Notice of Meeting

HEALTH & WELLBEING BOARD

Tuesday, 11 June 2019 - 6:00 pm
Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB

Date of publication: 3 June 2019

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 Saima Ashraf	LBBD (Cabinet Member for Community Leadership and Engagement)
Cllr Sade Bright	LBBD (Cabinet Member for Employment, Skills and Aspiration)
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 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 15 January 2019 (Pages 3 - 6)**

BUSINESS ITEMS

4. **Annual Report of the Director of Public Health 2018/19 (Pages 7 - 64)**

5. **Children and Young People Evidence Review (Pages 65 - 84)**

6. **Older People Evidence Review (Pages 85 - 100)**

7. **Global Burden of Disease Study Data 2017 (Pages 101 - 134)**

8. **LGBT+ Policy Statement and Action Plan (Pages 135 - 166)**

9. **Health and Wellbeing Outcomes Framework Performance Report - Q3 and Q4 2018/19 (Pages 167 - 183)**

Health Scrutiny Reviews

10. **Childhood Obesity Scrutiny Review (Pages 185 - 194)**

11. **Cancer Scrutiny Review - Update on progress of Action Plan (Pages 195 - 208)**

12. **Oral Health in Early Years Scrutiny Review - Update on progress of Action Plan (Pages 209 - 213)**

STANDING ITEMS

13. **Chair's Report (Pages 215 - 220)**

14. **Forward Plan (Pages 221 - 226)**

15. **Any other public items which the Chair decides are urgent**

16. **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.***

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

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

A New Kind of Council

- Build a well-run organisation
- Ensure relentlessly reliable services
- Develop place-based partnerships

Empowering People

- Enable greater independence whilst protecting the most vulnerable
- Strengthen our services for all
- Intervene earlier

Inclusive Growth

- Develop our aspirational and affordable housing offer
- Shape great places and strong communities through regeneration
- Encourage enterprise and enable employment

Citizenship and Participation

- Harness culture and increase opportunity
- Encourage civic pride and social responsibility
- Strengthen partnerships, participation and a place-based approach

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MINUTES OF
HEALTH AND WELLBEING BOARD

Tuesday, 15 January 2019
(6:00 - 8:08 pm)

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

Also Present: Brian Parrott, Independent Chair of the B&D Local Safeguarding Adults Board.

Apologies: Ian Winter, Independent Chair of the B&D Local Safeguarding Children Board.

34. Apologies for Absence

35. Declaration of Members' Interests

Melody Williams, NELFT declared an interest and took no part in the discussions in relation to Item 5-Health-Based Places of Safety.

36. Minutes - To confirm as correct the minutes of the meeting on 7 November 2018

The minutes of the meeting held on 7 November 2018 were confirmed as correct subject to the inclusion of Ceri Jacobs, CCG in the list of those present.

37. Barking Riverside: Developing the health and care model and specification for a Health and Wellbeing Hub

Following a workshop convened for Board members on 5 September 2018, the Board received a presentation from Mark Howard, Project Manager on the findings/conclusions to date on the proposed design of the Health & Wellbeing Hub in the new district centre and the health/care model; the approach to the associated community engagement, which at the Board's request should also include the Adult College as a key stakeholder. The Board also had regard to the governance model which has been drawn up around the formation of the 'Locality 4 Board' and the technical aspects around the development of the Healthy New Town infrastructure.

The slides that accompanied the report and which were presented at the meeting, will be subsequently circulated to all Board Members.

The Board emphasised the importance of bringing together the existing Thames View community and those emerging in the Riverside development as well as engaging with partners such as the Police and Faith leaders to bring them onboard with the 'Healthy New Town' concept, a model of care, the principles of which the Board would like to see embedded in other developments across the Borough.

Aside of the design principles developed to this point the Board want the next stage of consultation focusing on drawing out the different needs of both the existing and emerging local communities, and what the culture and values of the Hub will represent, such as a place to study for young people and being dementia friendly.

It was recognised that beyond the current client brief there is no structure in place to keep stakeholders informed including how the faith community can play its part. In that respect the Board welcomed the offer of Healthwatch to support the wider community engagement. Consequently, in all likelihood further interim arrangements will need to be put in place.

The model of care is seen as a developing plan as the Riverside develops and new communities/residents emerge. Further development work will therefore be undertaken to firm up the governance arrangements etc including the relationship between this Board and the planned Locality 4 Board, with a view to reporting progress to a future meeting.

38. Health-Based Places of Safety

The Board received a presentation from the Mental Health Programme Director, City and Hackney CCG outlining a report from the East London Health & Care Partnership setting out in full the pan-London business case for fewer, better quality health-based places of safety for people typically detained by the Police under Section 136 of the Mental Health Act. The Board noted that this matter has previously been presented to the Joint Health and Overview & Scrutiny Committee, who from a local perspective did not raise any strong objections.

Although the proposals will see the existing 20 dedicated sites across London reduced to 9 hubs, each will have improved capacity with more rooms and 24/7 staffing on site including for the North East London Region, Sunflower Court in the neighbouring Borough of Redbridge, for which additional funding has been secured.

Whilst issues were raised concerning the additional capacity and quality of care across London to support children and young people with mental health needs, overall the Board have welcomed the proposals and noted that the Chair intends to ask Councillor C. Rice in his role as the Council's Mental Health Champion to take a view on the business case in the context of the Board's Mental Health Strategy.

39. Borough Data Explorer: Opportunities for improved analytical capacity for health and wellbeing

The Board received a presentation by the Council's Insight Unit concerning the development of a Borough Data Explorer and a Social Progress Index at a ward level; the first of its type. Similar presentations have been made to a number of health & wellbeing system partners. The presentation demonstrated how data at ward level based on the 91 indicators in the Borough Manifesto when drilled down further could be used to target specific areas for direct health interventions.

The Board expressed their excitement at the opportunities for deploying the tool to support health and wellbeing activity. They have requested a further report in six months to assess the value of it in terms of benefiting the health and wellbeing of Borough residents.

40. Update on 'Breezie' Pilot Project

The Board noted a report and welcomed the progress and current status of the 'Breezie' pilot project, a tablet device which has been rolled out to over 60 elderly residents across the borough, the results of a survey of which has shown to be significantly reducing the feelings of isolation for the participating elderly residents by helping them to get online.

The Board is keen to see the further expansion of the tablets and integration opportunities to deliver on the outcomes of the Joint Health & Wellbeing Strategy. In particular the Chair would like to see the devices used to help support people with long term health conditions such as diabetes. Dr John, Deputy Chair from the CCG would also welcome testing and integrating the devices to allow for online booking of GP appointments.

The Board noted that the user survey will continue to be undertaken and monitored so as to track progress and provide a better understanding of the effectiveness of the intervention with a view to considering further funding opportunities for an expansion of the project beyond the initial 2 year pilot phase which will also include officers working with partners to further integrate the project with other digital solutions across the health and social care economy.

41. Joint Health and Wellbeing Strategy 2019 - 2023

Following approval at the Board in November 2018 the draft Joint Health & Wellbeing Strategy was subject to an eight week online public consultation which resulted in a total of 39 responses.

In reviewing the final draft and specifically the three priorities *(Best Start in Life, Early Diagnosis & Intervention and Building Resilience)* the proposal is that under each priority the various *Enablers:' What needs to change? Our Pledges'* should reference 'Peer to Peer' as the Board recognise the value of this approach to help achieve positive outcomes.

Subject to the above, and clearer sign posting to the Council's website to access relevant documentation, the Board

RESOLVED: To approve for publication the Strategy as set out in Appendix 1 to the report and noted that it will be presented to the Council Assembly on 30 January 2019.

42. Integrated Care Partnership Update

Mark Tyson Commissioning Director presented an update on progress with the Integrated Care Partnership (ICP) which included a summary of a workshop session with the ICP Board. This reviewed the current position on governance, transformation priorities and future developments of the ICPB work plan; and concluded with Councillor Worby as Chair issuing a challenge to partners to

provide from their collaborative working three clear, publicly demonstrable outcomes. These are currently being worked on by partners and expected to report back next month.

The Board also received an update from Sharon Marrow, CCG on an overview of the NHS Financial Recovery Plan which is being managed alongside the wider ICPB programme and which aims to bring the NHS Partners/System back to financial balance by March 2021. This is an ambitious evolving plan with the expectation that further reports will be presented to the Board as additional funding streams come on line to support the transformation of services.

The Chair reported that she is mindful to suggest to the Partnership that going forward it would be more appropriate for the Provider Alliance to be represented on this Board rather the Trust.

Accordingly, the Board noted the report and current position and will await a further report in due course setting out ways in which the ICP programme aims to support the delivery of the Health & Wellbeing Strategy.

43. Forward Plan

The Board noted the current draft edition of the Forward Plan.

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	**Annual Report of the Director of Public Health 2018/19 - Creating Health: A progressive approach for Barking and Dagenham**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Matthew Cole, Director of Public Health	**Contact Details:** Tel: 0208 227 3657 E-mail: matthew.cole@lbbd.gov.uk
Sponsor: Elaine Allegretti, Director of People and Resilience	

Summary:

The Director of Public Health's Annual Report is a statutory requirement under the provisions of the Health and Social Care Act 2012. It provides an opportunity for me to give an independent assessment of the health of the population and focus on some priority areas where I consider that the Council and its partners need to think through individually and collectively where more needs to be done to realise health gain.

Chapter 1 will focus on outlining the public health problem facing Barking and Dagenham and the systems in which we operate. This will include the opportunities presented by the Barking and Dagenham, Havering and Redbridge Integrated Care System and our own transformation journey, through the Theory of Change work. Chapter 2 outlines the progress of the implementation of place-based care and how this is replicated for residents across the borough. Chapter 3 highlights the strand of the 2019-2023 Joint Health and Wellbeing Strategy on adverse childhood experience (ACEs) and how this will form a key part of the Council's early help agenda moving forward. Chapter 4, utilising the examples of childhood obesity and frailty, examines how the council can commission a system wide integrated approach which improves outcomes for our residents.

Finally, Chapter 5 focuses on what we have done so far and our plan on how we will commission programmes funded by the Public Health Grant differently going forward in order to achieve savings and transform delivery to achieve outcomes.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Note and comment on the observations of the Director of Public Health in his Annual Report and

(ii) Discuss how we can use the Report to drive improvements in the long-term health outcomes and achievement of the Borough Manifesto Targets, including the ongoing transformation in the BHR Integrated Care System to ensure it provides

an opportunity for the implementation of new models of care and an increased focus on prevention.
Reasons Several of the Director of Public Health's specific responsibilities and duties arise directly from Acts of Parliament – mainly the NHS Act 2006 and the Health and Social Care Act 2012 – and related regulations. The Director of Public Health has a duty to write a report, whereas the authority's duty is to publish it (section 73B(5) & (6) of the 2006 Act[1], inserted by section 31 of the 2012 Act). The content and structure of the report is something to be decided locally.

Appendix A

Annual Report of the Director of Public Health 2018/19 Creating Health:
A progressive approach for Barking and Dagenham

Appendix A

Director of Public Health
Annual Report 2018/2019

Creating Health

A progressive approach for Barking and Dagenham

London Borough of Barking & Dagenham
lbbd.gov.uk

A vision for Barking and Dagenham

One Borough; One community; No one left behind

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

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

Theme 1: A New Kind of Council	Theme 2: Empowering People	Theme 3: Inclusive Growth	Theme 4: Citizenship and Participation
Priorities: • Build a well-run organisation • Ensure relentlessly reliable services • Develop place-based partnerships	**Priorities:** • Enable greater independence whilst protecting the most vulnerable • Strengthen our services for all • Intervene earlier	**Priorities:** • Develop our aspirational and affordable housing offer • Shape great places and strong communities through regeneration • Encourage enterprise and enable employment	**Priorities:** • Harness culture and increase opportunity • Encourage civic pride and social responsibility • Strengthen partnerships, participation and a place-based approach

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

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

Contents

Foreword

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

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

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

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

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

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

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

2. Baxter S, Johnson M, Chambers D, Sutton A, Goyder E, Booth A. Understanding new models of integrated care in developed countries: a systematic review. Health Serv Deliv Res. 2018;6(29).
3. Lloyd T, Brine R, Pearson R, Caunt M, Steventon A. The impact of integrated care teams on hospital use in North East Hampshire and Farnham: Consideration of findings from the Improvement Analytics Unit. Health Foundation. 2018. www.health.org.uk/publications/impact-integrated-care-teams-hospital-use-north-east-hampshire-and-farnham
4. http://www.hilarycottam.com/radical-help/
5. http://www.hilarycottam.com/radical-help/

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

Inclusive Growth is key to how we deliver the social infrastructure across our borough to enable human relationships and participation, so that 'health creation' might happen organically and sustainably. This investment is essential for effective early intervention that is co-designed with residents and delivered in ways that support people across the life course to thrive. For example, focusing on intervening early to support residents who are experiencing stresses, such as debt, family breakdown, exploitation and homelessness, is an essential enabler. We know that such stresses can often lead to lives spiralling out of control and a deterioration in both physical and mental health. This problem isn't confined to adults, some children experience chaotic lives and domestic abuse. The way that these problems can be transmitted down the generations, makes it more difficult for individuals to break out of the cycle. However, early intervention through wider parts of the system is vital, but it's also about the system's universal approach to the whole community i.e. primary prevention. All this drives demand for our health and care services.

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

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

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

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

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

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

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

Matthew Cole

Director of Public Health

London Borough Barking & Dagenham

Chapter 1

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

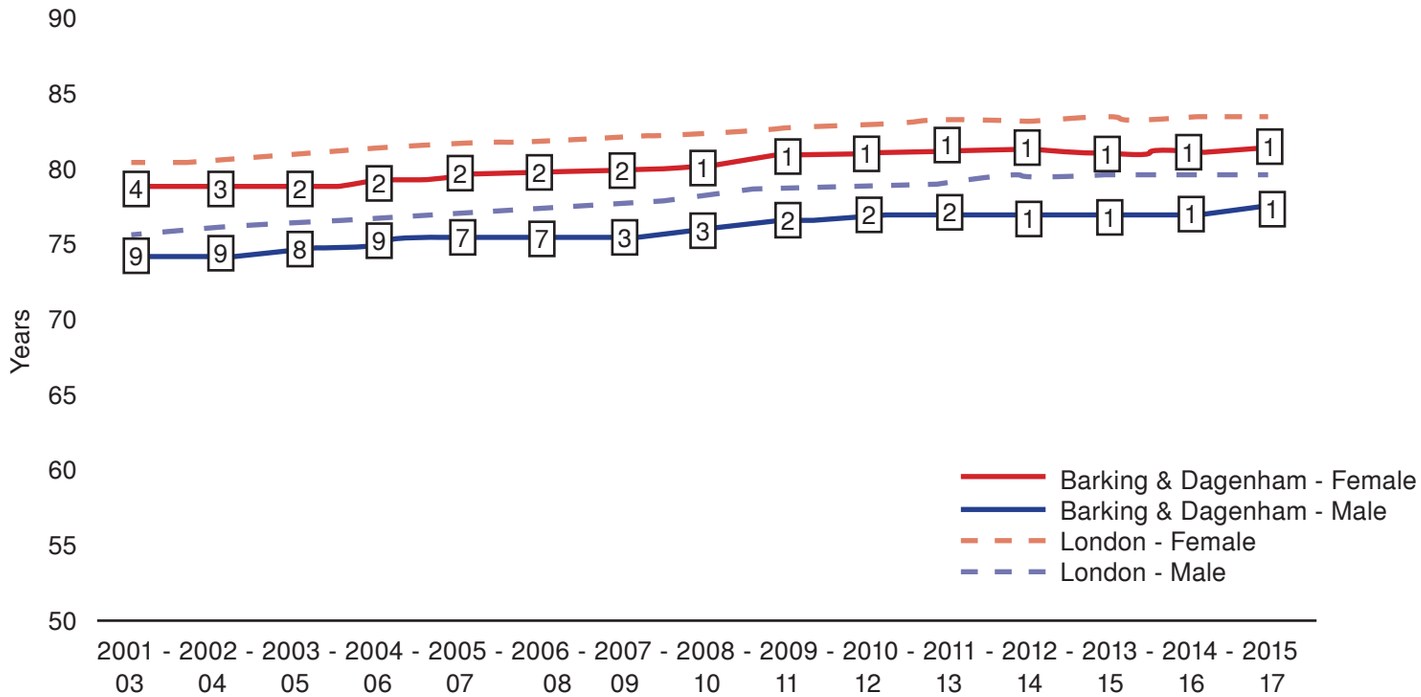
Page 15

What is the life expectancy in Barking and Dagenham?

Barking and Dagenham has the lowest life expectancy for both men and women in London: 77.8 years for men and 82.1 years for women.[6] This type of life expectancy is better understood as a summary of mortality over the last 3 years rather than the average length of time our residents are likely to live for, but it nonetheless means that our residents are dying earlier than their London counterparts.[7]

Barking and Dagenham has had the lowest life expectancies for both genders across London since 2012–14 (Figure 1). This is a decline from ninth lowest position in 2004–6 for males, whilst female life expectancy has been among the lowest in London since, at least, the turn of the millennium. The most recent data puts life expectancy in Barking and Dagenham 2.7 years (for males) and 2.2 years (for females) lower than the London average.

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



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

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

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

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

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

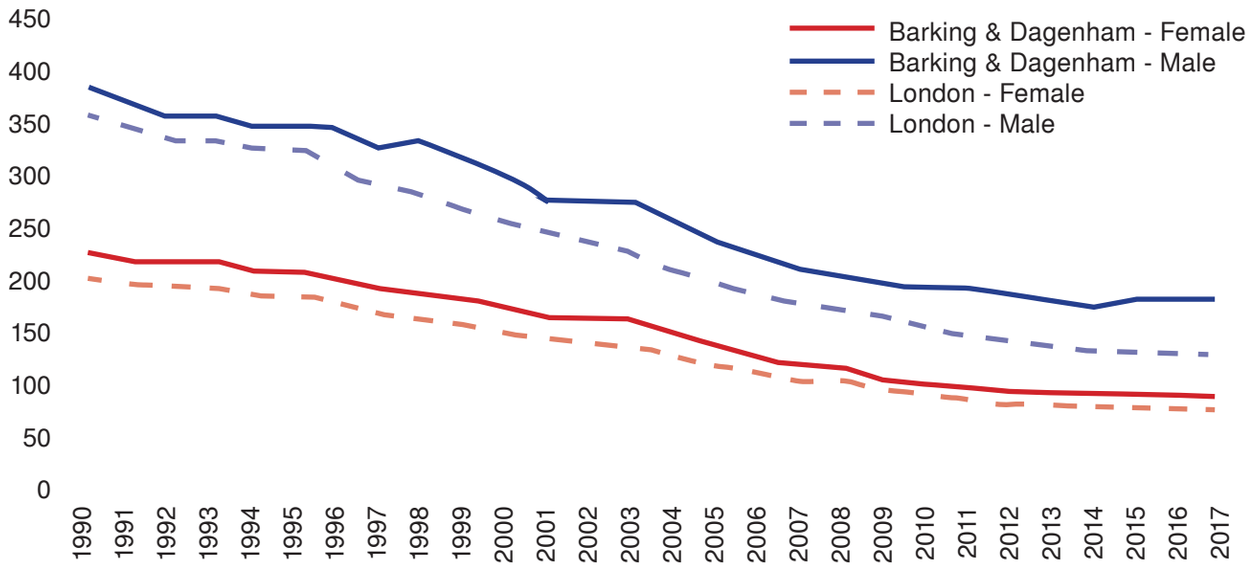
While we should not ignore the positive message in Figure 2 – that the rate of deaths from cardiovascular disease has more than halved for both males and females since 1990 – the current slowdown of improvement and the widening gap between Barking and Dagenham and London for males are causes for concern.

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

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

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

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



Source: Global Burden of Disease Study, 2017 round

8. PHE. *A review of recent trends in mortality in England.* London: PHE; 2018 [https://www.gov.uk/government/publications/recent-trends-in-mortality-in-england-review-and-data-packs]
9. Department for Communities and Local Government. English indices of deprivation 2015.
10. For more information, see: http://www.healthdata.org/gbd/about/protocol.

How does this relate to healthy life expectancy?

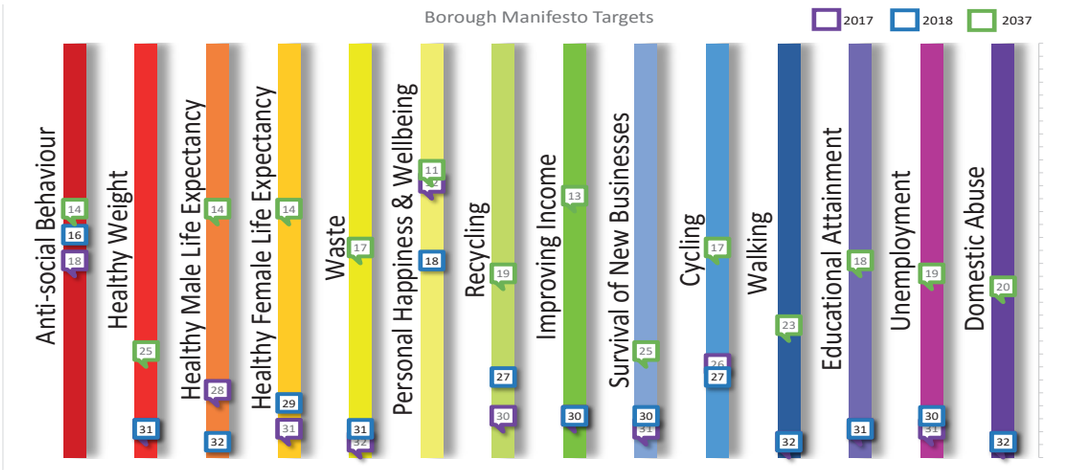
Life expectancy, however, only tells part of the story. We do not just want our residents to live longer lives, we also want them to spend more years in good health. This is important both for our resident's quality of life, but also to ensure that our health and care services are sustainable. In the next 5 years, Barking and Dagenham's population is projected to increase by 12%, but it is not as simple as increasing the capacity of our health and care services by the same amount.[11] While an extra £20.5 billion a year in real terms will be made available to the NHS through the Long Term Plan by the end of 2023–24,[12] our main provider of acute healthcare, Barking, Havering and Redbridge University Hospitals NHS Trust is in financial special measures. The future of public health funding remains unclear, and local authority budgets (through which councils need to finance both adult and children's social care) have been cut dramatically in recent years.

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

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

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

Figure 3: Borough Manifesto targets



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

11. Greater London Authority 2016-based Unconstrained Borough Preferred Option projection, 2018.
12. Gov.uk, Prime Minister sets out 5-year NHS funding plan [https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan]. Accessed 2019 Apr 23.

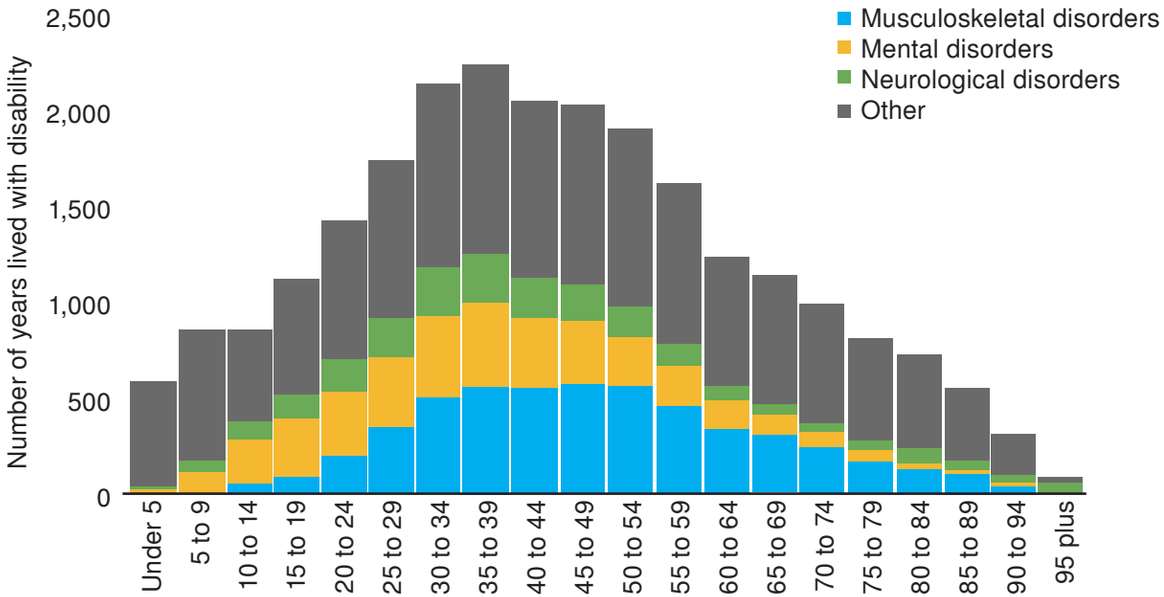
The most recent data (2015–17) estimates male healthy life expectancy at 62.8 years and female healthy life expectancy at 62.3 years, suggesting an average of 19.8 years in poor health for females and 15 years in poor health for males.[13]

Healthy life expectancy tends to be more variable than life expectancy because it requires people of both genders and a wide variety of age groups for each area to be surveyed on how they perceive their health. As it is not feasible to ask everyone in a specific area about their health (except in censuses), this leads to uncertainty about whether the results are representative of the broader population of that area. This is especially pronounced when the number of people surveyed for each age–gender group is small. Nonetheless, it is the best routine summary measure we have for looking at ill health across a population.

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

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

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



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

Source: Global Burden of Disease Study, 2017 round.

13. PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/].
14. See: Steel N, Ford JA, Newton JN, Davis ACJ, Vos T, Naghavi M, et al. Changes in health in the countries of the UK and 150 English Local Authority areas 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet 2018;392(10158):1647–61.

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

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

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

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

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

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

Source: Global Burden of Disease Study, 2017 round.

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

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

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

After lung cancer, the next most important causes of excess cancer death accounted for 6 excess deaths each – colorectal cancer, prostate cancer and stomach cancer – showing just how dominant lung cancer is in causing excess cancer mortality in Barking and Dagenham relative to London. Within cardiovascular diseases, the next most important causes of excess death after ischaemic heart disease is stroke (10 excess deaths) and aortic aneurysm (7 excess deaths).[16]

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

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

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

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

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

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

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

The wider determinants of health relate to the conditions in which you live your life and the places and people you share it with, as these have a significant impact on your health. This includes issues such as housing, employment, income, social status, crime (or fear of crime) and education. This is intuitive; health is not something that happens in isolation from the rest of your life. Residents in the poorest communities are 4.4 times more likely to smoke than those in the wealthiest communities,[17] while residents of the most deprived areas are 3.9 times more likely to die of cardiovascular disease by age 75 and 2.2 times more likely to die of cancer by this age than those in the least deprived areas.[18] Levels of childhood obesity are more than double in children from the most deprived communities than those living in the least deprived areas.[19]

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

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

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

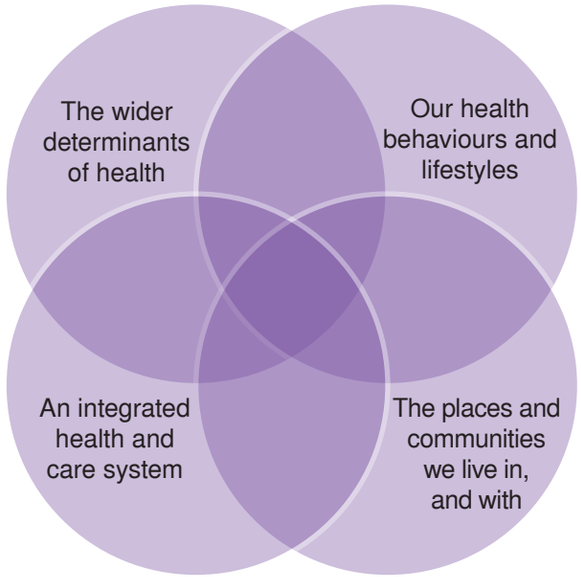
What are we doing to improve life expectancy?

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

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

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

Figure 5 The King's Fund framework for population health



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

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

The Joint Health and Wellbeing Strategy 2019–23

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

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

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

We wanted to make sure that action was targeted at areas that were important to residents, so for the first time there was strong engagement with our residents in the development of this strategy, and their views contributed to 'I' statements. This sort of co-production is key to the implementation of effective action. If we are not working with our residents to address their needs and understand how to tackle the issues we have identified, then how can we be surprised if top-down approaches do not resonate with them and do not have the intended effect. I build on this point in Chapter 2.

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

Box 3: Joint Health and Wellbeing Strategy themes

Best start in life: Best start in life refers to all interventions and conditions from preconception to age 7 which promote or support healthy early child development. This could include aspects which directly affect a child's mental or physical health or school readiness, but also the background conditions (such as poverty) that influence these.

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

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

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

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

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

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

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

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

24. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health 2017;2(8): e356–e366.
25. Brown DW, Anda RF, Felitti VJ, Edwards VJ, Malarcher AM, Croft JB, et al. Adverse childhood experiences are associated with the risk of lung cancer: a prospective cohort study. BMC Public Health 2010;10:20.
26. Breast cancer – PHE, Public Health Outcomes Framework [http://www.phoutcomes.info/]; 2017/18; Bowel cancer data – PHE, Young person and adult screening KPI data: Q1 (1 April 2018 to 30 June 2018).
27. Bosma H, Marmot MG, Hemingway H, Nicholson AC, Brunner E, Stansfeld SA. Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) study. BMJ 1997;314(7080):558–65.
28. NHS. NHS Long Term Plan [https://www.longtermplan.nhs.uk/]. Accessed 2019 Apr 12.

The Joint Health and Wellbeing Strategy 2019–23 has already been used in the Council in reviewing spending from the public health budget. In addition, it has been widely shared with partners to inform decisions across the health, care, community safety, housing and community sectors. Furthermore, the 2018 Joint Strategic Needs Assessment was created in parallel with the Strategy, so they are closely aligned, and information is available to support its implementation. The Council's transformation work is also supported by the Strategy's key themes and focus on early intervention and our vulnerable population. I go into more depth about how the transformation aligns with a Public Health approach in Chapter 2.

We have also carried out the first phase of a review of the lifestyle services provided by Community Solutions (the Council's front door to services) to align them with the Strategy's priorities, the long-term aims outlined within the Borough Manifesto and the public health savings plan. Phase 2 will consist of the development of detailed proposals with cost savings and service delivery plans from April to September 2019 in consultation with key stakeholders.

Box 4: Review of public health commissioned Community Solutions programmes

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

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

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

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

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

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

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

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

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

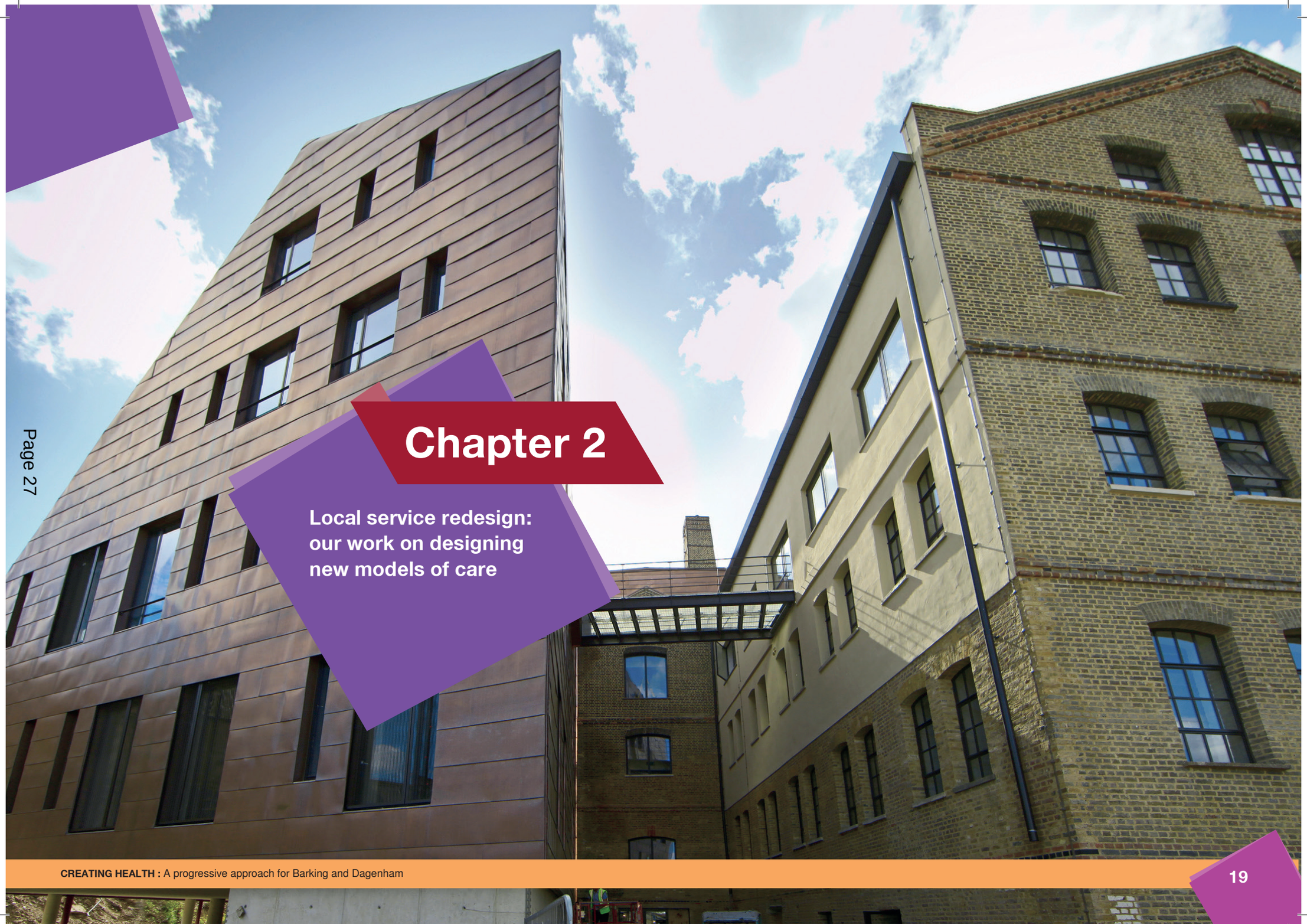
Conclusion

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

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

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

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



Chapter 2

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

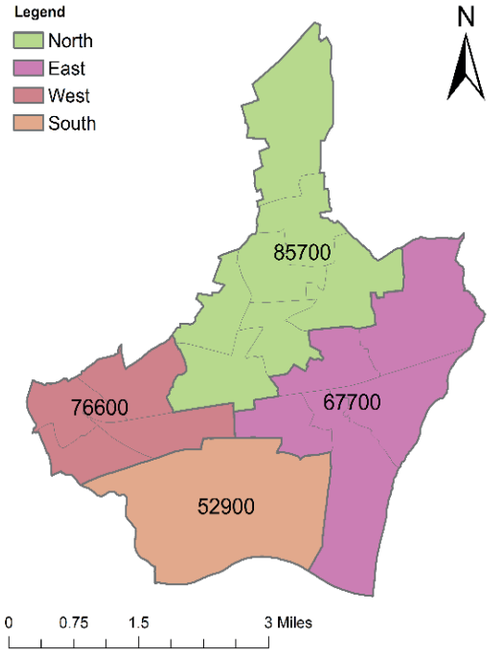
National policy context and an introduction to place-based care

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

Central to this is the place-based care model, which encourages providers of services to work together to improve the health and care of their population around a shared vision and shared objectives, using pooled budgets to deliver services that work together. In Barking and Dagenham, we can build upon our well-established Integrated Care Model that works in our existing localities, which includes co-located health and social care teams. We need to build on this existing good practice with a clear focus on population-level outcomes and shared decision-making processes to assess how best to get there. A consequence of this is that we will need to review whether to deliver our current integrated services from outside of traditional settings and delivered differently from expecting residents to attend doctors' surgeries or buildings.

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

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



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

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

The further development of these localities is key to supporting our transformation agenda in Barking and Dagenham. The Health and Wellbeing Board see the proposed primary care networks being built around our four agreed localities and drawing in expertise as required from hospital-based care, community services, social care, public health and the voluntary community and social enterprise sectors, to deliver services customised to the locality population. The starting point to establish place-based systems of care is to define the population served and what the barriers to, and boundaries of, collective working are. The scope should not just be focused on the NHS and social care but also on the wide range of other Council services and other partners that contribute to health, such as the Metropolitan Police, London Fire Brigade, schools and the voluntary community sector and so on. This provides the opportunity to focus on the needs of the population that they serve – it provides the opportunity to take responsibility for all the residents living within a given area.

Although there is a strong and steadily growing evidence base that prevention is a cost-effective way to reduce demand on the NHS and social care services, our existing prevention programmes and services are yet to realise these demand reduction benefits that have been achieved in other parts of London and the country as a whole. We will miss a trick if we don't capitalise on this opportunity to jointly commission integrated prevention programmes that go beyond care to tackle, for example, social isolation, neglect and homelessness. It is important to acknowledge that reducing demand and prevention are not the same thing. A key long-term outcome of prevention would be a reduction in the use of high-cost downstream services, such as A&E, adult social care and care homes and prevention programmes are part of the solution.

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

Figure 7: North East London Primary Care Vision

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

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

Learning from our experience of the existing Integrated Care Model, progression and development of a successful place-based care model requires a radical transformation of primary care: Radical in not being a GP-centric model as workforce constraints and demand is putting primary care under unprecedented strain. Despite efforts to increase the number of GPs and practice nurses we are not keeping pace with demographic pressures as identified in Figure 8 below. The Strategy's aim to increase our GP workforce by 20% (from a September 2015 baseline) by 2021 is a challenging one.

What are the key messages for Barking and Dagenham?

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

We also need to consider how other aspects of our prevention approach will fit within this integrated model. Firstly, interventions that seek to change behaviour without addressing the wider social and environmental constraints on choice are likely to have limited impact. Secondly, only if we use all the data at our disposal and every resident contact to improve the experience and service provided to that individual, we can push the boundaries of our prevention approaches.

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

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

Figure 8: GP and practice nurse workforce ratios

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

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

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

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

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

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

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

What does this mean for Barking and Dagenham residents?

Barking Riverside progress:

Since my 2016/17 annual report, there has been ongoing progress towards developing the new model of care for Thames ward. As a new development accommodating 10,800 new homes and a population increase of over 22,000 residents by 2037, the development will bring a new town to the borough, with a range of implications and opportunities for health, including the opportunity to reduce health inequalities and the challenge to make sure they do not widen. Barking Riverside Ltd (the developers) are obliged under planning regulations to make financial contributions for the new community and health infrastructure that is required to support the new population. This provides BHR System partners with the opportunity to explore the development of an innovative new model of wellbeing in an area of high deprivation, where services are delivered in a truly place-based model.

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

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

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

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

Co-production of Care

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

As referenced in Chapter 1, we also consulted with residents when we refreshed our Joint Health and Wellbeing Strategy in 2018/19. This was the first time we have co-produced the Strategy with residents by including 'I' statements which outline the priorities of residents in relation to each of the three themes. When we looked at the results of our resident engagement, the most popular 'I' statements, highlighted by the blue stars below, across all three themes were ones relating to connections with others. These came out above accessing information about their child's health, or long-term conditions, which suggests we should consider this in the way we deliver care.

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

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

'I' statement 1 I am provided with information about how to best to ensure my child's health and development	**'I' statement 4** I feel my mental health conditions are treated with the same respect as my physical conditions without stigma	**'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 2 I am supported to meet other parents in the community ★	**'I' statement 5** When I am diagnosed, my family and I know where to find community support services, including emotional support ★	**'I' statement 8** I have opportunities to connect to inividuals and communities ★
'I' statement 3 I am supported to make healthy choices for me and my child	**'I' statement 6** When I am diagnosed, I am supported with the information about my condition I need to make decisions and choices	**'I' statement 9** I can access mental health support services when I need them

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

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

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

Social prescribing

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

Around 20% of people visit their GPs for non-clinical reasons – from finance to social isolation. Social prescribing can help tackle the root of their problem. In an area such as Barking and Dagenham, which has some of the highest deprivation rates in the country, this is as high as 50%. For those with personalised care, including personal health budgets and personal independence payments, it is more important than ever that they can access high-quality services that can complement clinical provision, to protect their health and wellbeing.[34]

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

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

Box 5: Examples of Hilary Cottam's work:

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

34. https://www.london.gov.uk/sites/default/files/social-prescribing-our-vision-for-london-2018-2028-v0.01.pdf
35. https://www.theguardian.com/society/2011/feb/09/tough-love-troubled-families-swindon-participle

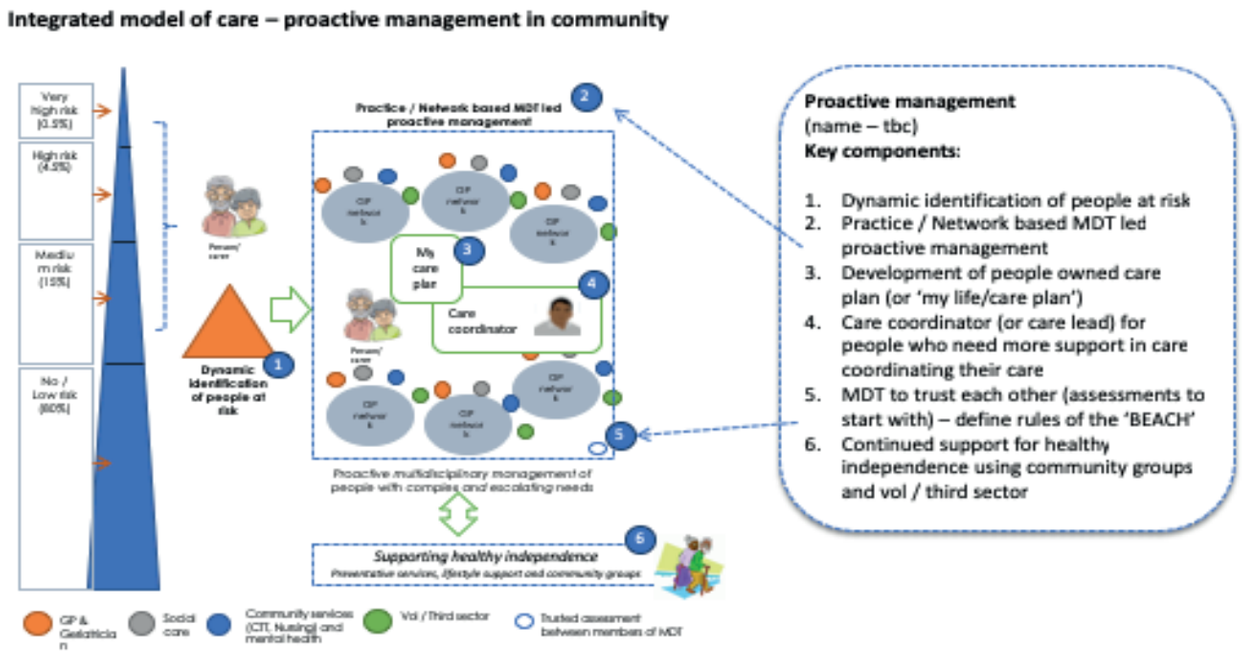
Working with residents differently, through approaches which emphasise the importance of human relationships, such as social prescribing, provides the opportunity to make a real difference to residents' lives by addressing root causes. In addition to social prescribing, we're also working on developing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

Dynamically identifying those residents who are at risk of frailty using data is a key component of place-based care. Better understanding of our population will enable us to target our interventions based on what we know about residents including their values and behaviours. We can stop residents escalating to our specialist and statutory services, as we know frailty is the biggest driver of demand for our health and care services, whilst also improving outcomes for our residents.

Accountability

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

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



Box 6: Social Prescribing

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

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

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

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

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

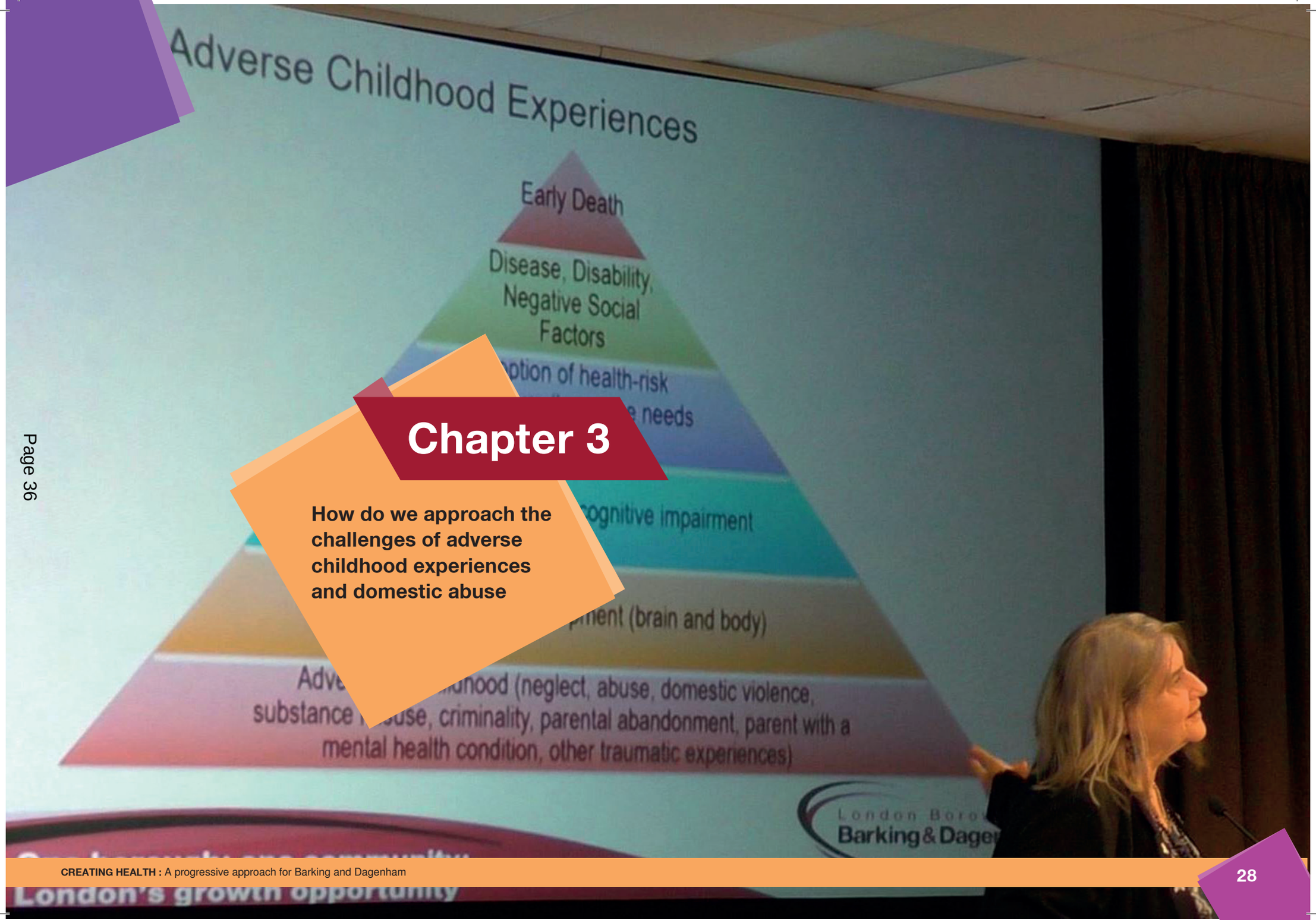
Conclusion

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

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

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

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



Chapter 3

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

As I have referenced in Chapters 1 and 2, making a difference to some of the key health challenges in Barking and Dagenham requires us to look outside the scope of traditional health and care. This 'whole picture' Public Health approach is reflected in our Joint Health and Wellbeing Strategy 2019/23. One of its three themes is resilience, which means enabling our residents to thrive, not just survive, and bounce back in the face of adversity. While there are several aspects of resilience, one key way to build resilience is through targeting support as early as possible to lead to long-term benefits in both improving the health and wellbeing outcomes of residents and decreasing demand on specialist services.

