Notice of Meeting

HEALTH & WELLBEING BOARD

Wednesday, 7 November 2018 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 30 October 2018

Chris Naylor
Chief Executive

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Membership

Cllr Maureen Worby (Chair)	LBBD (Cabinet Member for Social Care and Health Integration)
Dr Jagan John	Barking & Dagenham Clinical Commissioning Group
Elaine Allegretti	LBBD (Director of People and Resilience)
Cllr Evelyn Carpenter	LBBD (Cabinet Member for Educational Attainment and School Improvement)
Bob Champion	North East London NHS Foundation Trust
Matthew Cole	LBBD (Director of Public Health)
Det. Insp. John Cooze	Metropolitan Police
Dr Nadeem Moghal	Barking Havering & Redbridge University NHS Hospitals Trust
Sharon Morrow	Barking & Dagenham Clinical Commissioning Group
Cllr Margaret Mullane	LBBD (Cabinet Member for Enforcement and Community Safety)
Cllr Lynda Rice	LBBD (Cabinet Member for Equalities and Diversity)
Nathan Singleton	Healthwatch - Lifeline Projects Ltd.

Standing Invited Guests

Cllr Eileen Keller	LBBD (Chair, Health Scrutiny Committee)
Stephen Norman	London Fire Brigade
Brian Parrott	Independent Chair of the B&D Local Safeguarding Adults Board
vacant	London Ambulance Service
Ian Winter CBE	Independent Chair of the B&D Local Safeguarding Children Board
Vacant	NHS England London Region

AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. Minutes - To confirm as correct the minutes of the meeting on 5 September 2018 (Pages 3 - 5)

BUSINESS ITEMS

4. Joint Health and Wellbeing Strategy 2019-2023 (Pages 7 - 52)

5. Ending Violence Against Women and Girls Strategy 2018-2022 (Pages 53 - 73)

6. Joint Strategic Needs Assessment 2018 (Pages 75 - 146)

7. Health and Wellbeing Outcomes Framework Performance Report - Q2 2018/19 (Pages 147 - 163)

STANDING ITEMS

8. Sub-Group Reports (Page 165)

9. Chair's Report

The Chair will present her report at the meeting.

10. Forward Plan (Pages 167 - 173)

11. Any other public items which the Chair decides are urgent

12. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.

Private Business

The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

13. Any other confidential or exempt items which the Chair decides are urgent

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London Borough of Barking & Dagenham
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Our Vision for Barking and Dagenham

One borough; one community; London's growth opportunity

Our Priorities

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

Well run organisation

- A digital Council, with appropriate services delivered online
- Promote equalities in the workforce and community
- Implement a smarter working programme, making best use of accommodation and IT
- Allow Members and staff to work flexibly to support the community
- Continue to manage finances efficiently, looking for ways to make savings and generate income
- Be innovative in service delivery

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MINUTES OF
HEALTH AND WELLBEING BOARD

Wednesday, 5 September 2018
(6:30 - 8:17 pm)

Present: Cllr Maureen Worby (Chair), Dr Jagan John (Deputy Chair), Cllr Evelyn Carpenter, Matthew Cole, Sharon Morrow, Cllr Margaret Mullane, Cllr Lynda Rice and Nathan Singleton

Also Present: Cllr Eileen Keller, Brian Parrott and Ian Winter

14. Apologies for Absence

Apologies were submitted on behalf of Elaine Allegretti, Director of People and Resilience, Detective Inspector John Cooze and Dr Nadeem Moghal, BHRUT.

The Chair expressed concern that no representatives were in attendance from BHRUT and the Metropolitan Police, and that both organisations should be reminded in future of the importance of sending substitutes.

15. Declaration of Members' Interests

There were no declarations of interest.

16. Minutes (12 June 2018)

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

17. Safeguarding Adults Board Annual Report 2017/18

The Board noted the Safeguarding Adult Board Annual Report for 2017/18 as set out as an appendix to the report presented by Brian Parrott, Independent Chair. This included an outline of the purpose and function of the Board, namely to ensure vulnerable adults feel safe and protected from harm and abuse, its achievements over the past year and relationships with core partners as well as the key challenges and priorities for the coming year incorporated into the Board's strategic and work plans, as detailed in the annual report.

The Board welcomed the report and reflected on the SAB priorities for 2018/19, specifically the need for greater awareness raising with the wider community and health agencies of safeguarding issues particularly around the exploitation agenda, including advice on how best to report and capture concerns.

18. Development of Barking Riverside Health and Wellbeing Hub - Outputs of Board Workshop

The Board noted the outcome of the first of a series of workshops convened to look at the high-level outcomes as part of the development of the health and wellbeing approach at Barking Riverside, including the design specification for the Health and Wellbeing Hub as part of the new district centre. A note summarising the outcomes of the workshop will be available alongside the Board minutes.

The Chair stressed that this Board and its health partners cannot afford to miss the opportunity to develop a unique and innovative model of health care for local residents. This was echoed by Dr John who stated that colleagues at the CCG are excited and refreshed about the plans for the location and are hopeful that partners can and will deliver.

It was noted that updates would be given at future meetings on the emerging shape of the health and wellbeing programme for the locality.

19. Update on Development of Joint Health and Wellbeing Strategy 2019-2023

At its meeting in March 2018 the Board endorsed the process for the Joint Health and Wellbeing Strategy for 2019-2023 including incorporating an 'I' statements approach to achieving real outcomes for local communities.

The report and accompanying presentation from officers in Public Health provided an update on the development work of the Strategy including the outcomes of a series of resident focus groups to formulate the statements and stakeholder workshops which looked at outcomes and measures of the three themes of the Strategy, namely:

- Best Start in Life
- Early Diagnosis and Intervention
- Building Resilience

Due to the difficulties in defining the meaning of resilience for different groups of residents, the latter workshop focused on getting a consensus from which a total of 10 outcomes have been produced, and which were presented to the Board to consider and prioritise. A number of observations were made with an overall consensus that the objectives are too broad in definition and would benefit from grouping together, and from which specific measures can then be agreed.

In terms of the next steps, taking onboard the above comments, officers will refine the draft strategy for presentation at the Board in November for approval to go out to public consultation. Final approval will then be sought from the Board in January 2019.

20. Health and Wellbeing Outcomes Framework Performance Report - Q1 2018/19

The Board were presented with the dashboard of performance information for quarter 1 (1 April – 30 June 2018) which included the RAG ratings of 20 indicators. The report also referred to the rating of 16 CQC inspection reports for the period. The Director of Public Health highlighted for the Board's attention a number of indicators including:

- % reduction in the uptake of MMR2 immunisation at 5 years old and in that respect the recent measles outbreak in London;
- Early diagnosis with older adult screening programmes not where they need to be, and
- % increase in A&E attendances (target 4 hours from arrival to admission,

transfer or discharge).

Reference was made to the recently published report by the CQC into its findings from an inspection of the King George's Emergency Urgent Care Centre (EUCC) earlier in the year, which has resulted in an inadequate rating and the Centre placed in special measures. Given these concerns the CCG has undertaken its own inspection and whilst there are areas requiring improvement, given the work undertaken since the review took place, the CQC feel the situation is not as critical as first thought and is regarded as safe for all three boroughs residents to use. It is hoped this assessment will be confirmed when the CQC carries out its follow up review.

It was noted that a report would be presented to the Council's Health Scrutiny Committee looking at the areas for improvement.

21. Sub-Group Reports

The Board received and noted the minutes of recent meetings of both the Learning Disability Partnership and the Integrated Care Partnership Boards. The Chair intends to come back with a report on the IC Partnership Board to demonstrate the good work taking place.

The Board noted that a report on the work of the Mental Health Sub Group will be separately circulated to Board members for information.

22. Chair's Report

The Board received and noted the Chair's report, which included details of the LGA Green Paper for Adult Social Care and Wellbeing, the NHS Continuing HealthCare National Framework and its affect for the Borough, a "right to thrive" project as a development of Thrive London Health Board, the Citywide movement to improve the mental health and wellbeing of all Londoners, which was reported on at the last meeting, and the outcomes from consultations from Learning Disabilities Week 2018.

23. Forward Plan

The Board received and noted the current Forward Plan for the 2018/19 municipal year.

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HEALTH AND WELLBEING BOARD

7 November 2018

Title:	**Joint Health and Wellbeing Strategy 2019-2023**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** Yes
Report Author: Florence Henry, Public Health Strategy Officer, London Borough of Barking and Dagenham	**Contact Details:** Tel: 020 8227 3059 E-mail: florence.henry@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary

As required by the Health and Care Act 2012, a new Health and Wellbeing Strategy is required for 2019-2023 to follow on from the 2015-2018 strategy.

The draft strategy (**Appendix 2**) sets a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives. The three priority themes for the strategy have been were agreed by Health and Wellbeing board in January when presented with the 2017 Joint Strategic Needs Assessment (JSNA):

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

To create this document, we have run 12 focus groups with residents to formulate the 'I' statements within this document, which outline what good health looks like to residents These are included within each theme of the strategy. We have also held 3 professional stakeholder workshops to discuss the outcomes and measures in each theme in July.

This work is evolving – we are working with commissioners and providers to integrate these priorities into commissioning plans. The 6 outcomes within this document will stay the same for the duration of this strategy, but the measures will evolve as we gain greater insight of the local population. This document does not contain a detailed delivery plan, as it sets the overall strategic outcomes. Commissioners and the Alliance of Providers will use these outcomes and priorities to develop a detailed delivery plan which will include outputs and targets. The strategy will be designed before publication in the new year.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Provide any comments on the narrative; and

(ii) Approve the draft Joint Health and Wellbeing Strategy 2019-2023 for an 8-week public consultation.

Mandatory Implications

Joint Strategic Needs Assessment

1.1 The three themes within this document were informed by the Joint Strategic Needs Assessment 2017. This strategy has been created alongside the Joint Strategic Needs Assessment 2018.

Joint Health and Wellbeing Strategy

1.2 Once approved by the board for publication in early 2019, this Joint Health and Wellbeing Strategy 2019-2023 will replace the 2015-2018 Joint Health and Wellbeing Strategy and informs the work of Health and Wellbeing Board partners.

Integration

1.3 As a partnership document between the council and the CCG, the Joint Health and Wellbeing Strategy outlines how as an integrated health and social care system, Health and Wellbeing Board partners will work together around the three key themes.

Financial Implications

Implications completed by Katherine Heffernan, Service Finance Group Manager

1.4 The Joint Health and Wellbeing Strategy assumes that it will be delivered within existing resources. The Public Health Grant will be made available to the London Borough of Barking and Dagenham from 1 April 2018 until 2021. Under section 75 of the NHS Act 2006, we will consider flexibilities such as pooled budgets and lead commissioning that can better meet the needs identified in the JSNA. The NHS England (London) is also under a duty in the legislation to encourage the use of these flexibilities by clinical commissioning groups, where it considers use of flexibilities would secure the integration of health services and health related or social care services. The desired effect of using these flexibilities is improved quality of services provided or reduced inequalities between persons about access to services or outcomes from them.

Legal Implications

Implications completed by Dr. Paul Feild, Senior Governance Solicitor

1.5 As set out in the body of this report the Health and Social Care Act 2012 places a statutory duty on the Health and Wellbeing Board to prepare a Joint Health and Wellbeing Strategy to meet the needs identified in the Joint Strategic Needs Assessment.

Local authorities and each of its partner clinical commissioning groups must when exercising any functions have regard to any relevant Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) prepared by

them (s193 of the Health and Social Care Act 2012).

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

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

Patient / Service User Impact

1.5 A full Equality Impact Assessment has been completed for this strategy. This systematic equalities and diversity screening process determines whether the proposals in a new policy or development are likely to have significant positive, negative or adverse impacts on the different groups in our community. The Equality Impact Assessment can be found in Appendix 3.

2 Non-mandatory Implications

Crime and Disorder

2.1 In preparation of this document, we went to the council's Community Safety Partnership on 26 September 2018 to ask for comments from board members about the approach to this Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment. We have also worked with officers to ensure that the upcoming Community Safety Plan and the Joint Health and Wellbeing Strategy are aligned. Both documents talk about the role of Adverse Childhood Experiences.

Public Background Papers Used in the Preparation of the Report:

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

List of Appendices:

Appendix 1	Joint Health and Wellbeing Strategy Executive Summary
Appendix 2	Joint Health and Wellbeing Strategy 2019-2023 (Draft)
Appendix 3	Equality Impact Assessment

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Appendix 1

Joint Health and Wellbeing Strategy Executive Summary

Vision

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

Context and strategic framework

The Joint Health and Wellbeing Strategy is required by the Health and Social Care Act 2012. A joint document with Barking and Dagenham Clinical Commissioning Group, the strategy focuses on setting the outcomes that will be used by the Alliance of Providers and Commissioners to create a detailed delivery plan.

Health and Wellbeing Board partners will work together to promote a place-based system of care, where partners work together to improve the health of their population, across the Barking Havering Redbridge integrated care system (ICS). As outlined in the NHS Five year Forward View, in order to improve the health of our population, and creating a sustainable health-care system we need to increase our focus on prevention. Integration is the priority of this strategy– ensuring our children get the best start in life, improving rates of early diagnosis and intervention and building resilience all help us to prevent health problems before they happen.

In drafting this strategy, we have engaged with communities differently. Both the NHS Five Year Forward View and *the Borough Manifesto,* a consultation of over 3000 residents, talk about the need to engage with communities in new ways, and involve them in decisions relating to their health and care. In *The Borough Manifesto'*, residents told us that they wanted more of a say on their health – with this in mind, we consulted with 12 resident groups and used 'I' statements within each theme of this strategy, outlining what good health looks like to residents.

We have also positioned our 6 outcomes as helping to achieve the longer-term targets of *the Borough Manifesto*, specifically:

- Healthy life expectancy better than the London average by 2037
- Level 1 and Level 4 skills % higher than London average by 2037
- Unemployment rate lower than the London average by 2037

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

Engagement, consultation and co-production

We have co-produced this strategy with residents, through 12 resident focus groups speaking to residents about what good health looks like to them. We have included these 'I' statements within each theme of the strategy.

In addition to this, we held 3 professional stakeholder workshops with a range of partners in July 2018 on each theme of the strategy to discuss the outcomes and measures to be used within the strategy.

There will be a consultation period with the draft strategy, where residents will be able to have their say on the priorities contained within it. .

Resident 'I' statements'

Theme 1: Best Start in Life
'I' statement 1 – I am provided with information about how best to ensure my child's health and development
'I' statement 2 – I am supported to meet other parents in the community
'I' statement 3 – I am supported to make healthy choices for me and my child

Theme 2: Early Diagnosis and Intervention
'I' statement 4 – I feel my mental health conditions are treated with the same respect as my physical conditions without stigma
'I' statement 5 – When I am diagnosed, my family and I know where to find community support services, including emotional support
'I' statement 6 – When I am diagnosed, I am supported with the information about my condition I need to make decisions and choices

Theme 3: Building Resilience
'I' statement 7 – I feel safe in my home and in my family, and my community, and I know where to go for help
'I' statement 8 – I have opportunities to connect to individuals and communities
'I' statement 9 – I can access mental health support services when I need them

APPENDIX 2

Barking and Dagenham

Joint Health and Wellbeing Strategy

2019-2023

Vision

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

Priority Theme 1: Best Start in Life Vision

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

Priority Theme 2: Early Diagnosis and Intervention Vision

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

Priority theme 3: Building individual and community strength vision

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

Foreword

The Barking and Dagenham Health and Wellbeing Board has reviewed its priorities and how to tackle health inequalities in the borough over the next 5 years. Across all partners, focusing on prevention is a priority - it offers the opportunity to improve outcomes for residents. Successful integrated prevention across partners will also reduce demand for high cost statutory and specialist health, social care and council services and help us to create a sustainable health and care system.

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

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

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

This strategy describes our vision - what we need to do, and what impact we aim to have over the upcoming 5 years. This strategy also contains 10 pledges, which have been formulated from the resident consultation and the 3 professional workshops held in July. We have applied them to each theme within the strategy to demonstrate our commitments to empowering communities and building resilience.

We would like to thank everybody that has been involved in developing this strategy. Residents for their views and support, the Health and Wellbeing Board,

elected members and individuals who demonstrated their commitment to this important agenda. Finally, the success of any strategy is in its execution, and our first step is to widely communicate what we intend to do. We then begin the challenging and exciting journey of implementing a strategy which will deliver the best outcomes for local residents – to live longer, healthier and happier lives.

CLLR WORBY	DR JAGAN JOHN
Cabinet Member	Chair of Barking & Dagenham CCG
Social Care & Health Integration	Deputy Chair of the Health & Wellbeing Board
Chair of the Health and Wellbeing Board	

Context

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

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

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

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

-*Theme 1) Best Start in Life* – To give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 5 years to build up their resilience

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

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

Our population and its health challenges: Population and Demographic data

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

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

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

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

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

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

Strategic Framework

Growth Commission Report 2016

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

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

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

The Borough Manifesto

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

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

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

in the 5 following areas of the *Borough Manifesto* targets:

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

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

London Borough of Barking and Dagenham Corporate Plan

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

North East London Sustainability and Transformation Plan (Draft 2016)

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

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

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

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

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

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

Equality and Diversity

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

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

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

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

Secondly, this document contains a series of 'I' statements, which ensure that local communities are represented in the strategy. Resident focus-groups have ensured that different groups of protected characteristics are represented in the co-production of this document. We have spoken to community groups with

disabilities, LGBT+ Groups, Mental Health Peer Support Groups, Carers and Children in Care groups amongst others. We have also ensured a variety of ages, genders and ethnicities have been spoken to, and included these views within each theme of the strategy in the form of 'I' statements. These 'I' statements will encourage providers and commissioners to work around the needs of residents.

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

Engagement, Consultation & Co-Production

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

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

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

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

Vision & Priority Themes

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

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

Theme 1) Best Start in Life

To give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 5 years. Evidence demonstrates the first 5 years shape mental and physical health for the rest of their lives and is therefore a key time to invest.

Theme 2) Early Diagnosis and Intervention

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

Theme 3) Building Resilience

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

Priority 1: Best Start in Life

Ensuring every child has the best start in life – To give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 5 years.

Why Best Start in Life?

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

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

The Marmot Review demonstrates that the first 5 years of life have a huge impact on almost every aspect of physical and mental health for the rest of life, including obesity and mental health. Evidence from Public Health England demonstrates that **for every £1 spent in the Early Years, £7 would have to be spent in adolescence to have the same impact on health.**

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

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

Therefore, we will focus on ensuring our residents have the best start in life, to give them the foundations for resilience for the rest of their lives. We will focus on ensuring that across our partners, the universal services we provide focus on ensuring that children in the borough are best prepared to start school by the age of 5.

Enablers: What needs to change? Our pledges

- work to build up a universal level of resilience across all Early Years Services to provide our under 5's with the building blocks for resilience that they need

1) Resilience

- focus our efforts on utilising alternatives and community solutions earlier, reserving specialist and statutory servcies for our most vulnerable residents.

2) Seek alternative community solutions earlier

- focus on protecting vulnerable children within our communities

3) Safeguarding

- focus on the first 5 years, because evidence shows this is a key time to invest to influence outcomes through-out adulthood

4) A focus on communities where there is largest potential for impact

- put residents at the heart of service design to ensure that our services are designed around the needs of our residents, and the different ways in which residents have children.

5) Co-production

- take a family-based approach to increase prevention and reduce the impacts of adversity and challenges on children and young people

6) Family-based approach

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

7) Integrated care

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

8) Providing quality services through our workforce

- work together to look at the factors driving adversity and challenges in partnership.

9) Investigating the drivers of adversity

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

10) Speaking Straight

OUTCOME 1: To increase the percentage of children in Barking and Dagenham who are best prepared to start school by the age of 5

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

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

<u>I' statements produced through resident focus groups</u>

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

'I' statement 1 – I am provided with information about how best to ensure my child's health and development

'I' statement 2 – I am supported to meet other parents in the community

'I' statement 3 – I am supported to make healthy choices for me and my child

Priority 2: Early Diagnosis and Intervention

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

Why Early Diagnosis and Intervention?

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

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

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

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

Enablers: What needs to change? Our pledges

- work to build up a universal level of resilience to generate new ways of thinking around their long-term conditions

1) Resilience

- focus our efforts on early intervention and prevention. We will use social prescribing to reduce the demand to our high-cost specialist services

2) Seek alternative community solutions earlier

- focus on protecting vulnerable children within our communities

3) Safeguarding

- focus on the four conditions which have been identified as having the largest potential for impacts

4) A focus on communities where there is largest potential for impact

- put residents at the heart of service design to ensure that our services are designed around the needs of our residents, and their support needs

5) Co-production

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

6) Family-based approach

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

7) Integrated care

- ensure that our services are safe-and evidence-based, and cost-effective. We will work to ensure that our staff are trained to provide the support our residents require.

8) Providing quality services through our workforce

- work together to look at the factors driving adversity and challenges in partnership

9) Investigating the drivers of adversity

- have honest and open conversations with our residents about their health, how services can support them and manage expectations around waiting times, and treatment delays

10) Speaking Straight

Outcome 2: To increase healthy life expectancy by removing barriers to early diagnosis and intervention in 5 key areas

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

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

'I' statements produced through resident focus groups

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

'I' statement 1 – I feel my mental health conditions are treated with the same respect as my physical conditions without stigma

'I' statement 2 – When I am diagnosed, my family and I know where to find community support services, including emotional support

'I' statement 3 – When I am diagnosed, I am supported with the information about my condition I need to make decisions and choices

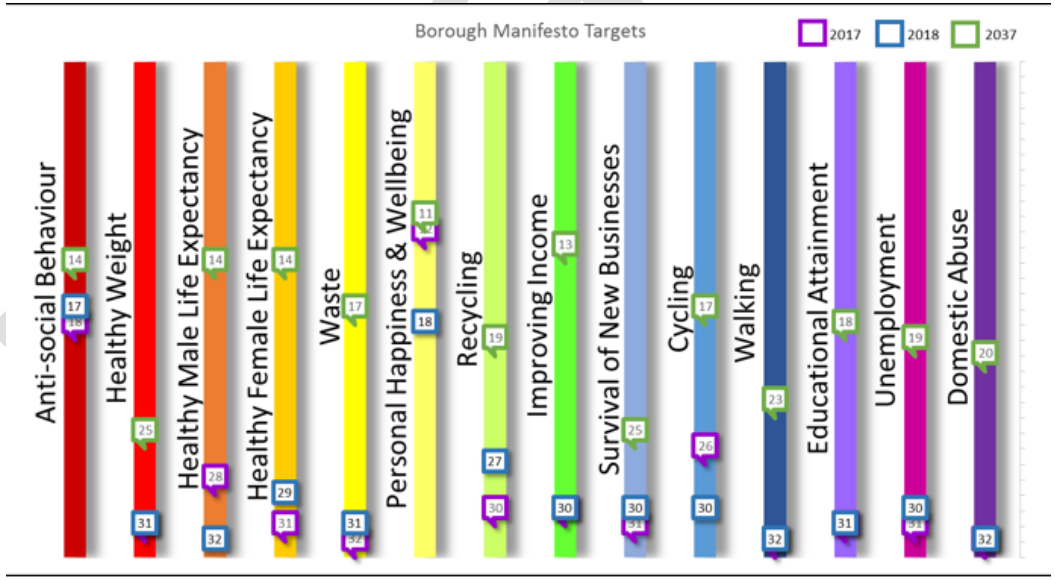
Priority 3: Building Resilience

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

Why resilience?

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

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

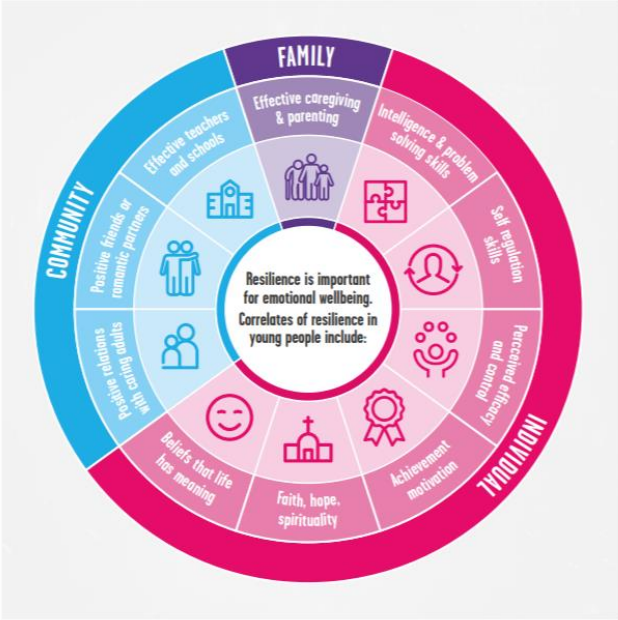


The 10 themes in *the Borough Manifesto* can all be seen as structural factors that impact on resilience – these themes empower residents to build resilience at a structural level. The below graphic demonstrates that looking at the interlink between these structural factors, well-being and social capital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

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

Solving these complex problems requires partners to work together and develop a place-based system of health and care and an integrated approach to prevention. A collective approach is required, where **all agencies have a shared agenda for change,** including a common understanding of the problem. Prioritising early help for residents can improve residents' health and wellbeing, while importantly reducing demand for specialist and statutory services. To build resilience, evidence by Public Health England talks about how we can do this at three levels – individual, family and community:

Figure 2: Building resilience (the ability to cope with adversity and adapt to change)



Source: PHE (2016)

Our Approach

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

Similarly, our residents who are in regular touch with some of our services, require a different approach to our most vulnerable residents, who are accessing our statutory and specialist services. As our residents' transition through the life-course, we also need to ensure that the support to build their resilience is there.

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

Enablers: What needs to change? Our pledges

- work to build up a universal level of resilience

1) Resilience

- work to use alternative and Community Solutions earlier, reserving specialist and statuory services for our most vulnerable

2) Seek alternative community solutions earlier

- focus on protecting vulnerable children within our communities

3) Safeguarding

- focus on residents who need a bit more help in key areas that evidence demonstrates impacts resilience

4) A focus on communities where there is largest potential for impact

- put residents at the heart of service design, involving lived experience when designing our support services

5) Co-production

- commit to take a family-based approach to deal with domestic violence and abuse, child sexual exploitation and abuse

6) Family-based approach

- We will work in partnership to ensure that health and social care is personalised, and delivered in the right place at the right time - in community settings and close to home where possible

7) Integrated care

- We will ensure that we provide value for money, and be both clinically effective and cost-effective. We will work to ensure that our staff are trained to provide the support our residents require.

8) Providing quality services through our workforce

- work together to look at the factors driving adversity and challenges we're facing in the borough

9) Investigating the drivers of adversity

- have honest and open conversations with our residents about the signs of DVA, CSE and serious crime, where to get help and why we need to work together to tackle these problems

10) Speaking Straight

- work to use peer to peer models to make a difference to engage with survivors of DVA, CSE and serious crime

11) Peer to Peer

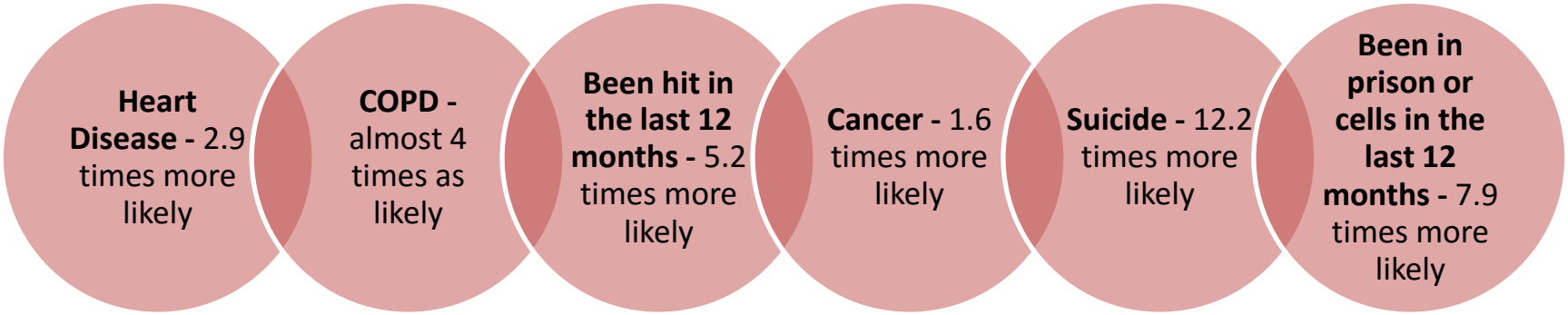
- work to use formal and informal community resources to help foster shared responsibility and support

12) Mobilising communities

OUTCOME 3) Improved multi-agency support for those with Adverse Childhood Experiences

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

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



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

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

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

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

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

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

OUTCOME 4) Aspiration: Increased level of educational attainment, skills and employment

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

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

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

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

OUTCOME 5) To improve physical and mental wellbeing

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

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

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

OUTCOME 6) Ageing Well: An increased level of residents who age well

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

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

‘I’ statements produced through resident focus groups

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

‘I’ statement 7 – I feel safe in my home and in my family, and my community, and I know where to go for help

‘I’ statement 8 – I have opportunities to connect to individuals and communities

‘I’ statement 9 – I can access mental health support services when I need them

Governance

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

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

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

References and links to supporting documents

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

Health and Wellbeing Board Reports

-Barking and Dagenham Joint Health and Wellbeing Strategy 2015-2018 - https://www.lbbd.gov.uk/sites/default/files/attachments/Joint-health-and-wellbeing-strategy-2015-18.pdf

-Barking and Dagenham Joint Strategic Needs Assessment 2017 - https://www.lbbd.gov.uk/sites/default/files/attachments/JSNA-2017-report.pdf

-Creation of the Joint Health and Wellbeing Strategy, Barking and Dagenham Health and Wellbeing Board, March 2017
https://modgov.lbbd.gov.uk/Internet/documents/s121000/Item%208.%20Creation%20of%20the%20Joint%20Health%20and%20Wellbeing%20Strategy.pdf

-Update on Development of Joint Health and Wellbeing Strategy, Barking and Dagenham Health and Wellbeing Board, September 2018
https://modgov.lbbd.gov.uk/internet/documents/s125718/JHWS%20Update%20Report.pdf

Best Start in Life

Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair Society, Healthy Lives: The Marmot Review. London: UCL; 2010 [http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review].

-PHE, Health Matters: Ensuring all children have the best start in life [https://publichealthmatters.blog.gov.uk/2015/08/10/ensuring-all-children-have-the-best-start-in-life/], 2015

Early Diagnosis and Intervention

- PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].

Building Resilience

-Institute of Health Inequality, The Impact of Adverse Experiences in the home on children and young people, 2015 [http://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf]

-Bellis M, Hughes K, Hardcastle K, Ashton K, Ford K et al. The impact of childhood experiences on health service use across the life course using a retrospective cohort study, Journal of Health Services Research and Policy [-https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5549819/]. 2017

ONS. Understanding well-being inequalities: Who has the poorest personal well-being? [https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/understandingwellbeinginequalitieswhohasthepoorestpersonalwellbeing/2018-07-11], 2014

Key documents

-JSNA 2018 (attached)

-EIA (attached)

Internal documents/strategies which inform this strategy

-Barking and Dagenham Together: Borough Manifesto - https://www.lbbd.gov.uk/sites/default/files/attachments/Barking-and-Dagenham-Together-Borough-Manifesto.pdf

Borough Manifesto targets rationale - https://www.lbbd.gov.uk/sites/default/files/attachments/Targets-rationale.pdf

-State of the Borough: Barking and Dagenham 2018 - https://www.lbbd.gov.uk/sites/default/files/attachments/State%20of%20the%20Borough%20report-compressed.pdf

-North East London Sustainability and Transformation Plan, 2016 [http://eastlondonhcp.nhs.uk/wp-content/uploads/2017/06/NEL-STP-draft-policy-in-development-21-October-2016.pdf]

-Violence Against Women and Girls Strategy (VAWG Strategy)

-Community Safety Plan 2019-2022

Appendix 3

Community and Equality Impact Assessment

As an authority, we have made a commitment to apply a systematic equalities and diversity screening process to both new policy development or changes to services.

This is to determine whether the proposals are likely to have significant positive, negative or adverse impacts on the different groups in our community.

This process has been developed, together with **full guidance** to support officers in meeting our duties under the:

- Equality Act 2010.
- The Best Value Guidance
- The Public Services (Social Value) 2012 Act

About the service or policy development

Name of service or policy	Joint Health & Wellbeing Strategy 2019-2021
Lead Officer Contact Details	Florence Henry, florence.henry@lbbd.gov.uk 020 8227 3059

Why is this service or policy development/review needed?
The Joint Health and Wellbeing Strategy 2019-2023 is a statutory strategy, and the current 2015-2018 strategy due to expire. The strategy will set out a renewed vision for improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives by 2023. The aim of the strategy to help residents to improve their health by identifying the key priorities based on the evidence from the JSNA 2017 and updated data from the JSNA 2018 focusing on three themes. The priorities in the document will underpin commissioning plans, and outline how the council and partners will work together to deliver the proposed priorities.

1. Community impact (this can be used to assess impact on staff although a cumulative impact should be considered).

What impacts will this service or policy development have on communities?
Look at what you know? What does your research tell you?

Consider:

- National & local data sets
- Complaints
- Consultation and service monitoring information
- Voluntary and Community Organisations
- The Equality Act places a specific duty on people with 'protected characteristics'. The table below details these groups and helps you to consider the impact on these groups.

Demographics

Barking and Dagenham has a young and diverse population of around 21,700 residents in a densely populated urban location. The equivalent of around 1 in 12 residents left and entered the borough between 2016 and 2017. Estimates suggest that as of 2019, 47% of Barking and Dagenham's population will be white, 23% black, 23% Asian, 5% Mixed and 2% other.

Barking and Dagenham performs poorly in a variety of health indicators. LBBD residents live shorter lives in poor health when compared to London – Barking and Dagenham has the lowest life expectancies in London for both women and men. Male healthy life expectancy, the years lived in good health, in LBBD is 58.2, compared to the London average of 63.5 years. Female healthy life expectancy in LBBD is 58.5 years, compared to the London average of 64.1 years. Barking and Dagenham also the highest rates of Year 6 obesity.

The Joint Health and Wellbeing Strategy focuses on three priority areas, which have been decided on by Health and Wellbeing Board. The Joint Strategic Needs Assessment 2018 has also focused on producing in depth data around these three themes:

1. *Best Start in Life,* focuses from preconception up until the age of 5. This theme aimes to give our residents healthy pregnancies and the best platform to grow, develop and explore in the first 5 years. Evidence demonstrates that the first 5 years shape mental and physical health for the rest of life, and is therefore a key time to invest.

As outlined in our 2018 Joint Strategic Needs Assessment, we have the highest proportion of residents aged 0-4 in the UK. Our 2017 birth rate was also the highest in England and Wales at 82.56 live births per 1000 women between the ages of 15 and 44.

