

Joint Strategic Needs Assessment 2018

London Borough of Barking and Dagenham

Contents

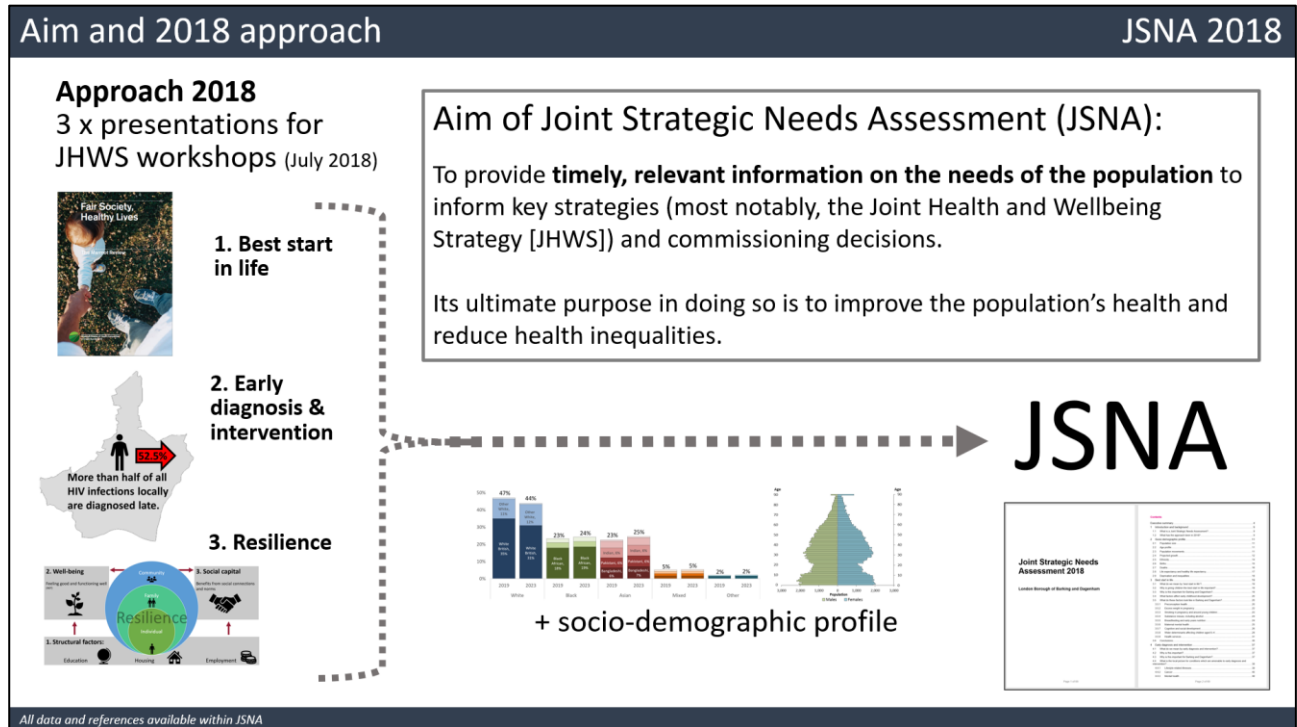
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Executive summary

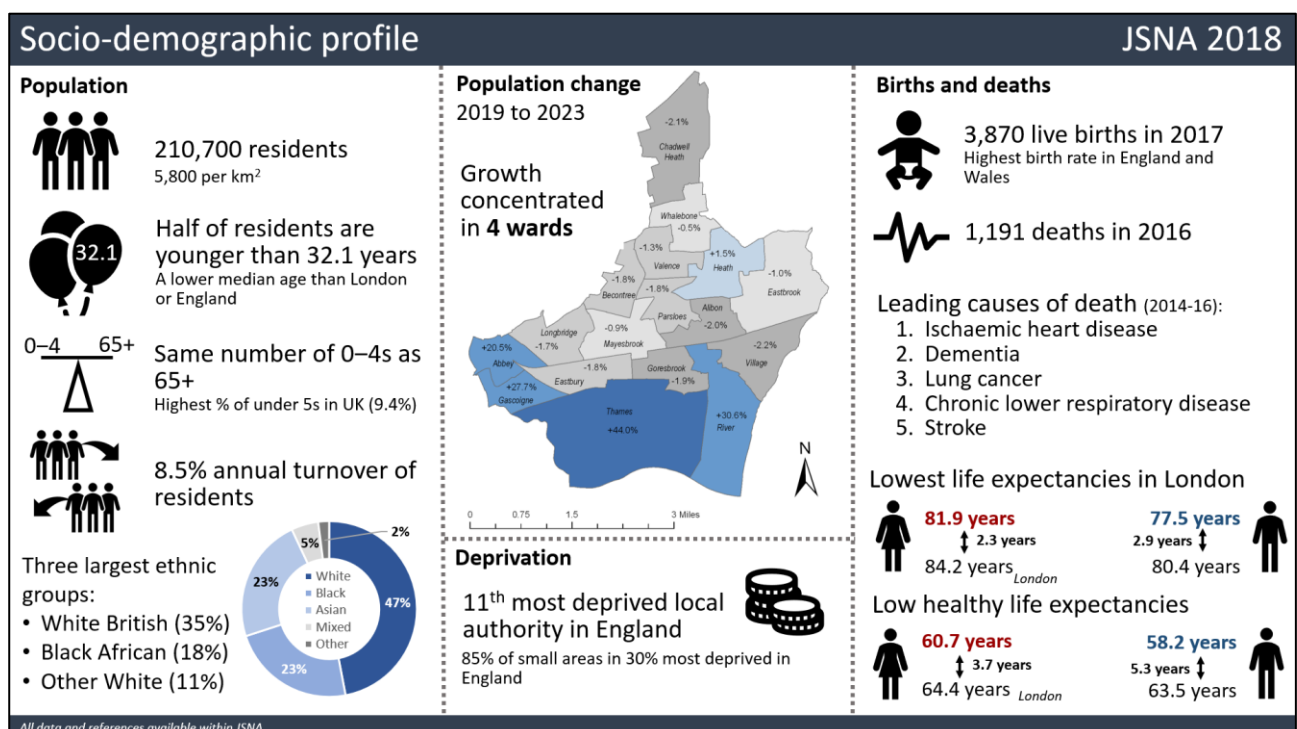
Introduction and background

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

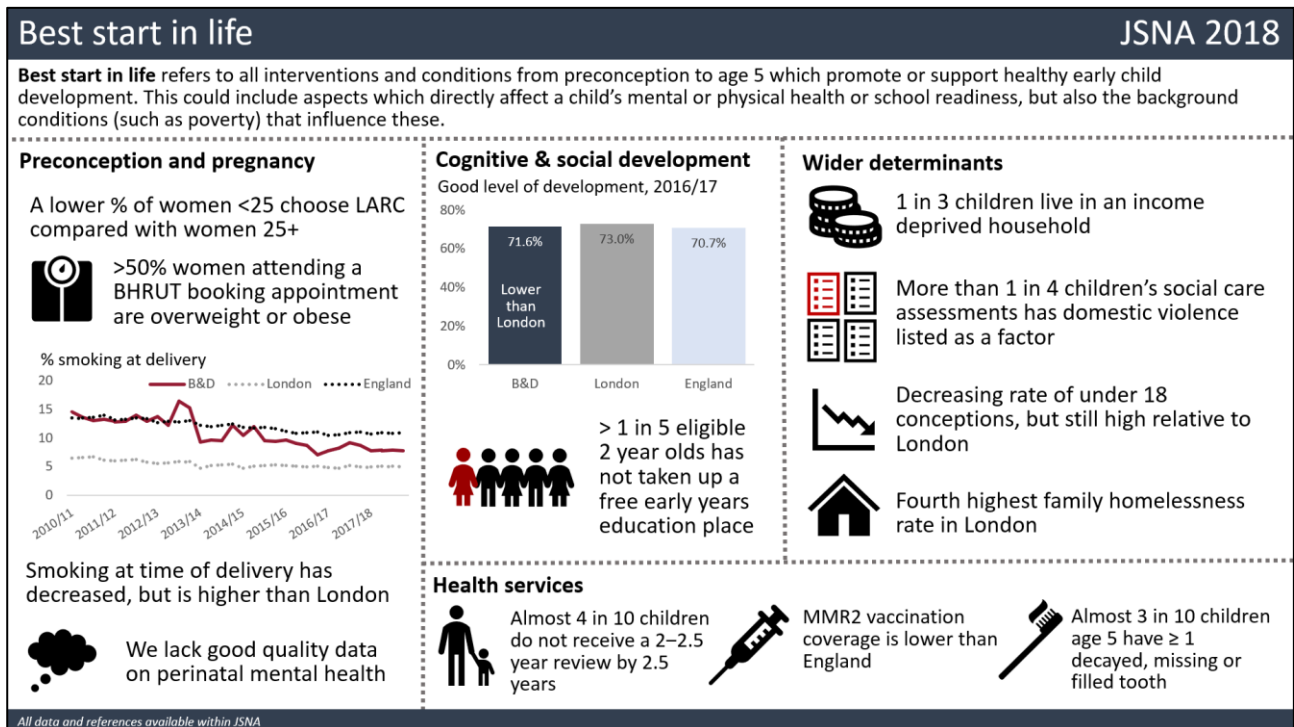


Socio-demographic profile

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



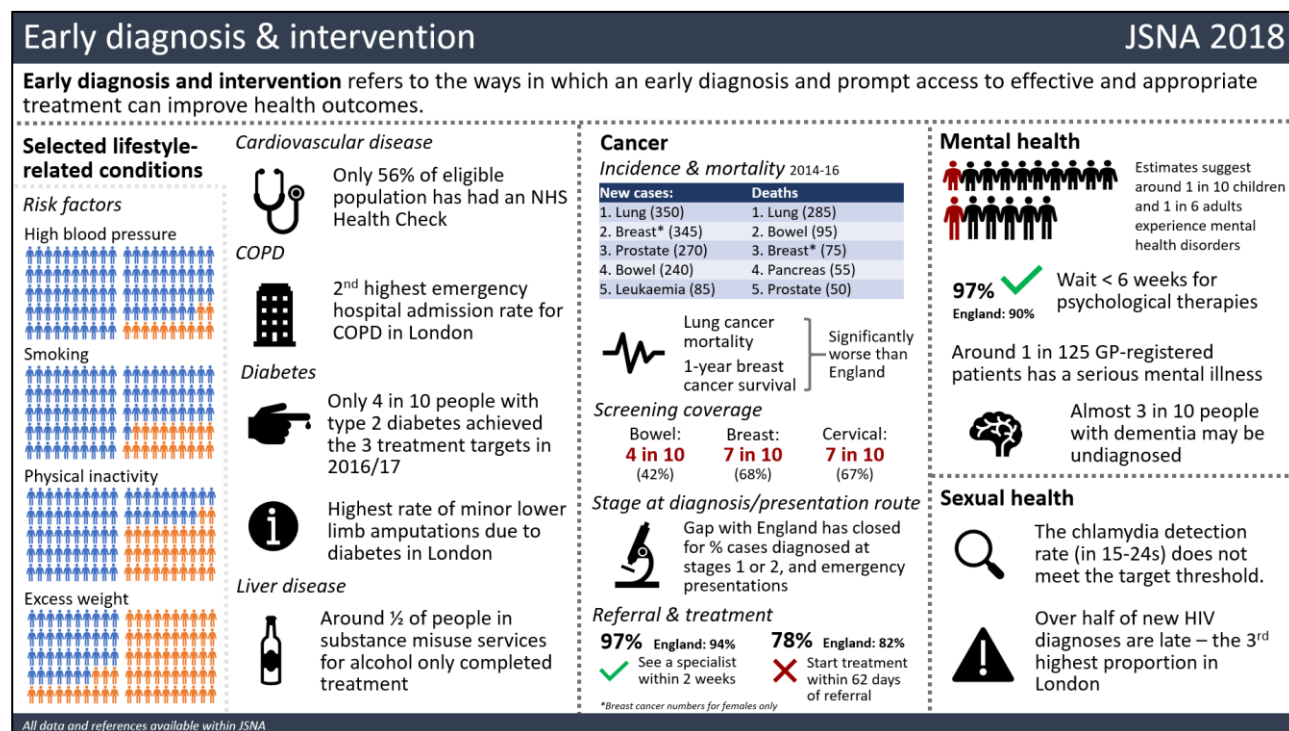
Best start in life



Key implications for commissioning:

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

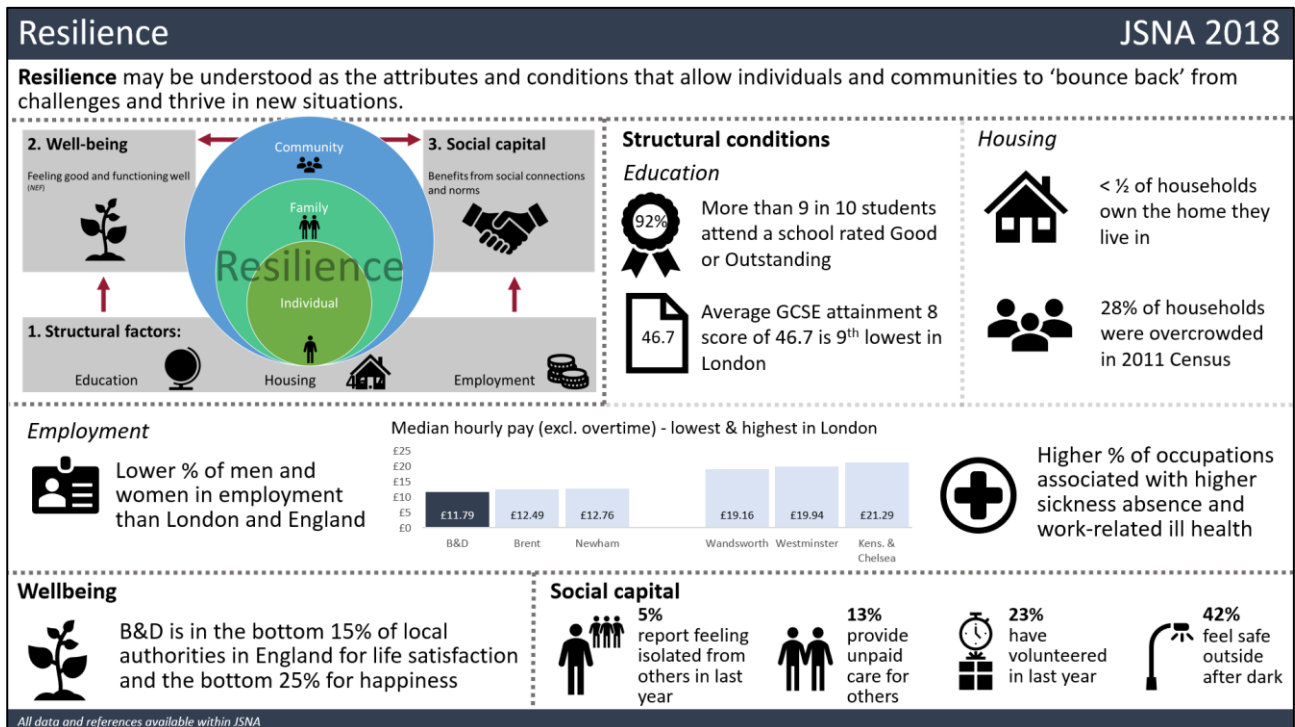
Early diagnosis and intervention



Key implications for commissioning:

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

Resilience



Key implications for commissioning:

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

1 Introduction and background

1.1 What is a Joint Strategic Needs Assessment?

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

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

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

1.2 What has the approach been in 2018?

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

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

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

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

Box 1.1: Definitions of the three themes

Best start in life

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

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

Early diagnosis and intervention

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

Resilience

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

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

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

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

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

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

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

Although the three themes in this JSNA are wide ranging, this document cannot cover all health and social care issues. Further data is available via the Borough Data Explorer³ and other online resources, such as Public Health England's Fingertips suite of tools⁴ and directory of resources by topic.⁵

² Public Health England (PHE), Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

³ London Borough of Barking and Dagenham (LBBD), Emu Analytics, Borough Data Explorer [<https://lbbd.emu-analytics.net/>].

⁴ PHE, Public Health Profiles [<https://fingertips.phe.org.uk/>].

⁵ PHE, PHE data and analysis tools [<https://www.gov.uk/guidance/phe-data-and-analysis-tools>].

2 Socio-demographic profile

2.1 Population size

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

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

2.2 Age profile

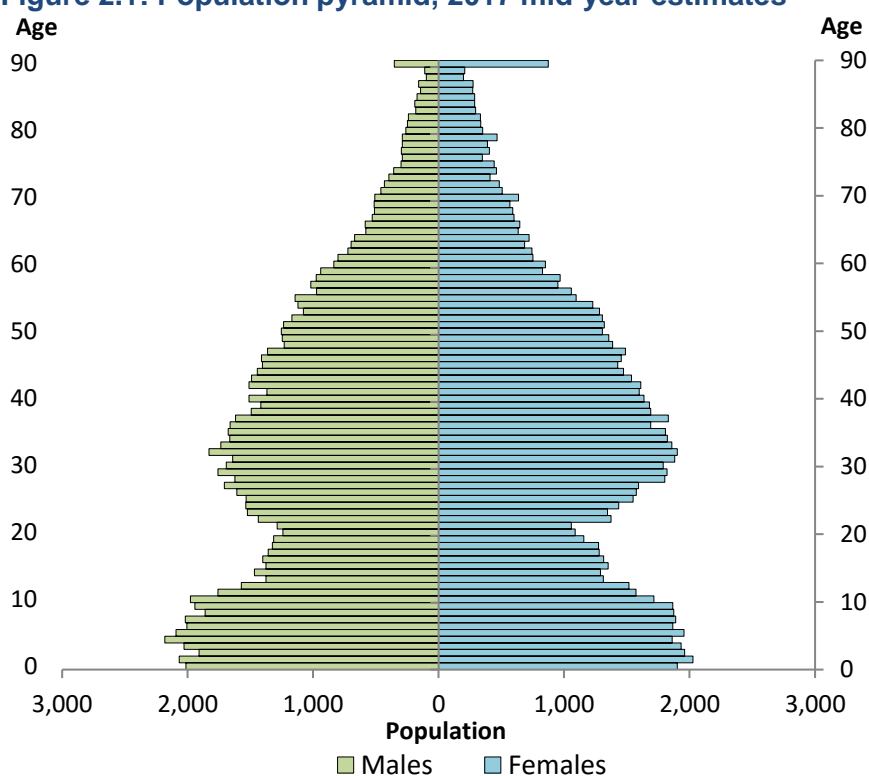
Barking and Dagenham has a young population, with a median age of 32.1 years, compared with 35.1 years for London and 39.8 years for England.

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

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

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

Figure 2.1: Population pyramid, 2017 mid-year estimates



Source: Office for National Statistics (ONS).

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

2.3 Population movements

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

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

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

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

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

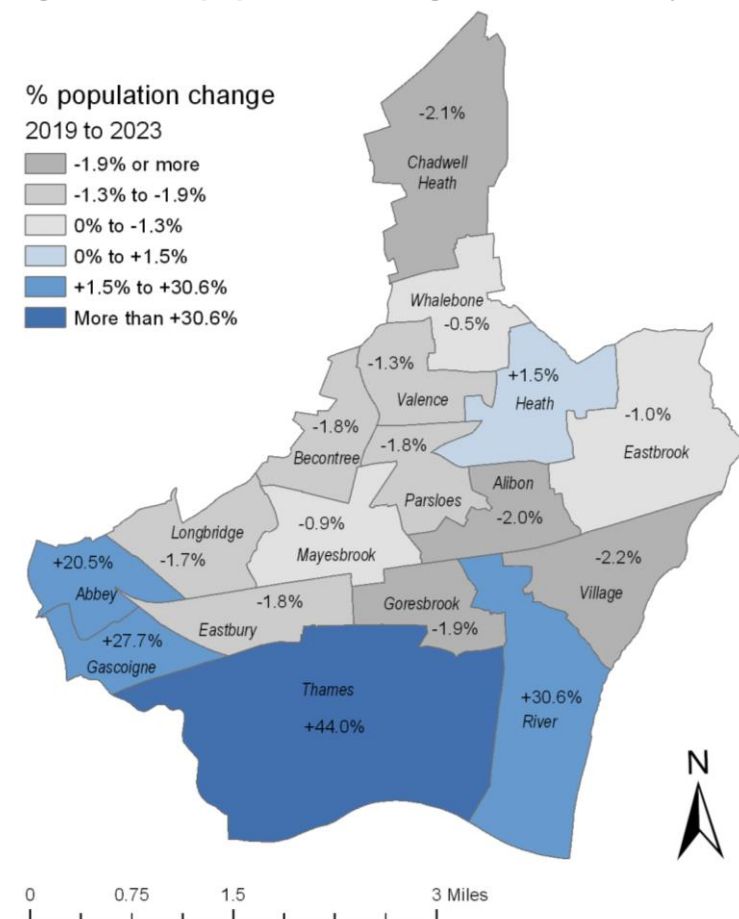
Moves from other areas of UK to LBB	Moves to other areas of UK from LBB
1. Newham (2,800)	1. Havering (2,200)
2. Redbridge (2,600)	2. Redbridge (1,800)
3. Waltham Forest (900)	3. Thurrock (1,400)
4. Havering (800)	4. Newham (1,000)
5. Tower Hamlets (700)	5. Basildon (500)

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

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

2.4 Projected growth

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



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

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

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

These growth areas reflect planned housing developments in the south and west of the borough; the population of Thames ward is

projected to increase the most due to the Barking Riverside development.

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

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

Table 2.2: Estimated population changes 2019–2023

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

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

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

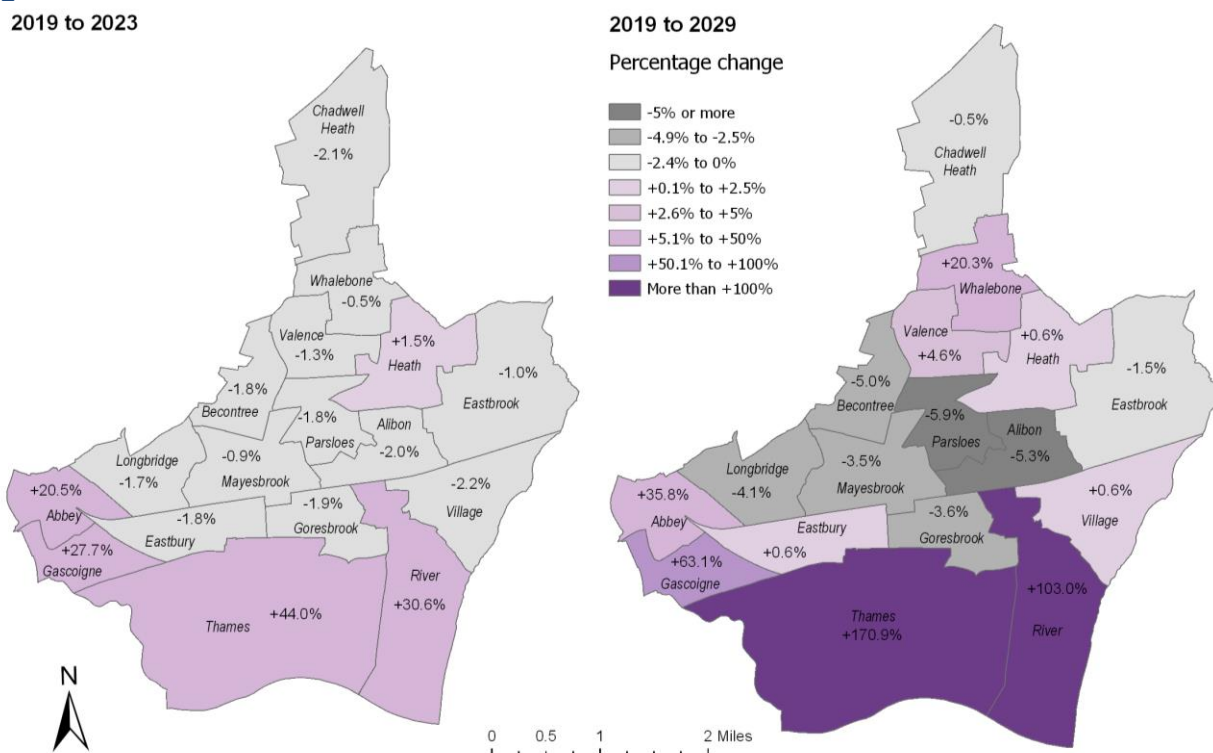
Table 2.3: Estimated population changes 2019–2029

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

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

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

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

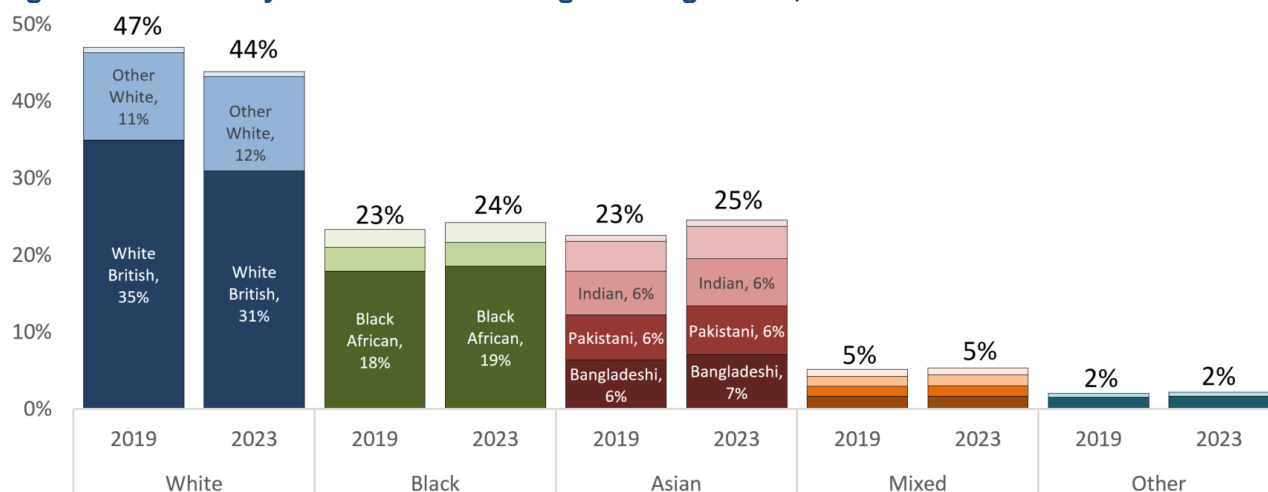


Data: GLA interim 2015-based BPO projection, 2017. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.

