Director of Public Health
Annual Report 2015/2016

Focusing on what matters: Opportunities for improving health

50th anniversary
one borough; one community

London Borough of Barking & Dagenham
lbbd.gov.uk

A vision for Barking and Dagenham

One borough; one community; London's growth opportunity

The Council's vision recognises that over the next twenty years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing.

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

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

Cover picture: Community Food Enterprise providing freshly made fruit juices at the Eastbrookend Country Fair

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Foreword

Matthew Cole
Director of Public Health

View of Barking Town Square from the 50th anniversary celebrations

Welcome to the Director of Public Health Report 2015/16 which coincides with Barking and Dagenham's 50th anniversary of becoming one borough. The next 50 years are going to be defined by how we use the Council's growth agenda and the investment it brings to release the unmet potential in our communities.

Council Leader Councillor Darren Rodwell health assessment by Harmony Health Clinic

Over the next five years we will need to radically redesign public services to address the scale of the financial savings to be made while the borough's population continues to increase. Meanwhile National Government is implementing reforms that will have a major impact on Council services, residents and local businesses. Collectively they present a profound challenge to many of the prevailing policy approaches of the Council and the services people are accustomed to receiving.

Simply put we can no longer afford to meet the rising needs of our population by spending more money on the kinds of services we currently provide. Instead we need to re-focus what we do so that we identify the root cause of need and tackle it so that the individual or family in question have a better chance of living more independently now and in the future. At the heart of the Council's Ambition 2020 transformation programme[1] has to be the opportunity to improve the health of residents and future generations.

As Director of Public Health it's my responsibility to describe and advocate the need to improve health through a lens that's wider than care to the root causes of our poorer Life Expectancy relative to other London boroughs. In my reports of 2013[2] and 2014[3], I identified a number of opportunities where collectively the partners could use their resources to improve health. Better Health for London[4] and the NHS Five Year Forward View[5] acknowledge that the future sustainability of the local health and social care economy hinges on a radical upgrade in prevention that addresses the wider determinants of health such as income and housing; unless we take prevention and public health seriously, this will adversely affect the future health and wellbeing of residents, particularly our young residents, and the sustainability of the public services.

How we radically transform the relationship between our residents and the Council as well as between patients and the NHS will determine the delivery approaches we take where the best outcomes can be delivered at the right cost. The Health and Wellbeing Board recognises that whatever the solutions, it is increasingly clear that the future depends on much closer joint working between our partners both locally and at London level.

1 http://moderngov.barking-dagenham.gov.uk/documents/g8164/Public%20reports%20pack%20Tuesday%2019-Apr-2016%2019.00%20Cabinet.pdf?T=10
2 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
3 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/018583-BD-Annual-Health-Report-2014-WEB.pdf
4 http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
5 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

A young Barking and Dagenham resident pledging to eat an apple everyday as part of the #makeachange campaign

My report gives a professional perspective that informs this approach based on sound epidemiological evidence and objective interpretation taken primarily from our Joint Strategic Needs Assessment 2015[6]. I hope my observations in the following chapters act as a starting point for systematically identifying 'where to look' before 'what to change' and finally 'how to change'.

In 2010, the 2012 Olympic boroughs agreed "that within 20 years the communities who hosted the 2012 Games will have the same social and economic chances as their neighbours across London[7]. A key outcome agreed was narrowing the gap or difference in both female and male Life Expectancy to the London level. Chapter 1 focuses on our borough's Life Expectancy and Healthy Life Expectancy where improvement is noted, however the nature of the problem includes persistent and widening inequalities in health, the challenge of increasing numbers of adults with multiple long term conditions who account for a high proportion of need and demand for health and care services. There are a number of known interventions which are explored that have a strong evidence-base and cost-effectiveness in preventing and treating these conditions.

I continue this theme in chapter 2, where health status is for many determined by where people live, by their education, employment, the homes they live in, the lifestyle they choose and how they deal with ill health once it has developed. The Council established a Growth Commission in 2015[8] to examine the opportunities provided by becoming London's growth opportunity. I discuss these in the context of how planners can shape the borough in ways that address health inequalities over the next 15 to 20 years.

In chapter 3, I examine what health outcomes could be considered for health improvement in the context of a rapidly changing and growing borough population. Left unchecked, and coupled with entrenched social problems, demand for health and

6 https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/?loggedin=true
7 http://www.gamesmonitor.org.uk/files/strategic-regeneration-framework-report.pdf
8 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/

Community Games in Barking and Dagenham

care services will soon become unaffordable and unsustainable. This means we need to be clear about what does and doesn't work so that we increasingly focus our efforts on those things that have the most pivotal impact on Life Expectancy and Healthy Life Expectancy.

Chapter 4 follows on neatly to explore the opportunities provided by a partnership-based Accountable Care Organisation (ACO) method, using devolved powers which would deliver better outcomes for our residents. This will require the creation of an ambitious local blueprint for Barking and Dagenham, Havering and Redbridge health and social care system that is place-based, underpinned by multi-year plans that are built around the needs of residents. Can the ACO method evolve our thinking from purely an integrated care focus for transforming care to one that has concern for the broader health of local populations and the impact of the wider determinants of health?

In the final chapter, I discuss the scope and scale of health protection work by the Council and Public Health England to prevent threats to health emerging, or reducing their impact, driven by the borough's and London's health risks. Changes to the health protection system are being planned and this is discussed in respect of our major programmes such as the national immunisation programmes, the provision of health services to diagnose and treat infectious diseases, surveillance and response to incidents and outbreaks.

I hope you find the 2015/16 Report of the Director of Public Health for Barking and Dagenham 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

1 What matters:

Changing the fact that both women and men in Barking and Dagenham live shorter lives when compared to London and England.

Kinder Kitchen serve students at Monteagle Primary School as part of a theme day organised by Barking and Dagenham Catering Services. Photo courtesy of the Barking and Dagenham Post

The funding for local government is set to fall significantly over the next five years. By 2020 the cuts in funding mean that the Council will have roughly half the amount of money that it had to spend in 2010. Because of the growing needs of our residents, we estimate that if we did nothing, there would be a shortfall in our budget of £63 million by 2020. Instead of working out how to make cuts, we have concluded that we need to decide how to best spend what we still have available to us each year.

Diversity with the Olympic torch at the 2012 torch relay events in the borough

This reduction in resources requires us to think differently about the services we provide and how we provide them. It's a huge challenge, but one in which tackling health inequalities is a key goal within the Council's Ambition 2020 transformation programme[1]. In short with our partners we want to focus on increasing Healthy Life Expectancy to improve outcomes such as quality of life and to reduce the demand on health and social care services; in turn, reducing the burden of disease in the borough.

This means re-imagining health care delivery and seeking a system that opens up the definition of health from clinical care to one that also encompasses the wider determinants such as income and educational attainment. There is significant evidence that where and how people live, affects their health. Professor Sir Michael Marmot suggests that 80% of health outcomes are determined by wider factors such as lifestyle choices, the physical environment and family and social networks[2]. I address the wider determinants of health in chapter 2. In this chapter I consider the impact of primary and secondary prevention in the context of disease and Life Expectancy.

There is no doubt that people are living longer than they used to twenty years ago[3]. The reality is that people are often living longer with multiple health needs and long term conditions such as cardiovascular disease including hypertension, chronic obstructive pulmonary disease, diabetes and mental health problems. As a society our failure to prevent these conditions, where they are preventable, has meant that the demand on health and social care services is increasing annually. This trend is set to continue as our ageing population increases; however, it is clear that this state of affairs is not sustainable.

1 Ambition 2020, Barking and Dagenham http://lbbdstaff/Marketing/Pages/Ambition2020.aspx
2 http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
3 Barking and Dagenham, Joint Strategic Needs Assessment 2015 https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/

How long are people in Barking and Dagenham living?

Both women and men in Barking and Dagenham live shorter lives when compared to London and England. We also know that Life Expectancy in the borough is lower than in any other London borough. Table 1 shows Life Expectancy in Barking and Dagenham and compares this with London and England, Figures 1a and b show the increasing trend in Life Expectancy in the borough for women and men.

Life Expectancy for females in the borough is increasing generally, but fell in 2012-14 from the high point of 2011-13. Baby girls growing up locally are more likely to die around 13 months earlier than the 'average' English girl. This gap has improved by approximately 6 months over the last 10 years; however, compared with the London average, the gap in Life Expectancy of women has widened by approximately 3 months in the last 10 years.

For males, improvements in Life Expectancy at birth have not been as fast as those seen nationally or in London, and the gap has widened over the last ten years. Baby boys living in Barking and Dagenham are likely to die 23 months earlier than the 'average' English boy. The gap between local Life Expectancy and the national rate has widened slightly in the last 10 years, with the gap being 4 months wider than in 2002-04. This is mirrored when compared with the London average, with the gap being two months wider than ten years ago.

Life Expectancy is a prediction of how long a baby born in this area would live if current age and sex death rates apply throughout its life. Life Expectancy for people has increased over the past 10 years in Barking and Dagenham, in London and in England.

Table 1:

Life Expectancy in women and men 2012-14.

Indicator	Period	England	London Region	Barking and Dagenham
Life Expectancy at birth (Male)	2012-2014	79.5	80.3	77.6
Life Expectancy at birth (Female)	2012-2014	83.2	84.2	82.1

Source: PHOF

Figure 1a:

Female Life Expectancy from birth, Barking and Dagenham, London and England, 2002-2004 to 2012-2014.

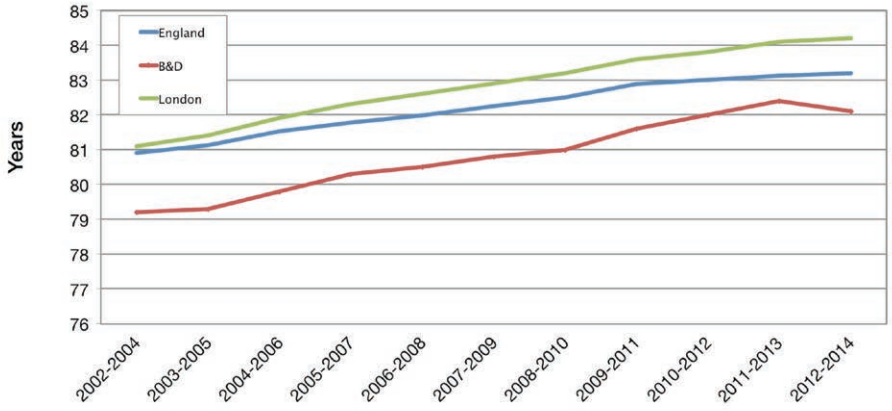
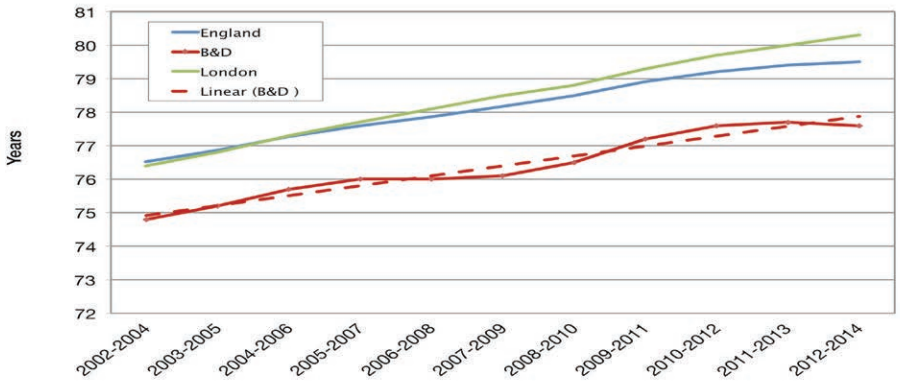


Figure 1b:

Male Life Expectancy from birth, Barking and Dagenham, London and England, 2002-2004 to 2012-2014.



Source: HSCIC/PHOF

How long are people in Barking and Dagenham living healthy lives?

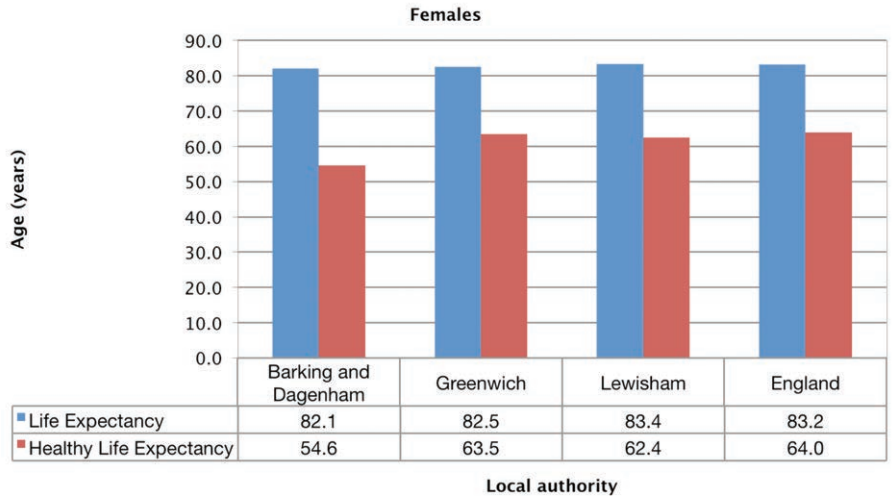
Healthy Life Expectancy (or disability–free Life Expectancy) is a prediction of the length of time that an individual can expect to live free from a limiting long-standing illness or disability.

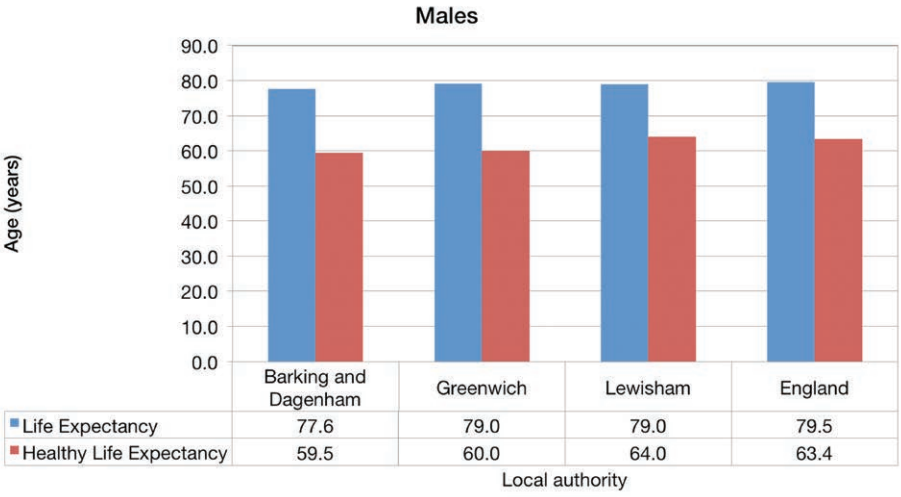
Healthy Life Expectancy in Barking and Dagenham for males is 4 years and for females is almost 7 years lower than the England average, and also is lower than for the most similar statistical neighbours in London (Greenwich and Lewisham). This difference is associated with the number of years' people live with chronic health issues, and often is dependent on health and social care support. Figure 2 compares the Life Expectancy, Healthy Life Expectancy and years with chronic health issues for males and females in Barking and Dagenham, Greenwich, Lewisham and England in 2012-14 (3 year average).

The difference between Life Expectancy and Healthy Life Expectancy shows the years that a person spends in poor health is important because it highlights the years where a person's demands on health and social care are greatest. Our joint Health and Wellbeing Strategy priorities include reducing this gap between Healthy Life Expectancy and Life Expectancy to improve quality of life and reduced demands on the health and care system. Barking and Dagenham has broadly similar figures to our statistical neighbours and England for Life Expectancy, but significantly lower Healthy Life Expectancy for all people, particularly for females.

Figure 2:

Life Expectancy and Healthy Life Expectancy, Barking and Dagenham, Greenwich, Lewisham and England, 2012-2014 (3 year average).



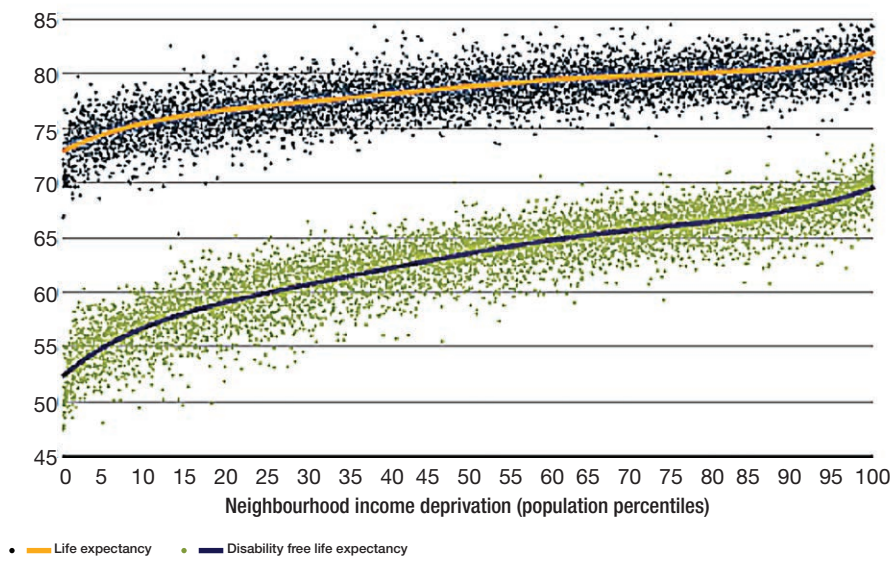


How can we increase Healthy Life Expectancy in Barking and Dagenham?

Fair society, healthy lives, more widely known as 'The Marmot Review' after its author Professor Sir Michael Marmot, has been highly influential in debate on health inequalities policy since its 2010 publication, especially among local authorities and health and wellbeing boards. One of the iconic charts in the review, referred to below as 'the Marmot curve', Figure 3, shows how Life Expectancy and disability-free Life Expectancy (that is, the number of years that we live free from disease) are systematically and consistently related to differences in income deprivation across thousands of small areas in England.

Figure 3:

The Marmot Curve.



Source: Bernstein et al 2010

Note: The original figure was first published in an independent review for government in early 2010, supported by the Fair society, healthy lives team.