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

Outcome 3

Improved multi agency support for those with Adverse Childhood Experiences

Outcome 7

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

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

What are adverse childhood experiences?

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

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

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

- The Mayor's Office for Policing and Crime (MOPAC) data suggests Barking and Dagenham has the third highest reported rate of child sexual exploitation in London in 2015/16.[36]
- Barking and Dagenham had the highest rate of domestic abuse offences in London in 2016/17 at 11.2 per 1,000.72. This is higher than the London average of 8.2 per 1,000. Domestic abuse is a national problem and fear of reporting causes significant levels of domestic abuse to go unreported.

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

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

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

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

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

36. https://www.london.gov.uk/sites/default/files/mopac_lcpf_co-commissioning_workshop_cse_july_2017.pdf
37. Felitti et al 1998 cited in Trauma-informed Care 2013 Wilson, C. Pence, Donna and Conrad, L at http://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063?p=emailAilDLZvuY00ho&d=/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063
38. BMC Public Health 'Stress begets stress: the association of adverse childhood experiences with psychological distress in the presence of adult life stress' (2018) - https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5767-0

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

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

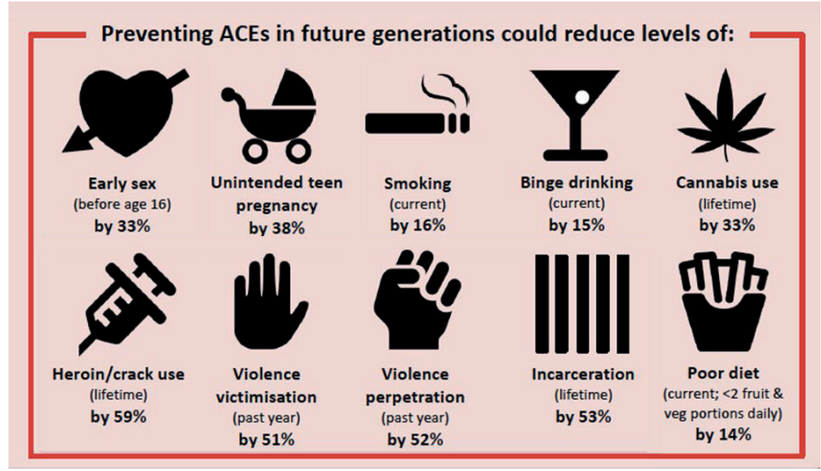
Prevention and early help are important to mitigate the impact of ACEs in the lives of children and young people. Barking and Dagenham are set to partner with the Early Intervention Foundation to deliver the Early Years Transformation Academy. The Academy will be delivered locally as well as in four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

Knife crime

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

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

Box 7 Positive impact of preventing ACEs



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

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

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

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

Therefore, legislation to make sure professionals in health, education, police, social services, housing and the voluntary community sector work together and are held accountable for preventing and tackling serious violence may be counter-productive. A strong focus should be pursued in ensuring every part of the system invests resources in and works together to provide targeted interventions that support young people not to commit violence or become vulnerable to being groomed by gangs.

What is a trauma-informed approach?

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

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

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

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

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

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

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

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

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

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

- Access to Speech and Language Therapy (SALT), Child and Adolescent Mental Health Services (CAMHs) and School Nursing. This, in their opinion, is having a negative impact on vulnerable groups including looked after children and special educational needs and disability (SEND).
- The effects of adverse childhood experiences that lead to social care intervention stretch well into adulthood and include mental health difficulties and crime.
- Despite efforts to prioritise looked after children in schools, through virtual school heads and the looked after child pupil premium, their experiences are still characterised by instability and poor outcomes.
- Within this concerning picture, there is hope that longer-term stable care placements can result in better outcomes, including a lower chance of permanent exclusion from school.

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

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

Outcomes of the deep dive are to identify:

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

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

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

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

Focusing on domestic abuse

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

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

Within Barking and Dagenham, we are looking at domestic abuse differently. Councillor Maureen Worby, Cabinet Member for Social Care and Health Integration has recently launched a commission to investigate the underlying causes of domestic abuse, and the normalisation of it within Barking and Dagenham. Rather than focusing on the response of services around domestic abuse, the commission, the first of its kind, will investigate why domestic abuse is tolerated within our community to the extent it appears to be and to make recommendations for change.

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

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

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

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

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

The services will be aimed at:

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

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

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

41. https://www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse
42. https://www.womensaid.org.uk/survival-beyond-report/
43. SHEU School Survey, commissioned by Public Health, 2017

Conclusion

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

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

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

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

Chapter 4

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

Making it real

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

The Government's promised Green Paper on the reform of the social care system has been delayed again until a Brexit deal is agreed in Parliament. Without a clear long-term solution for a sustainable future for the social care system, transformation is challenged. The social care system is currently under a tremendous amount of financial pressure. The Local Government Association estimates that adult social care services will face a funding gap of £1 billion by 2019/20[44] and Age UK predicts that by 2020/21 public spending for older people's social care would need to increase by a minimum of £1.65 billion to £9.99 billion to manage the impact of demographic and cost pressures.[45] However, recent figures are not encouraging; the amount spent on social care has decreased every year since 2010/11 excluding transfers from the NHS.[46] Reforming the design of the social care funding system is extremely important for older people's wellbeing and dignity and must be addressed as a matter of urgency. However, it will do nothing to address demand.

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

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

The status quo is no longer an option

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

What prevents us from working as an effective system?

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

44. House of Commons Library, Adult Social Care Funding (England), (2017)|
45. Age UK, 'Briefing: Health and Care of Older People in England 2017', February 2017, available here: http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true
46. The Health Foundation, 'Health and social care funding explained', January 2017, available here: http://www.health.org.uk/health-and-social-care-funding-explained
47. http://www.hilarycottam.com/radical-help/

How can we build the social infrastructure to enable human relationships and participation, so that 'health creation' might happen organically and sustainably?"

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

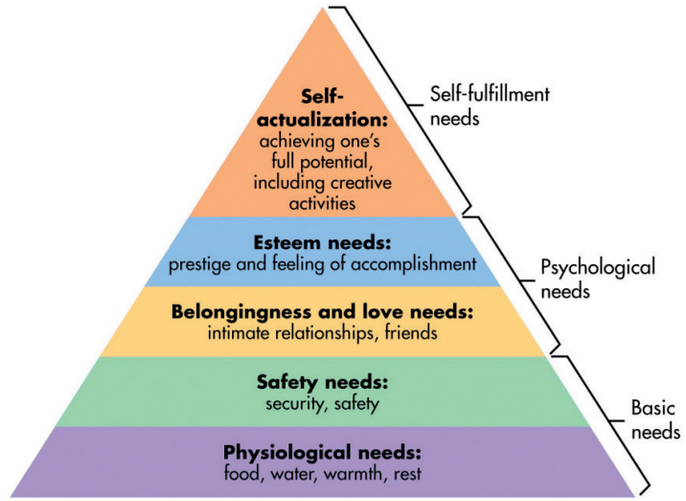
The Council and its partners recognise our approach to reducing demand must focus on a way of creating health that decreases dependency, increases resilience and reduces their demands on traditional health and care services. This requires understanding of and insight into what motivates our residents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

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

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

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

Figure 11: Maslow's Hierarchy of needs



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

Figure 12: Barking and Dagenham theory of change

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

System design principles

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

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

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

What would this look like in practice?

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

Childhood obesity

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

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

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

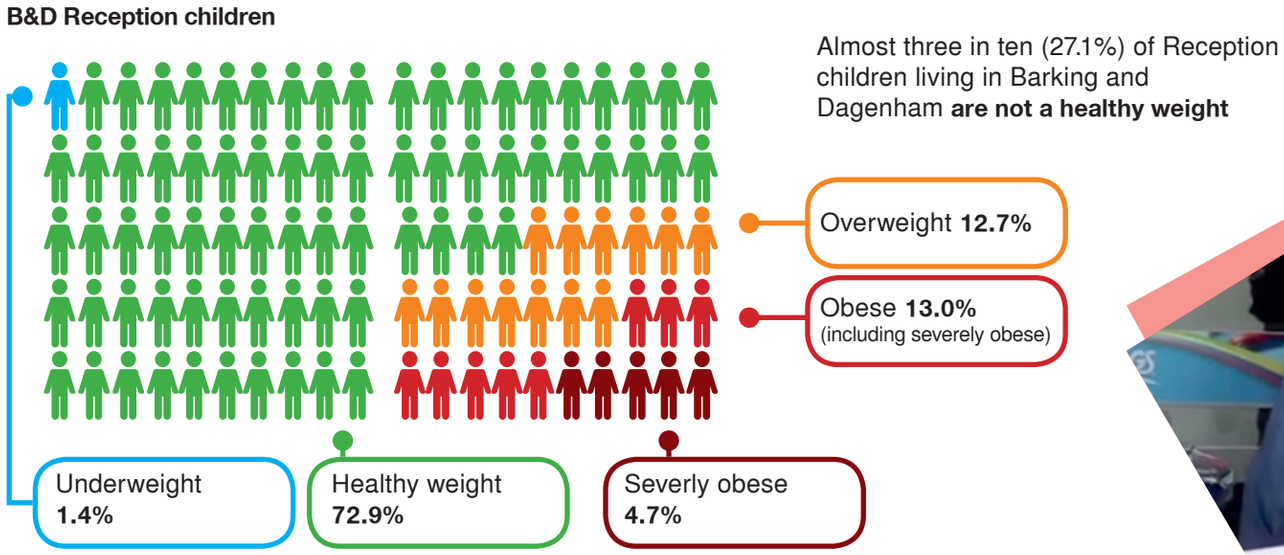
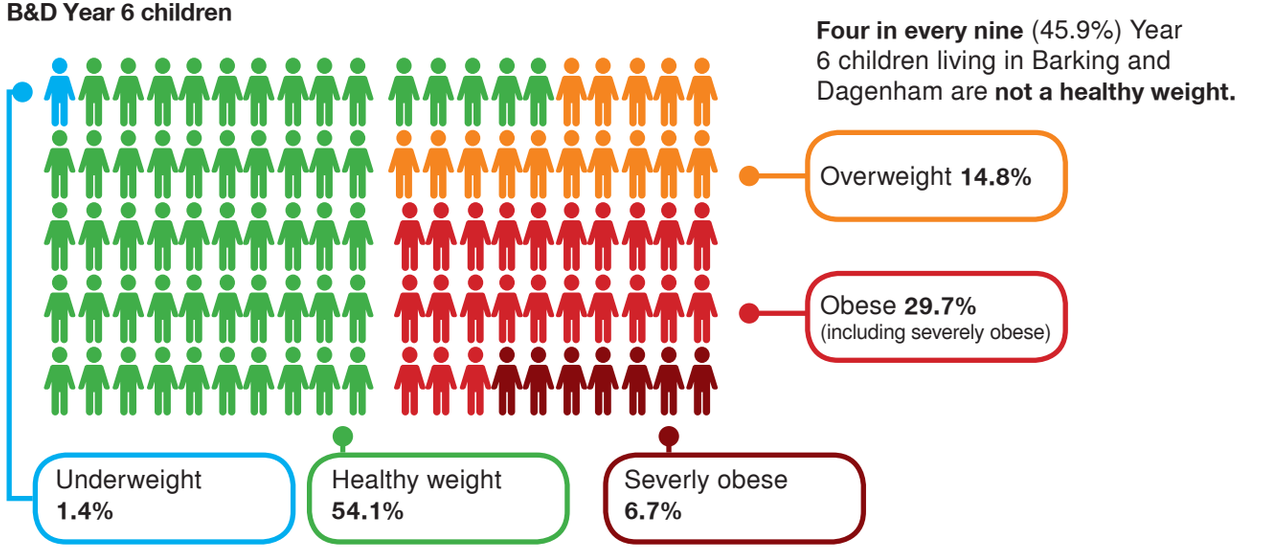
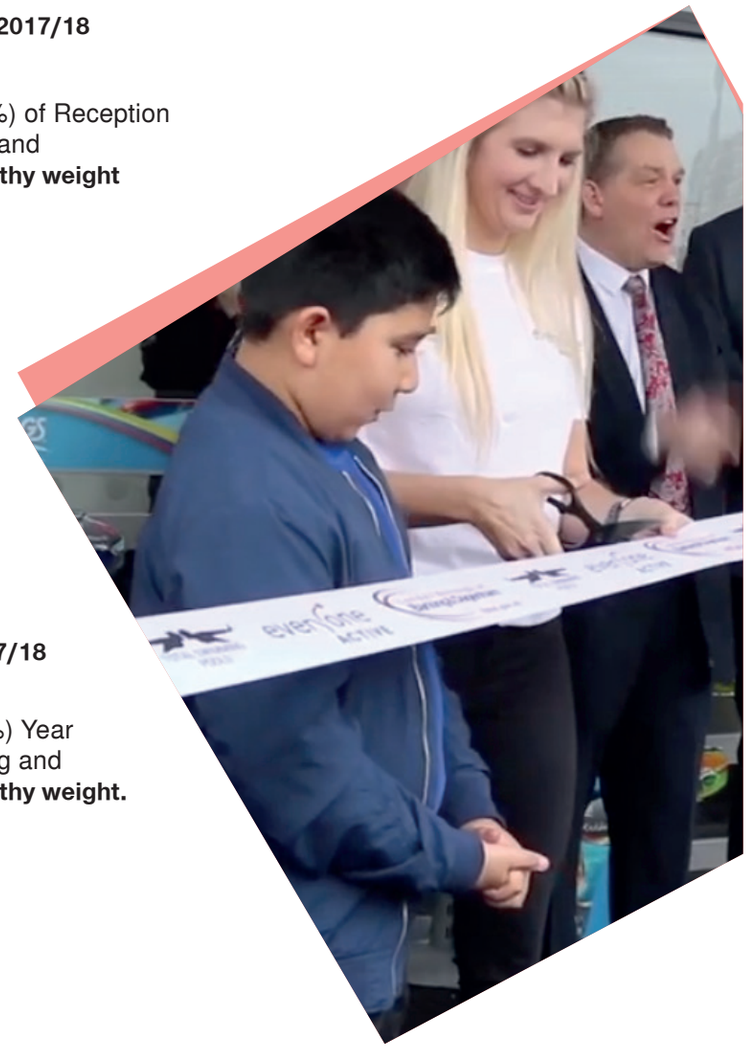


Figure 14. Infographic showing levels of weight in Year 6 children in Barking and Dagenham in 2017/18





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

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

In 2018 the Council commissioned a piece of insight work to understand how our residents viewed the issue of healthy weight and their approaches to healthier lifestyle behaviours such as exercise and healthy eating.[48] This research told us that our residents view health as the presence or absence of illness and therefore our work around healthy lifestyle wasn't always having the impact we hoped for. Healthy behaviour change is more likely to occur when approached through the lens of social improvement, when it is easier for people to make these changes and they see others in their community doing so. This evidence from our residents demonstrates the need to work differently across different groups to tailor programmes that unlock their motivation for change. Harnessing the whole system approach can allow this to happen.

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

- Commissioned programmes are working in silos and not having a population-level impact.
- Cost of Lean Beans, HENRY and other initiatives is £320K. From HENRY (45 children) and Level 2 services (155 children), in total 200 children completed the programme. The unit cost is £1600 which seems quite expensive and cannot justify value for money.
- Lean Beans programme should be more targeted as currently it is universal and costly.

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

A whole system approach to childhood obesity can be led locally but needs to consider the wider London system that we exist in. As outlined in Chapter 1 The King's Fund framework for population health based on four separate pillars:
1) the wider determinants of health;
2) our health behaviours and lifestyles;
3) an integrated health and care system; and
4) the places and communities we live in, and with.[49]

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

48. Healthy Weight – Changing Behaviour in Barking and Dagenham, April 2018
49. Buck D, Baylis A, Dougall D, Robertson R. *A vision for population health: Towards a healthier future.* London: The King's Fund; 2018 [https://www.kingsfund.org.uk/publications/vision-population-health].

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

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

Box 10: The EPODE and Amsterdam childhood obesity models

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

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

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

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

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

Box 11: Integrated prevention approach

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

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

Frailty

Frailty has been identified by both the Health & Wellbeing Board and the Integrated Care Partnership Board as a key driver in financial recovery and demand management. The new models of care I outlined in Chapter 2 are the start of commissioning across health and social care in Barking and Dagenham for older adults. The healthy ageing work stream in the BHR Older People and Frailty Transformation Board is the start of a whole system approach to health creation that takes NHS commissioning intentions directly into the Council remit. The implementation of a healthy ageing programme will align both the work in targeting frailty and the work keeping residents healthier and in their homes for longer.

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

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

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

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

50. https://www.ncbi.nlm.nih.gov/pubmed/22348701
51. https://www.emeraldinsight.com/doi/abs/10.1108/JICA-01-2014-0002
52. https://www.cambridge.org/core/journals/ageing-and-society/article/addressing-loneliness-and-isolation-in-retirement-housing/59EAF68079ED5A83AAB792D0DEE174DA

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

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

Other interventions we should consider are in Table 2.

Future of wellbeing and care for frail people

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

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

Table 2: Frailty interventions

Programmes that should be Consistent across borough	Working Well Scale-Up	New Ideas
• MECC • Social Prescribing and health unlocked • Frailty Pilot – care navigation • Falls prevention	• Breezie pilot • Good Gym • BuddyHub • Telecare	• Expert carer – Care City • Group exercise • Participatory arts

Box 12: Dartmouth Institute and UCL Partners

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

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

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

Design principles

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

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

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

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

Figure 15: Amanda's journey

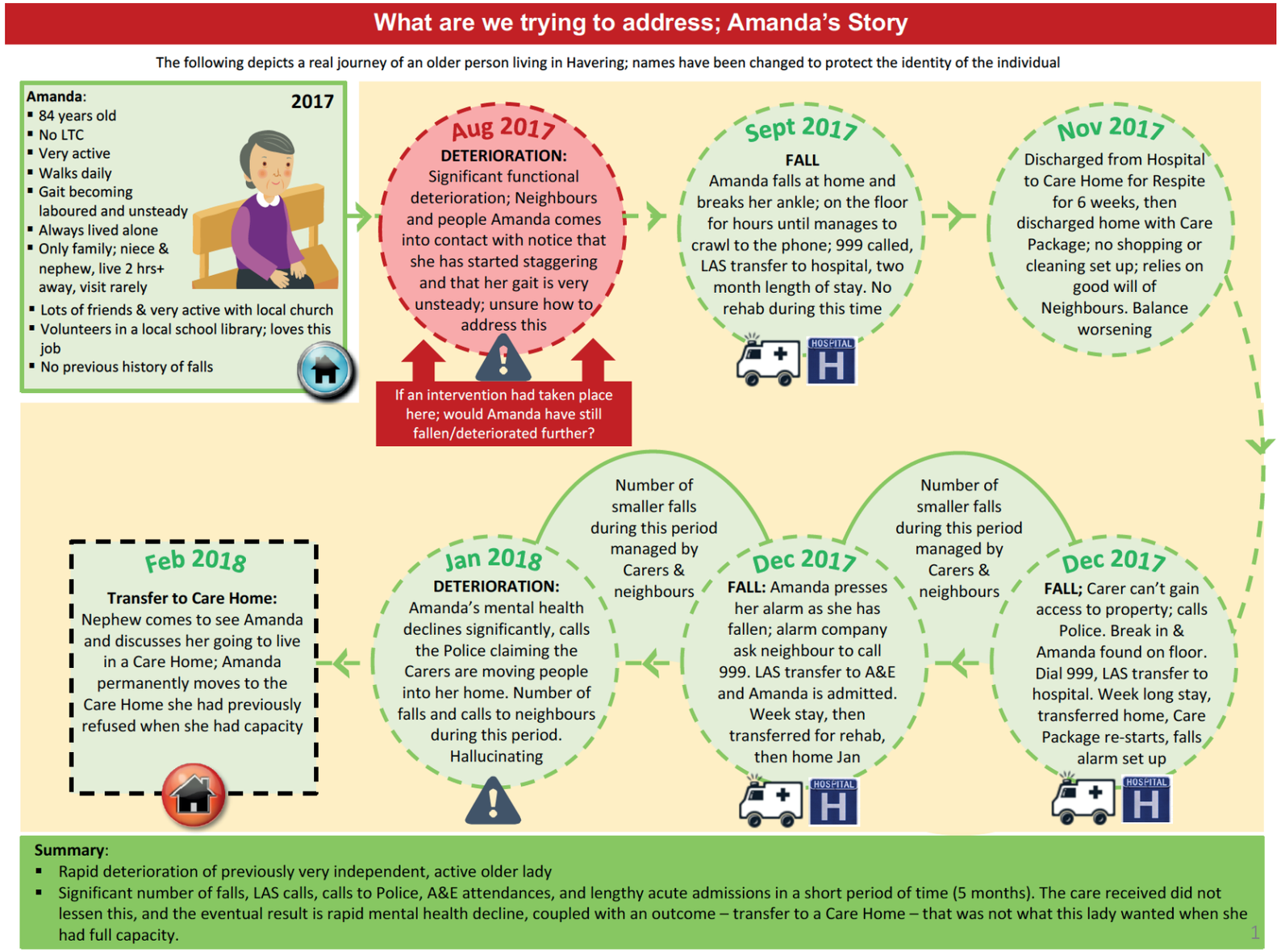


Figure 16 describes how we would do things differently based on Amanda's experience. We explored the **potential to use existing resources differently**, for example, Integrated Case Management teams, based on the existing locality structure. Key processes:

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

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

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

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

Behaviour change approach

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

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

- Target
- Explore
- Solution
- Trial

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

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

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

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

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

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

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

Summary of proposed changes/interventions

We intend to develop a proposal to make changes to the way in which care is delivered to frail people locally, with local stakeholders to ensure that care is tailored, built from the ground up, and reflects local nuances. We will start with complex patients within a GP practice, working with local health and care staff, as well as the patient themselves, the community and voluntary sector, and wider agencies to design care that truly places the patient/person at the centre, and reduces frustrating processes and artificial boundaries to the delivery of seamless care.

How is this approach different?

- ✓ Designed from the ground up around local people by those who deliver health, care and wider services
- ✓ Those who recognise the deterioration in Amanda feel confident to speak to her about it, and have a clear person to refer her to for comprehensive guidance; as this support is not necessarily the traditional 'social care' or 'health' route, Amanda feels more comfortable about having an assessment (from her perspective, a 'chat' about how she is doing, and what she feels she needs)
- ✓ Support is given **before** Amanda deteriorates further and starts to fall; **before** she reaches crisis, not once the damage has already been done
- ✓ Because the support is given earlier in Amanda's journey – **upstream** – Amanda is able to stabilise and remain at home, **where Amanda wants to be;** all of Amanda's wishes and personal 'outcomes' are achieved

Amanda's journey post the intervention

Month 1

DETERIORATION:

Significant functional deterioration; Amanda has started staggering and her gait is very unsteady. Amanda visits GP for a Flu Jab, GP notices gait and following discussion with Amanda, refers her on to the Health Navigator based in her GP practice

Month 1-2

INTERVENTION:

Develop a place based, integrated 'community of care and wellbeing' co-designed with local people and staff on the ground, with a strong focus on outcomes

Month 3

OUTCOME:

EXAMPLE: Following an MDT review and receipt of rehab in her own home, Amanda's mobility and balance have improved. Home adaptations have been made to reduce the risk of falls. Falls alarm in place. Shopping service set up through a local charity. Amanda feels confident and secure and is able to remain as independent as possible at home, where she wants to be.

Summary:

- Rapid deterioration of previously very independent, active older lady
- This is recognised by the care professionals that Amanda comes into contact with, and they have the pathway and resources/remit to refer her for immediate intervention before things deteriorate. The response is tailored to Amanda's needs and wishes, and enables Amanda to remain independent at home (where she wants to be), for longer

2

Conclusion

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

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

Chapter 5

Our future commissioning plans

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

The Public Health Grant

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

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

In addition to the Grant reduction, it is unclear at this moment if the Grant will cease after 2021 and the Council will be expected to fund its Public Health programmes from generated business rates. Therefore, now is a good opportunity to look at the ways in which our programmes are being delivered in order to achieve savings and transform delivery to achieve outcomes.

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

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

53. https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2019-to-2020
54. https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06844
55. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213009/Public-health-role-of-local-authorities-factsheet.pdf

Box 15: Public Health Grant allocation and reduction

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

Public Health Grant savings exercise

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

The first step is to look closely at why we provide programmes, who we provide them for and how we can manage demand to ensure that we deliver statutory and other services for residents, with capacity for the future. This includes evaluating the whole range of Public Health funded programmes being delivered by the Council. Several options were identified where services can be decommissioned or where monies could be released to fund other Council services which fall within the scope of the Grant's conditions; a total of £1m savings (700k recurring and 300k one-off) was generated from the Grant to contribute to the reduction in deficit in general funds. These have included increasing efficiencies through new procurements; protecting services where funding is tied into existing contracts; reducing funding and in some cases cutting budgets/posts completely. The approach took account of factors, including notice period for services in contract, staffing implications for the borough; a significant amount of public health funding is used to directly pay for posts within the Council, accounting for around 80-90% of the Grant's internal spend.

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

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

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

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

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

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

Priorities

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

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

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

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

Our future commissioning plans

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

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

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

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

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

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

Conclusion

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

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

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

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

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

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

56. Public Health England, Public Health Outcomes Framework [http://www.phoutcomes.info/]
57. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767549/Annual_report_of_the_Chief_Medical_Officer_2018_-_health_2040_-_better_health_within_reach.pdf
58. https://www.hsj.co.uk/download?ac=3041414

Acknowledgements

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HEALTH AND WELLBEING BOARD

11 June 2019

Title:	BHR Children and Young People's Transformation Board – Best Practice Evidence Review

Report of the Health and Wellbeing Board

Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Authors: Florence Henry, Public Health Strategy Officer, London Borough of Barking and Dagenham Paul Starkey, Health Improvement Advanced Practitioner, London Borough of Barking and Dagenham	**Contact Details:** Tel: 020 8227 3059 E-mail:florence.henry@lbbd.gov.uk Tel: 020 8227 5170 E-mail: paul.starkey@lbbd.gov.uk

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Summary:
The report was written at the request of the BHR Children's and Young People's Transformation Board to provide the evidence on best practice for the three priority areas mentioned above. It was taken to the board on the 28th March 2019 supported by a presentation that outlined the three key areas covered in the report. During the writing of the report we were mindful of the fact that in BHR, each council is at a different stage of transformation and the challenges that this creates for developing an integrated BHR health creation approach. It should be noted that the aim was to inform and provoke discussion about what is currently taking place in BHR and how we can best make the changes that will enhance the lives of children and young people. This paper is also being presented at Redbridge and Havering's Health and Wellbeing Boards.

The three priority areas identified in this report are the Best Start in Life, Adverse Childhood Experiences (ACEs) and Special Educational Needs and/or Disabilities (SEND). These strategic areas of focus were chosen by the Joint Commissioning Board because of their potential to significantly improve health outcomes for children and young people living in BHR. For each of these priority areas, the purpose of the report was to outline why this is an important area of focus for BHR, by including some headline BHR data and national and international best practice for interventions in these areas.

Recommendation(s)

The Health and Wellbeing Board is recommended:

i) To note the report and
ii) To discuss how local partners should be working as an integrated care system in this area to improve outcomes for residents.

1.0 Background/ Introduction

1.1 Transforming the experience of health and care for children and young people not only provides the opportunity to improve the experiences of current residents in BHR but is also a key element of prevention and reducing future need. Investment at this stage will create a long-term impact that will span throughout the life course and improve the outcomes for children and young people. To this end, prevention and early intervention have been recognised as key components of the Transformation Board. This will importantly have longer term effects on other transformation programmes, including mental health, long-term conditions and older people. Evidence from the Marmot Review demonstrates that a good start in life, including being physically and emotionally healthy, provides the cornerstone for a healthy, productive adulthood. Ensuring outcomes for BHR children and young people provides the opportunity to prevent key health problems later in life before they take place.

1.2 The importance of ensuring this good start for the future health of children, for the sustainability of the NHS and the economic prosperity of Britain is echoed in the NHS Long Term Plan as one of the key themes (2019)[1]. In addition, the plan also highlights that the health of children and young people are determined by far more than healthcare. The wider determinants of health such as household income, education, housing, a stable and loving family life and a healthy environment all significantly influence young people's health and life chances. For this reason, in order to make a difference to the outcomes of children and young people in BHR, we will need to work together cross-organisation as an Integrated Care System and importantly look beyond care including the wider work of local authorities, the community and voluntary sector.

2.0 Priority 1: Best Start in Life, focusing on preconception up until the age of 7

2.1 Why is focusing on the Best Start in Life important?

The Marmot Review demonstrates that the first 5 years of life have a substantial impact on physical and mental health for the rest of life. What happens in the early years can impact on a range of health and wellbeing areas including obesity, heart disease, mental health, smoking, educational achievement and economic status. Furthermore, many of the key issues that we are trying to tackle across our health and care system are determined by residents' experience in the Early Years – prioritising the Early Years offers the potential to prevent some of the key health challenges facing the BHR system before they happen. In order to create a sustainable health and care system across BHR, offering a co-ordinated focus on the Early Years could help to reduce the demand for future health and care services, and help to reduce health inequalities and improve health outcomes across the life course. Whilst the traditional Best Start in Life focuses on preconception up until the age of 5, increasing this up to the age of 7 allows for a focus on managing the transition between the school and home effectively, and focuses on providing continuity of care from primary and home including play and communication. [1]

There is also a clear economic case for prioritising work in the Early Years. Evidence from Public Health England demonstrates that for every £1 spent in the

[1] 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

Early Years, £7 would have to be spent in adolescence to have the same impact on health[2]. Evidence shows that later interventions, although important, are considerably less effective when residents have a lack of good early foundations. Therefore, in order to create the most substantial change in successful health and care interventions across the life-course, and interventions across our other transformation boards, and workstreams, especially mental health, help to provide all residents with the Best Start in Life.

2.2 What does the data say about the BHR population?

Additionally, although the three boroughs have different populations, looking at population data for all three boroughs provides further evidence on why this is important. There are increasing numbers of children in all three populations:

- Barking and Dagenham - Barking and Dagenham have the highest proportion of residents aged 0-4 in the UK, and the highest 2017 birth rate in the UK. 3

- Havering - In Havering, there has been an increase in the number of births, equating to an additional 10 births per 1,000 women aged 15-44 between 2004 and 2017. In addition to this, from 2011 to 2016, Havering experienced the largest net inflow of children across all London boroughs4

- Redbridge - By 2026, it is predicted that there will be over 118,000, 0-25 years olds living in Redbridge, and nearly 21% of dependent children and young people under 20 years old live in households subject to relative poverty.5

2.3 Best practice

Evidence shows that a child's early development score at 22 months is an accurate predictor of educational outcomes at age 26 (Feinstein, 2003), which is in turn related to long-term health outcomes. Therefore, focusing on providing early years programmes are key in order to improve the life chances of those within BHR.

NICE guidelines recommendations are a helpful resource to draw on. Within Best Start in Life, they cover home visiting, early education and childcare for vulnerable children. They state that a 'life course perspective', recognising that disadvantage before birth and in a child's early years can have life-long, negative effects on their health and wellbeing. A focus on the social and emotional wellbeing of vulnerable children as the foundation for their healthy development helps to offset the risks relating to disadvantage. This is in line with the overarching goal of children's services, that is, to ensure all children have the best start in life. The aim is to ensure universal, as well as more targeted services, provide the additional support all vulnerable children need to ensure

[2] 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

[3] https://modgov.lbbd.gov.uk/internet/documents/s126826/JSNA%20Report%20-%20App.%20A%20Draft%20JSNA.pdf

[4] https://www.haveringdata.net/wp-content/uploads/2018/09/Published-201819_Havering-Demographic-Profile-v4.1.pdf

[5] https://www.redbridge.gov.uk/media/4814/health-wellbeing-strategy-2017_2021.pdf

their mental and physical health and wellbeing (Key services include maternity, child health, social care, early education and family welfare.)[6]

The Kings Fund also makes a series of recommendations to provide effective early years support to improve health and reduce inequalities, partners should work to look at targeting:

- **Focus on promoting early childhood development, especially social and emotional development –** Evidence demonstrates that a child's early development score at 22 months, is an accurate predictor of educational outcomes at the age of 26, which is also related to long-term health outcomes. **Strategies identified as effective in supporting personal, social and emotional development in children including staff modelling prosocial behaviour, small group activities that supported children to work together, share and take turns, a consistent approach to behaviour management and using snacks and mealtimes as an opportunity to foster prosocial behaviour**.

- **Target the most disadvantaged children and their families with intensive support, supplementing specific interventions with mainstream universal family support services.** Successful interventions tend to be behaviour focused – for example, coaching parents during play sessions with children, rather than simply providing information can be more effective in improving outcomes.[7] Across our health and care systems, we have a key opportunity to intervene during the early years – not only are the early years a time when our health and care systems have frequent contact with parents, evidence demonstrates the early years are a key time to intervene to effectively improve outcomes.

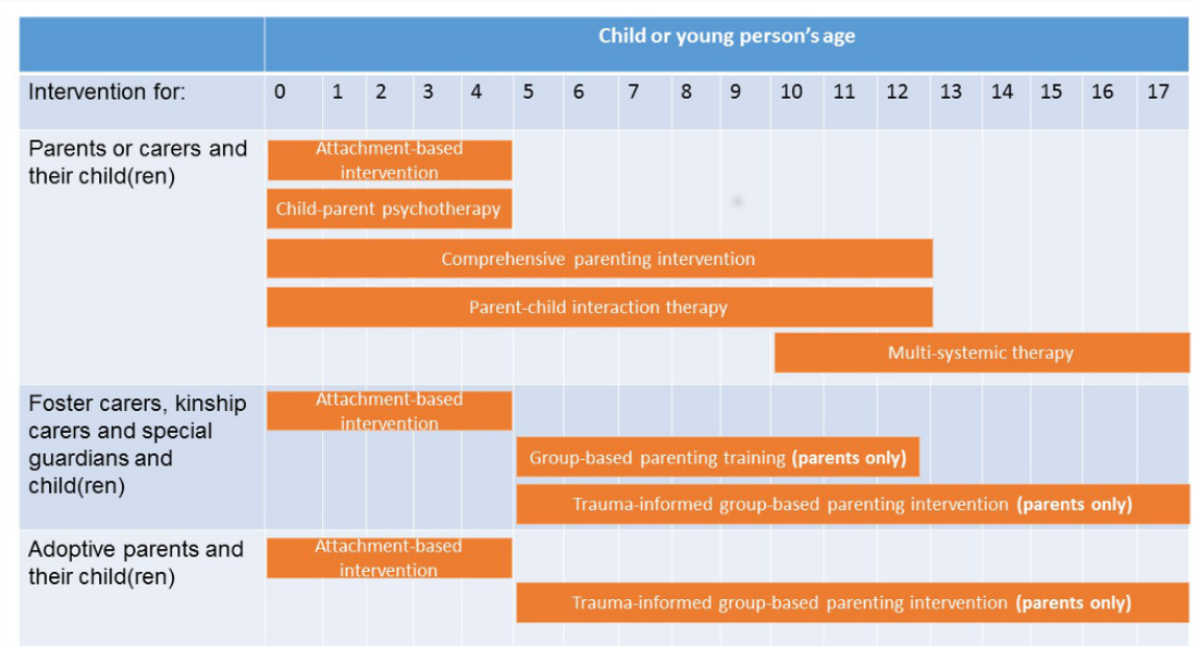
- **Using multisystemic therapy for neglect –** The early years are also a key time to identify and support out most vulnerable children. We know that NICE guidance on child abuse and neglect makes a number of best practice recommendations for child abuse and neglect. These include offering early help for families, multi-agency response and therapeutic interventions.[8]

[6] – Social and emotional wellbeing: early years – Public health guideline (PH40) – Published date: October 2012

[7] https://www.kingsfund.org.uk/projects/improving-publics-health/best-start-life

[8] https://www.nice.org.uk/guidance/ng76/chapter/Recommendations

Figure 1 Interventions following physical abuse, emotional abuse or neglect



Multi-systemic therapy is one form of therapeutic intervention that can be effective for neglect. Multi systemic therapy for Child Abuse and Neglect was developed to treat families who have come to the attention of Children's Services due to physical abuse and/or neglect and who have one or more children aged 6 to 17 years who are subject to a child protection plan. Evaluation in trials demonstrates that MST-CAN was twice as effective as the alternative outpatient therapy at preventing out-of-home placement. Moreover, MST-CAN was more effective at reducing parent and child mental health problems and increasing natural social supports. In the UK, of the 71 families evaluated during the pilot period:

- 98% of the children remain at home
- 97% are in school or working

There has been work to establish the cost effectiveness of MST-CAN within UK, Europe and US. A recent evaluation study in Leeds established during the pilot phase, there was a £1.59 return for every £1 spent on the programme.[9]

- **Further exploring the link between family poverty, child abuse and neglect**
  An evidence review by the Joseph Rowntree Foundation (2016) explores the relationship between poverty, child abuse and neglect and had 3 key findings:

  1) <u>There is currently a lack of joined up thinking and action about poverty, and child abuse and neglect in the UK.</u> It recommends a secure recognition of the strong association between families' socio-economic circumstances and the chance of being subject to abuse or neglect through:

     - child protection policies including explicit and specific consideration of the impact of families' socio-economic circumstances
     - all anti-poverty policies include the relationship to Child abuse and Neglect (CAN) as a significant dimension
     - training programmes for frontline staff to develop thinking around.

[9] http://www.mstuk.org/about-mst-uk/mst-can

2) <u>There is currently a need for an improved evidence-base</u>
In the UK, there is limited evidence base in terms of official data and research. The paper recommends that there is a need to expand this evidence-base through official data collected on child protection systems should include a common core dataset that supports comparisons of which children and families are involved, how services intervene and the short, medium and long-term outcomes:

- identify ways of including information on family socio-economic circumstances or linking data on family circumstances to CAN data
- develop improved measures of the longer term economic and social outcomes of child protection systems for individual children beyond the current information around care leavers up to age 21.

3) <u>There should be a focus on reducing family poverty in the population</u>
- Work on anti-poverty policies which reduce inequities in child health and education and incorporate a focus on their relevance for Child Abuse and Neglect
- data gathering which enables groups and neighbourhoods.

- **Focus on vulnerable mothers from pregnancy until the child reaches the age of 2.** Programmes that involve health visitors and specialist nurses undertaking home visits have had successful outcomes, including improvements in prenatal health, fewer childhood injuries, fewer subsequent unplanned pregnancies and increases in maternal employment and children's school readiness.

  Family Nurse Partnership is one example: hip (FNP), a voluntary internationally accredited home visiting programme for vulnerable mothers from early in pregnancy until their child is 2, has generated savings of more than five times the programme cost, and is an example of an evidence-based licensed programme. The programme has three aims: to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the age of 2.

  The criteria for women to be offered the FNP are: all first-time mothers age 19 and under at conception; living in the catchment area; eligible if previous pregnancies ended in miscarriage, termination, still-birth; enrolment no later than 28th week of pregnancy and as early as possible. 30 years of high-quality US research has shown benefits for vulnerable young families including improvements in antenatal health, reduction in child injuries, neglect and abuse, improved early language development, school readiness and academic achievement, increased maternal employment and reduced welfare use as well as fewer subsequent pregnancies and improved parenting. [10]As this demonstrates, the wide-ranging impact on improving outcomes for BHR children and reducing demand for further health and care systems of an effective FNP service would be substantial and long-term.

[10]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729018/Making_the_case_for_preconceptioncare.pdf

- Identifying mental health issues early: evidence from the WHO demonstrates that maternal mental health problems can have negative impacts on child development – it can impact breastfeeding, mother-child bonding and parenting quality. Suicide is one of the commonest causes of maternal mortality, and 20% of women experience mental health issues in pregnancy and the first year after birth, and up to 10% fathers suffer from postnatal depression [11]The Kings Fund also highlights that early intervention to support people experiencing mental health problems can produce significant cost savings and productivity improvements in the longer term, for the NHS, local authorities and others. For example, **health visitors identifying and treating post-natal depression improves productivity and leads to cost savings i**n the medium to short term and targeted parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested with savings to the NHS, education and criminal justice systems.[12] Nationally, it is considered that the ability to identify post-natal depression with screening tools would have a large impact. Warwick University have created the Parent-Infant Interaction Observation Scale (PIIOS) in screening parent-infant interaction at 2-7 months.

- Smoking during pregnancy has a range of impacts on both mother and child, which are also outlined in the mayoral healthy early years London programme. The diagram below demonstrates some of the impacts:

Importantly it has increased costs to the NHS, and our health and care system more widely – an economic report by the Public Health Research Consortium aimed to estimate the additional costs to the NHS during pregnancy and the year following birth, of a mother continuing to smoke during pregnancy. **The research estimates that the total cost of smoking during pregnancy for maternal outcomes for the NHS could be as much as £64 million,** whereas the total **cost of infant outcomes as a consequence of smoking during pregnancy to the NHS could be as high as £23.5 million**. This is NHS specific research, so importantly are conservative estimates given the wider costs to the health and care system. **The research finds that low cost smoking cessation programmes could have economic cost savings for the NHS.** Spending between £13.60 and £37 per pregnant smoker would yield positive cost savings for the NHS, plus further costs across our health and care system. [13]

[11]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf

[12] Kings Fund, Best Start in Life, https://www.kingsfund.org.uk/projects/improving-publics-health/best-start-life

[13] Public Health Research Consortium. 'Estimating the costs to the NHS of smoking in pregnancy for pregnant women and infants' http://phrc.lshtm.ac.uk/papers/PHRC_A3-06_Short_Report.pdf

- Obesity is a significant problem across BHR, and London. The cost of obesity nationally is substantial – at least £5.1 billion to the NHS and tens of billions to UK society every year. Evidence from Lambeth and Southwark estimate that the total cost of childhood obesity to Lambeth and Southwark's economy is £17 million due to direct costs of treating obesity and consequences of obesity and the indirect costs of obesity, through the loss of earnings due to sickness and premature mortality.[14] BHR has higher childhood obesity rates than Southwark and Lambeth, suggesting the economic cost of obesity would be higher. **25 studies with a total of 226,508 participants showed that breastfeeding was associated with a significantly reduced risk of obesity in children.** Therefore, looking at levels of breastfeeding in BHR, and interventions to include breastfeeding could have a future impact on our childhood obesity rates. [15]

- Addressing violence against women and girls is important, as evidence from the WHO demonstrates that violence against girls and women's preconception and during pregnancy, results in adverse physical, psychological consequences as well as increased risk for premature delivery and low-birth weight infants. In addition, Female Genital Mutilation (FGM) increases the risk of neonatal death by 15% to 55%**.** [16] With Domestic violence and abuse a big problem across BHR, and half of all reported cases of FGM (48% of newly recorded cases, and 48% of total attendances in the NHS) relate to the London region,[17] provision and support, and investigating how to prevent this from occurring in these areas could help to ensure the health of BHR children. FGM is an issue currently gaining national attention - on the 8th February, the British Parliament voted on an FGM proposal, called the Children Act 1989 (amendment – female genital mutilation bill) which intends to improve the 2003 law that prohibited the practice by allowing family courts to make interim care orders about children deemed at risk, simplifying the process. Although this bill was controversially blocked by MP Christopher Cope, there are expected to be further debates and discussions on FGM.[18]

  In addition, Barking and Dagenham have the highest rate of reported domestic abuse in London and have just launched a cross-partner Domestic Violence commission, which will look at the causes of the normalisation of domestic abuse in the borough and how to address the issues.