2.5 Ethnicity

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

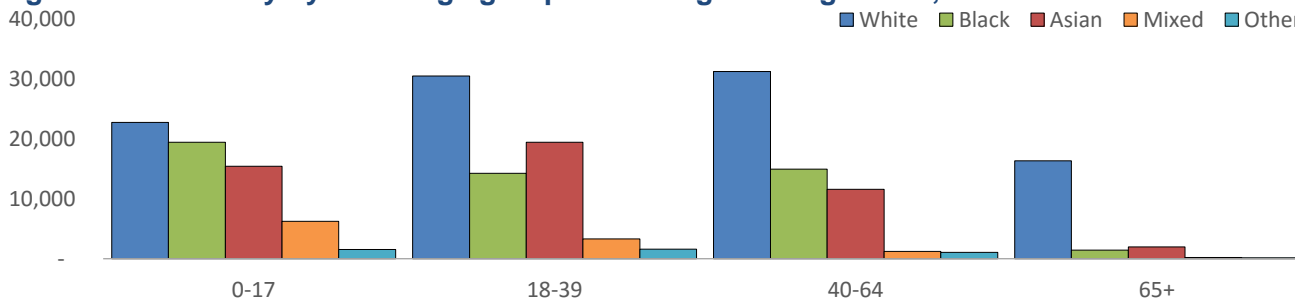
Figure 2.4: Ethnicity estimates in Barking and Dagenham, 2019 and 2023



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

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

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



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

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

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

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

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

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

2.6 Births

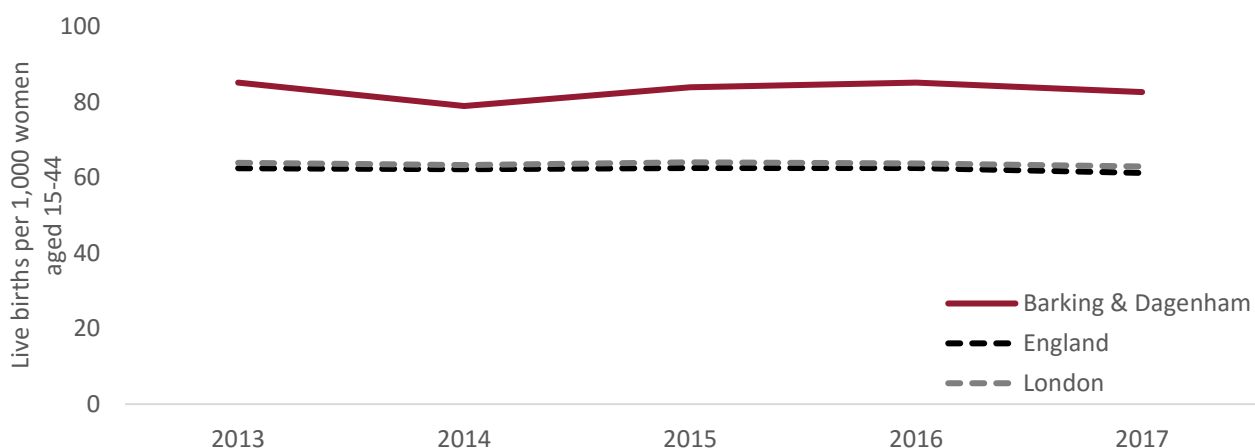
There were an average of 3,812 live births in Barking and Dagenham each year between 2013 and 2017, with 3,870 in 2017.⁹

Barking and Dagenham has the highest birth rate in England and Wales, with 82.6 live births per 1,000 women aged 15–44 in 2017.¹⁰ This is substantially higher than London (62.9 per 1,000) and England (61.2 per 1,000).

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

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

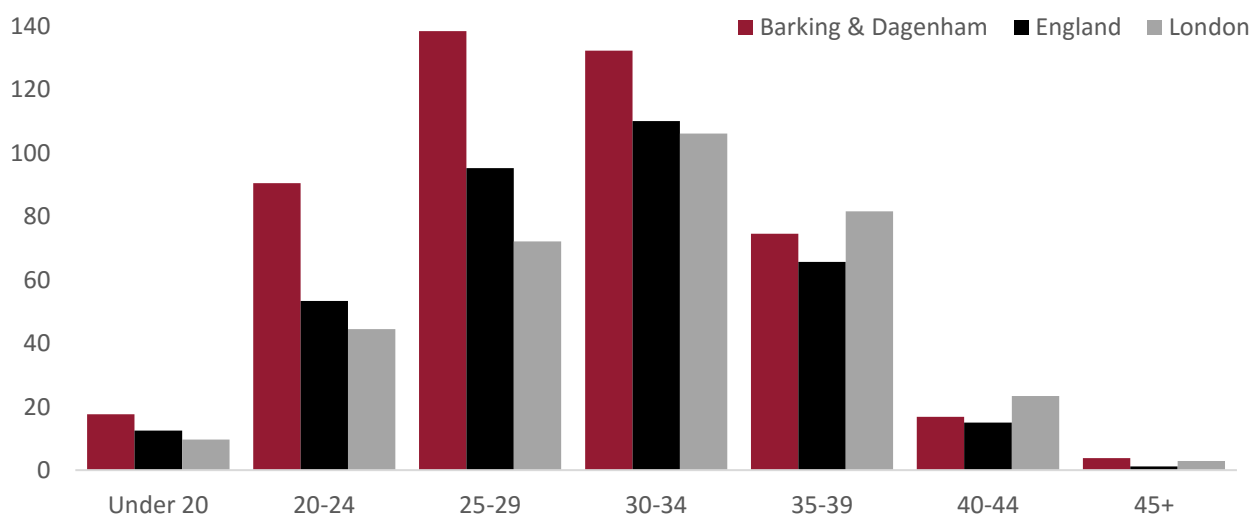
Figure 2.6: Live births per 1,000 women aged 15–44 (general fertility rate), 2013–2017



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

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

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



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

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

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

2.7 Deaths

There were an average of 1,268 deaths in Barking and Dagenham each year between 2014 and 2016, with 1,191 in 2016.¹¹

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

1. Ischaemic heart diseases (e.g. heart attack)
2. Dementia and Alzheimer’s disease
3. Lung cancer¹³
4. Chronic lower respiratory disease (chronic obstructive pulmonary disease [COPD], bronchitis, emphysema and asthma)
5. Cerebrovascular disease (stroke).

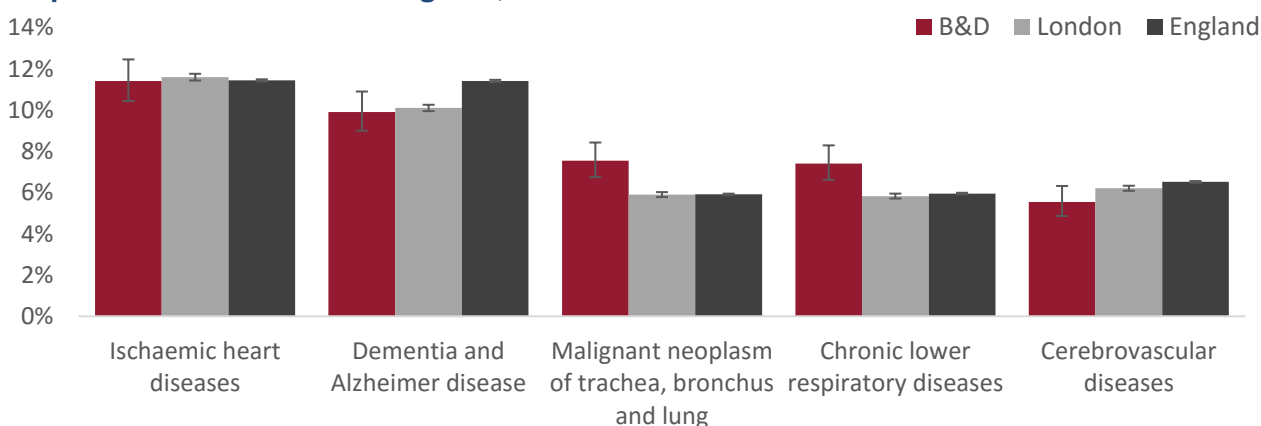
Table 2.5 Leading causes of death, Barking and Dagenham, 2014–16

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

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

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

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



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

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

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

¹¹ ONS via Nomis, Mortality statistics - underlying cause, sex and age.

¹² Cancers are counted separately for the purposes of this list. Overall, cancers accounted for 28% of deaths.

¹³ This is described as lung cancer for simplicity but is broader than this: Malignant neoplasm of trachea, bronchus and lung.

¹⁴ The fifth leading cause of death for women was Influenza and pneumonia (123 deaths); cerebrovascular disease was the sixth.

¹⁵ ONS via Nomis, Mortality statistics - underlying cause, sex and age.

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

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

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

2.8 Life expectancy and healthy life expectancy

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



Life expectancy:
77.5 years (London: 80.4 years)

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



Life expectancy:
81.9 years (London: 84.2 years)

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

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

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

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

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

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

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

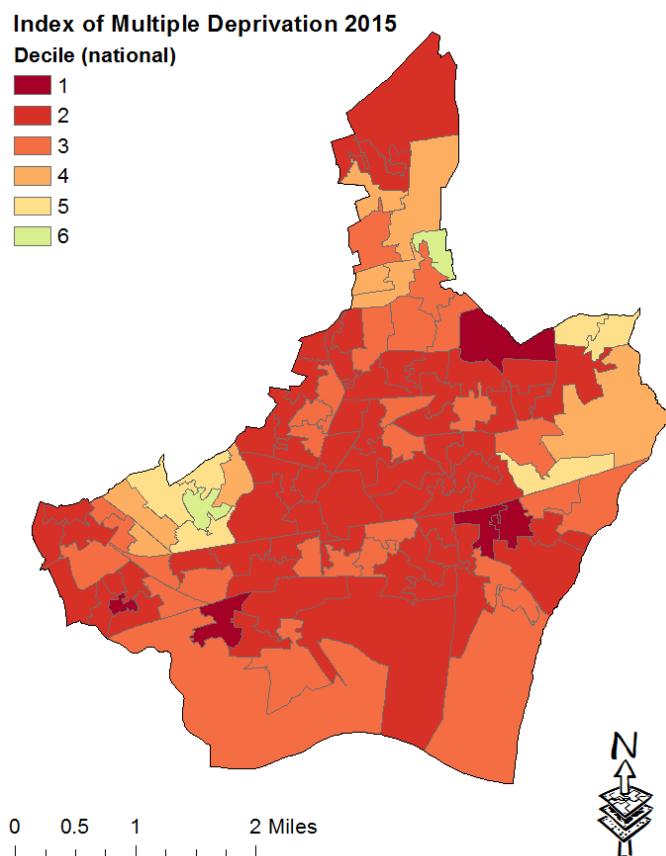
¹⁶ ONS, Avoidable mortality in the UK: 2016; ONS via Nomis, Mortality statistics - underlying cause, sex and age.

¹⁷ ONS, Avoidable mortality in the UK: 2016.

¹⁸ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

2.9 Deprivation and inequalities

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



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

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

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

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

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

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

¹⁹ Department for Communities and Local Government. English indices of deprivation 2015.

²⁰ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>]; 2014–16.

3 Best start in life

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

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

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

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

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

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

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

3.3 Why is this important for Barking and Dagenham?

Best start in life is especially important for Barking and Dagenham because of its high level of deprivation and the associated wide health inequalities between the borough and other areas in London and England. For example, it has the lowest life expectancies in London for both women and men²⁵ and the highest levels of Year 6 obesity in England.²⁶ Acting to reduce disadvantage in our youngest residents may help to reduce the intergenerational transmission of poverty and poor health outcomes.

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

²¹ For example, see: Center on the Developing Child at Harvard University. [The Foundations of Lifelong Health Are Built in Early Childhood](#). Cambridge, Massachusetts: Harvard University; 2010.

²² Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACEs) [<https://www.cdc.gov/violenceprevention/acestudy/index.html>]. Accessed 2018 Oct 03.

²³ For example, see section 2.6.1 in: Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. [Fair Society, Healthy Lives: The Marmot Review](#). London: UCL; 2010.

²⁴ Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. [Fair Society, Healthy Lives: The Marmot Review](#). London: UCL; 2010.

²⁵ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>]; 2014–16.

²⁶ NHS Digital, National Child Measurement Programme 2016/17.

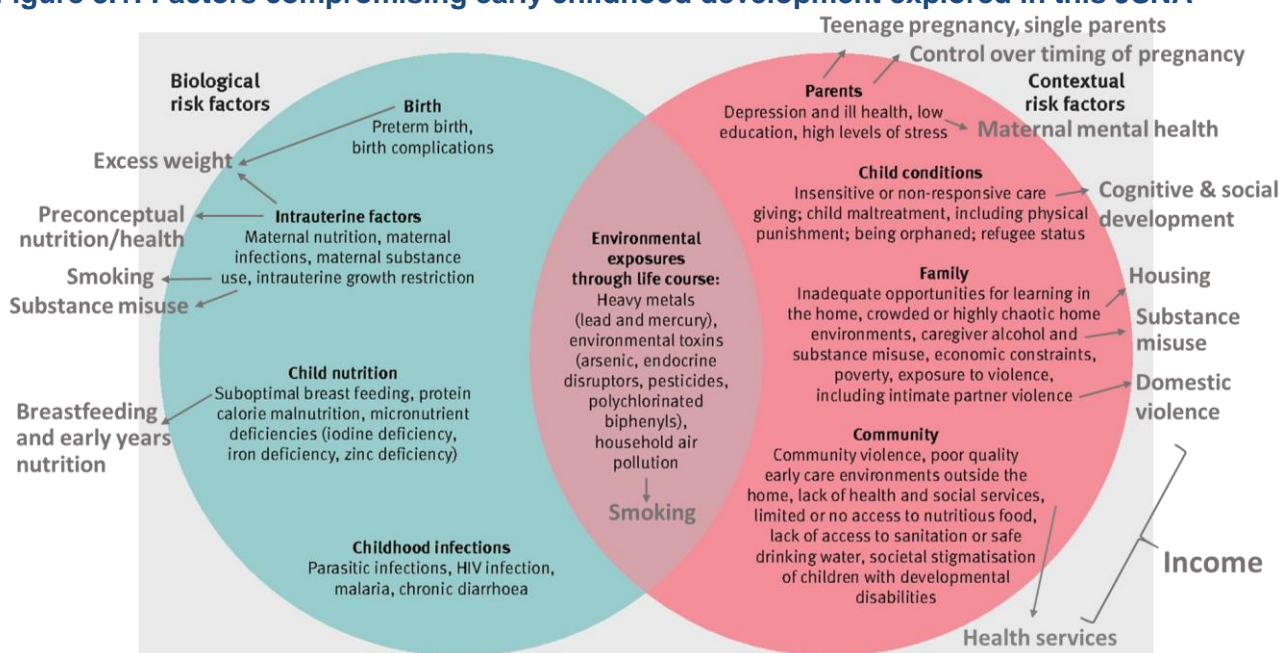
and 6.1% across England. This equates to around 19,900 children in 2017.²⁷ This is also a growing population, albeit at a slightly slower rate than the borough average; projected figures suggest we will have 20,300 children under 5 in 2019 and 21,600 by 2023.²⁸

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

3.4 What factors affect early childhood development?

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

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



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

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

3.5.1 Preconception health

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

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

What is preconception health?

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

²⁷ ONS 2017 mid-year population estimates.

²⁸ GLA interim 2015-based BPO projection, 2017.

²⁹ World Health Organization, e-Library of Evidence for Nutrition Actions (eLENA), Periconceptional folic acid supplementation to prevent neural tube defects http://www.who.int/elena/titles/folate_periconceptional/en/. Accessed 2018 Oct 03.

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

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

Control over timing of pregnancy

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

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

Figure 3.2: Prevalence of unplanned pregnancies

Pregnancies:

16%	Unplanned
29%	Ambivalent
55%	Planned

Full-term pregnancies:

6%	Unplanned
28%	Ambivalent
66%	Planned

Data: Wellings et al., 2013.

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

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

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

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

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

³⁰ PHE. [Health of women before and during pregnancy: health behaviours, risk factors and inequalities. An initial analysis of the Maternity Services Dataset antenatal booking data](#). London: PHE; 2018.

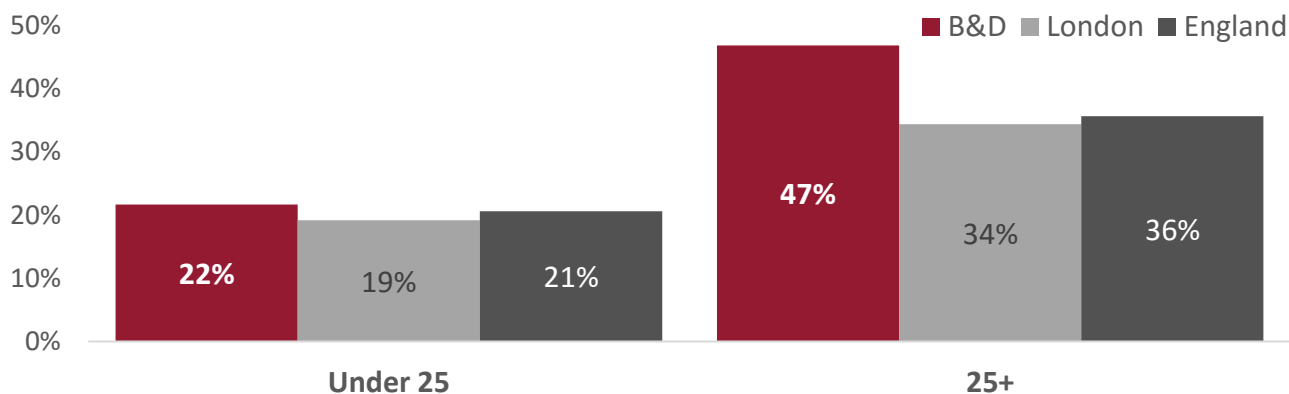
³¹ Wellings K, Jones KG, Mercer CH, Tanton C, Clifton S, Datta J, et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Lancet* 2013;382(9907):1807–16.

³² Wellings et al., 2013.

³³ ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas; Wellings et al., 2013. Rounded to nearest 100.

³⁴ Wellings et al., 2013.

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



Data: PHE, Sexual and Reproductive Health Profiles.

General health of women and men of child-bearing age

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

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



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



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



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



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



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

Source: PHE/GP Patient Survey

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

3.5.2 Excess weight in pregnancy

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

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

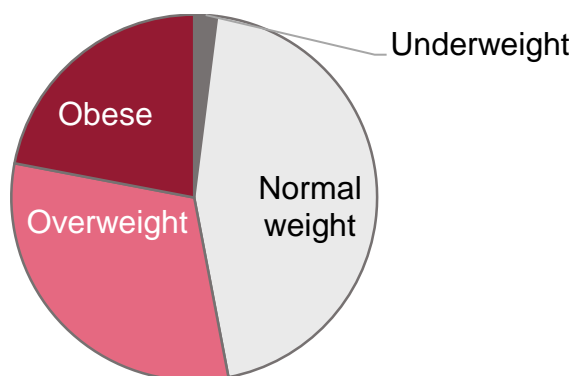
³⁵ NHS Digital, Health Survey for England 2016.

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

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

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

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



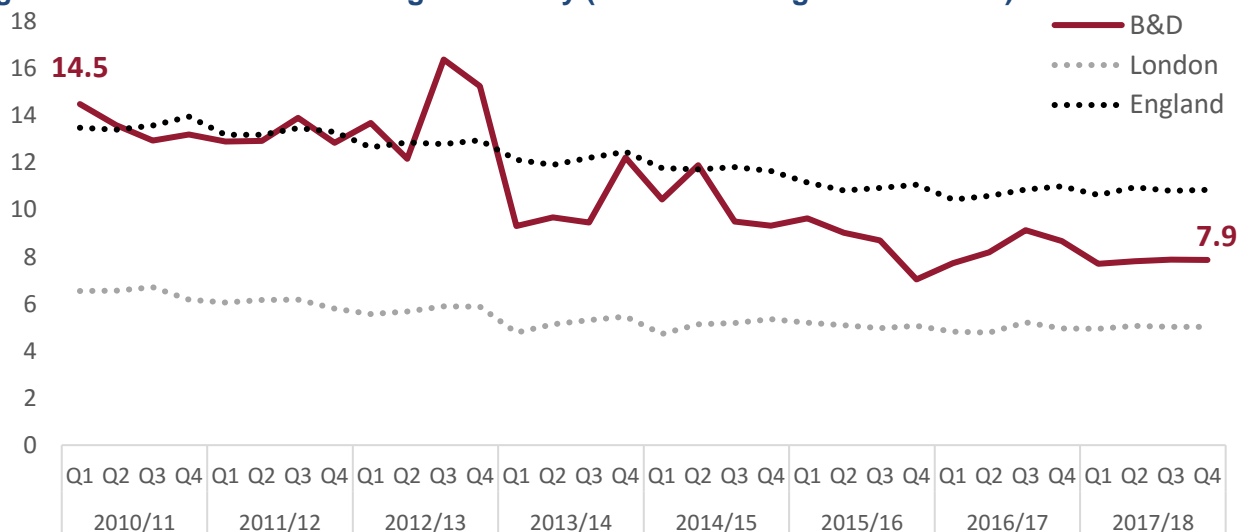
Data: NHS Digital, Maternity Services Data Set, February 2018.

3.5.3 Smoking in pregnancy and around young children

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

In 2017/18, around one in thirteen pregnant women (7.8%) smoked at time of delivery. This has decreased substantially in recent years but is the third highest proportion in London and corresponded to 273 women in 2017/18.³⁹

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



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

³⁷ NHS Digital, Maternity Services Data Set, February 2018. Note: this is not specific to Barking and Dagenham residents.

³⁸ Royal College of Physicians. *Passive smoking and children*. A report by the Tobacco Advisory Group. London: RCP, 2010.

³⁹ NHS Digital, Statistics on Women's Smoking Status at Time of Delivery, England, 1 April 2017 to 31 March 2018.

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

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

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

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

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

What impact could reducing smoking in pregnancy have?

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

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

3.5.4 Substance misuse, including alcohol

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

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

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

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

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

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

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

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

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

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

In 2017/18, Barking and Dagenham's children's social services carried out 596 assessments on children under 5.⁴⁸ Of these, 5.2% had alcohol use in the household listed as a factor, while 9.0% had drug misuse in the household listed as a factor.

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

3.5.5 Breastfeeding and early years nutrition

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

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

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

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

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

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

⁴⁸ LBBB children's social care. Duplicates from multiple assessments where the factor is duplicated removed.

⁴⁹ LBBB.

⁵⁰ NHS. Benefits of breastfeeding [<https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/>]. Accessed 2018 Oct 03.

⁵¹ Horta BL, Loret de Mola C, Victora CG. Breastfeeding and intelligence: a systematic review and meta-analysis. *Acta Paediatr* 2015;104(467):14–9.

