Director of Public Health
Annual Report
2016/2017

Reframing health challenges:
Gaining new insight into how to scope and shape new service approaches

London Borough of
Barking & Dagenham

lbbd.gov.uk

A vision for Barking and Dagenham

One borough; one community; no-one left behind.

The council's vision recognises that over the next 20 years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing

The borough's corporate priorities that support the vision are:

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

Contents

Key population and demographic facts

Did you know LBBD has...

206,460
Residents
7th smallest population in London

56,545
under 16s
Highest proportion
in London and the UK

130,122
16s to 64s
4th lowest proportion
in London

19,793
over 65s
10th lowest proportion
in London

33
average age
Lower than London
average (36)

59.8
male healthy
life expectancy
Below London average (64.1)

58.5
female healthy
life expectancy
Below London average (64.1)

54.1%
achieving 5 A*-C
GCSEs inc English and Maths
Below London average (60.6%)

14.7%
have no
qualifications
Above London average (6.6%)

84.8
births per 1000
women of childbearing age
Above London average (63.9)

72.5
crimes per
1000 people
Below London average (74.2)

£277,508
median house
price (all types)
Below London
average (£471,742)

18.7%
English not
first language
Below London average (22.1%)
for aged 3+

7.5%
unemployment
Above London average (5.8%)

67.1%
employment
Below London average (73.8%)

13.3%
DWP benefits
claimants
Above London average (9.4%)

50.5%
BME population
Below London
average (55.1%)

30.9%
born abroad
Below London average (36.7%)

4.7%
Nigeria most
common birthplace
outside the UK, followed
by India and Pakistan

Foreword

Welcome to the Director of Public Health Annual Report 2016/17. Every year, Directors of Public Health must compile an independent annual report. The annual report is the Director's professional statement about the health of local communities and assists in identifying key issues, flagging up problems and reporting progress.

My report gives a professional perspective that informs this approach based on sound epidemiological evidence and objective interpretation taken primarily from our Joint Strategic Needs Assessment 2016[1]. I hope my observations in the following chapters act as a starting point for systematically identifying 'where to look' before 'what to change' and finally 'how to change'.

This year, I have broken with my traditional approach and focused a large part of my report on the issue of serious youth violence. In Chapter 1, I examine this problem against the backdrop of a significant increase in serious youth violence involving assaults with knives and noxious substances. Two separate murders in 2016 redefined our understanding of the swathe of issues that led a minority of young people into gang culture and serious youth violence.

I agree that violence is a public health issue although many of the peer reviews conducted over the last 4 years reveal other areas have often struggled to understand this, interestingly there now appears a real appetite to re-look at this issue from a different angle of which public health makes a meaningful contribution.

Chapter 2, considers what support our children need to become more resilient to mental health issues. We know that what happens to children before they are born and their experiences as they grow and develop can affect their health and opportunities later in life. We also know that children and young people who grow up in a safe environment and have a positive relationship with their families and communities are more likely to do better as they go through life. Therefore, the council is committed to rethinking our view of mental health, how we approach the challenges children and young people face and how we support them to maintain their mental health and be there when things go wrong.

Chapter 3, continues my interest in using devolved powers to deliver better health and care outcomes for our residents. I examine our progress in establishing an accountable care system based on 'place based care' that evolves our thinking beyond care to one that has concern for the causes of poor health rather than the effects. I assess the potential of our newly created Community Solutions Service to add value and opportunity to this by supporting individuals and families, particularly the most vulnerable, to better help themselves and others flourish and lead fulfilling lives.

We are now in the fourth year of the Public Health Grant and Chapter 4, reviews the evidence and analysis on how we have used the Grant. Containing or reducing the costs of health and social care without negative effects on health outcomes requires cost effective prevention interventions to play a much more substantial role. I consider both how we have spent the Public Health Grant in Barking and Dagenham and what return we achieved.

In the final Chapter, I discuss progress so far of the Barking Riverside NHS Healthy New Town initiative to help "design in" health and modern care from the outset. With around 800 homes expanding to 10,800 extra homes being built by 2030, the challenges are significant but as construction picks up, there is a huge opportunity to shape places to radically improve population health, integrate health and care services, and offer new digital and virtual care fit for the future. I assess whether there is a wider opportunity to apply the principles through our Local Plan to support the many other developments in our borough that will gain momentum over the next year.

I hope you find my annual report of interest and value. Comments and feedback are welcome, and should be emailed to matthew.cole@lbbd.gov.uk.

Matthew Cole

Director of Public Health

London Borough of Barking and Dagenham

1 https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/

Acknowledgements

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Chapter 1

Tackling serious youth violence –
Can a Public Health perspective offer the way forward?

In January 2016, I took over the corporate responsibility for community safety. This marked my first operational service responsibility after transitioning from the NHS to the council in 2013 under the Health and Social Care Act 2012 and includes two services that can only be described as 'full on and under pressure', the Anti-Social Behaviour and Youth Offending Services. My taking up of these responsibilities coincided with a significant increase in serious youth violence involving assaults with knives and noxious substances. What then transpired over the last 12 months presented one of the most particular public health challenges I have faced in my 17 years as Barking and Dagenham's Director of Public Health.

Two separate murders redefined our understanding of the swathe of issues that lead a minority of young people into gang culture and serious youth violence.

- On 13 September 2016, police were called to an incident in Gibbfield Close, Chadwell Heath, where two men had been seriously injured with stab and slash wounds. The victims were Paul Hayden and his son Ricky, who subsequently died because of his injuries.

- On the 12 November 2016 police were called to Church Elm Lane, Dagenham. On arrival, they found a 16-year-old male with injuries consistent with knife wounds. The injuries were not considered to be life threatening or life changing and

he was taken to hospital. Around the same time police were called to a second male with suspected knife injuries who was in Wyhill Walk, Dagenham. Wyhill Walk is a short distance from Church Elm Lane. The male in Wyhill Walk was Duran Junior Kajiama, aged 17, who later died of his injuries.

The murders in Marks Gate and Village wards had a profound impact on residents, expressed through social media and a series of community meetings. Community engagement is one of public health's most powerful and valuable social epidemiological skills, unfortunately often overlooked in today's reliance on a data driven view of population health as it involves listening and learning about the reality of our

Family of Chadwell Heath's Ricky Hayden march against knife crime at north London rally

PUBLISHED: 12:14 08 May 2017 | UPDATED: 16:32 08 May 2017   Ann-Marie Abbasah

Ricky Hayden's mum, Suzanne Hedges, second from left, with members of Dean Pascal-Modeste's family at a knife crime rally in north London.

"Drop the knife save a life" chanted the relatives of a popular nightclub bouncer at an anti-knife rally in north London.

residents' lives. Two powerful community messages emerged:

• The resolve of the community to tackle serious youth violence was without question.

• There is no easy answer and we can no longer place the blame on one community or agency. This is about us as a borough coming together and being focused in our solution, part of which is to fully acknowledge violence as a public health issue and treat it as such because the current punishment-focused intervention is not working.

In a nutshell, despite an overall fall in crime in the borough over recent years, serious youth violence continues to represent a significant problem. A problem we don't fully understand, which, as with disease, changes with our evolving communities and their environment. The nature and increase in our serious youth violence is presenting a similar challenge to that nationally following the August disturbances in 2011. The then Secretary of State for Work and Pensions, The Rt. Hon Iain Duncan-Smith MP identified the need to change our approach from enforcement to one that addresses the social and environmental causation of violence, saying: "violence is a public health issue, we must start seeing and treating it as such"[2].

The idea of presenting serious youth violence as a public health issue is an interesting one. Traditionally considered an issue for law enforcement agencies alone, youth violence is now rightly being considered from a public health perspective. While a public health approach does not offer all the answers to this complex and multi-faceted problem, it does provide an opportunity for understanding youth violence, including providing guidance that builds on local best practice, encouraging analysis and scrutiny of how priorities are identified and translated into intervention programmes.

Understanding youth and gang violence

Understanding the problem from a community perspective is critical in establishing an effective solution. Our community engagement meetings in both Marks Gate and Village wards identified that public services don't always understand community issues or work together on solving the problems. Quite often, we just provide services and react to issues rather than investing in proactive solutions to reduce violent crime and with behaviour focused interventions addressing prevention and causes, rather than the symptoms.

During 2016 the media reporting[34567] of our high impact crimes such as the murders and other youth violence painted a worrying picture of young people in Barking and Dagenham but of course such reporting frequently overlooks the fact that the clear majority are not involved in any criminal behaviour whatsoever. Less than 1% of the total population of under 18s are accused of any physical violence each year[8]. Also, whilst difficult to calculate the number of people affected adversely by gangs, a conservative estimate, based on a Waltham Forest study, would suggest that gangs affect 4% of the total population (for Barking and Dagenham, this would represent approximately 8,000 people in the extended network of people affected (associates, peripheral members, younger siblings who are vulnerable etc.), with 1,096 directly affected)[9].

Whitney Iles[10] writing in the Guardian in August 2016, makes an important point "that many stories on social media and regional news would have us believe that knife crime is solely a London issue and is predominately a problem for black communities, but this is wrong. Knife crime affects us all and according to Home Office statistics, the UK's hot spots for knife crime include Cleveland (first place) and Durham (third place). In 2014/15 Cleveland - which includes towns such as Middlesbrough, Hartlepool and Redcar - was the knife crime hotspot of England and Wales with 55 knife crimes per 100,000 population". Whitney concludes "But regardless of where or who the victims and perpetrators are, knife crime is becoming an epidemic"[11].

The London Assembly Police and Crime Committee (2016) make an important distinction based on 2014-15 data, that a higher proportion of gang-related knife crime resulted in serious injury, but in terms of overall volume there were more serious knife crime injuries that were non-gang related[12]. The GLA Peer Outreach Team suggests that much of the violent activity in London involves peer groups, rather than gangs

2   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97861/gang-violence-summary.pdf
3   https://www.thesun.co.uk/news/1853124/cops-hunt-dagenham-knifeman-after-man-was-stabbed-to-death-in-residential-street/
4   http://news.met.police.uk/news/deceased-named-in-dagenham-murder-investigation-208284
5   http://www.itv.com/news/london/2016-11-17/two-teenagers-arrested-over-murder-of-a-17-year-old-boy-in-dagenham/
6   http://www.standard.co.uk/news/crime/ricky-hayden-death-fourth-teenager-19-arrested-on-suspicion-of-chadwell-heath-murder-a3368891.html
7   http://www.dailymail.co.uk/news/article-3476377/Shocking-moment-mob-youths-armed-baseball-bats-knives-ACID-mass-brawl-police-outside-London-McDonald-s.html
8   Metropolitan Police, Serious Youth Violence across the MPS between 01/04/2011 to 31/03/2016
9   Pitts, J. (2007) Reluctant Gangsters: Youth Gangs in Waltham Forest, University of Bedfordshire, Figure 9.2 p.74.
10 https://www.theguardian.com/commentisfree/2016/aug/22/youth-violence-epidemic-punishment-knife-crime-public-health-scotland
11 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingdecember2015
12 https://www.london.gov.uk/sites/default/files/serious_youth_violence_report_-_london_assembly.pdf

as they are traditionally known. However, young people feel that the Met and other services unhelpfully label these young people as 'gang members' when it is not the case[13]. The other way of seeing this is that our understanding of a 'gang' is out of date. The data could suggest that the Trident Gangs Matrix[14] is an ineffective tool to identify young people at risk.

The Policing and Crime Act 2009, set out that for violence to be 'gang-related' it must involve at least three people, associated with a specific geographical area, who have 'a name, emblem or colour' which allows others to identify them as a group. In 2015, this was revised in new statutory guidance from the Home Office[15]. There is no longer any mention of geographical territory or gang emblems: a 'gang' is any group that commits crime and has 'one or more characteristics that enable its members to be identified as a group'. The guidance doesn't describe what those characteristics might be and in Barking and Dagenham we try to get our peer groups to fit the gang definition, therefore the problem is being labelled and addressed wrongly. However, an interesting question to pose is: "If they are gangs rather than peer groups does that get better recognition for support for perpetrators or action by enforcement agencies?"

Definitions apart the Matrix itself has been seen by some as a tool of controversy[16]. Figures for 2016 show that of the 3626 people listed on that database across London 78% were black and a further 9%

were from other ethnic minority backgrounds. Ethnic minorities make up 40% of London's population. A snapshot of the gangs' matrix for Barking and Dagenham at January 2017 shows 79% were black and a further 14% were from ethnic minorities. Ethnic minorities make up 49% of the population of Barking and Dagenham. A review led by the Labour MP David Lammy ordered by David Cameron when he was prime minister has found that the Metropolitan Police may be overly targeting black and ethnic minority youths as gang members, resulting in them being treated more harshly by the courts, prisons and justice system[17]. A more effective approach would be to create and maintain a matrix that identifies the most at risk young people through, schools, police, youth service and youth offending service who may need specific targeted one to one work.

What do we know about youth violence locally?

Violence and youth violence is an area of interest for the Director of Public Health as the Public Health Outcomes Framework[18], the national performance monitoring and comparison framework for Public Health issues, contains several indicators relevant to youth violence:

• First time entrants into the youth justice system

• Violent crime (including sexual offences) – hospital admissions for violence

• Violent crime (including sexual

offences) – violence offences

• Re-offending levels – percentage of offenders that re-offend

• Re-offending levels – average number of re-offences per offender

The indicators are a key tool in measuring the progress made in improving the lives of young people affected by violent crime, and in the success of the Government's wider gang and youth violence agenda. They also provide a useful tool to understand the scale of the challenge facing Barking and Dagenham benchmarked against the other 32 areas of the country identified as having the most serious youth violence and gang problems and defined as Ending Gang and Youth Violence priority areas by the cross-government initiative led by the Home Office in 2012[19].

In 2011-12 when the 33 priority areas were designated, 18 of the 33 target areas had higher numbers of first time entrants to the youth justice system than the national average, with only three areas recording a lower rate. In 2011-12 Barking and Dagenham had similar levels of first time entrants to the youth justice system as that observed nationally[20], however more recent data in Table 1 shows that first time entrants now exceed national levels. Levels of reoffending – the average number of re-offences per offender, in Barking and Dagenham has also marginally increased in line with national levels, where previous levels were below. Hackney and Tower Hamlets, are two potential comparator boroughs that fall within the same Index of Multiple

13 MOPAC Challenge presentation, February 2016
14 https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/Strategic%20Ambitions%20for%20London_%20Gangs%20 and%20SYV%202014.pdf
15 https://www.gov.uk/government/news/changes-in-legislation-reflected-in-new-gang-definition
16 https://netpol.org/2015/07/23/racism-gangs-matrix/
17 https://www.theguardian.com/uk-news/2016/jul/19/metropolitan-police-may-be-overly-targeting-bame-youths-as-gang-members
18 https://www.gov.uk/government/publications/public-health-outcomes-framework-2016-to-2019
19 https://www.gov.uk/government/news/newsupport-to-tackle-gang-andyouthviolence
20 https://www.catch-22.org.uk/wp-content/uploads/2013/11/Catch22-Dawes-Unit-Violence-prevention-health-promotion-October-2013.pdf

Deprivation Decile as Barking and Dagenham, the most deprived decile. All three boroughs show a similar trend between 2011-12 and the recent data outlined above, first time entrants into the youth justice system have either remained or risen above the national average with levels of violent crime. Hospital admissions and violence offences remaining consistently above national levels for all three boroughs.

In October 2016, the Youth Justice Board completed a six month follow up audit of the Barking and Dagenham Youth Offending Service. During this latest audit, it was highlighted that the cases they looked at displayed a complexity of needs and were concerned that several of the cases audited involved high risk activity and the use of violence and weapons. They noted that this appeared to be more prevalent than when they had last visited and wanted to ensure that all partners were responding to this need and are working together to address the issues identified, particularly about the issues of gangs and youth violence.

When looking at population level data it is important to note that this table provides only a snapshot of the outcome for these areas and, of course, there will be a number of influential factors in each locality that contribute to performance and which should be considered.

To understand the issues locally we have carried out a Serious Violence Problem Profile which was completed in December 2016 (restricted and unpublished[21]) and gives a much more detailed picture of the nature and extent of serious violence in the borough.

The profile was based on quantitative and qualitative information collated between October 2015 and November 2016 as extracted from Metropolitan Police crime, intelligence and incident records. The data was used to conduct 'hot spot mapping', crime pattern analysis, offender demographics and needs, and qualitative information around vulnerable people, locations and activities in regard to serious violence.

The Serious Violence Problem Profile considered violence that affects young people and violence between strangers (public settings, violence in or near licensed venues and linked to alcohol consumption, robberies), which was not flagged as domestic abuse. A bespoke dataset was created for the analysis on Victims, Offenders, Location and Temporal features. The bespoke data set used Violence against the Person, Robbery and Sexual Offences crime records between the 1st October 2015 and 20th November 2016, triangulated with Gangs Offending, Serious Youth Violence, Knife Crime with Injury and Gun Crime Discharges datasets.

When the 'Violence with injury' crimes of serious wounding and assault with injury data sets was analysed the largest proportion of violence was between people known to one another in some way (56%). Stranger violence accounted for 44%. There were 14 categories of violence manually assigned to the crime data, of which five combined accounted for 74% of all records – miscellaneous stranger violence (27%), alcohol related (14%), familial but not domestic (12%), youth on youth (11%) and acquaintance/friend disputes (10%).

