

Director of Public Health  
Annual Report 2018/2019

# Creating Health

A progressive approach for  
Barking and Dagenham



## A vision for Barking and Dagenham

# One Borough; One community; No one left behind

Our vision is simple. No-one left behind. It is at the heart of our new kind of council and everything we do. It means a relentless focus on creating the conditions, partnerships and services that support improvements in the lives of our residents, ensuring they have opportunities to succeed and thrive<sup>1</sup>.

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

Theme 1: A New Kind of Council	Theme 2: Empowering People	Theme 3: Inclusive Growth	Theme 4: Citizenship and Participation
<p><b>Priorities:</b></p> <ul style="list-style-type: none"><li>• Build a well-run organisation</li><li>• Ensure relentlessly reliable services</li><li>• Develop place-based partnerships</li></ul>	<p><b>Priorities:</b></p> <ul style="list-style-type: none"><li>• Enable greater independence whilst protecting the most vulnerable</li><li>• Strengthen our services for all</li><li>• Intervene earlier</li></ul>	<p><b>Priorities:</b></p> <ul style="list-style-type: none"><li>• Develop our aspirational and affordable housing offer</li><li>• Shape great places and strong communities through regeneration</li><li>• Encourage enterprise and enable employment</li></ul>	<p><b>Priorities:</b></p> <ul style="list-style-type: none"><li>• Harness culture and increase opportunity</li><li>• Encourage civic pride and social responsibility</li><li>• Strengthen partnerships, participation and a place-based approach</li></ul>

We understand that there is overlap between these themes and priorities. What is important is that we understand the dependencies and interdependencies between the priorities and use the flexibility to strengthen our new kind of council.

1. <https://www.lbbd.gov.uk/sites/default/files/attachments/LBBD-Corporate-Plan-2018-2022.pdf>

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## Foreword

**Health Creation is a route to wellness. It comes about when local people and professionals work together as equal partners and focus on what matters to people and their communities. Putting the relational, participatory approach to public service up front and centre is at the heart of the Council's approach to developing our new relationship with residents, a relationship that is not paternalistic but instead is empowering and participatory.**

The announcement of the NHS Long Term Plan in the summer of 2018 provides further support on this point, recognising that waiting for problems related to health and social care to occur, treating those problems when they become apparent, and then hoping for a successful outcome is not a satisfactory strategy. Building upon recent local success of which there are a number, it's only by working with residents and communities that we will be able to find an effective solution that goes beyond treating and preventing disease and into health creation. Health creation enables people to live to their full potential.

Future improvement now demands strong local leadership across the Barking, Havering and Redbridge Integrated Care System, working

together to build a coherent, shared ambition for both managing demand for our services and addressing need. The Health and Wellbeing Board's Joint Health and Wellbeing Strategy 2019–2023 recognises health creation as a critical outcome. This is not about doing more but is about doing things differently – maybe even stopping doing some things – as a means to improve residents' lives, deliver financial savings and help relieve the unsustainable pressures facing our health and care system.

What shapes both councillor's and resident's views of our health and care services is experience, not outcomes. Better coordination between services can improve patient satisfaction and perceived quality of care, although evidence on health outcomes, service use, and costs is less clear<sup>2,3</sup>. Integration for us particularly with our rapidly changing communities, means the process of developing equality, participation, and belonging in order to achieve cohesion in a community. Our health and care services are an integral part of this and therefore needs constant humanising so that our services and interventions reinforce the links that bring people together in health creation across opinions and beliefs, culture, ethnicity, age, sexual orientation and gender. The influence of the evidence given in ethnographic research should not be ignored in this pursuit, such as the analysis and ideas that Hilary Cottam puts forward in her book *Radical Help*<sup>4</sup>.

**Inclusive Growth is key to how we deliver the social infrastructure across our borough to enable human relationships and participation, so that 'health creation' might happen organically and sustainably.**

Cottam argues that *"our 20th century system is beyond reform and suggests a new model for this century: ways of supporting the young and the old, those who are unwell and those who seek good work. At the heart of this new way of working is human connection. When people feel supported by strong human relationships, change happens. If we design new systems that make this sort of collaboration feel simple and easy, people want to join in"*<sup>5</sup>.

It's quite simply unfair that our residents live shorter and less healthy lives than those living in other parts of London. We can view these inequalities through a range of different lenses; but regardless of the lens you are looking through, the overwhelming message is the

2. Baxter S, Johnson M, Chambers D, Sutton A, Goyder E, Booth A. Understanding new models of integrated care in developed countries: a systematic review. *Health Serv Deliv Res.* 2018;6(29).

3. Lloyd T, Brine R, Pearson R, Caunt M, Steventon A. The impact of integrated care teams on hospital use in North East Hampshire and Farnham: Consideration of findings from the Improvement Analytics Unit. Health Foundation. 2018. [www.health.org.uk/publications/impact-integrated-care-teams-hospital-use-north-east-hampshire-and-farnham](http://www.health.org.uk/publications/impact-integrated-care-teams-hospital-use-north-east-hampshire-and-farnham)

4. <http://www.hilarycottam.com/radical-help/>

5. <http://www.hilarycottam.com/radical-help/>

impact of economic disadvantage. We will miss a trick if we persist in focusing on disease itself, without asking real questions and stimulating debate about what Community Solutions, My Place, Enforcement and BeFirst services can do to enable cost-effective care.

Inclusive Growth is key to how we deliver the social infrastructure across our borough to enable human relationships and participation, so that 'health creation' might happen organically and sustainably. This investment is essential for effective early intervention that is co-designed with residents and delivered in ways that support people across the life course to thrive. For example, focusing on intervening early to support residents who are experiencing stresses, such as debt, family breakdown, exploitation and homelessness, is an essential enabler. We know that such stresses can

**This report is set in the context of the Council's overarching approach to preventing demand by enabling greater independence across the community, using the capacity of the new kind of council and the Barking Havering and Redbridge Integrated Care System.**

often lead to lives spiralling out of control and a deterioration in both physical and mental health. This problem isn't confined to adults, some children experience chaotic lives and domestic abuse. The way that these problems can be transmitted down the generations, makes it more difficult for individuals to break out of the cycle. However, early intervention through wider parts of the system is vital, but it's also about the system's universal approach to the whole community i.e. primary prevention. All this drives demand for our health and care services.

This report is set in the context of the Council's overarching approach to preventing demand by enabling greater independence across the community, using the capacity of the new kind of council and the Barking Havering and Redbridge Integrated Care System. I hope my observations in the following chapters act as a starting point for systematically focusing on 'where to look' before identifying 'what to change' and finally 'how to change'.

In Chapter 1 I focus on outlining the public health problem facing Barking and Dagenham and the systems in which we operate. Extending our understanding of the way health outcomes are shaped, so that we can consider whether there are more effective ways to tackle health inequalities. Chapter 2 outlines progress with the implementation of place-based care and how we can use this to ensure residents are living as healthily as possible, are connected to their communities and can access services and engage in their co-production. This requires more than just financial investment; it requires a culture change across the whole system as well as behaviour change.

Chapter 3 continues my interest in mental health issues and how thinking differently about the impact of trauma can have a range of benefits, including supporting our children to become more resilient to mental health issues, as well as support across the life course.

In Chapter 4, I discuss childhood obesity and older adults, examining how the Council can commission a system-wide integrated approach which improves outcomes for our residents. If we continue to address inequalities through existing approaches, we will simply continue to see the same outcomes. In order to make progress on prevention a truly whole system approach to health and care which encompasses the wider determinants of health is needed. This will include the opportunities presented by the Barking Havering Redbridge Integrated Care System and our own transformation journey in how existing resources (people, time and money) are distributed, so that those communities experiencing the greatest disadvantage receive a greater level of resource.

The last chapter of my report will focus on what we have done so far and our plans on how we will commission programmes funded by the Public Health Grant differently going forward in order to deliver savings and transform delivery to deliver outcomes.

The Director of Public Health Annual Report 2018/19 gives a professional perspective that informs this approach based on sound epidemiological evidence and objective interpretation. I hope you find my annual report of interest and value. Comments and feedback are welcome and should be emailed to [matthew.cole@lbbd.gov.uk](mailto:matthew.cole@lbbd.gov.uk).



**Matthew Cole**

**Director of Public Health**

**London Borough Barking & Dagenham**



## Chapter 1

**What matters: Changing the fact that both women and men in Barking and Dagenham live shorter lives when compared to London and England life expectancy**

## What is the life expectancy in Barking and Dagenham?

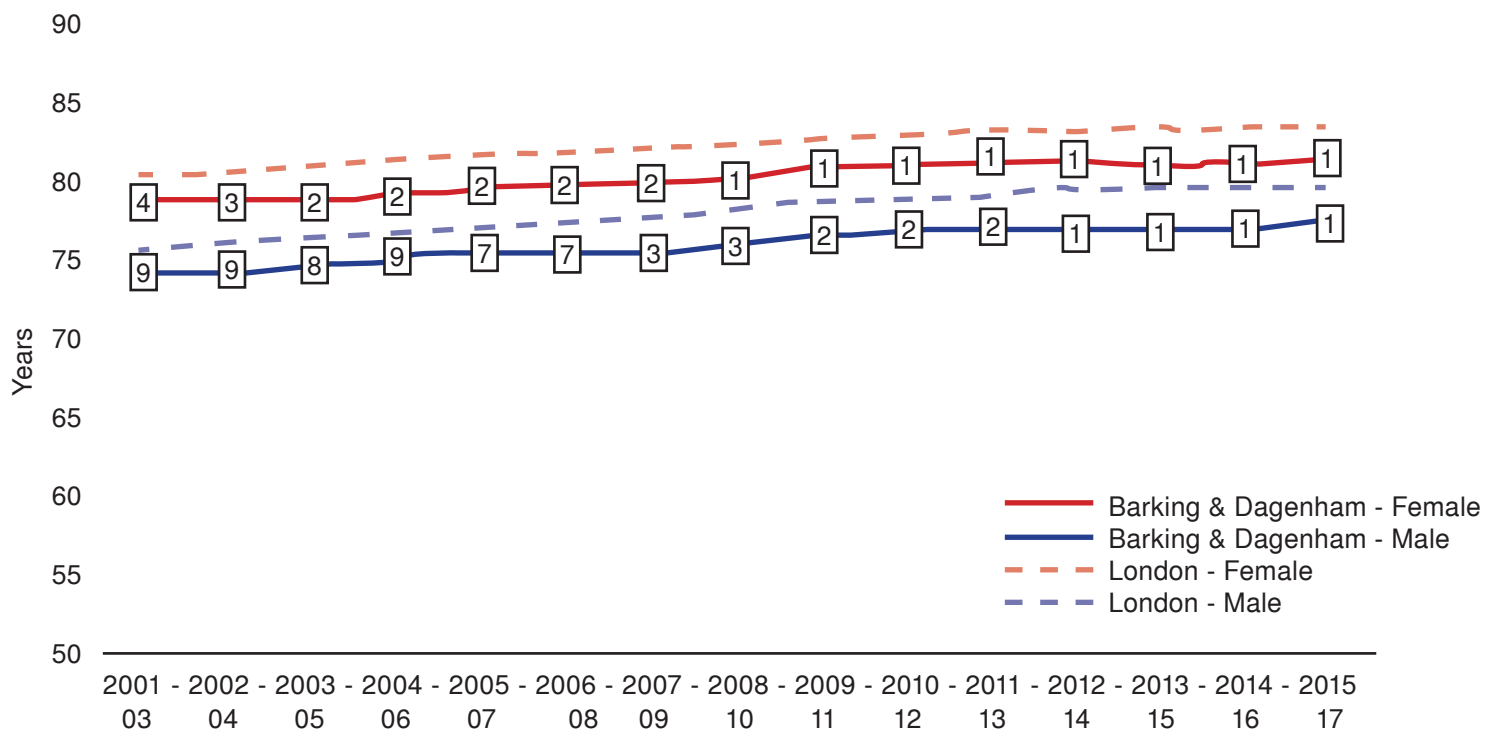
Barking and Dagenham has the lowest life expectancy for both men and women in London: 77.8 years for men and 82.1 years for women.<sup>6</sup> This type of life expectancy is better understood as a summary of mortality over the last 3 years

rather than the average length of time our residents are likely to live for, but it nonetheless means that our residents are dying earlier than their London counterparts.<sup>7</sup>

Barking and Dagenham has had the lowest life expectancies for both genders across London since 2012–14 (Figure 1). This is a decline

from ninth lowest position in 2004–6 for males, whilst female life expectancy has been among the lowest in London since, at least, the turn of the millennium. The most recent data puts life expectancy in Barking and Dagenham 2.7 years (for males) and 2.2 years (for females) lower than the London average.

**Figure 1: Life expectancy in Barking and Dagenham and London, 2001–3 to 2015–17, showing Barking and Dagenham's rank in London (1 = lowest of 32 boroughs)**



Source: Office for National Statistics via Public Health Outcomes Framework. Note: y-axis starts at 50

6. Public Health England (PHE), Public Health Outcomes Framework [<http://www.phoutcomes.info/>]; 2015–17.

7. As a period, life expectancy, it creates age-specific death rates from all deaths that were registered in 2015–17 and calculates the average number of years a hypothetical cohort of 100,000 babies would live for if they experienced the same death rates across their lifetimes as those observed for each age group over this period.



While some improvements over time are evident in Figure 1, with male life expectancy increasing by 3.3 years and female life expectancy by 2.8 years from 2001–3 to 2015–17, this trend has plateaued in recent years. Nationally, too, there has been a concern that improvements in life expectancy have stalled since 2011.<sup>8</sup> This is ascribed in part to a slowing down of improvements in cardiovascular disease mortality, which had previously been a key driver of improvements in life expectancy.

The Global Burden of Disease Study data (see Box 1) suggests that this slowdown of improvements in cardiovascular disease mortality is also evident in Barking and Dagenham (Figure 2).

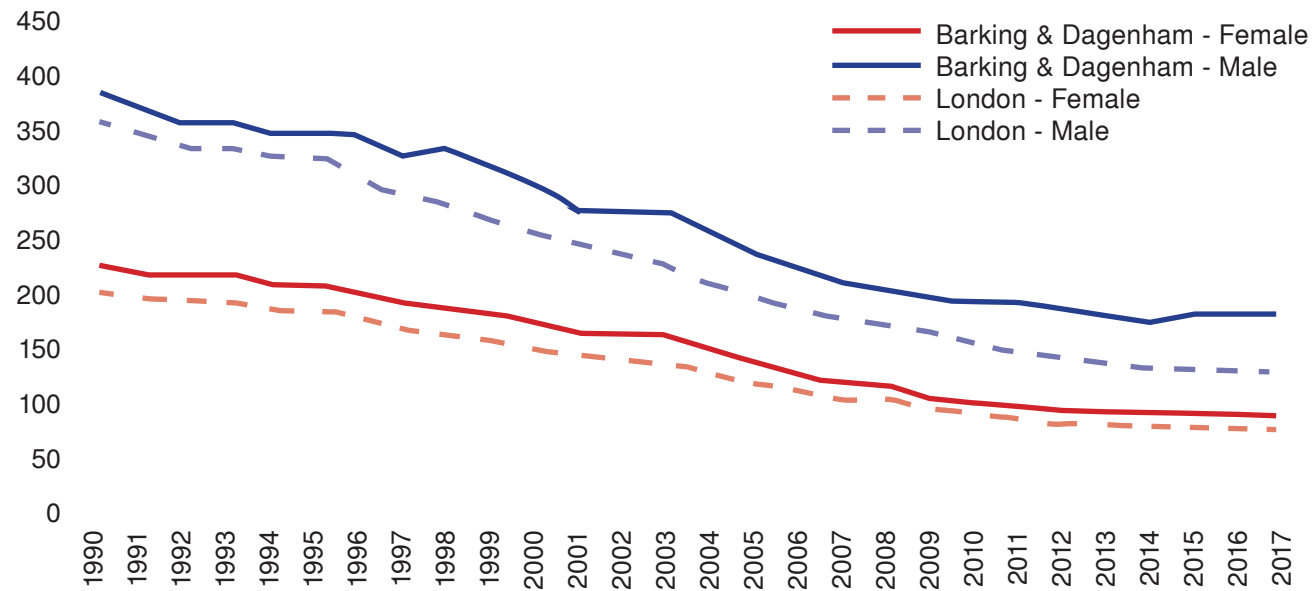
While we should not ignore the positive message in Figure 2 – that the rate of deaths from cardiovascular disease has more than halved for both males and females since 1990 – the current slowdown of improvement and the widening gap between Barking and Dagenham and London for males are causes for concern.

The situation in Barking and Dagenham is consistent with reports which suggest that the slowdown is affecting more deprived communities disproportionately, with Barking and Dagenham being the eleventh most deprived local authority in England.<sup>9</sup> Action is needed to reduce this inequality with the rest of London and ensure that it does not grow.

### Box 1: What is the Global Burden of Disease Study?

The Global Burden of Disease Study is an international collaborative project which provides modelled estimates on the amount of ill health, premature death and risk factors in a population. It allows an understanding of the relative contribution of each condition as well as the collective burden. It is ongoing, iterative project, with each modelling round defining the previous one<sup>10</sup>.

