then BHR results are explored for differences between protected characteristic groups.

5.2 A "protected characteristic" means a characteristic listed in section 149(7) of the Equality Act 2010. There are also certain vulnerable groups that experience a higher risk of poverty and social exclusion than the general population. These groups often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment.

5.3 A community questionnaire was used to engage with residents to understand their use and experience of local pharmacies. This questionnaire was approved for use with the local population by the PNA Steering Group and the communication teams of BHR.

5.4 The community questionnaire was disseminated via online and social media platforms. Over the period between 1st November 2021 to 31st December 2021, we engaged with 364 residents in BHR. 40 of those responses were from Barking and Dagenham residents, an additional 53 were from residents living in postcodes bordering Havering making a total of 93 responses. This is a small sample size of the population and therefore not a representative sample. The findings do provide some insights on local views to pharmacy provision, however there are limits to the conclusions made from this analysis.

Online:

- Residents E-Newsletters

Across BHR, e-newsletters were sent to 74947 residents from public health communications teams. This was done on multiple occasions.

- VCS community leads

Across BHR a total of 689 faith and community organisations were contacted by VCS community leads.

- Healthwatch website

The patient and public engagement survey was accessible on the Havering & Redbridge Healthwatch websites, and survey was available via Havering Healthwatch e-bulletin

- Public health website

Survey was also accessible via the Havering public health consultations page

Social media:

5.5 BHR public health communications teams disseminated links to the survey using various social media channels multiple times. Social media channels included Twitter, Facebook, Instagram, LinkedIn, and Next Door.

Other engagement:

5.6 Healthy Dialogues also contacted 18 cultural community and faith-based organisations within BHR via email, with a link to the survey to be disseminated to their community groups.

5.7 This chapter will first look at responses from people from Barking and Dagenham, then will take a deeper look at responses across groups of people from protected characteristics across BHR.

Pharmacy use by Barking and Dagenham residents

5.8 We first looked at how and why Barking and Dagenham residents use their pharmacy and what services they would like to see. When asked **how long it takes them to travel to their pharmacy** the top two responses where:

- Between 5-20 minutes: 56 respondents
- 5 minutes: 32 respondents

5.9 This result was similar across Redbridge and Havering where the top response from residents in both boroughs also indicated that 5-20 minutes of travel was the most popular choice.

5.10 When analysing the reasons why **chose their pharmacy**, the top three responses from Barking and Dagenham residents were:

- Accessibility: Good location (71 responses)
- Patient interaction: Happy with the overall service provided by the pharmacy (61 responses)
- Patient interaction: staff are friendly (55 responses)

5.11 This result was similar across Redbridge and Havering where residents chose their pharmacy based on good location, patient interaction including friendly staff, and satisfaction with the overall service provided by the pharmacy. Residents of Havering and Redbridge also used their pharmacy because of the short waiting times for prescriptions.

5.12 185 comments were left around what services the residents would like to see being provided from their local pharmacy that they do not currently provide. When breaking this down further, 27 comments were left by Barking and Dagenham residents. The top two **services the Havering residents would like to see within their pharmacies** included:

- Blood checks: 9 respondents

- Delivery service: 5 respondents

5.13 These results were similar across Redbridge and Havering, where the most popular service the residents of these boroughs would like to see within their pharmacy was also blood checks. Residents of Havering and Redbridge also wanted to see vaccination services within their pharmacy.

Barking and Dagenham, Havering and Redbridge combined results and Equalities Impact Assessment

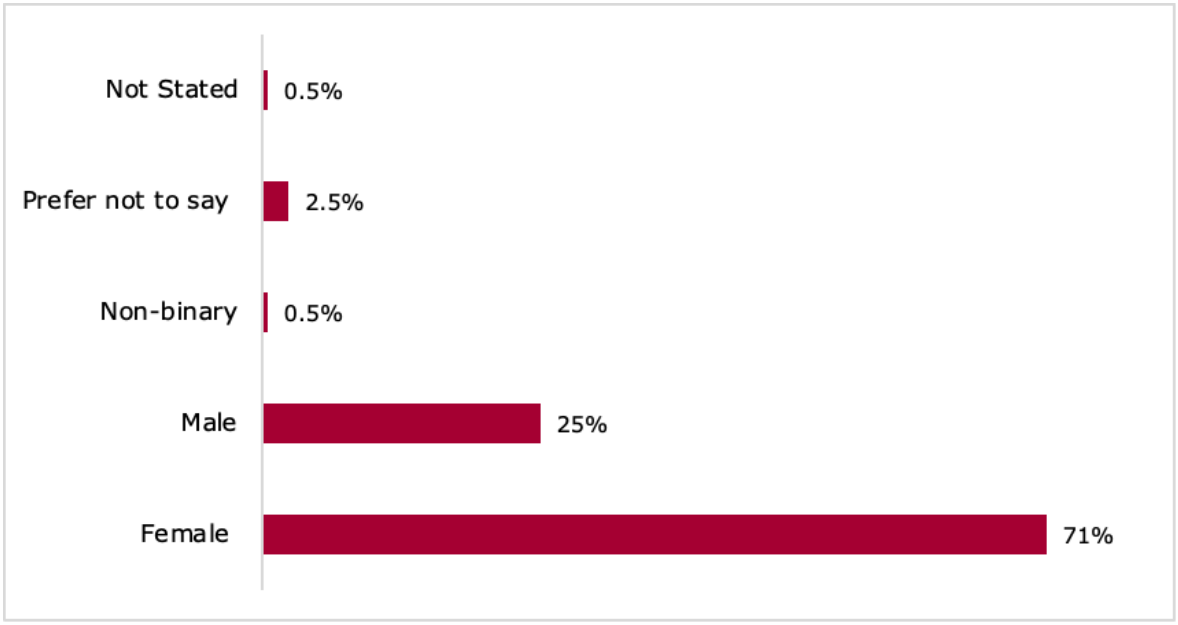
5.14 The 364 question responses collated were analysed to better understand the use of community pharmacies by residents of BHR and identify any potential gaps in service provision for the protected characteristics.

5.15 Please note: the user composition could not reflect the general population because the pharmacy and health needs are different. Therefore, the responders would not necessarily represent general population but provide some insights on user views.

Demographics of the sample population

5.16 A breakdown of the gender shows that 71% of the respondents were female, 25% were males, 2.5% preferred not to state their gender, 0.5% were non-binary, and 0.5% did not state their gender on the survey (see figure 5.1)

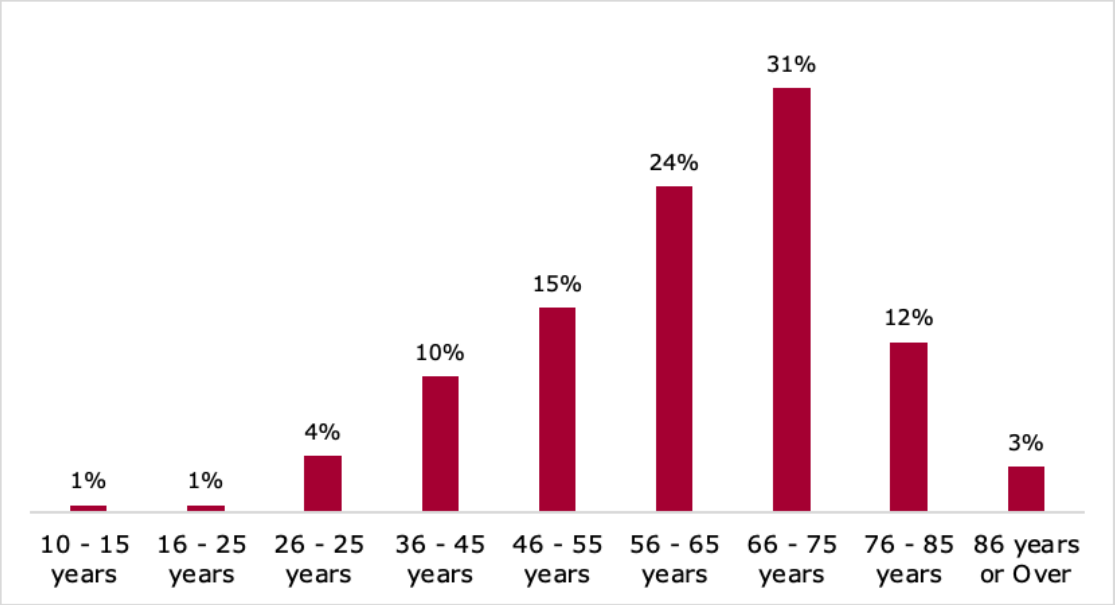
Figure 5.1: Breakdown by gender of patients' community survey respondents



5.17 The survey sample represented a wide range of **age** categories, with the highest representation from the 66-75 age group (31%), followed by the 56-65 age group (24%). The

least represented group was between the age categories of 10–15-year-olds (1 %) and 16–25-year-olds (1%) (see figure 5.2).

Figure 5.2: Breakdown by age groups of patients and community survey respondents



5.18 Below is the breakdown data from the survey represented the following **ethnic groups** between the period of 1st November 2021, to 31st December 2021 (figure 5.3):

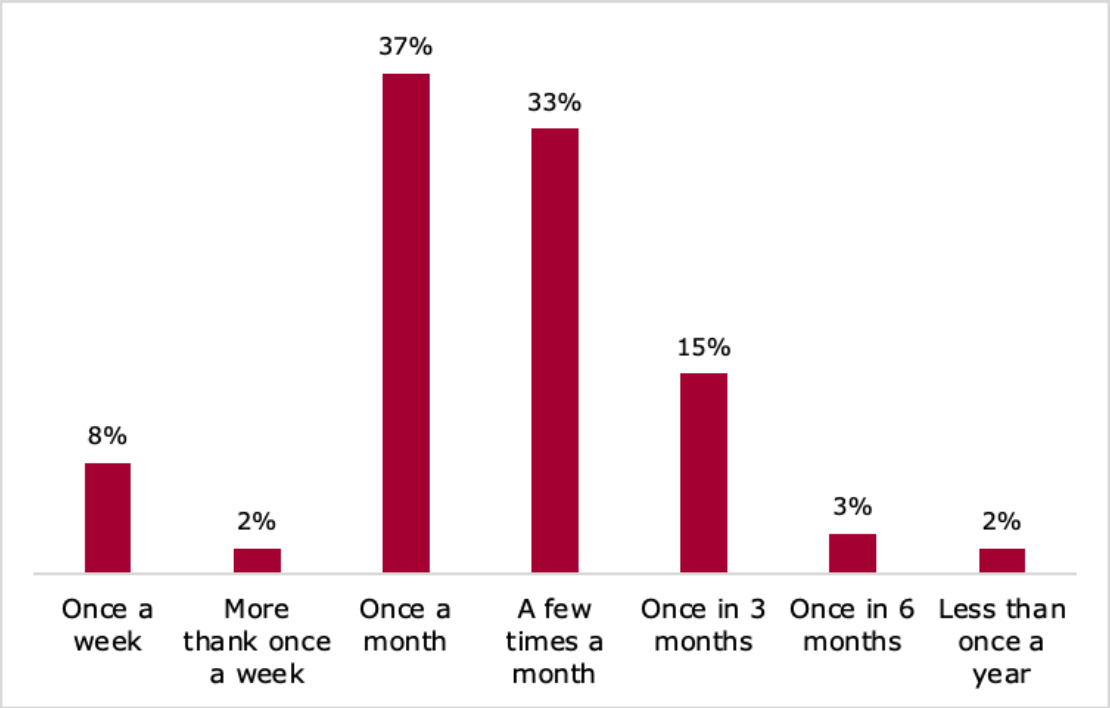
Figure 5.3: Breakdown of respondent's ethnicities

Ethnicity	Number of respondents
White (including English, Welsh, Scottish, Northern Irish, British, Irish, Gypsy or Irish Traveller, and other White background)	317 residents of BHR (87%)
Mixed ethnic groups (including White and Black Caribbean, White and Black African, White and Asian, any other mixed ethnic background)	5 residents of BHR (1.4%)
Asian or British Asian (including Indian, Pakistani, Bangladeshi, Chinese, any other Asian background)	26 residents of BHR (7%)
Black African, Caribbean or Black British (including African, Caribbean, any other Black African or Caribbean background)	11 residents of BHR (3%)
Any other ethnic group (including Arab)	1 resident of BHR (0.3%)
Did not state their ethnic background	4 residents of BHR (1%)

Overall use of Pharmacies

5.19 When asked around **how often they use the pharmacy** around 37% of the BHR residents use the pharmacy monthly, with 33% of residents use the pharmacy a few times in a month, and around 15% using it once in 3 months. Only 8% of residents use the pharmacy weekly, and around 2% more than once a week (figure 5.4).

Figure 5.4: A breakdown of how often respondents use their pharmacy



5.20 The majority (82%) of the respondents indicated that they would prefer to use the pharmacy during the weekday (figure 5.5), with the most popular times being between 9am- 12pm, followed by 2pm- 5pm (see figure 5.6). Note: residents could select multiple responses for this survey question.

Figure 5.5: Preference of when to use the pharmacy

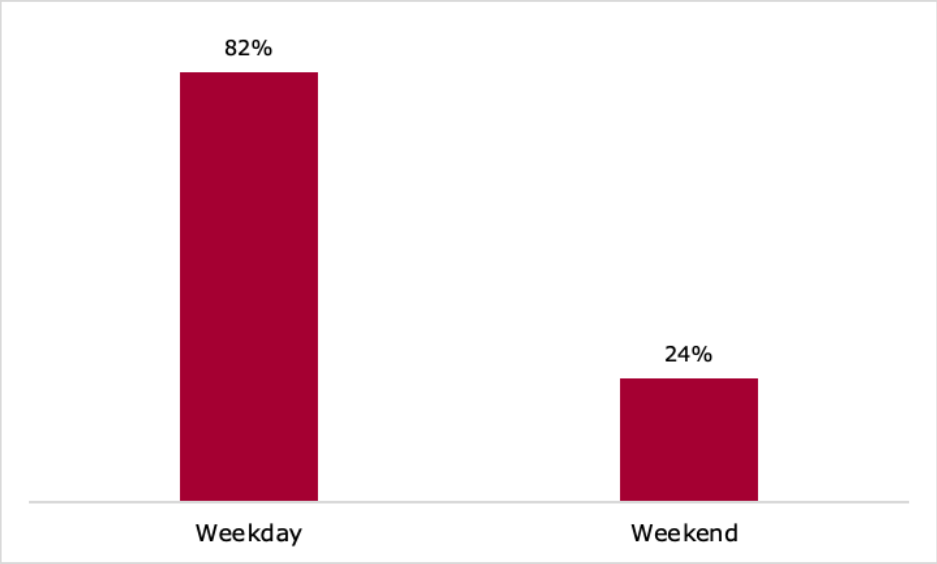
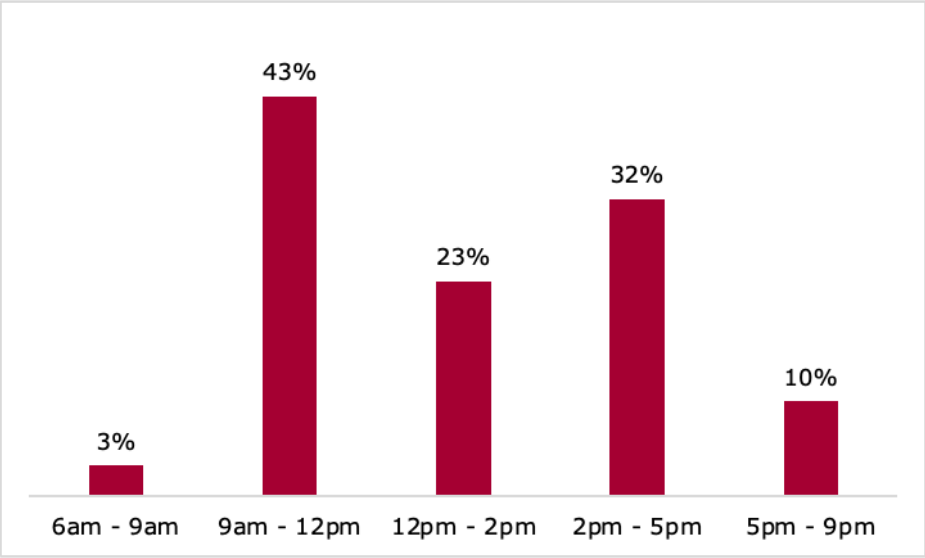


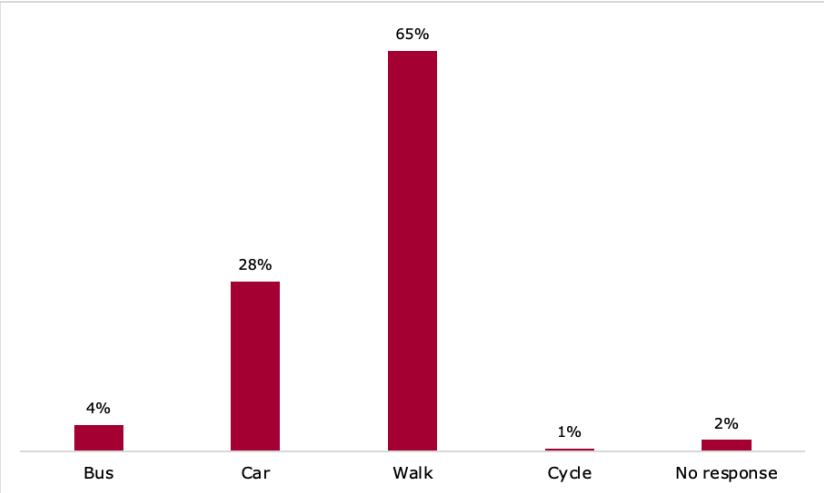
Figure 5.6: A breakdown of preference for time of day to use the pharmacy (includes weekend and weekday times)



5.21 When asked **who they are using the pharmacy for,** 91% of respondents use the pharmacy for themselves, 35% use the pharmacy for their partner/spouse, and 13% use the pharmacy for their children.

5.22 When asked around how they usually travel to their pharmacy, the majority of respondents, 65%, walk to their pharmacy. 28% use their car to get to their pharmacy, and 4% take the bus (figure 5.7).

Figure 5.7: A breakdown of usual travel to pharmacy



5.23 Of the 364 responses, 61 residents indicated that they do use an **online pharmacy service.** When asked **what they use their online pharmacy for**, 87% said that they use their online pharmacy to order repeat prescriptions.

5.24 The survey also asked how the patients and publics **use of pharmacy had changed since the COVID-19 pandemic**. 274 people responded to this question, of whom, 38% (107) felt that their use of the pharmacy had not changed since the start of the pandemic.

5.25 230 respondents (63%) left a comment on what they felt **could be improved about their pharmacy.** Of the 230 responses, 82 (35%) residents were very pleased, or had no further recommendations on improving their current pharmacy service.

5.26 An additional 140 comments were left around how residents felt pharmacy services could be improved. These have been categorised below into the top four recommendations for improvement:

The top four recommendations for improvement included:

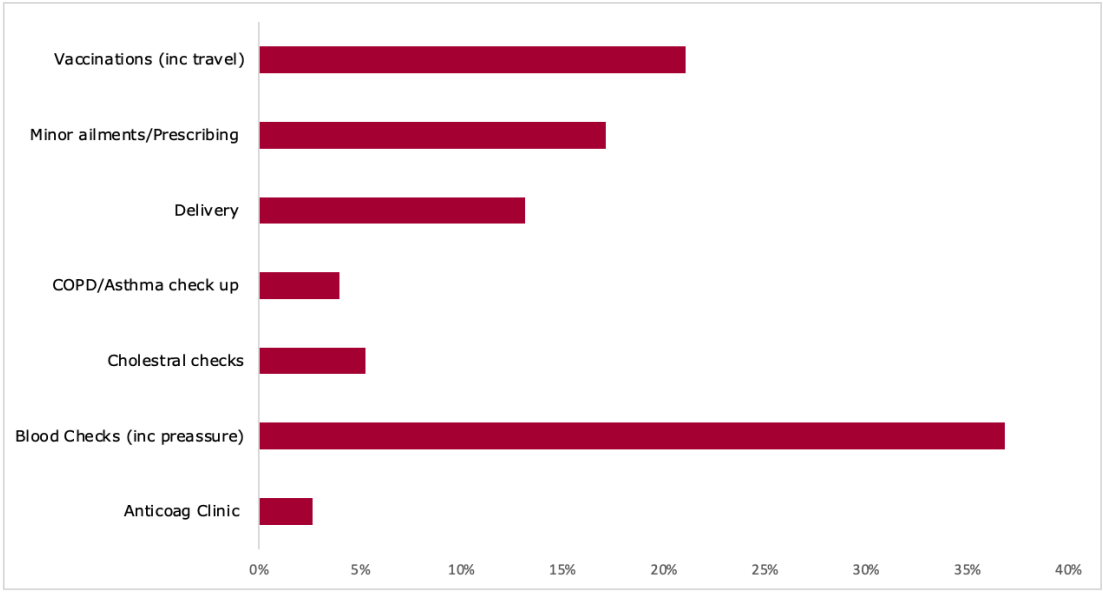
- Increased opening hours (11%)
- Staffing, including more staff, and friendlier staff (7%)
- Accessibility, including parking and disabled access (4%)
- Better, or more seating inside the pharmacy (3%).

5.27 Of the 364 respondents, 185 left a comment on how **what services they would like to see available** in their pharmacy (figure 5.8).

The top five services the public would like to see within their pharmacy were:

- Blood checks, including blood tests, and pressure checks
- Vaccinations, including travel, COVID-19, flu-jab
- Minor ailments and prescribing
- Delivery service
- Cholesterol checks.

Figure 5.8: Services public would like to see within their pharmacy



Protected Characteristics

Age

5.28 The current age profile and projections of the borough are discussed in Chapter 4. Pharmacies provide essential services to all age groups such as dispensing, promotion of healthy lifestyles and signposting patients to other healthcare providers. Pharmacies providing services to vulnerable adults and children are required to be aware of the safeguarding guidance and local safeguarding arrangements.

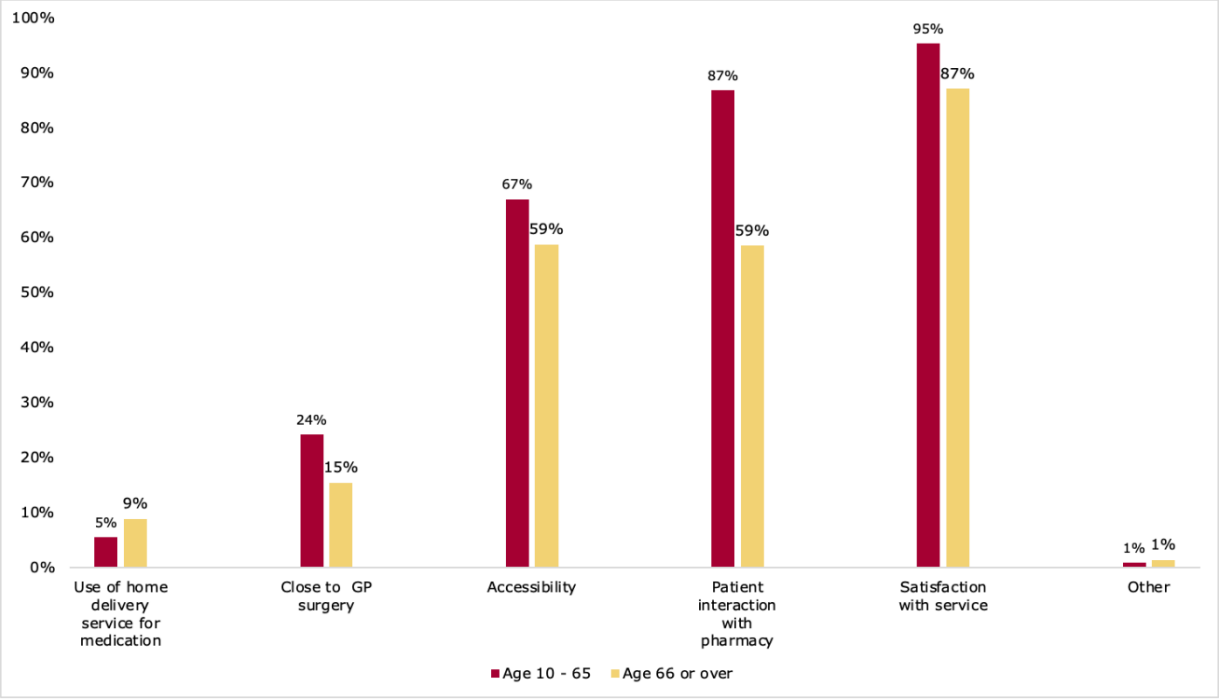
5.29 To understand any differences, we carried out the analysis by grouping together age groups that are over 66 and compared this with age groups under the age of 65.

5.30 We analysed the reasons for chosen pharmacy by age groups i.e., under 65's (n= 195) and over 66's (n=169).

5.31 The use of home delivery service for medication was more prevalent in the over 66's compared to the under 65 age group.

5.32 When analysing other reasons for chosen pharmacy, the under 65 age categories were more satisfied with the service compared to the over 66 age group. The under 65's also stated that they felt they had better patient-pharmacy interaction, the pharmacy was accessible, and it was closer to their GP surgery (Figure 5.9).

Figure 5.9: reasons for chosen pharmacy by age group



5.33 There were no differences between the two age categories in terms of which services residents would like to see within their pharmacy. The top three services both age categories would like to see included:

- Blood testing
- Vaccinations
- Blood pressure checks.

Ethnicity

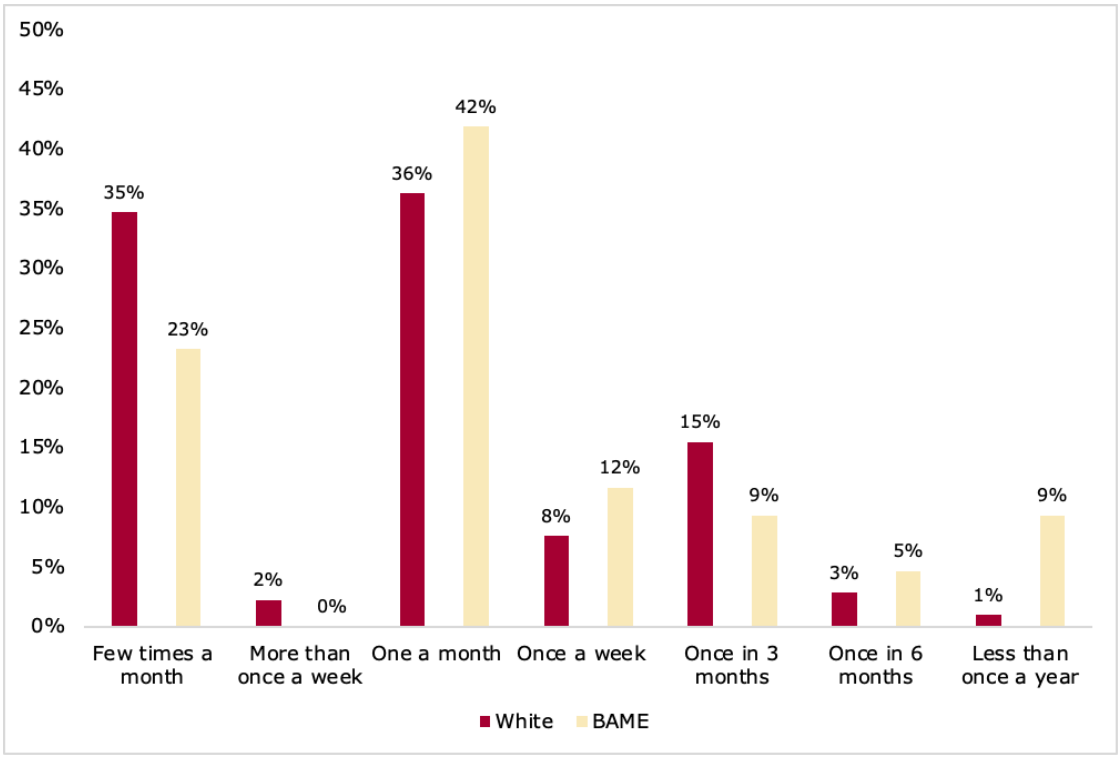
5.34 Of the respondents, 43 (12%) identifying as being from a Black, Asian and Ethnic minority (BAME) background (breakdown in section 5.9). 317 (87%) respondents identified themselves as White.

5.35 For the purposes of studying differences in the use and experience of pharmacies, we compared BAME populations with groups identifying as White (including British, Irish, and other White).

5.36 The majority of the residents used the pharmacy at least once a month, or a few times a month across all ethnic groups.

5.37 Those from a BAME background were more likely to be using the pharmacy at least once a week, White ethnic residents, are more likely to use the pharmacy at least once a month (figure 5.10).

Figure 5.10: Breakdown of ethnicity and pharmacy usage



5.38 19 comments were left by the BAME community in relation to what services they would like to see within their pharmacy. This entailed, delivery service including for single mothers, more minor ailments services and blood checks (cholesterol, pressure, blood tests).

5.39 162 comments were left by the White ethnic groups around what services they would like to see within their pharmacy. 43% of the respondents were happy with the service that was already being provided. Others that left comments felt their pharmacy could offer blood checks (cholesterol, blood tests), COVID-19 vaccinations and other vaccinations.

Pregnancy and maternity

5.40 Five (1%) of the respondents to the community engagement survey were pregnant or breastfeeding. Four of the respondents were aged between 26-35, and one aged between 36-45.

5.41 Those who were pregnant, or breastfeeding tended to use the pharmacy on the weekday. There was no significant difference in their use of pharmacies in comparison to the rest of the survey population.

5.42 No comments were left by those who were pregnant or breastfeeding in relation to what services they would like to see within their pharmacy.

5.43 Reasons for chosen pharmacy included being in a good location, within a 5-minute walk or drive.

5.44 Though pregnant and breastfeeding respondents made a small representation to the overall survey responses, this could be explained by the fact that most people who completed this survey were aged 66 and over.

Gender

5.45 Of the survey respondents, 259 identified themselves as female, 92 as males, nine preferred not to state, two as non-binary, and two were left blank.

5.46 The usage of pharmacy showed 38% of the 92 males, used the pharmacy a few times a month, compared to 31% of the 259 females. 49% of females used the pharmacy at least once a month, compared to 30% of males.

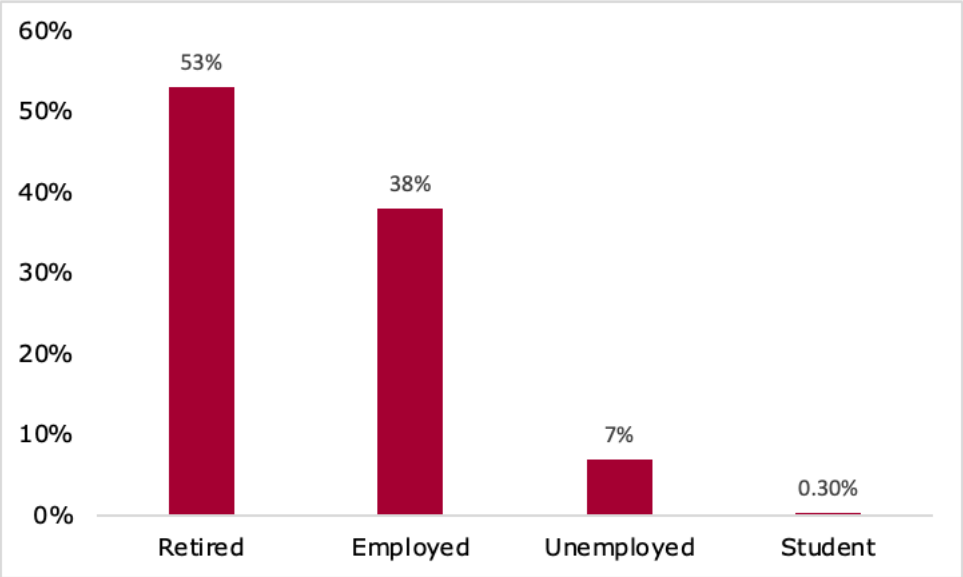
5.47 Overall, women also tended to use the pharmacies for their children, more than their male counterparts.

5.48 There were no significant differences in the reasons for chosen pharmacies across the genders.

Employment Status

5.49 A breakdown of employment status showed that over half of the survey responses were from retired residents. This was followed by employed (part-time, full-time, self-employed, full-time and part-time carers). 7% were unemployed, and we received one response from a student (figure 5.11).

Figure 5.11: Breakdown of employment status



5.50 The analysis showed that those working in employment still preferred to use their pharmacy during the weekday over the weekend. However, there were no significant differences across the groups around when they would prefer to use the pharmacy (weekend or weekday).

Disability

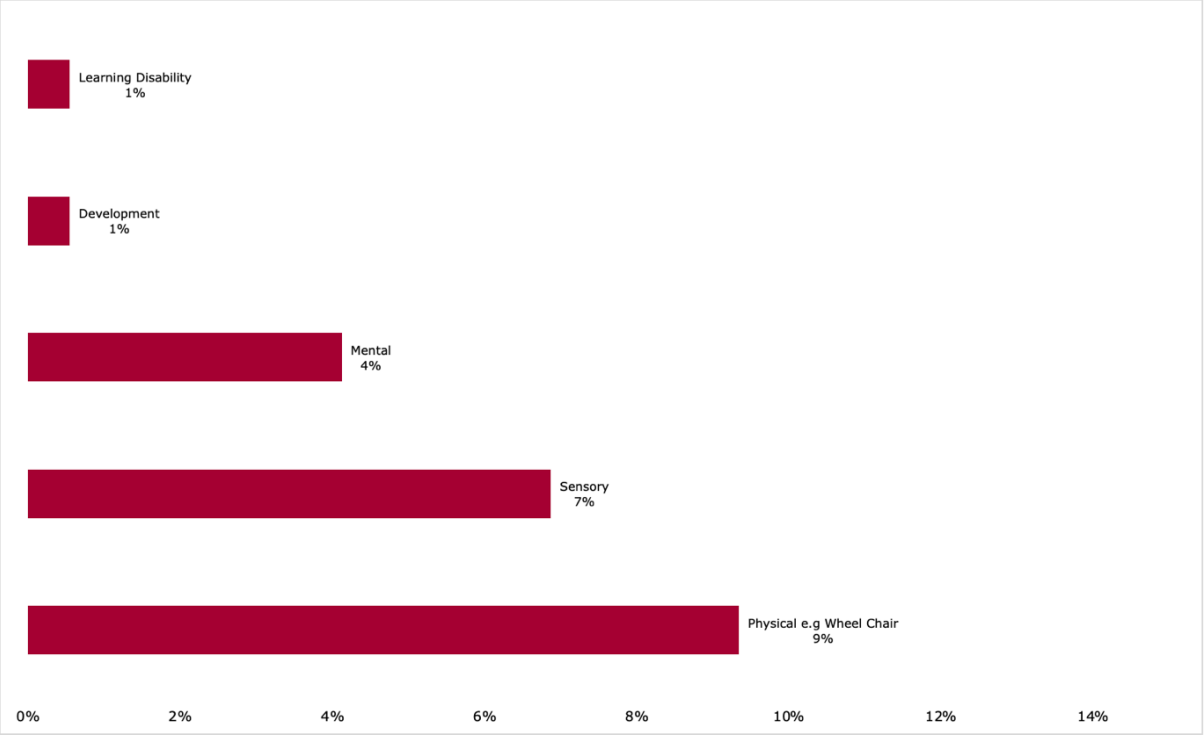
5.51 All pharmacies must comply with the Disability Discrimination Act 1995. Pharmacy contractors may have assessed the extent to which it would be appropriate to install hearing loops or provide access ramps wide aisles to allow wheelchair access. Accessible information formats are alternatives to printed information, used by blind and partially sighted people, or others with a print impairment.

5.52 The survey categorised disabilities into five main groups, followed by other:

- Physical e.g., wheelchair user
- Mental health issues e.g., bi-polar disorder, schizophrenia, depression
- Sensory e.g., mild deafness, partially sighted, blindness
- Learning disabilities e.g., Down Syndrome
- Developmental e.g., autistic spectrum disorder, dyslexia, dyspraxia
- Other.

5.53 112 (31%) respondents answered yes to having a disability (figure 5.12) When asked to state what kind, of which the majority of respondents had a physical disability (9%), followed by sensory (7%), and mental health disability (4%).

Figure 5.12: Breakdown of the top 5 disabilities



5.54 Those who said that they have a disability preferred to use the pharmacy during the weekday over the weekend. Weekdays between 9am – 12pm seemed to be the most popular time for use of pharmacies.

5.55 43 residents left comments on how they felt the pharmacy services could be improved for them. Of this, 28 felt very pleased with the service and had no recommendations. The top 3 recommendations included:

- Better access to pharmacy
- Home deliveries
- Opening hours at weekends.

5.56 The top two services respondents with a disability would like to see included:

- Blood checks (blood testing, cholesterol and pressure)
- Vaccinations.

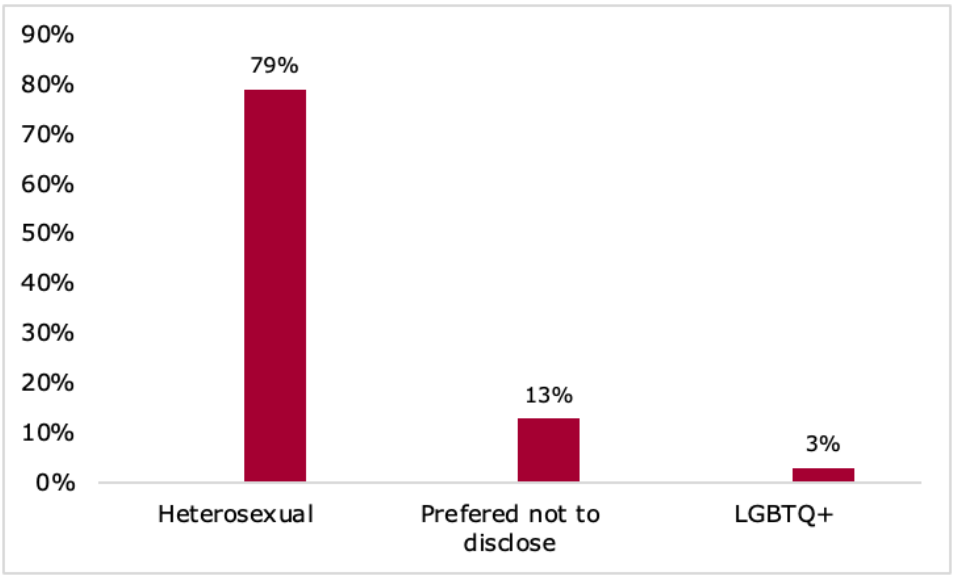
5.57 No significant differences were identified between the overall responses and this protected characteristic in relation to improvements to the pharmacy, and services residents would like to see within their pharmacy.

Sexual Orientation

5.58 Of the total number of respondents, 289 identified as heterosexual, 12 identified as LGBTQ+, and 46 preferred not to disclose (figure 5.13).

5.59 No significant differences were identified between groups of sexual orientation around the use of pharmacy, and services they would like to see.

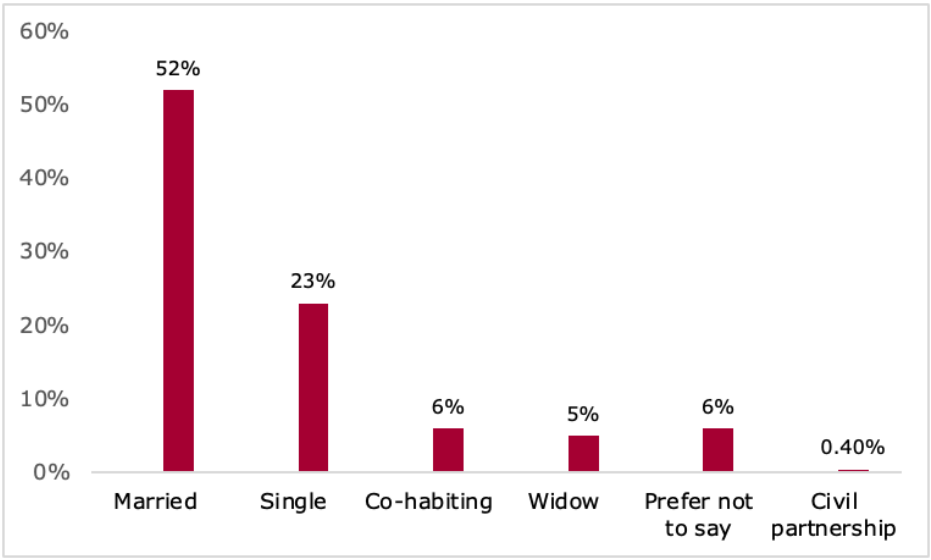
Figure 5.13: Breakdown of sexual orientation



Relationship Status

5.60 190 respondents were married, 85 respondents were single, 23 preferred not to disclose their relationship status, 22 were co-habiting, and 5 in a civil partnership (figure 5.14).

Figure 5.14: Breakdown of relationship status



5.61 No differences were found in the use and experience of those who were single and those who were married, co-habiting or in a civil partnership.

Summary of the Patient and Public Engagement and the Protected Characteristics

Patient and public engagement in the form of a survey was undertaken to understand how people use their pharmacies, what they use them for and their views of the pharmacy provision. It included an exploration of the health needs specific to protected characteristics and vulnerable groups.

Overall, 364 BHR residents and workers responded to the survey, 40 of whom were Barking and Dagenham residents. Results showed that residents choose their pharmacy based on overall satisfaction of their pharmacy service, ease of location, and friendly staff. Most people surveyed used their pharmacy during weekdays and normal working hours.

Overall, people are happy with the pharmacy services they receive in BHR. A small number of survey respondents made some suggestions for improvement. These were mainly around provision of providing simple health check-ups which largely included blood checks (cholesterol, pressure and testing). Other suggestions included providing vaccinations, including COVID-19 vaccines and travel vaccines flu vaccines.
Overall, no different needs were identified for people who share protected characteristics.

Chapter 6 – Provision of Pharmaceutical Services

6.1 This chapter identifies and maps the current provision of pharmaceutical services in order to assess the adequacy of provision of such services. Information was collected up until October 2021 (Information on Essential Pharmacy Services was updated in April 2022).

6.2 It assesses of the adequacy of the current provision of necessary services by considering:

- Different types of pharmaceutical service providers
- Geographical distribution and choice of pharmacies, within and outside the borough
- Opening hours
- Dispensing
- Pharmacies that provide essential, advanced and enhanced services.

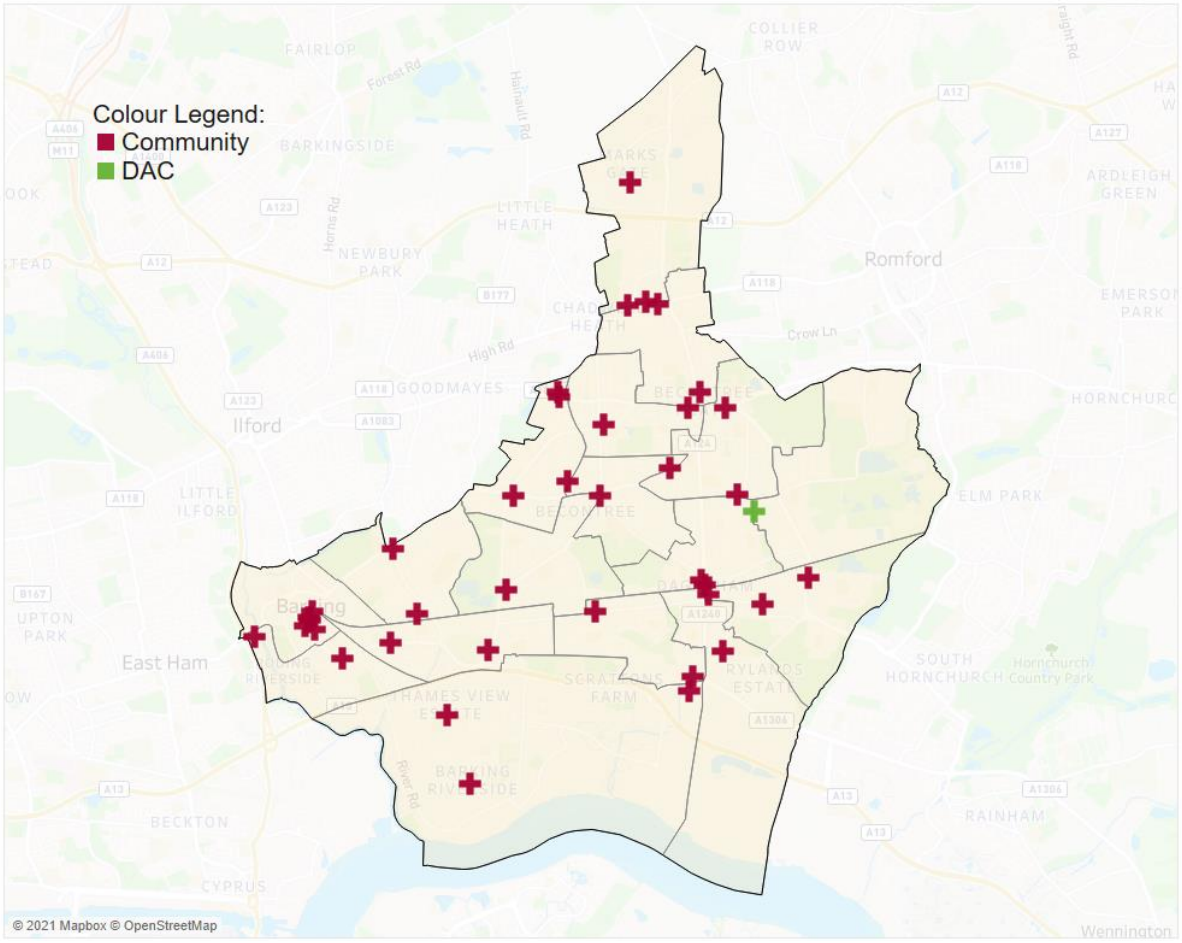
In addition, this chapter also summarises responses to the contractor survey where contractors have indicated willingness to provide a service to address a specific population health and wellbeing need in Barking and Dagenham, if commissioned.

Pharmaceutical Service Providers

6.3 As of April 2022, there are currently 39 pharmacies in Barking and Dagenham that hold NHS contracts, 38 community pharmacies and 1 dispensing appliance contractor. They are presented in the map in Figure 7.1 below.

6.4 All the pharmacy providers in the borough as well as those within 1 mile of its border are also listed in Appendix B.

Figure 6.1: Map of pharmacies in Barking and Dagenham, April 2022



Source: Contractor Survey and NHS England, 2021

Community Pharmacies

6.5 The 38 community pharmacies in Barking and Dagenham equates to 1.8 community pharmacies per 10,000 residents within Barking and Dagenham (based on a 2022 population estimate of 214,107). This ratio is just below the London and England averages, both of which stand at 2.2 based on 2014 data (LGA, 2021[32]).

Dispensing Appliance Contractor (DAC)

6.6 There is one DAC on the Barking and Dagenham's pharmaceutical list (Fittleworth Medical). A DAC is a contractor that specialises in dispensing prescriptions for appliances, including customisation. They cannot dispense prescriptions for drugs.

GP Dispensing practices

6.7 There are no GP dispensing practices in Barking and Dagenham.

[32] Local Government Association: LG Inform. Ratio of pharmacies per 10,000 population (Snapshot: 29 November 2014) https://lginform.local.gov.uk/reports/lgastandard?mod-area=E92000001&mod-group=DEFRA2009_OtherUrbanList&mod-metric=3707&mod-type=namedComparisonGroup (Accessed in December 2021).

Distance Selling Pharmacies

6.8 There no distance selling pharmacies in Barking and Dagenham.

Local Pharmaceutical services

6.9 There are no Local Pharmaceutical Service (LPS) contracts within Barking and Dagenham. No area in Barking and Dagenham have been designated as LPS areas.

Accessibility

Distribution and choice

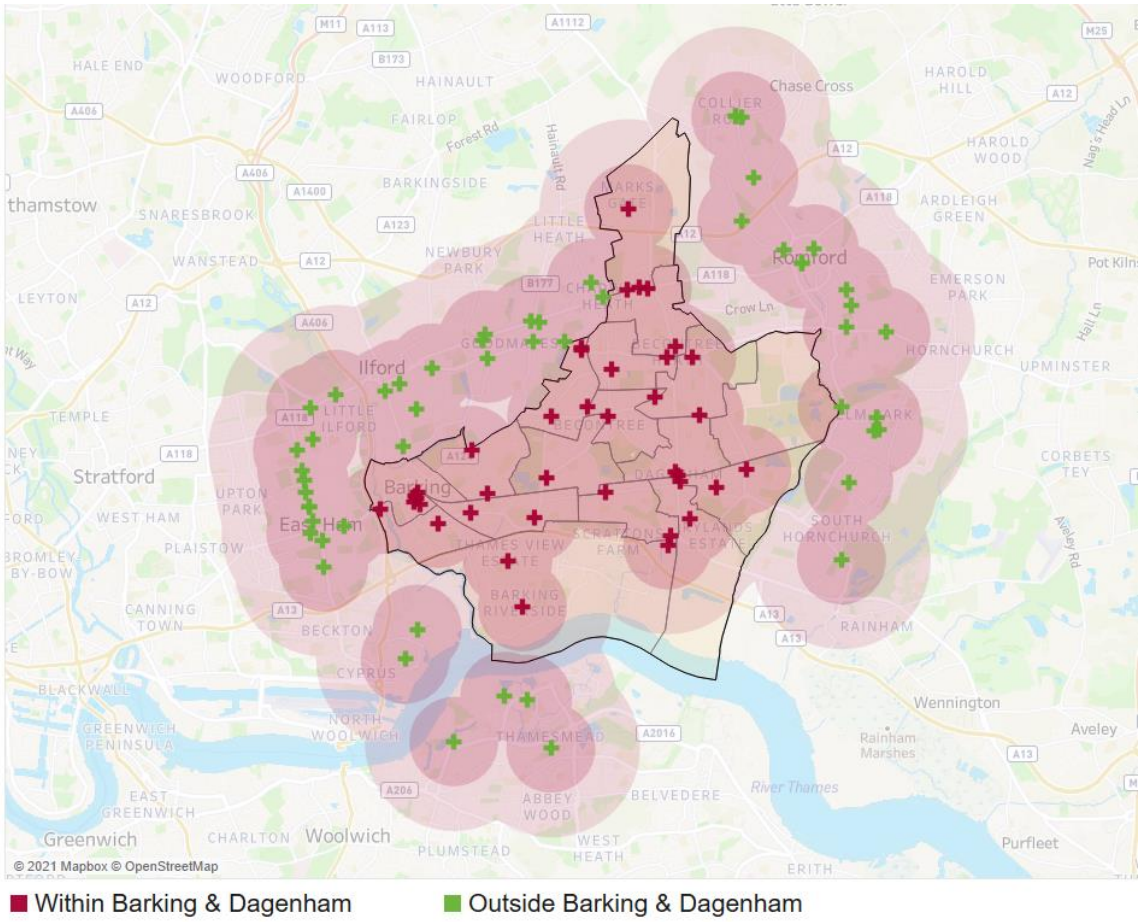
6.10 The PNA Steering Group agreed that the maximum distance for residents in Barking and Dagenham to access pharmaceutical services, should be no more than 1 mile. This distance equates to about a 20-minute walk.

6.11 Figure 6.1 below shows the 38 community pharmacies located in Barking and Dagenham as well as an additional 23 that are located in other boroughs but are within 1 mile of Barking and Dagenham's border. A 0.5- and 1-mile radius from each pharmacy's location is shown.

6.12 This shows that most of the borough is within 1 mile of at least one pharmacy. The south-eastern part of the borough shows a small area in River Ward that is not within 1 mile of any pharmacy, this is a non-residential area.

6.13 Additionally, there are 23 pharmacies outside the Barking and Dagenham located within 1 mile of the borough's border. These have been included in the pharmacies shown in Figure 6.2 as well as in Appendix B.

Figure 6.2: Distribution of community pharmacies in Barking and Dagenham and within 1 mile of the borough boundaries, with 0.5- and 1-mile coverage



Source: Contractor Survey and NHS England, 2021

6.14 The geographical distribution of the pharmacies by electoral ward and the pharmacy to population ratio is shown in Figure 6.2 and Table 6.1. As seen all wards have at least one pharmacy within them, except Eastbrook.

Table 6.1: Distribution of community pharmacies by ward

Ward	Number of Community Pharmacies	Population Size	Community Pharmacies per 10,000
Abbey	5	16,963	2.9
Becontree	4	14,837	2.7
Village	3	11,489	2.6
Thames	3	18,987	1.6
Chadwell Heath	3	11,181	2.7
Whalebone	2	12,526	1.6
Valence	2	10,904	1.8
Mayesbrook	2	10,918	1.8
Longbridge	2	12,499	1.6
Heath	2	11,886	1.7

Goresbrook	2	12,060	1.7
Gascoigne	2	13,931	1.4
Eastbury	2	12,458	1.6
Alibon	2	10,831	1.8
River	1	13,726	0.7
Parsloes	1	10,900	0.9
Eastbrook	0	11,289	0.0
Borough Total	**38**	**217,384**	**1.7**

Source: Contractor Survey and NHS England, 2021

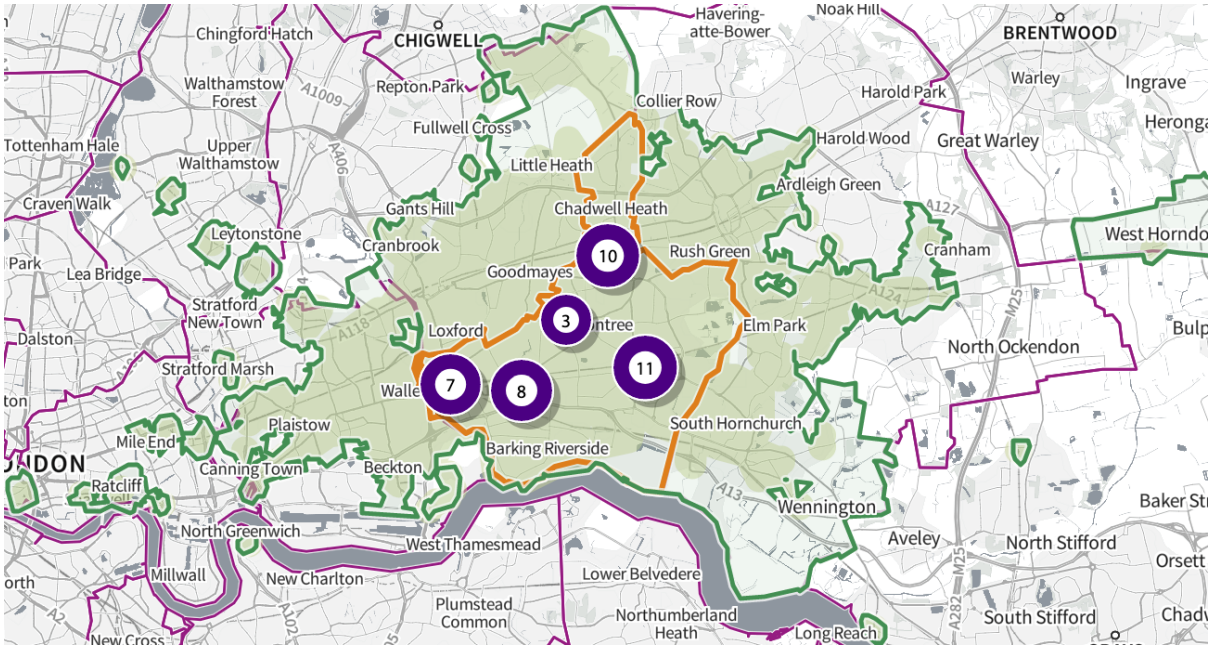
6.15 Although Eastbrook ward does not have a community pharmacy (it has a DAC), there is sufficient coverage of the ward from neighbouring wards and boroughs.

6.16 Additionally, all residents in Barking and Dagenham can reach a pharmacy using public transport within 20 minutes, attesting to the accessibility of the pharmacy provision in the borough. A total of 789,466 people in and outside the borough can reach a Barking and Dagenham pharmacy by public transport within 20 minutes (OHID, SHAPE Atlas Tool, 2021).

6.17 There are two pharmacies easily accessible to the new dwellings that are being developed within the Barking Riverside regeneration area located in Thames ward.

6.18 Figure 6.3 presents the coverage of the Barking and Dagenham pharmacies in consideration of public transport. Coverage is presented in green. There is a small area at the south-eastern region of Barking and Dagenham that is not covered. This is a non-residential area with River Ward.

Figure 6.3: Areas covered by 20-minute travel time by public transport to a Barking and Dagenham pharmacy from within and outside the borough



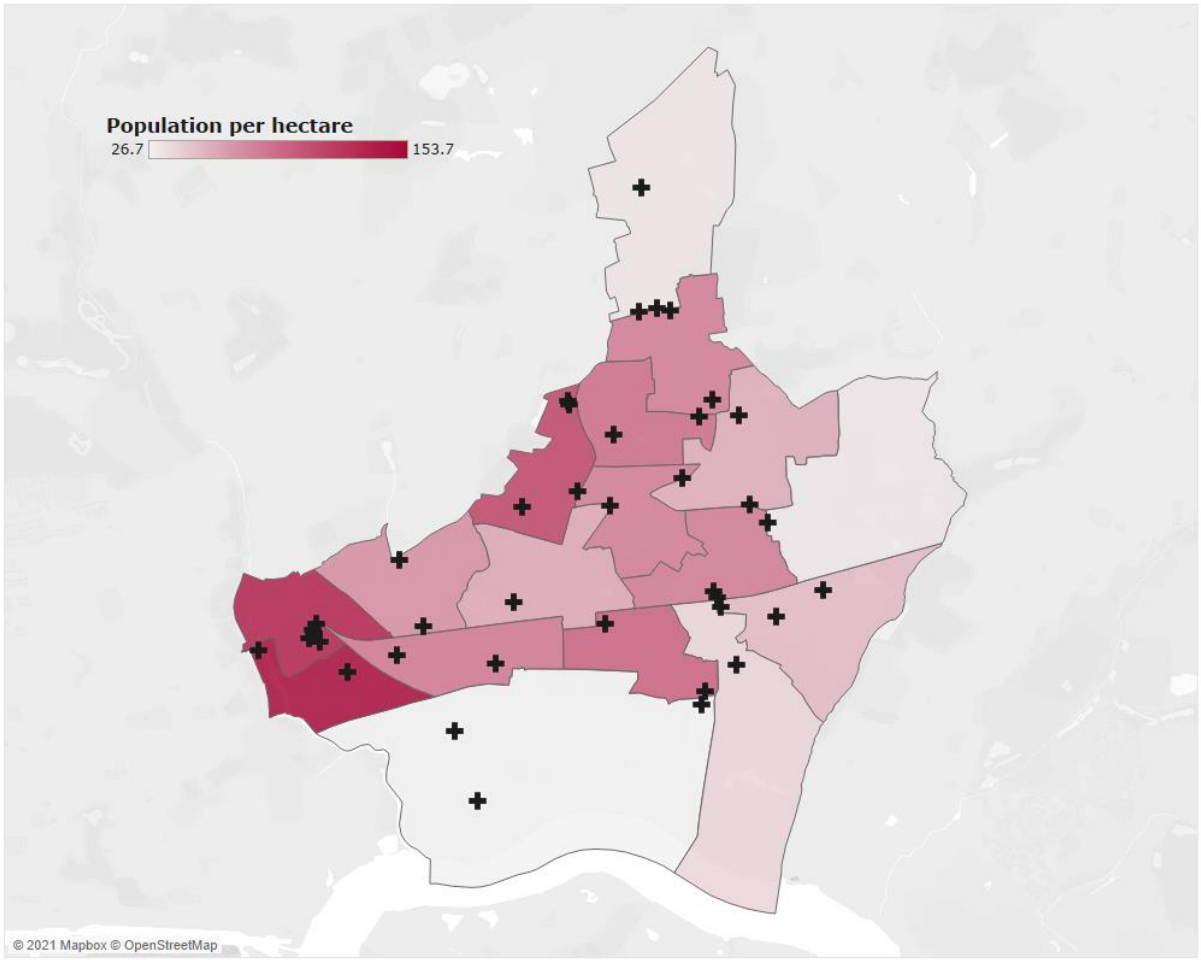
Source: **OVID, Strategic Health Asset Planning and Evaluation Atlas Tool, 2021**

6.19 Barking and Dagenham tend to fill their prescriptions at local pharmacies. NHSE data shows that in 2020-21, 83% (3,160,919) of items prescribed by GPs in Barking and Dagenham were dispensed by community pharmacies in the borough. 6.3% and 5.5% were dispensed by Havering and Redbridge pharmacies respectively.

Pharmacy Distribution in relation to population density

6.20 The population density map below indicates that the community pharmacy premises are predominantly located in areas of highest population density although a small number of pharmacies were identified in areas with the lowest population density.

Figure 6.4: Pharmacy locations in relation to population density by ward in Barking and Dagenham



Sources: **GLA (Land Area, and Population Density and NHSE)**

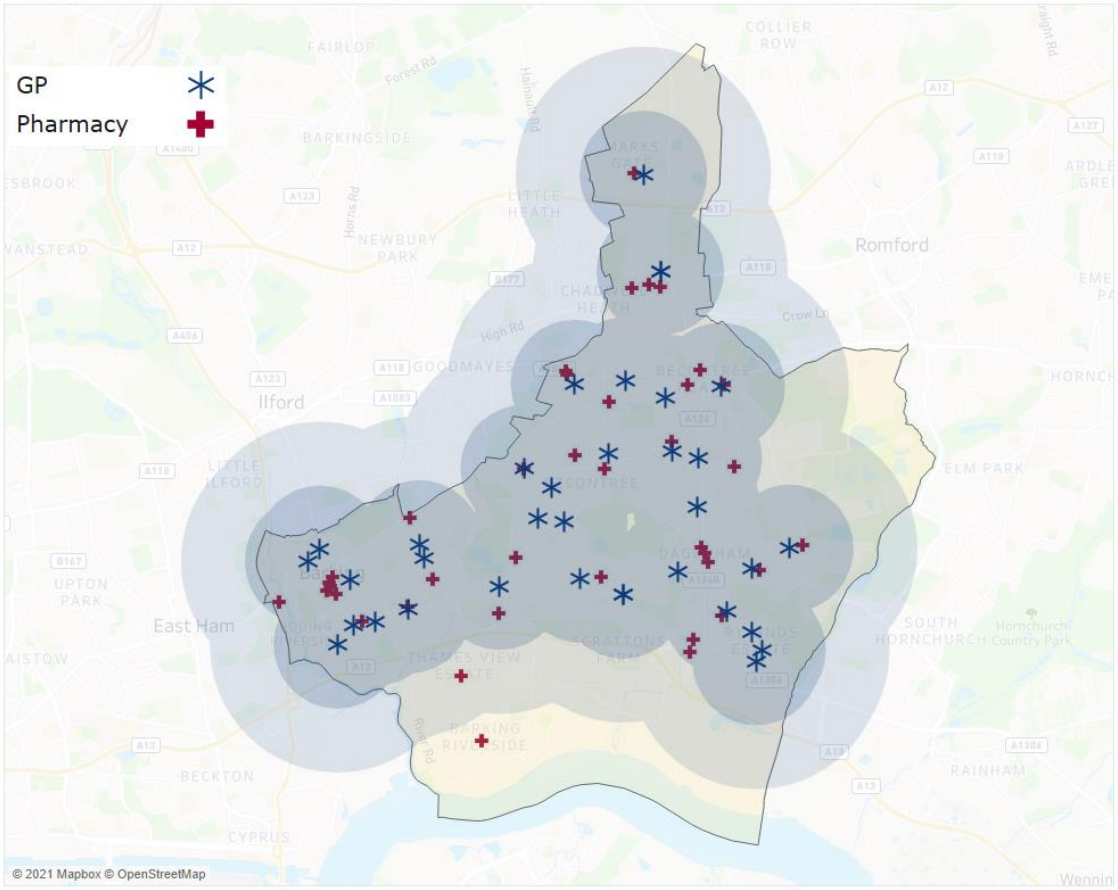
Pharmacy Distribution in relation to GP surgeries

6.21 As part of the NHS Long Term Plan[33] all general practices were required to be in a primary care network (PCN) by June 2019. Since January 2019 Barking and Dagenham GPs organised themselves into six PCNs within Barking and Dagenham. Altogether there are 35 GP member practices across these six PCNs. These are presented in Figure 6.5.

6.22 Each of these networks have expanded neighbourhood teams which will comprise of range of healthcare professionals including GPs, district nurses, community geriatricians, Allied Health Professionals and pharmacists. It is essential that community pharmacies are able to fully engage with the PCNs to maximise service provision for their patients and residents.

6.23 There is a pharmacy within accessible distance to all GP practices in Barking and Dagenham. Figure 6.5 shows that there is a pharmacy within half a mile of all GP practices in the borough.

Figure 7.5. GP practices in Barking and Dagenham and their 0.5- and 1-mile coverage, October 2021



Source: NHS England, 2021

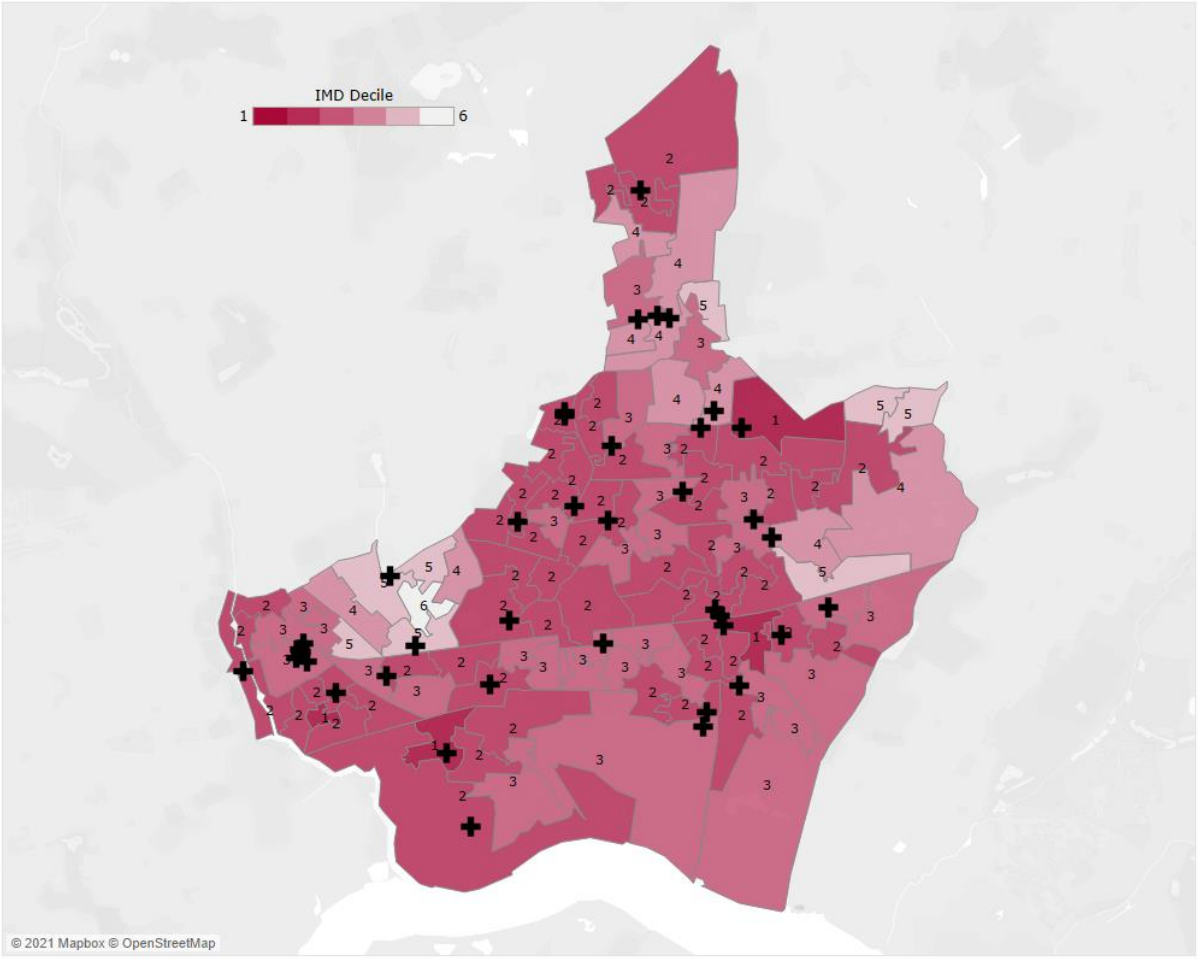
[33] NHS England (2019). The *NHS long term plan*. London, England

6.24 The Health and Wellbeing Board is not aware of any firm plans for changes in the provision of Health and Social Care services within the lifetime of this PNA. A new health and wellbeing hub is under development as part of the urban regeneration within Barking Riverside. It will serve the expected future growth in population and should be considered in future PNAs.

Pharmacy Distribution in relation to Index of Multiple Deprivation

6.25 There is correlation between health inequalities and the levels of deprivation. Figure 6.6 illustrates that people in areas of very high or high deprivation have access to a number of pharmacies.

Figure 6.6: Pharmacy locations in relation to deprivation deciles in Barking and Dagenham, 2021



Source: MHCLG & **NHSE**

Opening times

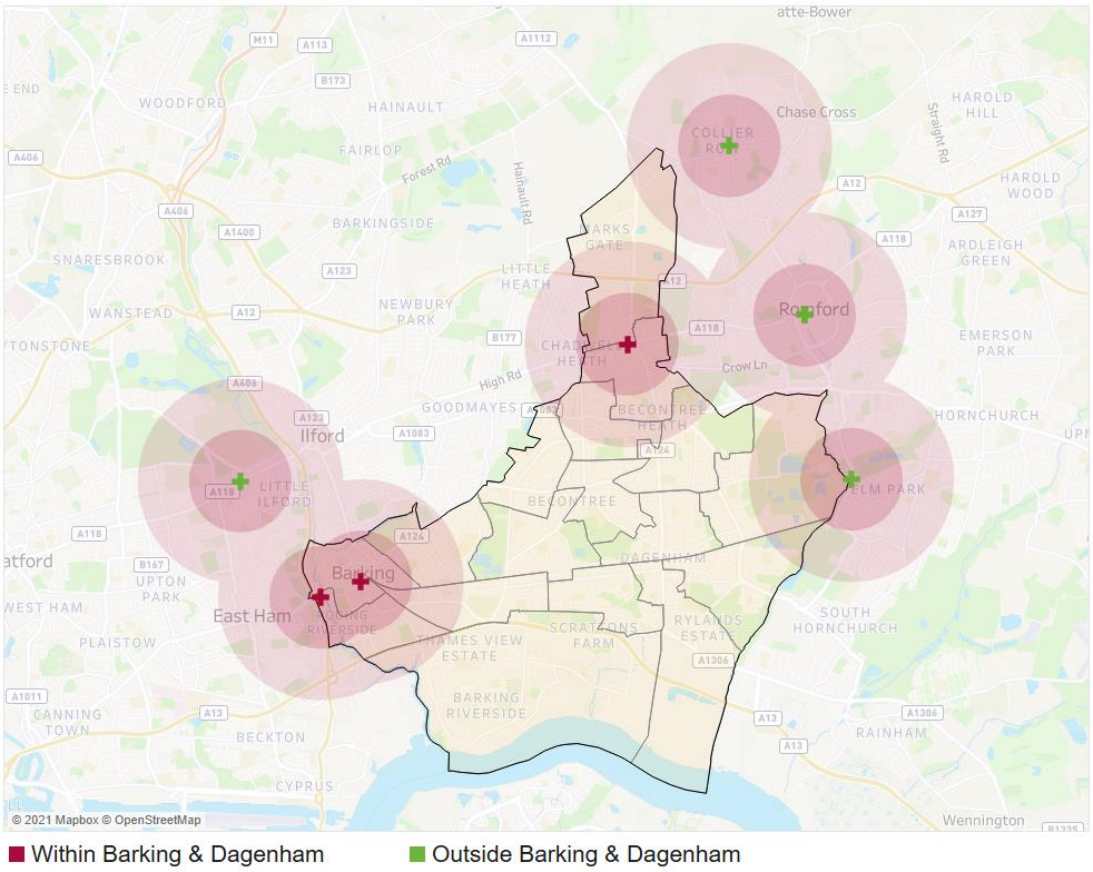
6.26 Pharmacy contracts with NHS England stipulate the core hours during which each pharmacy must remain open. Historically these have been 40-hour contracts (and some recent 100-hour contracts). A pharmacy may stay open longer than the stipulated core opening hours, these are called supplementary hours.

6.27 Opening times were obtained from NHS England in October 2021 and updated in April 2022. Additionally, market entry updates to the NHS England pharmaceutical list were reflected on the original list.

100-hour pharmacies

6.28 NHS England has three 100-hour pharmacies (core hours) on their list for Barking and Dagenham. These are presented in Figure 6.7 and Table 6.2. There are two other 100-hour pharmacies which are outside the borough but within 1 mile of its border (Figure 6.7)

Figure 6.7: 100-hour community pharmacies in Barking and Dagenham and their 0.5- and 1-mile coverage April 2022



Source: Contractor Survey and NHS England, 2021

Table 6.2: 100-hour pharmacies in Barking and Dagenham, April 2022

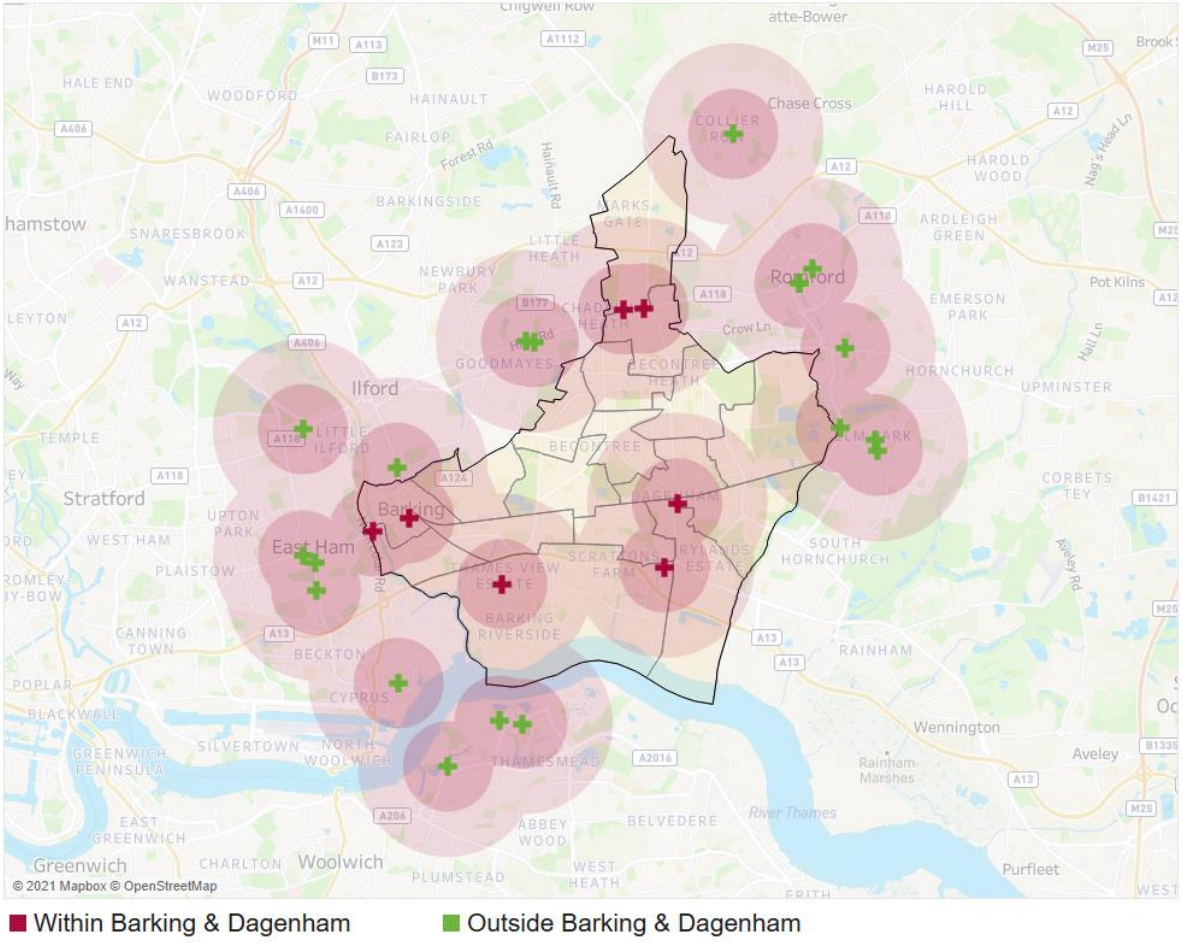
Pharmacy	Address	Ward
Tesco Pharmacy	Highbridge Road, Barking	Gascoigne
Super Care Pharmacy	198-200 High Road, Chadwell Heath	Whalebone
Daynight Pharmacy	17 Station Parade, Barking	Abbey

Source: Contractor Survey and NHS England, 2021

Early morning Opening

6.29 Seven pharmacies are open before 9am on weekdays within the borough and another 10 that are within 1 mile of the borough's border. These are shown in Figure 6.8, Table 6.3 and show that there is some coverage of early opening pharmacies in the borough.

