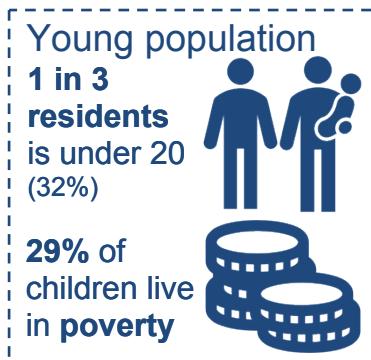
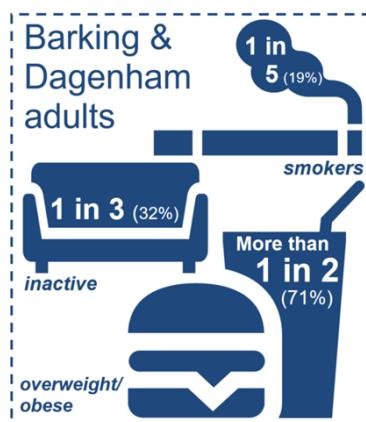


## 1 Background

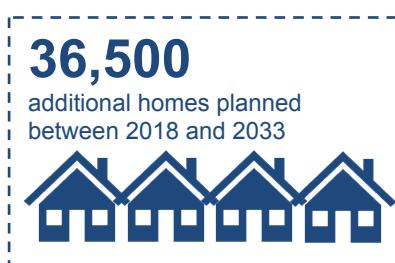
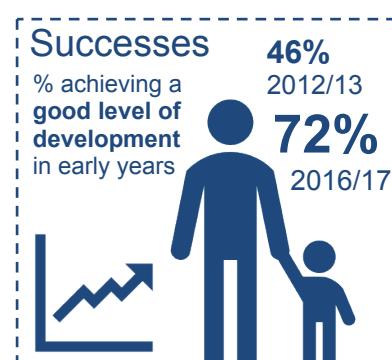
### Challenges and opportunities in Barking and Dagenham – a brief overview

- 1.1 Residents of Barking and Dagenham continue to face significant health challenges. There are high rates of smoking, overweight and obesity, and inactivity; all modifiable risk factors for serious conditions such as heart disease, stroke and cancer.<sup>1</sup>
- 1.2 This is borne out in our statistics; life expectancies for both men and women are the very lowest in London. In 2013–15, there were around 265 preventable deaths in Barking and Dagenham each year – the equivalent of around 5 preventable deaths each week. As an age-standardised rate, this is the second worst in London.<sup>2</sup>



1.3 However, mortality – as an outcome predominantly faced by older adults – only tells part of the story. Almost one-third of our residents are under the age of 20, the highest proportion of 0–19s in the UK. This sets down an opportunity and a challenge for us in terms of prevention; ensuring that these children have a good start in life and are supported in developing healthy lifestyles will pay dividends for the long-term health and wellbeing of our population. Yet, we have work to do here too, with high levels of child poverty – associated with worse health outcomes<sup>3</sup> – and childhood obesity.

- 1.4 Nonetheless, many of the trends in preventable mortality have decreased in the past 10 years and there are other areas where we are moving in the right direction. For example, the percentage of our children who achieve a ‘good level of development’ in their early years increased by more than 50% from 2012/13 to 2016/17.<sup>4</sup> Whereas in 2012/13, less than half of children achieved a good level of development (46%), in 2016/17 more than seven in ten did (72%).<sup>5</sup> Similarly, under 18 conceptions and the proportion of women smoking in pregnancy have both declined in recent years.



1.5 Furthermore, the anticipated growth and regeneration of the borough – including the designation of Barking Riverside as a ‘Healthy New Town’ – presents opportunities to tackle the wider determinants of health and embed structures that make healthy options the default, such as walking or cycling instead of driving. These have the potential to effect change at a structural rather than an individual level.

<sup>1</sup> Infographics data – adult risk factors: Public Health England (PHE), Public Health Outcomes Framework [<http://www.phoutcomes.info/>]; PHE, Local Tobacco Control Profiles [<https://fingertips.phe.org.uk/profile/tobacco-control>].

<sup>2</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>3</sup> Wickham S, Anwar E, Barr B, Law C, Taylor-Robinson D. Poverty and child health in the UK: using evidence for action. *Arch Dis Child* 2016;101:759–66 [<http://adc.bmjjournals.com/content/101/8/759>].

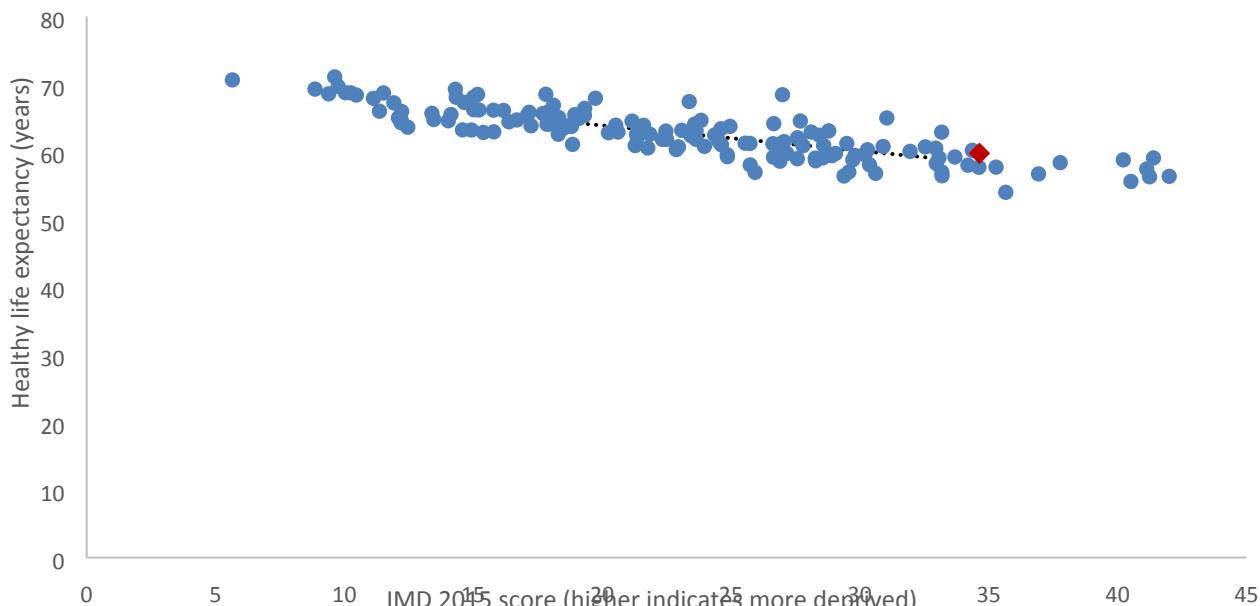
<sup>4</sup> An increase of 57% compared with an increase of 37% across England.

<sup>5</sup> Department for Education, Early years foundation stage profile results: 2016 to 2017.

## 'No-one left behind' – addressing inequalities

- 1.6 Reducing health inequalities is a fundamental aim of the JSNA. 'Health inequalities' refers to the differences in health outcomes experienced by groups of residents within Barking and Dagenham, as well as inequalities between Barking and Dagenham and other areas.
- 1.7 Socio-economic deprivation is not the only source of inequality, but it is one of the most pervasive. For example, men living in the 10% most deprived areas of Barking and Dagenham have a life expectancy almost 3 years lower than those living in the least deprived areas.<sup>6</sup> Nationally, there is also a strong correlation between an area's deprivation score and health outcomes, including healthy life expectancy (Figure 1), with a 14.2-year difference between the most and least deprived areas.

**Figure 1: Correlation between deprivation (Index of Multiple Deprivation 2015) and male healthy life expectancy (2013–15) among local authorities in England**



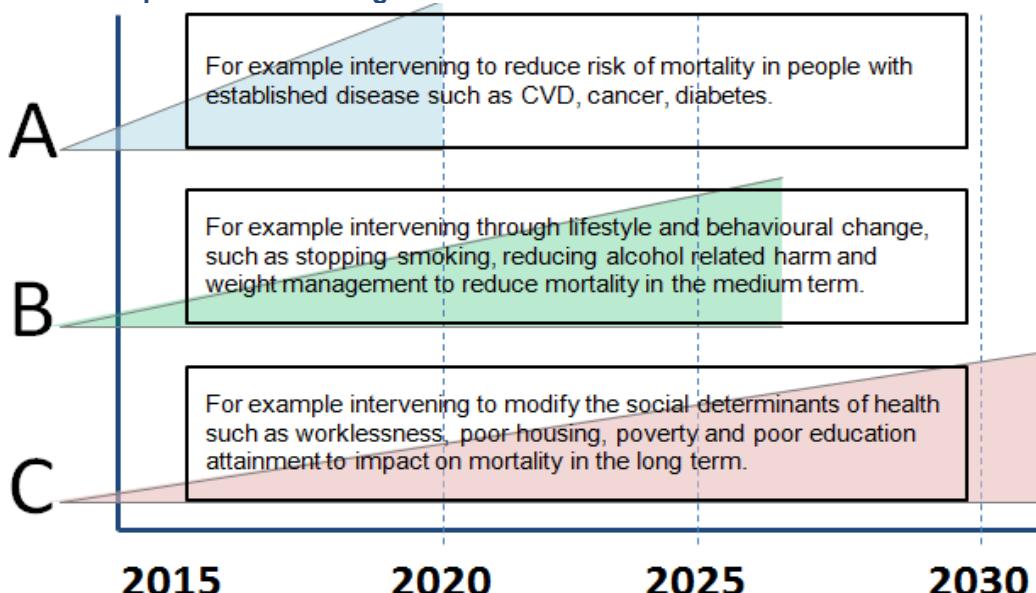
Source: Public Health Outcomes Framework.

Note: Barking and Dagenham indicated by red diamond.  $R^2 = 0.7$

- 1.8 However, it is not sufficient to address existing health inequalities; this is a period of change for the borough and all policies will need to anticipate the differential effect they may have on population groups before and during their implementation; Barking and Dagenham Council has committed to ensuring 'no-one [is] left behind' from the benefits of growth opportunities in the borough. The health impact assessment of the forthcoming 2018–2033 Local Plan demonstrates a commitment to this principle.
- 1.9 Figure 2, retained from the previous report due to its continued relevance, shows three approaches to reducing health inequalities and how long they take to be effective.

<sup>6</sup> PHE; Public Health Outcomes Framework [<http://www.phoutcomes.info/>]; 0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male), 2013–15.

**Figure 2: Health inequalities: different gestation times for interventions**



Adapted from: Health Inequalities National Support Team (2009)

- A: Intervening to reduce risk of death in people with established disease – e.g. improving quality and access to health and social care. This has the greatest impact in the short term.
- B: Intervening through lifestyle and behaviour change (prevention), such as smoking cessation and weight management – to reduce mortality in the medium term.
- C: Intervening to modify the social determinants of health such as worklessness or poor housing – to impact on mortality in the long term.

1.10 This JSNA report incorporates recommendations from key strategies that relate to all three approaches.

## 2 Our key strategies

### Joint Health and Wellbeing Strategy (2015)

- 2.1 The 2015–18 Joint Health and Wellbeing Strategy was updated in August 2015, making use of the 2014 JSNA. It set three key outcomes:

- To improve life expectancy
- To reduce the gap in life expectancy between LBBD and London
- To improve health and social care outcomes through the integration of services.

- 2.2 In line with the Marmot Review, the strategy took a life course approach, establishing priorities for different ages. This JSNA report takes a similar approach, although it merges 'early' and 'established' adulthood which were distinct in the Joint Health and Wellbeing Strategy.

- 2.3 Within each section, priorities were set under four themes:

- care and support
- protection and safeguarding
- improvement and integration of services
- prevention

- 2.4 In addition, an equality impact assessment was carried out for this strategy, which contained additional recommendations on reducing health inequalities, ensuring information needs are met and developing an engagement strategy.

- 2.5 The Joint Health and Wellbeing Strategy covers the period 2015–18 and hence work is anticipated to begin on the next strategy in 2018.

### The Growth Commission Report: 'No-one left behind: in pursuit of growth for the benefit of everyone' (2016)

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

- 2.7 Through these ambitions the council is prioritising:

- Social determinants of health – for example, a wide-ranging health impact assessment was carried out in 2017 for the forthcoming Local Plan.
- Prevention – for example, exploring how behaviour change interventions could work for childhood obesity.
- Integration and care – for example, the recently launched all-age disability service.

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



## North east London Sustainability and Transformation Plan (draft 2016)

2.9 The Sustainability and Transformation Plan (STP) outlines how the NHS in north east London (Barking and Dagenham, City of London, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest) will become financially sustainable and deliver improvements to health and health services by 2021.

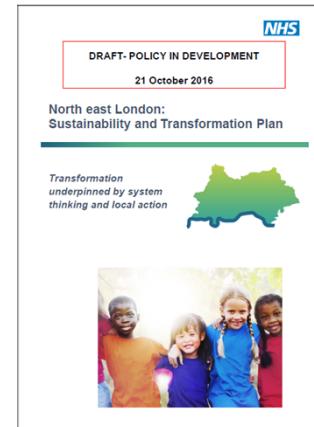
2.10 It sets out six key priorities:

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

2.11 As a joint strategy, many of the priorities relate to collaboration and integration of services.

There is already considerable partnership working between Barking and Dagenham, Redbridge and Havering, including the current review of urgent and emergency care services and the joint commissioning of pharmaceutical needs assessments for the three boroughs.

2.12 A framework for person-centred care has been developed (right), which emphasises prevention and draws on the social determinants of health.



## The Corporate Plan and the Borough Manifesto (2017)



2.13 The Council's corporate vision is: 'One borough; one community; London's growth opportunity'. The aim is to encourage civic pride, enable social responsibility and grow the borough. The Corporate Plan and the Borough Manifesto both detail how to achieve this vision.

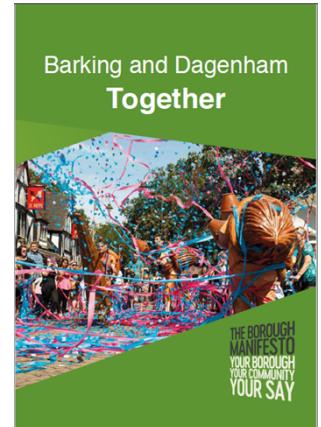
2.14 The 2017/18 Corporate Plan was published in June 2017. This sets out the short- and medium-term changes the Council is making to meet the shared 20-year vision for the borough, developed with residents, outlined in the Borough Manifesto.

2.15 These shorter-term changes include the transformation the Council is undergoing to become a commissioning organisation (see image below). This includes the formation of 'Community Solutions', which aims to tackle issues earlier and help increase residents' resilience and capacity for self-help. It has also seen the creation of a new all-age disability service, which aims to provide a more joined-up experience for users to support them across their life course.



2.16 The Borough Manifesto, ‘Barking and Dagenham Together’, sets out a shared vision for the next 20 years aimed around 10 themes:

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



2.17 In addition to the overt health and social theme, all the other themes can be viewed as social determinants of health. As such, this provides a blueprint for reducing health inequalities in the long term, not only within the borough, but also in relation to London and England. This is explicitly stated in its targets, the majority of which are to bring indicators above London and East London averages.

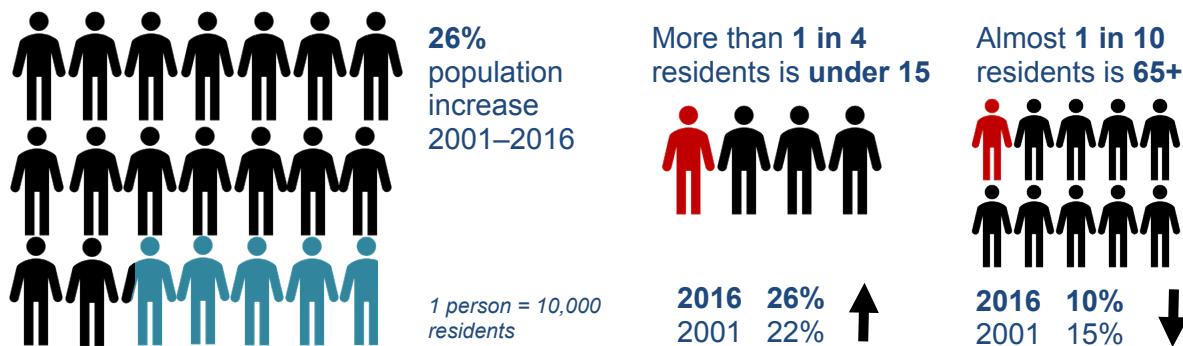
### 3 Our people and their health and wellbeing

- 3.1 This section summarises:
- the demographics of Barking and Dagenham
  - our residents' life expectancy and healthy life expectancy
  - data and current strategies on priority areas for each life course stage: pre-birth and early years, primary school children, adolescence, maternity, adulthood, and older adults.
- 3.2 For each of the life course areas, Joint Health and Wellbeing Strategy priorities are shown in bold.

#### Population growth and changes in composition

##### Population changes since 2001

- 3.3 Barking and Dagenham's population increased by more than one-quarter (26%) between 2001 and 2016 from 163,900 to 206,500 residents: an increase of 42,500 people.<sup>7</sup> This is a greater percentage change than England (12%) or London (23%).



- 3.4 Barking and Dagenham has a young population, with the highest proportion of 0–19s in the UK (32%). More than one in four (26%) residents is aged 0–14, compared with 18% across England and 25% in London, and this proportion has increased from 22% in 2001.
- 3.5 Barking and Dagenham also had the highest birth rate in England and Wales in 2016; there were 3,973 live births – a rate of 86.5 live births per 1,000 women aged 15–44.<sup>8</sup> After sustained year-on-year increases between 2002 and 2008 (increasing from 63.4 to 90 per 1,000), this appears to have stabilised.<sup>9</sup>
- 3.6 Conversely, fewer than one in ten residents is aged 65 or above (10%), compared with 18% across England and 12% in London. This also represents a decrease from 2001 in both numbers and proportion of the population, where the figure was 15%. The number, but not the proportion, of residents aged 85 and over increased between 2001 and 2016 (from 2,850 to 3,150<sup>10</sup>).
- 3.7 The ethnic make-up of the borough has also changed since the 2001 Census. The proportion of the population who are White British has decreased from 81% in 2001 to 49% in 2011. This is projected to continue to decrease to 38% in 2017.<sup>11</sup>

<sup>7</sup> Office for National Statistics (ONS), 2001 Census; ONS, 2016 mid-year population estimates. Rounded to nearest 100, hence difference does not match rounded values.

<sup>8</sup> ONS, Birth Summary Tables - England and Wales, 2016.

<sup>9</sup> Greater London Authority (GLA), Birth and Death Rates, Ward; ONS, Mid-year population estimates by ward (including Census data for 2011 and revised estimates for 2002–2010).

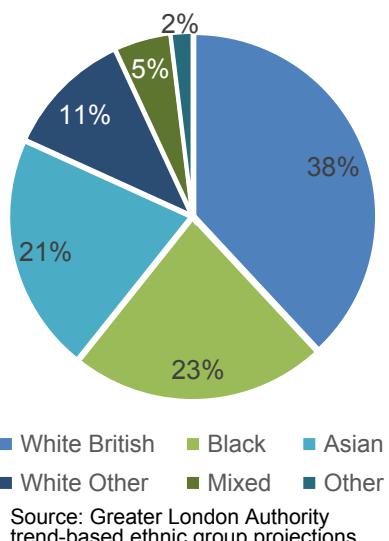
<sup>10</sup> Rounded to nearest 50.

<sup>11</sup> ONS, 2001 and 2011 Censuses; GLA 2015 round ethnic group population projections (short-term migration trend).