Deprivation in Barking and Dagenham

The impact of the factors that affect Life Expectancy and Healthy Life Expectancy on our residents is significant. Barking and Dagenham is the 3rd most deprived borough in London and the 12th most deprived borough in England. This has changed since 2010 when Barking and Dagenham was ranked 7th most deprived borough in London and 22nd most deprived borough in England. It's important to understand that this worsening in rank does not equate to a worsening in deprivation, but rather is a result of a slower relative improvement in the borough than some other London boroughs and local authorities.

Communities like Barking and Dagenham, where residents have low incomes tend to have more ill health and lower Life Expectancy, with more people dying of preventable disease

Young residents of Barking and Dagenham pledging to make a change

before 75 years of age than in less deprived areas. Therefore, delivery of Council plans to achieve priorities will need to target resources to optimise improvements in borough Life Expectancy.

What are the conditions that are causing our poorer Life Expectancy?

More than half of the gap in Life Expectancy and premature death are caused by four conditions: chronic obstructive pulmonary disease (COPD), lung cancer, coronary heart disease and pneumonia. Falls also contribute to mortality in women over 65 and diabetes is one of the causes of coronary heart disease. The commonest causes of premature death (under 75 years old) in men and women are detailed in Table 2 in decreasing order.

Table 2:
Most common causes of ill health and premature death in Barking and Dagenham.

	Men	Women
1	Coronary heart disease	Lung cancer
2	Lung cancer	Breast cancer
3	COPD	Coronary heart disease
4	Stroke	COPD
5	Colorectal cancer	Pneumonia
6	Liver disease	Colorectal cancer

Main Action 1

The London Health Observatory model estimates that around 7,000 people would need to quit annually in Barking and Dagenham to decrease the inequalities gap by around 32% in each sex over 10 years. Of these, it is estimated that 71% (around 5,000 annually) will start smoking again within a year so follow up is required and another quit attempt encouraged.

How many deaths do we need to prevent to bring Barking and Dagenham in line the London and the national averages?

The common feature for all the conditions in Table 2 is that they are caused by smoking and the numbers of smokers in the borough (prevalence). Nationally, 17.2% of people currently die of a condition directly caused by their smoking (Table 3). This proportion will change as the effects of historic smoking prevalence rates work through the life course. In 2014, 218 deaths in Barking and Dagenham were directly attributable to smoking.

Table 3:
Risk percentage population attributable.

Condition	Number of deaths in B&D in 2014	Smoking attributable Percentage, England 2013	Estimated number of deaths in B&D attributable to smoking- 2014
COPD	96	85.3%	82
Lung cancer	93	80.5%	75
CHD	161	13.2%	21
Pneumonia	69	17.9%	12
Total deaths	1,266	17.2%	218

Data source: PCMD and HSCIC – 2013 Statistics on Smoking

In 2009, modelled smoking prevalence in Barking and Dagenham was the highest in London at 32%, and 8th highest in England. By 2013 it was estimated that local prevalence had declined to 23%, still the highest in London, almost 6% higher than the London and 4.5% higher than the national average. In 2014, it was estimated that smoking prevalence had further declined to 21.7% which puts Barking and Dagenham as the fourth highest in London. However, these estimates are based on responses to a national survey and should be treated with caution, particularly in relation to changes and trends. It is, however, clear that smoking is the cause of health problems for many residents in the borough.

In addition, according to research, the majority (two-thirds to three-quarters) of quit attempts are performed without any health service intervention. These have a poorer quit rate than supervised people but this will still be the largest route of quitting in Barking and Dagenham. This is an important route with vaping now being the preferred quit method for the majority of the population in the UK. Modelling would suggest that fewer than 1,000 people quit permanently each year in the borough. The stop smoking service contribution to this would only have been modest – between 140 and 360 people.

To substantially decrease the gap between Barking and Dagenham and the national Life Expectancy rate smoking must be seen as the highest priority. The following are key actions:

i). Increase the stop smoking quitters (at 4 weeks) to at least 2,000 people annually. This quit rate has not been attainable over the past three years in Barking and Dagenham, and in part this is due to the variation in approach in independent practitioners in primary care.

Table 4:

Risk percentage population attributable.

	Estimate of current smoking prevalence	Estimate of number of smokers in B&D if same rate	Numbers needed to quit in B&D to reach same rate as national or regional rates
Barking and Dagenham	21 to 23%	30,100 (28,700 to 31,500)	-
London	17%	23,200	6,900 (5,500 to 8,300)
England	18%	24,600	5,500 (4,100 to 6,900)

Source: PHOF and ONS Population Estimation

Stop Smoking Service with Council Leader Councillor Darren Rodwell, Councillor Saima Ashraf and Councillor Syed Ahammad for No Smoking Day

ii). Catching potential smokers before they start. Education interventions to decrease new starters are effective and the numbers of young people smoking in the borough is low in comparison to national averages.

iii). Creating an environment that makes smoking the hard choice.

iv). Strengthening tobacco enforcement and general education/advertising on how best to quit alone as around 2/3rds of future quitters will not seek any assistance.

v). Training all front line staff to give smoking advice to all smokers.

vi). Increase the extent and diversity of front line staff who can give Level 2 stop smoking advice, so that almost all facilities and staff groups have at least one provider.

Chronic obstructive pulmonary disease (COPD)

There are two main interventions that increase Life Expectancy in COPD. These are:

i). Stopping smoking.

ii). Domiciliary oxygen for those late in the disease.

It is particularly important to identify people with COPD at an early stage in their disease in order to advise on stop smoking techniques and referral for management to give symptomatic relief.

Main Action 2

To eliminate the inequalities gap around 12,000 hypertensives would need to be diagnosed and/or known hypertensives have their blood pressure lowered into the target range over 10 years. It is not just a question of improving blood pressure control as there are only 4,000 people with inadequately controlled blood pressure. Instead, at least 8,000 hypertensives will need to be diagnosed (mainly via the Health Check programme) and the number excluded for not attending or where medication cannot be prescribed, commonly known as exception reported, (820) needs to be reduced substantially. Adequately, treating 1,200 hypertensive's annually would decrease the inequalities gap by around 10% over 10 years.

Coronary heart disease (CHD)

The rate of CHD in Barking and Dagenham is only slightly higher than the national and regional rates. However, this slight elevation results in 11 male deaths and 7 female deaths more than would be expected annually if the local rate was the same as the national rate. The London Health Observatory has performed modelling to show what interventions would have the most effect in reducing cardio vascular disease. These are:

i). Decreasing smoking prevalence:

- In the general population.
- In those at high risk of cardiovascular disease (CVD) or with evidence of the disease. This is likely to include equipping more primary care professionals to deliver stop smoking advice.

ii). Improving blood pressure control:

- Increasing diagnoses of hypertension to raise the prevalence nearer to the expected level.
- Decreasing the number of hypertensives who are excluded from monitoring i.e. exception reported in primary care.
- Improving drug and lifestyle management of hypertension to achieve adequate control.

iii). Controlling cholesterol in those at risk of CVD:

- Assessing all hypertensives for overall vascular risk and commencing a moderate proportion on statins.
- Roll out of the vascular risk assessment project in order to detect more hypertensives and more people at high risk of CVD.

iv). Secondary prevention of CVD:

- This involves maximising the use of drug treatments with a good evidence base.

From a local perspective the work that is required is:

- Detecting more people who have undiagnosed CVD but have not been placed on the primary care registers.
- Decreasing the number of patients with disease who are excluded from performance monitoring i.e. exception reporting in primary care.
- Improving drug and lifestyle management of CVD using well known evidence based approaches. This includes increasing uptake of some of the more 'difficult' treatments like Warfarin in atrial fibrillation and B-blockers in heart failure.

Newborn and infant mortality

There are only a small number of deaths in the first year of life or in the early years but each one causes a disproportionately large decrease in the overall Life Expectancy in the borough. A large proportion of children who die in infancy are born to mothers who have some degree of socio-economic deprivation. Worldwide, the level of infant mortality is more dependent on the educational and economic positions of the mother than the nature and extent of maternity and infant care. Hence, the major inputs into infant mortality include:

i). Collaborative work to increase the wellbeing, education and aspirations of young people, especially women.

ii). Antenatal care aspects especially:

- Stopping smoking.
- Early booking (first trimester) so that maternal or foetal problems can be identified and ameliorated at an early stage.

iii). Delivery and early postnatal care including:

- Promotion and maintenance of breastfeeding.

iv). Care at home including:

- Completion of vaccinations in timely fashion.
- Continuation of breastfeeding to 6 months.

Taking action to decrease newborn and infant mortality

Preventing deaths around birth and in the first year of life are highly effective in decreasing the inequalities gap. Interventions include:

Main Action 3

Each life saved in utero, in the newborn or in the first year of life decreases the Life Expectancy inequalities gap by 0.5% in a single year. Reducing the annual number of deaths to around 17 infants (4.7 per 1,000 births over 3 years) will keep the infant mortality gap to a minimum.

i). Collaborative work to increase the wellbeing, education and aspirations of young people, especially women.

ii). Antenatal aspects especially:

- Stopping smoking.
- Early booking (first trimester) so that maternal or foetal problems can be identified and ameliorated at an early stage.
- Delivery and early postnatal care.
- Promotion and maintenance of breastfeeding.

iii). Care in the first year of life include:

- Completion of vaccinations in timely fashion.
- Continuation of breastfeeding to 6 months.
- Decreasing second hand smoke exposure.

There are very many socio-economic inputs with big effects on infant mortality. They are documented in the next chapter of my report.

Cancer

My aim to improve cancer outcomes demonstrates the need for a radical prevention approach to improve Life Expectancy and Healthy Life Expectancy.

Why is Barking and Dagenham an outlier?

Overall, Barking and Dagenham has the lowest net survival amongst London and West Essex clinical commissioning groups (CCGs), ranking 33 (1 highest, 33 lowest). In part this is due to:

- Low percentage of residents able to recall a symptom of cancer[4].
- Breast cancer screening coverage and uptake is consistently (over the period 2012 -2014) lower than the England average.
- There are 352 cancer deaths per 100,000 people each year. This is higher than the England average.
- Low bowel screening uptake.
- Two-week wait conversion rate. This is the number of referrals from general practice against the number of cancers detected.
- 25% of patients with cancer are diagnosed via emergency care services.
- Significantly lower Healthy Life Expectancy.

In 2009/10, only 31% of residents could recall a lump or swelling as a sign of cancer (68% England, 57% Havering and 50% Redbridge). This meant that we were the 2nd lowest out of 22 CCGs (Primary Care Trusts) in London who were surveyed using the Cancer Awareness Measure. Although one-year net survival index for Barking and Dagenham has increased steadily with 63.9% of those with all newly diagnosed cancers surviving one year or more in 2012 (ONS), it is lower than the London average of 69.7% and the overall England figure of 69.3%.

4 http://www.cancerresearchuk.org/health-professional/prevention-and-awareness/the-cancer-awareness-measures-cam

If we are to tackle one-year survival rates, we have to address variation within general practice.

Table 5 shows the considerable variation in early diagnosis within our general practices. Caution should be used when interpreting 0 as the bottom of the range.

Screening has a huge part to play in addressing one-year survival. 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 each year (Cancer Research, 2013). Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16% (Cochrane Database of Systematic Reviews, 2006). Colorectal cancer (using the faecal occult blood test) screening programme's target is 60% of patients with a definitive screening result, out of those invited. Uptake in Barking and Dagenham is below the England average and the screening programme target.

Routes to diagnosis have a significant impact on survival rates in Barking and Dagenham:

Table 6 identifies all malignant tumours newly diagnosed between 2006 and 2013 as well as selected benign and in-situ tumours. The methodology is consistent with previous work on the routes to diagnosis of cancers. Improved linkage to Hospital Episode Statistics data has helped to reduce the proportion of tumours with an unknown route and provided a better understanding of how other routes originated.

If we examine further the routes of diagnosis and compare against 1-year survival rates in Tables 7 and 8 clear inequalities can be seen.

Table 5:

Indicator	Barking and Dagenham	England	Lowest	Highest
Two-week conversion rate	8.6%	8.4%	0%	22%
Breast screening	68.6%	77%	30%	82.1%
Bowel screening	43.7%	58.8%	28.1%	52.3%

Table6:

	Routes to diagnosis - 2006 to 2013. All tumours (excluding C44)								
	Screen detected	Two week wait	GP referral	Other outpatient	Inpatient elective	Emergency presentation	Death certificate only	Unknown	Number of cases
2006	3%	20%	27%	11%	2%	32%	0%	5%	793
2007	1%	26%	30%	11%	2%	26%	0%	4%	771
2008	8%	24%	30%	9%	2%	26%	0%	2%	852
2009	4%	26%	34%	10%	1%	24%	0%	2%	875
2010	2%	29%	32%	10%	1%	24%	0%	2%	781
2011	8%	28%	27%	11%	1%	22%	0%	3%	809
2012	3%	34%	27%	11%	1%	22%	1%	2%	842
2013	1%	32%	28%	13%	1%	23%	1%	2%	818

Table 7:

Lung Route to Diagnosis - % for those diagnosed between 2006 and 2010, England.

Lung	All routes	Two Week Wait	GP referral	Other Outpa-tient	Inpatient Elective	Emer-gency Presenta-tion	Unknown
Route	-	**24%**	**21%**	**10%**	**2%**	**38%**	**3%**
1-year survival	**29%**	**42%**	**38%**	**42%**	**32%**	**11%**	**23%**

Table 8:

Breast Route to Diagnosis - % for those diagnosed between 2006 and 2010, England.

Lung	All routes	Screen detected	Two Week Wait	GP referral	Other Outpa-tient	Inpatient Elective	Emer-gency Presenta-tion	Unknown
Route	-	**28%**	**43%**	**16%**	**3%**	**0%**	**5%**	**5%**
1-year survival	**96%**	**100%**	**98%**	**96%**	**91%**	**85%**	**50%**	**95%**

Delivering the Forward View: NHS Planning Guidance 2016/17[5]

The guidance describes Ambition 2020 for cancer in respect of the Government's mandate to NHS England 2016/17. Overall the 2020 goal is to deliver the recommendations of the Independent Cancer Taskforce[6], including:

- Significantly improving one-year survival to achieve 75% by 2020 for all cancers combined (up from 69% currently); and
- patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.

The clear priority and deliverables for 2016-17 include:

- Adult smoking rates should fall to 13%.
- 57% of patients should be surviving for 10 years or more.
- 1 year survival should reach 75% for all cancers.
- 95% with a definitive cancer diagnosis within 4 weeks or cancer excluded 50% within 2 weeks.
- 75% bowel screening uptake.
- Achievement of cancer waiting time standards of 2 weeks, 31 days and 62 days.

The Health and Wellbeing Board in its system leadership role will need to focus on the following, if we are going to deliver the 2020 cancer goals:

Prevention

- Supporting a radical prevention approach to improve recall of signs and symptoms.
- Ensuring an active smoking control plan is in place.

Early Diagnosis

- Supporting primary care to reduce variation, improve early diagnosis and 1 year survival.
- Increasing the uptake of effective screening programmes e.g. cervical cancer screening, bowel cancer screening.
- Encouraging the population to present and improving access to primary care.

Survivorship

- As at the end of 2010, around 3,600 people in the borough were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 7,000 by 2030.
- Endorsing a move towards cancer being viewed as a long term condition.
- Encouraging improved, standardised Cancer Care Reviews in primary care.
- Lifestyle schemes are commissioned but currently underutilised.

Mental Health

Equally as important as physical health is mental health and although I have not reviewed the evidence base in this chapter mental health also impacts on Life Expectancy[7]. It's long been known that people with mental health problems tend to live shorter, less healthy lives, than people who are more resilient. In part this is due to the drug and alcohol dependency that people with mental health problems experience, and also due to the impact of drugs used to treat mental health problems.

There is a very large gap in Life Expectancy between people with mental health problems and the general population. A woman born in 2009 is likely to die twelve years early and a man is likely to die sixteen years early. Although suicide has some impact on the Life Expectancy of people with mental health problems, at most 20% of all early deaths are as a result of suicide, all other early deaths are as a result of medical conditions. This is not an acceptable position to be in and the borough has in place plans to improve both adult and children's mental health.

Conclusion

We need to address variation in care offered across the life course. In the cancer example we want to be able to say that our patients are diagnosed faster, have a better chance of survival, a better experience of care and are better informed and supported. The development of new models of care has to reduce variations in care from the front door, primary care providers, through to our hospital and community services.

The evidence base for what works and impacts on Healthy Life Expectancy and Life Expectancy is vast. This is best represented by Figure 4. In a very simple way this diagram shows that social determinants of health, such as housing, can take up to 15 years to impact on health, lifestyle interventions take up to 10 years and clinical interventions take up to 5 years to impact. It is important that all three approaches (A-C) are taken as shown in Figure 4. I examine this in chapter 2.

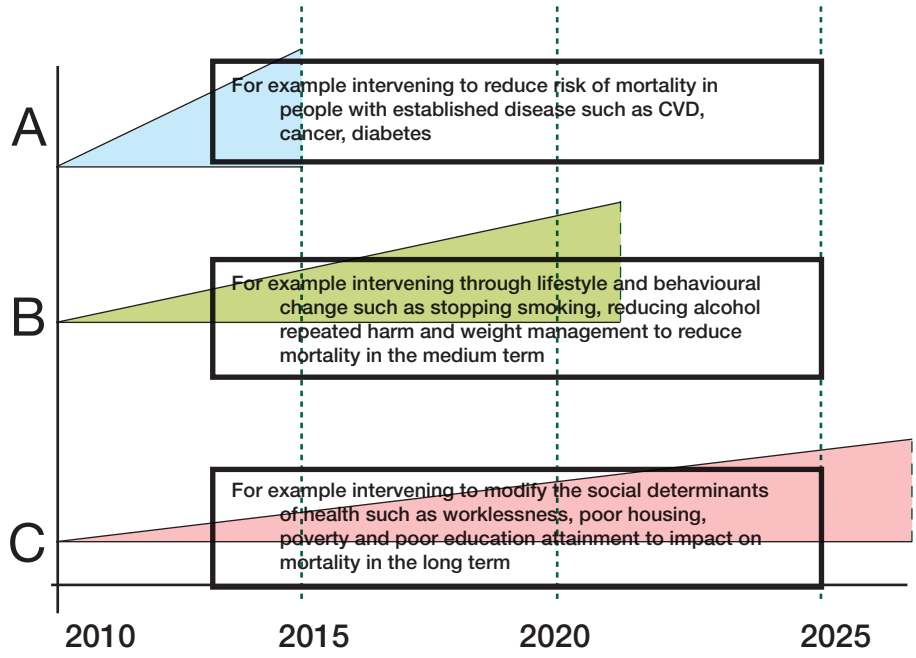
5 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
6 http://www.cancerresearchuk.org/about-us/cancer-taskforce
7 Lawrence, D (2011) Life Expectancy Gap Widens Between Those with Mental Illness and General Population. British Medical Journal. 21 May 2013.