⁵² Unicef. Skin-to-skin contact [<https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/skin-to-skin-contact/>]. Accessed 2018 Oct 03.

⁵³ NHS Digital, Maternity Services Data Set, February 2018. Note: this is not specific to Barking and Dagenham residents.

⁵⁴ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

⁵⁵ NHS Digital, [Infant Feeding Survey – UK, 2010](#). Note: this survey has been discontinued.

⁵⁶ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>], 2016/17.

3.5.6 Maternal mental health

Perinatal mental health issues⁵⁷ are estimated to have long-term costs equivalent to around £10,000 per woman giving birth. For the 3,870 births in Barking and Dagenham in 2017, this would suggest a cost of £38.4m for a single year's cohort.⁵⁸

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

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

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

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

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

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

3.5.7 Cognitive and social development

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

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

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

⁵⁷ Specifically perinatal depression, anxiety and psychosis.

⁵⁸ ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas. This is based on births rather than maternities as 2017 maternities data is not yet available. However, the cost will be of the same order of magnitude.

⁵⁹ Bauer A, Parsonage M, Knapp M, Lemmi V, Adelaja B; London School of Economics; Centre for Mental Health. *The costs of perinatal mental health problems*. London: Centre for Mental Health; 2014.

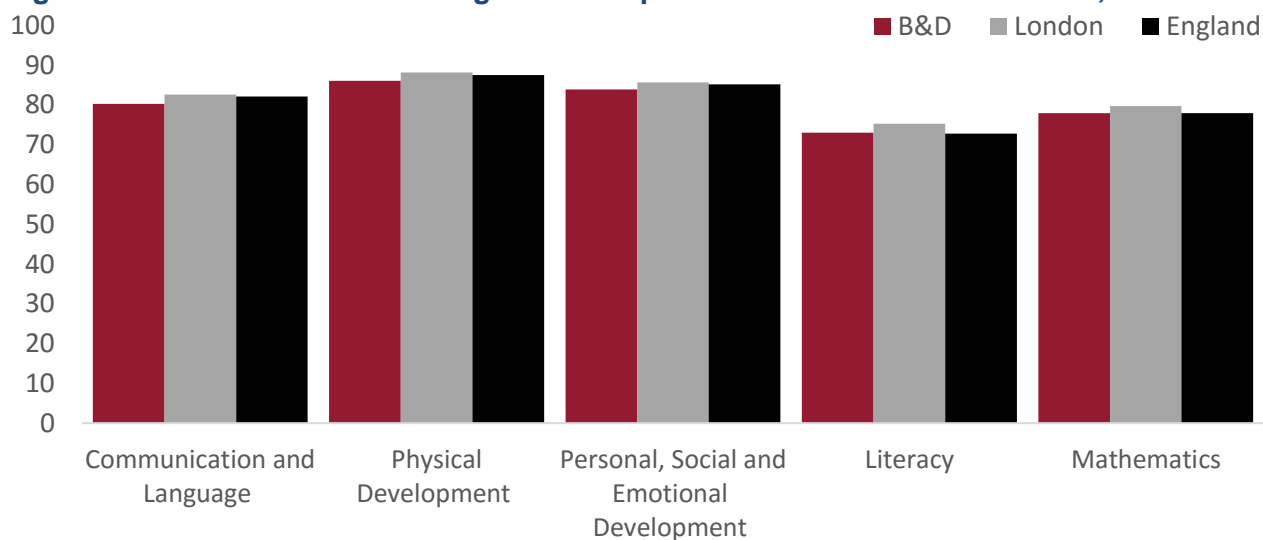
⁶⁰ See: NHS, Your baby's health and development reviews [<https://www.nhs.uk/conditions/pregnancy-and-baby/baby-reviews/>]. Accessed 2018 Oct 03.

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

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

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

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



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

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

The home learning environment is an important factor in how children develop and is more influential than parents’ incomes in determining the child’s development at age 5.⁶³ This includes parents reading to their child, doing painting and drawing, teaching them songs and nursery rhymes and visiting libraries.

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

Another important way in which children can prepare for school (and develop the skills measured above) is by attending a high quality early years education provider.⁶⁶ Almost four in five Barking and Dagenham 2 year olds who are eligible⁶⁷ from funded early education places were taking this up in January 2018.⁶⁸ This is higher than London (61%)

⁶¹ Department for Education (DfE), *Early years foundation stage profile (EYFSP) results: 2017*.

⁶² DfE, *Early years evidence pack*. [London]: DfE, 2011.

⁶³ DfE, *Early years evidence pack*. [London]: DfE, 2011.

⁶⁴ Oxford University Press. *Why Closing the Word Gap Matters: Oxford Language Report*. [Oxford]: OUP; 2018, p.4.

⁶⁵ Oxford University Press. *Why Closing the Word Gap Matters: Oxford Language Report*. [Oxford]: OUP; 2018.

⁶⁶ DfE, *Early years evidence pack*. [London]: DfE, 2011.

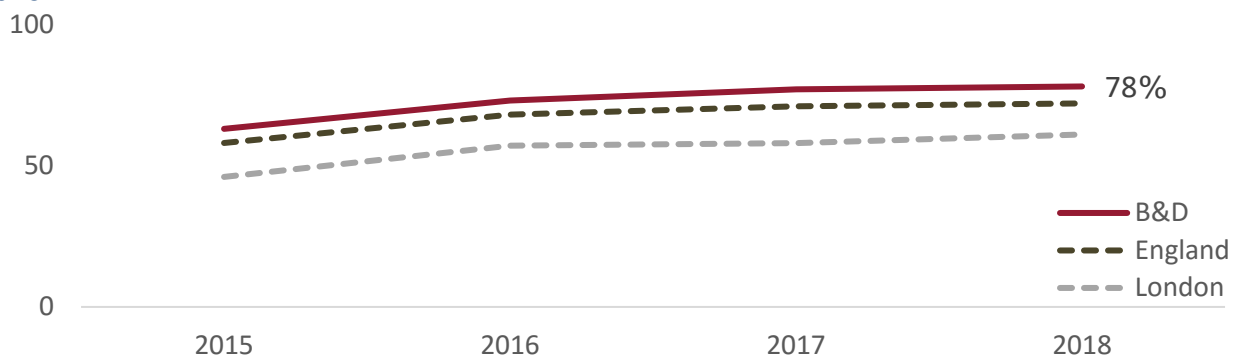
⁶⁷ Eligibility for funded childcare for 2 years olds is based on benefits that the parent(s) receive. See: Gov.UK, *Free education and childcare for 2-year-olds* [<https://www.gov.uk/help-with-childcare-costs/free-childcare-2-year-olds>]. Accessed 2018 Oct 03.

⁶⁸ DfE, *Provision for children under 5 years of age in England: January 2018*.

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

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

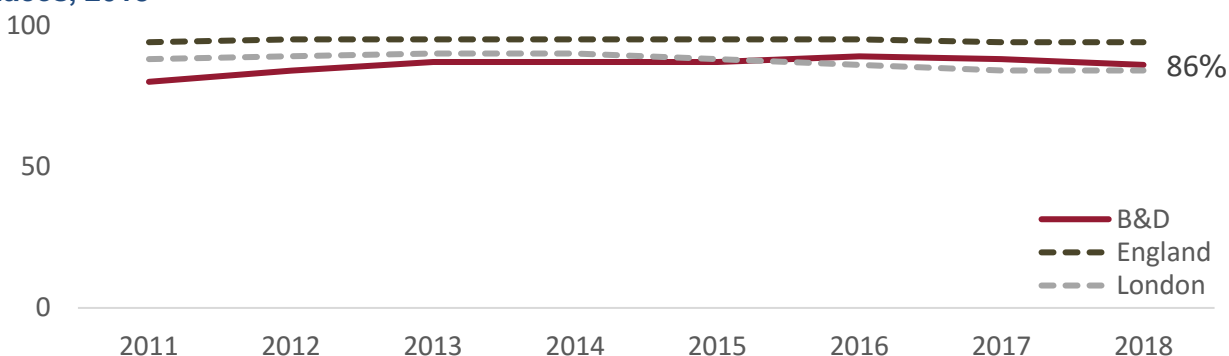
Figure 3.8: % of eligible 2-year-old children benefitting from funded early education places, 2018



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

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

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



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

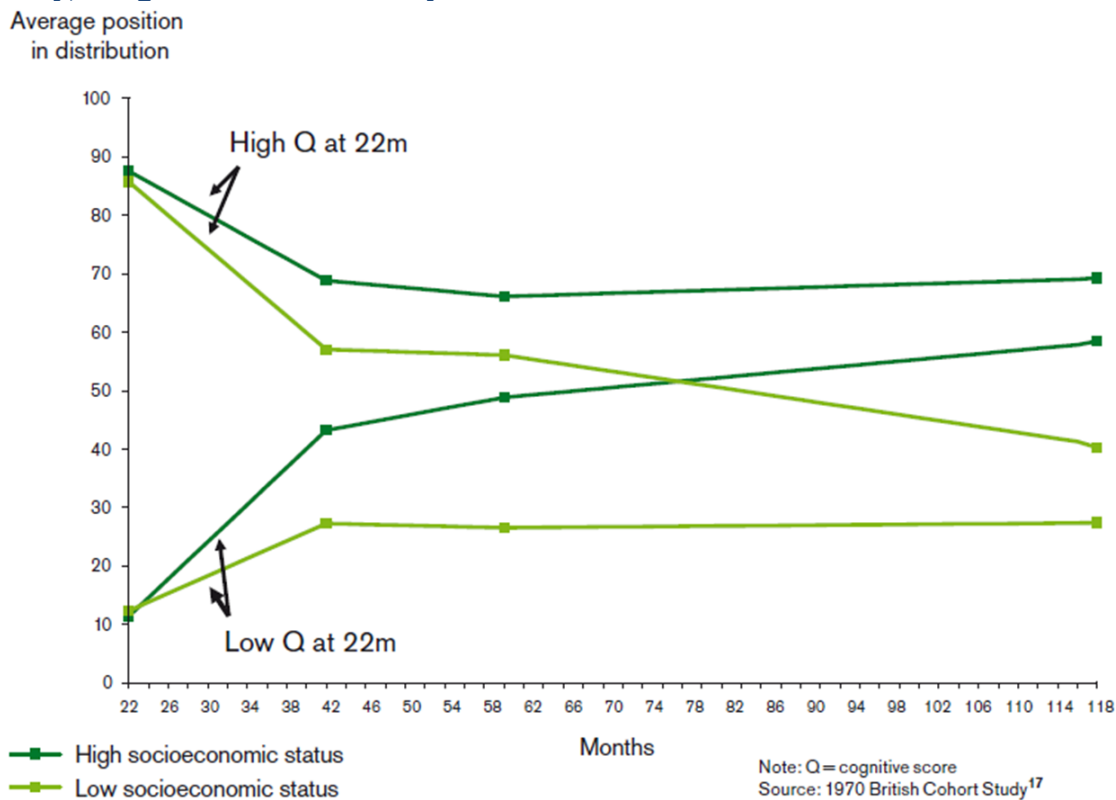
3.5.8 Wider determinants affecting children aged 0–4

Income deprivation

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

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

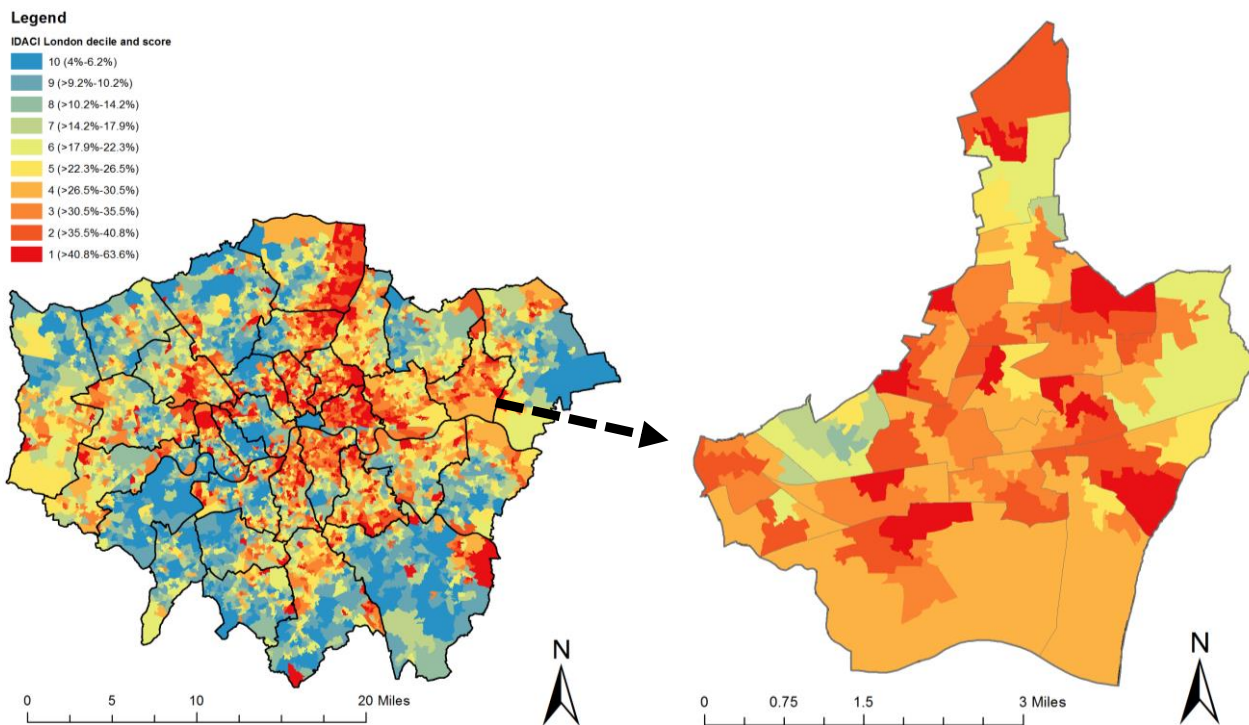
Figure 3.10: Inequality in cognitive development by children in the 1970 British Cohort Study, at ages 22 months to 10 years



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

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

Figure 3.11: Income deprivation affecting children index



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

Domestic abuse

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

Barking and Dagenham had the highest rate of domestic abuse offences in London in 2016/17 at 11.2 per 1,000.⁷² This is higher than the London average of 8.2 per 1,000.

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

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

Under 18 conceptions

Evidence suggests that babies born to teenage mothers are at a higher risk of adverse outcomes, including hospitalisation for gastroenteritis or accidental injury, and lower spatial, non-verbal and verbal ability at age 5.⁷⁵

Across 2016, there were 27.9 conceptions per 1,000 women under the age of 18.⁷⁶ This is higher than London or England (17.1 and 18.8 per 1,000 respectively). However, this is part of a long-term downward trend (Figure 3.12).

⁷⁰ Royal College of Psychiatrists. Domestic violence and abuse – its effects on children: the impact on children and adolescents: information for parents, carers and anyone who works with young people. Mental Health and Growing Up Factsheet. [<https://www.rcpsych.ac.uk/expertadvice/parentsandyouthinfo/parentscarers/domesticviolence.aspx>]. Accessed 2018 Oct 03.

⁷¹ National Institute for Health and Care Excellence. *Domestic violence and abuse: multi-agency working*. Public health guideline 50. [Manchester]: NICE; 2014.

⁷² Mayor's Office for Policing and Crime, London Landscape. [<https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/london-landscape>]. London figure is aggregate of boroughs and does not include cases not allocated to a borough.

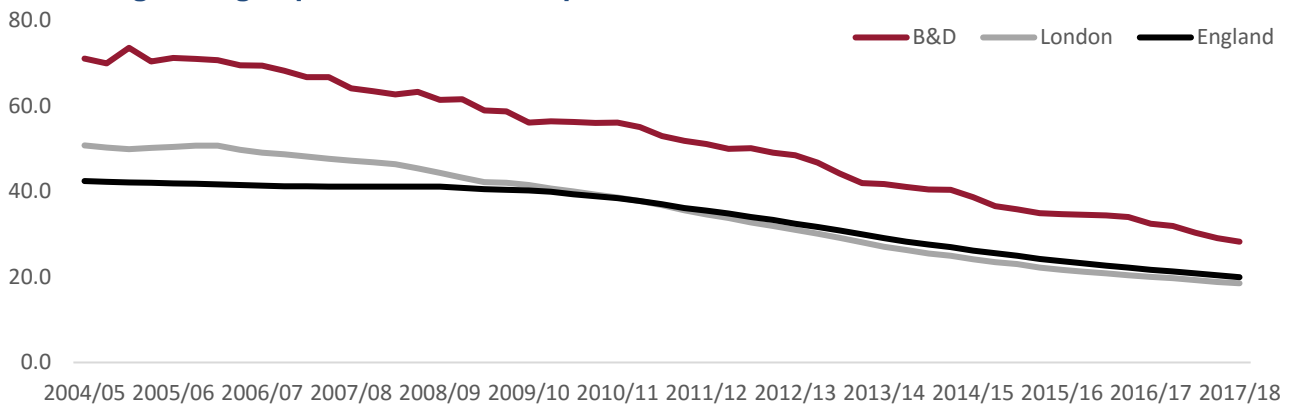
⁷³ LBBD School Survey 2017.

⁷⁴ LBBD children's social care. Duplicates from multiple assessments where the factor is duplicated removed.

⁷⁵ PHE, Local Government Association (LGA). *A framework for supporting teenage mothers and young fathers*. London: PHE, 2016.

⁷⁶ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

Figure 3.12: Under 18 conceptions per 1,000 15–17 year olds, quarterly data presented as 3-year rolling average, quarter 1 2004/5 to quarter 1 2017/18⁷⁷



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

Single parents

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

Housing and homelessness

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

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

⁷⁷ Data is presented as a 3-year rolling average; quarter 1 2004/5 relates to data from quarter 2 2001/2 to quarter 1 2004/5.

⁷⁸ ONS, *Live births by mothers' usual area of residence*, 2016.

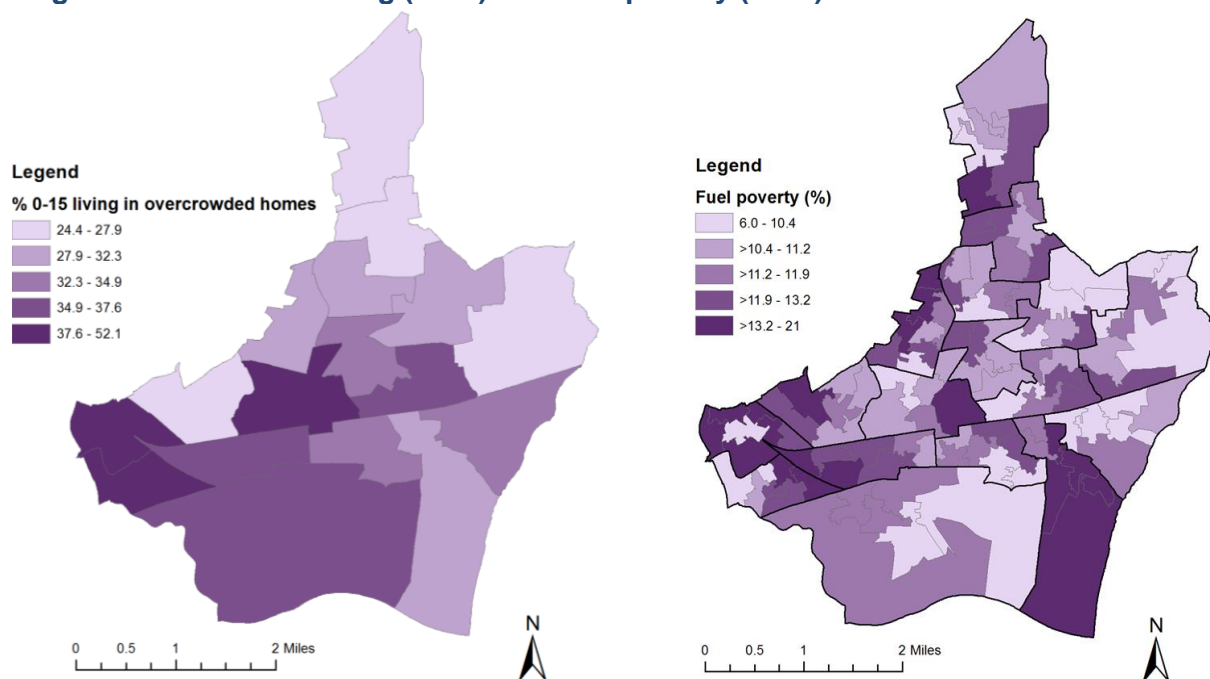
⁷⁹ Gingerbread. *Single parent statistics* [<https://www.gingerbread.org.uk/policy-campaigns/publications-index/statistics/>]. Accessed 2018 Oct 03.

⁸⁰ Scharte M, Bolte G; GME Study Group. Increased health risks of children with single mothers: the impact of socio-economic and environmental factors. *Eur J Public Health* 2013;23(3):469–75.

⁸¹ Shelter. *Chance of a lifetime. The impact of bad housing on children's lives*. London: Shelter; 2006. Note: Some outcomes are specific to overcrowding, unfit housing or homelessness.

⁸² PHE, *Public Health Outcomes Framework* [<http://www.phoutcomes.info/>]. Family homelessness = ‘Number of applicant households with dependent children or pregnant women accepted as unintentionally homeless and eligible for assistance’ per 1,000 households.

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



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

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

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

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

3.5.9 Health services

Health visiting services

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

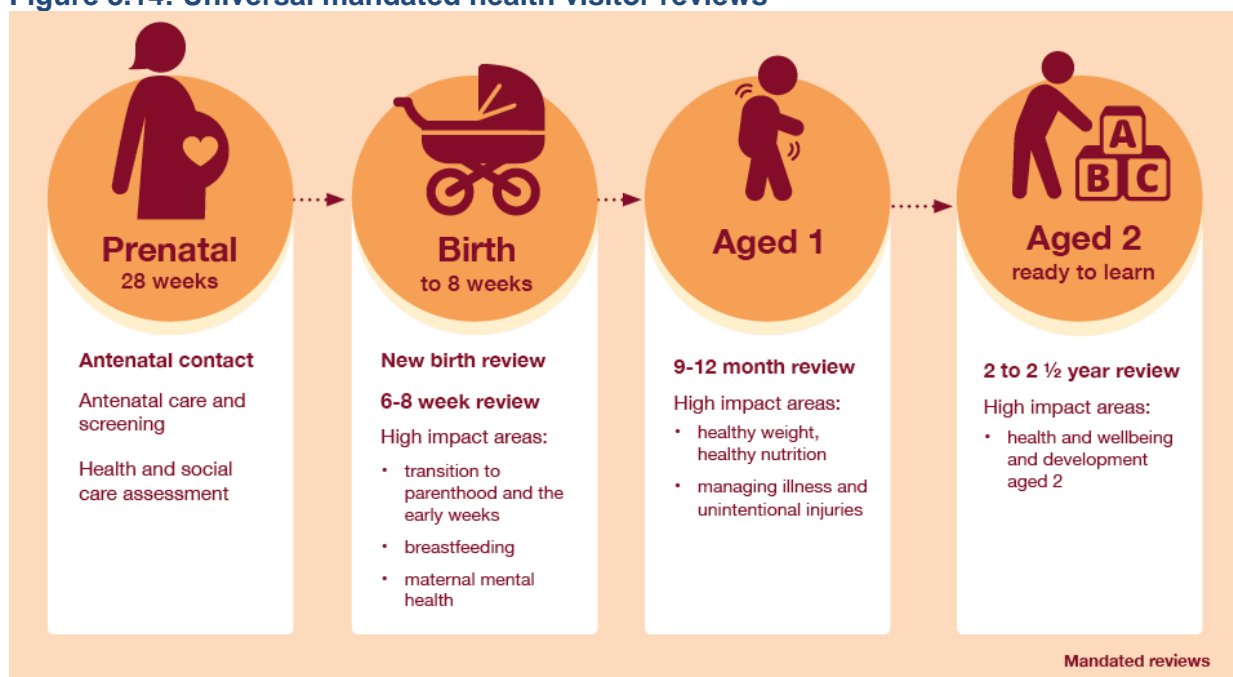
In 2017/18, 61.8% of children received a 2–2.5 year review by the age of 2.5 years, compared with 75.7% across England.⁸⁴

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

⁸³ Department for Business, Energy & Industrial Strategy, Sub-regional Fuel Poverty. England 2018 (2016 data).

⁸⁴ North East London NHS Foundation Trust [Barking and Dagenham data]; Public Health England, Health Visitor Service Delivery Metrics, 2017/18 Annual Data (October 2018 release) [England data].

Figure 3.14: Universal mandated health visitor reviews



Source: PHE.