**Figure 2: Age-standardised mortality rate per 100,000 from cardiovascular disease by gender, Barking and Dagenham and London, 2017**



Source: Global Burden of Disease Study, 2017 round

8. PHE. *A review of recent trends in mortality in England*. London: PHE; 2018 [<https://www.gov.uk/government/publications/recent-trends-in-mortality-in-england-review-and-data-packs>]

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

10. For more information, see: <http://www.healthdata.org/gbd/about/protocol>.

### How does this relate to healthy life expectancy?

Life expectancy, however, only tells part of the story. We do not just want our residents to live longer lives, we also want them to spend more years in good health. This is important both for our resident's quality of life, but also to ensure that our health and care services are sustainable. In the next 5 years, Barking and Dagenham's population is projected to increase by 12%, but it is not as simple as increasing the capacity of our health and care services by the same amount.<sup>11</sup> While an extra £20.5 billion a year in real terms will be made available to

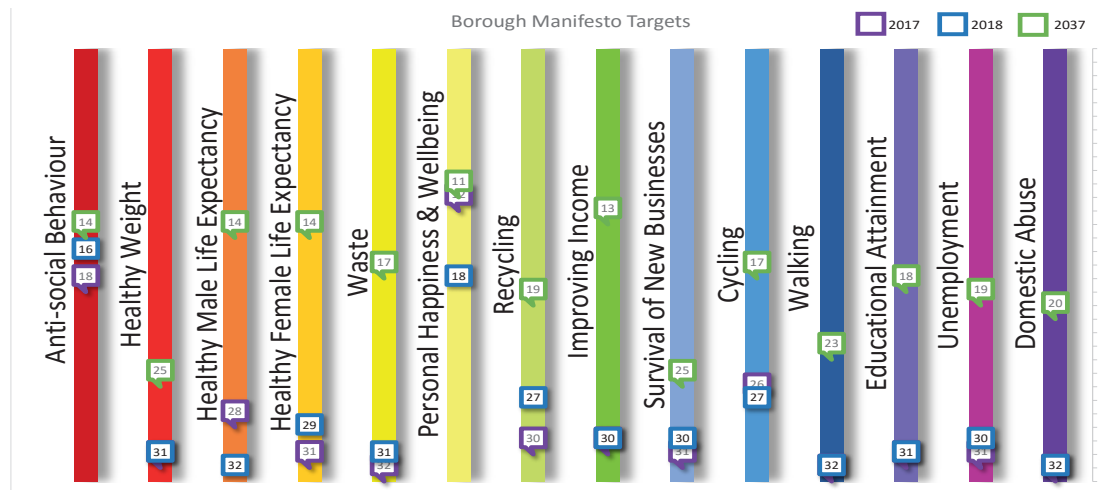
the NHS through the Long Term Plan by the end of 2023–24,<sup>12</sup> our main provider of acute healthcare, Barking, Havering and Redbridge University Hospitals NHS Trust is in financial special measures. The future of public health funding remains unclear, and local authority budgets (through which councils need to finance both adult and children's social care) have been cut dramatically in recent years.

There are workforce issues that need addressing. We already do not have enough GPs for our population, so it is unlikely that we are going to be able to simply increase GP capacity in order to meet a growing population.

Helping our residents spend a greater proportion of their lives in good health is therefore important for managing demand so that the health and social care system can function effectively, as well as fulfilling our moral and legal duty to improve their health.

The main measure we use for this is healthy life expectancy. Healthy life expectancy takes life expectancy as a starting point and then estimates the proportion of life years that residents are expected to spend in good health. Improving healthy life expectancy, with the aim of being in the top half of London boroughs for this measure by 2037, is a Borough Manifesto target (Figure 3).

Figure 3: Borough Manifesto targets



Source: State of the Borough report, 2018; 1 = best in London; 32 = worst in London.

11. Greater London Authority 2016-based Unconstrained Borough Preferred Option projection, 2018.

12. Gov.uk, Prime Minister sets out 5-year NHS funding plan [https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan]. Accessed 2019 Apr 23.

The most recent data (2015–17) estimates male healthy life expectancy at 62.8 years and female healthy life expectancy at 62.3 years, suggesting an average of 19.8 years in poor health for females and 15 years in poor health for males.<sup>13</sup>

Healthy life expectancy tends to be more variable than life expectancy because it requires people of both genders and a wide variety of age groups for each area to be surveyed on how they perceive their health. As it is not feasible to ask everyone in a specific area about their health (except in censuses), this leads to uncertainty about whether the results are representative of the broader population of that

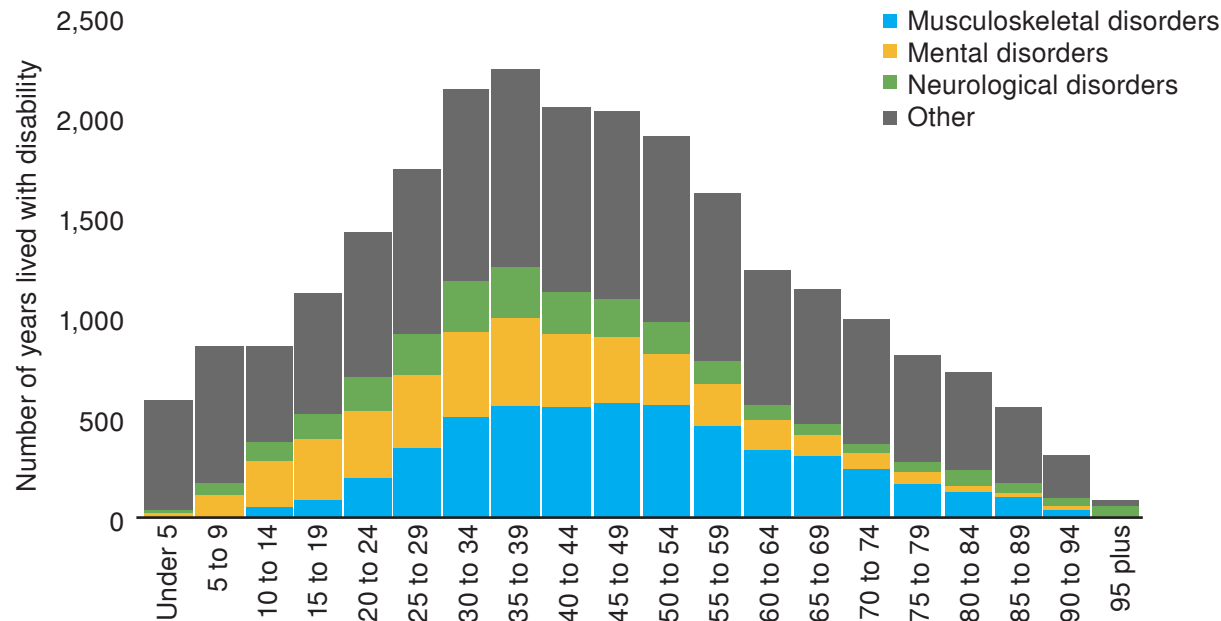
area. This is especially pronounced when the number of people surveyed for each age–gender group is small. Nonetheless, it is the best routine summary measure we have for looking at ill health across a population.

Unlike recent years, the most recent data points for both males and females are no longer significantly lower than London, which is a positive improvement, but it needs to be maintained.

Analysis using Global Burden of Disease data suggests that the highest burden of ill health in the borough comes from low back pain,

headache disorders and depressive disorders. Although ill health increases with age, our young population structure means that over half of years lived with disability (a measure of ill health rather than disability in the way it might commonly be understood) are experienced by people under the age of 45 (Figure 4). However, there are limitations with the modelling of ill health at local authority level, such that while these are likely to be key causes of ill health, we cannot necessarily pinpoint exactly why our burden of ill health is higher than that of London from this source alone.<sup>14</sup>

**Figure 4: Crude burden of ill health (as number of years lived with disability) by broad condition type by age, Barking and Dagenham, 2017**



*Note: the crude numbers above reflect both the underlying rate of ill health and the population size by age group. 'Neurological disorders' largely relates to headache disorders (migraine and tension headache), with a smaller burden from Alzheimer's disease/other dementias, epilepsy, and other conditions.*

Source: Global Burden of Disease Study, 2017 round.

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

14. See: Steel N, Ford JA, Newton JN, Davis ACJ, Vos T, Naghavi M, et al. Changes in health in the countries of the UK and 150 English Local Authority areas 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet* 2018;392(10158):1647–61.

## What are the drivers of low life expectancy relative to the rest of London?

Returning to life expectancy as the foundation for both measures and an area where more robust data is available at local authority level, modelled data from the Global Burden of Disease Study (2017 round) suggests that the largest contributors to the gap in life expectancy, between Barking and Dagenham and London, are higher death rates in people aged around 50 and above from cancer and cardiovascular disease, and to a lesser extent chronic respiratory disease, respiratory infections and digestive disorders.

This is based on analysis looking at how many deaths we would expect if we had the same age-specific mortality rates as London in 2017. This is a pragmatic benchmark; it does not mean that London mortality rates could not be improved, and nor should it underestimate the scale of the challenge in comparing Barking and Dagenham to a region which includes areas with some of the very highest life expectancies in England. It makes no attempt to account for differences in population other than the age profile by gender. Nonetheless, it provides a starting point for trying to understand what is driving the difference in life expectancy.

The analysis suggests that the scale of this inequality with London, and between the genders, is staggering. If our population had London's age- and gender-specific death rates, there would be around 170 fewer male deaths a year and around 80 fewer female deaths. This is in the context of a borough with around 620 deaths per gender in 2017.<sup>15</sup>

**Table 1: Barking and Dagenham deaths compared with expected deaths if Barking and Dagenham had London age-specific rates, 2017**

	Male				Female			
	Deaths			Excess mortality	Deaths			Excess mortality
	No.	No. if had London rates	Difference		No.	No. if had London rates	Difference	
Cancers	200	139	61	44%	170	145	25	17%
Cardiovascular diseases	175	129	46	36%	159	148	11	7%
Chronic respiratory diseases	55	33	22	67%	51	37	15	40%
Respiratory infections	38	25	13	52%	50	39	10	27%
Digestive diseases	31	23	8	34%	33	27	6	24%
Neurological disorders	51	40	11	28%	91	89	2	2%
Other	71	60	11	18%	67	56	11	19%
<b>Total</b>	<b>621</b>	<b>449</b>	<b>172</b>	<b>38%</b>	<b>621</b>	<b>541</b>	<b>80</b>	<b>15%</b>

Source: Global Burden of Disease Study, 2017 round.

15. It is worth noting that the difference between Barking and Dagenham and London life expectancies by sex is more pronounced in the Global Burden of Disease (3.0 years for males and 1.6 years for females for 2017, compared with 2.7 and 2.2 years in the Office for National Statistics (ONS) data for 2015–17). While the Global Burden of Disease data uses the same underlying source as the ONS data, it applies modelling to try to account for real world inaccuracies in the data (e.g. incorrect coding of cause of death). The two sources also differ in time periods and methodology for constructing the life expectancy.

The highest numbers of excess deaths from the modelled 2017 data were from cancers (86 deaths) and cardiovascular diseases (57 deaths), which reflects the fact that these are the most common causes of death across the country. Looking at the excess mortality column in Table 1, we can see that other conditions, notably chronic respiratory diseases, are associated with higher excess mortality than cancers or cardiovascular diseases in males. Mortality in Barking and Dagenham from chronic respiratory diseases is 67% higher than we would expect from London rates and in females 40% higher.

Certain causes of death dominate within this: ischaemic heart disease accounted for 40 excess deaths (30 male; 10 female), chronic obstructive pulmonary disease (COPD) accounted for 34 excess deaths (19 male; 14 female) and lung cancer accounted for 32 excess deaths (22 male; 10 female).

After lung cancer, the next most important causes of excess cancer death accounted for 6 excess deaths each – colorectal cancer, prostate cancer and stomach cancer – showing just how dominant lung cancer is in causing excess cancer mortality in Barking and Dagenham relative to London. Within cardiovascular

diseases, the next most important causes of excess death after ischaemic heart disease is stroke (10 excess deaths) and aortic aneurysm (7 excess deaths).<sup>16</sup>

The three main causes of excess deaths – ischaemic heart disease, COPD and lung cancer – are largely preventable; Global Burden of Disease data suggests that 93% of ischaemic heart disease deaths, 63% of COPD deaths and 85% of lung cancer deaths in Barking and Dagenham are theoretically preventable.

**Box 2: Top five risk factors for ischaemic heart disease, COPD and lung cancer deaths in Barking and Dagenham**

<i>Ischaemic heart disease</i>	<i>COPD</i>	<i>Lung cancer</i>
1. Dietary risks	1. Tobacco	1. Tobacco
2. High blood pressure	2. Air pollution	2. Occupational risks
3. High cholesterol	3. Occupational risks	3. High fasting plasma glucose
4. High fasting plasma glucose		4. Air pollution
5. High BMI		5. Dietary risks

**The three main causes of excess deaths – ischaemic heart disease, COPD and lung cancer – are largely preventable**

16. Note: for some causes Barking and Dagenham had lower mortality rates than London, so individual causes can add to more than 57

The biggest population impact on life expectancy – looking solely at immediate risk factors – would therefore come from measures to improve cardiovascular health (e.g. diet and exercise) and reducing smoking.

These are not new observations from the Director of Public Health – the role of diet, exercise and smoking cessation are already widely understood. The challenge is how to tackle the underlying issues that impact the incidence of these conditions – the wider determinants of health – in order to effectively reduce premature mortality in our population.

The wider determinants of health relate to the conditions in which you live your life and the places and people you share it with, as these have a significant impact on your health. This includes issues such as housing, employment, income, social status, crime (or fear of crime) and education. This is

intuitive; health is not something that happens in isolation from the rest of your life. Residents in the poorest communities are 4.4 times more likely to smoke than those in the wealthiest communities,<sup>17</sup> while residents of the most deprived areas are 3.9 times more likely to die of cardiovascular disease by age 75 and 2.2 times more likely to die of cancer by this age than those in the least deprived areas.<sup>18</sup> Levels of childhood obesity are more than double in children from the most deprived communities than those living in the least deprived areas.<sup>19</sup>

These are strong and persistent drivers of health inequalities, leading to differing trajectories and outcomes over the course of a resident's life, and influencing life expectancy and healthy life expectancy. Some residents are impacted more by the negative influences of health, leading to shorter life expectancy and more years living with disability. Therefore, the Council's overarching approach is about enabling independence, participation and human relationships across the community, because local government has immense potential to act as a facilitator in this sense to influence these wider determinants of health. We are not solely interested in just delivering traditional health and care services to those with acute needs today but consider primary and secondary prevention key to every part of the Council.

The case for tackling the wider determinants of health along with appropriate policy recommendations are outlined in the 2010 Marmot Review on health inequalities: **Fair Society, Healthy Lives.**<sup>20</sup>

We need to seek to understand and consider the context in which people live their lives in order to effectively tackle issues such as smoking, diet and exercise, and to reduce inequalities. Across partners, creating opportunities for health is everyone's responsibility – working to improve the wider determinants is how we can make a real difference to the health, and therefore life expectancy of residents in Barking and Dagenham. Chapters 2, 3 and 4 all outline the different ways we can look beyond health and care to make improvements to health and wellbeing, and life expectancy in Barking and Dagenham.

### What are we doing to improve life expectancy?

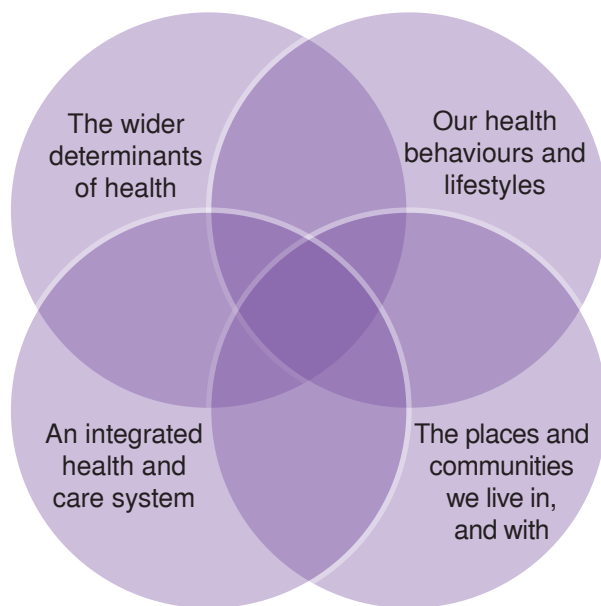
Given the complexities involved in tackling life expectancy, a single programme of work is not the answer. Instead, we need to influence a wide range of actors and actions. This is in line with a November 2018 report from The King's Fund<sup>21</sup> which suggested a framework for population health based on four separate pillars: 1) the wider determinants of health; 2) our health behaviours and lifestyles; 3) an integrated health and care system; 4) the places and communities we live in, and with.<sup>22</sup>

Figure 5 shows the four pillars and how they can interact with each other. Prioritising interventions that target multiple pillars or bringing together the work of multiple partners is important for progress to be made. The rebalancing between the pillars and the focus on these areas aligns with the Council's focus on inclusive growth, participation and engagement, and prevention, independence and resilience.

17. ONS/PHE, Smoking inequalities in England, 2016. Refers to odds ratios comparing smoking in most deprived and least deprived deciles nationally.  
18. PHE, Health profile for England: 2018. Chapter 5: inequalities in health: [https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-5-inequalities-in-health].  
19. National Childhood Measurement Programme 2017-18 https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2017-18-school-year  
20. Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair Society, Healthy Lives: The Marmot Review. London: UCL; 2010.  
21. https://www.kingsfund.org.uk/publications/vision-population-health  
22. Buck D, Baylis A, Dougall D, Robertson R. A vision for population health: Towards a healthier future. London: The King's Fund; 2018 [https://www.kingsfund.org.uk/publications/vision-population-health].