While there are a number of known interventions that have a strong evidence-base and cost-effectiveness in preventing and treating the health conditions that lead to pre-mature death and ill health in respect of intervention design there is no one-size fits all solution that works across all community groups. For this reason, insight into our resident's needs and into the evidence-base is critical to the delivery of successful programmes to achieve good outcomes.

Implementation of the Council's Ambition 2020 programme and The Five Year Forward View both provide the opportunity to integrate approaches to commissioning and take more radical action on prevention. It is essential that we engage communities in developing all our plans and also to implement a combination of individual and societal interventions. These interventions can be universally applied and also targeted to reach those with the greatest need to improve the health of the poorest fastest.

Figure 4:

Health Inequalities, Different Gestation Times for Interventions.



Source: Health Inequalities National Support Team (2009)

Raising awareness of the impact of domestic violence on individuals, families, communities and services. Supporters included Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health, and Chair of the borough's Health and Wellbeing Board

2

Growing the borough to improve health

Barking Riverside new housing opposite lake

In 2015, the Council asked a team of independent experts to form a Barking and Dagenham Growth Commission[1], to review our ambition to be London's growth opportunity and recommend how to maximise the contribution of the borough to the London economy; generating growth in Barking and Dagenham in a way that benefits all residents. Their report was published on 24 February 2016 and included 109 recommendations.

Councillor Evelyn Carpenter Member of the Health and Wellbeing Board and children from Northbury Primary school planting apple and pear trees in Barking Park to encourage healthier eating

The growth agenda gives us a chance to shape the whole borough very differently in the longer term with up to 35,000 new homes and 10,000 additional jobs over the next 20 years. It also brings challenges, in particular maximising the opportunities for improving health and tackling the inequalities. The challenge continuing on from chapter 1 is narrowing the gap in Healthy Life Expectancy in Barking and Dagenham compared to London. The outcome is defined in our joint Health and Wellbeing Strategy[2].

There is substantial scope for improvement in both Life Expectancy and Healthy Life Expectancy. Both aim to narrow the gap between those with poor health status and the population as a whole, a gap that is generally widening. Achievement of narrowing the gap is not only about saving lives overall, but is about ensuring that a higher proportion of the gains are made by those in poorer circumstances. It focuses attention on the distribution of health benefit, rather than simply on overall health outcomes from the provision of programmes and services. Improvements in Life Expectancy will be achieved through the wide range of actions recommended by the Commission.

The latest official Life Expectancy data for 2012-14 shows that Healthy Life Expectancy in Barking and Dagenham is lower than that for London as a whole with Healthy Life Expectancy in the borough being 4.5 years less for males and 9.5 years less for females. Over the next 15 years we need to increase the Healthy Life Expectancy trajectory to achieve the London rate. For illustrative purposes in Tables 1 and 2 the values are based on a linear regression line generated from the three year rolling data based on 2009-11 to 2012-14. Table 1 predicts the current trend in both London and Barking and Dagenham over the next 15 years.

1 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/
2 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

Table 2 examines the increased Healthy Life Expectancy trajectory to the London rate. In order for Barking and Dagenham to reduce the Healthy Life Expectancy gap with London and match Healthy Life Expectancy for males and females in 15 years time (2030) there will need to be a 2.4 year improvement in the next five years for males and 10.6 year improvement for females as described below.

This chapter draws on the evidence from the expert Growth Commission and elsewhere. I explore the potential for addressing the social determinants and for reducing inequalities in health for the whole borough.

Table 1:

Projection of Healthy Life Expectancy linear progression from 3 year rolling averages.

	Males			Females		
	B&D	London	Difference	B&D	London	Difference
2015-17	60.4	64.4	4	51.2	64.3	13.1
2020-22	60.9	66.0	5.1	45.6	64.9	19.3
2025-27	61.5	67.6	6.1	40.0	65.4	25.4
2030-32	62.0	69.2	7.2	34.4	66.0	31.6

Table 2:

Increased Healthy Life Expectancy trajectory to the London rate.

	Males			Females		
	B&D Projected	B&D Target	Difference	B&D Projected	B&D Target	Difference
2015-17	60.4	60.4	-	51.2	51.2	-
2020-22	60.9	63.3	2.4	45.6	56.2	10.6
2025-27	61.5	66.2	4.7	40.0	61.1	21.1
2030-32	62.0	69.2	7.2	34.4	66.0	31.6

Addressing social determinants to improve health in the long term

Inequalities in health result from inequalities in society, not simply because of inequalities in healthcare. Lack of access to high quality healthcare can contribute to health inequalities, and universal access is necessary to deal with problems of illness when they arise. But and it is an important but, if the causes of health inequalities are social, economic, cultural and political, then so should be the solutions[3].

A clear understanding of health inequalities is paramount for the development of our Growth policies and interventions that support all our communities in Barking and Dagenham. Many researchers view social position as the fundamental cause of ill health[4]. Using a pathways approach, important influences on population health are presented in the form of an interlocking framework. Factors such as the education system and labour market, and the structure of society, help shape people's lives. An individual's social position, based on for example socioeconomic factors, sex, ethnicity and sexuality, affects their access to resources and relative exposure to health risks. Intermediary factors, including personal behaviour or lifestyle, environmental factors such as poor housing and the provision of health and social care, impact on health outcomes or a person's health and wellbeing.

Social determinants of health and health are inextricably linked. The cost to society, for example, from transport-related poor air quality, ill health and accidents is at least £40 billion per year[5]. Figure 4, chapter 1 shows the different gestation times for interventions (with people with established disease, lifestyle factors or via social determinants) to address health inequalities. The time lag for impact of social determinants is 0-15 years. Whilst the lag might be many years Marmot would argue that the social determinants approach, via housing and employment or environmental factors for example,

3 http://www.bris.ac.uk/poverty/downloads/keyofficialdocuments/Tackling%20HE%2010%20years%20on.pdf
4 http://nwph.net/nwpho/inequalities/health_wealth_ch2_(2).pdf
5 http://www.instituteofhealthequity.org/projects/understanding-the-economics-of-investments-in-the-social-determinants-of-health

has the most impact in the long term at reducing inequalities in health[6]. The Growth Commission supports this approach stating that the focus of the Council and its staff should be on "enabling every resident of the borough to fulfil their potential through the reform and the delivery of services aimed at reducing dependency and increasing employment, skills and growth in every part of the community"[7].

The growth agenda

The Commission has advised the Council to focus on its much wider role of shaping local places. The opportunities to radically improve health lie in promoting economic, social and environmental wellbeing at the local level, for which it is ideally placed to deliver on behalf of residents.

There are 7 growth hubs which are the focus for the next 20 years in the borough[8]. Alongside the capacity for 35,000 new homes and 10,000 additional jobs, developments include transport infrastructure, industrial development (including on the former Ford stamping plant), green energy industries and advanced manufacturing industries, social infrastructure such as schools and health and social care as well as plentiful green and blue spaces including parks, nature reserves and two rivers.

The first of the Barking and Dagenham major growth areas and part of the London Riverside opportunity area is the Barking Riverside development[9]. Figure 1 shows a plan of this area.

Figure 1:

Artist impression of Barking Riverside Development

It is being developed on mainly brownfield, ex–industrial sites. It sits within Thames electoral ward, a ward with some of the worst socio-economic and health outcomes of the borough. There is planning permission for 10,800 new homes by 2031– a new town similar to the size of Windsor. This will be supported by 65,500 square metres of commercial, retail and leisure space that will create an estimated 3,000-3,500 temporary construction jobs and 2,500 new permanent jobs. There will be five new schools, health centres, places of worship and community facilities. Transport developments will also be key, for example the extension of the Barking to Gospel Oak overground line into Barking Riverside. There are plans for extensive new sports facilities, play stations, public open spaces, extensive parkland, nature reserve, green belt and there will be a reconnection of residential areas to 2km of the River Thames as well as other areas of open water (blue spaces). An innovative feature is a Community Interest Company (CIC), ultimately to be predominantly residents that will manage the public realm of Barking Riverside[10]. Work has already started and there are currently nearly 700 units built. This is a mix between private and affordable homes. Schools and green space developments are in place.

6 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235358/
7 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/
8 https://www.lbbd.gov.uk/wp-content/uploads/2014/09/GrowingTheBorough.pdf
9 https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas/london-riverside
10 http://moderngov.barking-dagenham.gov.uk/mgOutsideBodyDetails.aspx?ID=642

Barking Riverside – London's Healthy New Town

For Barking Riverside, as a new area on a brownfield site we can plan to get the social determinants of health right from the start. We can develop our housing, the built environment, use of green and blue spaces and economic regeneration to maximise health. This is a powerful opportunity to build a healthy new town. In recognition of this the area has now been designated a Healthy New Town (HNT) – the only one in London and one of 10 in the country. In chapter 4 I also examine this approach in context of the Accountable Care Organisation method.

The HNT affirmation brings access to expertise and some limited funding to rise to the challenge of regenerating the area in a way that improves health. As Barking Riverside will be built as a staged process over a further 15 years we have unique opportunities to work with our partners to evaluate impact and improve upon this as we go along and also to learn from other growth areas in the borough. The HNT proposal identified creation of an "age friendly" built environment and new models of health and social care as key opportunities. The proposal also majored on the use of green and blue spaces, community involvement and social and economic regeneration, including employment and skills, as key issues for Barking Riverside.

Looking in detail at two of these aspects, utilisation of green and blue spaces and the development of employment and skills, we can see how they offer opportunities to improve health through addressing the wider determinants.

Green and blue spaces

Green spaces include parks, gardens, natural and semi-natural urban spaces, green corridors, outdoor sports facilities, community gardens, and landscape around buildings[11]. Blue spaces cover ponds, lakes, canals, rivers, and any other areas of open water.

Why are they important?

Green and blue spaces bring a range of health benefits: the health benefits of green spaces include: space for physical activity (impacting on obesity), improved mental health (for those living in green areas), community cohesion and participation (for example, through a wide range of activities with vulnerable groups). Other impacts include benefits from community gardens in an improved environment, increased opportunities for older people to live independently and potentially reducing food poverty. Whilst there is less evidence for blue spaces[12] they have been shown to improve mental health (psycho restorative effect), and provide opportunity for physical activity and community participation[13].

Opportunities from the green and blue spaces in Barking and Dagenham: green spaces comprise 34% of the borough. Barking Riverside has 2 km of frontage on the River Thames and access to the River Roding. There are sports facilities, open spaces, a nature reserve and green belt.

Inequalities in access and use of green spaces: despite the large amount of green space in the borough we have one of the lowest levels of utilisation in England. There are also parts of the borough with limited green space; in 4 wards more than 50% of the households have inadequate access to nature and green space. Nationally the most affluent 20% of wards have five times the amount of green space as the least affluent 10%. There are also inequities in utilisation by vulnerable groups such as the elderly, disabled and urban deprived.

Potential to improve poor health outcomes in the borough: in Barking and Dagenham we have the highest rate of adult obesity in London and high childhood obesity rates (26.2%) and low levels of physical activity (less than half our adults) compared to London and England[14]. Physical inactivity and obesity are risk factors for major causes of premature mortality in our residents: cancer (lung and colorectal) and cardiovascular disease (heart disease and strokes).

The future pattern of land development will shape the choice and mode of travel for future generations, as well as determine housing location and affordability. Evidence clearly shows that people who live in spread-out, car-dependent neighbourhoods are likely to walk less, weigh more, and suffer from obesity and high blood pressure and consequent diabetes, cardio-vascular and other diseases, compared to people who live in more efficient, higher density communities with access to green space (Ewing et al, 2003a).

11 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
12 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
13 http://www.ecehh.org/research-projects/blue-health/
14 http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

What works?

Reasons given for not using green and blue spaces include poorly maintained spaces, fear of safety, inadequate facilities and lack of transport. Accessible, good quality green spaces increase their utilisation. The evidence suggests that development of new spaces or physical regeneration of old spaces increases utilisation. Few studies demonstrate outcomes or address inequities or uptake by socially excluded groups[15].

A cost effectiveness study showed £23 returned for each £1 spent in the Birmingham "Be Active" programme[16]. There are fewer studies of blue spaces, particularly fresh water, than of green spaces. However, the issues about access and use overlap with green spaces[17]. A new study of the use of blue spaces, "Blue Health", is in development and we are in liaison with the researchers[18].

Parsloes Park, Dagenham

Issues to consider

We have opportunities in our growth areas with plentiful blue and green spaces. A health impact assessment (HIA) of the green and blue spaces of the development built so far on the Barking Riverside site identified some issues for consideration including the role of the CIC in ensuring places are well maintained and actions to maximise wider health benefits such as tobacco free spaces and improved mental health. The HIA highlighted the importance of addressing issues such as transport (linked with active travel), fear of crime and affordability of formal facilities to ensure accessibility[19]. There is a gap in the evidence base regarding uptake by socially excluded groups and impact upon inequalities in use or access of green spaces. We have an opportunity to work with academics to strengthen this research area and help to optimise the health benefits for the development.

Employment and skills

Why is this important?

Addressing the link between employment and skills and health: unemployment impacts on health through lower living standards, also influencing social integration and self-esteem; through increasing distress, anxiety and depression and through impacting upon health behaviours (such as lower rates of physical activity)[20]. The relationship between unemployment and health is cyclical: unemployment leads to poor health and poor health increases the risk of unemployment; the two becoming mutually reinforcing[21].

Evidence suggests one in seven men develop clinical depression within six months of leaving their job. Good work is generally good for wellbeing but this is not necessarily the case for poor quality work. Job stress, job insecurity and lack of job control are strongly

15 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
16 http://www.instituteofhealthequity.org/projects/understanding-the-economics-of-investments-in-the-social-determinants-of-health
17 http://www.instituteofhealthequity.org/projects/improving-access-to-green-spaces
18 http://www.ecehh.org/research-projects/blue-health/
19 Wright F. Retrospective rapid health impact assessment (HIA) of green and blue spaces of Barking Riverside development to date. Barking and Dagenham Council, 2016.
20 http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
21 https://www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain

related to poor mental and physical health outcomes[22]. Many people who are in paid employment live in poverty. Education and skills provide a route to good quality employment as well as increasing health literacy, reducing the risk of ill health[23] and increasing Life Expectancy.

Providing opportunities for employment and skills in the borough: the borough has a strong history of industry - most notably Ford, which is still a local employer[24]. There are new opportunities within the creative (such as the Ice House Quarter), advanced manufacturing and green energy industries. Developments of the health and social care sector include key worker housing and skills development in the innovative Care City test bed site[25].

High unemployment and low skill levels: unemployment rates are higher than London and England at 13.1% compared to London's 6.5%. More than 10,000 residents have been claiming out of work benefits for more than a year (8.5% of working age) – the third highest in London (6.3%). For full time workers in the borough the median hourly pay is the third lowest in London and one of five are earning less than the £9.20 that is effectively equivalent to the London Living Wage[26]. 42% of our residents of working age are unable to understand and make every day use of health information[27].

Potential to improve poor health outcomes: good quality work and higher educational attainment can reduce the risk of unhealthy lifestyle behaviours and increase Life Expectancy. As discussed in chapter 1 smoking rates in the borough (23.1% of adults) are amongst the highest in London and both Life Expectancy and Healthy Life Expectancy for men and women in the borough is amongst the lowest. Women in our borough spend on average 26.9 years in poor health (difference between Healthy Life expectancy and Life Expectancy).

What works?

For most families' an adequate income is essential to live a healthy life. More widespread adoption of the living wage can reduce the number of working families on low income and improve public health, provided that the increase in wages is not cancelled out by reductions in benefits. Increasing benefit uptake amongst eligible households alongside addressing low wages is also important[28].

We can also improve the health of employees through positive work cultures, development of health promotion initiatives and establishing systems to recognise and manage ill health. Supported employment and job retention schemes, for example for people with mental health problems, are beneficial. Employee wellness programmes have been shown to return between £2 and £10 for each £1 spent[29].

Issues to consider

The Growth Commission proposes bringing in key work opportunities including the Billingsgate fish market[30]. The Greater London Authority runs a Healthy Workplace charter award scheme that recognises good quality employment. The Council could lead the way and encourage partners and businesses to aim to achieve this award alongside implementation of the healthy living wage. Care City is an opportunity for skill development and key worker roles in health and social care.

One borough, one community?

Improving health or reducing inequalities?

The growth of the borough will bring communities into new, mixed tenure houses. Some of these will be more affluent people into a very deprived borough, potentially increasing both wealth and health inequalities. Whilst it may be welcome or necessary to do this for local economic regeneration (especially in a financially tight environment), arguably this presents the biggest challenge for improving health and, with that, reducing health inequalities through the growth agenda.

