APPENDIX A

Annual Director of Public Health Report 2022/23

Living Longer; Living Healthier

– a focus on prevention and early diagnosis

Barking & Dagenham

Foreword

Preventing ill health has obvious benefits, a person who is in good enough health is likely to be happier, to keep in work, to pay taxes, not to require welfare or social care support, and to be able to support others.

A Covenant for Health, 2018

Welcome to the Director of Public Health's Annual Report for 2022/23. The last year has been challenging for many residents due to cost-of-living pressures and these have impacted on health and wellbeing in many ways. Our health and social care system remains firmly in the eye of the inflationary storm and severe funding and demand pressures mean that NHS and council finances are under pressure like never before. Simply put we can no longer afford to meet the rising needs of our population by spending more money on the kinds of services we currently provide.

Against this backdrop as Director of Public Health, it is my responsibility to describe and advocate how we can improve health through a lens that's wider than traditional health and care. This is challenging at a time when we need resources to keep pace with need and, dare I say it, a levelling up of resourcing!

Over the next 12 months we will be rethinking how we deliver public services to address the scale of the financial savings to be made while the borough's population continues to increase. Our Integrated Care System arrangements have now been established with our Health & Wellbeing Board and Integrated Care Board Sub Committee forming a groundbreaking Committees in Common. This arrangement will provide the leadership and oversight to ensure the collective efforts of all our partners are focused on delivering the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 and closing the gap for those with the poorest outcomes.

Central to realising the opportunities of 'Place Leadership' is the need to change the engagement relationship between our residents and the council as well as between patients and the NHS to determine the way we provide services where the best outcomes can be delivered at the right cost. The partners recognise that whatever the solutions, it is increasingly clear that the future depends on a much closer working relationship with residents and communities focused on the neighbourhoods in which they live.

As we know services on their own will not improve our agreed public health outcomes or manage health and social care demand without a radical upgrade in prevention that addresses the wider social determinants of health. Real world evidence tells us that approximately 20 per cent of a person's health is dependent on the healthcare services they receive. The other 80 per cent is accounted for by what is known as the social determinants of health.

The World Health Organisation states that "the social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and poor quality one. Social determinants of health include experience during the early years, education, working conditions, income, housing, communities and environment, and discrimination and exclusion".

We now need to apply a laser-like focus to improving population health, be clear where our inequalities in outcomes within and between communities are, for example by providing opportunities for children suffering from neglect or actions to improve access to mental and physical health services for those with mental health conditions. There is much still to do, but the guiding principles should be for tangible actions that inspire residents in terms of what we can achieve and to gather enough meaningful actions so we can see that the sum of these actions leads to real change. Without this we risk piecemeal and inconsistent activities that are not enough to make a real difference.

My report gives a professional perspective that informs this approach based on sound evidence and objective explanation, taken mostly from our 2022 Joint Strategic Needs Assessment. I hope my observations in the following chapters act as a starting point for identifying 'where to look' before 'what to change' and finally 'how to change.'

In Chapter 1, I reflect on my professional advice given over the last 10 years following Public Health's transfer from the NHS to local authorities in 2013. Themes have been repeated from the evidence base in our pursuit of finding better ways to tackle our deep seated and entrenched inequalities. Providing comments on how Best Value may be achieved has been at the centre of my reports. This has led me to provide focused advice on realising the ambitions of new models of care and meet the transformation targets of the council and NHS that require us to work beyond traditional organisational boundaries. Underpinned by the need for local determination around resources and ensure that we are cleverly using data to effectively manage demand and prioritising human relationships in the way we connect with residents.

Chapter 2 examines the next steps in using the opportunities of the integrated care system at place to improve the health of our residents. Particularly how we transition the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 into drivers for commissioning a whole systems approach. This will help to widen the reach and impact of our combined partnership resources by overcoming the challenge of individual partners focussing on their own organisational priorities dominated by measuring inputs and outputs. A better understanding both of what matters to people, and what works will reinforce our shared efforts to meet national outcomes and regulation requirements.

Part of this ask is to streamline the complexity of the integrated care system that by design has developed 'systems within systems' to focus on various aspects of performance, transformation, and access, drawing on skills and services from across the partnership. The challenge is to ensure that activities of separate groups form part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives.

Chapter 3 examines our understanding of the data to support the prioritisation of long-term conditions based on prevalence and the variation in outcomes between our communities which is critical to our ability not only to improve healthy life expectancy but also for population health management.

Focusing on the long-term conditions that are driving our health and social care demand is essential to how we effectively manage the local system. Early intervention and diagnosis are critical to deal with issues before they impact negatively on a person's health and wellbeing and the wellbeing of the community. The answer to improving healthy life expectancy is not solely a medical one its one that integrates our primary care and secondary care disease management programmes with council and voluntary and community sector services.

In following reports, I have focused on the need for continuous improvement in addressing the borough's widening health inequalities and the need to have ways of working that target residents through their networks and where they are to further our efforts in closing

the gap. Chapter 4 examines how we can do this. Better use of data and community insight will enable us to focus down on where the variations in outcomes exist and identify those variations that that have an uneven impact on healthy life expectancy, thus targeting our resources proportionate to need.

Setting a small number of strategic inequality outcome measures linked to the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 would be helpful in bringing clarity on what variation we are targeting. This can then be built into a coherent narrative through strategies, plans and communications. Key to this is the enhanced ability to systematically measure performance against variation as well as gaining a deeper understanding of the risk and protective factors for vulnerable groups across the life course. This will provide a more powerful mechanism for embedding an integrated approach to tackling health inequalities.

Chapter 5 takes forward the commitment in last year's report to undertake an in-depth review of our 0-5 (health visiting) and 5-19 (school nursing) services. The review was timely as the Department for Health released revised Healthy Child Programme Guidance on 27th June 2023, which aligns outcomes with the Family Hubs programme.

The review recommended that consideration is given to reviewing investment levels, service change (including the impact of reduced services elsewhere) and innovation to improve the outcomes of children's public health services. This is to ensure that our service offer is reflective of the changing demographic profile of the borough and delivery of the Healthy Child programme, including the universal mandated elements.

In the closing chapter, I discuss the significant efforts into promoting the importance of vaccination, mainly amongst groups with the lowest uptake, greatest vulnerability, and lowest vaccine confidence. Childhood immunisation uptake continues to remain a concern due to performance remaining below national uptake target levels. Poliovirus detection in London and decreases in MMR vaccination uptake pose a particular concern for child health.

As for the challenge of winter, we know that vaccine hesitancy remains a big issue. For flu, the personal risk perception is likely to have reduced following limited case numbers in recent seasons. For COVID-19, learning to live with the 'new normal' may also lead to lower interest.

Later this year we will publish the refreshed Barking and Dagenham Joint Strategic Needs Assessment. This will provide an overview of the local data and insights that will both support the understanding of the key local population health needs that I highlight in this report and inform a partnership approach to reduce health inequalities and improve healthy life expectancy.

I hope you enjoy reading this report as well as finding it of interest and value.

Matthew Cole
Director of Public Health
London Borough of Barking and Dagenham

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Chapter 1:
Back to the Future

It has been 10 years since public health responsibilities moved into local authorities, and therefore I feel this is an opportune moment to look back and learn from what has happened.

Interestingly, over this time, the landscape of commissioning and providing social care, health care and public health, has considerably changed through government policy. However, several issues remain as significant today, such as the importance of place; strong relationships with residents; a vibrant voluntary sector; and integrated services to deliver health outcomes. But most importantly, poor health and profound health inequalities persist, with a very worrying trend in infant mortality getting worse in most deprived communities partly by the cost of living crisis.

Changes in outcomes take years to happen (the Health Foundation report highlights it can take up to 10 years to see changes in health inequalities) and be seen in the data, but data published this year from Census 2021 improves our understanding of relevant factors. The Census provides the most accurate data on changes over time of key determinants of health and health inequalities (population and households, housing, employment, health, education and transport).

Key findings and comparison for the borough, versus other areas of England and Wales between 2011 and 2021 include:

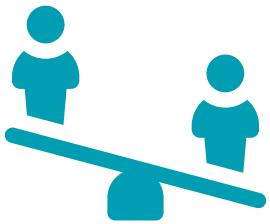
- *Rapid population growth* – 3rd highest increase in ten years (17.7%)
- *Young population* – Highest proportion (26.1%) of residents' under-16 years old
- *Deprivation* – Highest proportion of households (62.4%) deprived for education, employment, health or housing
- *Household structure* – 4th highest average household size (2.96%), highest lone parent households (12.8%) and 2nd highest multi-family households (8.6%)
- *Employment* – 3rd highest proportion of adults who had never worked (42%) and highest proportion who work offshore, in no fixed place or outside the UK (22.4%)
- *Disability within household* – Highest proportion of households in London with a disabled resident (29.8%)
- *Change in diversity* – Highest increase in residents born outside the UK (10.4%) and greatest increase in ethnic diversity (including highest proportion of Black African and 4th highest proportion of Asian Bangladeshi residents, 16.0% and 10.2%)
- Compared to the 2011 Census, a lower proportion of residents considered themselves to be in either *bad health or very bad health* – mirrored in London and nationally
- After accounting for age, Barking and Dagenham is higher than both London and England in terms of residents with *fair, bad and very bad health* in 2021

The Office for Health Improvement and Disparities Health Inequalities Dashboard also highlights:

- *Healthy life expectancy and life expectancy* has reduced in males and for females (although not significantly)
- Under 75 year old mortality rates for *cardiovascular disease* has gone up, but under 75 year old mortality rates for **cancer** has reduced (although neither are big changes)
- Suicides have increased (though not majorly)

Firstly, it should be recognised that many of these changes and characteristics (e.g. diversity, youth etc) bring benefits to our communities. Yet the pace of population change often brings big challenges for services and communities, e.g. an analysis of London house prices and life expectancies between 2002 and 2019 suggested areas with low house prices and rapid inflow of people have seen growing inequality in life expectancy[1]. A recent NHS North East London profile of the demography of north east London highlighted that Barking and Dagenham is expecting the greatest population growth in north east London of 37% (83,000) respectively by 2041. The largest growth will be seen in Barking Riverside where major development is planned to provide 10,000 new homes to house an additional 55,000 people – this is equivalent to growth of 520% of the current ward population.

This sets the context of my look back at the themes of my annual reports of the last decade.



Making the Healthier Choices, the Easier Choice for All

In 2013 I set out my challenge to make healthier choices the easier choice for all, which required supporting people to stay healthier; joined up and high-quality care; protecting people's health and providing care and support of children.

Now, 10 years on, the focus of this report has not changed. There remains a high burden of ill health (high mortality, coronary heart disease, cancer and respiratory disease); the need to continue to develop primary and social care to provide better care outside the hospital. If these services are going to be unsustainable, they need to effectively manage the demand pressures of the rapidly changing population. Keeping pace with changing needs and numbers must be at the forefront of partnership planning. As well as the knowledge that many healthy choices have become even harder, for example the diet meeting the Eatwell guidance is less affordable.

Obesity remains one of the biggest public health problems, still needing a system wide approach to tackle. Alongside other health improvement areas such as reducing smoking and improving mental health and wellbeing, the newly formed place-based partnership provides the best chance for this to now happen, alongside the commitment of the council to develop a 'Health in All Polices approach within its Corporate Plan. This recognises the role of green spaces, active travel and transport, access to training opportunities and good quality jobs and healthy homes has on health. The transfer of Public Health responsibilities in 2013 allowed the council to take a population focus as democratic stewards of local population well-being; shaping services to meet needs including environment; influencing wider social factors of health; and tackling health inequalities by taking strategic action across several functions e.g. housing, economic and environmental regeneration.

My call for a focus on good mental health 'as everybody's business' also remains a key building block for good health and enables people to participate in society, not least because good mental health is positive to the economy – people are less likely to be in employment or take more days off sick.

The need for better interventions to improve early years outcomes in the first five years - through the healthy child (0-5) programme was back in 2013 supported by the Family Nurse Partnerships and Troubled Families Programme, but we now have the opportunity through the re-procurement of 0-19 healthy child programme, the development of the family hubs and early start programmes.

The high numbers of early deaths identified in 2013, are still based on a high level of residents with long term conditions (LTCs) which need planned and proactive management, including optimum case finding to reduce need for hospital admissions and primary and social care support.

In 2014, The NHS Five Year Forward view was published which marked a radical upgrade in prevention, promoting crucial partnership between NHS and council, and the Transforming Primary Care in London programme set the context for better coordinated, accessible, and proactive care - focusing on health and well-being, which remains, alongside the integration of health and social care. At this time, we were working across a three-council footprint Barking Havering and Redbridge, which has now moved to be more localised with the formation of borough-based Place based Partnership, enabling our elected members and residents to have a stronger voice in decision making for their communities.

Growing the Borough to Improve Health

Throughout the years I continued to bring a focus back to the role of Place to grow the borough to improve health – demonstrating the opportunities of its regeneration plans, for example through the aspirations of the Barking Riverside 'healthy new town' proposal, recognising the broader role the council has in improving the public's health:

Growth and regeneration provide an opportunity to develop and use community assets, strengthen partnerships between communities and service providers.

Focusing on What Matters and Reframing Health Challenges

Reports 2015/16 and 2016/17 continued to focus on:

- Diagnosing illness early and managing it well including increasing breast, cervical, and bowel cancer screening uptake and identifying cardiovascular disease risk factors via the NHS Health Check, supported by a drive to reduce variation of quality of primary care by reshaping models of care pathways.
- Prevention to help residents to maintain their independence and reduce the risk of needing care or support, or delay the need for increased care and support, emphasised in the Prevention and Care Act 2014.
- Continued widening of health inequalities and together with the increase in long term conditions; action driven by the acknowledgement that we can no longer afford the services as they are by *not doing more but doing things differently or even stop doing something.*
- The need for a proper and robust framework around spending choices of the Public Health Grant to ensure effective use of the grant against agreed health outcomes with: *Better quality data on activities cost and outcomes to assess performance is required.*
- Importance of evolved power to commission and deliver against locally shared health and care outcomes, the delivery of integrated health and social care pathways, and the concept of place-based working in localities through the new model of care proposed through Accountable Care Organisations.

All of which at the time were captured in the new Sustainability and Transformation Plan.

The council's 2020 ambition to address the funding gap it faced was started, through which I identified the need for programme of change to tackle health inequalities through reducing smoking, improving blood pressure and cholesterol control and a focus on secondary prevention (detection of undiagnosed LTCs i.e. reducing numbers not included on GP monitoring lists, increase drug and lifestyle management and improving and reducing variations in cancer screening uptake, which developed different strategies to meet the different health needs of our population). It also needed to focus on requirements for a 'best start in life' including a reduction in newborn and infant mortality, providing good quality antenatal care, delivery and postnatal care including increasing vaccine and breastfeeding uptake, increasing well-being education, improving the goals of young people.

In **2015/16** I also first reported that pandemic influenza was the biggest communicable disease threat to the health of the population, but not even I could have foreseen the level, depth, spread and impact across the globe that the COVID-19 pandemic would have. Both directly on how death rates were unequal across communities and the indirect impact of the public health measures that we introduced at the time. And the ongoing negative impact on mental health, especially of children and the experiences of long COVID throughout the population. The pandemic has also changed the way we work on health protection issues today. I return to this in this report.

Creating Health

In **2018/19** I introduced the importance of improving healthy life expectancy - with the desire for residents to live longer in good health. I acknowledged that interventions that seek to change behaviour – won't work without understanding the specific needs of the population and addressing wider social and environmental constraints on choice – system wide working is paramount. The focus of my report today, builds on this by emphasising if we address factors which impact on healthy life expectancy in the short term; for example, managing LTCs this would have a direct link to reducing demand on health and social care services.

Equalities Challenges

The **2020/21** report focused on equalities challenges and learning from COVID, which recognised the impact of COVID-19 and impact of housing, and the indirect impact on employment with out of work benefits increased, increase of support levels.

And the key messages remain. We need to: better understand the different needs of our communities; continue to develop the role of council and partners in reducing health inequalities; create more opportunity for resident engagement and involvement particularly with underserved, vulnerable and marginalised groups; focus on best start in life, including reducing family poverty and access to mental health services, education and training for young people, increase diagnosis and early intervention; address social determinants of health to remove barriers to health and develop the use of social prescribing.

People, Partnerships and Place

In 2021/22 I reported on the development of the Place-based Partnership, the publication of the best start in life strategic framework, with a particular focus on supporting parents to improve development and school readiness, and the actions needed to address inequalities using the Marmot principles within the population intervention triangle which remains the model of place-based working.

2023

So, to 2023 - this report takes the issues laid out over the last 10 years further, with a particular focus on improving healthy life expectancy, looking at how:

- The Partnership through the development of placed based working (localities)
  - creates a shared understanding of health outcomes based on data and evidence of need to develop community civic and services-based interventions (the population intervention triangle (see Figure 3)
  - can lead the coordination of more accessible and engaged services using the POTS framework (see Figure 4)
  - can take a systematic approach to early identification and treatment of health conditions causing greatest problems to individuals' communities and care system
  - creates opportunities for pooling budgets
- An in-depth review of services for 0-5- and 5–19-year-olds can help us re-procure the 0-19 healthy child programme services to meet the agreed Joint Local Health and Wellbeing Strategy 2023-28 shared outcomes and developing healthy building blocks for the future.
- We need to develop the current lifestyles services to meet the differing needs of the population and produce population health outcomes, based on what good looks like.
- We can meet the level of investment needed to protect the population from communicable disease threats and meeting the new health protection responsibilities of the council, learning from COVID-19.

Chapter 2:
Exploiting Opportunities to Improve Health

Key facts

Residents are around three times more likely to suffer an avoidable death than people living in the 10 least deprived areas of England[2].

Adults in Barking and Dagenham are more likely to have a long-term health condition than their counterparts in other areas, with the borough having the highest prevalence of four of the 'Top 10' health conditions (heart disease, chronic obstructive pulmonary disease, lung cancer and stroke).

Many residents suffer unrecognised and therefore unmanaged long-term conditions, with around 38,000 estimated undiagnosed cases of the six most common long-term conditions. Approximately 1 in 3 people have at least 1 long term condition and 1 in 6 people have 2 or more long term conditions.[3]

In 2022/23 there were 790 school reception children in Barking and Dagenham measured as overweight or obese (24%) which was the highest in London.

This report is focusing what we can do in the short term (during the next 5 years) to improve the health of the population, to increase the number of years our residents spend in good health and able to live independently for longer.

The recently published annual report of the Chief Medical Officer highlights the importance of improving the quality of life of older people by tackling conditions – both medical and environmental - which impact on their ability to live independently and in good health. Even though he was particularly highlighting issues in areas where there is often a higher population of older people than in Barking and Dagenham – the issues remain important to our residents as:

- Black ethnicities develop a long-term health condition over five years earlier than their White neighbours (see Table 3),
- have high demand for support services.
- high levels of unhealthy behaviours and
- are more impacted by the cost-of-living crisis which puts them at higher risk of poor health.

Therefore, the report's recommendations are useful to take into our current planning discussions:

a) **Services to prevent or treat disease and provide infrastructure** need to be planned, including support services e.g. housing.

b) **Develop the environmental infrastructure** which can delay or prevent the chances of early ageing (primary prevention), for example making it easy and attractive for people to exercise throughout their lives; reducing smoking, air pollution and exposure to environments that promote obesity.

c) **Delaying disease to the greatest possible extent**, to delay the period of disability in older age - the longer people live with risk factors such as hypertension or high cholesterol, the earlier the start of their disabilities will be. Screening programmes help to delay or stop the onset of serious disease and therefore prevent ill health in later life. It is essential that we prioritise secondary prevention and screening services and do more to extend these services to groups with reduced access and historically low uptake.

d) The medical profession needs to **respond to the rise of multiple long term conditions.** NHS organisations also need to minimise the probability that the same person must attend multiple clinics for a predictable cluster of diseases.

I therefore advise **we need to consider** introducing shared outcomes aligned to reducing the gap in both female and male healthy life expectancy, focused on:

1. Preventing and managing long term conditions, ensuring early diagnosis and pathways are clear to support early intervention.
2. Reducing obesity and smoking through targeting services to those who need is greatest as well as developing wider system working (see Figure 4).
3. Improving the number of children achieving a good level of development by five.

To set this in context this chapter provides an overview of the key health needs of our residents; particularly focusing on improving our healthy life expectancy outcomes and the need for us to tackle the large health differences experienced by our residents; the need to level up of resources across the NHS North East London (NHS NEL) footprint based on the significant unmet need there is within our population recently reported and acknowledged by NHS NEL, including the opportunities we have to address these through our current agreed strategic direction; leadership to deliver outcomes through joint delivery plans, our place-based working and how we decide to invest our collective resources.

Strategic Plans and Agreed Outcomes

The recently published Joint Local Health and Well Being Strategy, which aligns with the councils Corporate Plan and NHS North East London Joint Forward Plan provide us foci for our direction of travel including the desire to address the differences in health experienced by different communities – what our data shows is that some residents die earlier than we would expect against the national average and too many of our residents live longer in poorer health than others. This is unacceptable and despite many commitments across partner organisations this situation has not changed over the last 10 years.

It is however difficult to assume a cause-and-effect relationship between what has been done and these outcomes as we have seen the 3rd highest increase in London in ten years (17.7%), and the highest raise (26.1%) in our residents under-16 years old the young population, bringing families with more complex needs and ethnic diversity as Barking and Dagenham is seen as a more affordable borough to its counterparts in inner London with excellent transport links into central London.

But we must not be disheartened and remain committed to addressing these differences and meet the vision of our Joint Local Health and Wellbeing Strategy for our residents to have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham residents and people living elsewhere.