Figure 6.8: Pharmacies that are open before 9am on a weekday and their 0.5- and 1-mile coverage, April 2022



Source: Contractor Survey and NHS England, 2021

Table 6.3: Community Pharmacies open before 9am on weekdays in Barking and Dagenham

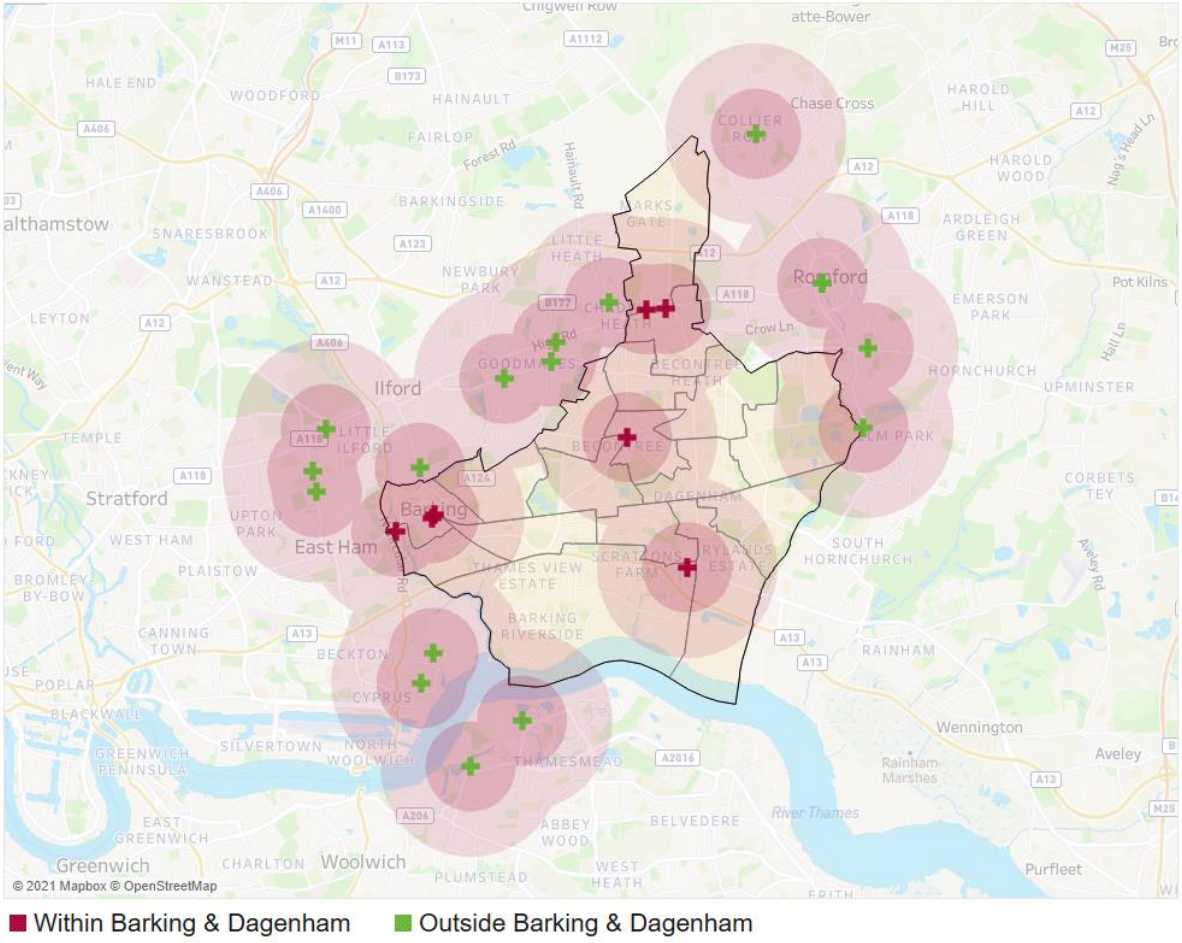
Pharmacy	Address	Ward
Asda Pharmacy	Asda Superstore, Merrielands Crescent, Dagenham	Thames
Boots UK Limited	17 The Mall, Heathway, Dagenham	Village
Britannia Pharmacy	Thames View Health Centre, Bastable Avenue, Barking	Thames
Daynight Pharmacy	17 Station Parade, Barking	Abbey
Lloyds Pharmacy	97-131 High Road, Chadwell Heath, Essex	Chadwell Heath
Super.Care Pharmacy +	198-200 High Road, Chadwell Heath, Romford	Whalebone
Tesco Pharmacy	Highbridge Road, Barking	Gascoigne

Source: Contractor Survey and NHS England, 2021

Late Evening Closure

6.30 There are 6 pharmacies in the borough that still open after 7pm on weekdays with nine other pharmacies within 1 mile of Barking and Dagenham (see Figure 6.9 and Table 6.4).

Figure 6.9: Community Pharmacies that are open after 7pm on weekdays and their 0.5- and 1-mile coverage, April 2022



Source: Contractor Survey and NHS England, 2021

Table 6.4: Community Pharmacies closing after 7pm on weekdays in Barking and Dagenham

Pharmacy	Address	Ward
Asda Pharmacy	Asda Superstore, Merrielands Crescent, Dagenham	Thames
David Lewis Chemist	16 Porters Avenue, Dagenham, Essex	Mayesbrook
Daynight Pharmacy	17 Station Parade, Barking	Abbey
Lloyds Pharmacy	97-131 High Road, Chadwell Heath, Essex	Chadwell Heath
Lords Dispensing Chemists	35 Station Parade, Barking, Essex	Abbey
Super.Care Pharmacy +	198-200 High Road, Chadwell Heath, Romford	Whalebone
Tesco Pharmacy	Highbridge Road, Barking	Gascoigne

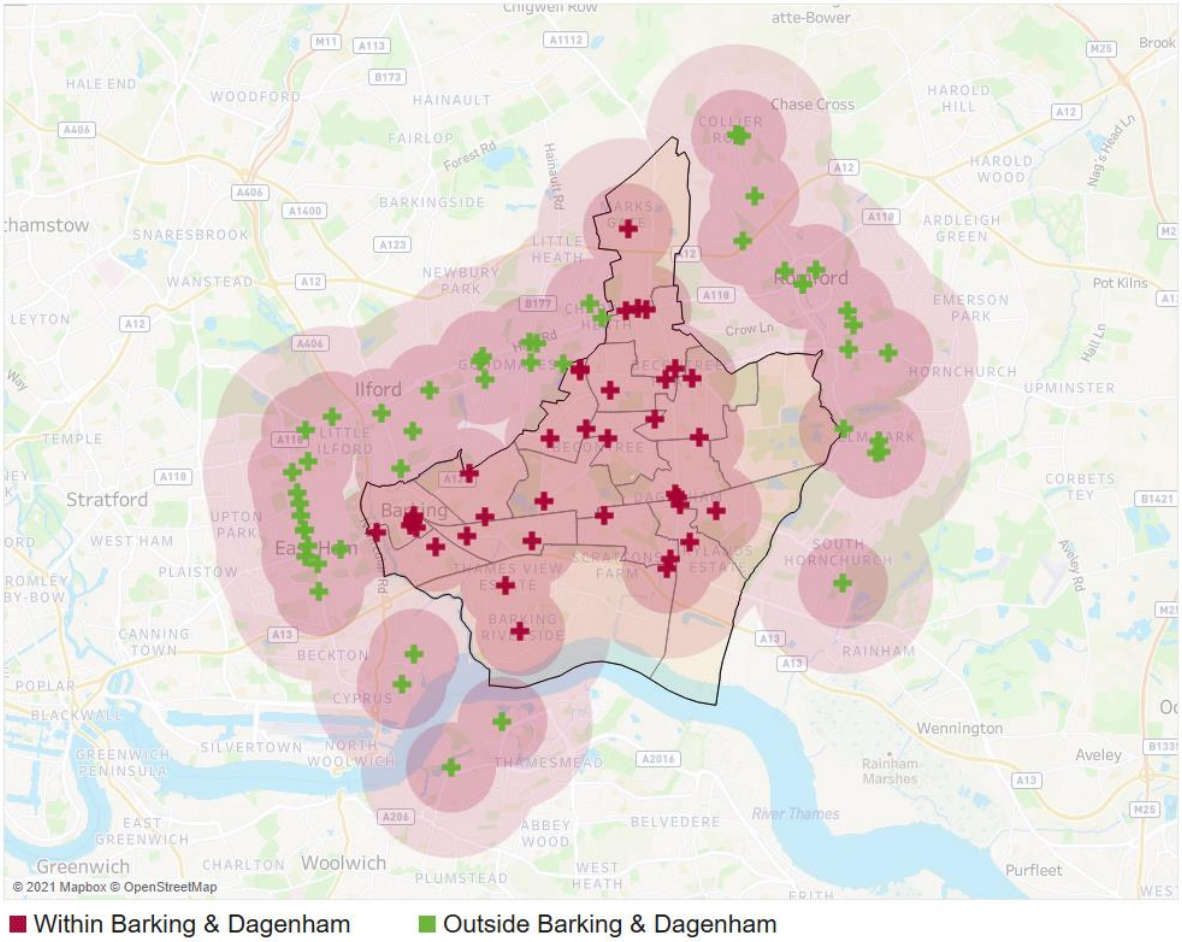
Source: Contractor Survey and NHS England, 2021

6.31 In terms of travel distance, 100% of Barking and Dagenham residents live within 20-minute reach of an early opening and late closing pharmacy by public transport (OHID, SHAPE Atlas Tool, 2021).

Saturday Opening

6.32 All but two of the pharmacies in Barking and Dagenham are open on Saturday (the exceptions being Day Lewis on Beadles Parade and Day Lewis on Ripple Road). There are another 48 pharmacies near the borough's border that are also open on Saturday. This highlights that there is good coverage of pharmacies available on Saturdays.

Figure 6.10 Community Pharmacies open on Saturday and their 0.5- and 1-mile coverage, April 2022

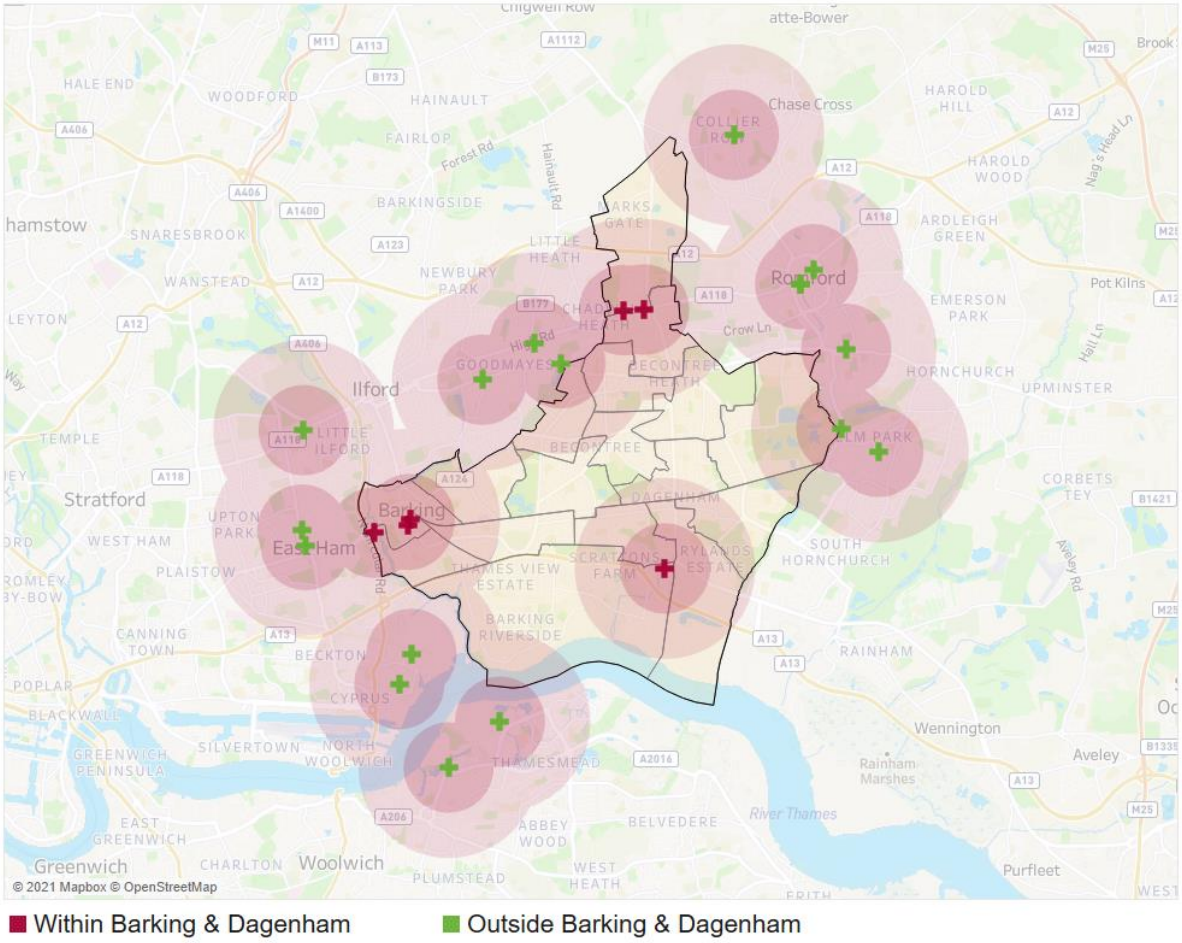


Source: Contractor Survey and NHS England, 2021

Sunday Opening

6.33 Just six pharmacies are open on a Sunday within the borough with eight open in boroughs around Barking and Dagenham within 1 mile of the borough's borders (Figure 6.11, Table 6.5).

Figure 6.11: Pharmacies open on a Sunday and their 0.5- and I-mile coverage, April 2022



Source: Contractor Survey and NHS England, 2021

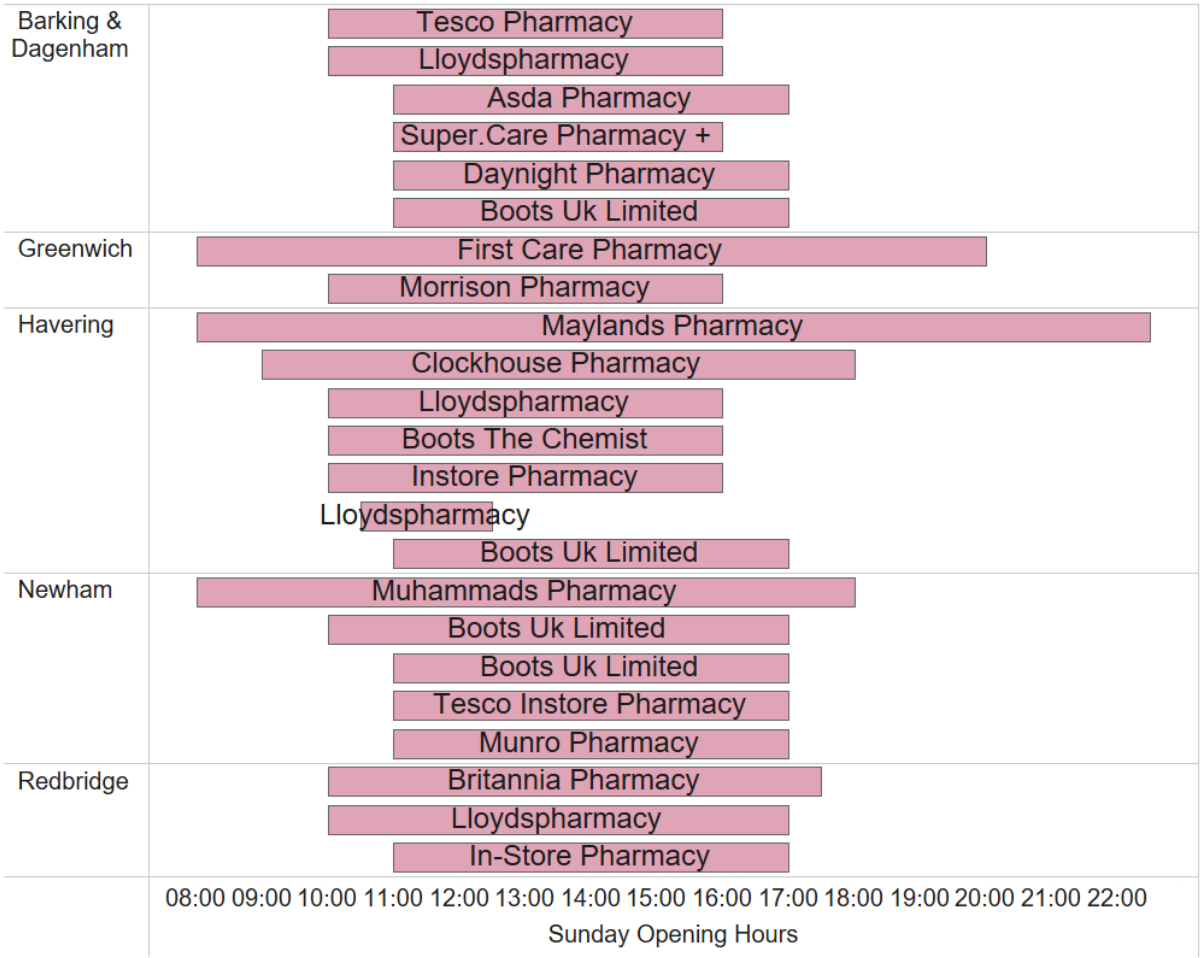
Table7.5: Community Pharmacies open on Sunday in Barking and Dagenham, April 2022

Pharmacy	Address	Ward
Asda Pharmacy	Asda Superstore, Merrielands Crescent, Dagenham	Thames
Boots UK Limited	68 East Street, Barking, Essex	Abbey
Daynight Pharmacy	17 Station Parade, Barking	Abbey
Lloyd Pharmacy	97-131 High Road, Chadwell Heath, Essex	Chadwell Heath
Super.Care Pharmacy +	198-200 High Road, Chadwell Heath, Romford	Whalebone
Tesco Pharmacy	Highbridge Road, Barking	Gascoigne

Source: Contractor Survey and NHS England, 2021

6.34 Overall, as shown in Figure 6.12 below, there is a wide range of Sunday opening hours offered to residents in Barking and Dagenham.

Figure 6.12: Opening times of pharmacies on Sundays



Source: Contractor Survey and NHS England, 2021

6.35 All Barking and Dagenham residents can reach a pharmacy within 20 minutes if using public transport on Saturday and on Sundays (OVID, Strategic Health Asset Planning and Evaluation Atlas Tool, 2021). Therefore there is good access to pharmacy services in Barking and Dagenham outside normal working hours.[34]

Essential Services

6.36 Essential services are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework. All pharmacy contractors required to deliver and comply with the specifications for all essential services, these are:

[34] NB: 'Good' is when the population is able to access their local pharmacy within 20-minutes, a statistic as defined by the Local Government Association: Local Government Association (March 2016). The community pharmacy offer for improving the public's health: a briefing for local government and health and wellbeing boards.

- Dispensing Medicines
- Dispensing Appliances
- Repeat Dispensing
- Clinical governance
- Discharge Medicines Service
- Public Health (Promotion of Healthy Lifestyles)
- Signposting
- Support for self-care
- Disposal of Unwanted Medicines

Dispensing

6.37 Barking and Dagenham pharmacies dispense an average of 7,092 items per month (based on NHS Business Services Authority, 2020/21 financial year data). While this is higher than the London average of 5,295 per month and slightly higher than England average at 6,675 per month, there is good distribution and capacity amongst Barking and Dagenham pharmacies to fulfil current and anticipated need in the lifetime of this PNA.

Summary of the accessibility pharmacy services and of essential services

Overall, there is good pharmacy coverage to provide necessary services across the borough in both inside normal working hours and outside normal working hours.

Advanced pharmacy services

6.38 Advanced services are NHS England commissioned services that community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary

.

6.39 As of October 2021, the following services may be provided by pharmacies:

- new medicine service
- community pharmacy seasonal influenza vaccination
- community pharmacist consultation service
- Community pharmacy blood pressure service, and
- community pharmacy hepatitis C antibody testing service (currently until 31 March 2022).

6.40 In early 2022 a stop-smoking service in pharmacies will be introduced for patients who started their stop-smoking journey in hospital.

6.41 As of October 2021, the community pharmacy COVID-19 lateral flow device distribution service and community pharmacy COVID-19 medicines delivery service are also commissioned to be delivered from community pharmacies. NHS England data was not yet available at the time of publication of this PNA.

6.42 There are two appliance advanced services that pharmacies and dispensing appliance contractors may choose to provide:

- appliance use reviews, and
- stoma appliance customisation.

6.43 Medicine Use Reviews is an Advanced Service that was decommissioned on the 31st of March 2021.

New Medicines Services

6.44 The New Medicine Service (NMS) supports patients with long-term conditions, who are taking a newly prescribed medicine, to help improve medicines adherence.

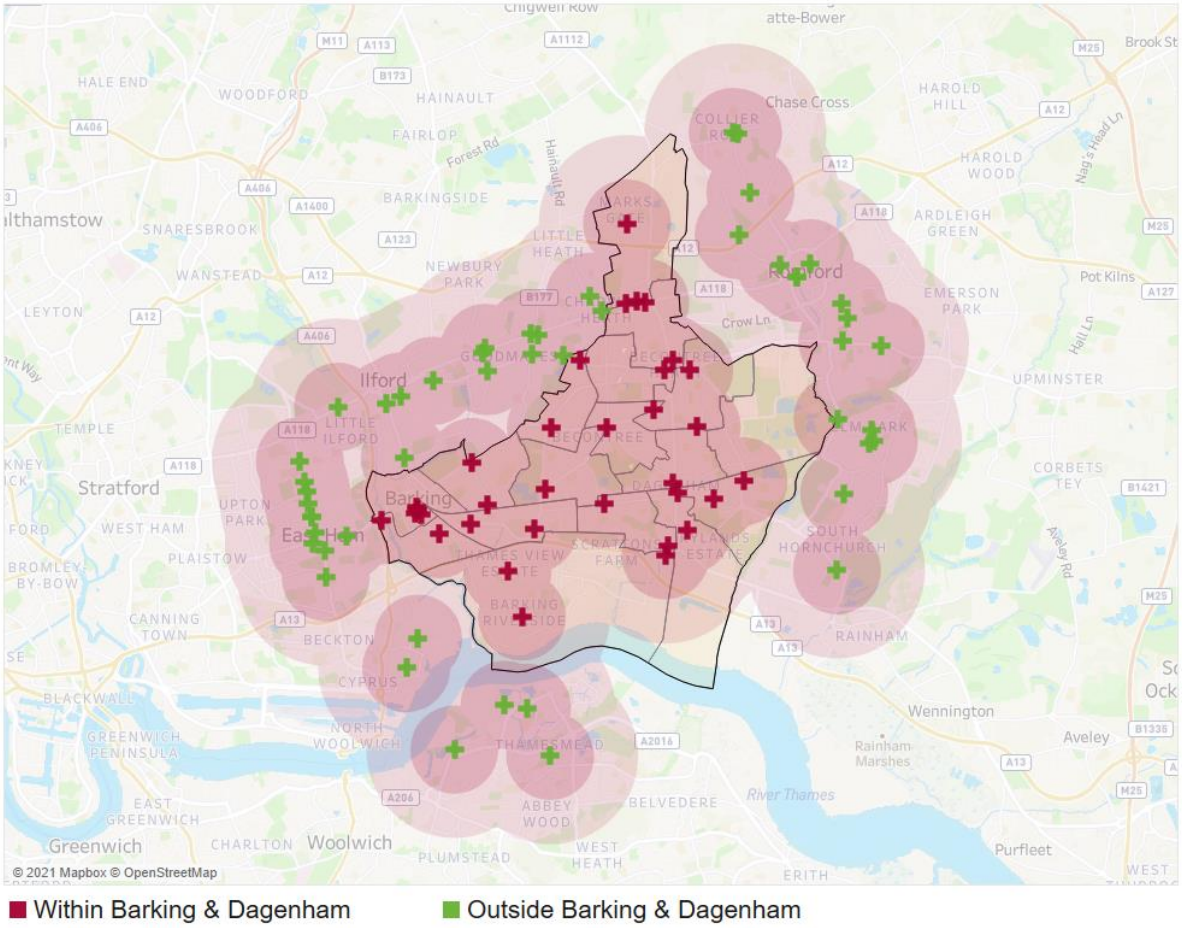
6.45 This service is designed to improve patients' understanding of a newly prescribed medicine for their long-term condition and help them get the most from the medicine. It aims to improve adherence to new medication, focusing on people with specific conditions

- Asthma and COPD
- Type 2 diabetes
- Antiplatelet or anticoagulation therapy
- Hypertension

6.46 New Medicines Service can only be provided by pharmacies and is conducted in a private consultation area to ensure patient confidentiality.

6.47 Thirty-three pharmacies provided NMS in Barking and Dagenham in 2020/21. There are an additional 49 pharmacies in bordering boroughs that provided NMS. All these pharmacies are shown in Figure 6.13 below

Figure 6.13: Pharmacies providing NMS and their 0.5- and I-mile coverage, October 2021



Source: NHS England, 2021

6.48 Table 6.5 below shows NMS provision by ward.

Table 6.5: Number of NMS provided by Barking and Dagenham pharmacies by ward, 2020/21

Ward	Number of Pharmacies	Total Number of NMSs provided	Average Number per Pharmacy
Abbey	4	613	153
Alibon	1	9	9
Becontree	2	114	57
Chadwell Heath	3	215	72
Eastbury	2	327	164
Gascoigne	2	570	285
Goresbrook	2	665	333
Heath	2	338	169
Longbridge	2	108	54
Mayesbrook	2	122	61
Parsloes	1	317	317
River	1	160	160
Thames	3	136	45

Valence	1	4	4
Village	3	447	149
Whalebone	2	13	7
Total	**33**	**4,158**	**126**

Source: **NHS England, 2021**

6.49 NMS are supplied widely across the borough within areas of high density and need, **therefore the current provision of the NMS is sufficient to meet the needs of this borough.**

Community pharmacy seasonal influenza vaccination

6.50 Flu vaccination by injection, commonly known as the "flu jab" is available every year on the NHS to protect certain groups who are at risk of developing potentially serious complications, such as:

- anyone over the age of 65
- pregnant women
- children and adults with an underlying health condition (particularly long-term heart or respiratory disease)
- children and adults with weakened immune systems

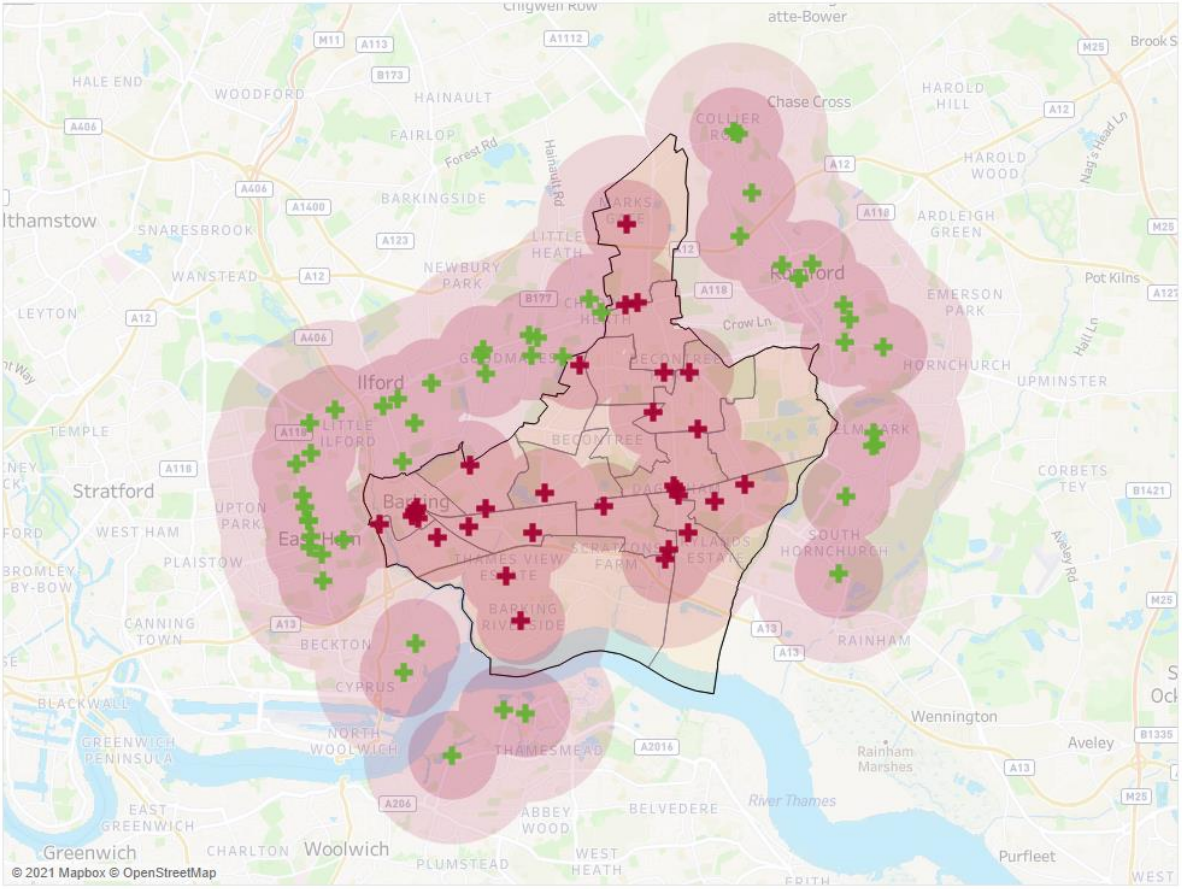
6.51 GPs currently provide the majority of flu vaccinations and pharmacies can help improve access to this service given their convenient locations, extended opening hours and walk-in service. The National Advanced Flu Service is an advanced service commissioned by NHS England to maximise the uptake of the flu vaccine by those who are ‘at-risk’ due to ill-health or long terms condition.

6.52 In addition to the Advanced Flu Service the NHS England London Region commissions the London Pharmacy Vaccination Service. This can be provided by any pharmacy in London. The aims of the service are to:

- sustain and maximise uptake of flu vaccine in at risk groups by continuing to build the capacity of community pharmacies as an alternative to general practice attendance
- to provide more opportunities and improve convenience for eligible patients to access flu vaccinations

6.53 A large proportion of community pharmacies in the borough provided flu vaccines (31/38) in Barking and Dagenham in 2020/21. Another 50 outside but bordering the borough provided the service. The distribution of these pharmacies is shown in Figure 6.14 and Table 6.6.

Figure 6.14: Pharmacies providing Flu vaccination and their 0.5- and I-mile coverage, October 2021



Source: NHS England, 2021

Table 6.6: Pharmacies that provide Flu Vaccinations in Barking and Dagenham by ward, October 2021

Ward	Number of Pharmacies	Ward	Number of Pharmacies
Abbey	5	Eastbury	2
Village	3	Alibon	2
Thames	3	Valence	1
Chadwell Heath	3	River	1
Longbridge	2	Parsloes	1
Heath	2	Mayesbrook	1
Goresbrook	2	Becontree	1
Gascoigne	2	**Total**	**31**

Source: NHS England, 2021

6.54 Overall, there is strong coverage of this service across Barking and Dagenham. Therefore, the **current provision Advanced Flu Service is sufficient to meet the needs of this borough**.

6.55 However, as outlined in Chapter 4, UK Health Security Agency vaccination data shows that uptake of the flu vaccination is low among the over 65 population in Barking and Dagenham. In addition, public survey respondents stated they would like their pharmacy to provide flu-vaccinations. Local commissioners should work with community pharmacies and primary care networks to explore how to better promote the service to raise awareness of it and to improve vaccination uptake in the borough.

Community pharmacist consultation service (CPCS)

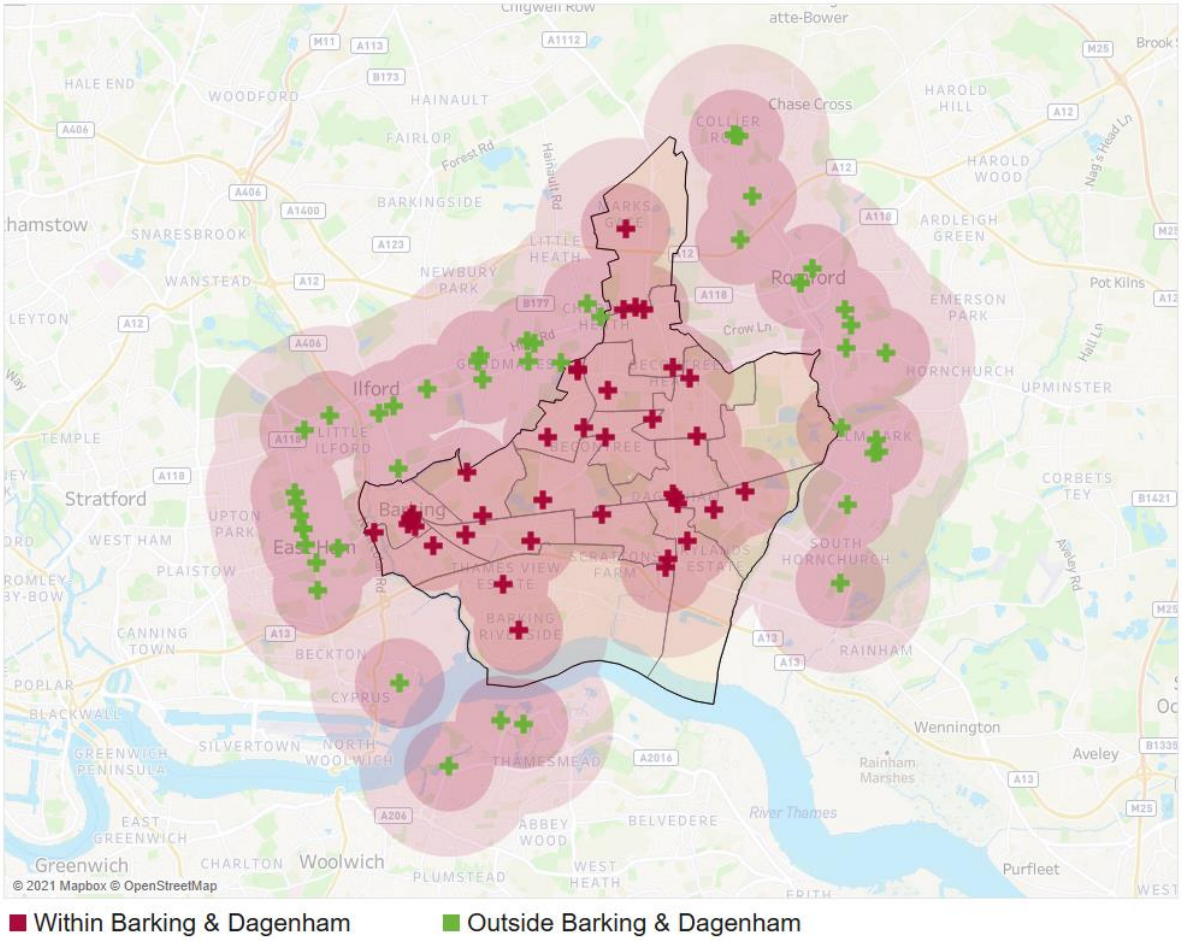
6.56 The community pharmacist consultation service (CPCS) is a new service provided by pharmacies that was launched in October 2019. The aims of the service are to support the integration of community pharmacy into the urgent care system, and to divert patients with lower acuity conditions or who require urgent prescriptions from the urgent care system and to community pharmacy.

6.57 It will also offer patients who contact NHS 111 the opportunity to access appropriate urgent care services in a convenient and easily accessible community pharmacy setting on referral from an NHS 111 call advisor and via the NHS 111 Online service.

6.58 There is strong coverage of CPCS in Barking and Dagenham. All but one of the community pharmacies (37/38) in the borough provided CPCS in 2020/21. There are an additional 46 pharmacies in neighbouring boroughs that provided the service (Figure 6.15 and Table 6.7).

6.59 The current provision of CPCS is sufficient to meet the needs of this borough.

Figure 6.15 Pharmacies providing CPCS and their 0.5- and I-mile coverage, October 2021



Source: NHS England, 2021

Table 6.7: Pharmacies that provide CPCS in Barking and Dagenham by ward, October 2021

Ward	Number of Pharmacies	Ward	Number of Pharmacies
Abbey	5	Heath	2
Becontree	4	Goresbrook	2
Village	3	Gascoigne	2
Thames	3	Eastbury	2
Chadwell Heath	3	Alibon	2
Whalebone	2	Valence	1
Mayesbrook	2	River	1
Longbridge	2	Parsloes	1
		Total	**37**

Source: NHS England, 2021

Community pharmacy blood pressure service

6.60 Community pharmacy blood pressure service is a relatively new service and at the time of publication NHSE does not report any pharmacy in Barking and Dagenham offering this service.

6.61 Twenty-eight respondents to the contractor survey indicated being willing to provide the service if commissioned.

Community pharmacy hepatitis C antibody testing service

6.62 NHSE data does not show any pharmacy offering Community pharmacy hepatitis C antibody testing service as of the time of publication.

6.63 Twenty-one respondents to the contractor survey indicated being willing to provide the service if commissioned.

Community pharmacy COVID-19 lateral flow device distribution service and community pharmacy COVID-19 medicines

6.10 As at the time of publication, NHSE data was not yet available for these services. However, these services are stopping at the end of March 2022.

6.64 Six respondents from the contractor survey indicated that they currently provide COVID-19 vaccinations, while another 20 indicated being willing to provide the service if commissioned.

6.65 Twenty-four respondents to the survey indicated they currently provide rapid COVID-19 lateral flow test kits and another five are willing to provide the kits if commissioned to do so.

Appliance Use Reviews

6.66 Appliance Use Review (AUR) is another advanced service that community pharmacy and appliance contractors can choose to provide so long as they fulfil certain criteria.

6.67 AURs can be carried out by, a pharmacist or a specialist nurse either at the contractor's premises or at the patient's home. AURs help patients to better understand and use their prescribed appliances by:

- Establishing the way the patient uses the appliance and the patient's experience of such use
- Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient
- Advising the patient on the safe and appropriate storage of the appliance
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

6.68 No pharmacies within or bordering the borough provided this AURs in 2020/21. However, NEL LPC have assured the Health and Wellbeing Board that should the need arise, there would be pharmacies in Barking and Dagenham willing to provide the service. Therefore, **no gap is evident in the current provision of this service.**

Stoma Appliance Customisation service

6.69 The SAC service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

6.70 Two pharmacies, Fittleworth Medical (Midas Bus Centre, Wantz Road, Dagenham) and Lloyds Pharmacy (281 Wood Lane, Dagenham) provided SACs within Barking and Dagenham in 2020/21.

6.71 Residents can access the SAC service either from non-pharmacy providers within the borough (e.g., community health services) or from dispensing appliance contractors outside of the borough. **Therefore, the current provision of SAC service is sufficient to meet the needs of this borough.**

Medicine Use Reviews

6.11 34 pharmacies in Barking and Dagenham delivered Medicine Use Reviews (MURs) up until the service contract was decommissioned by NHS England in March 2021. With MURs patients were offered a structured review of their medicine use to help them manage their medicines more effectively. MURS ensured that patients understood how their medicines should be used, why they have been prescribed and identified any problems patients may encounter. Where necessary would provide feedback to the prescriber.

Summary of the Advanced Pharmacy Services

It is concluded that there is currently sufficient provision for the following enhanced services to meet the needs of residents in Barking and Dagenham:

- new medicine service
- community pharmacy seasonal influenza vaccination
- community pharmacist consultation service
- Community pharmacy blood pressure service
- community pharmacy hepatitis C antibody testing service (currently until 31 March 2022)
- Stoma Appliance Customisation service

However, uptake of the flu vaccination is low among the over 65 population in Barking and Dagenham. Local commissioners should work with community pharmacies and primary care networks to explore how to better promote the community pharmacy seasonal influenza vaccination service locally.

At the time of data collection for this PNA, no data was available on the following newly commissioned services:

- stop-smoking service in pharmacies for patients who started their stop-smoking journey in hospital
- COVID-19 lateral flow device distribution service and community pharmacy COVID-19 medicines delivery service

Barking and Dagenham pharmacies have indicated their willingness to provide this service, therefore no gap is evident for future access to these advanced services.

No local pharmacies provided Appliance Use Reviews between October 2020 and October 2021. However, Barking and Dagenham pharmacies will be willing to provide them, should the need arise. Therefore, the current provision of the AUR service is sufficient to meet the current and future needs of this borough.

6.72 Residents can access the SAC service either from non-pharmacy providers within the borough (e.g., community health services) or from dispensing appliance contractors outside of the borough. **Therefore, the current provision of SAC service is sufficient to meet the needs of this borough.**

Enhanced Pharmacy Services

6.73 There are currently three locally enhanced services commissioned by NHSE&I, the London Region. These are the London Seasonal Influenza Vaccination Service, the Bank Holiday Rota Service, and the COVID-19 Vaccination Service.

London Seasonal Influenza Vaccination Service

6.74 In addition to the Advanced Flu Service the NHSE&I commissions the London Seasonal Influenza Vaccination Service. It provides a vaccination service where there may otherwise be gaps and is offered to a wider patient group, including carers, asylum seekers and the homeless and children from 2 to 18 years.

6.75 They also offer provision for pneumococcal vaccination to eligible cohorts and MenACWY for 18–24-year-olds living permanently or temporarily in London.

6.76 As at the time of publication, NHSE data was not yet available for these services.

Bank Holiday Rota Service

6.77 Community pharmacies are not obliged to open on nominated bank holidays. Since 2020 NHSE&I commission pharmacies to open during bank holidays on a rota basis as an enhanced service. This is to ensure pharmacy services are available during bank holidays and they are accessible to other out of hours providers, thus enabling patients to easily access medication if required.

6.78 In Barking and Dagenham this service is provided by Britannia Pharmacy, Upney Lane in Barking.

COVID-19 Vaccination Service

6.12 The aim of this service is to maximise uptake of COVID-19 vaccine by providing vaccination services from accessible pharmacy locations and improving patients' convenience and choice. This service is commissioned as and when required. At the time of the production of this PNA, eight pharmacies provide COVID-19 vaccinations in Barking and Dagenham.

Other NHS Services

6.79 These are services commissioned by the London Borough of Barking and Dagenham, and Barking and Dagenham, Havering and Redbridge CCG to fulfil a local population's health and wellbeing needs. Barking and Dagenham enhanced services are listed below:

6.80 Local authority commissioned services:

- Needle exchange
- Supervised consumption
- Stop smoking services
- Emergency hormonal contraception

6.81 Barking and Dagenham, Havering and Redbridge CCG commissioned services:

- Community anticoagulation service
- End of life care medication provision

The provision of these services is explored below.

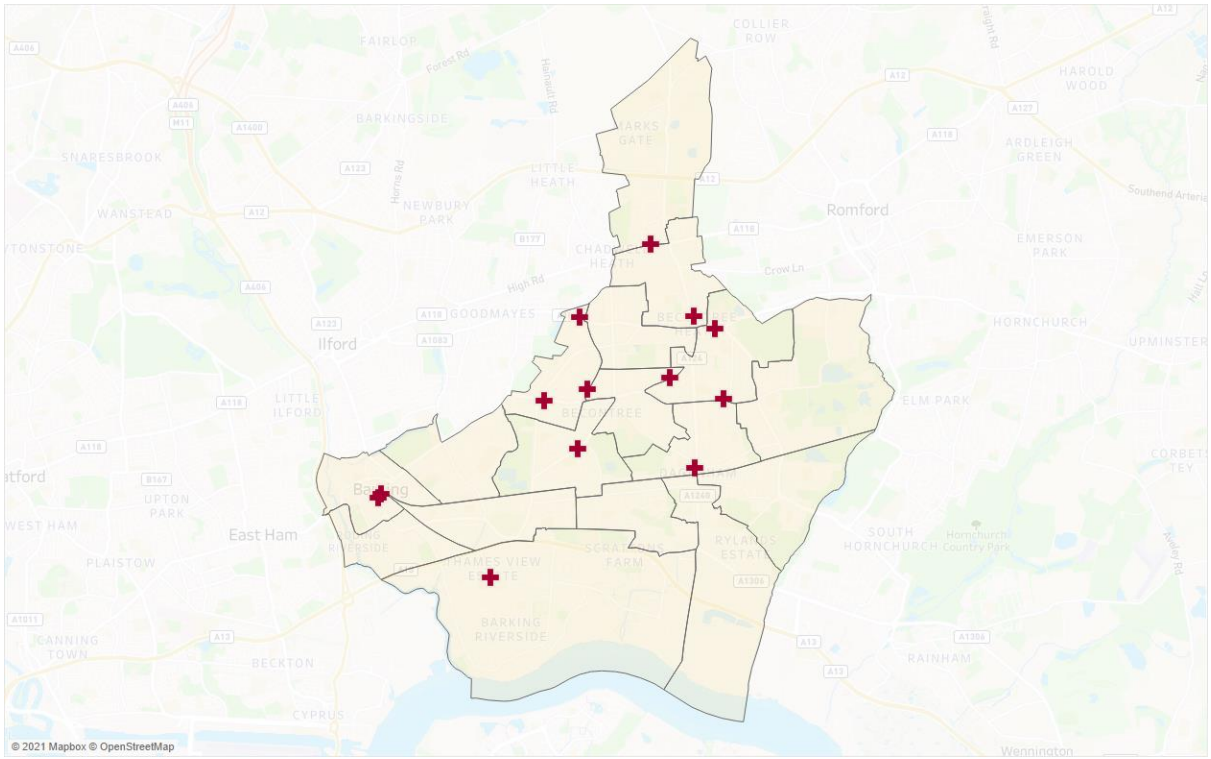
Needle exchange

6.82 Needle exchange service in Barking and Dagenham is subcontracted by Change Grow Live, a national health and social care charity. The needle exchange service supplies needles, syringes and other equipment used to prepare and take illicit drugs. The purpose of this services is to reduce the transmission of blood-borne viruses such as hepatitis B and C, and other infections caused by sharing injecting equipment.

6.83 Needle exchange services also aim to reduce the harm caused by injecting drugs through providing information and advice and acting as a gateway to other services, including drug treatment centres.

6.84 Twelve pharmacies offer the needle exchange service. Their locations are shown in Figure 6.16 and Table 6.8.

Figure 6.16: Pharmacies that provide Needle Exchange Services in Barking and Dagenham, October 2021



Source: NHS England, 2021

Table 6.8: Number of Pharmacies that provide Needle Exchange Services in Barking and Dagenham by ward, October 2021

Ward	Number of Pharmacies	Ward	Number of Pharmacies
Becontree	3	Thames	1
Heath	2	Parsloes	1
Abbey	2	Chadwell Heath	1
Whalebone	1	Alibon	1

Source: Change Grow Live, 2021

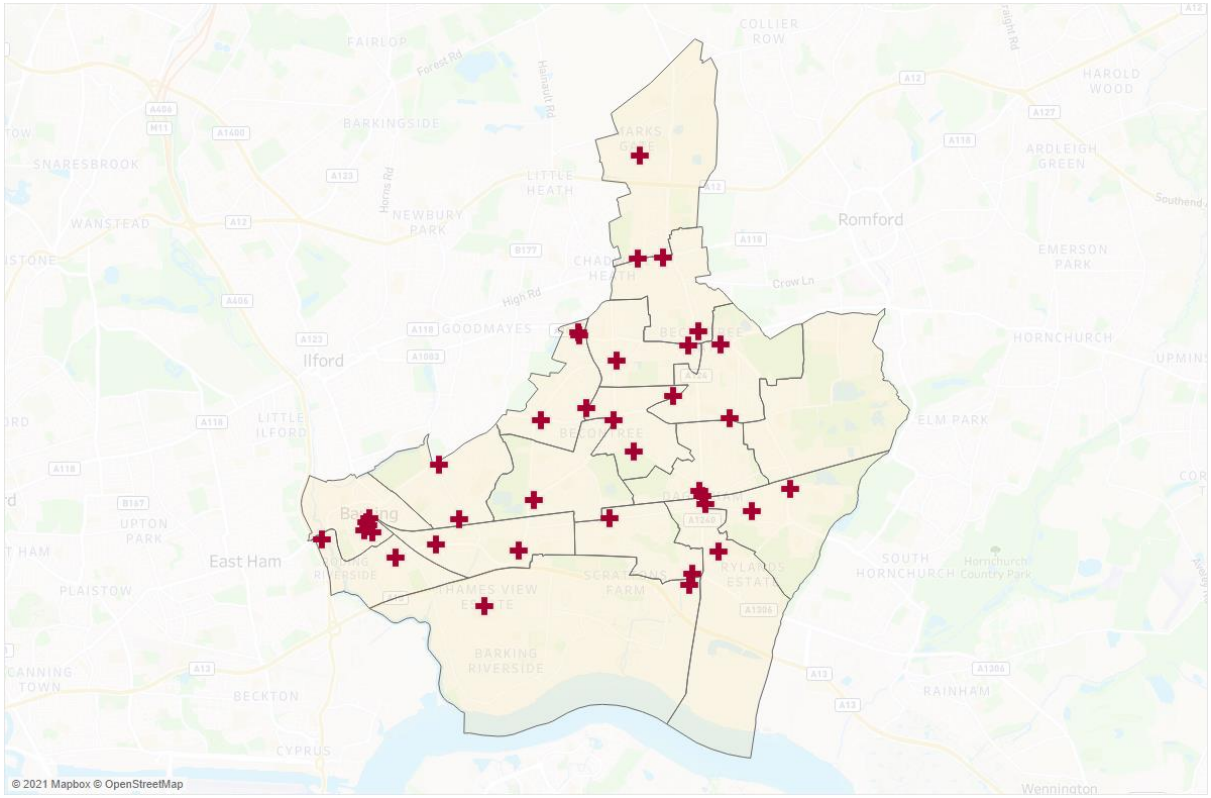
Supervised consumption

6.85 The London Borough of Barking and Dagenham commission community pharmacies to provide supervised consumption as part of as part of treatment services for opioid dependency.

6.86 Supervised consumption of opioid substitution treatment forms a critical element of safe and effective treatment in the community. It reduces risk of overdose and non-compliance with treatment, minimises diversion and enables people being treated for opioid dependency to utilise the benefits of pharmacy intervention around health choices. It is typically used for people who are new to treatment and/or have complex needs.

6.87 There is good provision of this service in the borough. Thirty-six pharmacies have been commissioned to provide supervised consumption services in Barking and Dagenham. These are presented in Figure 6.17 and Table 6.9.

Figure 6.17: Pharmacies that provide Supervised Consumption in Barking and Dagenham, October 2021



Source: London Borough of Barking and Dagenham, 2021

Table 6.9: Number of Pharmacies that provide Supervised Consumption in Barking and Dagenham by ward, October 2021

Ward	Number of Pharmacies	Ward	Number of Pharmacies
Abbey	5	Heath	2
Becontree	4	Goresbrook	2
Village	3	Gascoigne	2
Whalebone	2	Eastbury	2
Valence	2	Chadwell Heath	2
Thames	2	Alibon	2
Mayesbrook	2	River	1
Longbridge	2	Parsloes	1

Source: London Borough of Barking and Dagenham, 2021

Stop smoking services

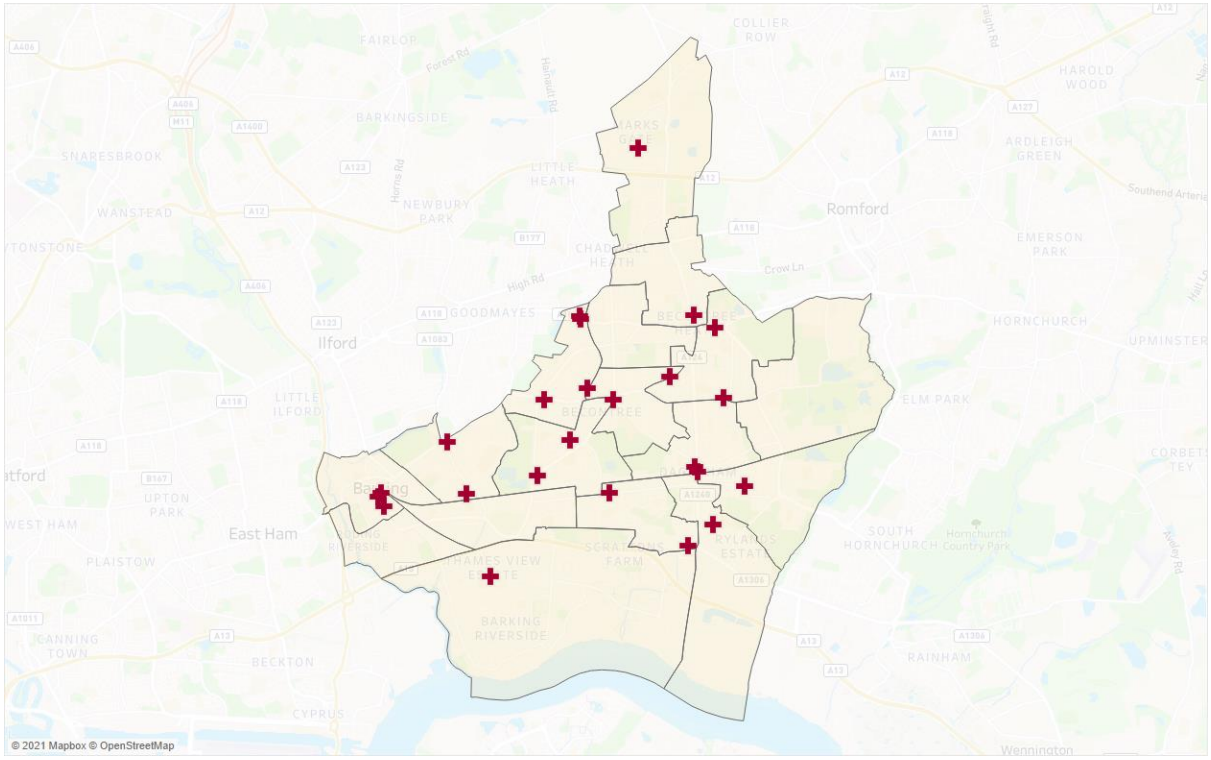
6.88 One of the recommendations of the Barking and Dagenham JSNA[35] is to ensure that smokers who wish to quit can continue to access counselling support and pharmaceutical aids, including prescription only medication where clinically indicated.

6.89 The stop smoking service provided in pharmacies in Barking and Dagenham is a 'Level 2 enhanced smoking cessation service' for Barking and Dagenham GP registered patients who have a recorded smoking status. The aim of the service is to provide a comprehensive and consistent smoking cessation treatment for smokers in Barking and Dagenham who wish to quit, which is equitable and accessible, and which meets local authority targets and aspirations.

6.90 The service is a Patient Group Direction service which is delivered through community pharmacies by staff trained and accredited as level 2 stop smoking advisors. Patients receive an initial assessment, weekly behaviour change support for four weeks and offer of pharmacotherapies.

6.91 Twenty-three pharmacies offer stop smoking services in the borough and are shown in Figure 6.18 and Table 6.10.

Figure 6.18: Pharmacies that provide Stop Smoking Services in Barking and Dagenham, October 2021



Source: London Borough of Barking and Dagenham, 2021

[35] BHR JSNA profile: LB Barking and Dagenham 2020

Table 6.10: Number of Pharmacies that provide Stop Smoking Services in Barking and Dagenham by ward, October 2021

Ward	Number of Pharmacies	Ward	Number of Pharmacies
Becontree	4	Whalebone	1
Abbey	3	Village	1
Mayesbrook	2	Thames	1
Longbridge	2	River	1
Heath	2	Parsloes	1
Goresbrook	2	Chadwell Heath	1
Alibon	2		

Source: London Borough of Barking and Dagenham, 2021

Emergency Hormonal Contraception

6.92 There are two Emergency Hormonal Contraception services that are delivered through Barking and Dagenham pharmacies. These are:

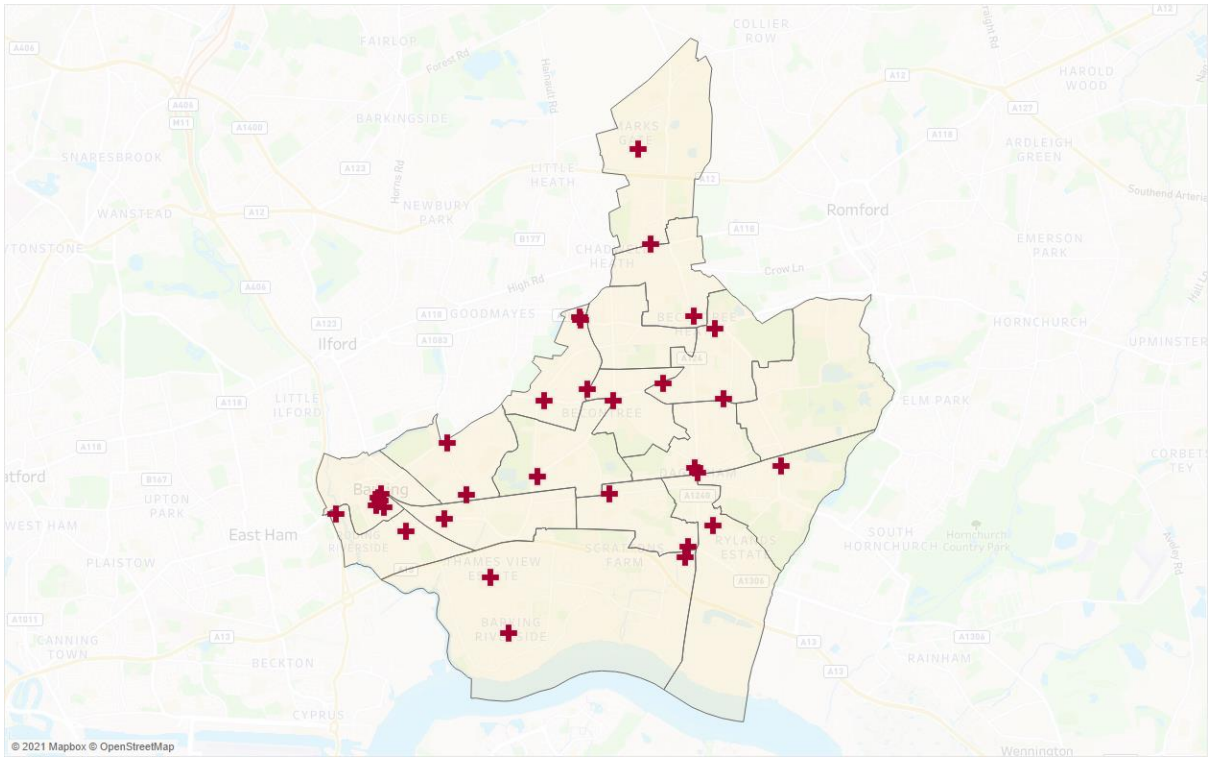
1. Ulipristal acetate 30mg
2. Levonorgestrel 1500mcg

6.93 Both services are Patient Group Direction services that are commissioned by the London Boroughs of Barking and Dagenham, Havering and Redbridge, and Barts Health NHS Trust. Community pharmacists must complete mandatory training approved by Train All East, Barts Sexual Health Primary Care Support Team and access regular commissioner-approved updates.

6.94 The aim of the emergency contraception is to reduce the number of unwanted pregnancies in Barking and Dagenham, particularly in teenagers and young women. It is for women aged from 13 years to 25 years, within 72 hours following unprotected sexual intercourse or contraceptive method failure with the intention of preventing an unintended pregnancy. Clients who seek this service are also offered advice and guidance on other forms of contraception.

6.95 Thirty pharmacies offer this service in Barking and Dagenham. Their locations are showing in Figure 6.19 and Table 6.11 below.

Figure 6.19: Pharmacies that provide Emergency Hormonal Contraception in Barking and Dagenham, October 2021



Source: London Borough of Barking and Dagenham, 2021

Table 6.11: Number of Pharmacies that provide Emergency Hormonal Contraception in Barking and Dagenham by ward, October 2021

Ward	Number of Pharmacies	Ward	Number of Pharmacies
Abbey	5	Gascoigne	2
Becontree	4	Chadwell Heath	2
Thames	3	Alibon	2
Mayesbrook	2	Whalebone	1
Longbridge	2	Village	1
Heath	2	River	1
Goresbrook	2	Eastbury	1

Source: London Borough of Barking and Dagenham, 2021

Community anticoagulation service

6.96 This service is commissioned by Barking and Dagenham, Havering and Redbridge CCG to reduce the expected prevalence of atrial fibrillation in Barking and Dagenham.

6.97 The overall aim of this service is to provide on-going monitoring and management of anticoagulation therapy in the community for patients aged 18 and over, who are registered

with a GP practice in Havering and Barking and Dagenham CCG, including temporary residents.

6.98 The provision of the service includes:

- Point of Care Testing
- Organisation and provision of domiciliary service for housebound patients who require anticoagulation monitoring and on-going management.
- Use of Computer Decision Support Software (CDSS) for dosing advice and frequency of testing.
- Prescribing conducted in accordance with the prescribing protocol

6.99 Two pharmacies in the borough offer this service: Britannia Pharmacy on Upney Lane, Barking (Longbridge ward) and Oxlow Chemist on Oxlow Lane, Dagenham (Heath ward)

End of life care medication provision

6.100 The aim of the end of life care (EoLC) medication is to improve access to medications for patients, carers and healthcare professional when they are required. This is to ensure that there is no delay to treatment whilst also providing access and choice.

6.101 Commissioned pharmacies who provide this service maintain a required stock of EoLC medication. Where requested, the pharmacist will provide advice to the healthcare professional regarding the prescribing or dosage of EoLC that should be administered to the patient.

6.102 Commissioned pharmacies may also opt-in to provide an Out-Of-Hours dispensing service for EoLC medication. These pharmacies would provide EoLC medication when no other commissioned pharmacies are open, namely:

- Mon- Saturday 12am-7am
- Sunday 12am - 9am

6.103 The Out-Of-Hours service is to ensure there is 24 hours 7 days a week availability of medicines for EoLC from community pharmacies across the CCGs three boroughs, Barking and Dagenham, Havering and Redbridge.

6.104 Within Barking and Dagenham, three pharmacies offer EoLC medication (shown in Table 6.12)

Table 6.12: Pharmacies providing the EOLC medicines access scheme only in Barking and Dagenham

Pharmacy	Address	Ward
Britannia Pharmacy	Barking Community Hospital, Upney Lane, Barking	Longbridge
Daynight Pharmacy	17 Station Parade, Barking	Abbey
Supercare Pharmacy	198-200 High Road, Chadwell Heath, Romford	Whalebone

Source: BHR CCG, 2021

6.105 Just one pharmacy in the borough offers both EoLC medicines and OOH provision: Alvin Rose Chemist Longbridge Road, Dagenham. It is situated with Beacontree ward.

Summary of enhanced pharmacy services
It is concluded that there is currently sufficient provision for the following enhanced services to meet the likely needs of residents in Barking and Dagenham:

- Needle exchange
- Supervised consumption
- Stop smoking services
- Emergency hormonal contraception
- Community anticoagulation service
- End of life care medication provision

Contractor survey responses

6.98 There are some areas of population health and wellbeing need identified in Chapter 4 that pharmacies do not provide specialist support for. The contractor survey identified where pharmacies would be willing to provide additional services to address these needs if commissioned. These are summarised below.

6.99 Chlamydia detection rates are higher than national figures, this is an area that pharmacies can support locally. 27 Barking and Dagenham pharmacies stated in the contractor survey they would be willing to provide chlamydia treatment if commissioned. 24 pharmacies would be willing to provide a contraceptive service that is not EHC if commissioned.

6.100 Nearly a quarter (22.4%) of Barking and Dagenham adults have a common mental illness. 22 pharmacies responded that they would be willing to provide a disease specific service for depression.

6.101 Premature mortality for cancers, stroke, coronary heart diseases and respiratory diseases are high in Barking and Dagenham. There are a number of services Barking and Dagenham community pharmacies would be willing to provide if commissioned:

- 23 pharmacies stated that they would be willing to provide Anticoagulant Monitoring Service.
- 27 pharmacies were willing to provide a disease specific service for coronary heart disease
- 22 pharmacies were willing to provide a disease specific service for heart failure

6.102 Dementia detection rates are low in Barking and Dagenham. 23 pharmacies stated that they were willing to provide an Alzheimer's or Dementia disease specific service if commissioned.

Communication

6.103 The most common **languages** spoken by residents in the borough other than English are Lithuania, Bengali, Urdu and Polish.

6.104 There are a wide range of languages spoken in Barking and Dagenham pharmacies. According to the responses to the contractor survey most common languages besides English spoken by pharmacy staff are Gujarati, Hindi and Punjabi. No pharmacies report Polish as one of the languages they provide.

6.105 Table 6.13 lists the most common languages spoken by a member of staff in Barking and Dagenham pharmacies.

Table 6.13: Top 10 languages spoken by a member of staff at the pharmacies in Barking and Dagenham

Language	Number of Pharmacies
Gujarati	17
Hindi	15
Punjabi	9
Urdu	8
Bengali	6
Romanian	6
Lithuanian	5
Russian	5
Cantonese	3
Albanian	2

Source: Barking and Dagenham Contractor Survey, 2021

6.106 27 Barking and Dagenham pharmacies would be willing to provide a Language Access Service if commissioned.

Chapter 7 - Conclusions

7.1 There are pockets of high deprivation and inequalities throughout Barking and Dagenham and several health and wellbeing needs have been identified. Pharmacies in Barking and Dagenham are geographically well placed within areas of deprivation and high population density.

7.2 They provide an accessible, community-focused service that support efforts to tackle health inequalities by promoting public health campaigns and offering a safe place where people can get information and support as part of the essential services pharmacies provide. They also provide locally commissioned services such as sexual health services to address locally identified needs. Public survey responses showed that overall people are happy with the pharmacy services they receive.

7.3 This pharmaceutical needs assessment has considered the current provision of pharmaceutical services across Barking and Dagenham in alongside the health needs and demographics of its population.

7.4 It has assessed whether current provision meets the needs of the population and whether there are any gaps in the provision of pharmaceutical service either now or within the lifetime of this document, 1st October 2022 to 30th September 2025.

7.5 This chapter will summarise the provision of these services in Barking and Dagenham and its surrounding local authorities.

Current provision

7.6 The Barking and Dagenham Health and Wellbeing Board has identified the following services as necessary to this PNA to meet the need for pharmaceutical services:

- Essential services provided at all premises included in the pharmaceutical lists.

7.7 Other Relevant Services are services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have secured improvements or better access to medicines. The Barking and Dagenham Health and Wellbeing Board has identified the following as Other Relevant Services:

- Good provision of advanced and enhanced services to meet the need of the local population.

Current access to essential services

7.8 In assessing the provision of essential services against the needs of the population, the Health and Wellbeing Board considered access (distance, travel time and opening hours) as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

7.9 To determine the level of access with the borough to pharmaceutical services, the following criteria were considered:

- The ratio of community pharmacies per 10,000 population
- Distance and travel time to pharmacies
- Opening hours of pharmacies
- Proximity of pharmacies to GP practices

7.10 There are 1.8 community pharmacies per 10,000 residents in Barking and Dagenham. Though this ratio is lower than the national average of 2.2, as indicated by the contractor survey, the pharmacies have capacity to offer more services.

7.11 As demonstrated by the maps in Chapter 7, the entirety of borough's population is within 1 mile (or 20 minutes commute) of a pharmacy. Additionally, all GP practices are within 1 mile of a pharmacy.

7.12 No different needs were identified for vulnerable groups or people who share protected characteristics.

7.13 Considering all this, the residents of the borough are well served in terms of the number and location of pharmacies.

Current access to essential services during normal working hours

7.14 All pharmacies are open for at least 40 hours each week. There are 38 community pharmacies in the borough, providing good access as determined in the previous section.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of essential services during normal working hours.

Current access to essential services outside normal working hours

7.15 On weekdays, seven pharmacies are open before 9am and six are open after 7pm. These are mapped out on Chapter 7 and show good coverage of services available on weekdays outside normal working hours.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of essential services outside normal working hours.

7.16 36 of the borough's 38 community pharmacies are open on Saturday. Six pharmacies in the borough are open on Sunday. Considering these pharmacies and those in neighbouring local authorities, as shown in the maps in Chapter 7, there is good accessibility of pharmacies to residents on weekends.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of essential services on Saturdays or Sundays.

Current access to advanced services

7.17 The following advanced services are currently available for provision by community pharmacies: new medicine service, community pharmacy seasonal influenza vaccination, community pharmacist consultation service, Community pharmacy blood pressure service, community pharmacy hepatitis C antibody testing service, COVID-19 lateral flow device distribution service, COVID-19 medicines delivery service, appliance use reviews and stoma appliance customisation.

7.18 NMS is widely available with 33 pharmacies in the borough providing it.

7.19 Flu vaccinations are provided by 31 pharmacies in the borough, they are also offered by GPs. There is good provision of this service, however there are opportunities for local commissioners and community pharmacies to promote this service to improve vaccination uptake.

7.20 37 of the borough's 38 community pharmacies offer the Community Pharmacy Consultation Service.

7.21 Community pharmacy blood pressure service, hepatitis C antibody testing service, COVID-19 lateral flow device distribution and COVID-19 medicines. This service is closing in March 2022 as it is no longer required.

7.22 Though there are pharmacies in the borough and its surrounding that dispense appliances, none provided reviews of their usage in the last recorded year (AURs). The LPC has assured the Health and Wellbeing Board that should the need arise, there would be pharmacies willing to provide the service in Barking and Dagenham.

7.23 Stoma Appliance Customisation service is offered by two pharmacies.

7.24 It is therefore concluded that there is sufficient provision of advanced services to meet the needs of the residents of Barking and Dagenham.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of advanced services.

Current access to enhanced pharmacy services

7.25 There are currently three enhanced services commissioned by the London region of NHSE&I. These are the London Seasonal Influenza Vaccination Service, the Bank Holiday Rota Service (provided by one pharmacy) and the COVID-19 Vaccination Service (delivered by eight pharmacies). These are commissioned as and when required.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of advanced services.

Current access to Other NHS services

7.26 Other NHS services are services commissioned by the London Borough of Barking and Dagenham, or the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group. Pharmacies are commissioned to deliver these services to fulfil the specific health and wellbeing of the Barking and Dagenham population. Other NHS Services include: needle exchange, supervised consumption, stop smoking services, emergency hormonal contraception, community anticoagulation service and end of life care medication provision.

7.27 Twelve pharmacies offer the needle exchange service, 36 offer supervised consumption, 33 provide stop smoking services, emergency hormonal contraception is available from 33 pharmacies while two offer anticoagulation services.

7.28 Three pharmacies offer End of Life Care medicines, and one offers both the medications and out-of-hours provision.

7.29 Overall, there is very good availability of the enhanced services in the borough.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no current gaps in the provision of Other NHS Services.

Future Provision

7.30 The Health and Wellbeing Board has considered the following future developments:

- Forecasted population growth
- Housing Development information
- Regeneration projects
- Changes in the provision of health and social care services
- Other changes to the demand for services

Future access to essential services

Future access to essential services during normal working hours

7.31 The Health and Wellbeing Board is not aware of any firm plans for changes in the provision of Health and Social Care services within the lifetime of this PNA.

7.32 A new health and wellbeing hub is under development as part of the urban regeneration within Barking Riverside. It is not expected to be completed during the lifetime of this PNA but will serve the expected future growth in population and should be considered in the next PNA.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of essential services during normal working hours.

Future access to essential services outside normal working hours

7.33 The Health and Wellbeing Board is not aware of any notifications to change the supplementary opening hours for pharmacies at the time of publication.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of essential services outside of normal working hours.

Future access to advanced services

7.34 Through the contractor survey local pharmacies have indicated that they have capacity for future increases in demand for advanced services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of advanced services.

Future access to enhanced services

7.35 Through the contractor survey local pharmacies have indicated that they have capacity and future increases in demand for enhanced services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of enhanced services.

Future access to other NHS services

7.36 Through the contractor survey local pharmacies have indicated that they have capacity and future increases in demand for other NHS services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no gaps in the future provision of other NHS services.

Improvements and better access

Current and future access to essential services

7.37 In consideration of population health and wellbeing needs and needs of those who share protected characteristics the PNA did not identify any services, that if provided either now or in future specified circumstances, would secure improvements or better access to essential services. Further, there is sufficient capacity to meet any increased future demand.

The Health and Wellbeing Board identified no gaps in essential services that if provided, either now or in the future, would secure improvements or better access to essential services.

Current and future access to advanced services

7.38 NMS, CPCS and flu vaccination services are all widely available throughout the borough

7.39 There is no data available publicly for the relatively new services namely community pharmacy blood pressure service and hepatitis C antibody testing service but there is sufficient capacity for pharmacies to provide these.

7.40 There is good availability of SAC provision and SACs and AURs is also offered by hospital and other health providers.

The Health and Wellbeing Board did not identify any gaps in the provision of advanced services at present or in the future, that would secure improvements or better access to advanced services.

Current and future access to enhanced services

7.41 These are commissioned as and when required. The PNA did not identify any services, that if provided either now or in future would secure improvements or better access to the enhanced services offered. Through the contractor survey local pharmacies have indicated that they have capacity for future increases in demand for enhanced services.

Based on the information available at the time of developing this PNA, the Health and Wellbeing Board identified no services that if provided would secure improvements or better access to enhanced services.

Current and future access to other NHS services

7.42 There is good provision of services commissioned by the London Borough of Barking and Dagenham, or the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group. The PNA did not find any evidence to conclude that these services should be expanded.

The Health and Wellbeing Board identified no gaps, either now or in the future, that if provided would secure improvements or better access to other NHS services in the area.

Appendix A - Steering group membership and terms of reference

BARKING AND DAGENHAM, HAVERING AND REDBRIDGE PHARMACEUTICAL NEEDS ASSESSMENT

STEERING GROUP

Terms of reference

1. Background

The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only), who wishes to provide NHS Pharmaceutical services, must apply to be on the Pharmaceutical List.

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) and subsequent amendments set out the system for market entry. Under the Regulations, Health and Wellbeing Boards are responsible for publishing a Pharmaceutical Needs Assessment (PNA); and NHS England is responsible for considering applications.

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The PNA is used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or to provide additional services. In addition, it will provide an evidence base for future local commissioning intentions.

The Barking and Dagenham, Havering and Redbridge Health and Wellbeing Boards have now initiated the process to refresh the PNAs by 1st April 2021.

2. Role

The primary role of the group is to advise and develop structures and processes to support the preparation of a comprehensive, well researched, well considered and robust PNA, building on expertise from across the local healthcare community; and managed by Healthy Dialogues Ltd.

In addition, the group is responsible for:

- Responding to formal PNA consultations from neighbouring HWBs on behalf of the Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards.
- Establishing arrangements to ensure the appropriate maintenance of the PNA, following publication, in accordance with the Regulations.

3. Objectives

- Ensure the new PNA meets the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and its amendments.
- Develop the PNA so that it documents all locally commissioned services, including public health services commissioned; and services commissioned by the CCG/ICS and other NHS organisations as applicable; and provides the evidence base for future local commissioning.
- Agree a project plan and ensure representation of the full range of stakeholders.
- Ensure a stakeholder and communications plan is developed to inform pre-consultation engagement and to ensure that the formal consultation meets the requirements of the Regulations.
- Ensure that the PNA, although it is a separate document, integrates, and aligns with, with both the joint strategic needs assessment and the health and wellbeing strategies of each of the boroughs as well as other key regional and national strategies.
- Ensure that the requirements for the development and content of PNAs are followed, and that the appropriate assessments are undertaken, in accordance with the Regulations. This includes documenting current and future needs for, or improvements and better access to, pharmaceutical services as will be required by the Barking and Dagenham, Havering and Redbridge populations.
- Approve the framework for the PNA document, including determining the maps which will be included.
- Ensure that the PNA contains sufficient information to inform commissioning of enhanced services, by NHS England; and commissioning of locally commissioned services by the CCG and other local health and social care organisations.
- Ensure a robust, and timely consultation is undertaken in accordance with the Regulations; including formally considering and acting upon consultation responses and overseeing the development of the consultation report for inclusion in the final PNA.
- Consider and document the processes by which the HWB will discharge its responsibilities for maintaining the PNA.
- Comment, on behalf of the Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards, on formal PNA consultations undertaken by neighbouring HWBs

- Advise the HWB, if required, when consulted by NHS England in relation to consolidated applications.
- Document and manage potential and actual conflicts of interest.