When looking at the most serious violence, which is more costly and harmful to society, the largest categories were gang and weapon injuries (30%), alcohol related (22%) and miscellaneous stranger violence (21%) –these three categories combined accounted for 73% of most serious violence in Barking and Dagenham. Using the number of recorded violent crime offences as a basis, it is estimated that the incidence of violent crime in the borough in the rolling 12 months to September 2016 is equivalent to one violent offence for every five people[22]. Serious youth violence, as demonstrated in the murders of Ricky Hayden and Duran Junior Kajiama, in September and November 2016 respectively has now returned to peak levels last experienced in 2011. Table 2 highlights the key findings from the Serious Violence Problem Profile in relation to youth on youth violence and serious youth violence in Barking and Dagenham.

21 The Serious Violence Problem Profile document is confidential to the council and its partners because of small numbers and the potential for identification of individuals.

22 Revised multipliers of crime published by the home office (to account for under reporting) were used to multiply the actual number of violent offences in Barking & Dagenham in the rolling 12 months to September 2016 to get an overall estimated number of offences (40,259) and when used with the ONS Mid year population estimate for Barking and Dagenham (202,000)

Table 1: Indicators relevant to youth violence from the Public Health Outcomes Framework mapped against the Government's 33 target areas for tackling serious crimes. Figures in red are higher than the national average, while those in green are lower.

	1.04 - First time entrants to the youth justice system (2015)	1.12i - Violent crime (including sexual violence) - hospital admissions for violence (12/13 - 14/15)	Violent crime (including sexual violence) - violence offences: rate per 1,000 population (15/16)	Health and Justice: Re-offending levels - percentage of offenders who re-offend (2013)
Barking and Dagenham	540.52	48.14	26.30	27.29
Birmingham	498.59	58.18	17.40	26.10
Bradford	433.56	74.57	22.14	26.77
Brent	445.50	48.19	22.64	28.81
Camden	488.63	45.50	25.56	29.77
Croydon	560.65	48.94	22.73	26.64
Derby	529.03	55.16	18.78	30.01
Ealing	328.82	58.80	22.32	25.75
Enfield	424.60	32.72	18.20	26.66
Greenwich	458.81	37.86	24.91	27.54
Hackney	491.61	56.71	25.93	27.80
Hammersmith and Fulham	573.33	69.29	25.39	31.36
Haringey	454.62	54.95	24.68	26.93
Islington	531.91	67.56	27.30	30.34
Knowsley	388.52	118.92	14.70	27.35
Lambeth	631.16	67.75	26.78	28.65
Leeds	460.03	65.85	23.98	28.21
Lewisham	712.68	60.22	24.36	27.98
Liverpool	368.00	143.54	22.26	30.65
Manchester	537.34	83.16	25.63	28.57
Merton	299.42	45.19	16.71	22.95
Newham	443.95	67.82	25.70	27.67
Nottingham	821.95	62.74	23.24	28.17
Oldham	367.77	94.05	22.46	26.78
Salford	398.87	82.63	15.14	25.45
Sandwell	425.34	76.45	14.35	24.53
Sheffield	525.87	61.93	13.46	26.37
Southwark	578.37	66.07	24.76	27.56
Tower Hamlets	548.04	54.84	26.27	26.19
Waltham Forest	419.35	69.02	22.44	25.01
Wandsworth	369.94	42.13	18.49	25.18
Westminster	306.73	41.83	35.20	27.31
Wolverhampton	605.98	75.18	18.15	24.89
England	368.65	47.49	17.18	26.36
less 10%	331.78	42.74	15.46	23.72
plus 10%	405.51	52.24	18.90	29.00

Table 2: Key findings from the Barking and Dagenham Serious Violence Problem Profile

Victims:	**Offenders:**
Analysis of recorded crime data taken from the Metropolitan Police Crime Recording Information System (CRIS) between October 2015 and November 2016 shows: • Victimisation rates for Serious Violence in Barking and Dagenham are highest for those aged between 12 and 35, peaking between the ages of 12 and 20 (more than 2 times above average), with those aged 14-18 (more than 4 times above average) being the most overrepresented victims. • When the violence offence categories were broken down by victim age groups and expressed as a proportion of the population (using Office for National Statistics 2014 mid-year estimates) individuals aged 10 - 24 accounted for up to half of all gang flagged incidents, weapon injuries and gang indicator crimes, despite making up less than one fifth of the population denoting levels of vulnerability.	Analysis of recorded crime data taken from the Metropolitan Police Crime Recording Information System (CRIS) between October 2015 and November 2016 shows: • Offending rates for Serious Violence in Barking and Dagenham are highest for those aged 13 and 25, peaking between the ages of 15 and 20 (more than 4.5 times above average), with ages 15 and 16 being the riskiest years). • When the violence offence categories were broken down by victim age groups and expressed as a proportion of the population (using Office for National Statistics 2014 mid-year estimates) those aged 10-24 were significantly overrepresented as perpetrators of most categories of violence, including weapon enabled robbery, gang flagged and indicator crimes, and weapon injury offences. This age group perpetrated more than two-thirds of all offences despite making up less than a fifth of the population. • More than half of all serious wounding (including GBH with intent, attempted murder, stabbing and shooting) was perpetrated by those aged 10-24.

Location:
Using variations of the Jill Dando Institute of Crime Science, Vulnerable Localities Index (VLI) vulnerability mapping was completed to identify areas of Barking and Dagenham which are most susceptible to gangs and serious violent crime, and areas where the risk of youth involvement in crime may be greatest. Above average risk of youth offending for Serious Violence was identified in all but two wards of Barking and Dagenham.
London Borough of Barking and Dagenham 2016 Unpublished

What is the socio-economic impact on the borough?

The impact of serious youth violence in terms of individual, social and economic costs to Barking and Dagenham is significant. The wider socio-economic effects, while less visible, are far-reaching, and have the potential to cause sustained, long-term damage to the borough. For all recorded violent crime, the estimated cost was £67.6m during the previous 12 months, whilst for estimated levels of crime (accounting for underreporting) the socio-economic cost is £356.9m (sexual offences account for a significant proportion of the latter figure due to more chronic levels of underreporting)[23]. Using the

Cambridge Crime Harm Index[24], we can surmise that the most serious violence in Barking and Dagenham (serious wounding, weapon enabled crime, serious sexual offences) accounts for just 18% of all violent crime, but contributes 80% of the harm experienced and 42% of the socio-economic costs. Interestingly within these figures, it has been suggested, the total estimated socio-economic cost of known violence linked to gangs in Barking and Dagenham for the previous 12 months was £7.98million (12%).

From an NHS perspective alongside the economic impact, youth violence also has a personal cost for the individual. In 2015-16, 337 Barking

and Dagenham residents were admitted to accident and emergency because of a violence related incident. In the same period, 114 Barking and Dagenham residents aged 13-24. were admitted to hospital in an emergency for assault involving a knife or sharp object[25].

The population level costs as outlined are clearly a driver for action in times of austerity, however, understanding the problem is more than a quantitative data exercise and no single piece of evidence decides an intervention programme. We need to link what the data is telling us with the individual and environmental causes of serious youth violence.

23 Brand, S. and Price, R. (2000) Home Office Research Study 217: The economic and social costs of crime - assigns socio-economic costs to individual categories of crime based on costs borne in anticipation of crime (i.e. security), as a consequence of crime (i.e. victim and health services), and in response to crime (i.e. policing and criminal justice system). These costs were revised in 2011 and used to work out socio-economic costs of violent crime in Barking & Dagenham. See https://www.gov.uk/government/statistics/unit-costs-of-crime-and-multipliers-revised Accessed 01.12.2016

24 Sherman, L. et al (2015) The Cambridge Crime Harm Index – based on Criminal Justice System sentencing guidelines, the principle is that not all crimes are equal in terms of harm (e.g. 1 homicide has greater impact than 1 shoplifting offence). To calculate harm score, the number of offences is multiplied by the harm score for that crime type. Therefore, the weighting for arson without endangering life = 33 and for rape = 1825 – if an area records 10x arsons and 10x rapes, the harm score for arson is 330 (33x10) and for rape 18,250 (1825x10). This has been done for all Violent Crime offences in Barking & Dagenham in order to calculate the proportion of harm. See also Keay, S. (2015) Lancashire Police strategic assessment technical report.

25 Secondary User Services Data, Barking and Dagenham Admissions to Accident and Emergency 2015-16. Accessed 25/01/17

Adapted from WHO 2004[29]

Diagram 1: Some cross-cutting risk factors for violence

- Poverty
- High unemployment
- High crime levels
- Local illicit drug trade
- Inadequate victim care services

- Victim of child maltreatment
- Psychological/personality disorder
- Delinquent behaviour
- Alcohol consumption/drug use

SOCIETY   COMMUNITY   RELATIONSHIP   INDIVIDUAL

- Economic inequality
- Gender inequality
- Cultural norms that support violence
- High firearm availability
- Weak economic safety nets

- Poor parenting practices
- Marital discord
- Violent parental conflict
- Low sociaeconomic household
- Delinquent peers

Why does youth violence happen?

The reasons that young people become victims and perpetrators of serious youth violence are many and varied[26 27]. Factors such as the influence of peer groups; the level of exposure to violence within the family; or the impact of the community have all been cited as reasons why a young person might engage in serious violence. From a population health perspective violence within the community is strongly related to inequalities, with the poorest fifth of society suffering rates of hospital admissions for violence five times higher than those of the most affluent fifth[28].

Diagram 1 shows the interaction between risk factors at the individual, relationship, community and societal levels. Different types of violence also have specific risk factors.

The Fear and Fashion report, written in 2004, identifies the breakdown in social structures (families, extended families, supportive communities), the established alienation of large sections of the youth population and the fashionable nature of violence as being key elements that fuel violence[30]. Likewise, the Youth Justice Board has identified several risk factors for criminal activity among young people, including poor housing, poor educational achievement, and living in a disadvantaged neighbourhood[31].

In July 2016, the London Assembly Police and Crime Committee examined the detail behind the rising number of victims of serious youth violence in London, and the reasons why some young people find themselves victims or perpetrators of serious violence[32]. In Barking and Dagenham, as in London, the number of victims has been rising slowly over the past four years, following a sharp drop in 2011-12[33]. The Met attributes that drop to a reduction in personal robbery at that time. It also suggests that the recent rise can in part be explained by a change in recording practices of Grievous Bodily Harm, which ranges from incidents such as 'a fight in the playground to a really serious assault outside a nightclub'[34].

26 http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap2.pdf

27 http://researchbriefings.files.parliament.uk/documents/CDP-2016-0045/CDP-2016-0045.pdf

28 Protecting People Promoting Health: A Public Health Approach To Violence Prevention For England, Department of Health 2012

29 http://apps.who.int/iris/bitstream/10665/43014/1/9241592079.pdf

30 Youth Crime , Community safety.org

31 A summary of risk and protective factors associated with youth crime, and effective interventions to prevent it, Youth Justice Board, Institute of Criminology

32 https://www.london.gov.uk/sites/default/files/serious_youth_violence_report_-_london_assembly.pdf

33 Metropolitan Police, Serious Youth Violence across the MPS between 01/04/2011 to 31/03/2016

34 Chief Superintendent Dave Stringer, meeting of the Police and Crime Committee, 14 July 2016

Other commentators, however, suggest that several other factors are driving the recent increase. These include the changing 'criminal economy', with young people more involved in serious crimes such as drugs; increased population mobility creating tensions among different communities; and an increased willingness of young people to carry weapons[35]. Although not talked about as widely in the literature one cannot ignore the influence of materialism on young people and crime. The cost of an iPhone 7 for example, is significant and yet having luxury goods is constantly normalised by social media to the point where some young people see these items as a basic human right. If you also have a drugs market which provides people with access to more wealth than they could achieve through legitimate employment, you have a gateway into criminal activity which is difficult to dissuade young people out of.

In dealing with the murder of Duran Junior Kajiama, who was a popular and up and coming rap/grime artist, I reviewed the interface between criminality and current youth culture. 'UK Grime' is a hip-hop sub-genre that has now formed its own industry and focuses primarily on the negative aspects of inner city life. The lyrics often glorify criminal activity and postcode rivalries and incite violence. This genre of music and youth culture has been a source of tremendous controversy and is often cited as the cause of the increase in violence within communities, leading to arrests where artists have incriminated themselves by producing music about incidents that have occurred.

This is particularly true amongst certain pockets of inner city youth who attempt to merge the persona of the artist with everyday life and want to live and be perceived in a certain way. A topic that has become more high profile recently is the continued sexualisation of women, not only in the lyrics of this genre, but more importantly in the visual representation of young females in music videos. The link with the glorification and distribution of drugs cannot be understated.

Despite all this, hip hop has generated a significant fan base around the world with a wide demographic of listeners, mostly among youths. This raises the question of whether the negativity commonly linked with rap music is not just one side of the coin. The reality is that rap music is greatly misunderstood as it has been vital in promoting social and political awareness among the youth of today. Rap music educates people on a range of perspectives and raises many social issues. Rap is a channel for people to speak freely about their view on political or social issues and by doing so it engages teenagers to become concerned and aware of these issues. We need to harness rap music as a community engagement intervention with the intention of sending a positive message to young people. For my generation, such harnessing of music for community action was the whole point of the Sir Bob Geldof inspired 'Live Aid' fundraising initiative.

Understanding the negative perception of safety

Research suggests that exposure to violence, particularly during childhood, is consistently found in the individuals most likely to be involved in violence (as victims and/ or perpetrators) in adolescence and later life. When one examines the background of our young people who are in contact with the Youth Offending Service this is a striking risk factor. The London Assembly Police and Crime Committee (2016) report stated that a dominant driver, particularly of knife crime among young people, appears to be a belief that they need to be prepared to defend themselves[36]. This could, in part, be fuelled by a perception of the number and severity of weapons on the streets. It may also be a fear fuelled by incidents that occur in their communities, which cause a negative perception of safety. If a serious incident occurs, there needs to be a concerted effort by the police and other agencies to ensure that young people are safe and reassure them of this.

Whitney (2016) suggests that the long-term impacts of violence should not be underestimated. He argues that in understanding the impact of trauma we need to recognise that a traumatised young person, perhaps one suffering from Post- Traumatic Stress Disorder for example, will try to work through their trauma by re-enactment to master their emotions. The re-enactment could play out in the young person now carrying a knife for two reasons: firstly, because they believe they will be a victim again and on some level, is still the victim trying to get to grips with their reality; and secondly because they want to be the victimiser and move away from the position of victim[37].

Intervention programmes need to consider a range of actions that focus specifically on identifying young people who have witnessed and been victims of serious offences at the earliest opportunity who may

35 Graham Robb, meeting of the Police and Crime Committee, 14 July 2016

36 https://www.london.gov.uk/sites/default/files/serious_youth_violence_report_-_london_assembly.pdf

37 https://www.theguardian.com/commentisfree/2016/aug/22/youth-violence-epidemic-punishment-knife-crime-public-health-scotland

be more vulnerable and susceptible to crime in the future. We should not be waiting until the teenage years before acting to prevent youth violence. The emergence of the risks that put some young people on a path towards violence can often be in evidence during early childhood. Commissioners and service providers should examine the potential value of utilising a trauma recovery model[38] with those young people affected both within and outside the youth offending service.

There is more to be done not only to understand the drivers of serious youth violence in Barking and Dagenham, but also why some young people that are exposed to risk factors manage to avoid becoming victims or perpetrators. Matt Watson suggested that currently "the problem with prevention [of youth offending] is you throw the net very, very wide. That is obviously very expensive, and you are not sure what the key factors are with all these people with very, very similar issues and difficulties"[39].

Understanding why people do and do not involve themselves in serious youth violence should help with "learning your way out of the problems" and shaping more targeted preventative measures[40].

Community engagement

Communities affected by violence can be difficult to engage. Factors such as acceptance that violence is the norm or cannot be prevented, fear of reprisals, a 'no grass' culture and lack of trust that reporting violence will lead to action are barriers that need to be addressed. It is difficult to create a strong and cohesive community where it doesn't exist, but

statutory agencies such as councils and the police, and community safety partnerships can act as catalysts for change.

There are no easy solutions and each community is different, as we saw when we engaged with the residents in Marks Gate and Village wards. Three key themes were consistently voiced in both ward engagement events:

• The sustainable answer can only be achieved through effective community engagement that is wider than the civic minded few and is serious about dialogue with young people

• The impact of housing and environment

• The fear of crime

How do we engage with hard to reach communities?

In exploring this issue, it is important for the reader to note that I am not contradicting the fact that knife crime impacts everyone. There is no universal definition of 'community engagement', but it is generally agreed that community engagement strategies include partnership building and networking, community mobilisation and community coalition building. However, there are numerous problems associated with successfully engaging disengaged communities. In a Scrutiny Review of Engaging with 'Hard to Reach Communities', the London Borough of Haringey found that barriers to engagement included: lack of contact points; staff not necessarily being aware of dual needs and cultural aspects; practicalities e.g. timing of events; and information provision e.g. language used[41]. Whilst Ted

38 https://www.crimeandjustice.org.uk/sites/crimeandjustice.org.uk/files/PSJ%20220%20July%202015.pdf
39 Matt Watson, meeting of the Police and Crime Committee, 14 July 2016
40 Graham Robb, meeting of the Police and Crime Committee, 14 July 2016
41 Scrutiny Review of Engaging With Hard To Reach Communities, London Borough of Haringey, March 2010

Cantle also noted that communities can be disempowered by the authorities focusing on self-appointed community leaders, who may not be the most appropriate leaders, who then act as gatekeepers to their communities[42].