- 3.8 The representation of other ethnic groups has increased:
- The Black African population has increased from 4% in 2001 to 15% in 2011, and is estimated at 17% in 2017.
  - The 'Other White' category has also increased (from 3% in 2001 to 8% in 2011, to an estimated 11% in 2017), which is likely to relate to increased migration from eastern Europe.
  - There has been an increase in those of Indian, Pakistani and Bangladeshi ethnicity; together these groups accounted for 5% of the population in 2001, 12% in 2011 and are estimated to make up 17% of the population in 2017.
  - Although the estimated proportions of these three groups in 2017 are similar (5.3% Indian, 5.5% Pakistani and 5.8% Bangladeshi), this represents a much larger increase for the Bangladeshi community since 2001, where these proportions were 2.2%, 1.9% and 0.4% respectively.

- 3.9 Socio-economic changes in recent years include a rise in private renting (from 14% in 2008 to 25% in 2015),<sup>12</sup> an increase in employment rates (from 61% in 2004 to 67% in 2016)<sup>13</sup> and a lower proportion of working-age residents with no qualifications (from 23% in 2004 to 15% in 2016).<sup>14</sup>

**Figure 3: Ethnicity in LBB, 2017**



### Predicted changes in the population: 2017 to 2033

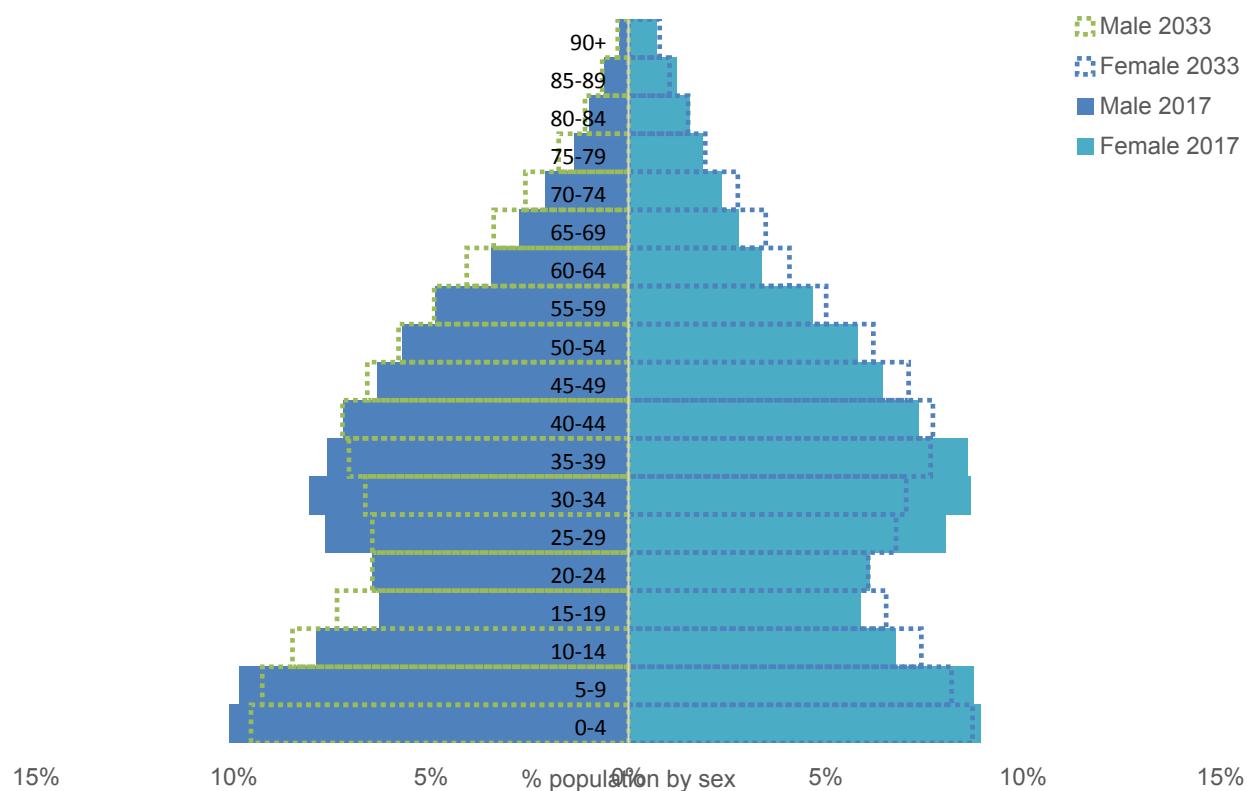
- 3.10 Figure 4 shows the population pyramid for LBB for males and females comparing 2017 with 2033. It includes assumptions in relation to fertility rates, death rates, inward and outward migration as well as information on housing developments in growth areas.

<sup>12</sup> ONS, Annual Population Survey via Greater London Authority [<https://data.london.gov.uk/dataset/housing-tenure-households-borough/resource/bbbb86bb-d647-4d77-b04a-7a80d0d899cd>].

<sup>13</sup> ONS, Annual Population Survey via Nomis; ages 16-64.

<sup>14</sup> ONS, Annual Population Survey via Nomis; ages 16-64.

**Figure 4: Population pyramid for Barking and Dagenham 2017 versus projected population 2033**



Source: GLA Witan, 2016

- The population pyramid is based on proportions of the total population by sex; however, it is important to note that while the relative size of some groups will decrease between 2017 and 2033, **absolute numbers in all age groups are predicted to increase**, with a predicted 29% rise in the overall population between 2017 and 2033 – an increase of 59,800 individuals (see Appendix 1).
- Compared with 2017, Barking and Dagenham in 2033 is projected to have a lower proportion of children aged 0–9 years (reducing from 19% to 18%) and a lower proportion of adults aged 25–39 years (reducing from 24% to 21%).
- The lower proportion of children is likely to result from the lower proportion of adults under 40.
- The proportion of older adults is conversely projected to increase, particularly females aged 40–74 years and males aged 60–79 years; preventing chronic conditions and trying to ensure our adults age ‘healthily’ will therefore be important.

### Predicted population size within the ‘growth areas’

- 3.11 The borough’s emerging Local Plan 2018–33 will allocate sufficient capacity for some 55,100 homes. It is expected that 36,500 homes will be delivered between 2018 and 2033. This would provide housing for an additional 98,550 residents if the average household size in Barking and Dagenham were to remain constant.<sup>15</sup>

### Predicted health needs

- 3.12 Modelled estimates of health needs are generally condition-specific. For example:
- The number of long-term cancer survivors (diagnosis 20 or more years ago) is expected to increase from about 3,600 to 5,500 or 7,000 (dependant on different

<sup>15</sup> ONS, Census 2011 (2.7 persons per household).

assumptions about incidence and survival) in Barking and Dagenham between 2010 and 2030.<sup>16</sup>

- The number of people aged 65 and above with dementia is expected to increase from 1,470 in 2017 to 2,080 in 2030.<sup>17</sup>
- The number of people living with sight loss is expected to increase from 4,160 to 5,190 between 2016 and 2030, which is an increase of almost one-quarter (24.8%).<sup>18</sup>

---

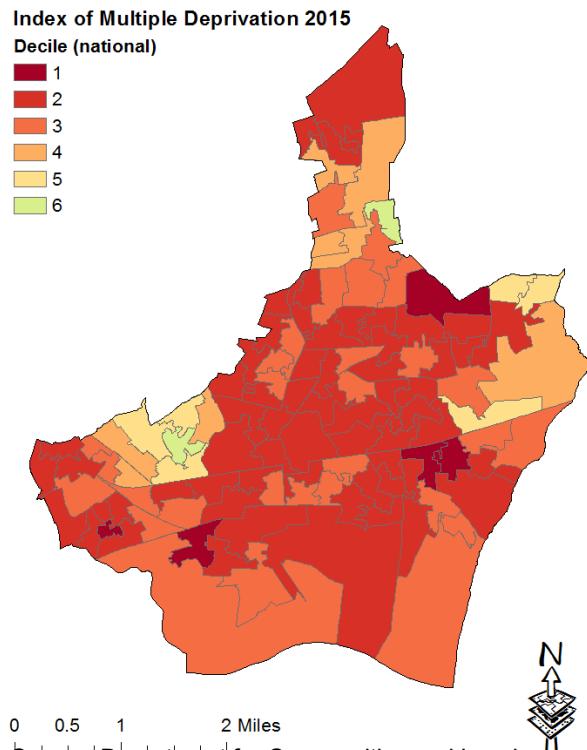
<sup>16</sup> Local Cancer Intelligence, England, and Macmillan Cancer Support, Cancer prevalence in NHS Barking and Dagenham CCG [<https://lci.macmillan.org.uk/England/071/prevalence>].

<sup>17</sup> Projecting Older People Population Information System (POPPI) [<http://www.poppi.org.uk/>]. Figures rounded to nearest 10.

<sup>18</sup> Royal National Institute of Blind People, Sight Loss Data Tool, version 3.5 [<http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool>].

## Deprivation, employment and income

**Figure 5: Deprivation by area within LBBD**



Source: Department for Communities and Local Government. English indices of deprivation 2015; Ordnance Survey.

### Deprivation

3.13 Barking and Dagenham remains among the most deprived areas in the country. In 2015, the relative deprivation of the borough (Index of Multiple Deprivation) increased from a rank of 20th to 11th in the country and from 7th to 3rd in London compared with 2010 index.<sup>19</sup> Key subdomains contributing to this appear to be income, crime, and barriers to housing and services.

3.14 More than half (55%) of lower super output areas (small areas) in Barking and Dagenham are within the 10–20% most deprived in England (decile 2 in Figure 5), with a further quarter (26%) in the 20–30% most deprived (decile 3).

### Employment

3.15 In 2016, 67.3% of working-age residents (ages 16–64) were in employment, compared with 74.2% in England and 73.7% across London.<sup>20</sup>

3.16 As in other areas, this is lower in women (59.6%) than men (74.0%). There is an almost 10-percentage point difference between the female rate in Barking and Dagenham and the female rate in England, compared with a 5.4 percentage point difference for men between these areas. However, the difference with London rates is similar for men and women (7.3 percentage points for women and 6.5 for men).

**Table 1: Proportion of 16–64-year olds in employment by sex, 2016**

	Male	Female
Barking & Dagenham	74.0%	59.6%
England	79.4%	69.1%
London	80.5%	66.9%

Source: Annual Population Survey, via Nomis

3.17 Of the estimated 42,600 working-age people not in employment in Barking and Dagenham:<sup>21</sup>

- 12,100 (28%) were looking after family/home (this group is 93% female)
- 10,400 (24%) were students
- 7,200 (17%) were long-term sick
- 7,000 (16%) were unemployed<sup>22</sup>
- 2,700 (6%) were retired
- 2,400 (6%) had another reason.

<sup>19</sup> Department for Communities and Local Government. English indices of deprivation 2015 [<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>].

<sup>20</sup> ONS, Annual Population Survey via Nomis.

<sup>21</sup> Percentages are approximate and do not round to 100% as created from rounded figures.

<sup>22</sup> This is not the unemployment rate, but a description of the proportion of people not in employment who are classed as unemployed; unemployment rates are usually given as a proportion of the 'economically active' population (consisting of the employed and the unemployed combined).

- 3.18 Across London, the proportion looking after family/home is lower (24%) while the proportion of students is higher (27%). The proportion who are long-term sick is lower (14%), while a similar proportion were unemployed (17%) or retired (6%). A higher proportion had another reason (6%), while at London level, we can also identify 2% who are temporary sick and 0.2% who are discouraged.

#### *Benefits*

- 3.19 A number of state benefits are in the process of being consolidated within Universal Credit, including income-based Jobseeker's Allowance and Housing Benefit. Universal Credit is currently available for single claimants in Barking and Dagenham and due to be rolled out to couples and families in Barking and Dagenham in February 2018.<sup>23</sup>
- 3.20 Provisional data for October 2017 indicate that 1,336 individuals were in receipt of Universal Credit.<sup>24</sup> In the same period, 2,279 people claimed Jobseeker's Allowance.<sup>25</sup> The latter is 1.8% of the population; higher than the 1.0% claiming in England or 1.1% in London, although this could reflect geographical differences in the roll-out of Universal Credit.
- 3.21 There were 20,548 Housing Benefit claimants in Barking and Dagenham in August 2017 (most recent data),<sup>26</sup> with an average award amount of £123.56 per week (a total of £2.5 million each week). This is 14.2% of the population aged 18 and above,<sup>27</sup> compared with 11.0% and 8.6% for London and England respectively, although similarly this comparison should be viewed with caution as it may reflect geographical differences in the roll-out of Universal Credit.
- 3.22 For people requiring extra support due to disabilities, Personal Independence Payment (PIP) is replacing Disability Living Allowance (DLA) for people aged 16–64. At the end of May 2017, there were 7,040 DLA claimants in Barking and Dagenham, with the most common disabilities being musculoskeletal disease, mental disorders and learning difficulties.
- 3.23 In July 2017, there were 4,551 PIP claimants. The most common disabilities among claimants were musculoskeletal disease (general or regional; 40.2%) and psychiatric disorders (28.6%), followed by neurological disease (11.6%) and respiratory disease (4.9%).
- 3.24 This differs from England where a similar proportion of PIP claims were for musculoskeletal disease and psychiatric disorders (34.7% versus 34.8%), although neurological disease (12.0%) and respiratory disease (4.7%) were similar to Barking and Dagenham. Caution may need to be applied to this analysis in case the transition from DLA biases this towards new cases rather than lifelong conditions.
- 3.25 In line with the national picture, there is an uneven distribution of PIP claimants by sex, with women making up a higher proportion of claims except in the youngest age groups. The age profile of claimants suggests that Barking and Dagenham women suffer an earlier burden of chronic disease than women nationally.

---

<sup>23</sup> Gov.UK, Jobcentre areas where you can claim Universal Credit [<https://www.gov.uk/guidance/jobcentres-where-you-can-claim-universal-credit>]. Accessed 2017 Nov 8; Gov.UK, Universal Credit transition to full service [<https://www.gov.uk/government/publications/universal-credit-transition-to-full-service>]. Accessed 2017 Nov 8.

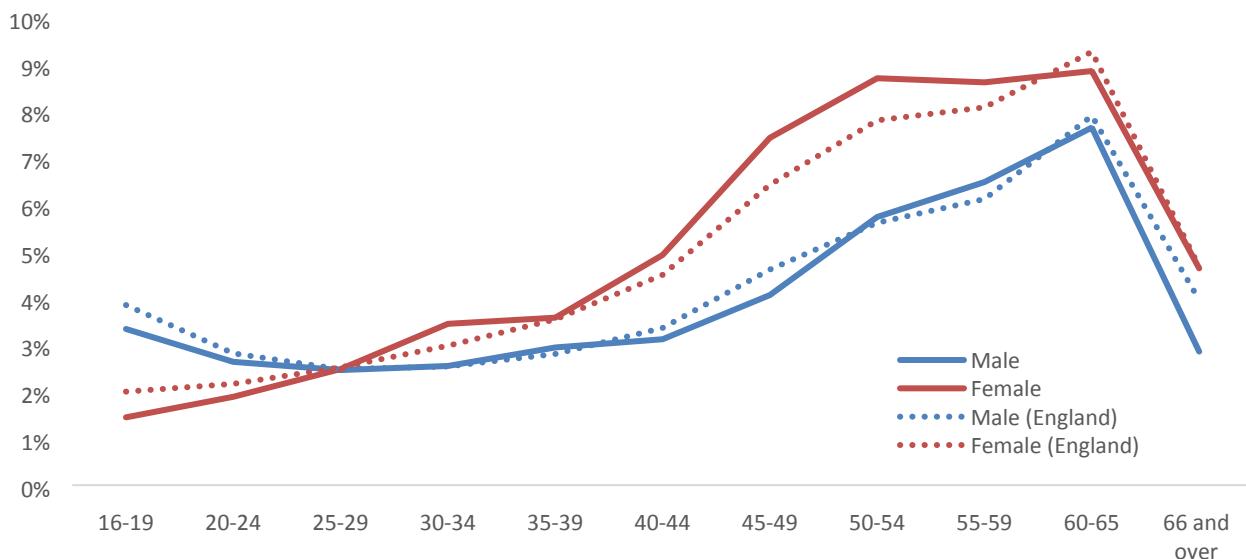
<sup>24</sup> Department for Work and Pensions via Stat-Xplore.

<sup>25</sup> ONS via Nomis.

<sup>26</sup> Department for Work and Pensions via Stat-Xplore.

<sup>27</sup> The number of those eligible to claim will be lower – if living in a couple, only one person can claim, and you cannot claim if you are living with a close relative or are a full-time student or an EEA jobseeker

**Figure 6: Percentage of PIP claimants by age and sex, Barking and Dagenham and England, July 2017**



Source: Department for Work and Pensions, Stat-Xplore

### *Income*

3.26 Median gross annual pay in Barking and Dagenham in 2017 was £24,593; the second lowest in London after Newham.<sup>28</sup> The mean gross annual pay (£25,896) is the closest in value to the median of any London borough, suggesting that there is a relatively narrow distribution of earnings in the borough, unlike others which are skewed by very high earners.<sup>29</sup> There is therefore less wage inequality in Barking and Dagenham than in other London boroughs. Median gross annual pay in London was £29,666, and across England this was £23,743.

<sup>28</sup> ONS Annual Survey of Hours and Earnings, provisional 2017 data. These figures are based on a sample of the Pay As You Earn (PAYE) system and hence do not include the self-employed and are by job rather than per person.

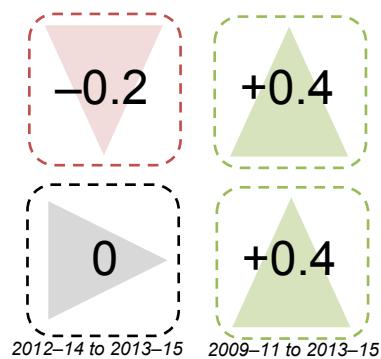
<sup>29</sup> The median is the middle value (half of jobs are paid less than this), whereas the mean is the sum of all wages divided by the number of jobs.

## Life expectancy and health life expectancy

**Life expectancy at birth**  
2013–15



Change (years) from  
Prev. data point    5 data points



Rank in  
London



Rank in  
England



3.27 Life expectancy at birth in Barking and Dagenham is 77.5 years for males and 81.8 for females (2013–15).<sup>30</sup>

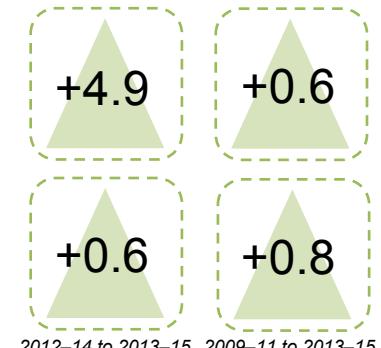
3.28 Male life expectancy has not changed from the 2012–14 figures reported in the last report, while female life expectancy has decreased by 0.2 years. Despite improvements in the longer term (an increase of 0.4 years since 2009–11 for both sexes), this has been insufficient to catch up with London or England; both male and female life expectancies are the lowest of all London boroughs, as well as significantly lower than the English averages.

3.29 The gap in life expectancy between Barking and Dagenham and London and England was narrowing for females until 2011–13 but has since widened due to decreases in female life expectancy in Barking and Dagenham. For males, the gap with London has widened from 1.5 years in the first data point available (2001–03) to 2.7 years in 2013–15.

**Healthy life expectancy at birth**  
2013–15



Change (years) from  
Prev. data point    5 data points



Rank in  
London



Rank in  
England



3.30 Healthy life expectancy (the years lived in good health) in Barking and Dagenham is 59.8 years for males and 58.5 years for females. Improving healthy life expectancy to be above the London average is a target in the 2017/18 Corporate Plan; currently Barking and Dagenham is 4.3 years (males) and 5.6 years (females) lower than the London averages. Our women have the second lowest healthy life expectancy in London and men have the fifth lowest.

