**Notice of Meeting of the**

**ASSEMBLY**

**to be held on Wednesday, 30 January 2019**
**commencing at 7:00 pm in the**
**Council Chamber, Town Hall, Barking**

To all Members of the Council of the London Borough of Barking and Dagenham

Date of publication: 22 January 2019

Chris Naylor
Chief Executive

Councillors and senior officers are also invited to attend a presentation in the Council Chamber at 6.00 pm on the topic of Data Protection Practicalities for Members. This will be chaired by Councillor Dominic Twomey, Deputy Leader of the Council and Cabinet Member for Finance, Performance & Core Services and led by Claire Symonds, Chief Operating Officer.

Each Councillor is a registered Data Controller and responsible for how he/she retains and processes the data residents give them. This briefing will update Members on the statutory
requirements and outline practical measures they need to take. Kindly bring your IPAD/laptop with you to this session.

Contact Officer: David Symonds
Tel: 020 8227 2638
E-mail: david.symonds@lbbd.gov.uk

London Borough of
Barking&Dagenham
lbbd.gov.uk

Please note that this meeting will be webcast, which is a transmission of audio and video over the internet. Members of the public who attend the meeting and who do not wish to appear in the webcast will be able to sit in the public gallery on the second floor of the Town Hall, which is not in camera range.

To view webcast meetings, go to https://www.lbbd.gov.uk/council/councillors-and-committees/meetings-agendas-and-minutes/overview/ and select the meeting from the list.

## AGENDA

**1. Apologies for Absence**

**2. Declaration of Members' Interests**

In accordance with the Council's Constitution, Members 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 held on 21 November 2018 (Pages 3 - 13)**

**4. Leader's Statement**

The Leader will present his statement.

**5. Appointments**

The Labour Group Secretary will announce any nominations to fill vacant positions on Council committees or other bodies.

**6. Barking and Dagenham Youth Forum and Young Mayor Annual Report 2018 (Pages 15 - 42)**

**7. Final Third Local Implementation Plan Submission (Pages 43 - 64)**

**8. Joint Health and Wellbeing Strategy 2019/23 (Pages 65 - 164)**

**9. Council Tax Support Scheme 2019/20 (Pages 165 - 169)**

**10. Motions (Pages 171 - 177)**

**11. Questions With Notice**

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

**13. 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 Assembly, 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.***

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

Our Vision for Barking and Dagenham

## ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

**A New Kind of Council**

- Build a well-run organisation
- Ensure relentlessly reliable services
- Develop place-based partnerships

**Empowering People**

- Enable greater independence whilst protecting the most vulnerable
- Strengthen our services for all
- Intervene earlier

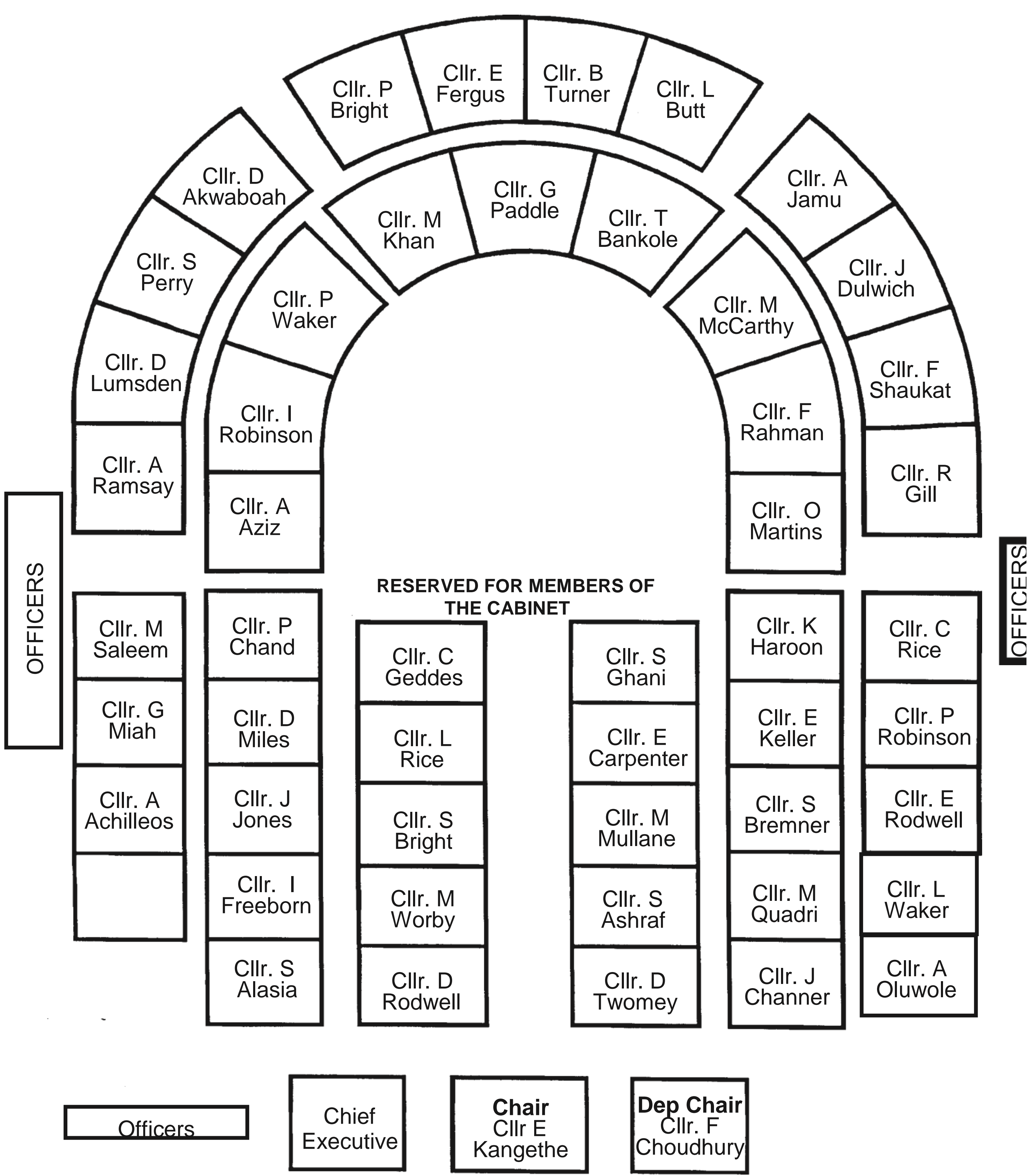
**Inclusive Growth**

- Develop our aspirational and affordable housing offer
- Shape great places and strong communities through regeneration
- Encourage enterprise and enable employment

**Citizenship and Participation**

- Harness culture and increase opportunity
- Encourage civic pride and social responsibility
- Strengthen partnerships, participation and a place-based approach

# BARKING TOWN HALL
# COUNCIL CHAMBER




## SEATING PLAN FOR THE ASSEMBLY

October 2018

# MINUTES OF ASSEMBLY

Wednesday, 21 November 2018
(7:04 - 9:00 pm)

**PRESENT**

Cllr Elizabeth Kangethe (Chair)
Cllr Faruk Choudhury (Deputy Chair)

| | | |
|---|---|---|
| Cllr Dorothy Akwaboah | Cllr Sanchia Alasia | Cllr Saima Ashraf |
| Cllr Abdul Aziz | Cllr Toni Bankole | Cllr Simon Bremner |
| Cllr Princess Bright | Cllr Sade Bright | Cllr Laila M. Butt |
| Cllr Evelyn Carpenter | Cllr Josie Channer | Cllr John Dulwich |
| Cllr Edna Fergus | Cllr Irma Freeborn | Cllr Cameron Geddes |
| Cllr Syed Ghani | Cllr Rocky Gill | Cllr Kashif Haroon |
| Cllr Amardeep Singh Jamu | Cllr Jane Jones | Cllr Eileen Keller |
| Cllr Mohammed Khan | Cllr Donna Lumsden | Cllr Olawale Martins |
| Cllr Giasuddin Miah | Cllr Dave Miles | Cllr Margaret Mullane |
| Cllr Adegboyega Oluwole | Cllr Glenda Paddle | Cllr Simon Perry |
| Cllr Moin Quadri | Cllr Foyzur Rahman | Cllr Tony Ramsay |
| Cllr Chris Rice | Cllr Lynda Rice | Cllr Paul Robinson |
| Cllr Emily Rodwell | Cllr Muhammad Saleem | Cllr Faraaz Shaukat |
| Cllr Bill Turner | Cllr Dominic Twomey | Cllr Lee Waker |
| Cllr Phil Waker | Cllr Maureen Worby | |

**APOLOGIES FOR ABSENCE**

| | | |
|---|---|---|
| Cllr Andrew Achilleos | Cllr Peter Chand | Cllr Mick McCarthy |
| Cllr Ingrid Robinson | Cllr Darren Rodwell | |

## 30. Declaration of Members' Interests

There were no declarations of interest.

## 31. Minutes - To confirm as correct the minutes of the meeting held on 12 September 2018

The minutes of the meeting held on 12 September 2018 were confirmed as correct.

## 32. Minutes of Sub-Committees - To note the minutes of the JNC Appointments, Salaries and Structures Panel held on 15 October 2018

The Assembly received and noted the minutes of the JNC Appointments, Salaries and Structures Panel held on 15 October 2018.

## 33. Leader's Statement

The Deputy Leader of the Council (Cllr Ashraf) presented a verbal statement on

behalf of the Leader, updating the Assembly on a range of matters since the last meeting including:

-The appointment of two Member Champions, working closely alongside Cabinet Members: Councillor Freeborn (Quality in Care) and Councillor Chris Rice (Mental Health). A work programme is being organised for these posts.

**-**The Innovation in Politics Award was held in Vienna, won by the Deputy Leader for Community Leadership and Engagement for the work the Council was undertaking in promoting community participation, although was no complacency about the work that lay ahead. The Council were the first UK project that has won the Innovation in Politics Award.

**-**The Chancellor's Budget & its impact on the borough- There was a need to maintain pressure on the Government to fund the NHS, social care and all public services after years of underfunding. The Government's Budget on 29 October 2018 would provide little relief for the Borough's residents at this difficult time.

**34. Appointments**

The Assembly **resolved** to appoint:

- Councillor Rahman to the Office for Raising Standards in Education, Children's Services and Skills (OFSTED) Panel;
- Councillor Khan as a trustee of the Chadwell Heath Community Trust Board; and
- Councillors Akwaboah and Saleem to the Standing Advisory Council on Religious Education (SACRE)

**35. Annual Report 2017/18 -Safeguarding Adults Board**

The Cabinet Member for Health and Social Care Integration introduced a report on the Annual Report 2017/18 for the Safeguarding Adults Board.

The Annual Report described the work and priorities of the Barking and Dagenham Safeguarding Adults Board (SAB) from April 2017 to March 2018 and set out how the Board had worked to improve the protection of vulnerable adults across Barking and Dagenham along with its achievements in 2017/18 and key priorities into the future.

The annual reports contained contributions from a range of organisations who were involved in safeguarding vulnerable adults in Barking and Dagenham. Joint working has been effective over the past year, and the membership of the Board has strengthened. During the year, the Board had appointed a new Independent Chair. The statutory partners provided financial resources to support the SAB a to fulfil their functions and to support the undertaking of Safeguarding Adult Reviews (SARs).

The Annual Report had been agreed by the Safeguarding Adults Board at its meeting on 17 July 2018 and was presented and discussed at the Health & Wellbeing Board on 5 September 2018. The Health & Wellbeing Board noted the

need to improve awareness across frontline teams and the wider community about safeguarding concerns, especially around issues of exploitation and modern slavery, and on how to report concerns for attention by statutory agencies.

The Cabinet Member for Health and Social Integration considered that one of the Safeguarding partners, the East Basic Command Unit (BCU) needed to improve its transparency and she would be inviting the Borough Police Commander to address a future meeting of the Assembly for an update on crime and violence safeguarding issues.

In answer to a question, the Cabinet Member advised that records of care are kept including those of inspections and quality assurance.

Members welcomed the report and in particular agreed that it was a priority to help and support vulnerable adults. They were concerned to ensure that partnerships and agencies continued to work together in light of 1,632 safeguarding concerns that had been raised to the Council which was an increase on the previous year. They also noted that work on awareness of mental health was on-going and the Serious Case Review contained in the report. They were also concerned about the adult social care budgets and the effect of the introduction of Universal Credit (UC), which is was felt had put vulnerable residents at risk and raised the level of homelessness.

(i) The Assembly **resolved** to note the contents of Annual Report of the Safeguarding Adults Board for 2017/18; and

(ii) Noted the discussion at the Health & Wellbeing Board and add further comments to shape the priorities of the SAB through its Strategic Plan.

**36. Annual Reports 2017/18- Adoption and Corporate Parenting- a new approach**

The Cabinet Member for Health and Social Care Integration introduced the annual reports on Adoption and Corporate Parenting. They described the new approach that will be taken to producing these in future, highlighting key achievements and priorities for the coming year. One of the critical things Looked After Children needed was stability and clear permanence and this approach cut across children's care and support and not just children in care and the Council were developing a Permanency Strategy, which would underpin plans for performance through every child's journey and be developed over the next two months.

The Cabinet Member stated that greater improvement (targets) was necessary in dealing with adoption and corporate parenting however the Council was doing the best it could at a time of severe financial constraint. This included the Government's reductions in funding the Adoption Support Fund.

Members welcomed the report and considered that targets needed to be improved, also that in terms of adoption and corporate parenting, siblings should be kept together as far as possible.

The Assembly received a short video presentation in relation to Skittlz, Barking and Dagenham's Children in Care Council, made up of a range of Looked After Children that are actively consulted regarding being in care.

Members welcomed the report and video presentation.

The Assembly **resolved** to:

(i) Note the contents of the two annual reports on adoption and corporate parenting respectively; and

(ii) Note developments in children's social care over the last 6 months and support their reflection in a more useful, timely and purposeful strategy.

## 37. Treasury Management 2018/19 Mid-Year Review

The Cabinet Member for Finance, Performance and Core Services introduced the Treasury Management 2018/19 Mid-Year Review. The mid-year review provided details of the current position for treasury activities and highlighted compliance with the Council's policies previously approved by the Assembly. This report was prepared in compliance with CIPFA's Code of practice on Treasury Management, and covered a number of areas, including the Council's Investment and Acquisition Strategy, Debt position and Commercial Lending.

The Assembly had agreed the Treasury Management Strategy Statement for 2018/19 on 28 February 2018, which incorporated the Prudential Indicators. This report updated Members on treasury management activities in the current year.

The Cabinet Member for Finance, Performance and Core Services underlined that this report was at a time of continuing severe financial constraint for local authorities and uncertainty about Brexit. He underlined that (draw down of debt-commercial lending had been agreed by Cabinet, with borrowing at £248m. There was a need to borrow and invest more but remain within the Council's spending limits.

The Cabinet had agreed the report at its meeting on 13 November 2018.

The Assembly **resolved** to:

(i) Approve the revised 2018/19 Minimum Revenue Provision at Appendix 1 to the report;

(ii) Note the Treasury Management Strategy Statement Mid-Year Review 2018/19;

(iii) Note that in the first half of the 2018/19 financial year the Council complied with all 2018/19 treasury management indicators;

(iv) Note the value of investments as at 30 September 2018 totalled £300.2m;

(v) Note the value of long term borrowing as at 30 September 2018 totalled £612.0m. This comprised market, Public Works Loan Board, Local Authority and European Investment Bank loans;

(vi) Note the value of short term borrowing as at 30 September 2018 totalled £144.7m; and

(vii) Note the increased resources made available through the finance restructure to monitor the Council's Investment and Acquisitions Strategy's funding requirement and cashflow monitoring requirements.

## 38. Corporate Plan 2018 - 2022

The Cabinet Member for Community Leadership and Engagement introduced a report on the Corporate Plan 2018-22. Over the past few years, the Council had undergone a period of significant change, focussing on establishing a new kind of council and had transformed the way it delivered services, introduced new ways or working and facilitating a change in the relationship that the Council has with residents. These changes were made as the Council was required to make savings of £48K by 2021.

In consultation with residents, the Council had shaped and defined the vision for Barking and Dagenham through the production of the Borough Manifesto. This provided a clear direction for the Council over the coming years. As an enabler and facilitator, the Council's job was to make the community's vision a reality. The Corporate Plan 2018-2022 set out the Council's contribution over the next four years to deliver the Borough Manifesto. It clearly articulated the Council's vision and priorities as it continued its journey and the transformation programme.

The Cabinet Member placed on record that the Council were delivering on the themes in the Corporate Plan, namely: a new kind of Council, Empowering People, Inclusive Growth and Citizenship and Participation. She was pleased that despite severe financial constraints, it had won the award of Council of the Year at the Local Government Chronicle Awards in 2018.

The Assembly **resolved** to approve the Council's Corporate Plan 2018-2022 as set out at Appendix 1 to the report.

## 39. Report of a Decision of the Standards (Hearing) Sub-Committee

The Assembly noted the outcome of the Standards (Hearing) Sub-Committee held on 28 September 2018.

Councillor Butt was invited to address the Assembly and provided an oral statement to Assembly and apologised to fellow Members and the borough's residents for breaching of the Councillors' Code of Conduct. She contended that she did not know she was required to register disclosable pecuniary interests in respect of two properties and stated that she did not mislead the Leader of the Council and Monitoring Officer. In reference to a press report in the Barking and Dagenham Post, she confirmed that she was advised and not instructed to apologise to Assembly as part of the decision of the Standards (Hearing) Sub-Committee.

## 40. Motions

Moved by Councillor Alasia and seconded by Councillor Channer:

“Barking and Dagenham’s migrant communities contribute a huge amount to the borough and are the heart of the borough’s cultural identity.

Approximately 21% of the borough’s population is of African or Caribbean heritage and although the Council does not have precise figures, it is believed the borough is home to hundreds if not thousands, of the Windrush generation and many more come from other Commonwealth countries across the globe.

Barking and Dagenham Council expresses dismay at the ‘hostile environment’ initiated by Theresa May when she was Home Secretary and at the financial and emotional impact this has had on the Windrush generation and their families, including children and grandchildren.

This Council welcomes:

- the contribution that Eastside Heritage have undertaken over many years to capture the history and legacy of the Windrush Generation, particularly those that worked in the NHS
- the work of organisations the JCWI, BME Lawyers 4 Justice, the Runnymede Trust, MPs and the All Parliamentary Group on Race who have been campaigning on these issues, and
- the role the Caribbean High Commissions have played in lobbying the Government.

In response Barking and Dagenham Council resolves to:

- call on the Government to implement a fair compensation scheme for the emotional, financial and physical trauma the Windrush generation suffered whilst their immigration status was undefined
- Celebrating Windrush Day in Barking and Dagenham on the 22 June each year with an annual celebration to recognise and honour the enormous contribution of those who arrived between 1948 and 1971
- press the Prime Minister to call for an independent public enquiry into the Windrush scandal,
- demand the Government fully supports advice agencies in their work to achieve justice (and compensation for all losses, injury and damages to date where necessary) for all Barking and Dagenham residents of the Windrush generation,
- review our own policies and procedures to ensure we support those affected,
- support the call for fees for naturalisation to be waived for all those who have been affected, and
- oppose the criminalisation of Windrush families.”

Members of the Assembly spoke in support of the motion.

The motion was **carried** unanimously.

## 41. Questions With Notice

### Question 1

### From Councillor Martins

Can the Cabinet Member for Finance explain what impact the Chancellor of the Exchequer’s recent Budget Announcement will have on residents in Barking and Dagenham?

### Response

The Government’s Budget did provide some good news for Local Authorities including Barking and Dagenham. For example, capital funding has been made available to improve roads (£0.42m for this borough in 2018/19) and additional funding has been promised to support Social Care for both Adults and Children’s social care in 2019/20 which will allow the Council to support the most vulnerable in our community, although it will not be sufficient to compensate for many years of austerity and cuts to Local Government budgets, particularly social care. In addition, the social care funding is one off and the Government have not provided any long-term solutions to the growing issues in Social Care.

The Government has removed the borrowing cap on the Housing Revenue Account which allows Local Authorities to build some additional housing, however, it does not in itself create any new funding for Local Authorities or Housing Associations.

The Government budget made no long-term announcements about Schools funding. Although there is a small one-off capital payment for all schools (£10,000 to £50,000 per school, there is no new permanent investment in either Schools or High Needs with a likelihood of very small sub-inflation increases in funding.

The Government is still committed to the implementation of Universal Credit although they have introduced a number of measures have been introduced to mitigate the impact on individual claimants including those in Barking and Dagenham.

### Question 2

### From Councillor Perry

After 8 years of Tory austerity, coupled with continued increases in the cost of living in London, can the relevant Cabinet Member explain what the Council is doing to ensure that key public sector workers are not priced out of Barking & Dagenham?

### Response

Whilst Barking and Dagenham is one of London’s most affordable boroughs, it is still very difficult for many residents to buy or rent homes on the market. Our residents and the jobs they do are vital to the London economy.

When housebuilders stopped building during the credit crunch, the Council created its own housing company, Reside, to deliver genuinely affordable homes for local people. There are now 810 households living in affordable Reside homes and we have ambitious plans to triple this to 2,529 by 2022/23. In addition, we are building an additional 397 homes for sale and 290 homes for students.

In addition to the new affordable housing being developed for Reside, the Council has also recently completed 34 new shared ownership homes at the Leys, via the HRA and 32 of those recently released have been snapped up by Barking and Dagenham residents. Rents on Reside homes will vary from 50%-80% of a market rent and we will build shared ownership homes too. The Reside and HRA homes will be affordable to those people whose households are on the London Living Wage.

Such an ambitious home building programme is only possible because the Council has set up its own regeneration company, Be First, which has the expertise and capacity to deliver these new homes for Reside by 2023 and in the process ensure that financial returns are reinvested into vital local services.

The Council are also working hard with other developers to ensure their developments provide genuinely affordable homes. We have recently approved 12,000 new homes at Barking Riverside and Beam Park half of which are affordable including homes at London Affordable Rent and London Living Rents and Shared Ownership homes.

The Council are also working with Pocket Living who are building 78 new homes, for which key workers are prioritised (incl. teachers and social workers), in Barking Town Centre (to be completed in 2019)

**Question 3**

**From Councillor Haroon**

Has the Council's recruitment drive for its refuse and waste services been successful?

**Response**

The introduction of new service improvements is nearing completion and seen the recruitment of 62 posts in waste and street cleansing service. This is being conducted in 3 main phases, with new starters from October- December 2018.

The Council aimed to recruit 30 post in Street Cleansing, and 32 posts in Refuse. Currently these posts are being covered by agency staff, which is expensive and unstable. Initially the first wave of recruitment saw 798 applications, for 11 job roles. With most refuse posts now filled, there have been significant improvements in missed collection rates, and reduction of complaints for refuse, with a collection rate of October 2018 of 99.89%.

There is a "New Cleansing" model for town centres now in place, with coverage from 5:30 to 10:30 pm over 4 shifts. Better supervision and more mechanized

sweeping is at weekends, together with quicker response times for removal of fly tips and sweeper bags. Currently 80% of town centre team are new starters from the on-going recruitment drive.

**Question 4**

**From Councillor Saleem**

What is being done to deal with problem of fly tipping in the Borough and the perpetrators of this crime?

**Response**

Fly-tipping is a priority for the Council. We undertake a number of functions that address fly-tipping. These include:

- Wall of Shame – The Council has a dedicated section on the Council's website that provides images and videos of people who have been caught on camera fly-tipping. We identified 6 perpetrators since July 2018 and issued 12 Fixed Penalty Notices.

- CCTV cameras – The council has a number of CCTV cameras, intel is regularly passed to our enforcement team who deal with fly tipping to follow up actions on anyone observed fly tipping on camera. There have been in excess 20 Fly tipping Fixed Penalty Notices being issued in recent months to residents/business of Sunningdale for fly tipping at the end of the road.

- Environmental Enforcement Cameras – The council currently has 16 enviro cameras deployed, the images from the cameras are regularly reviewed and action taken.

- Working in Partnership with managing agents – The council has been approached by private housing estates and managing agents who are very interested in our wall of shame and innovative ways of enforcing to tackle fly tipping and other enviro crime.

- Fixed Penalty Notice's = The council's enforcement team have issued 137 fixed penalty notices for fly tipping since April 2018.

- Prosecutions = Street Enforcement Team have had 16 successful prosecutions in 2018 directly related to fly tipping and waste offences with a further 5 awaiting summons. Fines in the region of £8,700 have been issued to fly tipping criminals.

- Grime Crime Stickers - The council launched Grime Crime Stickers campaign in October 2018. These notify the public that cases of fly tipping are being investigated and the council is taking action.

- Leaflet drops - The council has started a programme, leafleting local residents in enviro-crime hotspots to identify local culprits. Over 200

Leaflets have been distributed in hotspot areas.

- Littering patrols - Week commencing 19/11/18 for 7 days, we have early and late littering patrols in Barking and Heathway. Street Enforcement officers primarily will be dealing with littering outside the stations, however will also undertake to issue penalties to anyone in the location obviously in breach of the PSPO.

**Question 5**

**From Councillor Oluwole**

Following the fire at Roding Primary School in Mayesbrook Ward, can the Cabinet Member outline what steps have been taken to minimise the disruption for children at the school?

**Response**

We thank the London Fire Brigade for their speedy actions which limited the extent of the damage at Roding Primary School on 4 September, the day before the start of the Autumn Term. The Council immediately put into place their recovery procedures to ensure that the school could become operational as soon as possible. The school worked closely with parents and carers and provided regular progress updates through their website and social media.

Through the strong partnership working AIG plans were put in motion which were supported by the Council's term contractors and the specialist provided by AIG. The team worked hard during the week and over the weekend to ensure that the school opened its doors less than a week after the incident. Eight temporary classrooms were craned into place over the two following weekends which was a major logistics achievement itself for which we thank local residents for their co-operation and Be First are rebuilding these classrooms scheduled by early summer 2019.

**Supplementary Question**

Councillor Oluwole enquired what steps were being taken to try and ensure that the fires may not happen again at this and other school sites. The Cabinet Member responded that schools were taking all appropriate measures.

**Question 6**

**From Councillor Akwaboah**

Can the relevant Cabinet Member outline what efforts the Council is making to promote vocational training for local people in the borough?

**Response**

The majority of the Borough's secondary schools purchase an independent career advice and guidance and work experience service from Barking and Dagenham School Improvement Partnership.

Work experience is provided to 2,000 young people annually through schools, as well as an extensive range of careers and work-related learning events and 1-2-1 guidance that highlight and promote vocational pathways.

The numbers of young people stating they intend to embark on apprenticeships at post-16 is increasing year on year, with 6.7% of last year's Year 11 pupils stating they wished to pursue an apprenticeship at post-16, compared to 5.1% in the previous year. The proportion of young people going on to participate in apprenticeships is steadily increasing year on year, although there was a dip last year in line with national as the apprenticeship levy was rolled out.

The council's adult college and job shop provide:

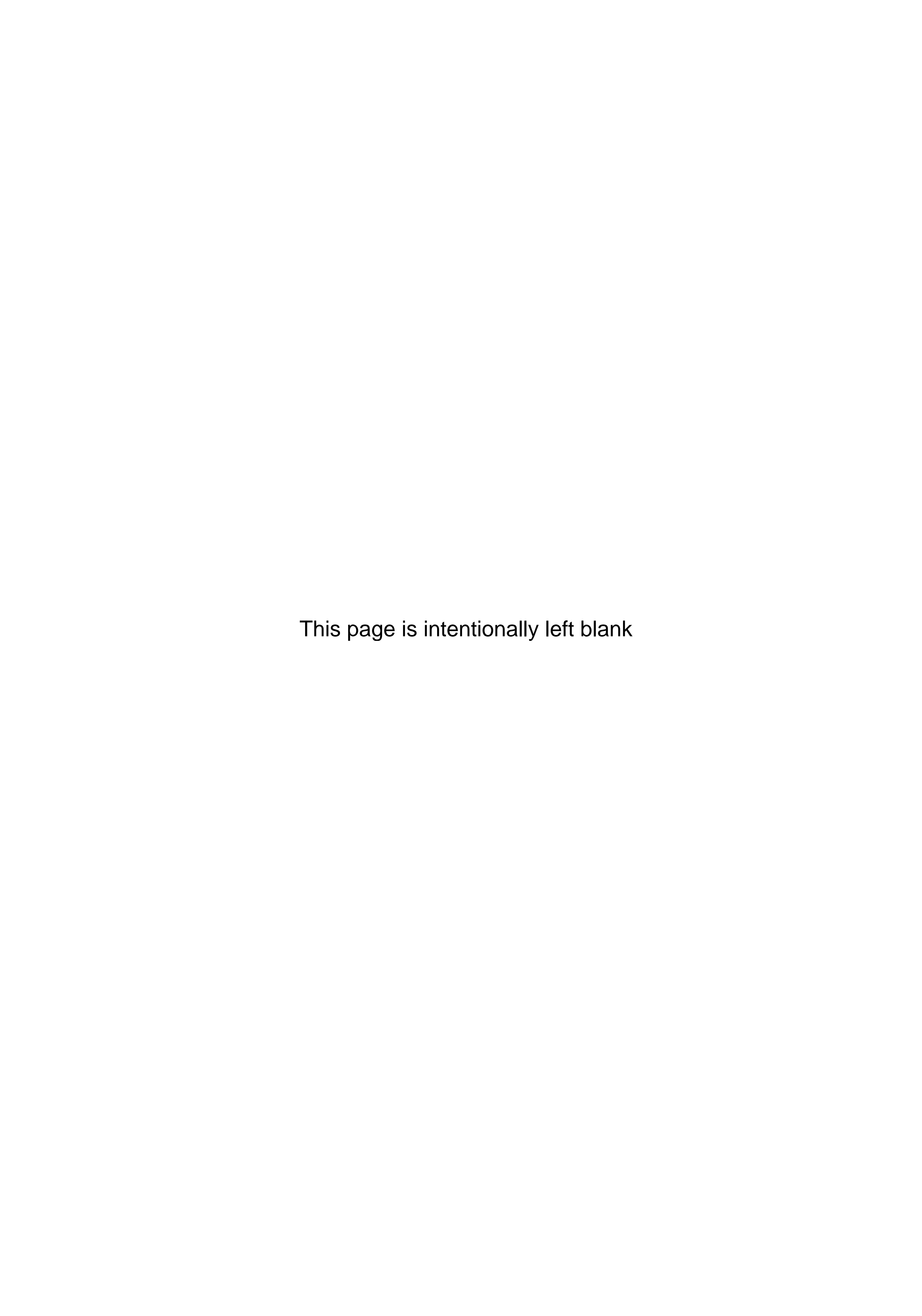
- A closer relationship with the onsite Job Shop enables learners to enjoy the benefits of the on-site Job Brokerage service. They also provide other initiatives including the

- Talk English Project, which specifically targets Muslim women with little or no English skills, has encouraged participants to become more involved in the community as well as improving English language skills.

- In-house innovative tutor development programme 'Grow Our Own' develops opportunities for those who are non, part or fully qualified and looking to enter or return to education, either in a supportive or teaching role.

- Volunteering and training outcomes under the Work & Health programme as part of the Contractual Customer Service Standards.

- Construction team are target work experience. This allows an introduction with young people into the Construction sector and supports S106 obligations with Contractors.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**ASSEMBLY**

**30 January 2019**

| **Title:** Barking and Dagenham Youth Forum and Young Mayor Annual Report 2018 | |
|---|---|
| **Report of the Director for People and Resilience** | |
| **Open Report** | **For Information** |
| **Wards Affected:** None | **Key Decision:** No |
| **Report Author:** Sally Allen-Clarke, Senior Youth Worker, Participation, Opporunity and Wellbeing | **Contact Details:** Tel: 020 8227 3297 E-mail: sally.allen-clarke@lbbd.gov.uk |
| **Accountable Director:** Jane Hargreaves, Commissioning Director, Education | |
| **Accountable Strategic Leadership Director:** Elaine Allegretti, Director for People and Resilience | |

**Summary**

This report details the achievements of the Barking and Dagenham Youth Forum during 2018. Outlining the work of each of the sub-groups, their aims and the impact of the work have completed.

The Barking and Dagenham Youth Forum is now in its 17th year. It exists to provide young people with a formal platform to express their views and be ambassadors for young people locally. The Forum elects 60 young people each year through a democratic election process in each school, supported by Democratic Services. In 2018 ELUTEC opted to become members of the Forum, electing their first ever representatives. Trinity Special School elected new representatives this year, via an internal election process suitable to the needs of students.

The Forum year started with a team building evening, enabling new members to get to know each other along with a Full Forum meeting in Barking Town Hall Chambers. Each year, the Forum splits in to three sub-groups focussing on different campaigns.

Our Community Action sub-group opted to work on a range of different issues that young people had identified at the start of the year. The group were keen to address concerns about the standard of supply teaching in Barking and Dagenham schools, learn more about drug and alcohol misuse, be involved in an intergenerational work and tackle concerns about crime and safety. The young people were supported by Youth Workers to arrange appropriate visits and workshops. The group met with Ian Starling, Principal Advisor, and shared their concerns about supply teachers. This feedback has been recognised and reinforces the need to recruit and retain good quality teachers for the Borough. Towards the end of the year the group focussed on crime and safety concerns and met with Councillor Carpenter and Councillor Mullane to share their experiences. Following this meeting an high level action plan was created to address young people’s concerns. Young people contributed to this by creating a powerpoint presentation to be used in schools, colleges and alternative provisions informing young people about

anonymous reporting options to encourage people to report crimes, thus helping to make the Borough a safer place. The group also produced a short film detailing their experiences to be shown at the Serious Crime Summit in January/February and made good links with Safer Schools Officers.

The Young Mayor sub-group has once again had a very productive year. The group has been well attended throughout the year, which has resulted in a good number of events being hosted/attended and a large sum of money raised. The Young Mayor was elected in February 2018 and began working in partnership with a sub-group of the Forum. The group researched local, regional and national youth charities. Following a public youth vote, New Horizon Youth Centre was voted as the Young Mayor's Charity Appeal for 2018. New Horizon Youth Centre offers services and resources to young people aged 16-21 all across London who are homeless. Services include; support with housing, education, employment and training, a place to eat each day, wash clothes and shower and also conducts outreach work. Over the course of the year young people attended 4 local events to fundraise for it, hosted 3 events of their own and arranged non-uniform days in 4 schools. The group raised a total of £4340, which is a 24% increase on the fundraising total of last year's Young Mayor and is the most that any Barking and Dagenham Young Mayor has raised to date.

The Young Inspectors sub-group was commissioned once again by Public Health to quality assure the Come Correct C-Card scheme in local pharmacies. The group were trained at the start of the year to become mystery shop inspectors. Following their detailed training the group conducted practice inspections, supported by experienced Young Inspectors. The group inspect every aspect of the service, assessing how friendly and welcoming the staff are, how comfortable they make them feel, ensuring that all aspects of the condom/ femidom demonstration is delivered accurately and nothing is missed and lastly assessing whether all relevant information regarding testing, timescales and confidentiality are shared. Each inspector completes a detailed report after every inspection which is shared with the Borough's Condom Distribution Officer to feedback to pharmacies. In 2018, a total of 115 inspections were completed, which included inspections of femidom demonstrations for the first time. There is an apparent correlation between the work of the Young Inspectors and a decline in teenage pregnancy rates locally, which have started to decline at a faster rate than national and London.

**Recommendation(s)**

The Assembly is asked to note the Barking and Dagenham Youth Forum and Young Mayor report for 2018 and to ensure support for its work.

**Reason(s)**

The Barking and Dagenham Youth Forum acts as the council's youth parliament and enables the council to fulfil its duties to listen to the views of young people as set out in the Statutory Guidance for Local Authorities on Services and Activities to Improve Young People's Well-being (2012). First established in 2001, the Forum works with secondary schools to annually democratically elect representatives that serve the borough via the Forum's campaigns, consultations and social action projects. The work of the forum supports the council's aim to encourage civic pride and enable social responsibility.

## 1. Introduction and Background

1.1 Please refer to main report.

## 2. Financial Implications

*Implications completed by: Feroza Begum, Group Finance Manager*

2.1 Any incidental costs associated with the Forum will be contained from within the service's existing budget.

## 3. Legal Implications

*Implications completed by: Lucinda Bell, Education Lawyer*

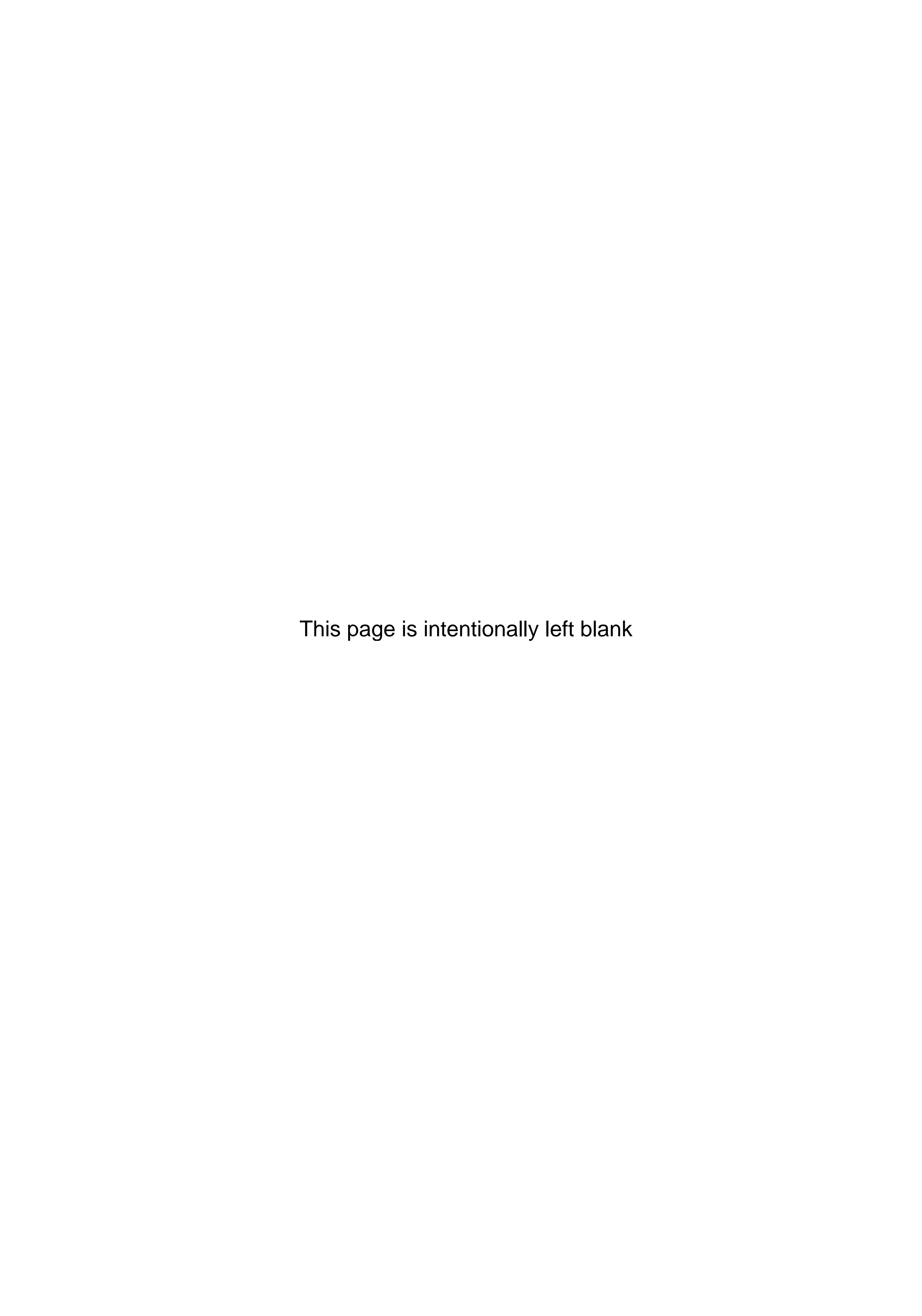
3.1 This report updates Assembly on the work done this year by the Youth Forum this year. The Council has a statutory duty imposed by s507B of the Education Act 1996 "so far as is reasonably practicable" to secure access for young people in their area to sufficient positive leisure-time activities. S6 of the 2006 Education and Inspections Act amended this section added responsibilities on Local Authorities to secure access to sufficient youth work activities, ascertain young people's views on positive activities, publicise positive activities and consider alternative providers.

## 4. Public Health Implications

*Implications completed by: Matthew Cole, Director of Public Health*

The Young Inspectors Group are funded from the Public Health Grant received from central government for trained youths to carry out quality assurance visits of the pharmacies providing the condom distribution scheme in Barking and Dagenham. Feedback from inspections have been useful in improving service provision to Barking and Dagenham residents including young people. Barking and Dagenham has the best performing C-Card programme in London.

Public Health will continue to fund the service with the expectation that the funds provided is used by to support the Young Inspectors in carrying out their work.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Overview 2018

# Introduction and background

The BAD Youth Forum was created in 2001, to give young people a formal and recognised platform to express their views and make a positive impact in their community

In 2018 60 young people were democratically elected representing each secondary school including ELUTEC for the first time. Trinity Special School are also members of the BAD Youth Forum, the school conduct their own election process, suitable to the needs of students.

Up to 3 female and 3 male representatives are elected from each school, aged 13-19 or 25 with a disability).

Each year up to 15 young people are invited back to the forum based on their contribution and attendance in the previous year. These young people by-pass the election process and support with the initial sessions, supporting new young people to engage.

At the start of the year the BAD Youth Forum held a Full Forum meeting in Barking Town Hall, introducing them to how the council works and what the role of the forum is.

The newly elected young people discussed current local youth issues as potential campaigns/projects. Topics included: education, knife crime, transport, gender equality and equal pay and health.

First Full Forum meeting photo (February 2018)

Houses of Parliament trip (October 2018)

# Team building day

FEBRUARY 2018

At the start of each year all newly elected forum members and 'returning' Forum members are invited to attend a team building day.

The aim of the day is for everyone to get to know each other, including the workers, and to start to cement good working relationships.

Young people participate in an evening full of fun games and exercises that will get people socialising.

30 young people attended the evening.

# Election of the 2018 Young Mayor

A special meeting is held each year to elect the new Young Mayor for Barking and Dagenham. All newly elected members are requested to attend, but only returning members are eligible to nominate themselves for the position.

In 2018, five young people stood for election to become the next Young Mayor. Each young person delivered a speech outlining why they would be suitable for the position. Following a democratic vote Wesley Oparaugo was elected as the borough's fourth Young Mayor, *please see Young Mayor section detailing Wesley's achievements.*

# Community Action sub-group 2018

## Introduction and background

The BAD Youth Forum Community Action sub-group plays a vital role within the Forum retaining the flexibility year after year to pursue a variety of youth related issues in Barking and Dagenham that they see as a priority. This sub-group does not have a set remit and this year has focused on:

**Education**; raising concerns about the numbers of supply teachers in their schools and the quality of teaching they provide,

**Crime**; expressing fears about levels of crime, and the threat of crime, including in schools - sharing examples of personal experiences with Police and Cabinet Members,

**Health**; educating themselves through workshops with Subwize (Drug and Alcohol misuse service for young people in Barking and Dagenham) about the dangers of alcohol and drugs and how to stay safe in various situations,

**Community intergenerational visit** to an elderly person's care home.

The members of this sub-group consulted with their peers at the start of the year, ensuring they understood the breadth of issues facing young people in Barking and Dagenham in 2018 from a range of young people's perspectives, not just their own.

Regular updates have been sent to schools throughout the year informing them of the Forum's progress and offering other young people an opportunity to share ideas and views.

# Education

The group were concerned about the numbers of supply teachers in schools, there was an overwhelming feeling that the quality of teaching from some of the supply teachers was not to a high enough standard. The group met with Ian Starling, Principal Advisor, who was able to give a local and national perspective on the current situation. Young people shared personal experiences from their schools. The group were informed of the work happening locally to secure high quality teachers and the incentives being made available to encourage teachers to stay in Barking and Dagenham.

# Intergenerational visit

The sub-group decided they would like to do some work in the community and settled on the idea of visiting an elderly care home. The young people wanted to spend some time with elderly residents because they felt it would brighten their day and they wanted to know more about the lives of older members of the community. The young people were able to talk about how life is for young people in 2018 and find out about elderly people's experiences when they were young.

# Crime and disorder

Having completed smaller projects earlier in the year, the group shifted their focus to concerns about crime, and the perceived threat of crime, including in secondary schools. The young people discussed at length their own experiences and concerns and found that many others in the group also felt the same. Despite a wealth of knowledge about the dangers in schools, all young people felt a lack of confidence to report any crimes. The group recognised the potentially positive outcome of reporting crimes (in particular, people carrying weapons or dealing drugs), but felt the possible repercussions were too great a risk.

Members of the sub-group attended the first Youth Independent Advisory Group (YIAG) meeting, this is a meeting set up to bring young people and police together to discuss and challenge Police on local crime issues and policing. At the meeting young people asked questions about tackling crime, and the perceived threat of crime, in schools. Following this young people continued the conversation in their sub-group. As young people felt unable to report concerns to their teachers they decided to write to Councillor Carpenter and Councillor Mullane to invite them to attend a sub-group session, Police were also invited to attend. Young people reported back personal experiences and the effect these experiences have had on them.

Following this meeting, Cllr Carpenter and Cllr Mullane arranged a meeting with several council officers, a representative from schools and police, where an action plan was agreed. As a result of these discussions young people have created a powerpoint presentation about Fearless i.e. anonymous reporting charity (Crimestoppers). Through discussions with the borough's Youth Engagement Officer, a proposal has been put forward for School Police Officers to deliver the presentation. School Police Officers have also all received refresher training in how to work with young people. Young people are also creating a short film to be shown at the Serious Crime Summit in January/February 2019, detailing their experiences first hand, but anonymously.

## Safeguarding

Part of the action plan from the meeting Councillors held with senior officers and Police, focusses on the 'lost hours' which is the time between young people finishing school and parents typically getting home from work. The youth forum plan to look at how they can address this issue and encourage their peers to participate in more positive activities. The Forum have been requested to create a film to be used at the forthcoming Serious Crime Summit in the new year.

# Health

Young people spent some time discussing their understanding of drugs and alcohol and recognised that their knowledge about the negative effects each of these can have was very limited. The young people requested two sessions with Subwize (Drugs and Alcohol misuse service for young people), the first was a general overview, and the second was focussed entirely on alcohol. The whole forum were invited to these sessions, a total of 21 young people attended. As a result of these sessions, young people participated in a series of age-restricted test purchases in partnership with Trading Standards.

# Young Mayor Sub-group achievements 2018

## Introduction and background

For the third year in a row, the Barking and Dagenham Youth Forum have been responsible for the Young Mayor, which this year was Wesley Oparaugo.

Once democratically elected by Forum members, a group is created for newly elected young people to join, to support the Young Mayor and their activities.

At the start of the year the group participate in some communication training and spend time getting to know each other.

By the end of February the group are completely operational and ready to get to work on choosing a charity and creating fundraising ideas.

# Charity appeal 2018

As in previous years, young people carried out research about what registered youth charities are an option for the group to fundraise for. The group looked at local, regional and national options. Having discussed all of the options, the group reduced the list to three main charities. These were Barnardo's, Ab Phab and New Horizon Youth Centre.

All group members took responsibility for obtaining votes through their peers, school assemblies and youth groups they attend. There were more than 400 votes cast with a resounding winner - New Horizon Youth Centre.

# Setting up fundraising events

Our chosen charity for 2018 is New Horizon Youth Centre. The charity was founded in 1967, based in Euston, London. The charity supports vulnerable, homeless young people across London, recognising that the challenges homeless young people face are different to those of homeless adults.

The charity offers a range of services to young people through their centre and outreach programmes. These include advice and support to obtain education, employment and training. Support to secure suitable housing and access benefits, if they are not currently employed. The charity also offers substance misuse advice and counselling along with many other services.

# Fundraising

The group have been involved in devising, organising and delivering a range of fundraising events this year. Here is a full list of all of the activities and the amounts raised:

**Bucket shaking at the Summer of Festivals - £301.02**

BAD Youth Forum and Young Mayor attending the Youth Parade, celebrating young people's achievements and fundraising- **£102.54**

This event was a lot of fun and we raised **£63.40**

## Sponsored walk

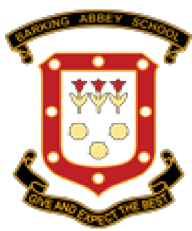
The young people personally fundraised for this sponsored walk event and collectively raised **£1068.10**

BARKING TOWN HALL CAKE SALE - £25

## Non-uniform days in schools:

**£451.46**

**£1054.78**




**£974.30**

**£300.00**

# Young Mayor - Wesley Oparaugo

Wesley Oparaugo was elected in February 2018 to be Barking and Dagenham's $4^{th}$ Youth Mayor. Wesley was elected to his position by the newly elected Youth Forum members, after giving a powerful speech. Over the course of the year Wesley has committed himself to working in partnership with a BAD Youth Forum sub-group and raising money for, and awareness of, their chosen charity.

Wesley has been a driving force for securing such a large sum of money for the charity and is personally responsible for raising more than half of the sponsored walk money. Wesley met with his school, with support from Youth Workers, and discussed options for raising funds in school. This was an exceptionally productive meeting, securing vital support from his Head Teacher and Deputy Head Teacher to arrange fundraising events in school (some of which will happen after this report is submitted).

As well as weekly sessions with Forum members and fundraising activities, Wesley has attended 13 events to date in his ceremonial role with a further 2 planned. Events include:

Women's Empowerment Month Launch

Mayor's inauguration ceremony

Mayors Civic Parade

African Showcase

London Youth Assembly planning meeting

Dagenham Eagles event

Youth Parade

Jack Petchey $18^{th}$ Birthday celebration event at City Hall

West Ham game- a generous gift from Mulalley construction company to 6 members of the BAD Youth Forum

Community Against Knife Crime event

Houses of Parliament visit

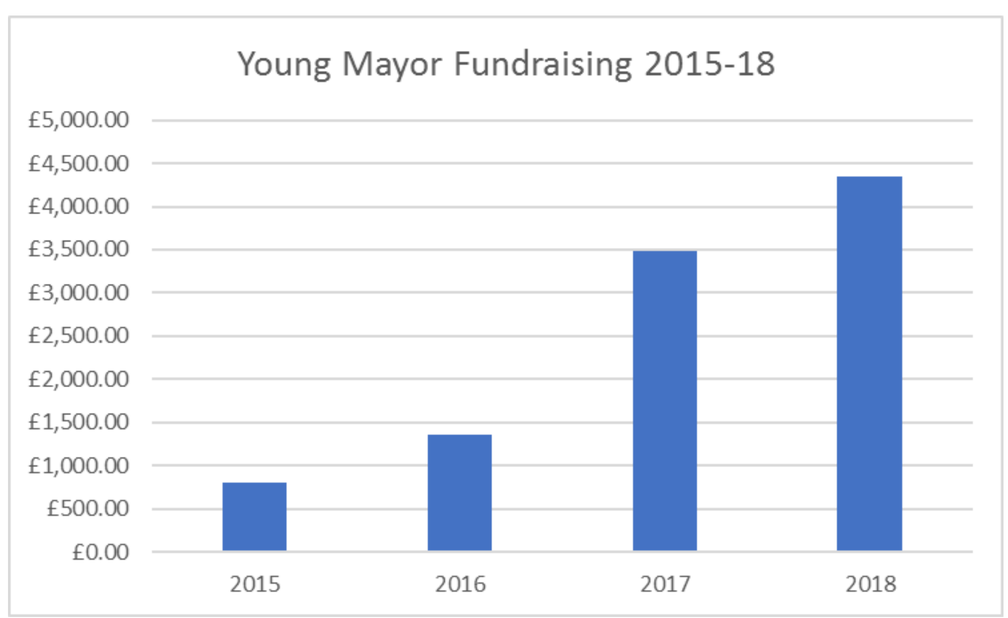
NCS Dragons Den event- being a member of the judging panel

Barking Enterprise Centre launch of the dedicated space for young entrepreneurs 16+

# Grand total raised in 2018

## (at the point of writing this report - November 2018)

# £4340.00




**Year on year we have seen an increase in the funds raised, 2015-16: 70% increase, 2016-17: 156% increase and 2017-18: 25% increase. This is a positive upward trend.**

"I have absolutely enjoyed being the Young Mayor of the borough this year. I have experienced so many things and met so many people I did not think I would be able to. Being a part of the Women's Empowerment Event Launch, attending the African Showcase Event, leading the Youth Parade and liaising with the Leader of the Council were some of the highlights of this year. It surpassed my expectations and broadened my abilities. Leading the Young Mayor's group has been tough but very profitable. The sponsored walk we did was, I believed the culmination, of the hard work we put in as a group. The fact that we have been able to raise over £4,000 as of now, is astonishing and a testament to the Forum and its leaders. I have to appreciate every single member of the Forum for their teamwork and dedication, but more so, the workers that have tirelessly led such a great cohort and have given me immense support in my role. I can confidently say I was a fish out of waters without them, but their guidance helped me so much. Without these workers, this experience wouldn't be what it was. I am extremely grateful to have been Young Mayor this year and it was truly a wonderful opportunity that I believe, will have a

profound impact on whoever takes this role. I sincerely hope that the Young Mayor role can grow and become greater than it already is today”. *Wesley - Young Mayor*

“We can’t thank the young people involved in the BAD Youth Forum enough! They have been amazing supporters of New Horizon Youth Centre and our work of helping homeless young people! We think youth empowerment and participation are really important, and have been really impressed with the enthusiasm of the forum to help raise awareness of the scale and often hidden realities youth homelessness experienced by their peers. But they also put money where their mouth is by raising an incredible £4340.00 for us – and rising! The money will go toward to making sure the day centre is open space 7-days per week, because homelessness doesn’t take a break at weekends and young people need a safe place to be. Big thank you to the BAD Youth Forum from the young people and team at New Horizon.” *Phil Kerry, CEO of New Horizon*

# Young Inspectors
## Sub-group achievements 2018

## Introduction and background

The Young Inspectors group are commissioned by Public Health to carry out quality assurance visits of the pharmacies providing the free pan-London Come Correct condom distribution scheme in Barking and Dagenham.

Each year newly elected members join this sub-group, with some returning members remaining with the group to ensure continuity and to help train new members. Once they become a member of the Young Inspectors, the group participate in training to ready them for their role.

Young Inspectors are responsible for accessing pharmacies like any other young person would, registering for a 'C-Card' and reporting on their experience.

**115 inspections** were undertaken during 2018.

### Report writing

After EVERY inspection each Young Inspector completes a report about their findings, paying particular attention to the recommendations of how the service could improve in the future.

# Training

Newly recruited Young Inspectors have often never been involved in mystery shop inspections before. It is vital that young people present like all other service users would, which can be complicated when you know you are completing an inspection.

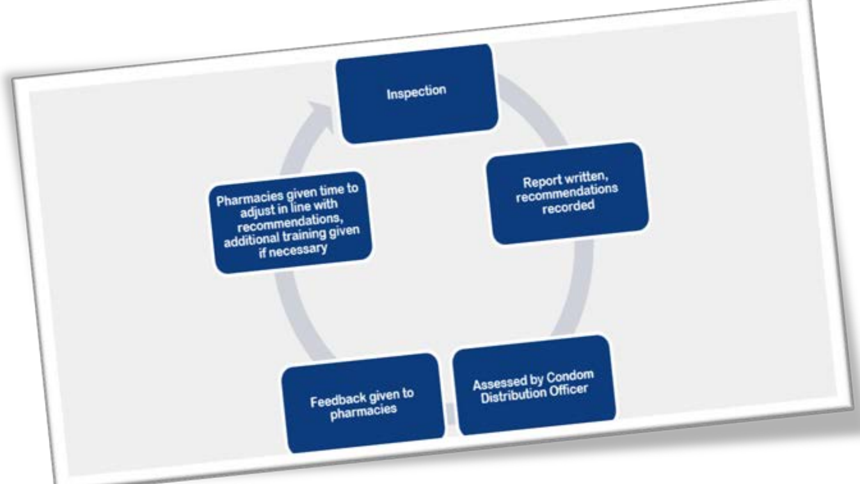
Training focusses on ensuring young people fully understand all parts of the C-Card registration process, for both condoms and femidoms. Young people are assessing the following areas:

- Friendliness, environment and how welcoming the staff are;
- How comfortable the staff make young people feel;
- 10 specific areas of condom/femidom demonstration;
- 7 pieces of information that pharmacists should tell young people, including testing time periods for different sexually transmitted infections, clinics where young people can be tested, time frame for the use of Emergency Hormonal Contraception (EHC) and whether the young person is informed that the service is confidential.