As part of the Index of Multiple Deprivation, the income deprivation of children measures the proportion of children under the age of 16 that live in low income households. Barking and Dagenham has the eleventh highest proportion of children under the age of 16 living in poverty in England, and the fourth highest in London with 32% of children in the borough living in poverty.

2. *Early Diagnosis and Intervention:*

Early diagnosis and intervention increases the chances for successful treatement across a range of diseases and illness. The borough runs a number of screening programmes in partnership with the NHS – the JSNA 2018 outlines the borough context surrounding the borough's screening programmes:

- We have the highest rate of deaths from cancer considered preventable in London
- We have the third highest prevalence of chronic obstructive pulmonary disease (COPD) in London
- We have the third highest proportion of late HIV diagnoses in London

3. *Building resilience*

By resilience, we mean empowering residents to not just survive, but to thrive.

Whilst resilience of residents is hard to measure, we know that outcomes for our residents are towards the bottom of most London league tables in key areas. We also know that these areas such as employment skills and enterprise, and domestic violence have huge impacts on resilience. Barking and Dagenham has a higher unemployment rate than the London average – 6.9% of working age people unemployed compared to the London average of 5.7% and the highest recorded incidents of Domestic Violence in London.

Within the building resilience theme of the strategy, there is a focus on Adverse Childhood Experiences. This is because evidence demonstrates that those who suffer from 4 or more Adverse Childhood Experiences, are more likely to have higher GP use, greater use of

emergency care and increased hospitalisation, and are over twice as likely to have a range of health conditions including heart disease, cancer and COPD.

Further data on these three themes can be found within the 2018 Joint Strategic Needs Assessment.

Potential impacts	Positive	Neutral	Negative	What are the positive and negative impacts?	How will benefits be enhanced and negative impacts minimised or eliminated?
Local communities in general	X			The Health & Wellbeing Strategy will improve the health of populations within Barking and Dagenham by focusing on the health inequality interventions that have the biggest potential for impact. The strategy will not take a life course approach as has been taken in previous years, but will address age, disability and specific groups within each theme of the strategy.	We have made the effort to include local communities in the co-production of the strategy, through the creation of 'I' statements through resident focus groups. Through Healthwatch, we are speaking to three specific user groups to formulate these 'I' statements: -Mental health service users -Older people -Younger people These will ensure that the different experiences of different age groups are included. We are also consulting with parents of disabled children, Just Say Yes and disabled youth groups in the borough to formulate I statements to ensure that those with disabilities are represented. The data update included in part of the strategy, also includes data on all equality groups. This data will then form the basis of workshop discussions, detailing the actions taken in the strategy, to ensure that the views of equality groups are represented in the actions outlined in the strategy. The workshops will operate a life-course approach, ensuring that issues affecting each age group are discussed.
Age	X				
Disability	X				

Gender reassignment		X			We have consulted with LGBT+ Flipside and ran a focus group to co-produce these 'I' statements, to include the views of those who have undergone gender reassignment.
Marriage and civil partnership		X			
Pregnancy and maternity	X			One of the themes of the Health and Wellbeing Strategy is best start in life, focusing from pre-natal through to the age of 0. This focus on pregnancy and childbirth will mean that have positive impacts on women's pre-natal and perinatal health and wellbeing. Barking and Dagenham has the highest birth rate in England and Wales, making this a key area to focus on.	Parent forums within children's centres have been consulted through resident focus groups. Medical professionals from the CCG with expertise in prenatal and perinatal attended our Best Start in Life professional workshop in July, and have also been consulted through engagement with the Joint Executive. One of the table groups for discussion at the 'Best Start in Life' workshop in July focused entirely on pregnancy and maternity to ensure that there was a discussion on this within the strategy.
Race (including Gypsies, Roma and Travellers)		X			The data update included in part of the strategy, also includes data on all equality groups where available. This data then formed the basis of workshop discussions, detailing the actions taken in the strategy, to ensure that the views of different races are represented in the actions outlined in the strategy.
Religion or belief		X			The data update included in part of the strategy, also includes data on all equality groups where available. This data will then form the basis of workshop discussions, detailing the actions taken in the strategy, to ensure that the views of different races are represented in the actions outlined in the strategy. To ensure that the views of different faith groups are accounted for and represented in the Health and Wellbeing Strategy, we sent out a message in the Faith Leaders newsletter asking if they would be

					willing for us to hold a focus group to formulate "I" statements which are included within the strategy
Gender		X		Overall, women in the borough live longer with their life expectancy 81.8 years, compared to the male 77.5 years. However, they live more years in ill health with their health life expectancy, the years lived in good health, at 58.5, compared to the male 59.8 years, whereas the London average has the Healthy Life Expectancy for both genders at 64.1 years. Therefore women in the borough live more of their life in ill health than the London average. . The aforementioned focus on pregnancy and maternity through best start in life will have positive impacts for women. The 2017 schools survey also shows that female year 10 students perform worse in every indicator of emotional well-being. However, locally, the percentage of girls at the age of 5 achieving a good level of development is higher than boys –	The data used in the Joint Strategic Needs Assessment 2018, which informs this strategy, looks at both genders where this data is available. Given the onset of postnatal depression, and the dipropionate affect this has on women, we ran a focus group in the borough's Mental Health Peer Support Network's drop in women's coffee morning.

				78.8% compared to 67.8%, and therefore the Health and Wellbeing Strategy's focus on best start in life will have positive impacts for boys in the borough.	
Sexual orientation		X			To ensure that the views of LGBT+ communities are accounted for and represented in the Health and Wellbeing Strategy, ran focus group with Flipside LGBTQ+ members to formulate "I" statements to be included in the strategy. The leaders of Flipside LGBTQ+ also were invited to the professional Stakeholder workshop
Any community issues identified for this location?		X			

2. Consultation.

Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups?
The strategy has a strong consultation element. We have consulted with: • Children's commissioning • Adult's commissioning • CCG • Participatory City • Inclusive Growth • Community Enterprise Team • Strategy & Performance Team • Community Solutions • NHS partners • Drug and alcohol team • Domestic Violence Team • Cultural Educational Partnership • CVS • B&D Carers • Faith groups • Parks commissioning team In order to create 'I' statements to include in the strategy, through-out May and June, we ran a series of resident focus groups. These focus groups will explore what is important to residents in regard to their Health and Wellbeing, and the results of these focus groups will be used to create 'I' statements for each theme in the strategy, that providers will be held accountable against. Focus groups have been arranged with in May and June: • Carers of Barking and Dagenham • CVS • BAD Youth Forum • LGBTQ+ Flipside • Children's Centres' Parents Forums • Community Health Champions • HealthWatch Service User Groups • Patient Engagement Forum • Mental Health Peer Support Group • Mental Health Patient Engagement Forum • Streetwise • CGL In total, 128 residents attended 12 resident focus groups.

Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups?
A wide-range of organisations have been contacted to arrange these focus groups. We also held 3 professional workshops in July with internal and external stakeholders, and NHS CCG partners to discuss each theme of the strategy. The attendance at each workshop was as below: *1. Best start in life – 4h July – 27 attendees* *2. Early diagnosis and intervention – 9th July – 21 attendees* *3. Building resilience through prevention – 18h July – 41 attendees* We are also running an 8 week online week consultation to gain views on the draft strategy before publishing the strategy.

3. Monitoring and Review

How will you review community and equality impact once the service or policy has been implemented?
*These actions should be developed using the information gathered in **Section1 and 2** and should be picked up in your departmental/service business plans.*

Action	**By when?**	**By who?**
To monitor the outcomes of the strategy on a quarterly basis in a performance report to Health and Wellbeing Board	Quarterly	Health and Wellbeing Board
To produce an Annual Monitoring report to Health and Wellbeing Board on the 'attitudes' elements of the measures, which are only available on an annual basis	Annual	Health and Wellbeing Board

4. Next steps

It is important the information gathered is used to inform any Council reports that are presented to Cabinet or appropriate committees. This will allow Members to be furnished with all the facts in relation to the impact their decisions will have on different equality groups and the wider community.

Take some time to précis your findings below. This can then be added to your report template for sign off by the Strategy Team at the consultation stage of the report cycle.

Implications/ Customer Impact
The strategy outlines the council's commitment to improve health and wellbeing in the borough, by focusing on three priority areas: 1. Best Start in Life – preconception up to the age of 5 2. Early Diagnosis and Intervention 3. Building resilience through prevention to achieve better health and wellbeing The strategy will have positive impacts for the community. Through co-producing resident focused 'I' statements with residents through focus groups, the council has taken extra effort to create the strategy for improving health inequalities based around what is important to residents. The strategy also details 6 outcomes, which outline what we want to achieve to make improvements in each of these areas. Once the strategy is approved by Health and Wellbeing Board, we will be doing work with the Alliance of Providers and Commissioners to create the detailed delivery plans that will deliver the outcomes in this document.

5. Sign off

The information contained in this template should be authorised by the relevant project sponsor or Divisional Director who will be responsible for the accuracy of the information now provided and delivery of actions detailed.

Name	Role (e.g. project sponsor, head of service)	Date
Matthew Cole	Director of Public Health	10-Oct-18

HEALTH AND WELLBEING BOARD

7 November 2018

Title:	**Ending Violence Against Women and Girls Strategy 2018 – 2022**
Report of the Director of People and Resilience	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Hazel North Stephens Domestic Abuse Commissioner	**Contact Details:** Tel: 020 8227 5969 E-mail: hazel.northstephens@lbbd.gov.uk
Sponsor: Elaine Allegretti, Director of People and Resilience, LBBD	

Summary:

The four-year Ending Violence Against Women and Girls Strategy 2018 - 2022 has been presented at the Violence Against Women and Girls sub group of the Community Safety Partnership, and the Community Safety Partnership for consultation, and their comments have been incorporated. It has been developed through stakeholder workshops, survivor engagement and testimony and supported by the Delivery Unit who undertook a priority review specific to domestic abuse.

The strategy content has been agreed by the Corporate Strategy Group with status as an interim strategy considering the developing Health and Wellbeing Strategy.

The Strategy is now being presented to the Health and Wellbeing Board, who are invited to comment further and to recommend the Strategy for final approval.

Recommendation(s)

The Health and Wellbeing Board is invited to:

(i) Comment on the strategy;

(ii) Recommend the adoption of the strategy subject to any amendments requested; and

(iii) Recommend that partner organisations also take the steps necessary to formally adopt the strategy through their organisational arrangements.

Reason(s)

The Strategy sets out four priorities that have been agreed following consultation with local stakeholders including statutory services, voluntary and community sector groups, and with survivors. Delivery of these priorities would support the Borough Manifesto, Health and Wellbeing Strategy and the Corporate Plan in their vision to tackle domestic abuse.

1 Introduction and Background

1.1 Domestic and sexual violence is so widespread and prevalent that it can affect any person from any back ground.

1.2 The London Police and Crime Plan 2017-2021 sets VAWG as a clear priority and a refreshed London VAWG strategy was published in early 2018. The level of recorded violence against women and girls in London is increasing with 1 in 10 crimes recorded by the Metropolitan Police being domestic abuse related.

1.3 Key stakeholders expressed the need to move to a Violence Against Women and Girls approach which acknowledges how crimes such as domestic and sexual abuse affect women and girls disproportionately.

1.4 Domestic violence and abuse have been a longstanding problem for Barking and Dagenham. According to figures from the Metropolitan Police Service (MPS), Barking and Dagenham has consistently had the highest recorded rate of domestic abuse for the last 10 years compared to other London boroughs. Prevalence is reportedly 23 incidents per 1000 of the population

1.5 During 2017/18 there were over 1700 referrals to children's social care for domestic abuse alone. There were 390 referrals for other forms of violence against women and girls such as female genital mutilation, forced marriage, stalking, sexual abuse and sexual exploitation.

1.6 Of reported domestic abuse incidents to the local police, 76% are reported by women and 24% by men. Many victims who are men are still experiencing violence from another man or men, for example in gay relationships or from male family members.

1.7 The Violence Against Women and Girls Strategy has been presented at the Corporate Strategy Group and the Community Safety Partnership Board. Following Health & Wellbeing Board approval the strategy will be published.

2 Proposal and issues

2.1 The strategy highlights four priorities which have been agreed through various consultations. They are:

- Support Survivors
- Educate and Communicate
- Challenge Abusive Behaviours
- Include Lived Experiences

2.2 The purpose of the strategy is to ensure that continued investment in domestic abuse support services continues in order for provision to be the most effective and relevant it can be.

2.3 The strategy requires investment from across the council and the local partnership in order for it to be effective and influence change.

2.4 An action plan, which will dictate future work in this area, will be monitored at the

VAWG Sub Group of the Community Safety Partnership.

3 Mandatory Implications

3.1 Joint Strategic Needs Assessment

The strategy compliments the identification of need and the priorities for future action described in the JSNA, specifically section 3.5.8 Domestic Abuse. The JSNA highlights the need to commit to taking a family-based approach to deal with domestic violence, abuse and child sexual exploitation. It also demonstrates the link between Adverse Childhood Experiences such as abuse or domestic violence and multiple health risk factors and poor health outcomes in adulthood.

3.2 Health and Wellbeing Strategy

The VAWG strategy supports the 3 priorities from the Health and Wellbeing Strategy, namely to ensure the best start in life, early diagnosis and intervention and resilience. The VAWG commissioning plan will incorporate the priorities to ensure that support services embrace local intentions.

3.3 Integration

The strategy encourages the integrated approach to commissioning and planning of domestic abuse support provision, that incorporates a whole system approach across the partnership within the borough. It also sets out aims around bringing together sources of intelligence which will enable joint decision-making around VAWG interventions, based on wide-ranging evidence.

4 Financial Implications

Implications completed by Olufunke Adediran, Group Accountant:

4.1 This report is mainly for information and sets out to assist the Health and Wellbeing Board to make relevant recommendations for the adoption of the Council's 'Ending Violence Against Women and Girls' Strategy. As such there are no financial implications arising directly from the report.

5 Legal Implications

Implications completed by Dr. Paul Feild, Senior Governance Solicitor

5.1 It is a key role of the Health and Well-Being Board function to ensure that the providers of health and social care services work in their delivery in an integrated manner. There is close working with the Barking and Dagenham Community Safety Partnership which has a strategic priority sub-group ((VAWG) sub-group) set up to take action to prevent violence against women and girls. This strategy, and its commitments will be the responsibility of the sub-group which will also link with the Health and Wellbeing Board and the safeguarding boards to ensure that the response to violence against women and girls is robust, representative of need and well understood across all other priority areas. The VAWG sub group is Chaired by the Borough Director for NELFT.

5.2 There has been several significant legal measures taken to tackle the scourge of

VAWG, both criminal and civil. Civil having a lower burden of proof and of use where there is difficulty in obtaining evidence from victims. Domestic Violence Protection Orders are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

5.3 Significant new criminal legislation is now in place including specific offences of stalking, forced marriage, failure to protect from Female Genital Mutilation (FGM), and revenge pornography, as well as the new domestic abuse offence to capture coercive or controlling behaviour in an intimate or family relationship. Furthermore, there is are FGM Protection Orders and an FGM mandatory reporting duty. In 2015 the Government introduced the Modern Slavery Act and rolled out (DVPOs) and the Domestic Violence Disclosure Scheme (DVDS) nationally and strengthened measures to manage sex offenders or those who pose a risk of sexual harm.

6 Risk Management

6.1 Through approaches to service commissioning, there are mechanisms for ensuring that the risks around individuals who have experienced domestic abuse in any form are managed, jointly as necessary with the systems in place for perpetrators of domestic abuse.

6.2 In terms of the delivery of the Strategy and its action plan which is to follow, the VAWG CSP sub group will have in place a risk management system to ensure that delivery remains on track and remedial action can be taken as necessary.

7 Patient / Service User Impact

7.1 The strategy sets out clear commitment to work with residents directly to improve accessibility and visibility of services. Survivor voice is a key element to improving the experiences of service users through specialist commissioned services. The impact of this strategy should be positive, with an emphasis put on working with survivors holistically and through an understanding of the importance of their identity.

7.2 The focus on community led campaigns will ensure that early help seeking with friends and family is validated, and that survivors are able to come forwards earlier in their experiences.

7.3 A zero-tolerance approach to perpetrators of abuse, and a recognition that in order to impact change we need to work with people who are using violence should help tackle repeat victimisation specifically, having a further positive impact on service users.

7.4 The priorities in the strategy are designed to raise the profile of violence and abuse, empower communities to identify and respond to it early on and to see improvements in the support provided to service users.

8 Non-mandatory Implications

Crime and Disorder

8.1 Domestic and sexual violence impacts on many other types of crime and is correlative with all types of violent crime, anti-social behaviour and offending. There are clear correlations with child sexual exploitation, criminal exploitation and youth violence.

8.2 Under the Community Safety Partnership work is taking place to design preventative approaches to tackling violent crime, including domestic and sexual violence which is underpinned by trauma informed ways of working, and recognising the damaging impacts of childhood adversity.

8.3 These implications have been extensively reviewed by the Community Safety Partnership in their approval of the strategy.

9 Safeguarding

9.1 Domestic and sexual violence presents a range of behaviours that pose a risk to the individuals themselves and others around them and can give rise to a range of safeguarding concerns.

9.2 The strategy recognises the impacts of domestic violence on children in the home and recommends working closely to support the victim to safeguard their children, whilst tackling the risk: the perpetrator. Working with the whole family provides a framework to reduce risk, reduce the use of abusive behaviours, and to address trauma experienced by the victim and children.

9.3 The borough's systems for reporting and investigating both adult and child safeguarding concerns have established links to specialist support services, and the Strategy recognises the need for commissioning interventions to continue to foster these links and provide training for those involved in safeguarding.

Public Background Papers Used in the Preparation of the Report: None

List of Appendices:

Appendix A Barking and Dagenham Ending Violence Against Women and Girls Strategy, 2018 – 2022

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Ending violence against women and girls:

A gender-informed strategy to tackle domestic and sexual violence

2018-2022

London Borough of Barking & Dagenham

lbbd.gov.uk

Ending violence against women and girls | 2018 - 2022

Vision

Domestic and sexual violence has severe long-lasting and wide-ranging social, health and economic impacts in Barking and Dagenham. The costs are high to individuals, families, to our community, and to services. Therefore, the Borough Manifesto sets out a clear target to reduce domestic abuse.

We understand that domestic abuse is rarely experienced in isolation; it is often experienced alongside other forms of violence, which is set out in international law as Violence Against Women and Girls. We will adopt a violence against women and girls approach to tackling domestic and sexual violence to improve outcomes for women and girls, and men and boys.

Our ambition is to improve social, economic and health outcomes to survivors by working with communities to prevent violence happening in the first place and to improve early help seeking by building resilience. Resilience is not about individuals being able to cope with violence and abuse on their own. It is about increasing the internal resources and protective factors of families, communities, and local networks to recognise when it is happening, respond appropriately and challenge abusive behaviours. This will relieve pressure on overstretched services, still ensuring survivors are able to access the type of support that works for them and helping us to get it right first time.

This strategy sets out the main pieces of work taking place 2018-2022 but is underpinned by work towards a whole system approach where tackling violence against women and girls is seen as everybody's business.

Contents

Ending violence against women and girls | 2018 - 2022

Strategy on a Page

Vision
Violence and abuse has severe long-lasting and wide-ranging social, health and economic impacts in Barking and Dagenham. Our response is to work towards a whole systems approach to tackling it. We want survivors to have early access to supportive services that can help keep them and their families safe. We want to disrupt the normalisation of violence through robust preventative approaches and we want to improve the resilience in individuals, families and communities so that we can work together in getting it right first time.

Context and strategic framework
- Barking and Dagenham has a high prevalence rate of reported domestic abuse – 23 incidents are reported per 1000 of the population.
- In 2017/18 there were 2093 referrals to children's social care for domestic and sexual violence against women and girls.
- A gender informed approach is required to improve outcomes for women and girls, men and boys, and for people who identify outside of the gender binary.
- As London's growth opportunity we anticipate dynamic population growth and change, and this will impact how we design services to reflect local need, but it also offers us opportunities to seek out funding through social capital.
- Our young population offers us clear opportunity to tackle the high acceptance of abusive behaviours early.

Engagement, consultation and co-production
- Domestic and sexual violence is so widespread and prevalent that it can affect any person from any back ground.
- Survivors have told us we need to work on the normalisation of abusive behaviours, raise awareness and educate young people.
- Self-disclosure is often traumatic, and survivors have told us that responses need to be more empathetic, compassionate, and that they should be believed when they have the courage to come forwards.
- Survivors have told us they need more support with housing, children's social care and criminal justice processes.

Priority 1: Support Survivors
Outcomes:
- Improved effectiveness and efficiency through services
- Reduction in repeat victimisation
- Reduced levels of high risk cases
- Increased confidence in services
- Improved joined up response to survivors

Target:
- Reduction in repeat victimisation through police reporting

Priority 2: Educate and Communicate
Outcomes:
- Reduction in victimisation and repeat victimisation Improved resilience in individuals, families, and communities.
- Reduced socioeconomic costs related to VAWG
- Disruption of the normalisation of violence.

Target:
- Decreased percentage of young people reporting an acceptance of abusive behaviours through the biennial school health survey

Priority 3: Challenge Abusive Behaviours
Outcomes:
- Reduction in repeat offending
- Reduction in victimisation and repeat victimisation
- Reduction in risk to children and survivors where families choose to remain together

Target:
- An increased conviction rate through the criminal justice system.

Priority 4: Include Lived Experience
Outcomes:
- Earlier positive engagement with survivors
- Services are designed to work towards positive outcomes as set by survivors
- Services are cost effective as a result of being more visible, accessible and responsive to the needs of survivors.

Target:
- Improved engagement rate through specialist advocacy services

Context

Violence Against Women and Girls (VAWG) is recognised in international law as a violation of human rights, that has severe and lasting impacts on victims, from the cradle to the grave. In 2016 the UK government published a VAWG strategy for parliament, highlighting the huge impacts on our economy, health services and criminal justice system. The Femicide Report published in December 2017 by Women's Aid revealed that 113 women were killed by men in England, Wales and Northern Ireland in 2016, 90% of which knew the man who murdered them as a current or former intimate partner.

The London Police and Crime Plan 2017-2021 sets VAWG as a clear priority and a refreshed London VAWG strategy was published in early 2018. The level of recorded violence against women and girls in London is increasing with 1 in 10 crimes recorded by the Metropolitan Police being domestic abuse related. In the year to September 2017 there were 18,757 sexual offences reported to police; a 9.4% increase on the previous year.

In Barking and Dagenham, there is a high prevalence rate of domestic abuse understood locally, and this is a clear demand driver for services. The Barking and Dagenham Borough Manifesto sets a clear target to reduce the number of incidents of domestic abuse to the East London average. However, recent priority reviews have highlighted the limitations of using police reporting to understand local prevalence and makes it clear that steps towards positive change may increase reporting as more people are supported to come forwards.

We know that in the financial year 2017/18 there were over 1700 referrals to children's social care for domestic abuse alone. There were 390 referrals for other forms of violence against women and girls such as female genital mutilation, forced marriage, stalking, sexual abuse and sexual exploitation.

In the short term, there continues to be demand for specialist support and interventions to assist survivors with navigating the criminal justice system, social care, housing, employment, and support for their emotional wellbeing. Historically, the Borough has provided advocacy services, which are effective ways of supporting people experiencing violence against women and girls to access practical support to increase their safety. Going forwards there is a need to improve service delivery to be more trauma-informed to improve outcomes for survivors.

In the long term, we need to develop preventative approaches for sustainable positive change. Our young population offers us clear opportunity to tackle the high acceptance of abusive behaviours early. Our resident community groups and local voluntary sector offer opportunities to tackle the normalisation of abuse locally, develop recognition of abusive behaviours and improve prospects for validating survivor's experiences to assist with their help-seeking.

Definitions

Domestic violence and abuse is defined by the Home Office as:

Any incident or pattern of incidents of controlling and/or, coercive behaviour, violence, or abuse between those aged 16 or over who have been intimate partners or family members regardless of gender or sexuality.

This can encompass but is not limited to the flowing types of abuse: psychological, physical, sexual, financial, and emotional.

Controlling behaviour is a range of acts designed to make a person subordinate and/ or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for in-dependence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten, their victims.

Violence Against Women and Girls is defined within the United Nations Declaration on the Elimination of Violence towards Women (1993, Article 1) as:

'Any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women [or girls], including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'.

Strands of violence against women and girls include:

- Domestic Violence and Abuse
- Sexual Violence (including rape)
- Stalking
- Prostitution and Trafficking
- Sexual Harassment
- Female Genital Mutilation
- Forced Marriage
- So called 'Honour' Based Violence
- Sexual Exploitation (including Child Sexual Exploitation)
- Faith Based Abuse

Strategic Framework

The Borough Manifesto sets domestic abuse as a priority. Barking and Dagenham is currently recorded as having the highest prevalence rate of domestic abuse incidents reported to the police in London – 23 per 1000 of the population. A priority review on domestic abuse, delivered by the Council's Delivery Unit highlighted the limitations with using recorded reporting as representative of the true prevalence of domestic abuse. The Crime Survey for England and Wales clearly demonstrates that around 80% of victims do not report to the police.

The Council's Corporate Plan sets out that the implementation of Community Solutions – a new approach to working with residents and empowering them to change their lives – will help tackle the complex challenges facing the borough, including domestic abuse. A strategy to tackle domestic and sexual violence in the Borough is a key commitment in the plan. This strategy has been developed in partnership with local stakeholders including statutory services, voluntary and community sector groups, and of course, with survivors. There has been appetite from across the key stakeholders to move to a Violence Against Women and Girls approach which acknowledges how crimes such as domestic and sexual abuse affect women and girls disproportionately.

Adopting a VAWG approach provides the framework to move towards a local understanding that is gender informed, recognising the way gender and identity impact experiences of violence. It provides the basis for open dialogue that informs service development and delivery and examines the needs of all people experiencing domestic and sexual violence. All people can experience violence and abuse, and a gender informed approach to service design and delivery creates improved outcomes for women and girls, men and boys.

The Barking and Dagenham Health and Wellbeing strategy highlights domestic abuse as a demand driver for social care referrals. The strategy also communicates the impact domestic abuse has on children throughout their lives and draws attention to the importance of a good start in life – an area drastically impacted by violence against women and girls.

Barking and Dagenham's Equality and Diversity Strategy demonstrates an ethnically diverse and young population. Despite the borough's strong historical record of advancing equality, particularly regarding women's rights and suffrage, the people in Barking and Dagenham are more deprived, die earlier, have poorer health and lower education and skills than in most other London Boroughs. These are all indicators that are correlative with violence against women and girls.

Barking and Dagenham is the main growth area in London over the next 20 years. Our status as an East London Growth Borough combined with our high proportion of children and young people offers both challenges and opportunities in the coming years.

As the borough changes there is likely to be changes in the socioeconomic and demographic make-up of our residents. This will bring challenges around ensuring the diverse and changing needs of survivors are met. Integrating work to tackle violence against women and girls provides the context for shaping how services respond to the crossover between the different strands of violence against women and girls.

Child sexual exploitation is regarded as a strand of violence against women and girls. This strategy is directly linked to the Barking and Dagenham Child Sexual Exploitation strategy 2018-2021. Specific work to link the two strategies will focus on a review of commissioned services for young people affected by domestic and sexual violence, and work to develop and implement a transitional pathway for young people at risk of or experiencing domestic and sexual violence so that they are adequately supported as they move into adulthood.

Vision & Priorities/ Themes

Domestic and sexual violence has severe long-lasting and wide-ranging social, health and economic impacts in Barking and Dagenham. The costs are high to individuals, communities and to services. Therefore, the Borough Manifesto sets out a clear target to reduce domestic abuse.

We understand that domestic abuse is rarely experienced in isolation; it is often experienced alongside other forms of violence, which is set out in international law as Violence Against Women and Girls. We will adopt a violence against women and girls approach to tackling domestic and sexual violence to improve outcomes for women and girls, and men and boys.

Our ambition is to improve outcomes to survivors by working with communities to prevent it happening in the first place and to improve early help seeking by building resilience. Resilience is not about individuals being able to cope with violence and abuse on their own. It is about increasing the internal resources and protective factors of families, communities and local networks to recognise when it is happening, respond appropriately and challenge abusive behaviours. This will relieve pressure on overstretched services and strengthen community resilience ensuring survivors are able to access the type of support that works for them and will tackle the normalisation of abusive behaviours.

Priorities or Themes

The culmination of desk-based research, engagement and consultation led to the identification of four key priorities for the strategy.

Support Survivors

Survivors identified the need for practical support early in their experiences and we know that successful help seeking requires a response that is empathetic, compassionate, and validating. We want survivors to have access to trauma-informed specialist support, and we also want to ensure non-specialist services, whether statutory or non-statutory adopt the same level of understanding. If we get it right first time, we will be able to tackle repeat victimisation. It will help ensure that survivors and their families are safe, and that they are able to move forwards with their lives.

Educate and Communicate

We want to see Barking and Dagenham as a place where open dialogue is encouraged and helps raise awareness of violence against women and girls across the population. We want to engage children and young people with trauma-informed approaches to break the cycle and end the intergenerational transmission of violence. We recognise that this is a long-term approach to tackling violence and abuse. This needs to be delivered alongside a communications plan that includes collaboration with different community groups to improve recognition of abusive behaviours locally, support early help seeking, and to avoid a top down approach. By educating our young people, and openly communicating with our adult community groups about abusive behaviours we can best work towards long term sustainable change.

Ending violence against women and girls | 2018 - 2022

Challenge Abusive Behaviours:

We want people who are perpetrating violence against women and girls to be held to account and to stop being abusive. However, we can see that the number of perpetrators held to account through the criminal justice system is minimal. The Crime Survey of England and Wales demonstrates that approximately 3.6% of perpetrators of domestic abuse end up with a conviction. Therefore, we need to disrupt perpetrators abusive behaviours through criminal justice where possible, but we also need to support them to change through community interventions.

Include Lived Experiences:

We are fully committed to including lived experience from people from different backgrounds and identities in all aspects of strategic commissioning, service design and delivery. We recognise that there are limitations with data indicators and value survivors as experts in their own recovery. Co-production with survivors will help us shape and improve outcomes for future survivors. By understanding the lived experiences of people using violence we can improve understanding of what is needed to stop them using violence.

Priority 1: Support Survivors

Experiencing violence or abuse of any kind is traumatic. Multiple or complex traumatic incidents have severe and lasting impacts on a person's physical and mental health needs, their behaviour, and interpersonal capabilities. It also has a massive impact on cognition and can negatively affect the person's ability to process what is happening to them, to think logically, forward plan or problem solve. The impact on cognition can also leave the person with no sense of continuity and time, disrupting memory recall.

Survivors need trauma-informed practical support to help them make sense of what has been done to them, to navigate services and systems such as the criminal justice system, children's social care, housing, and employment. Support services needs to be independent and specialist to mitigate the barriers of engaging with statutory services. If support services are not trauma-informed and advocacy is not self-determined, then we risk a survivor not engaging and we continue to disempower the them. This further perpetuates their victimisation.

To deliver this, we need to develop a commissioned specialist support service that can work to a trauma-informed approach. We also need to ensure that statutory services can communicate in the same language as the specialist services and are able to recognise trauma and work with people experiencing trauma reminders. They too are responsible for supporting survivors through their services, and this is particularly relevant for Community Solutions housing services and children's care and support. Community Solutions offers us an opportunity to improve access to all local services. Local support programmes around employment, education, and training are particularly relevant. For survivors of violence and abuse, not having access to financial resources or not being able to budget can be an enormous barrier to leaving their perpetrators or living independently. We can work to improve employability prospects that many of us take for granted.

The output for this priority will be the development of a specialist support service that can offer advocacy and practical guidance as well as therapeutic interventions for people experiencing the violence against women and girls strands. Survivors will receive practical and therapeutic support in a trauma informed way to assist with navigating their physical and mental health needs, safety and security needs such as housing and employment, support through social care and criminal justice processes. Additional outputs will include regular focus groups and service user surveys to ensure lived experience continues to inform service delivery across the borough.

In addition to specialist advocacy support the Council commits to the ongoing provision of refuge accommodation for women fleeing domestic and sexual violence. This includes 13 bed spaces with six month move on and will continue to build on the excellent working relationship had with Community Solutions, which is able to assist women move on into appropriate permanent accommodation.

This will lead to short and long-term outcomes. Improved support to survivors will lead to better retention through services and reduced repeat victimisation. Over time, this will lead to reduced service demand, including reduced number of children taken into local authority care and reduced socioeconomic costs associated with violence against women and girls.

The target for this priority is a reduction in repeat victimisation through police reporting. In September 2017, the repeat victimisation rate for domestic abuse was 28% of all domestic abuse cases. The total number of repeat case victims for the same month was 138. This priority will be further supported through the measurement of repeat cases through MARAC and specialist services, in order to build the context for need across the borough.

This requires funding, which is committed by the Council through Public Health Grants, General Fund, Housing revenue account allocations and through allocations from the MOPAC London Crime Prevention Fund. The recommissioning of services is due for Summer 2019 and specification building will be informed by priorities set out in this strategy.

We recognise that as more people feel re-empowered to seek support we are likely to see short term outcomes that increase reporting of incidents to police which conflicts with the Borough Manifesto target to reduce recorded incidents. However, we would expect to see this number decrease over time.

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Priority 2: Educate and Communicate

A plan to create long term sustainable change must be preventative in nature, working with young people to break the cycle of intergenerational transmissions of violence whilst simultaneously challenging the existing cultural scaffolding that upholds the normalisation of violence.

To seek long term sustainable change, we will support work being undertaken across the Community Safety Partnership, Safeguarding Boards and Health and Wellbeing board to develop a trauma-informed health intervention model to address adverse experiences in children and young people. This links with Priority 1 and will include wraparound support for the family and the young people to encourage the development of emotional intelligence and resilience in individuals and improve their support networks. We need to educate our young people to recognise abusive behaviours and be able to seek help when they experience or use them.

Education does needs to be targeted towards our young residents but should also include a comprehensive training and awareness raising programme for local professionals. Buy-in from across the partnerships and boards is important to ensure all services receive the same quality of training and can work consistently to provide support to survivors. This will include how to recognise and work with perpetrators. This work will be supported through domestic abuse operational forum membership, as all members have knowledge to share.

Awareness campaigns will be designed in collaboration with community groups to ensure messages are strong and appropriate. By linking with resident-led initiatives, we can avoid a 'top-down' approach and be led by the needs of our residents, working in partnership to address the normalisation of abusive behaviours in the borough.

To deliver this, we need to have an education and communications plan in place with clear goals for the life of the strategy. This will include a training offer targeting services as well as community and resident's groups. It will support the development of a trauma-informed health intervention model to tackle the adverse childhood experiences and improve health indicators for young people. The final output will be a community campaign programme in which local community groups are encouraged and funded to run campaigns about domestic and sexual violence.