<sup>30</sup> ONS, Health state life expectancy - All ages, UK, 2016. Note: this is based on death rates experienced by each 5-year age group in 2013–15. It is therefore only an indication of how long someone born in this period will live if these age-specific death rates were to remain constant throughout their life and they remained in this area their whole life. However, it is a useful summary measure of population mortality that can be compared with other time periods and areas.

- 3.31 Given Barking and Dagenham women's healthy life expectancy of 58.5 years and their life expectancy of 81.8 years, they therefore live 23.3 years not in 'good' health, or 28.5% of their lives. For men, this is 17.7 years, or 22.8% of their lives.

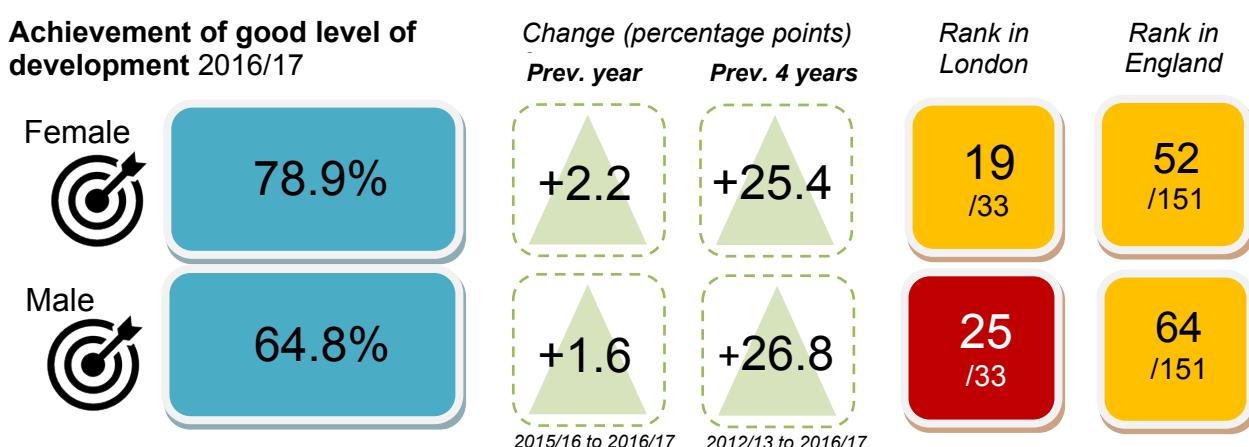
## Pre-birth and early years

- 3.32 The early years are a key time to act to reduce health and socio-economic inequalities.<sup>31</sup> The experiences children have in the first few years of life (for example, breastfeeding and healthy weaning, exposure to cigarette smoke, secure parental attachment or domestic violence) can have lifelong effects.<sup>32</sup>
- 3.33 Mitigating against socio-economic disadvantage in this age group is also key;<sup>33</sup> child poverty can have an enormous impact on a child's start to life and to future educational achievement and employment prospects.<sup>34</sup> In Barking and Dagenham, 29% of children live in poverty, significantly higher than the London and England averages of 23% and 20% respectively.<sup>35</sup>

## Level of development

- 3.34 Early years development is measured by the Early Years Foundation Stage Profile; those meeting the criteria across specified components are deemed to have 'a good level of development'.

## Our data:



- In the academic year 2016/17, 71.6% of our children achieved a good level of development at age 5, a 1.8-percentage point increase on 2015/16 results.<sup>36</sup> Comparable figures for England and London are 70.7% and 73.0%.
- Girls continue to do better than boys (78.9% compared with 64.8%) in Barking and Dagenham in 2016/17. The gap between them, 14.1 percentage points, has also increased from 13.5 percentage points in 2015/16.
- Barking and Dagenham's children's centres offer Play and Communication services. Of 197 children identified with speech, language and communication needs who attended sessions to address these needs in the financial year 2016/17, 90% improved in all targeted areas of language and 50% achieved expected levels of language for their age.

<sup>31</sup> Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. *Fair Society, Healthy Lives: The Marmot Review*. London: UCL; 2010 [<http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>].

<sup>32</sup> Center on the Developing Child at Harvard University. *The Foundations of Lifelong Health Are Built in Early Childhood*. Cambridge, Massachusetts: Harvard University; 2010 [<http://developingchild.harvard.edu/wp-content/uploads/2010/05/Foundations-of-Lifelong-Health.pdf>].

<sup>33</sup> Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. *Fair Society, Healthy Lives: The Marmot Review*. London: UCL; 2010 [<http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>].

<sup>34</sup> Griggs J, Walker R. *The costs of child poverty for individuals and society: A literature review*. York: Joseph Rowntree Foundation; 2008 [<https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/2301-child-poverty-costs.pdf>].

<sup>35</sup> PHE, Public Health Outcomes Framework; indicator 1.01ii: Children in low income families (under 16s). Proportion of children living in families receiving out-of-work benefits or tax credits where reported income is less than 60% of median income, for under 16s. Note different measures of child poverty result in different figures.

<sup>36</sup> Department for Education, Early years foundation stage profile results: 2016 to 2017.

## Our priorities and strategies:

**Joint Health and Wellbeing Strategy priorities are shown in bold.**

- The early years were recognised as a priority area for intervention by the Growth Commission's report on ensuring the equitable distribution of the benefits of growth in Barking and Dagenham.<sup>37</sup>
- **Most children achieve a healthy standard of school readiness by age 5 through coherent and integrated support (improvement and integration of services).**
- **Introduce an integrated early years service from conception to age 5 (improvement and integration of services).**

## Immunisations

3.35 Vaccinations are a simple, safe way of protecting children from diseases that at a minimum cause suffering, but may have more severe consequences or result in death. Vaccination not only protects the health of the child, but also that of the wider community.

### Our data:

#### Two doses of MMR vaccine by age 5 2016/17



81.9%

Change (percentage points)  
Prev. year      Prev. 5 years

-0.5

2015/16 to 2016/17

+4.0

2011/12 to 2016/17

Rank in London  
16 /32

Rank in England  
131 /149

- Only 81.9% of Barking and Dagenham 5-year olds have had two doses of the measles, mumps and rubella (MMR) vaccine, lower than the England figure of 87.6%.<sup>38</sup>
- Coverage remains below the national target of 95%; this was not achieved for any individual universal vaccination in 2016/17, although 95.2% of infants eligible for Hepatitis B vaccination had received this by their first birthday.
- Despite coverage generally decreasing in the past year, there have been some longer term upward trends in vaccination uptake; for example, 89.5% of 2-year olds received their first MMR dose in 2016/17, compared with 81.4% in 2010/11, and the proportion of children receiving their DTaP/IPV/Hib<sup>39</sup> vaccine by age 1 has increased from 86.3% in 2010/11 to 91.9% in 2016/17. However, the coverage for Hib/MenC<sup>40</sup> at age 2 (85.9%) is now at its lowest point since 2011/12.

#### • Our priorities and strategies:

- The proportion of children receiving two doses of the MMR vaccine by age 5 is a performance indicator reviewed quarterly by the Health and Wellbeing Board.
- **Most children are protected through vaccination against measles, mumps, rubella and whooping cough (protection and safeguarding).**
- **Fewer children attend school without the protection of immunisation (prevention).**

<sup>37</sup> Barking and Dagenham Growth Commission. *No-one left behind: in pursuit of growth for the benefit of everyone: Report of the Barking and Dagenham Independent Growth Commission*. London: LBBB; 2016 [<https://www.lbbd.gov.uk/wp-content/uploads/2015/11/No-one-left-behind-in-pursuit-of-growth-for-the-benefit-of-everyone.pdf>].

<sup>38</sup> NHS Digital, Childhood Vaccination Coverage Statistics, England, 2016-17 [<http://digital.nhs.uk/catalogue/PUB30085>]

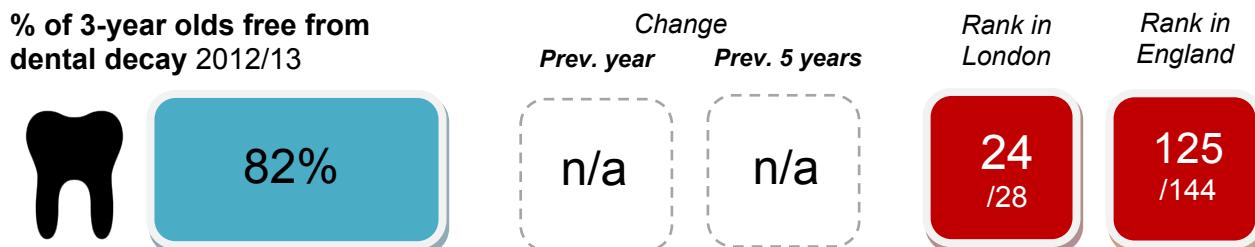
<sup>39</sup> Diphtheria, tetanus and pertussis, inactivated polio vaccine, and Haemophilus influenzae type b (DTaP/IPV/Hib); PHE, Vaccinations and Immunisations Profile [<https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-vaccinations>]; 2015/16.

<sup>40</sup> Meningococcal C

## Dental health

- 3.36 The early years are a time when good oral health behaviours (e.g. brushing teeth twice a day and regular dentist visits) can be instilled in children for later life.<sup>41</sup>
- 3.37 Poor dental health in children is largely preventable, yet decay can lead to pain or need for treatment that interferes with children's ability to eat, sleep, study or play and may also require parents or guardians to take time off work.<sup>42</sup> Tooth extractions under general anaesthesia also present a small but avoidable risk to children.

### Our data:



- Our 3-year olds have significantly worse oral health than the England average; 82% of Barking and Dagenham children were free from dental decay in 2012/13 compared with 88.4% in England. Barking and Dagenham is also lower than London (86.6%), but this difference is not significant.<sup>43</sup>
- Our understanding of how this is changing over time is limited by the fact that our data are from surveys which are not yearly.
- A local survey of 3 and 4-year olds carried out in 2010 found that our Asian children had high rates of decay and untreated disease and that this group was less likely to have their teeth brushed twice a day compared with White and Black children.<sup>44</sup>
- In 2015/16, there were 56 finished consultant episodes for hospital dental extractions in 0–4s in Barking and Dagenham, affecting 0.3% of that age group, which is similar to London (0.4%) and England (0.3%). Almost three-quarters of these had caries (decay) as the primary diagnosis, although this is lower than London or England (73.2% versus 87.5% and 85.2%).<sup>45</sup>
- Our 5-year olds also have significantly worse dental health than the England average; 68.6% of 5-year olds were free from dental decay in a 2014/15 survey compared with 75.2% in England. The proportion in London was also higher (72.6%) than Barking and Dagenham, but not to a significant extent. This means that just under one in three 5-year olds in Barking and Dagenham showed signs of dental decay compared with one in four in England.<sup>46</sup>
- Less than half of Barking and Dagenham children had been to a dentist in the 12 months up to the end of June 2017 (48.1%), with especially low rates in 1–4s (28.4%), despite guidance that children should start visiting a dentist as soon as their first tooth appears (around 6 months of age).<sup>47</sup>

<sup>41</sup> National Institute for Health and Care Excellence. *Oral health: local authorities and partners*. Public Health guideline PH55. [Manchester]: NICE; 2014 [<https://www.nice.org.uk/guidance/ph55>].

<sup>42</sup> Public Health England. *Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities*. London: PHE; 2014 [[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/321503/CBOHMaindocumentJUNE2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf)].

<sup>43</sup> PHE, Oral Health Profile [<https://fingertips.phe.org.uk/profile/oral-health>].

<sup>44</sup> LBBD Oral Health Promotion Strategy.

<sup>45</sup> PHE, Dental Public Health Intelligence Programme [<http://www.nwph.net/dentalhealth/Extractions.aspx>].

<sup>46</sup> PHE, Oral Health Profile [<https://fingertips.phe.org.uk/profile/oral-health>].

<sup>47</sup> NHS Digital, NHS Dental Statistics for England - 2016-17 [<https://digital.nhs.uk/catalogue/PUB30069>].

## Our priorities and strategies:

- An oral health strategy, with a focus on early years, was approved by the Health and Wellbeing Board in January 2017 and is now being implemented. This has the following priorities:
  - A. Promote and protect oral health by raising awareness about oral health
  - B. Improve diet and reduce consumption of sugary food and drinks, alcohol and tobacco (and thereby improve general health as well)
  - C. Encourage people to go to the dentist regularly
  - D. Address inequalities in oral health
  - E. Improve access to local dental services particularly for priority groups
  - F. Improve oral hygiene
  - G. Promote the provision of preventive dental care
  - H. Increase early detection of mouth cancer and dental decay
  - I. Increase exposure to fluoride.
- The LBBD Health and Adult Services Select Committee will be undertaking a review on oral health, with a focus on the early years, within the financial year 2017/18.
- **More children have regular dental checks and as a result have less dental decay aged 4/5 years (care and support)**

## Accident and emergency attendances in 0–4 years

3.38 Rates of A&E attendances are higher in under-fives than in older children and there is also evidence to suggest that inappropriate attendances may be more likely in young children.<sup>48</sup> Among under-fives, the most common causes of A&E attendances are injuries, together with illnesses such as gastroenteritis and respiratory conditions.<sup>49</sup>

## Our data:

### A&E attendances per 1,000 children aged 0–4 2015/16



781 per 1,000

Change (rate per 1,000)  
Prev. year      Prev. 5 years

+23

2014/15 to 2015/16

+256

2010/11 to 2015/16

Rank in London  
24 /32

Rank in England  
125 /150

- There were 15,333 A&E attendances in Barking and Dagenham children under 5 in 2015/16: a rate of 781 attendances per 1,000 children. This is significantly higher than the London and English averages (707 and 558 per 1,000, respectively).<sup>50</sup>
- Barking and Dagenham figures show an upward trend, with an additional 400 attendances in 2015/16 compared with 2014/15 and an additional 6,000 attendances in 2015/16 compared with 2010/11. This corresponds to increases in rates of 23 and 256 attendances per 1,000 respectively.
- BHR CCG have also identified an increase in children's A&E attendances across Barking and Dagenham, Havering and Redbridge (BHR), with a 19% increase in

<sup>48</sup> McHale P, Wood S, Hughes K, Bellis MA, Demnitz U, Wyke S. Who uses emergency departments inappropriately and when - a national cross-sectional study using a monitoring data system. *BMC Med* 2013;11:258 [<https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-11-258>].

<sup>49</sup> Downing A, Rudge G. A study of childhood attendance at emergency departments in the West Midlands region. *Emerg Med J* 2006;23(5):391–3 [<http://emj.bmjjournals.org/content/emermed/23/5/391.full.pdf>].

<sup>50</sup> PHE, Overview of child health profile [<http://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview>].

0–5 attendances in 2 years.<sup>51</sup> This has been identified as a key issue to explore as part of the current review of urgent care being carried out by BHR CCG.

- The case for change for BHR CCG's review also highlights an audit of 100 A&E child attendances at Queen's Hospital carried out in 2017 which found that almost one-third (32 children) did not need to attend A&E for emergency care.

### **Our priorities and strategies:**

- Urgent care provision for children is a focus of the BHR CCG's urgent care review.
- An effective urgent and emergency care is a priority in the STP.
- **More children and families have access to urgent care community services which meet their needs (improvement and integration of services).**
- **Introduce an integrated early years services from conception to age 5 (improvement and integration of services).**

---

<sup>51</sup> Papers of the NHS Barking and Dagenham Clinical Commissioning Group Governing Body meeting 18 July 2017 [<http://www.barkingdagenhamccg.nhs.uk/Downloads/About-us/Governing-body-papers/2017/BD-CCG-Governing-Body-18-July-2017.pdf>]. Accessed 2017 Sep 1.

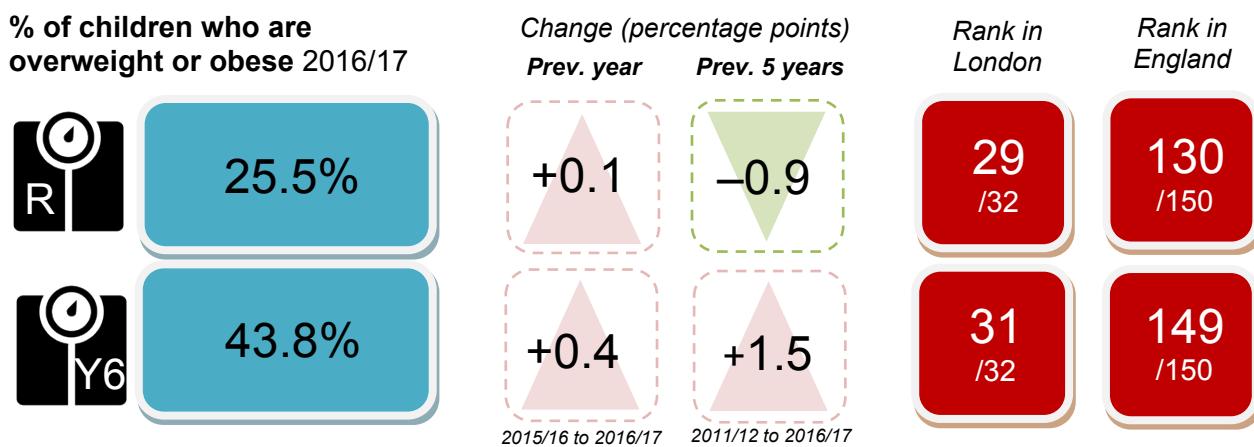
## Primary school children

- 3.39 Over their primary school years, children begin to make some of their own choices about their lifestyles – for example, activities they enjoy. Promoting and normalising healthy lifestyles is therefore important. Supporting those who may be unable to make the most of their education and social development through issues such as mental health or physical health disorders is also important.

## Childhood obesity, physical activity and healthy diet

- 3.40 Key outcomes for this age group are to prevent overweight and obesity and to promote healthy behaviours such as regular physical activity and a healthy diet. Childhood obesity is linked to poorer health in later life, including heart disease, diabetes, musculoskeletal conditions, some types of cancer and psychological problems such as anxiety.<sup>52</sup>

### Our data:



- In 2016/17, Barking and Dagenham had the fourth highest proportion of overweight and obese children in Reception (25.5%) among local authorities in London (21<sup>st</sup> of 150 councils in England<sup>53</sup>). This has increased slightly +0.1 percentage points compared with the previous year.<sup>54</sup>
- The percentage of overweight or obese children in Year 6 in 2016/17 was the second highest in London and England (after Brent): 43.8%. It increased by 0.4 percentage points from the year before.
- As is seen nationally, there is ethnic variation in overweight and obesity rates.<sup>55</sup> In Reception children, overweight and obesity prevalence ranges from 21.8% in Asian children to 32.2% in Black children. These values are significantly different. In Year 6, overweight and obesity prevalence ranges from 38.5% in White children to 47.7% in Black children. These values are again significantly different.
- It is also of note that there is a strong correlation between deprivation and overweight and obesity nationally, demonstrating the importance of addressing the socio-economic determinants as well as looking at proximal causes:

<sup>52</sup> World Health Organization. *Why does childhood overweight and obesity matter?* [[http://www.who.int/dietphysicalactivity/childhood\\_consequences/en/](http://www.who.int/dietphysicalactivity/childhood_consequences/en/)]. Accessed 2017 Sep 1.

<sup>53</sup> There are 353 councils; City of London and Isles of Scilly data were included with Hackney and Cornwall respectively.

<sup>54</sup> National Child Measurement Programme. Refers to resident children.

<sup>55</sup> National Child Measurement Programme, pooled data 2013/14 to 2015/16, children attending Barking and Dagenham schools.

