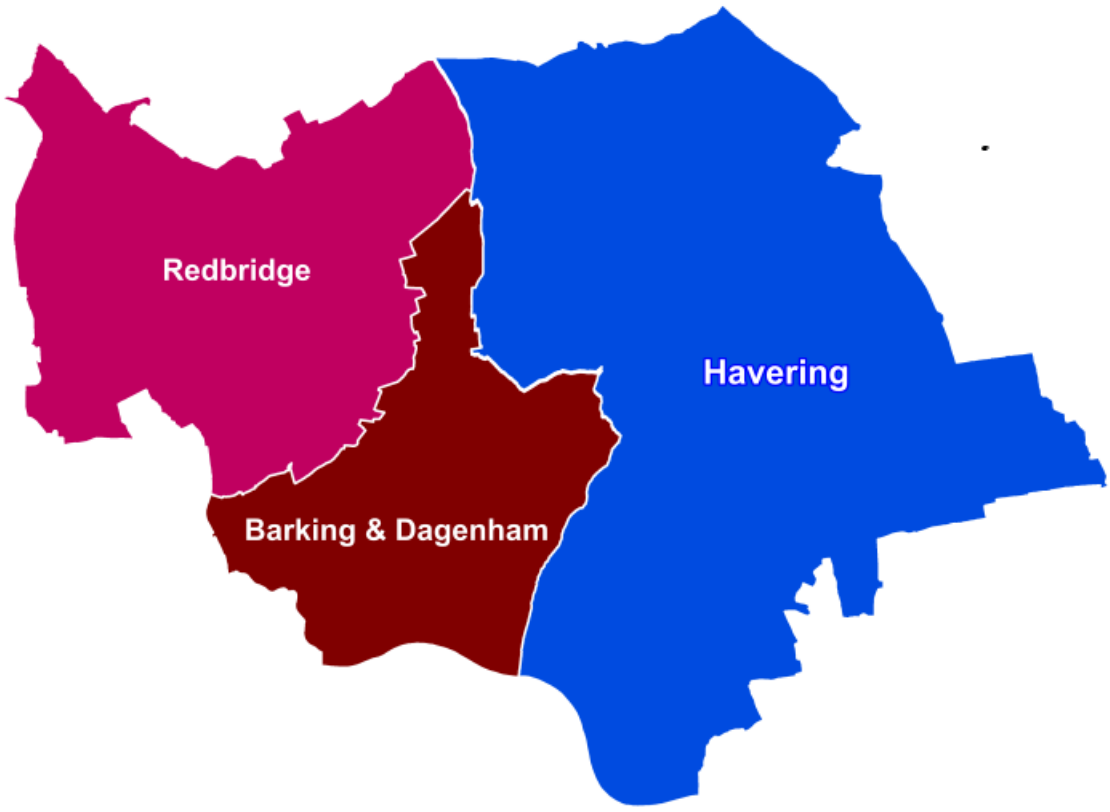
Barking & Dagenham, Havering and Redbridge Joint Strategic Needs Assessment Profiles

Executive Summary

London Borough of Havering



October 2022

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Introduction

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

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

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

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

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

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

The population of BHR

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

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

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

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

Current health outcomes of BHR residents

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

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

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

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

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

Achieving better health and narrowing inequalities.

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

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

Pillar 1: The wider determinants of health

Addressing the wider determinants of health, e.g. by improving income, employment opportunities, educational attainment, high quality affordable housing etc. will have the greatest impact on physical and mental health of an individual and the population as a whole in the long term. Inequalities regarding the wider determinants of health are the underlying cause of the great majority of health inequalities.

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

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

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

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

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

Pillar 2: The places and communities we live in

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

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

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

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

Pillar 3: Lifestyles and behaviours

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

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

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

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

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

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

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

Pillar 4: The integrated health and social care system

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

Antenatal and maternity services

Fertility rates in all three BHR boroughs are above the national average, markedly so in Redbridge and Barking and Dagenham. Some local women deliver their babies in maternity units elsewhere in inner northeast London, rather than their designated unit. Due to these flows, it makes sense that **maternity services** are planned across the NEL footprint. The East London Local Maternity System (ELLMS) priorities are to provide women with personalisation, safety and choice, and access to specialist care whenever needed.