Immunisations

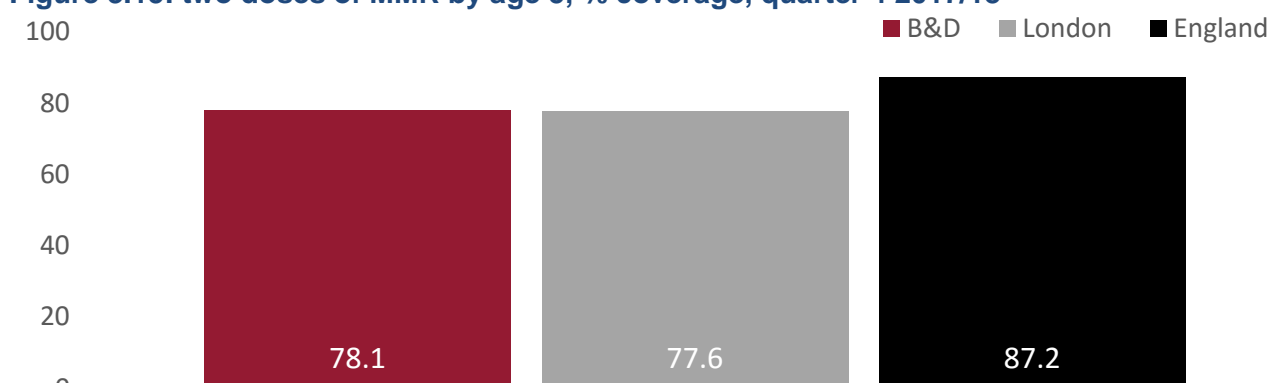
Giving children the best start in life includes protecting them from avoidable harm. Vaccinations are a simple and safe way to protect children from illnesses that can have serious consequences.

Measles, mumps and rubella

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

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

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



Data: PHE.

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

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

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

Flu

The flu vaccine has been freely available to selected age groups of children on the NHS since 2013.⁸⁶ This is both because children can be more severely affected by flu but also because of their role in the spread of flu to others.⁸⁷

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

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

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

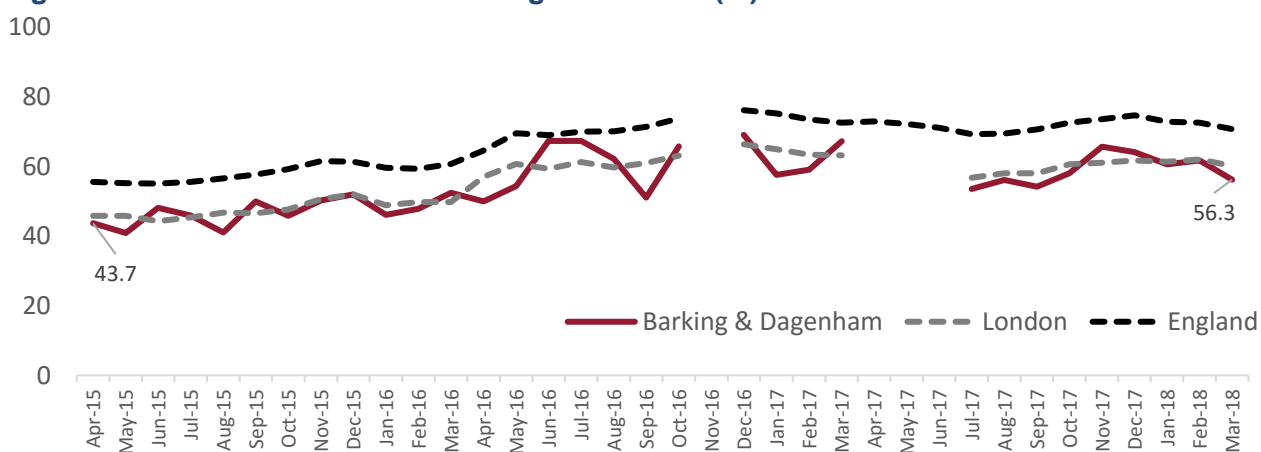
Pertussis (whooping cough) vaccine in pregnancy

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

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

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

Figure 3.16: Pertussis vaccine coverage estimates (%)⁸⁹



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

⁸⁶ PHE. *The National Childhood Flu Immunisation Programme 2018/19. Information for healthcare professionals*. London: PHE; 2018.

⁸⁷ NHS. Children's flu vaccine [<https://www.nhs.uk/conditions/vaccinations/child-flu-vaccine/>]. Accessed 2018 Oct 03.

⁸⁸ NHS. Whooping cough vaccination in pregnancy [<https://www.nhs.uk/conditions/pregnancy-and-baby/whooping-cough-vaccination-pregnant/>]. Accessed 2018 Oct 03. See also: PHE, NHS. *Whooping cough and pregnancy: Your questions answered on how to help protect your baby*. [London]: PHE, 2017.

⁸⁹ For more information on interpretation, see: PHE, Pertussis vaccination programme for pregnant women update: vaccine coverage in England, Jan-March 2018. *Health Protection Report* Volume 12 Number 27.

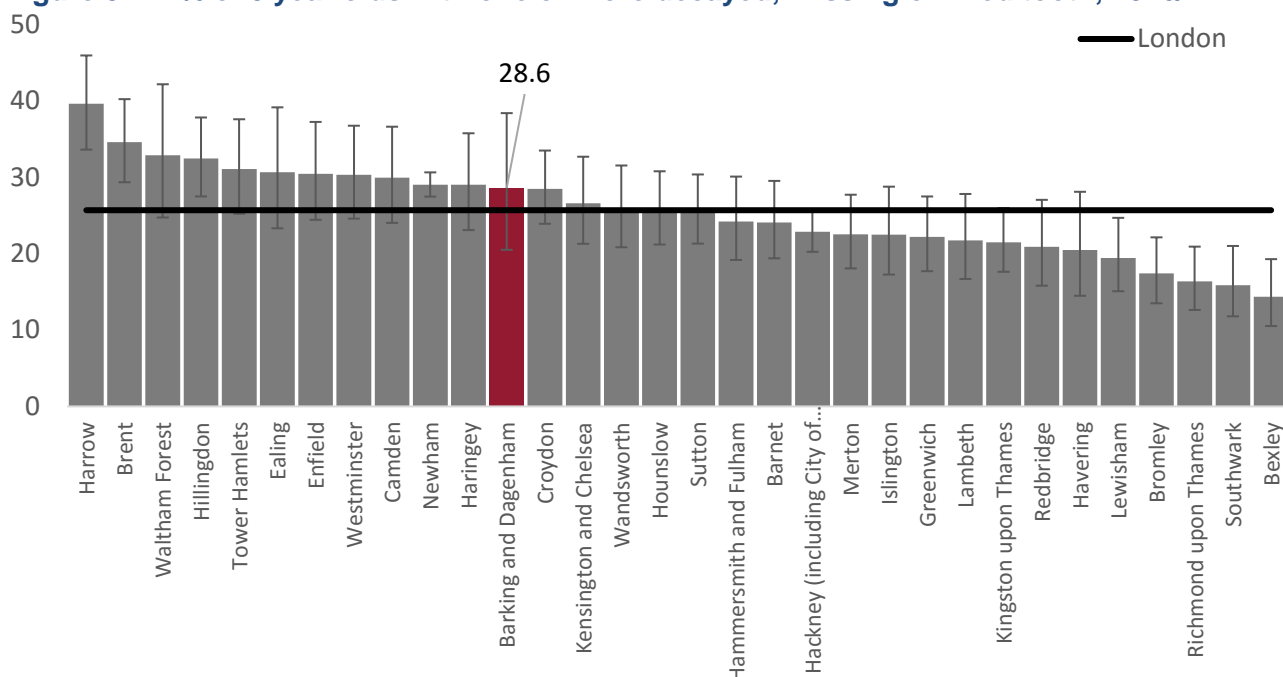
Oral health

Oral health problems such as cavities can cause children pain, difficulty eating and sleeping and time away from school.⁹⁰

18% of 3 year olds surveyed in 2013 had one or more decayed, missing or filled tooth – higher than England (11.7%) but similar to London (13.6%).⁹¹

For 5 year olds (Figure 3.17), approaching three in ten children in Barking and Dagenham surveyed in 2016/17 had one or more decayed, missing or filled tooth (28.6%), which is similar to London (25.7%) and England (23.3%).⁹² However, this still means that children are suffering unnecessarily.

Figure 3.17: % of 5 year olds with one or more decayed, missing or filled tooth, 2016/17



Data: PHE, National Dental Epidemiology Programme for England. Oral health survey of five-year-old children 2017.

Hospital admissions for dental caries (0-4 years) are lower than London but similar to England.⁹³

3.6 Conclusions

Early child development has lifelong influences and early childhood is a key time to intervene to reduce health inequalities. Best start in life is particularly important in Barking and Dagenham due to its level of deprivation and high proportion of children aged 0–4 (9.4%, the highest in the UK).

Best start in life ideally begins before conception, with preparation for a healthy pregnancy from both parents. However, nationally, around one in three births is likely to be unplanned or the mother feels ambivalent. Parents may also not understand the benefits of optimising their health prior to pregnancy or be motivated or able to do so. For example, more than half (53%) of pregnant women attending a booking appointment at BHRUT in February

⁹⁰ PHE, Health Matters: Child Dental Health [<https://publichealthmatters.blog.gov.uk/2017/06/14/health-matters-child-dental-health/>]. Accessed 2018 Oct 03.

⁹¹ PHE, Oral Health Profile [<https://fingertips.phe.org.uk/profile/oral-health/>]; 2012/13.

⁹² PHE, Child and Maternal Health profile [<https://fingertips.phe.org.uk/profile/child-health-profiles/>]. The Barking and Dagenham and England figures are classed as similar as they have overlapping confidence intervals; as this is based on a survey, there is considerable uncertainty around the 'true' population values.

⁹³ PHE, Child and Maternal Health profile [<https://fingertips.phe.org.uk/profile/child-health-profiles/>]; 2014/15-2016/17.

2018 (not specifically Barking and Dagenham residents) were overweight or obese. **Improving adult population health in areas such as excess weight and physical activity (both Borough Manifesto targets) would benefit the next generation.**

Contraception allows women to choose when or if to have a baby, but younger women are less likely than older women in Barking and Dagenham to use long-acting reversible contraceptives (LARC), despite their greater effectiveness. **Ensuring women are aware of the benefits and can access LARC may give them more control over their fertility.**

Around 1 in 13 pregnant women smoked at time of delivery in 2017/18. This is declining but is still the third highest in London. We lack data on substance misuse in pregnancy specifically, but this also has recognised harms. **Pregnancy should continue to be recognised as a key moment to intervene to help women and their partners make a long-term change.**

Substance misuse, breastfeeding and perinatal mental health are important areas where we lack good quality data; for example, in 2017/18, 53% of infants were totally or partially breastfed at 6–8 weeks, but we were missing breastfeeding data on one in five children. Similarly, we only have estimated figures of perinatal mental health conditions available to us. **We should explore how we can bring together existing sources of early years data to effectively monitor and identify inequalities and areas for improvement.**

In 2016/17, 71.6% of children achieved a 'Good level of development' in Barking and Dagenham, which is lower than London but similar to England. High quality early years education contributes to this, but one in five eligible 2 year olds is not receiving early years education that they are entitled to. **We should continue to improve take-up of funded early years places, while continuing to support parents to develop a suitable home learning environment.**

Income deprivation affecting children is widespread in Barking and Dagenham, with an estimated 32% of children living in income deprived families. Barking and Dagenham is also affected by high levels of family homeless and overcrowding. It had the highest rate of domestic abuse offences in London in 2016/17, while more than one in four children's social care assessments in 2017/18 recorded domestic abuse as a factor. Reducing domestic abuse is a Borough Manifesto priority. **The conditions in which children spend their early years are likely to have a large impact on their future health outcomes.**

The proportion of children receiving a 2–2.5-year review is lower than England. Almost four in ten Barking and Dagenham children do not receive this check by 2.5 years of age. Vaccination coverage of MMR and flu vaccines in young children is significantly lower than England. **Services should continue to find ways to identify and reach children who have not received these.**

4 Early diagnosis and intervention

4.1 What do we mean by early diagnosis and intervention?

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

4.2 Why is this important?

Many conditions are more amenable to treatment or there is improved quality of life if they are diagnosed early. There may also be benefits for families and communities, while demand for health services can be managed more effectively.

For example, prompt diagnosis and treatment for cancer can reduce mortality, while diagnosing diabetes early and effectively can reduce the likelihood of complications. Diagnosing communicable diseases early, such as sexually transmitted infections or tuberculosis, can also limit onward transmission.

The avoidable consequences of health conditions can have costs to the local economy (for example, if they result in the individual needing to take more time off work than if they had been treated early), costs to health services, costs to social care and opportunity costs.

However, there is a need to remain vigilant to harms as well as benefits, especially where we are looking to diagnose preclinical disease or considering new methods of screening, to ensure we are not overtreating individuals or causing unnecessary anxiety.⁹⁴ Ensuring that there is a clear evidence base for action is therefore important in this, as in all public health measures.

4.3 Why is this important for Barking and Dagenham?

Barking and Dagenham has the highest avoidable mortality rate in London.⁹⁵

Avoidable mortality comprises two components: preventable mortality and amenable mortality. 'Preventable' encompasses deaths that are potentially preventable through public health measures, whereas 'amenable' specifically refers to deaths that could be prevented through suitable health care.⁹⁶ Avoidable mortality includes both preventable and amenable deaths, but each death is only counted once.

Not only does Barking and Dagenham have the highest *preventable* mortality rate in London, it also has the highest *amenable* mortality rate in London, and the 13th highest of 324 areas in England. Between 2014 and 2016, 612 residents died of conditions that were potentially amenable to high quality healthcare.

This suggests that together with work around primary prevention (e.g. reducing smoking, increasing physical activity) to decrease the number of preventable deaths, there is also a need to ensure that residents experiencing illness have access to and use good quality healthcare services to avoid their condition resulting in premature death.

⁹⁴ Kale MS, Korenstein D. Overdiagnosis in primary care: framing the problem and finding solutions. *BMJ* 2018;362:k2820.

⁹⁵ ONS, Avoidable mortality in the UK: 2016.

⁹⁶ ONS, Avoidable mortality in the UK: 2016. Statistical bulletin

[<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2016>]. Accessed 2018 Oct 03. The number of avoidable deaths is derived from a list of causes of death with the age ranges they apply to; most deaths from the causes on this list are only considered preventable or amenable under the age of 75.

Three of Barking and Dagenham's five leading causes of death are considered amenable when they occur in under 75s: ischaemic heart disease, chronic lower respiratory diseases,⁹⁷ and stroke.

Furthermore, mortality is only part of the story as living with an undiagnosed or untreated illness has individual and societal costs of its own. A focus only on mortality would not address the burden of illnesses that can cause a significant reduction in quality of life, but rarely directly result in death, such as common mental health conditions.

As a further example, diagnosing HIV early reduces the risk of morbidity and transmission to others. However, in Barking and Dagenham, 52.5% of HIV infections are diagnosed late, compared with 33.7% across London and 40.1% in England.⁹⁸ This is the third highest in London (with the second highest being City of London, which is not very reliable due to the small number of cases).

4.4 What is the local picture for conditions which are amenable to early diagnosis and intervention?

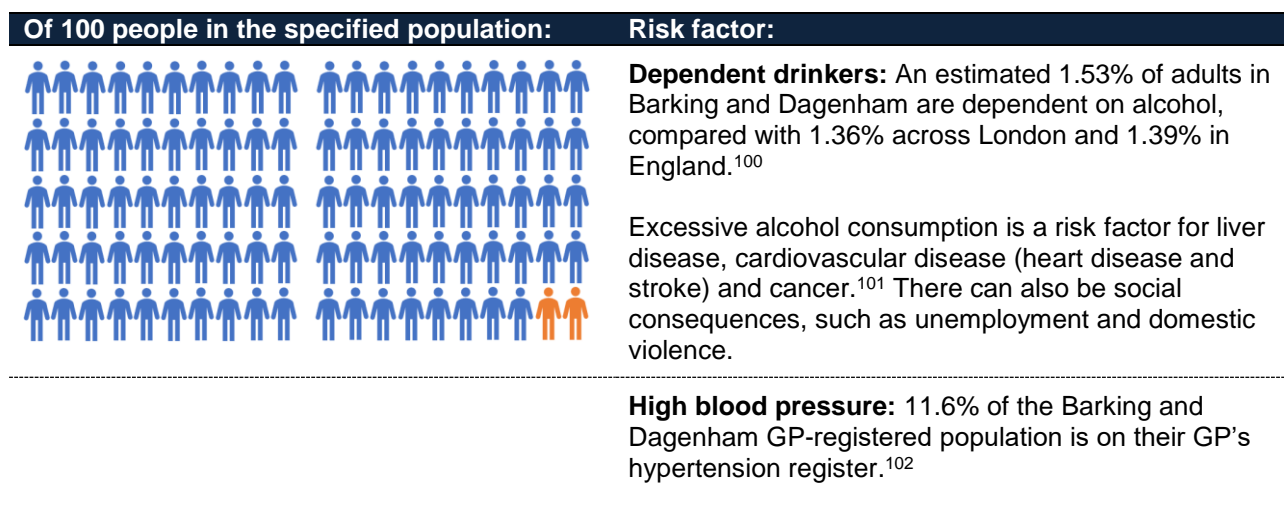
4.4.1 Lifestyle-related illnesses

A number of lifestyle factors such as smoking, excessive drinking or being obese increase the risk of poor health outcomes.

This section focuses on cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes and liver disease, since all four conditions contribute to morbidity and mortality in the borough and early diagnosis or identification of risk and intervention could improve health outcomes.

Although lifestyle factors can also increase the risk of cancer, this is considered separately below.

*Lifestyle risk factors*⁹⁹



⁹⁷ With the exception of bronchiectasis (International Classification of Diseases, tenth revision [ICD-10] code J47).

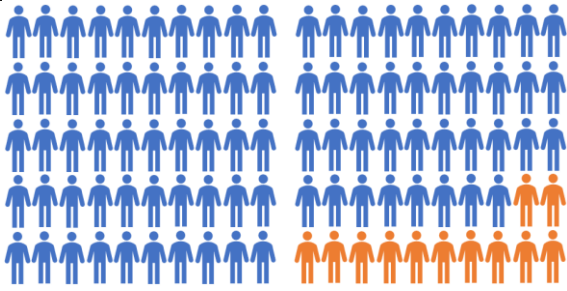
⁹⁸ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]; 2015–17.

⁹⁹ Note: percentages in infographics rounded to nearest whole person. One block = 50%, one row = 10%, one person = 1%.

¹⁰⁰ PHE, Local Alcohol Profiles for England [<https://fingertips.phe.org.uk/profile/local-alcohol-profiles>]. Note: these are modelled figures for 2014/15.

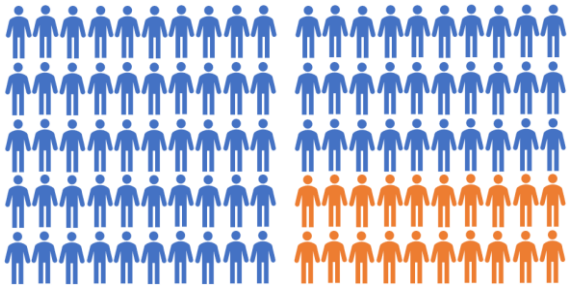
¹⁰¹ NHS. Overview: Alcohol misuse [<https://www.nhs.uk/conditions/alcohol-misuse/>]. Accessed 2018 Oct 03.

¹⁰² PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.



High blood pressure is a risk factor for cardiovascular disease, including heart disease and stroke.¹⁰³

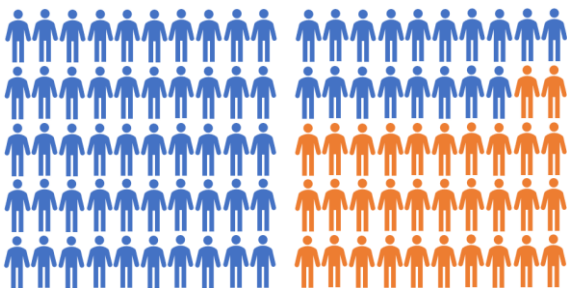
Modifiable risk factors for high blood pressure include a high salt diet, overweight/obesity, physical inactivity, smoking, and excessive alcohol intake.¹⁰⁴



Smoking: 19.9% of the Barking and Dagenham GP-registered population are smokers, compared with 17.3% in London and 17.6% across England.¹⁰⁵

This is the fifth highest in London and the 41st highest in England.

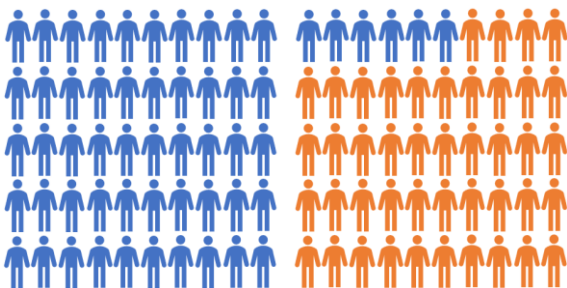
Smoking is a major risk factor for conditions including lung cancer, chronic obstructive pulmonary disease (COPD), heart disease and stroke.¹⁰⁶



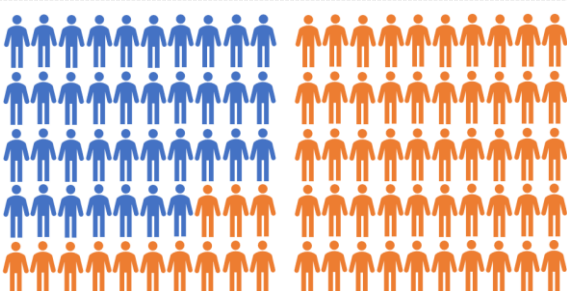
Physical inactivity: 32.1% of Barking and Dagenham adults (19+) are physical inactive (less than 30 minutes of moderate intensity exercise a week), compared with 22.9% in London and 22.2% across England.

This is the highest in London and 4th highest in England.

Physical inactivity increases the risk of conditions including heart disease, type 2 diabetes and breast cancer.¹⁰⁷



Overweight/obesity in children (age 10–11): 43.8% of Barking and Dagenham Year 6 children are overweight or obese. This is higher than London (38.5%) and similar to England (34.2%)



Overweight/obesity in adults: 62.8% of Barking and Dagenham adults are overweight or obese, compared with 55.2% in London and 61.3% across England.

This is the second highest in London and 65th highest of 152 local authorities in England.

Obesity is a risk factor for type 2 diabetes, coronary heart disease, cancer, mental health problems and stroke.¹⁰⁸

¹⁰³ NHS. Overview: High blood pressure (hypertension) [<https://www.nhs.uk/conditions/high-blood-pressure-hypertension/>]. Accessed 2018 Oct 03.

¹⁰⁴ NHS. Causes: High blood pressure (hypertension) [<https://www.nhs.uk/conditions/high-blood-pressure-hypertension/causes/>]. Accessed 2018 Oct 03.

¹⁰⁵ PHE, Local Tobacco Control Profiles [<https://fingertips.phe.org.uk/profile/tobacco-control>]. 2016/17 Quality and Outcomes Framework data.

¹⁰⁶ NHS Digital, Statistics on Smoking – England 2018 – Data tables.

¹⁰⁷ Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT; Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *Lancet* 2012;380(9838):219–29.

¹⁰⁸ NHS. Overview: Obesity [<https://www.nhs.uk/conditions/obesity/>]. Accessed 2018 Oct 03.

Cardiovascular disease is a general name for a group of conditions affecting the heart and blood vessels that includes coronary heart disease and stroke.

Prevalence

Coronary heart disease (also known as ischaemic heart disease) is relatively common; 1 in 53 (1.9%) patients registered with a Barking and Dagenham GP is on their GP's coronary heart disease register.¹⁰⁹ As this is across all age groups, but we would not expect children and young people to have these conditions, the prevalence in the age groups where this typically occurs will be much higher.

Based on modelled estimates, we would expect around 9.6% of adults aged 55–79 in Barking and Dagenham to have coronary heart disease.¹¹⁰ This is estimated to be the second highest in London.

Around 1 in 111 (0.9%) patients registered with a Barking and Dagenham GP is on their GP's stroke and transient ischaemic attack (TIA) register.¹¹¹

The modelled estimated prevalence of stroke in adults aged 55–79 in Barking and Dagenham is 3.8%.¹¹² This is estimated to be the highest in London.

Both coronary heart disease and stroke are leading causes of death in Barking and Dagenham; 13.7% of deaths in men and 9.3% of deaths in women between 2014 and 2016 were due to ischaemic heart diseases (around 85 and 60 deaths each year respectively).¹¹³ A further 5.3% of deaths in men and 5.7% of deaths in women were due to stroke (around 35 and 40 deaths each year respectively).

Early diagnosis and intervention

Early diagnosis and intervention in this context can include assessing risk and making changes based on this. It also includes the effective diagnosis and treatment of those presenting with symptoms.