**Figure 7: Excess weight in Year 6 pupils by IMD 2015 score, local authorities in England**



Source: Public Health Outcomes Framework – National Child Measurement Programme data is from 2015/16

Note: Barking and Dagenham indicated by red diamond.  $R^2 = 0.6$

- 92% of schools with any primary age provision in Barking and Dagenham are registered with Healthy Schools London (49/53). This programme encourages schools to review and enhance the measures they have put in place to promote health and wellbeing in their pupils.
- Of these, 18% (9) have achieved a gold award, 27% (13) have achieved a silver award, 20% (10) have achieved a bronze award and 35% (17) have registered but not achieved an award.<sup>56</sup> This compares favourably with the rest of London where 6% of registered schools (any ages) have achieved a gold award and 44% are registered but with no award.

### Our priorities and strategies:

- Improving healthy weight is a target in various council-wide strategies and plans, including the Corporate Plan for 2017/18 and the Borough Manifesto.
- Improving the proportion meeting physical activity targets is an aim in the Borough Manifesto; although this will be measured in adults, this will also be a priority for children.
- A Healthy Weight Strategy was developed in 2016.<sup>57</sup> This drew together different areas of work around healthy weight and included action plans based on a life course approach. Children are a key target group within the strategy and specific actions were proposed for children at different ages. For primary school age children, the actions include:
  - enabling access to healthy weight support for those who need it.
  - supporting schools in addressing this (e.g. through achievement of ‘Healthy Schools London’ awards)
  - increasing access to healthy food choices
  - supporting children to develop skills, confidence and knowledge
  - promoting local community ownership and the family role in achieving and maintaining a healthy weight.

<sup>56</sup> Healthy Schools London [<http://www.healthyschools.london.gov.uk/>]. Accessed 2017 Jul 26. Denotes highest level of award.

<sup>57</sup> Barking and Dagenham Health and Wellbeing Board. *Healthy Weight Strategy 2016-2020. Let's #makeachange: a healthy weight strategy for Barking and Dagenham*. London: LBBD; 2016 [<https://www.lbbd.gov.uk/wp-content/uploads/2016/10/Healthy-Weight-Strategy-V1-14-WEB.pdf>].

- More children are eating healthy school meals and continuing to improve the food environment around schools (prevention)
- More children are taking regular physical activity through school and leisure service provision (prevention).

### **Looked-after children**

3.41 A child is considered a looked-after child if a court has granted a care order or if the local authority children's services has cared for the child for a period of more than 24 hours.<sup>58</sup> Young people in care are often over-represented within mental health statistics.<sup>59</sup>

#### **Our data:**

- At the end of 2016/17, Barking and Dagenham had 66.2 per 10,000 under 18 population that were considered looked-after children.
- This is higher than that observed in London and England (50 and 62 per 10,000 respectively) at the end of 2016/17.<sup>60</sup>
- There were 409 looked-after children in the borough at the end of 2016/17.<sup>61</sup>
- Of the looked-after children in care the percentage that received a health check decreased from 94% at the end of 2015/16 to 91% at the end of 2016/17.<sup>62</sup>
- Dental checks for all looked-after children have increased from 85% to 89%, and medicals from 82% to 84% from the end of 2015/16 to the end of 2016/17.<sup>63</sup>
- Eye checks increased from 76% to 80% between these time points.<sup>64</sup>
- At the end of 2016/17, 57.7% of care leavers were in education, employment or training. This compares with 50.2% at the end of 2015/16.<sup>65</sup>

#### **Our priorities and strategies:**

- Improving health outcomes for looked-after children, care leavers and youth offenders (protection and safeguarding).
- Dental, eye and health checks for all children in care remain areas for improvement.
- Child and adult safeguarding and child protection plans are also key priorities in the council KPIs and Joint Health and Wellbeing Strategy.

<sup>58</sup> CommunityCare. Children in care [<http://www.communitycare.co.uk/2007/05/23/children-in-care/>]. Accessed 2017 Aug 18.

<sup>59</sup> PHE. Public Health Profiles

[<http://fingertips.phe.org.uk/search/looked%20after#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/90401/age/173/sex/4>]. Accessed 2017 Aug 18.

<sup>60</sup> Department for Education, Children looked after in England including adoption: 2016 to 2017.

<sup>61</sup> LBBDD Children's Care and Support, ICS.

<sup>62</sup> LBBDD Children's Care and Support, ICS.

<sup>63</sup> LBBDD Children's Care and Support, ICS.

<sup>64</sup> LBBDD Children's Care and Support, ICS.

<sup>65</sup> LBBDD Children's Care and Support, ICS.

## Mental health

3.42 Promoting mental wellbeing and resilience and addressing mental disorders at any age is important. Understanding the mental health needs of children and young people may also allow for early intervention and management; mental health disorders usually appear for the first time in childhood and adolescence, with one study finding that half of those who had a psychiatric disorder at age 26 had had a diagnosis of a mental illness when tested at age 15 and around three-quarters by age 18.<sup>66</sup> It may also help to mitigate against the disadvantage children may face if they cannot fully participate in the educational and social opportunities of school.

3.43 This section covers both children of primary school age and adolescents.

### Our data:

- Modelled data suggest that 10.3% of Barking and Dagenham children aged 5–16 may have a mental health disorder.<sup>67</sup>
- This is higher than London and England (9.3% and 9.2%), which is likely to be due to the model accounting for the distribution of socio-economic classifications within areas. In general, children in a household whose family reference person<sup>68</sup> is of lower socio-economic status have a higher prevalence of mental health disorders, while there is also a relationship with household income.<sup>69</sup> As Barking and Dagenham is a deprived area, we would expect more children to be affected.
- No trend data is available as this is based on prevalence rates from the last national survey, which was carried out in 2004. A new national survey is being undertaken in 2017, which will cover ages 2–19.
- Table 2 presents the modelled prevalence estimates and approximate number of children thought to be affected by a mental health disorder by age and sex:

**Table 2: Modelled prevalence of mental health disorders in 5–16-year olds in Barking and Dagenham**

Age group	Male		Female		All	
	%	N	%	N	%	N
5–10	11.4%	1,300	5.7%	600	8.6%	1,900
11–16	14.0%	1,200	11.2%	900	12.6%	2,100
5–16	12.5%	2,500	8.0%	1,500	10.3%	4,000

Source: Calculated using methodology outlined in Children and Young People's Mental Health and Wellbeing, Fingertips profile, from: Mental health survey 2004, ONS mid-year population estimates 2016; Census 2011

- The most common disorders experienced are emotional disorders (encompassing anxiety and depression disorders) and conduct disorders.
- There are large differences by sex nationally, especially in younger children. In 5–10s, this is largely due to higher rates of conduct disorders in boys (6.9% of males versus 2.8% of females), although boys also have higher rates of hyperkinetic disorders (also known as attention-deficit hyperactivity disorder or ADHD) and less common disorders. Girls, conversely, have higher rates of emotional disorders,

<sup>66</sup> Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Arch Gen Psychiatry* 2003;60:709–17

[<http://jamanetwork.com/journals/jamapsychiatry/fullarticle/207619>]. This is based on a group of adults born in 1972/3 who have been tested at different time periods during their lives. See also: Murphy M, Fonagy P. Chapter 10: Mental health problems in children and young people. In: Lemer C, editor. *Annual Report of the Chief Medical Officer 2012: Our Children Deserve Better: Prevention Pays*. [London]: Department of Health; 2013

[[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/252660/33571\\_2901304\\_CMO\\_Chapter\\_10.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252660/33571_2901304_CMO_Chapter_10.pdf)].

<sup>67</sup> PHE, Children and Young People's Mental Health and Wellbeing [<https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh>].

<sup>68</sup> The person who owns the home or is responsible for rent; if multiple people do this, the highest earner is chosen. If two people earn the same income, the oldest is chosen [<http://webarchive.nationalarchives.gov.uk/20160106042025/http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html>].

<sup>69</sup> Green H, McGinnity, Á, Meltzer H, Ford T, Goodman R. *Mental health of children and young people in Great Britain, 2004: A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive*. Basingstoke: Palgrave Macmillan; 2005 [<http://content.digital.nhs.uk/catalogue/PUB06116>].

although at ages 5–10, this difference is not large. At ages 11–16, the conditions noted above are still more common in boys, but the gaps are diminished, whereas the gap between boys and girls suffering from emotional disorders increases.<sup>70</sup>

- From January to March 2017, an average of 790 young people (0–18) from Barking and Dagenham were in contact with mental health services at the end of each month, of whom an average of 575 were in contact with children and young people's mental health services.<sup>71</sup>
- From January to March 2017, an average of 490 individuals each month attended at least one contact, with an average of 1320 total contacts per month.

### **Our priorities and strategies:**

- A key local and national policy priority is to ensure the mental health has parity of esteem with physical health, including in the STP.
- Increasing levels of personal wellbeing and happiness to be above the London average is a target in the Borough Manifesto. Although this is to be measured in adults, the experiences of children will also be important.
- A detailed Children and Adolescent Mental Health Services (CAMHS) needs assessment for Barking and Dagenham was published in 2016, with recommendations for improving mental health services and outcomes for children and young people.
- The Barking and Dagenham Children and Young People's Mental Health Transformation Plan (updated October 2016) sets out a vision for improving mental health services for children and young people.
- Barking and Dagenham's Director of Public Health's annual report for 2016/17 includes mental health in children and young people as a priority area.
- **More children are developing coping and rebound skills to manage life stresses (prevention).**

---

<sup>70</sup> Green H, McGinnity, Á, Meltzer H, Ford T, Goodman R. *Mental health of children and young people in Great Britain, 2004: A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive*. Basingstoke: Palgrave Macmillan; 2005 [<http://content.digital.nhs.uk/catalogue/PUB06116>].

<sup>71</sup> NHS Digital, Mental Health Services Monthly Statistics; Barking and Dagenham refers to GP-registered population; those for whom NHS Barking and Dagenham CCG is responsible.

## Adolescence

- 3.44 During adolescence individuals develop health behaviours, beliefs and identities that form the basis of their health and wellbeing for the rest of their lives. The impacts of developing physical or mental ill health in adolescence can affect educational attainment and core life skills around relationships, identity as well as health in adulthood. At the start of 2017 Public Health commissioned an in-depth school-based survey to better understand the health and lifestyle behaviours of adolescents in the borough. For adolescents in Year 10 and above, questions on sexual lifestyles were included.

## Reproductive and sexual health

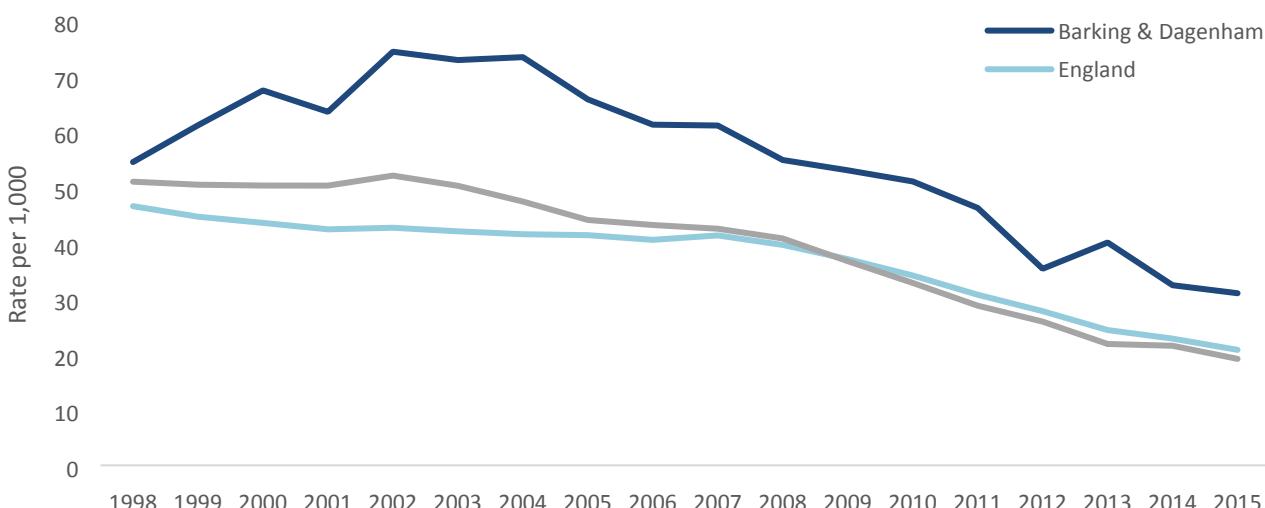
- 3.45 Adolescence is a period of complex social and biological development where individuals are likely to experiment with independence<sup>72</sup> in a context of significant social pressure from peers. Adolescents often face threats to their sexual and reproductive health,<sup>73</sup> with sexual debut often occurring within this period. Access to quality youth-friendly information and services as well as comprehensive Sex and Relationship Education (SRE) are key to the prevention of poor reproductive and sexual health outcomes during adolescence, with implications into adulthood.

## Our data:

### Teenage pregnancy

- Research suggests that teenage pregnancy is often associated with poorer outcomes for both children and young parents, with implications for the mother's educational attainment and mental health.<sup>74</sup>
- In 2015, Barking and Dagenham had the highest rate of under 18 conceptions in London (31 per 1,000), significantly higher than both the London and England averages (19.2 and 20.8 per 1,000 respectively).<sup>75</sup> However, it is important to note that despite having the highest rate regionally, the rate of under 18 conceptions in Barking and Dagenham has shown a considerable downward trend.

**Figure 8: Under 18 conception rate per 1,000 women aged 15–17, 1998–2015**



Source: Sexual and Reproductive Health Profiles, Fingertips

<sup>72</sup> Save the Children, *Adolescent Sexual and Reproductive Health*

[[http://www.savethechildren.org/site/c.8rKLIxMGlpI4E/b.9080949/k.F576/Adolescent\\_Sexual\\_and\\_Reproductive\\_Health.htm](http://www.savethechildren.org/site/c.8rKLIxMGlpI4E/b.9080949/k.F576/Adolescent_Sexual_and_Reproductive_Health.htm)].

Accessed 2017 Jul 10.

<sup>73</sup> Bearinger LH, Sieving RE, Ferguson J, Sharma V. Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *Lancet* 2007;369(9568):1220–31 [[http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(07\)60367-5.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(07)60367-5.pdf)].

<sup>74</sup> PHE. *Sexual and Reproductive Health Profiles. Indicator Definitions and Supporting Information*

[<http://fingertips.phe.org.uk/profile/sexualhealth/data#page/6/gid/8000057/pat/6/par/E12000007/ati/102/are/E09000002/iid/20401/age/17/3/sex/2>]. Accessed 2017 Jul 10.

<sup>75</sup> PHE, Sexual and Reproductive Health Profiles [<http://fingertips.phe.org.uk/profile/sexualhealth>].

- Most teenage pregnancies are unplanned, with approximately half ending in abortion.<sup>76</sup> In 2015, 58.3% of under 18 conceptions in Barking and Dagenham resulted in abortion.<sup>77</sup>

### *Sexual health*

- Valid responses within the school survey highlighted that approximately one in ten Year 10 pupils (aged 14–15) reported sexual debut.
- Of Year 10 students that reported being sexually active, approximately half reported ‘always’ utilising a form of protection or contraception during sex, with others reporting ‘never’ (26%), ‘sometimes’ (9%), and ‘usually’ (13%) making use of protective methods. These findings are similar for Year 12 pupils, with inconsistent use of contraception increasing risk of unplanned conception and sexually transmitted infections (STIs).
- Chlamydia is the most commonly diagnosed sexually transmitted bacterial infection in England, with 15–24-year olds accounting for 62% of chlamydia diagnoses.<sup>78</sup> Chlamydia is often asymptomatic, with untreated infections posing risk for the development of complications as well as further spread of the infection within the population.<sup>79</sup> Complications can include pelvic inflammatory disease (PID) with long-term consequences for reproductive health and fertility. In 2016, less than 16.7% of the Barking and Dagenham 15–24-year-old population was screened for chlamydia, significantly worse than both London and England (27% and 20.7% respectively).
- The chlamydia detection rate in those aged 15–24 in Barking and Dagenham is lower than the Public Health England (PHE) recommended rate of 2,300 per 100,000; in 2016, it was 1,946 per 100,000, with a decreasing trend since 2012. A growing adolescent population in conjunction with decreased screening coverage poses a risk of spread of asymptomatic chlamydia within the 15–24-year-old population.

### **Chlamydia proportion aged 15–24 screened**

2016

*Change (Percentage points)*  
*Prev. year*      *Prev. 5 years*

*Rank in*  
*London*

*Rank in*  
*England*



16.7%



27  
/32

115  
/152

### *Healthy relationships*

- National guidance by Brook, the Personal Social and Health Education (PHSE) Association and the Sex Education Forum recommends the inclusion of healthy relationships within sex and relationship education.<sup>80</sup>
- The commissioned survey included a question aiming to identify experience of respondents that have experienced controlling, threatening and abusive

<sup>76</sup> PHE. *Sexual and Reproductive Health Profiles. Indicator Definitions and Supporting Information*

[<http://fingertips.phe.org.uk/profile/sexualhealth/data#page/6/gid/8000057/pat/6/par/E12000007/ati/102/are/E09000002/id/20401/age/173/sex/2>]. Accessed 2017 Jul 10.

<sup>77</sup> PHE, Sexual and Reproductive Health Profiles [<http://fingertips.phe.org.uk/profile/sexualhealth>].

<sup>78</sup> PHE. *Sexually Transmitted Infections and Chlamydia Screening in England, 2016*. Health Protection Report, Volume 11 Number 20, 9 June 2017. London: PHE; 2017

[[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/617025/Health\\_Protection\\_Report\\_STIs\\_NCSP\\_2017.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/617025/Health_Protection_Report_STIs_NCSP_2017.pdf)].

<sup>79</sup> PHE. *Opportunistic Chlamydia Screening of Young Adults in England: An Evidence Summary*. London: PHE; 2014

[[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/497371/Opportunistic\\_Chlamydia\\_Screening\\_Evidence\\_Summary\\_April\\_2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497371/Opportunistic_Chlamydia_Screening_Evidence_Summary_April_2014.pdf)].

<sup>80</sup> Brook, PSHE Association, Sex Education Forum. *Sex and relationships education (SRE) for the 21<sup>st</sup> century*. Supplementary advice to the Sex and Relationship Education Guidance DfEE (0116/2000). [London]: Brook; 2014 [[https://www.pshe-association.org.uk/sites/default/files/SRE%20for%20the%2021st%20Century%20-%20FINAL.pdf\\_0.pdf](https://www.pshe-association.org.uk/sites/default/files/SRE%20for%20the%2021st%20Century%20-%20FINAL.pdf_0.pdf)].

behaviour within a romantic relationship. Of the respondents that had reported having or previously had a boyfriend or girlfriend, the leading behaviours reported included; ‘being jealous/possessive’ (18%), ‘telling you who you can and can’t see’ (12%), ‘checking your phone’ (12%) and ‘checking where you are all the time’ (12%), with some respondents detailing experience of physical abuse including hitting (3%) or pushing (5%).

### **Our priorities and strategies:**

- **Empower adolescents to make informed choices about their sexual and emotional health (prevention).**
- **More adolescents are protecting their own health through contraceptive and sexual health services (improvement and integration of services).**
- **More adolescent girls to are protected through vaccination against cervical cancer (protection and safeguarding).**

### **Training, educational and socio-economic outcomes**

3.46 Adolescence is a period of rapid development where biological maturity precedes psychosocial maturity,<sup>81</sup> often confounded by peer pressure and experimental independence. Supporting educational attainment and professional development during this period are key to enabling the successful transition into adulthood, with implications for future socio-economic standing in adulthood.