Outcomes

The vision of the Joint Local Health & Wellbeing Strategy 2023-28 (JLHWS) has been translated into shared outcomes for overall improvement in life expectancy and healthy life expectancy (I return to this later in this chapter).

The following long-term outcomes have been agreed:

Best Start in Life

We want babies, children, and young people in the borough to:

- Get the best start, be healthy, be happy and achieve
- Thrive in inclusive schools, settings and communities
- Be safe and secure, free from neglect, harm, and exploitation
- Grow up to be successful young adults

Living Well

We want to ensure residents live well and realise their potential, and when they need help, they can access the right support, at the right time in a way that works for them.

Ageing Well

We want residents to live healthily for longer and:

- Be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions.
- Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious.
- Their health and wellbeing are improved to support better opportunities (educational, employment, social) and independent living for as long as possible.
- Achievements of these outcomes will take time and shorter actions are needed. I return to this later in this chapter.

Our Priorities Over the Next Five Years

Ensuring good health and wellbeing and preventing the need for expensive health and social care is crucial in this financial climate, with funding pressures for all our system partners. We must therefore prioritise; focusing on impacts over the next five years on those interventions which will improve healthy life expectancy and address health inequalities which will also help us meet the wider priorities of the council for example good quality employment doesn't only enable good health, good health also is important to maintain economic activity.

As a report from ONS[2] identified; the number of people economically inactive because of long-term sickness has risen to over 2.5 million people, an increase of over 400,000 since the start of COVID-19. And for those economically inactive because of long-term sickness, nearly two-fifths (38%) reported having five or more health conditions (up from 34% in 2019), suggesting that many have interlinked and complex health issues.

A recent report[3] revealed that nearly 460,000 people in the UK are unemployed due to the consequences of health-harming products, resulting in a loss of £31.1bn from the economy. The analysis shows that 289,000 people are not working due to poor health caused by smoking, while 99,000 are unemployed because of illness caused by alcohol, and 70,000 are unemployed because of weight-related health conditions.

The following priorities have been agreed within the JLHWS; but we need to focus our attention on actions which will make the biggest difference in healthy life expectancy over the next five years, and therefore are suggesting we focus on the top three, but recognising there will be elements of the last three reflected in delivery plans.

The Joint Strategic Needs Assessment 2023 has been complemented by other important sources (such as the 2021 Census) to create a set of key priorities agreed by the Place-Based Partnership and set out in the Joint Local Health and Wellbeing Strategy 2023-28.

These are:

- Improving outcomes for people with long term conditions in children and adults.
- Addressing unhealthy weight and smoking in children and adults.
- Providing the best start in life for our babies, children, and young people.
- Preventing and addressing domestic abuse.
- Preventing exposure to and the consequences of adverse childhood experiences.
- Addressing wider determinants of health- for example unemployment, poor housing, low level of training, education and skills development.

Measuring Impact

It will be important that the Place-based Partnership decides on the measures it wants to reach against its agreed outcomes, based on realistic timescales (see Figure 2). For example, the Health Foundation reports that it can take up to 10 years to see a difference in health inequalities[4] and a review of the impact of the comprehensive programme to reduce health inequalities in England implemented by the UK government between 1997 and 2010. Health inequalities Strategy[5] suggested improvements in inequalities in life expectancy between more and least deprived areas could be seen within three years, which is likely to have been related to the targeted action (although this cannot be proved with the analysis[6].)

This would be underpinned by the actions we are taking to address health inequalities and work is currently underway to identify and agree using targets to better support health inequalities reduction, and we will use the key recommendations from the Health Foundation to do this, which include:

- Focus on improving the health of the most disadvantaged groups and geographic areas (e.g. the 20% most deprived areas***, children and minority ethnic groups).
- Taking a long-term viewpoint, as it takes around 10 years to achieve measurable reductions in health inequalities.
- Focus on ambitious, but achievable targets using both a range of long-term health indicators (e.g. infant mortality rates, life expectancy, healthy life expectancy, prevalence of overweight and obesity in adults and children, prevalence of anxiety and depression in adults, and suicide rates) and interim indicators of social and behavioural determinants of health (e.g. household relative poverty rates, employment rates, relative child poverty rates, educational attainment rates, physical activity, diet).

We also need to consider the existing Borough Manifesto targets:

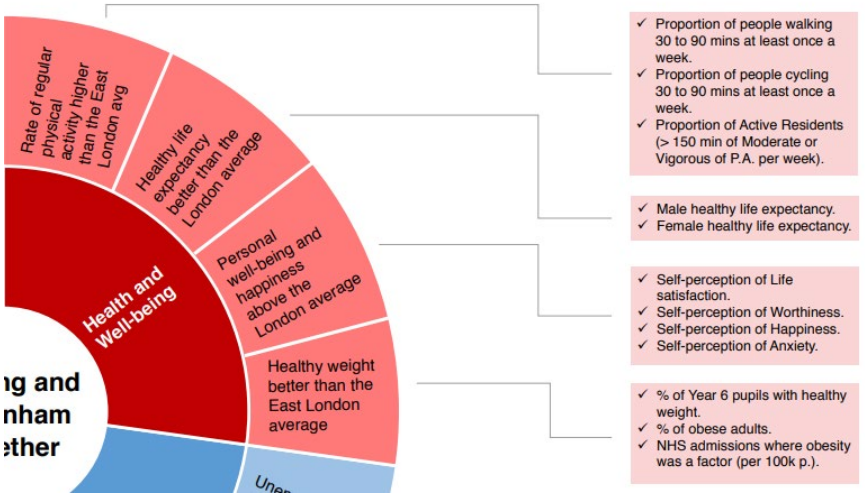


Figure 1: Barking and Dagenhams' Borough Manifesto health and wellbeing targets

*** all but 3 of our wards are in 20% most deprived by Index of Multiple Deprivation nationally, which means there is a need for hyper-localised approaches to target the communities most in need

Delivery Plans

Actions to deliver our agreed priorities have different development times (see Figure 2) which would need to be considered in any overall delivery plan, particularly if we want to see impacts over the next 5 years. A logic model can be a useful tool to provide an overview of the different interventions which will have incremental impacts to achieve our agreed outcomes.

This figure shows which actions will have impact in the short term, benefiting high service demands. But we should not forget the importance of the longer-term benefits of interventions within A and B, which must run alongside any actions benefiting the short term. They also coexist and often people need support to deal with many social determinants of health for example impacts of the cost-of-living crisis before they can consider health behaviour choices.

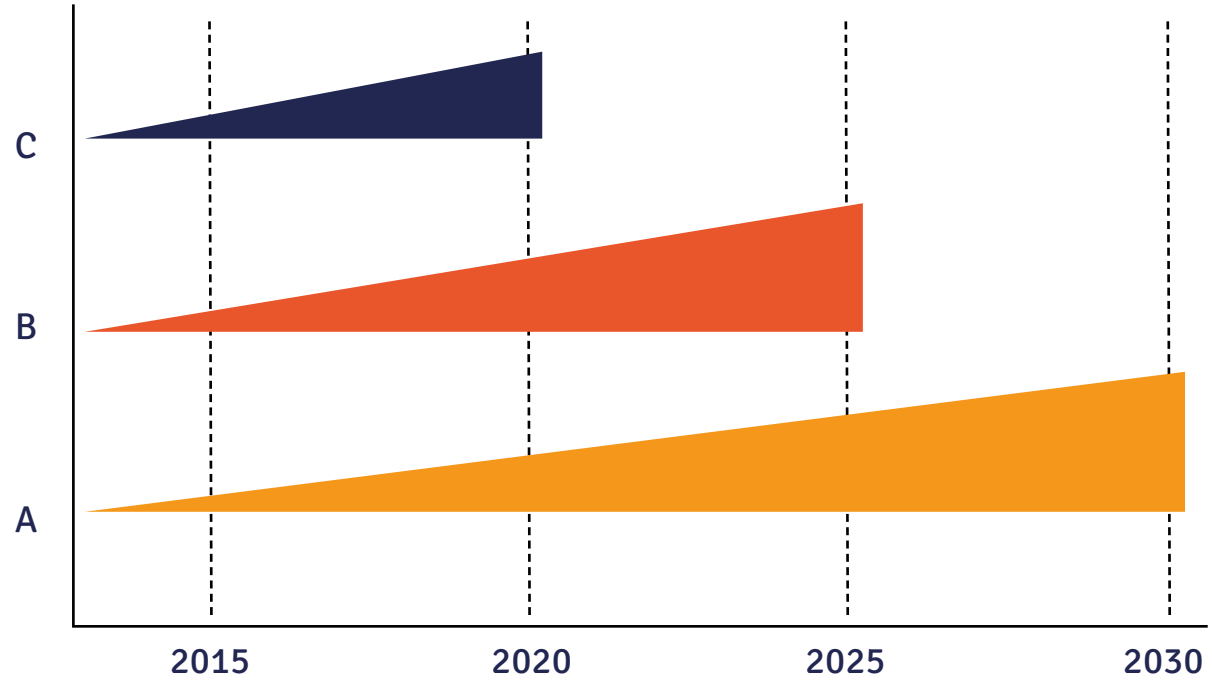


Figure 2: Time needed to deliver outcomes from different intervention types[7]

Place Based Working

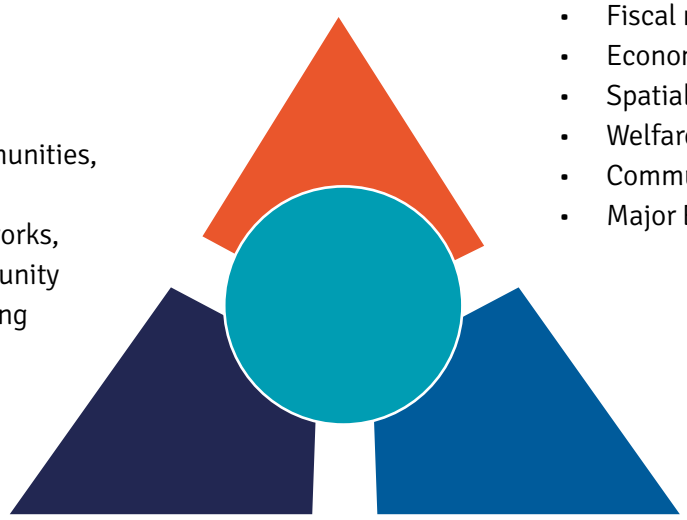
Effective delivery will only happen if **place-based action** is framed within the Population Intervention Triangle - which requires robust governance with clear leadership and evidence - based delivery plans setting out responsibilities across all partner organisations, that have been coproduced with residents.

Working in localities is a key delivery model for this way of working.

Civic-level Interventions

- Legislation; regulation; licencing; by-laws
- Fiscal measures: incentives; disincentives
- Economic development and job creation
- Spatial and environmental planning
- Welfare and social care
- Communication; information; campaigns
- Major Employer

- The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, as building blocks for good health.



- Delivering intervention systematically with consistent quality and scaled to benefit enough people.
- Reduce unwarranted variation in service quality and delivery
- Reduce unwarranted variability in the way the population uses services and is supported to do so.

Community-based Interventions

Sevice-based Interventions

Figure 3: The Population Intervention Triangle

Developing Place-Based Working – The Role of Localities

At the forefront of action is a genuine commitment to the value of relationships and coproduction with residents in designing or discovering changes to meet the needs of our communities

Joint Local Health & Wellbeing Strategy 2023-28

Three of the key principles underpin delivery – coproduction with communities, Integrated Care and taking place based action are central to the development of an effective model to deliver services and develop healthy places which address health inequalities and improve healthy life expectancy.

My reports in 2016/17 and 2018/19 describe an evolving locality model in Barking and Dagenham, which enables a place-based response to improve the health and wellbeing of our residents and reduce service demands. The following principles reported then, remain relevant today:

- The locality model provides health improvement, and health and social care for a defined population, usually (50,000 – 70,000 people) and will involve developing different strategies for different segments of the populations that they serve, depending on needs and levels of health risk.
- 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. This provides the opportunity to focus on the wider health and social care needs of the population that they serve.

- Within the locality model there will need to be a neighbourhood level. This is primarily to address inequalities by delivering a range of interventions aimed at improving the health of individuals within the small geographical areas (such as deprived estates). These interventions are many and varied and involve input from several organisations and services.
- 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.
- We can build upon our 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.

Since my last report, the Fuller report was published- this recognises the essential role primary care (including community pharmacy, dentistry, optometry, and audiology) must play working in partnership to prevent ill health, tackle health inequalities and manage long-term conditions.

This vision is key to an integrated locality model which aims to deliver prevention and early intervention tailored to the needs of the local community; providing choice about how they access care; proactive personalised care supported by multidisciplinary teams and action to help people stay well for longer.

This approach and a recognition of the broader role of primary care, provides an excellent opportunity to tie this workforce into the wider localities model we are currently leading (described below), particularly when looking at our approach to preventing, and managing long term conditions.

This reorientation of the workforce will also enable us to support our most vulnerable residents and those with complex needs to stay at home and access care in the community which will, over time, contribute significantly to efforts to reduce growth in hospital demand.

Locality Working

The development of locality working at Place is an iterative process comprised of several stages. The experience of those who are further ahead suggests it is important that places invest in the process of developing locality ways of working, approaching engagement in this as a meaningful way of furthering integrated working arrangements, and recognising that there is the likelihood of further iteration and evolution of the model over time.

This is where the shared outcomes outlined in our Joint Local Health & Wellbeing Strategy 2023-28 are a powerful mechanism for making integrated services a reality. From there, our partners set out how the priorities will be delivered, and the measurables used to monitor progress. A locality focused delivery plan may map out how organisations and services will collectively deliver the priorities.

Shared outcomes support integration at place level and are key in connecting our partners plans and strategies into coherent and focused delivery plans for meeting those outcomes. For me, the key benefit will be to address current complexity of service planning that by design has developed 'systems within systems' to focus on various aspects of performance, transformation, and access across the life course, drawing on skills and services from across the partnership. The challenge to new 'ways of working' going forward is to ensure that the services we deliver forms part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives. And puts residents in the heart of decision making to improve accessibility and acceptability of services and programmes to improve health.

This approach also provides the opportunity to deliver an evidenced base approach to tackle health inequalities. As discussed earlier this chapter, achieving a reduction in population health inequalities requires a long-term, place-based approach across three types of interventions (i.e. the Population Intervention Triangle): Civic-level interventions (e.g. licensing, economic development); Community-based interventions (e.g. using and building assets within communities); and Services-based interventions (e.g. quality and scale, reducing variation).

But more specifically to address factors which are driving our poor healthy life expectancy and related health inequalities I advise that the Barking and Dagenham Place-based Partnership use the Population Outcomes through Services (POTS) (Figure 4) evidence-based framework to determine which interventions to develop and apply the following criteria needs to ensure these interventions are effective:

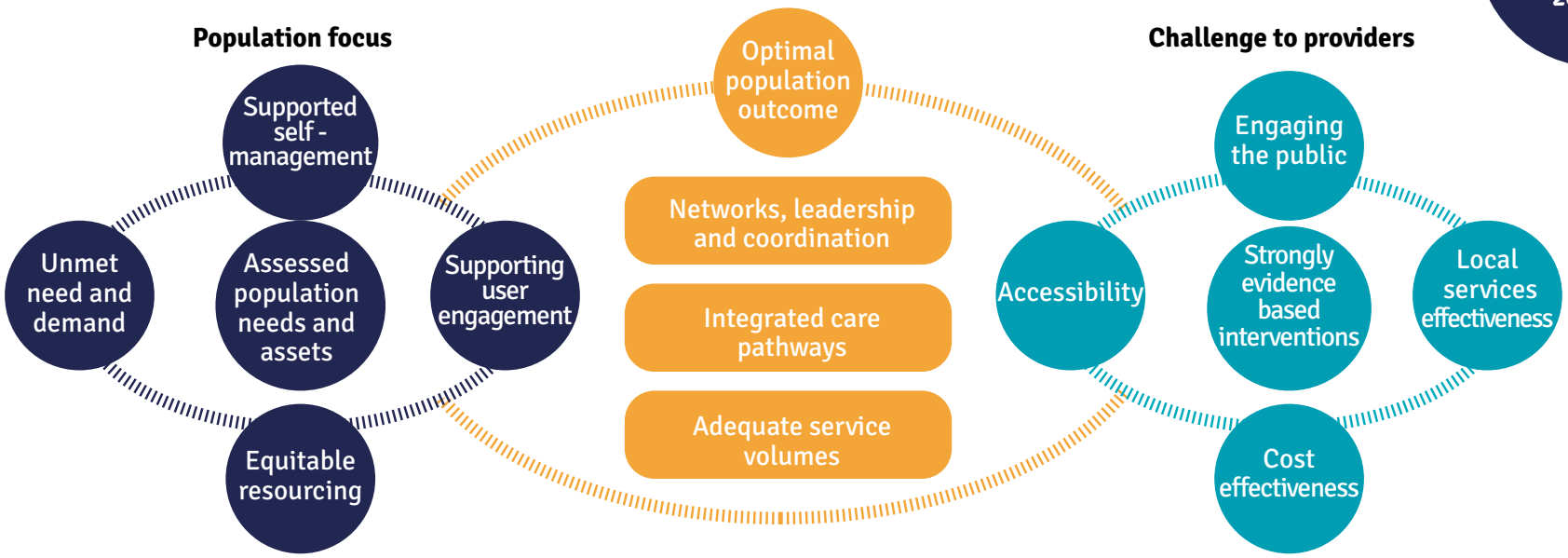


Figure 4: The population outcomes through services (POTS) framework[68]

Localities network case study

In the first year of the health inequalities programme, invested in community sector infrastructure to improve health at a population level through creating networks of civil society organisations working with residents to re-define local problems and solutions related to health inequalities and the cost-of-living crisis, alongside statutory sector partners building on the lessons of the BD CAN partnership during the pandemic.

Community Locality Leads were established and have operated over the last year borough-wide across six areas, roughly the same geographies as the Primary Care Networks, across the borough's three localities. The Leads are voluntary sector organisations that provide local connections in communities; triage support for residents; build a connected network of community partners and working with residents to design prototypes to meet cost-of-living and health inequality challenges as identified by residents.

Through their triage process, Community Locality Leads have held around 2,600 conversations with residents, which informs their approaches, as does the mapping of 'connecting places' such as civil society organisations, social spaces and natural points of connection, with an estimated 500+ such places in each locality. Community-led design has ranged from collaboration with statutory sector partners to bring health services into the community and improve access for marginalised groups, such as pop-up clinics for those who are homeless, to small-scale community groups like choirs.

To date, the approach has enabled shared learning between the voluntary sector, NHS and council partners and a shift in statutory partners' understanding of the value of the voluntary sector and the relationships they hold with residents.

Following this 'proof of concept', is currently being reviewed which will complete in early 2024 with the revised approach planned for Summer 2024 onwards.

Investing to Improve Health

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 provide these benefits, as achieved in other parts of London and the country. We will miss a trick if we don't capitalise on this opportunity to jointly plan, invest, and deliver integrated prevention programmes that go beyond care to address our agreed outcomes and priorities.

It is also 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 emergency departments, adult social care and care homes and prevention programmes are part of the solution.

The Place based Partnership has made a strategic commitment to improve the health of the residents of Barking and Dagenham. Therefore, core funding and activities must be jointly considered to deliver agreed plans against our priorities. The funding provided by the Public Health Grant (PHG) can add value to this mainstream activity and funding. Over time formal joint funding arrangements could be considered, learning from our experience with the existing Better Care Fund which is a joint budget between the NHS and the council with a focus on prevention.

Firstly however, I need to consider whether the PHG is being invested in the right services/interventions which impact on our shared public health outcomes as detailed in our Joint Local Health and Wellbeing Strategy 2023-28. As well as the required balance of the PHG allocation to deliver both population health management as well the shared public health outcomes.

The allocation has remained mostly unchanged since 2016 and now is an opportunity for this to be reviewed in line with the borough's changing demography and need. This section provides an overview of how the grant was spent in 2022/23 and changes to responsibilities and accountability for delivery of value for money and outcomes for public health programmes and services linked to assurance statements.

The Health and Care Act 2012 transferred public health responsibilities to local authorities by way of a ring-fenced PHG received from national government to:

- Significantly improve the health and wellbeing of local populations.
- Carry out health protection functions delegated from the Secretary of State.
- Reduce health inequalities across the life course, including within hard-to-reach groups.
- Ensure the provision of population healthcare advice.

Local authorities are mandated, through the grant to fund a range of public health activities including sexual health services, sexually transmitted infections testing and treatment and contraception; NHS Health Check programme; health protection; public health advice to commissioners; the National Child Measurement Programme and mandated children's 0-5 services and health visiting.

It is planned that from 2023 end of year returns, categories for reporting local authority public health spend will be split into prescribed and non-prescribed functions[8].