In order to complete a comprehensive report of each inspection, young people are trained to write reports and carry out practice inspections to test their ability to remember details. Experienced members of the group accompany all new members on initial inspections to help them relax and support them with remembering all of the details of the visit.

# Young Inspectors' impact

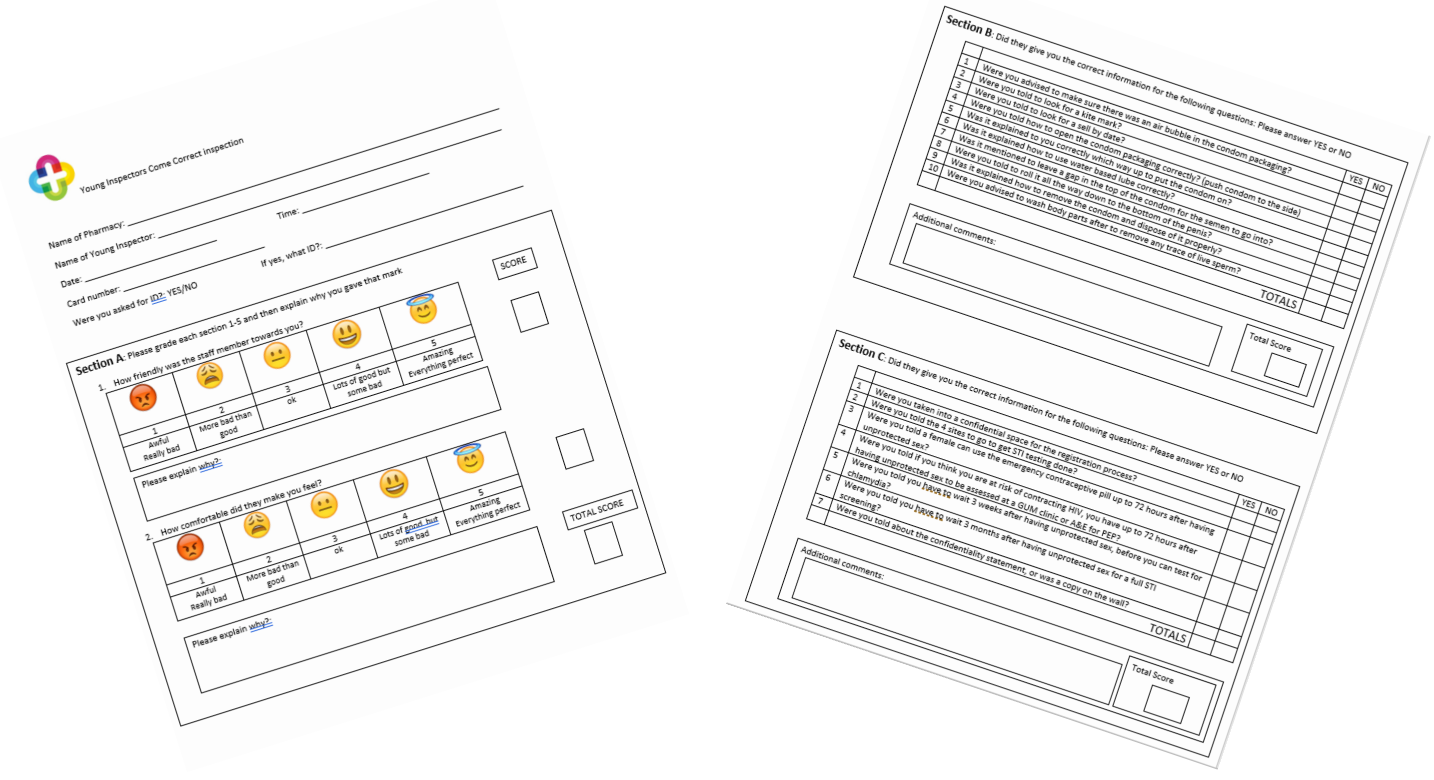
Continuous quality assurance for the past 4 years has enabled the Condom Distribution Officer of the borough to provide up to date information about the quality of service each pharmacy is providing to young people. These inspections are the only way to know how efficient the service is and whether young people are receiving the service they should be. After each inspection the Young Inspectors report is sent to the Condom Distribution Officer, Heather McKelvey. Heather then contacts each pharmacy to relay the results. If needed, further training or support is offered to poor performing pharmacies, to support them to improve.




Barking and Dagenham has the best performing C-Card programme in London. This includes having a repeat encounter rate that is more than double that of any other London borough, which is an indicator of the quality of the service being delivered i.e. young people who sign up and repeatedly use the service. Over the course of 2018, we have seen an improvement in 15 pharmacies, only 2 pharmacies did not have a good inspection during the year. These pharmacies continue to be offered support to improve.

There is an apparent correlation between the work of the Young Inspectors and teenage pregnancy figures, which are now the lowest they've ever been for Barking and Dagenham and are starting to fall at a faster rate than national.

# Example of a registered Young Inspector's inspections report



Young Inspectors Come Correct inspection

Name of Pharmacy:

Name of Young Inspector: Time:

Date:

Card number: If yes, what ID?:

Were you asked for ID?: YES/NO

**Section A**: Please grade each section 1-5 and then explain why you gave that mark

1. How friendly was the staff member towards you?

| 1 Awful Really bad | 2 More bad than good | 3 ok | 4 Lots of good but some bad | 5 Amazing Everything perfect |
| --- | --- | --- | --- | --- |

SCORE

Please explain why?:

2. How comfortable did they make you feel?

| 1 Awful Really bad | 2 More bad than good | 3 ok | 4 Lots of good but some bad | 5 Amazing Everything perfect |
| --- | --- | --- | --- | --- |

TOTAL SCORE

Please explain why?:

**Section B**: Did they give you the correct information for the following questions: Please answer YES or NO

| | | YES | NO |
| --- | --- | --- | --- |
| 1 | Were you advised to make sure there was an air bubble in the condom packaging? | | |
| 2 | Were you told to look for a kite mark? | | |
| 3 | Were you told to look for a sell by date? | | |
| 4 | Were you told how to open the condom packaging correctly? (push condom to the side) | | |
| 5 | Was it explained to you correctly which way up to put the condom on? | | |
| 6 | Was it explained how to use water based lube correctly? | | |
| 7 | Was it mentioned to leave a gap in the top of the condom for the semen to go into? | | |
| 8 | Were you told to roll it all the way down to the bottom of the penis? | | |
| 9 | Was it explained how to remove the condom and dispose of it properly? | | |
| 10 | Were you advised to wash body parts after to remove any trace of live sperm? | | |
| | TOTALS | | |

Additional comments:

Total Score

**Section C**: Did they give you the correct information for the following questions: Please answer YES or NO

| | | YES | NO |
| --- | --- | --- | --- |
| 1 | Were you taken into a confidential space for the registration process? | | |
| 2 | Were you told the 4 sites to go to get STI testing done? | | |
| 3 | Were you told a female can use the emergency contraceptive pill up to 72 hours after having unprotected sex? | | |
| 4 | Were you told if you think you are at risk of contracting HIV, you have up to 72 hours after having unprotected sex to be assessed at a GUM clinic or A&E for PEP? | | |
| 5 | Were you told you have to wait 3 weeks after having unprotected sex, before you can test for chlamydia? | | |
| 6 | Were you told you have to wait 3 months after having unprotected sex for a full STI screening? | | |
| 7 | Were you told about the confidentiality statement, or was a copy on the wall? | | |
| | TOTALS | | |

Additional comments:

Total Score

Section D:

Were Fraser guidelines mentioned if you are under 16 years of age? YES NO OVER 16

What recommendations do you have to improve the service of this pharmacy?

1.

2.

3.

4.

Name or Description of Staff Member Name?:

**Or**

Male/female:

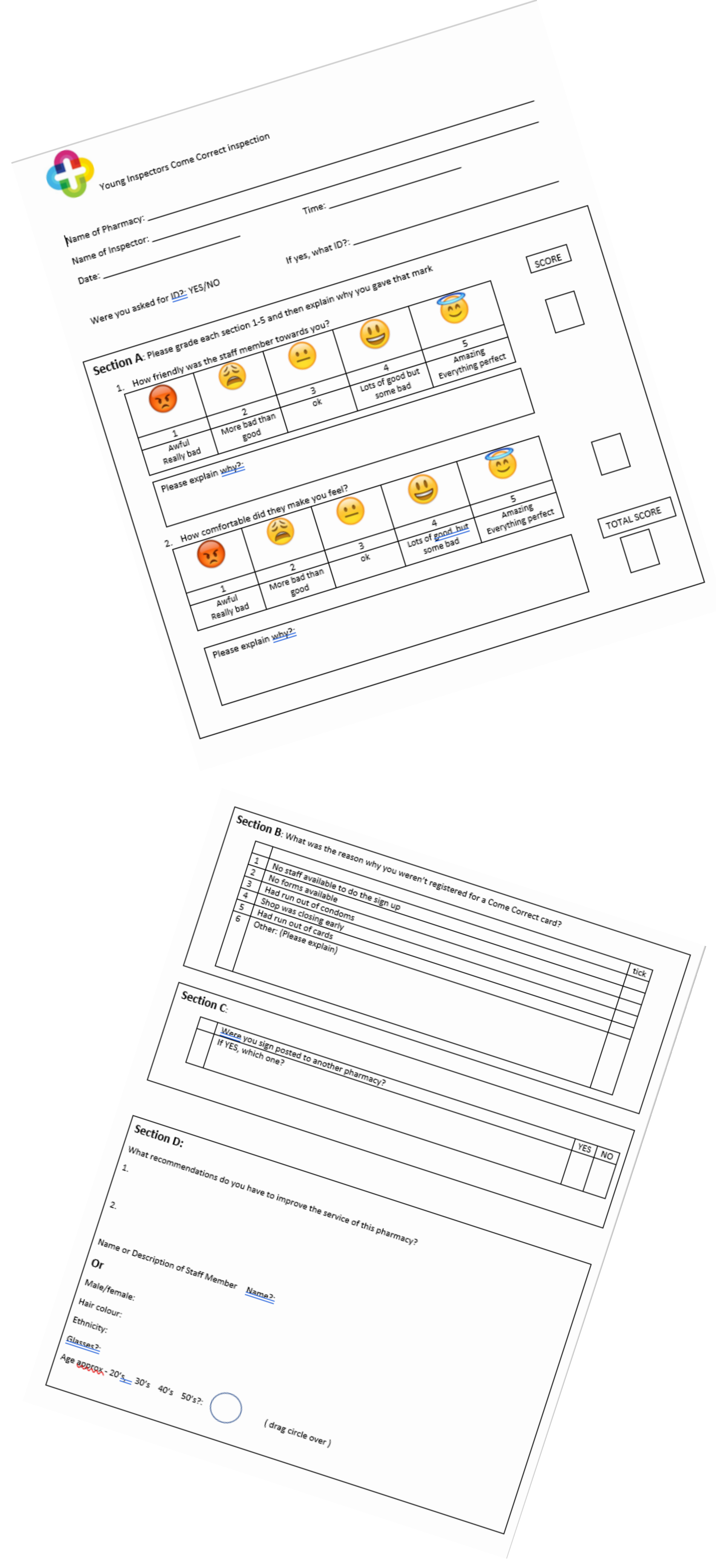
Hair colour:

Ethnicity:

Glasses?:

Age approx - 20's 30's 40's 50's?: ( drag circle over )

# Example of a non-registered Young Inspector's inspections report



Young Inspectors Come Correct inspection

Name of Pharmacy:

Name of Inspector: Time:

Date:

Were you asked for ID?: YES/NO If yes, what ID?:

SCORE

**Section A**: Please grade each section 1-5 and then explain why you gave that mark

1. How friendly was the staff member towards you?

| 1 Awful Really bad | 2 More bad than good | 3 ok | 4 Lots of good but some bad | 5 Amazing Everything perfect |
|---|---|---|---|---|

Please explain why?:

2. How comfortable did they make you feel?

| 1 Awful Really bad | 2 More bad than good | 3 ok | 4 Lots of good but some bad | 5 Amazing Everything perfect |
|---|---|---|---|---|

Please explain why?:

TOTAL SCORE

**Section B**: What was the reason why you weren't registered for a Come Correct card?

| | | tick |
|---|---|---|
| 1 | No staff available to do the sign up | |
| 2 | No forms available | |
| 3 | Had run out of condoms | |
| 4 | Shop was closing early | |
| 5 | Had run out of cards | |
| 6 | Other: (Please explain) | |

**Section C**:

| | | YES | NO |
|---|---|---|---|
| | Were you sign posted to another pharmacy? If YES, which one? | | |

**Section D**:

What recommendations do you have to improve the service of this pharmacy?

1.

2.

Name or Description of Staff Member Name?:

**Or**

Male/female:

Hair colour:

Ethnicity:

Glasses?:

Age approx.- 20's 30's 40's 50's?:

( drag circle over )

# Additional Forum activities 2018

## Engagement and Participation

**Youth Independent Advisory Group (YIAG)**

The Senior Youth Worker for the BAD Youth Forum was approached by Police asking for a young persons' version of the Police Independent Advisory Group to be set up. A proposal was formulated and agreed. To date, two meetings have taken place. The remit of this group is to provide young people and Police the opportunity to discuss local issues that relate to crime and policing. Young people have provided an honest account of concerns they have about crime in the borough and have discussed pro-active ways of addressing these concerns.

The YIAG is advertised to a wide range of groups in the borough, not just the BAD Youth Forum. At the last meeting, in October, representatives from the Onside Youth Zone Development Group, Progress Project Disabled Young People's Forum and the Peer Support Group for young people with mental health concerns attended.

The YIAG will continue as a long standing platform for young people and police to address issues and concerns about crime and challenge policing in Barking and Dagenham.

**Community Against Knife Crime event**

Fifteen BAD Youth Forum members attended the Community Against Knife Crime event in October 2018. Young people were keen to attend and to pledge their support to the Council to help tackle knife crime. As a current issue of interest to one of our sub-groups, and something that affects many young people in the borough, young people were pro-active in addressing questions to the panel. These questions included 'Why are schools not willing to have knife arches outside on random days?' and 'What can be done to encourage young people to report crimes anonymously through Fearless or Crimestoppers?'.

All young people signed the pledge at the end of the event and youth workers also took the pledge to the YIAG which occurred the week after, securing further support for the pledge.

**London Youth Assembly (LYA)**

In 2018, all London Borough participation teams were approached to attend a meeting to discuss the proposal to initiate a London Youth Assembly, mirroring the work of the London Assembly. The proposal has the backing of the Mayor of London. A worker attended the initial meeting and the Young Mayor attended the follow up meeting to discuss practical ways to set the LYA up and secure the participation of young people all over London.

At the time of writing this report the first meeting is scheduled but has not taken place. The BAD Youth Forum will elect a Representative and a Deputy to the LYA, and this will be a continuous project we will be involved in.

**Houses of Parliament trip**

In October half term, twenty BAD Youth Forum members participated in an annual visit to the Houses of Parliament. The young people were treated to a tour of the Palace of Westminster, learning about the history of the building and how politics is conducted and affects all citizens of the country. Following the tour the young people were hosted by Jon Cruddas MP and Margaret Hodge MP. Young people had carefully planned questions for both MP's focussing on issues currently important to young people. These included questions about knife crime, housing, health services, votes at 16 and policing in the borough.

## Borough Manifesto Film

Members of the Forum, along with the Young Mayor were requested to participate in the making of the Borough Manifesto Film, marking the Council's achievements one year on. The Young Mayor and three Forum members participated, sharing their positive view of the borough and its recent developments. View: Barking and Dagenham Together: The Borough Manifesto

## West Ham Director's Box visit

At the Leader's Summer reception, Eamon O'Malley, Director of Mullalley Construction Company generously offered a unique experience for six young people to attend a West Ham game, dining in an exclusive restaurant in the grounds and sitting in the Directors' area. Six very deserving BAD Youth Forum members were selected to attend. The experience was incredible for young people and they had the opportunity to promote the work of the Forum with a range of people. Here are some of their thoughts about the event:

*I felt honoured to be chosen for this wonderful opportunity, I enjoyed how professional everything felt and the food was exquisite.* **Joshua- 14**

*It was an amazing experience to see a West Ham match, especially with an outcome of 8-0! The whole experience was phenomenal and I have never been to an event like this.* **Mantas- 15**

*I would like to take this opportunity to first of all thank Eamon at Mulalley for giving us the tickets to watch the game. The hospitality offered was beyond expectation, the atmosphere was electric and we were received warmly by other people attending and staff. I believe this was a once in a lifetime opportunity that I certainly will not forget.* **Wesley- 15**

*I felt the West Ham football game was a diamond experience, I was treated very well by the staff members. The football game was just amazing and it is an experience I will never forget. I thank Eamon (Mulalley) for the tickets and the whole experience.* **Nathan- 17**

## Consultations

Every year the Forum are approached to participate in a range of single consultations, offering them the opportunity to shape local services. During 2018, young people participated in 12 consultations detailed below.

1) Local Implementation Plan. This consultation focussed on the Borough's transport plan and asked young people for their views about how to encourage more people to walk, cycle or use public transport to help the Borough to reach its target set by the Mayor of London.

2) Health Lifestyle Team. The team visited the Forum to ask for their views on how to rebrand their service to make it appealing to young people. The specific project discussed related to obesity, young people gave their views about activities that would engage young people to participate and how to make advertising eye catching.

3) SCO19 Police Officers (Firearms). Young people had raised concerns about crime and safety in the borough, particularly the use of knives and other weapons. SCO19 officers visited the Forum with a powerful presentation that was thought provoking and educational. The young people also had the opportunity to question Police Officers and discuss the use of stop and search in the borough.

4) Cultural Education. The Forum were asked to share their experiences of cultural education in schools, outlining the positive aspects and also offering opinions about how it could be improved. Young people's views were included in the new Cultural Education Strategy.

5) Barking and Dagenham Music Service. The aim of this consultation was to consult Forum members on the most appropriate way to embed youth voice in services planning and service delivery. The Forum were asked to share information about their musical experiences in the borough, what they thought was missing and how it could be better. The views of young people were used to shape the Music Service going forward.

6) Education. Young people met with Natasha Cook, Policy and Projects Manager for Barking and Dagenham Council. The young people gave their views on the draft Education and Participation Strategy which were included in the final strategy.

7) Heritage. Young people were engaged in a consultation about heritage in Barking and Dagenham and gave their views about how best to involve them in future heritage activities. At the point of consulting with the Forum there was very minimal engagement by young people, the aim of gathering the Forum's views was to improve participation figures.

8) Future Youth Zone. The Youth Community Engagement Worker consulted with young people about what facilities should be available in the borough and how best to advertise the Centre in the run up to its opening. Young people engaged in an honest way, relaying what will be the most effective way of promoting the Centre. This information will be used in the planning of the opening.

9) Accessing further education. A council officer and a colleague from Goldsmiths University met with the Forum to consult with them on the wording of a set of questions which they planned to use with other young people. The questions related to why 16-18 year olds leave their further education courses within the first year. The draft questions were presented and young people gave their views, making amendments where necessary.

10) Missing People Service. This consultation aimed to find out what young people already know about the Missing People service and how the service can be more accessible and better known to young people. Young people gave their views on different aspects of the service, which will contribute to updating the service plan.

11) Come Correct C-Card. This consultation was led by the Borough's Condom Distribution Officer. The Forum were asked to review the current C-Card website and give their views about how best to update it. These views will be taken to a pan-London meeting and shared with views from other young people, resulting in a more young people friendly and appealing website.

12) Sharon White, Education Inclusion Manager, consulted with forum members about the use of survey monkey to question young people about exclusions in B & D schools. Sharon asked about the use of the surveys in schools and gathered young people's views about the questions.

# Contributing to the borough's priorities 2018

The work of the Barking and Dagenham Youth Forum contributes to two of the borough's key priorities as set out in its vision. Detailed below is a summary of how the BAD Youth Forum's work from 2018 has contributed to these priorities.

**Encouraging Civic Pride**

- The borough's Young Mayor attending various events throughout the year, representing young people and promoting a positive view of young people both locally and regionally.
- Young people participated in the Youth Parade which celebrated the achievements of young people in the borough.
- Being positive ambassadors for young people, demonstrating that young people are pro-active, well engaged citizens of the borough.
- Contributing to decision making, through consultations, ensuring the borough is listening to young people's views and having a positive impact. Young people feel engaged in matters that affect them and are proud to live, work or study in the borough. This helps young people to 'shape their quality of life' which we hope will continue in to adulthood.
- Intergenerational visit to an elderly care home, with young people taking the time out of their day to meet with elderly residents and talk about life from each other's perspective. This piece of work promotes community cohesion and challenges the views each age group may have about the other.
- In an effort to highlight the negative impact some supply teaching is having on young people's attainment, the Community Action sub-group met with Ian Starling, Principal Advisor, to share their experiences. The meeting content adds weight to the ongoing efforts to recruit and retain high quality teachers for Barking and Dagenham schools.

**Enabling social responsibility**

- Representing their peers, listening to their views and expressing these with local decision makers.
- Developing campaigns that address current youth issues in Barking and Dagenham e.g. crime and safety campaign.
- Young Inspectors quality assurance visits to pharmacies and ensuring a fit for purpose service. Taking responsibility to carry out visits independently to ensure full coverage of the pharmacies in the borough.
- The skills that young people learn by being a member of the BAD Youth Forum are transferable to all aspects of their life, for example, communications skills (listening and speaking), confidence, being assertive, report writing, sharing views in an appropriate way and challenging decision makers/service providers, to name but a few. Some young people use their forum time towards their Duke of Edinburgh award or similar volunteering programmes, whilst others grow and learn in an environment that is supportive and stimulating. The forum actively encourages

young people to take responsibility for themselves and their own life, as well as other members of the community.

- Projects such as the crime and safety project and the work of the Young Inspectors, helps to protect some of the more vulnerable members of the borough. The crime and safety project has contributed to the understanding of knife crime issues in the borough which has resulted in council officers and Councillors focussing more time and resources on tackling the issue. The Young Inspectors project has ensured the C-Card service available to young people continues to improve and areas of weakness are addressed swiftly, thus providing a good service to young people.
- The Forum works with young people with a range of abilities, through the Forum young people become more confident and can access support to achieve their full potential. For many young people the forum provides the right platform to support their growth and development (please see case studies).

**ASSEMBLY**

**30 January 2019**

| **Title:** Final Third Local Implementation Plan Submission | |
|---|---|
| **Report of the Cabinet Member for Regeneration and Social Housing** | |
| **Open Report** | **For Decision** |
| **Wards Affected:** All | **Key Decision:** Yes |
| **Report Author:** Tim Martin – Transport Planning & Policy Manager; BeFirst | Contact Details:<br>Tel: 020 8227 3939<br>E-mail: timothy.martin@lbbd.gov.uk |
| **Accountable Director:** Caroline Harper – Chief Planner, BeFirst | |
| **Accountable Strategic Leadership Director:** Graeme Cooke – Director of Inclusive Growth | |

**Summary**

The third Local Implementation Plan (LIP3) outlines the Council's strategy for delivering improvements to the transport network and services in Barking and Dagenham to 2041 and to support our Borough Manifesto ambitions for delivering inclusive, sustainable growth in the borough.

A draft LIP3 was approved by Cabinet on 16 October 2018 (Minute 42 refers) and submitted to Transport for London (TfL) for comment on 2 November. A five-week period of consultation with a range of statutory and local stakeholders then ensued which ended on 7 December. At the same time, consultation was undertaken on a draft Environmental Report, produced as part of a Strategic Environmental Assessment of the LIP - required under European Union regulations.

During the course of the consultation comments were received from a number of stakeholders including the Metropolitan Police, the local branch of the London Cycling Campaign and the London Borough of Bexley. TfL has also provided further feedback and has made a number of recommendations. As a result, a number of small-scale changes to the LIP are now proposed. The changes, which are summarised in Appendix 1, include:

- Providing additional information on how the borough will achieve 'Vision Zero' – to support the Mayor's objective of eliminating all deaths and serious injuries on the Capital's transport network by 2041;
- Providing further information on how LIP schemes/programmes are, and will be, prioritised, both in scale and geographical location – as a means of giving further confidence in the delivery of the borough's transport objectives;
- Updating a number of charts/graphs to include recently published data.

In addition to these changes, a minor reprofiling of the three-year Programme of Investment is also proposed. This is to support the Council's proposed bid for circa

£450,000 funding through the Mayor's Air Quality Fund which requires a commitment to provide an element of match funding; and to reflect that Public Health Grant funding is no longer available.

Approval is now sought for these minor changes to the draft LIP. Upon approval a final draft version of the LIP will be submitted to TfL in February 2019, ahead of final sign-off by the Mayor of London. An updated version of the Environmental Report will also be produced and will be published on the Council's website.

The Cabinet is to consider this report at its meeting on 22 January 2019 (the date of publication of this Assembly agenda). Any issues arising from the Cabinet meeting will be reported at the Assembly meeting.

**Recommendation(s)**

The Assembly is recommended to:

(i) Note the minor changes to the draft Third Local Implementation Plan (LIP3) following the formal consultation period; and

(ii) Approve the final draft version of the LIP3 for submission to Transport for London and sign-off by the Mayor of London.

**Reason(s)**

To help deliver the Borough Manifesto priorities and Health and Wellbeing Strategy outcomes – in particular those related to growing the borough, enhancing the local environment and improving health and wellbeing. The proposals in the LIP will also help tackle crime and anti-social behaviour on the borough's streets and improve personal safety whilst travelling.

## 1. Introduction and Background

1.1 On 16 October 2018 Cabinet approved the Draft Third Local Implementation Plan (LIP3) for submission to Transport for London (TfL) (Minute 42 refers). The LIP outlines the short, medium and long-term programmes and measures which will facilitate the delivery of improvements to the transport system for the benefit of all those living and working in and travelling through Barking and Dagenham.

1.2 Following submission of the draft plan, BeFirst undertook a five-week consultation exercise with a range of statutory and local stakeholders and the general public. Consultees were asked to give their views on the various aspects of the plan. At the same time, consultation was undertaken with a number of statutory bodies on a draft Environmental Report, produced as part of a Strategic Environmental Assessment (SEA) of the LIP – a duty placed on the Council by the European Union when producing such documents.

1.3 This report outlines the results of the consultation exercises and details the various improvements/additions that are recommended to be included in the final draft version of the LIP ahead of submission to TfL in February 2019.

## 2. Proposal and Issues

### Consultation Exercises

2.1 Consultation on the draft LIP and the draft Environmental Report was undertaken with a range of statutory and local stakeholders and the general public between 2 November and 7 December 2018. Several forms of consultation were carried out including:

- A questionnaire uploaded to the Consultation Portal on the Council website;
- Individual stakeholder meetings;
- Circulation of the draft plan to a range of organisations including neighbouring boroughs; transport user and campaign groups; access and equalities groups; the emergency services; and business and community groups.

### Consultation Responses

On-line questionnaire

2.2 Response to the on-line questionnaire was very low, with only 13 responses received in total. In general, there was some support for the approach adopted in the draft LIP, with over half of the respondents either ‘strongly agreeing’ or ‘agreeing’ with the proposed objectives. There was strong support for additional transport links/services to places such as Stratford and Canary Wharf, as well as measures to improve safety and security on the local transport network and improve the local street scene. However, there was less support for the proposed Delivery Plan and three-year Programme of Investment, with only a third of respondents either ‘strongly agreeing’ or ‘agreeing’ with the proposals. Chief among the concerns raised were the potential impacts on general traffic as a result of proposals to implement bus priority schemes and the potential for further conflict between pedestrian and cyclists with the introduction of new cycling schemes.

Stakeholder engagement

2.3 One stakeholder meeting was carried out during the course of the consultation exercise. This took the form of a question and answer session with the Barking and Dagenham Access Group at a meeting of the Access & Planning Review Forum. Again, there was broad support for the approach adopted in the plan, with forum members welcoming investment in measures and interventions that would result in improved accessibility; improved safety and security; and the creation of healthy, inclusive places. However, members reiterated the need for the perceptions of safety to be addressed as much as actual safety issues and for all schemes to be designed taking into consideration the needs of the least abled.

Written responses

2.4 In addition to the on-line questionnaire and meeting responses, four separate written responses to the consultation were also received. These included comments made by TfL, the Metropolitan Police, the local branch of the London Cycling Campaign and the London Borough of Bexley. All these organisations were broadly in support of the approach/content of the LIP.

2.5 As a key mandatory stakeholder, TfL considered that the LIP aligned with the MTS and welcomed the Council's commitment to increasing sustainable travel and seeking to reduce traffic and levels of car ownership across the borough. They also welcomed the borough's adoption of the 'Vision Zero' approach as a means of seeking to eliminate all deaths and serious injuries from the local transport network. TfL has also put forward a number of recommendations on how aspects of the plan could be strengthened. These include:

- Providing additional information on how the borough will achieve 'Vision Zero' – to support the Mayor's objective of eliminating all deaths and serious injuries on the Capital's transport network by 2041;
- Providing further information on how LIP schemes/programmes are, and will be, prioritised, both in scale and geographical location – as a means of giving further confidence in the delivery of the borough's transport objectives;
- Updating a number of charts/graphs to include recently published data.

2.6 Consultation on the draft Environmental Report was undertaken with three key statutory bodies - Natural England, Historic England and the Environment Agency. No responses were received.

2.7 Details of the various representations made during the consultation period and the Council's response to these are set out in Appendix 1 to this report. None of the proposed amendments alter significantly the content or direction of the LIP.

## 3. Options Appraisal

3.1 The draft LIP is being updated to take on board some of the comments and suggestions made by various stakeholders, as detailed in the tables in Appendix 1. No significant material changes to the content or the direction of the plan are proposed. However, the minor amendments/additions will serve to further strengthen the LIP and ensure the various objectives and targets can be met. An amended version of the draft LIP will be submitted to the Mayor of London for approval in February 2019.

3.2 In addition to the text changes, a minor reprofiling of the three-year Programme of Investment is also proposed:

- The Council will shortly be submitting a bid for circa £450,000 funding through the Mayor's Air Quality Fund which requires a commitment to provide an element of match funding. It is proposed to meet this commitment through the LIP as the only viable source of match funding currently available;
- The value of the Borough-wide Healthy/Active Travel Programme has been reduced by £40,000 each year to reflect the fact that Public Health Grant funding is no longer available;
- All other schemes proposed in the Cabinet approved draft Programme of Investment are proposed to be retained, but the scope of works/spend on some has been downgraded slightly. An updated three-year Programme of Investment is included at Appendix 2 to this report.

## 4. Consultation

4.1 As described above, a formal five-week consultation exercise with a range of statutory and local stakeholders and the wider public was undertaken between 2 November and 7 December 2018. This was in addition to the wide-ranging consultation, participation and partnership working that has been central to the development of the draft LIP – the outcomes of which are summarised in section 1.3 in chapter 1 and Annex C of the LIP (https://www.lbbd.gov.uk/sites/default/files/attachments/LBBD%20Consultation%20Draft%20LIP3%20-%20Final.pdf).

4.2 Ongoing engagement will continue to inform the planning and implementation of our transport schemes and programmes, with a strong emphasis on ensuring that decisions and delivery more closely reflect the needs of local people and that, ultimately, 'nobody is left behind'.

4.3 The Cabinet is to consider this report at its meeting on 22 January 2019.

## 5. Financial Implications

*Implications completed by: Rodney Simons, Principal Accountant Capital*

5.1 The annual funding available for the LIP three-year period is circa £1.5m in 2019/20 and £1.5m in both 2020/21 and 2021/22. The exact amount of funding for 2020/21 and beyond is, however, subject to confirmation. These figures are broadly in line with the level of funding the Authority has received from TfL in 2017/18 and 2018/19. The funding will continue to be claimed from TfL periodically during the year in line with actual level of spending against each scheme.

5.2 It is anticipated that the full programme of works will be carried out within the allocated funding and there will be no impact on the Authority's internally funded capital programme or level of borrowing. Some of the proposed projects will be treated as revenue expenditure as, rather than enhancing the highways infrastructure, they relate to training, publicity or the staging of events. However, there will be no impact on existing revenue budgets.

5.3 Whilst it is unlikely that there will be any ongoing revenue implications associated with the programme (e.g. infrastructure maintenance costs), if additional ongoing maintenance costs do arise, they will be met from the existing highway maintenance programme budget with additional external funding sought where possible.

## 6. Legal Implications

*Implications completed by: Dr. Paul Feild, Senior Governance Lawyer*

6.1 The Council is required under Section 146 of the Greater London Authority Act 1999 ('the GLA Act') to submit its Local Implementation Plan to the Mayor of London for his approval. The plan must include a timetable for implementing its proposals and a date by which all the proposals will be delivered.

6.2 In preparing a Local Implementation Plan the Council must have regard to the Mayor's Transport Strategy. The Mayor will take into consideration whether the Plan

is consistent with the Transport Strategy and the proposals and timetable are adequate for its implementation. The Council's submission to the Mayor will consist of the version of the plan agreed by the Cabinet.

## 7. Other Implications

7.1 **Risk Management –** Failure to produce a robust LIP could result in the Council's funding allocation for the period 2019/20 - 2021/22 being withdrawn and the Council having to bear the full costs of any planned transport schemes. This in turn could impact on the Council's ability to meet its targets in respect of increasing the mode share of cycling/walking; reducing the number of casualties on our transport network and reducing vehicle emissions. A number of the LIP schemes still require further investigation/detailed design work to be carried out before they can be progressed, to ensure all potential risks are properly mitigated.

7.2 **Corporate Policy and Equality Impact –** The LIP is broadly in line with Council priorities. The LIP objectives and Delivery Plan will contribute to enabling social responsibility through protecting the most vulnerable, keeping adults and children healthy and safe and will also benefit all those who live in or travel through the borough. The plan also contributes to the Council's 'Growing the borough' priority through investment in enhancing our environment. An Equality Impact Assessment (EIA) has also been carried out on the LIP. The assessment indicates that the overall impact of the LIP on different groups is likely to be positive. There are no negative impacts shown, and the remainder are judged either positive or neutral. The results of the EIA are set out in Annex E of the LIP.

7.3 **Safeguarding Adults and Children –** The LIP Delivery Plan and Programme of Investment include schemes to improve road safety both through highway safety measures and also through initiatives such as cycle training for all. More generally the LIP aims to improve safety and security for all users of the borough transport network.

7.4 **Health Issues –** The promotion and enabling of cycling and walking in Barking and Dagenham figures prominently in the LIP and is a key component of the Council's Health and Wellbeing Strategy and sits at the heart of the borough manifesto theme of "health and wellbeing".

7.5 **Crime and Disorder Issues –** The Crime and Disorder Act requires the Council to have regard to crime reduction and prevention in all its strategy development and service delivery. Through the LIP the Council aims to address concerns of personal safety by working to ensure that roads and footways are well maintained and free from obstructions and infrastructure is safe and secure.

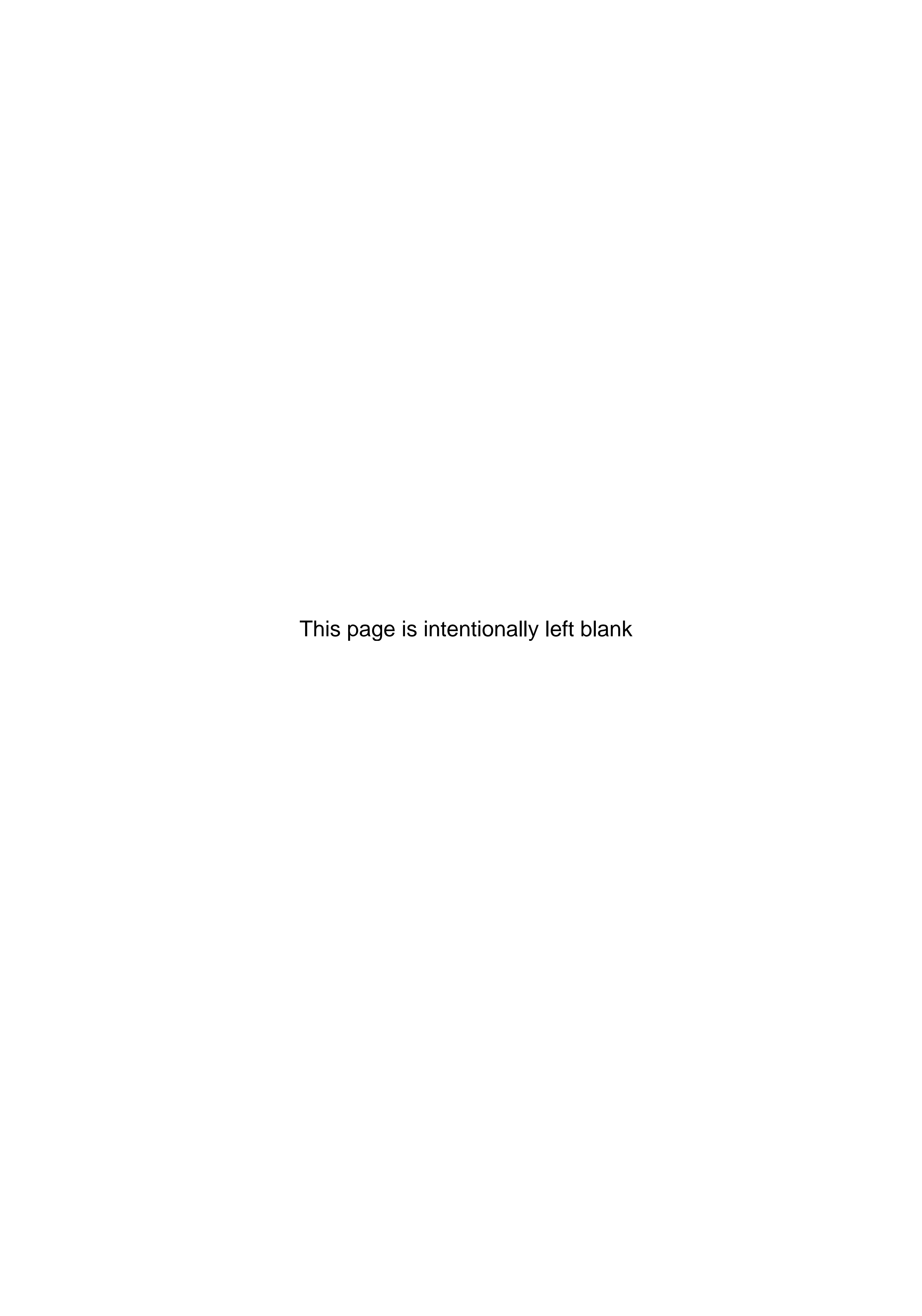
7.6 **Property / Asset Issues –** Where new infrastructure is required as part of a LIP scheme, the Council will seek to ensure that high quality, durable products are used and that schemes are well- designed and engineered to ensure that short term maintenance is not required. In most circumstances, ongoing maintenance costs will be met through the existing highway maintenance programme budgets with additional external funding sought where possible.

**Public Background Papers Used in the Preparation of the Report:**

LB Barking and Dagenham Consultation Draft Third Local Implementation Plan 2019/20 – 2021/22
https://www.lbbd.gov.uk/sites/default/files/attachments/LBBD%20Consultation%20Draft%20LIP3%20-%20Final.pdf

**List of Appendices:**

**Appendix 1**: LIP Consultation Response Summary
**Appendix 2**: Revised LIP Three-Year Programme of Investment (2019/20 – 2021/22)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# Appendix 1: LIP Consultation Response Summary

## Public Consultation Feedback

| Consultee | Date/Method of Engagement | Summary of Response/Issues Raised | Council Response/Actions |
|---|---|---|---|
| General Public | 02/11/18 – 07/12/18 - Online Questionnaire 13 responses received | • There was some support for the overall approach adopted in the draft LIP, with over half of the respondents either 'strongly agreeing' or 'agreeing' with the proposed objectives.<br>• There was broad support for additional transport links/services to places such as Stratford and Canary Wharf, as well as measures to improve safety and security on the local transport network and improve the local street scene.<br>• There was less support for the proposed Delivery Plan and three-year Programme of Investment, with only a third of respondents either 'strongly agreeing' or 'agreeing' with the proposals.<br>• Chief among the concerns raised were the potential impacts on general traffic as a result of proposals to implement bus priority schemes and the potential for further conflict between pedestrian and cyclists with the introduction of new cycling schemes. | • Given the very low response rate to the online questionnaire, it is not possible to draw any meaningful conclusions from the consultation exercise.<br>• No changes are proposed to the draft LIP as a result of the feedback received from the general public. However, the Council is mindful of the concerns raised by respondents around the potential impacts/conflicts of new bus priority and cycling schemes and will ensure that detailed public engagement is undertaken as part of all scheme development/ implementation work to allay these concerns and ensure measures are fully supported by the wider community. |
| Barking and Dagenham Access Group | 19/11/18 - Access and Planning Review Forum | • There was broad support for the approach adopted in the draft LIP, with forum members welcoming investment in measures and interventions that would result in improved | • Comments noted. Additional text to be included in the final draft LIP highlighting how the 'co-design' approach to scheme development/ implementation can address perceptions of safety. |

| Consultee | Date/Method of Engagement | Summary of Response/Issues Raised | Council Response/Actions |
|---|---|---|---|
| | | accessibility; improved safety and security; and the creation of healthy, inclusive places.<br>• Forum members highlighted the need for people's perceptions of safety to be addressed as much as actual safety issues themselves and for all schemes to be designed taking into consideration the needs of the least abled. | • Adoption of 'Healthy Streets' approach will ensure that the needs of the least abled are taken into consideration during scheme development/ implementation. |
| Metropolitan Police | 19/11/18 – Written Representation | • Response highlighted the need for a greater commitment to be made in the LIP to adopting 'Secured by Design' principles as a proven means of reducing crime and fear of crime within the borough.<br>• Adoption of SBD principles would bring a number of benefits to the Council and the wider community, including the creation of areas in which resident feel safe and secure and the promotion of healthy, sustainable living. | • Comments noted. Adoption of 'Healthy Streets' approach will ensure that issues around crime and fear of crime are taken into consideration during scheme development/implementation. However, additional text to be included in final draft LIP highlighting a greater commitment to adopting key SBD principles. |
| London Cycling Campaign | 03/12/18 – Written Representation | • LCC generally encouraged by the many mentions of cycling throughout the document, accepting that it is a vital form of transport. However, has some concerns about the specifics of some proposals, the lack of specifics in others and the absence of some projects from the LIP. Key issues/considerations include:<br>▪ Lack of clarity and ambition on targets, especially interim targets;<br>▪ Insufficient detail on/weight given to proposed new strategic cycling and | • Targets: Interim/final targets align to those set by TfL. Proposed small increase to cycle mode share reflects existing low-level mode share figure and availability of funding to affect change.<br>• Routes: Alterations to text proposed to clarify position on/add weight to borough commitments around existing/proposed new cycle routes.<br>• Cycling schemes: Scheme design/ implementation will be informed by 'Healthy Streets' and 'Vision Zero' approach, with all schemes built to London Cycling Design |

| Consultee | Date/Method of Engagement | Summary of Response/Issues Raised | Council Response/Actions |
|---|---|---|---|
| | | Quietway routes and existing LCN/LCN+ routes;<br>▪ Need for good quality and safe cycle connections to/from Barking Riverside;<br>▪ Proposals to use central reservations to provide fully-segregated cycling facilities problematic – would involve additional carriageway crossings, deplete greenery and unlikely to be comfortable/legible;<br>▪ Pledge needed to fix legacy permeability and maintenance issues;<br>▪ Important that proposed river crossings incorporate cycling from the outset. | Standards. 'Co-design' approach also central to successful development/delivery of all schemes.<br>• Legacy issues: LIP scheme design process will address legacy permeability/ maintenance issues in specific areas. Councils HIP programme will also address long-standing carriageway maintenance issues. Local Transport Fund 'Minor Works' programme will look to address all other small-scale legacy issues.<br>• River crossings: Proposed crossings will accommodate pedestrians/cyclists and would feed into the long-planned National Cycle Network route along the Thames north bank and River Roding. |
| LB Bexley | 11/12/18 – Written Representation | • Welcomes proposals to extend riverboat services to Barking Riverside as this could lead to future services calling at wharves and piers along Bexley's riverfront.<br>• Notes that draft LIP does not include any commitment to petition TfL to continue to consider further road-based Thames river crossings at Belvedere/Rainham and Gallions Reach/Thamesmead. Consider a missed opportunity given the potential for such crossings to enable and support significant economic growth in east and southeast London. | • Comments noted. Introduction of timetabled river passenger services to/from Barking Riverside would provide the borough with additional cross-river connectivity, a direct transport link to the key employment hubs of Canary Wharf and central London and relieve pressure on the local road/public transport networks.<br>• Focus of long-term schemes/ interventions listed in cpt3 is mainly on those schemes that would directly impact on the borough and which support the Council's wider growth ambitions. The Council is broadly supportive of additional Thames River |

| Consultee | Date/Method of Engagement | Summary of Response/Issues Raised | Council Response/Actions |
|---|---|---|---|
| | | | crossings and will continue to lobby for these key infrastructure improvements. |
| TfL City Planning | 12/12/18 – Written Representation | • TfL considered that the LIP aligned with the MTS and welcomed the Council's commitment to increasing sustainable travel and seeking to reduce traffic and levels of car ownership across the borough.<br>• TfL also welcomed the borough's adoption of the 'Vision Zero' approach as a means of seeking to eliminate all deaths and serious injuries from the local transport network.<br>• A number of recommendations have been made on how aspects of the plan could be strengthened. These include:<br>▪ Providing additional information on how the borough will achieve 'Vision Zero';<br>▪ Providing further information on how LIP schemes/programmes are/will be prioritised, both in scale/geographical location;<br>▪ Updating a number of charts/graphs to provide clarity and to reflect recently published data. | • This content/direction of the LIP reflects the Council's commitment to looking at new and innovative ways of addressing the various transport, environmental, health and inequality issues that affect the borough and large parts of London.<br>• Following further discussions with the City Planning team, the Council accepts the recommended changes/additions and the draft LIP has been updated to reflect these comments/suggestions. Details of how/where these changes have been made are set out in the table below. |

## TfL Consultation Feedback

| TfL Comment/Recommendations | Council Response/Actions | Where Addressed |
|---|---|---|
| **LIP Guidance Requirements/General Feedback** | | |
| • The LIP does not follow the structure in the template but includes a table in Annex A that identifies where in the document each of the LIP mandatory requirements can be found. Each requirement has been addressed. | • Current structure represents preferred approach to LIP development. | N/A |
| **Chapter 1: Introduction and Wider Context** | | |
| • The democratic process taken to approve the submission of the LIP is well set out. It may be beneficial to name the portfolio holder that initially approves the document. | • LIP document approved by Council Cabinet and Assembly. Relevant portfolio holder is acknowledged in Foreword. | Foreword |
| • Statutory consultees have been referenced although this section will read differently following consultation. Any amendments to the document based on feedback should be noted in the final version, along with the naming of groups consulted (as opposed to generic terms). | • Text updated to highlight additional consultation/ engagement undertaken in November 2018 and the outcomes of this. Details of specific individuals/groups consulted provided. | Section 1.3 (Formal Consultation) – Paras 1.3.4 – 1.3.7<br>Annex C |
| **Chapter 2: Borough Transport Issues and Objectives** | | |
| • Figures have been provided within this chapter to set out the local context but several of the maps / images (e.g. Figures 2.1 and 2.5) are unclear and their quality / resolution should be improved in the final LIP. | • Maps/images reviewed and updated to provide greater clarity. | Section 2.2 (Borough Overview) – Figure 2,1<br>Section 2.4 (Section 2.4 (Challenges and Opportunities) – Figure 2.5 |
| • Additional analysis and information on casualties in the borough to show that Barking and Dagenham have understood their local issues to show further commitment to the Vision Zero approach. | • Additional information on borough casualties provided, including 2017 casualty figures and details of those vehicles which present the greatest risk. | Section 2.3 (Local Transport Context) - Table 2.2 |

| TfL Comment/Recommendations | Council Response/Actions | Where Addressed |
|---|---|---|
| | | Section 2.4 (Challenges and Opportunities) – Paras 2.4.7 – 2.4.9 |
| • Point of accuracy on 2.5.9, KSIs in Barking and Dagenham rose in 2017 by 38%, 42% for serious injuries. | • Paragraph updated to reflect 2017 casualty figures. | Section 2.5 (Borough Transport Objectives) – Para 2.5.9 |
| **Chapter 3: LIP Delivery Plan and Programme of Investment** | | |
| • The LIP states adoption of the Healthy Streets Approach under the priority area of 'Creating Better Streets and Places' however adopting the approach implies all schemes delivered on the borough's streets should encourage more walking, cycling and public transport use and deliver improvements against the ten 'Healthy Streets' indicators. As such, 'improvements to traffic flow' and 'reducing traffic bottlenecks' should not be priorities in themselves. | • Text updated to highlight all-encompassing nature of the Health Streets Approach.<br>• Reference to 'improvements to traffic flow' and 'reducing traffic bottlenecks' removed and replaced with 'improvements to bus journey times' and 'creating liveable spaces'. | Section 3.2 (Measures and Interventions) – Para 3.2.12 |
| • Additional details on how casualty savings will be made and how the borough will deliver according to the Vision Zero approach should be included to show a thorough understanding and commitment, for example there is no mention of adopting a Safe Systems Approach, road risk or tackling danger at the source in the document. | • Text updated to include details on how the Council will achieve casualty savings and deliver Vision Zero approach. | Section 3.2 (Measures and Interventions) – Paras 3.2.9 – 3.2.10 |
| • With further regards to Vision Zero the focus of the 2019/20 delivery plan is heavily on engineering with no mention of analysis of riskiest locations such as town centres and no mention of vehicle improvements, work related road risk (or FORS). Also, education appears to focus on vulnerable road users and not those who cause harm. | • Text updated to highlight different range of road safety measures/interventions the Council will implement in line with the Vision Zero approach. | Section 3.2 (Measures and Interventions) – Paras 3.2.9 – 3.2.10 |
| • It would be helpful to include details on how programmes are, and will be, prioritised both in terms of scale and geographical location (as per requirement 21a). For example, how would the | • Details of how Delivery Plan is prioritised by geographical location already provided in Section 3.2. | Section 3.2 (Principles and Priorities) – Paras 3.2.1 – 3.2.2; Table 3.1; Figures 3.1 |

| TfL Comment/Recommendations | Council Response/Actions | Where Addressed |
|---|---|---|
| prioritisation process be used if schemes need to be added / removed. | • Further clarification provided on how prioritisation process would be used for adding/removing schemes. | Section 3.5 (Programme Prioritisation and Monitoring Arrangements) – Paras 3.5.2 – 3.5.4 |
| • Despite no bus priority funding in table 3.5 the borough could show commitment to bus priority highlighting where new measures would be sought e.g. pinch points, as part of future scheme development etc. | • Text updated highlighting how the Council will work with TfL to identify other locations within the borough where bus priority improvements may be beneficial. | Section 3.4 (Strategic Funding Programmes) – Para 3.4.8 |
| • Table 3.9, stakeholder management plan(s) may be helpful and could also include producing risk assessments at a scheme level. | • Table updated to include reference to stakeholder management plans.<br>• New table added containing risk assessment at scheme level. | Section 3.5 (Managing Risk) Tables 3.9 and 3.10 |
| • Points of accuracy:<br>o Figure 3.1 is unclear and should be improved in the final LIP;<br>o In 3.3.5 the new bus/transit river crossing is expected to be part of a Housing Infrastructure Fund bid rather than a Growth Fund bid;<br>o In 3.4.6 the Ilford to Barking cycle route should be referred to as a 'Future Route' as opposed to a 'Quietway';<br>o 3.4.8 Suggestion to mention the City in the East growth study that identified the need for increased bus services for Barking Town Centre and measures being developed as a result;<br>o Make it clear if 'The Heathway' in row two of Table 3.8 is the same as point 2 in Figure 3.2. | • Relevant text has been updated to reflect correct terminology.<br>• Maps/images reviewed and updated to provide greater clarity. | Section 3.3 (Funding Sources) – Para 3.3.5<br>Section 3.4 (Strategic Funding Programmes) – Paras 3.4.6 and 3.4.8<br>Figures 3.1; 3.2<br>Table 3.8 |
| **Chapter 4: Performance Management and Monitoring** | | |
| • Targets follow the TfL trajectories issued in the borough data pack. However, two targets have been set for KSIs in 2041, there should only be one of zero. | • Erroneous target removed. | Section 4.2 (LIP Indicators and Targets) – Table 4.1 |

| TfL Comment/Recommendations | Council Response/Actions | Where Addressed |
|---|---|---|
| • A revised set of borough trajectories for Outcome 2 and Vision Zero have been issued and boroughs need to update their targets to reflect these new trajectories in their final LIP for 2022 and 2030 (2041 is unchanged at 0). The borough is also asked to include additional text in the final LIP under Outcome 2 explaining the reasoning for the change in trajectories and targets. | • Road safety targets updated to reflect revised borough trajectories and additional explanatory text added. | Section 4.2 (LIP Indicators and Targets) – Figure 4.2 (+ new text box) and Table 4.1 |
| • To demonstrate commitment to and understanding of the targets set commentary around Figure 4.1 and 4.3 should include the impact of growth and housing delivery on these targets e.g. an increasing mode share in the context of increasing trips. | • Text update to highlight impacts of growth/ housing delivery on targets. | Section 4.2 (LIP Indicators and Targets) – Paras 4.2.5 and 4.2.10 |