Cardiovascular disease risk is calculated as part of the NHS Health Check that should be offered to all 40–74 year olds without pre-existing long-term conditions every 5 years. Based on risk score and findings, patients may be offered lifestyle advice (including referral to any relevant weight management/physical activity programmes) or medication.

5,862 people received an NHS Health Check in 2017/18. Between 2013/14 and 2017/18, 55.6% of the eligible population had a health check, compared with 49.3% in London and 44.3% across England.¹¹⁴

Good cardiovascular health may reduce the risk of vascular dementia and Alzheimer's disease in later life¹¹⁵ and hence an early assessment of risk and support to make changes could also be an early intervention to prevent these conditions.

¹⁰⁹ PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.

¹¹⁰ PHE, Modelled prevalence estimates profile [<https://fingertips.phe.org.uk/profile/prevalence>]. Estimate is for 2015.

¹¹¹ PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.

¹¹² PHE, Modelled prevalence estimates profile [<https://fingertips.phe.org.uk/profile/prevalence>]. Estimate is for 2015.

¹¹³ ONS via Nomis, Mortality statistics - underlying cause, sex and age.

¹¹⁴ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

¹¹⁵ NHS. Overview: Vascular dementia [<https://www.nhs.uk/conditions/vascular-dementia/>]. Accessed 2018 Oct 04; NHS. Overview: Alzheimer's disease [<https://www.nhs.uk/conditions/alzheimers-disease/>]. Accessed 2018 Oct 04.

Chronic obstructive pulmonary disease (COPD)

Chronic obstructive pulmonary disease (COPD) is a respiratory condition characterised by varying degrees of chronic bronchitis (inflammation of the airways) and emphysema (damaged air sacs in the lungs).¹¹⁶ It is primarily caused by smoking.

Prevalence

Around 1 in 63 people registered with a Barking and Dagenham GP (1.6%) have been diagnosed with COPD.¹¹⁷ This is the third highest prevalence in London despite the fact that this is a non-age standardised measure and COPD is rarely diagnosed in the younger age groups that make up the majority of our population.

Furthermore, modelled estimates suggest that the prevalence of COPD across all age groups is 2.4% in Barking and Dagenham, or 1 in 42.¹¹⁸

This suggests that only two in three people living with COPD have a recorded diagnosis.

Barking and Dagenham has the highest age-standardised COPD mortality rate in London and the 15th highest (of 150 local authorities) in England.¹¹⁹

Early diagnosis and intervention

Although COPD cannot be cured, the loss of lung function can be slowed, and hence early diagnosis is important.¹²⁰ If the patient smokes, stopping smoking is a key intervention and ensuring that GPs are able to effectively communicate the specific benefits of quitting to COPD patients and know how to refer or signpost them to smoking cessation services who can support them to quit is important.

We can also look at treatment and outcomes for those with a diagnosis. In 2016/17, 82.7% of patients with COPD registered with a Barking and Dagenham GP had a review by a medical professional in the last year, compared with 84.0% in London and 80.1% in England.¹²¹

As people with COPD are a high-risk group for flu, they are offered this free annually. However, only three-quarters (76.5%) of people with COPD took this up in 2016/17, which is similar to London (76.9%) but higher than England (79.2%).¹²²

Barking and Dagenham has the second highest age-standardised rate of emergency COPD hospital admissions in London and the 18th highest (of 148 local authorities) in England.¹²³ Although this reflects in part the high prevalence of COPD in Barking and Dagenham, suitable diagnosis and management should reduce the need for emergency admission.

¹¹⁶ NHS. Overview: Chronic obstructive pulmonary disease (COPD) [<https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/>]. Accessed 2018 Oct 04.

¹¹⁷ PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.

¹¹⁸ PHE, Modelled prevalence estimates profile [<https://fingertips.phe.org.uk/profile/prevalence>]. Estimate is for 2015.

¹¹⁹ PHE, Local Tobacco Control Profiles [<https://fingertips.phe.org.uk/profile/tobacco-control>]; 2014-16.

¹²⁰ NHS. Overview: Chronic obstructive pulmonary disease (COPD) [<https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/>]. Accessed 2018 Oct 04.

¹²¹ PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.

¹²² PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.





¹²³ PHE, Local Tobacco Control Profiles [<https://fingertips.phe.org.uk/profile/tobacco-control>]; 2016/17, 35+.

Diabetes

Diabetes is a condition where the body is unable to regulate (or effectively regulate) its blood sugar levels.

Although this is in the 'lifestyle related illnesses' section, there are important non-modifiable risk factors for diabetes, notably ethnicity, age and family history.

Table 4.1: Types of diabetes, risk factors, treatment and potential complications

	Type 1	Type 2	Gestational diabetes (GDM)
 <i>Pathway</i>	Autoimmune – no insulin produced by body	Insufficient insulin produced or insufficient response to it	Insufficient insulin produced during pregnancy
 <i>Risk factors</i>	Family history	Obesity Age Family history Ethnicity	Obesity Previous GDM Family history of diabetes Ethnicity
 <i>Treatment</i>	Insulin injections or pump	Lifestyle changes, medication and/or insulin	As type 2
 <i>Complications</i>	Heart disease/stroke Sight loss Kidney disease Risks to mother/baby during pregnancy	Nerve damage Foot problems/amputation Sexual dysfunction	Risks in pregnancy, increased risk of type 2 diabetes afterwards

Source: Compiled from information on NHS website.¹²⁴

Prevalence

Overall, around 1 in 13 adults (aged 17 and above) registered with a Barking and Dagenham GP have diabetes (7.9%).¹²⁵ However, closer to 1 in 11 people (9.2%, 16+) are estimated to be living with diabetes. This means that a substantial proportion of people with diabetes may be undiagnosed.

Most diagnosed diabetes in Barking and Dagenham is type 2 diabetes (4% type 1; 85% type 2; 11% unspecified).¹²⁶

Diabetes has a strong relationship with both ethnicity and age. For example, among the Barking and Dagenham GP-registered population, the age-standardised diabetes rate in the Asian population is 2.5 times higher than in the White population.¹²⁷ People of Black and Mixed ethnicity also have significantly higher age-standardised diabetes rates than the CCG average. Nonetheless, 45% of people with diabetes registered with a Barking and Dagenham GP are White as this is the predominant ethnic group in the older population, in whom diabetes is more common.

Early diagnosis and intervention

If not diagnosed and managed effectively, diabetes can lead to complications that include sight loss and amputations.

¹²⁴ NHS. Understanding medication: Type 2 diabetes [<http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Treatment.aspx>]. Accessed 2018 Oct 04; NHS. Type 1 diabetes [<http://www.nhs.uk/conditions/Diabetes-type1/Pages/Introduction.aspx>]. Accessed 2018 Oct 04; NHS. Diabetes [<http://www.nhs.uk/Conditions/Diabetes/Pages/Diabetes.aspx>]. Accessed 2018 Oct 04. NHS. Overview: Gestational diabetes [<http://www.nhs.uk/Conditions/gestational-diabetes/Pages/Introduction.aspx>]. Accessed 2018 Oct 04. NHS. Diabetes and pregnancy [<http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/diabetes-pregnant.aspx>]. Accessed 2018 Oct 04.

¹²⁵ PHE, Cardiovascular Disease profile [<https://fingertips.phe.org.uk/profile/cardiovascular>].

¹²⁶ Health Analytics, September 2017. Directly age standardised rate based on Barking and Dagenham GP-registered population.

¹²⁷ Health Analytics, September 2017.

The National Diabetes Prevention Programme has been in operation across Barking and Dagenham, Havering and Redbridge since July 2018 and the aim is to refer 150 eligible people a month (across the patch).

For those with a diabetes diagnosis, nine annual care processes are recommended, of which eight are carried out in primary care.¹²⁸ It is also recommended that when patients attend a structured education programme following their diagnosis.

In 2016/17, 96.8% of people with type 2 diabetes registered with a Barking and Dagenham GP received a blood pressure check, 91.3% received a cholesterol check, and 89.3% received an annual foot check. Around half of people with type 2 diabetes received all eight care processes in 2016/17 (48.4%).

Figure 4.1: Annual care processes for people with diabetes

Nine Annual Care Processes for all people with diabetes aged 12 and over	
Responsibility of Diabetes Care providers (included in the NDA 8 Care Processes)	
1. HbA1c (blood test for glucose control)	5. Urine Albumin/Creatinine Ratio (urine test for early kidney disease)
2. Blood Pressure (measurement for cardiovascular risk)	6. Foot Risk Surveillance (foot examination for foot ulcer risk)
3. Serum Cholesterol (blood test for cardiovascular risk)	7. Body Mass Index (measurement for diabetes management)
4. Serum Creatinine (blood test for kidney function)	8. Smoking History (question for cardiovascular risk)
Responsibility of NHS Diabetes Eye Screening (screening register drawn from practices)	
9. Digital Retinal Screening (photographic eye test for diabetic eye disease)	

Source: Reproduced from NHS Digital. National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report. [Leeds]: NHS Digital; 2017, p.4.

There are also three treatment targets, consisting of specific thresholds for HbA1c, blood pressure and cholesterol.¹²⁹ In 2016/17, four in ten people with type 2 diabetes (39.0%) achieved all three treatment targets, which is significantly worse than England.¹³⁰

In terms of known complications, between 2014/15 and 2016/17, 18 Barking and Dagenham residents (aged 12+) were issued with a Certification of Visual Impairment due to diabetic eye disease.¹³¹ This equated to a rate of 3.1 per 100,000 in 2016/17, which is similar to London and England.

Furthermore, Barking and Dagenham had the highest rate of minor diabetic lower-limb amputation procedures (amputations of the foot or toe) in London in 2014/15–2016/17, and the sixth highest rate of major diabetic lower-limb amputation procedures (amputations above the ankle).¹³² This corresponds to 102 and 21 procedures respectively over this three-year period. The rate of minor lower-limb amputation procedures is increasing in Barking and Dagenham.

¹²⁸ NHS Digital. [National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report](#). [Leeds]: NHS Digital; 2017.

¹²⁹ NHS Digital. [National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report](#). [Leeds]: NHS Digital; 2017.

¹³⁰ PHE, Diabetes profile [<https://fingertips.phe.org.uk/profile/diabetes-ft>].

¹³¹ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

¹³² PHE, Diabetes profile [<https://fingertips.phe.org.uk/profile/diabetes-ft>].

Liver disease refers to a range of conditions affecting the liver, affecting its ability to function due to inflammation (hepatitis) or scarring (cirrhosis). Most liver disease is caused by alcohol, obesity or viral hepatitis, and is hence preventable.

Prevalence

In 2014–16, there were 82 deaths from liver disease in under 75s in Barking and Dagenham, of which 70 were considered preventable (85%).¹³³ Barking and Dagenham has the sixth highest mortality rate from liver disease in under 75s, and the seventh highest rate for preventable liver disease.

Under 75 mortality from liver disease is substantially higher in men than in women, with 13.3 per 100,000 deaths in females in 2014–16 compared with 30.2 per 100,000 in males.¹³⁴

Early diagnosis and intervention

In its early stages, liver disease is reversible, but liver disease may not be symptomatic until it is at a late stage. However, as the risks to the liver from drinking are well documented, ensuring that individuals understand whether they are drinking at a hazardous level and have support to cut down and stop drinking would comprise a form of early intervention.

Barking and Dagenham commission substance misuse services for both adults and young people. In 2017/18, 334 adults were in treatment solely for alcohol misuse and around half of these successfully completed treatment (49.1%).¹³⁵

As liver disease may be asymptomatic, a different approach may be to screen patients with risk factors using a fibroscanner. Diagnosis via fibroscanner has been costed at £2,138 per quality-adjusted life year (QALY) for non-alcohol fatty liver disease and £6,537 per QALY for alcoholic liver disease. This is cost-effective as per NICE guidelines (up to £20–30,000 per QALY).¹³⁶

People who inject drugs are at increased risk of Hepatitis B and C infection, as this can be spread through the sharing of needles. Just under nine in ten (88.0%) eligible people in drug misuse treatment who inject drugs received a Hepatitis C test in 2016/17.¹³⁷ This has declined from 95.3% in 2014/15.

At-risk individuals can also be vaccinated against Hepatitis B, but only 5.9% of eligible person entering drug misuse treatment in Barking and Dagenham in 2016/17 completed a course of Hepatitis B vaccination, which is significantly worse than London.¹³⁸ The percentage completing has declined in the last 3 years from 27.5% in 2014/15 to 14.0% in 2015/16 to 5.9% in 2016/17.

¹³³ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

¹³⁴ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>]. Age-standardised rate – cannot be directly applied back to Barking and Dagenham population.

¹³⁵ National Drug Treatment Monitoring System.

¹³⁶ York Health Economics Consortium. *NHS Innovation Accelerator. Economic Impact Evaluation Case Study: Liver Disease Diagnostic Pathway*. York: YHEC; 2018 [<https://nhsaccelerator.com/wp-content/uploads/2018/03/Scarred-Liver-Pathway-Economic-Case-Study.pdf>]; Tanajewski L, Harris R, Harman DJ, Aithal GP, Card TR, Gkoutouras G, et al. *Economic evaluation of a community-based diagnostic pathway to stratify adults for non-alcoholic fatty liver disease: a Markov model informed by a feasibility study*. *BMJ Open* 2017;7(6):e015659; National Institute for Health and Care Excellence. The scarred liver project: a new diagnostic pathway to detect chronic liver disease across primary and secondary care [<https://www.nice.org.uk/sharedlearning/the-scarred-liver-project>]. Accessed 2018 Oct 05; The King's Fund. Early diagnosis of chronic liver disease [<https://www.kingsfund.org.uk/publications/innovation-nhs/early-diagnosis-chronic-liver-disease>]. Accessed 2018 Oct 05.

¹³⁷ PHE, Liver disease profiles [<https://fingertips.phe.org.uk/profile/liver-disease/>].

¹³⁸ PHE, Liver disease profiles [<https://fingertips.phe.org.uk/profile/liver-disease/>].

4.4.2 Cancer

Early diagnosis of cancer can give patients more effective treatment options and can increase chances of survival.

Incidence, mortality and survival

Incidence

Crudely, by number of new cases in 2014–16, the five most commonly diagnosed cancers in Barking and Dagenham were lung cancer (350), breast cancer (345), prostate cancer (270), bowel cancer (240) and leukaemia (85).¹³⁹

Barking and Dagenham has a significantly higher age-standardised incidence of lung cancer compared with England; rates for the other four cancer types are similar to England.

Mortality

Crudely, by number of deaths in 2014–16, the five most common cancer causes of death in Barking and Dagenham were lung cancer (285), bowel cancer (95), breast cancer (75), pancreatic cancer (55) and prostate cancer (50).¹⁴⁰

Barking and Dagenham has a significantly higher age-standardised lung cancer mortality rate compared with England; rates for the other four cancer types are similar to England.

Barking and Dagenham has the highest rate of deaths from cancers considered preventable in London (17th highest of 150 local authorities in England), which is likely to be related to the high lung cancer mortality, since this is considered a preventable cancer due to its association with smoking.

Survival

In Barking and Dagenham, 94.0% of those diagnosed with breast cancer in 2015 were alive 12 months after their diagnosis, which is significantly worse than the England average of 96.7%.¹⁴¹

1-year survival rates for bowel cancer and lung cancer in Barking and Dagenham are similar to England. Of those diagnosed with bowel cancer in 2015, 78.5% were alive 12 months after diagnosis, and of those diagnosed with lung cancer in 2015, 38.3% were alive 12 months after diagnosis.

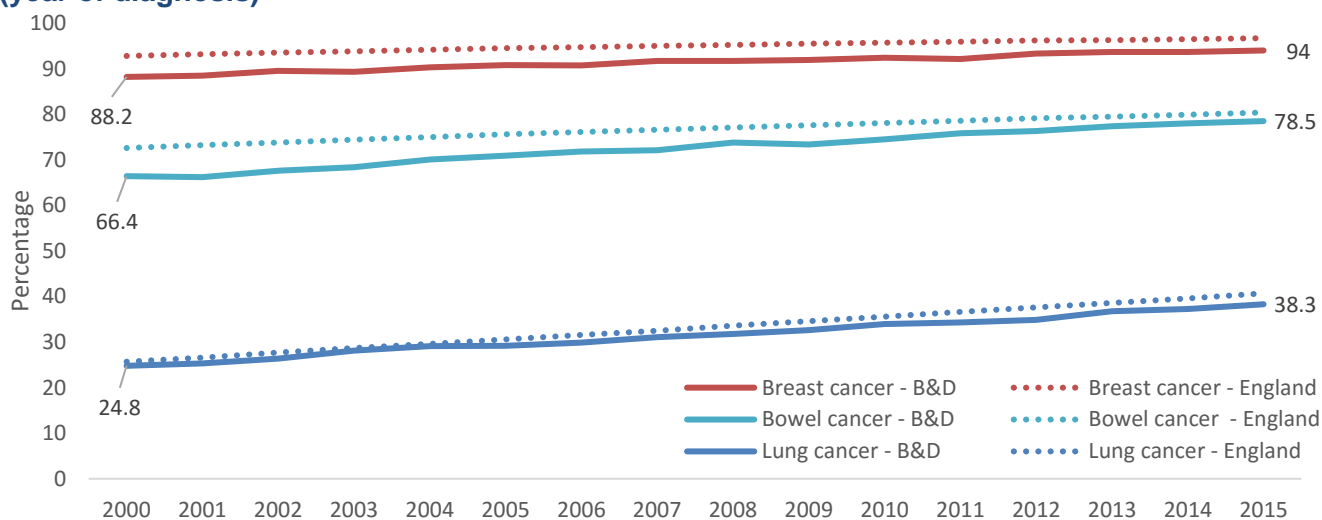
1-year survival rates have increased over the last 15 years, particularly for lung cancer, and the gap between Barking and Dagenham and England survival rates for breast cancer and bowel cancer has narrowed, although the former is still significantly lower in Barking and Dagenham compared with England.

¹³⁹ PHE, CancerData [<https://www.cancerdata.nhs.uk/>]. 2014-16. Numbers rounded to nearest 5. Breast cancer figures are for women only, since the incidence rate is only available for women.

¹⁴⁰ PHE, CancerData [<https://www.cancerdata.nhs.uk/>]. 2014-16. Numbers rounded to nearest 5. Breast cancer figures are for women only, since the mortality rate is only available for women.

¹⁴¹ ONS, [Cancer survival in Clinical Commissioning Groups, England: Adults diagnosed between 2000 and 2015 and followed up to 2016](#).

Figure 4.2: 1-year survival for lung cancer, bowel cancer and breast cancer, 2000–2015 (year of diagnosis)



Data: ONS, *Cancer survival in Clinical Commission Groups, England: Adults diagnosed between 2000 and 2015 and followed up to 2016*.

Early diagnosis and intervention

Screening

Of these cancers with a high incidence and/or mortality, breast cancer and bowel cancer have national screening programmes. There is also a national cervical screening programme.

Barking and Dagenham has one of the worst bowel cancer screening coverages in England. The most recent data (snapshot at end of December 2017) showed that 42.1% of eligible residents had been adequately screened in the last 2.5 years, compared with 49.9% in London and 58.9% across England.¹⁴² This is the third lowest coverage in both London and England.

Breast cancer screening coverage is significantly lower than London and England.¹⁴³ At the end of March 2017, 67.8% of eligible women had been adequately screened in the last 3 years, compared with 69.4% in London and 75.3% across England.

Cervical cancer screening coverage is also a cause for concern; at the end of March 2017, 67.0% of eligible women had been adequately screened in the previous 3.5 or 5.5 years (depending on their age).¹⁴⁴ This is significantly higher than London (65.7%) but significantly lower than England (72.0%) and has shown a consistent decline over the past 4 years.

Stage at diagnosis

Cancers are typically classified using a staging system that indicates the size of the tumour and extent of its spread.¹⁴⁵ Cancers diagnosed at an earlier stage are associated with increased 1-year survival, although the relationship between stage and survival depends on the cancer type.¹⁴⁶

¹⁴² PHE, [Young person and adult screening KPI data: Q3 \(1 October 2017 to 31 December 2017\)](#).

¹⁴³ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

¹⁴⁴ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

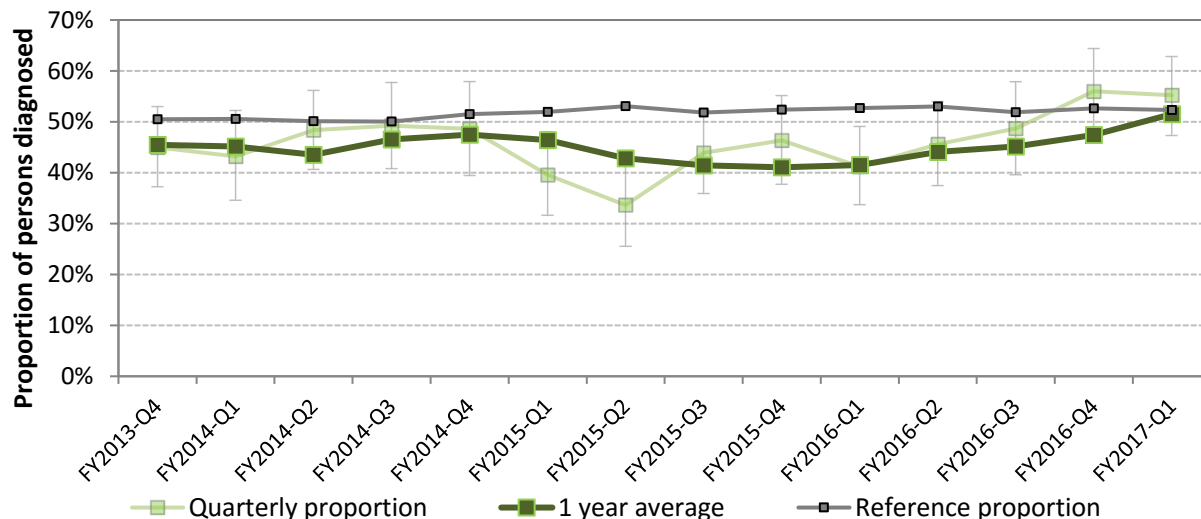
¹⁴⁵ Cancer Research UK. Stages of cancer [<https://www.cancerresearchuk.org/about-cancer/what-is-cancer/stages-of-cancer/>].

Accessed 2018 Oct 04.

¹⁴⁶ PHE. [Stage at diagnosis 2012-2014 and one-year cancer survival in England](#). National cancer registration and analysis service briefing. [London]: PHE; 2016. See also: McPhail S, Johnson S, Greenberg D, Peake M, Rous B. [Stage at diagnosis and early mortality from cancer in England](#). *Br J Cancer* 2015;112 Suppl 1:S108–15.

In Barking and Dagenham, 51.5% of cancers were diagnosed at stages 1 or 2 (12-month rolling average to end of December 2017), similar to the figure for England (52.5%).¹⁴⁷ As Figure 4.3 shows, the gap between Barking and Dagenham and England has decreased in the last few years. Furthermore, this data is not adjusted for case mix; as Barking and Dagenham has a higher incidence of lung cancer and lung cancer is typically diagnosed at a late stage (64.8% of cases were diagnosed at stages 3 or 4 in Barking and Dagenham between 2014 and 2016¹⁴⁸), we might expect the proportion to be higher.

Figure 4.3: Proportion diagnosed at early stage (stage 1 or 2): NHS Barking and Dagenham, reference: England

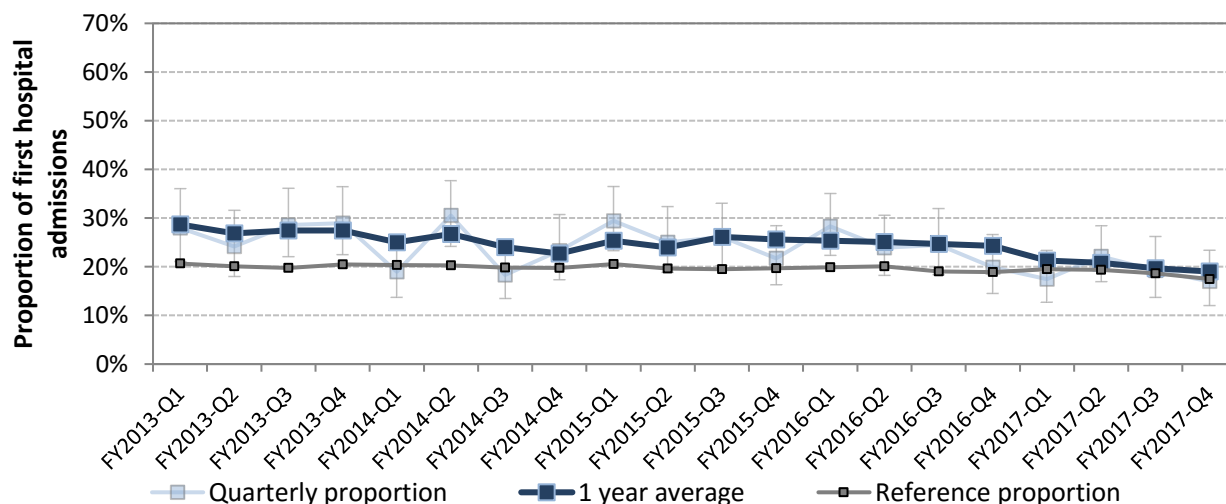


Source: PHE, Cancer Outcomes: Stage at Diagnosis. August 2018.