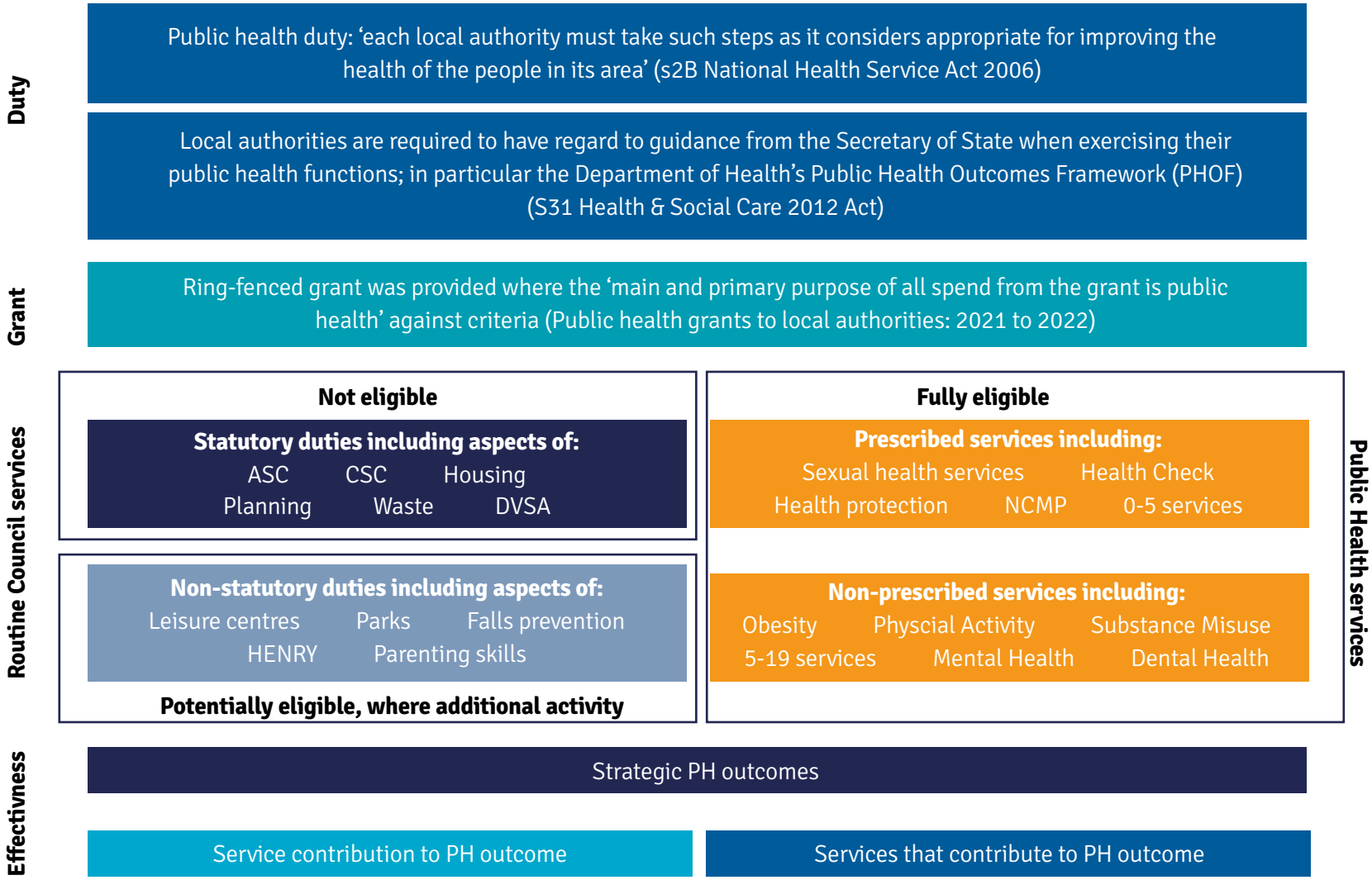


Figure 5: The public health duty for local authorities

For financial year 2022/23, the council received a PHG allocation of £17,787,080.

The grant allocation is mainly as below, going forward, the allocations will be reviewed to see if they are still the right thing to commission from next year, to meet our priorities.

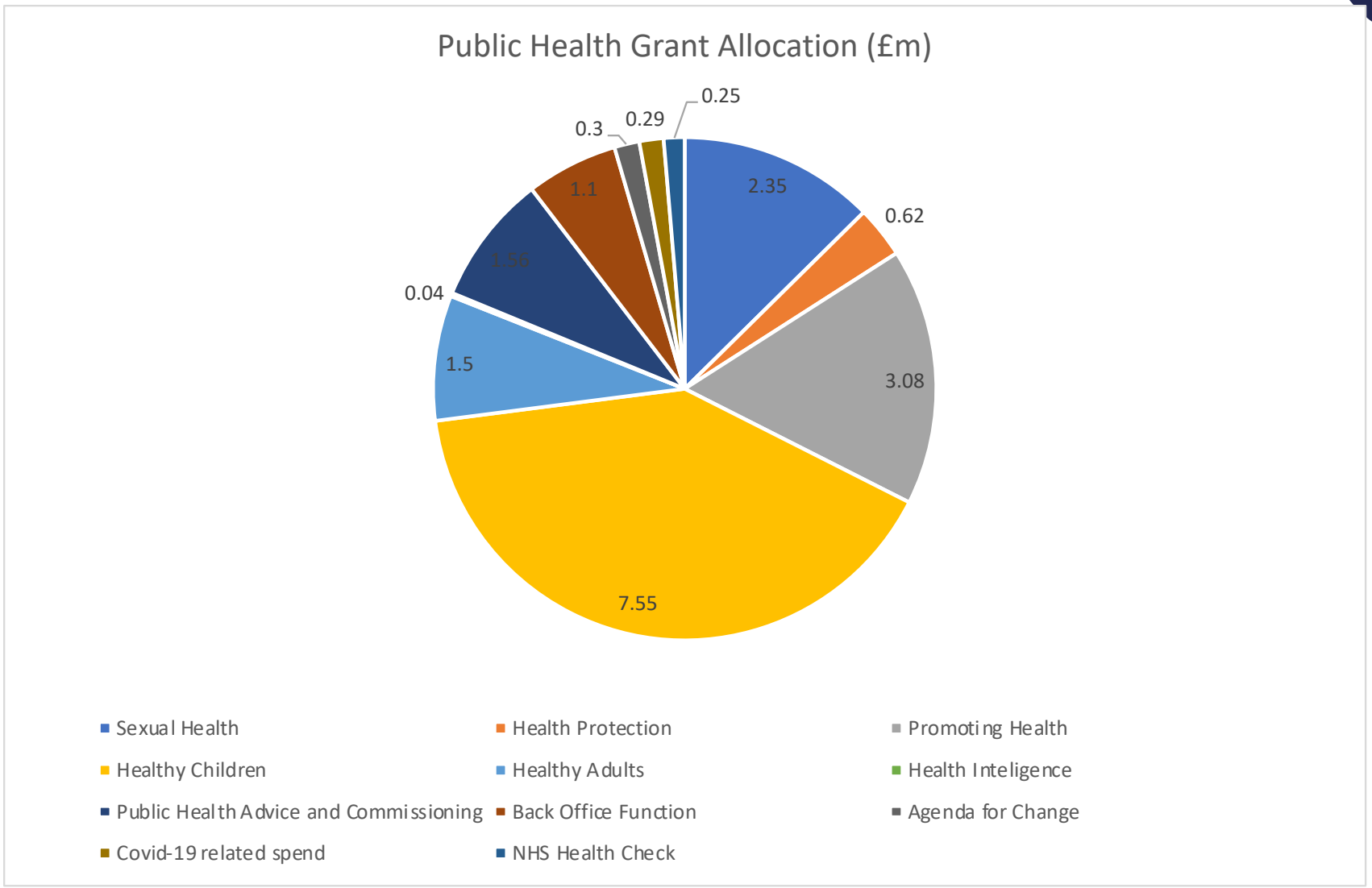


Figure 6: Breakdown of spend for the Barking and Dagenham Public Health Grant in 2022/23

The PHG spend is monitored by a public health programmes board chaired by the Director of Public Health.

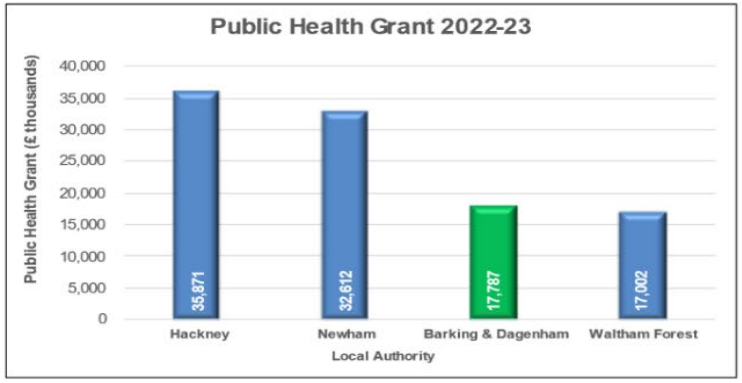
Figure 7 below gives an overview of the grant allocation compared to other north east London borough neighbours that are similar in socioeconomic profile. This reflects that the PHG received does not meet the needs in the borough as the allocation per head is 3rd lowest of the boroughs, despite having one of the highest needs.

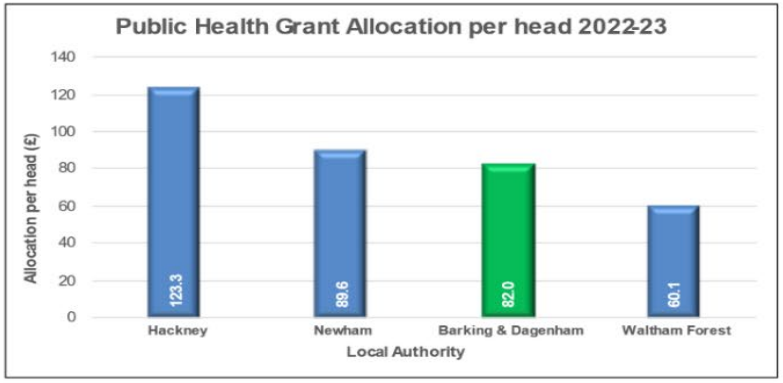
Benchmarking of Cost Drivers

Public Health grant allocations for 2022-23

Local Authority	Public Health Grant (£ thousands)	Allocation per head (£)	2022 projected population
Hackney	35,871	123.3	290,891
Newham	32,612	89.6	364,021
Barking & Dagenham	**17,787**	**82.0**	**216,826**
Waltham Forest	17,002	60.1	283,108

Barking and Dagenham is compared to NEL neighbours who are also CIPFA nearest neighbours (matched on socioeconomic profile). CIPFA does not take into account ethnicity, but NEL boroughs will have similar ethnic profiles.





graphs to redraw/add

Source: Public Health local authority allocations 2022 -23

Figure 7: Public health grant allocations for similar north east London boroughs 2022-23

This is demonstrated when we look at performance across key public health outcomes (see Table 1); we are among the worst nationally for healthy life expectancy, obesity, school readiness, and some sexual health and immunisations outcomes. Whilst this is associated with our local deprivation; when we compare ourselves to Newham, a local neighbour with similar socioeconomic need and public health allocation per head, we are worse in relation to healthy life expectancy, obesity and school readiness outcomes.

Key Performance Indicators

Source: Public Health Outcomes Framework

Barking & Dagenham

Category	Outcome Indicators (indicative sample, not all represented)	National performance	LBBD performance	Newham performance	Period	LBBD National Benchmarking Summary
Overarching	Life Expectancy M F	M 79.4 F 83.1	**M 77.0 F 81.7**	M 79.0 F 83.1	2018-20	worst/lowest to 25th percentile
	Healthy Life expectancy at birth M F	M 63.1 F 63.9	**M 58.1 F 60.1**	M 59.5 F 64.6	2018-20	worst/lowest to 25th percentile
	Cumulative percentage of people who received a healthcheckage 40-74	27.4%	**46.5%**	100% (data quality issue)	2018/19-22/23	75th percentile to best/highest
Child Health	Low birth weight of term babies	2.8%	**3.8%**	5.0%	2021	worst/lowest to 25th percentile, no significant change
	Hospital admissions caused by unintentional and deliberate injuries in childrenage 0-14 crude rate/1000	84.3	**52.3**	58.2	2021/22	75th percentile to best/highest
	% of school children achieving a good level of development at reception	81.1%	**62.5%**	68.7%	2021/22	worst/lowest to 25th percentile
Sexual Health	New STI diagnoses (excluding chlamydia aged under 25) per 100,000'	496	**599**	990	2022	worst/lowest to 25th percentile
	Under 18 Conception Rate/1000	13.1	**12.5**	9.9	2021	25th percentile to 75th percentile
Substance Misuse	Admissions episodes for alcohol (persons) (per 100,000)	494	**354**	352	2021/22	75th percentile to best/highest
	Deaths from Drug misuse (per 100,000)	5.0	**3.0**	2.6	2018 - 20	75th percentile to best/highest
Health Protection	Population vaccination coverage : MMR (5yrs old)	1 dose 93.4% 2 doses 85.7%	**1 dose 86.4%** **2 doses 67.8%**	1 dose 84.9% 2 doses 69.9%	2021/22	worst/lowest to 25th percentile, worsening
	Cancer Screening coverage: bowel cancer	70.3%	**57.4%**	55.4%	2022	worst/lowest to 25th percentile, improving
Tobacco	% smoking prevalence in adults (18+)- current smokers (APS)	13.0%	**11.3%**	13.9%	2021	25th percentile to 75th percentile
Obesity/ Physical Activity	% overweight/obese at reception	22.3%	**27.5%**	22.7%	2021/22	worst/lowest to 25th percentile, no significant change
	% overweight/obese at yr6	37.8%	**49.1%**	46.3%	2021/22	worst/lowest to 25th percentile, worsening
	% overweight/obese at adult	63.8%	**70.5%**	47.3%	2021/22	worst/lowest to 25th percentile
	% physically active adults	67.3%	**58.4%**	63.9%	2021/22	worst/lowest to 25th percentile
Mental Health	Self reported wellbeing: % with a low satisfaction score	5.0%	**2.8%**	low count	2021/22	75th percentile to best/highest
	Emergency hospital admissions for intentionalself harm (per 100,000)	163.9	**69.6**	52.1	2021/22	75th percentile to best/highest

Table 1: Public health outcomes for Barking and Dagenham compared with national averages and Newham's performance

The Future Direction of the Public Health Grant

We are proposing to transform public health programmes from 2024/25; partially through the development of partnership plans to delivery our priorities, but also through changes to the PHG allocation and services commissioned and delivered against public health outcomes, which recognises the commitment of all partners to meet the priorities set out in the Joint Local Health & Wellbeing Strategy 2023-28.

Therefore, the PHG needs to be directed towards those factors which the evidence suggests will improve health life expectancy (which I describe in chapter 3) i.e. addressing long term conditions and risk factors for poor health – smoking and obesity, focusing on the underpinning health inequalities within in these contributory factors. To address these issues, there are several building blocks for health which are needed, including best start for life, in particular school readiness, health literacy, community cohesion, unemployment and improving mental health and wellbeing that need to be addressed (see Figure 8).

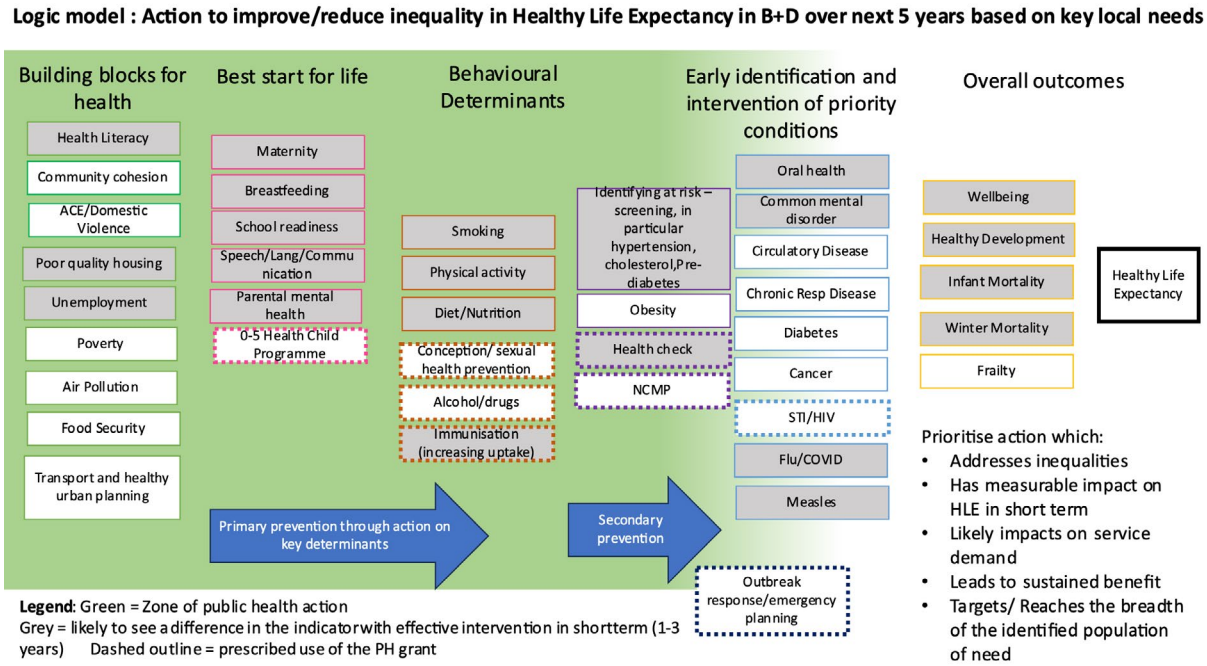


Figure 8: Action to improve/reduce inequality in healthy life expectancy in Barking and Dagenham over 5 years

Public Health Advice

We need to exploit the opportunities we have in the Place based Partnership to improve female and male healthy life expectancy by:

- Agreeing shared outcomes and priorities.
- Aligning strategic plans, develop agreed delivery plans and outcomes of the locality model.
- Invest together on programmes to deliver our priorities and reprioritise our spending of the Public Health Grant.

Chapter 3:
Why is healthy life expectancy key to improving health and managing health and social care demand?

Measuring Impact

Although increasing life expectancy, particularly the inequalities we see in Barking and Dagenham is important (see JSNA, 2022), I suggest in this report that we focus on increasing healthy life expectancy and addressing those contributing factors which in the short term, impact on overall health, ability to live independently in later life, and on the increasing demand on our health and care system. If an approach is well structured, actions identified can provide results within the five years of the Joint Local Health & Wellbeing Strategy 2023-28 (JLHWS).

Healthy Life Expectancy

Healthy life expectancy (HLE) describes the average number of years a baby born today would expect to live in good health. It is based on data combining risk of death and people's self-reported good health. Analysis of why we have lower healthy life expectancy can also help us develop a plan to reduce the impact on the rising demands on social care and health services. It is often measured through 'Disability Adjusted Life Years'. This is a measure of the number of healthy years of life lost from disease and ill-health.

Nationally there has been little change in HLE between 2014-16 and 2017-19 because improvements in health in older people have been balanced by worsening health in the younger population. The cost-of-living crisis has put additional strain on the wider determinants of health. It is therefore important to focus on efforts to improve HLE across the life-course, as our JLHWS identifies starting well, living well and ageing well, even if the impacts on children and young people take years to realise.

Our Borough Manifesto in 2017 set out targets to achieve a better healthy life expectancy than the London Average by 2037 (14th out of all London Boroughs). However, recent, and ongoing challenges mean we have seen little improvement in recent years – and this is true both of London and nationally.

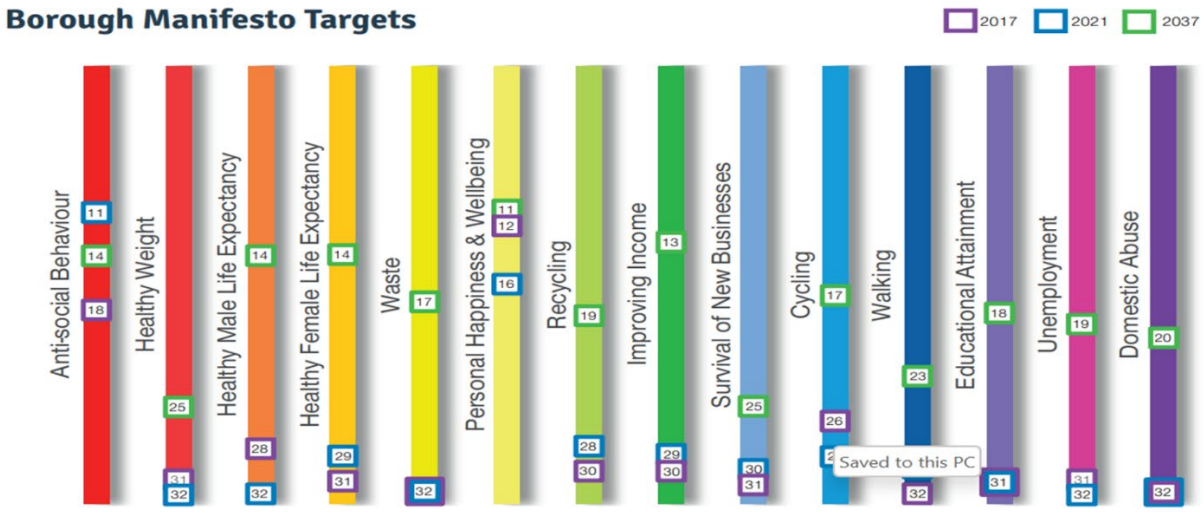


Figure 9: The Borough Manifesto targets for 2017-2037

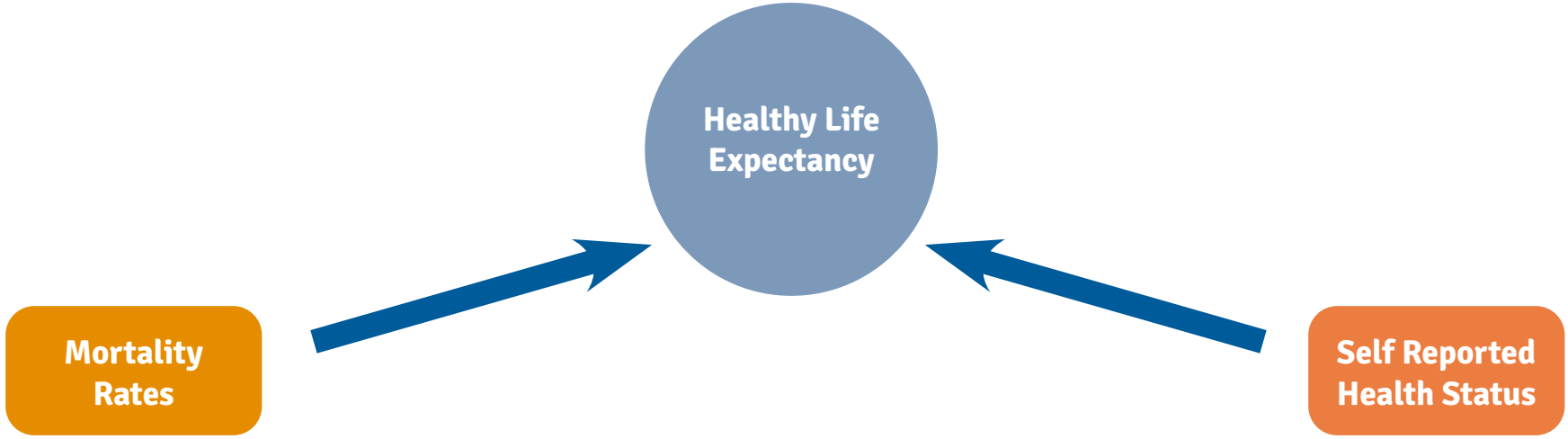


Figure 10: The relationship of self-reported health status, mortality rates and healthy life expectancy[9]

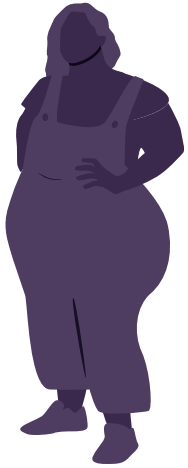
Male healthy life expectancy is 58.1 years in Barking and Dagenham, which is lower than the England average of 63.1 years (in 2018-20) and has been significantly lower most years during the last decade.