This will bring positive outcomes. Survivors validated in early help seeking will be more able to engage with offers of support earlier in their experience, lessening the likelihood of escalation to higher levels of risk and reducing repeat victimisation. Young people progressing into adulthood will be less likely to experience or use abusive behaviours, therefore disrupting the intergenerational transmission of violence. Improved resilience in individuals, families, and communities will lead to attitudinal shifts regarding the normalisation of violence leading to less violence against women and girls in the long term.

The target for this priority is to decrease the percentage of young people reporting an acceptance of abusive behaviours through the biennial school health survey. This will be supported through regular focus groups with young people and adults, which will be facilitated through commissioned services and the trauma informed health intervention model. The target is chosen to measure the acceptance level of types of abusive behaviour rather than one strand of violence against women and girls.

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The baseline data for this target is from the 2017 Barking and Dagenham School Survey report in which several abusive behaviours are listed, and the young people asked which were always wrong in a relationship. 38% of students surveyed said that abusive behaviours were not always wrong. Working with this target is difficult – the survey is completed every other year. However, there is scope to include the targets from the trauma-informed health intervention model to support our understanding of how accepting young people are in relation to domestic abuse behaviours.

Resources include the recommissioning of support services to include a robust training offer, complemented by training available through voluntary sector projects. The communications plan will be supported through funds available for the International Day to Eliminate Violence Against Women and Girls campaign, and through the domestic abuse operational forum. The Community Safety Partnership are seeking resources through various funding opportunities for the health intervention model for young people.

This priority has links to the Borough Manifesto, Corporate Plan and Health and Wellbeing Strategy. It also links to the Crime and Disorder Strategic Needs Assessment produced by the Community Safety Partnership.

Priority 3: Challenge Abusive Behaviours

Less than 3.6% of domestic abuse perpetrators receive a conviction. This is even lower for other violence against women and girls strands. Survivors often feel 'punished' for being victims. They are told they need to move away, leave their jobs, move their children's schools, leave their support networks etc. We recognise the need for these actions, but we want to step away from the narrative where the perpetrator is free to go on to victimise another person and so we will take a zero-tolerance approach to tackling perpetrators of violence. Over the course of the 4 year strategy we will work towards a whole system approach to tackling violent perpetrators.

When we think of perpetrators, we tend to think of domestic abuse perpetrators and not perpetrators of sexual violence and exploitation, and harmful practices. To challenge all abusive behaviours and deliver against this priority, we need to consider community interventions that will engage with abusive behaviours, encouraging perpetrators to change. We need interventions that keep the perpetrator visible and accountable through child protection cases. The 2014 Ofsted Single Inspection of Barking and Dagenham Children's Services and LSCB commented that the lack of specialist programmes for perpetrators contributes to delays in some child in need and protection plans being progressed.

We are exploring how we can make better use of coercive and controlling behaviour legislation. Social care, health, community, and voluntary sector groups often hold information about cases which would form evidence in coercive and controlling behaviour trials. Precedent has now been set to use this evidence in court, taking the emphasis away from the survivor to give witness testimony. The use of criminal or civil orders to compel the perpetrator to stop returning to the family home also need to be better promoted.

The outputs for this priority are to develop a programme of engagement through one to one and group work for people using abusive behaviours against family or intimate partners. This should work closely with MARAC partners and integrate with Children's Care and Support to disrupt offending behaviour, address risk factors such as substance misuse, employment, housing and mental health needs and encourage the use of non-abusive behaviour alternatives. This will be balanced with work to improve victim experiences through the criminal justice process.

The expected outcomes for this priority include reduced victimisation and repeat victimisation, a reduction in risk to children and survivors where families choose to remain together, reduction in repeat offending and attitudinal shift towards survivors being able to remain in the family home (where safe to do so) which would reduce strain on stretched housing resources.

The target for this priority is an increased conviction rate through the criminal justice system. The baseline is 58% for domestic abuse with target to increase to 65% over the course of the strategy.

Limited resources exist within commissioning budgets to procure perpetrator programmes, but through working with partners and pooling funds and opportunities for joint working we can be innovative with how we commission community interventions to tackle perpetrators. This includes exploring opportunities to adopt models such as the DRIVE programme, or whole family approaches.

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This priority directly relates to the Borough Manifesto aim to see a reduction in domestic abuse, and to the Council's vision to enable social responsibility. Challenging abusive behaviours starts with challenging harmful attitudes to gender and gender roles. Please see the boroughs Gender Equality Charter.

Priority 4: Include Lived Experience

We include all people in our strategy to tackle violence against women and girls – and we recognise the diverse and unique needs and experiences of people from different backgrounds and identities.

We will improve local response by working collaboratively with survivors to understand and meet their needs. Their input has helped shape this strategy, and we commit to continuing to develop mechanisms for lived experience to inform strategic discussions and commissioning. We will work closely with survivors at various stages in their journeys, and from a wide variety of identities to co-design services.

To deliver this priority, we need to develop a structure for lived experience to inform all aspects of design and delivery and we will ensure that equality impact assessments are used for all projects. The output for this priority is to bring together a partnership for experience-based co-design of services. The group should collate experiences of the wider community through interviewing, group discussions and co-design workshops. We can do this by creating an advisory group that includes local survivors, local community and faith leads, and key stakeholders. This group should be part of the membership of the domestic abuse operational forum, which will create a clear framework of accountability through the violence against women and girls sub group to the Community Safety Partnership.

There have been structural changes in statutory services over 2017/18 including within the police, the council, probation, and health. The advisory group will create a space to highlight good work and raise concerns when necessary.

This work will also help with connecting various voluntary sector provisions together to ensure that survivors have access to holistic services and

early validation in their help-seeking. It will also support work with the Excel Women's Centre, the Muslimah Women's Association and London Sport to set up a Women's Activity Network, and work around employability for women, helping to address some of the wider socioeconomic and health inequalities affecting women and girls.

The outcomes for this priority will be improved confidence in commissioned services which are inclusive, accessible, and visible to survivor's requiring support. Services will be cost-effective as survivor's requirements are met more quickly and more effectively. Early access to support will decrease wider socioeconomic costs associated with violence against women and girls and outcomes for survivors and communities will be self-determined and based on an understanding of challenges that services are facing. In addition, there will be an improved understanding of violence against women and girls locally.

The target for this priority is an improved engagement rate through locally commissioned domestic abuse services. The baseline is 64% due to high numbers of survivors declining support when first referred.

Current resources include a well-attended domestic abuse operational forum and strong links with specialist voluntary sector services. Funding will be allocated for delivering workshops and this will include the need for incentives to encourage survivors at different stages of their journeys to take part.

This priority has a clear link to the Council's Equality and Diversity Strategy, in which engagement and consultation is a key theme.

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Lived Experiences

Naming Violence Against Women and Girls recognises that women and girls are predominantly impacted by violence and abuse at global, international, regional, and local levels. It pulls together types of crime that when viewed together provides a framework for understanding that violence against women and girls is both a cause of, and a consequence of gender inequalities. It is widely recognised that men can be victims of domestic abuse and other strands of violence such as forced marriage, sexual violence, and 'honour' based violence. However, women and children experience more domestic and sexual violence and their experiences are more likely to be higher risk than that experienced by men. Our response must be tailored accordingly.

Our vision and priorities have been influenced by what local survivors have told us, what we know through data and research analysis and by adopting an intersectional approach; by exploring how power hierarchies impact need within relationships, families, communities and within society. Violence against women and girls should be viewed through the lens of social inequality, which is upheld through the normalisation and acceptance of violence. The acceptance of abusive behaviours amongst our young people has been clearly evidenced through the Barking and Dagenham School Health Survey.

Work has been undertaken to look at diversity data through local specialist support services which are able to explore widely the representation of different groups. This has been cross-examined with national research and specialist organisations recommendations such as SafeLives, who provide recommendations for MARAC. Findings have shown that although the people accessing services are generally representative of the people living in the borough, there are some groups that remain under or overrepresented such as Lesbian, Gay, Bisexual and Transgender (LGBT) people, people from black and minority ethnic backgrounds and people with disabilities.

Data can only tell us so much. We have put a real emphasis on ensuring lived experience informs the development of this strategy, and this

is particularly relevant to ensure we are human-centred in our approach. Local data, national and international research has helped us shape an understanding of who we should expect to be impacted, but it is through open dialogue we can learn about how different people are affected, what challenges they have faced and what has helped them find safety and emotional wellbeing.

Specific groups face unique experiences of violence and barriers to accessing support:

Lesbian, Gay, Bisexual and Trans (LGBT) Experiences

The experiences of LGBT survivors of domestic violence and abuse rarely fit in to the public narrative of domestic abuse. The public narrative of intimate partner violence tends to follow a heterosexual and cisgender model of abuse, in which the privilege and power held by cisgender heterosexual men leads to the conclusion that perpetrators of domestic abuse are cisgender heterosexual men and that victims of domestic abuse are cisgender heterosexual women. This is reflected in various research publications as well as from what local LGBT groups have said to us.

Experiences may not always exist in the domestic sphere in terms of intimate and familial relationships but may include sexual exploitation, prostitution, and trafficking. Extended family abuse forced marriage and so called 'honour' based violence brings additional considerations for LGBT survivors. The notion of identity abuse may be unique to LGBT experiences of domestic abuse - when a survivors' sexuality or gender identity is used as a weapon to exert power and control over them.

The murders of four young gay men in 2015 in Barking were a stark reminder that we need to recognise the unique experiences of LGBT people and include the experiences of LGBT people in campaigns and service provision. One element that requires better understanding is the sometimes-transient nature of LGBT relationships – people may be more likely to move across boroughs or regions to meet with each other. Better understanding of the tools, particularly technology facilitated tools, used to meet each other is also required.

Experiences of black and/or minority ethnic (BME) people

Violence and abuse impacts people from all ethnic groups and there is no evidence to suggest that a person from one ethnic or cultural group is any more at risk than a person from another group. However, violence and abuse may be experienced differently. The experiences of BME women in particular, may be compounded by additional barriers to accessing services. This might include, among others:

- A fear of a racist response from services
- Services basing their response on stereotypes, or not responding for fear of being perceived as racist
- A fear of rejection from their community if they speak out
- If they are from a community that places great value on marriage, it may be particularly hard to admit that there is abuse in the marriage, and there may be additional pressure to remain in the marriage
- Language constraints
- They may be more likely to experience abuse from multiple perpetrators
- Women with no recourse to public funds (NRPF) who experience violence are particularly vulnerable because of their immigration status. The NRPF condition imposed on them during their stay in the UK presents a major obstacle in accessing services.
- A lack of understanding from services of the trauma experienced by BME women who often are not 'just' leaving a perpetrator which is massively traumatic and highly risky but may also be separating from their whole family, community, and identity. BME experiences require an approach that relays understanding of needs and is sensitive to the trauma experienced.

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A BME woman could experience 'honour' based violence in the context of domestic abuse. Despite being just as likely to experience abuse as any other ethnic group, research shows that the level of disclosure for BME victim/survivors of domestic abuse is far lower than that of the general population (Walby & Allen, 2004). This is reflected in local MARAC and service data which shows the service user profile is not fully representative of the borough demographic profile.

Men's Experiences

It is widely recognised that men can be victims of domestic abuse and other strands of violence such as forced marriage, sexual violence and 'honour' based violence.

Of reported domestic abuse incidents to the local police, 76% are reported by women and 24% by men. As an indicator this may be impacted by confidence in reporting; comparatively higher levels of women are arrested when reported for domestic abuse in comparison to the numbers of men arrested when reported for domestic abuse (Professor Marianne Hester, 2009). Counter allegations are common tactics by people perpetrating abuse and it can often be difficult for first responders to identify the victim and perpetrator. This is particularly difficult when victims are in crisis and may be in 'fight mode' because of their own survival response.

Many victims who are men are still experiencing violence from another man or men, for example in gay relationships or from male family members. In these situations, the victims/survivor's experiences of risk are comparatively like heterosexual female victims as the abuse often follows the same patterns: higher levels of post separation abuse, stalking, harassment, physical violence etc.

A barrier to men reporting their experiences as victim/survivors can be that they feel they are perceived as weak, or that their masculinity is questioned. Taking a gender informed approach that seeks to create attitudinal change around accepted gender norms will help support male victims to come forwards. A gender informed approach brings many positive outcomes over time including reduced victimisation, reduced repeat victimisation, reduction in substance misuse, mental health needs etc. It brings additionality by creating space for boys and men to connect with their emotional needs, which may also impact on levels of suicide in male populations.

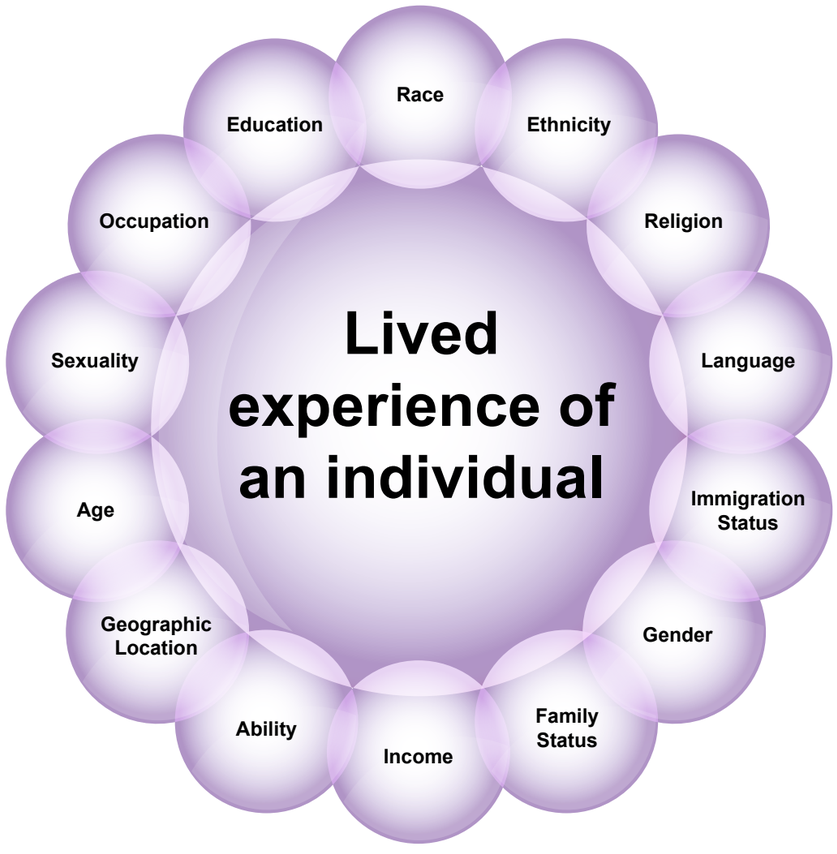
Men survivors often require different types of services to women survivors. Men survivors are more likely to make use of helplines rather than face to face interventions. Taking a gender informed approach will build on the understanding that men do not necessarily require a replication of what is traditionally perceived to be women's services. Instead of designing services to be generic in their approach and therefore struggle to be effective in response to different needs, we will seek to design service provision that understands the commonalities shared by different groups and works to create areas of support specific to the needs of the borough's residents.

Intersectionality

Part of the problem services and organisations face is that they are sometimes missing a holistic view of a survivor's experience and options available. Giving advice without taking a full assessment of need that includes all factors is problematic and leads to a misunderstanding of risk and need.

Intersectionality is a gender and anti-oppression theory. It considers the various aspects of humanity (class, race, sexual orientation, gender, age, disability etc.) do not exist separately from each other but are complexly interwoven and that their relationships are essential to an understanding of the human condition. This perspective recognises the unique experience of individuals and the difference within communities and explains how multiple forces interact to reinforce conditions of inequality and social exclusion.

It is important to note that intersectional theory is not the sum of the various aspects of an individual's identity but is an analysis of power hierarchies present within identities and reflects multiple forms of discrimination. When applied to violence and abuse, this can translate as barriers to accessing services, lack of recognition of violence and abuse, and lack of ability or perceived ability to respond to it.



Intersectional understanding provides space for expanding our analysis of how our borough profile may impact local need: Barking and Dagenham's status as an East London Growth Borough will lead to changes within our socioeconomic and demographic profile. This is likely to impact the need locally as we may see changes in languages spoken, the make-up of families, employment figures, changes in the residential layout of borough and so on. All these factors correlate and create additional or unique needs for individuals and families experiencing violence and abuse.

Children and Young People

The 2017 Joint Targeted Area Inspections of the response to children living with domestic abuse (multiple local authorities) called for a national public service initiative to raise awareness of domestic abuse and violence. The report highlighted patterns that suggest agencies focus on the victim as the only solution. The end of an abusive relationship was considered to reduce the risk to children, when in fact research tells us that separation can escalate risk. This is reflected in what local survivors have told us in Barking and Dagenham.

The use of written agreements was called into question for domestic abuse cases, which places inappropriate attribution of responsibility on the mother to protect her children, and often does not consider the coercive control that she has likely been subjected to. Inspectors found that there was no evidence that written agreements were effective in domestic abuse cases and that not enough emphasis was placed on the source of the abuse – the perpetrator.

Intergenerational Transmission of Violence and Trauma Theory

The intergenerational transmission of violence is a well-researched hypothesis in violence research in recent decades and the notion that family violence persists across generations is pervasive amongst clinicians, researchers, and the public. Estimates of likelihood of intergenerational transmission of violence varies widely and researchers have found several risk and protective factors that may alter the rate of transmission.

Exploring attachment theory, neuroscience and the role of trauma can help provide a backdrop for understanding the likelihood of transmission. The Adverse Childhood Experiences Study (ACES) is a research study conducted in the United States that demonstrated an association of adverse childhood experiences with health and social problems as an adult. All adverse childhood experiences researched as part of the study are also able to be framed as traumatic experiences. ACES is a useful piece of work to demonstrate the need to address trauma experienced by the children and young people on the borough.

People accessing support locally report varying levels of trauma in their histories, particularly when they were children or young people. The impacts of complex trauma on children and young people can be wide ranging and will depend upon various characteristics of the individual such as their age, their development, and their level of resilience. Complex trauma can negatively impact children in several ways: their attachment and relationships, physically (body and brain), emotionally, their behaviour, cognition. It also impacts their self-concept and future realisation leaving them unable to plan for or even dream about the future. Tackling trauma in young people helps to tackle disillusionment, and creates space to nurture ambition, learning and self-development.

It is important to note that not all people who experience violence and abuse as a child will go on to become a victim or perpetrator of abuse; this would be a disempowering message to a child or young person, and to their families. However, where people experience multiple or prolonged trauma in childhood and are not provided support to address that trauma, they are likely to be more vulnerable to negative social, economic and health experiences in their adult lives.

Engagement, Consultation and Co-Production

We have ensured lived experience is at the heart of this strategy through one to one interviews, telephone interviews, focus groups, and workshops with local survivors including representation of affected groups within the community. This has been facilitated through commissioned support services and local community groups but there is a need to ensure ongoing consultation to adapt to changes within the Borough and to expand the engagement to people who have experienced different forms of violence.

Tackling Violence Against Women and Girls offers excellent opportunities for co-production, and we recognise how powerful it can be for survivors to share their experiences. Survivor testimony has a real impact when raising awareness and training, and it is so important that we hear what survivors tell us and use it to shape service delivery. We can also share opportunities by employing survivors where appropriate to deliver peer support and advocacy.

We have faced challenges with quantitative engagement. Numbers of survivors attending workshops and focus groups have been small and have tended to be focused on domestic abuse and sexual violence within the context of the domestic sphere, and less on other forms of violence such as sexual exploitation, female genital mutilation and 'honour' based violence. Nevertheless, we have consulted with 38 survivors through workshops and focus groups, and one to one interviews.

This qualitative learning has very much been more focused towards the practical needs of women experiencing violence and therefore has guided the development of the priorities in this strategy around wider service development and delivery, particularly regarding housing need and support with advocacy through children's social care.

We would like to acknowledge the invaluable feedback and input from local survivors and their support workers over 2017/18. Their experiences and suggestions have been vital to shaping this strategy. They have shown great strength and tenacity despite their experiences and have also shared their vulnerabilities to help create a change for people in the future. We recognise that this can be retraumatising and we offer real thanks, a genuine commitment to do better and we look forward to continuing working with you over the course of this strategy

Understanding Data

Measuring success around VAWG is difficult. Much of the violence and abuse happening on the borough will be in the domestic sphere, our outside of the public domain. Organisations working to support survivors often respond in the context of number of incidents and risk. Survivors do not necessarily view their experiences through this lens, instead putting forwards the cumulative effects of abuse over time. To survivor's success is simple: the abuse stops, and support is provided for them to process what has been done to them. For the partnership, this is somewhat more complex and relies on improving recognition, identification and then response.

It is important to note that to create positive and sustainable long-term changes, short term indicators are very likely to get worse. The more work that is done to raise awareness and encourage survivors to seek help and abusers to change, the more likely it is that we will see reporting and service demand increase in the short-term. This is in direct conflict with Borough Manifesto targets and some targets set in this strategy.

However, in the long-term, the work undertaken will start to tackle the normalisation of abuse, and the intergenerational transmission of violence leading to a steady decline in reporting and service demand.

To support the understanding of indicators and give context to what is happening on the borough we are developing a wider VAWG data set including information collated from a wide range of services and agencies.

Governance

The Barking and Dagenham Community Safety Partnership has five strategic priority sub-groups which report to the Community Safety Partnership board. The sub-groups have been set up to mirror the five areas of vulnerability as set out within the London Police and Crime Plan 2016/17. One of the priority sub groups is violence against women and girls. This strategy, and its commitments will be the responsibility of the Violence Against Women and Girls (VAWG) sub-group. This sub-group will also link with the Health and Wellbeing Board and the safeguarding boards to ensure that the response to violence against women and girls is robust, representative of need and well understood across all other priority areas.

The VAWG sub group is Chaired by the Borough Director for NELFT and supported by the domestic abuse commissioning manager. The membership consists of partners from children's care and support, adult's care and support, community solutions, commissioning managers, local police, national probation service, London community rehabilitation centre, as well as several specialist voluntary sector partners. A quarterly report analysing target performance will be discussed at the VAWG sub group and will be reported up to the Community Safety Partnership.

There are several resources that will assist in delivering this strategy:

- The Council fund a domestic abuse commissioning manager post responsible for commissioning services to tackle domestic abuse and other violence against women and girls strands. The post is also responsible for coordinating this strategy and supports the violence against women and girls sub group to the Community Safety Partnership.
- The MARAC is a meeting that facilitates strategic discussion of the boroughs highest risk domestic abuse cases. The Council fund a MARAC coordinators post to support this function. The coordinator also supports the Missing and Sexual Exploitation (MASE) meeting and the hate crime and intolerance panel. MARAC steering is undertaken by the VAWG sub Group.
- Domestic abuse operational forum comes together quarterly, and the membership includes several local services with an appetite to tackle violence against women and girls. This group feeds into the VAWG sub group to the Community Safety Partnership.
- The Independent Domestic and Sexual Advocacy (IDSVA) service which consists of three advocates, a caseworker, a young person advocate and a children's domestic abuse caseworker. The service works with medium and high-risk cases of domestic abuse and other violence against women and girls strands. The service is not gender specific – any person victimised by a perpetrator of domestic or sexual violence can access support.
- The Domestic violence programme is a support group programme for children who have experienced domestic abuse. A concurrent group for mothers is also provided and a peer support group meets every other week.
- Refuge provision includes 13 beds with 6 months move on, supporting 26 women and their children each year.
- Violence Against Women and Girls counselling is provided through London Councils funding and an uplift is provided through the London Crime Prevention Fund allocations.
- A diversionary programme to empower girls and deliver peer to peer education in schools is funded through London Crime Prevention allocations.
- Excel Women's Centre is an open-door community hub based in Barking but working across the borough providing services to children, women, and families. The centre offer help to vulnerable women and their families to fight discrimination, demand their right and increase their self-esteem and confidence within our multicultural society.
- Huggett Women's Centre, based at Dagenham Heathway is managed by Nia and is a safe space for women to access women-centred psycho-educational support groups, drop ins and support.

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References and links to supporting documents

1. Council for Europe Istanbul Convention
2. UK Government's Strategy to end violence against women and girls: 2016 to 2020
3. MOPAC Violence Against Women and Girls Strategy 2018-2021
4. MOPAC Police and Crime Plan 2017-2021
5. MOPAC Survivors Consultation: Listening to women and girls affected by gender based violence
6. Galop Domestic Violence Library (a collection of LGBT specific research papers, studies and statistics)
7. Adverse Childhood Experiences Study, Public Health England
8. Imkaan Good Practice Briefing Intersectionality and VAWG
9. The Cost of Domestic Violence: Up-date 2009, Sylvia Walby
10. The concept and measurement of violence against women and men, Sylvia Walby (ISBN 978-1-4473-3263-3)
11. Domestic Violence, Intersectionality and Culturally Competent Practice Lettie Lockhart, Fran Danis (ISBN: 9780231140270)
12. Criminal Prosecution Service VAWG Report
13. Prison Reform Trust: Leading change: the role of local authorities in supporting women with multiple needs
14. School Survey Report*
15. Barking and Dagenham Delivery Unit Priority Review on Domestic Abuse*

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HEALTH AND WELLBEING BOARD

7 November 2018

Title:	**Joint Strategic Needs Assessment 2018**
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** Yes
Report Author: Rosanna Fforde, Senior Intelligence and Analysis Officer, London Borough of Barking and Dagenham	**Contact Details:** Tel: 020 8227 2394 E-mail: rosanna.fforde@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary:

This report comprises the 2018 Joint Strategic Needs Assessment (JSNA). It takes a themed approach, based upon the priority areas of the Joint Health and Wellbeing Strategy:

- Best start in life
- Early diagnosis and intervention
- Resilience.

This paper aims to:

- allow the Health and Wellbeing Board to discharge its duties in relation to the JSNA
- present updated demographic and health data in the context of the draft Joint Health and Wellbeing Strategy 2019–2023.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Approve the Joint Strategic Needs Assessment 2018, as set out at Appendix A to the report;

(ii) Agree that the findings of the JSNA should be taken into account in the development of strategies and the appraisal of strategies developed by partner organisations; and

(iii) Support the commissioning of services by partner organisations that align with the JSNA findings.

Reason(s)

The JSNA provides the evidence base on which strategic decisions of the Health and

Wellbeing Board are made. It directly informs the development of the Joint Health and Wellbeing Strategy. The Health and Wellbeing Board has a statutory responsibility for the JSNA and the Council and the NHS Barking and Dagenham Clinical Commissioning Group have an equal and joint duty to prepare it.

1 Introduction and Background

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

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

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

2 What has the approach been in 2018?

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

2.2 The workshops each addressed one of the three themes of the Strategy:

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

2.3 In addition to the sections based on the three presentations, this JSNA contains a socio-demographic profile to provide context to the themed chapters.

3 Issues

3.1 As this is a themed report, it does not cover all areas. A 'deep dive' into vulnerable groups is planned to supplement this report. We will also be considering how the JSNA could be done differently in the future.

4 Mandatory Implications

Joint Strategic Needs Assessment

4.1 The appended report comprises the 2018 JSNA.

Joint Health and Wellbeing Strategy

4.2 The 2018 JSNA has directly informed the revised JHWS; the presentations upon which this report is based were created for three stakeholder workshops that informed the JHWS in July 2018.

[1] Department of Health. *JSNAs and JHWS statutory guidance*. London: DH; 2013 [https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance].

Integration

4.3 The JSNA is a partnership report and provides information of relevance to different partners.

Financial Implications

Implications completed by Olufunke Adediran, Group Accountant.

4.4 This report is mainly for information and sets out to provide the Health and Wellbeing Board the evidence base required to make strategic decisions on key health issues affecting residents of the London Borough of Barking and Dagenham. As such there are no financial implications arising directly from the report. However, the information set out does provide a useful context for the financial pressures faced by both Health and Social Care within the Borough.

Legal Implications

Implications completed by Dr Paul Feild, Senior Governance Lawyer

4.5 The Health and Social Care Act 2012 conferred the responsibility for health improvement to local authorities. In addition, as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement. The Health and Well-Being Board terms of reference establish its function to ensure the delivery of which the Joint Strategic Needs Assessment is a key component.

Risk Management

4.6 Any commissioning decisions based on the JSNA will need to be risk assessed.

Patient / Service User Impact

4.7 As stated above, the ultimate aims of the JSNA are to improve the population's health and to reduce health inequalities. However, it does so in an indirect way, through providing an evidence base for commissioning. The impact of the JSNA on patients and service users is therefore dependent on the quality and usefulness of the information provided and how it is used by commissioners.

4.8 To address the former point, about the content of the JSNA, by following the three themes of the Joint Health and Wellbeing Strategy, we anticipate that this will be a valuable resource for commissioners. We recognise that a single document cannot contain all information needed for commissioning, which is why we leave open the possibility of 'deep dives' to supplement this report.

4.9 To address the latter point, about how the JSNA is used, we are planning to take the JSNA to the Barking and Dagenham Delivery Partnership and would ask all members of the Health and Wellbeing Board to disseminate the JSNA widely once published.

5 Non-mandatory Implications

Crime and Disorder

5.1 Officers went to the council's Community Safety Partnership on 26 September 2018 to ask for comments from board members about the approach to the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment. Work has also been undertaken to ensure that the upcoming Community Safety Plan and the Joint Health and Wellbeing Strategy are aligned.

Safeguarding

5.2 Any commissioning decisions based on the JSNA will need to consider safeguarding issues.

Property / Assets

5.3 None.

Customer Impact

5.4 See patient/service user impact.

Contractual Issues

5.5 None.

Staffing issues

5.6 None.

Public Background Papers Used in the Preparation of the Report:

- Department of Health. *JSNAs and JHWS statutory guidance*. London: DH; 2013 [https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance].

- The JSNA is referenced; please see footnotes in the appended report.