- The What Works Centre for Children's Social Care, including the Early Intervention Foundation, ensures that our children have the best start in life, requires looking across our health and care system and looking beyond care. The What Works Centre for Children's Social Care is a new initiative to foster evidence-informed practice in England led by Nesta and promoted by the Social Care Institute of Excellence (SCIE). As well as launching a new evidence store, as an innovation unit, they are looking for pilot sites to be involved to further help their work. They are currently calling for local authority partners to embark on a series of pilot studies to explore the use of predictive analytics in children's social care and specifically to test if it can help to reduce the escalation of cases. The centre hopes these pilots will help to answer key questions including: can

[14] https://www.gsttcharity.org.uk/what-we-do/our-programmes/childhood-obesity-0/why-childhood-obesity/cost-childhood-obesity
[15] https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-1267
[16] https://www.who.int/maternal_child_adolescent/documents/preconception_care_policy_brief.pdf
[17] https://digital.nhs.uk/news-and-events/news-archive/2017-news-archive/annual-statistical-publication-for-fgm-shows-5-391-newly-recorded-cases-during-2016-17
[18] https://inews.co.uk/news/politics/christopher-chope-fgm-bill-blocked-details-explained/

predictive analytics be useful in children's social care? If so, in what circumstances? and importantly, just because we use predictive analysis, should we? Participating local authorities will be expected to make case notes and outcome data available to the What Works Centre and the Office of the Children's Commissioner, and to participate in occasional workshops to help us understand the results of the analysis. This would provide the opportunity for BHR to be at the forefront of investigating stepping down social care.

The Early Intervention Foundation are looking to partner with four local authorities to participate in a 12-month intensive, applied programme to develop the local maternity and early years system in the light of the latest evidence. Barking and Dagenham council have been successful in progressing to the final stage of assessment, the process remains a competitive one with the council aspiring for partnership. Academy partnership could see transferable learning around how best to transform BHR systems to improve the outcomes for our children, young people and families.

2.4 Priority 1: Best Start in Life: Key areas for discussion

Given the evidence above, the Children and Young People's Board are asked to consider:

As there are wide-ranging impacts, are there key learnings from the Family Nurse Partnership that we could take into consideration in BHR? How different are our health visiting services within the Family Nurse Partnership?

N.B. Redbridge has a Family Nurse Partnership, hosted by NELFT, who are also the providers of the 0-19 Healthy Child Programme.

Level of development at the age of 5 is a key indicator of outcomes later in life and impacts educational attainment. As a Transformation Board, how can we work together to help improve this indicator?

Maternity and Health Visiting services are a universal offer for our population, how can we ensure that BHR work on MECC helps to identify those vulnerable residents to make a difference?

Is the Health Visiting Offer equitable across BHR and what are the potential consequences?

The first years of life have a substantial impact on health and physical outcomes for the rest of life as listed above. The Marmot Review highlights that health inequalities are widespread in this area. How can we work as an integrated care system to reduce health inequalities?

Are our smoking cessation services currently effective and accessible? Are they working to improve outcomes for mothers and children?

Should BHR local authorities express an interest in working with the What Works for Children's Social Care Centre? A commitment across all three local authorities could help to identify the journey across the health and care system

3.0 Priority 2: Adverse Childhood Experiences (ACEs)

3.1 Why is focusing on ACEs important?

A growing body of research identifies the harmful effects that ACEs occurring during childhood or adolescence (e.g. child maltreatment or exposure to domestic violence) have on health throughout life. Individuals who have ACEs tend to have more physical and mental health problems as adults than those who do not have ACEs and ultimately greater premature mortality[3]. Chronic toxic stress resulting from ACEs can impact on the neurological, immunological and hormonal development of children. Repercussions of such impacts include substantive increases in risk of adopting anti-social and health harming behaviours, accelerated development of chronic disease and premature death[4].

3.2 What are ACEs?

ACEs are stressful or traumatic events and include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical or emotional neglect
- Intimate partner violence or mother treated violently
- Substance Misuse within the household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

3.3 What is the impact of ACEs?

As the diagram below demonstrates, individuals who have 4 or more ACEs in childhood (compared to those with none) have a range of adverse health outcomes, these include:

- Unhealthy health behaviours and social outcomes – more than twice as likely to smoke and nearly 6 times as likely to be problem alcohol users.
- An increased risk of illnesses - twice as likely to develop conditions such as cancer and heart disease, and more likely to have poorer mental health problems.
- Increased utilisation, and consequently cost, to public services - those with ACEs are predictors of high-cost health users. Those who have 4 or more ACEs in childhood are more likely to be increased users of health services at three levels - GP level, A&E and hospitalisation across the life-course.

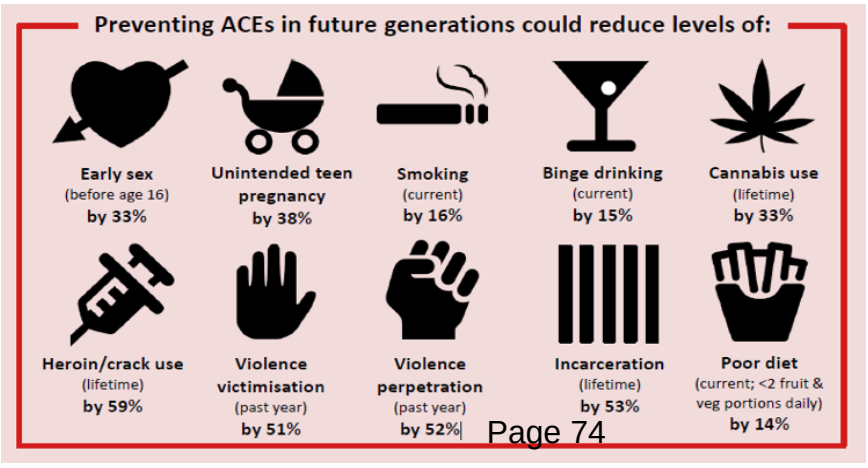
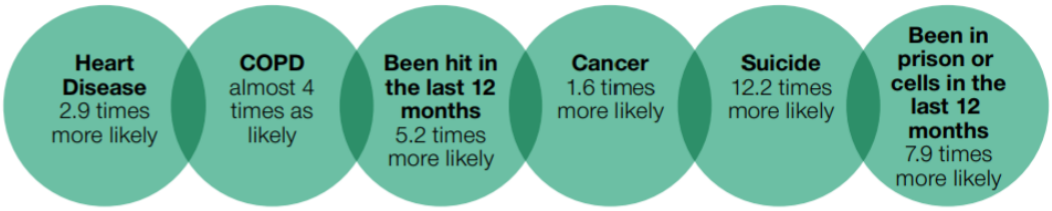


Figure: Preventing ACEs in future generations……[19]



3.4 How can we moderate ACEs?

If we can intervene before these problems become a crisis, we can help individuals while reducing the demand for our health, social care and wider local authority services.

The concept of **developing resilience in children** as a moderator of ACE harms is widely advocated. A range of factors may moderate the impact of ACEs on life course health, providing resilience to developmental harms and consequently, better outcomes despite a history of multiple ACEs. Although many definitions are available, resilience typically describes the ability to adapt successfully to disturbances that threaten development of a positive life course or the ability to resume one following periods of adversity[5]. Sources of resilience can include, but are not limited to, cultural engagement, community support, opportunity to control one's personal circumstances and access to a trusted adult throughout childhood who can provide sanctuary from the chronic stress of ACEs. A range of interventions aim to enhance resilience through supporting parents, strengthening links with other family members, peers and schools; developing team working, decision-making abilities and confidence; and enhancing academic, athletic and other individual strengths.

3.5 What the data says about ACEs

It is not currently possible to measure the levels of ACEs within our populations due to lack of screening, however the available data from our population suggests that there may be a high level of ACEs in the population. For instance:

- The Mayor's Office for Policing and Crime (MOPAC) data suggests that Havering had the highest reported rate of child sexual exploitation in London in 2015/16, with Barking and Dagenham the 3rd highest, and Redbridge the 13th highest London borough. This demonstrates that child sexual exploitation is an issue across BHR.
- Domestic abuse is a national problem, and fear of reporting causes lots of domestic abuse to go unreported. Data also demonstrates that Barking and Dagenham has the highest rates of reported domestic abuse in London, with Havering the 17th highest rate of reported domestic abuse offences and Redbridge has the 20th highest rate of reported domestic abuse.
- It is also worth noting that across BHR, there has been a recent spike in knife crime. From January 2017 to January 2019 the following data was reported across BHR for possession of an article with a blade or point:
-

[19] http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/61c1e930f9121fd080256f2a004937ed/00c40b58ce773d5e80257f3700390f65/$FILE/ACE%20Infograph%20FINAL%20(E).pdf

London Borough Barking and Dagenham	151 offences
London Borough Havering	141 offences
London Borough Redbridge	146 offences

Source: Metropolitan Police Crime Data Dashboard

National evidence and those who work within our Youth Offending Services report that those who are involved with serious violent crime across the board have experienced 4 or more ACEs in childhood.

Ensuring a focus on ACEs within BHR has huge potential for change. This could in turn both help improve outcomes and reduce demand for health services.

3.6 What is the best practice for mitigating the impacts of Adverse Childhood Experiences?

Mitigating some of the impact of ACE's can be done through existing services such as health visiting - our local health visiting services are good examples of local best practice of working with mothers and families directly to build resilience. In addition to this, there are both national and international examples of further work on ACEs.

Blackburn and Darwen Borough Council have adopted an ACE assessment that was developed and robustly tested in the United States. It provides an evidence-based assessment of the impact of childhood trauma such as emotional and sexual abuse and physical and emotional neglect. These studies led Blackburn and Darwen to develop the Routine Enquiry about Adversity in Childhood (REACh) screening tool to enable practitioners to identify adults with high ACE scores who have experienced multiple adverse experiences, which may lead to not only poor health and social outcomes but also to higher risks of exposing their own children to adverse experiences[10].

Liverpool John Moores University have published a report entitled: *Routine Enquiry about Adverse Childhood Experiences Implementation pack pilot evaluation (May 2018*). It states that in 2016 the Department of Health commissioned Lancashire Care NHS Foundation Trust to implement a pathfinder project to develop a standalone Implementation Pack to support services in developing, implementing and embedding REACh (highlighted above), and to pilot its use across 3 services in North West England (pilot sites)[11].

For those who have experienced ACES, trauma-informed care also provides the opportunity to mitigate the impact of trauma and helps survivors to rebuild a sense of control and empowerment. Trauma-informed care means that services take into consideration the impact of trauma of individuals and behaviours, so for instance services being designed with an awareness that trauma has wide-ranging impacts on individuals and can affect their behaviour and responses.

In addition to the serious violence summit that was held in Barking and Dagenham, CSP have commissioned community and voluntary organisations to deliver trauma informed positive diversionary activities to children and young people. This would support the links to the CSP, and professionals can refer to these programmes. This

increases the range of services available to young people that offer a trauma informed response. It is worth noting that Havering and Redbridge are also planning the next summits to keep the conversations going across the boroughs and partnership boards. Redbridge will be leading on the next summit in the summer of this year.

3.7 Priority 2: Adverse Childhood Experiences: Key areas for discussion

Given the evidence above, the Children and Young People's Transformation Board are asked to consider:

How we can increase awareness of ACEs within staff across our health and care system?

For instance, would partners on the Children and Young People's Transformation Board sign up to, offering training to all staff on ACEs and their impacts?

If so, there is a number of useful resources that could be used: the section above in this paper on ACEs could be used as a resource to staff across BHR; BHR public health staff also have a presentation on ACEs. There is also a range of useful resources online, including this video from Public Health Wales https://vimeo.com/189604325.

In addition, within local authorities and local Community Safety Partnerships there is ongoing work on ACEs that we can learn from within health and care. For instance, Barking and Dagenham Domestic Violence Commissioning have been working on bids for funds to train people across partners and opened this up to elements of health. The Barking and Dagenham Community Safety Partnership have also just secured funding for ACEs specific training which improves behaviours. The training provides knowledge on how this impacts the brain and the body after prolonged trauma from ACE's. In this light, there may be learnings and evaluations that we can benefit from across all three local authorities and Community Safety Partnerships.

Screening tool – Would it be possible to implement an ACE screening tool across BHR health and care systems? How would we use this screening tool to make sure that it was both safe and effective? What would the role of the screening tool be and what would the changes to services be?

Identifying those with ACEs provides the opportunity to offer them targeted interventions. How could we work with partners (including education) to implement and share an ACE screening tool?

How can we link ACEs into work being done in the borough on Making Every Contact Count (MECC)?

Work is already being done across BHR on MECC. Would this be an enabler to improving experiences of those with ACEs.
How can we ensure that the action taken by the Children and Young People's Transformation Board, and key health and care partners, are linked up to the Community Safety Partnerships' work on ACEs and referral pathways to trauma-informed care models?

The first tri-borough Serious Violence Summit for BHR took place in Dagenham on Wednesday 16th January with key partners across the three boroughs. Future tri-

borough summits are due to take place in Havering and Redbridge. Working with our local Community Safety Partnerships and through these forums could provide the opportunity to discuss a cross-organisation approach to ACEs.

4.0 Priority 3: Special Educational Needs and/or Disabilities (SEND)

4.1 Why is focusing on SEND important?

A number of recent studies have shown that a 'hidden majority' of adults identified in childhood as having a learning disability are not identified as such within health and social care services. The studies analysed data from the Understanding Society Survey which follows the lives of 40,000 UK households to provide valuable evidence about 21st century life. The survey collects information from more than 20,000 adults aged 16-49 years about many aspects of their lives, including their health and the wider social determinants.

Pervasive socio-economic inequalities are experienced by people with learning disabilities, who are less likely to be 'doing alright' financially or 'living comfortably', are less likely to be employed for 16 hours or more each week, live in an affluent neighbourhood, feel safe outside in the dark, have two or more close friends or go out socially. People with learning disabilities were also more likely to have experienced threatened or actual violence and being a victim of hate crime. The poorer health of people with learning disabilities can therefore consistently be accounted for by differences in social determinants.

Further evidence shows that there are a range of ways in which disability links to health and the wider determinants of health and links to poorer outcomes:

- Disabled people remain significantly less likely to be in employment than non-disabled people
- Disabled people are around 3 times less likely to hold a degree level qualification
- Around 19.2% of working age disabled people do not hold any formal qualification
- National employment rate for disabled people is 45%, equating to a 30% gap between employment rate for disabled and non-disabled people. [20]

Working across an integrated health and care system provides the opportunity to improve these poor outcomes.

4.2 Learning disabilities and autism

A section of the newly published NHS Long Term plan focuses on learning disability and autism. It also makes a commitment for the whole NHS to improve its understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing. Sustainability and Transformation Partnerships (STPs) and integrated care systems (ICS) will be expected to make sure all local healthcare providers are making reasonable adjustments to support people with a learning disability or autism.

[20] Public Health Matters (2016) 'Health inequalities and the hidden majority of adults with learning disabilities' - https://publichealthmatters.blog.gov.uk/2016/10/04/health-inequalities-and-the-hidden-majority-of-adults-with-learning-disabilities/

The three local authorities in BHR have different populations, and the evidence below provides some brief information about SEND:

Information from Public Health England shows that the levels of children with learning disabilities, known to schools, varies across the three boroughs:[21]

London average	23 per 1000
England average	33.9 per 1000
Barking and Dagenham average	37.7 per 1000
Havering average	31.1 per 1000
Redbridge average	26.2 per 1000

This highlights that all three boroughs have higher rates of children with learning disabilities known to schools than London averages. **Barking and Dagenham is the only local authority within BHR to have higher levels of children with learning disabilities known to schools higher than the England average.**

The Department of Education also publish annual data on the percentage of pupils with statements or EHC plans:

Barking and Dagenham – 2.5%
Havering – 2.5%
Redbridge – 2.5%[22]

Both the London and outer London average is 3% of pupils, so as well as having higher than average rates of children with learning disabilities known to schools, the percentage of pupils with statements or EHC plans is lower than the London average.

4.3 What is the best practice around SEND?

Involving disabled people, their families and organisations' groups in decision making – Integrated Personal Commissioning (IPC) looks to involve patients in their own care and is based on 5 key shifts in people's experience of care as shown in the diagram below:[23]

[21] Public Health England, Fingertips data on learning disabilities - https://fingertips.phe.org.uk/profile/learning-disabilities
[22] https://www.gov.uk/government/statistics/statements-of-sen-and-ehc-plans-england-2018
[23] https://www.england.nhs.uk/ipc/what-is-integrated-personal-commissioning-ipc/

NICE guidelines recommend that those with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral, and that those who have a diagnostic assessment for autism are also assessed for co-existing physical health conditions and mental health problems. People with autism should have a personalised plan.[24]

The programme is a partnership with the LGA and NHS England and has been working to integrate health, care and education services around people rather than organisations. There are strong indications that when individuals take part in designing their care, they have a better experience with improved outcomes and more efficient use of limited resources. IPC sites across the country are taking different approaches, with the programme operating across the whole of England by 2020. Although none of the current Integrated Personal Commissioning areas are within BHR, Tower Hamlets and Islington are both IPC areas. SEND is one of four priority areas that Tower Hamlets are focusing on. The focus in Tower Hamlets has been working with these cohorts to find out what they think of current services, the integration between health and social care, and improving care partners.

4.4 Best Practice within BHR

Working with individuals to design their care has started in BHR. Barking and Dagenham has a strong track record of supporting children and young people with SEND inclusively in local mainstream education settings wherever possible and appropriate to their needs, building on the key aims of the borough's 'Inclusive Framework Strategy for Children and Young People with SEND'. These aims include to enable the best possible outcomes for all children and young people with SEND; and the provision of local education and training with high quality support, mainstream where appropriate.

As part of the work for a new upcoming SEND and Inclusion Strategy, a consultation was carried out and has identified some key areas supported by parents of those with SEND:

- Develop more local specialist provision in BHR to meet the needs of our children and young people
- Promote independence for children, young people and their families
- Prepare young people with SEND for adulthood which includes appropriate training, employment and leisure opportunities
- Develop the capacity of therapies (especially Speech and Language) to meet demand
- Provide better support for children and young people with health issues (including mental health)
- Ensure good progress and outcomes for children and young people with SEND in their educational setting from their relevant starting points
- Keep children, young people and their families involved in the planning and designing of provision.

A consultation took place with headteachers, SENCO's, school governors, local authority staff, social care colleagues, health colleagues, nurseries, pre-schools,

[24] https://www.nice.org.uk/guidance/qs51

educational psychologists, commissioners and young people, with a positive response.[25]

4.5 National best practice examples

SEND is a wide-ranging area, but there are a number of national examples in a variety of areas that can help to guide discussions about how we can transform the BHR system.

In terms of building resilience for those children and young people with mental health problems, there are examples of good practice. Devon has a programme called Early Help 4 Mental Health. The prevention and early intervention programme focus is on culture change. The programme is carried out in schools and the aim is to build mentally healthy behaviours and resilience. The programme was initiated after Devon received an inadequate judgement by Ofsted. The targeted prevention and interventions to support the mental health of children and young people between 11-18 years was aimed at young people who are vulnerable and whose mental health is beginning to deteriorate. The programme has demonstrated real value and improvements in children's emotional wellbeing. A rigorous performance management and reporting system was created which provides detailed data relating to outcome measures being used by providers, set into contracting arrangement. Devon captures this information through:

- Measuring the impact of the direct support offer; by using YP-Core tool which measures emotional wellbeing following individual counselling sessions
- Introducing a goal-based outcome measure where young people create their own goal and then score to what extent they feel they are achieving this intervention.

In a report entitled: Developing and sustaining an effective local SEND system published by the Local Government Association (2018) the following four areas of good practice for local SEND systems are identified: **taking a pro-active, evidence-informed, strategic approach to shaping local support, services and provision** emphasises the importance of gathering and triangulating data, intelligence and feedback, and using this to inform discussions with partners and stakeholders, as well as individual young people and families, about the shape of local support and services.

Developing co-productive relationships shows that local SEND systems should include many different partners, organisations and sets of interests and responsibilities. Getting it right in supporting young people with SEND effectively is not something that any one organisation or agency, support group or provider can achieve on their own. Meaningful partnerships, based on a shared appreciating of the context and challenges, and with solutions developed through co-productive working are crucial to effective operation of local SEND systems.

Effective processes and routines identify the need to consider the multi-faceted nature of local SEND systems and therefore that consistent practice in identifying needs, putting in place support, reviewing support plans, planning for young people's progression which is crucial in enabling young people with SEND to make the most of their education and childhood and pursue their aspirations as they move into adulthood. This is not about having a ''one-size-fits-all" approach, it is about

[25] Internal work on SEND from Education Team, led by Joy Barter

established mechanisms that enable professionals to be pro-active, creative and person-centred when working with young people with SEND and their families.

Focusing on long-term outcomes consists of the need for a joined-up, coherent approach to preparing young people for adulthood from their earliest years. Too often, it was highlighted within this report that what goes under the banner of ''transition planning'' is simply preparing the young person for their next placement, rather than something focused on the young person's long-term goals. Within local SEND systems, a focus on specific outcomes for young people needs to be at the heart of system-level commissioning decisions as well as individual support for young people and their families.

Although not an example of best practice as such, the 0-25 SEND code of practice: a guide for health professionals, provides advice for clinical commissioning groups, health professionals and local authorities (February 2016). This was published by the Department for Education and the Department of Health shows that for too long, health was the missing partner in the SEND system. However, the SEND reforms introduced by the Children and Families Act 2014 aimed to change that with a focus on two key themes: greater co-operation between education, health and social care and a greater focus on the outcomes which will make a real difference to how a child or young person lives their life.

Echoing the ideas for integrated personal commissioning, the report shows that partners must engage children and young people with SEND and children's parents in commissioning decisions. Local authorities, CCGs and NHS England should develop effective ways of harnessing views of their local communities so that commissioning decisions on services for those with SEND are shaped by users' experiences, ambitions and expectations. To do this, local authorities, CCGs and health professionals should engage with local Healthwatch organisations, patient representative groups, Parent Carer Forums, groups representing young people with SEND or disabilities and other local voluntary organisations and community groups.

4.6 Priority 3: SEND: Key areas for discussion

Given the above, the Children and Young People's Transformation Board are asked to consider:

What co-production of services, and involvement in service planning and care with SEND service users currently exists across BHR? How could this be strengthened? The new GMS contract includes provision for physiotherapists that needs to be considered in this too.

For our CAMHS service, what are the quick wins to create a service that improves outcomes for residents and saves our system money?

Speech and language is a key priority area for SEND and has substantial impacts for the rest of life. What are the barriers to speech and language services? within BHR? How can partnership working help to improve this?

Service provision in relation to SEND varies across the three local authority boundaries – residents' experience will be dependent on the borough in which they live. With this in mind, are there opportunities for joint commissioning in these areas?

5.0 Points for discussion

To summarise the points for discussion within each priority theme, The Children and Young People's Transformation Board are recommended to discuss:

How can we increase awareness of ACEs within staff across our health and care system?

Screening tool – Would it be possible to implement an ACE screening tool across the BHR health and care systems?

How can we link ACEs into work being done in the borough on MECC?

How can we ensure that the action taken by the Children and Young People's Transformation Board, and key health and care partners, are linked up to the Community Safety Partnerships' work on ACEs?

What co-production of services, and involvement in service planning and care with SEND service users currently exists across BHR? How could this be strengthened?

For our CAMHS service, what are the quick wins to create a service that improves outcomes for residents and saves our system money?

5.1 General points for discussion

Across the three priorities: what are the next steps and 'quick wins' in these above areas?

Should BHR express an interest in working with the What Works in Children's Social Care?

What opportunities are there for Joint Commissioning in these three areas across the boroughs?

Given the increase in the number of pupils with special needs in mainstream schools, should the board consider commissioning more Specialist School Nurses for mainstream schools?

6.0 Integration

6.1 As a partnership document across BHR, the Children and Young People's Transformation Board – Best Practice Evidence Review outlines the importance of focusing on the three priority areas to support the key health outcomes for children and young people.

7.0 Financial Implications

Implications completed by Murad Khan, Group Finance Manager:

7.1 This report is mainly for information and sets out to provide the Health and Wellbeing Board the evidence base required for best practice in three key priority areas of Best Start in Life, Adverse Childhood Experiences (ACEs) and Special Educational Needs and/or Disabilities (SEND). As such, there are no financial implications arising directly from the report.

8.0 Legal Implications

Implications completed by Dr. Paul Feild Senior Governance Lawyer

8.1 This is an information and discussion item. 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 established its function to ensure that the providers of health and social care services work in their delivery in an integrated manner. The report from Barking Havering Redbridge (BHR) Children's and Young People's Transformation Board highlights three priority areas for young people being Best Start in Life, Adverse Childhood Experiences (ACEs) and Special Educational Needs and/or Disabilities (SEND). These strategic areas of focus were chosen by the Joint Commissioning Board because of their potential to significantly improve health outcomes for children and young people living in BHR. For each of these priority areas, the purpose of this report is to outline why this is an important area of focus for BHR, by including some headline BHR data and national and international best practice for interventions in these areas.

Public Background Papers Used in the Preparation of the Report:

None.

List of Appendices

None.

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	**BHR Older People and Frailty Transformation Board – Best Practice Evidence Review**

Report of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Jill Williams Shared Care Officer, London Borough of Barking and Dagenham Tom Stansfeld Health Improvement Advanced Practitioner – Policy Officer, London Borough of Barking and Dagenham	**Contact Details:** Tel: 020 8227 2857 E-mail: jill.willams@lbbd.gov.uk Tel: 020 8227 5120 E-mail: Thomas. stansfeld@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary:
The report was written at the request of the BHR Older people and Frailty Transformation Board to provide evidence on best practice. The paper is structured around the following four priorities:

1. **Healthy Well** – Helping residents to age well, reducing social inequalities and improve primary prevention and community integration/socialisation.
2. **Integrated Models of Care** – Create new models of care that are co-designed in the local area and that support older people to maintain or reduce their risk of deterioration.
3. **High Intensity Interventions** – Create a system that responds to urgent needs within usual places of residence, and design interventions that prevent increasing dependence.
4. **End of Life** – Supporting a good end of life experience for the older person, their family and carers, particularly supporting elder residents to die in their preferred place, thereby reducing the number of deaths in hospital.

The aim of the paper is to stimulate ideas and discussion on how best BHR can achieve an integrated system of care capable of delivering effective support in a timely way and in the right place. Developing a place-based approach will involve cultural change across BHR with health and social care together with the voluntary sector delivering the right mix of services, including prevention, to individuals and families. This paper was presented to the Older Peoples Transformation Board 11 March 2019.

Recommendation(s)
The Health and Wellbeing Board is recommended:

1. To note the report
2. To discuss how local partners should be working as an integrated care system in this area to improve outcomes for residents.

BHR Older People & Frailty Transformation - Best Practice Evidence Review

1 Introduction

1.1. This paper aims to generate discussion around initiatives and best practice in relation to older people in order to realise a place-based system that improves the health and care for the population of BHR.

1.2. There is a need to change the way health and social care is delivered across BHR in way that reduces demand on specialist services and brings care closer to home whilst allowing people more control over their health and wellbeing throughout their life course.

1.3. Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England. Their development represents a fundamental and far-reaching change in how Health and Social Care works across different services and with external partners. ICSs' development has been locally led and there is no national blueprint.

1.4. In transformation terms best practice needs to be considered not within the current system but the future system. The Integrated Care Partnership Board in order to bring about improvements in health and care, and to place services on a sustainable footing will need to be clear on the distinction between "the whole system" and "place". This will involve a set of principles to enable us to transform to new models of care focused on developing Locality/Primary Care Network - based health and social care relationships within council boundaries.

1.5. This involves partners moving away from a 'fortress mentality' whereby health and social care organisations each act to secure their individual interests and future. Instead they must establish place-based 'systems of care' in which they collaborate across the BHR integrated care system to address challenges and improve the health of the residents. This will only happen if we tailor new models of care to local needs and linking to local assets.

1.6. Integrated working across health and social care and the voluntary sector is required to deliver the right mix of services to the individual, their family and carers at the right time and in the right place.[1]

[1] Making our health and social care systems fit for an aging population (2014)

1.7. An integrated care service that delivers improved outcomes for people is challenging to get right. This paper has identified seven key themes which outline best practice in the development of integrated care. These key themes have been adopted from The National Palliative Care Council's six ambitions[2] alongside the provision of choice.

1. **Each person is seen as an individual**
2. **Each person gets fair access to care**
3. **Maximising comfort and well-being**
4. **Care is coordinated**
5. **All staff are prepared to care**
6. **Each community is prepared to care**
7. **Choice** (*this report has been added choice to the principles to underlie a strengths based approach[3], coproduction, including personalised commission and personal health budgets)*

1.8. These seven themes enable a model which focusses on care being delivered in the community and at the preferred place of residence with the hospital being utilised in a step up scenario.

1.9. Social prescribing and the ongoing frailty pilots are examples of where this new method of working is being implemented already incorporating both statutory services and the voluntary sector. This approach should be extended across the system as a whole.

1.10. This means that no one service can deliver or that old organisational cultures can remain the same and involves unified purpose and sharing risk and costs.

1.11. For reference the Older People and Frailty Transformation Programme Board has identified 4 key work streams to help frame system-change and will be discussed separately in the priority areas below:

- **Healthy Well** – Helping residents to age well, reducing social inequalities and improve primary prevention and community integration/socialisation.
- **Integrated Models of Care** – Create new models of care that are co-designed in the local area and that support older people to maintain or reduce their risk of deterioration.
- **High Intensity Interventions** – Create a system that responds to urgent needs within usual places of residence, and design interventions that prevent increasing dependence.
- **End of Life** – Supporting a good end of life experience for the older person, their family and carers, particularly supporting elder residents to die in their preferred place, thereby reducing the number of deaths in hospital.

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[2] http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf
[3] Care Act 2014

1.12. This paper will consider the impact of prevention and tackling issues beyond traditional healthcare in improving the quality of their lives and reducing demand on our health and care system in relation to the key work streams above.

2. Demographics

2.1. Older People's health and social care has been identified as an area where cost savings can be made to contribute towards the BHR recovery plan. Specifically, a reduction in non-elective admissions and increasing the number of patients who die in their preferred place of death.

2.2. It is estimated that by reducing the non-elective admissions by 12 per day across BHR and decreasing predictable deaths in an acute setting from 45% to 35% would provide £15.1 million net over two years. This paper will highlight interventions that could contribute towards these targets.

2.3. Opportunities for reducing non-elective admissions are not necessarily uniform across the three boroughs. For example, Havering and Redbridge have similar rates of unplanned hospitalisations for chronic ambulatory care sensitive conditions and urgent care sensitive conditions to England for 65–74, 75–79, 80–84 and 85+ year olds (2016/17 data).[4] In contrast, Barking and Dagenham has significantly lower rates in 75–79 and 85+ year olds compared with England, but significantly higher rates in 80–84 year olds.

2.4. Comparison with similar areas (defined separately for each CCG) suggests that Barking and Dagenham has significantly more non-elective hospitalisations for these conditions in older people. However, the higher populations in Havering and Redbridge suggest that modest improvements in those areas has the potential to see big returns.

2.5. However, there are similarities for emergency admissions due to falls in people aged 65+ across the three boroughs; Barking and Dagenham, Havering and Redbridge all have lower age-standardised rates than London or England, with the lowest, second lowest and fourth lowest rates respectively in London (12th, 15th and 24th lowest in England).[5] Nonetheless, this accounted for almost 2,000 admissions across BHR in 2017/18 and hence is not a reason for complacency. Forty-five percent of these admissions were in Havering, 36% in Redbridge and 19% in Barking and Dagenham in line with the population split within the boroughs.

2.6. Strategies looking at place of death should also consider the variation across BHR. More than half of deaths (54%) in people aged 65+ occurred in hospital across BHR in 2016.[6] This is significantly higher than England (47%) and especially high in Redbridge (60%) compared with Barking and Dagenham (53%) and Havering (51%).

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[4] NHS RightCare, Equality and Health Inequality NHS RightCare Packs, December 2018 [https://www.england.nhs.uk/rightcare/products/ccg-data-packs/equality-and-health-inequality-nhs-rightcare-packs/].
[5] Public Health England, Public Health Outcomes Framework.
[6] Public Health England derived from data in End of Life Care Profiles.

3. Transformation Workstream - Healthy Well

2.1. Healthy Well incorporates healthy ageing. The World Health Organisation (WHO) defines healthy ageing as *"the process of developing and maintaining the functional ability that enables wellbeing in older age".*[7] Functional ability enables people to live meaningful lives. It includes a person's ability to meet their basic need and remain socially connected. An individual's functional ability is influenced by the presence of disease and age-related changes and their environment such as the built environment, the ability to stay warm in winter and to participate and contribute to society.

2.2. WHO reiterates that older people are not a homogenous grouping, and this awareness should be reflected in local plans. An 80 year old may have the functional ability of a person many years their junior. Alternatively, someone of the same age may require intensive care and support. How well a person lives with disease is another factor along with the cumulative effect of advantage or disadvantage and its impact on the individual's experience of aging, their resilience and ability to adapt to new circumstances.

2.3. Social connection appears to offer a protective effect against ill health.[8] However, as a group older people are more vulnerable to social isolation.[9] Engaging people with others can have a specific effects. For example, group exercise intervention is able to help reduce the onset or progression of frailty.

2.4. The Mental Health Foundation conducted a review into the impact of participatory arts on the health and wellbeing of older adults, they found there was increased confidence and self-esteem as well as adoption of new positive aspects of their identity. Where adults had dementia there was improved cognitive function memory and enjoyment of life[10].

2.5. Within the NHS Long Term Plan there is a commitment to increase the provision of social prescribing and with that provide Primary Care Networks with funding for social prescribing link workers. This funding is available from 2019/2020 for 1 link worker per Primary Care Network, which within BHR consists of populations of circa 80,000 residents.

2.6. Social prescribing is particularly relevant for elderly populations who might be high frequency users of primary care services. Social Prescribing can help the socially isolated and frail elderly residents' access community-based support, this results in reduced demand on the traditional care system. The utilisation of community assets

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[7] What is healthy aging? Accessed at https://www.who.int/ageing/healthy-ageing/en/ on 05/02/2019
[8] Social Connectedness and Health Amongst Older Adults 2005 Malta, S. Accessed on 14/02/2019 at https://www.researchgate.net/publication/268416064_Social_Connectedness_and_Health_Amongst_Older_Adults
[9] ibid
[10] https://www.mentalhealth.org.uk/sites/default/files/evidence-review-participatory-arts.pdf

in social prescribing increases the resilience of the community. Reducing social isolation can improve mental health and improve outcomes in the frail.

2.7. Currently there are social prescribing programmes running in Redbridge and Barking and Dagenham from which a BHR wide model could be developed.

BHR Frailty Pilots

2.8. The Place-Based Care Frailty Pilot in BHR is based on concepts from the Dartmouth Institute, and offers the opportunity to test a new care pathway which uses care navigators and community resources to both improve patient outcomes and reduce the demand for specialist health services. The idea is to improve the integration between health and care professionals with care navigators, or link workers, employed to help frail residents to better navigate the health and care system and stop re-admissions due to falls. There are two pilots taking place in GP surgeries in BHR – one at Thames View Health Centre due to its proximity to Barking Riverside, a test-bed for health and care innovation, and the other at Wood Lane Surgery in Havering. The BHR Frailty Pilots are exploring how clinical care systems can cross over with community based organisations.

2.9. Conversely, older people continue to play an important role in local volunteering activity. They benefit the community while enjoying the social participation and sense of purpose volunteering brings.[11] It is important to recognise that older people still have a contribution to make and that they are not simply passive recipients of care. Involving older people in the delivery of social prescribing or community initiatives can help reduce demand on care and grow more resilient communities.

2.10. Greater use of digital technology can support better self-care and healthy living. The Health Innovation Network South London undertakes a range of clinical and innovation themes including healthy aging. For example, supporting people to live well with long term conditions is part of healthy aging. Here digital solutions can produce significant improvements. ESCAPE[12] is an exercise programme app specifically designed for people who have chronic joint pain due to osteoarthritis to self-manage their condition.

3.1. As digital technology transforms the way health and social care is delivered Age UK cautions that older people are not left behind.[13] Many Public Services are now accessed online and in order that older people are not disadvantaged Age UK recommends three complementary approaches:

- greater support for digital inclusion
- user friendly technology and design

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[11] Effects of volunteering on the Well-Being of Older Adults Marrow-Howell, N. Hinterlong,J. Rozario, A.P. and Fengyan, T. (2003) accessed on 08/02/19 at https://academic.oup.com/psychsocgerontology/article/58/3/S137/583366

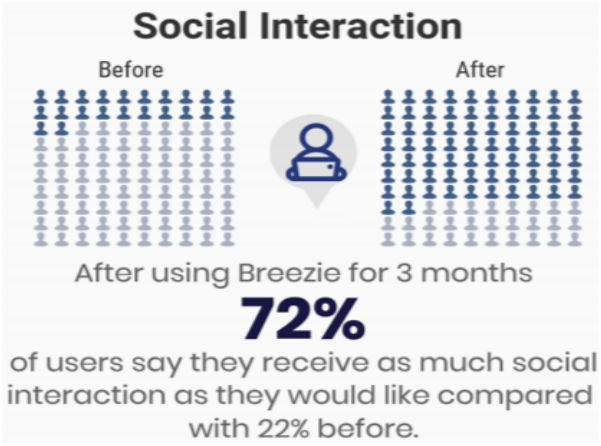
[12] https://healthinnovationnetwork.com/about/what-we-do/ accessed on 05/01/2019

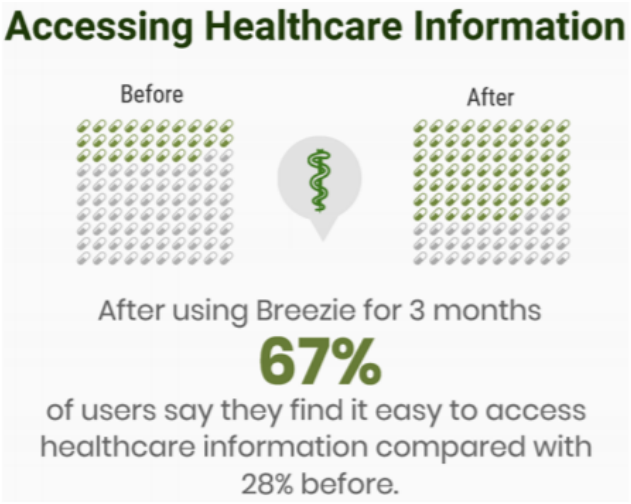
[13] Later Life in a Digital World December 2015 Age UK

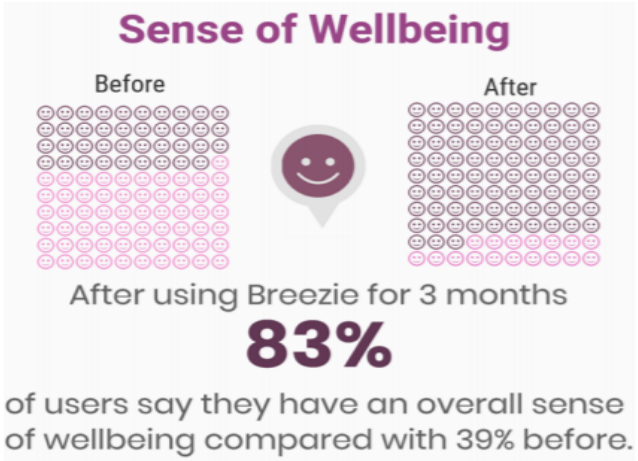
- alternative access for people who are not online

Breezie scheme

3.2. The “Breezie” scheme in Barking and Dagenham provides isolated older people with user-friendly tablets enabling internet access. This can help to alleviate social isolation and improve digital skills leading to a sense of greater connection.[14]







Inequalities

3.13. The Marmot Review[15] outlines outcomes which improve health and tackle the wider determinants of health across the population. The review highlights outcomes across the wider determinants of health such as education, employment, living standards, healthy places and prevention. Work on these areas of wider determinants are key in helping the older residents to age well. Prevention will play a key role in achieving success in healthy ageing and this will require cross organisational working.

3.14. Older people are particularly vulnerable to colder periods and cold temperatures can increase the risk of strokes and other circularity problems. Fuel poverty is also related to increased hospital admittance. Cold homes are also associated with excess winter

[14] https://modgov.lbbd.gov.uk/internet/documents/s128088/Breezie%20Report.pdf
[15] Fair Society Healthy Lives: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

deaths.[16] The transformation board should understand the importance of wider determinants on older people's health in efforts to reduce demand and build resilient communities.

3.15. Barking and Dagenham Council has created its own white label[17] energy supplier with the aim of reducing fuel bills. The agreement is with Robin Hood Energy based in Nottingham and the resulting not-for-profit Beam Energy offers pay as you go rates which is estimated to make an average saving of £91 for customers compared with fixed price tariffs. Beam Energy is available to customers in Greater London, including Havering and Redbridge, and East Anglia. Energy supply is 100% from green energy sources.

3.16. Other interventions that help tackle the wider determinants of health as outline in the Marmot review such as education, employment, living standards and the places we live are in important. Interventions such as further education for adults and the creation of liveable neighbourhoods can help keep elder residents well for longer and reduce demands on services.

3.17. Utilising the new funding from within the NHS Long Term Plan to increase access to these sorts of interventions could prove positive in reducing demand on the are system while improving outcomes.

4. Transformation Workstream - Integrated Models of Care (IMC)

4.1. Integrated Care systems are a way of joining up care around the needs of the population[18] in the context of a multi-disciplinary/agency framework. Co-ordinating cross sector work will be integral to making this system work, the BHR frailty pilots are an early example of where this is being embedded across the footprint.

4.2. Older populations will require more specialist services than those from the normal population. This is where a truly integrated care system can result in improved outcomes, whether this is in aiding timely access, discharge, hospital prevention or end of life care.

4.3. A Kings Fund report[19] makes the critical point that any system of integrated care *"… requires us to consider each component of care, since many people use multiple services, and the quality, capacity and responsiveness of any one component will affect others."*[20] Unfortunately, the reality is that nationally for many service users, their families and carers, the experience is one of trying to navigate a confusing, fragmented system.

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[16] Public Health England, Local Action on Health Inequalities: Fuel Poverty and Cold Home Related Problems
[17] A white label means that an organisation which does not hold a energy supply licence partners with a licensed partner supply – in this case Robin Hood Energy.
[18] A Year of Integrated care systems p,12
[19]Making our health and social care systems fit for an aging population (2014)
[20] Ibid p. iv

4.4. A review from the Care Quality Commission[21] (CQC) found familiar issues nationally:

- Poor follow-up ***"I have had lots of falls and fractures and no follow-up...I was weak and there was no plan in place to help this."***
- Service users having to give the same information over and over again to different professionals ***"Every doctor or other person who came to see me asked the same questions."***
- Poor communication between services and service users, families and carers ***"I didn't even know he was (coming) home so I hadn't brought his clothes for him to go home in."***
- Poor communication between professionals ***"Professionals should sit around a table to discuss a patient's care plan…a key document that is available to everyone. This is about health talking to social care but also about health talking to health."***

4.5. The CQC found that where poor integration of health and social care existed leaders had not created a culture in which organisations could work across traditional boundaries to deliver end-to-end person-centred care. Leadership from the transformation boards on working across these boundaries is vital for the success of a truly integrated programme.

4.6. There are numerous case studies where health and social care integration has been successful and resulted in improved outcomes further upstream in the care journey. Improving how technology is used can yield greater results with integration too. In the BHR system the effective partnership between the NHS and local authorities is also key as much of the upstream prevention work lies in the gift of local authorities.

4.7. Shared records provide the framework for end to end holistic care planning. Hammersmith and Fulham CCG have focused on improving communication between general practices and services in the community including introducing information sharing agreements. A significant investment in IT means that GPs share online medical records with hospitals and community groups.

4.8. In Camden, Age UK run the Care Navigation Service to help people access voluntary and community services to better help them to self-manage their conditions. The service is for people aged 60 plus who are either frail or identified as being at high risk of frailty. The team consists of six care navigators who provide case management, multi-disciplinary team meetings and complex referrals.

4.9. In Hammersmith and Fulham, the Imperial College NHS Trust runs the Community Independence Service (CIS). The CIS includes GPs, a social worker, hospital consultant, community matron, a health and social care coordinator. It aims to provide a single point of referral for older people and a rapid response team. Not only does CIS reduce hospital admissions but it also supports people recovering from a hospital stay helping them to regain independence in their own homes.

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[21] Building Bridges, breaking Barriers (2016)The Care Quality Commission accessed at https://www.cqc.org.uk/sites/default/files/20160712b_buildingbridges_report.pdf on28/01/2019

4.10. The Islington integrated Community Aging Team project (ICAT) provides community-based care for care homes, alongside GPs and other community services. This was put in place due to significant duplication and confusion in the provision of care. The acute trust provides geriatrician time to provide sessions in the community which provides continuity of care and allows for better communication upon discharge of patients from acute services back to care homes. A GPwSI and pharmacists also work in the system which provides a blend of clinical experience and prescribing support for care home staff. Since inputting this service there have been a reduction of 26% in transfers to local acute centres from care homes and this has reduced bed days required from care homes by 18%.

4.11. A North Wiltshire case study demonstrates how the creation of joint care plans when vulnerable or frail patients are well can contribute to a decrease in bed days, an increase in patient satisfaction and early discussions about end of life preferences. This is a GP led intervention where a plan is created between primary care and the patient during an extended appointment. Community teams and geriatricians are involved in the development of plans. The idea is that the patient has the opportunity to outline their view of their care should their health deteriorate and also for clinicians to outline any known issues with medications etc. This can help to reduce unnecessary or unwanted investigations and admissions to care homes.

4.12. The NHS Long Term Plan 2019 observes that people, especially those living with frailty, need support to remain as healthy and independent for as long as possible. The Comprehensive Geriatric Assessment toolkit for GPs and other professionals working in primary care developed by the British Geriatric Society explains the assessment and how it links in with social service involvement.

4.13. Comprehensive Geriatric Assessment is a multi-dimensional, multi-disciplinary diagnostic and therapeutic process conducted to determine the medical, mental, and functional problems of older people with frailty so that a co-ordinated and integrated plan for treatment and follow-up can be developed. Evidence shows that where a CGA has been completed there is an increased likelihood that patients will be alive in their own homes and are less likely to have been admitted to a nursing home after a year. CGAs are conducted on admission to hospital and are associated with a slightly increased cost to the health service.

