North East London Integrated Care Board

Barking & Dagenham

Notice of Meeting

HEALTH & WELLBEING BOARD AND ICB SUB-COMMITTEE (COMMITTEES IN COMMON)

Tuesday, 10 September 2024 - 4:30 pm
Council Chamber, Town Hall, Barking IG11 7LU

Date of publication: 2 September 2024

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Membership

Name	Title	HWBB	ICB
Cllr Maureen Worby (Chair)	Cabinet Member for Adult Social Care and Health Integration, LBBD	✓	✓
Charlotte Pomery (Deputy Chair)	Executive Director, NHS North East London	✓	✓
Elaine Allegretti	Strategic Director, Children and Adults, LBBD	✓	✓
Pooja Barot	Director, Care Provider Voice		✓
Clare Burns	Interim Executive Director of Partnerships, NELFT		✓
Matthew Cole	Director of Public Health, LBBD	✓	✓
Tom Ellis	Director of Strategy, Newham University Hospital	✓	
Cllr Syed Ghani	Cabinet Member for Enforcement and Community Safety, LBBD	✓	
Jenny Hadgraft	Interim Healthwatch Manager, B&D Healthwatch		✓
Kathryn Halford	Chief Nursing Officer, BHRUT	✓	✓
Dr Ramneek Hara	Clinical Care Director, NHS North East London	✓	✓
Louise Jackson	Chief Inspector, Metropolitan Police	✓	
Cllr Jane Jones	Cabinet Member for Children's Social Care and Disabilities, LBBD	✓	
Cllr Elizabeth Kangethe	Cabinet Member for Educational Attainment and School Improvement, LBBD	✓	
Sharon Morrow	Director of Partnership Impact and Delivery Barking and Dagenham, NHS North East London	✓	✓
Elspeth Paisley	Health Lead, BD Collective	✓	✓
Dr Kanika Rai	Place based Partnership Primary Care, Development Clinical Lead		✓
Dr Shanika Sharma	Primary Care Network Director - West One		✓
Nathan Singleton	Chief Executive, Healthwatch - Lifeline Projects Ltd	✓	
Fiona Taylor	Chief Executive (Place Partnership Lead), LBBD	✓	✓
Sunil Thakker	Director of Finance or nominated rep, NHS North East London		✓
Chetan Vyas	Director of Quality or nominated rep, NHS North East London		✓
Melody Williams	Integrated Care Director, NELFT	✓	

Non-voting members

Craig Nikolic	Chief Operating Officer, Together First CIC, B&D GP Federation	✓	
Dr Uzma Haque	Primary Care Network Director, North	✓	
Dr Deeksha Kashyap	Primary Care Network Director, North West	✓	
Dr Jason John	Primary Care Network Director, New West	✓	
Dr Afzal Ahmed	Primary Care Network Director, East	✓	
Dr Natalya Bila	Primary Care Network Director, East One	✓	
Dalveer Johal	NEL Local Pharmaceutical Committee Representative	✓	

Standing Invited Guests

Cllr Paul Robinson	Chair, Health Scrutiny Committee, LBBD	✓	
Andrea St. Croix	B&D Independent NHS Complaints Advocate	✓	
Narinder Dail	Borough Commander, London Fire Brigade	✓	
Anju Ahluwalia	Independent Chair Local Safeguarding Adults Board, LBBD	✓	
Vacant	London Ambulance Service	✓	
Vacant	NHS England, London Region	✓	

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**
   In accordance with the Council's Constitution and the ICB Sub-Committee's Terms of Reference, Members of the Committees in Common are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting on 12 March 2024 (Pages 6 - 15)**

4. **Resident's Story (pages 16 - 17)**
   Archna Mathur, on behalf of Amarjit Sembhi, will address the CiC on the subject of Specialised Services.

5. **Focus on Specialised Services (Pages 18 - 35)**

6. **Adult Social Care Prevention Plan (Pages 36 - 63)**

7. **Joint Strategic Needs Assessment 2023/24 (Pages 64 - 159)**

8. **Child Death Overview Panel Annual Report 2023/24 (Pages 160 - 162)**

9. **Maternity and Neonatal Services Update (Pages 163 - 181)**

10. **Winter Planning 2024/25 (Pages 182 - 192)**

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

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

Private Business

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

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

MINUTES OF
HEALTH & WELLBEING BOARD and
ICB SUB-COMMITTEE
(COMMITTEES IN COMMON)

Tuesday, 12 March 2024
(5:00 - 7:00 pm)

Members Present: Cllr Maureen Worby (Chair), Charlotte Pomery (Deputy Chair), Matthew Cole, Tom Ellis, Cllr Syed Ghani, Jenny Hadgraft, Dr Ramneek Hara, Ann Hepworth, Cllr Jane Jones, Cllr Elizabeth Kangethe, Dr Kanika Rai, Dr Shanika Sharma, Nathan Singleton, Fiona Taylor, Melody Williams, Craig Nikolic and Dr Uzma Haque

Invited Guests, Officers and Others Present: Debbie Harris and John Dawe, Kelvin Hankins, Philip Williams, Alan Mordue, Patrick Brooks, Susanne Knoerr and Jamie Postendorfen

Apologies: Elaine Allegretti, Pooja Barot, Sharon Morrow, Elspeth Paisley, Sunil Thakker, Christine Brand and Sarah Carter

40. Declaration of Members' Interests

There were no declarations of interest.

41. Minutes (16 January 2024)

The minutes of the Health and Wellbeing Board and ICB Sub-Committee meeting held on 16 January 2023 were confirmed as correct.

42. Resident's Story

The Chair welcomed Jamie Postendorfen from the Just Say Forum to the meeting.

Jamie was the first resident invited to address the Committees in Common and was asked to outline her story and experiences as a local resident who used services from all those represented at the meeting.

Jamie outlined her background as a fostered / adopted child and her experiences as a carer, initially supporting her mother and father from a very young age and now caring for her 19-year-old son who had severe learning disabilities and a partner who was awaiting a diagnosis for autism. She explained the difficulties she had experienced in securing the support that her son needed and deserved and referred to the particular hurdles she was currently facing as her son transitioned into adulthood.

Jamie volunteered in the capacity of Chair to the Just Say Forum, an information group made up of carers from Barking & Dagenham which worked closely with the local authority and formed part of a national network of carers and parents. The Forum received a small amount of funding from the Department of Education which they use to provide parents and carers with appropriate training, hold open meetings to share information, problems and life experiences, which in turn they

feed back to the local authority to get help and assistance. That said even with that support, life can be very difficult and challenging for individual carers/parents, as well she knew from her own experiences. She had a lot of knowledge about 0-16 but when it came to managing the transition into adulthood, she was unprepared for, as she described, the 'bombshell' that it is. Although she had done a considerable amount of research she was shocked as to how much a carer/parent needs to know because in her experience the local authority who have a duty to help quite often don't know themselves.

The Chair encouraged all those in attendance who had not already meet with the Forum to do so, given their knowledge and experiences. She referenced a recent joint session where they looked at why the services collectively were getting the issue of transition so wrong, especially as in most cases this was not about children who were not known to authorities. It certainly should not be left to carers/parents to have to do their own research. One of the challenges, and why the Committees in Common had decided to invite the likes of Jamie to address the meeting was so that everybody could think about whether they offered the right services and what each provides to support residents, highlighting as an example the case outlined by Jamie regarding her non-verbal son, who has rights himself.

Opening up to discussion, the Cabinet Member for Educational Attainment and School Improvement asked Jamie of her experience regarding her son's education, whether there was enough preparation and support for him, what the challenges were and, going forward, what could be improved. Jamie responded that she was not made aware that transition should have started in year 9 and, in her son's case, it did not start until year 13. She had also had to undertake a lot of her own research and despite raising issues through his EHCP review, her son should have had the likes of careers and housing officer support in place much earlier than it was. She felt that, other than education, no other services had been involved in the review process and gave the example of having to suggest herself an adult speech and language referral due to her son being non-verbal. Her son was currently at Trinity and despite the deadline of the end of the month to put in place an educational setting for him, she was still chasing to get a plan in place. Whilst he had severe learning difficulties and would struggle with everyday learning such as Maths and English, that should not preclude him. The Cabinet Member for Childrens Social Care and Disabilities acknowledged the points made by Jamie, recognising that the earlier the transition process started the better the chance of support being in place when it was needed.

In response to a question on the one thing all the bodies represented at the meeting could do to improve things, Jamie suggested that better communication for any parent entering into world of SEND would help greatly.

Fiona Russell, Director of Care, Community and Health Integration said that better support around pre-diagnosis was something that the Council was currently looking at. Turning to Jamie's carer role for her father with Alzheimer's she asked her to expand on the challenges this presented and what was it that the Council could have done better to support her. She responded that it was hard watching the deterioration of a loved one before you, especially their mental capacity, seeing in her father's case he was phenomenal with maths and spoke four languages. In the later stages he did not recognise any of the family. That led to her mother having a mental breakdown and suffering long term depression and

why Jamie become a carer at such a young age. Generally, there was not a lot of support for the family and why Jamie had to do most of the care.

Jenny Hadgraft made reference to a report which Healthwatch were about to publish about pathways to EHCP. Whist the majority of parents and carers had good support, she echoed Jamie's point about some feeling isolated and requiring more support and guidance.

Dr Sharma paid tribute to what Jamie has done. Seeing she had been a carer since the age of eight, she asked her what three things she would want to see in place that could really help and support young carers in Barking and Dagenham. Jamie responded that training for teachers to pick up the signal behaviour signs of problems in early years was vital, as was information for parents to be more aware of the unduly influence they might have on their children as young carers. Also maybe putting in place a system for children to talk to someone if they feel they needed to.

Andrea St. Croix, NHS Independent Complaints Advocate for B&D, said it was so important to have a holistic approach between the NHS and social care, seeing the number of people who were falling through the gaps. Melanie Williams, NELFT, stated that whilst the focus is on the growing younger population, we are seeing a significant increase in dementia diagnosis in the Borough's older population, and there was clearly a need for better support for carers in this group, otherwise we end up with significantly higher support costs given the complexity of their health needs, something this Board and Committees in Common should not lose sight of.

The Chair thanked Jamie for telling her story, the reason behind which was for this Board and Committees in Common to reflect in our own services as to whether actually do we think enough about the families of young people, particularly as to the sorts of issues highlighted this evening.

43. London Ambulance Service Update

Patrick Brooks from the London Ambulance Service made a presentation about the pressures the service had been under this winter, the proactive work the LAS has been doing with stakeholders and partners, and against that backdrop, information around response times and performance particular in relation to Borough GP practices.

LAS was the only Pan London NHS Trust which operates across the whole of London covering all the London Boroughs and the City. He outlined the number of calls taken over a typical day including over 5,000 and 6,000 to 999 and 111 respectively. There are three levels of service namely 'hear and treat' where people are dealt with over the phone by callers and clinicians with a range of pathways and advice suggested, then others dealt with at the scene through what is known as 'see and treat' and finally 'see and convey' where people are taken to A&E.

Currently there are 3,200 paramedics supported by 1,400 emergency medical technicians, with a broad range of skills together with 380 nursing and medical staff in control rooms and 1,300 call handlers. In NE London there are 853 paramedics and technicians who collectively carried out over 33,000 face to face responses between 1 January and 26 February 2024.

Mr Brooks outlined the various categories of calls and response times. Over the last winter period there was a call increase of 7,000 in core demand, in response to which he outlined the strategy for managing this demand. Hospital handovers played a crucial part and the Service continued to work with its NHS partners in NE London to reduce delays and safely release ambulance crews from hospitals which has made a big difference for medics and patients, freeing up clinicians to attend to those who need the most urgent care. The main thing is to ensure patients are directed to the right pathways and minimising the number conveyed to hospital emergency departments. As things stand less than 50% of patients attended are ending up at hospital.

In response to the presentation a number of questions/observations arose. These included whether the LAS felt there are enough services in the community available to avoid escalation to hospital. The primary pathway available are the GP's. In NEL there are a lot of community service pathways available, however the challenge comes when they reach capacity.

From a customer care perspective, issues were raised regarding how the level of harm caused by ambulance delays was evaluated and, from an acute perspective, how many individuals were driving relatives or others direct to hospital when they should be in an ambulance receiving treatment before they arrive at hospital. Although the current response time to category 1 (life threatening) met the 7-minute national target and category 2 (emergency / potentially serious) at 29 minutes had, over the past few months, dramatically improved, it was recognised that the service did not know with any certainty on a case-by-case basis where the greatest risks sat, resulting in many unwell patients requiring treatment self-presenting to hospital.

The LAS continue to work closely with hospitals to access the 'front door' risk, but perhaps it would be useful to conduct an audit to assess the number of patients that should/should not have been convened to hospital by ambulance rather than self-present. It was important to note that in NEL it is not possible to self-present at a hospital emergency department. Those individuals are required to go through an urgent treatment centre unless convened by ambulance. Of course, some will then be referred through to ED which has a knock-on effect for the whole pathway. The LAS also has a contract for a taxi service for those patients assessed as not requiring an ambulance but needing to attend hospital.

In response to a question about community support Mr Brooks explained that the 111 service has a huge directory of robust and comprehensive community services to ensure patients go through to the right pathway through set algorithms and triage. That said the service is always keen to develop new pathways so as to promote patient care and most importantly keep them in the community, when appropriate to do so.

The work described in today's presentation over the last 12 to 18 months had focused on partnership working at both at site and regional level. It now felt very different with real innovations coming through. It's a constant improvement cycle and there are questions about how things can be joined up better to manage the pathways for patients generally.

Melody Williams, NELFT referenced a pilot going live on 2 April in NE London with NHS 111 press 2, a direct line through to a mental health clinician, given a significant number of calls through to LAS are to do with mental health crisis.

Ann Hepworth, BHRUT commended the LAS as a great partner for improvement who have together worked well to make some massive improvements over the past 12 months to the hospital 'front door' into ED. That said there is still a massive demand which continues to grow. There are two things in particular that could be done in partnership across the system to improve matters. These include getting a better shared understanding where the risks are held across urgent emergency care, so that on any given day it would be possible to identify where the real pressures are for local residents. The second is about longer-term output, given that Queens Hospital remains a significant outlier across the whole of NE London for avoidable emergency attendance compared to the Royal London for example. Consequently, there is a need to properly understand why this is happening and look to reduce it to improve people's lives. Mr Brooks stated that it was a point well-made and agreed it's a good time to look at new innovations and have single points of access.

Councillor Jones referencing an experience from a recent family emergency made the point about ambulances taking patients to alternative hospitals out of the BHRUT area and the concerns that the social care relationships at these hospitals (in this case Newham General) are not the same as in BHRUT. Mr Brooks stated that in general patients should be conveyed to their nearest hospital particularly where they have ongoing needs as that is where their records will be. He undertook to look into the case highlighted as it seems they should have been convened to the preferred place of care for which he apologised.

Other points raised concerned the Duty Doctor Scheme which was a great example of successful multi-disciplinary working looking after the needs of the patient, which was trialled in this area but then dropped. Mr Brooks agreed with the comments and would support its reintroduction.

It was reported that Healthwatch did a report last year on service user experiences in the Borough and 50% of respondents stated that hearing of excess waiting times on calling for an ambulance had stopped them requesting one or would deter them in the future. It was suggested that the recent improvements should be better communicated to local residents to give them more confidence to call an ambulance should it be required. Mr Brooks undertook to provide contact details of the patient experience team who could pass on the results of satisfaction surveys etc.

Reference was made to the 45-minute limit that was introduced in January to ease pressure on the LAS at hospitals and the impact this has had, as well as other ways to solve the problems. Mr Brooks responded that prior to this there was no maximum wait time for crews who could spend an entire shift waiting in a hospital corridor with a patient for a hand over. This had led to hospitals introducing a whole range of improvements such as streaming and assessment of patients. This now allows crews to be released quicker and has led to response times for category 2 incidents to be brought down as reported earlier. For the record the plan is to reduce the handover time to 30 minutes.

The Chair thanked Mr Brooks for his informative presentation and for responding to questions.

44. Verbal update on CIC Development Session

Fiona Russell, LBBD Director of Care, Community and Health Integration together with input from Kelvin Hankins, NEL ICB and Matthew Cole, LBBD Director of Public Health provided a summary of the recent discussions at the Committees in Common Development Session which focussed on how the CIC had operated over the past year.

She highlighted the main findings which included that the CIC had reduced duplication, facilitated consistent and strong engagement, that relationships were growing and deepening, that there was healthy challenge and a preparedness to have the difficult conversations, an appreciation for a space for good discussions and the ability for deep diving. Issues for improvement focussed on matters of governance and specifically thinking about ideas for joint agenda planning, following up actions, as well as the tensions and conflicts around having space for both discussion and to business, such as making decisions around commissioning, finance etc, especially seeing there are only have two hours available every two months.

Finally, a questionnaire and survey had been issued to all participants who were encouraged to complete and return it, the review and evaluation of which would be used to form a report to be presented to the next meeting of the Council's Health Scrutiny Committee.

Kelvin Hankins then summarised the discussions on the proposed priorities for this Forum as a system which led to a lively debate and helpful feedback. Whilst there was broad agreement, there was work to be done about achieving an all-age approach, the challenge as to where assisted technology sat, how outcomes would be measured, not just the historical ones, and their relevance to residents, and how this linked to the big conversation and residents' views, and how this would be articulated into the overall plan. All this would be pulled together and reported back to the next meeting of the CIC for more discussion.

Finally, Matthew Cole, LBBD Director of Public Health reported on the LGA Public Health Review feedback where eight recommendations were made, most of which related to how partners work together in this Forum and in Place arrangements. A series of meetings were planned to work through the next steps which would be presented for consideration to the Place Executive on its journey to the Committees in Common.

45. A New Strategic Approach to Healthy Weight in Barking & Dagenham

Philip Williams, Head of Localities Commissioning made a presentation on a new strategic approach to healthy weight in Barking and Dagenham. He outlined the scale of the problem with the Borough having one of the highest rates of overweight and obese adults and children in London leading to increased risk of morbidity and mortality from conditions such as type 2 diabetes, hypertension, cardiovascular diseases, liver disease and some cancers. National child weight measurements had recently been issued which were not good, but also masked some considerable differences across the Borough with some schools having up

to 70% of the children that were considered overweight or obese compared to an overall average of around 40%.

The primary means for tackling the issue has been through the delivery of individualised weight management programmes, with the focus of many of these programmes focussing on supporting individuals who were at higher risk of disease due to their unhealthy weight. Given there were of the order of 100,000 adults classified as overweight/obese it would take more than 150 years to offer everybody a programme, which was simply not practical. Also, evidence showed that generally this approach did not lead to sustained changes in healthy behaviours beyond the life of the programme. Therefore, this has necessitated a different way of doing things at a population level. There were many different interconnecting factors involved with the issue from environment, social, economic, cultural, biological, to where people live etc. Consequently, this needed to be addressed in the round rather than focussing on simply being overweight. There were hard choices to make and certainly no quick fixes, but it was vital to start somewhere.

The approach needed to be a whole Borough Partnership. It was not feasible for one body such as the Council to solve the problem. It would require a partnership approach around food, activity, the environment collectively supporting work around healthy weight. The proposal involved designing a new model of support that recognises all these factors, providing upstream interventions connecting heath, the Council, the VCS and local community groups.

To achieve the aims of this new approach this Forum needs to facilitate the change working with a provider who will act as an enabler in the process, using their expertise in engaging with communities, networks and partners, and their experience of developing innovative healthy weight initiatives. Once a partner was in place it was proposed to engage them to do the design work in Phase 1 between July 2024 and March 2025 and implement a Health Weight Plan under Phase 2 from April 2025.

Mr Williams outlined what the Plan would look like, which would involve amongst other things, supporting ongoing partnership work around food, activity, and the environment, facilitating the delivery of co-produced community weight and nutrition activities, and working with the likes of the VCFS and partners, to build a volunteer/ network of healthy weight champions and peer support groups.

There were of course inherent risks. It would be a lot harder to achieve, but unless it was tackled as a system approach then inevitably it would fail. It needed to be inclusive and accessible and something that fitted in with people’s lives. Tackling obesity would require a sustained and integrated set of measures to address social norms so that over time healthy behaviours would become easier for all. When delivered across a whole system multiple small changes in large numbers of people can have a large impact at population level.

The Chair recognised that this was a huge shift for everybody, but seeing the results of recent engagement work around healthy lifestyles it was clear that residents were keen to make positive changes, and therefore the challenge for this Forum, was: are we ready to help our residents make those changes?.

The approach being advocated was very much supported by this Forum as clearly the current strategy was not working for residents, although along with lifestyle changes it was important to consider pathways as currently there was not a pathway for obese children in the Borough.

A lot of work was achieved in the recent Borough wide pop up where child height and weight measurements were undertaken. The results of that work showed that a number fell into the overweight category. According to the parents there was very little knowledge as to where to seek help and advice. Most of the parents wanted to see a family approach. Dr Hara who did this work would be happy to share the results with this Forum, as she had with the Public Health team, whom she was working with on childhood obesity.

Dr Hara requested that the membership and co production of the strategy needed to be a little wider, suggesting that it would be helpful to reach out to the likes of Tesco and other major supermarket chains who run young children activity and lifestyle programmes, to see how the Borough might tap into the resources they have. A lot of her patients were getting obese as they could not afford the cost of fresh fruit and vegetables, and to that end perhaps the supermarkets could be asked to support us, and then we could ‘retrain their plate’ to eat more healthier, seeing many have an emotional connection to their plate.

Craig Nikolic, Together First CIC said that they now had considerably more data, and the right level of demographic information, and were now in a position to target those with severe obesity in a more informed way. The Chair responded that whilst we might have the data, the key was how do we change the overall approach, not just eating habits, but also the lack physical exercise, seeing that the Borough has the least active population in the Country. A whole system approach needed to be tackled and what represented the biggest challenge.

Fiona Taylor, Chief Executive added that all partners could get behind the strategy. She stated that in the past most had run programmes with no definable outcomes, thinking that was enough. Moving forward we needed to identify what are the key things that as system leaders we can really impact change and certainly obesity was one of those things. This forms an essential part of the localities model which as Fiona Russell added needed to be community lead. In terms of system wide and it being a priority, the recent Peer Review into Public Health indicated that partners had too many priorities and made too many commitments. Therefore, there needed to be a clear focus and to that end coming together behind childhood obesity, felt like a step in the right direction.

Other comments expressed were about the wider aspects of the strategy, highlighting as an example that if we advocate greater exercise in green spaces, then how safe do people feel about using these spaces and consequently we may need to consider other factors such as the prevalence of knife crime in certain parts of the Borough. Acknowledging this point, there was already a Childhood Obesity Task and Finish Group, the membership of which could be expanded to consider these aspects. On this point the Cabinet Member for Enforcement and Community Safety outlined the work of the SNT’s in the Council’s parks and open spaces which was having a positive effect in reducing anti-social behaviour and knife crime, and leading to a greater use of our green spaces by the community.

Charlotte Pomery, ICB and Deputy Chair in supporting the whole system approach made a few comments. She recognised that whilst it was a good start there was clearly a lot more work required such as what would the strategy mean for commissioning, if health services adopted something that was less individually based, and what would this look like. She was pleased it was aligned to localities and proposed to be community led, as this sent a powerful message and something she would be keen to run with across NEL. She was also aware that a lot was being done around health equalities funding and whether we should top slice some of that. She felt that there was a lot more that could be done to achieve a wider population health approach to commissioning of the health services.

Ann Hepworth, BHRUT felt that we must accept that we cannot fix the problem and that for this whole system approach to succeed we must not follow the usual path and potentially suffocate this with our processes such as Task and Finish Groups, but instead support communities to find their own solutions and create possibilities.

Healthwatch were putting together its work plan for next year and would be happy to revisit this topic and build on its existing community engagement and equally would be keen to co plan. This was particularly welcomed by Dr Sharma, Clinical Director, Barking & Dagenham who was keen to get our workforces involved, as maintaining staff health and wellbeing was vital in terms of helping and supporting residents.

Mention was made that whilst families may have the knowledge and awareness to buy and cook fresh food, the fact that many were in fuel poverty was a significant factor and should form part of the whole system approach. This had been highlighted by parents in the engagement feedback, with one solution being to establish communal kitchens where families could prepare and eat together. This could build on similar initiatives which community groups are operating in the Borough.

In conclusion in welcoming the report, the HWBB and Committees in Common recognised the need to urgently change the approach to managing healthy weight in Barking and Dagenham and therefore **AGREED** the new strategic way forward as presented.

46. Adult Substance Misuse (Drug and Alcohol) Integrated Service - Contract Variation

Claire Brutton, Head of Disabilities' Commissioning, presented a report explaining that due to delays in the current procurement exercise for a new contract, for the reasons set out in the report, it was necessary to seek approval for a variation of the contract for the provision of Adult Substance Misuse Service with CGL to extend it for five months from 1 April to 31 August 2024, in accordance with the Council's Contract Rules.

The Health and Wellbeing Board **resolved** to:

(i) Approve the variation of the contract for the provision of Adult Substance Misuse Service with CGL for a period of five months from 1 April to 31 August 2024 in accordance with the strategy set out in the report; and

(ii) Delegate authority to the Strategic Director, Children and Adults, in consultation with the Cabinet Member for Adult Social Care and Health Integration, to extend the contract and all other necessary or ancillary agreements.

47. Young People Substance Misuse (Drug and Alcohol) Integrated Service - Contract Variation

Claire Brutton, Head of Disabilities' Commissioning, presented a report explaining that due to delays in the current procurement exercise for a new contract, for the reasons set out in the report, it was necessary to seek approval for a variation of the contract for the provision of Young People Substance Misuse Service with V-I-A (formally known as WDP) to extend it for five months from 1 April to 31 August 2024, in accordance with the Council's Contract Rules.

The Health and Wellbeing Board **resolved** to:

(i) Approve the variation of the contract for the provision of Young People Substance Misuse Service with V-I-A for a period of five months from 1 April to 31 August 2024 in accordance with the strategy set out in the report; and

(ii) Delegate authority to the Strategic Director, Children and Adults, in consultation with the Cabinet Member for Adult Social Care and Health Integration, to extend the contract and all other necessary or ancillary agreements.

48. Questions from the public

There were no questions from the public.

Patient Story – NHS North East London ICB Board

Amarjit Sembhi

31 January 24

Presented by Archna Mathur, Director of Specialised Services and Cancer on behalf of Amarjit Sembhi

Amarjit describes himself as the ideal candidate to share his experience of using renal services at the Royal London Hospital with the NHS NEL ICB Board.
Timing of the board coincides with his dialysis treatment and caring responsibilities for his mother, recently discharged from hospital, have presented challenges for Amarjit to attend in person.

Background and history
Amarjit is a 68year old Sikh male, married with 3 children and resides in Waltham Forest. He is a retired teacher. He is overall fit and healthy despite receiving haemodialysis three times a week. He enjoys sports and is an avid squash player, has played at national level, all of which has been enabled by his regular dialysis.

In 1984, aged 28, Amarjit presented to his GP with symptoms of nausea, headache, water retention and loss of energy, particularly whilst playing squash, which was unusual given his level of fitness.
Further tests revealed protein in his urine (proteinuria) which was as the result of an underpinning infection at the time leading to his diagnosis of early stage of renal failure.
He deteriorated suddenly and rapidly which was frightening as he was young and expecting his first child.

What treatment were you given at this point?
Following his diagnosis, he was in hospital for a catheter insertion in order to facilitate CAPD (Continuous Ambulatory Peritoneal Dialysis).

CAPD is a treatment for kidney failure that uses the lining of your abdomen (the peritoneum) to filter your blood inside your body. Dialysis solution, of water, salt and other additives, flows from a bag through the catheter into your belly. When the bag is empty, it is disconnected and a cap is placed on the catheter so you can move around as normal. Whilst the dialysis solution is inside your belly, it absorbs wastes and extra fluid from your body. After a few hours, the solution and wastes are drained out of your belly into the empty bag. The bag is then disposed and the process repeats with a new bag.

Whilst on CAPD, Amarjit would take the bags to school where he worked as a teacher, and do the manual exchanges there.
A key issue was the amount of space he needed in his house to store the boxes of CAPD bags, which come as a 30-day supply. He needed a whole room to store them!

How long did you have CAPD and what happened next?
Amarjit was on CAPD for 4.5 years after which a kidney became available for transplant. He received a successful renal transplant for 25 years, during which he lived a full and active life with only the medication to prevent organ rejection required.
He then started to experience a slow deterioration. He described his deterioration as a “dimmer switch”.

Commencement of Haemodialysis
Amarjit has subsequently commenced Haemodialysis. This involves diverting blood into an external machine where it is filtered before being returned to the body.

Amarjit has haemodialysis sessions three times a week which he has at the Royal London Hospital but he has also undertaken some home dialysis in the past.

Home Dialysis requires significant usage of electricity and special plumbing arrangements in the home. He has received support from Waltham Forest Local Authority who have paid a percentage contribution towards his electricity and water bills.

Demands on space at home, and caring responsibilities for his elderly mother, mean that home dialysis is no longer suitable for Amarjit.

He is therefore now on a self-care programme run by the Royal London, that will allow him to manage his own haemodialysis in another setting (intended to be in self-care bays at Mile End Hospital), enabling him to “plug” into a dialysis machine on his own, without the need for staff and even interpret his own results.
This will give him independence, does not generate additional electricity costs at home and is more efficient in terms of reducing bed utilisation at the Royal London and enable a more cost-effective service as the staff requirement is minimal.

Until this unit opens, he attends his sessions at the Royal London. There is currently an unconfirmed opening date for the unit at Mile End (Independent Treatment Centre) and capacity is constrained.

What’s next for Amarjit?
Amarjit is well currently and is also now back on the transplant list.
He feels that renal services provided by the Royal London have given him a fantastic life.
He is healthy and fit and takes good care of himself through diet and exercise, and has always done this.
He now also supports other dialysis patients through their experience.

Amarjit’s message to the Board
Amarjit is very mindful of the current obesity crisis, the strain of a growing population and the importance of a healthy lifestyle, particularly within his own Sikh community, where he feels pressure on renal services could grow and the need to expand these vital life saving services.

As a keen sportsman he is also wanted to specifically request that East London hosts The British Transplant Games. He has been awarded a lifetime achievement award for Tennis and squash and would like east London to be the place to showcase other achievements of transplant patients.

Barking and Dagenham Health and Wellbeing Board and ICB sub-committee

10 September 2024

Title of report	Focus on Specialised Services Ahead of Delegation in April 2025
Author	Archna Mathur, Director of Specialised Services and Cancer
Presented by	Archna Mathur, Director of Specialised Services and Cancer
Contact for further information	archnamathur@nhs.net
Executive summary	The NHS England Board has approved the decision for London to continue working in formal joint working arrangements through 2024/25 prior to delegation in April 2025. The paper is being presented to the Place Based Partnership committees following discussion at the NEL ICB Board in January and March 2024 intended to ensure familiarisation of the non-executive members to: • what specialised services are, • how they are currently commissioned; • changes associated with delegation including funding formula • an outline of risks and opportunities • examples of current transformation work in place and intended impact on future specialised service demand. Following the March 2024 ICB Board, a request from the ICB CEO to share the update with place-based partnerships has led to a programme of attendance to borough-based committees to share information on specialised service delegation.
Action required	Note the paper
Previous reporting	Delegation of specialised services has been discussed at: • NEL Specialised Services Programme Board • North London Specialised Service Programme Board • APC Executive Committee • APC Joint Committee • ICB Executive Management Team • ICS Executive Committee • ICB Board • City and Hackney Place based delivery group
Next steps/ onward reporting	A refreshed formal Joint Working Agreement for 2024/25 between London ICBs and NHSE London will be presented to the March 2025 ICB Board for approval.

Conflicts of interest	N/A
Strategic fit	The NEL Specialised Service programme, which includes joint working towards delegation aligns to the following ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Delegation of specialised service commissioning and transformation will enable us to integrate specialised pathways, address inequalities across complex pathways and manage future demand for complex specialised care.
Impact on finance, performance and quality	During 2024/25, the Finance, performance and quality liabilities remain with NHS England after which responsibility transfers to ICBs, with accountability retained at NHSE. Delegation should drive the improvement in access, quality and finance through the integration of pathways, end to end pathway approach and holistic overview of funding for specialised and non-specialised pathways.
Risks	Risks are described within the slide pack, and relate to delayed delegation, quality and transformation and finance and contracting.

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Focus on Specialised Services

Archna Mathur, Director of Specialised Services and Cancer

NEL ICB and Acute Provider Collaborative

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Specialised services – now & opportunities of future delegation

What are specialist services ?

- Specialised services are a diverse portfolio of c150 services generally accessed by people living with rare or complex conditions.
- NHSE commission specialised services currently, including a wide range of treatments such as chemotherapy, kidney dialysis, secure inpatient mental health care; complex surgical procedures e.g. stem cell transplants; cardiac surgery and complex treatments for stroke such as mechanical thrombectomy meeting the needs of much larger populations.
- Specialist services are a catalyst for innovation, supporting pioneering clinical practice. Specialist services are currently planned nationally and regionally and delivered by hospitals with specialist clinical teams with expert training.
- Demand for specialised services continues to increase as advances in medical technology enable the NHS to train more people, meaning the cost of providing specialist care is also increasing, further driven by significant forecasts in population growth.
- Collectively the specialised services portfolio delivers care to large numbers of people. Nationally this equates to roughly 15% of the overall NHS commissioning budget, **and for NEL ICB, specialised services equate to about c20% of the NEL Commissioning budget.**

How are specialised services currently commissioned, how this is changing and why?

- NHSE currently commission all specialised services; however, in December 2023 the NHS England Board approved plans to:
  - ❖ Fully delegate the commissioning of appropriate specialised services to Integrated Care Boards (ICBs) in the East of England, Midlands and the North West regions of England from April 2024.
  - ❖ Continue to jointly commission appropriate specialised services with ICBs in the South West, South East, London and the North East and Yorkshire regions of England for a further year. **This will help support a smooth transition of commissioning responsibility (Delegation) by April 25.**
- These arrangements are part of a careful and considered approach to delegating full commissioning responsibility across England for appropriate services by April 2025.
- **Moving to ICB-led commissioning supports a focus on population health management across whole pathways of care, improving the quality of services, tackling health inequalities and ensuring best value.**
- These plans, which were first set out in the *Roadmap for Integrating Specialised Services within Integrated Care Systems*, have been developed in close collaboration with NHS England's regional teams, ICBs and specialised service providers. They represent the outcome of a thorough assessment of ICB system readiness, and a comprehensive analysis of services to determine their suitability and readiness for more integrated commissioning.
- **NHS England regional and national teams will continue to work with those ICBs who are continuing with joint commissioning arrangements as we work towards full delegation in those geographical areas from April 2025**; and alongside ICBs taking on delegated responsibility to support them in their commissioning.

Why NHSE is delegating commissioning to ICBs – the benefits & opportunities

What should this mean for our patients, populations and their communities?

ICBs and providers to have **freedom to design services and to innovate** in meeting the national standards where they take on delegated or joint commissioning responsibility

ICBs and providers able to **pool specialised budget and non-specialised budgets** to best meet the needs of their population, tackle health inequalities and to join up care pathways for their patients

ICBs and providers able to use world class assets of specialised services to **better support their communities closer to home** (e.g. designing local public health initiatives, greater diagnostics and screening)

Quality of patient care

Patients will receive more **joined up care** – better communication and sharing of information between professionals and services.

More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care.

Increase focus and investment on **prevention**.& LTC management

Patients will receive the **right care at the right time in the right place**.

Better **step-down care** to support patients who are ready to leave specialised care.

Equity of access

Population based budgets means decisions on spend are based on the **needs of a local population** – the demographics, health behaviours etc rather than on activity in hospitals.

Specialised clinical expertise will have a role in managing population health and to **challenge underlying drivers of health inequalities**.

Providers and professionals working collaboratively, free from organisational constraints and commissioning boundaries, will help improve **quality of care and tackle unwarranted variation**.

Opportunity to **level up access across the country**

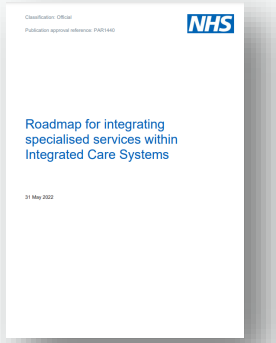
Value

Investment in preventative care could **reduce demand** for specialised services.

Providers and professionals can **better manage patient demand**, even when one part of the system becomes stretched. Patients can be re-directed or transferred so they have faster and better access to treatment

A whole system approach creates opportunities **to protect and build 'workforce resilience'**, as shown during the pandemic.

Pooled/delegated budgets allow **underspends to be shared or reinvested** and avoids commissioning pressures on any one organisation.



- Accessible care
- Tailored care
- Seamless care
- Effective care
- Preventative care

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The financial overview

The financial overview of specialised services in NEL

- The table below represents the agreed 2023/24 NHSE specialised services baseline value for the three NEL providers.
- NHSE have chosen to classify service lines into **green** (for delegation), yellow/**orange** (not yet for delegation), **blue** (hosted/networks) and **red** (not for delegation).
- The combined contract value for NEL providers is £823.6m, of which £587m will be delegated to the ICBs – ***71% of the total contract value***

Provider	Green	Organge	Blue	Red	Red - Drugs	Total
Barts	£465,067,768	£22,688,992	£7,806,357	£20,912,867	£143,462,052	£659,938,036
BHRUT	£94,713,041	£1,363,125	£0	£3,611,901	£24,051,990	£123,740,057
Homerton	£27,270,356	£6,202,878	0	£652,678	£5,882,678	£40,008,590
NEL Total	**£587,051,165**	**£30,254,995**	**£7,806,357**	**£25,177,446**	**£173,396,720**	**£823,686,683**

2023/24 financial overview – *commissioner split*

- The table below represents the green services which are to be delegated to the ICBs.
- From the total £587m which is to be delegated to the ICBs, £377m will go to NEL ICB (64%), £80m to other London ICBs (14%) and £96m will go to East of England (16%).
- This is important in terms of understanding our flow of patients accessing specialist care in NEL from other ICBs, and how we work together to plan and commission services, across and outside London, ensuring sustainability of provision and income within NEL.

Provider	NEL ICB	Other London	East of Englan	Midlands	South East	South West	Total
Barts	£295,050,842	£74,068,282	£62,233,732	£3,474,349	£23,704,300	£6,536,263	£465,067,768
BHRUT	£62,484,289	£1,465,053	£30,763,699				£94,713,041
Homerton	£19,664,459	£4,490,621	£3,115,276				£27,270,356
NEL Total	**£377,199,590**	**£80,023,956**	**£96,112,707**	**£3,474,349**	**£23,704,300**	**£6,536,263**	**£587,051,165**

How are allocations for specialised services changing

2013 – NHS England established

- Allocations for specialised services, previously part of needs-based PCT funding, shifts to historic funding of providers of those services.

Integration paper [NHS England » The journey to integrated care systems in every area]

- From ’23/24 we have shifted from historic funding ***of providers*** to historic funding ***of populations,*** as a step towards integration.

Proposed change through this programme

- Allocations shift over time ***to reflect estimated need*** for delegable specialised services based on personal, demographic and other factors.

The move to population-based allocations will facilitate delegation of the commissioning function for most specialised services to ICBs from April ’24/25

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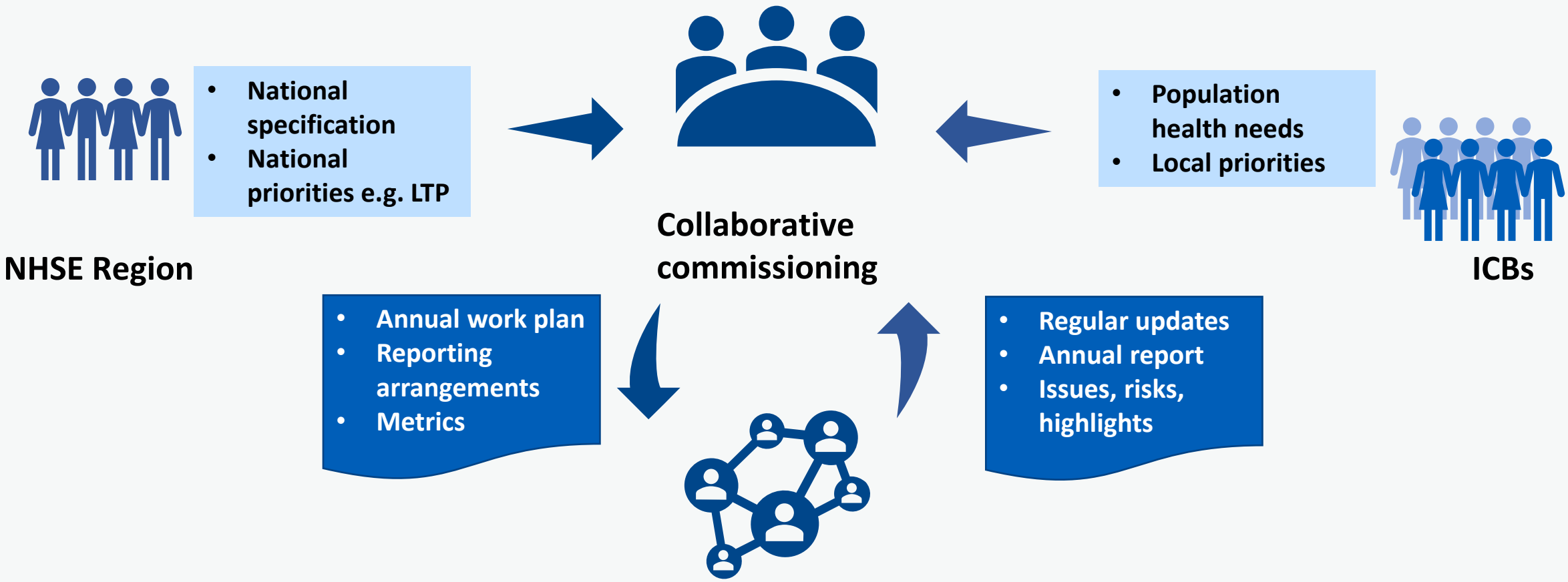
Specialised Service Transformation: Clinical Networks & examples of end to end pathway transformation

Clinical Network Commissioning



- There are 15 commissioned mandated specialised services clinical networks which are hosted by provider organisations (6 networks hosted within Barts Health. Staff are employed by those host organisations, with networks operating under a service level agreement and funding is recurrent.
- Their footprint is usually larger than individual ICBs . NHSE have therefore agreed to move to a model of joint commissioning the networks between NHSE regional teams and ICBs, ensuring network's work plan reflects national, regional and local ICB priorities which is a positive opportunity.

New ways of working: Upstream prevention to manage future Specialised service demand

- Delivery of specialised services will face a number of challenges in the future:
  - Funding for specialised services will shift from historic population-based allocation towards needs-based allocation, CFOs across London are proactively working with regional and national colleagues to clarify how the change in practice will work and also refine the methodology to understand the potential funding gap within each ICS.
  - Additionally, our population to grow by 364k people over the next 20 years, which puts pressure on specialised services, but also non-specialised services which patients may step down into e.g. level 1 specialised neuro-rehabilitation patients may eventually access community rehabilitation programmes as part of their longer-term treatment plan
- Unless **upstream programmes, improving productivity, encourage joint working and scoping consolidation**, there will be significant growth and financial challenges with specialised services across NEL.
- The NEL Specialised Services Transformation Sub Group was established earlier this year bringing together senior clinical expertise across NEL, working with our local and London Mandated Clinical Networks. Our clinicians have highlighted the best practice being achieved in a number of programmes and networks in '**joining up' the pathway which includes cardiology, cancer, children and young people programmes.**

- **OUR NEL WIDE SPECIALISED TRANSFORMATION PRIORITIES ARE: HIV, LIVER/HEP C, CARDIOLOGY/CVD, RENAL, SICKLE CELL, NEUROSCIENCES AND COMPLEX UROGYNAE**

Implemented HIV and hepatitis testing in emergency departments and work with local charities and communities to improve out-of-hospital care and reduce stigma. Since April 2022, we have identified > 100 new cases in NEL

Pharmacist led hypertension review project with Black patients. It demonstrated (48%) were not taking their medication as prescribed. In the short-term, patients adhered to their medicine and reduction in systolic blood-pressure and longer-term, we aim for patients to continue to manage their LTC proactively and not progress onto specialised services for stroke, cardiology and renal

Working with the Neonatal Clinical Network to improve quality outcomes, including reducing mortality and equity to care by expanding provision at Barts by 4 additional cots, and focusing on a longer-term plan for 1:1 care.

A quarter of London's homeless and rough sleepers are located within NEL, and chronic lung diseases have been identified as an area of concern within this community. We are working with 'in-reach services' to widen the scope and support provided by giving pulmonary rehab on-site rather than at a clinical or hospital.

Human immunodeficiency virus (HIV)

Our Challenge

- All NEL 'places' have been identified as having a very high number of HIV diagnoses (>5/1000) and on average one in 12 people living with HIV do not know they have it.
- While ED (Emergency Department) opt out testing has increased 32% over the last 12 months (55%), it is still below the national target of 90%
- Via ED opt of Testing programme, of newly diagnosed residents only 74% engage with care, while of those re diagnosed only 19% re-engage with care
- This summer, Fast Track Cities have identified that HIV community and voluntary sector is still recovering from the impact of COVID and cost of living impacting their service users, with current services reporting further demand on mental health support and financial services
- Stigma in local communities and care , along with self-stigma this is preventing people with lived exercise to access care and support

National Targets

- Towards zero for HIV transmission rates by 20230 An 80% reduction in new HIV infections by 2025
- zero preventable HIV-related deaths by 2025
- A 50% reduction in of patients diagnosed with AIDS within 3 months of diagnosis.
- A 50% reduction in the number of deaths from HIV/AIDS.
- 90% of all the identified cohort will receive a HIV blood test in ED

Our response

Working collectively with the regional specialised service team and Fast Track Cities, we are building on previous successes and collectively agreeing funding for end to end transformation proposals, which has brought together people with lived experience, community, voluntary, local authorities, primary and secondary care.
We are proactively working with Barts Clinical Reference Groups to merge governance, which will support the development and delivery of our local strategy.

Over the last 12 months, the regional specialised service programme has funded NEL £2.75m

Acute/Specialised Upstreaming

Working with place based teams, and other partners we are delivering…

- With Fast Track and Terrence Higgins Trust to educate different parts of the health and social care sector including front line staff, and Tackle internalised stigma for people living with HIV
- Positive East ran three courses aimed at women, African communities, and gay men. The courses included five sessions focusing on addressing internalised stigma, developing support networks, regaining power
- Opt out testing in all EDs in NEL and delivered circa. 250,000 HIV blood tests in ED's, which has offered 137 patients the opportunity to enter the clinical pathway
- Working with Public Health in C&H Integrating the 40+yr old Primary Care health checks into the HIV pathway
- With Positive East and local authorities to improve community pathway, which includes peer to peer support and counselling, and development of hardship fund with an aim to support people sustain care or re-arrange them with care.
- Increased clinical and non-clinical capacity to reduce follow up backlogs, with a focus on BHRUT

Initial outcomes

- Across NEL there has been 250,00 HIV blood test taken in EDs, with 60% improvement in testing rate in 2 months across 2 sites
- Staff education across our acute trusts to reduce stigma and raise awareness
- 5 WTE frontline and 2 back-office staff been recruited to increase capacity and support flow ups

Next steps

- Roll out of automised testing and 'blocking' across all acute trusts (Q4 2023/24) and improve ED opt out testing rates
- Reviewing medicines optimisation
- Increasing the number of patients who entre or re-engage with the clinical pathway
- Develop an NEL integrated HIV strategy that prioritises primary prevention, HIV testing, secondary prevention and empowerment and wellbeing

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Risks and Challenges

Risks and challenges of specialised service delegation

- With the NHSE Board approval for London to delay delegation until April 25, there is more time to map and mitigate the potential risks through the 24/25 shadow year of continued Joint Working Arrangements with NHSE London.

- London region has stipulated 4 conditions to delegation:

❖the development of a Legacy Risk Log,

❖the development of a clinical risk-based strategic framework,

❖Agreement of the future operating model with the regional specialised commissioning support team, and

❖Agree a model for multi-ICB decision making.

- Whilst there are challenges with delegation itself, there are also risks associated with delayed delegation and continued Joint Working Arrangements which have been considered from both a provider and broader system perspective.

1. Risks of delegation & delayed delegation

Risk theme	Risk description	Mitigation Plan	Risk owner
	As a result of delayed delegation, there is a risk that:		
Risks of delayed delegation	Success measures for newly imposed **regional conditions for delegation may be ill-defined** leading to an inability to lift conditions prior to April 25, specifically the strategic risk based clinical framework.	Workstreams & governance identified with a newly appointed programme lead to ensure focus	NHSE region
	Increased variation on account of a mixed economy and fragmented delegation landscape across England making it increasingly challenging to understand and mitigate the impact on London; affects London's ability to achieve the intended outcome of delegation compared to other regions.	Mutual Joint Committee membership with East of England to ensure clarity on strategic intention	Joint NHSE region/ ICB
	Developing a stable and sustainable workforce to deliver delegation tasks and accept roles and responsibilities for the specialist portfolio, on account of organisation restructuring and development of new operating models; includes reduced buy in from the current regional team (Finance & contracting)	Joint membership of finance & contracting colleagues with NHSE colleagues to NEL groups with planned workshops	ICB
Quality & transformation risks	Lack of visibility of current quality issues, means we are **unable to develop a robust quality plan with clear mitigations** in place.	Schedule speciality specific quality deep dives. Developing governance between ICB/ region on quality and transfer of knowledge.	NHSE region/ICB
	Due to unfunded activity growth, some services have significant **demand and capacity constraints** resulting in reduced or severely delayed access to life saving treatment, thus impacting quality, safety and outcomes for NEL patients.	Refresh NEL and/or North London demand & capacity, negotiating both short term contractual solutions & longer term opportunities for upstream prevention	NHSE region/ICB
	Due to handover of network oversight and developing engagement of ICB stakeholders, the **mandated London networks are not delivering objectives that are aligned to local priorities**. This may impact the networks ability to meet local population needs.	Embed clinical networks into NEL specialised transformation governance to shape direction & delivery targeted to our population. Joint commissioning will enable us to align priorities for 24/25.	NHSE/ICBs
Finance & contracting risks	The move towards a population health budget (new-ACRA supported formula), will shift **service funding away from London, potentially destabilising NEL providers** currently serving a large number of out of area patients (incentivising repatriation of simpler elements of specialised service provision, leaving London providers with a more complex case mix).	Strengthening relationships with ICBs in and outside of London. Detailed review of NEL specific impacts of cross border flows by service with mitigation being developed including coding, productivity, contractual opportunities, end to end pathway and ultimate longer term consolidation.	ICB
	If capital expenditure is not effectively joined up between ICBs and NHSE London, historic service risks may not be effectively addressed making it **increasingly challenging for the system to secure the appropriate capital investment**, particularly for muti-ICB arrangements and services with costly capital requirements.	Collaborative discussions and clear capital prioritisation	ICB/NHSE/Providers

What happens next ?

- Continued work on the end to end pathway transformation for specialised priorities ensuring continued focus on pathway improvement.
- To deliver delegation by April 25 working through the four delegation conditions with NHSE London and London ICBs, ensuring parallel work on our agreed transformation priorities, aligning with the strategic objectives of the ICB to reduce inequalities and ensure whole pathway transformation to improve outcomes and patient experience.
- We will need to enter a further year of formal joint working arrangements with NHSE, hence a revised Joint Working Arrangement (JWA) will need to be approved by the ICB Board in March.
- Work to establish clinical transformation priorities alongside statutory delegation due diligence has been undertaken but work to finalise ICB resources for delivery with NHSE resources is required as a matter of urgency.

HEALTH AND WELLBEING BOARD and ICB SUB-COMMITTEE
(Committees in Common)

10 September 2024

Title:	Adult Social Care Prevention Plan 2024-2034

Report of the Cabinet Member for Adult Social Care and Health Integration

Open Report	**For Decision**
Wards Affected: All	**Key Decision:** No
Report Author: Joanne Starkie, CQC Assurance Programme Lead	**Contact Details:** E-mail: joanne.starkie@lbbd.gov.uk

Sponsor: Elaine Allegretti, Strategic Director for Children and Adults

Summary:

The Adult Social Care Prevention Plan sets out the commitment from adult social care and the local authority to prevent, reduce and delay the need for adult care and support. It also summarises the priorities and actions from the wider partnership. To move towards effective prevention, adult social care will prioritise technology, culture change, early help and community-driven, local support.

The plan covers the next 10 years, recognising that prevention is a long-term commitment and that the impact often needs time to emerge. It will be reviewed annually to ensure it reflects changes in the wider environment and that the plan continues to align to partnership and local authority priorities and insights.