The Home Office report, Ending Gang and Youth Violence Community Engagement (2014) noted that community engagement in this context requires an acceptance that universal approaches to community engagement need to be balanced with targeted interventions which address the needs of specific groups within the community[43]. The specific groups that need to be engaged include active and former gang members, young people involved in violence, their close associates, and those who are in prison or a youth offender institution. But equally as important, community engagement strategies should also include members of the wider community, including those who are most at risk of, or most affected by, violence. This can create an environment in which violence can be stopped and maintained in the long term. Such an approach requires collaboration between a range of partners, including statutory and non-statutory partners, residents, community, faith and youth groups, and businesses[44].

An evaluation of effective engagement of communities in regeneration for the Scottish Government reported that community planning partnerships are reported to have employed a wide range of methods for engaging communities. This has included residents' panels made up of a representative cross section of the community who were asked for views on service provision and other issues; 'Planning for Real' – an opportunity for residents to design

improvements in their community; civic forums and assemblies – either made up of community representatives or regular events that are open to the public. They provide an opportunity for the community to discuss service delivery issues with the service providers; community involvement in (or leadership of) the development of local community plans; residents' juries made up of about 15 local people who consider a single issue in considerable depth; surveys and questionnaires; and approaches based on information technology – touch screens in public areas and 'online polling' using the internet[45].

The Village community engagement event was attended by a parent of each of the victims and the subsequent community march against knife crime was organised on behalf of Duran Junior Kajiama's mother Beatrice. Both events highlighted the role of individuals who have experienced serious youth violence first hand and that has been key in engaging the community in Village as they can challenge young people in a way that we, as professionals and service providers cannot, using emotion and their respect for the individual's loss which is necessary to motivate people to take action. The reaction of a parent towards young people for carrying knives can be a powerful voice, whereas our responses as professionals have to be un-emotional and focused on enforcement or support.

How do we engage effectively with young people?

The single most important issue arising from youth violence in general,

and the murder of Ricky Hayden and Duran Junior Kajiama in particular is the need to engage young people. Young people who are involved in gangs and crime are amongst the hardest groups within the community to engage. However, there is strong evidence to show that community groups and leaders can successfully work with hard to reach groups of young people.

Evidence from the Neighbourhood Support Fund (NSF)[46] between 2000 and 2006, shows that a gradualist community approach can slowly engage even the hardest to reach groups. NSF projects engaged young people through informal networks, and informal activities such as sport, computers and DJ-ing. This was combined with advice, information and guidance, help with school work, accredited activities and training. When young people were 'signed off' NSF projects, 71% were noted as moving onto a 'positive outcome'. Few remained NEET (Not in education, employment or training), and young people gained new experiences and qualifications that will help them in the long term. As part of a 'community approach', most NSF projects encouraged young people to be involved beyond their role as participants[47].

An evaluation of effective engagement of communities in regeneration for the Scottish Government reported that methods of youth engagement in Scotland include youth forums, youth groups or committees. Other approaches included A Young People's Manifesto developed as a result of a youth conference and young people being directly involved in decision-making on how Community Regeneration Funds are spent. More innovative ways of engaging with the young

42 Ted Cantle, Beyond Gatekeeper Community Leaders 'Making Diversity Less Divisive', Municipal Journal 1st August 2013'
43 https://www.gov.uk/government/publications/ending-gang-and-youth-violence-community-engagement
44 Ending Gang and Youth Violence Community Engagement, Home Office, 2014.
45 Evaluation of the Effective Engagement of Communities in Regeneration: Final Baseline Report, Communities Scotland, 2006
46 Gavin Bailey, Reengaging Young People, An evaluation of the Neighbourhood Support Fund, Community Development Foundation, 2006
47 Gavin Bailey, Reengaging Young People, An evaluation of the Neighbourhood Support Fund, Community Development Foundation, 2006

communities were also found including use of video, DVD and the internet to engage young people, the use of drama, a youth festival, participation in debates in the council chambers, links to the Scottish Youth Parliament, and training and support of young people to conduct a survey on young people[48].

This shows that the key to engaging hard to reach communities often lies in the way that the engagement is carried out. In 'Not another Consultation', Local Government Improvement and Development[49] noted that many of the old rigid consultation techniques are simply not up to the challenge of improving local democratic legitimacy. Instead, the report emphasises the value of informal consultation events that are fun and which provide opportunities to influence decisions through participative and direct democracy. This form of consultation is just one of a series of activities that give people confidence in their capacity to control their own circumstances.

Protecting People Promoting Health: A Public Health Approach to Violence Prevention for England, Department of Health 2012, suggests that violence can be prevented by a range of different interventions throughout the life course to reduce individuals' propensity for violence, lower the chances of those involved in violence being involved again, and ensure that those affected by violence get the support they require. Programmes that support parents and families, develop life skills in children, work with high-risk youth, and which reduce the availability and misuse of alcohol, have all proven to be effective at reducing levels of violence[50].

In terms of the links between health

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and crime the use of messaging and social media is crucial in engaging young people. Evidence suggests teenagers can't control impulses and make rapid, smart decisions like adults can. This is simply due to brain development, with the frontal lobe of the teenage brain, which controls decision-making, being not fully developed, so signals move more slowly[51]. This may assist in explaining why teenagers can be especially susceptible to addictions such as drugs, alcohol, violence, smoking and digital devices. This also suggests that the normal education 'health warning' type messages through non-digital media are likely to be less effective.

The role housing and environment can play

One issue on which community and youth engagement can potentially reap positive benefits for violence

reduction are environmental improvements to public space and housing. Environmental improvements can also benefit mental and physical health by promoting social interaction, increasing perceptions of safety and promoting physical exercise. Potential strategies can include improving neighbourhood infrastructures (e.g. better transport and street lighting and increasing access to green space). For example, a study in the USA found that urban public housing residents who lived in buildings with more nearby green space reported lower levels of aggression, violence and mental fatigue than their counterparts with less green space. A different study found that the presence of greenery in common spaces in a large public housing development was associated with greater use of, and social activity in, the outdoor space[52]

48   Evaluation of the Effective Engagement of Communities in Regeneration: Final Baseline Report, Communities Scotland, 2006
49   http://www.involve.org.uk/wp-content/uploads/2011/09/Not-Another-Consultation.pdf
50   Protecting People Promoting Health: A Public Health Approach To Violence Prevention For England, Department of Health 2012.
51   https://www.google.co.uk/search?q=nterview+Frances+Jensen+On+The+Teenage+Brain++Shots+-+Health+News++NPR&sourceid=ie7&rls=c om.microsoft:en-US:IE-Address&ie=&oe=&gfe_rd=cr&ei=SVeLWLnmM6KN8QfWpY3wCQ
52   Protecting People Promoting Health: A Public Health Approach To Violence Prevention For England, Department of Health 2012

This is important for spatial planners as Barking and Dagenham is London's growth opportunity. Barking Riverside is one of several growth areas in the borough, expecting a population of 75,000 people by 2030[53]. Key to our vision is growth which is inclusive, with 'no one left behind'. The recent independent Growth Commission report and its recommendations begin our conversation to connect the whole community of Barking Riverside and the surrounding areas, both new and existing, physically, socially and economically, thus making a positive contribution to physical and mental health[54].

Reducing fear of crime

Community engagement following the murder of Ricky Hayden revealed deep seated concerns around anti-social behaviour and drug dealing in the area. Most categories of violent crime in Barking and Dagenham are currently experiencing increases in recorded levels, which in turn has led to a growing demand for services to protect and safeguard victims and vulnerable people, and to effectively manage perpetrators. In Village ward a number young people voiced a lack of confidence in current witness protection programmes.

In the US, Department of Justice guidance, Reducing Fear of Crime: Strategies for Police, highlights the devastating impact that fear of crime can have on communities, and argues that fear reduction should be included among the explicit components of the modern police mission[55]. This has led to several innovative solutions at local level within US cities. Case Study 1 offers an innovative solution:

Case Study 1: Targeting Fear Baltimore County COPE (Citizen Oriented Police Enforcement) .

COPE officers survey the community, and work with neighbourhood organizations, local businesses, and local government agencies, to understand and solve each community's problem, on the community's own terms. COPE officers recognise that every neighbourhood has different problems that stem from different causes—and they tailor their responses accordingly. The results have been exceptional. COPE teams have substantially reduced fear of crime among residents of the communities they served. Residents are more satisfied with their communities, with the police, and with their local government in general. And, perhaps best of all, the three COPE units' activities have driven serious crime and calls for police service down by 10 percent or more in the neighbourhoods they have served.

To address these concerns, the Borough Commander has instituted a targeted programme of reassurance policing with focused patrols in areas of high demand accompanied by the legitimate use of Stop and Search. In addition, the search for those offenders who are wanted by police continues. Evidence shows that reassurance policing can achieve a whole range of objectives, including: reducing fear of crime; increasing public confidence in the police; reducing crime; and reducing anti-social behaviour[56].

A positive outcome observed in both wards following community engagement has been the increasing confidence in the capacity of local agencies to manage crime, which reduces anxiety, if local people believe that the police and the council can manage and deal with the crime and anti-social behaviour effectively. Furthermore, anxiety reduces if residents feel involved in and informed about the process. The theory is that increased confidence reduces personal anxiety and latest research suggests that, by improving confidence in the agencies charged with crime and disorder reduction, there will be consequent impacts on a resident's perception of crime. Despite the events of the last 12 months the latest results taken from the Public Attitude Survey for 2016-

17 shows that public confidence in policing is at 77% which is the highest it has been in recent years[57].

The way forward

The Community Safety Partnership hosted a Youth Violence Conference in September 2016 to examine the Partnership's proposed action plan for dealing with the increase in serious youth violence. Will Linden, Analyst Co-ordinator from the Violence Reduction Unit in Scotland, was invited as the key note speaker. Case Study 2 offers a powerful example on what can be achieved by public health violence reduction models.

Whilst data may not always be readily available in respect of prevention, there is a wealth of literature and research examining the underlying risk factors of violence which can be drawn upon to shape our interventions. The Partnership has used this evidence base to develop a violence reduction and prevention plan to combat youth violence in the borough, which contains a suite of interventions to both engage young people and to reassure the wider community. One of the principal focuses for the action plan is prevention and the identification of and work with perpetrators, with agreed actions at family and

53 https://www.lbbd.gov.uk/residents/planning-and-building-control/planning-guidance-and-policies/local-plan-review/one-borough-one-community-one-plan/

54 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/

55 Gary Cordner, Reducing Fear of Crime Strategies for Police, Department of Justice, 2010.

56 Andrew Millie & Victoria Herrington, Reassurance Policing In Practice, Views From The Shop Floor, British society of Criminology

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

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Case Study 2: Violence Reduction Unit Scotland

A decade ago Glasgow was branded the murder capital of Europe. Determined to tackle the city's addiction to violence Strathclyde Police decided they needed a new approach. In January 2005, the force established the Violence Reduction Unit (VRU). The unit's remit was to target all forms of violent behaviour, knife crime and weapon carrying among young men in and around Glasgow.

Influenced by the World Health Organisation's World Report on Violence and Health (2002) , the newly formed VRU became the only police force in the world to adopt a public health approach to violence. Treating it like a disease the VRU sought to diagnose the problem, analyse the causes, examine what works and for whom and develop solutions, which once evaluated, could be scaled up to help others.

To achieve this the unit teamed up with agencies in the fields of health, education and social work. The VRU aims to reduce violent crime and behaviour by working with partner agencies to achieve long-term societal and attitudinal change. It also focuses on enforcement, to contain and manage individuals who carry weapons or who are involved in violent behaviour. The unit aims to explore best practices and develop sustainable, innovative solutions to the deep-rooted problem of violence.

More than a decade on from the formation of the VRU Glasgow is no longer the murder capital of Europe and recorded crime in Scotland is at a forty-year low. However, violence is still a chronic problem in Scotland with domestic abuse and sex crimes a growing concern. The VRU remain committed to its public health approach to violence and are the only police members of the World Health Organisation's Violence Prevention Alliance.

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community level to identify young people at risk and provide support both within the family setting and the community, particularly through positive diversionary activities and mentoring services for young people. The plan also provides for a range of policing and intelligence activities, to provide community reassurance against the risk of crime.

The following programmes have been suggested as potential areas that will have most impact on serious youth violence.

- Youth Risk Matrix - The early identification and targeting of young people that may be more likely to become involved in criminal activity and potential violence will assist the partner agencies to work more proactively at an earlier stage to intervene and prevent the escalation of offending for young people. The proposal would be for the borough to create and maintain a matrix that identifies the most at risk young people through, schools, police, youth service and youth offending service that will need specific targeted one to one work. This will need the support and time of an analyst that can work across the information

from all partner agencies to create real time information regarding those young people most at risk, areas of hotspots, peer associations, and trends in offending to inform the ongoing support provided.

- Provision of targeted support within school aimed at Year 6 and Year 7 pupils to provide one to one support for those young people identified through the matrix. This support will focus primarily on supporting and diverting young people away from current behaviours. This will require two dedicated workers who work across a group of primary and secondary schools to offer this support. These workers will work very closely with the schools, schools police officers and the Out of Court Disposal work within the Youth Offending Service to regularly monitor and review the matrix and can respond to changing needs.

- High level mentoring support given to those young people identified as at high risk of violence and gang involvement, and those resettling back into the community after a custodial sentence. The

provision of this service needs to be delivered by mentors with an experience and understanding of the current issues facing these young people. This will be a more intense level of mentoring with a focus on education training and employment and moving young people into an alternative lifestyle.

The plan supports the London Mayor Sadiq Khan's commitment to tackling the "growing problems" of knife crime and youth violence . Among his proposals to tackle serious youth violence is a knife crime strategy that will focus on tackling gangs and shops illegally selling knives; an anti-gang strategy developed alongside local authorities, schools and youth services; and greater control of the youth justice system to deliver a joined-up approach to cutting youth crime.

In the longer term, the Mayor's commitments and the tactical responses to serious youth violence will need to adapt as the threat, risk and harm evolves . This dovetails with the council's 20-year manifesto on "enabling every resident of the borough to fulfil their potential through the reform and the delivery of services aimed at reducing

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58 https://www.london.gov.uk/press-releases/mayoral/tackling-knife-crime
59 https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/mopac-consultations/your-views-policing-and-crime

dependency and increasing employment, skills and growth in every part of the community"[60].

I remain very optimistic that we can effectively make a difference if the links are made between crime and disorder and vulnerability, social integration and inequalities. This mirrors the premise of the council's new Community Solutions service: that it is more effective and sustainable if the root causes are tackled rather than dealing with the symptoms. The suggestion that The

Mayor's Office for Policing and Crime (MOPAC) will want to work closely with local authorities on anti-gang strategies is also positive as it is an area where we have started some good partnership work and may provide the opportunity to widen this further. Many of our issues are similar to those throughout London so the opportunity to work across boroughs could be very valuable, particularly around the issue of the placement of high risk young people which is an important local issue.

Peace march in January 2017, for Duran Junior Kajiama and Ricky Hayden.

60 https://www.lbbd.gov.uk/council/get-involved/consultations/borough-manifesto/

Chapter 2

How do we approach the challenges children and young people face and how we support them to maintain their mental health and be there when things go wrong?

The importance of mental health continues to, rightly, dominate the headlines and remains a key priority for partners in Barking and Dagenham. Last year I reported that physical health and mental health are equally as important as each other, parity of esteem[61] and this year I look at the topic in more detail focusing on children and young people.

Good mental health for our children and young people is dependent on ensuring that they have mental health resilience, and can deal with emotional impact of everyday life, and when they do need services

that these services are available. To this end, we have jointly produced two transformation plans and commissioned a number of new services with our partners.

The Government is very clear that it supports enhancing mental health services, across prevention and treatment, and they recognise, as do I, that children who live in challenging circumstances e.g. looked after children, or those in the youth justice system, are at greater risk of poor mental health. The Secretary of State has set out a clear vision and planning process in The Mental

Health Five Year Forward View[62] and The Mental Health Five Year Forward View Implementation Plan. Our thinking also responds to Future in Mind[63], a national report produced by the Children and Young People's Taskforce.

In December 2015, we set out our vision to transform community adolescent mental health services (CAMHS). The local transformation plan (LTP)[64] CAMHS sets out our intention to accelerate improvements, build capacity and capability and exploring new ways of working for both prevention and treatment

61 NHS England (2016) The Year Forward View: Mental Health Taskforce. Available at https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf Accessed 4 January 2016.

62 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

63 Future in Mind (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf Accessed 18 January 2017

64 http://www.barkingdagenhamccg.nhs.uk/Our-work/child-and-adolescent-mental-health-transformation-plan.htm

services. This plan is underpinned by our Child and Mental Health needs assessment which was completed in 2016[65]. I set out a summary of what we found, and I follow this with an update on the activity that has been commissioned as an outcome of the LTP.

Picture of need

Public Health England states that 70% of children and young people who experienced mental health problems did not receive appropriate interventions at a sufficiently early age (Public Health England, 2015)[66]. Only 25% of children who need treatment receive it (Burstow and Jenkins, 2016)[67].