We know that policies may inadvertently widen health inequalities

22 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
23 http://www.nber.org/digest/mar07/w12352.html
24 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/
25 http://carecity.london/
26 http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/bulletins/annualsurveyofhoursandearnings/previousReleases
27 http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-80
28 http://www.instituteofhealthequity.org/projects/health-inequalities-and-the-living-wage
29 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf
30 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/

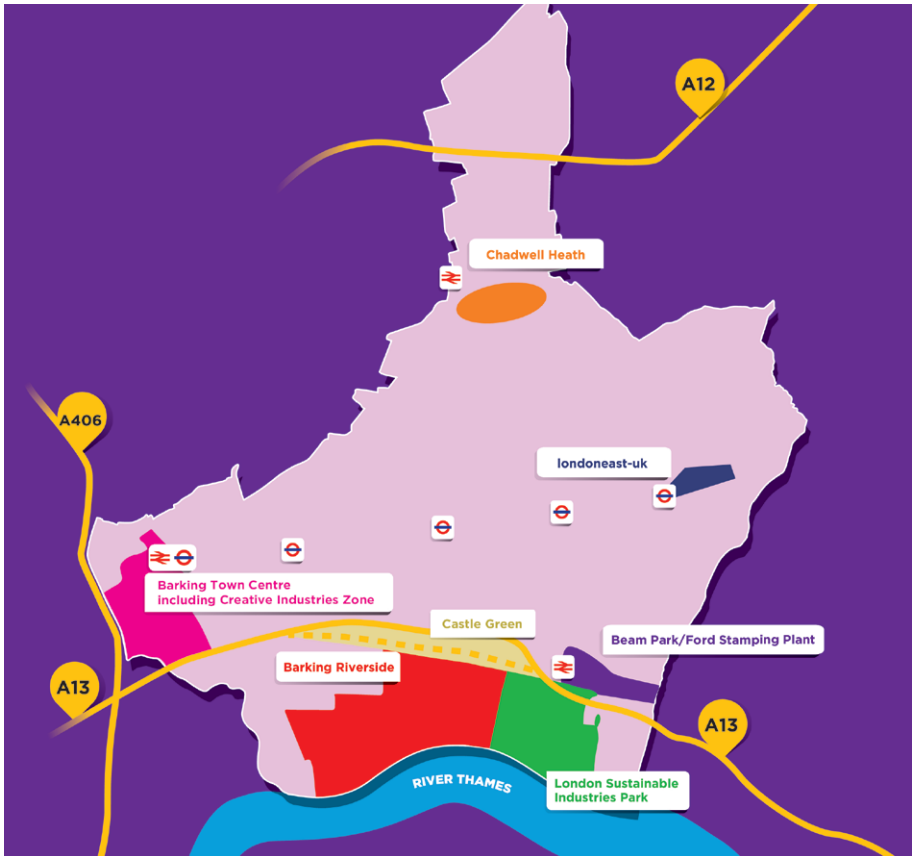
unless we specifically work against this[31]. There are plenty of examples of this such as uptake of screening programmes which are accessed disproportionately by more affluent groups. Even when taking action to address social determinants of health, such as in this regeneration programme, it is important to ensure our policies narrow rather than widen inequalities in health.

Wilson and Pickett[32] explain that more equal societies are healthier societies. Less equal societies have poorer health outcomes, not only for those who are less affluent but for the affluent in those societies. Also strong social capital improves the health of the less advantaged in that community[33].

To achieve a healthy new town, it is important to have community cohesion and social capital. How do we bring old and new communities together so "no one is left behind"? How do we truly develop a growth area and the surrounding areas in the borough to achieve equality of health, social, economic outcomes over the coming years? How do we maximise assets in the borough and in the growth areas so as to ensure that health inequities are narrowed and not widened?

Some approaches and principles

The two examples above give insights into the potential for positive or negative impacts on community cohesion within a society and on inequalities. Inequities in access or utilisation of green spaces or of employment opportunities are seen by socio economic group and by vulnerable groups such as the elderly or disabled.



Barking and Dagenham's growth hubs

Notably much of the research evidence for both examples discusses the impact on health and fails to evidence impact on health inequalities or cost effectiveness. There are examples of good practice but these are often poorly evaluated. Resources for evaluation and health impact assessments of new developments will be important to further develop the evidence base. Local assets, such as the River Thames, as well as new creative or green technology industries are there to be maximised but again we need to be mindful to promote equity of access. For example, we should keep down costs of using formal recreation facilities so as not to exclude low income groups and should skill up lower socio-economic groups to be able to obtain employment.

We can see that health cuts across different social determinants. A health in all policies approach is needed. For example, to maximise the health benefits of green spaces, accessible transport is needed. There are strong recommendations throughout the report of the Growth Commission about the importance of involving communities in planning and delivery of policy in order to address inequalities[34]. The CIC for Barking Riverside is an example of this.

31 https://www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report
32 https://www.equalitytrust.org.uk/about-inequality/spirit-level
33 personal communication Dr Tim Huijts, Lecturer in Global Health, Queen Mary's University,2014
34 https://www.lbbd.gov.uk/business/growing-the-borough/our-strategy-for-growth/overview-2/

Figure 2 proposes some principles to consider in policy development in order to achieve a reduction in inequalities. These are by no means complete as these issues are complex and challenging and merit further exploration. However, building on the expertise from the Growth Commission we will seek support from experts within the Healthy New Towns network to consider how we can address inequalities and community cohesion to ensure no one is left behind as we grow our borough.

Figure 2:

Key approaches to consider in addressing inequities in the long term.

- **Address social determinants of health.**
- **Utilise local assets.**
- **Take a "health in all policies" approach.**
- **Implement proportionate universalism – mindful of a social gradient in many health outcomes - rather than just focusing on the most vulnerable.**
- **Consider vulnerable groups, such as the mentally ill or people with learning disabilities.**
- **Use health impact assessments and health inequality impact assessments to maximise positive impacts for the disadvantaged.**
- **Put resources into monitoring and evaluation, including of equity.**
- **Involve communities in decisions, planning and delivery.**

Conclusions

The Council and our partners' commitment to reduce inequities and address the root causes of ill health are outlined in our joint Health and Wellbeing Strategy and Local Plan[35]. Although the Growth Commission has refreshed our ambition of shaping a borough where people want to live, work, invest and visit whilst enabling our residents and businesses to achieve their potential, the basic principle has not changed. It is important to recognise the progress made over the last 10 years and look forward towards the next 10 years.

The Commission recommended developing a Borough Manifesto that casts our vision into concrete 20 year goals. These are to be developed in consultation with residents, businesses and partners. Learning from the failure to capitalise on the Olympic legacy, we then stick to it like glue delivering a step-change in regeneration activity in Barking and Dagenham. The Manifesto underpinned by our Local Plan will drive an integrated programme of activity across the borough, taking advantage of our key assets and tackles constraints on growth. As with other interventions, planning solutions need evaluation of their appropriateness, cost and effectiveness, to help avoid future costs associated with ill-health, and wasted expenditure on what may be poorly designed, ineffective prevention approaches.

The 'lost art' of undertaking local health impact assessments, especially around policy and planning will need to be found again. This will involve working with partners on policy aimed at reducing the impact of social disadvantage on health and minimising the influences that the physical and social environment has on health. Good health impact assessments move beyond the purely technical assessment of impacts on outcomes, to include community views. Imposing solutions on the public will be neither welcomed nor sustainable; and what matters to the public is not always what matters to experts. This commitment to improvement is an opportunity not to be missed, but improvements inevitably take time.

35 https://www.lbbd.gov.uk/residents/planning-and-building-control/planning-guidance-and-policies/local-plan-review/one-borough-one-community-one-plan/

3 Commissioning for Population Health

Her Majesty The Queen receiving gifts whilst on her visit to Barking and Dagenham to celebrate the borough's 50th anniversary

In my reports of 2013[1] and 2014[2] I set out that in order to improve our Life Expectancy and Healthy Life Expectancy as described in chapter 1 we needed to look beyond illness to the wider social and public health context, reaching out to high-risk groups and working together to tackle the wider determinants of ill-health. This is essential if the future burden of increasing numbers of people experiencing multi-morbidity and dementia is to be reduced, against a back drop of tighter financial controls and cuts that pose risks to the quality of care.

This chapter explores the means of delivering a radical prevention agenda at the scale needed to deliver the services, transformation and public health programmes required to achieve our joint Health and Wellbeing Strategy outcomes[3].

Council Leader Councillor Darren Rodwell with children at Gascoigne Keep Active Fest

The challenge - We need to get to the root cause of problems

The combined impacts of austerity, socio-economic change and government policy lead us to a more profound conclusion about the need for change in the way we design and deliver services. Simply put we can no longer afford to meet the rising needs of our population by spending more money on the kinds of services we currently provide. Instead we need to re-focus what we do so that we identify the root cause of need and tackle it so that the individual or family in question have a better chance of living more independently now and in the future. Our job becomes one of building resilience so that people are better able to help themselves. Over the next 5 to 15 years we need to work on significantly reducing the demand for our higher cost health, social care and housing services.

Reduction in demand can only be fully achieved by understanding and addressing the underlying causes of our residents' poor Life Expectancy. To achieve this you have to look beyond efficiency and effectiveness of health

1 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
2 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/018583-BD-Annual-Health-Report-2014-WEB.pdf
3 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

and care services as evidence tells us the single most important thing that drives the health of our residents is the wider determinants of health such as education and economic development. We are indeed London's growth opportunity and with that growth comes the prospect of significantly improved lives for our residents now and in the future. But with this comes the challenge to cast our ambitions into concrete long term plans of up to 20 year goals. The science underpinning that is even stronger than the science underpinning healthcare.

To exemplify the point, the Council has examined the potential impact of the Housing and Planning Bill[4] and the Welfare Reform and Work Bill[5] currently going through the parliamentary process:

- 1% Rent reduction: wipes £33M from the Housing Revenue Account over the next 4 years (£450m over the next 30 years). Reduces our ability to build and maintain our social housing stock.
- Pay to stay: Market Rent for households earning over £40K. This will make Council housing unaffordable for many tenants and provide a further impetus for Right to Buy.
- Forced sales of high value council homes: will reduce our stock by up to 800 units over the next 5 years.
- Changes requirement for affordable housing: emphasis is on starter homes (not affordable) and some limited shared ownership. New public investment will not be available for social housing.
- Welfare reform (benefit cap and local housing allowance): expect to see a 100% increase in homelessness applications with a £5m cost to the Council by 2020.

Set against our level of deprivation as measured by the Index of Multiple Deprivation[6] the above will exacerbate housing as a health inequality issue and increase recognition of the importance of decent affordable housing as a prime requisite for health. Poor housing may pose a health risk that is of the same magnitude as smoking (and clearly interrelated) and, on average, greater than that posed by excessive alcohol consumption. The British Medical Association 2003 report Housing and Health[7] drew attention to the vital importance of access to good quality housing for those in poor health.

Better Health for London[8] and the NHS Five Year Forward View[9] acknowledge that the future sustainability of the local health and social care economy hinges on a radical upgrade in prevention that addresses the wider determinants of health such as income and housing. When examining NHS sustainability in particular one should reflect on

the analysis by Dominic Harrison, Director of Public Health, Blackburn with Darwen Borough Council of the recent Public Health England Older Age Mortality Report[10]: "Although variations in life expectancy are multi–faceted one cannot ignore the loss of wider 'community care' emerging because of social isolation and now dangerously exacerbated by cuts to Local Authority Adult Social Care Services: Older adults (the majority of deaths each year), with a number of long term conditions (which will be the majority) when becoming frail will contract routine infections – particularly respiratory- which, if unobserved, undiagnosed and untreated will exacerbate quickly to the point that death is inevitable. Whilst their underlying vulnerability is biomedical, increasing social isolation coupled with the dramatic withdrawal of preventive adult social care services and the voluntary services they often commission which had often provided daily contact are now disappearing".

Dominic Harrison goes on to question whether it is possible to meet all four requirements of the NHS Planning Guidance - contain costs, improve quality, reduce inequalities and improve outcomes within a diminishing resource envelope. In Barking and Dagenham, we too need to acknowledge the risk to health outcomes from the pressure to contain costs in a context of increasing need, and comprehensively assess the impact of our policies against all four criteria.

4 http://services.parliament.uk/bills/2015-16/housingandplanning.html
5 http://services.parliament.uk/bills/2015-16/welfarereformandwork/documents.html
6 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
7 http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/G7L4PYYLM6HGKVT8CXLVJGQBEPBK8K.pdf
8 http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
9 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
10 https://www.gov.uk/government/news/life-expectancy-at-older-ages-is-the-highest-its-ever-been

What is Population Health?

The Kings Fund[11] describes population health as more than just access to traditional health and care services, although recognising this plays an important part in determining the health of a population, evidence suggests that this is not as important as lifestyle, the influence of the local environment, and the wider determinants of health. This means that improving population health requires efforts to increase incomes, change behaviours and living conditions across communities. It also means that accountability for population health is spread widely across these communities, not concentrated in single organisations or within the boundaries of traditional health and care services.

For us the scale for the health and social care system is now defined as a population of 750,000 covering the geographical area of the London boroughs of Barking and Dagenham, Havering and Redbridge. This as a minimum requires greater pooling of data and budgets; population segmentation; place-based leadership drawing on skills from different partners and communities based on a shared vision and strategy; shared goals based on analysis of local needs and evidence-based interventions; effective community engagement; and incentives to encourage joint working.

However, using a population level lens to plan cross borough programmes at scale is not a means to an end in addressing the impact of changing demography, lifestyles and health and care needs on facilities and services provided for local people and the role that individuals can take in their health and wellbeing. One size certainly doesn't fit all and there is a clear need in developing different strategies for different population segments, according to needs and level of health risk. In meeting the challenge the Health and Wellbeing Board in its system leadership role over the last 24 months has been setting out what good care and prevention looks like through the refresh of our joint Health and Wellbeing Strategy 2015–2018[12] and delivery plan. The Board recognises that commissioning at scale is an essential part of containing costs and managing demand in the health and care system.

Population Health: The role of commissioners

The history of well-intentioned public health strategies that have promised much but delivered less – dating at least as far back as Prevention and health: everybody's business in 1976 (Department of Health and Social Security 1976)[13] suggests caution in claiming that things will be different this time around. This view has maintained through the decades as traditional commissioning strategy has tended to focus on processes, individual organisations and single inputs of care or lifestyle.

The government published a joint Spending Review and Autumn Statement on 25 November 2015[14] which is a 'game changer' in respect of public sector planning and performance introducing five year commissioning plans. The strategic commissioning focus is now:

- Place based budgets predicated on the scale of natural health and social care economies.
- The role councils play in shaping the local health economy transformation plans.
- A five-year financial settlement.
- The ability and willingness of councils to use new council tax powers to fund social care. Even if councils decide to raise revenue in this way there remains a strong possibility that we could see serial failures of social care providers.
- Improving the quality of health and care sustainably with an 'upgrade in prevention and public health'.

The NHS Planning Guidance 2016/17-2020/21[15] has asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View. Sustainability and Transformation Plans will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term.

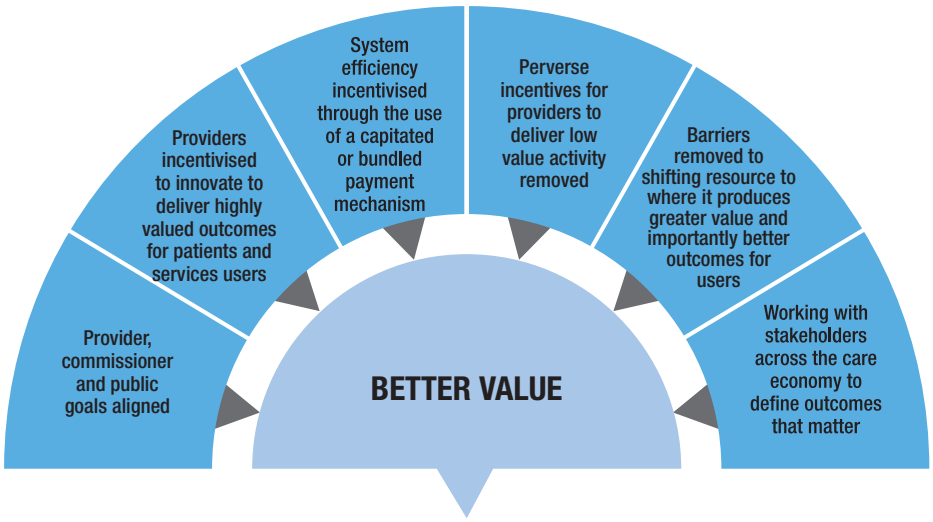
11 http://www.kingsfund.org.uk/publications/population-health-systems
12 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true
13 Prevention and Health, Everybody's Business: A Reassessment of Public and Personal Health. Dept. of Health and Social Security, Majesty's Stationery Office, 1976.
14 https://www.gov.uk/government/topical-events/autumn-statement-and-spending-review-2015
15 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Whatever your view point there is an undeniable opportunity to assess how the prevention opportunities might contribute to the current demand and financial challenges. The analysis will support our Health and Wellbeing Board to identify where improved health outcomes and benefits can be achieved sustainably by working at scale and therefore which part of the system commissions and which particular prevention interventions are invested in.

This will require a fresh approach to commissioning that releases energy and ambition focusing the right conversations and decisions on prevention as an integral part of improving health and care outcomes, identifying the opportunities for co-ordinated and targeted intervention across agencies, and seeking to redeploy resource across the provider landscape. Commissioners will need to focus on what matters, improving population health, helping people to achieve goals, and delivering a quality service. Such a move to system wide outcomes-based commissioning approaches have already been successful in helping transform the delivery of care internationally, but are in their infancy in England. Careful thought is needed to understand how outcomes-based commissioning can be developed locally to enable changes in the way services are delivered.

Figure 1:

How does an outcomes-based approach provide better value?