Figure 5 The King's Fund framework for population health



We are also operating in the context of austerity; therefore, radical changes may be needed in order to make a difference with the resources we have – Chapter 2 sets out a new model of care that moves away from a traditional GP centred approach. Similarly, a prevention approach where we create health rather than manage ill health is the best option for both our residents' wellbeing and the sustainability of our services – Chapter 3 builds on this to look at how tackling issues such as domestic abuse can be part of a strategy to prevent ill health. Chapter 4 looks at how a whole systems approach can bring both strands together.

**We need to seek to understand and consider the context in which people live their lives in order to effectively tackle issues such as smoking, diet and exercise, and to reduce inequalities.**

### The Joint Health and Wellbeing Strategy 2019–23

In 2018/19, we revised our Joint Health and Wellbeing Strategy<sup>23</sup>. It focuses on three key areas that we thought would make the most difference to the health of our residents:

- Best start in life
- Early diagnosis and intervention
- Building resilience

This approach recognises the importance of action needed at every stage of life, including

at working and older ages, to improve equity within and between generations. This will, in turn, allow more focus on preventing health risks and reducing their cumulative effect throughout life and across generations, and mitigate the economic burden of health care costs.

We wanted to make sure that action was targeted at areas that were important to residents, so for the first time there was strong engagement with our residents in the development of this strategy, and their views

contributed to 'I' statements. This sort of co-production is key to the implementation of effective action. If we are not working with our residents to address their needs and understand how to tackle the issues we have identified, then how can we be surprised if top-down approaches do not resonate with them and do not have the intended effect. I build on this point in Chapter 2.

23. <https://www.lbbd.gov.uk/sites/default/files/attachments/Joint-Health-and-Wellbeing-Strategy-2019-2023.pdf>

### Box 3: Joint Health and Wellbeing Strategy themes

**Best start in life:** Best start in life refers to all interventions and conditions from preconception to age 7 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.

This work on new ways of engaging with residents around their health and wellbeing reflects the wider strategic approach currently being developed by the Council. Participation and engagement are key themes that will drive service design principles and professional culture moving forward. Focusing on these areas should result in gains in life expectancy through different mechanisms and at different stages in the life course. For example, best start in life is essentially a prevention approach. Early childhood is a crucial time for setting the foundations for future health. Studies suggest that the odds of experiencing cardiovascular disease are about twice as high for those with four or more adverse childhood experiences compared with those who have none.<sup>24</sup> Another study suggests that the risk of lung cancer increases with number of adverse childhood experiences – even after adjusting for smoking status.<sup>25</sup>

We explore how tackling adverse childhood experiences and recognising these in our approaches to health and care should benefit our residents health in Chapter 3.

Early diagnosis and intervention are about ensuring that individuals receive prompt diagnosis and treatment. For example, this could include improving coverage of screening programmes, such as for breast, bowel and cervical cancers. Our breast cancer screening coverage (67%) is significantly lower than London or England, while our bowel cancer screening coverage is amongst the lowest in England (43.7%).<sup>26</sup>

Improvements are required in targeting those vulnerable and hard to reach groups who do not come into contact with health services or who may require additional support. One way that this is being addressed is through Barking and Dagenham acting as an NHS England test bed for the digital NHS Diabetes Prevention Programme. There are other initiatives such as making every contact count (MECC), for which training is being rolled out across the borough to help frontline staff in the early detection and diagnosis of conditions.

Including resilience as a priority underlines our recognition that the wider determinants of health are key levers for action. We have already highlighted the stark impact of deprivation on health. As another example, employees working in jobs where they have low control have been found to have a higher risk of cardiovascular disease, even accounting for other factors such as age, smoking status and cholesterol.<sup>27</sup>

As such, the Joint Health and Wellbeing Strategy 2019–23 includes measures relating to the wider determinants of health, including education and employment. The social prescribing pilot running in the borough provides an opportunity to tackle wider determinants of health such as housing, finance and employment. Social prescribing will be supported by the NHS Long Term Plan, so understanding now, how we can make this work most effectively locally, should provide us with a good foundation for the future.<sup>28</sup>

24. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health* 2017;2(8): e356–e366.


25. Brown DW, Anda RF, Felitti VJ, Edwards VJ, Malacher AM, Croft JB, et al. Adverse childhood experiences are associated with the risk of lung cancer: a prospective cohort study. *BMC Public Health* 2010;10:20.

26. Breast cancer – PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>]; 2017/18; Bowel cancer data – PHE, Young person and adult screening KPI data: Q1 (1 April 2018 to 30 June 2018).

27. Bosma H, Marmot MG, Hemingway H, Nicholson AC, Brunner E, Stansfeld SA. Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) study. *BMJ* 1997;314(7080):558–65.

28. NHS. NHS Long Term Plan [<https://www.longtermplan.nhs.uk/>]. Accessed 2019 Apr 12.





The Joint Health and Wellbeing Strategy 2019–23 has already been used in the Council in reviewing spending from the public health budget. In addition, it has been widely shared with partners to inform decisions across the health, care, community safety, housing and community sectors. Furthermore, the 2018 Joint Strategic Needs Assessment was created in parallel with the Strategy, so they are closely aligned, and information is available to support its implementation. The Council's transformation work is also supported by the Strategy's key themes and focus on early intervention and our vulnerable population.

I go into more depth about how the transformation aligns with a Public Health approach in Chapter 2.

We have also carried out the first phase of a review of the lifestyle services provided by Community Solutions (the Council's front door to services) to align them with the Strategy's priorities, the long-term aims outlined within the Borough Manifesto and the public health savings plan.

Phase 2 will consist of the development of detailed proposals with cost savings and service delivery plans from April to September 2019 in consultation with key stakeholders.

#### Box 4: Review of public health commissioned Community Solutions programmes

In early 2019 we carried out a review of public health services provided by Community Solutions, such as weight management and smoking cessation programmes. The review's purpose was to look at Community Solutions services funded from the Public Health Grant to:

- Assess their impact, cost-effectiveness and efficiency
- Identify any gaps and issues in service provision
- Put forward service design principles, recommendations and guidelines on how to embed prevention within the system by targeting the most vulnerable groups
- To devise a system-wide approach to tackle unhealthy behaviours

The recommendations included transforming the lifestyle services to develop a robust system-wide place-based offer with input from the NHS, community voluntary sector and Council services to tackle the risk factors for ill health and low life expectancy.

The recommendations also propose a multi-disciplinary team approach in making this happen with targeted interventions for those with complex and higher needs and a universal offer at a population level. The review stresses the need to make use of technology to scale up lifestyle programmes for population level access at minimum cost.



## Supporting a public health approach across the Barking Havering and Redbridge integrated care system

I reported on the Barking Havering and Redbridge integrated care system (BHR System) in my 2016–17 report. Since then, the integration of health and social care services across the three boroughs has picked up speed and governance structures have been established.

This has allowed for more joined-up working, including those in relation to prevention. All transformation workstreams will consist of a prevention element which poses an opportunity to work with the NHS to scale-up and target these programmes to the right communities.

We have created a toolkit to facilitate the creation of prevention action plans for the transformation boards (the boards which are transforming services across the BHR System). This provides a structured approach to determining which issues to tackle and how to monitor success.

Progress towards outcomes-based commissioning also represents an opportunity to make prevention a core part of an integrated health and care system. Another important feature of future working will be place-based care, which is a key part of the NHS Long Term Plan. Place-based care in Barking and Dagenham relates to three localities, with a fourth to be created as the population of Barking Riverside grows. Place-based care is explored further in Chapter 2.

## Conclusion

Our male and female life expectancies remain the lowest in London. Our residents are dying earlier than they should from potentially preventable conditions. Analysis using Global Burden of Disease data suggests that if Barking and Dagenham had London's mortality rates, around 250 deaths each year could be averted, with ischaemic heart disease, COPD and lung cancer being the key contributors to this gap.

However, we don't just want our residents to live longer lives, we want them to live more of their lives in good health. Ensuring that more residents live more of their lives in good health is not simply a medical issue – a focus on prevention and the wider determinants is likely to have the biggest impact at a population level, and there is also a need for a system-wide approach to enable and facilitate this work. I outline what this looks like in practice in Chapters 2, 3 and 4.

The ongoing challenge is to break the generational cycle of disadvantage that drives health inequalities. Our Joint Health and Wellbeing Strategy suggests that we focus on the right areas by taking a preventive approach, working to ensure that those with health conditions receive an early diagnosis and intervention, and recognising wider determinants. The BHR System is similarly supporting a system-wide view that should enable these approaches to be undertaken more effectively.



**We have created a toolkit to facilitate the creation of prevention action plans for the transformation boards (the boards which are transforming services across the BHR System).**



## Chapter 2

Local service redesign:  
our work on designing  
new models of care

## National policy context and an introduction to place-based care

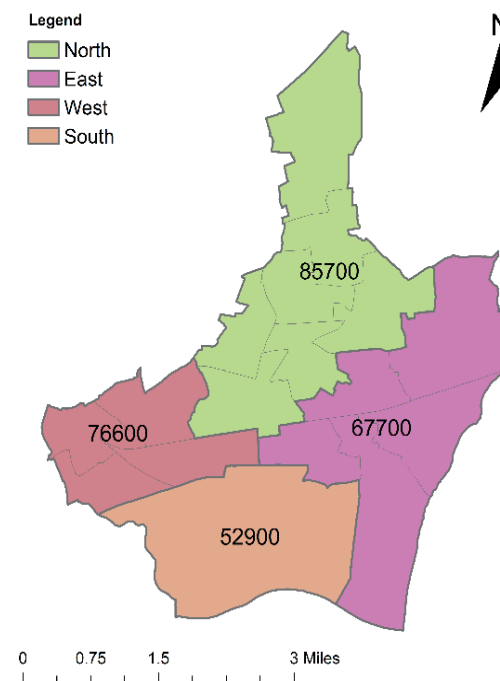
In my 2016/17 annual report,<sup>29</sup> I discussed the ongoing work of the Integrated Care Partnership to help make the vision of a Barking Havering Redbridge Integrated Care System (BHR System) a reality. The Rt. Hon Matt Hancock MP, Secretary of State for Health and Social Care has set out a vision for prevention and has signalled that a Green Paper on social care for adults will be published in 2019. His vision both '*sets out how we can use new technology, workplace strategies and the power of local communities to support people with health issues and prevent worsening health*' and also an expectation for the extra £20.5bn a year by the end of 2023–4 that the NHS will receive to be spent '*with the health and social care system working in an integrated way*'.<sup>30</sup>

Central to this is the place-based care model, which encourages providers of services to work together to improve the health and care of their population around a shared vision and shared objectives, using pooled budgets to deliver services that work together. In Barking and Dagenham, we can build upon our well-established Integrated Care Model that works in our existing localities, which includes co-located health and social care teams. We need to build on this existing good practice with a clear focus on population-level outcomes and

shared decision-making processes to assess how best to get there. A consequence of this is that we will need to review whether to deliver our current integrated services from outside of traditional settings and delivered differently from expecting residents to attend doctors' surgeries or buildings.

The direction of travel for integrated care within the London boroughs of Barking and Dagenham, Havering and Redbridge along with the publication of the NHS Long Term Plan in January 2019<sup>31</sup> and the proposed changes to the General Medical Services (GMS) contracts for GPs<sup>32</sup>, all highlight the importance of our well-established approach of integrated health and care localities. Figure 6 identifies the localities that will deliver services to populations of at least 50,000 to 80,000.

**Figure 6: Map showing population estimates 2030 for the four Barking and Dagenham localities**



Source: Greater London Authority 2016-based Unconstrained Borough Preferred Option projection, 2018. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.

29. Director of Public Health Annual Report 2016/17: Reframing health challenges: gaining new insight into how to scope and shape new service approaches (2017) - <https://www.lbbd.gov.uk/sites/default/files/attachments/LBBD-Annual-Health-Report-2016-17.pdf>  
30. Department of Health and Social Care (2018) – Our vision to help you live well for longer - [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/753688/Prevention\\_is\\_better\\_than\\_cure\\_5-11.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf)  
31. NHS Long Term Plan (2019) <https://www.longtermplan.nhs.uk/>  
32. General Medical Services (GMS) contract changes 19/20 - <https://www.england.nhs.uk/publication/gms-contract-changes-2019-20/>

The further development of these localities is key to supporting our transformation agenda in Barking and Dagenham. The Health and Wellbeing Board see the proposed primary care networks being built around our four agreed localities and drawing in expertise as required from hospital-based care, community services, social care, public health and the voluntary community and social enterprise sectors, to deliver services customised to the locality population. The starting point to establish place-based systems of care is to define the population served and what the barriers to, and boundaries of, collective working are. The scope should not just be focused on the NHS and social care but also on the wide range of other Council services

and other partners that contribute to health, such as the Metropolitan Police, London Fire Brigade, schools and the voluntary community sector and so on. This provides the opportunity to focus on the needs of the population that they serve – it provides the opportunity to take responsibility for all the residents living within a given area.

Although there is a strong and steadily growing evidence base that prevention is a cost-effective way to reduce demand on the NHS and social care services, our existing prevention programmes and services are yet to realise these demand reduction benefits that have been achieved in other parts of London and the country as a whole. We will miss a trick if we don't capitalise on this

opportunity to jointly commission integrated prevention programmes that go beyond care to tackle, for example, social isolation, neglect and homelessness. It is important to acknowledge that reducing demand and prevention are not the same thing. A key long-term outcome of prevention would be a reduction in the use of high-cost downstream services, such as A&E, adult social care and care homes and prevention programmes are part of the solution.

The new 2019 North East London Primary Care Strategy provides an opportunity through a vision of primary care that is both person-centred and prioritises a radical approach to prevention.

Figure 7: North East London Primary Care Vision



It is important to acknowledge that reducing demand and prevention are not the same thing

Despite considerable progress, we recognise that we have a long way to go to achieve our vision of delivering high quality seamless care, enabled by new workforce models, better use of estates and resources and connected data and innovative digital technology. General practice will be responsible for delivering core services and ensuring continuity of care for each resident in our population.

Learning from our experience of the existing Integrated Care Model, progression and development of a successful place-based care model requires a radical transformation of primary care: Radical in not being a GP-centric model as workforce constraints and demand is putting primary care under unprecedented strain. Despite efforts to increase the number of GPs and practice nurses we are not keeping pace with demographic pressures as identified

in Figure 8 below. The Strategy's aim to increase our GP workforce by 20% (from a September 2015 baseline) by 2021 is a challenging one.

### What are the key messages for Barking and Dagenham?

To achieve the ambition over the next 5 years, not only does general practice need to look and feel very different, we also need to ensure that the NHS commissioners and NHS trusts have clearly defined interdependencies with the Council and other partners, such as joint commissioning and estates strategies, joint digital plans and strategies and integration of services that go beyond care.

We also need to consider how other aspects of our prevention approach will fit within this integrated model. Firstly, interventions that seek to change behaviour without addressing

the wider social and environmental constraints on choice are likely to have limited impact. Secondly, only if we use all the data at our disposal and every resident contact to improve the experience and service provided to that individual, we can push the boundaries of our prevention approaches.

We should, therefore, seek a better balance between a system focused on detecting and treating ill health with one that also predicts and prevents poor health. The Council has a clear leadership role to ensure a balanced focus on the wider determinants that impact on health as discussed in Chapter 1.


To maximise the impact of targeted prevention and early intervention programmes, the insight the Council has, at its disposal, through proactive use of data to identify individuals who

**Figure 8: GP and practice nurse workforce ratios**

CCG	GP RATIO	GPN RATIO
Barking and Dagenham	1:2225	1:5856
Havering	1:2133	1:5436
Redbridge	1:2591	1:9659
TOTALS	1:2319	1:6709

Source Primary Care Web Tool (Sep 2017 and Sep 2018)

London Average GP:Patient	National Average GP:Patient	National Average Nurse:Patient
1:2100	1:2000	1:3600



could benefit from interventions is a key element of place-based care. Through segmenting the population using a range of data and using best practice evidence to identify *which* population groups are contributing most to demand, *where* in the borough they live, *what* characteristics they share, and how we might intervene differently in order to either prevent this demand from accruing to our health and care services or stepping it down once it does. This allows us to better target our interventions and key messages through the localities to ensure that they resonate with residents, and consequently have a greater impact on health outcomes.

For example, the excellent insight work undertaken by the Council has identified that demand for our services is manifesting across the life course as four themes: neglect, frailty, mental health/disability and homelessness. What we need to understand is what factors are causing this demand, i.e. why does someone end up neglected or homeless? That intelligence will enable us to identify residents who are not yet holding this complex demand, but who might in the future, i.e. who would benefit most from prevention. Given the widespread nature of these issues in the borough, there is an argument for reassessing the balance of resourcing between our universal and targeted prevention programmes. New models of care being developed, such as Barking Riverside, allow us to trial a new integrated early intervention approach in respect of these four themes.

To unlock the health improvement potential, we need to re-focus what we do collectively to develop an effective early intervention offer across the life course that reflects the reality of the pressures on our integrated care system.