List of Appendices:

Appendix A Joint Strategic Needs Assessment 2018

Joint Strategic Needs Assessment 2018

London Borough of Barking and Dagenham

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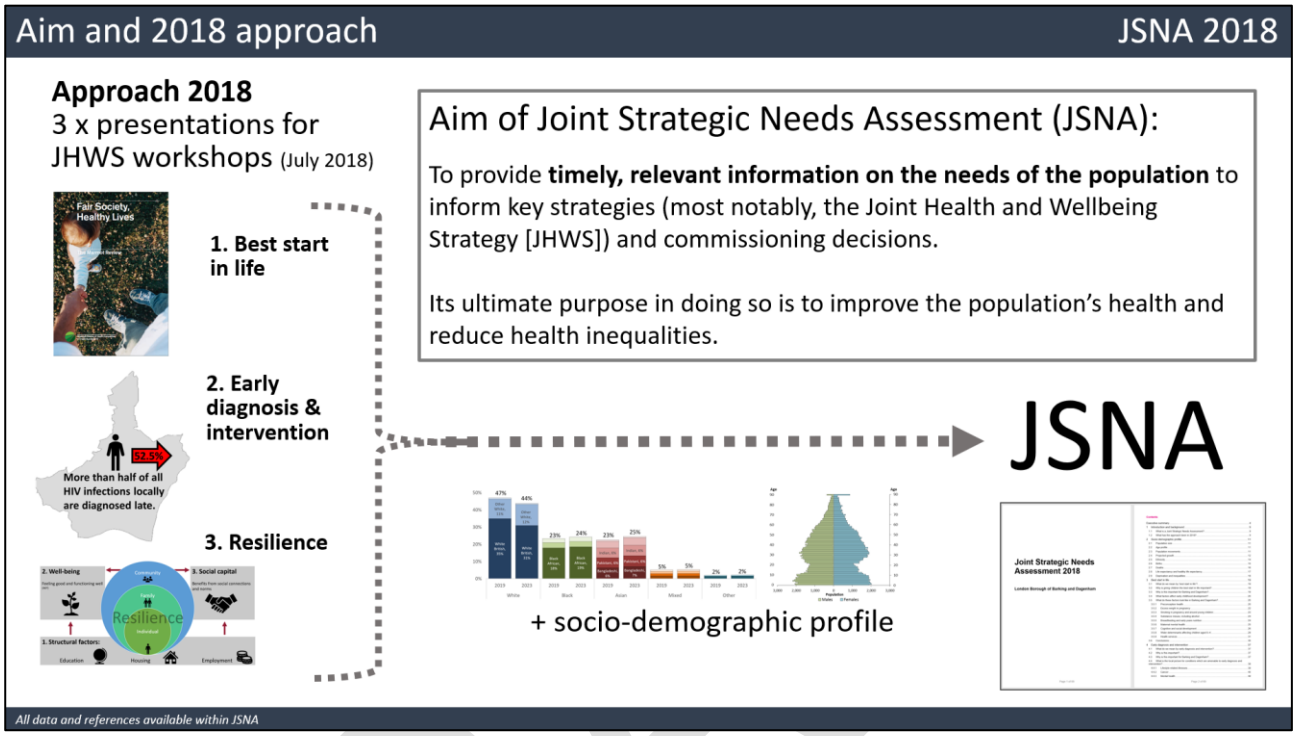
Contents

Executive summary

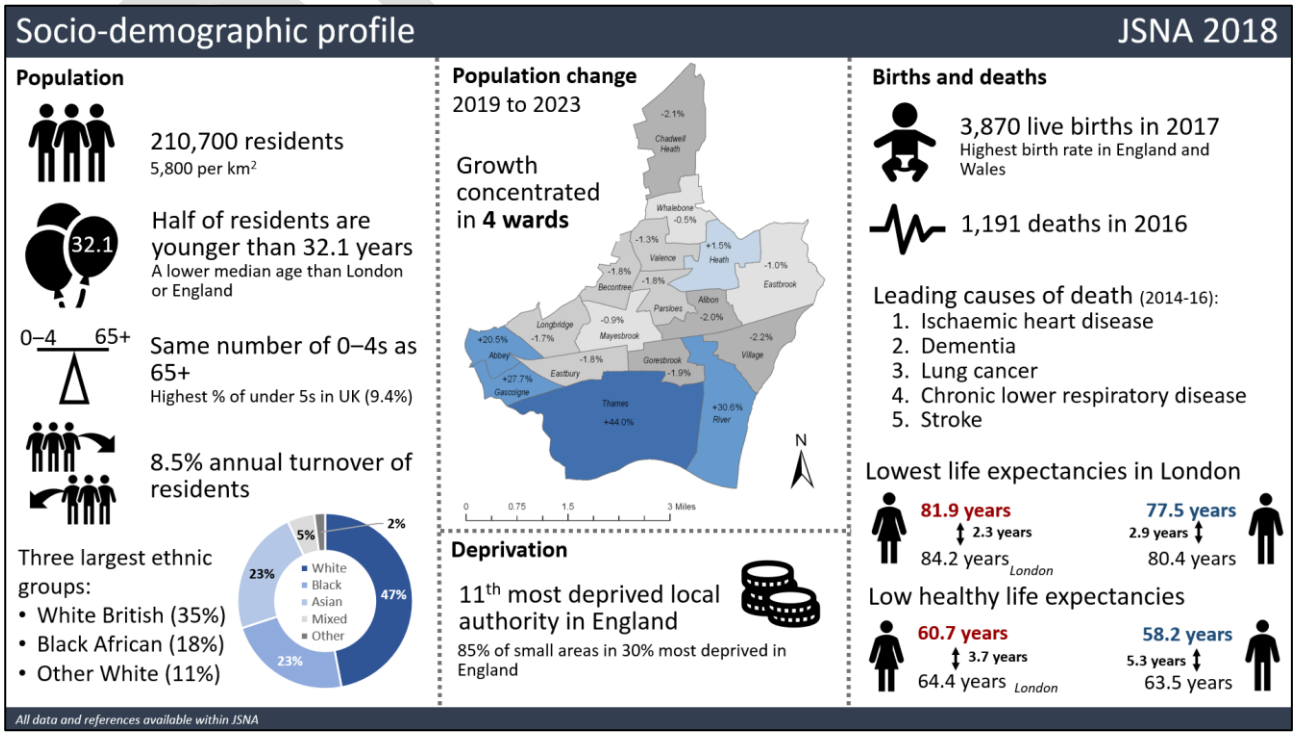
Introduction and background

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

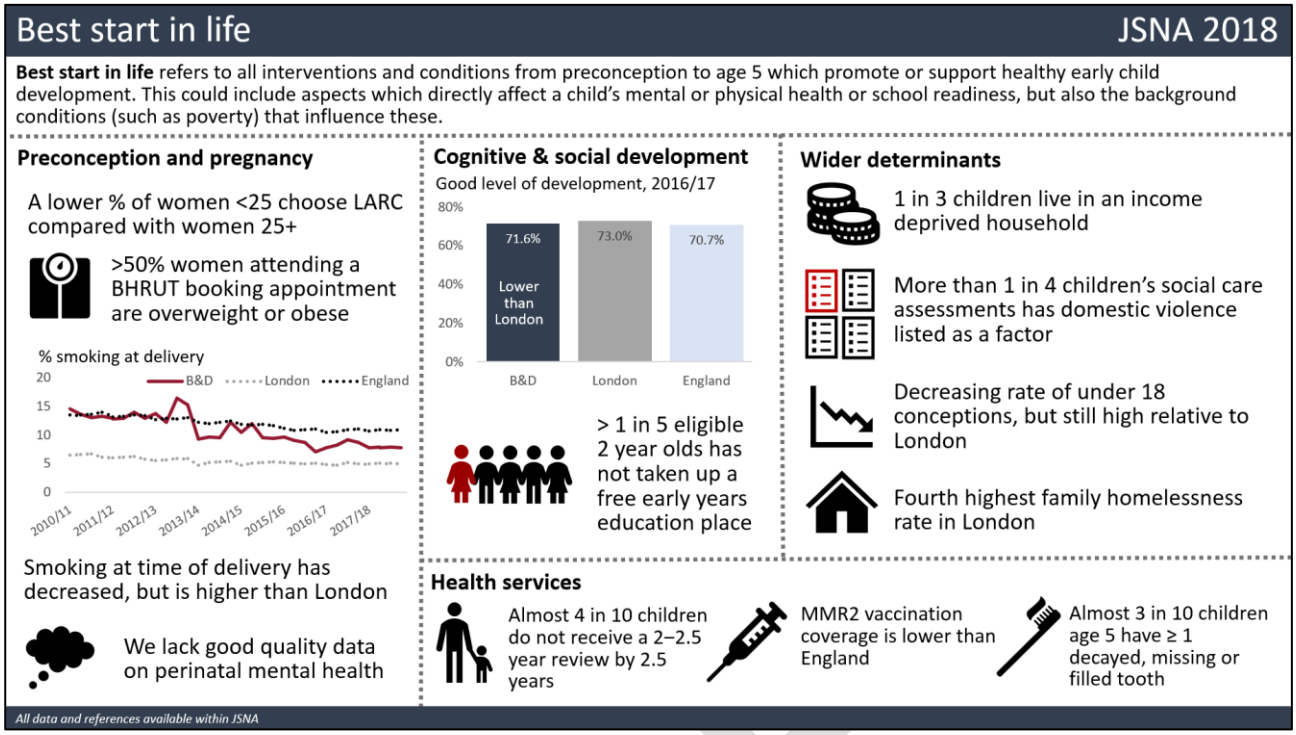


Socio-demographic profile

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



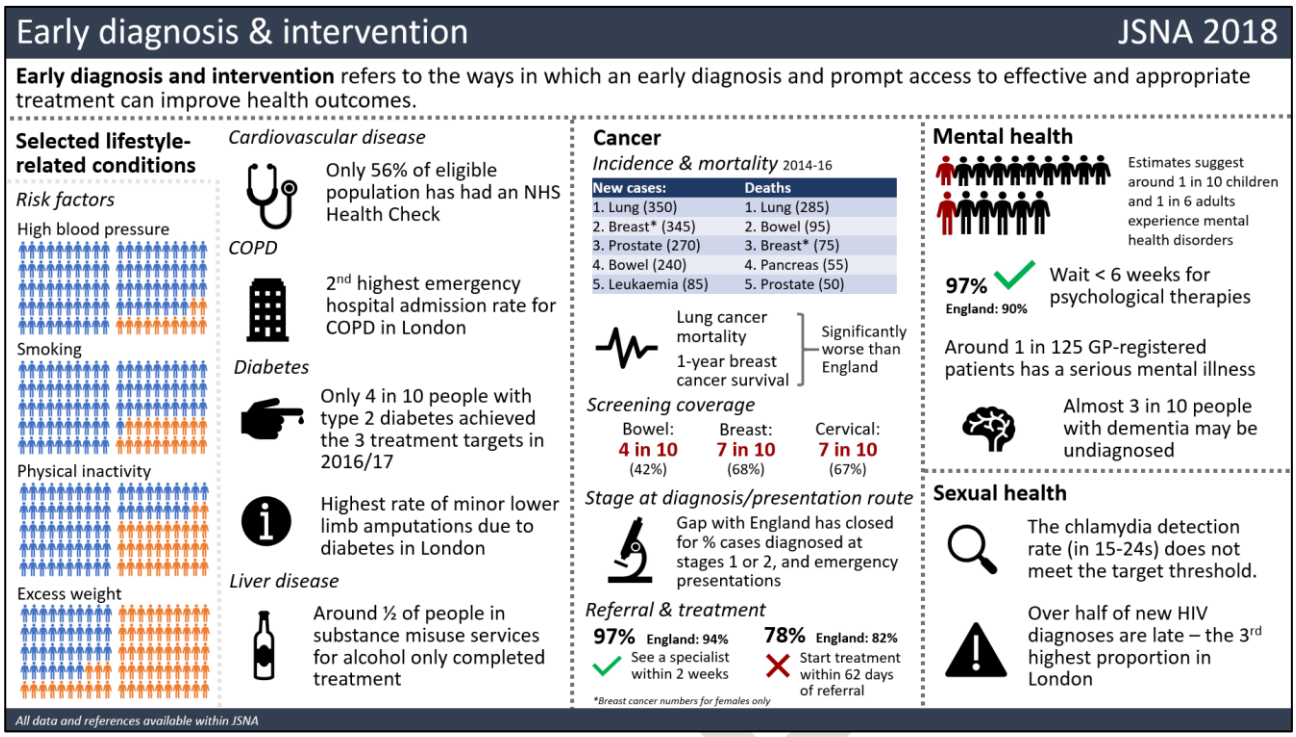
Best start in life



Key implications for commissioning:

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

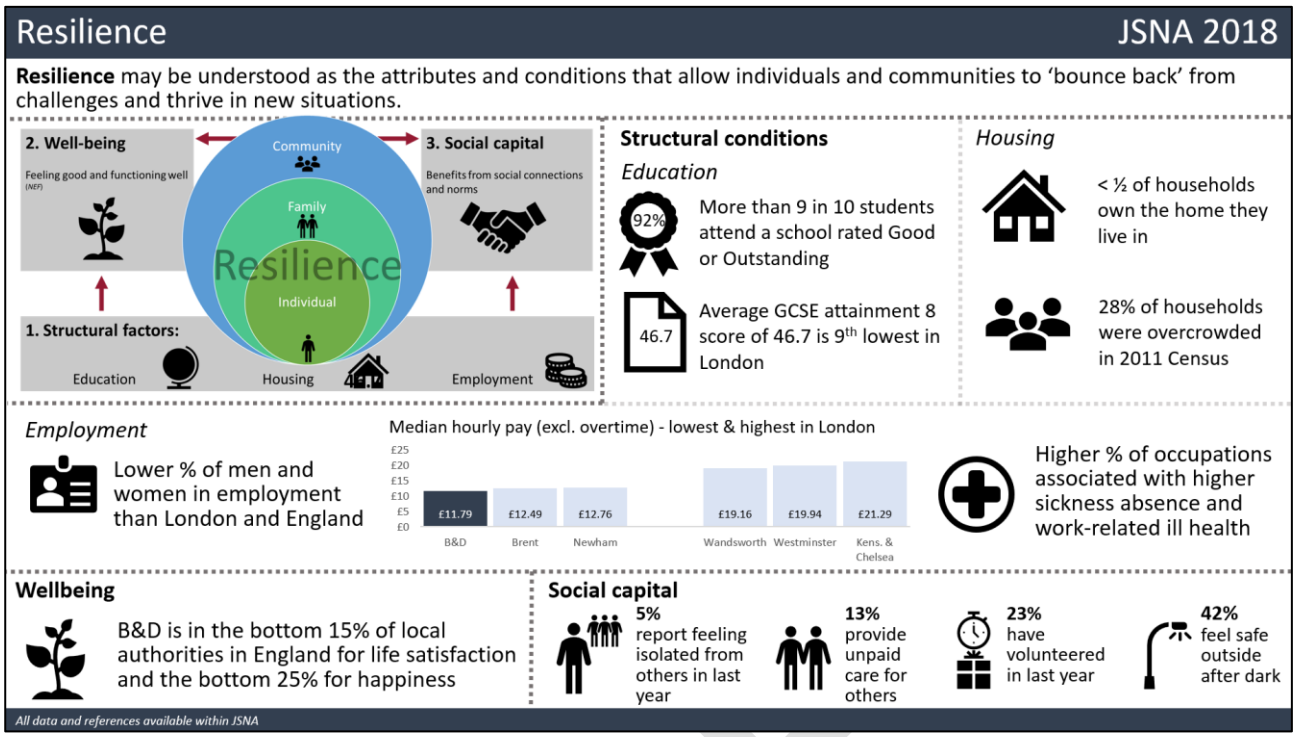
Early diagnosis and intervention



Key implications for commissioning:

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

Resilience



Key implications for commissioning:

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

1 Introduction and background

1.1 What is a Joint Strategic Needs Assessment?

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

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

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

1.2 What has the approach been in 2018?

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

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

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

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

Box 1.1: Definitions of the three themes

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

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

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

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

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

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

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

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

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

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

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

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

2 Socio-demographic profile

2.1 Population size

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

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

2.2 Age profile

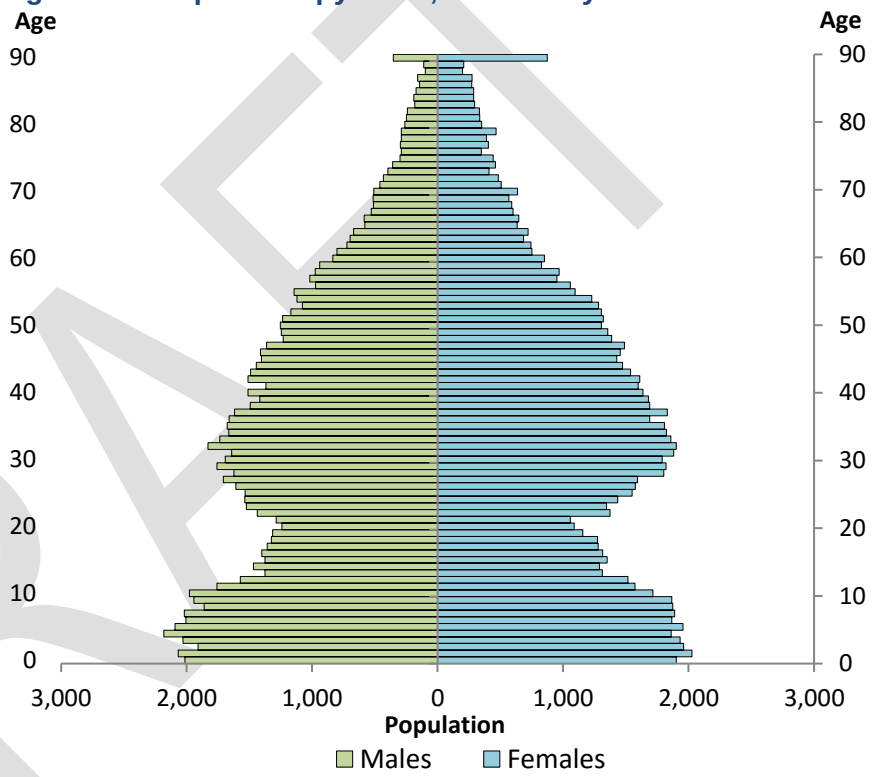
Barking and Dagenham has a young population, with a median age of 32.1 years, compared with 35.1 years for London and 39.8 years for England.

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

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

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

Figure 2.1: Population pyramid, 2017 mid-year estimates



Source: Office for National Statistics (ONS).

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

2.3 Population movements

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

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

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

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

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

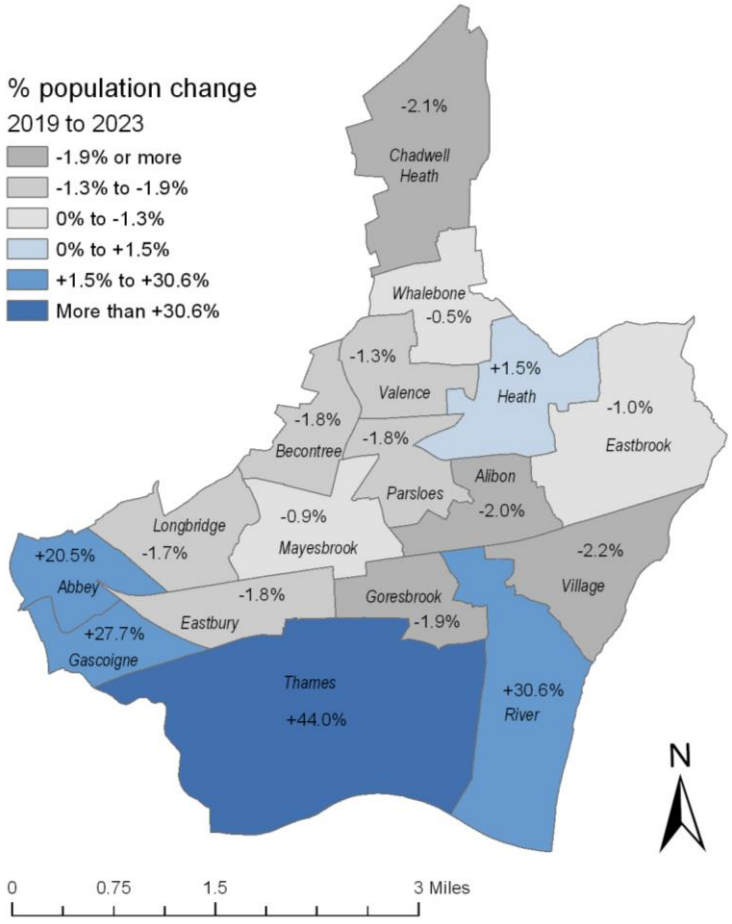
Moves from other areas of UK to LBBD	Moves to other areas of UK from LBBD
1. Newham (2,800)	1. Havering (2,200)
2. Redbridge (2,600)	2. Redbridge (1,800)
3. Waltham Forest (900)	3. Thurrock (1,400)
4. Havering (800)	4. Newham (1,000)
5. Tower Hamlets (700)	5. Basildon (500)

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

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

2.4 Projected growth

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



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

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

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

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

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

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

Table 2.2: Estimated population changes 2019–2023

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

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

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

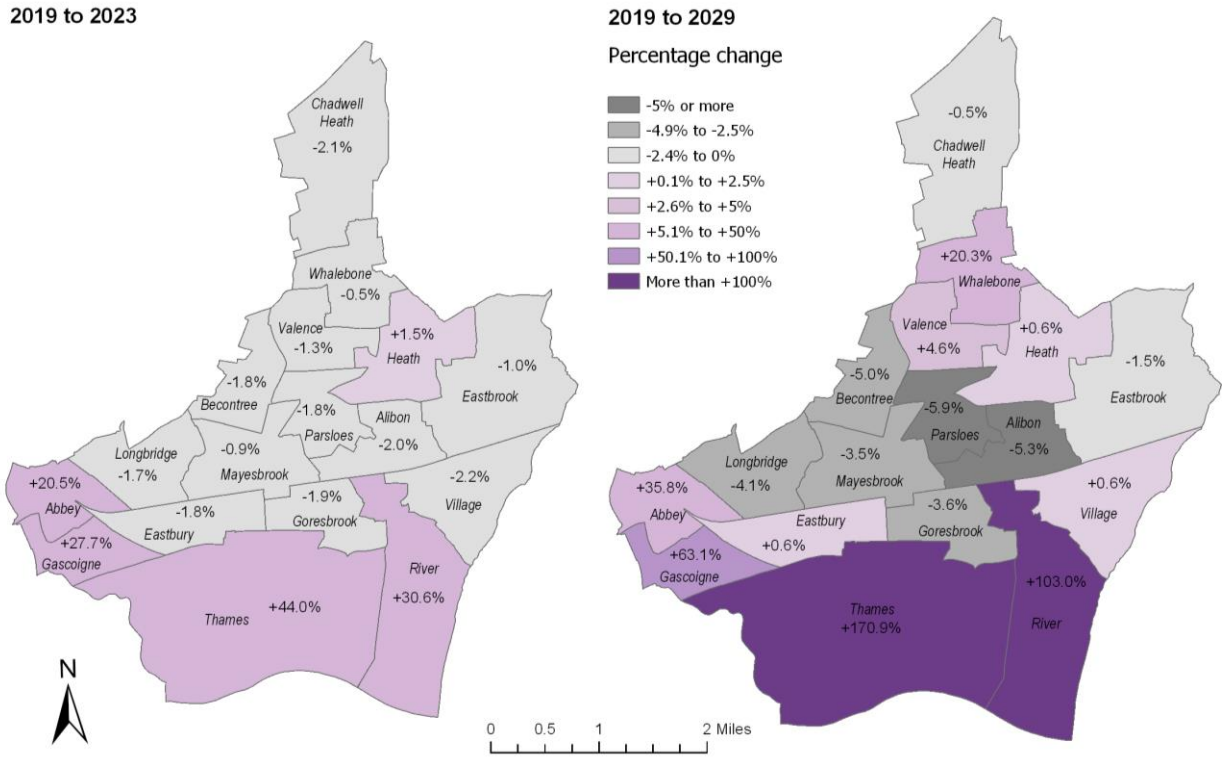
Table 2.3: Estimated population changes 2019–2029

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

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

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

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



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

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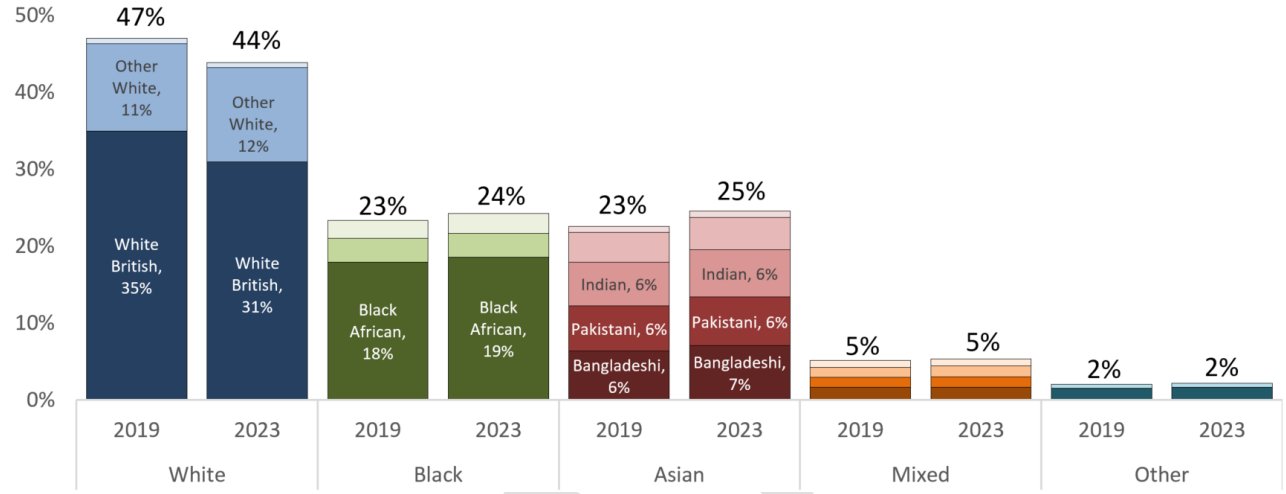
2.5 Ethnicity

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

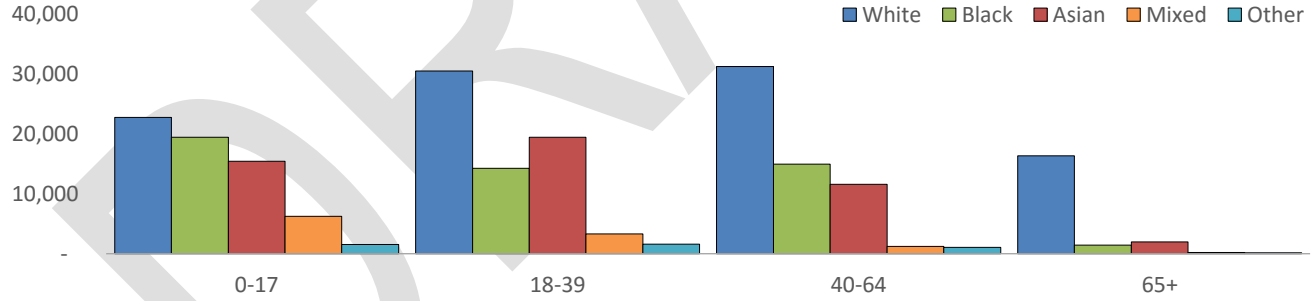
Figure 2.4: Ethnicity estimates in Barking and Dagenham, 2019 and 2023



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

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

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



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

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

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

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

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

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

2.6 Births

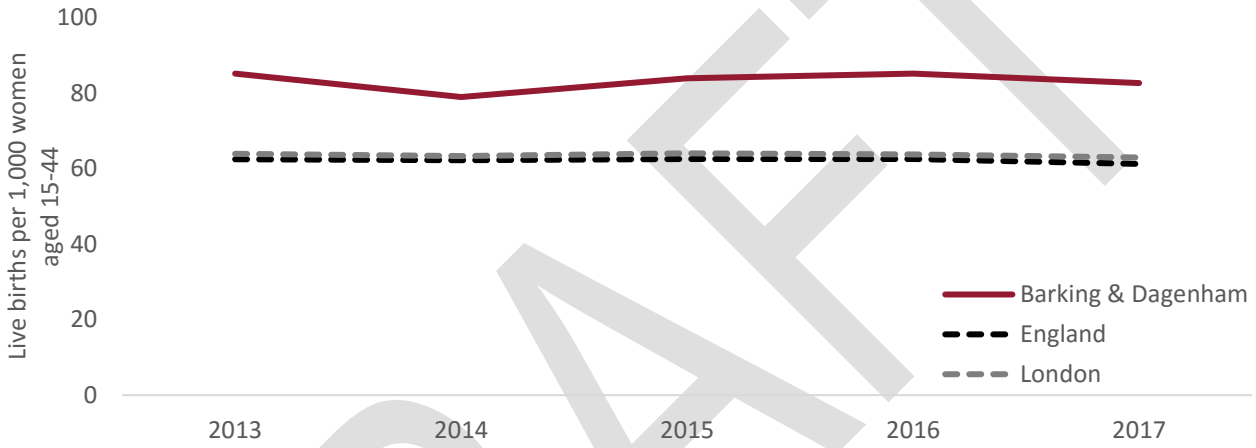
There were an average of 3,812 live births in Barking and Dagenham each year between 2013 and 2017, with 3,870 in 2017.[9]

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

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

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

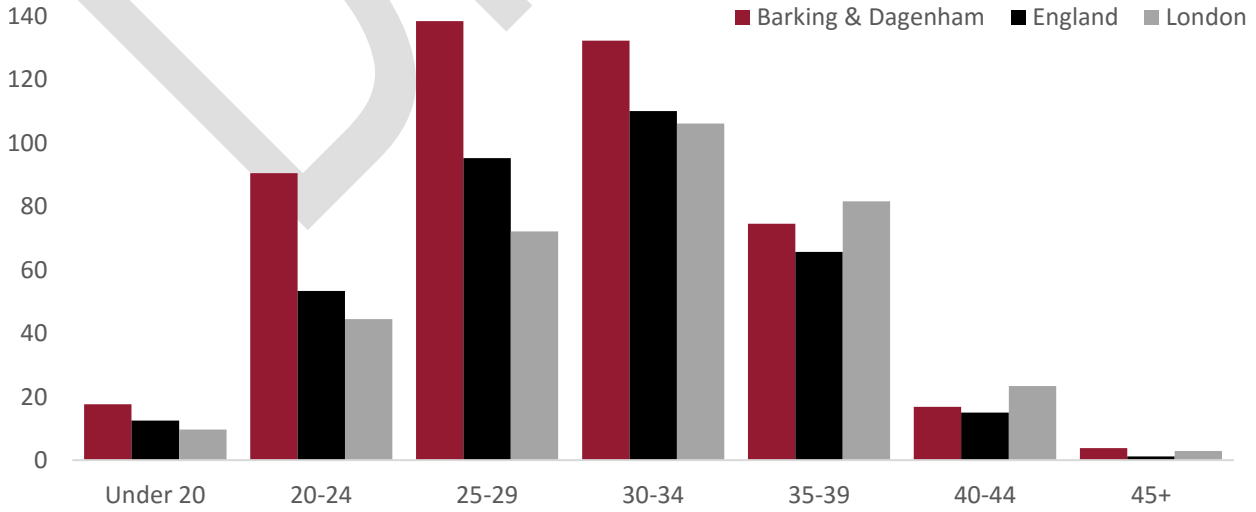
Figure 2.6: Live births per 1,000 women aged 15–44 (general fertility rate), 2013–2017



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

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

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



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

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

2.7 Deaths

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

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

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

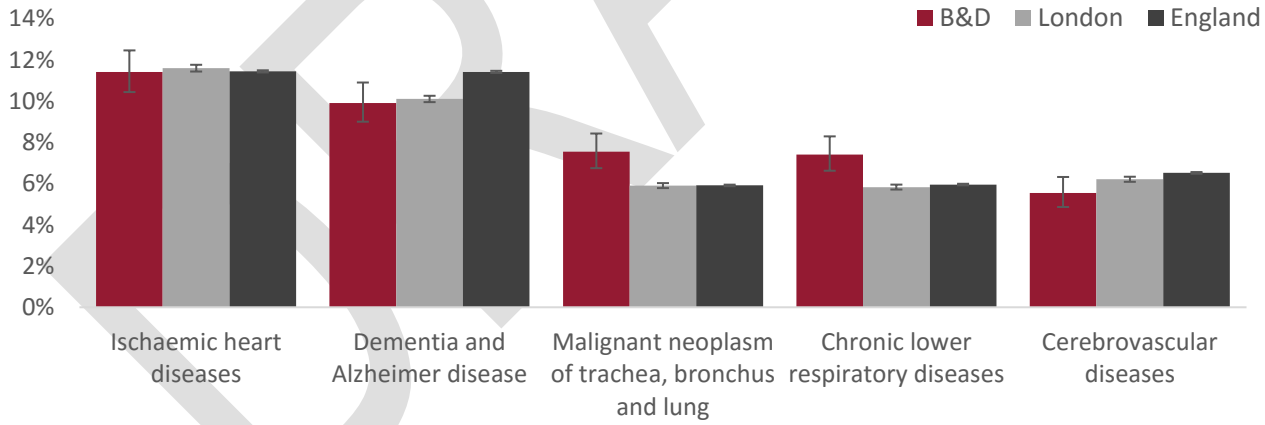
Table 2.5 Leading causes of death, Barking and Dagenham, 2014–16

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

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

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

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



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

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

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

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

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

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

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

2.8 Life expectancy and healthy life expectancy

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

Life expectancy:
77.5 years (London: 80.4 years)

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

Life expectancy:
81.9 years (London: 84.2 years)

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

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

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

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

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

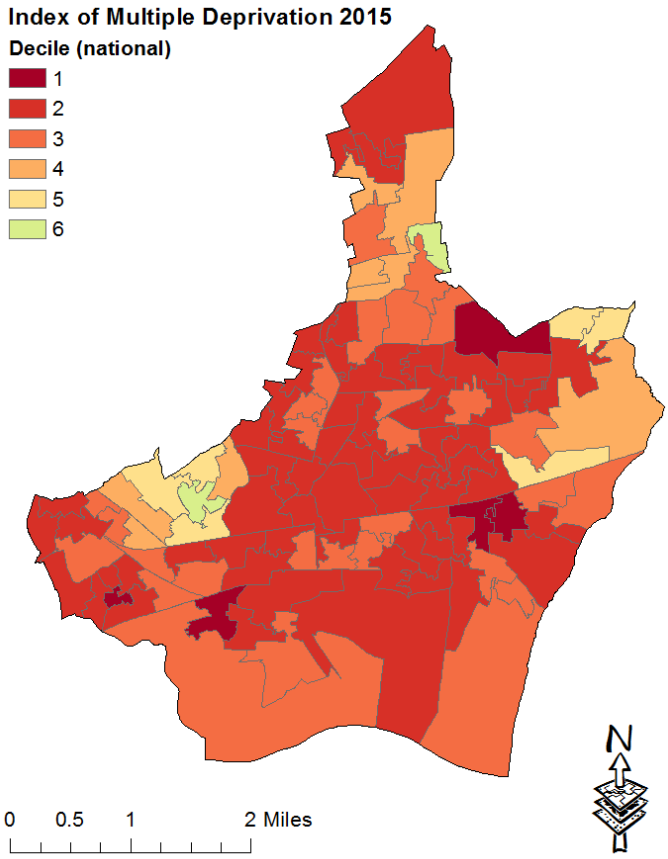
Male HLE is the lowest in London – 5.3 years lower than the London average and 11.7 years lower than Richmond upon Thames (London borough with the highest HLE).

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

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

2.9 Deprivation and inequalities

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



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

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

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

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

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

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

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

3 Best start in life

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

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

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

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

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

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

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

3.3 Why is this important for Barking and Dagenham?

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

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

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

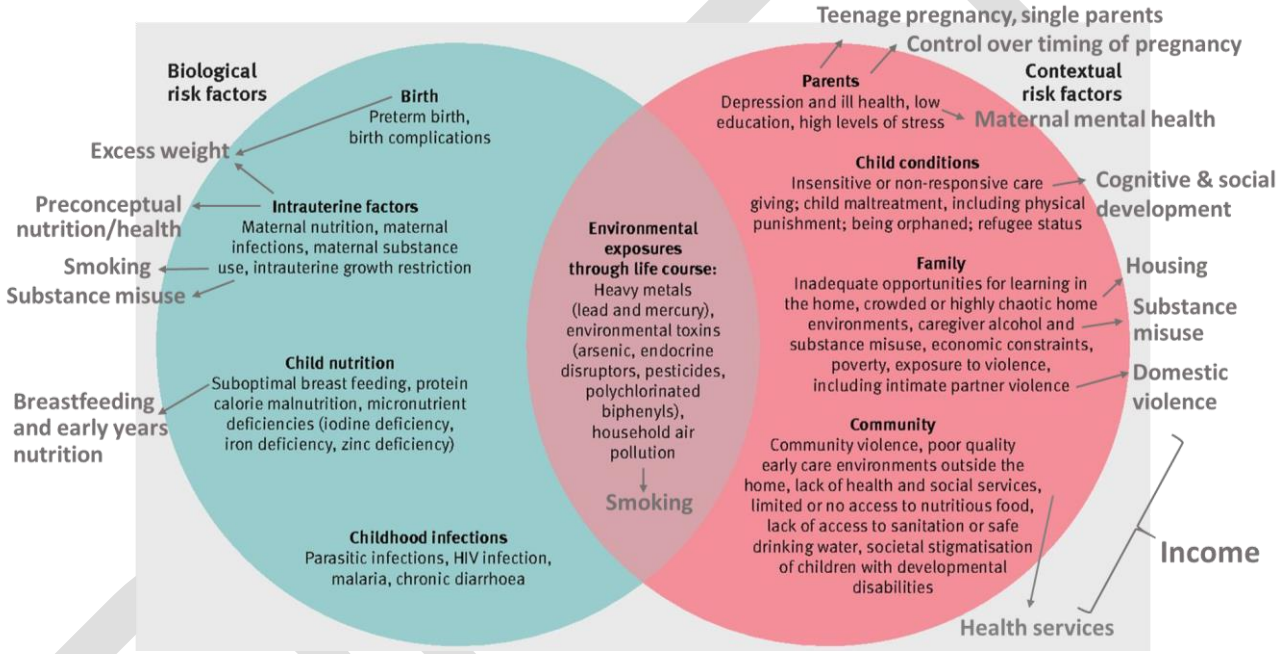
and 6.1% across England. This equates to around 19,900 children in 2017.[27] This is also a growing population, albeit at a slightly slower rate than the borough average; projected figures suggest we will have 20,300 children under 5 in 2019 and 21,600 by 2023.[28]

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

3.4 What factors affect early childhood development?

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

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



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

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

3.5.1 Preconception health

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

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

What is preconception health?

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

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

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

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

Control over timing of pregnancy

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

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

Figure 3.2: Prevalence of unplanned pregnancies

Pregnancies:

16%	Unplanned
29%	Ambivalent
55%	Planned

Full-term pregnancies:

6%	Unplanned
28%	Ambivalent
66%	Planned

Data: Wellings et al., 2013.