Source: Outcome Based Commissioning Alliance (OBC Alliance) formed of PwC, Wragge & Co, Cobic and Beacon

In principal the approach:

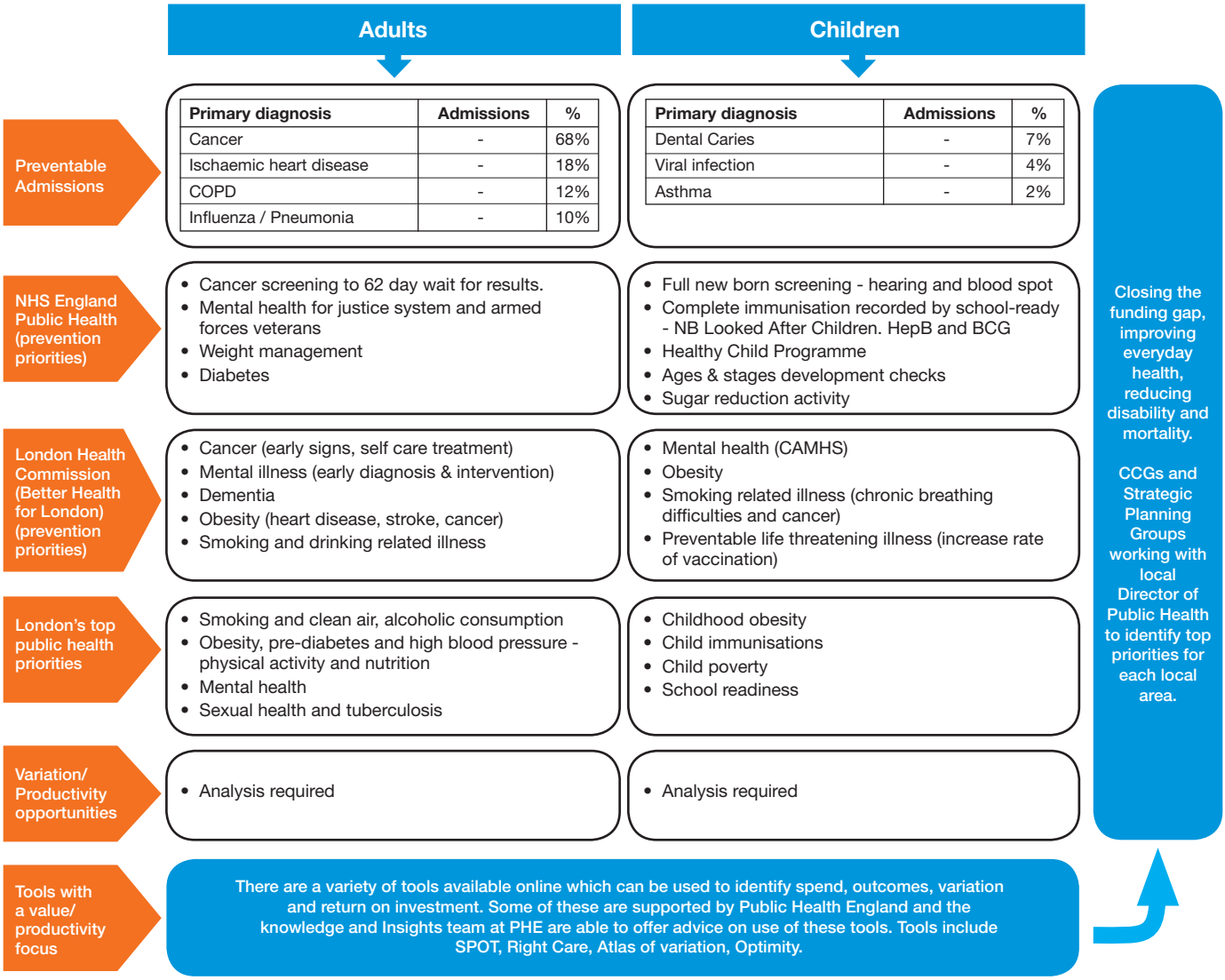
- is a way of paying for health and care services based on rewarding the outcomes that are important to the people using them;
- typically involves the use of a fixed budget for the care of a particular population group, with aligned incentives for care providers to work together to deliver services which meet outcomes; and
- aims to achieve better outcomes through more integrated, person centred services and ultimately provides better value for every pound spent on health and care.

This approach incentivises high-value interventions, shifting resources to community services, a focus on keeping people healthy and in their own homes, and co-ordinated care across settings and systems. The aim (see Figure 1) is to achieve better outcomes through integrated person-centred services and ultimately provide better value for every pound spent on health and care[16]. It also encourages a resident focus on becoming self sufficient and resilient, the experience of using the services, and achieving the outcomes that matter to them.

16 http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Beginning-with-the-end-in-mind.pdf

Figure 2:

Proposed approach to identifying priorities using illustrative figures.



Source: NHS England (London) (2015)

Being clear about the outcomes that matter

The Council, NHS England (London) and NHS Barking and Dagenham Clinical Commissioning Group are refreshing their 5 year plans in 2016 and there is an opportunity to align local strategies for prevention. All acknowledge that the future sustainability of the NHS and social care hinges on a radical upgrade in prevention.

No partner can do everything that's needed by itself, but all acknowledge that collectively all public service partners need to be more activist agents of health-related social change, leading where possible, or advocating when appropriate, a range of new approaches to improving health and wellbeing. The NHS Planning Guidance 2016/17-2020/21[17] specifically calls on the NHS to offer more proactive prevention activities through primary care. Figure 2 from NHS England (London) outlines a draft approach to identifying those priorities that could describe a local cross-partner prevention plan, with particular action on national priorities of obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people.

17 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Wheelchair Basketball put on for the Festival of Sport as part of the 50th anniversary celebrations

Is this radical enough or just the usual NHS response that looks to ensure sustainability by developing priorities relevant to the full cycle of health and care, from an initial problem through to recovery? 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.

For the most part this can only be realised in the way we focus our resources in delivering key health outcomes across the life course to enable a fairer distribution of health and wellbeing for our residents. From the Joint Strategic Needs Assessment 2015[18], we know what impacts on the residents' health and Life Expectancy (social, environmental, physical and mental). The joint Health and Wellbeing Strategy[19] sets out how the Council and its partners address the borough's poor Life Expectancy and Healthy Life Expectancy. Informed by this understanding of need the following five outcomes are put forward for discussion for improving both Life Expectancy and Healthy Life Expectancy over the next 5 to 15 years:

Starting Well

- **Childhood:** Children to have a good level of development at age 5 in order that they can participate effectively in school and aspire to become good citizens.
- **Adolescence:** Adolescents, including our most vulnerable, to have a good level of education, indicated by qualifications, in order that they can engage with society and aspire to maximise their potential to grow into healthy, socially and economically active adults.

Living Well

- **Early and established adults:** Adults to have opportunities to earn a good income in order to engage with society and maximise their social and economic potential.

Aging Well

- **Established and older adults:** Established and older adults who develop a long term condition and have unhealthy lifestyles (smoking, poor diet, alcohol and/or inactivity) to be able to maximise opportunities to manage their own health.
- **Older adults:** Older adults who are at the end of their lives to have a choice of where they die.

Once key outcomes are selected, we need to identify a range of indicators that will reflect change in the health of residents. It includes both indicators of the wider determinants of health and indicators of health. This will enable us to measure how education, housing and lifestyle impact on the mental and physical health of our residents.

How could this look for 0-5 year olds?

If we examine an outcome for early years: to enable children to have a good level of development at age 5 in order that they can participate effectively in school and aspire to become good citizens, we can see how this approach can be applied.

Why this is important?

The path to poor health and social outcomes starts before birth, with children in families with multiple risk factors such as debt, substance misuse, poor housing and domestic violence being more likely to experience development and behaviour problems, mental illness, substance misuse, low educational attainment and offending behaviour. Investment in our interventions has to focus on improving early years outcomes in the crucial first five years of life, and identify what matters most in preventing poor children becoming poor adults.

18 https://www.lbbd.gov.uk/council/statistics-and-data/jsna/overview/?loggedin=true
19 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

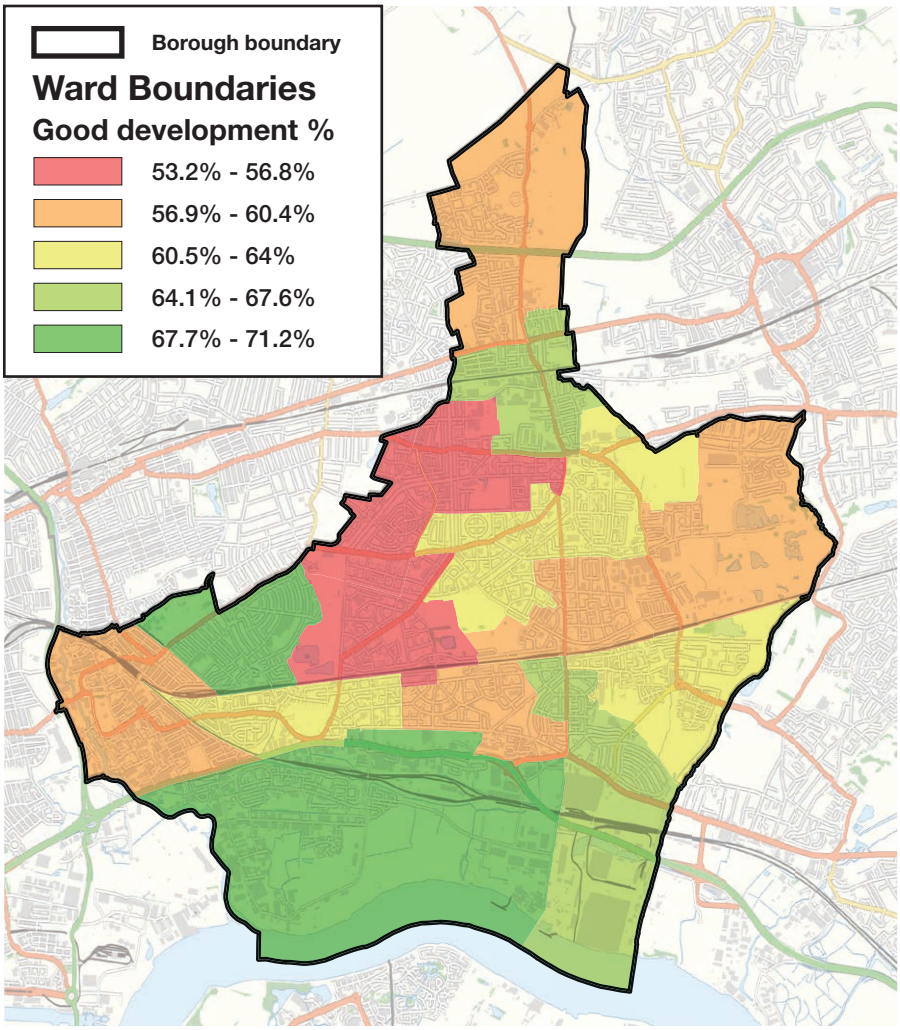
Detailed research has been undertaken to identify the factors that affect child outcomes[20]. As an example, maternal factors have been shown to be particularly influential when the child is 3 years old. In chapter 4 of my 2013 report[21] I examined the evidence and factors influencing child outcomes including living in poverty and having parents who disagree about the upbringing of the child, as well as more obvious factors such as the child having a life-limiting illness and poor general health of the mother. A number of the indicators proposed in the 2013 report are included here.

We want our children to have a good level of development at age 5. What happens during early years, starting in the womb, has lifelong effects on many aspects of health and well-being from obesity, heart disease and mental health, to educational achievement and economic status[22]. Good health supports good development. Figure 3 shows the level of good development in the borough.

In super output areas in the west of the borough children had a less good level of development in 2011/12. This indicates that the greatest need for child help is in this area and hence this area should be targeted.

Figure 3:

Barking and Dagenham heat map of wards percentage of population achieving a good level of development at age 5, 2011/12.



The health economic case?

Public Health England in their report Improving school readiness Creating a better start for Londoners[23] put forward a compelling case to why we should invest. They argue that failing to invest sufficiently in quality early care for those who need it and education short changes taxpayers because the return on investment is greater than many other economic development options:

- Every £1 invested in quality early care and education services saves taxpayers up to £13 in future costs.
- For every £1 spent on early years education £7 has to be spent to have the same impact in adolescence.
- The benefits associated with the introduction of literacy hour have in the UK outstripped the costs by a ratio between 27:1 and 70:1.

For improving self sufficiency and resilience in later life investment in early years interventions targeted at those that need them have been shown to have a higher rate of return per investment than later interventions

20 http://www.chimat.org.uk/preview/evidence
21 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
22 https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
23 https://www.gov.uk/government/publications/improving-school-readiness-creating-a-better-start-for-london

with improved educational outcomes, reduced healthcare costs, reduced anti-social behaviour and increased taxes paid due to higher earnings as adults.

What works for our population?

There is an expectation that there will be whole system reforms both to streamline and to join up local services in order to provide better outcomes for families and reduce costs. This provides an opportunity to promote more effective integration of services locally with a focus on early intervention which will secure better returns on investment. Therefore, the partners are encouraged to work with families in ways that evidence shows to be more effective, such as:

- Joining up local services.
- Dealing with each family's problems as a whole rather than responding to each problem, or person, separately.
- Appointing a single key worker to get to grips with the family's problems and work intensively with them to change their lives for the better over the long term.
- Using a mix of methods that support families and challenge poor behaviour.

There is good evidence that the following interventions support good development:

- Giving priority to pre and postnatal interventions, such as early booking, stop smoking and intensive home-visiting programmes that reduce adverse outcomes of pregnancy and infancy.
- Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet health and social need via outreach to families. This approach is particularly important for 'at risk' families and links closely with our work on community solutions[24]. One example of such a programme is Family and School's Together.
- Providing school based health services and lifestyle programmes to support good development and informed decision making.
- Additionally to improve immunisation uptake[25] a universal approach is needed that supports all children's services to encourage vaccination underpinned by appropriate training and information systems. Again this approach is particularly important for 'at risk' families and links closely with our work on community solutions.

Conclusions

Being clear on the outcomes that matter is the driver for transforming care and innovative prevention approaches. There is established consensus that outcomes based commissioning will expect providers to encompass and work with all the services and functions that contribute to achieving those outcomes. Finding ways to align providers' incentives to outcomes will be crucially important.

This chapter establishes that if we commission for outcomes for what matters, the Growth Commission recommendations and Accountable Care Organisation method in chapters 2 and 4 respectively illustrate the place based approaches to achieving the outcomes. The principles on which the success of the approaches discussed in chapters 2 and 4 include:

- Focusing on the outcomes that matter to improve our borough's Life Expectancy and Healthy Life Expectancy for both females and males, combined with the alignment of incentives and indicators to drive improvement and co-ordination between providers.
- One size doesn't fit all and there is a clear need in developing different strategies for different population segments, according to needs and level of health risk.
- Moving to outcomes based commissioning predicated on longer term contracts will make it easier to focus on prevention and invest in services whose health improvement return may take several years to achieve.
- The need to focus our resources in delivering key health outcomes across the life course to enable a fairer distribution of health and wellbeing for our residents this includes economic benefits in reducing losses from illness associated with health inequalities.

24 https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
25 https://www.nice.org.uk/guidance/ph21 .

4 New Model of Care:

Accountable Care Organisation

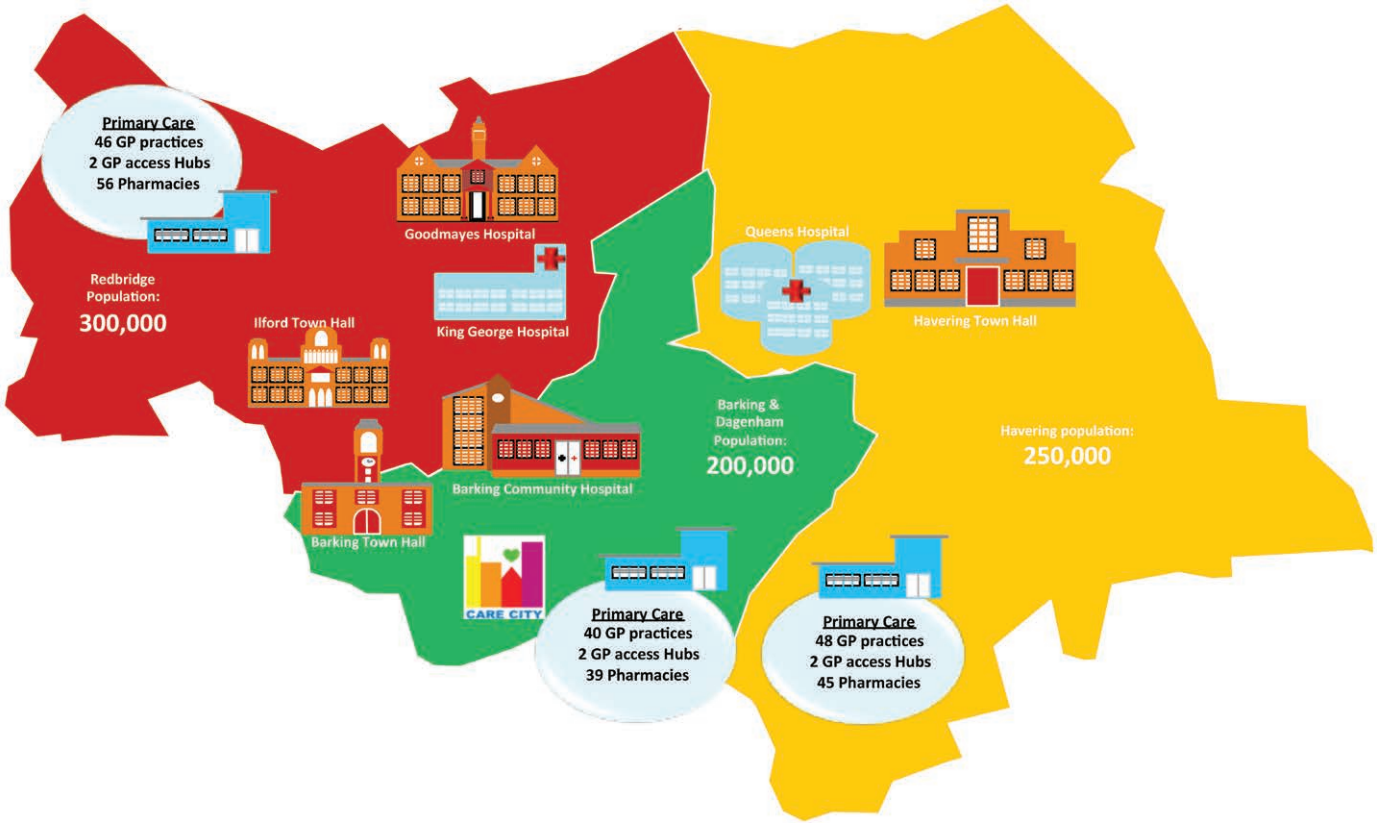
Council Leader Councillor Darren Rodwell, Councillor Laila Butt and staff from Asda raising money for White Ribbon Day as part of the '16 Days of Activism' campaign against domestic violence

In this chapter I continue my interest in transformation with consideration of the new care models programme which was launched by NHS England in January 2015[1].

In my annual reports of 2013[2] and 2014[3] I examined the necessity to identify ways of preventing ill health and moderate demand through integration of services. Our joint Health and Wellbeing Strategy[4] directs us to shape fundamentally more productive services that are integrated and operate as a co-ordinated system. This requirement encompasses primary, community, hospital and social care services and is driven by the need to ensure meeting the needs of the residents goes hand in hand with the provision of services that are of high quality, but are also sustainable and affordable.

The Barking and Dagenham, Havering and Redbridge (BHR) health and social care system (see Figure 1) is recognised nationally as a patch with strong clinical and political leadership. We are now exploring whether a partnership-based Accountable Care Organisation (ACO) method, using devolved powers would deliver better outcomes for our residents while also helping to bridge our funding gap. The ACO method is set out in the NHS Five Year Forward View as one of five transformational models of care, which effectively mean the development of 'place based care' at a local level.