## Appendix 2: Revised LIP Three-Year Programme of Investment (2019/20 – 2021/22)

| Scheme Name/ Location | Scheme Summary | Ward(s) Affected | Link to LIP Objectives, MTS Outcomes, Borough Manifesto Priorities | Indicative Costs 2019/20* | Indicative Costs 2020/21* | Indicative Costs 2021/22* |
|---|---|---|---|---|---|---|
| **Corridors, Neighbourhoods and Supporting Measures Programme Indicative Allocation:** | | | | **£1,377,000** | **£1,377,000** | **£1,377,000** |
| Barking Station Improvements | Contribution to redevelopment costs of Barking Station to improve accessibility, passenger safety and relieve overcrowding. Key priority is the provision of step-free access between the station concourse and platforms. Improvements to be delivered by end of 2019/20 in line with C2C franchise requirements. | Abbey | *LIP Objectives:* Connecting people and places; Improving safety and security<br>*MTS Outcomes:* Accessible; Quality; Safe<br>*Manifesto Priorities:* Safety | £875,000 | - | - |
| Dagenham Heathway 'Healthy Streets' Corridor Improvements | Development/delivery of range of 'Healthy Streets' measures identified in recent scoping reports produced by Sustrans/ Living Streets to address a range of safety issues/road user conflicts in the area and increasing levels of walking and cycling to this major District centre. Focus will be on the provision of safe, accessible facilities for pedestrians/cyclists; introduction of measures to tackle localised congestion and improve air quality; and delivery of enhancements to the public realm. 2-year collaborative design and build scheme with main works undertaken in 2020/21. | Alibon, River, Village | *LIP Objectives:* Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br>*MTS Outcomes:* Active; Safe; Efficient; Green; Accessible<br>*Manifesto Priorities:* Health and Wellbeing; Safety; Environment; Community Engagement | £50,000 | £500,000 | - |

| Scheme Name/ Location | Scheme Summary | Ward(s) Affected | Link to LIP Objectives, MTS Outcomes, Borough Manifesto Priorities | Indicative Costs 2019/20* | Indicative Costs 2020/21* | Indicative Costs 2021/22* |
|---|---|---|---|---|---|---|
| Valance Avenue 'Healthy Streets' Corridor Improvements | Development/delivery of range of 'Healthy Streets' measures with the aim of improving walking and cycling links between the Becontree Estate and the Elizabeth Line (Crossrail) station at Chadwell Heath. Focus will be on the provision of safe, accessible facilities for pedestrians/cyclists, including the potential for dedicated cycle facilities on the central reservation along Valence Avenue. 2-year collaborative design and build scheme with main works undertaken in 2021/22. | Valance, Parsloes | *LIP Objectives:* Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br>*MTS Outcomes:* Active; Safe; Efficient; Green; Accessible<br>*Manifesto Priorities:* Health and Wellbeing; Safety; Environment; Community Engagement | - | £50,000 | £500,000 |
| 'Greening the Fiddlers' - Becontree Heath Low Emission Neighbourhood | Community-led neighbourhood improvements scheme focused on reducing the dominance of vehicular traffic in Becontree Heath and creating a more welcoming, healthy place for everyone to enjoy; with the aim of encouraging more active, sustainable travel and delivering improvements to air quality in the area. Key elements include the creation of a 'Green Corridor' along Whalebone Lane South; the delivery of a 'Green Living Room' centred on the Merry Fiddlers shopping parade; and supported with a range of complementary behavioural and regulatory measures. Allocation represents match funding commitment in support of recent funding bid through the Mayor's Air Quality Fund. | Whalebone, Heath, Valance | *LIP Objectives:* Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br>*MTS Outcomes:* Active; Safe; Efficient; Green; Accessible<br>*Manifesto Priorities:* Health and Wellbeing; Safety; Environment; Community Engagement | £100,000 | £250,000 | £100,000 |

| Scheme Name/ Location | Scheme Summary | Ward(s) Affected | Link to LIP Objectives, MTS Outcomes, Borough Manifesto Priorities | Indicative Costs 2019/20* | Indicative Costs 2020/21* | Indicative Costs 2021/22* |
|---|---|---|---|---|---|---|
| Eastbury Manor House Access Improvements | Public realm enhancement scheme aimed at improving visitor access to and reflecting the Grade 1 listed status of Eastbury Manor House. Focused on Eastbury Square and surrounding streets, the scheme will deliver a range of 'Healthy Streets' improvements which will better meet the needs of visitors and reflect the requirements of residents. Priorities include the need to reduce the speed/dominance of vehicles; improve conditions for pedestrians/cyclists; and improve the quality of the street scene. The scheme will complement wider improvements underway at the manor house aimed at providing an enhanced visitor experience. | Eastbury | *LIP Objectives:*<br>Connecting people and places; Improving safety and security; Creating better streets and places<br><br>*MTS Outcomes:*<br>Active; Safe; Efficient; Green; Accessible<br><br>*Manifesto Priorities:*<br>Health and Wellbeing; Safety; Community Engagement | - | £50,000 | £250,000 |
| Station Access Improvements Programme – Upney and Dagenham East | Continuation of station access improvements programme aimed at providing high quality, attractive approaches to the borough's transport interchanges. Focusing on Upney and Dagenham East stations schemes will deliver improved walking, cycling and bus access to stations; improved safety and security and an enhanced public realm. Utilising our preferred approach of collaborative design and build, scheme delivery will be undertaken in 2020/21 (Upney) and 2021/22 (Dagenham East). | Longbridge, Eastbury, Eastbrook, Village | *LIP Objectives:*<br>Connecting people and places; Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br><br>*MTS Outcomes:*<br>Active; Safe; Connected; Accessible; Quality<br><br>*Manifesto Priorities:*<br>Health and Wellbeing; Safety; Environment; Community Engagement | £50,000 | £250,000 | £250,000 |

| Scheme Name/ Location | Scheme Summary | Ward(s) Affected | Link to LIP Objectives, MTS Outcomes, Borough Manifesto Priorities | Indicative Costs 2019/20* | Indicative Costs 2020/21* | Indicative Costs 2021/22* |
|---|---|---|---|---|---|---|
| Marks Gate – Chadwell Heath Cycling Link | Introduction of a dedicated cycle route linking the Marks Gate Estate to the Elizabeth Line (Crossrail) station at Chadwell Heath, as a means of encouraging healthy, sustainable travel. Scheme will utilise the existing quiet, green routes of St. Chad's Park to provide a safe, direct cycle link, whilst seeking to address some of the key barriers/ accessibility issues. | Chadwell Heath | *LIP Objectives:* Connecting people and places; Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br>*MTS Outcomes:* Active; Safe; Green<br>*Manifesto Priorities:* Health and Wellbeing; Safety; Environment | £75,000 | - | - |
| Road Safety and Access Improvement Programme (Various Locations) | Small-medium scale, site specific road safety and access improvements in support of LIP objectives around reducing the number of casualties on our roads, improving access for all and promoting healthy/sustainable travel; and to complement the various corridor/ neighbourhood initiatives. Priorities tbc, but likely to focus on proposals for new neighbourhood 20mph zones, filtered permeability schemes and 'school gate' road safety/access improvements. Schemes will be guided by TfL 'Healthy Streets' and 'Vision Zero' approach. | All | *LIP Objectives:* Connecting people and places; Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br>*MTS Outcomes:* Active; Safe; Efficient; Green<br>*Manifesto Priorities:* Health and Wellbeing; Safety; Environment; Community Engagement | £100,000 | £150,000 | £150,000 |

| Scheme Name/ Location | Scheme Summary | Ward(s) Affected | Link to LIP Objectives, MTS Outcomes, Borough Manifesto Priorities | Indicative Costs 2019/20* | Indicative Costs 2020/21* | Indicative Costs 2021/22* |
|---|---|---|---|---|---|---|
| Borough-wide Healthy/Active Travel Programme | Continuation of work with borough schools, businesses and residents to promote healthy, active and sustainable travel practices. Funding earmarked for:<br>• Provision of cycle training to people of all ages/abilities and the delivery of various walking events/initiatives;<br>• Review/update of school and workplace travel plans, including funding for promotional events and small-scale physical measures. Includes contribution towards appointment of London Riverside Travel Coordinator. | All | *LIP Objectives:*<br>Promoting healthy, sustainable travel; Improving safety and security<br><br>*MTS Outcomes:*<br>Active; Safe; Green<br><br>*Manifesto Priorities:*<br>Health and Wellbeing; Safety; Environment; Community Engagement | £127,000 | £127,000 | £127,000 |
| | | | **TOTAL:** | **£1,377,000** | **£1,377,000** | **£1,377,000** |
| | | | **Local Transport Funding Indicative Allocation:** | **£100,000** | **£100,000** | **£100,000** |
| Future Scheme Development (Various Locations) | Investigative studies to inform future LIP Corridor/Liveable Neighbourhood schemes. Focus will be on promoting healthy, active travel and on securing road safety/accessibility improvements. | All | *LIP Objectives:*<br>Connecting people and places; Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br><br>*MTS Outcomes:*<br>Active; Safe; Efficient; Green; Connected; Accessible; Quality<br><br>*Manifesto Priorities:* | £60,000 | £60,000 | £60,000 |

| Scheme Name/ Location | Scheme Summary | Ward(s) Affected | Link to LIP Objectives, MTS Outcomes, Borough Manifesto Priorities | Indicative Costs 2019/20* | Indicative Costs 2020/21* | Indicative Costs 2021/22* |
|---|---|---|---|---|---|---|
| | | | Health and Wellbeing; Safety; Environment; Community Engagement | | | |
| Minor Works (Various Locations) | Ad-hoc measures such as pedestrian access improvements; small-scale public realm enhancements; implementation of cycle parking; reviews of parking and waiting/loading restrictions; etc. | All | *LIP Objectives:*<br>Connecting people and places; Promoting healthy, sustainable travel; Improving safety and security; Creating better streets and places<br><br>*MTS Outcomes:*<br>Active; Safe; Efficient; Green; Connected; Accessible; Quality<br><br>*Manifesto Priorities:*<br>Health and Wellbeing; Safety; Environment; Community Engagement | £40,000 | £40,000 | £40,000 |
| | | | **TOTAL:** | **£100,000** | **£100,000** | **£100,000** |
| | | | **GRAND TOTAL:** | **£1,477,000** | **£1,477,000** | **£1,477,000** |

** Schemes funded through LIP Corridors, Neighbourhoods and Supporting Measures Programme unless otherwise stated.*

**ASSEMBLY**

**30 January 2019**

| **Title:** Joint Health and Wellbeing Strategy 2019-2023 | |
|---|---|
| **Report of the Cabinet Member for Social Care and Health Integration** | |
| **Open Report** | **For Information** |
| **Wards Affected:** All | **Key Decision:** No |
| **Report Author:** Florence Henry, Public Health Strategy Officer | **Contact Details:**<br>Tel: 020 8227 3059<br>E-mail:<br>florence.henry@lbbd.gov.uk |
| **Accountable Director:** Matthew Cole, Director of Public Health | |
| **Accountable Strategic Leadership Director:** Elaine Allegretti, Director of People and Resilience | |


**Summary**

As required by the Health and Care Act 2012, a new Health and Wellbeing Strategy is required for 2019-2023 to follow on from the 2015-2018 strategy. The strategy sets a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives. The three priority themes for the strategy have been were agreed by Health and Wellbeing board in January when presented with the 2017 Joint Strategic Needs Assessment (JSNA):

1) *Best Start in Life*
2) *Early Diagnosis and Intervention*
3) *Building Resilience*

To create this document, we have run 12 focus groups with residents to formulate the 'I' statements within this document, which outline what good health looks like to residents These are included within each theme of the strategy. We have also held 3 professional stakeholder workshops to discuss the outcomes and measures in each theme in July. After Health and Wellbeing Board approved the draft document for consultation on 7 November, the document has been through an 8 week online public consultation and Health and Wellbeing Board will approve the final document for publication on 15 January.

The response to the public consultation were overall positive and supportive of the document and its three themes. Following the comments in the consultation, we have amended Best Start in Life to include up until the age of 7 to ensure the transition to school is covered. We have also included additional references communication and speech.

This work is evolving – we are working with commissioners and providers to integrate these priorities into commissioning plans. The 7 outcomes within this document will stay the same for the duration of this strategy, but the measures will evolve as we gain greater insight into our population.

| This document does not contain a detailed delivery plan, as it sets the overall strategic outcomes. Commissioners and the Alliance of Providers will use these outcomes and priorities to develop a detailed delivery plan which will include outputs and targets. |
| --- |
| **Recommendation(s)**<br><br>The Assembly is recommended to:<br>(i) Note the 3 priority themes, and the 7 outcomes within the document. The document outlines how we will work together across the borough and services to improve the health and wellbeing of residents. |

## 1. Introduction and Background

1.1 As required by the Health and Care Act 2012, a new Health and Wellbeing Strategy is required for 2019-2023 to follow on from the 2015-2018 strategy. The Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) are statutory items of Health and Wellbeing Board.

1.2 When Health and Wellbeing Board were presented with the JSNA 2017, they decided on the three priority themes of the strategy as Best Start in Life, Early Diagnosis and Intervention and Resilience. Health and Wellbeing Board approved the process to be taken for the creation of the strategy on 13 March. An update paper on the status of the creation of the strategy was provided to Health and Wellbeing Board on 5 September, and the draft document was approved for public consultation by the board on 7 November.

1.3 The document has now undergone an 8-week public online consultation and will be presented to Health and Wellbeing Board for approval for publication on 15 January.

## 2. Consultation

2.1 There has been a strong consultation element to the production of the Joint Health and Wellbeing Strategy. This is the first Joint Health and Wellbeing Strategy to be co-produced with residents. We ran 12 resident focus groups in community groups across the borough to formulate the 9 ‘I’ statements, 3 within each theme, which feature within the strategy. We also ran 3 stakeholder workshops with professionals, with 89 attendees from a variety of service areas and organisations across 3 workshops to discuss the outcomes and measures to be used within the document.

2.2 During the creation of the strategy, we also consulted with a range of both internal and partnership boards. This included giving presentations at the Community Safety Partnership, Health and Wellbeing Board, Barking and Dagenham Delivery Partnership, Core Directors Meeting, the Leader’s Advisory Group on People and Resilience and People and Resilience Management Team. We have also involved CCG colleagues in the process of creating draft documents.

2.3 The proposals in this report were considered and endorsed by the Corporate Strategy Group at its meeting on 18th October and at the Leader's Advisory Group on People & Resilience on 23rd October. The draft document was approved for consultation by the Health and Wellbeing Board on 7th November, with the final document for publication due at Health and Wellbeing Board on 15th November.

2.4 The Joint Strategic Needs Assessment, which provides the data which informs the strategy, and has been created in parallel, was also endorsed by the Corporate Strategy Group at its meeting on 18th October and at the Leader's Advisory Group on People & Resilience on 23rd October. The document was approved by Health and Wellbeing Board on 7th November. The document is attached as an Appendix 2 to this report.

## 3. Financial Implications

*Implications completed by Feroza Begum, Interim Group Accountant*

3.1 Although this report is largely for information only, the Joint Health and Wellbeing Strategy assumes that it will be delivered within existing resources, especially the Public Health Grant, which is available to the London Borough of Barking and Dagenham until 2021.

3.2 Under section 75 of the NHS Act 2006, the Council will consider flexibilities such as pooled budgets and lead commissioning that can better meet the needs identified in the JSNA. The NHS England (London) is also under a duty in the legislation to encourage the use of these flexibilities by clinical commissioning groups, where it considers use of flexibilities would secure the integration of health services and health related or social care services.

## 4. Legal Implications

*Implications completed by Dr Paul Field, Senior Governance Solicitor*

4.1 As set out in the body of this report the Health and Social Care Act 2012 places a statutory duty on the Health and Wellbeing Board to prepare a Joint Health and Wellbeing Strategy to meet the needs identified in the Joint Strategic Needs Assessment. Local authorities and each of its partner clinical commissioning groups must when exercising any functions have regard to any relevant Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) prepared by them (s193 of the Health and Social Care Act 2012).

4.2 When preparing JSNAs and JHWSs health and wellbeing boards must have regard to the Statutory Guidance and as such boards have to be able to justify departing from it. The proposed refreshed joint Health and Wellbeing Strategy will need to be been prepared and consulted on in accordance with the requirements under the Health and Social Care Act 2012 and under the Local Government and Public Involvement in Health Act 2007. Health and wellbeing

boards must meet the Public Sector Equality Duty under the Equality Act 2010, and due regard must be given to the duty throughout the JSNA and JHWS process.

## 5. Other Implications

### 5.1 Corporate Policy and Equality Impact

*Growth Commission Report 2016*

An independent 'Growth Commission' was commissioned by the council in 2015 to consider how growth opportunities in the borough could be maximised for the benefit of all its residents. In early 2016, they delivered their report, with recommendations for achieving this.
One of the key recommendations within the Growth Commission is to focus on increasing health and life expectancy in the borough. The report details how to achieve goals listed including much more active involvement of local people and communities. This strategy focuses on improving health and life expectancy in the borough, by focusing on key areas which have the largest potential for impact.
The Growth Commission Report provided the impetus for the Borough Manifesto (below).

*The Borough Manifesto*

The Borough Manifesto, 'Barking and Dagenham Together' sets out a shared vision for the borough through to 2037 aimed at around 10 themes:

- Employment, Skills and Enterprise
- Education
- Regeneration
- Housing
- Health and Social Care
- Community and Cohesion
- Environment
- Crime and Safety
- Fairness
- Arts, Culture and Leisure

These themes all impact on the health and the resilience of all residents. As such, this provides a blueprint for reducing health inequalities in the long term, not only within the borough, but also in relation to London and England. This aim is explicitly stated within *the Borough Manifesto's* targets, the majority of which are to improve key indicators to London and East London averages. In particular, the outcomes within this strategy focus on helping to achieve progress
in the 5 following areas of the *Borough Manifesto* targets:

- Healthy life expectancy better than London average by 2037
- An increased level of residents with Level 1 and Level 4 skills higher than the London average by 2037
- Unemployment rate lower than the London average by 2037

- Personal wellbeing and happiness above the London average
- Rate of regular physical activity higher than East London by 2037

During the *Borough Manifesto* consultation, residents also told us they wanted to have more of a say on their health. Because of this and the recommendations of the Growth Commission to increase community engagement, we have co-produced this strategy with residents. We have run 12 resident focus groups with a total of 128 residents to find out resident priorities in terms of good health and formulated these into a series of 'I' statements which are featured within each theme of the strategy.

*London Borough of Barking and Dagenham Corporate Plan*

The 2018-2022 London Borough of Barking and Dagenham's Corporate Plan has been created in parallel to and informed by this strategy. One of the themes of the Plan focusing on empowering people and closely aligns with the strategy his document. The Corporate Plan's focus is strengthening our services for all, and intervening early to prevent a problem from becoming a crisis, whilst protecting the most vulnerable.

*North East London Sustainability and Transformation Plan (Draft 2016)*

The Sustainability and Transformation Plan (STP) outlines how the NHS in North East London will become financially sustainable and deliver improvements to health and care services by 2021. It sets out six key priorities:

- Aligning demand with the most suitable type of services, including reducing demand via prevention and self-care
- Supporting self-care, locally based care and high-quality secondary care services
- Ensuring that providers can overcome the financial challenges that many are facing
- Collaborating on specialised services
- Developing a system-wide decision-making model that enables place-based care and partnership working
- Better use of physical assets.

As a joint strategy, many of the priorities relate to collaboration and integration of services. There is already considerable partnership working between Barking and Dagenham, Redbridge and Havering, including the current review of urgent and emergency care services and the joint commissioning of a pharmaceutical needs assessment for the three boroughs.

This strategy also builds upon the transformation plans developed through Barking Havering and Redbridge Integrated Care Partnership. Taking forward the planned 6 key areas - Older People, Planned Care, Cancer Transformation, Children and Maternity, Long-term conditions and Primary Care.

A framework for person-centred care has also been developed as part of the STP which emphasises prevention and draws on the social determinants of health. Within

this strategy, we will focus on outcomes-based commissioning and this model of person-centred care through the use of resident-created ‘I’ statements.

To create a condensed document, this strategy does not contain a detailed delivery plan. It will be the role of the Alliance of Providers and commissioners to outline the delivery plans and how they are held to account

A full Equality Impact Assessment is attached as Appendix 3 of this report, detailing the impact on each protected group.

5.2 **Safeguarding Adults and Children –** As outlined within the strategy itself, one of the pledges of partners detailed is safeguarding both vulnerable children and adults. This is a priority of the board to help ensure that all residents have the Best Start in Life and build resilience.

5.3 **Health Issues –** As the Joint Health and Wellbeing Strategy, the document outlines how partners will work together over the next 5 years. The strategy is designed to have a positive impact on health in the borough, providing the strategic framework with which to guide discussions around improving health and wellbeing.

5.4 **Crime and Disorder Issues –** As part of the creation of this document, we consulted with colleagues in Community Safety to ensure that this document compliments the upcoming Community Safety Plan. We presented at Community Safety Partnership on 26 September on our approach to resilience to get feedback from the Board. We have also included trauma-informed approaches, part of the Community Safety Plan, within our resilience theme of the document and referenced the Community Safety Plan within this. Within the Community Safety Plan 2019-21, Priority 1, Keeping Children and Young People Safe, references the importance of Adverse Childhood Experiences and how this is also an outcome within the Joint Health and Wellbeing Strategy.

**List of appendices:**

Appendix 1: Joint Health and Wellbeing Strategy 2019-2023 Document
Appendix 2: Joint Strategic Needs Assessment 2018
Appendix 3: Joint Health and Wellbeing Strategy Equality Impact Assessment

# Barking and Dagenham Joint Health and Wellbeing Strategy
2019-2023

# Contents

| | |
|---|---|
| Vision | 3 |
| Foreword | 4 |
| Context | 5 |
| Strategic Framework | 6 |
| Equality and Diversity | 8 |
| Engagement, Consultation and Co-Production | 9 |
| Vision and Priority Themes | 9 |
| Priority 1 – Best Start in Life | 10 |
| Outcome 1 | 13 |
| Priority 2 – Early Diagnosis and Intervention | 14 |
| Outcome 2 | 17 |
| Priority 3 – Building Resilience | 18 |
| Outcome 3 | 23 |
| Outcome 4 | 24 |
| Outcome 5 | 24 |
| Outcome 6 | 25 |
| Outcome 7 | 25 |
| Governance | 26 |
| References and links to supporting documents | 27 |

# Vision

By 2023, as Barking and Dagenham continues to grow, our residents will have improved health and wellbeing, with less health inequalities between Barking and Dagenham residents and the rest of London: no-one will be left behind. Our residents will have increased resilience, empowered to not just survive, but to thrive. Residents will benefit from a place-based system of care, where partners across the BHR system work together to get upstream of care and improve the health of the population. Partners will increasingly focus on outcomes and impact, rather than outputs with outcomes-based commissioning working effectively to improve outcomes for residents.

## Priority Theme 1:
**Best Start in Life**

Our residents will be best prepared for school by the age of 5, giving them the foundations of resilience.

## Priority Theme 2:
**Early Diagnosis and Intervention**

Our residents will be empowered to recognise symptoms, act on them and manage their long term conditions, through an increased focus on early diagnosis and intervention.

## Priority Theme 3:
**Building individual and community strength**

Our residents will be empowered to not survive in the face of adversity, but to thrive across the life-course.

# Foreword

The Barking and Dagenham Health and Wellbeing Board has reviewed its priorities and how to tackle health inequalities in the borough over the next 5 years. Across all partners, focusing on prevention is a priority - it offers the opportunity to improve outcomes for residents. Successful integrated prevention across partners will also reduce demand for high cost statutory and specialist health, social care and council services and help us to create a sustainable health and care system. Domestic Abuse is a priority for the Board because of the long-lasting social, economic and health impacts, making it a key public health issue for Barking and Dagenham. We will hold Health and Wellbeing Board partners to account on prioritising Domestic Abuse.

As the NHS Five Year Forward View and our North East London Sustainability Transformation Plan states, we need to get to the root cause of problems to change the health of the population. Much of the borough's poor health is linked to social causes, and the wider determinants of health: most of them can be effectively addressed outside of hospitals, GP surgeries and traditional healthcare settings. Yet, our local health and care system continues to focus on ill-health and illness rather than putting a strong emphasis on prevention, early intervention and building resilience. The Borough Manifesto recommends that a greater emphasis on preventative measures can help Barking and Dagenham to become a place that supports residents to achieve independent, healthy, safe and fulfilling lives.



To improve health and wellbeing outcomes, we need to work across partners in the Integrated Care System (ICS) to promote a place-based system of care. Through working together, we can build up resilience in our residents, and help to influence the wider determinants of health, while establishing a sustainable model of health and social care.

Since, the NHS Five Year Forward View we've been looking at new ways to engage communities on issues relating to health and care. Residents also told us during the Borough Manifesto consultation that they would like more say over their health, which is why we have co-produced this strategy with residents. We ran a series of focus groups with different community groups to find out what resident priorities are in terms of good health. We have formulated these into a series of 'I' statements which are featured within each theme of the strategy and outline a standard of what good health looks like to residents. 'I' statements will ensure that the outcomes and plans from the strategy will be rooted in what residents prioritise and want. They are used to create a person-centred strategy which will encourage partners to work together to improve the health and care of residents.

We would like to thank everybody that has been involved in developing this strategy. Residents for their views and support, the Health and Wellbeing Board, elected members and individuals who demonstrated their commitment to this important agenda. Finally, the success of any strategy is in its execution, and our first step is to widely communicate what we intend to do. We then begin the challenging and exciting journey of implementing a strategy which will deliver the best outcomes for local residents – to live longer, healthier and happier lives.

**Councillor Worby**
Cabinet Member
Social Care and Health Integration
Chair of the Health and Wellbeing Board

**Dr Jagan John**
Chair of Barking and Dagenham CCG
Deputy Chair of the Health and Wellbeing Board





# Context

The Barking and Dagenham Joint Health and Wellbeing Strategy 2015-2018 follows the previous strategy for 2012-2015. A refresh of the strategy is now required for another 5 years. Our strategy will set out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of residents' lives by 2023.

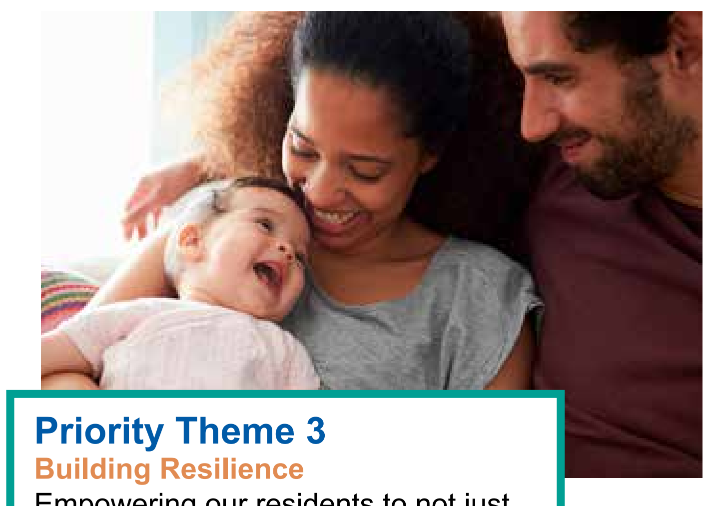
This strategy describes the key health and wellbeing outcomes for the borough. Central to this is addressing the challenges that exist and making a difference where it is needed most. To create a borough where no one is left behind, we need to place health and wellbeing at the heart of what we do. We need to empower communities to cope with, adapt to and shape change at all levels. We need to build resilience for all our residents, including those already in touch with our services and for our most vulnerable residents.

No single organisation can improve the health and wellbeing of our residents in isolation. A place-based model of health and care where organisations and partners work together to tackle the health challenges and improve the health of our population is needed. As we do not have the ability to change everything, our Health and Wellbeing Board have agreed a new approach that includes taking a system-wide focus on three priority areas that have the largest potential to create impact on our residents' lives. The three priority themes within this strategy are those where the Board thinks there is the largest potential to improve health inequalities: they have the potential to improve health and wellbeing through-out the life course from childhood into adulthood, and older life.

This strategy provides the direction for that shared goal over the next five years, overseen by the Health and Wellbeing Board. They show our ambition and the outcomes we want to achieve in the borough:

**Priority Theme 1**
**Best Start in Life**
To give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 7 years to build up their resilience.

**Priority Theme 2**
**Early Diagnosis and Intervention**
To give our residents the best chance of recovering from illness or disease.



**Priority Theme 3**
**Building Resilience**
Empowering our residents to not just survive, but to thrive.

## Our population and its health challenges: Population and Demographic data

Barking and Dagenham has a young and diverse population of around 210,700 residents in a densely populated urban location. Its population is dynamic, with the equivalent of around 1 in 12 residents leaving and entering the borough between 2016 and 2017.

Estimates suggest that as of 2019, 47% of Barking and Dagenham's population will be White, 23% Black, 23% Asian, 5% Mixed and 2% other.

Barking and Dagenham has the highest birth rate in England and Wales, with 82.6 live births per 1,000 women aged 15-44 in 2017. This is substantially higher than London and England, and the equivalent to around 1 in 12 women aged 15 to 44 having a baby in a given year, compared with around 1 in 16 in England and London.



As required by the 2012 Health and Social Care Act, this strategy has been informed by the Joint Strategic Needs Assessment (JSNA), which looks at the current and future health and social care needs of residents.

The JSNA 2017, was presented to the Health and Wellbeing Board in January 2018 and used to inform the decision on the three priority themes used in this strategy: best start in life, early diagnosis and intervention and building resilience.

In addition to this, the 2018 JSNA has been created out in parallel to this strategy and can be found here (add the link). It contains population and demographic analysis, and data relating to each theme.

# Strategic Framework

## Growth Commission Report 2016

An independent 'Growth Commission' was commissioned by the council in 2015 to consider how growth opportunities in the borough could be maximised for the benefit of all its residents. In early 2016, they delivered their report, with recommendations for achieving this.

One of the key recommendations within the Growth Commission is to focus on increasing health and life expectancy in the borough. The report details how to achieve goals listed including much more active involvement of local people and communities. This strategy focuses on improving health and life expectancy in the borough, by focusing on key areas which have the largest potential for impact.

The Growth Commission Report provided the impetus for the Borough Manifesto (below).

## The Borough Manifesto

The Borough Manifesto, 'Barking and Dagenham Together' sets out a shared vision for the borough through to 2037 aimed at around 10 themes:

- Employment, Skills and Enterprise
- Education
- Regeneration
- Housing
- Health and Social Care
- Community and Cohesion
- Environment
- Crime and Safety
- Fairness
- Arts, Culture and Leisure

These themes all impact on the health and the resilience of all residents. As such, this provides a blueprint for reducing health inequalities in the long term, not only within the borough, but also in relation to London and England. This aim is explicitly stated within the Borough Manifesto's targets, the majority of which are to improve key indicators to London and East London averages.





In particular, the outcomes within this strategy focus on helping to achieve progress in the 5 following areas of the Borough Manifesto targets:

- Healthy life expectancy better than London average by 2037
- An increased level of residents with Level 1 and Level 4 skills higher than the London average by 2037
- Unemployment rate lower than the London average by 2037
- Personal wellbeing and happiness above the London average
- Rate of regular physical activity higher than East London by 2037.

During the Borough Manifesto consultation, residents also told us they wanted to have more of a say on their health. Because of this and the recommendations of the Growth Commission to increase community engagement, we have co-produced this strategy with residents. We have run 12 resident focus groups with a total of 128 residents to find out resident priorities in terms of good health and formulated these into a series of 'I' statements which are featured within each theme of the strategy.

## Corporate Plan

The 2018-2022 London Borough of Barking and Dagenham's Corporate Plan has been created in parallel to and informed by this strategy. One of the themes of the Plan focusing on empowering people and closely aligns with the strategy his document. The Corporate Plan's focus is strengthening our services for all, and intervening early to prevent a problem from becoming a crisis, whilst protecting the most vulnerable.

## North East London Sustainability and Transformation Plan (Draft 2016)

The Sustainability and Transformation Plan (STP) outlines how the NHS in North East London will become financially sustainable and deliver improvements to health and care services by 2021. It sets out six key priorities:

- Aligning demand with the most suitable type of services, including reducing demand via prevention and self-care
- Supporting self-care, locally based care and high-quality secondary care services
- Ensuring that providers can overcome the financial challenges that many are facing
- Collaborating on specialised services
- Developing a system-wide decision-making model that enables place-based care and partnership working
- Better use of physical assets.

As a joint strategy, many of the priorities relate to collaboration and integration of services. There is already considerable partnership working between Barking and Dagenham, Redbridge and Havering, including the current review of urgent and emergency care services and the joint commissioning of a pharmaceutical needs assessment for the three boroughs.

This strategy also builds upon the transformation plans developed through Barking Havering and Redbridge Integrated Care Partnership. Taking forward the planned 6 key areas - Older People, Planned Care, Cancer Transformation, Children and Maternity, Long-term conditions and Primary Care.

A framework for person-centred care has also been developed as part of the STP which emphasises prevention and draws on the social determinants of health. Within this strategy, we will focus on outcomes-based commissioning and this model of person-centred care through the use of resident-created 'I' statements.

In order to create a condensed document, this strategy does not contain a detailed delivery plan. It will be the role of the Alliance of Providers and commissioners to outline the delivery plans and how they are held to account.

# Equality and Diversity

The Equality and Diversity Strategy is the keystone of our policy framework and notes that the borough faces stark health inequalities at all stages of the life course and outlines the council's commitments to work with partners to improve both physical and mental health outcomes in vulnerable and minority groups.

As required by the Equality Act 2010, an Equality Impact Assessment (EIA) has been completed to give regard to the impact of the priorities set out in this strategy on residents in Barking and Dagenham across the protected characteristics.

The EIA found that overall the Strategy has in place actions that will contribute to the reduction of existing barriers to equality and address potential inequalities, as its overarching purpose is to address the greatest need by reducing health inequalities through universal and targeted action.



Firstly, the strategy is data-driven, looking at what the current gaps in service provision are and to assess what current and future demand might look like so that we can use resources wisely and effectively. The three priorities for the strategy were decided by the Health and Wellbeing Board based on the findings of the Joint Strategic Needs Assessment 2017. This data looks at all groups of residents, including those vulnerable groups listed in the Equality and Diversity Strategy.

Secondly, this document contains a series of 'I' statements, which ensure that local communities are represented in the strategy. Resident focus-groups have ensured that different groups of protected characteristics are represented in the co-production of this document. We have spoken to community groups with disabilities, LGBT+ Groups, Mental Health Peer Support Groups, Carers and Children in Care groups amongst others. We have also ensured a variety of ages, genders and ethnicities have been spoken to, and included these views within each theme of the strategy in the form of 'I' statements. These 'I' statements will encourage providers and commissioners to work around the needs of residents.

The Full EIA can be found (lbbd.gov.uk/INSERTLINK).





# Engagement, Consultation and Co-Production

As the NHS Five Year Forward View outlines, we need to engage with communities and residents in new ways, involving them directly in decisions about the future of health and care services. This strategy has been co-produced with Barking and Dagenham residents. Through our resident focus groups, residents' thoughts have been included in the form of 'I' statements, outlining what good health means for residents, placing them at the heart of this strategy. These are included within each theme of the strategy and will be monitored by the Health and Wellbeing Board.

We also held 3 successful professional workshops on each theme of the strategy in July, to discuss the outcomes and measures to be used within the strategy. The outcomes, measures and pledges within the strategy have been developed from conversations with stakeholders and residents.

The outcomes within this strategy set out what we want to achieve in Barking and Dagenham, the principles detail our commitments within this and the measures demonstrate how we'll check that partners are on track. The Alliance of Providers and commissioners will use this to create detailed delivery plans with actions that they will take forward over the next 5 years to help achieve our ambitious outcomes.

In return, every resident has the responsibility to play their part and make positive and healthy decisions for themselves, their families and the community.

# Vision and Priority Themes

By 2023, as Barking and Dagenham continues to grow, residents will have improved health and wellbeing, with less health inequalities between Barking and Dagenham residents and the rest of London: no-one will be left behind. This will be achieved by focusing on the three priority areas where we have the largest potential to make a difference. Our residents will have increased resilience, empowered to not just survive, but to thrive. Residents will benefit from partners working together around their needs and priorities, focusing on outcomes, as opposed to a focus on process and outputs.

These three priority themes were decided by the Health and Wellbeing Board in January 2018 when presented with the 2017 Joint Strategic Needs Assessment:

## Priority Theme 1
### Best Start in Life
To give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 7 years. Evidence demonstrates that the Early Years shape mental and physical health for the rest of life, and is therefore a key time to invest.

## Priority Theme 2
### Early Diagnosis and Intervention
To give our residents the best chance of recovering from illness or disease by removing barriers to Early Diagnosis and Intervention in 5 key areas – Cancer, Liver Disease, Mental Health, Diabetes and Sexual Health. Focusing on Early Diagnosis and Intervention improves outcomes for residents, while being cost-effective for our services.

## Priority Theme 3
### Building Resilience
Enabling our residents to not just survive, but to thrive across the life course. Focusing on 4 key areas, each at a different stage in the life course, we will focus on building resilience in our residents, even in the face of adversity.

Credit ©Jimmy Lee

Page 76

# Priority 1
## Best Start in Life

***Ensuring every child has the best start in life – To give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 7 years.***

### Why Best Start in Life?

There is a strong case for focusing on the first 5 years of life in Barking and Dagenham. As outlined in our 2018 JSNA, **we have the highest proportion of residents aged 0-4 in the UK.**

We expect to have around 20,300 Under 5's in the borough in 2019, with this projected to grow to 21,600 by 2023. **Our 2017 birth rate was also the highest in England and Wales at** 82.56 live births per 1000 women between the ages of 15 and 44.

The Marmot Review demonstrates that the first 5 years of life have a huge impact on almost every aspect of physical and mental health for the rest of life, including obesity and mental health. We have opted to have our best start in life up until the age of 7, because we want to ensure that we prioritise the transition from home into school. This is to prioritise managing the transition between the school and home effectively, and focus on providing continuity of care from primary and home including play and communication. We also know that this transition period is a key time to identify and support our vulnerable children. Evidence from Public Health England demonstrates that **for every £1 spent in the Early Years, £7 would have to be spent in adolescence to have the same impact on health.**

Ensuring that every resident has the best start in life so that they are ready to start school at the age of 5, both improves outcomes for residents and is cost-effective for our services. Evidence also shows that the Early Years are crucial for protecting against adverse experiences throughout life. Through working in partnership to help families navigate through the early parenting journey, and providing them with support, we can improve outcomes for residents throughout the life course.

**The number of Barking and Dagenham children who achieved a good level of development by the age of 5 is lower than London.** In 2016/17, 71.6% of children in the borough achieved a good level of development by the age of 5.

Therefore, we will focus on ensuring our residents have the best start in life, to give them the foundations for resilience for the rest of their lives.





## Enablers: What needs to change? Our pledges

**1. Resilience**
Work to build up a universal level of resilience across all Early Years Services to provide our under 8s with the building blocks for resilience that they need.

**2. Seek alternative community solutions earlier**
Focus our efforts on utilising alternatives and community solutions earlier, reserving specialist and statutory servcies for our most vulnerable residents.

**3. Safeguarding**
Focus on protecting vulnerable children within our communities.

**4. A focus on communities where there is largest potential for impact**
Focus on the first 7 years, because evidence shows this is a key time to invest to influence outcomes through-out adulthood.

**5. Co-production**
With services we provide, putting residents at the heart of service design and the different ways in which residents have children.

**6. Family based approach**
Take a family-based approach to increase prevention and reduce the impacts of adversity and challenges on children and young people.

**7. Integrated care**
Work in partnership to ensure that health and social care is personalised, and delivered in the right place at the right time - in community settings and close to home where possible.

**8. Providing quality services through our workforce**
Ensure that our services are both clinically effective and cost-effective. We will work to ensure that our staff are trained with the skills our residents require to give their children the best start in life.

**9. Investigating the drivers of adversity**
Work together to look at the factors driving adversity and challenges in partnership.

**10. Speaking straight**
Have honest and open conversations with our residents about their child's expected level of development by the age of 5, why this is important and how our services can support them.

# Outcome 1

## To increase the percentage of children in Barking and Dagenham who are best prepared to start school by the age of 5.

To ensure that children in Barking and Dagenham have the best start in life, we will look at outcome measures across the life-course. These were co-created by participants:

- Decreased number of women smoking at the time of delivery
- Increased immunisation rates (at MMR2)
- Higher proportion of children receiving their 2 year developmental check
- Increased % of Barking and Dagenham children achieving a good level of social and emotional development by the age of 5
- Increased % of Barking and Dagenham children achieving a good level of development by the age of 5
- Decreased obesity prevalence in reception aged children (National Child Measurement Programme)

### ‘I’ statements produced through resident focus groups

The below ‘I’ statements have been formulated through resident focus groups – they describe a good standard of health and wellbeing in relation to best start in life:

**‘I’ statement 1**
I am provided with information about how best to ensure my child’s health and development

**‘I’ statement 2**
I am supported to meet other parents in the community

**‘I’ statement 3**
I am supported to make healthy choices for me and my child

Page 78

# Priority 2

## Early Diagnosis and Intervention

***To give our residents the best chance of recovering from illness or disease by removing barriers to Early Diagnosis and Intervention in 5 key areas – Cancer, Liver Disease, Mental Health, Diabetes and Sexual Health***

**Why Early Diagnosis and Intervention?**
As outlined in our JSNA 2018, our residents are affected by long-term conditions more than we would like. We have **the highest rate of deaths from cancer considered preventable in London.** Despite our young population, **we have the third highest prevalence of chronic obstructive pulmonary disease (COPD) in London**, and the second highest rate of emergency COPD-related hospital admissions.

**Barking and Dagenham also has the third highest proportion of late HIV diagnosis in London** – people whose HIV infection is diagnosed late have a 10-fold increased risk of dying within the first year, compared to those diagnosed early.

Early diagnosis and intervention can decrease avoidable mortality, social costs, dependence on service and complications in care and management for a range of conditions. It is therefore key to **improving outcomes for individuals and communities, while helping health services to effectively manage demand.**

Working across partners, prioritising early diagnosis and intervention and looking how we can improve the patient journey from diagnosis can create real change for residents and our health care system. Early diagnosis and intervention decreases avoidable mortality, social costs, dependence on services and complications in care and management.





## Enablers: What needs to change? Our pledges

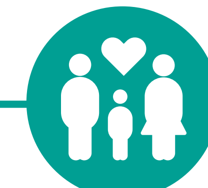
**1. Resilience**
Work to build up a universal level of resilience to generate new ways of thinking around their long-term conditions.

**2. Seek alternative community solutions earlier**
Focus our efforts on early intervention and prevention. We will use social prescribing to reduce the demand to our high-cost specialist services.

**3. Safeguarding**
Focus on protecting vulnerable children and adults within our communities.

**4. A focus on communities where there is largest potential for impact**
Focus on the five conditions which have been identified as having the largest potential for impacts.

**5. Co-production**
Put residents at the heart of service design to ensure that our services are designed around the needs of our residents, and their support needs.

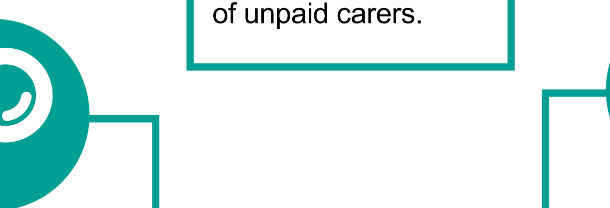


**6. Family based approach**
Take a family-based approach to supporting residents with long-term conditions. We hugely value the role of unpaid carers.

**7. Integrated care**
Work in partnership to ensure that health and social care is personalised, and delivered in the right place at the right time - in community settings and close to home where possible.

**8. Providing quality services through our workforce**
Ensure that our services are safe-and evidence-based, and cost-effective. We will work to ensure that our staff are trained to provide the support our residents require.

**9. Investigating the drivers of adversity**
Work together to look at the factors driving adversity and challenges in partnership.



**10. Speaking straight**
Have honest and open conversations with our residents about their health, how services can support them and manage expectations around waiting times, and treatment delays.

# Outcome 2

## To increase healthy life expectancy by removing barriers to early diagnosis and intervention in 5 key areas.

To achieve the 'Borough Manifesto' target of healthy life expectancy better than the London average by 2037, we will look at the following outcome measures across the 5 key conditions to improve early diagnosis and intervention. These were co-created by participants at our Early Diagnosis and Intervention workshop in July:

- Increased uptake in screening programmes in the eligible population
- Increased proportion of NHS health checks completed in eligible population
- Decreased proportion of HIV diagnosis diagnosed late
- Increased proportion of cancers diagnosed at an early stage

### 'I' statements produced through resident focus groups

The below 'I' statements have been formulated through resident focus groups – they describe a good standard of health and wellbeing in relation to early diagnosis and intervention:

**'I' statement 4**
I feel my mental health conditions are treated with the same respect as my physical conditions without stigma

**'I' statement 5**
When I am diagnosed, my family and I know where to find community support services, including emotional support

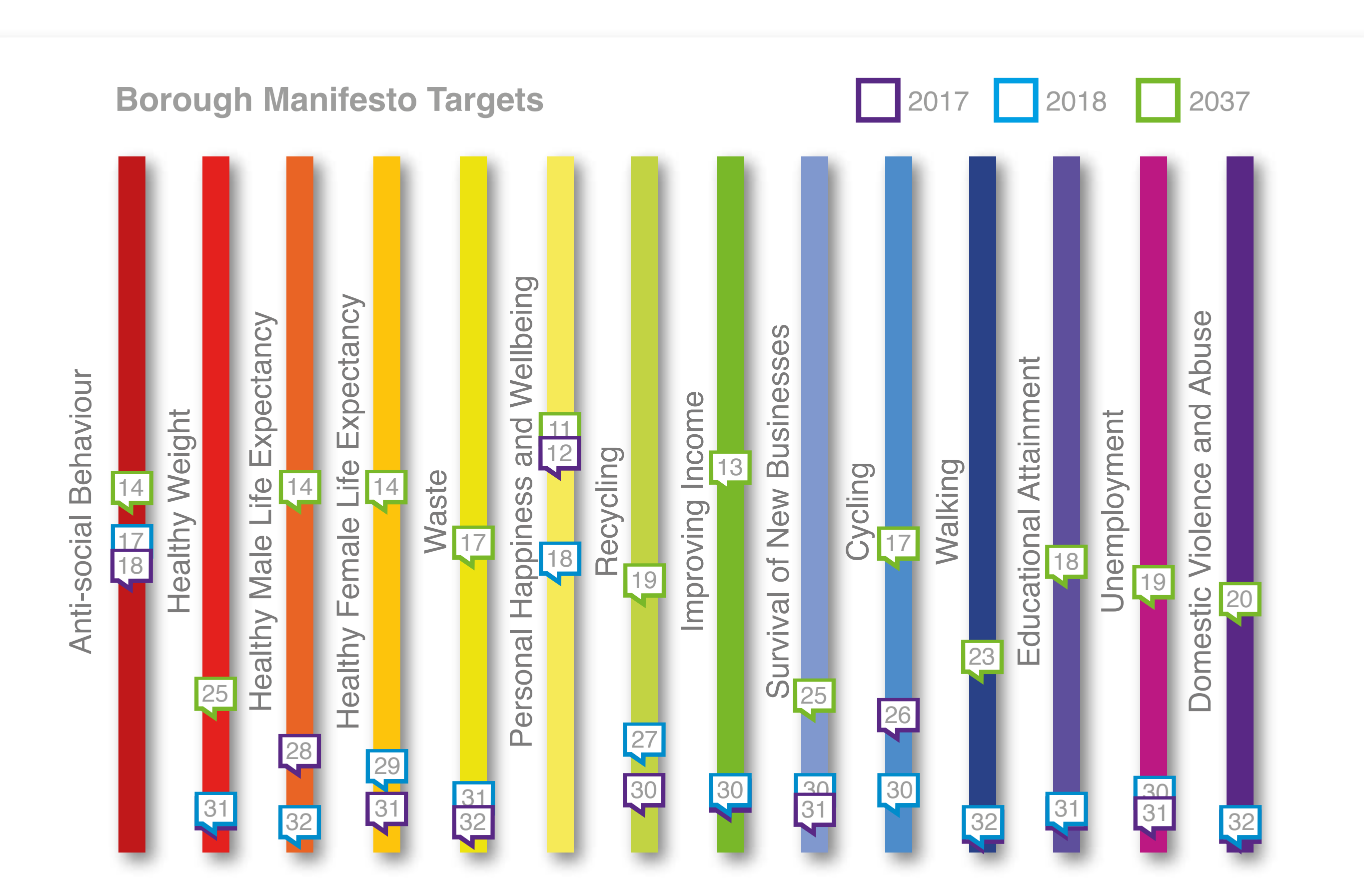
**'I' statement 6**
When I am diagnosed, I am supported with the information about my condition I need to make decisions and choices

# Priority 3
## Building Resilience

***Empowering our residents to not just survive, but to thrive across the life-course.***

**Why resilience?**
As outlined in our 2018 JSNA, we know that our residents face more health inequality and adversity in a range of areas than we would like. Our Borough Manifesto also highlights the scale of the challenge in Barking and Dagenham.

**Outcomes for residents are towards the bottom of most London league tables.** The graph below shows where Barking and Dagenham aspires to be in London league tables by 2037, alongside where we were in 2017 and where we are now in 2018. The graph shows our performance one year into the 20-year vision of the Manifesto. Shifting outcomes up the league tables in sustainable ways will take years, and even decades to achieve. The targets are deliberately long-term in nature:

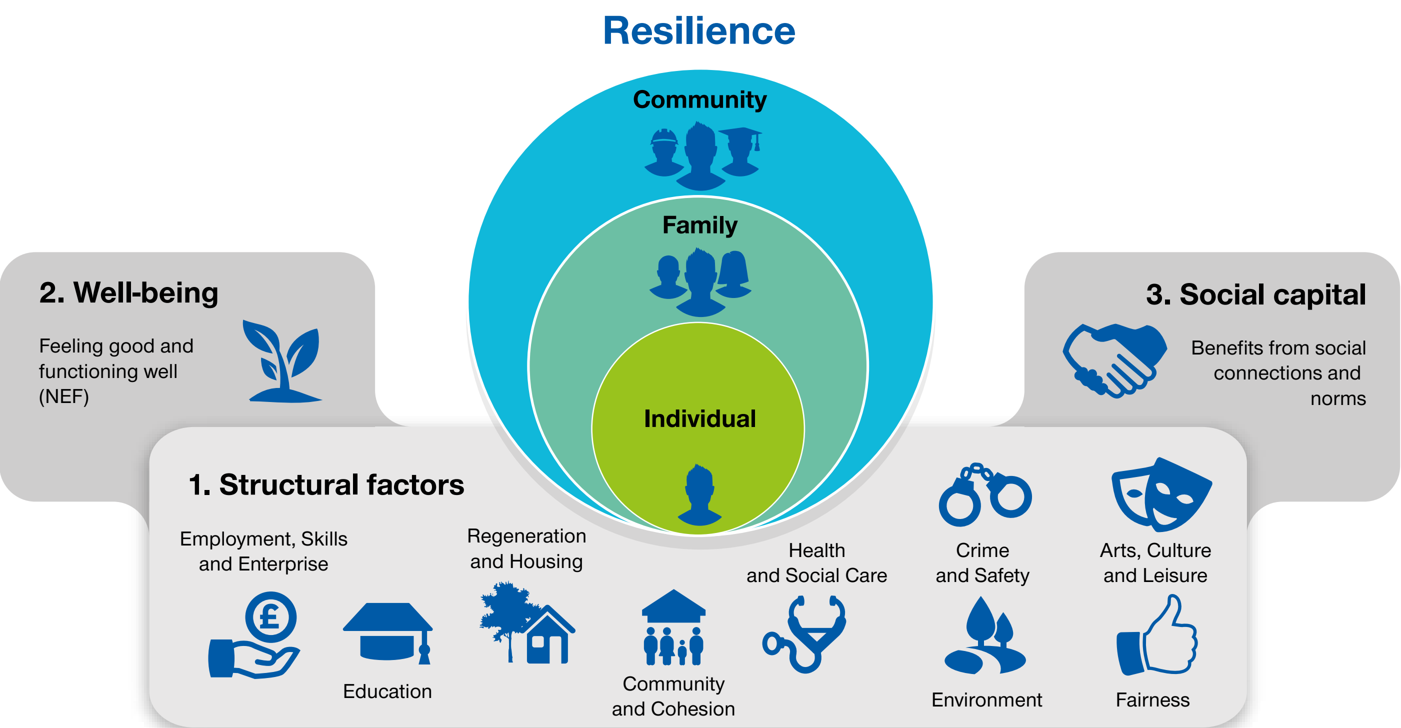









The 10 themes in the Borough Manifesto can all be seen as structural factors that impact on resilience – these themes empower residents to build resilience at a structural level. The below graphic demonstrates that looking at the interlink between these structural factors, well-being and social capital is important to understand how we can empower residents to build resilience:




Trauma-informed intervention models raise awareness of the impact that adversity and trauma can have on an individual. The borough's Community Safety Partnership are also looking at using trauma-informed models to look at problems such as gang violence and substance misuse. Some of the above structural factors are also protective factors within these trauma-informed intervention models – for instance, evidence demonstrates that educational attainment and community participation reduces the risk of young people being involved in violence.

Solving these complex problems requires partners to work together and develop a place-based system of health and care and an integrated approach to prevention. A collective approach is required, where **all agencies have a shared agenda for change,** including a common understanding of the problem.

Prioritising early help for residents can improve residents' health and wellbeing, while importantly reducing demand for specialist and statutory services. To build resilience, evidence by Public Health England talks about how we can do this at three levels – **individual, family and community**:

**Building resilience**
*'the ability to cope with adversity and adapt to change'*
Source: PHE (2016)

FAMILY
Effective caregiving & parenting
Intelligence & problem solving skills
Self regulation skills
Perceived efficacy and control
INDIVIDUAL
Achievement motivation
Faith, hope, spirituality
Beliefs that life has meaning
Positive relations with caring adults
Positive friends or romantic partners
Effective teachers and schools
COMMUNITY
Resilience is important for emotional wellbeing. Correlates of resilience in young people include:

Page 81

## Our Approach

Resilience operates differently at different levels, and a one-size fits all approach won't work. A targeted approach will allow us to focus on the challenges at hand and increase prevention. Building resilience in all our residents, many of whom don't regularly access council, police or NHS services, requires a very different approach to those residents who need a bit more help, and are already in regular contact with some of our services.

Similarly, our residents who are in regular touch with some of our services, require a different approach to our most vulnerable residents, who are accessing our statutory and specialist services.

As our residents' transition through the life-course, we also need to ensure that the support to maintain and build their resilience is there.

The role of this strategy is with limited resource to focus on the areas that have the largest potential to improve the health and wellbeing of residents over the next 5 years – we will work to build resilience across all these levels to empower and re-empower all communities and increase prevention. To do this, we will work towards achieving four outcomes, each looking at an area of the life-course and focusing on where we can have the biggest impact on the health and wellbeing of our residents in these areas.





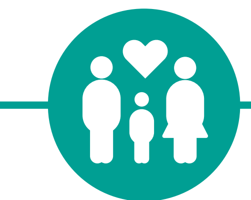
## Enablers: What needs to change? Our pledges

**1. Resilience**
Work to build up a universal level of resilience.

**5. Co-production**
Put residents at the heart of service design to ensure that our services are designed around the needs of our residents, and their support needs.

**9. Investigating the drivers of adversity**
Work together to look at the factors driving adversity and challenges we're facing in the borough.

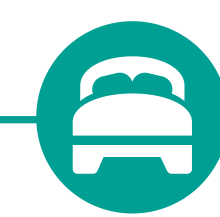
**2. Seek alternative community solutions earlier**
Work to use alternative and community solutions earlier, working with the community and voluntary sector"



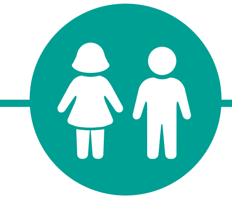
**6. Family based approach**
Commit to take a family-based approach to deal with domestic violence and abuse, child sexual exploitation and abuse.

**10. Speaking straight**
Have honest and open conversations with our residents about the signs of DVA, CSE and serious crime, where to get help and why we need to work together to tackle these problems.

**3. Safeguarding**
Focus on protecting vulnerable children and adults within our communities.



**7. Integrated care**
Work in partnership to ensure that health and social care is personalised, and delivered in the right place at the right time - in community settings and close to home where possible.



**11. Peer to Peer**
Work to use peer to peer models to make a difference to engage with survivors of DVA, CSE and serious crime.

**4. A focus on communities where there is largest potential for impact**
Focus on residents who need a bit more help in key areas that evidence demonstrates impacts resilience.

**8. Providing quality services through our workforce**
Ensure that our services are safe-and evidence-based, and cost-effective. We will work to ensure that our staff are trained to provide the support our residents require.

**12. Mobilising communities**
Work to use formal and informal community resources to help foster shared responsibility and support.

# Outcome 3

## Improved multi-agency support for those with Adverse Childhood Experiences

The framework of Adverse Childhood Experiences (ACEs) can help us to understand how a focus on building resilience, early intervention and an awareness of the impact of trauma can improve residents' health and wellbeing. ACEs are defined as traumatic experiences that occur before the age of 18 and have impacts on a range of mental, social and physical health issues for the rest of adulthood. These include abuse, neglect, domestic violence and substance misuse.

The more ACEs an individual experiences in childhood, the greater the risk to their overall health and wellbeing. Research demonstrates that those who face four or more ACEs within childhood are significantly more likely to have a range of health and social related problems.

Evidence also suggests that those **suffering from ACEs are more likely to have higher GP use, greater use of emergency care and increased hospitalisation.** The more ACEs an individual experiences in their childhood, the more their interaction with health services throughout adulthood.

These impacts show the benefits that a two-tier approach of provision and prevention to resilience can have. We have a range of strategic documents that outline how we will specifically focus on tackling these key challenges. For instance, Our Violence Against Women and Girls Strategy 2018-2022 outlines our approach to Domestic Violence and Abuse, and our 2018-2021Community Safety Partnership outlines our approach to tackling serious violence and hate crime and extremism. Our Local Safeguarding Children's Board Early Help Strategy outlines our approach to intervening early in cases of neglect, and abuse.

**Heart Disease** 2.9 times more likely

**COPD** almost 4 times as likely

**Been hit in the last 12 months** 5.2 times more likely

**Cancer** 1.6 times more likely

**Suicide** 12.2 times more likely

**Been in prison or cells in the last 12 months** 7.9 times more likely

If we can intervene before these problems become a crisis, we can help individuals while reducing the demand for our health, social and wider council services. Working across partners to look at the journey our residents face when dealing with these issues, and in particular their journey when referred to social care, will help us to make real changes to residents' lives.

Looking at Adverse Childhood Experiences is also a way in which the Community Safety Plan 2018-2021 will work to achieve its priority of keeping children and young people safe. The Health and Wellbeing Board will work with the Community Safety Partnership to tackle the impacts of Adverse Childhood Experiences in partnership and increase awareness of the impact of trauma on behaviour:

To measure our progress, we will look at the following resilience measures over the next 5 years:

- Improved engagement rate through specialist advocacy Domestic Violence services
- Increased % of drug service users with trauma-informed care programmes and completion rates
- Increased number of early help referrals from ComSol Triage to Support visited within 72 hours
- Increased IAPT (Improving Access to Psychological Therapies) completion rate per 100,000 population
- Decrease % of young people reporting an acceptance of unhealthy behaviours in school survey

# Outcome 4

## Aspiration: Increased level of educational attainment, skills and employment

Worklessness is an important public health issue. There is strong evidence that shows that for most of the population, being in 'good' work is better for residents' mental and physical health, than being out of work. The income from work also allows residents to meet their basic needs and withstand financial shocks.