This can only be achieved if NHS and Social Care commissioners and the Alliance of Providers automatically include collaboration with other Council services, voluntary community services and sectors beyond health and care to focus on the broader aim of improving population health and wellbeing – not just on delivering better quality and more sustainable health and care services. For example, in moving forward how do we connect primary care with our intervention programmes in personal, health, social and economic (PSHE) education in schools, domestic abuse, homelessness, poor housing, childcare, drugs and alcohol? Through this, we have the potential to get upstream and reduce the demand for more expensive interventions further down the line, such as mental ill health management, temporary accommodation, looked after children and long-term worklessness.

### What does this mean for Barking and Dagenham residents?

#### Barking Riverside progress:

Since my 2016/17 annual report, there has been ongoing progress towards developing the new model of care for Thames ward. As a new development accommodating 10,800 new homes and a population increase of over 22,000 residents by 2037, the development will bring a new town to the borough, with a range of implications and opportunities for health, including the opportunity to reduce health inequalities and the challenge to make sure they do not widen. Barking Riverside Ltd (the developers) are obliged under planning regulations to make financial contributions for the new community and health infrastructure

that is required to support the new population. This provides BHR System partners with the opportunity to explore the development of an innovative new model of wellbeing in an area of high deprivation, where services are delivered in a truly place-based model.

The intention is to develop an integrated Health and Wellbeing Hub located in Barking Riverside and serving the wider Thames ward area. The vision is for the Hub to be a building that connects people with one another, with the wider community and with a broad range of services to support their aspirations and needs. The Hub aims to link together health, leisure and a range of community services to offer a new model of delivering health and care. A series of workshops took place in autumn 2018, bringing together partners from the BHR Clinical Commissioning Group, the Council and the Barking Riverside System Development Board, together with a programme of engagement with residents to feed into the development of the proposed model of care, to ascertain the key requirements of the physical building and wider Thames ward environment.

One of the key challenges that we must ensure we answer going forward is how we're reducing health inequalities – **how can we ensure that existing residents are benefiting from the new development in Barking Riverside?** This process demonstrates that delivering a new model of care requires substantial cross-organisational working and engagement, including developing sustainable models of co-production with residents. Developing a model of care at Barking Riverside that will truly transform the way that local people receive care – as well as how they perceive health and wellbeing – marks the exciting start of a journey towards

place-based care in Barking and Dagenham. Teams of existing health and care staff across the borough will continue to explore ways of creating more seamless high-quality care within place-based care, building on the learning from the development of this new model of care at Barking Riverside.

To enable this, **we need to ensure that a focus on new contractual arrangements must not neglect the good groundwork that has taken place to make meaningful changes to the way care is delivered.** Other approaches to supporting the development of new service models such as use of quality improvement methods, dedicated resources for care redesign and other approaches related to leadership culture and management are likely to be just as if not more, important than technical changes to contracting models.

### Co-production of Care

Another key way in which we're looking to deliver health and care differently is through **prioritising co-production to work differently with health and care service users.** Within health and care, co-production recognises that residents who use services and others involved in the process are key to future proofing services. There has already been a large amount of work with local communities to date, including the engagement around the Health and Wellbeing Hub discussed above.

As referenced in Chapter 1, we also consulted with residents when we refreshed our Joint Health and Wellbeing Strategy in 2018/19. This was the first time we have co-produced the Strategy with residents by including 'I' statements which outline the priorities of

residents in relation to each of the three themes. When we looked at the results of our resident engagement, the most popular 'I' statements, highlighted by the blue stars below, across all three themes were ones relating to connections with others. These came out above accessing information about their child's health, or long-term conditions, which suggests we should consider this in the way we deliver care.


Hilary Cottam argues that *"we need to look at the way our public services are delivered and place relationships and human connection at the heart of services. That when people feel supported by strong relationships, change happens"*<sup>33</sup>. Taking these arguments into consideration, we need to look at the ways in which we deliver our health services: we need to work on engaging in new ways with residents around health and wellbeing.

Figure 9: Joint Health and Wellbeing Strategy 'I' statements produced through resident focus groups

<p><b>'I' statement 1</b></p> <p>I am provided with information about how to best to ensure my child's health and development</p>	<p><b>'I' statement 4</b></p> <p>I feel my mental health conditions are treated with the same respect as my physical conditions without stigma</p>	<p><b>'I' statement 7</b></p> <p>I feel safe in my home and in my family, and my community, and I know where to go for help</p>
<p><b>'I' statement 2</b></p> <p>I am supported to meet other parents in the community</p> <p style="text-align: right;">★</p>	<p><b>'I' statement 5</b></p> <p>When I am diagnosed, my family and I know where to find community support services, including emotional support</p> <p style="text-align: right;">★</p>	<p><b>'I' statement 8</b></p> <p>I have opportunities to connect to individuals and communities</p> <p style="text-align: right;">★</p>
<p><b>'I' statement 3</b></p> <p>I am supported to make healthy choices for me and my child</p>	<p><b>'I' statement 6</b></p> <p>When I am diagnosed, I am supported with the information about my condition I need to make decisions and choices</p>	<p><b>'I' statement 9</b></p> <p>I can access mental health support services when I need them</p>

33. <http://www.hilarycottam.com/radical-help/>





The Wigan Deal provides useful insight. Since 2011, Wigan Council has embarked on a major process of change involving moving towards asset-based working at scale, empowering communities through a 'citizen-led' approach to public health and creating a culture which permits staff to redesign how they work in response to the needs of individuals and communities. At the heart of this is an attempt to strike a new relationship between public services and local people that has become known as the 'Wigan Deal'.

This work on new ways of engaging with residents around their health and wellbeing reflects the wider strategic approach currently being developed by the Council. Participation and engagement are one of three key themes that will drive the strategy, commissioning intention, service design principles and organisation leadership and culture of the organisation moving forward.

### Social prescribing

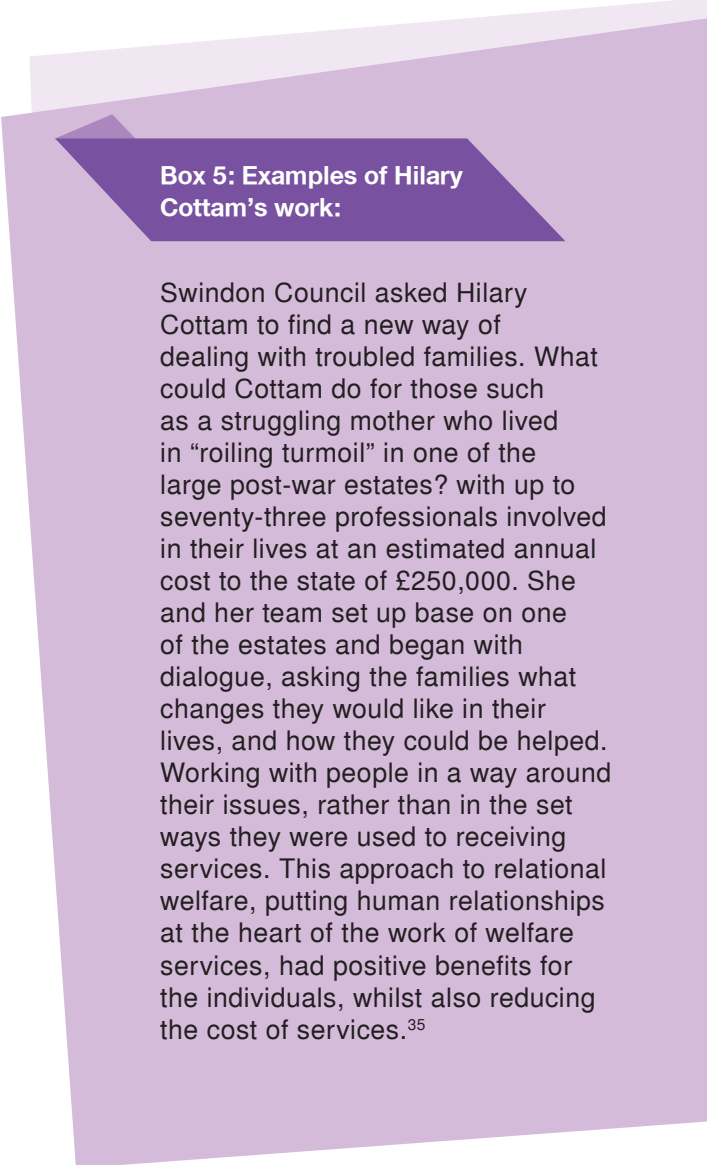
One of the ways in which we've started this process in Barking and Dagenham is through social prescribing. Our partners in North East London NHS Foundation Trust's Care City have been trialling a programme called **Health Unlocked** which is a digital social prescribing system in GP practices in Barking and Dagenham, while Community Solutions are also piloting a social prescribing model.

Around 20% of people visit their GPs for non-clinical reasons – from finance to social isolation. Social prescribing can help tackle the root of their problem. In an area such as Barking and Dagenham, which has some of the

highest deprivation rates in the country, this is as high as 50%. For those with personalised care, including personal health budgets and personal independence payments, it is more important than ever that they can access high-quality services that can complement clinical provision, to protect their health and wellbeing.<sup>34</sup>

The social prescribing projects described above have seen residents able to access information, interventions and support that previously their GP had been unable to provide them with. By utilising social prescribing and place-based care we can create a community that needs less intervention from healthcare professionals, but which is resilient by being supported holistically when required through some of life's challenges. The idea of creating a population that can bounce-back (and bounce-forward) from a challenge is mirrored in the Joint Health and Wellbeing Strategy.

As I noted in Chapter 3 of my 2016/17 report, the radical redesign of Council services that aimed to get upstream of cases of complex need by tackling the root causes through the creation of Community Solutions presented a real opportunity for social prescribing. The Community Solutions social prescribing pilot has seen some of our most vulnerable residents be linked with support for housing, debt and employment issues to help address their underlying issues and improve their overall wellbeing. This is an outcome that would not have been realised through traditional health care, but by bringing the model of care outside the walls of a GP practice we have been able to help residents thrive.



### Box 5: Examples of Hilary Cottam's work:

Swindon Council asked Hilary Cottam to find a new way of dealing with troubled families. What could Cottam do for those such as a struggling mother who lived in "roiling turmoil" in one of the large post-war estates? with up to seventy-three professionals involved in their lives at an estimated annual cost to the state of £250,000. She and her team set up base on one of the estates and began with dialogue, asking the families what changes they would like in their lives, and how they could be helped. Working with people in a way around their issues, rather than in the set ways they were used to receiving services. This approach to relational welfare, putting human relationships at the heart of the work of welfare services, had positive benefits for the individuals, whilst also reducing the cost of services.<sup>35</sup>

34. <https://www.london.gov.uk/sites/default/files/social-prescribing-our-vision-for-london-2018-2028-v0.01.pdf>

35. <https://www.theguardian.com/society/2011/feb/09/tough-love-troubled-families-swindon-participle>

Working with residents differently, through approaches which emphasise the importance of human relationships, such as social prescribing, provides the opportunity to make a real difference to residents' lives by addressing root causes. In addition to social prescribing, we're also working on developing a place-based model of care in Barking and Dagenham using care navigation, community resources and multi-disciplinary team meetings to help keep residents out of hospital. This is outlined in Figure 10 below.

Dynamically identifying those residents who are at risk of frailty using data is a key component of place-based care. Better understanding of our population will enable us to target our

interventions based on what we know about residents including their values and behaviours. We can stop residents escalating to our specialist and statutory services, as we know frailty is the biggest driver of demand for our health and care services, whilst also improving outcomes for our residents.

### Accountability

Health and wellbeing boards are the only partnership arrangement in the current system formed on a statutory basis. The boards bring together political, clinical, social care, public health and Health Watch leaders as equal partners. Therefore, our Board needs to

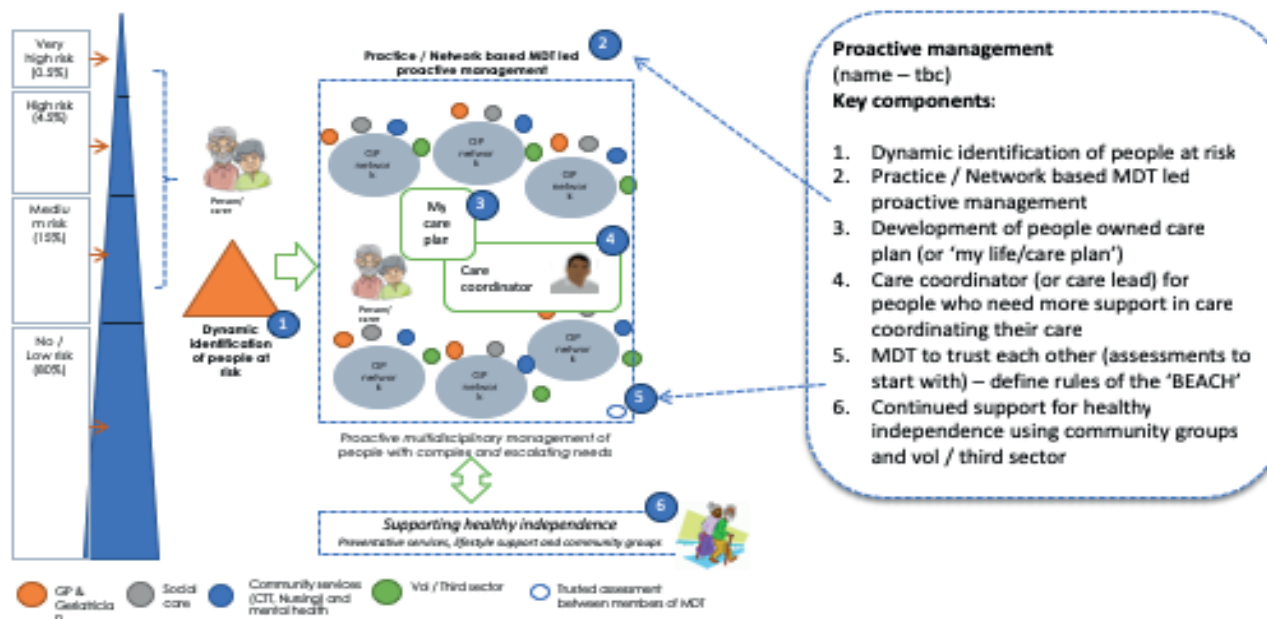
### Box 6: Social Prescribing


A patient was referred into the social prescribing pilot due to reported symptoms of depression, anxiety and social isolation. The link worker met with the patient and discussed what activities they might like to get involved in. They discussed interests in gardening and sewing. Together they identified an arts and crafts group run by Green Shoes, who support people with poor mental health. They attended the first session together until the patient felt comfortable to be there alone.

A few days later the link worker got back in touch and they discussed the positive experience at Green Shoes. The patient said they were going to attend regularly, and their family was happy they were able to get out of the house again. During their work together, the link worker was able to encourage the patient to restart talking therapies to help with depression and anxiety.

Figure 10: Place-Based Model of Care from BHR Older People's Transformation Board

### Integrated model of care – proactive management in community





continue being at the heart of driving the shift in health and social care thinking from what partner organisations ‘do’ to what organisations ‘do together’.

To embrace Cottam’s argument, we need to look at the way our public services are delivered, and place relationships and human connection at the heart of services. We need to consider locality accountability and governance arrangements that further ensure clear lines of accountability to residents and enable commissioners and front-line staff to step outside of ‘silo’ thinking; we need a focus on the broader needs of the locality and how this can be better addressed by combining resources. As in many areas of integration, there is no ‘one size fits all’ model of accountability and governance. When assessing these new arrangements, our Health and Wellbeing Board should consider these elements:

- Clear lines of accountability to residents.
- Decision making goes beyond the co-ordination of services.
- Elected Members provide democratic accountability in oversight and decision making.
- The experience and voice of people (including children and young people) who use services, carers and communities within decision making.
- Clinical and professional expertise in oversight and decision making.

## Conclusion

Our Health and Wellbeing Board and the Barking Havering and Redbridge Integrated Care Board have set out the main commitments to the establishment of an integrated care system and a collective view of what this might mean, highlighting the opportunities and challenges as we move to put the plan into practice. We are on a journey in establishing what the role of our communities are in improving health. An important part of this involves using existing social care ‘strength-based’ or ‘asset-based’ approaches, which nurture the strengths of individuals and communities to build independence and improve health.

We need to ensure that emerging locality governance needs strong local accountability and effective commissioners and providers, working together to create the integrated services. No return to a system that imposes one size fits all solutions and second guesses local decision making, without fully understanding the local context and issues. From a resident’s perspective, health and social care services still mostly operate in silos. Therefore, as we develop new models of health and care, prioritising human relationships is key. By working directly with patients across service boundaries, we can create a radically different model of care. Co-production with residents is central to any new models of care moving forward.

Both Barking Riverside and social prescribing provides opportunities for us to deliver a new model of care for residents. Only then can we see an improved experience for our residents and a reduction in the demand for our services.



**Both Barking Riverside and social prescribing provides opportunities for us to deliver a new model of care for residents.**

# Adverse Childhood Experiences

Early Death

Disease, Disability,  
Negative Social  
Factors

Reduction of health-risk  
behaviors and needs

Cognitive impairment


Impairment (brain and body)

Adverse Childhood Experiences (neglect, abuse, domestic violence, substance abuse, criminality, parental abandonment, parent with a mental health condition, other traumatic experiences)

## Chapter 3

How do we approach the challenges of adverse childhood experiences and domestic abuse

London Borough  
Barking & Dagenham



As I have referenced in Chapters 1 and 2, making a difference to some of the key health challenges in Barking and Dagenham requires us to look outside the scope of traditional health and care. This 'whole picture' Public Health approach is reflected in our Joint Health and Wellbeing Strategy 2019/23. One of its three themes is resilience, which means enabling our residents

to thrive, not just survive, and bounce back in the face of adversity. While there are several aspects of resilience, one key way to build resilience is through targeting support as early as possible to lead to long-term benefits in both improving the health and wellbeing outcomes of residents and decreasing demand on specialist services.