Recommendation(s)

The Health and Wellbeing Board and ICB Sub-Committee are recommended to approve the Adult Social Care Prevention Plan 2024-2034, as set out at Appendix A to the report.

Reason(s)

The plan has been developed for two reasons: Firstly, to articulate how the local authority meets the adult social care 'prevention duty' described in the 2014 Care Act; and secondly, because the need to strengthen prevention has been identified as a priority for the partnership, the local authority and adult social care. The priorities are expressed:

- In the 2023-26 Corporate Plan and the principle of 'prevention and early intervention to be applied to work across the whole council'.
- In the Joint Health and Wellbeing Strategy outcomes on early diagnosis, the wider determinants of health, managing health behaviours and long-term conditions.
- The emerging health and care system priorities for Barking and Dagenham, including 'developing a proactive and prevention approach to the delivery of services'.

1. Introduction and Background

1.1 Over 3,000 people get long-term support from adult social care each year, including older people, adults with a learning disability, mental health issue or other support needs. We also support a number of unpaid carers. Our 'vision' in adult social care is people living safe, happy, healthy lives. The Adult Social Care Prevention Plan is intended to move us towards this vision. Accordingly, the three objectives in the plan are:

- To identify and engage residents.
- To reduce crisis demand through early help.
- To increase the independence and wellbeing of local residents.

2 Proposal and issues

2.1 The proposal is for the Health and Wellbeing Board and ICB Sub-Committee (Committees in Common) to approve the Adult Social Care Prevention Plan. The plan is summarised below.

2.2 **Section 1** of the Adult Social Care Prevention Plan describes the rationale for change, our shared definition of prevention, the national and local picture and action that has been taken in recent years to progress prevention.

2.3 There is no single definition of prevention in health and care, however, the 2014 Care Act suggests prevention can be broken down into three main approaches:

- **Prevent:** Primary prevention and wellbeing. This is generally a universal offer, aimed at those with no support needs to help prevent them developing.
- **Reduce:** Secondary intervention and early intervention. This is more targeted, aimed at those with an increased risk of needing support.
- **Delay:** Tertiary prevention and formal intervention. This is aimed at minimising the effect of disability or deterioration for people with support needs.

This plan is shaped around these headings.

2.4 Strengthening prevention has been highlighted by staff, by residents and by stakeholders as an area to improve across the partnership. By strengthening prevention in adult social care, we can:

- Reduce the risk of disease, disability and death.
- Help people live safe, happy, health lives.
- Help manage a rising demand for adult social care due to a growing, ageing population with complex needs.
- Help address the significant system pressures facing adult social care.

2.5 In addition, the 2014 Care Act sets out that local authorities must ensure preventative services are provided. This prevention duty relates to adult social care and is applicable to all adults living in Barking and Dagenham. The Adult Social Care Prevention Plan describes how we are meeting the prevention duty.

2.6 **Section 2** of the plan sets out the actions that will be taken by adult social care and the local authority to reach our objectives and articulates the related priorities

and actions from the wider partnership. Actions are framed around the themes of 'prevent', 'reduce' and 'delay'. Some the actions are about continuing what we already do, whilst others require us to do things differently. To move towards effective prevention, adult social care will prioritise technology, culture change, early help and community-driven, local support.

2.7 The plan also summarises commitments and actions needed by the wider partnership to achieve success. This includes actions around the wider determinants of health, health behaviours, the development of locality and integrated neighbourhood teams, the proactive care programme and long-term condition early identification and management.

2.8 **Section 3** of the plan looks at how prevention can be measured and identifies opportunities for social care to learn from and further develop our approach. The plan notes that recognising that prevention is a long-term commitment, that it can be challenging to measure and that the impact often needs time to emerge.

2.9 When the Adult Social Care Prevention Plan has been finalised and agreed, the next steps will be to:

- Add clear timescales to the plan, including a delivery plan in year 1 with clear roles and responsibilities.
- Agree the governance of the plan.
- Articulate what a successfully delivered plan will look like from the perspective of residents and people who need social care.

2.10 The Adult Social Care Prevention Plan will be reviewed annually to ensure it reflects changes in the wider environment and that the plan continues to align to partnership and local authority priorities and insights**.**

3 Consultation

3.1 The Adult Social Care Prevention Plan has been informed by discussions with residents, people with lived experience of social care and carers over the last 12 months. Insights include the following:

- Community, families and connections are important.
- There is a need to consider the affordability of healthy lifestyles and activities.
- Information and advice helps people get issues resolved at an early stage but is often not easy to understand. It can be hard to know what support is out there and what activities area available locally.
- Help at an early stage is important and could be more accessible.
- Technology has a role to play in helping people stay well and connect with others.
- Proactive help and communication is helpful.
- The quality of conversations between staff and residents is important.
- Behaviour change takes time.

3.2 Consultation on the plan has taken place with adult social care, public health, the Adults Delivery Group and the Executive Group in April 2024. The plan has been amended in line with feedback, including:

- Clarity on the actions that will be led by social care, the local authority and by partners.
- Culture change being seen as change both within organisations and in the wider community.
- Ensuring the plan includes commitments on support that is easy to access and navigate.

4 Mandatory implications

4.1 **2014 Care Act -** As previously noted, the 2014 Care Act sets out that local authorities must ensure preventative services are provided. This prevention duty relates to adult social care and is applicable to all adults living in Barking and Dagenham. The Adult Social Care Prevention Plan describes how we are meeting the prevention duty.

4.2 **Joint Strategic Needs Assessment -** The Adult Social Care Prevention Plan has been informed by both the Joint Strategic Needs Assessment and the 2023 Director of Public Health Report.

4.3 **Health and Wellbeing Strategy -** The Adult Social Care Prevention Plan is aligned to the Joint Health and Wellbeing Strategy. In the strategy, outcomes for 'ageing well' include "be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions" and "have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious" and priorities include "addressing wider determinants of health".

4.4 **Financial implications**

Implications completed by: Amish Soni – Senior Finance Business Partner

The Adult Social Care Prevention Plan will seek to prevent, reduce and delay the need for adult care and support over the next 10 years. As suggested in Appendix A there will be an emphasis on technology, cultural change, early help and community driven support to ensure that the local authority meet the "prevention duty" outlined in the Care Act and to ensure that the prevention mechanism is strengthened.

There are no specific financial implications associated with the proposed plan as investment and changes in current ways of working will be funded within existing resources. There are currently schemes which are already geared towards prevention, namely the introduction of reablement and care tech.

It is imperative that any future proposals that have budgetary or contractual implication which are supplementary to the prevention plan are appropriately costed and budgeted for and are driven through the appropriate governance measures.

Additionally, it is important to note that as part of the annual review stated in 2.10, there should be a stock-take of any actions that may be considered to have financial effect with regards to both budget commitment and potential savings.

4.5 **Legal implications**

Implications completed by Nicola Monerville, Principal solicitor for Safeguarding, Community care and Education

One of six the core Care Act 2014 principles is prevention. It is both a principle, to encourage action to be taken by the local authority to enable adults to live independently, free from neglect, abuse and harm, and a statutory duty placed on each local authority towards every individual adult in its borough who have needs for care and support or eligible needs, no matter how long they have lived in the borough, to promote early intervention to achieve outcomes such as avoiding services, maintaining independence and preventing deterioration.

This plan clearly sets out the Council's strategic aims and objectives over the next 10 years.

4.6 **Risk management -** The Adult Social Care Prevention Plan is part of the mitigation against the following risk on the Adult Social Care Risk Register: 'Risk of ineffective and insufficient targeted activity to prevent, reduce and delay the need for care and support; resulting in increased demand for adult social care and an increase in complexity and chronicity of need'.

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

List of Appendices:

Appendix A - Adult Social Care Prevention Plan

Appendix B - Community and Equality Impact Assessment

2024-34 Prevention Plan
Adult Social Care

Barking & Dagenham

Version: 0.9
Status: Final draft to approve

one borough; one community; no one left behind

Introduction and summary

Preventing, reducing and delaying the need for social care can change the direction of people's lives. To be successful, prevention needs everyone to take action – as the root causes of care and support needs are much broader than the care system itself.

This Prevention Plan sets the commitment from adult social care and the local authority to prevent, reduce and delay the need for adult care and support over the next 10 years, as well as the priorities and actions from the wider partnership. The three objectives of the plan are:

1. To identify and engage residents.
2. To reduce crisis demand through early help.
3. To increase the independence and wellbeing of local residents.

The objectives in this plan are the same as the objectives held in relation to developing integrated, local models of working; recognising that the two are closely linked. Indeed, this Prevention Plan can be seen as part of a wider system change, interfacing with other plans that include those on health inequalities and proactive care. The plan is also part of achieving the vision in adult social care for people with support needs to lead safe, happy healthy lives; providing support that that keeps people well and as independent as possible.

The plan covers the next 10 years, recognising that prevention is a long-term commitment and that the impact often needs time to emerge. It will be reviewed annually to ensure it reflects changes in the wider environment and that the plan continues to align to partnership and local authority priorities and insights.

Section 1 of the plan describes the rationale for change, our shared definition of prevention, the national and local picture and action that has been taken in recent years to progress prevention.

Section 2 sets out the actions that will be taken by adult social care and the local authority to reach our objectives and articulates the related priorities and actions from the wider partnership. Actions are framed around the themes of 'prevent', 'reduce' and 'delay'. Some the actions are about continuing what we already do, whilst others require us to do things differently. The diagram opposite summarises these differences: To move towards effective prevention, adult social care will prioritise technology, culture change, early help and community-driven, local support.

Section 3 looks at how prevention can be measured and identifies opportunities for social care to learn from and further develop our approach.

When the priorities and actions in this Prevention Plan are agreed, further work will then be carried out to:

- Add clear timescales to the plan, including a delivery plan in year 1 with clear roles and responsibilities.
- Agree the governance of the plan.
- Articulate what a successfully delivered plan will look like from the perspective of residents and people who need social care.

Technology

Utilise tech in its broadest sense to build evidence, take targeted action, and enable residents to use care and other technology to stay well.

Culture change

Build a prevention-focused culture, where prevention is embedded in conversations and in policy.

Early help

Articulate a clear, accessible offer of support with and for people who are just below the eligibility threshold for adult social care.

Community

Develop community-driven, integrated, local support – co-producing and utilising community organisations and networks.

Section 1

Background

1. Rationale for change – why we need a plan

- **Prevention reduces the risk of disease, disability and death**. This is particularly pertinent in Barking and Dagenham, where residents suffer worse health and wellbeing than peers in most other areas of London and England. Adult social care supports a higher proportion of the population compared to the London average and adults are more likely to have a long-term health condition than their counterparts in other areas.
- **Prevention can help people live safe, happy, healthy lives.** Preventative activity can enable people to be as independent as possible and achieve the outcomes that are important to them.
- **Prevention will help us manage a rising demand for adult social care due to a growing, ageing population with complex needs**. A focus on prevention and managing demand will ensure that the right resources are there for people when they need more intensive care and support. This focus will also help prevent the breakdown of unpaid care, recognising that the same drivers of increased demand for support will mean a potential increase in demand on unpaid carers. As stated in the 2023 Director of Public Health report: "Driving our social care demand is essential to how we effectively manage the local system. Early intervention and diagnosis are critical to deal with issues before they impact negatively on a person's health and wellbeing and the wellbeing of the community".
- **Prevention will help us address the significant financial and system pressures facing adult social care**. The cost of late intervention is estimated at £16.6 billion per year across the UK (source). Putting a focus on prevention aims, in the long term, to decrease the demand for high-cost services which will lead to reduced use of resources and lower costs.

Summary of health and care needs

- Approximately 219,000 people live here - an increase of 18% in ten years. We have high levels of 'churn' and the population is expected to grow further in future.
- 3,045 adults received long-term support through 2022-23 from adult social care. We support a higher proportion of our older residents compared to the England average and, as a young borough, supporting working-age adults with support needs has been a particular area of growth in recent years.
- There are an estimated 14,000 unpaid carers in the borough, and only a small proportion access support. The number of unpaid carers and the level of care they provide may increase in tandem with an increased demand for support.
- The experiences of our communities, residents, people who need social care and carers make it clear that we need to put a focus on engagement, early help and promoting independence. Insights are summarised in Section 4.
- Healthy life expectancy from birth was 58 years for men and 60 years for women in 2018-20, compared to a London average of 63.5 and 64 years respectively
- The wider determinants of health – social isolation, housing, employment, deprivation – are challenges in LBBD overall and for people who need social care. Environment and wider determinants of health determine 50% of poor health.
- Health behaviours, particularly smoking and poor diet and physical activity, are challenges in the borough. Health behaviours determine 30% of poor health.
- Long-term conditions are a major driver of health and social care needs. An estimated 38,000 cases are unidentified and therefore unmanaged.
- Multiple unhealthy behaviours and health conditions makes supporting individuals more complex and costly. An estimated 13% of LBBD residents have two or more health conditions. Research highlights the importance of services taking a holistic approach.

2. Definitions and scope

Definition

The focus of this plan is around preventing adults' support needs from developing or increasing; recognising that this can improve the quality of people's lives and reduce demand on services.

There is no single definition of prevention in health and care – and none is provided in statutory social care guidance - which can make it challenging to understand the current picture and agree future action. However, the 2014 Care Act provides a useful framework for understanding prevention. Statutory guidance suggests prevention can be broken down into three main approaches:

- **Prevent:** Primary prevention and wellbeing. This is generally a universal offer, aimed at those with no support needs to help prevent them developing
- **Reduce:** Secondary intervention and early intervention. This is more targeted, aimed at those with an increased risk of needing support
- **Delay:** Tertiary prevention and formal intervention. This is aimed at minimising the effect of disability or deterioration for people with support needs.

This plan is shaped around these headings.

Scope

This Prevention Plan is focused on adult social care and action to prevent, reduce and delay adults from developing care and support needs. However, successful prevention in adult social care requires action to be taken across the local authority, partners and communities. For this reason, the plan articulates both social care and wider partnership actions and commitments.

Whilst the focus is on adults, effective long-term prevention needs to start young, particularly when looking at the wider determinants of physical and mental health and adverse childhood experiences. This plan should therefore be considered as part of a wider, life-course approach to prevention, with the actions for children and young people articulated in the partnership 'Best Chance' strategy.

Finally, as previously noted, the plan covers a 10-year period in recognition that prevention is a long-term commitment and that the impact often needs time to emerge. However, the plan will be reviewed annually to ensure it reflects changes in the wider environment and that the plan continues to align to partnership and local authority priorities and insights.

3. The national policy picture

This section summarises both local authority statutory duties on prevention and the wider policy and research environment across health and social care:

- **2014 Care Act.** The Care Act is core legislation in adult social care. The Act describes our statutory duties in relation to prevention, setting out that local authorities must ensure preventative services are provided. This prevention duty relates to adult social care and is applicable to all adults living in Barking and Dagenham.
- **2023 National Major Condition Strategy** case for change and strategic framework focuses on prevention, earlier diagnoses and treatment for six groups of major health conditions responsible for 60% of death and illness in England: cancers; cardiovascular disease, musculoskeletal disorders, mental ill health, dementia and chronic respiratory disease.
- **2019 NHS Long Term Plan** sets out new commitments for action that the NHS itself will take to improve prevention, including in relation to smoking, obesity, alcohol, air pollution and health inequalities. The plan confirms the role of the NHS in secondary prevention, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life.
- **A 'Prevention is Better than Cure' government vision** was published in 2018, highlighting the importance of prevention being at the heart of health. This was followed by a government consultation in 2019 that has not since progressed.
- **Research** – Whilst research has been carried out on a number of issues relevant to prevention, there is limited national research on prevention in adult social care specifically. The Social Care Institute for Excellence notes that "Evidence about what works in prevention remains under-developed so local policy-makers lack information about how best to invest their resources (Allen and Glasby, 2013; Miller and Allen, 2013; Curry, 2006 reported in Marczak et al. 2019)."

4. The local picture

This Prevention Plan is part of a wider, system-wide approach and commitment to prevention – articulated in a range of wider plans that are summarised below:

- **Joint Health and Wellbeing Strategy**. Outcomes for 'ageing well' include "be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions" and "Have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious" and priorities include "Addressing wider determinants of health".
- **System priorities for Baking and Dagenham 2024-24.** Draft health and care partnership priorities are:
  - Development of locality and integrated neighbourhood teams across health, care and community / voluntary sector partners taking an all-age approach; and
  - Developing a proactive and prevention approach to delivery of services.
- **Adults and Communities Strategy 2024**: Work has started to develop a partnership strategy to articulate shared priorities and how we will achieve these with communities. This Prevention Plan forms part of this wider strategy.
- **The 2023-26 Corporate Plan** from the local authority includes a principle of 'prevention and early intervention' to be applied to work across the whole council.
- **Adult social care vision and values:** The vision for adult social care in Barking and Dagenham is living safe, happy, healthy lives, with support that keeps people well and as independent as possible.
- **2023 Adult social care improvement plan:** The improvement plan includes actions to prioritise prevention.
- **Director of Public Health report 2023** recommends shared outcomes on three topics, one of which is: "Preventing and managing long term conditions, ensuring early diagnosis and pathways are clear to support early intervention",
- **Joint Strategic Needs Assessment 2023** includes information on current health and care needs in the borough.

Insights and people's experiences

Insights from residents, people with lived experience of support and partners in relation to prevention include the following:

- Community, families and connections are important.
- There is a need to consider the affordability of healthy lifestyles and activities.
- Information and advice helps people get issues resolved at an early stage but is often not easy to understand. It can be hard to know what support is out there and what activities area available locally.
- Help at an early stage is important and could be more accessible.
- Technology has a role to play in helping people stay well and connect with others.
- Proactive help and communication is helpful.
- The quality of conversations between staff and residents is important.
- Behaviour change takes time.

5. What action has been taken so far?

A range of work has been carried out over the 12 months to lay the foundations of this plan. This includes:

5.1 Gathering expert insights

- An adult social care prevention needs assessment was carried out in November 2023, summarising local evidence and needs.
- A peer review of care and health support to adults with a learning disability and autism took place in February 2024.
- Insight work into how to develop the front-door of adult social care was carried out in March 2024.
- A programme engagement with partners, residents and people with lived experience of care has taken place over the last year to understand what works well and where improvements are needed.

5.2 Reviewing core activity and plans

- A review of the Better Care Fund is being planned for 2024.
- Work has started to develop an umbrella partnership Adults and Communities Strategy, of which this Prevention Plan forms part.

5.3 Strengthening joint working

- Joint working between health, social care and community partners has been strengthened through our place-based partnership, the work and emerging priorities of the Adults Delivery Group.
- Work to strengthen early help through developing integrated, locality-based multi-disciplinary teams has started, and work to develop integrated commissioning is underway.

5.4 Developing technology

- Over the last year, social care has changed from offering only Careline to offering a wider range technology-enabled care focused on data-led prevention, used by over 3000 residents.

5.5 Insights and improvements in adult social care

- The Adult Social Care Improvement Plan was agreed in October 2023 and is now being implemented. This includes improvements to information and advice related to social care, via website updates, new printed information and developing the ‘front door’ of adult social care.

Section 2

Prevent, reduce and delay

6. Primary prevention

Definition Primary prevention is generally a universal offer open to all, aimed at those with no support needs to help prevent them developing.

What do we need to think about? Preventing care needs from developing means working as a whole system and acting at an early stage.
The wider determinants of health and health lifestyles are both critical issues, particularly given that the environment and wider determinants determine 50% of poor health and health behaviours determine 30%

Technology	Culture change	Early help	Community
1. **Care technology**: Develop a comprehensive universal care technology offer aimed at preventing care needs developing. 2. **Information:** Produce new information for residents on digital technology that supports health and wellbeing, and how residents can access this directly.	4. **Conversations**: Agree and roll out training so prevention and strengths-based practice is embedded in resident conversations. 5. **Staff in universal services:** Upskill staff working in council universal services to focus on working with communities at an early stage, through training and support 6. **'Prevention first' culture:** Agree actions to further build a prevention-first culture with council staff and residents, utilising community organisations and networks. This can include self-care, resilience and how and when to get support.	8. **Health in all policies**: Work with public health to ensure a 'health in all policies' approach across the local authority. 9. **Wider determinants**: Work with colleagues to agree and carry out plans to improve social isolation, housing and employment. 10. **Health behaviours**: Work with colleagues to carry out plans to tackle smoking and obesity as primary risk factors associated with health conditions with high levels of prevalence in the borough, co-deigning healthy lifestyles support with communities. 11. **Planning:** Use research on demographic change to prepare and plan for future social care demand.	12. **Information:** Develop more local, accessible information on staying well with communities, targeting people with low health literacy. This includes via an online community and family hubs site. 13. **Universal activity:** Review universal and/or community wellbeing activities (e.g. council resident events) so healthy lifestyles promotion is built-in. 14. **Access:** Work with communities to continually understand and improve access to support services.

Partnership action: The partnership action needed in this area relates to the wider determinants of health, health behaviours, tackling health inequalities, promoting culture change through information and advice, and improving access to early help.

7. Reduce

Definition Secondary intervention and early intervention. This is more targeted, aimed at those with an increased risk of needing support.

What do we need to think about? Reducing care and support needs by targeting those at-risk means working closely with communities and continually using evidence and insights to make a difference. It also means ensuring there is robust support to unpaid carers. Early intervention is important here, particularly as long-term conditions are a major driver of health and social care needs, and that an estimated 38,000 cases are unidentified and therefore unmanaged.

Technology	Culture change	Early help	Community
1. **Proactive, predictive approaches**: Develop an approach or tool that utilises data and insights and enables proactive outreach, helping people at-risk before needs develop. 2. **Share knowledge**: Keep up-to-date on changes in digital technology that can support targeted prevention work.	2. **Targeting in adult social care:** Develop resources and training so staff – including those in the 'front door' of adult social care - can provide targeted information and advice on self-care and early help.	3. **Early help from social care**: Articulate and develop the early help offer for residents from social care. This includes information and advice, equipment, adaptations, technology, and support to connect with communities. 4. **Focus on reablement and intermediate support:** Develop reablement as a robust early help offer to support people to regain independence. 5. **'Below threshold' offer:** Articulate and develop the offer for people with support needs who are just below the threshold for social care to stay as independent as possible. This includes older people, people with complex needs, with a learning disability or autism. 6. **Unpaid carers:** Carry out the Carer Charter so carers have information and advice to help them look after their own mental and physical health, are supported to maximise their income and to continue to work or study. 7. **Falls prevention:** Work with health colleagues to implement the Falls Prevention Delivery Plan. 8. **Early diagnosis**: Work with partners to improve the detection and diagnosis of long-term conditions.	9. **Locality model:** Build targeted prevention into plans for integrated locality and neighbourhood teams, asset based-community development and coproduction with communities – so early help is easy to access. 10. **Social prescribing:** Work with colleagues to develop the role of social prescribers to put the right early help in place with communities.

Partnership action: The partnership action needed in this area relates to delivering the Carer Charter Action Plan, the development of locality and integrated neighbourhood teams, falls prevention, and long-term condition identification and support. There are also interfaces with NEL Joint Forward Plan aims to invest in primary care resources and infrastructure.

8. Delay

Definition Tertiary prevention and formal intervention. This is aimed at minimising the effect of disability or deterioration for people with support needs.

What do we need to think about? Delaying the need for greater support for people with support needs means taking a proactive and holistic approach, recognising that people often have complex issues and multiple health conditions and focused on supporting people to be as independent as possible.

Technology	Culture change	Early help	Community
1. **Care technology:** Develop a comprehensive range of care technology aimed at people with support needs being as independent as possible. 2. **Integrated data:** Integrate data and insights from care technology and elsewhere into a single system, enhancing holistic support to people with support needs.	3. **Holistic approaches**: Provide support to staff to take a holistic approach when working with people with complex needs. 4. **Complex needs:** Share good practice and learning on how best to support people with complex needs to be as independent as possible.	5. **Wider support:** Work with communities and colleagues to enable wider community support and connections for people with support needs (e.g. peer support). 6. **Healthy lifestyles and social care**: Work with colleagues to articulate a clear offer of healthy lifestyle support targeted people using adult social care. 7. **Support from adult social care:** Ensure prevention is core part of future social care commissioning – including reablement, homecare, direct payment support, equipment and adaptations, and accommodation-based support. 8. **Unpaid carers**: Carry out the Carer Charter Action Plan so carers can access a range of support, including breaks from caring.	9. **Proactive care**: Work with health partners to carry out the proactive care programme, to provide personalised and co-ordinated support and interventions for people living with complex needs. 10. **Direct payment market**: Co-design community support with adults with a learning disability or autism to develop a community-led market for people with a direct payment in social care. 11. **Local, community care:** Build prevention into plans to develop more integrated support available in local communities – making sure early help is easy to access.

Partnership action: The partnership action needed in this area relates to delivering the Carer Charter Action Plan, the development of locality and integrated neighbourhood teams, the proactive care programme and long-term condition support and management. There are also interfaces with hospital admission avoidance work.

Section 3

Understanding and measuring prevention

9. Understanding and measuring the impact

A 2019 research report from the London School of Economics report looks at the effectiveness of preventative activity related to social care and concludes:

- There is currently limited evidence on the effectiveness and cost-effectiveness of preventative activity related to adult social care.
- Existing evidence is concentrated on reablement, telecare, falls prevention and wellbeing/isolation.
- The report notes that this lack of evidence 'may lead to underinvestment in prevention in the current climate of financial austerity with long-term negative consequences for the users' outcomes and the effectiveness of the system'.
- The challenges with measuring the effectiveness of preventative action include:
  - It is difficult to measure what would have happened without the activity, and to establish cause-and-effect given the impact of other factors.
  - The impact of some interventions is likely to take considerable time to emerge.
  - There is no consensus on what prevention is, making it harder to build a comprehensive evidence base.
  - Prevention often needs system-wide action that requires system-wide measurement.
- The report notes that "there is an untapped potential to employ experimental set-ups and control groups when piloting new interventions".

Measuring the impact of specific initiatives

New initiatives carried out through this plan will consider experimental set-ups and control groups in order to more effectively evaluate the impact of new preventative activity.

Understanding the impact of the Prevention Plan

The three core contextual measures to monitor over the lifetime of the plan are:

- Healthy life expectancy in Barking and Dagenham
- People receiving long-term adult social care as a percentage of the population
- The percentage of adult social care users who say support improves their quality of life.

Once the Prevention Plan has been finalised, a more detailed set of contextual measures to understand the current picture and how it is changing over time will be agreed.

10. Opportunities for learning

At the end of 2023, a partnership Prevention Task and Finish group identified three key areas of focus in relation to prevention:

- Social isolation.
- Early diagnosis and intervention.
- Learning disability and autism.

Work is going on across the partnership on each of these areas, providing an opportunity for learning for social care (and partners) in relation to prevention.

Social isolation

42% of respondents to a 2022 survey sent to social care users in Barking and Dagenham said they have as much social contact as they want. 15% said they were often or always lonely – compared to 8% of the general population in a 2024 ONS survey. People who need adult social care are more likely to have loneliness risk factors, including health conditions, older age or being an unpaid carer.

Insights and work to be carried over 2024 by Care City and the wider B&D Collective is focusing on social isolation following hospital discharge and is likely to have wider applicability, informing how we can tackle social isolation and loneliness overall in social care. Actions to tackle social isolation suggested by the Task and Finish Group included further utilising digital technology, improving the quality of conversations between staff and residents, ensuring people know what local activities and out there, and ensuring the built environment promotes social connections.

Early diagnosis and intervention

As previously noted, long-term conditions are a major driver of health and social care needs, and an estimated 38,000 cases are unidentified and therefore unmanaged. The GP registered population with mental illnesses is much lower than estimates, raising the question of potential unmet need. 548 adults with mental health as a primary need got long-term support from adult social care in 2022-23.

Actions arising from the 2023 Director of Public Health Report provide an opportunity for learning for social care in relation to prevention. Additional actions suggested by the Prevention Task and Finish group included monitoring the impact and outcomes of targeted resident health and wellbeing pop-up events, ensuring people know where to go for help at an early stage, and improving health literacy.

Learning disability and autism

There are an estimated 3,271 adults with a learning disability in Barking and Dagenham, of which 753 have a moderate or severe disability, and an estimated 1.527 autistic adults (PANSI). 518 adults with a learning disability as a primary need got long-term support from adult social care in 2022-23.

Many of the actions articulated in this plan will directly impact on adults with a learning disability and autistic adults. In addition, linked strategies for adults with a learning disability and/or autism will be developed over 2024. Emerging priorities are listed below, and will provide an opportunity to test and learn from preventative approaches:

- Improving understanding and acceptance of learning disability and autism
- Improving accessibility
- Improving housing
- Improving employment
- Improving the transition to adulthood
- Having a clear pre- and post- autism diagnosis support offer
- Ensuring there are targeted health interventions.

Appendix I: Inequalities summary

Wider determinants of health

- **Employment:** Regional insights indicate that people aged 16-24, people who are disabled and people from a Bangladeshi, Black “mixed/multiple” and “other ethnic groups are more likely to be unemployed.
- **Overcrowding:** Research indicates that people of a Bangladeshi, Pakistani or Black African ethnic background experience higher rates of overcrowding.
- **Social isolation:** People with a disability or long-term health condition, people going through a ‘disruptive life event’ (e.g. bereavement, unemployment, migration) are more likely to experience social isolation. Personal risk factors include being aged 16-24 or over 50, being LGBT+ or being an unpaid carer.

Mental health

- People from deprived areas, LGBT+ people, older people, people with a long-term condition or learning disability are at a higher risk of mental health issues.
- Other risk factors include discrimination, child neglect and abuse, unemployment, poor quality work, debt, drug and alcohol misuse, homelessness, loneliness and violence.
- People from Black, Asian or minority ethnic backgrounds are less likely to engage with mental health services other than at a time of crisis.
- Locally, there is evidence indicating Asian ethnicities are underrepresented in mental health referrals by 12% and in admissions by 15% (NEL MHLDA Provider Collaborate Report, 2024)

Healthy life expectancy and long-term conditions

- The prevalence of multiple conditions is higher, and the age of onset is younger in those living in more deprived areas. There is currently a 6.4-year difference in healthy life expectancy between the least and most deprived males and a 5.8-year difference between the least and most deprived females with the borough (2023 DPH report).
- The likelihood of having one or multiple long-term conditions increases with age. One report suggests a picture of earlier frailty in LBBD. (NIHR, frailty among older adults, 2020).
- Residents of Black ethnicities develop a long-term health condition over five years earlier than their White neighbours (2023 DPH report)
- Life expectancy and deaths from certain diseases (e.g. morbidity in cancer, dementia and Alzheimer’s) are highest in White residents (2023 DPH report).
- The 2021 Census indicates that a significant proportion of the local population originate from Romania and Lithuania. It may be useful to look in more detail at the health needs and experiences of these communities, building on a previous 2010 report.
- Self-reported health is a key indicator for healthy life expectancy. Self-reported bad health is more prevalent in LBBD for those aged 65+ and people of a White British ethnic background (the two are possibly linked). Self-reported bad health was most likely to be reported in Becontree, Heath, Parsloes and Valance wards (2021 Census)
- Demographic change in LBBD indicates that those aged 35-39 make up a significant proportion of the population. This cohort will soon enter the age band at which long term conditions often appear.
- The proportion of the LBBD population from an Asian ethnic background increased from 15.9% in 2011 to 25.9% in 2021. As members of the Asian ethnicity are overrepresented in certain long term health conditions, such as diabetes, this demographic change will affect public health need within the borough

Interfaces

- There are many interfaces between the risk factors described here. For example, there is evidence that physical and mental health are closely connected and affect each other through a number of pathways.

Appendix II: Adult social care activity - summary

- In 2022/23 in Barking & Dagenham, 3,045 adults received long term support through the council during the year. 1,275 were aged 18-64, and 1770 were aged 65+.
- This equates to 9.3 adults per 1,000 aged 18-64 and 91.1 adults per 1,000 aged 65+ received long term support during the year. The figures for England are 8.5 and 51 respectively.
- The number of clients in long-term support as a proportion of the population has grown slightly between 2017-18 and 2022-23. The figure is slightly higher than the England benchmark overall. Our 65+ clients in long-term support as a proportion of the population has benchmarked high for a number of years (see below tables).
- 6419 contacts were made with the Adult Intake Team in 2022-23, of which 26% led to an adult social care or safeguarding referrals. 1239 referrals to adult social care were made in 2022-23
- Requests for support as a percentage of the population is higher than England and London benchmarks, although the local figure has been decreasing in recent years.
- Spend and outcomes in relation to short-term support was comparatively low in 2022-23, likely impacted by both recording and service design. Work to pilot and develop reablement in 2023-24 is intended to help address this.

Clients in long-term support as % of population	
LBBD – 2017-18	LBBD – 2022-23
1.78%	1.96%
England – 2017-18	England – 2022-23
1.96%	1.87%

Ranking against all LA's – clients in long-term support as proportion of population		
Aged 18+	Aged 18-64	Aged 65+
57	43	9

Community and Equality Impact Assessment

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

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

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

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

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

About the service or policy development

Name of service or policy	Adult Social Care Prevention Plan
Lead Officer Contact Details	Joanne Starkie Joanne.starkie@lbbd.gov.uk

Why is this service or policy development/review needed?
An Adult Social Care Prevention Plan has been developed to articulate and strengthen how the local authority is meeting its statutory duty to prevent, reduce and delay the need for care and support. The rationale for change described in the plan is that: - Prevention reduces the risk of disease, disability and death - Prevention can help people live safe, happy, healthy lives - Prevention will help us manage a rising demand for adult social are due to a growing, ageing population with complex needs - Prevention will help us address the significant financial and system pressures facing adult social care.

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

What impacts will this service or policy development have on communities? Look at what you know. What does your research tell you? Please state which data sources you have used for your research in your answer below *Consider:* • National & local data sets • Complaints • Consultation and service monitoring information • Voluntary and Community Organisations • The Equality Act places a specific duty on people with 'protected characteristics'. The table below details these groups and helps you to consider the impact on these groups. • It is Council policy to consider the impact services and policy developments could have on residents who are socio-economically disadvantaged. There is space to consider the impact below.
The plan aims to have a positive impact on: - All residents in the borough – through primary prevention, which is defined as generally a universal offer open to all, aimed at those with no support needs to help prevent them developing. - Adults at risk of developing social care needs – through secondary intervention and early intervention. - Adults getting support from adult social care – through tertiary prevention and formal intervention aimed at minimising the effect of disability or deterioration for people with support needs. Looking at each group in more detail:

- **All residents in the borough**
- 2021 Census information has been analysed to understand the demographics of the borough.
- Appendix I in the Prevention Plan describes disparities by protected characteristic in relation to the wider determinants of health, based on national research and local insights. In terms of employment, people aged 16-24, people who are disabled and people from a Bangladeshi, Black “mixed/multiple” and “other ethnic groups are more likely to be unemployed. Looking at housing, people of a Bangladeshi, Pakistani or Black African ethnic background experience higher rates of overcrowding in housing. Looking at social isolation: People with a disability or long-term health condition, people going through a ‘disruptive life event’ (e.g. bereavement, unemployment, migration) are more likely to experience social isolation. Personal risk factors include being aged 16-24 or over 50, being LGBT+ or being an unpaid carer.
- This information will be used to inform primary prevention approaches.

- **Adults at risk of developing social care needs**
- Appendix I in the Prevention Plan and the Prevention Needs Assessment that informed the plan identifies groups at risk of developing social care needs by protected characteristic.
- This includes people from deprived areas, LGBT+ people, older people, people with a long-term condition or learning disability being at a higher risk of mental health issues.
- The prevalence of multiple conditions is higher, and the age of onset is younger in those living in more deprived areas.
- The likelihood of having one or multiple long-term conditions increases with age.
- Residents of Black ethnicities develop a long-term health condition over five years earlier than their White neighbours.
- Life expectancy and deaths from certain diseases (e.g. morbidity in cancer, dementia and Alzheimer’s) are highest in White residents.
- Self-reported bad health is more prevalent in LBBD for those aged 65+ and people of a White British ethnic background (the two are possibly linked).
- This information will be used to target early intervention activity.

- **Adults at risk of developing social care needs**
- 3,045 adults received long-term support from adult social care in 2022-23.
- 59% were women and 41% were men.
- 56% were aged 65 or over and 44% were aged 18-64 years.
- 31% were of a White British ethnic background, 26% were of an Asian/Asian British ethnic background, 21% were of a Black/Black British ethnic background and 14% were of a ‘White Other’ ethnic background.
- The nature of adult social care is such that a significant proportion of people will have a disability. In 2022-23, 17% had a learning disability, 18% needed support primarily due to mental health, 15% needed support primarily due to memory and cognition and 48% needed physical or personal care support.
- Recording on our Liquid Logic system of the following protected characteristics is insufficient to produce meaningful data on religion or belief, gender reassignment, sexual orientation, martial status or pregnancy or maternity.
- Prevention Plan actions aimed at delaying the need for care and support will impact these groups.

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

Potential impacts	Positive	Neutral	Negative	What are the positive and negative impacts?	How will benefits be enhanced and negative impacts minimised or eliminated?
Local communities in general	X				The plan includes commitments and actions aimed at all residents, to prevent care and health needs developing.
Age	x				The plan includes actions aimed at older people, as a group more likely to develop care and support needs.
Disability	x				The plan includes actions aimed at people with a disability, as a group more likely to develop care and support needs.
Gender reassignment	x				The plan does not include specific commitments targeted at gender reassignment. However, commitments to tackle the wider determinants of health and improve access to healthcare should have a positive impact on people with a gender identity different to the sex assigned to them at birth.
Marriage and civil partnership		x			There is no perceived differential impact based on this characteristic
Pregnancy and maternity		x			There is no perceived differential impact based on this characteristic
Race (including Gypsies, Roma and Travellers)	x				The plan includes commitments to target preventative activity at those most at risk of developing health and care needs. This includes targeting people of different ethnicities, as detailed in Appendix I of the plan.
Religion or belief		x			There is no perceived differential impact based on this characteristic
Sex	x				The plan does not include actions that are specific to women or men. However, the commitments in the plan will be delivered with an understanding of how care and health needs vary according to sex and will be targeted accordingly (e.g. early diagnosis of conditions that are more prevalent in men and women)
Sexual orientation	x				The plan does not include specific commitments around sexual orientation. However, commitments to tackle the wider determinants of health and improve access to healthcare should have a positive impact on people who identify as LGBT+, as described in Appendix I of the plan.

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

Socio-economic Disadvantage	x				The plan includes commitments to target preventative activity at those most at risk of developing health and care needs. This includes targeting people living in more deprived areas as detailed in Appendix I of the plan.
Any community issues identified for this location?		x			No

2. Consultation.

Provide details of what steps you have taken or plan to take to consult the whole community or specific groups affected by the service or policy development e.g. on-line consultation, focus groups, consultation with representative groups. If you have already undertaken some consultation, please include: • Any potential problems or issues raised by the consultation • What actions will be taken to mitigate these concerns
Formal consultation on the Prevention Plan has not taken place, however, the plan has been informed by the views and experiences of residents and people who use social care. These insights are summarised in Section 4 of the plan. They were gathered via a range of mechanisms, including: - Conversations with residents carried out as part of the development of the planned Adults and Communities Strategy - Meetings with people with lived experience of social care, carried out over the last 12 months. - Survey results from the annual adult social care survey and carer survey (sent to people getting support). Insights do not indicate any concerns with strengthening prevention but do indicate what actions to prioritise. Further engagement will be carried out in the delivery of the plan. In addition, engagement on the Prevention Plan has been carried out via the health and care partnership, who have commented on and agreed the Prevention Plan.

3. Monitoring and Review

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

Action	By when?	By who?
In line with Section 9 of the Prevention Plan, we will develop a more detailed set of contextual measures to understand the current picture on health and care needs and how it is changing over time. Protected characteristics will be incorporated into this.	December 2024	Joanne Starkie

COMMUNITY AND EQUALITY IMPACT ASSESSMENT	

How will you review community and equality impact once the service or policy has been implemented? *These actions should be developed using the information gathered in **Section1 and 2** and should be picked up in your departmental/service business plans.*		
The Prevention Plan will be reviewed annually. This review will include a review of the community and equality impact, using qualitative (e.g. resident insights) and quantitative insights.	September 2025 then annually	Joanne Starkie

4. Next steps

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

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

Implications/ Customer Impact
An Adult Social Care Prevention Plan has been developed to strengthen how the local authority prevents, reduces and delays the need for care and support. This is intended to have a positive impact on all residents through tackling health inequalities and reducing and delaying the risk of disease, disability and avoidable death. The plan includes commitments to target those most at risk of develop care and health needs and those already receiving care. This includes older people, people with disabilities, people living in more deprived areas and people of a Black, Asian or minority ethnic background. It also includes people of different ages and ethnic backgrounds, depending on the issue being targeted. Research indicates that people with a gender identity different to the sex assigned to them at birth and people who identify as LGBT+ can experiences barriers in accessing healthcare and challenges around the wider determinants of health (e.g. social isolation). In tackling the wider determinants of health and in aiming to improve access to health and care services, the plan will also have a positive impact in relation to gender reassignment and sexual orientation.

5. Sign off

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

Name	Role (e.g. project sponsor, head of service)	Date
Susanne Knoerr	Interim Operational Director, Adult Social Care	12/08/2024

HEALTH AND WELLBEING BOARD and ICB SUB-COMMITTEE (Committees in Common)

10 September 2024

Title:	**Barking and Dagenham Joint Strategic Needs Assessment 2023/24**
Report of the Cabinet Member for Adult Social Care and Health Integration	
Open Report	**For Decision**
Wards Affected:	**Key Decision:** Yes
Report Author: Neha Shah, Consultant in Public Health Bianca Hossain, Senior Public Health Analyst Richard Johnston, Public Health Analyst Chrisa.Tsiarigkli, Interim Snr Public Health Analyst	**Contact Details:** E-mail: neha.shah@lbbd.gov.uk E-mail: chrisa.tsiarigkli@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	

Summary:

It is a statutory duty for Joint Health and Wellbeing Boards to produce Joint Strategic Needs Assessments (alongside Joint Health and Wellbeing Strategies) that address population health needs and inform strategic commissioning across the partnership.

The resource is used by council, NHS and VCFSE colleagues to support strategic planning and prioritisation of resources.

Recommendation(s)

The Health and Wellbeing Board and ICB Sub-Committee are recommended to:

(i) Approve for publication the Joint Strategic Needs Assessment 2023/24 at Appendix A to the report; and

(ii) Provide feedback on the proposed schedule for the next full JSNA and deep-dive Needs Assessments.

Reason(s)

It is the statutory responsibility for the HWBB to ensure a JSNA is published for its local area and ensure local plans reflect the needs identified within it.

1. Introduction and Background

1.1 The JSNA 2022 was previously conducted as a joint collaboration between Barking Havering and Redbridge and was published in late 2022 via council website. The Barking and Dagenham JSNA 2023/4 reflects the agreed partnership priorities in the Joint Health and Wellbeing Strategy 2023-28 and the key recommendations of the Annual Director of Public Health Report 2023. Rather than providing discrete recommendations within the document, the JSNA will

provide the data to support the delivery of the Joint Health and Wellbeing Strategy; and is designed to be read alongside the Annual Director of Public Health Report 2023 (ADPHR). Sections are focussed on the overall desired outcome of improving health life expectancy and give an overview of relevant data. A key findings and public health advice section is included at the end of each main subsection.

1.2 A consistent approach to comparison has been applied across the document with performance against London and England averages and the three North East London Boroughs that are also statistical neighbours similar in socioeconomic profile (Waltham Forest, Hackney, Tower Hamlets).

2. Proposal and Issues

2.1 The JSNA will be published following approval by the Committees in Common.

2.2 Findings will be used to inform developing priorities across the Barking and Dagenham Place partnership, Adults and Communities Strategy and local delivery plans.

2.3 There is scope to produce further visuals and slide sets to support partners in their work following publication.

Future JSNAs and Deep Dive Needs assessments

2.4 A new approach is proposed where, given limited annual difference in overall trends, the refresh of the full borough JSNA is carried out on a 3-5 year basis in alignment with the Joint Health and Wellbeing Strategy. In the interim a series of deeper dive analyses and Needs Assessments will be planned by the public health intelligence team to support focussed work across the Barking and Dagenham partnership.

2.5 At present the following areas are being considered and we invite further suggestions for future work:

- Mental Health and wellbeing: Understanding unmet need and community approaches, aligning data on wider determinants with clinical metrics, audit on suicides.
- Targeted inequalities analysis/synthesis: to address inequalities in access and outcomes aligned to a discrete number of core priorities for partnership action
- Social care: Analysis of future needs projections based on population changes; scoping potential aligned analyses supporting joint work across health and social care

Key Messages

2.6 Healthy life expectancy is a measure of the number of years a child born today can expect to live in good health and is determined by risk of death and health status throughout life. In the five years to 2020, there was no improvement in healthy life expectancy at birth in Barking and Dagenham despite improvements

being seen in neighbouring boroughs and London across this timeframe, and we remain one of the worst performing areas in the country.

2.7 There are a number of factors that contribute to the lack of improvement in healthy life expectancy in recent years: demands of a growing population and increasingly diverse, widening inequalities due to impacts of the pandemic and the cost of living crisis; and the need to harness a system wide approach to improving health.

2.8 The ADPHR 2023 recommends that partners across Barking and Dagenham should agree to outcomes aligned to reducing the gap in both female and male healthy life expectancy, with a key focus on priority areas:

1) Preventing and managing long term conditions, ensuring early diagnosis and pathways are clear to support early intervention. Locally there are high rates of preventable mortality, largely due to cancer and cardiovascular disease but many causes of death do not fall into these areas needing preventative action across the spectrum of conditions. Data also suggests many people with conditions are not accessing the care they need.
2) Reducing high levels of obesity and continuing to reduce rates of smoking through targeting services to those who need is greatest as well as developing wider system working. This includes addressing low rates of physical activity and poor nutrition.
3) Improving the number of children achieving a good level of development by five.

2.9 Residents in Barking and Dagenham are more likely to live in unhealthy environments with easy access to fast food outlets, pubs, tobacconists, gambling outlets and less access to green space / with rates of air pollution. With the growing population and new residential developments comes the need to address access to health care and health promoting environments including not creating inequalities across the changing borough; and the need to focus on the early years. Rising rates of suicide and poor birth and early development outcomes signify the need for cross-cutting preventative action.

2.10 Lastly, residents need to be supported to take action to improve health and make supportive connections within their communities: local residents have the worst levels of health literacy and numeracy in the country; and whilst overall reported wellbeing levels are good, in 2019/2020 1 in 4 surveyed residents reported feeling lonely all or some of the time and wellbeing amongst children and young people is worsening.

2.11 We will not shift the dial on the poor healthy life expectancy experienced by residents without aligned action on early diagnosis and care of known conditions, and action on the building blocks of health (environment, housing employment and good mental wellbeing), working with our communities.

3 Consultation

3.1 As part of the development process a series of engagement workshops was carried out with staff across council, health and voluntary sector services to identify key themes and core indicators of interest, and stakeholder consultation on the content.

4. Mandatory implications

4.1 **Health and Wellbeing Strategy -** The JSNA 2023/4 will support the delivery of the agreed partnership priorities of the Joint Health and Wellbeing Strategy 2023-28, Findings will be used to inform developing priorities across the Barking and Dagenham Place partnership, Adults and Communities Strategy and local delivery plans

4.2 **Financial Implications** - There are no direct financial implications arising from this report.

4.3 **Legal Implications**

4.3.1 The Health and Social Care Act 2012 ('the Act') amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

4.3.2 The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning – the core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

4.3.3 In preparing JSNAs and JHWSs, health and wellbeing boards including this Committee in Common must have regard to guidance issued by the Secretary of State.

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

List of Appendices:

Appendix A - Draft Barking and Dagenham Joint Strategic Needs Assessment 2023/24

APPENDIX A

Barking and Dagenham

Joint Strategic Needs Assessment 2023-24

Barking & Dagenham

Table of Contents

1. Introduction

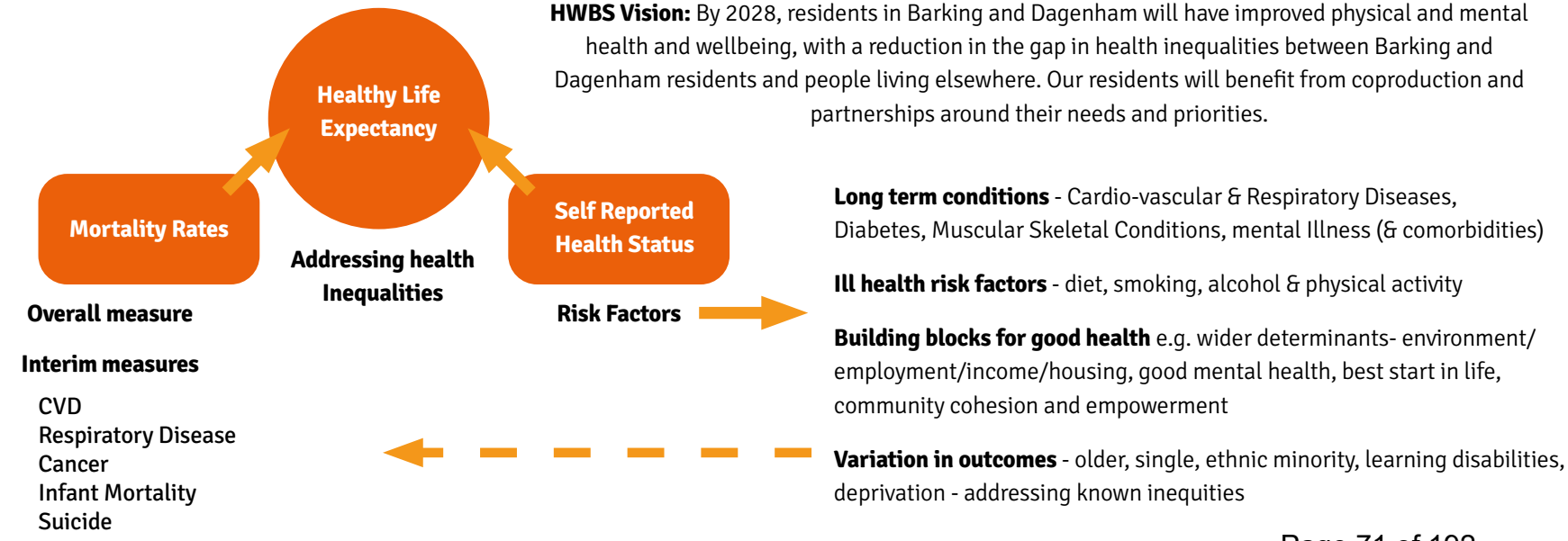
The Barking and Dagenham Joint Strategic Needs Assessment (JSNA) for 2023-2024 focuses on the population health needs of Barking and Dagenham. The overarching aim is to provide an overview of the local data and insights that will both support the understanding of the key local population health needs and inform a partnership approach to reduce health inequalities and improve healthy life expectancy. This will support the aims of the Barking and Dagenham Joint Health and Wellbeing Strategy 2023-28. This refresh of the JSNA will revert to a single borough publication to reflect the unique needs at place; but will inform work across the North East London Partnership.

As part of a new approach, the JSNA will be refreshed on a 3-5 year basis, with subsequent deeper dives into areas where greater focus is needed to inform effective Place based action to improve Healthy Life Expectancy. This overarching JSNA will provide an overview of the data and insights that inform local priorities and suggest areas for further focussed action or future analysis.

How to read the report

The Barking and Dagenham JSNA 2023-24 is intended to be read alongside the Annual Director of Public Health Report 2023 which provides the accompanying context, rationale and steer for action. Key messages and advice have been summarised at the end of each JSNA chapter.

Figure 1: Health and Wellbeing Strategy Vision



Child health indicators have been integrated with adult indicators throughout the document and are clearly labelled within contents, but broader factors supporting child health are focussed on in the 'Building blocks – best start in life' section.

Comparators:

For each indicator where adequate data is available; comparison and benchmarking has been made against London average, the England average and with NEL neighbours that are similar in socioeconomic profile according to the CIPFA nearest neighbours model: Hackney, Tower Hamlets and Waltham Forest. These are referred to as 'peer boroughs' throughout the document. Greenwich has been included as a peer borough for indicators relating to children as it is one of Barking and Dagenham's nearest neighbours. Trends over the last 5 years have been depicted where there is an important change to note. An updated list of peer boroughs has been used meaning there is variation in some of the comparators used in this report and some analyses the ADPHR 2023.

Other key pieces of analysis which are referred to and contain additional detail include:

North East London Population Health Profile

LBBD Borough Data Explorer

LBBD Social Progress Index

OHID Fingertips Public Health Profiles

Where we use the word significant; this relates to statistically significant change.