Within the borough, 6.9% of working age people are unemployed, higher than the London average of 5.7%. We also know that 32% of working people who live in the borough are paid below the London living wage. 15% of residents are estimated to be in elementary occupations, compared to the London average of 9%.



The Borough Manifesto' targets those with Level 1 and 4 skills to be better than the London average, and for unemployment to be lower than the London average by 2037. To help achieve this, over the next 5 years we will look at the following resilience measures:

- Increased attendance levels from those who are persistently absent from school
- Increased % of those with Level 1, Level 3 and Level 4 skills (attainment)
- Reduced % of 16-17 years old who are not in employment, education or training (NEET)
- Increased % of Barking and Dagenham Job Shop outcomes sustained
- % of young people feeling optimistic about the future (Schools Survey)

# Outcome 5

## To improve physical and mental wellbeing

At an individual level, living well at any age has huge impacts on resilience, health and wellbeing. Evidence links participation in the community, feelings of safety and physical activity levels to wellbeing.

The Borough Manifesto' sets an ambition for healthy weight to be better than the East London average by 2037, personal wellbeing and happiness to be above the London average, healthy life expectancy to be better than London average and rate of regular physical activity to be higher than East London by 2037. To help achieve these targets, over the next 5 years we will look at the following resilience measures:

- Reduced level of physical inactivity levels
- Increased residents using outdoor space for physical activity
- Increased residents participating in the community
- Perceived community harmony (%) – think that the neighbourhood is an area where people get on well together (residents survey)
- Proportion of residents feeling safe in their local area during the day, and after dark
- Mental Health – "During your last general practice appointment, did you feel that the healthcare professional recognised and/or understood any mental health needs that you might have had?" (Annual GP survey)





# Outcome 6

## Ageing Well: An increased level of residents who age well

All residents have the right to age well with dignity, independence and autonomy. To help monitor our progress, over the next 5 years we will look at the following resilience measures:

- Reduced number of first time and recurrent falls in Barking and Dagenham
- Decreased % of adult social care users who would like more social contact
- Decreased % of adult carers who would like more social contact
- Increased % of life in good health (healthy life expectancy as a proportion of life expectancy)

# Outcome 7

## A borough with zero tolerance to Domestic Abuse that tackles underlying causes, challenges perpetrators, and empowers survivors

Domestic abuse has severe long-lasting and wide-ranging social, health and economic impacts in Barking and Dagenham. It is not ok, and we will not tolerate it. We will work differently across partners around domestic violence across the life course, to re-empower domestic abuse survivors to thrive in our communities, and to take a zero tolerance approach to abusive behaviours. To help monitor our progress and to hold ourselves accountable, over the next 5 years we will look at the following resilience measures:

- Improved engagement rate through specialist advocacy Domestic Violence services

- Reduced number of child-in-need re-referrals related to Domestic Abuse
- Decreased % of young people reporting an acceptance of unhealthy behaviours in school survey

### 'I' statements produced through resident focus groups

The below 'I' statements have been formulated through resident focus groups – they describe a good standard of health and wellbeing in relation to early diagnosis and intervention:

**'I' statement 7**
I feel safe in my home and in my family, and my community, and I know where to go for help

**'I' statement 8**
I have opportunities to connect to individuals and communities

**'I' statement 9**
I can access mental health support services when I need them

# Governance

Producing the Joint Health and Wellbeing Strategy is a statutory requirement of the Health and Wellbeing Board. The outcomes and measures featured within this strategy will form the performance monitoring report which goes to the Health and Wellbeing Board every quarter and will be discussed by the board.

This strategy will be used by commissioners and the Alliance of Providers to create a detailed delivery plan, which notes the outputs and workstreams that will help us to achieve these outcomes.

Performance management arrangements have been developed for the strategy in order to measure its effectiveness. This ensures responsibility and accountability of the outcomes and measures within it. The Health and Wellbeing Board will hold NHS and social care organisations to account through the strategy.

# References and links to supporting documents

List and link all relevant documents to support the strategy, including:

**Health and Wellbeing Board Reports**
- Barking and Dagenham Joint Health and Wellbeing Strategy 2015-2018 - https://www.lbbd.gov.uk/sites/default/files/attachments/Joint-health-and-wellbeing-strategy-2015-18.pdf
- Barking and Dagenham Joint Strategic Needs Assessment 2017 - https://www.lbbd.gov.uk/sites/default/files/attachments/JSNA-2017-report.pdf
- Creation of the Joint Health and Wellbeing Strategy, Barking and Dagenham Health and Wellbeing Board, March 2017 https://modgov.lbbd.gov.uk/Internet/documents/s121000/Item%208.%20Creation%20of%20the%20Joint%20Health%20and%20Wellbeing%20Strategy.pdf
- Update on Development of Joint Health and Wellbeing Strategy, Barking and Dagenham Health and Wellbeing Board, September 2018 - https://modgov.lbbd.gov.uk/internet/documents/s125718/JHWS%20Update%20Report.pdf

**Best Start in Life**
Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair Society, Healthy Lives: The Marmot Review. London: UCL; 2010 - http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
- PHE, Health Matters: Ensuring all children have the best start in life https://publichealthmatters.blog.gov.uk/2015/08/10/ensuring-all-children-have-the-best-start-in-life/, 2015

**Early Diagnosis and Intervention**
- PHE, Public Health Outcomes Framework - http://www.phoutcomes.info/.

**Building Resilience**
- Institute of Health Inequality, The Impact of Adverse Experiences in the home on children and young people, 2015 http://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf
- Bellis M, Hughes K, Hardcastle K, Ashton K, Ford K et al. The impact of childhood experiences on health service use across the life course using a retrospective cohort study, Journal of Health Services Research and Policy https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5549819/. 2017
ONS. Understanding well-being inequalities: Who has the poorest personal well being? https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articlesunderstandingwellbeinginequalitieswhohasthepoorestpersonalwellbeing/2018-07-11, 2014

**Key documents**
- JSNA 2018
- EIA

**Internal documents/strategies which inform this strategy**
- Barking and Dagenham Together: Borough Manifesto - https://www.lbbd.gov.uk/sites/default/files/attachments/Barking-and-Dagenham-Together-Borough-Manifesto.pdf
- Borough Manifesto targets rationale - https://www.lbbd.gov.uk/sites/default/files/attachments/Targets-rationale.pdf
- State of the Borough: Barking and Dagenham 2018 - https://www.lbbd.gov.uk/sites/default/files/attachments/State%20of%20the%20Borough%20report-compressed.pdf
- North East London Sustainability and Transformation Plan, 2016 - http://eastlondonhcp.nhs.uk/wp-content/uploads/2017/06/NEL-STP-draft-policy-in-development-21-October-2016.pdf
- Violence Against Women and Girls Strategy (VAWG Strategy)
- Community Safety Plan 2019-2022

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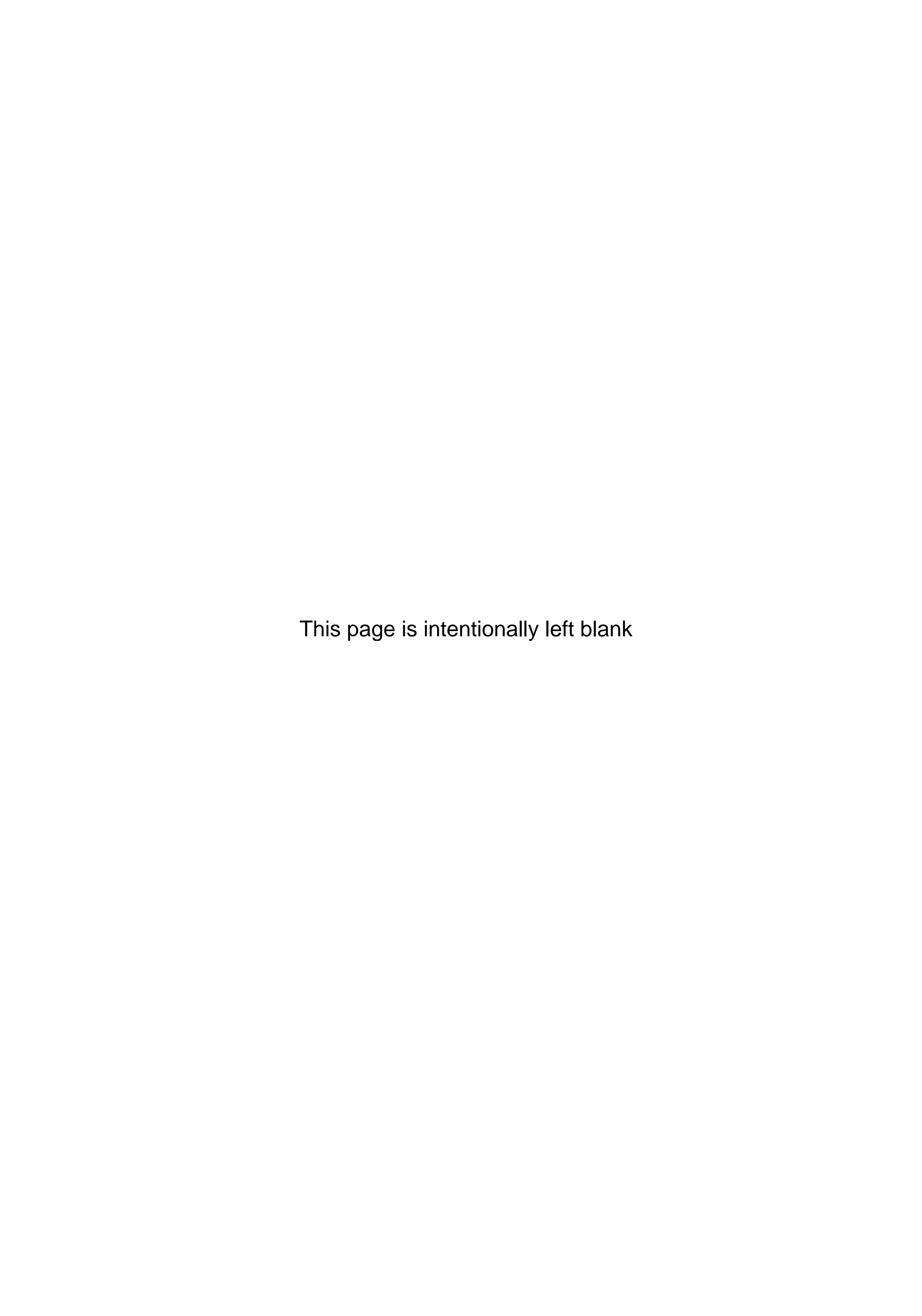
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# Joint Strategic Needs Assessment 2018

## London Borough of Barking and Dagenham

## Contents

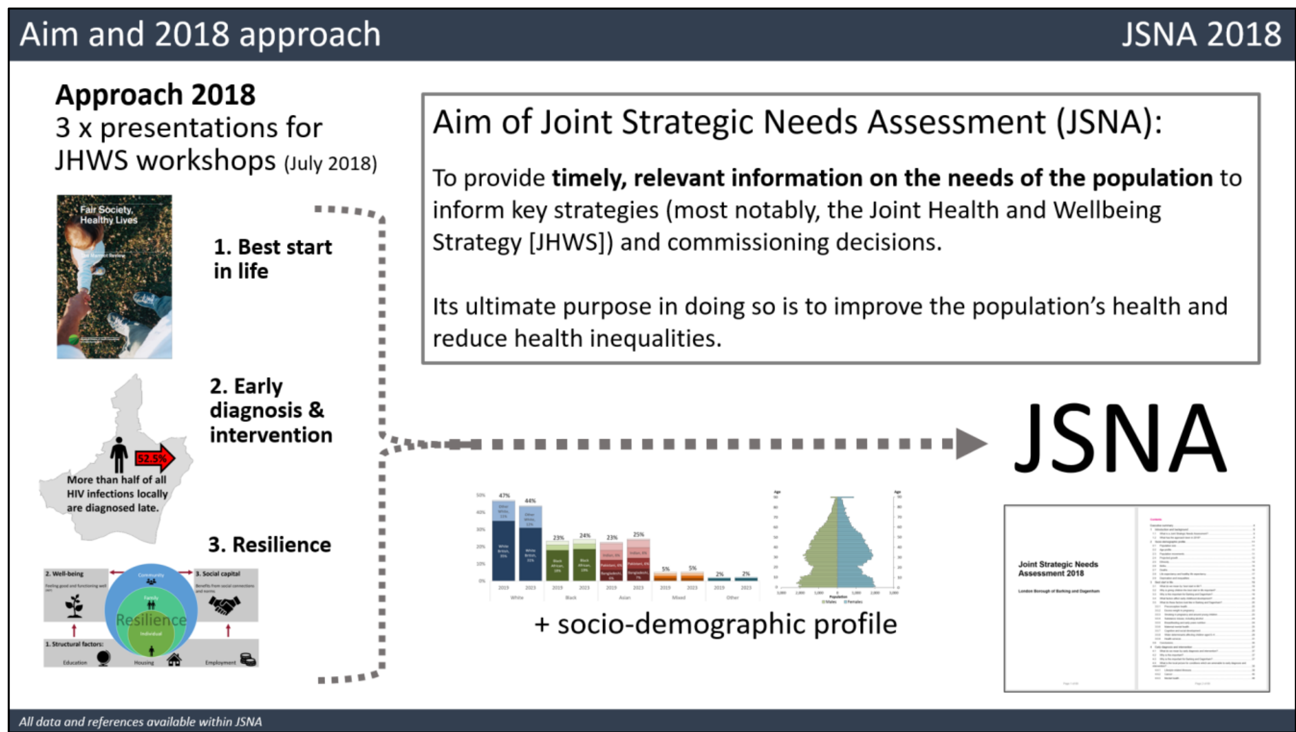

Executive summary ....4
1 Introduction and background ....8
1.1 What is a Joint Strategic Needs Assessment? ....8
1.2 What has the approach been in 2018? ....8
2 Socio-demographic profile ....10
2.1 Population size ....10
2.2 Age profile ....10
2.3 Population movements ....10
2.4 Projected growth ....11
2.5 Ethnicity ....13
2.6 Births ....14
2.7 Deaths ....15
2.8 Life expectancy and healthy life expectancy ....16
2.9 Deprivation and inequalities ....17
3 Best start in life ....18
3.1 What do we mean by ‘best start in life’? ....18
3.2 Why is giving children the best start in life important? ....18
3.3 Why is this important for Barking and Dagenham? ....18
3.4 What factors affect early childhood development? ....19
3.5 What do these factors look like in Barking and Dagenham? ....19
3.5.1 Preconception health ....19
3.5.2 Excess weight in pregnancy ....21
3.5.3 Smoking in pregnancy and around young children ....22
3.5.4 Substance misuse, including alcohol ....23
3.5.5 Breastfeeding and early years nutrition ....24
3.5.6 Maternal mental health ....25
3.5.7 Cognitive and social development ....25
3.5.8 Wider determinants affecting children aged 0–4 ....27
3.5.9 Health services ....31
3.6 Conclusions ....34
4 Early diagnosis and intervention ....36
4.1 What do we mean by early diagnosis and intervention? ....36
4.2 Why is this important? ....36
4.3 Why is this important for Barking and Dagenham? ....36
4.4 What is the local picture for conditions which are amenable to early diagnosis and intervention? ....37
4.4.1 Lifestyle-related illnesses ....37
4.4.2 Cancer ....44
4.4.3 Mental health ....47

4.4.4 Sexual health ........ 50
4.5 Conclusions ........ 52
5 Resilience ........ 54
5.1 What is resilience? ........ 54
5.2 Why is resilience important? ........ 54
5.3 Why is resilience important for Barking and Dagenham? ........ 54
5.4 What builds resilience? ........ 54
5.5 Structural factors ........ 55
5.5.1 Education ........ 55
5.5.2 Housing ........ 56
5.5.3 Employment ........ 58
5.6 Wellbeing ........ 62
5.7 Social capital ........ 64
5.8 Conclusions ........ 67

## Executive summary

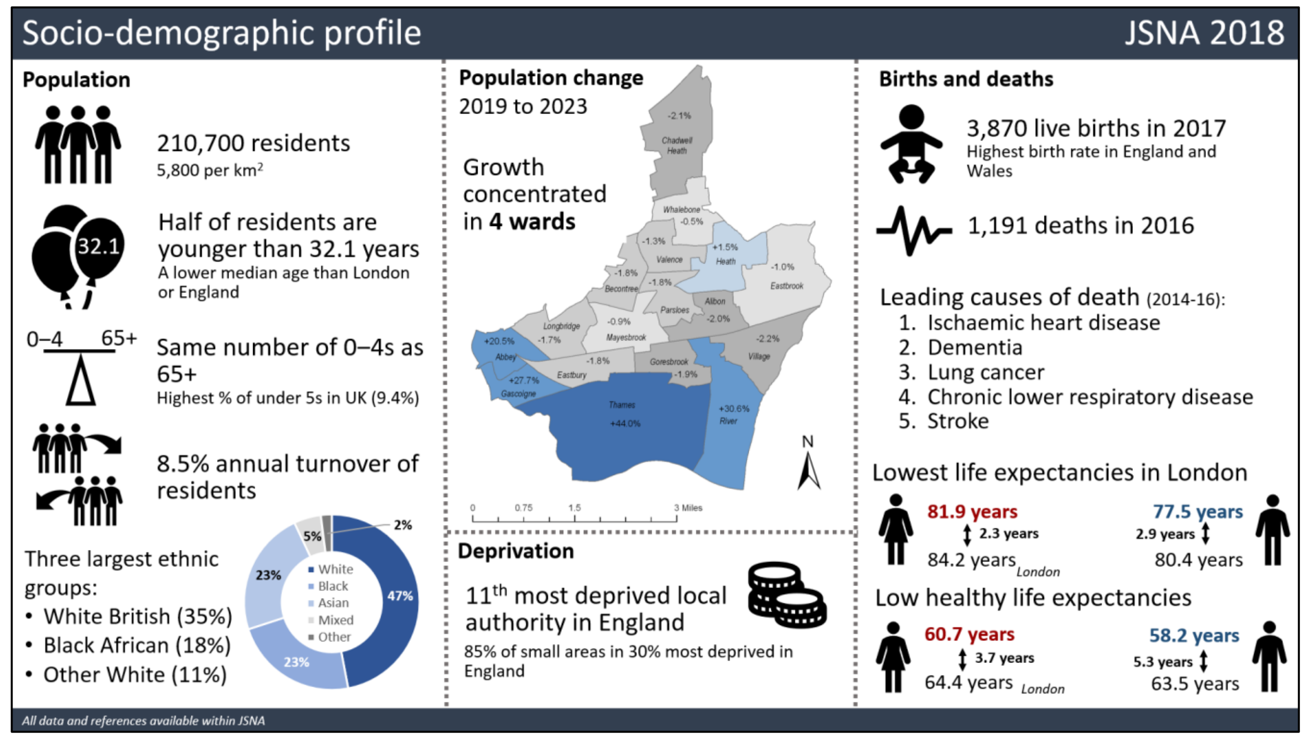
### Introduction and background

This Joint Strategic Needs Assessment (JSNA) is based upon presentations given to three themed workshops informing the Joint Health and Wellbeing Strategy in July 2018. As such, this JSNA directly provided an evidence base for the 2019–2023 Strategy.

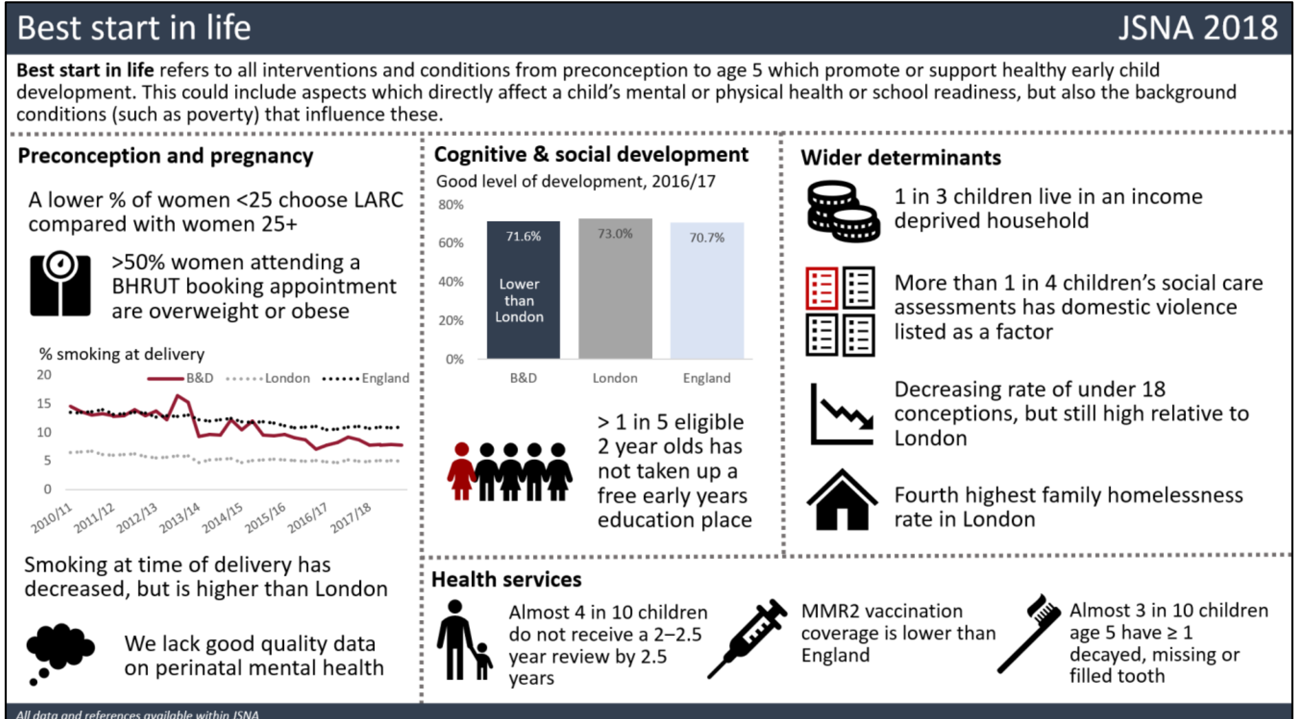



### Socio-demographic profile

Barking and Dagenham has a young and diverse population of around 210,700 residents in a densely populated, urban location.



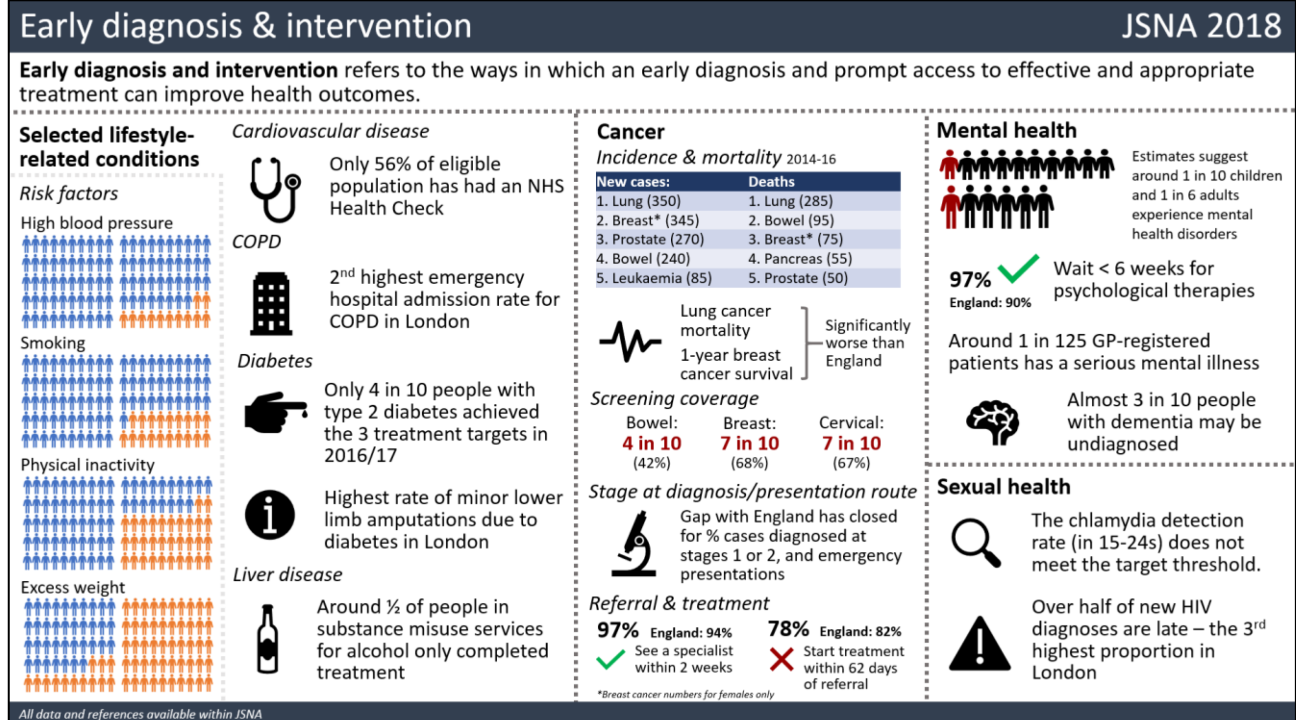
## Best start in life




*Key implications for commissioning:*

- Improving adult population health in areas such as excess weight and physical activity (both Borough Manifesto targets) would benefit the next generation.
- Ensuring women are aware of the benefits and can access long-acting reversible contraceptives (LARC) may give them more control over when or if they choose to become pregnant.
- Pregnancy should continue to be recognised as a key moment to help women and their partners make a long-term change in areas such as smoking cessation.
- We should explore how we can bring together existing sources of early years data to effectively monitor and identify inequalities and areas for improvement.
- We should continue to improve take-up of funded early years places, while continuing to support parents to develop a suitable home learning environment.
- Services should recognise that the conditions in which children spend their early years are likely to have a large impact on their future health outcomes.
- Services should continue to find ways to identify and reach children who have not received vaccinations.

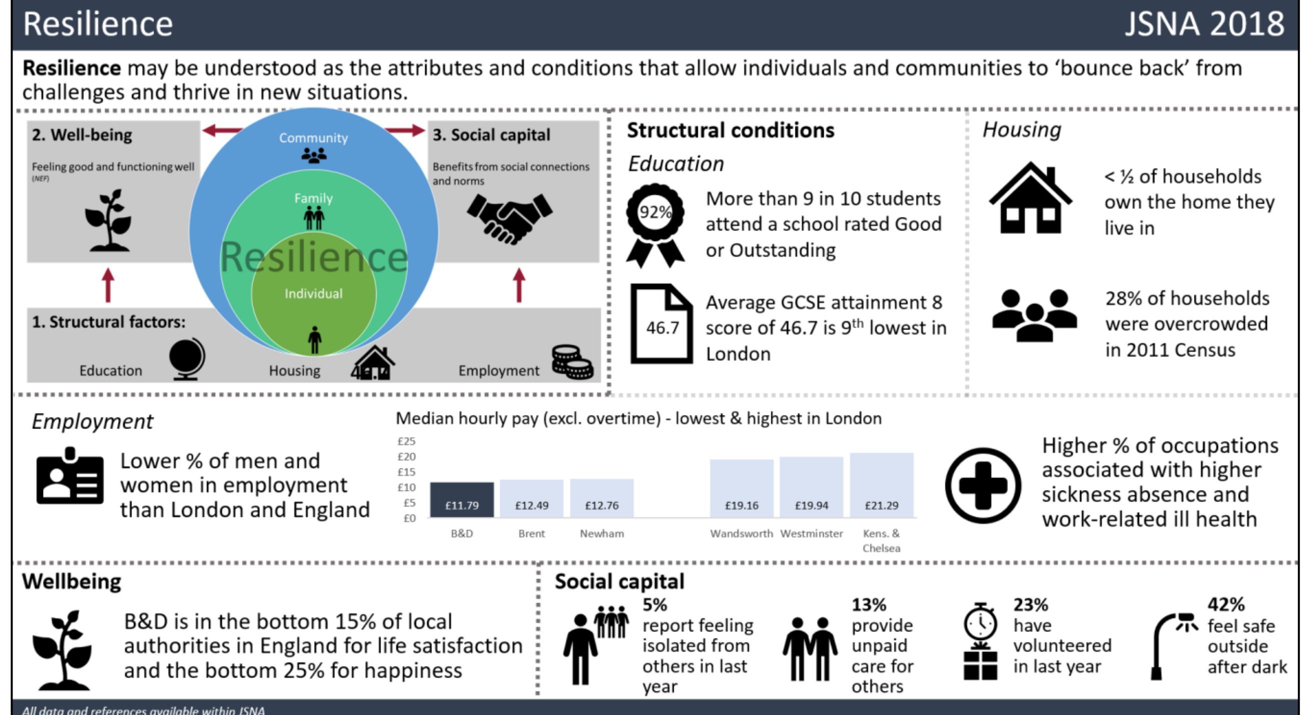
## Early diagnosis and intervention




*Key implications for commissioning:*

- A focus on prevention is key to intervening early for conditions such as cardiovascular disease and diabetes.
- Increasing NHS Health Check and national cancer screening programme coverage would increase early diagnosis and intervention.
- Referral to cancer treatment figures should be analysed to identify the reasons for delay.
- Recognising and diagnosing mental health disorders, and ensuring residents recognise when they should seek medical advice, and feel able to do so, is important.
- Recent evidence on the burden of physical ill health suffered by people with serious mental illnesses underlines the need for joined up services and a holistic understanding of needs.
- Reducing the proportion of undiagnosed dementia cases may allow these individuals to receive support to slow its progression and plan for future needs.
- Increasing coverage of routine chlamydia testing in young people would prevent possible complications and reduce onward transmission.
- Strategies to reduce the proportion of late HIV diagnoses should be explored.

## Resilience




*Key implications for commissioning:*

- Structural factors such as education, housing and employment support resilience. As such some key focus areas could be:
    - Improving school readiness, maintaining high school standards and environments, and increasing attainment and attendance.
    - Supporting the availability of high quality, affordable housing.
    - Supporting the unemployed and the economically inactive who would like to work to enter employment.
    - Advocating for the London Living Wage, helping uncover cases where the National Minimum Wage is not being paid, enforcing health and safety requirements (where under local authority remit), supporting training, and encouraging the development of skilled jobs in the area.
- Another key aspect of resilience is wellbeing. Addressing underlying socio-economic factors may increase wellbeing.
- The third strand of resilience explored in this JSNA is social capital. This suggests that:
    - Reducing social isolation would be beneficial to resilience.
    - Exploring whether social support networks are equally distributed may help us understand who may need more support.
    - As with support networks, it would be worth exploring whether volunteering is evenly distributed within the borough to understand who and who does not volunteer.
    - Exploring residents' attitudes to their local area will give us insights into how norms are changing over time and how we might intervene to affect these positively.

# 1 Introduction and background

## 1.1 What is a Joint Strategic Needs Assessment?

Local authorities and Clinical Commissioning Groups (CCGs) have a joint and equal statutory responsibility to produce a Joint Strategic Needs Assessment (JSNA) via the Health and Wellbeing Board.[1]

The aim of a JSNA is to provide timely, relevant information on the needs of the population to inform key strategies (most notably, the Joint Health and Wellbeing Strategy) and commissioning decisions.

Its ultimate purpose in doing so is to improve the population's health and reduce health inequalities.

## 1.2 What has the approach been in 2018?

This JSNA report is based upon presentations given to three themed workshops informing the Joint Health and Wellbeing Strategy in July 2018. As such, this JSNA directly provided an evidence base for the refreshed 2019–2023 Strategy.

Each workshop addressed one of the three themes of the Strategy:

- best start in life
- early diagnosis and intervention
- resilience.

For definitions of these themes, see box 1.1. In addition to the sections based on the three presentations, this JSNA contains a socio-demographic profile to provide context to these.

**Box 1.1: Definitions of the three themes**

**Best start in life**
Best start in life refers to all interventions and conditions from preconception to age 5 which promote or support healthy early child development.

This could include aspects which directly affect a child's mental or physical health or school readiness, but also the background conditions (such as poverty) that influence these.

**Early diagnosis and intervention**
This theme refers to the ways in which an early diagnosis and prompt access to effective and appropriate treatment or intervention can improve health outcomes.

**Resilience**
Resilience may be understood as the attributes and conditions that allow individuals and communities to 'bounce back' from challenges and thrive in new situations.

As noted above, a key aim of the JSNA is to reduce health inequalities. Health inequalities – differences in health outcomes by characteristics such as age, sex, deprivation, geography and ethnicity – exist both in relation to other areas and within Barking and

[1] Department of Health. *JSNAs and JHWS statutory guidance*. London: DH; 2013.

Dagenham. Deprivation is one of the most pervasive sources of inequality; almost 70% of the variation in life expectancy in males across England is explained by deprivation.[2]

However, reporting data on health inequalities presents challenges, including data availability and reliability, being able to address all types of inequality fairly, and the implications for the length and cohesiveness of the account. Given these challenges, the approach of this JSNA to health inequalities has been to highlight some examples throughout, but for all topics it should be assumed that inequalities are likely to exist and need to be considered in the commissioning and provision of services. Other sources of information on inequalities, such as the forthcoming lesbian, gay, bisexual and trans (LGBT+) needs assessment, should also be consulted.

This JSNA does not exist in isolation and should be read in the wider context of strategic documents, including:

- the London Borough of Barking and Dagenham (LBBD) Borough Manifesto
- the East London Health and Care Partnership Sustainability and Transformation Plan document
- the London Mayor's Health Inequalities Strategy.

Although the three themes in this JSNA are wide ranging, this document cannot cover all health and social care issues. Further data is available via the Borough Data Explorer[3] and other online resources, such as Public Health England's Fingertips suite of tools[4] and directory of resources by topic.[5]

[2] Public Health England (PHE), Public Health Outcomes Framework [http://www.phoutcomes.info/].
[3] London Borough of Barking and Dagenham (LBBD), Emu Analytics, Borough Data Explorer [https://lbbd.emu-analytics.net/].
[4] PHE, Public Health Profiles [https://fingertips.phe.org.uk/].
[5] PHE, PHE data and analysis tools [https://www.gov.uk/guidance/phe-data-and-analysis-tools].

## 2 Socio-demographic profile

### 2.1 Population size

With around 210,700 residents, Barking and Dagenham is the seventh smallest of the 32 London boroughs (excluding the City of London) by population size.[6] It is comparable in population size to York (208,200), Warrington (209,700) and Solihull (213,900).

Barking and Dagenham's footprint of 36 square kilometres means that it has a population density of around 5,800 residents per square kilometre. Although this is below average for a London borough, it is nonetheless the 18th highest population density in the UK.

### 2.2 Age profile

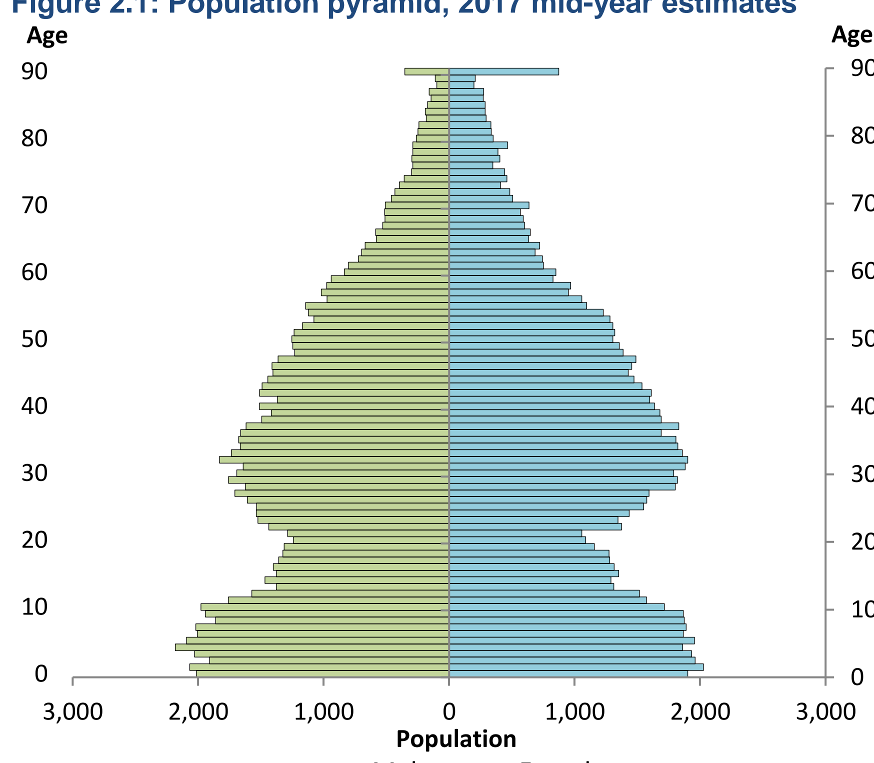
Barking and Dagenham has a young population, with a median age of 32.1 years, compared with 35.1 years for London and 39.8 years for England.

This means that there are as many people under 32.1 as there are over 32.1 in Barking and Dagenham.

Barking and Dagenham has the highest proportion of children (0–17) in the UK: almost three in ten residents (29.8%) are under 18. This compares with 22.7% across London and 21.3% across England.

We also have the highest proportion of under 5s in the UK: 9.4%.

**Figure 2.1: Population pyramid, 2017 mid-year estimates**




*Source: Office for National Statistics (ONS).*

Conversely, Barking and Dagenham has the ninth lowest proportion of residents aged 65 and above in the UK: 9.4%, compared with London and England averages of 11.8% and 18.0% respectively. This also means that Barking and Dagenham has the same proportions of residents aged 0–4 and aged 65 and above.

### 2.3 Population movements

Barking and Dagenham's population is not fixed; there is a substantial amount of movement in and out of the borough. From 2016 to 2017, around 17,900 people moved in to the borough and around 18,000 residents moved out of the borough.

This is equivalent to gaining and losing around 8.5% of the borough's population, or 1 in 12 residents, in the course of a year.

[6] Data in this section is from the Office for National Statistics (ONS) 2017 mid-year population estimates unless otherwise stated.

For movements within the UK, there appears to be a rough pattern of residents moving to Barking and Dagenham from more central neighbouring London boroughs and residents moving from Barking and Dagenham to areas further out of London (Table 2.1). There are also international movements: 23% of in-migration between 2016 and 2017 was from outside the UK and 5% of out-migration.

**Table 2.1: Population flows to/from Barking and Dagenham within the UK, 2016 to 2017**

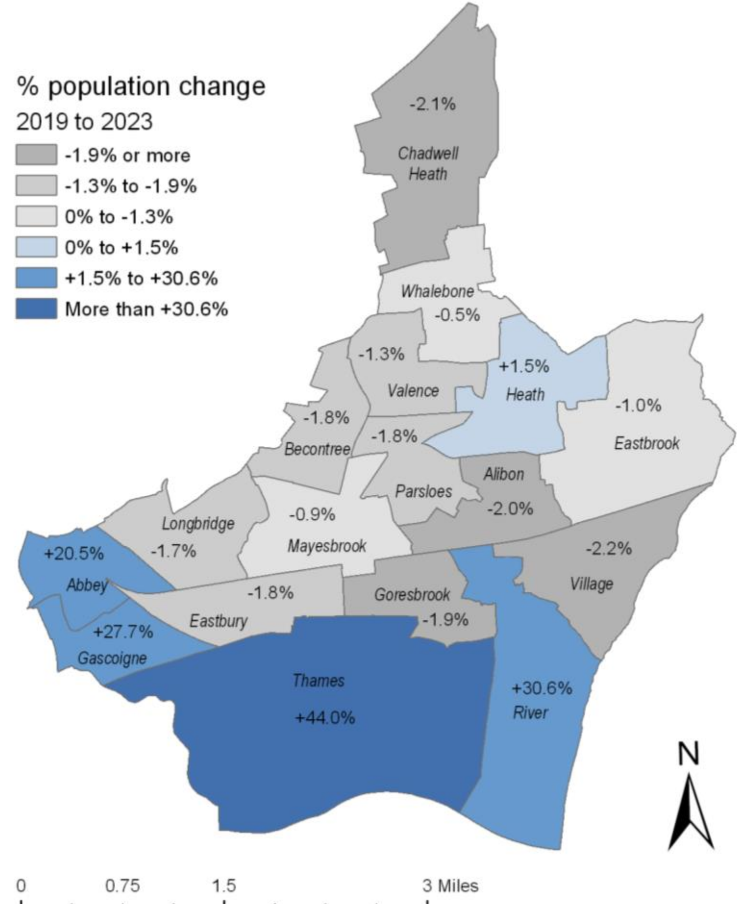
| Moves from other areas of UK to LBBD | Moves to other areas of UK from LBBD |
|---|---|
| 1. Newham (2,800) | 1. Havering (2,200) |
| 2. Redbridge (2,600) | 2. Redbridge (1,800) |
| 3. Waltham Forest (900) | 3. Thurrock (1,400) |
| 4. Havering (800) | 4. Newham (1,000) |
| 5. Tower Hamlets (700) | 5. Basildon (500) |

*Data: ONS, Internal migration: detailed estimates by origin and destination local authorities, age and sex, year ending June 2017.*

The flow of residents between Barking and Dagenham, Havering and Redbridge (highlighted in Table 2.1) further supports the case for integrating services effectively between the three boroughs.

## 2.4 Projected growth

**Figure 2.2: % population change 2019 to 2023 by ward in Barking and Dagenham**




Barking and Dagenham's population is projected to increase by 8% between 2019 and 2023, from 215,100 to 232,200 residents.[7]

Above-average increases are projected for school-age children (5–17 year olds) and the middle aged to older working age population (40–64 year olds) (Table 2.2).

Despite the overall population growth, the populations of most wards are projected to decrease slightly in the next 5 years (Figure 2.2), with population increases focused in four wards: Thames, River, Gascoigne and Abbey.

These growth areas reflect planned housing developments in the south and west of the borough; the population of Thames ward is projected to increase the most due to the Barking Riverside development.

*Data: Greater London Authority (GLA) interim 2015-based Borough Preferred Option (BPO) projection, 2017. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.*

[7] Greater London Authority (GLA) interim 2015-based Borough Preferred Option (BPO) projection, 2017.

**Table 2.2: Estimated population changes 2019–2023**

| Age group | Est. population 2019 | Est. population 2023 | % change | Change |
|---|---|---|---|---|
| 0–4 | 20,300 | 21,600 | +6.0% | +1,200 |
| 5–17 | 45,400 | 49,800 | +9.8% | +4,500 |
| 18–39 | 69,400 | 73,600 | +6.2% | +4,300 |
| 40–64 | 60,000 | 65,900 | +9.7% | +5,800 |
| 65+ | 20,000 | 21,300 | +6.8% | +1,400 |
| **Total** | **215,100** | **232,200** | **+8.0%** | **+17,100** |

*Data: GLA interim 2015-based BPO projection, 2017.*

Looking further ahead, Barking and Dagenham's population is projected to increase by 27.3% between 2019 and 2029, from 215,100 to 273,800 residents. The largest percentage increases are projected to be in the population aged 40 and above (Table 2.3).

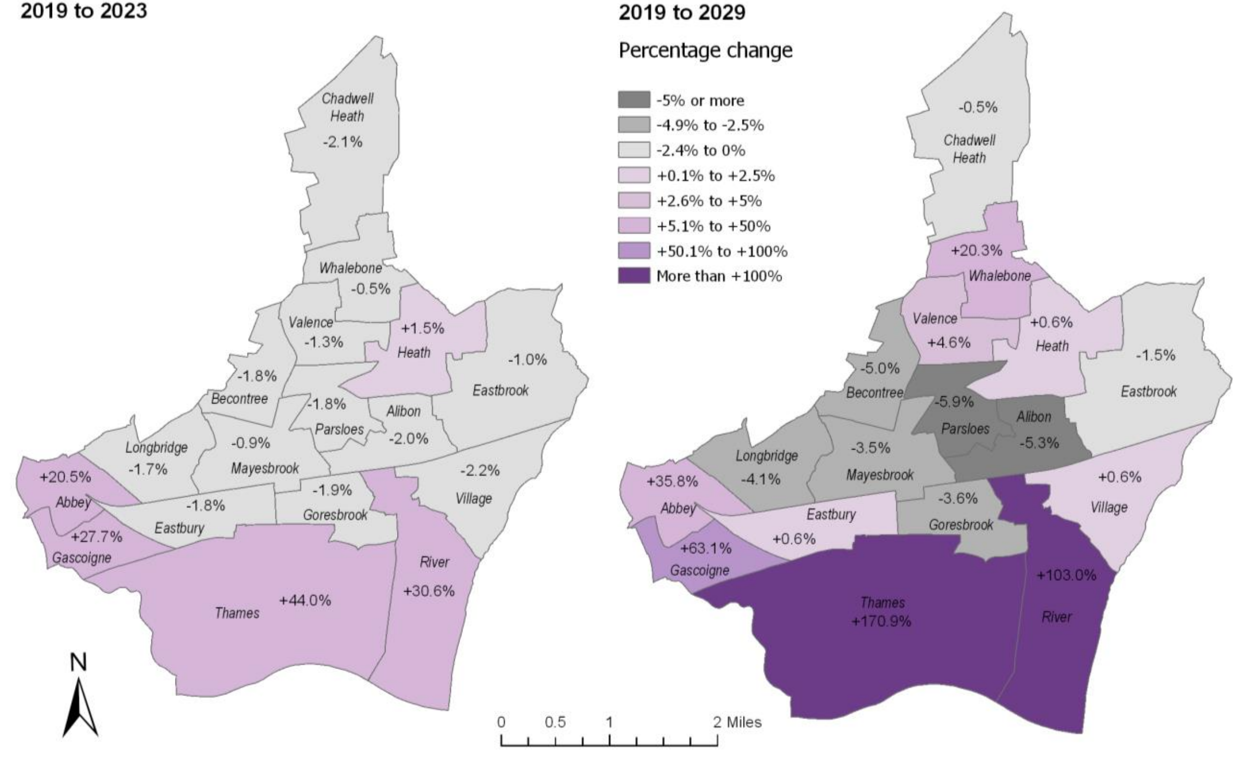
**Table 2.3: Estimated population changes 2019–2029**

| Age group | Est. population 2019 | Est. population 2029 | % change | Change |
|---|---|---|---|---|
| 0–4 | 20,300 | 25,400 | +24.8% | +5,000 |
| 5–17 | 45,400 | 56,600 | +24.8% | +11,200 |
| 18–39 | 69,400 | 88,200 | +27.2% | +18,900 |
| 40–64 | 60,000 | 77,700 | +29.3% | +17,600 |
| 65+ | 20,000 | 25,900 | +29.9% | +6,000 |
| **Total** | **215,100** | **273,800** | **+27.3%** | **+58,700** |

*Data: GLA interim 2015-based BPO projection, 2017.*

As with the picture for 2023, these projections suggest that population growth will be focused in the south and west of the borough. Increases are also projected for Whalebone and, to a lesser extent, Valence. All other wards are projected to grow only marginally (less than 1%) or decrease in size, with three wards predicted to decrease in size by 5% or more (Parsloes, Alibon and Becontree) relative to 2019.

**Figure 2.3: % population changes 2019–2023 and 2019–2029 by ward in Barking and Dagenham**

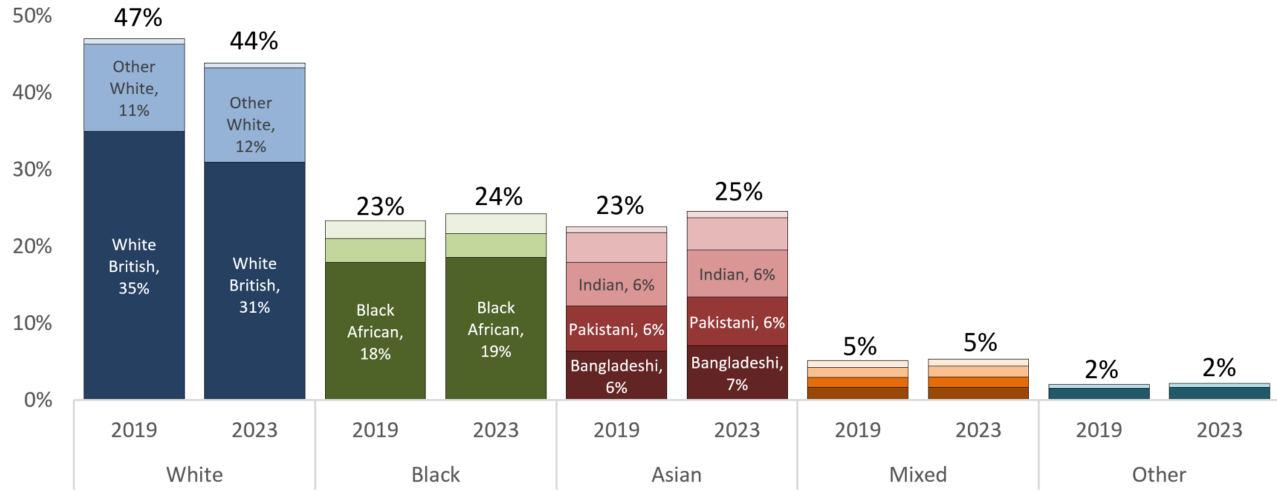



*Data: GLA interim 2015-based BPO projection, 2017. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.*

## 2.5 Ethnicity

Estimates suggest that, as of 2019, 47% of Barking and Dagenham's population is White, 23% is Black, 23% is Asian, 5% is Mixed and 2% is Other.[8] However, within these broad groupings, there is a large amount of diversity (Figure 2.4). At the next level of classification, the three largest groups are White British (35%), Black African (18%) and Other White (11%). Asian and Black ethnic groups are projected to increase by 2023, whereas White ethnic groups are predicted to decrease.

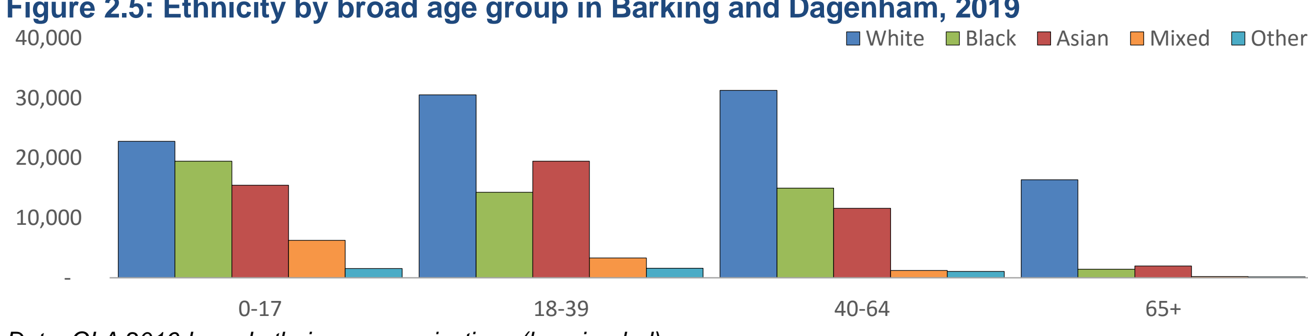
**Figure 2.4: Ethnicity estimates in Barking and Dagenham, 2019 and 2023**




*Data: GLA 2016-based ethnic group projections (housing-led).*

There is wide variation in ethnicity by age, with under 18s more evenly split between White, Black and Asian ethnicities, whereas those aged 65 and above are predominantly White (Figure 2.5).

**Figure 2.5: Ethnicity by broad age group in Barking and Dagenham, 2019**




*Data: GLA 2016-based ethnic group projections (housing-led).*

The largest changes by age and broad ethnic group (in number of people) between 2019 and 2023 are projected to be in 40–64 year olds of Asian ethnicity (+3,200), under 18s of Asian ethnicity (+2,100) and 40–64 year olds of Black ethnicity (+1,900) (Table 2.4).

**Table 2.4: Ethnic group projections by age, 2019–2023**

| Ethnic group | 0-17 | | 18-39 | | 40-64 | | 65+ | |
|---|---|---|---|---|---|---|---|---|
| | *2019* | *2023* | *2019* | *2023* | *2019* | *2023* | *2019* | *2023* |
| **White** | 22,800 | 22,700 | 30,500 | 29,700 | 31,300 | 30,800 | 16,400 | 16,200 |
| **Black** | 19,500 | 20,800 | 14,300 | 15,100 | 15,000 | 16,900 | 1,400 | 2,100 |
| **Asian** | 15,500 | 17,500 | 19,500 | 20,700 | 11,600 | 14,800 | 2,000 | 2,600 |
| **Mixed** | 6,200 | 6,800 | 3,300 | 3,600 | 1,200 | 1,400 | 200 | 200 |
| **Other** | 1,600 | 1,700 | 1,600 | 1,700 | 1,100 | 1,300 | 200 | 200 |

*Data: GLA 2016-based ethnic group projections (housing-led).*

[8] GLA 2016-based ethnic group projections (housing-led).

## 2.6 Births

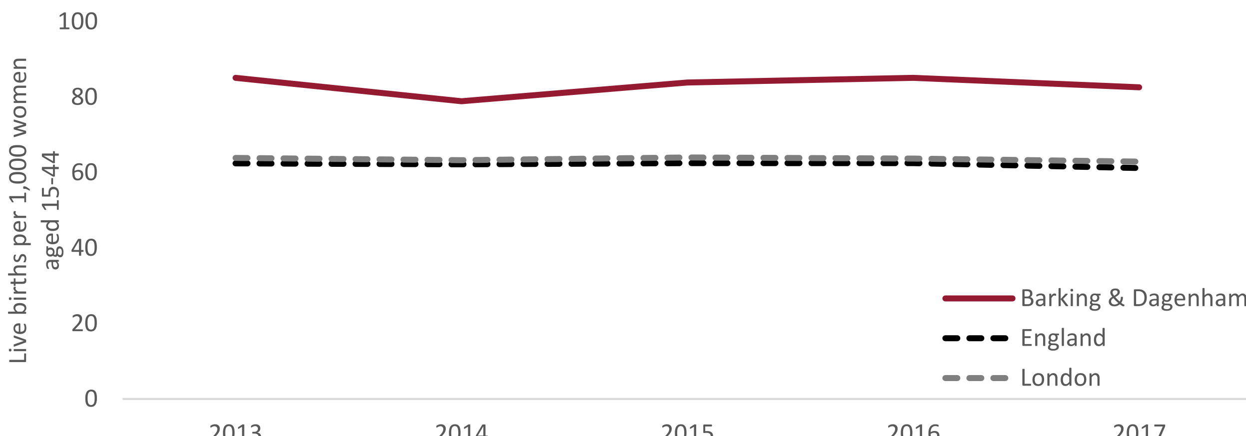
There were an average of 3,812 live births in Barking and Dagenham each year between 2013 and 2017, with 3,870 in 2017.[9]

Barking and Dagenham has the highest birth rate in England and Wales, with 82.6 live births per 1,000 women aged 15–44 in 2017.[10] This is substantially higher than London (62.9 per 1,000) and England (61.2 per 1,000).

This is equivalent to around 1 in 12 women aged 15–44 having a baby in a given year, compared with around 1 in 16 in England and London.

This birth rate has remained relatively constant over the last 5 years, except for a small dip in 2014 (Figure 2.6).