4. Accountability and reporting

The Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards have delegated responsibility for the development and maintenance of the PNA; and for formally responding to consultations from neighbouring HWBs to the PNA Steering Group

The PNA steering group will be accountable to the Barking and Dagenham, Havering and Redbridge Health and Wellbeing boards and will report on progress on a two-monthly frequency or as required by the Health and Wellbeing Board.

The pre-consultation draft and the final draft PNAs will be presented to the Health and Wellbeing Board for approval.

5. Membership

Membership of the group shall be:

Name	**Organisation**
Chair: Ian Diley	**Redbridge Council**
Janaka Perera	NEL LPC
Wassim Fattahi-Negro	LB Barking & Dagenham
Anthony Wakhisi	LB Havering
Leaman Jane	LB Barking & Dagenham
Ashlee Mulimba	Healthy Dialogues
Beattie Sturrock	Redbridge Council
Camille Barker	Redbridge Council
Emily Plane	BHR CCG
Manisha Modhvadia	Healthwatch Barking and Dagenham
Ian Buckmaster	Healthwatch Havering
Cathy Turland	Healthwatch Redbridge

An agreed deputy may be used where the named member of the group is unable to attend.

Other staff members / stakeholders may be invited to attend meetings for the purpose of providing advice and/or clarification to the group.

6. Quorum

A meeting of the group shall be regarded as quorate where there is one representative from each of the following organisations / professions:

- Chair (or nominated deputy)
- Barking and Dagenham HWB
- Havering HWB
- Redbridge HWB
- LPC
- Healthy Dialogues

7. Declaration of Interests

It is important that potential, and actual, conflicts of interest are managed:

- Declaration of interests will be a standing item on each PNA Steering Group agenda.
- A register of interests will be maintained and will be kept under review by the HWB.
- Where a member has a potential or actual conflict of interest for any given agenda item, they will be entitled to participate in the discussion but will not be permitted to be involved in final decision making.

8. Frequency of meetings

The group will meet monthly for the lifetime of this project. Meetings may be held, or decisions taken, virtually, where appropriate.

Appendix B – Pharmacy provision within Barking and Dagenham and within 1 mile of border

Borough	ODS Code	Pharmacy	Contract Type	Address	Post Code	Early Opening	Late Closing	Open on Saturday	Open on Sunday
Barking & Dagenham	FYG11	Alvin Rose Chemist	Community	606 Longbridge Road, Dagenham, Essex	RM8 2AJ	No	No	Yes	No
	FH672	Andrew Bass Pharmacy	Community	1148 Green Lane, Becontree Heath, Dagenham	RM8 1BP	No	No	Yes	No
	FGR47	Asda Pharmacy	Community	Asda Superstore, Merrielands Crescent, Dagenham	RM9 6SJ	Yes	Yes	Yes	Yes
	FE360	Boots UK Limited	Community	17 The Mall, Heathway, Dagenham	RM10 8RE	Yes	No	Yes	No
	FV010	Boots UK Limited	Community	68 East Street, Barking, Essex	IG11 8EQ	No	No	Yes	Yes
	FQV74	Maplestead Pharmacy	Community	454 Lodge Avenue, Dagenham	RM9 4QS	No	No	Yes	No
	FKA24	Britannia Pharmacy	Community	167- 169 High Road, Chadwell Heath, Romford	RM6 6NL	No	No	Yes	No
	FL779	Britannia Pharmacy	Community	Barking Community Hosp, Upney Lane, Barking	IG11 9LX	No	No	Yes	No
	FPR28	Britannia Pharmacy	Community	The Rivergate Centre, Unit 1 Minter Road, Barking	IG11 0TH	No	No	Yes	No
	FPW40	Britannia Pharmacy	Community	453 Porters Avenue, Dagenham	RM9 4ND	No	No	Yes	No
	FQN03	Britannia Pharmacy	Community	420 Wood Lane, Dagenham	RM10 7FP	No	No	Yes	No
	FTY66	Britannia Pharmacy	Community	19 Faircross Parade, Barking, Essex	IG11 8UW	No	No	Yes	No
	FX308	Britannia Pharmacy	Community	Thames View Health Centre, Bastable Avenue, Barking	IG11 0LG	Yes	No	Yes	No
	FH855	David Lewis Chemist	Community	16 Porters Avenue, Dagenham, Essex	RM8 2AQ	No	Yes	Yes	No
	FKX93	Day Lewis Chemist	Community	149 Broad Street, Dagenham	RM10 9HX	No	No	Yes	No
	FAP61	Day Lewis Pharmacy	Community	2 Royal Parade, Church Street, Dagenham	RM10 9XB	No	No	Yes	No
	FRA86	Day Lewis Pharmacy	Community	7 Beadles Parade, Rainham Road South, Dagenham	RM10 8YL	No	No	No	No
	FVG95	Day Lewis Pharmacy	Community	359 Ripple Road, Barking	IG11 9PN	No	No	No	No
	FMP00	Daynight Pharmacy	Community	17 Station Parade, Barking	IG11 8ED	Yes	Yes	Yes	Yes

Borough	ODS Code	Pharmacy	Contract Type	Address	Post Code	Early Opening	Late Closing	Open on Saturday	Open on Sunday
	FCE87	Fittleworth Medical	DAC	Unit 6A Midas Bus Centre, Wantz Road, Dagenham	RM10 8PS	No	No	Yes	No
	FGH11	Hannigan	Community	240 Bennetts Castle Lane, Beacontree, Dagenham	RM8 3UU	No	No	Yes	No
	FA366	Hedgemans Pharmacy	Community	438 Hedgemans Road, Dagenham	RM9 6BU	No	No	Yes	No
	FE678	Kry-Ba Pharmacy	Community	21 Goresbrook Road, Dagenham, Essex	RM9 6XA	No	No	Yes	No
	FRH15	Lloyds Pharmacy	Community	97-131 High Road, Chadwell Heath, Essex	RM6 6PA	Yes	Yes	Yes	Yes
	FWG54	Lloyds Pharmacy	Community	281 Wood Lane, Dagenham	RM8 3NL	No	No	Yes	No
	FYX52	Lords Dispensing Chemists	Community	35 Station Parade, Barking, Essex	IG11 8EB	No	Yes	Yes	No
	FAR43	Mastaa-Care Pharmacy Ltd	Community	26 Whalebone Lane South, Dagenham, Essex	RM8 1BJ	No	No	Yes	No
	FTH55	Mayors Chemist	Community	214 Ripple Road, Barking, Essex	IG11 7PR	No	No	Yes	No
	FTK70	Nuchem	Community	778 Green Lane, Dagenham, Essex	RM8 1YT	No	No	Yes	No
	FY843	Oxlow Chemist	Community	217 Oxlow Lane, Dagenham, Essex	RM10 7YA	No	No	Yes	No
	FAV09	Sandbern Chemist	Community	703-705 Green Lane, Dagenham, Essex	RM8 1UU	No	No	Yes	No
	FJT17	Super.Care Pharmacy +	Community	198-200 High Road, Chadwell Heath, Romford	RM6 6LU	Yes	Yes	Yes	Yes
	FPE92	Superdrug Chemist	Community	12-13 Station Parade, Barking	IG11 8DN	No	No	Yes	No
	FNA96	Talati Chemist	Community	282 Heathway, Dagenham	RM10 8QS	No	No	Yes	No
	FA207	Tesco Pharmacy	Community	Highbridge Road, Barking	IG11 7BS	Yes	Yes	Yes	Yes
	FNW81	Thomas Pharmacy	Community	19 Ripple Road, Barking, Essex	IG11 7NP	No	No	Yes	No
	FFX94	Valence Pharmacy	Community	453 Becontree Avenue, Dagenham, Essex	RM8 3UL	No	No	Yes	No
	FQF47	Waller Chemist	Community	279 Heathway, Dagenham, Essex	RM9 5AQ	No	No	Yes	No
	FML56	Well Chadwell Heath - Rose Lane	Community	107 Rose Lane, Chadwell Heath, Romford	RM6 5NR	No	No	Yes	No
Greenwich	FTR52	Morrison Pharmacy	Community	2 Twin Tumps Way, Thamesmead, London	SE28 8RD	Yes	Yes	Yes	Yes
	FPG23	Worthcare Ltd	Community	Gallions Reach Health Ctr, Bentham Road, Thamesmead	SE28 8BE	Yes	No	No	No

Borough	ODS Code	Pharmacy	Contract Type	Address	Post Code	Early Opening	Late Closing	Open on Saturday	Open on Sunday
Havering	FVE89	Alliance Pharmacy	Community	21 Clockhouse Lane, Collier Row, Romford	RM5 3PH	No	No	Yes	No
	FR092	Bencrest Chemist	Community	67/69 Park Lane, Hornchurch	RM11 1BH	No	No	Yes	No
	FV092	Boots The Chemist	Community	Unit 7, The Brewery, Waterloo Road, Romford	RM1 1AU	Yes	Yes	Yes	Yes
	FGD64	Boots UK Limited	Community	12 The Liberty, Romford, Essex	RM1 3RL	Yes	No	Yes	Yes
	FFX17	Clockhouse Pharmacy	Community	5 Clockhouse Lane, Collier Row, Romford	RM5 3PH	Yes	Yes	Yes	Yes
	FC513	Day Lewis Pharmacy	Community	113 Rainham Road, Rainham, Essex	RM13 7QX	No	No	Yes	No
	FEP91	Day Lewis Pharmacy	Community	109 Mungo Park Road, Rainham, Essex	RM13 7PP	No	No	No	No
	FQP07	Day Lewis Pharmacy	Community	52 Collier Row Lane, Romford	RM5 3BB	No	No	Yes	No
	FXW05	Day Lewis Pharmacy	Community	6 Station Parade, Broadway Elm Park, Hornchurch	RM12 5AB	No	No	Yes	No
	FMD27	Elm Park Pharmacy	Community	208-212 Elm Park Avenue, Elm Park, Hornchurch	RM12 4SD	Yes	No	Yes	No
	FYN65	Instore Pharmacy	Community	Tesco Superstore, 300 Hornchurch Road, Hornchurch	RM11 1PY	Yes	Yes	Yes	Yes
	FA111	Lloyds Pharmacy	Community	1-15 The Brewery, Waterloo Road, Romford	RM1 1AU	Yes	Yes	Yes	Yes
	FCC42	Lloyds Pharmacy	Community	2 Tadworth Parade, Elm Park, Hornchurch	RM12 5AS	Yes	No	Yes	Yes
	FN391	Lloyds Pharmacy	Community	12 Chase Cross Road, Collier Row, Romford	RM5 3PR	No	No	Yes	No
	FQV93	Maylands Pharmacy	Community	300 Upper Rainham Road, Hornchurch	RM12 4EQ	Yes	Yes	Yes	Yes
	FTV79	Park Lane Pharmacy	Community	Park Lane Pharmacy, 1 Park Lane, Hornchurch	RM11 1BB	No	No	Yes	No
	FRF15	Pharmacare Chemist	Community	164 Hornchurch Road, Hornchurch, Essex	RM11 1QH	No	No	Yes	No
	FKK95	Rowlands Pharmacy	Community	3 Fairview Parade, Mawney Road, Romford	RM7 7HH	No	No	Yes	No
	FN123	Wh Burdess Chemist Ltd	Community	178 Mawney Road, Romford, Essex	RM7 8BU	No	No	Yes	No
Newham	FVH94	Bell Pharmacy	Community	995 Romford Road, Manor Park, London	E12 5JR	No	No	Yes	No
	FE474	Blakeberry Ltd	Community	9 High Street South, East Ham, London	E6 6EN	Yes	No	Yes	No
	FF788	Blakeberry Ltd	Community	96 High Street South, East Ham, London	E6 3RL	Yes	No	Yes	No

Borough	ODS Code	Pharmacy	Contract Type	Address	Post Code	Early Opening	Late Closing	Open on Saturday	Open on Sunday
	FEV46	Boots Uk Limited	Community	82-84 High Street North, East Ham, London	E6 2HT	No	No	Yes	Yes
	FMC69	Boots Uk Limited	Community	Unit 15, Galleons Reach, Beckton	E6 7ER	No	Yes	Yes	Yes
	FNM10	Catto Chemist	Community	388 High Street North, Manor Park, London	E12 6RH	No	Yes	Yes	No
	FWR56	Church Road Pharmacy	Community	30 Church Road, Manor Park	E12 6AQ	No	No	Yes	No
	FL753	Ghir Limited	Community	426-428 Barking Road, East Ham, London	E6 2SA	No	No	Yes	No
	FL521	Kingsway Chemist	Community	214 High Street North, London,	E6 2JA	No	No	Yes	No
	FXQ63	Kingsway Chemists	Community	290 Barking Road, East Ham, London	E6 3BA	Yes	No	Yes	No
	FE374	Muhammads Pharmacy	Community	829 Romford Road, Manor Park	E12 6EA	Yes	Yes	Yes	Yes
	FQX93	Munro Pharmacy	Community	5-7 High Street North, East Ham	E6 1HS	No	No	Yes	Yes
	FRK52	Prime Pharmacy	Community	234 High Street North, Manor Park, London	E12 6SB	No	No	Yes	No
	FHH62	Sai Pharmacy	Community	150-152 High Street North, East Ham,	E6 2HT	No	No	Yes	No
	FQX57	Solanky Mk	Community	324 High Street North, Manor Park, London	E12 6SA	No	Yes	Yes	No
	FQC93	Tesco Instore Pharmacy	Community	1 Armada Way Gallions Rch, Royal Dock Road, Beckton	E6 7FB	Yes	Yes	Yes	Yes
Redbridge	FMC24	Allans Pharmacy	Community	1207 High Road, Chadwell Heath, Romford	RM6 4AL	No	No	Yes	No
	FC396	Britannia Pharmacy	Community	414-416 Green Lane, Seven Kings, Ilford	IG3 9JX	No	Yes	Yes	Yes
	FCX56	Britannia Pharmacy	Community	Loxford Polyclinic, 417 Ilford Lane, Ilford	IG1 2SN	Yes	Yes	Yes	No
	FMN80	Britannia Pharmacy	Community	53 Green Lane, Ilford	IG1 1XG	No	No	Yes	No
	FYT00	Cordeve Ltd Dispensing Chemist	Community	70 Chadwell Heath Lane, Chadwell Heath, Romford	RM6 4NP	No	Yes	Yes	No
	FEL84	DP Pharmacy	Community	84 Albert Road, Ilford	IG1 1HW	No	No	No	No
	FG274	Eden Pharmacy	Community	79-85 Goodmayes Road, Goodmayes, Ilford	IG3 9UB	No	Yes	Yes	No
	FPN09	In-Store Pharmacy	Community	Tesco Stores, 822 High Road, Chadwell Heath	RM6 4HY	Yes	Yes	Yes	Yes
	FN372	Lloyds Pharmacy	Community	2 Brooks Parade, Green Lane, Goodmayes	IG3 9RT	No	No	Yes	Yes

Borough	ODS Code	Pharmacy	Contract Type	Address	Post Code	Early Opening	Late Closing	Open on Saturday	Open on Sunday
	FHR36	Mydirect Pharmacy	DSP	Unit 19, Thompson Close, Ilford	IG1 1TY	No	No	Yes	No
	FNA31	P & S Chemist	Community	111 Ilford Lane, Ilford, Essex	IG1 2RJ	No	No	Yes	No
	FTL36	Pharmaram Chemist	Community	600 High Road, Seven Kings, Ilford	IG3 8BS	No	No	Yes	No
	FQD31	Well-Chem Pharmacy	Community	641 High Road, Seven Kings, Ilford	IG3 8RA	No	No	Yes	No
	FEY00	Woodlands Pharmacy	Community	119 Hampton Road, Ilford, Essex	IG1 1PR	No	No	Yes	No
	FGK94	Zadams Chemist	Community	841 High Road, Goodmayes, Essex	IG3 8TG	Yes	No	Yes	No

Appendix C: Consultation report

The table below presents a summary of the comments received during the statutory 60-day consultation period and the response from the steering group.

Summary of comments	Steering group response
The term 'Adequate' is subjective	The PNA has revisited this term and considers the access to pharmacy as 'good' in both inside and outside normal working hours. 'Good' is described in paragraph 3.5.
Include information on 'Enhanced' services: - COVID-19 - Bank Holiday - Enhanced Flu	This has been included.
Services listed as enhanced are locally commissioned services and need to be labelled as such.	This has been amended.
Updates to openings/closures of pharmacies, times and names of pharmacies: • FVG95 is showing in the draft PNA as opening on Saturdays when it is closed on Saturdays since 2020. • There is a discrepancy in one entry, FQV74 Elimwells Ltd t/a Maplestead Pharmacy is showing as being owned by Boots (UK) Ltd, (FX839).	These amendments have been made to reflect updates to pharmacy details.
Be clear that we have assessed Improvements or Better Access and included protected characteristics.	This has been included in 'Improvements or better access statement' in chapter 7.
Some of the COVID-19 services are stopping at the end of March 2022 and should therefore be noted as such on the PNA.	Text has been amended to reflect this.
Urban regeneration: Be clear on what we took into account, i.e. housing, population projections and pharmacy can support capacity.	This has been included in Chapter 6&7.
Hypertension Case finding service – now called – Community Pharmacy blood pressure service	This has been amended.

Summary of comments	Steering group response
Essential services now needs to include DMS.	This is already listed on Pg. 76
The PNA does not mention GPCPS	This is called the Community Pharmacist Consultation Service Which is discussed in chapter 6&7.
There should be improved channels of communication including an accessible resource of pharmacies with opening times included – available for GPs and patients to see. There should be a map of Supervised consumption and Hepatis C Antibody Testing	These comments have been feedback to the LPC. Pharmacy opening times can be found on https://www.nhs.uk/service-search/pharmacy/find-a-pharmacy A map of supervised consumption is shown within the PNA. Data on Hepatis C Antibody Testing is not yet available for mapping.
As GPs and the NHS are so keen to push patients towards pharmacy services, the services need to be more accessible, including outside usual shop opening hours. This is also true when doctors from 111 send prescriptions direct to pharmacies for collection, particularly out of hours. It is not acceptable to conclude that having pharmacies a bus ride (or two) away is acceptable or realistic for some LBBD residents, particularly when factoring the cost of prescriptions. It requires a person to have funds for transport and medication, if they do not have a vehicle. The consultation is geared towards concluding that the current provision is sufficient, by indicating that the lower than national average pharmacy provision could be countered by extending services by current providers. This fails to take account of the push, from GPs in particular, towards pharmacies and the pressure being passed on. So many report of the difficulties in getting urgent (or any) GP appointments and pharmacists are being pressed to fill the vacuum, which does not appear to be mentioned in the consultation document. If pharmacies are taking an increased role in primary care the availability needs to be enhanced and the current provision is not sufficient, particularly	The provision of pharmacy services outside normal working hours, including Sunday and Bank Holidays were reviewed again by the steering group. The PNA concludes that there is good provision and choice to support the Barking and Dagenham population.

Summary of comments	Steering group response
outside usual shop/pharmacy hours (and Sundays/bank holidays).	
access to end of life drugs and anticipatory medicines out side of normal working hours is often an area of challenge with no access in dagenham unless means to travel to other sites - we feel this is a gap and hours of access need to reflect other 24/7 services that delvier EoL care	This comment has been fed back to the NEL ICS.
NEL LPC will support any current contractors in offering services if a need arises as all contractors are keen to do more and are willing to do so as long as a service is commissioned	No action required
The purpose of the PNA is to: • inform local plans for the commissioning of specific and specialised pharmaceutical services - it highlights where essential, enhanced and advance services can be accessed, nothing around commissioning plans of specific and specialised services such as smoking cessation, Blood pressure checks, Blood testing, vaccinations. • to support the decision-making process for applications for new pharmacies or changes of pharmacy premises undertaken by NHS England - a forecast to future provision has been considered taking into account of population growth, housing development, regeneration projects, and hence demands of the service. Nothing around the process for applying for new pharmacies. From the survey a number of pharmacies would like to offer advanced and enhanced services. Pharmacies are mainly used weekdays and hence only 6 pharmacies open on Sunday is sufficient. I do not agree with the conclusions as there were some services that pharmacies would be happy to provide if they were commissioned to do so. In the conclusion it was stated that services met the needs of the population, it may be helpful if there was clear direction of what pharmacies can do to help	Additional explanation of how we have included consideration of new developments and population growth has been included in chapter 6 & 7. The process for applying for new pharmacies is outside the scope of the PNA. The PNA considered both inside and outside normal working hours. Outside normal working hours include evenings, early mornings, Saturdays and Sundays. There is good provision outside normal working hours as all residents can reach a pharmacy on Sunday by public transport within 20 minutes.

Summary of comments	Steering group response
support on the areas they can support in by highlighting the process to set up these services within the pharmacy.	
Update the text to reflect that data on pharmacy numbers, locations and opening times was up to April 2022	This is updated in chapter 3 and throughout chapter 6.
Include narrative on how Healthy Living Pharmacies support health and behaviours in chapter 4. Highlight that the framework covers the period up to 2024 and not the lifetime of this PNA.	Narrative on Healthy Living Pharmacies has been included in Paragraph 4.40. A note has been added in para 2.15 to highlight the impact of the next framework will be considered by the Health and Wellbeing Board.

Appendix D: List of Pharmacy Necessary and Other Services

Necessary Services

The Health and Wellbeing Board have identified Essential services as necessary to this PNA to meet the need for pharmaceutical services. Essential services are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework. All pharmacy contractors required to deliver and comply with the specifications for all essential services, these include (but not limited to) dispensing medicines and appliances, repeat dispensing, clinical governance, signposting and support for self-care.

In assessing the provision of essential services against the needs of the population, the Health and Wellbeing Board considered access (distance, travel time and opening hours) as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

Other Relevant Services

Other Relevant Services are advanced services and enhanced services commissioned by NHS England to be provided by pharmacies. These are:

Advanced services:

- New medicine service
- community pharmacy seasonal influenza vaccination
- community pharmacist consultation service
- community pharmacy blood pressure service
- community pharmacy hepatitis C antibody testing service
- COVID-19 lateral flow device distribution service
- appliance use reviews and stoma appliance customisation.

Enhanced services:

- London seasonal influenza vaccination service
- Bank holiday rota service
- COVID-19 vaccination service.

Other NHS services

Other Services include the locally commissioned services pharmacies provide which are commissioned by the local authority or CCG. These are listed below.

London Borough of Barking and Dagenham commissioned services:

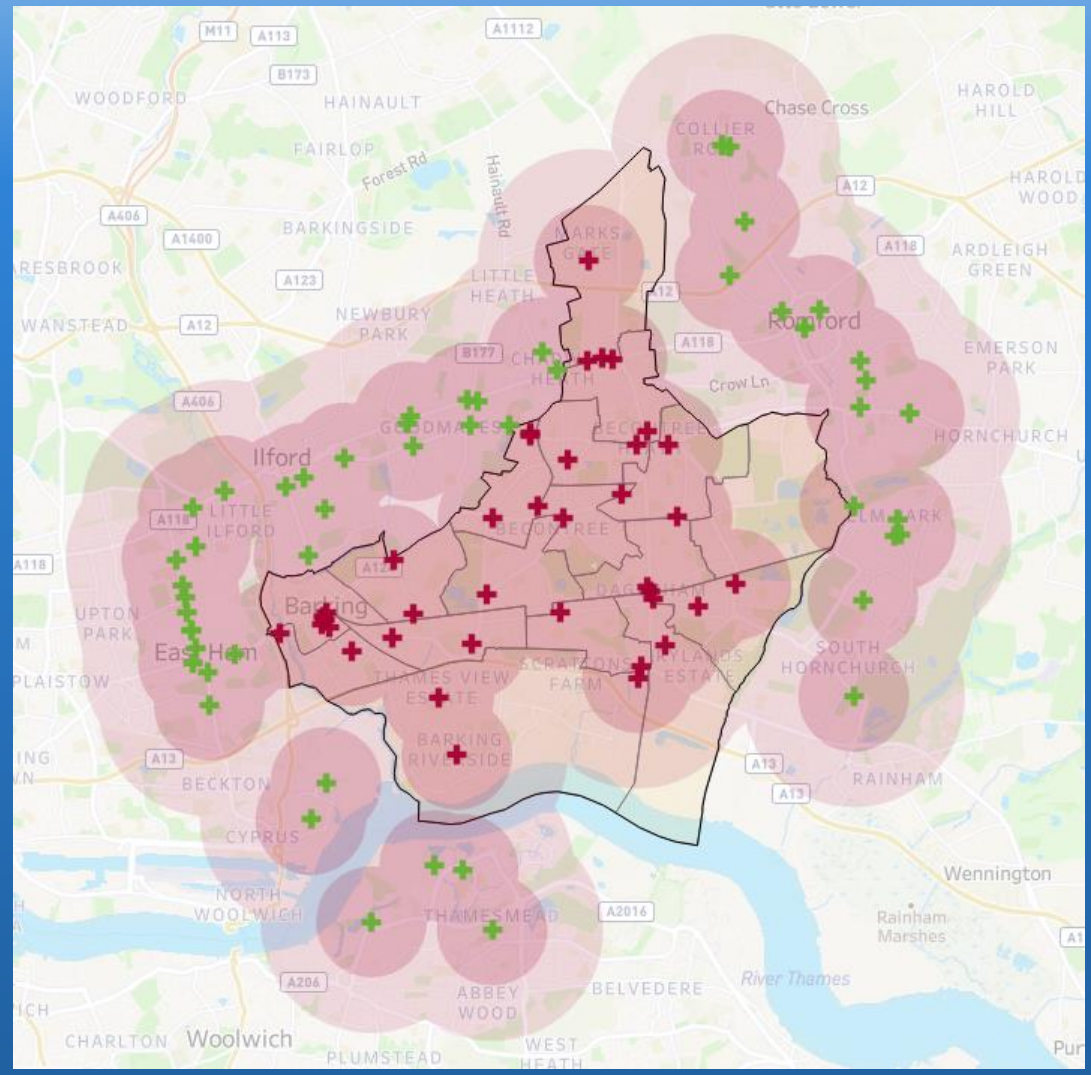
- Needle exchange
- Supervised consumption
- Stop smoking services
- Emergency hormonal contraception

Barking and Dagenham, Havering and Redbridge CCG commissioned services:

- Community anticoagulation service
- End of life care medication provision

The assessment of the provision of Necessary and Other services is presented in Chapter 6 and summarised in Chapter 7 of this PNA.

London Borough of Barking and Dagenham Pharmaceutical Needs Assessment 2022-2025



HWB Board Update
13th September, 2022

Healthy Dialogues LTD

What is the Pharmaceutical Needs Assessment?

Each Health and Wellbeing Board has a statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for their population. This is called the Pharmaceutical Needs Assessment (PNA) (NHS Pharmaceutical Regulations 2013).

The purpose of the PNA is to:

- inform local plans for the commissioning of specific and specialised pharmaceutical services
- to support the decision-making process for applications for new pharmacies or changes of pharmacy premises undertaken by NHS England

The PNA assesses whether the current provision of pharmacies and the commissioned services they provide meet the needs of the LBBD residents and whether there are any gaps between 1st October 2022 to 30th September 2025.

Process

1. Establish governance process
2. Gather health, demographic, planning data
3. Contractor and public survey
4. Pharmacy service provision – NHSE and contractors
5. Analysis and drafting
6. Steering group to review and sign off pre consultation
7. 60 day consultation
8. Final review and drafting of report
9. Sign off by HWBB and publication

Essential Services

Essential services are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework.

- Dispensing Medicines
- Dispensing Appliances
- Repeat Dispensing
- Clinical governance
- Discharge Medicines Service
- Promotion of Healthy Lifestyles
- Signposting
- Support for self-care
- Disposal of Unwanted Medicines

Advanced Services

NHS England commissioned services:

- new medicine service
- community pharmacy seasonal influenza vaccination
- community pharmacist consultation service
- blood pressure monitoring/hypertension case finding
- community pharmacy hepatitis C antibody testing service
- appliance use reviews
- stoma appliance customisation

Enhanced pharmacy services

NHSE London *commissioned* services:

- London seasonal influenza vaccination service
- Bank holiday rota service
- COVID-19 vaccination service

‘Other NHS’ pharmacy services

CCG* & LBBD *commissioned* services

- Needle exchange
- Supervised consumption
- Emergency hormonal contraception
- Community anticoagulation service
- End of life care medication provision

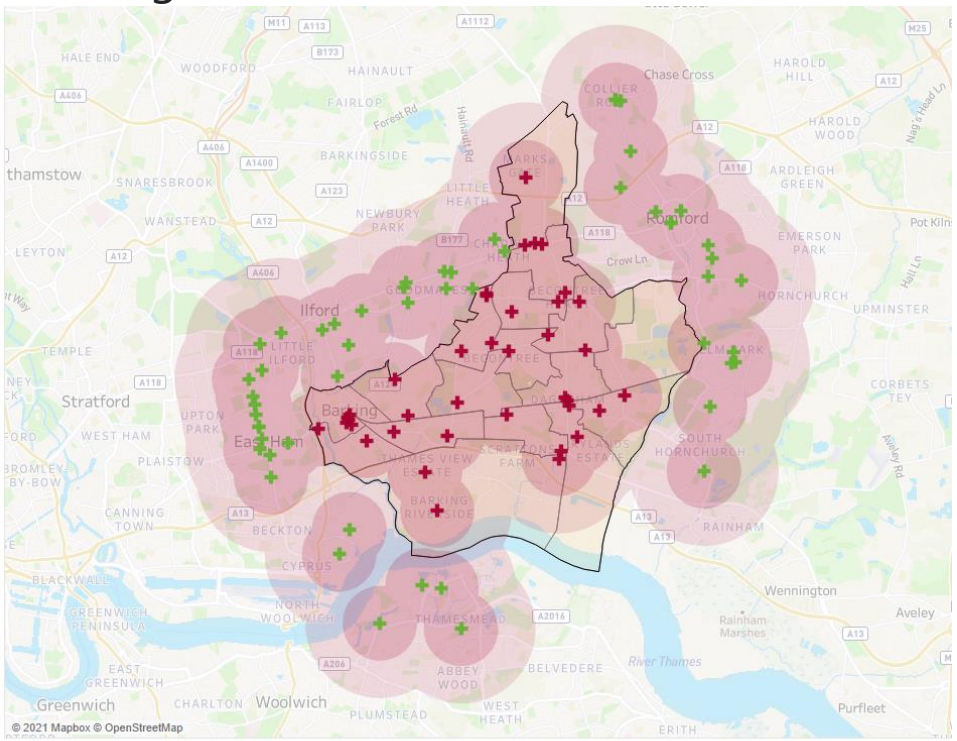
**PNA was completed pre-July 2022.*

Process and content

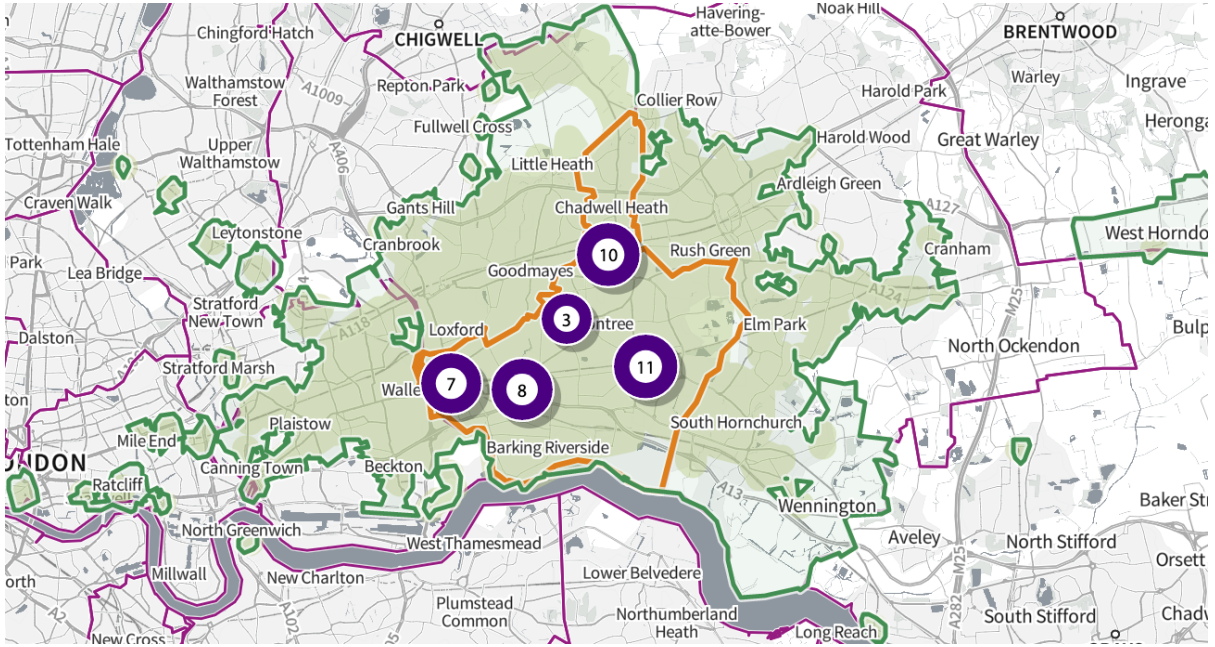
- **Localities** in HWBB area (borough, wards, LSOAs);
- **How assess different needs** of the different localities, and the different needs of those who share a protected characteristic;
- Whether there is **sufficient choice** with regard to obtaining pharmaceutical services (options re identify gaps in provision):
  - geographical gaps in the location of premises
  - geographical gaps in the provision of services
  - gaps in the times at which, or days on which, services are provided

Maps of pharmacy provision

Distribution of community pharmacies in LBBD and within 1-mile of the borough boundaries, with their 0.5 and 1-mile coverage

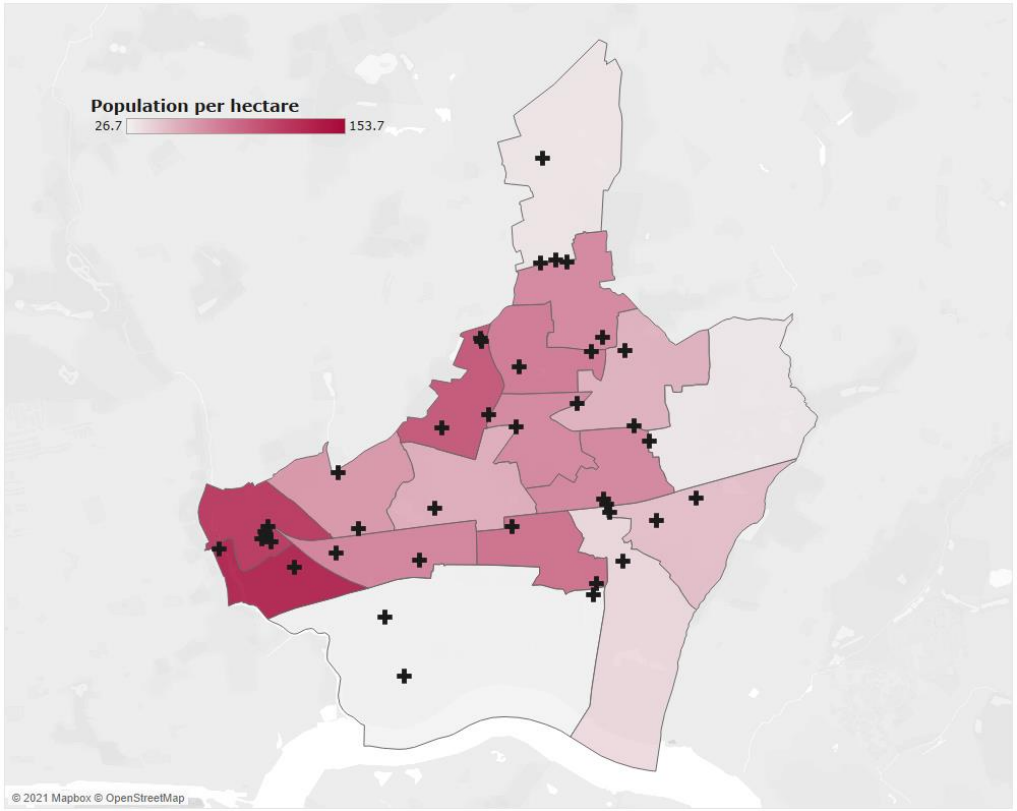


Areas covered by 20-minute travel time by public transport to a LBBD pharmacy from within and outside the borough

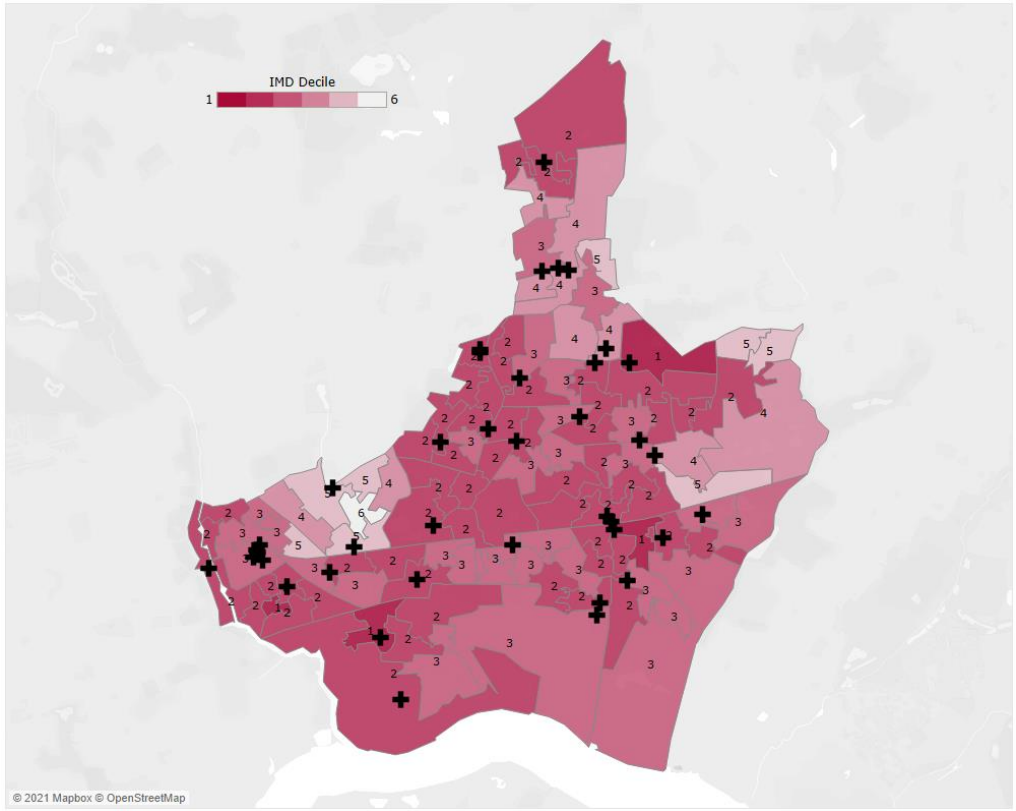


Pharmacies and deprivation and population density

Pharmacy locations in relation to population density by ward in LBBD



Pharmacy locations in relation to deprivation deciles in LBBD, 2022



Conclusions

LBBD is well served in relation to the number and location of pharmacies, with:

-39 community pharmacies

-one dispensing appliance contractor

There are a further seven community pharmacies within a mile of LBBDs border.

There is good access to essential, advanced, enhanced and other NHS pharmaceutical services for the residents of LBBD with no gaps in the current and future provision of these services identified.

Although the primary aim of a PNA is to support Pharmacy's entry into a local area, it can be used in conjunction with JSNA data on deprivation and health inequalities, to identify if Community Pharmacy could fill a service gap that would improve the health and well being of residents and support delivery against the place based partnership's agreed outcomes.

HEALTH AND WELLBEING BOARD

13 September 2022

Title:	**BHR Joint Strategic Needs Assessment 2022 Update**

Report of the Cabinet Member for Social Care and Health Integration

Open Report	**For Information**
Wards Affected: All	**Key Decision**
Report Author: Benhildah Dube, Senior Public Health Analyst Jane Leaman, Consultant in Public Health (interim) Mike Brannan, Consultant in Public Health	**Contact Details:** E-mail: Benhildah.Dube@lbbd.gov.uk E-mail: Jane.Leaman@lbbd.gov.uk

Lead Officer: Matthew Cole, Director of Public Health

Summary:

An update to apprise the board on publication of the refreshed Joint Strategic Needs Assessment (JSNA) 2022 in July 2022.

Barking and Dagenham, Havering and Redbridge collaborate to meet this statutory requirement via the production of three individual needs assessments, each of which mirror the other ones in both format and content whilst offering a localised and detailed view of the health needs in each borough.

The production of the BHR JSNA is further enhanced by an online mapping tool that allows stakeholders to further interrogate and access relevant data. The online tool was updated and is available online at https://bhrjsna.communityinsight.org/map/.

Key findings of the 2022 Barking and Dagenham JSNA are provided as a summary.

The Board will also be apprised regarding development and publication of the 2023 and future JSNAs.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1. note publication of the Joint Strategic Needs Assessment and its key findings and

2. feedback on options for future development of JSNAs

Reason(s)
It is the statutory responsibility for the HWBB to ensure a JSNA is published for its local area and ensure local plans reflect the needs identified within it.

1. Introduction and Background

1.1 The Health and Social Care Act 2012 introduced duties and powers for health and wellbeing boards to produce Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

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

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

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

1.5 In 2019 the Directors of Public Health in Barking and Dagenham, Havering and Redbridge led on the project of delivering a Joint Strategic Needs Assessment for the BHR area. In 2020 each Local Authority delivered a unique JSNA to their area that gave full regards to the other areas and offered a comparative approach This approach delivers a JSNA that is both local to the individual areas and to the BHR area at the same time.

1.6 The published JSNAs incorporated, and were complemented by, an online tool called Local Insight which allowed detailed interrogation of data referred to in the JSNA along with a package of analytical reports that can be downloaded by the public to facilitate both the interrogation and further exploration of useful data, reports, and maps.

2. Proposal and Issues

Publication of JSNA 2022

2.1 The 2022 refresh of the Barking and Dagenham JSNA has been published on our local website.

2.2 The current aim is to publish the combined BHR JSNA 2022 in September, when Havering sign off their version.

2.3 Data from the BHR JSNA has been published on the Local Insight online platform is available online, which is crucial to reach wider audiences including commissioners, commercial entities, professionals and other stakeholders. It includes a larger set of data and gives regards to newer geographies (e.g. primary care networks) compared to previous versions. Link: https://bhrjsna.communityinsight.org/map/

Plans for future JSNAs

2.4 The planning of the delivery of the BHR JSNA 2023 is underway led by the JSNA Steering Group, this includes delivery and maintenance of the online tool for at least a further year. This includes the agreement in principle for each borough to progress its JSNA separately.

2.5 Three options have been considered

- Option #1 (recommended) is to stop the full annual JSNA document, instead undertaking an annual 'deep dive' JSNAs focus on a specific area agreed as a priority by the Place Partnership. The online tool would continue to be updated with data and an annual summary of key outcomes would also be produced.
- Option #2 would be top continue to produce the full ~200 page JSNA for Barking team alone, but this would be a lot of work and is not considered a good use of resources.
- Option #3 would be to negotiate a continuation of the BHR arrangement, but there is limited support or justification for this approach.

2.6 A consultation of key stakeholders is being undertaken to understand current usage of the JSNA, what people would like to see in the JSNA and feedback on the proposed options.

2.7 **For Feedback:** The Board is invited to give feedback on the proposed options.

Issues:

2.8 BHR intelligence teams do not have access to primary care data. This is an impasse that prevents the teams from offering an analysis at a greater granularity in support of service delivery and the overall locality/PCN population health agenda. We will continue to pursue this with NHS NEL colleagues.

3. Consultation

3.1 Where relevant each topic chapter was shared with lead clinicians/transformation boards

4 Mandatory Implications (delete if none)

4.1 Joint Local Health and Wellbeing Strategy

The JSNA will inform the 2023- 2028 Joint Local Health and Wellbeing Strategy

4.4 Financial Implications

None

4.5 Legal Implications

None

Weblinks:

Link to most recent Barking and Dagenham JSNA profile:
https://www.lbbd.gov.uk/joint-strategic-needs-assessment-jsna

Link to most recent BHR JSNA profiles:
https://bhrjsna.communityinsight.org/custom_pages?view_page=43

Link to BHR online Local Insight tool:

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

List of Appendices:

Appendix A – Joint Strategic Needs Assessment 2022 highlights

Appendix B - Joint Strategic Needs Assessment 2022

Barking & Dagenham

Joint Strategic Needs Assessment (JSNA) 2022

Highlights for Barking and Dagenham

one borough; one community; no one left behind

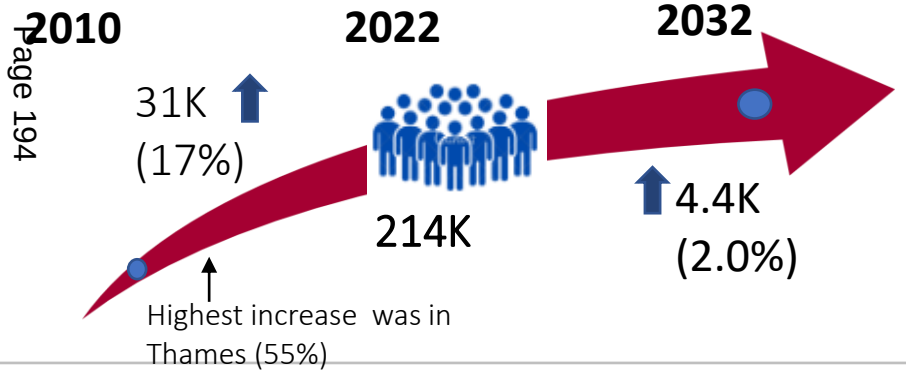
Joint Strategic Needs Assessment 2021/2022; Barking and Dagenham's Population

The JSNA is produced jointly across Barking & Dagenham, Havering and Redbridge to highlight local disparities and priorities for action. ***Focused on four pillars;***

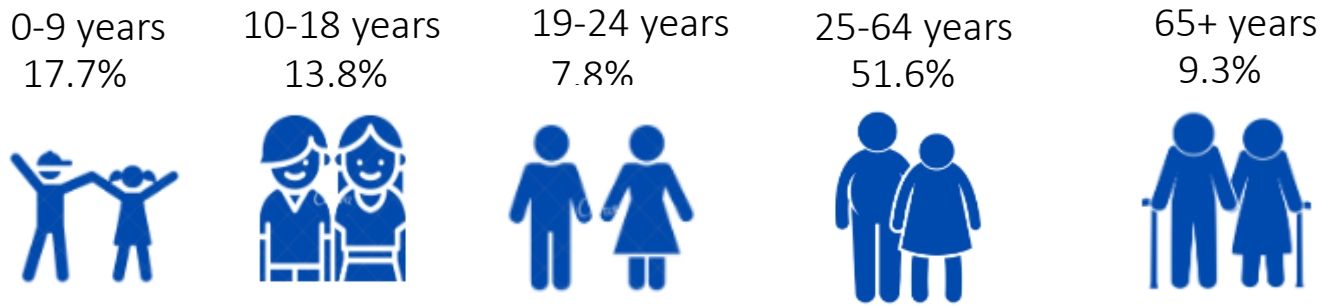
Pillar 1	*Pillar 2*	*Pillar 3*	*Pillar 4*
Wider Determinants of Health	**Health Behaviours & Lifestyles**	**Places & Communities**	**Integrated Health & Social Care**

Population Demographics in Barking and Dagenham

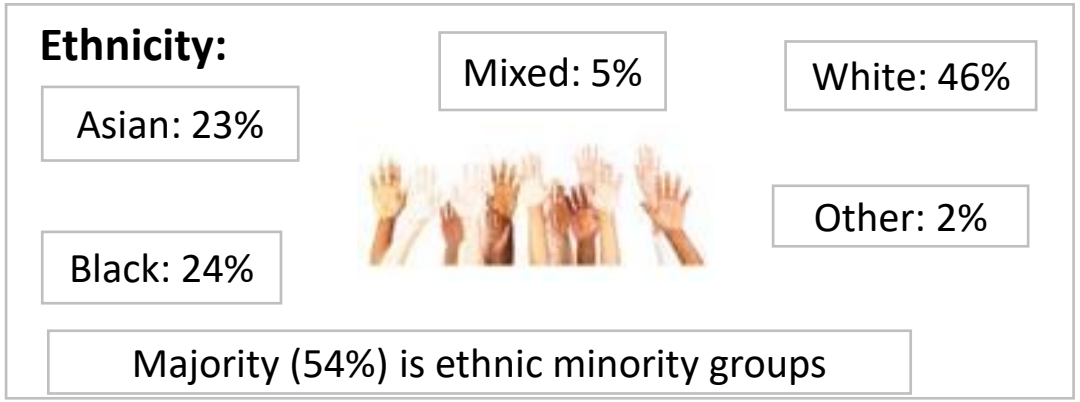
Population:



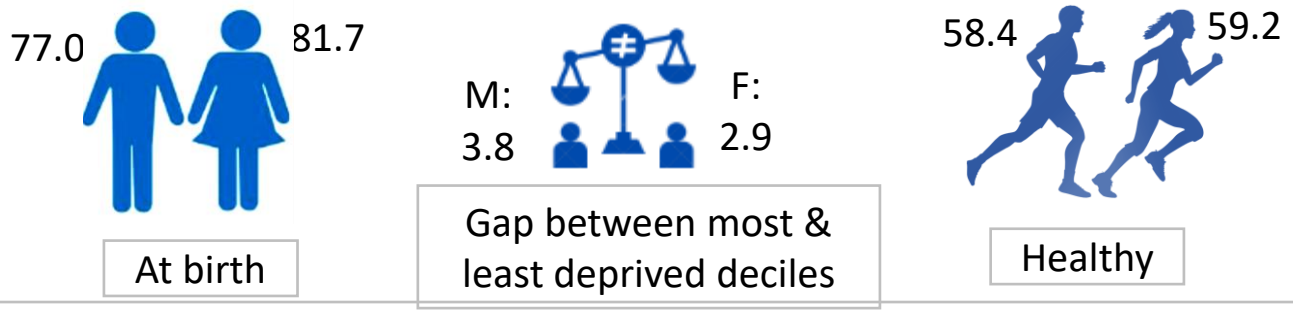
Age:



Ethnicity:



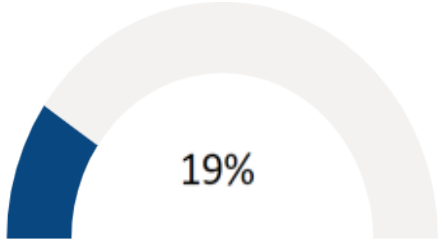
Life Expectancy (in years):



Joint Strategic Needs Assessment 2021/2022; Pillars 1 and 2

Pillar 1; The Wider Determinants of Health

Deprivation:



41K adult residents

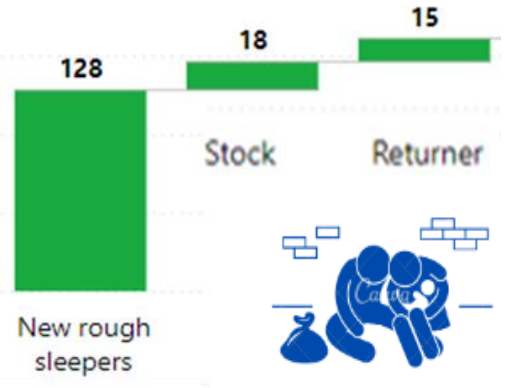
Income deprived

Employment rate:

Adult employment: 62.6%

London rate: 73.8%
England rate: 74,7%

Homelessness:



England average (12.9%)

- 2nd highest of the 32 London boroughs
- Higher than
  - Havering: 11%
  - Redbridge: 12%

- Working age population unemployed
  - Barking & Dagenham: 9.1% (8,600 residents)
  - England average: 5.1%
  - London average: 6.5%

- Rough sleepers in
  - Havering: 159
  - Redbridge: 253
- Rate of family homelessness: 5.4/1000 households (426)
  - England: 1.7/1000

Priority actions: Developing the role of "anchor institutions" and "Health in All Policies", expanding social prescribing and maximizing the benefits of regeneration work.

Joint Strategic Needs Assessment 2021/2022; Pillars 1 and 2

Pillar 2; Our Health Behaviours and Lifestyles

Smoking:

18.1% of adults (27,000 residents) with most disadvantaged at greatest risk of poor health.

Overweight/Obesity (substantial contributor to health inequalities):

by age 5
1 in 10

by age 11
1 in 2

Adults
2 in 3 (66%)

Substance misuse:

5.7% of opiate users
37.1% of adults dependent on alcohol

Successfully completed treatments in 2019

- England average: 13.9%
- Highest in London
- Higher than
  - Havering: 13.2%
  - Redbridge: 13.4%

- By age 5: 2nd highest in London
- By age 11: Highest in London
- Adults: 3rd highest in London
- England average:
  - By age 5: 23%
  - By age 11: 35%
  - Adults 64%

- Opiate users: 14th lowest in London
- Alcohol dependent adults: 16th highest in London
- England averages
  - Opiate users: 4.7%
  - Alcohol dependent adults: 35.3%

Priority actions : Promoting smoking cessation and food and financial support; implement a whole system approach to obesity; improve support for drug and alcohol through tackling wider issues such as mental health and the impacts on families.

Joint Strategic Needs Assessment 2021/2022; Pillars 3 and 4

Pillar 3; Places & Communities

Active travel:

19.8%

Adults walking for travel three or more times per week

- England average: 15.1%
- London average: 22.1%
- Most LSOAs (over 80%) have poor/very poor public transport accessibility.

Climate Change

- poses a substantial public health risk, particularly through increased severity of heatwaves and cold weather.

- Abbey and Gascoigne wards have highest risk in the borough, posed by excess heat, flood and overall climate risk.

Air pollution;

Deaths attributable to air pollution

6.8%

- England average: 5.1%
- London average: 6.4%
- Lower than
  - Havering: 6.0%
  - Redbridge: 6.7%

Priority actions : Develop partnership response to climate change; develop approach to effectively reduce air pollution; develop effective active travel infrastructure.

Joint Strategic Needs Assessment 2021/2022; Pillars 3 and 4

Pillar 4; Integrated Health & Social Care

Children and Young People (CYP);

10.3% with mental health issues

Increases forecasted in the coming years.

- England average: 9.2%
- Higher than
  - Havering: 9%
  - Redbridge: 9%

Long Term Conditions (LTCs):

Individuals with LTCs felt they received the support they needed

49%

- England average: 54.9%
- London average: 52.1%
- Higher than
  - Havering: 46.5%
  - Redbridge: 46.8%

Older People:

Healthy life expectancy at 65 years

Males
8.4 years

Females
8.5 years

Dementia, falls and social isolation contributing to poorer health.

- Shorter than England average
  - Males: 10.6 years
  - Females: 11.1 years
- Statistically similar to
  - Havering: Males: 10.9 years
    Females: 10.8 years
  - Redbridge: Males: 8.4 years
    Females: 12.1 years

Priority actions: strengthen local Child and Adolescent Mental Health Services (CAMHS) services; improve prevention of LTCs as well as support for those with multiple LTCs; improve support for older residents at risk of falls, social isolation and preventable illness.

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

London Borough of Barking and Dagenham

p

v4.1 2021

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Executive Summary

This is a refresh of the BHR JSNA 2020, with where possible there is a reflection on the impact of the Covid-19 pandemic The BHR JSNA 2020 was the 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].

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

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] and through the newly formed **Place Based Partnerships and Integrated Care Board sub committees**[3], recently introduced through the Health and Social Care Act 2022. 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.

[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.

[3] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

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) increases the risk of a range of negative outcomes in later life opens up another approach to prevention. Nationally over half (55%) of people feel their health have been negatively impacted by the rising cost of living.

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[4] 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

[4] 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.

struggling enabling early intervention e.g., to ensure children are ready to learn by school age.

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 Adverse Childhood Experiences (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 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, particularly as a result of the Covid -19 Pandemic. 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 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[5]. Approaches such as local area coordination are needed

[5] 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.

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.

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.

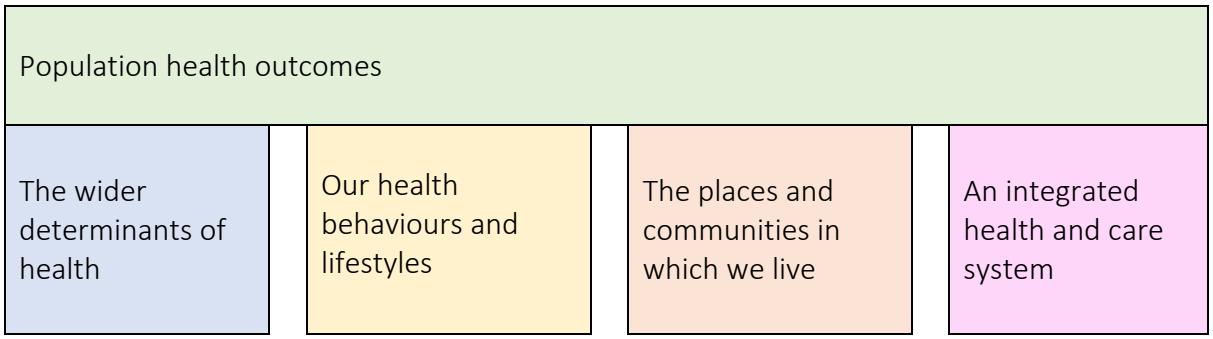
The process followed in developing the profiles is summarised here. They are a first attempt at producing a JSNA in a consistent way across the developing BHR ICS. An interactive, on-line product will be available in the near future.

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

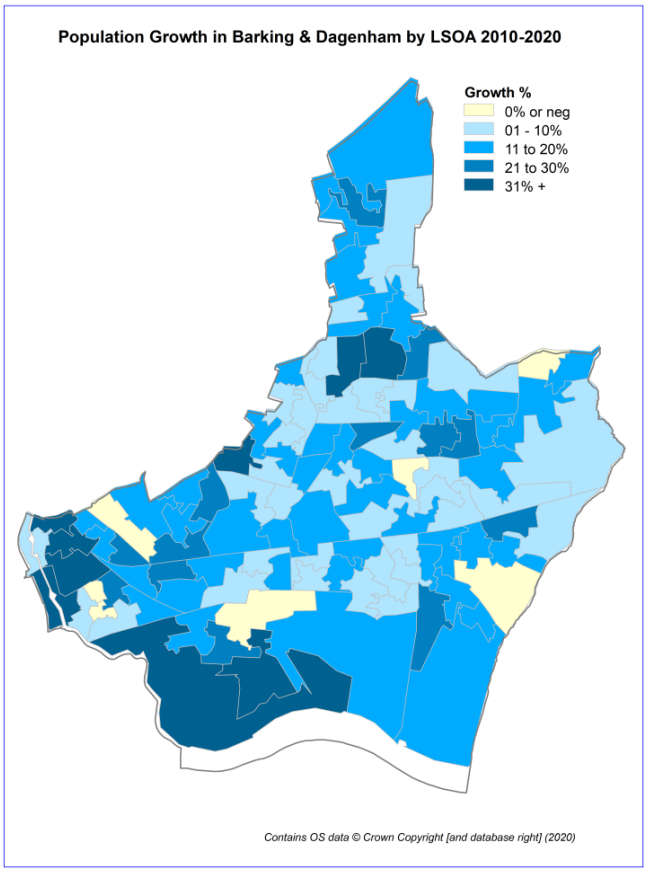
**Indicators and data used in this section can be accessed by clicking here*

2.1 Population Size & Growth

The resident population of Barking and Dagenham in 2020 was estimated to be 214K[6].

The population registered with a Barking and Dagenham GPs in 2021 is 187K[7]. The Barking and Dagenham GP registered population is 22% of the total patients registered with a GP in the 3 BHR boroughs.

Figure 1: Population Growth in Barking and Dagenham by LSOA 2010-2020



Source: ONS mid-year population estimates.

The population resident in Barking and Dagenham is estimated to have increased by 31K (17%) in the ten years from 2010.

Over the same period, population growth varied at ward level from 55% in Thames to 5% in Gascoigne (Figure 1).

Further significant population growth is likely within Barking and Dagenham, the population is projected to grow by another 4.4K (2.0%) from 217K in 2022 to 222K in the ten years to 2032.

[6] Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

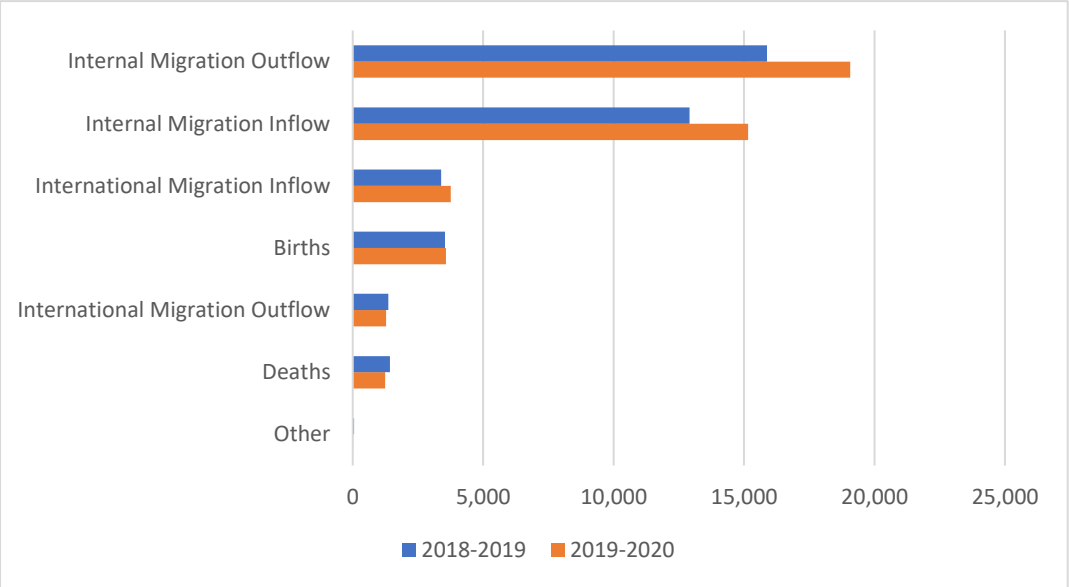
[7] B&D GP registrations derived from the UK Health Security Agency, Covid-19 Situational Awareness Explorer Portal. Vaccine Data - Power BI

Local and national impacts of COVID-19 pandemic on population changes

Rate of population change in Barking and Dagenham before the COVID-19 pandemic (2019-2020) is similar to population changes during the pandemic (2020-2021) (Figure 2). It has been noted that nationally internal and cross-border migration may have reduced in 2020 for reasons such as difficulties in travelling to different areas, changing personal circumstances, reduced job opportunities and an increase in people working from home[8]. However, local data does not indicate any significant changes.

Since March 2020, there have been significant national changes in international migration and mobility as well as a fall in the number of visa application issued for work and study to non-EU nationals[9]. This may explain the reduction in the rates of international migration into and out of Havering between 2019-2020 and 2020-2021.

Figure 2. Population Churn Estimates for 2018-19 and 2019-20



Data Source: ONS Mid-Year Population Estimates: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

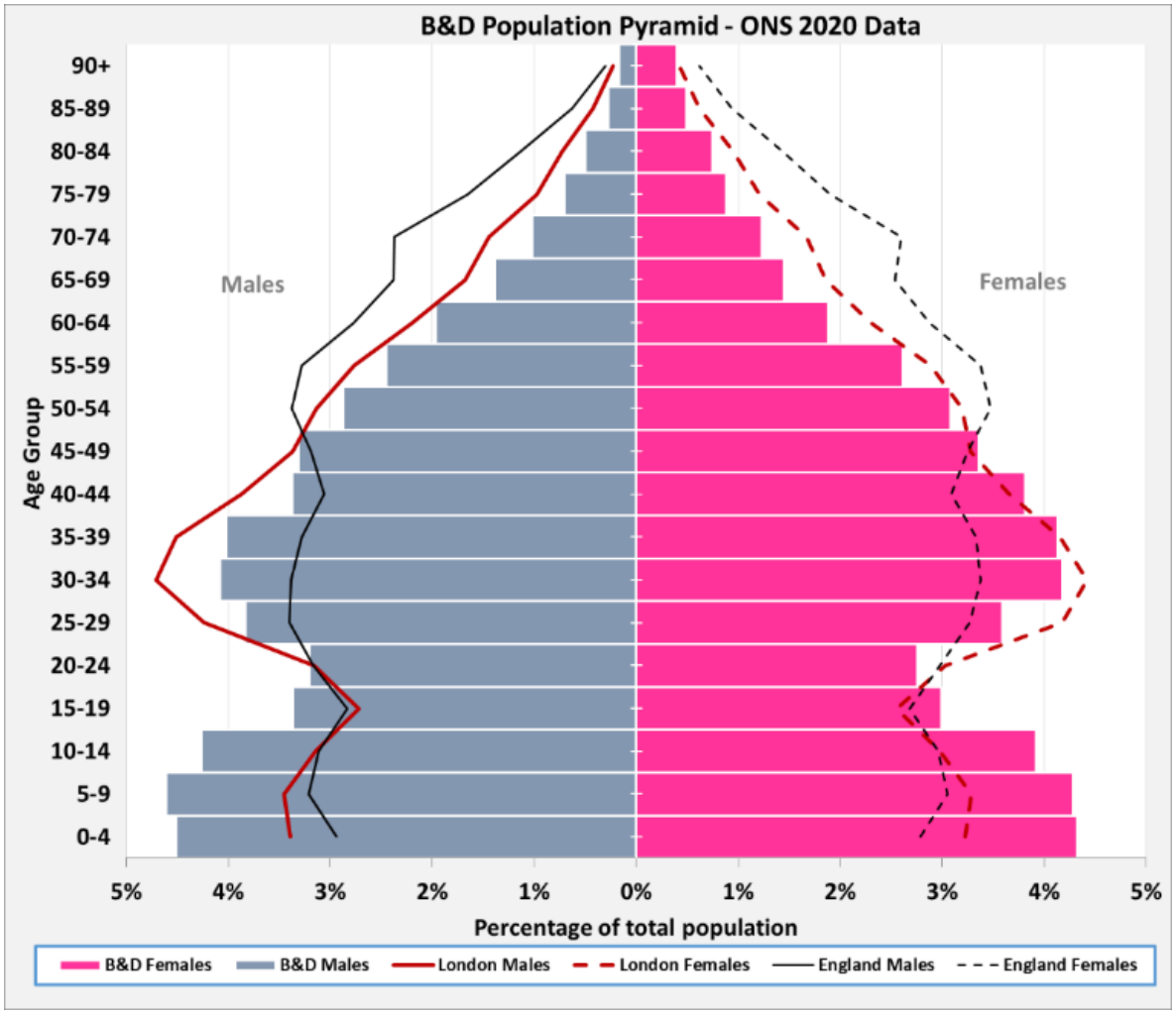
[8] Office of National Statistics 2021. What could impact the impact of COVID-19 be on UK demography? Available at: https://blog.ons.gov.uk/2020/12/07/what-could-the-impact-of-covid-19-be-on-uk-demography/

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

2.2 Age Structure

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

Figure 3. Barking and Dagenham Population Estimates 2020



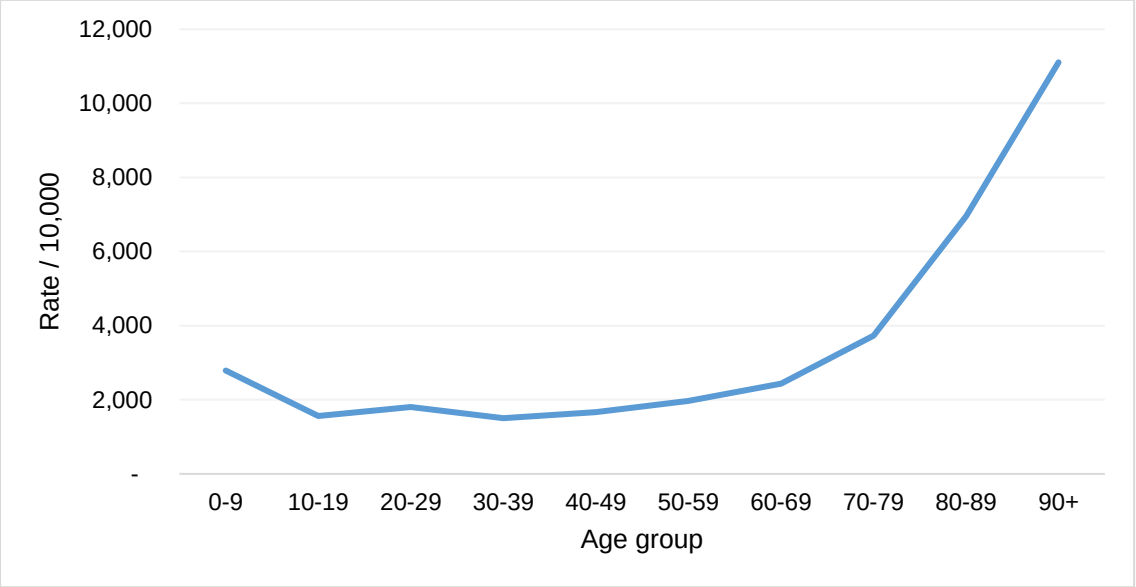
The population of Barking and Dagenham is a relatively young population compared to the aggregate population of London. Residents aged 9 and under make up 13.4% of all London residents, but 17.7% of Barking and Dagenham residents. Age groups containing residents aged 20 and over make up a smaller percentage of the Barking and Dagenham population than the London population, but the underrepresentation is modest. Underrepresentation peaks in adults aged 25-29, who make up 8.4% of the London population but 7.4% of the Barking and Dagenham population who are therefore underrepresented by 1.0%. Underrepresentation in the adult population of Barking and Dagenham reduces as age increases, reducing to 0.1% in the population aged 90 and above.

As well as growing, the age profile of Barking and Dagenham population is also projected to change with proportionally greater growth amongst older age groups. All age groups

containing residents aged 40 and older are projected to increase in absolute terms and as a percentage of the Barking and Dagenham population by the year 2030. The population of residents aged 60 and over is expected to increase by over 5.3K by the year 2030. Conversely, younger age groups are expected to contract in absolute and percentage terms over the same period, indicating an aging population projection.

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 (Figure 4). For example, people aged 80-89 are 4 times more likely to attend A&E than adults aged 40-49 years. Utilisation of health and social care services is likely to be proportionally higher in Havering due to its relatively old population (see **Chapter 7.6 Older People & Frailty**).

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



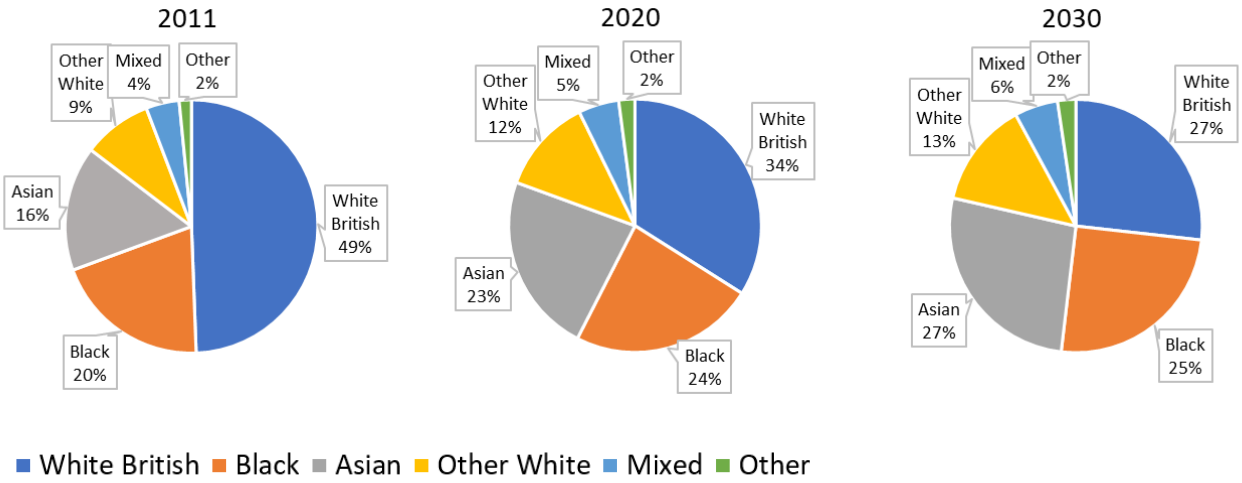
Source: NHS Digital

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 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.[10]

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

Figure 5. Barking and Dagenham change in ethnic populations, 2011-2030



Data Source: GLA 2016-based Demographic Projections, 2017

Barking and Dagenham has become more ethnically diversity in the years from 2011 to 2020. The borough's BAME population made up 41.8% of the total population in 2011, in 2020 it has risen to 53.9%.

Projections of the population in Barking and Dagenham in 2030 estimate the borough is set to become more diverse. By 2030, BAME residents are projected to make up 59.7% of the borough's population.

Barking and Dagenham is a more diverse borough than Havering but has a smaller percentage of its population made up of BAME residents than Redbridge.

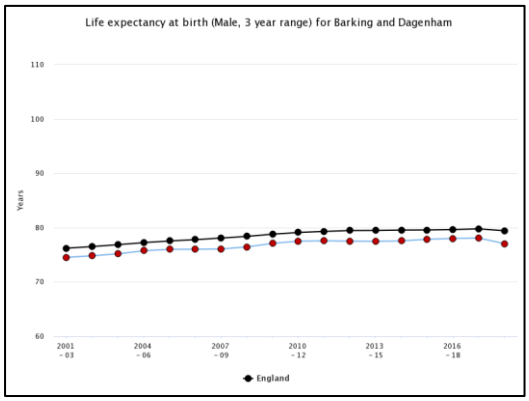
3. Population Health Outcomes

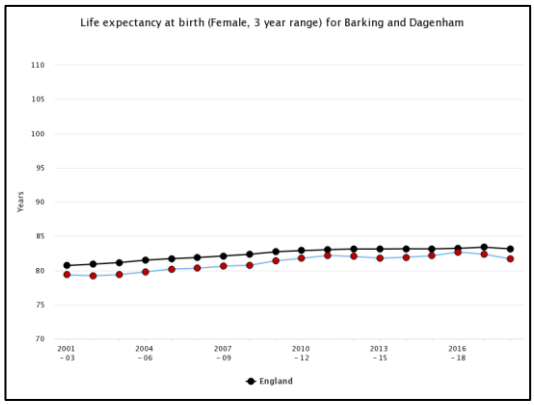
**Indicators and data used in this section can be accessed by clicking here.*

As is the case nationally, life expectancy at birth in Barking and Dagenham has increased steadily over recent decades but the rate of improvement has slowed markedly since 2000.

The most recent data available at borough level, for the period 2018-2020, shows that life expectancy in Barking and Dagenham reduced for both men (by 1.1 years to 77.0 years) and women (by 0.6 years to 81.7 years) and remains significantly worse than the national averages, which also experienced a downturn.

Figure 6 & 7: Female & Male Life Expectancy at Birth Barking and Dagenham 2018 -2020





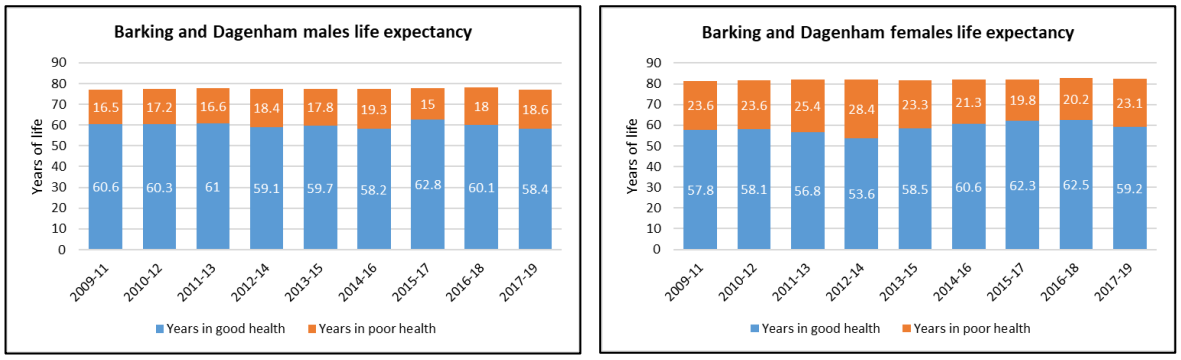
Source: PHE Fingertips

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

The pandemic is also likely to leave a legacy of persistent ill-health and disability. A summary of our early understanding of Long COVID is provided as section 7.5 and the implications for mental health in section 7.3.