In Barking and Dagenham, we have a higher than expected number of children and young people with mental health needs. This is because many of them are exposed to one or more of the five key risk factors for mental illness.

1. Living in poverty, particularly in lone parent families

2. Being a looked after child

3. Having a learning disability

4. Living in homes where there is domestic violence

5. Living with parents who have poor mental health themselves

We experience a higher rate of diagnosable mental health problems compared to the England average. According to our Joint Strategic Needs Assessment (2015)[68], there are currently 65,345 children and young people under the age of 19 living in the borough and it's likely that between 6,769 and 7,188 have a diagnosable mental illness (around 10%). This doesn't mean that all these children and young people have been diagnosed with mental illness but all do need support, whether that be from family or local services.

65 Children and Adolescent Mental Health Integrated Needs Assessment https://www.lbbd.gov.uk/wp-content/uploads/2016/08/CAMHS_Needs_ Assessment_web.pdf Accessed 18 January 2017

66 Public Health England (2015) Early adolescence: Applying All Our Health. [Online] Available at: www.gov.uk/government/publications/early-adolescence-applying-all-our-health/early-adolescence-applying-all-our-health

67 Kessler RC, Berglund P, Demler O et al (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national co-morbidity survey replication. Archives of General Psychiatry, 62, 593–602

68 LBBD (2015) Joint Strategic Needs Assessment. Health and Wellbeing Board.

The best available data in Table 1 shows that compared to England rates of autism, attention deficit hyperactivity disorder (ADHD) learning disability and pupils with behavioural, emotional, and social support needs are lower than national rates. This demonstrates a compelling picture of where our needs lie.

Table 1: Comparison figures for Barking and Dagenham[69]
Red Line- Benchmark Value (England)

Indicator	Barking and Dagenham (%)	England (%)	Ranking of Barking and Dagenham compared to England average
Prevalence of any MH disorder: % population aged 5-16	10.4	9.3	Significantly higher: above 75th percentile
Estimated prevalence of emotional disorders: % population aged 5-16	3.9	3.6	Significantly higher: above 75th percentile
Estimated prevalence of conduct disorders: % population aged 5-16	.5	5.6	Significantly higher: above 75th percentile
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	1.8	1.5	Significantly higher: above 75th percentile
Pupils with autism spectrum disorder: % of pupils with this disorder[70]	0.7	1.4	Significantly lower than the national average: on 25th percentile
Pupils with Learning Disability: % of pupils with Learning Disability	2.26	2.87	Significantly lower than the national average: on 25th percentile
Pupils with behavioural, emotional, and social support needs: % of pupils with behavioural, emotional, and social support needs	1.1	2.2	Significantly lower than the national average: on 25th percentile
Pupils with speech, language, or communication needs: % of pupils with these needs	2.3	2.2	Similar
Pupils with special educational needs (SEN): % of all school age children with SEN	18.1	17.9	Similar
Pupils with a SEN statement or EHC plans: % of all school age pupils	2.3	2.79	Similar
Number of young people in substance misuse treatment (<18)	302 (0.5%)	N/A	N/A
Prevalence of potential eating disorders among young people: % of 16-24 year olds	4.9	2.7[71]	Significantly higher: above 75th percentile
Prevalence of ADHD among young people: estimated % of 16-24 year olds	5.2	13.8[72]	Significantly lower than the national average: on 25th percentile

The impact of mental health and resilience is becoming more significant as drinking, smoking, drug taking and teenage pregnancy are down among young people, however, rates of depression and anxiety have increased. We conducted a School Health Related Behaviour Survey in 2017 the results of the emotional health and wellbeing section are quite stark. These are summarised in Box 1.

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69 The figures in this table were obtained from and cross-referenced between Public Health England (http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh), Child and Maternal Health Observatory (http://www.chimat.org.uk/) and LBBD Joint Strategic Needs Assessment (http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx)
70 Department for Education (2016) special educational needs statistics – January. UK: DfE
71 HSCIC (2012) Provisional monthly topic of interest: Eating disorders
72 Adult Psychiatric Morbidity in England - 2007, Results of a household survey

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Box 1: School Health Behaviour Survey 2017 – Health and emotional wellbeing

- On average pupils scored 48 (medium-high 42-55) on the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) with 71% of pupils having a med-high/high score
- 33% of pupils had a high measure of resilience (26+)
- 63% of pupils responded that they have been feeling loved "often" or "all" of the time
- 29% of pupils had a low/med-low score on the Warwick-Edinburgh Mental Wellbeing Scale and 27% of pupils had a low measure of resilience (0-19)
- Only 37% said they talk to someone about a problem that worries them or when they are feeling stressed – the equivalent figure in 2016 in the Y8/Y10 aggregate SHEU data set = 61%
- 30% said they have been feeling optimistic about the future "rarely" or "none of the time

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What is the impact of our rapidly changing demographics on this picture of need?

The answer is straightforward - an expected increase in the number of children with diagnosable mental health problems by 2020. This prediction equates to at least 8,044 children and young people in Barking and Dagenham having mental health problems requiring CAMHS. This increase is, in part, due to the predicted 30% increase in the number of 10 -15 year olds in the

borough over the next few years.

With our services seeing year-on-year increases in demand of more than 10%, often combined with a rise in case complexity. If the goal is to get good quality and timely help to the young people who need it, then the new resources need to be targeted. The focus needs to ensure children, young people and their families have access to quality services, delivered in a timely manner, by the right professional with appropriate skills and in a setting, that meets the needs of the child. Clearly, it's essential that

we, in our service planning, account for addressing this predicted increase in service demand.

Whilst we want to keep what is good and effective about our local mental health services while developing an approach that will help our children and young people to develop resilience to mental health problems. I believe that the New Philanthropy Capital's (2008)[73] diagram 1 illustrates, very well, the challenges in addressing the risks that our children and young people face.

Diagram 1: New Philanthropy Capital's (2008)

45% of children in care have a mental health disorder.

Children of parents with mental disorders are twice as likely to experience a childhood psychiatric disorder.

Bullying triggers mental health problems: at school or outside the gate.

Unsafe communities make children anxious; unhealthy communities = no play, no exercise and boredom.

50% of people receiving mental health services report abuse as children.

Media and public messages, expectation and stigma affect children's views of themselves and their behaviour.

society

community

school

family of carers

individual

peer group

More than a third of children with a generalised learning disability will have a psychiatric diagnosis.

A child with a genetic predisposition to mental health problems is five times more likely to develop problems if he or she is bullied.

The number of under-25s admitted to hospital with mental and behavioural problems linked to illegal drug use has risen by 18% in the last decade.

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73 NPC (2008) Heads Up. Mental health of children and young people. A guide for donors and charities. www.philanthropycapital.org

The borough has been successful in putting in place support to develop mental health resilience and this continues to improve. This is good news but there are still some gaps that need to be filled. These have been identified as:

- Services provided to children and young people are sometimes missing the signals of risk which results in missed opportunities for families.

- Families and staff are not always aware of what support and services are available to support mental wellbeing and deal with mental health problems.

- Improvements in pathways will reduce demand; however, within specialist services there are some capacity issues.

- Understanding of need should be driving the outcomes we set for our services.

Taking actions to meet local need

Evidence directs us that interventions during childhood and adolescence can lead to improved educational outcomes, reduced antisocial behaviour, reduced crime and violence, improved family health, as well as improved earnings in adulthood (DoH 2010)[74]. Barking and Dagenham in 2016-17 received additional funding of £444,000 plus an allocation of £111,358 for eating disorders to transform services. This has delivered the additional staffing, training and piloting of new services and models as summarised in Table 2 below.

Building resilience and promoting prevention

I am particularly pleased that there has been a much needed increase in the focus on prevention that builds on our current good practice. NHS Barking and Dagenham Clinical

Commissioning Group (CCG) and the council have jointly commissioned the Thrive programme based on four levels of intervention (Box 2) and the Positive Parenting Programme. Progress to date includes:

- Thrive training – this early intervention person centred approach to children and young people with mental health issues is being developed in our local schools. To date it has been adopted by the Thomas Arnold School with 35 practitioners trained. This will be developed further in the borough during 2017 and linked to the wider i-Thrive developments.

- A new mental health professional post has been created to work directly on provision of Social, Emotional, and Mental Health with identified schools in the borough. This role will support schools to deal more effectively with pupil mental health issues that arise.

Table 2 : Use of additional funding 2016-17

Workstream area	Activity delivered
Resilience and Promoting Prevention	Thrive Training delivered Positive Parenting (Triple P) programme delivered Additional 1 WTE social work post agreed to work on provision of Social, Emotional and Mental Health in schools
Vulnerable children pathways	Additional 1 WTE social work post to work with Looked After Children
Maximising digital support and guided self-support	Pilot started of online counselling service
Wellbeing Hub	Redesign and review work started, additional staffing agreed of 3 WTE therapists
Crisis care	Successful Vanguard bid for additional £847,000 for mobilisation of new model of care across Barking & Dagenham, Havering and Redbridge
Community Eating Disorder Service	Additional investment agreed to increase service capacity by 7.6 WTE across Barking & Dagenham, Havering, Redbridge and Waltham Forest (4 boroughs)
Early Intervention in Psychosis service	Additional investment agreed to increase service capacity by 16.5 WTE across the 4 boroughs
Outcomes Framework	Outcomes framework commissioned

74 New Horizons: Confident Communities, Brighter Futures A framework for developing well-being, DOH 2010
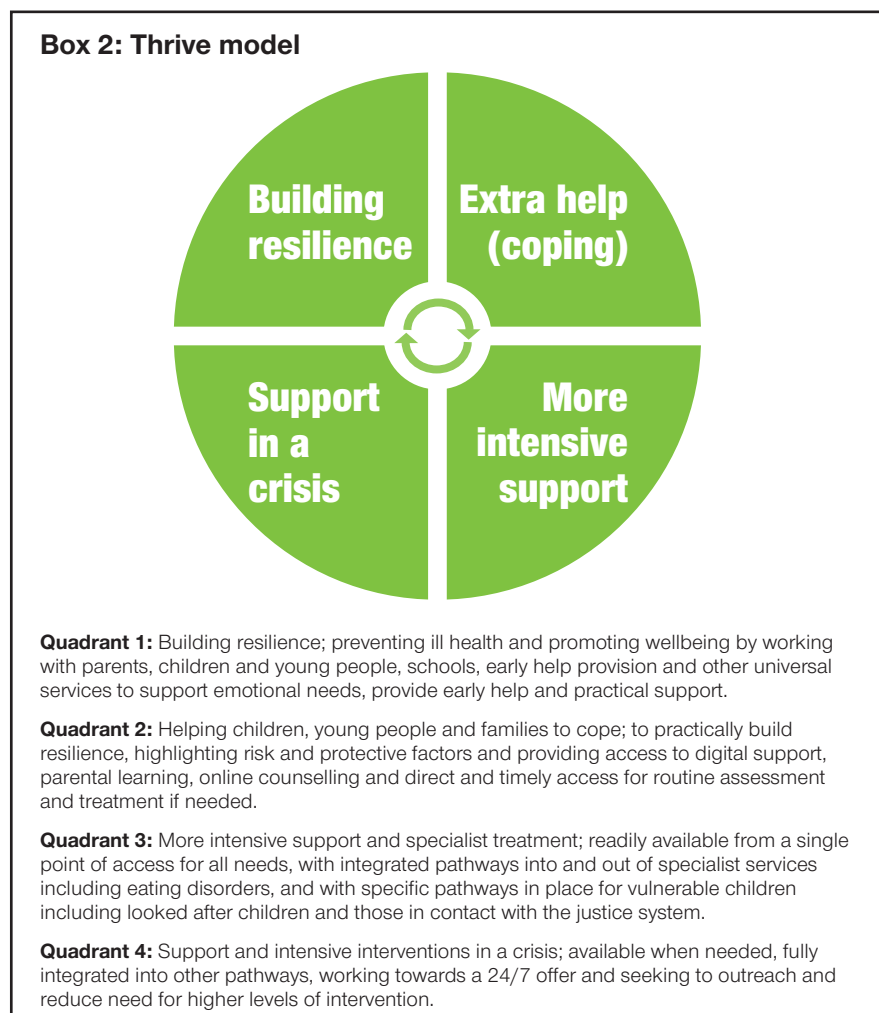
As with many Public Health issues, intervening early in childhood can have lifelong positive effects. Many people's mental health problems begin in childhood or adolescence so these are crucial times to intervene. The importance of supporting good parenting skills, developing children's social and emotional skills and intervening early to help prevent children developing enduring mental health problems.

Positive developments in these areas have included an increase in the availability of schools based mental health promotion activities and the introduction of a team of Health Link Workers for local secondary schools.

We need to ask ourselves what is causing mental health problems in the first place. Because it's my belief that many of these struggles could be avoided if we get our approach right in the early years and school settings. The question we should be asking ourselves is what are the emotional and mental health needs of all children and young people and are they being met in our schools.

A key part of moving forward on this is how we integrate and use our public health workforce. Prevention and early intervention initiatives must provide the cornerstone of the outcomes we set for redesigning our Health Visiting and School Nursing Services into an integrated 0-19 Healthy Child programme with schools, CAMHS, early years and education psychology services.

School nurses have a key role in promoting emotional wellbeing. Due to the number of pupils and schools covered, the workforce is overstretched and often not able to deliver the support required. The Royal College of Nursing (2016)[75] are strong advocates of integrated, initiatives aimed to ensure young people can access the right services from the right person in a timely manner. This includes access to school nurses who have received

Box 2: Thrive model

Building resilience | **Extra help (coping)**

Support in a crisis | **More intensive support**

Quadrant 1: Building resilience; preventing ill health and promoting wellbeing by working with parents, children and young people, schools, early help provision and other universal services to support emotional needs, provide early help and practical support.

Quadrant 2: Helping children, young people and families to cope; to practically build resilience, highlighting risk and protective factors and providing access to digital support, parental learning, online counselling and direct and timely access for routine assessment and treatment if needed.

Quadrant 3: More intensive support and specialist treatment; readily available from a single point of access for all needs, with integrated pathways into and out of specialist services including eating disorders, and with specific pathways in place for vulnerable children including looked after children and those in contact with the justice system.

Quadrant 4: Support and intensive interventions in a crisis; available when needed, fully integrated into other pathways, working towards a 24/7 offer and seeking to outreach and reduce need for higher levels of intervention.

specific training in child mental health, and child and adolescent mental health nurses who are also able to provide support and advice to those professionals working in schools and community settings.

75 Child and Adolescent Mental Health - Royal College of Nursing

Good practice example

An RCN Wales Nurse of the Year Winner 2016, Jacqueline Jones worked tirelessly with children, young people and families to develop and provide a model of school nursing that is highly visible, accessible and makes a difference to those who need it. It included the school nurse speaking at the school assembly each month, a presence on the school website, posters about the school nurse role and contact information, as well as increased involvement in personal, social and health education (PSHE) lessons to support young people to build emotional resilience. Young people and fellow professionals have provided exceptionally positive feedback in terms of the way in which the role of the school nurse has been highly instrumental in supporting young people to protect, re-establish and maintain their emotional and mental health wellbeing. Already her pupils have identified a difference in their lives, one pupil stating, 'I would have kept cutting if I didn't have her to talk to.' Another pupil, who was referred to the school nurse by a member of school staff (having a new awareness of what her role covered), happily commented, 'everyone just thought I couldn't be bothered to change my clothes and that I wanted to smell.' School staff had referred her with hygiene issues but, in reality, the school nurse discovered home conditions had deteriorated due to her mother's physical ill health. This school nurse could be viewed as just doing her job; however, by constantly raising her profile and making herself more visible, she is now visited by pupils who just want to update her on how they are doing following her involvement. One school teacher simply said, 'she makes a difference to children's lives.'

Conclusions

We cannot afford to be complacent, as demand for help is outstripping supply as the numbers of children and young people with mental health needs will increase in the next five years. The much-improved focus on prevention, particularly when dealing with emotional and mental distress is part of the day-to-day business of teachers, social workers and other professionals is a proud and positive move.

Although I have focused on the merits of early intervention the reader must not lose sight of the importance of safe and appropriate child and young person focused inpatient mental health facilities. As well as the difficulty of supporting a young person in transition between adolescent and adult services. An arbitrary age cut-off can do untold harm. Mental health and social care relies on strong therapeutic relationships between service users and the care team. Care should be organised around an individual's circumstances not of service boundaries and funding.

I commend that our Health and Wellbeing Board continues to champion the prioritisation of investment into children and young people's mental health.

Chapter 3

Accountable Care: One year on – can we make the step change in transforming our services to make place based care a reality?

In Chapter 4 of my 2015-16 Report[76], I examined the necessity of preventing ill health and moderating demand at a population level through prevention and integration of services. This direction of travel is supported by the NHS Five Year Forward View[77], our Joint Health and Wellbeing Strategy[78] and our Borough Manifesto, Your Borough, Your Community, Your Say, which received over 3000 responses during the consultation phase, and not surprisingly our residents do prioritise their health and their health and care services as very important.

Last year the move toward devolved services focused around the feasibility of establishing an Accountable Care Organisation (ACO). The business case for the ACO did not, ultimately, recommend the final step of dissolving all organisational boundaries and establishing a single organisation to take on the running of all elements of health and social care. It did, however, lay the foundations for the work to develop an accountable care system: organisations remaining ultimately responsible for their business, but with a set of incentives and new contracting and

accountability arrangements that ensure that organisational boundaries have minimal impact on how residents experience their health and care services.