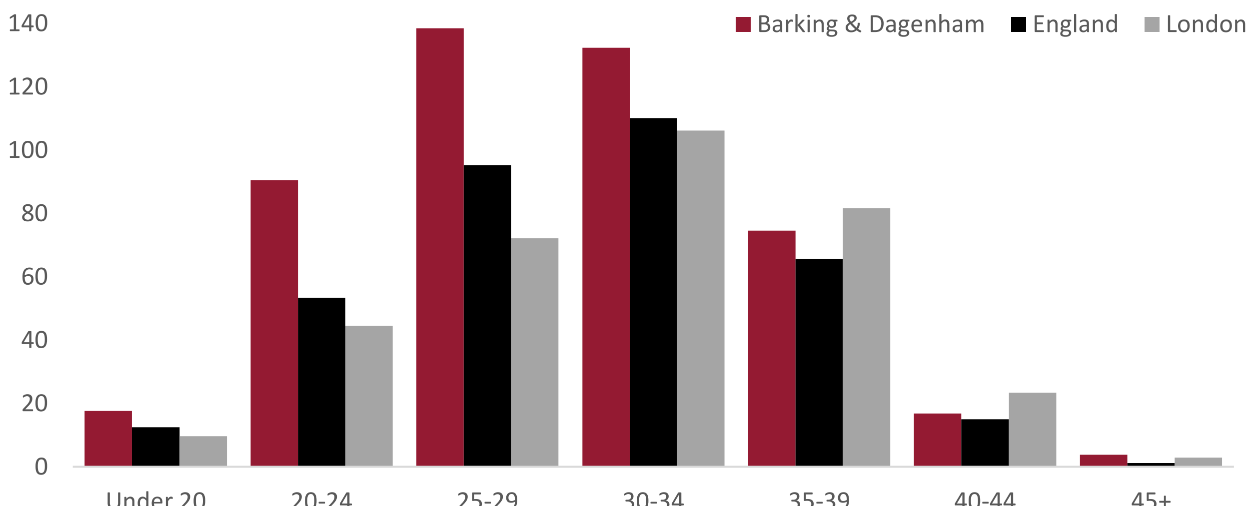
**Figure 2.6: Live births per 1,000 women aged 15–44 (general fertility rate), 2013–2017**




*Data: ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas.*

Figure 2.7 shows age-specific fertility rates for 2017. The difference relative to England and London is particularly pronounced for women in their 20s; Barking and Dagenham women aged 20–24 and 25–29 were around twice as likely to have given birth in 2017 than the London average.

**Figure 2.7: Age-specific fertility rates (live births per 1,000 women in age group), 2017**




*Data: ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas. The denominators for lowest and highest age categories are the female population aged 15–19 and 45–49 respectively.*

[9] ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas.
[10] ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas.

## 2.7 Deaths

There were an average of 1,268 deaths in Barking and Dagenham each year between 2014 and 2016, with 1,191 in 2016.[11]

Across 2014–16, the five leading causes of deaths in Barking and Dagenham were (Table 2.5):[12]

1. Ischaemic heart diseases (e.g. heart attack)
2. Dementia and Alzheimer's disease
3. Lung cancer[13]
4. Chronic lower respiratory disease (chronic obstructive pulmonary disease [COPD], bronchitis, emphysema and asthma)
5. Cerebrovascular disease (stroke).

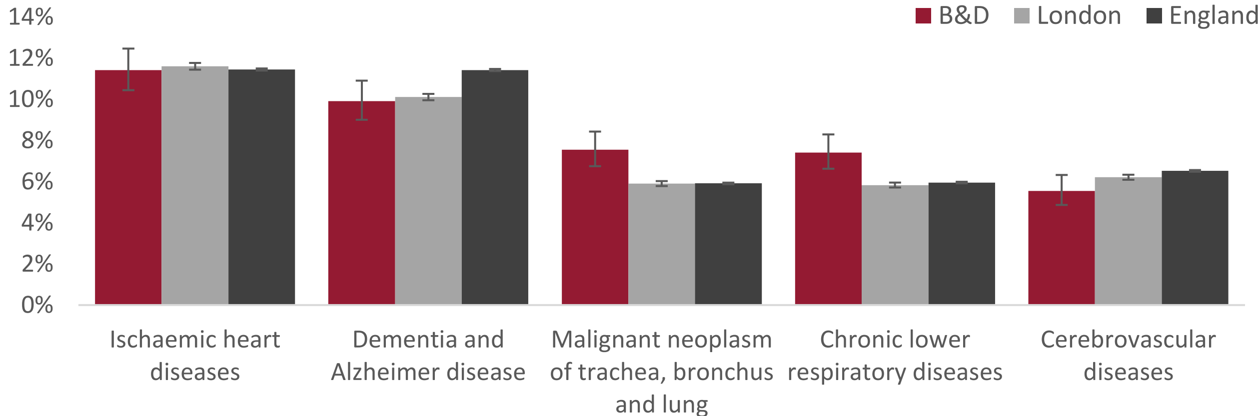
**Table 2.5 Leading causes of death, Barking and Dagenham, 2014–16**

| Cause | Total deaths | % of total deaths | Males | Females[14] |
|---|---|---|---|---|
| 1. Ischaemic heart diseases | 434 | 11.4% | 253 | 181 |
| 2. Dementia and Alzheimer's disease | 377 | 9.9% | 117 | 260 |
| 3. Lung cancer | 287 | 7.5% | 152 | 135 |
| 4. Chronic lower respiratory diseases | 282 | 7.4% | 127 | 155 |
| 5. Cerebrovascular disease | 211 | 5.5% | 99 | 112 |

*Source: ONS via Nomis, Mortality statistics - underlying cause, sex and age.*

The order of the same five leading causes differs at England and London level, with lung cancer and chronic lower respiratory diseases contributing significantly more to the burden of deaths in Barking and Dagenham than in England and London (Figure 2.8).

**Figure 2.8: Leading causes of death in Barking and Dagenham as percentage of all deaths, compared with London and England, 2014–16**




*Data: ONS via Nomis, Mortality statistics - underlying cause, sex and age. 95% confidence intervals shown.*

As age has a strong relationship with death, mortality rates need to be age-standardised to assess whether an area has more or fewer deaths than you would expect; all else being equal, you would expect fewer deaths in a population with a high proportion of young people (such as Barking and Dagenham) than in an older population.

The age-standardised mortality rates in 2016 were 1,003.3 per 100,000 in Barking and Dagenham compared with 959.8 per 100,000 in England and 859.4 per 100,000 in London.[15]

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[11] ONS via Nomis, Mortality statistics - underlying cause, sex and age.
[12] Cancers are counted separately for the purposes of this list. Overall, cancers accounted for 28% of deaths.
[13] This is described as lung cancer for simplicity but is broader than this: Malignant neoplasm of trachea, bronchus and lung.
[14] The fifth leading cause of death for women was Influenza and pneumonia (123 deaths); cerebrovascular disease was the sixth.
[15] ONS via Nomis, Mortality statistics - underlying cause, sex and age.

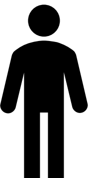
This means that if age-specific mortality rates from Barking and Dagenham, London and England were applied to the same population structure, Barking and Dagenham residents would have around a 17% greater risk of dying than the London average and around a 5% greater risk than the England average.

Furthermore, across 2014–16, 27.2% of deaths in Barking and Dagenham were classed as avoidable, compared with 22.8% across England and 25.3% across London.[16]

Barking and Dagenham's age-standardised avoidable mortality rate is the highest in London and 30th highest of 324 areas across England.[17] Males fare relatively worse than females; their age-standardised avoidable mortality rate is the highest in London and 22nd in England, whereas females are fourth highest in London and 61st highest in England. Avoidable mortality is explored further in chapter 4.

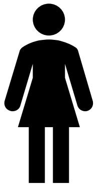
## 2.8 Life expectancy and healthy life expectancy

Life expectancy in Barking and Dagenham for males is 77.5 years and for females this is 81.9 years.[18] Both are the lowest in London.



**Life expectancy:**
77.5 years (London: 80.4 years)

***Healthy life expectancy:***
*58.2 years (London: 63.5 years)*



**Life expectancy:**
81.9 years (London: 84.2 years)

***Healthy life expectancy:***
*60.7 years (London: 64.4 years)*

These are 2.9 years and 2.3 years lower than the averages for males and females in London and 6.2 years and 4.9 years lower than the areas with the highest life expectancies in London.

This does not mean that this is the average amount of time any given resident will live for; instead it is a snapshot of mortality in the area over a period of time (2014–2016) and indicates the amount of time a new born child would live for if he or she experienced these age- and sex-specific mortality rates over the course of his or her life.

Healthy life expectancy (HLE) in Barking and Dagenham for males is 58.2 years and for females this is 60.7 years.

This is a measure of how long a person might expect to spend in good health, with the same caveats as above. It takes the life expectancy measure above and uses the age-specific proportion of people who self-report being in good health to create an average number of years in which people feel they are in good health. It is a key part of the picture on population ill health and healthy aging but is more vulnerable to random variation than life expectancy due to its reliance on survey data for the self-reported health component.

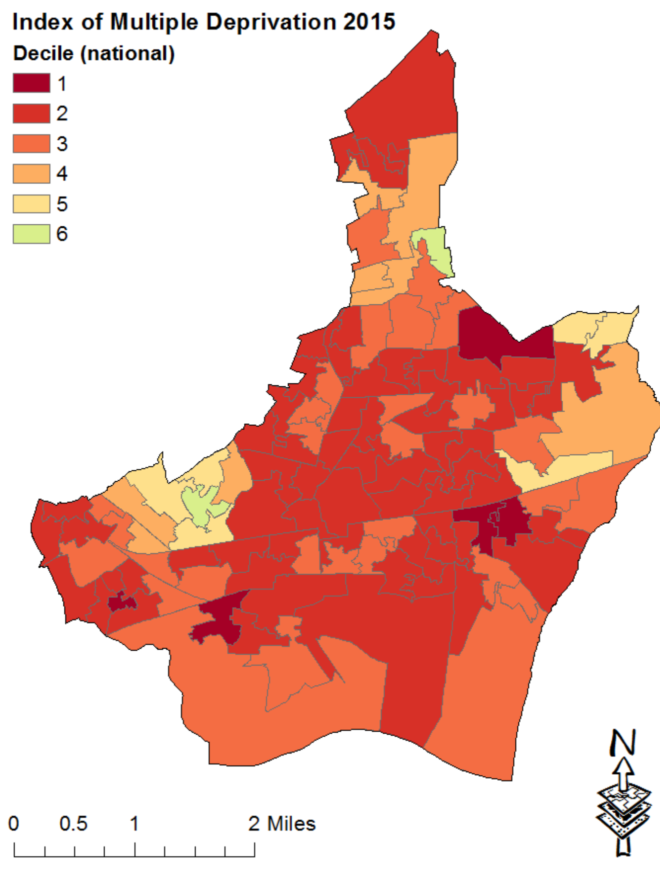
Male HLE is the lowest in London – 5.3 years lower than the London average and 11.7 years lower than Richmond upon Thames (London borough with the highest HLE).

Female HLE is the fourth lowest in London – 3.7 years lower than the London average and 9.3 years lower than Richmond upon Thames (which has the highest HLE for females as well as males in London).

[16] ONS, Avoidable mortality in the UK: 2016; ONS via Nomis, Mortality statistics - underlying cause, sex and age.
[17] ONS, Avoidable mortality in the UK: 2016.
[18] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].

## 2.9 Deprivation and inequalities

**Figure 2.9: Deprivation by area within LBBD (national deciles)**




*Data: Department for Communities and Local Government. English indices of deprivation 2015. Contains National Statistics data © Crown copyright and database right 2009, 2016. Contains OS data © Crown copyright and database right 2009, 2016.*

Barking and Dagenham is one of the most deprived areas in the country, ranked 11th most deprived in England in the 2015 Index of Multiple Deprivation.[19]

Fifty-five percent of lower super output areas (LSOAs; small areas) are within the 10–20% most deprived in England (decile 2) and 26% of areas are within the 20–30% most deprived (decile 3). A total of 85% of LSOAs were in deciles 1–3: i.e. the 30% most deprived in England.

The areas within Barking and Dagenham are therefore fairly uniformly deprived; within the borough, there is not a large amount of inequality due to deprivation.

Life expectancy for males is estimated to be 3.2 years greater in the least deprived part of the borough compared with the most deprived and for females this is 1.1 years.[20] Both are the smallest gaps in England.

A larger inequality is between Barking and Dagenham and other areas, as highlighted in the section above.

[19] Department for Communities and Local Government. English indices of deprivation 2015.
[20] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/]; 2014–16.

# 3 Best start in life

## 3.1 What do we mean by 'best start in life'?

**Best start in life** refers to all interventions and conditions from preconception to age 5 which promote or support healthy early child development.

This could include aspects which directly affect a child's mental or physical health or school readiness, but also the background conditions (such as poverty) that influence these.

## 3.2 Why is giving children the best start in life important?

Preconception, pregnancy and early childhood are vital times in a child's development. Exposures such as smoking and alcohol in pregnancy can have significant or lifelong effects on the child, while in early childhood, the brain is developing neural connections and biological responses that determine how he or she reacts to situations for the rest of her life. [21] Adverse childhood experiences, such as abuse or domestic violence, are linked to multiple health risk factors and poor health outcomes in adulthood.[22] The developing field of epigenetics is providing increasing evidence on the mechanisms linking a child's environment (including in the womb) and outcomes in later life.[23]

This is also the single most important time to act to mitigate against the effects of disadvantage and reduce health inequalities. For this reason, the Marmot Review on health inequalities stated that giving every child the best start in life was their 'highest priority recommendation'.[24]

In addition, the early years are a period where healthy patterns of behaviour can be internalised, such as an understanding of healthy relationships, while ensuring access to suitable healthcare will help to ensure that children do not miss out on opportunities to socialise with other children and become ready for school. Finally, given that this is upstream of most health outcomes, there are potentially large returns on investment to be made.

## 3.3 Why is this important for Barking and Dagenham?

Best start in life is especially important for Barking and Dagenham because of its high level of deprivation and the associated wide health inequalities between the borough and other areas in London and England. For example, it has the lowest life expectancies in London for both women and men[25] and the highest levels of Year 6 obesity in England.[26] Acting to reduce disadvantage in our youngest residents may help to reduce the intergenerational transmission of poverty and poor health outcomes.

Barking and Dagenham also has the highest proportion of residents aged 0–4 in the UK. Almost one in ten residents is under the age of 5 (9.4%), compared with 7.1% in London

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[21] For example, see: Center on the Developing Child at Harvard University. *The Foundations of Lifelong Health Are Built in Early Childhood*. Cambridge, Massachusetts: Harvard University; 2010.
[22] Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACEs) [https://www.cdc.gov/violenceprevention/acestudy/index.html]. Accessed 2018 Oct 03.
[23] For example, see section 2.6.1 in: Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. *Fair Society, Healthy Lives: The Marmot Review*. London: UCL; 2010.
[24] Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. *Fair Society, Healthy Lives: The Marmot Review*. London: UCL; 2010.
[25] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/]; 2014–16.
[26] NHS Digital, National Child Measurement Programme 2016/17.

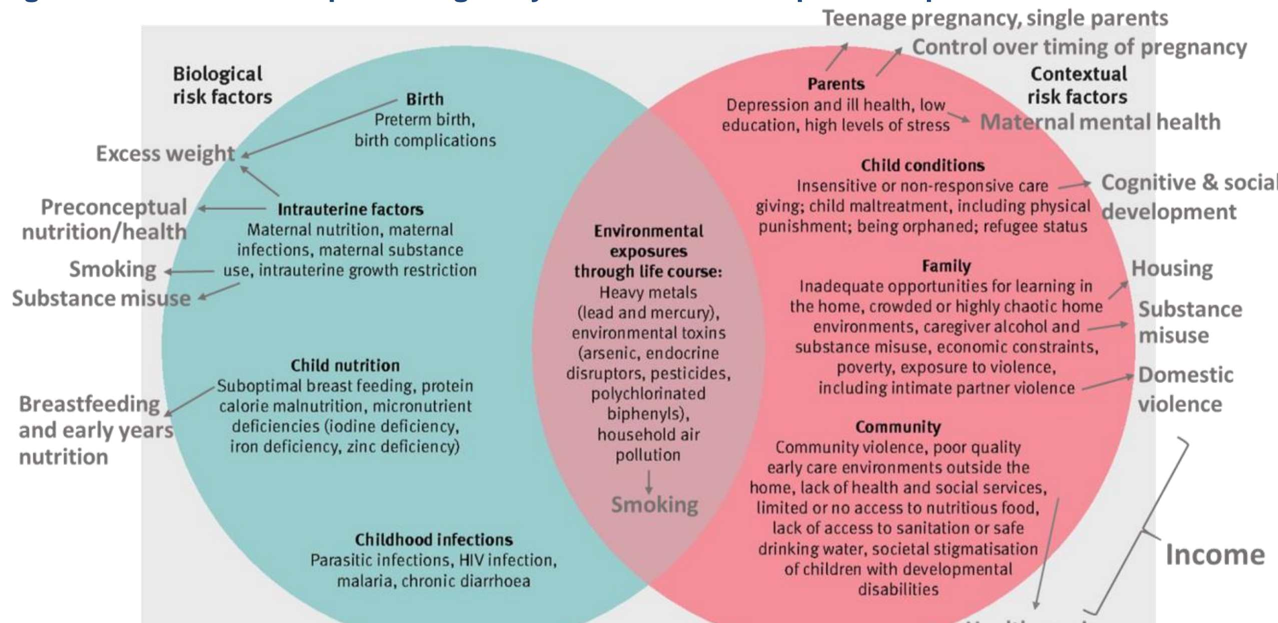
and 6.1% across England. This equates to around 19,900 children in 2017.[27] This is also a growing population, albeit at a slightly slower rate than the borough average; projected figures suggest we will have 20,300 children under 5 in 2019 and 21,600 by 2023.[28]

Therefore, while best start in life is important for all areas, we can have a potentially greater impact in Barking and Dagenham by reaching a larger segment of our population with this one approach.

## 3.4 What factors affect early childhood development?

Conditions affecting early childhood development can be broadly split into biological or contextual factors, with environmental exposures spanning the two (Figure 3.1). Figure 3.1 shows how a global framework has been adapted for the purposes of this chapter to explore factors locally.

**Figure 3.1: Factors compromising early childhood development explored in this JSNA**




*Source: Adapted from Daelmans B, Black MM, Lombardi J, Lucas J, Richter L, Silver K, et al.; steering committee of a new scientific series on early child development. Effective interventions and strategies for improving early child development.* BMJ *2015;351:h4029. ©2015 by British Medical Journal Publishing Group.*

## 3.5 What do these factors look like in Barking and Dagenham?

### 3.5.1 Preconception health

Giving children the best start in life ideally begins before conception; for example, women are recommended to take folic acid from the time they begin trying to conceive until 12 weeks of pregnancy.[29]

A national analysis of antenatal booking appointment data found that folic acid use data was often missing, but there appeared to be

*What is preconception health?*

Preconception health is relevant for both men and women and includes maintaining or achieving a healthy weight, treating health conditions such as diabetes effectively, and seeking support for mental health conditions. [https://www.cdc.gov/preconception/index.html]

[27] ONS 2017 mid-year population estimates.
[28] GLA interim 2015-based BPO projection, 2017.
[29] World Health Organization, e-Library of Evidence for Nutrition Actions (eLENA), Periconceptional folic acid supplementation to prevent neural tube defects [http://www.who.int/elena/titles/folate_periconceptional/en/]. Accessed 2018 Oct 03.

inequalities by age, deprivation and ethnicity.[30] A higher proportion of women under 18 were known not to be taking folic acid than women in their 30s, while women in the most deprived areas were more likely not to be taking folic acid than women in the least deprived areas. By ethnicity, Black women were the ethnic group with the highest proportion known to be not taking folic acid at their booking appointment. Black and Asian women were also less likely to be recorded as having taken folic acid prior to pregnancy compared with Chinese and White women.

A challenge for preconception health is that not all pregnancies are planned and not all those who plan a pregnancy may understand the benefits of optimising their health prior to pregnancy or be motivated or able to do so.

*Control over timing of pregnancy*

Nationally, around four in nine pregnancies, and around one in three full-term pregnancies, are thought to be unplanned or the mother feels 'ambivalent'.[31]

Potential health effects of unplanned pregnancy include later presentation for antenatal care, a higher risk of prenatal/postnatal depression, lower birthweight and poorer health and cognitive scores in the child.[32]

**Figure 3.2: Prevalence of unplanned pregnancies**

**Pregnancies:**

| | |
|---|---|
| 16% | Unplanned |
| 29% | Ambivalent |
| 55% | Planned |

**Full-term pregnancies:**

| | |
|---|---|
| 6% | Unplanned |
| 28% | Ambivalent |
| 66% | Planned |

*Data: Wellings et al., 2013.*

If this prevalence of unplanned full-term pregnancies applied to Barking and Dagenham births in 2017 (3,870 live births):

- Around 200 births would be unplanned
- 1,100 would be ambivalent
- 2,600 would be planned.[33]

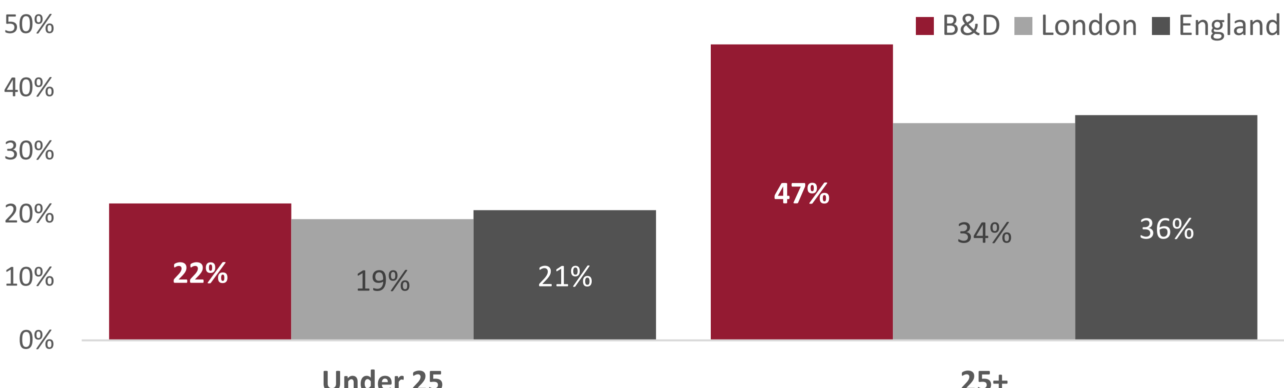
National survey data suggest that 16–19 year olds who become pregnant are at higher risk of unplanned pregnancy, although most unplanned pregnancies occur in 20–34 year olds.[34]

In Barking and Dagenham as well as nationally, under 25s are less likely to choose long-acting reversible contraceptives (LARC), such as the implant or intrauterine device, compared with over 25s, despite these being more effective at preventing pregnancy than user-dependant methods such as the pill or condoms (Figure 3.3). However, a higher proportion of over 25s in Barking and Dagenham choose LARC compared with London and England.

Promoting LARC as an option to all women requiring contraception may give them more control over if or when they choose to become pregnant.

[30] PHE. Health of women before and during pregnancy: health behaviours, risk factors and inequalities. An initial analysis of the Maternity Services Dataset antenatal booking data. London: PHE; 2018.
[31] Wellings K, Jones KG, Mercer CH, Tanton C, Clifton S, Datta J, et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Lancet* 2013;382(9907):1807–16.
[32] Wellings et al., 2013.
[33] ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas; Wellings et al., 2013. Rounded to nearest 100.
[34] Wellings et al., 2013.

**Figure 3.3: % of women choosing LARC (excl. injection) at sexual and reproductive health services, 2016**




*Data: PHE, Sexual and Reproductive Health Profiles.*

*General health of women and men of child-bearing age*

If we consider that pregnancies may not always be planned, and that making large changes to lifestyles ahead of pregnancy may not occur, looking at the general health of the population highlights areas where we could have an impact:

**Figure 3.4: Overview of lifestyle factors affecting health in Barking and Dagenham**

**Physical activity** – **lowest** % physically active in England (all adults, 2016/17)

**Excess weight** – **2nd highest** % in London (all adults, 2016/17)

**Nutrition** – **4th lowest in London** for % eating **'5 a day'** fruit/veg on a usual day (50.5%) (all adults, 2016/17)

**Smoking** – **14%** of women reported smoking in the GP patient survey vs 22% of men (and 13% of women nationally) (2017, weighted figures)

**Alcohol** – **256 per 100,000 years of life lost** due to alcohol-related conditions – similar to England/London (females, 2016, age-standardised)

*Source: PHE/GP Patient Survey*

This suggests that continuing to work with residents to improve levels of physical activity, overweight and obesity, poor nutrition, smoking and excess alcohol consumption would likely benefit future children conceived in the borough.

### 3.5.2 Excess weight in pregnancy

Nationally, one in five (20%) 25–34-year-old women are obese, which rises to almost one in four (24%) 35–44-year-old women.[35]

Excess weight in pregnancy increases the risk of miscarriage, congenital anomalies, preterm delivery, blood clots in the mother, childhood obesity and cardiovascular disease in the child's later life.[36]

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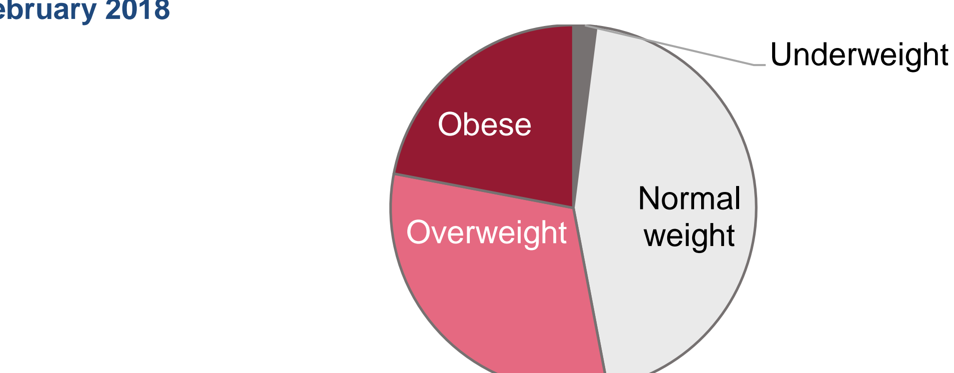
[35] NHS Digital, Health Survey for England 2016.
[36] NHS. Overweight and Pregnant [https://www.nhs.uk/conditions/pregnancy-and-baby/overweight-pregnant/]. Accessed 2018 Oct 03; Chandrasekaran S, Neal-Perry G. Long-term consequences of obesity on female fertility and the health of the offspring. *Curr Opin Obstet Gynecol* 2017 Jun;29(3):180–7.

Of pregnant women attending a booking appointment provided by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) in February 2018:[37]

- 2% were underweight
- 45% were a normal weight
- 31% were overweight (225 women), compared with 28% across England and 29% in London (of providers submitting data)
- 22% were obese (160 women), compared with 22% across England and 17% in London (of providers submitting data).

**Figure 3.5: Weight categories of women attending booking appointments at BHRUT in February 2018**



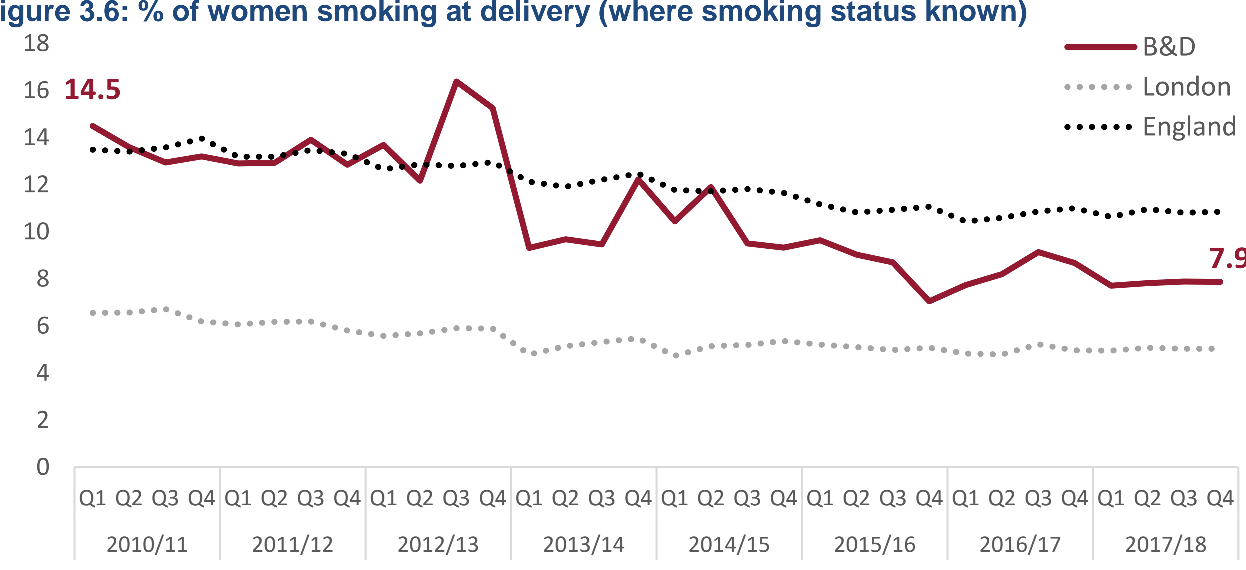

*Data: NHS Digital, Maternity Services Data Set, February 2018.*

### 3.5.3 Smoking in pregnancy and around young children

Smoking in pregnancy increases the risk of miscarriage, stillbirth, low birthweight and premature birth.[38]

In 2017/18, around one in thirteen pregnant women (7.8%) smoked at time of delivery. This has decreased substantially in recent years but is the third highest proportion in London and corresponded to 273 women in 2017/18.[39]

**Figure 3.6: % of women smoking at delivery (where smoking status known)**




*Data: NHS Digital, Statistics on Women's Smoking Status at Time of Delivery*

[37] NHS Digital, Maternity Services Data Set, February 2018. Note: this is not specific to Barking and Dagenham residents.
[38] Royal College of Physicians. *Passive smoking and children.* A report by the Tobacco Advisory Group. London: RCP, 2010.
[39] NHS Digital, Statistics on Women's Smoking Status at Time of Delivery, England, 1 April 2017 to 31 March 2018.

Furthermore, this is likely to be an underestimate; research by Shipton et al. found that the self-reported rate of smoking in pregnancy was around 20% lower than that based on anonymised blood samples.[40]

Nationally, being a smoker at the time of the booking appointment is more common in younger women (under 25), women living in deprived areas and women of White ethnicity.[41] However, this is with the caveat that smoking status was missing across 17% of records used in this analysis, with some variation by deprivation and ethnicity.

In 2017/18, 63 pregnant women accessed Barking and Dagenham's smoking cessation service and set a quit date. Of these, just over half (52%) successfully quit, which is higher than London (32%) and England (27%), although both had high proportions of women with unknown outcomes (21% and 26% compared with 5% in Barking and Dagenham).[42]

By focusing on smoking in pregnancy, it is important not to lose sight of the effect of others in the household smoking during pregnancy or smoking around the child once born.

Passive smoking in early life is associated with an increased risk of sudden infant death, lower respiratory infections (especially bronchiolitis), wheeze, asthma, middle ear infections and meningitis.[43] Exposure to smoking in pregnancy and in the early years is also associated with an increased risk of dental caries (tooth decay) as a child or teenager.[44]

*What impact could reducing smoking in pregnancy have?*

The council published their Tobacco Harm Reduction Strategy in 2017, which set targets for reducing smoking at delivery to 5% by 2022 and to 3% by 2025.

Looking at one possible trajectory to achieve this target between 2018 and 2025, almost 900 fewer babies in Barking and Dagenham would be exposed to smoking in pregnancy if we were to achieve our targets of 5% and 3% by 2022 and 2025 respectively, compared with if smoking at delivery rates stayed at 7.8%.[45]

### 3.5.4 Substance misuse, including alcohol

Alcohol in pregnancy increases the risk of low birthweight, preterm birth, small for gestational age, fetal alcohol spectrum disorder (FASD) and fetal alcohol syndrome (FAS).[46]

The use of opiates in pregnancy can lead to withdrawal symptoms in neonates (neonatal abstinence syndrome), behavioural changes in neonates and hyperactivity.[47]

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[40] Shipton D, Tappin DM, Vadiveloo T, Crossley JA, Aitken DA, Chalmers J. Reliability of self reported smoking status by pregnant women for estimating smoking prevalence: a retrospective, cross sectional study. *BMJ* 2009;339:b4347.

[41] PHE. *Health of women before and during pregnancy: health behaviours, risk factors and inequalities. An initial analysis of the Maternity Services Dataset antenatal booking data*. London: PHE; 2018.

[42] NHS Digital, Statistics on NHS Stop Smoking Services, England, April 2017 to March 2018.

[43] Royal College of Physicians. *Passive smoking and children*. A report by the Tobacco Advisory Group. London: RCP, 2010

[44] González-Valero L, Montiel-Company JM, Bellot-Arcís C, Almerich-Torres T, Iranzo-Cortés JE, Almerich-Silla JM. Association between passive tobacco exposure and caries in children and adolescents. A systematic review and meta-analysis. *PLoS One* 2018;13(8):e0202497.

[45] NHS Digital, Statistics on Women's Smoking Status at Time of Delivery, England, 1 April 2017 to 31 March 2018.; GLA interim 2015-based BPO projection, 2017.

[46] Department of Health and Social Care, *UK Chief Medical Officers' Low Risk Drinking Guidelines*. [London]: DHSC, 2016.

[47] Behnke M, Smith VC; Committee on Substance Abuse; Committee on Fetus and Newborn. Prenatal substance abuse: short- and long-term effects on the exposed fetus. *Pediatrics*.2013;131(3):e1009–24.

In 2017/18, Barking and Dagenham's children's social services carried out 596 assessments on children under 5.[48] Of these, 5.2% had alcohol use in in the household listed as a factor, while 9.0% had drug misuse in the household listed as a factor.

More generally, one in four new presentations to substance misuse treatment in 2017/18 for non-opiates (24.9%) lived with children (under the age of 18).[49] This was 21.9% for alcohol, 19.7% for alcohol and non-opiates, and 12.3% for opiates.

### 3.5.5 Breastfeeding and early years nutrition

There is a strong body of evidence on the benefits of breastfeeding, where possible, for mother and child. For the child, the benefits include a lower risk of infection, diarrhoea and vomiting, sudden infant death syndrome, middle ear infection, childhood leukaemia, type 2 diabetes in later life, obesity, and cardiovascular disease in later life.[50] It is also associated with better performance on intelligence tests.[51]

Skin-to-skin contact in first hour of life has been shown to increase the success of breastfeeding.[52] In February 2018, 82% of term babies born via a BHRUT maternity service had skin-to-skin contact in their first hour of life, similar to national (81%) and London (78%) figures.[53]

In 2016/17, 73.6% of babies were breastfed in their first 48 hours.[54] This is similar to England (74.5%), but of local authorities with data (24 of 32 London boroughs), it is the second lowest in London.

The 2010 UK Infant Feeding Survey found that breastfeeding initiation was associated with multiple factors. These could be roughly categorised into support and information factors (such as whether the women received help putting the baby to the breast and had been told how to recognise the baby was getting enough milk), norms (such as how the mother's friends fed their babies and how the mother had been fed as a baby), and socio-demographic factors (such as: ethnicity, with women from ethnic groups other than White more likely to initiate breastfeeding; socio-economic classification, with women in managerial or professional occupations more likely to initiate breastfeeding; and age (with the lowest initiation rates in women aged 20–24).[55]

Across 2017/18, 53.0% of infants were totally or partially breastfed at 6–8 weeks. This compares with 42.9% across England and 45.1% across London. However, Barking and Dagenham and London figures are not considered reliable due to the high proportion of infants with unknown breastfeeding status. Although this has been improving, across 2017/18, we were lacking breastfeeding data on one in five children.

We also lack good quality data on the nutritional status of young children in the borough; however, one in four Reception students (age 4–5) is overweight or obese (25.5%), which is significantly higher than London (22.3%) and England (22.6%).[56]

[48] LBBD children's social care. Duplicates from multiple assessments where the factor is duplicated removed.
[49] LBBD.
[50] NHS. Benefits of breastfeeding [https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/]. Accessed 2018 Oct 03.
[51] Horta BL, Loret de Mola C, Victora CG. Breastfeeding and intelligence: a systematic review and meta-analysis. *Acta Paediatr* 2015;104(467):14–9.
[52] Unicef, Skin-to-skin contact [https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/skin-to-skin-contact/]. Accessed 2018 Oct 03.
[53] NHS Digital, Maternity Services Data Set, February 2018. Note: this is not specific to Barking and Dagenham residents.
[54] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[55] NHS Digital, Infant Feeding Survey – UK, 2010. Note: this survey has been discontinued.
[56] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/], 2016/17.

### 3.5.6 Maternal mental health

Perinatal mental health issues[57] are estimated to have long-term costs equivalent to around £10,000 per woman giving birth. For the 3,870 births in Barking and Dagenham in 2017, this would suggest a cost of £38.4m for a single year's cohort.[58]

Almost three-quarters of these costs are based on the impact on the child,[59] although this should not downplay the impact perinatal mental health issues have on women and their partners and families. Impacts on the child modelled to produce these estimates included preterm birth, infant death, emotional problems, conduct problems, special educational needs, and leaving school without qualifications.

Mental health conditions in the perinatal period are common, but we lack good quality data. Table 3.1 provides estimates of the number of cases we might expect in a year based on the number of births in Barking and Dagenham.

**Table 3.1: Estimated number of cases of perinatal mental health conditions in Barking and Dagenham in 2016**

| Condition | Number |
|---|---|
| Postpartum psychosis | 10 |
| Chronic serious mental illness | 10 |
| Severe depressive illness | 115 |
| Mild–moderate depressive illness & anxiety | 375–560 |
| Post-traumatic stress disorder | 115 |
| Adjustment disorders & distress | 560–1,120 |

*Data: PHE,* Mental health in pregnancy, the postnatal period and babies and toddlers. *Report for Barking and Dagenham local authority. [London]: PHE, 2017.*

This does not account for characteristics such as deprivation in our population that may make new mothers more vulnerable than the population in which the prevalence was calculated.

### 3.5.7 Cognitive and social development

Education does not begin at age 5; the early years are a key time for the development of skills that will allow a child to learn when they start primary school.

Development is reviewed at different times; all parents are offered a 2–2.5-year review by a health visitor and will be sent an Ages and Stages Questionnaire to complete which assesses the child's development.[60] Work is ongoing to allow us to report on the outcomes of the developmental questionnaires. Data on the coverage of these reviews is presented in section 3.5.9.

The current main measure of development is the Early Years Foundation Stage profile; all children are assessed (through observation by their teacher) at the end of their Reception year to provide a measure of their level of development across different domains.

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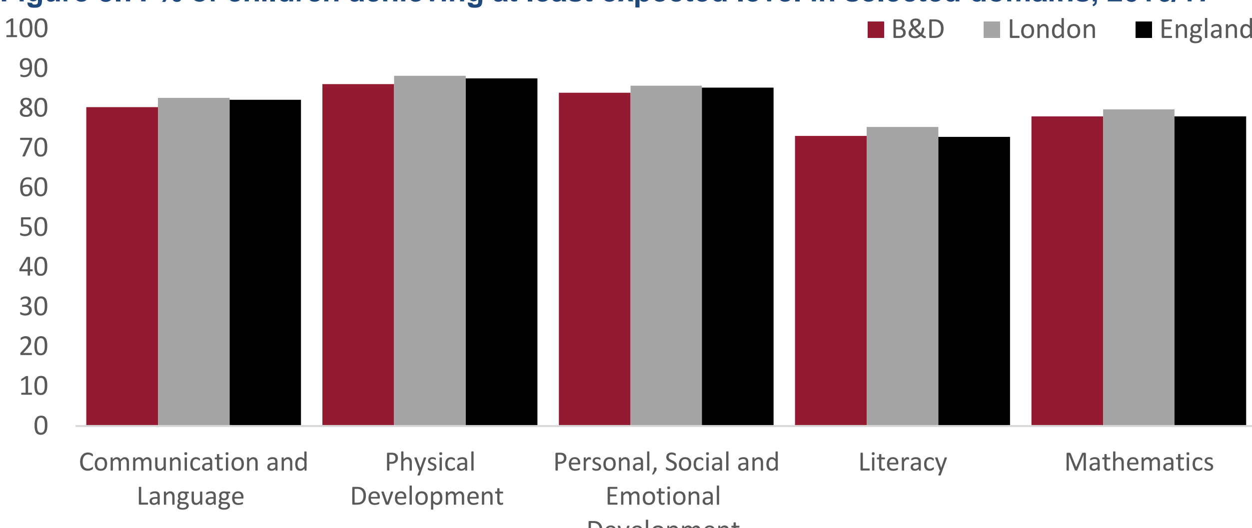
[57] Specifically perinatal depression, anxiety and psychosis.
[58] ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas. This is based on births rather than maternities as 2017 maternities data is not yet available. However, the cost will be of the same order of magnitude.
[59] Bauer A, Parsonage M, Knapp M, Iemmi V, Adelaja B; London School of Economics; Centre for Mental Health. *The costs of perinatal mental health problems*. London: Centre for Mental Health; 2014.
[60] See: NHS, Your baby's health and development reviews [https://www.nhs.uk/conditions/pregnancy-and-baby/baby-reviews/]. Accessed 2018 Oct 03.

Children are judged to have achieved a 'Good level of development' if they meet the expected level across five specified domains. In 2016/17, 71.6% of children met this level, which was lower than London (73.0%) but similar to England (70.7%).[61]

There was a 14.1 percentage point gap between boys and girls (64.8 and 78.9), which is similar to the gap at England level (13.7 percentage points).

Figure 3.7 suggests that the gap with London is not concentrated in a particular domain, but across all five relevant areas.

**Figure 3.7: % of children achieving at least expected level in selected domains, 2016/17**




*Data: Department for Education (DfE), Early years foundation stage profile (EYFSP) results: 2017.*

Key influences on good level of development include the home learning environment, high quality early years education and a high quality primary school.[62]

The home learning environment is an important factor in how children develop and is more influential than parents' incomes in determining the child's development at age 5. [63] This includes parents reading to their child, doing painting and drawing, teaching them songs and nursery rhymes and visiting libraries.

For example, this influences language skills; a survey conducted in the UK in late 2017 and early 2018 found that primary school teachers who responded reported that around half (49%) of Year 1 students had a 'limited vocabulary to the extent that it affects their learning', and reported concerns for such children's learning and achievement.[64] The extent and type of communication between parents and children in the early years is understood to be a key part of language development. [65]

Another important way in which children can prepare for school (and develop the skills measured above) is by attending a high quality early years education provider.[66] Almost four in five Barking and Dagenham 2 year olds who are eligible[67] from funded early education places were taking this up in January 2018.[68] This is higher than London (61%)

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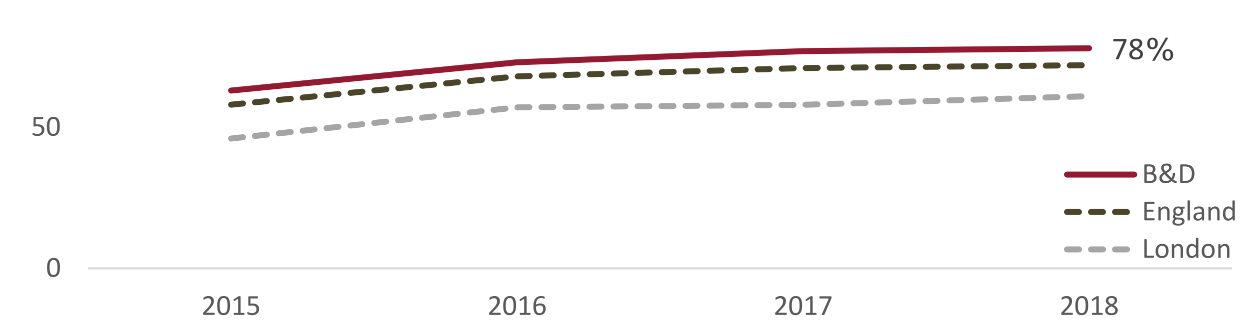
[61] Department for Education (DfE), Early years foundation stage profile (EYFSP) results: 2017.
[62] DfE, Early years evidence pack. [London]: DfE, 2011.
[63] DfE, Early years evidence pack. [London]: DfE, 2011.
[64] Oxford University Press. *Why Closing the Word Gap Matters: Oxford Language Report*. [Oxford]: OUP; 2018, p.4.
[65] Oxford University Press. *Why Closing the Word Gap Matters: Oxford Language Report*. [Oxford]: OUP; 2018.
[66] DfE, Early years evidence pack. [London]: DfE, 2011.
[67] Eligibility for funded childcare for 2 years olds is based on benefits that the parent(s) receive. See: Gov.UK, Free education and childcare for 2-year-olds [https://www.gov.uk/help-with-childcare-costs/free-childcare-2-year-olds]. Accessed 2018 Oct 03.
[68] DfE, Provision for children under 5 years of age in England: January 2018.

and England (72%). However, this nonetheless means that almost one in five children in a low-income household is not receiving funded early years education that they are entitled to.

Furthermore, only 72.6% of Barking and Dagenham 2 year olds with a funded early education place have 12.51–15.00 funded hours a week compared with 87.0% across England and 92.7% across London.

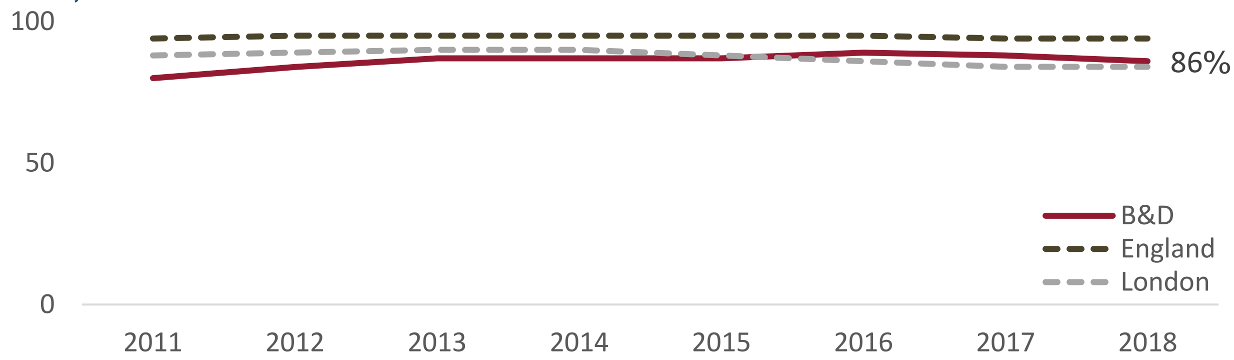
**Figure 3.8: % of eligible 2-year-old children benefitting from funded early education places, 2018**




*Data: DfE, Provision for children under 5 years of age in England: January 2018.*

In January 2018, 86% of 3- and 4-year-old children were benefitted from some form of funded early education. All parents are eligible for 15 hours a week of free childcare and parents in work are eligible for 30 hours a week.[69]

**Figure 3.9: % of 3- and 4-year-old children benefitting from universal funded early education places, 2018**




*Data: DfE, Provision for children under 5 years of age in England: January 2018.*

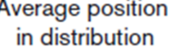
### 3.5.8 Wider determinants affecting children aged 0–4

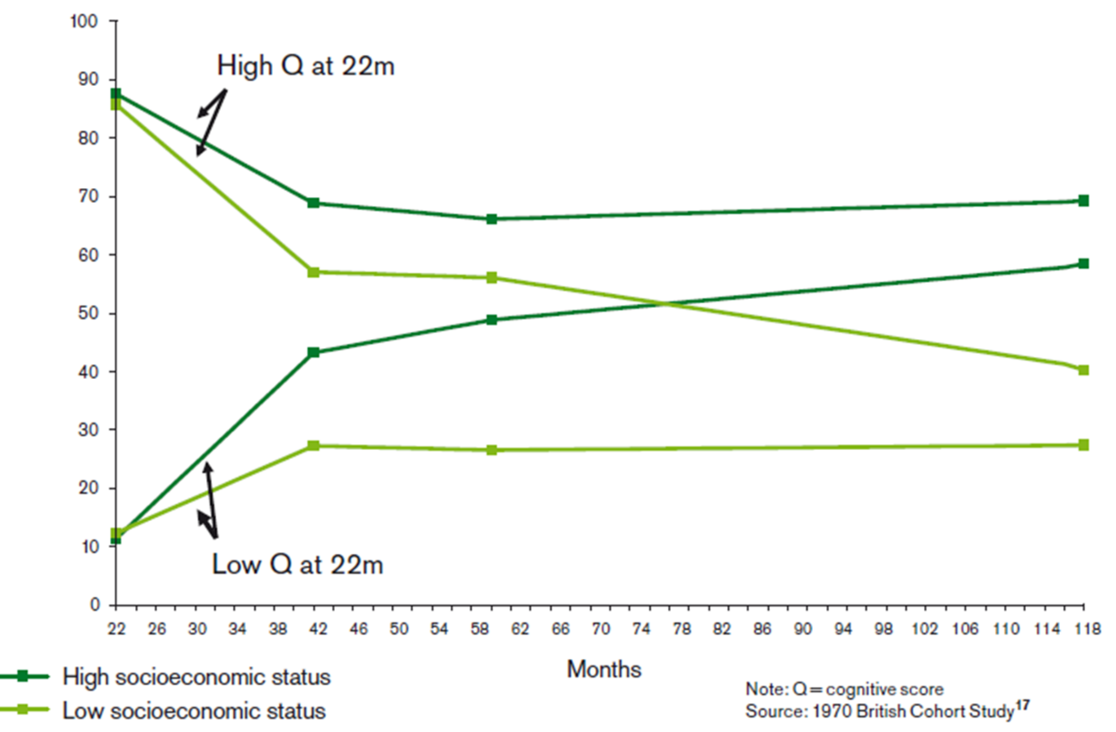
*Income deprivation*

Figure 3.10 (reproduced from the Marmot Report on health inequalities) shows how children with similar cognitive scores at 22 months can have very different scores at 10 years based on their socio-economic status and hence the need to mitigate against the effects of disadvantage from an early age.

[69] Gov.UK, 15 hours free childcare for 3 and 4-year-olds [https://www.gov.uk/help-with-childcare-costs/free-childcare-and-education-for-2-to-4-year-olds]. Accessed 2018 Oct 03.

**Figure 3.10: Inequality in cognitive development by children in the 1970 British Cohort Study, at ages 22 months to 10 years**

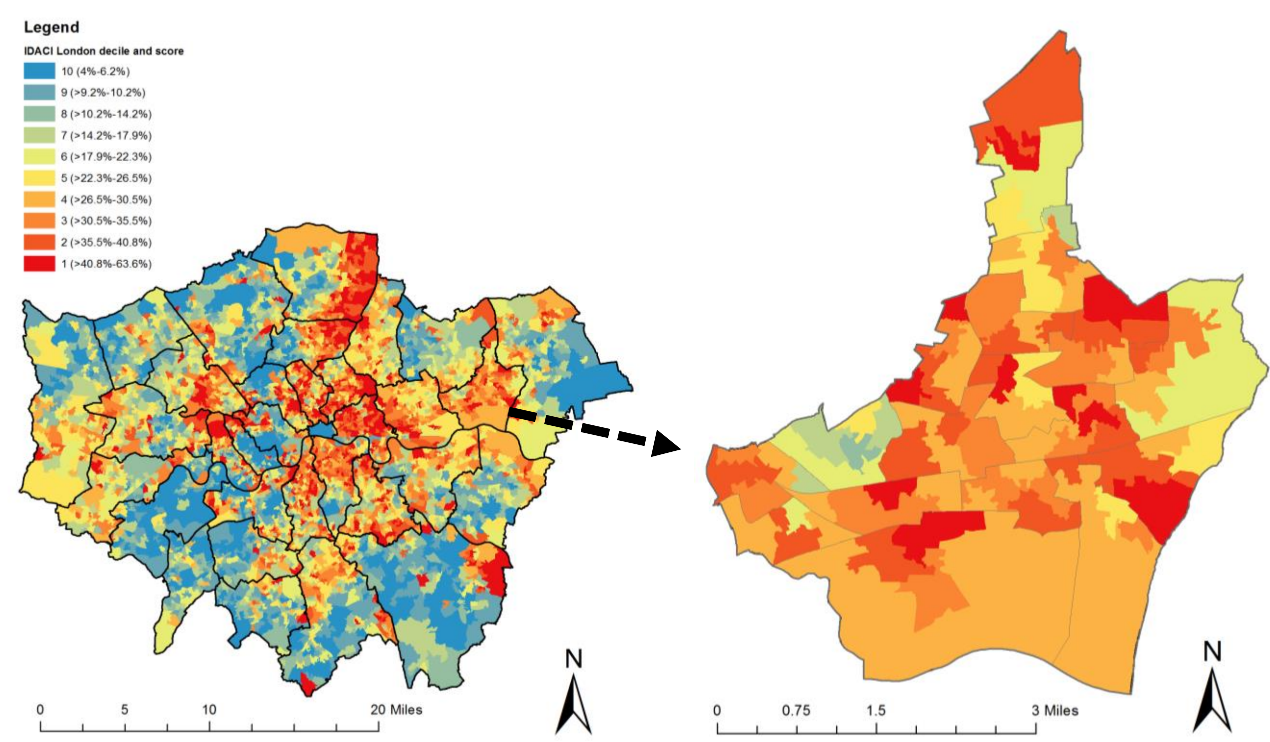



*Source: Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair Society, Healthy Lives: The Marmot Review. London: UCL; 2010.*

A high proportion of children in the borough are affected by income deprivation, with a fairly even distribution. The average across LBBD is 31.9%.

**Figure 3.11: Income deprivation affecting children index**




*Data: Ministry of Housing, Communities & Local Government, 2015. Contains National Statistics data © Crown copyright and database right 2009, 2014, 2016. Contains OS data © Crown copyright and database right 2009, 2014, 2016.*

*Domestic abuse*

Experiencing domestic violence and abuse can have a range of short- and long-term psychological and behavioural effects on children.[70] Domestic abuse can affect anyone, but evidence suggests that the risk is higher for women, young people, people with long-term conditions or disabilities, people with mental health disorders, pregnant or postnatal women, gay or bisexual men, and trans people.[71]

Barking and Dagenham had the highest rate of domestic abuse offences in London in 2016/17 at 11.2 per 1,000.[72] This is higher than the London average of 8.2 per 1,000.

The 2017 Barking and Dagenham School Survey found that 74% of students surveyed (from Years 8, 10 and 12) thought that hitting was always wrong in a relationship, while 61% believed that 'telling you who you can and can't see' was always wrong in a relationship.[73] This suggests that important proportions of young people believed that these behaviours were not always wrong in a relationship.

Of 596 assessments on children under 5 carried out by Barking and Dagenham's children's social services in 2017/18, more than one in four had domestic violence towards a parent or carer listed as a factor (26.0%).[74] When domestic violence towards the child or towards other members of the household are also included, 28.0% of assessments had at least one of these three factors recorded.

*Under 18 conceptions*

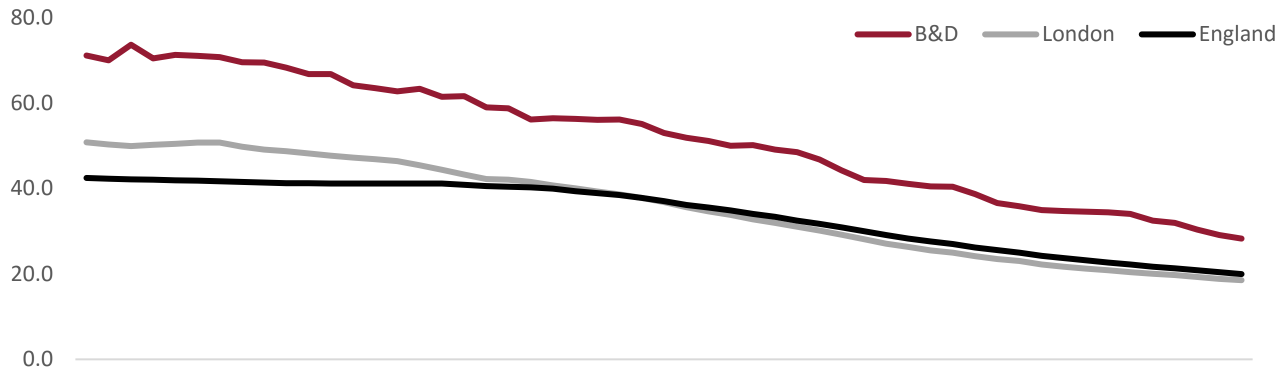
Evidence suggests that babies born to teenage mothers are at a higher risk of adverse outcomes, including hospitalisation for gastroenteritis or accidental injury, and lower spatial, non-verbal and verbal ability at age 5.[75]

Across 2016, there were 27.9 conceptions per 1,000 women under the age of 18.[76] This is higher than London or England (17.1 and 18.8 per 1,000 respectively). However, this is part of a long-term downward trend (Figure 3.12).