Female healthy life expectancy is 60.1 years, this is also significantly lower than the England average of 63.9 years for England (in 2018-20), and again has been for most years during the last decade, although improvements have been seen since 2012-2014 when healthy life expectancy for women in Barking and Dagenham was only 53.6 years.

Self-reported Health

National analysis[10] shows an increase in self-reported good health has a greater impact on healthy life expectancy compared to a decrease in mortality rates, although it should be noted that factors linked with poorer mortality and self-reported health status are complex, overlapping, and likely to interact with one another.

In addition to the strength of association between the health condition and self-reported poor health, the prevalence of the condition will also be important in determining its overall influence on population-level healthy life expectancy.



For example, a 2% improvement in mortality rates would improve healthy life expectancy by 0.1 years, compared to a 2% increase in self-reported good health that would improve healthy life expectancy by 1.3 years.

What Are the Main Contributors to Self-Reported Ill Health?

Research shows that the most consistent and strongest links with self-reported poor health are **chronic health conditions and multiple long term conditions**. In almost all studies, having a chronic condition significantly increased the chances of self-reported poor health. There was also strong evidence that a cumulative effect of having multiple chronic conditions increased the odds of self-reporting poor health further.

National data and wider research suggest the following are linked with worse self-reported good health.[11],[12], Data below shows that our residents are affected by all contributors.

Ill health:

- Having a long-term condition: 29.1% of GP registered patients have one or more long-term condition in Barking and Dagenham[13] (there are more registered patients than those living in the borough, as some patients do not always re-register when they move).
- Having multiple long term conditions (has a cumulative effect): 13.4 % of GP registered patients have 2 or more long term conditions[14].
- Muscular Skeletal Conditions are one of the top three conditions which impact on numbers of healthy years lost. [15]

Risk factors for ill health:

- Smoking: 13.7% of residents smoke (similar to England 12.7%)[16].
- Obesity/overweight: 70.5% of adult residents are obese or overweight. (worse than London 55.9%, England 63.8%).
- Being physically inactive: 35% of residents (worse than London 22.9%, England 22.3%).

Wider determinants:

- Having low income (23.9% of children live in relative low-income families, (England 19.9%).
- Low educational attainment (Average Attainment 8 score age 15-16 is 49.9, similar to England 48.7; 22.7% have no qualifications (higher than London, 16.2%)[17].
- Living in deprived areas. (62.4%[18] of households are subject to 1 or more forms of deprivation, the highest level of deprivation experienced by any London borough).
- Psychological distress: Time lived in country of residence, financial stability and regularity of contact with family and friends are all protective factors for this in urban settings[19].
- Reduced access to health care. Average journey times to hospital for Barking and Dagenham residents are public transport 33 minutes; cycle 25 minutes; car 17 minutes; walking 56 minutes.[20]
- Food insecurity: 26.7% of Barking and Dagenham pupils are eligible for free school meals[21].

Demographics[22]:

- Being older (above 35 years). Currently 53.4% of the population is under 35, but as they age the likelihood of good self-reported health will reduce.
- Ethnic minority status (55.2% of residents are non-white).
- Being single (57.3% of adult residents are single or separated/widowed).

As the research identifies long term conditions, are one of the most important contributors to healthy life expectancy; demands on health social care services, and with concerted effort at place, impacts can be seen in the next 5 years.

Long Term Conditions

Long term conditions (LTCs) – also called chronic conditions – are health conditions for which there is no cure and require management through medication or other treatment. Therefore, identifying someone with a condition and getting them onto treatment programmes is vitally important.

As long-term conditions increase, what was once considered a health issue is now a societal one and needs a societal response requiring a focus on wider determinants of health.

Around 15 million people have a long-term health condition in England, including over half (58%) of us by the age of 60[23]. This impacts all aspects of life for individuals and communities, e.g.:

- **Employment** – e.g. over 1 in 3 working age people have a long term condition, with 2.5 million people not working nor looking for work as a consequence[24].
- **Demand for health services** – e.g. 50% of GP appointments, 64% of outpatient appointments and over 70% of inpatient bed days are for people with long-term conditions[25]
- **Cost of health and social care – e.g.** £7 in every £10 of health and social care funding is spent on treatment and care of long-term conditions[26]
- **Impacts on friends, families and communities** – e.g., almost 1 in 10 (9%) of the population provide care for someone[27] with a cost to their own health, social and economic wellbeing (e.g. caring results in a £6-9k drop in annual income for a carer[28])
- **Social participation and wellbeing –** e.g. 1 in 6 people with a LTC find it difficult to find or stay in work, 1 in 2 say it reduces their ability to maintain social relationships[29]
- **Susceptibility to illness and worse outcomes –** e.g.: 90% of COVID-19 deaths were in people with LTCs
- **Informal caring** – 52% of carers have a long-term health condition, with 87% reporting health has impacted their caring responsibilities[30]

Modelling by the Health Foundation suggests that there will be 2.5 million more people in England with a major illness by 2040; 1 in 5 adults compared to 1 in 6 currently. Although mostly driven by an ageing population (i.e. 80% of the increase will be in people aged 70 years and over), ill health is increasing across all ages. The 37% increase in people with major conditions is nine times the rate at which the working age population (20-69 year olds) is expected to grow, creating additional pressures on how to care for and fund a growing population with high health needs.

Increasing multiple long term conditions

Historically, focus on long term conditions has taken a single condition focus (e.g. strategies, funding, etc.); however, that is not the reality. Increasingly people are suffering from 'multi-morbidity, which is the presence of two or more health conditions[31]. Multiple long term conditions is associated with[32]:

- Reduced quality of life and life expectancy.
- Mental health difficulties, such as anxiety and depression.
- Higher treatment needs and use of services (including unplanned or emergency care).

Inequalities in Long Term Conditions

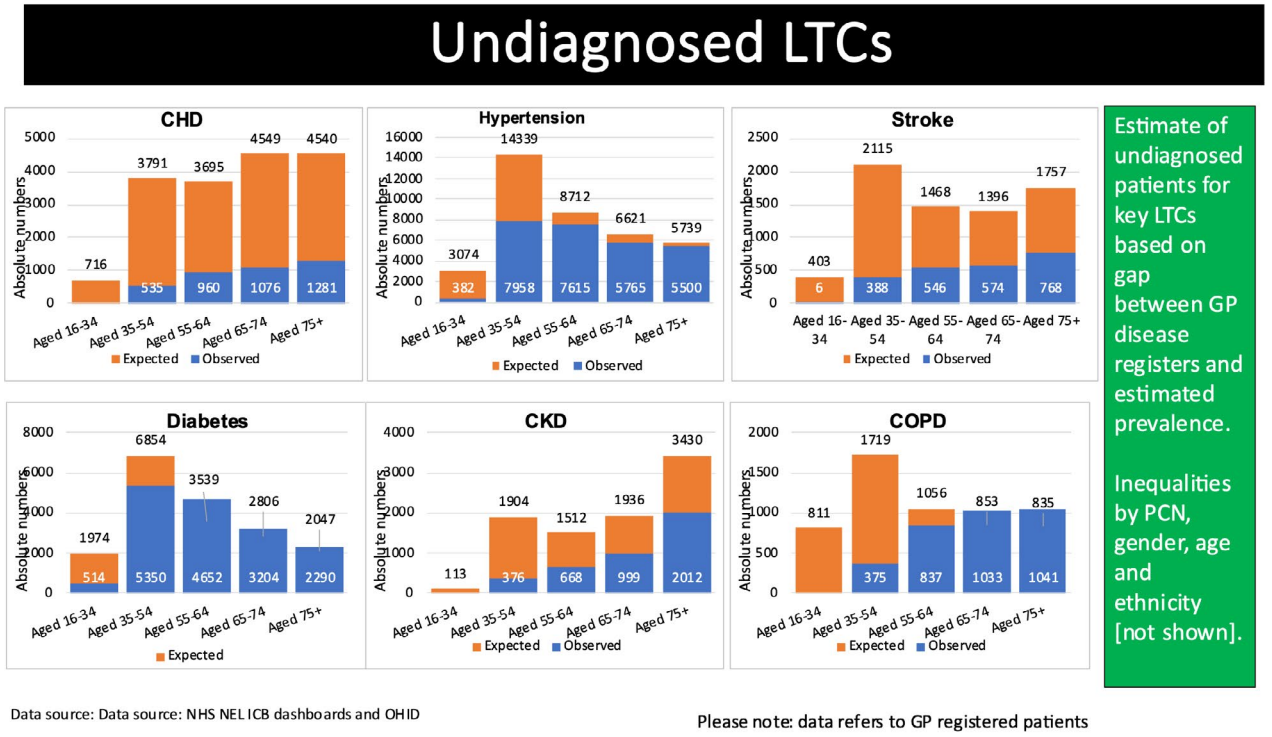
There are inequalities across all aspects of long term conditions: risk factors for developing a condition, likelihood of having a condition, risk of multiple conditions and management of that condition. These inequalities can be seen across gender, ethnicity, socioeconomics, etc.[33]

Residents and communities in Barking and Dagenham have a higher level of LTCs than their counterparts in other areas, ranking us worst in London for four of the 'top 10' health conditions; heart disease, chronic obstructive pulmonary disease, lung cancer and stroke[34], with almost 1 in 8 (13%) having two or more conditions[35]. Musculoskeletal conditions and mental health disorders caused the third and fourth greatest number of years of healthy life lost to disability, after cancer and cardiovascular disease (JSNA, 2022).

As health conditions amendable to secondary prevention, it is alarming to know that, by comparing the number of people we expect to have the six common LTCs versus those in treatment (based on being on a GP disease register) our findings suggest around 38,000 cases are unidentified and therefore unmanaged[36].

There appears to be inequalities by geography, genders (higher in males apart from chronic kidney disease (CKD)), age (highest in 35-54, except for coronary heart disease (CHD) and ethnicity (highest in White ethnicity, except for hypertension and diabetes).

Long term conditions are a major driver of health and social care needs in Barking and Dagenham



Data source: Data source: NHS NEL ICB dashboards and OHID

Please note: data refers to GP registered patients

Figure 11: Estimated number of undiagnosed long-term conditions in the borough, by type and age

In respect to multiple long-term conditions, Barking, Havering and Redbridge University Hospitals NHS Trust have also analysed LTCs across their three boroughs, including undertaking projections for the next 2, 5 and 10 years[37]. Analysis of 2022 found the highest number of avoidable deaths are in Barking and Dagenham; 37% and 54% higher than in Havering and Redbridge respectively. It also analysed use of acute services by people with LTCs, which was lower in Barking and Dagenham – which might be expected, having a younger population– and were driven (in order) by asthma, depression, diabetes, high blood pressure and cancer.

Table 2: Projections for key LTCs in Barking and Dagenham for 2, 5 and 10 years[38]

	18-64 years				65+ years				All ages			
	2023	2 years	5 years	10 years	2023	2 yeas	5 years	10 years	2023	2 years	5 years	10 years
Obesity	45,216	46,695	49,190	54,673	7,793	8,231	9,095	11,063	53,009	54,926	58,285	65,736
Hypertension	17,847	18,431	19,415	21,580	12,211	12,897	12,252	17,334	30,058	31,328	31,667	38,914
Depression	16,651	17,196	18,114	20,134	2,378	2,512	2,775	3,376	19,029	19,708	20,889	23,510
Diabetes	45,216	46,695	49,190	54,673	7,793	8,231	9,095	11,063	53,009	54,926	58,285	65,736
Asthma	7,035	7,265	7,653	8,506	1,877	1,982	2,191	2,665	8,912	9,247	9,844	11,171
CKD	1,594	1,646	1,734	1,927	4,064	4,292	4,743	5,769	5,658	5,938	6,477	7,696
% increase on 2023		**3**	**9**	**21**		**6**	**17**	**42**		**5**	**14**	**36**

Public Health Advice

To address long term conditions, we need to focus our efforts on:

- Reducing smoking and obesity by 2028 as they are primary risk factors associated with heart and lung diseases, cancers and diabetes.
- Identifying markers of early disease through improving identification of hypertension, high cholesterol and HbA1c blood levels, and identifying cancers early through the NHS screening programmes.
- Identify and tackle the health inequalities that exist within these risk factors.

What Are the Main Contributors to Mortality Rates?

However, although as explained earlier, focusing action on mortality rates will not impact as much on healthy life expectancy, as self-reported ill health, it is still important to recognise that deaths from cancer and cardiovascular disease make the largest contribution to years of life lost and therefore have the biggest impact on life expectancy; and tobacco is the risk factor making the largest contribution to years of life lost for both sexes followed by high body mass index (BMI), high cholesterol and high blood pressure. A recent analysis has shown that residents are around three times more likely to suffer an avoidable death than people living in the 10 least deprived areas of England[39].

Infant mortality is another key avoidable outcome impacting on healthy life expectancy, driven by perinatal maternal health and support received. Overall approaches to addressing health inequalities will impact on the health of women giving birth; as part of an overall approach to giving children the best start in life as highlighted in Chapter 5.

What Are the Health Inequalities Related to Healthy Life Expectancy?

Not only do we need to improve overall healthy life expectancy for females and males we also need to address the differences in healthy life expectancy experienced by our residents.

Last year's Annual Report highlighted the extent of health inequalities our residents and communities suffer.

The healthy life expectancy experienced by our residents is 58.1/60.1 years (males / females) compared to 63.8/65.0 and 63.1/63.9 years for London and England respectively, which means they will develop a life-limiting condition impacting their ability to undertake normal activities (e.g. work, see friends and family, etc.) five years earlier than their counterparts in other areas of London and England.

And healthy life expectancy is also not felt the same within the borough, with inequalities within communities that vary by outcome and risk factor. There is currently a 6.4 year difference in healthy life expectancy between the least and most deprived males and a 5.8 year difference between the least and most deprived females within the borough,[40] and residents of Black ethnicities develop a long term health condition over five years earlier than their White neighbours (Table 3), while life expectancy and deaths from certain diseases (e.g. morbidity in cancer, dementia and Alzheimer's) are highest in White residents.

Table 3: Age of the first health condition by ethnicity[41]

Ethnicity	1st condition (age)	2nd condition (age)	3rd condition (age)
BAME	54.1	60.3	63.6
Asian / Asian British	52.6	57.5	60.7
Black/African/ Caribbean/Black British	49.8	55.0	57.8
Mixed/Multiple ethnic groups	55.4	62.2	65.6
White	55.4	62.1	66.2

Ethnicity of residents with 1 known long term condition

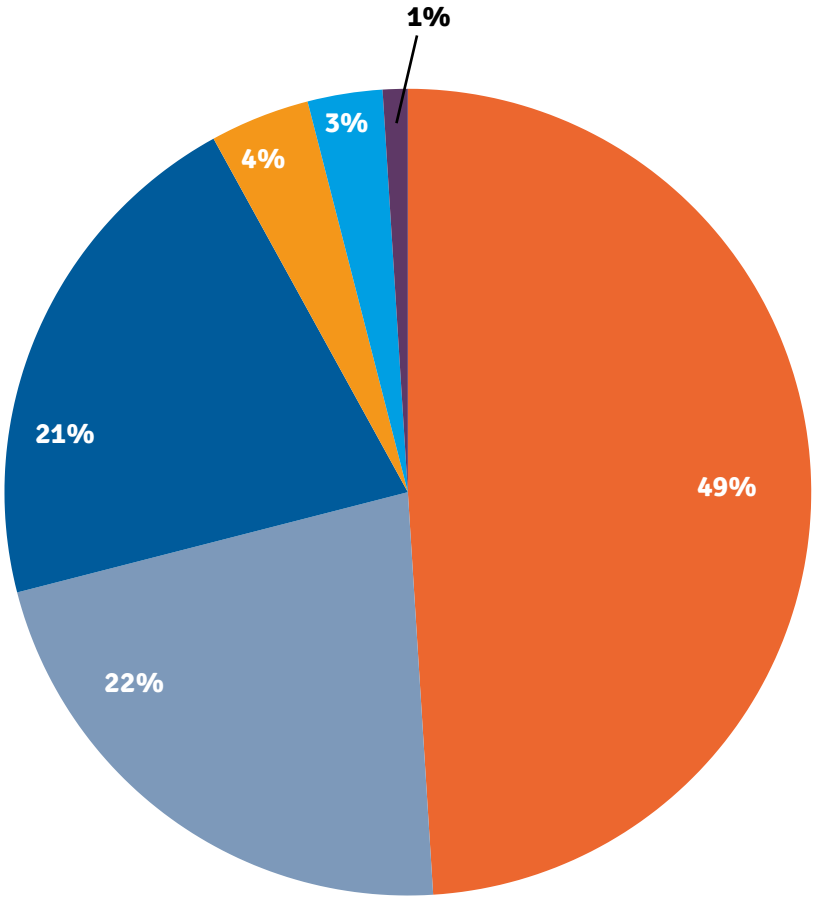


Figure 12: The percentage of residents with 1 known long term condition, by major ethnic group

Ethnicity of residents with 4 known long term conditions

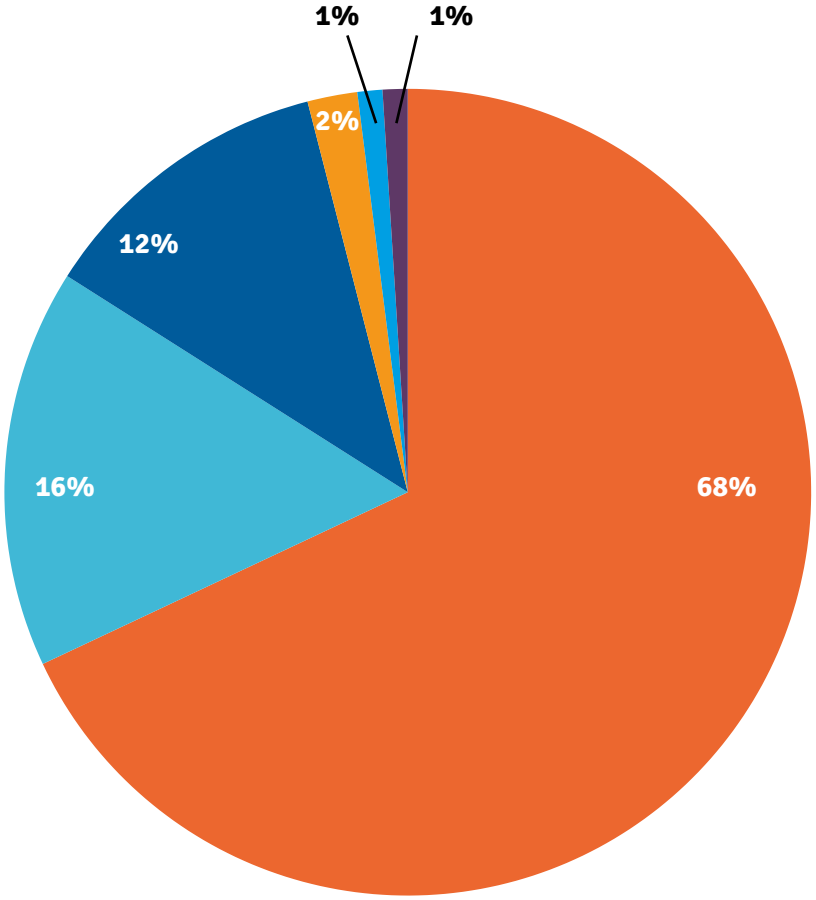


Figure 13: The percentage of residents with 4 known long term conditions, by major ethnic group

White
Asian or Asian British
Black or Black British
Other Ethnic Group
Mixed
Not Known

These inequalities are made worse by the cost-of-living crisis, reflecting the importance of addressing wider determinants of health alongside health behaviour and access to health services.