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

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

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

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

Health and care for children and young people

Barking and Dagenham and Redbridge are young boroughs. Havering has an older demographic. Nonetheless, Havering has seen a significant increase in numbers of children and young people recently. Therefore, **the capacity of health and care services for children and young people is an issue** in all three boroughs. Happily, **most children are born in good health**. Nonetheless, maternity and health visiting services offer essential support to all parents at a time that inevitably brings new and sometimes significant challenges. Provision in the community, alongside other family-orientated services provided by Councils and Voluntary & Community Sector organisations (VCS), can help introduce new parents to the full range of support available.

Health visitors provide a series of checks through the early years and are ideally placed to identify those families that are struggling, enabling **early intervention** to avoid problems escalating e.g. by identifying a child who is at risk of not being school ready.

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

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

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

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

The mental health of children and young people is a significant and growing concern. **Child and Adolescent Mental Health Services** (**CAMHS)** capacity is increasing significantly in response, but even so, only a minority of the 1 in 10 children

and young people with a diagnosable condition will be under the care of specialist services at any point in time. Further effort is needed to improve the capability of GPs to support them and engage services commissioned by schools to make the most of overall capacity and ensure that cases are escalated when needed. In addition, there is a need to build the resilience of our children and young people and give their parents, teachers, social workers etc. the skills and knowledge to identify and help them cope with mental health issues.

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

A proportion of children are born with, or develop, significant and lifelong problems. More than 1 in 10 children with **Special Education Needs and Disability** (**SEND**) may need support from health, social care and education professionals to learn. The most common type of need is mild to moderate learning disability followed by speech, language and communication needs. The needs of a growing cohort of children are captured in an **Education, Health and Care Plan** (**EHCP**). Autistic Spectrum Disorder is the most common primary need identified in EHCPs. Development and delivery of EHCPs can involve contributions from schools, children's social care and NHS services (e.g. therapies, community paediatrics, CAMHs etc.). Changes in legislation have combined to significantly increase demand (and parental dissatisfaction) and put pressure on services and budgets. Some children with particular needs have to be bussed long distances, at great expense, to specialist provision or in exceptional cases are in residential placements out of borough. Cooperation across the ICS is needed to grow capacity as a whole and fill gaps in some specialist provision, allowing support to be provided closer to home and at lower cost.

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

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

serious mental illness, substance misuse, domestic violence, suicide, criminality, homelessness etc.

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

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

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

Lockdowns also deprived children of social interaction and may have increased exposure to ACEs in the home e.g. domestic violence. Such factors, coupled with anxiety regarding the pandemic itself, may account for reported lower mental wellbeing and higher rates of referral into CAMHs.

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

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

Adult mental health services

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

As with physical ill health; the burden of mental ill health shows marked inequalities and there are significant opportunities to prevent mental illness throughout the life course e.g. by reducing exposure to ACEs. The impact of the **wider determinants** on mental health is particularly marked. Factors like debt, unemployment,

homelessness, relationship breakdown and social isolation predispose to mental illness. Action to address the wider determinants can aid recovery but people with mental health issues, particularly serious mental illness, are much less likely to have stable accommodation or be in work. A coordinated, proactive approach on the part of multiple agencies is necessary.

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

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

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

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

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

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

Cancer services

Cancer, with cardiovascular disease, remains the **big killer.** Cancers account for a quarter of all years of life lost.
1 in 2 people will be diagnosed with cancer in their lifetime. More than 3,200 people in BHR are diagnosed each year. 46% of cases are in Havering due to its older age profile. More than half of all cases are cancer of the breast, prostate, lung or bowel.