---

[70] Royal College of Psychiatrists. Domestic violence and abuse – its effects on children: the impact on children and adolescents: information for parents, carers and anyone who works with young people. Mental Health and Growing Up Factsheet. [https://www.rcpsych.ac.uk/expertadvice/parentsandyouthinfo/parentscarers/domesticviolence.aspx]. Accessed 2018 Oct 03.
[71] National Institute for Health and Care Excellence. *Domestic violence and abuse: multi-agency working*. Public health guideline 50. [Manchester]: NICE; 2014.
[72] Mayor's Office for Policing and Crime, London Landscape. [https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/london-landscape]. London figure is aggregate of boroughs and does not include cases not allocated to a borough.
[73] LBBD School Survey 2017.
[74] LBBD children's social care. Duplicates from multiple assessments where the factor is duplicated removed.
[75] PHE, Local Government Association (LGA). *A framework for supporting teenage mothers and young fathers.* London: PHE, 2016.
[76] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].

**Figure 3.12: Under 18 conceptions per 1,000 15–17 year olds, quarterly data presented as 3-year rolling average, quarter 1 2004/5 to quarter 1 2017/18**[77]




*Data: ONS, Quarterly conceptions to women aged under 18 years, England and Wales; ONS, mid-year estimates.*

### *Single parents*

In 2016, 8.3% of live births were registered by one parent only.[78] Although this is not necessarily a marker of single parenthood, this is higher than London (5.5%) and England (5.1%). Children in single parent households are more likely to experience poverty than those living with two adults.[79] Evidence from surveys in Germany found that children living in a single-mother family had a higher risk of parent-reported poor health, but this was no longer significant in boys once socio-economic characteristics were adjusted for.[80] It remained significant in girls, but with a smaller effect than before the adjustment.

### *Housing and homelessness*

A Shelter report on 'bad housing' and children focused on three key issues: homelessness, overcrowding, and unfit housing. These issues had a range of adverse health outcomes, including an increased risk of meningitis, tuberculosis, respiratory problems, missing immunisations, slow growth (itself linked with coronary heart disease risk in adulthood), accidents, mental health issues, more school absences, and behavioural issues at school.[81]

Barking and Dagenham had the fourth highest family homelessness rate in London in 2016/17, at 6.2 per 1,000 households.[82] This is higher than London (4.0) and England (1.9) averages. This corresponds to 477 households with dependent children or pregnant women were accepted as unintentionally homeless and eligible for assistance.

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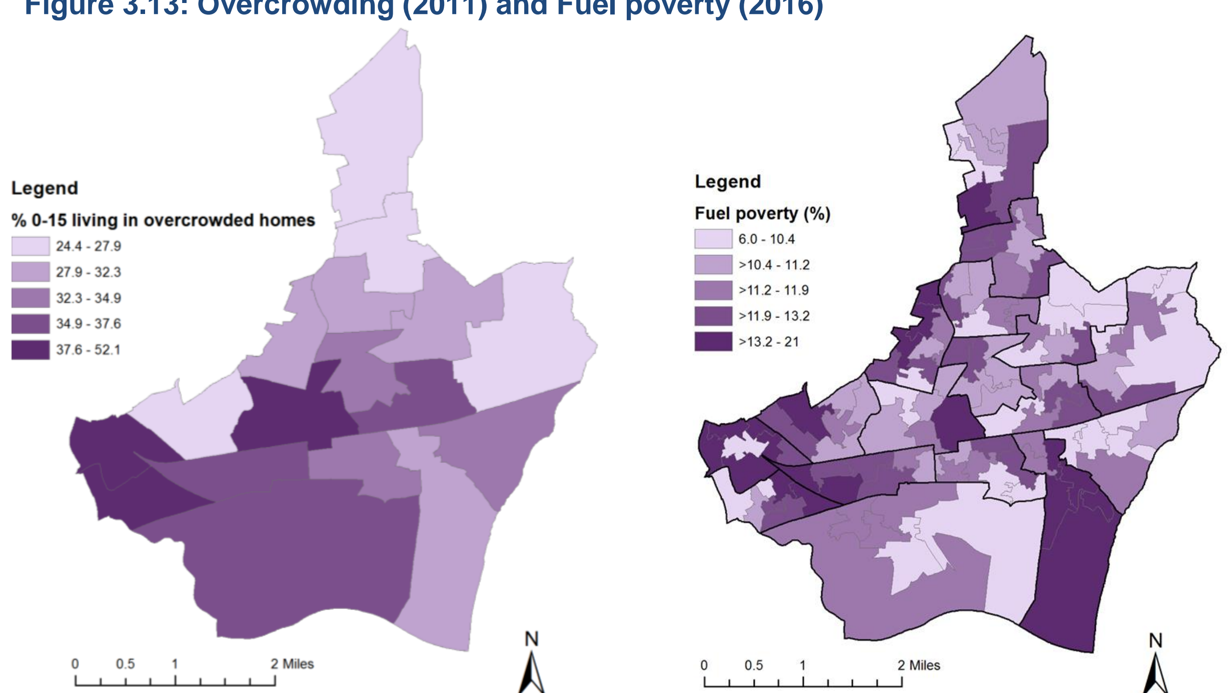
[77] Data is presented as a 3-year rolling average; quarter 1 2004/5 relates to data from quarter 2 2001/2 to quarter 1 2004/5.
[78] ONS, Live births by mothers' usual area of residence, 2016.
[79] Gingerbread. Single parent statistics [https://www.gingerbread.org.uk/policy-campaigns/publications-index/statistics/]. Accessed 2018 Oct 03.
[80] Scharte M, Bolte G; GME Study Group. Increased health risks of children with single mothers: the impact of socio-economic and environmental factors. *Eur J Public Health* 2013;23(3):469–75.
[81] Shelter. *Chance of a lifetime. The impact of bad housing on children's lives.* London: Shelter; 2006. Note: Some outcomes are specific to overcrowding, unfit housing or homelessness.
[82] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/]. Family homelessness = 'Number of applicant households with dependent children or pregnant women accepted as unintentionally homeless and eligible for assistance' per 1,000 households.

**Figure 3.13: Overcrowding (2011) and Fuel poverty (2016)**




*Data: Overcrowding – Census. Fuel poverty – Department for Business, Energy & Industrial Strategy. Contains National Statistics data © Crown copyright and database right 2012, 2016. Contains OS data © Crown copyright and database right 2012, 2016.*

Furthermore, Census data show high levels of overcrowding affecting children. By ward, this ranges from 24.4%–52.1%; between one in two and one in four children aged 0–15 in every ward was living in an overcrowded home at the time of the census.

Fuel poverty affects an estimated 8,433 households in Barking and Dagenham: around one in nine (11.6%) households in the borough.[83] This is the sixth highest proportion in London and the 67th highest of 152 local authorities in England.

Further information on housing is available in chapter 5 (Resilience).

### 3.5.9 Health services

*Health visiting services*

All mothers and babies in Barking and Dagenham should receive five reviews from a health visitor: an antenatal contact from 28 weeks of pregnancy, a new birth review in the first 14 days, a 6–8-week review, a 12-month review and a review at 2–2.5 years.

In 2017/18, 61.8% of children received a 2–2.5 year review by the age of 2.5 years, compared with 75.7% across England.[84]

Ensuring that parents are aware of the importance of these reviews and tackling logistical barriers will be important to ensuring take-up is as high as possible.

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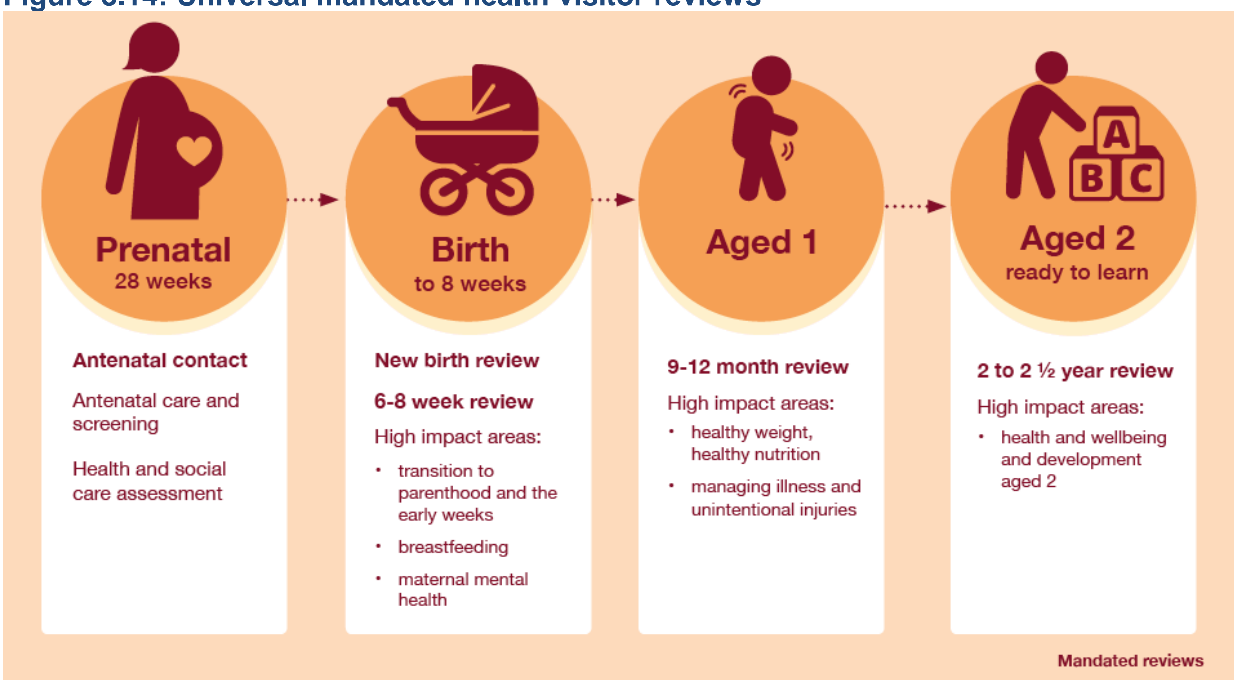
[83] Department for Business, Energy & Industrial Strategy, Sub-regional Fuel Poverty. England 2018 (2016 data).
[84] North East London NHS Foundation Trust [Barking and Dagenham data]; Public Health England, Health Visitor Service Delivery Metrics, 2017/18 Annual Data (October 2018 release) [England data].

**Figure 3.14: Universal mandated health visitor reviews**




*Source: PHE.*

*Immunisations*

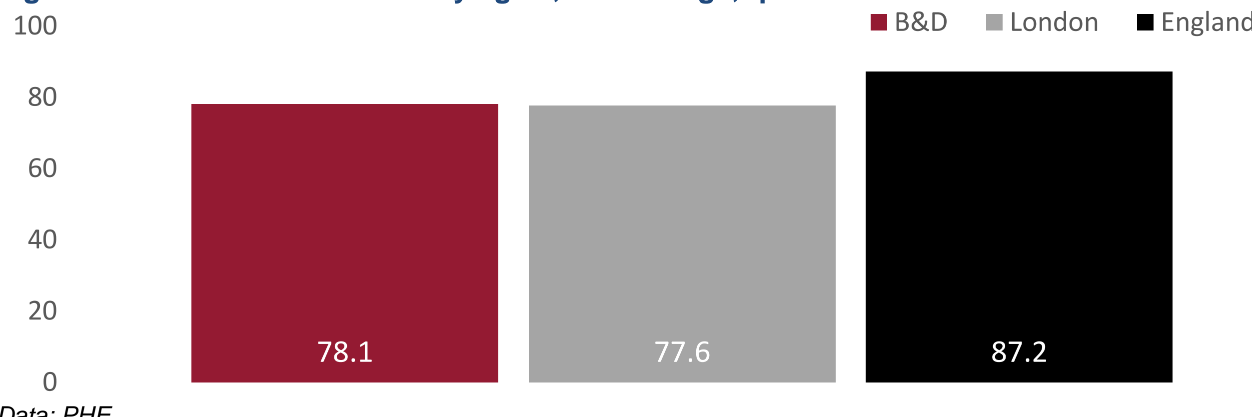
Giving children the best start in life includes protecting them from avoidable harm. Vaccinations are a simple and safe way to protect children from illnesses that can have serious consequences.

Measles, mumps and rubella

The mumps, measles and rubella vaccine should be given to children at 12 months, with a second dose at 3 years 4 months.

Coverage should ideally be at 95% or above to create herd immunity and protect vulnerable people who are not immune in the community.[85]

**Figure 3.15: two doses of MMR by age 5, % coverage, quarter 4 2017/18**




*Data: PHE.*

In the 52 weeks to week 32 2018, there were five reported cases of mumps and three of measles in Barking and Dagenham. There were no reported cases of rubella.

[85] This is where coverage is high enough so that an occurrence of the disease cannot spread as there are not enough suitable hosts in the population for it to spread to. This provides projection for individuals who are not immune as there is a lower risk they will come into contact with the infection. See: NHS. How vaccines work [https://www.nhs.uk/conditions/vaccinations/how-vaccines-work/]. Accessed 2018 Oct 03.

There were 2,665, 6,913 and 328 cases of measles, mumps and rubella respectively across England and Wales in the same time period; these diseases do occur and can have serious consequences.

Flu

The flu vaccine has been freely available to selected age groups of children on the NHS since 2013.[86] This is both because children can be more severely affected by flu but also because of their role in the spread of flu to others.[87]

Around one-third of 2–3 year olds had a flu vaccine in 2017/18 (32.3%), which is similar to London (33.2%), but significantly lower than England (43.5%).

Unlike other vaccines, a new flu vaccine is developed each year to try to match the strains which are predicted to be circulating so it is important that children are vaccinated annually.

In 2018/19 it will be available to all children who were aged 2 or 3 on 31 August 2018 and primary school children except Year 6.

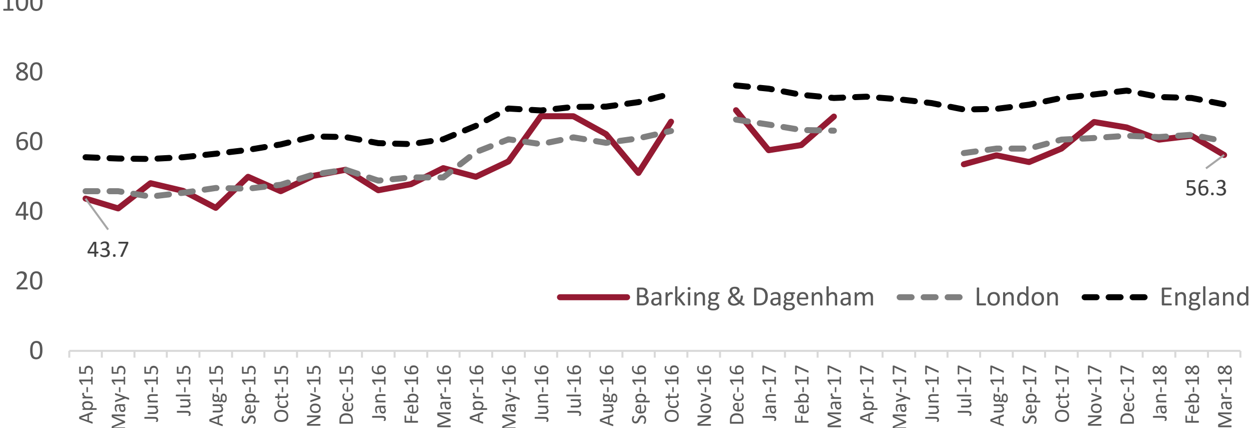
Pertussis (whooping cough) vaccine in pregnancy

Pregnant women are advised to receive the whooping cough vaccine between 16 and 32 weeks of pregnancy.[88] This is because young babies are at risk before their first set of vaccinations at 8 weeks; vaccinating women in pregnancy provides protection in these first few months of life as antibodies pass through the placenta to the baby and continue to provide passive protection after birth.

Coverage in Barking and Dagenham in March 2018 was estimated at 58.3% (Figure 3.16). This means that more than one-third of pregnant women had not had the vaccine.

Although there were no cases of whooping cough in Barking and Dagenham in the 52 weeks to week 32 2018, there were 3,005 cases across England and Wales in the same time period.

**Figure 3.16: Pertussis vaccine coverage estimates (%)[89]**




*Data: PHE, Prenatal pertussis Vaccine Coverage Monitoring Programme, England, April 2015 to March 2018.*

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[86] PHE. *The National Childhood Flu Immunisation Programme 2018/19. Information for healthcare professionals.* London: PHE; 2018.
[87] NHS. Children's flu vaccine [https://www.nhs.uk/conditions/vaccinations/child-flu-vaccine/]. Accessed 2018 Oct 03.
[88] NHS. Whooping cough vaccination in pregnancy [https://www.nhs.uk/conditions/pregnancy-and-baby/whooping-cough-vaccination-pregnant/]. Accessed 2018 Oct 03. See also: PHE, NHS. *Whooping cough and pregnancy: Your questions answered on how to help protect your baby.* [London]: PHE, 2017.
[89] For more information on interpretation, see: PHE, Pertussis vaccination programme for pregnant women update: vaccine coverage in England, Jan-March 2018. *Health Protection Report* Volume 12 Number 27.

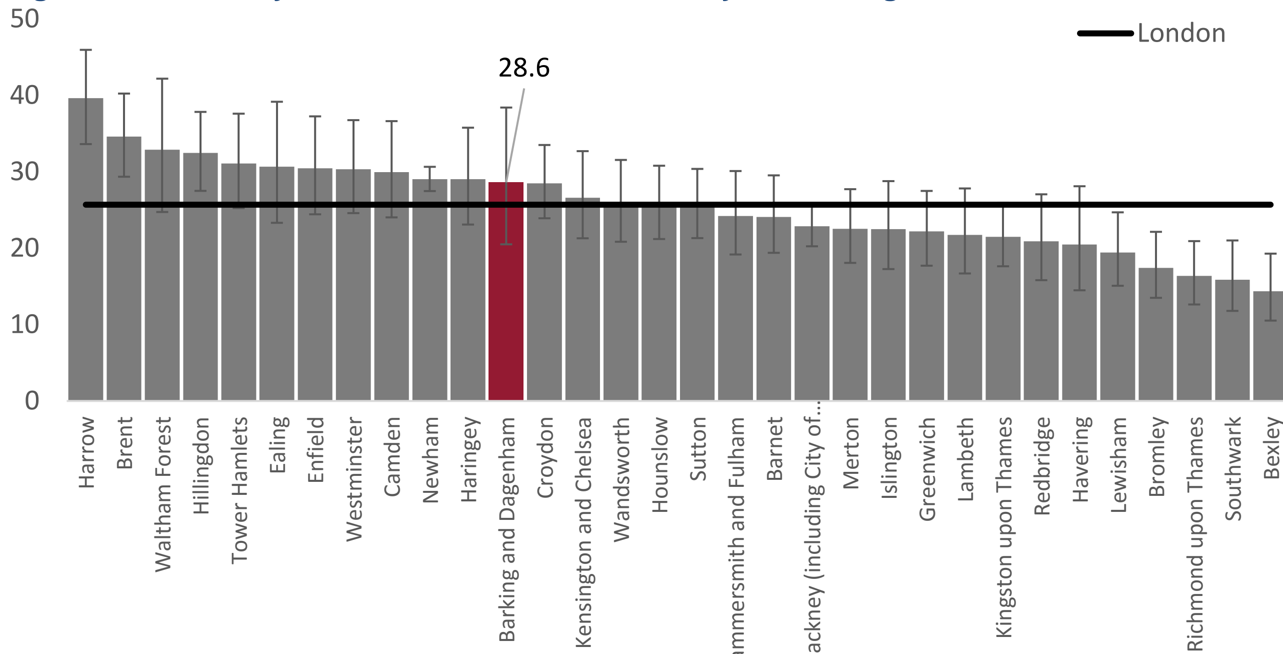
*Oral health*

Oral health problems such as cavities can cause children pain, difficulty eating and sleeping and time away from school.[90]

18% of 3 year olds surveyed in 2013 had one or more decayed, missing or filled tooth – higher than England (11.7%) but similar to London (13.6%).[91]

For 5 year olds (Figure 3.17), approaching three in ten children in Barking and Dagenham surveyed in 2016/17 had one or more decayed, missing or filled tooth (28.6%), which is similar to London (25.7%) and England (23.3%).[92] However, this still means that children are suffering unnecessarily.

**Figure 3.17: % of 5 year olds with one or more decayed, missing or filled tooth, 2016/17**




*Data: PHE, National Dental Epidemiology Programme for England. Oral health survey of five-year-old children 2017.*

Hospital admissions for dental caries (0-4 years) are lower than London but similar to England.[93]

## 3.6 Conclusions

Early child development has lifelong influences and early childhood is a key time to intervene to reduce health inequalities. Best start in life is particularly important in Barking and Dagenham due to its level of deprivation and high proportion of children aged 0–4 (9.4%, the highest in the UK).

Best start in life ideally begins before conception, with preparation for a healthy pregnancy from both parents. However, nationally, around one in three births is likely to be unplanned or the mother feels ambivalent. Parents may also not understand the benefits of optimising their health prior to pregnancy or be motivated or able to do so. For example, more than half (53%) of pregnant women attending a booking appointment at BHRUT in February

[90] PHE. Health Matters: Child Dental Health [https://publichealthmatters.blog.gov.uk/2017/06/14/health-matters-child-dental-health/]. Accessed 2018 Oct 03.
[91] PHE, Oral Health Profile [https://fingertips.phe.org.uk/profile/oral-health]; 2012/13.
[92] PHE, Child and Maternal Health profile [https://fingertips.phe.org.uk/profile/child-health-profiles]. The Barking and Dagenham and England figures are classed as similar as they have overlapping confidence intervals; as this is based on a survey, there is considerable uncertainty around the 'true' population values.
[93] PHE, Child and Maternal Health profile [https://fingertips.phe.org.uk/profile/child-health-profiles]; 2014/15-2016/17.

2018 (not specifically Barking and Dagenham residents) were overweight or obese. **Improving adult population health in areas such as excess weight and physical activity (both Borough Manifesto targets) would benefit the next generation.**

Contraception allows women to choose when or if to have a baby, but younger women are less likely than older women in Barking and Dagenham to use long-acting reversible contraceptives (LARC), despite their greater effectiveness. **Ensuring women are aware of the benefits and can access LARC may give them more control over their fertility.**

Around 1 in 13 pregnant women smoked at time of delivery in 2017/18. This is declining but is still the third highest in London. We lack data on substance misuse in pregnancy specifically, but this also has recognised harms. **Pregnancy should continue to be recognised as a key moment to intervene to help women and their partners make a long-term change.**

Substance misuse, breastfeeding and perinatal mental health are important areas where we lack good quality data; for example, in 2017/18, 53% of infants were totally or partially breastfed at 6–8 weeks, but we were missing breastfeeding data on one in five children. Similarly, we only have estimated figures of perinatal mental health conditions available to us. **We should explore how we can bring together existing sources of early years data to effectively monitor and identify inequalities and areas for improvement.**

In 2016/17, 71.6% of children achieved a 'Good level of development' in Barking and Dagenham, which is lower than London but similar to England. High quality early years education contributes to this, but one in five eligible 2 year olds is not receiving early years education that they are entitled to. **We should continue to improve take-up of funded early years places, while continuing to support parents to develop a suitable home learning environment.**

Income deprivation affecting children is widespread in Barking and Dagenham, with an estimated 32% of children living in income deprived families. Barking and Dagenham is also affected by high levels of family homeless and overcrowding. It had the highest rate of domestic abuse offences in London in 2016/17, while more than one in four children's social care assessments in 2017/18 recorded domestic abuse as a factor. Reducing domestic abuse is a Borough Manifesto priority. **The conditions in which children spend their early years are likely to have a large impact on their future health outcomes.**

The proportion of children receiving a 2–2.5-year review is lower than England. Almost four in ten Barking and Dagenham children do not receive this check by 2.5 years of age. Vaccination coverage of MMR and flu vaccines in young children is significantly lower than England. **Services should continue to find ways to identify and reach children who have not received these.**

# 4 Early diagnosis and intervention

## 4.1 What do we mean by early diagnosis and intervention?

**Early diagnosis and intervention** refers to the ways in which an early diagnosis and prompt access to effective and appropriate treatment or intervention can improve health outcomes.

## 4.2 Why is this important?

Many conditions are more amenable to treatment or there is improved quality of life if they are diagnosed early. There may also be benefits for families and communities, while demand for health services can be managed more effectively.

For example, prompt diagnosis and treatment for cancer can reduce mortality, while diagnosing diabetes early and effectively can reduce the likelihood of complications. Diagnosing communicable diseases early, such as sexually transmitted infections or tuberculosis, can also limit onward transmission.

The avoidable consequences of health conditions can have costs to the local economy (for example, if they result in the individual needing to take more time off work than if they had been treated early), costs to health services, costs to social care and opportunity costs.

However, there is a need to remain vigilant to harms as well as benefits, especially where we are looking to diagnose preclinical disease or considering new methods of screening, to ensure we are not overtreating individuals or causing unnecessary anxiety.[94] Ensuring that there is a clear evidence base for action is therefore important in this, as in all public health measures.

## 4.3 Why is this important for Barking and Dagenham?

Barking and Dagenham has the highest avoidable mortality rate in London.[95]

Avoidable mortality comprises two components: preventable mortality and amenable mortality. 'Preventable' encompasses deaths that are potentially preventable through public health measures, whereas 'amenable' specifically refers to deaths that could be prevented through suitable health care.[96] Avoidable mortality includes both preventable and amenable deaths, but each death is only counted once.

Not only does Barking and Dagenham have the highest *preventable* mortality rate in London, it also has the highest *amenable* mortality rate in London, and the 13th highest of 324 areas in England. Between 2014 and 2016, 612 residents died of conditions that were potentially amenable to high quality healthcare.

This suggests that together with work around primary prevention (e.g. reducing smoking, increasing physical activity) to decrease the number of preventable deaths, there is also a need to ensure that residents experiencing illness have access to and use good quality healthcare services to avoid their condition resulting in premature death.

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[94] Kale MS, Korenstein D. Overdiagnosis in primary care: framing the problem and finding solutions. *BMJ* 2018;362:k2820.
[95] ONS, Avoidable mortality in the UK: 2016.
[96] ONS, Avoidable mortality in the UK: 2016. Statistical bulletin [https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2016]. Accessed 2018 Oct 03. The number of avoidable deaths is derived from a list of causes of death with the age ranges they apply to; most deaths from the causes on this list are only considered preventable or amenable under the age of 75.

Three of Barking and Dagenham's five leading causes of death are considered amenable when they occur in under 75s: ischaemic heart disease, chronic lower respiratory diseases,[97] and stroke.

Furthermore, mortality is only part of the story as living with an undiagnosed or untreated illness has individual and societal costs of its own. A focus only on mortality would not address the burden of illnesses that can cause a significant reduction in quality of life, but rarely directly result in death, such as common mental health conditions.

As a further example, diagnosing HIV early reduces the risk of morbidity and transmission to others. However, in Barking and Dagenham, 52.5% of HIV infections are diagnosed late, compared with 33.7% across London and 40.1% in England.[98] This is the third highest in London (with the second highest being City of London, which is not very reliable due to the small number of cases).

## 4.4 What is the local picture for conditions which are amenable to early diagnosis and intervention?

### 4.4.1 Lifestyle-related illnesses

A number of lifestyle factors such as smoking, excessive drinking or being obese increase the risk of poor health outcomes.

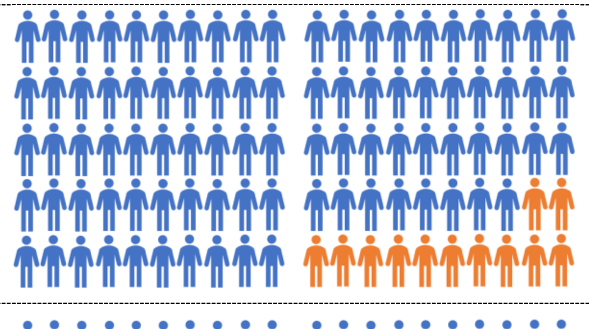
This section focuses on cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes and liver disease, since all four conditions contribute to morbidity and mortality in the borough and early diagnosis or identification of risk and intervention could improve health outcomes.

Although lifestyle factors can also increase the risk of cancer, this is considered separately below.

*Lifestyle risk factors*[99]

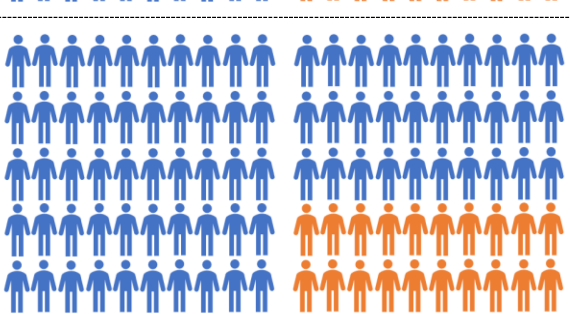
| Of 100 people in the specified population: | Risk factor: |
| --- | --- |
| | **Dependent drinkers:** An estimated 1.53% of adults in Barking and Dagenham are dependent on alcohol, compared with 1.36% across London and 1.39% in England.[100]<br><br>Excessive alcohol consumption is a risk factor for liver disease, cardiovascular disease (heart disease and stroke) and cancer.[101] There can also be social consequences, such as unemployment and domestic violence. |
| | **High blood pressure:** 11.6% of the Barking and Dagenham GP-registered population is on their GP's hypertension register.[102] |

[97] With the exception of bronchiectasis (International Classification of Diseases, tenth revision [ICD-10] code J47).
[98] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]; 2015–17.
[99] Note: percentages in infographics rounded to nearest whole person. One block = 50%, one row = 10%, one person = 1%.
[100] PHE, Local Alcohol Profiles for England [https://fingertips.phe.org.uk/profile/local-alcohol-profiles]. Note: these are modelled figures for 2014/15.
[101] NHS. Overview: Alcohol misuse [https://www.nhs.uk/conditions/alcohol-misuse/]. Accessed 2018 Oct 03.
[102] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.



High blood pressure is a risk factor for cardiovascular disease, including heart disease and stroke.[103]

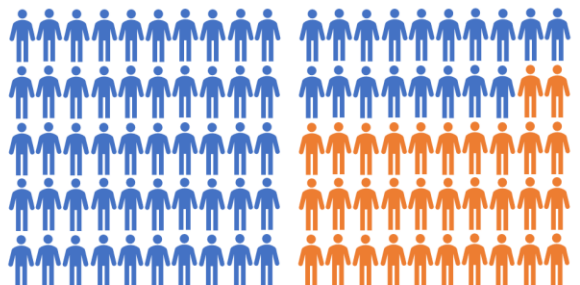
Modifiable risk factors for high blood pressure include a high salt diet, overweight/obesity, physical inactivity, smoking, and excessive alcohol intake.[104]



**Smoking:** 19.9% of the Barking and Dagenham GP-registered population are smokers, compared with 17.3% in London and 17.6% across England.[105]

This is the fifth highest in London and the 41st highest in England.

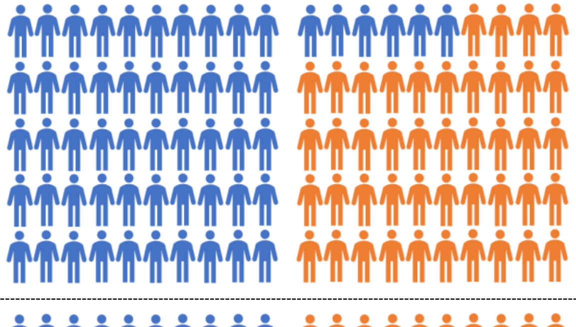
Smoking is a major risk factor for conditions including lung cancer, chronic obstructive pulmonary disease (COPD), heart disease and stroke.[106]



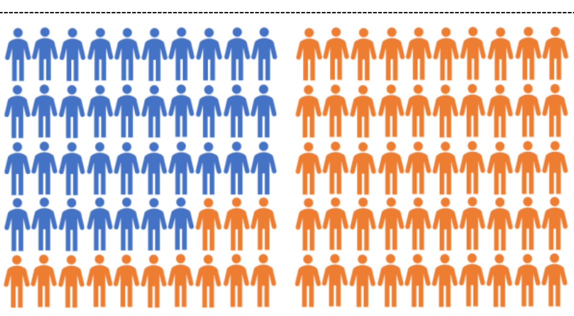
**Physical inactivity:** 32.1% of Barking and Dagenham adults (19+) are physical inactive (less than 30 minutes of moderate intensity exercise a week), compared with 22.9% in London and 22.2% across England.

This is the highest in London and 4th highest in England.

Physical inactivity increases the risk of conditions including heart disease, type 2 diabetes and breast cancer.[107]



**Overweight/obesity in children (age 10–11):** 43.8% of Barking and Dagenham Year 6 children are overweight or obese. This is higher than London (38.5%) and similar to England (34.2%)



**Overweight/obesity in adults:** 62.8% of Barking and Dagenham adults are overweight or obese, compared with 55.2% in London and 61.3% across England.

This is the second highest in London and 65th highest of 152 local authorities in England.

Obesity is a risk factor for type 2 diabetes, coronary heart disease, cancer, mental health problems and stroke.[108]

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[103] NHS. Overview: High blood pressure (hypertension) [https://www.nhs.uk/conditions/high-blood-pressure-hypertension/]. Accessed 2018 Oct 03.

[104] NHS. Causes: High blood pressure (hypertension) [https://www.nhs.uk/conditions/high-blood-pressure-hypertension/causes/]. Accessed 2018 Oct 03.

[105] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control]. 2016/17 Quality and Outcomes Framework data.

[106] NHS Digital, Statistics on Smoking – England 2018 – Data tables.

[107] Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT; Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *Lancet* 2012;380(9838):219–29.

[108] NHS. Overview: Obesity [https://www.nhs.uk/conditions/obesity/]. Accessed 2018 Oct 03.

**Cardiovascular disease** is a general name for a group of conditions affecting the heart and blood vessels that includes coronary heart disease and stroke.

**Prevalence**

Coronary heart disease (also known as ischaemic heart disease) is relatively common; 1 in 53 (1.9%) patients registered with a Barking and Dagenham GP is on their GP's coronary heart disease register.[109] As this is across all age groups, but we would not expect children and young people to have these conditions, the prevalence in the age groups where this typically occurs will be much higher.

Based on modelled estimates, we would expect around 9.6% of adults aged 55–79 in Barking and Dagenham to have coronary heart disease.[110] This is estimated to be the second highest in London.

Around 1 in 111 (0.9%) patients registered with a Barking and Dagenham GP is on their GP's stroke and transient ischaemic attack (TIA) register.[111]

The modelled estimated prevalence of stroke in adults aged 55–79 in Barking and Dagenham is 3.8%.[112] This is estimated to be the highest in London.

Both coronary heart disease and stroke are leading causes of death in Barking and Dagenham; 13.7% of deaths in men and 9.3% of deaths in women between 2014 and 2016 were due to ischaemic heart diseases (around 85 and 60 deaths each year respectively).[113] A further 5.3% of deaths in men and 5.7% of deaths in women were due to stroke (around 35 and 40 deaths each year respectively).

**Early diagnosis and intervention**

Early diagnosis and intervention in this context can include assessing risk and making changes based on this. It also includes the effective diagnosis and treatment of those presenting with symptoms.

Cardiovascular disease risk is calculated as part of the NHS Health Check that should be offered to all 40–74 year olds without pre-existing long-term conditions every 5 years. Based on risk score and findings, patients may be offered lifestyle advice (including referral to any relevant weight management/physical activity programmes) or medication.

5,862 people received an NHS Health Check in 2017/18. Between 2013/14 and 2017/18, 55.6% of the eligible population had a health check, compared with 49.3% in London and 44.3% across England.[114]

Good cardiovascular health may reduce the risk of vascular dementia and Alzheimer's disease in later life[115] and hence an early assessment of risk and support to make changes could also be an early intervention to prevent these conditions.

[109] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[110] PHE, Modelled prevalence estimates profile [https://fingertips.phe.org.uk/profile/prevalence]. Estimate is for 2015.
[111] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[112] PHE, Modelled prevalence estimates profile [https://fingertips.phe.org.uk/profile/prevalence]. Estimate is for 2015.
[113] ONS via Nomis, Mortality statistics - underlying cause, sex and age.
[114] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[115] NHS. Overview: Vascular dementia [https://www.nhs.uk/conditions/vascular-dementia/]. Accessed 2018 Oct 04; NHS. Overview: Alzheimer's disease [https://www.nhs.uk/conditions/alzheimers-disease/]. Accessed 2018 Oct 04.

**Chronic obstructive pulmonary disease (COPD)** is a respiratory condition characterised by varying degrees of chronic bronchitis (inflammation of the airways) and emphysema (damaged air sacs in the lungs).[116] It is primarily caused by smoking.

**Prevalence**

Around 1 in 63 people registered with a Barking and Dagenham GP (1.6%) have been diagnosed with COPD.[117] This is the third highest prevalence in London despite the fact that this is a non-age standardised measure and COPD is rarely diagnosed in the younger age groups that make up the majority of our population.

Furthermore, modelled estimates suggest that the prevalence of COPD across all age groups is 2.4% in Barking and Dagenham, or 1 in 42.[118]

This suggests that only two in three people living with COPD have a recorded diagnosis.

Barking and Dagenham has the highest age-standardised COPD mortality rate in London and the 15th highest (of 150 local authorities) in England.[119]

**Early diagnosis and intervention**

Although COPD cannot be cured, the loss of lung function can be slowed, and hence early diagnosis is important.[120] If the patient smokes, stopping smoking is a key intervention and ensuring that GPs are able to effectively communicate the specific benefits of quitting to COPD patients and know how to refer or signpost them to smoking cessation services who can support them to quit is important.

We can also look at treatment and outcomes for those with a diagnosis. In 2016/17, 82.7% of patients with COPD registered with a Barking and Dagenham GP had a review by a medical professional in the last year, compared with 84.0% in London and 80.1% in England.[121]

As people with COPD are a high-risk group for flu, they are offered this free annually. However, only three-quarters (76.5%) of people with COPD took this up in 2016/17, which is similar to London (76.9%) but higher than England (79.2%).[122]

Barking and Dagenham has the second highest age-standardised rate of emergency COPD hospital admissions in London and the 18th highest (of 148 local authorities) in England.[123] Although this reflects in part the high prevalence of COPD in Barking and Dagenham, suitable diagnosis and management should reduce the need for emergency admission.

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[116] NHS. Overview: Chronic obstructive pulmonary disease (COPD) [https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/]. Accessed 2018 Oct 04.
[117] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[118] PHE, Modelled prevalence estimates profile [https://fingertips.phe.org.uk/profile/prevalence]. Estimate is for 2015.
[119] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control]; 2014-16.
[120] NHS. Overview: Chronic obstructive pulmonary disease (COPD) [https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/]. Accessed 2018 Oct 04.
[121] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[122] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[123] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control]; 2016/17, 35+.

**Diabetes** is a condition where the body is unable to regulate (or effectively regulate) its blood sugar levels.

Although this is in the 'lifestyle related illnesses' section, there are important non-modifiable risk factors for diabetes, notably ethnicity, age and family history.

**Table 4.1: Types of diabetes, risk factors, treatment and potential complications**

| | Type 1 | Type 2 | Gestational diabetes (GDM) |
|---|---|---|---|
| *Pathway* | Autoimmune – no insulin produced by body | Insufficient insulin produced or insufficient response to it | Insufficient insulin produced during pregnancy |
| *Risk factors* | Family history | **Obesity**<br>Age<br>Family history<br>Ethnicity | **Obesity**<br>Previous GDM<br>Family history of diabetes<br>Ethnicity |
| *Treatment* | Insulin injections or pump | Lifestyle changes, medication and/or insulin | As type 2 |
| *Complications* | Heart disease/stroke<br>Sight loss<br>Kidney disease<br>Risks to mother/baby during pregnancy | Nerve damage<br>Foot problems/amputation<br>Sexual dysfunction | Risks in pregnancy, increased risk of type 2 diabetes afterwards |

*Source: Compiled from information on NHS website.*[124]

## Prevalence

Overall, around 1 in 13 adults (aged 17 and above) registered with a Barking and Dagenham GP have diabetes (7.9%).[125] However, closer to 1 in 11 people (9.2%, 16+) are estimated to be living with diabetes. This means that a substantial proportion of people with diabetes may be undiagnosed.

Most diagnosed diabetes in Barking and Dagenham is type 2 diabetes (4% type 1; 85% type 2; 11% unspecified).[126]

Diabetes has a strong relationship with both ethnicity and age. For example, among the Barking and Dagenham GP-registered population, the age-standardised diabetes rate in the Asian population is 2.5 times higher than in the White population.[127] People of Black and Mixed ethnicity also have significantly higher age-standardised diabetes rates than the CCG average. Nonetheless, 45% of people with diabetes registered with a Barking and Dagenham GP are White as this is the predominant ethnic group in the older population, in whom diabetes is more common.

## Early diagnosis and intervention

If not diagnosed and managed effectively, diabetes can lead to complications that include sight loss and amputations.

[124] NHS. Understanding medication: Type 2 diabetes [http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Treatment.aspx]. Accessed 2018 Oct 04; NHS. Type 1 diabetes [http://www.nhs.uk/conditions/Diabetes-type1/Pages/Introduction.aspx]. Accessed 2018 Oct 04; NHS. Diabetes [http://www.nhs.uk/Conditions/Diabetes/Pages/Diabetes.aspx]. Accessed 2018 Oct 04. NHS. Overview: Gestational diabetes [http://www.nhs.uk/Conditions/gestational-diabetes/Pages/Introduction.aspx]. Accessed 2018 Oct 04. NHS. Diabetes and pregnancy [http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/diabetes-pregnant.aspx]. Accessed 2018 Oct 04.
[125] PHE, Cardiovascular Disease profile [https://fingertips.phe.org.uk/profile/cardiovascular].
[126] Health Analytics, September 2017. Directly age standardised rate based on Barking and Dagenham GP-registered population.
[127] Health Analytics, September 2017.

The National Diabetes Prevention Programme has been in operation across Barking and Dagenham, Havering and Redbridge since July 2018 and the aim is to refer 150 eligible people a month (across the patch).

For those with a diabetes diagnosis, nine annual care processes are recommended, of which eight are carried out in primary care.[128] It is also recommended that when patients attend a structured education programme following their diagnosis.

In 2016/17, 96.8% of people with type 2 diabetes registered with a Barking and Dagenham GP received a blood pressure check, 91.3% received a cholesterol check, and 89.3% received an annual foot check. Around half of people with type 2 diabetes received all eight care processes in 2016/17 (48.4%).

**Figure 4.1: Annual care processes for people with diabetes**

| Nine Annual Care Processes for all people with diabetes aged 12 and over | |
|---|---|
| **Responsibility of Diabetes Care providers (included in the NDA 8 Care Processes)** | |
| **1. HbA1c**<br>(blood test for glucose control) | **5. Urine Albumin/Creatinine Ratio**<br>(urine test for early kidney disease) |
| **2. Blood Pressure**<br>(measurement for cardiovascular risk) | **6. Foot Risk Surveillance**<br>(foot examination for foot ulcer risk) |
| **3. Serum Cholesterol**<br>(blood test for cardiovascular risk) | **7. Body Mass Index**<br>(measurement for diabetes management) |
| **4. Serum Creatinine**<br>(blood test for kidney function) | **8. Smoking History**<br>(question for cardiovascular risk) |
| **Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices)** | |
| **9. Digital Retinal Screening**<br>(photographic eye test for diabetic eye disease) | |

*Source: Reproduced from NHS Digital.* National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report. *[Leeds]: NHS Digital; 2017, p.4.*

There are also three treatment targets, consisting of specific thresholds for HbA1c, blood pressure and cholesterol.[129] In 2016/17, four in ten people with type 2 diabetes (39.0%) achieved all three treatment targets, which is significantly worse than England.[130]

In terms of known complications, between 2014/15 and 2016/17, 18 Barking and Dagenham residents (aged 12+) were issued with a Certification of Visual Impairment due to diabetic eye disease.[131] This equated to a rate of 3.1 per 100,000 in 2016/17, which is similar to London and England.

Furthermore, Barking and Dagenham had the highest rate of minor diabetic lower-limb amputation procedures (amputations of the foot or toe) in London in 2014/15–2016/17, and the sixth highest rate of major diabetic lower-limb amputation procedures (amputations above the ankle).[132] This corresponds to 102 and 21 procedures respectively over this three-year period. The rate of minor lower-limb amputation procedures is increasing in Barking and Dagenham.

[128] NHS Digital. *National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report*. [Leeds]: NHS Digital; 2017.
[129] NHS Digital. *National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report*. [Leeds]: NHS Digital; 2017.
[130] PHE, Diabetes profile [https://fingertips.phe.org.uk/profile/diabetes-ft].
[131] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[132] PHE, Diabetes profile [https://fingertips.phe.org.uk/profile/diabetes-ft].

**Liver disease** refers to a range of conditions affecting the liver, affecting its ability to function due to inflammation (hepatitis) or scarring (cirrhosis). Most liver disease is caused by alcohol, obesity or viral hepatitis, and is hence preventable.

**Prevalence**

In 2014–16, there were 82 deaths from liver disease in under 75s in Barking and Dagenham, of which 70 were considered preventable (85%).[133] Barking and Dagenham has the sixth highest mortality rate from liver disease in under 75s, and the seventh highest rate for preventable liver disease.

Under 75 mortality from liver disease is substantially higher in men than in women, with 13.3 per 100,000 deaths in females in 2014–16 compared with 30.2 per 100,000 in males.[134]

**Early diagnosis and intervention**

In its early stages, liver disease is reversible, but liver disease may not be symptomatic until it is at a late stage. However, as the risks to the liver from drinking are well documented, ensuring that individuals understand whether they are drinking at a hazardous level and have support to cut down and stop drinking would comprise a form of early intervention.

Barking and Dagenham commission substance misuse services for both adults and young people. In 2017/18, 334 adults were in treatment solely for alcohol misuse and around half of these successfully completed treatment (49.1%).[135]

As liver disease may be asymptomatic, a different approach may be to screen patients with risk factors using a fibroscanner. Diagnosis via fibroscanner has been costed at £2,138 per quality-adjusted life year (QALY) for non-alcohol fatty liver disease and £6,537 per QALY for alcoholic liver disease. This is cost-effective as per NICE guidelines (up to £20–30,000 per QALY).[136]

People who inject drugs are at increased risk of Hepatitis B and C infection, as this can be spread through the sharing of needles. Just under nine in ten (88.0%) eligible people in drug misuse treatment who inject drugs received a Hepatitis C test in 2016/17.[137] This has declined from 95.3% in 2014/15.

At-risk individuals can also be vaccinated against Hepatitis B, but only 5.9% of eligible person entering drug misuse treatment in Barking and Dagenham in 2016/17 completed a course of Hepatitis B vaccination, which is significantly worse than London.[138] The percentage completing has declined in the last 3 years from 27.5% in 2014/15 to 14.0% in 2015/16 to 5.9% in 2016/17.

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[133] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].

[134] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/]. Age-standardised rate – cannot be directly applied back to Barking and Dagenham population.

[135] National Drug Treatment Monitoring System.

[136] York Health Economics Consortium. *NHS Innovation Accelerator. Economic Impact Evaluation Case Study: Liver Disease Diagnostic Pathway.* York: YHEC; 2018 [https://nhsaccelerator.com/wp-content/uploads/2018/03/Scarred-Liver-Pathway-Economic-Case-Study.pdf]; Tanajewski L, Harris R, Harman DJ, Aithal GP, Card TR, Gkountouras G, et al. Economic evaluation of a community-based diagnostic pathway to stratify adults for non-alcoholic fatty liver disease: a Markov model informed by a feasibility study. *BMJ Open* 2017;7(6):e015659; National Institute for Health and Care Excellence. The scarred liver project: a new diagnostic pathway to detect chronic liver disease across primary and secondary care [https://www.nice.org.uk/sharedlearning/the-scarred-liver-project]. Accessed 2018 Oct 05; The King's Fund. Early diagnosis of chronic liver disease [https://www.kingsfund.org.uk/publications/innovation-nhs/early-diagnosis-chronic-liver-disease]. Accessed 2018 Oct 05.

[137] PHE, Liver disease profiles [https://fingertips.phe.org.uk/profile/liver-disease].

[138] PHE, Liver disease profiles [https://fingertips.phe.org.uk/profile/liver-disease].

### 4.4.2 Cancer

Early diagnosis of cancer can give patients more effective treatment options and can increase chances of survival.

**Incidence, mortality and survival**

*Incidence*
Crudely, by number of new cases in 2014–16, the five most commonly diagnosed cancers in Barking and Dagenham were lung cancer (350), breast cancer (345), prostate cancer (270), bowel cancer (240) and leukaemia (85).[139]

Barking and Dagenham has a significantly higher age-standardised incidence of lung cancer compared with England; rates for the other four cancer types are similar to England.

*Mortality*
Crudely, by number of deaths in 2014–16, the five most common cancer causes of death in Barking and Dagenham were lung cancer (285), bowel cancer (95), breast cancer (75), pancreatic cancer (55) and prostate cancer (50).[140]

Barking and Dagenham has a significantly higher age-standardised lung cancer mortality rate compared with England; rates for the other four cancer types are similar to England.

Barking and Dagenham has the highest rate of deaths from cancers considered preventable in London (17th highest of 150 local authorities in England), which is likely to be related to the high lung cancer mortality, since this is considered a preventable cancer due to its association with smoking.

*Survival*
In Barking and Dagenham, 94.0% of those diagnosed with breast cancer in 2015 were alive 12 months after their diagnosis, which is significantly worse than the England average of 96.7%.[141]

1-year survival rates for bowel cancer and lung cancer in Barking and Dagenham are similar to England. Of those diagnosed with bowel cancer in 2015, 78.5% were alive 12 months after diagnosis, and of those diagnosed with lung cancer in 2015, 38.3% were alive 12 months after diagnosis.

1-year survival rates have increased over the last 15 years, particularly for lung cancer, and the gap between Barking and Dagenham and England survival rates for breast cancer and bowel cancer has narrowed, although the former is still significantly lower in Barking and Dagenham compared with England.

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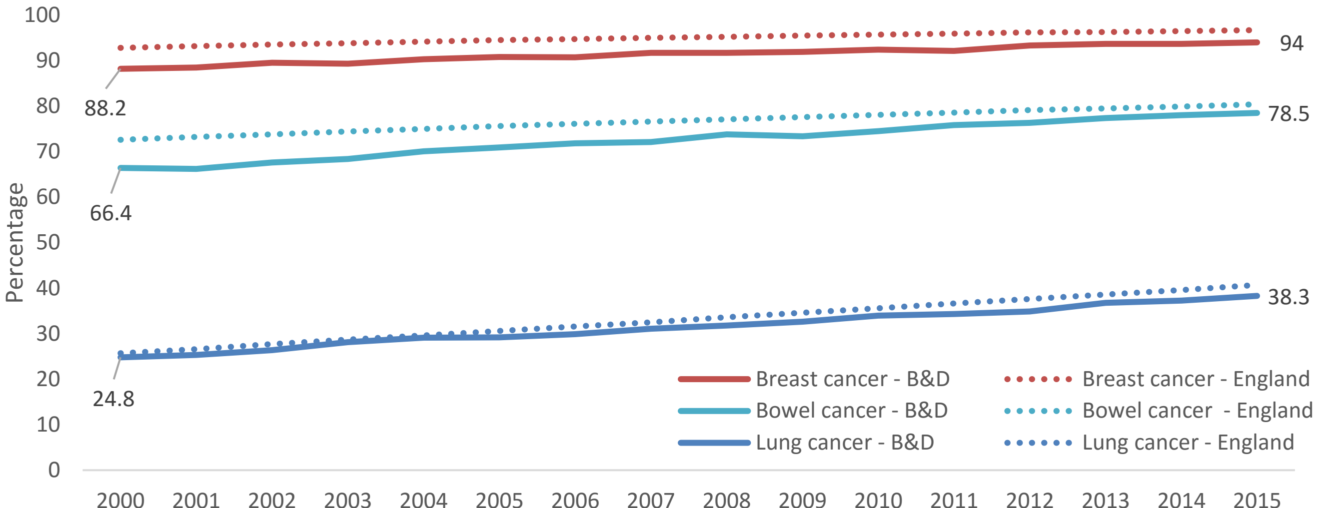
[139] PHE, CancerData [https://www.cancerdata.nhs.uk/]. 2014-16. Numbers rounded to nearest 5. Breast cancer figures are for women only, since the incidence rate is only available for women.
[140] PHE, CancerData [https://www.cancerdata.nhs.uk/]. 2014-16. Numbers rounded to nearest 5. Breast cancer figures are for women only, since the mortality rate is only available for women.
[141] ONS, Cancer survival in Clinical Commissioning Groups, England: Adults diagnosed between 2000 and 2015 and followed up to 2016.

**Figure 4.2: 1-year survival for lung cancer, bowel cancer and breast cancer, 2000–2015 (year of diagnosis)**




*Data: ONS, Cancer survival in Clinical Commission Groups, England: Adults diagnosed between 2000 and 2015 and followed up to 2016.*

### Early diagnosis and intervention

*Screening*

Of these cancers with a high incidence and/or mortality, breast cancer and bowel cancer have national screening programmes. There is also a national cervical screening programme.

Barking and Dagenham has one of the worst bowel cancer screening coverages in England. The most recent data (snapshot at end of December 2017) showed that 42.1% of eligible residents had been adequately screened in the last 2.5 years, compared with 49.9% in London and 58.9% across England.[142] This is the third lowest coverage in both London and England.

Breast cancer screening coverage is significantly lower than London and England.[143] At the end of March 2017, 67.8% of eligible women had been adequately screened in the last 3 years, compared with 69.4% in London and 75.3% across England.

Cervical cancer screening coverage is also a cause for concern; at the end of March 2017, 67.0% of eligible women had been adequately screened in the previous 3.5 or 5.5 years (depending on their age).[144] This is significantly higher than London (65.7%) but significantly lower than England (72.0%) and has shown a consistent decline over the past 4 years.

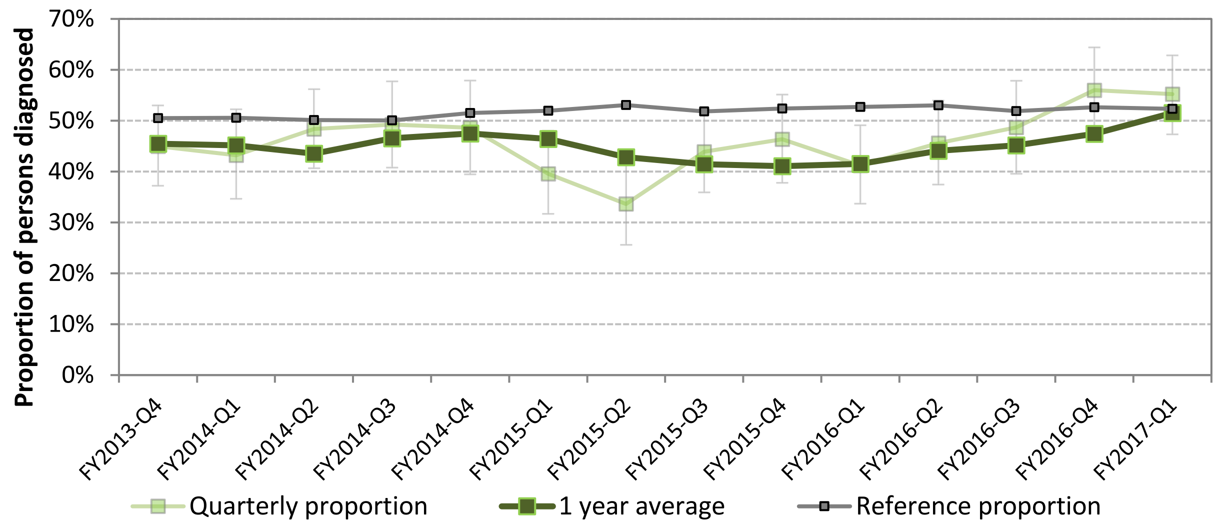
*Stage at diagnosis*

Cancers are typically classified using a staging system that indicates the size of the tumour and extent of its spread.[145] Cancers diagnosed at an earlier stage are associated with increased 1-year survival, although the relationship between stage and survival depends on the cancer type.[146]

[142] PHE, Young person and adult screening KPI data: Q3 (1 October 2017 to 31 December 2017).
[143] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[144] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[145] Cancer Research UK. Stages of cancer [https://www.cancerresearchuk.org/about-cancer/what-is-cancer/stages-of-cancer]. Accessed 2018 Oct 04.
[146] PHE. *Stage at diagnosis 2012-2014 and one-year cancer survival in England*. National cancer registration and analysis service briefing. [London]: PHE; 2016. See also: McPhail S, Johnson S, Greenberg D, Peake M, Rous B. Stage at diagnosis and early mortality from cancer in England. *Br J Cancer* 2015;112 Suppl 1:S108–15.