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

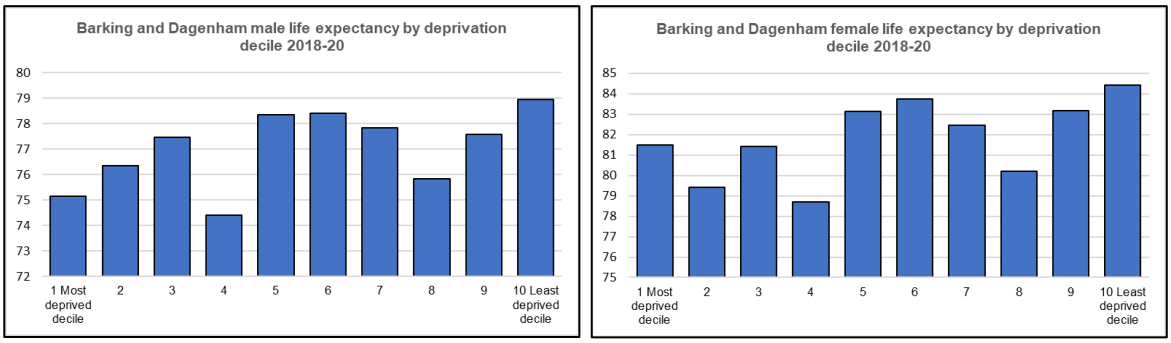
Figures 8 & 9: Barking and Dagenham Life expectancy 2009-11 to 2017-19



Source: Public Health England

Residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (3.8 years for males and 2.9 years for females) than peers in the least deprived decile (Figures 10 & 11).

Figures 10 & 11. Barking and Dagenham Life expectancy by Deprivation Decile, 2018-20



Source: Public Health England

As well as lower life expectancy, national evidence shows people living in disadvantage have proportionally less healthy life expectancy than less disadvantaged peers.[11]

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

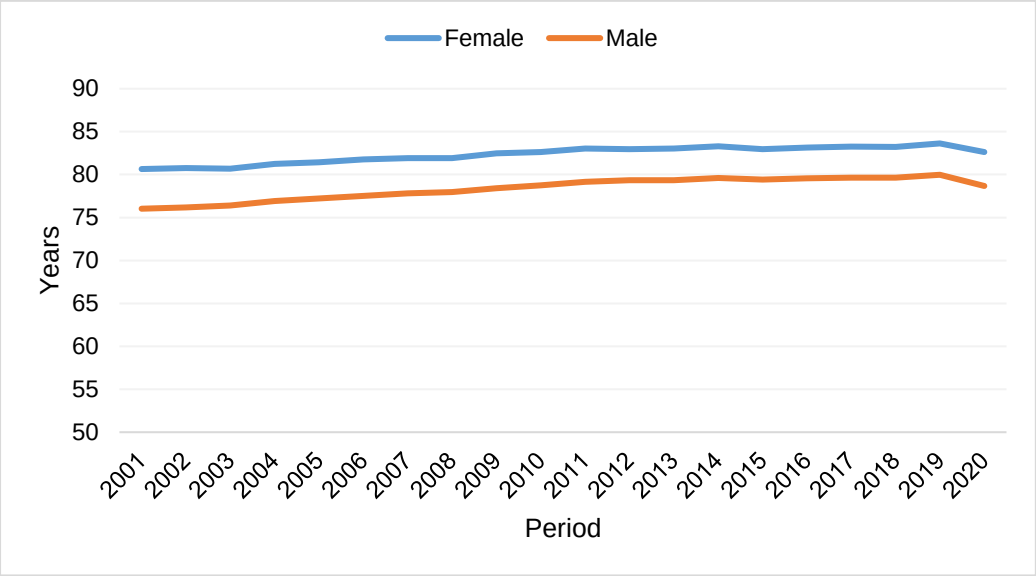
National impacts

The COVID-19 pandemic has had both direct and indirect impacts on life expectancy. Direct impacts being deaths from COVID-19 and indirect impacts including higher rates of otherwise avoidable deaths due to late presentation and/or impaired access to healthcare. The very high level of excess deaths due to the pandemic caused life expectancy in England to fall in 2020, by 1.3 years for males and 0.9 years for females [12] (Figure 12). This was the lowest life

[11] Life expectancy and healthy life expectancy at birth by deprivation - The Health Foundation
[12] Public Health England, Health Profile for England 2021. Found at: https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html#summary-5---life-expectancy (accessed 11 November 2021)

expectancy since 2011 for males and females. Regional data show that London experienced a still larger fall in life expectancy between 2019 and 2020 for both males (2.5 years) and females (1.6 years).

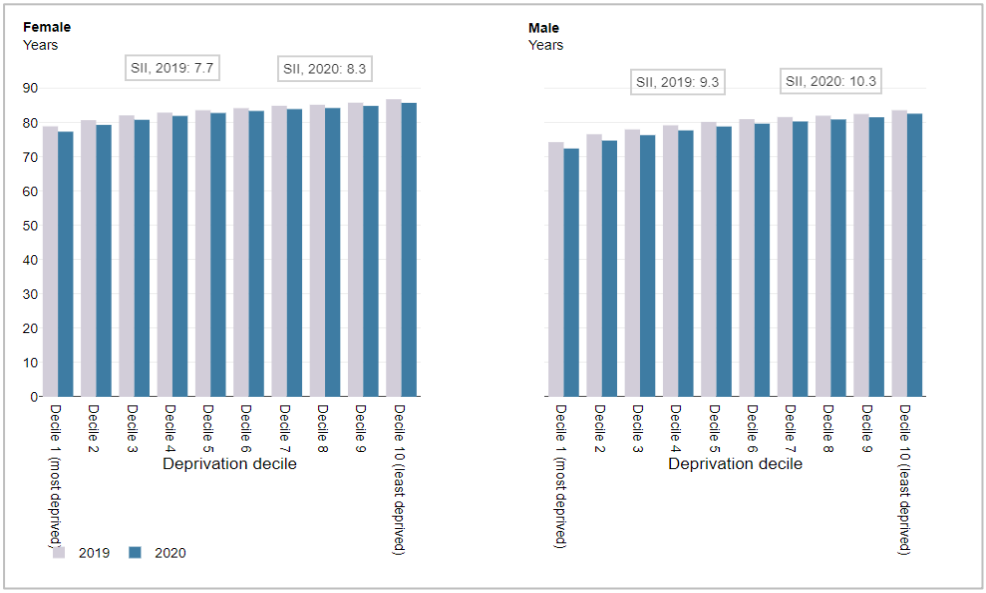
Figure 12. Life expectancy at birth, by sex, England 1981 to 2020



Source: Office for National Statistics

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

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



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

Similarly, the pandemic has replicated pre-existing inequalities between different ethnic groups. After adjusting for a number of different confounders, men of Black ethnic background

were 2.0 times more likely to die with COVID-19 than White males and females 1.4 times more likely. Males of Bangladeshi, Pakistani and Indian ethnic background also had a significantly higher risk of death (1.5 and 1.6 times respectively) than White males.[13]

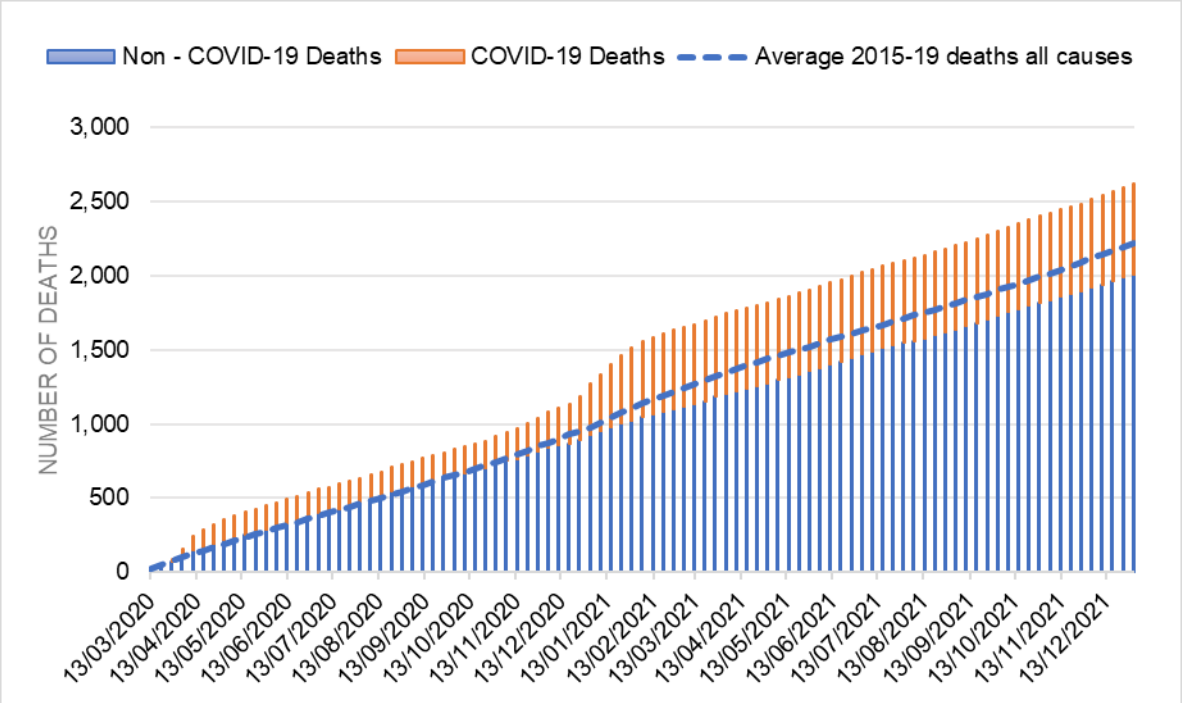
The causes of these inequalities are complex and in part reflect underlying inequalities in the wider determinants of health. In addition, a suspicion of statutory services, including the NHS and greater levels of hesitancy regarding vaccination have been implicated.[7]

Local impacts

Due to small numbers, life expectancy at borough level is calculated based on a rolling three-year period, currently 2018-2020. As such, the majority of the time period predates the pandemic. Nonetheless, life expectancy fell by 1.1 years to 77.0 years for men and by 0.6 years to 81.7 years for women and the size of the fall is likely to grow further as the period of analysis shifts to include the second year of the pandemic.

Figure 14 shows the cumulative number of deaths of Barking and Dagenham residents from March 2020, when the first death with coronavirus death was registered through to December 2021. Two distinct periods of excess mortality are evident, the first in April – May 2020 following the first wave of the original Wuhan variant, followed by another in January to February 2021 associated with the second wave caused by the Alpha (Kent) variant. Over the 20-month period as a whole, there were 610 deaths where COVID-19 was recorded as a contributory factor and the total number of deaths from any cause was 18% higher than the average in the preceding 5 years.

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



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

Total registered deaths from 13th March 2020 to 31st December 2021	2,615
Total Average 2015-19 Deaths All Causes / Expected Deaths	2,220
Total Excess Deaths	395
Total COVID-19 related deaths	610
Total Non-COVID-19 deaths	2,005

Source: ONS Mortality Data

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

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

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

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

This is the business of a wide variety of statutory agencies; private enterprise and communities themselves operating locally, nationally and internationally. Borough level Health and Wellbeing Boards (H&WBs) and new placed based partnerships (as part of the NEL ICS) 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 placed based partnerships, to take the opportunity to ensure there are robust plans in place regarding all four pillars of the population health model.*

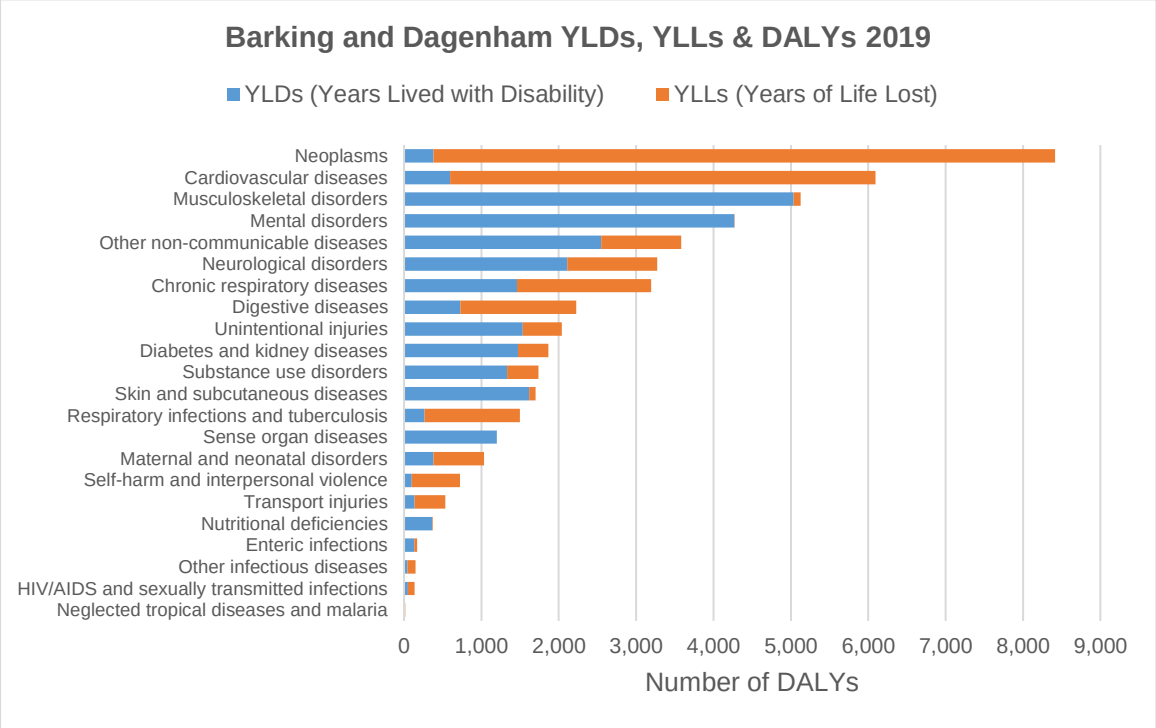
Life expectancy and other measures based on death rates highlight diseases that result in early death. Considerable harm to health is also caused by diseases that primarily result in prolonged illness and disability.

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

Pre-pandemic, neoplasms (cancers) and cardiovascular diseases (e.g., heart attack and stroke) caused the greatest loss of good health as measured in DALYs, largely due to premature

mortality. Musculoskeletal conditions and mental health disorders caused the next greatest loss of DALYS but as a result of years of healthy life lost to disability.

Figure 15. Barking and Dagenham YLDs, YLLs & DALYs, 2019



Data Source: Global Burden of Disease, 2019

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

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

The opportunity to reduce the harm caused by premature death and long-term illness through improved prevention and treatment and care is discussed in sections 7.5. Prevention and treatment are equally important, and both must be at the heart of the developing integrated care system.

Recommendation 2b: *All partners within the developing integrated care system must give prevention and treatment equal priority if they are to succeed in improving health, narrow inequalities and provide high quality, affordable health and social care services.*

The health and social care system will face a massive recovery challenge as the pandemic recedes. This explored in some detail in section 4.2.

Simply reinstating traditional models of care will not suffice and learning can be gained from new ways of working needed through the pandemic. The health outcomes achieved for resident's pre-pandemic lagged behind the best and varied such that some communities and population groups experienced significant and persistent inequalities. Much of the ill health seen was both predictable and preventable.

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

Recommendation 2c: Plans regarding the recovery of health and social care services from the pandemic are essential but must not divert from the commitment to adopt a population health management approach that seeks to prevent ill health and pre-empt crises by the timely, proactive offer of support, care and effective treatments to an empowered and informed population.

4. Pillar 1: The Wider Determinants of Health

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

The wider determinants of health e.g., income, employment, education, housing etc. are the most important drivers of health/ill-health at population level.

They are the fundamental cause (the 'causes of the causes') of health outcomes, and health inequalities will continue so long as significant social inequalities persist.

4.1 Income

Income affects health in a variety of different ways:

- living on a low income is stressful and directly impacts on physical and mental health
- an adequate income enables us to buy health-improving goods and participate more fully in society
- low income is associated with unhealthy behaviours (See chapter 7.2)

People are unable to make healthy choices, as even before the pandemic three in four (74%) people living in the greatest deprivation would have to spend 75% of their disposable income to meet healthy eating guidelines; in Barking and Dagenham this would be over half (54%) of the population are in lowest 2 deciles.

Concerns that have been raised from the community include:

- Being unable to pay for medicines and care (e.g. 'prescription poverty', dental poverty)
- Poverty (e.g. 'eat or heat' decisions, increasing debt)
- Mental health and wellbeing of children and young people
- Social isolation
- Unhealthy weight and obesity (unable to afford good food an exercise)
- Generational unemployment

Median gross weekly pay of people living in Barking and Dagenham (£643pw) is below the London average (£728pw) but slightly higher than the England average (£613 pw). However, earnings of people who work in Barking and Dagenham (£623) are very similar to the England average suggesting that residents who work outside the borough e.g., commute into central London, attract a slightly higher rate of pay than peers who work locally.[14]

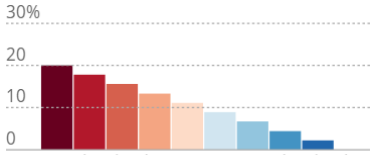
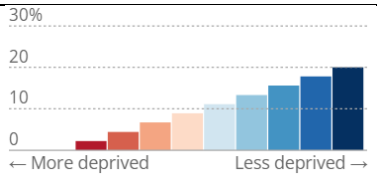
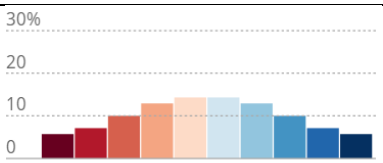
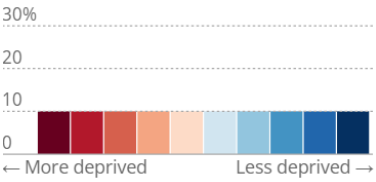
The proportion of adults in Barking and Dagenham that are income deprived[15] (19.4%) is higher than the national average (12.9%) and is the 2nd highest of the 32 London boroughs.

[14] ONS (2021) Annual survey of hours and earnings – residence analysis NOMIS Labour Market Profile - Barking and Dagenham

[15] 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).

ONS has grouped local authorities into four distinct income deprivation profiles according to the distribution of deprivation within them (see Table 1 below). Barking and Dagenham has a more income deprived profile with more neighbourhoods towards the deprived end of the scale.

Table 1: ONS income deprivation profiles

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

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

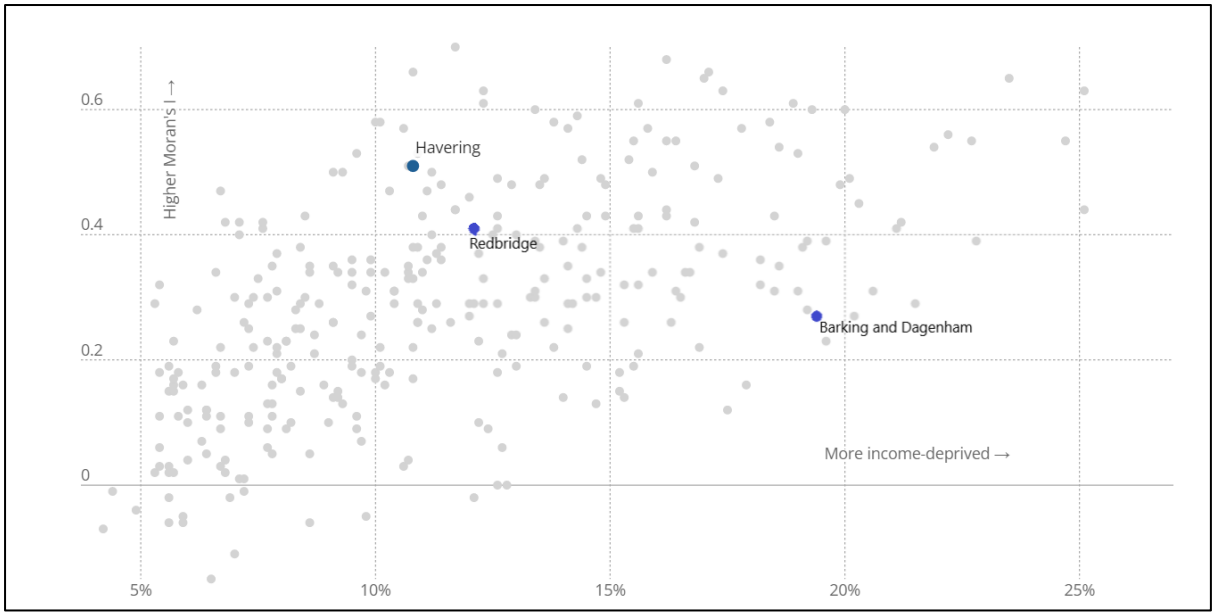
Approximately 39,000 adult residents in the borough are income deprived overall, and there is significant variation across Barking and Dagenham.

In the least deprived neighbourhood in Barking and Dagenham, 8.7% of people are estimated to be income deprived. In the most deprived neighbourhood, 34.1% of people are estimated to be income deprived. The gap between these two figures, the internal disparity in income deprivation is 25.4 percentage points in Barking and Dagenham. Generally, the local authorities in England with the greatest internal disparity (around 50%) have the highest levels of income deprivation overall. Local authorities with the smallest internal disparities, around 15%, tend to be rural, high income, and non-coastal.

ONS use a metric called Moran's I to quantify the extent to which neighbourhoods with higher levels of income deprivation are clustered together or alternatively, distributed evenly

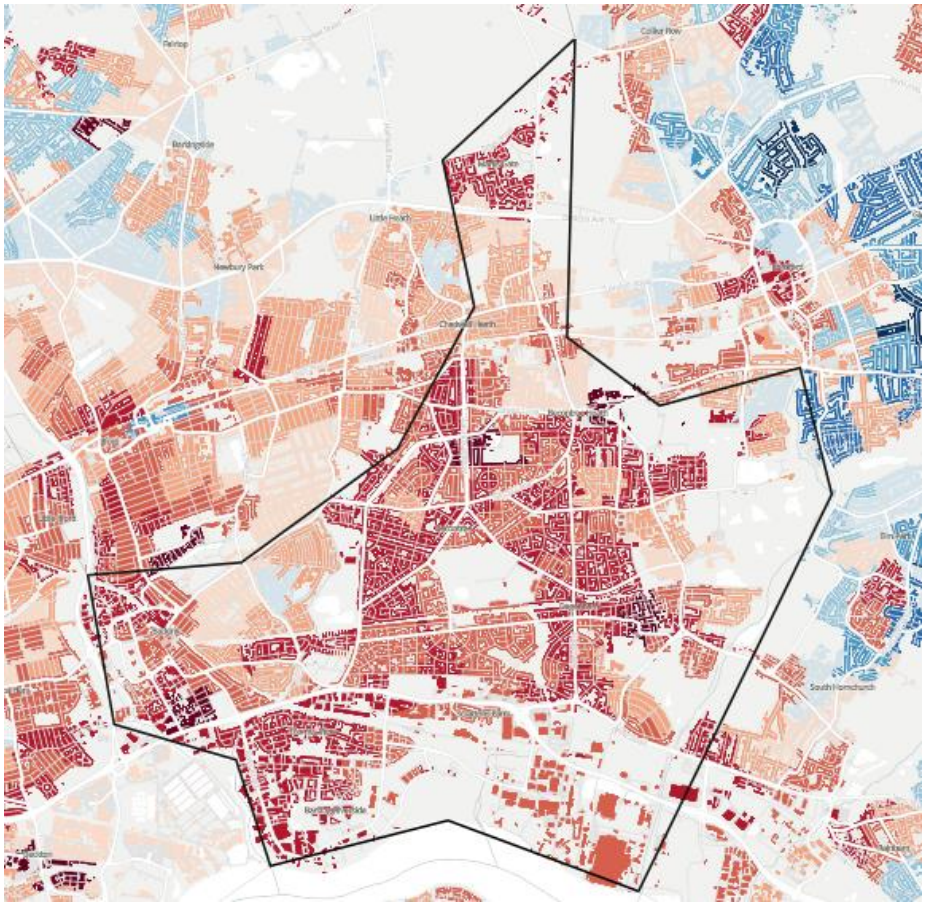
throughout a local authority. The Moran I is measured from -1 to +1, where +1 is highly clustered, 0 is random and +1 is highly clustered or separated. Generally, there is an association such that authorities with high levels of overall income deprivation have a high Moran's I (around 0.6) whereas areas with low levels of income deprivation have a low Moran's I (around 0). Barking and Dagenham has a Moran's I score of 0.27 as there is a relatively even spread of more income deprived residents across the borough. 49 of the 110 neighbourhoods in Barking and Dagenham were among the 20 percent most income-deprived in England. Clusters in the borough with very high levels of deprivation were Old Dagenham Park and Village (MSOA 014D), Central Park and Frizlands Lane (006C) and Gascoigne Estate and Roding (021B, 021C, 021F). No neighbourhoods in Barking and Dagenham were in the 20 percent least income-deprived in England, Eastbrook End (003B), which nears the border with Havering is one area with there are less deprived residents in Barking and Dagenham (see Figure 17).

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



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

Figure 17. Distribution of income deprivation at neighbourhood level, Barking and Dagenham, 2019



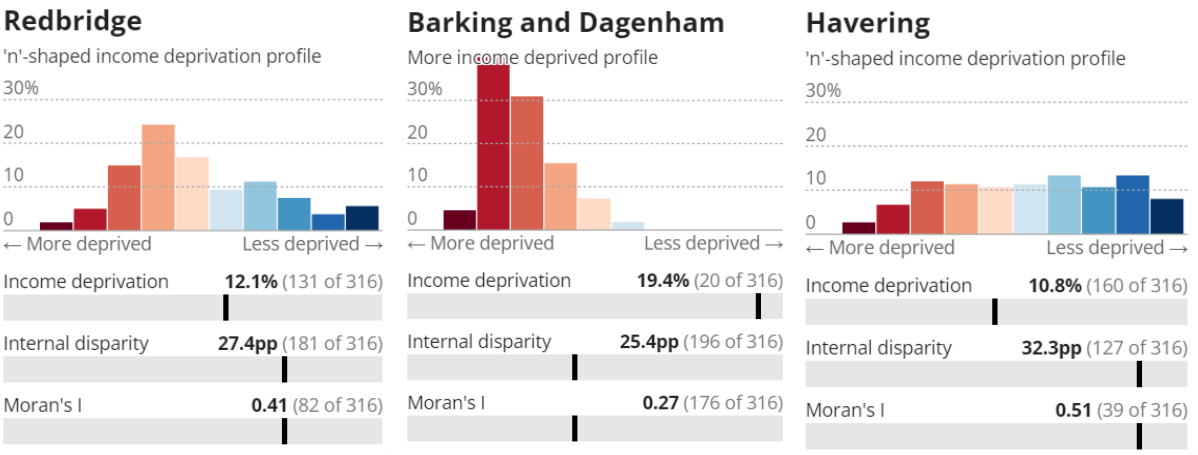
Source: Exploring local income deprivation (ons.gov.uk)

To avoid inequitable access to services, and reduce inequality in life outcomes, including health inequalities, decision makers must ensure that resources and service provision are married to the level of need at locality, if not sub-locality level, consistent with the principle of 'proportionate universalism'[16] advocated by Marmot et al[17].

The extent and distribution of income disadvantage is very different in each of the three BHR boroughs. In the case of Barking and Dagenham, the pockets of very high deprivation in the aforementioned areas have significantly greater need and will need proportionally greater resources.

[16] Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are universally available and able to respond to the level of presenting need in the area / community served.

[17] See LGA summary of the Marmot review into health inequalities in England and the role of local government in tackling the social determinants of health inequalities. https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives



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

4.2 Work

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

Rates of employment in Barking and Dagenham (62.6%) are lower than the London (73.8%) and England (74.7%) average.

The Job density rate (JDR)[18] in Barking and Dagenham (0.50) is below the London (1.03) and England average (0.88). Although the overall rate of employment is lower than London and national averages, it being higher than the JDR would suggest that a proportion of residents commute out of borough to work and may gain a higher rate of pay in doing so.

About 8,600 of the working age population in Barking and Dagenham is unemployed (9.1%), higher than the London (6.5%) and England averages (5.1%).

A much bigger proportion (30.9% - 43,100 individuals) of working age residents are economically inactive[19] for a variety of reasons including being a student, retirement, caring responsibilities and sickness. As with unemployment, this is a lower percentage than reported for London (21%) and England 21.6%. However, a relatively large proportion of economically inactive residents (27%, n = 11,700) nonetheless want a job.

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

28% of working age adults resident in Havering are employed in management or professional roles – below both the national (50%) and London (62%) averages.

Conversely, Barking and Dagenham residents are overrepresented in administrative and secretarial roles and skilled trades, collectively accounting for 25.7% of the working population, compared with the England (19.2%) and London averages (15.6%). 25.6% of residents are employed in Process Plant & Machine Operations and Elementary occupations compared to 9.7% in London and 9.4% in England.

[18] Job density is the ratio of total jobs to population aged 16-64
[19] Economic Inactive: the section of the working age population that is not in employment or actively seeking employment.

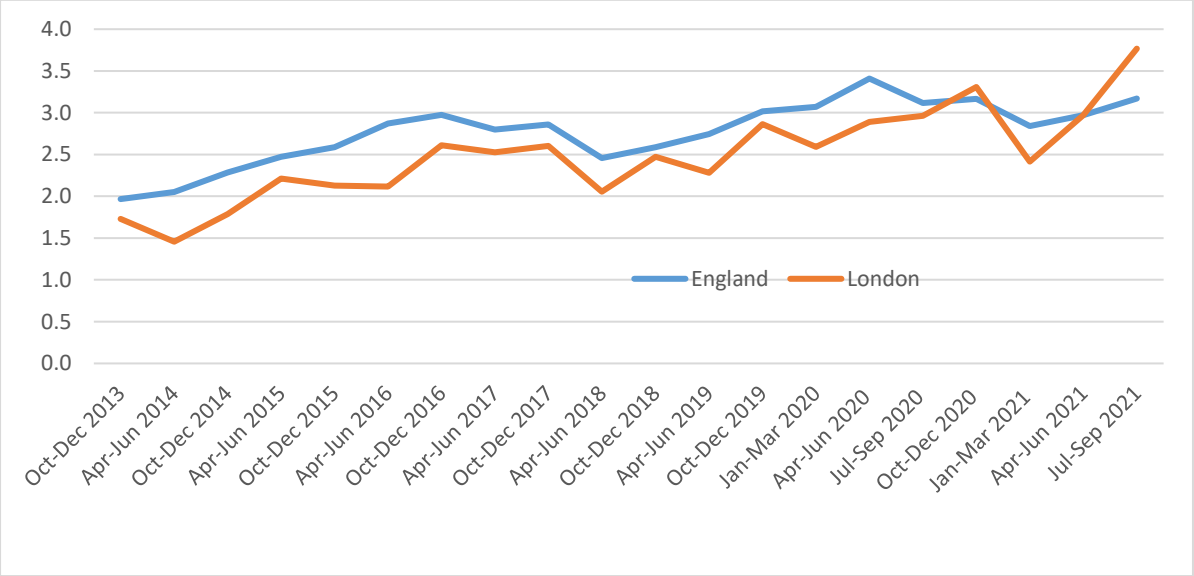
The wholesale and retail trades sector (19.0%), administration (12.1%), health and social care (10.3%), transportation (10.3%) and construction (6.0%) are the largest sources of employment for Barking and Dagenham residents.[20]

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

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

Atypical employment including zero hours contracts (ZHCs), short-hour contracts and various self-employment options within the gig economy, as well as more established models including part-time employment, temporary positions and agency work have been the cause of much concern over the past decade, in part regarding the rights to which such workers are entitled to and whether they are being consistently upheld. The lack of certainty around income has been raised particularly in relation to ZHCs.[21]

Figure 18 - Percentage of people in employment on a zero-hours contract



A small (4% in London) but growing proportion of workers are on ZTCs. This rises to about 10% amongst the youngest workers (16-24). Rates are generally higher for women than men, and non-UK residents than UK residents. For some, ZTCs offer valuable flexibility but a quarter of people on ZTCs say they are under- employed i.e., want to work more hours, four times more than peers employed on other forms of contract.[22]

[20] NOMIS Labour Market Profile - Barking and Dagenham

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

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

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 3: *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.*

Impact of the pandemic

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

- a number of lockdowns were imposed
- working from home where possible, was recommended for long periods although this was not possible for many face-to-face service roles e.g., carers, transport workers, shop and factory workers – exposing them to high risk of infection
- various social distancing measures were introduced to reduce close contact between staff and between staff and customers

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

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

Unsurprisingly, the proportion of residents claiming out of work benefits increased during the pandemic, but rates have since begun to decline. Overall, the available evidence suggests that the UK labour market continues to recover from the pandemic. However, rates of self-employment have not recovered at the same rate and workers from ethnic minority groups, young workers, low paid workers and disabled workers, have been most impacted economically.[23,24]

Thus, the pandemic has tended to hit communities and groups already experiencing inequalities with regard to work. As such, health and social care partners should redouble their

[23] The Health Foundation (2021) Unequal pandemic, fairer recovery
[24] Research Briefing - Coronavirus: Impact on the labour market https://commonslibrary.parliament.uk/research-briefings/cbp-8898/

efforts to support these priority groups into employment, including providing opportunities to enter the health and social care professions and enable local SMEs to tender to provide services (see recommendation 11).

Residents' occupation affected their risk of infection and hence serious illness and death[25]. The reasons are complex and difficult to disentangle at the level of specific occupations[26] but it clear that those who were able to work at home were at less risk of exposure than peers who could not.

During the first lockdown, nearly half of all workers worked from home (49%). Lower earners, frontline workers, and men were less likely to be able to work from home[27]. Over a third of working adults (36%) report having worked from home at least once in the past seven days during the last two weeks of January 2022[28] and working from home is likely to persist in full or as part of hybrid working arrangements for the longer term.

Separate for COVID-19 related affects, working from home has positive and negative impacts for health and wellbeing and associated risk factors at an individual and population level, for example increase levels of obesity and reduced positive mental health

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

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

Recommendation 4: Consider the impact working from home on the existing workplace health offer to employees and advice provided to local businesses.

Despite the provision of isolation payments, various studies have suggested that lack of job security and the non-availability of sick pay for some, e.g., those in the gig economy or on zero hour contracts - and the low rate of statutory sick pay for some on more traditional contracts

[25] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020

[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965094/s1100-covid-19-risk-by-occupation-workplace.pdf

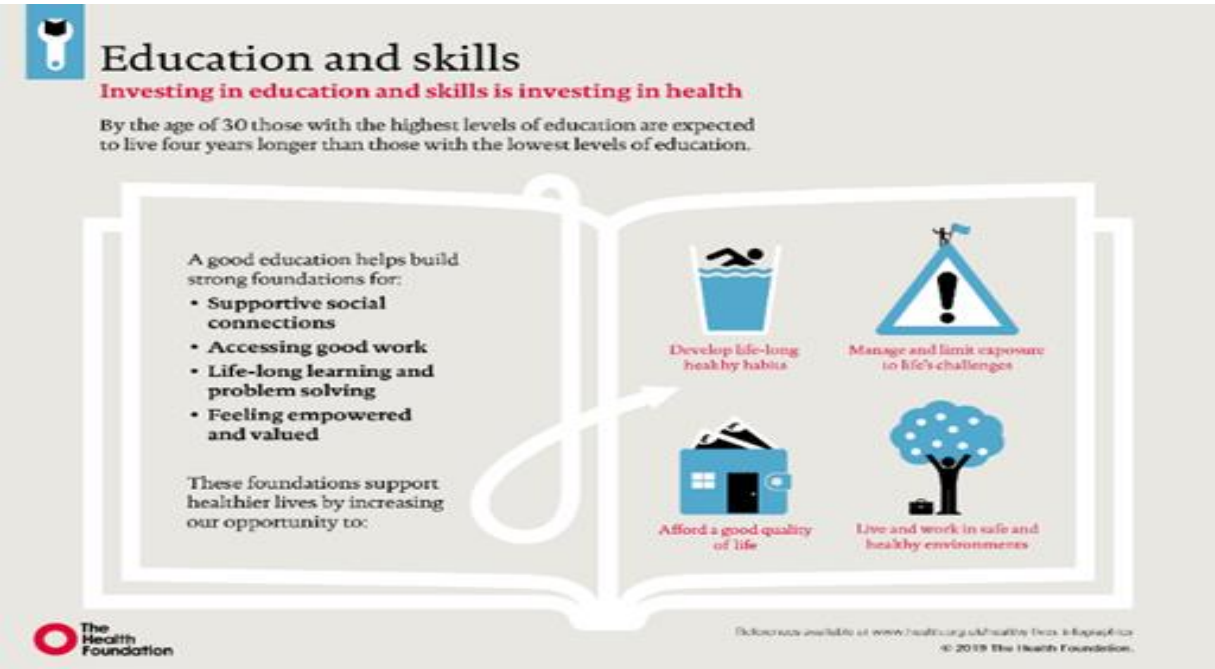
[27] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichjobscanbedonefromhome/2020-07-21

[28] Homeworking and spending during the coronavirus (COVID-19) pandemic, Great Britain - Office for National Statistics (ons.gov.uk)

has militated against full compliance with isolation contributing to enduring prevalence in some disadvantaged communities[29].

4.3 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 Barking and Dagenham is modest – 55.5% of working age adults have 'A' level or higher qualifications compared with 71% for London and 61% for the country as a whole.

This may translate into lower parental expectations for the next generation. See Section 4.3 for a discussion about the educational attainment of children and young people.

More immediately, lack of higher-level qualifications may limit the opportunity for residents to compete for higher paid jobs and / or secure employment in new roles and sectors, which may be necessary if opportunities in retail and administration continue to shrink.
Health and social care partners should consider how they can provide opportunities for entry into the caring professions for residents with the required commitment and aptitude but limited formal qualifications.

4.4 Housing

The impact of homelessness on health and wellbeing outcomes, particularly street homelessness, can be profound.

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

Poor housing in all its forms affects a much larger group, harming physical and mental health, at all life stages.
Furthermore, high housing costs put pressure on the household budgets of the many who are on moderate as well as low incomes.
Hence, high quality, affordable housing is a key element in ensuring the health and wellbeing of the population.

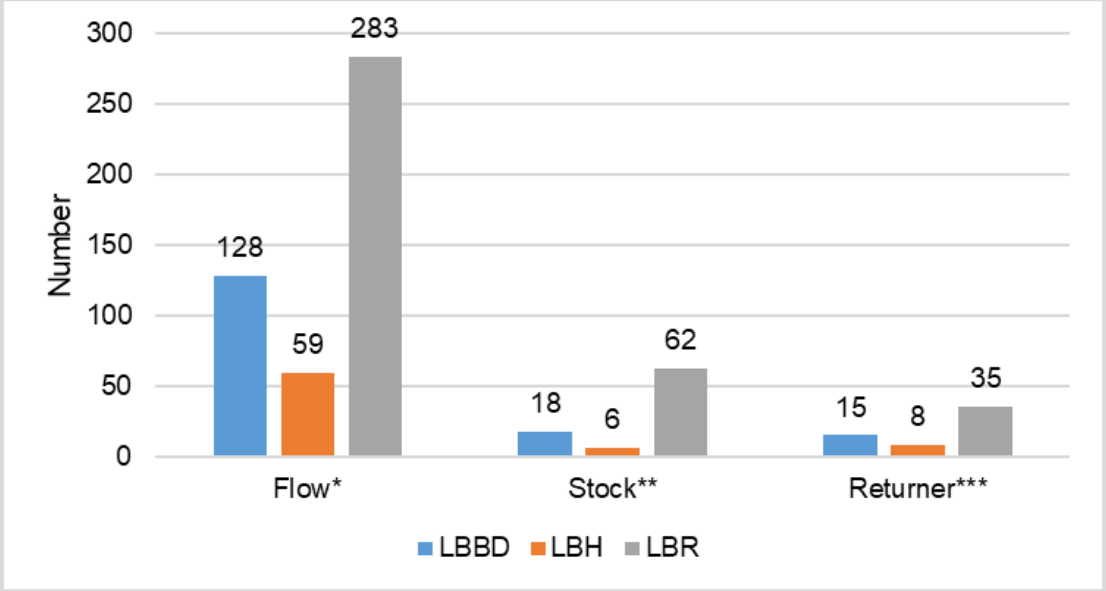
The health impact of street homelessness cannot be overstated: the average age of a homeless man at death is 47 years; the figure for women is even lower at only 43 years[30]. Hence the continued increase in the number of new rough sleepers recorded between 2018/19 (21) and 2020/21 (59) is of enormous concern.[31] Rough sleepers often have complex physical and mental health issues, including drug and alcohol dependency as well as good access to health and care services. Action regarding housing issues is more likely to succeed as part of a comprehensive, well-coordinated package of support delivered with health and social care partners.

***Recommendation 5**: Partner must work together to mitigate the worst harms of street homelessness and help those affected with the ultimate aim of enabling them to maintain suitable permanent accommodation.*

***Recommendation 5a:** To undertake a deep dive into the homeless population in Barking and Dagenham as part of an overall needs assessment of housing as part of the 2023 JSNA*

[30] 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/
[31] Chain Annual Report: Outer Boroughs April 2020 – March 2021 https://data.london.gov.uk/dataset/chain-reports

Figure 9: Number of people seen rough sleeping, 2020-21



Data Source: London Datastore

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

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

In 2020/21, 8.0% of Barking and Dagenham's housing stock fails the decent homes standard [32] (n = 1,361), this is lower than the mean for all London boroughs (exc. City) which is 9.9%[33].

Cold homes, whether due to poor design, inability to pay for heating or a combination of the two, contribute to excess winter mortality. The proportion of households in fuel poverty in Barking and Dagenham (22.5%) is above the national average (13.5%) and worse than the average for London (15.2%); nonetheless, more than 1:5 households are affected, and this figure can only increase given the very significant energy price rises planned for 22/23.

Houses in multiple occupation (HMO) are a part of the privately rented sector that causes particular concern given the inherent additional risks of overcrowding and consequent impact on safety and health. Only a small proportion (0.25%, n = 192) of dwellings in Barking and Dagenham are verified HMOs, much lower than the national (2.17%) and London (4.88%) figures but the number is increasing.

[32] DCLG 2006 A Decent Home: Definition and guidance for implementation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7812/138355.pdf
[33] GOV.UK Department for Levelling Up, Housing and Communities, Local authority housing statistics data returns for 2020 to 2021 (https://www.gov.uk/government/statistical-data-sets/local-authority-housing-statistics-data-returns-for-2020-to-2021)

Under supply of housing and unaffordability contribute to homelessness. In Barking and Dagenham housing growth is expected as the council, working in partnership with BeFirst, are aiming to achieve a target of 1,944 new homes each year until 2029. These proposals are set out in the draft Local Plan 2037[34].

Approximately 51% of the Barking and Dagenham population are homeowners, this is in-line with the London average (50%) but below the national average of 65%.

The average house price in Barking and Dagenham is 9.8 times average earnings. Houses in Barking and Dagenham have become significantly less affordable over the last decade and are less affordable than the national average (7.8 times). Nonetheless, homes in Barking and Dagenham remain more affordable than in many other London boroughs (see Fig 10 below).

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

£1,200 is the monthly private rental cost in Barking and Dagenham. This is significantly higher than the national average (£755) but below the average for London as a whole (£1,425) which is skewed by the much higher prices in inner London boroughs (see Fig. 11 below).

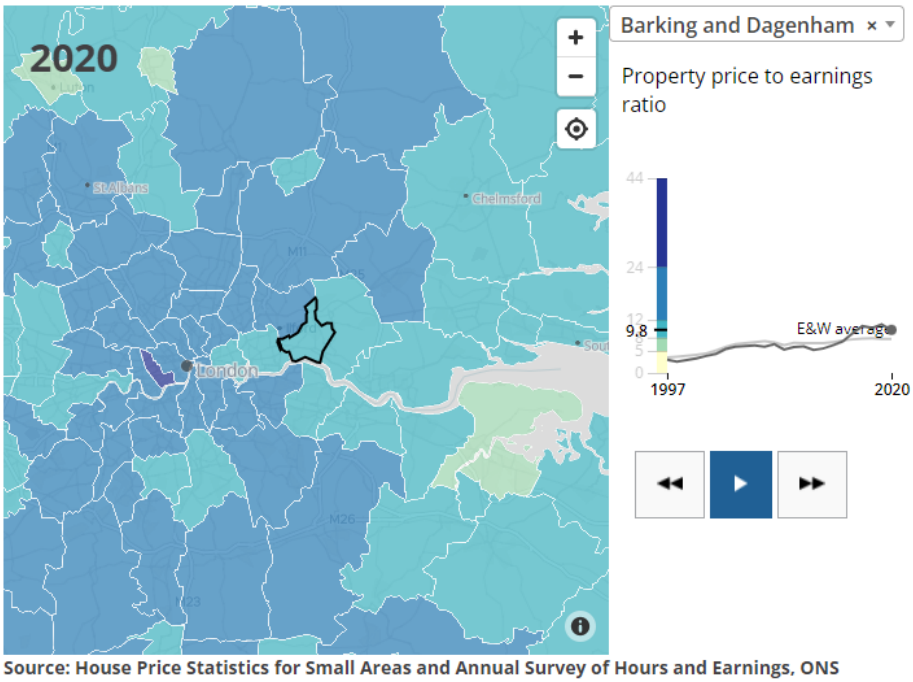
The cost of housing is a very significant charge on all household incomes. Saving for a deposit, on top of the cost of rental, may be too much for some, reducing the opportunity for more residents to buy and increasing the need for rental properties that meet the needs of individuals and families, throughout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

Recruitment of health and social care professionals is a significant problem in the BHR health economy. As with many younger adults, they may struggle to meet the cost of housing, whether rental or ownership. Significant regeneration is ongoing in all three BHR boroughs. The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.

> ***Recommendation 6:*** *The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.*

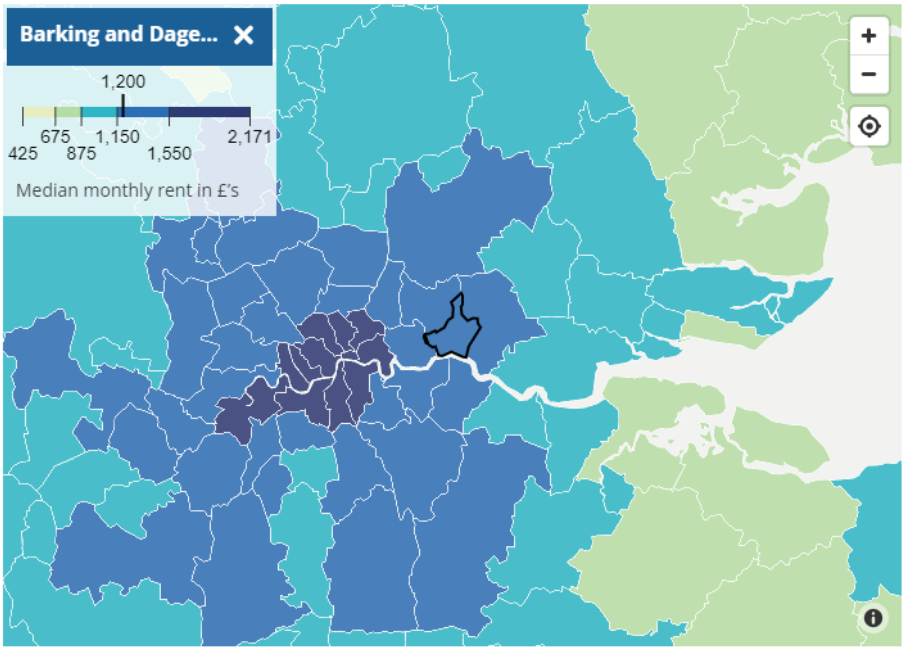
[34] London Borough of Barking and Dagenham draft local plan 2037 – Second revised regulation 19 consultation version (Autumn 2021) https://yourcall.befirst.london/submission-documents

Figure 10 - Housing affordability ratio by local authority district, England and Wales, 1997 to 2020 [35]



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

Figure 11: Median monthly rental price, by local authority, all categories, 1st October 2020 – 30th September 2021 [36]



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

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

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

Impact of the pandemic on housing

The pandemic affected housing in a variety of ways, and housing affected the course of the pandemic.

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

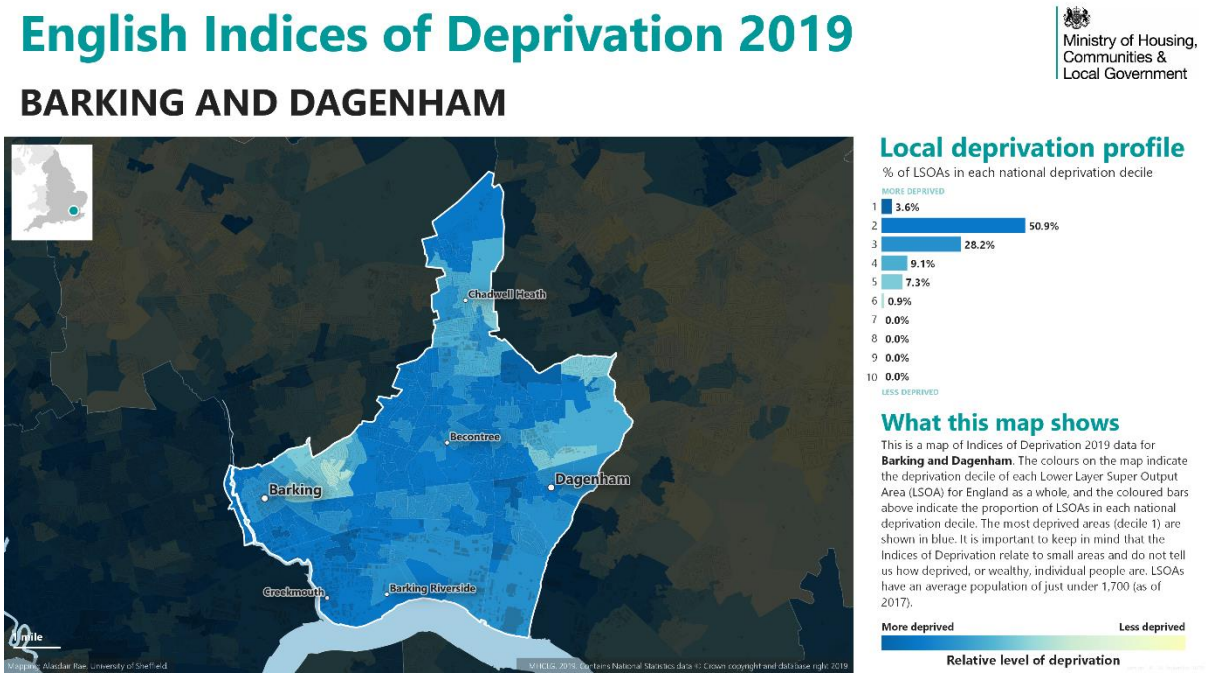
A range of measures including the furlough scheme, mortgage holidays and a halt on evictions of renters were implemented to mitigate the impact of the pandemic on housing and rates of homelessness in the short term. The longer-term impacts are unclear at this time, but those groups most vulnerable to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

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

4.4 Overall Disadvantage

The Index of Multiple Deprivation (IMD) combines many different facets of disadvantage into a single measure. The most deprived areas (decile 1) are shown below in blue. Levels of deprivation are high throughout Barking and Dagenham with almost 83% of LSOAs being in top 3 more deprived national deciles (deciles 1-3).

Figure 12: Barking and Dagenham % of LSOAs in national deprivation decile, 2019[38].



Source: Ministry of Housing Communities & Local Government

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

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

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

At local level, the levers to affect the socio-economic determinants of health tend to lie with councils rather than the NHS, although they can impact on the way residents access health services.

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. The NEL ICS has prioritised addressing health inequalities and the new placed based ICB committees will be required to act to address health inequalities at place (i.e., LBBD)

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

Recommendation 8: *Strengthen social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options as well as an effective signposting function and bring together NHS, council and CVS stakeholders.*

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

- Further 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.
- Provide an exemplary workplace health scheme to employees and help local SMEs to improve the offer to their workforce.

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

- Routinely consider the potential for additional 'social value' when procuring goods and services; and how bids from local businesses can be facilitated

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

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

Impact of the pandemic

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

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

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

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

[41] ONS (2020) Deaths involving Covid-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020 Deaths involving COVID-19 by local area and socioeconomic deprivation - Office for National Statistics (ons.gov.uk)
[42] Havering London Borough (2021) Coronavirus in Havering Coronavirus in Havering – Week 45, ending 12 November 2021 | The London Borough Of Havering

5. Pillar 2: 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 risk factors associated with poor diet, physical inactivity and obesity; and the use of drugs and alcohol.

Figure 13: Risk factors and percentage contribution to DALYs as measured by Population Attributable Fraction (PAF), BHR, 2019.[43]

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

Behavioural	
Environmental / Occupational	
Metabolic	

Data Source: Global Burden of Disease, 2019

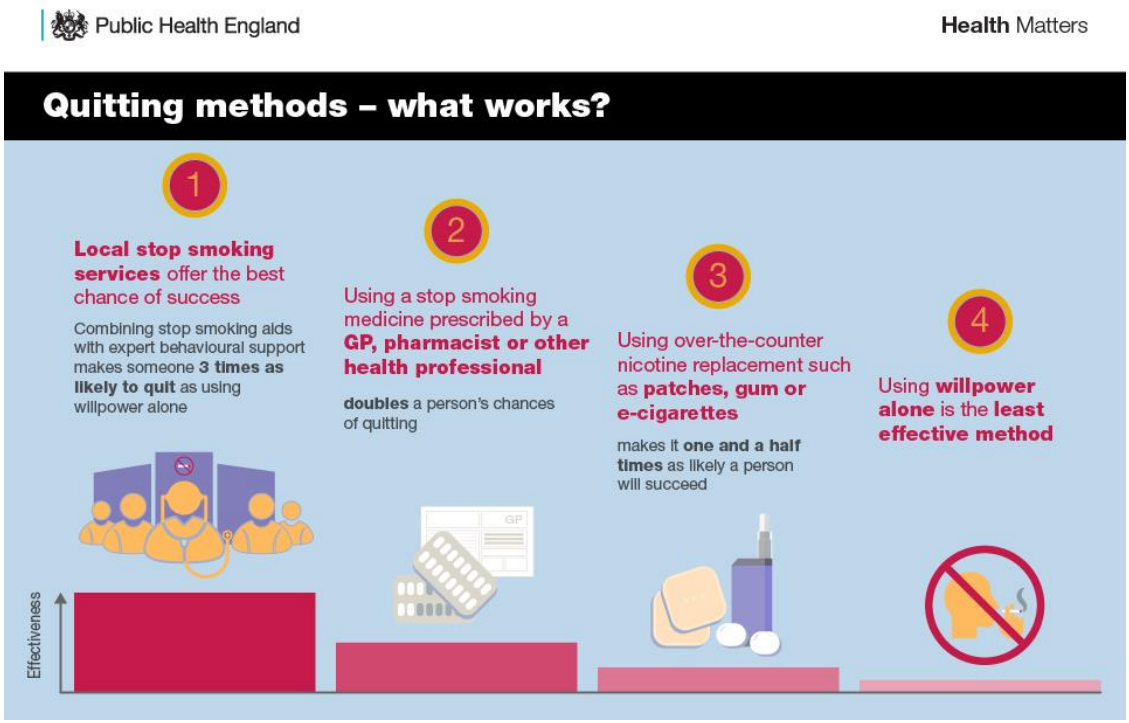
Smoking remains the leading preventable cause of premature mortality and ill health (Figure 13). Although smoking has been in decline since the 1950s, as of 2019, almost 27K (13%) adults in Barking and Dagenham continue to smoke.

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

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., in 2019, the proportion of Barking and Dagenham residents in routine and manual occupations identifying as current smokers was 24.3%. This was 6.2 percentage points higher than the smoking prevalence of Barking and Dagenham adults (18+) at 18.1%. Smoking is also particularly high amongst people with serious mental illness and smoking rates increase with the severity of mental illness.[44] Differences in smoking prevalence are the immediate cause of a significant proportion of health inequalities.

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

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



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

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

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

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

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

***Recommendation 15:** Contribute towards the aspiration of a smoke free society by 2030 e.g., by continuing the de-normalization 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. high intake of saturated fat, salt, free sugars, and processed meats; and low intake of whole grains, fruits, vegetables, legumes, oily fish and fibre) is similar in scale to the harm caused by smoking, in part because so many people eat unhealthily in one way or another e.g. in 2019/20, only 47.9% of adults in Barking and Dagenham were able to consume the recommended 5 portions of fruit and vegetables on a usual day.

The socioeconomic impacts of the COVID-19 pandemic (see Chapter 4 for further details) have left more people across England food insecure than before the pandemic. It is estimated that a fifth of households cut down or skipped meals since the pandemic started, with households with children more likely than other households to reduce meal sizes or skip meals due to not having enough money. Households with lower financial or food security were also more likely to have poorer diets than other households.[48]

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

A **sedentary lifestyle** results in a lesser but nonetheless very significant burden of ill health. In the period May 2020-21, more than one in three (36.6%) adults (aged 16+) in Barking and Dagenham were physically inactive, significantly more than the national average. The number of physically inactive adults in Barking and Dagenham increased by around 1.2% in comparison

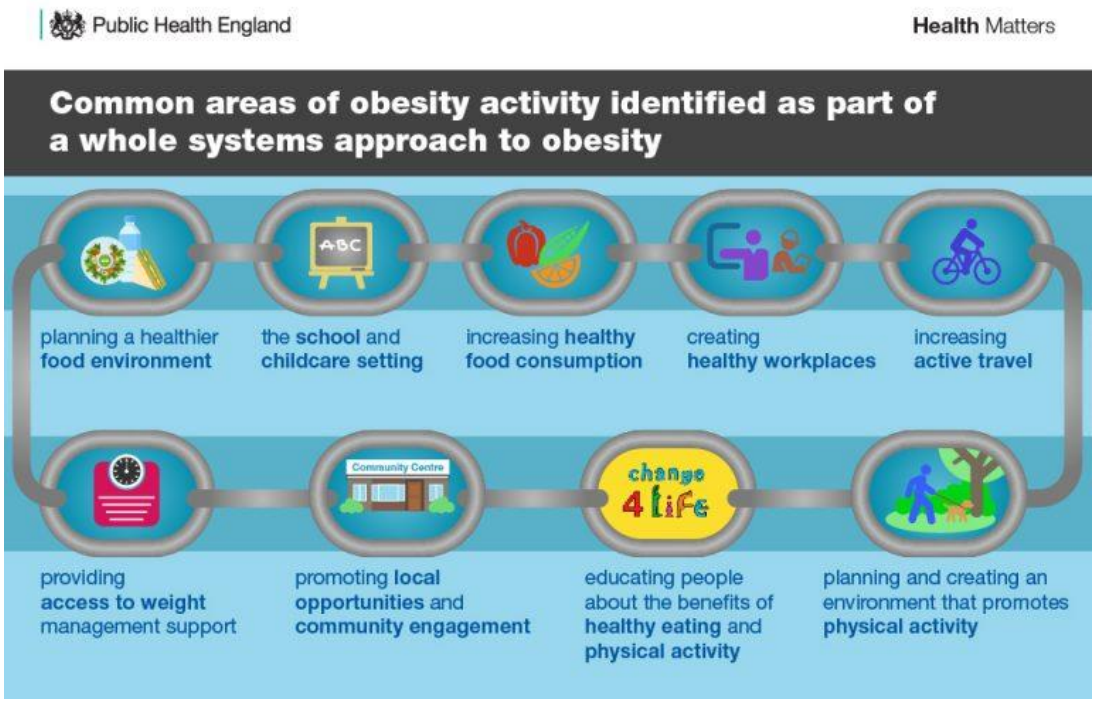
[46] Office for Health Improvement and Disparities (OHID) Smoking and tobacco: applying All Our Health, 2021
[47] ONS, Adult smoking habits in the UK: 2019
[48] PHE, National Diet and Nutrition Survey: Diet, nutrition and physical activity in 2020 - A follow up study during COVID-19, 2021

to the previous 12 months as a result of the national and tiered restrictions introduced to counter the coronavirus pandemic.[49]

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

The changing balance between diet, in terms of energy consumed, and physical activity (energy expended) underpins the steady growth in levels of **obesity**. The proportion of adults in Barking and Dagenham living with overweight or obesity (66%) in 2019/20 was significantly higher than the London (56%) and national (63%) averages. People with learning disabilities and those living in social disadvantage are more likely to experience obesity than the rest of the population[51]. Obesity results in a separate and rapidly growing burden of disease and thus exacerbates the other health inequalities experienced by these groups.

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

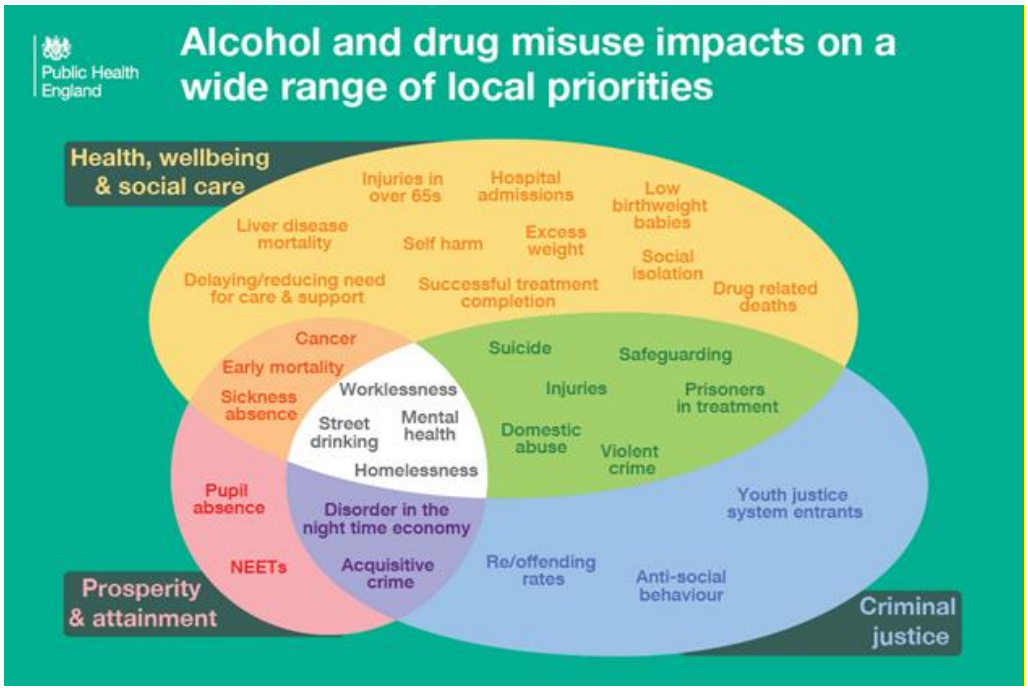


Recommendation 17: Ensure that there is a comprehensive whole system approach to tackling obesity across BHR as a whole with additional efforts aimed at supporting groups known to have higher prevalence of obesity.

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

See Section 7.2 for analysis of childhood obesity.

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



In 2018-19, there was an estimated 2,105 adults in Barking and Dagenham with an alcohol dependency and potentially in need of specialist treatment. This represents 1.4% of the adult population aged 18 or over[53]

9.6% (n=1,293) of individuals aged between 15-64 in Barking and Dagenham were using opiates and / or crack cocaine between 2016-17[54]. The age-standardised mortality rate for deaths related to drug poisoning in Barking and Dagenham between 2018-20 was 5.8 per 100,000 – lower than the national average of 7.6. The age-standardised mortality rate for deaths related to drug misuse was 3.0 per 100,000, again lower than the national average of 5.0[55]. However, despite this, the number of drug-related deaths in England rose to its highest on record in 2020, with approximately half of all drug poisoning deaths involving an opiate.[56]

Increasing the number of individuals recovering from addiction not only has significant health and well-being benefits, such as increased longevity, reduced blood-borne virus transmission and improved physical and psychological health, it also reduces the harm caused within the wider community. In Barking and Dagenham during 2020, only 5.7% of the total number of opiate users in treatment successfully completed their treatment and did not re-present themselves to treatment again within 6 months[57] compared to 37.1% of alcohol users who

[53] Alcohol dependence prevalence in England - GOV.UK (www.gov.uk)
[54] Estimated prevalence of opiate and/or crack cocaine use - OHID public health profiles
[55] ONS. Drug-related deaths by local authority, England and Wales. 2021
[56] ONS. Deaths related to drug poisoning in England and Wales: 2020 registrations. 2021
[57] Successful completion of drug treatment - opiate users - OHID public health profiles

successfully completed structured alcohol treatment who did not re-present within 6 months[58].

A much larger group run a more modest, but nonetheless significant risk of harm because of drinking more than recommended – in the period 2015-18, almost 1 in 6 (15.8%) adults in Barking and Dagenham were drinking more than 14 units of alcohol over the course of a week[59].

Before the COVID-19 pandemic, there was an increase in alcohol-related hospital admissions and deaths across England, but the pandemic seems to have further accelerated these trends. From May 2020 onwards, there have been significant and sustained increases in the rates of unplanned admissions for alcoholic liver disease and total alcohol-specific deaths, with a large proportion (33%) of deaths occurring in the most deprived group.[60]

Recommendation 18: *Partners should work to:*

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

[58] Successful completion of alcohol treatment - OHID public health profiles
[59] Percentage of adults drinking over 14 units of alcohol a week. Local Alcohol Profiles for England. OHID
[60] PHE Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary. 2021

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

The places and communities we live in affect health and wellbeing in many other ways, both positively and negatively.

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

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

The capacity of individual residents, their families and of the wider community as a whole is perhaps its greatest asset e.g., there is strong evidence about the protective effects of social relationships and community networks, particularly on mental wellbeing[61].

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

Climate change already poses a risk to the wellbeing of current residents and is an existential threat to humanity if left unchecked[62]. It is fundamentally a consequence of how we live. Shifting to a sustainable future will require changes at all levels including within local

[61] The Marmot Review 10 years on. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf
[62] Understanding the health effects of climate change - UK Health Security Agency (blog.gov.uk) https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/

communities e.g., how we as individuals travel from place to place; how our homes are built and heated etc.

Climate change is both an immediate risk to the health and wellbeing of residents and an existential threat to humanity in the longer term if left unchecked. Already we face increasingly frequent and extreme weather events, including prolonged heatwaves and flooding[63].

In England, during the summer of 2020, there were 3 periods, totalling 20 days that met Public Health England's heatwave definition. The total cumulative all-cause excess mortality over this period was 2,556 deaths. Just under 90% of deaths were people aged 65 and above, and half were aged 85 or older. About 20% of deaths were in London, consistent with the 'urban heat island' effect whereby cities tend to be hotter than surrounding rural areas. Mortality was significantly greater than that experienced in previous summers, raising the possibility that the concurrent risks of COVID-19 and heatwaves may amplify the harm caused by either alone[64].

Deaths from flooding in the UK are thankfully very infrequent. Nonetheless, there are long term negative impacts on the mental health of people whose lives are affected by flooding.

Bloomberg Associates, in collaboration[65] with the GLA, have produced London-wide climate risk maps showing the risk posed by excess heat, flood and overall climate risk. In Barking and Dagenham, the risk is higher in Abbey and Gascoigne wards.

***Recommendation 19a**: Partners should collaborate to reduce greenhouse emissions and mitigate the harms caused, ensuring that causes and impacts of climate change are considered in every policy and decision, including all new regeneration developments, for example, use of innovative heating and waste management methods to be more climate friendly in Barking Riverside.*

***Recommendation 19b**: Partners should collaborate to raise public understanding and awareness on causes and impacts of climate change, and how they can keep themselves safe.*

Cities consume 78% of world's energy and produce more than 60% of greenhouse gas emissions[66], with transport and buildings among the largest contributors. Cutting emissions will reduce the impact of climate change in the long term and improve air quality in the short term.

Air pollution is a huge public health problem now; 6.8% of all deaths in Barking and Dagenham are attributable to air pollution, higher than the national average (5.1%) and the figure for London as a whole (6.4%).

[63] Understanding the health effects of climate change - UK Health Security Agency (blog.gov.uk) https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/
[64] Heatwave mortality monitoring report: 2020 - GOV.UK (www.gov.uk)
[65] https://gisportal.london.gov.uk/portal/apps/webappviewer/index.html?id=7322196111894840b5e9bae464478167
[66] https://www.un.org/en/climatechange/climate-solutions/cities-pollution

Long-term exposure to air pollution reduces life expectancy, mainly due to its contribution to cardiovascular and respiratory diseases and lung cancer, but it is also linked to dementia, cognitive decline, and risk factors in early life (for example low birth weight).

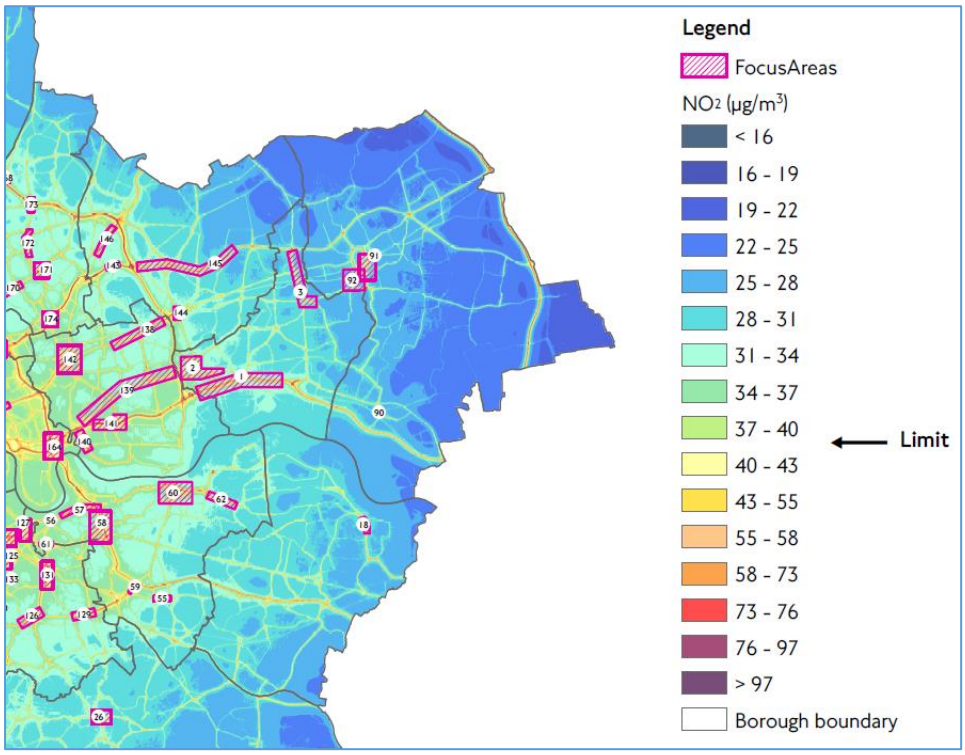
Some people will also experience immediate effects during episodes of particularly poor air quality, with reduced lung function and exacerbations of asthma contributing to an increase in respiratory and cardiovascular hospital admissions. In December 2020, a London Coroner concluded that Ella Adoo-Kissi-Debrah died, aged nine in 2013, from a combination of acute respiratory failure, severe asthma and air pollution exposure. The first time that air pollution had been listed as a medical cause on a death certificate in the UK.

The main pollutants of concern are nitrogen dioxide (NO2) and particulate matter (PM) produced by traffic, heating, and burning of solid fuels. Air quality in Barking and Dagenham is worse than London and national averages, the annual average concentration of fine particulate matter in Barking and Dagenham is 9.4 µg m^{-3} compared with the London average of 8.9µg m^{-3} and the England average of 6.9µg m^{-3}.

Local authorities have a statutory responsibility in Local Air Quality Management (LAQM). They must declare an Air Quality Management Area (AQMA) anywhere where the national air quality objectives will not be achieved. Barking and Dagenham have designated the whole borough as an AQMA due to levels of Nitrogen Dioxide. Local authorities designating their boroughs as AQMAs must produce an Air Quality Action Plan (AQAP) set out how local authorities, working with other agencies, will use their powers to meet the air quality objectives.

In addition, the Greater London Authority has identified 187 Air Quality Focus Areas that not only exceed the national air quality objective but also have high levels of footfall. Three locations in Barking and Dagenham are listed, one in Abbey ward, a second one stretching across Gascoigne, Eastbury and Thames wards and a third one across Whalebone and Chadwell Heath wards.

Figure 15: Air Quality Focus Areas in the three 'BHR' boroughs



Source: GLA Air Quality Team[67].

The pandemic demonstrated that poor air quality is not inevitable. During the spring 2020 lockdown, NO2 decreased by 59% in London[68]. More modest but nonetheless hugely beneficial improvements are attainable as recovery from the pandemic progresses e.g., by encouraging individuals to use public transport, and the adoption of cleaner fuels for transport, heating, and manufacturing.

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

In parallel with action to reduce air pollution, residents can, if appropriately informed take action to reduce their personal exposure. Nationally, the Daily Air Quality Index (DAQI)[69] offers information on levels of air pollution and provides recommended actions and health advice. In London, the Mayor's air quality alerts system[70] advises Londoners on days where air pollution is elevated e.g., by sending warning emails to signed-up stakeholders. Similarly, subscribers to the airTEXT[71] system receive a text message, call or voicemail whenever moderate or high levels of pollution are expected. Such alerts enable residents to determine what steps they should take given the expected level of pollution. For example, taking a different route/mode

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

of transport to work, keeping their medication with them, or not exercising outside on certain days.

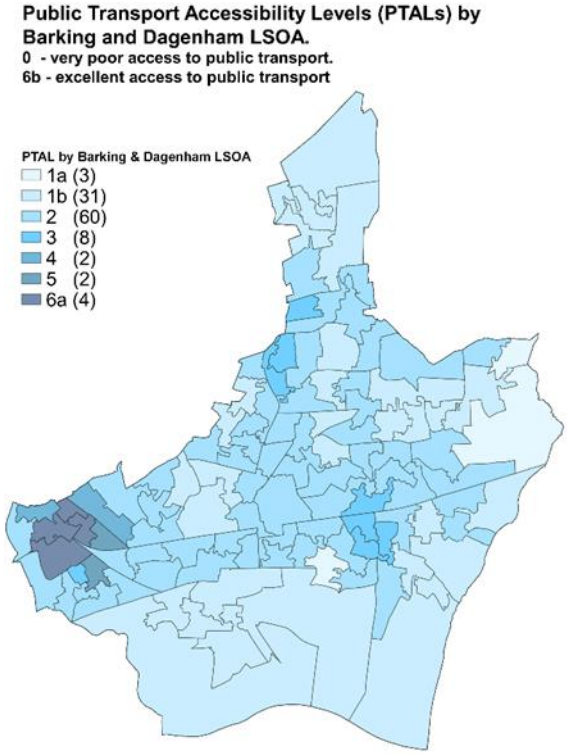
Recommendation 21: Partners should collaborate to raise public understanding and awareness of current local levels of air pollution using the 'air pollution forecast' and encourage residents to adjust their behaviour, accordingly, taking into account any health problems that might put them or their family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

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

Many people could incorporate some form of **active travel** with public transport during a longer journey or commute which would serve to reduce air pollution and provide the individual, who may otherwise be in a largely sedentary occupation with beneficial physical activity. Pre-pandemic, 19.8% of adults in Barking and Dagenham walked for travel three or more times per week, statistically similar to London average of 22.1%[72].

Barking and Dagenham is one of London's best-connected boroughs with excellent road and rail links to outside London and other boroughs. But public transport links within the borough is poor, with most LSOAs having Public Transport Accessibility Levels (PTAL) score of 2 or low[73].

Figure 16: Public Transport Accessibility Levels (PTALs) for LSOAs in Barking and Dagenham



Public transport Accessibility Level (TfL) – London Datastore https://data.london.gov.uk/dataset/public-transport-accessibility-levels (2015) *Contains OS data Crown Copyright (and database right) (2020)*

[72] Source: https://fingertips.phe.org.uk/

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

There has been a very modest increase in car ownership in recent years and rate of ownership in Barking and Dagenham are about 83 cars per 100 households in the borough.

Table 3: Cars registered per 100 households: 2019, 2020 and 2021

Borough	Havering	Redbridge	Barking & Dagenham	Greater London Average
2019	110.65	97.24	82.11	75.74
2020	109.50	96.63	81.98	75.07
2021	108.99	96.81	83.53	74.74

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

However, car ownership is not universal. in and not have access to a car; with higher rates amongst older people and disadvantaged communities who are most likely to make use of public services in general and health and social care in particular.