Authors: Richard Johnston, Bianca Hossain, Neha Shah, Tony Doherty

The following groups/organisations were consulted in the process of developing an approach and selecting indicators for the JSNA:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- North East London Foundation Trust
- Together First CiC
- BD Collective, Lifeline
- North East London Integrated Care System: Business Insights, Barking and Dagenham Place Partnership
- London Borough of Barking and Dagenham: Public Health, Commissioning, Adults and Children's Services (Social care and education), Community Solutions, Performance, Insight and Innovations, Transport, planning and infrastructure, Housing/enforcement, Inclusive Growth

We would like to thank all the stakeholders who have helped inform the presentation and indicators presented in this document, and commented on drafts.

2. Population overview

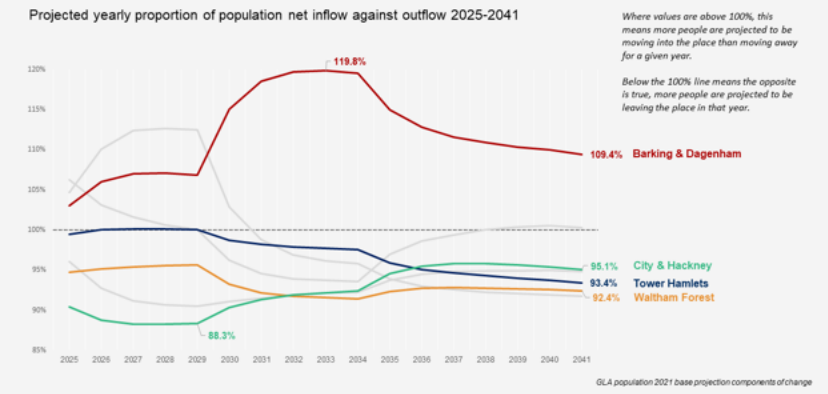
Barking and Dagenham is a borough where the population has undergone significant growth and change in the last decade. Below are some key elements of Barking and Dagenham's resident population as defined in the Office of National Statistics Census of 2021. The population size based upon census estimates is smaller than the number of people registered with a GP in Barking and Dagenham. This pattern is similar to other peer boroughs, as individuals do not always unregister or register at another GP if they move out of borough, and some may choose to register at practices in different boroughs.

- From 2011 to 2021, Barking and Dagenham's population increased by 17.7%, to just under 220,000 residents. England's population grew by 6.6% over the same time period. Barking and Dagenham was the second fastest growing borough in London after Tower Hamlets, where the population grew by 22.1%.[1] Projections estimate a further 20% growth through migration into the borough by 2034, largely driven by development in the south of the borough (See Figure 2).
- Barking and Dagenham also has a high rate of births relative to other parts of England. The Total Fertility Rate (TFR) shows the average number of children a woman is expected to have over her lifetime. In 2022, the TFR in Barking and Dagenham was 1.98 births per woman. It is the highest TFR of any borough in London and England, whose rates were 1.39 and 1.49 respectively[2].
- In 2021 in Barking and Dagenham, just over 57,000 residents were aged under 16 (26.0% of the population), just over 143,000 were aged 16 to 64 (65.2% of the population) and just over 19,000 were aged 65 and over (8.7% of the population). In England, these percentages were 18.6%, 63.0% and 18.4% respectively, meaning Barking and Dagenham has a greater proportion of young residents and a smaller proportion of elderly residents than England as a whole (see figure 2). This is also reflected in Barking and Dagenham's median age, which is 33, compared to 36 for London and 40 for England[3].
- From 2011 to 2021, the proportion of Barking and Dagenham residents identifying as Asian or Asian British increased from 15.9% to 25.9%, the largest increase of any ethnic group. The White or White British ethnic group made up 58.3% of the population in 2011 and 44.9% in 2021, which was the largest decrease of any group. Residents identifying as Black, Black British, Caribbean of African made up 20.0% of Barking and Dagenham residents in 2011 and 21.4% in 2021. The proportion of residents of mixed or multiple ethnicities in Barking and Dagenham rose from 4.2% in 2011 to 4.3% in 2021. The proportion of residents belonging to other ethnic groups rose from 1.6% to 3.6% from 2011 to 2021[4].
- In the 2021 census, 72.1% of Barking and Dagenham residents spoke English as their main language. Other than English, the most prevalent main languages include Romanian (4.5%), Bengali (2.9%), Lithuanian (2.0%), Urdu (1.7%), Panjabi (1.1%) and Bulgarian (1.1%)[5].

- In 2011, 13.7% of Barking and Dagenham residents described themselves as Muslim. This increased to 24.4% by 2021, which was the largest increase of any broad religious group. In 2011, 56.0% of residents described themselves as Christian. This decreased to 45.4% by 2021. The proportion of those describing themselves as having no religion was almost unchanged, falling from 18.9% to 18.8% from 2011 to 2021. Other religions present in Barking and Dagenham in 2021 include Hinduism (3.0%), Sikhism (2.0%), Buddhism (0.4%) and Judaism (0.1%)[6].
- Barking and Dagenham had the 21st highest deprivation score of the 317 English local authorities measured on the Index of Multiple Deprivation (IMD) 2019. It also had the highest IMD score of all London boroughs[7] 5 LBBD wards are amongst the 10% most deprived wards in England and 11 LBBD wards are amongst the 20% most deprived wards in England (see Figure 4 IMD decile by ward, Barking and Dagenham).
- In the 2021 Census, 46,100 households in Barking and Dagenham (62.4%) were deprived in at least 1 of the four dimensions of deprivation (education, employment, health and housing). This is the highest proportion of deprived households within local authorities in England.
- Household income is another source of deprivation in Barking and Dagenham, and there is a link between lower average incomes and lower life expectancy[8]. In 2023, 38% of households in Barking and Dagenham had a household income below £30,000, the highest proportion of any London borough. The borough's median income is also the lowest in London at £38,400[9].
- As of 2021, there were 6,066 residents living in Barking and Dagenham for every square kilometre of land in the borough [10]. Across all of London, there were 5,598 residents for every square kilometre of land. On average, every football pitch sized area of land in Barking and Dagenham has 43 residents living on it, making it the 16th least densely populated borough of London's 32 boroughs.

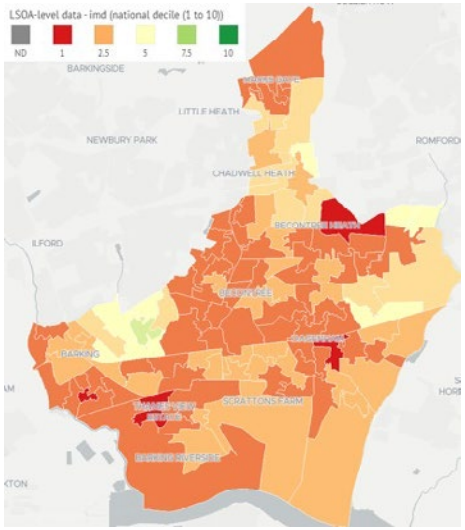
Additional information about Barking and Dagenham's population demographics can be accessed through the Council's Borough Data Explorer or the Office for National Statistics Census profile.

Figure 2: Projected proportion of people moving into a Place (inflow) compared with people leaving (outflow)



Source: North East London Population Health Profile

Figure 3: IMD Decile by Lower Super Output Area (LSOA), Barking and Dagenham



Source: Borough Data Explorer (emu-analytics.net)

Figure 4: IMD decile by ward, Barking and Dagenham

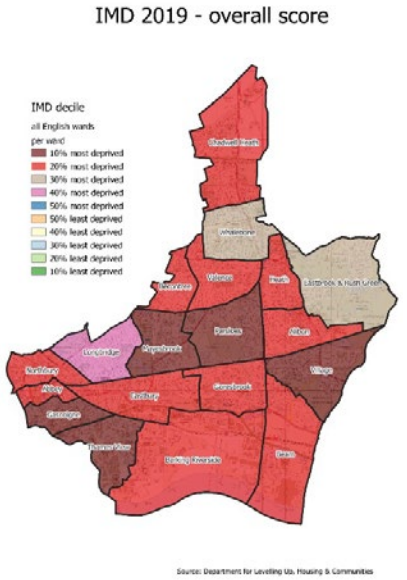


Figure 5: Age distribution compared to England (in black), ONS Census 2021

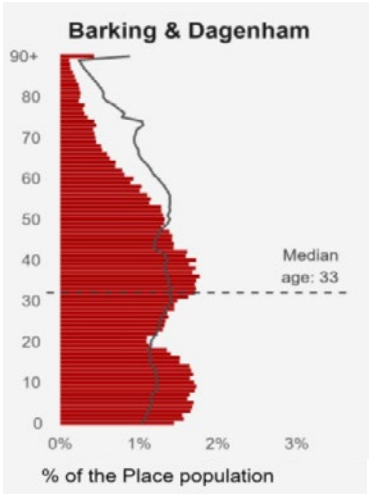
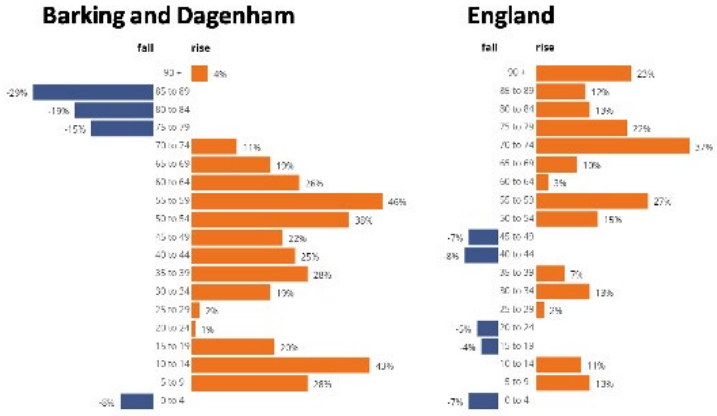


Image source: North East London Population Health Profile

Figure 6: Population change (%) by age group, Census 2011 vs Census 2011



Source: Barking and Dagenham population change, Census 2021 – ONS

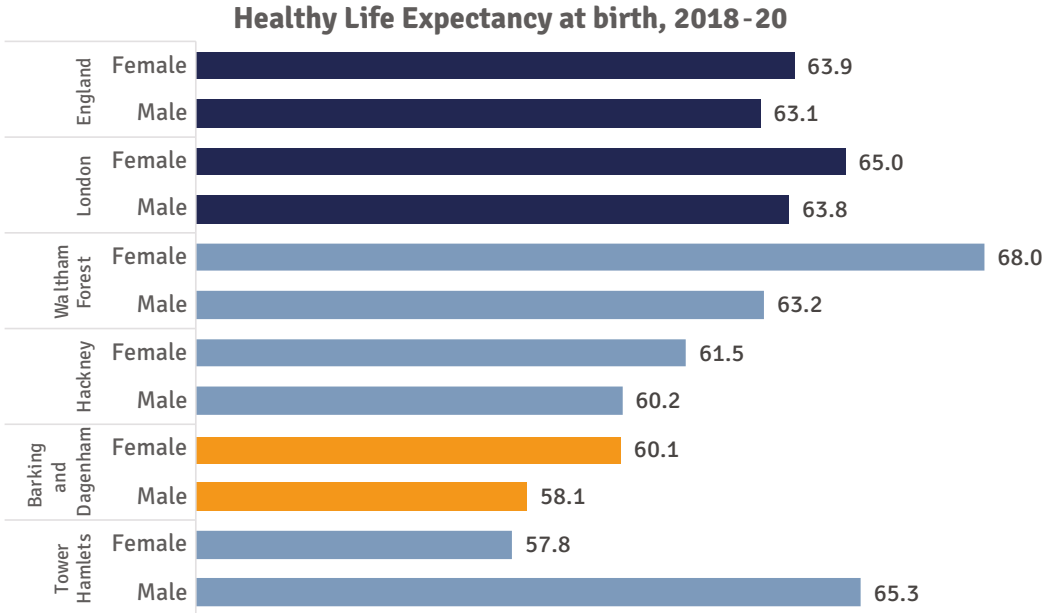
3. Healthy life expectancy

Healthy life expectancy (HLE) at birth describes the average number of years a baby born today would expect to live in good health. It is based on data combining risk of death and people's self-reported good health from the Annual Population Survey (APS). The ADPHR 2023 outlines the key elements that contribute to healthy life expectancy, highlighting the importance of a focus on improving self-reported good health across the population.

On average, Barking and Dagenham males born from 2018-2020 can expect to live 58 years in good health. This is the shortest healthy life expectancy at birth in London and is significantly below the London and England averages. Females in Barking and Dagenham can expect two additional years of good health compared to males but this again is significantly below the London and England averages for females.

At the age of 65, the healthy life expectancy for borough males is 8.4 years, compared to 9.2 years for females. This again falls short of the London and England averages but to a lesser extent than life expectancy at birth.

Figure 7: Healthy life expectancy in years for males and females at birth (years)



Source: OHID Fingertips Indicator ID 90362, accessed 08/12/2023

Figure 8: Healthy life expectancy in years for males and females at 65

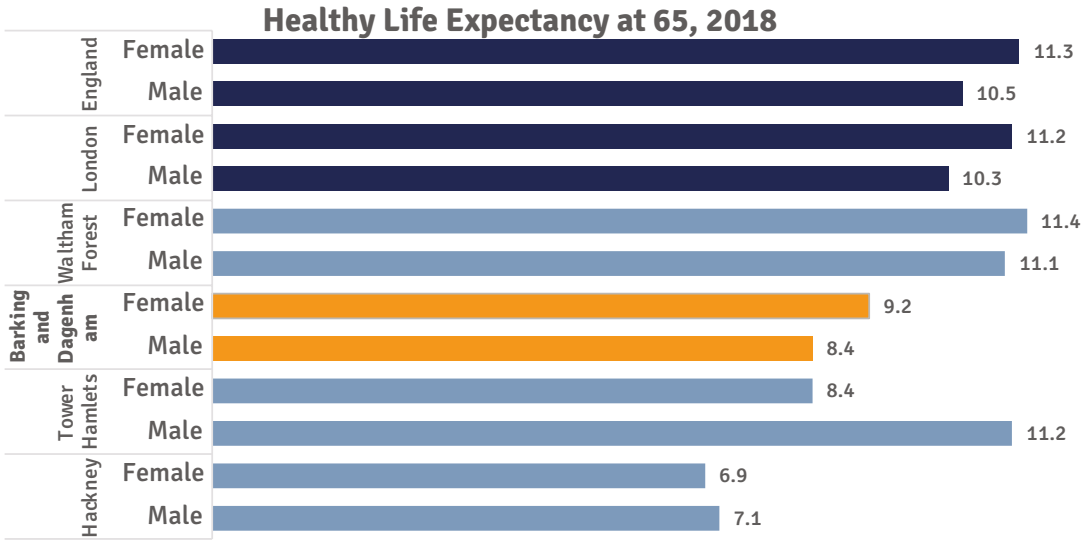


Figure 9: Changes in male and female healthy life expectancy at birth from 2014-16 to 2018-20 (life expectancy in years)

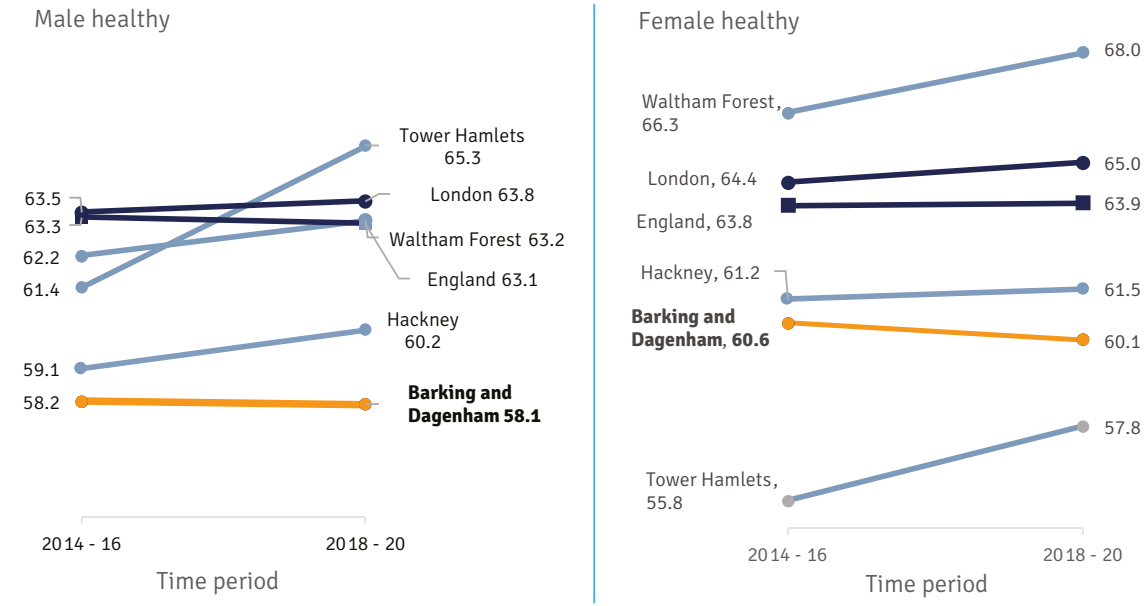
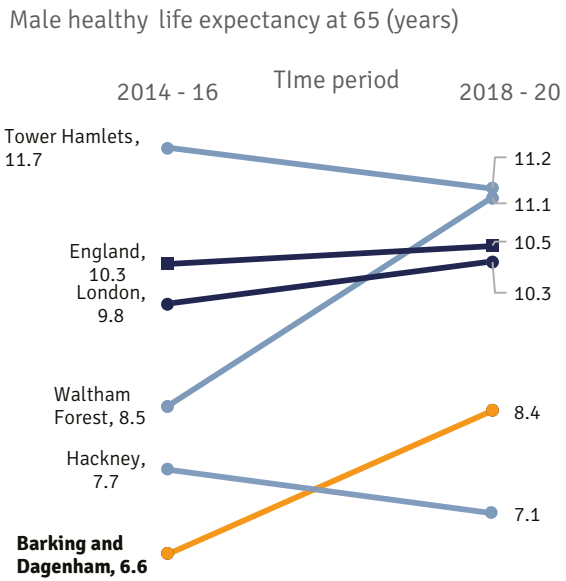
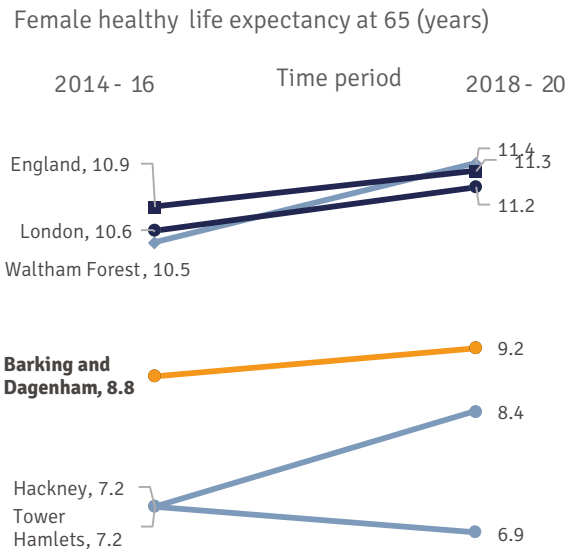


Figure 10 Changes in male and female healthy life expectancy at 65 from 2014-16 to 2018-20 (life expectancy in years)





Healthy life expectancy at birth in Barking and Dagenham has fallen slightly over time for both male and female residents, whilst all peer boroughs and London have seen rising trends as shown in the slope charts above. Conversely, healthy life expectancy at age 65 rose for males and females in the borough across this same time.

It should be noted the effect of the Covid-19 pandemic and cost of living crisis is not yet fully captured within the collected data which does not go beyond 2020. Significant excess mortality was seen in 2020 and 2021 but has tended back towards expected levels in recent years.[11] Self-reported good health will also have been impacted by access to healthcare and health promoting services, and latest data relating to long term conditions and lifestyle behaviours will be further explored later in this document.

Inequality in healthy life expectancy at birth measures the difference between the least and most deprived Middle Super Output Areas (a MSOA contains approximately 5,000-7,000 residents).

For female Barking and Dagenham residents in 2009-13, this difference was 5.8 years, for male residents it was 6.4 years. These values are significantly lower than their equivalents in London and England, which were 24.6 and 19.1 years for males in London and England respectively, and 21.1 and 18.6 years for females in London and England respectively, which is likely partially reflective of the fact there is a much less variation in levels of deprivation seen in Barking and Dagenham than across the entirety of London and England.

Figure 11: Relative contribution of determinants of health, taken from Health in All Policies, a manual for Local Government, Local Government Association

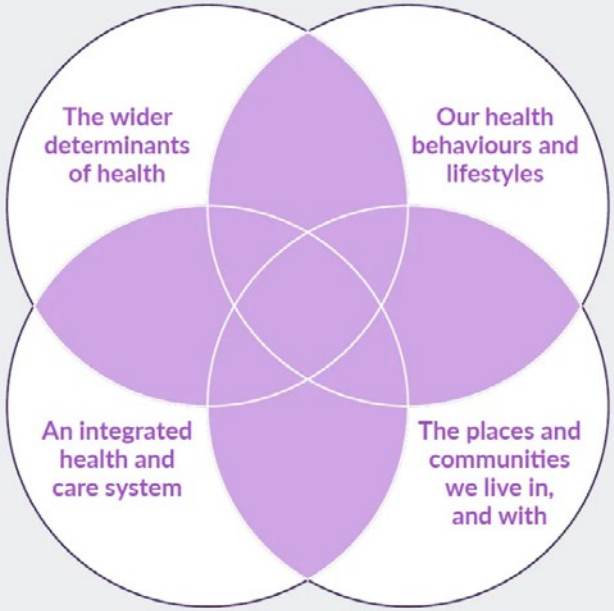
Health Behaviours 30%	Socio-economic Factors 40%	Clinical Care 20%	Built environment 10%
Smoking 10%	Education 10%	Access to care 10%	Environmental Quality 5%
Diet/Exercise 10%	Employment 10%	Quality of care 10%	Built Environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/Social Support 5%		
	Community Safety 5%		

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

Several analyses estimate that socioeconomic factors and our environment contribute to about 50% of our health , so these need to be addressed alongside health behaviours and diseases themselves to improve healthy life expectancy. The need for this cross-cutting approach has also been outlined in a vision for population health focussing on four key pillars: wider determinants of health, the communities and places we live in, our health lifestyles and behaviours and an integrated health and social care system (see Figure 12).

This is explored in more detail in Chapters 3 and 4 of the Annual Director of Public Health Report, where we highlight key areas for focussed action in Barking and Dagenham.

Figure 12: Four Pillars of Population Health. Source: Kings Fund



Healthy life expectancy: key messages and public health advice

In the five years to 2020, there was no improvement in healthy life expectancy at birth in Barking and Dagenham despite improvements being seen in neighbouring boroughs and London across this timeframe.

Some improvement was seen in Healthy life expectancy at age 65, in particular for males, but it is not clear whether this has been maintained following the pandemic.

Public health advice:

There are a number of factors that contribute to the lack of improvement in healthy life expectancy in recent years: demands of a growing population, widening inequalities due to impacts of the pandemic and the cost of living crisis; and the need to harness a system wide approach to improving health. The ADPHR 2023 recommends that partners across Barking and Dagenham should agree to outcomes aligned to reducing the gap in both female and male healthy life expectancy, with a key focus on priority areas:

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

We will not shift the dial on the poor healthy life expectancy experienced by residents without action on the building blocks of health and well-being, wider determinants of health and working with our communities. Delivering across these golden strands in the Joint Health and Wellbeing Strategy requires development of strong partnership working across the borough, including engagement of a Health in All Policies approach across the council.

Specific areas of focus will be explored in later chapters of the JSNA.

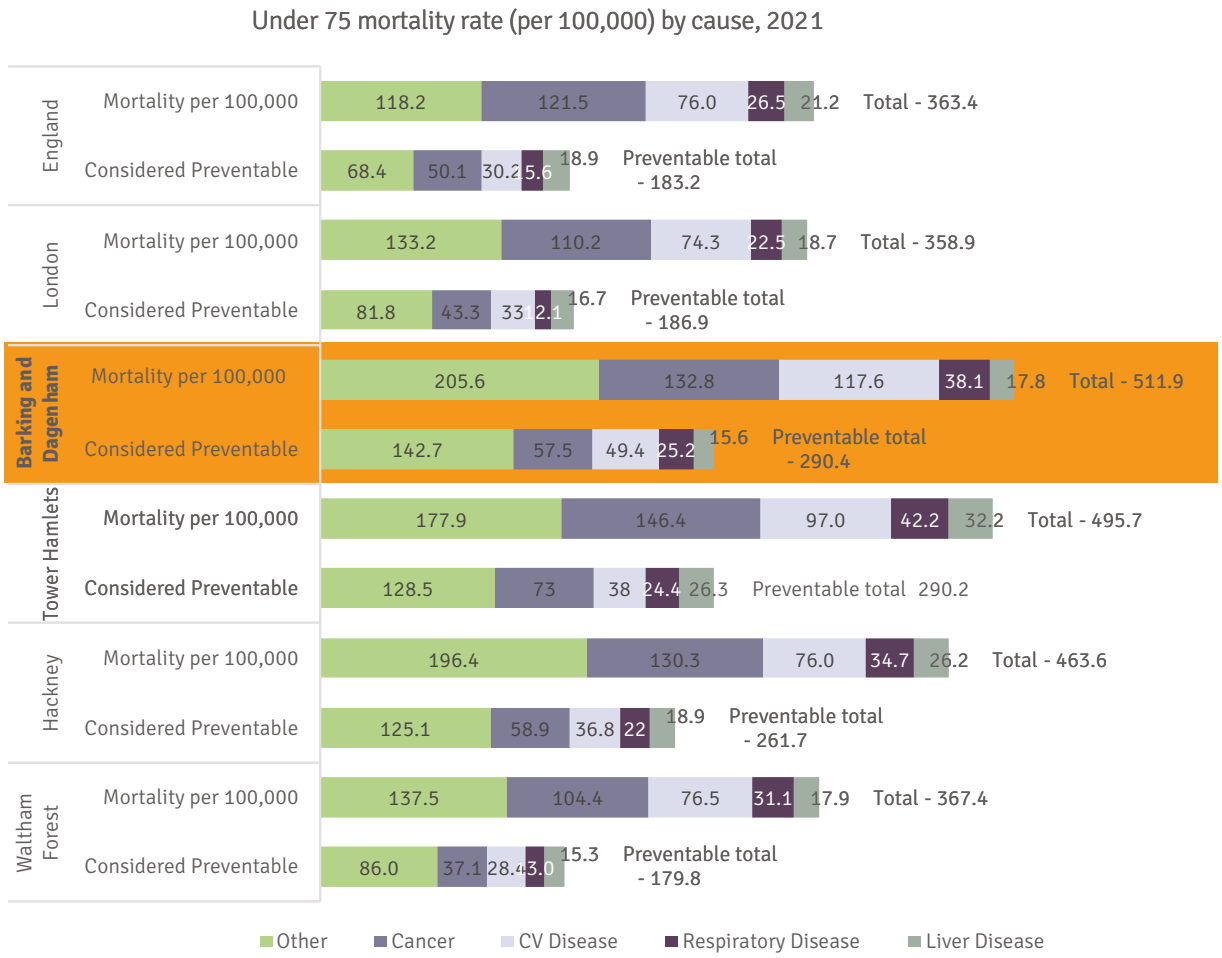
a. Mortality

Incidents of preventable mortality are deaths that could have potentially been prevented by public health interventions (Mortality Profile - OHID (phe.org.uk)).

The most frequent cause of premature mortality, including preventable premature mortality in 2021 in Barking & Dagenham was cancer. This is also true of London, England and all peer boroughs. The rate of mortality per 100,000 residents in Barking and Dagenham in 2021 was 132.8. This was higher than the London and England averages, which were 110.2 and 121.5 respectively, and all peer boroughs bar Tower Hamlets, whose rate was 146.4.

Cardiovascular disease had the second highest rate of mortality and preventable mortality in Barking and Dagenham, and at 117.6 per 100,000 residents, was significantly higher than the London and England averages, which were 74.2 and 76.0 respectively.

Figure 13 Premature mortality and premature mortality from causes considered preventable, rate per 100,000 by cause



Source: OHID Fingertips Indicator ID's, accessed 08/12/2023:
Other: 108
Other considered preventable: 93721
Cancer: 40501
Cancer considered preventable: 93723
Cardiovascular disease: 40401
Cardiovascular disease considered preventable: 93722
Respiratory disease: 40701
Respiratory disease considered preventable: 93724
Liver Disease: 40601
Liver Disease considered preventable: 93720

Rates of mortality due to respiratory disease were also elevated in Barking and Dagenham compared to London, England and peer boroughs.

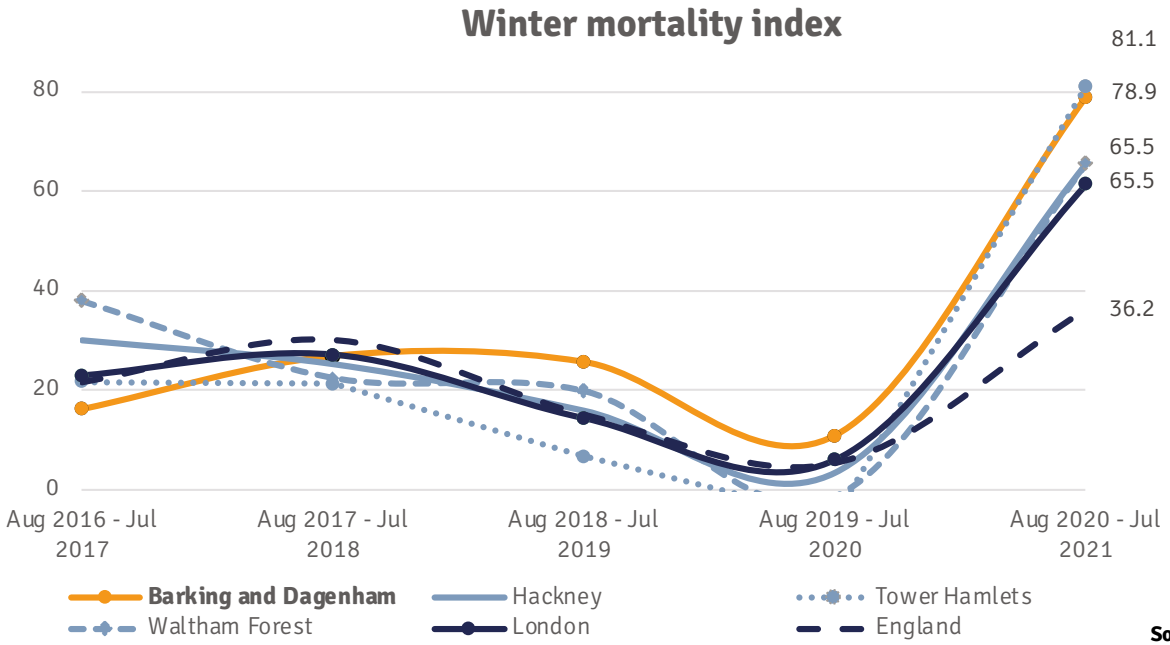
The rate of mortality in Barking and Dagenham due to liver disease was lower than London, England and all peer boroughs.

A recent analysis has shown that residents are around three times more likely to suffer an avoidable death than people living in the 10 least deprived areas of England, highlighting the importance of wider determinants of health in influencing outcomes for these diseases.[13]

The Winter Mortality Index (WMI) expresses the difference in the average all-cause mortality during winter months (December to March) compared to the average in non-winter months (April to November) as a ratio. A value of 100, would mean there were twice as many deaths in winter months than non-winter months for a given year.

The COVID-19 pandemic significantly affected this dataset in the 2019-2020 year. As COVID-19 resulted in a larger than average number of deaths throughout the year, a larger than normal number of deaths occurred within non-winter months, meaning the ratio was lower than normal. In the following year, acquired and vaccinated immunity to COVID-19 rose, and milder strains of COVID-19 became dominant, resulting in a re-concentration of deaths in winter months and a spike in the WMI in the 2020-2021 year. These effects can be seen in Barking and Dagenham and all peer boroughs, London and England.

Figure 14 Winter Mortality Index: Difference in all cause mortality during winter months (Dec - Mar) compared to non winter months.

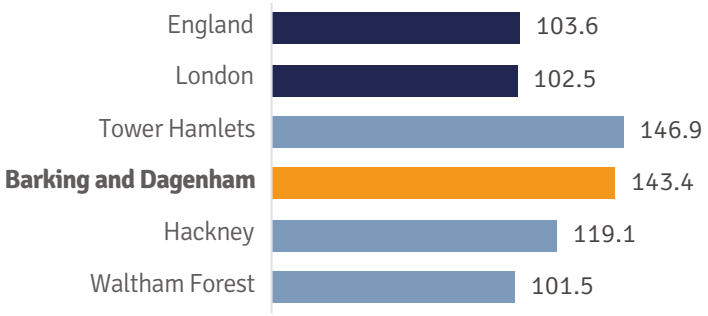


Source: OHID Fingertips Indicator ID 90360, accessed 08/12/2023

From 2018-19 onwards, throughout these fluctuations, Barking and Dagenham's WMI was higher than peer boroughs, London and England. As of 2020/21, only Waltham Forest has a higher WMI than Barking and Dagenham.

Premature mortality in adults with serious mental illness (psychotic disorders, bipolar disorder, or other mental illness with significant functional impairment), aged 18 to 74, in Barking and Dagenham is significantly higher than the London and England averages and higher than two of the three peer boroughs.

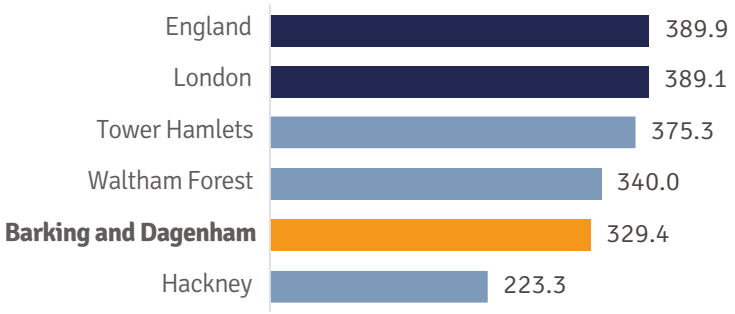
Figure 15: Premature mortality in adults with serious mental illness, rate per 100,000 population.



Source: OHID Fingertips Indicator ID 93581, accessed 08/12/2023

The graph showing excess mortality indicates the inequality gap – people with severe mental illness are approximately three times as likely to die prematurely as those without. The gap locally is less than in the majority of comparator areas, but this smaller gap likely reflects the higher premature mortality in the non-SMI population.

Figure 16: Excess premature mortality experienced by adults with Severe Mental Illness (SMI) over adults without SMI.



Source: OHID Fingertips Indicator ID 93582, accessed 08/12/2023

Suicide rates have increased over the 5 years to the 2019-2021 period. In Barking and Dagenham in the 2015-17 period, the rate of deaths from suicide per 100,000 residents was 6.2. This increased to a rate of 8.8 by the end of the 2019-21 period. A downward trend in suicide rates can be seen in all peer boroughs and in the London average over this period. These 2 changes mean Barking and Dagenham's rate has risen from below the London and England averages and those of all peer boroughs in 2015-17 to being higher than all peer boroughs and the London average by 2019-21.

Mortality: key messages and public health advice

In 2019-2021, premature mortality rates and winter mortality in Barking and Dagenham were higher than in peer boroughs, London and England averages. Over half of deaths are considered preventable through public health action. Cancer and cardiovascular disease were the single measured areas where preventive activity could show most benefit, but half of preventable mortality is due to 'other causes' highlighting the need for broad action.

In 2018-2020, people with serious mental illness were over three times as likely to die prematurely in Barking and Dagenham than those without; and rates in Barking and Dagenham are higher than London and England averages.

Suicide rates have been increasing in the four years to 2021 despite decreasing trends in London, and are higher than London but Lower than England averages.

Public Health Advice:

A focus should be maintained on winter planning across Barking and Dagenham, including rollout of flu and covid vaccination and mitigating the health risks associated with poor quality housing.

Cardiovascular disease, cancer and reducing life expectancy inequality for those with serious mental illness should remain priority areas for preventative action. Performance in these areas is further explored in the JSNA chapter on Long Term Conditions.

Rising trends in suicide rates suggest that a refreshed strategic approach to suicide prevention should be considered in line with the new National Suicide Prevention Strategy; alongside exploration of the uses of Real Time Suspected Suicide Surveillance Data.

b. Self-reported good health

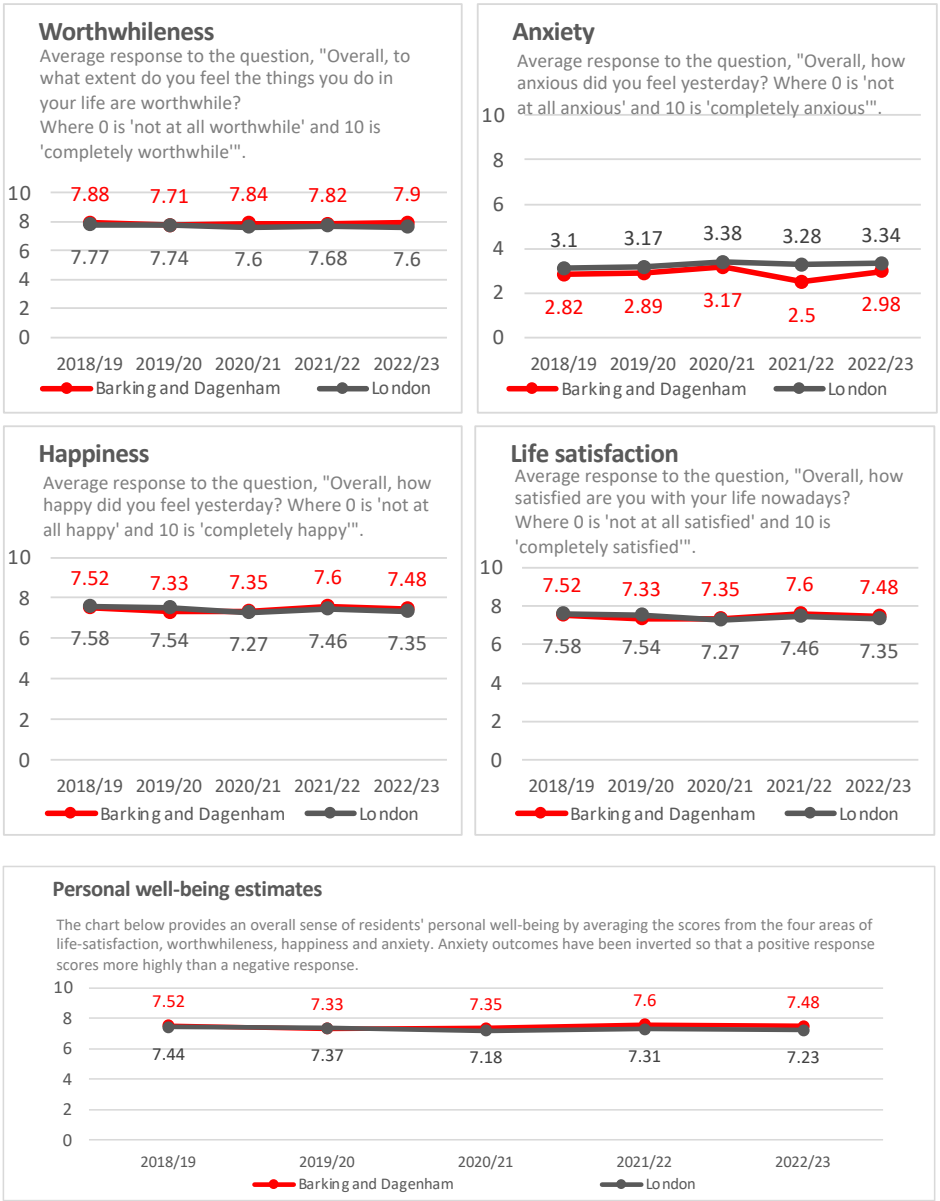
Personal well-being

Well-being is a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic and environmental conditions. Well-being encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose,[14] it is also associated with increased life expectancy and healthy life expectancy.[15] Mental wellbeing is often defined as a combination of 'feeling good' and 'functioning well', the latter linked to a sense of purpose, personal growth and development and living aligned with values.[16]

The Office for National Statistics (ONS) conducts an Annual Population Survey (APS) which focusses in part on personal well-being. Borough level estimates suggest that overall, Barking and Dagenham residents have relatively high levels of personal wellbeing; they score highly for life satisfaction, feel that the things they do in life are worthwhile, are happy and have low levels of anxiety.

Personal well-being estimates for borough residents have closely followed the London average over the last five years, with slightly lower levels of anxiety, as seen below. Borough outcomes also compare favourably to the statistical neighbours of Hackney, Tower Hamlets and Waltham Forest as can be seen in the ONS report Personal Well-being in the UK: April 2022 to March 2023.

Figure 17: Personal wellbeing outcomes from the Annual Population Survey: scores are out of 10 where 10 is the highest and 0 is the lowest.



A ward-level view of well-being can be found within Barking and Dagenham's Social Progress Index (SPI), which looks at whether the building blocks are in place for individuals and communities to enhance and sustain well-being. The SPI defines this as being able to benefit from a basic education and good healthcare, being able to access information and communicate freely and living in a healthy environment. These foundations of wellbeing are not experienced equally by all borough residents and overall, it seems that residents in the west of the borough have a better experience than those in the north and east.

Loneliness is another area which can have a serious impact on an individual's wellbeing. According to the 2019/20 Active Lives Adult Survey conducted by Sport England, 26.8% of borough residents feel lonely at least some of the time, compared to 22.3% nationally and a London average of 23.7%.

The wellbeing of younger residents is measured in the Barking and Dagenham Children and young people's Health and Wellbeing Survey, conducted by the Schools Health Education Unit. Survey outcomes suggest that wellbeing in school pupils reduces with age. Wellbeing has also reduced over time with 22% of year 8 pupils and 26% of year 10 pupils scoring within the medium-low range for wellbeing in 2017, compared to 34% and 36% respectively in 2022.[17] Wellbeing for males in secondary schools is far lower than for females whilst in primary school there is very little difference in average scores for males and females.

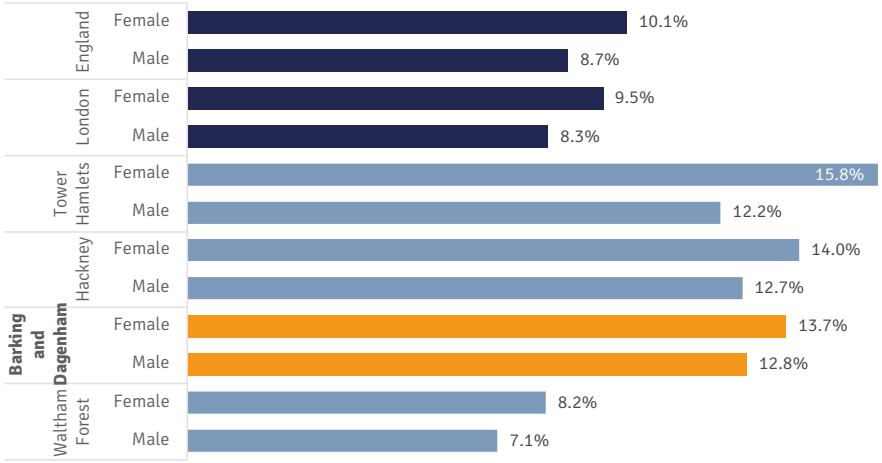
c. Frailty

Frailty has been described as a distinctive health state related to the ageing process, in which multiple body systems gradually lose their in-built reserves. Frailty is associated with poor quality of life, adverse health outcomes, such as falls, and increased use of health and social care services, but research has shown that frailty is not an inevitable consequence of ageing and can be preventable, particularly by targeting those in early stages or 'prefrailty'.[18]

A national study has estimated the prevalence of frailty, pre-frailty and those in robust health across local authorities using a bespoke frailty Index. A wide range of physical and cognitive abilities make up the frailty index referenced in this document, which can been seen in full here: Accumulation of Deficits as a Proxy Measure of Aging (nih.gov). These include cognitive impairment (such as clouding or memory issues), sleep disturbances, mobility limitations, mood changes, difficulty with daily activities (like grooming or cooking), urinary and bowel incontinence, visual or auditory sensory impairments, chronic health conditions (like hypertension or diabetes), onset of neurological conditions (like stroke or Parkinson's disease), measures of coordination, posture or the presence of tremors, functional assessments of Activities of Daily Living (ADL) and a range of laboratory test results for levels of markers like electrolytes and glucose.

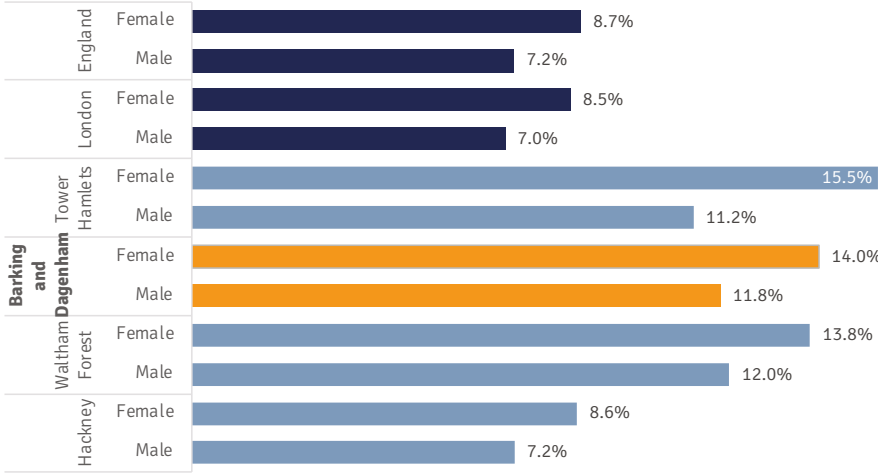
In 2020, a greater proportion of Barking and Dagenham residents aged 50 and over experienced pre-frailty and frailty than that seen in London and England. This was true for both male and female residents. Rates of frailty and prefrailty are high in all peer boroughs apart from Hackney. The probability of frailty and pre-frailty generally increases with age and deprivation.

Figure 18: Pre-frailty in those aged 50 and over (%)



Source: J Frailty Aging 2022;11(2)163-168 Published online December 23, 2021, http://dx.doi.org/10.14283/jfa.2021.55

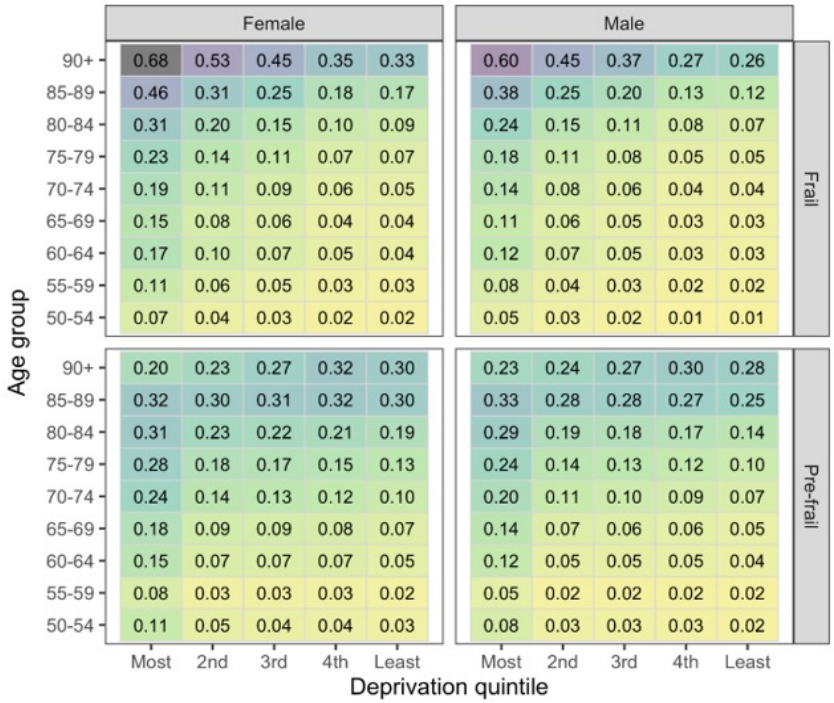
Figure 19: Frailty in those aged 50 and over (%) in 2020



Source: J Frailty Aging 2022;11(2)163-168 Published online December 23, 2021, http://dx.doi.org/10.14283/jfa.2021.55

Figure 20 Probability of pre-frailty and frailty by age group, deprivation quintile and sex

Appendix 5b: Probability of pre-frailty and frailty for each age group, deprivation quintile and sex. The probability of pre-frailty and frailty generally increases with age and deprivation. The exception is for the most deprived people, whose probability of pre-frailty decreases for 85-89 to 90+, however this is due to a marked increase in their probability of frailty, rather than any increase in the probability of not being pre-frail or frail.



Source: J Frailty Aging 2022;11(2)163-168 Published online December 23, 2021, http://dx.doi.org/10.14283/jfa.2021.55

Self reported good health: key messages and public health advice

Personal well-being estimates for borough residents have closely followed the London average over the last five years. However, wellbeing of school age children is showing worsening trends. In 2019/20, 1 in 4 borough residents felt lonely at least some of the time, higher than London and England Averages.

Approximately 14% of women and 12% of men over 50 are estimated to be frail; and 14% of women and 13% of men over 50 are estimated to be pre-frail. Combined this represents over a quarter of the population over 50. This is higher than London an England averages but similar to peer boroughs apart from Hackney.

Public health advice

There remains significant need in the borough (and nationally) around mental wellbeing for children and young people. There is a clear role for School Nurses, as public health leaders, to advise schools and work with the wider system to support maximising the mental wellbeing of our children and young people. The system should increase focus on providing a better offer for those with social, emotional, and mental health needs, including timely access to CAMHS aligned with the priorities of the Best Chance Strategy. This is explored further in Chapter 5 of the ADPHR 2023.

Good mental health is a key prerequisite across all factors impacting on healthy life expectancy, as well as people who have poor mental health are more likely to have higher health risk behaviour and suffer a long term condition, often due to the same pathways that influence both (Psychosocial pathways and health outcomes: informing action on health inequalities (publishing.service.gov.uk) – as such mental health and wellbeing should be addressed as an underpinning factor in action to address health behaviours and prevent and manage long term conditions. Given the relatively high reported rates of loneliness, addressing loneliness and social isolation should be considered as an initial priority outcome to influence. These areas are explored further in Chapter 4 of the ADPHR 2023.

Targeted preventative action for local residents identified as pre-frail and frail through emerging proactive care programmes[19] and physical activity and nutrition support[20] as part of a combined system approach[21] has the potential to improve the healthy life expectancy of residents over 50. This is especially important given the high burden of long term conditions in younger adults in Barking and Dagenham, explored in the following chapter.

d. Long term Conditions

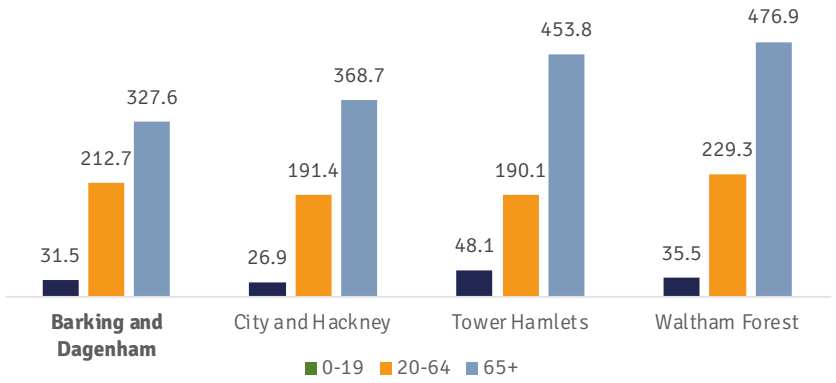
Prevalence

Long term conditions (LTCs) are a key driver of poor self-reported health and mortality. The risk of developing a long term condition increases with age. Rates of long term conditions are far higher in older age groups than younger age groups.

For every 1,000 residents aged 65+ registered with a GP, approximately 328 have at least 1 long term condition, the lowest of all peer boroughs. Conversely, for those aged 20-64, Barking and Dagenham has the second highest rate of long term conditions when compared to its peer boroughs.

Despite having a lower rate per 1,000 than the 65+ age group, the 20-64 age group contains by far the largest number of residents with a long term condition. Prevention and early intervention for this population could have a measurable impact on healthy life expectancy.