5. Transformation Workstream - High Intensity Interventions

5.1. High Intensity Interventions are designed to be delivered to prevent a crisis or an escalation in the support required and support a return to normal for the older person. Within this the transformation board outlines a priority to keep people in their normal place of residence and reduce the need for hospitalisation. Should hospitalisation be required then interventions should be designed to support hospital discharge to a place of resident that optimises independence.

5.2. This is an important area of work for the older people's transformation board as hospitalisation is related to worse outcomes and increased costs to the health and

social care system. One of the key targets in the BHR recovery plan is reduce the number of non-elective admissions by twelve each day, which high intensity interventions have the potential to deliver. Obviously, where there is clinical need for admission or specialist care that this is still provided in a safe and timely fashion.

Hospital at Home

5.3. The Hospital at Home initiative that has been trialled in Scotland is designed to support those with significant health issues remain in their own home. GPs refer into the team and the patient's care is transferred through to the geriatrician, strong communication remains in place with the GP. A multi-disciplinary team (MDT), with advanced nurse practitioners, occupational therapists and physiotherapists, is based in the community and can deliver care at the place of residence including intravenous and subcutaneous medication. Importantly they have the same access to investigation as traditional inpatients.

5.4. There is also a community psychiatric nurse attached to the team and the old age psychiatry service office is located next door to the hospital at home team's office. This close geographical location, as well as a truly integrated community-based MDT means that care packages for those who need them can still be provided at home, which is a huge benefit of integrating health and social care. Only 20% of patients in the programme are admitted to hospital for acute care and many of these return to the community the next day.

Holistic Care – South Sefton

5.5. Local GPs in South Sefton a scheme to facilitate coordained care across organisational boundaries to fill a gap in community urgent care. A community geriatrician is employed to provide clinical support to the programme. Three main programmes support a strong relationship between the geriatrician, nurses and GPs.

1) Virtual Ward – and MDT of community matrons, district nurses, therapists, social workers, health and wellbeing trainers and mental health liaison officers meet virtually to discuss cases as if on a ward round. This allows primary care staff to have access to specialist advice and for strong integration. The community matron and GPs identify patients for the virtual ward and the health and wellbeing trainers ensure strong links with the community.
2) Urgent Care Team – The aim of this team is to avoid admissions for sub-acute patients. The team works out of a walk-in centre and GPs can refer older frail patients who would otherwise have been sent to hospital. A&E staff are also able to refer to the service.
3) Care Home Innovation Programme – Community Matrons and GPs work with allocated care homes to ensure that care plans are in place for patients. The GPs and Matrons have direct access to the community geriatrician for advice and case reviews. Care homes have installed secure NHS video conferencing software which allows for care home staff to have a direct link to the community matron and community geriatrician during officer house and a 24/7 link to a senior nurse.

5.6. These three programmes have seen improvement in care outcomes and a 23% reduction in ambulance conveyances. Only 10% of cases seen by the urgent care team have resulted in admissions and crucially patient satisfaction is reported at over 95%.

Extensive Care

5.7. With a move to place-based care across the BHR footprint the opportunities for across sector working allow for improvements in outcomes, smarter use of the workforce and an increase in efficiencies.

5.8. On the Fylde Coast an NHS vanguard site aims to support proactive and coordinated care in order to reduce the need for unplanned hospital admissions. The programme provides a single point of access to support proactive care. The team is led by a consultant geriatrician, but the aim of the project is to widen the skill set of allied health care professionals and support patients to self-manage in the community. Patients are referred into the service, which is run through local hubs, and then a multidisciplinary assessment is carried out with the patient's care transferred from the GP to the extensive care team. The first year of running has seen positive results within the service population.

- 19% reduction in A&E attendance
- 22% reduction in non-elective admissions
- 13% reductions in new outpatient appointments
- 18% reduction in follow-up outpatient appointments

6. Transformation Workstream - End of Life

6.1. The key aims for the End of Life work stream are to support good end of life experience for older people, their families and carers, and to support more people to die in their preferred place of care, and reducing end of life deaths in hospital.

6.2. Cross sector collaboration and working is essential to the delivery of end of life care. This includes working with health, social care and the voluntary sector, especially hospice care.

6.3. Within this section are evidence of best practice which could create part of the Barking, Havering and Redbridge Social Prescribing Offer especially for older residents.

NICE Guidelines on End of Life

6.4. NICE Guidelines state that this includes any care that is delivered to someone who may die within 12 months. Within the NICE guidelines there are 16 statements that

relate to the provision of end of life care. These statements include the timely identification of those who are approaching end of life, proper and timely communication with them and their families, that personalised care is delivered, and their medical and wider social needs are met. The statements have a focus on the provision of integrated care where multiple services are required. Upon death the NICE guidelines outline the timely and sensitive manner that everything is dealt with.

National Council for Palliative Care

6.5. The National Council for Palliative Care (NCPC) have produced a resource which looks at best practice in coordination in end of life care[22]. Coordinating care around the individual is essential for good end of life care. They reviewed 66 end of life care co-ordination systems those that scored highest shared a number of core features including:

- A care coordination system centre where trained staff signposted and coordinated care across different services and sectors.
- One single access telephone number to the system
- Clinical and non-clinical call handling staff with non-clinical call handling guided to identify clinical need.
- Integration with all other providers in the area.
- Implement digital tools such as EPaCCS to support coordination and record sharing of end of life preferences.
- Consideration of harder to reach groups and how to build links with those communities
- Provides emotional support and interventions for the individuals and their carers where required.
- Is recurrently funded by the CCG.

[22] http://endoflifecareambitions.org.uk/wp-content/uploads/2017/06/Care-Coordination-Quick-Guide-for-Commissioners.pdf

6.6. This work by the NCPC complements the Commissioning Person Centred End of Life Care – a toolkit for health and social care by NHS England[23], this toolkit can be used to help in the commissioning or redesign of services across the BHR footprint.

6.7. In addition to creating a co-ordinated care system being at the forefront of best practice in end of life care, the NCPC has also outlined six ambitions (figure above) that should be met in the provision of high-quality end of life care. [24]

6.8. A case study of Rushcliffe in Nottingham where key issues around delayed transfers of care, readmissions and high rate of death in hospital created a ward-based community team to support acute colleagues. The sharing of GP data was key and allowed ward staff to identify end of life preferences that had previously been discussed. The community team based on the ward also increased the knowledge of step up or step-down facilities to aid with discharge. The positive impact on end of life care was noted as a key outcome for patients within the pilot area.

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[23] https://www.england.nhs.uk/wp-content/uploads/2016/04/nhsiq-comms-eolc-tlkit-.pdf
[24] http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

7. Discussion and Conclusion

5.3. There is a wide evidence base, including peer reviewed literature and case studies that outline the benefits and successes in evidence-based integrated care. Throughout the literature there are common threads that have been identified and these apply through all the key workstreams of the Transformation Board. These are:

- Work through the primary care networks – whether it is social prescribing, hospital at home or community based teams on the ward working through established primary care networks allows for a local approach to be delivered throughout the BHR footprint.

- Access to specialist support – the most successful interventions have been when those delivering the interventions have access to specialist support, whether a consultant geriatrician or specialist nurses. The ability of community based teams to seek advice and support allowed them to realise improved outcomes and help keep people in their community for longer.

- Technology – The use of technology is very important in providing the transformation required. Use of social technology such as Breezie and other apps that can help reduce social isolation and increase connectivity and education opportunities for older adults are key in aiding prevention. Whilst ensuring that the professionals working across the health and social care have access to technology that makes sharing actions and care records as seamless as possible.

- Centre of coordination – In order to ensure quality and equity in care there should be central coordination for the work ongoing across BHR.

<u>Questions for Discussion:</u>

1) What are the main opportunities and threats to successfully moving away from a hospital centric system to one that is based in the community?

2) Which of the seven key themes outlined at the start of the paper will present the greatest opportunity for successful transformation?

3) Based on this what does the transformation board need to do differently to change?

8. Financial Implications:

Implications completed by Murad Khan, Group Accountant:

8.1. This report is mainly for information and sets out to provide the Health and Wellbeing Board the evidence base required to review initiatives and best practice of a place-based system that improves the health and care for the older people's population of BHR. As such, there are no financial implications arising directly from the report.

9. Legal Implications:

Implications completed by Dr. Paul Feild Senior Governance lawyer:

9.1. 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 that the providers of health and social care services work in their delivery in an integrated manner.

9.2. In a proportion of older people, the normal gradual age-related decline in can be accelerated, resulting in them having limited functional reserve, so that even a relatively minor illness or event such as a fall has a substantial impact on their health. This increased vulnerability is termed frailty. This report is an information item and sets out to support the Health and Wellbeing Board in evidence-based decision making required as a function of the Board. As such, there are no legal implications arising directly from the report.

Public background papers used in the preparation of the report:

None.

Appendices

None.

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	**Global Burden of Disease Study Data 2017**
Report of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
Report Author(s): Rosanna Fforde, Senior Intelligence and Analysis Officer, London Borough of Barking and Dagenham Soumya Chatterjee, Business Intelligence Public Health Lead, London Borough of Redbridge Anthony Wakhisi, Principal Public Health Specialist, London Borough of Havering	**Contact Details:** Rosanna.Fforde@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	

Summary

This briefing on Global Burden of Disease Study data was requested by the Managing Director of Barking, Havering and Redbridge (BHR) CCGs to support the BHR Transformation Boards in their commissioning decisions. This briefing can help inform joint commissioning decisions across BHR by gaining an understanding of drivers of ill health and mortality.

Premature mortality: Ischaemic heart disease and lung cancer have the highest age-standardised rate of years of life lost (YLL) across BHR followed by chronic obstructive pulmonary disease (COPD) in Barking and Dagenham and Havering, and lower respiratory infections in Redbridge. These need to be targeted to improve life expectancy.

Ill health: the conditions with the highest rates of years lived with disability (YLDs) were low back pain, headache disorders and depressive disorders. These are therefore likely to be key conditions to target to improve healthy life expectancy.

Risk factors: The main risk factors for ill health and premature death across BHR are tobacco, dietary risks (e.g. diet low in whole grains), high body mass index (excess weight), high fasting plasma glucose (indicative of diabetes/diabetes risk) and high blood pressure. These are key issues to target for prevention.

A strength of the dataset is that it allows all health conditions causing ill health/disability and death to be quantified and compared. However, these are best estimates based on modelled available data and there remains a need to triangulate this with local data.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Note the findings of the report and the associated caveats and

(ii) Provide any feedback and comments on how the findings of the report could be taken forward for prioritisation and resource allocation across BHR Integrated Health and Care System.

1. Introduction

1.1 The Global Burden of Disease Study (GBD) is an international collaborative project which provides authoritative modelled estimates on the amount of ill health, premature death and risk factors in a population.

1.2 These measures are comparable across time and different geographies with a list of conditions that is 'mutually exclusive and collectively exhaustive': that is, into which every condition can be placed without double counting.

1.3 The GBD therefore allows an understanding of the relative contribution of each condition as well as the collective burden. It is an ongoing, iterative project, with each modelling round refining the previous one.[1]

1.4 England local authority level estimates were first published for the 2016 round in October 2018 and refreshed for the 2017 round in late December 2018.

1.5 The GBD also includes estimates of life expectancy and healthy life expectancy.[2] Life expectancy and healthy life expectancy in BHR have been rising over the last few decades (Appendix A), but the gap between the two measures has increased, such that BHR residents are living longer, but spending a greater period of time in ill health. Together with the human cost of years lived in ill health, this has implications for health services. Understanding YLLs and YLDs will help us to understand the drivers of life expectancy and healthy life expectancy respectively. This briefing has been brought to the Board to help inform joint commissioning decisions by gaining an understanding of drivers of ill health and mortality across BHR

1.6 A list of terms and abbreviations is included in Appendix B.

2. Years of life lost

Years of life lost (YLLs) are a measure of premature mortality; they estimate the years of potential life lost due to premature death by summing the remaining life expectancy of individuals dying in the period.[3] Hence, deaths at a younger age correspond to more YLLs than deaths at an older age.

YLLs can be used in public health planning and commissioning to compare the relative importance of different causes of premature deaths, to set priorities for prevention, and to compare the premature mortality experience between populations.

[1] For more information, see: http://www.healthdata.org/gbd/about/protocol.
[2] Note: these are not the same as the Office for National Statistics life expectancies/healthy life expectancies.
[3] Based on a theoretical highest possible life expectancy – see Appendix B.

What are the leading causes of premature mortality?

2.1 Based on age-standardised rates, the three leading causes of YLLs across BHR are ischaemic heart disease, lung cancer and COPD (Barking and Dagenham and Havering) and lower respiratory infections (Redbridge) (Table 1).[4] Ischaemic heart disease on its own accounts for 12% of the YLL rate across all three boroughs.

2.2 The conditions in Table 1 are likely to be key ones to target to improve life expectancy, although they should be viewed in conjunction with the absolute burden discussed later in this section (see Figure 2).

Table 1: Top ten causes of YLL in BHR, age-standardised rate per 100,000, 2017[5]

Barking & Dagenham		Havering		Redbridge	
Causes	ASR	Causes	ASR	Causes	ASR
All causes	*9,491*	*All causes*	*8,513*	*All causes*	*7,321*
IHD	1,115	IHD	993	IHD	914
Lung cancer	792	Lung cancer	607	Lung cancer	458
COPD	548	COPD	416	LRIs	330
LRIs	420	Stroke	376	Stroke	322
Neonatal disorders	395	Dementia	369	Dementia	320
Stroke	382	LRIs	355	COPD	287
Dementia	348	Breast cancer	317	Neonatal disorders	267
Bowel cancer	276	Bowel cancer	283	Breast cancer	252
Breast cancer	266	Self-harm	281	Self-harm	236
Cirrhosis	259	Neonatal disorders	263	Bowel cancer	215

2.3 Barking and Dagenham has the highest all-cause age-standardised YLL rate (9,491 per 100,000) of the three boroughs, followed by Havering (8,513 per 100,000) and Redbridge (7,321 per 100,000).

How do the causes of premature mortality compare with London/England?

2.4 Barking and Dagenham has a significantly higher all-cause YLL rate than the England average (Table 2).[6] Rates are also significantly higher than England for causes including ischaemic heart disease, lung cancer, COPD and lower respiratory infections.

2.5 In Havering, rates for lower respiratory infections, dementia, and breast cancer are significantly higher than the England average.

2.6 Most of the leading causes in Redbridge, and across London as a whole, have significantly lower rates than the England average.

[4] Tracheal, bronchus, and lung cancer is referred to as lung cancer in this report.
[5] See Appendix B for abbreviations/shortened terms used in table.
[6] Significance is determined by non-overlapping confidence intervals.

Table 2: Leading causes of YLLs in BHR, London and England, age-standardised rate per 100,000, 2017[7]

Cause	B&D	Havering	Redbridge	London	England
All causes	*9,491*	*8,513*	*7,321*	*7,603*	*8,521*
IHD	1,115	993	914	838	928
Lung cancer	792	607	458	519	563
COPD	548	416	287	345	379
LRIs	420	355	330	308	317
Neonatal disorders	395	263	267	349	403
Stroke	382	376	322	320	396
Dementia	348	369	320	311	335
Bowel cancer	276	283	215	227	270
Breast cancer	266	317	252	228	259
Cirrhosis	259	218	199	225	244
Self-harm	251	281	236	232	314
Congenital birth defects	243	192	183	207	252
Pancreatic cancer	188	170	155	151	161
Drug use disorders	168	132	114	161	186
Road injuries	146	165	131	128	166

Key

Significantly lower than the England average

Similar to the England average

Significantly higher than the England average

2.7 This reiterates the need for tailored approaches to tackle premature mortality across the three boroughs; even accounting for different population sizes and age structures, there are fundamental differences in burden. Nonetheless, the leading causes are similar.

How does premature mortality vary by age and sex?

2.8 Males have a substantially higher age standardised YLL rate than females (around 40% higher than females in Havering and Redbridge and 65% higher in Barking and Dagenham). This compares with around 50% and 45% higher rates for London and England males respectively compared with females. In part this reflects what we already know about differences in life expectancy by sex, but it suggests male premature mortality in Barking and Dagenham is a particular cause for concern.

2.9 Ischaemic heart disease is a key contributor to this gap; males in Barking and Dagenham have 3.2 times the female rate of YLLs from ischaemic heart disease, while the male rate is around 2.7 times higher than the female rate in both Havering and Redbridge.

2.10 The top three causes of YLLs in males mirror the overall top causes across the three boroughs (ischaemic heart disease, lung cancer and COPD/lower respiratory infections). For females, lung cancer, breast cancer and ischaemic heart disease make up the three leading causes for all three boroughs but in different orders. The

[7] The order of this table is based on Barking and Dagenham. Fifteen causes are shown to ensure the top ten are included for each borough. Drug use disorders are not in the top 15 leading causes for Havering or Redbridge

top causes are lung cancer in Barking and Dagenham, breast cancer in Havering and ischaemic heart disease in Redbridge.

2.11 The amount and causes of YLLs across different life stages vary substantially. These are summarised in Table 3 (as age-specific rates). Further data on YLLs by age group and sex is available in Appendix C.

Table 3: Top three causes of YLLs by age group, rate per 100,000, BHR, 2017

Age	*All-cause YLL rate*	Top cause	2nd largest cause	3rd largest cause
Under 5	*B&D: 7,758* *H: 5,656* *R: 5,809*	Neonatal disorders	Congenital birth defects	Sudden infant death syndrome
5–14	*B&D: 565* *H: 626* *R: 573*	Brain and nervous system cancer	Congenital birth defects	Other malignant neoplasms *(B&D)* Road injuries *(Havering)* Leukaemia *(Redbridge)*
15–49	*B&D: 3,614* *H: 4,176* *R: 3,015*	Self-harm	Drug use disorders *(B&D)* IHD *(Havering/Redbridge)*	IHD *(B&D)* Drug use disorders *(Havering/Redbridge)*
50–64	*B&D: 20,489* *H: 18,707* *R: 15,530*	IHD	Lung cancer	COPD *(B&D/Havering)* Breast cancer *(Redbridge)*
70+	*B&D: 64,638* *H: 56,222* *R: 50,425*	IHD	Dementia	COPD *(B&D/Havering)* LRIs *(Redbridge)*

What is the total burden of premature mortality (crude YLLs, not standardised for age)?

2.12 Crude numbers show the burden of disease regardless of population size or structure. This may be useful for service provision, but caution is needed in the interpretation given the difference in populations across BHR (see below).

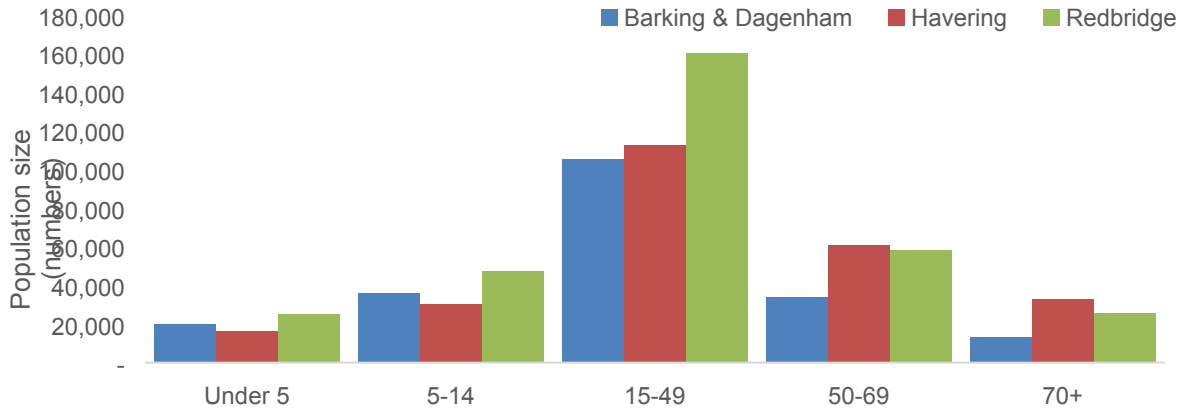
2.13 The highest crude number of YLLs (for all causes) was in Havering (35,677), followed by Redbridge (28,390) and Barking and Dagenham (20,997).

2.14 The differences between the boroughs are driven by both population size and structure. Redbridge has the largest population (315,800), followed by Havering (252,600) and Barking and Dagenham (208,300).[8] Havering's higher crude number of YLLs than Redbridge – despite its smaller overall population size – reflects its older population; as seen in Table 3, the YLL rate increases dramatically with age.

[8] 2017 population estimates within GBD.

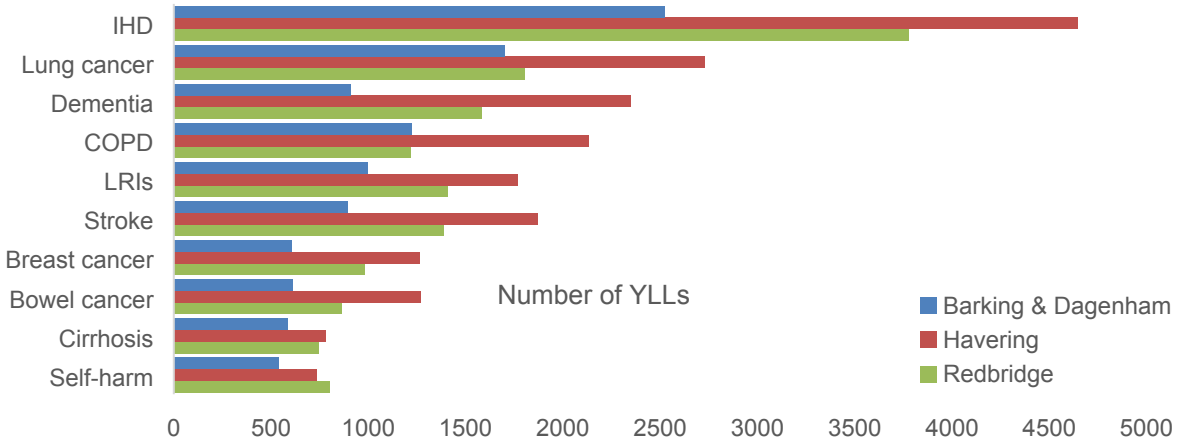
There are 32,900 people aged 70 and above in Havering: 7,500 more than in Redbridge and 19,800 more than in Barking and Dagenham.

Figure 1: Population size by age group in BHR, 2017



2.15 Figure 2 shows the top ten conditions contributing to the total crude YLL burden across BHR. These conditions account for half of YLLs across BHR (53%). Unlike the age-standardised rates, where dementia was the fifth (Havering and Redbridge) or seventh (Barking and Dagenham) leading cause, dementia is the third largest cause of crude YLLs.

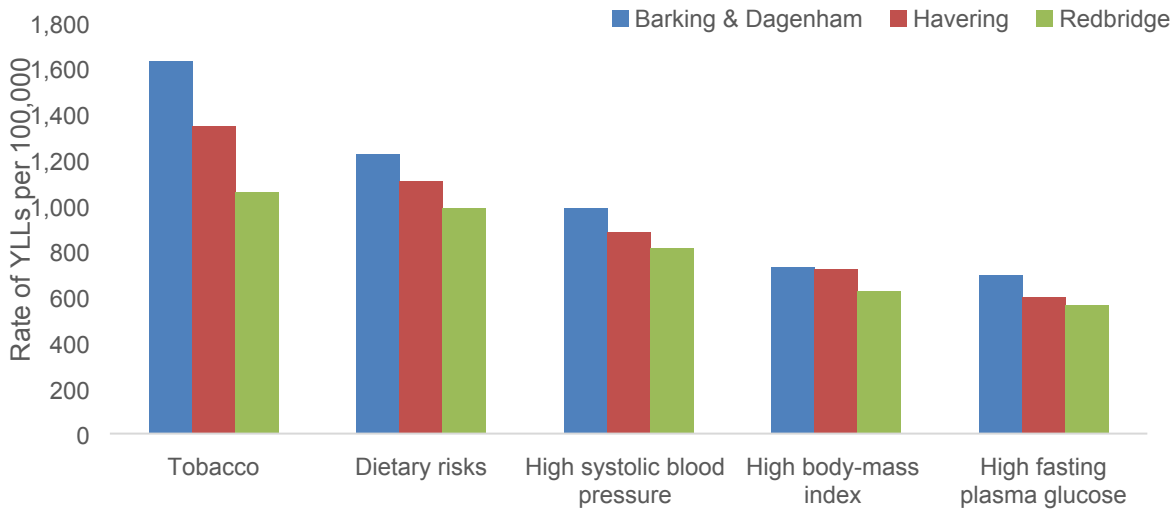
Figure 2: Top ten causes of YLLs based on total YLL burden across BHR by borough, 2017



What are the risk factors for premature mortality?

2.16 Tobacco (a category comprising smoking, passive smoking and chewing tobacco) is the single largest risk factor for YLL across the three boroughs, with a notably higher rate of YLLs attributable to tobacco in Barking and Dagenham, especially when compared with Redbridge. Other key risk factors include dietary risks (e.g. diet low in whole grains), high systolic blood pressure, high body mass index (excess weight) and high fast plasma glucose (indicative of diabetes/diabetes risk).

Figure 3: Age-standardised YLL rates per 100,000 – top five risk factors contributing to YLL in BHR



2.17 Analysis by condition group suggests that the largest burden of YLLs associated with these risk factors comes from cardiovascular disease and cancers for all three boroughs (Appendix D).

3. Years lived with disability

Years lived with disability (YLDs) are a measure of ill health. They are calculated by multiplying the prevalence of a condition by the short- or long-term loss of health associated with it (its disability weighting).[9]

What are the leading causes of ill health?

3.1 The three leading causes of YLD across BHR are low back pain, headache disorders and depressive disorders (Table 4). Addressing these is therefore likely to be important for improving healthy life expectancy.

Table 4: Top ten causes of YLDs in BHR, age-standardised rate per 100,000, 2017

Barking & Dagenham		**Havering**		**Redbridge**	
Causes	ASR	Causes	ASR	Causes	ASR
All causes	*11,511*	*All causes*	*11,401*	*All causes*	*11,304*
Low back pain	1,459	Low back pain	1,459	Low back pain	1,457
Headache disorders	844	Headache disorders	844	Headache disorders	839
Depressive disorders	625	Depressive disorders	625	Depressive disorders	623
Neck pain	491	Neck pain	491	Neck pain	490
Dermatitis	402	Falls	401	Falls	398
Anxiety disorders	397	Anxiety disorders	397	Anxiety disorders	395
Falls	397	Diabetes mellitus	378	Diabetes mellitus	378
Diabetes mellitus	384	Asthma	364	Asthma	363

[9] Disabilities have different 'weights' that signify the severity of the disability (e.g. 0.061 for lower back pain, and 0.594 for blindness).

Asthma	361	Neonatal disorders	357	Neonatal disorders	359
Neonatal disorders	361	Age-related and other hearing loss	316	Dermatitis	313

3.2 Barking and Dagenham had the highest age-standardised YLD rate (11,511 per 100,000) in BHR, although all three boroughs had similar rates. This relates to a limitation in the data available to model YLDs (outlined in Appendix E).

How do the causes of ill health compare with London/England?

3.3 Similarly, due to the data limitation outlined in Appendix E, rates across BHR for the leading causes of YLDs are similar to the England average (Table 5).

Table 5: Leading causes of YLDs in BHR, age-standardised rate per 100,000, London & England, 2017

Cause	B&D	Havering	Redbridge	London	England
All causes	*11,511*	*11,401*	*11,304*	*11,393*	*11,385*
Low back pain	1,459	1,459	1,457	1,462	1,441
Headache disorders	844	844	839	840	838
Depressive disorders	625	625	623	623	623
Neck pain	491	491	490	490	489
Dermatitis	402	314	313	316	319
Anxiety disorders	397	397	395	396	395
Falls	397	401	398	398	405
Diabetes mellitus	384	378	378	398	391
Asthma	361	364	363	367	330
Neonatal disorders	361	357	359	358	357
COPD	332	308	272	304	303
Age-related and other hearing loss	316	316	308	313	314
Drug use disorders	297	288	287	300	311
Other musculoskeletal disorders	275	264	265	269	271
Oral disorders	239	236	237	230	233

How does ill health vary by age and sex?

3.4 Unlike YLLs, where rates are higher in males, age-standardised rates of YLDs are higher for females, albeit to a lesser extent. Females experience 12–14% higher rates of YLDs than males in Barking and Dagenham, Havering and Redbridge. This is in line with London (12%) and England (14%).

3.5 YLDs by age group are summarised in Table 6 (as age-specific rates). Further data on YLDs by age group and sex is available in Appendix F.

Table 6: Top three causes of YLDs by age group, rate per 100,000, BHR, 2017

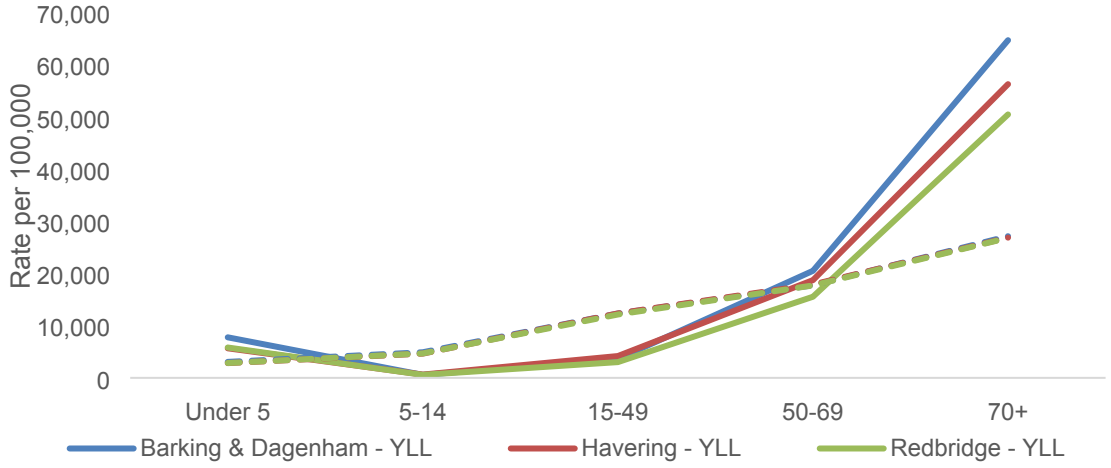
Age	*All-cause YLL rate*	Top cause	2nd largest cause	3rd largest cause
Under 5	*B&D: 3,057* *H: 2,822* *R: 2,839*	Dermatitis	Neonatal disorders	Asthma *(B&D/Havering)* Congenital birth defects *(Redbridge)*
5–14	*B&D: 4,902* *H: 4,641* *R: 4,675*	Dermatitis	Neonatal disorders *(B&D)* Asthma *(Havering/ Redbridge)*	Asthma *(B&D)* Neonatal disorders *(Havering/Redbridge)*
15–49	*B&D: 12,315* *H: 12,337* *R: 12,128*	Low back pain	Headache disorders	Depressive disorders
50–64	*B&D: 17,726* *H: 17,871* *R: 17,689*	Low back pain	Neck pain	Headache disorders
70+	*B&D: 27,116* *H: 26,845* *R: 26,784*	Low back pain	Age-related and other hearing loss	COPD

What is the total burden of ill health (crude YLDs, not standardised for age)?

3.6 Across all conditions, the highest crude burden of YLDs was in Redbridge (39,415), followed by Havering (35,449) and Barking and Dagenham (24,936). This is in contrast to YLLs, where Havering had the largest burden of the three boroughs.

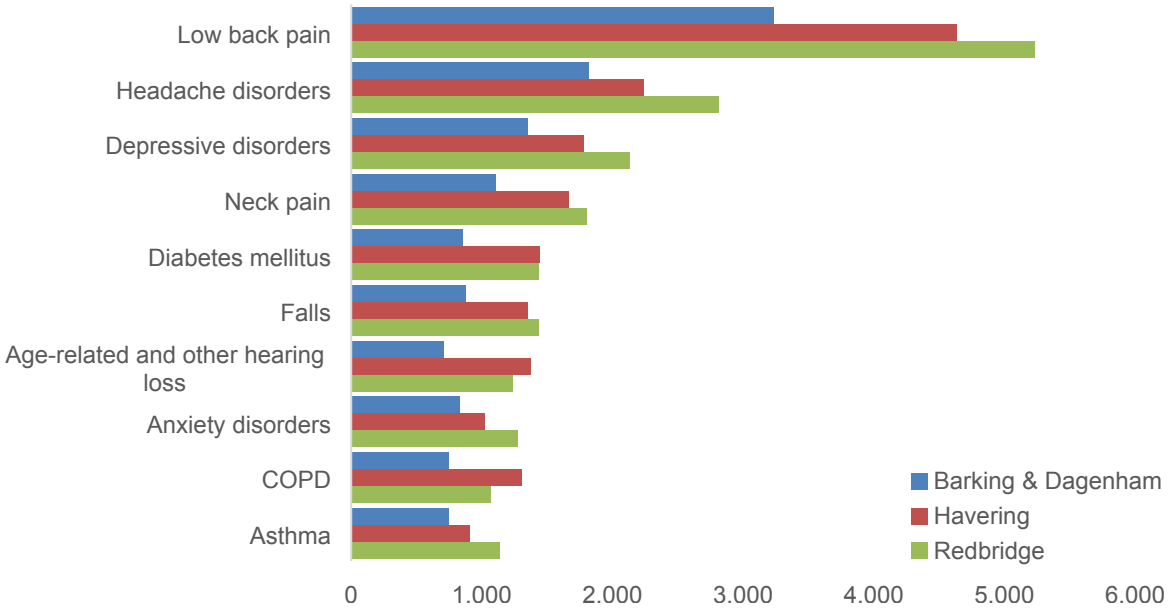
3.7 This is because ill health exists across the life course, whereas death only happens once and generally occurs in older age. This is evident in the shallower gradient between YLDs and age (dashed lines in Figure 4) compared with YLLs (solid lines). This explains why Havering's older population was more influential on YLLs than YLDs. There nonetheless remains a strong relationship between YLDs and age and this will also vary by condition (e.g. age-related and other hearing loss, neonatal disorders).

Figure 4: Age-specific rates of YLLs (solid lines) and YLDs (dashed lines), BHR, 2017



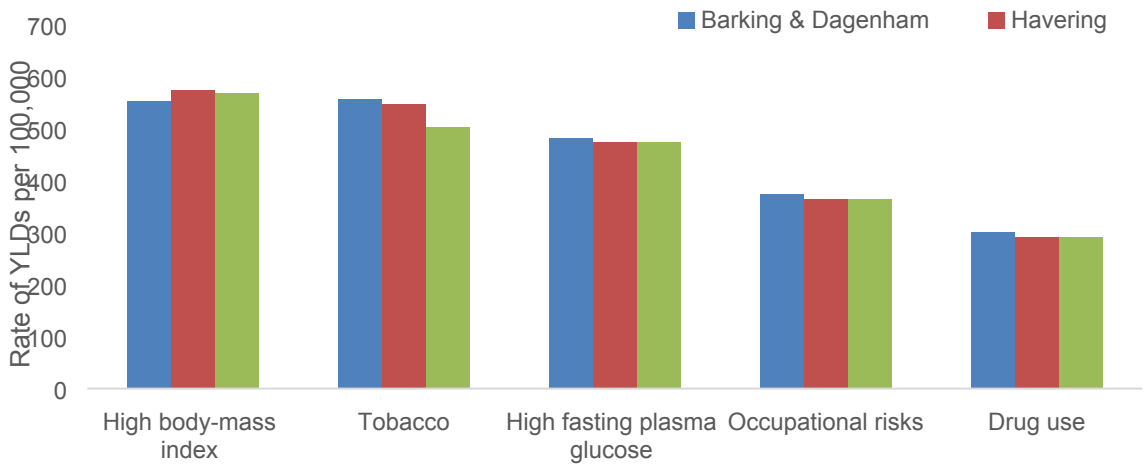
3.8 Figure 5 shows the ten conditions contributing the most to the YLD burden across BHR. These account for of half of YLDs across BHR (50%). As with the age-standardised rates, the three conditions contributing the most to this were low back pain, headache disorders and depressive disorders.

Figure 5: Top ten causes of YLDs based on total YLD burden across BHR by borough, 2017



What are the risk factors for ill health?

Figure 6: Age-standardised YLD rates per 100,000 – top five risk factors contributing to YLD in BHR



3.9 High body mass index (excess weight) is the leading risk factor for YLDs in BHR (except for Barking and Dagenham, where tobacco is the leading risk factor). 'Occupational risks' is a group of work-related causes of ill health, with the main contributor to YLDs being low back pain caused by work.

3.10 Analysis by condition suggests that the condition groups with the largest preventable burden are diabetes and chronic kidney disease, and musculoskeletal disorders for all three boroughs (Appendix G).

4. Disability-adjusted life years

Disability-adjusted life years (DALYs) are a composite measure summarising the number of healthy years of life lost in a population due to both ill health and deaths. They are created by summing YLLs and YLDs.

4.1 DALYs are an additional measure created from YLLs and YLDs. They are reported on only briefly here (with more details in Appendix H), but the value of looking at DALYs (in addition to YLLs/YLDs) is that they quantify all ill health and preventable mortality into one summary measure and allow comparison between conditions largely causing one or the other.

4.2 The leading causes of DALYs in BHR are low back pain and ischaemic heart disease, followed by COPD for Barking and Dagenham and headache disorders for Havering and Redbridge.

Table 7: Top ten causes of DALYs in BHR, age-standardised rates per 100,000, 2017

Barking & Dagenham		**Havering**		**Redbridge**	
Causes	ASR	Causes	ASR	Causes	ASR
All causes	*21,002*	*All causes*	*19,914*	*All causes*	*18,624*
Low back pain	1,459	Low back pain	1,459	Low back pain	1,457
IHD	1,171	IHD	1,046	IHD	973
COPD	880	Headache disorders	844	Headache disorders	839

Headache disorders	844	COPD	724	Neonatal disorders	626
Lung cancer	804	Depressive disorders	625	Depressive disorders	623
Neonatal disorders	756	Neonatal disorders	619	COPD	560
Depressive disorders	625	Lung cancer	618	Neck pain	490
Stroke	501	Stroke	497	Lung cancer	466
Neck pain	491	Neck pain	491	Falls	461
Falls	475	Falls	473	Diabetes mellitus	439

5. Strengths and limitations

5.1 A key strength of the GBD dataset is that the burden from all conditions is estimated and hence the relative contribution of conditions can be assessed, which is valuable for prioritisation. This is not novel for causes of death but is new for ill health. It also means that the morbidity and mortality from a condition can be considered together (as DALYs), which may provide a different perspective for assessments about where health gains can be made.

5.2 However, it is worth noting that all outputs are modelled, including where there is good data coverage. All measures are based on a wide variety of sources and it is not straightforward to see how any given figure has been arrived at and what the limitations of the individual data sources may be.

5.3 One of these limitations is the lack of local data available to inform estimates for some conditions (see Appendix E). This is reflected in the lack of variation of YLD estimates for some conditions at local authority level.[10]

5.4 A further limitation is that the risk factors modelled are generally proximate, physiological risk factors. More upstream factors, such as unemployment or poverty, do not appear here, yet we know, for example, that there is a strong relationship between deprivation and life expectancy. The risk factor analysis should therefore be used to guide discussions around prevention, but not to limit such strategies from thinking more broadly.

5.5 To summarise, the GBD is a tool for understanding the likely distribution of ill health in our population rather than a direct source of data. It will need triangulation with local data sources to build a more nuanced picture, especially around risk factors – but is nonetheless extremely valuable in the absence of local data.

6. Conclusions

6.1 This briefing includes data on YLLs, YLDs, DALYs and risk factors for BHR from the 2017 Global Burden of Disease Study to present a picture of the causes of premature mortality and ill health and its preventable components across the three boroughs.

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

6.2 The data suggests that common chronic conditions such as low back pain and headache disorders (migraines and tension-type headaches) contribute to a substantial burden of disease across BHR, together with more high-profile conditions such as ischaemic heart disease, lung cancer and COPD. These are likely to be key conditions to target to improve life expectancy and healthy life expectancy, especially given that many of the leading conditions have substantial preventable components.

6.3 As age-standardised rates, the burden of YLLs is highest in Barking and Dagenham, while the burden of YLDs is similar across BHR due to the modelling methods. As crude numbers (i.e. ignoring population size and structure), the YLL burden is highest in Havering, reflecting its older population structure, and the YLD burden is highest in Redbridge, the borough with the largest population.

6.4 Understanding what the Global Burden of Disease Study is and what it is not is important; it is not a replacement for all local data analysis, but it is a framework for understanding the overall burden of disease across BHR and how any given condition fits into this, using modelling to provide best estimates based on the available data. A key next step will be to triangulate this against local data, but in the absence of other data, the GBD is likely to be a valuable tool for resource prioritisation and allocation. The GBD data analysis has the potential to inform the joint commissioning decisions and policy development by the HWBB by gaining an understanding about the factors responsible for ill health, mortality and the preventable risk factors across BHR to tackle these effectively as a joint health and care system.

7. Mandatory Implications

Joint Strategic Needs Assessment

The findings within the GBD analysis generally correlate with those in the Joint Strategic Needs Assessment (JSNA) 2018. Additionally, the data suggests that common chronic conditions such as low back pain and headache disorders (migraines and tension-type headaches) contribute to a substantial burden of disease across BHR, which will be considered for the next JSNA as the likely key conditions to target to improve healthy life expectancy.

Joint Health and Wellbeing Strategy

7.1 The three priority themes for the Joint Health and Wellbeing Strategy 2019–2023 are

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

7.2 The GBD data analysis will add value to our existing JSNA and the local data analysis to help implement the Joint Health and Wellbeing Strategy and action plan.

Integration

7.3 The GBD data analysis was requested by the BHR CCGs to support the implementation of the Financial Recovery Plan across the health and social care

system. The GBD analysis highlights the causes of premature mortality and ill health and its preventable components across the three boroughs that need to be targeted within the integrated health and social care system to manage demand, realise efficiencies and to improve the quality of care.

Financial Implications

7.4 Implications completed by Murad Khan – Group Accountant:

7.5 This report is largely for information and sets out to seek the Health and Wellbeing Board's feedback and comments on how the findings of the report could be applied for prioritisation and resource allocation across BHR Integrated Health and Care System. As such, there are no financial implications arising directly from the report.

Legal Implications

7.6 Implications completed by Dr Paul Feild – Senior Governance lawyer:

7.7 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 Wellbeing Board terms of reference establish its function to ensure that the providers of health and social care services work in their delivery in an integrated manner.

7.8 This report is an information item and sets out to support the Health and Wellbeing Board in evidence-based decision making required as a function of the Board. As such, there are no legal implications arising directly from the report.

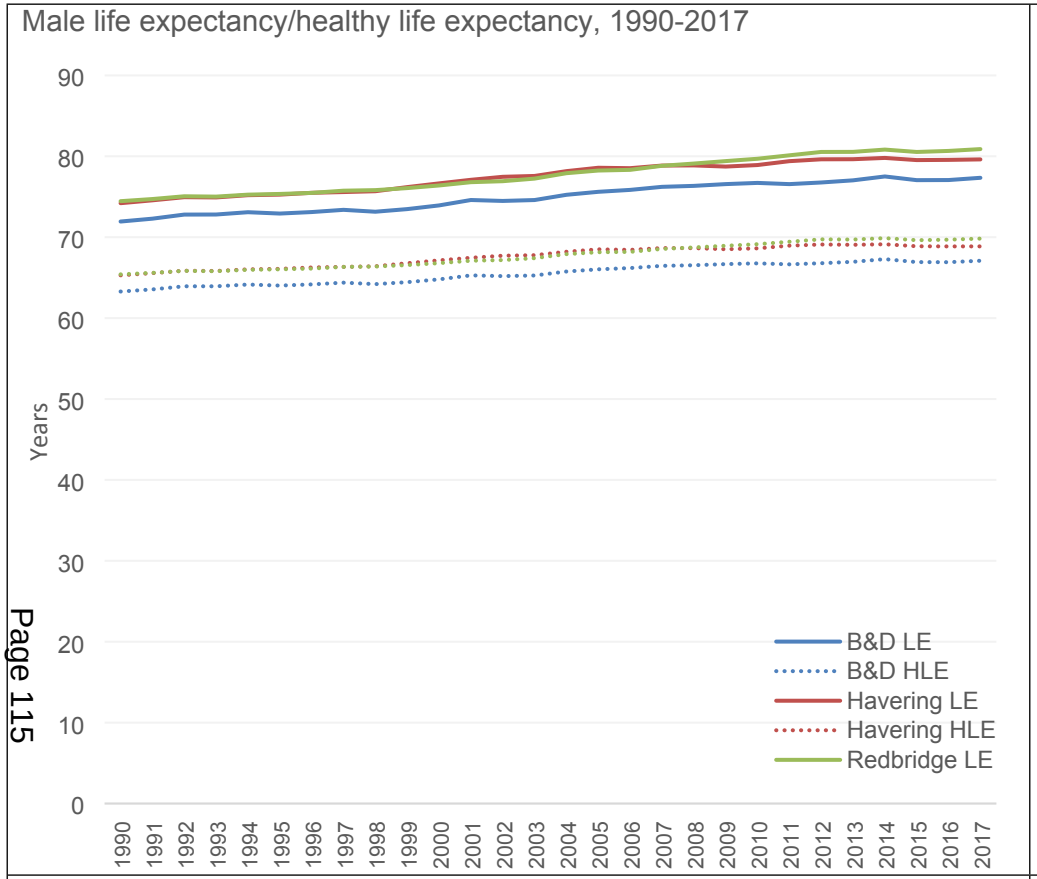
Public background papers used in the preparation of the report:

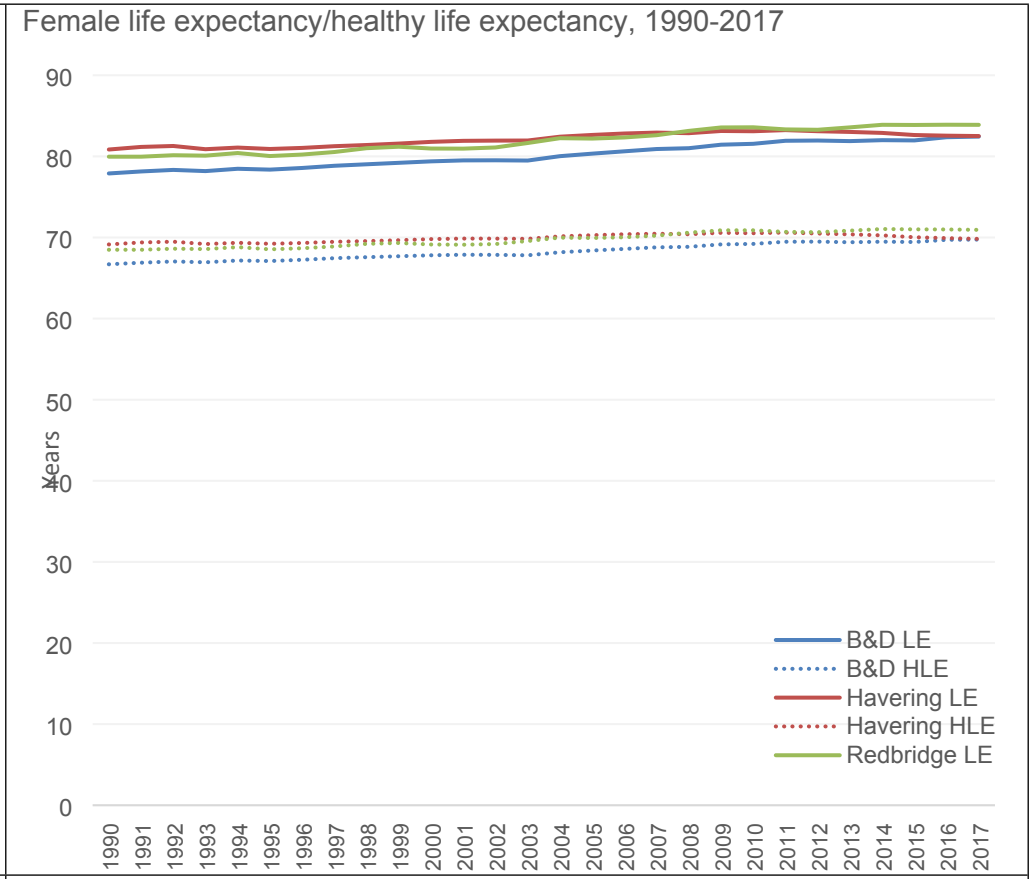
- Global Burden of Disease FAQ, including simple definitions of measures: http://www.healthdata.org/gbd/faq
- Global Burden of Disease Study protocol: http://www.healthdata.org/gbd/about/protocol
- Data visualisation tool: https://vizhub.healthdata.org/gbd-compare/
- Data download tool: http://ghdx.healthdata.org/gbd-results-tool
- Published GBD articles in the Lancet: https://www.thelancet.com/gbd.