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

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

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

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

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

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

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

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

Long term conditions

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

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

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

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

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

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

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

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

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

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

It seems increasingly likely that another legacy of the pandemic will effectively be a new LTC in the form of **long COVID**. Symptoms vary widely, including fatigue,

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

Older people and frailty services

Older people experience more ill health and have greater need for health and social care than other age groups. Consequently, ongoing population ageing will pose a growing challenge to health and social care services.
Greater focus on **prevention** is needed at every stage of the life, including in old age, to improve quality of life for older residents and delay the point at which ill-health results in significant loss of independence and reliance on health and care services. Prevention in old age can take many forms.

Older people are at very much higher risk of serious illness and death because of COVID-19. Vaccination reduces that risk, but immunity wanes quickly and boosters are needed when the incidence of coronavirus infection is high to minimise harm and pressure on the health and care system. As we slowly move out of the pandemic, the frequency of boosters is still linked to successive waves of infection but in time these will settle and **COVID vaccination** may be offered in advance of winter when other respiratory illnesses peak.

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

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

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

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

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

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

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

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

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

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

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

Care homes will continue to be high risk settings with regard to COVID-19 for several years to come; requiring ongoing support from the UK Health Security Agency

(UKHSA) and local authorities, and not least from NHS partners providing **booster vaccinations** and timely access to **antivirals** for those eligible. The pandemic has demonstrated that **care homes and domicillary care are essential elements of the health and care system** and neglect for any one part has consequences for the whole.

Urgent and unplanned care

BHRUHT is often full to capacity, with long waits in A&E, ambulances queueing and patients unable to be admitted until someone else is discharged. Whereas previously this would have only happened in the depths of winter, it has become a regular occurrence year round.
Work is underway under the auspices of the BHR Urgent and Emergency Care Transformation Board to create alternatives to A&E attendance. Further action will be needed to ensure that patients and clinicians use these new services as intended.

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

Pillar 4: Planned (non-urgent) care

A huge variety of care is provided on a planned basis, including diagnostic investigations, specialist assessment and then treatment, including surgery. Much of this is traditionally provided in acute hospitals through outpatient clinics.
The number of people waiting for care, and the duration of that wait, was growing before the pandemic hit and has grown greatly since as services stopped entirely and then returned with reduced capacity.

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

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

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

Population Health Management

There is a recurrent theme through the JSNA and particularly the section regarding integrated health and care. A different approach is required to the organisation and delivery of health and social care.
We need to make better use of information to inform how we plan and deliver services for the population as a whole, as well as the clinical management of individual patients. Stratification of the population by life stage and complexity of need will improve the planning and delivery of services for specific patient cohorts:

- **People who are generally well**: who will benefit from primary prevention interventions to maintain good health; with more intensive support where people are currently well but at risk of developing LTCs.

- **People with long term conditions**: who in addition to the primary prevention interventions above, will benefit from early identification and treatment of LTCs, personalised care planning, self-management support, medicine management and secondary prevention services.
- **Older people with complex needs or frailty**: who in addition to the interventions above would benefit from a case management approach offering integrated, holistic, personalised, co-ordinated care with a high degree of continuity.

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

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

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

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

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

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

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

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

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

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

Equally, health professionals and public will need to recognise the impact of personal circumstances and place on health and look beyond health care for more effective ways of improving wellbeing. Strong links between general practice, other statutory services such as housing and the Department of Work Pensions, the community and voluntary sector within the locality should be an essential element of locality working. The development of an effective **social prescribing** function, whereby patients are actively encouraged to access other forms of support, will maximise the likelihood of success e.g. with 1:1 support from a care navigator. Partners and the community itself will also need to consider the assets available relative to needs and how any gaps may be filled[7]. Approaches such as **local area coordination** are needed to strengthen the capacity of communities to identify and support our most vulnerable residents and hence reduce pressure on statutory services.

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

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

However, people's decisions about engagement with health services and more widely regarding behaviours that impact on health are not made in isolation. Instead, they are shaped by the place which they live; prevailing cultural norms, their previous experiences and aspirations for the future. A focus solely on health and social care is not enough. We come back to the message underpinning this JSNA – that we cannot

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

achieve significant improvement in health outcomes and a reduction in health inequalities without **tackling all four pillars of the population health model**.

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

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