Figure 1:
The Barking and Dagenham, Havering and Redbridge (BHR) health and social care system.



1 https://www.england.nhs.uk/wp-content/uploads/2015/12/acc-uec-support-package.pdf
2 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/DHP-Annual-Report-2013-14-WEB.pdf
3 https://www.lbbd.gov.uk/wp-content/uploads/2015/02/018583-BD-Annual-Health-Report-2014-WEB.pdf
4 https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/overview/?loggedin=true

What is devolution?

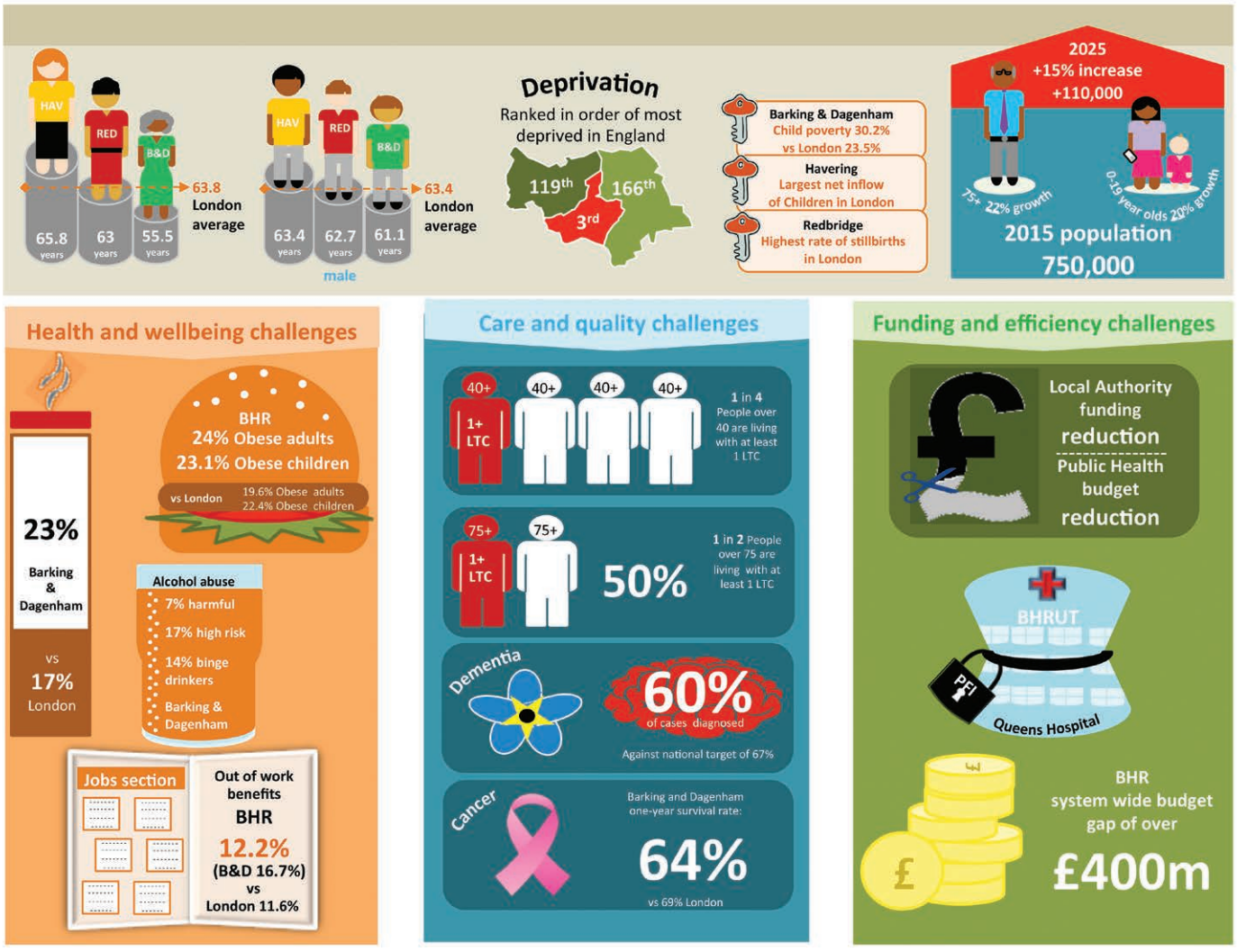
Devolution is: "The transfer or delegation of power to a lower level, especially by central government to local or regional administration". There is an opportunity to use these new powers and resources that are available through the London Health Devolution Agreement[5] to build on what's already working in BHR. With clinicians and elected representatives in the driving seat, we can work to dissolve the barriers between primary care, community services, mental health services, hospital and social care and come together in a stronger partnership for the benefit of our population.

The ACO is the method through which we will explore the potential benefits of devolution to determine whether we can deliver better outcomes and bridge the funding gap. A core goal of the London Health and Care Devolution Pilots is to shift services to prevention and early intervention, both to improve outcomes and reduce pressures on services. A key question in the business planning process is whether the creation of an ACO can unlock a significant shift towards prevention, in line with the Council's aspiration to tackle the root causes of ill health. Any outcomes agreed to address the key system challenges to BHR which are outlined in Figure 2 below, will require focused impact at the scale commensurate with population health gain.

The first full devolution model in England is 'Devo Manc' the new Greater Manchester Combined Authority, which like London, also has an elected mayor and assembly[6]. The evidence suggests that like 'Devo Manc' the ACO method is likely to be more effective if it can be aligned with a range of other public sector reforms to welfare and housing which also increase the emphasis on, and support for, improving quality and reducing costs.

Figure 2:

BHR Health and Social Care key System Challenges.



5 https://www.gov.uk/government/publications/london-health-devolution-agreement/london-health-devolution-agreement

6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/369858/Greater_Manchester_Agreement_i.pdf

What does the evidence tell us about the benefits of establishing an ACO?

The growing interest in new models of service delivery has been driven by a consensus that the existing NHS health care delivery and payment systems are neither effective nor sustainable[7]. The current system, based on volume and intensity, pays more for overuse of referrals to hospitals and undermines efforts to invest money and effort in delivery-system improvements that can sustainably reduce costs.

A review of the international evidence tells us that ACOs are essentially groups of doctors, hospitals, and other care providers, who come together voluntarily into networks to provide co-ordinated high quality care to a defined patient population[8]. The Kings Fund (2015)[9] has found that the ACO method has a number of different potential configurations and that claims about its effectiveness are not yet fully supported by a particularly strong evidence base. However, commentators argue that a real and enduring impact can potentially be achieved if understanding goes beyond the integration of care for patients and service users to explore how they can use their resources to improve the health of the populations they serve. Put simply, it is a case of simple economics; since providers only share in ACO savings when they decrease costs, it will be crucial for ACOs to switch from merely treating sickness to maintaining or improving health, to prevent costly avoidable illness and unnecessary care.

Whilst there are no set structures for ACOs[10], there are some common basic principles, which include:

- Primary care being placed at the heart of all services.
- The development of integrated service models that span across organisational boundaries.
- A provider or group of providers is allocated a fixed budget to manage all health and care needs for a defined population group (capitated payment), patient-linked IT datasets and a culture of continuous improvement/innovation.
- Closer working with local partners including primary care, social care and community services.

An important difference in the England context is the definition of the population group whose health is being managed or improved. Nevertheless, the American ACO method can be applied to English context. When considering the system challenges faced by BHR that are outlined in Figure 2, the NHS can no longer look through the narrow lens of care and needs to embrace its dual role in prevention and lifestyle support as well as developing new models of care. Indeed, changes to the planning framework outlined in the previous chapter now make the ACO an attractive option for delivering the population health benefits that we need to achieve.

A summary of the benefits for improving population health are contained in Box 1 and the challenges in Box 2 below:

Box 1:

The ACO method offers a number of opportunities for improving population health.

- Patients and service users will be at the centre of care, and should be offered increased involvement and engagement in the design, delivery and improvement of services.
- Health and care staff will be better able to keep their patients informed, as well as keep listening to and honouring their choices. This includes proactively contacting individuals to prevent disease in the first place, actively involving patients and their caregivers in setting care goals, and sharing decision-making.
- Provides the ability to better manage and co-ordinate the care of individuals along the full length of clinical and social care pathways. This offers the potential to improve access and reduce the number of care transitions. Improved co-ordination should also lead to patients being treated and supported in a range of different, more appropriate, settings, which should contribute to ensuring greater continuity of care.
- Enhanced sharing of performance data within the network means the best performing partners within the ACO can be identified, and they can then share what they are doing with the other partners in the network. The sharing of patient information and co-ordination of care within the network should improve patient care and also help drive efficiencies, for example by reducing the number of repeated medical tests.
- Proactive management of their defined patient populations, to inform early intervention and prevention. The aim will be to keep people healthy for longer, through an increased focus on primary care and a bias toward early intervention.

7 http://hsr.sagepub.com/content/early/2015/06/16/1355819615590845.abstract
8 http://www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england
9 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf
10 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf

Box 2:

The ACO method offers a number of challenges for improving population health.

Whilst the ACO concept offers significant opportunities for improving population health, there are also a number of challenges that would need to be overcome to achieve them. These include:

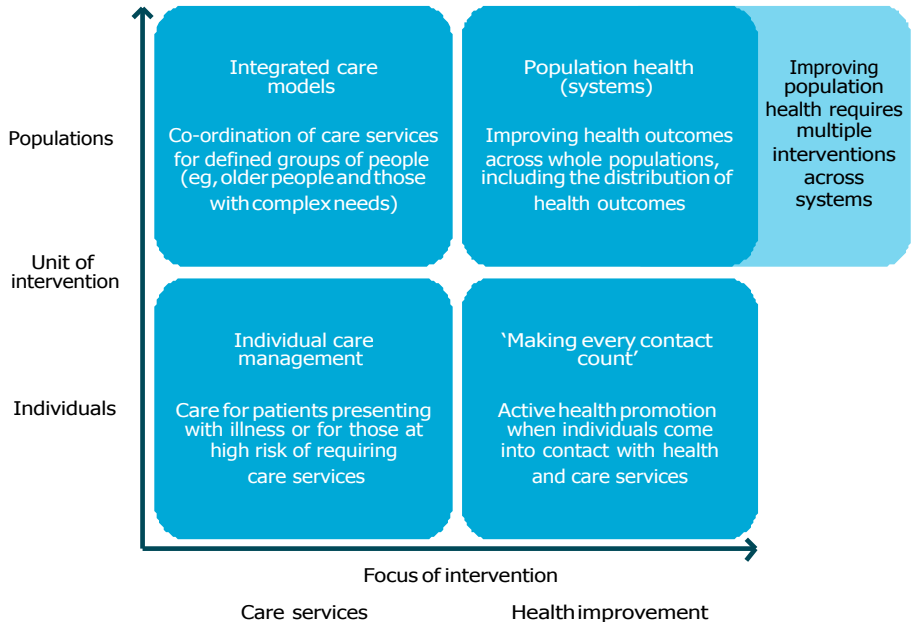
- The formation of seamless provider networks across the BHR system.
- The development of effective mechanisms to share data and information within the BHR Integrated Care Coalition.
- The development of mechanisms for actively engaging patients and their families in their care.
- Overcoming existing institutional barriers. Budgets within the Partner organisations and between the NHS and social services are separate and institutional separation between primary care, hospital care and social care is currently a significant obstacle. Staff employed by these different institutions may work together but they are separated through different cultures, and different terms and conditions.
- The need to develop effective joint commissioning between the partners of the BHR Integrated Care Coalition.
- Striking a balance between delivering standardised care and adopting a flexible personal tailored approach.

How can we make it work?

Firstly:

The Kings Fund set out a challenge to those involved in integrated care and public health to 'join up the dots'. This means that any ACO development must have improving population health at its centre. Figure 3, describes the need to have a wider focus than our traditional approach to integrated care. While interventions focused on individuals and integrating care services for key population groups are important, they must be part of a broader focus on promoting health and reducing health inequalities across whole populations[11]. Therefore, the ACO method will need to be shaped to support the Council's vision as London's growth opportunity as well as addressing the Government's reforms that will have a major impact on Council services, residents and local businesses.

Figure 3: The focus of population health.



11 http://www.kingsfund.org.uk/publications/population-health-systems

Secondly:

Partners within the Coalition must embrace the concept of 'place based care'. This involves organisations 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 health and social care system to address challenges and improve the health of the populations that they serve.

This means that, rather than organising care around disease or organisation, it should be organised around the place in which people live. Consequently, teams should be structured around geographical areas and work as part of the local community in which they operate. This will enable them to tailor the care they provide to local needs and linking to local assets. While there are some current examples of this extending into population health, most of the current initiatives have started with local government (as in the case of the health commissions established in Liverpool and London).

For Barking and Dagenham a real opportunity has emerged as part of the growth agenda, which provides a place based and population health hook for the ACO approach. On 10th March 2016 NHS England chief executive Simon Stevens announced Barking Riverside (10, 800 new homes) as one of the locations of the 10 "healthy new towns". These are communities across England where health and wellbeing will be "designed into" their construction. The programme, runs in conjunction with Public Health England, aims to join up design of the built environment with health and care services. NHS England plans to bring in clinicians, designers and technology experts to shape care provision in each location. Mr Stevens stated: "The much needed push to kick start affordable housing across England creates a golden opportunity for the NHS to help promote health and keep people independent. As these new neighbourhoods and towns are built, we'll kick ourselves if in 10 years' time we look back having missed the opportunity to 'design out' the obesogenic environment, and 'design in' health and wellbeing".

Although, caution should be used when comparing models used in other countries, there is sufficient evidence available to suggest that the 'healthy new town' model can be applied to the England ACO context. The Kings Fund (2015) looks at a number of successful international approaches that have evolved past a pure care based method. Counties Manukau Health, New Zealand provides an interesting case study of how an ACO method can go beyond care to incorporate housing and health as part of its community solution.

Thirdly:

In respect of population health, a planning framework operating at 3 levels within the BHR system may serve to improve outcomes for the diverse populations across the three boroughs:

- The BHR health and care economy level estimated population 750,000. This will involve partner organisations working together across systems to improve health outcomes for defined population groups. Unlike typical approaches to integrated care that focus primarily on groups that are frequent users of health and care services, the aim here is to improve people's health across the whole of the populations that they serve. This population-level lens is used to plan programmes and interventions across a range of different services and sectors to maximise value for money and effectiveness of large blocks of care.
- The Locality model provides care for a defined population, usually 50,000 – 70,000 people. This will involve localities developing different strategies for different segments of the populations that they serve, depending on needs and levels of health risk. By grouping people with similar needs and tailoring services and interventions accordingly, this approach recognises that improving the health of older people and children, or healthy adults and those living with multiple long-term conditions, will require a different set of approaches, and involvement from different system partners to be effective.
- With the locality model there will need to be a neighbourhood level. This is primarily to address inequalities by delivering a range of interventions aimed at improving the health of individuals within the small geographical areas (such as deprived estates). These interventions are many and varied, and involve input from a number of organisations and services. In the Counties Manukau Health case study they include housing support, education programmes, vocational services, employment advice, exercise programmes, smoking cessation services and other lifestyle support, as well as more traditional health and care services like care planning and individual case management for people with complex health and care needs.

Case Study

Counties Manukau, New Zealand

Counties Manukau Health (CMH) is responsible for commissioning health and care services for the whole population of 500,000 people living in South Auckland, and for providing hospital and specialist services in the area.

It works with a range of local and national partners to integrate services and improve the health of the population living in Counties Manukau. This has had a major impact on Council services, residents and local businesses.

As with many other integrated care systems, CMH has worked with local providers to develop locality-based integrated health and care teams that are aligned with networks of general practices and working in partnership with hospital services. Services are tailored to the needs of different population groups within each locality, based on population risk stratification. Services range from primary prevention services and lifestyle support through to active case management for patients with complex health and social care needs, with the emphasis being on supporting people to manage their own health. Each locality is served by a wider social care network to provide help and support to families with complex needs whose living environments are impacting on their health.

An example of this is CMH's Healthy Housing Programme which is a joint initiative between CMH, neighbouring district health boards and Housing New Zealand, (the government-owned social housing provider) which ran from 2001 to 2013. The programme was open to all people living in rented Housing New Zealand accommodation, and focused on:

- Improving access to health and care services;
- reducing the risk of housing-related health issues; and
- identifying social and welfare issues and providing a link to relevant agencies.

After a joint visit and assessment from local health and housing teams, typical interventions included educating families about their health risks, referrals to health and social care services, installing insulation to make houses warmer and drier, modifying houses to meet health and disability needs, and transferring families to alternative houses in cases of overcrowding. These interventions were tailored to the needs of different families and population groups, in particular, the Māori and Pacific Island groups, which are disproportionately affected by poor housing conditions. The programme took a locality-by-locality approach to ensure that every eligible household was reached systematically and to reduce the potential for stigmatisation of families involved in the programme.

Residents taking part in events for Older People's Week

Fourthly:

Local elected councillors and local authority chief officers will need to make some hard choices as they seek to increase the accountability of the health and care services that are provided to their local populations. The ACO method is an opportunity for the Council to think creatively about the powers and democratic representation they can bring to bear. The Nuffield Trust[12] argues that accountability for public services has three, inter-related elements (Brinkenhoff, 2003):

- Accountability for strategic decisions on provision and the allocation of resources, particularly which services are provided and to whom;
- accountability for the quality of services delivered, such as access, clinical quality, safety and outcomes; and
- accountability for the management of resources including value for money, probity and fairness.

All three of these elements are important. Over the next 5 years, for example, it will be crucial for the Health and Wellbeing Board to exert its system leadership role in how services respond to challenges such as:

- Emerging needs, such as addressing the challenge of care for the rapidly rising number of people with dementia and the demographic growth in children;
- how health and care services can be better integrated to provide more seamless care;
- how health and care services can be better integrated with other public services such as employment support, housing and leisure to better prevent ill-health; and
- embedding an ethos of quality across all care, following a number of high-profile failures in recent years.

The Health and Adult Services Select Committee (health scrutiny) also has a strategic role in taking an overview of how well integration of health, public health and social care is working. Relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration and in making recommendations about how it could be improved. Scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system and will have to evolve within a population health system.