Presentation route

In Barking and Dagenham, 19.0% of cancers first presented as an emergency (12-month rolling average to end of March 2018), which is only slightly higher than the figure for England (17.5%). While the proportion at England level has remained fairly constant over time, this figure has been decreasing in Barking and Dagenham.

Figure 4.4: The estimated proportion of all malignant cancers (excluding non-melanoma skin cancer) which present as an emergency: NHS Barking and Dagenham, reference: England



Source: PHE, Cancer Outcomes: Emergency Presentations.

¹⁴⁷ PHE, [Cancer Outcomes: Stage at Diagnosis. August 2018.](#)

¹⁴⁸ PHE, National Cancer Registration and Analysis Service. [TNM stage group by CCG by tumour type for 10+3 tumour types. 2016.](#)

Referral

96.7% of patients registered with a Barking and Dagenham GP urgently referred due to suspected cancer saw a specialist within 2 weeks in the 12 months to end of June 2018, compared with 93.5% across England and an operational standard of 93%.¹⁴⁹

The target for referral to treatment is not being met locally, with more than one in five patients registered with a Barking and Dagenham GP not receiving their first cancer treatment within 62 days of urgent GP referral (78.1%, 2017/18) compared with an England average of 82.1% and an operational standard of 85%.¹⁵⁰

4.4.3 Mental health

Early diagnosis of mental health conditions supports better outcomes for the individual and those around them.

Common mental illnesses

'Common mental illnesses' include conditions such as depression, anxiety, obsessive-compulsive disorder (OCD) and phobias.

Their label as 'common' rather than 'serious' does not mean that they cannot cause severe harm and disruption to the lives of those they affect and those around them.

Prevalence

Mental health disorders are common, but we lack good quality data; not all of those experiencing a condition seek medical help. For population prevalence (rather than just those who have sought medical advice), we are reliant on modelled estimates and survey data:

- For children (5–16), estimates suggest that around one in ten (10.3%) residents experience mental health disorders locally.¹⁵¹
- For adults (16–74), estimates suggest that around one in six patients registered with a Barking and Dagenham GP (15.7%) experience a common mental disorder at any given point in time.¹⁵²

Furthermore, based on healthcare and survey data:

- Around 1 in 19 people registered with a Barking and Dagenham GP have been diagnosed with depression and are on their practice's depression register (5.4%).
- In the 2018 GP Patient Survey, 6.0% of respondents in Barking and Dagenham reported having a long-term mental health condition; this could include both 'common' and 'serious' mental illnesses.¹⁵³

Early diagnosis and intervention

Based on what we know about the prevalence of common mental health disorders in the community compared with the prevalence of diagnosed conditions, recognising and diagnosing mental health disorders, and ensuring residents recognise when they should seek medical advice, and feel able to do so, is important.

¹⁴⁹ NHS England, [Waiting Times for Suspected and Diagnosed Cancer Patients: Commissioner Based. Quarter One 2018-2019.](#)

¹⁵⁰ NHS England, [Waiting Times for Suspected and Diagnosed Cancer Patients: Commissioner Based. Quarter One 2018-2019.](#)

¹⁵¹ PHE, Children and Young People's Mental Health and Wellbeing [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh>]. Estimate is for 2015.

¹⁵² PHE, Common Mental Health Disorders [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders>]. Estimate is for 2014/15

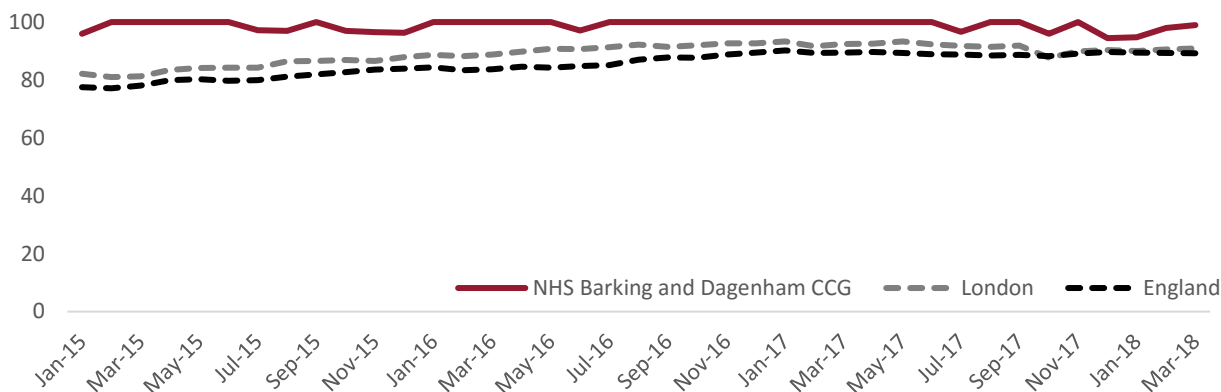
¹⁵³ GP Patient Survey 2018 [<https://www.gp-patient.co.uk/>]

Data is also available on the effectiveness or likely effectiveness of interventions following diagnosis: within primary care, around two-thirds of newly diagnosed patients with depression (65.7%) had a review 10–56 days after diagnosis, which is similar to London (63.2%) and England (64.4%).¹⁵⁴ This is measured in the Quality and Outcomes Framework (QOF, a performance-related pay scheme for GPs) in recognition of the fact that treatment is often short-term despite the usually long-term nature of depression, medication may need reviewing, and this provides an opportunity to use a validated measure to assess the effectiveness of treatment.¹⁵⁵

Psychological therapies are a key treatment method for common mental health illnesses. Since 2008, the Improving Access to Psychological Therapies (IAPT) programme has aimed to make it easier for patients to receive evidence-based psychological treatment for mental health disorders.¹⁵⁶ As a key aim is around access, one measure is whether patients wait less than 6 weeks for their first treatment.

In general, a higher proportion of Barking and Dagenham referrals to IAPT take less than 6 weeks compared with England and London (Figure 4.5). In quarter 1 2018/19, 97% of referrals to IAPT entered treatment within 6 weeks, compared with 90% across England.¹⁵⁷

Figure 4.5: Waiting < 6 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <6 weeks for first treatment



Data: PHE, Common Mental Health Disorders profile.

Data is also collected on the proportion of people who show ‘reliable improvement’ on a validated psychological questionnaire and those who are classed as ‘moving to recovery’ (those who met the criteria for treatment at the beginning of their treatment and no longer meet it at the end). In quarter 1 2018/19, 65% showed ‘reliable improvement’ and 47% were ‘moved to recovery’, compared with 65% and 45% in London and 67.7% and 52.4% in England.

Serious mental illnesses

‘Serious mental illnesses’ refers to schizophrenia, bipolar affective disorder and other psychoses.¹⁵⁸

Prevalence

¹⁵⁴ PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.

¹⁵⁵ PHE. National General Practice Profiles. Indicator Definitions and Supporting Information [<https://fingertips.phe.org.uk/profile/general-practice/data#page/6/qid/2000003/pat/46/par/E39000018/ati/152/are/E38000004/iid/91243/age/168/sex/4>]. Accessed 2018 Oct 04.

¹⁵⁶ National Collaborating Centre for Mental Health. *The Improving Access to Psychological Therapies Manual*. [London]: NCCMH; 2018.

¹⁵⁷ NHS Digital, [Improving Access to Psychological Therapies \(IAPT\). Interactive data tool – Quarter 1 2018/19](#).

¹⁵⁸ PHE. National General Practice Profiles. Indicator Definitions and Supporting Information [<https://fingertips.phe.org.uk/profile/general-practice/data#page/6/qid/2000003/pat/46/par/E39000018/ati/152/are/E38000004>]. Accessed 2018 Oct 04.

Around 1 in 125 people registered with a Barking and Dagenham GP has been recorded as having a serious mental illness.¹⁵⁹

Early diagnosis and intervention

In quarter 1 2018/19, 83% of people registered with a Barking and Dagenham GP with first episode psychosis referred to early intervention had a waiting time of 2 weeks or less.¹⁶⁰ However, as relatively few referrals are received each quarter (20 in quarter 1 and 15 in quarter 4, rounded to nearest 5), this is subject to variation; the previous quarter, this was 44%. The nationally set target is 50%.¹⁶¹

People with serious mental illness suffer from health inequalities including higher mortality rates for liver disease, respiratory disease, cardiovascular disease and cancer.¹⁶² This group is also more likely to be obese or have diabetes, asthma, coronary heart disease or stroke than those without these conditions. This indicates that part of the intervention for these conditions is likely to involve supporting and preventing other health issues.

For example, smoking rates among people with a serious mental illness are much higher than in the general population: 40.2% of patients with a serious mental illness in Barking and Dagenham were current smokers in 2015/16, compared with an adult prevalence of 20.4%.¹⁶³ Intervening with this group would therefore also include supporting attempts to quit. The LBBT Tobacco Harm Reduction Strategy has set a target to halve the number of smokers with mental health conditions by 2022.¹⁶⁴

Dementia

Dementia is a condition largely affecting older people that is characterised by symptoms including memory loss, loss of mental acuity and changes to mood.¹⁶⁵

Alzheimer's disease is a type of dementia; another common type is vascular dementia which is caused by decreased blood flow to the brain.

Prevalence

Around 1 in 21 people aged 65 and above have a recorded dementia diagnosis in Barking and Dagenham.¹⁶⁶ This rises to one in eight for individuals aged 85–89 and one in five for individuals aged 90 and above.

Early diagnosis and intervention

Diagnosing dementia early is important because it can be possible to slow down its progression and to plan for extra help and support that might be needed in the future.¹⁶⁷

As discussed in the cardiovascular disease section above, good cardiovascular health may reduce the risk of vascular dementia and Alzheimer's disease in later life¹⁶⁸ and

¹⁵⁹ PHE, National General Practice Profiles [<https://fingertips.phe.org.uk/profile/general-practice>]; 2016/17.

¹⁶⁰ NHS Digital, [Mental Health Services Monthly Statistics. Access and Waiting Times. Data Tables, Final April 2018 to June 2018, Experimental Statistics](#); NHS Digital, [Mental Health Services Monthly Statistics. Access and Waiting Times. Data Tables, Final January 2018 to March 2018, Experimental Statistics](#).

¹⁶¹ Baker, C. [Mental health statistics for England: prevalence, services and funding](#). Briefing Paper Number 6988, 25 April 2018. [London]: House of Commons Library; 2018.

¹⁶² PHE. Severe mental illness (SMI) and physical health inequalities: briefing [<https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing>]. Accessed 2018 Oct 04; data is national and does not relate to Barking and Dagenham specifically.

¹⁶³ PHE, Local Tobacco Control Profiles [<https://fingertips.phe.org.uk/profile/tobacco-control>].

¹⁶⁴ LBBT, [Tobacco harm reduction strategy](#). [London]: LBBT; 2017.

¹⁶⁵ NHS. Dementia guide: About dementia [<https://www.nhs.uk/conditions/dementia/about/>]. Accessed 2018 Oct 04.

¹⁶⁶ Health Analytics, March 2018.

¹⁶⁷ NHS. Dementia guide: About dementia [<https://www.nhs.uk/conditions/dementia/about/>]. Accessed 2018 Oct 04.

¹⁶⁸ NHS. Overview: Vascular dementia [<https://www.nhs.uk/conditions/vascular-dementia/>]. Accessed 2018 Oct 04; NHS. Overview: Alzheimer's disease [<https://www.nhs.uk/conditions/alzheimers-disease/>]. Accessed 2018 Oct 04.

hence an early assessment of risk and support to make changes could also be an early intervention to prevent these conditions. Diabetes is also a risk factor for vascular dementia.

Estimates suggest that 71% of people with dementia in Barking and Dagenham have a diagnosis; there were 881 people on Barking and Dagenham GP dementia registers in August 2018, but 1,240 people were estimated to have dementia.¹⁶⁹ This suggests that around 350 people may be living with dementia without a diagnosis.

In 2016/17, the rate of emergency admissions for dementia (in those aged 65 and above) was higher than the England average.¹⁷⁰

Self-harm and suicide

Prevalence

The rate of emergency hospital admissions for intentional self-harm is decreasing in Barking and Dagenham and is significantly lower than England and similar to London.¹⁷¹ There were 194 such admissions in 2016/17, down from 344 in 2011/12.

Admissions for young people specifically show a similar pattern in terms of being similar to London but lower than England.¹⁷²

Admissions for self-harm do not tell us about individuals who may self-harm but do not present to hospital; the prevalence of self-harm in the community will be higher.

There were 34 suicides in Barking and Dagenham in 2014–16. Most suicides were among men.

Early diagnosis and intervention

Barking and Dagenham has produced a Suicide Prevention Strategy jointly with Havering.

4.4.4 Sexual health

Sexually transmitted infections (STIs) often remain undiagnosed due to social barriers to testing and the asymptomatic nature of some infections. As these conditions are, by definition, transmittable to others, early diagnosis and intervention benefits not only the individual, but also the wider population, in the form of reduced onward transmission.

Chlamydia and gonorrhoea

Incidence

The chlamydia detection rate in Barking and Dagenham is 1,679 per 100,000 aged 15–24.¹⁷³ This is below Public Health England's target threshold of 2,300 per 100,000; in this case, a low incidence rate is seen as negative as – based on what is known about chlamydia in young people – there is an assumption that if not diagnosed, these cases are undetected rather than do not exist.

Barking and Dagenham has a higher incidence of gonorrhoea than the England average, but is below the London average.¹⁷⁴ There is an upward trend in this.

¹⁶⁹ NHS Digital, [Recorded Dementia Diagnoses – August 2018](#). GP-registered population.

¹⁷⁰ PHE, Dementia Profile [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>].

¹⁷¹ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

¹⁷² PHE, Children and Young People's Mental Health and Wellbeing [<https://fingertips.phe.org.uk/cypmh>].

¹⁷³ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]. Data is for 2017.

¹⁷⁴ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]. Data is for 2017.

Early diagnosis and intervention

13% of 15–24 year olds were screened for chlamydia in 2017. Screening coverage is declining and is significantly lower than both London and England. As chlamydia is often asymptomatic and young people are at high risk, screening is recommended annually for sexually active 15–24 year olds, or upon change of a partner (whichever is more frequent).

Pelvic inflammatory disease (PID) can be a complication of prolonged chlamydia infection. Barking and Dagenham had the highest rate of admissions for PID per 100,000 in London – 337.5 per 100,000 in 2016/17. However, this can also reflect different treatment pathways and recording of PID in different areas.

Another form of intervention to reduce the impacts of STIs is partner notification. In 2017, 82 partner notifications for gonorrhoea and 360 for chlamydia were supported by genitourinary medicine (GUM) services.¹⁷⁵

HIV

Incidence/prevalence

There were 32 new cases of HIV diagnosed in Barking and Dagenham in 2017, which – as a rate per 100,000 aged 15 and over – is higher than England but similar to London.¹⁷⁶

In 2017, 742 people were living with an HIV diagnosis locally – 5.77 per 1,000 people aged 15–59.¹⁷⁷ This is higher than England but similar to London.

People most likely to be living with diagnosed HIV locally are:¹⁷⁸

- in the three most deprived quintiles
- women
- black African
- aged 35-49.

Early diagnosis and intervention

Late HIV diagnosis is associated with greater mortality; a national cohort study covering all individuals diagnosed with HIV in England from 1997 to 2012, with an average follow-up of 5 years, found that people whose HIV infection is diagnosed late had a 3.5-times greater risk of death than those diagnosed early.¹⁷⁹ An earlier study also found that the risk of death in the first year after diagnosis in people who are diagnosed late is 10 times higher than in those who are diagnosed early.¹⁸⁰

In Barking and Dagenham, over half of new HIV diagnoses in 2015–17 were late (52.5%).¹⁸¹ This is the third highest proportion in London.

¹⁷⁵ Data from GUMCADv2 surveillance, PHE.

¹⁷⁶ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]. Data is for 2017.

¹⁷⁷ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]. Data is for 2017.

¹⁷⁸ Data from SOPHID surveillance, PHE. 2016

¹⁷⁹ Croxford S, Kitching A, Desai S, Kall M, Edelstein M, Skingsley A, et al. [Mortality and causes of death in people diagnosed with HIV in the era of highly active antiretroviral therapy compared with the general population: an analysis of a national observational cohort.](#) *Lancet Public Health* 2017;2(1):e35–e46.

¹⁸⁰ Brown AE, Kall MM, Smith RD, Yin Z, Hunter A, Delpech VC. [Auditing national HIV guidelines and policies: The United Kingdom CD4 Surveillance Scheme.](#) *Open AIDS J* 2012;6:149–55.

¹⁸¹ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]. Data is for 2017.

If we have the same proportion of undiagnosed cases as national figures, we would expect around 100 people to be living with undiagnosed HIV in Barking and Dagenham (12% of people living with HIV).¹⁸² This is likely to be an underestimate.

Barking and Dagenham has the highest overall uptake of HIV testing in London and the eighth highest in England; 88.8% of those offered a test took it up.¹⁸³ However, in men who have sex with men (MSM), this is the lowest in London and 11th lowest in England.

However, the coverage of HIV testing, while still higher than England, is similar to London; 72.4% of 'eligible new attendees' attending sexual health services had an HIV test.¹⁸⁴

109 rapid HIV tests were undertaken in 2017.¹⁸⁵

There were 32 incidents in which post-exposure prophylaxis for HIV was given in GUM clinics in 2017, reducing the risk of HIV transmission.¹⁸⁶

4.5 Conclusions

Early diagnosis and intervention is important as Barking and Dagenham has the highest avoidable mortality rate in London and mortality is only part of the story as living with an undiagnosed or untreated illness has individual and societal costs of its own.

Barking and Dagenham has a high prevalence of many risk factors for conditions such as cardiovascular disease, including smoking, physical inactivity and excess weight. **One way to intervene early for these conditions is therefore to focus on prevention.**

All 40–74 year olds without long-term conditions should be offered an NHS Health Check. This is a valuable tool for assessing risk and diagnosing cardiovascular disease and diabetes. Although a higher proportion of the eligible population had a check between 2013/14 and 2017/18 than England (56% compared with 44%), this means a little less than half of eligible 40–74 year olds did not receive one. **Increasing NHS Health Check coverage should increase early diagnosis and intervention.**

Barking and Dagenham has the third highest prevalence of COPD and the highest COPD mortality rate in London. Although COPD cannot be cured, the loss of lung function can be slowed. **If the patient smokes, stopping smoking is a key intervention. Suitable management in primary care should also reduce the need for hospital admission.**

Around 1 in 13 adults registered with a GP in Barking and Dagenham have a diabetes diagnosis, but a higher proportion are estimated to be living with diabetes. If not diagnosed and managed effectively, diabetes can lead to complications that include sight loss and amputations. Care processes and treatment targets for diabetes have been set nationally; in 2016/17, four in ten people with type 2 diabetes achieved all three targets, which was significantly worse than England. **Ensuring that patients with diabetes receive all eight care processes annually and achieve the three treatment targets should lead to better outcomes for patients.**

Most liver disease is caused by alcohol, obesity or viral hepatitis. In its early stages, liver disease is reversible, but liver disease may not be symptomatic until it is at an early stage.

¹⁸² 12% undiagnosed based on national data applied to 2017 number aged 15–59 living with HIV. See: PHE, [Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK](#). London; PHE: 2017; PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>].

¹⁸³ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]. Data is for 2017.

¹⁸⁴ PHE, Sexual and Reproductive Health Profiles [<https://fingertips.phe.org.uk/profile/sexualhealth>]. Data is for 2017.

¹⁸⁵ Data from GUMCADv2 surveillance, PHE.

¹⁸⁶ Data from GUMCADv2 surveillance, PHE.

One way to intervene early is to address hazardous drinking. Options to screen at-risk individuals could also be evaluated.

The five most common types of cancer in Barking and Dagenham are lung cancer, breast cancer, prostate cancer, bowel cancer and leukaemia (based on numbers of new cases). Lung cancer incidence and mortality rates are significantly higher than England, while breast cancer 1-year survival is significantly lower than England. Coverage on the three national screening programmes is low, especially bowel screening. **We should continue working to increase coverage and uptake on the national cancer screening programmes.**

The proportion of cancers diagnosed at stages 1 or 2 and the proportion of cancers first presenting as an emergency are now in line with England, despite the high incidence of lung cancer, which is typically diagnosed at a late stage. **Monitoring these trends through quarterly data should continue.**

Barking and Dagenham performs well on the 2-week wait measure, with 96.7% of patients seeing a specialist within 2 weeks. However, more than one in five patients did not receive their first cancer treatment within 62 days of urgent GP referral (quarter 1 2017/18). **Referral to treatment figures should be analysed to identify the reasons for delay.**

Mental health disorders are common, but we lack good quality data. Based on what we know about the prevalence of common mental health disorders in the community compared with the prevalence of diagnosed conditions, **recognising and diagnosing mental health disorders, and ensuring residents recognise when they should seek medical advice, and feel able to do so, is important.**

Around 1 in 125 people in Barking and Dagenham has been recorded as having a serious mental illness. People with serious mental illness have been identified as suffering from inequalities in physical health; **this underlines the need for joined up services and a holistic understanding of needs.**

Diagnosing dementia early is important because it can be possible to slow its progression and to plan for extra help and support. However, estimates suggest that only 71% of people with dementia in Barking and Dagenham have a diagnosis. **We should continue working to reduce the proportion of undiagnosed dementia cases.**

STIs often remain undiagnosed due to social barriers to testing and the asymptomatic nature of some infections. Screening coverage of chlamydia in young people is declining and significantly lower than both London and England. **Increasing coverage of routine chlamydia testing in young people would prevent possible complications and reduce onward transmission.**

Barking and Dagenham has similar HIV incidence and prevalence rates to London. However, over half of new HIV diagnoses are late, the third highest proportion in London. Late diagnosis is associated with increased risk of mortality. **Strategies to reduce the proportion of late diagnoses should be explored.**

5 Resilience

5.1 What is resilience?

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

‘Resilience’ as a concept has been defined and used in different ways. The working definition for the presentation on which this report is based was ‘*developing the capacity for populations to endure, adapt and generate new ways of thinking and functioning in the context of change, uncertainty or adversity*’.¹⁸⁷

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

5.2 Why is resilience important?

Resilience is important for health and wellbeing because it is closely connected with mental wellbeing; how you react to a challenging situation is linked to your state of mind and coping effectively may help prevent or limit the situation causing mental distress.

Resilience can also be specific to health and social care ‘challenges’, such as being diagnosed with a long-term condition, or ageing.

5.3 Why is resilience important for Barking and Dagenham?

Focusing on resilience is a priority for Barking and Dagenham as it is interlinked with prevention, and in the current financial climate, ensuring that residents have the tools they require to reduce the need for intensive support from the council and other organisations, such as the NHS, benefits everyone.

Secondly, maximising mental wellbeing is an important priority in its own right; helping individuals ‘feel good and function well’ will have a large impact on their quality of life. Despite a widespread call to give mental health conditions parity of esteem with physical health conditions, the role of preventive mental health measures is still not widely established compared with measures to prevent poor physical health (e.g. physical activity programmes).

Furthermore, we live in a time of change – locally, nationally and globally. We all need to be able to adapt and thrive in the context of such changes. With the growth in Barking and Dagenham that is expected in the coming years, building resilient communities and individuals can help to ensure that ‘no-one is left behind’.

5.4 What builds resilience?

Figure 5.1 is a framework for resilience based on ideas from a Mind report on resilience for supporting mental health and a paper on resilience by the Glasgow Centre for Population Health.