Table 4: % of households with no cars or vans; 2011

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

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

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

Pre-pandemic, only 0.8% of adults in Barking and Dagenham cycled for travel purposes at least three times per week, significantly below the England and London averages, 2.3% and 4.1% respectively.

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

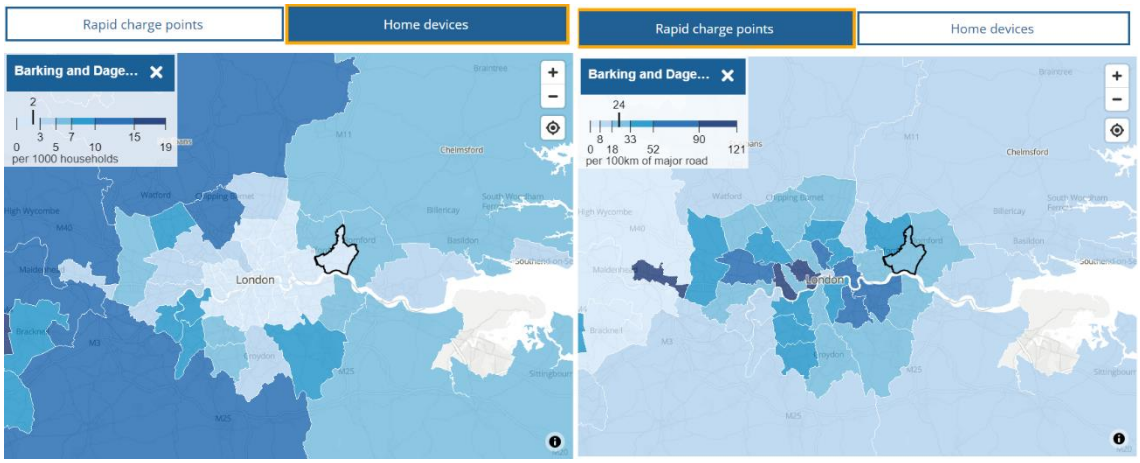
Pending a significant improvement in public and active transport infrastructure, cleaner forms of private transport e.g., car clubs and electric vehicles (EVs) may yield more rapid improvements in air quality.

The sale of new vehicles reliant on fossil fuels is set to end in the UK by 2030 and over half of younger drivers say they are likely to switch to electric in the next decade[74]. The initial cost of electric vehicles remains the biggest barrier to switching to EVs and currently ownership is

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

more common in areas with the highest disposable income. Difficulties recharging electric cars –"range anxiety" - is cited as another key factor against switching from conventional fuels.

Figure 17: Provision of public rapid charge points per 100km of motorway (October 2021) and home devices installed per 1,000 households (2013 to July 2021), UK



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

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

Recommendation 24: All partners to facilitate the shift to electric vehicles including their own fleet. For example, by lobbying for national investment in charging infrastructure

About 39% of Barking and Dagenham's surface area is classified as green cover[75] - parks, green spaces, gardens, woodlands, rivers and wetlands, as well street trees and green roofs. The second highest proportion of any London borough and significantly lower than the London average (approximate 50%).

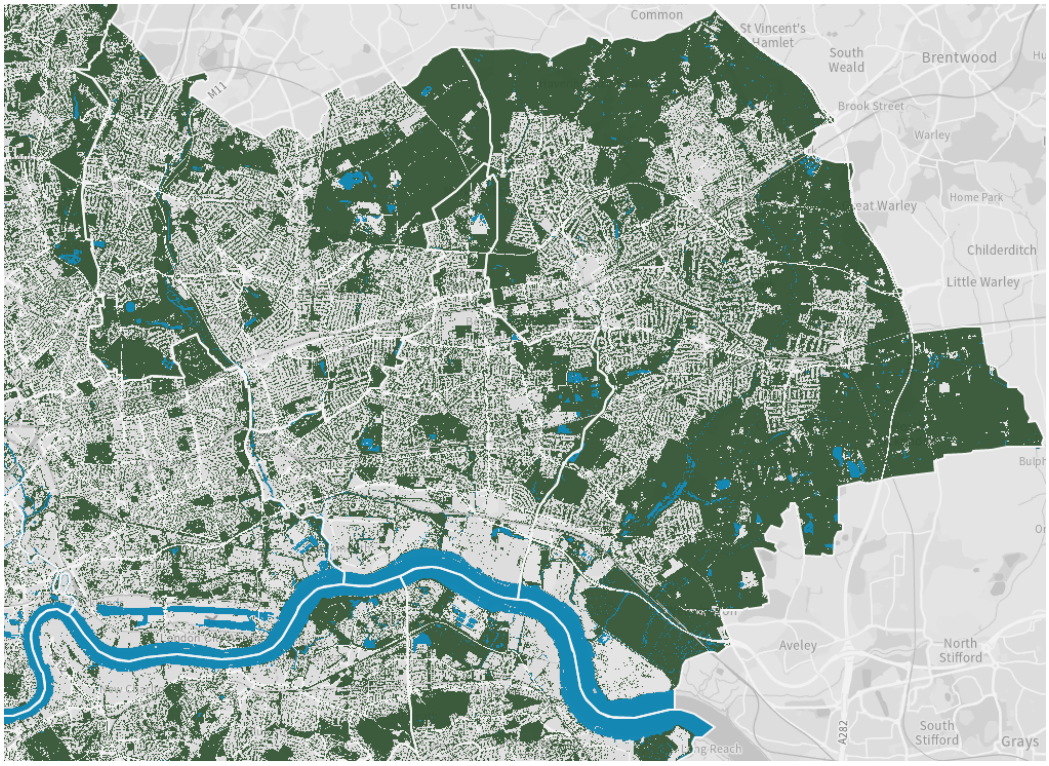
Green infrastructure is an important asset as it serves to: -

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

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

- create better quality and better-connected habitats to improve biodiversity and ecological resilience

Figure 18: Green Cover, BHR boroughs



Source: GLA Environment Team

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The RSPH reports 'Health on the High Street [76] [77] investigated the relationship between local high streets and health. A healthy high street can provide the public with healthy choices, support community cohesion and social interaction, promote access to health services and do much to support individual wellbeing. The health promoting assets identified included libraries, pubs, greengrocers, gyms, pharmacists, and GP surgeries. Equally, high streets also facilitate activities that can have a detrimental effect on our health, particularly if provided in excess and in communities with greater vulnerability e.g., betting shops, tanning parlours, payday lenders and fast-food[78]. The RSPH created a league table of 146 high streets across London[78]. The two high streets in Barking and Dagenham in the league table were ranked 33 (Dagenham Heathway) and 45 (Chadwell Heath), where 1 was the least healthy and 146 the most healthy.

The authors noted that planning and licensing legislation did not necessarily prioritise health and wellbeing as it should, and Government was asked to provide Councils with stronger

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

powers to restrict the spread of unhealthy outlets, particularly in areas with a high density. In the absence of further powers, Councils were encouraged to

- introduce planning restrictions within 400 metres of schools (as part of the whole system approach to reducing obesity (see section 7.2).
- set differential rent classes for tenants based on how health promoting their business is.
- give business rates relief for businesses that try to improve the public's health e.g., by selling e-cigarettes but not cigarettes
- work with vape shops to ensure staff can sign post to stop smoking services
- work with betting shops and pay day loan providers so staff can sign post customers with debt problems to sources of support.

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

The wider environment, as well as the service offer available, affects the extent to which high streets support good health.

TfL's 2014 transport action plan[79] identified 10 indicators of a healthy street environment (see Fig. 19).

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

Figure 19: Indicators of a healthy street environment

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

These directly benefit health e.g., by promoting physical activity or by reducing exposure to air pollution and noise; but also serve to make high streets more attractive and safe places to spend time – increasing the opportunity for social interaction, which is good for mental wellbeing, and the likelihood of residents spending money, thereby benefiting local businesses. The report noted that whereas most streets will have one or two positive characteristics, it often takes multiple positive characteristics to achieve a significant change in the number of people (enjoying) spending time on the street. Hence, regeneration, potentially driven by largescale house building and associated investment in appropriate community infrastructure, may offer the most realistic means to achieve a step change in the street scene and its benefit for current and future residents.

Access to good quality housing is an important determinant of population health (see section 4.4). An increase in housing stock is necessary given anticipated population growth (see section 2.1) and to maintain affordability (see section 4.4). As well as increasing the housing stock, **regeneration** is an opportunity to build in the physical infrastructure that will underpin healthy communities in the future e.g., green space, active travel infrastructure, healthy street environment, digital connectivity, etc. It is important that all regeneration and house building takes into account needs to the population which will inhabit these new homes and ensures that appropriate capacity for schooling, healthcare and community facilities is provided as part of the development.

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

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[80]. Barking Riverside is a Healthy New Town demonstrator site embedding design principles which promote health and wellbeing and secure high quality health and care services[81].

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

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

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

Appropriately qualified and experienced professionals are essential to the effective functioning of public services (health and social care, but also schools and colleges etc). Staff shortages are already a problem affecting quality of care and increasing the cost-of-service provision (see section 4.2). This can only worsen as the population grows unless local providers succeed in recruiting the next generation of professionals. The opportunity to buy or rent high quality, affordable housing could be part of a wider package (e.g. high performing schools, easy access to green space, safe and welcoming communities etc) BHR can offer to attract professionals into the patch.

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

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

Crime, particularly violent crime, impacts negatively on the health of victims and the wider community. As well as health and the wider determinants of health are risk factors associated with being involved in crime

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

Fear of crime and antisocial behaviour has wider effects, deterring residents from using assets in the community and reducing social interaction.

Whereas a significant proportion of violent crime is within the home, knife crime, by or against vulnerable adolescents, is the cause of massive public concern and contributes disproportionately to fear of crime. Some serious violence is gang related; 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 people in from adjacent boroughs.

Total notifiable offences (TNO) in Barking and Dagenham for the 12-month period Oct 2020 to Sept 2021 were 19,559, a rate of 91.4 per 1,000 residents, higher than the average for London (85.7) and England and Wales (81.8). The rate in 2020/21 was 1% higher than 2019/20 and 1% lower than 2018/19.

Domestic abuse accounted for over 20% of reported crimes in 20/21, a 1.3% increase from 2019/20. Reported domestic abuse in Barking and Dagenham was ranked 11th highest out of the 32 boroughs in London (excluding City of London). The rate of total domestic and sexual violence offences in 2021/22 was 17.3 offences per 1000 in Barking and Dagenham, the highest rate in London.

Violence against person was one of the highest reported crime categories during 20/21, ranked the 14th safest out of the 32 boroughs in London.

Knife crime is particular concern across London due to the increasing number of offences year on year from 2015/16 to 2019/20. Barking and Dagenham ranked 16th lowest in London in relation to number of knife crimes.

Health and social care services have a significant contribution to make in taking a public health approach to reducing violence, as part of a comprehensive multi-agency response to identify and support vulnerable residents from being involved and being impacted by violence in all forms and crime more generally.

Recommendation 31: Health and Social Care Partners should participate in Community Safety Partnerships and contribute to the delivery of agreed plans and strategies, taking a public health approach - focusing on areas of highest concern .

The pandemic demonstrated the importance of digital connectivity e.g., in allowing a proportion of the population to work from home, children to participate in education while restrictions on face-to-face learning were in force, families to keep in contact with loved ones via zoom and patients to access health care advice. However, it was equally clear that some of the population were excluded due to unaffordability and/ or lack of skills. This will remain an important barrier for many as we recover from the pandemic e.g., online applications are the usual means of accessing state benefits and job opportunities and digital competence is often a pre-requisite to access education and skills development. Residents with sensory and physical

disabilities may be particularly at risk of digital exclusion[82]. Although moving many support services online has meant that many harms e.g., domestic abuse, may have remained hidden.

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

Social networks with family, friends, work colleagues, neighbours etc can mitigate some of life's challenges and setbacks e.g., ill-health, relationship breakdown, job loss, experience of crime etc. Some groups and communities may be less likely to have strong networks and hence less resilient.

New housing developments or areas with a high level of population churn (see section 2.1) because of having more rental property, particularly HMOs, are likely to have a higher proportion of residents with weaker social networks.

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

ONS[83] have identify three distinct cohorts as being more likely to self-report loneliness:

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

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

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

At community level, Barking and Dagenham Council has community hubs to support the borough's most disadvantaged communities. In Barking, these are Gascoigne Children's Centre, Sue Bramley Community Hub, Barking Learning Centre and the Marks Gate Community Hub. In Dagenham there are four hubs; Becontree Children's Centre, Leys Children's Centre, Dagenham Library and the William Bellamy Community Hub[84]. The community hubs are designed with the community, with the intention of improving access to statutory services and support from the community and voluntary sector in the expectation that the timelier provision of advice and support, closer to home, will help stop problems escalating to crisis point. As such, community hubs shift the focus towards prevention and away from more costly and intrusive intervention by statutory services in response to a significant deterioration or crisis. To this end, the hubs provide an information service across the wider determinants of health including debt, housing, work, education as well as health and social care services and access to immediate support including a community food shop, access to computers and the

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

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

[84] The London Borough of Barking and Dagenham – Children's Centres (https://www.lbbd.gov.uk/childrens-centres)

internet alongside training and skills opportunities. Community hubs complement the 1:1 support provided by local area coordinators to individual residents. The borough also has a dedicated Family Information Service (FIS) which provides free, confidential, impartial guidance on childcare[85].

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

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

A variety of harms to the physical and mental health of residents have been reported subsequently e.g., increased levels of obesity and sedentary behaviour (see section 5) and poorer mental health (see section 7.3.3).

The Government is now signposting a return to normality in COVID-19 Response: Living with COVID-19[86].

However, there is considerable evidence that residents have not returned to pre-pandemic patterns of work and leisure and therefore, social interaction. Google's mobility data[87] shows how resident activity in various sectors has changed compared to their pre-pandemic baseline.

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

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

Source: COVID-19 Community mobility reports

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

[85] The London Borough of Barking and Dagenham – Family Information Service (https://www.lbbd.gov.uk/family-information-service)
[86] https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19
[87] COVID-19 Community Mobility Reports (google.com)

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

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

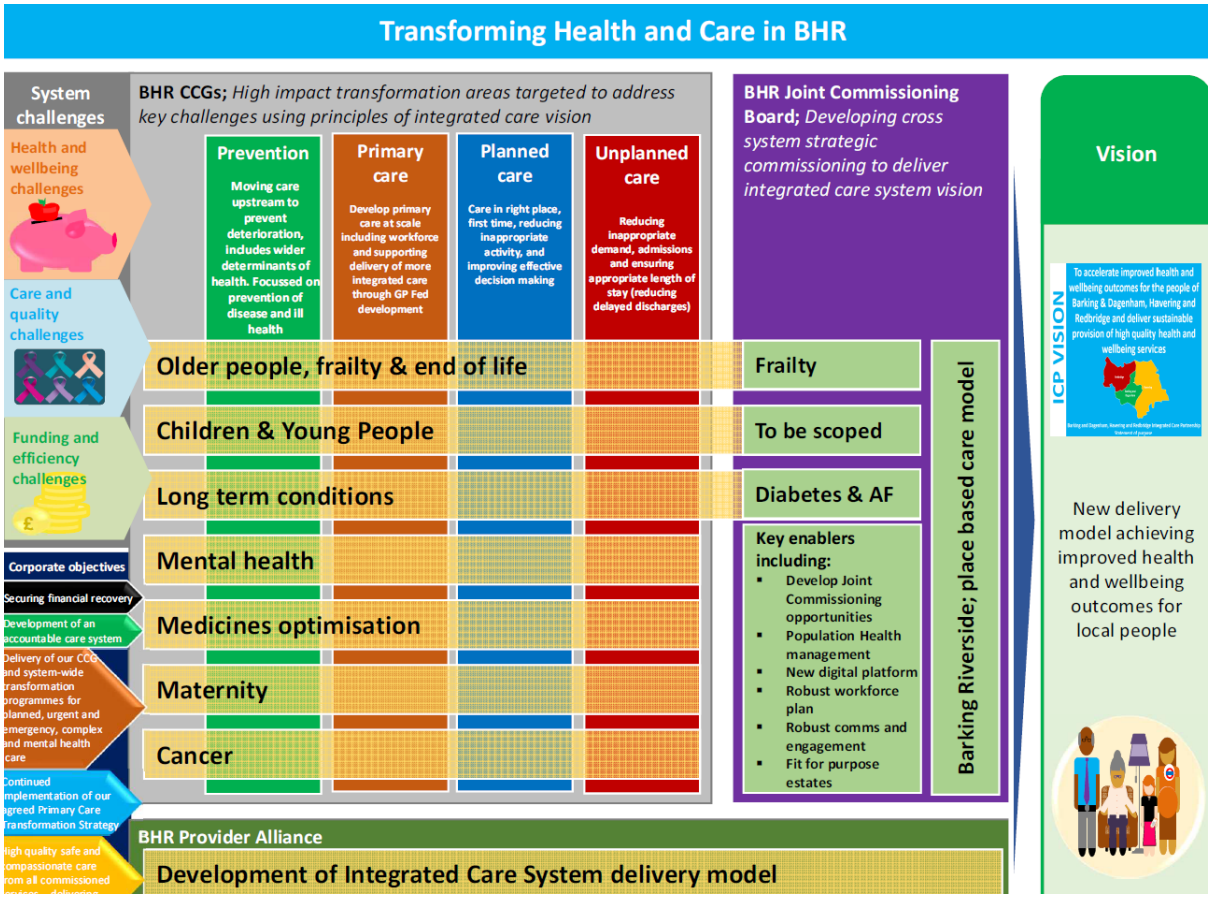
Outside of work, people who were particularly hard hit by the pandemic or who were thought to be particularly at risk e.g., residents who were asked to shield, may require more time and / or reassurances before they fully re-engage with the community. Until then, they will remain more isolated than otherwise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

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

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

7. Pillar 4: 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 11,300 live births to women resident in the three BHR boroughs in 2019. 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 residents 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)[88], 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.

The National Institute for Health and Care Excellence (NICE) recommends antenatal booking by 10 weeks of pregnancy[89]. This is an opportunity to gather the information needed to support a healthy pregnancy. Women booking after 20 weeks are considered a much higher risk as the opportunity for early screening to identify risk factors, such as infectious and inherited diseases, has passed. Data from the Maternity Services Dataset (MSDS) for 2018/19 shows that across BHR that 6,290 women (51.1%) had their booking appointment with a midwife within 10 completed weeks of their pregnancy. Less than half of Barking and Dagenham and Redbridge pregnant women had a 10-week booking, a trend noted across

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

London at 47.8%. 58.6% of pregnant women in Havering had a midwife appointment within 10 weeks - outperforming BHR, London and National comparators.

Table 6: Midwife appointment within 10 weeks

	NUMBER OF WOMEN WHO HAD AN APPOINTMENT BOOKED WITHIN 10 WEEKS OF THEIR PREGNANCY	10-WEEK BOOKINGS AS A % OF THE TOTAL NUMBER OF PREGNANCY BOOKINGS IN THE PERIOD
LBBD	1,865	47.6%
LBH	2,055	58.6%
LBR	2,370	48.5%
LONDON	57,400	47.8%
ENGLAND	377,235	57.8%

Source: Maternity Services Dataset (MSDS) v1.5

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

BOROUGH	TOTAL BIRTHS (RATE)	STILLBIRTHS (RATE)	NEONATAL DEATHS*
LBBD	3,406 (15.9)	20 (5.8)	12
LBH	3,116 (12.0)	7 (2.2)	5
LBR	4,343 (14.2)	27 (6.2)	7
LONDON	111,688 (12.4)	485 (4.3)	285
ENGLAND	585,195 (10.3)	2,231 (3.8)	1,674

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

*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

***The number of stillbirths and deaths under 28 days, per 1,000 live births and stillbirths (The number of stillbirths and deaths under 28 days, per 1,000 live births and stillbirths).

Smoking is a risk factor for stillbirth and neonatal death. The number of mothers known to be smokers at the time of delivery as a percentage of all maternities with known smoking status. A maternity is defined as a pregnant woman who gives birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in a NHS hospital in 2019-20 in: LBBD (7%), LBH (7.7%) and LBR (4.2%) is significantly lower than the national average (10.4%). Rates in LBBD and LBH having improved significantly in recent years, however they are considerably higher than the London average (4.8%).

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

ASPECT OF CARE	PATIENT RESPONSE	COMPARED WITH OTHER TRUSTS
LABOUR AND BIRTH	8.7/10	About the same
STAFF	8.4/10	About the same
CARE IN HOSPITAL AFTER THE BIRTH	7.8/10	About the same

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

The benefits of breastfeeding are clear[90] 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[91]. 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.

In the London Borough of Barking and Dagenham, there were 3,395 domestic abuse offences – a rate of 16.5 per 1,000 population, the highest of all BHR boroughs. Domestic abuse incidents are also higher at 5,460; a rate of 26.5 per 1000.

	LBBD		LBH		LBR	
	Count	Rate per 1000	Count	Rate per 1000	Count	Rate per 1000
DOMESTIC ABUSE OFFENCES	3,395	16.5	2,560	10.2	3,121	10.4
DOMESTIC ABUSE INCIDENTS	5,460	26.5	4,393	17.5	5,019	16.7

Source: MOPAC Domestic and Sexual Violence Dashboard

Across every ward in Barking and Dagenham, Havering and Redbridge, Abbey ward in Barking and Dagenham has both the highest count of domestic and violence offences (273) and domestic violence incidents (419).

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

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

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

Recommendation 38: *Continuously improve maternal safety including by full implementation of the second version of the Saving Babies' Lives Care Bundle and 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 39*: Improved quality of postnatal care for all women including enhanced support to vulnerable women (e.g., perinatal mental health, drug and substance misuse) and focusing on infant feeding.*

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

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-natal, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies.

Impact of Covid

- The pandemic resulted in reduced NHS and community based/peer face to face support to pre- and post-natal parents. Therefore, the role of health visitors and third sector organisations is even more vital. The support needs could also include wider concerns relating to cg job insecurity, reduced income and general anxieties caused by the pandemic
- Late presentation due to anxieties about utilising health services may have also impacted on the health of the mother and baby. This would need review
- It has been reported that domestic violence has also risen during the pandemic, particularly during the periods of lockdown, and although it is not known if this has specific concern for pregnant women, maternity services are an ideal opportunity to identify those who would benefit from further support

- Covid-19 vaccine uptake of two vaccines by pregnant women reported on 20th October 2021 was 28.16% (B&D) 40.33% (Redbridge) and 43.05% (Havering). 4.2% (B&D) 5.55% (Redbridge) and 2.9% (Havering) women declined the offer. 36.17% (B&D) 25.07% (Redbridge) and 17% (Havering) had a no coded invite.

A Maternity Services Equity and Equality needs assessment was recently prepared by North East London Local Maternity System (November 2021).

The assessment offers equity and equality finding for health outcomes, community assets and staff experience.

Key findings are covered in appendix 5(b) (full report can be found here: PowerPoint Presentation (eastlondonhcp.nhs.uk)).

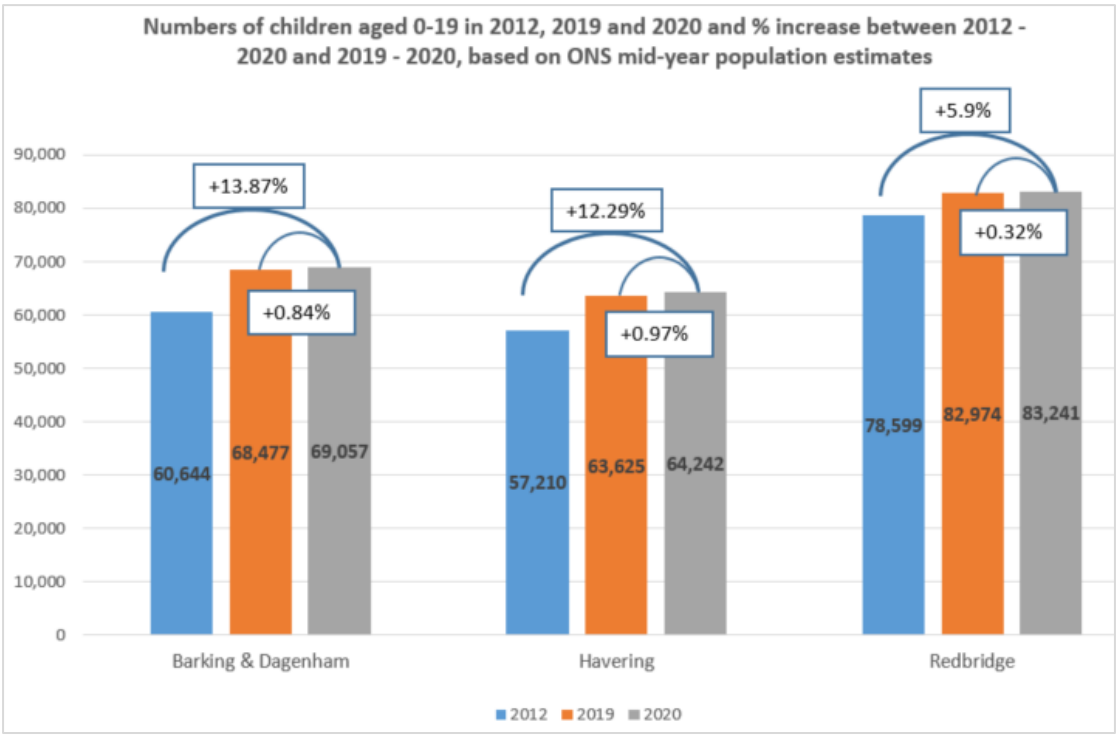
7.2 Children & Young People

**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, and high numbers, of children and young people, with 32.2% and 27.2% of the resident population aged 0-19 years respectively. LBH has a smaller proportion of CYP aged 0-19 years (24.6%) but has experienced the greatest relative change in recent years, requiring existing services to expand rapidly to meet increasing demand (Figure 20).

Figure 20: Number of children aged 0-19 and % increase up to 2020



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). Mid-year population estimates for 2021 indicate that 74.6% of LBH total population is white British, compared to 32.7% in LBBD and 23.8% in LBR. Roughly one quarter of the local population in LBBD are Black/Black British and another quarter Asian/Asian British, whilst LBR has a predominantly Asian population, roughly half of the residents.

Recommendation 41: Boroughs will need to ensure that cultural competence is integral to the development of future services to meet the changing needs of the population. To reduce potential inequities in access to local services, cultural appropriateness of services, and English as a foreign language, should be considered in translating appropriate information and signposting to services.

The growth in child numbers has been driven by the relatively high general fertility rate (GFR) in all three boroughs – higher than the average GFR for London (Appendix 3) and by children moving into the patch from elsewhere[92]. 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.

Recommendation 42: The Transformation Boards 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 and proportionate to 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. Following changes introduced in the Children and Social Work Act 2017 and the subsequent Child Death Review Statutory and Operational Guidance 2018, the three Local Authorities (LBBD, LBH, LBR) and Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group (BHR CCG) agreed to strengthen local working and develop a new Child Death Review (CDR) system. The Barking and Dagenham, Havering and Redbridge Child Death Overview Panel (BHR CDOP) began work in October 2019, putting processes in place across the BHR system to comply with the guidance and embedding the use of e-CDOP. This has resulted in a more robust review of child deaths, which allows identification of local patterns regarding cause of death, underlying modifiable factors and monitor trends over time.

The death of a child is thankfully a relatively rare event. The risk of death is greatest in the first year of life often linked to prematurity and / or congenital problems. Infant mortality rates for the period 2018-2020 in all three boroughs are similar to the national average, ranging from 2.3 per 1,000 in LBH to 2.8 per 1,000 LBR and 3.9 per 1,000 LBBD[93] . Between 2019 and 2021 the BHR CDOP was notified of a total of 103 deaths, of which 48 were reviewed by the CDOP.

[92] Havering data source: https://www.haveringdata.net/wp-content/uploads/jsna/this_is_havering/201819_Havering-Demographic-Profile-v4_2.pdf
[93] PHE Fingertips (2021) https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133228/pat/6/par/E12000007/ati/302/are/E09000016/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

Such reviews provide the means of systematically identifying opportunities to prevent future deaths e.g., by improvements in health care services or public health action.

Recommendation 43: *Lessons learned through the CDR process should be shared with the Maternity and CYP Transformation boards, who may consider how to incorporate priority improvements to the health and social care system in their respective work plans.*

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, and 5th most deprived upper tier local authority in England[94]. LBH and LBR have lower levels of disadvantage overall but focused in smaller areas; LBBD has 4 LSOAs which fall into the first (most deprived) decile on IMD rankings and LBH has 1 LSOA in the first decile (LBR has none). The proportion of children affected by income deprivation varies in a similar fashion from 23.8% in LBBD (13.1K children) to 16.0% in LBH (7.7K) and 13.7% in LBR (9.3K) (Appendix 3). The percentage of children living in relative low-income families is highest in the most deprived wards[95]:

The Covid-19 pandemic is also likely to have had a **disproportionate impact** on families. Those families who experienced greater levels of disadvantage before the pandemic are therefore likely to have been more severely impacted by the pandemic, exacerbating their existing inequalities; data is still emerging on these issues.

School closures are likely to have disrupted access to the social care protection that the school environment provides. Children from disadvantaged backgrounds, BAME ethnic groups, children of lone parents or parents who are key workers are most likely to have been disproportionately affected. In LBBD 23.5% of households are lone parent, compared to 18.1% in LBR and 14.1% in LBH[96].

Whilst younger children may not have been as directly affected by Covid-19 infection as older adults, there is national evidence of an impact on their mental health and wellbeing, and disruption to education. Children and young people who are disadvantaged economically, teenage girls and youths with pre-existing mental health problems are associated with worse effects to their mental health and wellbeing as a result of the pandemic[97]. More comprehensive local data needs collecting to assess the ongoing impact of the pandemic on health and wellbeing of disadvantaged groups.

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

[95] Data Intelligence Hub Deprivation Reports https://www.haveringdata.net/deprivation/report/view/bd0a5ebe1b4f41428c04a05ccd26dc80/E05000319/)

[96] ONS (2021) Data for LBBD, LBH and LBH for 12 months to September 2021. https://www.nomisweb.co.uk/

[97] HM Government (2021). Covid-19 Mental Health and Wellbeing Suveillance Report. Chapter 7: Children and Young People. https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/7-children-and-young-people

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. However, the take-up of funded early education places by eligible 2-year-old children in 2021 has decreased by around 2% from 2018 in LBBD and LBH, with the largest reduction in take-up seen in LBR (12% reduction). This is likely due to the impact of the pandemic on nursery closures, discussed further below. In 2021, take up of places for 2-year-old children remained relatively higher in LBBD (76%) than LBH (54%) or LBR (45%). The take-up of 3–4-year-old places across the three boroughs is more evenly spread at 84% in LBBD, 90% in LBR and 89% in LBH, although again there has been around a 2-5% reduction in take up since 2018[98].

Preschool and nursery closures during the Covid-19 lockdown had wider impacts on parents' ability to work and the additional pressure home schooling placed on parents was exacerbated for those living alone with children. Women are more than twice as likely to be key workers as men. In addition, parents were more likely to be key workers than non-parents, with 39% of working mothers employed as key workers before the crisis began, compared to 27% of the working population as a whole. During the first lockdown, only a third of childcare providers remained open nationally and fewer than 100,000 children nationally attended on any given day[99].

A study conducted in October 2020 by Ofsted in 208 **early years providers** and maintained nursery schools found that the pandemic had significantly impacted the **learning and development** of children who had left and subsequently returned[100]. They were particularly concerned about children's personal, social and emotional development. Some children had returned less confident and more anxious. In some cases, children had also become less independent, for example returning to their setting using dummies or back in nappies having previously been toilet trained.

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

Separate **assessments** are undertaken in early years settings and by health visitors (ASQ3) at age 2 – 2 ½ years. These reviews provide opportunities for health visitors and families to assess the child's physical, social and emotional needs, identify any potential issues or developmental delays early and enable support to be provided as early as possible. Undertaking these

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

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

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

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. The last available data regarding the proportion of children receiving an ASQ3 review is shown below in the section regarding health visiting services (Section 7.2.6, Table 4). 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 45: Increase joint assessments by early years settings and health visitors. HV teams are recommended to implement a failsafe follow up procedure to capture all children eligible for the 2-year offer.

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

School readiness is measured at the end of the reception year to determine the level of development in 4–5-year-olds against the Early Years Foundation Stage (EYFS) learning goals. The last available data (2018-19) showed that at the end of reception year, the majority of children are assessed as having a good level of development. The proportion who achieved this good level of development in LBBD (72.4%) and LBH (71.7%) is similar to the England average (71.8%); the proportion in LBR (75.6%) 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.

In addition, there is a gender inequality for the percentage of children achieving a good level of development at this time, with fewer boys than girls achieving this level of development. The gap is highest in LBBD (14.9 percentage points difference), with a difference of 11.0 and 11.1 respectively in LBR and LBH.

Unfortunately, the statistics release for the Early Years Foundation Stage Profile results in England for 2019-2020 and 2020-2021 were both cancelled. This was primarily as a result of school closures during Covid lockdowns compromising the established data collections. Local data collection for school readiness will be an important indicator for recovery.

Recommendation 47: Schools, HV and EYFS providers to work together to improve the percentage of children achieving at least expected level across all learning goals, and those achieving a good level of development. Consider an additional focus on the gender difference in school readiness.

Throughout the pandemic the Health Visiting providers across all three boroughs have experienced significant challenges in maintaining their ability to deliver the 2-2 ½ year checks. This has included lockdown impacting on ability to deliver face to face checks, and NHS staff redeployment to delivering vaccination which has reduced staff capacity. This is also the case nationally where respondents to an NIHR funded survey in June 2020 reported that Health visitors appeared to have experienced the highest level of redeployment to provide Covid care or vaccination across four professional groups including midwives, HV, community paediatricians and social workers[101].There is currently a lack of data in 2-2½ year checks due to issues in data quality; many of the checks were conducted remotely rather than in-person and were reliant on parents self-assessing their child.

Recommendation 48: Ensure 2-2 ½ year checks are delivered face to face, in partnership with early years staff, to ascertain current level of development need in school readiness. 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 need requiring timely assessment and care from relevant specialist health care services.

GCSE Attainment for 2019/20, as measured in terms of average attainment 8 score, is similar to the national average (50.2 mean score) in LBBD (50.1) and significantly better than national in LBR (56.0) and LBH (52.2). Equivalent scores for children in receipt of free school meals are lower, particularly in LBH (34).

Recommendation 49: As part of a comprehensive approach to building greater aspiration and educational 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 or whose activity is not known; 2.9% in LBH and 3.1% in LBR.

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

[101] UCL/University of Oxford/NIHR (2020) https://www.ucl.ac.uk/children-policy-research/sites/children_policy_research/files/the_impact_of_the_covid-19_pandemic_on_services_from_pregnancy_through_age_5_years_interim_report_june_2020_0.pdf

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). By July 2021, there were 314 households in LBH assessed as threatened with homelessness, or homeless, of which 49% were families with dependent children. In LBBD and LBR there were 219 and 32 households at risk of or homeless respectively, of which 58% and 60% were families with dependent children.

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%).[102]

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.

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

There has been a noticeable change in use of digital media throughout the pandemic and providing digital connectivity has been essential to provide some services. 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[103].

One lifestyle related risk factor that is 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 2 by age 11 at Year 6 (Table 9). Although a full data collection was made through the National Child Measurement Programme (NCMP) in 2019-2020, due to the restrictions imposed by COVID, a representative 10% sample was taken for the academic year 2020-21. The results for the 2020-21 year are therefore less robust. Nevertheless, the percentage of those overweight and obese remain high. Whilst the NCMP is a surveillance too, not a screening tool, children who are measured as above or below the healthy weight range should be offered appropriate support, such as through healthy schools' approaches or evidence-based weight management services.

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

[103] 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'

Table 8. Indicative Prevalence of overweight (including obesity) by school year and borough (unpublished 2020-2021 data).

Prevalence of overweight (including severe obesity)	LBBD	LBH	LBR
Reception	12.9%	10.1%	11.2%
Year 6	52.7%	24.3%	41.7%

Recommendation 51: *Boroughs to review and refresh their obesity strategies and consider options to implement Tier 2 and Tier 3 weight management approaches for CYP*

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.

7.2.5 Community and place

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

Recommendation 52: *Encourage and support early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the relevant HEYL/HSL scheme or similar.*

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[104].

***Recommendation 53: Utilise the Borough Partnership approach to** 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'** (ACEs) is one way of describing these negative factors.

UK studies[105] have suggested a simple dose/ response relationship between the number of ACEs experienced and the number and type of risky health behaviours engaged in, the social and community impact and impact on use of services as a result of these risky behaviours (Table 9).

Table 9. Likelihood of children with 4 or more ACEs engaging in risky behaviours and the impact on services by the consequences of those behaviours.

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

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: -

- **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.

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

- **Early intervention** - effective safeguarding arrangements, identification and effective family focused treatment of parental MH and drug and alcohol problems; support for victims of domestic violence.
- **Mitigation** in support those affected – trauma aware services; Child and Adolescent Mental Health Services (CAMHS) and Youth Offending Services (YOS).

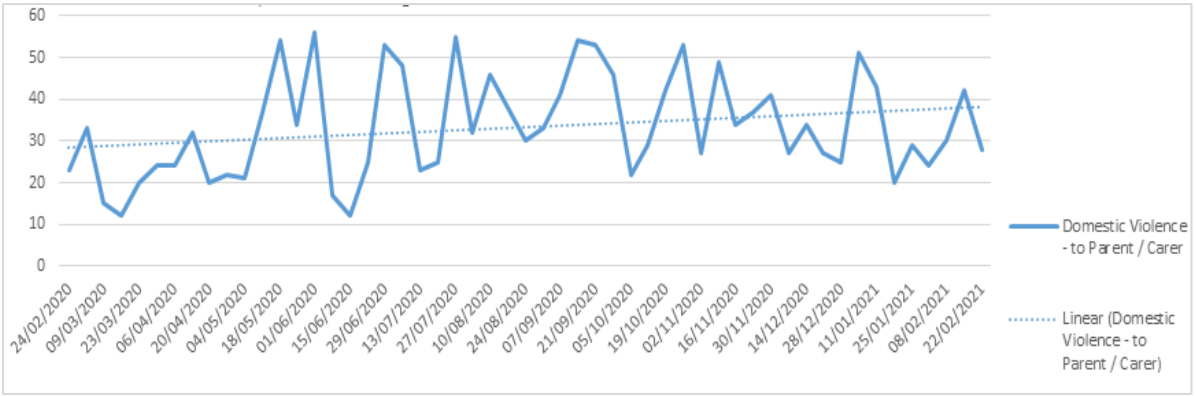
LBBD, for example, is continuing to work with the Early Intervention Foundation to better protect children from harm.

Recommendation 54: *Put in place 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.*

Impact of the Covid-19 Pandemic on ACEs

The stresses and strains of lockdown, illness, bereavement, coping with young children at home, whilst furloughed or experiencing a significant drop in income has also led to increased reports of domestic violence. Havering saw a 35% increase in the number of parents/carers reporting domestic abuse over the course of 2020, and pregnant women are more at risk of such violence (Fig 3.1.3). Nationally, data from the Ministry of Justice reports that calls for help via domestic abuse helplines and webchats/online support increased by 52% compared with pre-covid levels[106].

Figure 21. Number of Domestic Violence Reports in Havering by Parent/Carer February 2020 to February 2021



Reduction in income has also led to increased levels of food insecurity. Over the course of the pandemic, 5 million people in the UK living in households with children under 18 have experienced food insecurity since the lockdown started. 1.8 million experienced food insecurity solely due to the lack of supply of food in shops, leaving 3.2 million people (11% of households) suffering from food insecurity due to other issues such as loss of income or

[106] Ministry of Justice (2020) Ministry of Justice Silver Command data: Domestic abuse and sexual violence demand reporting. Unpublished data.

isolation[107]. This is double the level of food insecurity among households with children reported by the Food Standards Agency in 2018 (5.7%).

Safeguarding vulnerable adolescents from harm must be a priority for all partners (& is discussed further in section 7.2.7 below). The threat may come in many forms. Serious youth violence is an ACE of major concern, which has sadly resulted in the deaths of young people in each of the BHR boroughs. In some instances, violence is gang related. Criminal gangs may also involve vulnerable young people in the supply of drugs in 'county lines' operations. Young people are also at risk of sexual exploitation from individuals, organised groups and other young people. Still others may be at risk of involvement in religious or politically inspired hate crime. Alongside a vigorous criminal justice response, a public health approach is recommended to tackle serious youth violence.[108]

A Public Health approach has 6 broad criteria:

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

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

Recommendation 55: *Capitalise on relationships built through the Borough Partnerships to embed a public health approach to tackling serious youth violence focusing on adverse childhood experiences and addressing risk factors for gateways to youth crime.*

Youth offending - Contact with the Youth Criminal Justice System is an indicator of how crime can have a wide-ranging effect on people's health and wellbeing. Data from 2018/19 and 2019/20 showed that both LBBD and LBR had a rate of first-time entrants to the youth justice system significantly higher than the rate for England (377 and 280 per 10,000 respectively). Havering's rate was significantly better than England (at 183 per 10,000). However, the rate of youth justice custodial sentences and overall youth proven offending rate were significantly worse (higher) in all three boroughs than England (Appendix 6, refs 27 & 28). A significant proportion have significant mental health problems that maybe unrecognised and / or inadequately managed; in England, 72% of children in the youth justice system were assessed as having mental health concerns[109].

[107] Food Foundation (2020) https://foodfoundation.org.uk/new-food-foundation-survey-five-million-people-living-in-households-with-children-have-experienced-food-insecurity-since-lockdown-started/
[108] https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence
[109] Gov.UK (2021). https://www.gov.uk/government/statistics/youth-justice-statistics-2019-to-2020

Teenage parents have poorer outcomes e.g., in terms of educational attainment, employment and earning power than peers who have children later in life. Their offspring are more likely to be raised in poverty with impacts on their life chances – hence teen pregnancy serves to transmit disadvantage from one generation to the next. 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[110] and yet uptake is falling and cases of vaccine preventable disease notably measles are on the increase. Uptake rates have reduced in the majority of primary childhood vaccinations by age 5 years in both LBBD and LBH (Table 10.) 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[111].

Table 10. Percentage uptake of primary vaccinations by age 5 years in 2020-21 compared to pre-pandemic levels 2018-19 by local authority

Borough	Year	DTaP/IPV/ Hib	DTaP/IPV booster	MMR1	MMR2	Hib/MenC
LBBD	2018-19	*93.8*	*72.0*	*92.1*	*73.3*	*90.4*
	2020-21	*92.5*	*69.0*	*89.6*	*69.8*	*87.9*
LBH	2018-19	*96.7*	*82.2*	*95.1*	*83.9*	*94.2*
	2020-21	*96.0*	*79.2*	*93.8*	*79.7*	*92.9*
LBR	2018-19	*91.8*	*69.0*	*89.9*	*71.5*	*87.1*
	2020-21	*90.7*	*70.1*	*88.4*	*71.5*	*86.3*

Recommendation 56: *Review the delivery of childhood immunisation in BHR with the aim of increasing uptake to levels necessary to achieve herd immunity, including Covid vaccinations for 12–15-year-olds and 5–11-year-olds if and when approved by Government.*

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.

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

Delivery of the 5 mandated checks across BHR is variable (Table 4.)[112]. As a result, opportunities to offer advice about issues of concern and identify families needing additional support are missed.

Table 11. Delivery of 5 mandated checks 2019-2020

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

Recommendation 57*: Work with providers common to the patch to recover from the impacts of Covid and improve delivery of mandated early years checks as a priority.*

Health visiting, early years services, nurseries and schools play a vital role in safeguarding children and reduced access to school, youth workers or other key points of contact for children during the Covid-19 pandemic and lockdowns may have led to increased vulnerability in children, particularly exploitation through gang associated activities, domestic abuse, online abuse or sexual exploitation.

The pressure on community services has been immense, both to maintain face to face contact to complete the mandated early years checks and keep up with caseload increases in highly challenging circumstances.

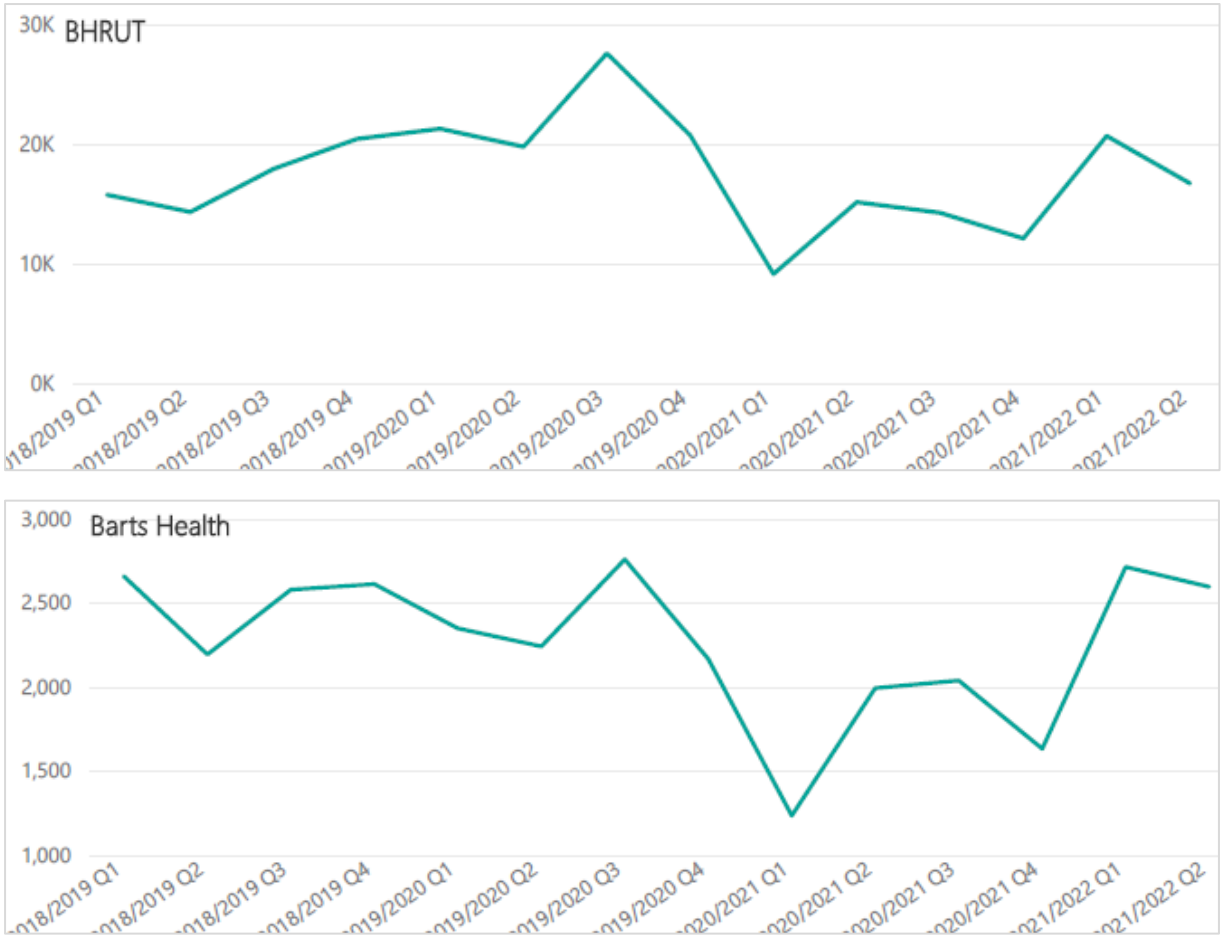
The 2021 Annual Report of the Institute of Health Visiting showed that 80% of respondents to their survey (completed in October 2021) reported an **increase in domestic abuse**, 72% reported an **increase in poverty affecting families** and 71% reported an **increase in child safeguarding** cases. In LBH, for example, the number of initial child protection conferences attended by HVs increased from a total of 18 for April 2019 to March 2020; to 30 by the end of March 2021. In the first 2 quarters of 2021-22 (end September 2021) there have already been 50 initial CP conferences attended. Similarly, caseloads in LBH have increased from 595 per HV in June 2019 to 615 per HV by October 2021 despite significant investment to increase the numbers of HV staff. Staff shortages have been affected by redeployment to vaccination services, sickness, isolation and a number of staff reaching retirement age accompanied by shortages of new recruits to the service.

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

Recommendation 58: *Health Visiting, School Nursing and Early Years staff are critical in the wellbeing of children and young people and early prevention of avoidable illness. CYP Transformation Boards and Local Authority Commissioners are recommended to prioritise review of these services to ensure they are fit for purpose. Seeking service user feedback and reporting findings to Commissioners will help facilitate any changes required to the delivery of the service.*

Access to primary care as a first contact point is essential, especially to avoid inappropriate attendance at secondary care service. During lockdown (Q4 2019-20) attendance at A&E dropped significantly due to the pandemic at both major hospital trusts in NEL – BHRUT and Barts Health (Fig. 3). However, this returned to baseline levels by Q2 2021-22 (July to September 2021), suggesting both that the need for urgent care is still there, and that secondary care access may be the preferred choice of parents.

Figure 22. A&E attendances by patients aged under 18 years old at local secondary care providers (BHRUT and Barts Health) Q1 2018-19 to Q2 2021-22



F.Year	2018/2019				2019/2020				2020/2021				2021/2022	
Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
BHRUT	15,679	14,244	17,846	20,345	21,195	19,693	27,493	20,652	9,066	15,063	14,178	12,036	20,592	16,633
Barts	2,654	2,190	2,575	2,608	2,345	2,238	2,755	2,163	1,232	1,990	2,035	1,630	2,710	2,592
Total	**18,333**	**16,434**	**20,421**	**22,953**	**23,540**	**21,931**	**30,248**	**22,815**	**10,298**	**17,053**	**16,213**	**13,666**	**23,302**	**19,225**

Across NEL, rates of A&E attendances for children under 1 year old are significantly higher than England rates (957.4 per 1,000 persons) in LBR (1038 per 1,000) and similar in LBBD (983.2 per 1,000) and LBH (951.0 per 1,000)[113].

Recommendation 59*: Statutory agencies to work in partnership with CCG, Early Years partners and children's centres, and build on the development of the Paediatric Integrated Nursing Service (PINS) to increase access to primary care services.*

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 60: *The CYP Transformation Board should consider how best to support the development of joint working for better safeguarding as a priority workstream, ensuring staff across the ICS are clear on relevant pathways for raising and acting on safeguarding concerns.*

The primary purpose of child protection arrangements is 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[114].

[113] PHE/UKHSA Fingertips (2022) Rates of A&E attendances under 1 year 2018/19 data https://fingertips.phe.org.uk/indicator-list/view/iYi2ex7my0#page/0/gid/1/pat/6/par/E12000007/ati/302/are/E09000002/iid/90809/age/28/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

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

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.

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.

About 1 in 10 children and young people have SEND; reported rates in LBBD (14.5%) LBH (11.0%) and LBR (11.8%) are lower than the England average (14.4%).[115]

Delivery of the required help can involve contributions from schools, children's social care and NHS services (e.g., therapies, community paediatrics, CAMHs etc.). Complex care is captured in an Education Health Care Plan specifying the support needs of individual young people up to the age of 25 to achieve what they want in their life. The percentage of CYP in need with statements of SEN or an EHC Plan varies considerably across the patch - LBBD 7.5%, LBH 36.7%, LBR 54.0. In total, just under 4000 children and young people in BHR have an EHCP or statement.

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

Recommendation 61: *CYP transformation board and local based placed partnerships 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 and closer to home wherever possible.*

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[116].

[115] 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
[116] Green et al 2005

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

Recommendation 62: *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[117]. Rates of hospital admission for self-harm in all 3 BHR boroughs are less than half the national average. Amongst 10–24-year-olds, rates of hospital admissions as a result of self-harm per 100,000 are 166 in LBH, 136.2 in LBBD and 126.2 in LBR, However, hospital admission captures only a small proportion of cases. Data about attendances at A&E would give a better measure of the incidence of self-harm. Systems to follow up people attending A&E with self-harm are an element of robust suicide prevention plans.

Recommendation 63: *ICS partners to*

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

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

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

[117] 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.

average in all 3 BHR boroughs (See also section 7.2.6 above). Improving the management of minor illness and injuries is a high impact area for health visiting services.

Recommendation 64: *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 (192/100,000) in LBR (238/100,000), and similar in LBBD (235/100,000) and LBH (190/100,000). However, young people have died from asthma in all three boroughs in recent years and the system has developed a detailed improvement plan in response to a Regulation 28 Letter from the local coroner following the inquest into one of these deaths.

Recommendation 65: *CYP Transformation Board, and Borough Partnerships to prioritise and consider how best to implement 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

> 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.

While the great majority of people will experience problems with their mental wellbeing at some point in their lives, prevalence of poor mental health disproportionately affects those who experience other disadvantages. Wider determinants such as: poverty (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) all play a major part in mental health and wellbeing[118]. Whilst people from all walks of life can be affected at any point in their lives, there are groups who are more at risk of poor mental health, for example1 in 5 of older people living in the community and 40% of older people living in care homes are thought to be affected by depression, and as many as nine out of ten people in prison have a mental health, drug or alcohol problem.[119]

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 more than 108K people with a common mental health problem living in the three BHR boroughs.
The GP recorded prevalence of depression for adults in each of the three boroughs is below the national average which may indicate unidentified need, particularly in LBBD and LBR where recorded prevalence is lowest. Almost 52k people across BHR are known to have depression.

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

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.[120]

Mental health problems are more common among people who are lesbian, gay, bisexual, trans, intersex, queer or questioning (LGBTIQ+).[121]

[118] PHE Guidance: Wellbeing and mental health: Applying All Our Health Updated 28 August 2019
[119] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[120] https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities
[121] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-lgbtiq-people

Studies suggest that the rate of mental health problems in people with a learning disability is double that of the general population.[122]

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.[123] Many people who sleep rough have co-occurring mental ill health and substance misuse needs, combined with physical health needs and past experience of significant trauma.

Perinatal disorders are associated with increased risk of psychological and developmental disturbances in children.[124] It is estimated that between 1.3k and 2.7k of women in BHR experience adjustment disorders and distress in the perinatal period, and 273 women in BHR experience post-traumatic stress disorder as a result of traumatic events during labour or childbirth.

Prevalence of recorded dementia in BHR is two-thirds of that in England; almost 5k of registered patients have dementia. Evidence suggests that up to 40% of all cases of dementia are linked to modifiable lifestyle factors, but just a third of UK adults think it is possible for people to reduce their risk. Women are less likely than men to think it's possible (30% compared to 37%).[125] Smoking is one of the biggest risk factors and can double individual risk.[126]

7.3.2 Harm caused by mental illness

People with severe mental illness die on average 10 - 20 years sooner than the general population[127]. Cardiovascular disease, respiratory illness and cancers are the main causes of the observed gap in life expectancy, in part due to the very high prevalence of smoking (and heavier smoking) amongst people with mental health problems[128][129]. Over 1,700 people across BHR are recorded as smokers with SMI. Some of the drugs used to treat SMI can cause obesity and thus increase cardiovascular risk.[130]
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).[131]

[122] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/mental-health
[123] https://publichealthmatters.blog.gov.uk/2019/09/30/health-matters-rough-sleeping/
[124] Steain, A et al (2014) *Effects of perinatal mental disorders on the fetus and child*
[125] Alzheimer's Research UK *Public attitudes towards dementia*
[126] National Government (2018) *Dementia: applying all our health*
[127] 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
[128] Kings Fund (2014) *Smoking and severe mental ill health*
[129] ASH (2019) *Factsheet: Smoking and Mental Health*
[130] NHS England (2019) Achieving more for people with severe mental illness
[131] JSNA Chapter 3 Population Health Outcomes

7.3.3 The impact of the pandemic on mental health

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

A national study observed that depression and anxiety levels were greatest during lockdowns, reducing when lockdowns were eased, although symptoms increased over Christmas 2021 and on a par with levels during lockdown at the start of 2021. This was driven by concerns about catching Covid-19, as well as concerns about finance. Working age adults were twice as likely to report concerns as older adults.[132] Further common causes for worry were being separated from friends and family, being unable to cope with uncertainty, how the mental health of one's own children will be affected by the pandemic, and making one's existing mental health problems worse.[133]

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

7.3.3 Use and outcomes of local mental health services

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

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

Rates of mental health admissions to hospital across BHR are lower than the national average. In total, there were 135 mental health hospital admissions in 2019/20.
The rate of people subject to the Mental Health Act in Q2 2019/20 is lower in LBH Compared to England; rates in LBR and LBBD are similar, 240 people across LBR during the quarter. It is unknown how many are repeat episodes.

The proportion of patients in concurrent contact with mental health services for substance misuse in LBBD is similar to the national average but much lower in LBH and LBR.

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

The percentage of people in contact with mental health services with a diagnosis or provisional diagnosis recorded Q2 2019/2020 is far below the averages for London (21.9%) and England (30%); B&D 8.9%, LBH 8.6%, LBR 7.3%. 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. Issues with mental wellbeing are an almost universal experience at some point in life. Self-help information and aids have been brought together by the NHS under the 'Every Mind Matters' banner, providing useful advice about how to cope with low level mental health issues.

Recommendation 66: Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.

Recommendation 67: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience, including by making use of 'Every Mind Matters' resources and self-help aids; giving particular consideration to groups who appear less likely to seek help such as LGBT and BAME residents, and older people.

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

Recommendation 68: Promote the Making Every Contact Counts (MECC) approach by providing training to front facing staff across the wider partnership to promote awareness of mental health issues including stigma, suicide prevention and the benefits of Talking Therapies.

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

Recommendation 69: 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 70**: Continue to develop the capacity and capability of primary care to manage patients with common mental disorders and integrate consideration of mental health into the management of other care groups known to be at high risk of mental health problems.*

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

***Recommendation 71**: Develop partnerships between primary care, specialist mental health services, other statutory services and the VCS at locality level to provide holistic support addressing the wider determinants as well as health and social care needs of people with mental health problems. An effective social prescribing function will assist patients to engage with relevant support.*

People with co-occurring substance misuse and mental health conditions have a heightened risk of other health problems and early death but are often excluded from services.[134] People in the criminal justice system and the street homeless have particularly complex social issues and are at high risk of both substance misuse and mental health problems. Effective care requires specialist input for both problems. Concurrent contact with mental health services for drug and alcohol misuse is much lower in LBR and LBH, compared to England.

***Recommendation 72:** Improve and increase joint working between mental health services and drug and alcohol services to improve outcomes for patients with co-occurring substance/alcohol misuse and mental health conditions.*

***Recommendation 73:** - Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.*

***Recommendation 74:** Review arrangements for those in contact with the criminal justice system, including ex-prisoners and their access to mental health services, and mental health service provision for offenders served with community orders, particularly for those subject to Alcohol Treatment Orders and Drug Rehabilitation Requirements*

Following changes in national policy, this JSNA has discontinued indicators describing the Care Programme approach that were previously used to describe quality outcomes for service users, and replaced with indicators describing 72-hour follow up for all adult patients discharged from inpatient care, as per NHSE and NHSI recommendations.[135] Patients followed up within 72 hours of discharge from adult acute beds in LBBD (80%) and LBH (87%) is higher than the national average (77%), but lower in LBR (70%). In the 6 month period to March 2021, 95

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

patients were not followed up within 72 hours across BHR. The national standard is 80%, with the evidence base showing that there is an increased risk of patients dying by suicide on days 2-3 following discharge from inpatient services.[136]

Recommendation 75: *MH services should audit readmissions to identify the underlying causes of readmission and whether improvements could be made as part of planned discharge, and ongoing treatment and support (including support from local authority housing teams).*

Recommendation 76: *Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.*

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

Recommendation 77: *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 78: *Improve the management of physical health of patients with SMI; ensure all get an annual health check and, through joining up initiatives across the system, improve effectiveness of support available to assist with lifestyle change, starting with smoking.*

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

Despite concerns about a rise in suicide during the pandemic, early indications from real time suicide surveillance systems have not shown a significant increase in suicides when comparing pre and post lockdown periods. However these are provisional figures and further monitoring is essential. Periods of financial recession are known to impact suicide rates, which is a concern

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

in the event of an economic downturn or increases in the costs of living, and the subsequent impact on employment and financial stressors such as unmanageable debt.[137]

Outside of the pandemic, rates of suicide and self-harm in under 24 year olds in England have been steadily increasing over the last decade.[138] It is suggested that around half of people who die by suicide have previously self-harmed. Reported rates of self-harm across BHR are lower than England, with 460 people admitted to hospital for intentional self-harm. However, the majority of self-harm is known to occur in the community and does not lead to hospital attendance.[139]

Recommendation 79: *Ensure there are comprehensive strategies/plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.*

Recommendation 80: *Monitor suicides in real time to identify trends.*

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

7.4 Cancer

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

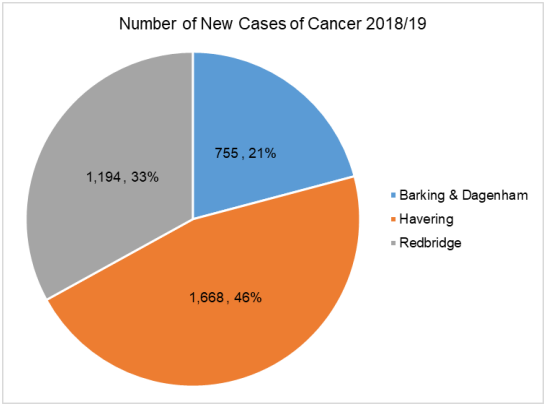
Cancer is the cause of enormous harm to health – accounting for 26 % of all years of life lost across BHR.[140] 1 in 2 people will be diagnosed with cancer in their lifetime. Adjusting for differences in age structure; the incidence of all cancers in LBBD and LBH is similar to the national average; the 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.

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.



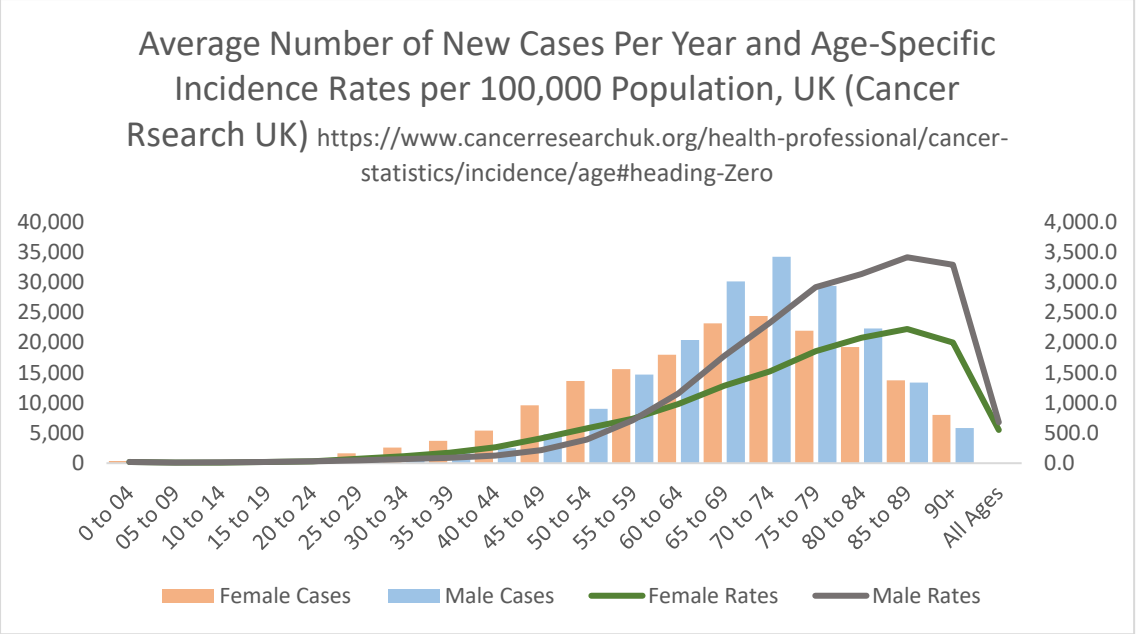
Source: Public Health England

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[141].

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

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

[141] 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[142].

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 2019-20, coverage in BHR boroughs outperformed the national average. Nonetheless, more than 700 13–14-year-old girls in the three boroughs were not protected.

POPULATION VACCINATION COVERAGE – HPV VACCINATION COVERAGE (FOR ONE DOSE) *			
AREA	12-13 Female	13-14 Female**	12-13 Male
LBBD	86.8%	81.2%	83.9%
LBH	90.2%	83.3%	84.6%
LBR	86.0%	83.4%	82.7%
NATIONAL	59.2%	64.7%	54.4%

*PHE Fingertips 2019-20
** Two doses

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

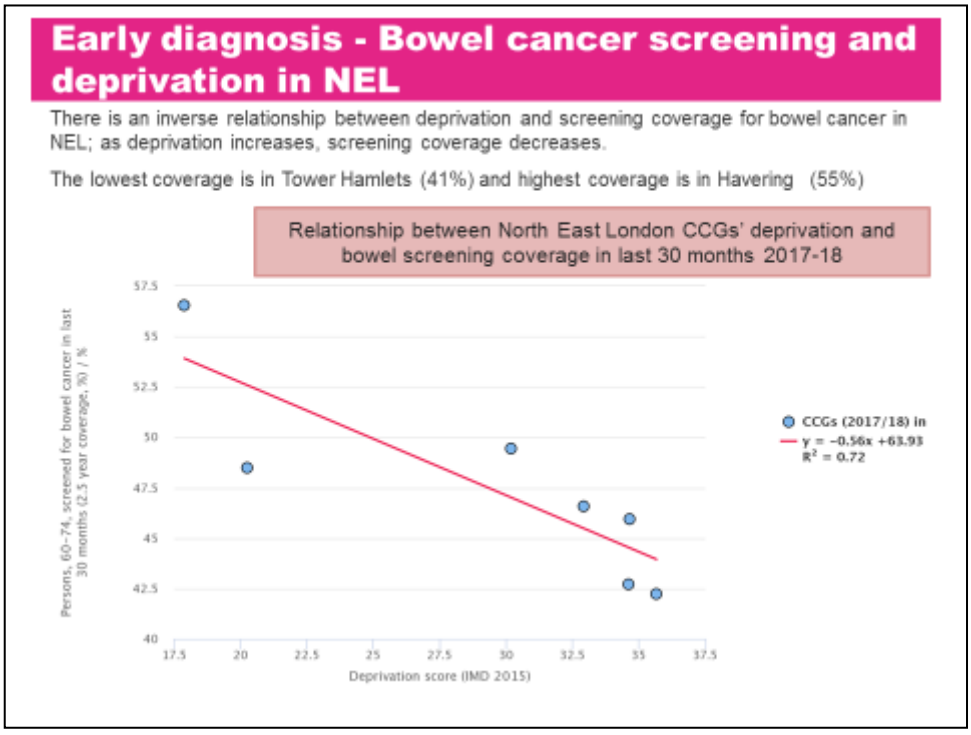
Recommendation 81: *Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.*

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[143].

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 54.2% in 2002 to 69.7% in 2017. However, survival in all BHR boroughs has consistently lagged behind the national average – now 73.3%, particularly in LBBD at 69.7%.

For some cancers, screening offers a means of identifying cancers before any signs of disease are evident, increasing the likelihood of successful treatment.
Screening coverage for the three national screening programmes (bowel, breast and cervical) is lower than England in 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 uptake. Hence, coverage in LBH is higher than that achieved in any other borough in NEL for all three screening programmes[144].



Source: Healthy London - Inequalities Toolkit

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

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

CANCER SCREENING COVERAGE (2020) *				
	Cervical Cancer (25-49)	Cervical Cancer (50-64)	Breast Cancer	Bowel Cancer
LBBD	65.6%	72.9%	66.4%	50.2%
LBH	72.9%	77.6%	78.7%	62.3%
LBR	61.5%	74.6%	71.8%	55.3%
LONDON	61.8%	73.2%	67.2%	56.2%
ENGLAND	70.2%	76.1%	74.1%	63.8%

*NHS Digital via PHE Fingertips.

The national cancer screening programmes have recently been the subject of a review[145] 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. These factors are further exacerbated by those under served by not being registered with GPs, often having chaotic lifestyles and services are poorly engaged with these population groups

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 82**: - 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[146] testing for diagnosing colorectal cancer and breast screening.*

***Recommendation 83**:* - undertake a deep dive/equity audit to understand which populations are not taking up screening and support a programme of community engagement, working with those identified as less likely to participate in screening programmes to increase uptake.

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.

[145] https://www.england.nhs.uk/wp-content/uploads/2019/02/report-of-the-independent-review-of-adult-screening-programme-in-england.pdf
[146] https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/faecal-immunochemical-test-fit#FIT2

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. it is still too early to tell the impact of Covid on late presentation.

Recommendation 84: *To undertake an audit to assess the impact of Covid-19 on Cancer screening and service delivery including emergency presentations post-pandemic*

Recommendation 85: *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 86: *Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)*[147]

Recommendation 87*: Implement the national optimal cancer pathways*[148]*.*

[147] https://www.england.nhs.uk/cancer/early-diagnosis/
[148] 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 88: *Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways[149] for prostrate, breast and bowel cancer patients.*

Recommendation 89: *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.

[149] 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

What are Long Term Conditions?

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

As described in *Section 4*, despite recent increases in life expectancy, most of the additional years of life gained are affected by ill health or disability. A significant proportion of this ill health is the result of long-term conditions (LTCs), and they contribute substantially to health inequalities by ethnicity and deprivation in England.

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

Appropriate management of LTCs through medication, lifestyle change, and therapies can lead to significant improvements in quality of life for individuals. Many LTCs are also preventable, through reducing key risk factors such as poor diet, smoking or low levels of physical activity. As a result, ensuring early detection, diagnosis and treatment of LTCs and effective prevention is important.

In addition to individual lifestyle factors, many LTCs are also linked to environmental exposures that may be outside of an individual's control. For example, a key risk factor for both chronic obstructive pulmonary disease (COPD) and asthma is regular exposure to poor air quality, which disproportionately affects areas of high deprivation. Similarly, areas of high deprivation often have poorer access to opportunities to be physically active and eat a healthy diet, increasing the risk of obesity related conditions such as diabetes and heart disease. This means that tackling LTCs requires action not just at an individual level but on the wider determinants of health and the environments around us.

Common Long-Term Conditions:

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

Who is most at risk from long term conditions?

Inequalities by age

The risk of developing an LTC increases with age, with 62% of people over 60 years old reporting at least one LTC compared to only 24% of those under 40 years old nationally (*ONS Annual Population Survey*, ONS, 2019). As a result, forecasted increases in the number of older individuals in the population (see Section 2.2) are likely to lead to increases in the number of individuals with LTCs without effective prevention, diagnosis and treatment.

Inequalities by ethnicity

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

Inequalities by deprivation

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

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

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

Impact of lifestyle and environmental factors

The risk of developing LTCs is only partly determined by non-modifiable factors such as age and ethnicity. An estimated 50-80% of CVD result from modifiable or preventable factors such as smoking, obesity, poor diet, harmful drinking and low levels of physical activity. This represents an important opportunity for effective prevention at an individual level to have a substantial impact on the prevalence of LTCs.

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

What is being done to support those with Long Term Conditions?

Primary prevention of Long-Term Conditions

Primary prevention aims to prevent people developing long term conditions in the first place and is the most effective way to improve quality of life and prevent ill-health. Due to the strong link between modifiable lifestyle factors (such as alcohol, smoking and obesity) and long-term conditions, effective primary prevention should be prioritised to reduce the prevalence of long-term conditions and health inequalities.

NHS Health Checks

NHS Health Checks are an opportunity to identify people with, or at high risk of, CVD and related conditions including diabetes, hypertension and chronic kidney disease (CKD). Health Checks are offered to anyone aged 40-74 years who does not have a pre-existing LTC. Public Health England have previously estimated that for every 6 to 10 NHS Health Checks completed, one person is identified as being at high risk of CVD. Health checks provide an opportunity to encourage people to tackle lifestyle related risk factors before they cause ill health. It aims to connect these individuals with sources of support that might assist them to achieve change reflecting their needs and preferences.

A proportion of eligible patients are not offered or do not attend their NHS Health Check. This means that the full potential benefit of the programme is only partially realised and opportunities for primary prevention are missed. Currently, only Barking and Dagenham are achieving above the London average of 49.9% of eligible individuals receiving an NHS Health Check (see Table 7.5.1).

When broken down by relative local deprivation, in the period 2012/13-2017/18, all three boroughs have the lowest rate of health check attendance in those from the most deprived quintile (see Figure 7.5.1). In addition to having the lowest overall health check attendance, Havering also has the largest inequalities by deprivation, with a gap of 7.7 percentage points between the least and most deprived quintile (see Figure 7.5.1).

When broken down by broad ethnic group, in the period 2012/13-2017/18, Asian groups recorded the highest percentage attendance in all three boroughs, followed by Black groups and White groups. Despite the high percentage of attendance, non-White groups remain at greatest risk from experiencing poor health resulting from preventable LTCs and so remain a priority group to increase uptake of Health Checks. In all three boroughs, those of "any other ethnicity" (including those of mixed ethnicity and those with no ethnicity data recorded) recorded the lowest percentage of attendance. This suggests that there may be particular barriers to access for these groups requiring more detailed investigation and more comprehensive collection ethnicity data to understand these challenges.

Table 7.5.1. Percentage of eligible individuals invited and receiving an NHS Health Check Q1 2016/17 –2020/21 across Barking & Dagenham, Havering and Redbridge

	LBBD *(%)*	LBH *(%)*	LBR *(%)*	London *(%)*	England *(%)*
Percentage of eligible individuals invited for an NHS Health Check	85.4	71.9	82.1	73.4	71.8
Percentage of eligible individuals receiving an NHS Health Check	53.4	38.0	49.1	49.9	46.5

= Below London Average

= similar to London average

= Above London Average

Source: Public Health England Fingertips

Figure 7.5.1; Percentage of individuals attending an NHS Health Check after receiving an invitiation by relative deprivation quintiles within each local authority for ther period 2012/13-2017/18, based on the Index of Multiple Deprivation 2015 (Source: *N*

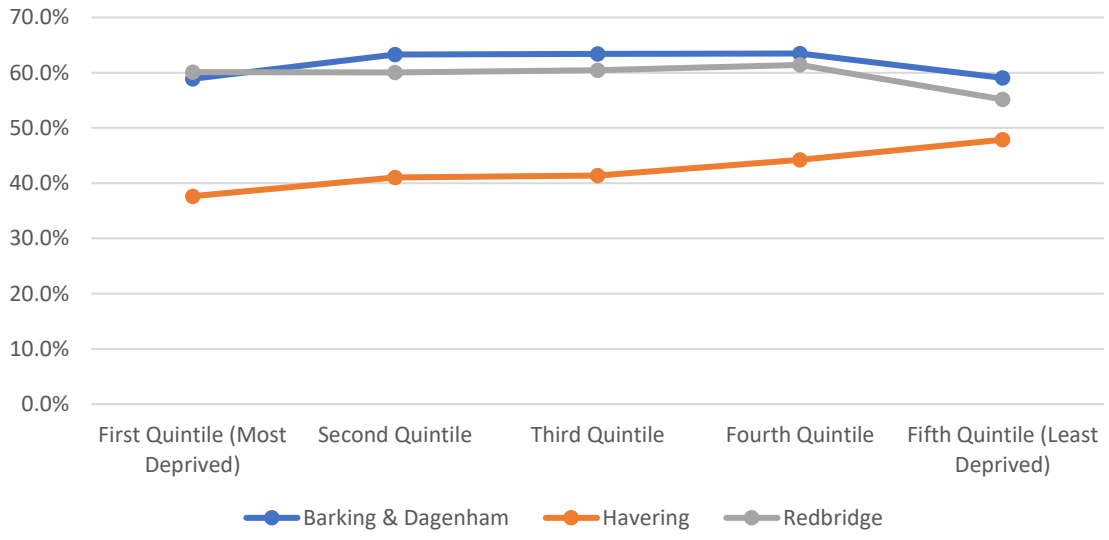
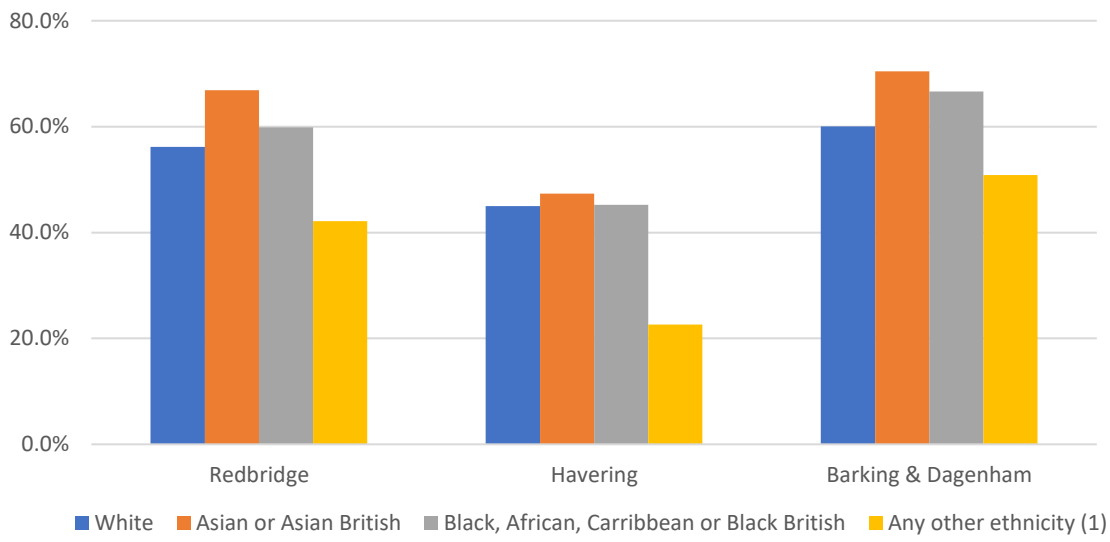


Figure 7.5.2; Percentage of individuals attending an NHS Health Check after receiving an invitation within each ethnic group and by local authority from 2012/13-2017/18
(Source: *NHS Digital*, Health Check Dashboard)



(1) "Any other ethnicity" includes those of mixed ethnicity, any other ethnic group and those without recorded ethnicity data)

On average, individuals in disadvantaged areas suffer from one or more long term conditions between ten to fifteen years earlier when compared to individuals residing in better off neighbourhoods[150]. In Barking and Dagenham work is currently underway to analyse the inequalities which may exist within the NHS Health Check programme. Data analysts from Public Health alongside colleagues within the Performance and Intelligence Team will explore the available demographic data on the NHS Health Check invitations sent to the Barking and Dagenham GP registered population and evaluate what proportion of this eligible cohort has come forward and received a NHS Health Check.