### **Our data:**

- Young people who are not in education, employment or training (NEET) are more vulnerable to a range of negative health outcomes such as depression with increased likelihood of early parenthood.<sup>82</sup> Barking and Dagenham has similar levels than seen nationally, with 16–18-year olds that are NEET in London as at the end of 2016/17 (6.6% compared with 6.0% nationally). Previous data show a stable trend with figures for the last two years being significantly higher than both London and England.<sup>83</sup>
- Absenteeism from school can influence quality of education received as well as labour market prospects, which in turn influences income, material resources and housing.<sup>84</sup> In 2015/16, pupil absenteeism in Barking and Dagenham was at 4.39% (the percentage of half days missed by pupils due to overall absence). This is similar to levels of absenteeism reported for London (4.45%) and England (4.57%).<sup>85</sup>
- As referenced above, labour market prospects influence income and are often linked with health and health inequalities.<sup>86</sup> In 2016/17, Barking and Dagenham pupils achieved their best ever results, with 42.5% of pupils achieving the new, higher standard, grade 5 or better in English and Maths. This exceeded national results but was lower than the London average.
- Young people in the youth justice system or at risk of committing an offence often have more unmet health needs than other young people and a lack of commitment to improving this area can result in worsening of health inequalities. In 2016, Barking and Dagenham had the highest rate of all London boroughs for

<sup>81</sup> World Health Organization (WHO). *Maternal, newborn, child and adolescent health* [[http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/development/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/)]. Accessed 2017 Jul 10.

<sup>82</sup> PHE. *Public Health Profiles. Indicator Definitions and Supporting Information*

[<https://fingertips.phe.org.uk/search/neet#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002>]. Accessed 2017 Jul 10.

<sup>83</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>84</sup> PHE. *Public Health Profiles. Indicator Definitions and Supporting Information*

[<https://fingertips.phe.org.uk/search/absence#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/10301/age/193/sex/4>]. Accessed 2017 Jul 10.

<sup>85</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>]. Please note this is for pupils aged 5–15.

<sup>86</sup> PHE. *Sexual and Reproductive Health Profiles. Indicator Definitions and Supporting Information*

[<https://fingertips.phe.org.uk/profile/sexualhealth/data#page/6/gid/8000037/pat/6/par/E12000007/ati/102/are/E09000002/iid/92199/age/175/sex/4>]. Accessed 2017 Jul 10.

first time entrants to the youth justice system, with 653.9 entrants per 100,000. This is significantly worse than both London and England (407.3 and 327.1 per 100,000 respectively).<sup>87</sup>

- The Marmot Review highlighted the centrality of employment to health, with worklessness contributing to poor health outcomes.<sup>88</sup> In Barking and Dagenham, the monthly average of 18–24-year olds claiming Jobseeker's Allowance for 2016 was 2%; this is lower than both regional (1.4%) and national levels (1.3%).<sup>89</sup>

### **Our priorities:**

- **Continued improvement in educational attainment (improvement and integration of services).**
- A Council corporate priority is that educational attainment at all levels and phases should be above the London average in the borough.
- As part of a larger corporate priority to narrow the gap in attainment and realise high aspirations for every child, the Council seeks to ensure all young people are in education, employment or training as well as working with partners (particularly schools) to get more young people to go on to study at 18 and ensure all young people achieve good GCSE and A Level results.

### **Healthy lifestyles**

#### **Our data:**

- At the start of 2017 Public Health commissioned an in-depth school-based survey to better understand the health and lifestyle behaviours of adolescents in the borough. The below data utilises some of the findings from the survey with data based on Years 8, 10 and 12 (aged 12–17).

#### ***Smoking, drinking and drug use***

- Smoking, drinking and drug use can have varying impacts on adolescent health, including increasing the risk of heart disease and stroke<sup>90</sup> as well as impacts on brain development,<sup>91</sup> function and cognition<sup>92</sup>.
- The school survey highlighted that 84% of respondents had never smoked across all three-year groups, with the proportion of pupils that had never smoked being lower in older respondents (93% of Year 8 respondents, compared with 76% of Year 12 respondents).
- Based on the 2017 survey results, 23% of respondents reported smoking waterpipe tobacco (also known as shisha or hookah) occasionally, monthly or on a more frequent basis. There is growing concern around young people's consumption of waterpipe tobacco, with research by the World Health Organization (WHO) suggesting an hour of waterpipe smoking is equivalent to 100–200 times the volume of smoke inhaled from a single cigarette.<sup>93</sup>

<sup>87</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>88</sup> Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. *Fair Society, Healthy Lives: The Marmot Review*. London: UCL; 2010 [<http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>].

<sup>89</sup> ONS via Nomis, Jobseeker's Allowance by age and duration.

<sup>90</sup> WHO. *Tobacco Free Initiative (TFI). Health effects of smoking among young people* [[http://www.who.int/tobacco/research/youth/health\\_effects/en/](http://www.who.int/tobacco/research/youth/health_effects/en/)]. Accessed 2017 Sep 7.

<sup>91</sup> Drinkaware. *Teenage drinking* [<https://www.drinkaware.co.uk/advice/underage-drinking/teenage-drinking/>]. Accessed 2017 Sep 7; National Institute on Drug Abuse. *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*. Last updated 2014 [<https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/principles-adolescent-substance-use-disorder-treatment>]. Accessed 2017 Sep 7.

<sup>92</sup> Squeglia LM, Jacobus J, Tapert SF. The influence of substance use on adolescent brain development. *Clin EEG Neurosci* 2009;40(1):31–8 [<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2827693/>].

<sup>93</sup> WHO Study Group on Tobacco Product Regulation. *Advisory Note: Waterpipe Tobacco Smoking: Health Effects, Research Needs and Recommended Actions by Regulators*. Geneva: World Health Organization; 2005 [[http://www.who.int/tobacco/global\\_interaction/tobreg/Waterpipe%20recommendation\\_Final.pdf](http://www.who.int/tobacco/global_interaction/tobreg/Waterpipe%20recommendation_Final.pdf)].

- For most young people engaged in Subwize services (70% of 171 service users), alcohol was their stated problem. Subwize is a young people's substance misuse service that supports young people in the borough up to the age of 21.
- Data from the 2017 school survey highlighted that 30% of respondents had previously consumed an alcoholic drink, with 6% having consumed alcohol in the last week.
- Alcohol-related admissions for under 18s continue to decrease (15.8 per 100,000 2013/14–2015/16) and remain lower – though not significantly – than national and London averages (37.4 and 22.4 per 100,000 respectively).<sup>94</sup>

### *Healthy eating*

- Healthy eating is essential across all stages of life, particularly during adolescence, when bodily changes affect an individual's nutritional and dietary needs.<sup>95</sup>
- Data from the 2017 school survey highlighted that 19% of respondents reported eating five or more fruit and vegetables in the last day. With an average of 2.8 portions of fruit and vegetables being consumed for a given day, this was similar for both males and females.
- A survey of 15-year olds in 2014/15 showed an average fruit consumption of 2.53 with regional and national averages at 2.64 and 2.39 respectively.<sup>96</sup> The average vegetable consumption was significantly lower in Barking and Dagenham (2.23) than that observed regionally and nationally (2.56 and 2.40 respectively).<sup>97</sup>

### *Physical activity*

- WHO guidelines recommend that children undertake at least one hour of moderate-to-vigorous physical activity (MVPA) daily.<sup>98</sup> Physical activity has considerable health benefits, including increased musculoskeletal, cardiovascular and psychological health.<sup>99</sup>
- Data from the 2017 school survey highlighted that 53% of the respondents did not do any 'hard exercise' while exercising within the last seven days, with 8% of respondents reporting not having undertaken any physical activity within the last 7 days.
- The leading reason cited for barriers to undertaking physical activity was 'I don't have enough time', followed by 'I am shy in front of other people/worried about being seen'.

### **Our priorities and strategies:**

<sup>94</sup> PHE, Local Alcohol Profiles for England [<http://fingertips.phe.org.uk/profile/local-alcohol-profiles>].

<sup>95</sup> Johns Hopkins Medicine. *Health Library. Healthy Eating During Adolescence* [[http://www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/healthy\\_eating\\_during\\_adolescence\\_90,P01610/](http://www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/healthy_eating_during_adolescence_90,P01610/)]. Accessed 2017 Jul 25.

<sup>96</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>97</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>98</sup> PHE. *Physical Activity. Indicator Definitions and Supporting Information* [<http://fingertips.phe.org.uk/profile/physical-activity/data#page/6/gid/1938132899/pat/6/par/E12000007/ati/102/are/E09000002/iid/91494/age/44/sex/4>]. Accessed 2017 Jul 25.

<sup>99</sup> PHE. *Physical Activity. Indicator Definitions and Supporting Information* [<http://fingertips.phe.org.uk/profile/physical-activity/data#page/6/gid/1938132899/pat/6/par/E12000007/ati/102/are/E09000002/iid/91494/age/44/sex/4>]. Accessed 2017 Jul 25.

- Fewer adolescents smoke and/or problematically use alcohol (prevention).
- More adolescents are taking regular physical activity and improve the opportunities to use green space (prevention).
- More adolescents take up the opportunity for a mid-teen health review with qualified health professionals (care and support).
- We want to prevent our teenagers from starting smoking as well as supporting them to stop. This is a priority in the STP and a Council key indicator.
- The 2017 Tobacco Control Strategy highlights key priorities within prevention, protection and treatment, to combat the impacts of tobacco on young people and other groups. This includes how to engage with young people around tobacco use, creating an environment where people choose not to smoke, and reducing exposure to second-hand smoke, illicit and counterfeit tobacco and the harms caused by smokeless tobacco and shisha.

### **Emotional and mental health**

3.47 The mental health of children and young people is addressed in section 3.4 (Primary school children).

### **Special educational needs and disabilities**

3.48 A young person has special educational needs and disabilities (SEND) if they have a learning difficulty or disability which calls for special educational provision to be made to support their educational needs.

3.49 A March 2017 SEND inspection reviewed the effectiveness of the local area in relation to identifying, meeting the needs of and improving the outcomes for children and young people with special educational needs and/or disabilities. The inspection highlighted both strengths as well as areas for improvement within the above three areas.

3.50 The main strengths identified were commitment from all local partners to implementing reforms with effective collaboration between healthcare, local authority and school partners, strong governance and relationships between local partners as well as effectiveness to engage the views of young people and their parents in aspects of local area provision.

3.51 Some areas for improvement included better incorporation of detailed targets and timescales in plans, recruitment and training of staff for the delivery of therapies such as speech and language, better consistency of engagement of parents and young people in Education, Health and Care (EHC) plans.

### **Our data:**

- The proportion of children identified with special educational needs in Barking and Dagenham was 14.2% in the academic year of 2015/16. This is similar to the London average (14.6%) as well as the national average (14.4%) for the same year.<sup>100</sup>
- Percentage of pupils with a statement or EHC was 2.2% in Barking and Dagenham in 2015/16, slightly lower than the national average of 2.7%.<sup>101</sup>

<sup>100</sup> Department for Education, Special Educational Needs in England. Metric ID: 2212.

<sup>101</sup> Department for Education, Special Educational Needs in England. Metric ID: 2213.

- January 2017 data from the Department for Education provides an overview of pupils that have autistic spectrum disorder as their primary need type in primary, secondary and special schools within the borough at 9.8%, 6.8% and 12.7% respectively.<sup>102</sup>

#### **Looked after children:**<sup>103</sup>

- In Barking and Dagenham, 41.9% of looked after children with SEN were without a statement compared with an average for all English regions of 37.9% in 2013/14.<sup>104</sup>

#### **Children in need:**<sup>105</sup>

- In Barking and Dagenham, 27.8% of children in need are on SEN support and 7.8% of children in need have a statement of SEN or EHC plan.<sup>106</sup> In Barking and Dagenham, 6.3% of school-aged children in need have a disability compared with an average of 12.8% for all English regions.<sup>107</sup>

#### **Statutory timelines for issuing plans:**

- It is in the interest of everyone that EHC needs assessments are undertaken in a timely manner, with regulation stipulating final EHC plans should be issued in no longer than 20 weeks. In Barking and Dagenham, 78.1% were issued within 20 weeks (excluding exceptions) compared with an average for all English regions of 58.9%.<sup>108</sup>

#### **Attainment of pupils with SEN:**

- In Barking and Dagenham pupils with SEN reach similar levels of attainment in terms of Early Learning Goals (ELGs) as observed nationally. More pupils with statements or EHC plans and those with SEN support in Barking and Dagenham meet the expected standard of phonic decoding than that observed nationally, 57% and 47% respectively.<sup>109</sup> For pupils with a statement of SEN or EHC or those with no identified SEN the levels of attainment for phonic decoding were similar to national levels.<sup>110</sup> Attainment at Key Stage 2 and Key Stage 5 were similar to national levels for pupils with SEN and a statement as well as with SEN without a statement,<sup>111</sup> with Key Stage 4 being lower than the mean observed for all English regions (2014/15).<sup>112</sup>

#### **Absence and exclusion:**

- The level of fixed<sup>113</sup> and permanent exclusion<sup>114</sup> of pupils with SEN with a statement as well as those with SEN without a statement<sup>115</sup> in Barking and Dagenham is considerably lower than the observed national average.

<sup>102</sup> Department for Education, Special educational needs in England: January 2017.

<sup>103</sup> Looked-after children are defined as those looked after by the local authority for one day or more.

<sup>104</sup> Department for Education, Outcomes for Children Looked After by Local Authorities in England. Metric ID: 2134.

<sup>105</sup> Children in need are defined in law as children who need local authority services to achieve or maintain a reasonable standard of health or development, need local authority services to prevent significant or further harm to health or development or are disabled.

<sup>106</sup> Department for Education, Characteristics of Children in Need in England: Outcomes tables. Metric ID: 4855.

<sup>107</sup> Department for Education, Characteristics of Children in Need in England. Metric ID: 2246.

<sup>108</sup> Department for Education, Statements of SEN and EHC plans England. Metric ID: 4737.

<sup>109</sup> Department for Education, Phonics screening check and key stage 1 assessments: England. Metric ID: 4667.

<sup>110</sup> Department for Education, Phonics screening check and key stage 1 assessments: England. Metric ID: 4668; Department for Education, Phonics screening check and key stage 1 assessments: England. Metric ID: 4664.

<sup>111</sup> Department for Education, National curriculum assessments: key stage 2, 2016 (revised).

<sup>112</sup> Department for Education, GCSE and equivalent attainment by pupil characteristics. Metric ID: 921.

<sup>113</sup> A fixed period exclusion refers to a pupil who is excluded from a school for a set period. A fixed period exclusion can involve a part of the school day and does not have to be for a continuous period.

<sup>114</sup> A permanent exclusion refers to a pupil who is excluded and has their name removed from the school register. Such a pupil would then be educated at another school or via some other form of provision.

<sup>115</sup> Department for Education, Permanent and Fixed Period Exclusions from Schools in England. Metric ID: 4732; Department for Education, Permanent and Fixed Period Exclusions from Schools in England. Metric ID: 4729.

### **Our priorities and strategies:**

**The Joint Health and Wellbeing Strategy priority for our children with special educational needs and disabilities is to have their needs met and demonstrate improved educational and health outcomes.**

Areas for improvement identified within the recent inspection and consequent recommendations form the basis for our priorities in relation to SEND.<sup>116</sup>

---

<sup>116</sup> Ofsted. *Joint local area SEND inspection in Barking and Dagenham* [<https://reports.ofsted.gov.uk/local-authorities/barking-and-dagenham>]. Accessed 2017 Aug 18.

## Maternity

- 3.52 Barking and Dagenham has the highest birth rate in England and Wales; there were 3,973 live births in 2016 – a rate of 86.5 live births per 1,000 women aged 15–44.<sup>117</sup> This means that approximately one in 12 women in this age group had a baby in 2016.



1 in 12 Barking and Dagenham women aged 15–44 had a baby in 2016

## Smoking

- 3.53 There is strong evidence that smoking in pregnancy has risks for the unborn child, including an increased risk of miscarriage and stillbirth.<sup>118</sup>

### Our data:

#### Smoking at delivery

2016/17



8.4%

Change (percentage points)  
Prev. year  
Prev. 5 years

-0.2

2015/16 to 2016/17

-4.4

2011/12 to 2016/17

Rank in London

31  
/32

Rank in England (CCGs)

138  
/209

- In 2016/17, around 8 in 100 women (8.4%) who gave birth in the borough were smokers at the time of delivery, compared with 5 in 100 across London (4.8%) and 11 in 100 across England (10.5%).<sup>119</sup> This is the second highest proportion in London, after Greenwich.
- This is part of a downward trend; it is 0.2 percentage points lower than 2015/16 and has decreased by 4.4 percentage points since 2011/12, when it was 12.8%.

### Our priorities and strategies:

- Barking and Dagenham's 2017 Tobacco Control Strategy sets an aim of reducing the proportion of pregnant women who smoke to 5% by 2022 and 3% by 2025.
- **Fewer parents are exposing their children to cigarette smoke (prevention).**

## Breastfeeding

- 3.54 Breastfeeding has proven benefits for mother and child. These include increasing short-term immunity and reducing the risk of obesity in later life for the child and a lower risk of breast and ovarian cancer for the mother.<sup>120</sup>

### Our data:

- Data completeness for breastfeeding is low, leading to uncertainty about the proportions of women who are breastfeeding.
- Barking and Dagenham has low breastfeeding initiation rates (54.5%) compared with London and England (85.9% and 72.9% respectively) for October–December 2016.<sup>121</sup> This has decreased from 80.5% in April–June 2014. However, from July 2015 our data have not been complete.

<sup>117</sup> ONS, Birth Summary Tables - England and Wales, 2016.

<sup>118</sup> For example, Royal College of Physicians. *Passive smoking and children*. A report by the Tobacco Advisory Group. London: RCP, 2010

<sup>119</sup> NHS Digital, Statistics on Women's Smoking Status at Time of Delivery, annual data 2016/17.

<sup>120</sup> National Institute for Health and Care Excellence. *Maternal and child nutrition*. Public health guideline 11. [Manchester]: NICE; 2008 [<https://www.nice.org.uk/guidance/ph11/resources/maternal-and-child-nutrition-pdf-1996171502533>].

<sup>121</sup> NHS England, Quarter 3 2016/17. Note: does not include women giving birth at Barts Health NHS Trust due to non-submission of data.

- We only have data on around 60% of infants' breastfeeding status at 6–8 weeks. Of those we know about, 65.5% were partially or totally breastfed in July–September 2016.<sup>122</sup> This is lower than London (71.7%) but higher than England (50.7%). This has increased slightly from 61% in April–June 2015, but we cannot draw conclusions about the trend given the amount of missing data.

### **Our priorities and strategies:**

- We need to work with our partners to improve the quality of breastfeeding data.
- **More infants are breastfed in the first months of life (prevention).**

### **Maternal mental health**

3.55 Mental health issues in pregnancy and the postpartum period are common. They negatively impact women's quality of life and can also have adverse outcomes for the child.<sup>123</sup> They have a substantial cost to society, with an estimated cost equivalent to £9,929 per woman giving birth, of which most of the costs relate to the child. Given that there were 3,973 births in Barking and Dagenham in 2016, this could indicate a cost of £39.4m for a single year's cohort.<sup>124</sup>

### **Our data:**

- Based on published prevalence data and the number of maternities in Barking and Dagenham in 2015 we might expect in a single year:
  - around 10 women with postpartum psychosis
  - around 10 women with chronic serious mental illness
  - around 115 women with severe depressive illness
  - around 385 and 575 women with mild–moderate depressive illness and anxiety states
  - around 115 women with post-traumatic stress disorder
  - around 575 to 1150 women with adjustment disorders and distress.<sup>125</sup>
- However, this does not consider the socio-economic deprivation among Barking and Dagenham women, which is likely to increase their risk.<sup>126</sup>
- In 2016/17, 75% of Barking and Dagenham mothers received a maternal mood review from a health visitor by the time their baby turned 8 weeks old. This improved from 70% in April–June 2016 to 80% in January–March 2017 and had further increased to 87% at the end of April–June 2017.
- There were 31 antenatal referrals and 114 postnatal referrals to IAPT (Talking Therapies Barking & Dagenham) in 2016/17.
- Barking and Dagenham women have access to a perinatal parent infant mental health service, provided by NELFT. 295 referrals for Barking and Dagenham registered patients were received in 2016/17, an increase from 279 and 275 in 2015/16 and 2014/15 respectively.