12 http://www.nuffieldtrust.org.uk/publications/reconsidering-accountability-integrated-care

Conclusions

The Kings Fund (2014) in their paper Accountable care organisations in the United States and England testing, evaluating and learning what works[13] concludes that the context in which integrated care develops is itself a critical variable, suggesting that a 'made in England' approach is likely to have a greater chance of success than seeking to copy a model that itself remains emergent in the Unites States. Beyond the obvious attraction of a network of providers working under a capitated budget that creates incentives to improve outcomes lies the hard slog of converting concepts into practice. As Burns and Pauly (2012) argue, strategic change of the kind represented by ACOs needs to be carefully implemented, and yet implementation and execution are poorly understood processes.

Key messages which can be drawn to inform discussion include:

- There is neither a 'one-size-fits-all' approach to ACOs nor are ACOs the only solution, yet they provide a potentially viable means to realising the principal aim of using devolved powers to deliver better outcomes for our residents while also helping to bridge our funding gap.
- Review has shown that progress to date has been mixed and there needs to be realism about the hard work and time it will take for this method to demonstrate measurable benefits. While some ACOs in some contexts have slowed the rate of health care spending and delivered improvements in quality of care, other ACOs in other contexts have not done so.

Residents taking part in a class in the Ageing Well programme

- Real and enduring impact can be achieved if the ACO method is aligned with a range of other public sector reforms to welfare and housing. Understanding needs to go beyond the integration of care for patients and service users to using resources to improve the health of the populations of the three boroughs.
- Development of a primary care and localities approach based on populations of 50,000 – 70,000 is helpful. Establishment of a locality structure to enable general practice and wider health and care teams develop as a group of providers, to reward the achievement of better outcomes and to encourage discussion and exploration of solutions within each locality that address the wider determinants of health such as income and housing will increase the chance of success.
- Accountability arrangements are critical to any system. A clear framework needs to be in place for strategic decisions about how services are provided and to whom, the quality of those services and whether the funds available are well spent.

13 http://www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england

5

Protecting the health of the local population:

focusing on health protection (infectious disease and non-infectious environmental hazards) – the future?

Diabetes UK roadshow in the borough

Background

Local authorities have a key role in protecting the health of their population, both in terms of planning to address threats that are a Local Authority lead responsibility, and in ensuring appropriate responses are undertaken by other agencies when incidents occur, particularly Public Health England (PHE) and NHS England (NHSE).

PHE was formed in 2013 and saw the then Health Protection Units become Health Protection Teams but working closely with Local Authorities. Local teams have detailed plans in place for dealing with infectious and non-infectious environmental hazards. They are responsible for leading and responding to cases and incidents and report to the local Director of Public Health (DPH) who holds the assurance role to the Council. If there is a need for an incident meeting the DPH would be invited.

NHSE responsibilities include commissioning immunisation and screening. This was a change from the work originally undertaken by Primary Care Trusts and at first a difficult transition. The DPH, with their assurance role, found they were no longer responsible for many of the key initiatives such as linking directly with General Practitioners in order to improve vaccination uptake.

The Council have had a Health Protection Committee running before and after the transition in 2013 and this ensured that those responsible for the delivery of health protection were reporting to the DPH at regular meetings. Initially there were a few teething problems as it was difficult to get representation from NHSE who were working across London and were stretched. This was rectified some time later with staff from NHSE being responsible for patches. The Health Protection Committee since has seen regular attendance from the health protection team and the immunisation team but to date no representation from the screening team.

Consultations – "Securing our future"

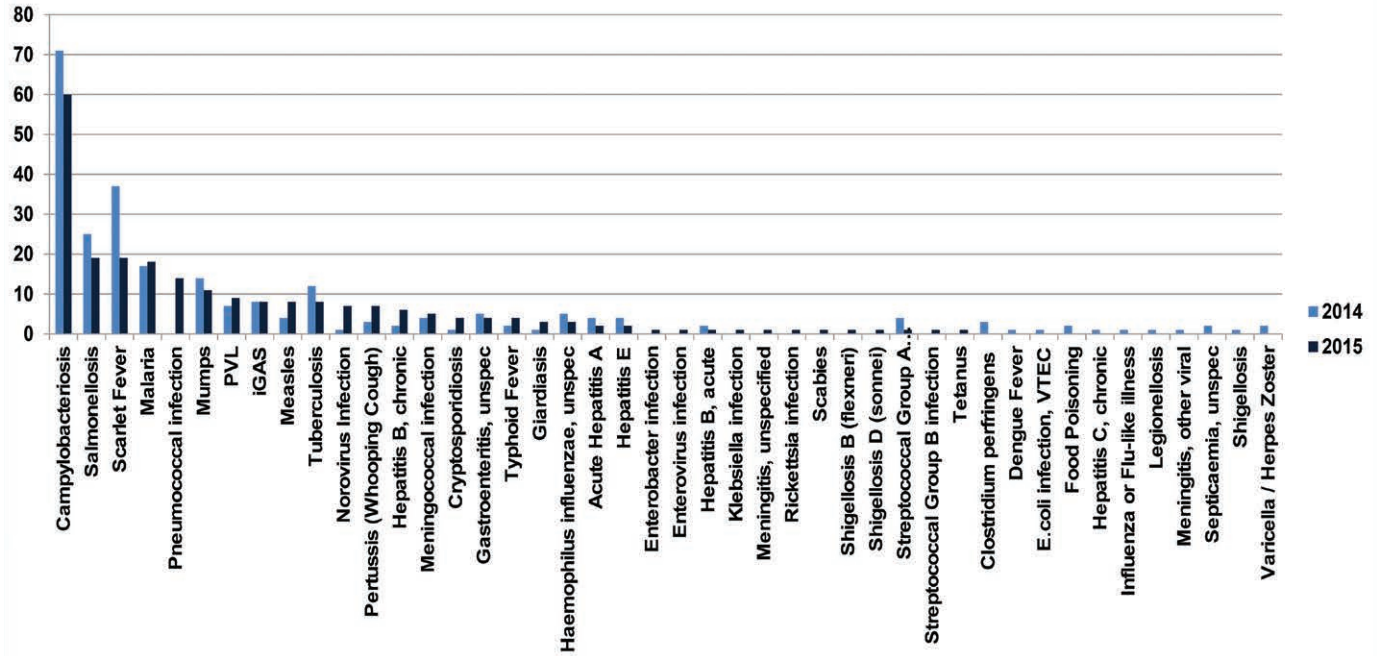
The Council have always had a Consultant in Communicable Disease Control/Consultant in Health Protection who works closely with the DPH and more recently a named health protection practitioner. This has worked extremely well with cross cover for leave and ensures there is always a named person from PHE who can be called in the event of an incident. This can be especially important when there are concerns from the public or media interest.

Several consultations from PHE have been sent to the DPH for comment which are called "Securing our Future" Phases 1 and 2 and are looking at redesigning health protection teams due to cuts in funding. For many parts of the system it isn't broken and doesn't require fixing and the Health Protection Committee recommended that the system stays intact as much as possible with emphasis on improving the model for immunisation and screening.

The main changes seem to be, sadly, some redundancies with fewer Consultants left in London but those still left, working more strategically with boroughs (which has historically always happened in Barking and Dagenham). There appears to be a move to more reactive work for those who are not Consultants. Certainly from the Council's perspective we would want to keep our current links with our named PHE person(s) working in partnership with us and hope that this is not eroded. The danger could be that practitioners would not have the capacity to deal with incidents in depth or attend important local borough meetings due to reactive on call and with less Consultants in London there would be a potential to have too few, spreading them across areas with a lack of capacity to deal with anything strategically in a meaningful way. This report highlights some of the key successes and future challenges in our borough.

Figure 1:

Barking and Dagenham Cases by year reported (2014 & 2015)



Infectious Disease Cases and Incidents

Higher numbers of campylobacter, panton-valentine leukocidin (PVL), pneumococcal, scarlet fever, tuberculosis, hepatitis B, and gastro intestinal infections were reported in 2014/15 compared with 2015. Campylobacter was due to differences in laboratory techniques and there was a national outbreak of scarlet fever. Increases in the other infections are too small to show a significant trend (Figure 1).

In 2015 there were 14 reported outbreaks in the borough mainly related to gastroenteritis outbreaks in care homes, two tuberculosis incidents in workplaces, a hepatitis B incident in a Spa, three cold chain incidents in surgeries, a water incident and a “needlestick” incident in a school.

Tuberculosis (TB)

Following major declines in the incidence of TB during most of the 20th century, the incidence of TB in England increased steadily from the late 1980s to 2005, and has remained at relatively high levels ever since. TB is concentrated in large urban centres, with rates in London, Leicester, Birmingham, Luton, Manchester and Coventry more than three times the national average.

In 2014, 68 cases of TB were notified in residents of Barking and Dagenham, a rate of 34 per 100,000 population. The rate varied across different wards in the borough. Overall in London, there were 2572 TB cases notified and a rate of 34 per 100,000 population. The TB rate in Barking and Dagenham decreased slightly in 2014 but is above the London rate.

In 2014, 9% of non-UK born cases were diagnosed within 2 years of entry to the UK and 18% in 2-5 years. The most common countries of birth for cases in 2014 were the UK, India, Pakistan and Somalia.

Figure 2:

TB rates for North East London residents.

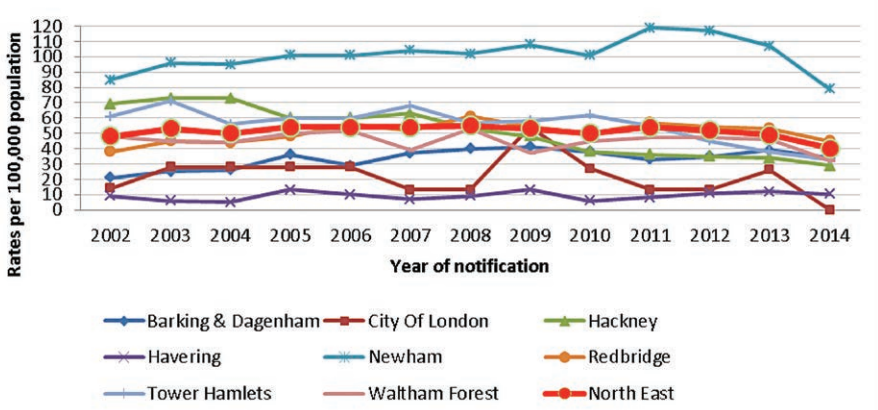
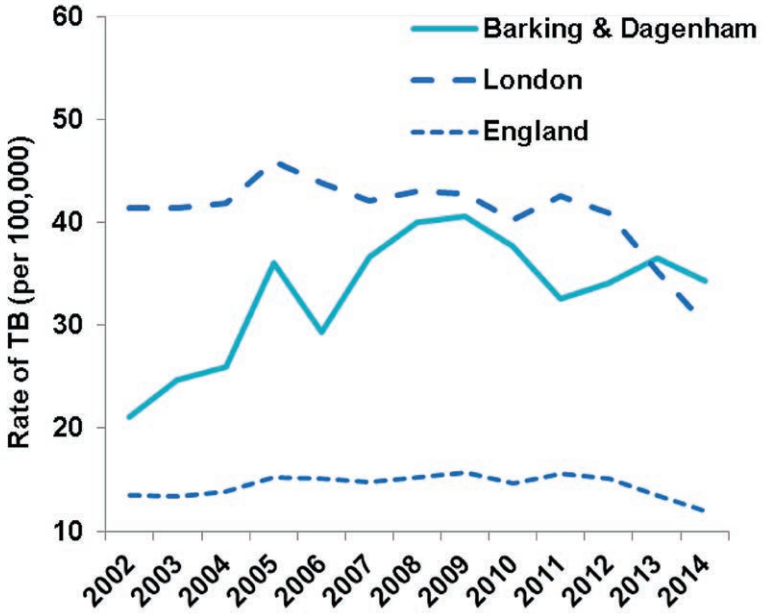


Figure 3:

TB case rates Barking and Dagenham compared with London and England 2002-2014.



A small number of TB cases in the borough were infectious and there were public health implications in two instances, where contact tracing exercises were undertaken in order to offer screening tests to those who were exposed.

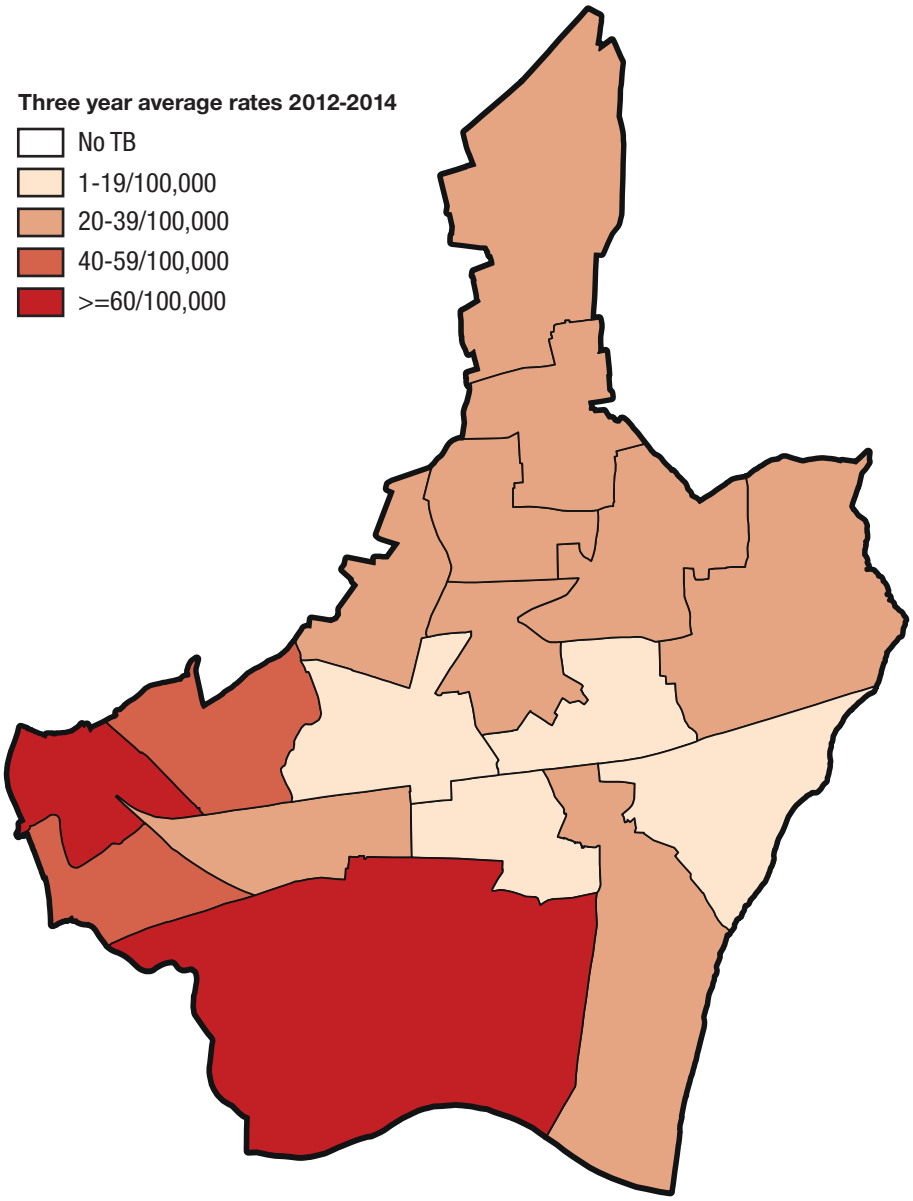
It has been found that it is likely that the majority of TB cases in England are the result of 'reactivation' of latent TB infection. Latent TB is where someone is carrying the bacteria that causes TB but are not infectious or symptomatic with active disease, an asymptomatic phase of TB, which can last for years. For this reason, funding has now become available for latent TB testing in some local authorities (those local authority areas with a TB incidence of ≥20 per 100,000 population or over).

We have had funding approved to carry out Latent TB testing in new migrants as part of the programme being rolled out across England. The testing is for those people who are: aged 16 to 35 years, entered the UK from a high incidence country (≥150/100,000 or Sub Saharan Africa) within the last five years and been previously living in that high incidence country for six months or longer.

The London TB team Extended contact tracing team (LTBEx) are to be disbanded in 2016 and although we have set up a proactive approach by engaging in latent Tuberculosis screening, the LTBEx team have been invaluable in dealing with contact tracing for large tuberculosis incidents. They were able to respond quickly and screen TB contacts on-site (e.g. at schools, workplaces, etc.) to ensure there is no onward transmission. With this function removed, there is a concern over capacity to deal with large scale TB incidents when there is a reduction in staff at a Health Protection Team level.

Figure 4:

Three-year average annual TB incidence rate by ward, 2012-2014.



Vaccination

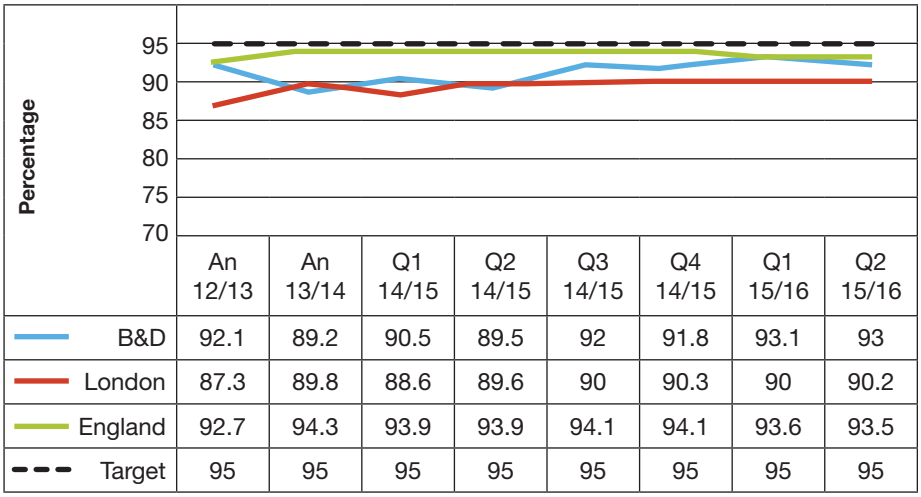
Vaccination continues to have a historical place - on a par with the provision of clean water and improved sanitation - as one of our society's most fundamental tools in the continuing battle for better public health. The borough has, for many years, had lower than average vaccination coverage levels, often markedly so.