[150] NHS England » The Long Term Plan for tackling health inequalities

Recommendation 67*: BHR should review the care pathway and provision of support for patients found to be at high risk of LTCs following an NHS Health Check (or other identification route) to ensure that behaviour change support is effective, high quality and in line with best practice guidelines. This should include reviewing whether support is culturally appropriate for each borough's communities, with a focus on contributing to reductions in health inequalities by ethnicity and deprivation.*

Recommendation 68: *BHR should review the current service delivery model and approach to increasing the offer and uptake of NHS health checks in each borough and develop a robust action plan for improvements in uptake, particularly among those at greatest risk of poor health. Key opportunities to explore should include the accessibility of Health Checks appointments by time and geography, the role of PCNs and exploring the potential for delivery of workplace-based programmes.*

Recommendation 69 *To review the processes for analysis and reporting of key local data on preventative interventions to support local Public Health teams in improving delivery. This should include both the Health Check and National Diabetes Prevention programmes. There should be a focus on improving the granularity of data, both by geography (in particular by Primary Care Networks) and inequalities by ethnicity, deprivation and age, as well as regular reporting of data on invitation, uptake and outcomes.*

Secondary prevention of Long-Term Conditions

Secondary prevention aims to reduce or reverse the negative impacts of LTCs. The effects of many LTCs, such as diabetes, may be reversed or prevented through effective secondary prevention and so lead to substantial improvements in quality of life.

For most LTCs there is a significant difference between the proportion of the population expected to have the disease and the number actually diagnosed as a result many thousands of residents are unaware, they have an LTC. Moreover, of those that do have a diagnosis, many do not receive all the treatments that would benefit them leading to missed opportunities for effective prevention.

Healthier You: NHS Diabetes Prevention Programme (NDPP)

The NDPP is based on a strong evidence base that shows supporting people to maintain a healthy weight and be more active, can significantly reduce the risk of developing Type 2 diabetes. Individuals aged 18 years or over at high risk of progressing to Type 2 Diabetes (known as non-diabetic hyperglycaemia) are eligible for referral to the NDPP.

The intervention consists of a series of predominantly group-based sessions delivered in person across a period of at least nine months. There are at least 13 sessions, lasting between one and two hours, and at least 16 hours of contact time. Each session covers topics geared towards the NDPP's main goals of weight reduction and improved glycaemic control through

dietary improvements and increased physical activity and reduction in sedentary behaviour. They are underpinned by behavioural theory and involve the use of behavioural techniques. Sessions are offered in the community at various sites within BHR. In addition, a digital stream offers an alternative service to face-to-face programmes making use of technologies, including wearables and apps.

The NDPP was offered in BHR relatively late and there is a considerable way to go in terms of increasing participation and completion if the potential benefits are to be realised. The harm to residents is very great. Locally, diabetes is responsible for 1.6% of all Years of Life Lost, 4.4% of Years Lived with Disability and 3.1% of all Disability Adjusted Life Years. Nationally, about 9% of the total NHS budget is spent on the treatment of diabetes and the complications arising.

Years of Life Lost (YLL); YLL estimates the number of years of potential life lost due to premature deaths from a condition, based on the average life expectancy of a population.

Years Lived with Disability (YLD); YLD estimates the number of years lived with a disability resulting from a condition.

Disability Adjusted Life Years (DALY); DALYs measure the impact of a condition on both mortality and morbidity. DALYs are calculated through combining the Years of Life Lost (YLL) and Years Lived with Disability (YLD) measures for a condition. One DALY is equivalent to the loss of one year of healthy life.

Care and Support for those with Diabetes

Of the 49,000 people in BHR known to have diabetes, only two thirds received all eight care processes in LBBD and less than half in LBH and LBR (PHE *Fingertips*). This suggests there are significant improvements possible in ensuring all individuals with Diabetes receive the care they need. In addition, around 1 in 6 of the people with diabetes in BHR do not know they have the condition which is equivalent to 10,000 undiagnosed cases across the three boroughs not receiving effective treatment and at risk of poor outcomes.

Recommendation 70; *BHR should review the local approach to maximising participation in the National Diabetes Prevention Programme and develop an action plan for improved uptake and outcomes. This should include actions to ensure that the NDPP is culturally appropriate for the different communities of BHR to reduce inequalities by ethnicity and deprivation.*

Recommendation 71; *BHR should explore opportunities to expand the target populations for preventative interventions, including the NDPP and Health Checks programmes, beyond the statutory minimum to enable more effective early intervention and prevent ill health. This should include developing actions to increase uptake by under-served populations (such as homeless residents) and to support those outside the statutory minimum age range to access preventative support (currently 40-74 years for Health Checks and 35+ for the NDPP).*

LTCs following acute COVID-19 infection

Most children, young people and adults who have had an acute COVID-19 infection recover and return to normal health. However, some patients can have symptoms that can last for weeks or even months after recovery from acute illness. Persistent symptoms following a COVID-19 infection is commonly termed 'long COVID' but has also been referred to as 'ongoing symptomatic COVID-19' and 'post-COVID-19 syndrome'[151].

The Office of National Statistics has estimated that 1.2 million people in private households (1.9% of the population) were experiencing self-reported long COVID as of 2nd October 2021[152]. The types and duration of long Covid symptoms vary widely, with the main symptoms being fatigue, shortness of breath, muscle ache and difficulty concentrating[153]. Most individuals with long Covid are able to self-manage their symptoms and will only need generalist assessment, support and rehabilitation.
To support those with greater needs, a dedicated service for individuals with long Covid has been commissioned in Barking and Dagenham, Havering, and Redbridge, offering access to physical therapy, physical activity and mental health support.

***Recommendation 72**: Consider commissioning of further services for those with long Covid, based on learning from newly commissioned services in BHRUT. These should include dedicated support services and self-management, for example mobile apps, community exercise programmes and peer support groups.*

According to Greenhalgh et al, approximately 11% of patients with long Covid will need specialist assessment and management for specific long-term complications[154]. Emerging evidence suggests that these patients were previously hospitalised due to COVID-19, particularly those who were admitted to ICU. A study found that there were significantly more new diagnoses of respiratory disease, diabetes, major adverse cardiovascular event (MACE), chronic kidney disease and chronic liver disease following hospital admission due to acute COVID-19 infection[155]. Nevertheless, more information is needed to understand the emerging needs associated with long Covid.

[151] National Institute for Health and Care Excellence (2020) COVID-19 rapid guideline: managing the long-term effects of COVID-19 (NICE guideline 188). Available at: https://www.nice.org.uk/guidance/ng188
[152] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 4 November 2021. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/latest
[153] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 July 2021. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1july2021
[154] 'Long Covid': evidence, recommendations and priority research questions. Available at: https://committees.parliament.uk/writtenevidence/12345/pdf/
[155] Ayoubkhani D, Khunti K, Nafilyan V, Maddox T, Humberstone B, Diamond I et al. Post-covid syndrome in individuals admitted to hospital with covid-19: retrospective cohort study *BMJ* 2021; 372 :n693 doi:10.1136/bmj.n693

Long Covid clinics have been set-up across England, including a clinic in BHRUT based at King George's Hospital[156]. The clinic hosts professionals who provide physical, cognitive and psychological assessments for those referred by their GP for suspected long Covid. The clinic is for those with ongoing symptomatic COVID-19 (4-12 weeks post confirmed or probable infection) or post-COVID syndrome (more than 12 weeks after confirmed or probable infection) and need a programme of physical and/or psychological therapy.

***Recommendation 73**: Borough partnerships should work with primary care clinicians and directly with the public to raise awareness of long Covid, opportunities for self-care and appropriate referral for specialist assessment*

Tertiary prevention for long term conditions

Tertiary prevention for LTCs refers to efforts to reduce the negative impacts on health and quality of life for those with LTCs and prevent further complications. This is particularly challenging as individuals may have more than one LTCs affecting their lives. Key actions are likely to include supporting people to remain independent and manage their conditions to prevent avoidable negative outcomes such as unplanned hospital admissions.

Effective tertiary prevention can ensure those individuals with one or more LTCs are able to live as long and happy a life as possible and requires close working across many different health and social care organisations.

Of a sample of individual with LTCs surveyed locally, all three boroughs report that less than 50% felt they received all or some of the support they needed, below the national average of 54.9% (see table 7.5.2).

One method for assessing the effectiveness of care for those with LTCs is by looking at rates of preventable deaths and surgical procedures locally. With effective tertiary prevention in place, these deaths and procedures should be prevented. From 2017-2019, both Havering and Barking and Dagenham reported a mortality rate from preventable respiratory conditions for those under 75 years above the national and London averages, representing preventable deaths in part from LTCs (see table 7.5.2). From 2016/17-2018/19 all three boroughs also reported a rate of avoidable major lower limb amputations resulting from diabetes above that of the national average (see Table 7.5.2).

***Recommendation 74:** BHR should review current levels of preventable mortality and surgical procedures linked to LTCs, to understand in detail differences across the three boroughs. A robust action plan should be developed to reduce preventable mortality and procedures including understanding the missing population who are not being diagnosed and treated early*

[156] https://www.england.nhs.uk/2020/12/long-covid-patients-to-get-help-at-more-than-60-clinics/

Table 7.5.2 – summary data on avoidable negative health outcomes for individuals with LTCs (taken from Appendix 9: Long Term Conditions dashboard)

			Local authority				
Indicator	Period	Count	*Havering*	*Barking & Dagenham*	*Redbridge*	London average	England average
Percentage of individuals with LTCs reporting that they have received all or some of the support they need	2019/2020	798	46.5%	49.1%	46.8%	52.1%	54.9%
Under 75 mortality rate from respiratory conditions considered to be preventable (Rate per 100,000)	2017-2019	128	20.2	38.2	11.8	17.3	20.0
Major Diabetic lower-limb amputation procedures (Rate per 10,000)	2016/17-2018/19	40	9.2	10.7	13.3	N/A	8.2

= better than London/England average

= similar to London/England average

= worse than London/England average

Multiple Long-term conditions

An increasing proportion of people are affected by more than one LTC at a time, also known as "multimorbidity". Due to the added complexity of managing multiple conditions, multimorbidity has been identified as one of the greatest challenges facing the NHS and social care and has been highlighted in the UK Government's Health and Care White Paper (UK Government, 2021).

More than one in four adults nationally live with two or more LTCs ("Multiple Long-Term Conditions – making sense of the evidence" NIHR, 2021). A previous analysis by BHR CCGs in

2019/2020 identified nearly 24,000 patients with 2 LTCs, more than 12,000 with 4 LTCs and more than 400 with 6 LTCs.

Due to the challenge and complexity of managing multiple conditions, individuals affected by multimorbidity are also at substantially increased risk of poor mental health. One in three patients with multiple LTCs also experiences poor mental health, increasing the chances of individuals with multi-morbidity experiencing both poor physical and mental health outcomes.[157] Table 7.5.3 provides the most common range of LTCs experienced by those with six or more conditions as an example of the complexity of issues involved in delivering effective care for these individuals.

Table 7.5.3 Number of patients across BHR with different combinations of six LTCs concurrently

Combination of LTCs	Number of Patients
Asthma, CHD, CKD, COPD, diabetes, AF	7
Asthma, CHD, CKD, COPD, hypertension, AF	46
CHD, CKD, COPD, diabetes, hypertension, AF	127
Asthma, CHD, CKD, diabetes, hypertension, AF	85
Asthma, CHD, COPD, diabetes, hypertension, AF	104
Asthma, CKD, COPD, diabetes, hypertension, AF	53

Recommendation 75; *BHR should conduct a review of the current provision of prevention and care to those with multiple conditions and develop a robust action plan for improving local care pathways across all three boroughs to reduce levels of preventable ill health, morbidity and mortality.*

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 those improvements in the care of older people are likely to yield

[157] "Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study", Salisbury, C. et al, *British Journal of General Practice* 2011; 61 (582): e12-e21. DOI: https://doi.org/10.3399/bjgp11X548929

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.

Looking at data between 2018-20, an average female and male at age 65 in LBBD, and an average male at age 65 in LBH can expect to live 16.7, 19.8 and 18.2 more years respectively, which are significantly shorter than an average male and female of age 65+ in England expect to live (18.7 years for male and 21.1 more years for female). Nonetheless an average male and female of age 65+ in Redbridge can expect to live 19.2 and 22.0 more years which are similar to England averages.

In terms of healthy ageing, an average male aged 65 years in LBR, and an average female aged 65 years in LBBD can expect to live 8.4 and 8.5 more years respectively, thus they live a shorter proportion of their life in good health than England averages of 10.6 (M) and 11.1(F) more years. Healthy life expectancy at age 65 for both male and female in LBH, male in LBBD and female in LBR are similar to England averages.

In Section 4, we discussed 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. A greater focus on the **prevention** of ill health at every stage of the life including in old age is crucial to improve the quality of life and sustainability of health and care services.

Nationally, 20.8% more deaths occurred among residents of age 85 years and above during the winter months. The proportion of **excess winter deaths** among aged 85 years and above in LBBD (17.5%, 20 people aged 85+), LBH (18.4%, 70 people aged 85+) and LBR (25.6%, 60 people) are similar to England average. Therefore 150 out of 320 additional deaths across BHR in the winter of 2019/20 are aged 85 years and above. The bulk of excess winter deaths result from an increase in deaths from respiratory conditions, some linked to flu; dementia and CVD (heart disease and stroke)[158].

Flu vaccination along with adequate heating reduces the risk of excess winter deaths among the elderly. The flu vaccine 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. LBH has started to see a modest increase in the last few years[159].

COVID booster vaccine: The International Journal of Epidemiology, which found that patients with SARS-CoV-2 and influenza virus coinfection were around twice as likely to die (odds ratio 2.27 (95% confidence interval 1.23 to 4.19)) than people with SARS-CoV-2 alone. Therefore, COVID booster vaccine and flu vaccination work synergistically to reduce illness and death among older people.

[158] ONS Excess winter mortality in England and Wales: 2019 to 2020 (provisional) and 2018 to 2019 (final).
[159] Source: https://fingertips.phe.org.uk

Recommendation 76: *Contact and support older people in receiving both flu vaccine and covid vaccine as recommended. Also review the status of pneumococcal and zoster vaccine.*

PHE estimates that 1 in 10 excess winter deaths are directly attributable to fuel poverty[160]. More than 1 in 10 households in BHR are affected by **fuel poverty** ranging from 9% in LBH to 12.7% in LBR[161].

UK based surveys show that people can feel **lonely** at any stage of life, but that the experience is most severe among older people. Social networks shrink with retirement and the associated reduction in income may limit social activities. Additional contributory factors for loneliness in old age include the loss of a loved one. An estimated 35,000 BHR residents aged 65 and above live alone[162]; 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[163].

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[164]. In 2021, dementia diagnosis rate of Redbridge (63.5%) is the closest to the national target of 66%, whereas that of Havering and B&D trailed significantly at 53% and 58.9% respectively.

Recommendation 77: *Maintain efforts to further increase the completeness of dementia diagnosis, and improve access to the information and support for patients and their families*

Delirium

Delirium is 10 times more common in those with dementia. It can be brief and transient (resolved in 24 hours), but may persist (30% at a month, 20% at six months) or the person may not recover at all. Half of those with delirium on general and geriatric medical wards will die within six months.

Any medical condition can cause delirium, and more than half of cases have multiple potential causes. At the end of life this may be the underlying condition (cancer, hypoxia, infection), surgery, a complication, a drug side-effect (especially higher doses of opiates, anticholinergics such as hyoscine, and polypharmacy), or drug withdrawal (following de-prescribing, or alcohol withdrawal). About 1 in 3 cases of delirium can be prevented. It is important that the clinician can talk to someone who knows the person well and, hopefully, knows what has been happening recently. Delirium usually gets better when the cause is treated.

[160] Public Health England & UCL Institute of Health Equity (2014) Local action on health inequalities: Fuel poverty and cold home-related health problems.
[161] Source https://fingertips.phe.org.uk
[162] Source poppi.org.uk
[163]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
[164] https://www.scie.org.uk/dementia/symptoms/diagnosis/early-diagnosis.asp

There is a high prevalence of **mental health** issues in older people so Comprehensive Geriatric Assessment is not complete without addressing both mood and cognition. Care that looks at a 'whole person' and that is undertaken by a geriatric MDT is the gold standard approach not to miss either physical or mental health conditions. **Depression** often co-exists with physical illness or dementia. In addition, the health of an older person could also be adversely impacted by hazardous drinking of alcohol.[165]

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.[166] Falls are the number one precipitating factor for a person losing independence and going into long-term care. **Deconditioning** is the loss of physical, psychological, and functional capacity due to inactivity – can occur rapidly in older adults, and, among other health impacts, increases the risk of falls. Public Health England found that older people experienced a considerable reduction in strength and balance activity between March to May 2020, with the greatest change in the 70 to 74 age group with a 45% (males) and 49% (females) decrease observed in activity. Without mitigation, modelling predicts that:

• More older people (an increase of 3.9%) will fall as a result of reduced strength and balance activity during the pandemic

• The total number of falls could increase by 6.3% for males and 4.4% for females.

> ***Recommendation 78:*** *Refer older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitations services.*

Age standardised rates of hospital admission for falls for over 65's is better (lower) than the national average in all three BHR boroughs. Nonetheless, close to 2000 admissions were recorded in 2019/20.

Hip fracture is a particularly serious consequence of falls especially among those with osteoporosis, malnutrition, weak muscle strength, sensory impairment and frailty. One in three people with a hip fracture dies within a year. Rates of hospital admission for hip fracture are similar to the national average in LBH and LBBD but better (lower) in LBR than the national average. More than 600 were recorded in 2019/20.

Falls are not an inevitable consequence of ageing; the risk of falling and the harm caused can be reduced. The Falls and Fragility Fractures Pathway[167] defines the core components of an optimal service for people who have suffered a fall or are at risk of falls and fragility fractures. The pathway focuses on the three priorities for optimisation:

- Falls prevention

[165] https://academic.oup.com/ageing/article/42/5/598/18032?login=true
[166] https://publichealthmatters.blog.gov.uk/2014/07/17/the-human-cost-of-falls/
[167] https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

- Detecting and Managing Osteoporosis
- Optimal support after a fragility fracture

Higher value interventions include:

- Targeted case-finding for osteoporosis, frailty and falls risk
- Strength and balance training for those at low to moderate risk of falls
- Multi-factorial intervention for those at higher risk of falls
- Fracture liaison service for those who have had a fragility fracture

Recommendation 79: *Ensure the BHR Falls prevention pathway is consistent with national guidance and equitably implemented according to need.*

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[168].

Recommendation 80: *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 65+ years (around 10,500 across BHR in mid-2019) live with frailty, rising to 25- 50% of 85+ years (4,000 to 8,000). Being frail can mean that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing 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 is not frail.

A comprehensive approach to minimise the harm caused by frailty[169] 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.

[168] National Institute for Health and Care Excellence (NICE) - Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (https://www.nice.org.uk/guidance/ng16)
[169] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

- Urgent Community Response – crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.

> *Recommendation 81: Ensure that patients at risk of frailty are systematically identified, using population health management approach; effectively supported by the local partners to stay well; or to receive urgent additional help in times of crisis.*

Polypharmacy

Over our lifetime we accumulate diagnoses, such that many people experience old age as a state of multimorbidity.[170] Multimorbidity thus breeds polypharmacy. In addition, polypharmacy promotes further prescribing. This can be the addition of drugs explicitly to manage side effects (e.g., laxatives and opiates) or when side effects are wrongly interpreted as new conditions through prescription cascades (e.g., furosemide and amlodipine). Multimorbidity, and thus polypharmacy, is linked to frailty.

Sometimes the balance between risks and benefits becomes lost and people are exposed to harm. Fortunately, polypharmacy can be addressed through deprescribing, which is a term for the discontinuation of medications in a systematic and considered manner. Currently there are few randomised controlled trial data to support its efficacy, but this has to be offset against the near complete lack of evidence that continuing medications in people with advanced frailty is beneficial. Deprescribing requires a thoughtful explanation to patients and carers. There needs to be some acceptance of the risk of withdrawal effects and disease or symptom recurrence, which necessitates monitoring and follow up. It can be aided by the use of multidisciplinary teams that include pharmacists and nurse specialists. Deprescribing is not about restricting the access of some people to healthcare but instead an acceptance of the limitations of medicines in some situations. Prescribing fewer drugs is not the same as offering less care.

> *Recommendation 82: Ensure that there is a systematic approach of reviewing patients with multimorbidity and frailty that includes a medication review to maximise the benefits of medications and minimise side effects.*

COVID-19

COVID-19 disproportionately affect older people as the risk of severe disease and mortality increases substantially with age. Therefore, JCVI recommended 50 years and above in the first stage of vaccine roll out. Booster vaccine is also required to fully protect older people and it is

[170] https://www.bgs.org.uk/blog/more-is-less-and-less-is-more-breaking-the-cycle-of-polypharmacy-with-deprescribing

seen that the booster becomes key in preventing severe illness including new variants. In the future COVID-19 vaccine will become a key intervention to reduce excess winter deaths.[171] It is found that the wider impact of covid such as deconditioning among older people can increase the risk of falls. [172]

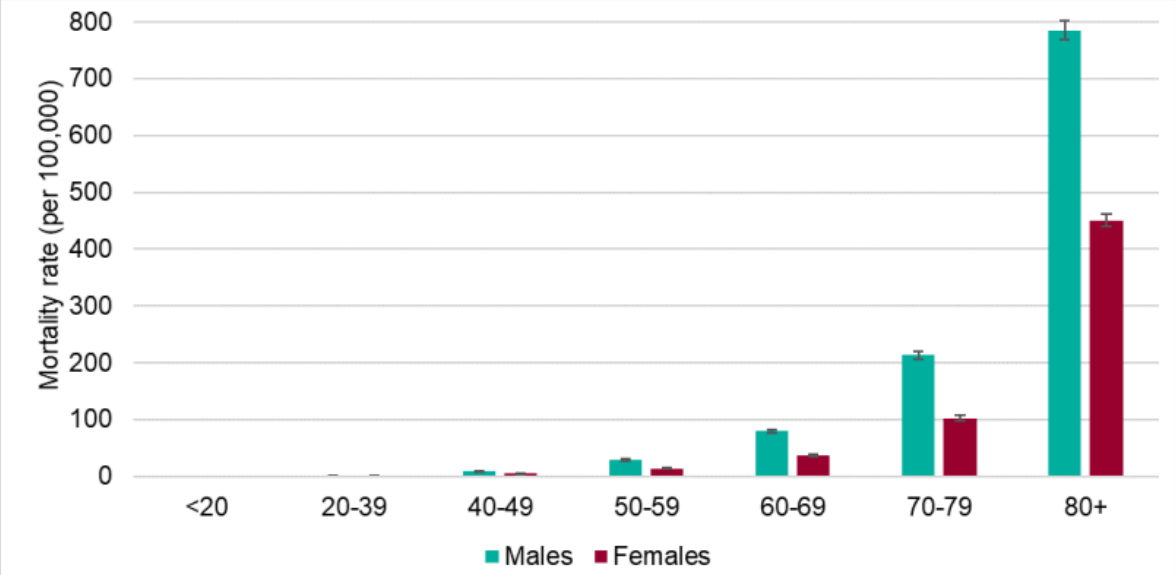


Figure Crude mortality rates of laboratory confirmed COVID-19 deaths per 100,000 population by age group and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

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. LBH and LBR 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 and LBBD is similar to the national average.

Recommendation 83: 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

171 https://www.bmj.com/content/373/bmj.n1137

172 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1010501/HEMT_Wider_Impacts_Falls.pdf

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 10. Care home beds, number and rate / 100 people aged 75+, 2021

Area	Number	Rate
LBBD	718	8.0
LBH	1,834	8.0
LBR	1,379	7.7
London	35,435	7.1
England	458,955	9.4

Source: Care Quality Commission (CQC) and Office for National Statistics (ONS)

Many people in care homes are not having their needs assessed and addressed as well as they could be, resulting in unnecessary unplanned and avoidable admissions to hospital. The Enhanced Health in Care Homes (EHCH) model is designed to put this right.

> ***Recommendation 84:*** *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 all three boroughs are significantly higher (worse) than England average. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. The BHR end of life care workstream aim is to acknowledge a person's wishes and support their end-of-life needs in their preferred place of care and is addressing this challenge across three boroughs. Care Home Support, rapid response team and 24-hour support line are being implemented and the palliative care capacity is increased to improve the quality of the end-of-life care.

> ***Recommendation 85:*** *Strengthen end of life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.*

Older people's mental health

The most common mental health condition in older people is depression, affecting 22% of men and 28% of women aged 65 or over, followed by anxiety.[173] 40% of older people who are living in care homes have depression; 30% of older carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience

[173] Health and Social Care Information Centre (2007). Health Survey for England, 2005: Health of Older People. [online] Available at: http://www.hscic.gov.uk/pubs/hse05olderpeople

depression than older people who haven't been bereaved.[174]

Older people living with dementia may struggle to express how they are feeling which also increases the difficulty of diagnosis.[175] Not only can dementia trigger mental health problems, with estimates suggesting that 20-40% of people living with dementia are depressed.[176]

It is important that older people are able to access services which are appropriate for their needs.[177] A target was set in 2011 to increase the proportion of older people referred to IAPT (Improving Access to Psychological Therapies) services to 12%. However, the proportion of users to the IAPT service who are over 65 has remained stagnant at or below 7% despite this age group making up 18% of the population.[178]

> ***Recommendation 86:*** *Services should be designed so that older people's needs can be met including mental health and dementia.*

[174] Independent Age (2018), Good grief: older people's experiences of bereavement, London: Independent Age. Available at: https://independent-age-assets.s3.eu-west-1.amazonaws.com/s3fs-public/2018-04/Good Grief report.pdf

[175] British Geriatric Society and Royal College of Psychiatrists (2019), Collaborative approaches to treatment: depression among older people living in care homes, London: British Geriatric Society. Available at: https://www.bgs.org.uk/sites/default/files/content/attachment/2018-09-12/Depression%20among%20older%20people%20living%20in%20care%20homes%20report%202018.pdf

[176] Alzhimer's society, 'Depression and dementia'. Available at: https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/depression

[177] Hamid, Abdul et al (2015), "Comparison of how old age psychiatry and general adult psychiatry services meet the needs of elderly people with functional mental illness: cross-sectional survey", British Journal of Psychiatry, 207 (5), pp. 440-443.

[178] Colins, N., and Corna, L. (2018), 'General practitioner referral of older patients to Improving Access to Psychological Therapies (IAPT): an exploratory qualitative study', BJPsych Bulletin, 42(3). pp. 115-118.

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	
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	

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

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Appendix 1: BHR JSNA Process

1 Background

1.1 To support the BHR ICP fulfil its functions, BHR Public Health teams worked jointly to 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[179] namely:

i. The wider determinants of health e.g., income, education, housing.
ii. Our health behaviours and lifestyles e.g., smoking, alcohol consumption, diet and exercise.
iii. Places and communities e.g., environment, community networks and support systems, social relationships and culture.
iv. The integrated health and care system with a focus on the 4 priorities of the ICPB:
    - Children and young people
    - Mental health
    - Long term conditions

[179] https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean

- Older people and frailty

3.2 The JSNA also included sections on demography and population health outcomes.

4 Form and Content

4.1 Following several consultations between Public Health Consultants / service leads, PHI leads and transformation boards, indicators for each pillar were agreed. PHI leads facilitated data collation, analysis and presentation for indicators where data was available. The report therefore only includes analysis and commentary for indictors which data could be sourced within the provided timelines.

4.2 It's intended that this product will develop in an iterative manner with BHR PH consulting with stakeholders after publication of each edition to identify opportunities for improvement.

4.3 The initial edition is static, but BHR PH are currently working with an external provider to develop an interactive product that will be available to all stakeholders.

5 Final Report

The current report includes data analysis and commentary at borough and BHR levels. It includes some data at locality level but without commentary. This is due to time and specialist resource constraints experienced and will be included in the next iteration.

Appendix 2: Population & Health Outcomes dashboard

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

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population & Health Outcomes

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower	No Data

		Indicator	Period	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
Resident Population	1	Percentage of resident population aged 0 - 4 years	2020	18,910	8.8	6.6	7.3	7.5	6.6	5.7	5.7	5.7
	2	Percentage of resident population aged 5 - 9 years	2020	19,042	8.9	6.6	7.0	7.4	6.7	6.3	6.3	6.3
	3	Percentage of resident population aged 10-19 years	2020	31,105	14.5	11.4	12.9	12.9	11.4	11.6	11.6	11.6
	4	Percentage of resident population aged 20-64 years	2020	125,243	58.5	57.5	59.9	58.7	63.1	58	57.9	57.9
	5	Percentage of resident population aged 65-74 years	2020	10,885	5.1	9.1	7.0	7.2	6.6	10	9.9	9.9
	6	Percentage of resident population aged 75-84 years	2020	6,069	2.8	5.9	4.0	4.3	3.9	6	6.1	6.1
	7	Percentage of resident population aged 85+ years	2020	2,853	1.3	2.9	1.8	2.0	1.7	2.5	2.5	2.5
	8	Total resident population	2020	214,107								
GP Registered Population	9	Percentage of GP population aged 0 - 4 years	2021	17,464	7.4	6.0	6.5	6.7	5.4	5.1	5.1	5.1
	10	Percentage of GP population aged 5 - 9 years	2021	19,670	8.4	6.4	6.9	7.3	5.8	5.8	5.8	5.9
	11	Percentage of GP population aged 10-19 years	2021	34,538	14.7	11.4	12.5	12.9	10.9	11.4	11.4	11.4
	12	Percentage of GP population aged 20-64 years	2021	143,563	61.2	58.8	61.9	60.9	66.9	60.1	60.1	60.1
	13	Percentage of GP population aged 65-74 years	2021	11,350	4.8	9.1	6.4	6.9	6.1	9.5	9.4	9.5
	14	Percentage of GP population aged 75-84 years	2021	5,708	2.4	5.7	3.5	4.0	3.4	5.8	5.8	5.8
	15	Percentage of GP population aged 85+ years	2021	2,477	1.1	2.6	1.5	1.8	1.4	2.3	2.3	2.3
	16	Total GP population	2021	234,770								
Ethnic Population	17	Percentage White British	2021	145,051	32.7	74.6	23.8	43.0	38.3			
	18	Percentage Black	2021	105,455	23.8	6.8	8.2	12.0	13.3			
	19	Percentage Asian	2021	104,671	23.6	7.6	50.5	28.9	20.5			
	20	Percentage Other White	2021	55,311	12.5	6.9	10.0	9.6	18.0			
	21	Percentage Mixed	2021	23,133	5.2	3.5	4.6	4.4	5.8			
	22	Percentage Others	2021	9,388	2.1	0.7	2.9	2.0	4.1			
Health Outcomes	23	Life expectancy at birth (Male)	2018-2020		77.0	79.7	80.5		80.3	79.4	79.4	79.4
	24	Life expectancy at birth (Female)	2018-2020		81.7	83.5	84.6		84.3	83.1	83.1	83.2
	25	Healthy Life Expectancy at birth (Male)	2017-2019		58.4	65.2	62.8		63.5	63.2	63.0	63.4
	26	Healthy Life Expectancy at birth (Female)	2017-2019		59.2	64.5	63.7		64.0	63.5	63.3	63.7

Appendix 3: Wider Determinants dashboard

To return to chapter 4: Wider Determinants - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: Wider Determinants of Health

Benchmark: England

Compared with Benchmark: Better | Similar | Worse | Not Compared | Higher | Lower

	Indicator	Period	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
			Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Median Annual Household Income (£)	2012/13		£29,420	£36,670	£36,670		£39,110	£30,600		
2	Gross Weekly Pay for Full Time Workers (£)	2020		£609	£690	£719		£716	£590	454.2	893.2
3	Index of Multiple Deprivation (IMD) 2019 Rank/Score	2019		32.8	16.8	17.2	21.3	21.8	21.7	45.0	5.5
4	Proportion of residents who are Income Deprived (%)	2019	39,312	19.4%	10.8%	12.1%			12.9%		
5	Proportion of residents aged 16 - 64 in employment (%)	2020	94,000	67.3%	77.5%	74.0%		75.3%	75.7%		
6	Proportion of residents aged 16 - 64 in management / professional roles (%)	2020-21	31,900	35.8%	50.0%	54.6%	48.5%	62.3%	50.2%		
7	Proportion of residents 16-64 who are economically inactive (%)	2020	35,800	25.6%	19.1%	24.6%	23.1%	19.9%	20.5%	12.6%	30.6%
8	Proportion of residents 16-64 who are economically inactive and want a job (%)	2020	9,500	26.5%	27.2%	19.0%	23.5%	25.8%	22.6%	9.6%	53.0%
9	Jobs Density Ratio for population 16-64	2019		0.50	0.61	0.49		1.03	0.88	0.40	102.30
10	Proportion of residents by level of education - NVQ 4 & Above (%)	2020	61,000	43.7%	40.2%	51.5%	45.7%	58.5%	42.8%		
11	Proportion of residents by level of education - No Qualifications (%)	2020	12,800	9.2%	6.5%	9.3%	8.4%	5.1%	6.2%		
12	Number of homeless people/households (rate per 1,000 estimated total households)	2017/18	512	6.5	3.2	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	1,876	23.9	8.9	20.3		14.9	3.4		
14	Number of households on waiting list	2019/20		5350	1995	5979	13324	250992	1145501		
15	Proportion of homes that are not 'Decent Homes' (%)	2018-19	1,638	9.6%	0.7%	13.8%	7.5%		4.5%	37.2%	0.0%
16	Proportion of Households experiencing Fuel Poverty (%)	2019	16,739	22.5%	13.2%	15.4%	16.4%	15.2%	13.5%		
17	Rate of verifiable Houses of Multiple Occupation (HMOs) to dwellings (%)	2020	177	0.2%	0.1%	1.9%	0.8%	1.2%	0.56%	0.01%	6.10%
18	Estimated rate of HMOs to dwellings including the verifiable HMOs (%)	2020	192	0.3%	0.3%	3.7%	1.5%	4.9%	2.17%	0.02%	16.60%
19	Number of people seen rough sleeping in the year	2020	10	10	3	24	37	714	2688	242	0
20	Income deprivation affecting Children (under 16)	2019		23.8%	16.0%	13.7%	17.6%		17.1%	32.7%	3.2%
21	Child Development at age 5	2013/14		60.0	65.4	62.8		62.2	60.4		
22	Attendance levels from children who are persistently absent from school (%)	2018/19	4,251	11.2%	10.7%	9.9%	10.5%	10.1%	10.9%	3.4%	16.1%
23	Average Attainment 8 score (mean - score)	2019/20	145,612	50.1	52.2	56.0		53.4	50.2		
24	16-17 year olds not in education, employment or training (NEET) or whose activity is not known (%)	2019	210	3.5%	2.9%	3.1%		4.2%	5.5%		
25	Proportion of economically active population claiming Job Seekers Allowance (%)	2021	801	0.8%	0.6%	0.5%		0.6%	0.5%	1.5%	0.2%
26	Claimant count (16+) and claimants as a proportion of residents aged 16-64 (%)	2021	13,615	10.1%	5.7%	7.6%		7.4%	5.7%	10.8%	2.2%

Appendix 4: Health Behaviour & Lifestyle dashboard

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

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

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	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Percentage of adults (aged 18+) classified as overweight or obese (ALS)	2019/20			65.5	67.3	60.6		55.7	62.8	78.3	41.6
2	Percentage of physically inactive adults (16+ ALS)	2020/21			36.6	37.8	30.6		26.7	27.5	27.2	27.8
3	Smoking Prevalence (% of adult population) (APS)	2019		26,982	18.1	13.2	13.4		12.9	13.9	13.6	14.1
4	Smoking Prevalence (%) in adults in routine and manual occupations (18-64) - current smokers (Persons, 18-64 yrs) APS)	2019			24.3	20.7	22.8		20.7	23.2	36.8	10.3
5	Percentage of adults drinking over 14 units of alcohol a week (HSE)	2015-18			15.1	20.7	10.7		20.1	22.8	41.3	7.9
6	Smoking prevalence in adults (age 18-64 years) - gap between current smokers in routine and manual occupations and other occupations (APS)	2019			1.5	1.8	1.9		1.9	2.5	5.7	0.7
7	Proportion of dependent drinkers not in treatment (%) (Current method) (NDTMS	2019/20		1,833	85.9	84.3	85.2		82.0	82.2	92.3	59.5
8	Successful completion of drug treatment - % opiate users (NDTMS)	2019		22	6.1	6.4	8.3		6.7	5.6	1.6	12.2
9	Proportion of the population meeting the recommended '5-a-day' on a 'usual day	2019/20			47.9	51.8	53.2		55.8	55.4	41.4	67.7

Appendix 5 (a): Maternity dashboard

To return to chapter 6: Maternity - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

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	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Smoking status at time of delivery	2020-21		228	7.6%	6.7%	3.4%		4.6%	0.1	0.2	0.0
2	Number of live births	2019		3,574								
3	Number and percentage of stillbirths	2017-19		69	6.2%	5.2%	4.6%		4.5%	0.0		
6	Low Birth Weight of term babies	2020		130	4.2%	2.2%	4.5%		3.3%	0.0	0.0	0.0

Appendix 5 (b): Maternity dashboard

Maternity Services: Equity and Equality needs assessment

A *Maternity Services Equity and Equality needs assessment* was recently prepared by North East London Local Maternity System (November 2021).

The assessment offers equity and equality finding for health outcomes, community assets and staff experience, where the report forms the first part towards the production of an equity and equality action plan that aligns with the health inequalities work of the Integrated Care System (ICS) with the aim to improve maternity and neonatal care by: ensuring equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas, and also race equality for staff.

Along with this, North East London Local Maternity System is also working on supporting and strengthening the workforce to ensure all our BME women receive continuity of carer, alongside the rest of our population, by 2023.

The assessment suggests that East London has the highest birth rate in the UK. Where the health and care services need to cope with such growth and continue to ensure the best possible outcomes for mothers and babies. The endeavour is for babies born in North East London to have the best possible start in life and that their parents experience the best possible pregnancy and birth.

Key findings from the assessment – and where relevant key findings for BHR are highlighted:

The **stillbirths** among babies born to Black and Asian women are concentrated in 3 boroughs with rates markedly higher than for babies born to White women. Overall, across NEL there were 90 stillbirths in 20/21. The size of the sample means that any conclusions on the 'true' differences between ethnicities based on the sample may not be reliable. Across NEL, the rate of babies that were stillborn was higher for babies born to Black women (3.8 per 1000) and Asian women (4 per 1000) compared to the rate for those both to White women (2.6 per 1000). This compares with the national average of 3.8 per 1000 babies. Stillbirths to Asian and Black women tend to be concentrated in 3 boroughs: Hackney, Newham, and Waltham Forest

Babies born to Black and Asian women are more likely to have had a **neonatal admission** than those born to White women; On average, nearly a quarter of babies born in NEL were admitted to neonatal care (24%) although there is a much higher degree of variation between boroughs. Havering and Barking and Dagenham had the highest proportion of admissions (48% and 39%).

Babies born to Black and Asian women are also nearly twice as likely to **have a low birth weight** than those born to White women. Across NEL, 11% of babies born to Black and Asian women had a low birth weight – nearly double the rate for babies born to White women (6%). In Waltham Forest and Tower Hamlets this difference is twice as high.

In total across NEL there were 5 **women that died** within 42 days of delivery (i.e., direct deaths). However, collection and validation of data at on neonatal deaths or infant mortality was not available.

Black women are more likely to have **attended A&E** than White women within 6 months of delivery. On average across NEL, Black ethnicities (11%) had the highest percentage of women attending A&E within 6 months of delivery, compared to White (7%) and Other ethnicities (7%) who had the lowest percentage.

Women in Black, Mixed and Other groups tend to present to healthcare services at least 2 weeks later into their pregnancy than White women. On average across NEL, Mixed women take an average of 11 weeks into their pregnancy to present, Black women 11 weeks, and women from other ethnicities 10 weeks, compared to 8 weeks for White women.

Black and Asian women are also more likely to have attended A&E during their pregnancy than White women; on average across NEL, 37% of Black women and 31% of Asian women had at least one attendance to A&E during their pregnancy compared with 23% among White women. This pattern is consistent at the borough level, with Black women having the highest percentage of women with an A&E attendance during pregnancy in all 7 NEL boroughs. In Havering the rate among Black women (23%) is more than twice that for White women (11%).

Black women are also more likely than White women to have been admitted to hospital during their pregnancy.

Black pregnant women are almost twice as likely to be obese than White women; At the borough level, Black women also have the highest rates of obesity across every NEL borough except for women of Mixed ethnicity in Barking & Dagenham where the rate is as high as 45%.

Asian pregnant women are more than 3 times - and Black women more than two times – more likely to have diabetes than White women.

Black pregnant women tend to have higher rates of hypertension than White women.

Black and Asian women are less likely than White women to be taking folic acid in pre/early pregnancy although deprivation is potentially the more important driver underlying differences.

Black pregnant women are more likely to be out of employment compared with all other ethnicities.

There are no consistent trends in the rates for 'complex social factors' but this may be due to lack of reporting consistency; Redbridge (15%) and Barking & Dagenham (13%) have much higher rates of women that gave birth in 2021 having complex social factors, the accuracy of these findings may be undermined by inconsistent reporting practices.

The likelihood of a vaginal delivery is relatively similar across ethnicities, with larger variations in unplanned C-section deliveries, while the average rate of vaginal delivery for Mixed women across NEL is only slightly higher at 59%, the rate among this group this markedly higher than in any other ethnicity in three of the boroughs: Newham (71%), Redbridge (67%) and Havering (65%).

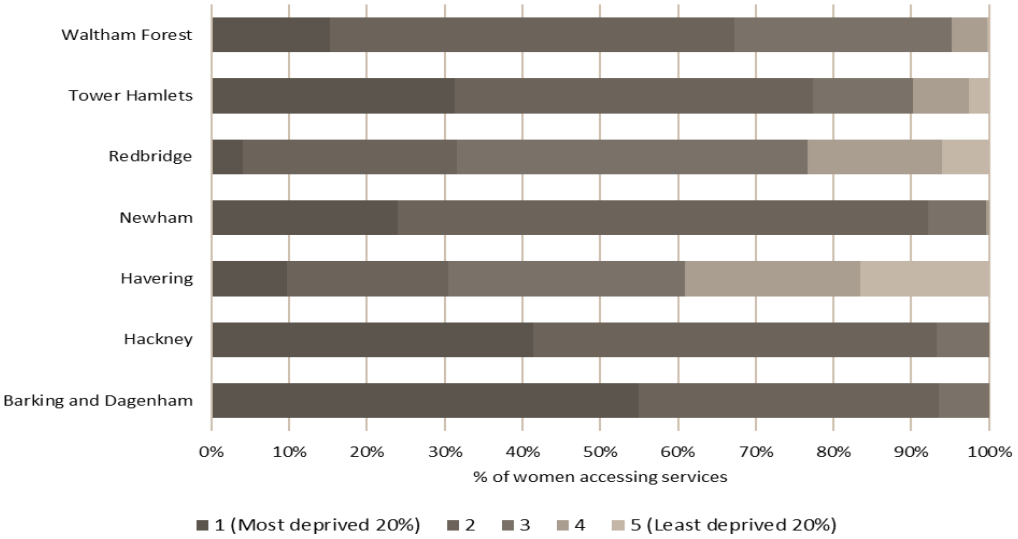
Black and Asian women are more likely to have an unplanned C-section compared with White women.

White women are twice as likely to deliver via forceps compared to Black women.

Deprivation profile of women accessing Maternity services:

As with both age and ethnicity, deprivation masks a lot of variations at the borough level, with over half of the women in this population in Barking and Dagenham living in the most deprived quintile compared with under 5% in Redbridge and 10% in Havering. These two boroughs also have the highest proportion of women living in areas that are in the two least deprived quintiles (23% and 39% respectively).

Figure 3: Breakdown (%) of all women accessing Maternity services by deprivation - IMD quintile (20/21)



Source: Data from SUS

Gestational age at first contact with NHS services:

Interestingly, the average gestational age at first contact for the most deprived pregnant women in Tower Hamlets (3 weeks) was at least 2 times earlier than in Newham (7 weeks) and Barking & Dagenham (8 weeks).

Figure 1: Average gestational age at first contact – by borough (2020/21)

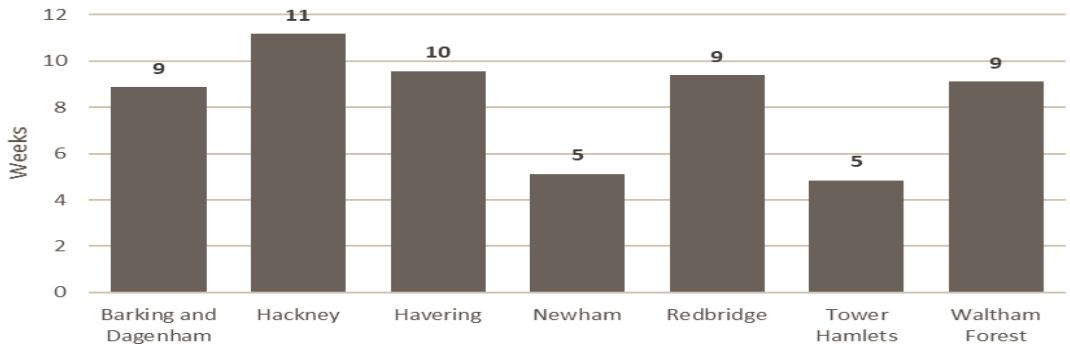
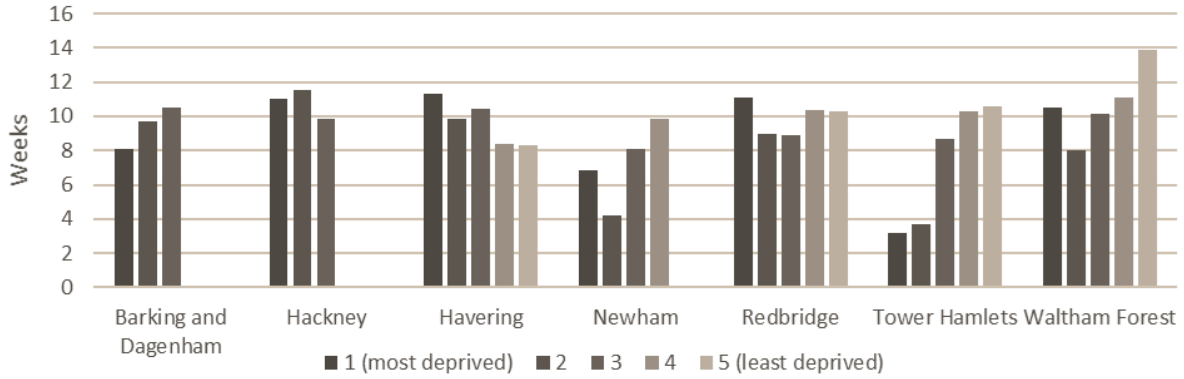


Figure 3: Average gestational age at first contact – by deprivation and borough (2020/21)



COVID-19 Infections by ethnicity and deprivation:

Across NEL, 4% of pregnant women were infected with COVID while pregnant. There were only small differences between boroughs, with all boroughs having an admission percentage between 4-5%.

In Barking and Dagenham and Redbridge the percentage of women from a Mixed ethnic background infected by COVID was twice that for White women.

Figure 1: % of pregnant women infected with COVID-19 - by borough (2020/21)

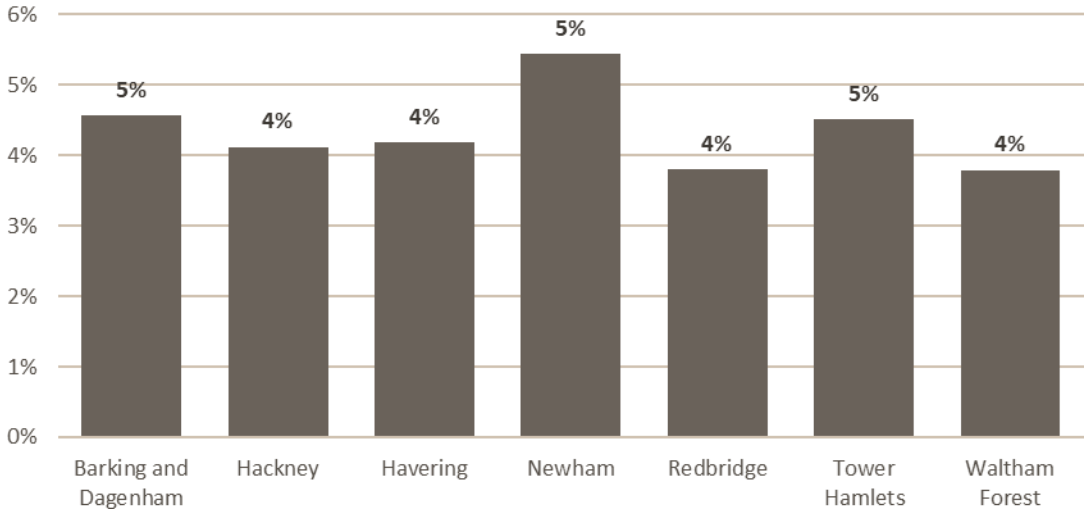


Figure 4: % of pregnant women admitted to hospital with COVID-19 - by borough (2020/21)

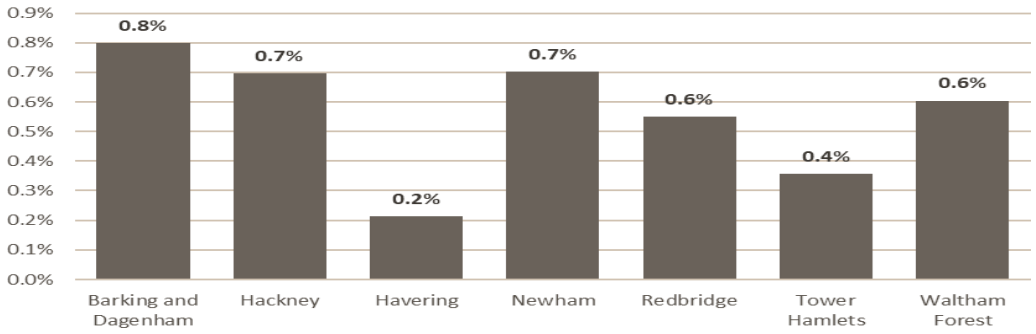
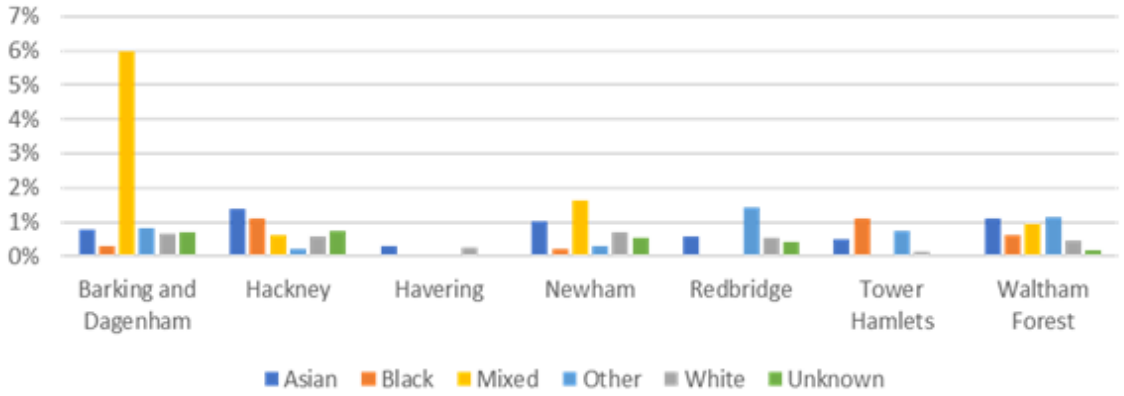


Figure 5: % of pregnant women admitted to hospital with COVID-19 - by ethnicity and borough (2020/21)

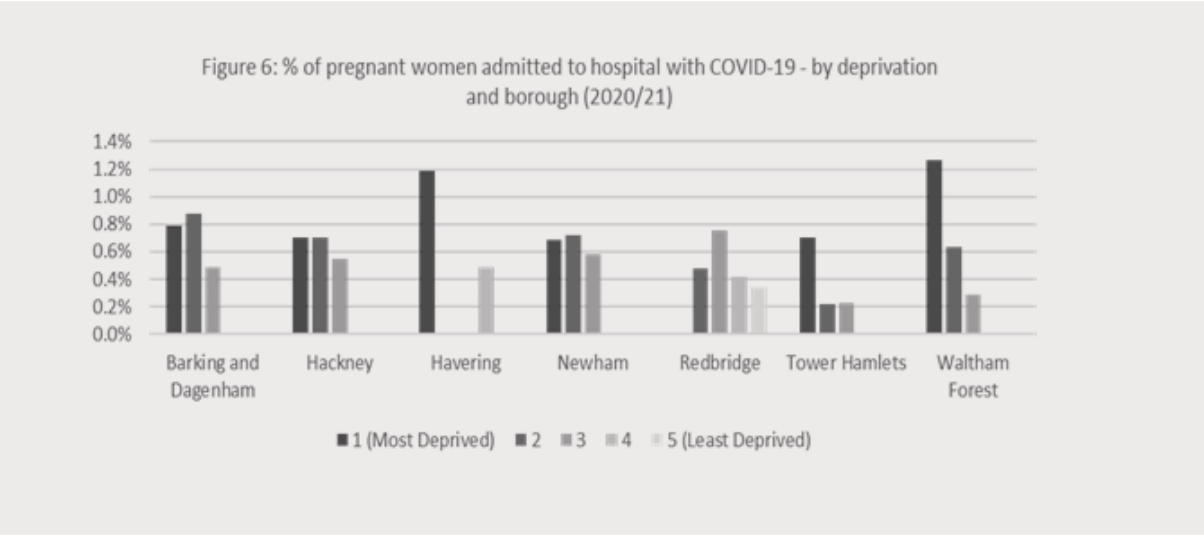


COVID-19 Admissions by ethnicity & deprivation:

Havering had the lowest percentage of women admitted to hospital at 0.2% while the percentage for Barking and Dagenham (0.8%) was 4 times greater.

In Barking & Dagenham, the percentage of pregnant woman admitted to hospital with COVID-19 of Mixed ethnicities (6%) is 6 times higher than the value for all other ethnicities in the borough (less than 1% for all).

Although the percentage of pregnant women admitted to hospital with COVID-19 by deprivation quintile is low for all boroughs, the percentage admitted falls from the most deprived quintiles to the least deprived in all boroughs except Redbridge.



Moving forward the North East London assessment suggests the need to have further data analysis, further community asset mapping and co-production, and to co-produce a five-year strategy based on the needs of our population, aligning to the ICS planning guidance.

Key findings – Barking & Dagenham:

- 2,805 births in 20/21 (11% of total NEL births)
- 50% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 30 years
- Has the second highest average rate across NEL of women giving birth to babies that are admitted to neonatal care.
- Has the second highest average rate across NEL of women having an unplanned C-section (22%) with rates among Black (24%), Asian (24%) and Mixed (24%) women higher than those among White women (20%).

- It has the second highest average rate across NEL of women having an unplanned C-section (22%) with rates among Black (24%), Asian (24%) and Mixed (24%) women higher than those among White women (20%).
- Black women twice as likely than White women to have attended A&E within 6 months of delivery (10% compared with 5%) and to have been admitted to hospital within 6 months of delivery (6% compared with 3%)

Key findings - Havering

- 2,010 births in 20/21 (8% of total NEL births)
- 31% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 31 years
- While it has the lowest rates of stillbirths per 1000 births overall, nearly half of women (49%) have babies that are admitted to neonatal care – although no notable differences across ethnicities with rates for BME babies the same of less than for those born to White women.
- It has the highest average rate across NEL of women having an unplanned C-section (24%) with rates for Black and Asian women which are markedly higher than for White women (32% and 28% compared with 22%)
- Black women are 10 times more likely and Mixed women 9 times more likely than White women to suffer post-partum haemorrhages (2.2% and 1.8% compared with 0.2%)
- Black women more than twice as likely as White women to have hypertension (11% compared with 5%)
- While it has one of the lowest overall average prevalence of diabetes across NEL (13%) the rate among Asian women is more than twice as high as for White women (25% compared with 10%).

Key findings – Redbridge:

- 3,757 births in 20/21 (14% of total NEL births)
- 59% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 31 years
- It has the third highest average rate across NEL of women giving birth to babies that are admitted to neonatal care.
- Rates among babies born to Asian and Black women are much higher than those born to White women (37%, 34% compared with 25%)
- Black women are twice as likely to have attended A&E within 6 months of delivery compared with White women (11% compared with 5%) and are twice as likely to have been admitted to hospital over the same time frame (4% compared with 2%)
- Black women are much more likely to be obese than White women (34% compared with 21%).
- Black women are twice as likely and Asian women are three times more likely to have diabetes than White women.
- Black women are also more than twice as likely than White women to have hypertension (9% compared with 3%)

Appendix 6: Children & Young People dashboard

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

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

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	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Pupils with special educational needs (SEN): % of school pupils with special educational needs (School age)	2018		5,958	14.4%	9.3%	10.9%		14.4%	14.4%		
2	Number and percentage of pupils with Special Educational Needs (SEN) based on where the pupil attends school	2020-21		6,481	14.5%	11.0%	11.8%	12.4%	15.3%	15.8%	11.0%	21.3%
3	Number and percentage of children and young people with EHC Plan (Denominator Age 0-25 ONS mid-2020)	2020-21		1,389	1.6%	1.6%	1.8%	1.7%	1.8%	1.9%		
4	Number and percentage of children (Age 5-15) with EHC Plan (Denominator Age 5-15 ONS 2018)	2020-21		1,215	2.1%	2.2%	2.5%	2.3%	2.4%			
5	Number of primary school pupils with EHCP - Education, Health and Care Plan (local data)	2021		540	2.2							
6	Number of secondary school pupils with EHCP (local data)	2021		367	1.9							
7	Number and rate SEND pupils resident and educated in Borough (Local data)	2021		1,286	92.7							
8	Estimated number of children and young people with mental disorders - aged 5 to 17 (count)	2017-18		5,122								
9	Percentage of school pupils with social, emotional and mental health needs (school age)	2020		1,104	2.5%	1.7%	1.9%		2.5%	2.7%	1.5%	4.4%
10	Hospital admissions as a result of self harm (Age 10-24) directly standardised rate per 100,000	2019-20		55	136.2	166.0	126.2		191.7	439.2	203.1	1105.4
11	Hospital admissions for asthma (under 19 years) - CCG data. Crude rate per 100,000	2019-20		125	158.8	149.8	180.9			158.3	48.5	376.7
12	Hospital admissions diabetes (under 19 years) Crude rate per 100,000	2019-20		15	22.3	63.1	36.2			51.1	49.9	52.3
13	Children on child protection plans: Rate per 10,000 children <18	2019/20		335	52.7	24.3	41.7	40.1	34.9	42.8	11.5	124.3
14	Children in Care (number of children looked after at 31st March (including adoption and care leavers)	2020		400	63.0	40.0	31.0		49.0	67.0		
15	The number and rate of children on a Child Protection Plan (CPP) as at 31st March 2020'	2020		335	52.7	24.3	41.7	40.1	34.9	42.8	11.5	124.3
16	The number and rate of Looked after Children (LAC) as at 31st March 2020	2020		402	63.3	39.8	31.1	44.0	49.3	66.6	23.0	223.0
17	The number and rate of Children in Need (CIN) as at 31st March 2020'	2020		2,352	370.1	297.6	279.4	313.8	336.7	323.7	141.9	931.5
18	The number and rate of children in the youth justice system (10-17 yrs)	2019-20		188	7.4	4.4	3.9		4.4	3.5		
19	Number of 2 year olds taking up offer of free nursery care (local data)	2021		1,118								

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

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

				Barking & Dagenham		Havering	Redbridge	BHR	London	England		
	Indicator	Period	Recent Trend	Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
19	Number of 2 year olds taking up offer of free nursery care (local data)	2021		1,118								
20	Number and percentage of unauthorised school absence sessions	2018-19	↓	233,341	1.8%	1.1%	1.2%	1.4%	1.3%	1.4%	0.5%	2.6%
21	Reception: Prevalence of overweight (including obesity) %	2019/20	↓	545	24.6%	21.6%	22.3%		21.6%	23.0%		
22	Year 6 : Prevalence of overweight (including obesity) %	2019/20	↓	1,545	44.7%	38.1%	39.6%		44.7%	35.2%		
23	Reception: Prevalence of obesity (including severe obesity) %	2019/20	↓	285	12.9%	10.1%	11.2%		10.0%	9.9%		
24	Year 6: Prevalence of obesity (including severe obesity) %	2019/20	↑	1,005	29.0%	23.8%	25.0%		23.7%	21.0%		
25	Youth offending: first time entrants to the youth justice system, rate per 10,000	2018		646	377.0	183.0	280.0		251.0	211.0		
26	Youth justice custodial sentences per 10,000	2019/20		20	3.1	2.9	2.1		1.5	1.0		
27	Youth proven offending rate per 10,000	2018/19		88	13.7	9.0	11.2		8.0			
28	School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19	↓	2,486	72%	72%	76%		74%	71.8%		
29	School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	2018/19	↑	2,744	80%	84%	83%		83%	82.2%		
30	Hospital admissions due to substance misuse (15-24 years) count and rate per 100,000	2017/18 - 19/20		55	67.7	78.6	73.8		55.6	84.7		
31	Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2019/20	→	2,929	100.0	100.0	100.0		91.1	92.6		
32	Number and rate (per 10,000) of children and young people accessing NHS funded community mental health services (CAMHS)	2020/21							400	491		
33	Percentage of children in need with statements of SEN or EHC plans	2019/20			8%	37%	54%			23%		
34	16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2019		7,360	4%	3%	3%		4%	6%		

Data Sources: *(Indicators 1,9-12,14,15,22-25,26,29-32 PHE Fingertips) (Indicators 2,3,4,16-19,21,27,28 Gov.uk) (Indicators 5-7,20 local data) (Indicators 33 NHS Digital)*

Appendix 7: Adult Mental Health dashboard

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

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

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	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Estimated prevalence of common mental health disorders - Age 16+	2017		34,276	22.4%	15.9%	17.7%	18.3%	19.3%	16.9%	11.6%	24.4%
2	Number and percentage of adults: Depression recorded prevalence - Age 18+ (QOF)	2019/20	↑	14,540	8.0%	10.1%	6.3%	8.0%	8.2%	11.6%	4.0%	18.5%
3	Rate of SMI (All Ages) (QOF)	2019/20	→	1,955	0.8%	0.7%	0.9%	0.8%	1.1%	0.9%	0.6%	1.5%
4	Adjustment disorders and distress in perinatal period (lower estimate): Estimated number of women	2017/18		443	443	386	535	1364	14431	73828		
5	Adjustment disorders and distress in perinatal period (upper estimate): Estimated number of women	2017/18		887	887	773	1070	2730	28863	147656		
6	PTSD in perinatal period: Estimated number of women	2017/18		89	89	77	107	273	2886	14766		
7	Number and percentage of school pupils with social, emotional and mental health needs	2020	→	1,104	2.5%	1.7%	1.9%	2.1%	2.5%	2.7%	2.7%	2.7%
8	Number of children in need due to family stress or dysfunction or absent parenting and rate per 10,000 children under 18	2017		578	93.6	46.6	46.8	61.7	97.9	93.8	0.0	265.9
9	Self reported wellbeing - Percentage of people with a high anxiety score	2019/20			20.1%	21.9%	19.9%		22.4%	21.9%	14.5%	29.2%
10	Number and percentage in concurrent contact with Mental Health Services for drug misuse	2016/17		76	20.0%	11.7%	12.9%	15.6%		24.3%	2.8%	60.7%
11	Number and percentage in concurrent contact with Mental Health Services for alcohol misuse	2016/17		45	22.0%	5.8%	6.7%	11.4%		22.7%	3.3%	72.5%
12	Percentage of adult social care users who have as much social contact as they would like - Age18+	2019/20		1,140	49.5%	48.3%	50.5%	49.5%	42.9%	45.9%	34.3%	56.6%
13	Access to IAPT services: people entering IAPT (month) as % estimated to have anxiety\depression	Sep-19	→	250	14.7%	17.8%	19.4%	17.6%		18.3%	7.0%	29.9%
14	APT reliable improvement: % of people in IAPT (quarter) who achieved reliable improvement (18+)	Q2 2019/20	→	285	71.3%	75.4%	72.6%	73.3%		71.7%	62.0%	79.2%
15	Percentage of social care users who suffer depression and anxiety	2018/20			51.9%	48.7%				50.5%	38.5%	63.6%
16	Dementia: QOF prevalence (all ages) Number and % of patients with dementia against total GP patients	2019/20	↓	900	0.4%	0.8%	0.6%	0.6%	0.5%	0.8%	0.3%	1.3%
17	Number and % of adults on GP list recorded as smokers with Serious Mental Illness	2014/15		523	40.2%	39.4%	30.4%	35.7%	38.9%	40.5%	27.2%	52.3%
18	Number of hospital admissions for mental health conditions and rate per 100,000 population	2019/20	→	35	55.1	68.5	78.7	68.1	64.5	89.5	26.3	249.7
19	Proportion of people (18-74) in contact with secondary mental health services rate per 100,000	Q2 2019/20	→	2,995	2016	1910	1498	1774	2201	2381.0	1208.0	4633.0
20	Number and age standardised mortality rate from suicide per 100,000 population (Persons)	2017/19		32	6.1	7.2	7.1		8.2	10.1	4.9	19.0
21	Number and directly age standardised rates for emergency hospital admissions for intentional self harm	2019/20	↓	135	63.9	73.5	44.5	59.2	81.6	192.6	44.5	457.6
22	Mental Health service users on Care Programme Approach (CPA)	Q2 2019/20	→	765	25.5%	19.9%	26.1%	23.6%	19.3%	15.0%	0.3%	51.3%
23	Stable and appropriate accommodation - % of people on CPA	Q2 2019/20	↑	595	83.2%	87.1%	58.6%	75.2%	59.2%	57.8%	57.5%	58.1%
24	CPA Adults in Employment	Q2 2019/20	→	50	7.0%	11.3%	5.1%	7.5%	7.2%	9.1%	0.0%	36.6%

Appendix 8: Cancer dashboard

To return to chapter 7.4: Cancers - Click Here

BHR Joint Strategic Needs Assessment 2019

London Borough of Barking & Dagenham

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	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	New cancer cases (Crude incidence rate: new cases per 100,000)	2018-19	→	755	328.0	589.0	363.0			529.0	217.0	728.0
2	All Tumours (Age standardised incidence rate per 100,000)	2017		949	744.6	727.9	630.5	694.9	653.5	713.9		
3	Incidence breast cancer (Age standardised rate per 100,000)	2017		128	181.2	160.6	161.2	165.3	164.8	166.7		
4	Incidence colorectal cancer (Age standardised rate per 100,000)	2018		91	79.7	74.0	52.3			69.0		
5	Incidence lung cancer (Age standardised rate per 100,000)	2018		131	119.5	74.4	61.8			75.8		
6	Incidence prostate cancer (Age standardised rate per 100,000)	2018		161	303.5	343.3	218.7			204.1		
7	The percentage of patients with cancer, as recorded on practice disease registers	2017/18	↑	3,128	1.4%	2.7%	1.7%	1.9%	1.8%	2.7%	4.2%	0.9%
8	Cancer 1 year survival rate (%)	2017		557	69.7%	73.2%	72.6%			73.3%		
9	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2018-19	↓	6,090	42.8%	56.3%	48.4%		49.2%	58.0%		
10	Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2018-19	↓	3,148	41.7%	56.5%	47.9%		47.9%	57.9%		
11	Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2019-20	↑	9,573	48.6%	62.0%	55.1%		55.6%	63.8%	45.1%	70.9%
12	Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2019-20	→	4,505	50.9%	63.7%	55.8%		56.8%	65.8%	45.9%	72.5%
13	Breast screening uptake (%)	2020	↓	11,209	66.4%	78.7%	71.8%		67.2%	74.1%	54.1%	81.7%
14	Cancer screening coverage - cervical cancer (aged 25 to 49)	2020	↓	32,056	65.6%	72.9%	61.5%		61.8%	70.2%	46.4%	80.1%
15	Cancer screening coverage - cervical cancer (aged 50 to 64)	2020		11,849	72.9%	77.6%	74.6%		73.2%	76.1%	59.2%	90.6%
16	Percentage of cancers detected at stage 1 and 2	2019		243								
17	Percentage of cancers diagnosed through emergency presentation	2018		340	54.4%	55.4%	60.2%		56.5%	55.0%	47.5%	76.5%
18	Premature mortality from all cancers (rate per 100,000)	2017-19		495	147.1	130.6	102.8		117.4	129.2	87.4	182.4
19	Premature mortality from lung cancer (rate per 100,000)	2017-19		233	70.8	52.9	34.8		48.0	53.0		
20	Premature mortality from breast cancer (rate per 100,000)	2017-19		39	19.1	20.8	20.9		19.6	20.0	15.6	26.1
21	Premature mortality from colorectal cancer (rate per 100,000)	2017-19		37	11.4	10.8	8.3		10.4	11.8	17.6	5.8
22	Excess cancer deaths and attributable life years gap; females, compared to England	2015-17		44	0.4	0.0	-0.4		-0.3	1.0	-0.8	1.0
23	Excess cancer deaths and attributable life years gap in most/least deprived quintile; females within area	2015-17		23	1.3	0.8	-0.1		1.0	1.4	-1.5	3.0
24	Excess cancer deaths and attributable life years gap; males, compared to England	2015-17		95	0.6	0.4	-0.7		-0.3	1.0	-1.0	1.0
25	Excess cancer deaths and attributable life years gap in most/least deprived quintile; males within area	2015-17		25	0.8	1.4	0.8		1.3	1.6	-0.8	3.2

Appendix 9: Long Term Conditions dashboard

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

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: HSC - Long Term Conditions

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

	Indicator	Period	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
			Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Diabetes: QOF prevalence (Age 17+) (%)	2019/20	14,582	8.6%	7.5%	9.1%	8.4%	6.8%	7.1%	3.6%	11.1%
2	Diabetes: Estimated prevalence (Age 16+) (%)	2017	14,973	9.2%	8.6%	10.5%			8.5%		
3	Major diabetic lower-limb amputation procedures (Per 10,000)	2016/17 - 18/19	25	10.7	9.2	13.3	11.1		8.2	27.0	3.4
4	Percentage of LTCs reporting that they have received all or some of the support they need (%)	2019/20	549	49.1%	46.5%	46.8%	47.5%	52.1%	54.9%	46.5%	61.2%
5	Coronary Heart Disease: QOF prevalence (All Ages) (%)	2019/20	4,403	1.8%	2.6%	2.4%	2.3%	1.9%	3.1%	1.2%	5.0%
6	Coronary Heart Disease: Estimated prevalence (Age 55-79) (%)	2015		9.6%	8.7%	7.6%	8.6%		7.9%	14.8%	6.7%
7	Emergency hospital admissions for coronary heart disease, standardised admission ratio	2019/20		114.0	85.9	113.6	104.5		102.1	78.6	127.2
8	Coronary Heart Disease: Mortality Under 75 (DSR per 100,000)	2017/19	162	47.7	37.7	33.4	39.6		37.5	108.5	16.1
9	COPD: QOF prevalence (All Ages) (%)	2019/20	3,508	1.5%	1.8%	0.8%	1.4%		1.9%		
10	COPD: Estimated prevalence (All Ages) (%)	2015		2.4%	2.8%	1.9%	2.4%		3.0%	4.9%	1.5%
11	COPD: Emergency hospital admissions standardised admission ratio	2019/20	405	597.0	363.0	266.0	408.7		415.0		
12	COPD: Mortality (DSR per 100,000)	2017-19	263	81.8	55.1	41.8	59.6		53.9		
13	Hypertension: QOF prevalence (All Ages) (%)	2019/20	26,337	11.3%	14.4%	11.7%	12.5%	11.0%	14.1%	7.4%	18.9%
14	Diagnosed Hypertension: Estimated prevalence (%)	2017	31,650	20.7%	26.3%	22.4%	23.1%	21.6%	26.2%	15.8%	32.8%
16	Hypertension: Mortality Under 75 (Require PCMD) (DSR per 100,000)	2017-2019	15	4.6	2.7	2.1	3.1	3.8	3.0	1.2	10.8
17	Under 75 mortality rate from respiratory conditions considered to be preventable (DSR per 100,000)	2017-19	114	38.2	20.2	11.8	23.4	17.3	20.0	44.7	6.4
18	Stroke QOF Prevalence (All Ages) (%)	2019/20	2,160	0.9%	1.6%	1.1%	1.2%	1.1%	1.8%	0.7%	2.9%
19	Emergency hospital admissions for stroke, standardised admission ratio	2019/20	215	175.1	144.0	155.2	158.1		170.2	298.1	110.3
20	Stroke - Under 75 Mortality (DSR per 100,000)	2017-19	62	17.6	12.1	12.7	14.1		12.5	24.7	6.8
21	Learning Disability QOF Prevalence (All Ages) (%)	2019/20	1,078	0.5%	0.4%	0.4%	0.4%	0.4%	0.5%	0.2%	0.8%
22	Learning Disability: Completed Health checks (%)	2018/19	652	66.2%	73.7%	61.2%	67.0%	58.2%	52.3%	3.4%	87.2%