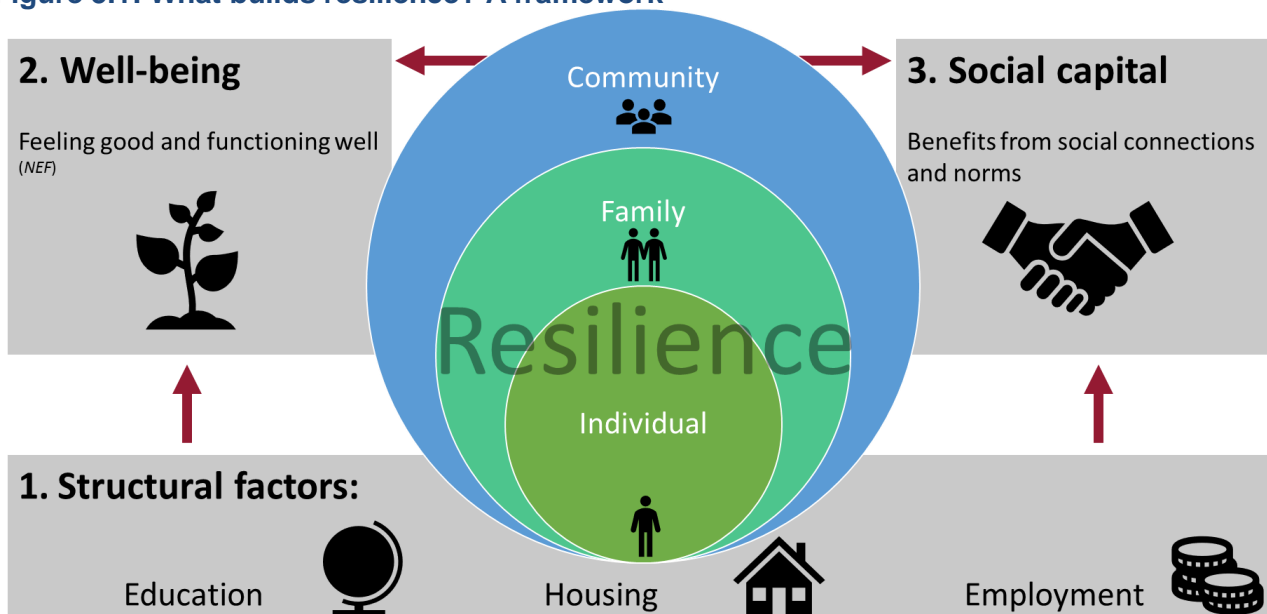
¹⁸⁷ Glasgow Centre for Population Health. [Resilience for public health: supporting transformation in people and communities](#). Briefing paper 12, Concepts series. Glasgow: Glasgow Centre for Population Health; 2014.

Both papers recognise the importance of structural pre-conditions that allow and facilitate resilience. We have selected three here which we believe are key: education, housing and employment.

Once those conditions are met, resilience is closely tied to personal well-being, as well as social capital, which refers to the benefits that individuals can gain from social connections and norms.

This chapter explores these three areas (structural conditions, wellbeing and social capital) in turn.

Figure 5.1: What builds resilience? A framework



Source: Developed from ideas in Mind/Mental Health Foundation and Glasgow Centre for Population Health reports.¹⁸⁸

5.5 Structural factors

5.5.1 Education

Education supports resilience as it provides one of the foundations for children’s later lives.

The impact of education on resilience can be understood through four key areas:

1. Early years foundation prior to school

Early years education builds resilience by enhancing educational attainment, enabling communication skills and improving expression and emotional intelligence.

In Barking and Dagenham, 72% of children achieved a good level of development in 2016/17 and the proportion achieving this is showing an increasing trend. However, there is a 14-percentage-point gap between boys and girls, which is similar to the gap at England level. This is explored in more detail in the *Best start in life* chapter.

2. Environment

The school environment builds resilience as it can nurture emotional and physical wellbeing, impact on socioeconomic outcomes and facilitate social networks.

¹⁸⁸ Mind, Mental Health Foundation; Mental Health Strategic Partnership. [Building resilient communities: Making every contact count for public mental health](#). London: Mind; 2013; Glasgow Centre for Population Health. [Resilience for public health: supporting transformation in people and communities](#). Briefing paper 12, Concepts series. Glasgow: Glasgow Centre for Population Health; 2014.

In Barking and Dagenham, 88% of schools are rated Good or Outstanding by Ofsted and 92% of learners in Barking and Dagenham attend these schools.¹⁸⁹

Furthermore, most schools in Barking and Dagenham are registered with the Healthy Schools London programme, and half have achieved a bronze award.¹⁹⁰

3. *Educational attainment*

Education attainment builds resilience as it enhances problem solving skills, widens socioeconomic opportunities and improves health literacy.

The average GCSE attainment 8 score looks at the grades of all pupils in their eight best subjects with a double weighting for maths and English. The average attainment 8 score in Barking and Dagenham was 46.7 in 2016/17, which was lower than London (48.9). This was the ninth lowest score in London.¹⁹¹

4. *School attendance*

The act of attending school can increase resilience as it enables access to services and resources, social networks and peer learning, as well as impacting on educational attainment.

In 2016/17, 4.4% of sessions were missed, with around 30% of session absences being unauthorised.¹⁹² A higher proportion of absences were unauthorised in Barking and Dagenham relative to London and England.

There were around 3,900 persistent absentees, which is equivalent to almost 1 in 9 pupils (10.7%). This is slightly higher than London (10.0%) but similar to England (10.8%).

Inequalities

In Barking and Dagenham, there are inequalities in achievement of high attainment 8 score at GCSE, with girls and children of Asian ethnic origin being more likely to achieve this than boys, children of White ethnicity or children who are eligible for free school meals.¹⁹³ Children in care also have a lower average attainment 8 score (22.5) compared with all pupils (46.7).

There are also inequalities in attendance; more than one in five students had persistent absenteeism in Barking and Dagenham special schools.¹⁹⁴ In special schools, 7.5% of sessions were missed compared to 4.4% across all schools.

5.5.2 Housing

How does housing support resilience?

Home ownership and good quality housing can support resilience, whereas precarious or poor-quality housing can challenge it. This includes issues such as overcrowding, fuel

¹⁸⁹ Ofsted. Data View [<https://public.tableau.com/views/Dataview/Viewregionalperformancevertime>]. Accessed 2018 Sept 28. Data as at 31 March 2018.

¹⁹⁰ Healthy Schools London [<http://www.healthyschools.london.gov.uk/>]. Accessed 2018 Sept 28. 55 registered schools, 34 with bronze award, 32 with silver, 15 with gold.

¹⁹¹ DfE, SFR01/2018: GCSE and equivalent results in England 2016/17 (revised).

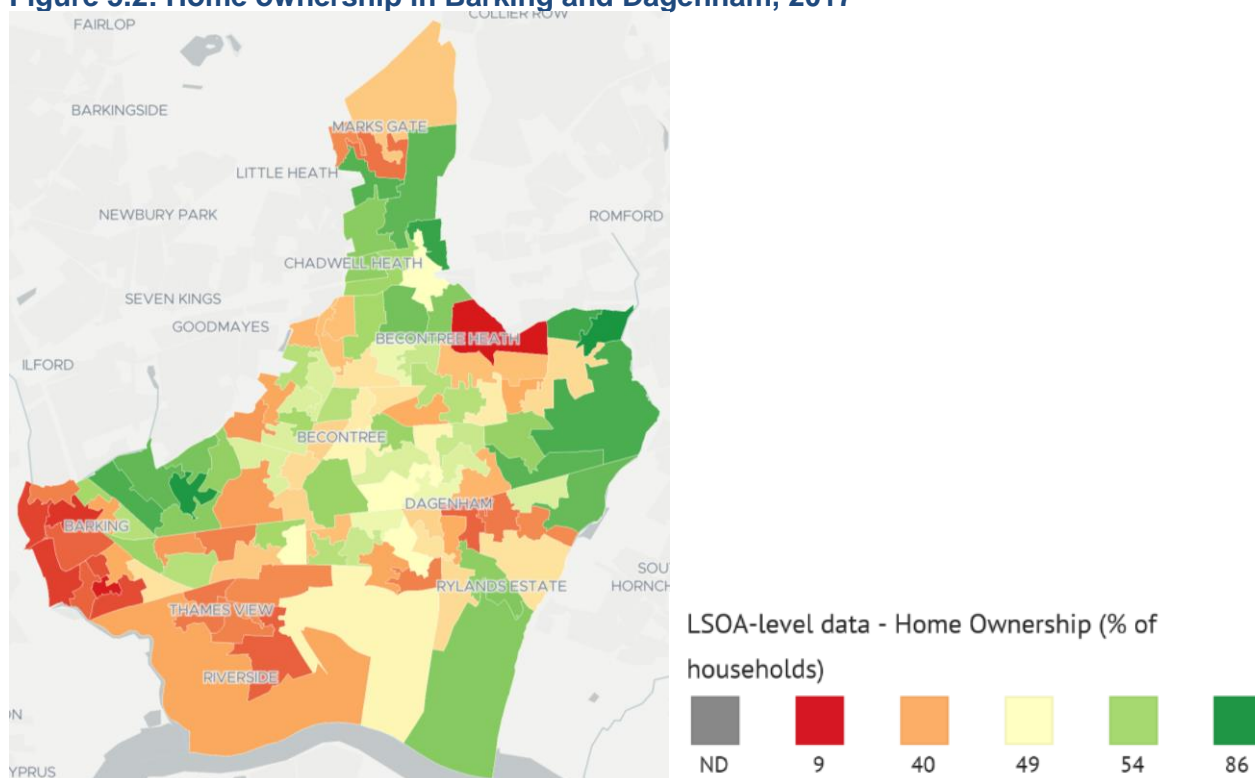
¹⁹² DfE, Pupil absence in schools in England: 2016 to 2017. Main tables.

¹⁹³ DfE, SFR01/2018: GCSE and equivalent results in England 2016/17 (revised).

¹⁹⁴ DfE, Pupil absence in schools in England: 2016 to 2017. Main tables.

poverty, unaffordable rents or purchase prices, poor quality housing, evictions and homelessness.¹⁹⁵

Figure 5.2: Home ownership in Barking and Dagenham, 2017



Source: Borough Data Explorer, using LBBB Residents Matrix data.

Less than half of all households in Barking and Dagenham are estimated to own the property they live in (45.9%).¹⁹⁶ Households in Gascoigne, Abbey and Thames are least likely to own their own home.

Home ownership can support greater stability but is becoming less affordable locally. Figure 5.3 shows a widening gap between affordability in Barking and Dagenham and England, with house price affordability moving closer to the London picture.

Figure 5.3: Affordability of home ownership: Ratio of median house price to median gross annual residence-based earnings



Data: Wider Determinants of Health profile, PHE.

¹⁹⁵ Cairney J, Boyle MH. Home ownership, mortgages and psychological distress. *Housing Studies* 2002;19(2):161–74; Macintyre S, Ellaway A, Der G, Ford G, Hunt K. Do housing tenure and car access predict health because they are simply markers of income or self esteem? A Scottish study. *J Epidemiol Community Health* 1998;52(10):657–64.

¹⁹⁶ LBBB Residents Matrix.

Census data shows high levels of overcrowding in Barking and Dagenham; in 15 of the 17 wards, at least one in five people lived in an overcrowded home at the time of the 2011 Census.¹⁹⁷ The highest levels of overcrowding were in Abbey, Gascoigne and Thames. Across the borough, 27.7% of households were overcrowded. Data on overcrowding for 0–15s and fuel poverty is explored in the *Best start in life* section.

Just under half of all Barking and Dagenham-owned housing stock is non-decent, which is the highest proportion in London, although this may be due to inconsistencies in reporting. The east London average is 18.7%. A programme of refurbishment of council housing stock is being undertaken.

There were 115 evictions from local authority owned homes in 2016/17, of which 93% were due to rent arrears.¹⁹⁸

Barking and Dagenham has the fourth highest level of family homelessness in London (6.2 per 1,000; 477 households) and the seventh highest rate of homelessness among young people aged 16–24 (1.09 per 1,000; 84 households in 2016/17).¹⁹⁹ It has the third highest rate of eligible homeless people not in priority need (2.8 per 1,000; 214 households in 2016/17).²⁰⁰

5.5.3 Employment

How does employment support resilience?

A review exploring whether work is good for health and wellbeing found that it generally was and suggested some mechanisms for this, which are relevant to resilience; work provides income which allows basic needs to be met; it has psychosocial benefits as working is seen as a ‘normal’ part of society and your job is often a key part of how you perceive yourself and how others see you; and employment status and deprivation are key contributors to inequalities in mental and physical health.²⁰¹ However, it also noted that you need suitable types of work/working conditions to avoid harm to your mental and physical health.

To explore how employment supports resilience in Barking and Dagenham, we would therefore want to ascertain the proportion of residents in employment, whether these jobs provide sufficient income, and whether the type of jobs are likely to support resilience.

What proportion of Barking and Dagenham residents are in employment?

Overall, 75.3% of working-age men and 61.0% of working-age women in Barking and Dagenham are in employment, compared with 80.2% and 67.7% in London, and 80.0% and 70.3% in England.²⁰²

If we had the same employment rates as London, around an additional 3,200 men and 4,400 women would be in work. If each earned the London Living Wage (£19,890 annually, based on a 37.5-hour week), this would equate to £151m of income (before tax and other deductions) for residents.²⁰³

¹⁹⁷ ONS, 2011 Census.

¹⁹⁸ Ministry of Housing, Communities & Local Government, [Local Authority Housing Statistics data returns, England 2016-17](#).

¹⁹⁹ PHE, Child and Maternal Health profiles [<https://fingertips.phe.org.uk/child-health-profiles>]. Both refers to households accepted as homeless. Family homelessness refers to households with dependent children or pregnant women; homelessness among young people aged 16–24 refers to households where the head is aged 16–24.

²⁰⁰ PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

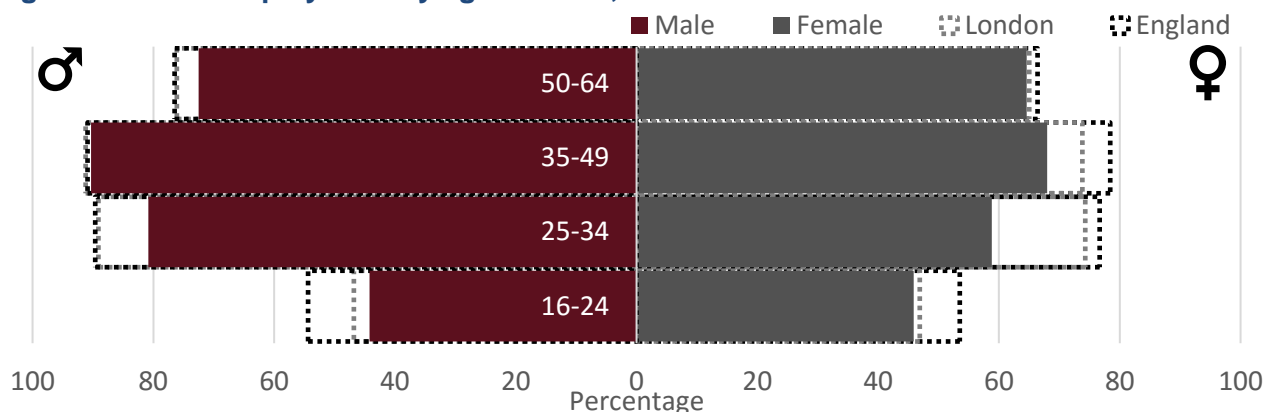
²⁰¹ Waddell G, Burton AK. *Is work good for your health and well-being?* London: TSO; 2006. See p.vii.

²⁰² ONS, Annual Population Survey, Jan 2017-Dec 2017.

²⁰³ Based on London Living Wage of £10.20 per hour. See: Living Wage Foundation. FAQs [<https://www.livingwage.org.uk/faqs>]. Accessed 2018 Oct 04.

By age, the largest gaps compared with London and England are in under 35s in men and under 50s in women, especially women aged 25–34 (Figure 5.4).

Figure 5.4: % in employment by age and sex, 2017



Data: ONS, Annual Population Survey.

Table 5.1: Employment status by sex

Working age residents (16–64)	Male			Female		
	B&D	England	London	B&D	England	London
In employment	75%	80%	80%	61%	70%	68%
Unemployed*	9%	4%	4%	6%	3%	4%
Economically inactive (e.g. student, looking after home)	16%	16%	16%	33%	27%	28%

Data: ONS, Annual Population Survey.

Note: unemployment is given here is a proportion of all working age residents so that percentages add to 100%; typically, unemployment is given as a proportion of the economically active workforce (the employed and unemployed).²⁰⁴

For males, the lower employment rate is explained by higher rates of unemployment than England or London; for females, this is explained by a combination of higher rates of unemployment and of economic inactivity (Table 5.1).²⁰⁵

As this is aggregated across all groups, this may hide patterns related to age and ethnicity. For example, a higher proportion of economically inactive women look after home and family in Barking and Dagenham than England or London (47% versus 36% and 43% respectively), but this is likely to be concentrated in certain age groups and is also likely to vary by ethnic group; at the time of the 2011 Census, 18% of all Barking and Dagenham women aged 25–49 looked after their home or family, but this ranged from 7% in the Chinese and Black Caribbean populations to 38% of those of Pakistani, Bangladeshi or Arab ethnicity.²⁰⁶

Working statuses other than employment could potentially support resilience in the right conditions; economically inactive residents may be students or raising families, among other reasons, which could have longer-term economic or social effects.

Is employment supporting resilience by providing suitable incomes in Barking and Dagenham?

²⁰⁴ ONS. Methodology: A guide to labour market statistics

[<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/aguidetolabourmarketstatistics>]. Accessed 2018 Oct 04.

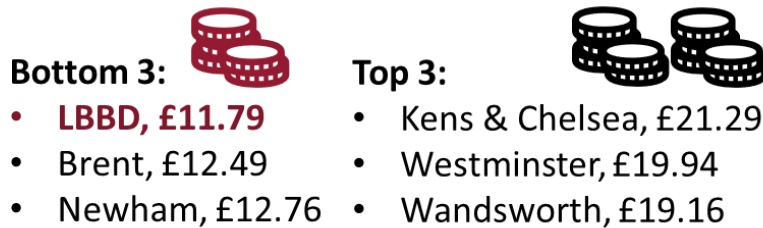
²⁰⁵ ONS, Annual Population Survey, Jan 2017-Dec 2017.

²⁰⁶ ONS, 2011 Census, DC6201EW – Economic activity by ethnic group by sex by age.

Residents of Barking and Dagenham have the lowest median hourly pay in London, at £11.79 per hour. This is 70p per hour less than the next lowest (Brent) and £9.50 per hour less than the highest (Kensington and Chelsea).²⁰⁷ Furthermore, the London Living Wage is currently £10.20 per hour. At least 30% of Barking and Dagenham men in work and 40% of women are paid less than this.²⁰⁸

Figure 5.5: Median hourly pay (excluding overtime), 2017

Lowest in London for median hourly pay (excl. overtime)

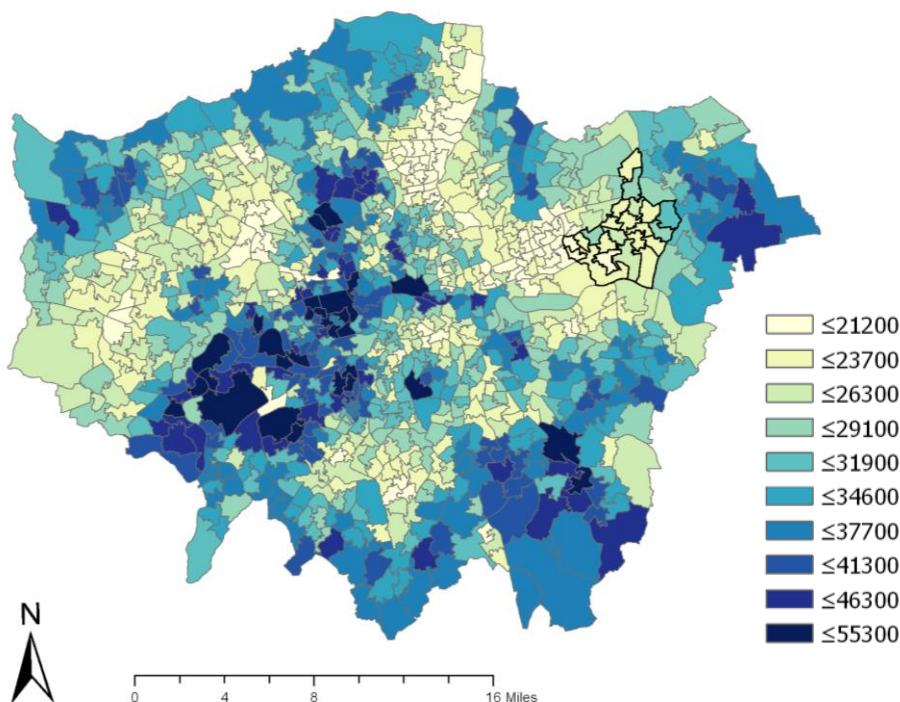


Data: ONS, Annual Survey of Hours and Earnings, 2017.

This is not just about the mix of part-time and full-time jobs; full-time Barking and Dagenham workers also have the lowest median hourly pay: £13.75.²⁰⁹

Small area income estimates in Figure 5.6 further highlight the low income of residents across the borough relative to other areas in London.

Figure 5.6: Net annual income after housing costs (£), 2015/16, middle-layer super output area, London



Data: ONS, Small area income estimates for middle layer super output areas, England and Wales. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.

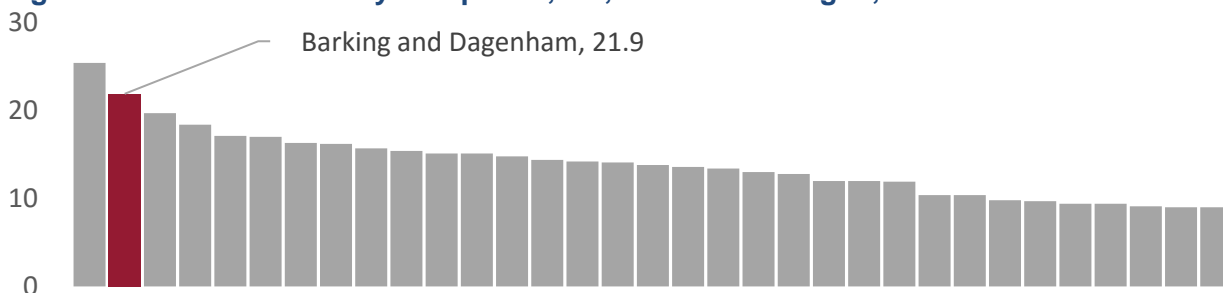
²⁰⁷ ONS, Annual Survey of Hours and Earnings (ASHE), 2017. Median hourly pay excluding overtime. Measure does not include self-employed.

²⁰⁸ ONS, ASHE, 2017. Hourly pay excluding overtime. Measure does not include self-employed.

²⁰⁹ ONS, ASHE, 2017. Median hourly pay excluding overtime. Measure does not include self-employed.

In addition, Barking and Dagenham has the second highest rate of insolvencies per 10,000 in London (Figure 5.7).

Figure 5.7: Total insolvency rate per 10,000, London boroughs, 2017



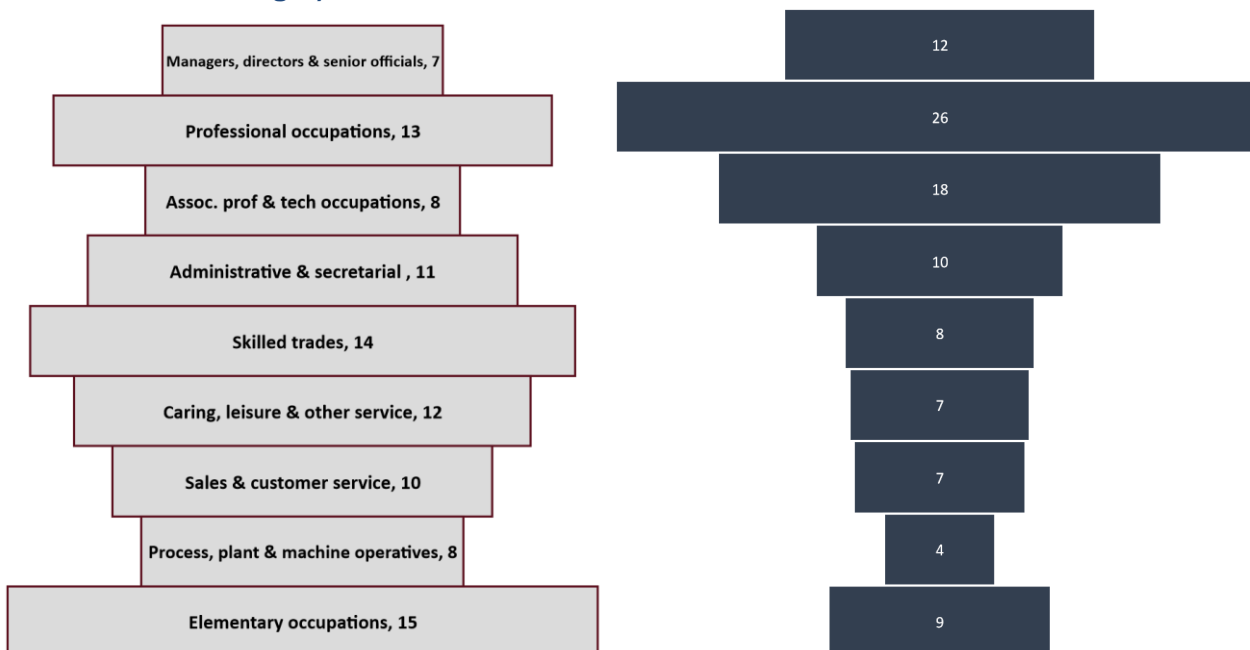
Data: The Insolvency Service, 2017.