<sup>122</sup> Public Health England, Quarter 2 2016/17. Note: Quarter 2 chosen due to lag in data completeness.

<sup>123</sup> Bauer A, Parsonage M, Knapp M, lemmi V, Adelaja B; London School of Economics; Centre for Mental Health. The costs of perinatal mental health problems. London: Centre for Mental Health; 2014 [<http://everyonesbusiness.org.uk/wp-content/uploads/2014/12/Embargoed-20th-Oct-Final-Economic-Report-costs-of-perinatal-mental-health-problems.pdf>].

<sup>124</sup> Bauer A, Parsonage M, Knapp M, lemmi V, Adelaja B; London School of Economics; Centre for Mental Health. The costs of perinatal mental health problems. London: Centre for Mental Health; 2014 [<http://everyonesbusiness.org.uk/wp-content/uploads/2014/12/Embargoed-20th-Oct-Final-Economic-Report-costs-of-perinatal-mental-health-problems.pdf>].

<sup>125</sup> Created from prevalence figures compiled by the Joint Commissioning Panel for Mental Health and the number of maternities in Barking and Dagenham recorded by the ONS for 2015. Numbers rounded to nearest five and women could have multiple conditions. Note that this is not data for Barking and Dagenham women, but is indicative of the numbers we might expect.

<sup>126</sup> Ban L, Gibson JE, West J, Fiaschi L, Oates MR, Tata LJ. Impact of socioeconomic deprivation on maternal perinatal mental illnesses presenting to UK general practice. *Br J Gen Pract* 2012;62(603):e671–8 [<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3459774/>].

### **Our priorities and strategies:**

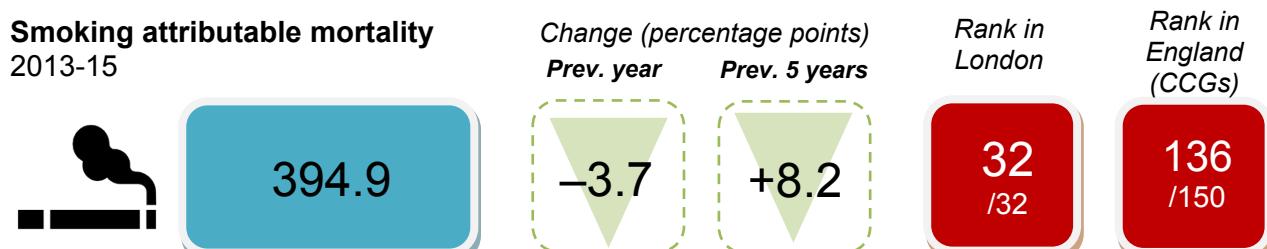
- All women in pregnancy receive high quality health care support during pregnancy and labour and as a result fewer women and babies experience preventable complications (care and support).
- More women who are identified in pregnancy with additional needs have their needs met and demonstrate improved outcomes (care and support).
- All mothers have an integrated maternity care plan which they develop in partnership with the relevant healthcare professionals (improvement and integration of services).
- Maternity pathways including those delivered outside of the borough, have clear and integrated pathways of care with local service providers and safeguarding mechanisms (improvement and integration of services).
- More young adults with depression are supported, through improved access, and uptake of, talking therapies (improvement and integration of services).

## Adulthood

### Changing lifestyle behaviours

- 3.56 Lifestyle and behaviour change is a key way to improve life expectancy that will have an impact in the medium term. To address health inequalities interventions must be universal but with an intensity according to the level of disadvantage in addition to targeted interventions for some specific vulnerable groups.
- 3.57 Targeting certain disadvantaged groups who have changing lifestyle behaviours (Obesity, smoking, substance misuse, teenage pregnancy) are key priorities of the plans of the council, STP, integrated model of care as well as the JHWS.

### Smoking



- 3.58 Smoking tobacco is the single biggest cause of health inequalities in the borough. The prevalence of smoking in Barking and Dagenham remains one of the highest in London, but certain groups have a higher prevalence or are at greater risk from smoking, such as 'routine and manual' workers (26.9%), pregnant women (8.6%), those with mental health conditions (40.2%), single parents on benefits and people with long term conditions. A recent school health survey indicates that while the rate of smoking in our young people is relatively low, the use of shisha (19.3%) and vaping (10.8%) are notably higher.<sup>127</sup>
- 3.59 Smoking is the largest cause of preventable ill health and premature mortality in the UK and is a risk factor for diseases such as chronic obstructive pulmonary disease, heart disease, and lung cancer.<sup>128</sup> More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates among poorer people. With smoking prevalence being high in the borough, smoking has a significant impact on the poor life expectancy and quality of life discussed previously.<sup>129</sup>

#### Our data:

- The smoking prevalence in adults in LBBD has reduced significantly between 2014 and 2016, falling from 23.1% to 18.8% according to the Annual Population Survey, although this is still significantly higher than the national average and the sixth highest in London.<sup>130</sup>
- Barking and Dagenham has the highest rate of smoking attributable mortality in London, with 394.9 per 100,000 people dying from causes related to smoking in 2013-15. This is significantly higher than the London average of 260.4 and is a big concern.<sup>131</sup>
- 9 out of 10 deaths from lung cancer are attributable to smoking. This is the leading cause of premature death in women, and second highest cause in men.

<sup>127</sup> London Borough of Barking and Dagenham, *Tobacco Control Strategy: A Vision for Tobacco-free Living*, 2017.

<sup>128</sup> Department of Health. *Towards a Smokefree Generation*. London: DH; 2017 [<https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england>].

<sup>129</sup> Action on Smoking and Health, *Health Inequalities* [<http://ash.org.uk/category/information-and-resources/health-inequalities/>].

<sup>130</sup> Office for National Statistics, Annual Population Survey 2016.

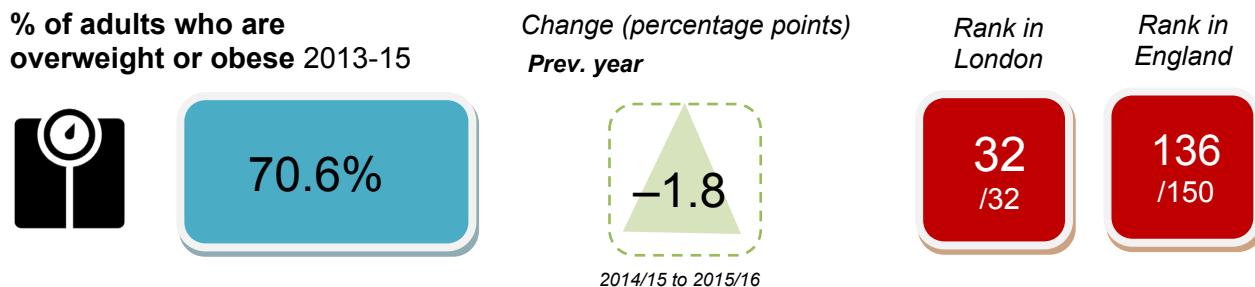
<sup>131</sup> Office for National Statistics, Annual birth and death extracts, 2013-15.

- Hospital admissions attributable to smoking are much higher than those seen in London and England, with 1,984 per 100,000 people in LBBD compared to 1,597 and 1,726 for London and England respectively.<sup>132</sup>

### **Our priorities and strategies:**

- This is a priority in the council corporate plan, as well as being a key priority for prevention in the STP and key to the integrated model of care.**
- The Tobacco Control Strategy was presented to the Health and Wellbeing Board in September 2017, and further highlighted the following key proposals:<sup>133</sup>**
- A smoke-free future, where our community is free from the harm caused by tobacco.**
- To reduce the smoking prevalence and to tackle the health inequalities across the borough through supporting existing smokers to give up, to reduce the take up of smoking, and to promote a smoke-free environment.**

### **Weight and diet**



3.60 After smoking, excess weight is one of the most important risk factors to being healthy for our residents, as it is nationally, with it being recognised as a major cause of premature mortality and avoidable ill health.<sup>134</sup>

3.61 As discussed previously, our primary school children have among the highest prevalence rates in the entire country, and these high levels of excess weight carry through into adulthood.

### **Our data:**

- Over two-thirds of adults in the borough have excess weight (either overweight or obese) (70.6%) compared with 58.8% in London and 64.8% in England. This is the highest prevalence in London.<sup>135</sup>
- 31.6% of the adult population is obese, which is also the highest prevalence seen in London.<sup>136</sup>
- Only 44.5% of the adult population consumes the recommended number of fruit and vegetables in a usual day in 2015/16, the second lowest figure in London.<sup>137</sup>

<sup>132</sup> Health and Social Care Information Centre, Hospital Episodes Statistics, 2015/16.

<sup>133</sup> London Borough of Barking and Dagenham, *Tobacco Control Strategy: A Vision for Tobacco-free Living* [<http://moderndgov.lbbd.gov.uk/documents/s115475/6%20-%20HWBB%20Tobacco%20control%20report.pdf>].

<sup>134</sup> Department of Health, *Health Lives, Healthy People: A Call to action obesity in England*. London: DH; 2011 [<https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england>].

<sup>135</sup> Sport England, Active People Survey, 2013–15.

<sup>136</sup> London Datastore, *Obesity in Adults* [<https://data.london.gov.uk/dataset/obesity-adults>].

<sup>137</sup> Public Health England; *Active Lives, Sport England*

### **Our priorities and strategies:**

- More adults to have a healthy weight and have access to healthy food/produce (prevention).
- Key strategies need to prioritise referral to healthy lifestyle programmes and health
- Future planning needs to incorporate active travel and the impact of the built environment on obesity levels.
- A Healthy Weight Strategy has been developed and continues to be implemented in the council's work on obesity.

### **Physical activity**

3.62 Physical inactivity is the fourth leading risk factor for mortality in the world, with 6% of deaths coming as a result of inactivity. People who are more active physically have lower risk of cardiovascular disease, coronary heart disease, and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year.<sup>138</sup>

### **Our data:**

- Only 55.7% of Barking and Dagenham's adult population are physically active, the lowest percentage in London. The definition of being active is an adult who undertakes 150 or more minutes of moderate intensity exercise per week.<sup>139</sup>
- 25.5% of the population use outdoor space for exercise or health reasons in Barking and Dagenham, which is the second highest proportion in London.<sup>140</sup>

### **Our priorities and strategies:**

- It is a corporate priority to increase leisure centre attendance and measures should be put in place to ensure this continues.
- The utilisation of green spaces and the built environment is an STP priority and should continue to be prioritised, particularly active travel.
- Healthy New Towns should focus on developing green spaces.
- More adults need to take regular physical activity including cycling and walking (prevention).

### **Early intervention and prevention of long-term conditions**

3.63 Cancer, heart disease and chronic obstructive pulmonary disease are the major causes of premature death in our residents. Early diagnosis and intervention for people with established disease and screening programmes improve the quality of life and reduce mortality by identifying these key diseases early.

3.64 The NHS Health Check programme is a key mandatory programme identifying diabetes, heart disease, high blood pressure, and stroke to support early identification and appropriate interventions. Cancer screening programmes are key. These are priorities within our key strategies and performance indicators.

3.65 This section summarises key data for the long-term conditions that are key to our residents' health: cancer, cardiovascular diseases (including diabetes, heart disease and stroke), and respiratory diseases.

<sup>138</sup> Department of Health, *Start Active, Stay Active*, London: DH; 2011.

<sup>139</sup> Public Health England, *Active Lives*, 2015/16.

<sup>140</sup> Natural England, *MENE Survey*, March 2015 – February 2016.

## Cancer

### Our data:

- Cervical screening rates have declined over the last two years, with 68.2% of the eligible population being screened in 2015/16 compared to 72.0% in 2013/14.<sup>141</sup>
- Breast cancer screening rates increased slightly between 2014/15 and 2015/16 from 60.4% to 62.7%. This is lower than both the level for London (65.1%) and England (72.5%).
- Bowel screening continues to be an area of concern, with only 40.4% of the eligible population being screened in 2015/16, the lowest of all London CCGs and significantly lower than the national average (58.5%)
- Premature mortality from cancer is falling nationally, but Barking and Dagenham's rate continues to be significantly worse than the national average, with 169.6 deaths per 100,000 residents compared to 138.8 nationally.<sup>142</sup>
- Lung cancer is the most common cause of death in our Barking and Dagenham residents with smoking causing 9 out of every 10 lung cancer deaths. Barking and Dagenham also has the highest rate of mortality from lung cancer of any London Borough, with 85.1 people dying per 100,000 residents from the disease in 2013–15.

### Our priorities and strategies:

- Screening uptake must be increased, and the early diagnosis of cancer must be improved. These are both key priorities of the JHWS.
- More adults to take up the offer of screening for cancers including breast, bowel and cervical.
- More adults with the early signs of chronic disease to be identified in primary care and start treatment and care.

## Diabetes

3.66 Diabetes is a major public health problem, with approximately 10% of the NHS budget spent on diabetes care. 90% of adults with diabetes have Type 2 or adult onset diabetes. Unhealthy diet, low physical activity and obesity are major contributors to Type 2 diabetes.

### Our data:

- In 2015/16, there were 11,484 people aged 17 years or older who had a diabetes diagnosis. This is equivalent to 7.6% of this age group compared to 6.5% for England. Barking and Dagenham has the sixth highest prevalence of diabetes in London, with neighbouring boroughs Redbridge and Newham in the top five.
- This is a 0.3 percentage point increase on the previous year's data.

### Our priorities and strategies:

- The number of people identified with pre-diabetes must be increased, and they must be prevented from developing diabetes. This is a key STP priority.
- The quality of care and support for people living with diabetes must be improved, as well as empowering our residents to manage their own condition.
- Services for people living with long term conditions will be improved.
- More adults with the early signs of chronic disease will be identified in primary care and will start their treatment and care earlier.

<sup>141</sup> NHS Cancer Screening Programme, *Open Exeter*, 2015/16.

<sup>142</sup> Public Health England, *ONS Mortality File*, 2013–15.

## **Stroke**

3.67 Residents who do have strokes in Barking and Dagenham are more likely to have severe strokes, and are more likely to die under 75 years of age. Stroke is the third most common cause of death in the developed world and one quarter of stroke deaths occur under the age of 65 years. There is evidence that appropriate diagnosis and management can improve outcomes.<sup>143</sup>

### **Our data:**

- The prevalence of stroke is 0.9% in Barking and Dagenham in 2015/16 significantly lower than the national rate of 1.7%.<sup>144</sup>
- Barking and Dagenham has one of the lowest rates of admission for strokes in London, with 153.5 admissions per 100,000 residents in 2015/16. This figure was slightly lower than the national average, though not significantly so.
- Despite having low recorded prevalence rates and relatively low stroke admission rates, Barking and Dagenham has the seventh highest rate of mortality from stroke in under 75s in London in 2013–15.

### **Our priorities and strategies:**

- NHS Health Checks must identify more people with stroke risk factors to enable proper consideration of evidence-based lifestyle advice and treatments where indicated. The NHS Health Check is a mandatory programme and a corporate priority for the council.
- It is a priority to ensure GP stroke registers are up to date and blood pressure monitored more regularly.
- Services for people living with long-term conditions must be improved.
- More adults with the early signs of chronic disease need to be identified in primary care and start their treatment and care earlier.

## **Respiratory diseases e.g. chronic pulmonary disease**

3.68 Chronic obstructive pulmonary disease (COPD) is a common disabling condition with high mortality associated with it. The most effective treatment is smoking cessation. Most patients with COPD are managed by GPs and members of the primary healthcare team with onward referral to secondary care when required.<sup>145</sup>

### **Our data:**

- Barking and Dagenham has the third highest prevalence of COPD among the 32 London boroughs, with 1.7% of residents diagnosed with the disease in 2015/16.
- LBBD had the highest rate of hospital admissions in London for emergency COPD admissions per 1,000 population (2.41), significantly higher than the national average.
- The borough also has the highest mortality rate in London for premature respiratory disease, with 54.3 per 100,000 residents compared to the national average of 33.1

### **Our priorities and strategies:**

- Case finding needs to be improved, with around a half of all patients with COPD remain undiagnosed.
- Smoking cessation needs to target those with COPD (prevention).

<sup>143</sup> Public Health England, 2017.

<sup>144</sup> Quality Outcomes Framework Indicators, 2015/16.

<sup>145</sup> Public Health England, COPD, 2017.

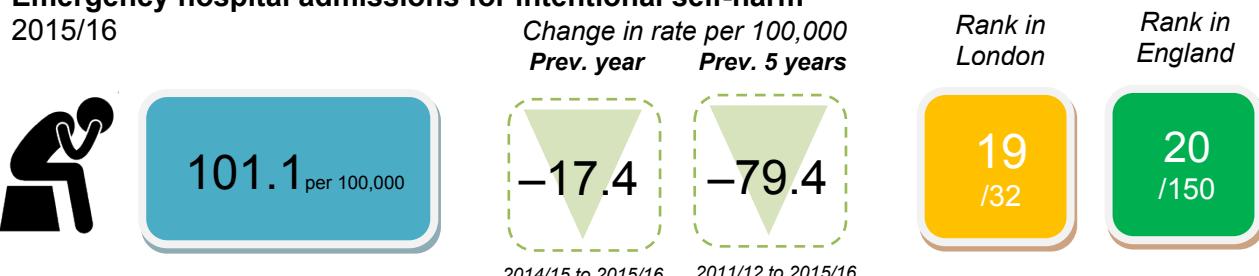
## Adult mental health

- 3.69 Mental health issues are extensive, incapacitating and often hidden. In any given year, it is estimated that a quarter of all adults will experience at least one diagnosable mental health problem.<sup>146</sup>

### Our data:

- It is estimated that 3.9% of adults in the Barking and Dagenham adult population were in contact with secondary mental health services in 2014/15. This is slightly below the London and national averages of 4.7% and 5.4% respectively.<sup>147</sup>
- Self-harm is defined as the deliberate act of self-injury or self-poisoning, independent of motivation or intention to commit suicide.<sup>148</sup> An individual that has experienced an episode of self-harm is at significant and persistent risk of suicide.<sup>149</sup> In 2015/16, emergency admissions for intentional self-harm in Barking and Dagenham were at 101.1 per 100,000, similar to levels observed regionally in London at 93.8 per 100,000.<sup>150</sup> The trend shows a considerable decline in admissions since 2010/11 with the rate of admissions almost half of that observed in 2010/11 with 2015/16 being the first year the borough has had a similar rate of admissions to that observed regionally.

#### Emergency hospital admissions for intentional self-harm



### Common mental disorders

- Common mental disorders are recognised as different forms of depression and anxiety. They result in emotional distress and disruption to daily function with the impacts on insight or cognition being limited.<sup>151</sup>
- It is estimated that in Barking and Dagenham the prevalence of common mental health disorders affects approximately 15.7% of the 16–74-year-old population, similar to the estimated prevalence for London and England.<sup>152</sup>
- Depression and anxiety is estimated to affect 13.3% of the adult population in Barking and Dagenham (aged 18 and above), with 4.3% experiencing long-term mental health problems, similar levels to those observed in London and a lower prevalence of long-term mental health problems than England.<sup>153</sup>

### Severe mental health issues

- Severe and enduring mental health issues are commonly understood to include schizophrenia, bipolar affective disorder and other psychoses as defined by the

<sup>146</sup> NHS England. *Mental Health. Adults* [<https://www.england.nhs.uk/mental-health/adults/>]. Accessed 2017 Aug 21.

<sup>147</sup> PHE. *Public Health Outcomes Framework*

[<http://www.phoutcomes.info/search/disability#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/id/92327/age/181/sex/4>]. Accessed 2017 Aug 21.