The key health risks associated with this are:

- Estimates suggest that some 10% of excess winter deaths are directly attributable to fuel poverty and 21.5% of excess winter deaths are attributable to the coldest 25% of homes.[42] Of note in 2021 15.3% of the population were in fuel poverty, worse than the London and England averages of 11.9% and 13.1% respectively. The number of deaths in the winter period was 78.9% higher when compared to non-winter period in 2020-2021; the third highest in the country.
- An increase of 1% in the percentage of households living in relative poverty is associated with a 6-month decrease in male healthy life expectancy[43].
- National analysis indicates prevalence of moderate to severe depressive symptoms was higher among adults who were economically inactive because of long-term sickness (59%), unpaid carers for 35 or more hours a week (37%), disabled adults (35%), adults in the most deprived areas of England (25%), young adults aged 16 to 29 years (28%) and women (19%). [44]
- Rates of mental health problems increased nationally during the pandemic and have still not recovered to pre-pandemic rates[45]. Estimated local prevalence of mental health problems in those age 16+ prior to the pandemic 2017 was 22.4%, higher than the England average (16.9%) and this is likely to have been exacerbated by recent events.
- Rates of economic inactivity and unemployment from 2021/22 in Barking and Dagenham were higher than London and England average locally, with 67.6% in employment compared to 75.2% and 75.4% respectively.[46] As a report from ONS[47] identified; the number of people economically inactive because of long term sickness has risen to over 2.5 million people, an increase of over 400,000 since the start of COVID-19. And for those economically inactive because of long term sickness, nearly two-fifths (38%) reported having five or more health conditions (up from 34% in 2019), suggesting that many have interlinked and complex health issues.

Last year's report also referred to the risk to health and health inequalities of the 'Cost of Living Crisis', with our residents who are amongst the most vulnerable due to underlying issues (e.g., food insecurity, fuel poverty, child poverty, economic inactivity, etc.). As stated, it takes time for impacts to be seen in outcomes and data, but we can see the impact through increasing need for services.

All services and support provided by the council, NHS and community report increasing need and demand for services. For example, data from Citizens Advice highlight issues for residents include:

- **High energy costs** – By end March 2023, energy debt was the most common type of debt that the local Citizens Advice helped residents with, whereas it used to be rent or council tax arrears.
- **Need for crisis support** – Residents requiring crisis support (e.g. food banks) doubled in Q4 2022/23 compared to the previous year (13.54 people per 10,000 compared to 6.17 in Q4 of 2021/22)
- **Disproportionate impact on vulnerable people** – More than 60% of the people Citizens Advice have helped with crisis support nationally have been disabled or had a long term health condition.

Our Resident's Survey has also recorded the lived experience of residents suffering, e.g. the July-August 2023 Survey highlighted:

- **Inability to cope** – Almost 1 in 3 (31.2%) of residents reported that their living costs had increased and they were no longer able to cope; twice the proportion of the previous year's Survey.
- **Debt** –Just under 2 in 3 residents (59%) had to borrow from families and friends to pay bills, whilst many residents have also had to borrow from legal and illegal money lenders.
- **Inability to live healthily** – Over 1 in 2 residents (52%; versus 15.6% nationally) have smaller or skip meals due to cost and over 1 in 5 (21%; versus 10.9%) have been hungry but not eaten as could not afford or access food.

Public Health Advice

To increase the number of years residents spend in good health, we should focus our collective resources into:

- Enhancing our early diagnosis programmes, that target key cohorts of residents, supported by assessable and culturally appropriate chronic disease management programmes.
- Reducing the high levels of smoking and obesity.
- Reducing mortality rates associated with cardiovascular disease and cancer.
- Addressing the variation in health and social care outcomes experienced within and between our communities in each of these areas.

Chapter 4:
Action To Increase Healthy Life Expectancy and Address Health Inequalities

To improve healthy life expectancy, we need to create foundations for self-reported good health and tackle the more direct causes of mortality; with a focus on the local challenges.

This chapter sets how and what we need to do to address the key contributing factors to healthy life expectancy, identified in chapter 3:

- Long term conditions
- Key behavioural risk factors
- Wider determinants of health – developing the building block for good health

How to Address the Problem of Long-Term Conditions

The figures on long term conditions in the previous chapter are worrying and show England & Wales have amongst the worst population health in Europe, particularly so in Barking and Dagenham. However, we can do something about it.

The Government has published the case for change and strategic framework for the National Major Condition Strategy. It focuses on prevention, earlier diagnoses and treatment for six groups of major health conditions responsible for 60% of death and illness in England: cancers; cardiovascular disease, musculoskeletal disorders, mental ill health, dementia and chronic respiratory disease. It also identifies five areas for action to have the greatest impact over the next five years (Figure 14), which need to shape our Place based Partnership response.

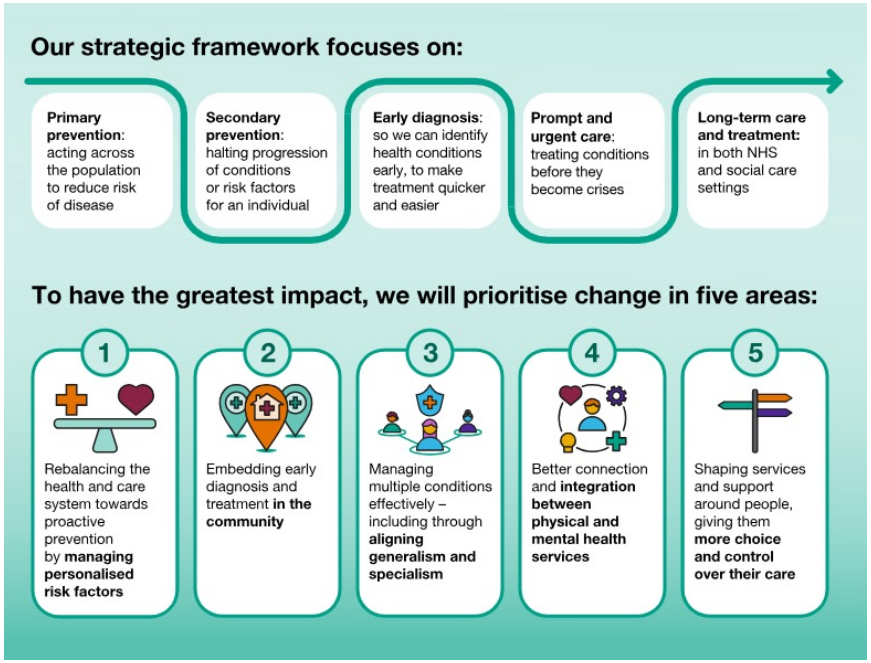


Figure 14: National Major Conditions Strategy strategic framework

The National Institute for Health and Care Research has also published an evidence review on multi-morbidity which found:

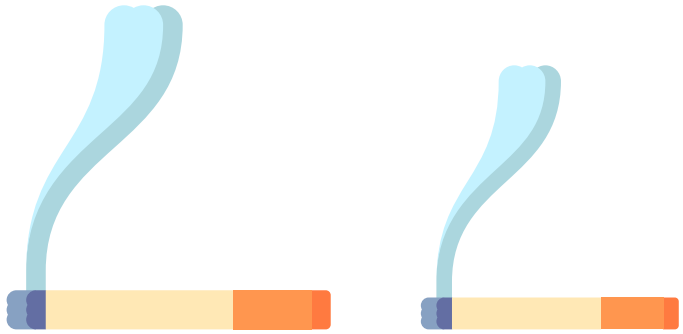
- Complexity and difficulty in accessing and navigating services, with a strong desire for greater service integration and coordination.
- Tendency for services to focus on symptoms and conditions and fail to see the things that matter to people. There is a need for more person-centred, holistic care.
- People felt that their mental health needs and emotional wellbeing were frequently ignored, which often resulted in a worsening of symptoms. Mental health services should be offered at the outset.

Addressing Long Term Conditions in Barking and Dagenham

The key contributor to our poor female and male healthy life expectancy is the prevalence of long-term conditions within our borough. This is recognised and prioritised by the Barking and Dagenham Local Joint Health and Wellbeing Strategy 2023-28.

At north east London level, addressing long term conditions (LTCs) is central to NHS North East London's (NHS NELs) Health and Care Partnership approach. LTCs are one of the four priorities in NHS NELs interim Integrated Care Strategy, which also includes Tackling health inequalities, Prevention, Personalised Care and Co-production with local people as cross-cutting themes. NHS NELs Joint Forward Plan places LTCs as a strategic priority and calls for greater focus on prevention and addressing unmet need (specifically on child obesity, mental health, tobacco and premature cardiovascular disease deaths).

To address the early identification of risk factors and early diagnosis of cardiovascular related conditions is the NHS Health Check. Our offer of an NHS Health Check is provided through General Practice and engagement activities at borough events. A nine-month pilot for the eligible 30–39-year-olds was carried out in 2022/23 by Together First, with positive health outcomes. Plans to reinstate the programme in our community pharmacies is currently in place, as a pilot.



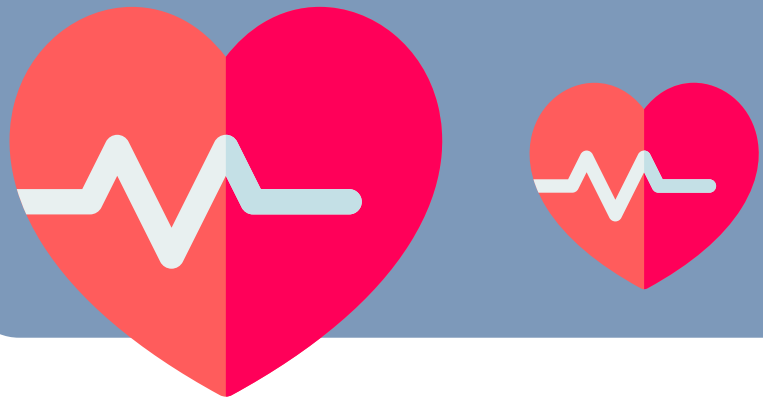
However more needs to be done to find many more residents who we estimate are likely to have one or more long term condition but have not yet been diagnosed (see our analysis in the 'Inequalities in Long Term Conditions' section). We need to agree a single, multi-agency active case finding plan to identify these residents and enhance our efforts and programmes for LTC early diagnosis, by:

- Continuing to work with primary care to support our general practices to improve early diagnosis of key LTCs.
- Agreeing prioritisation of long-term conditions where data and evidence increase scale and pace of action to deliver the greatest health benefits (e.g. hypertension).
- Encouraging our general practices to identify patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, (as recommended by NICE, 2016).
- Delivering Phase 2 pilot of 30–39-Year-Old targeted NHS Health Check service, offering more opportunities on reducing differences between people and communities from different backgrounds.
- Continuing to provide health checks through engagement activities at borough events and outreach.

Case Study: Targeted Case Finding by Together First

Taking the Public Health team's estimate of the number of residents in the borough with undiagnosed long-term conditions as a starting point, the GP Federation Together First CIC set up a case finding project to find and treat residents across five disease areas. General Practice went through Clinical Effectiveness Group searches to identify patients who were not on disease registers but appeared to have symptoms of one or more of the following conditions: coronary heart disease, chronic kidney disease, hypertension, chronic obstructive pulmonary disease and asthma.

Patients were then invited in for a check-up and tests undertaken to confirm diagnosis. The pilot of this case finding work over spring 2023 uncovered 718 diagnoses of hypertension and 215 new cases of chronic kidney disease. Evaluation was undertaken by Together First and recommends exploring a mobile unit and having blood pressure monitoring in community venues, along with working with partners to identify other approaches to attract residents for checks.

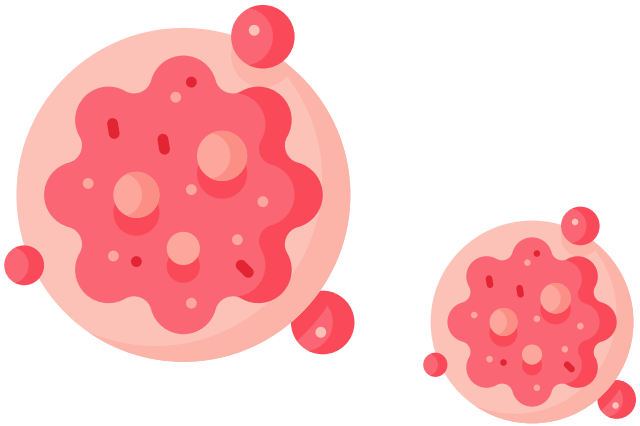


Identifying Cancer Early

Cancer although not classified as a long-term condition does have significant impact on mortality rates in Barking and Dagenham, and therefore identifying cancer early to improve treatment outcomes is important.

The North East London Cancer Alliance works to improve and transform cancer patient pathways from prevention through to treatment and survival. The ambitions of the NHS Long Term Plan are to diagnose 75% of cancers at stage 1 or 2 and increase the number of people surviving cancer for more than a year by 55,000 by 2028.

Cancer Screening is the process of identifying healthy people who may have an increased chance of a disease or condition, to reduce associated problems or complications (UK National Screening Committee, 2023). Improving uptake is a regional priority for NHS England - London.



Cancer Screening Programmes performance in Barking and Dagenham:

Our bowel cervical and breast cancer, screening uptake rates are all significantly worse than England averages.[48]

Bowel cancer screening: the current uptake in Barking and Dagenham is lower than the expected uptake in London of >60%.

Breast cancer screening: The uptake in the outer north east London boroughs increased significantly from 48.5% in Q1 22/23 to 68.5% in Q2 22/23 (highest in London), because the service started sending second timed appointments for all women that did not attend their appointment.

Cervical cancer screening: There has been no increase in coverage.

We are working with NHS North East London to improve the uptake of screening and improvement in coverage across the borough, aligned to public information so our residents know what they can do to reduce the risk of developing cancer.

We need to do the following to improve uptake:

1. Cervical Screening

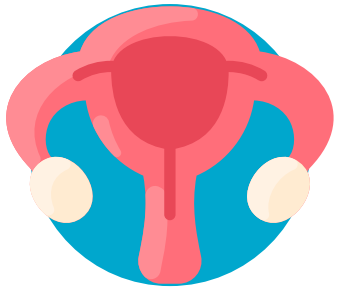
- Work with general practices to support and promote the universal MSM human papillomavirus (HPV) vaccination programme for eligible adolescents and gay, bisexual, and other men who have sex with men (GBMSM) aged under 25 years.
- Support Vaccination UK to deliver the HPV vaccines to Year 8 students in January 2024 in all schools in the borough.
- Work with comms/engagement channels to support and promote the HPV vaccination programme.
- Support practices to promote the HPV screening tests in areas with low uptake.

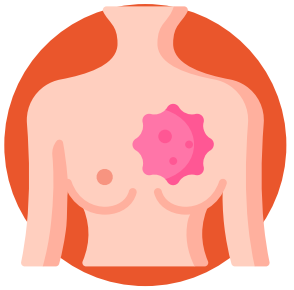
2. Breast Screening

- Support NHS InHealth and partners to promote the mobile Breast Screening Units every 3 years in Barking and Dagenham.
- Support NHS InHealth's ongoing engagement activities and promotional work at borough events/outreaches and strengthen Breast Cancer Nurse Specialist's links in with Primary Care Networks.
- Build a strong partnership between public health, general practices and community organisations to raise awareness of breast screening.
- Support the current project to improve uptake for women with severe mental illness funded by NEL Cancer Network.
- Help practices promote breast screening at the InHealth Group fixed clinic for residents in areas with low uptake.

3. Bowel screening

- Have health promotional materials and information available in languages most suitable for the borough.
- Work with the Bowel Cancer Borough Lead, to continue to investigate barriers faced by men that prevent them from participating in screening and use this information to develop solutions.
- Support the annual NHS Bowel Cancer Screening Campaign in London in delivering the community outreach, to increase awareness of the home testing kit and increase uptake across ethnic minority groups.
- Support practices to increase uptake across all ages and target key areas of low uptake.





How To Address the Behavioural Risk Factors of Low Healthy Life Expectancy

As I have regularly highlighted, a long-term system wide place-based approach is required to achieve population level health outcomes. Action is required across three types of interventions (i.e. the Population Intervention Triangle): Civic-level interventions (e.g. licensing, economic development); Community-based interventions (e.g. using and building assets within communities); and Services-based interventions (e.g. quality and scale, reducing variation).

Service based interventions to support the reduction of weight, smoking cessation and to promote physical activity have the potential to generate population-level change but this is often not achieved for several reasons, mostly:

- Differences in service quality and delivery (effectiveness; efficiency and accessibility).
- Variability in the way the population uses those services (based on knowledge, skills and health-seeking behaviours and resources) - and therefore variable needs for support to use those services appropriately.

Therefore, high-quality services can reduce unwarranted variation in outcomes, but they will not reduce inequalities at a population level unless they also identify and (with partners) give **graduated and targeted support to the populations in greatest need**, who are not using those services to best effect. The level of health inequalities experienced in Barking and Dagenham means that alongside providing high quality services, direct action is needed to address the needs of underserved populations.

We recently reviewed our weight management, smoking cessation and exercise on referral services against these principles and the main findings were:

- The need to develop strong place-based leadership.
- A need for a system wide approach to the issue, for example tackling smoking cannot ignore the legislative requirements of enforcement and addressing obesity must tackle the obesogenic environment we live in.
- More robust outcome commissioning and contract monitoring.
- Better targeted services to meet underserved populations and
- A stronger focus on delivering evidence-based practice.

The review also looked at **social prescribing** as a key part of Universal Personalised Care through which local agencies can refer people to a link worker for holistic support to address their health and wellbeing needs. Our findings identified that we need to take a more strategic look at how the service could play an important part in promoting healthy behaviours and providing support to personalisation and anticipatory care in social care, to help manage demands. An internal council review of evidence-based opportunities to improve anticipatory care suggested a range of actions across the themes of maximising resourcing and efficacy; and realising a focus on social care within Place and integrated care.

As muscular skeletal conditions are one of our key causes to loss of years due to disability, we need to consider the anticipatory care offer to reduce frailty, falls and loss of independence to manage demand on our services.

What is anticipatory care and personalisation aiming to achieve?

Anticipatory Care aims for patients who are at high risk of unwarranted health outcomes to live well and independently for longer, through structured proactive care.

Personalisation aims for every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.

Since the review on our services, we have received the following direction on smoking cessation.

Stopping the start: a new plan to create a smokefree generation

In October 2023, the Government set out a new ambition to create a smokefree generation in the 'command' paper, to raise the age of access to tobacco one year every year, to prevent smoking before it starts.

The command paper sets out policy proposals for additional funding: to local Specialist Smoking Services to support smokers to quit, for awareness raising campaigns, for a national Swap to Vapes Scheme to stop smoking, and financial incentives for pregnant smokers to quit. Enforcement: there will be additional funding proposed for Trading Standards, Border Force, HMRC; on spot fines to be introduced and online age verification.

This will provide an additional 58k ring-fenced funding for Stop Smoking Services (28% increase) from 2024/25 to 2018-29 and an opportunity to participate in a 'Swap to Stop' pilot (which we have submitted an expression of interest for).

How To Create Building Blocks to Improve Healthy Life Expectancy

Creating Healthy Places

For us to be healthy, the building blocks of good health need to be in place in our communities – things like decent homes, good school and sound business practices. When these building blocks of health are weak or missing, our health can suffer: for example, when businesses promote unhealthy products like alcohol and junk food.

We need to balance our supporting to individuals to change their behaviour with creating healthy places for everyone[69]

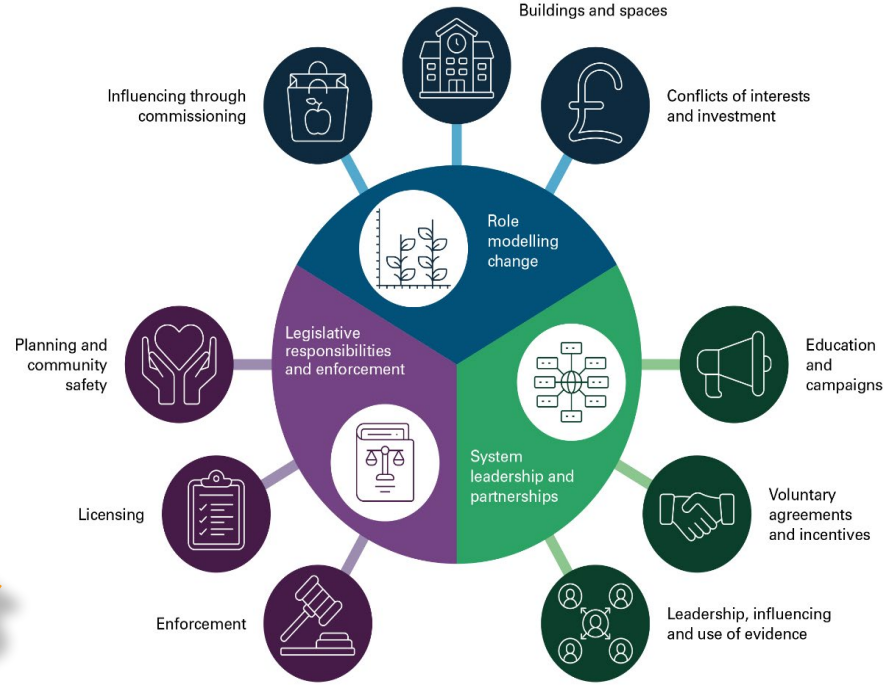


Figure 15: Tackling tobacco, alcohol and unhealthy food: A framework for local authorities[49]

The council is in a unique position to create healthy places, using opportunities combining statutory responsibilities, broad priorities, and local relationships – including with communities, businesses and with our place-based partnership. Due to the complexity of public health challenges, there is also a need for involvement and collaboration between council directorates and teams by taking a health in all polices approach. This means embedding a health lens across council services and decision making.