Accountable Care Partnership

Formation of an Accountable Care Partnership (ACP) across Barking and Dagenham, Havering and Redbridge (BHR System) was agreed in October 2016. An ACP is a new type of managed system that is formed to integrate health and social

76 https://www.lbbd.gov.uk/wp-content/uploads/2016/08/Barking-and-Dagenham-Annual-Health-Report-2016-WEB.pdf
77 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
78 https://www.lbbd.gov.uk/wp-content/uploads/2014/11/Health-and-Wellbeing-Strategy.pdf

care services more closely and invest in prevention.

Their vision is to enable and empower people to live a healthy lifestyle, to access preventative care, to feel part of their community, to live independently for as long as possible, to manage their own health and wellbeing, which creates an environment that encourages and facilitates healthy and independent lifestyles.

The vehicle for achieving this is the Sustainability and Transformation Plan[79] which were announced in the NHS planning guidance published in December 2015. This affords the opportunity for health and care services, whether hospital or community based, to be organised around the individual and that the resident does not, and should not see the divide between the different organisations that provide their services.

What are Sustainability and Transformation Plans?

Sustainability and Transformation plans (STPs) are five-year plans covering all aspects of NHS spending in England. They are designed to bring together NHS organisations with local authorities and other partners to agree the future direction of health and care services in 44 areas of England. The context in which STPs have been developed is much more challenging than when the Forward View was published in October 2014.

In north east London financial and operational performance

has deteriorated sharply, and the additional resources allocated to the NHS by the government are being used mainly to reduce hospitals' deficits. Funds to invest in strengthening and redesigning care in the community, one of the top priorities in the STP, are in short supply, raising serious questions about the credibility of the plan to close gaps in health and wellbeing, care and quality, and funding and efficiency for the BHR System.

The council and our local partners have faced practical challenges in working together on the plans. The STP footprint in north east London is large and involves many different organisations, each with its own culture and priorities. One of the biggest challenges facing our local leaders is that the STP is being developed in an NHS environment that was not designed to support collaboration between organisations. In many ways, STPs represent an imperfect 'workaround' to the fragmented and complex organisational arrangements in the NHS created by the Health and Social Care Act 2012[80]. Two other major challenges facing STPs include:

• the need to adopt a realistic timescale for implementation of the plans that recognises how long it takes for innovations in care to become established and deliver results.

• the need to create sufficient capacity to build on the foundations that have been laid already, when so much attention is being given to financial and operational pressures. New care models have the

potential to address the root causes of these pressures in the medium term, which is why transformation and sustainability must be seen as two sides of the same coin.

Embedding our priorities in the system

The scope of STPs is broad and the challenge is how we connect with our Borough Manifesto in making sure no-one is left behind in our drive to increase prosperity. Initial guidance from NHS England and other national NHS bodies set out around 60 questions for local leaders to consider in their plans, covering three headline issues: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. Leaders were asked to identify the key priorities needed for their local area to meet these challenges and deliver financial balance for the NHS. The plans needed to cover all aspects of NHS spending, as well as focusing on better integration with social care and other local authority services. They also needed to be long term, covering October 2016 to March 2021.

After considerable debate the ACP has focused on 3 prevention priorities, 6 resident focused (improving person) priorities, and 2 integrated health and social care priorities across BHR System as identified in Tables 1 and 2.

79 http://www.healthcampaignstogether.com/pdf/NE%20London.pdf
80 https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

Table 1: Prevention priorities

Investing in prevention		
	Interventions / actions	**Impact**
Housing	• Home improvement schemes • Home adaptions • Fall prevention schemes, for example, Safe at Home	Demand for health and social care services is expected to fall leading to reinvestment cost savings.
Employment schemes	• Clear focus on getting people back to work • Effective healthy workplace schemes to reduce sickness	People are empowered to take care of themselves and are taken care of by employers. This will lead to a reduced strain on health and social care services and cost savings for the system.
• **Lifestyle interventions** • **Smoking** • **Obesity** • **Alcohol** • **Physical inactivity**	• Primary care and A&E interventions (to target smoking and alcohol) • Weight management programmes • Birmingham Be Active Programme	Cost savings in primary care and reduction in number of health problems among population.

Source: ACO strategic outline case

Table 2: Person centred and health and social care priorities

Improving person pathways		
	Interventions / actions	**Impact**
Diabetes	• Implement the National Diabetes Prevention Programme • Screening for pre-diabetes • Better control in 1 care • Weight control bariatric surgery for targeted groups	Early indicators are detected and treated as soon as possible.
Chronic Obstructive Pulmonary Disease (COPD)	• Primary care clinics • Smoking cessation programmes	People are provided with the most effective treatments leading to improved outcomes at a lower cost
Genito Urinary (GU)	• Better testing and control for kidney disease • Treatment for Urinary Tract Infections in primary care	Co-ordinated care with the most effective treatment provided to people.
Gastro Intestinal (GI)	• Reducing liver disease through alcohol interventions	Co-ordinated care with the most effective treatment provided to people.
Musculoskeletal	• ESCAPE knee pain programme • Cognitive Behavioural Therapy interventions for back pain • Testing for Bone Marrow Density • Improved pathways	Co-ordinated care with the most effective treatment provided to people.
Mental Health (MH)	• Improved access to IAPT services • Internet delivered Cognitive Behavioural Therapy • End of Life Care for people with dementia to reduce deaths in hospital	Empowering people to manage their own conditions and providing the most effective and suitable treatment.

Delivering Integrated health and social care pathways		
	Interventions / actions	**Impact**
Social prescribing	• Social prescribing projects using voluntary sector agencies to signpost to various support programmes • Programmes will be commissioned and co-ordinated to engage a range of stakeholders	Reduced hospital admissions leading to cost savings for the system.
Falls prevention	• Co-ordinated strategy and pathway across all relevant agencies to reduce the risk of (repeated) falls	Reduction in the number of falls in older people and savings in emergency admissions.

Source: ACO strategic outline case
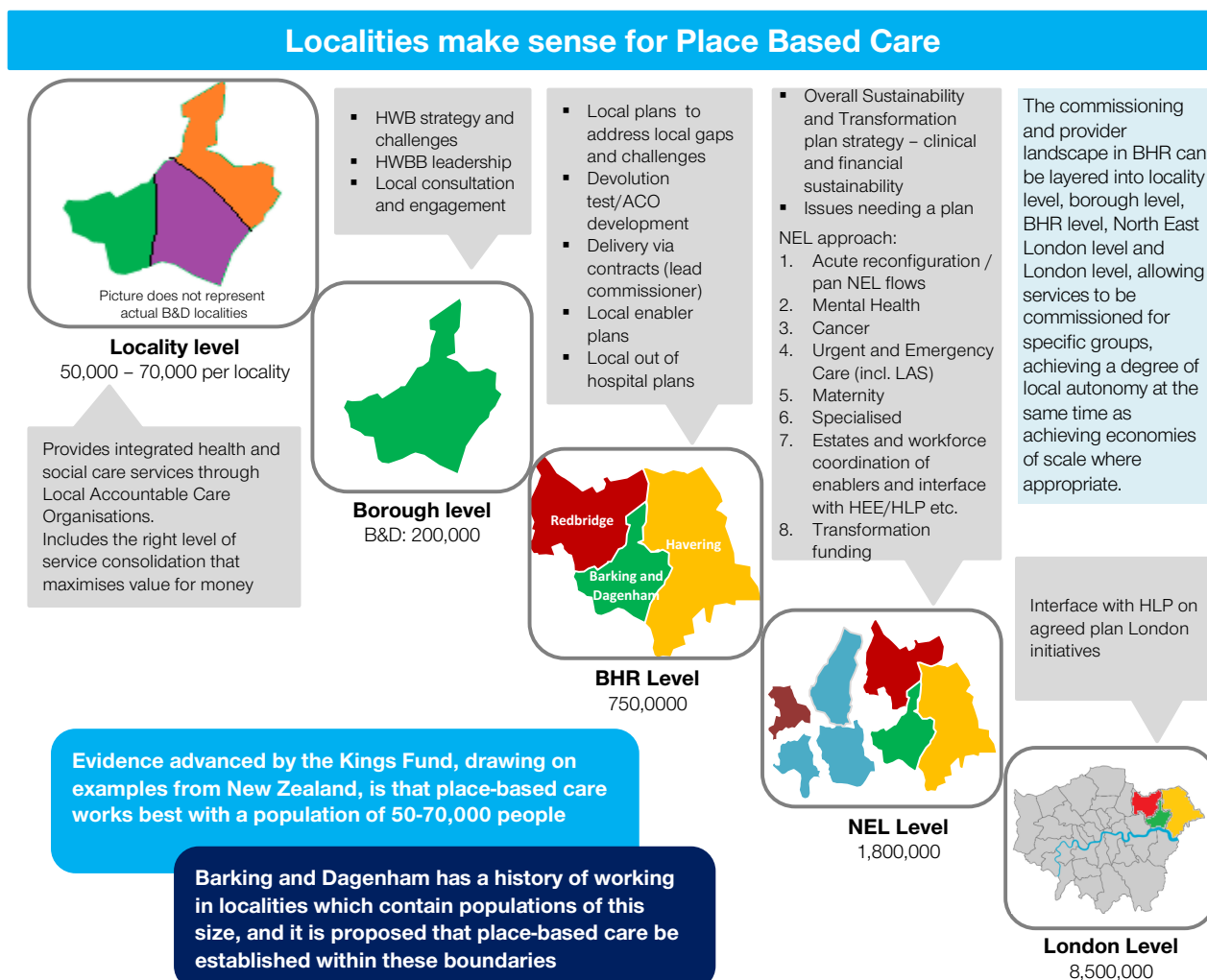
Place-based care

In Chapter 4 of my 2015/16 annual report I argued that taking a place-based approach to planning and delivering health and social care services is the right thing to do. The STP represents a shift in the way that NHS organisations are now being told to collaborate rather than compete to respond to the challenges facing their local services.

The Integrated Care Partnership is overseeing an ambitious programme to deliver these improvements, set out in the business case for the accountable care system agreed in November 2016. At its heart, place-based care means that services are structured in a way, so that at local level (in localities) health and social care organisations provide services to populations between 50,000-70,000. This approach to health and care

delivery is bringing care directly to those that need it, strengthening the focus on preventing ill-health and avoiding increased care needs.

The vision for our health and care system is a long-term one. It places the emphasis on local services as opposed to acute services; something that the BHR system has needed for a long time. See Figure 1 below.

Figure 1: Place-based care

Localities make sense for Place Based Care

- HWB strategy and challenges
- HWBB leadership
- Local consultation and engagement

- Local plans to address local gaps and challenges
- Devolution test/ACO development
- Delivery via contracts (lead commissioner)
- Local enabler plans
- Local out of hospital plans

- Overall Sustainability and Transformation plan strategy – clinical and financial sustainability
- Issues needing a plan

NEL approach:
1. Acute reconfiguration / pan NEL flows
2. Mental Health
3. Cancer
4. Urgent and Emergency Care (incl. LAS)
5. Maternity
6. Specialised
7. Estates and workforce coordination of enablers and interface with HEE/HLP etc.
8. Transformation funding

The commissioning and provider landscape in BHR can be layered into locality level, borough level, BHR level, North East London level and London level, allowing services to be commissioned for specific groups, achieving a degree of local autonomy at the same time as achieving economies of scale where appropriate.

Picture does not represent actual B&D localities

Locality level
50,000 – 70,000 per locality

Provides integrated health and social care services through Local Accountable Care Organisations.
Includes the right level of service consolidation that maximises value for money

Borough level
B&D: 200,000

Redbridge
Havering
Barking and Dagenham

BHR Level
750,0000

Interface with HLP on agreed plan London initiatives

NEL Level
1,800,000

London Level
8,500,000

Evidence advanced by the Kings Fund, drawing on examples from New Zealand, is that place-based care works best with a population of 50-70,000 people

Barking and Dagenham has a history of working in localities which contain populations of this size, and it is proposed that place-based care be established within these boundaries

This shift reflects a growing consensus within the NHS and social care that more integrated models of care are required to meet the changing needs of the population. In practice, this means different parts of the NHS and social care system working together to provide more

co-ordinated services to patients, for example, by GPs working more closely with hospital specialists, district nurses and social workers to improve care for people with long-term conditions.

However, this can be seen as self-limiting as it doesn't automatically

include collaboration with other services and sectors beyond health and care to focus on the broader aim of improving population health and wellbeing – not just on delivering better quality and more sustainable health and care services. This means services at the periphery need to

become central to our thinking. For example, how do we connect with our intervention programmes in Personal Health and Social Education in schools, domestic violence, homelessness, poor housing, childcare, drugs and alcohol? These interventions open the barriers which unlocks the potential to reduce the demand for more expensive interventions, such as mental ill health management, temporary accommodation, looked after children and long term worklessness.

The new care models will only have the potential to effectively manage demand by developing the insight and intelligence on what makes a public service intervention pivotal to someone's life. As I discussed in Chapter 1 in tackling serious youth violence, any new approach must address the root causes of the problem and its pressures.

The development of place-based services[81] needs to take a locality perspective that captures the root causes of ill health in that locality. Public Health have been leading the development of locality boundaries, and embedding prevention into the development of services within the localities based on the picture of holistic needs. See figures 2 and 3 below.

Figure 2: Localities in Barking and Dagenham

Figure 3: Locality profile
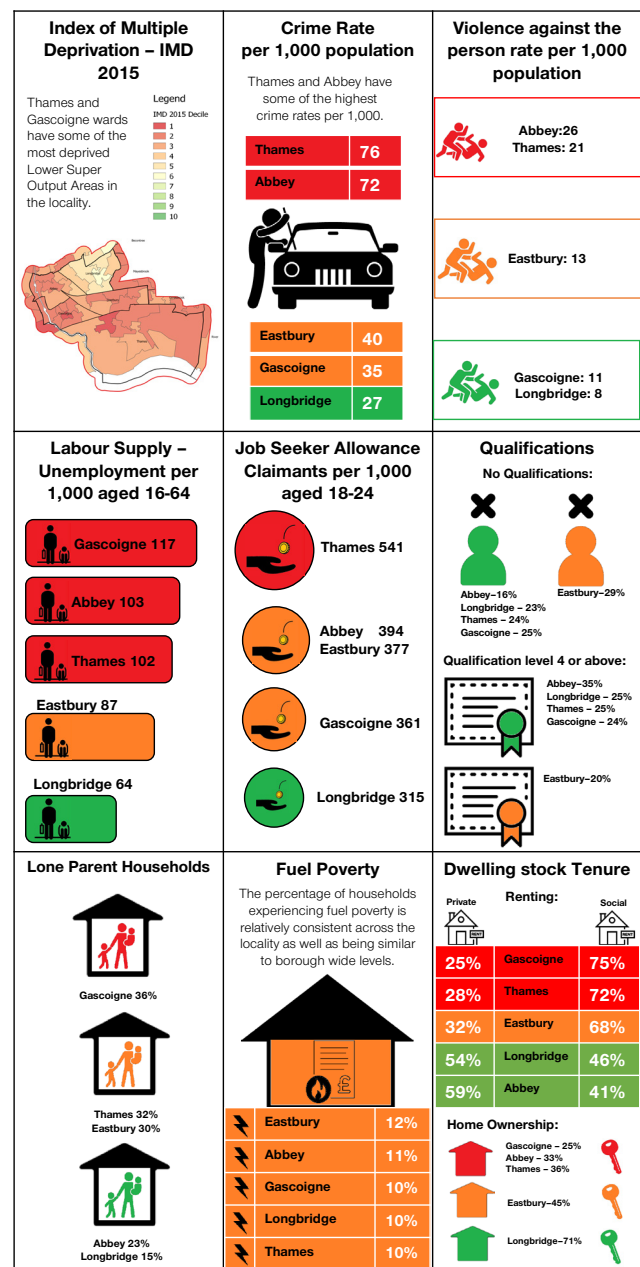
81 Partner members- Primary care, LBBD - Adult Social Care, Public Health, Children's Social Care, North East London NHS Foundation Trust, BHR Clinical Commissioning Group.
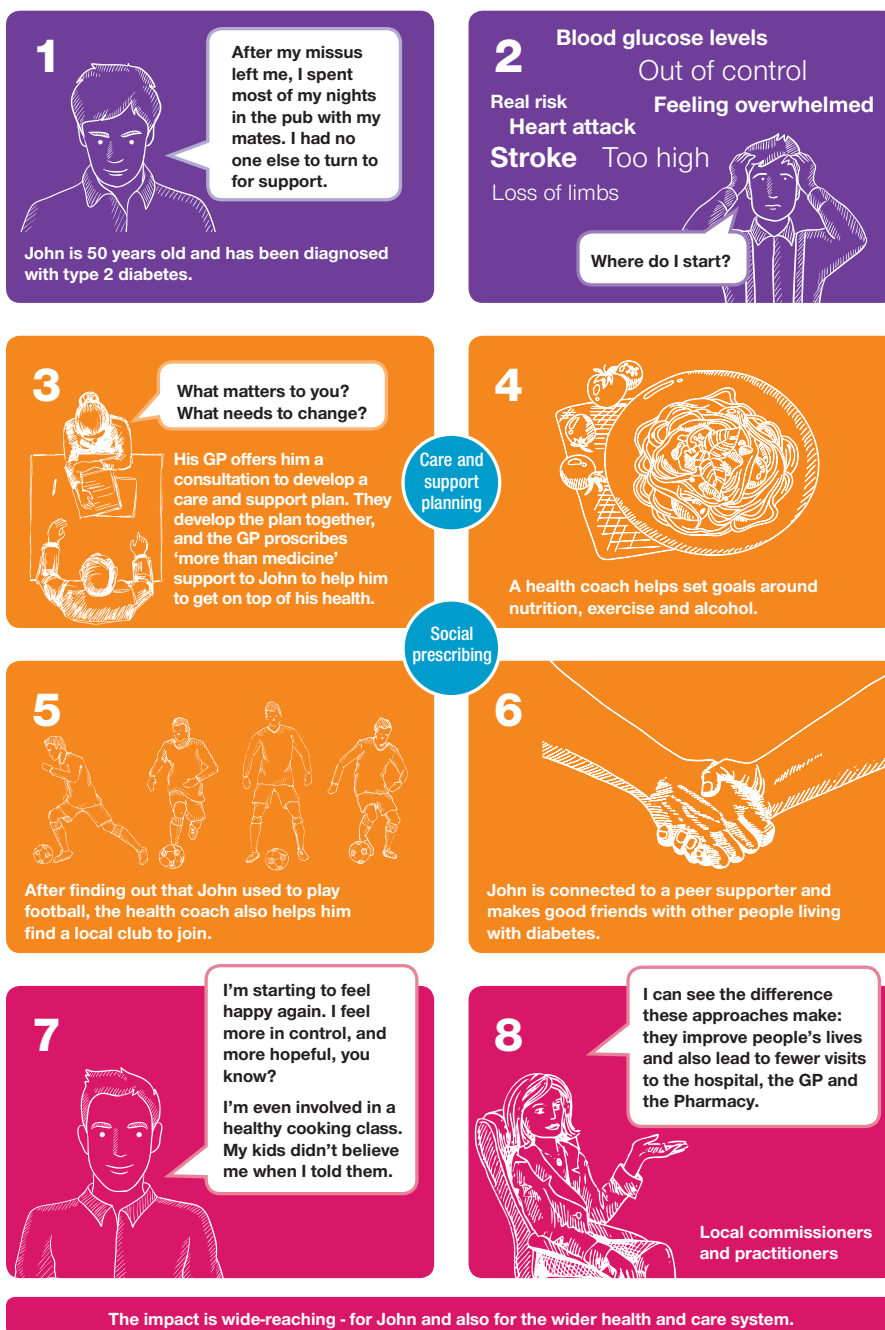
Place-based care requires radical primary care innovation