<sup>148</sup> PHE. *Public Health Outcomes Framework*

[<http://www.phoutcomes.info/search/intentional%20self%20harm#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/id/21001/age/1/sex/4>]. Accessed 2017 Aug 24.

<sup>149</sup> PHE. *Public Health Outcomes Framework*

[<http://www.phoutcomes.info/search/intentional%20self%20harm#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/id/21001/age/1/sex/4>]. Accessed 2017 Aug 24.

<sup>150</sup> PHE, *Public Health Outcomes Framework* [<http://www.phoutcomes.info/>].

<sup>151</sup> Stansfeld S, Clark C, Bebbington P, King M, Jenkins R, Hinchliffe S. Chapter 2: Common mental disorders. In: McManus S, Bebbington P, Jenkins R, Brugha T, editors. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital; 2016 [<http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-cmd.pdf>].

<sup>152</sup> PHE, *Common Mental Health Disorders* [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders>].

<sup>153</sup> PHE, *Common Mental Health Disorders* [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders>].

Royal College of Psychiatrists.<sup>154</sup> People experiencing these issues are often considered a vulnerable group.

- It is recognised that serious mental illness contributes to excess under 75 mortality. In 2014/15, it was estimated that for every 100 deaths in the general English population, there were 342.6 deaths among Barking and Dagenham residents who experienced severe mental illness.<sup>155</sup>
- In 2015/16, 0.78% of patients registered with a Barking and Dagenham GP were recorded as having a severe mental illness.<sup>156</sup> This is significantly lower than the recorded prevalence regionally (1.09%) and nationally (0.9%). It should be noted that this is likely to underestimate the proportion of the population experiencing severe mental illness as it is limited to the patient-registered population in whom an illness has been identified.

#### *Life circumstances of people with mental health disorders*

- Stable and appropriate accommodation is essential to bettering the outcomes of adults with mental health problems, as it contributes to the improvement of their safety and reducing risk of social exclusion. In Barking and Dagenham, 80.2% of adults that were in contact with secondary mental health services were understood to be in stable and appropriate accommodation, significantly lower than levels observed in London and nationally (68.2% and 67.2% respectively).<sup>157</sup>
- In 2006, an evidence review entitled 'Is work good for your health and wellbeing?' concluded that generally work has positive impacts on mental and physical health and wellbeing.<sup>158</sup> In Barking and Dagenham, the gap in employment rate for 18–69-year olds in contact with secondary mental health services relative to working-age adults is 61.4%, significantly lower than both London and England (68.2% and 67.2% respectively).

#### **Our priorities and strategies:**

- **More people living with severe mental illness will be physically healthy.**
- **More young adults with depression are supported, through improved access, and uptake of, talking therapies.**
- **More adults with early signs of dementia are recognised in primary care and referred for treatment.**
- **Fewer adults with depression require hospital admission because of better community care and support.**

#### **Domestic violence**

##### **Our data:**

- Barking and Dagenham had the highest domestic abuse incident rate per 1000 of the population of all 32 London boroughs in 2016/17. In terms of the number of incidents Barking and Dagenham sit 16<sup>th</sup> of the London boroughs as of April 2017.<sup>159</sup>
- In 2016/17, there were 2,408 offences which represents a decrease of 7.3% compared with 2,598 offences in 2015/16. Incidents have also decreased by 6.8% from 5,393 in 2015/16 to 5,024 in 2016/17. It is important to note that the dynamics of abuse can lead to significant under-reporting and therefore falling incidents may

<sup>154</sup> Royal College of Psychiatrists (2014). *Severe mental illness (psychosis)*. London.

<sup>155</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>156</sup> PHE, Severe Mental Illness [<http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness>].

<sup>157</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>158</sup> Waddell G, Burton AK. *Is work good for your health and well-being?* London: TSO; 2006

[[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/09214326/hwwb-is-work-good-for-you.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/09214326/hwwb-is-work-good-for-you.pdf)].

<sup>159</sup> MOPAC. *Domestic and sexual violence dashboard*. April 2017 [<https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-research/crime%20/domestic-and-sexual>].

highlight the need to work towards raised awareness of abuse and confidence in reporting.<sup>160</sup>

- There were 1,697 child social care contacts for domestic incidents, domestic violence, female genital mutilation, forced marriage, sexual abuse, sexual exploitation and stalking in 2016/17, with 1,464 being for domestic incidents/violence.
- During 2016/17, the total number of cases discussed at MARAC (multi-agency risk assessment conference) was 348, which represented a 3.3% increase compared with 337 cases the previous year. A significant number of children (419) were attached to these cases, which represents a 10% increase compared with 381 in 2015/16.<sup>161</sup>

### **Our priorities and strategies:**

- **The Joint Health and Wellbeing Strategy priority is for our children's and adults' domestic violence services to meet the needs of residents.**
- Domestic violence is also a priority performance indicator for the council and going forwards a subgroup of the CSP has been formed to tackle violence against women and girls (VAWG). The subgroup will explore local need and response and a full strategy to tackle domestic and sexual violence will be launched in summer 2018 in line with the Mayoral VAWG Strategy refresh. This group will also act as the steering for MARAC to ensure the effectiveness of the local response to VAWG.
- Children to be protected against child sexual exploitation. There will also be a CSP subgroup formed to focus on the needs of children and young people.

### **Homelessness**

3.70 Barking and Dagenham is one of the less wealthy London councils and has a significant issue with homelessness. Homelessness directly links to health, as homeless individuals and families are likely to be less healthy than the general population. Homelessness is associated with poor health, educational, and social outcomes, especially for children.<sup>162</sup>

### **Our data:**

- The number of households making a formal homeless application to the council more than doubled between 2011 and 2016, rising from 408 to 1,285 applications. However, the number of applications has decreased relative to 2015 (1,811).<sup>163</sup>
- The number of households owed a housing duty shows a similar trend to applications, with an increase between 2011 and 2016 from 199 and 609, with a decrease in those owed a housing duty relative to 2015 (961).<sup>164</sup>
- In 2015/16, 23 per 1,000 households in Barking and Dagenham were in temporary accommodation, significantly higher than that observed in England (3.1) and the fifth highest rate of the 32 London boroughs, with an overall upward trend since 2010/11.<sup>165</sup>
- The leading three causes of homelessness in 2016 were termination of assured shorthold tenancies (54%), parental ejection (13%) and family/living arrangement breaks down (12%).<sup>166</sup>

<sup>160</sup> MOPAC. *Domestic and sexual violence dashboard*. April 2017 [<https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-research/crime%20/domestic-and-sexual>].

<sup>161</sup> LBBB, MARAC Data Capture

<sup>162</sup> PHE. *Public Health Outcomes Framework. Indicator Definitions and Supporting Information* [<http://www.phoutcomes.info/search/homeless#page/6/gid/1/pat/6/par/E12000007/ati/101/are/E09000002/iid/11502/age/1/sex/4>]. Accessed 2017 Sep 18.

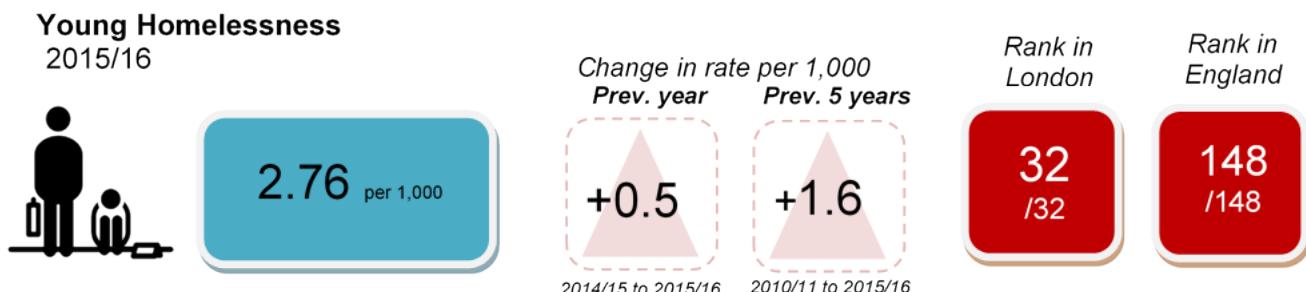
<sup>163</sup> Department for Communities and Local Government: P1E quarterly returns. Accessed 2017 Aug 14.

<sup>164</sup> Department for Communities and Local Government: P1E quarterly returns. Accessed 2017 Aug 14.

<sup>165</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>166</sup> Department for Communities and Local Government: P1E quarterly returns. Accessed 2017 Aug 14.

- In 2016, the rate of family homelessness in Barking and Dagenham was the second highest in London, with 9.5 per 1,000 households experiencing unintentional homelessness classed as priority need (households with dependent children or pregnant women).<sup>167</sup>
- In addition to family homelessness, homeless households headed by young people aged 16–24 (homeless young people) is a significant problem in Barking and Dagenham. In 2016, 2.40 per 1,000 households were headed by a homeless young person, with Barking and Dagenham having the highest rate of young homelessness in England, with an increasing trend since 2010/11.<sup>168</sup>



- The proportion of homelessness applicants from BME communities has continued to increased year on year since 2013 (46%), with 64% of applicants in 2016 from BME communities.
- Preventing homelessness requires consistent and joint intervention from central and local government, health and social care as well as the voluntary sector. In 2016, 2,492 households received housing support and advice from the local authority preventing the need for making a homeless application.<sup>169</sup>

### Our priorities and strategies:

- A Joint Health and Wellbeing Strategy priority is to provide independence for our residents and tackle homelessness.
- The 2012–17 *Barking and Dagenham Housing Strategy* includes several key priorities including; the provision of a range of good quality housing options and to ensure that wherever necessary there is supply of high quality support services to facilitate people to live as independently as possible. Further priorities are detailed in the Housing strategy.<sup>170</sup>

<sup>167</sup> PHE, Overview of child health [<https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview>].

<sup>168</sup> PHE, Young people [<https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people>].

<sup>169</sup> Department for Communities and Local Government: P1E quarterly returns. Accessed 2017 Aug 14.

<sup>170</sup> LBBB. *Barking and Dagenham Housing Strategy 2012–2017*. London: LBBB; [no date] [<https://www.lbbd.gov.uk/wp-content/uploads/2014/11/Barking-and-Dagenham-Housing-Strategy-2012-17.pdf>].

## Learning disabilities and autism

- 3.71 People with learning disabilities have a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which starts before adulthood, and has a lasting effect on their development. People with learning disabilities can experience considerable health inequalities and are more likely to experience health conditions including dementia, epilepsy and respiratory disease.<sup>171</sup> Health inequalities experienced by people with learning disabilities relative to the general population cannot be wholly explained by their underlying condition but are also a result of treatment by health, mental health and social care services as well as lifestyle factors.<sup>172</sup>
- 3.72 Autism is a spectrum condition that is a form of lifelong developmental disability which impacts people's ability to perceive the world and their interaction with those around them.<sup>173</sup> Autism is distinct from mental illnesses or learning disabilities; however, people with autism may experience additional or related problems.<sup>174</sup> Appropriate psychological interventions such as parent skills training programmes can reduce communication difficulties with positive implications for quality of life and wellbeing for individuals with autism spectrum disorder (ASD) as well as their caregivers.<sup>175</sup>

## Our data:

### Learning disabilities

- According to estimates by Projecting Adult Needs and Service Information (PANSI), based on the Institute of Health research prevalence figures and ONS population projections, 3,150<sup>176</sup> adults in Barking and Dagenham (2017) are thought to be living with a learning disability, this is equal to approximately 2.5% of the 18-64 population. This number is predicted to increase by 20% (650<sup>177</sup> people) by 2030.<sup>178</sup>
- 2015/16 data from the Quality and Outcome Framework (QOF) shows a prevalence of learning disabilities at 0.4% in the Barking and Dagenham population. This is based on people with learning disabilities that are recorded on practice registers and is therefore likely to underestimate the prevalence considerably.<sup>179</sup>
- In 2016/17 4.5% of people with learning disabilities that were receiving a long-term package of care were in paid employment, a small increase from 3.5% in 2015/16.<sup>180</sup>

---

<sup>171</sup> Mencap. *Health – research and statistics* [<https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health-research-and-statistics>]. Accessed 2017 Aug 17.

<sup>172</sup> Mencap. *Health – research and statistics* [<https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health-research-and-statistics>]. Accessed 2017 Aug 17.

<sup>173</sup> The National Autistic Society. *Autism* [<http://www.autism.org.uk/about/what-is/asd.aspx>]. Accessed 2017 Aug 17.

<sup>174</sup> Social Care, Local Government and Care Partnership Directorate, Department of Health. 2016, *Progress Report on Think Autism: the updated strategy for adults with autism in England*. [[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/492011/autism-progress-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492011/autism-progress-report.pdf)].

<sup>175</sup> World Health Organisation. 2017. *Autism Spectrum disorders*. [<http://www.who.int/mediacentre/factsheets/autism-spectrum-disorders/en/>]. Accessed 2017 Aug 17.

<sup>176</sup> Rounded to the nearest 50.

<sup>177</sup> Rounded to the nearest 50.

<sup>178</sup> Projecting Adult Needs and Service Information [<http://www.pansi.org.uk/index.php?pageNo=388&areaID=8640&loc=8640>].

<sup>179</sup> NHS Digital. 2015/16. Quality and Outcomes Framework (QOF) – 2015-16, Prevalence, achievements and exceptions at CCG Level, Table 20. [[http://www.content.digital.nhs.uk/article/2021/Website-Search?productid=23378&q=Quality+and+Outcomes+Framework+\(QOF\)&sort=Relevance&size=10&page=1&area=both#top](http://www.content.digital.nhs.uk/article/2021/Website-Search?productid=23378&q=Quality+and+Outcomes+Framework+(QOF)&sort=Relevance&size=10&page=1&area=both#top)]. Accessed 2017 Aug 17.

<sup>180</sup> NHS Digital, SALT. 2016/17

- Adults with learning disability in settled accommodation are likely experience improved safety and reduced risk of social exclusion.<sup>181</sup> In 2016/17, in Barking and Dagenham 90.9% of adults with learning disabilities were in settled accommodation. This is a small increase relative to 2015/16 at 88.9%, for which there is comparable data available with both London and England lower at 70.1% and 75.4% respectively.<sup>182</sup>

### **Autism**

- According to estimates by Projecting Adult Needs and Service Information (PANSI), based on the Adult Psychiatric Morbidity Survey 2007 and ONS population projections, 1250<sup>183</sup> adults in Barking and Dagenham in 2017 are thought to be living with ASD.<sup>184</sup>

### **Our priorities and strategies:**

#### **Learning disabilities**

#### **Create employment opportunities and ensure appropriate support for people with Learning Disabilities.**

All individuals with learning difficulties and/or disabilities have a key worker and a structured health and wellbeing plan which considers key life stages and transitions e.g. the move from education into employment.

### **Autism**

To enable people with autism and their families; independent voice and involvement in planning provision, safeguarding with access and rights, access to meaningful activities, a robust transition process for the future needs for all young people, supporting housing needs for adults, a clear and effective diagnostic pathway with information and support for parents/carers<sup>185</sup> and access to employment, training and skills.<sup>186</sup> Further details regarding priorities in relation to autism are available in the Children's Autism Strategy 2015-2018<sup>187</sup> and the Adult Autism Strategy 2015-2017.<sup>188</sup>

<sup>181</sup> PHE. *Public Health Profiles*

[<https://fingertips.phe.org.uk/search/learning#page/6/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/10601/age/183/sex/4>]. Accessed 2017 Aug 17.

<sup>182</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>183</sup> Rounded to the nearest 50.

<sup>184</sup> Projecting Adult Needs and Service Information [<http://www.pansi.org.uk/index.php?pageNo=388&areaID=8640&loc=8640>].

<sup>185</sup> London Borough of Barking & Dagenham. 2015-18. *Children's Autism Strategy 2015-18* [<http://bit.ly/2uOvTUy>]. Accessed 2017 Aug 18.

<sup>186</sup> London Borough of Barking & Dagenham. 2015-18. *Children's Autism Strategy 2015-18* [<http://bit.ly/2uOvTUy>]. Accessed 2017 Aug 18; London Borough of Barking and Dagenham. 2015-2017 *Adult Autism Strategy 2015-17* [<http://bit.ly/2ic9B9s>]. Accessed 2017 Aug 18.

<sup>187</sup> London Borough of Barking & Dagenham. 2015-18. *Children's Autism Strategy 2015-18* [<http://bit.ly/2uOvTUy>]. Accessed 2017 Aug 18.

<sup>188</sup> London Borough of Barking and Dagenham. 2015-2017 *Adult Autism Strategy 2015-17* [<http://bit.ly/2ic9B9s>]. Accessed 2017 Aug 18.

## Older adults

3.73 The health and wellbeing of older adults is often characterised by increased dependence as well as greater levels of frailty and long-term conditions.<sup>189</sup> Health deteriorates for many of our residents in older age. The impact of social isolation, poverty and the lifetime effects of health risk behaviours such as smoking, all contribute to an older person's health and wellbeing. There is no avoiding that old age is followed by death, and providing individuals support and dignity in dying is an important part of the health and social care agenda. The Joint Health and Wellbeing Strategy outlines our aim to support older adults in Barking and Dagenham to live with dignity and independence enabling them to achieve their full potential in older life as they would in any other life stage.

## Health and care system

3.74 Barking and Dagenham has the second lowest disability-free life expectancy for women aged 65 in London, which is also significantly lower than the England estimate.<sup>190</sup> Disability-free life expectancy at age 65 aims to provide a measure of functional health status for people at age 65. Essentially this means that women over the age of 65 in Barking and Dagenham are more likely to live with limiting longstanding illness or disability at age 65 than women living in other areas of London and some parts of England.<sup>191</sup> Years of living with disability in particular at an old age increases dependence on the health and care system.<sup>192</sup> Local health and care infrastructure must also account for the growing prevalence of long-term conditions in the elderly population, these can be largely influenced by health and lifestyle behaviours in earlier stages of the life course.<sup>193</sup> It is important to note that demand for health and care services is increasingly driven by the complexity of multiple long-term conditions and disabilities.<sup>194</sup>

## Our data:

- Requests for social care support can be used as a proxy indicator of social care demand, although it should be noted that this has limitations.
- There was a 5% increase in requests for social care support between 2016/17 and 2015/16 (just under 300 additional requests). Support requests for those aged 65 and above constituted 60% of the increase in requests, with the remaining requests linked to those aged 18–64.

---

<sup>189</sup> The King's Fund. *Long-term conditions and multi-morbidity* [<https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity>]. Accessed 2017 Aug 25.

<sup>190</sup> ONS. *Disability-Free Life Expectancy (DFLE) and Life Expectancy (LE) at age 65 Upper Tier Local Authority, England* [<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/disabilityfreelifeexpectancydfleandlifeexpectancyatbirthbyuppertierlocalauthorityatage65england>]. Accessed 2017 Aug 25.

<sup>191</sup> ONS. *Disability-Free Life Expectancy (DFLE) and Life Expectancy (LE) at age 65 Upper Tier Local Authority, England* [<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/disabilityfreelifeexpectancydfleandlifeexpectancyatbirthbyuppertierlocalauthorityatage65england>]. Accessed 2017 Aug 25.

<sup>192</sup> Age UK. *Briefing: Health and Care of Older People in England* 2017. [London]: Age UK; 2017 [[http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The\\_Health\\_and\\_Care\\_of\\_Older\\_People\\_in\\_England\\_2016.pdf](http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf)].

<sup>193</sup> The King's Fund. *Long-term conditions and multi-morbidity* [<https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity>]. Accessed 2017 Aug 25.

<sup>194</sup> Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012;380(9836):37–43 [[http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)60240-2.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60240-2.pdf)].