Figure 21: Rate of patients with 1 or more LTC per 1,000 registered patients by age group



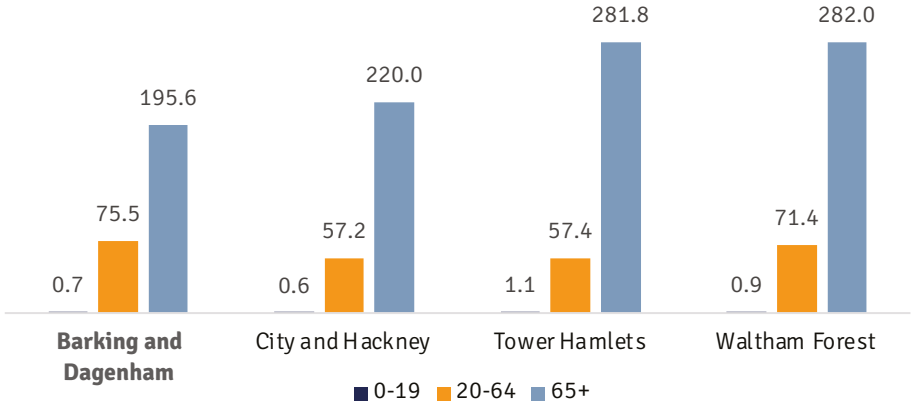
Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

Multiple long term conditions

The Chief Medical Officer's annual report 2023, 'Health in an Ageing Society' highlights the need to reorientate ourselves towards a society with increasing multimorbidity. It is estimated that around 70% of adults living with frailty have multimorbidity, but less than a fifth of older adults with multimorbidity are living with frailty and those in deprived areas are more likely to have multiple long term conditions[22].

For patients with two or more long term conditions, Barking and Dagenham has a higher rate than peers in the 20-64 age group and a lower rate than peers in the 65+ age group.

Figure 22: Rate of patients with 2 or more LTCs per 1,000 registered patients in age group



Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

Inequalities in long term conditions

Long term conditions are not uniformly distributed between ethnic groups in Barking and Dagenham, as shown on Figure 23 which shows the rate of long term conditions for those registered at a GP practice in Barking and Dagenham, by age and ethnic group. In each age group, both Black and Asian patients have a higher prevalence of long term conditions than their White counterparts. The Black ethnic group has the highest prevalence of any ethnic group. This gap also increases with age, being highest in the 65+ age group.

Deprivation is another factor affecting the prevalence of long term conditions within Barking and Dagenham. The inequality in risk of developing a long term condition for residents in more deprived areas is most marked in the age 65+ group and less apparent for younger populations. Of note, registered patients in the least deprived quintiles represent patients who are registered with a GP in Barking and Dagenham but live outside the borough, as all areas in Barking and Dagenham are within the three most deprived quintiles.

Figure 23: Rate of patients with 1 or more LTC per 1,000 Barking and Dagenham registered patients in age and ethnic group

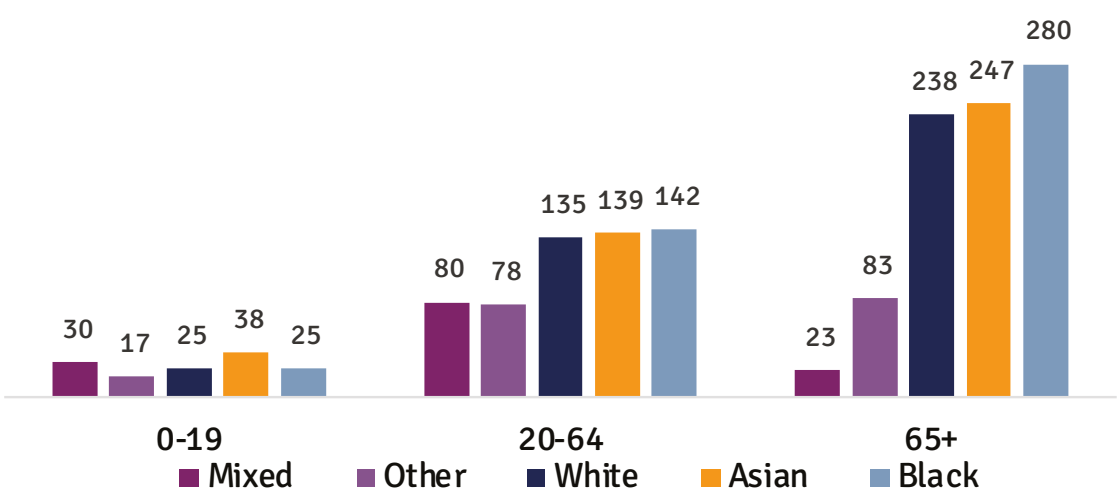
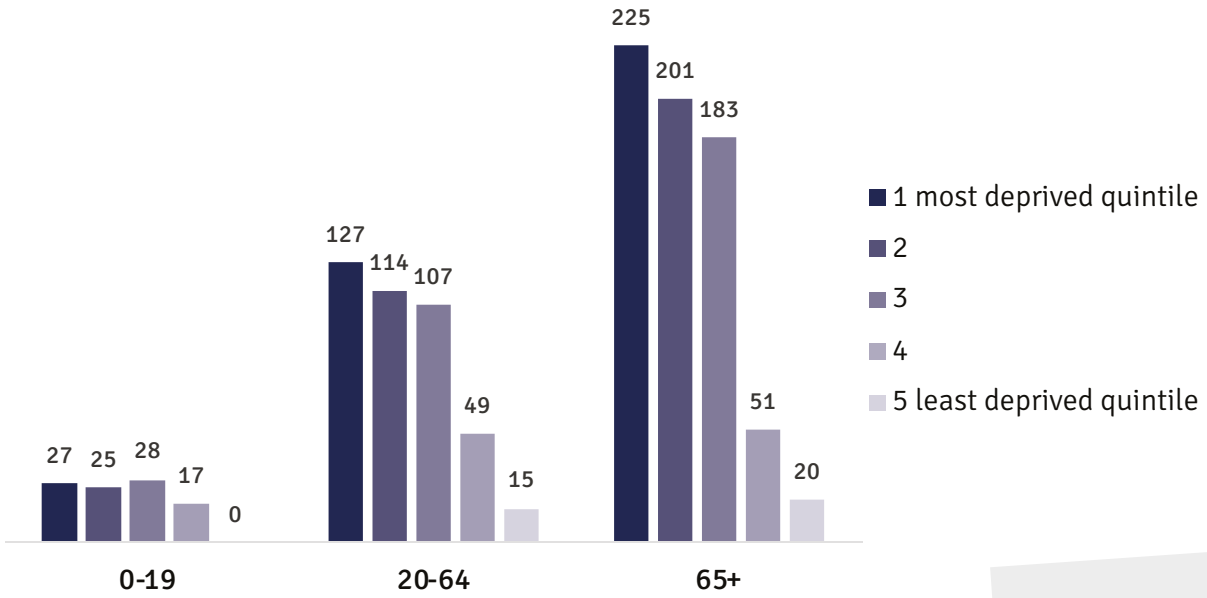


Figure 24: Patients with 1 or more Long Term Condition by age group and deprivation quintile (rate per 1,000 registered patients)

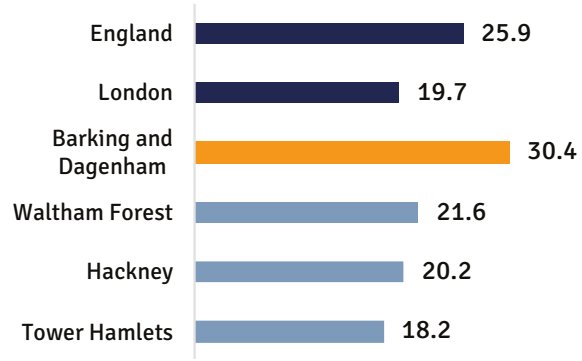


Specific long term conditions

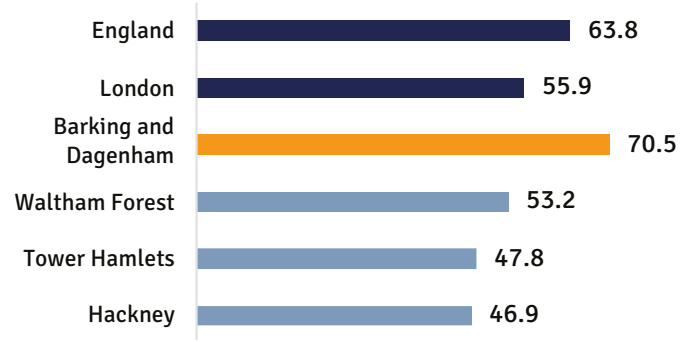
Obesity

Obesity is a condition where a person has excess body fat that poses a risk to health and is linked in particular with physical activity and diet. Obesity and overweight are measured using Body Mass Index, a combination of height and weight. Most adults in England are living with overweight or obesity, and the percentage of adults in Barking and Dagenham who are overweight or obese (70.5%) is significantly higher than the London and England averages (55.9% and 63.8% respectively). Additionally, there has been no consistent improvement of adult obesity prevalence over time in Barking and Dagenham since 2015.

Figure 25: Percent of overweight and obese adults (age 18+)

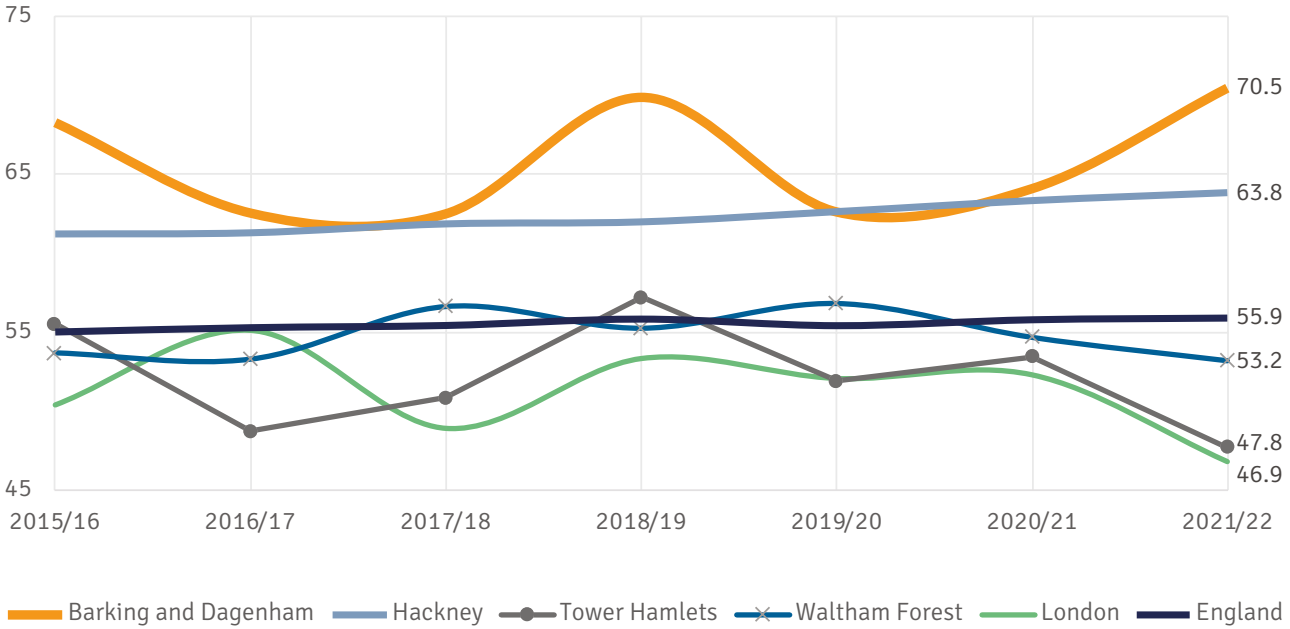


Source: OHID Fingertips Indicator ID 93881 accessed 08/12/2023



Source: OHID Fingertips Indicator ID 93088, accessed 08/12/2023

Figure 26: Trends in adults (age 18+) classified as overweight or obese



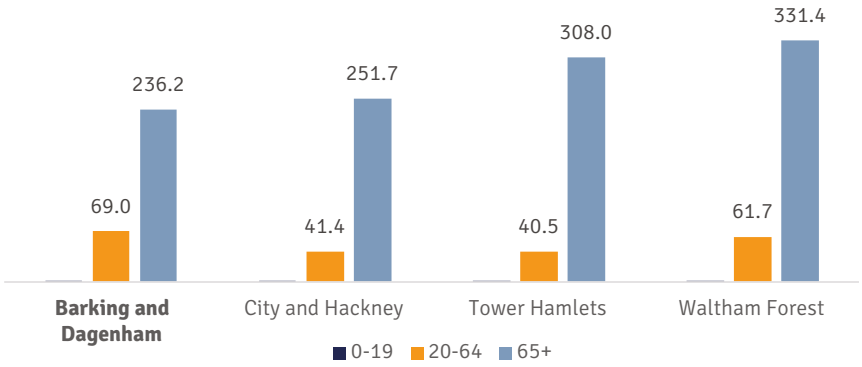
Source: OHID Fingertips Indicator ID 93088, accessed 08/12/2023

Nationally there is a large gap in obesity rates between people from the most deprived areas and those from the least deprived areas (17 percentage points for women and 8 percentage points for men)[23]. Hospital admission rates directly attributable to obesity are over three times more likely in the most deprived areas (31 per 100,000 population) compared to the least deprived areas (9 per 100,000 population).[24]

Chronic Obstructive Pulmonary Disease (COPD), hypertension, cardiovascular disease and cancer

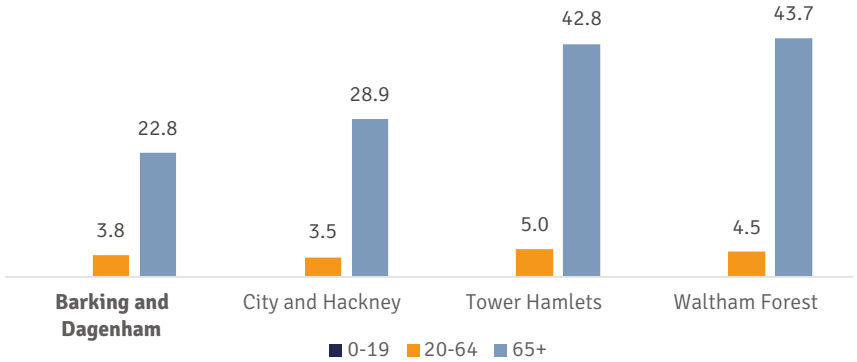
When we look at core health conditions (COPD, hypertension, cardiovascular disease and cancer), registered rates of patients are lower than in peer boroughs despite raised mortality rates for these conditions. The exception to this is hypertension where registered rates are higher than in peer boroughs in the 20-64 age bracket. Registered rates of asthma patients are lower than in peer borough in the 65+ age bracket, but more comparable in younger age brackets.

Figure 27: Rate of patients with hypertension by age group (per 1,000 registered patients)



Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

Figure 28: Rate of patients with coronary heart disease by age group (per 1,000 registered patients)

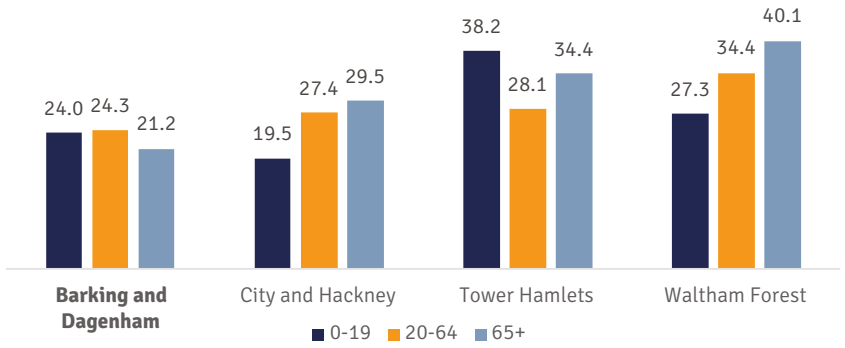


Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

Figure 29: Rate of patients with cancer by age group (per 1,000 registered patients)

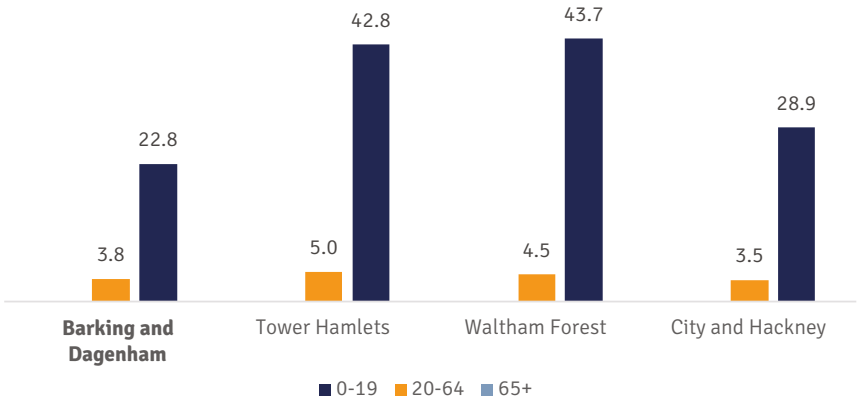
Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

Figure 30: Rate of patients with asthma by age group (per 1,000 registered patients)



Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

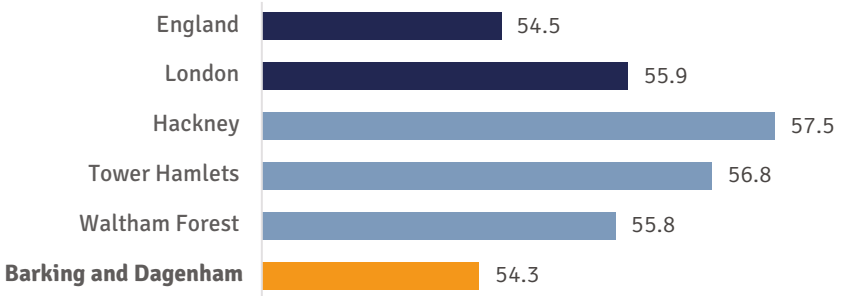
Figure 31: Rate of patients with chronic obstructive pulmonary disease per 1,000 registered patients in age group



Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

In 2018, just over half of new cancer diagnoses of Barking and Dagenham residents were diagnosed at stages 1 or 2[25]. This was in line with the England average but slightly below the London average of 55.9% and below the peer borough averages. More recent averages are unavailable for London and many of the London boroughs, including Barking and Dagenham, due to data quality concerns.

Figure 32: Percentage of cancers diagnosed at stages 1 and 2

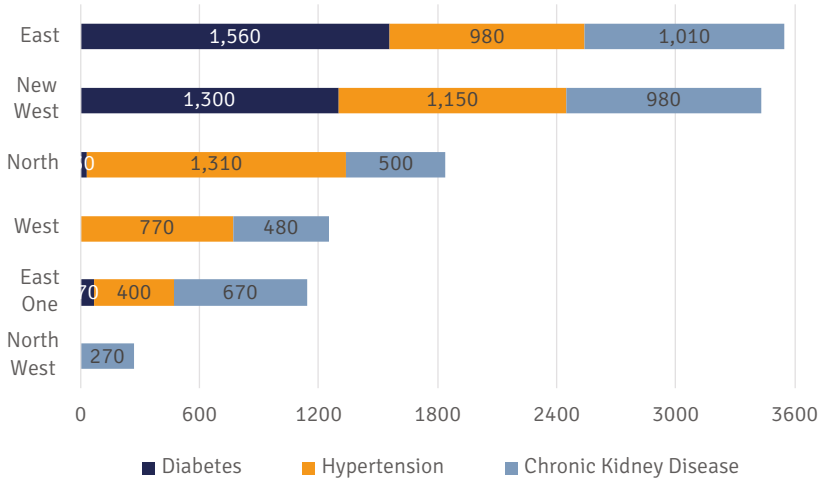


Source: OHID Fingertips Indicator ID 93671, accessed 08/12/2023

Undiagnosed long term conditions

Figure 33 shows the number of potentially undiagnosed cases of diabetes, hypertension and chronic kidney disease (CKD) for each Primary Care Network in Barking and Dagenham. The estimates for these conditions have been taken from the number of expected cases generated by a model produced by the National Cardiovascular Intelligence Network (NCVIN). The model for all three conditions is based on a regression model that quantified the statistical relationship between individual risk factors and whether an individual suffered from the condition. Inputs for this model were taken from the Health Survey for England for 2016 and 2017 responses and include the age-group, sex and general health status of the respondents. The model outputs, referred to as odds-ratios, were then applied to the modelled populations of GP Practices, providing estimates of the number of cases that could be expected to be within a given PCN. Subtracting the number of cases of each condition registered at each GP in that PCN from the estimated number of cases then provides the estimated number of cases that have not been diagnosed. As with all modelled outputs, these numbers are subject to error and may over or underestimate the number of undiagnosed cases. A full explanation of the methodology used is available in the technical documentation on the NCVIN website.

Figure 33: Number of cases of undiagnosed long term conditions by Primary Care Network, Barking and Dagenham



Sources:

Observed Disease cases: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023xpected CKD Cases: Public Health England, CKD prevalence estimates for local and regional populations, available at: https://www.gov.uk/government/publications/ckd-prevalence-estimates-for-local-and-regional-populations

Expected hypertension cases: Public Health England, Hypertension prevalence estimates for local populations, available at: https://www.gov.uk/government/publications/hypertension-prevalence-estimates-for-local-populations

Expected Diabetes cases: Public Health England, Diabetes prevalence estimates for local populations, available at: https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations

Local analysis suggests that not all people with long term conditions are accessing treatment, representing unmet need. If residents have undiagnosed conditions they are more likely to have exacerbations needing emergency care. The degree of unmet need varies across the borough. The values shown in this chart are the difference between the number of estimated cases (via National Cardiovascular Intelligence Network) and diagnosed cases (the North East London Quality Outcomes Framework (QoF) LTC Dashboard) of three key LTCs where data was available, for each PCN in Barking and Dagenham. For both hypertension and diabetes, all PCNs in Barking and Dagenham, bar 2, have potentially undiagnosed cases and all PCNs in Barking and Dagenham have potentially undiagnosed cases of chronic kidney disease (CKD). There are potentially over 1,000 undiagnosed cases in some PCNs. Instances where the number of observed cases exceeded the predicted cases have been excluded.

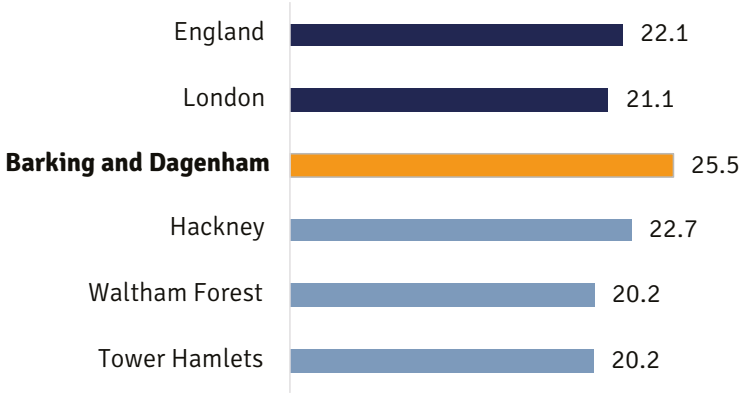
Data is available broken down by age group in relation to CKD. When looking at CKD cases by age group, the number of diagnosed cases exceeds the predicted number among borough residents aged 55 to 75, suggesting that cases are being registered but also that the prevalence is actually higher than predicted for these age groups.

Cases are potentially going undiagnosed in younger residents aged 16 to 54 and older residents aged over 75.

Long term conditions in children and young people

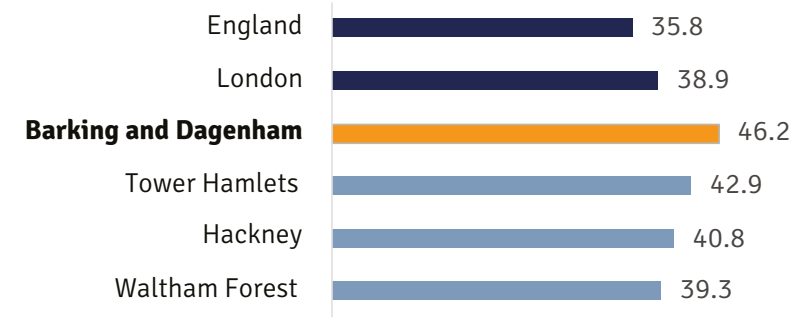
The percentage of overweight or obese Reception children in Barking and Dagenham is higher than the London and England averages and all peer boroughs (based on a 3 year average from 2020/21 to 2022/23). The percentage of overweight or obese Year 6 children in the three years from 2020/21 to 2022/23 is significantly higher than the London and England averages and all peer boroughs.

Figure 34: Percentage of overweight or obese Reception children, 3 year average from 2020/21 to 2022/23



Source: OHID Fingertips Indicator ID 93106, accessed 08/12/2023

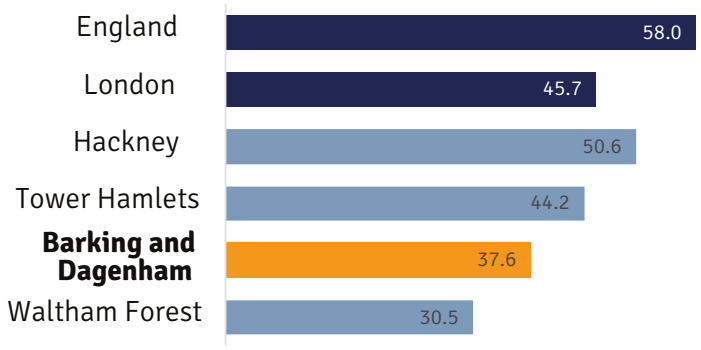
Figure 35: Percentage of overweight or obese year 6 children, 3 year average from 2020/21 to 2022/23



Source: OHID Fingertips Indicator ID 93108, accessed 08/12/2023

Diabetes, asthma, epilepsy, oral health and mental health are highlighted as priority conditions for the reduction of health inequities in children and young people as part of NHS England's 'CORE20 plus 5' approach, which are more prevalent in deprived populations.[26] In the 2021/22 year, hospital admissions in residents aged under 19 for diabetes were lower in Barking and Dagenham than both the London and England average, but higher for epilepsy and significantly higher for asthma, as were all the comparative London boroughs.

Figure 36: Hospital Admissions for Diabetes 2021/22 (under 19yrs, crude rate per 100k)

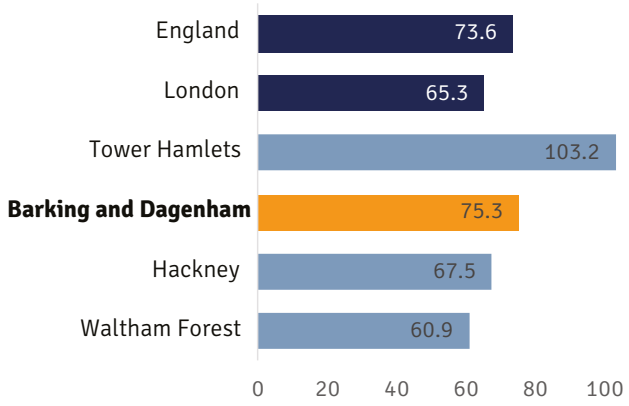


Source: OHID Fingertips Indicator ID 92622, accessed 08/12/2023

Figure 37: Hospital Admissions for Asthma 2021/22 (under 19yrs, crude rate per 100k)

Source: OHID Fingertips Indicator ID 90810, accessed 08/12/2023

Figure 38: Hospital Admissions for Epilepsy 2021/22 (under 19yrs, crude rate per 100k)



Source: OHID Fingertips Indicator ID 92623, accessed 08/12/2023

Mental illness

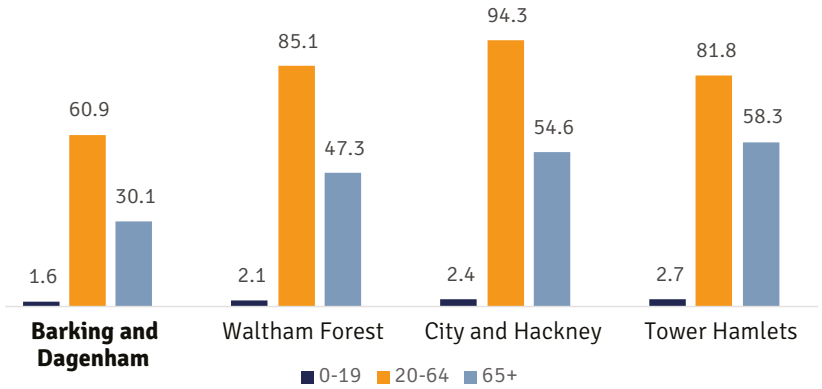
Mental illness can be broadly grouped into common mental disorders (largely mild-moderate anxiety and depression) and serious mental illness (psychotic disorders, bipolar disorder and other mental illness with functional impairment. However psychological distress that does not meet diagnostic thresholds also contributes to poor self reported health. More than 1 in 5 residents aged 16 and over are estimated to have a common mental disorder, compared to 1 in 6 nationally; this is in line with peer boroughs. The GP registered population with mental illnesses is much lower, indicating there is unmet need locally.

Rates of depression follow a similar trend to physical illnesses, being lower than in peer boroughs across all age brackets. Modelling based upon population growth projections indicates

the numbers are likely to increase by 2040 by 28%; highlighting the need for community-based services and action to support mental health.

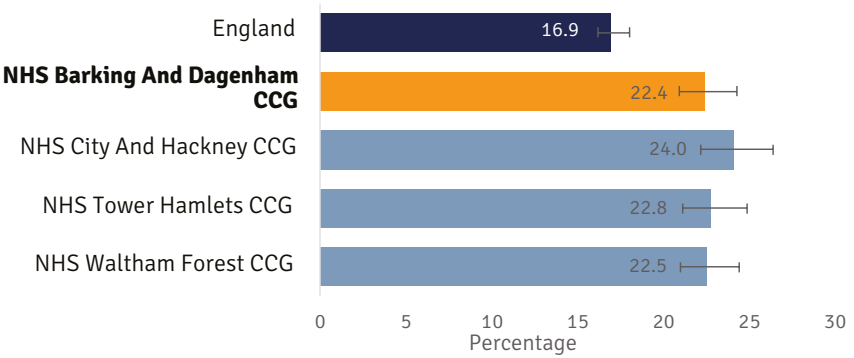
Nationally 0.9% of the population are estimated to suffer from a serious mental illness. The inequalities in life expectancy for this group are discussed in the Mortality section. The incidence of new psychoses is 41.0 per 100,000; which is significantly higher than the England (24.2 per 100,000) average but significantly lower than peer boroughs of Hackney (71.9 per 100,000) and Tower Hamlets (59.7 per 100,000) , and lower than Waltham Forest (48.5 per 100,000),but not significantly so.

Figure 39: Rate of patients with depression per 1,000 registered patients in age group



Source: LTC Dashboard: NEL CCG Long Term Conditions Dashboard, data collected as of 31st October 2023

Figure 40: Estimated prevalence of Common Mental Disorders: % of population aged 16 & over (2017)



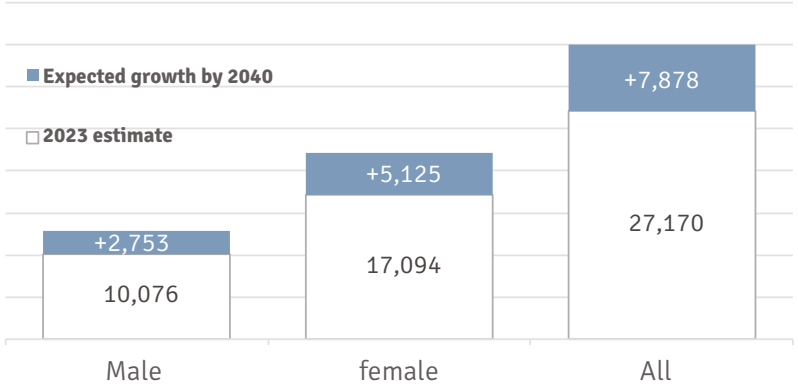
Source: OHID Fingertips Indicator ID 93495, accessed 22/11/2023

According to the Adult Psychiatric Morbidity Survey 2014, 23.1% of women and 14.7% of men met the diagnostic criteria for at least one Common Mental Disorder (CMD).

Applying these national rates to © GLA 2021-based demographic projections for the borough gives an estimate of 27,170 Barking and Dagenham residents with a CMD in 2023, increasing to over 35,000 in 2040.

Note that these estimates only account for age and gender. Other factors not taken into account here will have an impact on local prevalence.

Figure 41: Number of Barking and Dagenham residents aged 18-64 estimated to have a Common Mental Disorder in 2023 with expected growth by 2040



Source: National prevalence rates from Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 (2016), NHS Digital (as referenced by www.pansi.org.uk) have been applied to © GLA 2021-based demographic projections.

An estimated 56.2% of Barking and Dagenham residents aged over 65 estimated to have dementia have received a recorded diagnosis, meaning many will not be accessing support and early intervention. This is below the London average of 65.6% and is the lowest of all peer boroughs. The estimated diagnosis rate in the borough has been on a downward trend since 2019 when it stood at 63.5%, and the gap between Barking and Dagenham and the London average has broadened in each of the last three years, from 6.7 percentage points in 2021 to 8.8 percentage points in 2023.

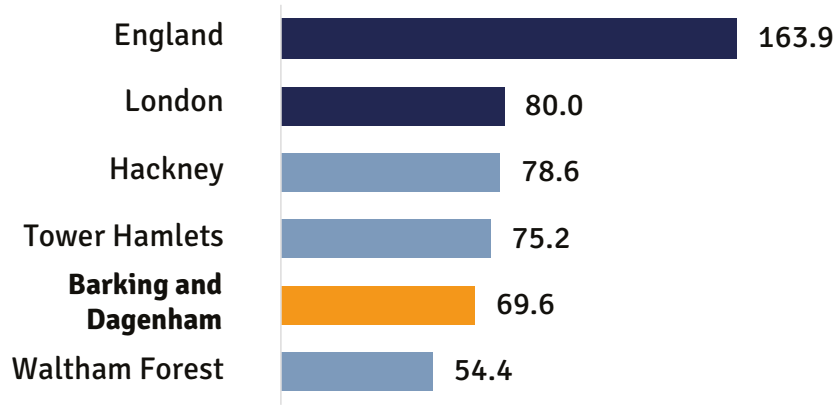
Barking and Dagenham has one of the lowest rates of emergency hospital admissions for intentional self-harm in the country. There were 155 residents admitted to hospital for intentional self-harm in 2021/22, giving a rate of 69.6 per 100,000 population. The number of females admitted was greater than the number of males (95 compared to 60) and this reflects national trends.

The hospital admissions data is being used as a proxy of the prevalence of severe self-harm, in the absence of data representing all aspects of mental health and wellbeing. However this is only a small proportion of self-harm, most of which does not present to emergency care. There is a significant and persistent risk of future suicide following an episode of self harm, and there can be long term effects detrimental to an individual's long term physical health. The relatively lower rates of self- harm admissions are in contrast to increasing trends in suicides (see Mortality Section) suggesting a more complex picture of mental health risk in the borough.

Figure 42: Estimated dementia diagnosis rate per person estimated to have dementia.

Source: OHID Fingertips Indicator ID 92949 accessed 8/12/2023

Figure 43: Emergency hospital admissions for intentional self-harm.



Source: OHID Fingertips Indicator ID 21001 accessed 8/12/2023

Mental illness in children and young people

National data indicates that in children aged 7 to 16 years, rates of probable mental disorder rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020, then remained stable between 2020, 2021 and 2022. In young people aged 17 to 19 years, rates of a probable mental disorder rose from 1 in 10 (10.1%) in 2017 to 1 in 6 (17.7%) in 2020. Rates were stable between 2020 and 2021, but then increased from 1 in 6 (17.4%) in 2021 to 1 in 4 (25.7%) in 2022. Rates of probable mental disorder were more likely in those experiencing financial hardship[27].

1,881 referrals were made to North East London Foundation Trust's (NELFT) Children and Adolescent Mental Health Service (CAMHS) in the 12 months from August 2022 to July 2023[28]. Referrals peaked in November and February due to an increase in referrals from schools for emotional wellbeing interventions.

NELFT now has Mental Health Support Teams (MHSTs) in 16 schools (primary and secondary inclusive) to support with emotional wellbeing, and has an integrated systemic approach to care delivery.

Within the same period, 134 routine and 42 urgent referrals were sent to NELFT's London Eating Disorders service. NELFT aims to see urgent referrals within 1 week and routine referrals within 4 weeks.

Learning disabilities and Autism

In 2023 a needs assessment was carried out on Children and young people with Special Educational Needs and Disabilities.

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

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

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

- There are several risk factors in the borough that could drive increases in SEND needs, including increasing ethnic variation and deprivation. The existing challenges to delivering support that families need include shortages linked with difficult recruitment and retention of specialist staff; delays in obtaining EHC Plans and in effective multidisciplinary communication; and lack of clarity on the local offer. The current and new challenges will require both additional provision and new ways of working to address this.

An Autistic Adults needs assessment for Barking and Dagenham is currently in development. The needs assessment looks at what autism is and provides an overview of national policy and statutory guidance. It then summarises local information on autism prevalence and need in Barking and Dagenham and the support currently available in the borough. Analysis suggests that GP registered populations with Autism are higher than population prevalence estimates using POPPI and PANSI tools. While the ratio of autism prevalence between males to females is 3:1 in national figures, POPPI and PANSI estimates calculate a ratio of 8.5:1 for LBBD, which may be indicative of an underrepresentation of autistic adult women. This ratio of male to female (9.8) is especially high when looking at the number of autistic residents in the 18-24 age range.

In the future, the number of autistic adults is estimated to rise by 6% by 2030 compared to 2023, and the age ranges that will see the biggest percentage increase will be the 65-74 and 18-24 age ranges.[29]

Long term conditions: key messages and public health advice

Approximately 1 in 3 registered patients age 65+ in Barking and Dagenham have 1 or more long term conditions, and 1 in 5 registered patients age 20-65 have 1 or more long term conditions. Rates are lower than peer boroughs in the age 65+ bracket but higher in the age 20-64.

Inequalities can be seen, with higher rates of long term conditions in Black and Asian patients, particularly in the older age bracket; and higher rates of long term conditions in patients coming from more deprived areas.

There is likely to be significant unmet need across specific long term conditions: hypertension, diabetes and chronic kidney disease, common mental disorder and dementia. Early diagnosis of cancer and dementia is a concern.

The percentage of adults, children in year 6 and reception in Barking and Dagenham who are overweight or obese is significantly higher than the London and England averages. Additionally, there has been no consistent improvement of adult obesity prevalence over time in Barking and Dagenham since 2015.

In 2021/22, hospital admissions for diabetes in residents under 19 years old were lower than the average in in London and England. However, admissions for epilepsy and asthma in the same age group were higher and significantly higher respectively when compared to the rest of the capital and England.

Rates of probable mental disorder in children and young people are rising in the borough and nationally, and particular pressures are seen locally on CAMHS and eating disorder services.

Public health advice

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

- Reducing smoking and obesity by 2028 as they are primary risk factors associated with heart and lung diseases, cancers and diabetes. Action should include system wide approaches to tackling obesity and enhancing local action on smoking in line with the government's Smokefree generation policy.
- Identifying markers of early disease through improving identification of hypertension, high cholesterol and HbA1c blood levels, and identifying cancers early through the NHS screening programmes.
- Continue targeted case-finding and explore ways to make services more accessible through delivering care closer to communities.
- Identify and tackle the health inequalities that exist within these risk factors, with further analysis and targeted action on specific ethnic, socioeconomic and geographical inequalities associated with priority conditions.
- Supporting mental health of children and young people (both in schools and through care pathways and service improvement to address increasing demand) and improving management of asthma and epilepsy should be prioritised.
- Address the findings of the SEND Needs assessment and Autistic Adults needs assessment in SEND improvement plans and strategic planning.
- Consider further local insights work to better better understand the changing picture of mental health needs in the borough.
- These areas are further explored in Chapter 4 and 5 of the ADPHR 2023.

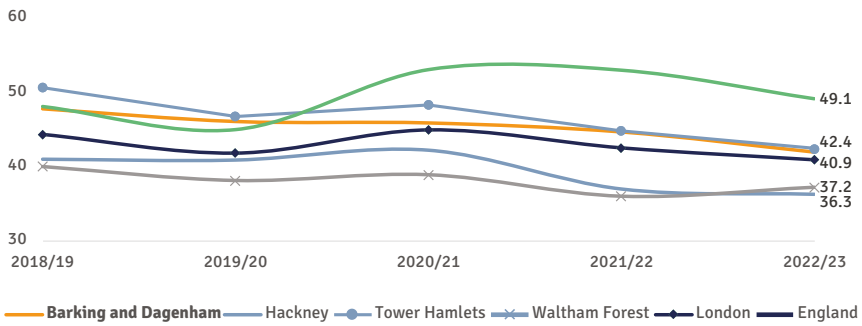
d. Health protection

Vaccination coverage

Vaccination coverage for key immunisations in Barking and Dagenham is comparable or above the vaccination coverage levels achieved by peer boroughs. These vaccinations include Dtap, IPV and Hib vaccine[30], Influenza vaccine for people 65+ and those aged 6 months to 64 years who are at risk.Influenza vaccine coverage was also comparable to, or higher than all peer boroughs and the London average in the 2022/23 year but lagged the England average significantly in the same year.

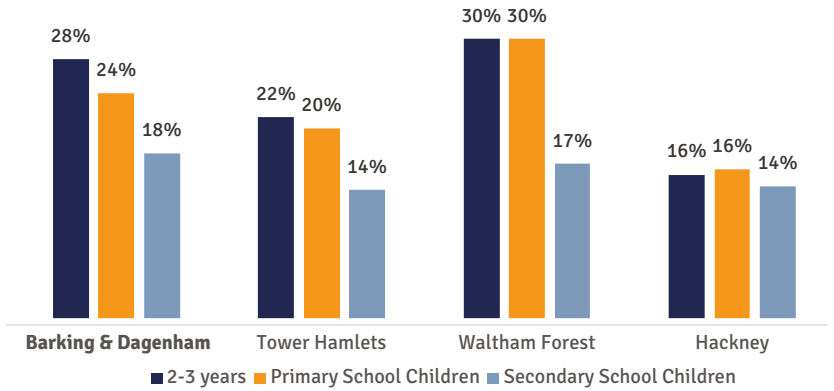
Vaccination coverage for Influenza in at risk individuals aged 6 months to 64 years has also trended downward in recent years, from as high as 50.9% in 2016/17 to 41.9% in 2022/23. Over the same period, the Dtap IPV Hib coverage percentage in 2 year olds in Barking and Dagenham has declined from 94.1% to 84.9%, in line with downwards trends across London and England.

Figure 44: Influenza vaccine coverage in at risk individuals, time trends



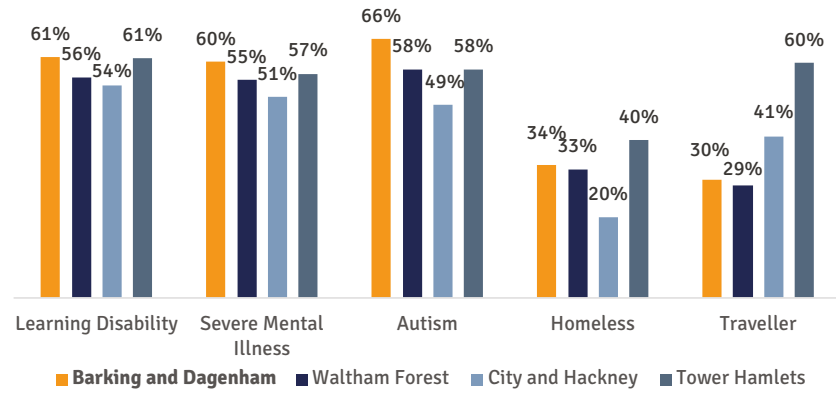
Source: OHID Fingertips Indicator ID 30315, accessed 08/12/2023

Figure 45: Influenza seasonal vaccination uptake proportion - Jan 2024



Source: North East London Health & Care Partnership, COVID-19 vaccinations and Flu immunisations data report, 30th Jan 2024

Figure 46: Influenza vaccination uptake proportion - Jan 2024



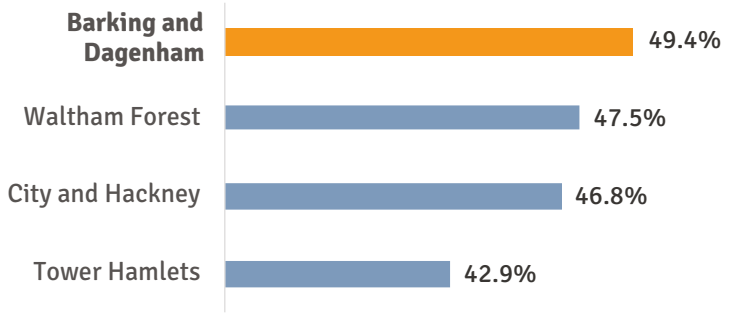
Source: North East London Health & Care Partnership, COVID-19 vaccinations and Flu immunisations data report, 30th Jan 2024

As of January 2024, Waltham Forest was the only peer borough to achieve a higher level of influenza vaccine coverage in children aged 2-3 years and primary school children than Barking and Dagenham. However, Barking and Dagenham vaccinated a higher proportion of secondary school children than any peer borough.

Seasonal influenza vaccination coverage was also equal to or higher than peer boroughs for residents experiencing learning disability, severe mental illness and autism. Only Tower Hamlets had a higher uptake in homeless residents than Barking and Dagenham. Uptake in the Traveller community was lower in Barking and Dagenham than most peer boroughs and was half the coverage achieved in Tower Hamlets.

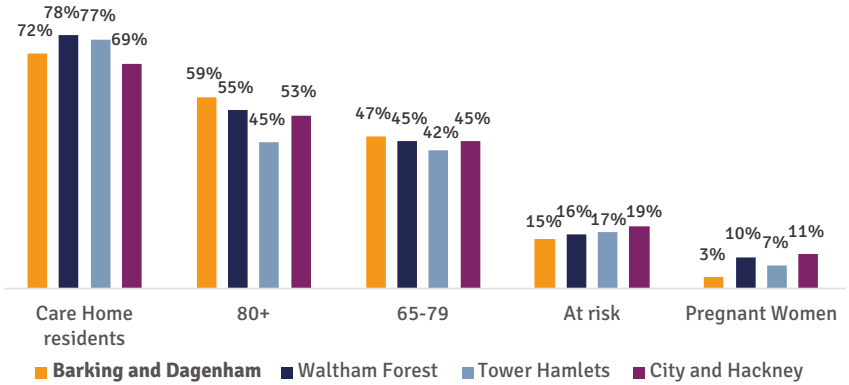
As of January 2024, the COVID-19 Autumn/Winter booster campaign, which began in September 2023, delivered a booster dose of a COVID-19 vaccine to 49.4% of Barking and Dagenham residents aged 65 and over. This is higher than the coverage achieved in all peer boroughs. Older age bands within the 65 and over cohort achieved higher proportions of booster coverage, with 58.8% of Barking and Dagenham residents aged 80 and over receiving a booster dose as part of the Autumn booster campaign.

Figure 47: Proportion of residents aged 65 and over who received a COVID-19 vaccine during the Autumn 2023 booster campaign - Jan 2024



Source: Public Health England: https://coronavirus.data.gov.uk/details/vaccinations

Figure 48: COVID-19 Autumn booster campaign uptake proportion - Jan 2024



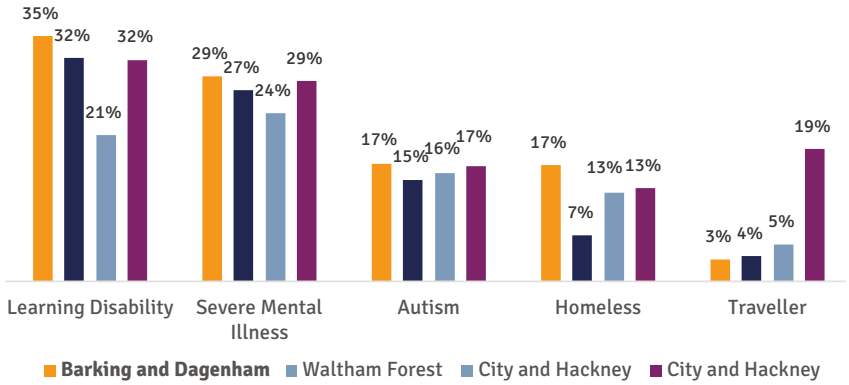
Source: Source: North East London Health & Care Partnership, COVID-19 vaccinations and Flu immunisations data report, 30th Jan 2024.

Barking and Dagenham achieved vaccination coverage of residents aged 65 and above that is higher than all peer boroughs. However, COVID-19 booster coverage of care home residents achieved in the Autumn booster campaign in Barking and Dagenham lagged behind that achieved in Waltham Forest and Tower Hamlets. Coverage of clinically at-risk individuals (including the immunocompromised) and pregnant women were also lower in Barking and Dagenham than all peer boroughs.

Barking and Dagenham has also achieved higher or equivalent levels of COVID-19 booster coverage than all peer boroughs for residents who experience learning disability, severe mental illness, autism and homelessness. However, the booster uptake of Barking and Dagenham's traveller community is lower than all peer boroughs. An additional area in which Barking and Dagenham could improve vaccination was among the borough's frontline health care workers, whose COVID-19 vaccination rate fell from 23.6% in January 2023 to 13.9% in January 2024.

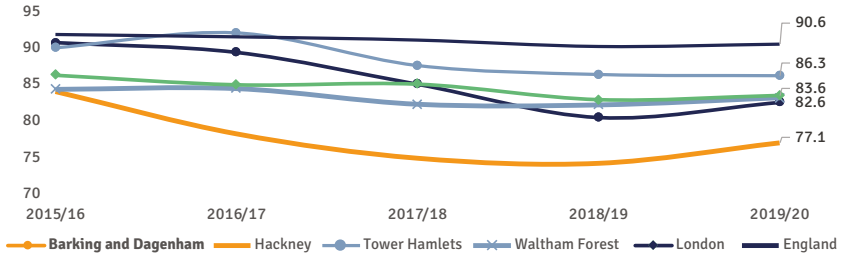
Over the same time period the vaccination rate of social care workers also fell from 14.4% to 13.2%.[31]

Figure 49: COVID-19 Autumn booster campaign uptake proportion - Jan 2024



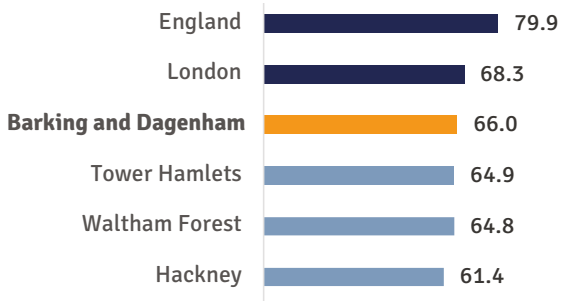
Source: North East London Health & Care Partnership, COVID-19 vaccinations and Flu immunisations data report, 30th Jan 2024.