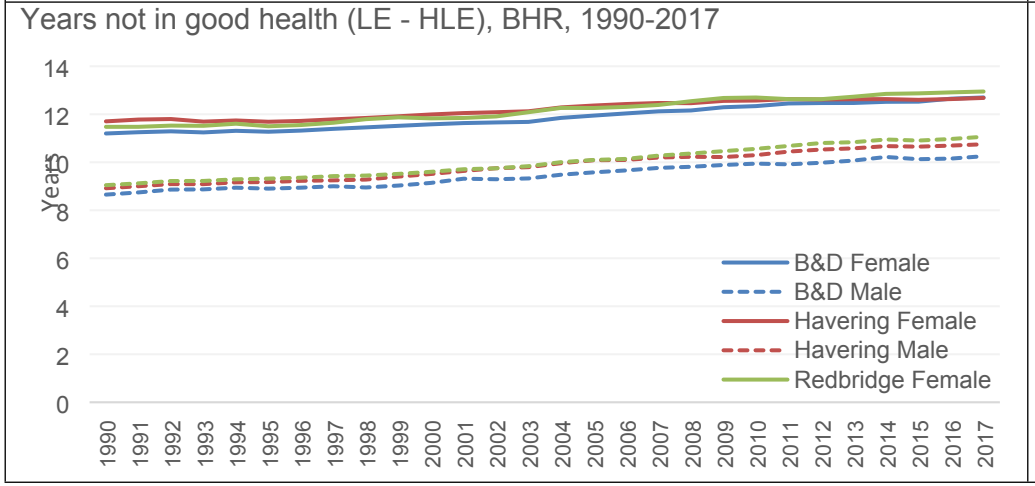
Appendices

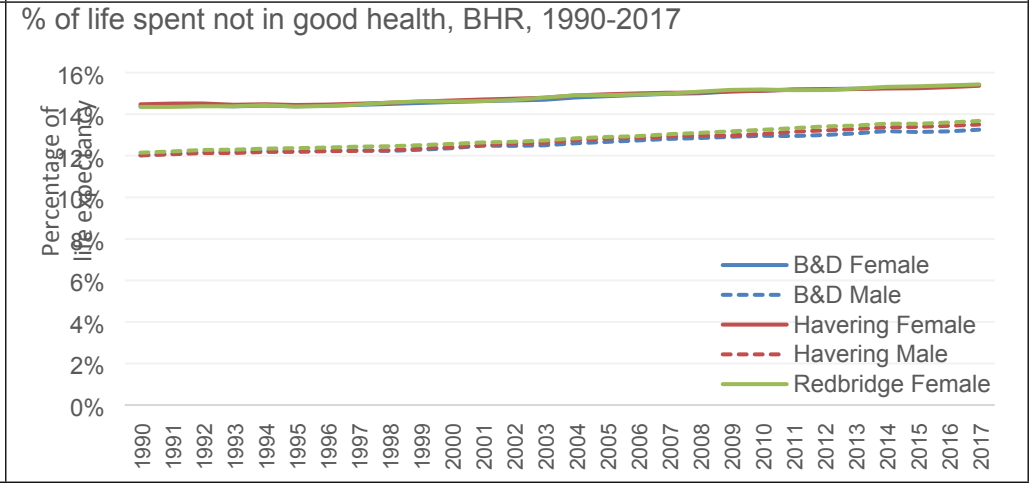
Appendix A: Life expectancy (LE) and healthy life expectancy (HLE), BHR, 19902017
Appendix B: Key terms and abbreviations
Appendix C: Years of life lost (YLL) by sex and age group
Appendix D: Risk factors for YLLs by cause
Appendix E: Limitations of modelled data for ill health
Appendix F: Years lived with disability (YLD) by sex and age group
Appendix G: Risk factors for YLDs by cause
Appendix H: Additional DALY analysis

Appendix A: Life expectancy (LE) and healthy life expectancy (HLE), BHR, 1990–2017









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Measures

Years of life lost (YLLs): YLLs are a measure of premature mortality; they estimate the years of potential life lost due to premature death by multiplying the number of deaths at each age by the highest life expectancy possible at the age the deaths occurred. Hence, deaths at a younger age correspond to more YLLs than deaths at an older age. This life expectancy is calculated by looking at the lowest age-specific mortality rates in populations over 5 million people in total and using these to create a theoretical highest possible life expectancy at each age.

Years lived with disability (YLDs): YLDs are a measure of ill health. They are calculated by multiplying the prevalence of a condition by the short- or long-term loss of health associated with it (its disability weighting).

Disability-adjusted life years (DALYs): DALYs are a composite measure summarising the number of healthy years of life lost in a population due to both ill health and deaths. They are created by summing YLLs and YLDs.

Metrics

Crude numbers: The total number of YLLs or YLDs for a given population, with no reference to the underlying population size or structure.

Age-specific rates: The number of YLLs or YLDs for a particular age group as a rate for the number of people in that age group: for example, 500 YLLs per 100,000 5–9 year olds.

Age-standardised rates: As age has a strong relationship with ill health and death, comparing crude rates per 100,000 between areas with different proportions of older people and children can be misleading. Age-standardised rates avoid this by showing what the rate would be if each area in question had the same population structure.

In this briefing, an age-standardised rate refers to one which has been directly age standardised. Directly standardised rates are calculated by segmenting the data into different age categories and creating age-specific rates for each area. These age-specific rates are then applied to the corresponding age groups in what is known as a ‘standard population’ (a hypothetical or real population, broken down into numbers by different age groups) to create an expected number of YLLs or YLDs. For example, if the age-specific rate for area A was 500 YLLs per 100,000 and there are 5,000 children aged 5–9 in the standard population, we would expect 25 YLLs. The expected numbers of YLLs or YLDs for each age group are summed and then divided by the total standard population to create an overall rate for each area.

Abbreviated cause terms

Several cause names have been abbreviated for use in the text and tables to improve readability. These are as follows:

Cause	Abbreviated term
Alzheimer’s disease and other dementias	Dementia
Chronic obstructive pulmonary disease	COPD
Cirrhosis and other chronic liver diseases	Cirrhosis

Colon and rectum cancer	Bowel cancer
Ischaemic heart disease	IHD
Lower respiratory infections	LRIs
Tracheal, bronchus, and lung cancer	Lung cancer

Appendix C: Years of life lost (YLL) by sex and age group

Key

Significantly lower than the England average
Similar to the England average
Significantly higher than the England average

Sex

Table C.1: Leading causes of YLLs, males, age-standardised rate per 100,000, 2017

Males					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*12,119*	*10,003*	*8,618*	*9,191*	*10,150*
IHD	1,776	1,482	1,363	1,267	1,380
Lung cancer	1,027	715	556	621	654
COPD	703	480	338	420	438
LRIs	530	377	372	364	366
Neonatal disorders	471	288	290	386	452
Stroke	463	403	362	370	432
Self-harm	422	462	363	354	485
Dementia	367	314	287	287	309
Bowel cancer	352	330	249	272	323
Cirrhosis	346	273	267	303	314
Prostate cancer	312	260	221	241	270
Congenital birth defects	259	189	193	216	267
Drug use disorders	250	230	178	244	280
Road injuries	229	258	196	197	254
Pancreatic cancer	214	187	165	166	174

Table C.2: Leading causes of YLLs, females, age-standardised rate per 100,000, 2017

Females					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*7,334*	*7,168*	*6,122*	*6,151*	*7,002*
Lung cancer	602	516	371	431	484
IHD	562	557	506	452	515
Breast cancer	495	595	479	432	496
COPD	439	367	246	285	333
LRIs	344	336	295	261	274
Dementia	338	404	342	327	353
Stroke	320	350	287	276	362
Neonatal disorders	315	236	242	311	352
Congenital birth defects	227	196	172	198	237
Bowel cancer	215	241	185	187	222
Cirrhosis	179	166	135	150	175
Pancreatic cancer	165	153	145	136	147

Ovarian cancer	150	195	164	145	171
Other malignant neoplasms	129	107	104	94	106
Other cardiovascular and circulatory diseases	113	101	90	90	104

Age

Table C.3: Leading causes of YLLs, under 5s, rate per 100,000, 2017

Under 5s					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*7,758*	*5,656*	*5,809*	*7,410*	*7,915*
Neonatal disorders	3,640	2,541	2,537	3,483	3,798
Congenital birth defects	1,825	1,375	1,367	1,684	1,934
Sudden infant death syndrome	418	262	298	389	413
LRIs	348	241	276	304	281
Endocrine, metabolic, blood, and immune disorders	176	153	162	186	191
Meningitis	115	94	109	120	111
Foreign body	99	84	87	95	98
Other malignant neoplasms	90	68	66	71	71
Other neurological disorders	75	69	81	89	95
Leukaemia	67	60	66	67	63
Brain and nervous system cancer	65	74	64	67	67
Cardiomyopathy and myocarditis	64	43	55	67	61
Other unspecified infectious diseases	54	41	47	73	63
Diarrheal diseases	50	26	38	46	42
Road injuries	46	43	40	48	53

Table C.4: Leading causes of YLLs, 5–14 year olds, rate per 100,000, 2017

5–14 year olds					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*565*	*626*	*573*	*614*	*596*
Brain and nervous system cancer	57	84	64	65	63
Congenital birth defects	54	58	52	56	56
Other malignant neoplasms	51	52	45	44	43
Leukaemia	44	50	49	49	46
Road injuries	42	55	44	49	58

Endocrine, metabolic, blood, and immune disorders	35	44	38	41	39
LRIs	28	24	26	25	21
Epilepsy	19	19	15	19	19
Asthma	14	12	12	14	14
Interpersonal violence	14	9	17	18	13
Other neurological disorders	13	15	17	16	18
Foreign body	13	18	14	16	17
Cardiomyopathy and myocarditis	10	10	11	13	11
Meningitis	10	12	13	13	11
Fire, heat, and hot substances	9	7	9	10	8

Table C.5: Leading causes of YLLs, 15–49 years, rate per 100,000, 2017

15–49 year olds					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*3,614*	*4,176*	*3,015*	*3,098*	*4,123*
Self-harm	397	474	382	371	527
Drug use disorders	308	249	214	306	354
IHD	252	353	224	191	282
Road injuries	211	246	189	177	242
Cirrhosis	183	189	150	162	206
Breast cancer	168	237	145	134	182
Lung cancer	118	134	76	85	109
LRIs	98	109	79	74	92
Stroke	97	134	82	78	129
Alcohol use disorders	96	106	91	118	182
Brain and nervous system cancer	86	125	81	74	103
Other malignant neoplasms	82	81	56	52	74
Epilepsy	76	81	53	54	75
Bowel cancer	74	103	60	62	91
Other cardiovascular and circulatory diseases	60	68	44	45	64

Table C.6: Leading causes of YLLs, 50–69 year olds, rate per 100,000, 2017

50–69 year olds					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*20,489*	*18,707*	*15,530*	*16,142*	*17,896*
IHD	2,998	2,745	2,422	2,233	2,492
Lung cancer	2,620	2,154	1,556	1,778	2,022

COPD	1,214	986	643	794	928
Cirrhosis	956	729	697	807	828
Breast cancer	824	936	811	725	797
Bowel cancer	824	857	640	683	824
Stroke	715	718	581	595	730
Pancreatic cancer	620	585	509	503	552
LRIs	614	527	470	450	467
Oesophageal cancer	462	479	325	368	479
Stomach cancer	386	357	254	266	294
Brain and nervous system cancer	343	390	304	296	332
Other cardiovascular and circulatory diseases	337	277	235	254	275
Liver cancer	320	248	242	277	244
Self-harm	313	282	278	299	325

Table C.7: Leading causes of YLLs, 70+ year olds, rate per 100,000, 2017

70+ year olds					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*64,638*	*56,222*	*50,425*	*49,498*	*53,550*
IHD	9,459	7,842	7,926	7,205	7,801
Dementia	6,293	6,631	5,711	5,319	5,679
COPD	5,829	4,501	3,178	3,672	4,038
Lung cancer	5,230	3,863	3,066	3,419	3,701
LRIs	4,608	3,887	3,649	3,175	3,217
Stroke	4,156	3,893	3,599	3,488	4,177
Bowel cancer	1,938	1,929	1,557	1,604	1,875
Prostate cancer	1,529	1,317	1,168	1,261	1,438
Aortic aneurysm	1,275	986	780	795	848
Pancreatic cancer	1,215	1,061	1,044	983	1,047
Urinary diseases and male infertility	1,199	936	797	703	648
Breast cancer	1,128	1,303	1,089	970	1,055
Stomach cancer	1,059	889	718	726	783
Parkinson's disease	960	952	847	813	852
Atrial fibrillation and flutter	920	892	863	824	850

Appendix D: Risk factors for YLLs by cause

Please note that the x-axes of the three charts have different scales.

Figure D.1: Proportion of age-standardised YLLs attributable to risk factors, Barking and Dagenham, 2017

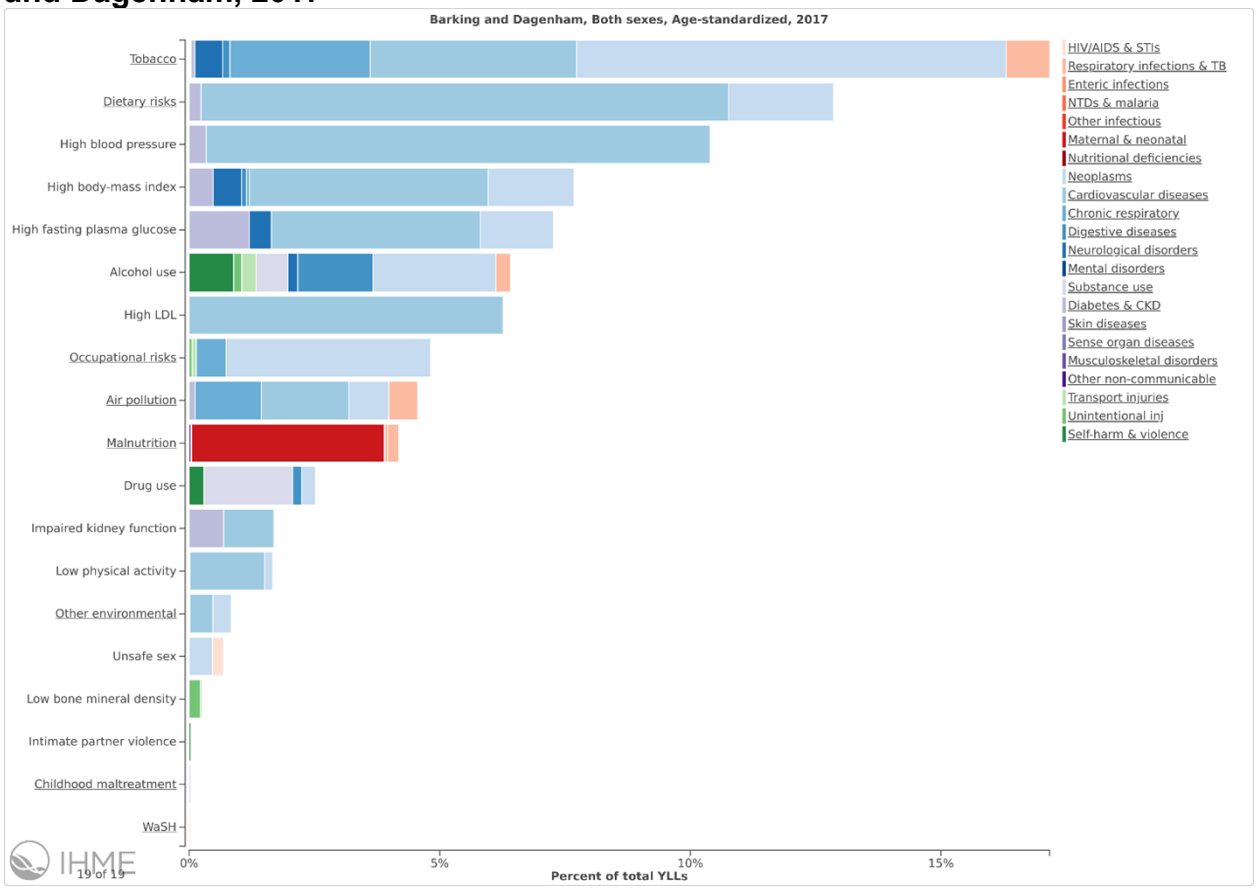


Figure D.2: Proportion of age-standardised YLLs attributable to risk factors, Havering, 2017

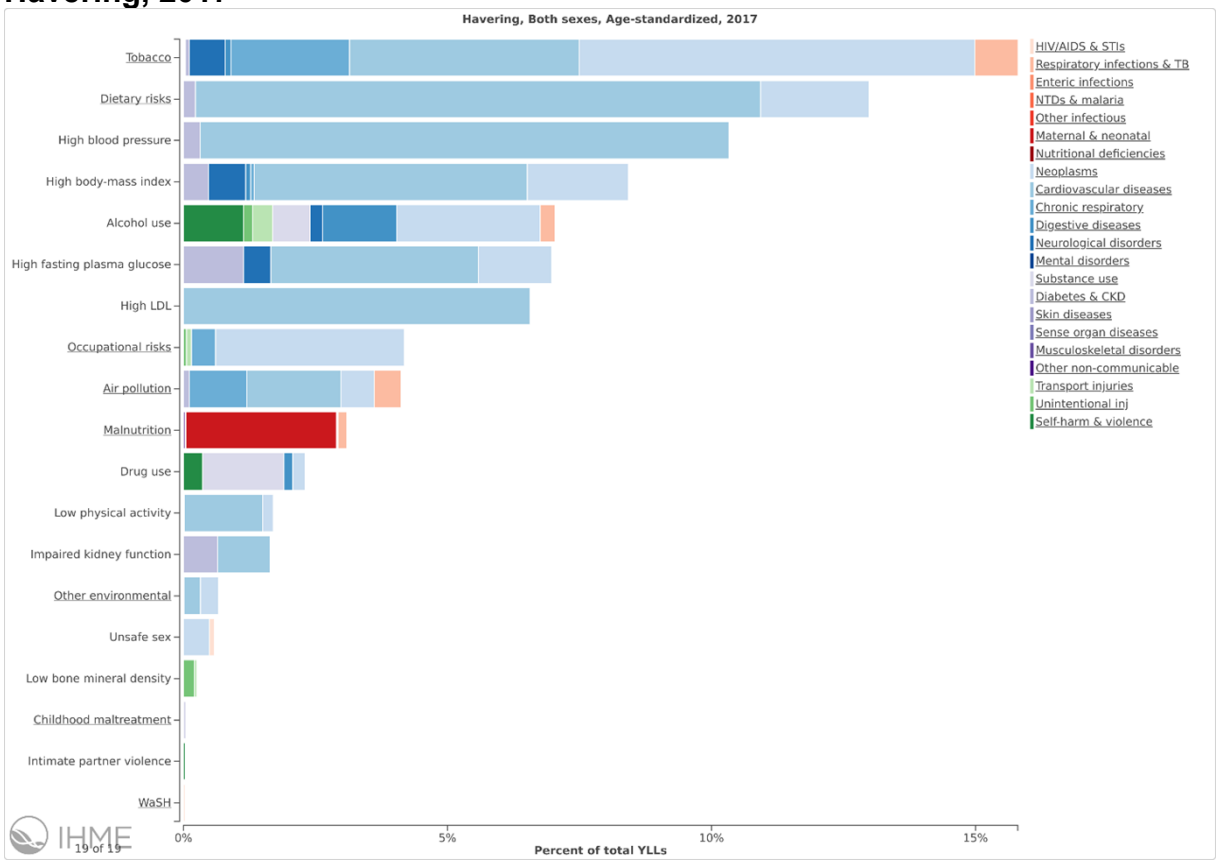
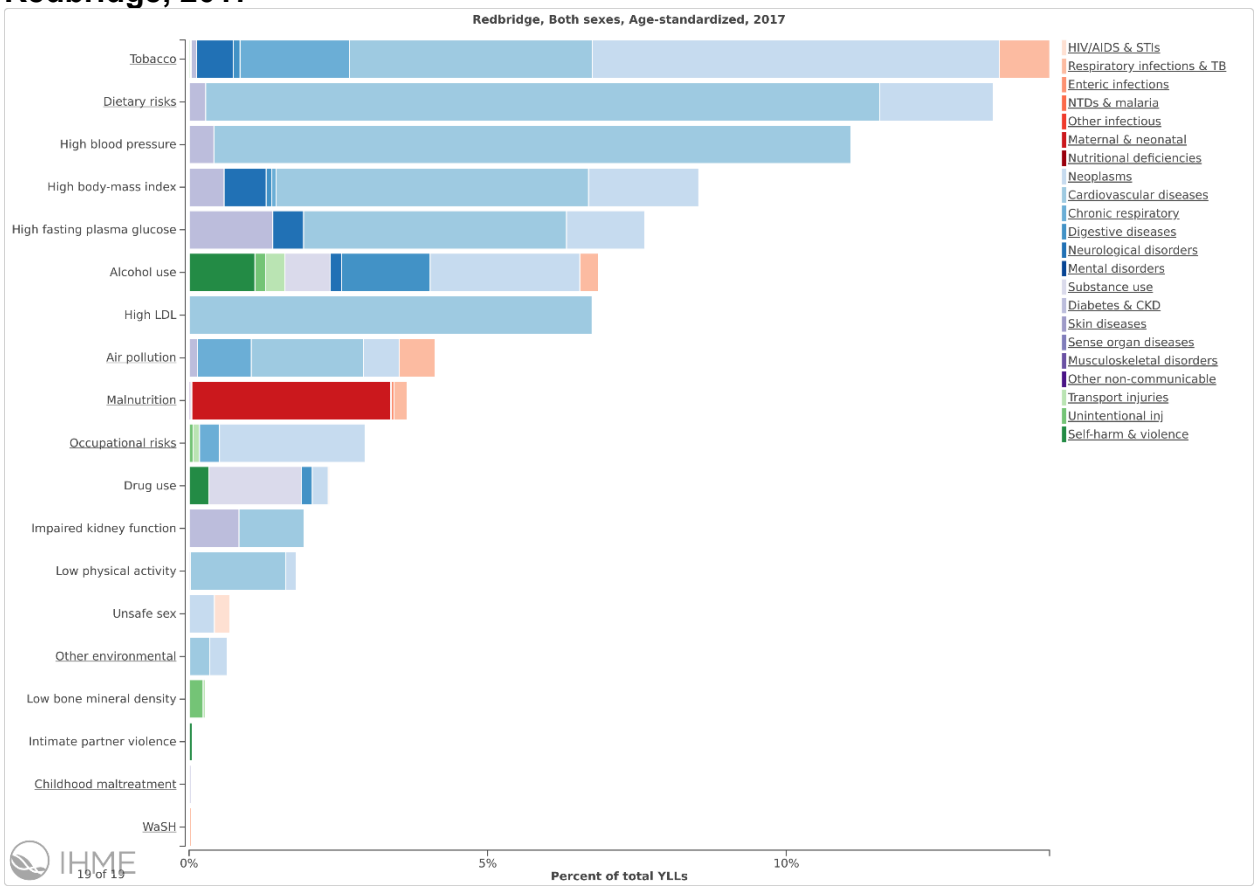


Figure D.3: Proportion of age-standardised YLLs attributable to risk factors, Redbridge, 2017



Appendix E: Limitations of modelled data for ill health

A limitation of the GBD data is the lack of local data available to inform estimates for some conditions. This affects YLDs (and to some extent DALYs) rather than YLLs as better data is available on deaths. This limitation is reflected in the lack of variation between age-standardised estimates for some conditions (e.g. Figure E.1 compared with Figure E.2).[1] Therefore, comparison within and between BHR, London and England should be made with caution for YLDs, as well as for cause-specific DALYs where these are largely driven by ill health rather than death.

Figure E.1: Age-standardised rate of DALYs per 100,000 for low back pain, London boroughs, 2017

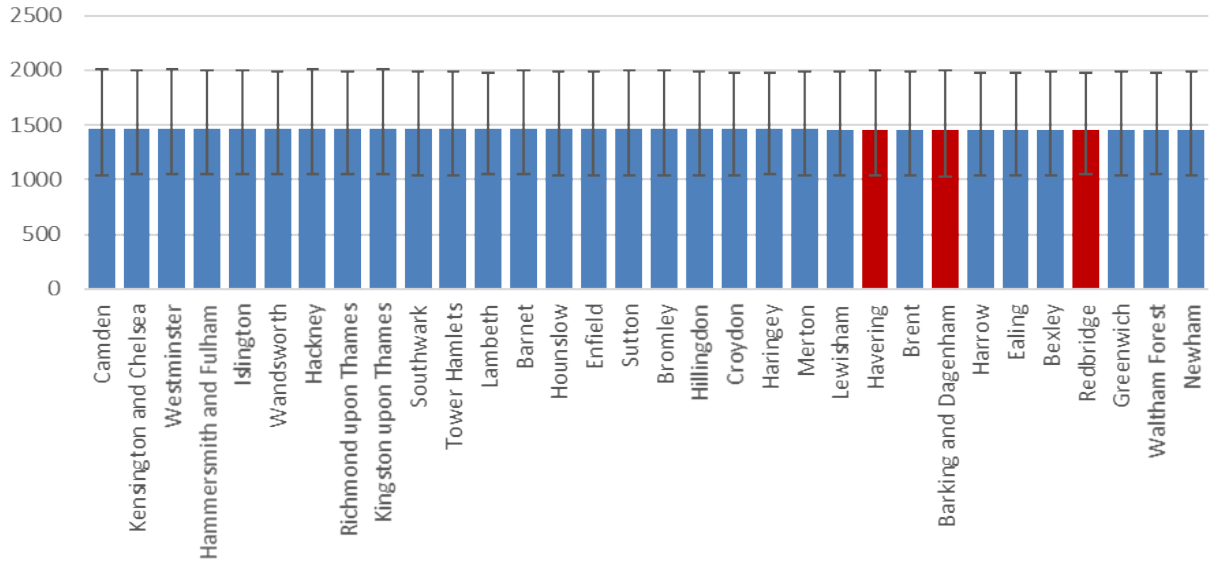
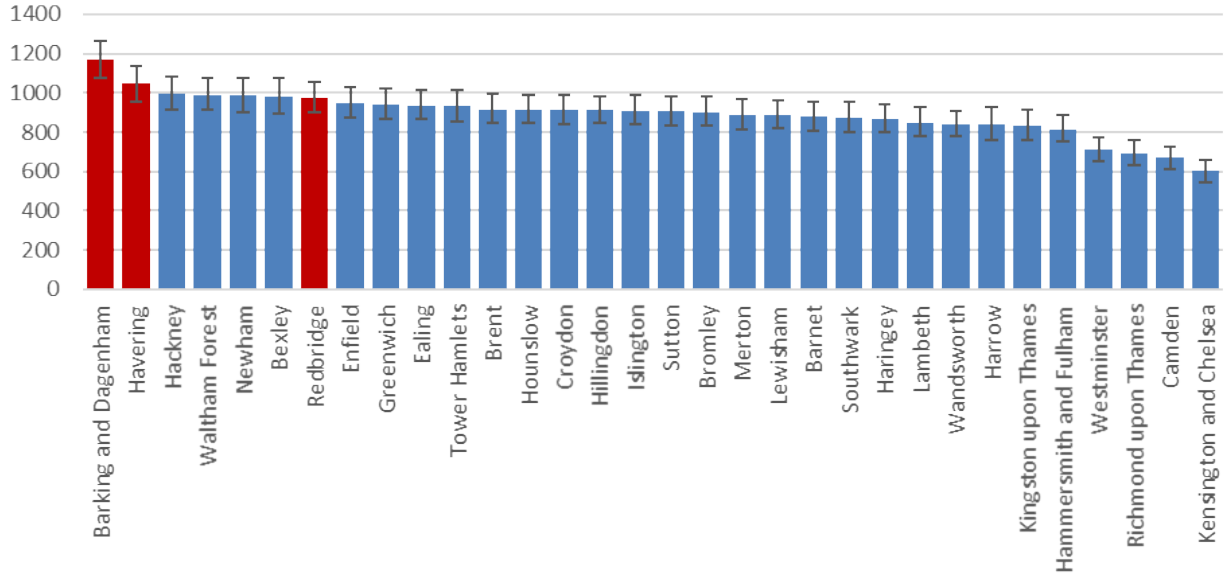


Figure E.2: Age-standardised rate of DALYs per 100,000 for ischaemic heart disease, London boroughs, 2017



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

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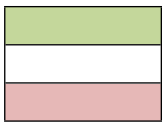
Appendix F: Years lived with disability (YLD) by sex and age group

Key



Significantly lower than the England average
Similar to the England average
Significantly higher than the England average

Sex

Table F.1: Leading causes of YLDs, males, age-standardised rate per 100,000, 2017

Males					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*10,821*	*10,649*	*10,650*	*10,727*	*10,650*
Low back pain	1,345	1,345	1,344	1,348	1,339
Headache disorders	565	565	565	565	565
Depressive disorders	500	501	501	500	501
Falls	425	432	428	431	435
Diabetes mellitus	414	399	405	428	430
Neck pain	413	413	413	413	412
Drug use disorders	402	396	387	405	416
Asthma	369	372	372	375	308
Neonatal disorders	364	361	379	367	365
Dermatitis	357	273	274	276	280
Age-related and other hearing loss	329	330	321	326	338
COPD	307	279	246	278	274
Anxiety disorders	295	294	295	295	295
Other musculoskeletal disorders	244	224	230	229	232
Oral disorders	199	197	198	191	195

Table F.2: Leading causes of YLDs, females, age-standardised rate per 100,000, 2017

Females					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*12,168*	*12,116*	*11,957*	*12,054*	*12,125*
Low back pain	1,564	1,566	1,567	1,572	1,540
Headache disorders	1,113	1,112	1,114	1,113	1,112
Depressive disorders	743	744	745	744	744
Neck pain	565	565	565	565	564
Anxiety disorders	496	496	497	496	496
Dermatitis	448	354	354	357	360
Falls	365	367	364	362	371
Gynaecological diseases	360	403	327	316	353
Diabetes mellitus	359	360	354	371	356
Neonatal disorders	357	352	338	349	349
COPD	355	335	298	329	332

Asthma	352	356	354	359	351
Other musculoskeletal disorders	306	303	299	308	310
Age-related and other hearing loss	303	303	295	301	292
Oral disorders	274	272	274	265	269

Age

Table F.3: Leading causes of YLDs, under 5s, rate per 100,000, 2017

Under 5s					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*3,057*	*2,822*	*2,839*	*2,816*	*2,870*
Dermatitis	722	571	574	572	585
Neonatal disorders	507	497	501	504	501
Asthma	238	236	236	235	215
Congenital birth defects	228	228	241	229	237
Upper respiratory infections	179	179	179	179	179
Diarrheal diseases	130	129	133	127	142
Dietary iron deficiency	124	83	78	62	88
Autism spectrum disorders	108	109	109	110	110
Viral skin diseases	105	104	104	103	105
Urticaria	72	72	72	72	72
Falls	67	68	67	67	68
Epilepsy	60	59	58	59	59
Blindness and vision impairment	53	53	52	51	52
Otitis media	50	50	52	49	50
Vitamin A deficiency	40	19	17	19	26

Table F.4: Leading causes of YLDs, 5–14 year olds, rate per 100,000, 2017

5–14 year olds					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*4,902*	*4,641*	*4,675*	*4,622*	*4,607*
Dermatitis	656	498	499	505	508
Neonatal disorders	401	392	395	398	394
Asthma	397	400	398	401	354
Dietary iron deficiency	353	199	237	194	188
Anxiety disorders	337	351	347	347	351
Conduct disorder	314	324	323	320	325
Headache disorders	259	278	272	270	277
Congenital birth defects	179	178	191	179	189
Falls	158	162	161	159	162
Low back pain	157	168	165	163	164
Upper respiratory infections	152	152	151	151	151
Depressive disorders	145	157	154	152	157
Viral skin diseases	140	138	138	139	138
Autism spectrum disorders	106	105	106	106	107
Blindness and vision impairment	88	88	87	87	87

Table F.5: Leading causes of YLDs, 15-49 year olds, rate per 100,000, 2017

15–49 years old					
Cause	**B&D**	**Haverin g**	**Redbri dge**	**London**	**Englan d**
All causes	*12,315*	*12,337*	*12,128*	*12,314*	*12,334*
Low back pain	1,785	1,782	1,787	1,820	1,775
Headache disorders	1,243	1,240	1,235	1,244	1,232
Depressive disorders	864	862	861	866	859
Neck pain	555	558	551	558	559
Drug use disorders	493	477	477	500	516
Anxiety disorders	487	487	483	481	483
Falls	382	387	385	387	390
Asthma	380	384	382	386	347
Neonatal disorders	370	365	366	362	363
Gynaecological diseases	354	394	311	306	335
Other musculoskeletal disorders	333	326	328	330	331
Bipolar disorder	303	307	303	305	302
Diabetes mellitus	301	304	299	319	313
Dermatitis	300	233	232	231	236
Alcohol use disorders	251	249	256	281	289

Table F.6: Leading causes of YLDs, 50–69 year olds, rate per 100,000, 2017

50–69 years old					
Cause	**B&D**	**Haverin g**	**Redbri dge**	**London**	**Englan d**
All causes	*17,726*	*17,871*	*17,689*	*17,823*	*17,871*
Low back pain	2,767	2,781	2,774	2,780	2,748
Neck pain	1,070	1,073	1,071	1,070	1,071
Headache disorders	1,025	996	1,008	1,013	994
Diabetes mellitus	930	933	925	968	955
COPD	854	820	695	788	811
Depressive disorders	844	838	843	842	838
Falls	655	679	665	665	689
Other musculoskeletal disorders	629	604	604	625	629
Age-related and other hearing loss	606	646	626	615	657
Oral disorders	531	550	548	522	546
Anxiety disorders	432	425	429	429	425
Osteoarthritis	385	415	402	415	431
Asthma	342	346	345	350	319
Blindness and vision impairment	306	312	305	298	310
Neonatal disorders	286	284	292	291	284

Table F.7: Leading causes of YLDs, 70+ year olds, rate per 100,000, 2017

70+ year olds					
Cause	**B&D**	**Havering**	**Redbridge**	**London**	**England**
All causes	*27,116*	*26,845*	*26,784*	*26,868*	*26,734*
Low back pain	2,682	2,687	2,671	2,687	2,640
Age-related and other hearing loss	2,373	2,359	2,358	2,302	2,294
COPD	2,022	1,868	1,649	1,833	1,819
Diabetes mellitus	1,644	1,604	1,615	1,689	1,711
Dementia	1,483	1,452	1,454	1,386	1,369
Falls	1,365	1,354	1,331	1,313	1,359
Neck pain	1,150	1,152	1,146	1,149	1,147
Blindness and vision impairment	1,127	1,075	1,070	1,025	1,028
Stroke	1,027	1,032	979	1,006	1,083
Oral disorders	906	897	903	869	880
Osteoarthritis	820	832	815	839	839
Depressive disorders	764	759	756	754	753
Atrial fibrillation and flutter	572	583	597	617	616
Headache disorders	477	476	472	475	474
IHD	466	440	514	452	443

Please note that the x-axes of the three charts have different scales.

Figure G.1: Proportion of age-standardised YLDs attributable to risk factors, Barking and Dagenham, 2017

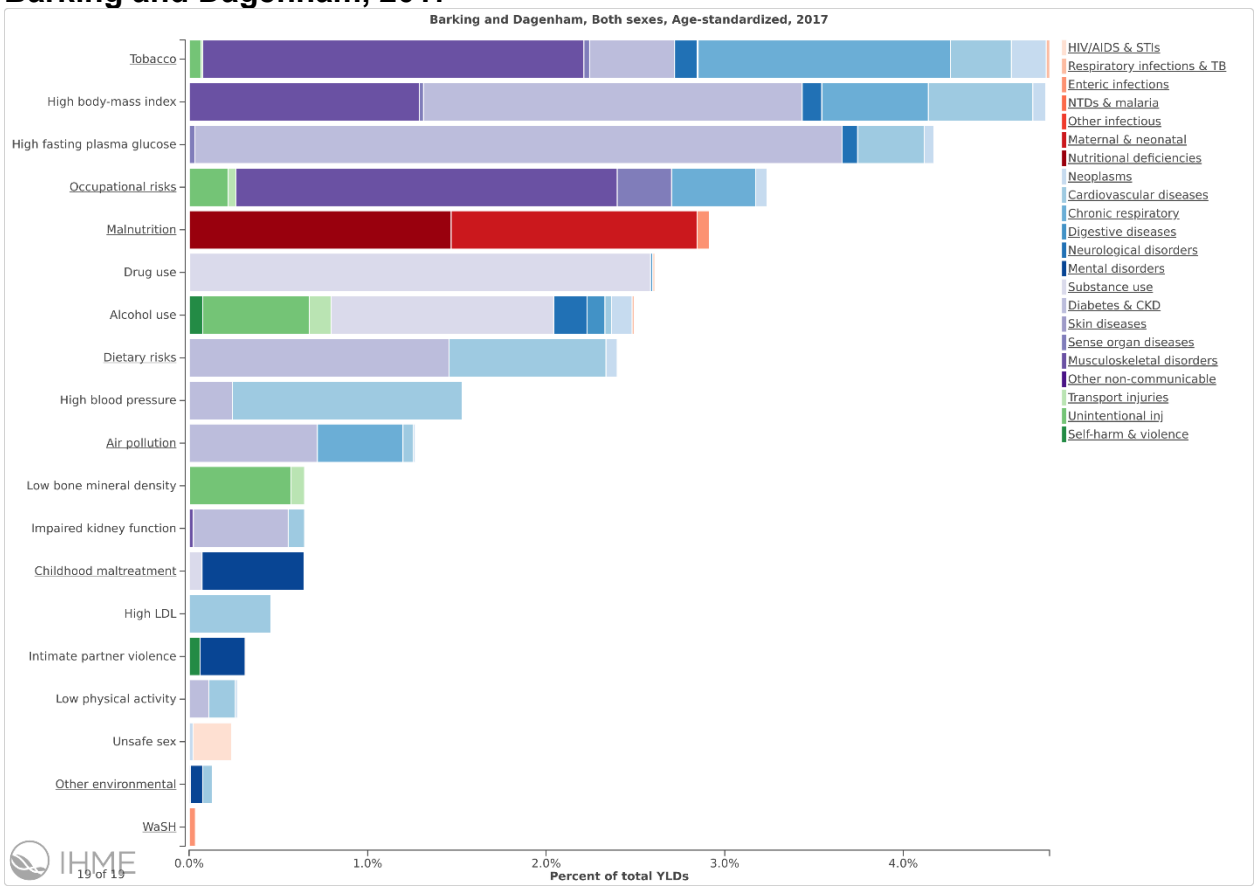


Figure G.2: Proportion of age-standardised YLDs attributable to risk factors, Havering, 2017

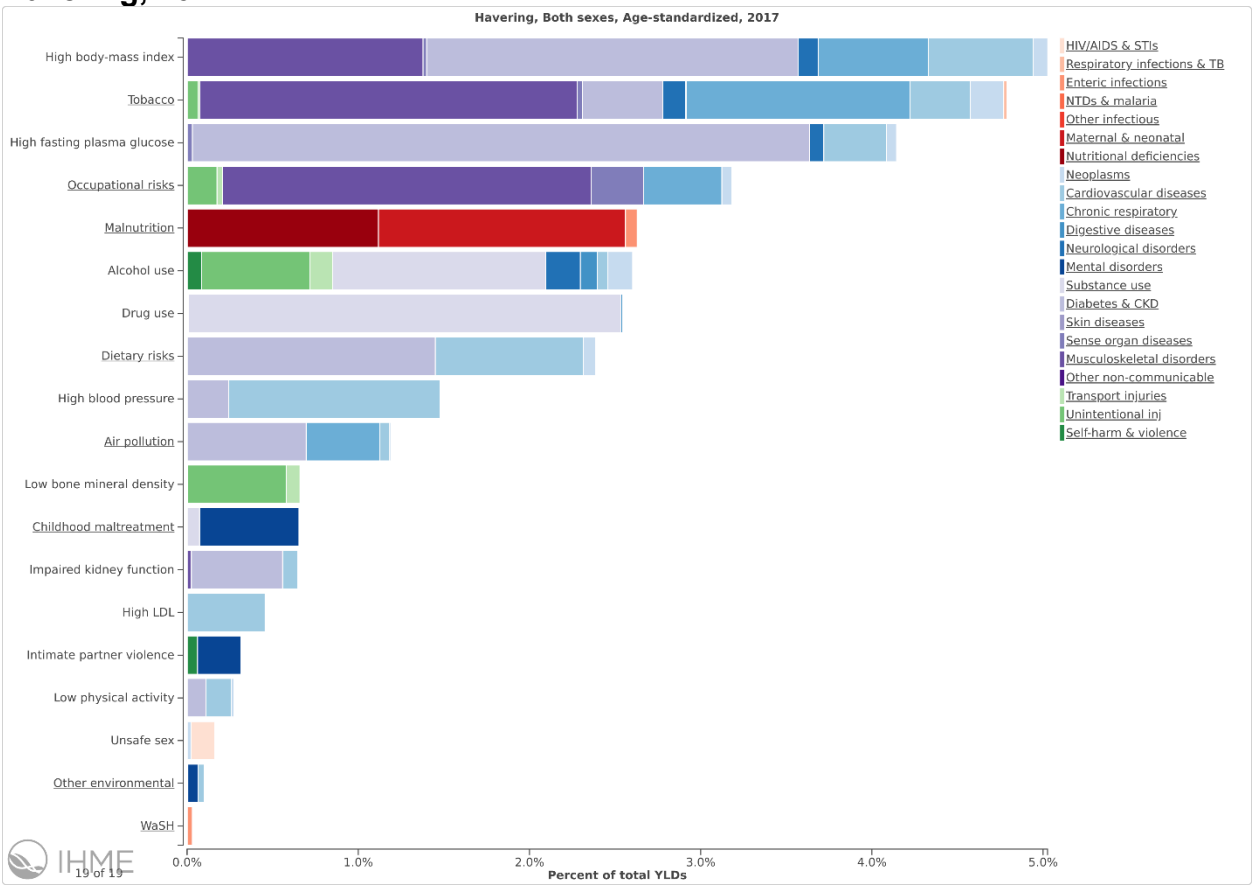
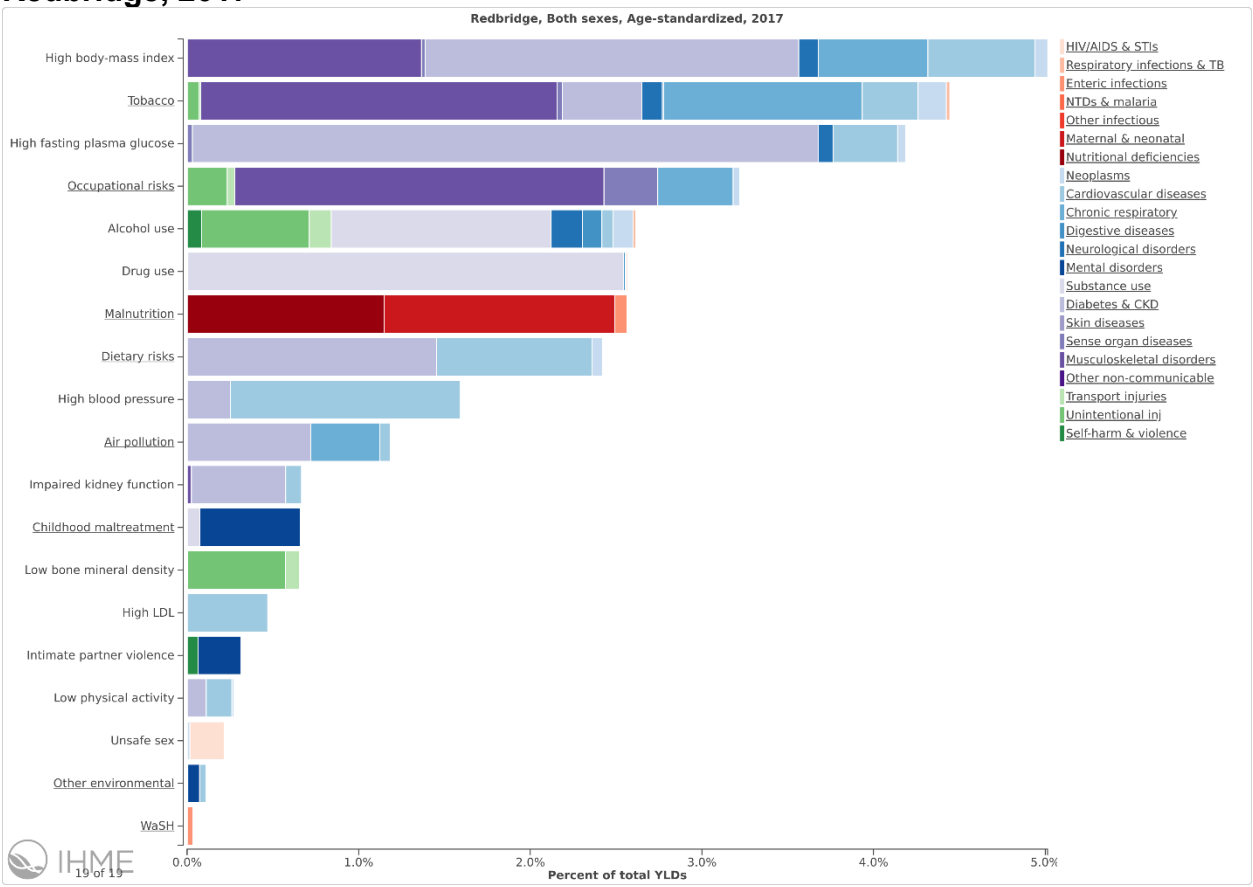


Figure G.3: Proportion of age-standardised YLDs attributable to risk factors, Redbridge, 2017



Comparison with London/England

- Barking and Dagenham and Havering have significantly higher rates of DALYs from ischaemic heart disease and lung cancer than either or both London or England (Table H.1), with Barking and Dagenham also having significantly high rates of DALYs for COPD.
- Redbridge, conversely, has significantly lower rates for either or both London or England for COPD, lung cancer and stroke.