Within the Joint Health and Wellbeing Strategy, there are five outcomes relating to resilience. Within this chapter, I focus on two of them to demonstrate what looking beyond care looks like for our services:

### **Outcome 3**

**Improved multi agency support for those with Adverse Childhood Experiences**

### **Outcome 7**

**A borough with zero tolerance to domestic abuse that tackles underlying causes, challenges perpetrators and empowers survivors**



We know that adverse childhood experiences (ACEs) including domestic violence and abuse, have a range of negative impacts on health and wellbeing for individuals. We also know that they cost our services a huge amount. Looking at these issues in a health and care context therefore helps to both improve outcomes for residents and reduce demand for our specialist and statutory services.

### What are adverse childhood experiences?

ACEs are traumatic or stressful events which occur during childhood or adolescence. These events include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical or emotional neglect
- Intimate partner violence or mother treated violently within household
- Substance misuse (drug and/or alcohol misuse)
- Household mental illness
- Parental separation or divorce
- A household member who is in prison
- Poverty
- Risk of homelessness
- Witnessing community violence

While it is not currently possible to measure the level of ACEs within our population, because of a lack of available screening, we have some evidence to suggest that there may be a high rate of residents who have experienced ACEs in Barking and Dagenham:

- The Mayor's Office for Policing and Crime (MOPAC) data suggests Barking and Dagenham has the third highest reported rate of child sexual exploitation in London in 2015/16.<sup>36</sup>
- 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. Domestic abuse is a national problem and fear of reporting causes significant levels of domestic abuse to go unreported.

There is an increasingly large body of evidence that points to the harm that ACEs have on individuals throughout the course of their lives. Experiencing four or more ACEs in childhood means that individuals are more likely to experience a range of negative health and social impacts through into adulthood. For example, there appears to be a strong graded relationship between ACEs and heart disease, cancer, chronic lung disease, skeletal fractures and liver disease.<sup>37</sup> This not only impacts on residents and their families – in terms of personal distress and suffering – but also on demand for specialist services.

A proposed mechanism for the ill health mentioned above is the exposure to persistently high levels of stress. This is thought to cause physiological changes to the brain and body leading to the development of damaging behaviours.<sup>38</sup> These include self-soothing behaviours such as smoking, substance misuse and overeating, all of which are likely to negatively impact on a person's health and wellbeing.

An early study into the impact of ACEs conducted in an American obesity clinic showed that more than half of the people in the clinic dropped out each year, for over a period of five consecutive years, despite successfully losing weight when leaving the programme. Medical records demonstrated that all the participants who dropped out had been born at a normal weight, but when they gained weight it was abrupt, and when they lost weight, they regained all of it, or more over a very short period.

Through face to face interviews with participants who had dropped out, where they asked individuals for their weight when they were first sexually active, which led to participants disclosing childhood abuse. The researchers found that for many, eating was a fix, a solution to the problem – it soothed the anxiety, fear, anger or depression that they experienced.

This demonstrates how by increasing awareness of ACEs and an agenda of early help can change the way we look at, understand, and tackle some of our biggest health challenges such as obesity, mental health issues and even criminal behaviour. The original ACE study in America consisted of participants who were mostly white, middle class, college-educated adults who had good health care,

36. [https://www.london.gov.uk/sites/default/files/mopac\\_lcpf\\_co-commissioning\\_workshop\\_cse\\_july\\_2017.pdf](https://www.london.gov.uk/sites/default/files/mopac_lcpf_co-commissioning_workshop_cse_july_2017.pdf)

37. Felitti et al 1998 cited in Trauma-informed Care 2013 Wilson, C. Pence, Donna and Conrad, L at <http://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063>?p=emailAilDLZvuY00ho&d=/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063

38. BMC Public Health 'Stress begets stress: the association of adverse childhood experiences with psychological distress in the presence of adult life stress' (2018) - <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-018-5767-0>

demonstrating that these issues are not confined to deprived communities, but are prevalent across communities. The study has been replicated internationally – with the English study finding that 46% of the adult population in England had at least one ACE, while 8% had four or more.

Mitigating the impact of ACEs and broadening our understanding of their impact, provides an opportunity to reduce harm across a range of social and health behaviours. Importantly, it provides the opportunity to both improve future outcomes and reduce demand for future services through offering proper support that prevents problems from occurring.

Prevention and early help are important to mitigate the impact of ACEs in the lives of children and young people. Barking and Dagenham are set to partner with the Early Intervention Foundation to deliver the Early Years Transformation Academy. The Academy will be delivered locally as well as in four other local authorities and involves a 12-month intensive applied programme to develop the local maternity and early years system, in light of the latest evidence. It will help the Council and partners put early intervention at the centre of how they interact with the local population, supporting prevention of ACEs.

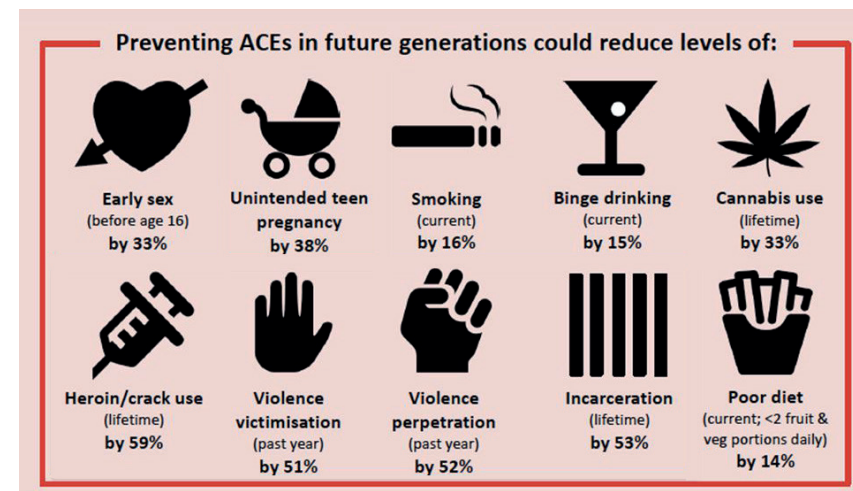
### Knife crime


ACEs are also key in understanding knife crime. In my 2016/17 annual report which focused on knife crime, I talked about the importance of children and young people’s mental health needs, and how in Barking and Dagenham we have a higher than expected number of children and young people with mental health problems. I also discussed the evidence that interventions during childhood and adolescence can lead to improved outcomes. Prioritising ACEs reflects a development in this thinking – building resilience, intervening early where possible and recognising the impact of trauma, can lead to improved health outcomes.

I also discussed the existence of knife crime as a Public Health issue. It is worth noting that the borough has experienced a recent spike in knife crime – according to MOPAC data, between March 2015 and 2016, there were 362 reported incidents of knife crime offences in Barking and Dagenham, whereas between March 2018 and March 2019, there were 432 reported incidents of knife crime. This marks a 19.3% increase on the reported rates of knife crime in the borough in a three-year period.<sup>39</sup>

39. MOPAC Weapon-enabled Crime Dashboard: <https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/weapon-enabled-crime-dashboard>

### Box 7 Positive impact of preventing ACEs





Recent tragic fatalities both in the borough and across London have highlighted the urgent need to work in new ways to stem the tide of knife crime. Early intervention, at a multi-agency level, has been identified as a key intervention in dealing with crime as a Public Health issue. Diversionary trauma-informed services are now included in the menu of interventions for young people involved in the criminal justice system.

Additionally, knife crime is at the center of national attention, with a Public Health approach being championed by the Government. In April 2019, Rt Hon. Sajid Javid MP, Home Secretary launched a consultation to ensure public bodies, including hospitals, raise concerns about children at risk of becoming involved in knife crime.<sup>40</sup> The proposed new, multi-agency, 'public health duty' is intended to help spot the warning signs that a young person could be in danger, such as presenting in A&E with a suspicious injury, to worrying behaviour at school or issues at home.

This would place a statutory duty on police, hospitals, schools and other bodies to report those at risk of being drawn into knife crime. Early intervention is at the heart of tackling knife crime. We know, however, much like domestic abuse, there is under reporting and legislation on its own does not always improve outcomes for our residents, which emphasises the need for a wide-ranging holistic approach that looks at root causes.

Therefore, legislation to make sure professionals in health, education, police, social services, housing and the voluntary community sector work

together and are held accountable for preventing and tackling serious violence may be counter-productive. A strong focus should be pursued in ensuring every part of the system invests resources in and works together to provide targeted interventions that support young people not to commit violence or become vulnerable to being groomed by gangs.

### What is a trauma-informed approach?

A trauma-informed approach (TIA) simply means ensuring that services reflect an understanding of the impact of trauma on an individual's behaviour. It means working to build an awareness of trauma among staff and to ensure that services can recognise this and are designed with this in mind. The principles of a trauma-informed model for services includes:

- Members of staff able to recognise the signs and impacts of trauma in a person and work with them accordingly. For instance, this may be staff being aware that an individual's behaviour is related to them being triggered from past trauma, rather than them trying to be non-cooperative.
- The service is a user-friendly environment in which a sense of safety and trustworthiness is paramount.

A TIA requires whole system-based partnership working to be successful and is being championed by the Council. I go into more depth into how a whole systems approach can benefit Barking and Dagenham in Chapter 4 of this report.

Barking and Dagenham Community Safety Partnership has commissioned a range of voluntary and community services to deliver trauma-informed positive diversionary activities to children and young people. In addition, a training programme, run by Rockpool, has created an awareness of trauma-informed practice and proposed simple ways to integrate this into the delivery of front-line services run by the Council, NHS and other public sector partners, such as the Metropolitan Police and the voluntary sector.

In addition to this, the Council has commissioned Change, Grow, Live to provide adult drug and alcohol services which are based on a TIA. This is also the case for Subwize, the service which works with young people who have substance misuse issues. Again, this is about working with service users in a way that recognises the trauma they have experienced and understands that it has an impact on their behaviour.

This shows how Public Health thinking and analysis is being championed across the Council. Increased focus on ACEs and trauma-informed care through outcomes in the Joint Health and Wellbeing Strategy 2019/23, discussions by the Barking Havering Redbridge Integrated Care Board, and the development of a range of initiatives by the Community Safety Partnership demonstrates that increased awareness of ACEs and trauma-informed approaches are helping to inform the design of services.

40. <https://www.gov.uk/government/news/serious-youth-violence-summit-to-launch-public-health-duty-to-tackle-serious-violence>



## Educational and long-term outcomes for children in contact with services

Our schools have a major part to play in our efforts to address the challenge of ACEs. An integrated system response is required to support families and our schools to deliver long-term outcomes for children and young people in respect of mental health support. For many of our school's frustration is centred on the difficulties they are facing in accessing and working in partnership with colleagues from health and social care, as well as other outside agencies. Despite increased investment, whether it be educational psychologists, speech and language therapists, specialist school nurses, occupational therapists or child and adolescent mental health specialists, the concept of ongoing close partnership working still presents challenges.

However, head teachers have consistently raised concerns on access to high quality paediatric/child health expertise required to sustain some pupils progress, attendance, access and wellbeing. In particular:

- Access to Speech and Language Therapy (SALT), Child and Adolescent Mental Health Services (CAMHS) and School Nursing. This, in their opinion, is having a negative impact on vulnerable groups including looked after children and special educational needs and disability (SEND).
- The effects of adverse childhood experiences that lead to social care intervention stretch well into adulthood and include mental health difficulties and crime.
- Despite efforts to prioritise looked after children in schools, through virtual

school heads and the looked after child pupil premium, their experiences are still characterised by instability and poor outcomes.

- Within this concerning picture, there is hope that longer-term stable care placements can result in better outcomes, including a lower chance of permanent exclusion from school.

Our integrated approaches to adverse childhood experiences, trauma-informed care and domestic abuse will require new models of funding and potentially shared resource to remove organisational barriers in providing the most effective care for children and their families.

I am currently conducting a *deep dive* to provide the Local Safeguarding Children's Board with a picture of the care challenges where a whole system, integrated approach is needed to achieve a real change in healthcare quality and positive outcomes of care for vulnerable children and young people.

Outcomes of the deep dive are to identify:

- Where changes and investment are required across complex pathways of care to improve outcomes.
- Best approaches to policies and priorities to directly improve planning and delivery of local services.
- Co-ordinated combined practical improvement approaches to overcome health/care challenges, which have not responded previously to other improvement efforts.

### Box 8: Joint Health and Wellbeing Strategy 2019/23 commitment

Our Joint Health and Wellbeing Strategy outlines a clear commitment to create:

*"A borough with zero tolerance to domestic abuse that tackles underlying causes, challenges perpetrators and empowers survivors."*



## Focusing on domestic abuse

Domestic abuse, included in the list of ACEs including where children witness violence, has profound social, health and economic impacts on both individuals and communities. The Home Office announced in January 2019 that domestic abuse costs our national economy £66 billion a year, including £2.3 billion to our health service.<sup>41</sup> Barking and Dagenham has the highest rate of reported domestic abuse in London, and evidence highlights that under-reporting is a huge issue. For instance, a 2018 report by Women's Aid notes that only 28% of women using community-based services and 43.7% of those who use refuges had reported domestic abuse, beginning to suggest how prevalent under-reporting is, even in those who have taken the step to access services that many do not.<sup>42</sup>

In addition to this, there are also some worrying indicators within our population. We commissioned a school survey in 2017 that asked secondary school students across Barking and Dagenham about their health behaviours and found that 26% of Year 8, 10 and 12 students thought that there were times it was okay to hit your partner.<sup>43</sup> This concerning finding suggests domestic abuse may be entrenched, widespread and tolerated within our community.

Within Barking and Dagenham, we are looking at domestic abuse differently. Councillor Maureen Worby, Cabinet Member for Social Care and Health

Integration has recently launched a commission to investigate the underlying causes of domestic abuse, and the normalisation of it within Barking and Dagenham. Rather than focusing on the response of services around domestic abuse, the commission, the first of its kind, will investigate why domestic abuse is tolerated within our community to the extent it appears to be and to make recommendations for change.

As part of its commitment to tackle domestic abuse, the Council also announced in March 2019 that staff experiencing domestic abuse will get up to 10 days' paid leave as part of a ground-breaking policy on domestic abuse. Councillor Worby states:

*"We are proud to be the first council in the country to adopt this policy as part of a whole system approach to tackling domestic violence and abuse. As the borough's biggest employer, domestic abuse directly impacts our employees. We are fully committed to keeping our employees and residents safe: in the home, on the streets and in the workplace".*

Given that 40% of Council employees live in the borough, the Council is aware that domestic abuse directly impacts on its employees. This leave is available for those who need assistance to leave the abuse. It is also available to perpetrators of abuse providing they use this time to actively seek help and support to end violence. This shows that as a Council, we are taking the impact of domestic abuse seriously.

### Box 9: Bringing it all together. A Commissioning Case Study

New services for domestic abuse are being commissioned for Barking and Dagenham in the light of borough priorities that take a zero-tolerance approach to domestic abuse, seek to understand and take account of the impact of trauma and recognise the importance of preventing future harm.

The services will be aimed at:

- People enduring domestic and sexual violence
- People using abusive behaviours in their intimate and family relationships
- Children and young people affected by domestic abuse.

The scope of the new services will include increased accessibility, with a focus on need, prevention, therapeutic support, crisis support, taking account of the survivors' voice and community resilience.

The services will take an explicit trauma-informed, family and whole-system approach, together with an understanding of the impact of intersectionality and multiple disadvantage. Our work with children and young people will take into account the impact of ACEs, and how early intervention can significantly reduce future harm to both the individual and the community. The new services are planned to commence in October 2019.

41. <https://www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse>

42. <https://www.womensaid.org.uk/survival-beyond-report/>

43. SHEU School Survey, commissioned by Public Health, 2017

## Conclusion

Growth in demand for mental health and community services, and heightened pressure on child and adolescent mental health services requires a whole system view of early intervention. Thinking inwardly is not the answer as the Council and indeed our partners, can no longer operate as a series of discrete concerns or silos and must move together to enable a systems approach to become embedded.

Building on our collective good practice is needed for identifying and providing early support across the life course. In particular children and young people who are at risk of poor outcomes, such as mental health problems, poor academic attainment, or involvement in crime or antisocial behaviour. Addressing the impacts of ACEs and domestic abuse is a BHR System challenge.

We need to develop a clear evidence-based narrative building on the continued importance of early intervention and prevention at the heart of our services. Knowing that improving multi-agency support for those with ACEs, through interventions such as a trauma-informed approach and taking a zero-tolerance approach towards domestic abuse can have significant positive impacts on health and wellbeing. This will involve jointly resourcing an integrated prevention, care and clinical approach that connects with, and enhances, the good early intervention and statutory work the Council does, that supports individuals and families, particularly the most vulnerable, to better help themselves and others flourish and lead fulfilling lives.

As part of achieving transformational change to support families and our schools to deliver on long-term outcomes for children and young people in respect of EHC (education, health and care) plans and mental health support, a shared commissioning arrangement for the BHR System should be considered. Although these opportunities should be explored with cautionary considerations of local issues within wider determinants of health and health inequalities.