Appendix 10: Older People & Frailty dashboard

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

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: HSC - Older People

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

	Indicator	Period	Barking & Dagenham	Havering	Redbridge	BHR	London	England		
			Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Life expectancy at 65 (Years) - Females	2018-20	19.8	21.2	22.0		22.0	21.1	21.1	21.2
2	Life expectancy at 65 (Years) - Males	2018-20	16.7	18.2	19.2		19.2	18.7	18.7	18.7
3	Healthy life expectancy at 65 (Years) - Females	2017-19	8.5	10.8	12.1		10.0	11.1	2.4	16.7
4	Healthy life expectancy at 65 (Years) - Males	2017-19	8.5	10.9	8.4		9.7	10.6	6.1	16.0
5	Disability-free life expectancy at 65 (Years) - Females	2017-19	8.6	9.8	12.1		9.7	9.7	6.0	13.5
6	Disability-free life expectancy at 65 (Years) - Males	2017-19	9.3	10.8	10.0		10.0	9.9	7.0	15.1
7	Emergency hospital admissions due to falls in people aged 65 and over- Females (DSR per 100,000)	2017/18	1843.0	1862.2	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	1538.0	1588.7	1424.2		1981.5	1775.1		
9	Emergency hospital admissions due to falls in people aged 65 and over- Persons (DSR per 100,000)	2019/20	1670.4	1623.1	1743.2		2214.7	2221.8	1325.0	3394.0
10	Hip fractures in people aged 65 and over- Females (DSR per 100,000)	2017/18	710.0	705.5	712.7		611.7	697.1		
11	Hip fractures in people aged 65 and over- Males (DSR per 100,000)	2017/18	409.9	414.4	294.0		372.3	410.7		
12	Hip fractures in people aged 65 and over- Persons (DSR per 100,000)	2019/20	472.4	563.0	488.8		472.7	571.6	326.0	912.0
13	Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital (%)	2019/20	85.0	89.3	92.9	89.6	83.4	82.0	42.9	96.9
14	Emergency readmissions within 30 days of discharge from hospital (%)	2018/19	16.6	16.8	15.4	16.7		14.4	11.7	17.2
15	Delayed transfers of care from hospital, per 100,000	2019	5.7	6.2	5.3	5.7	6.8	10.8		
16	Percentage of deaths that occur in hospital (ages 65-74)	2019	55.3	54.2	61.3	56.6	56.1	48.3	35.4	63.6
17	Percentage of deaths that occur in hospital (ages 75-84)	2019	50.7	50.3	63.9	54.8	56.6	48.4	39.8	63.9
18	Percentage of deaths that occur in hospital (ages 85+)	2019	47.4	45.7	54.6	48.7	50.7	41.4	31.7	59.0
19	Rate of permanent admissions to residential and nursing care homes (ages 65+, per 100,000)	2019/20	677.5	631.6	401.5	555.3	431.3	584.0	61.0	1724.0
20	Older People who are Income Deprived (IMD) %	2019	26.1	11.7	19.5	17.4	20.6	14.2	5.0	43.9
21	Excess winter mortality	2018/19	26.2	20.5	17.7		13.7	14.6	-20.0	210.0
22	Population vaccination coverage - Flu (aged 65+)	2019/20	65.0	70.0	68.0		66.2	72.4	58.3	80.1
23	Care home beds, number and rate / 100 people aged 75+,	2021	8.0	8.0	7.7	7.9	7.1	9.4	2.3	17.2
24	People invited for an NHS Health Check per year	2020/21	4.5	2.3	4.5	3.7	3.6	3.1		
25	People receiving an NHS Health Check per year	2020/21	2.5	0.8	1.4	1.5	2.2	1.2	0.0	9.2
26	People taking up an NHS Health Check invite per year	2020/21	56.7	36.0	30.8	39.8	62.5	39.0		

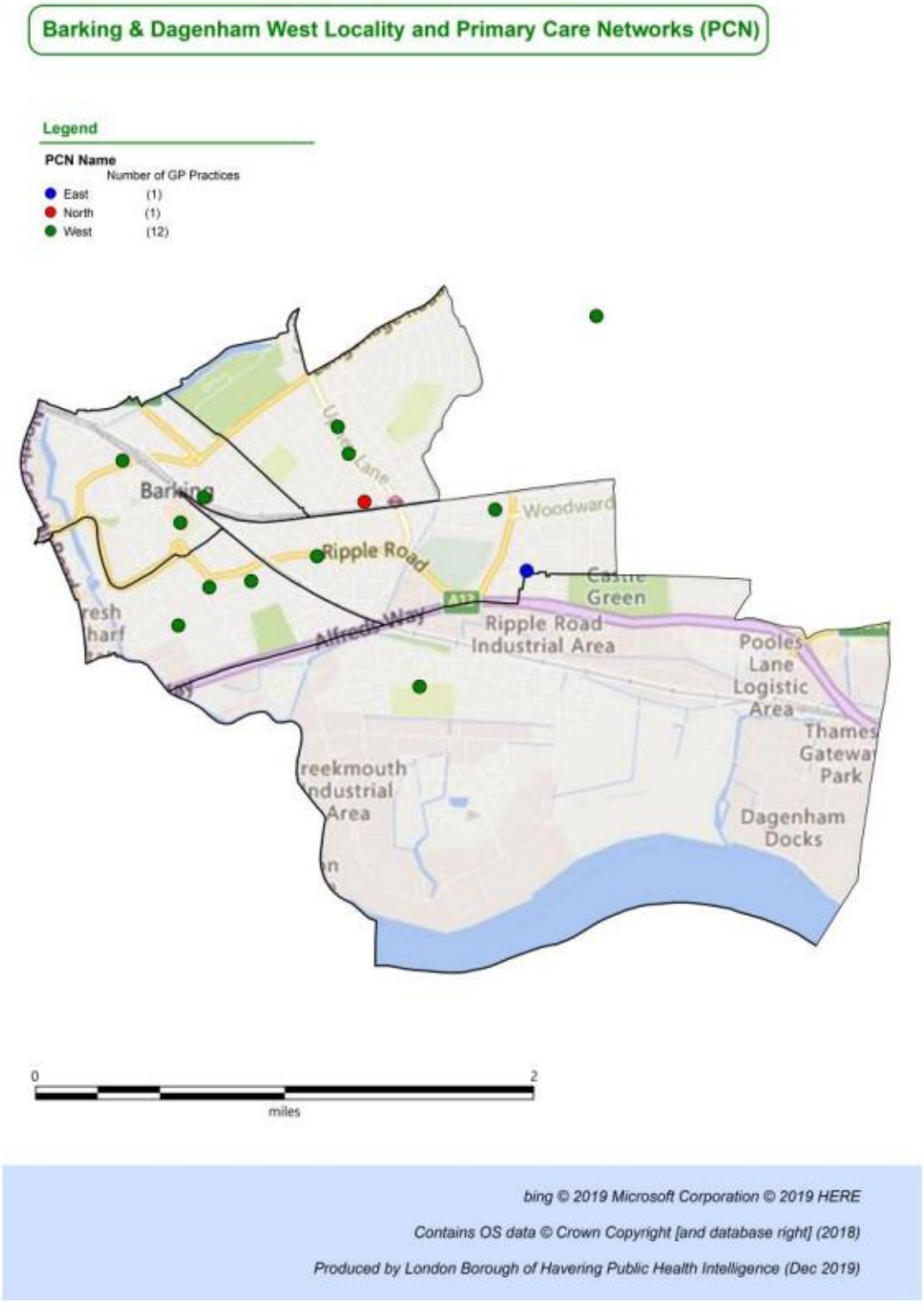
Appendix 11: Localities Data

London Borough of Barking and Dagenham (LBBD) – West Locality

1. Places and Communities

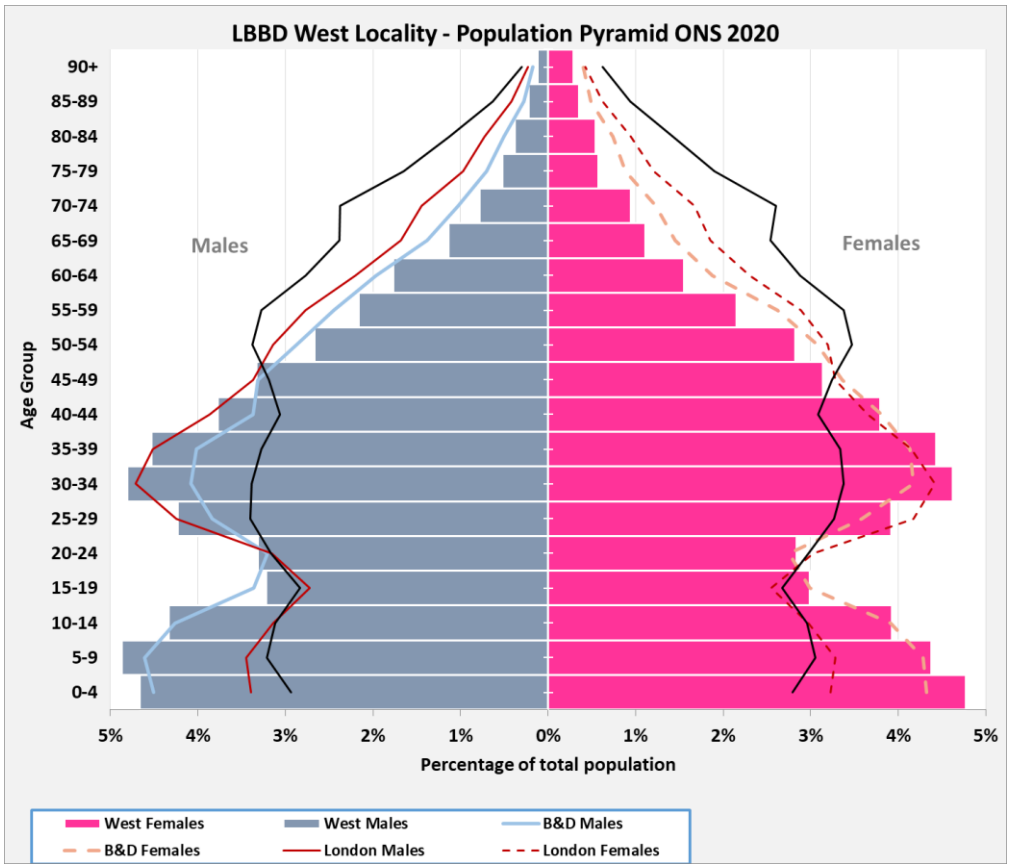
1.1 LBBD West locality map

Wards include Abbey, Eastbury, Gascoigne, Longbridge, Thames,



1.2 Estimated population of LBBD West locality residents by gender and five-year age groups - 2020

Age Band (Years)	Males	Females	Total
0-4	3,279	3,357	6,636
5-9	3,423	3,082	6,505
10-14	3,048	2,761	5,809
15-19	2,266	2,105	4,371
20-24	2,332	1,999	4,331
25-29	2,975	2,758	5,733
30-34	3,379	3,252	6,631
35-39	3,184	3,118	6,302
40-44	2,654	2,667	5,321
45-49	2,340	2,206	4,546
50-54	1,878	1,984	3,862
55-59	1,523	1,514	3,037
60-64	1,241	1,095	2,336
65-69	798	780	1,578
70-74	550	664	1,214
75-79	366	407	773
80-84	269	383	652
85-89	155	252	407
90+	82	204	286
Totals	35,742	34,588	70,330



Source: ONS 2020 Mid-Year Estimates

1.3 LBBD PCN Profile - GP population 5-year age groups

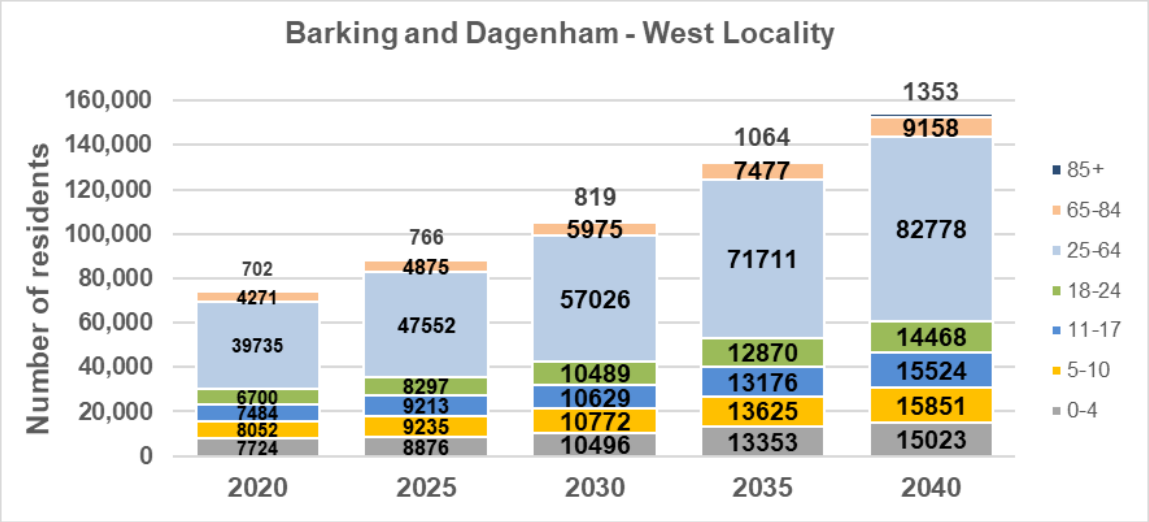
	East PCN			East One PCN			New West PCN			North PCN			North West PCN			West PCN		
Age Band	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**
0-4	1,804	1,952	3,756	1,697	1,756	3,453	1,245	1,257	2,502	1,721	1,739	3,460	1,103	1,091	2,194	1,442	1,412	2,854
5-9	2,137	2,262	4,399	1,961	2,018	3,979	1,398	1,369	2,767	1,992	2,012	4,004	1,398	1,413	2,811	1,531	1,646	3,177
10-14	1,990	2,120	4,110	2,028	2,178	4,206	1,341	1,508	2,849	1,933	2,015	3,948	1,379	1,519	2,898	1,528	1,515	3,043
15-19	1,502	1,604	3,106	1,682	1,873	3,555	1,211	1,194	2,405	1,665	1,795	3,460	1,209	1,360	2,569	1,323	1,448	2,771
20-24	1,425	1,277	2,702	1,587	1,627	3,214	1,069	1,081	2,150	1,487	1,598	3,085	1,013	1,057	2,070	1,401	1,452	2,853
25-29	1,661	1,543	3,204	1,858	1,895	3,753	1,361	1,216	2,577	1,825	1,855	3,680	1,145	1,114	2,259	1,693	1,713	3,406
30-34	2,335	2,035	4,370	2,208	1,961	4,169	1,566	1,553	3,119	2,170	2,060	4,230	1,294	1,186	2,480	1,901	2,082	3,983
35-39	2,355	2,449	4,804	2,088	2,065	4,153	1,612	1,676	3,288	2,182	2,134	4,316	1,512	1,343	2,855	1,833	2,124	3,957
40-44	2,074	2,263	4,337	2,040	1,977	4,017	1,401	1,558	2,959	1,893	2,012	3,905	1,363	1,347	2,710	1,611	1,875	3,486
45-49	1,618	1,880	3,498	1,789	1,841	3,630	1,099	1,369	2,468	1,692	1,898	3,590	1,158	1,217	2,375	1,324	1,704	3,028
50-54	1,356	1,562	2,918	1,616	1,716	3,332	1,025	1,150	2,175	1,551	1,746	3,297	1,062	1,164	2,226	1,192	1,434	2,626
55-59	1,037	1,154	2,191	1,390	1,518	2,908	726	871	1,597	1,433	1,542	2,975	973	918	1,891	1,103	1,197	2,300
60-64	700	776	1,476	1,045	1,149	2,194	512	630	1,142	1,094	1,196	2,290	689	715	1,404	837	976	1,813
65-69	512	474	986	792	757	1,549	347	389	736	923	845	1,768	514	457	971	660	636	1,296
70-74	382	289	671	615	566	1,181	256	237	493	668	617	1,285	365	357	722	516	412	928
75-79	289	195	484	516	383	899	190	139	329	535	419	954	291	240	531	365	271	636
80-84	201	120	321	328	234	562	108	79	187	377	275	652	221	130	351	306	205	511
85-89	125	82	207	244	143	387	69	43	112	256	149	405	144	95	239	170	125	295
90-94	82	33	115	128	62	190	30	17	47	129	77	206	81	33	114	88	39	127
95+	33	6	39	39	15	54	5	4	9	45	21	66	19	3	22	24	18	42
Total	**23,618**	**24,076**	**47,694**	**25,651**	**25,734**	**51,385**	**16,571**	**17,340**	**33,911**	**25,571**	**26,005**	**51,576**	**16,933**	**16,759**	**33,692**	**20,848**	**22,284**	**43,132**

Source: NHS Digital GP Registrations (April 2022)

1.4 LBBD West Locality Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
West	74,668	88,814	106,206	42.2%	133,276	78.5%	154,155	106.5%

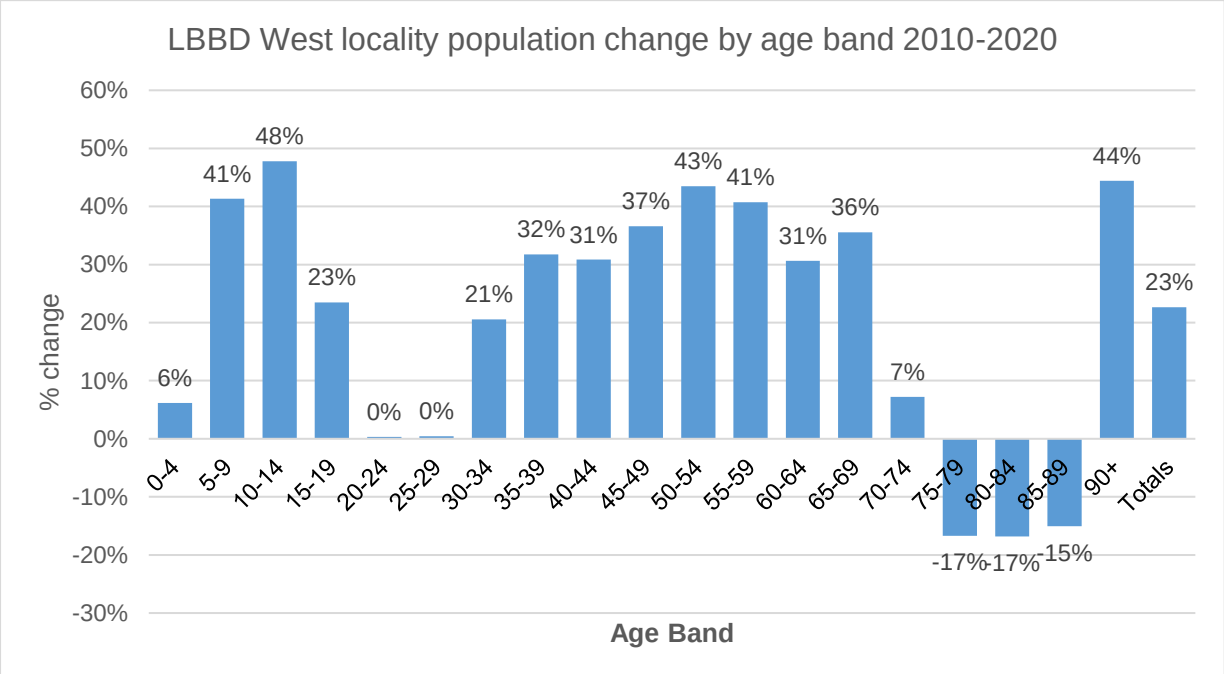
West	2020	2025	2030	2035	2040
0-4	7,724	8,876	10,496	13,353	15,023
5-10	8,052	9,235	10,772	13,625	15,851
11-17	7,484	9,213	10,629	13,176	15,524
18-24	6,700	8,297	10,489	12,870	14,468
25-64	39,735	47,552	57,026	71,711	82,778
65-84	4,271	4,875	5,975	7,477	9,158
85+	702	766	819	1,064	1,353
Total	74,668	88,814	106,206	133,276	154,155



Source: Greater London Authority (GLA) Population Projections. 2016-based ward level population projections

1.5 LBBD West Locality population change by age band 2010 – 2020

Age Band (Years)	2010	2020	Change	%
0-4	6,252	6,636	384	6%
5-9	4,602	6,505	1,903	41%
10-14	3,931	5,809	1,878	48%
15-19	3,540	4,371	831	23%
20-24	4,316	4,331	15	0%
25-29	5,707	5,733	26	0%
30-34	5,500	6,631	1,131	21%
35-39	4,783	6,302	1,519	32%
40-44	4,066	5,321	1,255	31%
45-49	3,328	4,546	1,218	37%
50-54	2,692	3,862	1,170	43%
55-59	2,158	3,037	879	41%
60-64	1788	2336	548	31%
65-69	1164	1578	414	36%
70-74	1132	1214	82	7%
75-79	928	773	-155	-17%
80-84	784	652	-132	-17%
85-89	479	407	-72	-15%
90+	198	286	88	44%
Totals	**57,348**	**70,330**	**12982**	**23%**



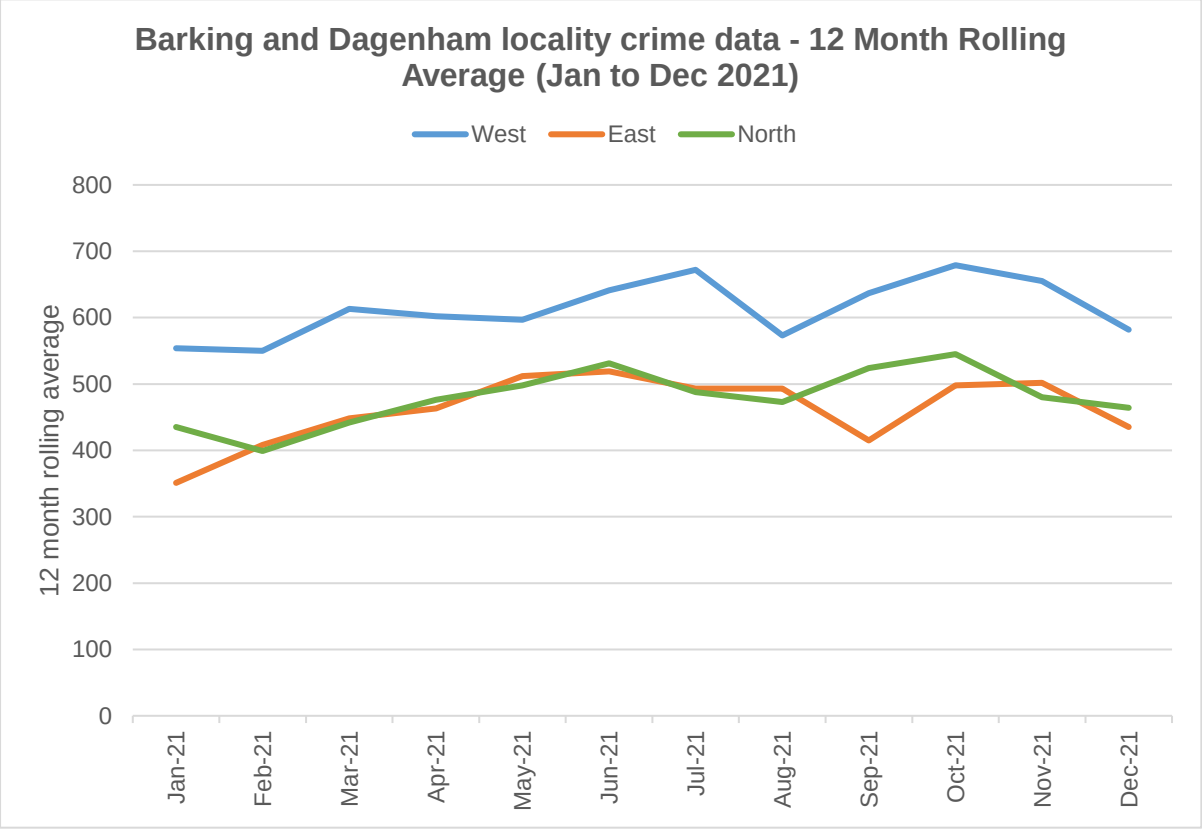
Source: ONS population estimates – Ward level population estimates

1.6 Ethnicity

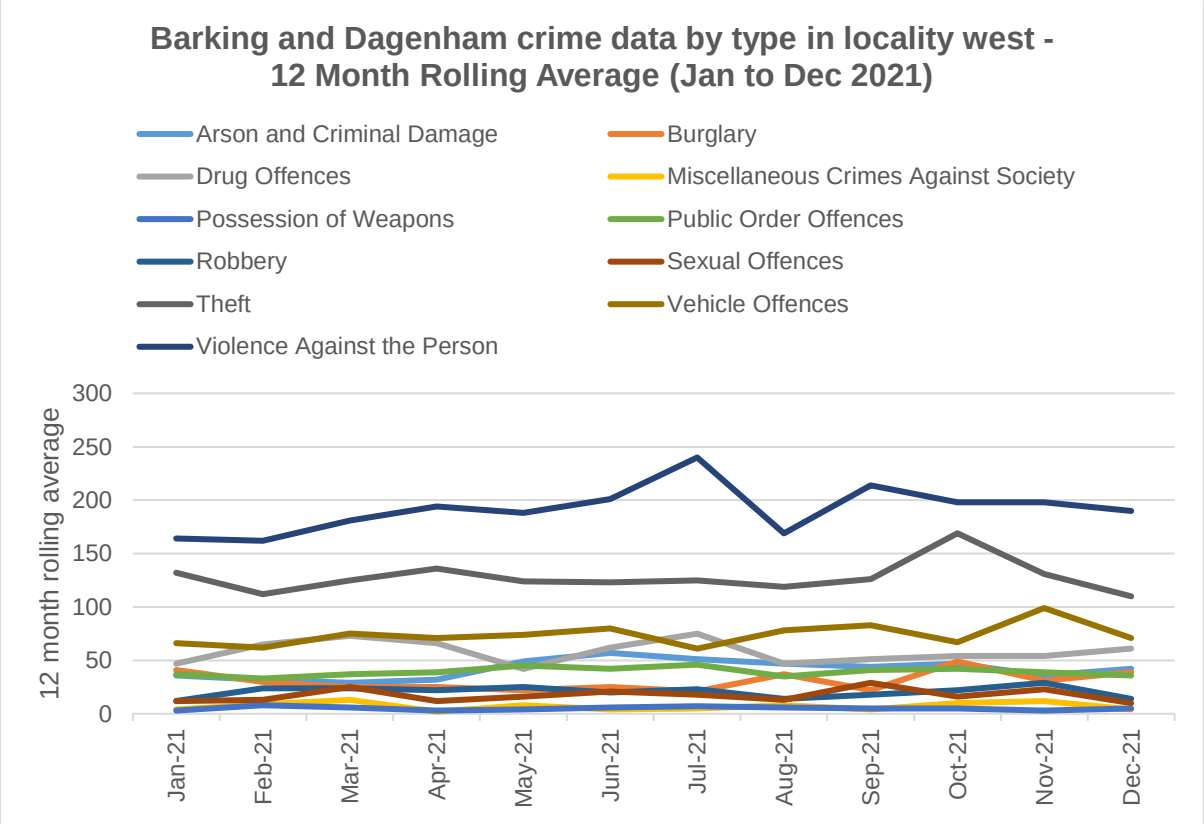
Ethnic Group	Number	%
British	18,900	32
African	10,702	18
Pakistani or British Pakistani	5,117	9
Bangladeshi or British Bangladeshi	4,507	8
Indian or British Indian	3,988	7
Caribbean	1,724	3
Baltic States	1,041	2
White and Black Caribbean	740	1
European Mixed	904	2
White and Black African	849	1
Other	10,596	18
Total	59,068	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in West Locality

The London Plan 2021 sets a ten-year housing target for Barking and Dagenham of 19,440 new homes between 2019/20 and 2028/29 or 1,944 per annum.

As of 1st September 2021, land was available for a total of 12,374[180] homes within Barking and Dagenham. There are plans for these to be delivered over a five-year period from 2021-21 to 2024-25.

Below is the approximate breakdown by Locality.

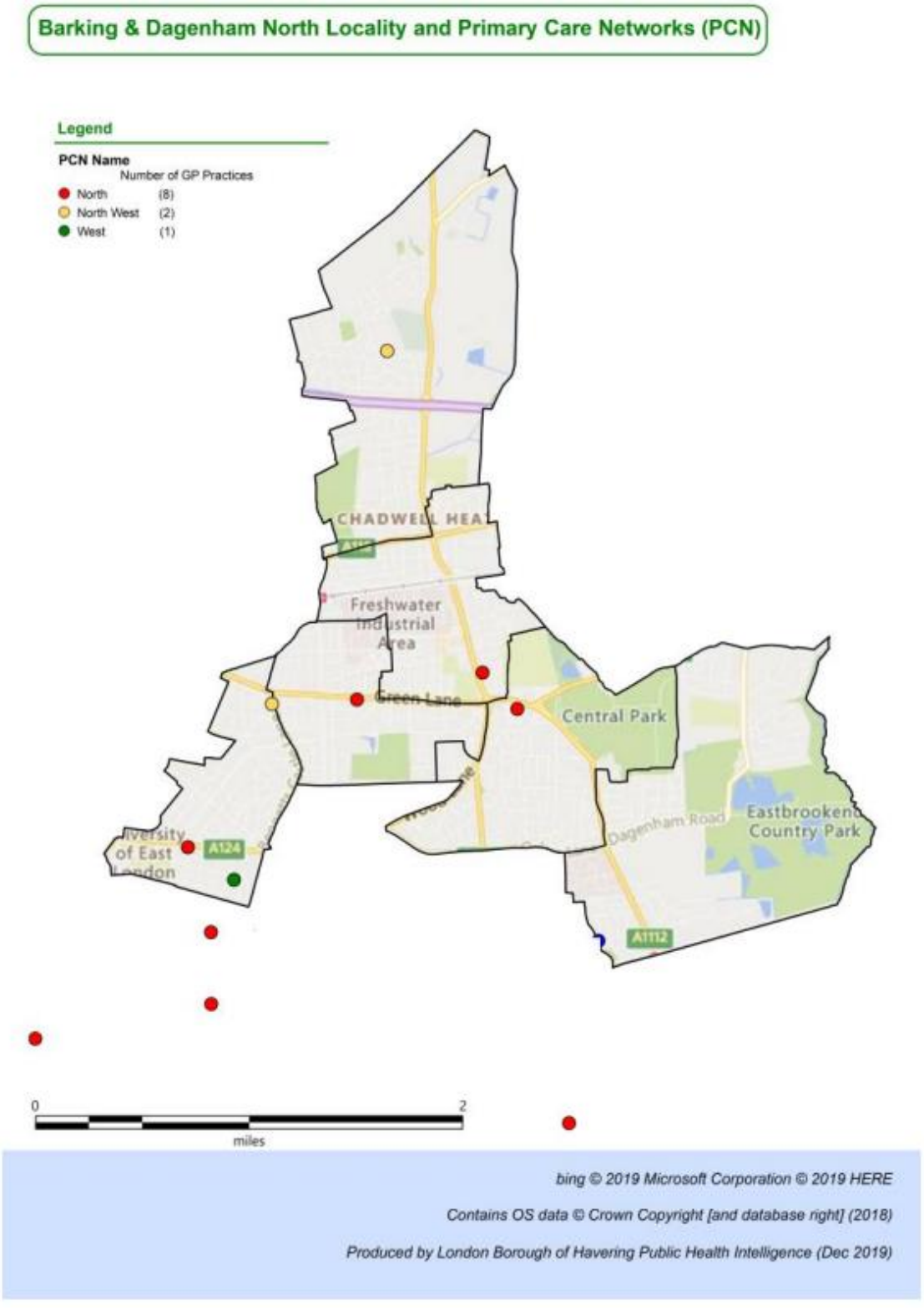
Locality	Number of houses
North	1,114
West	5,320
East	5,940
Total	**12,374**

[180] London Borough of Barking and Dagenham Interim Five-Year Housing Supply Statement: For the five-year period commencing 1st September 2021. Available from: https://www.lbbd.gov.uk/sites/default/files/attachments/Five%20year%20land%20supply%20statement%20October%202021.pdf

London Borough of Barking and Dagenham (LBBD) – North Locality

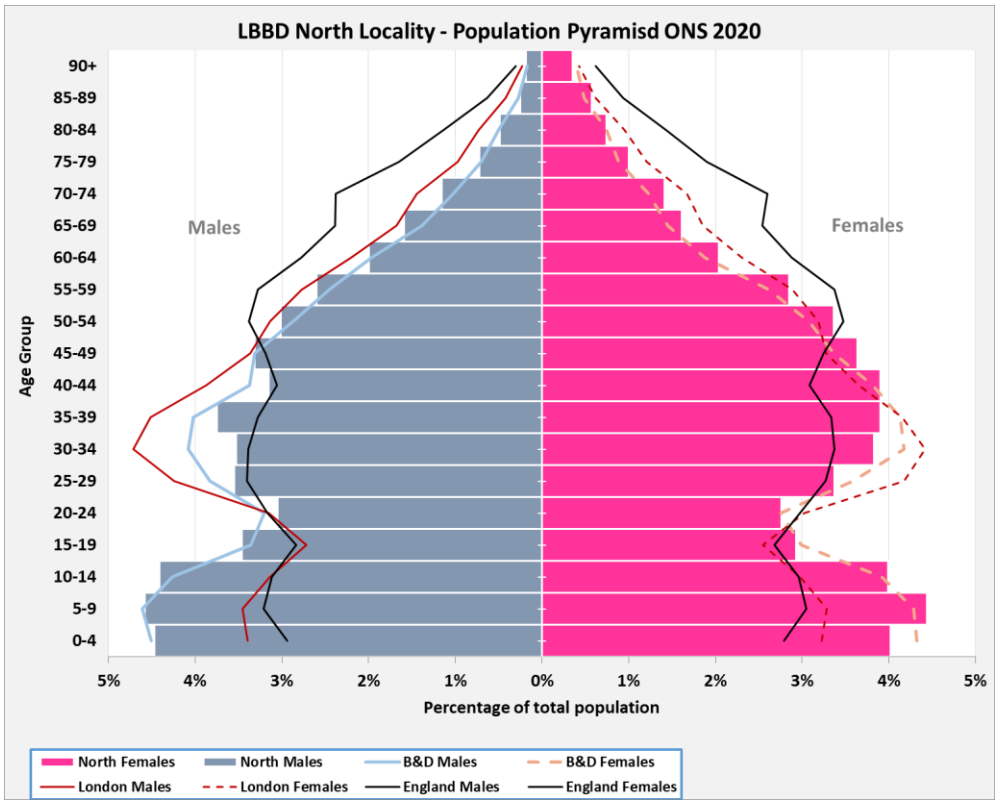
1. Places and Communities

1.1 Barking and Dagenham North locality map Wards include: Becontree, Chadwell Heath, Eastbrook, Heath, Valence, Whalebone



1.2 Estimated population of LBBD North locality residents by gender and five-year age groups

Age Band (Years)	Males	Females	Total
0-4	3,265	3,099	6,364
5-9	3,258	2,999	6,257
10-14	3,013	2,845	5,858
15-19	2,518	2,253	4,771
20-24	2,397	1,979	4,376
25-29	2,758	2,568	5,326
30-34	2,906	3,025	5,931
35-39	2,807	3,007	5,814
40-44	2,372	2,780	5,152
45-49	2,443	2,463	4,906
50-54	2,173	2,263	4,436
55-59	1,913	2,103	4,016
60-64	1,577	1,506	3,083
65-69	1055	1196	2,251
70-74	834	984	1,818
75-79	631	794	1425
80-84	472	690	1162
85-89	258	395	653
90+	155	402	557
Totals	36,805	37,351	74,156



Source: ONS 2020 Mid-Year Estimates

1.3 LBBD PCN Profile - GP population 5-year age groups

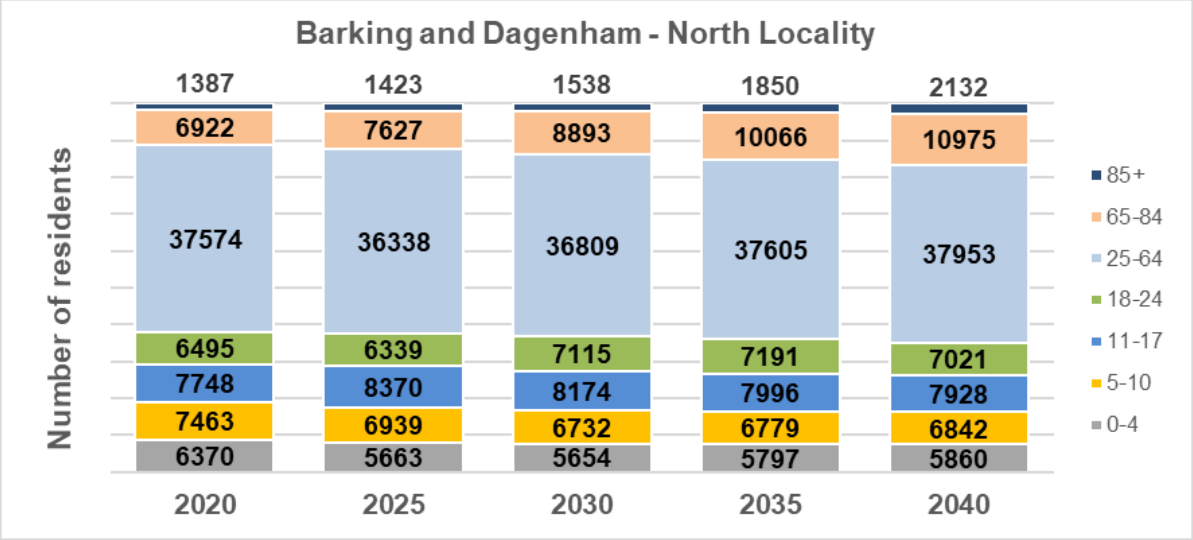
	East PCN			East One PCN			New West PCN			North PCN			North West PCN			West PCN		
Age Band	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**
0-4	1,804	1,952	3,756	1,697	1,756	3,453	1,245	1,257	2,502	1,721	1,739	3,460	1,103	1,091	2,194	1,442	1,412	2,854
5-9	2,137	2,262	4,399	1,961	2,018	3,979	1,398	1,369	2,767	1,992	2,012	4,004	1,398	1,413	2,811	1,531	1,646	3,177
10-14	1,990	2,120	4,110	2,028	2,178	4,206	1,341	1,508	2,849	1,933	2,015	3,948	1,379	1,519	2,898	1,528	1,515	3,043
15-19	1,502	1,604	3,106	1,682	1,873	3,555	1,211	1,194	2,405	1,665	1,795	3,460	1,209	1,360	2,569	1,323	1,448	2,771
20-24	1,425	1,277	2,702	1,587	1,627	3,214	1,069	1,081	2,150	1,487	1,598	3,085	1,013	1,057	2,070	1,401	1,452	2,853
25-29	1,661	1,543	3,204	1,858	1,895	3,753	1,361	1,216	2,577	1,825	1,855	3,680	1,145	1,114	2,259	1,693	1,713	3,406
30-34	2,335	2,035	4,370	2,208	1,961	4,169	1,566	1,553	3,119	2,170	2,060	4,230	1,294	1,186	2,480	1,901	2,082	3,983
35-39	2,355	2,449	4,804	2,088	2,065	4,153	1,612	1,676	3,288	2,182	2,134	4,316	1,512	1,343	2,855	1,833	2,124	3,957
40-44	2,074	2,263	4,337	2,040	1,977	4,017	1,401	1,558	2,959	1,893	2,012	3,905	1,363	1,347	2,710	1,611	1,875	3,486
45-49	1,618	1,880	3,498	1,789	1,841	3,630	1,099	1,369	2,468	1,692	1,898	3,590	1,158	1,217	2,375	1,324	1,704	3,028
50-54	1,356	1,562	2,918	1,616	1,716	3,332	1,025	1,150	2,175	1,551	1,746	3,297	1,062	1,164	2,226	1,192	1,434	2,626
55-59	1,037	1,154	2,191	1,390	1,518	2,908	726	871	1,597	1,433	1,542	2,975	973	918	1,891	1,103	1,197	2,300
60-64	700	776	1,476	1,045	1,149	2,194	512	630	1,142	1,094	1,196	2,290	689	715	1,404	837	976	1,813
65-69	512	474	986	792	757	1,549	347	389	736	923	845	1,768	514	457	971	660	636	1,296
70-74	382	289	671	615	566	1,181	256	237	493	668	617	1,285	365	357	722	516	412	928
75-79	289	195	484	516	383	899	190	139	329	535	419	954	291	240	531	365	271	636
80-84	201	120	321	328	234	562	108	79	187	377	275	652	221	130	351	306	205	511
85-89	125	82	207	244	143	387	69	43	112	256	149	405	144	95	239	170	125	295
90-94	82	33	115	128	62	190	30	17	47	129	77	206	81	33	114	88	39	127
95+	33	6	39	39	15	54	5	4	9	45	21	66	19	3	22	24	18	42
Total	**23,618**	**24,076**	**47,694**	**25,651**	**25,734**	**51,385**	**16,571**	**17,340**	**33,911**	**25,571**	**26,005**	**51,576**	**16,933**	**16,759**	**33,692**	**20,848**	**22,284**	**43,132**

Source: NHS Digital GP Registrations (April 2022)

1.4 LBBD North Locality Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
North	73,959	72,698	74,914	1.3%	77,284	4.5%	78,710	6.4%

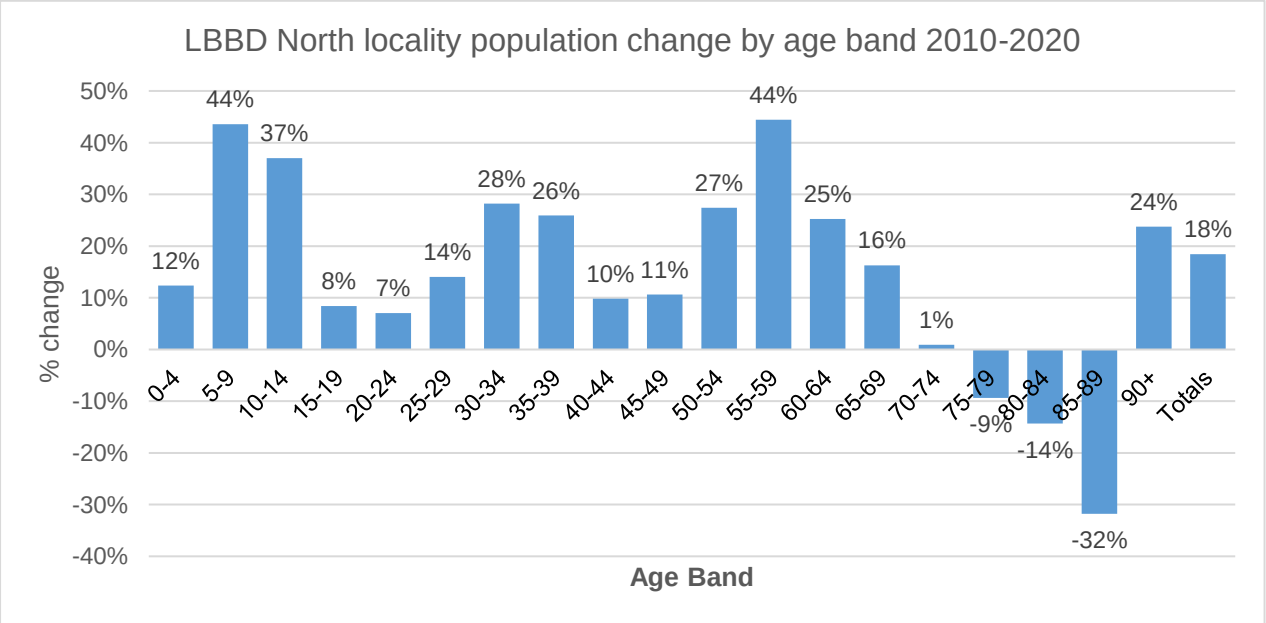
North	2020	2025	2030	2035	2040
0-4	6,370	5,663	5,654	5,797	5,860
5-10	7,463	6,939	6,732	6,779	6,842
11-17	7,748	8,370	8,174	7,996	7,928
18-24	6,495	6,339	7,115	7,191	7,021
25-64	37,574	36,338	36,809	37,605	37,953
65-84	6,922	7,627	8,893	10,066	10,975
85+	1,387	1,423	1,538	1,850	2,132
Total	73,959	72,698	74,914	77,284	78,710



Source: Greater London Authority (GLA) Population Projections. 2016-based ward level population projections.

1.5 LBBD North Locality population change by age band 2010 - 2020

Age Band (Years)	2010	2020	Change	%
0-4	5,664	6,364	700	12%
5-9	4,359	6,257	1,898	44%
10-14	4,276	5,858	1,582	37%
15-19	4,401	4,771	370	8%
20-24	4,087	4,376	289	7%
25-29	4,671	5,326	655	14%
30-34	4,625	5,931	1,306	28%
35-39	4,618	5,814	1,196	26%
40-44	4,691	5,152	461	10%
45-49	4,434	4,906	472	11%
50-54	3,482	4,436	954	27%
55-59	2,780	4,016	1,236	44%
60-64	2462	3083	621	25%
65-69	1936	2251	315	16%
70-74	1802	1818	16	1%
75-79	1572	1425	-147	-9%
80-84	1356	1162	-194	-14%
85-89	957	653	-304	-32%
90+	450	557	107	24%
Totals	62,623	74,156	11533	18%



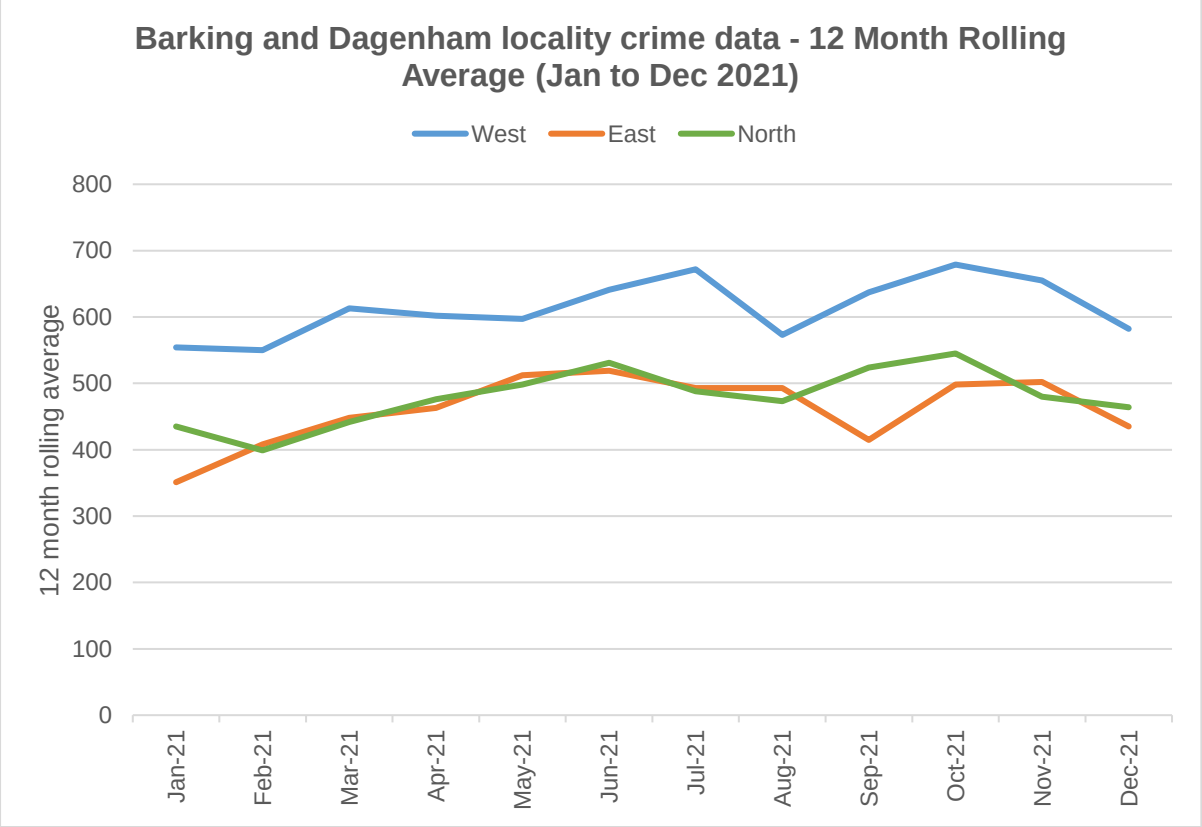
Source: ONS population estimates – Ward level population estimates

1.6 Ethnicity

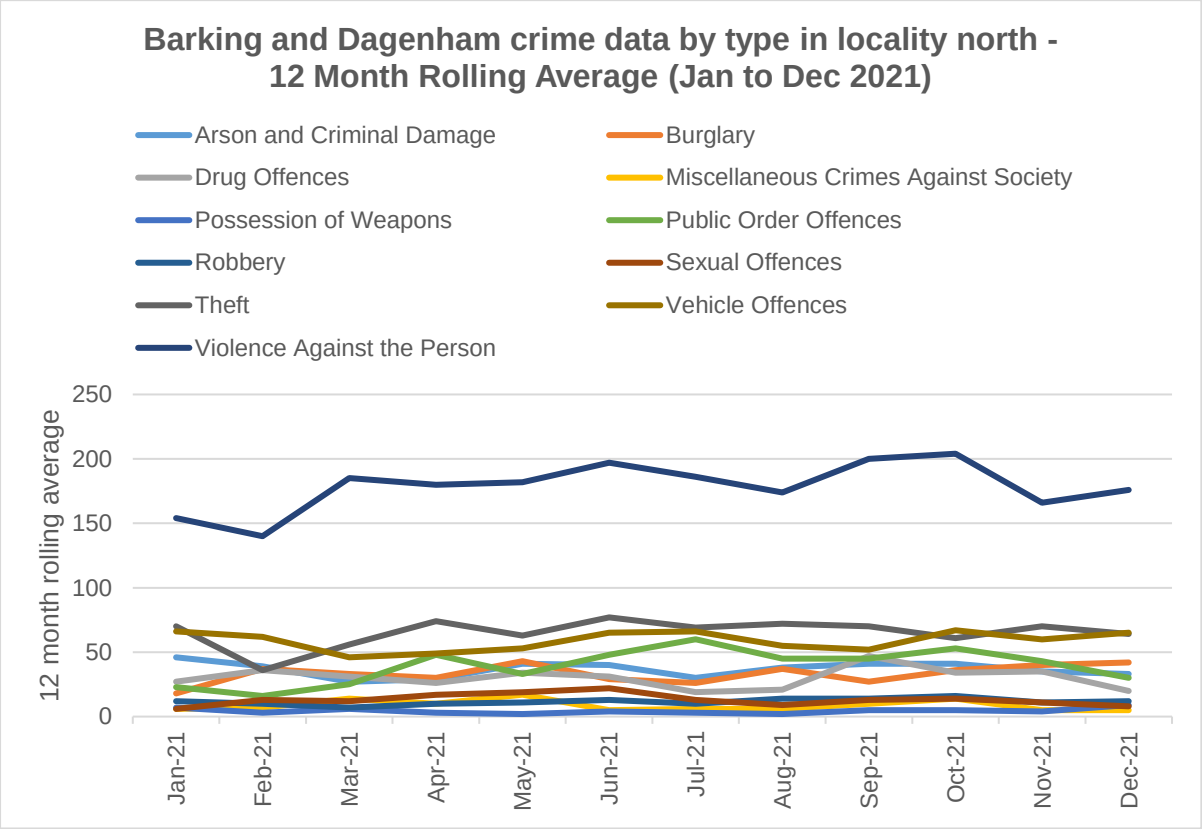
Ethnic Group	Number	%
British	36,390	57
African	7,776	12
Pakistani or British Pakistani	2,052	3
Bangladeshi or British Bangladeshi	1,824	3
Indian or British Indian	2,427	4
Caribbean	2,110	3
Baltic States	908	1
White and Black Caribbean	930	1
European Mixed	673	1
White and Black African	607	1
Other	7,603	12
Total	63,300	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in North Locality

The London Plan 2021 sets a ten-year housing target for Barking and Dagenham of 19,440 new homes between 2019/20 and 2028/29 or 1,944 per annum.

As of 1st September 2021, land was available for a total of 12,374[181] homes within Barking and Dagenham. There are plans for these to be delivered over a five-year period from 2021-21 to 2024-25.

Below is the approximate breakdown by Locality.

Locality	Number of houses
North	1,114
West	5,320
East	5,940
Total	**12,374**

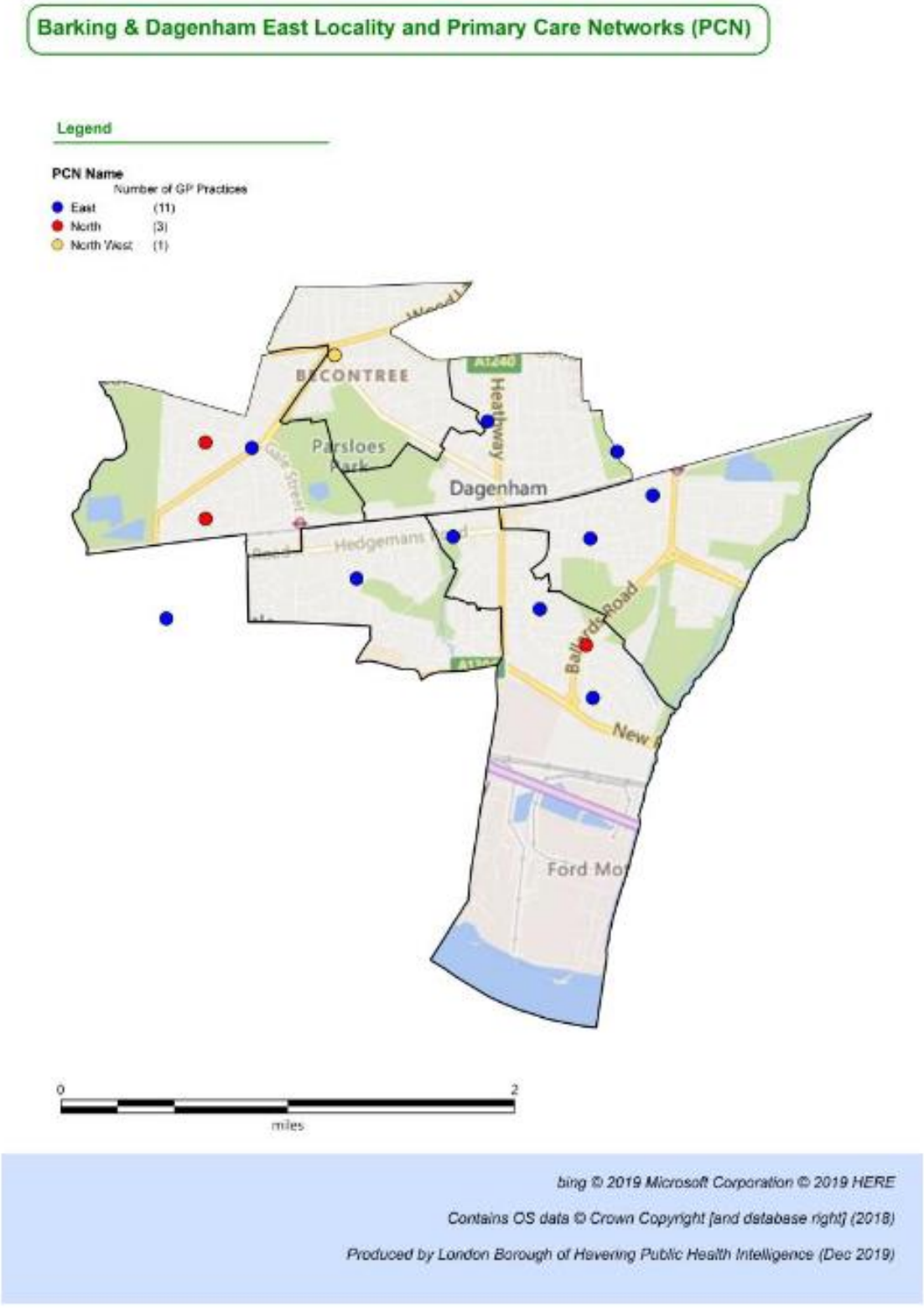
[181] London Borough of Barking and Dagenham Interim Five-Year Housing Supply Statement: For the five-year period commencing 1st September 2021. Available from: https://www.lbbd.gov.uk/sites/default/files/attachments/Five%20year%20land%20supply%20statement%20October%202021.pdf

London Borough of Barking and Dagenham (LBBD) – East Locality

1. Places and Communities

1.1 Barking and Dagenham east locality map

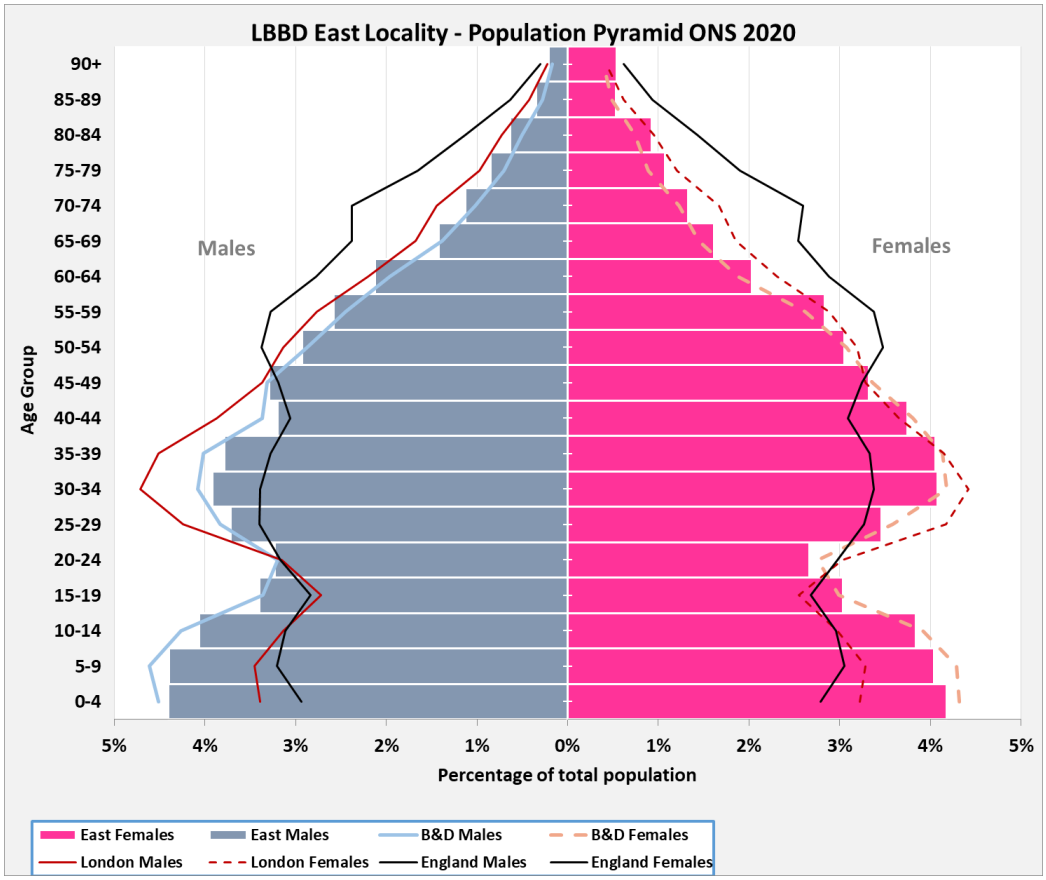
Wards include Albion, Goresbrook, Mayesbrook, Parsoles, River, Village.



1.2 Estimated population of LBBD east locality residents by gender and five-year age groups – 2020

Age Band (Years)	Males	Females	Total
0-4	3,111	2,799	5,910
5-9	3,188	3,092	6,280
10-14	3,070	2,779	5,849
15-19	2,409	2,038	4,447
20-24	2,123	1,924	4,047
25-29	2,472	2,349	4,821
30-34	2,455	2,666	5,121
35-39	2,611	2,718	5,329
40-44	2,192	2,715	4,907
45-49	2,307	2,534	4,841
50-54	2,095	2,342	4,437
55-59	1,808	1,984	3,792
60-64	1,388	1,421	2,809
65-69	1108	1125	2,233
70-74	807	984	1,791
75-79	505	696	1201
80-84	336	520	856
85-89	176	399	575
90+	129	246	375
Totals	34,290	35,331	69,621

Source: ONS Mid 2020 Population Estimates.



Source: ONS 2020 Mid-Year Estimates

1.3 LBBD PCN Profile - GP population 5-year age groups

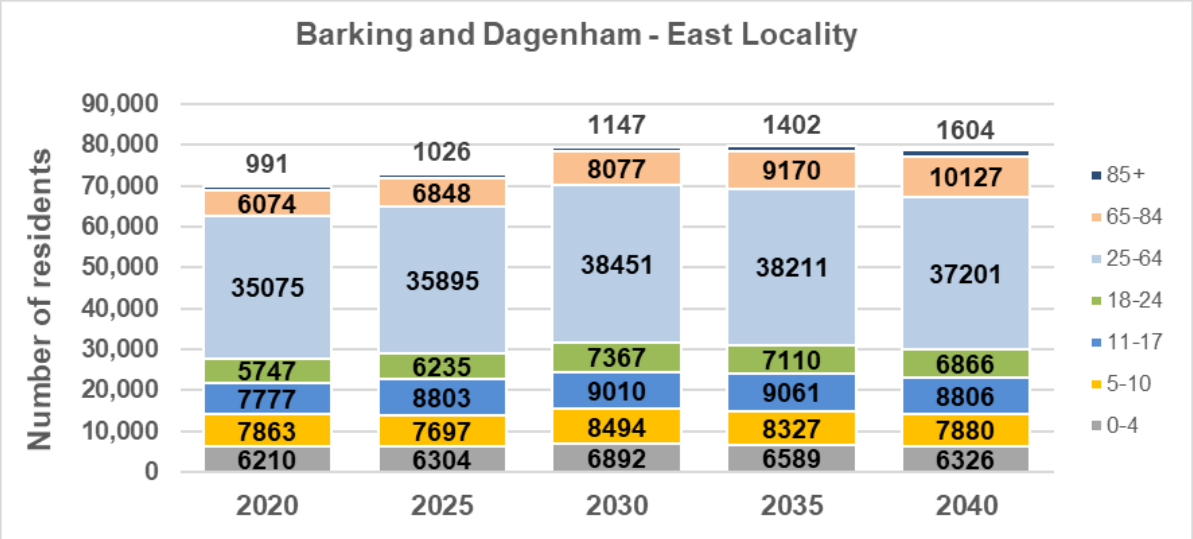
	East PCN			East One PCN			New West PCN			North PCN			North West PCN			West PCN		
Age Band	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**
0-4	1,804	1,952	3,756	1,697	1,756	3,453	1,245	1,257	2,502	1,721	1,739	3,460	1,103	1,091	2,194	1,442	1,412	2,854
5-9	2,137	2,262	4,399	1,961	2,018	3,979	1,398	1,369	2,767	1,992	2,012	4,004	1,398	1,413	2,811	1,531	1,646	3,177
10-14	1,990	2,120	4,110	2,028	2,178	4,206	1,341	1,508	2,849	1,933	2,015	3,948	1,379	1,519	2,898	1,528	1,515	3,043
15-19	1,502	1,604	3,106	1,682	1,873	3,555	1,211	1,194	2,405	1,665	1,795	3,460	1,209	1,360	2,569	1,323	1,448	2,771
20-24	1,425	1,277	2,702	1,587	1,627	3,214	1,069	1,081	2,150	1,487	1,598	3,085	1,013	1,057	2,070	1,401	1,452	2,853
25-29	1,661	1,543	3,204	1,858	1,895	3,753	1,361	1,216	2,577	1,825	1,855	3,680	1,145	1,114	2,259	1,693	1,713	3,406
30-34	2,335	2,035	4,370	2,208	1,961	4,169	1,566	1,553	3,119	2,170	2,060	4,230	1,294	1,186	2,480	1,901	2,082	3,983
35-39	2,355	2,449	4,804	2,088	2,065	4,153	1,612	1,676	3,288	2,182	2,134	4,316	1,512	1,343	2,855	1,833	2,124	3,957
40-44	2,074	2,263	4,337	2,040	1,977	4,017	1,401	1,558	2,959	1,893	2,012	3,905	1,363	1,347	2,710	1,611	1,875	3,486
45-49	1,618	1,880	3,498	1,789	1,841	3,630	1,099	1,369	2,468	1,692	1,898	3,590	1,158	1,217	2,375	1,324	1,704	3,028
50-54	1,356	1,562	2,918	1,616	1,716	3,332	1,025	1,150	2,175	1,551	1,746	3,297	1,062	1,164	2,226	1,192	1,434	2,626
55-59	1,037	1,154	2,191	1,390	1,518	2,908	726	871	1,597	1,433	1,542	2,975	973	918	1,891	1,103	1,197	2,300
60-64	700	776	1,476	1,045	1,149	2,194	512	630	1,142	1,094	1,196	2,290	689	715	1,404	837	976	1,813
65-69	512	474	986	792	757	1,549	347	389	736	923	845	1,768	514	457	971	660	636	1,296
70-74	382	289	671	615	566	1,181	256	237	493	668	617	1,285	365	357	722	516	412	928
75-79	289	195	484	516	383	899	190	139	329	535	419	954	291	240	531	365	271	636
80-84	201	120	321	328	234	562	108	79	187	377	275	652	221	130	351	306	205	511
85-89	125	82	207	244	143	387	69	43	112	256	149	405	144	95	239	170	125	295
90-94	82	33	115	128	62	190	30	17	47	129	77	206	81	33	114	88	39	127
95+	33	6	39	39	15	54	5	4	9	45	21	66	19	3	22	24	18	42
Total	**23,618**	**24,076**	**47,694**	**25,651**	**25,734**	**51,385**	**16,571**	**17,340**	**33,911**	**25,571**	**26,005**	**51,576**	**16,933**	**16,759**	**33,692**	**20,848**	**22,284**	**43,132**

Source: NHS Digital GP Registrations (April 2022)

1.4 LBBD East Location Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
East	69,737	72,807	79,438	13.9%	79,868	14.5%	78,809	13.0%

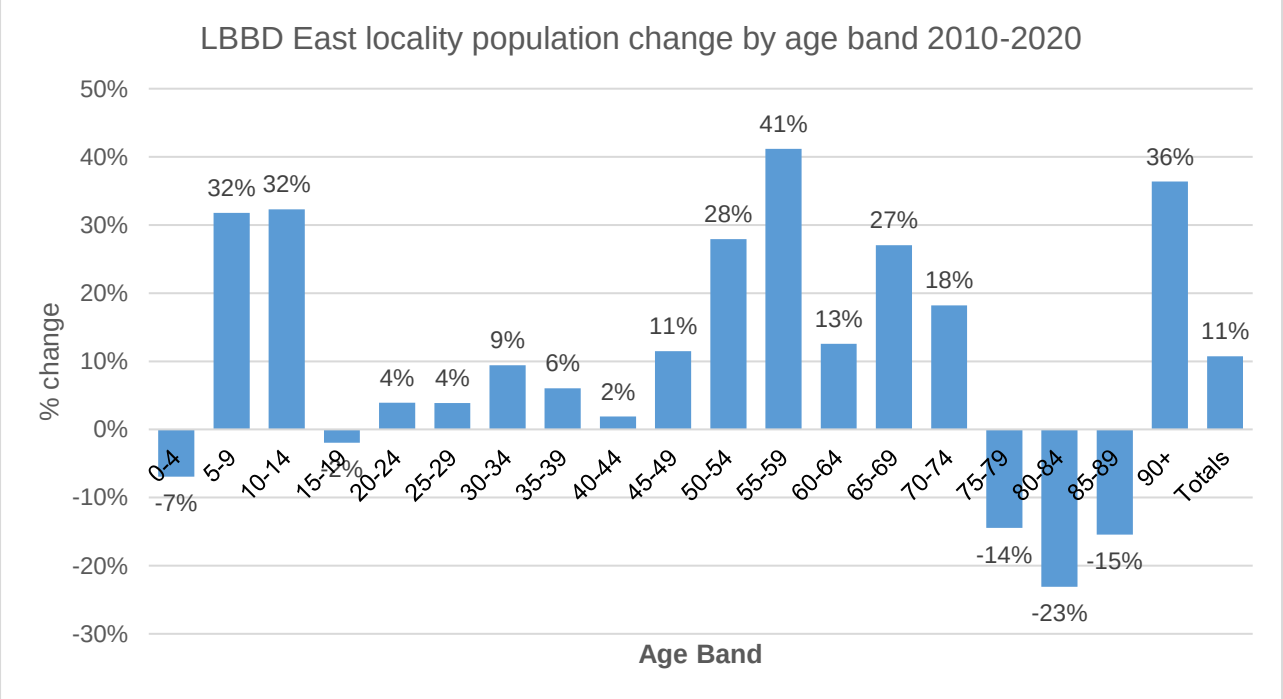
East	2020	2025	2030	2035	2040
0-4	6,210	6,304	6,892	6,589	6,326
5-10	7,863	7,697	8,494	8,327	7,880
11-17	7,777	8,803	9,010	9,061	8,806
18-24	5,747	6,235	7,367	7,110	6,866
25-64	35,075	35,895	38,451	38,211	37,201
65-84	6,074	6,848	8,077	9,170	10,127
85+	991	1,026	1,147	1,402	1,604
Total	69,737	72,807	79,438	79,868	78,809



Source: Greater London Authority (GLA) Population Projections. 2016-based ward level population projections.

1.5 LBBD East Locality population change by age band 2010 - 2020

Age Band (Years)	2010	2020	Change	%
0-4	6,349	5,910	-439	-7%
5-9	4,766	6,280	1,514	32%
10-14	4,421	5,849	1,428	32%
15-19	4,535	4,447	-88	-2%
20-24	3,895	4,047	152	4%
25-29	4,642	4,821	179	4%
30-34	4,680	5,121	441	9%
35-39	5,025	5,329	304	6%
40-44	4,816	4,907	91	2%
45-49	4,343	4,841	498	11%
50-54	3,468	4,437	969	28%
55-59	2,686	3,792	1,106	41%
60-64	2496	2809	313	13%
65-69	1758	2233	475	27%
70-74	1515	1791	276	18%
75-79	1404	1201	-203	-14%
80-84	1113	856	-257	-23%
85-89	680	575	-105	-15%
90+	275	375	100	36%
Totals	**62,867**	**69,621**	**6754**	**11%**



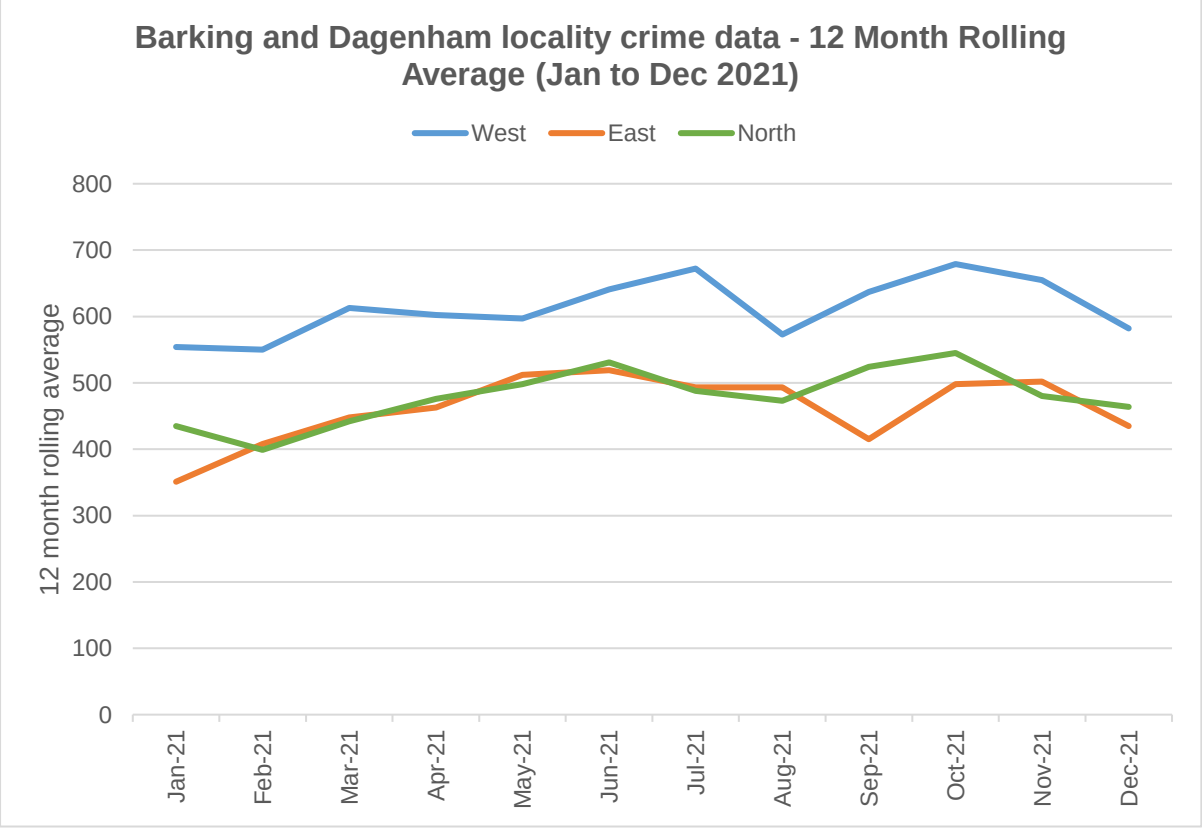
Source: ONS population estimates – Ward level population estimates

1.6 Ethnicity

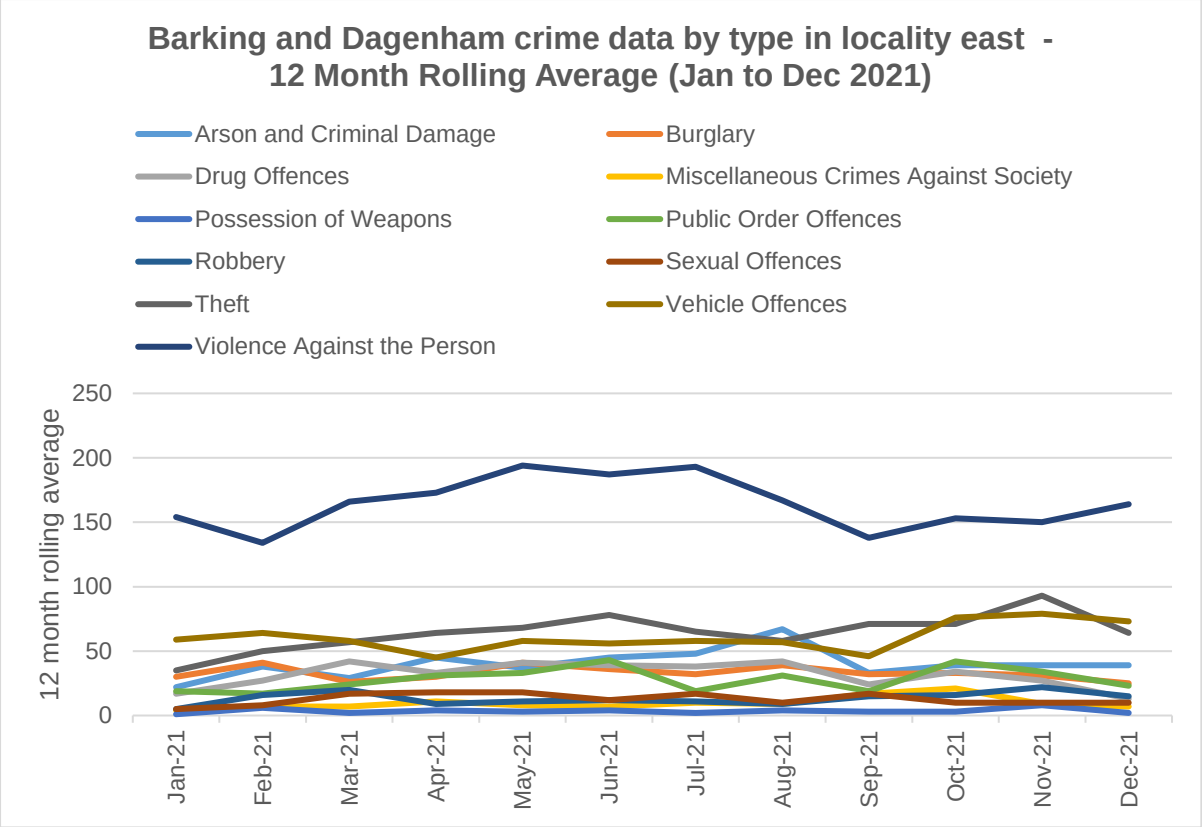
Ethnic Group	Number	%
British	37,738	60
African	9,985	16
Pakistani or British Pakistani	858	1
Bangladeshi or British Bangladeshi	1,346	2
Indian or British Indian	890	1
Caribbean	1,336	2
Baltic States	1,319	2
White and Black Caribbean	968	2
European Mixed	833	1
White and Black African	659	1
Other	7,073	11
Total	63,005	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).



Source: Recorded Crime: Geographic Breakdown - London Datastore
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1.8 Projected new homes in East Locality

The London Plan 2021 sets a ten-year housing target for Barking and Dagenham of 19,440 new homes between 2019/20 and 2028/29 or 1,944 per annum.

As of 1st September 2021, land was available for a total of 12,374[182] homes within Barking and Dagenham. There are plans for these to be delivered over a five-year period from 2021-21 to 2024-25.

Below is the approximate breakdown by Locality.