Table H.1: Ranking of 'top 10' conditions with London and England, 2017[1]

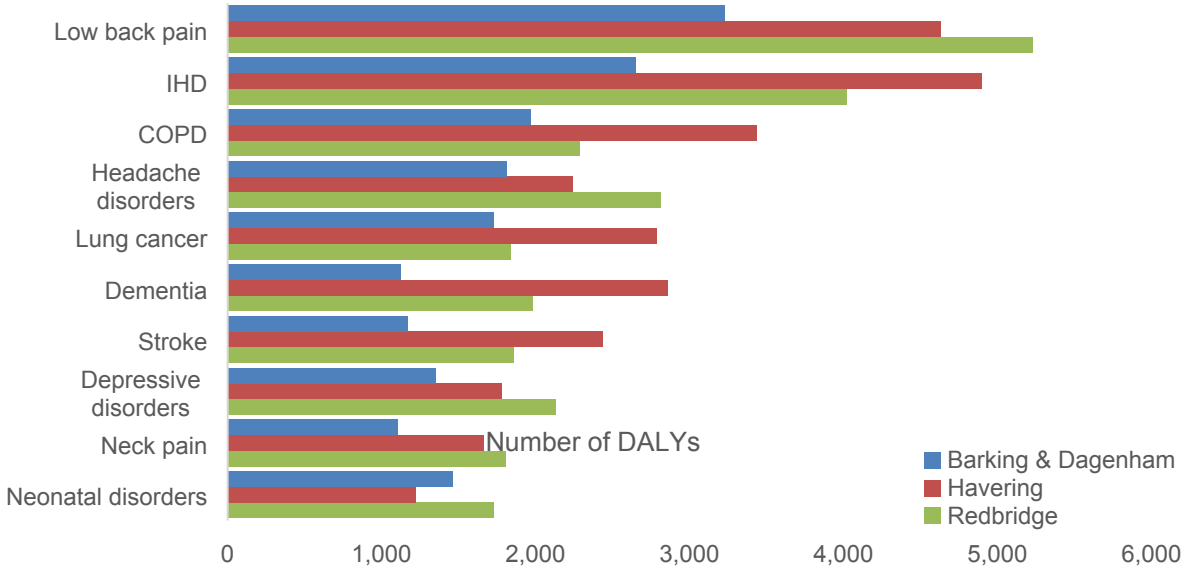
Cause	B&D			Havering			Redbridge		
	Rate	*Lond. rank*	*Engl. rank*	Rate	*Lond. rank*	*Engl. rank*	Rate	*Lond. rank*	*Engl. rank*
Low back pain	1,459	*25*	*46*	1,459	*23*	*42*	1,457	*29*	*57*
IHD	1,171	*1*	*29*	1,046	*2*	*60*	973	*7*	*85*
Headache disorders	844	*12*	*15*	844	*13*	*16*	839	*20*	*61*
COPD	880	*1*	*18*	724	*11*	*65*	560	*28*	*133*
Neonatal disorders	756	*9*	*62*	619	*26*	*134*	626	*23*	*128*
Lung cancer	804	*1*	*14*	618	*6*	*59*	466	*25*	*126*
Depressive disorders	625	*14*	*18*	625	*11*	*12*	623	*17*	*40*
Neck pain	491	*10*	*13*	491	*11*	*14*	490	*17*	*39*
Stroke	501	*2*	*88*	497	*4*	*92*	438	*19*	*130*
Falls	475	*11*	*98*	473	*13*	*104*	461	*16*	*127*
Diabetes mellitus	453	*20*	*76*	439	*28*	*89*	439	*26*	*87*

Crude numbers: what is the burden of disease?

- As stated previously, crude numbers show the burden of disease regardless of population size and structure. This type of analysis may be useful for service provision; however, across BHR, this may over-represent conditions which are more prevalent in Havering and Redbridge than Barking and Dagenham given their larger populations.
- Figure H.1 shows the top ten conditions contributing to the crude DALY burden across BHR. Together, these account for two-fifths (39%) of DALYs.
- This is similar to the conditions with high age-standardised rates, except that dementia appears in the top ten and neonatal disorders are less prominent.

[1] Based on the top ten causes for each of the three boroughs (11 causes total). London/England rank is of 32/150 local authorities respectively ordered from high to low. Shading shows values that are significantly higher (red) or lower (green) than London/England based on non-overlapping confidence intervals only. Numbers in grey indicate conditions with low variability across England; for these four conditions, the standard deviation across the rates for 150 local authorities was less than 2% of the average rate for that condition (compared with 7–23% for the other conditions in Table H.1).

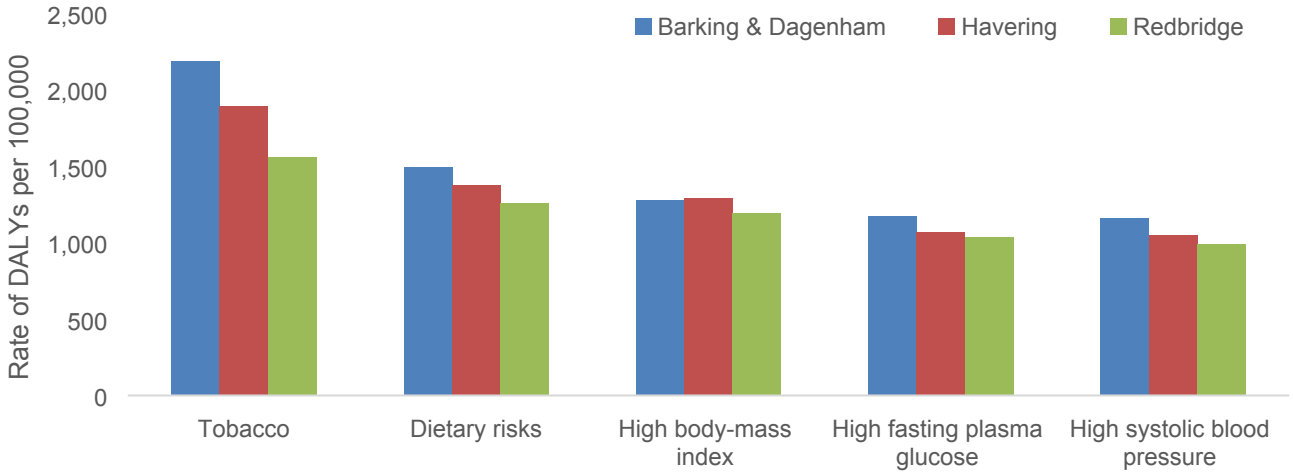
Figure H.1: Top ten causes of DALYs based on total DALY burden across BHR by borough, 2017



Risk factors for DALYs

- Figure H.2 shows the five risk factors with the highest associated DALY rates across BHR. Tobacco is the leading risk factor across all three boroughs.

Figure H.2: Age standardised DALY rates per 100,000 – top five risk factors contributing to DALYs in BHR



HEALTH AND WELLBEING BOARD

11 June 2019

Title:	LGBT+ Policy Statement and Action Plan
Report of the Health and Wellbeing Board	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** No
Report Author: Fiona Wright, Consultant in Public Health, LBBD Susan Botros, Community Development Officer – Equalities, LBBD	**Contact Details:** E-mail: susan.botros@lbbd.gov.uk
Sponsor: Tom Hook, Director of Policy and Participation, LBBD	

Summary:

The attached document is the policy statement and action plan for our LGBT+ community in Barking and Dagenham.

The policy statement is a standalone document informed by the LGBT+ community needs assessment. The needs assessment will be published on the LBBD website once final checks have been completed.

The policy statement outlines the context for this work and the key messages and recommendations that the council will take forward. To better engage with the LGBT+ community and improve outcomes, for example in health, wellbeing and community safety requires actions broader than the council. The document also makes recommendations for partners.

It is suggested that the Partnership Equalities Group would have oversight of delivery of the recommendations, reporting on progress on a six-monthly basis.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) Endorse the LGBT+ policy statement and action plan and associated recommendations and

(ii) Approve the Partnership Equalities Group having oversight of delivery of the recommendations.

1. Financial Implications

Implications completed by Murad Khan – Group Accountant

1.1 This report is mainly for information. As such, there are no financial implications arising out of the report.

2. Legal Implications

Implications completed by: Dr Paul Feild Senior Governance Solicitor

2.1 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 that the providers of health and social care services work in their delivery in an integrated manner.

2.2 As observed in the body of this report, the proposals are consistent with the legal responsibilities of the Board.

2.3 It is unlawful under the Equality Act 2010 to discriminate against someone on the grounds of their:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

2.4 These qualities are called protected characteristics and our LGBT+ community may have one or more of the characteristics. The Council and its partner providers of health and social care services must work together to ensure that services and outcomes are not discriminatory.

List of Appendices:

Appendix A LGBT+ Policy Statement and Action Plan

Appendix A

Barking Dagenham

LGBT+ position statement and action plan

London Borough of Barking and Dagenham, March 2019

Foreword by the Leader of the Council

As Leader of the Council I am proud of the progress that has been made over recent years to tackle inequality in the borough. We have shown that together we are stronger, and this is reflected in our vision; one borough; one community; no-one left behind.

Our LGBT+ residents and communities make an invaluable contribution to our borough. Our vision is to create a place where people understand, respect and celebrate each other's differences. A place where tolerance, understanding and a sense of responsibility can grow.

Barking and Dagenham is a vibrant, diverse and changing borough. These are things we should all celebrate. However, many members of the LGBT+ community still experience discrimination, their health and wellbeing is worse than their fellow citizens and services are not always suitable for their needs. This is not acceptable. We want everyone to enjoy full equality and fulfil their potential. There is much we can be proud of but more we can do.

The tragic deaths of four young men in the borough have further highlighted the need for a better understanding of the needs of our LGBT+ community. This report is an important step towards that. These deaths have affected confidence in public services and we must all work together to restore this trust. A fundamental question has to be asked as to how welcoming and safe Barking and Dagenham feels to LGBT+ individuals and what can we all do to improve this.

We have engaged with members of the LGBT+ community in carrying out the Needs Assessment which has informed this report. They have told us what issues they face and areas that need to be addressed. We have taken information and advice from stakeholders and experts. We must now ensure that we tackle the issues and continue the dialogue. The Council, partners and the community will commit to collectively delivering the actions set out in this report.

If we are to realise our vision we must ensure that everyone is valued, respected and our differences are celebrated. And that's why I have said time and time again that one of my proudest moments as Leader has been representing Barking and Dagenham at Pride in London.

It was for me the highlight of my year and for good reason. The Council, community, partners, and our LGBT+ youth community contributed to an amazing event. The joy and pride on our young people's faces as they were cheered by the crowds and their excitement and energy was visible for all to see. Seeing themselves reflected in the people around them increased their confidence and self-esteem. For me this encapsulates the importance of tackling inequality and celebrating diversity. We all must feel like we belong.

Cllr Darren Rodwell

Summary

Barking and Dagenham is an increasingly diverse borough. The Council celebrates this and wants to create a place where all residents are able to have equality and enjoy their full potential. Discrimination, hate crime, and inequalities must be tackled. These ambitions are stated clearly in core Council documents.

Locally and nationally there are many examples of LGBT+ people having poorer health and wellbeing or suffering such as through domestic violence or mental health issues. They also may not have fair access to services.

There are some good examples of local community infrastructure and opportunities for local LGBT+ people and organisations to engage with the community. Examples include the Practitioners and Activist Group and the LGBT+ Forum, Huggett's LBT women's group, Diverse Communities for young people and regular social clubs. However, this infrastructure needs strengthening, for example, to enhance mutual community support and service advocacy.

The Stephen Port murders shocked the LGBT+ community. The report from the Independent Office of Police Conduct is awaited. The distrust of public services within the borough is recognised. The Council will work with partners and the community to restore trust.

A community needs assessment, developed with stakeholders and the community sits behind this report. A survey, interviews and group discussions and best practice guidance all informed the needs assessment findings. Recommendations were tested with the community and stakeholders.

Four themes emerged and inform the high level recommendations of this report.

- Recommendation 1): inclusive, visible leadership and accountability - particularly from the Council and the police
- Recommendation 2): training - and inclusive leadership to increase skills and understanding in working with the LGBT+ community and promote a change in culture
- Recommendation 3): community and resident engagement infrastructure – strengthen this to support the community and enable them to engage with and help improve services
- Recommendation 4): considering the needs of the LGBT+ community in commissioning and providing accessible and visible services that meet the needs of the community – including services such as mental health and sexual health and a focus on those experiencing multiple disadvantage
- Recommendations 5)6): community safety and health and wellbeing – tackle priority issues with specific recommendations for action, for example tackling hate crime, social isolation and substance misuse

The Council and partners will follow through on the recommendations of this report and will collectively monitor delivery of actions identified to ensure these lead to improved outcomes for the LGBT+ community.

Commitment

Figure 1: The LBBD Commitment to our LGBT+ Community

We are a borough that prides itself on our diversity and we must continue to strive for equality, inclusion and respect for *all* residents. So far we have not achieved this for our LGBT+ residents.

The Council is committed to working with the LGBT+ community and relevant stakeholders to take forward the recommendations of the LGBT+ Policy Statement and Action Plan set out in this report. This document will be published, and we will report progress to the Equalities Partnership every six months.

We want to strengthen our engagement with the local LGBT+ community. With good community involvement and advocacy and increased understanding of local issues, we can work together to strengthen local policies and improve visibility, accessibility and outcomes of our commissioning and service provision.

The discrimination and inequalities that our LGBT+ residents face will not be tolerated. We will work with partners and the community to regain trust in public services and support the LGBT+ community to thrive and flourish.

Introduction

Barking and Dagenham is becoming an increasingly diverse borough. It has a history of strong advocates for equalities. The Council works hard with partners and communities to embrace diversity and equalities. The LGBT+ community make a huge contribution to Barking and Dagenham. However, both at a local level and at a national level there is much more needed to understand and address the needs of the LGBT+ community, and support and engage with them to co-produce solutions. This document is the result of a collaborative piece of work responding to local drivers. We know that overall LGBT+ people have poorer wellbeing than the general population. For example, substance misuse, domestic violence, and mental health issues are prevalent in sub groups of the LGBT community. We have heard from the local community that some public services are not seen as accessible or appropriate to their needs.

The abhorrent Stephen Port murders have shaken the community. Port was convicted of the murders of four young men between 20 and 25 over a period of 16 months. These took place over a period of less than 16 months and three of the four bodies were found in a similar location within half a kilometre of a church in Barking, close to Ports flat.

A series of community meetings facilitated by the Barking and Dagenham Council for Voluntary Services (BDCVS) highlighted the mistrust and disconnect between the local LGBT+ community and public institutions in the Borough. Whilst brought into stark relief by the Port Murders this mistrust needs to be understood as more long-term and deep-rooted.

We have had a clear message that support is wanted in developing and strengthening local LGBT+ infrastructure. This would facilitate mutual support in the community and a strong system of advocacy for policy and service improvement. There is also strong desire for action and public accountability. The Council is committed to working with the LGBT+ community to take action (see Figure 1, above).

This document outlines: the background and context, approach of the LGBT+ community needs assessment, key findings, high level recommendations for the Council and partners. It sets out the next steps to take action to end stigma and discrimination in our borough and ensure our services are visible, accessible and appropriate to the needs of our LGBT+ community.

This document summarises the high-level recommendations that the Council will take forward to support the LGBT+ community in Barking and Dagenham (B and D). **It also invites partners to join us in being more responsive to supporting the LGBT+ community locally.**

Aim of this report

The context of this report is within the national and local evidence of poor health and wellbeing, discrimination, poor access to services and a stretched local community infrastructure for the LGBT+ community. The Stephen Port murders drive an urgent need to work more closely with the local community and stakeholders to address the concerns of the local LGBT+ community. We are also in a time of unprecedented pressure on public resources and many widening inequalities. However recent national LGBT+ policy and our own commitment to improving equalities for all residents provides an opportunity for transformation.

The report is informed by the 2019 LGBT+ Community Needs Assessment, which can be found online.

The purpose of this document is to:

- outline the key issues relating to health and wellbeing, community safety, community engagement and partnership work for members of the LGBT+ community who live, work, visit, study in Barking and Dagenham, based upon the Community Needs Assessment.
- to outline the Council's commitments and to make high level recommendations to inform policy and strategy, commissioning and service provision of the Council and key partners to address the needs of the LGBT+ community.
- to describe next steps for the Council and partners to work together to take action.

Overview of the Policy Context

The Borough Manifesto sets out a strong vision for Barking and Dagenham. A partnership and community-based document, it was developed with the help of responses from more than 3000 residents. Fairness is a key theme, cutting through the document that aims to address inequalities. Other themes of employment, housing and health and social care are relevant to our LGBT+ community.

The Equality and Diversity Strategy and action plan sets out a vision for equality and diversity: to create a place where people understand, respect and celebrate each other's differences. Where tolerance, understanding and a sense of responsibility can grow and all people can enjoy full equality and fulfil their potential. It goes beyond the Council's duties under the 2010 Equality Act for all those with protected characteristics (including sexual orientation, sex, gender reassignment) and also pays regard to socio-economic factors. Priorities include fair and open service delivery, for example through engaging communities in service development and equality impact assessments. It aims to improve outcomes across a range of areas including on domestic violence and hate crime. A programme of festivals and events celebrates and raises awareness of the diversity within the borough.

The Independent Growth Commission Report, 'No one left behind', sets out how the Borough can utilise its growth potential to improve the outcomes for all Barking and Dagenham residents.

The Joint Health and Wellbeing Strategy 2019-2023 recognises the importance of working with communities and building resilience. It has priority themes of on the best start in life, early diagnosis and intervention and building individual and community strength. Key areas of focus are mental health and domestic violence.

Charter for Faith & Belief Inclusion: signed on behalf of the Council, this charter includes principles of "..an inclusive society where people of different faiths and beliefs have strong and positive relations. ….that intolerance has no place in our communities or workplaces, and that diversity adds value to our society; … encourage people to engage more across differences and learn to understand each other better" and a commitment to working together with other signatories in a spirit of partnership to promote good relations between people of different beliefs in our communities, workplaces and wider society.

Stephen Port: was jailed for life in November 2016 after being found guilty of the four murders, three counts of rape and a string of other offences. The matter was subject to an investigation by The Independent Office of Police Conduct (IOPC).

The IOPC investigation explored 'whether the police response to the deaths of all four men was thorough and appropriate in the circumstances, including whether discrimination played any part in actions and decisions. At Port's trial a police commander who leads of the Met's Specialist Crime and Operations Unit offered personal letters of apology to the victims' families for the missed opportunities to catch Port sooner. Further background reading on the Post case is available online. The Council has been in communication with the police and the LGBT+ community since the murders and during the course of the investigation and will stand by its LGBT+ residents and communities

Community infrastructure: within a challenging context, the local LGBT+ community have worked together as a community and to engage with the public sector to ensure their voice is heard and their needs met. The LGBT+ Forum, the Practitioners Forum and BDCVS have worked hard in this regard. There are also dedicated individuals and innovative services throughout Barking and Dagenham. Much is happening but the infrastructure needs recognition, supporting and strengthening.

National survey and action plan: the Government Equalities Office undertook a comprehensive survey of 108,000 participants, the largest of its kind in the world. In July 2018 it published an LGBT action plan to improve the lives of LGBT nationally. Key priorities include ending bullying in schools and taking further action on hate crime and reducing health inequalities related to LGBT.

Our Approach

LGBT+ are a diverse group or groups. There are also communities within communities e.g. people who are from black and minority ethnic (BAME) groups or disabled who may experience multiple disadvantage. There will also be political and cultural differences between sub groups of the L,G, B, T, + community.

In order to propose recommendations for action to support/engage with our LGBT+ community we undertook a Community Needs Assessment (CNA). Figure 2 shows the approach and scope of our CNA.

The Community Needs Assessment sought to inform service commissioning and provision, community involvement and engagement and accountability and monitoring. It was purposefully broad in scope – not just health and wellbeing but also community safety, community assets and engagement. This was particularly important given our local context. The Community Needs Assessment focused on adults, over 18. However where key messages came through from stakeholders and the community about needs for younger age groups, these have been reported, for example in relation to bullying.

It was also overseen by a multi-agency steering group of stakeholders (including health service, police, Council staff, Greater London Authority) and community representatives who were involved from identifying the scope and methods through to developing key messages and a long list of proposed recommendations.

The decision to use multiple methodologies/information sources was important. Any one method/information source can only give a limited picture. For example, national and local data sources on the numbers of LGBT+ are inadequate; best practice guidance is also very limited and much of it is drawn from consensus views of special interest bodies rather than peer reviewed research. Our own community survey, despite wide promotion, was under representative of certain groups (e.g. BAME and women).

The triangulation and cross checking of these multiple sources of information and strong engagement in stakeholders and the community in our process, (focus groups, interviews and cross checking the findings) however meant that we are able to draw key messages and proposed recommendations from the CNA.

One output of the CNA is a technical evidence report available on the Council and BDCVS websites. The key messages and proposed recommendations (see Appendix of full report) were discussed at two points in time with a wide range of stakeholders in order to sense check, identify omissions and help with prioritisation of the recommendations. Community representatives and key stakeholders also commented on the draft CNA report.

This document is the other key output from the needs assessment intended for those involved in developing policy and responding to the findings of the needs assessment. It sets the context and describes key messages drawn from the needs assessment and feedback from stakeholders. It then outlines a high-level set of recommendations for action by the Council and recommendations for partner organisations. There is a clear audit trail of how they relate to the recommendations discussed as part of the community needs assessment.

It is now essential, as recommended in best practice guidance and congruent with our own policies as a Council, that we continue to work with key stakeholders and community representatives in further developing these policies and priorities. The community is also clear that they want to see implementation of the needs assessment and to be engaged in that process.

The actions set out in this document will be reported on a six-monthly basis to the Borough's Equality Partnership Group. A representative from the LGBT+ community will be invited to sit on the partnership to help monitor its implementation.

Figure 2: LGBT+ Community Needs Assessment

What did it cover?

- Health and wellbeing e.g. sexual health, mental health
- Community Safety e.g. hate crime
- Community Engagement and Partnership Working e.g. community infrastructure

What information sources were used?

- Community survey of people working, living, studying in the borough (108 respondents)
- Interviews with stakeholders, including clinicians, commissioners and providers
- Focus groups and group interviews with stakeholders
- Review of published and unpublished literature
- Additional short mapping of community assets and services within the borough

What was the output?

Triangulation of these multiple sources of information were used to identify:

- issues facing LGBT+ community
- current service provision, assets and gaps
- best practice and potential solutions

and draw out key messages and proposed recommendations in relation to health and wellbeing, community safety, community engagement and partnership working.

Where can I view it?

The full needs assessment is available at www.lbbd.gov.uk and BDCVS website

Size of the LGBT+ in Barking and Dagenham

The table below summarises the estimates of LGBT+ in Barking and Dagenham from available information sources.

Nationally, there is as paucity of information sources. This in part, relates to concerns of the LGBT+ community in disclosing their identity. It may also reflect research priorities.

Estimates from three different sources for LGB in Barking and Dagenham are shown in Figure 3. The most robust is from PHE, 2017: final "synthesised" estimates from the 15 most robust sources of a review of 22 national surveys. GP surveys will be based upon those registered with primary care. Stonewall adopted the UK Department of Trade and Industry's 2003 estimate. The PHE reports LGB variability between the sexes where males are more likely to identify as gay (1.7%) than bisexual (0.6%) while women are as likely to identify as lesbian or bisexual (0.9% each). There are no official estimates of gender variant but the GIRES (Gender Identity Research and Education Society) give estimates as in Figure 3. The proportion of LGBT+ in different sub groups such as BAME and by geographical area is discussed further in the Community Needs Assessment. These data sources are limited, emphasising the importance of improved monitoring and data collection at local and national levels.

Figure 3: Estimates of the number of LGBT+ people in Barking and Dagenham

LGB population over 16. Three estimates:

- 2.5 % to 5.9%, 3800 to 9000 LGB people (PHE estimates)
- 3.9% of the population, 6000 LGB people (GP survey)
- 5-7% of the population, 7700 – 10700 people (Stonewall estimates)

Gender variant population:

- 1% of population, approximately 1500 people
- 0.015% transitioned, 0.025% referred for consideration of transition. This would be 20 to 40 people respectively in B & D

Key Messages and Findings

1. Leadership and accountability key messages

1.1 A very strong message from the community and from key stakeholders was the lack of trust and feeling let down by public services. Concern focused on the need to see action to improve outcomes for LGBT+ in Barking and Dagenham. Key issues highlighted were the need for:

- Better engagement with the community and public services;
- Clear follow up action as the result of the community needs assessment;
- Developing and strengthening community infrastructure;
- Improving individual's service experience and outcomes for the LGBT+ locally.

1.2 Key assets locally to build trust are two active community engagement points: The Practitioners and Activist Group and the LGBT+ Forum. The Council is committed to working with these groups and the wider LGBT+ community to address their needs in particular. The development of this piece of work has led to more active engagement again between the Council and the community and provides a platform for further action.

1.3 Best practice and proposals to take this forward come from the national literature and our local stakeholders. The National LGB&T Partnership recently published a toolkit (2018) for creating a 'whole systems' approach to tackling inequalities in health and wellbeing (this includes the wider determinants of health such as poverty, housing etc.). Whilst it is developed for health and wellbeing it provides a useful framework for the approach to action to improve outcomes for LGBT+ in Barking and Dagenham. Key elements included are:

- How critical it is to involve LGBT+ people from the beginning and that they are central to the whole system;
- Recognising the complexities of individuality and intersectionality;
- Training staff in public services and making data collection a priority to better understand needs;
- Encouraging and developing collaboration;
- Assuring high-level accountability.

1.4 Our local stakeholder views chime with many of these elements and inform our recommendations. There was a strongly held view that the Council and partners needs to take action on this Community Needs Assessment (CNA) with named accountable officers and feedback to the community on progress. There was also support for the Council to lead the way in action to support the LGBT+ community. Best practice leadership by the Council and its partners embedded throughout the management hierarchy is important to ensure incremental system change is realised. A culture change is needed, that moves beyond providing staff training. There was a strong feeling that a Council LGBT+ champion was needed to drive forward the recommendations of this report.

2. Service provision and commissioning key messages

2.1 Whilst LGBT+ people face the same access barriers as other people in general, for example housing waiting lists, the local survey and interviews showed that LGBT+ people still face an additional range of difficulties due to their experiences. LGBT+ people are entitled to equal

treatment by public services under the Equality Act 2010, however some key issues have been highlighted, these include:

- hostile, dismissive or inappropriate comments or attitudes from front-line staff;
- fear of hostility or other unwelcoming behaviour from front-line staff which prevents any contact being made;
- lack of staff awareness about aspects of services that accommodate LGBT+ needs;
- misinformation e.g. on cervical screening.

2.2 Transgender individuals experience significant issues with service provision, particularly in connection with potential gender reassignment.

2.3 Lack of information was reported by both local service users and professionals – limited knowledge, for example of specialist services and resources available (e.g. social support) for LGBT+.

2.4 The issue of intersectionality came up frequently. For example, disabled people (20% of the survey sample) appeared to have a number of inequalities; half of them reported having experienced domestic abuse. BAME LGBT+ members experience higher rates of hate crime. Lesbian and bisexual women experiencing high levels of mental health issues.

2.5 Stakeholders and survey respondents called for specialist LGBT+ services, in particular for mental health, domestic violence and sexual health and for both local and out of borough (for privacy) services.

2.6 Best practice solutions to create an accessible, appropriate, visible service that improves outcomes for the LGBT+ community are again found in the literature, such as the National LGBT+ Partnership document above, with additional insights from our local stakeholders.

2.7 Engaging the community in planning and development of services is a strong feature of the *Still Out There* report and the Equality Network publication, *Engaging LGBT People in Your Work*. Their recommendations include that service providers take more responsibility to engage with the LGBT+ community and there is collaboration and community engagement in service commissioning. This was echoed by our local stakeholders who made the case that involving LGBT+ people in the development of services is essential – community engagement and collaboration creates well-informed service provision based on real experiences and insights. This also reduces marginalisation and creates more representative services.

2.8 *Out of Our Mind* advised that commissioners could address LGBT+ needs through service specifications and monitoring outcomes to support inclusion; this also features in the national partnership guidance. Our local stakeholders, for example commissioners, flagged that gender identity and sexual orientation monitoring is important for services to be tailored to meet the community's needs and encourage inclusivity. Developing LGBT+ friendly Key Performance Indicators (on equality and diversity) and operationalising them across service provision can encourage robust monitoring standards. KPIs are also a way of closing the gap on intersectional vulnerabilities. Contract performance monitoring for service improvement can generate positive change. As part of this it is important that LGBT+ service evaluations and monitoring are understood by the LGBT+ community so that it is not seen as intrusive but a tool to develop inclusive services.

2.9 *Still out There* reports that commissioners should develop specialist service provision alongside mainstream provision, in part to protect LGBT+ from other clients. Segregated time slots may be

sufficient. Local stakeholders expressed a view that both specialist and generic services should be developed. Out of borough services may also have a role to play.

2.10 Training was raised as an important issue locally and seen relevant particularly to the health and care system and the police. It was noted that if LGBT+ people were aware of staff having had the appropriate training, then they would be more inclined to access certain services. Trained frontline staff with a good understanding of LGBT+ identities are essential.

2.11 Similarly survey respondents and stakeholders saw visibility as important. More open signs of inclusivity, particularly in frontline services would encourage access. Examples could be a visual clue such as a rainbow flag, position statements or an accreditation system such as the GP Lanyard scheme.

2.12 Clear referral pathways and information about services in and out of borough is important to professionals and service users.

3. Community infrastructure and engagement key messages

3.1 Social isolation is an important issue amongst the LGBT+ community in Barking and Dagenham (See below). A strong community infrastructure is important for wellbeing and also supports community safety.

3.2 Stakeholders reported that there was a lack of LGBT+ community spaces and need for better infrastructure. The community survey also voiced a need for specific LGBT+ support, ranging from social space to more specific specialist intervention like mental health support (as above). It was emphasised that there are specific gaps for specialist support groups (i.e. older people, women's groups, youth, domestic violence etc.)

3.3 There is no permanent LGBT+ space in the borough and, despite the commitment of a few organisations and individuals, only a few temporary spaces held once each week or each month. The current LGBT+ groups in the borough have challenges in sustaining or growing their activity and are often reliant on voluntary unfunded resource. The fragmentation of local consistent provision was seen to contribute to difficulties building networks and not feeling safe in the borough.

3.4 There is a lack of communication and promotion with information difficult to find on existing services and they tend to be underused. 60% of survey respondents were not aware of any LGBT+ activities in the borough. Local research suggests that most people go outside of the borough for connections and social opportunities.

3.5 In terms of community infrastructure, there are two active LGBT+ community engagement points now established, with the Practitioners and Activist Group and the LGBT+ Forum providing communication opportunities with the wider LGBT+ community. Other examples of infrastructure include regular social clubs, Flipside, Hugget's LBT women's group and an LGBT+ social in Thames Ward. For young people there is the Good Youth Forum's Lesbian group which meets on an ad hoc basis and support for young people from the Diverse Communities.

3.6 Some non-LGBT+ specialist community services have knowledgeable and accessible staff. There are also some online resources for local networking. Both NELFT and LBBD have worked based LGBT+ groups.

3.7 There is strong literature about the benefits to mental and physical health of engaging in communities. A community infrastructure is also necessary to be able to engage and advocate with service providers and commissioners and policy makers, and contribute to training for example, as described in the sections above.

3.8 There was general agreement of the need to strengthen links between Council, partners and the community. A specific proposal from stakeholders and the community was to develop social spaces and events such as a full-time LGBT+ venue for socialising and support groups (e.g. older people, women's, youth groups, domestic violence).

3.9 To improve the information sharing of services that are available, an on line up to date resource outlining specialist LGBT+ services – accessible by community and professionals was proposed. Camden Council has a best practice example of sharing information relevant to LGBT+ on their website.

3.10 Overall whilst there are some valuable community assets in Barking and Dagenham, these could be strengthened greatly.

4. Health and wellbeing key messages

4.1 National evidence shows that health outcomes are generally worse for LGBT+ people than the rest of the population. Studies show that LGBT+ people don't feel that their specific needs are considered in their care and expect to be treated worse by their GP and by staff in a care home than the general population.

4.2 Best practice includes ensuring staff are trained and have a good understanding of identities, gender identity and sexual orientation monitoring takes place; and LGBT people are involved in the development of services.

4.3 Local stakeholders felt information on how to refer to specialist LGBT+ services would be useful. For example, a pack or on-line resource with information for GPs, including specialist support for LGBT+ community. They also suggested specialist training in LGBT+ issues could be helpful. One example of best practice is Pride in Practice: that supports LGBT+ through a quality assurance accreditation for GPs, dentists, optometrists and others, endorsed by the Royal College of General Practitioners.

4.4 Given the varied needs of different subgroups of the LGBT+ community many raised the importance of considering these intersectionality's in-service planning.

Social and psychological support key messages

4.5 The national literature and surveys show that LGBT+ community in general have lower wellbeing in terms of life satisfaction, happiness, anxiety than the general population.

4.6 There are several community assets for social support in the borough. However, the current LGBT+ groups in the borough have challenges in sustaining or growing their activity.

4.7 Our stakeholders and community were of the clear view that more social groups are needed as they bring mental health benefits. Personalised psychological support is also advocated by local stakeholders with a view that this should be available for individuals as well as in groups. Additionally, better information on the services existing needs to be made available to local services users and professionals.

4.8 Other key messages and recommendations on the community infrastructure for LGBT+ in Barking and Dagenham are described above.

Mental health key messages

4.9 There is a body of research that shows that lesbian and bisexual women have high rates of mental health inequalities. Bisexual women having even greater prevalence than lesbian women. This was echoed in our local survey where lesbian and bisexual women's mental health is of particular concern, with 1 in 4 having poor mental health, and bisexual people overall have the worst mental health.

4.10 National evidence is that than a quarter of gay men, rising to more than a 1/3 in BAME gay men and higher still for disabled gay or bisexual men have thought of taking their own life. Young LGBT+ also have high rates of self-harm. Minority groups within the LGBT+ community, such as disabled people, have even higher rates of mental ill health and self-harm than the LGBT+ community as a whole.

4.11 Nationally, eating disorders are prevalent within the LGBT+ community, at about 1: 5 people. The main mental health problems faced by our LGBT+ community is stress, depression and anxiety. This is supported by the national literature.

4.12 Most people sought support from their GPs or a non-LGBT+ specific mental health service. These were however seen as mostly inclusive. Services were sought from within and without of the borough and included statutory and voluntary sector e.g. East London Out Project and London Friend. More than 1/3 of LGBT+ reporting mental health issues in our survey did not seek support. Less bisexual people and lesbian women have sought mental health support compared to gay men. The reasons for not seeking mental health support locally, and again supported by national findings includes LGBT+ related barriers such as: worry of GP's reaction / lack of understanding / feeling they wouldn't be taken seriously; previous bad experiences and overstretched services.

4.13 North East London Foundation Trust (NELFT) Mental Health services state that they already offer a fit-for-purpose gateway for adult LGBT+ residents to access mental health services through IAPT and NELFT uses a Rainbow Lanyard. However specific concerns are expressed by the community

regarding IAPT services. These included a lack of follow up on actions from the previous needs assessment, insufficient connections with other services in the system and generic issues such as waiting times. This supports a national picture of LGBT+ people having higher levels of dissatisfaction with mental health services than the general population.

4.14 Our LGBT+ community, in line with national literature, and supported by some stakeholders would like to see specialist LGBT+ mental health services. There are none in the borough.

4.15 Best practice from PHE to improve mental health services for LGBT+ includes to ensure staff receive training on LGBT+ issues, promotional materials use LGBT+ imagery, service use by LGBT+ is monitored and data is used to improve services. LGBT+ service requirements should be in strategies and procurement plans. Health and Wellbeing Boards should also include LGBT+ people in their strategies.

Physical health key messages

4.16 There is a strong interrelationship between mental and physical health and wellbeing. However more people in our survey experienced better physical health when compared to their mental health. About two fifths of reported a long-standing health problem.

4.17 National studies show LGBT+ to be less physically active than the general population, though no difference between male and females. Lesbian and bisexual women appear to be the least physically active in our LGBT+ community.

4.18 More than half of our local survey respondents stated that LGBT+ friendly settings/facilities would encourage more exercise. There were mixed views re the inclusivity of our local leisure facilities. There are no dedicated LGBT+ exercise facilities in the borough. However, the Diverse Community runs Box Fit classes for LGBT+ young people.

4.19 Obesity rates were higher in LGBT+ than the general population in our 2009 B and D needs assessment. A recent national study in the British Medical Journal? confirms higher rates in lesbian women.

4.20 Local trans people face difficulties in accessing knowledge of treatment pathways. More information is needed for those undergoing gender reassignment surgery.

Sexual and reproductive health key messages

4.21 The risk of STIs (sexually transmitted infections), HIV, Hep B and Hep C is higher in bi or gay men and transgender women. Research suggests the rate of HIV in transgender women is 50 times the general population.

4.22 Lesbian, bisexual or transgender women access sexual health clinics less than gay and bisexual men, and bisexual men are less likely then gay men to access clinics.

4.23 Local reports were that BAME Men who have sex with Men (MSM) may not necessarily identify as gay or bisexual and respond to public service messaging targeted at these groups.

4.24 Local stakeholders reported that some individuals involved in Chemsex. Chemsex (sex, often group sex, under the influence of psychoactive substances) tends to involve men, mostly gay or bisexual and sometimes unprotected. Little is known re the extent of this locally. It impacts upon physical (e.g. risk of STIs) and mental health (e.g. drug related). The Stephen Port case in Barking involved Chemsex with his victims.

4.25 There is national evidence that lesbian and bisexual women are less likely to attend cervical and breast cancer screening, this is linked to hetero normative assumptions about risk and eligibility by professionals and patients. For example, more than 1 in 3 LB women have been told that don't need cervical screening. Local clinicians voiced concerns regarding transgender men being overlooked and the need for promoting cervical screening.

4.26 Our survey showed that the majority of people sought care from sexual health clinics and only a few used LGBT+ specific services. Barking Hospital and Dean Street were used most frequently; one being local and Dean Street offering specialist care.

4.27 Community based and mobile HIV testing is shown to increase uptake. Promotion of condom use, and HIV testing remains a priority for MSM. Some specialist sexual health services, such as Positive East were reaching BAME communities and issues of hate crime and drug use were also being discussed.

4.28 It is important that a holistic approach to service provision is taken, making connections between sexual health and drug misuse (e.g. Chemsex) and sexual health, domestic violence, drug misuse and mental health issues. There was a call for services outside the borough to enable anonymity.

Substance use and abuse key messages

4.29 Research shows that LGBT+ people have higher rates of smoking, alcohol and drug misuse than the general population. National research and our local stakeholders suggested that this might be related to experience of discrimination and marginalisation. Tackling these root causes is therefore a method for addressing substance misuse.

4.30 Studies show that more lesbian and bisexual women, and gay and bisexual men smoke than women or men in general. Trans people have the highest rates of smoking in the LGBT+ community. LGB people are twice as likely to binge drink as men and women in general and nearly 2/3 of the trans community are dependent on alcohol. LGB people are seven times more likely to use recreational drugs as the general population.

4.31 Locally a large proportion of respondents drank alcohol, a small number had used cocaine, crack or cannabis and an even smaller number used other illicit drugs including Gamma hydroxybutyrate (GHB) and amphetamine. More men had used recreational drugs and more smoked than women.

4.32 Research evidence suggests that LGBT+ have barriers to accessing substance misuse services both in relation to recognition that they may have a problem and feeling the services are accessible. There is no specialist LGBT+ substance misuse service in the borough; a London-wide service exists, offered by Antidote for clients and professionals.

4.33 Best practice guidance is as for other services above e.g. ensure staff are trained in LGBT+ issues, promotional materials use LGBT+ language and imagery, monitoring and inclusion of LGBT+ issues in policies and strategies.

4.34 There is a need for interconnected, holistic services which do not see the needs of LGBT+ people as isolated issues – for example, there are connections between mental health, sexual health, substance abuse and domestic violence. Community safety key messages

5. Discrimination and homophobia key messages

5.1 A national study suggested more than 40% of LGBT+ experience some form of prejudice or discrimination on a regular basis (*Still Out There,* 2016).

5.2 Of the local LGBT+ people who have experience homophobia or transphobia, the majority received abuse from strangers. This occurred mostly on the street, public transport and outside/near their home.

5.3 Locally 2/3 of LGBT+ were out to friends to family about their sexual orientation.

5.4 Our local BDCVS survey (2016) suggests LGBT+ residents felt unable to access a variety of services because of their sexuality/gender status including bars/clubs, swimming pools, gyms and places of workshop. They felt more able to access services such as libraries, theatres, parks.

5.5 Respondents also experienced homophobia in service provision (see health and wellbeing messages above).

5.6 These findings suggest more is needed to tackle discrimination and stigma of the LGBT+ community.

6. Crime and fear of crime key messages

6.1 National evidence suggests that LGBT+ individuals are at greater risk of crime. Safety after dark is a particular concern for B and D residents. This is also so for LGBT+ residents. Men are more likely to feel safe than women and trans women after dark and during daylight hours. Disabled people are largely overrepresented as feeling less safe after dark.

Hate crime key messages

6.2 Hate Crime is of importance given its link with suicidal tendencies and self-harm inflicting behaviours. Fear of hate crime leaves many people feeling unsafe in their homes and communities. Research shows it is a continuing threat for LGBT+ people and there has been a sharp rise in London. National evidence (GALOP 2016) shows 4 in 5 LGBT+ had experienced hate crime, 1 in 4 had experienced violent hate crime, 1 in 3 on line hate crime, 1 in 10 had experienced sexual violence within hate crime. Our survey results suggest 1 in 6 reported experiencing hate crime; it is likely that there is significant under reporting in this survey.

6.3 Certain subsets of the community are at higher risk of hate crime: national research (Stonewall 2017) states 1/3 BAME LGBT+ experienced hate crime compared to 1/5 of the white population. Women and disabled people were overrepresented in experiencing hate crime in our local survey. In our local interviews and focus groups BAME LGBT+ hate crime and discrimination were reported as mostly originating from within their own diaspora communities; whilst also facing racism within the LGBT+ community.

6.4 Residents reported unsatisfactory performance by the police, with comments on inaction and discrimination being common. The withdrawal of LGBT liaison officers has also attracted negative comment.

Reporting of hate crime and crime and experience of the police key messages

6.5 National evidence (GALOP 2016) (and Stonewall 2013) 1in 4 reported hate crime to police, 1 in 4 said would not report in the future. Concerns were that it would not be taken seriously or that they may be subject to further homophobia on reporting. half were not satisfied with the way it was handled. In our local survey, of the people who experienced hate crime, half did not report it to the police; i.e. higher under reporting than nationally, although there are small numbers in our survey. The BDCVS survey identified concerns similar to the national picture about reporting.

6.6 Local interviewees stated a lack of awareness and appropriateness in the police and this caused some resentment. Community representatives expressed that the community felt let down reporting that, following a series of meetings aimed at building confidence in the police after the Stephen Port case, actions haven't been taken to work with the community to strengthen the Police's reporting response.

6.7 During the engagement, community representatives raised concern that there was not a dedicated LGBT+ police liaison officer. GALOP is currently providing some hate crime incident advice and support to BDCVS. The Community Safety Partnership is promoting Stop Hate UK as an initial contact for our of hours and urgent reporting of hate crimes.