In London, 68% of residents live in areas (measured at levels called lower super output areas which translate to approximately 1000-3000 residents) which are in the worst performing 20% of environments in the region for access to health promoting and health demoting factors[50];

including: access to retail services (fast food outlets, gambling outlets, pubs/bars/nightclubs, off licences, tobacconists), access to health services (GP surgeries, Emergency Department hospitals, pharmacies, dentists and leisure centres), the physical environment (access to green spaces, and three air pollutants: nitrogen dioxide (NO2) , airborne particulate matter (PM10), sulphur dioxide (SO2) levels). This means that people's homes are clustered in the unhealthiest environments. We plan to map this in the 2024 JSNA.

There are clear opportunities to use development and council management to create healthier environments. For some determinants there are clear links to improvements in healthy life expectancy that may be achieved in the next 5 years; and opportunities to build on existing strengths.

Example: Housing and Health

A recent study identified that challenging housing circumstances negatively affect health through faster biological ageing. However, biological ageing is reversible, highlighting the significant potential for housing policy changes to improve health[51]. We have also highlighted the links between fuel poverty and healthy life expectancy (ref). More immediate effects can be seen through damp and mould worsening respiratory disease (ref) and overcrowding enabling easier spread of infectious disease.

Local authorities have levers through planning, licensing and enforcement to regulate housing quality and there are emerging areas where we can focus and develop work to mitigate against the health risks associated with poor housing:

- Work is currently underway to ensure damp and mould issues are resolved quickly and to support education for landlords alongside enforcement in the housing sector.
- The Healthy New Towns principles have been embedded into Barking Riverside regeneration plans.
- A homelessness Health Needs Assessment is underway to understand how best to support this vulnerable population in partnership with health pop up clinics with our NHS partners.

Other key opportunities include:

- Targeted work to help residents with long term conditions and disabilities gain and stay in employment, building on our existing local pilots.
- Work to support residents most vulnerable to the cost-of-living crisis.
- Using our connections with communities to establish connection, trust and belonging; aligned with the work of the BD Collective. For example, we are currently funding a health and faith initiative, co-producing health promotion projects with faith communities.
- Creating healthy streets that encourage walking and cycling, and safe streets around school zones.
- Reducing and mitigating the impacts of air pollution through a combination approach of transport, planning, industrial and behavioural interventions.[52]
- Supporting local health partners to develop as anchor institutions.[53]

Mental Health and Wellbeing

Good mental health is a key prerequisite across all factors impacting on healthy life expectancy, as well as people who have poor mental health are more likely to have higher health risk behaviour and suffer a long term condition, often due to the same pathways that influence both [54]

Our mental health incorporates mental illness, psychological distress and mental wellbeing (the positive aspects of mental health).

There are considerable inequalities in life expectancy for those with serious mental illness. Barking and Dagenham residents with severe mental illness are over three times as likely to die prematurely than those without.[55]

However, the burden of psychological distress and common mental disorders (anxiety and depression) will cause a greater impact on healthy life expectancy overall. Additionally, as recognised by the Major Conditions strategy, mental and physical illness are inextricably interlinked[56]: Residents with physical health problems, especially long-term conditions, are at increased risk of poor mental health, particularly depression and anxiety. Around 30% of residents with any long-term physical health condition also have a mental health problem. Poor mental health, in turn, exacerbates some long-term conditions, such as chronic pain, as well as being linked to unhealthy behaviours such as disordered eating, alcohol consumption and smoking.

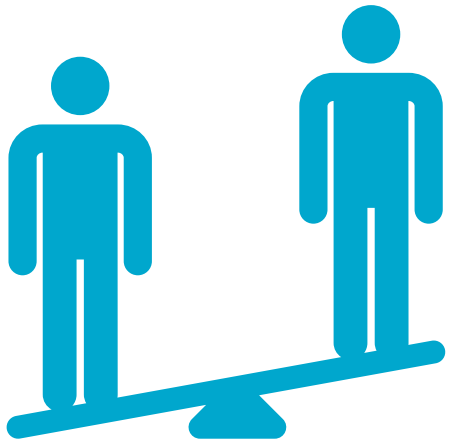
The determinants of mental health are in many ways the same as for physical health, but a greater importance is placed on the relationships around us in families and communities; our position in society and exposure to stressors such as abuse, discrimination, or financial hardship: many of our residents will be vulnerable to these stressors.

Prevention needs to start young: Half of all mental health problems have been established by the age of 14, rising to 75% by age 24.[57]

Addressing mental health therefore, needs to feature across work on long term conditions, inequalities and the best start in life, as well as building healthy places.

Addressing Health inequalities

The flipside of great need is the exciting potential to make improvements, and our health inequalities programme is making steps to develop an evidence-based 'whole place' approach. Yet there are few 'quick fixes' in health inequalities, so there is the need to coproduce, identify and invest in 'what works' to make tangible improvements in the medium and long terms. But targeting our action to address inequalities in cardiovascular disease, respiratory disease and diabetes, smoking and obesity will provide short term gains.



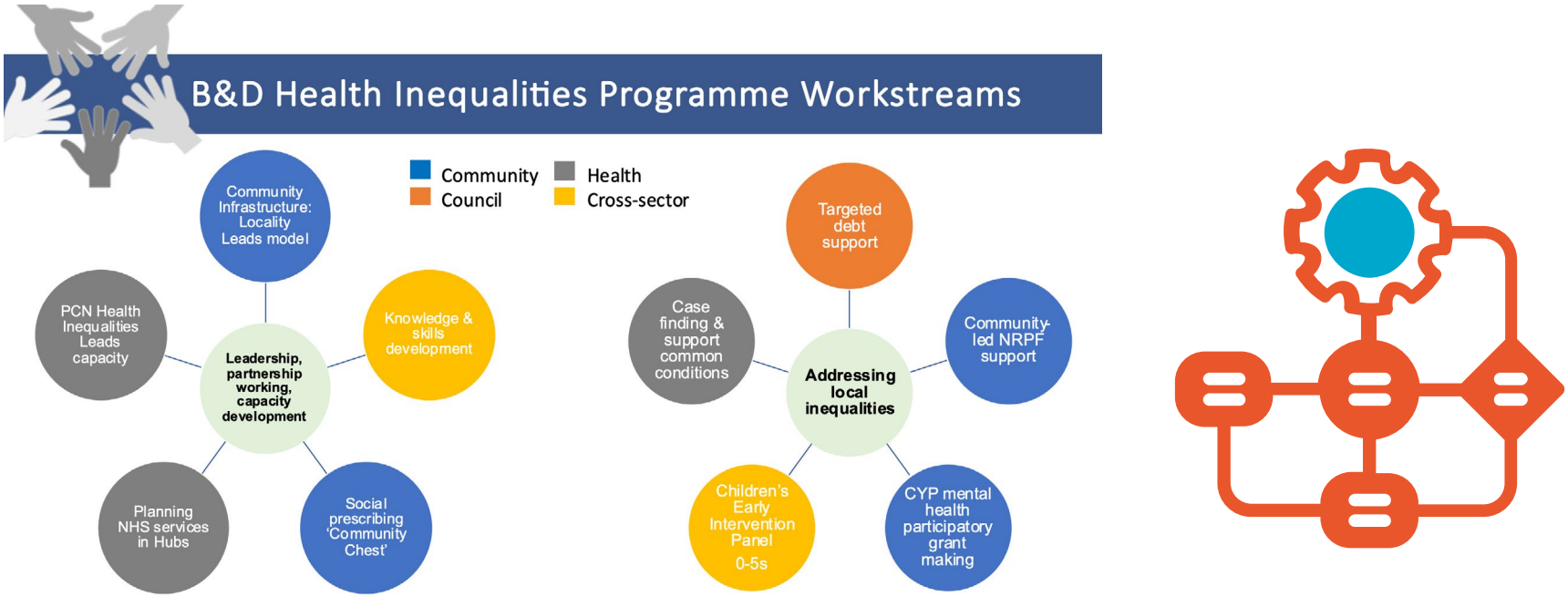


Figure 16: Summary of the Health Inequalities Programme 2022-23

The programme is in its first year of delivery several agreed milestones have been achieved:

Improved place working & action on health inequalities:

- Establishment of Community Locality Leads and Primary Care Network Health Inequalities Leads providing strategic and practical leadership for and between community and primary care sectors.
- 80% of professionals involved in the Place-based Children's Early Intervention Panel reported good, very good or excellent shared understanding of workforce behaviours across the partnership that lead to positive outcomes.
- 95% of Adult Social Care staff who attended Trauma Informed Practice training and completed the post course evaluation felt confident or very confident to apply the practice.
- 97% of frontline workers in statutory and voluntary sector working with residents with No Recourse to Public Funds (NRPF) said the local NRPF guidance significantly enhanced their awareness of local services and 96% agreed it significantly improved understanding of the needs of residents with NRPF.

Services-led health improvement & inequalities reduction:

- 933 residents have been identified and assessed for undiagnosed / unmanaged health conditions.
- 213 residents with unidentified low level mental health issues were proactively contacted and a total of 80 holistic support interventions were delivered.
- All professionals who presented a family of concern to the Children Young People Early Intervention Panel for 0-5s said it left them more confident in the next steps with a family and many said they got families on their caseload access to appropriate services in a time effective way.

Community-led health improvement & reduction:

- Community mental health interventions by local community groups achieved improvements of their mental wellbeing (a one-point increase in their score on the Short Warwick-Edinburgh Mental Wellbeing Scale).
- 15 community organisations received funding through the Community Chest for Social Prescribing, 10 of which were global majority led and nine of which had never received external funding before.

Case Study: Understanding the Needs of Residents with Special Educational Needs and Disabilities

One approach to addressing inequalities across a population is to focus on those with the worst outcomes, not just to act equitably but by improving support for the most underserved you can improve access to support for all.

For example, people with learning disabilities die 22-26 years younger than the general population, with 49% of deaths rated as 'avoidable' (over twice the 22% in the general population)[58]. Significant inequalities can also be seen within the population of people with learning disabilities, with an average of death of 34 years for people with learning disabilities of non-White ethnicities compared to 62 for their White counterparts[59].

Consequently, the Barking and Dagenham Public Health Team recently led a cross-sector educational and health needs assessment for residents with Special Educational Needs and Disabilities (SEND), which will include those with learning disabilities.

Currently, proportions of pupils in Barking and Dagenham accessing SEND support (12%) are like London but lower than England averages; but proportions of pupils with Education Health and Care (EHC) Plans are lower than London averages. Over the past 5 years (2018-2023) proportions of pupils with SEND support or EHC Plans have been increasing locally, regionally and nationally.

Assuming trends to date are maintained; the following projections can be made:

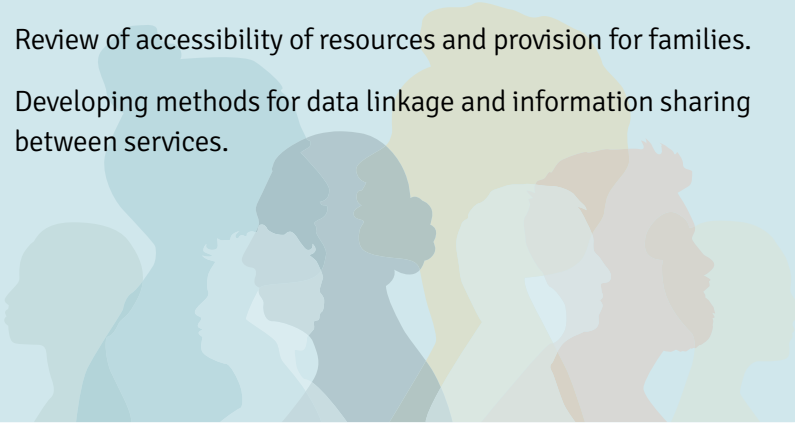
- The total number of pupils in primary, secondary and special schools combined on an EHC Plan is projected to rise threefold between 2018 and 2035 – this is faster than the rate of increase in the school population based on GLA projections.
- The total number of pupils on Special Education Need support is predicted to rise by 27% between 2018 and 2035, which is more aligned with increases in school population sizes.

There are several risk factors in the borough that could drive increases in SEND needs, including increasing ethnic variation and deprivation.

The existing challenges to delivering support that families need: shortages linked with difficult recruitment and retention of specialist staff; delays in obtaining EHC Plans and in effective multidisciplinary communication; and lack of clarity on the local offer.

The current and new challenges will require both additional provision and new ways of working to address this, including:

- Improving the accessibility of the local offer for families.
- Improving EHC Plan processes.
- Development of integrated care pathways.
- Early intervention to prevent escalation of problems; in particular for Speech, Language and Communication needs.
- Work to enhance recruitment and retention of specialist staff; and upskill wider health and education staff to support families.
- Review of accessibility of resources and provision for families.
- Developing methods for data linkage and information sharing between services.



Public Health Advice

To improve healthy life expectancy the evidence suggests the following action:

- Take a place-based approach to address early identification and early treatment for people with long term conditions:

  - to ensure all residents with a health condition are identified and are supported to manage their condition.

  - that addresses social, economic, and physical environment that causes our residents to make decisions that damage their health and lead to long term conditions, such as those driving obesity through unhealthy diets and lack of physical activity.

- Provide a targeted support programme to residents to address obesity and smoking.
- Address wider determinants of health for example to insulate and remove damp and mould in homes; support people with long term conditions or disabilities, including young people with special educational needs and disabilities to gain and stay in employment, and mitigate the health harms of the cost of living crisis.
- Improve mental health and wellbeing as an underpinning factor.

To address underpinning health inequalities, we need to:

- Develop a shared understanding of health inequalities, its drivers and local priorities (including across our population groups and geographic areas) to direct decision making and action.
- To align the NHS's mandated duty to address health inequalities with the overall place-based programme.
- Work with NHS North East London on their Healthy Equity Academy and their evolving Health Equity Fellowship (including extending beyond the NHS to create analogous community sector fellowships).
- Continue and expand cross-sector action on the ongoing health legacy of COVID-19 and impacts of the cost of living crisis that are increasing health inequalities for residents.
- Ensure a 'health in all policies approach' in which all systems partners are engaged to understand and address the role of health inequalities in driving community priorities (e.g., employment).

Chapter 5:
Best Start in Life - The Building Blocks for a Healthy Life

KEY FACTS

Approximately 57,150 children are under 16 in the borough (the highest proportion in England and Wales) and we have the highest proportion of children aged 0-5 in the UK (8.8%).

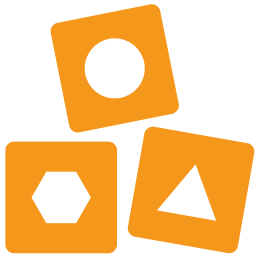
In 2021/22, only 6 in every 10 of Barking and Dagenham's children achieved a Good Level of Development (GLD) by the end of Reception year (for those children on free school meals, it was only 5 in 10).

Children who score badly on school readiness at the age of 5 are far less likely to succeed in secondary school – and far more likely to experience poor health and low pay as adults (Save the Children, 2018).

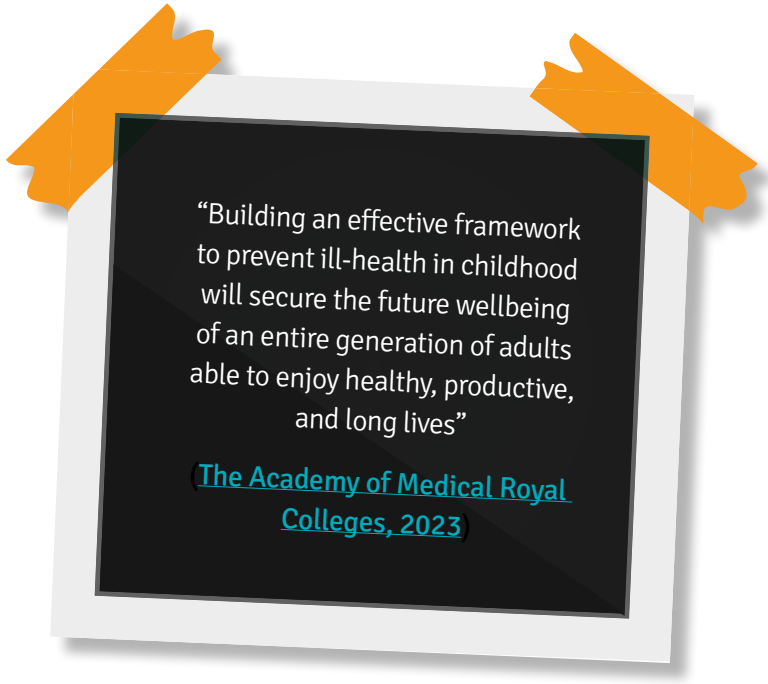
In 2022/23 just under half of our Year 6 children were overweight or obese (the 3rd highest rate in England and the highest in London).

Individuals who have adverse childhood experiences (ACEs) during childhood or adolescence tend to have more physical and mental health problems as adults and more likely to have an earlier death (Hughes et al., 2017).

The National Child Mortality Database (NCMD) recently reported the death rate in England for white infants has stayed steady at about three per 1,000 live births since 2020, but for Black and Black British babies it has risen from just under six to almost nine per 1,000. Death rates also doubled in more deprived areas compared to non-deprived, and the mortality for Asian and Asian British babies rose by.



A large part of this report has been focusing on actions which relate to adults and actions that can affect short term change, but action across the life course is important - today's children will be tomorrow's adults, and the things that happen to them in childhood can shape the trajectory of their health across childhood, into adulthood and throughout adulthood into older age. We need to maintain a focus for children to improve the health outcomes for our general population across the life course. It is significant to note that the JSNA, 2022 shows Barking and Dagenham has a very young population which has increased significantly over the past decade (17.7% total population increase since 2011 census – second highest increase in London).



The council's Corporate Plan, Joint Local Health and Wellbeing Strategy and Best Chance Strategy (for babies, children and young people) all have the best start in life as a key priority, alongside reducing inequalities and giving our children and young people opportunities to achieve.

Risk Factors for Ill Health

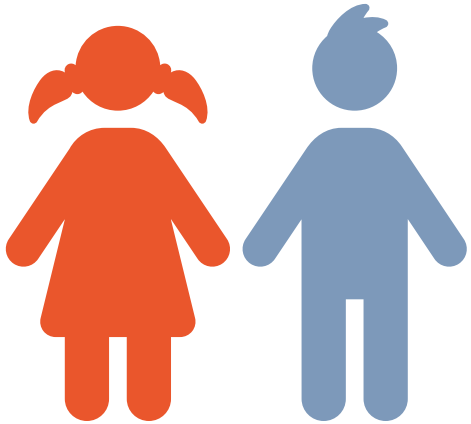
In 2022/23 around 45 in 100 year 6 children were overweight or obese (45.4%) – this was the 3rd highest rate in England and just under a quarter of our Year R children were overweight or obese (24.0%). Both are the highest in London. The evidence suggests that children who are overweight or obese are likely to stay obese into adulthood and to develop long term conditions like diabetes and cardiovascular diseases musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon) (World Health Organisation, 2020).

Investing in Early Years

But how we treat young children also shapes their lives. If we get the early years right, we pave the way for a lifetime of achievement. The first 1001 days from conception to age 2 is widely recognised as a key period in the life course of a developing child, providing a unique opportunity for professional involvement because it is the time when parents are often the most receptive to behaviour change interventions and where the evidence suggests it is most effective.

Figure 17: An example of the return on investment in school readiness

"The highest rate of return in early childhood development comes from investing as early as possible, from birth through age five, in disadvantaged families. Starting at age three or four is too little too late, as it fails to recognize that skills beget skills in a complementary and dynamic way. Efforts should focus on the first years for the greatest efficiency and effectiveness. The best investment is in quality early childhood development from birth to five for disadvantaged children and their families."— James J. Heckman, 2012



Preparing Children for School

Ensuring children can get the best from education is vital; too many of our children are not starting school with the range of skills they need to succeed. Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life. School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally, and it links to educational attainment, which impacts on life chances – having been shown to impact on health, future earnings, involvement in crime, and even death (Public Health England, 2015).

Children who score badly on school readiness at the age of 5 are far less likely to succeed in secondary school – and far more likely to experience poor health and low pay as adults (Save the Children, 2018).

School readiness is a key area for inequality – with more children from deprived backgrounds not being school ready, and a lack of school readiness contributing to further inequalities across the life course. There is a pronounced social gradient in early language development, with more young children from disadvantaged backgrounds having poor language skills (Public Health England, 2015). Nationally, children from the poorest homes are a year behind in their language and literacy skills by the age of 5 (Save the Children, 2018). In 2021/22, only 62.5% of our children achieved a good level of development (GLD) by the end of Reception year.

For children eligible for free school meals, only 51.8% had reached their key development milestones by this time
. Children who have a special educational need or disability (SEND) are also less likely to achieve a GLD by the end of reception year (The British Association for Early Childhood Education, 2022). The gap in language and communication among children in reception classes continue and widen throughout the school years. Over half of the inequality in learning outcomes at age 11 can be traced back to the pre-school years.

Figure 18: A summary of the importance of school readiness

Adverse Childhood Experiences

The experiences we have early in our lives, particularly in our early childhoods, have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings and behaviours.

Barking and Dagenham have some of the highest rates of child poverty in London, high levels of domestic abuse, high demand for social care, and high rates of homelessness amongst families with children – so the exposure of our children to potential adverse childhood experiences (ACEs) is significant. The cost of living crisis in the UK is worsening physical and mental health outcomes for children and young people and worsening health inequalities (Academy of Medical Royal Colleges, 2023).

Individuals who have ACEs during childhood or adolescence tend to have more physical and mental health problems as adults and more likely to have an earlier death (Hughes et al., 2017).

One study suggested that 12% of binge drinking, 14% of poor diet, 23% of smoking, 52% of violence perpetration, 59% of heroin and crack cocaine use and 38% of unintended teenage pregnancy prevalence nationally could be attributed to ACE experience below the age of 18 (The Institute of Health Equity, 2015).