## Chapter 4

A systems approach  
to place-based care:  
from thinking to  
practice



## Making it real

Our vision for the future of the health and care system is one that is focused on prevention and wellbeing, enabling people to live their lives in good health for as long as possible. The new models of care that have been outlined in Chapter 2 of this report, the stagnation of life expectancy progression and the findings from the Global Burden of Disease outlined in Chapter 1 necessitate continual fine tuning to the way that care is delivered and our understanding of where responsibility for health lies.

The Government's promised Green Paper on the reform of the social care system has been delayed again until a Brexit deal is agreed in Parliament. Without a clear long-term solution for a sustainable future for the social care system, transformation is challenged. The social care system is currently under a tremendous amount of financial pressure. The Local Government Association estimates that adult social care services will face a funding gap of £1 billion by 2019/20<sup>44</sup> and Age UK predicts that by 2020/21 public spending for older people's social care would need to increase by a minimum of £1.65 billion to £9.99 billion to manage the impact of demographic and cost pressures.<sup>45</sup> However,

recent figures are not encouraging; the amount spent on social care has decreased every year since 2010/11 excluding transfers from the NHS.<sup>46</sup> Reforming the design of the social care funding system is extremely important for older people's wellbeing and dignity and must be addressed as a matter of urgency. However, it will do nothing to address demand.

Set against this context, the Council's overarching approach to preventing/managing social care demand is a person-centred approach that delivers care and support in partnership with individuals and, where they wish, their families and communities, to achieve the best outcomes for them, rather than designing systems and processes around organisational silos. The health and care system should be one that recognises that 'health' services only constitute a tiny part of what makes people 'healthy'.

In order to make progress it must be as a truly whole system, where partners come together with residents to create coordinated actions in response to a problem. This would result in the system having a greater impact on the problem than our current isolated interventions alone would have.

## The status quo is no longer an option

This is a complex area in which Cottam argues *"that our 20th century system is beyond reform and suggests a new model for this century: ways of supporting the young and the old, those who are unwell and those who seek good work. At the heart of this new way of working is human connection"*<sup>47</sup>.

## What prevents us from working as an effective system?

One argument is the way we currently commission prevents this. For example, it is apparent that several different commissioners potentially contribute to a single pathway of care. This is further complicated by the fact that different providers may be paid by a block contract, payment by results tariffs or year of care bundles amongst other mechanisms. This inevitably leads to 'blocks' in the pathway of care for individuals and can lead to fragmentation of care or different thresholds for access. New models of care will require new models of funding and potentially shared resource to remove organisational barriers to providing the most effective care for residents.

44. House of Commons Library, Adult Social Care Funding (England), (2017)

45. Age UK, 'Briefing: Health and Care of Older People in England 2017', February 2017, available here: [http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The\\_Health\\_and\\_Care\\_of\\_Older\\_People\\_in\\_England\\_2016.pdf?dtrk=true](http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true)

46. The Health Foundation, 'Health and social care funding explained', January 2017, available here: <http://www.health.org.uk/health-and-social-care-funding-explained>

47. <http://www.hilarycottam.com/radical-help/>

**How can we build the social infrastructure to enable human relationships and participation, so that ‘health creation’ might happen organically and sustainably?”**

This presents a key challenge for NHS and Council commissioners as insight and understanding of residents is paramount. Service redesign needs to be informed by the wants and needs of residents, directed by knowledge of where interventions will have the greatest impact. But in our integrated care system, we know very little about what patients and residents really want and at the front lines of care the silent misdiagnosis of patients’ preferences is widespread.

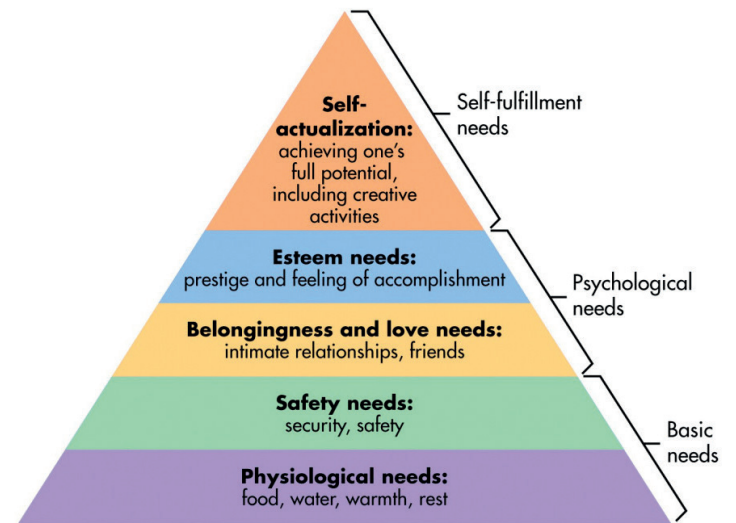
The Council and its partners recognise our approach to reducing demand must focus on a way of creating health that decreases dependency, increases resilience and reduces their demands on traditional health and care services. This requires understanding of and insight into what motivates our residents and communities to change and flourish. Maslow’s hierarchy of needs in Figure 11 observes that most behaviour is multi-motivated and noted that “any behaviour tends to be determined by several or all of the basic needs simultaneously rather than by only one of them”.

Therefore, commissioning interventions that seek to change behaviour without addressing the wider environmental constraints on choice, are likely to have limited impact on providing the foundation for improvements in health-related quality of life. For example, improving physiological needs helps the community to become more resilient and support each other through a crisis. This will contribute to prevention of ill health and help mitigate the impact of long-term conditions.

In practice, this means all services knowing who is being left behind and who is at risk. And it means the whole system taking seriously its role in preventing those residents from slipping further behind and thereby placing additional demands on the system. Developing resilience in our population requires action that is at a scale and intensity that is proportionate to the level of disadvantage. Figure 12 below describes the Council’s approach to change in respect of the who, what, where and how.

The development of the Borough Data Explorer and One View has the potential to provide in-depth analysis of our population, a key element of place-based care. Thus allowing us to refine and target our offers of services to the right people in the right way. Through segmenting the population using a range of data and using best practice evidence to identify which population groups are contributing most to demand, where in the borough

**Figure 11: Maslow’s Hierarchy of needs**



Source: <https://www.simplypsychology.org/maslow.html>

**Figure 12: Barking and Dagenham theory of change**



they live, what characteristics they share, and how we might intervene differently, in order to either prevent this demand from accruing to our health and care services or stepping it down once it does. This allows us to better target our interventions and key messages through the localities to ensure that they resonate with residents, and consequently have a greater impact on health outcomes.

### System design principles

Once we have created new insights and evidence, we can generate solutions based on what really matters to residents. With this more detailed understanding of the needs and expectations of residents and the resources available to meet those needs we need to apply a set of design principles.

These principles will be specific to the service redesign challenge, but effectively would fall on the following:

- system view of demand and community
- identify who are the residents that come through as demand – what led to this?
- focus on lived experience and bring together health and care staff with residents in a new way
- targeted behaviour change activity, informed by behavioural and data insights
- builds community skills and capabilities to improve health outcomes
- individuals using health and care services experience positive outcomes
- individuals, populations and communities maximise their health and wellbeing

- front-line staff use their experience and expertise to shape seamless care
- leaders work effectively across health and care to drive transformation.

### What would this look like in practice?

The rest of this chapter looks at two case studies designed to introduce concepts, provoke discussions about what our integrated prevention outcomes should be, and how we should ensure that as a system, we are at the forefront of the national prevention agenda.

### Childhood obesity

In 2018/19 the Health Scrutiny Committee requested a scrutiny review into the systems wide approach to childhood obesity in Barking and Dagenham. The review is timely as Public Health England and the Local Government Association have been working on developing guidance for a whole systems approach to obesity since 2015. The programme places considerable emphasis on creating the right environment for change in the local area, collaborative working across the local system and the dynamic nature of such a system.

Barking and Dagenham has amongst the highest levels of childhood obesity in London despite running numerous evidence-based programmes to help support children and families live healthier lives. However, Figures 13 and 14 state obesity in Year 6 pupils has increased from 26.3% in 2013/14 to 29.7% in 2017/18 (a significant increase) while in Year 1 reception pupils this decreased from 14.2% in 2013/14 to 13.0% in 2017/18.



Figure 13. Infographic showing levels of weight in Reception children in Barking and Dagenham in 2017/18

B&D Reception children

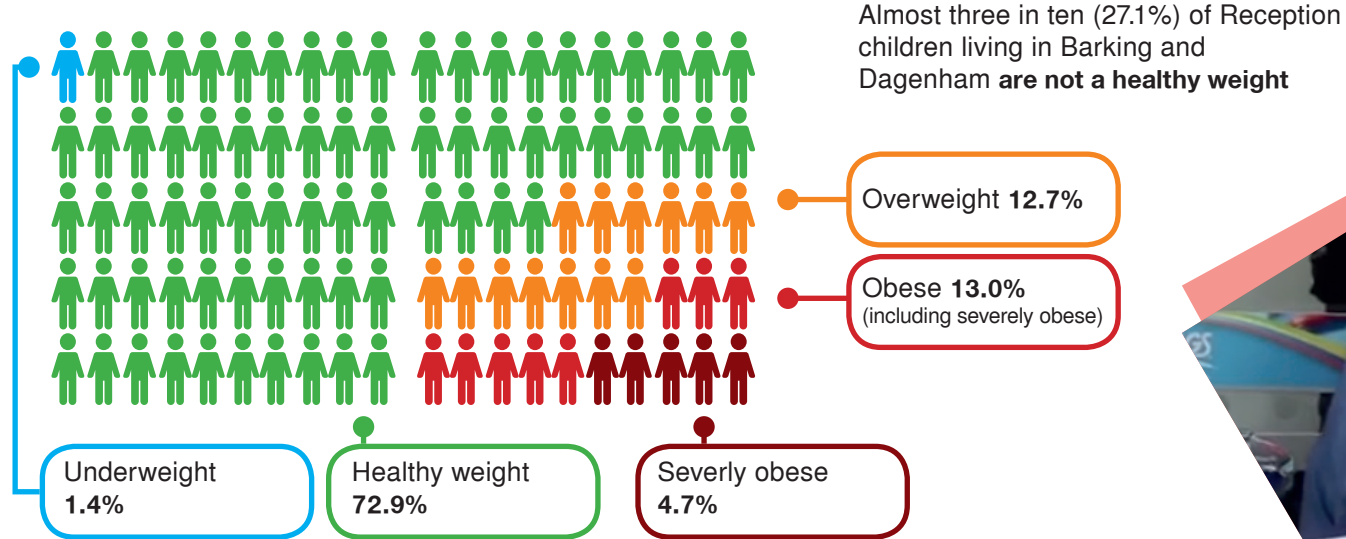
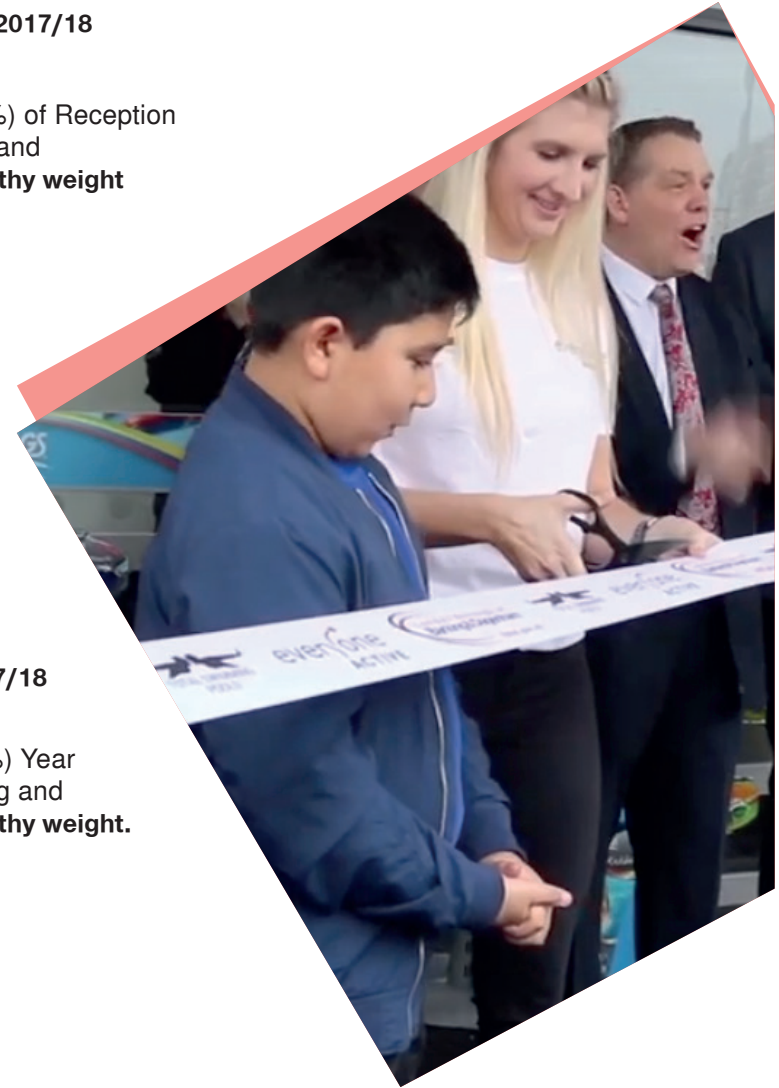
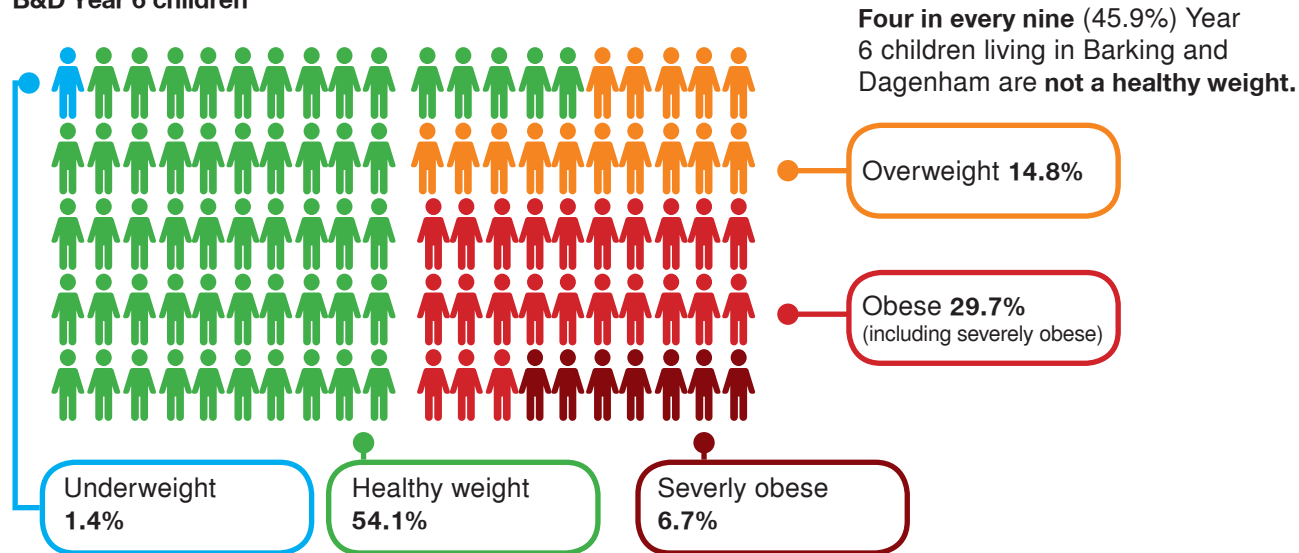



Figure 14. Infographic showing levels of weight in Year 6 children in Barking and Dagenham in 2017/18

B&D Year 6 children







New analysis (published on 24/07/2018) of the National Childhood Measurement Programme data from Public Health England mapped trends in weight of children in Reception and Year 6 over the past 10 years.

The findings show that, nationally, the prevalence of excess weight, obesity and now a category of severe obesity, is increasing more in the most deprived areas than the more affluent areas of England and that severe obesity is at its highest ever level of the past 10 years. In terms of ethnicity the analysis found levels of excess weight in Black and Minority Ethnic Year 6 boys was increasing faster than in White British Boys. However, in Reception White British Girls were amongst the only groups showing an upward trend in excess weight. In Barking and Dagenham children have been found to have the highest levels of severe obesity in England.

In 2018 the Council commissioned a piece of insight work to understand how our residents viewed the issue of healthy weight and their approaches to healthier lifestyle behaviours such as exercise and healthy eating.<sup>48</sup> This research told us that our residents view health as the presence or absence of illness and therefore our work around healthy lifestyle

wasn't always having the impact we hoped for. Healthy behaviour change is more likely to occur when approached through the lens of social improvement, when it is easier for people to make these changes and they see others in their community doing so. This evidence from our residents demonstrates the need to work differently across different groups to tailor programmes that unlock their motivation for change. Harnessing the whole system approach can allow this to happen.

This was manifested in the key findings of our evaluation the year the borough's child weight management programmes centred on a 12-week weight management class-based programme delivered at 15 community locations in the borough including children centres, leisure centres, libraries, community centres and churches. These include:

- Commissioned programmes are working in silos and not having a population-level impact.
- Cost of Lean Beans, HENRY and other initiatives is £320K. From HENRY (45 children) and Level 2 services (155 children), in total 200 children completed the programme. The unit cost is £1600 which

seems quite expensive and cannot justify value for money.