Figure 50: Vaccination coverage in 2 year olds (MMR)



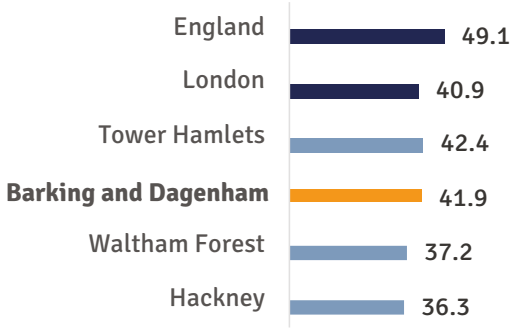
Source: OHID Fingertips Indicator ID 30304, accessed 08/12/2023

Figure 51: Influenza vaccine coverage age 65+



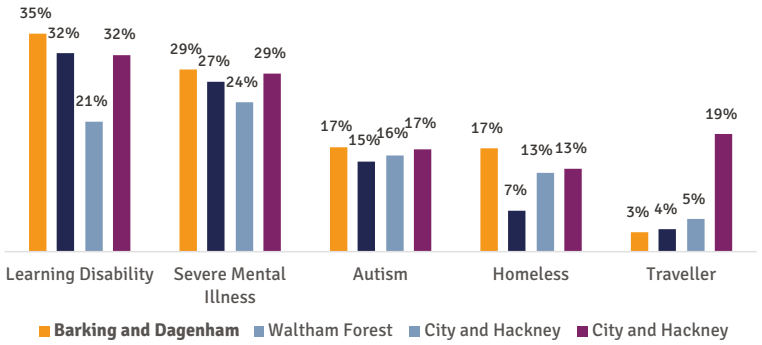
Source: OHID Fingertips Indicator ID 30314, accessed 08/12/2023

Figure 52: Influenza vaccine coverage for at risk individuals



Source: OHID Fingertips Indicator ID 30315, accessed 08/12/2023

Figure 53: Vaccination coverage in 2 year olds (Dtap IPV Hib)



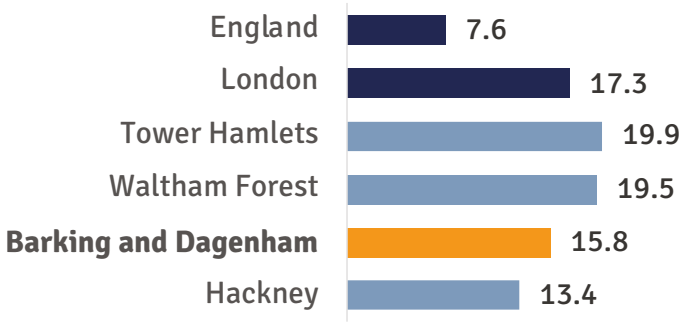
Source: OHID Fingertips Indicator ID 30304, accessed 08/12/2023

Tuberculosis (TB) is a highly infectious disease caused by airborne bacteria, spread through the air when people with TB disease cough, sneeze, or speak. Closely linked to deprivation, overcrowding and malnutrition, it is a serious long term condition which is now curable.[32] Treatment of TB is often complex and lengthy and requires sustained support.

Having seen a sustained decline over the last decade, TB numbers and rates have started to increase in the last few years.

At a local authority level, rates of TB are reported as a three year average. In the three years from 2020 to 2022, Barking and Dagenham had a TB incidence rate of 15.8 people per 100,000. This is below the London average of 17.3 per 100,000 but significantly above the national average of 7.6 per 100,000 and is the 2nd highest of the peer boroughs.

Figure 55: Tuberculosis incidence- 3 year average



Source: OHID Fingertips Indicator ID 91361, accessed

In London, TB disproportionately affects certain groups. During 2023:

- median age of TB notifications for females was 37 years compared to 48 years for males,
- 39% of the notifications were for females,
- 85% were born outside the UK with India being the most common country of birth (31%) followed by Pakistan (8%) and Bangladesh (6%),
- 17% of people with TB aged 15 or older had one or more social risk factors associated with poor outcomes (alcohol misuse, drug misuse, homelessness, imprisonment, mental health needs and asylum seeker status). [33]

The BCG (Bacillus Calmette-Guérin) vaccine helps to protect against TB. Whilst at one time the BCG immunisation programme in England was universal, the rates of TB declined to the extent that it was no longer deemed necessary to vaccinate all children. The BCG immunisation programme is now a selective programme recommended for individuals at higher risk of exposure to TB.

In 2022-23, BCG vaccination coverage at age 3 months was recorded for the first time. The published statistics are designated as experimental. In Barking and Dagenham, 50.8% of eligible infants (1,139 out of 2,242 infants) were vaccinated for BCG by age 3 months, compared to 81.1% in Greenwich, 73.4% in City of London and Hackney (combined), 78.7% in Tower Hamlets and 40.9% in Waltham Forest. The London average was 70.1% and the England average was 68.8%.[34]

Sexual health

In 2021, the prevalence of diagnosed HIV per 1,000 people aged 15-59 years in Barking and Dagenham was 5.1. This is worse that the England rate of 2.3 and is 18th highest out of 150 local authorities. Of the peer boroughs only Waltham Forest had a lower rate than Barking and Dagenham at 4.1 per 1,000 people. Hackney had a rate of 6.8 per 1,000 and Tower Hamlets a rate of 6.9. NICE HIV testing guidance classifies areas with a diagnosed HIV prevalence rate of 2-5 as areas of high prevalence and greater than 5 as areas of extremely high prevalence.

If diagnosed promptly, people living with HIV in the UK who adhere to treatment can now expect to have a near normal life expectancy. Late diagnosis however increases the risk of premature death. In Barking and Dagenham, between 2020-22, 64.7% of HIV diagnoses amongst those first diagnosed in the UK were made at a late stage of infection - the 3rd highest proportion in London. The London average is 39.4% and the national average is 43.3%. National late HIV diagnosis data shows that two-thirds of late HIV diagnoses occur in high-prevalence and extremely-high-prevalence local authorities. This means that if the national recommendation to implement routine HIV testing for all general medical admissions as well as new registrants in primary care in high and extremely high prevalence areas were to be applied locally, it could potentially affect two-thirds of late diagnoses.

More information regarding HIV diagnosis rates can be found in the Summary profile of local authority sexual health (SPLASH) on the Office for Health Improvement & Disparities Fingertips website.

The SPLASH profile includes information about the prevalence of different sexually transmitted diseases within the borough. In 2022, Barking and Dagenham had a new STI prevalence rate of 807.7 per 100,000, compared to an England average of 694.2. The London average was 1,397 per 100,000. From 2021 to 2022 large increases in the rates of syphilis and gonorrhoea were seen in the borough. New syphilis cases have increased from 6 in 2012 to 40 in 2022.

Table 1 Number of new STIs by year, Barking and Dagenham

Diagnoses	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
New STIs	2,023	1,950	1,952	1,928	1,804	1,835	1,798	2,000	1,413	1,498	1,765
New STIs (exc chlamydia aged <25)	1,402	1,392	1,386	1,424	1,296	1,390	1,355	1,474	984	1,128	1,310
Chlamydia	816	759	795	778	800	774	770	937	684	728	871
Gonorrhoea	124	154	153	209	174	243	271	311	272	261	322
Syphilis	6	13	8	8	10	21	19	24	21	32	40
Genital warts	287	276	258	243	234	244	219	207	123	117	122
Genital herpes	138	143	159	153	129	126	143	103	84	89	122
Mycoplasma genitalium[1]	-	-	-	-	-	-	-	11	9	47	52
Trichomoniasis[1]	77	58	59	70	78	64	73	75	50	62	67
Sexually transmitted Shigella spp.	-	-	-	2	0	2	0	1	3	0	0

[1] Data for Mycoplasma genitalium and trichomoniasis were included for the first time in 2022. Testing for these infections is not included as part of a standard sexual health screen, but is advised for those with symptoms and the partners of those diagnosed (see BASHH guidelines for Mycoplasma genitalium and trichomoniasis).

Cancer

There are three screening programmes in the UK for cancer: bowel, breast and cervical cancer screening. The Breast Screening Programme supports early detection of cancer in women aged 53 to 70 registered with a GP. The programme is still recovering from the effects of the COVID-19 pandemic and so coverage is lower than is was prior to the pandemic.

In Barking and Dagenham in 2022, 59.9% of eligible women had had a test in the previous 3 years, exceeding the London average of 55.5%.

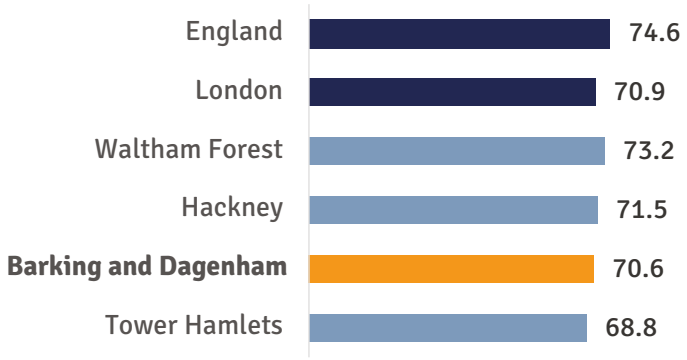
Figure 56:Screening coverage (breast cancer)

OHID Fingertips Indicator ID 22001, accessed 08/12/2023

Figure 57: Screening coverage (bowel cancer)

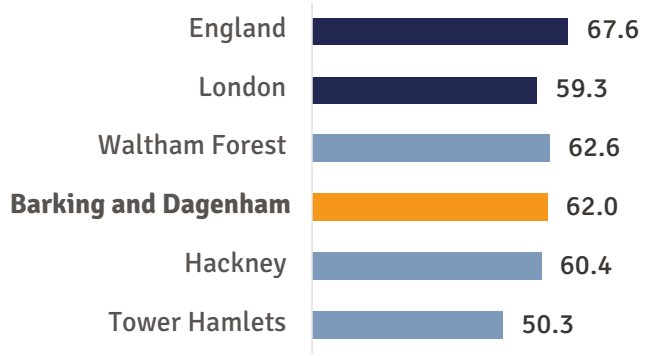
Source: OHID Fingertips Indicator ID 91720, accessed 08/12/2023

Figure 58: Screening coverage (cervical cancer, age 50 - 64yrs)



Source: OHID Fingertips Indicator ID 93561, accessed 08/12/2023

Figure 59: Screening coverage (cervical cancer, 25-49yrs, 2022)



Source: OHID Fingertips Indicator ID 93560, accessed 08/12/2023

Health protection: key messages and public health advice

Vaccination coverage in Barking and Dagenham is comparable to or above the levels achieved by peer boroughs for most key vaccinations, including the Dtap, IPV and Hib vaccine, and the Influenza vaccination for both residents aged 65 years and above and for at risk individuals aged 6 months to 64 years old. Available data on COVID vaccine uptake indicates performance for specific inclusion groups is favourable when compared to peer boroughs, but there is a case for targeted action to improve uptake rates from travellers, pregnant women and those at risk through health conditions.

Barking and Dagenham experiences relatively high rates of TB when compared to peer boroughs, although lower than London average. Only half of eligible babies received the BCG vaccine for TB infection, lower than peer boroughs and London and England Averages.

In 2021, the prevalence of diagnosed HIV per 1,000 people aged 15-59 years in Barking and Dagenham was 5.1. This is worse that the England rate of 2.3 and is 18th highest out of 150 local authorities. From 2021 to 2022 large increases in the rates of syphilis and gonorrhoea were seen in the borough. New syphilis cases have increased from 6 in 2012 to 40 in 2022.

Screening uptake across cervical (70.6%) , bowel (57.4%) and breast (59.9%) cancers has fallen since the pandemic and is generally comparable to London but worse than national performance.

Public health advice:

Continue efforts to improve uptake of childhood and seasonal immunisations, with specific focus on improving BCG uptake in eligible babies, and improving rates of MMR coverage given recent increased cases of Measles in London. These areas are explored in Chapter 6 of the ADHPR.

Sexual health preventative action should focus on early diagnosis of HIV and syphilis and gonorrhoea.

Continue working with NHS North East London to improve the uptake of screening and improvement in coverage across the borough, aligned with public information on how to prevent and identify cancer. This is further explored in Chapter 4 of the ADPHR 2023.

Health related behaviours

Poor diet, physical inactivity or low levels of activity, smoking/ vaping, risky drinking behaviours and drug misuse are all key behaviours that impact on our healthy life expectancy and risk of developing physical and mental health conditions.

Physical activity

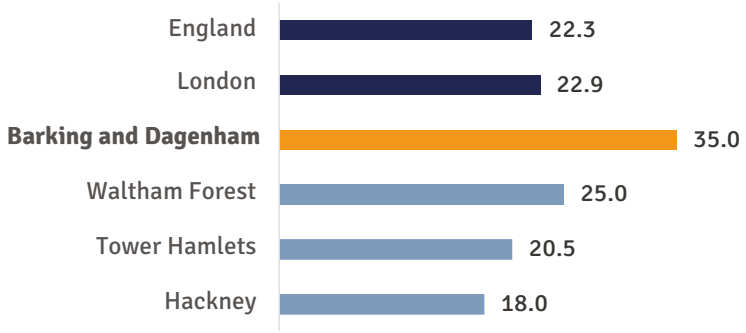
Apart from smoking prevalence, all the key health behaviour indicators show Barking and Dagenham residents performing worse than the London and England averages and all peer boroughs.[35] The percentage of adults who are physically inactive is significantly higher in Barking and Dagenham than in comparators as shown in Figure 61. Conversely, the percentage of adults defined as physically active (participation in at least 150 minutes

of moderate physical activity or equivalent per week) in Barking and Dagenham was 51.9% in 2021/22, which is significantly lower than the London and England averages of 66.8% and 67.3% respectively, as well as all peer boroughs. Although this level of activity represents a recovery from levels seen during the COVID-19 pandemic, activity levels remain lower than pre-pandemic. The recovery in activity levels has not been uniform across all demographics with women's activity levels recovering slower than men's and the gap in activity levels between the most and least affluent areas increasing in the 2021/22 year[36].

The percentage of Barking and Dagenham residents aged 16 and over who report eating 5 portions of fruit and vegetables a day was 47.9% in 2019/20, significantly below the London and England averages, which were 55.8% and 55.4% respectively[37].

In 2022, 23.5% of residents walked at least 5 times per week for any reason, compared to 34.2% and 31.8% for London and England respectively. The percentage achieved in Hackney in the same year was 42.3%. Only 6.5% of Barking and Dagenham residents cycled at least once a week for any reason, compared to 12.4% and 9.3% in London and England and 28.0% in Hackney.

Figure 60: Physically inactive adults



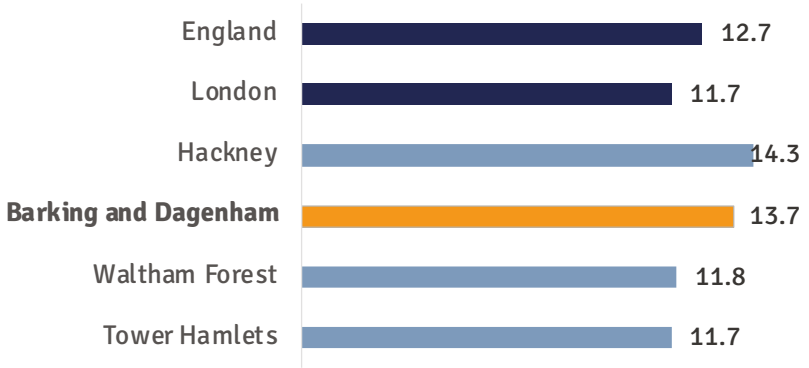
Source: OHID Fingertips Indicator ID 93015, accessed 08/12/2023

Smoking

Smoking prevalence has seen a steep decline in recent years. In Barking and Dagenham, smoking in adults fell from 22.4% in 2018 to 13.7% in 2022. Adult smoking prevalence in the borough is however higher than both the national and regional averages and higher than both Waltham Forest and Tower Hamlets (see Figure 62: Percentage smoking prevalence).

Inequalities persist across London with those in routine and manual occupation, with mental illness and socially or privately renting being more likely to smoke[38]. In Barking and Dagenham in 2022[39], 1 in 4 adults in routine and manual jobs were estimated to smoke, compared to just 4.5% of those in managerial and professional roles (normally requiring a degree or equivalent period of relevant work experience). Prevalence is higher amongst males than females and in 2022 the gap between the two widened in Barking and Dagenham with 21% of males compared to 6.9% of females estimated to smoke.

Figure 61: Percentage smoking prevalence - current smokers, adults 18+, 2022



Source: OHID Fingertips Indicator ID 92443, accessed 08/12/2023

An ONS report on adult smoking habits in the UK[40] showed that 5.2% of survey respondents were daily e-cigarette users, up from 4.9% in 2021. Further, 3.5% reported occasional use, up from 2.8% in 2021. The highest rates were for young people aged 16-24. Vapers in this age group increased to 15.5% in 2022, up from 2021 (11.1%). The rate for female daily users aged 16-24 was 6.7% in 2022, up from 2021 (1.9%); indicating the need to revise smoking cessation efforts in line with changing behaviours.

Alcohol and drugs

Rates of hospital admissions for alcohol-specific conditions in Barking and Dagenham were 461 per 100,000 in 2021/22, which is comparable to Waltham Forest (433 per 100,000) but lower than the London average (586 per 100,000) and peer boroughs of Tower Hamlets (672 per 100,000) and Hackney (combined with City of London, 869 per 100,000). In 2020/21, the rate of people in substance misuse treatment in Barking and Dagenham was 4.2 per 1,000; similar to the England and London averages of 4.5 and 4.1 per 1,000, significantly lower than peer boroughs of Hackney (6.6 per 1,000) and Tower Hamlets (6.3 per 1,000), and similar to Waltham Forest (4.1 per 1,000).

In the charts below, national prevalence rates for alcohol and drug misuse have been applied to Barking and Dagenham population projections[41] to provide a rough estimate of both current and future prevalence. It should be noted that this methodology assumes that the rates of the behaviours will remain unchanged from the period in which it was assessed. Local prevalence rates are likely to differ to those shown at a national level.

The Health Survey for England 2014 commissioned by NHS Digital found that males aged 45-64 are more likely to consume alcohol at levels associated with a higher risk of health problems. Below are the findings as referenced by http://www.pansi.org.uk. Total prevalence for males aged 18-64 is 5.3% for males and 3.4% for females.

Table 2: percentage of people at high risk of alcohol related health problems, England

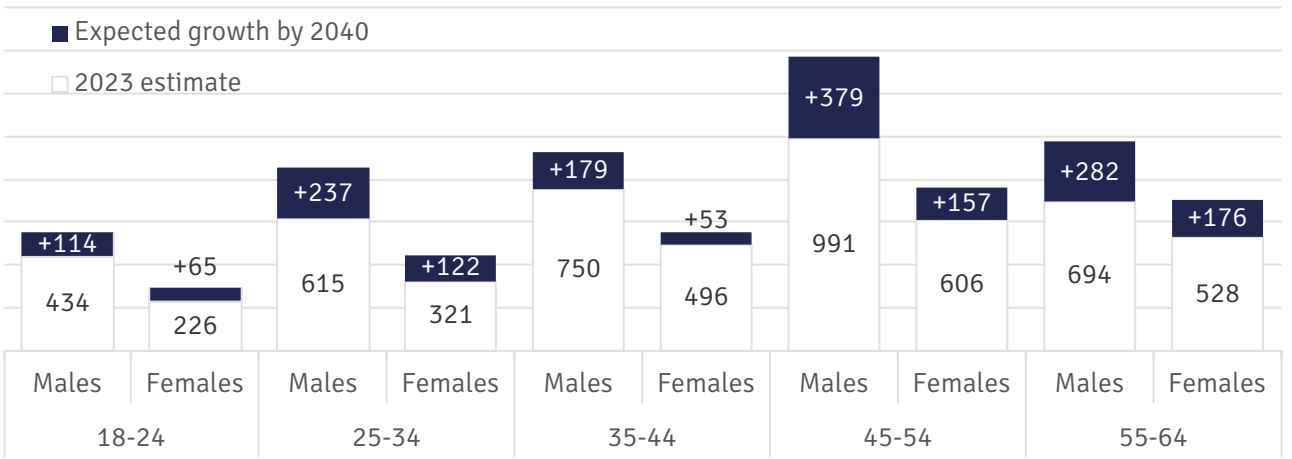
Age range	males	females
18-24	4.3	2.6
25-34	3.6	2
35-44	4.4	2.8
45-54	7.3	4.2
55-64	6.8	4.9

The Adult Psychiatric Morbidity Survey 2014 commissioned by NHS Digital found that males aged 18-34 are more likely to develop dependency on drugs. Below are the findings as referenced by http://www.pansi.org.uk. Total prevalence for males is 4.7% for males and 2.3% for females.

Table 3: Percentage of people estimated to be dependent on drugs, England

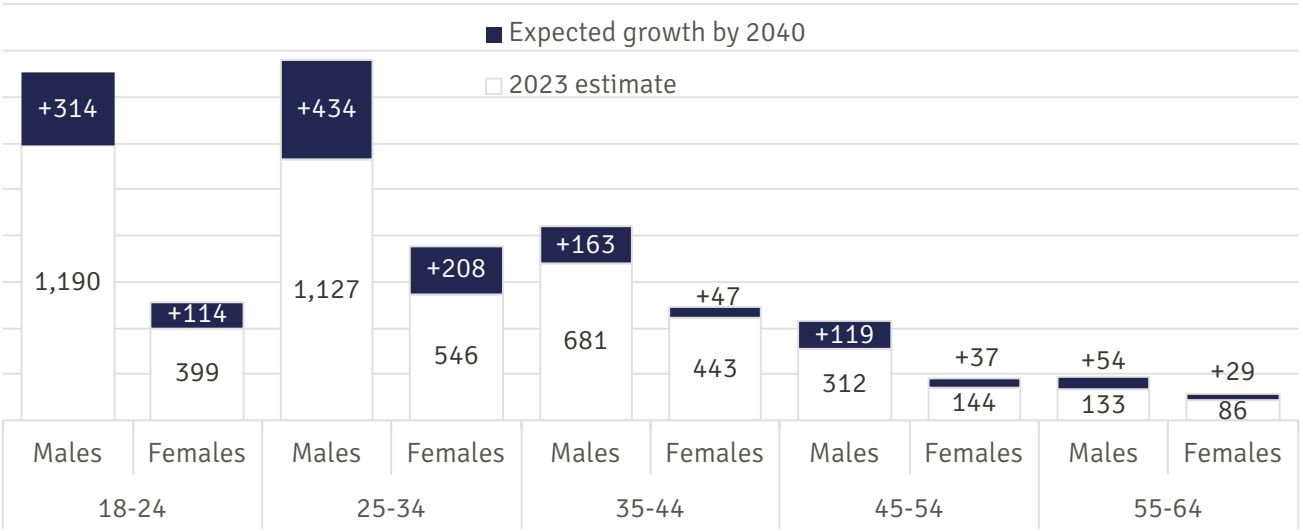
Age range	males	females
18-24	11.8	4.6
25-34	6.6	3.4
35-44	4	2.5
45-54	2.3	1
55-64	1.3	0.8

Figure 62: High risk alcohol consumption age 18-64, projections



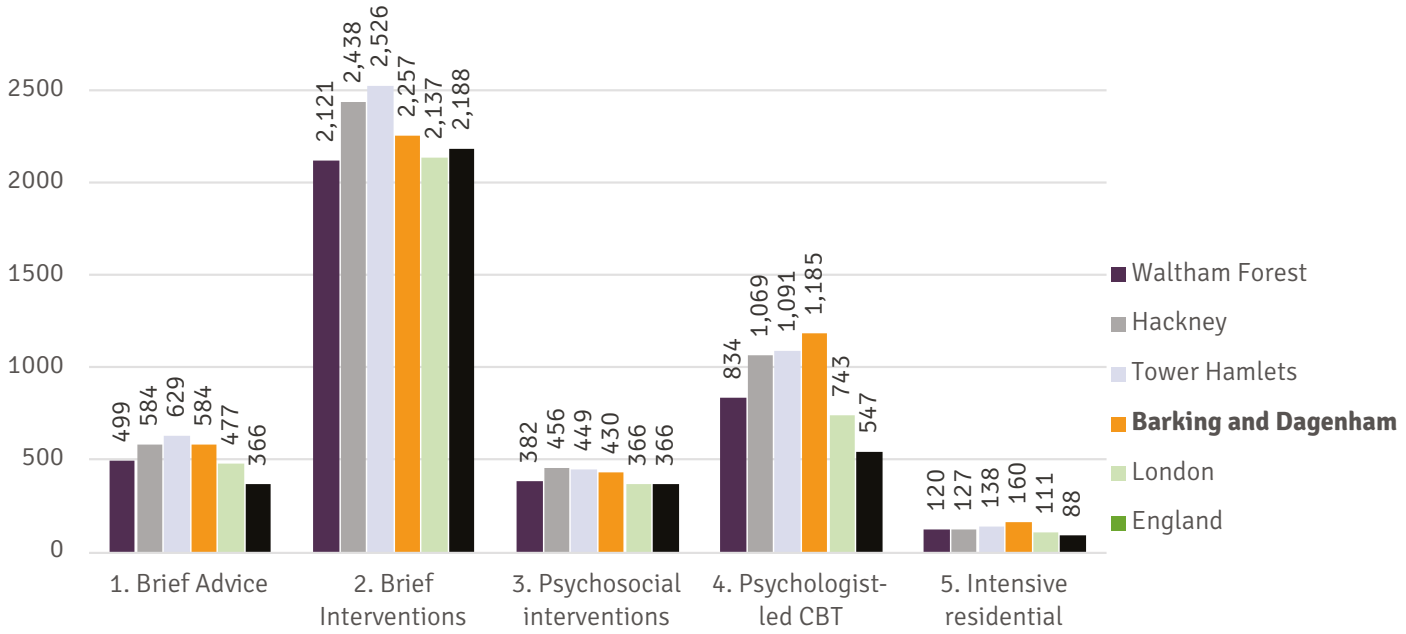
Notes: higher risk is associated with alcohol consumption of above 50 units a week for men and above 35 units for women. This is based on the UK Chief Medical Officers low risk drinking guidelines published in 2016

Figure 63: Drug dependence in age 18-64, projections



Problem gambling

Figure 64: Estimated rate per 100,000 adult population who would benefit from gambling treatment - by intensity of treatment support (2015-18 combined data)



Source: Gambling treatment need and support: prevalence estimates. Office for Health Improvements and Disparities. Available at: https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates

Figure 64 shows the rate per 100,000 adults who would benefit from gambling treatment, grouped by the intensity of treatment required. The list below describes each level of treatment intensity:

1. **Brief advice:** brief conversation delivered by non-specialists and referral to 'self-help' sources.
2. **Extended brief interventions**: 2 or 3 sessions of motivational interviewing delivered by gambling-specialist practitioners.
3. **Psychosocial interventions delivered in the third sector**: Around 6 sessions of psychosocial treatment delivered by gambling treatment practitioners in the third sector.
4. **Psychologist-led cognitive behavioural therapy (CBT):** 8 to 14 sessions of CBT for gambling disorder, delivered by clinical psychologists or CBT-accredited psychotherapists. It may also include psychological therapy for comorbid mental health conditions.
5. **Intensive residential treatment**: A 12-week residential treatment programme that would include one-to-one therapy and group sessions.

For every level of gambling treatment, Barking and Dagenham exhibits a higher rate of need than the London and England averages. For lower levels of treatment intensity (1 to 3), Barking and Dagenham exhibits similar or lower levels of need to peer boroughs, but for the most intense 2 levels of treatment (4 and 5), Barking and Dagenham has a higher need than London, England and all peer boroughs, suggesting need for access to problem gambling services in the borough.

Health related behaviours in children and young people

The effects of negative health behaviours are also visible in children in Barking and Dagenham and will impact on their future risk of illness.

Physical activity

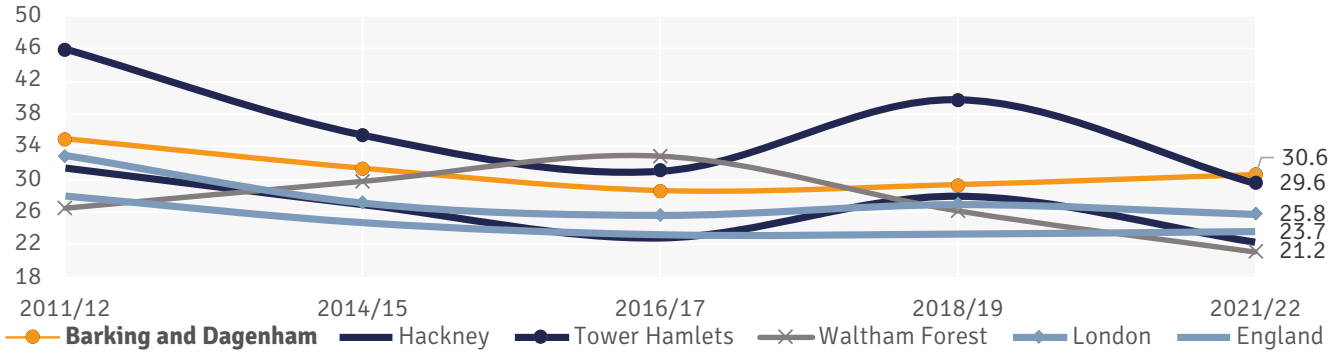
The Chief Medical Officer recommends that children and young people aged 5-18 engage in at least 60 minutes of moderate-to-vigorous physical activity per day (or averaged across the week).[42] According to the 2022/23 Active Lives Survey of children and young people, less than half of Barking and Dagenham respondents (43.9%) meet this recommendation, and over a third (35.4%) do less than 30 minutes a day on average.

Oral health

The NHS Child Health Insights Tool shows that in 2022/23, less than half of Barking and Dagenham's 0-17 year olds were seen by a dentist. Nationally, children living in the 20% most deprived Lower Super Output Areas (the 'Core20 population') are less likely to receive dental treatment than children living in less deprived areas, but are more likely to have decay or fillings, or require urgent treatment. Boys from both the Core20 and Non-Core20 population are less likely than girls to visit a dentist, and more likely to have serious dental health issues.

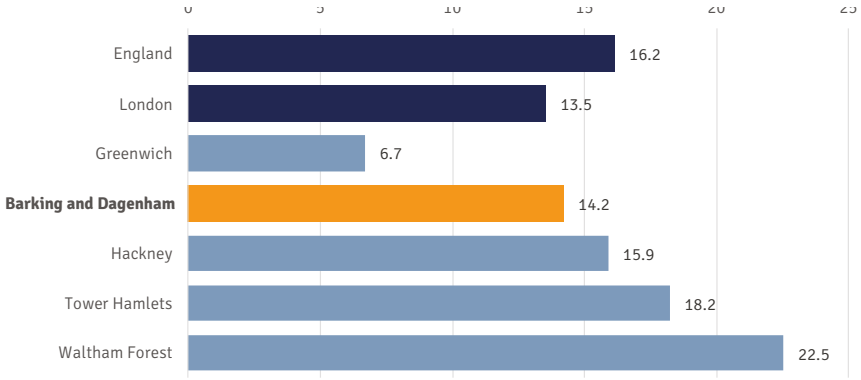
In 2021/22, 30.6% of 5-year-olds in Barking and Dagenham had visually obvious dentinal decay, and this was higher than the London, England and all peer borough averages. The proportion of 5 year olds with visually obvious dentinal decay was on a downward trend, however it has been on a slight upward trend since 2016/17.

Figure 65: Percentage of 5 year olds with experience of visually obvious dentinal decay



In the 2022/23 academic year the first ever oral health survey of year 6 children was carried out as part of the Office for Health Improvement and Disparities' National Dental Epidemiology Programme (NDEP). The proportion of year 6 children in the borough experiencing dentinal decay was 14.2%; under half that seen in 5 year olds. National data for Year 6 children shows that the percentage of children with dentinal decay increases with deprivation (from 10.4% in the least deprived to 23.3% in the most deprived quintile) and varies according to ethnicity. The White Gypsy / Irish Traveller ethnic group is an outlier with 34.7% of year 6 children experiencing dentinal decay compared to the next highest group of Other Arab ethnicity with 24.9%. There was little difference between sexes nationally, with 15.3% of male and 16.9% of female year 6 children experiencing dentinal decay.

Figure 66: Percentage of Year 6 children with experience of visually obvious dental decay, 2023



Source: OHID Oral health survey of children in year 6, 2023

Children and young people's health and wellbeing survey

An additional source of information about the health behaviours of children in Barking and Dagenham is the Barking and Dagenham Children and young people's Health and Wellbeing Survey, which is conducted by the Schools Health Education Unit and is available here: https://www.sheu.org.uk/. The following behaviours were reported by Year 8 and 10 schoolchildren in Barking and Dagenham in 2022.

Significant disparities in various health-related behaviours were reported in the 2022 Children and young people's Health and Wellbeing Survey. Notably, both Year 8 and Year 10 children who identify as lesbian, gay, or bisexual exhibit higher rates of engaging in risky or unhealthy behaviours compared to the all-child average in the same year. They are significantly more likely to have tried:

- smoking (Y8: 7% vs. 3% average, Y10: 19% vs. 7% average)
- vaping (Y8: 25% vs. 10% average, Y10: 40% vs. 22% average)
- illegal drugs (Y10: 15% vs. 4% average)
- sexual activity (Y10: 9% vs. 4% average)
- unprotected sex (Y10: 7% vs. 2% average)

This indicates potential challenges in tobacco and substance use prevention, and sexual health promotion efforts within this demographic. Additionally, Year 10 children identifying as lesbian, gay or bisexual reported markedly lower levels of satisfaction with weight (19% below average), the highest incidence of med-low scores on the Warwick-Edinburgh Mental Wellbeing Scale, low resilience scores and the lowest percentage of any group reporting that they are satisfied with their life (22% vs. 40% average).

Figure 67: Young people's health behaviours, results from SHEU Survey, 2022

84%
of pupils responded that they cleaned their teeth at least twice the day before the survey.

2%
of pupils responded that they have taken at least one recreational drug listed in the survey during the last month.

1%
of pupils responded that they smoke cigarettes 'regularly'.

14%
of pupils responded that they ate at least 5 portions of fruit and vegetables on the day before the survey, down from 17% in the 2019 survey. comparable to national averages.

60%
of pupils responded that they have been to the dentist in the last year.

16%
of pupils responded that they have at least tried vaping, while

2%
said they vape 'regularly'.

17%
of pupils responded that they have had an alcoholic drink at some point (a whole drink, not just a sip), down from 24% in the 2019 survey.

Bullying, having someone you can trust, positive feelings about weight and healthy social media use are important determinants of child mental health. LGB children also reported the second highest rate of experience of past or current bullying at 46%, compared to the average of 24%. This figure was 45% and 40% in the 2019 and 2017 SHEU surveys respectively, marking the second increase in consecutive surveys. Only Year 10 children belonging to a single parent family reported higher rates of bullying, at 55%. Children with Special Educational Needs (SEN) also reported above average rates of bullying, at 33% as did young carers, at 31%.

Year 10 children from single parent families reported the highest rate of trying vaping and illegal drugs (44% and 20% respectively) and the lowest percentage of children who said they knew at least one adult they could "really trust", at 71% compared to the all-child average of 88%.

39% of all Year 10 children reported more than 5 hours of screentime a day. This number was 62% for LGB children, 47% for children in single parent families and 47% of children with special educational needs.

A minority of Year 8 children reported being happy with their weight (46%) in the 2022 survey, including just 31% of the LGB children. This figure has fallen from 47% in 2019 and 52% in 2017. 41% of Year 10 children reported being happy with their weight in 2022, down from 42% in 2019 and 46% in 2017. Again, LGB children reported the lowest percentage of any demographic, at 22%, closely followed by children living in a single parent family at 29%.

Health related behaviours: key messages and public health advice

In 2021/22, 35% of adults in Barking and Dagenham, were physically inactive, higher than all peer boroughs and London and England averages.

The percentage of Barking and Dagenham residents aged 16 and over who report eating 5 portions of fruit and vegetables a day was 47.9% in 2019/20, significantly below the London and England averages.

The highest proportions of high-risk alcohol consumption are seen in the age 45-54 bracket, and most growth in need is projected in this age group. The highest proportions of drug misuse are seen in the age 18-35 bracket, and most growth is projected in this age group.

In the 2021/22 year, 30.6% of 5-year-olds in Barking and Dagenham had visually obvious dentinal decay, and this was higher than the London, England and all peer borough averages. Available data suggests that at age 15/16, 14.2% have visually obvious dentinal decay, which is comparable to London and England averages.

In a survey of children in years 8 and 10, 16% of pupils responded that they have at least tried vaping, while 2% said they vape 'regularly' and 1% said they smoke cigarettes regularly. 17% said they had dried an alcoholic drink; and 2% of pupils responded that they have taken at least one recreational drug listed in the survey during the last month. Lesbian, gay or bisexual young people have higher rates of risky behaviours, and worse wellbeing, including higher risk of being bullied, than their non-LGB peers.

Public health advice

- Develop a place based approach to improving physical activity and nutrition aligned with work across the council on food environments and planning for healthy places.
- Plan to align drug and alcohol service provision with projected growth and priority groups and consider targeted preventative action for those with highest projected growth.
- Review the local offer for gambling support based on available need data.
- Focus action on treating and preventing dentinal decay in young children.
- Consider targeted approaches for health promotion for LGB young people and children of single parents including action on wellbeing and bullying.

Service use and access

Health and social care services support the health and wellbeing needs of the local population. Planning for these services must take into account changing needs, but it is also important to address inequalities in access and outcomes for these groups; including barriers to access. Data relating to health and social care use, and future need projections, is outlined in this section.

Hospital waiting lists

There were just over 17,000 Barking and Dagenham patients on inpatient and outpatient waiting lists in January 2024, representing nearly 19,800 different pathways. The below charts show the average waiting time for each of the pathways, according to different factors such as sex and deprivation. The average wait overall is 18.6 weeks, however some patients (representing 2% of pathways) have been waiting over 52 weeks.

Females have been waiting a week and a half longer than males on average, however females represent a greater proportion of the waiting list at 60%. The waiting time also varies according to age with those aged under 10 and those aged 80 and over experiencing shorter waiting times.

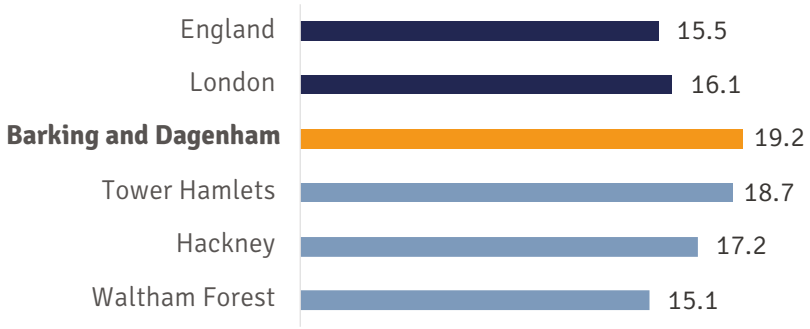
Waiting times increase as deprivation levels decrease, though it should be noted that patients in quintiles 4 and 5 reside in other Local Authorities (but are registered with an in-borough GP) as all areas of Barking and Dagenham are in quintiles 1-3.

Waiting times by ethnic group vary slightly, with patients from the Black or Black British group waiting 18.8 weeks compared to 18.2 weeks for Other Ethnic Groups. The proportion of patients of White ethnicity on the waiting list (52%) is disproportionate to the broader patient population (37%).

Emergency readmissions

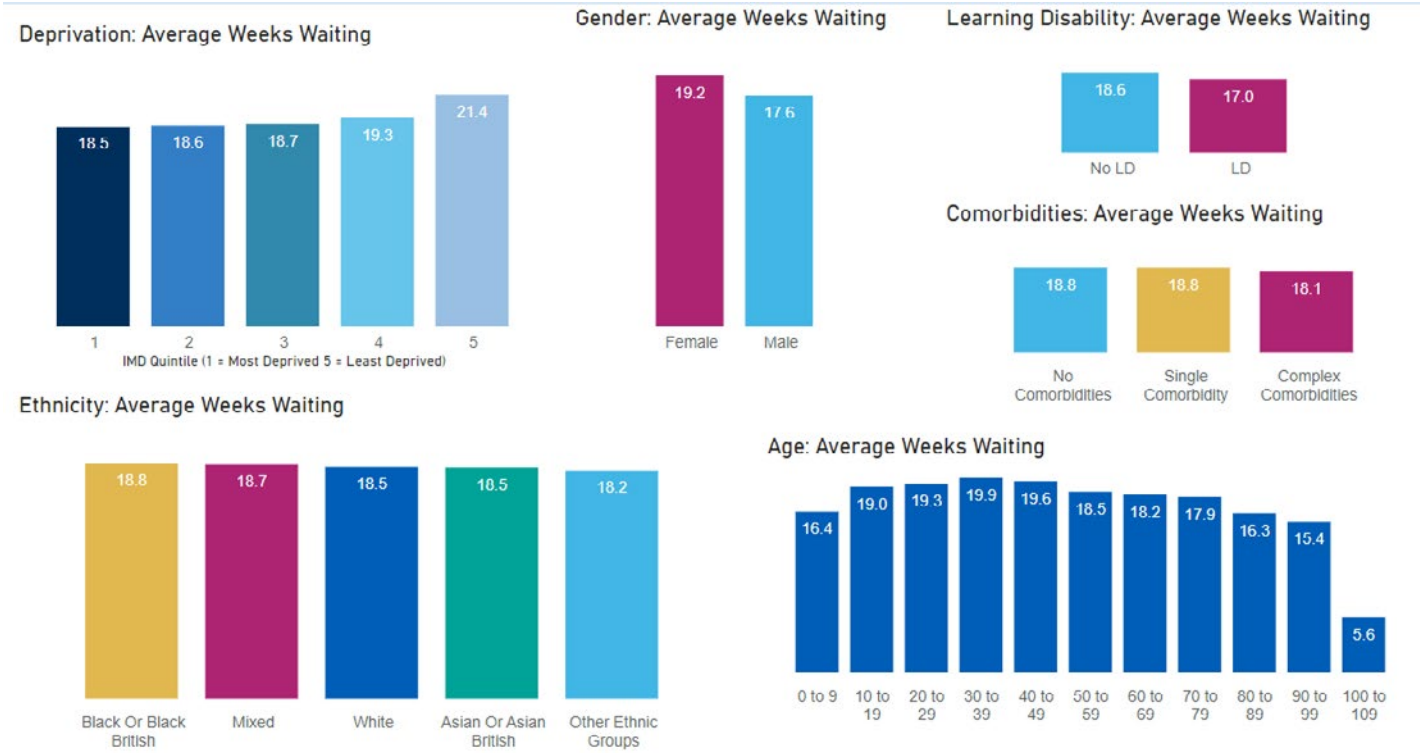
In 2020/21, 19.2% of residents in Barking and Dagenham who were admitted to hospital were readmitted within 30 days. This is higher than London and England averages and all peer boroughs, suggesting local residents are less likely to successfully recover following a hospital episode. This could be related to a number of reasons, including baseline health status, support received in the community and care received. This rate increased since 2019-20 when it was 16.8%, mirroring national trends following the pandemic.

Figure 68: Emergency readmissions within 30 days



Source: OHID Fingertips Indicator ID 41101, accessed 08/12/2023

Figure 69: Inequalities for Barking and Dagenham patients on hospital waiting lists at 21st January 2024, produced by the NHS North East London Business Intelligence Team



Experiences of primary care

Barking and Dagenham Healthwatch reports receiving persistently high signposting phone calls from residents about people struggling to access appointments, but some do talk about improvements to access

"My GP does not look after me and does not give me appointments. I cannot use online services due to the language barrier. No scans were offered, and I am in pain. No interpreting services. My son-in-law goes to appointments with me. We spoke to the practice manager but got nowhere."

"I feel that GPs are getting better. A multicultural community lives in this borough and a lot of work is being done to support everyone. Hospitals are good but there isn't enough convenient parking around them."

Experiences of maternity care

Healthwatch Barking and Dagenham recently conducted analysis on understanding choice in maternity care for Barking and Dagenham residents[43] - 42 respondents were from Barking and Dagenham and over half of them (57%) were from Black, Asian and Minority Ethnic communities. Findings suggested some lack of clarity over support and a lack of continuity of care.

'They need more funding for more midwives and for women to have one point of contact through their pregnancy .'

'Clarity over who you can contact for what support'

'Improve signposting procedures - I had conflicting advice.'

'They need more funding for more midwives and for women to have one point of contact through their pregnancy'

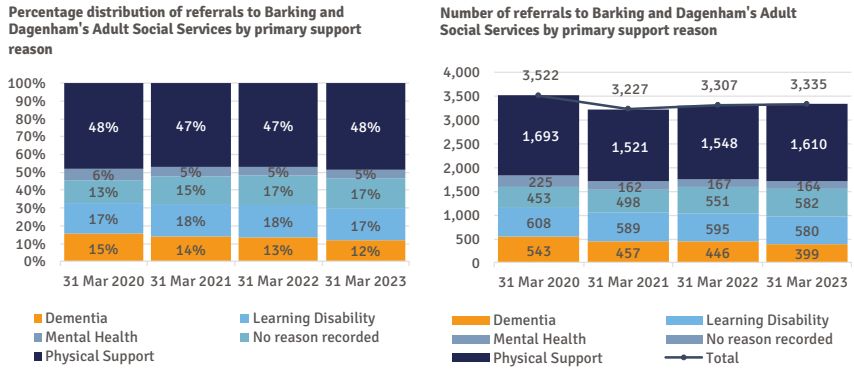
For antenatal care, the following groups felt less likely to be listened to:

- Aged under 25
- White ethnicities other than White British, particularly Polish and Romanian single mothers-to-be
- Disabled
- Not fluent in English
- Digitally excluded

Adult social care needs

In the year ending 31st March 2023, 3,335 referrals were made to Barking and Dagenham's Adult Social Services. The total number of referrals received, as well as the distribution by primary support reason, has remained relatively stable over the last 3 years. Almost half of all referrals are for physical support with a further third being divided equally between learning disability and mental health support needs. 12% of referrals are for dementia support. This proportion is slowly declining.

Figure 70: Number and percentage Referrals to Adult Social Services by primary care need



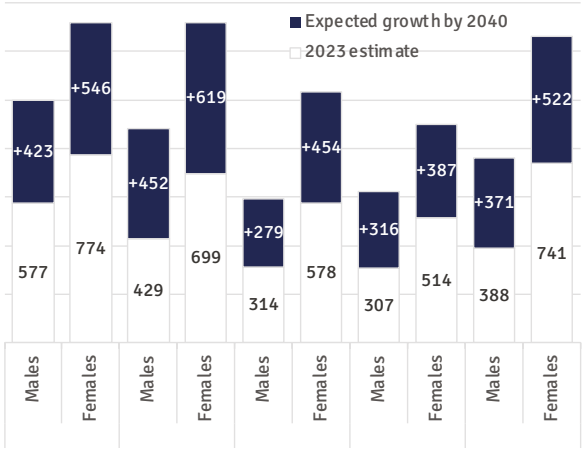
Source: Local authority administrative data

Looking ahead

People with long term conditions are likely to have greater care needs and be at higher risk of falls as they age. People with learning disabilities are also likely to need additional support and care. To aid service planning for these populations, projections have been made by applying national prevalence rates to Barking and Dagenham population projections to provide a rough estimate of both current and future prevalence. Numbers of those needing help with at least 1 self care need are likely to double across the majority of age bands over 70 by 2040. Numbers of falls are also projected to approximately double across all age bands over 65 by 2040. Estimated increases in adult populations with learning disabilities needing care in this time frame are more modest, but may be an underestimation given emergent findings of the SEND and Autism Needs assessments referenced in the long term conditions chapter of the JSNA.

It should be noted that this methodology assumes that the rates of these problems in the local population will remain unchanged from the period in which they were calculated. Additionally, local prevalence rates are likely to differ to those shown at a national level due to differences in the socio-economic profile and demographic make up of the population.

Figure 71: Residents age 65+ needing help with at least 1 self care activity,



The below rates show the % of males and females who had at least one fall within a 12 month period, as reported by Health Survey for England (2005), volume 2, and referenced by www.poppi.org.uk. According to poppi.org.uk, a more recent study suggests rates remain similar.

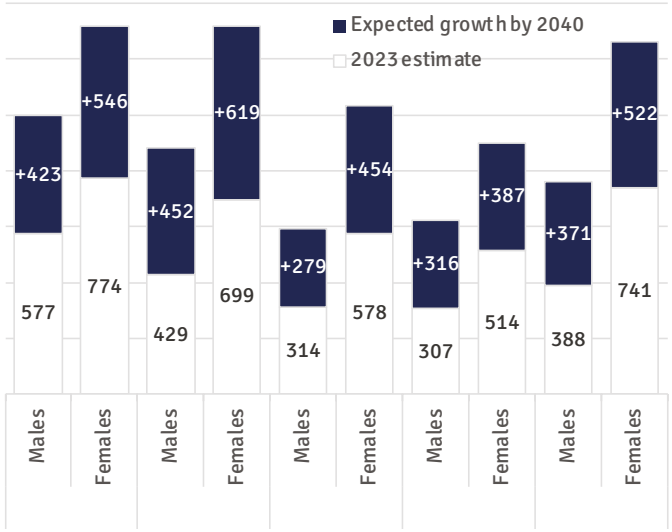
These rates have been applied to © GLA 2021-based demographic projections to create estimates for the borough.

% people who had at least one fall during the last 12 months		
Age range	% males	% females
65-69	18	23
70-74	20	27
75-79	19	27
80-84	31	34
85+	43	43

Notes: self-care activities include having a bath or shower, using the toilet, getting up and down stairs, getting around indoors, dressing or undressing, getting in and out of bed, washing face and hands, eating (including cutting up food), taking medicine.

Source: POPPI and PANSI Projections

Figure 72: Residents age 65+ estimated to have a fall, projections



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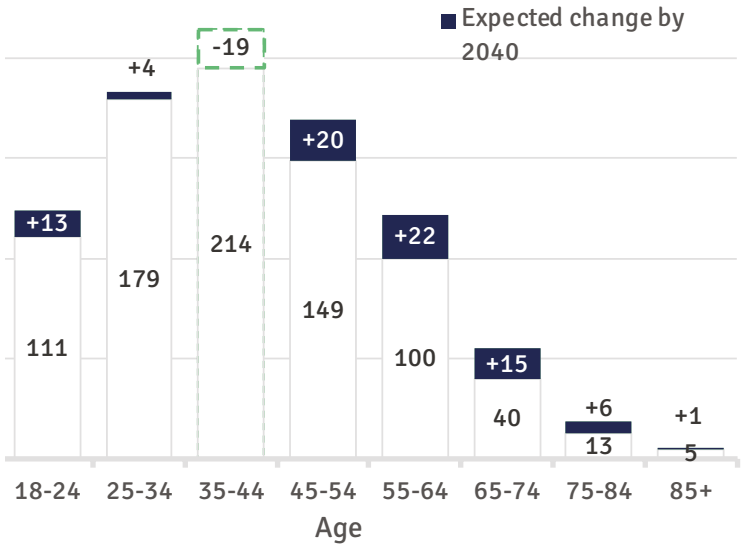
% people who had at least one fall during the last 12 months		
Age range	% males	% females
65-69	18	23
70-74	20	27
75-79	19	27
80-84	31	34
85+	43	43

Source: POPPI and PANSI Projections

Figure 73: Adults age 18+ with learning disability projections



Source: POPPI and PANSI Projections

These estimates are based on prevalence rates from a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004, as referenced by www.poppi.org.uk. The rates include adjustments for mortality and ethnicity but are based on the national population. They are likely to be an underestimation in areas with large South Asian communities, such as Barking and Dagenham, as the prevalence of learning disabilities within this population is higher.

Projection rates have been applied to ONS population projections of the 18 and over population in the years 2011 and 2021 and linear trends projected to give estimated numbers predicted to have a moderate or severe learning disability.

Children's social care

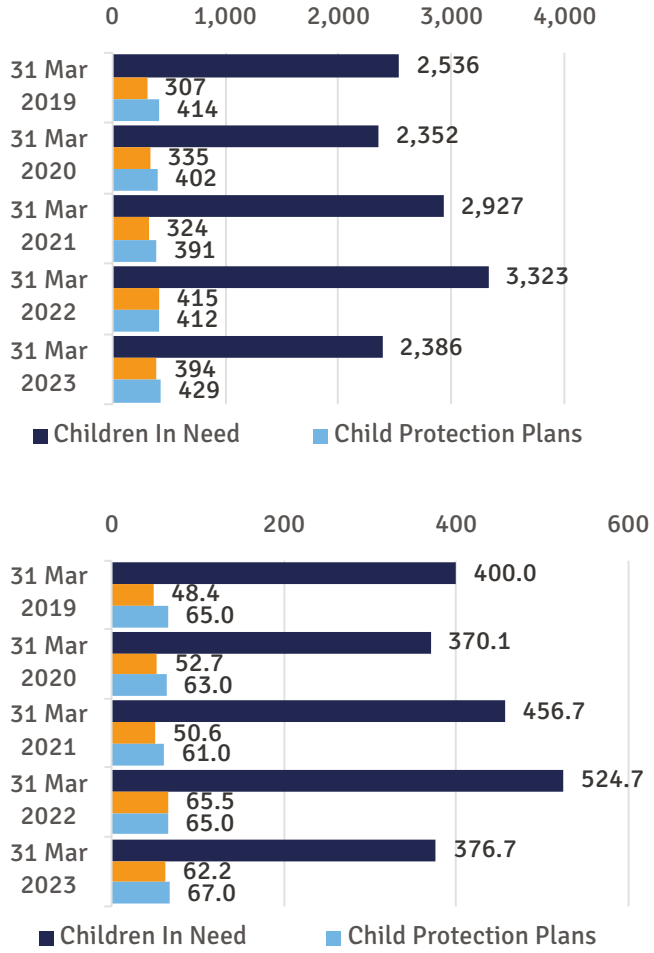
Children referred to social care may have current health needs or disabilities and are more likely to have risk factors for poor health and attainment in later life. An analysis found that adults who spent time in care as children between 1971-2001 were 70% more likely to die prematurely than those who did not. [44] They therefore represent a key vulnerable part of the population where targeted prevention and early intervention efforts could be of benefit.