6.8 Examples of best practice are the *LGBT Hate Crime Quality Standard: A service Improvement Tool for Organisations*, a resource produced by the National LGBT Hate Crime Partnership for services such as the police, Council and third sector. This includes seven areas of best practice:

user-centred service; workforce and learning; reaching out; addressing diverse LGBT needs; policies and procedures; monitoring and evaluation; and strategy. There is also *Hate Crime Operational Guidance* from the College of Policing, which, if followed, ensures that officers are equipped to identify, monitor and deal with hate crime effectively.

6.9 Low reporting to the police, together with other stakeholder feedback strongly suggests that more work needs to be done with the police to improve their relations and enhance trust with the LGBT+ community. Local views on how to improve work with the police includes specialist training for front line police personnel as some of the difficulties appear to be due to their lack of awareness and better communication about services available e.g. the Pan London service offers.

6.10 A view from community representative stated that it is important for the Metropolitan Police Service to refresh an effective LGBT+ reporting pathways now that the Tri-Borough reorganisation has taken place. This might include a LGBT+ police liaison officer and, also agreeing the role of CAB e.g. in reporting.

Domestic violence key messages

6.11 National evidence (Geo survey) is that LBT women have high rates of domestic violence (DV): 1 in 4 LB women and 1 in 4 women have experienced domestic violence.

6.12 1 in 2 gay and bisexual men have experienced abuse at some time. Local stakeholders reported that rates are high in gay men and transgender people with transgender women being the highest. Our local surveys and interviews also showed that disabled people are overrepresented.

6.13 National evidence reports that DV in the LGBT+ community is given little attention from police or health service. It is rarely reported to the police and most who do are not happy with the response they receive. Female same sex abuse is not taken seriously by police. Local stakeholder interviews suggest that there is an assumption that perpetrators are men and violence is only against women that supports lack of understanding. Local and national research suggest little awareness of LGBT+ domestic violence and low reporting.

6.14 Our local domestic violence services are reported as being inadequate with a lack of LGBT+ facilities or understanding. The Hugget centre is available and inclusive for LBT women but a relatively small number of those attending disclose as LBT. There is a lack of specific provision for gay and bisexual men and transgender men.

6.15 GALOP (the LGBT+ anti-violence charity) has formulated recommendations for domestic violence of LGBT+ people. This includes being clear that a domestic violence service is inclusive of LGBT+ people (e.g. in publicity) and being clear what support/services are offered to different subgroups; appropriate staff training; providing remote services e.g. telephone/email/online support; establishing links and signposting with specialist LGBT+ services; to not always assume – ensure gender neutral language.

6.16 GALOP is working with Domestic Violence commissioner in the Council so that the service is inclusive of LGBT+ issues. They could do more with service providers in B and D to strengthen partnership offers. Stakeholders raised the importance of training and specialist provision.

Bullying key messages

6.17 The remit of the CNA was over 18yr-olds. However, stakeholders raised concerns about young people, particularly bullying. The national evidence (Stonewall) is that nearly 2/3 of LGBT+ are bullied for being LGBT+ at school. This includes nearly 2/3 of transgender pupils with 1 in 10 transgender pupils received death threats at school.

6.18 LGBTQ young people feel discriminated against in social settings and experience higher levels of abuse; with transgender experiencing the greatest discrimination.

6.19 Local issues identified were the blurring of the responsibility for incidents between the victim and the perpetrator and common problems in schools such as homophobia, racism and negative stereotyping setting a context for bullying. Whilst some schools were reported as dealing with bullying well, it was generally thought that others could manage this more effectively.

6.20 Local assets include: The Diverse Community which is setting up LGBT+ services in 4 secondary schools and looking to develop activity for 18-25-year olds. Some generic services could work with LGBT+ more for example: The Barking and Dagenham Youth Forum (BADYF) that influences policy and the Youth Mentoring Scheme.

6.21 Schools are seen by stakeholders as an important place to change attitudes and create acceptance and provide a safe place for current LGBT+ students. An example of a school doing positive and effective work is the Jo Richardson Community School. Schools could participate in Pride and share good practice. Many non governmental organisations are available to support schools with educational materials and workshops and some mentoring. For example: The Proud Trust, Mermaids, The Mosaic Youth Club, Albert Kennedy Club and Jigsaw.

6.22 There is also national evidence of bullying of LGBT+ in the workplace. LBBD and NELFT have LGBT+ staff fora and could lead the way with ensuring LGBT+ awareness is embedded within the local anti-bullying policy and training.

Sexual exploitation and sex work key messages

6.23 Some respondents to the national Geo survey spoke of sex work an essential source of employment" due to financial and employment difficulties. Our local stakeholders similarly discussed: "transgender sex workers, young men making money, young men being groomed"; "trans women selling sex was known to medics and not to the police" and increase in people resorting to "survival sex" and some particularly vulnerable groups such as those with learning disabilities. Particular concerns were raised in relation to young people and the practice of 'Chemsex'.

6.24 There is no specific LGBT+ support for those who engage in sex work locally.

6.25 Examples of best practice include the holistic sexual health and support service – SASH – that includes counselling, links with other service and groups.

6.26 Local stakeholder views were that there is a need to ensure that the child sexual exploitation policy includes male youth and LGBT+. Also, that the needs of LGBT+ young people need to be better understood in relation so child sexual exploitation and including survival sex. Good practice guidelines have been produced by Barnardo's on this topic. Stakeholders views were that these risks of exploitation should be picked up under a community safety remit involving victim support, enforcement, and safeguarding strategies.

Other community safety issues: homelessness and housing key messages

6.27 Nearly half of our survey respondents own their homes, of which most were satisfied with them, but this may reflect the demographics of the survey participants.

6.28 National literature says that 1 in 5 LGBT+ have been homeless at some point in their lives. Those requesting housing assistance and in financial hardship has increased. LGBT+ youths are overrepresented in the homeless young people (e.g. 20-40%).

6.29 The dynamics of homelessness for LGBT+ includes hate crime, DV, mental health issues contributing to elevated levels of homelessness. There are national and local reports of young people homelessness as a result of family breakdown on coming out.

6.30 Stakeholders reported local hidden homelessness of LGBT+ including sofa-surfing, squatting. They stated that homelessness may lead to poor mental health, substance misuse, risky sexual behaviours including survival sex.

6.31 LGBT+ expect to receive worse treatment when applying for social housing and homeless shelters may not be accessible to transgender people.

6.32 The housing needs of older LGBT+ people need to be accounted for and with social support. There are no existing care homes focusing on this group.

6.33 Local assets included the Outside Project – an LGBT+ specialist homeless service that was within the borough and set up London's first winter shelter.

6.34 Several organisations provide help and best practice. Stonewall housing gives free advice to LGBT+ clients, training of housing staff and offers consultancy and information. St Mungo's homelessness services include a specialist service for those with protected characteristics; the London Youth Gateway addresses the demands of young people at risk of homelessness. Other organisations offer support e.g. GALOP, Albert Kennedy.

6.35 Despite a lack of dedicated LGBT+ services locally, there are embedded cross-referral practices at a local level and scope to develop and extend this model.

Conclusion

The key messages above summarise a description of the issues, of assets that can be developed and of potential solutions that have been identified locally within the Community Needs Assessment or from national best practice in order to improve outcomes for the LGBT+ community. These key messages informed a long list of tested recommendations that were discussed with stakeholders at round tables. Key themes emerged from this work that inform our recommendations in the next section. The themes are:

- Inclusive, visible leadership and accountability – particularly from the Council and the police.
- The need for training to increase skills and understanding in working with the LGBT+ community (alongside a shift to inclusive leadership and a culture change)
- Strengthening the community and resident engagement infrastructure
- Developing more accessible, visible, effective services that meet needs of the LGBT+ community including of intersectional groups.
  In addition, the community needs assessment, particularly investigated health and wellbeing and community safety as two priority areas. Specific recommendations to address some of the issues highlighted for these two areas are therefore put forward.

High level recommendations

These are laid out in the following few pages. There is a clear audit trail of how they relate to the long list of proposed recommendations discussed as part of the Community Needs Assessment.

Recommendations

Recommendation for LGBT+ Policy Statement	Lead Officer
1) Inclusive, visible leadership and accountability	
a) Monitor the actions arising from this report through the Equality Partnership, reporting every six months.	Director of Policy & Participation
b) Establish mechanisms to ensure that the LGBT+ community is engaged in the development of strategies and services to ensure sensitivity and inclusivity to LGBT+ needs.	Director of Policy & Participation
c) Regular engagement with the LGBT+ community, for example the LGBT+ Forum, through the LGBT+ subgroup.	Director of Policy & Participation
d) Appoint a senior Officer of the Council as an LGBT+ champion.	Chief Executive
e) Add the actions agreed in this report to the Key Accountabilities of the Cabinet Members for Equalities and Diversity within the Corporate Plan.	Chief Executive
f) Embed an understanding and awareness of LGBT+ needs into the culture change programme of the Council and develop "inclusive leadership" of senior managers in the organisation.	Director of Law & Governance
g) Harness the experience of the LGBT+ Staff Forum to support the Council in delivering the key recommendations and in progressing to an exemplar employer for LGBT+.	Chair of the LGBT+ Staff Forum
h) Adopt visual clues to build confidence e.g. flags, stickers, lanyards	Director of Policy & Participation

Recommendation for LGBT+ Policy Statement	Lead Officer
2) Training	
a) Make e-learning for LGBT+ (including gender and sexual orientation) awareness training mandatory for all Council staff including front line (on email) and managers.	Director of Law & Governance
b) The Council recommends that partner agencies e.g. CCG, BHRUT, NELFT, the police and Be First also make LGBT+ and all contractors awareness training mandatory for staff where it is not already so.	Director of Policy & Participation
c) Ensure all Council staff and Members are trained on Equality issues generally and LGBT+ issues by: i. Report mandatory training statistics to Cabinet on an annual basis ii. Explicitly link training to appraisal outcomes and performance monitoring iii. Develop a wider package of LGBT+ training for Managers iv. Include LGBT+ training in Tool Box training v. Provide additional LGBT+ training to staff in Community Solutions vi. Embed LGBT+ training into face to face training on safeguarding.	Director of Law & Governance
d) Health and care professionals in relevant commissioned or provider services given training to respond appropriately to Chem sex.	Director of People & Resilience

Recommendation for LGBT+ Policy Statement	Lead Officer
3) Community and resident engagement infrastructure:	
a) Share a framework of best practice in relation to Equalities Impact Assessment with partners in order to improve the quality of EIAs locally.	Director of Policy & Participation
b) Commission the development of an on-line resource to be developed/hosted by or with very close involvement of the community. This will include description and contact information for community assets including social groups, specialist support and also of key services for the LGBT+ community. It will be accessible by the community, by professionals in front line services and others.	Director of Policy & Participation
c) The Council has recently appointed a Community Development Officer with a focus on Equality Issues. Additional resource will be allocated to support this work.	Director of Policy & Participation
d) Support the LGBT+ community in identifying a space(s) for meeting, social activities, potentially drop in services.	Director of Policy & Participation
e) LGBT+ needs will also be considered in the forthcoming review of community assets within the Borough.	Director of Policy & Participation
f) Work with the youth forum and the youth mentoring schemes to ensure that they engage in equalities work and explicitly inclusive of LGBT+ young people.	Director of People & Resilience

Recommendation for LGBT+ Policy Statement	Lead Officer
4) Commissioning and providing accessible, visible services that meet the needs of the community	
a) Ensure that equality monitoring in relation to LGBT+ across commissioned services and Council provided services is consistently applied and the findings acted upon. Areas for improvement in monitoring will be identified, including monitoring of intersectionality and activities to raise awareness of the importance of obtaining information on gender and sexuality.	Chief Operating Officer
b) Ensure that contract monitoring of all commissioned services and service reviews of provider services include equality monitoring of LGBT+ accessibility, utilisation and outcomes from the services.	Chief Operating Officer
c) Ensure LGBT+ considerations are embedded in the commissioning process and across Council providers to inform service improvement and future commissioning and Council provider policy through: i. Visibility and inclusivity of services provided (e.g. flags and Lanyards) ii. Staff awareness training LGBT+ (see training above) iii. Review (at least annually) the information collated through monitoring iv. LGBT+ engagement in consultation and service evaluations v. Raising awareness of referral pathways (including links with out of borough options where appropriate) vi. Understanding local needs, including better understanding the needs of intersectional groups of the LGBT+ community	Chief Operating Officer
d) Ensure all tendered services comply with Equality and Diversity policy specifically including LGBT+	Chief Operating Officer
e) The Council recommends that partners include service inclusivity and visibility, staff training, monitoring of LGBT+ in provided and commissioned services, LGBT+ engagement in consultations and evaluations to improve service accessibility, utilisation and outcomes.	Director of Policy & Participation

Recommendation for LGBT+ Policy Statement	Lead Officer
5) Community Safety	
a) Discrimination, stigmatisation, bullying i. Work with schools to ensure that anti bullying best practice is consistently replicated across schools and they work with existing LGBT+ groups. ii. Ensure anti bullying best practice is implemented consistently across the Council	Director of Education Director of Law & Governance
b) Crime, fear of crime and working with the police. The Community Safety Partnership works with police, other key partners to take forward the following recommendations: i. Ensure the police undertake specialist training in understanding and responding to LGBT+ individuals ii. Adopt the LGBT+ Hate Crime Quality Standard as a partnership and individually iii. Adopt visual clues e.g. flag at police stations to increase visibility of LGBT+ and increase confidence in the police iv. Ensure the police engages the LGBT+ community effectively on the issues identified in this report v. Promote and raise awareness of the Hate Crime reporting services vi. Ensure that all strategies and policies relating to community safety are reviewed to take account of LGBT+, particularly intersectional groups and further research is undertaken if needed vii. Continue to link with pan London victim support groups e.g. GALOP and feed into regional level reviews such as the new Victim Support contract	Director of Law & Governance
c) Domestic Violence Account is taken of the findings of this work in re-commissioning local Domestic Violence services. This will include, key Performance Indicators to continue to monitor accessibility, utilisation and outcomes for LGBT+ community and promotion of Domestic Violence services to ensure visibility and accessibility to the LGBT+ community.	Director of People & Resilience and Director of Community Solutions
d) Homelessness and housing. The Council, in delivering its statutory duties relating to homelessness, will ensure that: i. The needs of the LGBT+ community are included in their homelessness prevention work; ii. Links and awareness raising of other services (such as the Citizens Advice Bureau specialist LGBT+ housing advice and Stonewall Housing) are made as required.	Director of Community Solutions
e) Safeguarding and Exploitation and Sex Work	Director of People & Resilience

i. The Council will consider LGBT+ needs in the Contextual Safeguarding and Exploitation Strategy (focusing on adolescents up to 25 years). This should include concerns regarding Chemsex. ii. The Council will work with partners to ensure that a coordinated and LGBT+ appropriate response to Chemsex is put in place with appropriate specialist service links.	

Recommendation for LGBT+ Policy Statement	Lead Officer
6) Health and Wellbeing	
a) Mental Health The Council and other commissioning organisations will work with providers to review the appropriateness of Adult mental health services and Child and Adolescent Mental Health Services their visibility, accessibility, utilisation and outcomes for LGBT+ community.	Director of People & Resilience
b) Physical Health	
i. Commissioner of leisure services to encourage leisure providers develop measures to ensure that the services are more accessible and visible to the LGBT+ community, especially LB women. Also to make sure that the wider leisure offer in B&D is LGBT+ friendly.	Director of Policy & Participation Director of People & Resilience
ii. The referral pathway for people wanting to become transgender is strengthened and appropriately promoted.	
c) Sexual health and screening	
i. Through sexual health commissioning we will ensure the service provider (BHRUT) takes on board the findings of the Community Needs Assessment including implementation of best practice and targeting of their services LGBT+ (particularly lesbian women and bisexuals). They can also ensure the links with drug and alcohol services are strengthened where necessary, including in relation to Chemsex.	Director of People & Resilience
ii. The sexual health commissioner can ensure that community testing for STI and HIV can be targeted to the whole LGBT+ community (including lesbians and bi sexual women) through an e service and through GPs. The new community HIV support service is aimed at increasing testing, supporting and signposting for BME and Men who have sex with Men and tenders will be awarded based on the provision of this by the successful bidder.	Director of People & Resilience
iii. We recommend that NHS England as commissioners and the CCG as the managers of GP performance of cervical cancer screening programme ensure the service is promoted to professionals and lesbian and bi sexual women.	Director of People & Resilience
d) Substance Misuse The Council will work with partners to ensure that a coordinated and LGBT+ appropriate response to Chemsex is put in place with appropriate specialist service links. (see also Community Safety and Sexual Health)	Director of People & Resilience

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	**Health and Wellbeing Outcomes Framework Performance Report – Q3 and Q4 2018/19**
Report of the Director of Public Health	
Open Report	**For Decision:** No
Wards Affected: ALL	**Key Decision:** No
Report Author: Rosanna Fforde, Senior Intelligence and Analysis Officer, London Borough of Barking and Dagenham	**Contact Details:** 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 in quarters 3 and 4 2018/19 or the latest data available.

This indicator set is due be reviewed to bring it into alignment with the refreshed Joint Health and Wellbeing Strategy.

Recommendation(s)

Members of the Board are recommended to:

i. Review the overarching dashboard and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit 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 three appendices provide updated data and commentary on key performance indicators for the Health and Wellbeing Board. They also summarise CQC inspection reports published in quarters 3 and 4 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 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 quarters 3 and 4.

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, two were rated amber and one could not be rated:

i) **Percentage uptake of measles, mumps and rubella (MMR2) immunisation at 5 years old:** Quarter 3 performance (72.7%) is lower than London (75.7%) and England (86.6%) and remains below the target of 90%.

ii) **Prevalence of children in Year 6 that are obese or overweight:** This is an annual indicator and the latest data for Barking and Dagenham shows an increase from 43.8% in 2016/17 to 44.5% in 2017/18. This is above the target of the London average (37.7%) and is therefore RAG-rated red.

iii) **Percentage of looked-after children with a completed health check:** This increased from 79.4% in quarter 3 to 91.2% in quarter 4 2018/19. This is within 10% of the target of 92% and is therefore RAG-rated amber.[1]

iv) **The number of children who turn 15 months old in the reporting quarter who receive a 12-month review:** This measure increased from 66.1% in quarter 3 to 70.5% in quarter 4 2018/19 and is rated amber as it is within 10% of the target of 75%.

v) **Number of children and young people accessing Tier 3/4 CAMHS services:** Updated data shows that there were 565 children and young people in contact with CAMHS at the end of quarter 3, a decrease from 590 at the end of quarter 2. 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 Of the two adolescents' indicators, one was rated red and one was rated amber:

a) **Under 18 conception rate (per 1,000 population aged 15–17 years):** Although this measure continues to decrease, it remains above target. In the most recent time period, Barking and Dagenham had 26.8 conceptions per 1,000 15–17 year olds compared with a target (the London average) of 17.2 per 1,000. This is a rolling 3-year average measure.

b) **Care leavers in education, employment or training (EET):** This measure improved from 49.6% in quarter 2 to 51.4% in quarter 3 and finally to 54.1% in quarter 4. The proportion of care leavers in EET is within 10% of the target of 57.0% and is therefore RAG-rated amber.

Adults

3.4 Of the three adults' indicators, one was rated amber and two were rated green:

a) **Smoking prevalence in adults – current smokers:** This is an annual indicator, with the latest data (2017/18) placing this at 19.5%. This is less than 10% above the target of 18.6% and is therefore RAG-rated amber. Barking and Dagenham has a higher smoking prevalence compared with London (16.8%) or England (17.2%).

b) **Cervical screening – coverage of women aged 25–64 years:** Based on 2017/18 data, cervical screening coverage is rated green, as coverage (66.8%)

[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.

is above the London average (64.7%). Nonetheless, coverage in Barking and Dagenham shows a downward trend and 2017/18 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).

c) **Percentage of eligible population that received a health check:** Coverage in quarter 4 was 4.79%, which is above the pro-rata target for the quarter of 3.75%. This is based on self-reports from practices and hence is marked as provisional.

Older adults

3.5 Of the three older adults' indicators, one was rated red, one was amber and one was green:

a) **Bowel screening – coverage of people aged 60–74 years:** Coverage remained stable between quarter 1 (43.7%) and quarter 2 (43.9%) and this continues to be RAG-rated red. Barking and Dagenham had the fourth lowest bowel cancer screening coverage among all local authorities in England in quarter 2.

b) **Breast screening – coverage of women aged 53–70 years:** Based on 2017/18 data, breast screening coverage is rated amber as Barking and Dagenham's coverage (67.0%) was within 10% of the figure for London (69.3%). This is a small decline from 67.8% in 2016/17.

c) **Number of long-term needs met by admission to a residential or nursing care home:** This is a cumulative figure. Performance in quarter 4 remains below the target, although higher than the same point in 2017/18.

Across the life course

3.6 Of the six 'across the life course' indicators, three indicators were rated red, two were amber[2] and one was 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 50.0% in quarter 2 of 2018/19 to 48.3% in quarter 3. 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):** This quarter is the second successive fall from 83.2% in quarter 2 to 80.6% in quarter 3 to 76.9% for the latest quarter (quarter 4 2018/19). Set against the target of 90.0%, this measure has dropped below 10% of the target and is now RAG-rated red. Looking at performance across 2018/19, England (88.0%) and London (88.6%) performed better than Barking and Dagenham (80.7%) but were also below the 90% target.

[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.

c) **Percentage of people using social care who receive services through direct payments:** This has consistently decreased throughout the last four quarters, from 65.5% in quarter 1 to 49.1% in quarter 4. This is more than 10% below the target of 60% and is therefore RAG-rated red.

d) **Emergency admissions aged 65 and over per 100,000 population:** No updated data is available.

e) **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.

f) **Delayed transfers of care:** Across quarter 4, there were an average of 178.4 delayed days per 100,000, which is below the threshold target of 194.9 per 100,000 and hence RAG-rated green. This relates to 728 delayed days, of which 669 days (91.9%) were attributable to NHS organisations, 54 delayed days (7.4%) to social care and 5 days (0.7%) to both services.

4 CQC inspections

4.1 Eighteen reports of CQC inspections to healthcare organisations in the borough were published in quarter 3 and 16 reports in quarter 4. In total over the two quarters, 23 inspections (67.6%) were rated as 'Good', while eight providers (23.5%) received a rating of 'Requires Improvement', two (5.9%) were rated as 'Inadequate' reports and one inspection did not result in a rating. Appendix C contains details of all the inspection reports published in quarters 3 and 4 2018/19.

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 This indicator set is due be reviewed to bring it into alignment with the refreshed Joint Health and Wellbeing Strategy.

5.3 The current indicators chosen are grouped by the 'life course' themes of the previous Strategy and reflect core priorities.

Integration

5.4 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.

Financial and Legal Implications

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 quarters 3 and 4.

Appendix A

Key

	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

Appendix A: Indicators for HWBB - 2018/19 Q3 and Q4

Note: where 2018/19 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	2018/19	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%	72.9%	72.7%	..	..	↘	90.0%	R	86.6%	75.7%	1	PHOF
Data from Q1 2018/19 onwards may not be comparable with previous data 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%**	55.5%	72.5%	65.1%	77.8%	**67.5%**	76.3%	72.6%	66.1%	70.5%	**71.4%**	↗	75.0%	A	82.2%	75.8%	3	HWBB OF
Benchmarking data is for quarter 3 2018/19. Data prior to Q1 2017/18 may not be comparable due to changes in reporting.																				
Number of children and young people accessing Tier 3/4 CAMHS services	**1,217**	**1,114**		585	565	620	695		675	590	565	..		↘	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%	79.4%	91.2%	**91.2%**	↗	92.0%	A	86.0%	86.6%	5	HWBB OF
Benchmark is for 2017/18 (equivalent published figure for Barking and Dagenham is 92.2%). Measure based on average of number of children in care with dental check in timescales and number of children with health assessment in timescales, divided by number of children in care for 12 months or more.																				
2 - Adolescents																				
Under 18 conception rate (per 1,000 population aged 15-17 years)	**34.9**	**34.0**	**29.1**	28.3	28.7	27.9	26.8	**26.8**	..	..	..	..	..	↘	London average	R	18.7	17.2	6	PHOF
Data is a rolling 3-year average, with the data presented representing the last quarter of the 3-year period, i.e. quarter 4 will represent the time period quarter 1 2015/16 to quarter 4 2017/18.																				
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%	51.4%	54.1%	**54.1%**	↗	57.0%	A	54.9%	56.1%	7	HWBB OF
Benchmarking data relates to 2017/18.																				
3 - Adults																				
Smoking prevalence in adults - current smokers (QOF)	**20.8%**	**20.4%**	**19.9%**					**19.5%**					..	↘	18.6%	A	17.2%	16.8%	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%**					**66.8%**					..	↘	London average	G	71.4%	64.7%	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 2018 (for 2017/18).																				
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%**	2.70%	3.60%	3.67%	4.79%	**14.76%**	↗	15.0%	G	8.3%	9.6%	10	PHOF
Benchmarking data relates to 2017/18 (equivalent published figure for Barking and Dagenham 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. Data for Q2, Q3, Q4 and 2018/19 are provisional due to a change in the data system.																				

Key

Appendix A: Indicators for HWBB - 2018/19 Q3 and Q4

	Data unavailable due to reporting frequency or the performance indicator being new for the period
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	Data missing and requires updating
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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 2018/19 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

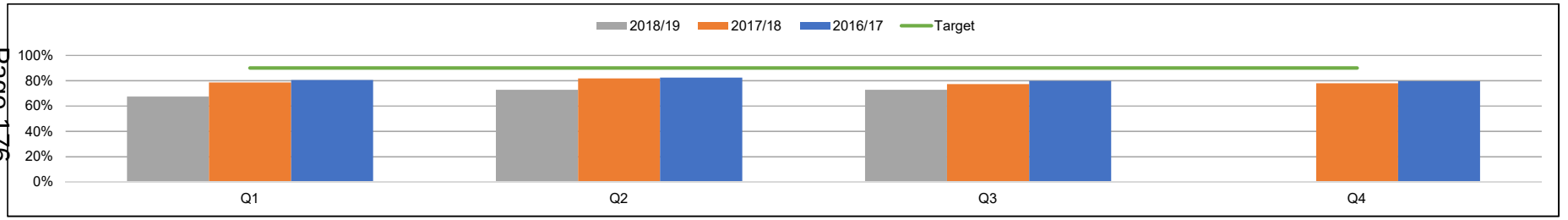
Title	2014/15	2015/16	2016/17	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2017/18	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2018/19	DoT	Target	RAG Rating	BENCHMARKING England Average	BENCHMARKING London Average	HWBB No.	Reported to
4 - Older Adults																				
Breast screening - coverage of women aged 53-70 years	**64.4%**	**66.5%**	**67.8%**					**67.0%**					..	↘	London average	A	74.9%	69.3%	11	PHOF
Percentage of women whose last test was less than three years ago.																				
Bowel screening - coverage of people aged 60-74 years	**39.7%**	**41.1%**	**39.7%**	40.7%	41.4%	42.1%	43.0%	**43.0%**	43.7%	43.9%	..	..	..	↗	60.0%	R	59.5%	50.6%	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	409.8	702.3	**702.3**	232.4	444.5	646.6	722.4	**722.4**	↘	858.9	G	585.6	406.2	13	BCF/ASCOF
Rates are cumulative throughout the year. Benchmarking data relates to 2017/18.																				
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%	57.0%	49.1%	**49.1%**	↘	60.0%	R	28.3%	27.5%	14	ASCOF
Delayed transfers of care	**135.2**	**205.3**	**205.8**	117.5	158.1	106.7	115.2	**124.4**	125.8	159.7	187.2	178.4	**162.8**	↘	194.9	G	306.1	193.0	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%	80.6%	76.9%	**80.7%**	↘	90.0%	R	88.0%	88.6%	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 programme			**48.8%**	63.4%	68.9%	58.8%	58.2%	**61.9%**	65.3%	50.0%	48.3%	..	..	↘	65.0%	R			19	ComSol

Health and Wellbeing Board
Performance Report 2018/19 Q3 and Q4
11 June 2019

Back to summary page	Percentage uptake of measles, mumps and rubella (MMR2) immunisation at 5 years old	Health and Wellbeing Board Indicators	Q3 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%	72.9%	72.7%	
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
Performance in quarter 3 2018/19 was 72.7%, similar to quarter 2 (72.9%). Both are substantially below the target of 90%. However, data quality issues across London have been reported from quarter 1 2018/19 onwards and hence 2018/19 figures should be interpreted with caution.	There has been a big push over the last 2 years where all GP practices were visited/audited on their performance and this was accompanied by a national campaign. There is still an MMR catch-up campaign being provided by GPs, so when patients are identified as having missed their MMR vaccinations, the GP will offer these. Additionally the school-aged vaccination provider is contracted to also offer MMR vaccinations in schools or local clinics. There have been briefings from Public Health England about the measles outbreaks and the three CCGs have an action plan to improve immunisation uptake with more GP visits to be carried out to support lower performing practices. The new GP contract signed off at the NHS England Board includes an item of service payment of £5 per patient for a catch-up campaign for the MMR vaccine for 10 and 11 year olds.	2018/19 quarter 3: London: 75.7% England: 86.6%.

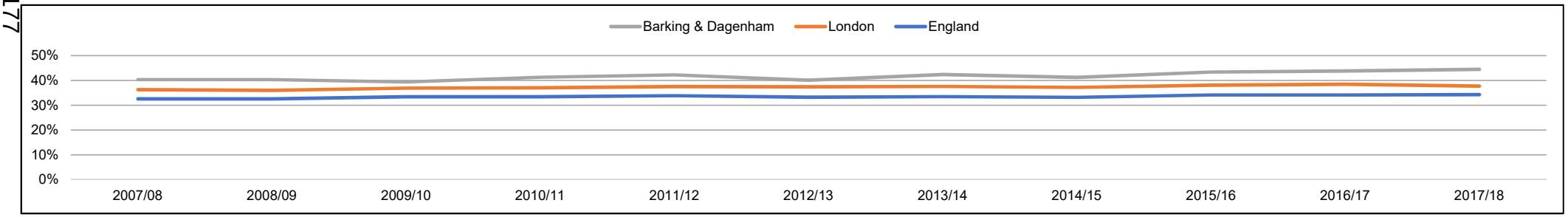
Responsible Director	Matthew Cole	Status	

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%



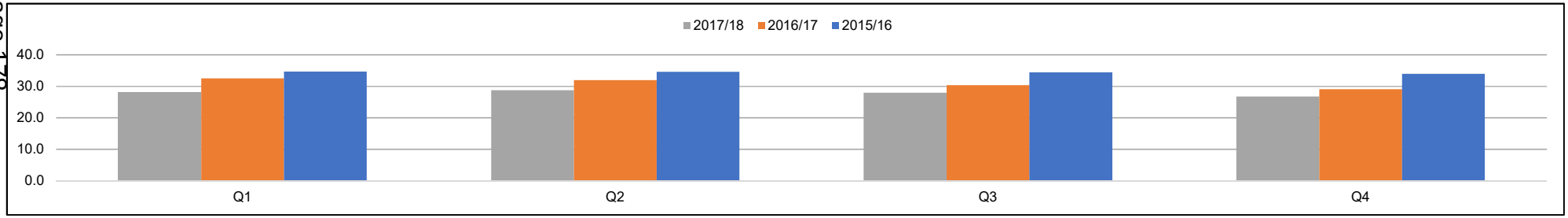
Performance overview	Actions to sustain or improve performance	Benchmarking
Barking and Dagenham has had sustained poor performance on this indicator, having a higher prevalence of Year 6 children with excess weight than seen nationally and regionally. In 2017/18, Barking and Dagenham was the worst performing local authority in the country for this measure.	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 completion indicator.	2017/18: London: 37.7% (target) England: 34.3%

Responsible Director	Matthew Cole	Status	

Back to summary page	Under 18 conception rate (per 1,000 population aged 15-17 years)	Health and Wellbeing Board Indicators	Q4 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 the 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 under 18 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	28.7	27.9	26.8
	2016/17	32.5	31.9	30.4	29.1
	2015/16	34.7	34.6	34.4	34.0



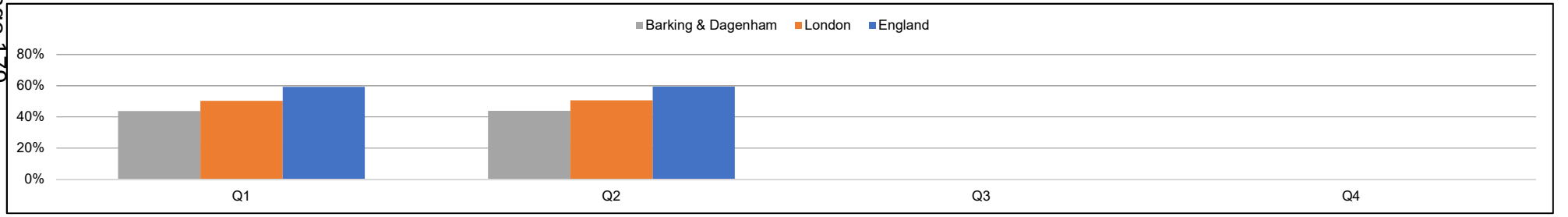
Performance overview	Actions to sustain or improve performance	Benchmarking
Note: the data presented above is a 3-year rolling average, containing data for the 12 quarters up to and including the quarter named. Barking and Dagenham's 3-year rolling average of under 18 conceptions has more than halved in the past decade. However, its rate remains substantially higher than the London average (target) of 17.2 conceptions per 1,000 females aged 15 to 17 years.	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 past few 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 quarter 4 (rolling 3-year average): London: 17.2 England: 18.7.

Responsible Director	Matthew Cole	Status	

Back to summary page	Bowel screening - coverage of people aged 60-74 years	Health and Wellbeing Board Indicators	Q2 2018/19

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				2018/19			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Barking & Dagenham	40.7%	41.4%	42.1%	43.0%	43.7%	43.9%		
	London	49.8%	49.9%	49.9%	50.2%	50.4%	50.6%		
	England	58.8%	58.9%	58.9%	58.9%	59.2%	59.5%		



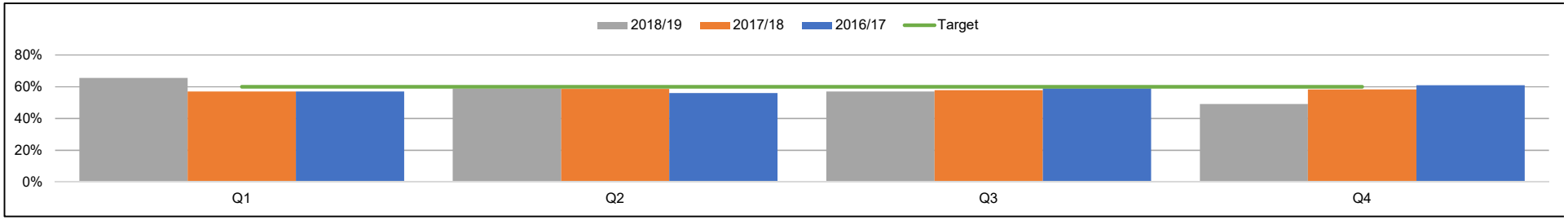
Performance overview	Actions to sustain or improve performance	Benchmarking
Barking and Dagenham continues to perform worse than the national and regional averages, as well as being considerably below the 60% performance threshold, with only 43.9% coverage of the eligible population at Q2 of 2018/19. This is the fourth lowest coverage in both London and England.	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.	2018/19 quarter 2: London: 50.6% England: 59.5%.

Responsible Director	**Matthew Cole**	**Status**	

Back to summary page	The percentage of people using social care who receive services through direct payments	Health and Wellbeing Board Indicators	Q4 2018/19

Definition	**Numerator**	The number of adult social care services provided in the form of a direct payment.	**How this indicator works**	This is a measure of the packages service users receive as direct payments as a percentage of all services delivered in the community.
	Denominator	The total number of adult social care service users in receipt of community services.		
Source		Liquid Logic Adults System		
What does good performance look like?		Good performance is above the target of 60% receiving direct payments in lieu of directly managed services.	**Why is this indicator important?**	Direct payments are cash payments given to service users in lieu of community care services they have been assessed as needing and are intended to give users greater choice in their care.

Quarterly data		Q1	Q2	Q3	Q4
	2018/19	65.5%	58.9%	57.0%	49.1%
	2017/18	57.0%	58.7%	57.8%	58.3%
	2016/17	57.0%	56.0%	59.0%	60.9%
	Target	60.0%	60.0%	60.0%	60.0%



Performance overview	Actions to sustain or improve performance	Benchmarking
Performance has decreased steadily throughout the 2018/19 year from a peak of 65.5% in quarter 1, falling to 59.9% in quarter 2, 57.0% in quarter three and finally falling to 49.1% which is more than 10% below the target of 60% and therefore RAG-rated red. Over the past 3 years only two quarters have exceeded the 60% target: Q4 2016/17 (60.9%) and, more recently, Q1 2018/19 (65.5%). Q4 2018/19 is the only quarter in the last 3 years that has been RAG-rated red.	As indicated over the past years since 2016/17, the strategy of providing choice and control in the form of direct payment packages was focussed on rapid roll-out with the 60% target in mind. This has proven difficult to sustain and would have be inappropriate to continue. It is expected that this measure may remain RAG-rated red in the short term in order to restore quality outcomes.	This is a local indicator.

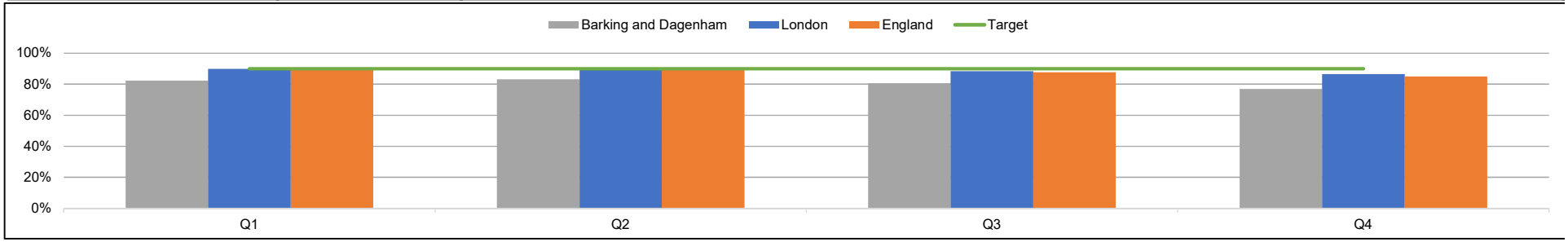
Responsible Director	Stefan Liebrecht	Status	

Back to summary page	A&E attendances ≤ 4 hours from arrival to admission, transfer or discharge (type all)	Health and Wellbeing Board Indicators	Q4 2018/19

Definition	**Numerator**	Number of A&E attendances where the time to admission, transfer or discharge is 4 hours or less	**How this indicator works**	This indicator shows the proportion of people attending A&E who are admitted, transferred or discharged within 4 hours. It describes a provider rather than a population. The figures below are for Barking, Havering and Redbridge University Hospitals NHS Trust, which runs A&Es at King George Hospital and Queen's Hospital. The figures are not specific to residents of Barking and Dagenham, and Barking and Dagenham residents may also attend A&Es run by other trusts.
	Denominator	Total number of A&E attendances		
Source		NHS England		
What does good performance look like?		For the proportion to be as high as possible and above the target of 90%	**Why is this indicator important?**	The Handbook to the NHS Constitution pledges that individuals should face a maximum wait of 4 hours from arrival in A&E to admission, transfer or discharge.

Quarterly data

	Q1	Q2	Q3	Q4
Barking and Dagenham	82.3%	83.2%	80.6%	76.9%
London	89.9%	89.9%	88.4%	86.5%
England	89.9%	89.3%	87.7%	85.1%
Target	90.0%	90.0%	90.0%	90.0%



Performance overview	Actions to sustain or improve performance	Benchmarking
The proportion of people attending A&E where the time to admission, transfer or discharge was 4 hours or less at Barking, Havering and Redbridge University Hospitals NHS Trust fell from 83.2% in quarter 2 to 80.6% in quarter 3 and further decreased to 76.9% in quarter 4.	Perfect week in March which focused on bed flow - which has a direct impact on A&E performance. The learning from this has been implemented and Emergency Department (ED) performance has improved. The Trust have implemented a weekly flow programme. In addition, there are workstreams focusing on reducing ambulance conveyance, community capacity (as alternatives to ED), and hospital flow which will also focus on the non-admitted pathway from ED. This work is all overseen by the BHR A&E Delivery Board.	2018/19 quarter 4: London: 86.5% England: 85.1%.

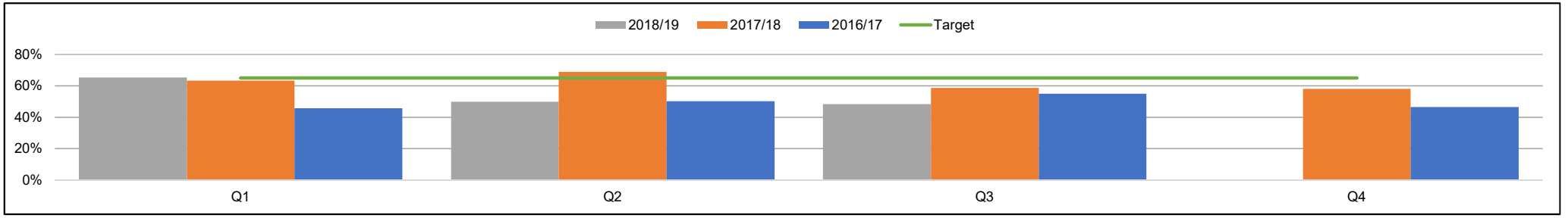
Responsible Director	N/A	Status	

Back to summary page	The percentage of children and adults starting healthy lifestyle programmes that complete the programme	Health and Wellbeing Board Indicators	Q3 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	65.3%	50.0%	48.3%	
2017/18	63.4%	68.9%	58.8%	58.2%
2016/17	45.8%	50.2%	55.0%	46.5%
Target	65.0%	65.0%	65.0%	65.0%



Performance overview	Actions to sustain or improve performance	Benchmarking
Performance for this measure has decreased from 65.3% in quarter 1 to 50.0% in quarter 2 and 48.3% in quarter 3. Since 2016/17, only two quarters (quarter 1 2018/19 and quarter 2 2017/18) have exceeded the target of 65%.	Recruitment to vacant posts has recently occurred and will increase number of delivery staff and raise the number of appointments and programmes available. A revised National Child Measurement Programme (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.	This is a local indicator.

Responsible Director	Matthew Cole	Status	

Appendix C - CQC inspections - 2018/19 Q3 and Q4

Name	Report publication date	Link to inspection report	Overall rating	Service type
Barking Hospital	04/10/2018	http://www.cqc.org.uk/location/1-1790509337	Good	Doctors/GPs
Angels Care Solutions	04/10/2018	http://www.cqc.org.uk/location/1-3827655866	Good	Homecare agencies
Zenith Care Recruitment	09/10/2018	http://www.cqc.org.uk/location/1-4236808110	Good	Homecare agencies
Westminster Homecare Limited (Barking & Dagenham, Havering, Redbridge and Newham)	18/10/2018	http://www.cqc.org.uk/location/1-3583896721	Good	Homecare agencies
Chestnut Court Care Home	18/10/2018	http://www.cqc.org.uk/location/1-2891456486	Good	Nursing homes
Barking Main Office	19/10/2018	http://www.cqc.org.uk/location/1-3254248932	Good	Homecare agencies
Redspot Care Limited	20/10/2018	http://www.cqc.org.uk/location/1-4539030915	Good	Homecare agencies
Recruitcare Professionals Ltd	23/10/2018	http://www.cqc.org.uk/location/1-1590155581	Good	Homecare agencies
Diversity Health and Social Care Limited	02/11/2018	http://www.cqc.org.uk/location/1-2001163039	Requires Improvement	Homecare agencies
Five Elms Medical Practice	09/11/2018	http://www.cqc.org.uk/location/1-2871346124	Requires Improvement	Doctors/GPs
Valentines Way	10/11/2018	http://www.cqc.org.uk/location/1-4544366730	Good	Residential homes
Dr Aarron Patel	28/11/2018	http://www.cqc.org.uk/location/1-516078976	Good	Doctors/GPs
Oceanic Care Services Ltd	04/12/2018	http://www.cqc.org.uk/location/1-2693321374	Inspected but not rated	Homecare agencies
Barking Enterprise Centre	06/12/2018	http://www.cqc.org.uk/location/1-3696883479	Good	Homecare agencies
Trading Office	11/12/2018	http://www.cqc.org.uk/location/1-3594766836	Good	Homecare agencies, Supported living
Alexander Court Care Centre	18/12/2018	http://www.cqc.org.uk/location/1-3977761030	Requires Improvement	Nursing homes
Candid Health Care (CHC) Ltd	19/12/2018	http://www.cqc.org.uk/location/1-2562870320	Good	Homecare agencies
Essex	28/12/2018	http://www.cqc.org.uk/location/1-3678676111	Requires Improvement	Homecare agencies
Chenai Holistic Home Care Agency Ltd	09/01/2019	http://www.cqc.org.uk/location/1-3110022187	Requires Improvement	Homecare agencies
The Abbeyfield East London Extra Care Society Limited	12/01/2019	http://www.cqc.org.uk/location/1-112951275	Good	Residential homes
The Upstairs Surgery	15/01/2019	http://www.cqc.org.uk/location/1-609934909	Requires Improvement	Doctors/GPs
Outreach Support Services Limited	22/01/2019	http://www.cqc.org.uk/location/1-2432717721	Good	Homecare agencies
Highgrove Surgery	05/02/2019	http://www.cqc.org.uk/location/1-3182924246	Requires Improvement	Doctors/GPs
SASA Homes Limited	07/02/2019	http://www.cqc.org.uk/location/1-4838490711	Good	Residential homes
Barking	13/02/2019	http://www.cqc.org.uk/location/1-2869391206	Good	Homecare agencies
Faircross Care Home London Limited	15/02/2019	http://www.cqc.org.uk/location/1-3224519865	Requires Improvement	Residential homes
Abbey Medical Centre	19/02/2019	http://www.cqc.org.uk/location/1-2793694187	Good	Doctors/GPs
Fern Care Services Limited	28/02/2019	http://www.cqc.org.uk/location/1-216915492	Good	Homecare agencies
Outlook Care - Dagenham Road	01/03/2019	http://www.cqc.org.uk/location/1-124583481	Good	Residential homes
Gascoigne Road Care Home	09/03/2019	http://www.cqc.org.uk/location/1-142472435	Good	Residential homes, Shared lives
Hart Lodge	13/03/2019	http://www.cqc.org.uk/location/1-4604765482	Good	Residential homes
Valence Medical Centre	20/03/2019	http://www.cqc.org.uk/location/1-584952137	Good	Doctors/GPs
Halbutt Street Medical Practice	22/03/2019	http://www.cqc.org.uk/location/1-584799345	Inadequate	Doctors/GPs
Dr Yousef Rashid	29/03/2019	http://www.cqc.org.uk/location/1-494257660	Inadequate	Doctors/GPs

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HEALTH AND WELLBEING BOARD

11 June 2019

Title:	Childhood Obesity Scrutiny Review – Proposed Action Plan

Report of the Health Scrutiny Committee

Open Report	**For Decision**
Wards Affected: All wards	**Key Decision: Yes**
Report Author: Mary Knower, Public Health Strategist and Tom Stansfeld – Advanced Health Improvement Practitioner	**Contact Details:** Tel: 020 8227 5120 E-mail: thomas.stansfeld@lbbd.gov.uk

Sponsor:
Matthew Cole, Director of Public Health

Summary:

For 2018/19, the Health Scrutiny Committee agreed that childhood obesity would be the topic on which to undertake an in-depth scrutiny review. It was requested that the Review look at the evidence around tackling the issue at a system-wide level. This Review was timely as Public Health England and the Local Government Association had been working on developing a whole systems approach to obesity since 2015.