In Barking and Dagenham, 51.5% of cancers were diagnosed at stages 1 or 2 (12-month rolling average to end of December 2017), similar to the figure for England (52.5%).[147] As Figure 4.3 shows, the gap between Barking and Dagenham and England has decreased in the last few years. Furthermore, this data is not adjusted for case mix; as Barking and Dagenham has a higher incidence of lung cancer and lung cancer is typically diagnosed at a late stage (64.8% of cases were diagnosed at stages 3 or 4 in Barking and Dagenham between 2014 and 2016[148]), we might expect the proportion to be higher.

**Figure 4.3: Proportion diagnosed at early stage (stage 1 or 2): NHS Barking and Dagenham, reference: England**

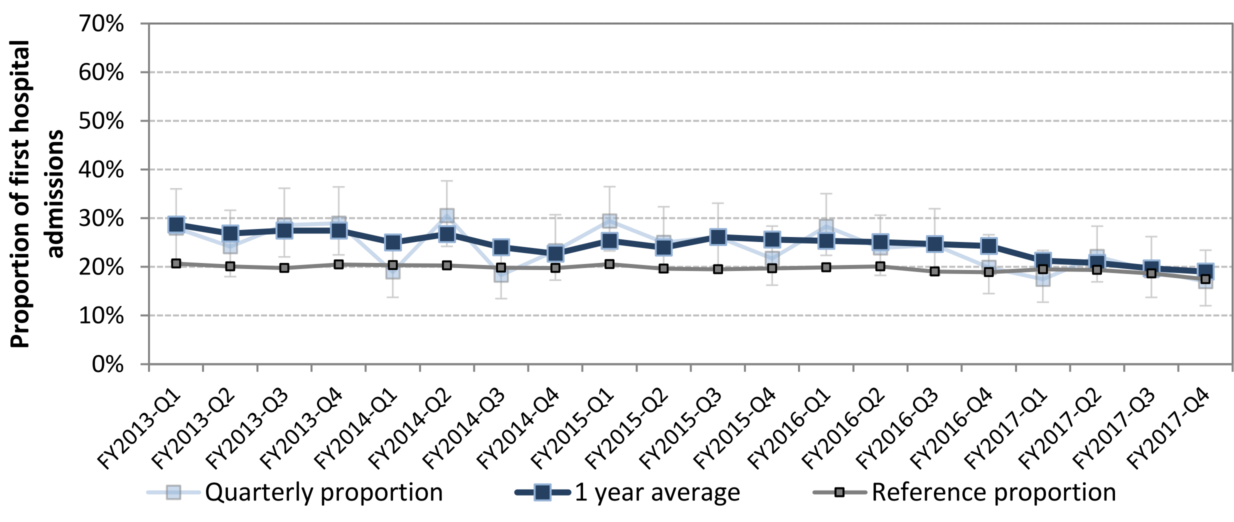



*Source: PHE, Cancer Outcomes: Stage at Diagnosis. August 2018.*

### *Presentation route*

In Barking and Dagenham, 19.0% of cancers first presented as an emergency (12-month rolling average to end of March 2018), which is only slightly higher than the figure for England (17.5%). While the proportion at England level has remained fairly constant over time, this figure has been decreasing in Barking and Dagenham.

**Figure 4.4: The estimated proportion of all malignant cancers (excluding non-melanoma skin cancer) which present as an emergency: NHS Barking and Dagenham, reference: England**




*Source: PHE, Cancer Outcomes: Emergency Presentations.*

[147] PHE, Cancer Outcomes: Stage at Diagnosis. August 2018.
[148] PHE, National Cancer Registration and Analysis Service. TNM stage group by CCG by tumour type for 10+3 tumour types, 2016.

*Referral*

96.7% of patients registered with a Barking and Dagenham GP urgently referred due to suspected cancer saw a specialist within 2 weeks in the 12 months to end of June 2018, compared with 93.5% across England and an operational standard of 93%.[149]

The target for referral to treatment is not being met locally, with more than one in five patients registered with a Barking and Dagenham GP not receiving their first cancer treatment within 62 days of urgent GP referral (78.1%, 2017/18) compared with an England average of 82.1% and an operational standard of 85%.[150]

### 4.4.3 Mental health

Early diagnosis of mental health conditions supports better outcomes for the individual and those around them.

*Common mental illnesses*

'Common mental illnesses' include conditions such as depression, anxiety, obsessive–compulsive disorder (OCD) and phobias.

Their label as 'common' rather than 'serious' does not mean that they cannot cause severe harm and disruption to the lives of those they affect and those around them.

**Prevalence**
Mental health disorders are common, but we lack good quality data; not all of those experiencing a condition seek medical help. For population prevalence (rather than just those who have sought medical advice), we are reliant on modelled estimates and survey data:

- For children (5–16), estimates suggest that around one in ten (10.3%) residents experience mental health disorders locally.[151]
- For adults (16–74), estimates suggest that around one in six patients registered with a Barking and Dagenham GP (15.7%) experience a common mental disorder at any given point in time.[152]

Furthermore, based on healthcare and survey data:

- Around 1 in 19 people registered with a Barking and Dagenham GP have been diagnosed with depression and are on their practice's depression register (5.4%).
- In the 2018 GP Patient Survey, 6.0% of respondents in Barking and Dagenham reported having a long-term mental health condition; this could include both 'common' and 'serious' mental illnesses.[153]

**Early diagnosis and intervention**
Based on what we know about the prevalence of common mental health disorders in the community compared with the prevalence of diagnosed conditions, recognising and diagnosing mental health disorders, and ensuring residents recognise when they should seek medical advice, and feel able to do so, is important.

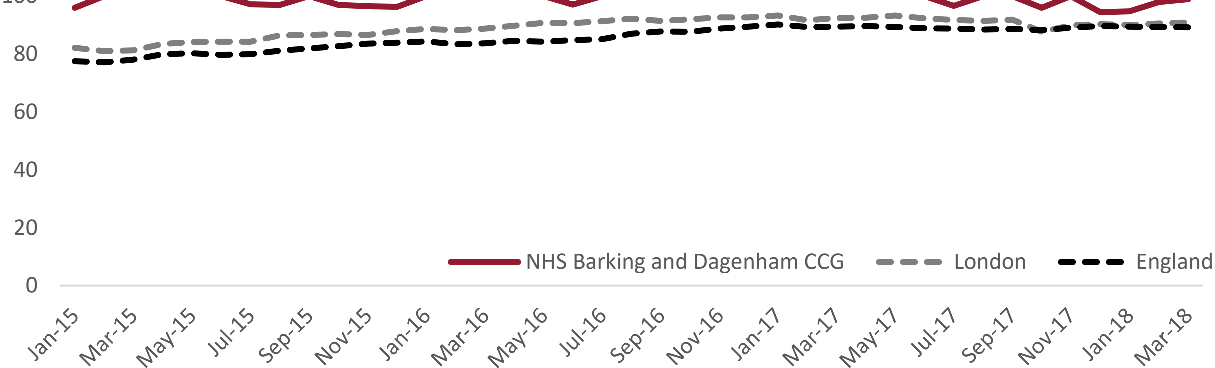
[149] NHS England, Waiting Times for Suspected and Diagnosed Cancer Patients: Commissioner Based. Quarter One 2018-2019.
[150] NHS England, Waiting Times for Suspected and Diagnosed Cancer Patients: Commissioner Based. Quarter One 2018-2019.
[151] PHE, Children and Young People's Mental Health and Wellbeing [https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh]. Estimate is for 2015.
[152] PHE, Common Mental Health Disorders [https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders]. Estimate is for 2014/15
[153] GP Patient Survey 2018 [https://www.gp-patient.co.uk/]

Data is also available on the effectiveness or likely effectiveness of interventions following diagnosis: within primary care, around two-thirds of newly diagnosed patients with depression (65.7%) had a review 10–56 days after diagnosis, which is similar to London (63.2%) and England (64.4%).[154] This is measured in the Quality and Outcomes Framework (QOF, a performance-related pay scheme for GPs) in recognition of the fact that treatment is often short-term despite the usually long-term nature of depression, medication may need reviewing, and this provides an opportunity to use a validated measure to assess the effectiveness of treatment.[155]

Psychological therapies are a key treatment method for common mental health illnesses. Since 2008, the Improving Access to Psychological Therapies (IAPT) programme has aimed to make it easier for patients to receive evidence-based psychological treatment for mental health disorders.[156] As a key aim is around access, one measure is whether patients wait less than 6 weeks for their first treatment.

In general, a higher proportion of Barking and Dagenham referrals to IAPT take less than 6 weeks compared with England and London (Figure 4.5). In quarter 1 2018/19, 97% of referrals to IAPT entered treatment within 6 weeks, compared with 90% across England.[157]

**Figure 4.5: Waiting < 6 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <6 weeks for first treatment**




*Data: PHE, Common Mental Health Disorders profile.*

Data is also collected on the proportion of people who show 'reliable improvement' on a validated psychological questionnaire and those who are classed as 'moving to recovery' (those who met the criteria for treatment at the beginning of their treatment and no longer meet it at the end). In quarter 1 2018/19, 65% showed 'reliable improvement' and 47% were 'moved to recovery', compared with 65% and 45% in London and 67.7% and 52.4% in England.

*Serious mental illnesses*

'Serious mental illnesses' refers to schizophrenia, bipolar affective disorder and other psychoses.[158]

**Prevalence**

[154] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[155] PHE. National General Practice Profiles. Indicator Definitions and Supporting Information [https://fingertips.phe.org.uk/profile/general-practice/data#page/6/gid/2000003/pat/46/par/E39000018/ati/152/are/E38000004/iid/91243/age/168/sex/4]. Accessed 2018 Oct 04.
[156] National Collaborating Centre for Mental Health. *The Improving Access to Psychological Therapies* Manual. [London]: NCCMH; 2018.
[157] NHS Digital, Improving Access to Psychological Therapies (IAPT). Interactive data tool – Quarter 1 2018/19.
[158] PHE. National General Practice Profiles. Indicator Definitions and Supporting Information [https://fingertips.phe.org.uk/profile/general-practice/data#page/6/gid/2000003/pat/46/par/E39000018/ati/152/are/E38000004]. Accessed 2018 Oct 04.

Around 1 in 125 people registered with a Barking and Dagenham GP has been recorded as having a serious mental illness.[159]

**Early diagnosis and intervention**
In quarter 1 2018/19, 83% of people registered with a Barking and Dagenham GP with first episode psychosis referred to early intervention had a waiting time of 2 weeks or less.[160] However, as relatively few referrals are received each quarter (20 in quarter 1 and 15 in quarter 4, rounded to nearest 5), this is subject to variation; the previous quarter, this was 44%. The nationally set target is 50%.[161]

People with serious mental illness suffer from health inequalities including higher mortality rates for liver disease, respiratory disease, cardiovascular disease and cancer.[162] This group is also more likely to be obese or have diabetes, asthma, coronary heart disease or stroke than those without these conditions. This indicates that part of the intervention for these conditions is likely to involve supporting and preventing other health issues.

For example, smoking rates among people with a serious mental illness are much higher than in the general population: 40.2% of patients with a serious mental illness in Barking and Dagenham were current smokers in 2015/16, compared with an adult prevalence of 20.4%.[163] Intervening with this group would therefore also include supporting attempts to quit. The LBBD Tobacco Harm Reduction Strategy has set a target to halve the number of smokers with mental health conditions by 2022.[164]

*Dementia*

Dementia is a condition largely affecting older people that is characterised by symptoms including memory loss, loss of mental acuity and changes to mood.[165]

Alzheimer's disease is a type of dementia; another common type is vascular dementia which is caused by decreased blood flow to the brain.

**Prevalence**
Around 1 in 21 people aged 65 and above have a recorded dementia diagnosis in Barking and Dagenham.[166] This rises to one in eight for individuals aged 85–89 and one in five for individuals aged 90 and above.

**Early diagnosis and intervention**
Diagnosing dementia early is important because it can be possible to slow down its progression and to plan for extra help and support that might be needed in the future.[167]

As discussed in the cardiovascular disease section above, good cardiovascular health may reduce the risk of vascular dementia and Alzheimer's disease in later life[168] and

[159] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[160] NHS Digital, Mental Health Services Monthly Statistics. Access and Waiting Times. Data Tables, Final April 2018 to June 2018, Experimental Statistics; NHS Digital, Mental Health Services Monthly Statistics. Access and Waiting Times. Data Tables, Final January 2018 to March 2018, Experimental Statistics.
[161] Baker, C. *Mental health statistics for England: prevalence, services and funding*. Briefing Paper Number 6988, 25 April 2018. [London]: House of Commons Library; 2018.
[162] PHE. Severe mental illness (SMI) and physical health inequalities: briefing [https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing]. Accessed 2018 Oct 04; data is national and does not relate to Barking and Dagenham specifically.
[163] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control].
[164] LBBD, Tobacco harm reduction strategy. [London]: LBBD; 2017.
[165] NHS. Dementia guide: About dementia [https://www.nhs.uk/conditions/dementia/about/]. Accessed 2018 Oct 04.
[166] Health Analytics, March 2018.
[167] NHS. Dementia guide: About dementia [https://www.nhs.uk/conditions/dementia/about/]. Accessed 2018 Oct 04.
[168] NHS. Overview: Vascular dementia [https://www.nhs.uk/conditions/vascular-dementia/]. Accessed 2018 Oct 04; NHS. Overview: Alzheimer's disease [https://www.nhs.uk/conditions/alzheimers-disease/]. Accessed 2018 Oct 04.

hence an early assessment of risk and support to make changes could also be an early intervention to prevent these conditions. Diabetes is also a risk factor for vascular dementia.

Estimates suggest that 71% of people with dementia in Barking and Dagenham have a diagnosis; there were 881 people on Barking and Dagenham GP dementia registers in August 2018, but 1,240 people were estimated to have dementia.[169] This suggests that around 350 people may be living with dementia without a diagnosis.

In 2016/17, the rate of emergency admissions for dementia (in those aged 65 and above) was higher than the England average.[170]

*Self-harm and suicide*

**Prevalence**
The rate of emergency hospital admissions for intentional self-harm is decreasing in Barking and Dagenham and is significantly lower than England and similar to London.[171] There were 194 such admissions in 2016/17, down from 344 in 2011/12.

Admissions for young people specifically show a similar pattern in terms of being similar to London but lower than England.[172]

Admissions for self-harm do not tell us about individuals who may self-harm but do not present to hospital; the prevalence of self-harm in the community will be higher.

There were 34 suicides in Barking and Dagenham in 2014–16. Most suicides were among men.

**Early diagnosis and intervention**
Barking and Dagenham has produced a Suicide Prevention Strategy jointly with Havering.

### 4.4.4 Sexual health

Sexually transmitted infections (STIs) often remain undiagnosed due to social barriers to testing and the asymptomatic nature of some infections. As these conditions are, by definition, transmittable to others, early diagnosis and intervention benefits not only the individual, but also the wider population, in the form of reduced onward transmission.

*Chlamydia and gonorrhoea*

**Incidence**
The chlamydia detection rate in Barking and Dagenham is 1,679 per 100,000 aged 15–24.[173] This is below Public Health England's target threshold of 2,300 per 100,000; in this case, a low incidence rate is seen as negative as – based on what is known about chlamydia in young people – there is an assumption that if not diagnosed, these cases are undetected rather than do not exist.

Barking and Dagenham has a higher incidence of gonorrhoea than the England average, but is below the London average.[174] There is an upward trend in this.

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169 NHS Digital, Recorded Dementia Diagnoses – August 2018. GP-registered population.
170 PHE, Dementia Profile [https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia].
171 PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
172 PHE, Children and Young People's Mental Health and Wellbeing [https://fingertips.phe.org.uk/cypmh].
173 PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
174 PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.

**Early diagnosis and intervention**
13% of 15–24 year olds were screened for chlamydia in 2017. Screening coverage is declining and is significantly lower than both London and England. As chlamydia is often asymptomatic and young people are at high risk, screening is recommended annually for sexually active 15–24 year olds, or upon change of a partner (whichever is more frequent).

Pelvic inflammatory disease (PID) can be a complication of prolonged chlamydia infection. Barking and Dagenham had the highest rate of admissions for PID per 100,000 in London – 337.5 per 100,000 in 2016/17. However, this can also reflect different treatment pathways and recording of PID in different areas.

Another form of intervention to reduce the impacts of STIs is partner notification. In 2017, 82 partner notifications for gonorrhoea and 360 for chlamydia were supported by genitourinary medicine (GUM) services.[175]

*HIV*

**Incidence/prevalence**
There were 32 new cases of HIV diagnosed in Barking and Dagenham in 2017, which – as a rate per 100,000 aged 15 and over – is higher than England but similar to London.[176]

In 2017, 742 people were living with an HIV diagnosis locally – 5.77 per 1,000 people aged 15–59. [177] This is higher than England but similar to London.

People most likely to be living with diagnosed HIV locally are:[178]
- in the three most deprived quintiles
- women
- black African
- aged 35-49.

**Early diagnosis and intervention**
Late HIV diagnosis is associated with greater mortality; a national cohort study covering all individuals diagnosed with HIV in England from 1997 to 2012, with an average follow-up of 5 years, found that people whose HIV infection is diagnosed late had a 3.5-times greater risk of death than those diagnosed early.[179] An earlier study also found that the risk of death in the first year after diagnosis in people who are diagnosed late is 10 times higher than in those who are diagnosed early.[180]

In Barking and Dagenham, over half of new HIV diagnoses in 2015–17 were late (52.5%).[181] This is the third highest proportion in London.

[175] Data from GUMCADv2 surveillance, PHE.
[176] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
[177] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
[178] Data from SOPHID surveillance, PHE. 2016
[179] Croxford S, Kitching A, Desai S, Kall M, Edelstein M, Skingsley A, et al. Mortality and causes of death in people diagnosed with HIV in the era of highly active antiretroviral therapy compared with the general population: an analysis of a national observational cohort. *Lancet Public Health* 2017;2(1):e35–e46.
[180] Brown AE, Kall MM, Smith RD, Yin Z, Hunter A, Delpech VC. Auditing national HIV guidelines and policies: The United Kingdom CD4 Surveillance Scheme. *Open AIDS J* 2012;6:149–55.
[181] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.

If we have the same proportion of undiagnosed cases as national figures, we would expect around 100 people to be living with undiagnosed HIV in Barking and Dagenham (12% of people living with HIV).[182] This is likely to be an underestimate.

Barking and Dagenham has the highest overall uptake of HIV testing in London and the eighth highest in England; 88.8% of those offered a test took it up.[183] However, in men who have sex with men (MSM), this is the lowest in London and 11th lowest in England.

However, the coverage of HIV testing, while still higher than England, is similar to London; 72.4% of 'eligible new attendees' attending sexual health services had an HIV test.[184]

109 rapid HIV tests were undertaken in 2017.[185]

There were 32 incidents in which post-exposure prophylaxis for HIV was given in GUM clinics in 2017, reducing the risk of HIV transmission.[186]

### 4.5 Conclusions

Early diagnosis and intervention is important as Barking and Dagenham has the highest avoidable mortality rate in London and mortality is only part of the story as living with an undiagnosed or untreated illness has individual and societal costs of its own.

Barking and Dagenham has a high prevalence of many risk factors for conditions such as cardiovascular disease, including smoking, physical inactivity and excess weight. **One way to intervene early for these conditions is therefore to focus on prevention.**

All 40–74 year olds without long-term conditions should be offered an NHS Health Check. This is a valuable tool for assessing risk and diagnosing cardiovascular disease and diabetes. Although a higher proportion of the eligible population had a check between 2013/14 and 2017/18 than England (56% compared with 44%), this means a little less than half of eligible 40–74 year olds did not receive one. **Increasing NHS Health Check coverage should increase early diagnosis and intervention.**

Barking and Dagenham has the third highest prevalence of COPD and the highest COPD mortality rate in London. Although COPD cannot be cured, the loss of lung function can be slowed. **If the patient smokes, stopping smoking is a key intervention. Suitable management in primary care should also reduce the need for hospital admission.**

Around 1 in 13 adults registered with a GP in Barking and Dagenham have a diabetes diagnosis, but a higher proportion are estimated to be living with diabetes. If not diagnosed and managed effectively, diabetes can lead to complications that include sight loss and amputations. Care processes and treatment targets for diabetes have been set nationally; in 2016/17, four in ten people with type 2 diabetes achieved all three targets, which was significantly worse than England. **Ensuring that patients with diabetes receive all eight care processes annually and achieve the three treatment targets should lead to better outcomes for patients.**

Most liver disease is caused by alcohol, obesity or viral hepatitis. In its early stages, liver disease is reversible, but liver disease may not be symptomatic until it is at an early stage.

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[182] 12% undiagnosed based on national data applied to 2017 number aged 15–59 living with HIV. See: PHE, *Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK*. London; PHE: 2017; PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth].

[183] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.

[184] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.

[185] Data from GUMCADv2 surveillance, PHE.

[186] Data from GUMCADv2 surveillance, PHE.

**One way to intervene early is to address hazardous drinking. Options to screen at-risk individuals could also be evaluated.**

The five most common types of cancer in Barking and Dagenham are lung cancer, breast cancer, prostate cancer, bowel cancer and leukaemia (based on numbers of new cases). Lung cancer incidence and mortality rates are significantly higher than England, while breast cancer 1-year survival is significantly lower than England. Coverage on the three national screening programmes is low, especially bowel screening. **We should continue working to increase coverage and uptake on the national cancer screening programmes.**

The proportion of cancers diagnosed at stages 1 or 2 and the proportion of cancers first presenting as an emergency are now in line with England, despite the high incidence of lung cancer, which is typically diagnosed at a late stage. **Monitoring these trends through quarterly data should continue.**

Barking and Dagenham performs well on the 2-week wait measure, with 96.7% of patients seeing a specialist within 2 weeks. However, more than one in five patients did not receive their first cancer treatment within 62 days of urgent GP referral (quarter 1 2017/18). **Referral to treatment figures should be analysed to identify the reasons for delay.**

Mental health disorders are common, but we lack good quality data. Based on what we know about the prevalence of common mental health disorders in the community compared with the prevalence of diagnosed conditions, **recognising and diagnosing mental health disorders, and ensuring residents recognise when they should seek medical advice, and feel able to do so, is important.**

Around 1 in 125 people in Barking and Dagenham has been recorded as having a serious mental illness. People with serious mental illness have been identified as suffering from inequalities in physical health; **this underlines the need for joined up services and a holistic understanding of needs.**

Diagnosing dementia early is important because it can be possible to slow its progression and to plan for extra help and support. However, estimates suggest that only 71% of people with dementia in Barking and Dagenham have a diagnosis. **We should continue working to reduce the proportion of undiagnosed dementia cases.**

STIs often remain undiagnosed due to social barriers to testing and the asymptomatic nature of some infections. Screening coverage of chlamydia in young people is declining and significantly lower than both London and England. **Increasing coverage of routine chlamydia testing in young people would prevent possible complications and reduce onward transmission.**

Barking and Dagenham has similar HIV incidence and prevalence rates to London. However, over half of new HIV diagnoses are late, the third highest proportion in London. Late diagnosis is associated with increased risk of mortality. **Strategies to reduce the proportion of late diagnoses should be explored.**

# 5 Resilience

## 5.1 What is resilience?

**Resilience** may be understood as the attributes and conditions that allow individuals and communities to 'bounce back' from challenges and thrive in new situations.

'Resilience' as a concept has been defined and used in different ways. The working definition for the presentation on which this report is based was '*developing the capacity for populations to endure, adapt and generate new ways of thinking and functioning in the context of change, uncertainty or adversity*'.[187]

Resilience may therefore be understood as the attributes and conditions that allow individuals and communities to 'bounce back' from challenges and thrive in new situations.

## 5.2 Why is resilience important?

Resilience is important for health and wellbeing because it is closely connected with mental wellbeing; how you react to a challenging situation is linked to your state of mind and coping effectively may help prevent or limit the situation causing mental distress.

Resilience can also be specific to health and social care 'challenges', such as being diagnosed with a long-term condition, or ageing.

## 5.3 Why is resilience important for Barking and Dagenham?

Focusing on resilience is a priority for Barking and Dagenham as it is interlinked with prevention, and in the current financial climate, ensuring that residents have the tools they require to reduce the need for intensive support from the council and other organisations, such as the NHS, benefits everyone.

Secondly, maximising mental wellbeing is an important priority in its own right; helping individuals 'feel good and function well' will have a large impact on their quality of life. Despite a widespread call to give mental health conditions parity of esteem with physical health conditions, the role of preventive mental health measures is still not widely established compared with measures to prevent poor physical health (e.g. physical activity programmes).

Furthermore, we live in a time of change – locally, nationally and globally. We all need to be able to adapt and thrive in the context of such changes. With the growth in Barking and Dagenham that is expected in the coming years, building resilient communities and individuals can help to ensure that 'no-one is left behind'.

## 5.4 What builds resilience?

Figure 5.1 is a framework for resilience based on ideas from a Mind report on resilience for supporting mental health and a paper on resilience by the Glasgow Centre for Population Health.

[187] Glasgow Centre for Population Health. *Resilience for public health: supporting transformation in people and communities*. Briefing paper 12, Concepts series. Glasgow: Glasgow Centre for Population Health; 2014.

Both papers recognise the importance of structural pre-conditions that allow and facilitate resilience. We have selected three here which we believe are key: education, housing and employment.

Once those conditions are met, resilience is closely tied to personal well-being, as well as social capital, which refers to the benefits that individuals can gain from social connections and norms.

This chapter explores these three areas (structural conditions, wellbeing and social capital) in turn.

**Figure 5.1: What builds resilience? A framework**

2. Well-being
Feeling good and functioning well
(NEF)
Community
Family
Resilience
Individual
3. Social capital
Benefits from social connections and norms
1. Structural factors:
Education
Housing
Employment

*Source: Developed from ideas in Mind/Mental Health Foundation and Glasgow Centre for Population Health reports.*[188]

## 5.5 Structural factors

### 5.5.1 Education

Education supports resilience as it provides one of the foundations for children's later lives.

The impact of education on resilience can be understood through four key areas:

*1. Early years foundation prior to school*
Early years education builds resilience by enhancing educational attainment, enabling communication skills and improving expression and emotional intelligence.

In Barking and Dagenham, 72% of children achieved a good level of development in 2016/17 and the proportion achieving this is showing an increasing trend. However, there is a 14-percentage-point gap between boys and girls, which is similar to the gap at England level. This is explored in more detail in the *Best start in life* chapter.

*2. Environment*
The school environment builds resilience as it can nurture emotional and physical wellbeing, impact on socioeconomic outcomes and facilitate social networks.

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[188] Mind, Mental Health Foundation; Mental Health Strategic Partnership. *Building resilient communities: Making every contact count for public mental health*. London: Mind; 2013; Glasgow Centre for Population Health. *Resilience for public health: supporting transformation in people and communities*. Briefing paper 12, Concepts series. Glasgow: Glasgow Centre for Population Health; 2014.

In Barking and Dagenham, 88% of schools are rated Good or Outstanding by Ofsted and 92% of learners in Barking and Dagenham attend these schools.[189]

Furthermore, most schools in Barking and Dagenham are registered with the Healthy Schools London programme, and half have achieved a bronze award.[190]

*3. Educational attainment*

Education attainment builds resilience as it enhances problem solving skills, widens socioeconomic opportunities and improves health literacy.

The average GCSE attainment 8 score looks at the grades of all pupils in their eight best subjects with a double weighting for maths and English. The average attainment 8 score in Barking and Dagenham was 46.7 in 2016/17, which was lower than London (48.9). This was the ninth lowest score in London.[191]

*4. School attendance*

The act of attending school can increase resilience as it enables access to services and resources, social networks and peer learning, as well as impacting on educational attainment.

In 2016/17, 4.4% of sessions were missed, with around 30% of session absences being unauthorised.[192] A higher proportion of absences were unauthorised in Barking and Dagenham relative to London and England.

There were around 3,900 persistent absentees, which is equivalent to almost 1 in 9 pupils (10.7%). This is slightly higher than London (10.0%) but similar to England (10.8%).

*Inequalities*

In Barking and Dagenham, there are inequalities in achievement of high attainment 8 score at GCSE, with girls and children of Asian ethnic origin being more likely to achieve this than boys, children of White ethnicity or children who are eligible for free school meals.[193] Children in care also have a lower average attainment 8 score (22.5) compared with all pupils (46.7).

There are also inequalities in attendance; more than one in five students had persistent absenteeism in Barking and Dagenham special schools.[194] In special schools, 7.5% of sessions were missed compared to 4.4% across all schools.

### 5.5.2 Housing

*How does housing support resilience?*

Home ownership and good quality housing can support resilience, whereas precarious or poor-quality housing can challenge it. This includes issues such as overcrowding, fuel

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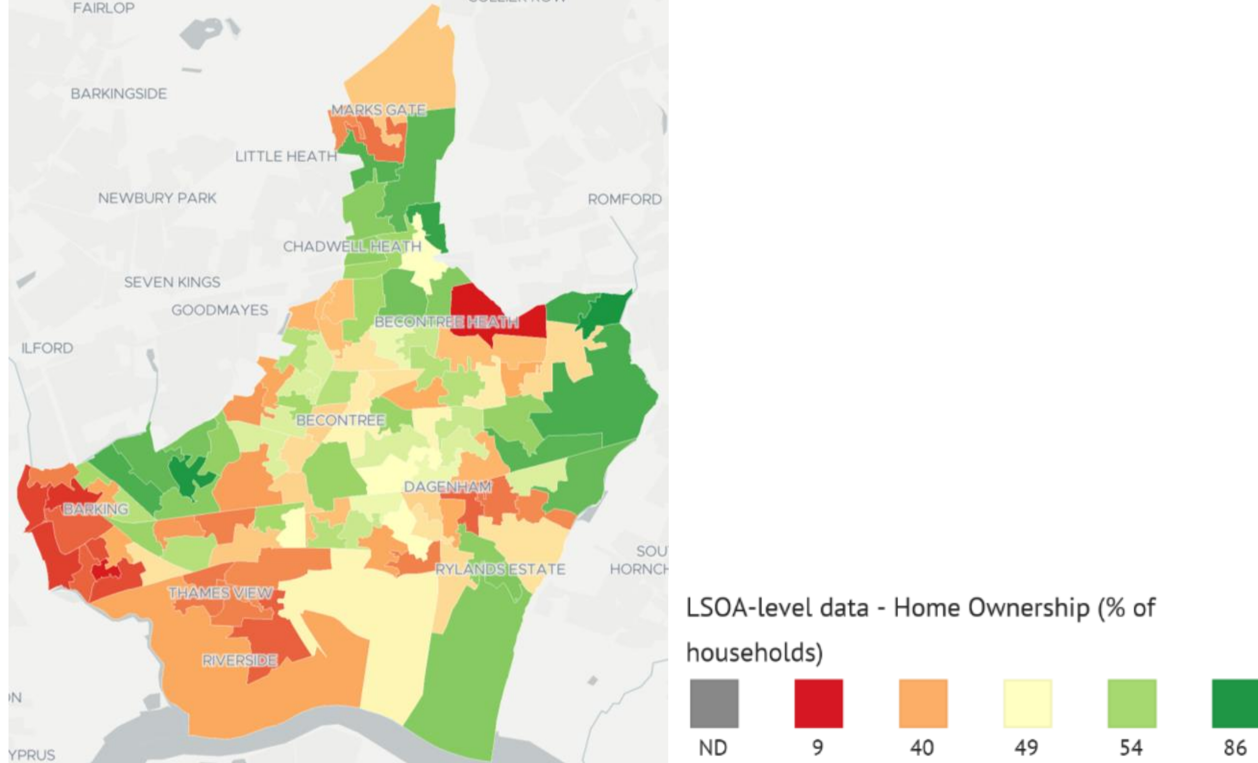
[189] Ofsted. Data View [https://public.tableau.com/views/Dataview/Viewregionalperformanceovertime]. Accessed 2018 Sept 28. Data as at 31 March 2018.
[190] Healthy Schools London [http://www.healthyschools.london.gov.uk/]. Accessed 2018 Sept 28. 55 registered schools, 34 with bronze award, 32 with silver, 15 with gold.
[191] DfE, SFR01/2018: GCSE and equivalent results in England 2016/17 (revised).
[192] DfE, Pupil absence in schools in England: 2016 to 2017. Main tables.
[193] DfE, SFR01/2018: GCSE and equivalent results in England 2016/17 (revised).
[194] DfE, Pupil absence in schools in England: 2016 to 2017. Main tables.

poverty, unaffordable rents or purchase prices, poor quality housing, evictions and homelessness.[195]

**Figure 5.2: Home ownership in Barking and Dagenham, 2017**

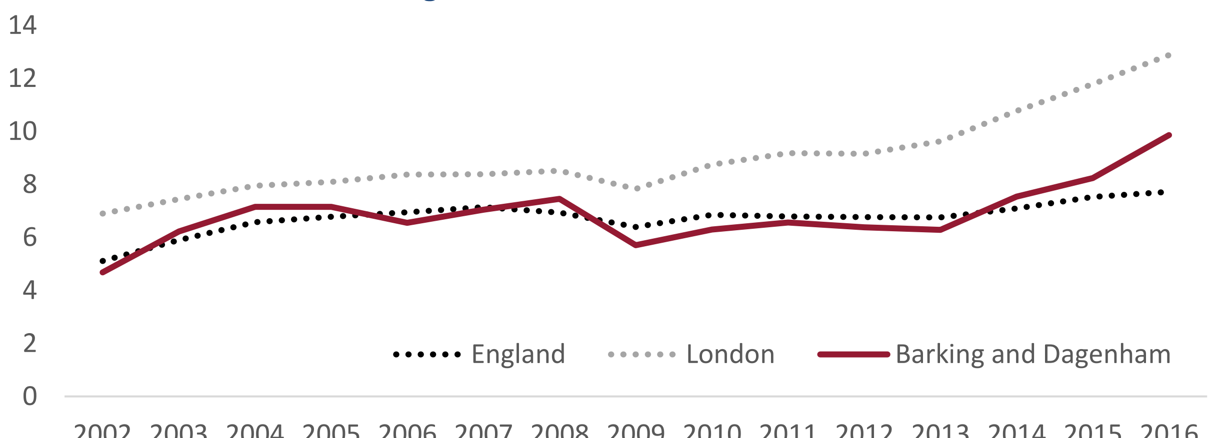



*Source: Borough Data Explorer, using LBBD Residents Matrix data.*

Less than half of all households in Barking and Dagenham are estimated to own the property they live in (45.9%).[196] Households in Gascoigne, Abbey and Thames are least likely to own their own home.

Home ownership can support greater stability but is becoming less affordable locally. Figure 5.3 shows a widening gap between affordability in Barking and Dagenham and England, with house price affordability moving closer to the London picture.

**Figure 5.3: Affordability of home ownership: Ratio of median house price to median gross annual residence-based earnings**




*Data: Wider Determinants of Health profile, PHE.*

[195] Cairney J, Boyle MH. Home ownership, mortgages and psychological distress. *Housing Studies* 2002;19(2):161–74; Macintyre S, Ellaway A, Der G, Ford G, Hunt K. Do housing tenure and car access predict health because they are simply markers of income or self esteem? A Scottish study. *J Epidemiol Community Health* 1998;52(10):657–64.
[196] LBBD Residents Matrix.

Census data shows high levels of overcrowding in Barking and Dagenham; in 15 of the 17 wards, at least one in five people lived in an overcrowded home at the time of the 2011 Census.[197] The highest levels of overcrowding were in Abbey, Gascoigne and Thames. Across the borough, 27.7% of households were overcrowded. Data on overcrowding for 0–15s and fuel poverty is explored in the *Best start in life* section.

Just under half of all Barking and Dagenham-owned housing stock is non-decent, which is the highest proportion in London, although this may be due to inconsistencies in reporting. The east London average is 18.7%. A programme of refurbishment of council housing stock is being undertaken.

There were 115 evictions from local authority owned homes in 2016/17, of which 93% were due to rent arrears.[198]

Barking and Dagenham has the fourth highest level of family homelessness in London (6.2 per 1,000; 477 households) and the seventh highest rate of homelessness among young people aged 16–24 (1.09 per 1,000; 84 households in 2016/17).[199] It has the third highest rate of eligible homeless people not in priority need (2.8 per 1,000; 214 households in 2016/17).[200]

### 5.5.3 Employment

*How does employment support resilience?*

A review exploring whether work is good for health and wellbeing found that it generally was and suggested some mechanisms for this, which are relevant to resilience; work provides income which allows basic needs to be met; it has psychosocial benefits as working is seen as a 'normal' part of society and your job is often a key part of how you perceive yourself and how others see you; and employment status and deprivation are key contributors to inequalities in mental and physical health.[201] However, it also noted that you need suitable types of work/working conditions to avoid harm to your mental and physical health.

To explore how employment supports resilience in Barking and Dagenham, we would therefore want to ascertain the proportion of residents in employment, whether these jobs provide sufficient income, and whether the type of jobs are likely to support resilience.

*What proportion of Barking and Dagenham residents are in employment?*

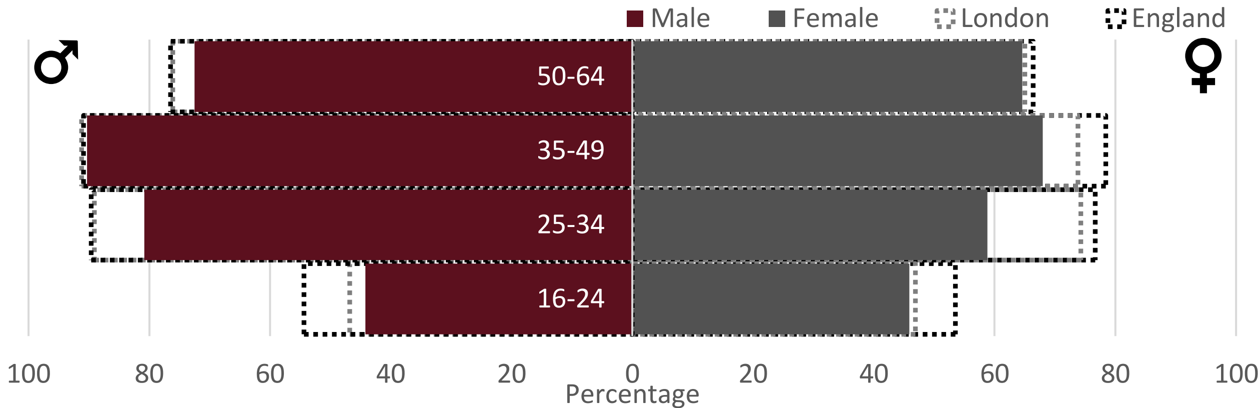
Overall, 75.3% of working-age men and 61.0% of working-age women in Barking and Dagenham are in employment, compared with 80.2% and 67.7% in London, and 80.0% and 70.3% in England.[202]

If we had the same employment rates as London, around an additional 3,200 men and 4,400 women would be in work. If each earned the London Living Wage (£19,890 annually, based on a 37.5-hour week), this would equate to £151m of income (before tax and other deductions) for residents.[203]

[197] ONS, 2011 Census.
[198] Ministry of Housing, Communities & Local Government, Local Authority Housing Statistics data returns, England 2016-17.
[199] PHE, Child and Maternal Health profiles [https://fingertips.phe.org.uk/child-health-profiles]. Both refers to households accepted as homeless. Family homelessness refers to households with dependent children or pregnant women; homelessness among young people aged 16–24 refers to households where the head is aged 16–24.
[200] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[201] Waddell G, Burton AK. *Is work good for your health and well-being?* London: TSO; 2006. See p.vii.
[202] ONS, Annual Population Survey, Jan 2017-Dec 2017.
[203] Based on London Living Wage of £10.20 per hour. See: Living Wage Foundation. FAQs [https://www.livingwage.org.uk/faqs]. Accessed 2018 Oct 04.

By age, the largest gaps compared with London and England are in under 35s in men and under 50s in women, especially women aged 25–34 (Figure 5.4).

**Figure 5.4: % in employment by age and sex, 2017**




*Data: ONS, Annual Population Survey.*

**Table 5.1: Employment status by sex**

| Working age residents (16–64) | Male | | | Female | | |
|---|---|---|---|---|---|---|
| | **B&D** | **England** | **London** | **B&D** | **England** | **London** |
| In employment | 75% | 80% | 80% | 61% | 70% | 68% |
| Unemployed* | **9%** | 4% | 4% | **6%** | 3% | 4% |
| Economically inactive (e.g. student, looking after home) | 16% | 16% | 16% | **33%** | 27% | 28% |

*Data: ONS, Annual Population Survey.*
*Note: unemployment is given here is a proportion of all working age residents so that percentages add to 100%; typically, unemployment is given as a proportion of the economically active workforce (the employed and unemployed).[204]*

For males, the lower employment rate is explained by higher rates of unemployment than England or London; for females, this is explained by a combination of higher rates of unemployment and of economic inactivity (Table 5.1).[205]

As this is aggregated across all groups, this may hide patterns related to age and ethnicity. For example, a higher proportion of economically inactive women look after home and family in Barking and Dagenham than England or London (47% versus 36% and 43% respectively), but this is likely to be concentrated in certain age groups and is also likely to vary by ethnic group; at the time of the 2011 Census, 18% of all Barking and Dagenham women aged 25–49 looked after their home or family, but this ranged from 7% in the Chinese and Black Caribbean populations to 38% of those of Pakistani, Bangladeshi or Arab ethnicity.[206]

Working statuses other than employment could potentially support resilience in the right conditions; economically inactive residents may be students or raising families, among other reasons, which could have longer-term economic or social effects.

*Is employment supporting resilience by providing suitable incomes in Barking and Dagenham?*

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[204] ONS. Methodology: A guide to labour market statistics [https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/aguidetolabourmarketstatistics]. Accessed 2018 Oct 04.
[205] ONS, Annual Population Survey, Jan 2017-Dec 2017.
[206] ONS, 2011 Census, DC6201EW – Economic activity by ethnic group by sex by age.

Residents of Barking and Dagenham have the lowest median hourly pay in London, at £11.79 per hour. This is 70p per hour less than the next lowest (Brent) and £9.50 per hour less than the highest (Kensington and Chelsea).[207] Furthermore, the London Living Wage is currently £10.20 per hour. At least 30% of Barking and Dagenham men in work and 40% of women are paid less than this.[208]

**Figure 5.5: Median hourly pay (excluding overtime), 2017**

**Lowest in London** for median hourly pay (excl. overtime)

**Bottom 3:**

- **LBBD, £11.79**
- Brent, £12.49
- Newham, £12.76

**Top 3:**

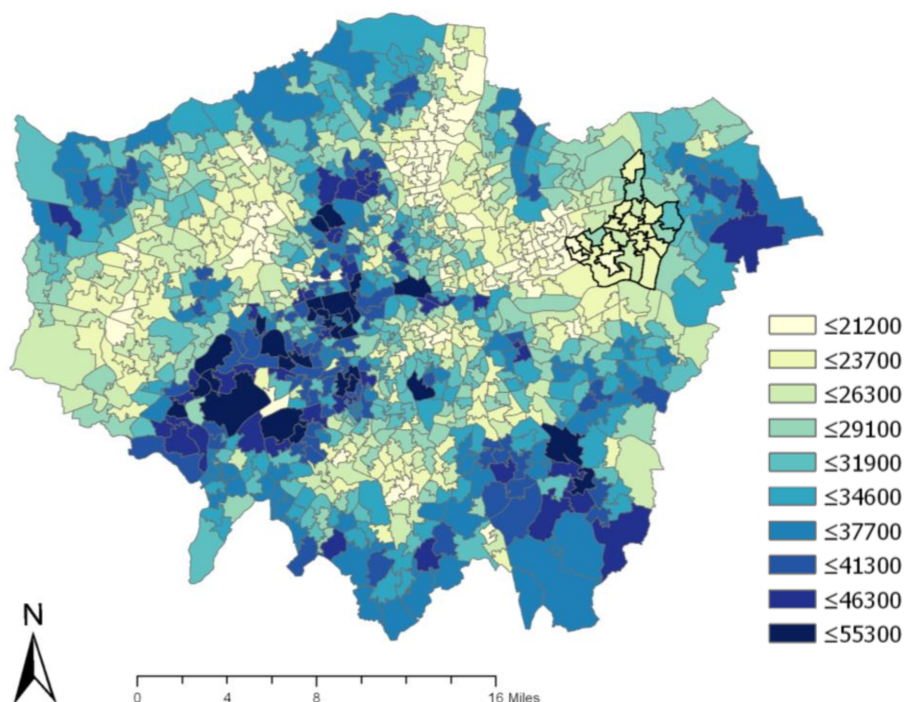
- Kens & Chelsea, £21.29
- Westminster, £19.94
- Wandsworth, £19.16

*Data: ONS, Annual Survey of Hours and Earnings, 2017.*

This is not just about the mix of part-time and full-time jobs; full-time Barking and Dagenham workers also have the lowest median hourly pay: £13.75.[209]

Small area income estimates in Figure 5.6 further highlight the low income of residents across the borough relative to other areas in London.

**Figure 5.6: Net annual income after housing costs (£), 2015/16, middle-layer super output area, London**

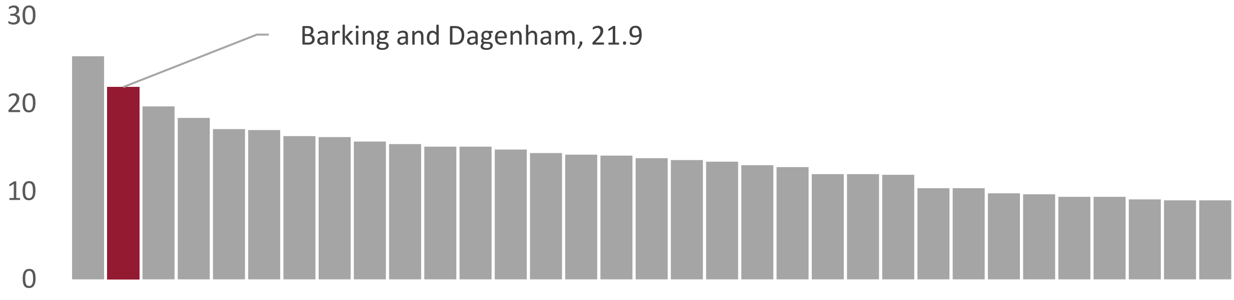



*Data: ONS, Small area income estimates for middle layer super output areas, England and Wales. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.*

[207] ONS, Annual Survey of Hours and Earnings (ASHE), 2017. Median hourly pay excluding overtime. Measure does not include self-employed.
[208] ONS, ASHE, 2017. Hourly pay excluding overtime. Measure does not include self-employed.
[209] ONS, ASHE, 2017. Median hourly pay excluding overtime. Measure does not include self-employed.

In addition, Barking and Dagenham has the second highest rate of insolvencies per 10,000 in London (Figure 5.7).

**Figure 5.7: Total insolvency rate per 10,000, London boroughs, 2017**



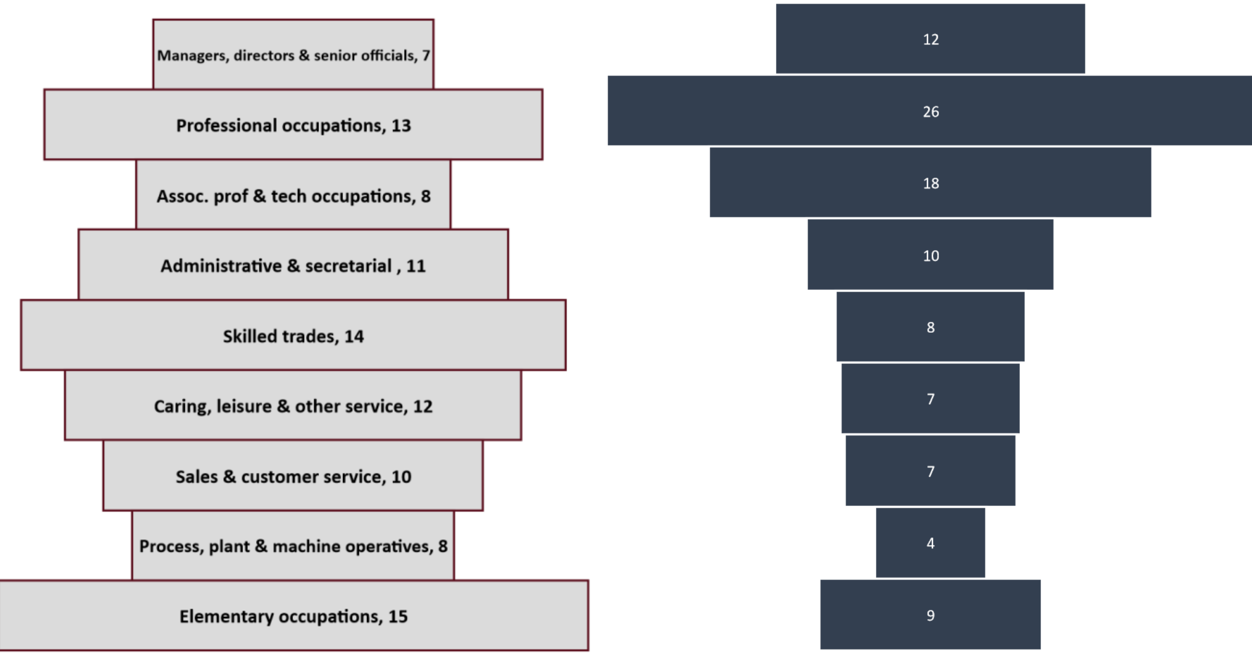

*Data: The Insolvency Service, 2017.*

*Are the type of jobs in Barking and Dagenham likely to support resilience?*

Barking and Dagenham has a different mix of jobs to the national or regional picture. For example, 13% of jobs in Barking and Dagenham are classed as 'professional occupations', compared with 26% across London.

Barking and Dagenham has a higher proportion of workers in sectors such as skilled trades, process, plant and machine operatives, and elementary occupations than London (Figure 5.8).

**Figure 5.8: Workforce mix – higher % in elementary occupations (Barking and Dagenham – left and London – right)**




*Data: ONS, Annual Population Survey, 2017.*

Sickness absence figures show that, based on October 2016 to September 2017 data, compared with 'professional occupations':[210]

- process, plant and machine operatives have an 80% increased risk of sickness absence
- people in elementary occupations have a 75% increased risk
- people in sales and customer service occupations have a 55% increased risk
- people in caring, leisure and other service occupations have a 65% increased risk.

[210] ONS, Sickness absence in the UK labour market.

- managers and senior officials have a 15% lower risk of sickness absence.

Higher sickness absence may adversely affect the ways in which a job provides resilience (for example, for workers who are only paid for days or shifts they work) and if the work itself is connected to poor health, then it would be directly detrimental to resilience.

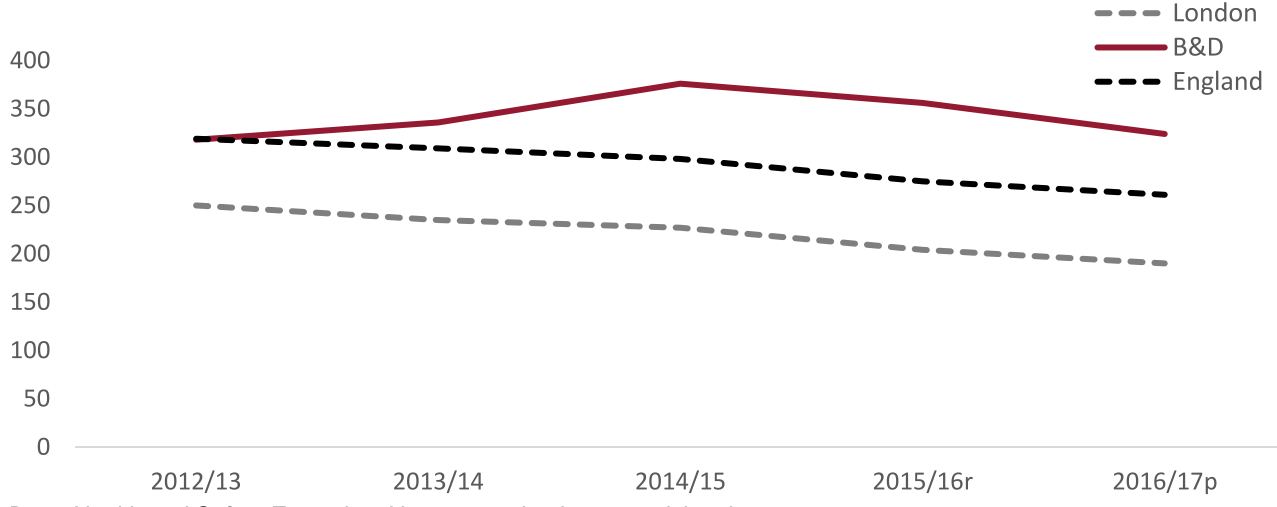
Furthermore, national health and safety data from a sentinel GP reporting scheme suggests that people in elementary occupations, process, plant and machine operatives and skilled trades occupations have a higher risk of work-related ill health than the average across all occupations.[211] These groups make up 38.0% of the workforce in Barking and Dagenham, but only 20.7% of the workforce across London.

Conversely, people in associate professional and technical occupations, professional occupations and managers and senior officials have a lower risk of work-related ill-health; 28.5% of the workforce in Barking and Dagenham is in one of these three groups but 55.4% of the workforce in London.

Finally, Barking and Dagenham has a high rate of non-fatal injuries to employees, as reported to RIDDOR, compared with London and England (Figure 5.9).[212] The rates are likely to be underestimates (across all geographies) as injuries at work are known to be under-reported.

There have been two fatal injuries at work in Barking and Dagenham in the past 5 years.[213]

**Figure 5.9: Non-fatal injuries to employees reported via RIDDOR, rate per 100,000**




*Data: Health and Safety Executive. Note: r = revised, p = provisional.*

## 5.6 Wellbeing

Wellbeing has been defined as:

> *A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment. A state in which an individual is able to realise his or her own abilities, cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.*[214]

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[211] Health and Safety Executive. Table THORGP08. Incidence of work-related ill-health seen in THOR-GP by major occupational group (SOC). Figures for 2015 and annual average for 2013 to 2015.
[212] Health and Safety Executive, RIDREG: RIDDOR reported Injuries by country, region, county and local authority.
[213] Health and Safety Executive, RIDREG: RIDDOR reported Injuries by country, region, county and local authority.
[214] Mind, Mental Health Foundation; Mental Health Strategic Partnership. *Building resilient communities: Making every contact count for public mental health*. London: Mind; 2013.

This can be broken down into 'feeling well' and 'functioning well'. The former relates to feelings of happiness, contentment, enjoyment, engagement and safety. This does not necessarily mean the absence of sadness, anger and stress, but people feeling well are often better equipped to cope with these without significant impact on their health.

The latter relates to your ability to function in the world and have positive relationships and social connections, as well as having control over your life and a sense of purpose.

Survey data on wellbeing places Barking and Dagenham in the bottom third of all measures (life satisfaction, feeling that the things you do are worthwhile, feeling happy and feeling anxious) (Figure 5.10).

**Figure 5.10: Barking and Dagenham's performance on four measures of self-reported personal wellbeing relative to other local authorities in England, 2016/17**

*Data: ONS.*

The Office for National Statistics has analysed the factors which are associated with low wellbeing nationally. Many of these factors are high in Barking and Dagenham (Table 5.2).

**Table 5.2: Factors associated with low wellbeing nationally**

| Factor[215] | B&D position relative to London |
|---|---|
| self-reported bad/very bad health | 3rd highest in London in 2011 Census |
| economically inactive due to long-term illness or disability | 3rd highest proportion of working-age residents on long-term sick leave in London in 2017 – 5.8% or 1 in 17. |
| unemployment | joint highest unemployment rate in London in 2017 |
| aged 40–59 | 8th lowest proportion in London (however, this group is nonetheless almost 1 in 4 of population – 24.3%) |
| not married or in a civil partnership (i.e. single, separated, widowed or divorced) | 17th highest proportion of residents in London aged 16+ who were not married or in a civil partnership in the 2011 Census (57.9% or 6 in 10) |

215 ONS. Understanding well-being inequalities: Who has the poorest personal well-being? [https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/understandingwellbeinginequalitieswhohasthepoorestpersonalwellbeing/2018-07-11]. Accessed 2018 Oct 04.

| | |
|---|---|
| renting (social or private) | 17th highest proportion of rented households in London in 2011 Census (51.4% or 1 in 2) |
| no qualifications or qualifications below GCSE level | joint 2nd highest % of working age residents with no qualifications in London in 2017 (12.5% or 1 in 8) |

*Data: ONS, Census 2011, Annual Population Survey, mid-year estimates.*

There is also a rough correlation with deprivation. Figure 5.11 shows life satisfaction by deprivation quartile, with the darkest colour representing the most deprived quartile and the lightest colour the least. There is a tendency for the most deprived quartiles to cluster towards the lower end of the scale, which underscores the importance of structural factors in wellbeing and hence resilience. The average life satisfaction score for the least deprived areas was 7.76, compared with 7.52 for the least deprived areas.