The imperatives for innovation is that increased funding in the primary care system will not be sufficient to stem the tide of current demand and address the under doctoring and nursing workforce challenges. The focus remains the need to direct our resources to support people where possible to help themselves to stay healthy and self-care. How we radically transform the relationship between our residents and the council as well as between patients and the NHS will determine the delivery approaches we take where the best outcomes can be delivered at the right cost.

The outcomes of care in a large part must address the wider determinants of health such as income and housing; unless we take prevention and public health seriously, this will adversely affect the sustainability of our public services. Recognising, that disease is determined primarily by a range of social, economic and environmental factors, the connection of GPs, nurses and other primary care professionals to a range of local, non-clinical services is an essential component of our locality approach. Our primary care colleagues have the means to do this through social prescribing. Social prescribing is designed to support people with a wide range of social, emotional or practical needs, and our schemes locally are focussed primarily on improving mental health and physical well-being (See figure 4).

Figure 4: Social prescribing[82]

1. John is 50 years old and has been diagnosed with type 2 diabetes.
   "After my missus left me, I spent most of my nights in the pub with my mates. I had no one else to turn to for support."

2. Blood glucose levels Out of control. Real risk. Feeling overwhelmed. Heart attack. Stroke. Too high. Loss of limbs. *"Where do I start?"*

3. His GP offers him a consultation to develop a care and support plan. They develop the plan together, and the GP proscribes 'more than medicine' support to John to help him to get on top of his health.
   "What matters to you? What needs to change?"
   Care and support planning

4. A health coach helps set goals around nutrition, exercise and alcohol.

   Social prescribing

5. After finding out that John used to play football, the health coach also helps him find a local club to join.

6. John is connected to a peer supporter and makes good friends with other people living with diabetes.

7. *"I'm starting to feel happy again. I feel more in control, and more hopeful, you know? I'm even involved in a healthy cooking class. My kids didn't believe me when I told them."*

8. *"I can see the difference these approaches make: they improve people's lives and also lead to fewer visits to the hospital, the GP and the Pharmacy."*
   Local commissioners and practitioners

The impact is wide-reaching - for John and also for the wider health and care system.

82 http://www.health.org.uk/realising-the-value

In Barking and Dagenham, a real opportunity has emerged to link our GPs social prescribing directly with our new Community Solutions service. 'Community Solutions' is a bold and radical redesign of council services with the aim of getting upstream of complex needs by determining and tackling root causes. The key to our Community Solutions approach is that it is both person and community centred. It enables individuals to link with local community networks for the support that they need including health and care, which is central to delivering our outcomes for improving health and wellbeing.

Community Solutions is set to increase resilience, resolve problems early and reduce demand for services. Support will be on-line, face-to-face and importantly through pro-active outreach for community networks and pro-active outreach support for families for example through accessible front door
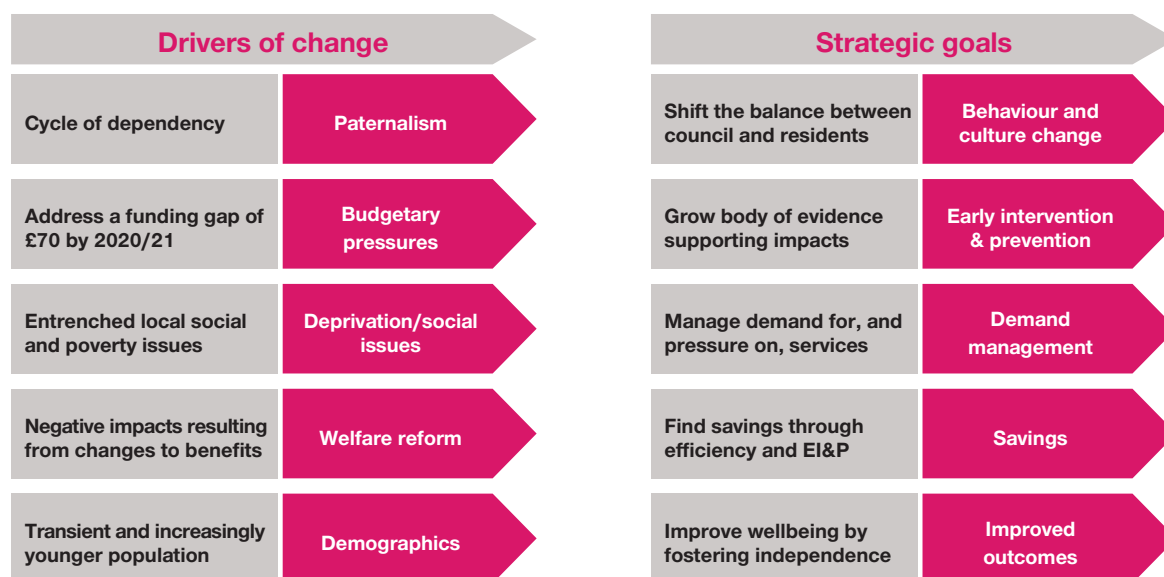
locations like libraries.

The potential offered to general practice by Community Solutions is significant as it is estimated that less than 30% of presenting issues at GP surgeries need clinical intervention, and 70% of appointments are down to issues such as housing, income, work etc. Using a similar approach to the Rotherham social prescribing pilot[83], we can increase the capacity of GPs to meet the non-clinical needs of patients with complex long-term conditions, who are the greatest users of primary and social care resources.

Using Community Solutions, we can support and signpost residents to local voluntary and community sector (VCS) organisations. These services would need to be commissioned to meet the increased demand created by Social Prescribing. Such services would include advice and information, befriending services, volunteering opportunities and physical activity.

This approach proved successful in Rotherham where the pilot (across the entire borough) resulted in a reduction in inpatient admissions, attendances at Accident and Emergency and outpatient appointments. The pilot also resulted in improvements in wellbeing of the patients referred, with many reporting improved mental and physical health, feeling less lonely and socially isolated as well as becoming more independent. From a public health perspective, the pilot focused on reducing NHS demand, where from my perspective I would like to see demand reduction spread across the public services.

The evidence is very clear that giving people control over their own lives improves 'wellness' , this in turn increases resilience and reduces demand on services. We are making great strides towards achieving, this driven by several strategic goals, which form the core principles of Community Solutions, Figure 5.

Figure 5: Core principles of Community Solutions

Drivers of change		Strategic goals	
Cycle of dependency	Paternalism	Shift the balance between council and residents	Behaviour and culture change
Address a funding gap of £70 by 2020/21	Budgetary pressures	Grow body of evidence supporting impacts	Early intervention & prevention
Entrenched local social and poverty issues	Deprivation/social issues	Manage demand for, and pressure on, services	Demand management
Negative impacts resulting from changes to benefits	Welfare reform	Find savings through efficiency and EI&P	Savings
Transient and increasingly younger population	Demographics	Improve wellbeing by fostering independence	Improved outcomes

The links between improving population health and Community Solutions are clear.

84 Harry Burns (2016): Chief Medical Officer- Scotland: What Causes Wellness https://www.youtube.com/watch?v=yEh3JG74C6s.

Conclusions

Whether these ambitions for an accountable care system can be delivered under this model is yet to be seen. There are, of course, opportunities to manage care more effectively in the community but only if we grasp the need to go wider than care. But developing new models of health and social care takes time and resources – both of which are in short supply. For example, to improve child health outcomes innovative thinking would lead us to redesign our 0-19 Healthy Child Programme into a more coherent model of family health and wellbeing service. Delivering a comprehensive and fully integrated service through the localities requires aligning this provision with the range of services already set to move into Community Solutions. In doing this

allows for disparate service elements such as health visitors, school nurses, youth health workers, children's centres/early years' provision, Family Intervention Service, parenting support, child weight management programme, active lifestyle interventions, Infant feeding support service and Educational Psychology Service to come together to enable our most vulnerable families and young people overcome inequalities.

In an environment where our local organisations find themselves under significant pressure from regulators to improve organisational performance has led to a focus on their own services and finances rather than working with others for the greater good of the local population. The mindset should shift from the traditional position of meeting the

rising demands of our population by spending more money on the services we currently provide. Instead we need to re-focus what we do collectively so that we identify the root cause of need and tackle it to enable the individual or family in question to have a better chance of living more independently now and in the future.

If sustainability is our critical driver then one of the questions for innovation should be: "How do we effectively build population resilience so that residents are better able to help themselves?" - then Community Solutions should become a service that transcends organisational boundaries that unlocks the health improvement potential of place-based care.

Chapter 4

Investing in Public Health – Can our prevention investments contain and reduce the costs of demand on our health and social care?

We are living through a period of escalating demand for health and social care services in Britain, whilst at the same time local councils are having to manage this growing demand within the new reality of sustained austerity. This is creating major concerns about the capacity of the system to cope, with almost daily news reports of services creaking and straining under the pressure.

It is generally agreed that maintaining the status quo is not sustainable and local authorities and NHS organisations across the country are facing hard choices and being forced to make difficult decisions about how they can best allocate their limited resources. Barking and Dagenham is no different in having to face and deal with this unprecedented position, but it also has its own individual social and economic challenges to meet in doing so as detailed in Chapters 1 and 2 of my 2015-16 Report[85].

Prevention programmes play a key role in providing part of the solution to these challenges. 'Prevention is better than cure' is an old saying and it would be equally true, if less catchy, to say that 'prevention is more cost effective than cure'.

Population level approaches are estimated to cost on average five times less than individual interventions and WHO[86] evidence shows that 'a wide range of preventive approaches are cost-effective, including interventions that address the environmental and social determinants of health, build resilience and promote healthy behaviours, as well as vaccination and screening'.

Investing in evidence based, well targeted preventative interventions can significantly reduce the financial impact on health and social care

85 https://www.lbbd.gov.uk/wp-content/uploads/2016/08/Barking-and-Dagenham-Annual-Health-Report-2016-WEB.pdf
86 The Case for Investing in Public Health: A public health summary report for EPHO 8. World health Organisation 2014

organisations, wider society and individuals themselves for example, increasing physical activity and healthy eating and promoting ways to help people stay mentally well are largely cost-effective and can help create sustainable health systems and economies for the future.

The ongoing evaluation of current Public Health programmes in the borough outlined in this chapter continues to highlight the challenges encountered in changing long held attitudes and entrenched behaviours across many of the adult population. This, in turn, has thrown into sharper focus the issue of how we prevent harmful behaviours from developing in the first place, particularly with children and young people.

'Lifestyles and habits established during childhood, adolescence and young adulthood influence a person's health throughout their life.' For example, up to 79% of obese adolescents remain obese in adulthood, and adolescents who binge drink are 50% more likely to be dependent on alcohol or misusing other substances when they reach the age of 30 . For Barking and Dagenham intervening early in infancy, childhood and young adulthood are critical stages in the development of habits that will affect people's health in later years.

Whilst work should, and will, continue to challenge health inequalities in the adult population through the provision of high quality, well targeted interventions. However, the longer-term health of the borough lies with ensuring that children and young people, growing up today, do not acquire harmful lifestyle habits and that we don't continue to store up problems for the future.

The Public Health Grant

The Public Health Grant (Grant) is central government funding provided by the Department of Health to Local Authorities in England. The purpose of the Grant is to provide local authorities with the resources required to discharge their public health functions and to reduce inequalities between the people in its area.

In June 2015, it was announced by the Chancellor of the Exchequer that Local Authorities' funding for public health would be reduced by an average of 3.9% in real terms per annum (an annual saving of £200 million) until 2020. This equates to a total reduction in cash terms of 9.6% over this period. The impact on Barking and Dagenham in 2015-16, with the final quarter payment of the Grant being reduced by £1.035m. However, additional Grant funding was provided from 1st October 2015 to allow for the transfer of responsibility for commissioning health visiting, and other children's public health services, from NHS England to local authorities - see Table 1. There will be a further reduction in the total Grant of 2.2% in 2016-17 and another reduction of 2.5% in 2017-18.

How has the Grant been spent?

Public health activity is usually divided into three domains – health improvement, health protection and preventative health services.

The Grant is spent on key health initiatives across these three areas, covering the whole life course – from ensuring that our children have the best start in life to making sure that adults have the knowledge, skills and opportunities to live and age well.

This includes providing programmes to tackle some of the more long-term public health issues such as child and adult obesity, smoking, reducing teenage conception, supporting those with multiple complex illnesses and improving the health of our ageing population. Figure 1. shows how we allocated the funding in Barking and Dagenham in 2015/16.
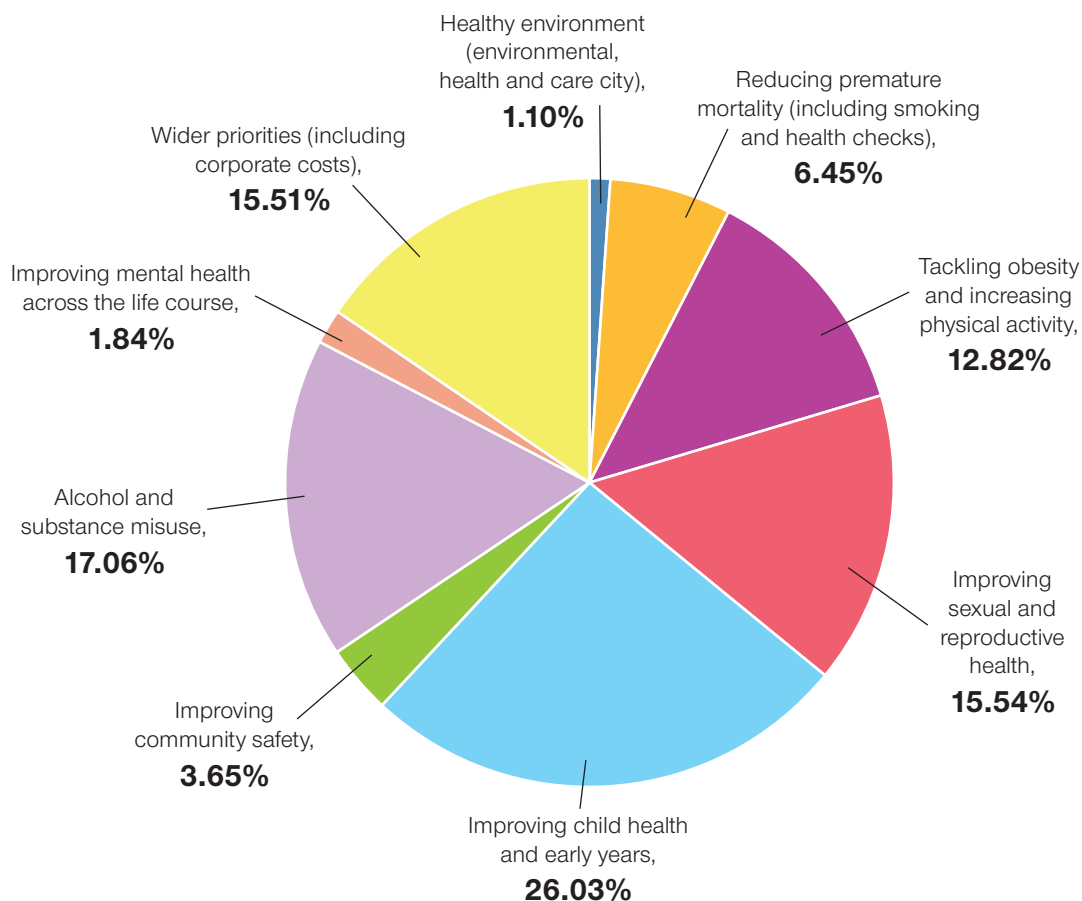
Table 1: Barking and Dagenham Public Health Grant 2015/16 allocation

B&D Public Health Grant 2015-16 Allocation	£	£	
2015-16 Original Allocation Reduction in funding announced in June 2015	14.213m -1.035m		%change on 2015-16 baseline = 5.4%
	13.178m		
Children's 0 to 5 Services (health visitors) – part-year Oct15 to Mar16	2.512m		
Total Grant		**15.690m**	

87 Healthy Child Programme: From 5–19 years old
88 Chief Medical Officer's Annual Report 2007

Figure 1: Distribution of Public Health Grant by service area 2015-16

Healthy environment (environmental, health and care city), **1.10%**

Reducing premature mortality (including smoking and health checks), **6.45%**

Wider priorities (including corporate costs), **15.51%**

Tackling obesity and increasing physical activity, **12.82%**

Improving mental health across the life course, **1.84%**

Alcohol and substance misuse, **17.06%**

Improving sexual and reproductive health, **15.54%**

Improving community safety, **3.65%**

Improving child health and early years, **26.03%**

There are a number of these programmes that we have a legal duty to provide. These are: sexual health services (sexually transmitted infections and contraception); NHS Health Check Programme; National Child Measurement Programme; and providing public health advice to NHS commissioners and ensuring plans are in place to protect the health of the public. In addition, the commissioning responsibilities for children aged 0 to 5 transferred from NHS England to local authorities on 1 October 2015. This service is also mandated and marks the

final part of the overall public health transfer which saw wider public health functions successfully transfer to local government on 1st April 2013. It is also expected, although not mandated, that the Grant be used to provide drug and alcohol misuse treatment services and a Healthy Child Programme 5 to 19 school nursing programme. Other programmes and associated spend are decided and agreed locally based on need and prevalence.