The Scrutiny Committee were concerned that although most partners were working well to tackle childhood obesity there was a lack of joined up approach in the system. The proposed action plan sets out a series of actions to create better integration which can amplify the impact and outcomes of work already taking place.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree the proposed action plan as set out in Appendix A.

Reason(s)

Addressing the obesity problem reflects the Council's ambition to make Barking and Dagenham a Borough where all residents get an opportunity to thrive and enjoy good health and well-being. The work of the Council to manage demand and improve resilience in our residents links to the Scrutiny Committee's findings to create a system that prioritises healthier choices and earlier intervention for children.

This report also comes at a time when the health system is seeking greater integration of services across the Barking, Havering and Redbridge integrated care system. The questions in this Review can play a role in shaping how this new health system addresses one of the greatest health challenges facing us today.

1. Introduction and Background

1.1 Prevalence of childhood obesity, children over the 95th centile of weight, is increasing more in the most deprived areas than the more affluent areas of England and severe obesity is at its highest ever level of the past 10 years. In terms of ethnicity, analysis has found that levels of excess weight in Black and Minority Ethnic (BME) Year 6 boys were increasing faster than in White British Boys. However, in Reception, White British Girls were amongst the only groups showing an upward trend in excess weight.

1.2 Barking and Dagenham has the worst childhood obesity rates in London and little has changed over the past 5 years. This is impacting our children's' lives now and will continue to do so in the future.

1.3 The long-term cost of obesity and the impact on the quality of life for those who are overweight or obese means that system-wide action is required to reduce the level of obesity in this Borough. This Scrutiny Review and the recommendations that were produced as a result provide an opportunity to impact the current and future health and wellbeing of children across Barking and Dagenham.

2. Proposal and Issues

2.1 Based on evidence gathered during the review, which can be read here https://modgov.lbbd.gov.uk/internet/documents/s127513/Draft%20scrutiny%20review%20report.%20final.pdf, the following 11 actions have been proposed:

- The Council reviews how we use data to help us better understand residents' perspectives and needs, because the evidence demonstrates that we haven't understood enough about the obesity issue.
- The Council's goal for residents becomes the achievement of healthy weight, rather than just reduction of excess weight, because being overweight or underweight are both indicators for poor health outcomes.
- NELFT and the Council review the NCMP data and its use and consideration given to how the process can improve the targeting of weight management services, which will support families that need it most.
- All partners, as part of the overarching work to review services ensure that the pathway for signposting and referral to the HENRY programme is able to reach the families most in need.
- The Council adopt a whole systems approach to obesity, as advocated by the LGA and PHE and follow in the footsteps of the vanguard local authorities who have been implementing the approach.
- The HWBB support the formation of a system-wide stakeholder group that includes all relevant personnel, to take forward the actions at a system level.
- The Council supported by PHE, look to instigate a local healthier catering commitment by the fast food outlets.
- GPs/GP networks commit to liaising with schools and education to support families with the greatest need to access services e.g. referrals into HENRY and Lean Beans and to make lifestyle changes

- The CCG reviews its mental health commissioning arrangements to focus on work within education to support schools in improving the mental health and social integration of pupils.
- NELFT and the Commissioning Director for Education review its 0-19 service to take account of the need for a more nuanced mental health offer and better support for obesity work in schools.
- The Council, Education and Be First prioritise roads around schools with a view to making active travel for families the easiest way to get to and from school.

2.2. These actions focus on building a system where the healthier choice is the default and easier option and where actions are coordinated and joined up.

3 Consultation

3.1 The Stakeholder workshop which was part of the evidence review included a wide variety of partners whose comments were captured in the body of the report. The action plan has been shared with all partners who are leads for any of the actions.

3.2 Residents' views were sought through surveys and meetings with community focus groups.

4. Mandatory Implications

4.1 **Joint Strategic Needs Assessment**
The JSNA outlines the importance of improving the prevalence of healthy weight in achieving the outcomes for best start in life and the borough manifesto.

4.2 **Health and Wellbeing Strategy**
The report links well with and compliments the Health and Well-being Strategy, particularly the themes of the Best Start in Life and Building Resilience https://www.lbbd.gov.uk/sites/default/files/attachments/Joint-Health-and-Wellbeing-Strategy-2019-2023.pdf

4.3 **Integration**

The report and its recommendations support the implementation of system working, advocating all partners in health and social care working together to tackle the issue

4.4 **Financial Implications**

Implications completed by Murad Khan – Group Accountant

This report is mainly for information as such, there are no direct financial implications arising out of the report. The report does not identify any additional cost in carrying out the duties stated in the recommendations and therefore it is assumed that these will be achieved within existing resources.

4.5 **Legal Implications**

Implications completed by: Dr Paul Feild, Senior Lawyer, Law and Governance

4.5.1 There is a legal requirement under section 21 of the Local Government Act 2000 for councils which establish executive governance (this includes leader and cabinet, our model) to establish scrutiny and overview committees.

4.5.2 This report is from the work of the Heath Scrutiny Committee which has specific responsibilities with regard to health functions in the borough. Such Health Scrutiny Committees shall carry out health scrutiny in accordance with Section 244 (and Regulations under that section) of the National Health Services Act 2006 as amended by the Local Government and Public Involvement in Health Act 2007 relating to local health service matters. The Health Scrutiny Committee in its work has all the powers of an Overview and Scrutiny Committee as set out in section 9F of the Local Government Act 2000, Local Government and Public Involvement in Health Act 2007 and Social Care Act 2001 (including associated Regulations and Guidance).

4.5.3 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 that the providers of health and social care services work in their delivery in an integrated manner.

4.5.4 The body of the report indicates childhood obesity is a major public health concern. As the quantitative evidence demonstrates, the scale and prevalence in the borough is significant and without intervention leads to young people having over their lifetimes serious but avoidable poor health outcomes. The recommendations for action proposed in this report are consistent with the Health and Wellbeing Boards responsibly to promote the health and Well Being Strategy.

Public Background Papers Used in the Preparation of the Report:

None.

List of Appendices

Appendix A Proposed Action Plan arising from the Scrutiny Review

Appendix A

Childhood Obesity – system-wide review: Proposed action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating January 2019**
1.	The Council reviews how we use data to help us better understand residents' perspectives and needs, because the evidence demonstrates that we haven't understood enough about the obesity issue.	Borough Explorer expands its database on obesity figures and is reflective of resident input and perspective, so that interventions and work can be more targeted and meet resident expectations.	March 2020		Commissioning Directors and Community Solutions Mark Tyson, Chris Bush, Mark Fowler	
		Continue to consult with resident focus groups from the community as plans are developed to ensure that our programmes and work reflect the attitudes and beliefs of our population even as they develop.	March 2020		Commissioning Directors and Community Solutions Mark Tyson, Chris Bush, Mark Fowler	
		Service monitoring needs to provide assurance that this is being done, so that it becomes business as usual.	March 2020		Commissioning Directors and Community Solutions Mark Tyson, Chris Bush, Mark Fowler	
2.	The Council's goal for residents becomes the achievement of healthy weight, rather than just excess weight, because being overweight and underweight are both indicators for poor health outcomes.	Review our current targets and metrics to ensure that they are focussed on this and are reflected in the performance scorecard of the Council and its partners, through the HWB.	March 2020		Policy & Participation, Tom Hook	

Appendix A

Childhood Obesity – system-wide review: Proposed action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating January 2019**
3.	NELFT and the Council review the NCMP data and its use and consideration is given to how the process can improve the targeting of weight management services, which will support families that need it most.	0-19 commissioners, PH, NELFT and Community Solutions establish a working group to review the referral pathway from NCMP assessment to admission to WM services. (This will link with the review being undertaken of Community Solutions services; the report on which is due in March 2019.) The outcome will be that children and their families who need it most are supported by our services, not just for traditional weight management but also for wider mental health issues associated with weight. This working group and other sub-groups will report every 6 months into the Childhood Obesity system-wide Transformation group (see recommendation 6)	March 2020		Children's commissioning: Heather Storey	

Appendix A

Childhood Obesity – system-wide review: Proposed action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating January 2019**
4.	All partners, as part of the overarching work to review services ensure that the pathway for signposting and referral to the HENRY programme is able to reach the families most in need.	Partners establish a working group to review and revise pathway so that families who are in most need of support are enabled and encouraged to access it. Community Solutions should review their services and how they link with other partners; and there should be a single integrated pathway to refer children through. Group to report into system-wide Transformation group every 6 months.	March 2020		Community Solutions: Danielle Walker	

Appendix A

Childhood Obesity – system-wide review: Proposed action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating January 2019**
5.	The council adopt a whole systems approach to obesity, as advocated by the Local Government Association and PHE and follow in the footsteps of the vanguard local authorities who have been implementing the approach.	The Council draws up a prevention picture based on insight of the targeted populations to inform evidence-based approaches. Use evidence from the BHR Joint Commissioning Board Prevention Paper and the Community Solutions review Create evidence reports for each of the key prevention areas: • Active travel • Fast food outlets • Targeting of most needy in terms of wider determinants. • Effective early years support The outcome will be that our programmes and upstream interventions are relevant for our population and provide the best return on investment at a population level.	March 2020		Public Health team	
6.	The HWB support the formation of a system-wide stakeholder group that includes all relevant personnel, to take forward the actions at a system level	System-wide transformation group established with Community Solutions that will oversee the new model for delivering on system-wide obesity. This system wide group will work across sectors to coordinate efforts and actions to improve the environment and make it easier for our children to be and stay a healthy weight.	April 2019		Public Health – Tom Stansfeld	

Appendix A

Childhood Obesity – system-wide review: Proposed action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating January 2019**
7.	The Council supported by PHE, look to instigate a local healthier catering commitment by the fast food outlets.	Co-develop with local businesses a Barking and Dagenham catering commitment which benefits business and improves the healthy content of fast food catering thereby removing calories from our children's diet.	March 2020		Enforcement - Theo Lamptey	
8.	GPs/GP networks commit to liaising with schools and education to support families with the greatest need to access services e.g. referrals into HENRY and Lean Beans and to make lifestyle changes	Establish task group to formulate a feasible pathway between GP practices, schools and Community Solutions services; establish how GPs can use their role when they have contact with overweight children to flag the issue to schools and Community Solutions. Consider training needs for GPs. To be linked with group working on recommendations 3 & 4	April 2019		CCG Clinical Lead: Dr Jagan John	
9.	The CCG reviews its mental health commissioning arrangements to focus on work within education to support schools in improving the mental health and social integration of pupils.	To be a priority for the Children and Young Peoples' Transformation Board; produce a system-wide transformation plan to address the long-standing issues in relation to SEND and CAHMS and the mental health support required to deliver mental health and support in schools. The accountability for this is anchored in the HWB. Report into system-wide group	March 2020		Elaine Allegretti	

Appendix A

Childhood Obesity – system-wide review: Proposed action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating January 2019**
10.	The Commissioning Directors for Education and children review its 0-19 service to take account of the need for a more nuanced mental health offer and better support for obesity work in schools.	To be included as part of the remit of the working group for recommendation 3. Needs to ensure the delivery of the system-wide review of Community Solutions. Report into system-wide group. Accountability should be anchored in the HWB.	March 2020		Education Commissioning Director: Jane Hargreaves Children's Commissioning Director: Chris Bush	
11.	The Council, Education and Be First prioritise roads around schools with a view to making active travel for families the easiest way to get to and from school.	Identify the top 5 schools with a low level of active travel and work with them to create a model shift in order to have the greatest impact on an in-need population. The education commissioner should lead this piece of work and involve relevant partners. Working group to look at feasibility of further parking restrictions, cycle lanes etc	March 2020		Education commissioning Erik Stein	

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	**Progress report - The Cancer Prevention, Awareness, and Early Detection Scrutiny Review**
Report of the Director of Public Health	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: NO**
Report Authors: Usman Khan, Consultant in Public Health	**Contact Details:** Tel: 0208 227 5039 E-mail: usman.khan@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

At the start of the 2015/16 municipal year, the Health Scrutiny Committee agreed to undertake an in-depth scrutiny review into cancer prevention, awareness, and early detection.

The scrutiny review addressed 3 questions:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London Boroughs?
2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London Boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London Boroughs?

This paper provides a progress update the Board on implementing the eleven recommendations of the Scrutiny Review.

Recommendation(s)

The Health and Wellbeing Board is asked to

I. Review progress on implementation of the eleven recommendations and
II. Discuss and comment on any gaps and future actions.

Reason(s):

In line with standard scrutiny practice, a six-monthly monitoring report should be presented to the Board to provide an update on the progress of the recommendations in order to help the Committee evaluate the effectiveness of this scrutiny review and to what extent it has helped improve services for our Borough's residents.

1. Introduction and Background

1.1 In the municipal year 2017/18, the Health Scrutiny Committee undertook an in-depth scrutiny review into cancer prevention, awareness, and early detection.

1.2 The review report and proposed action plan were presented and approved at the Health and Wellbeing Board in September 2018.

2. Proposals and Issues

2.1 The Cancer Scrutiny Review report made 11 key recommendations to the Health and Wellbeing Board to help improve the cancer awareness and early intervention in the borough.

2.2 The 'Barking and Dagenham, Havering and Redbridge Cancer Transformation Plan on a page' is attached in **Appendix 1**. The priorities are at the top followed by the next tier of objectives for the year and then lower layer of key initiatives.

3. Scrutiny Review Report

3.1 The Health Scrutiny Committee reviewed the draft report in March 2017 and Councillor Worby, the Cabinet Member for Social Care & Health Integration, and Chair of the Health and Wellbeing Board, also had an opportunity to view the recommendations.

3.2 Progress against the 11 recommendations is attached as **Appendix 2.**

The Board if decided, will focus one of the themes of the Joint Health and Wellbeing Strategy on early detection.

4. Other Strategic documents

Joint Strategic Needs Assessment (JSNA) - The Barking and Dagenham JSNA highlights Achieving World Class Outcomes: A Strategy for England. The scrutiny review and linked action plan address the ambitions of the England Strategy and specifically the lower 1-year survival rate of Borough residents.

Joint Health and Wellbeing Strategy - The scrutiny review supports the ambitions of the borough's Joint Health and Wellbeing Strategy.

Early adulthood - More women will protect themselves through taking up the offer of screening for cervical cancer.

Established adults - More adults will take up the opportunity to protect themselves through cancer screening (cervical, bowel and breast).

Older adults - More older adults take up the opportunity to protect themselves through cancer screening (bowel and breast).

5. Financial and Legal Implications

5.1 Not required.

Public Background Papers Used in the Preparation of the Report

None

List of Appendices

Appendix 1	Barking, Havering and Redbridge Cancer Transformation Plan
Appendix 2	Health Scrutiny Committee Cancer Scrutiny Review Action Plan

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Appendix 1

Cancer transformation plan

Barking and Dagenham, Havering and Redbridge

By 2020/21 we will deliver:

the 28 day cancer diagnosis standard, embed stratified pathways for prostrate, breast and bowel cancer and national optimal pathways, and deliver a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long Term Condition.

2019/20 objectives:

- Increase uptake of cervical and bowel screening and implement the roll out of FIT testing for diagnosing colorectal cancer
- Continue to deliver sustained Cancer Waiting Time targets and implement the new 28 day Faster Diagnosis Standard (FDS).
- Awareness raising of symptoms with the public and all healthcare professionals
- Deliver personalised care for all cancer patients, resulting in improved patient experience

Key initiatives

Prevention

- Support the national Be Clear on Cancer campaigns to increase presentation with suspected symptoms.
  Progress: Not started | In progress | Complete | Off track
- Reduce smoking rates.
  Progress: Not started | In progress | Complete | Off track
- Implement bowel screening co-ordinator to improve screening rates.
  Progress: Not started | In progress | Complete | Off track
- Develop and deliver an education strategy for primary care and patients.
  Progress: Not started | In progress | Complete | Off track
- Health Promotion Champions to engage with BME and other hard to reach groups.
  Progress: Not started | In progress | Complete | Off track
- 'Teachable moments' for patients who have had an all clear following a 2WW.
  Progress: Not started | In progress | Complete | Off track
- School competition to raise awareness and increase uptake of the HPV vaccine.
  Progress: Not started | In progress | Complete | Off track

Primary care

- Deliver 'Talk Cancer' training for non-clinical staff.
  Progress: Not started | In progress | Complete | Off track
- Roll out Macmillan primary care toolkit.
  Progress: Not started | In progress | Complete | Off track
- Action plan to improve patient experience based on the outcome of National Cancer Patient Experience survey.
  Progress: Not started | In progress | Complete | Off track
- Practice and Network visits by Macmillan GPs and CRUK facilitator to improve outcomes.
  Progress: Not started | In progress | Complete | Off track
- Roll out of Cancer Care Reviews (CCR) including training for practice nurses.
  Progress: Not started | In progress | Complete | Off track
- FIT NG30 bowel screening roll out.
  Progress: Not started | In progress | Complete | Off track
- Out of Hours cervical screening to improve uptake.
  Progress: Not started | In progress | Complete | Off track
- Increasing uptake of bowel screening programme.
  Progress: Not started | In progress | Complete | Off track

Planned care

- Agree and implement stratified follow up arrangements for prostate patients.
  Progress: Not started | In progress | Complete | Off track
- Develop local lymphoedema service..
  Progress: Not started | In progress | Complete | Off track
- Implement cancer 28 day Faster Diagnosis Standard.
  Progress: Not started | In progress | Complete | Off track
- Implement lung, prostrate and colorectal optimal pathways.
  Progress: Not started | In progress | Complete | Off track
- Develop Multi Diagnostic Centre (MDC) pathways at Queen's Hospital.
  Progress: Not started | In progress | Complete | Off track
- Delivery of the Recovery Package – Treatment Summaries, Holistic Needs Assessment and Health & well-being events.
  Progress: Not started | In progress | Complete | Off track
- Agree service specification of integrated oncology service for BHR.
  Progress: Not started | In progress | Complete | Off track

Unplanned care

- Review the referral pathway for patients suspected of having cancer following attendance in Urgent Care/Hub settings to ensure safety netting processes in place.
  Progress: Not started | In progress | Complete | Off track
- Ensure consultant upgrade pathway is used for patients diagnosed via A&E.
  Progress: Not started | In progress | Complete | Off track

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Appendix 2

Health Scrutiny Committee (HSC) Cancer Scrutiny Review: Progress Action Plan						
	Cancer Awareness and early intervention Recommendation	**Action**	**Outcome**	**Target Date**	**Lead Agency**	**RAG status February 2019**
1	The Health and Wellbeing Board (HWB) takes action to reduce the prevalence of smokers in the borough, to levels comparable with London;	Continue to focus smoking cessation work with vulnerable groups e.g., pregnant women, mental health patients and substance misuse users.	Successful links established with MH teams and IAPT clinics. For further information refer to: ..\..\..\..\Smoking and Tobacco Control\Tobacco Control\Tobacco Alliance group\Tobacco Harm Reduction plan vs 3.docx	On-going	LBBD Commissioning Lead, Healthy Lifestyles	
			Successful maternity engagement which generates referrals. 'Risk Perception' project underway	March 2020	LBBD Commissioning Lead, Healthy Lifestyles	
		Link with and monitor the STP plans for Tobacco control, which is to address smoke-free sites, brief interventions in secondary settings and referrals and the London telephone service. Report back through corporate performance/key accountabilities system.	Being led by the STP Prevention Group. London Telephone service has made progress with revised website and referrals for B & D residents are now increasing.	March 2020	LBBD, PH	

	Cancer Awareness and early intervention	Action	Outcome	Target Date	Lead Agency	RAG status February
	Cancer Awareness and	**Action**	**Outcome**	**Target Date**	**Lead Agency**	**RAG**
2	The HWB sets out to the HSC what action it is taking to reduce the number of overweight and obese individuals in the Borough, to levels comparable with London.	Monitor implementation and outcome of the Childhood Obesity scrutiny review action plan based on system-wide implementation. Report progress back to HSC **Deliverables include**: Formation of system-wide stakeholder group Review of the NCMP Review of WM services towards a targeted service Review of fast food outlets offers 'Sugar Smart' campaign work in progress with schools.	Scrutiny review approved by HSC December 2018. Due for formal approval at HWBB. For further information on action plan go to: ..\..\..\..\Healthy Weight\HSC scrutiny Review - Childhood Obesity\Review Report\Final report\version for HSC 18 dec\HWB proposed action plan.vs 3.docx	 June 2019 March 2020	LBBD, PH Commissioning Lead, Healthy Lifestyles	
3	The HWB takes action to increase residents' awareness of how lifestyle, including exposure to the sun, can affect the likelihood of developing cancer, signs and symptoms of cancer and the importance of early diagnosis, and screening;	Implement a programme of engagement with local community groups around cancer awareness, screening and lifestyle issues.	This work is being led by the recently appointed BHR Project co-ordinator for Population Awareness. Jasmine Begum is developing a local strategy to deliver projects funded by 2018/19 transformation funds release	March 2020	NEL CSU Katherine Kavanagh Commissioning Manager Jasmin Begum, BHR Project Coordinator - Population Awareness	

	early intervention Recommendation					status February 2019
		Work with the UCLH partners to monitor the effect of the re-launched 'small c' website – review breast/bowel -screening figures to assess the impact of these public engagement plans	??			
4	The Barking and Dagenham Clinical Commissioning Group (BDCCG) ensures that GPs are auditing and acting on audit information	Review practice profiles for each GP area. Access and analyse 'routes to diagnosis' particularly via A&E data to target practice work. CRUK facilitators to work with practices to encourage review of internal systems. Encourage Barking and Dagenham practices to complete audits / SEAs to understand patients' diagnosis via A&E- subject to funding.		March 2020 Ongoing Ongoing	BHR / B&D CCG Jeremy Kidd/ CRUK Facilitator	

	Cancer Awareness and early intervention Recommendation	Action	Outcome	Target Date	Lead Agency	RAG status February 2019
5	The BDCCG, in partnership with Macmillan and Cancer Research UK, takes action to increase the proportion of residents returning bowel cancer screening kits, within the next year.	With Transformation money a project manager has been appointed for 12 months to focus on screening. This post had to go back out to ad after the initial candidate withdrew. A new Health Promotion Officer – screening has been appointed (May 2019) and currently waiting for pre-employment checks to be finalised.	Dedicated support can monitor programme progress and delivery against actions. Work with individual GP practices and GP Networks within primary care to look at screening data and agree actions to improve uptake.	June 2010 start date	NEL CSU Katherine Kavanagh Commissioning Manager	
		Bowel screening - Additional pot of money to engage GP practices to identify their rising 60s and 'DNAs' i.e. those who didn't return their previous screening pack and contact them out of hours to encourage uptake of the screening	Encourages participation in the screening programme and increases uptake.	March 2020	BHR / B&D CCG Jeremy Kidd	

	Cancer Awareness and early intervention Recommendation	Action	Outcome	Target Date	Lead Agency	RAG status February 2019
		FIT for screening is due to go live in early June. All screening centres are RAG rated GREEN for colonoscopy and pathology capacity, end-testing at the Hub has been completed.	Should help encourage greater uptake because of only 1 sample being needed and the new test gives better reliability of results.	June 2019	BHR / B&D CCG Jeremy Kidd	
		In addition, GP practices can start to offer the FIT test to those who are at low risk but not no risk in line with NICE DG30.	Should reduce need for colonoscopies because it better identifies those who need a referral in this cohort. Assists practices to deliver the initiatives.	May 2019	BHR / B&D CCG Jeremy Kidd	
6	The HWB, along with Macmillan and Cancer Research UK, takes action to raise awareness of the importance of screening and to increase uptake of **breast and bowel screening** in the Borough to a level comparable with England within the next year;	**Actions as per recommendation 5** Progression of the Cancer Collaborative Action Engagement with community groups by the Cancer Lead and CRUK Facilitator to include promotion of all screening programmes, leading to increased uptake		March 2020	LBBD – Matthew Cole NEL CSU Katherine Kavanagh BHR / B&D CCG Cancer Research UK Lubna Patel	

	Cancer Awareness and early intervention Recommendation	Action	Outcome	Target Date	Lead Agency	RAG status February 2019
7	The HWB, along with Macmillan and Cancer Research UK, acts to raise awareness of the importance of screening and reduce the **variation in cervical screenin**g uptake between GP practices within the next year;	Review the uptake within practices Cervical screening is promoted at all practice visits. The programme of engagement with community groups will to include promotion of the benefits of cervical screening. All practices to be advised of the option to undertake re-accreditation for experienced sample takers through online training. Text messaging being delivered to patients from GP practices that screening is due - **28/35 signed up** Out of hours clinic now funded to encourage those residents who are working. Social media posts being delivered.	Figures at June 2018 show uptake range of between 44% and 75% with majority of practices at an uptake of 60-68%	March 2020 Ongoing Ongoing March 2020	NEL CSU Katherine Kavanagh Commissioning Manager BHR / B&D CCG Jeremy Kidd/ Cancer Research UK Lubna Patel CRUK	

	Cancer Awareness and early intervention Recommendation	Action	Outcome	Target Date	Lead Agency	RAG status February 2019
8	The Committee urges NHS England to make the Cancer Dashboard available within one year;	London Dashboard now available.	Ability to monitor screening rates for bowel, breast & cervical screening.		Maggie Luck Commissioning Manager NHS England	
9	The HWB takes action to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices;	Create joint improvement plan, CCG and PH, to improve quality and uptake of NHS health checks Monitor improvement Specialist nurse appointed in January 2018 for a year		March 2019	LBBD Tom Stansfield, PH Advanced Practitioner Primary care networks Network managers	
10	NHS England provides assurance to HWB that residents will continue to have in-borough access to breast screening	Monitor and report breast screening rates in the Borough, through contact with the Provider	Screening rates for B & D have increased marginally compared to 17/18. The breast screening service has secured a mobile screening site in Barking Town Centre for the last round and hopes they can use the same location for the next screening round in December 2019/January 2020. Dagenham ladies currently go to King George Hosp to get screened.	March 2020	Maggie Luck Commissioning Manager NHS England LBBD, PH	

	Cancer Awareness and early intervention Recommendation	Action	Outcome	Target Date	Lead Agency	RAG status February 2019
11	The BDCCG, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.	Develop an NEL-wide strategy with key stakeholders. A population awareness project coordinator has been recruited for BHR and will lead on a programme to recruit cancer health promotion champions to work with hard to reach groups within the community, raising awareness of sign and symptoms	Ongoing via pan-NEL strategy for ED A project proposal has been developed and a provider is being identified.	March 2020	BHR / B&D CCG Sue Maughn – Director for Cancer for North East London Health and Care Partnership Jasmin Begun, BHR Project Coordinator - Population Awareness	

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	**Progress report – The Oral Health in The Early Years Scrutiny Review**

Report of the Director of Public Health

Open Report	**For Information**
Wards Affected: All	**Key Decision: No**
Report Authors: Thomas Stansfeld – Advanced Health Improvement Practitioner	**Contact Details:** Tel: 0208 227 5120 Email: Thomas.stansfeld@lbbd.gov.uk

Sponsor: Matthew Cole, Director of Public Health

Summary:

At the start of the 2017/18 municipal year, the Health Scrutiny Committee agreed to undertake a rapid scrutiny review into oral health in the early years.

The scrutiny review addressed 3 questions:

1. What are the reasons for young children in Barking and Dagenham having poor oral health?
2. What is the quality of services that are available to residents and what do they deliver to improve oral health?
3. What are the best ways of getting the right messages out to parents about looking after their children's oral health?

This paper provides a progress update the Board on implementing the eight recommendations of the scrutiny review.

Recommendation(s)

The Health and Wellbeing Board is asked to

I. Review progress on implementation of the eight recommendations and
II. Discuss and comment on any gaps and future actions.

Reason(s):

In line with standard scrutiny practice, a six-monthly monitoring report will be presented to the Board providing an update on the progress of the 8 recommendations. The Chair is required to provide a report for the Health Scrutiny Committee in order to help the Committee evaluate the effectiveness of this scrutiny review and to what extent it has helped improve services for our borough's children.

1. Introduction and Background

1.1. In the municipal year 2017/18, the Health Scrutiny Committee undertook a rapid scrutiny review into oral health in the early years.

1.2 The review report and proposed action plan was presented and approved at the Health and Wellbeing Board in September 2018.

2. Proposals and Issues

2.1 The Health Scrutiny Committee's report made eight key recommendations to the Health and Wellbeing Board to help improve the oral health in the early years.

3. Scrutiny Review Report

3.1 The Health Scrutiny Committee was reviewed the draft report in March 2017 and Councillor Worby, the Cabinet Member for Social Care & Health Integration, and Chair of the Health and Wellbeing Board, also had an opportunity to view the recommendations.

3.2 Progress against the eight recommendations is attached as **Appendix 1.**

4. Other Strategic documents

4.1 **Joint Strategic Needs Assessment (JSNA) -** The Barking and Dagenham JSNA highlights the higher number of poorer oral health outcomes for our 3 year olds compared to London and England and unnecessary suffering through poor oral care. This action plan and scrutiny review seek to reduce this in Barking and Dagenham.

4.2 **Joint Health and Wellbeing Strategy -** The scrutiny review supports the ambitions of the Borough's Joint Health and Wellbeing Strategy, particularly Theme 1: Best Start in Life.

5. Financial and Legal Implications

5.1 Not required

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

None.

List of Appendices

Appendix 1 – Health Scrutiny Committee Oral Health in the Early Years Action Plan

Appendix 1

HASCC Oral Health in Early Years Review – Progress Action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating May 2019**
1.	The Health and Wellbeing Board (HWB) takes action to support an integrated approach to oral health promotion across all children's services and that contract specifications for all early years' services include a requirement to promote oral health; this should include very early oral health promotion by health visitors to help prevent tooth decay from sweetened dummies, prolonged use of milk in bottles and other sweet foods.	Oral health promotion incorporated into the new specification for the 0-19 services contract with NELFT.	September 2018	The contract requires of the provider to: -Improve dental health and oral hygiene and reduce tooth decay and extractions in children aged 5 -Provide brief interventions, advice and guidance -Encourage attendance at a dentist -Signpost to any locally-commissioned dental health programmes	LBBD, Heather Storey, Commissioning Lead, Children's Services	
		Performance is monitored through commissioner/provider progress meetings and the Public Health Programme Board, but need to move more towards measuring outcomes rather than just activity, in keeping with other key agendas, like childhood obesity	March 2020	Currently this information is not collected but the monitoring framework is potentially being revised in the coming year, therefore oral health reporting could be added contingent on prioritisation in context of other indicators as well as feasibility of extracting this data from NELFT systems	LBBD Children's Commissioning,	
2.	The Committee urges NHS England to actively support the teaming up of dentists with children's centres to encourage engagement with dental services from an early age, so that dental disease can be detected early and children get used to going to the dentist.	Team up with the dental partners to agree the approach with NHSE.	September 2018	Partial progress; The North-East London oral health promotion team, commissioned by NHSE have been delivering education sessions at all children's centres in Barking and Dagenham One dental practice committed to promotion sessions during oral health week.	NHSE	

HASCC Oral Health in Early Years Review – Progress Action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating May 2019**
		Gather intelligence from other areas who are also looking at the feasibility of this project.	September 2018		LBBD, PH	
3.	The HWB is asked to monitor and report back on the progress of the oral health strategy, including the results of the 'Teeth for Life' (tooth-brushing) project	Maintain performance monitoring reports on distribution of toothbrushes and results from the project manager. Staff in participating centres receive training. Pre-schools and nurseries receive supplies of toothbrushes.	May 2018 September 2017	As at September 2018 62 pre-schools had joined the project. There is £15k to continue with training and supply of toothbrushes into 2019/20.	LBBD, Ade Winjobi, Procurement Manager	
4.	The Committee urges NHS England to implement the initiative proposed by the Chief Dental Officer and increase dental activity by 2%, so that dentists can see children at 1 year of age.	LBBD and the Local Dental Committee (LDC) send a joint letter of support for the Chief Dental Officer's proposal to NHSE.	September 2018	Contact made with the LDC who suggested that NHS England would be very difficult to engage with. We have prioritised contacting the dentists who have spare capacity in the first instance.	NHSE	
5.	The Committee urges NHS England to actively support those dentists who underperform in activity to utilise their spare capacity to target young families to engage with their dental service.	Action this recommendation in joint letter/petition to NHSE as per recommendation 4. .	September 2018	Letter sent to all dentists following Chief Dental Officer's appeal in 2018 for dentists to offer check-up appointments to 1-year olds with a particular focus on those with current spare capacity	LDC, LBBD, Matthew Cole.	
6.	The A&E Delivery Board investigate the impact of dental emergencies on paediatric A&E attendance and challenge the system (CCG's) as to what is being done to address this.	Request of the CCG to provide data on attendance and any plans that could address the situation. LBBD adult commissioning works with the CCG to assess impact and find solutions.	March 2020		LBBD, Matthew Cole	

HASCC Oral Health in Early Years Review – Progress Action Plan						
	Recommendation	**Action**	**Target Date**	**Progress**	**Lead Agency**	**RAG rating May 2019**
7.	The HWB, in collaboration with the British Dental Association, takes action to raise awareness of the importance of taking young children to the dentist and that it is a free service. This could include communication through images to help address the need for information in languages other than English	Agree a local plan with LDC and other stakeholders to raise the profile of going to the dentist; include communications and campaign messages.	September 2018	In 2018 Public Health partnered with the Community Solutions team, Children's Centre teams, the local Dental Committee and LBBD Communications to formulate a campaign which coincided with National Smile Month in June. 'My Dentist' dental practice and the NEL Oral Health promotion team joined in to help promote good dental health and deliver sessions across the Borough.	LBBD, PH	
8.	The HWB supports action around food outlets, cafes and restaurants as part of the drive to decrease sugar consumption and improve oral health; for example, the 'Sugar Smart' campaign.	Link in with the 'Healthy Weight Strategy' and the Childhood Scrutiny Review action plan ..\Scrutiny review\HWB proposed action plan.docx	March 2020	The 'sugar smart' campaign has continued and included fizz-free February initiatives to highlight the amount of sugar in fizzy drinks to more schools. 60 people were signed up from Barking and Dagenham libraries to commit to the challenge. Currently exploring the Local Government Declaration on Sugar Reduction and Healthier Food, with support from the GLA, Sustain and colleagues in Havering and Redbridge.	LBBD, Healthy Lifestyles Team, and Public Health	
		Initiate the 'Healthy Catering Commitment' with 50% of the existing fast food outlets to get buy-in for changing content of food to healthier constituents	March 2020		LBBD, PH, Enforcement	

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HEALTH AND WELLBEING BOARD

11 June 2019

Title:	**Chair's Report**
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Eleanor Parkin (Governance and Policy Manager)	**Contact Details:** Tel: 020 8227 3722 E-mail: Eleanor.parkin@lbbd.gov.uk
Sponsors: Mark Tyson, Commissioning Director, Adults' Care and Support Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: The June edition of the Chair's Report is attached at Appendix A. Board Members are invited to comment on the issues raised in the report.	
Recommendation(s) The Health and Wellbeing Board is recommended to note the Chair's Report, as set out at Appendix A to the report.	

List of Appendices:

Appendix A: Chair's Report, June 2019

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In this edition of my Chair's Report I talk about the changes made at King George's Emergency Urgent Care Centre, I am always pleased to see improvements in the care patients receive. It is particularly pleasing when a service that was previously rated inadequate jumps to a rating of Good.

I am delighted to report on Barking & Dagenham's success within the London Healthy Schools Programme, we are one of the top 5 boroughs in the capital in terms of the number of awards achieved. We were also successful in bidding for partnership to deliver the Early Years Transformation Academy, and finally I report back on Thrive LDN and work underway to enable Thames ward to flourish by working together to plan, develop and deliver the healthy new town.

Best wishes,
Cllr Maureen Worby, Chair of the Health and Wellbeing Board

King George Urgent Care Centre's CQC rating jumps from Inadequate to Good

King George's Emergency Urgent Care Centre (EUCC) in Ilford has been rated Good by the Care Quality Commission. Previously it had been Inadequate.

King George's EUCC was rated Good for being safe, effective, responsive and well-led. It was rated Requires Improvement for being caring, following an inspection in March 2019. The service is run by the Partnership of East London Co-operatives (PELC) Limited.

Inspectors found that action had been taken to deliver high-quality and person-centred care. There had been improvement in how the service assessed and monitored patients. This included availability of appropriate clinical equipment and introduction of new protocols and training to support how clinicians 'streamed' or assessed patients.

Action had been taken since the last inspection to improve the service's physical layout and make it more conducive to maintaining patients' privacy.

There was a strong focus on continuous learning and improvement at all levels of the organisation.

However, areas where the provider should improve include:

- To further improve how the physical layout ensures patients' privacy.
- Monitor how long patients wait in the queue.
- Take action to ensure electronic patient feedback terminals are available in languages other than English.

You can read the inspection report in full when it appears on CQC's website at: https://www.cqc.org.uk/location/1-351993193

Healthy Schools update

Barking & Dagenham is one of the best performing boroughs within the London Healthy Schools Programme. Current engagement is as follows:

- 57 schools registered (95% of all schools)
- 37 Bronze awards
- 36 Silver awards
- 15 Gold awards

36 Silver and 15 Gold awards places us in the top five boroughs in London in terms of numbers of awards achieved at this level and at or near the top in terms of awards achieved as a proportion of all schools.

There is excellent engagement with schools, with 26 actively working towards awards at present, including Parsloes and Eastbrook working towards their Gold awards. 12 schools have either developed, or are working towards, a silver award action plan focused on improving emotional wellbeing and mental health and within the last half term, Dorothy Barley Junior School have achieved both their Bronze and Silver awards.

Our locally commissioned provider for the programme, Health Education Partnership, are strategically placed in the borough and sit on our Sexual Health Board, Tobacco Alliance and CAMHS Local Transformation Plan partnership. They regularly provide resources and updates to 155 borough school contacts as well as 55 partners.

For further information please contact Erik.Stein@lbbd.gov.uk

Early Years Transformation Academy

Barking & Dagenham have partnered with the Early Intervention Foundation (EIF) to deliver the Early Years Transformation Academy (EYTA). The bid for partnership was a competitive one and the borough is one of five successful partners nationally.

The Academy offers applied learning opportunities to selected staff across local Maternity and Early Years services. Staff across Early Years, Community Solutions, Participation and Engagement, Public Health and Children's Commissioning have started work with health colleagues to deliver this vital programme. With the support and learning of the Academy the local team (EYTA team) will develop a maternity and early years transformation plan, based on best practice and guidance from experts at the EIF. This support will help the borough put early intervention at the centre of interaction with residents and supports delivering the strategic objectives set out in both the Corporate Plan 2018-2022 and Joint Health and Wellbeing Strategy 2019-2023.

Senior sponsors across the key partner organisations will support the EYTA team to deliver the academy aspirations with a specific focus on: vulnerable parents, speech language and communication as well as support for parents. Stakeholder and community engagement have begun to inform the team's planning process with graduation from the Academy set to take place in Spring 2020.

For Further information please contact Hollie.Stone@lbbd.gov.uk

Thrive LDN

Thrive LDN is a citywide movement to improve the mental health and wellbeing of all Londoners. It is supported by the Mayor of London and led by the London Health Board.

Thrive LDN has the following aspirations for the city:

a. A city where individuals and communities take the lead
b. To enable a citywide movement for all Londoners that empowers individuals and communities to lead change, address inequalities that lead to poor mental health and create their own ways to improve mental health and wellbeing. To support more Londoners to access a range of activities that help them to maintain good mental health and wellbeing.
c. A city free from mental health stigma and discrimination.
d. To work with partners to develop a programme that ends mental health stigma and discrimination in London. Ensuring support is available to help improve people's understanding of mental health and push for more mental health first aid training to be provided so London becomes a city that is more mental health aware and equipped to act.
e. A city that maximises the potential of children and young people.
f. To build on the exciting developments happening across London to engage children and young people in mental health, encourage them to lead initiatives, and develop training and resources for youth organisations, schools, and student societies.

Barking & Dagenham has commissioned the **Mental Health Foundation** (MHF) to develop a range of services and courses to improve mental health and wellbeing of children, young people, working age adults and older adults in the Thamesview ward. They have been running a programme since December in the ward on the following topics:

- Parents Together
- Peer Education Project
- Tree Shepherd
- Standing Together
- Health and Happiness Training
- Engaging the Community

MHF have also been working with another organisation called Our Time who will be delivering training to staff at Thames View Infants school and hopefully the Juniors too about mental health. Their focus is on helping young people who are affected by parental mental illness, the school felt their input would be helpful to them. The training consists of an awareness raising session to introduce the subject of parental mental illness. It will include an assessment of the school's needs and how they discuss mental health currently. A follow up session will be offered that explores materials and methods teaching staff can use to support discussions about mental health and ultimately enable staff to become familiar with the terminology, concepts and way of explaining mental illness.

For more information please contact clare.brutton@lbbd.gov.uk

Enabling Thames Ward to Flourish – working together to plan, develop and deliver the healthy new town

A workshop was held in April to discuss health and wellbeing in Thames Ward – it focussed on the health hub, the built environment and how we should partner with local community groups to deliver wellbeing for residents. There was great energy and input at the event and positive feedback was received including from community members, which provided a strong collaborative platform across the stakeholders on the project and the opportunity to do something **really exciting** in Thames Ward.

Some of the key issues discussed were:

- How do we ensure the Health Hub, the Thames View Health Centre, are progressed in a way we all feel proud of?
- How do we make sure the local area and environment becomes health promoting?
- How do community projects get integrated with health in a better way?

Three working groups were set up to look at community-led programmes, the built environment and collaboratively designing what the Health Hub will look like including finding a popular name for it.

For further information please contact: SarahMcCready@barkingriversideltd.org

Future Dates for the Health and Wellbeing Board

- BHR Health and Wellbeing Event – 12 July 2019, 10am – 3pm at Care City Barking
- Health and Wellbeing Board meeting – 10 September 2019, 6pm at Barking Learning Centre

HEALTH and WELLBEING BOARD
FORWARD PLAN

September 2019 Edition

Publication Date: 1 July 2019

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 Masuma Ahmed, Democratic Services Officer, Ground Floor, Town Hall, 1 Town Square, Barking IG11 7LU (telephone: 020 8227 2756, email: masuma.ahmed@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 2019/2020:

Edition	Publication date
June 2019 edition	13 May 2019
September 2019 edition	12 August 2019
November 2019 edition	15 October 2019
January 2020 edition	24 December 2019
March 2020 edition	10 February 2020
June 2020 edition	11 May 2020

Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Masuma Ahmed, Democratic Services Officer, Ground Floor, Town Hall, 1 Town Square, Barking IG11 7LU (telephone: 020 8227 2756, email: masuma.ahmed@lbbd.gov.uk).

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 Masuma Ahmed 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: 10.9.19	Feedback from the Ofsted Inspection of Children's Services The Health and Well-being Board will be presented with a report on the Inspection of Local Authorities Children's Services (ILACS) conducted by Ofsted in February 2019 and asked to note and comment on the headline improvement plan for publication by no later than 1 July 2019. • Wards Directly Affected: Not Applicable	Open	Chris Bush, Commissioning Director, Children's Care and Support (Tel: 020 8227 3188) (christopher.bush@lbbd.gov.uk)
Health and Wellbeing Board: 10.9.19	Multi-Agency Safeguarding Arrangements The Health and Well-being Board will be asked to note and comment on the new multi-agency safeguarding arrangements in Barking and Dagenham, in accordance with the Children and Social Work Act of 2017 and mandated through the revised statutory guidance "Working Together to Safeguard Children 2018". • Wards Directly Affected: Not Applicable	Open	Chris Bush, Commissioning Director, Children's Care and Support (Tel: 020 8227 3188) (christopher.bush@lbbd.gov.uk)

APPENDIX 1

Membership of Health and Wellbeing Board:

Cllr Maureen Worby (Chair), LBBD Cabinet Member for Social Care and Health Integration
Dr Jagan John (Deputy Chair), Barking and 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
D.I. John Cooze, Metropolitan Police
Dr Nadeem Moghal, Barking Havering and Redbridge University Hospitals NHS Trust
Sharon Morrow, Barking & Dagenham Clinical Commissioning Group
Cllr Lynda Rice, LBBD Cabinet Member for Equalities and Diversity
Nathan Singleton, Healthwatch Barking and Dagenham (CEO Lifeline Projects)