## **Our priorities and strategies:**

- Frail elderly adults to be supported to live independently.
- Key Joint Health and Wellbeing Strategy and council key performance indicators relating to the health and care system include: direct payments for social care, delayed transfer of care, unplanned hospitalisation, A and E attendances and older people's permanent admissions to residential homes.
- More older adults who are eligible use direct payments to control their own care and services.
- More older adults live active and independent live with support from integrated services.
- More older adults have access to community based urgent care services.

## **Mental health**

3.75 Older adults face multiple risk factors that can result in increased vulnerability to poor mental health outcomes. These factors can include deterioration of physical health, experience of disability, the loss of independence, social isolation and loneliness, psychological distress and experience of events such as bereavement and drop in socioeconomic status following retirement.<sup>195</sup> It is estimated that approximately 15% of adults aged 60 and over suffer from a mental disorder, with 6.6% of all disability-adjusted life years (DALYs)<sup>196</sup> attributed to mental and neurological disorders<sup>197</sup> for the 60 and over age group. Identification of individuals at risk of decline and engagement of elderly adults in physical activity and social participation are evidence-based recommendations to support better mental health outcomes for older adults.<sup>198</sup>

## **Our data:**

### Dementia

- Dementia is a condition in which the memory deteriorates, and thinking and everyday activities are often undermined. Although dementia affects many elderly people, it is not a normal part of the ageing process, with Alzheimer's disease being the most common cause of dementia (60–70%).<sup>199</sup>
- Increasing the number of people living with dementia who have a formal diagnosis is a political priority as part of the Prime Minister's challenge on dementia care.<sup>200</sup> Timely diagnosis enables informed decision making for care, enabling carers and healthcare staff to plan accordingly to work towards improving healthcare outcomes.<sup>201</sup>
- The recorded prevalence of dementia (aged 65+) was 4.32% in Barking and Dagenham in 2016, similar to both London and England (4.54% and 4.31% respectively).<sup>202</sup> This indicator details the proportion of the population aged 65+ that have a recorded dementia diagnosis.<sup>203</sup>

<sup>195</sup> WHO. *Mental health and older adults*. Fact sheet. Last updated 2016 [<http://www.who.int/mediacentre/factsheets/fs381/en/>]. Accessed 2017 Aug 15.

<sup>196</sup> Disability Adjusted Life Years (DALYs): This metric gives an indication of overall burden of disease, one DALY representing the loss of the equivalent of one-year full health; WHO. *Disability Adjusted Life Years (DALYs)* [[http://www.who.int/gho/mortality\\_burden\\_disease/daly\\_rates/text/en/](http://www.who.int/gho/mortality_burden_disease/daly_rates/text/en/)]. Accessed 2017 Aug 17.

<sup>197</sup> WHO. *Mental health and older adults*. Fact sheet. Last updated 2016 [<http://www.who.int/mediacentre/factsheets/fs381/en/>]. Accessed 2017 Aug 15.

<sup>198</sup> National Institute for Health and Care Excellence. *Mental wellbeing and independence for older people*. Quality standard 137. [Manchester]: NICE; 2016 [<https://www.nice.org.uk/guidance/qs137>].

<sup>199</sup> WHO. *Dementia*. Fact sheet. Last updated 2017 [<http://www.who.int/mediacentre/factsheets/fs362/en/>]. Accessed 2017 Jul 6.

<sup>200</sup> Department of Health. *Prime Minister's challenge on dementia: Delivering major improvements in dementia care and research by 2015*. Leeds: DH; 2012 [[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215101/dh\\_133176.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215101/dh_133176.pdf)].

<sup>201</sup> PHE. *Dementia Profile. Indicator Definitions and Supporting Information* [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/6/gid/1938133052/pat/6/par/E12000007/ati/102/are/E09000002/iid/92949/age/27/sex/4>]. Accessed 2017 Aug 14; Department of Health. *Prime Minister's challenge on dementia: Delivering major improvements in dementia care and research by 2015*. Leeds: DH; 2012 [[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215101/dh\\_133176.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215101/dh_133176.pdf)].

<sup>202</sup> PHE. *Dementia Profile* [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>].

- It is projected that in 2017 dementia will affect 74 per 1,000 people aged 65+ in Barking and Dagenham, similar to London projections (70 per 1,000).<sup>204</sup>
- It is estimated that 65% of people living with dementia are women.<sup>205</sup> In Barking and Dagenham, the 2017 projected rate of dementia for women is 86 per 1,000 women aged 65+ compared with 58 per 1,000 men aged 65+.<sup>206</sup>
- The estimated dementia diagnosis rate for those aged 65+ gives an indication of local services' ability to detect cases of dementia within their local communities. It is estimated that in Barking and Dagenham 64% of cases have a formal diagnosis, which is similar to London and England (71.1% and 67.9% respectively).<sup>207</sup>
- NHS Health Checks aim to raise awareness of dementia among those aged 65–74, with appropriate signposting to memory services if appropriate.<sup>208</sup> In Barking and Dagenham, 10.4% of the eligible population (aged 40–74 years) received a health check in 2016/17, higher than both the London and England averages (9.8% and 8.5% respectively).<sup>209</sup>
- Emergency admissions for people aged 65+ with dementia provide an indication of the local care provision for people living with dementia.<sup>210</sup> In 2015/16 in Barking and Dagenham, 3,621 per 100,000 of emergency hospital admissions among those aged 65+ were for those with dementia. This is below the London rate of 4,010 and similar to the England rate of 3,387.<sup>211</sup>
- Place of death is often used as a proxy indication for the quality of end of life care. People with dementia are often more likely to enter institutional care.<sup>212</sup> In 2015, in Barking and Dagenham 37% of people with dementia died in hospital, similar to levels observed in London but significantly higher than the proportion across England of 30.4%.<sup>213</sup>

### Depression, loneliness and social isolation

- Depression can result in significant suffering with the potential to impair daily functioning, while depression in older people can also result in an increased perception of poor health.<sup>214</sup>
- “*Loneliness is a dynamic concept that varies across the life course*”;<sup>215:8</sup> loneliness can lead to a decline in physical and mental health<sup>216</sup>, with prevalence estimates of loneliness concentrated within the older adult population<sup>217</sup>.

<sup>203</sup> PHE, Dementia Profile [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/6/gid/1938132811/pat/6/par/E12000007/ati/102/are/E09000002/iid/91891/age/27/sex/4>]. Accessed 2017 Aug 15.

<sup>204</sup> Projecting Older People Population Information System (POPPi) [<http://www.poppi.org.uk>]. Accessed 2017 Aug 16.

<sup>205</sup> Prince M, Knapp M, Guerchet M, McCrone P, Prina M, Comas-Herrera A, et al. *Dementia UK: Update*. Second edition. London: Alzheimer's Society; 2014 [[https://www.alzheimers.org.uk/download/downloads/id/2323/dementia\\_uk\\_update.pdf](https://www.alzheimers.org.uk/download/downloads/id/2323/dementia_uk_update.pdf)].

<sup>206</sup> Projecting Older People Population Information System (POPPi) [<http://www.poppi.org.uk>]. Accessed 2017 Aug 15. 2017 projections.

<sup>207</sup> PHE, Dementia Profile [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>]; [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/6/gid/1938132811/pat/6/par/E12000007/ati/102/are/E09000002/iid/92826/age/27/sex/4>].

<sup>208</sup> PHE. *NHS Health Check Best Practice, February 2017*

[[http://www.healthcheck.nhs.uk/commissioners\\_and\\_providers/guidance/national\\_guidance1/](http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/)]. Accessed 2017 Aug 15.

<sup>209</sup> PHE, Dementia Profile [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>].

<sup>210</sup> PHE, Dementia Profile [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>].

<sup>211</sup> PHE, Dementia Profile [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>].

<sup>212</sup> Jagger C, Andersen K, Breteler MM, Copeland JR, Helmer C, Baldereschi M, et al. Prognosis with dementia in Europe: A collaborative study of population-based cohorts. Neurologic Diseases in the Elderly Research Group. *Neurology* 2000;54(11 Suppl 5):S16–20.

<sup>213</sup> PHE, Dementia Profile [<https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>].

<sup>214</sup> WHO. *Mental health and older adults*. Fact sheet. Last updated 2016 [<http://www.who.int/mediacentre/factsheets/fs381/en/>]. Accessed 2017 Aug 15.

<sup>215</sup> Age UK. *Loneliness and isolation: Evidence Review*. [[http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence\\_review\\_loneliness\\_and\\_isolation.pdf?dtrk=true](http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true)]. Accessed 2017 Aug 15.

<sup>216</sup> NHS Choices. *Loneliness in older people*. Last reviewed 2015 [<http://www.nhs.uk/Livewell/women60-plus/Pages/Loneliness-in-older-people.aspx>] Accessed 2017 Aug 16.

<sup>217</sup> Age UK. *Loneliness and isolation: Evidence Review*. [[http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence\\_review\\_loneliness\\_and\\_isolation.pdf?dtrk=true](http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true)]. Accessed 2017 Aug 15.

- According to recent projections in 2017, it is estimated that 25% of the Barking and Dagenham 65–74 population will live on their own, with 51% of those aged 75 and over living on their own.<sup>218</sup> London has similar figures to Barking and Dagenham (25% and 50% respectively).<sup>219</sup>
- The 2016/17 Adult Social Care Survey highlighted that 33% of survey respondents reported social isolation (aged 65+),<sup>220</sup> with potential implications for older adult mental health.

### **Our priorities and strategies:**

- Residents with dementia to be on a GP register and to have access to the services they need.
- It is an aim of health strategies for mental health services for older people to have parity of esteem with physical health services.
- **More older adults with signs of dementia and/or depression are recognised in primary care and referred for treatment (care and support).**
- **Fewer adults with depression require hospital admission because of better community care and support (care and support).**

### **Falls**

3.76 People aged 65 and older have the highest risk of falls, with falls and fall-related injuries having considerable consequences for older people. Falls can result in injury, pain, distress, loss of confidence and loss of independence to the individual as well as health and healthcare costs.<sup>221</sup>

### **Our data:**

- In 2015/16, 1,625 per 100,000 emergency hospital admissions were due to falls in people aged 65 and over.<sup>222</sup>
- The rate of emergency hospital admissions due to falls in people aged 65 and over, was higher in females than males: 1,880 per 100,000 and 1,261 per 100,000 respectively.
- However, despite the rate of falls being higher in females, data since 2011/12 shows a decline in the rate of emergency hospital admissions in this population that are due to falls. In 2011/12 the rate for females was 3,171 per 100,000 aged 65 and over.<sup>223</sup> Since 2011/12 the rate has moved from being significantly higher than that observed in London and England to significantly below. The same trend can be observed for those aged 80 and above.<sup>224</sup>
- The rate for males was similar or significantly higher to the rate observed in London and England and is now significantly lower than both London and England.

<sup>218</sup> Projecting Older People Population Information System (POPPI) [<http://www.poppi.org.uk/>]. Accessed 2017 Aug 16.

<sup>219</sup> Projecting Older People Population Information System (POPPI) [<http://www.poppi.org.uk/>]. Accessed 2017 Aug 16.

<sup>220</sup> Adult Social Care Survey. 2016/17.

<sup>221</sup> National Institute for Health and Care Excellence. *Falls in older people: assessing risk and prevention*. Clinical guideline 161. Manchester: NICE; 2013 [<https://www.nice.org.uk/guidance/cg161>].

<sup>222</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>223</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

<sup>224</sup> PHE, Public Health Outcomes Framework [<http://www.phoutcomes.info/>].

## Emergency hospital admissions due to falls in aged 65 and over

2015/16



1,625 per 100,000

Change in rate per 100,000

Prev. year

Prev. 5 years

Rank in London

Rank in England



### Our priorities and strategies:

- Fewer older adults are injured through accidents in the home (protection and safeguarding).**

### End of life care

3.77 End of life care is care and support for individuals that are in the last months or years of their life. The purpose of this care is to support living well in the last period of life and enabling people to die with dignity.<sup>225</sup> End of life care can be challenging for those at an older age as they are more likely to be suffering from complex multiple morbidities.

### Our data:

- Place of death can serve as a proxy measure for quality of end of life care.
- In 2015, the leading place of death for adults aged 85 and over was hospital (49.5%) as opposed to other locations: care home (30.3%), home (17.9%), hospice (1.24%) and locations other than hospital, a care home, home or a hospice (1.03%).
- The proportion of adults aged 85 and over dying in hospital in Barking and Dagenham is significantly higher than the national average (43.7%) but similar to the London average (52.3%).
- The proportion of adults aged 85 and over dying in care homes in Barking and Dagenham is significantly lower than the national average (37.8%) but similar to the London average (26.3%).
- The data suggests that our care homes may be less well able to care for people who are dying and residents of care homes are more likely to go into hospital to die.

### Our priorities and strategies:

- With active case finding and good disease management, most of these deaths could be anticipated and the end of life adequately planned for.
- More older adults who are terminally ill die with dignity in a planned and supported way (improvement and integration of services).**

<sup>225</sup> NHS Choices. *End of Life Care*. Last reviewed 2015 [[www.nhs.uk/Planners/end-of-life-care/Pages/what-it-involves-and-when-it-starts.aspx](http://www.nhs.uk/Planners/end-of-life-care/Pages/what-it-involves-and-when-it-starts.aspx)]. Accessed 2017 Aug 21.

## Carers

3.78 It is estimated that one in eight adults in the UK provide unpaid care to family or friends that are older, frail, disabled or seriously ill.<sup>226</sup> Carers provide a significant contribution to society, enabling families to stay together, maintaining or improving people's quality of life as well as enabling considerable cost savings to the economy.<sup>226</sup> Caring can have an impact on carer physical and mental health, with those providing round the clock care being twice as likely to experience poor health than non-carers.<sup>227</sup> The importance of the contribution made by carers is reflected in the local carers strategy, 'Let's Care for Carers: A Carers' Strategy for Barking and Dagenham 2015-18'.<sup>228</sup>

### Our data:

- The 2017 Carer survey highlighted a decrease in carer satisfaction with quality of life to 7.4 out of a maximum of 12, a decline from the 2014–15 survey with a score of 7.9. Previously the measure had increased from 7.6 in 2012–13 to 7.9.
- National evidence shows that carers are more likely to experience loneliness and social isolation than non-carers, because of the nature and intensity of the caring role. The recent Carer survey highlighted a reduction in the proportion of carers who had as much social contact as they would like, with 34.2% of carers feeling they had an adequate level of social contact. This is lower than the previous survey where 40.1% were satisfied with their level of social contact.
- Inclusion of and consultation of carers in discussions regarding the person they care for is vital to enabling carers to feel respected as equal partners within the care process. The proportion of carers who reported they felt included or consulted in discussions about the person they care for decreased from 71.9% in the previous carer survey to 69.2% in the 2016/17 survey.
- As part of the Carers Survey, carers are asked about their experience of access to information and advice about social care in the past year. Information is essential to enabling early intervention and reducing dependency. The proportion of carers who found it easy to find information decreased marginally compared with 2014–15 carer survey, from 61.0% to 58.2%.
- Carers' satisfaction with social services for themselves or the person they care for has declined for the second survey in a row. It has decreased from 45.7% in 2012–13 to 43.5% in 2014–15 and 38.8% in 2016–17.
- It is estimated that 2,597 people aged 65 and over will provide unpaid care to a partner, family member or other person in Barking and Dagenham in 2017, approximately 13.1% of the 65 and over population. A similar proportion of those aged 65 and over provide unpaid care in London (12.7%).<sup>229</sup>

It is projected that 6.7% of the 65 and over population in Barking and Dagenham will provide 50 or more hours of unpaid care per week in 2017.<sup>229</sup>

### Our priorities and strategies:

Our priorities are outlined in the local carers strategy, 'Let's Care for Carers: A Carers' Strategy for Barking and Dagenham 2015-18', and include the following areas:

<sup>226</sup> Carers UK. *Why we're here* [<https://www.carersuk.org/about-us/why-we-re-here>]. Accessed 2017 Aug 16.

<sup>227</sup> Carers UK. *State of Caring 2017*. London: Carers UK; 2017 [<https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-report-2017>].

<sup>228</sup> LBBD. *Caring Together: A Carers' Strategy for Barking and Dagenham 2015 - 2018*. London: LBBD; 2015 [<http://moderngov.barking-dagenham.gov.uk/documents/s88997/Carers%20Strategy%20Appendix%201.pdf>].

<sup>229</sup> Projecting Older People Population Information System (POSSI) [<http://www.poppi.org.uk/>]. Accessed 2017 Aug 17.

- Current services: making current services more accessible for carers in the borough.
- Care-planning: ensuring that carers are involved in the care-planning process.
- Information provision: enabling clarity regarding personal budgets for carers.
- Health: to support GPs to recognise the value of carers' assessments and the potential clinical benefit of referring carers to community support.
- Future opportunities to support carers: support for carers in more ways than face-to-face groups, involving them in integrated care meetings.
- Identifying young carers: to identify young carers, particularly those under 9 years of age.

## **4 Next steps for JSNA 2017 and 2018**

- 4.1 This document will be published on the LBBD website. Work will then begin on reviewing the format, content and process for the 2018 JSNA, in conjunction with the review of the Joint Health and Wellbeing Strategy.

## **5 Impact of Care Act 2014**

- 5.1 The Care Act states that local authorities must prevent or delay the need for care services; this JSNA has a focus on prevention and hence supports this requirement. It also considers the needs of older people, who comprise one group who access care services.

## **6 Mandatory Implications**

### **Joint Strategic Needs Assessment**

- 6.1 This report comprises the 2017 JSNA.

### **Health and Wellbeing Strategy**

- 6.2 This report has been structured to mirror the format of the Joint Health and Wellbeing Strategy in terms of life course stages, while it also highlights relevant priorities from the strategy. However, as the strategy comes to an end in 2018, this may be a time to review and evaluate its targets.

### **Integration**

- 6.3 The report highlights several priorities from existing strategies relating to the integration of services and partnership working.

### **Financial Implications**

- 6.4 Implications completed by Katherine Heffernan Service Finance Group Manager: This report is mainly for information and sets out to provide the Health and Wellbeing Board a high-level overview of key health issues affecting residents at each stage of life, together with demographic information and a consideration of the needs of vulnerable groups. As such there are no financial implications arising directly from the report; however, the information set out does provide a useful context for the financial pressures faced by both Health and Social Care within Barking and Dagenham.

### **Legal Implications**

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

### **Risk Management**

- 6.6 There are no risks anticipated, provided that commissioning and strategic decisions informed by this report take into consideration equality and equity of access and provision.

### **Non-mandatory implications**

- 6.7 The JSNA seeks to review the evidence of need for residents across the breadth of health and wellbeing; therefore, the recommendations presented here and the full JSNA document will be of relevance to stakeholders across the health and social care economy.

## Appendix 1: Projected population numbers by age group, LBBD, 2017 and 2033

<b>Age</b>	<b>2017</b>	<b>2033</b>	<i>Increase in population</i>	<i>% increase</i>
0–4	19,700	24,400	4,700	24%
5–9	19,300	23,300	4,000	21%
10–14	15,200	21,300	6,100	40%
15–19	12,600	18,600	5,900	47%
20–24	13,100	16,800	3,700	28%
25–29	16,300	17,700	1,400	9%
30–34	17,400	18,300	900	5%
35–39	16,800	19,700	2,800	17%
40–44	15,100	20,000	4,800	32%
45–49	13,300	18,300	5,000	38%
50–54	12,000	16,100	4,100	34%
55–59	9,900	13,300	3,300	34%
60–64	7,100	10,900	3,800	53%
65–69	5,800	9,200	3,400	59%
70–74	4,600	7,200	2,600	55%
75–79	3,400	5,000	1,600	46%
80–84	2,600	3,500	800	32%
85+	2,900	3,700	800	26%
<b>Total</b>	<b>207,300</b>	<b>267,100</b>	59,800	<b>29%</b>

Source: GLA Witan, 2016. Note: calculations based on unrounded figures.