**Figure 5.11: Life satisfaction by deprivation quartile – mean, 2016/17**

*Data: ONS.*

The 2017 School Survey in Barking and Dagenham provides a partial picture of wellbeing in young people; two in three secondary school students felt optimistic about the future, while four in five students felt close to other people and two in three secondary school students felt they dealt with problems well.[216]

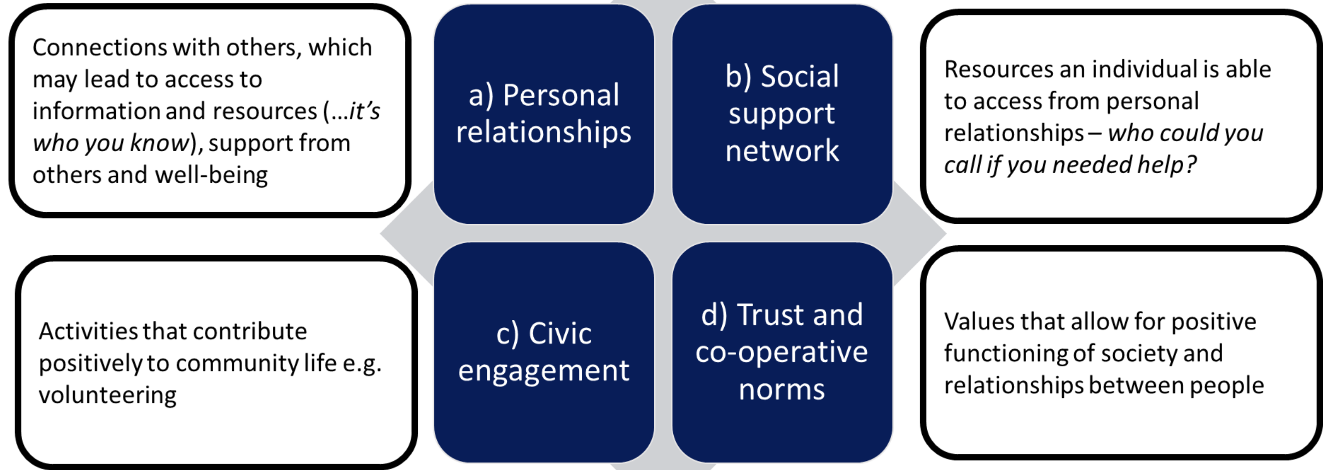
## 5.7 Social capital

Social capital can be broadly defined as the benefits that individuals and communities can gain from social connections and social norms. Social connections are important for good mental health and resilience.[217]

An Organisation for Economic Co-operation and Development (OECD) paper looking at how social capital could be measured described four definitions or facets (Figure 5.12).[218] This framework was adapted by the ONS when it developed indicators for social capital.[219]

[216] LBBD School Survey 2017.
[217] Mind, Mental Health Foundation; Mental Health Strategic Partnership. *Building resilient communities: Making every contact count for public mental health*. London: Mind; 2013.
[218] Scrivens K, Smith C. *Four Interpretations of Social Capital: An Agenda for Measurement*. OECD Statistics Working Papers, 2013/06. Paris: OECD Publishing; 2013.
[219] ONS, Social capital in the UK: May 2017. Statistical bulletin [https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/socialcapitalintheuk/may2017]. Accessed 2018 Oct 05.

**Figure 5.12: Four conceptions of social capital**




*Source: Created based on Scrivens and Smith, 2013.*

**Personal relationships** broadly described the benefits that you can gain from connections with others. For example, having a wide social network may help individuals find out about jobs or opportunities, while many people derive a positive sense of wellbeing from being connected with others. Therefore, one way in which this can be measured is by looking at loneliness and social isolation.

For more vulnerable adults, in Barking and Dagenham, around 60–65% of carers and users of adult social care would like more social contact:

- In 2016/17, 39.6% of adult social care users in Barking and Dagenham had as much social contact as they would like, compared with 41.0% in London and 45.4% in England.[220]
- In 2015/16, 34.2% of adult carers in Barking and Dagenham had as much social contact as they would like, compared with 35.6% in London and 35.5% in England.[221]

In 2018, 5% of respondents to the GP Patient Survey in Barking and Dagenham reported feeling isolated from others in the last 12 months.[222]

A national survey found that around 1 in 20 (5%) adults report being lonely 'often/always' and 1 in 6 (16%) 'some of the time'.[223] Analysis found that the following characteristics were associated with a greater risk of loneliness:

- younger age (16–24)
- female (versus male)
- single/widowed
- poor health/long-term illness or disability
- renter (versus homeowners)
- lower sense of belonging to neighbourhood
- lower satisfaction with local area
- little trust of others in local area.

The final three points illustrate the importance of social connections for wellbeing.

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[220] Public Health England (PHE), Public Health Outcomes Framework [http://www.phoutcomes.info/].
[221] Public Health England (PHE), Public Health Outcomes Framework [http://www.phoutcomes.info/].
[222] GP Patient Survey 2018 [https://www.gp-patient.co.uk/].
[223] ONS. Loneliness - What characteristics and circumstances are associated with feeling lonely? [https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10]. Accessed 2018 Oct 04.

**Social support network** looks specifically at the resources an individual can access through their personal relationships. For example, if you needed help – whether someone to talk to or someone to help with tasks such as shopping – who could you call? One way in which this can be measured is therefore to look at the prevalence of unpaid care in the community.

The 2018 GP patient survey found that 12.9% of Barking and Dagenham registered patients provide care for others (due to long-term physical or mental ill health/disability, or problems related to old age), compared with 16.7% across England.[224] However, the main difference was in the proportion of people providing 1–9 hours of care; a similar proportion provide 10 or more hours of care per week.

### Table 5.3: Care in Barking and Dagenham and England

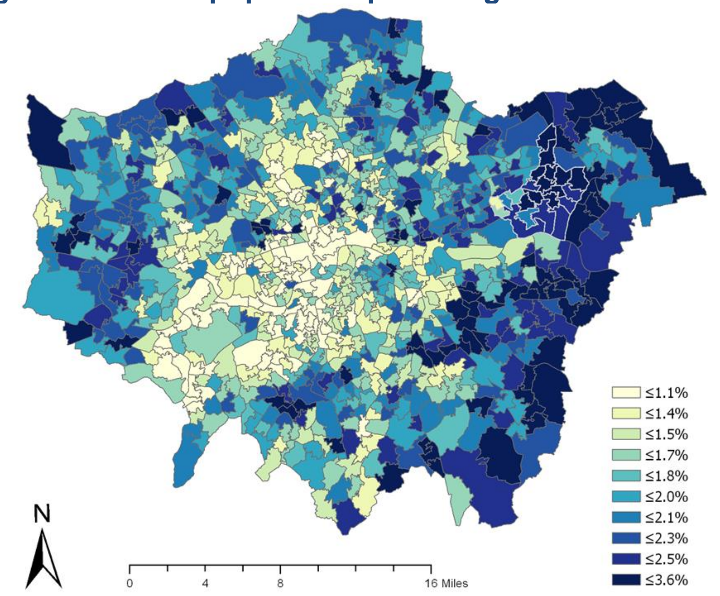
| Hours per week of care provided | B&D | England |
|---|---|---|
| *None* | *87.1%* | *83.3%* |
| 1–9 | 5.2% | 9.2% |
| 10–19 | 1.7% | 2.1% |
| 20–34 | 1.4% | 1.2% |
| 35–49 | 1.7% | 1.0% |
| 50+ | 3.0% | 3.2% |

*Data: GP Patient Survey 2018.*

As care is often provided for others in their old age, to have a similar rate of care provided as England may itself be meaningful; as we have seen in the demography section, 9.4% of Barking and Dagenham residents are aged 65 and above, compared with 18.0% across England.

Data from the 2011 Census is now somewhat out of date but provides more precise estimates than data based on a sample. Census data (Figure 5.13) indicates that, relative to the rest of London, a high proportion of residents provided 50 or more hours of unpaid care a week, especially in the north and east of the borough.

### Figure 5.13: % of population providing 50+ hours of unpaid care per week, 2011 Census




*Data: Census 2011, ONS. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.*

**Civic engagement** relates to activities that contribute positively to community life, such as volunteering. These may also have benefits to the individual.

[224] GP Patient Survey 2018 [https://www.gp-patient.co.uk/].

Just over 1 in 5 residents (23%) have volunteered in the last 12 months.[225] This is similar to national data; in 2014/15, 19% of people had volunteered more than once in the last 12 months.[226]

7% of Barking and Dagenham residents volunteered at least once a week, and an additional 8% at least once a month.

**Trust and co-operative norms** refer to values such as trust that allow for the positive functioning of society and relationships between people. We can look measures such as the percentage of people who agree that the local area is a place where people from different backgrounds get on well together as well as perceptions of safety at night.

Around seven in ten (72%) residents agree that their local area is a place where people from different backgrounds get on well together.[227] This is similar to 2015 and 2016 but lower than London (84%) and England (82%) figures for 2017/18.[228]

Furthermore, a declining proportion of residents feel safe outside after dark: 42% in 2017, down from 51% in 2015. This is lower than both London (73%) and England (76%).[229]

## 5.8 Conclusions

Resilience is important in Barking and Dagenham as it is interlinked with prevention and maximising mental wellbeing (a key component of resilience) is important in its own right. With the growth expected in the coming years, building resilient communities and individuals can help to ensure that 'no-one is left behind'.

Resilience requires structural prerequisites such as education, housing and employment. Once these conditions are met, resilience is closely tied to personal well-being and social capital (the benefits that individuals can gain from social connections and norms).

Education supports resilience as it provides children and young people with the skills and qualifications they need for later life. The average attainment 8 score in Barking and Dagenham in 2016/17 was 46.7, which was the eighth lowest score in London. **Improving school readiness, maintaining high school standards and environments, and increasing attainment and attendance should support resilience.**

Home ownership and good quality housing can support resilience. However, less than half of all households in Barking and Dagenham are thought to own the property they live in and home ownership is becoming less affordable. There were high levels of overcrowding at the time of the 2011 Census, while just under half of Barking and Dagenham-owned housing stock is non-decent. **Supporting the availability of better quality, more affordable housing would support resilience.**

Employment can support resilience as it provides income and psychosocial benefits. However, the type of job and conditions are also relevant. In Barking and Dagenham, 75.3% of working-age men and 61% of working-age women are employed; both are lower than the respective figures for London and England. For men, this is explained by higher rates of unemployment and for women this appears to be due to a combination of higher unemployment and economic inactivity. **Supporting the unemployed and the**

[225] LBBS Residents' Survey, 2017.
[226] ONS, Social capital headline indicators; May 2017.
[227] LBBD Residents' Survey, 2017.
[228] Department for Digital, Culture, Media & Sport. Community Life Survey: July 2018. Note: different survey method.
[229] LBBD Residents' Survey, 2017.

**economically inactive who would like to work to enter employment would support resilience in the borough.**

However, Barking and Dagenham has the lowest hourly pay in London; it is not clear that work with such income supports resilience. Barking and Dagenham also has a higher proportion of workers in occupational categories that are associated with higher levels of sickness absence and work-related ill-health relative to London. **Advocating for the London Living Wage, helping uncover cases where the National Minimum Wage is not being paid, enforcing health and safety requirements (where under local authority remit), supporting training, and encouraging the development of skilled jobs in the area would help employment to support resilience.**

Barking and Dagenham is in the bottom third of local authorities in England for all four measures of well-being. There is a high prevalence of factors associated with low wellbeing (such as unemployment and self-reported bad health). **Addressing underlying socio-economic factors (where applicable) may increase well-being.**

Social capital can be broadly defined as the benefits that individuals and communities can gain from social connections and social norms. This can be measured by looking at personal relationships, social support networks, civic engagement, and trust and co-operative norms.

'Personal relationships' describes the benefits you can gain from connections with others. This can be measured through social isolation; in 2018, 5% of respondents to the GP Patient Survey in Barking and Dagenham reported feeling isolated from others in the last 12 months. **Reducing social isolation would be beneficial to resilience.**

'Social support network' looks at the resources an individual can access through their personal relationships and can be measured by looking at unpaid care. Although a lower proportion of people in Barking and Dagenham provide care to others than England, this difference is largely in people providing 1–9 hours of care a week; a similar proportion provide 10 or more hours of care per week. **Exploring whether such support networks are equally distributed may help us understand who may need more support.**

'Civic engagement' considers activities that contribute positively to community life, such as volunteering. Just over one in five residents (23%) have volunteered in the last 12 months. **As with support networks, it would be worth exploring whether this is evenly distributed within the borough to understand who and who does not volunteer.**

'Trust and co-operative norms' refers to values that allow the positive functioning of society and relationships between people. This can be measured by the percentage of people who feel safe after dark. This is lower in Barking and Dagenham (42%) than London and England. **Exploring residents' attitudes to their local area will give us insights into how norms are changing over time and how we might intervene to affect these positively.**

# Community and Equality Impact Assessment

As an authority, we have made a commitment to apply a systematic equalities and diversity screening process to both new policy development or changes to services.

This is to determine whether the proposals are likely to have significant positive, negative or adverse impacts on the different groups in our community.

This process has been developed, together with **full guidance** to support officers in meeting our duties under the:

- Equality Act 2010.
- The Best Value Guidance
- The Public Services (Social Value) 2012 Act

| COMMUNITY AND EQUALITY IMPACT ASSESSMENT | |
|---|---|

## About the service or policy development

| Name of service or policy | Joint Health & Wellbeing Strategy 2019-2021 |
|---|---|
| Lead Officer<br>Contact Details | Florence Henry, florence.henry@lbbd.gov.uk<br>020 8227 3059 |

| Why is this service or policy development/review needed? |
|---|
| The Joint Health and Wellbeing Strategy 2019-2023 is a statuory strategy, and the current 2015-2018 strategy is due to expire. The strategy will set out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives by 2023. The aim of the strategy is to help residents improve their health by identifying the key priorities based on the evidence from the Joint Strategic Needs Assessment 2017 and updated data from the Joint Strategic Needs Assessment 2018 focusing on three themes. The priorities in the strategy will underpin commissioning plans, and outline how the council and partners will work together to deliver the proposed priorities. |

## 1. Community impact (this can be used to assess impact on staff although a cumulative impact should be considered).

What impacts will this service or policy development have on communities?
Look at what you know? What does your research tell you?

*Consider:*
- National and local data sets
- Complaints
- Consultation and service monitoring information
- Voluntary and Community Organisations
- The Equality Act places a specific duty on people with 'protected characteristics'. The table below details these groups and helps you to consider the impact on these groups.

**Demographics**

Barking and Dagenham has a young and diverse population of around 21,700 residents in a densely populated urban location. The equivalent of around 1 in 12 residents left and entered the borough between 2016 and 2017. Estimates suggest that as of 2019, 47% of Barking and Dagenham's population will be white, 23% black, 23% Asian, 5% Mixed and 2% other.

Barking and Dagenham performs poorly in a variety of health indicators. Residents live shorter lives in poor health when compared to London – Barking and Dagneham has the lowest life expectancies in London for both women and men. Male healthy life expectancy, the years lived in good health, in Barking and Dagenham is 58.2, compared to the London average of 63.5 years. Female healthy life expectancy in Barking and Dagenham is 58.5 years, compared to the London average of 64.1 years. Barking and Dagenham also the highest rates of Year 6 obesity.

## COMMUNITY AND EQUALITY IMPACT ASSESSMENT

The Joint Health and Wellbeing Strategy focuses on three priority areas, which have been decided by the Health and Wellbeing Board. The Joint Strategic Needs Assessment 2018 has also focused on producing indepth data around these three themes:

1. *Best Start in Life,* focuses from preconception up until the age of 5. This theme aims to give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 5 years. Evidence demonstrates that the first 5 years shape mental and physical health for the rest of life, and is therefore a key time to invest.

As outlined in our 2018 Joint Strategic Needs Assessment, we have the highest proportion of residents aged 0-4 in the UK. Our 2017 birth rate was also the highest in England and Wales at 83 live births per 1000 women between the ages of 15 and 44.

As part of the Index of Multiple Deprivation, the income deprivation of children measures the proportion of children under the age of 16 that live in low income households. Barking and Dagenham has the eleventh highest proportion of children under the age of 16 living in poverty in England, and the fourth highest in London with 32% of children in the borough living in poverty.

2. *Early Diagnosis and Intervention:*

Early diagnosis and intervention increases the chances for successful treatement across a range of diseases and illness. The borough runs a number of screening programmes in partnership with the NHS – the Joint Strategic Needs Assessment 2018 outlines the context surrounding the borough's screening programmes:

- We have the highest rate of deaths from cancer considered preventable in London
- We have the third highest prevalence of chronic obstructive pulmonary disease (COPD) in London
- We have the third highest proportion of late HIV diagnoses in London.

3. *Buidling resilience*

By resilience, we mean empowering residents to not just survive, but to thrive.

Whilst resilience of residents is hard to measure, we know that outcomes for our residents are towards the bottom of most London league tables in key areas. We also know that the areas such as employment skills and enterprise and domestic violence have huge impacts on resilience. Barking and Dagenham has a higher unemployment rate than the London average – 6.9% of working age people are unemployed compared to the London average of 5.7% and have the highest recorded incidents of domestic violence in London.

Within the building resilience theme of the strategy, there is a focus on Adverse Childhood Experiences. This is because evidence demonstrates that those who suffer from 4 or more Adverse Childhood Experiences, are more likely to have higher GP use, greater use of

emergency care and increased hospitalisation, and are over twice as likely to have a range of health conditions including heart disease, cancer and COPD.

Further data on these three themes can be found within the 2018 Joint Strategic Needs Assessment.

| Potential impacts | Positive | Neutral | Negative | What are the positive and negative impacts? | How will benefits be enhanced and negative impacts minimised or eliminated? |
|---|---|---|---|---|---|
| **Local communities in general** | X | | | The Health & Wellbeing Strategy will improve the health of populations within Barking and Dagenham by focusing on the health inequality interventions that have the biggest potential for impact. The strategy will not take a life course approach as has been taken in previous years, but will address age, disability and specific groups within each theme of the strategy. | We have made the effort to include local communities in the co-production of the strategy, through the creation of 'I' statements through resident focus groups.<br><br>Through Healthwatch, we ran one focus group which had within it:<br><br>-Mental health service users<br>-Older people<br><br>We have also consulted with parents of disabled children, Just Say Yes and disabled youth groups in the borough to formulate "I" statements to ensure that those with disabilities are represented.<br><br>The data update included in part of the strategy, also includes data on all equality groups. This data will then form the basis of workshop discussions, detailing the actions taken in the strategy, to ensure that the views of equality groups are represented in the actions outlined in the strategy.The workshops will operate a life-course approach, ensuring that issues affecting each age group are discussed. |
| **Age** | X | | | | |
| **Disability** | X | | | | |
| **Gender reassignment** | | X | | | We have consulted with LGBT+ Flipside and ran a focus group to co-produce these 'I' statements, to include the views of those who have undergone gender reassignment. |
| **Marriage and civil partnership** | | X | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Pregnancy and maternity** | X | | | One of the themes of the Health and Wellbeing Strategy is best start in life, focusing from pre-natal through to the age of 5. The focus on pregnancy and childbirth will have positive impacts on women's pre-natal and perinatal health and wellbeing. Barking and Dagenham has the highest birth rate in England and Wales, making this a key area to focus on. | Parent forums within children's centres have been consulted through resident focus groups.<br><br>Medical professionals from the CCG with expertise in prenatal and perinatal attended our Best Start in Life professional workshop in July, and have also been consulted through engagement with the Joint Executive. One of the table groups for discussion at the 'Best Start in Life' workshop in July focused entirely on pregnancy and maternity to ensure that there was a section on this within the strategy. |
| **Race (including Gypsies, Roma and Travellers)** | | X | | | The data update included in part of the strategy, also includes data on all equality groups where avaliable. This data then formed the basis of workshop discussions, detailing the actions taken in the strategy, to ensure that the views of different races are represented in the actions outlined in the strategy. |
| **Religion or belief** | | X | | | The data update included in part of the strategy, also includes data on all equality groups where avaliable. This data will then form the basis of workshop discussions, detailing the actions taken in the strategy, to ensure that the views of different races are represented in the actions outlined in the strategy.<br><br>To ensure that the views of different faith groups are accounted for and represented in the strategy, we sent out a message in the Faith Leaders Newsletter asking if they would be willing for us to hold a focus group to formulate "I" statements which are included within the strategy. |
| **Gender** | | X | | Overall, women in the borough live longer with their life expectancy 81.8 years, compared to | The data used in the Joint Strategic Needs Assessment 2018, which informs this strategy, looks at both genders where this data is available. |

| | | | | | |
|---|---|---|---|---|---|
| | | | | the male 77.5 years. However, they live more years in ill health with their healthy life expectancy, the years lived in good health, at 58.5, compared to the male 59.8 years, whereas the London average has the healthy life expectancy for both genders at 64.1 years. Therefore women in the borough live more of their life in ill health than the London average.<br>.<br>The aforementioned focus on pregnancy and maternity through best start in life will have positive impacts for women.<br><br>The 2017 schools survey also shows that female year 10 students perform worse in every indicator of emotional well-being.<br><br>However, locally, the percentage of girls at the age of 5 achieving a good level of development is higher than boys – 78.8% compared to 67.8%, and therefore the strategy's focus on best start in life will have positive impacts for boys in the borough. | Given the onset of postnatal depression, and the disproportionate affect this has on women, we ran a focus group in the borough's Mental Health Peer Support Network's drop in women's coffee morning. |

| | | | | | |
|---|---|---|---|---|---|
| **Sexual orientation** | | X | | | To ensure that the views of LGBT+ communities are accounted for and represented in the strategy, we ran focus groups with Flipside LGBTQ+ members to formulate "I" statements to be included in the strategy.<br><br>The leaders of Flipside LGBTQ+ also were invited to the professional Stakeholder workshop |
| **Any community issues identified for this location**? | | X | | | |

## 2. Consultation.

| Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups? |
|---|
| The strategy has a strong consultation element. We have consulted with:<br>• Children's commissioning<br>• Adult's commissioning<br>• CCG<br>• Participatory City<br>• Inclusive Growth<br>• Community Enterprise Team<br>• Strategy & Performance Team<br>• Community Solutions<br>• NHS partners<br>• Drug and Alcohol team<br>• Domestic Violence Team<br>• Cultural Educational Partnership<br>• CVS<br>• Barking & Dagenham Carers<br>• Faith groups<br>• Parks commissioning team<br><br>In order to create 'I' statements to include in the strategy, throughout May and June, we ran a series of resident focus groups. These focus groups explored what is important to residents in regard to their health and wellbeing, and the results were used to create 'I' statements for each theme in the strategy, that providers will be held accountable against. Those involved in the focus groups:<br>• Carers of Barking and Dagenham<br>• CVS<br>• BAD Youth Forum<br>• LGBTQ+ Flipside<br>• Children's Centres' Parents Forums<br>• Community Health Champions<br>• HealthWatch Service User Groups<br>• Patient Engagement Forum<br>• Mental Health Peer Support Group<br>• Mental Health Patient Engagement Forum<br>• Streetwise<br>• CGL<br>In total, 128 residents attended 12 resident focus groups.<br><br>A wide-range of organisations have been contacted to arrange these focus groups. |

| COMMUNITY AND EQUALITY IMPACT ASSESSMENT | |
|---|---|

| Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups? |
|---|
| We also held 3 professional workshops in July with internal and external stakeholders, and NHS CCG partners to discuss each theme of the strategy. The attendance at each workshop was as below:<br>*1. Best start in life – 4h July – 27 attendees*<br>*2. Early diagnosis and intervention – 9th July – 21 attendees*<br>*3. Buidling resilience through prevention – 18h July – 41 attendees*<br>We are also running an 8 week online consultation to gain views on the draft strategy before it is published. During this consultation, we will be going back to the community groups where we ran resident focus groups, to obtain their views on the draft strategy. |

## 3. Monitoring and Review

| How will you review community and equality impact once the service or policy has been implemented?<br>*These actions should be developed using the information gathered in **Section1 and 2** and should be picked up in your departmental/service business plans.* | | |
|---|---|---|
| **Action** | **By when?** | **By who?** |
| To monitor the outcomes of the strategy on a quarterly basis in a performance report to the Health and Wellbeing Board | Quarterly | Health and Wellbeing Board |
| To produce an Annual Monitoring report to the Health and Wellbeing Board on the 'attitudes' elements of the measures, which are only available on an annual basis. | Annual | Health and Wellbeing Board |

## 4. Next steps

It is important the information gathered is used to inform any Council reports that are presented to Cabinet or appropriate committees. This will allow Members to be furnished with all the facts in relation to the impact their decisions will have on different equality groups and the wider community.

Take some time to précis your findings below. This can then be added to your report template for sign off by the Strategy Team at the consultation stage of the report cycle.

| Implications/ Customer Impact |
|---|

The strategy outlines the Council's commitment to improve health and wellbeing in the borough, by focusing on three priority areas:

1. Best Start in Life – preconception up to the age of 5
2. Early Diagnosis and Intervention
3. Building resilience through prevention to achieve better health and wellbeing.

The strategy will have positive impacts for the community. Through co-producing resident focused 'I' statements with residents through focus groups, the Council has taken extra effort to create the strategy for improving health inequalities based around what is important to their residents.

The strategy also details 6 outcomes, which outline what we want to achieve to make improvements in each of these areas.

Once the strategy is approved by the Health and Wellbeing Board, we will be doing work with the Alliance of Providers and Commissioners to create the detailed delivery plans that will deliver the outcomes contained within the strategy.

## 5. Sign off

The information contained in this template should be authorised by the relevant project sponsor or Divisional Director who will be responsible for the accuracy of the information now provided and delivery of actions detailed.

| Name | Role (e.g. project sponsor, head of service) | Date |
|---|---|---|
| Matthew Cole | Director of Public Health | 10-Oct-18 |

**ASSEMBLY**

**30 January 2019**

| **Title:** Council Tax Support Scheme 2019/20 | |
|---|---|
| **Report of the Cabinet Member for Finance, Performance and Core Services** | |
| **Open Report** | **For Decision** |
| **Wards Affected:** All | **Key Decision:** Yes |
| **Report Author:** Donna Radley, Head of Benefits | **Contact Details:**<br>E-mail: donna.radley@elevateeastlondon.co.uk |
| **Accountable Director:** Helen Seechurn, Finance Director | |
| **Accountable Strategic Leadership Director:** Claire Symonds, Chief Operating Officer | |

**Summary**

The Council has a statutory duty to consider annually whether to revise its Local Council Tax Support Scheme (CTS) or replace it with another scheme. This report recommends keeping the current scheme for use in 2019/20, subject to minor amendments. The Assembly has a legal duty to approve the CTS by Assembly by 31st January 2019.

The Cabinet is to consider this report at its meeting on 22 January 2019 (the date of publication of this Assembly agenda). Any issues arising from the Cabinet meeting will be reported at the Assembly meeting.

**Recommendation(s)**

The Assembly is recommended to:

(i) Agree that the Council Tax Support (CTS) Reduction Scheme implemented for 2018/19 be retained for 2019/20, subject to the following minor amendments:

- Treat Universal Credit Award Notifications as an Intention to Claim CTS providing that a valid claim form for CTS is made within a month of the decision to award Universal Credit.
- Adopt a shortened claim form for the purposes of claiming CTS when Universal Credit has been awarded.
- Accept Universal Credit as a “passported” benefit when claiming within a month of a new liability for CTS purposes.
- Amend the capital threshold for CTS purposes to £10,000 for working age persons to align it with Pension Age capital limits.
- Re-introduce backdate on CTS of up to four weeks, subject to good cause to align it with the Housing Benefit scheme.

**Reason**
The Council's CTS scheme requires minor changes so the general administration of the scheme is simplified and compatible with all welfare reforms including Universal Credit. For effective processing the scheme should align with the administration of Housing Benefit and principles of passported benefits. It is further proposed that the Council continues with the core scheme, subject to the above amendments, it implemented last year.

## 1 Introduction and Background

1.1. The Welfare Reform Act in 2012 abolished Council Tax Benefit (CTB) from April 2013 and, in its place, support took the form of a local Council Tax Support Scheme (CTS). The Local Government Finance Act 2012 contains provisions for the setting up of local support schemes**.** The current scheme in Barking & Dagenham has been based around the Default Council Tax Reduction Scheme and has been ratified by Assembly.

1.2. The current scheme in operation ensures that;

- The scheme is means tested
- Pensioners are protected, i.e. they must be able to receive up to a 100% reduction (a provision of the national pension age scheme).
- Everyone of working age contributes something towards their Council Tax. A "minimum payment" of 25%. There is a 75% maximum on which any entitlement to CTS is based.
- Those who are not pensioners and with capital in excess of £6,000 are not eligible for a Council Tax reduction under this scheme.

## 2. Proposals and Issues

2.1. The proposed minor revisions to the current scheme do not affect the core elements of the scheme and only seek to make it easier to understand and administer and ensure it is compliant with the wider welfare system, principally the roll out of Universal Credit.

2.2. The proposed revisions are;

- Treat Universal Credit Award Notifications as an Intention to Claim CTS providing that a valid claim form for CTS is made within a month of the decision to award Universal Credit.
- Adopt a shortened claim form for the purposes of claiming CTS when Universal Credit has been awarded.
- Accept Universal Credit as a "passported" Benefit when claiming within a month of a new liability for Council Tax Support purposes.
- Amend the capital threshold for Council Tax Support purposes to £10,000 for working age persons to align it with Pension Age capital limits.
- Re-Introduce backdate on Council Tax Support of up to four weeks, subject to good cause to align it with the Housing Benefit scheme.

2.3. The adoption of these changes will simplify the administration of the scheme by bringing it more in line with how the Council currently administers Housing Benefit. It

also addresses the technical issues the Council have faced with applying some of the rules that currently apply to the current scheme.

2.4. Universal Credit, for the purposes of amending Housing Benefits and transitional Protection, is considered a passported benefit however for the purposes of claiming CTS it is considered a standard income. Passported Benefit is a term used under the old benefit system and means that if you claim you are entitled to either the maximum payable benefit and you have a longer period in which to claim in. For the CTS Scheme we are only considering it as a passported benefit for the period of time in which you can claim and not the maximum benefit entitled. By treating Universal Credit as a passported benefit for the purposes of a new liability and period in which you can claim allows the CTS to be awarded in accordance to passported benefits under the Housing Benefit scheme. Namely that if a claim Is made within a calendar month of the new liability CTS can be awarded from the start of the new liability which maximises the Council Tax Support awarded and ensures a resident, who will be on a low income, receives the maximum support avliable and reduces debt. The award the person receives, from the date it is payable from, will be based against their income under Universal credit

2.5. By adopting a shorter claim for CTS when Universal Credit Is in payment you simplify the process for residents who have already completed one lengthy application form. The information required to process a claim for CTS, when Universal Credit is in payment, is reduced as only household member details are required, income for the applicant is covered by the Universal Credit award notice, as is their Identity verification.

2.6. Universal Credit, for the purposes of amending Housing Benefits and transitional Protection, is considered a passported benefit however for the purposes of claiming CTS it is considered a standard income. By treating Universal Credit as a passported benefit for the purposes of a new liability allows the CTS to be awarded in accordance to passported benefits under the Housing Benefit scheme. Namely that if a claim Is made within a calendar month of the new liability CTS can be awarded from the start of the new liability which maximises the Council Tax Support awarded and ensures a resident, who will be on a low income, receives the maximum support avliable and reduces debt.

Passported Benefits are Income Related Employment Support Allowance, Income Related Job Seekers Allowance, Guaranteed Credit and Income Support.

2.7. Under the current scheme any persons of working age with capital over £6,000 are not entitled to Council Tax Support, it is proposed that this is extended to £10,000 to align it with the rules for persons of Pension Age for the simplification of administration.

2.8. As Council Tax Support is now claimed as a separate benefit, residents used to traditional and former schemes, are not aware of the requirement and need to claim Council Tax Support with a separate team and form. This often leads to a loss of entitlement and outstanding debts which result in requests for backdated Council Tax Support which doesn't currently exist in the scheme for LBBD. Whilst the scheme doesn't allow for a backdated awarded of benefit, all requests made must be addressed formerly and responded to utilising administration time. It is further proposed that backdate is re-introduced into the CTS scheme for the simplification

and alignment of its administration to match the rules applicable for Housing Benefit but also to ensure income maximisation.

## 3. Financial Implications

Implications completed by: Katherine Heffernan, Group Manager (Corporate Finance)

3.1 This report proposes a number of amendments to the Council Tax Support scheme in the light of the implementation of Universal Credit. Some of these amendments are administrative in nature and have no direct financial implications. Others however have the potential to increase the number of eligible recipients of council tax support or the duration of their claim and so will have a cost implication as described below.

3.2 When considering these cost implications, it must be remembered that households on very low incomes on or near the thresholds for Council Tax Support are likely to struggle to pay their Council Tax and so the true cost to the Council taking into account collection rates, arrears and bad debt is likely to be much lower.

3.3 The adoption of a shortened claim form is an administrative matter and has no direct financial implication. It reduces the burden on the customer but does not reduce processing time for staff as they will need to source the same information from elsewhere.

3.4 It is not possible to model the impact of treating Universal Credit Award notifications directly. However, accepting Universal Credit as a passported benefit when claiming within a month of new liability is estimated to affect around 248 claims (based on current caseload data) giving them up to one month's additional Council Tax Support. The cost is this is estimated to be up to £12k. This is not a new cost as this amendment mirrors the arrangements for the legacy benefits and so will be already covered within the cost of the scheme.

3.5 Reintroducing backdating of up to four weeks could affect around 56 people (based on current caseload data) and is estimated to cost up to £4k. In addition, this group of claimants and those affected by the passporting issue are a low-income group and it is very possible that Council Tax would not in fact be fully collectable if Council Tax Support was not payable during the month.

3.6 The proposal to raise the Capital Threshold from £6,000 to £10,000 in line with the threshold for pension age claimants would result in a new cost. It is estimated this could affect around 80 customers (based on current caseload data) at a potential cost of £70k. These customers are more likely to be able to pay Council Tax, so this is a real cost to the Council which should be weighed against the benefits of simplified administration and supporting residents to improve their financial circumstances.

3.7 The theoretical cost of all these proposals would be up to £90k. However, this should be seen in the context of the overall amount of Council Tax which is £58m in 2018/19. The Council Tax Support scheme is £12.8m in total.

3.8 All working age claimants remain responsible for meeting 25% or more of their own council tax liability and the scheme is highly targeted on the least able to pay. As Council tax charges rise, there is a risk that collection rates will fall. The overall collection rate in 2017/18 was 95.8%

3.9 The Council must set aside a discretionary fund for circumstances of exceptional hardship. It is anticipated that a discretionary fund of £50,000 can be created to assist those with exceptional circumstances. This would be monitored and reviewed quarterly, although case law does suggest that if exceptional hardship is shown the Council must grant a discretionary reduction and cannot refuse due to a "depleted budget". It is therefore vital that a clear policy is implemented so the Council can set their own criteria of whom would qualify for a discretionary reduction. The cost of the discretionary fund will reduce the overall Council Tax collected by £50,000.

## 4. Legal Implications

*Implications completed by Dr Paul Feild, Senior Governance Lawyer*

4.1 The CTS is a continuation of the scheme as approved by the Assembly last year following consultations as required by the Local Government Finance Act 1992 as amended by the Local Government Finance Act 2012.

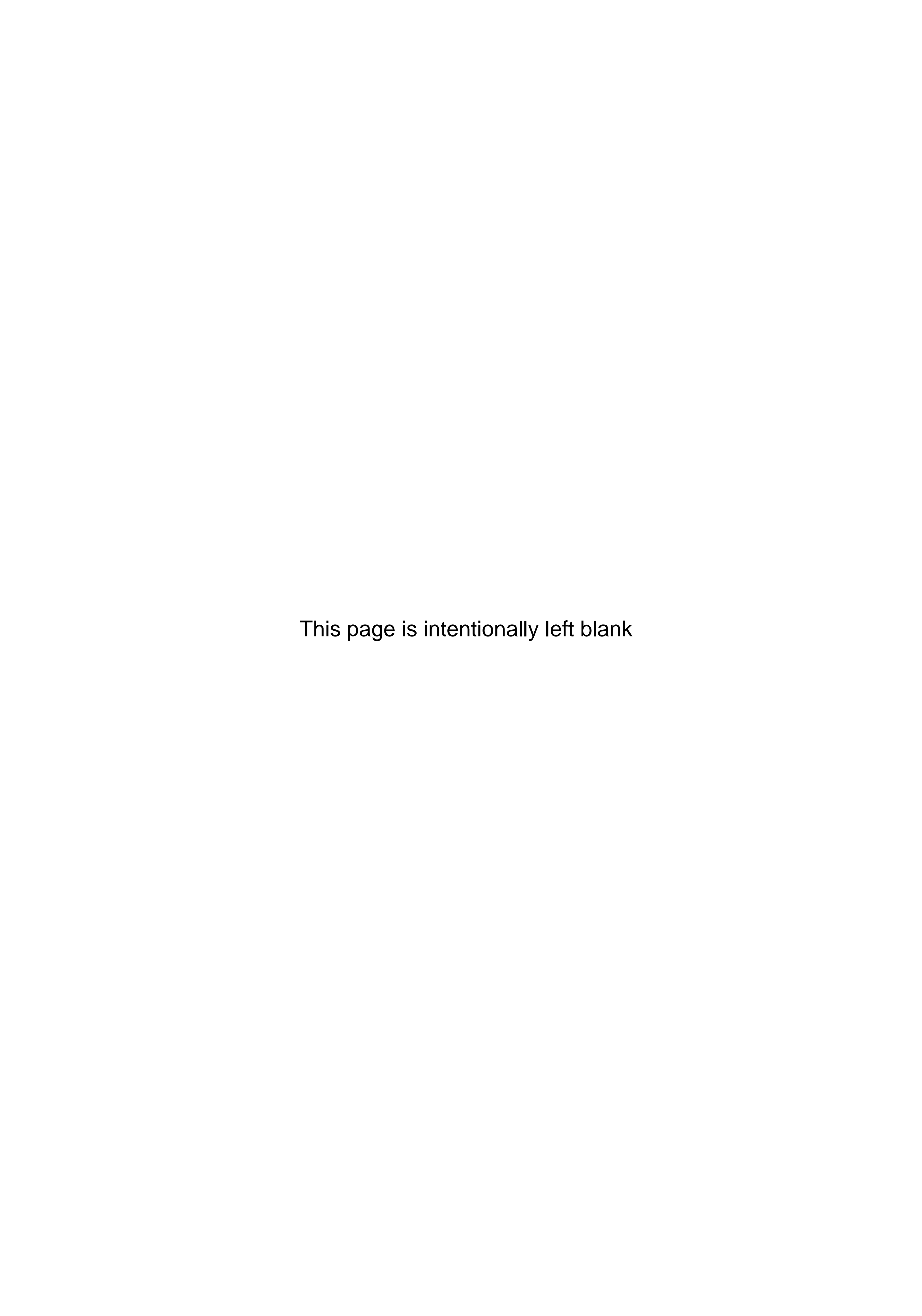
4.2 As observed in the report the discretionary hardship fund while set at £50,000 shall be administered according to the exceptional hardship policy and the cap is not a reason for refusal.

## 5. Other Implications

5.1 **Risk Management -** It is considered likely that keeping the current scheme will continue to make it difficult to collect Council Tax from those entitled to a reduction under the scheme. Presently there are 75,266 properties with a Council Tax Charge in this borough, as of 30th June 2018, and 16,651 Council Tax Support claims against these properties.

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

**List of appendices:** None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**ASSEMBLY**

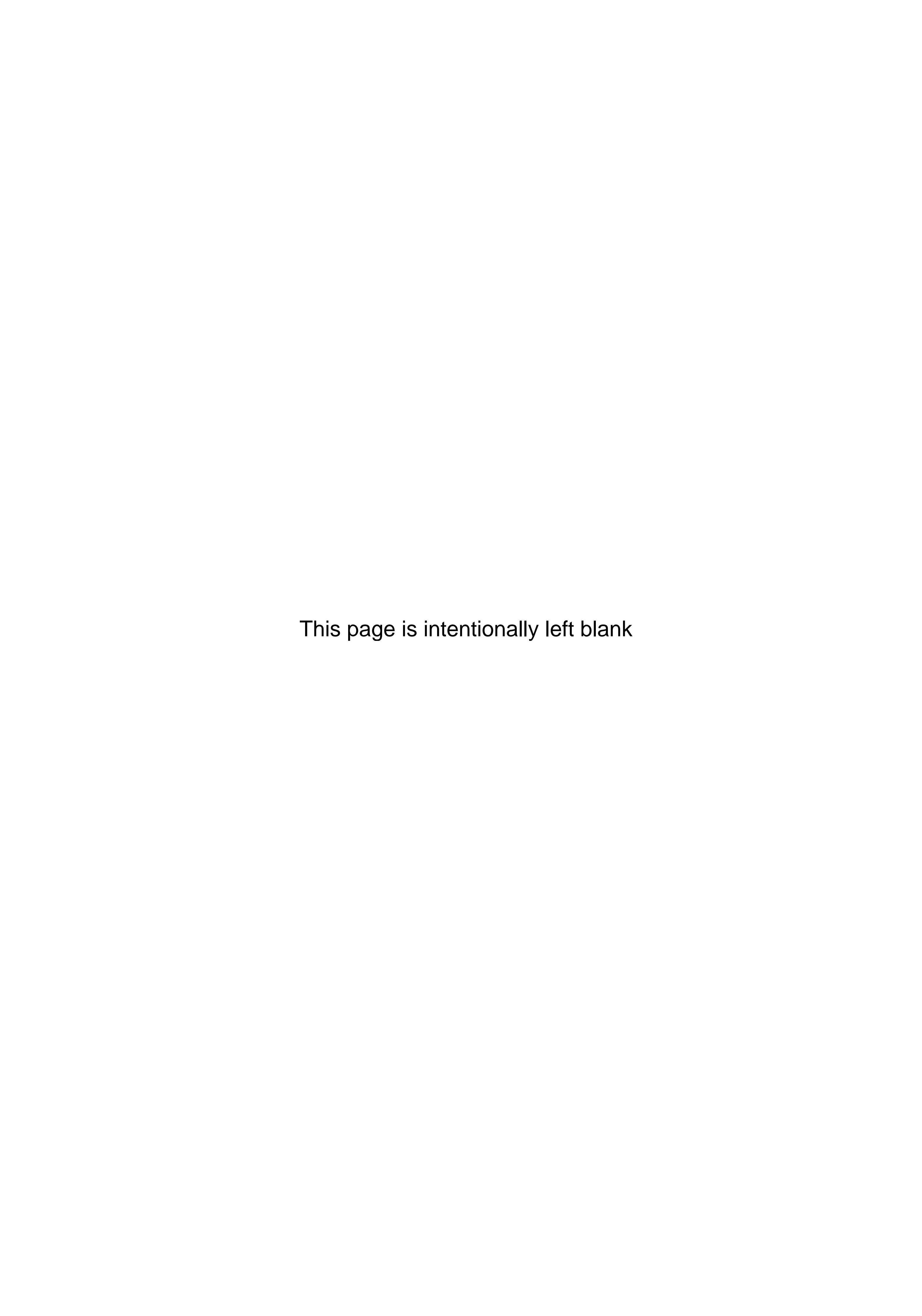
**30 January 2019**

| **Title:** Motions | |
|---|---|
| **Report of the Chief Executive** | |
| **Open Report** | **For Decision** |
| **Wards Affected:** All | **Key Decision:** No |
| **Report Author:** David Symonds Democratic Services Officer | **Contact Details:**<br>Tel: 020 8227 2852<br>E-mail: david.symonds @lbbd.gov.uk |
| **Accountable Director:** Fiona Taylor, Director of Law and Governance | |
| **Accountable Strategic Director:** Chris Naylor, Chief Executive | |
| **Summary**<br><br>In accordance with paragraph 10 of Part 2, Chapter 4 of the Council Constitution, motions and amendments to motions on issues directly affecting the borough may be submitted to the Assembly to be debated and voted on.<br><br>One motion has been received in accordance with the Council's procedure rules and is attached as **Appendix A.**<br><br>The deadline for amendments to the motions was noon on Friday 24 January 2019.<br><br>For information, attached at **Appendix B** is the relevant extract from the Council's Constitution relating to the procedure for dealing with Motions with Notice. | |
| **Recommendation(s)**<br><br>The Assembly is asked to debate and vote on the motions and any amendments proposed. | |

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

**List of appendices:**

- **Appendix A** – The International Holocaust Remembrance Alliance (IHRA) definition of Anti-Semitism
- **Appendix B –** Extract from the Council Constitution, Paragraphs 10, 11 and 12 of Part 2, Chapter 4 – The Assembly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**Appendix A**

**Notice of Motion – The International Holocaust Remembrance Alliance (IHRA) definition of Anti-Semitism**

Councillor Ashraf has submitted the following motion:

This Council expresses alarm at the rise in antisemitism in recent years across the UK. This includes incidents when criticism of Israel has been expressed using antisemitic tropes. Criticism of Israel can be legitimate, but not if it employs the tropes and imagery of antisemitism.

We therefore welcome the UK Government's announcement on December 11th 2016 that it will sign up to the internationally recognised International Holocaust Remembrance Alliance (IHRA) guidelines on antisemitism which define antisemitism thus:

"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

The guidelines highlight manifestations of antisemitism as including:

- Calling for, aiding, or justifying the killing or harming of Jews in the name of a radical ideology or an extremist view of religion.
- Making mendacious, dehumanizing, demonizing, or stereotypical allegations about Jews as such or the power of Jews as collective — such as, especially but not exclusively, the myth about a world Jewish conspiracy or of Jews controlling the media, economy, government or other societal institutions.
- Accusing Jews as a people of being responsible for real or imagined wrongdoing committed by a single Jewish person or group, or even for acts committed by non-Jews.
- Denying the fact, scope, mechanisms (e.g. gas chambers) or intentionality of the genocide of the Jewish people at the hands of National Socialist Germany and its supporters and accomplices during World War II (the Holocaust).
- Accusing the Jews as a people, or Israel as a state, of inventing or exaggerating the Holocaust.
- Accusing Jewish citizens of being more loyal to Israel, or to the alleged priorities of Jews worldwide, than to the interests of their own nations.
- Denying the Jewish people their right to self-determination, e.g., by claiming that the existence of a State of Israel is a racist endeavour.
- Applying double standards by requiring of it behaviour not expected or demanded of any other democratic nation.
- Using the symbols and images associated with classic antisemitism (e.g., claims of Jews killing Jesus or blood libel) to characterize Israel or Israelis.
- Drawing comparisons of contemporary Israeli policy to that of the Nazis.
- Holding Jews collectively responsible for actions of the state of Israel.

This Council welcomes the cross-party support around the country for combating antisemitism in all its manifestations. This Council hereby adopts the above definition

of antisemitism as set out by the International Holocaust Remembrance Alliance and pledges to combat this pernicious form of racism."

**10. Motions With Notice**

10.1 Written notice of any motions must be received by the Chief Executive by no later than 4.00pm on the Wednesday two weeks before the meeting, except in respect of a vote of no confidence in the Leader of the Council for which the process in paragraph 13 applies.

10.2 A notice of motion must relate to a matter which affects the Council or its area and must relate to a matter in respect of which the Council has a relevant function. There is no limit on the number of motions that a Councillor may submit but the notice of motion must be submitted either by the Councillor who is proposing the motion or via the Group Secretary.

10.3 A notice of motion may be in more than one part and contain more than one recommendation, but must all relate to the same subject matter.

10.4 The Chief Executive may reject a notice of motion if, in his/her opinion:

(a) it is of a vexatious or derogatory nature or otherwise considered improper or inappropriate;

(b) is contrary to any provision of any code, protocol, legal requirement or rule of the Council;

(c) it does not relate to the business of the Council;

(d) is substantially the same as another motion already considered at the Assembly within the previous twelve months.

10.5 Where the Chief Executive rejects a notice of motion on any of the above grounds, he/she shall inform the Chair and the Councillor who submitted the notice of motion as soon as possible. Prior to determining whether to accept or reject a motion, the Chief Executive may seek clarification or propose alternative wording to the Councillor who submitted the motion.

10.6 In the event that the Councillor who is proposing the motion is not present at the Assembly meeting, the motion will be withdrawn.

10.7 Any motions withdrawn as indicated above, or withdrawn at the request of the Councillor who proposed the motion, either before or during the meeting, may not be resubmitted to the Assembly within a period of six months. This condition will be waived where the Councillor, or a colleague on their behalf, has notified the Chief Executive by 5.00 pm on the day of the meeting of their inability to attend due to their ill health or other reason accepted by the Chief Executive.

10.8 Motions will be listed on the agenda in the order in which they are received, save that:

(a) where two or more notices of motion are received from a particular Councillor for the same meeting, that Councillor’s second notice of motion shall be included after all other Councillors’ first notices of motion, that Councillor’s third notice of motion shall be included after all other Councillors’ second notices of motion, and so on.

(b) where he/she considers that the notice of motion, statement or consideration of the notice of motion is likely to result in the disclosure of confidential or exempt information, in which case he/she may group such notices of motion together with other items of business which are, in his/her opinion, likely to involve the exclusion of press and public during their consideration.

10.9 Written notice of any amendments to motions must be received by the Chief Executive by no later than 12 noon on the Friday before the meeting. The same criteria and actions as described in paragraphs 10.2 - 10.8 will apply in relation to any amendments received.

10.10 Any amendments proposed after the time specified in paragraph 10.9 will only be considered for exceptional reasons such as a change in circumstances appertaining to the original motion, in which case the consent of the Chair will be required.

10.11 The Assembly shall not debate any motion which could give rise to a significant change to the income or expenditure of the Council or to contract terms unless, in the opinion of the Chief Executive acting on advice from the Chief Financial Officer and Director of Law and Governance as appropriate, the motion is accompanied by a report from the Chief Financial Officer or the Director of Law and Governance, as appropriate, setting out the financial or legal effect of the motion.

10.12 Where a motion which would require an accompanying report under Rule 10.11 falls to be moved without such accompanying report being made available to all Councillors, the motion shall stand adjourned without debate to the next available meeting of the Assembly.

10.13 Subject to Rule 10.14, if there are other motions or recommendations on the agenda that have not been dealt with by the close of the meeting, they are deemed formally moved and seconded and shall be put to the vote by the Chair without debate.

10.14 Where a notice of motion submitted under Rule 10 falls to be dealt with under Rule 10.13, the Councillor giving the notice may either:

(a) speak to the motion for not more than three minutes before the motion is put by the Chair without debate; or

(b) require that the motion is deferred to the next available meeting.

**11. Motion to rescind a previous decision**

11.1 A motion or amendment to rescind, or which has the effect of rescinding, a decision made at a meeting of the Assembly within the past six months, may not be moved except upon a recommendation from the Cabinet for a variation of the approved Budget or Policy Framework, or where the Monitoring Officer confirms that it is appropriate for the Assembly to reconsider the matter to comply with law, as a result of a change of law or material change of circumstances.

## 12. Rules of Debate

12.1 The following order / rules of debate shall apply:

(a) Except with the Chair's consent, the debate on each motion shall last no longer than 10 minutes and no individual speech shall exceed two minutes.

(b) The mover will move the motion and explain its purpose.

(c) The Chair will invite another Councillor to second the motion.

(d) If any amendment(s) has been accepted in accordance with paragraphs 10.9 or 10.10, the Chair will invite the relevant Councillor to move the amendment(s) and explain the purpose.

(e) The Chair will invite another Councillor(s) to second the amendment(s).

(f) The Chair will then invite Councillors to speak on the motion and any amendments.

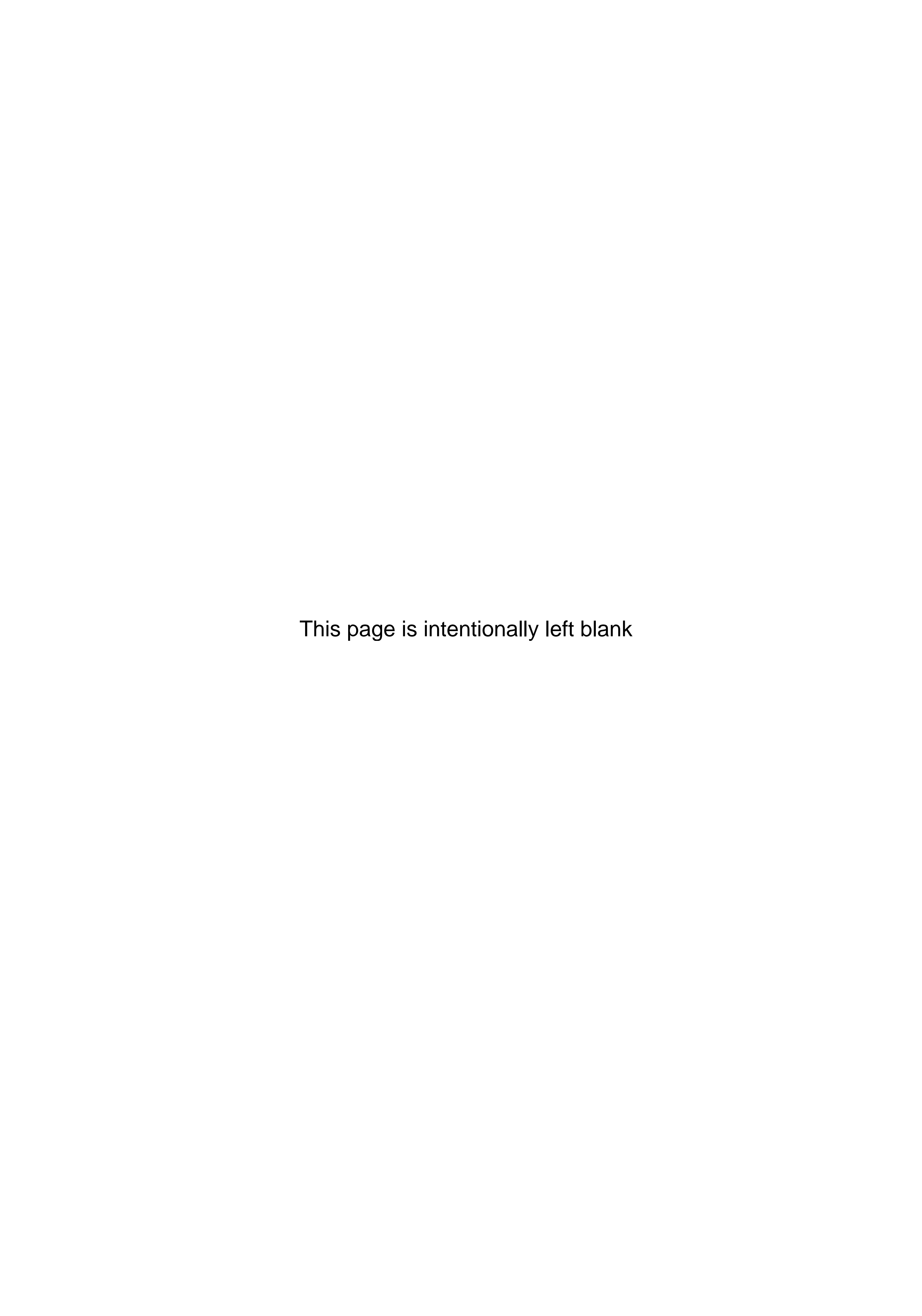
(g) Once all Councillors who wish to speak have done so, or the time limit has elapsed, the Chair will allow the mover(s) of the amendment(s) a right of reply followed by the mover of the original motion.

(h) At the end of the debate, any amendments will be voted on in the order in which they were proposed.

(i) If an amendment is carried, the motion as amended becomes the substantive motion to which any further amendments are moved and voted upon.

(j) After an amendment has been carried, the Chair will read out the amended motion before accepting any further amendments, or if there are none, put it to the vote.

(k) If all amendments are lost, a vote will be taken on the original motion.



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