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

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

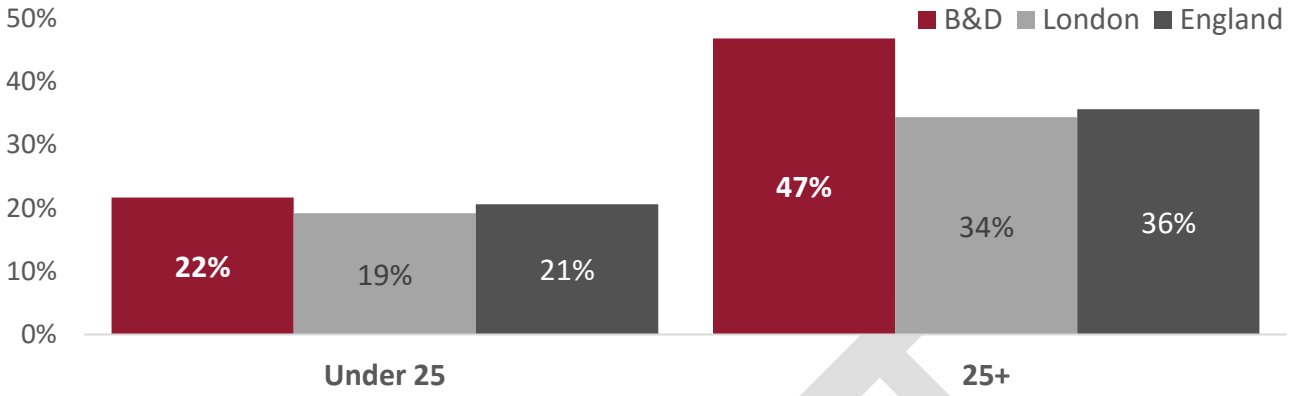
National survey data suggest that 16–19 year olds who become pregnant are at higher risk of unplanned pregnancy, although most unplanned pregnancies occur in 20–34 year olds.[34]

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

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

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

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



Data: PHE, Sexual and Reproductive Health Profiles.

General health of women and men of child-bearing age

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

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

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

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

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

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

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

Source: PHE/GP Patient Survey

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

3.5.2 Excess weight in pregnancy

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

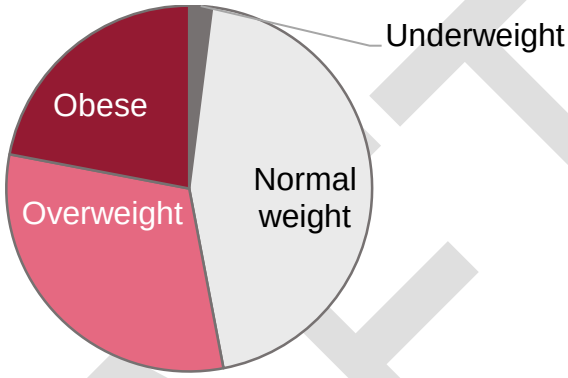
Excess weight in pregnancy increases the risk of miscarriage, congenital anomalies, preterm delivery, blood clots in the mother, childhood obesity and cardiovascular disease in the child's later life.[36]

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

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

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

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



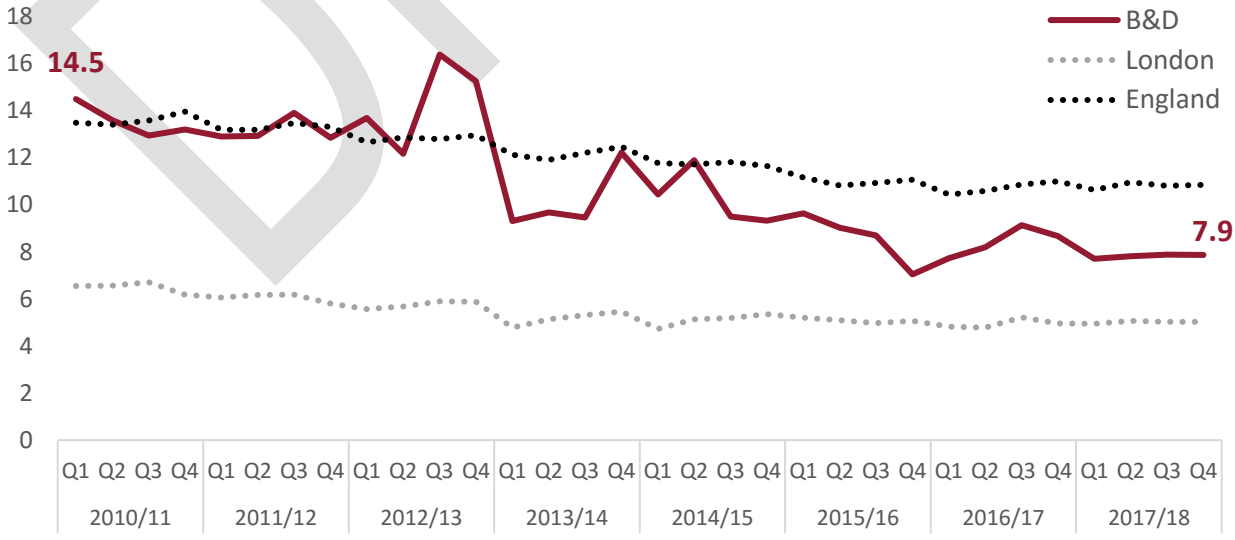
Data: NHS Digital, Maternity Services Data Set, February 2018.

3.5.3 Smoking in pregnancy and around young children

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

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

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



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

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

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

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

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

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

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

What impact could reducing smoking in pregnancy have?

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

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

3.5.4 Substance misuse, including alcohol

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

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

[40] Shipton D, Tappin DM, Vadiveloo T, Crossley JA, Aitken DA, Chalmers J. Reliability of self reported smoking status by pregnant women for estimating smoking prevalence: a retrospective, cross sectional study. *BMJ* 2009;339:b4347.
[41] PHE. *Health of women before and during pregnancy: health behaviours, risk factors and inequalities. An initial analysis of the Maternity Services Dataset antenatal booking data.* London: PHE; 2018.
[42] NHS Digital, Statistics on NHS Stop Smoking Services, England, April 2017 to March 2018.
[43] Royal College of Physicians. *Passive smoking and children*. A report by the Tobacco Advisory Group. London: RCP, 2010
[44] González-Valero L, Montiel-Company JM, Bellot-Arcís C, Almerich-Torres T, Iranzo-Cortés JE, Almerich-Silla JM. Association between passive tobacco exposure and caries in children and adolescents. A systematic review and meta-analysis. *PLoS One* 2018;13(8):e0202497.
[45] NHS Digital, Statistics on Women's Smoking Status at Time of Delivery, England, 1 April 2017 to 31 March 2018.; GLA interim 2015-based BPO projection, 2017.
[46] Department of Health and Social Care, *UK Chief Medical Officers' Low Risk Drinking Guidelines*. [London]: DHSC, 2016.
[47] Behnke M, Smith VC; Committee on Substance Abuse; Committee on Fetus and Newborn. Prenatal substance abuse: short- and long-term effects on the exposed fetus. *Pediatrics*.2013;131(3):e1009–24.

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

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

3.5.5 Breastfeeding and early years nutrition

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

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

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

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

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

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

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

3.5.6 Maternal mental health

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

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

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

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

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

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

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

3.5.7 Cognitive and social development

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

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

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

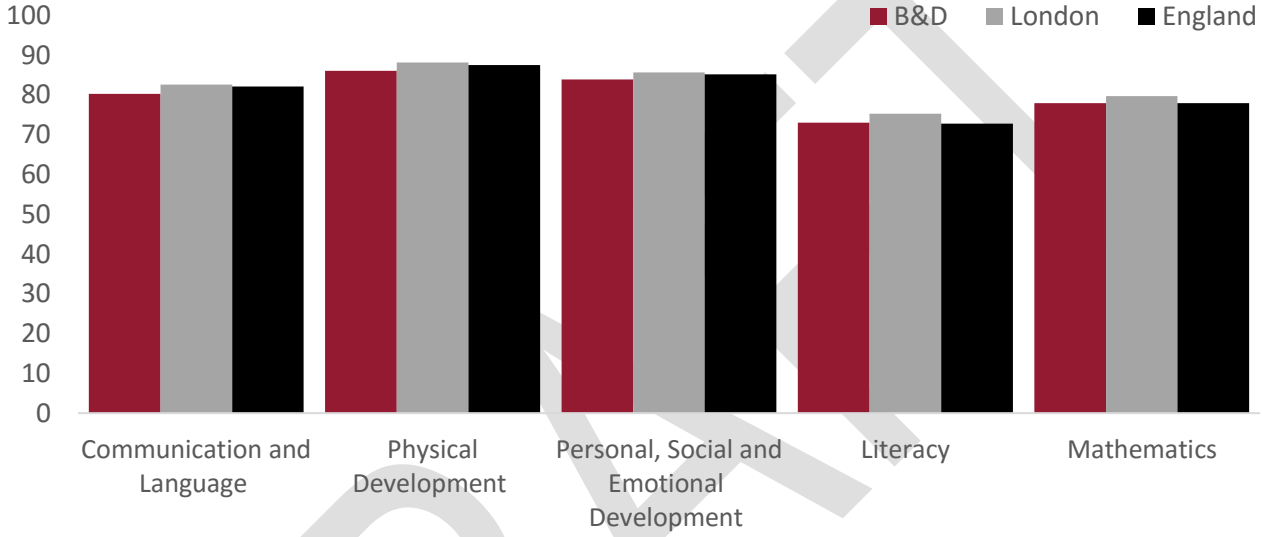
[57] Specifically perinatal depression, anxiety and psychosis.
[58] ONS via Nomis, Live births in England and Wales: birth rates down to local authority areas. This is based on births rather than maternities as 2017 maternities data is not yet available. However, the cost will be of the same order of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

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

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

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

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



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

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

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

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

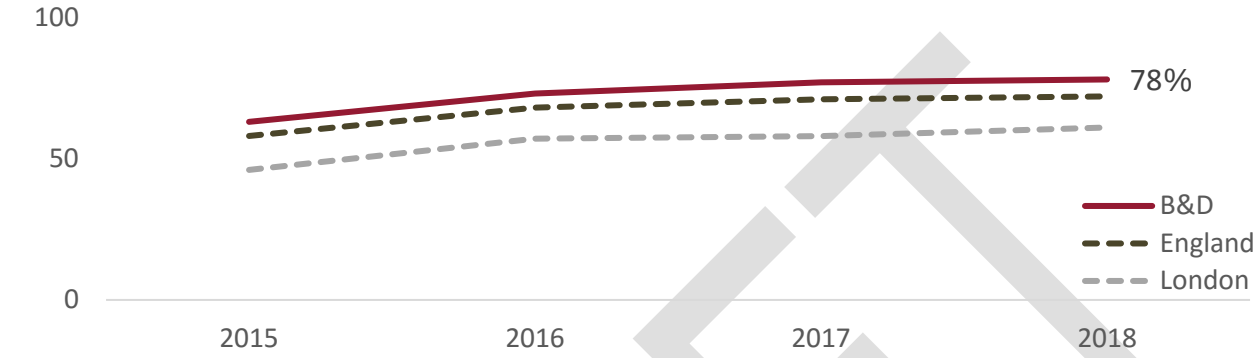
Another important way in which children can prepare for school (and develop the skills measured above) is by attending a high quality early years education provider.[66] Almost four in five Barking and Dagenham 2 year olds who are eligible[67] from funded early education places were taking this up in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

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

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

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

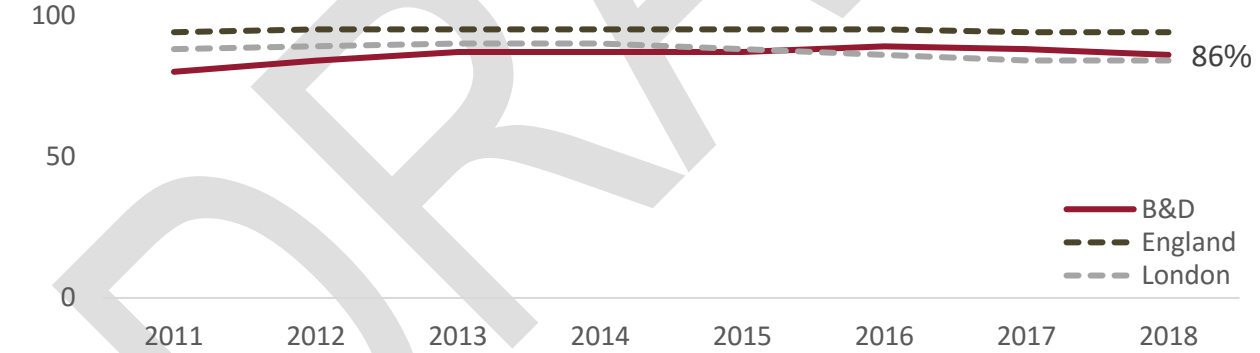
Figure 3.8: % of eligible 2-year-old children benefitting from funded early education places, 2018



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

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

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



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

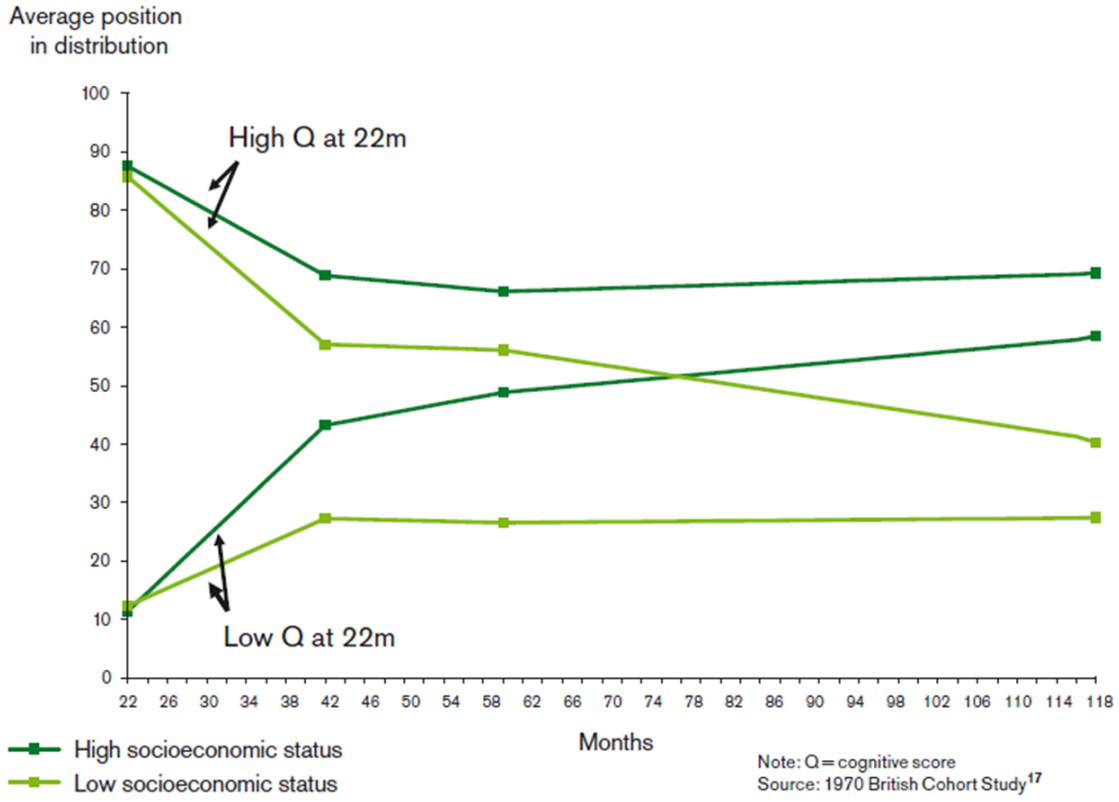
3.5.8 Wider determinants affecting children aged 0–4

Income deprivation

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

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

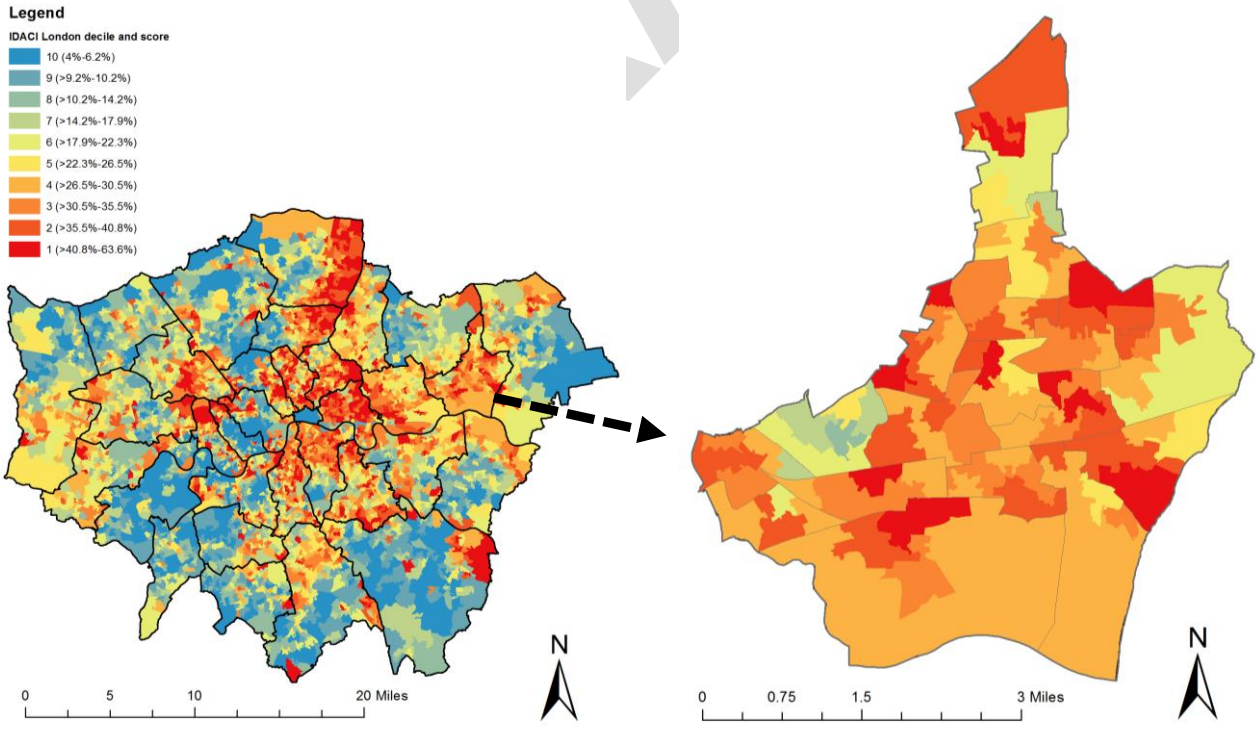
Figure 3.10: Inequality in cognitive development by children in the 1970 British Cohort Study, at ages 22 months to 10 years



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

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

Figure 3.11: Income deprivation affecting children index



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

Domestic abuse

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

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

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

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

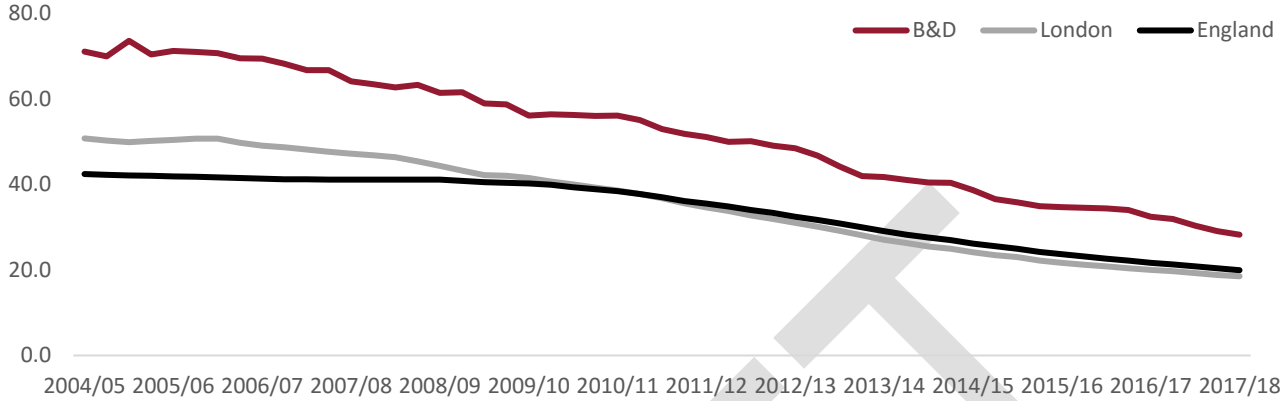
Under 18 conceptions

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

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

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

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



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

Single parents

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

Housing and homelessness

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

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

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

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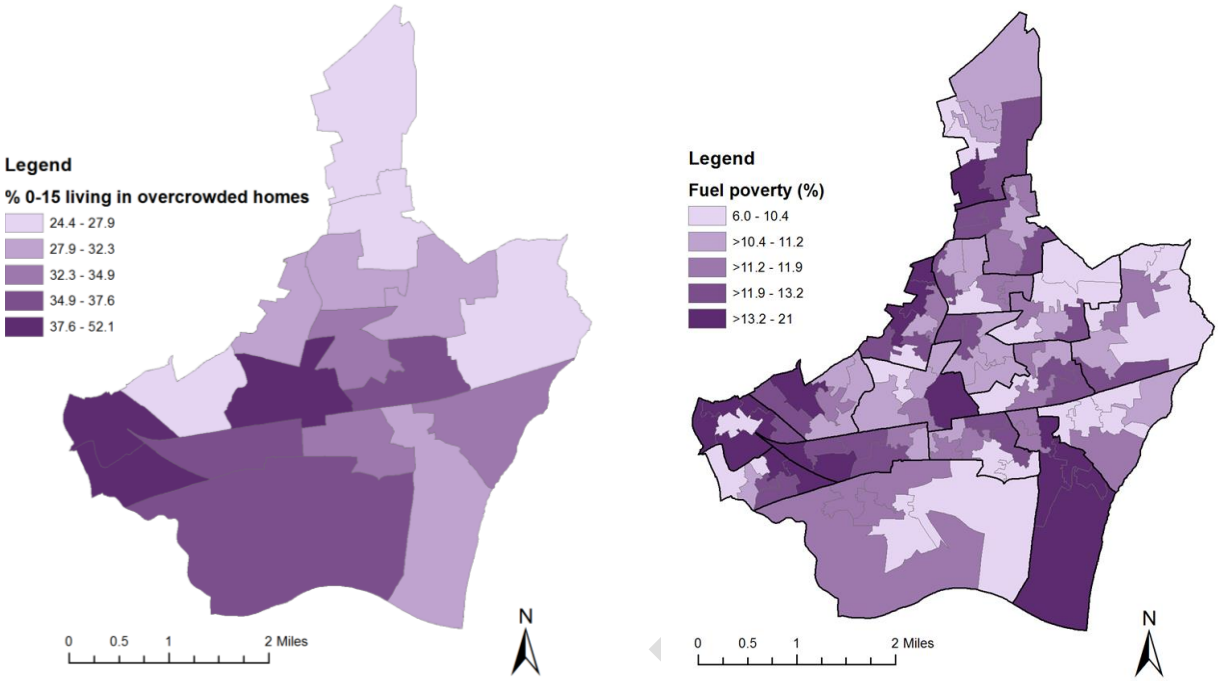
Figure 3.13: Overcrowding (2011) and Fuel poverty (2016)



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

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

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

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

3.5.9 Health services

Health visiting services

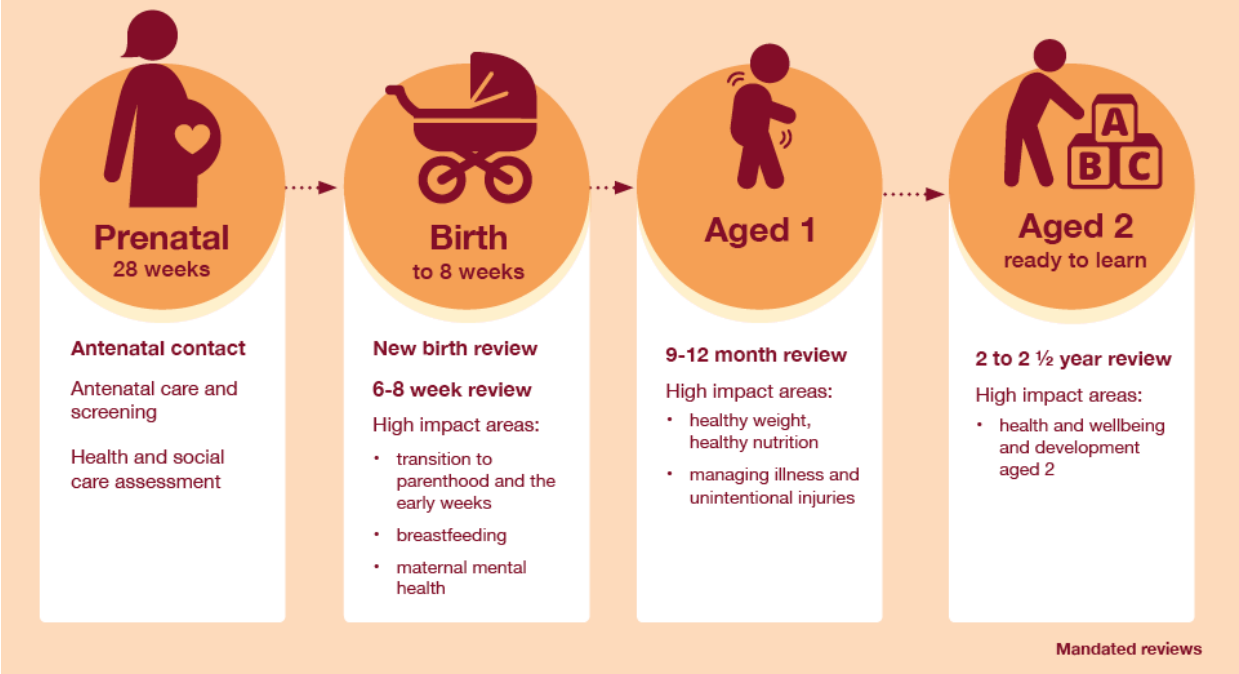
All mothers and babies in Barking and Dagenham should receive five reviews from a health visitor: an antenatal contact from 28 weeks of pregnancy, a new birth review in the first 14 days, a 6–8-week review, a 12-month review and a review at 2–2.5 years.

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

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

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

Figure 3.14: Universal mandated health visitor reviews



Source: PHE.

Immunisations

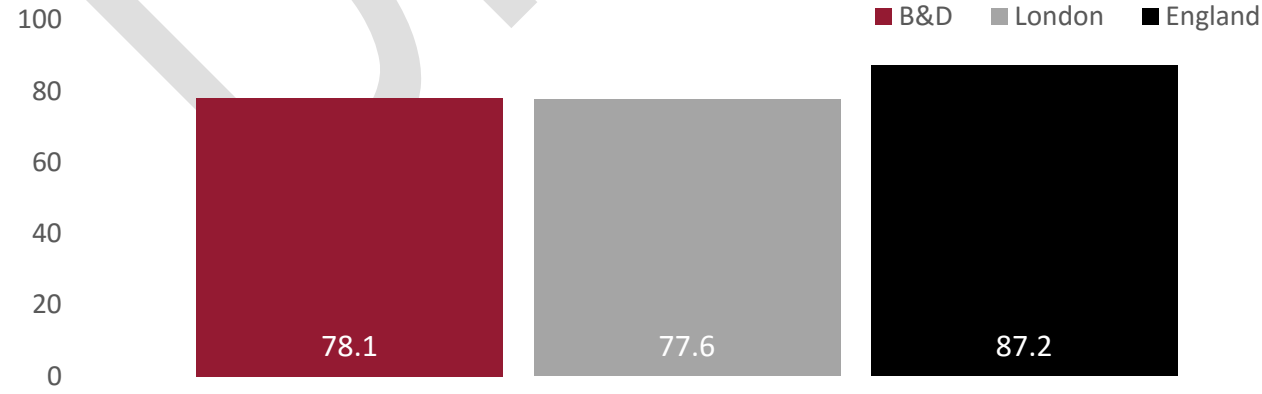
Giving children the best start in life includes protecting them from avoidable harm. Vaccinations are a simple and safe way to protect children from illnesses that can have serious consequences.

Measles, mumps and rubella

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

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

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



Data: PHE.

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

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

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

Flu

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

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

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

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

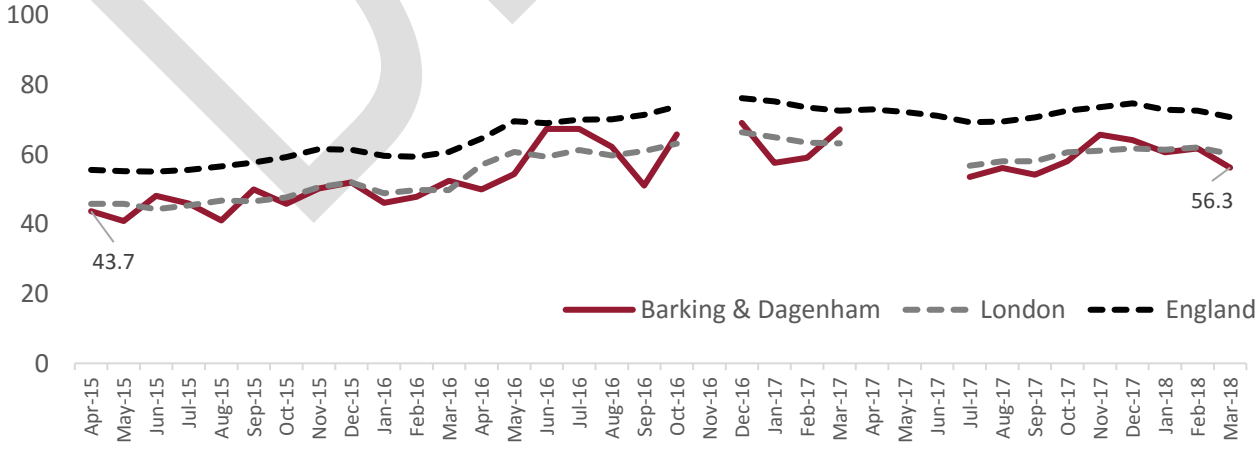
Pertussis (whooping cough) vaccine in pregnancy

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

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

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

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



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

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

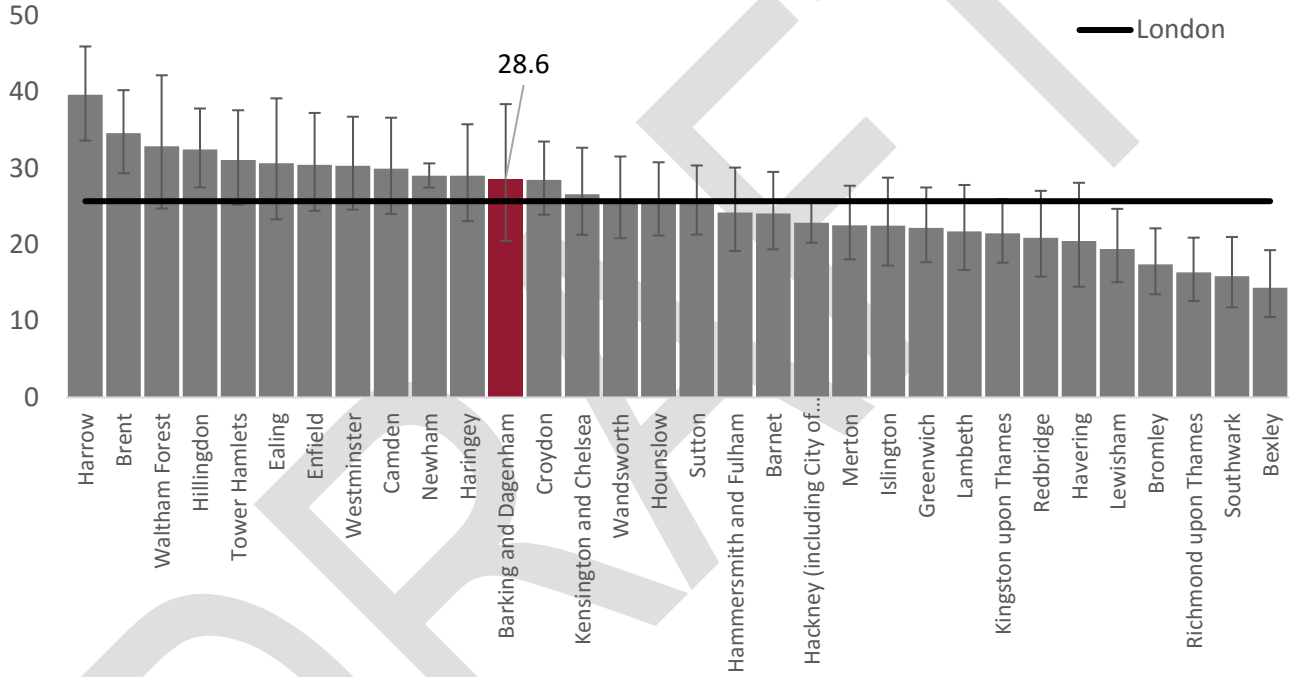
Oral health

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

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

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

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



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

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

3.6 Conclusions

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

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

[90] PHE. Health Matters: Child Dental Health [https://publichealthmatters.blog.gov.uk/2017/06/14/health-matters-child-dental-health/]. Accessed 2018 Oct 03.
[91] PHE, Oral Health Profile [https://fingertips.phe.org.uk/profile/oral-health]; 2012/13.
[92] PHE, Child and Maternal Health profile [https://fingertips.phe.org.uk/profile/child-health-profiles]. The Barking and Dagenham and England figures are classed as similar as they have overlapping confidence intervals; as this is based on a survey, there is considerable uncertainty around the 'true' population values.
[93] PHE, Child and Maternal Health profile [https://fingertips.phe.org.uk/profile/child-health-profiles]; 2014/15-2016/17.

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

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

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

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

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

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

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

4 Early diagnosis and intervention

4.1 What do we mean by early diagnosis and intervention?

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

4.2 Why is this important?

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

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

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

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

4.3 Why is this important for Barking and Dagenham?

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

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

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

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

[94] Kale MS, Korenstein D. Overdiagnosis in primary care: framing the problem and finding solutions. *BMJ* 2018;362:k2820.
[95] ONS, Avoidable mortality in the UK: 2016.
[96] ONS, Avoidable mortality in the UK: 2016. Statistical bulletin [https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2016]. Accessed 2018 Oct 03. The number of avoidable deaths is derived from a list of causes of death with the age ranges they apply to; most deaths from the causes on this list are only considered preventable or amenable under the age of 75.