Are the type of jobs in Barking and Dagenham likely to support resilience?

Barking and Dagenham has a different mix of jobs to the national or regional picture. For example, 13% of jobs in Barking and Dagenham are classed as ‘professional occupations’, compared with 26% across London.

Barking and Dagenham has a higher proportion of workers in sectors such as skilled trades, process, plant and machine operatives, and elementary occupations than London (Figure 5.8).

Figure 5.8: Workforce mix – higher % in elementary occupations (Barking and Dagenham – left and London – right)



Data: ONS, Annual Population Survey, 2017.

Sickness absence figures show that, based on October 2016 to September 2017 data, compared with ‘professional occupations’:²¹⁰

- process, plant and machine operatives have an 80% increased risk of sickness absence
- people in elementary occupations have a 75% increased risk
- people in sales and customer service occupations have a 55% increased risk
- people in caring, leisure and other service occupations have a 65% increased risk.

²¹⁰ ONS, [Sickness absence in the UK labour market](#).

- managers and senior officials have a 15% lower risk of sickness absence.

Higher sickness absence may adversely affect the ways in which a job provides resilience (for example, for workers who are only paid for days or shifts they work) and if the work itself is connected to poor health, then it would be directly detrimental to resilience.

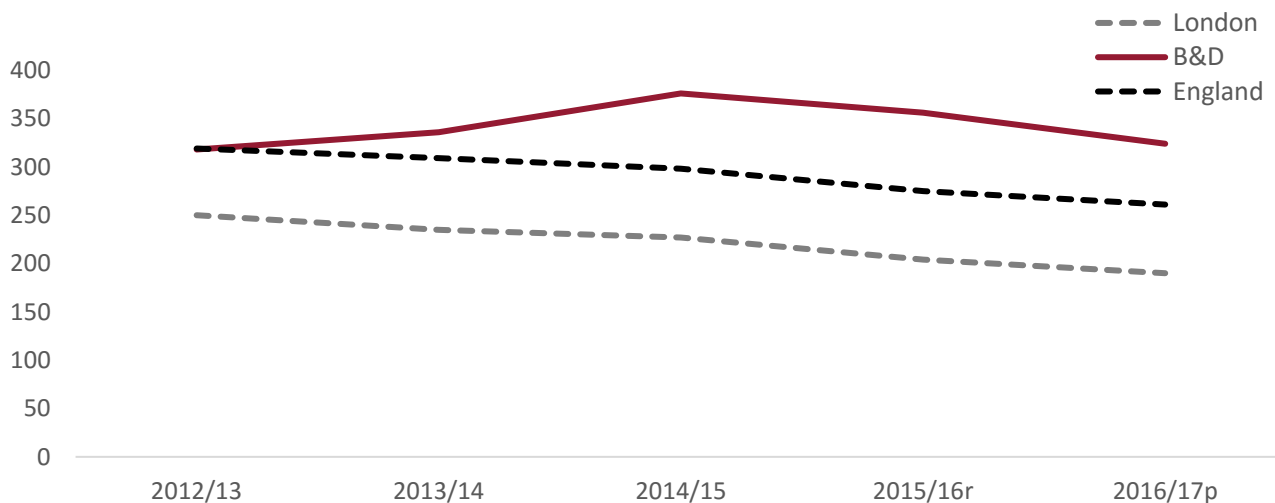
Furthermore, national health and safety data from a sentinel GP reporting scheme suggests that people in elementary occupations, process, plant and machine operatives and skilled trades occupations have a higher risk of work-related ill health than the average across all occupations.²¹¹ These groups make up 38.0% of the workforce in Barking and Dagenham, but only 20.7% of the workforce across London.

Conversely, people in associate professional and technical occupations, professional occupations and managers and senior officials have a lower risk of work-related ill-health; 28.5% of the workforce in Barking and Dagenham is in one of these three groups but 55.4% of the workforce in London.

Finally, Barking and Dagenham has a high rate of non-fatal injuries to employees, as reported to RIDDOR, compared with London and England (Figure 5.9).²¹² The rates are likely to be underestimates (across all geographies) as injuries at work are known to be under-reported.

There have been two fatal injuries at work in Barking and Dagenham in the past 5 years.²¹³

Figure 5.9: Non-fatal injuries to employees reported via RIDDOR, rate per 100,000



Data: Health and Safety Executive. Note: r = revised, p = provisional.

5.6 Wellbeing

Wellbeing has been defined as:

*A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment. A state in which an individual is able to realise his or her own abilities, cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.*²¹⁴

²¹¹ Health and Safety Executive. Table THORGP08. Incidence of work-related ill-health seen in THOR-GP by major occupational group (SOC). Figures for 2015 and annual average for 2013 to 2015.

²¹² Health and Safety Executive, RIDREG: RIDDOR reported Injuries by country, region, county and local authority.

²¹³ Health and Safety Executive, RIDREG: RIDDOR reported Injuries by country, region, county and local authority.

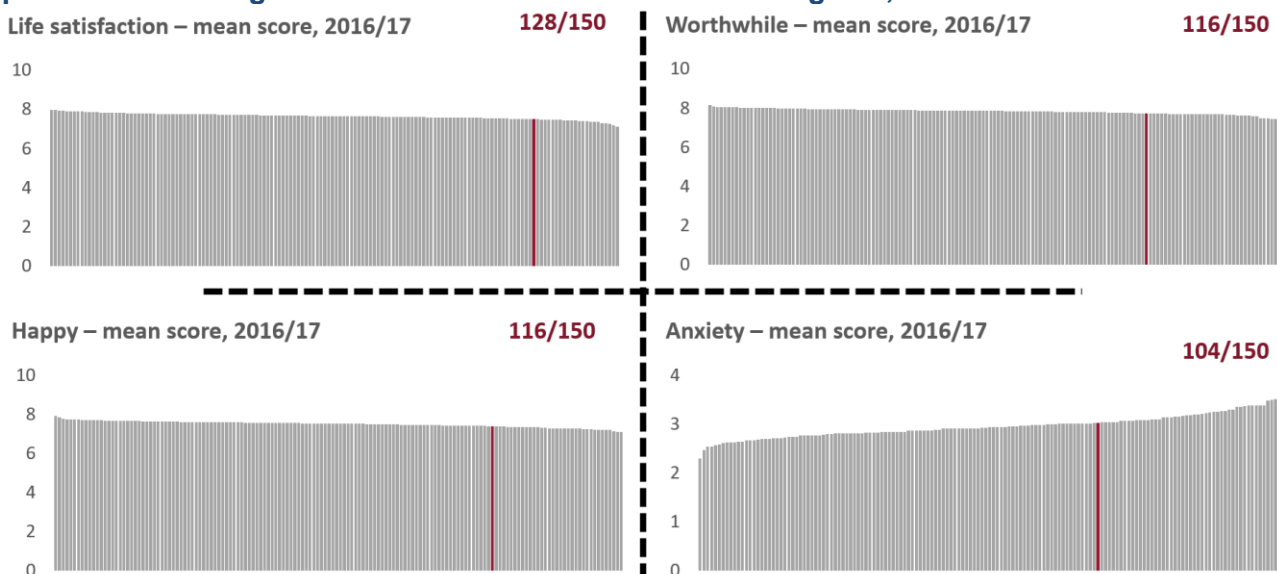
²¹⁴ Mind, Mental Health Foundation; Mental Health Strategic Partnership. [Building resilient communities: Making every contact count for public mental health](#). London: Mind; 2013.

This can be broken down into ‘feeling well’ and ‘functioning well’. The former relates to feelings of happiness, contentment, enjoyment, engagement and safety. This does not necessarily mean the absence of sadness, anger and stress, but people feeling well are often better equipped to cope with these without significant impact on their health.

The latter relates to your ability to function in the world and have positive relationships and social connections, as well as having control over your life and a sense of purpose.

Survey data on wellbeing places Barking and Dagenham in the bottom third of all measures (life satisfaction, feeling that the things you do are worthwhile, feeling happy and feeling anxious) (Figure 5.10).

Figure 5.10: Barking and Dagenham’s performance on four measures of self-reported personal wellbeing relative to other local authorities in England, 2016/17



Data: ONS.

The Office for National Statistics has analysed the factors which are associated with low wellbeing nationally. Many of these factors are high in Barking and Dagenham (Table 5.2).

Table 5.2: Factors associated with low wellbeing nationally

Factor ²¹⁵	B&D position relative to London
self-reported bad/very bad health	3 rd highest in London in 2011 Census
economically inactive due to long-term illness or disability	3 rd highest proportion of working-age residents on long-term sick leave in London in 2017 – 5.8% or 1 in 17.
unemployment	joint highest unemployment rate in London in 2017
aged 40–59	8 th lowest proportion in London (however, this group is nonetheless almost 1 in 4 of population – 24.3%)
not married or in a civil partnership (i.e. single, separated, widowed or divorced)	17 th highest proportion of residents in London aged 16+ who were not married or in a civil partnership in the 2011 Census (57.9% or 6 in 10)

²¹⁵ ONS. Understanding well-being inequalities: Who has the poorest personal well-being?

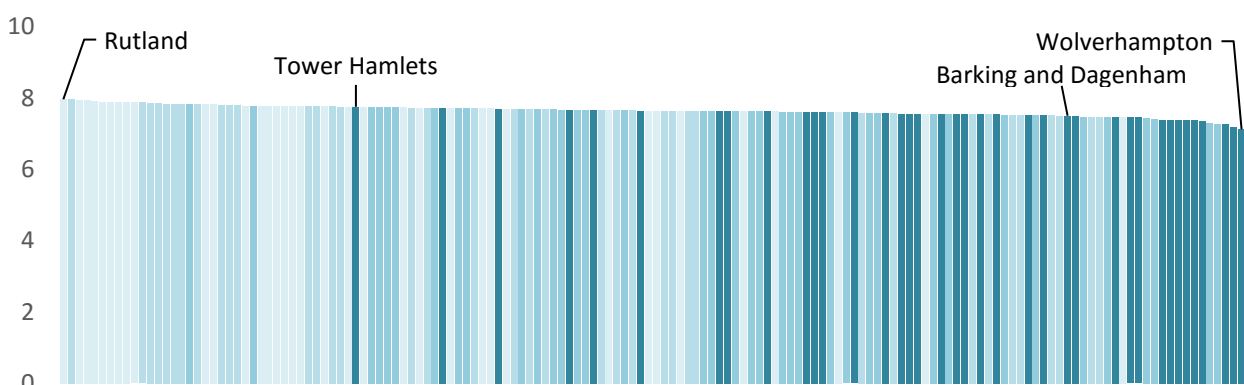
[<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/understandingwellbeinginequalitieswhohasthepoorestpersonawellbeing/2018-07-11>]. Accessed 2018 Oct 04.

renting (social or private)	17 th highest proportion of rented households in London in 2011 Census (51.4% or 1 in 2)
no qualifications or qualifications below GCSE level	joint 2 nd highest % of working age residents with no qualifications in London in 2017 (12.5% or 1 in 8)

Data: ONS, Census 2011, Annual Population Survey, mid-year estimates.

There is also a rough correlation with deprivation. Figure 5.11 shows life satisfaction by deprivation quartile, with the darkest colour representing the most deprived quartile and the lightest colour the least. There is a tendency for the most deprived quartiles to cluster towards the lower end of the scale, which underscores the importance of structural factors in wellbeing and hence resilience. The average life satisfaction score for the least deprived areas was 7.76, compared with 7.52 for the least deprived areas.

Figure 5.11: Life satisfaction by deprivation quartile – mean, 2016/17



Data: ONS.

The 2017 School Survey in Barking and Dagenham provides a partial picture of wellbeing in young people; two in three secondary school students felt optimistic about the future, while four in five students felt close to other people and two in three secondary school students felt they dealt with problems well.²¹⁶

5.7 Social capital

Social capital can be broadly defined as the benefits that individuals and communities can gain from social connections and social norms. Social connections are important for good mental health and resilience.²¹⁷

An Organisation for Economic Co-operation and Development (OECD) paper looking at how social capital could be measured described four definitions or facets (Figure 5.12).²¹⁸ This framework was adapted by the ONS when it developed indicators for social capital.²¹⁹

²¹⁶ LBBB School Survey 2017.

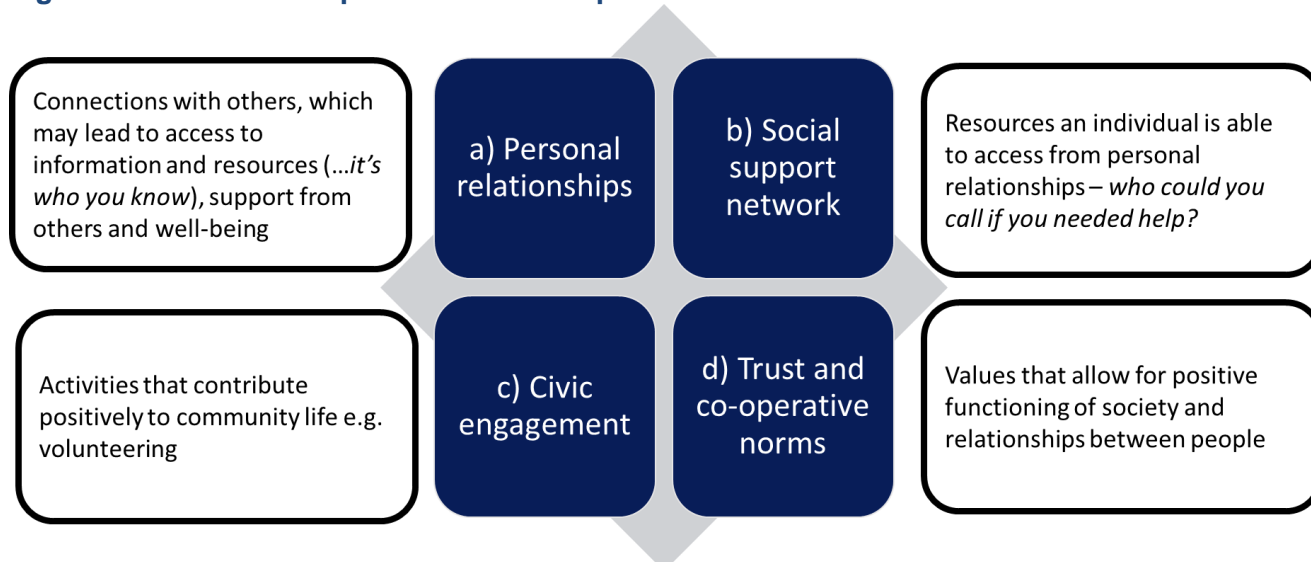
²¹⁷ Mind, Mental Health Foundation; Mental Health Strategic Partnership. *Building resilient communities: Making every contact count for public mental health*. London: Mind; 2013.

²¹⁸ Scrivens K, Smith C. *Four Interpretations of Social Capital: An Agenda for Measurement*. OECD Statistics Working Papers, 2013/06. Paris: OECD Publishing; 2013.

²¹⁹ ONS, Social capital in the UK: May 2017. Statistical bulletin

[<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/socialcapitalintheuk/may2017>]. Accessed 2018 Oct 05.

Figure 5.12: Four conceptions of social capital



Source: Created based on Scrivens and Smith, 2013.

Personal relationships broadly described the benefits that you can gain from connections with others. For example, having a wide social network may help individuals find out about jobs or opportunities, while many people derive a positive sense of wellbeing from being connected with others. Therefore, one way in which this can be measured is by looking at loneliness and social isolation.

For more vulnerable adults, in Barking and Dagenham, around 60–65% of carers and users of adult social care would like more social contact:

- In 2016/17, 39.6% of adult social care users in Barking and Dagenham had as much social contact as they would like, compared with 41.0% in London and 45.4% in England.²²⁰
- In 2015/16, 34.2% of adult carers in Barking and Dagenham had as much social contact as they would like, compared with 35.6% in London and 35.5% in England.²²¹

In 2018, 5% of respondents to the GP Patient Survey in Barking and Dagenham reported feeling isolated from others in the last 12 months.²²²

A national survey found that around 1 in 20 (5%) adults report being lonely 'often/always' and 1 in 6 (16%) 'some of the time'.²²³ Analysis found that the following characteristics were associated with a greater risk of loneliness:

- younger age (16–24)
- female (versus male)
- single/widowed
- poor health/long-term illness or disability
- renter (versus homeowners)
- lower sense of belonging to neighbourhood
- lower satisfaction with local area
- little trust of others in local area.

The final three points illustrate the importance of social connections for wellbeing.

²²⁰ Public Health England (PHE), Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

²²¹ Public Health England (PHE), Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

²²² GP Patient Survey 2018 [<https://www.gp-patient.co.uk/>].

²²³ ONS. Loneliness - What characteristics and circumstances are associated with feeling lonely?

[<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10>]. Accessed 2018 Oct 04.

Social support network looks specifically at the resources an individual can access through their personal relationships. For example, if you needed help – whether someone to talk to or someone to help with tasks such as shopping – who could you call? One way in which this can be measured is therefore to look at the prevalence of unpaid care in the community.

The 2018 GP patient survey found that 12.9% of Barking and Dagenham registered patients provide care for others (due to long-term physical or mental ill health/disability, or problems related to old age), compared with 16.7% across England.²²⁴ However, the main difference was in the proportion of people providing 1–9 hours of care; a similar proportion provide 10 or more hours of care per week.

Table 5.3: Care in Barking and Dagenham and England

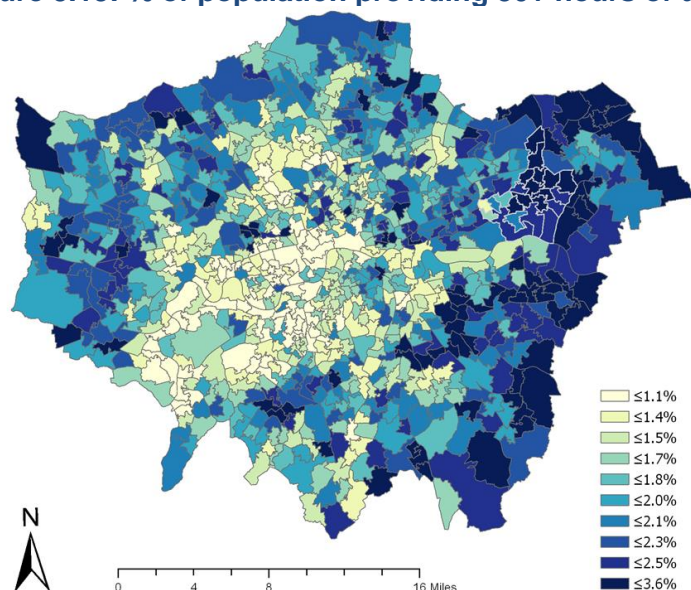
Hours per week of care provided	B&D	England
None	87.1%	83.3%
1–9	5.2%	9.2%
10–19	1.7%	2.1%
20–34	1.4%	1.2%
35–49	1.7%	1.0%
50+	3.0%	3.2%

Data: GP Patient Survey 2018.

As care is often provided for others in their old age, to have a similar rate of care provided as England may itself be meaningful; as we have seen in the demography section, 9.4% of Barking and Dagenham residents are aged 65 and above, compared with 18.0% across England.

Data from the 2011 Census is now somewhat out of date but provides more precise estimates than data based on a sample. Census data (Figure 5.13) indicates that, relative to the rest of London, a high proportion of residents provided 50 or more hours of unpaid care a week, especially in the north and east of the borough.

Figure 5.13: % of population providing 50+ hours of unpaid care per week, 2011 Census



Data: Census 2011, ONS. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.

Civic engagement relates to activities that contribute positively to community life, such as volunteering. These may also have benefits to the individual.

²²⁴ GP Patient Survey 2018 [<https://www.gp-patient.co.uk/>].

Just over 1 in 5 residents (23%) have volunteered in the last 12 months.²²⁵ This is similar to national data; in 2014/15, 19% of people had volunteered more than once in the last 12 months.²²⁶

7% of Barking and Dagenham residents volunteered at least once a week, and an additional 8% at least once a month.

Trust and co-operative norms refer to values such as trust that allow for the positive functioning of society and relationships between people. We can look measures such as the percentage of people who agree that the local area is a place where people from different backgrounds get on well together as well as perceptions of safety at night.

Around seven in ten (72%) residents agree that their local area is a place where people from different backgrounds get on well together.²²⁷ This is similar to 2015 and 2016 but lower than London (84%) and England (82%) figures for 2017/18.²²⁸

Furthermore, a declining proportion of residents feel safe outside after dark: 42% in 2017, down from 51% in 2015. This is lower than both London (73%) and England (76%).²²⁹

5.8 Conclusions

Resilience is important in Barking and Dagenham as it is interlinked with prevention and maximising mental wellbeing (a key component of resilience) is important in its own right. With the growth expected in the coming years, building resilient communities and individuals can help to ensure that 'no-one is left behind'.

Resilience requires structural prerequisites such as education, housing and employment. Once these conditions are met, resilience is closely tied to personal well-being and social capital (the benefits that individuals can gain from social connections and norms).

Education supports resilience as it provides children and young people with the skills and qualifications they need for later life. The average attainment 8 score in Barking and Dagenham in 2016/17 was 46.7, which was the eighth lowest score in London. **Improving school readiness, maintaining high school standards and environments, and increasing attainment and attendance should support resilience.**

Home ownership and good quality housing can support resilience. However, less than half of all households in Barking and Dagenham are thought to own the property they live in and home ownership is becoming less affordable. There were high levels of overcrowding at the time of the 2011 Census, while just under half of Barking and Dagenham-owned housing stock is non-decent. **Supporting the availability of better quality, more affordable housing would support resilience.**

Employment can support resilience as it provides income and psychosocial benefits. However, the type of job and conditions are also relevant. In Barking and Dagenham, 75.3% of working-age men and 61% of working-age women are employed; both are lower than the respective figures for London and England. For men, this is explained by higher rates of unemployment and for women this appears to be due to a combination of higher unemployment and economic inactivity. **Supporting the unemployed and the**

²²⁵ LBBS Residents' Survey, 2017.

²²⁶ ONS, Social capital headline indicators; May 2017.

²²⁷ LBBD Residents' Survey, 2017.

²²⁸ Department for Digital, Culture, Media & Sport. [Community Life Survey: July 2018](#). Note: different survey method.

²²⁹ LBBD Residents' Survey, 2017.

economically inactive who would like to work to enter employment would support resilience in the borough.

However, Barking and Dagenham has the lowest hourly pay in London; it is not clear that work with such income supports resilience. Barking and Dagenham also has a higher proportion of workers in occupational categories that are associated with higher levels of sickness absence and work-related ill-health relative to London. **Advocating for the London Living Wage, helping uncover cases where the National Minimum Wage is not being paid, enforcing health and safety requirements (where under local authority remit), supporting training, and encouraging the development of skilled jobs in the area would help employment to support resilience.**

Barking and Dagenham is in the bottom third of local authorities in England for all four measures of well-being. There is a high prevalence of factors associated with low wellbeing (such as unemployment and self-reported bad health). **Addressing underlying socio-economic factors (where applicable) may increase well-being.**

Social capital can be broadly defined as the benefits that individuals and communities can gain from social connections and social norms. This can be measured by looking at personal relationships, social support networks, civic engagement, and trust and co-operative norms.

‘Personal relationships’ describes the benefits you can gain from connections with others. This can be measured through social isolation; in 2018, 5% of respondents to the GP Patient Survey in Barking and Dagenham reported feeling isolated from others in the last 12 months. **Reducing social isolation would be beneficial to resilience.**

‘Social support network’ looks at the resources an individual can access through their personal relationships and can be measured by looking at unpaid care. Although a lower proportion of people in Barking and Dagenham provide care to others than England, this difference is largely in people providing 1–9 hours of care a week; a similar proportion provide 10 or more hours of care per week. **Exploring whether such support networks are equally distributed may help us understand who may need more support.**

‘Civic engagement’ considers activities that contribute positively to community life, such as volunteering. Just over one in five residents (23%) have volunteered in the last 12 months. **As with support networks, it would be worth exploring whether this is evenly distributed within the borough to understand who and who does not volunteer.**

‘Trust and co-operative norms’ refers to values that allow the positive functioning of society and relationships between people. This can be measured by the percentage of people who feel safe after dark. This is lower in Barking and Dagenham (42%) than London and England. **Exploring residents’ attitudes to their local area will give us insights into how norms are changing over time and how we might intervene to affect these positively.**