On the 31st March 2023, in Barking and Dagenham there were 2,386 children in need, 394 children on child protection plans and 429 children looked after (CLA) by the local authority.

The social and health issues which lead to children becoming in need of help and protection from the local authority were exacerbated during the Coronavirus pandemic, and this led to rapid increases in the numbers of children in need and in care. However, numbers have since stabilised. This seems to reflect the broader population of 0-17 year olds which is estimated to have changed very little from 2019 to 2023. The borough's 0-17 population is forecast to increase by 5% over the next 15 years and so the number of cases open to Children's Social Care can be expected to increase alongside this.

At 31st March 2023 there were 308 care leavers aged 18-24 entitled to support from the local authority. The number and rate of care leavers is higher now that it was 5 years ago suggesting that more Children Looked After by the local authority are remaining in care until their 18th birthday.

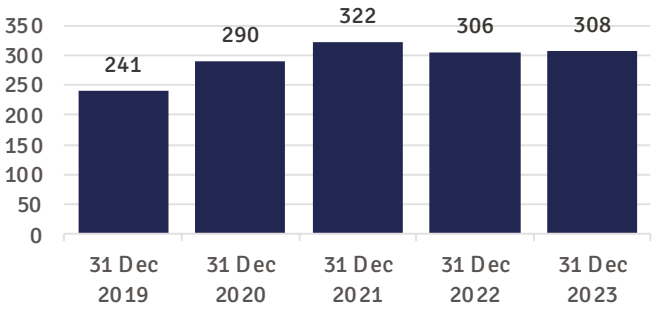
Figure 74: Number and rate of Children In Need, Child Protection Plans and Children Looked After

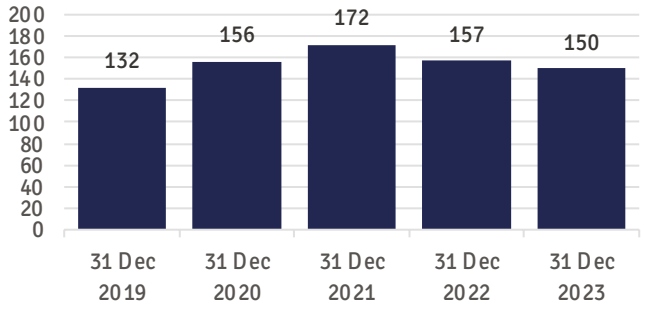


Source: POPPI and PANSI Projections

Care leavers

Figure 75: Care leavers in Barking and Dagenham, rate and time trends





Source: Local Authority administrative data. Rates are calculated using GLA 2021-based BPO Demographic Projections.

Children in need

Of the 2,386 Children In Need at the 31st March 2023, 174 children (7.3%) had been recorded as having a disability. This is an increase from 129 children (5.1%) in 2019 but remains low compared to the England average (12.8%) and the London average (14.6%). Amongst peer boroughs, the proportion of Children In Need with disabilities varies from 6.7% in Waltham Forest to 21.2% in Greenwich.

In Barking and Dagenham, almost half (47.1%) of Children In Need at the 31st March 2023 with a disability were recorded as having autism. This is high compared to the national average of 41.4% but aligns with the London average of 48.2%. 36.9% had learning difficulties.

Table 4: Children in need at 31st March 2023 by recorded disability and local authority

	England	London	Barking and Dagenham	Greenwich	Hackney	Tower Hamlets	Waltham Forest
Number of Children In Need	403,090	69,980	2,386	2,430	2,550	2,648	2,406
Number with a disability recorded	51,790	10,190	174	514	207	272	160
% with a disability recorded	12.8	14.6	7.3	21.2	8.1	10.3	6.7
Autism %	41.4	48.2	47.1	55.1	45.4	39.3	40.6
Behaviour %	19.4	14.8	14.9	17.5	3.4	7	21.9
Communication %	16.9	17.6	10.3	11.5	4.3	c	c
Consciousness %	3.6	4	c	c	0	6.6	0
Hand Function %	2	3	c	c	0	0	0
Hearing %	4	4	4	2.9	c	2.9	c
Incontinence %	4.5	2.5	c	c	c	c	0
Learning Difficulties %	36.9	32.2	21.8	36.4	30.4	33.1	47.5
Mobility %	13.7	11.9	8.6	16.1	11.6	7.4	15
Personal care %	5.5	4.8	c	1.8	0	0	c
Vision %	6.2	5.5	c	6.2	c	2.6	c
Other %	18.5	20.8	9.8	16	28	48.9	11.3

Children on child protection plans

Emotional abuse has remained the most common category of abuse recorded for children on protection plans in Barking

and Dagenham over the last 5 years, accounting for 54.6% of children on a protection plan at 31st March 2023. The next most common category is neglect, accounting for over one-third of children at 31st March 2023.

Sexual abuse was recorded as the latest category for 4.1% of children on a protection plan at the 31st March 2023. This is the highest of all four peer boroughs and higher than the London and England averages of 2.6% and 3.5% respectively.

Figure 76: Child protection plans by latest Category of abuse

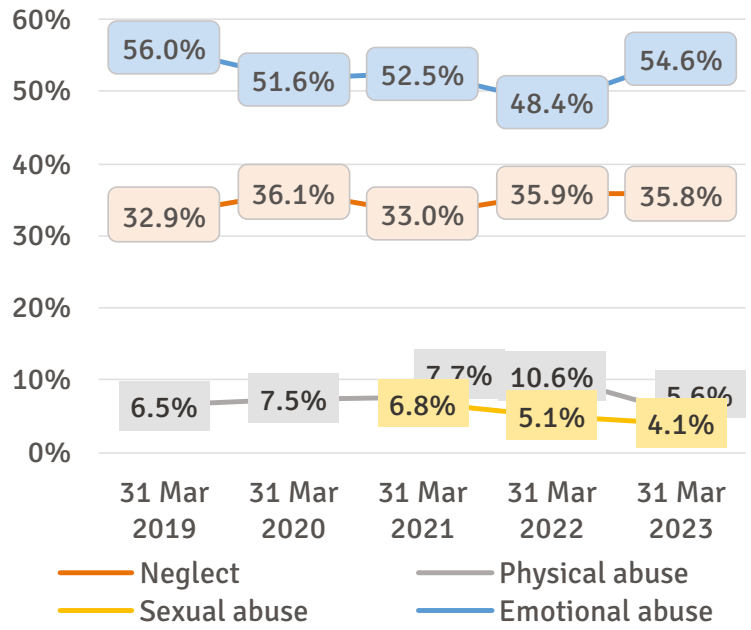


Figure 77: Child Protection Plans by latest Category of Abuse, 31st March 2023, with comparators

	England	London	Barking and Dagenham	Greenwich	Hackney	Tower Hamlets	Waltham Forest
CPP at 31st March 2023	50,780	7,580	394	236	181	214	232
Percentage by latest category of abuse							
Emotional abuse	40.6%	46.3%	54.6%	50.8%	52.5%	c	64.7%
Neglect	48.0%	43.0%	35.8%	30.9%	30.9%	61.7%	31.0%
Physical abuse	6.0%	6.9%	5.6%	4.2%	13.3%	c	c
Sexual abuse	3.5%	2.6%	4.1%	0.0%	3.3%	0.0%	c
Multiple	1.9%	1.3%	0.0%	14.0%	0.0%	0.0%	0.0%

Source: Local Authority Administrative data.

Children Looked After by the local authority at 31st March 2023.

There were 429 children being looked after by Barking and Dagenham Council on the 31st March 2023. Over half (54%) were male, and 70% were aged 10 and over.

Both the White and Mixed or Multiple ethnic groups are over represented within the Looked After population compared to the borough's broader population of 0-17 year olds: 52% of children looked after at 31st March 2023 were White compared to 32% of the broader population[45], 17% were of Mixed or Multiple ethnic groups (compared to 9%), 16% were of Black African, Caribbean or Black British ethnicity (compared to 25% in the broader population) and 11% were of Asian or Asian British ethnicity (compared to 30%). This indicates children of white ethnicity are overrepresented in the looked after population.

Of the 429 children looked after by Barking and Dagenham council, 327 children (76%) were placed 20 miles or less from home and 173 children (40%) were placed within the borough boundary. A further 213 children looked after by other local authorities were recorded as being placed within the borough boundary.

Twenty-seven of the borough's looked after children were unaccompanied asylum-seeking children.

Local authorities are responsible for ensuring that an assessment of physical, emotional and mental health needs is carried out for every child they look after. The focus of the assessment varies according to the age of the child; however, children of all ages should have an annual assessment, annual dental checks and up to date immunisations. Of the children in care on the 31st March 2023, 93% had had an annual health assessment, 90% had up to date immunisations and 68% had their teeth checked by a dentist. Pre-pandemic the proportion of children who had their dental check was higher at 91% (31st March 2019 and 2020)

Service use and access: key messages and public health advice

Barking and Dagenham has the highest rate of emergency readmissions within 30 days of discharge amongst peer boroughs, and higher than London and England averages.

Engagement with local pregnant women suggests a lack of clarity on support offered and continuity of care; with some groups feeling less listened to. There is a mixed picture relating to satisfaction with access to GP care.

The total number of Adult Social Care referrals received, as well as the distribution by primary support reason, has remained relatively stable over the last 3 years. Almost half of all referrals are for physical support with a further third being divided equally between learning disability and mental health support needs. 12% of referrals are for dementia support.

Numbers of those needing help with at least 1 self care need are projected to double across the majority of age bands over 70 by 2040. Numbers of falls are also projected to approximately double across all age bands over 65 by 2040; although these projections should be interpreted with caution.

Numbers of social care referrals have stabilised since increases during the pandemic. 7.3% of children in need have disabilities recorded, with autism, behavioural and speech and language difficulties comprising the majority of needs. Emotional abuse is the most common reason for child protection plans, followed by neglect. White and Mixed or Multiple ethnic groups are over represented within the Looked After population compared to the borough's broader population of 0-17 year olds. For looked after children, approximately 1 in 4 are placed more than 20 miles from home. Of the children in care on the 31st March 2023, 93% had had an annual health assessment, 90% had up to date immunisations and 68% had their teeth checked by a dentist. In 2019, it was estimated 70 in every 1000 children age 0-17 is estimated to live in a household affected by domestic abuse, this compares favourably with peer boroughs.

Public health advice

Wider action on health and wellbeing will reduce demand on health and social care, but attention also needs to be paid to equity of access. Data available points to the following specific actions

- Focus on improving community and self-management of long term conditions to reduce risk of emergency admissions.
- Address feedback on maternity care in service development.
- Consider further exploration of equity of access in primary care.
- Consider targeted work on prevention and management of falls given likely increase in demand.
- Review adult care and support provision to meet increasing demands, including use of assisted technology where appropriate.
- Continue system wide action on Adverse Childhood Experiences as prioritised in the Joint Health and Wellbeing Strategy and Best Chance Strategies. These are explored further in Chapter 5 of the ADPHR.
- Continue to monitor and address health, attainment and access inequalities experienced by children in social care

Building blocks of good health

The ADPHR 2023 and our Joint Health and Wellbeing Strategy 2023-28 highlight the importance of action on the building blocks to good health: giving children the best start in life, healthy places, and supporting communities to create and maintain health in partnership with services. Action across all of these areas will support people to adopt healthier behaviours and develop and grow healthily; and it is estimated that approximately 50% of our health is determined by these factors.[46]

To inform action, we have outlined key local data relevant to each of these areas.

Best start in life

Infant birth outcomes

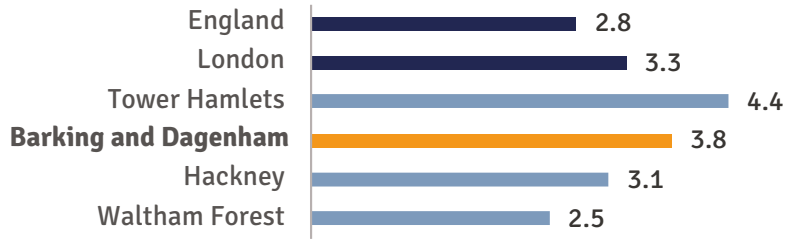
In Barking and Dagenham, a significantly higher proportion of term babies are born with a low birth weight (under 2500g) than the London and England averages. The rate of premature births (under 37 weeks gestation) in Barking and Dagenham (86.3 per 1,000) is also significantly higher than the London and England averages and is the second highest rate in London after Newham (99.8 per 1,000).

Stillbirth rates across London and England have been declining since 2010-12. However, the latest stillbirth rate in Barking and Dagenham (6.3 per 1,000 for 2019-21) is on a par with rates seen in the borough back in 2011-13 (6.6 per 1,000) and is the highest rate in the country. Smoking is one of the risk factors associated with stillbirth and is known to negatively impact the health of both the mother and the baby during pregnancy.

In 2022/23 in Barking and Dagenham, 1 in 20 mothers (4.8%) were known to be smokers at the time of delivery. The infant mortality rate (deaths under 1 year of age, per 1,000 live births) is also higher in Barking and Dagenham than England, London and all peer boroughs and the rate has been increasing since 2016-18.

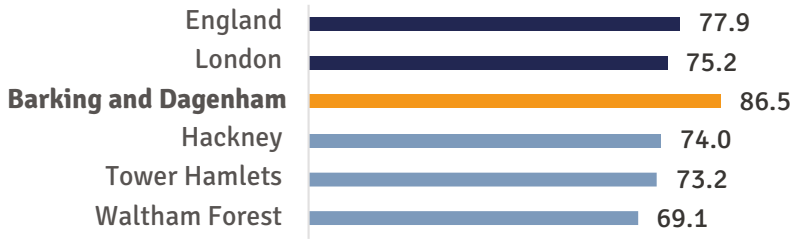
Figure 78: Infant birth outcomes

Percentage of births that are low birth weight children (gestational age above 37 weeks, 2021)



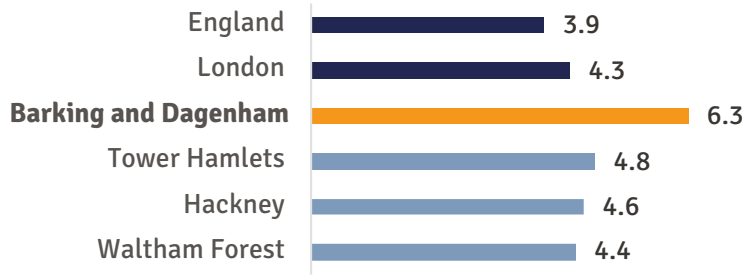
Source: OHID Fingertips Indicator ID 92530, accessed 08/12/2023

Rate of births per 1,000 that are premature (gestational age 24 -36 weeks, 2019 -21)



Source: OHID Fingertips Indicator ID 91743, accessed 08/12/2023

Still birth rate per 1,000 births in 2019 -21

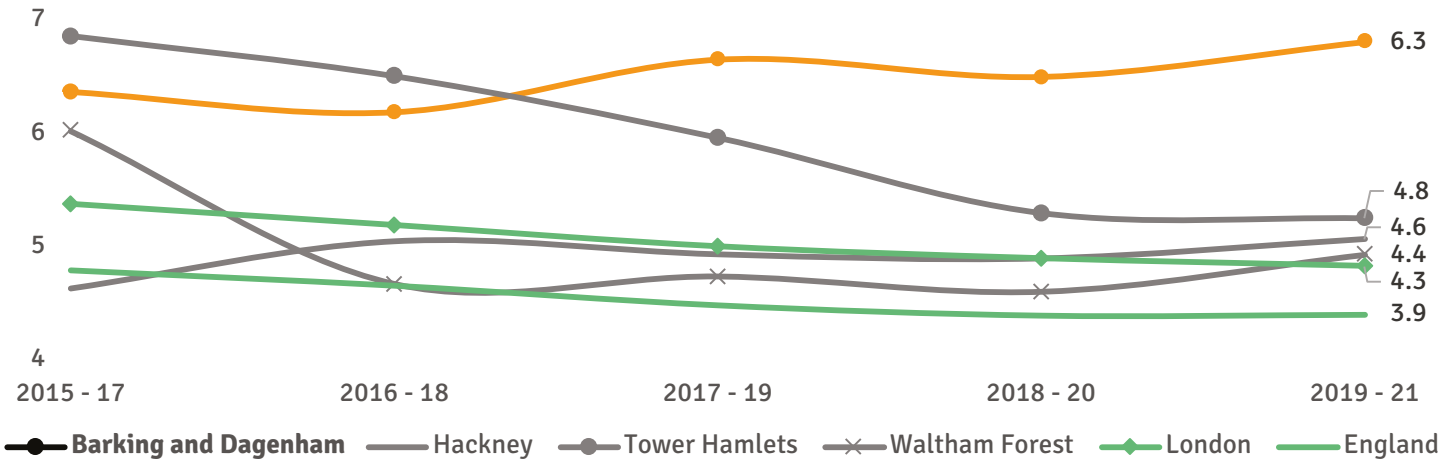


Source: OHID Fingertips Indicator ID 92530, accessed 08/12/2023

Rate of infant deaths per 1,000 live births (<1yr, 2019 - 21)

Source: OHID Fingertips Indicator ID 92196, accessed 08/12/2023

Figure 79: Still birth rate per 1,000 births , 3 year average, 2015-17 to 2019-21

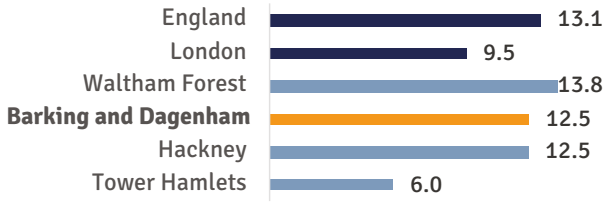


Source: OHID Fingertips Indicator ID 30315, accessed 08/12/2023

Maternal health

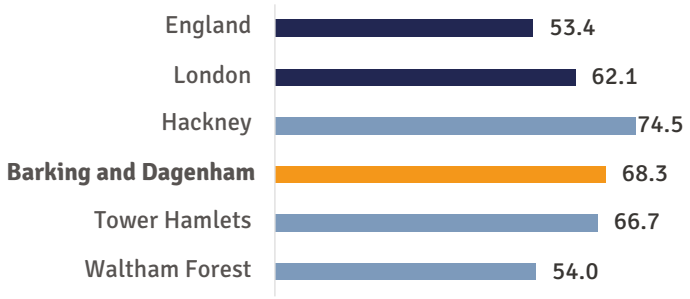
Teenage pregnancy is associated with poor outcomes for young women and their children. For mothers, there is a higher risk of poor educational attainment, social isolation and poorer mental and physical health, while their children are more likely to be born preterm or with low birthweight.

Figure 80: Conceptions in females aged under 18



Source: OHID Fingertips Indicator ID 30315, accessed 08/12/2023

Figure 81: Conceptions in females under 18 leading to abortion



Source: OHID Fingertips Indicator ID 30315, accessed 08/12/2023

Only one year of data is available for the above two measures, which show that women aged 15 to 17 in Barking and Dagenham experienced a higher rate of conceptions in 2021 than the London average but lower than the England average. The percentage of conceptions to women under 18 that resulted in an abortion in 2021 was higher in Barking and Dagenham than in London, England and all peer boroughs excluding Hackney.

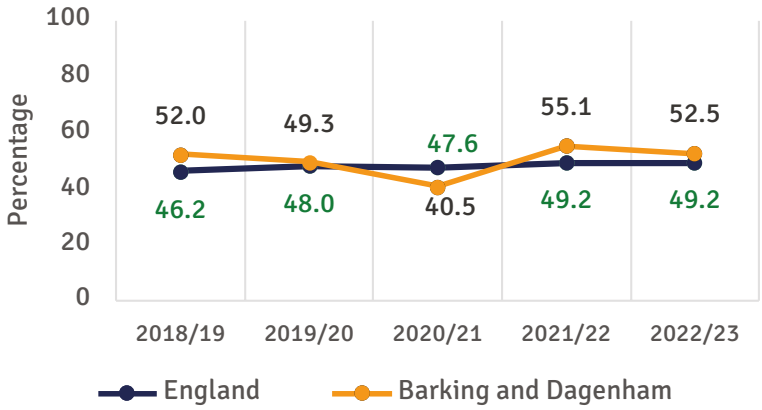
Maternity exemption certificates entitle women to free NHS prescriptions and free NHS dental treatment while pregnant. NHS data collected at the national level indicates that in 2021/22, only 36 maternity exemption certificates were issued per 100 live births to women aged 15-19, compared to 109 per 100 live births to women aged 45-49. Additionally, 47 certificates are issued to women per 100 live births in areas in the most deprived 10% of the country, compared to 82 per 100 in areas in the least deprived 10%. Combined, this data suggests a need to promote the uptake of these entitlements to young and less affluent pregnant women in Barking and Dagenham to reduce health inequalities and improve birth outcomes.[47]

Health visit outcomes and breastfeeding

Over the last 5 years in Barking and Dagenham, just under half of infants aged 6-8 weeks were being totally or partially breastfed. This compares favourably to the England average.

Not all infants receive a 6-8 week health visit and therefore these figures are likely to be an underestimation. It should also be noted that the data for Barking and Dagenham, along with that of most other London Boroughs, has not been included in national publications as it does not meet the national validation criteria. The criteria requires a breastfeeding record for at least 95% of all infants to ensure that the data is representative.

Figure 82: Breastfeeding at 6-8 weeks



Source: National data OHID Fingertips Indicator ID 92517, accessed 08/12/2023. Local authority data is from local administrative sources.

In Barking and Dagenham over the 5 year period shown, an average of 75% of infants received a 6-8 week visit. This increases to 79% if data for 2020/21 is excluded. 2020/21 was the year many services were negatively impacted by the Covid-19 pandemic

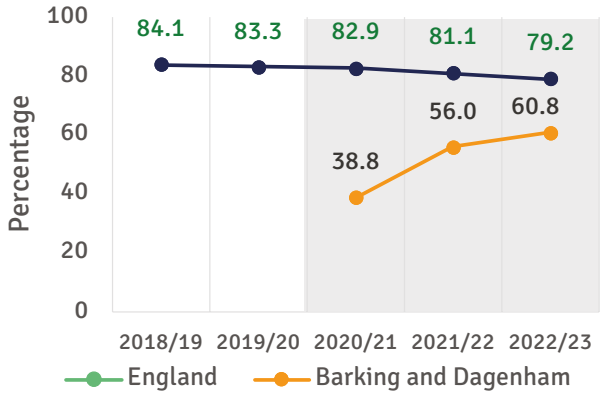
From 2015 all children in England became eligible for a Healthy Child Programme development review, delivered as part of the universal health visitor service, around their second birthday.

The Ages and Stages Questionnaire (ASQ 3) is used as a population measure of broad child development outcomes. Domains of development which are tested include communication, gross motor, fine motor, problem solving and personal-social skills.

Nationally there are inequalities in the number of children who achieve the expected level in their development, with children living in more deprived areas and boys less likely to be at the expected levels.

In Barking and Dagenham, children are achieving well below the national average. The Office for Health Improvement and Disparities has identified concerns about the quality of the last three years of data at both a national and local level. ASQ3 data was unable to be reported prior to the 2020/21 year due to licencing issues.

Figure 83: Child development age 2-2 ½



Source: OHID Fingertips Indicator ID 93436, accessed 30/01/2024.

School Attainment

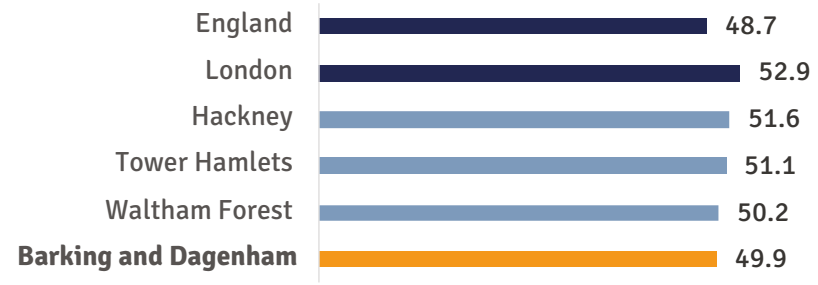
In Barking and Dagenham, a lower percentage of Reception children reach a Good Level of Development (GLD)[48] by the end of the year than the London and England average. Attainment in Reception is also lower in Barking and Dagenham than in the peer boroughs of Waltham Forest and Hackney, with a gap of 6 percentage points between Barking and Dagenham and Hackney, and a gap of 10.2 percentage points between Barking and Dagenham and Waltham Forest.

Figure 84: Children achieving a good level of development in reception

Source: OHID Fingertips Indicator ID 93381, accessed 30/01/2024.

The average Attainment 8 score (which measures pupils' performance in 8 GCSE-level qualifications) in Barking and Dagenham is lower than the London average and all peer boroughs, although less markedly than for GLD. The average attainment 8 scores of children in care in Barking and Dagenham are less than half the 'all pupil' total in the borough at 19.0 compared to 49.9, highlighting an inequality in outcomes for this group.

Figure 85: Average attainment 8 score of residents age 15-16

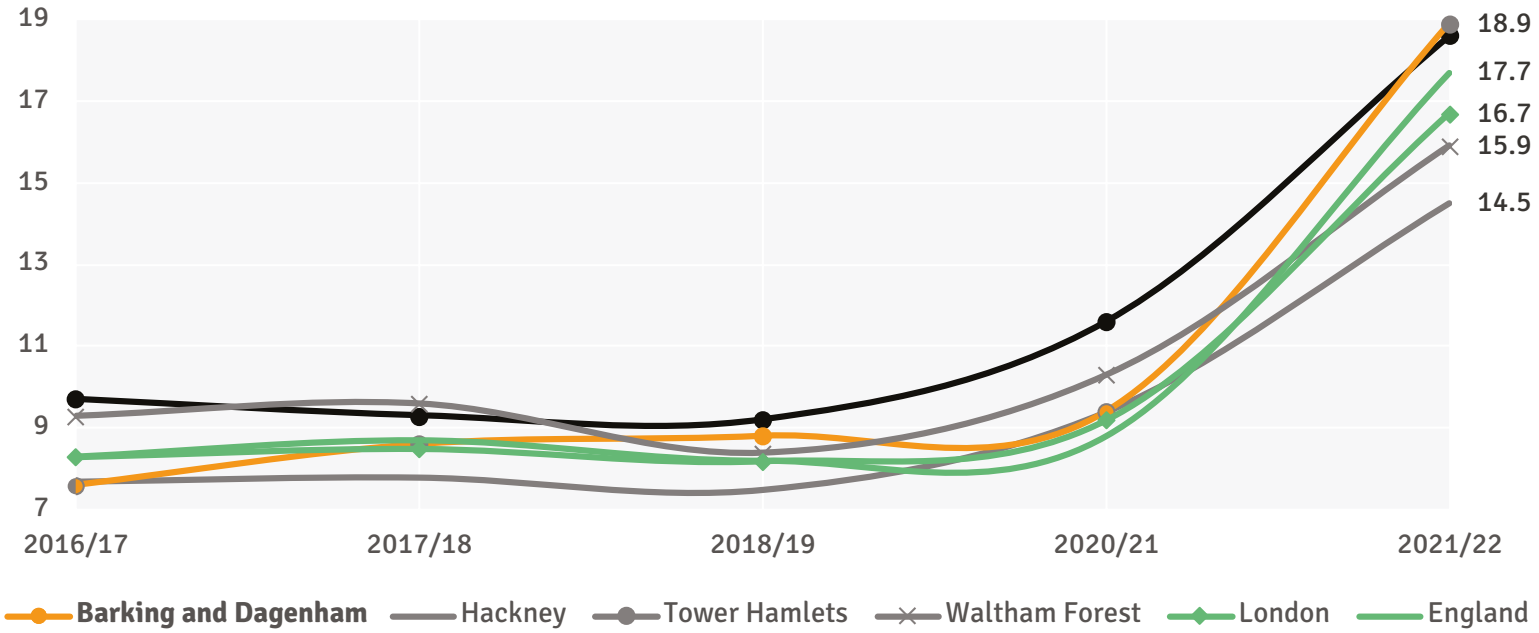


Source: OHID Fingertips Indicator ID 93378, accessed 30/01/2024.

Persistent absenteeism

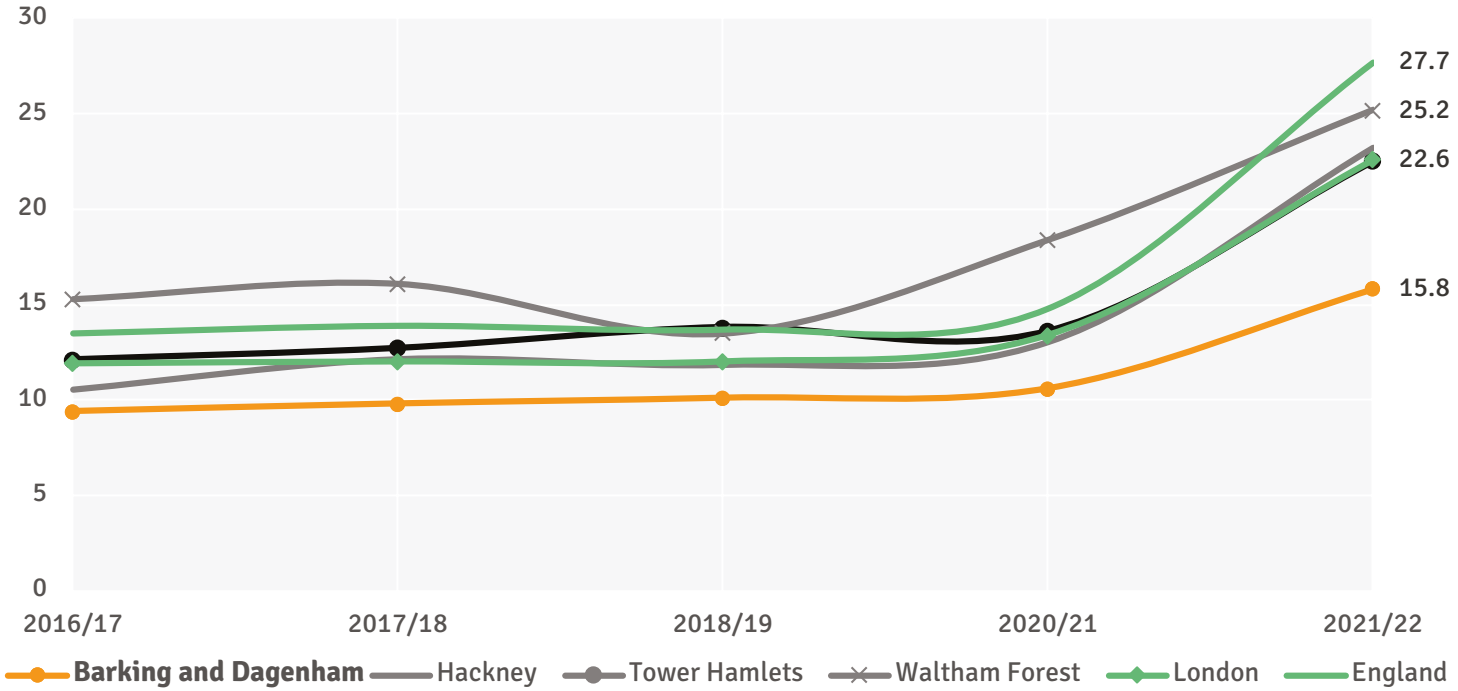
Children are described as persistent absentees if they miss 10% or more of possible school sessions. Persistent absenteeism in primary and secondary schools rose significantly following the COVID-19 pandemic restrictions. Increases have occurred in Barking and Dagenham, all peer boroughs, and the London and England averages, leaving Barking and Dagenham's relative position largely unchanged, but the absolute change is significant rising from 13.8% in 2018/19 to 22.5% in 2021/22 for secondary school children, and from 9.2% in 2018/19 to 18.6% in 2021/22 for primary school children. Please note no data was collected in the 2019/20 year as pandemic measures disrupted access to schools. This year is therefore not shown in the below charts. Recent analysis suggests mental health issues are a key driver of absence rates and that absence rates are higher for pupils with Special Education Needs and those eligible for free school meals.[49]

Figure 86: Persistent absenteeism in primary school pupils in 2021/22



Source: OHID Fingertips Indicator ID 92563, accessed 30/01/2024.

Figure 87: Persistent Absenteeism in secondary school pupils in 2021/22



Source: OHID Fingertips Indicator ID 92564, accessed 30/01/2024.

Adverse childhood experiences

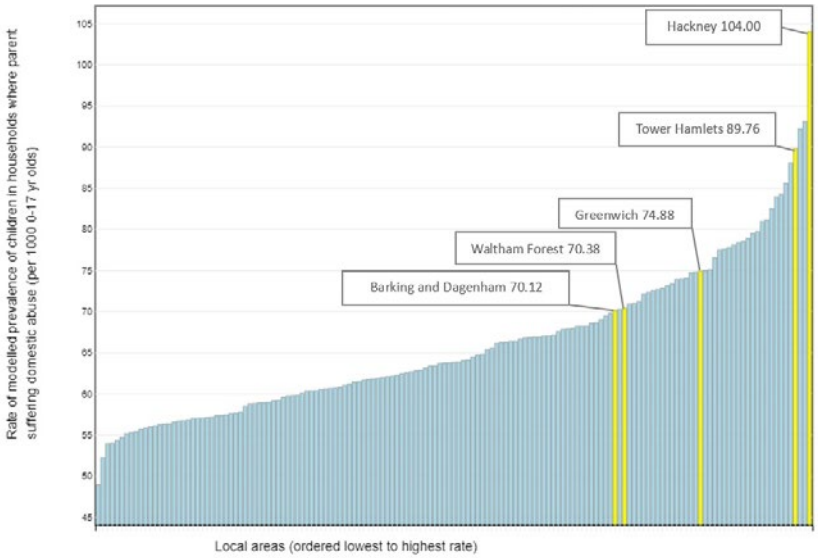
Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood such as experiencing violence, abuse and neglect, witnessing violence in the home, or parental substance misuse, mental illness, imprisonment or separation. Those who have ACEs during childhood or adolescence tend to have more physical and mental health problems as adults and are more likely to have an earlier death.[50] Data on domestic and sexual abuse is outlined below. There is further data on the prevalence of substance misuse and domestic abuse in the 'Health behaviours' and 'Place' sections.

In a report published by the Children's Commissioner in 2019, it was estimated that 4,500 children in Barking and Dagenham live in households where a parent was suffering domestic abuse. When calculated as a rate, 70.12 in every 1,000 0-17 year olds in the borough are affected by domestic abuse. This is slightly lower than the London average (73.08) and lower than all peer boroughs (see Figure 88) Modelled prevalence of children in households where a parent is suffering domestic abuse, by Upper Tier Local Authority (Children's Commissioner 2019). Children aged 0-4 have a slightly higher risk of exposure to domestic abuse (75.43) mirroring trends nationally and regionally (71.33 and 78.62 respectively)[51].

Whilst prevalence within the borough is lower than peer boroughs it remains high when compared to all other Upper Tier Local Authorities in England. The national average is 65.59 per 1,000 0-17 year olds.

Rates are likely to have changed since 2019 following increases in domestic abuse during the pandemic. Rates of adult domestic abuse are explored in the Place chapter of the JSNA.

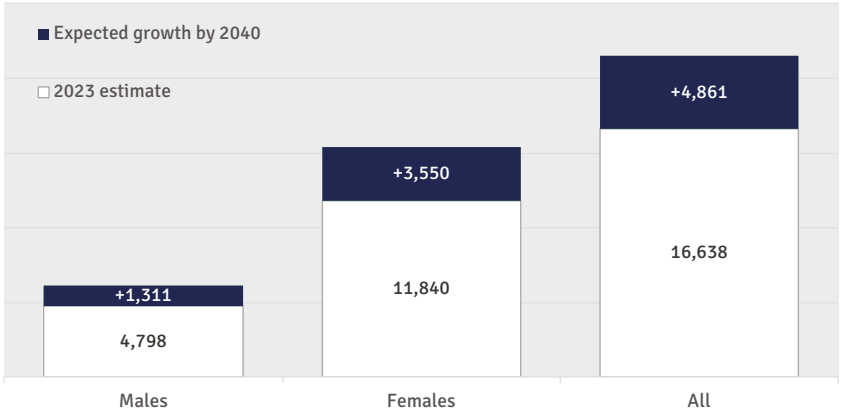
Figure 88: Modelled prevalence of children in households where a parent is suffering domestic abuse, by Upper Tier Local Authority (Children's Commissioner 2019)



The 2000 report Child Maltreatment in the United Kingdom[52] found that within a sample of 2,869 young adults aged 18 - 24 years (1,235 men and 1,634 women), 7% of males and 16% of females had been abused in childhood when they were 12 years old or younger (as referenced by www.pansi.org.uk).

These rates have been applied to ©GLA 2021-based demographic projections to create estimates for the borough.

Figure 89: Barking and Dagenham residents aged 18-64 in 2023 estimated to be survivors of childhood sexual abuse with estimated growth by 2040



Best start in life: key messages and public health advice

In Barking and Dagenham, a significantly higher proportion of term babies are born with a low birth weight (under 2500g) than the London and England averages. In 2019-2020, 7.6% of mothers were known to be smokers at the time of delivery, higher than the London overage of 4.6%.

Over the last 5 years in Barking and Dagenham, just under half of infants aged 6-8 weeks were being totally or partially breastfed. This compares favourably to the England average. Over the last 5 years only 75% of babies received a 6-8 week visit, although this increases to 79% if the pandemic period is discounted.

In Barking and Dagenham, children are achieving well below the national average at the 2-2.5 year developmental review. The percentage of reception aged children reaching a good level of development (62.5%) in Barking and Dagenham is lower than the London and England averages, but not significantly so. At age 15/16, attainment 8 scores across key educational areas is higher than national but lower than the London average. However, the average attainment 8 scores of children in care in Barking and Dagenham are less than half the average of all children in the borough at 19.0 compared to 49.9, highlighting an inequality in outcomes for this group.

Numbers of persistently absent pupils increased nationwide following the pandemic. In 2021/22, 18.6% primary school children and 22.5% of secondary school children were persistently absent, nearly doubling since pre-pandemic.

Public health advice:

- Strengthen our approach to giving children the best start in life, via universal support/prevention activities, early identification of emerging issues, and provision of timely help to support families. This can be achieved by maximising the opportunities of the 0-19 programme so it better links to the needs of the children and young people and the drivers of demands in Health and Social Care.
- A particular focus should be given to perinatal and parental health and improving early development.
- Improve the offer for children and young people with social and emotional health needs, and consider focussed efforts for those with persistent school absence.
- Continue borough approaches to address and prevent domestic abuse.

Place

Built and natural environment

In addition to lifestyle behaviours, the environment where we live, work and play contributes significantly to individual and population health.

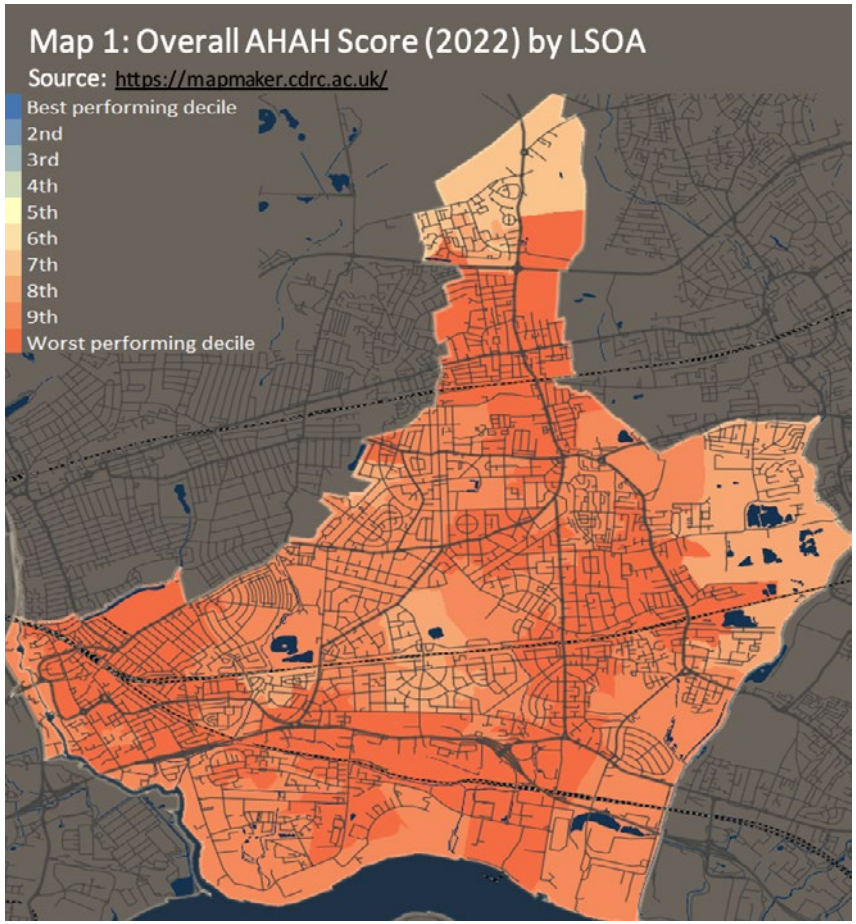
The index of Access to Healthy Assets and Hazards (AHAH), published by the Consumer Data Research Centre (CDRC), combines data from fourteen indicators to help describe some of the key features of neighbourhoods that affect our health and wellbeing. Measurement data and deciles are provided for the overall index, four domains and fourteen inputs by Lower Super Output Area (LSOA) level.[53]

The four domains of accessibility are:

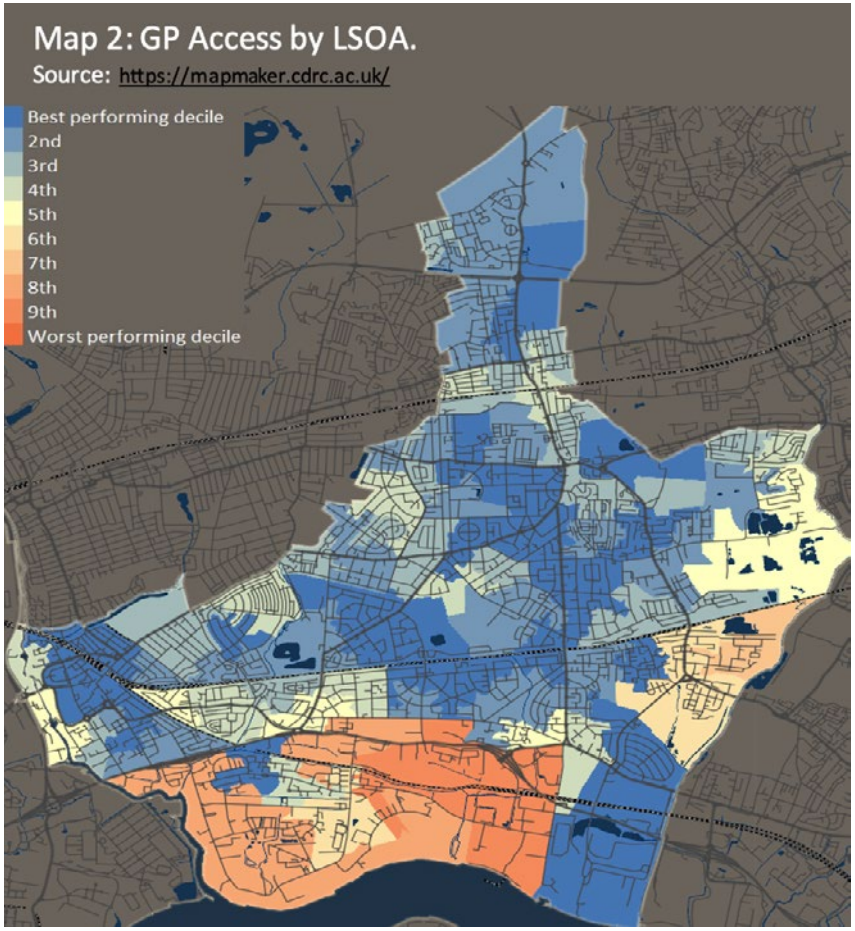
- Retail environment (access to fast food outlets, pubs, tobacconists, gambling outlets),
- Health services (access to GPs, hospitals, pharmacies, dentists, leisure services),
- Physical environment (Blue Space, Green Space - Passive), and
- Air quality (Nitrogen Dioxide, Particulate Matter 10, Sulphur Dioxide).

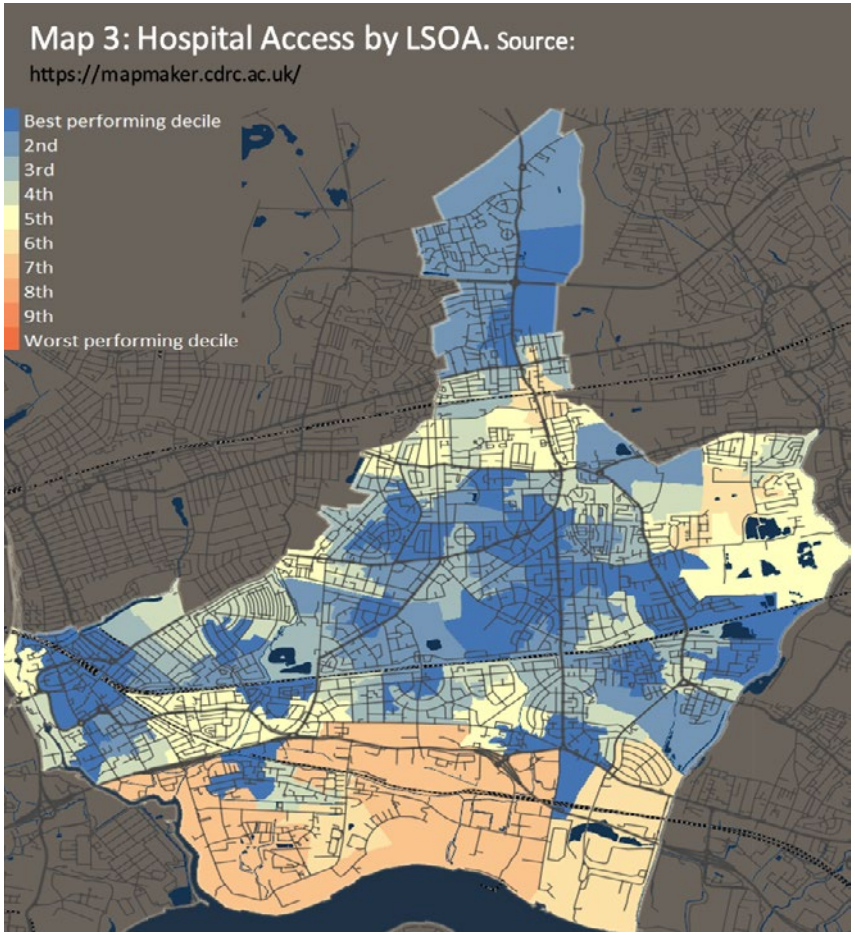
It is important to note these statistics compare neighbourhoods for the whole of England. Neighbourhoods in the worst performing deciles are more likely to be concentrated in urban areas, such as Barking and Dagenham. It should also be noted that not all areas of the borough are populated. There are a number of large parks as well as industrial areas and brownfield land. These are not shown on the maps.

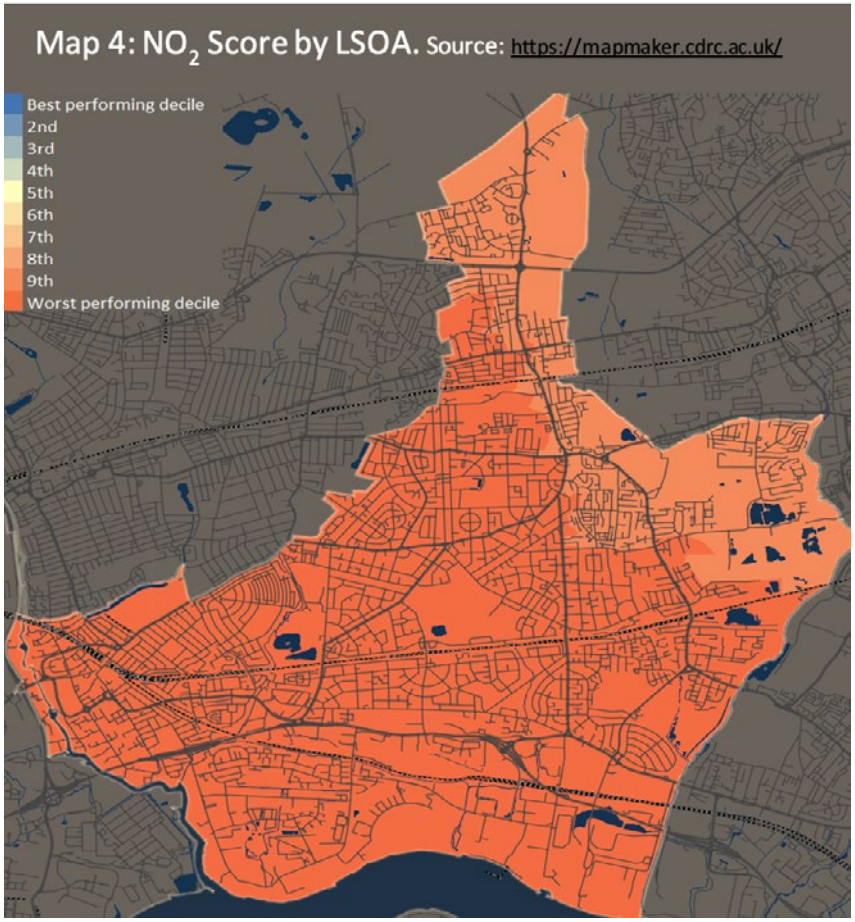
Map 1[54] below shows the deciles which LSOAs in Barking and Dagenham fall into for the overall AHAH score (2022). On the overall index scale, 42% of Barking and Dagenham LSOAs ranked in the 10th (worst performing) decile, and a further 43% ranked in the 9th decile. These rankings suggest that the majority of Barking and Dagenham's residents live in LSOAs which fall well below the national average for environmental health. No LSOAs in the borough ranked in the 4 best performing deciles.