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

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

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

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

4.4.1 Lifestyle-related illnesses

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

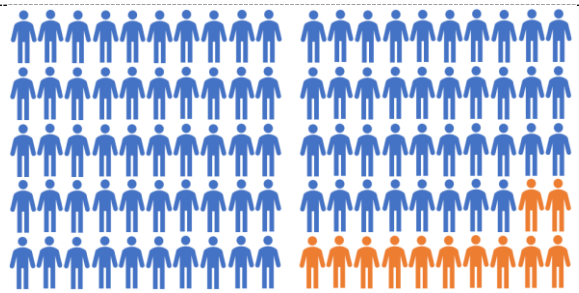
This section focuses on cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes and liver disease, since all four conditions contribute to morbidity and mortality in the borough and early diagnosis or identification of risk and intervention could improve health outcomes.

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

Lifestyle risk factors[99]

Of 100 people in the specified population:	Risk factor:
	**Dependent drinkers:** An estimated 1.53% of adults in Barking and Dagenham are dependent on alcohol, compared with 1.36% across London and 1.39% in England.[100] Excessive alcohol consumption is a risk factor for liver disease, cardiovascular disease (heart disease and stroke) and cancer.[101] There can also be social consequences, such as unemployment and domestic violence.
	High blood pressure: 11.6% of the Barking and Dagenham GP-registered population is on their GP's hypertension register.[102]

[97] With the exception of bronchiectasis (International Classification of Diseases, tenth revision [ICD-10] code J47).
[98] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]; 2015–17.
[99] Note: percentages in infographics rounded to nearest whole person. One block = 50%, one row = 10%, one person = 1%.
[100] PHE, Local Alcohol Profiles for England [https://fingertips.phe.org.uk/profile/local-alcohol-profiles]. Note: these are modelled figures for 2014/15.
[101] NHS. Overview: Alcohol misuse [https://www.nhs.uk/conditions/alcohol-misuse/]. Accessed 2018 Oct 03.
[102] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.



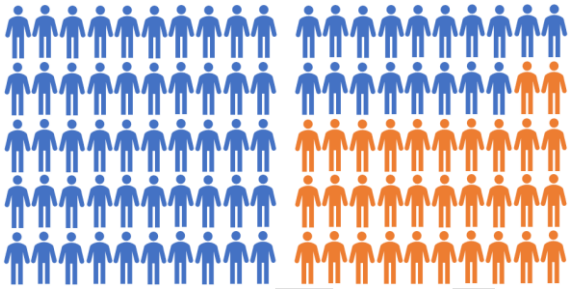
High blood pressure is a risk factor for cardiovascular disease, including heart disease and stroke.[103]

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

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

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

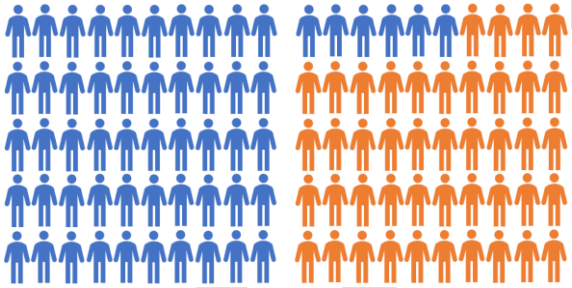
Smoking is a major risk factor for conditions including lung cancer, chronic obstructive pulmonary disease (COPD), heart disease and stroke.[106]



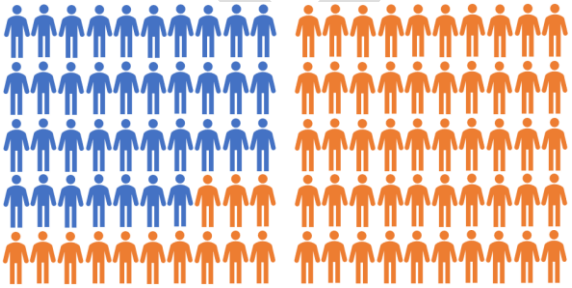
Physical inactivity: 32.1% of Barking and Dagenham adults (19+) are physical inactive (less than 30 minutes of moderate intensity exercise a week), compared with 22.9% in London and 22.2% across England.

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

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



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



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

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

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

[103] NHS. Overview: High blood pressure (hypertension) [https://www.nhs.uk/conditions/high-blood-pressure-hypertension/]. Accessed 2018 Oct 03.
[104] NHS. Causes: High blood pressure (hypertension) [https://www.nhs.uk/conditions/high-blood-pressure-hypertension/causes/]. Accessed 2018 Oct 03.
[105] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control]. 2016/17 Quality and Outcomes Framework data.
[106] NHS Digital, Statistics on Smoking – England 2018 – Data tables.
[107] Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT; Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *Lancet* 2012;380(9838):219–29.
[108] NHS. Overview: Obesity [https://www.nhs.uk/conditions/obesity/]. Accessed 2018 Oct 03.

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

Prevalence

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

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

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

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

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

Early diagnosis and intervention

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

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

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

Good cardiovascular health may reduce the risk of vascular dementia and Alzheimer's disease in later life[115] and hence an early assessment of risk and support to make changes could also be an early intervention to prevent these conditions.

[109] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[110] PHE, Modelled prevalence estimates profile [https://fingertips.phe.org.uk/profile/prevalence]. Estimate is for 2015.
[111] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[112] PHE, Modelled prevalence estimates profile [https://fingertips.phe.org.uk/profile/prevalence]. Estimate is for 2015.
[113] ONS via Nomis, Mortality statistics - underlying cause, sex and age.
[114] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[115] NHS. Overview: Vascular dementia [https://www.nhs.uk/conditions/vascular-dementia/]. Accessed 2018 Oct 04; NHS. Overview: Alzheimer's disease [https://www.nhs.uk/conditions/alzheimers-disease/]. Accessed 2018 Oct 04.

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

Prevalence

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

Furthermore, modelled estimates suggest that the prevalence of COPD across all age groups is 2.4% in Barking and Dagenham, or 1 in 42.[118]

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

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

Early diagnosis and intervention

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

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

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

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

[116] NHS. Overview: Chronic obstructive pulmonary disease (COPD) [https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/]. Accessed 2018 Oct 04.
[117] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[118] PHE, Modelled prevalence estimates profile [https://fingertips.phe.org.uk/profile/prevalence]. Estimate is for 2015.
[119] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control]; 2014-16.
[120] NHS. Overview: Chronic obstructive pulmonary disease (COPD) [https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/]. Accessed 2018 Oct 04.
[121] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[122] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[123] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control]; 2016/17, 35+.

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

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

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

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

Source: Compiled from information on NHS website.[124]

Prevalence

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

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

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

Early diagnosis and intervention

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

[124] NHS. Understanding medication: Type 2 diabetes [http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Treatment.aspx]. Accessed 2018 Oct 04; NHS. Type 1 diabetes [http://www.nhs.uk/conditions/Diabetes-type1/Pages/Introduction.aspx]. Accessed 2018 Oct 04; NHS. Diabetes [http://www.nhs.uk/Conditions/Diabetes/Pages/Diabetes.aspx]. Accessed 2018 Oct 04. NHS. Overview: Gestational diabetes [http://www.nhs.uk/Conditions/gestational-diabetes/Pages/Introduction.aspx]. Accessed 2018 Oct 04. NHS. Diabetes and pregnancy [http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/diabetes-pregnant.aspx]. Accessed 2018 Oct 04.
[125] PHE, Cardiovascular Disease profile [https://fingertips.phe.org.uk/profile/cardiovascular].
[126] Health Analytics, September 2017. Directly age standardised rate based on Barking and Dagenham GP-registered population.
[127] Health Analytics, September 2017.

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

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

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

Figure 4.1: Annual care processes for people with diabetes

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

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

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

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

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

[128] NHS Digital. *National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report*. [Leeds]: NHS Digital; 2017.
[129] NHS Digital. *National Diabetes Audit, 2016-17. Care Processes and Treatment Targets short report*. [Leeds]: NHS Digital; 2017.
[130] PHE, Diabetes profile [https://fingertips.phe.org.uk/profile/diabetes-ft].
[131] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[132] PHE, Diabetes profile [https://fingertips.phe.org.uk/profile/diabetes-ft].

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

Prevalence

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

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

Early diagnosis and intervention

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

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

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

People who inject drugs are at increased risk of Hepatitis B and C infection, as this can be spread through the sharing of needles. Just under nine in ten (88.0%) eligible people in drug misuse treatment who inject drugs received a Hepatitis C test in 2016/17.[137] This has declined from 95.3% in 2014/15.

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

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[133] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[134] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/]. Age-standardised rate – cannot be directly applied back to Barking and Dagenham population.
[135] National Drug Treatment Monitoring System.
[136] York Health Economics Consortium. *NHS Innovation Accelerator. Economic Impact Evaluation Case Study: Liver Disease Diagnostic Pathway.* York: YHEC; 2018 [https://nhsaccelerator.com/wp-content/uploads/2018/03/Scarred-Liver-Pathway-Economic-Case-Study.pdf]; Tanajewski L, Harris R, Harman DJ, Aithal GP, Card TR, Gkountouras G, et al. Economic evaluation of a community-based diagnostic pathway to stratify adults for non-alcoholic fatty liver disease: a Markov model informed by a feasibility study. *BMJ Open* 2017;7(6):e015659; National Institute for Health and Care Excellence. The scarred liver project: a new diagnostic pathway to detect chronic liver disease across primary and secondary care [https://www.nice.org.uk/sharedlearning/the-scarred-liver-project]. Accessed 2018 Oct 05; The King's Fund. Early diagnosis of chronic liver disease [https://www.kingsfund.org.uk/publications/innovation-nhs/early-diagnosis-chronic-liver-disease]. Accessed 2018 Oct 05.
[137] PHE, Liver disease profiles [https://fingertips.phe.org.uk/profile/liver-disease].
[138] PHE, Liver disease profiles [https://fingertips.phe.org.uk/profile/liver-disease].

4.4.2 Cancer

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

Incidence, mortality and survival

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

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

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

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

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

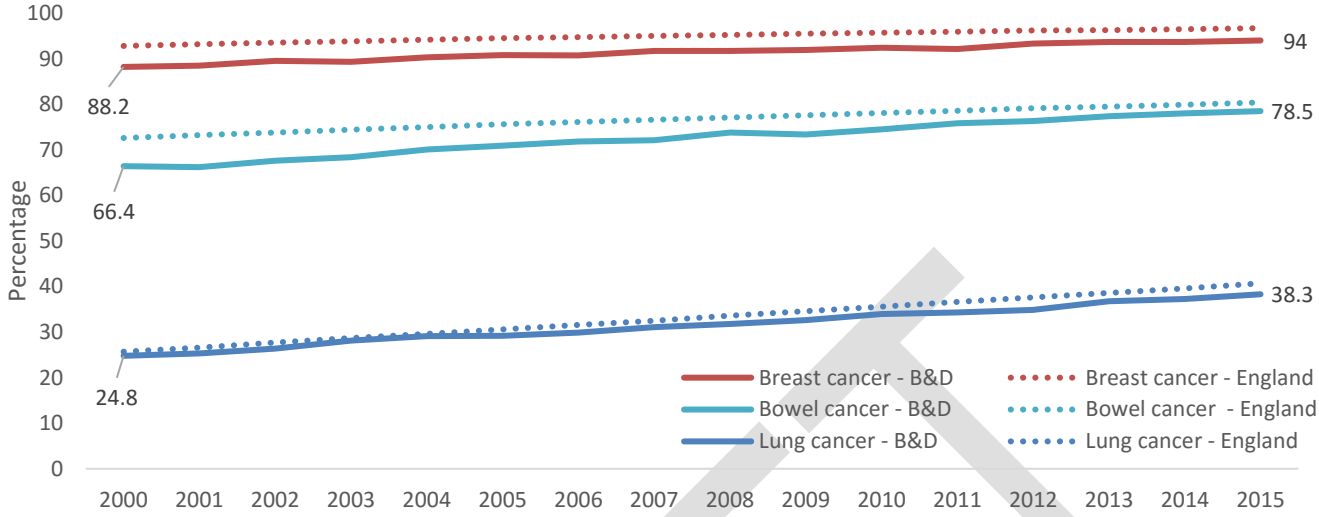
Survival
In Barking and Dagenham, 94.0% of those diagnosed with breast cancer in 2015 were alive 12 months after their diagnosis, which is significantly worse than the England average of 96.7%.[141]

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

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

[139] PHE, CancerData [https://www.cancerdata.nhs.uk/]. 2014-16. Numbers rounded to nearest 5. Breast cancer figures are for women only, since the incidence rate is only available for women.
[140] PHE, CancerData [https://www.cancerdata.nhs.uk/]. 2014-16. Numbers rounded to nearest 5. Breast cancer figures are for women only, since the mortality rate is only available for women.
[141] ONS, Cancer survival in Clinical Commissioning Groups, England: Adults diagnosed between 2000 and 2015 and followed up to 2016.

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



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

Early diagnosis and intervention

Screening

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

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

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

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

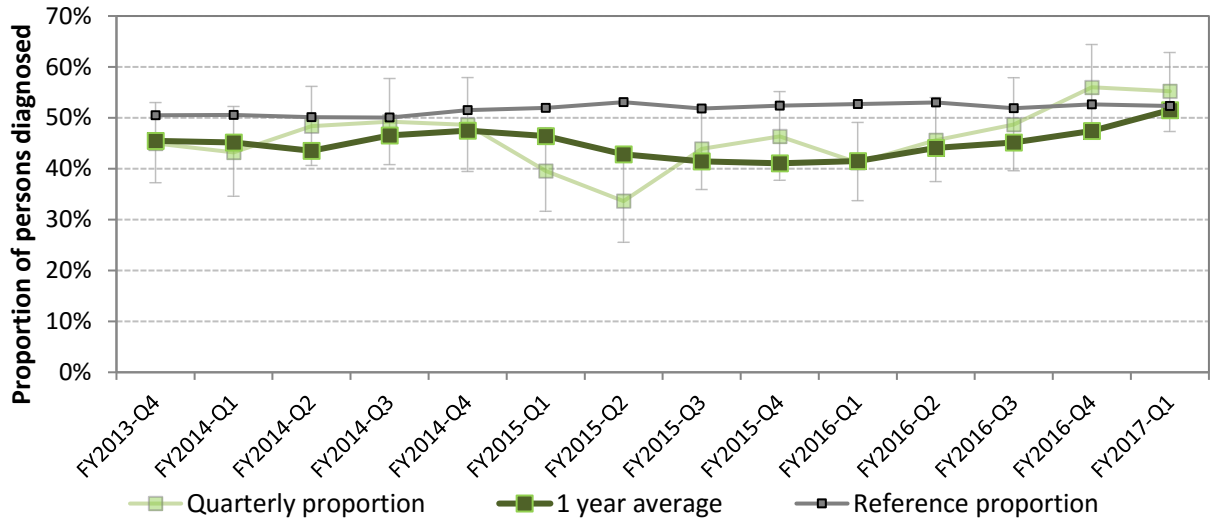
Stage at diagnosis

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

[142] PHE, Young person and adult screening KPI data: Q3 (1 October 2017 to 31 December 2017).
[143] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[144] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[145] Cancer Research UK. Stages of cancer [https://www.cancerresearchuk.org/about-cancer/what-is-cancer/stages-of-cancer]. Accessed 2018 Oct 04.
[146] PHE. *Stage at diagnosis 2012-2014 and one-year cancer survival in England*. National cancer registration and analysis service briefing. [London]: PHE; 2016. See also: McPhail S, Johnson S, Greenberg D, Peake M, Rous B. Stage at diagnosis and early mortality from cancer in England. *Br J Cancer* 2015;112 Suppl 1:S108–15.

In Barking and Dagenham, 51.5% of cancers were diagnosed at stages 1 or 2 (12-month rolling average to end of December 2017), similar to the figure for England (52.5%).[147] As Figure 4.3 shows, the gap between Barking and Dagenham and England has decreased in the last few years. Furthermore, this data is not adjusted for case mix; as Barking and Dagenham has a higher incidence of lung cancer and lung cancer is typically diagnosed at a late stage (64.8% of cases were diagnosed at stages 3 or 4 in Barking and Dagenham between 2014 and 2016[148]), we might expect the proportion to be higher.

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

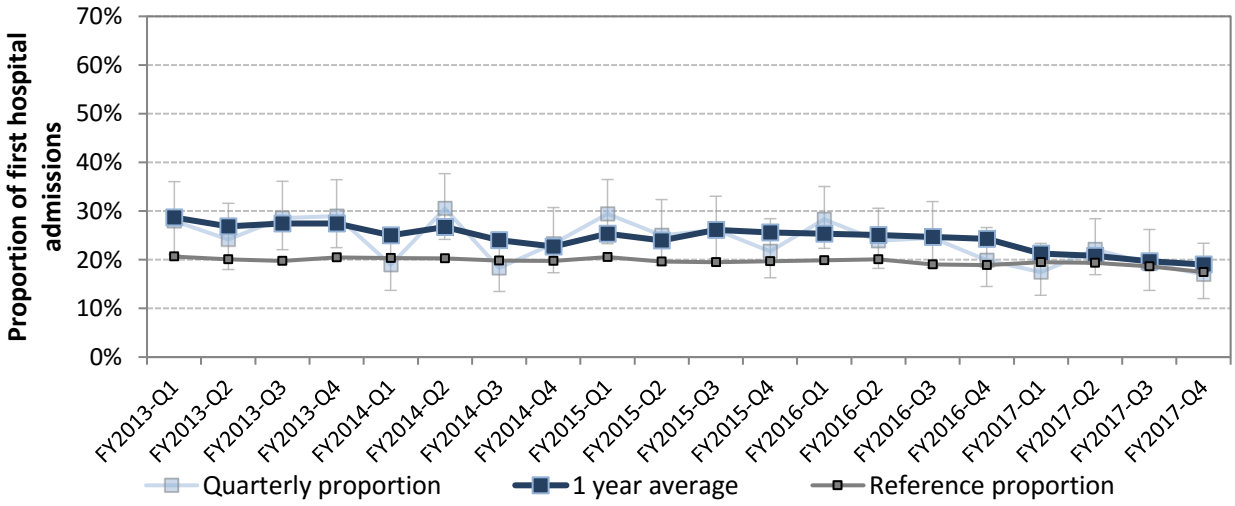


Source: PHE, Cancer Outcomes: Stage at Diagnosis. August 2018.

Presentation route

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

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



Source: PHE, Cancer Outcomes: Emergency Presentations.

[147] PHE, Cancer Outcomes: Stage at Diagnosis. August 2018.
[148] PHE, National Cancer Registration and Analysis Service. TNM stage group by CCG by tumour type for 10+3 tumour types, 2016.

Referral

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

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

4.4.3 Mental health

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

Common mental illnesses

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

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

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

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

Furthermore, based on healthcare and survey data:

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

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

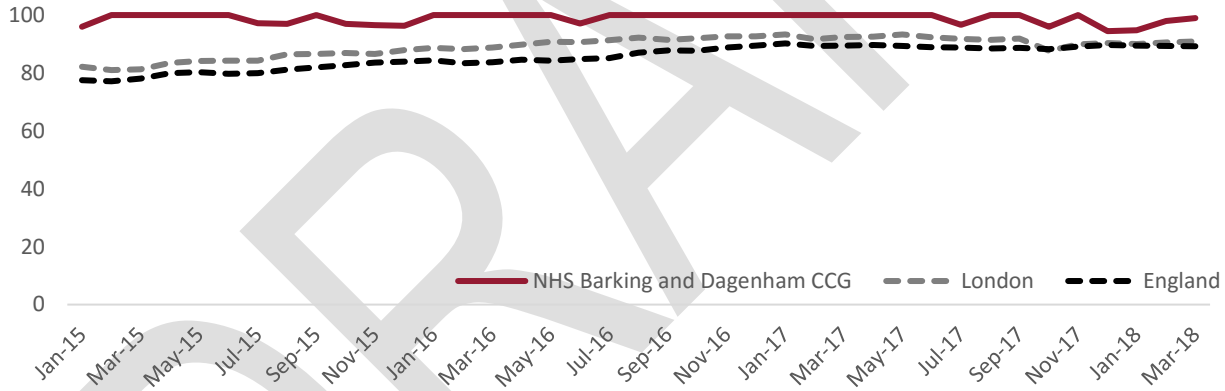
[149] NHS England, Waiting Times for Suspected and Diagnosed Cancer Patients: Commissioner Based. Quarter One 2018-2019.
[150] NHS England, Waiting Times for Suspected and Diagnosed Cancer Patients: Commissioner Based. Quarter One 2018-2019.
[151] PHE, Children and Young People's Mental Health and Wellbeing [https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh]. Estimate is for 2015.
[152] PHE, Common Mental Health Disorders [https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders]. Estimate is for 2014/15
[153] GP Patient Survey 2018 [https://www.gp-patient.co.uk/]

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

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

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

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



Data: PHE, Common Mental Health Disorders profile.

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

Serious mental illnesses

'Serious mental illnesses' refers to schizophrenia, bipolar affective disorder and other psychoses.[158]

Prevalence

[154] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[155] PHE. National General Practice Profiles. Indicator Definitions and Supporting Information [https://fingertips.phe.org.uk/profile/general-practice/data#page/6/gid/2000003/pat/46/par/E39000018/ati/152/are/E38000004/iid/91243/age/168/sex/4]. Accessed 2018 Oct 04.
[156] National Collaborating Centre for Mental Health. *The Improving Access to Psychological Therapies* Manual. [London]: NCCMH; 2018.
[157] NHS Digital, Improving Access to Psychological Therapies (IAPT). Interactive data tool – Quarter 1 2018/19.
[158] PHE. National General Practice Profiles. Indicator Definitions and Supporting Information [https://fingertips.phe.org.uk/profile/general-practice/data#page/6/gid/2000003/pat/46/par/E39000018/ati/152/are/E38000004]. Accessed 2018 Oct 04.

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

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

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

For example, smoking rates among people with a serious mental illness are much higher than in the general population: 40.2% of patients with a serious mental illness in Barking and Dagenham were current smokers in 2015/16, compared with an adult prevalence of 20.4%.[163] Intervening with this group would therefore also include supporting attempts to quit. The LBBD Tobacco Harm Reduction Strategy has set a target to halve the number of smokers with mental health conditions by 2022.[164]

Dementia

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

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

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

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

As discussed in the cardiovascular disease section above, good cardiovascular health may reduce the risk of vascular dementia and Alzheimer's disease in later life[168] and

[159] PHE, National General Practice Profiles [https://fingertips.phe.org.uk/profile/general-practice]; 2016/17.
[160] NHS Digital, Mental Health Services Monthly Statistics. Access and Waiting Times. Data Tables, Final April 2018 to June 2018, Experimental Statistics; NHS Digital, Mental Health Services Monthly Statistics. Access and Waiting Times. Data Tables, Final January 2018 to March 2018, Experimental Statistics.
[161] Baker, C. *Mental health statistics for England: prevalence, services and funding*. Briefing Paper Number 6988, 25 April 2018. [London]: House of Commons Library; 2018.
[162] PHE. Severe mental illness (SMI) and physical health inequalities: briefing [https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing]. Accessed 2018 Oct 04; data is national and does not relate to Barking and Dagenham specifically.
[163] PHE, Local Tobacco Control Profiles [https://fingertips.phe.org.uk/profile/tobacco-control].
[164] LBBD, Tobacco harm reduction strategy. [London]: LBBD; 2017.
[165] NHS. Dementia guide: About dementia [https://www.nhs.uk/conditions/dementia/about/]. Accessed 2018 Oct 04.
[166] Health Analytics, March 2018.
[167] NHS. Dementia guide: About dementia [https://www.nhs.uk/conditions/dementia/about/]. Accessed 2018 Oct 04.
[168] NHS. Overview: Vascular dementia [https://www.nhs.uk/conditions/vascular-dementia/]. Accessed 2018 Oct 04; NHS. Overview: Alzheimer's disease [https://www.nhs.uk/conditions/alzheimers-disease/]. Accessed 2018 Oct 04.

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

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

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

Self-harm and suicide

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

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

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

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

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

4.4.4 Sexual health

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

Chlamydia and gonorrhoea

Incidence
The chlamydia detection rate in Barking and Dagenham is 1,679 per 100,000 aged 15–24.[173] This is below Public Health England's target threshold of 2,300 per 100,000; in this case, a low incidence rate is seen as negative as – based on what is known about chlamydia in young people – there is an assumption that if not diagnosed, these cases are undetected rather than do not exist.

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

[169] NHS Digital, Recorded Dementia Diagnoses – August 2018. GP-registered population.
[170] PHE, Dementia Profile [https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia].
[171] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[172] PHE, Children and Young People's Mental Health and Wellbeing [https://fingertips.phe.org.uk/cypmh].
[173] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
[174] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.

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

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

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

HIV

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

In 2017, 742 people were living with an HIV diagnosis locally – 5.77 per 1,000 people aged 15–59. [177] This is higher than England but similar to London.

People most likely to be living with diagnosed HIV locally are:[178]
- in the three most deprived quintiles
- women
- black African
- aged 35-49.

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

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

[175] Data from GUMCADv2 surveillance, PHE.
[176] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
[177] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
[178] Data from SOPHID surveillance, PHE. 2016
[179] Croxford S, Kitching A, Desai S, Kall M, Edelstein M, Skingsley A, et al. Mortality and causes of death in people diagnosed with HIV in the era of highly active antiretroviral therapy compared with the general population: an analysis of a national observational cohort. *Lancet Public Health* 2017;2(1):e35–e46.
[180] Brown AE, Kall MM, Smith RD, Yin Z, Hunter A, Delpech VC. Auditing national HIV guidelines and policies: The United Kingdom CD4 Surveillance Scheme. *Open AIDS J* 2012;6:149–55.
[181] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.

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

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

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

109 rapid HIV tests were undertaken in 2017.[185]

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

4.5 Conclusions

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

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

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

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

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

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

[182] 12% undiagnosed based on national data applied to 2017 number aged 15–59 living with HIV. See: PHE, *Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK*. London; PHE: 2017; PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth].
[183] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
[184] PHE, Sexual and Reproductive Health Profiles [https://fingertips.phe.org.uk/profile/sexualhealth]. Data is for 2017.
[185] Data from GUMCADv2 surveillance, PHE.
[186] Data from GUMCADv2 surveillance, PHE.

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

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

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

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

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

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

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

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

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

5 Resilience

5.1 What is resilience?

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

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

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

5.2 Why is resilience important?

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

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

5.3 Why is resilience important for Barking and Dagenham?

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

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

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

5.4 What builds resilience?

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

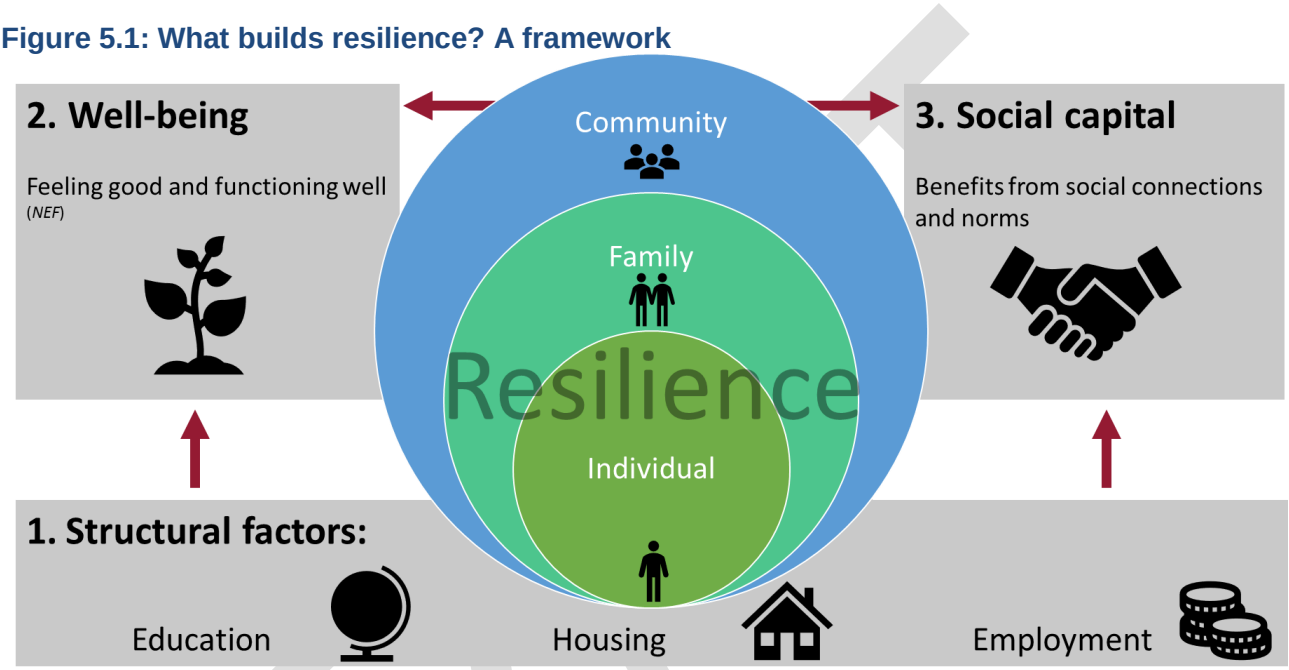
[187] Glasgow Centre for Population Health. *Resilience for public health: supporting transformation in people and communities*. Briefing paper 12, Concepts series. Glasgow: Glasgow Centre for Population Health; 2014.

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

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

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

Figure 5.1: What builds resilience? A framework



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

5.5 Structural factors

5.5.1 Education

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

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

1. Early years foundation prior to school
Early years education builds resilience by enhancing educational attainment, enabling communication skills and improving expression and emotional intelligence.

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

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

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

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

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

3. Educational attainment

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

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

4. School attendance

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

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

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

Inequalities

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

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

5.5.2 Housing

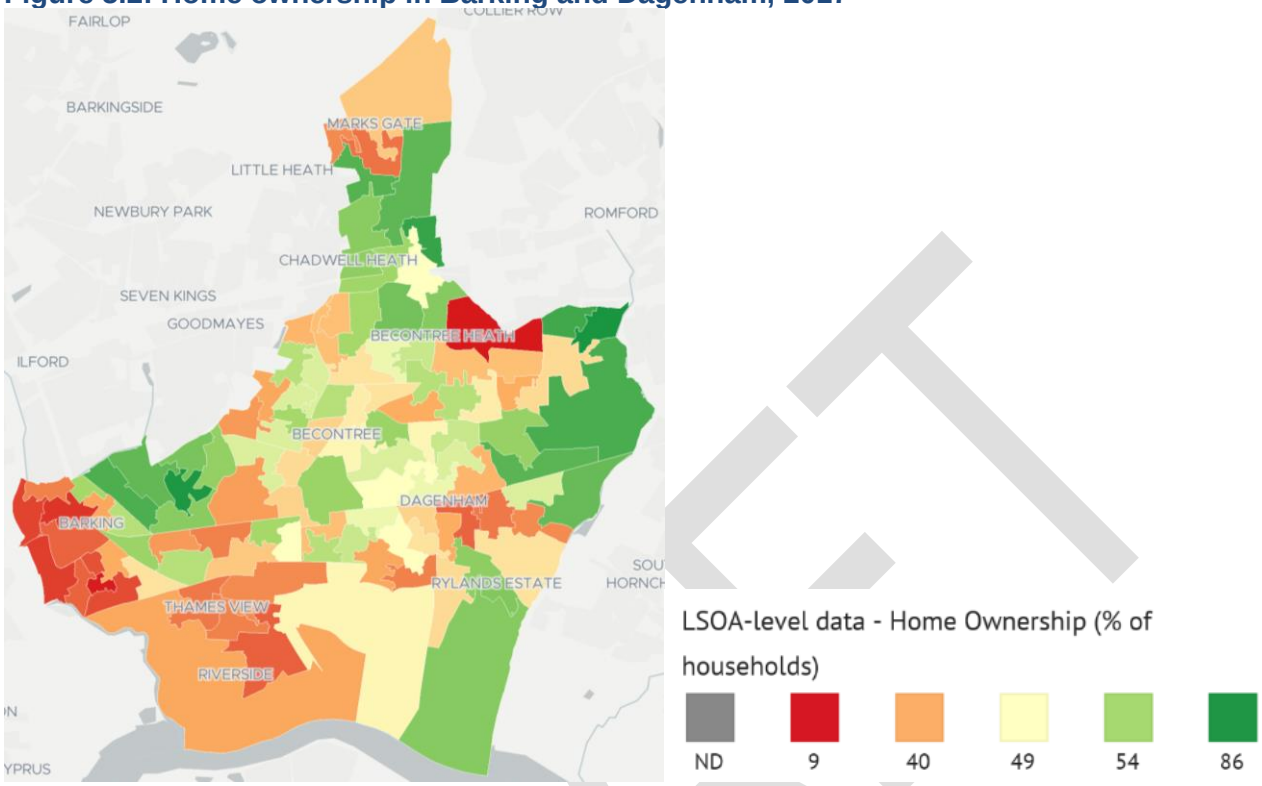
How does housing support resilience?

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

[189] Ofsted. Data View [https://public.tableau.com/views/Dataview/Viewregionalperformanceovertime]. Accessed 2018 Sept 28. Data as at 31 March 2018.
[190] Healthy Schools London [http://www.healthyschools.london.gov.uk/]. Accessed 2018 Sept 28. 55 registered schools, 34 with bronze award, 32 with silver, 15 with gold.
[191] DfE, SFR01/2018: GCSE and equivalent results in England 2016/17 (revised).
[192] DfE, Pupil absence in schools in England: 2016 to 2017. Main tables.
[193] DfE, SFR01/2018: GCSE and equivalent results in England 2016/17 (revised).
[194] DfE, Pupil absence in schools in England: 2016 to 2017. Main tables.

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

Figure 5.2: Home ownership in Barking and Dagenham, 2017



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

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

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

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

Data: Wider Determinants of Health profile, *PHE*.

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

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

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

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

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

5.5.3 Employment

How does employment support resilience?

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

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

What proportion of Barking and Dagenham residents are in employment?

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

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

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[197] ONS, 2011 Census.
[198] Ministry of Housing, Communities & Local Government, Local Authority Housing Statistics data returns, England 2016-17.
[199] PHE, Child and Maternal Health profiles [https://fingertips.phe.org.uk/child-health-profiles]. Both refers to households accepted as homeless. Family homelessness refers to households with dependent children or pregnant women; homelessness among young people aged 16–24 refers to households where the head is aged 16–24.
[200] PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
[201] Waddell G, Burton AK. *Is work good for your health and well-being?* London: TSO; 2006. See p.vii.
[202] ONS, Annual Population Survey, Jan 2017-Dec 2017.
[203] Based on London Living Wage of £10.20 per hour. See: Living Wage Foundation. FAQs [https://www.livingwage.org.uk/faqs]. Accessed 2018 Oct 04.