Domestic Abuse

There is increased potential for domestic abuse to escalate or start within a relationship during pregnancy. Early identification and intervention can reduce escalation and impacts on the parent-child relationship. A recent service impact review of the Barking and Dagenham Domestic Abuse service offer highlighted the wide range of services that are available to support people (mainly women) who are victims of domestic abuse, and the recent Commission commended the council on the leadership and wide-ranging support that is offered. However, there needs to be a greater focus on prevention and system wide approach through the new Place-based Partnership. There also needs to be clarity about what the overall outcome and impact measures are, to monitor progress of the work.

> "In short, failure to ensure that children are ready to learn not only robs them of their potential and squanders a vital national asset: it also reinforces inequality and obstructs social mobility".
> Save the Children, 2018

Mental Health

Poor parental mental health can have a large impact on the parent-child relationship and child development. Start for Life is currently funding a perinatal mental health support service for parents with low-moderate mental health distress, delivered by our partner MIND. This service is very popular, and outcomes are looking promising. We suggest that it would be sensible to consider the continuation of this service beyond the Start for Life grant period.

Opportunities to Address Issues Through the 0-19 Healthy Child Programme

Although not providing immediate impact, an area of focus to ensure our children and young people are healthy, is the 0-19 Healthy Child Programme.

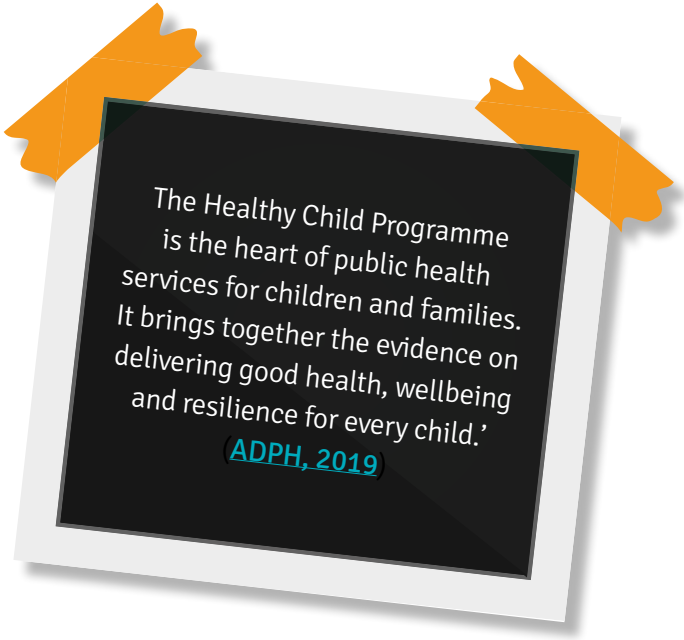
What is the 0-19 Healthy Child Programme?

The 0-19 Healthy Child Programme (HCP) service is a statutory service funded under the council's Public Health Grant, providing public health input for every child in the borough in the form of the Health Visiting (0-5 years), which includes the 5 mandated health assessment visits and School Nursing services and includes the mandated National Child Measurement Programme (NCMP) (5-19 years)[60]. The current provider of the integrated 0-19 Healthy Child Programme service is North East London Foundation Trust (NELFT).

The Department for Health released the latest 0-19 Healthy Child Programme Guidance in June 2023, updating the evidence base and aligning outcomes with the new Family Hubs programme. Barking and Dagenham made a successful bid for Start for Life and Family Hubs funding and has prioritised Family Hubs as the delivery model to achieve many of the outcomes in the Best Chance Strategy.

Key Opportunities

The evidence is clear, that a focus on key 'high impact areas' for 0-5 and 5-19 will maximise the outcomes achieved by this service. They are central to both delivery models, contributing to achievement of the Early Years aims (focusing on preconceptual care and continuity of care, reducing vulnerability and inequalities, improving resilience and promoting health literacy, and ensuring children are ready to learn at 2 and ready for school at 5) and the aims for school aged children and young people (reduce inequalities and risk, ensure readiness for school at 5 and for life from 11 to 24, support autonomy and independence, increase life chances and opportunity).



The 6 early years (0-5 years) high impact areas:

Figure 19: The high impact areas for early years

The 6 school age years (5-19) high impact areas:

Figure 20: The high impact areas for school age years

The 0-5 HCP Service provides a series of mandated visits to all children under 5 in the borough (see Figure 21) and is in a strong position to identify families who may need additional support, and either provide this themselves or connect them with services to prevent ACEs escalating and impacting on that child. They also provide an opportunity to identify signs of neglect and offer the support required.

Our data indicates a need for a stronger **universal offer** to support parents for the first 1001 days to ensure that more of our children are 'school ready' by the time they start school. Redesigning our current service will allow for us to align provision to needs and use the most up to date evidence and recommendations to improve our outcomes.

The 5-19 HCP service can work with the rest of the system, providing public health leadership, to help with prevention, earlier identification, and addressing of ACES, therefore reducing risk and impact of ACES, improving health and saving money. It can also support building resilience, raising awareness of behaviour norms and environments which contribute to ACEs, and developing trauma informed practice within communities and settings.

These **universal reviews** (in Figures 21 and 22) provide opportunity to support personalised or tailored interventions in response to individual or family need, using health visitors' and school nurses' specialist public health skills and clinical judgement to work with the child and family or young person to determine and address needs. They also work collaboratively with partners to deliver evidence-based interventions, protect children and keep them safe (PHE, 2021).

Figure 21: Universal health and wellbeing reviews and suggested contacts as part of overall support 0 to 5 years

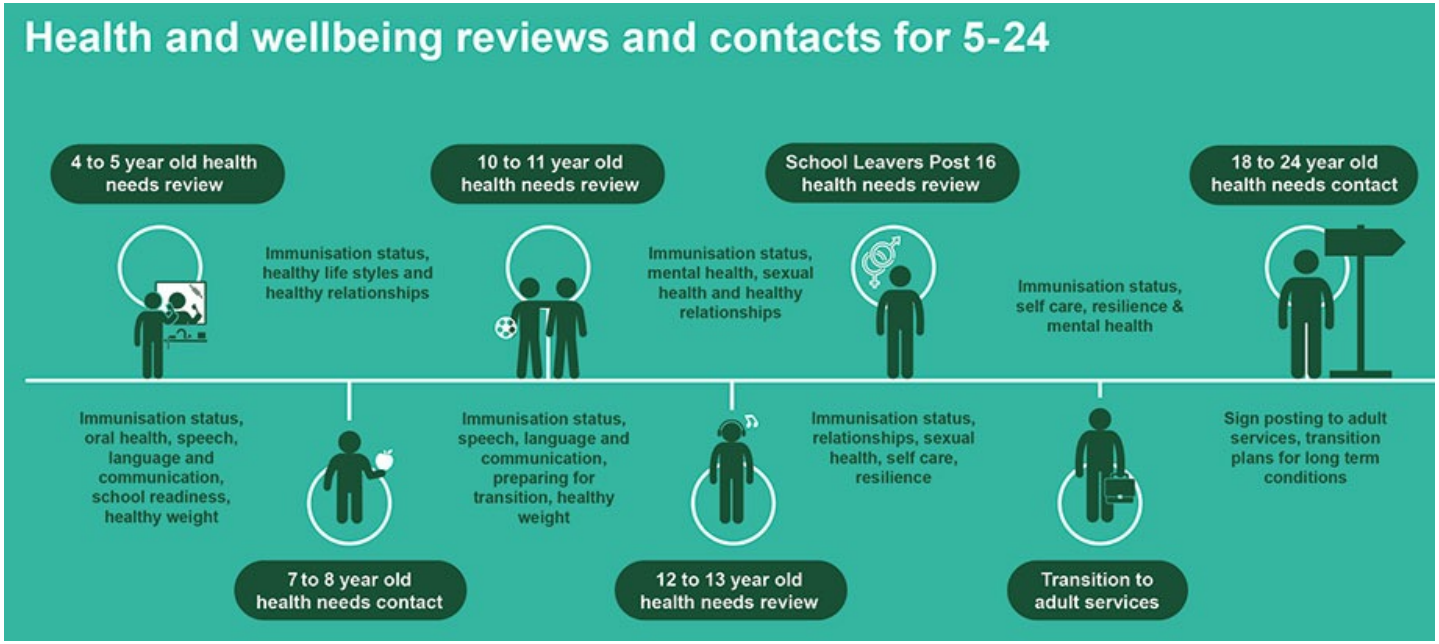


Figure 22: Universal health and wellbeing reviews and contacts as part of overall support 5 to 19, or 24

Prevention of ACEs

A redesigned 0-19 Healthy Child Programme would contribute to the following evidence-based approaches for preventing ACEs:

- Ensuring a strong start for children and paving the way for them to reach their full potential.
- Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges.
- Connecting youth to caring adults and activities.
- Intervening to lessen immediate and long-term harms (Centres for Disease Control and Prevention, 2019).

Mental Well Being of Children and Young People

There remains significant need in the borough (and nationally) around mental wellbeing for children and young people. There is a clear role for School Nurses, as public health leaders, to advise schools and work with the wider system to support maximising the mental wellbeing of our children and young people. We suggest that the system needs to have increased focus on providing a better offer for those with social, emotional, and mental health needs, including timely access to CAMHS.

Our plans for the 0-19 Healthy Child Programme Service

Our 0-19 service is currently under review as it faces significant pressures of demand and the contract coming to an end provides a great opportunity to review the service, our needs and priorities, the evidence-base, the guidance, and the opportunities for change.

The following key challenges are impacting on our 0-19 HCP provision and will need considering in devising the new service contract:

- Increased population and **increased numbers of children under 19**.
- **Increased complexity of need** - including increase in special educational needs and disability (SEND), high domestic abuse, increases in safeguarding input required.
- **Lack of universal support for parents** - Children's Centres previously had a role in providing universal support but these are no longer funded across the borough, leaving a gap in this provision which is needed by many of our families.
- **Short term funding packages ending** - The Start for Life and Family Hubs programme (including the Early Help consortia) is currently providing universal support within the borough in parenting, infant feeding, perinatal mental health, 'home start', and home learning environment but this ends March 2025.
- **Workforce challenges** – national shortages and competition for staff with inner north east London boroughs makes recruitment challenging – a well skill-mixed 0-19 workforce would reduce these challenges by using staff to their maximum potential.
- **A siloed system** – There is a lot of silo working between services and families are struggling with 'falling through the cracks'. The family hubs programme is an opportunity for integrated working across the system to ensure that families find 'no wrong door' and only tell their story once to get the outcomes that they need. There is a clear opportunity for better links between the maternity system and the Health Visiting service.
- **High child poverty** (46% of households) Families who were already deprived are facing more challenges with life post-COVID and the cost of living crisis.
- **Poor school readiness and attainment** – COVID-19 has disrupted development for our youngest children: personal, social, and emotional development delayed in 44% of pupils nationally in 2022 - disadvantaged children and those with SEND are worst affected.
- **COVID-19:** Children born during the pandemic missed out on these crucial face to face contacts. Especially those due the 2-2.5yr review – delays were not picked up. No visits to spot early signs of risk or neglect. Increase in children not meeting a good level of development at 2-year checks;
- **Increase in cost of delivery** – meaning the current contract is underfunded even before considering the population increases;
- **Provider market** - Lack of alternative provider in the market and value on contract not attractive to other providers;
- Lack of funding for **specialist school nursing for Additional Resourced Provision** (ARPs) settings (which isn't funded by the NHS North East London) which is putting a strain on the school nursing service – the new service will have additional clarity on responsibilities and work is needed at a system level to ensure there is provision for ARPs;
- **High and increasing Obesity rates.**
- **Poor oral health** – there is a lack of oral health promotion provision in the borough, poor diets, and nationally there is insufficient NHS dentists to meet demand.

Public Health Advice

We need to strengthen our approach to giving children the best start in life, via universal support/prevention activities, early identification of emerging issues, and provision of timely help to support families. This can be achieved by maximising the opportunities of the 0-19 programme so it better links to the needs of the children and young people and the drivers of demands in Health and Social Care.

Therefore, the 0-19 programme needs to focus on the high impact areas of the Healthy Child Programme and address the causes of Adverse Childhood Experiences including neglect, to support our vulnerable children to thrive in their home and school environment.

Chapter 6:
Keeping our Residents Safe from Infectious Disease

Protecting residents from communicable diseases remains one of my core statutory responsibilities, with the public health system working together to manage and prevent serious notifiable diseases and outbreaks. The most important function is the containment of notifiable infectious diseases.

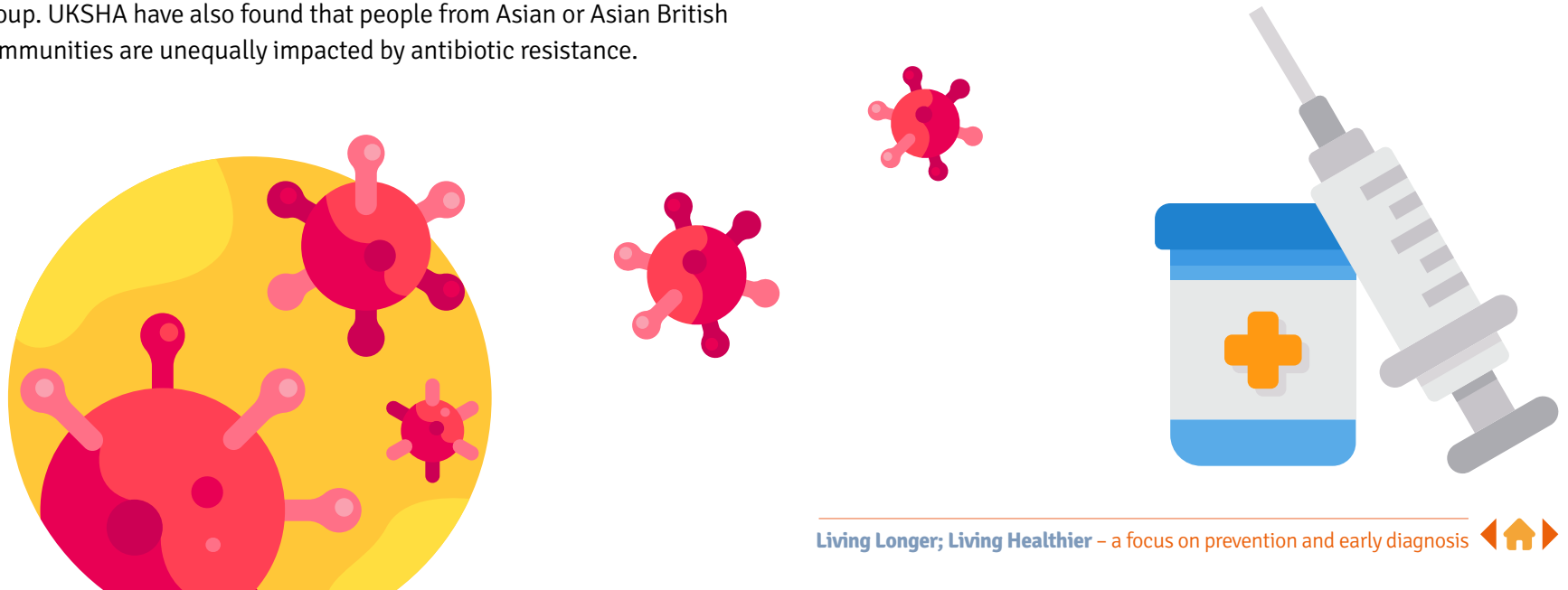
COVID-19 has changed the way we work on health protection issues today–for example we recognise the importance of all communities having access to vaccinations and we now seek to understand and address why people are hesitant to take up opportunities to protect their health. Furthermore, as was identified in the Public Health England report[61], people who have poorer health e.g. living with one or more long term condition, had less resilience and were more likely to become seriously unwell compared to others.

The latest analysis of national surveillance data on antibiotic resistant infection reported by UK Health Security Agency (UKSHA) at its recent conference also identified the stark inequalities in antibiotic resistance, with people in the lowest socio-economic group more likely to have a resistant infection compared to the highest group. UKSHA have also found that people from Asian or Asian British communities are unequally impacted by antibiotic resistance.

Vaccination & Immunisation

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health, (UKHSA, 2014). The World Health Organisation (2023) states that vaccines reduce risks of getting a disease by working with your body's natural defences to build protection. This means that many hospitalisations and deaths could be prevented by immunisation in the short term. Immunisation doesn't just protect the individual, it also helps to protect families and the community, especially those who cannot be immunised for medical reasons. It is important to have high coverage rates in Barking and Dagenham to maintain herd immunity, which means a large part of the population of an area is immune to a specific disease.

Work in the borough continues to improve the immunisation uptake rates especially for those eligible, and from the vulnerable and underserved communities.



The following vaccines are offered in Barking and Dagenham and childhood immunisations are generally delivered in GP practices/ health centres, while Vaccination UK delivers the school-age immunisations in schools:

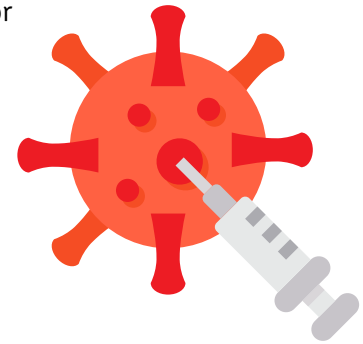
1. COVID-19 and Flu Vaccinations

These are offered to residents that are eligible at different seasons of the year. The offer is made via GP, community clinics, walk-in clinics, and community events. The seasonal booster uptake (2022/23) for older people was 65%, and frontline social care worker was 18%. Efforts to improve overall uptake are being made making more sites accessible, engagement activities, targeted messaging and communications, and a vaccination incentive programme within the care sector workforce.

2. School Aged Immunisations

School Age Immunisation Services providers are commissioned by NHS England - London (NHSE) to deliver the school-based immunisation programmes. Home schooled children and children not in mainstream schools for other reasons are also included. Vaccination UK are leading this programme and offering the following vaccinations in 2023/24: MMR, flu, HPV, two boosters to year 9s (DTP- Tetanus, diphtheria and polio, and Meningitis ACWY).

The public health team is supporting Vaccination UK and ensuring joint working and efforts with the schools, tailored communications, offering community clinics to also cater for homeschooling children, targeted clinics in areas with low vaccination uptake, and using the community organisations as levers to promote the programme.



3. Shingles Vaccination

Despite the seriousness of Shingles infection and the effectiveness of the vaccination to significantly reduce the chance of developing shingles, uptake rates of the vaccine are falling in London and across England. All eligible patients are offered the shingles vaccination by their GP as the practices are working to improve uptake all year-round following changes to the programme, from September 2023.

4. Polio

Following detections of polio virus in sewage samples in London in 2022, children aged 1-9 in London were offered an additional booster (or catch-up if not up to date) of the polio vaccine to ensure they were fully protected.

6. Measles Mumps and Rubella (MMR)

Measles is one of the world's most contagious diseases, spread by close or direct contact with an infected person via coughing or sneezing. One person infected by measles can infect nine out of 10 of their unvaccinated close contacts. Measles cases have been rising in London. There is no cure and vaccination is the only protection against becoming seriously unwell. Measles is one of the statutory notifiable infectious diseases.

The polio vaccination is offered in the MMR catch up programme and in April 2023, there were around 9,500 children aged 4-11 missing MMR or Polio in Barking and Dagenham. This equates to approximately, as reported by Together First: MMR Dose1 - 79%, and MMR Dose 2 - 67%. The World Health Organisation (WHO) recommends that an immunisation rate of 95% or more provides "herd immunity.

Vaccination UK started to deliver MMR catch-up campaign Phase 2 in August 2023 to the 4–11-year-old population, to ensure children are up to date with their childhood vaccinations, especially polio and MMR.

7. Chickenpox

The Joint Committee on Vaccination and Immunisation (JCVI) recommended in November 2023 that a universal varicella (chickenpox) vaccination programme should be introduced as part of the routine childhood schedule62. This should be a 2-dose programme offering vaccination at 12 and 18 months of age using the combined MMRV (measles, mumps, rubella and varicella) vaccine. It also recommended a catch-up programme should also be initiated following implementation of a programme to prevent a gap in immunity.

Why are Measles Vaccinations a Current Priority?

Background

Measles cases are rising in England this year. There were 128 cases between 1st January – 30th June 2023, of which the majority were in London, this is not expected to be higher. The vaccination rate is lower than the 95% target set by the WHO in areas of London, including Barking and Dagenham, in which 54% of 1–11-year-olds have received the full MMR vaccination dose as of September 2023[63].

Current Uptake of MMR in Barking and Dagenham

In 2021-22, only 67.8% of 5-year-old children in Barking and Dagenham had received 2 doses of the MMR vaccination. Of the 149 Local Authorities that submitted child vaccination data to NHS Digital that year, 143 had a higher second dose vaccination rate than Barking and Dagenham.

Analysis of our data shows a severe decline of our children receiving a first dose of the MMR vaccine at age 24 months, between 2013-14 and 2021-22, from 88.1% to 75.5%. This decline has occurred more rapidly in the borough than in London or England over the same period, highlighting the need for additional resource where available.

The decline in the first dose vaccination rate of children aged 5 years old has also declined between 2013-14 to 2021-22. However, the largest decline is seen in the percentage of 5-year-old children who have received a second dose of the MMR vaccine by the same age.

Inequalities in Uptake

NICE (2022) identifies the following population groups that are known to have low vaccine uptake or be at risk of low uptake:

- Some minority ethnic family backgrounds
- Gypsy, Roma and Traveller communities
- People with physical or learning disabilities
- Some religious communities (e.g., Orthodox Jewish)
- New migrants and asylum seekers
- Looked-after children and young people
- Children of young or lone parents
- Children from large families
- People who live in an area of high deprivation
- Babies or children who are hospitalised or have a chronic illness, and their siblings
- People not registered with a GP
- People from non-English-speaking families
- People who are homeless*

Many of these demographical characteristics can be seen within our population, so improving uptake needs more tailored approaches.