Figure 2 illustrates how our distribution of spend compares with

London as a whole. It shows that Barking and Dagenham spends a greater proportion of the Grant on children aged 0 to 5 years and on physical activity for adults and children and less on some areas such as sexual health services than the London average. This reflects the high proportion of children in the borough (the highest in London) and our concerns about weight management, diet and the low levels of physical activity amongst both children and adults across our population.

Figure 2: Distribution of Public Health Grant compared with London averages

**2015-16 Net Expenditure by Service Area -
Barking and Dagenham compared to other London Boroughs average**
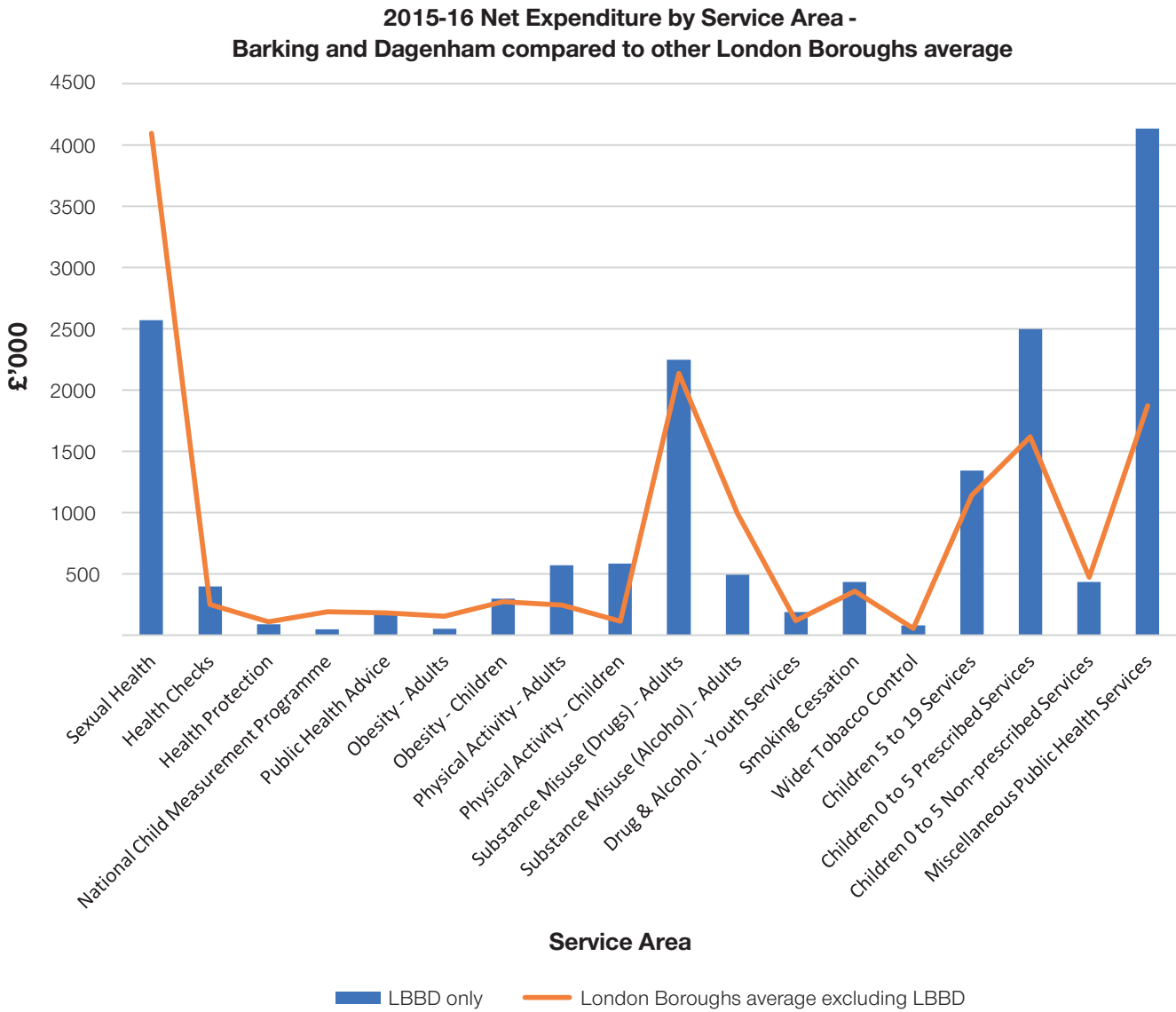
The Grant funds a wide range of services, as well as providing technical expertise in analysing health and wellbeing needs and evaluating evidence to maximise impact of what we commission. Table 2 also shows the service areas that are resourced through the Grant and details some of the programmes commissioned to meet local needs.

Table 2: Public Health Services resourced through the Public Health Grant 2015-16

Healthy environment	£million
Care City	0.082
Environmental health	0.100
Reducing premature mortality	
Smoking cessation	0.663
NHS Health Check Programme	0.405
Tackling obesity and improving physical activity	
Active age centres	0.327
Exercise on referral	0.368
Active Age offer for the over 60s	0.132
Get Active programmes	0.521
Weight management – adults & children	0.350
Other	0.423
Improving sexual and reproductive health	
Genitourinary medicine and family planning – STI testing etc. treatment	2.306
Other	0.264
Improving child health and early years	
Healthy Child Programme 0-5	2.500
Healthy Child Programme 5-19	1.150
National Child Measurement Programme	0.050
Early years prevention – Family Nurse Partnership	0.150
Early years prevention – Baby FIP	0.183
Integrated youth service	0.090
Other	0.182
Improving community safety	
Domestic violence – public health and crime	0.205
Children's domestic violence service	0.172
Summerfield House - mother and baby unit	0.140
Health protection	0.087
Alcohol and substance misuse	2.822
Improving mental health across the life course	0.304
Wider priorities (incl. corporate costs and public health team)	2.567
TOTAL	**16.544**
Funded from:	
Public Health Grant 2015-16 (including £37,300 Health Premium Incentive payment)	15.727
Public Health Grant Reserve (unspent grant from previous years)	0.817

These programmes are all designed to help our residents make healthier lifestyle choices, improve their physical and mental wellbeing and to minimise the risk and impact of illness.

A number of new Grant funded initiatives were introduced in 2015-16 to tackle identified areas of need. These included introducing the BabyClear service (see Box1), raising awareness of mental health issues by investing in Mental Health First Aid training across the council and increasing support for breastfeeding through funding a new specialist infant feeding lead with Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) to instill Baby Friendly best practice standards. This latter initiative has resulted in BHRUT achieving Stage 1 of the Baby Friendly Initiative process in 2016 (now working towards Stage 2) and a significant improvement in reported patient experience.

Box 1

Example – 'BabyClear'

The BabyClear programme introduced in 2015 has been very successful and is having a considerable impact on the number of pregnant smokers in the borough. The service provides intensive support and is currently achieving a 57% conversion rate (number setting a quit date against the number achieving a CO verified 4 week quit). This is much higher than the national rate and because of this Barking & Dagenham has been nationally recognised as an area of good practice.

Getting value for money from public health interventions

Although the above has concentrated on how we used the Grant in the last financial year (2015-16) it is worth noting the review activity we are currently undertaking to ensure that the programmes listed in the previous section are providing the most effective and efficient interventions possible.

A cultural shift is taking place in public service delivery, with an increasing focus on outcomes and impact. The reductions in public-sector funding caused by austerity measures and future financial uncertainty means that commissioners now need to see real, demonstrable results from the services they fund.

In the past, commissioning generally focused on outputs. This gives no indication of how effective an intervention has been and does not provide evidence of the longer-term financial benefits for the public purse.

For the council, as for any organisation providing public services, undertaking a regular and systematic programme of service evaluations is therefore essential in determining the effectiveness of specific interventions and, in turn, in deciding how to allocate resources to projects and programmes so that they have the greatest positive impact in achieving the outcomes of our joint Health and Wellbeing Strategy.

The council has a co-ordinated approach to delivering its vision and priorities. It is clear in its' aim of

wanting to make the best use of all the resources available to support residents to take responsibility for themselves, their homes and their community, by ensuring programmes promote greater self-reliance and focus on the root causes of demand not servicing the symptoms.

The first step is to look closely at 'why we provide programmes, who we provide them for and how we can manage demand to ensure that we deliver statutory and other services for residents, with capacity for the future'. This includes evaluating the whole range of Public Health funded programmes being delivered by the council.

The process for doing this is outlined in Figure 3.

Figure 3: Evaluation process
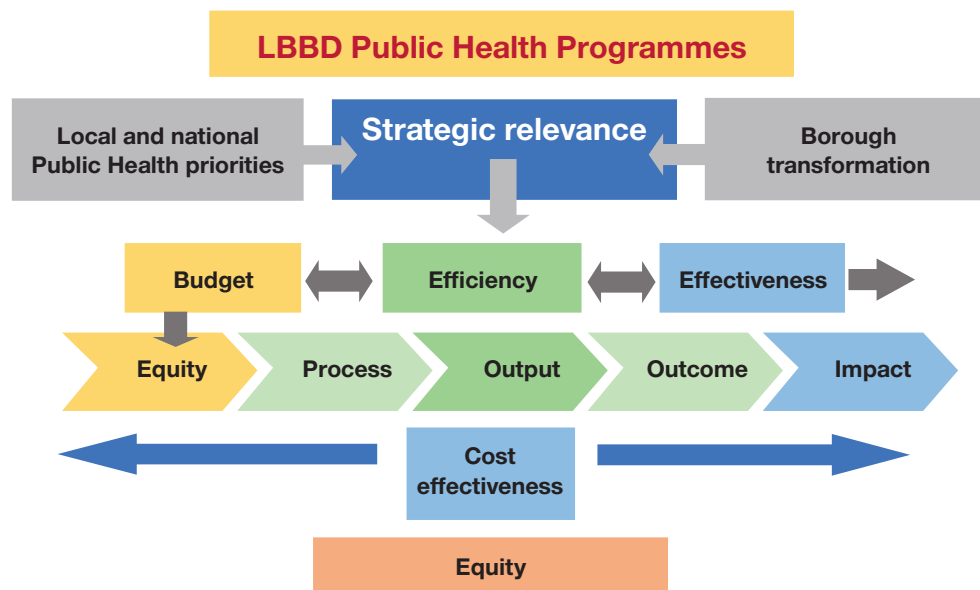
Services have changed and evolved considerably over the last few years and (irrespective of the new financial constraints) there is now a need to undertake a systematic review of these programmes to ensure that they remain relevant and that the priorities are aligned with the wider council's vision whilst focussing

on the greatest health inequalities and the most urgent needs in the borough. As well as ensuring they are relevant and targeting need, the evaluations we are undertaking are also looking at the efficiency of these programmes.

Efficiency can mean different things to different people but is often viewed

with a degree of cynicism as being synonymous with 'cutting services to cut costs'. Whilst it is true that being more efficient can sometimes involve cutting both costs and services this is not an automatic result and decisions need to take the long view into account when assessing the benefits of a given intervention. Whilst they

should be based on delivering the outcomes people want in the best way and at least cost this sometimes means that a greater investment is needed in certain areas to prevent more debilitating and costlier conditions developing.

Assessing efficiency is also about making sure that services are keeping pace with change and innovation and have the right tools and support to do the job required of them.

Clearly though the effectiveness of programmes is key to their success and services need to be able to demonstrate that they are making a positive difference to the health and wellbeing of individuals and the community as a whole. Measuring effectiveness is not just about producing rows of numbers and percentages – whilst important these are only one form of indicator of how well things are going but have often been used as the sole measure. Showing that services are making a real difference and assessing effectiveness is a more qualitative and, in truth, more difficult exercise. This is particularly the case in the field of public health where the benefits of specific interventions may not be realised for many years. Through our evaluation we are working with providers to ensure that services are able to assess and report outcomes in a meaningful way – enabling us to shape services and use our resources most effectively.

Services also need to be available to everyone that would benefit from them. Whilst public health programmes are evidence based people's experiences of life are very different across the population which means that the way services are delivered needs to reflect this. What works in one area or with one group may not be the best fit in another. Barking and Dagenham is

a very diverse borough with many social and economic factors leading to inequalities in wellbeing. Services need to be relevant and fit in with the way people live their lives, they also need to provide an attractive offer to differing groups and individuals, and be accessible to all. Our evaluations are showing that this is not always the case and that whilst we are reaching many people there is more we can do to fully engage with all groups and all communities.

In general, the evaluations completed to date do show that the services provided through use of the Grant are valuable and do provide many people with the impetus and tools to make significant life changes.

However, we live in a dynamic and continually evolving borough and reviewing services to ensure we are getting best value will often result in challenges to the way we do things. This is healthy – programmes should be adaptive to the pace of change and innovative in approach. The evaluations have shown that there are areas where we could make changes to improve outcomes for people by ensuring that the Grant is used to deliver real outcomes and provide a stronger focus on preventative interventions and a more effective reach into all areas of the borough and all communities.

Evaluation outcomes

We are only part way through our evaluation programme but as a result we have already identified a number of ways to help improve the effectiveness and efficiency of some of the services we commission and fund, including: the NHS Health Check programme; child and adult weight management; smoking cessation and prevention and sexual health services. We have also

ended some programmes where the evaluation has demonstrated that there are more effective ways of using the funding.

Conclusions

It is recognised that a comprehensive strategy needs to include a combination of population and targeted individual preventive approaches, but it should be noted that, on average, individual-level approaches were found to cost five times more than interventions at the population level[89]. In general, evidence also shows that investing in upstream population-based prevention is more effective at reducing health inequalities than more downstream prevention. The National Institute for Health and Care Excellence in the United Kingdom found that many public health interventions were a lot more cost effective than clinical interventions (using cost per QALY), and many were even cost-saving[90].

Investment in prevention reduces health costs and lowers welfare benefits[91]. Therefore, there may be an opportunity that efficiencies can be further increased by clustering a variety of cost-effective approaches in the design and delivery of programmes in our new Community Solutions service to enhance the effectiveness and efficiency of overall services. Investment in prevention reduces health costs and lowers welfare benefits. Therefore, there may be an opportunity that efficiencies can be further increased by clustering a variety of cost-effective approaches in the design and delivery of programmes in our new Community Solutions service to enhance the effectiveness and efficiency of overall services.

89 WHO (2011a).From burden to "best buys": reducing the economic impact of non-communicable diseases in low- and middle-income countries. Geneva: World Economic Forum (http://apps.who.int/medicinedocs/en/d/Js18804en/, accessed 2 September 2014).

90 Kelly MP (2012). Public health at National Institute for Health and Clinical Excellence (NICE) from 2012. Perspect Public Health. 132(3):111–113.

91 http://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf

Chapter 5

Does the Barking Riverside NHS Healthy New Town principles present wider opportunities to other areas of the borough?