- Lean Beans programme should be more targeted as currently it is universal and costly.

The Scrutiny Committee were concerned that although most partners were working well to tackle childhood obesity, there was a lack of a joined-up approach in the system.


A whole system approach to childhood obesity can be led locally but needs to consider the wider London system that we exist in. As outlined in Chapter 1 The King's Fund framework for population health based on four separate pillars:

- 1) the wider determinants of health;
- 2) our health behaviours and lifestyles;
- 3) an integrated health and care system; and
- 4) the places and communities we live in, and with.<sup>49</sup>

Prioritising interventions that target multiple pillars or bring together the work of multiple stakeholders is important for progress to be made. The rebalancing between the pillars and the focus on these areas aligns with the Council's focus on inclusive growth, participation and engagement, prevention, independence and resilience.

48. Healthy Weight – Changing Behaviour in Barking and Dagenham, April 2018

49. Buck D, Baylis A, Dougall D, Robertson R. *A vision for population health: Towards a healthier future*. London: The King's Fund; 2018 [<https://www.kingsfund.org.uk/publications/vision-population-health>].



In the context of the Council's overarching approach to preventing demand by using insight to identify the most vulnerable children and families. Who are these residents that are susceptible – what led to this?

Working with BeFirst and the Council's Planning and Policy teams to support the inclusion of health impacts across a range of policies. The integrated prevention approach outlined in Box 11 complements the traditional medical model of prevention by widening prevention beyond care to looking at the wider determinants of health that impact on maintaining a healthy weight.

#### **Box 10: The EPODE and Amsterdam childhood obesity models**

EPODE (the French acronym for Together let's prevent childhood obesity) is a large-scale, co-ordinated, capacity-building approach for communities to implement effective and sustainable strategies to prevent childhood obesity. Since 2004, the EPODE methodology, which originated in France, has been implemented in more than 500 communities in six countries.

The EPODE philosophy is based on multiple components, including a positive approach to tackling obesity, with no cultural or societal stigmatisation, step-by-step learning, and an experience of healthy lifestyle habits, tailored to the needs of all socioeconomic groups. It is this philosophy that was adopted in Amsterdam. The intervention (A Healthy Weight for All Children in Amsterdam by 2033) showed that within 3 years of the programme's implementation, the number of overweight children decreased from 27,000 to 24,500.

The intervention includes additional training for health professionals to support families in leading a healthy lifestyle. Every neighbourhood has an agreement in place between paediatricians, GPs, parent and child professionals, youth healthcare nurses, youth councillors, welfare professionals and community organisations. All of them are clear on their roles and work in partnership to meet the needs of the families.

In Amsterdam, a 'moving city' approach has been adopted, which is a city that is designed to encourage children to walk, run and cycle on an everyday basis. Playing outside has been made safer by improving playground areas. Leisure centres, swimming pools and sports events are healthy environments (for example, they do not advertise unhealthy food and drinks). A healthy food environment supports families to make healthy choices, so the Amsterdam municipality is working with the food industry to reduce fat, sweeteners, and salt in the products and make portion sizes smaller. There is also an alliance to prevent marketing of unhealthy foods to children and they create strategies that are used only for promotion of healthy food.

Key to both of these programmes is recognising the fact that childhood obesity will take a generation to reverse and requires co-ordinated multi-stakeholder action. Notably the Amsterdam model has strong political leadership which drives forward the cross-municipality work.

**Box 11: Integrated prevention approach**

Primary prevention	Secondary prevention	Tertiary prevention
Creating an economy and a place in which there are homes people can afford, jobs they can access, and neighbourhoods they can enjoy.	Using our data to identify residents who are most at risk, and better targeting interventions to mitigate these risks.	Supporting those residents with acute care/ support needs to recover and stay well.
<i>i.e. Reside and Be First</i> <i>Every One Every Day</i> <i>My Place</i> <i>Economic development</i>	<i>i.e. Community Solutions</i> <i>Homes and money hub</i> <i>Homelessness prevention</i>	<i>i.e. OFSTED improvement plan</i> <i>Children's Target Operating Model</i> <i>Disability and mental health</i>

This is the start of a whole systems approach, but we need to involve our wider partners, for example, private sector advertising companies, to ensure that our children and residents are exposed to less junk food advertising across our borough. Leadership can drive this engagement and set out the approach to system issues. Over the next year there needs to be greater engagement between health care, wider partners and the council systems to embed an approach to childhood obesity that encompasses the whole system.

**Frailty**

Frailty has been identified by both the Health & Wellbeing Board and the Integrated Care Partnership Board as a key driver in financial recovery and demand management. The new models of care I outlined in Chapter 2 are the start of commissioning across health and social care in Barking and Dagenham for older adults. The healthy ageing work stream in the BHR Older People and Frailty Transformation Board is the start of a whole system approach to health creation

that takes NHS commissioning intentions directly into the Council remit. The implementation of a healthy ageing programme will align both the work in targeting frailty and the work keeping residents healthier and in their homes for longer.

Longer lives are a benefit to society in many ways, including financially, socially and culturally, because older people have skills, knowledge and experience that benefit the wider population. There is an opportunity to utilise this increased longevity as a resource, whilst challenging ageism and the view that retirement is about 'sitting more and moving less'. This requires a pathway of care and support that promotes health and wellbeing, independence, community support and self-care in or close to residents' homes, to reduce the need for unplanned hospital admissions and long-term residential care. The Council's theory of change framework will be applied to the place-based work ongoing across the borough in respect of healthy ageing, with each aspect of place-based care linking in with at least one of the three key workstreams. Our focus will be on:

- Interventions in the community to prevent frailty
- Interventions to prevent social isolation in this cohort
- Any impact of wider determinants of health such as housing, environment, education and finance.

In respect of partners coming together with residents to create coordinated actions in response to a problem best practice suggests:

- **Community engaged arts** help expand community connections and establish supportive relationships<sup>50</sup>
- One study reported beneficial effects of **participatory arts programmes** for older people with sensory impairments<sup>51</sup>
- **Organised** activities in retirement housing etc. have considerable potential to meet residents' social support needs. A wider range of activities is needed, which may require the support of housing, volunteers and community.<sup>52</sup>

50. <https://www.ncbi.nlm.nih.gov/pubmed/22348701>

51. <https://www.emeraldinsight.com/doi/abs/10.1108/JICA-01-2014-0002>

52. <https://www.cambridge.org/core/journals/ageing-and-society/article/addressing-loneliness-and-isolation-in-retirement-housing/59EAF68079ED5A83AAB792D0DDEE174DA>

The Council and BeFirst should ensure that developers and providers of housing are enabling active ageing within the home environment. Important actions to promote active ageing within the home or housing with care include:

- recognising the need to plan and build housing that is appropriate and adaptable to the needs of older people
- supporting the development of extra care housing with its emphasis on inclusive design and independent living
- encouraging care homes to provide all residents with access to gardens and assistance to enjoy them
- ensuring that regeneration programmes consider the impact on older people in terms of active ageing
- landscaping and ongoing maintenance of external space to encourage outdoor activities
- developing partnerships with other local stakeholders to promote active ageing in the community

Other interventions we should consider are in Table 2.

### Future of wellbeing and care for frail people

In 2018 I joined a multi-disciplinary BHR System team undertaking the Practice Based Care Network Programme facilitated by UCL Partners and the Dartmouth Institute. The purpose was to propose a way forward to support development of genuinely place-based, integrated care in Barking and Dagenham, Havering and Redbridge that has been co-designed with staff and local people.

This is a first step towards the future of a co-designed model with local people and staff/clinicians on the ground, that will see a transformation in the way care is delivered, and the impact that this has on frail residents. As well as providing the next steps for the development of an 'integrated care system' this work will make clear the changes/permissions that we need in a much more concrete way, for the Integrated Care Partnership Board to respond to, including clear 'asks' of regulators etc.


**Table 2: Frailty interventions**

Programmes that should be Consistent across borough	Working Well Scale-Up	New Ideas
<ul style="list-style-type: none"> <li>• MECC</li> <li>• Social Prescribing and health unlocked</li> <li>• Frailty Pilot – care navigation</li> <li>• Falls prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Breezie pilot</li> <li>• Good Gym</li> <li>• BuddyHub</li> <li>• Telecare</li> </ul>	<ul style="list-style-type: none"> <li>• Expert carer – Care City</li> <li>• Group exercise</li> <li>• Participatory arts</li> </ul>

### Box 12: Dartmouth Institute and UCL Partners

**The Dartmouth Institute** contributed heavily to the US policy formulation which led to passage of the Affordable Care Act (ACA) in 2010. Key elements of the ACA shaped by Dartmouth research included emphasis on providers assuming accountability for quality and costs of services in Accountable Care Organisations, and patients engaging in shared decisions and care management in Patient Centred Medical Homes and other new care models at the frontlines of service. For more than a decade now, Dartmouth has been involved in bidirectional learning with the NHS to bring learnings from US based accountable care systems to the UK and take NHS based tools to the US to accelerate learning for transformation and sustainability on both sides of the Atlantic.

**UCL Partners** is one of the 15 Academic Health Science Networks across England. It brings people and organisations together to transform the health and wellbeing of the population by working collaboratively with various partners to identify, adopt and spread innovation and best practice.



Although new developments such as Barking Riverside afford the opportunity to develop a new model of care where there is a 'clean slate', this proposal provides a practical way to do this in other areas of our boroughs where services and behaviour patterns have been well established over a number of years, and where staff will have to make the proposed changes whilst ensuring there is no interruption in service provision to local people.

### Design principles

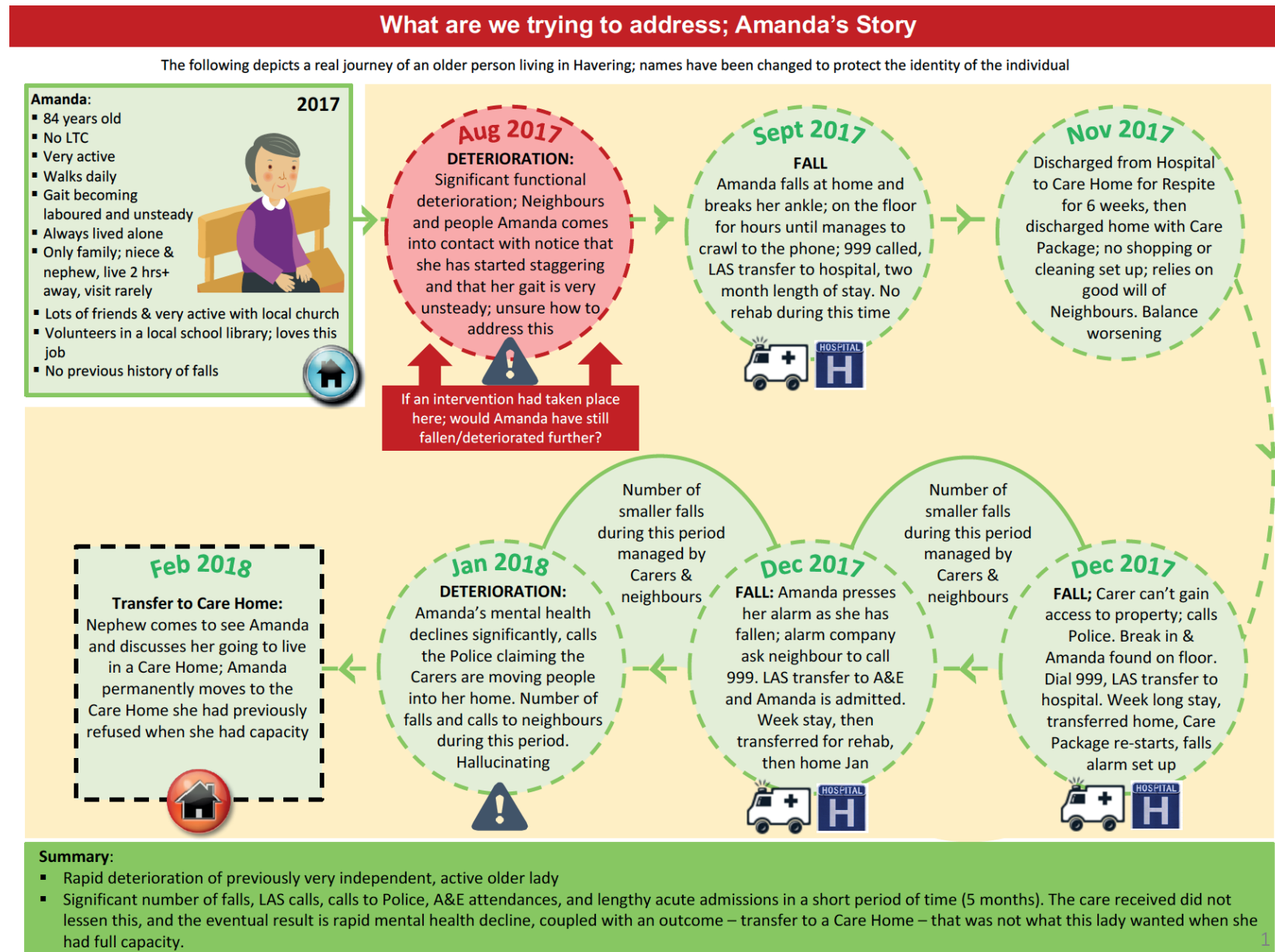
The intention is to design a different way of working around frailty at a locality level; we believe it is right that care should be patient centred. We chose a complex frail person (Amanda) with the help of a GP practice and mapped out Amanda's experience and journey which is described in Figure 15.

Using the design principals described in Box 13. We felt that it is sensible to start small; this will enable us to achieve all of our key goals; patient centred, co-design of care with local health and care staff, that will allow us to test closer integration of the community and voluntary sector and other key agencies, which can then be tested from a GP practice level, to locality level, and then replicated across the BHR System. The grass roots evolution of the proposed changes will enable the design of services to retain local nuances as required, but by keeping a key set of principles at the centre of the redesign, we will ensure that it can be scaled at a wider level to effect whole system change.

### Box 13 Design principles for working with frailty at a locality level

- Care is to be designed around patients, and we should start by looking at current services, performance and the experiences of local people and staff, and build our proposals around this; co-design is key.
- Look to use current services, staff and resources in a more integrated way to get the best out of what we have, exploring the potential to use existing resources differently, for example, Integrated Case Management teams.
- Multidisciplinary working across agencies and roles will be key to the new model of care.
- There will need to be the creation of a 'care navigator' type role to improve coordination of care at a local level, from a person's perspective, and will explore the creation of other new roles to strengthen our workforce and improve productivity.
- Local health and care staff will be acutely aware of the key barriers that prevent them delivering seamless care, they will also have ideas around how to improve productivity by reducing non value added activity that they may be currently required to undertake on a daily basis, and are the best people to suggest how the delivery of their services can be improved, and be more integrated.
- Explore the development of other system wide improvement programmes to address gaps and variation in care, such as roll out of the Significant 7 training to both paid, and unpaid, carers in the community to improve the delivery of care to local people.
- With the support of Care City, explore innovations in technology to support the improved delivery of care, provided that these deliver value for money and are scalable (based on our key design principles).

Figure 15: Amanda's journey




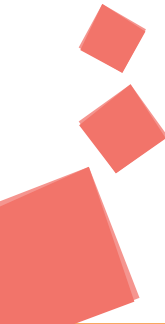


Figure 16 describes how we would do things differently based on Amanda's experience. We explored the **potential to use existing resources differently**, for example, Integrated Case Management teams, based on the existing locality structure. Key processes:

- Design a different way of working around frailty at a locality level; we believe it is right that care should be patient centred, and we therefore want to start with the care of a patient.
- Map all resources and assets within the local (place based) area, including staff, resident groups, buildings and community and voluntary sector services etc.
- Bring together the local health and care (and other agencies as appropriate) staff involved in the care, and work with them to talk through how they think care could be delivered in a more joined up way. We believe that the people on the ground are best placed to suggest what changes need to be made to local service configuration to deliver more integrated, seamless care.

This isn't about us imposing top down initiatives, it's about useful, grass roots improvements to the configuration of local services based around patients, designed by the local health and care staff involved.



From this co-design, we anticipate that those residents involved will be able to identify themselves the key barriers to the delivery of seamless care, and what prevents 'right care, first time', and suggest pragmatic solutions to this. The changes may be small or could involve the complete redesign of the delivery of care at ground level; the key point is that the changes will be designed by the people on the ground, both service users and staff.

The proposal was accepted, and work has started to implement this place-based care pilot in Thames ward and as a whole systems approach is being rolled out in Barking and Dagenham, with positive benefits for the population. The place-based care model is being progressed by BHR Clinical Commissioning Groups and aligns strongly with the theory of change work in the Council.

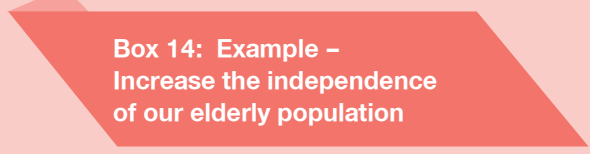
### Behaviour change approach

For both case studies a more targeted approach will need to be taken to behaviour change activity, which will be informed by behavioural and data insights, and delivered through a series of 'bursts' of activity over time and iterated through ongoing tracking. A one size fits all approach isn't going to work, there's no more speaking to the 'general public'.