There are also several specific issues relating to our residents that we also need to consider:

- The transient population who moves around frequently and register at multiple practices without notification.
- Low vaccine acceptance in certain ethnic minorities.
- Despite being invited for vaccinations multiple times, parents/ carers are still not bringing their child(ren) in to get vaccinated.
- Different immunisation schedule for Eastern Europeans clashes with the UK immunisation programme.
- Language barriers.
- Fear of link of MMR to autism causing the vaccine hesitancy.
- Cultural differences (due to diverse make-up of our population).

The following analysis provides some indication of this:

Deprivation

Primary Care Networks (PCN) in areas with higher levels of deprivation have lower rates of unvaccinated children than the areas with low levels of deprivation. There are also large variations in levels of vaccination uptake by GP Practice, even within the same PCN.

The most recent data received from Together First in August 2023 from our General Practices showed:

Ethnicity

When grouped into the 5 major ethnic groups, shows there are significant differences across ethnic lines in the proportion of children who have received a full MMR dose (when looking at all children aged 1-11) see Figure 23.

Children whose ethnicity is listed as Other (i.e. ethnicity not disclosed) had the highest proportion yet to complete the full MMR vaccination course.

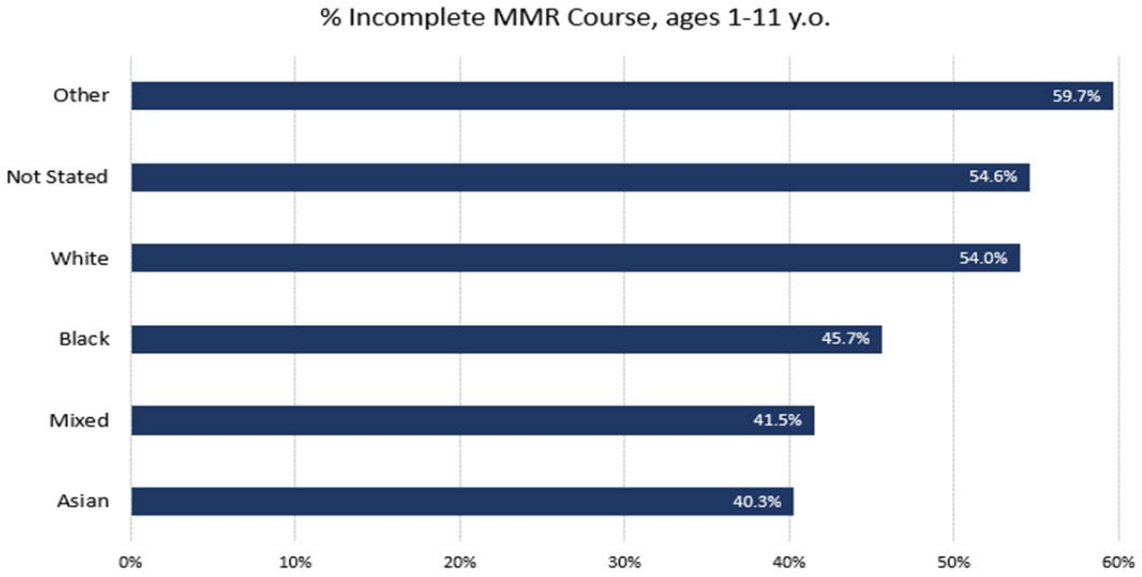


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Figure 23: Percentage of 1-11 year olds that haven't had a full MMR dose, by major ethnic group

When excluding the group that we do not have ethnicity information for (the Not Stated group), the next highest group is the White ethnic group, with 54.0% of White children aged 1-11 having not received a full MMR vaccination course.

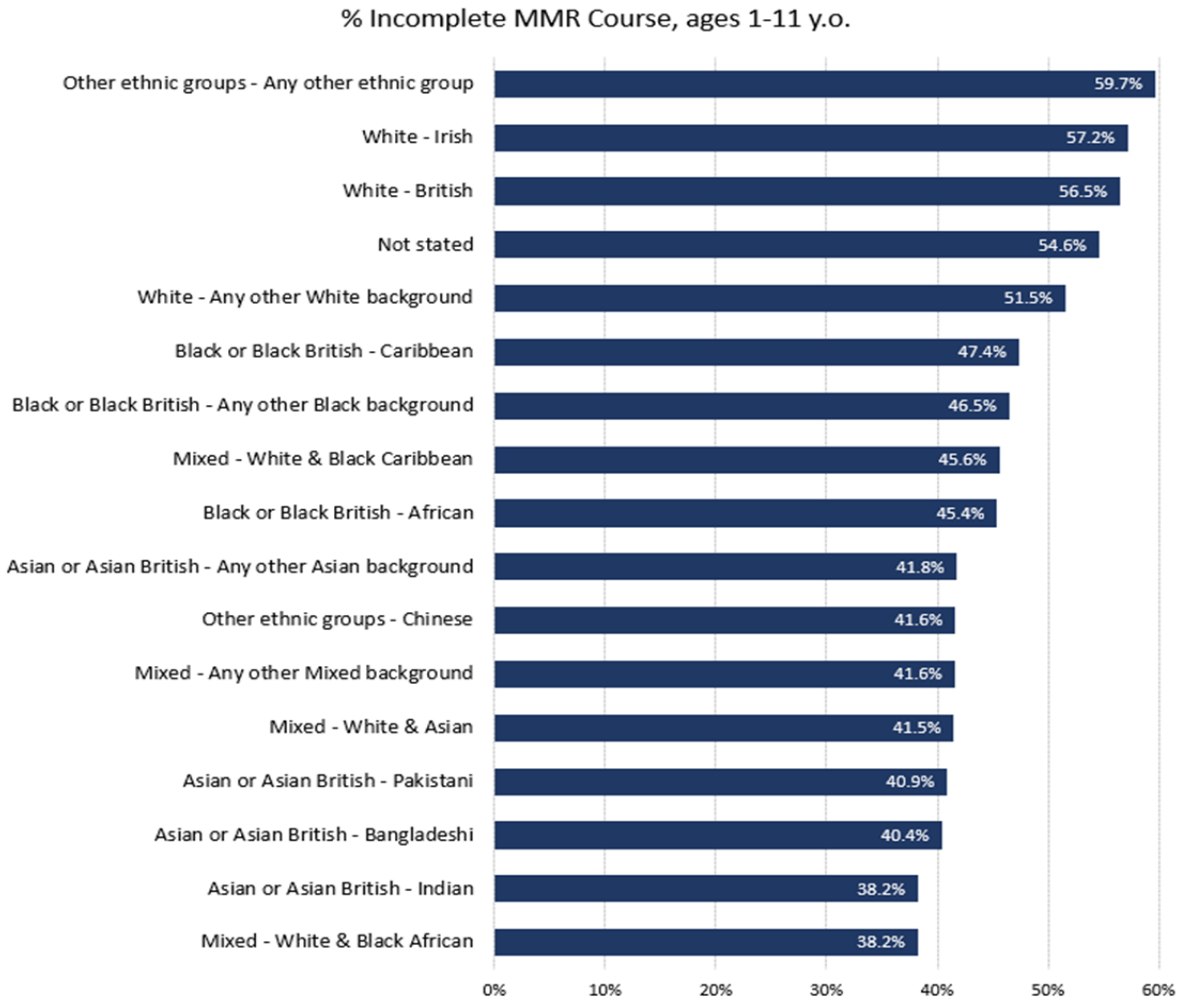


Figure 24: Percentage of 1- 11 year olds that haven't had a full dose of MMR, by specific ethnic group

This is reinforced in Figure 24 which shows that, after excluding the Not Stated group, 3 of the 4 ethnic subgroups with the highest proportion of incomplete full MMR courses were White. Those being the White – Irish (57.2%), White British (56.5%) and White – Any other background (51.5%) subgroups. Three of the next four highest groups are the 3 groups that combine to form the Black ethnic group: the Black or Black British – Caribbean (47.4%), the Black or Black British – Any other Black background (46.5%) and the Black or Black British – African (45.5%) subgroups. The gap between the highest and lowest groups in the borough is also quite high, at 21.5%, which is the difference between the Other ethnic group and the Mixed – White and Black African group.

There are also differences in incomplete vaccination proportions within ethnic groups at different ages. In particular, the 7 and 8-year-old age groups appear to be much less likely to have received a full course of vaccination than younger children of the same ethnicity in the White, Black, Asian and Not Stated groups.

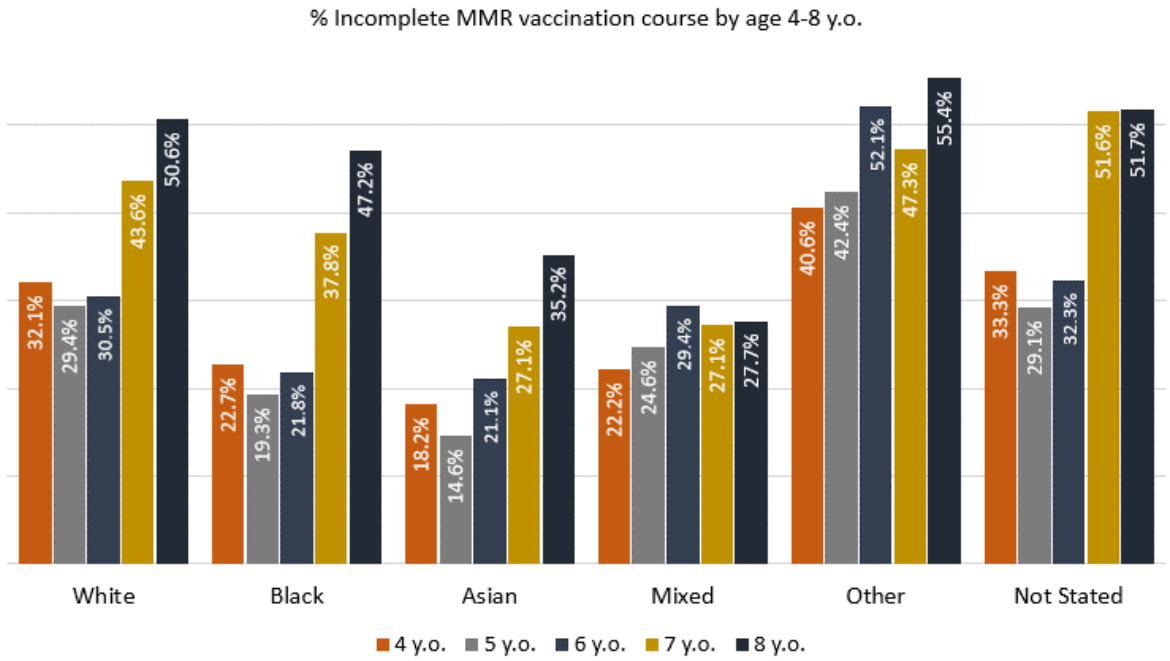


Figure 25: Percentage of 4–8-year-olds that haven't had a full dose of MMR, by major ethnic group

Action to Improve MMR Uptake in the Borough

Our plans are led through a partnership between the NHS, the council, and Vaccination UK, and have adopted the following UKHSA Risk Assessment recommendations[64] within our plans:

1. Assess population susceptibility to measles in all birth cohorts.
2. Improve MMR coverage to achieve 95% with 2 doses by time children are 5 years.
3. Urgent need for catch-up action for:
    - Children under-5 nationally
    - Children, teenagers and young people in London

Our plans also recognise the barriers identified by The Royal Society of Public Health[65] as accessibility and convenience of vaccination services and factors include timing of appointment and availability of appointments.

Plans are underpinned by Public Health England and NHS England (2020)[66] which recommended six areas of focus proven to optimise uptake of immunisations:

1. Strong leadership

2. Proactive promotion

3. Maintain accurate information

4. Effective call/recall

5. Maximise access and continuity

6. Trained and knowledgeable workforce

There were also lessons learnt from the COVID vaccine (NHSE, 2023):

- Lack of trust in government institution.
- Lack of trust in information.
- Belief that cost outweighs benefits, i.e., needing to inconvenience oneself. e.g., taking time off work to recover from the vaccine and its side-effects can lead to a reluctance to uptake.

And the following are recommended to overcome some of these challenges:

- Text messaging (information made available in relevant languages and proactively working to improve trust and relationships with patients).
- Community engagement.

The **MMR Action Group** commenced in August 2023 to improve vaccination MMR coverage with a target of 90%.

The following actions are taking place, adopted from NICE guidance, for areas with low vaccine uptake:

- Consider introducing targeted interventions to overcome identified local barriers and address identified inequalities in vaccine uptake between different population groups.
- Involve people in the local community when identifying barriers.
- Tailor service opening hours and locations for vaccinations to meet local needs.
- Provide a range of accessible options for booking appointments, consider using sites outside healthcare settings such as community and family hubs, or faith centres.
- The use of targeted messaging and community engagement. This will help to proactively improve trust and relationships with patients.

Examples of Specific Action

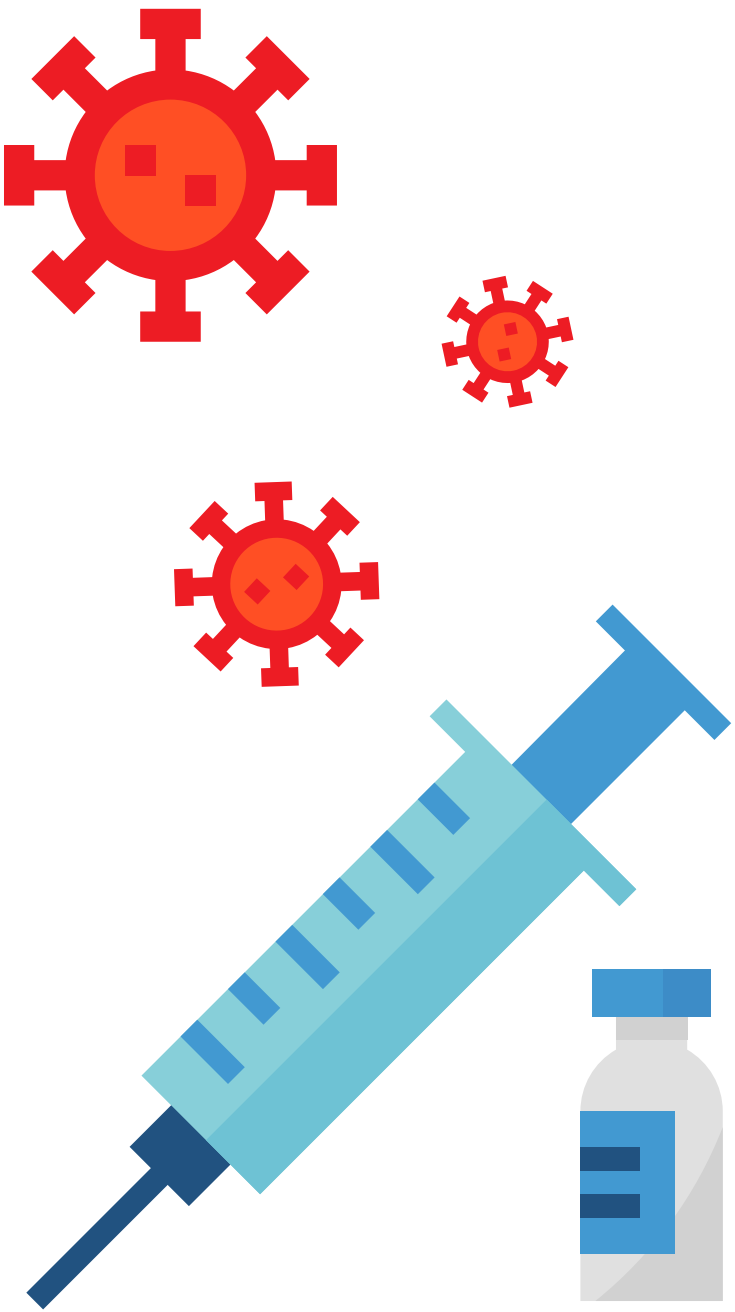
Together First has:

- Conducted Practice meetings with 27 out of 33 GP practices to better understand poor uptake and provide extra support where needed to help increase uptake rates.
- Set up a dedicated inbound booking line for parents/carers of registered patients and this has been extended to include outbound calls.
- Agreed with PCN East One about running a pilot to offer a 'full delivery' service option, where the team provide call handlers with a targeted list of parents/carers to contact and book in for MMR immunisations into the Enhanced clinics offered at the weekends to help working parents/carers.

Vaccination UK has delivered community clinics across all areas - 50 clinics being held in August 2023, mostly in libraries. Outreach clinics are also in the community hubs are being planned along with increasing extended hours at the GP practices.

Taking all this into consideration, a programme of action has been developed across Barking and Dagenham place partners to address the above lessons/challenges, with eight targeted workstreams:

1. **Phase 2 MMR Campaign led by Vaccination UK:** (catch-up school programme for over 5-year-olds) focuses on under-vaccinated children who are least protected and at the highest risk of becoming seriously unwell with polio as well as other preventable disease such as measles. Vaccinations will be given at the selected schools with the highest numbers of unvaccinated children. All primary schools will be supporting in facilitating a school-centric awareness programme for these children and helping to raise awareness of the importance of routine childhood vaccinations. Three levels of approach: 1) Schools: targeting the top 20 schools in the area that have the most children without MMR 2) GPs: targeting the top 20 GP's that have the most children short of MMR/polio scheduled Immunisation. 3) Community clinics to catch up during school breaks or after school sessions.
2. **Family and community hubs:** outreach work (including pop up clinics) at our family and community hubs to address vaccination hesitancy, promote benefits and to administer MMR vaccinations. Joint working with Vaccination UK in the delivery of community pop-up clinics in the wards that have the lowest vaccination rates.
3. **Targeted communications and messaging:** an integrated campaign using a two-pronged approach of targeted and broad-brush borough awareness raising activity to encourage vaccine uptake in the lead up and at the start of the new school year.



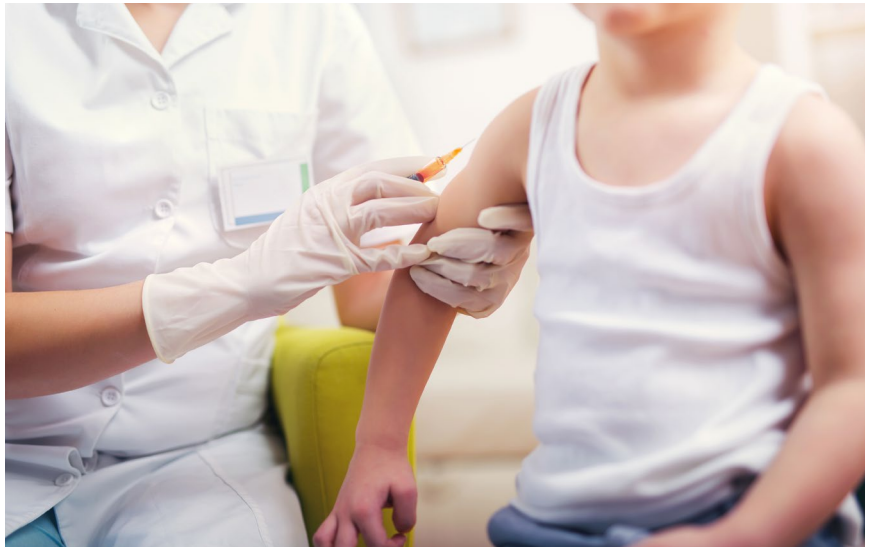
4. **Early years:** establish how to triangulate health visiting, GPs, and early years providers to improve take up, supported by GP Fed with additional enhanced clinics, for 0–5-year-olds. Training professionals and staff working in services in contact with families and young children, to ensure they have conversations to address vaccine hesitancy and to signpost families to the community clinics. These staff have a trusted relationship with the families, and this would encourage them to make every contact count.

5. **Engagement work with Eastern European communities:** (through our voluntary, community and faith partners) to provide additional support to practices and extra time for families who are vaccine hesitant to discuss their concerns with a health professional, through an interpreter where needed. An Eastern European organisation will work with public health for six months with the proposed activities for the MMR awareness outreach: venue/org mapping and ongoing engagement; leafleting; Barking food bank drop-ins; digital engagement; content resharing; online live events with a medical professional.

6. **Engagement work with faith groups:** links have been made with Black and African organisations/churches to engage with their community and address vaccine hesitancy. These will be levers and channels to promote the communications messaging and promote community clinics in the borough.

7. **Outreach work with refugee and asylum seekers:** dedicated health and wellbeing events for residents from migrant communities, delivered by local and community-based providers who specialise in providing holistic support for asylum seekers, refugees, and immigrants. Public health will promote MMR in the four hostels in the borough and include this cohort in the community pop-up events.

8. **Co-production:** partnership working with all key stakeholders, health, council and voluntary sector in the design and development of the plans. Effective data sharing arrangements with health and Vaccination UK, to ensure the effective continuity of the service delivery to the families.



Public Health Advice

We need:

- Our Place Based Partnership to prioritise childhood immunisation to improve and reduce the differences of uptake within our communities.
- Sustain investment to improve the uptake of vaccinations especially MMR, reduce the inequity of uptake and to introduce the chickenpox vaccination if directed, following recommendations of the Joint Committee of Vaccinations and Immunisations.
- Communications strategies that are simple and hard-hitting, with continuous messaging on the importance and benefits of vaccination.

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- Richard Johnston
- Sophie Keenleyside

References

References

To find out more information on our strategies, policies and plans click here.

Barking & Dagenham