We are starting to see many developments that will gain momentum over the next year. Further increases in the expected growth of our borough, with 50,000 homes and 20,000 jobs being introduced by 2042. The new Mayor of London, Sadiq Khan has included Social Inclusion in his manifesto pledge and the national landscape in now one of moving towards Brexit, alongside the continued wholesale cuts in public services. However last year we introduced London's Healthy New Town and describe the story of its first year and the achievements already made.

We are one of the higher achieving Healthy New Towns of the three-year NHS England programme. We are delighted to have secured additional funding for two years. However, one year on, our population remains one of poor health and social outcomes and to change this will, as our Borough Manifesto describes take up to 15-20 years. Therefore, our commitment to use the increasing growth of the borough to benefit the borough as a whole remains steadfast. In Barking Riverside and in the rest of Barking and Dagenham we are putting some of the "building blocks" for this in place and supportive policies are emerging from City Hall. I discuss therefore ways of maximising the opportunities for our residents, albeit in a very challenging national and international context building on the key messages from my 2015-16 report see Box 1.

Box 1: Key messages from the chapter on "Growing the Borough" in last year's Annual Public Health Report

- Social inequalities drive health inequalities. Addressing the social determinants of health is not a new approach. It will have the greatest impact on health inequalities in the longer term.
- Key approaches to addressing health inequalities in the long term include: a "Health in all Policies" approach, the use of health impact assessments, putting resources into monitoring and evaluation and involving communities in decisions.
- Growth presents an opportunity for an area. However, there are also serious risks of widening social and health inequalities.
- We have much more evidence of how to improve health than how to reduce health inequalities. We want to rise to the challenge of how we grow areas in ways that narrows rather than widen inequalities so that everyone benefits from growth.

Barking Riverside – London's Healthy New Town.

Barking Riverside sits in Thames ward, one of the most deprived wards in Barking with poor health and social outcomes. Historically Thames View and the early houses at Barking Riverside comprise an area that is quite geographically cut off.

Improving the connections such as transport as well as social infrastructure is critical to the new development as the number of homes on Barking Riverside expands from 800 to 10,800 by 2030. Plans for the area are being refreshed and reviewed as the development of the new over ground station at Barking Riverside, on the Gospel Oak to Barking rail link progresses.

In this first year, we have built on the historic work of Barking Riverside to bring all health-related activities under one umbrella. We have made a number of achievements as shown in Box 2. Moving forward the growth of Barking Riverside presents an opportunity to build communities and for economic, physical and social regeneration of the area with the associated benefits to health. However, there is a risk that these benefits are only reaped by a few. We are determined that this won't happen – but to achieve this is a major challenge.

Box 2: The key achievements in our first year as a Healthy New Town (HNT) include that we:

- Developed 10 Healthy New Town Principles (see box 3) derived from a review of evidence and good practice, which are central to the Section 106. This is being built into other plans and is a fine example of a health in all policies approach and has been copied by other HNTs.
- Modelled our community-centered approach from the outset, commissioning engagement activities to understand community perceptions and identify leaders, and engaging actively with the Community Interest Company (CIC) (that will, as the population grows, mean the community will manage the assets).
- Ensured our work is evidence-based, with integral research and knowledge exchange, including through an innovation summit bringing together researchers and practitioners from across the UK.
- Embedded health and care space requirements in Section 106 (S106) for a new facility in 2020 on Barking Riverside. This is based on an innovative and integrated model linked to the BHR Health and social Care System locality model, developed in partnership with stakeholders. We have also facilitated engagement with the NHS and developers to strengthen the interim offer for health and care for residents.
- Undertook population projections based on leading-edge practice, with the involvement of the GLA, Public Health England and others. This suggests the population is likely to be particularly young with families and children.
- Through our governance model, ensuring tight co-ordination and strong leadership from the developers, council, Care City and other key factors.

Box 3: 10 Healthy New Town Principles

1. Actively promoting and enabling community leadership and participation in planning, design and management of buildings, facilities and the surrounding environment and infrastructure to improve health and reduce health inequalities.

2. Reducing health inequalities through addressing wider determinants of health such as the promotion of good quality local employment, affordable house, environmental sustainability and education and skill development.

3. Providing convenient and equitable access to innovative models of local healthcare services and social infrastructure, with the promotion of self-care and prevention of ill health.

4. Providing convenient and equitable access to a range of interesting and stimulating open spaces and natural environments ("green" and "blue" spaces) providing informal and formal recreation opportunities for all age groups.

5. Ensuring and development embodies the principles of lifetime neighbourhoods and promotes independent living.

6. Promoting access to fresh, healthy and locally-sourced food (for example, community gardens, local enterprise) and managing the type and quantity of fast-food outlets.

7. Encouraging active travel, ensuring cycling and walking are safer and more convenient alternatives to the car for journeys within and outside the development, and providing interesting and stimulating cycle/footpaths.

8. Creating safe, convenient, accessible, well-designed built environment, and interesting public spaces and social infrastructure that encourage community participation and social inclusion for all population groups including older people, vulnerable adults, low income groups and children.

9. Embracing the Smart Cities by incorporating and future-proofing for new technology and innovation that improves health outcomes across a range of areas, both at an individual level and also within the public realm.

10. Ensuring workplaces, schools, indoor and outdoor sports and leisure facilities, the public realm and open spaces are well designed in ways which promote an active and healthy lifestyle, including regular physical activity, healthy diet and positive mental health.

As the homes develop on Barking Riverside, the railway will be put in and a district centre will emerge. Imagine if the new Barking Riverside was a destination for people to come to from the area to take up jobs, to play along the Thames and walk through the blue and green spaces. To connect easily across Barking Riverside and the neighbouring areas through cycle lanes, walk ways, good public transport leading to a new vibrant hub.

This is our vision for Barking Riverside:

'A place which is healthy for all who live and work in and around the area.'

Central to this ambition is that Barking Riverside is a healthy place for all, irrespective of wealth, background and personal characteristics and whether from new or existing communities.

We have been on a journey developing priority themes and actions to turn our vision into reality. In keeping with the conclusions from my 2015-16 Annual Report (see Box 4) last year, certain elements are central to our approach. The Healthy New Towns are building a social, economic and physical environment to maximise the positive impact on health and reduce health inequalities. This is an excellent example of a

"health in all policies" approach and addressing wider determinants that impact on health inequalities in the longer term. We have involved the community in developing our vision, priority themes and actions. Our actions are based on best practice and we are setting measures of success to monitor our impact. Central to the Healthy New Town (HNT) programme is sharing and replicating learning.

Box 4: Our approach to achieving inclusive and healthy growth in Barking Riverside

- Put the community at the centre: 4 months of community engagement activities, with more planned and engaging with the Community Interest Company.

- Political leadership: advocacy by our local politicians.

- Partnership: with the NHS, developers, council departments, academics and the community throughout our work.

- Evidence based: evidence reviews and collaboration with top academics.

- Embedding health in planning frameworks: within the Section 106 and sub framework plans. This is a fine example of a "health in all policies" approach.

- Proactive communications: with the public and professionals, for example New London Architecture conference and the BOLD magazine and development of a sustainable communication strategy, managed by residents and supporting knowledge sharing and upskilling.

- Monitoring and evaluation: developing a framework for learning what works in Barking Riverside.

Moving forward, building on our achievements of the last year, our overlapping priority themes are shown in figure 1. Below are some examples of our plans for taking them forward.

A.Connected community:

The four-months community engagement and liaison with the Community Interest Company have given us insights into what the community wants to see which has helped to inform our activities. They have told us they would like: more events and activities for all ages, and a space for these to happen - highlighting the local will for a more connected community. They would value better promotion and communication: finding an innovative way for local activities and events to be promoted and communicated to people in one central place or through one clear channel. They also suggested more local participation, leadership and skill building and introducing an improved mechanism for local people to participate in activities and be involved in running and leading on initiatives in the area. Some quotes are shown in Box 5


Box 5: Quotes

"Through the process I learnt about collaboration. Events like "Feel Good Friday" should come up more often!" (Sola - Fruit Stall from Ace Events)

"People want us to do more activities like this, if we could let residents get involved in an affordable way that would encourage us to do it again." (Triangoals Unlocking Potentials)

In response to this we are working with the community to develop sustainable communication vehicles that will be shaped and delivered by the community. We will also codevelop and test with Ebbsfleet Healthy New Town a best practice tool for supporting "inclusive growth" – including engaging with communities and community asset management.

Figure 1: Priority Themes
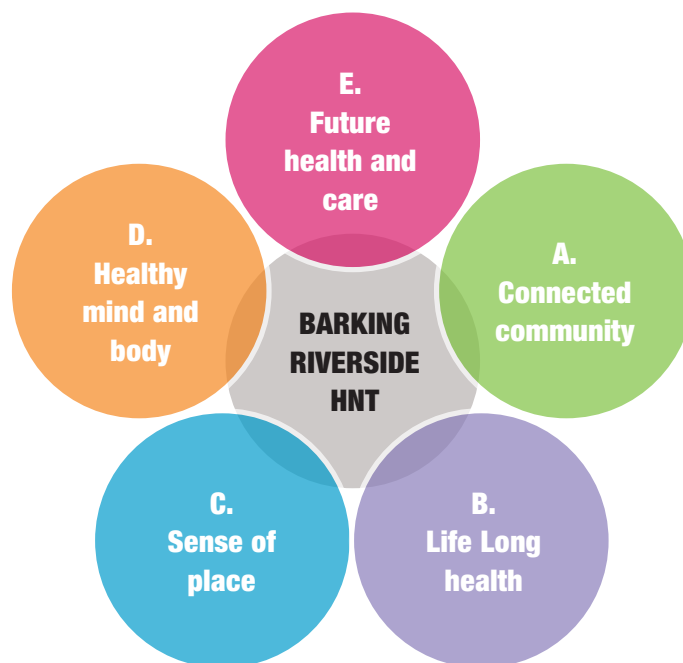
B. Life Long Health:

Professor Nick Tyler, from University College London, will work with the community on topics relating to access, mobility and design of the built environment- for example access to the river and enhancing older people's mobility.

C. Sense of Place:

Link with plans across the borough for how we encourage use of our open spaces – green spaces and "blue" (water) spaces and maximise the cultural opportunities.

D. Healthy Mind and Body:

SUSTRANS has started work to develop engagement, education and behaviour change interventions that will focus on improving local air quality and promoting active travel. We are offering opportunities to develop healthy eating and food skills for example, healthy eating on a budget and enterprise development.

E. Future Health and Care:

The NHS is developing increased capacity in the GP surgeries bordering on Barking Riverside. The NHS financial envelope and capacity planning does not allow for a new facility on Barking Riverside until

2020, when the population will have increased. However, there is now a pharmacy in Barking Riverside that will offer a range of services and we will work with the NHS to ensure that health and care facilities are as accessible as possible for Barking Riverside residents.

For 2020, the NHS, planning team, developers, public health and national experts are working to develop a truly integrated, innovative model of care in the new district centre – in line with, albeit even more ambitious than the new care models for the BHR Health and Social Care System. We are embedding this in planning frameworks for the development.

Moving forward there are key important challenges. How can we ensure that healthy policies are embedded for the long term? How can we ensure we have inclusive growth, improving health inequalities rather than health? How will we know if we are successful? Lastly, if we are successful – how can we scale up the successes to the borough, to London? In the context of this final question, I will look back at the story for the borough and for London over the last year.

Barking and Dagenham
Together

THE BOROUGH
MANIFESTO
YOUR BOROUGH
YOUR COMMUNITY
YOUR SAY

Our growth agenda

We are the fastest growing borough in London and one of the fastest changing communities in the UK. We are expecting a growth of approximately 32,000 new homes and the population will have increased to 280,000 by 2030. Beyond that year it will continue to grow. The health and social outcomes of the borough continue to be a challenge. The key population and demographic facts on page 4 shows key statistics that demonstrate the challenges to be addressed through our Borough Manifesto.

Last year we mentioned the Growth Report – a prestigious commission that gave 109 recommendations on how to ensure as a council, we maximise the opportunities of Growth in the borough. Since then we have made some key achievements.

• The Borough Manifesto is likely to describe our vision for 2037 and cross cutting ways to support that vision including strategic views on

housing, education, employment, green spaces and strengthening communities.

• The local plan has progressed and we've undertaken a health impact assessment of the local plan to maximise the opportunities for health. A characterisation study commissioned to fully understand the complex nature of the borough has given a wealth of information.

• The 10 HNT principles are embedded in the local plan – for all to follow. The Health and Wellbeing Board and Corporate Strategy Group have committed to ensuring the 10 HNT principles are embedded in future developments –the start of our journey to ensure that the learning from Barking Riverside is replicated elsewhere. The council is moving to a "New kind of council" with a commissioning core and innovative new agencies such as "Be First"

that will deliver regeneration and inclusive growth for the borough

• Our best practice examples and ambition for the borough are being shared e.g. at the New London Architecture conference – Barking and Dagenham on Location.

We have firm plans for a film studio in the borough and Coventry University is opening a new site at Dagenham Civic Centre, further developing skills and education. Utilisation of green spaces across the borough remains a challenge. There are examples, such as the pilot of a healthy lifestyle hub at Mayesbrook park

Our Borough Manifesto puts the community at the heart of Barking and Dagenham's core activities and is central to our approach. Some examples of our approaches and actions moving forward are:

A new kind of council – a shift in council focus/delivery: Be First – to

deliver regeneration and inclusive growth. Community solutions – to work with some of the most vulnerable in our community. Responding to public safety concerns and understanding the needs of specific communities e.g. through a population community needs assessment of the LGBTQ+ community locally. We are working with the Participatory City Foundation to develop Everyone Every Day– a five-year programme to engage our communities - potentially with a hub on Riverside. Key strategies are being developed – arts and culture, open spaces.

A key theme throughout and a "raison d'etre" for the Healthy New Town is about shared learning, therefore we will move from local -Barking Riverside and surrounding areas – to Barking and Dagenham borough – to London on our journey.

A Healthy London For All

Context

Sadiq Khan came into post (May 2016) with a number of election promises. Improving public health and health inequalities are key to his manifesto commitments. His vision is for a London where "no one is left behind" mirrors our Borough Manifesto and for:

"A healthier, fairer city for all Londoners, where nobody's health suffers because of who they are or where they live" (City for All Londoner's, 2016)

In his first year some of his key successes impacting upon health are – a consultation on air quality, freezing of Transport for London fares and opening a night tube. He has published a "City for All Londoners" that outlines his intentions across all the mayoral strategic areas including: growth, housing, economy, environment/transport and public space and community cohesion. He recognises in this the importance of wider determinants in improving health. The document is a precursor to the Mayoral strategies.

The City for All Londoners proposes key priorities – impacting on health. These include improving air quality e.g. through Ultra Low Emission Zone, Healthy Streets – encouraging people in active travel through changes to the environment and a commitment to a goal of 50%

affordable housing. A refresh of all the statutory strategies is planned, mostly within this year – this will include the Health Inequalities Strategy in 2017.

The refresh of the statutory strategies- gives a perfect example of the Health In all Policies, or preferably Health Equity in All Policies approach. Monitoring the impact of Healthy New Town or the subsequent growth areas would be key.

Conclusions

The story above has three layers. London, our borough and Barking Riverside HNT. At each layer there are common challenges - how do we make this sustainable? How do we address inequalities in health rather than just improve the average health of the population – with winners and losers? How do we strengthen the evidence base and evaluate what we have achieved to be assured of impact? In Box 6 below I propose a few key elements that I think would be common to all approaches.

The synergies in vision and approaches offered by London's Healthy New Town (Barking Riverside), London's Growth Opportunity (Barking and Dagenham) and the Mayor of London provide a unique opportunity to further tackle the "wicked issue" of ensuring growth benefits the many and not the few in our borough. This is exciting and timing is crucial.

To seize this opportunity there are a few key things we must do over the following year. The first is to ensure that the learning from what works and what doesn't work in the Barking Riverside Healthy New Town is digested and applied for other growth areas in the borough. We should replicate, with appropriate adaptations, what is of benefit and find new solutions to issues that we have not succeeded in overcoming. Much of the activities of the HNT are being achieved through the additional focus of partners and through working with the community. The additional budget is very modest and, arguably not the greatest driver for our achievements.

The second is to put in place mechanisms that will ensure the longevity of our achievements. No doubt much of this is out of our control with uncertain changes in the national and international context. However, as at London level, embedding the Health Equity in All Policies approach our Barking and Dagenham strategies can be powerful. A key example is the Local Plan.

Finally, our biggest challenge is to ensure that our policies narrow rather than widen the gap in inequalities. We will hold our own workshop and develop a tool and collaborate actively with emerging knowledge leaders to take steps towards developing approaches to "inclusive growth" over the year.

Box 6: Commonalities of Vision and Approaches between London, the borough and Barking Riverside HNT

- Visions: "No one left behind"
- Strong political leadership: Commonality of vision.
- Addressing wider determinants of health/Health Equity in All Policies – Agreed and is central to all levels of planning.
- Engaging the community and involving in the decision making, planning, delivery. - Central to all levels
- Using best practice and sharing our learning and replicating our actions: London: Healthy High Streets; Barking Riverside: Healthy New Town network. Replication/shared learning between levels –essential.
- Monitoring and evaluation of our impact. London, Borough, Barking Riverside. Outcome measures. E.g. Healthy Life Expectancy. Essential to be able to demonstrate that we are achieving.

Notes:

INVESTORS
IN PEOPLE