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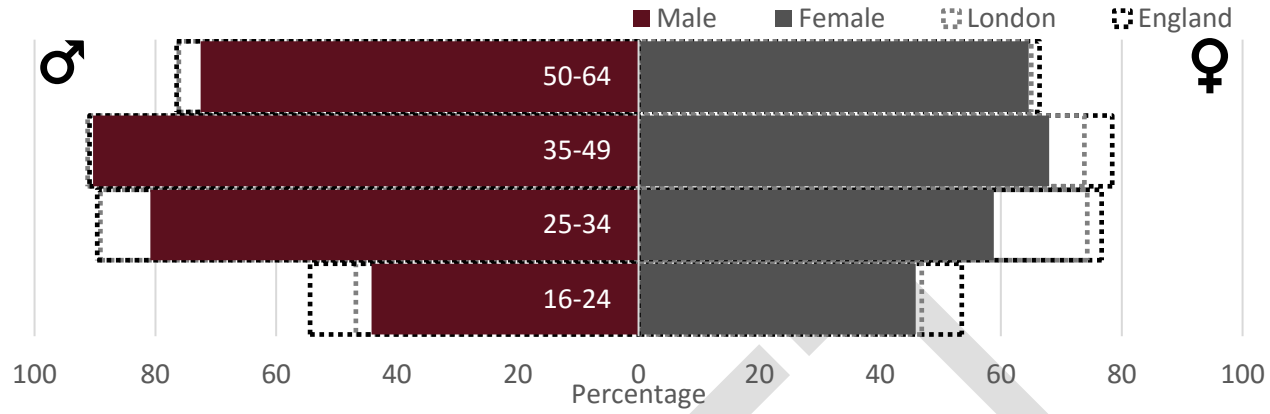
By age, the largest gaps compared with London and England are in under 35s in men and under 50s in women, especially women aged 25–34 (Figure 5.4).

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



Data: ONS, Annual Population Survey.

Table 5.1: Employment status by sex

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

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

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

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

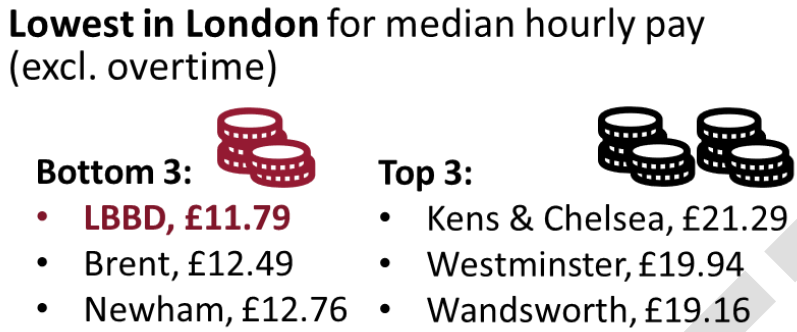
Working statuses other than employment could potentially support resilience in the right conditions; economically inactive residents may be students or raising families, among other reasons, which could have longer-term economic or social effects.

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

[204] ONS. Methodology: A guide to labour market statistics [https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/aguidetolabourmarketstatistics]. Accessed 2018 Oct 04.
[205] ONS, Annual Population Survey, Jan 2017-Dec 2017.
[206] ONS, 2011 Census, DC6201EW – Economic activity by ethnic group by sex by age.

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

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

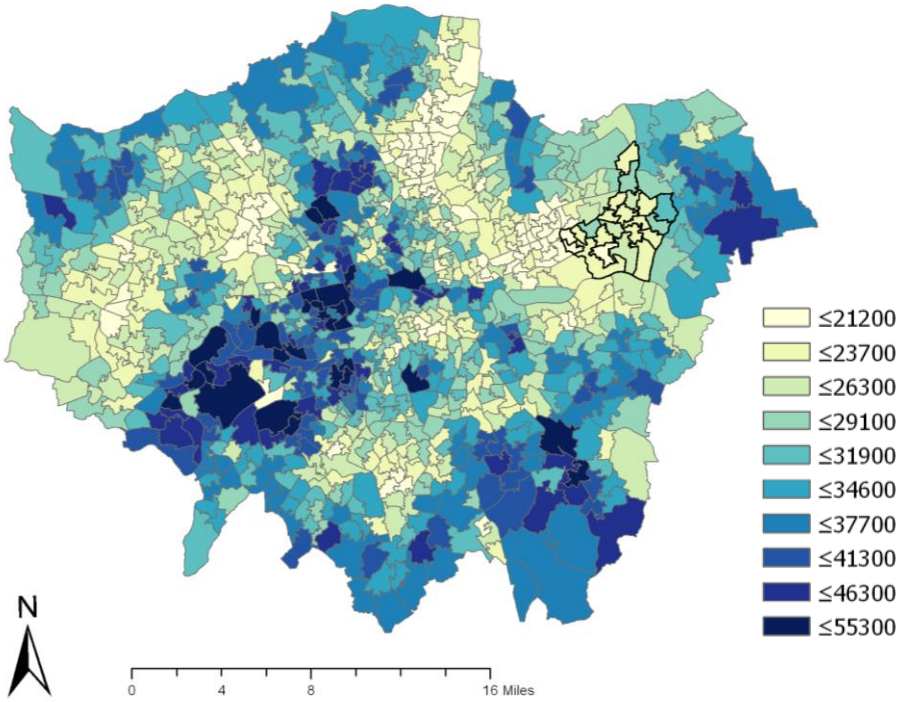


Data: ONS, Annual Survey of Hours and Earnings, 2017.

This is not just about the mix of part-time and full-time jobs; full-time Barking and Dagenham workers also have the lowest median hourly pay: £13.75.[209]

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

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

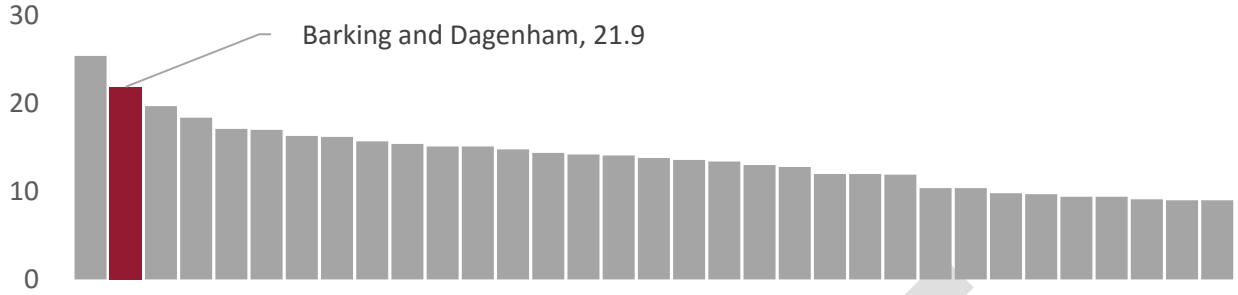


Data: ONS, Small area income estimates for middle layer super output areas, England and Wales. Contains National Statistics data © Crown copyright and database right 2016. Contains OS data © Crown copyright and database right 2016.

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

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

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



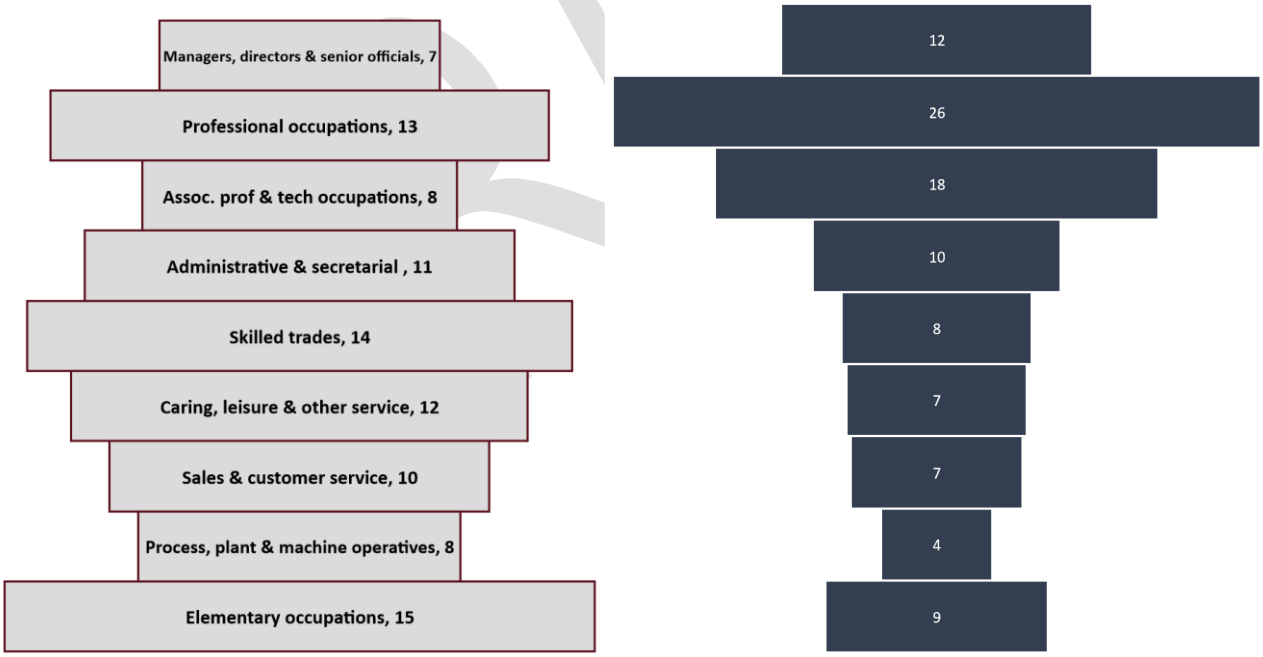
Data: The Insolvency Service, 2017.

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

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

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

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



Data: ONS, Annual Population Survey, 2017.

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

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

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

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

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

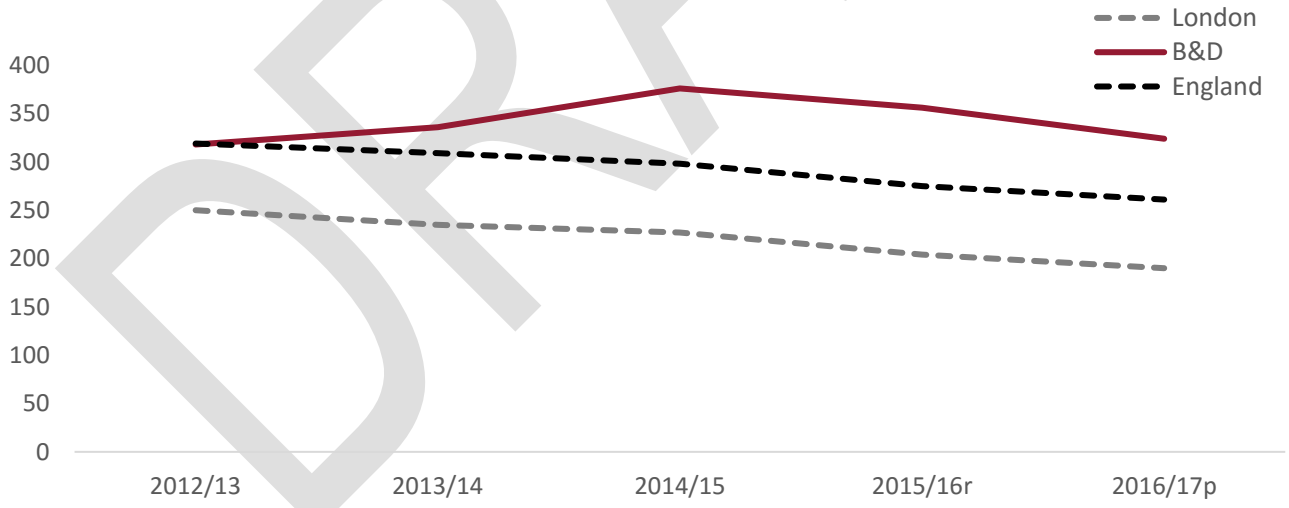
Furthermore, national health and safety data from a sentinel GP reporting scheme suggests that people in elementary occupations, process, plant and machine operatives and skilled trades occupations have a higher risk of work-related ill health than the average across all occupations.[211] These groups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

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

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

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

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



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

5.6 Wellbeing

Wellbeing has been defined as:

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

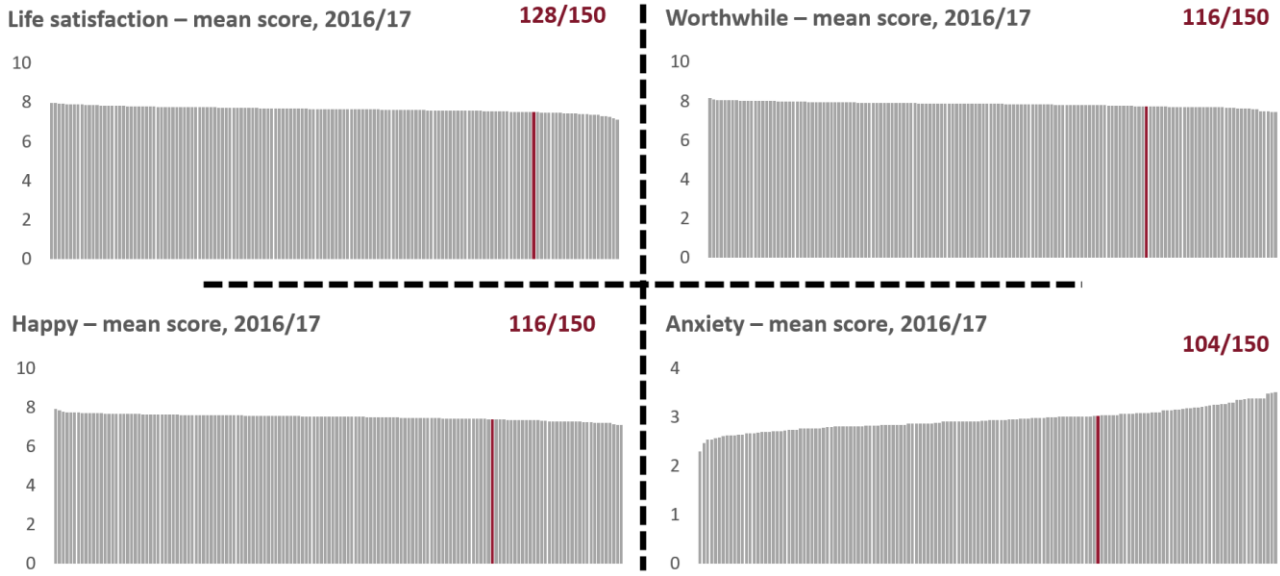
[211] Health and Safety Executive. Table THORGP08. Incidence of work-related ill-health seen in THOR-GP by major occupational group (SOC). Figures for 2015 and annual average for 2013 to 2015.
[212] Health and Safety Executive, RIDREG: RIDDOR reported Injuries by country, region, county and local authority.
[213] Health and Safety Executive, RIDREG: RIDDOR reported Injuries by country, region, county and local authority.
[214] Mind, Mental Health Foundation; Mental Health Strategic Partnership. *Building resilient communities: Making every contact count for public mental health*. London: Mind; 2013.

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

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

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

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



Data: ONS.

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

Table 5.2: Factors associated with low wellbeing nationally

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

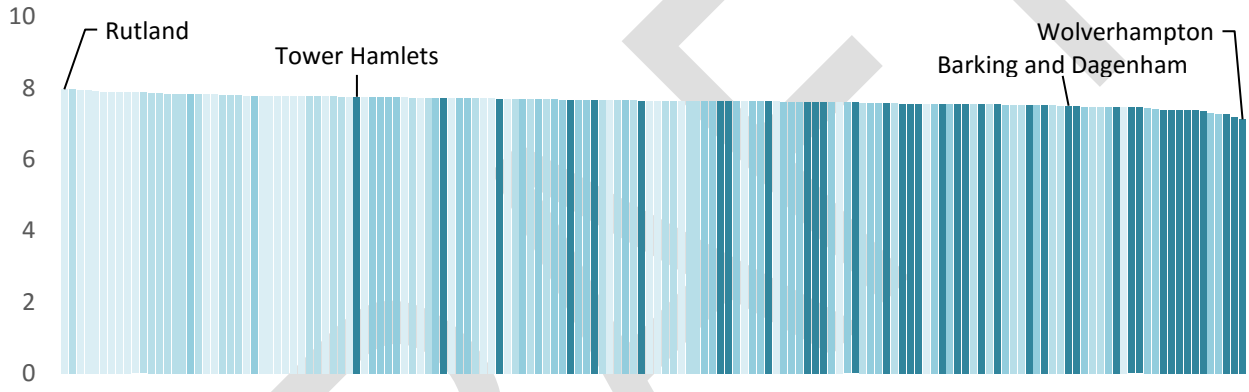
[215] ONS. Understanding well-being inequalities: Who has the poorest personal well-being? [https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/understandingwellbeinginequalitieswhohasthepoorestpersonalwellbeing/2018-07-11]. Accessed 2018 Oct 04.

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

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

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

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



Data: ONS.

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

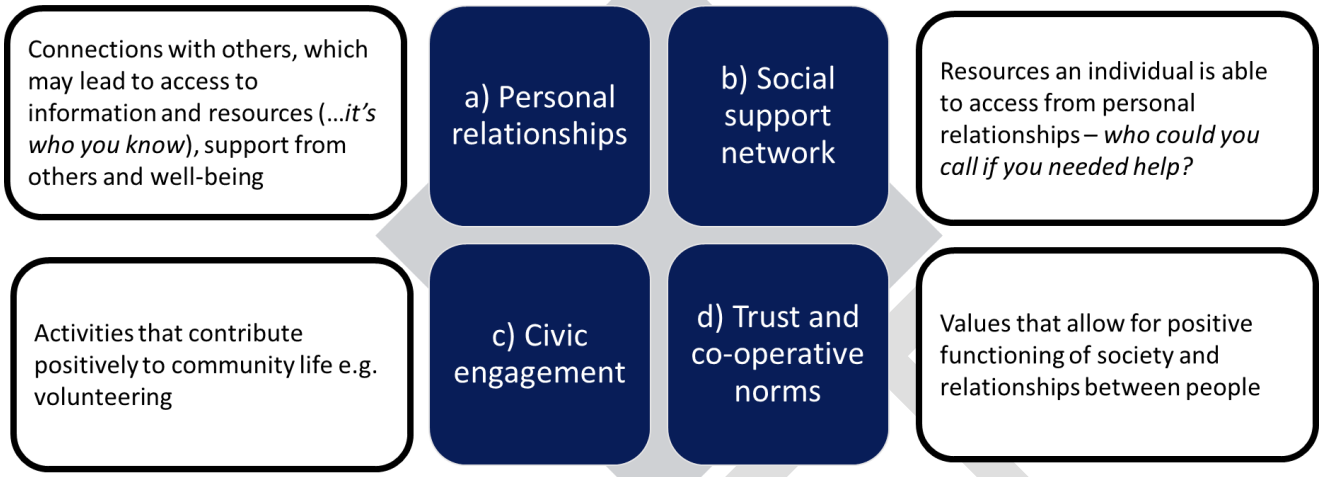
5.7 Social capital

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

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

[216] LBBD School Survey 2017.
[217] Mind, Mental Health Foundation; Mental Health Strategic Partnership. *Building resilient communities: Making every contact count for public mental health*. London: Mind; 2013.
[218] Scrivens K, Smith C. *Four Interpretations of Social Capital: An Agenda for Measurement*. OECD Statistics Working Papers, 2013/06. Paris: OECD Publishing; 2013.
[219] ONS, Social capital in the UK: May 2017. Statistical bulletin [https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/socialcapitalintheuk/may2017]. Accessed 2018 Oct 05.

Figure 5.12: Four conceptions of social capital



Source: Created based on Scrivens and Smith, 2013.

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

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

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

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

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

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

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

[220] Public Health England (PHE), Public Health Outcomes Framework [http://www.phoutcomes.info/].
[221] Public Health England (PHE), Public Health Outcomes Framework [http://www.phoutcomes.info/].
[222] GP Patient Survey 2018 [https://www.gp-patient.co.uk/].
[223] ONS. Loneliness - What characteristics and circumstances are associated with feeling lonely? [https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10]. Accessed 2018 Oct 04.

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

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

Table 5.3: Care in Barking and Dagenham and England

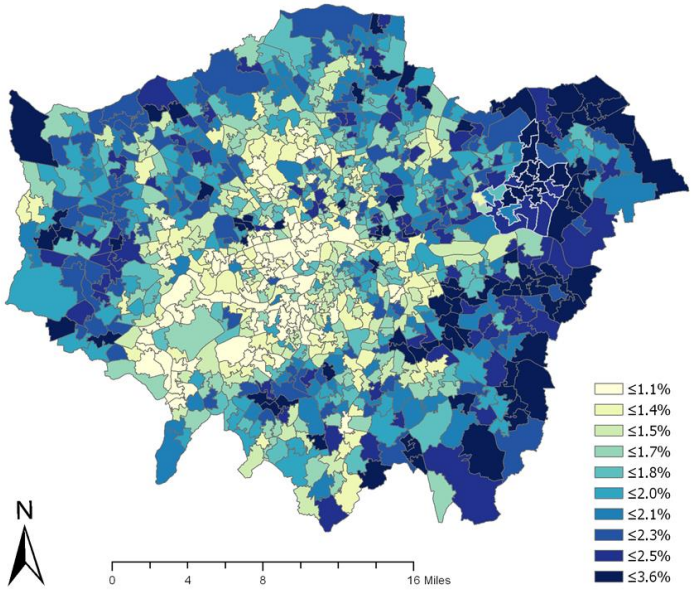
Hours per week of care provided	B&D	England
None	*87.1%*	*83.3%*
1–9	5.2%	9.2%
10–19	1.7%	2.1%
20–34	1.4%	1.2%
35–49	1.7%	1.0%
50+	3.0%	3.2%

Data: GP Patient Survey 2018.

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

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

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



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

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

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

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

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

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

Around seven in ten (72%) residents agree that their local area is a place where people from different backgrounds get on well together.[227] This is similar to 2015 and 2016 but lower than London (84%) and England (82%) figures for 2017/18.[228]

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

5.8 Conclusions

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

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

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

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

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

[225] LBBS Residents' Survey, 2017.
[226] ONS, Social capital headline indicators; May 2017.
[227] LBBD Residents' Survey, 2017.
[228] Department for Digital, Culture, Media & Sport. Community Life Survey: July 2018. Note: different survey method.
[229] LBBD Residents' Survey, 2017.

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

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

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

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

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

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

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

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

HEALTH AND WELLBEING BOARD

7 November 2018

Title:	**Health and Wellbeing Outcomes Framework Performance Report – Q2 2018/19**
Report of the Director of Public Health	
Open Report	**For Decision:** No
Wards Affected: ALL	**Key Decision:** No
Report Author: Suzanna Lee, Senior Intelligence and Analysis Officer, London Borough of Barking and Dagenham Rosanna Fforde, Senior Intelligence and Analysis Officer, London Borough of Barking and Dagenham	**Contact Details:** suzanna.lee@lbbd.gov.uk 020 8227 5739 rosanna.fforde@lbbd.gov.uk 020 8227 2394

Sponsor:

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

Summary:

To track progress across the wide remit of the Health and Wellbeing Board, the Board has agreed an outcomes framework which prioritises key issues for the improvement of the public's health and their health and social care services.

This high-level dashboard is monitored quarterly by the Board and this report forms the account of performance at the end of 2018/19 quarter 2 (to end September 2018) or the latest data available.

This indicator set is due be reviewed as part of the work currently underway to refresh the Joint Health and Wellbeing Strategy.

Recommendation(s)

The Board is recommended to:

(i) review the overarching dashboard and raise any questions with lead officers, lead agencies or the chairs of subgroups; and

(ii) note the detail provided on specific indicators, and to raise any questions on remedial actions or actions being taken to sustain good performance.

Reason(s)

The dashboard indicators were chosen to represent the wide remit of the Board while remaining manageable in number. It is therefore important that Board members use this opportunity to review key areas of Board business and confirm that effective delivery of services and programmes is taking place. Subgroups are undertaking further monitoring across the wider range of indicators in the Health and Wellbeing Outcomes Framework.

When areas of concern arise outside of the indicators ordinarily reported to the Board, these will be escalated as necessary.

1 Introduction

1.1 This report and its four appendices provide updated data and commentary on key performance indicators for the Health and Wellbeing Board. They also summarise CQC inspection reports published in quarter 2 to provide an update on the quality of local service provision.

1.2 The indicators included within this report provide an overview of performance of the whole health and social care system; the Health and Wellbeing Board has a wide remit and it is important to ensure that the Board has an overview across this breadth of activity. Indicators are categorised into life course stages (children, adolescents, adults, older adults, and across the life course).

1.3 In light of the work currently underway to refresh the Joint Health and Wellbeing Strategy, it was proposed in June's report that this indicator set be retained as it is, with one exception (the inclusion of a revised healthy lifestyles programme measure) and reviewed as part of the refresh.

1.4 In addition to the change made to the healthy lifestyles programme indicator, there is also now an alternative indicator for smoking cessation; the number of smoking quitters has been replaced by smoking prevalence in adults.

1.5 The dashboard is a summary of important areas from the Health and Wellbeing Board Outcomes Framework as well as indicators from the Local A&E Delivery Group's Urgent Care Dashboard. The outcomes framework itself is based on selections from the key national performance frameworks: the Public Health Outcomes Framework, Adult Social Care Outcomes Framework, and the NHS Outcomes Framework. Priority programmes such as the Better Care Fund have also been represented in the selected indicators.

2 Structure of the report

2.1 This report provides an overview of performance and CQC inspections, with further information contained in three appendices:

- Appendix A: Dashboard of indicators
- Appendix B: Performance summary reports of red-rated indicators
- Appendix C: CQC inspection reports, 2018/19 quarter 2

2.2 All indicators are rated red, amber or green (RAG) as a measure of success and risk to end-of-year delivery. Any indicator that is RAG-rated red has additional information available in Appendix B.

2.3 Board members should note that this means that Appendix B is focused on poor performance to highlight what needs improving and is not to be taken as indicative of overall performance.

3 Performance overview

3.1 Out of the 19 indicators, seven were RAG-rated red, seven were rated amber, four were rated green and one could not be rated. Please note that indicators are ordered from red to no rating in the following sections which may not correspond to their order in Appendix A.

Children

3.2 Among the five children's indicators, two were RAG-rated red, one was rated amber, one was rated green and one could not be rated:

i) **Percentage uptake of measles, mumps and rubella (MMR2) immunisation at 5 years old:** Quarter 1 performance (67.6%) is lower than London (72.2%) and remains below the target of 90%. No comparison with England is possible as England data was not published this quarter due to CHIS (Child Health Information Services) Hub data migration issues.

ii) **Prevalence of children in Year 6 that are obese or overweight:** The latest data for Barking and Dagenham shows an increase from 43.8% in 2016/17 to 44.5% in 2017/18. This is more than 10% above the target of the London average (37.7%) and is therefore RAG-rated red.[1]

iii) **Percentage of looked-after children with a completed health check:** This decreased from 86.0% in quarter 1 to 82.9% in quarter 2 2018/19. This is within 10% of the target of 92% and is therefore RAG-rated amber.

iv) **The number of children who turn 15 months old in the reporting quarter who receive a 12-month review:** This measure decreased from 79.0% in quarter 4 2017/18 to 78.5% in quarter 1 2018/19. It exceeds the target of 75% and is therefore rated green.

v) **Number of children and young people accessing Tier 3/4 CAMHS services:** Updated data shows that there were 675 children and young people in contact with CAMHS at the end of quarter 1, a decrease from 695 at the end of quarter 4. It is not possible to provide a target to 'rate' progress against for this measure due to the lack of national benchmarking information.

Adolescents

3.3 Both adolescents' indicators are RAG-rated red:

a) **Under 18 conception rate (per 1,000 population aged 15–17 years):** Although this measure continues to decrease, it remains more than 10% above its target, with a rolling 3-year average of 28.3 conceptions per 1,000 15–17 year olds compared with a target (the London average) of 18.5 per 1,000.

[1] RAG ratings based on measures being more than 10% above or below target are based on percentage difference rather than difference in percentage points.

b) **Care leavers in education, employment or training (EET):** Despite an improvement from 48.8% in quarter 1 to 49.6% in quarter 2 2018/19, the proportion of care leavers in EET remains more than 10% below the target of 57.0% and is therefore RAG-rated red.

Adults

3.4 Of the three adults' indicators, one was RAG-rated red, one was rated amber and one was rated green:

a) **Percentage of eligible population that received a health check:** No updated data is available in this report. Coverage in quarter 1 2018/19 (2.32%) was more than 10% below the quarterly and year-to-date target of 3.75%. It is therefore RAG-rated red. This figure is a decrease from quarter 4 2017/18 (3.55%) and is also lower compared to quarter 1 last year (2.81%).

b) **Smoking prevalence in adults – current smokers:** This GP-based measure was 19.9% for Barking and Dagenham in 2016/17. This is less than 10% above the target of 19.5% and is therefore RAG-rated amber. Barking and Dagenham has a much higher smoking prevalence compared with London (17.3%) or England (17.6%).

c) **Cervical screening – coverage of women aged 25–64 years:** No updated data is available as this is an annual measure. Based on 2016/17 data, cervical screening coverage is rated green, as coverage (67.0%) is above the London average (65.7%). Nonetheless, coverage in Barking and Dagenham shows a downward trend and 2016/17 data indicates that one-third of eligible women had not been adequately screened within the last 3.5 years (ages 25–49 years) or 5.5 years (ages 50–64 years).

Older adults

3.5 Of the three older adults' indicators, one is RAG-rated red, one is rated amber and one is rated green:

a) **Bowel screening – coverage of people aged 60–74 years:** At 42.1% of eligible people aged 60 to 74 years, bowel screening coverage continues to be RAG-rated red, with the latest available data (quarter 3 2017/18) placing Barking and Dagenham third lowest among all local authorities in England for coverage.

b) **Breast screening – coverage of women aged 53–70 years:** No updated data is available as this is an annual measure. Based on 2016/17 data, breast screening coverage is rated amber as Barking and Dagenham's coverage (67.8%) was within 10% of the figure for London (69.4%). This is an improvement from 66.5% in 2015/16.

c) **Number of long-term needs met by admission to a residential or nursing care home:** This is a cumulative figure. Performance in quarter 2 was below the year-to-date target and lower than at the same point in 2017/18.

Across the life course

3.6 Of the six 'across the life course' indicators, one was RAG-rated red, four were rated amber[2] and one was rated green:

a) **The percentage of children and adults who start healthy lifestyle programmes that complete the programme:** There has been a fall in this measure, from 57.2% in quarter 4 2017/18 to 50.9% in quarter 1 2018/19. This measure is more than 10% below the target of 65.0% and is therefore RAG-rated red. This is a local indicator so there are no benchmarking figures for London or England.

b) **A&E attendances ≤ 4 hours from arrival to admission, transfer or discharge (type all):** The last three quarters show continued improvements from 74.5% to 82.3% to 83.2% for the latest quarter (quarter 2 2018/19). However, set against the target of 90.0%, this measure continues to be RAG-rated amber.

c) **Emergency admissions aged 65 and over per 100,000 population:** No updated data is available.

d) **The number of leisure centre visits:** This indicator is no longer being updated and is presented for information only; performance of leisure centres is being managed through a separate contract management process following the transfer of management to Sports Leisure Management (SLM) Limited on 1 September 2017.

e) **Percentage of people using social care who receive services through direct payments:** This decreased from 65.5% in quarter 1 to 58.9% in quarter 2. This is below the target of 60% and is therefore RAG-rated amber.

f) **Delayed transfers of care:** Across quarter 1, there were an average of 125.8 delayed days per 100,000, which is below the target of 190.8 per 100,000 and hence RAG-rated green. This relates to 558 delayed days, of which 534 were attributable to NHS organisations and 24 (4.3%) to social care.

4 CQC inspections

4.1 Twenty-one reports of CQC inspections to healthcare organisations in the borough were published in quarter 2. Thirteen were rated as 'Good', while six received a rating of 'Requires Improvement'. Of the remaining two, one was a dental practice which are inspected but not rated by the CQC and one was a specialist service[3] which was inspected with favourable reporting but was not given an overall rating.

4.2 There were no CQC reports published that rated Barking and Dagenham organisations as 'Inadequate' in this quarter.

4.3 Appendix C contains details of all the inspection reports published in quarter 2 2018/19.

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[2] Note that two of the amber-rated measures (emergency admissions aged 65 and over per 100,000 population and the number of leisure centre visits) are no longer updated.
[3] Ear, nose and throat specialist provider.

5 Mandatory implications

Joint Strategic Needs Assessment

5.1 The Joint Strategic Needs Assessment provides an overview of the health and care needs of the local population, against which the Health and Wellbeing Board sets its priority actions for the coming years. By ensuring regular performance monitoring, the Health and Wellbeing Board can track progress against the health priorities of the JSNA

Joint Health and Wellbeing Strategy

5.2 The Outcomes Framework, of which this report presents a subset, sets out how the Health and Wellbeing Board intends to address the health and social care priorities for the local population. The indicators chosen are grouped by the 'life course' themes of the Strategy and reflect core priorities.

Integration

5.3 The indicators chosen include those which identify performance of the whole health and social care system, including indicators selected from the A&E Delivery Board's dashboard.

Legal

5.4 Not applicable.

Financial

5.5 Not applicable.

List of appendices

- Appendix A: Performance dashboard
- Appendix B: Performance summary reports of red-rated indicators
- Appendix C: CQC inspection reports, 2018/19 quarter 2.

Key

Appendix A: Indicators for HWBB - 2018/19 Q2

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
NC	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund
SRG	Systems Resilience Group

Note: where 2017/18 and quarter 4 data are available and differ, DoT arrow and RAG rating are for quarter 4 data. DoT for quarter 1 data relates to direction of travel from quarter 4 data.