A clear and consistent narrative will be developed that will act as a golden thread across all our communications. Campaign activity will be themed and targeted at specific groups based on their behaviour. Segmentation will be framed around targeted resident groups and underpinned by a behavioural insight approach;

- Target
- Explore
- Solution
- Trial

Supporting services to positively change residents' behaviour to improve outcomes and life chances. Box 14 gives an example of how we could increase the independence of our elderly population.



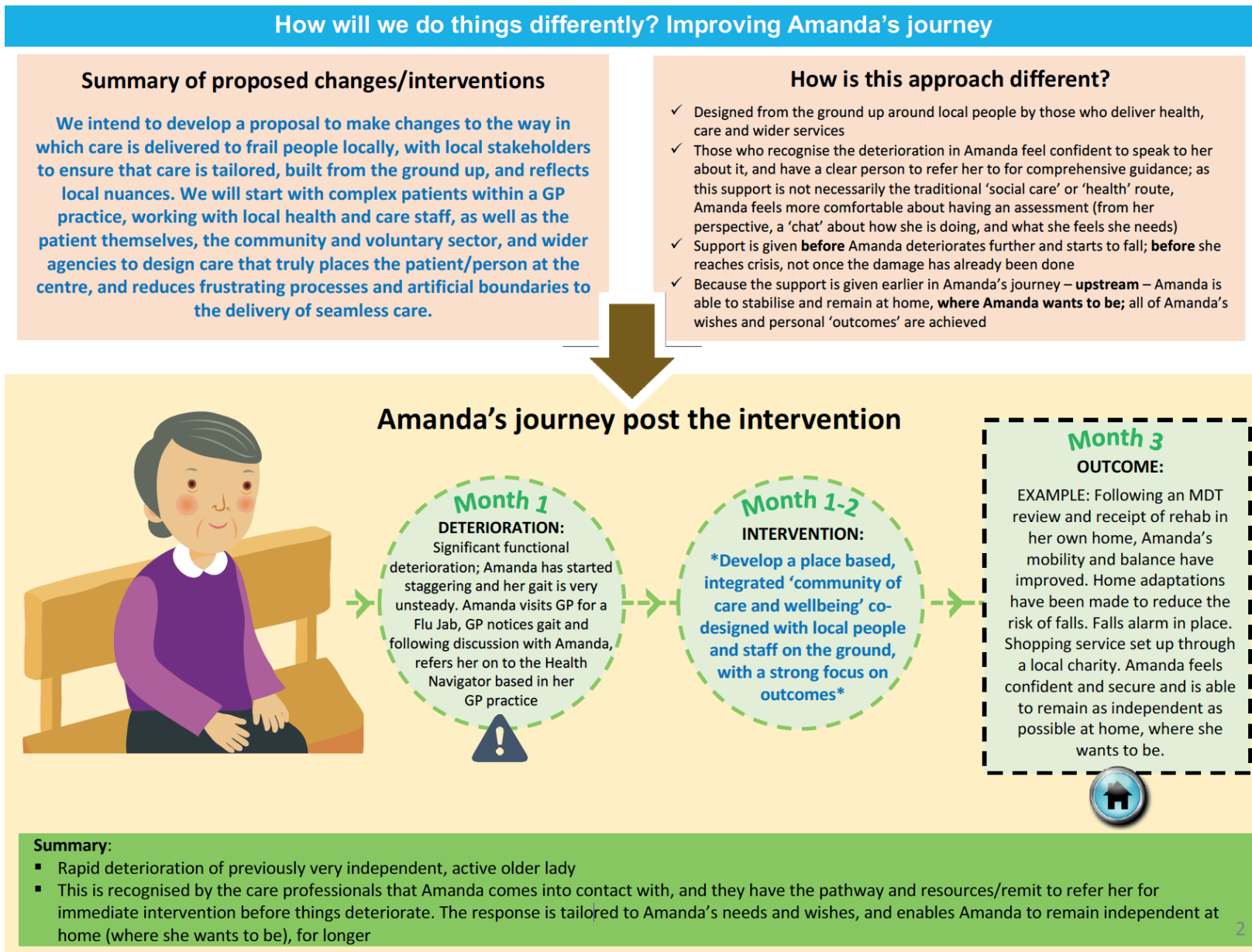
### Box 14: Example – Increase the independence of our elderly population

**Objective:** To increase the independence, health and resilience of our elderly population.

**Approach:** Integrating marketing with a programme of activity and interventions alongside commissioning to initiate a positive shift in behaviour and then support residents in maintaining that behaviour.

The campaign will be focused on an ethnographic approach, delivering a prescribed programme over the 3-year period to a cohort of representative residents. The cohort will serve as our 'control group' as well the face, or relatable advocates of a wider campaign that will run alongside the prescribed programme. The advocates will be included throughout the 3-year period alongside themed bursts of comms and interventions and mass participatory activity, to drive a social movement to help support a positive change amongst the target audience.

Figure 16 How will we do things differently? Improving Amanda's journey





## Conclusion

Within Barking and Dagenham, in both Council and NHS commissioned services there is a need to understand how commissioning as a whole system can help realise transformation aims and outcomes which will lead to improvements in the lives of our residents. Identifying our most vulnerable residents and understanding the root causes of crisis is fundamental to our approach to health creation. How this manifests as demand is critical to the design of our approach to preventing/managing health and care demand. A shift that will require services to organise around and co-design with our communities. As well as the need for professionals to behave in very different ways that connects voluntary sector workers, social workers, teachers, GPs, nurses and other primary care professionals to a range of local, non-clinical services as an essential component of our locality approach.

In this report, I have presented a relational, participatory approach that delivers care and support in partnership with individuals and, where they wish, their families and communities, to achieve the best outcomes for them, rather than designing systems and processes around separate organisations and structures. Our focus remains on the need to direct our resources towards prevention and early intervention.





# Chapter 5

Our future  
commissioning plans



This last chapter of my report focuses on what we have done so far and our plan on how we will commission programmes funded by the Public Health Grant differently going forward in order to achieve savings and transform delivery to achieve outcomes.

### The Public Health Grant

The Public Health Grant (“Grant”) is a ring-fenced central government funding provided by Public Health England to local authorities in England<sup>53</sup>. The purpose of the Grant is to provide local authorities with the resources required to discharge their Public Health functions and to reduce inequalities between the people in its area. We use the Grant to fund Public Health programmes across the life course – from ensuring that our children have the best start in life to making sure that adults have the knowledge, skills and opportunities to live and age well.

In June 2015, it was announced by the Chancellor of the Exchequer that local authorities’ funding for public health would be reduced by an average of 3.9% until 2020. The Council’s Grant allocation has been subjected to a central government cut from £16,906,000 in 18/19 to £16,460,000 in 19/20, this equates to a 2.6% Grant reduction and budgetary shortfall of £446,000 in 2019/20 and 2020/21.

In addition to the Grant reduction, it is unclear at this moment if the Grant will cease after 2021 and the Council will be expected to fund its Public Health programmes from generated business rates. Therefore, now is a good opportunity to

look at the ways in which our programmes are being delivered in order to achieve savings and transform delivery to achieve outcomes.

The allocation of the Grant across the various Public Health programmes in 2018/19 is described in Box 15. These programmes are all designed to help our residents make healthier lifestyle choices, improve their physical and mental wellbeing and to minimise the risk and impact of illness. Local authorities have, since 1 April 2013, been responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse<sup>54</sup>. The following Public Health functions are mandated in regulations relating to the Health and Social Care Act 2012<sup>55</sup> for local authorities to deliver:

- Open access sexual health services (Sexually Transmitted Infection treatment and testing and contraception)
- Health Check Programme
- The local authority role in health protection (screening and immunisation programmes, infection prevention and control, responding to threats to health, e.g. epidemics, pandemics, environmental hazards to health)
- Public health advice to health care commissioners – the ‘core offer’
- The National Child Measurement Programme
- Commissioning the Healthy Child Programme 0-5 (health visiting).

53. <https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2019-to-2020>

54. <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06844>

55. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213009/Public-health-role-of-local-authorities-factsheet.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213009/Public-health-role-of-local-authorities-factsheet.pdf)

## Box 15: Public Health Grant allocation and reduction

Public Health Grant Allocation and Reduction						
Programme	2017/18 budget	2018/19 Grant reduction	2018/19 Savings Proposal	Total Funding Reduction	2018/19 Base estimates	% Reduction
	£	£	£	£	£	%
Sexual Health	2,185,500	0	(40,000)	(40,000)	2,145,500	2
Health Protection	62,000	0	0	0	62,000	0
Promoting Health	3,696,300	0	(350,000)	(350,000)	3,356,300	9
Healthy Children	7,813,000	(333,300)	(125,000)	(458,300)	7,354,700	6
Healthy Adults	1,726,100	(112,700)	(185,000)	(297,700)	1,428,400	17
Healthy Intelligence	60,000	0	0	0	60,000	0
Public Health Services Team	1,220,00	0	0	0	1,220,00	0
Public Health Corporate	589,100	0	0	0	589,100	0
PH Savings for Qualifying General Fund Projects	0	0	700,000	700,000	700,000	4
<b>Public Health Grant</b>	<b>(17,352,000)</b>	<b>446,000</b>		<b>446,000</b>	<b>(16,906,000)</b>	<b>3</b>
<b>Balance</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	

### Public Health Grant savings exercise


The Council has a co-ordinated approach to delivering its vision and priorities. It is clear in its aim of wanting to make the best use of all the resources available to support residents to take responsibility for themselves, their homes and their community, by ensuring programmes promote greater self-reliance and focus on the root causes of demand not servicing the symptoms.

The first step is to look closely at why we provide programmes, who we provide them for

and how we can manage demand to ensure that we deliver statutory and other services for residents, with capacity for the future. This includes evaluating the whole range of Public Health funded programmes being delivered by the Council. Several options were identified where services can be decommissioned or where monies could be released to fund other Council services which fall within the scope of the Grant's conditions; a total of £1m savings (700k recurring and 300k one-off) was generated from the Grant to contribute to the reduction in deficit in general funds. These have included increasing

efficiencies through new procurements; protecting services where funding is tied into existing contracts; reducing funding and in some cases cutting budgets/posts completely. The approach took account of factors, including notice period for services in contract, staffing implications for the borough; a significant amount of public health funding is used to directly pay for posts within the Council, accounting for around 80-90% of the Grant's internal spend.

As part of the savings work, several programmes were identified as not having the required impact, but were tied up in contract arrangements, staffing



arrangements and often sat in other parts of the Council, although monitoring of impact remains within the public health governance. It was therefore agreed that an exercise that put a proper and robust framework around spending choices regarding the Grant needed to be undertaken to support better use of the Grant going forward in line with the outcomes described in the Joint Health and Wellbeing Strategy 2019 – 2023 and the Council's transformation programme. All resources realised from this exercise will be re-invested into delivery of evidence based Public Health programmes based on need in the borough.

In order to support our decisions and choices, several principles governed our approach to the Grant setting and budget saving process. All Public Health programmes were evaluated based on these criteria as follows:

- Mandated Public Health Services- Yes/ No
- Health and Wellbeing Priority- Yes/No
- Services outcome- whether achieving or not achieving outcomes
- Future considerations for review and redesign
- Services that could be funded elsewhere in the Council.

This exercise identified savings of 750k for 2019/20 to accommodate budgetary shortfall of £446,000 and increase budget allocation for the out of area non-contracted sexual health spend - a mandated Public Health programme which continues to increase spend more than the allocated budget. What is proposed for 2019/20 is to make some changes to how services are delivered to save money and, in some cases, reduce capacity but expect that services

will continue to meet most residents' needs, especially for the most vulnerable.

If the intention going forward is one of health creation we need to invest in different frameworks to support our decisions and choices otherwise most public health services will continue to be provided as they are now. Hilary Cottam (2018) developed a framework and tools for measuring four capabilities needed for a good life: the ability to create and sustain social relationships; the ability to work and learn; the ability to manage one's health and vitality; and the ability to actively care for and contribute to the community.

### Priorities

The Health and Wellbeing Board has reviewed its priorities and how to tackle health inequalities in the borough over the next 5 years. The refreshed Joint Health and Wellbeing Strategy 2019-2023 describes the key health and wellbeing outcomes for the borough.

The Strategy provides the direction for that shared goal over the next 5 years, overseen by the Health and Wellbeing Board. They show our ambition and the outcomes we want to achieve in the borough under the following themes:


- Theme 1) Best Start in Life – To give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 7 years to build up their resilience.
- Theme 2) Early Diagnosis and Intervention – To give our residents the best chance of recovering from illness or disease.
- Theme 3) Building Resilience – Empowering our residents to not just survive, but to thrive.

Future commissioning needs to be in line with the Strategy's three themes. Strategic evaluation is essential to determine how to allocate scarce resources to projects and programmes so that they have the greatest positive impact in achieving outcomes. The key debate is the extent to which we prioritise taking a targeted or universal approach in the Strategy's three key themes. Focusing on these areas should result in gains in life expectancy through different mechanisms and at different stages in the life course.

### Our future commissioning plans

We propose to transform Public Health programmes through fundamental changes into how they are commissioned and delivered. Services have changed and evolved considerably over the last few years and (irrespective of the new financial constraints) there is now a need to undertake a systematic review of these programmes, to ensure that they remain relevant and that the priorities are aligned with our Joint Health and Wellbeing Strategy outcomes. As well as ensuring they are relevant and targeting need, the evaluations we are undertaking are also looking at the efficiency of these programmes.

If we continue to address inequalities through existing approaches, we will simply continue to see the same outcomes. All resources and assets in place must be used to improve health and wellbeing outcomes. Over the past three years, the Council has made significant progress in assuring an adequate local public health infrastructure and promoting healthy communities and healthy behaviours. Essential for working differently both as a Council and with residents, stakeholders and partners to secure the ambitions set out in the **Borough Manifesto**.



The question remains are we truly targeting the root causes of ill health in the borough. The previous chapters outline that we may not be and that not all potential risk factors are included, especially risk factors relating to the wider determinants of health, which have a large role in prevention (e.g. unemployment, poor housing)<sup>56</sup>. While individual choices can mitigate some of these effects, resident's choices are constrained and structured by the environment they experience across the course of their lives. For example, the built environment could make it easy for people to be active and enjoy green space. Access to the cheapest, and most easily-available food, could be healthy food. Everyone should have enough money to meet their basic needs and have meaningful work to do. Local communities could be places where people turn to each other for support and no-one would be left out<sup>57</sup>.

To maximise the impact of targeted prevention and early intervention programmes, we need to proactively use data to identify individuals who could benefit from interventions as a key element of place-based care. Work towards improving health literacy through segmenting the population using a range of data and using best practice evidence to identify **which** population groups are contributing most to demand, **where** in the borough they live, **what** characteristics they share, and **how** we might intervene differently in order to either prevent this demand from accruing to our health and care services or stepping it down once it does. This allows us to better target our interventions and key messages through the localities to ensure that they resonate with residents, and consequently have a greater impact on health outcomes.

To achieve this the Board needs to ensure a balanced focus on the wider determinants that impact on health via the lifestyle and psychological measures featured within the Global Burden of Disease. Therefore, those most vulnerable within our communities, who are on the edge of care, will benefit from the wider work of the Council on employment, place-shaping and regeneration.

The move towards place-based planning, requires local decision-makers to consider the costs and benefits of preventive spend across organisations. In other words, we need to think not in terms of the NHS pound or the Council pound, but the place-based pound.<sup>58</sup> As I discussed previously in chapter 4, this is an opportunity to consolidate local strengths and achievements so far with ambitions for resident's outcomes into three distinct, but interconnected theories of change along with their associated delivery programmes; Prevention, Independence and Resilience, Inclusive Growth and Participation and Engagement.

## Conclusion

We need a clear understanding of current investment in prevention, nationally and locally, and ambition on spending to improve health and reduce health inequalities. Knowing how and where money is spent on prevention and by who, is essential in supporting decision-making across the system. These are important enablers of a shift in the focus to prevention.

In respect of productivity more work is needed to ensure the collection of better-quality data on activity, cost and outcomes in order to assess performance.

The Health and Wellbeing Board is not solely interested in just delivering traditional health and care services to those with acute needs today but consider primary and secondary prevention key to every part of public services delivery. Integral to this is increasing community capacity and cross sector working to provide better support through preventative activities.

Our Joint Health and Wellbeing Strategy has set the challenge to '**What Success Looks Like**' to partners. History tells us, we need to be more ambitious when defining outcomes that deliver a real shift in the way we plan and deliver services to achieve a switching focus towards identifying and achieving outcomes over 5 and 15 years that really matter, thus breathing new life into the services we commission.

Inequalities begin well before a baby is even born and early intervention should be a key factor from the start. We need to continue our 'whole-systems approach' with our use of the Grant for prevention and continue to address unhealthy environments as well as interventions that spot high-risk behaviours and conditions early on and help individuals make healthier choices.

Prevention means different things at points in the life course requiring a tailored approach. This requires a greater need to listen more to residents within communities so that they are engaged in the prevention process and feel part of the solution. Engaging with people experiencing health inequalities is important if we are to fully understand and address the barriers created by poverty and discrimination.

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

57. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/767549/Annual\\_report\\_of\\_the\\_Chief\\_Medical\\_Officer\\_2018\\_-\\_health\\_2040\\_-\\_better\\_health\\_within\\_reach.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767549/Annual_report_of_the_Chief_Medical_Officer_2018_-_health_2040_-_better_health_within_reach.pdf)

58. <https://www.hsj.co.uk/download?ac=3041414>



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