The Cover of vaccination evaluated rapidly (COVER) programme evaluates childhood immunisation in England. Quarter 2; July–September 2015 is the latest available data. The borough is below the national target of 95% but achieving above the London average for diphtheria, tetanus, pertussis, pneumococcal, haemophilus influenza type b (DTaP/IPV/Hib) at 12 months with 93% uptake in Q2 15/16 compared to 90.2% for London and is similar to the England average of 93.5%.

Uptake for the 24 month vaccinations is below the national target, with 86.6% uptake for the pneumococcal (PCV) booster and measles, mumps and rubella (MMR1), and 86.4% for the haemophilus influenza type B and meningitis C (Hib/MenC) booster.

Figure 5:

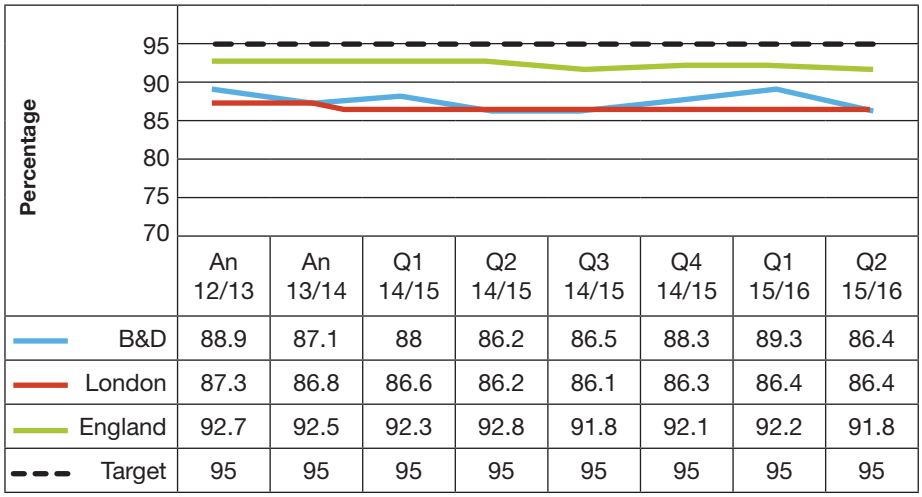
DTaP/IPV/Hib at 12 months.



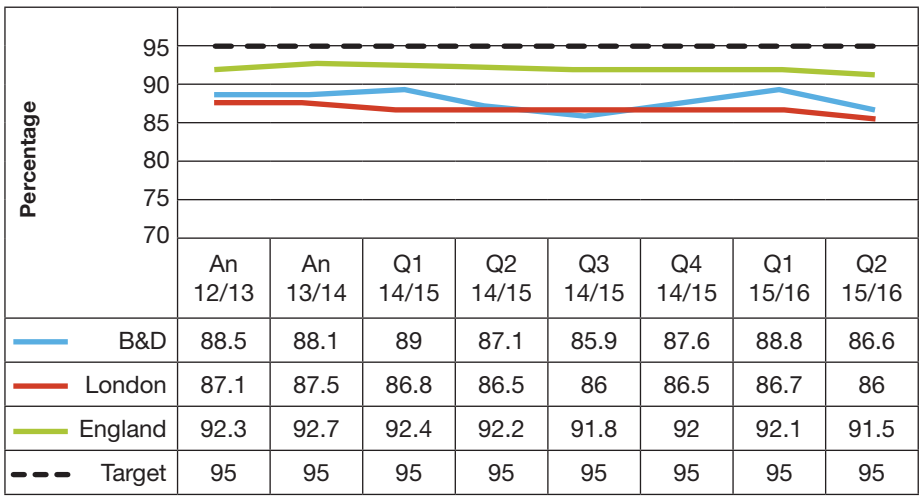
	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	92.1	89.2	90.5	89.5	92	91.8	93.1	93
London	87.3	89.8	88.6	89.6	90	90.3	90	90.2
England	92.7	94.3	93.9	93.9	94.1	94.1	93.6	93.5
Target	95	95	95	95	95	95	95	95

Figure 6:

Hib/MenC and MMR1 at 24 months.



	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	88.9	87.1	88	86.2	86.5	88.3	89.3	86.4
London	87.3	86.8	86.6	86.2	86.1	86.3	86.4	86.4
England	92.7	92.5	92.3	92.8	91.8	92.1	92.2	91.8
Target	95	95	95	95	95	95	95	95



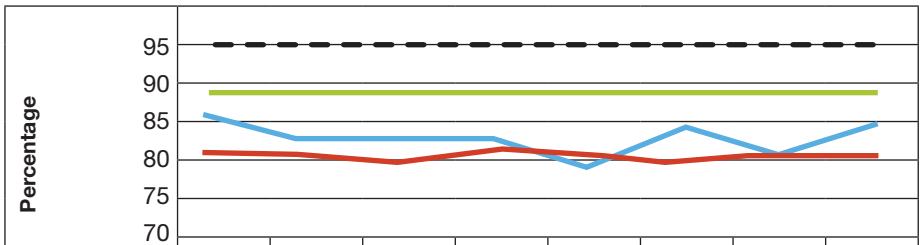
	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	88.5	88.1	89	87.1	85.9	87.6	88.8	86.6
London	87.1	87.5	86.8	86.5	86	86.5	86.7	86
England	92.3	92.7	92.4	92.2	91.8	92	92.1	91.5
Target	95	95	95	95	95	95	95	95

Uptake for the 5 year vaccinations is below the national target at 84.1% for the DTaP/IPV booster, and 83.6% for the MMR2.

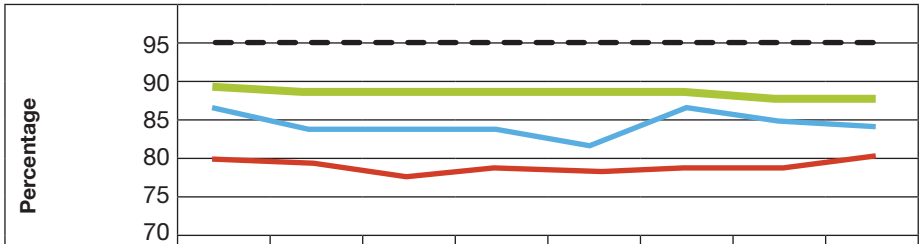
Barking and Dagenham hepatitis B vaccination rates are above the London and England averages.

Figure 7:

MMR2 at 5 years and the DTap/IPV Booster.



	An 12/13 3	An 13/14 4	Q1 14/15 5	Q2 14/15 5	Q3 14/15 5	Q4 14/15 5	Q1 15/16 6	Q2 15/16 6
B&D	85	82.3	82.2	82.2	78.8	83.4	81	83.6
London	80.8	80.7	79.9	80.8	80.5	80.1	80.4	80.5
England	87.7	88.3	88.5	88.5	88.5	88.6	88.5	87.9
Target	95	95	95	95	95	95	95	95



	An 12/13	An 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
B&D	85.9	83.4	82.8	83.3	80.9	86.2	84.4	84.1
London	79.9	79.3	77.3	78.2	78	78.5	78.5	79.8
England	88.9	88.6	88.6	88.6	88.4	88.4	87.7	87.9
Target	95	95	95	95	95	95	95	95

Table 1:

Barking and Dagenham Hepatitis B vaccination programme

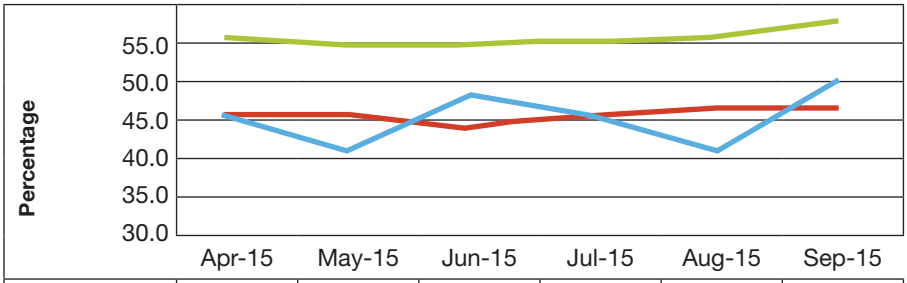
	12 Months			24 Months		
Quarter	**B&D**	**London**	**England**	**B&D**	**London**	**England**
Q1 14/15	100	86.9	83.4	92.3	78.5	72
Q2 14/15	100	92.5	87.3	88.2	87.2	79.4
Q3 14/15	100	84.7	85.4	91.7	75.2	72.1
Q4 14/15	82	83	84	91	79	72
Q1 15/16	86	88	85	80	81	75
Q2 15/16	100	91	87	88	80	72

Pertussis vaccinations in pregnant women:

This programme commenced September 2012 as an interim programme and has been extended until 2019. There is no nationally set target for uptake. Vaccinations are given between weeks 28 and 38 of pregnancy. The borough is performing above the London average but remains below the England average for uptake.

Figure 8:

Pertussis in pregnancy vaccinations.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
B&D	45.7	40.9	48.1	45.9	41.1	50.0
London	46.0	45.8	44.3	45.4	46.8	46.6
England	56.1	55.2	55.1	55.6	56.6	57.7

HPV Vaccination Programme:

Human papilloma virus (HPV) vaccine is offered to girls aged 12-13 years. The vaccine protects against cervical cancer. The borough is achieving above the London average for uptake. England uptake rates for 2014/15 are not currently available.

Shingles Vaccination Programme

The aim of the vaccination programme is to reduce the incidence and severity of shingles in those targeted by the programme. There is no national uptake target set. The borough is currently performing below the London average for shingles uptake, with 44.6% uptake in the 70 year olds, 45.4% in 78 year olds and 48.3% in the 79 year olds.

Stay Well this Winter national campaigning supported locally

Seasonal Flu programme

The seasonal flu programme is an annual programme offering flu vaccinations to people who are more likely to suffer from complications from getting flu. These include people aged over 65 years, people in clinical risk groups, pregnant women, children aged 2, 3 and 4 years and school years 1 and 2. Additionally carers and frontline health care workers can also receive free flu vaccinations. We rolled out the child flu school vaccination programme this academic year, for schools' years 1 and 2, and for children in special needs schools. National targets are set for those aged over 65years and those in clinical risk groups (75%). The borough historically fell below the national targets for flu vaccination uptake.

Table 2:

Seasonal Flu Vaccine uptake amongst GP patients 1 September 2015 to 30 November 2015 (compared to 2014 data)												
Area	over 65s 15/16	over 65s 14/15	clinical risk groups 15/16	clinical risk groups 14/15	Pregnant women 15/15	Pregnant women 14/15	2 Yr olds 15/16	2 Yr olds 14/15	3 Yr olds 15/16	3 Yr olds 14/15	4 Yr olds 15/16	4 Yr olds 14/15
B&D	62	65.8	41.1	48.9	39.3	38.7	19.3	29.5	21.1	29.2	15.5	19.9
London	61	66.9	37.7	46.6	34.3	38.3	20.4	28.4	22.1	30.8	17	22.1
England	66.9	68.5	39.3	44.4	38.3	38.5	29.2	31	30.4	33.1	24.7	26
Target	75	75	75	75	75	75	40	40	40	40	40	40

Increasing immunisation uptake for both children and older people is a priority for the Council, NHSE, local GPs and NHS Trusts. The DPH advises that NHSE provides quarterly performance reports to the Health and Wellbeing Board on the arrangements being put in place to improve performance in achieving the optimum uptake of immunisation programmes by the eligible population of Barking and Dagenham.

The immunisation and screening teams are also going through a period of change and a move to working much more closely with local boroughs, agreeing local plans with the DPH. From the initial difficult start NHSE are moving from patch based groups to having either multiagency immunisation meetings or inclusion in local health protection forums where NHSE will be represented.

Moving to a better reporting structure such as quarterly infectious disease reports and quarterly immunisation cover, representation from PHE and NHSE at the Health Protection Committee will ensure that the DPH can make assurances to the Health and Wellbeing Board.

HealthCare Associated Infection

(Data is for the time period: 2014/15)

Despite significant reductions in incidence, healthcare associated infections (HCAI) continue to be one of the biggest challenges the health and residential care services face. This is because, whilst we are performing much better, the targets we are setting ourselves are becoming ever-more challenging year-on-year, and rightly so. The rate of C. difficile infection for NHS Barking and Dagenham Clinical Commissioning Group in people aged over 2 years was 23.2/100,000 population. Although this is below the England average of 26.3/100,000 population, it is among the higher rates in North East London. This indicates that there is substantial work to be done around antimicrobial use and prevention of C. difficile infection in the community.

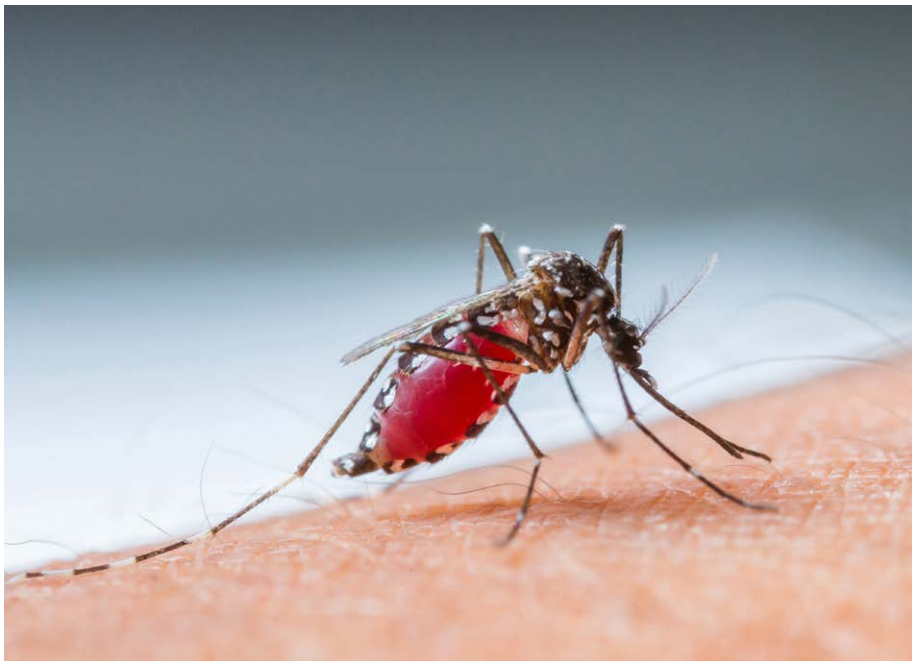
The Barking and Dagenham rate for MRSA bacteraemias for NHS Barking and Dagenham Clinical Commissioning Group was 2/100,000 population; this provides an important indicator of infections in the community population. This is the same as the national average of 2/100,000 population. Work is needed to continue to improve training in the care of intravenous therapy lines (infusion of liquid substances directly into a vein) and catheters in the community to ensure that they are inserted safely and managed properly, so that MRSA bacteraemia can be prevented.

There is work to be done around antimicrobial use and prevention of C. difficile infection in the community; looking at the cause of the infections; education; and ensuring samples are taken appropriately. The infection control team at Barking Havering and Redbridge University Hospitals NHS Trust are already auditing practice and educating staff. The DPH recommends that HCAI prevention through key initiatives. For example, appropriate use of antimicrobials, appropriate insertion and care of invasive devices and lines, and all providers of care being trained in infection prevention and control.

Mind the Gap?

The changes in landscape since 2013 had initially been difficult to work with but through excellent historic working relations and an established health protection forum, the Council are in a strong position despite on-going changes. However, there are gaps emerging from the new systems and these are areas we need to focus on:

- Immunisation and training for practice staff was a gap with ad hoc providers and poor evaluation. PHE have recently trained practice staff on the new immunisation programmes but will there be on-going capacity?
- The Infection Control provision in the community e.g. GP/Dentist training does not directly come under the DPH and we are currently unsure of the capacity, roles and responsibilities. This can be problematic with CQC visits to practices that get reported to the health protection team and the DPH, such as breaches in storage of vaccines leading to a cold chain incident. There also appears to be confusion from practices around the provision of infection control training. There is an infection control team in the community but they do not sit on the Health Protection Committee. This is an area for the Committee to take forward.
- Screening is still an issue that needs to be addressed as there has been no representative at the Health Protection Committee.



The future?

In 2015 an outbreak of Ebola Virus Disease in Sierra Leone showed how easily it is to import an infection due to global travel. PHE had to set up screening teams at major ports. North East & Central Health Protection Team (NECLHPT) were responsible for port health screening at St Pancras International Station. PHE have a national and international horizon scanning team whereby issues can be identified early and worked through with the local authority. In 2015, the Council ran an Ebola workshop with key stakeholders.

Zika virus has been recently reported in the news. Zika is a mosquito-borne infection caused by Zika virus, a member of the genus flavivirus and family Flaviviridae. It was first isolated from a monkey in the Zika forest in Uganda in 1947. Zika virus outbreaks have occurred in areas of Africa, Southeast Asia and the Pacific Islands. In May 2015, the Pan American Health Organisation issued an alert regarding the first confirmed Zika virus in Brazil. The infection causes symptoms such as mild fever, conjunctivitis and headache but has been linked to babies being born with undeveloped brains.

Aedes mosquitoes carry the virus and are found particularly in the above regions. The Aedes mosquito is not present in the UK and is unlikely to establish in the near future as the UK temperature is not consistently high enough for it to breed.

The mosquitoes predominately bite during the day and also around dawn and dusk (as opposed to mosquitoes

that transmit malaria, which bite at night between dusk and dawn). Advice for travellers is to use a good repellent containing N, N-diethylmetatoluamide on exposed skin, together with light cover-up clothing.

Locally the NECLHPT works closely with the Council to ensure any trends or changes in infections are identified and actions implemented. Some of the future priorities are around antimicrobial resistance. When drugs are no longer effective in treating infections caused by micro-organisms, minor surgery and routine operations could become high-risk procedures, leading to increased duration of illness and premature mortality.

The biggest threat to the UK and the borough is still pandemic influenza and through joint working with our partners we have plans in place which are exercised and tested yearly.

Conclusion

The historic links built up over many years have meant that the Council and our partners can safely respond to incidents and outbreaks. The potential of having immunisation links at a local level is welcomed and this same model could be used for screening. There appear to be gaps in service provision, some real and some perhaps due to lack of clarity that need to be addressed via our Health Protection Committee.

The health protection service re-design at PHE needs to ensure career pathways are attractive and maintain the established local links which have driven many excellent initiatives in the borough.

Acknowledgements

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