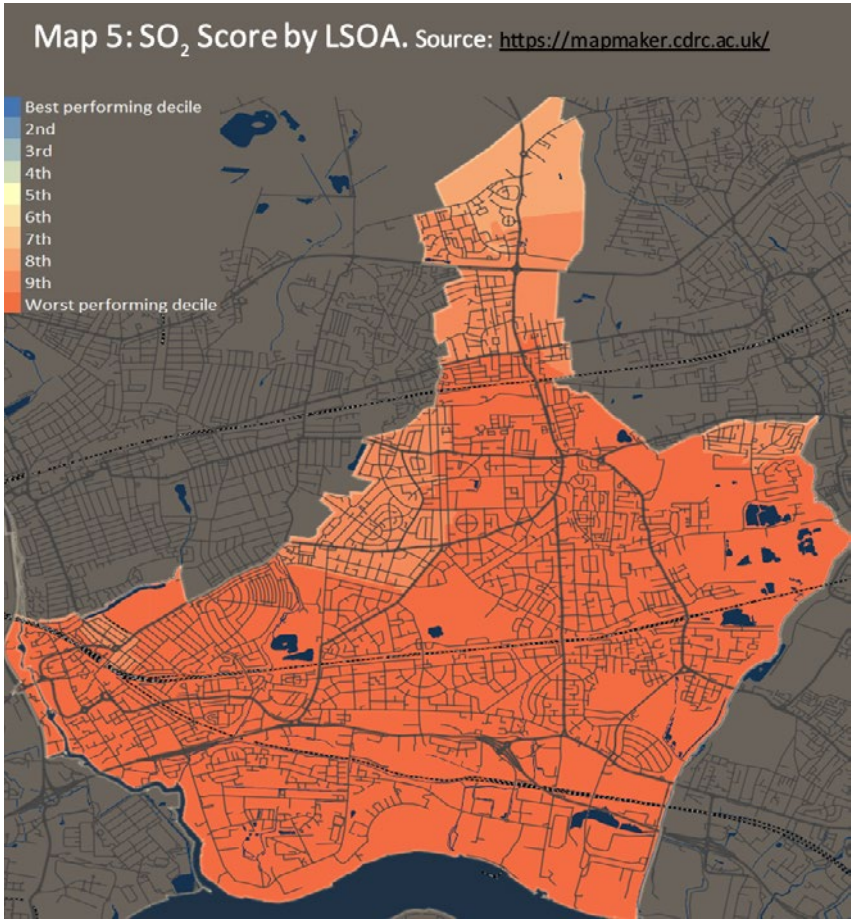


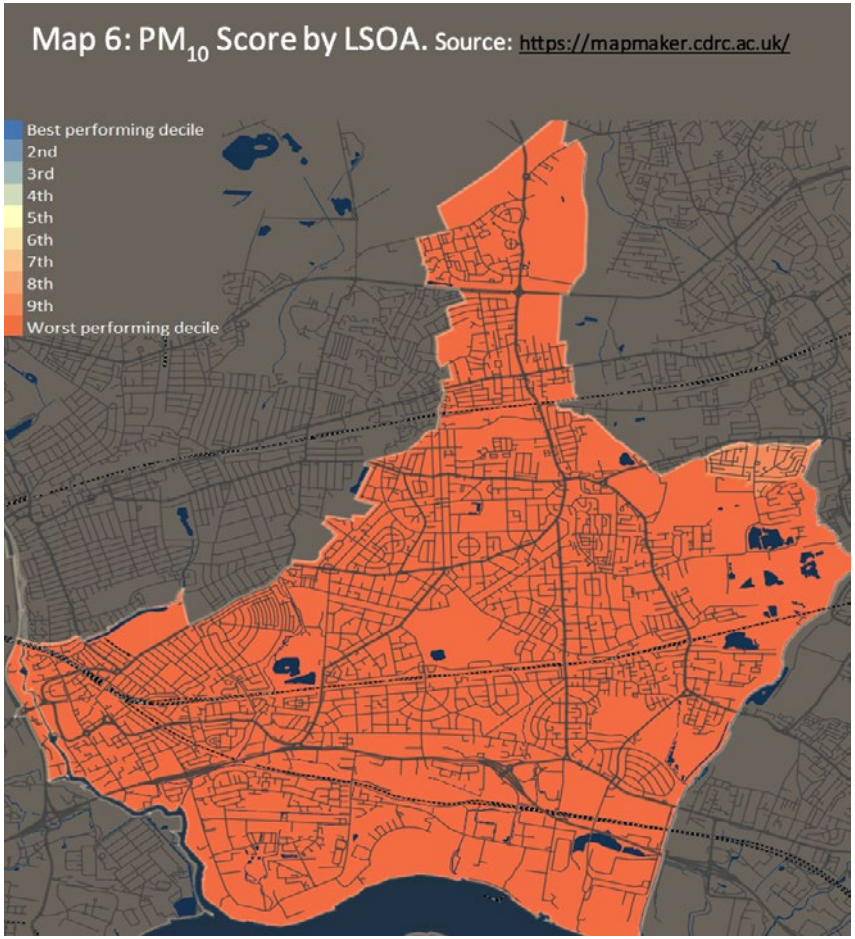
Despite the borough's low ranking for the overall AHAH index, results are more encouraging for measures like accessibility to a GP practice or hospital (maps 2 and 3). For these two measures the majority of the borough's LSOAs rank within the 5 best performing deciles, indicating average or above average accessibility. Towards the south of the Borough, however, access to primary and secondary health care is more challenging. These positive scores are significantly offset by the dimension on which the borough scores most poorly: air quality. Maps 4, 5 and 6 show the borough's level of Nitrogen Dioxide (NO_2), Sulphur Dioxide (SO_2) and Particulate Matter smaller than 10 micrometres (PM_{10}) in 2022. Most borough residents live in LSOAs that rank within the 3 worst performing deciles nationally for all 3 of these air quality measures. For levels of PM_{10} virtually all residents live in LSOAs that are in the worst performing decile.






Map 4: NO_2 Score by LSOA. Source: https://mapmaker.cdrc.ac.uk/
Best performing decile
2nd
3rd
4th
5th
6th
7th
8th
9th
Worst performing decile


Map 5: SO_2 Score by LSOA. Source: https://mapmaker.cdrc.ac.uk/
Best performing decile
2nd
3rd
4th
5th
6th
7th
8th
9th
Worst performing decile



One measure of the impact of poor air quality is the fraction of deaths attributable to particulate air pollution, measured as fine particulate matter or $PM_{2.5}$. $PM_{2.5}$ pollutants are small enough to enter deep into the lungs[55]. In Barking and Dagenham it is estimated that 6.4% of all deaths of residents aged 30 and above are attributable to particulate air pollution. Compared to its peer boroughs, Barking and Dagenham had the lowest proportion of mortality attributable to particulate air pollution.

However, all peer boroughs are in London and the London average (6.5) is higher than the England average (5.5). Although indoor air pollution is not monitored in the AHAH index, ambient outdoor air pollution can also directly decrease indoor air quality, furthering the health inequality residents in low air quality environments experience. Additional factors that reduce indoor air quality in less affluent areas include: higher rates of smoking, poor ventilation which can lead to higher incidence of damp and mould, ambient outdoor levels of pollution and aging housing components such as boilers, which emit more pollutants as they age[56].

Figure 90: Mortality attributable to air pollution

Source: OHID Fingertips Indicator ID 92561, accessed 30/01/2024.

One way to improve air quality is to reduce speed limits on the borough's road networks, which reduces particulate matter from car fumes, as well as break and tyre wear. According to the 2023 Healthy Streets Scorecard, only 27% of borough controlled roads in Barking and Dagenham have 20mph speed limits. This is the lowest proportion of the peer boroughs of Greenwich (62%), Waltham Forest (78%), and Tower Hamlets and Hackney (both 100%). The London average is 53%. While the 2023 Be First survey regarding the implementation of a boroughwide 20mph speed limits showed that most residents and councillors do not currently support this, residents were supportive of implementing 20mph limits on individual streets, especially near schools and areas where they felt unsafe or that traffic speeds were too high. As well as improving air quality, reducing speed limits reduces noise pollution, helps increase cycling and walking and reduces road casualties, moving the borough closer to meeting the Mayor of London's Vision Zero Policy, in which no one is killed or seriously injured, and the borough's draft local plan which commits to meeting the target of 75% of all trips in the borough to being made on foot, by cycle or public transport by 2041.

In 2021, Barking and Dagenham had the second highest rate of serious and fatal road collision pedestrian casualties in London (highest in Outer London) with 28 casualties per 100,000 daily walking stages. The London average is 17.7 per 100,000. In the same year, Barking and Dagenham had the highest rate of cyclist road collision casualties in London with 20.9 per 100,000 daily cycling stages compared to a London average of 4.6 per 100,000. Current projects across the borough that seek to address these problems include the provision of secure on-street cycle parking, protected cycle tracks on main roads, quietways, cycle hubs, secure parking, cycle training and bike share schemes.

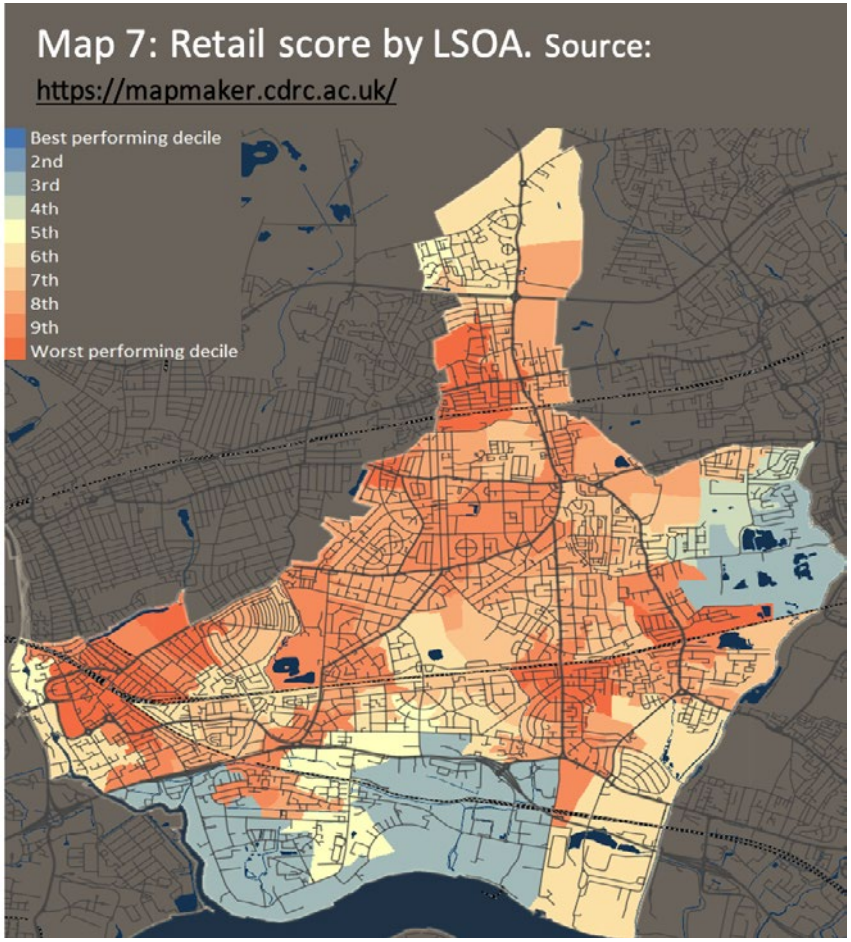
Figure 91: Pedestrian fatalities from road collisions

Source: Vision Zero Two-Year Action Strategy

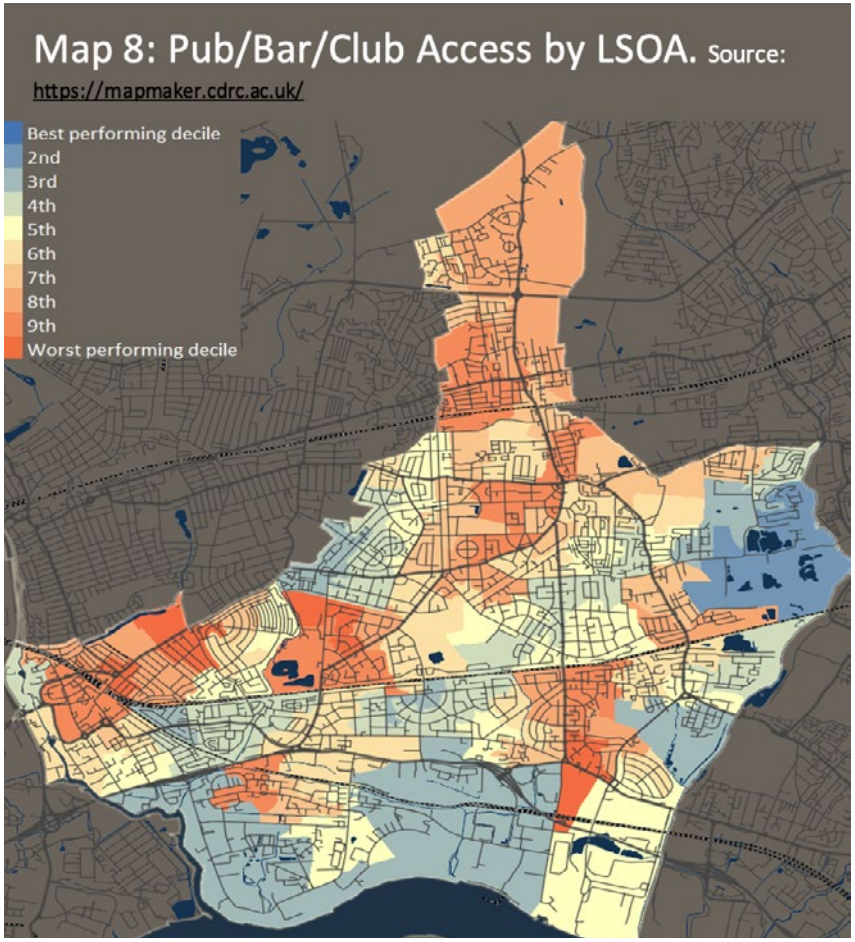
Returning to the index of Access to Healthy Assets & Hazards (AHAH), the retail environment domain ranks LSOAs based on the ease of access to fast food outlets, alcohol, tobacco and gambling outlets, which are defined as being hazardous to health. Map 7 shows that with the exception of the LSOAs in Thames View, Barking Riverside and Eastbrook and Rush Green wards (in the south and east), Barking and Dagenham residents are afforded easy access to all four health hazards.

Access to alcohol via pubs, bars and clubs, and tobacco via tobacconists is average to worst performing in most LSOAs outside of the 3 previously mentioned wards as shown in maps 8 and 9.

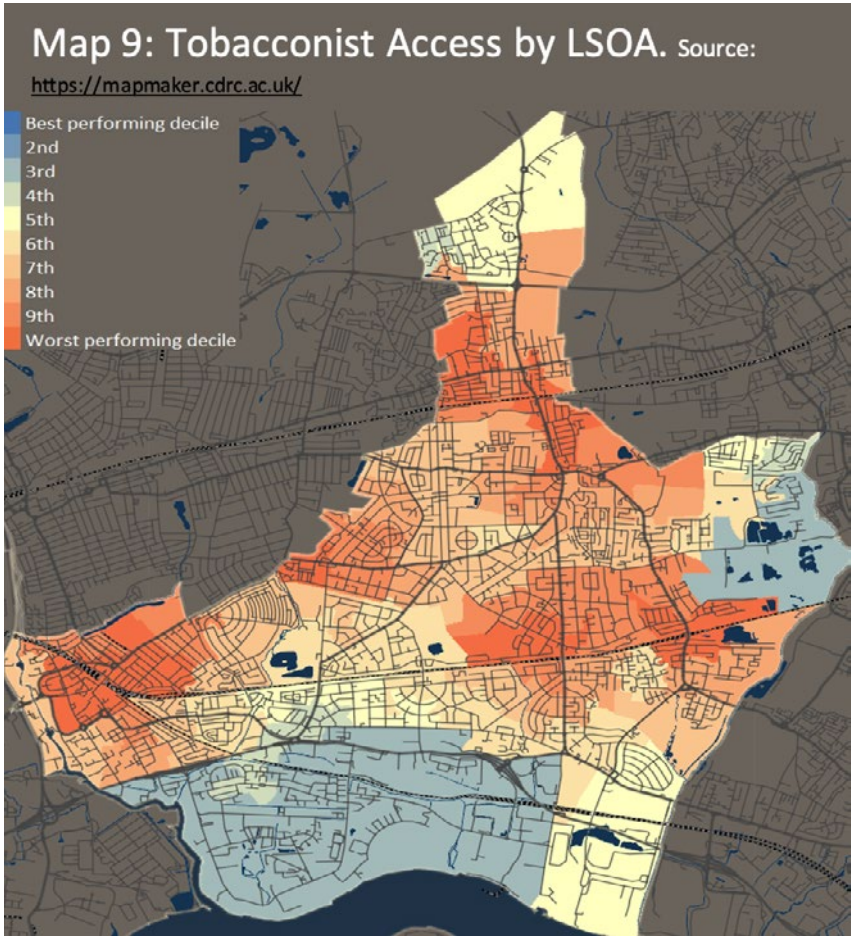
Access to fast food outlets and, in particular, gambling establishments is worse still, with nearly all LSOAs outside of Thames View, Barking Riverside and Eastbrook and Rush Green wards being ranked within the 4 worst performing deciles, as shown in maps 10 and 11. A majority of Barking and Dagenham residents therefore reside in a retail environment that will bring them into contact with these health hazards much more often than the national average.

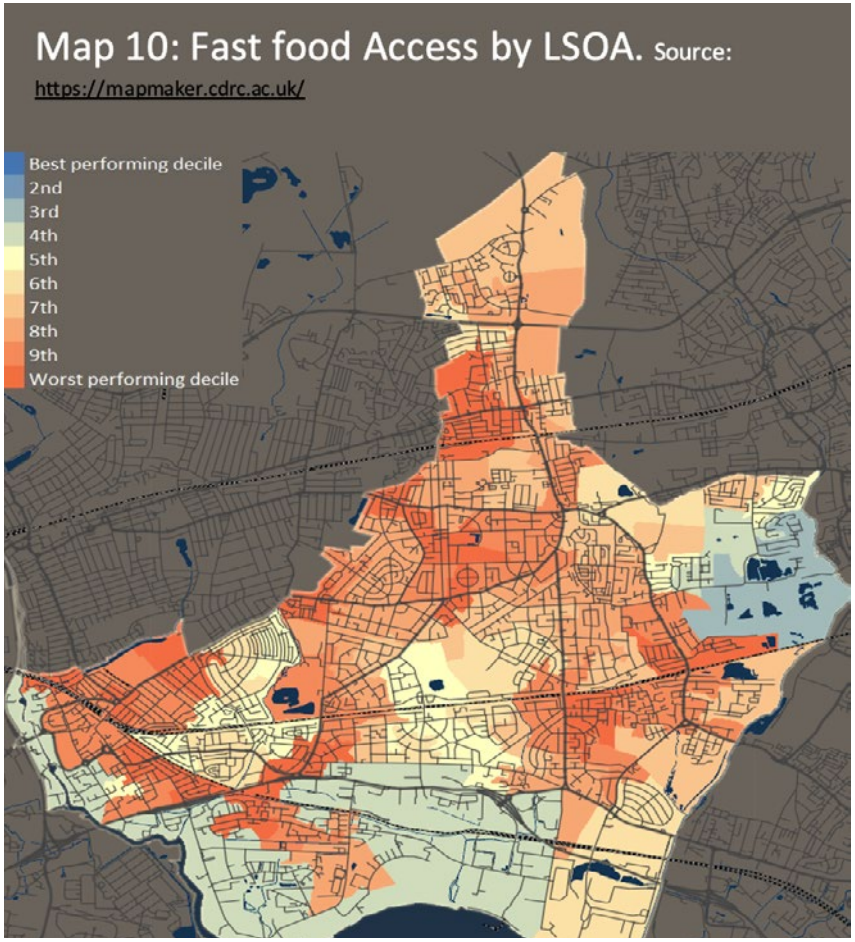


The Blue and Green space domain of the AHAH index measures ease of access to healthy outdoor environments and leisure services. The relatively large number of free-standing bodies of water within Barking and Dagenham and the presence of the River Roding means that the majority of LSOAs in the borough enjoy better than average access to blue spaces, particularly at the borders of the borough, shown in map 13.

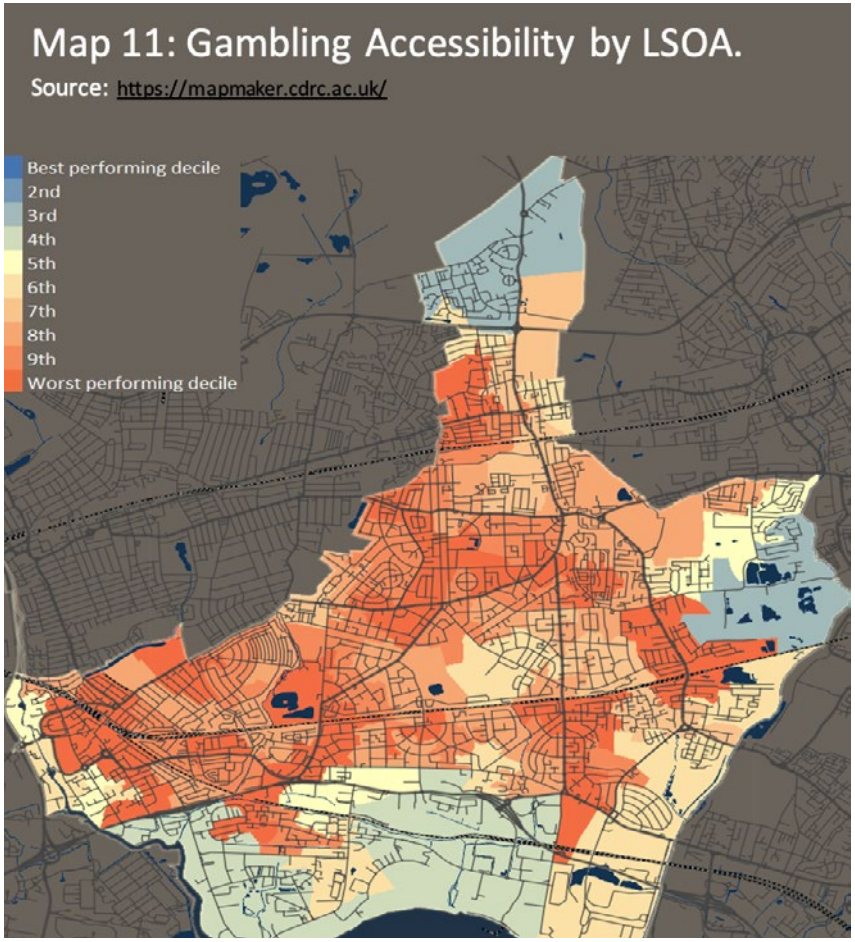


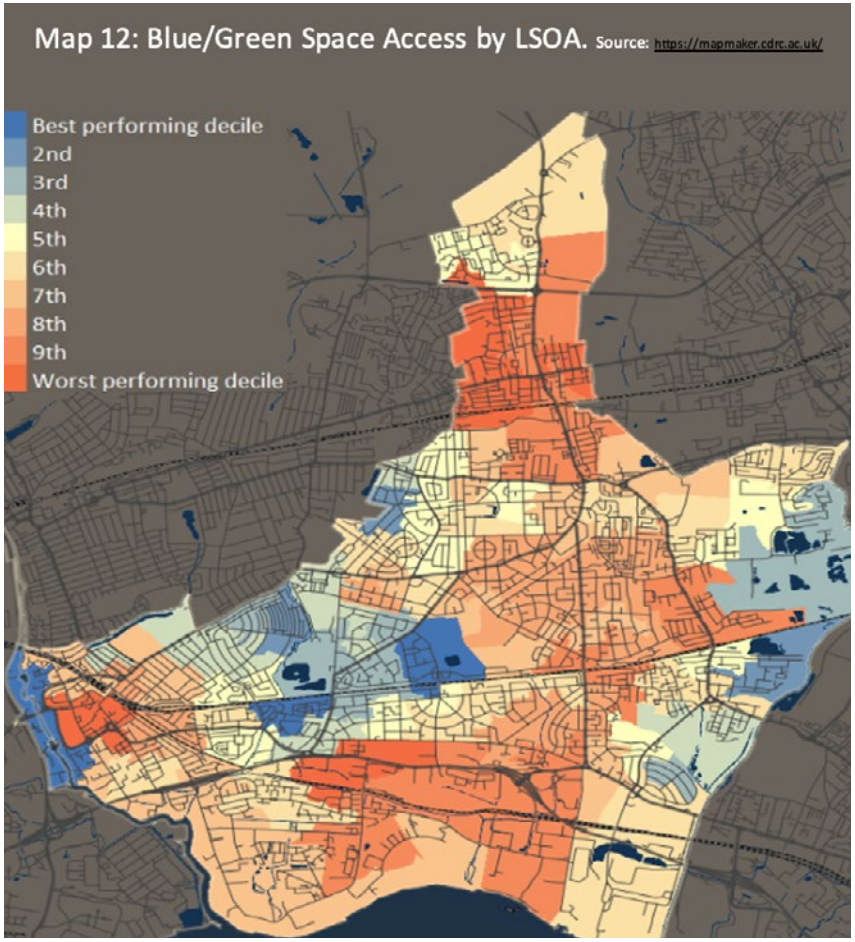
Access to leisure services is mixed within the borough (see map 14). Again, access is worst in the South and East wards, but many LSOAs in the centre and West of the borough enjoy access ranked in the best performing 3 deciles. Access to green space is by far the worst performing element of the Blue/Green space dimension (map 15). The best performing LSOAs in the borough have average access to green space, and they are outnumbered significantly by LSOAs whose access to green space is below, or far below average.

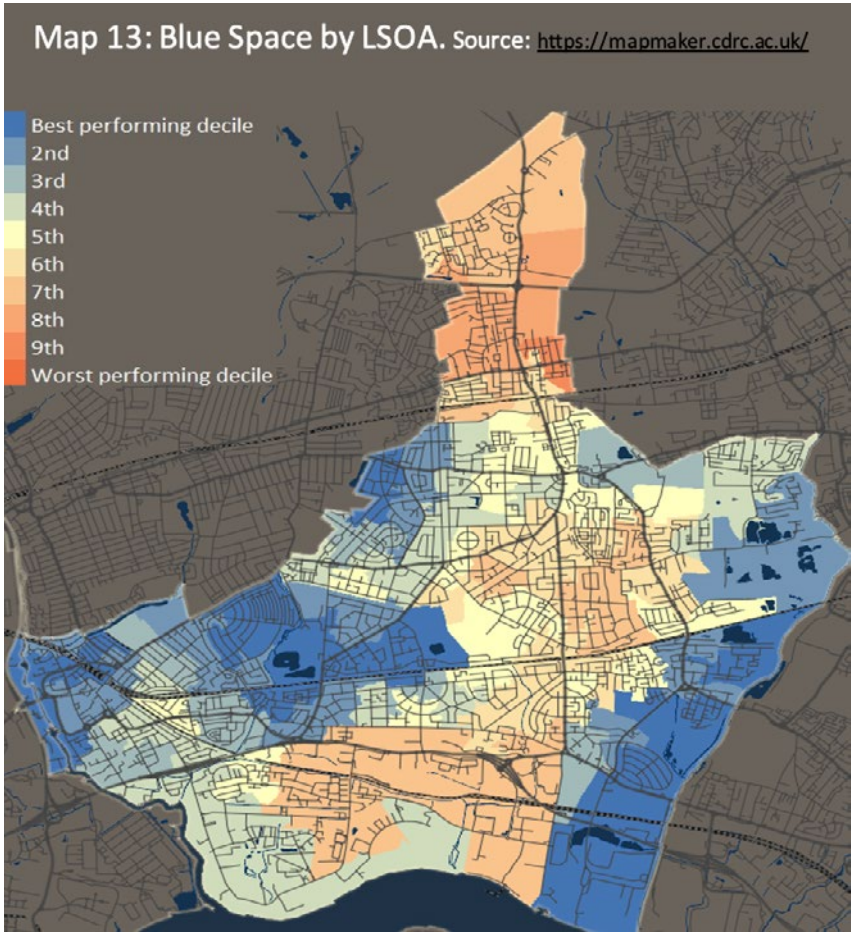


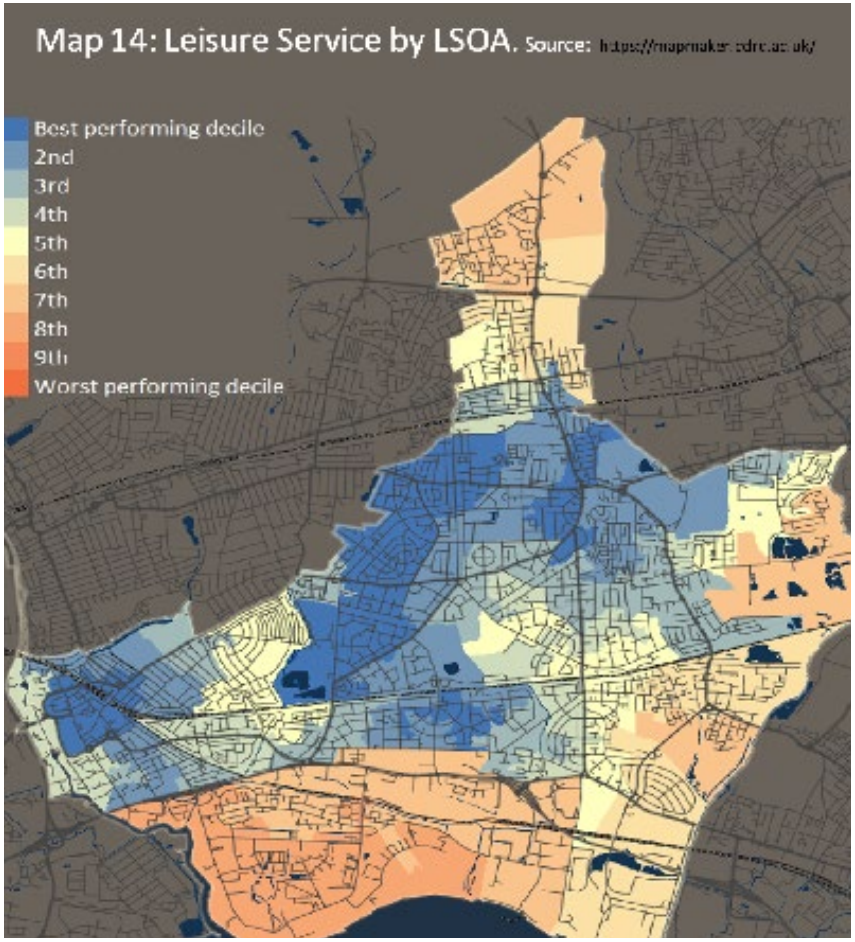


Another element that impacts the health environment in which residents live includes the condition of social housing. As at 31st March 2023, Barking and Dagenham has a lower percentage of non-decent social housing than the London and England averages and all peer boroughs excluding Waltham Forest. However, significant variation can be seen within the borough, with Map 16 showing that in Abbey, one of the borough's most deprived wards, over half of the social housing stock is non-decent suggesting a large inequality of provision for this wards' residents.


Map 11: Gambling Accessibility by LSOA.
Source: https://mapmaker.cdrc.ac.uk/
Best performing decile
2nd
3rd
4th
5th
6th
7th
8th
9th
Worst performing decile


Map 12: Blue/Green Space Access by LSOA. Source: https://mapmaker.cdrc.ac.uk/
Best performing decile
2nd
3rd
4th
5th
6th
7th
8th
9th
Worst performing decile


Map 13: Blue Space by LSOA. Source: https://mapmaker.cdrc.ac.uk/
Best performing decile
2nd
3rd
4th
5th
6th
7th
8th
9th
Worst performing decile


Map 14: Leisure Service by LSOA. Source:
Best performing decile
2nd
3rd
4th
5th
6th
7th
8th
9th
Worst performing decile

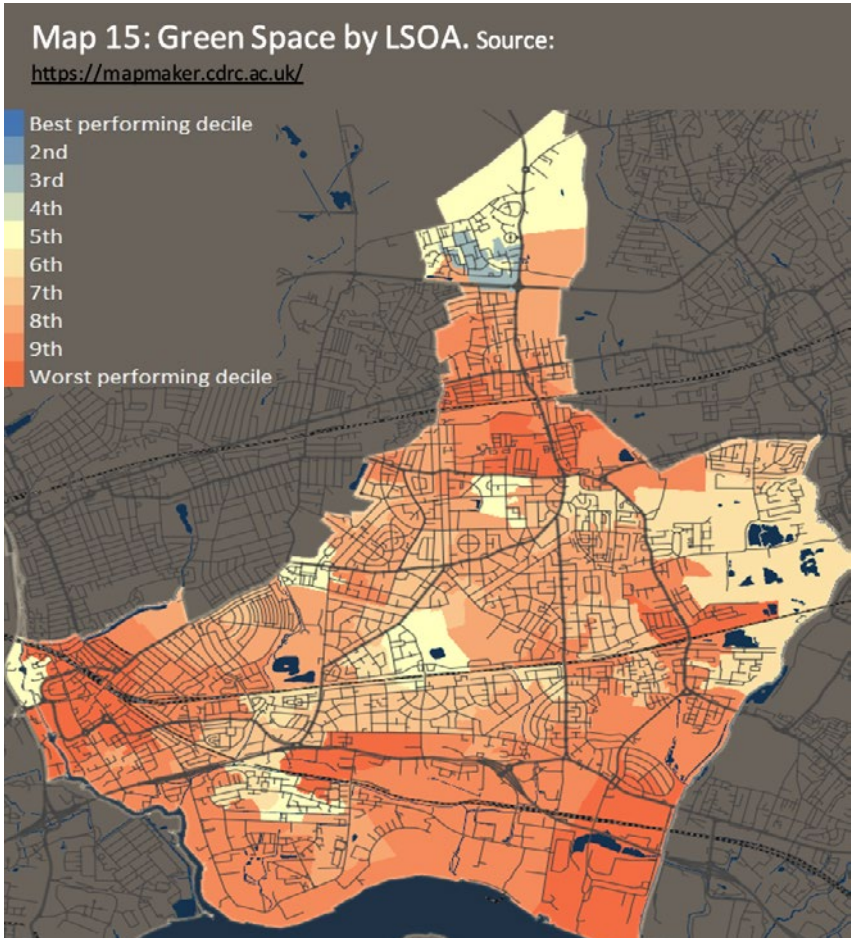
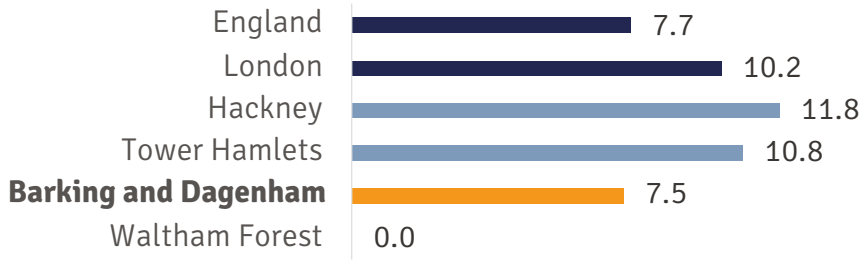
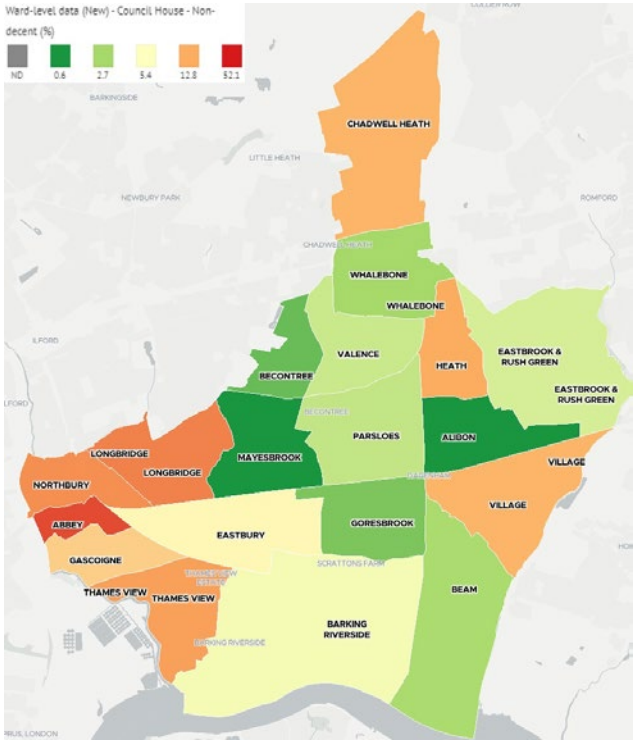


Figure 92: Percentage of non-decent local authority homes



Source: Local authority housing data - GOV.UK (www.gov.uk) accessed 03/01/2024

Map 16: Percentage of non-decent Council house stock - 2022

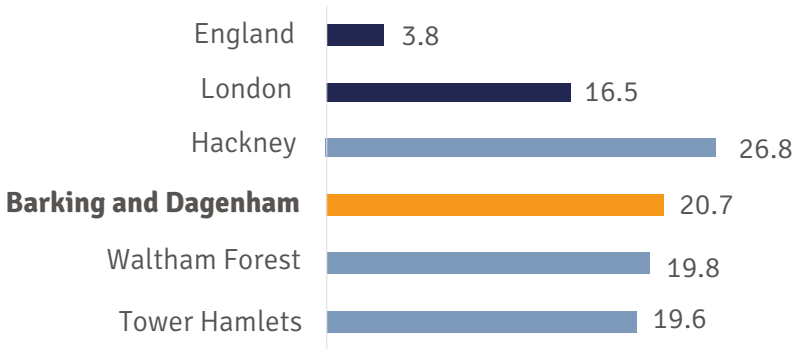


Source: Borough Data Explorer (emu-analytics.net)

Homelessness

Barking and Dagenham has a rate of households in temporary accommodation that is significantly higher than the London and England averages, although comparable to peer boroughs.

Figure 93: Rate of households in temporary accommodation per 1,000



Source: OHID Fingertips Indicator ID 93735, accessed 30/01/2024.

The Combined Homelessness and Information Network (CHAIN), commissioned and funded by the Greater London Authority (GLA), is a multi-agency database which records information collected by outreach teams in relation to rough sleepers and the wider street population in London. In 2019/20 85 people were seen rough sleeping in the borough and by 2022/23 the number had increased to 139 people. Waltham Forest also saw an increase in rough sleepers within this time period, from 133 to 186, whilst numbers in Hackney reduced and Tower Hamlets saw little change (from 459 to 460 with variations in the intervening years).

Comparison to previous years suggests that two thirds of the rough sleepers seen that year were new to rough sleeping. In 2022/23, just over two thirds of the rough sleepers seen by outreach teams were UK or European nationals and most (79 people) were of White British or White Other ethnicity. Most were male, and most were aged 26-55. None of the rough sleepers seen by the outreach teams were aged under 18.

Support workers from the homelessness sector carried out assessments of the support needs for 112 of the rough sleepers. The below table, taken from the 2022/23 CHAIN report for Outer London, shows that most of the rough sleepers required support with alcohol, drugs, their mental health or a combination of one or more of these support needs.

Figure 94: Support needs of people seen rough sleeping during 2022/23, CHAIN network

Borough	Alcohol	Drugs	Mental health	More than one of and mental health	No alcohol, drugs or mental health support needs	Total assessed
Barking and Dagenham	50	29	59	42	30	112

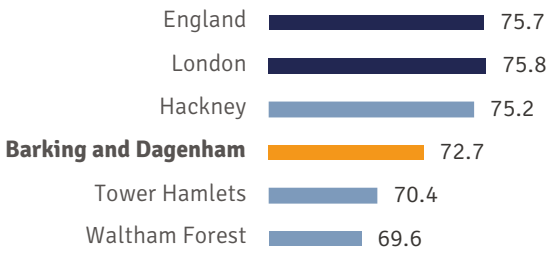
One-hundred and eight of the rough sleepers were also assessed for their institutional history, with 9 having previously been in care, 5 in the armed forces and 28 in prison.

More details for Outer London as a whole can be found within the Outer London CHAIN report, including details of any accommodation that the people seen rough sleeping may have been booked into, a more detailed breakdown by nationality and cause of departure from last settled base in the UK. Unfortunately, this more detailed overview is only available at borough level for the inner London boroughs.

Employment

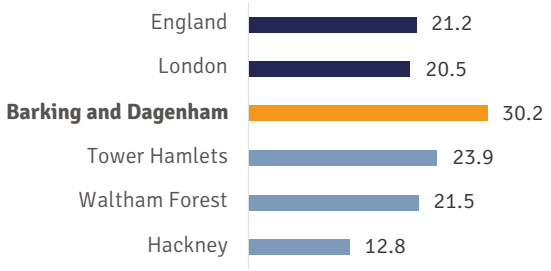
Economic opportunity and activity are strong determining factors of health. Unemployment and underemployment can make healthy behaviours such as participating in regular exercise more difficult and can negatively impact mental health. Indicators show that Barking and Dagenham residents experience slightly lower levels of employment and significantly higher rates of economic inactivity than the London and England averages for those of working age (16 to 64 years old). The economically inactive are defined as being neither employed or unemployed and comprise of groups including the long term sick or disabled, the temporarily sick, people looking after family members, students and the retired. In 2021, 11.9% of adults in Barking and Dagenham had no formal qualifications. This is the highest proportion of all London boroughs[57].

Figure 95: Percentage of residents aged 16-64 in employment in 2022-23



Source: OHID Fingertips Indicator ID 92313, accessed 30/01/2024.

Figure 96: Rate of economic inactivity in residents aged 16-64 in 2021/22



Source: OHID Fingertips Indicator ID 92899, accessed 30/01/2024.

Barking and Dagenham residents claim out of work benefit at a significantly higher rate than the England average.

Adult residents aged 18-64 in receipt of long term support for a learning disability experience far lower levels of unemployment than other residents and lower levels than peers in other boroughs. In 2022-23, 2.8% of adult residents with learning disabilities were in paid employment compared to a regional average of 5.3%. Rates in the borough are lower for females (0.6% in 2022-23) than males (4.0% in 2022-23). A similar trend can be seen nationally and regionally, however the gender gap is narrower within these larger geographical areas: there was a difference of 1.1pp between males and females in London and 1.2pp in England compared to 3.4pp in Barking and Dagenham.

Adult residents in contact with secondary mental health services also experience lower levels of paid employment with a rate of 7% in 2022-23). This is however higher than both the regional and national averages of 4% and 6% respectively, and has been maintained over the last 4 years whereas regional and national rates have declined. Conversely to the previous indicator, a higher proportion of females in contact with secondary mental health services are in paid employment than males, with a gender gap of 2.0pp.

Comparisons to other boroughs as well as time trends and gender breakdowns can be found in NHS England's Adult Social Care Outcomes Framework Interactive Dashboard.

Cost of living crisis

In September 2022, the Centre for Progressive Policy published a report called Hard Up: How rising prices are hitting different places and how they can respond. The report explores the challenges faced by different areas during the current cost of living crisis and names Barking and Dagenham as one of the ex-industrial towns "where residents are most vulnerable to the impact of rising prices".

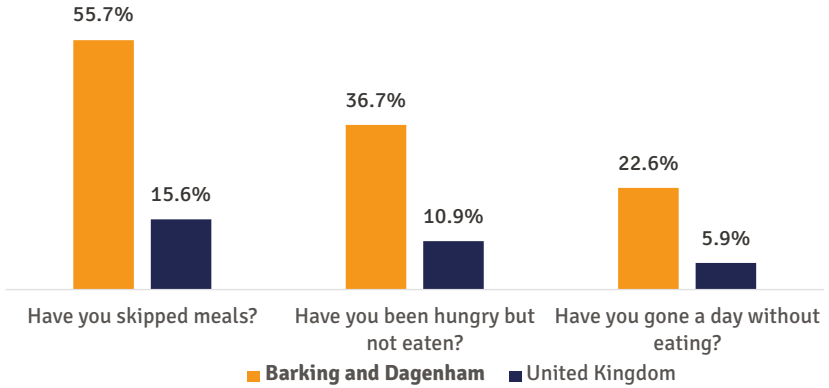
The report includes an update to the previously published Cost of Living Vulnerability Index which characterises vulnerability to the cost of living crisis as a combination of both poverty-based vulnerability and work-based vulnerability.

For the overall measure of vulnerability, London ranks centrally amongst the 9 English regions in 5th place. Barking and Dagenham however is ranked as the 4th most vulnerable Local Authority in the country. The only other London boroughs ranking in the top decile of the Cost of Living Vulnerability Index are Waltham Forest (28th) and Newham (29th).

Poverty-based vulnerability looks at existing levels of poverty within an area by combining the measures of food insecurity, fuel poverty and child poverty. Barking and Dagenham ranks 2nd in the country for poverty-based vulnerability with 18.6% of adults facing food insecurity[58]. Figure 98 shows the percentage of Barking and Dagenham residents answering yes to the three questions used by the Food Foundation to measure food insecurity. The chart compares national percentages collected by The Food Foundation to the percentages measured by the Barking and Dagenham Cost of Living survey, which show levels of food insecurity in Barking and Dagenham far exceed the national average. 18.6% of households also face fuel poverty[59] and 46.4% of children face child poverty[60]. Residents already living in poverty will be hit hardest by the pressures arising from the cost of living crisis.

Barking and Dagenham fares slightly better within the work-based vulnerability ranking at 29th place. Work-based vulnerability looks at rates of participation in the formal labour market alongside the prevalence of low-paid jobs within an area, both of which make residents vulnerable to rising prices.

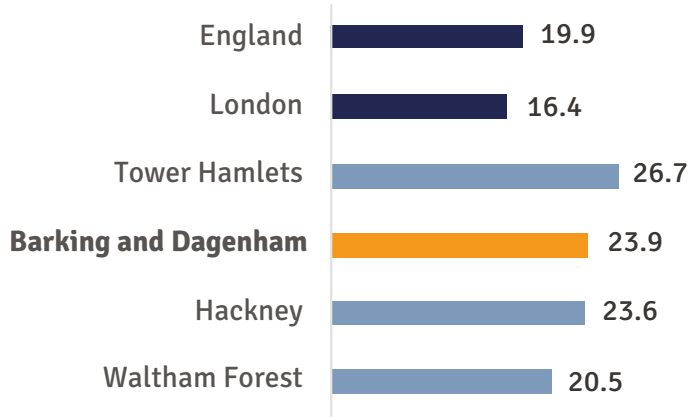
Figure 98: Percentage answering Yes to the following food insecurity questions



Sources: B&D Data: Barking and Dagenham Cost of Living Survey Analysis, July-December 2023. England: Food Insecurity Tracking (June 2023 value), The Food Foundation. Available at: https://foodfoundation.org.uk/initiatives/food-insecurity-tracking#tabs/Overview-of-surveys-

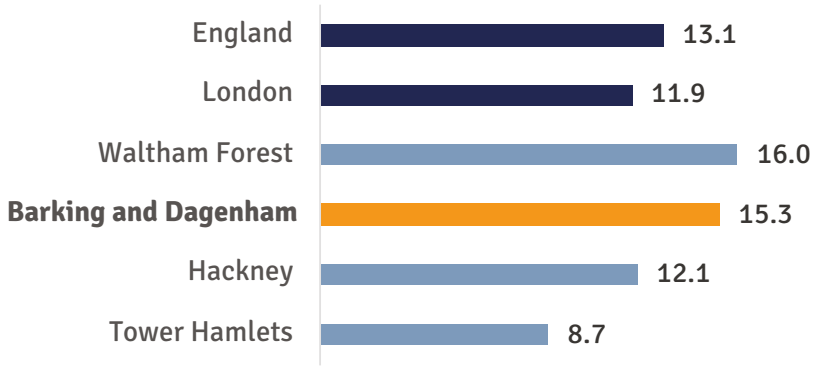
One of the recommendations made by the Centre for Progressive Policy is to reform the UK Shared Prosperity Fund (UKSPF) which supports the levelling up agenda. The report highlights Barking and Dagenham as one of the 10 most deprived local authorities in the country[61] receiving less than £40 per capita in UKSPF funding in contrast to Cornwall and Isles of Scilly which receive £225 per capita despite ranking far lower on both the Index of Multiple Deprivation and the Cost of Living Vulnerability Index.

Figure 99: Percentage of children aged under 16 living in relative low income families in 2021/22



Source: OHID Fingertips Indicator ID 93700, accessed 30/01/2024.

Figure 100: Percentage of residents in fuel poverty

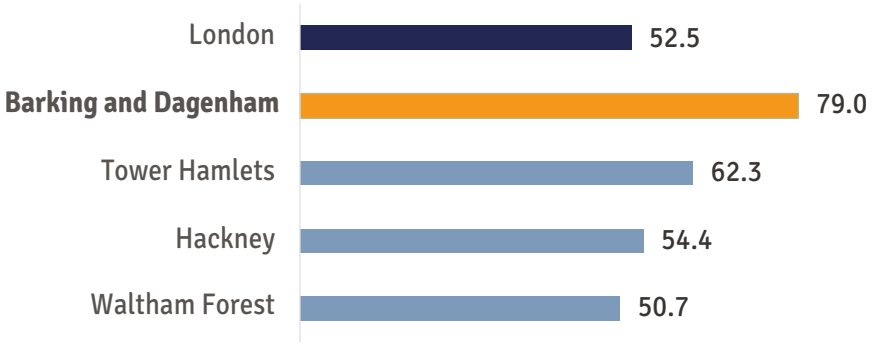


Source: OHID Fingertips Indicator ID 93799, accessed 30/01/2024.

Domestic abuse

One of the priorities in Barking and Dagenham Council's Corporate Plan (2023 to 2026) is to ensure residents are safe, protected, and supported at their most vulnerable. A public health approach includes intervening as early as possible to support victims of domestic abuse who may suffer injury to physical and mental health; including supporting children exposed to domestic abuse. Data from 2022/23 suggests rates of domestic abuse within households are significantly higher in Barking and Dagenham than in any peer borough and the London average rate.

Figure 101: Rate of domestic abuse offences per 1,000 people, Jan 2019 - Dec 2023



Source: Metropolitan Police Service, MPS Crime Data accessed 03/01/2024

From January 2019 to December 2023, on average, there have been 282 incidents of domestic abuse in Barking and Dagenham each month. In the month of December 2023, 305 incidents were recorded. This was the 9th month of the 12 previous months that saw an above average number of incidents, suggesting offences of this nature were recorded at above average levels throughout 2023. In the 12 months to December 2023, 3,747 domestic abuse

offences were recorded, of which 892 resulted in "domestic abuse violence with injury". This level of offending was 7.9% higher than in the 12 months to December 2022, signalling a concerning uptrend in domestic abuse in the borough.

Place: key messages and public health advice

A majority of Barking and Dagenham residents reside in an environment that will bring them into contact with health hazards of alcohol, tobacco, gambling and fast food much more often than the national average. Residents in most of the borough (apart from the most easterly and westerly parts) have poor access to green space. Access to GP and hospitals scores are amongst the best nationally across most of the borough but is poorer in the South of the borough.

Barking and Dagenham had the lowest estimated proportion of mortality attributable to particulate air pollution in residents aged 30 and over in 2021 of its peer boroughs. However, all peer boroughs are in London and the London average air pollution attributable mortality is higher than the England average. And air pollution levels across NO2, PM10 and sulphur dioxide in the borough are amongst the worst 3 performing deciles nationally.

Rates of people in temporary accommodation in Barking and Dagenham are higher than London and England averages but comparable to peer boroughs. Numbers of rough sleepers have increased since the pandemic and around 2/3 have some mental health, drug or alcohol support needs.

Rates of domestic abuse within households are significantly higher in Barking and Dagenham than in any peer borough and the London average rate.

Barking and Dagenham residents experience slightly lower levels of employment and significantly higher rates of economic inactivity than the London and England averages for those of working age (16 to 64 years old). In 2022-23, 2.8% of adult residents with learning disabilities were in paid employment compared to a regional average of 5.3%. 7% of those in contact with secondary mental health services were in employment compared to 4% in London and 6% in England.

Barking and Dagenham however is ranked as the 4th most vulnerable Local Authority in the country in the Cost of Living Vulnerability index, with higher than London and England average fuel poverty and child poverty, and high rates of food insecurity.

Public Health advice

- Council and place partnership should focus on building and maintaining healthy environments, and improve access to healthcare within newer developments.
- Continue work to shift from car travel to improve air pollution, physical activity and safety within the borough
- Act on findings from the forthcoming homeless health needs assessment to prevent and reduce health inequalities within this population
- Focus on targeted action to address housing, income and employment needs of those with existing physical and mental health problems.
- Align work on wider determinants of health and highlight the benefit of health improvements on the wider outcomes through a Health in All Policies approach.

These areas are further explored in Chapter 4 of the ADPHR 2023.

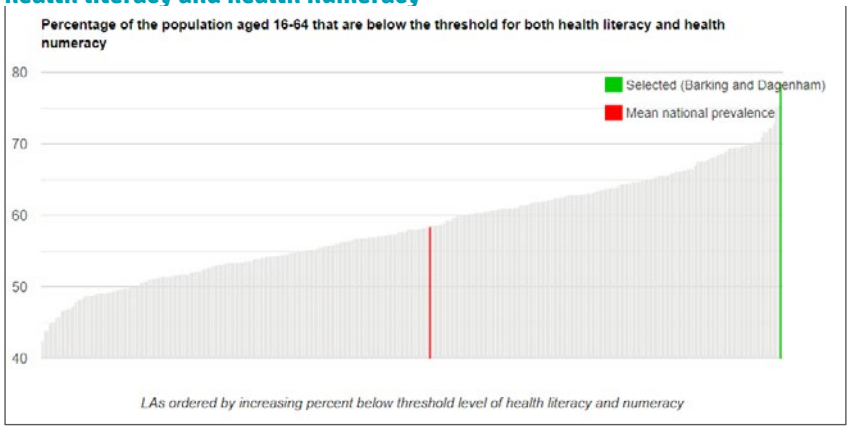
Community and health

Health literacy and numeracy

According to a study by the University of Southampton, funded by NHS England, Barking and Dagenham has the highest prevalence of low health literacy and numeracy in England. An estimated 78.4% of borough residents aged 16-65 are likely to have difficulties understanding and interpreting health information, compared to 67.6% in Tower Hamlets, 48.3% in Waltham Forest and 47.1% in Hackney. The England average is 58.3%.

More information about the study and data for other boroughs can be found at https://healthliteracy.geodata.uk/.

Figure 102: percentage of the population age 16-64 below threshold for health literacy and health numeracy



Additionally, 8% of borough residents have never used the internet[62] and are therefore excluded from opportunities such as securing employment, finding value for money services, information and news.