Locality	Number of houses
North	1,114
West	5,320
East	5,940
Total	**12,374**

[182] London Borough of Barking and Dagenham Interim Five-Year Housing Supply Statement: For the five-year period commencing 1st September 2021. Available from: https://www.lbbd.gov.uk/sites/default/files/attachments/Five%20year%20land%20supply%20statement%20October%202021.pdf

Appendix 12: Contacts

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HEALTH AND WELLBEING BOARD

13th September 2022

Title:	**Barking and Dagenham Place Partnership bid to NEL Integrated Care System for health inequalities funding in FY22/23**

Open Report	**For Decision:** No
Wards Affected: Barking and Dagenham	**Key Decision:** No
Report Author: Dr Mike Brannan, Consultant in Public Health	**Contact Details:** Tel: 07935 706002 E-mail: mike.brannan@lbbd.gov.uk

Sponsor:
Elaine Allegretti - Strategic Director Childrens and Adults

Summary:
At the previous Board meeting, progress was shared on development of a funding bid to address health inequalities by the Barking and Dagenham Place-Based Partnership to the North East London Health and Care Partnership.

This update reports Barking and Dagenham was successful in securing £1.1m to be spent during FY22/23. This was the maximum available to a Place-based Partnership and the largest award made in North East London. The funding will be transferred form NHS North East London ICB to the London Borough of Barking and Dagenham under a S256 agreement for distribution under grant agreements to the project delivery leads of the workstreams approved by the North East London Health and Care Partnership.

The Barking and Dagenham Place-based Partnership is to monitor progress, outcomes and approve financial monitoring back to NHS North East London ICB.

Mobilisation of projects is underway, with an aim to 'go live' in September and October 2022. The evaluation process being finalised will be used to inform continuation of work in FY23/24 and a potential future funding process.

Recommendation(s)

The Health and Wellbeing Board is recommended to note the successful outcome of the bid and oversight of the Health Inequalities Programme by the Barking and Dagenham Place-Based Partnership.

Reason(s)
The Health and Wellbeing Board was to be updated at the next meeting on the outcome of the funding application. In June 2022 the Health and Wellbeing Board had made comments on the process to put forward the funding bid, which will be taken into consideration in the design of an evaluation process for the programme of work to be delivered in FY22/23.

1. Introduction and Background

1.1 Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. As a borough and across its communities Barking and Dagenham has higher levels of health inequalities than most other areas, including neighbouring NEL boroughs (e.g. Barking and Dagenham has age standardised deaths under 75 years of age of 120.2 versus 100 for England).

1.2 Addressing health inequalities is embedded across priorities at national (e.g. Core20PLUS5, NHS Operating Plan), regional (e.g. ICS) and local levels. The 2021 Annual Director of Public Health report, *Equality Challenges*, directly highlighted the need to address health inequalities across Barking and Dagenham, including actions to be taken to do so.

1.3 NEL ICS was allocated £6.5m of funding from a national health inequalities pot from NHS England and undertook a process to allocate the majority of this money to Place-based Partnerships. Each Place-based partnership was to be allocated £0.5 million and could bid for up to an additional £0.6m to address local health inequalities, which will be allocated based on potential to reduce NEL inequalities.

1.4 Primary Care networks have an obligation to address health inequalities through the Network Contract DES requirements for Tackling Neighbourhood Health Inequalities. This includes identifying a PCN Health Inequalities Lead and developing planned interventions for a population experiencing health inequality.

1.5 Objectives of the funding were to:

- support leadership for tackling health inequalities in our place-based partnerships,
- support improved understanding of the health inequalities affecting local communities, maximise and accelerate local plans to tackle inequalities across health and care that takes a life course approach including babies, children and young people, as well as adults,
- enhance community resilience and widen participation

1.6 By 17 June 2022, Place based Partnerships were requested to submit a proposal covering:

i) Up to £500k allocation to develop leadership, partnership working and capacity building

ii) Up to £600k based on addressing health inequalities that exist locally, including deprivation, specific health needs of vulnerable populations, and historic under-investment in tackling inequalities

1.7 The proposal from Barking and Dagenham was co-produced across the breadth of system partners. The proposal was signed off by the Barking and Dagenham Delivery Group on 16th June and submitted to the North East London Health and Care Partnership on 17th June 2022.

1.8 A decision on funding was communicated to LBBD and the bid partners on 6th July 2022 and a draft funding award letter from the NHS North East London ICB was received on 4th August 2022.

1.9 Barking and Dagenham Place-based Partnership was successful in securing the full amount of funding available from the NHS North East London ICB of £1.1m for FY22/23. All but one of the workstreams in the proposal put forward by the Barking and Dagenham Partnership were funded; the panel suggested an alternative funding route for the Cradling Cultures maternity pilot that it opted not to fund.

1.10 Funding is to be transferred from the NHS North-East London ICB to the London Borough of Barking and Dagenham by a S256 agreement. The London Borough of Barking and Dagenham will then issue grant agreements to the partners at Place who are to take a role leading on delivery of a workstream(s). LBBD Procurement Board has approved the transfer of funding as per the successful bid to the partners BD_Collective, BDCVS and Together First Ltd.

1.11 Mobilisation of the workstreams is currently underway with partners, with delivery of projects due to commence from September 2022.

1.12 Key progress includes:

- *Workshop on community-led workstreams* – LBBD supported BD_Collective to run a workshop on 3rd August for potential community providers of three health inequalities workstreams. This includes appointing six Locality Leads and community-led support for People with No Recourse to Public Funds.

- *Appointment of lead community organisations* – Following the Workshop Expressions of Interest processes to community organisations were launched by BD_Collective for community-led workstreams and LBBD will support the process to enable delivery starting from October.

- *Appointment of Programme Director* – The PCN Clinical Directors nominated Dr Shanika Sharma as Programme Director who will oversee the Programme and support the relationship with PCN Health Inequality Leads

- *Recruitment of new PCN Health Inequalities Leads* – LBBD is supporting the PCN's in appointing new mandatory Health Inequalities Leads who will be funded part-time to provide strategic leadership across their PCN and in collaboration with the emerging community Locality Leads

- *Alignment with other developments* – Alignment and collaboration is being established with other developments, including with the Cost-of-Living Crisis work which will use and build on the Locality Leads.

1.13 The monitoring process proposed by the ICB has Place-based Partnerships taking on the role of monitoring their local health inequalities projects, including outcomes. Places are to return a quarterly monitoring template to the ICB, accounting for spend transacted and any risks to delivery or funding slippage by exception.

1.14 An evaluation plan is being developed and will be shared with the Place-based Partnership and the ICB by the end of September. The evaluation plan will: focus on 'does/could it work' to inform 22-23 decision; and focus on whether the initiative/ intervention is reaching known health inclusion groups/ underserved groups/ residents who do not typically engage with services.

1.15 As agreed at the previous Board meeting, there is a continuing process to build on the progress achievement during development of the funding bid to develop a common 'health inequalities 'narrative' for the Partnership. This will include developing a process and collating options for future funding opportunities.

1.16 An update for this programme will be going to the Health Scrutiny Committee in November 2022 and March 2023.

2. Proposal and Issues

To note the success of the bid and to note progress to enable delivery from September / October 2022 which will enable projects to be for funding to support system development and delivery on health inequalities during FY22/23

There are no issues expected.

3 Consultation

N/A.

4 Mandatory Implications

N/A.

4.2 Financial Implications

The funding of £1.1m to the Barking and Dagenham Partnership is to be transferred by S256 agreement from NHS North East London ICB to the London Borough of Barking and Dagenham through invoicing. The London Borough of Barking and Dagenham will allocate funding to relevant partners and managing and evaluating delivery. Management capacity was included and approved within the bid to ensure all costs are covered.

4.3 Legal Implications

Under Rule 6.6c of the Contract Rules, a waiver can be given to waive the requirement to undertake a competitive tender exercise if there is only one supplier in the market capable of providing the service. Waivers have been approved by the LBBD Procurement Board for projects in the Health Inequalities programme in which the delivery lead will be one of the organisations of the Barking and Dagenham Partnership that put forward the successful bid for funding.

4.4 Risk Management

The following risks have been identified and mitigating actions put in place:

a. Risk of undermining existing relationships and work (medium) – Despite the short timescale of the bid and time to deliver, significant effort was undertaken to coproduce the proposal with a breadth of Place partners and to mobilize project whilst maintaining due diligence.

b. Risk of financial liabilities (high) – Given the need to spend the funding within the FY22/23 financial year only projects capable of being rolled out and completed by April 2023 were proposed.

4.5 Patient / Service User Impact

This work will support reducing health inequalities and improving health equity across residents and communities in Barking and Dagenham. It will include increasing community involvement in decision making and delivery of health and wellbeing support.

4.6 Crime and Disorder

N/A

4.7 Safeguarding

N/A

4.8 Property / Assets

N/A

4.9 Customer Impact

This work will support reducing health inequalities and improving health equity across residents and communities in Barking and Dagenham. It will include increasing community involvement in decision making and delivery of health and wellbeing support.

4.10 Contractual Issues

N/A

4.11 Staffing issues

Any staff recruited would only be recruited for the length of the funding (i.e. until end-FY22/23)

Public Background Papers Used in the Preparation of the Report: None

List of Appendices: Presentation to Barking and Dagenham Delivery Group on Health Inequalities programme

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NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Barking & Dagenham

NHS
Barking, Havering and Redbridge University Hospitals
NHS Trust

Together First CIC
Barking & Dagenham Federation

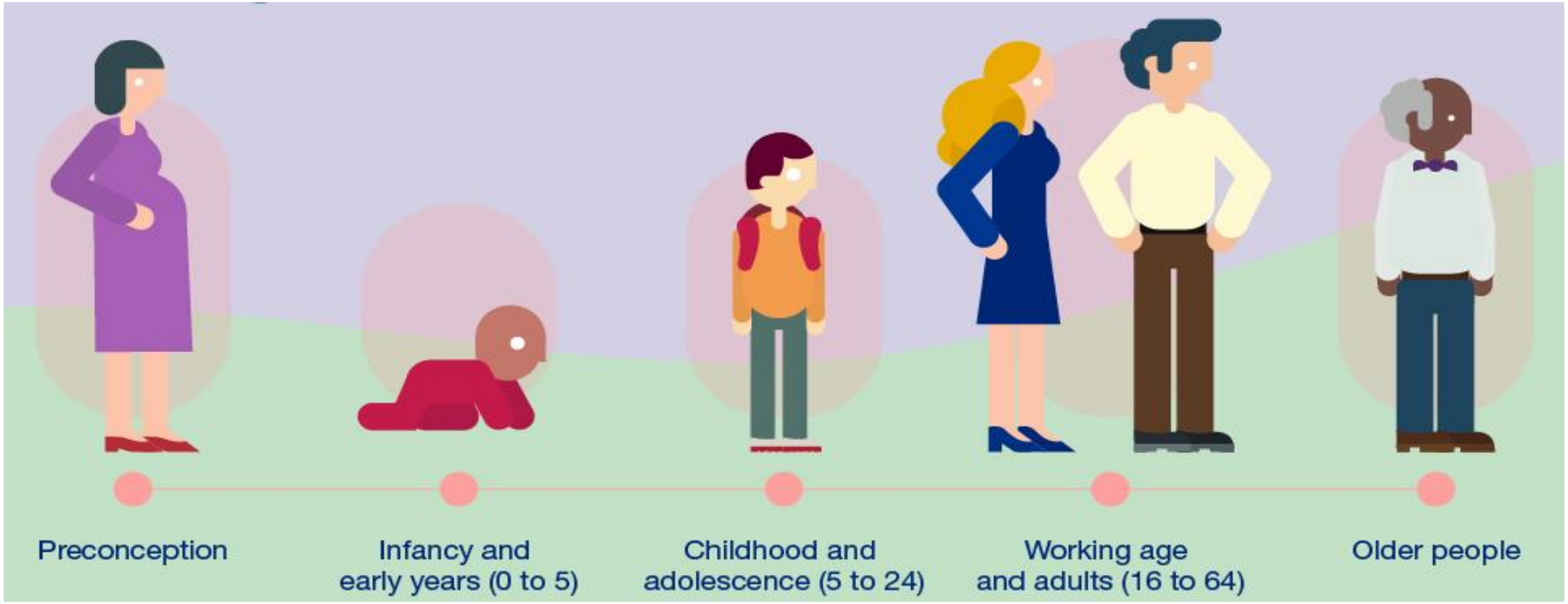
NELFT NHS
NHS Foundation Trust

BD COLLECTIVE

B&D Health Inequalities Programme 22/23

September 2022 update to Health and Wellbeing Board

Developing narrative:
B&D residents face worse health at all life stages



	Obesity in pregnancy	Low birth weight at term	Good development at 2-2.5yr	Child poverty	Unhealthy weight at 10/11 years	Economic inactivity 16-64yr	Domestic abuse per 1,000 people	Healthy Life expectancy M/F	Life expectancy M/F
B&D	27.4%	4.2%	38.8%	48%	44.7%	30%	16.0	58.1/60.1yrs	77/81.7yrs
London	17.8%	3.3%	79.6%	36%	38.2%	20.5%	10.5	63.8/65 yrs	80.3/84.3yrs
England	22.1%	2.9%	82.9%	27%	35.2%	20.9%	14.2	63.1/63.9yrs	79.4/83.1yrs

Co-creation of programme

Co-scoping

System-level – B&D Delivery Group Subgroup, Health and Wellbeing board

Community – BD Collective, Care City

Health services – Together First, NEFLT B&D Leadership Group, Local Pharmaceutical Committee, Primary Care Network Clinical Directors, CCG

Council – Public Health, Commissioning, Insight and Innovation, Community Solutions, PRMG BAU

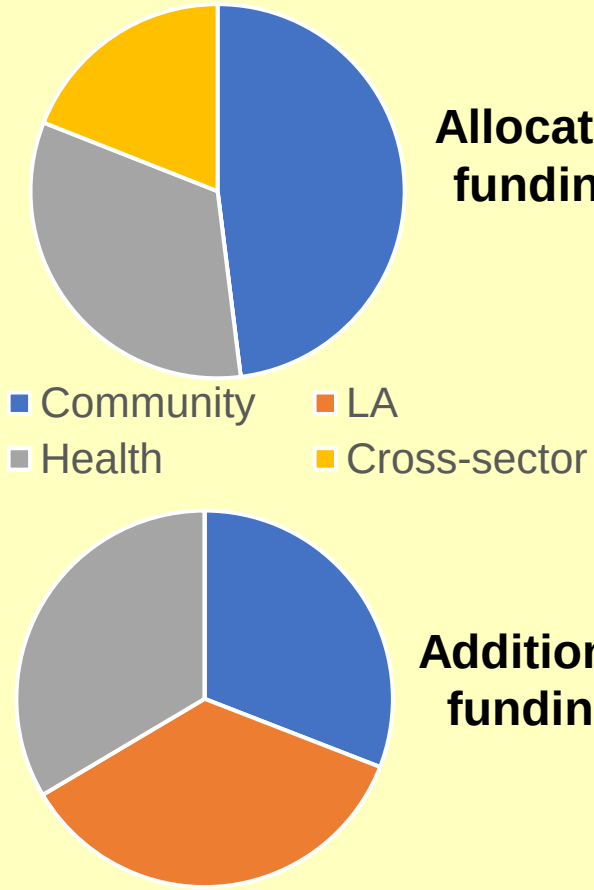
Co-design

Co-development Task and Finish Group:

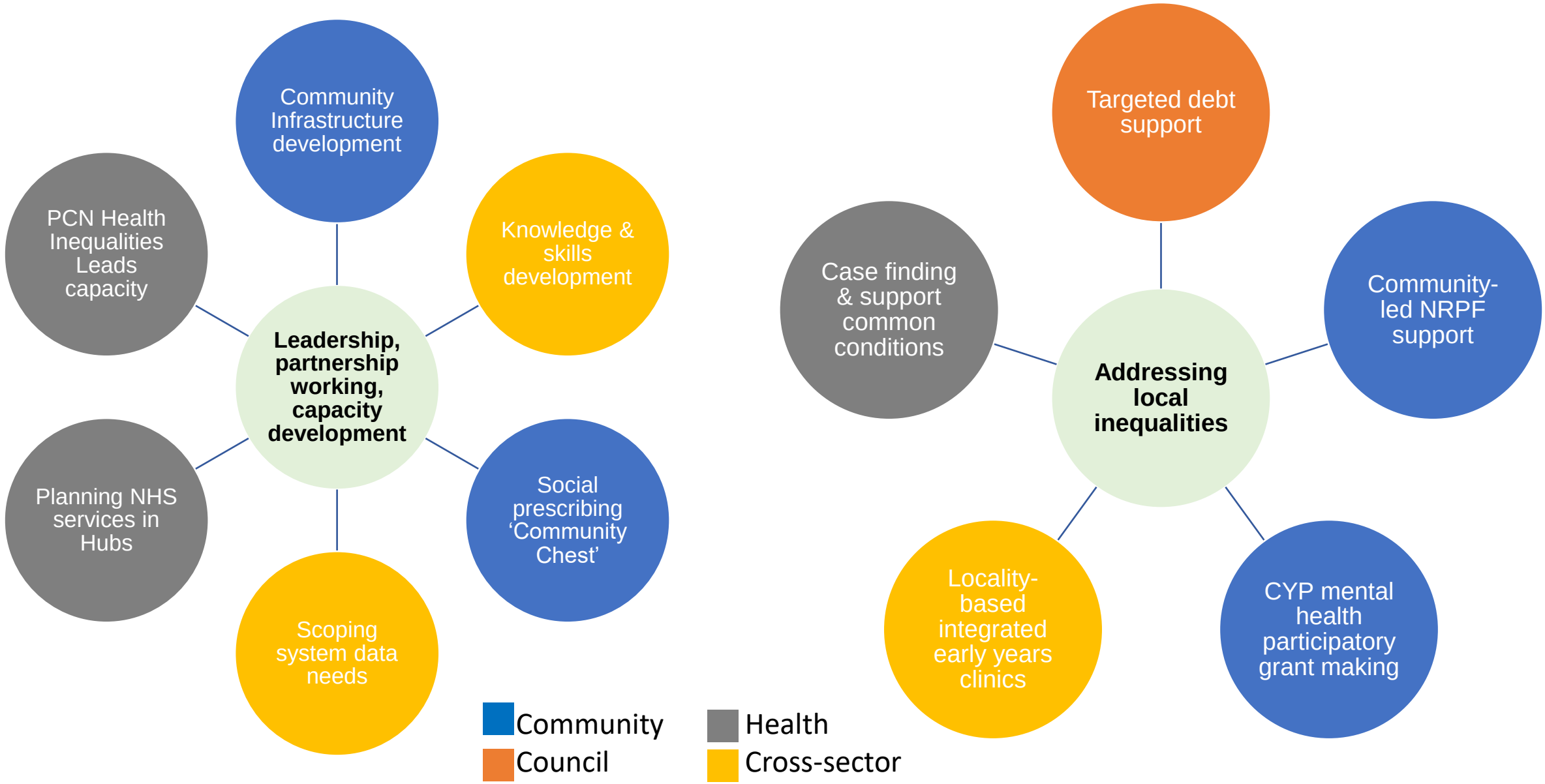
- Children's Services
- Public Health
- CCG
- Community Solutions
- BD Collective
- Care City
- Together First GP Federation
- Adults' Social Care
- Local Pharmaceutical Committee
- PCN Clinical Directors

Co-delivery

(% funding per sector)



B&D Health Inequalities Programme workstreams



Benefits of programme – System and people

B&D Health Inequalities Programme timeline update

17 June	Proposal submitted to NEL Integrated Care Board
24 June	Presentation to NEL Integrated Care Board Panel
6 July	Decision from NEL ICB to award maximum £1.1m funding
4 August	Formal funding letter from NEL ICB
August	BD_Collective workshop for potential community providers (2 August) Work with workstream lead partners to develop proposal into specification Expressions of interest process for community providers launched Nomination of Programme Director by PCNs
September	Sign-off partnership funding agreements for each workstream Submission of Evaluation Plan to NEL ICB Support BD_Collective appoint or community workstream providers Support appointment of new PCN Health Inequalities Leads
October	All workstreams delivering
November	Report to Health Scrutiny Committee
Ongoing	Work with NEL ICB to shape FY23/24 and future funding

HEALTH AND WELLBEING BOARD

13 September 2022

Title:	**Better Care Fund 22/23**
Report of the Strategic Director, Children's and Adults	
Open Report	**For Decision**
Wards Affected: All	**Key Decision: Yes**
Report Author: Louise Hider-Davies, Head of Commissioning, Adults' Care and Support	**Contact Details:** E-mail: louise.hiderdavies@lbbd.gov.uk
Sponsor: Elaine Allegretti, Strategic Director, Children's and Adults	

Summary:

The Better Care Fund (BCF) provides financial support for councils and NHS organisations to jointly plan and deliver local services. Every year the local authority and the CCG (now ICB) are required to submit a template and/or narrative to NHS England to set out how the BCF is delivered in Barking and Dagenham. This year we were given 8 weeks to produce the template and narrative, alongside partners in LBH, LBR and the ICB, showing how the plan meets the metrics and requirements of the BCF. The plan requires formal ratification by the Health and Wellbeing Board before submission to NHS England on 26 September.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1. Agree the Better Care Fund submission to NHS England

Reason(s)

The Better Care Fund enables the local authority and NHS organisations to jointly plan and deliver local services to support Barking and Dagenham residents. The BCF funds projects and services that are delivered by stakeholders from across the system, designed to improve health and social care outcomes, prevent re-admission to hospital, maintain and improve independence and support hospital discharge. The BCF works to deliver the Council's vision and priorities.

1. Introduction and Background

1.1 The Better Care Fund (BCF) provides financial support for councils and NHS organisations to jointly plan and deliver local services. It brings together ring-fenced budgets from Integrated Care Board (ICB) allocations, and funding paid

directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

1.2 In summary, this encompasses:

1) Minimum ICB (Min ICB):

- ICB funding including s256 proportion to LAs to support out-of-hospital services such as Reablement funding to maintain reablement capacity in LAs, community health services, independent/voluntary sectors
- Care Act monies to support the implementation of the Care Act 2014
- Carers' Break funding so carers can have a break

2) Disabled Facilities Grant (DFG) paid directly to LAs: for home adaptations and technologies to support people to live independently at home

3) Winter Pressures (WP): support the local health and care system to manage demand pressures including interventions that support people to be discharged from hospital, with the appropriate social care support in place, and promote people's independence.

4) Improved Better Care Fund (iBCF) paid directly to LAs for Social Care Funding:

- Meeting adult social care needs
- Reducing pressures on the NHS, including seasonal winter pressures
- Supporting more people to be discharged from hospital when they are ready
- Ensuring that the social care provider market is supported.

1.3 We have a Section 75 that governs the arrangement between us and NHS North East London. An executive group steers the development of the BCF and in terms of governance, this group feeds up into the Joint Commissioning Board (JCB). This arrangement will be reviewed as the Place Based Partnerships in each area develop over the coming year.

Preparation for BCF 22/23

1.4 Last year colleagues across BHR wrote a new joint plan with a set of new overarching schemes to meet changing guidance, metrics, terminology and the ongoing impact and recovery from the pandemic. It was agreed that due to the lack of time provided to submit the BCF plan and the developing agendas of the Place Based Partnerships and workstreams, we would update the last joint plan to be focused on 'Place' and to meet the conditions for 22/23 and look at whether we wish to disaggregate the plan to a Barking and Dagenham level over the coming year.

1.5 As a reminder, the four overarching schemes that were designed last year were as follows:

i) **Hospital Discharge Planning & Support:** Ensuring effective discharge & increasing patient independence

ii) **Targeted Out-of-Hospital Care:** Supporting people with higher care needs in the community

iii) **Community Wellbeing, Care & Support:** Prevention & early intervention for low level care & support needs.

iv) Integration, market stabilisation and Covid recovery: Strategic joint working to support integration and borough partnerships; essential market and provider support to ensure services are available; reducing the risk of provider failure and to minimise the impact of recent effects of the COVID 19 pandemic and beyond.

2. Proposal and Issues

1.6 Guidance for this year's BCF was released at the end of July (four months into the year's spend) and a planning template and narrative is required by the regional and national team for submission by 26 September. The policy framework/planning guidance can be found here: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023/2022-to-2023-better-care-fund-policy-framework

1.7 Attached at Appendix 1 and Appendix 2 is our BCF narrative, produced by the three BHR Boroughs and the ICB, as well as our Borough-based financial and metrics template.

1.8 The requirements echo previous years and conditions are as follows:

- A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
- NHS contribution to adult social care to be maintained in line with the uplift to the ICB minimum contribution.
- Invest in NHS commissioned out-of-hospital services.
- Plan for improving outcomes for people being discharged from hospital.
- Plans must have involvement from providers, VCS and housing colleagues.

2.4 The Adults Workstream of the Place-Based Partnership will take the lead for the development of the Better Care Fund. Discussions will take place through this workstream as to the future use of the BCF at a Place level, governance, the format of submissions and how funding decisions are made against local priorities, national requirements and other available funding streams. Further discussion will also be required to determine the consistency of approach and offer across NEL Boroughs, and whether joint commissioning approaches continue across BHR.

What's changed since previous years?

1.9 **Carers focus:** To support the government's commitments on empowering unpaid carers, as set out in the People at the Heart of Care White Paper, local areas have

been asked to provide a brief overview of how BCF funding available in their locality is being used to support unpaid carers. We have included this in the attached and have made particular reference to our Borough and partnership-wide Carers Charter.

1.10 **Capacity and demand plans:** Within this year's BCF, NHS England are particularly keen to see how reablement and rehabilitation services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care. For the BCF in 2022-23, systems are required to agree high level capacity and demand plans for intermediate care services. Plans should cover demand for both services to support people to stay at home (including admissions avoidance) and hospital discharge pathways 0–3 inclusive, or equivalent, for quarters 3 and 4 of 2022-23 across health and social care The plan is not assured by the NHS England team and is attached at Appendix 3.

1.11 **Two new policy objectives:** NHS England have asked for areas to ensure that their narratives particularly focus on the two objectives of:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

1.12 For both objectives, areas have been asked to describe their approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care. The attached narrative focuses on these two policy objectives.

1.13 **Metrics:** Metrics have remained the same as last year, apart from the removal of a metric measuring length of stay. Metrics are therefore as follows:

- Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)
- Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)
- Improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence).

1.14 **5.66% increase in ICB minimum contribution:** The ICB's minimum contribution to social care has increased by 5.66% since last year (in line with previous years). We will be reviewing how this increase will be spent and we are looking to use it innovatively and in line with the developing Adults workstream that forms part of the Place Based Partnership.

Financial summary

1.15 The below table is a summary of the pooled budget that will make up the BCF in 22/23. The DFG, iBCF and Winter Pressures Grant are all directly given to the local authority.

1.16 It should be noted that, as in previous years, all BCF money is allocated for 22/23 against schemes and activities apart from the 5.66% increase which will be discussed through the Adults workstream of the Place Based Partnership. Any changes in spend in future years would require early planning and engagement with all partners to enable changes to be made as a large majority of spend pays for packages, placements, services and teams that support the delivery of the national conditions/metrics.

Funding Sources	**Income**
DFG	**£1,856,901**
Minimum ICB Contribution	**£17,452,259**
iBCF	**£10,707,003**
Additional LA Contribution	**£0**
Additional ICB Contribution	**£227,527**
Total	£30,243,690

1.17 To provide some context to the above and the financial template in Appendix 2, the below list outlines the key areas that are funded by the Better Care Fund:

- Community Health Services
- Locality multi-disciplinary and integrated case management teams across the community, integrated care and mental health
- The Integrated Discharge Hub that coordinates hospital discharge and the Community Health and Assessment Team (CHAT) of social workers within the local authority that supports discharge and assessment
- The British Red Cross Home, Settle and Support Service
- Home First discharge process to facilitate same day and next day discharge
- Ageing Well urgent care and 2 hour response bridging services
- Packages and placements within extra care, domiciliary care, supported living, residential and nursing care
- Crisis intervention packages for the first six weeks of an individual leaving hospital
- Commissioning and safeguarding resource and systems
- Care Act implementation support
- Mental health and learning disabilities supported employment
- Admiral nurses
- Carers services
- Support for the Personal Assistant market

- Falls prevention
- End of life care
- Equipment, adaptations and care technology
- Social isolation support – in development with the voluntary sector
- Support to stabilise the market and respond to demand

Next Steps

1.18 Once the Board has approved the submission, the authority will be provided to NHS England colleagues. The narrative and template will go through a scrutiny process and we will be hoping to receive assurance in November as per the table below. Once the BCF is approved, the Section 75 arrangement will be updated.

Activity	Date
Submission	26 September
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	26 September – 24 October
Approval letters issued giving formal permission to spend (ICB minimum)	30 November
All Section 75 agreements to be signed and in place	By 31 December

3 Consultation

3.1 As stated in the narrative at Appendix 1, stakeholders, providers and residents are engaged in the BCF development and delivery throughout the year. The planning group for the Place Based Partnership have been consulted and their comments have been included in the above report. Additionally, the ICB Sub-Committee will be presented with the BCF Plan on 29 September. Charlotte Pommery has signed the Plan off on behalf of the ICB.

4 Implications

4.1 Financial Implications

Implications completed by Murad Khan, Finance Manager (Care & Support)

BCF is integral to funding the Adult Social Care Budget. This funding needs to be retained and utilised. If this funding were to be lost there would be a significant gap in the Council's finances that would result in deeper cuts. In addition, there would be significant detriment to the outcomes for service users and partnership working.

4.2 Legal Implications

Implications completed by: Kayleigh Eaton, Principal Contracts and Procurement Solicitor, Law & Governance

This report sets out an update on the Better Care Fund for the year 2022-2023. The Better Care Fund encourages the integration of health and social care systems locally to support person centred care by requiring the ICB and local authorities to enter into pooled budget arrangements and agree an integrated spending plan. Local Authorities and the ICB formalise these arrangements under a section 75 Agreement as provided for under the NHS Act 2006.

This report states that once the Council has approved the arrangements there will be an update to the existing section 75 agreement between LBBD, Havering, Redbridge and the ICB.

The Legal team will be on hand to assist with these updates to the agreement, where required.

4.6 Risk Management

The sign off of the BCF must be undertaken by the Health and Wellbeing Board otherwise NHS England will not assure our BCF narrative and plan.

Public Background Papers Used in the Preparation of the Report:
None

List of Appendices:
Appendix 1 - Better Care Fund BHR Narrative
Appendix 2 - Better Care Fund Barking and Dagenham Funding and Metrics Template
Appendix 3 Capacity and Demand Plan

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Barking & Dagenham Place, Havering Place & Redbridge Place

Joint Better Care Fund Plan 2022-23

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

Contents

SECTION HEADINGS

BHR Better Care Fund Plan 2022-23

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

- Barking & Dagenham
- Havering
- Redbridge

The following organisations have signed off the plan:

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

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

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

Summary of National Conditions
Our BHR BCF plan sets out how we will meet these requirements.

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

National Conditions		Covered in Sections
	• Provide the right care in the right place at the right time.	

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

Executive Summary

Our Joint Priorities

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

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

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

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

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

Market Stabilisation

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

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

Key Changes to the 21/22 BCF plan

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

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

3. NHS North East London continue to fund the first four weeks of Discharge to Assess (D2a) Nursing Placements for B&D, Havering and Redbridge places. The system also piloted “Block” D2a nursing beds (28) over three sites with a wraparound therapy team (Physiotherapy/Occupational Therapy) that has

supported 30% of local residents to return home, who would not have done so in a straight assessment only placement. This has continued into 22/23.

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

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

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

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

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

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

Section 1: Governance (National Condition 1)

1. BHR BCF Governance & Ambitions

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

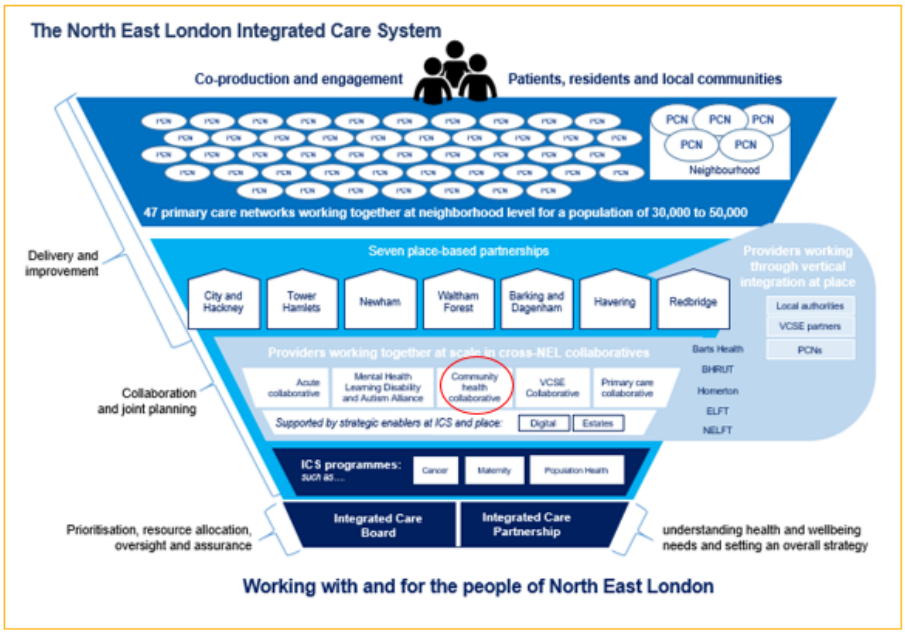
'Accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high-quality health and wellbeing services.'

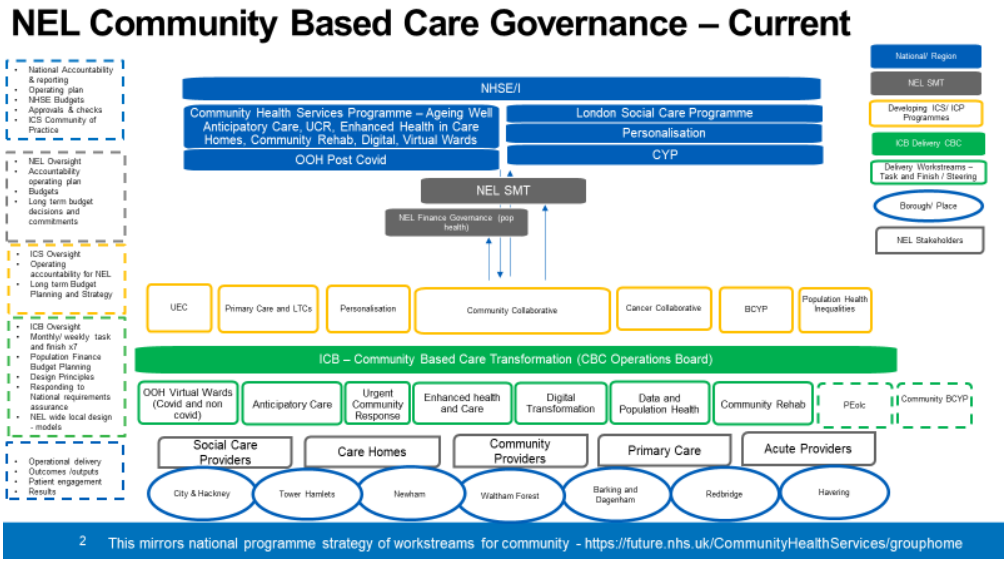
- **Create an environment that encourages and facilitates healthy and independent lifestyles** by enabling and empowering people to live healthily, to access preventive care, to feel part of their local community, to live independently for as long as possible and to manage their own health and wellbeing

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

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

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





Joint BHR S75 Agreement and Joint Working

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

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

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

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

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

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

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

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

NHS NEL	
Accountable Officer	Zina Etheridge, CEO NHS North East London
Finance Director	Henry Black, Chief Finance and Performance Officer - NHS North East London

Senior Responsible Officer	Place Directors NHS North East London - Sharon Morrow (Barking & Dagenham Place), Luke Burton (Havering Place) and Tracy Rubery (Redbridge Place)

Section 2: Approach to Integration

1. Summary

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

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

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

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

Integration Approaches, Joint Commissioning and transformation approaches

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

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

Embedding Integration - Joint and Collaborative Commissioning and transformation

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

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

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

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

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

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

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

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

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

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

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

Place Based Partnerships

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

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

The B&D Partnership Board will be supported by a programme structure that supports delivery across separate pathways of care for children and adults. This will allow the place to respond to local needs and priorities across the borough and include a wide range of relevant partners to develop solutions. The place based partnership aims to leverage the collaborative expertise to influence system working across NEL and unlocke barriers to the delivery of improvements in B&D. The ability to make informed decisions around health and care will support the partnership in tackling wider issues around inequalities.

Borough Partnerships Visions

Locality Models

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

Primary Care Networks

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

Direct Enhanced Services provided by PCNs

Direct Enhanced Service	Service Outline	Workforce Service Support
Structured Medication Reviews	• Aims to optimise use of medicines for some people (such as those who have LTCs or who take multiple medicines) • Can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. • Can lead to a reduction in adverse events.	Clinical Pharmacist
Enhanced health in care homes	• Access to consistent, named GP and wider primary care services • Medicines review • Hydration and nutrition support • Access to out-o-f hours / urgent care when needed	Clinical Pharmacist Community Paramedic
Anticipatory care with community services	• Thinking ahead and understanding the health needs of individual people • Knowing how to use services better • Helps people make choices about their future care. Those with LTCs or chronic health problems can benefit from having an Anticipatory Care Plan.	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Personalised care	• Care tailored to the needs of people and what matters to them • Prevention embedded • Personal Health budgets • Shared decision making	Social Prescriber Clinical Pharmacist Physician Associate Community Paramedic PCN Physiotherapists
Inequalities	Reducing inequalities between patients in access to, and outcomes from, healthcare services and in securing those services that are provided in an integrated way where this might reduce health inequalities	Social Prescriber Clinical Pharmacist Physician Associate

Section 3: BHR BCF Scheme Summary Overview

1. Summary

This section provides a summary preview of our schemes for the BCF 2022-23. Since the impact of COVID many of our services have had to adapt and amend their delivery models and Place Based Partnerships are now looking at these services going forward and how revised or new models need to be designed and

implemented. This is particularly linked to hospital discharge, the sustainability of homecare, residential care, the care workforce and our prevention and early intervention offer.

2. Schemes & Metrics

BCF National Metrics

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

Other Related Metrics

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

ASCOF Related Domains

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

Example ASCOF indicators include:

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

PHOF Related Domains

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

NHSOF Related Domains

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

BCF Priorities and Schemes

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

	BCF Policy Objectives and Scheme Names	SCHEME TYPES*

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

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

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

Approach to Risk
All partners are facing great financial pressures in the life of this plan and continuing to work to addressing ongoing sustainability. Partners to continue to be responsible for overspends on their respective budgets within the BCF. COVID and increased demand across all client groups placed a significant risk on the health and care system and financial landscape across BHR. This is impacting our NHS, social care and provider workforce. Within the local authority, social work and brokerage teams are often severely stretched to meet caseloads and demand and key workforce areas are struggling to meet the demand, for example the number of therapists available at a regional and national level. The system is working to mitigate these workforce issues with agency usage, the new BHR Academy and new apprenticeships through Care City, but these longer-term solutions will take a while to trickle through and mitigate these risks.

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

Section 4: Implementing BCF Policy Objectives

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

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

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

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

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

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

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

Supporting people to remain independent at home, including strengths-based approaches and person-centred care

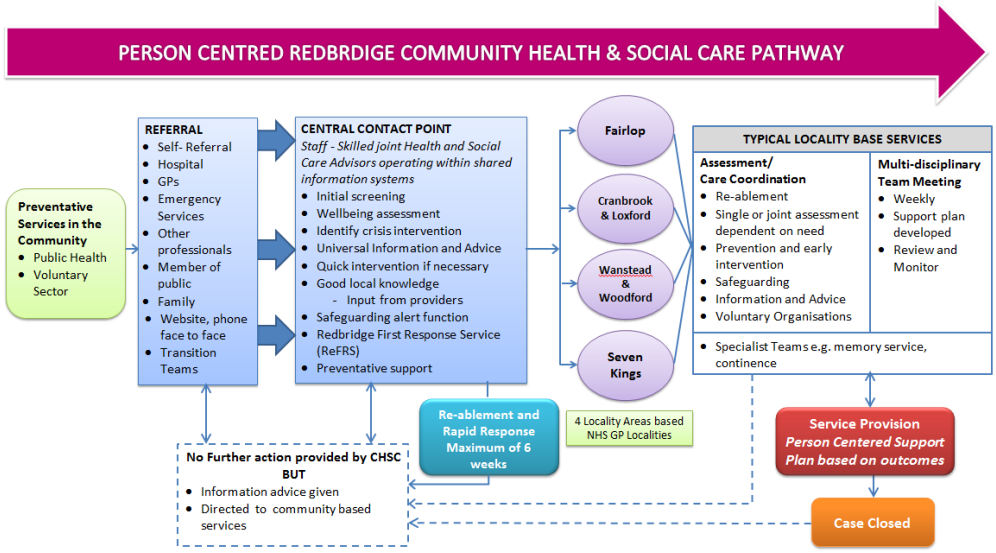
Improving the quality of people's lives and reducing the years of disability and illness will increase the length of time people can continue to live independent lives and reduce the need for and dependence on health and social care services. Retaining a level of independence supports both psychical and mental health through empowering and maintaining those close community links within a familiar environment.

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

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

Strength-based Model

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



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

Modern 21st century social work and social care in B&D seeks to move away from Care Management and a 'deficit' model, away from 'problems and issues' and how professionals can 'solve' this. Instead, we want to improve practice and support better outcomes through true collaboration with people and communities who use services and those who care for and about them. To drive this forward, we recognise that to maximise

empowerment and outcomes for and with people and communities the whole system needs to change, moving from a system built around the assumption that formal services are always the solution, and recognising we are partners in a wider system of relationships and support networks. In B&D, our strength is that we are an ethnically and culturally diverse workforce and population. We do however face significant challenges. On average, communities have less access to resources than the national average. At the same time the population in is growing faster than in any other area in the UK. By moving to a strengths and asset-based model we will seek to be bold, build on our diversity and the knowledge and experience in our communities; and deliver shared community and organisational benefits.

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

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

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

Mental Health & Carers Support

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

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

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

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

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

- Supporting young carers: Protect children and young people from inappropriate caring roles and ensure they have the support they need to learn, develop and experience positive childhoods.

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

Community Provision

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

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

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

For example, in Redbridge:

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

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

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

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

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

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

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

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

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

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

Local Area Coordination

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

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

We are piloting this approach in Havering and although management of the team sits within the Council structure, Local Area Coordination will support outcomes from all public sector partners and therefore the pilot

is jointly funded by a range of partners and from the BCF. An evaluation of the service is being developed and, when it has been operational for a sufficient amount of time, evidence will allow partners to make informed decisions about rolling out the service across Havering. Our ambition is that the LAC offer is expanded to cover the whole borough.

Personalisation

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

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

B&D is currently undertaking a direct payment reviews project to ensure that service users have the support available to them in their role as an employer and that they have a Personal Assistant or other service that meets their needs. The Borough's direct payment support service, run by Vibrance, is working closely with social workers to ensure that service users have the right advice and support when they are thinking about choosing a direct payment and can help a service user to find and employ a PA and put the right documentation in place. This service is being used across adults and children's services and the wider project is also reviewing processes and training needs to support the Care and Support workforce.

Integrated Community Equipment Service

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

Assistive Technology

Havering invests significantly in Assistive Technology, helping people to stay at home as independently as possible. Whilst current offers support people it is also our intention to look at innovative solutions as they develop to look to use the most effective solutions available. There is also interest in virtual reality providing

the opportunity for remote monitoring and identification of need without the need for face to face personal interactions.

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

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

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

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

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

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

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

1. Summary

All of our priorities above are designed to provide a range of services and supporting outcomes to meets the needs and demand of patients, service users and carers within the flow of the health and care system and support the maintenance of people to stay, well and supported within community and home settings – only needing acute settings when necessary. Therefore, our BCF monies are targeted towards our priorities in supporting this flow. This is as set out in schemes and expenditure plans.

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

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

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

2. Models of Care

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

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

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

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

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

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

Pathway 2 and 3 are supported through our jointly commissioned discharge pathways include the discharge to assess pathway referenced earlier. This pathway places individuals into nursing home beds that have a

rehabilitation team supporting the residents for a six-week period. The aim is that these residents will then be able to have their long-term care package reduced after the six-week period. The pathway works with contracted nursing home beds which also eases the discharge process as for those who are eligible for the pathway there are pre-arranged beds available. This initiative, piloted in Havering, was evaluated and has been effective in improving outcomes and cost effectiveness. The scheme has been extended to B&D and Redbridge in 22/23 with a total of 28 beds available with therapy support.

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

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

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

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

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

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

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

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

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

When people do go into hospital and come out with a new or on-going need for support there is a need for a quick and effective response, putting in place all the necessary support mechanisms that will re-able and

rehabilitate the person back to independent living as soon as possible. We are committed to the principles of 'Discharge to Assess', the idea of getting people out of the acute setting as soon as they are medically fit, ideally back home, where prompt assessment of needs leads to support in place quickly, in whatever form necessary, to enhance chances of rehabilitation and independence. There are a significant number of dependencies on this happening effectively.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Market Stabilisation

Care Market

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

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

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

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

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

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

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

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

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

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

BHR Place Challenges

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

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

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

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

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

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

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

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

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

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

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

Section 5: Supporting Unpaid Carers

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

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

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

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

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

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

The Carers Charter comprises a series of “I” statements that have been co-produced with carers in the borough alongside key stakeholders from health, social care and the community and voluntary sector.
The Carers Charter supports participation and engagement with residents and partners. The outcomes defined in the “I” statements of the Carers Charter and Action Plan will enable carers and their loved ones to thrive and live independent and healthy lives. This is accomplished through joint working across the partnership and bringing carers to the forefront of service delivery. Building on existing partnerships with health and the

community and voluntary sector, the Charter will work towards developing effective pathways with partners to identify 'hidden carers'. Hidden carers are those who do not recognise themselves as a carer or are not known to services as providing an informal, unpaid, caring role.

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

1. Summary

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

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

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

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

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

2. BHR Area DFGs

Barking & Dagenham

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

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

Within Barking and Dagenham, a Disabled Facility Grant can be awarded to residents who have a disability and also live in a privately owned property, a privately rented property or a housing association property. The resident must have the intention of living in the property for a minimum of five years. In order to receive a DFG, the resident must have had an assessment from an Occupational Therapist. Once an assessment has taken place and the Occupational Therapist has made their recommendations it will progress to the Adaptations Panel for agreement. In many homes with a disabled resident there are also other repairs that are needed to make the home safer to live in. As part of the DFG process officers will consider all aspects of the home (using

the parameters of the Housing Health and Safety Rating System) and will recommend other works, working with colleagues throughout the system, to reduce hazards like cold homes, and trips and falls and refer to other services such as the Handypersons Scheme.

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

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

Havering

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

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

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

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

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

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

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

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

Redbridge

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

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

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

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

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

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

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

Section 7: BHR BCF Finance Summary

- Refer to individual Planning Templates.

Section 8: Equality & Health Inequalities

Equality and health inequalities

1. Summary

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

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

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

3. Local Area Summary

The detail below provides a highlighted snapshot of the three boroughs. Further details about each borough profiles can be found on the respective websites with their Joint Strategic Needs Assessments (JSNA). As stated, all detail and data contained within this plan was correct at the time of submission.

Barking & Dagenham

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

Havering

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

Redbridge

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

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

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

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

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

Engagement with our service users, carers and providers and local community groups is a key component of understanding the issues at both a service delivery level and grass roots level – the lived experience. Feedback

and consultation with our communities is a cornerstone that is and will be embedded in our commissioning work. For example, we know that within Redbridge the Bangladeshi community was particular impacted by the COVID pandemic. By listening to our local community, we are beginning to understand the reasons behind this (such a lifestyle and dietary choices) and therefore provide the targeted support to mitigate the impact of this happening again.

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

Section 9: Stakeholder Engagement

1. Summary

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

Through this we will:

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

2. Engagement Activity

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

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

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

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

Service User & Carers

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

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

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

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

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

Provider Engagement

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

engagement has been an ongoing and active part of all the developments and initiatives outlined within this plan.

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

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

Voluntary Sector Engagement

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

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

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

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

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

In Havering, voluntary sector services have been re-commissioned, enabled by BCF funding. The focus of this voluntary sector commissioning has been on achieving particular outcomes including sustaining carers in their roles and looking to minimise social isolation and develop peer support groups for those facing particular issues. There is a tailored approach to support for those facing issues, for example carers of people with dementia will face different issues to carers of people with learning disabilities. Those facing physical disability will face different problems to those facing mental health issues. The range of organisations commissioned reflects the different issues faced and the specific needs of different groups.
Representatives of the voluntary sector join up with the local authority and the ICB to communicate about issues and initiatives that the voluntary sector can respond to at a regular 'compact' meeting. This has enabled the VCS to be intrinsically involved in the development of the borough partnership, where the VCS has established a more joined up means of engaging with the partnership and providing the particular insights they can bring.

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

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

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

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

Section 10: Links to other Plans

BHR Area Key Strategies & Plans

- Annual Public Health Reports
- Barts Plans
- BHR End of Life Strategy
- BHRUT Clinical Strategy
- Transformation Nous work on ED @ bhrut
- Discharge strategy
- Falls Strategy
- Health & Wellbeing Strategy's

- PHM work in B&D
- Nel End of Life strategy
- Integrated Sustainability Plan?
- JSNAs
- Market Position Statements
- Older People and Frailty Business Case
- Prevention Strategy
- Primary Care Plans
- Redbridge Commissioning Framework
- Redbridge Disability Charter
- Redbridge Good Practice Commissioning Charter (Draft)
- Urgent Care

Websites:

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

APPENDIX 1

BCF Risk Log

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

	IDENTIFIED RISK	RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
	indeed financial values into specific /shared schemes	Place Based Partnerships and NEL ICS. COVID was a cornerstone in demonstrating the necessity of working together to support the system under a period if extreme pressure. Integrated Care System is responsible for ensuring these tensions are understood and managed. Ensuring effective information and clarity of decision points.				
5.	Elections at both a local level result in changes to administration(s) and policy direction.	'Watching brief' on policy and guidance changes	1	2	Low	
6.	Budgetary deficits across health and care system	Monitoring of demand and costs in relation to funding to be closely monitored and any remedial action to be agreed and implemented where necessary.	5	5	High	
7.	Commissioning capacity and staffing resources	Improving joint and or lead commissioning across BHR will seek to reduce the burden of individual organisational activity, alongside our intention through the BCF plan to achieve a greater level of integration and available resource utilisation.	3	2	Medium	
8.	Service demand continues to increase for social care	Review of prevention and early interventions services to provide earlier intervention, passporting to alternative, community and universal services is expected to improve management of demand. Utilising new data sets from ONS in relation to the recent Census and refreshed JSNAs	High	High	High	
9.	Increasing costs faced by service providers, insurance, wages increases and workforce issues	BHR commissioners to work closely together and with partners to help stabilise the current market and develop a joint protocol around provider concerns and failure - adjusting rates where it can (if available) and taking a proactive approach to managing demand.	High	High	High	

IDENTIFIED RISK		RISK MITIGATION	LIKELIHOOD	IMPACT	RISK SCORE	RAG
		Use all available initiatives such as Skill for Care funding to support workforce issues.				
10.	Fair Cost of Care Exercise early indications are that home care and care home rates might need to rise significantly. It is still unclear how this is to be fully funded but it could threaten financial sustainability of Local Authorities if government funding is insufficient.	Work with other local authorities and DHSC to understand how this is to be mitigated	High	High	High	

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BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

		Checklist: Complete:
Health and Wellbeing Board:	Barking and Dagenham	Yes
Completed by:	Louise Hider-Davies	Yes
E-mail:	louise.hiderdavies@lbbd.gov.uk	Yes
Contact number:	020 8057 5553	Yes
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes	Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes
If using a delegated authority, please state who is signing off the BCF plan:		

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Councillor Maureen Worby	Yes
Name:	Chair of the Health and Wellbeing Board	Yes

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Maureen	Worby	maureen.worby@lbbd.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Charlotte	Pommery	charlotte.pomery@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Sharon	Morrow	sharon.morrow2@nhs.net	Yes
	Local Authority Chief Executive		Fiona	Taylor	fiona.taylor@lbbd.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Elaine	Allegretti	elaine.allegretti@lbbd.gov.uk	Yes

Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->

Better Care Fund Lead Official		Louise	Hider-Davies	louise.hiderdavies@lbbd.gov.uk	Yes
LA Section 151 Officer		Philip	Gregory	philip.gregory@lbbd.gov.uk	Yes
					Yes
					Yes
					Yes

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Barking and Dagenham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,856,901	£1,856,901	£0
Minimum NHS Contribution	£17,452,259	£17,452,259	£0
iBCF	£10,707,003	£10,707,003	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£227,527	£227,527	£0
Total	**£30,243,690**	**£30,243,690**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£4,959,437
Planned spend	£10,425,799

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£6,466,564
Planned spend	£7,026,460

Scheme Types

Assistive Technologies and Equipment	£810,000	(2.7%)
Care Act Implementation Related Duties	£962,607	(3.2%)
Carers Services	£164,380	(0.5%)
Community Based Schemes	£7,074,481	(23.4%)
DFG Related Schemes	£1,856,901	(6.1%)
Enablers for Integration	£126,000	(0.4%)
High Impact Change Model for Managing Transfer of	£4,403,527	(14.6%)
Home Care or Domiciliary Care	£923,062	(3.1%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£6,325,944	(20.9%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£1,942,657	(6.4%)
Personalised Budgeting and Commissioning	£150,000	(0.5%)
Personalised Care at Home	£1,072,000	(3.5%)
Prevention / Early Intervention	£1,884,521	(6.2%)
Residential Placements	£2,547,610	(8.4%)
Other	£0	(0.0%)
Total	**£30,243,690**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)				

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.3%	91.9%	90.6%	89.1%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	621	667

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	83.9%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Barking and Dagenham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Barking and Dagenham	£1,856,901
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,856,901**

iBCF Contribution	Contribution
Barking and Dagenham	£10,707,003
Total iBCF Contribution	**£10,707,003**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

Checklist

Complete:

Yes

Yes

NHS Minimum Contribution	Contribution
NHS North East London ICB	£17,452,259
Total NHS Minimum Contribution	**£17,452,259**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS North East London ICB	£227,527	Ageing Well
Total Additional NHS Contribution	**£227,527**	
Total NHS Contribution	**£17,679,786**	

	2021-22
Total BCF Pooled Budget	**£30,243,690**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over
£1,523,604 carry over of BCF from 21-22

Yes

Yes

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Barking and Dagenham

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,856,901	£1,856,901	£0
Minimum NHS Contribution	£17,452,259	£17,452,259	£0
iBCF	£10,707,003	£10,707,003	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£227,527	£227,527	£0
Total	**£30,243,690**	**£30,243,690**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,959,437	£10,425,799	£0
Adult Social Care services spend from the minimum ICB allocations	£6,466,564	£7,026,460	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Hospital discharge, planning and	Services and support to ensure timely discharge from hospital and	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£847,610	Existing
2	Targeted out of hospital care	Crisis Intervention/ Reablement/Homecare	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	iBCF	£500,000	Existing
2	Targeted out of hospital care	Crisis Intervention/ Reablement/Homecare	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,332,133	Existing
3	Community support and independence	Care Bill Implementation to support prevention, integration,	Care Act Implementation Related Duties	Other	Care Act fee increases and safeguarding	Social Care		LA			CCG	Minimum NHS Contribution	£657,607	Existing
2	Targeted out of hospital care	Managing homecare and additonal demand over winter in particular	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£913,062	Existing
2	Targeted out of hospital care	Support to manage safeguarding of Adults and DoLS	Care Act Implementation Related Duties	Other	Deprivation of Liberty Safeguards	Mental Health		LA			Local Authority	iBCF	£175,000	Existing

4	Market Stabilisation & COVID Recovery	Market Development /Fee increases and COVID Recovery	Residential Placements	Other	Fee increase to stabilise the care provider market	Social Care		LA			Private Sector	iBCF	£1,600,000	Existing
3	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Community Based Equipment		Social Care		LA			Private Sector	iBCF	£680,000	Existing
3	Community support and independence	Supporting people to remain in their homes through the provision of	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£1,856,901	Existing
1	Hospital discharge, planning and	Home is best	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum NHS Contribution	£24,000	Existing
2	Targeted out of hospital care	Additional Care Navigators, investment in Mental Health,	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	iBCF	£1,514,420	Existing
2	Targeted out of hospital care	Integrated case management delivered through cluster multi	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,748,500	Existing
2	Targeted out of hospital care	Develop joint commissioning to achieve the outcomes of	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£2,980,000	Existing
2	Targeted out of hospital care	Supporting adults of working age with mental health problems to live	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£572,000	Existing
2	Targeted out of hospital care	Supporting adults of working age with mental health problems to live	Personalised Care at Home	Mental health /wellbeing		Mental Health		LA			Local Authority	iBCF	£500,000	Existing
2	Targeted out of hospital care	Supported Employment	Prevention / Early Intervention	Other	Other approaches	Mental Health		LA			Local Authority	iBCF	£100,000	Existing
2	Targeted out of hospital care	Resource and systems to support integration, better processes and	Enablers for Integration	Data Integration		Social Care		LA			Private Sector	iBCF	£100,000	Existing
2	Targeted out of hospital care	Resource and systems to support integration, better processes and	Enablers for Integration	Data Integration		Social Care		LA			Local Authority	Minimum NHS Contribution	£26,000	Existing
3	Community support and independence	Care Bill Implementation to support prevention, integration,	Care Act Implementation Related Duties	Other	Safeguarding Adults	Social Care		LA			Local Authority	Minimum NHS Contribution	£130,000	Existing
3	Community support and independence	LD Demand growth and Transitions	Prevention / Early Intervention	Other	Placements	Social Care		LA			Local Authority	iBCF	£1,484,521	Existing
3	Community support and independence	LD Employment and NEETs	Prevention / Early Intervention	Other	Employment support	Social Care		LA			Local Authority	iBCF	£150,000	Existing
1	Hospital discharge, planning and	Care Home Trusted Assessors	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum NHS Contribution	£8,500	Existing
3	Community support and independence	Preventative services to prevent falls and promote health &	Prevention / Early Intervention	Risk Stratification		Social Care		LA			Private Sector	Minimum NHS Contribution	£50,000	Existing
3	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Community Based Equipment		Social Care		LA			Private Sector	Minimum NHS Contribution	£80,000	Existing
3	Community support and independence	Reconnections - social isolation pilot	Prevention / Early Intervention	Other	Social Isolation Pilot	Social Care		LA			Local Authority	Minimum NHS Contribution	£100,000	Existing

2	Targeted out of hospital care	Developing joint commissioning to achieve the outcomes of	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum NHS Contribution	£947,610	Existing
3	Community support and independence	Support for the Personal Assistant market	Personalised Budgeting and Commissioning			Social Care		LA			Local Authority	Minimum NHS Contribution	£150,000	Existing
3	Community support and independence	Support for service users with dementia and their informal carers	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	Minimum NHS Contribution	£100,000	Existing
3	Community support and independence	Support for carer support organsitons.	Carers Services	Other	Support for carer support organsitons.	Social Care		LA			Local Authority	Minimum NHS Contribution	£75,000	Existing
3	Community support and independence	Strengthening User and Carer Voice	Carers Services	Other	Strengthening User and Carer Voice	Social Care		LA			Local Authority	Minimum NHS Contribution	£62,500	Existing
1	Hospital discharge, planning and	Home from Hospital - Home, Settle and Support Service (British	Integrated Care Planning and Navigation	Other	Care Planning, Assessment and Review	Social Care		LA			Local Authority	Minimum NHS Contribution	£65,000	Existing
3	Community support and independence	Care technology, equipment and adaptations	Assistive Technologies and Equipment	Other	Care Planning, Assessment and Review	Social Care		LA			Local Authority	Minimum NHS Contribution	£50,000	New
4	Market Stabilisation & COVID Recovery	Market Development /Fee increases and COVID Recovery	Home Care or Domiciliary Care	Domiciliary care workforce development		Social Care		LA			Local Authority	iBCF	£10,000	New
1	Hospital discharge, planning and	Care - Coordination to support discharge	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£6,246,432	Existing
1	Hospital discharge, planning and	Various community based services	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,335,417	Existing
2	Targeted out of hospital care	Supported Employment	High Impact Change Model for Managing	Other	Other approaches	Mental Health		CCG			NHS Community Provider	Minimum NHS Contribution	£188,000	Existing
3	Community support and independence	CCG Contribution to the local carers organisation	Carers Services	Other	Carer Advice and Support	Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£26,880	Existing
1	Hospital discharge, planning and	Home from Hospital - Home, Settle and Support Service (British	Integrated Care Planning and Navigation	Other	Care Planning, Assessment and Review	Community Health		CCG			Local Authority	Minimum NHS Contribution	£18,024	Existing
1	Hospital discharge, planning and	Home First same & next day discharge - AHPs.	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£110,524	Existing
3	Community support and independence	Urgent Care 2 Hour response and Bridging services (Ageing Well)	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£500,522	Existing
3	Community support and independence	Urgent Care 2 Hour response and Bridging services (Ageing Well)	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£227,527	New

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.

16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Barking and Dagenham

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	Checklist: Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	295.2	289.5	288.3	190.3	Based on the overall local target to reduce unplanned hospitalisation by 7.8% agianst last years performance. We set our ambition by looking at our current data using the avoidable admissions	Expansion of of the local Urgent Care and Rapid Response services including the communty treatment team, expansion of out of hours end of life rapid response.	
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
(See Guidance)	Indicator value	202	198	198	162			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	Checklist: Complete:
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	95.8%	95.1%	95.3%	94.7%	SUS data used from 2021/22 to 2022/23 Q1 to forecast/predict 2022/23 Q2 to Q4 with a confidence level of 95%, which takes into account seasonality of each quarter.	There are a range of joint commissioned services to support dicharge, this includes - The Integrated Discharge Hub, Home First, Reablement and D2A therapy beds.	Yes
	Numerator	3,581	3,655	3,523	3,163			
	Denominator	3,739	3,843	3,696	3,340			
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
(SUS data - available on the Better Care Exchange)	Quarter (%)	92.3%	91.9%	90.6%	89.1%			
	Numerator	2,636	2,512	2,260	2,007			Yes
	Denominator	2,857	2,734	2,494	2,254			Yes

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	Checklist: Complete:
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	621.0	673.5	643.6	666.7	The target will remain the same with slight adjustment for population used to calculate the rate. Although we have maintained a rate of residential admissions within target levels this is increasingly challenging due to increased acuity of	There are a range of commissioned and operational teams supporting this metric, including commissioned discharge to assess therapy beds in one nursing home, extra care discharge flats, the Integrated Discharge Hub and social work discharge	Yes
	Numerator	123	135	129	135			Yes
	Denominator	19,807	20,044	20,044	20,249			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	77.9%	80.8%	82.9%	83.9%	We are seeing higher numbers of older people coming through this pathway. Despite higher acuity of need post discharge and other challenges, outcomes have improved and we expect to maintain activity levels and slightly improved	There are a range of commissioned and operational teams supporting this metric, including crisis intervention services, Home First, extra care discharge flats, Home Settle and Support, voluntary sector housing and blitz cleaning support, the	Yes
	Numerator	81	84	131	130			Yes
	Denominator	104	104	158	155			Yes

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Barking and Dagenham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Checklist Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	See narrative plan			Yes
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	See narrative plan			Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	See narrative plan			Yes
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	See template			Yes
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	See template			Yes
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	See narrative plan			Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes	See narrative plan and template			Yes
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes	See template			Yes

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Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful definitions and where to go for further support. This sheet provides further guidance on using the Capacity and Demand Template.

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23.

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth quarters of 2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in the guidance tab for readability if required.

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign-off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23

- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services at a given time.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home

- Urgent Community Response (2 hr response)
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23

- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Barking and Dagenham
Completed by:	Louise Hider-Davies
E-mail:	louise.hiderdavies@lbbd.gov.uk
Contact number:	020 8057 5553
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of the Health and Wellbeing Board
Name:	Councillor Maureen Worby

How could this template be improved?	

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Barking and Dagenham

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	27	27	27	27	27	27
1: Reablement in a persons own home to support discharge (D2A Pathway 1)						
2: Step down beds (D2A pathway 2)	14	15	16	16	16	16
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	9	9	11	13	15	15

Any assumptions made:	Forecasting is based on historic trend data. The following assumptions have been made: Seasonal increases in demand and capacity are expected in December, February and March, based on historic trend data. There are no waiting lists for Crisis services (Crisis Intervention and Discharge). Average length of Crisis services remains stable.

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSI	0: Low level support for simple hospital discharges - e.g. Voluntary or Community	27	27	27	27	27	27
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSI	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	67	67	75	67	70	75
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSI	2: Step down beds (D2A pathway 2)	18	15	15	14	16	16
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSI	3: Discharge from hospital (with reablement) to long term residential care (Discharge	9	9	11	13	15	15

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Barking and Dagenham

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	Forecasting is based on historic trend data. The following assumptions have been made: Voluntary or Community Sector services data from average social prescribing referrals Seasonal increases in demand and capacity are expected in December, January, February and March, based on historic trend data. There are no waiting lists for Crisis services (Crisis Intervention and Discharge) - LBBD reablement. UCR is based on 21/22 historical data.

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	60	60	60	60	60	60
Urgent community response	248	248	248	226	226	226
Reablement/support someone to remain at home	24	24	28	28	30	30
Bed based intermediate care (Step up)	1	1	1	1	1	1

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Barking and Dagenham

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Forecasting is based on historic trend data. The following assumptions have been made: VCS services to support discharge is the British Red Cross Home Settle and Support Service. There is no Urgent Community Response step-down for discharge for pathway 0. Seasonal increases in demand and capacity are expected in December, February and March, based on historic trend data

Capacity - Hospital Discharge

Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	34	34	34	34	34	34
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	0	0	0	0	0	0
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	67	67	75	67	70	75
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	15	16	17	17	17	17
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	9	9	11	13	15	15

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Barking and Dagenham

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Forecasting is based on historic trend data. The following assumptions have been made: Voluntary or community sector services data based on referrals and onward capacity from social prescribing data Seasonal increases in demand and capacity are expected in December, January, February and March, based on historic trend data. There are no waiting lists for Crisis services (Crisis Intervention and Discharge)

Capacity - Community

Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	60	60	60	60	60	60
Urgent Community Response	Monthly capacity. Number of new clients.	174	174	174	158	158	158
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	24	24	28	28	30	30
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	1	1	1	1	1	1

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board:	Barking and Dagenham

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	
BCF related spend	£4,478,249

Comments if applicable	ICT - includes CTT (UCR) and Community and Stroke Inpatient rehab beds provdied by NELFT in the D&C modlelling. The BCF spend also includes Intensive Rehab Support also provided by NELFT.

HEALTH AND WELLBEING BOARD

14 September 2021

Title:	Proposed Diagnostics at Barking Community Hospital
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author: John Mealey Senior Communications Officer, BHRUT	**Contact Details:** john.mealey@nhs.net
Lead Officer: Kathryn Halford, Chief Nurse, Barking, Havering and Redbridge University Hospital Trust	

Summary

An independent review of NHS diagnostics services was undertaken in October 2020. The review concluded that there was a need for increased diagnostic capacity. The attached report outlines how BHRUT intend to address the issues raised in the review.

Recommendations

The Health and Wellbeing Board is asked to note the report

Reasons for report

BHRUT is committed to keeping all stakeholders informed of its plans and objectives and to invite comment and discussion on all aspects of its activities.

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PROPOSED DIAGNOSTICS AT BARKING COMMUNITY HOSPITAL

Barking & Dagenham HWBB

September 2022

TAKING PRIDE IN OUR CARE

NHS
Barking, Havering and Redbridge
University Hospitals
NHS Trust

WHAT ARE COMMUNITY DIAGNOSTIC CENTRES (CDC)?

- An independent review of diagnostic services in October 2020 highlighted the need for increased diagnostic capacity

- In response, the NHS is implementing a national programme to develop CDCs, which provide a range of tests and scans, such as MRI, CT and ultrasound, in one place and away from an acute hospital environment

The CDCs will:

- Provide patients with a quicker, simpler, more integrated and personal service
- Improve health outcomes
- Increase diagnostic capacity
- Reduce inequalities
- Improve productivity and efficiency

COMMUNITY DIAGNOSTIC CENTRES ACROSS NORTH EAST LONDON (NEL)

North East London Health & Care Partnership

- The demand for tests and scans continues to rise, with waiting lists increasing from an average of 6 to 11 days in 2016 to 9 to 22 days in 2022

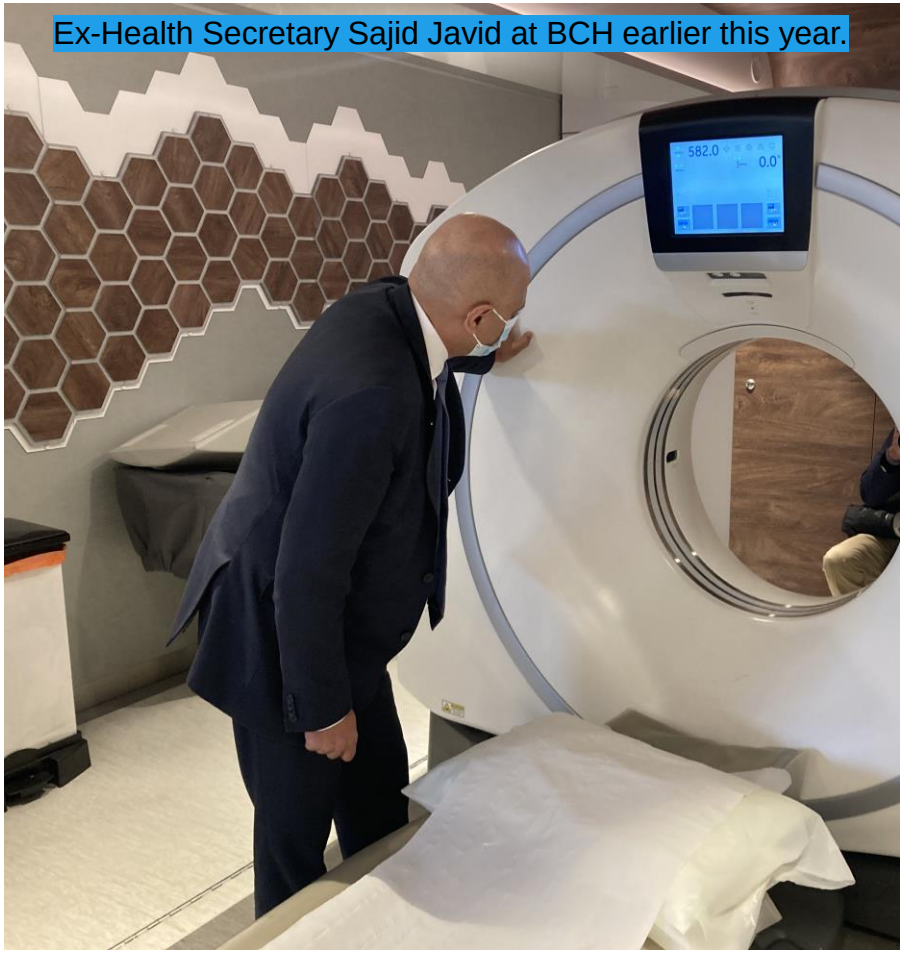
- With a projected population growth of 250,000 in the next 10 years and an ageing population, we need to make sure residents have quick access to checks, scans and tests

- Over the next three years, the NHS in NEL will receive £39m to build and run CDCs across its boroughs

- A public consultation is under way to get views from residents on the different proposals. It closes on Tuesday 13 September

PROPOSED CDC AT BARKING COMMUNITY HOSPITAL

- One proposal is to expand diagnostic services at Barking Community Hospital (BCH) and build a £15m CDC
- The purpose-built CDC would provide a range of tests and scans, such as CT, MRI, ultrasound and bloods
- BCH is an early adopter site and the addition of mobile CT and MRI scanners, ultrasound facilities and X-ray machines over the last few months has helped us make good progress in reducing waiting lists
- Further investment will help us continue to improve our services to residents



Ex-Health Secretary Sajid Javid at BCH earlier this year.

PROPOSED CDC AT BARKING COMMUNITY HOSPITAL

- As part of the wider consultation, we are engaging as a Trust locally with patients, residents and key stakeholders to help us understand what is important to them, for example, how can we make the environment relaxing and preferred appointment times

- Using a variety of targeted and broader communication tactics and by working closely with local partners, we've had a very successful response to our survey, which has been completed by more than 820 residents so far

- The survey closes on 9 September

NEXT STEPS

- We will continue to keep you updated

- For queries, please email bhrut.bch.cdc@nhs.net

Barking & Dagenham

HEALTH and WELLBEING BOARD
FORWARD PLAN

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).

In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Yusuf Olow, Senior Governance Officer, Ground Floor, Town Hall, 1 Town Square, Barking IG11 7LU (email: yusuf.olow@lbbd.gov.uk)

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to https://modgov.lbbd.gov.uk/Internet/ieDocHome.aspx?Categories=-14062 and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during 2021/22:

Edition	Publication date
June 2021 Edition	17 May 2021
September 2021 Edition	15 August 2021
November 2021 Edition	11 October 2021
January 2022 Edition	14 December 2021
March 2022 Edition	14 February 2022

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Yusuf Olow, Senior Governance Officer, Ground Floor, Town Hall, 1 Town Square, Barking IG11 7LU (email: yusuf.olow@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed. It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to https://modgov.lbbd.gov.uk/Internet/ieListMeetings.aspx?CId=669&Year=0 or by contacting Yusuf Olow on the details above.

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: 8.11.22	**NELFT NHS Foundation Trust Quality Report 2021/22** All NHS healthcare providers are asked to write an annual report about the quality of services they provide. The Quality Report will enable the NELFT to engage with service users, carers, staff, stakeholders, partner organisations and the public in an open and transparent way. The Report will identify NELFT's key priorities for the year ahead and look back, showing the improvements made in the last year to improve the quality of care that NELFT provides. • Wards Directly Affected: All Wards		Melody Williams, NELFT Integrated Care Director, melody.williams@nelft.nhs.uk
Health and Wellbeing Board: 8.11.22	**Annual Report of the Director of Public Health** The finalised report of the Director of Public Health, covering 2021/2022 will be presented to the Committee for approval. • Wards Directly Affected: Not Applicable		Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk) Matthew.Cole@lbbd.gov.uk
Health and Wellbeing Board: 8.11.22	**Covid-19 Update in the Borough** The Director of Public Health will provide the Board with an update on the effects of that Covid-19 is having on Borough residents and the Council's response to dealing with the challenge of Covid-19. • Wards Directly Affected: All Wards		Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk) Matthew.Cole@lbbd.gov.uk
Health and Wellbeing Board: 8.11.22	**SEND Green Paper, SEND Inspection, & SEND Area Committee** • Wards Directly Affected: All Wards		Melody Williams, NELFT Integrated Care Director, melody.williams@nelft.nhs.uk

Health and Wellbeing Board: 8.11.22	**Safeguarding Adults Board Annual Report** • Wards Directly Affected: All Wards		Anju Ahluwalia Chair of the Adult Safeguarding Board Anju.Ahluwalia@lbbd.gov.uk
Health and Wellbeing Board: 18.1.23	**Covid-19 update in the Borough** The Director of Public Health will provide the Board with an update on the effects of that Covid-19 is having on Borough residents and the Council's response to dealing with the challenge of Covid-19. • Wards Directly Affected: All Wards		Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)
Health and Wellbeing Board: 14.3.23	**Covid-19 update in the Borough** The Director of Public Health will provide the Board with an update on the effects of that Covid-19 is having on Borough residents and the Council's response to dealing with the challenge of Covid-19. • Wards Directly Affected: All Wards		Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

APPENDIX 1

Membership of Health and Wellbeing Board:

Cllr Maureen Worby (Chair), LBBD Cabinet Member for Social Care and Health Integration
Dr Jagan John (Deputy Chair), NHS North East London Clinical Commissioning Group
Elaine Allegretti, LBBD Strategic Director, Children and Adults
Cllr Jane Jones, LBBD Cabinet Member for Children's Social Care & Disabilities
Cllr Syed Ghani, LBBD Cabinet Member for Enforcement & Community Safety
Cllr Elizabeth Kangethe, LBBD Cabinet Member for Educational Attainment & School Improvement
Melody Williams, North East London NHS Foundation Trust
Elspeth Paisley, BD Collective
Matthew Cole, LBBD Director of Public Health
Louise Jackson, Metropolitan Police
Kathryn Halford, Barking Havering and Redbridge University Hospitals NHS Trust
Sharon Morrow, NHS North East London Clinical Commissioning Group
Nathan Singleton, Healthwatch Barking and Dagenham (CEO Lifeline Projects)

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