Note: benchmarking data uses the same time period as the most recent data point for Barking and Dagenham except where otherwise indicated

Title	2014/15	2015/16	2016/17	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2017/18	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	DoT	Target	RAG Rating	BENCHMARKING England Average	BENCHMARKING London Average	HWBB No.	Reported to
1 - Children																			
Percentage uptake of measles, mumps and rubella (MMR2) immunisation at 5 years old	**82.7%**	**82.4%**	**81.9%**	78.6%	81.8%	77.3%	78.1%	**78.6%**	67.6%	..	..	..	↘	90.0%	R	N/A	72.2%	1	PHOF
Q1 2018/19 data is currently not comparable retrospectively due to CHIS Hub data migration issues.																			
Prevalence of children in Year 6 that are obese or overweight	**41.2%**	**43.4%**	**43.8%**					**44.5%**					↗	London average	R	34.3%	37.7%	2	PHOF
Based on child's local authority of residence.																			
The number of children who turn 15 months old in the reporting quarter who receive a 12-month review			**61.2%**	58.2%	70.9%	67.5%	79.0%	**68.8%**	78.5%	..	..	..	↘	75.0%	G	82.1%	70.0%	3	HWBB OF
Benchmarking data is for quarter 4 2017/18 (equivalent published figure for Barking and Dagenham is 84.1%). Data prior to Q1 2017/18 may not be comparable due to changes in reporting.																			
Number of children and young people accessing Tier 3 CAMHS services	**1,217**	**1,114**		585	565	620	695		675	..	..	..	↘	N/A	NC			4	HWBB OF
Year end figure is the number of unique people accessing CAMHS over the course of the year. Data from Q2 2016/17 onwards is based on those in contact with CAMHS at the end of the quarter.																			
% looked after children with a completed health check	**91.8%**	**94.2%**	**90.9%**	78.7%	77.2%	69.7%	92.4%	**92.4%**	86.0%	82.9%	..	..	↘	92.0%	A	89.4%	91.8%	5	HWBB OF
Benchmark is for 2016/17 (equivalent published figure for Barking and Dagenham is 87.1%).																			
2 - Adolescents																			
Under 18 conception rate (per 1,000 population aged 15-17 years)	**34.9**	**34.0**	**29.1**	28.3	..	..	..	**..**	..	..	..	..	↘	London average	R	20.0	18.5	6	PHOF
Data is a rolling three-year average, with the data presented representing the last quarter of the three-year period, i.e. quarter 1 will represent the time period 2014/15 quarter 2 to 2017/18 quarter 1.																			
Care leavers in education, employment or training (EET)		**50.2%**	**55.1%**	53.1%	53.2%	57.4%	59.3%	**59.3%**	48.8%	49.6%	..	..	↗	57.0%	R	50%	52%	7	HWBB OF
Benchmarking data relates to 2016/17 and relates to those aged 19-21 only.																			
3 - Adults																			
Smoking prevalence in adults - current smokers (QOF)	**20.8%**	**20.4%**	**19.9%**					**..**					↘	19.5%	A	17.6%	17.3%	8	HWBB OF
Target is based on trajectory towads 15% by 2021/22.																			
Cervical screening - coverage of women aged 25-64 years	**70.1%**	**67.9%**	**67.0%**					**..**					↘	London average	G	72.0%	65.7%	9	PHOF
Percentage of eligible women screened adequately within the previous 3.5 (25-49 year olds) or 5.5 (50-64 year olds) years on 31 March. 2017/18 data due to be released on 29 November 2018.																			
Percentage of eligible population that received a health check	**16.30%**	**11.83%**	**11.00%**	2.81%	3.24%	3.22%	3.55%	**12.82%**	2.32%	..	..	..	↘	15.0%	R	8.3%	9.6%	10	PHOF
Benchmarking data relates to 2017/18 (equivalent published figure for B&D was 12.3%; data presented here has been refreshed since submission). Annual figures, target and London and England figures are cumulative annual figures. The eligible population changes on an annual basis. Quarter 2 data currently unavailable due to changes in reporting systems.																			

Key

Appendix A: Indicators for HWBB - 2018/19 Q2

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
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HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund
SRG	Systems Resilience Group

Note: where 2017/18 and quarter 4 data are available and differ, DoT arrow and RAG rating are for quarter 4 data. DoT for quarter 1 data relates to direction of travel from quarter 4 data.

Note: benchmarking data uses the same time period as the most recent data point for Barking and Dagenham except where otherwise indicated

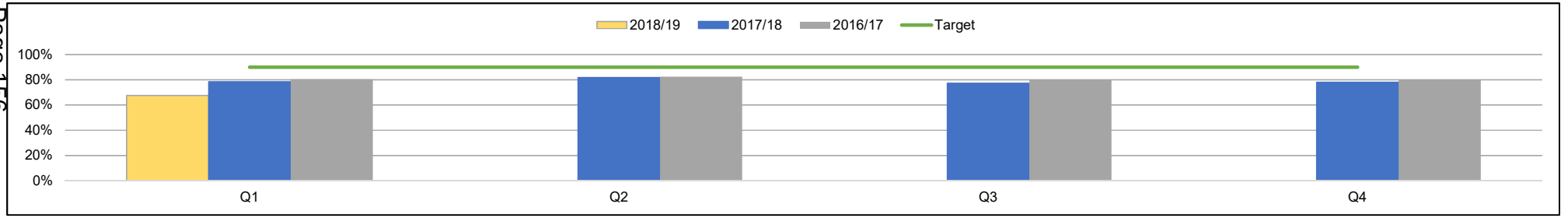
Title	2014/15	2015/16	2016/17	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2017/18	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	DoT	Target	RAG Rating	BENCHMARKING England Average	BENCHMARKING London Average	HWBB No.	Reported to
4 - Older Adults																			
Breast screening - coverage of women aged 53-70 years	**64.4%**	**66.5%**	**67.8%**					**..**					↗	London average	**A**	75.4%	69.4%	11	PHOF
Percentage of women whose last test was less than three years ago. 2017/18 data due to be published January 2019.																			
Bowel screening - coverage of people aged 60-74 years	**39.7%**	**41.1%**	**39.7%**	40.7%	41.4%	42.1%	..	**..**	..	..	..	..	↗	60.0%	**R**	58.9%	49.9%	12	PHOF
Percentage of eligible residents screened adequately within the previous 2.5 years.																			
Cumulative rate of long-term needs met by admission to a residential or nursing care home (65+)	**905.9**	**910.0**	**737.2**	207.1	384.0	576.0	702.3	**702.3**	222.3	343.5	..	..	↘	858.9	**G**	610.7	438.1	13	BCF/ASCOF
Rates are cumulative throughout the year. Benchmarking data relates to 2016/17. Additional benchmark: ASCOF Group - 479.2.																			
5 - Across the Life course																			
Percentage of people using social care who receive services through direct payments	**61.2%**	**62.6%**	**60.9%**	57.0%	58.7%	57.8%	58.3%	**58.3%**	65.5%	58.9%	..	..	↘	60.0%	**A**	28.3%	27.5%	14	ASCOF
Benchmarking data relates to 2016/17.																			
Delayed transfers of care	**135.2**	**205.3**	**205.8**	117.5	158.1	106.7	115.2	**124.4**	125.8	..	..	..	↗	190.8	**G**	318.9	N/A	15	ASCOF
Average number of delayed days during the period for NHS organisations and social care (acute or non-acute), per 100,000 population aged 18+.																			
A&E attendances ≤ 4 hours from arrival to admission, transfer or discharge (type all)	**85.3%**	**87.8%**	**85.6%**	85.5%	87.1%	80.6%	74.5%	**81.8%**	82.3%	83.2%	..	..	↗	90.0%	**A**	89.3%		16	SRG
Please note this figure is for BHRUT. Note: quarter 1 2015/16 figure based on weekly figures and hence reflects period 30 March-28 June. 2015/16 data therefore reflects 30 March-28 June, 1 July-31 March.																			
Emergency admissions aged 65 and over per 100,000 population			**28,949**										N/A	London average	**A**		27,342	17	
2016/17 is time period March 2016-February 2017.																			
The number of leisure centre visits	**1,282,430**	**1,453,925**	**1,467,293**	374,976	371,441								↘	754,936	**A**			18	Leisure
Target is a 6-month target.																			
The percentage of children and adults who start healthy lifestyle programmes that complete the			**48.8%**	63.6%	71.9%	58.8%	57.2%	**62.2%**	50.9%	..	..	..	↘	65.0%	**R**			19	ComSol

Health and Wellbeing Board
Performance Report 2018/19 Q2
7 November 2018

Back to summary page	Percentage uptake of measles, mumps and rubella (MMR2) immunisation at 5 years old	Health and Wellbeing Board Indicators	Q1 2018/19

Definition	**Numerator**	Total number of children who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday.	**How this indicator works**	All children for whom the local authority is responsible who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday as a percentage of all children whose fifth birthday falls within the time period.
	Denominator	Total number of children whose fifth birthday falls within the time period.		
Source		COVER data collected by PHE		
What does good performance look like?		For the percentage of children vaccinated to be as high as possible.	**Why is this indicator important?**	MMR is the combined vaccine that protects against measles, mumps and rubella. Measles, mumps and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage.

Quarterly data		Q1	Q2	Q3	Q4
	2018/19	67.6%			
	2017/18	78.6%	81.8%	77.3%	78.1%
	2016/17	80.5%	82.5%	79.9%	79.7%
	Target	90.0%	90.0%	90.0%	90.0%



Performance overview	Actions to sustain or improve performance	Benchmarking
Participation and data quality issues (Health Protection Report Volume 12 Number 35 - 28 September 2018): Child Health Information Services (CHIS) Hubs provide COVER data for the whole of London and the data submitted from these newly established Hubs reflects a system in transition. The NE London Hub has reported data quality issues associated with a second phase of migrating data in July 2018 which has resulted in decreases in London-level coverage estimates at 12 and 24 months and 5 year evaluations. As this issue is impacting across London, pan-London comparisons are consistent. The London average for uptake of two doses of MMR at age five is 72.2%, which is almost five percentage points higher than the Barking and Dagenham figure of 67.6%.	With the data migration issues at this juncture is difficult to establish a real picture for quarter 1 currently. Due to the nature of the data (tracking individuals on their immunisation history until their fifth birthday), revision of the current reported figures should be possible once data migration inconsistencies are resolved. It is also inconsistent to compare with previous quarters. However, the issues affecting the poor performance that was apparent in previous quarters are likely to remain.	The 2018/19 quarter 1 figure for Barking and Dagenham at 67.6% is well below the London average of 72.2% and ranks in position 23 out of 32 London boroughs. Due to participation and data quality issues of CHIS Hubs, no national data was published this quarter.

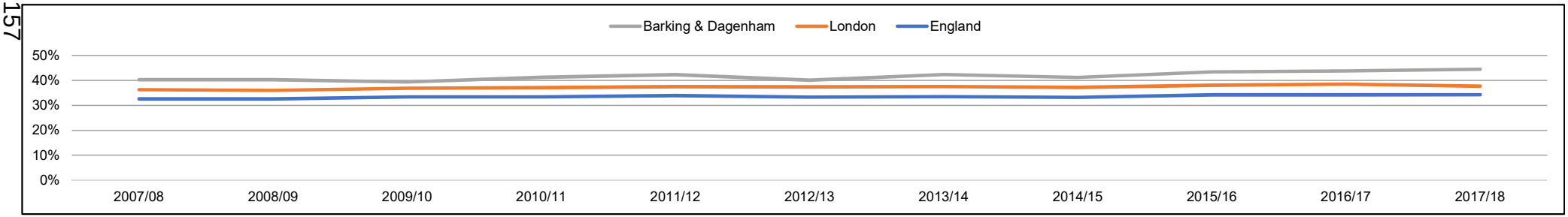
Responsible Director	Matthew Cole	Status	

Back to summary page	Prevalence of children in Year 6 that are obese or overweight	Health and Wellbeing Board Indicators	2017/18

Definition	**Numerator**	Number of children in Year 6 classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.	**How this indicator works**	Children in Year 6 (aged 10-11 years) classifed as overweight or obese in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England as a proportion of all children measured.
	Denominator	Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.		
Source		National Child Measurement Programme.		
What does good performance look like?		For the proportion of children who are overweight or obese to be as low as possible.	**Why is this indicator important?**	There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age.

Annual data

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Barking & Dagenham	40.3%	40.3%	39.4%	41.3%	42.3%	40.1%	42.4%	41.2%	43.4%	43.8%	44.5%
London	36.3%	36.0%	36.9%	37.1%	37.5%	37.4%	37.6%	37.2%	38.1%	38.5%	37.7%
England	32.6%	32.6%	33.4%	33.4%	33.9%	33.3%	33.5%	33.2%	34.2%	34.2%	34.3%

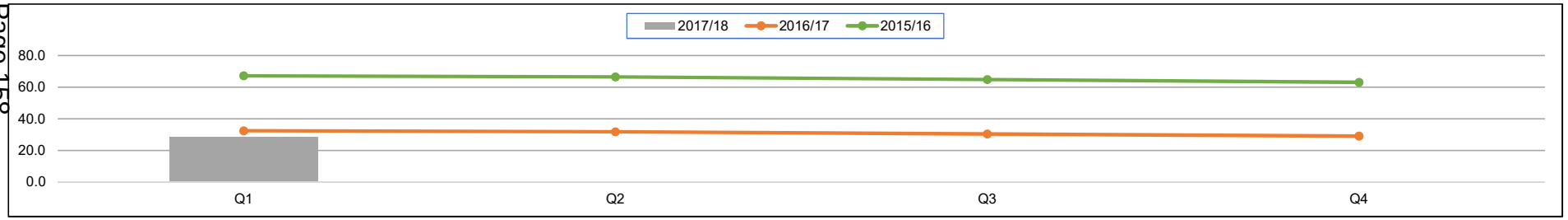


Performance overview	Actions to sustain or improve performance	Benchmarking
Barking and Dagenham has had sustained poor performance on this indicator, having a higher prevalence of Year 6 children with excess weight than seen nationally and regionally. In 2017/18, Barking and Dagenham was the worst performing local authority in the country for this measure.	As this is such a high level indicator it is not possible to show actions that directly impact on this indicator; however, a number of interventions are in place that aim to improve obesity-related outcomes, either by increasing levels of physical activity or through improved diet. One such example is the healthy lifestyles referral indicator.	2017/18: London: 37.7% (target) England: 34.3%

Back to summary page	Under 18 conception rate (per 1,000 population aged 15-17 years)	Health and Wellbeing Board Indicators	Q1 2017/18

Definition	**Numerator**	Number of pregnancies that occur to women aged under 18, that result in either one or more live or still births or a legal abortion under the Abortion Act 1967.	**How this indicator works**	Only about 5% of under 18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 age group is effectively treated as population at risk.
	Denominator	Number of women aged 15-17 living in the area.		
Source		Office for National Statistics		
What does good performance look like?		For the rate of teenage conceptions to be as low as possible.	**Why is this indicator important?**	Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers.

Quarterly data		Q1	Q2	Q3	Q4
	2017/18	28.3			
	2016/17	32.5	31.9	30.4	29.1
	2015/16	34.7	34.6	34.4	34.0



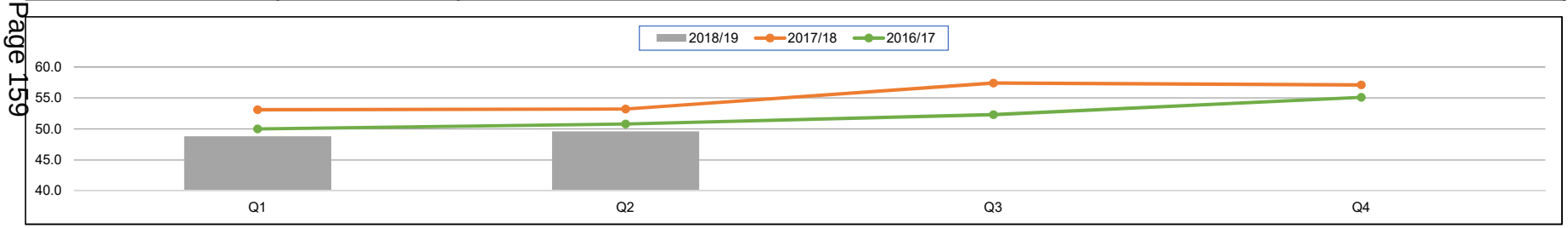
Performance overview	Actions to sustain or improve performance	Benchmarking
Please note: the data presented above is a 3-year rolling average, containing data for the 12 quarters up to and including the quarter named. The overall trend in Barking and Dagenham continues to be downward, with the 3-year rolling average more than halving over the last 10 years (from 64.1 per 1,000 females aged 15–17 years in quarter 1 2007/8 to 28.3 per 1,000 in quarter 1 2017/18). Barking and Dagenham had the eighth highest quarterly (non-rolling) rate in London in quarter 1 2017/18.	Several programmes are being undertaken to reduce the teenage pregnancy rate in the borough, such as the C-Card distribution scheme, which supplies teenagers with condoms. This has been the best performing programme in London for the last 2 years. The Healthy Schools Programme also supports schools to provide effective Relationships and Sex Education. The Programme in the borough is among the best performing in London.	2017/18 Q1 (rolling 3-year average): London: 18.5 England: 20.0

Responsible Director	Matthew Cole	Status	

Back to summary page	Care leavers in education, employment or training	Health and Wellbeing Board Indicators	Q2 2018/19

Definition	**Numerator**	Of those in the denominator, how many were engaged in education, employment or training within the period 3 months prior or one month after their birthday that falls within the collection period.	**How this indicator works**	This indicator counts all those in the definition and of those how many are in EET either between 3 months before or 1 month after their birthday. This is reported as a percentage.
	Denominator	The number of children who were looked after for a total of 13 weeks after their 14th birthday, including at least some time after their 16th birthday and whose 17th, 18th, 19th, 20th or 21st birthday falls within the collection period.		
Source		Liquid Logic		
What does good performance look like?		For the proportion of care leavers in education, employment or training to be as high as possible.	**Why is this indicator important?**	The data allows us to make performance comparisons with other areas and provides a broad overview of how well the borough is performing in terms of care leavers accessing EET and improving their life chances. This is an Ofsted area of inspection as part of our duty to improve outcomes for care leavers and is a key Children and Young People's Plan and Council priority area.

Quarterly data		Q1	Q2	Q3	Q4
	2018/19	48.8	49.6		
	2017/18	53.1	53.2	57.4	57.1
	2016/17	50.0	50.8	52.3	55.1



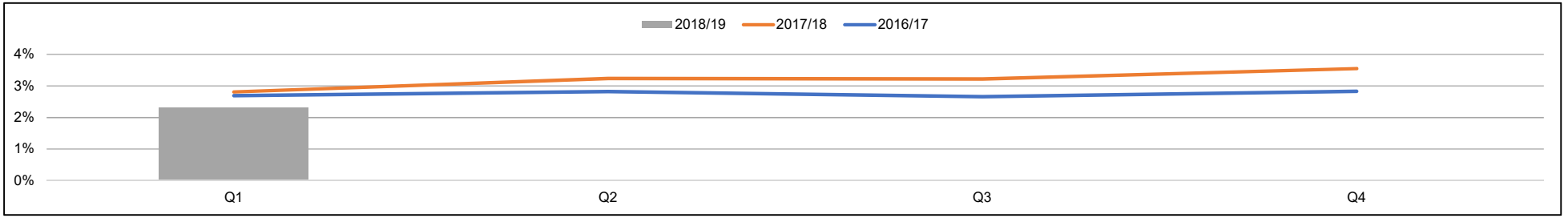
Performance overview	Actions to sustain or improve performance	Benchmarking
Quarter 2 performance has increased slightly to 49.6% (55/111) compared with quarter 1 performance of 48.8% (21/43). Performance is below all comparators. Of the 56 young people not in EET as of the end of quarter 2, <5 are in prison, <5 are young mothers, 21 we are not in contact with and 30 are open to the L2L service and are NEET. For those young people we are in contact with, performance is 60%.	The L2L team has been involved in the NEET workshops with Members and Officers, with care leavers having a particular profile. Progress has been made with regards to the development of internships and apprenticeships within the council for care leavers. Agreement has been obtained to provide a financial incentive in addition to the apprenticeship payment so that care leavers are not in deficit by loss of benefits. Further work is being planned to develop the support element to care leavers to ensure they are well prepared for the world of work and are supported through each stage of the process to successfully move from NEET to EET.	2016/17 (aged 19-21 only): London: 52% England: 50%

Responsible Director	Matthew Cole	Status	

Back to summary page	Percentage of eligible population that received a health check	Health and Wellbeing Board Indicators	Q1 2018/19

Definition	**Numerator**	Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check.	**How this indicator works**	Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess, raise awareness and support them to manage their risk of cardiovascular disease.
	Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period.		
Source		Public Health England		
What does good performance look like?		For the proportion of the eligible population in receipt of an NHS Health Check to be as high as possiible.	**Why is this indicator important?**	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions.

Quarterly data	Q1	Q2	Q3	Q4
2018/19	2.32%			
2017/18	2.81%	3.24%	3.22%	3.55%
2016/17	2.69%	2.82%	2.66%	2.83%



Performance overview	Actions to sustain or improve performance	Benchmarking
Please note: No updated data is available due to a change in the reporting system. Barking and Dagenham's performance is below the target figure of 3.75% coverage per quarter, but quarter 4 2017/18 figures were higher than both the national and regional averages. Performance has decreased in quarter 1 to 2.32%, which is lower than quarter 1 last year (2.81%) From quarter 1 to quarter 4 2017/18 we achieved 12.82% coverage, which is 85% of our yearly target to reach 15% of our eligible population and higher than achievement last year (11.00%).	Q2 figures will not be available until the end of October but there is some doubt as to whether we will have access to the data. Health Analytics is now switched off permanently; Public Health and Intelligence are working with the CCG to try to ensure that the new DDS system becomes operational as soon as possible. Public Health England have been informed about the issue and Public Health are keeping them informed about progress. The specialist nurse post has continued to make progress with some of the poorest performers whose figures have improved compared with 2017/18	2017/18 (quarter 4): London: 2.78% England: 2.35% Barking & Dagenham: 3.55%

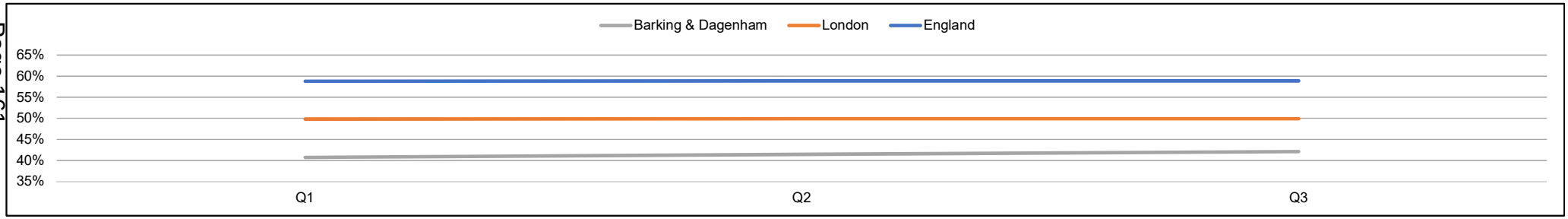
Responsible Director	Matthew Cole	Status	

Back to summary page	Bowel screening - coverage of people aged 60-74 years	Health and Wellbeing Board Indicators	Q3 2017/18

Definition	**Numerator**	Number of people aged 60–74 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous 2½ years.	**How this indicator works**	People are excluded from the eligible population if they have no functioning colon (e.g. following bowel surgery) or if they make an informed decision to opt out of the programme.
	Denominator	Number of people aged 60–74 resident in the area who are eligible for bowel screening at a given point in time.		
Source		Public Health England		
What does good performance look like?		For the percentage coverage to be as high as possible.	**Why is this indicator important?**	About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16% [www.phoutcomes.info].

Quarterly data

2017/18	Q1	Q2	Q3	Q4
Barking & Dagenham	40.7%	41.4%	42.1%	-
London	49.8%	49.9%	49.9%	-
England	58.8%	58.9%	58.9%	-



Performance overview	Actions to sustain or improve performance	Benchmarking
Barking and Dagenham continues to perform significantly worse than the national and regional averages, as well as being considerably below the 60% performance threshold, with only 42.1% coverage of the eligible population at Q3 of 2017/18. This is the third lowest coverage in both London and England. While the coverage for Barking and Dagenham is improving slowly, the rates for London and England as a whole have levelled off.	We continue to work through the UCLH Cancer Collaborative and the Uptake and Screening hub on plans to procure a reminder of screening and calling service. We have now been informed that each CCG has a sum of money that can be spend on education and training, so the group are currently working through some ideas about the most effective way to use this funding. Plans continue to roll out the qFit screening which only requires patients to supply one sample. Further training sessions from CRUK are planned which the Barking and Dagenham health champions are going to attend.	2017/18 (quarter 3): London: 49.9% England: 58.9%

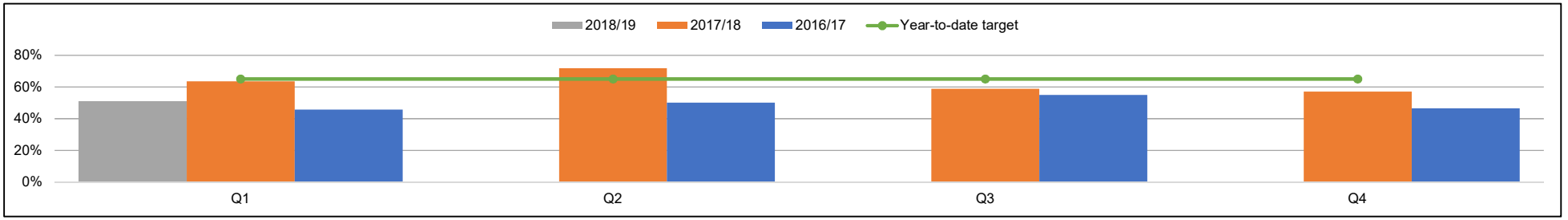
Responsible Director	Matthew Cole	Status	

Back to summary page	The percentage of children and adults starting healthy lifestyle programmes that complete the programme	Health and Wellbeing Board Indicators	Q1 2018/19

Definition	**Numerator**	The number of children and adult completing healthy lifestyle programmes.	**How this indicator works**	The proportion of people who complete the HENRY, Exercise on Referral (EOR), Adult Weight Management (AWM) and Child Weight Management (CWM) programmes of those who start the programmes.
	Denominator	The number of children and adult starting healthy lifestyle programmes.		
Source		Community Solutions		
What does good performance look like?		For the percentage of completions to be as high as possible.	**Why is this indicator important?**	The programmes allow the borough's GPs and health professionals to refer individuals who they feel would benefit from physical activity and nutrition advice to help them improve their health and weight conditions. Adult and Child Weight Management programmes also accept self-referrals if the individuals meet the referral criteria.

Quarterly data

	Q1	Q2	Q3	Q4
2018/19	50.9%			
2017/18	63.6%	71.9%	58.8%	57.2%
2016/17	45.8%	50.2%	55.0%	46.5%
Year-to-date target	65.0%	65.0%	65.0%	65.0%



Performance overview	Actions to sustain or improve performance	Benchmarking
Performance has decreased from a peak of 71.9% in quarter 2 last year (2017/18) when more than seven in ten completed their healthy lifestyles programmes. At 71.9% it was the only quarter that exceeded the target of 65.0%. In the latest quarter, half (50.9%) of all people completed their courses.	A restructure and recruitment to vacant posts will increase number of delivery staff and increase the number of appointments and programmes available; a revised NCMP referral pathway is being discussed with NELFT to align delivery with NCMP schedule in schools ensuring children get access to support after identification; a system is now in place where attendance is monitored weekly and people that do not attend are contacted to check how they are and to encourage them to come back. Staff delivering AWM have been assessed by Momenta. Training needs will be identified, and training provided. A quality assurance schedule is being put in place to identify good practice and training needs. We have reviewed current programmes and redirected resources to increase EOR appointment availability.	This is a local indicator.

Responsible Director	Matthew Cole	Status	

Appendix C - CQC inspections - 2018/19 Q2

Name	Report publication date	Link to inspection report	Overall rating	Service type
Dr KM Al-Kaisy Practice	08/07/2018	http://www.cqc.org.uk/location/1-529661202	Requires improvement	Doctors/GPs
Nomase Care Ltd - Chadwell Heath	09/07/2018	http://www.cqc.org.uk/location/1-3831279297	Good	Homecare agencies
Heathway Medical Centre	15/07/2018	http://www.cqc.org.uk/location/1-2687718289	Good	Doctors/GPs
Practice Based Clinical Services Limited*	15/07/2018	http://www.cqc.org.uk/location/1-542387422	N/A	Doctors/GPs
Harp House	16/07/2018	http://www.cqc.org.uk/location/1-3562725285	Good	Homecare agencies
St Albans Surgery	24/07/2018	http://www.cqc.org.uk/location/1-3234326755	Good	Doctors/GPs
Valence Medical Centre	30/07/2018	http://www.cqc.org.uk/location/1-584952137	Good	Doctors/GPs
ICare Resource Limited	02/08/2018	http://www.cqc.org.uk/location/1-2823066050	Requires improvement	Homecare agencies
Rosemont Care Limited t/a Rosemont Care	03/08/2018	http://www.cqc.org.uk/location/1-3917798363	Good	Homecare agencies
Sincere Care Limited	14/08/2018	http://www.cqc.org.uk/location/1-134376322	Good	Homecare agencies
Cloud House	14/08/2018	http://www.cqc.org.uk/location/1-320058309	Good	Residential homes
Rainham House	14/08/2018	http://www.cqc.org.uk/location/1-2778163935	Good	Homecare agencies, Supported living
Dr Hamilton-Smith And Partners**	22/08/2018	http://www.cqc.org.uk/location/1-609934909	Requires improvement	Doctors/GPs
Park View	30/08/2018	http://www.cqc.org.uk/location/1-125861732	Good	Nursing homes
Hanbury Court Care Home	31/08/2018	http://www.cqc.org.uk/location/1-119099319	Good	Nursing homes
Bestchoice Global Ltd	31/08/2018	http://www.cqc.org.uk/location/1-2972758305	Requires improvement	Homecare agencies
Dr Beheshti	04/09/2018	http://www.cqc.org.uk/location/1-541901529	Requires improvement	Doctors/GPs
Prompt Healthcare Staffing Limited	06/09/2018	http://www.cqc.org.uk/location/1-1002254715	Good	Homecare agencies
Bennetts Castle Care Centre	12/09/2018	http://www.cqc.org.uk/location/1-117294310	Good	Nursing homes
Sahara Parkside	17/09/2018	http://www.cqc.org.uk/location/1-164893164	Requires improvement	Residential homes
Woodlane Dental Practice	24/09/2018	http://www.cqc.org.uk/location/1-217978478	N/A	Dentist

*No overall rating given by CQC

**Located in borough but part of Havering CCG

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Mental Health Sub Group

Chair: Melody Williams (NELFT)

Feedback to the Health & Wellbeing Board

Mental Health sub group met for the first time since the group was confirmed as continuing under the HWBB sub-structure. Mental Health All Age Strategy and CAMHS Transformation remains the significant programmes and partners are contributing to updating the strategy and the Transformation plan. The August meeting also heard a presentation from Healthwatch following the publication of the Dementia report – noting the findings and the recommendations. Discussion took place as to how some of these will be embedded as part of the strategy refresh. Noted the memory walk being organised in Barking Park on the Sunday 9th September to raise awareness of dementia and support for carers and patients. Further details can be obtained from the B&D memory service on 0300 555 1017.

Performance and Risk

Performance report was not specifically reviewed this meeting, however risks were noted to now be lower in regards to AMHP availability post successful recruitment plan and that there remains a high risk within the health provision, particularly for high need clients and this is subject to parity of esteem investment discussions with the CCG.

The national MSNAP accreditation and achieving further recognition from the Royal College of Psychiatry in regards to excellence within the B&D Memory Service was noted.

Meeting Attendance

Date of last meeting – 20th August 2018

Action(s) since last report to the Health and Wellbeing Board

None to report on due to length of time since last full partnership meeting and refresh of sub groups

Action and Priorities for the coming period

(a) Support from the sub group for the development of the refreshed MH All Age strategy including focused workshop in December meeting

(b) Support from the sub group for the development of the refreshed CAMHS Transformation Plan for B&D in the October meeting

(c) Support the development of a range of activities as part of World Mental Health Day (10th October 2018)

Contact: Melody Williams, Integrated Care Director

Tel: 07534 918224 **Email:** melody.williams@nelft.nhs.uk

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HEALTH AND WELLBEING BOARD

7 November 2018

Title:	**Forward Plan**
Report of the Chief Executive	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
Report Authors: Alan Dawson Democratic Services, Law and Governance	**Contact Details:** Telephone: 020 8227 2348 E-mail: alan.dawson@lbbd.gov.uk
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board	

Summary:

Attached at **Appendix A** is the draft January 2019 edition of the Forward Plan for the Health and Wellbeing Board, showing the known business items to be presented to the Board in the coming months. The Forward Plan is an important document in terms of both planning the business of the Board and also ensuring that information on future key decisions is published at least 28 days before the meeting. The Forward Plan also helps the local community and partners to know what decisions will be taken at future Board meetings.

Recommendation(s)

The Health and Wellbeing Board is asked to note the draft January 2019 edition of the Board's Forward Plan, as set out at Appendix A to the report.

Public Background Papers Used in the Preparation of the Report: None

List of Appendices

- **Appendix A** – Draft January 2019 Forward Plan

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HEALTH and WELLBEING BOARD FORWARD PLAN

Draft January 2019 Edition

Publication Date: 17 December 2018

THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
(ii) Those that involve 'significant' spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).

In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)

- the date when the decision is due to be made;

Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Alan Dawson, Democratic Services Manager, Ground Floor, Town Hall, 1 Town Square, Barking IG11 7LU (telephone: 020 8227 2348, email: alan.dawson@lbbd.gov.uk)

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to https://modgov.lbbd.gov.uk/Internet/ieDocHome.aspx?Categories=-14062 and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during 2018/19:

Edition	Publication date
January 2019 edition	17 December 2018
March 2019 edition	11 February 2019
June 2019 edition	13 May 2019

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed. It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to https://modgov.lbbd.gov.uk/Internet/ieListMeetings.aspx?CId=669&Year=0 or by contacting Alan Dawson on the details above.

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.

Decision taker/ Projected Date	Subject Matter Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
Health and Wellbeing Board: 15.1.19	Older People's Housing Pathway The Board will be provided with an update on the Older People's Housing Pathway and will be asked to consider and comment on its key findings and recommendations. • Wards Directly Affected: All Wards	Open	Louise Hider-Davies, Head of Commissioning, Adults Care and Support (Tel: 020 8227 2861) (louise.hider@lbbd.gov.uk)
Health and Wellbeing Board: 15.1.19	Homelessness Strategy The Board will receive an update on the development of the Council's Homelessness Strategy. • Wards Directly Affected: All Wards	Open	Graeme Cooke, Director, Inclusive Growth (Tel: 020 8227 3735) (graeme.cooke@lbbd.gov.uk)
Health and Wellbeing Board: 15.1.19	Health Based Places of Safety The Board will receive a report on the Clinical Commissioning Group's plans for a new model of care for individuals detained under Section 136 of the Mental Health Act 1983, in response to recent changes to the CCGs responsibilities under the Act. • Wards Directly Affected: Not Applicable	Open	Alex Louis, Snr Comms Manager, ELHCP (Tel: 020 3688 1345) (alex.louis1@nhs.net)
Health and Wellbeing Board: 12.3.19	**Health and Wellbeing Strategy 2019/23 *: Community*** The Board will be asked to approve the Health and Wellbeing Strategy 2019/23. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

Health and Wellbeing Board: 12.3.19	Update on Tobacco Harm Reduction Action Plan The Board will be presented with an update report on the progress of the actions of the Tobacco Harm Reduction Action Plan. • Wards Directly Affected: All Wards	Open	Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)

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