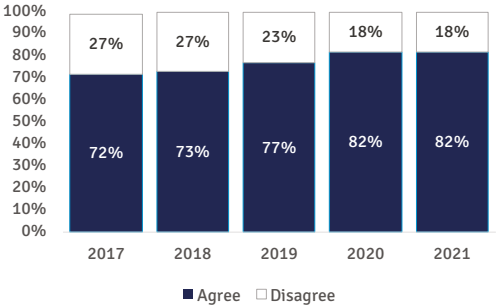
At ward level there is a great deal of variation in the proportion of residents who have access to the internet. In Goresbrook ward 10.0% of residents do not have access to the internet anywhere, compared to 3.8% in Becontree[63]. Data for all of the borough's wards can be found in the Skills & Education section of the Borough Data Explorer.

Community cohesion

Of 2,900 conversations held by the third sector with residents from November 2022 to October 2023, the vast majority of residents were proud of their resilience and ability to cope in times of need[64]. Their first port of call was family, friends, neighbours and local community. The feedback builds a picture a community who want to help each other, and are creative in doing so; with dreams, hopes and aspirations for their lives. Services were infrequently cited, and there was some sense that residents felt increasingly less well supported by health and council services.

In Barking and Dagenham's Residents Survey 2021, four out of every five residents surveyed agreed that the local area is "a place where people from different backgrounds get on well together". This aligns with the 2020 survey outcomes and is an improvement on previous years.

Figure 103: Residents Survey 2021, Community cohesion



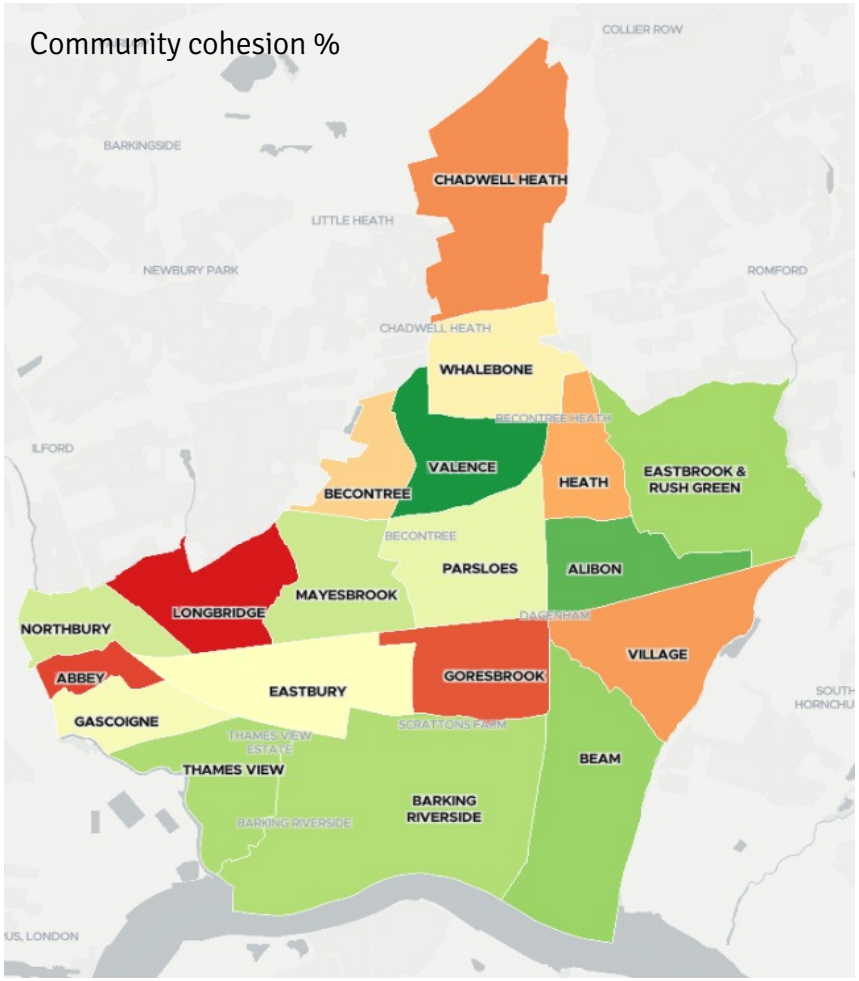
The map below shows that not all residents experience the same sense of community cohesion.

Outcomes varied from 86.4% in Valence to 67.7% in Longbridge. Nevertheless, in 8 of the

borough's wards more than 80% of residents agreed that people from different backgrounds get on well together.

Data for each of the wards and for previous years can be found in the Borough Data Explorer.

Figure 104: Ward-level variation in community cohesion, Resident's Survey 2021



Carers

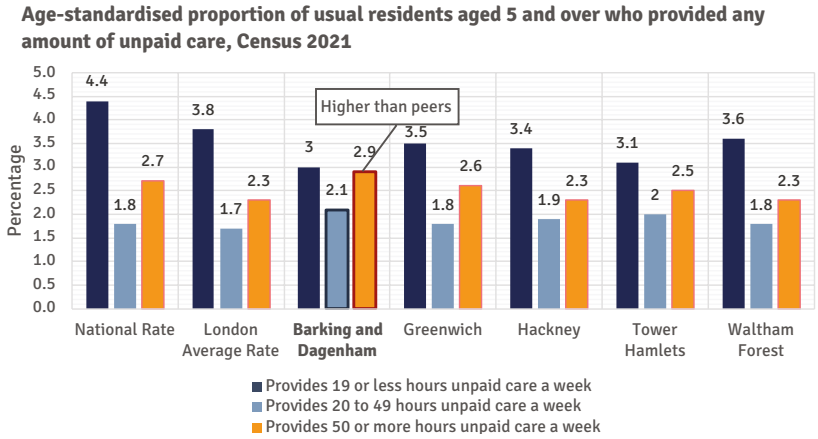
Census 2021 revealed that there has been a reduction in the age-standardised[65] proportion of people in the borough aged 5 years and over providing unpaid care, mirroring national trends.

In 2011, 8.7% of Barking and Dagenham residents were recorded as providing unpaid care compared to 8.0% in 2021. The reduction is the result of a lower proportion of people providing 19 hours or less of unpaid care (4.6% in 2011 compared to 3.0% in 2021).

Meanwhile, the proportion of residents providing more than 19 hours of unpaid care has increased. In 2011, 1.6% of Barking and Dagenham residents were providing 20 to 49 hours of unpaid care a week, whilst 2.5% were providing 50 hours or more. In 2021 these figures increased to 2.1% and 2.9% respectively; a higher proportion of Barking and Dagenham residents were providing 50 or more hours unpaid care than the peer boroughs and the London and England averages.

More information about unpaid care, as recorded in Census 2021 outputs can be found here.

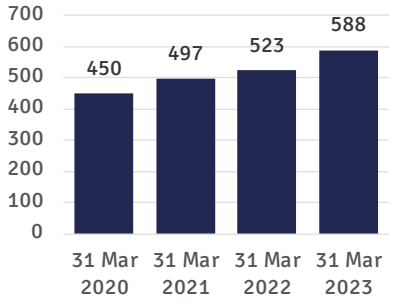
Figure 105: Proportion of residents providing any amount of unpaid care, 2021



Source: Census 2021 data is from ons.gov.uk.

Conversely, there has been an increase in the number of carers registered for support from Barking and Dagenham's Adult Social Services.

Figure 106: Carers registered with Adult Social Services



Source: Local Authority administrative data.

Every other year, a Survey of Adult Carers in England is completed by Councils with Adult Social Services Responsibilities. The survey is sent to unpaid carers aged 18 or over registered with the local authority, caring for someone aged 18 or over and it seeks their views on a number of topics considered to be indicative of a balanced life.

The proportion of carers in Barking and Dagenham that feel they have encouragement and support has fallen over time, from 34% in 2016-17 to 27.4% in 2021/22. Meanwhile the proportion that feel they have no encouragement or support has risen from 21.9% in 2016-17 to 28.4% in 2021/22.

In 2021/22, only 25% of carers said they had as much control over their daily life as they wanted and 11.5% said they had no control over their daily life. When asked to think about the amount of time they had to themselves, in terms of getting enough sleep and eating well, half (48%) of the carers surveyed said they were looking after themselves but nearly 1 in 5 (18.4%) said they felt like they were neglecting themselves.

One of the survey questions focuses on the impact of the caring role on the health of the carer. In 2021/22, 77.6% said it had led to them feeling tired, 44.9% reported feeling depressed and 50% had a general feeling of stress.

It should be noted that the results are based on 100 survey responses. As noted above, at the end of March 2022 there were 523 carers registered with Barking and Dagenham's Adult Social Services therefore the views expressed in the survey represent just under a fifth of registered carers.

Community and health: Key messages and public health advice

Barking and Dagenham has the highest prevalence of low health literacy and numeracy in England. An estimated 78.4% of borough residents aged 16-65 are likely to have difficulties understanding and interpreting health information. 8% of residents have never used the internet.

In a series of local conversations with residents, the vast majority of residents reported being proud of their resilience and ability to cope in times of need. Their first port of call is family, friends, neighbours and local community . Four out of every five residents surveyed agreed that the local area is “a place where people from different backgrounds get on well together”.

8% of Barking and Dagenham residents were recorded as providing unpaid care in 2021. However, the proportion of those providing more than 19 hours care per week has increased. In 2021/22, only 25% of surveyed carers said they had as much control over their daily life as they wanted and half reported feeling stressed.

Public health advice

- Prioritise action on health literacy through targeted intervention and health promotion focussed on priority health needs
- Consider digital exclusion in relation to health promotion and access to services
- Consider further work to understand concerns and promote community cohesion in wards where residents reported poorer results.
- Continue to engage communities and harness community assets in emerging locality working at Place. This is explored further in Chapter 2 of the ADPHR.
- Implement the commitments of the Barking and Dagenham Carer’s Charter to support the ongoing needs of local carers.

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Thank you for reading

To find out more please **click here**.

Barking & Dagenham

Barking and Dagenham CDOP Annual Report Data

2023-24

New Notifications of Child Deaths

This section gives an overview of all child deaths notified to CDOP between 1st April 2023 and 31st March 2024. It includes all children who are normally resident in the B&D area (regardless of where they died). This data is drawn from the database of notifications (Form A from the National Data Set).

In 2023-24 there were 17 child deaths of children normally resident in Barking and Dagenham, which is a significant reduction on the previous year. However, caution should be exercised regarding statistical significance because of the very small number of child deaths.

	2019-20	2020-21	2021-22	2022-23	2023-24
Barking and Dagenham	24	11	22	31	17

Child Death Notifications by Gender

In 2023-24, notifications in respect of male children were recorded as higher than female, a trend which has continued from previous years. This is in keeping with the national picture; the Child Death Review Data: Year ending 31 March 2022 . However, the proportion of male deaths to female is higher than previous years.

	Male	Female
Barking and Dagenham	13	4

Child Death Notifications by Age

The highest number of new notifications was received for the age range 0-27 days. Whilst this is a similar pattern to previous years, the number of neonatal deaths has increased across NEL. An ongoing, detailed review of these deaths is taking place to identify themes.

Age range	2022-23	2023-24
0-27 days	8	10
28 days – 364 days	9	0
1 year – 4 years	3	3
5-9 years	6	3
10-14 years	3	1
15-17 years	3	0

Child death notifications by ethnicity 1st April 2023 – 31st March 2024

Ethnicity	B&D
Asian or Asian British - Any other Asian background	1
Asian or Asian British – Bangladeshi	4
Asian or Asian British - Pakistani	0
Asian or Asian British – Indian	2
Black or Black British – African	3
Black or Black British – Caribbean	0
Black or Black British - Any other Black background	0
White - English/Welsh/Scottish/Northern Irish/British	1
Mixed – White and Black African	0
Mixed - any other	1
Mixed - White and Asian	0
Other White background	3
Other	2
Unknown	0

CDOP Meetings Held in 2023-24

This section reports on child deaths reviewed at CDOP in 2023-24. The number of notifications and reviews differ as the cases reviewed include deaths notified in previous years but not reviewed until the current year. This anomaly is due to the time needed to review the circumstances of each death following notification. This can be significant in the event of an inquest or criminal proceedings.

The CDOP met on 7 occasions in 2023-24 and reviewed 9 Barking and Dagenham Deaths.

Category of child deaths

During the CDOP meeting, panel members categorise a child's death according to nationally defined categories that are determined by the Department of Health.

During 2023-23, CDOP reviewed two deaths categorised at SUDI/SUDC. The BHR CDOP has identified the need to reinforce the safe sleeping message at all contacts with parents of infants less than 1 year.

A SUDI Prevention Task and Finish Group has been convened by the NEL CDOP teams, which identified the need for multiagency partnership working to ensure that SUDI Prevention messages reach the most vulnerable families. It is proposed that a 'Prevent and Protect Model' across NEL is adopted to ensure all relevant agencies/ practitioners have the necessary skills and knowledge to work with families where there is increased risk.

Completed cases by primary category of death

Acute Medical or Surgical Condition	Chromosomal, genetic or congenital anomaly	Infection	SUCI/SUDC	Perinatal/neonatal event
1	2	3	2	1

North East London
Integrated Care Board

Committees in Common of ICB Sub-Committee and Health and Wellbeing Board

Tuesday 10th September 2024

Title of report	NEL Maternity & Neonatal Demand and Capacity Case for Change
Author	NEL LMNS
Presented/Sponsored by	Diane Jones, Chief Nursing Officer NEL ICB Chineze Otigbah, Consultant Obstetrician and Gynaecologist BHRUT
Contact for further information	Daine Jones, Chief Nursing Officer NEL ICB diane.jones11@nhs.net
Wards affected	Maternity & Neonatal Service across NEL
Key Decision	For discussion and Information
Executive summary	NEL ICB has been working with stakeholders to a gain greater in-depth understanding how maternity and neonatal services in North East London can meet the changing needs of women (pregnant people) and their babies in developing future services. The programme of work includes meeting the needs of local people providing maternity and neonatal care that is safe, high quality and accessible. This work is being supported and led by clinicians and system leadership, working together across health and care organisations in an open transparent and collaborative way to develop this programme. NEL ICB (working with key stakeholders) have considered information from families, NHS staff and community representatives, reviewed service data, and looked at areas such as population growth, inequalities and health needs. We have written a Case for Change which sets out the findings of this review. The Case for Change found that in North East London we have a growing population, more complicated pregnancies and births, more babies needing medical care when they are born, and health inequalities that impact pregnancies, births and babies.

	The information gathered by the programme indicates that as a system, NEL needs to make some changes to maternity and neonatal services supporting opportunities and tackling barriers to ensure our services are safe, high quality and accessible for all.
Action / recommendation	The Board/Committee is asked to: Discussion
Reasons	• NEL ICB have shared this information with HWWB chairs, at the same time as launching public and stakeholder engagement on the case for change. • NEL ICB would like to provide the HWWB board to jointly discuss findings and the next steps, giving the Board the opportunity to ask further questions.
Previous reporting	List any other forums where this has previously been discussed • NEL ICB Board • NEL Local Maternity & Neonatal System (LMNS) Board • NEL Maternity & Neonatal Programme Board • Trusts Boards • NEL Health & Wellbeing Boards
Next steps/ onward reporting	List any other forums where this will be discussed. • NEL ICB Board • NEL Local Maternity & Neonatal System (LMNS) Board • NEL Maternity & Neonatal Programme Board • Trusts Boards • NEL Health & Wellbeing Boards
Conflicts of interest	• No Conflicts of Interest: An external consultancy was commissioned to work with the NEL ICB in supporting the ‘case for change’.
Strategic fit	• Three Year Delivery Plan: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development • Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment.
Impact on local people, health inequalities and sustainability	• NEL LMNS Equality and Equity Strategy (2022) • Maternity Choice Report (2023). • NEL LMNS Equality and Equity Framework (2024)

	• NEL ICB 2024/25 Priorities and Operational Plan: to maintain our collective focus on the overall quality and safety particularly maternity and neonatal services, and reduce inequalities in line with the • Delivery of the Core20PLUS5 approach
Impact on finance, performance and quality	• To support the need for NEL ICB to make changes for maternity and neonatal services ensuring that services are safe, high quality and accessible for all. • To considering the opportunities currently identified for future maternity and neonatal services in NEL. Based on best practice and strategic (national) guidance. This includes Three Year Delivery Plan, Better Births, Ockenden Reports, the Neonatal Critical care review and BAPM Standards
Risks	Risks include: The need to support the enablers within the case for change: • Digital and information systems • Workforce strategy • Estates and resources

NHS
North East London

NEL maternity and neonatal demand & capacity

Summary document

This document is a summary of the work that has been carried out as part of the maternity and neonatal demand and capacity programme

This piece of work is the starting point for exploring **how maternity and neonatal services in North East London can meet the changing needs of women and babies** and will inform how services in NEL in the future will meet the needs of local people through provision that is safe, high quality and accessible.

The first stage of this work has involved **understanding the current state**. This is through **collating and analysing data** to understand current activity and look at future demand projections, as well as **synthesis of existing work** done to date in NEL and national guidance, and **stakeholder engagement**. These findings have been brought together into a **case for change which identifies opportunities for the future**.

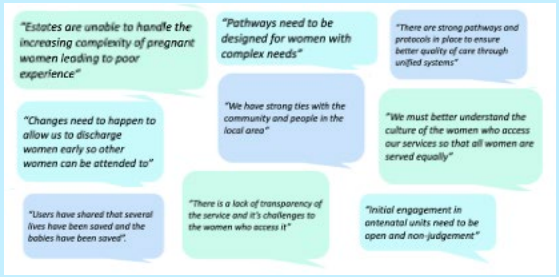
The second stage of the work was to **co-design best practice care models** for maternity and neonatal services, considering the opportunities identified in the case for change, national guidance and best practice examples. These care models were **developed with clinicians and wider stakeholders and** are intended as a starting point for future work

The high-level care models set out areas for further, data driven, exploration to develop more detailed care models that are deliverable, sustainable, make the best use of system assets, and deliver on the opportunities identified in the case for change.

The case for change themes were developed through the engagement with stakeholders, desktop review and analysis and modelling

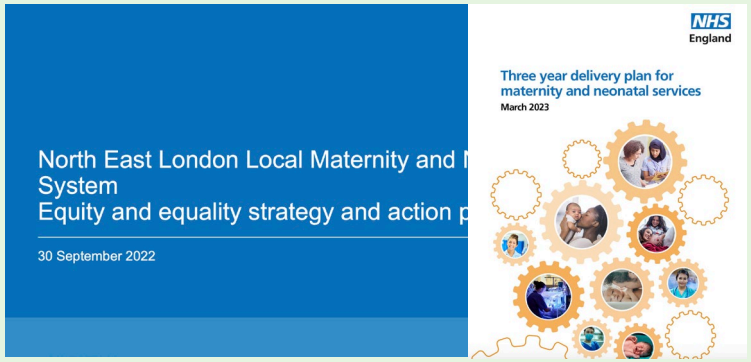
Stakeholder engagement

- Conducted 1:1 or small group interviews with over 50 stakeholders from across the system including service user representatives, Trusts, ICB, LMNS, ODN, LAS and Local authority colleagues
- Gathered views on current strengths of services, challenges and opportunities for the future



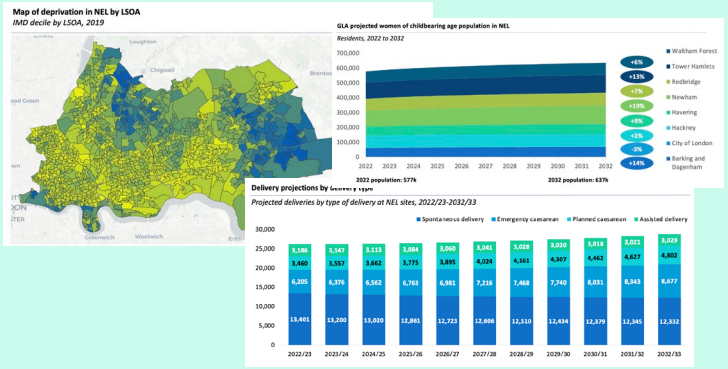
Desktop review

- Reviewed local NEL strategy, planning and work completed to date around maternity and neonatal services
- Reviewed service user feedback including from Healthwatch and CQC
- Reviewed national guidance and best practice documentation



Analysis and modelling

- Developed demand and capacity modelling to understand the projected future position in a 'do nothing' scenario
- Conducted further analysis including workforce, activity in and outflows and activity profiles by site



There is an opportunity to ensure maternity demand and capacity are matched across NEL, and to strengthen pathways and models of care to remove unwarranted variation

Matching demand and capacity across the system

- **Population growth** in NEL will outweigh a declining birth rate, which means that the NHS will need to support **more births** over the next 10 years
- Pregnancies and births are also **increasingly complex**, meaning **more resources are required for each birth**
- There is a need to **ensure capacity is matched to the needs of birthing people** in NEL

Strengthening antenatal and postnatal care pathways

- A high proportion of pregnant people in NEL have **other health conditions and may experience complex social factors** which mean their pregnancies are not low risk
- There are opportunities to **improve early booking** and **ensure effective communication**
- In addition to strengthening antenatal pathways, improving **pre-conception healthcare and prevention** is key
- **Postnatal care pathways** are a key element to contribute to improving health and care outcomes for families

Addressing variation in quality, access and experience

- **Service offer, pathways and processes are not consistent,** meaning pregnant people with similar needs have a different experience depending on where they choose to give birth
- There are opportunities to **ensure best practice is followed** (eg. around induction of labour)
- Service users report opportunities to improve access and their experience of care

Reducing health inequalities

- There are **stark and persistent inequalities in outcomes** for people from different population groups, for example, babies born to Black and Asian women are more likely to have a **low birth weight** and these women are **more likely to have a stillbirth** than White women
- Women in NEL are **more likely to book pregnancies later**, **particularly pregnant people from global majority communities**, which has implications for antenatal care and outcomes

There are opportunities for neonatal services to ensure care is delivered in the most appropriate setting, which will improve quality and safety

Delivering neonatal care in the appropriate setting

- It is important that neonatal care is provided in the most appropriate setting to ensure the highest possible quality of care is provided to each baby
- High occupancy levels in neonatal units increases quality and safety risks for babies; repatriating babies to LNUs from NICUs can free up vital capacity to care for the sickest babies
- Currently, **NEL neonatal units are experiencing high occupancy levels,** particularly at Royal London, and particularly in intensive care and high dependency
- There are opportunities both to **facilitate in-utero transfers** so babies are born in the appropriate care setting for their needs, as well as to ensure **repatriation of babies to their local unit** when they are well enough

Enhancing transitional care and care at home for neonatal services

- There is an **opportunity to improve transitional care across all neonatal units in NEL** to support improved discharge processes whilst maintaining contact between mother and baby, avoiding separation
- Transitional care supports the bond between the baby and their mother whilst maintaining support from midwives and neonatal nurses, which facilitates mothers being able to pick up issues more readily post discharge
- Developing the **neonatal outreach service** in NEL provides an opportunity to readily discharge babies and their families that require support which could be provided at home
- **Strong transitional care and outreach teams provide a better experience** for babies and their families whilst contributing to freeing up capacity on the neonatal unit at NEL hospitals

Stakeholders have described significant opportunities to ensure workforce models optimise the use of resources and prioritise staff wellbeing

Making the most effective use of staff resource

- There are **significant pressures on staff** across the system in both maternity and neonatal services with high **vacancy rates** and staff shortages being the cause of most escalations
- Alongside vacancies, **increasing acuity puts additional pressure on staff**, but the workforce model and model of care have not changed
- There is an opportunity to **optimise the future workforce model** to make best use of staff resources, ensuring **resourcing is aligned with case mix** and enabling staff to operate at the top of their skills and competencies
- There is also a need for **innovative approaches** to support recruitment in these areas

Improving staff wellbeing

- Stakeholders praise staff working in maternity and neonatal services as **hard-working, resilient and working together to provide safe care** in a challenging environment
- However, staff are feeling the pressure of the situation, increasing the **risk of burnout**
- NHS staff surveys show **reductions in staff morale and sense of wellbeing** in staff, particularly for midwives in NEL trusts
- Focusing on staff wellbeing is important for **their experience**, the ability to **retain and recruit** staff, as well as improving the **quality of care and experience for their patients**

The care models were developed based on a combination of national guidance, best practice and stakeholder engagement

- The case for change identified opportunities for improvement in maternity and neonatal services
- These opportunities provided a basis to understand what the future provision of maternity and neonatal services should be min NEL to best meet the needs of the population that they serve
- Considering the opportunities identified, initial drafts of future clinical models for maternity and neonatal services in NEL were developed based on best practice examples and national guidance including Better Births, Ockenden Report, the Neonatal Critical care review and BAPM Standards
- The care models were then shared and co-designed with clinicians and stakeholders in a workshop setting
- The current care models require further iteration with stakeholders in the next phase of work, so they can act as the basis for determining how services should be organized in the future and address all aspects of the case for change, including improving staff wellbeing

Maternity care pathway summary

This is a draft best practice model of care and represents how care could be delivered in the future and does not reflect the current care pathway

DRAFT WORK IN PROGRESS

Pre-conception | **Access to care** | **Antenatal care** | **Birth and treatment** | **Postnatal care**

Pre-conception support

- General advice
- Specialist advice
- Perinatal mental health support

Access to care

Woman or person confirms pregnancy:

- Self-referral (online)
- Primary care referral
- Institutional referral
- Hospital referral

If needed

Central booking system for preference selection*

**Helpline available*

Booking appointment

- Risk stratification of all pregnant women including women being induced
- Personalised care plan
- Options to book interpreters for all appointments
- Social support advice
- Mental health support

Antenatal care

Choice of Site and birth plan

- Home birth
- Standalone Midwife led unit
- Obstetric led unit
- Alongside Midwife led unit

Routine care

- Advice and education (obesity, smoking, alcohol)
- Routine appointments, investigations & scanning
- Immunisation hub
- Health visitor
- Antenatal education & classes
- Diabetes support and care

Additional services if required

- Community / peer support / VCSE
- Antenatal screening +/- referral to fetal medicine
- Mental health support

Additional care / specialist input

- Maternal medicine pathway
- Fetal medicine pathway (incl. counselling and other specialist clinics)
- Diabetes/ other condition support & care
- Placenta accrete network

Social prescribing is provided throughout

Birth and treatment

Care may be transferred to an alternative unit (patient choice or clinical indication) during the antenatal or birthing period or can be performed in-utero

Birthing

Triage of birthing location can occur earlier for a planned c-section

Triage to reassess suitability of birthing location and birthing plan:

- Induction of labour
- Booked C-section
- Home birth
- *Transfer if needed*
- Midwife led unit
- *Transfer if needed*
- Obstetric led unit
- Spontaneous delivery
- Emergency operative or assisted delivery

If needed

Complications

Pregnant woman or person
- Maternity HDU
- Adult ICU

Baby – enhanced ward-based care
- Transitional care

Baby – neonatal care
- Neonatal outreach
- Neonatal unit (LNU / NICU) co-located with an obstetric led unit

Access to mental health support / risk assessment if needed

Postnatal care

Parent and baby

- Postnatal ward / readmissions
- Transitional care
- Specialist neonatal referral
- Feeding support
- Home visits
- Health visitor
- Neonatal community outreach
- Repatriation to local unit
- Social care support
- Long-term education for a healthy lifestyle

Post partum woman or person specific

- Primary care support
- Mental health support
- Physiotherapy
- Community midwife
- Family planning
- Bereavement support (across whole maternity pathway)
- Postnatal education
- Referral to other healthcare services incl. pre-conception
- Care for complex woman and people

The maternity care model is split into four key phases with details around each to be iterated further (1/2)

Pre-conception and access to care

- Personalised pre-conception care for women or people considering pregnancy is key to support people to be in the best health before a pregnancy and increases the chances of conception, reduces the risks associated with a pregnancy, for example reducing the chances of a miscarriage or stillbirth, and optimise outcomes for the mother and the baby.
- These services should be community-based and delivered through proactive outreach, public health, social prescribing and the VCSE.
- Identification of people who should be signposted to pre-conception support services should be informed by risk stratification including demographic to target support to those who are most at risk of poor outcomes.
- Once someone identifies that they are pregnant, they can either self-refer to maternity services, or access maternity care via their primary care practitioner.
- There is an opportunity to provide a more streamlined approach to accessing care through a centralised booking system, providing a single point of access to book a first midwife appointment.

Antenatal care

- It is important that during the antenatal phase, care focuses on checking the health of the baby and pregnant woman or person, providing accessible information to support a healthy pregnancy and discussing the options and choices for care.
- It is important that previous birth experiences and baby loss are considered and targeted support provided as required. Additionally safeguarding and advocacy must be a core part of antenatal care pathways, as well as interpreting services for those who need them.
- The risk profile of pregnant women and people is increasing because of increasing complexity so access to specialist care and support must be optimised so that capacity matches demand.
- Multi professional working is key in understanding the right unit for a pregnant woman or person to book into for their delivery, particularly for those with co-morbidities.
- There must also be collaborative working across organisations including with public health, the VCSE and primary care, so that there is additional support for vulnerable women.

The maternity care model is split into four key phases with details around each to be iterated further (2/2)

Birth and treatment

- A pregnant women and people will be supported to make an informed choice as to where and how to give birth through the antenatal phase and this could be at home, in a midwifery led unit, or in an obstetric led unit.
- The profile of births in NEL has changed with the projected case-mix suggesting a greater share of more complex deliveries through planned and emergency caesarean deliveries and shift away from spontaneous, lower risk deliveries.
- Pregnant women and people need to be able to choose a place of birth that is best suited to their individual needs
- To provide the full range of choice, NEL would like to provide a standalone midwifery led unit as an option if feasible, but it is important that these units are sustainable and have sufficient staff to deliver high quality, safe care
- There is an opportunity to leverage learning from other hospital care pathways, such as inpatient elective care to optimise efficiency and use of resources for planned procedures. There is an appetite for further exploration of a hub for planned caesarean sections, for those whose medical needs are not highly complex.

Postnatal care

- High-quality postnatal care ensures that the mother and baby are recovering well and can have a significant impact on the life chances and wellbeing of the women or person, baby and family.
- Postnatal care can be provided to both the parent and baby or care that is specific to the post-partum woman or person and can range from routine care received following all births through to specialised care for the most complex women.
- Primary and community-based care will play a key role in providing equitable, high quality postnatal care for parents and their babies.
- Having postnatal pathways and services locally available to all residents makes it easier to navigate following delivery NEL sites and ensures that all women receive care in a fair and equitable manner.
- Currently it is mainly proactive women from affluent communities that make use of postnatal services so it is crucial that all women and people are made aware of the information and services that are available to them following their birth.

Neonatal care pathway summary

This is a draft best practice model of care and represents how care could be delivered in the future and does not reflect the current care pathway

DRAFT WORK IN PROGRESS

Labour | **Decision to admit** | **Inpatient stay** | **Onward care**

Triage to an appropriate site based on need

Choice of site can be made at any point up until the onset of labour

In-utero transfer to an alternative birth setting if anticipated level of neonatal care exceeds local availability with receiving units doing everything possible to take the transfer

Driven by BAPM standards

Delivery out of hospital with midwifery care → **Transferred to nearest neonatal unit in the ICB**

Presentation in labour at an Emergency Department

Delivery at an alongside midwifery-led unit

Delivery at an obstetric-led unit

→ **Admission to neonatal unit on site**

Transitional care can occur immediately after delivery if admission to neonatal unit is not required

Neonatal unit on admission (co-located with an obstetric unit)

Type of unit on admission depends on local availability:

- **NICU (level 3)**
- **LNU (level 2)**

Type of care provided:

- **Intensive care**
- *Step down in care*
- **High dependency care**
- *Step up in care*
- **Special care**

If needed

2 **Transfer between hospitals in the ICB**

If specialist input is required

NICU *Repatriation* / *Uplift* **LNU**

3 **Transfer to alternative NICU if specialist treatment is required**

Transfer to Royal London Hospital if specialised surgery is required

If needed

4 **Transfers to an appropriate level unit outside of the ICB**

Repatriation back to local hospital from specialist unit or unit outside of ICB

Transitional care on labour, neonatal and postnatal wards incl. feeding support

Mental health support for parents incl. wellbeing support

Community neonatal outreach

Outreach from the specialist hospital

Postnatal midwifery review and support for maternal health

Baby specific

- Repatriation to LNU closer to home
- Follow-up appointments (neonatal or paediatrics)
- Multidisciplinary team follow up
- Specific neurodevelopmental follow up for high-risk infants
- Primary care follow up
- Hospital at home services
- Feeding support
- Referral to social/palliative care
- Neonatal community outreach

Pregnant woman or person specific

- Onward referral
- Postnatal education
- Mental health support
- Primary care input
- Community midwife
- Physiotherapy
- Family planning advice
- Bereavement support
- Community support groups and networks
- Social care
- Referral to other healthcare services inc. pre-conception

The neonatal care model has three phases and will be subject to iteration in the next phase of work (1/2)

Labour and decision to admit

- To ensure care is delivered in the most appropriate setting, pregnant women and people would be advised to deliver at a unit where the level of neonatal support available is in line with their baby's anticipated needs.
- Babies that are expected to be at the highest risk of needing support from intensive care will deliver in an obstetric unit with a co-located NICU (level 3), aligned to the BAPM standards.
- Babies can be transferred in-utero transfer to an appropriate birth setting would ideally be undertaken to prevent mother and baby separation when there are unexpected complications which require an uplift in care
- Coordination across units in NEL could include establishing neonatal units as a single bed base for neonatal care which would be centrally managed and would enable collaboration between sites to manage flow
- Neonatal transfer and transport services with sufficient capacity to meet demands are critical to support this

Inpatient stay

- All neonatal inpatient care in NEL would continue to be delivered at either an LNU or a NICU; inpatient capacity at both levels needs to be aligned to demand
- The future care model should clearly define the catchment population for NEL and aim for all babies within that catchment area to be able to receive care within the system
- Capacity also needs to be sufficient to meet the needs of babies from other systems needing NICU care
- If a baby requires an uplift in care, they may require a transfer to another unit within or outside the ICS, or to a specialist hospital. A transfer for an uplift in care would typically result in a move from an LNU to a NICU.
- If a baby has been transferred for an uplift in neonatal care, they will be repatriated back to their closest LNU at the earliest opportunity where it is safe to do so. Enhancing repatriation processes ensures that the baby and parents can be as close to their family and support network as possible.
- The proposed care model would have a set of objective criteria for repatriating babies back to their local neonatal unit from the NICUs in NEL, utilising the neonatal ODN repatriation guidelines.

The neonatal care model has three phases and will be subject to iteration in the next phase of work (2/2)

Onward care

- An enhanced, properly funded Neonatal Transitional Care service will facilitate the smooth transition of care from a hospital setting back into the home setting following discharge.
- Transitional care will allow mothers and babies to be cared for together away from the neonatal unit, freeing up crucial capacity to allow for babies to be cared for in the most appropriate setting.
- Following discharge, babies and their families would have access to a range of onward care support services.
- A key aspect of the onward care will be the neonatal outreach service which will be operational 7 days a week and will provide care for these service users in the community setting and at home.
- Stakeholders expressed a desire to explore the opportunity to expand hospital at home services to include neonatal care to provide care away from the hospital setting where feasible.
- The future care model will have clear guidance on the step from neonatal to paediatric care across NEL to ensure that high quality, safe care continues for service users.

There are key enablers for the effectiveness of the proposed care models (1/2)

Culture of collaboration	• Developing a culture of collaboration across the ICS is a key condition for the future success as the draft care models are reliant on organisations in NEL working together to provide care that is centred around the service user. • It is crucial that all stakeholders deliver maternity and neonatal care as **one system** with individual organisations working as collaborative parts within the overall system, and service users experience a seamless set of services
Communications and engagement	• Clear and consistent communication across NEL is key to developing trusted relationships between organisations. • Engaging with other hospitals breaks down existing siloes and creates teams that want to work together which positively contributes to the development of a culture of collaboration. • It is important that communication is enhanced across all parts of the maternity and neonatal pathway
Digital and information systems	• Currently not all units are linked together, with some units still using paper records which limits the effectiveness of the care model. • An interoperable connected system would improve the way in which the organisations within NEL can work together by accessing data in a readily manner whilst facilitating transfers and network working.
Technology	• Enhancing the provision of technology across services in NEL is crucial in ensuring that care can be delivered effectively and productively in a capacity constrained system where demand is projected to increase. • The population has changed since these services were first designed and technology is key in making best use of the current configuration of space within the units in NEL.

There are key enablers for the effectiveness of the proposed care models (2/2)

Workforce strategy

- Developing a workforce strategy in NEL is crucial to the future success of the proposed care model to ensure that staff resource is being most effectively whilst considering their overall well-being.
- Looking after the workforce in maternity and neonatal services is key for the future success of the care model as will encourage staff buy in whilst improving retention and recruitment.
- Staff should feel heard regarding their ways of working preferences with consideration of their preferred work-life balance where possible through flexible working patterns with careful consideration.

Estates and resources

- The proposed draft care models require estates and resources to be aligned to the pathways that have been developed to ensure the success of the care model in the future.
- This may require a degree of flexibility within how estates are configured to ensure that there is sufficient space and resources available to meet the proposed pathway changes.
- The current estates were not built for the world that we have now and as such it is important to map the future requirements of the proposed care model to what the estates are currently to understand any gaps in consideration of potential capital constraints.

The next phase of work will include engaging on the case for change and further iterating the draft care models

Next steps

- Broader engagement on the case for change is now required with services users, patients, clinical staff working at all stages of the care pathway and partner organisations
- This engagement will refine the work and ensure it describes a future for maternity and neonatal services that aligns with the needs and wants of all stakeholders.
- Development of the more detailed care models will run in parallel with the engagement to develop a detailed description of what care will look like in the future, and what services are then required and where to deliver this. The work will be clinically led with multi-professional input and engagement, and take a data driven approach to develop deliverable, sustainable service models.
- Once this has taken place each partner organisation will need to align behind the care model, and commit to developing the plans for its delivery, recognising some aspects of this will rest with single organisations and some will require broader collaboration

North East London
Integrated Care Board

Barking and Dagenham Health and Wellbeing Board and ICB sub-committee

10 September 2024

Title of report	Barking and Dagenham Winter Plan 2024/25
Author	Kelvin Hankins, Deputy Director / Lead for Ageing Well, Barking and Dagenham Place Team, NEL ICB
Presented/Sponsored by	Kelvin Hankins, Deputy Director / Lead for Ageing Well, Barking and Dagenham Place Team, NEL ICB
Contact for further information	Kelvin.Hankins@nhs.net
Wards affected	All
Key Decision	No
Executive summary	The report provides a update on the development of the Barking and Dagenham Winter Plan for 2024/25. As with last year the place partnership has developed a local winter plan, which provides a coordinated response to support to residents during the winter period. The plan has been developed with engagement from all partners and has been developed with local understanding of pressures and challenges in previous winters. The Winter Plan is a live document and will be maintained on an ongoing basis, managed through the place partnership governance arrangements.
Action / recommendation	The Board/Committee is asked to discuss and note the contents of this report
Reasons	Not applicable
Previous reporting	An earlier version of the report was discussed at the Barking and Dagenham Executive Group.
Next steps/ onward reporting	A winter update will be presented at a future meeting.
Conflicts of interest	None identified.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The report detailed progress made on developing the Barking and Dagenham Winter Plan, this includes detailing the actions and support provided to residents.
Impact on finance, performance and quality	There are no financial decisions required in the report.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The purpose of this paper is to detail the proposed actions to support residents during the winter period. It is recognised that winter is a difficult time for many residents, which can have a direct impact on resident's health but also increases individual vulnerability. Alongside social and environmental impacts such as the cost-of-living challenges, warm homes and ability to maintain social connections.

1.2 On 1 August we held a system workshop, with representation from primary care, hospital, community, mental health, local authority and the voluntary sector, to identify areas for priority and focus to support residents. The plan is to compliment and provide additionality to existing arrangements and focuses in that way.

1.3 Winter planning is the collective term for planning for and understanding the winter period and the impact that this has on residents. A good process should take into consideration:

- Resident's risks, concerns and views on winter and what it means for them.
- Organisation, service and operational risks and develop clear mitigations
- National requirements and expectations aligned to local delivery models
- Previous winter periods, historical trend in data and performance and where different interventions had a positive impact on residents.

1.4 The plan also provides an opportunity to take a wider approach to resident challenges during winter and include and align cost of living support, warm spaces and inequalities programmes.

1.5 There should be a single plan, for Barking and Dagenham Place Partnership, which has been tested and endorsed by all statutory and community partners. For 2024/25 we are starting our planning earlier than previous years, this allows us time to take a more proactive and structured approach. The plan will has three overarching themes, aligned to national expectations:

- Engaging in proactive population health, care and support arrangements to keep people well in the community.
- Optimising flow through Acute, Mental Health and Community trust sites.
- Strengthening the provision and access of alternative pathways to reduce UEC and Primary Care footfall and attendance

1.6 It is also important to recognise that the winter plan is a live plan and intended to change over time as new issues are identified or planned issues change. This plan will also be considered alongside the Barking and Dagenham Immunisation Plan for winter.

2.0 Winter Planning last year

2.1 2023/24 was the first year of a Barking and Dagenham place plan, which was viewed to have been successful with the local focus on the borough. The plan was focussed on the following principles:

Plan well ahead of time and start early; engage with patients /residents so that services and schemes are co-designed and based on need

- Agree the priorities that will drive our plans – we don't have the resources to do all the things that have been suggested and need to focus on high impact areas
- Establish how we do things better together – make every contact count
- Get the comms right – right info needs to get to the right people and be correct and up to date
- Evaluate what we are doing and the impact it makes for residents.

The priorities were:

- Carers
- Children (0-4) and families
- People with long term conditions – focus on respiratory
- People over 50 – frailty/ multiple LTC
- People discharged from hospital
- Demonstrate how plans address needs of vulnerable groups -LDA, mental health

2.2 The partnership held a winter wash up in February 2024 which identified real successes of the plan but also some areas to consider going forward, in many cases we have built this into the 2024/25 Place Priorities. What we learned and what we would keep going:

- Respiratory Task and Finish Group will wrap-up and a new, year-round respiratory working group will be established to continue to improve provision for these patients (CYP and Adults). This will also allow for continual winter planning and not start the conversations in September. Needs to also link to other workstreams as appropriate
- Planning from scratch each winter- are we always on the back foot? We can apply our learning from this winter and previous years to get ahead
- Linking the outputs from the Winter review to 2024/25 transformation so we are prepared for Winter now.
- There is a lack of wider year-round winter planning that may be a good opportunity to increase efficiency and prepare resources/ risk management- do we also need to embed winter prep in other key workstreams too?
- Use key available data to inform the areas of focus.
- However, don't get too bogged down in data with a need to look at bigger picture and timeframes. Data does not present a complete narrative
- Coproduction and codesign has been invaluable
- Strong partnership working is essential to project success- provides the holistic, MDT support that best support residents in all areas- not just health
- Partnership working also supports networking/ signposting/ collaboration opportunities
- Build on good work being done across the partnership and interface with other priority areas e.g. MH, LDA, Homelessness

3.0 North East London approach to Winter 2024/25

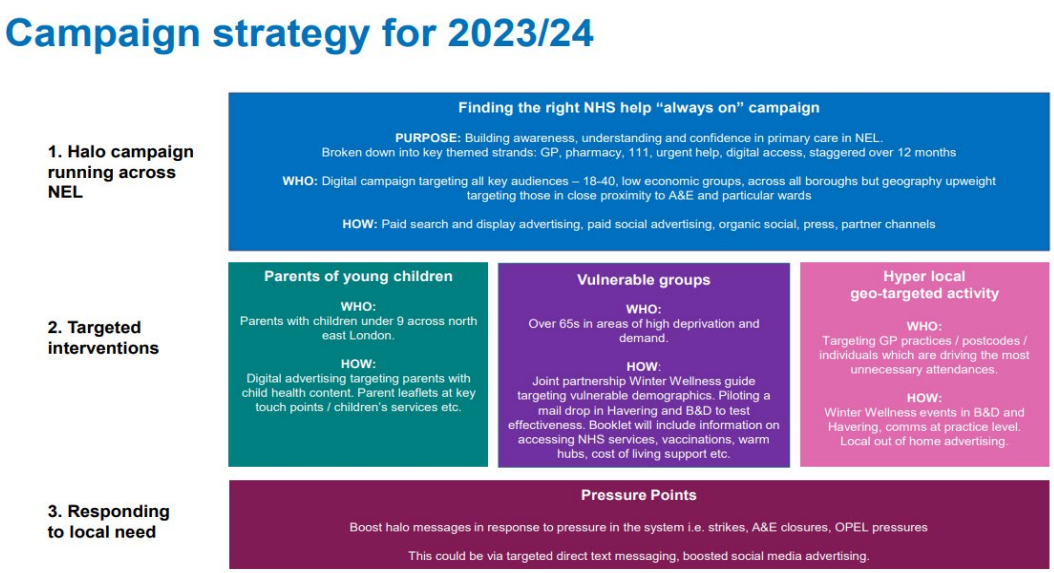
3.1 Currently the North East London approach to winter planning in 2024/25 has not been confirmed, however it would be fair to assume that a similar approach to previous years would be held. Each place partnership would be expected to develop a local plan working with system partners across health, care and

community ensuring that the discussions are wide ranging focusing on local pressures and resident requirements.

3.2 Each NHS provider trust would also be expected to input into the place plans but also have individual trust plans, which align with the place plans where required. The seven place plans and five NHS Trust plans all form the single North East London Winter Plan. As with previous years NHS England would issue key lines of enquiry which the ICB would need to assure plans are in place.

4.0 Communications

4.1 As with recent years there will be various communications to residents for Winter. In addition to national campaigns, the North East London seasonal campaign will be running. There will also be local opportunities for communication and engagement. Detailed below is the approach taken in 2023/24 and this will form the approach for this year.



5.0 Development of the Barking and Dagenham plan for 2024/25

5.1 The intention is to have a single winter plan for Barking and Dagenham which captures all the risks, issues, mitigations, agreed actions, governance of the plan, financial commitments and areas for further funding if this becomes available. There are three key goals:

- Engaging in proactive population health and care and support management to keep people well in the community.
- Optimising flow through Acute, Mental Health and Community trust sites.
- Strengthening the provision and access of alternative pathways to reduce UEC and Primary Care footfall and attendance

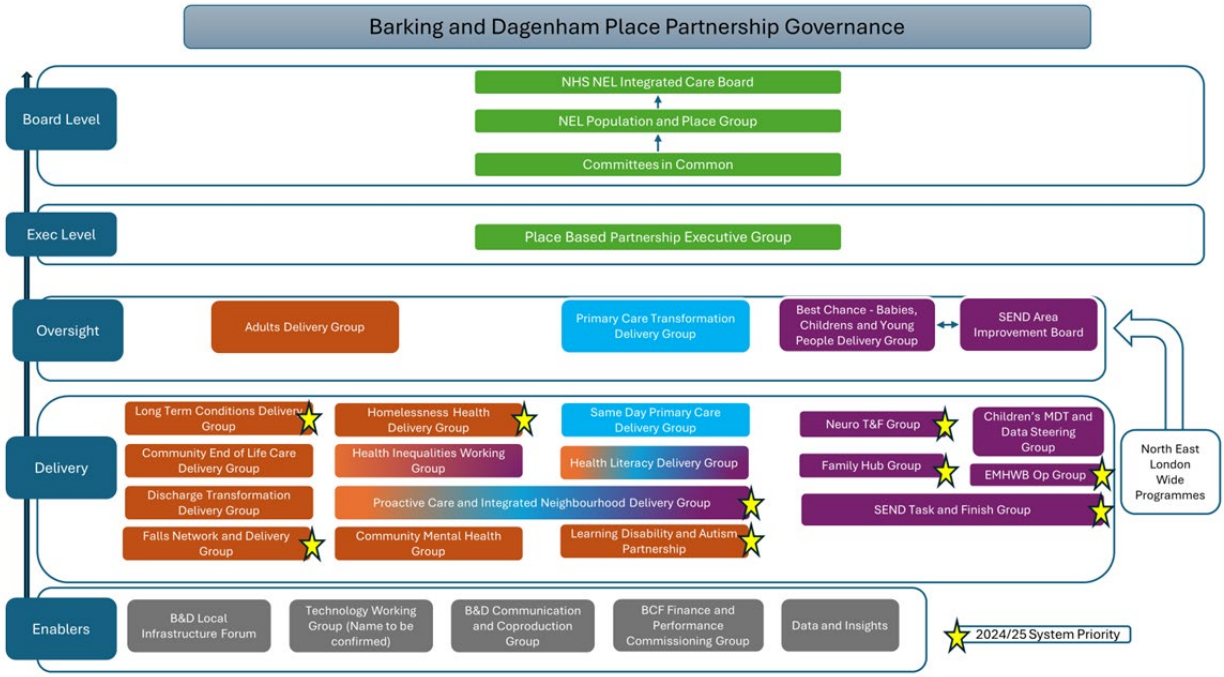
5.2 The winter plan must also ensure that it articulates our approach across the life courses and key resident groups.

5.3 On 1 August we held a system workshop, with presentations from primary care, hospital, community, mental health, local authority and the voluntary sector, to identify areas for priority and focus to support residents. The plan is to compliment and provide additionality to existing arrangements.

5.4 Since the workshop relevant components of the plan have been discussed and updated at the Adults Delivery Group, Best Chance – Babies, Children and Young People Delivery Group and the Barking and Dagenham Executive Group.

5.5 It is important to recognise that the winter plan is a live plan and intended to change over time as new issues are identified or planned issues change.

5.6 As the Winter Plan moves into delivery the expectation is that the actions are delivered and monitored through the existing place-based governance, with each action allocated to delivery groups.



6.0 Barking and Dagenham Delivery Plan for 2024/25

6.1 As detailed earlier, the plan is designed to identify actions to support residents that build on existing services and support available. We have broken the plan into four areas:

- Children and Young People
- Mental Health and Learning Disabilities
- Adults with Long Term Conditions
- Adults, where not covered by other areas

6.2 Through discussions a lot of actions have been identified, with some overlap between areas. The top three overarching priorities are:

1. Improving our communications to residents on what is available and how to access key services

2. Increasing the support to residents with respiratory needs. Including the development of the ARI Hub and pre-planning for winter ensuring all residents have an asthma or COPD care plan.

3. Taking a proactive approach for targeted groups, including people affected by the cost-of-living challenges, housebound, frailty and falls.

6.3 Children and Young People Actions

What else do we need to do to support residents for Winter?	Funding Required	Group / Person responsible for delivery
Supporting Children, Young People and their Families		
Ensure that appropriate residents have hospital passports: Mirror arrangements already in place in Learning Disabilities for vulnerable residents to have a up to date hospital passport. A hospital passport should aid support and care if accessing the emergency department and enable appropriate informed care to be delivered.	Yes – Exact detail to be confirmed	Best Chance – Babies, Children and Young People Delivery group
Mobilise the Asthma and Trinity School Proactive Care Pilots: Models developed with an aim to go live in late September. Both pilots are based on supporting complex health and care needs through a multi-agency approach.	Yes – Exact detail to be confirmed	Proactive Care Delivery Group
Support children and young people in acute respiratory to receive appropriate local care: To mobile the ARI Hub for Barking and Dagenham from October to March. The hub will cover both children and young people.	Yes	Long Term Conditions Delivery Group
Support children and young people to be discharged from an acute setting in a timely and appropriate manner To develop a Barking and Dagenham multi agency response to individual discharges which are complex and subject to delay. To cover both acute wards and emergency departments.	No	Best Chance – Babies, Children and Young People Delivery group
Raise awareness through a targeted approach the offer for Emotional health and wellbeing. Taking a targeted approach to promote existing services and online resources to residents.	No	EMHWG Operational Group
Ensure information is available on alterative pathways and services. Develop information tools on services that are available, as alternatives to emergency and Primary Care	Yes	Barking and Dagenham Communication and Coproduction Group (Supported by all delivery groups)
Raise residents understanding of the pharmacy offer and the minor ailments scheme (when live) -Linked to the above action	Yes	

6.4 Mental Health and Learning Disability Actions

What else do we need to do to support residents for Winter?	Funding Required	Group / Person responsible for delivery
Supporting residents with mental health and learning disabilities		
Ensure information is available on alterative pathways and services. Develop information tools on services that are available, as alternatives to emergency and Primary Care	Yes	Barking and Dagenham Communication and Coproduction Group (Supported by all delivery groups)
Raise residents understanding of the pharmacy offer and the minor ailments scheme (when live) Linked to the above action	Yes	
Understand why residents are accessing emergency departments and develop solutions to support alternative routes Gather information from care coordinators, ED, GPs and residents directly (where possible) to understand the 'why'. Based on formulation, solutions can be developed	No	Community Mental Health Delivery Group
Explore a proactive approach to identifying and supporting residents Workshop with residents to hear what support they feel would useful; see what forums are already available	To be confirmed	Community Mental Health Delivery Group
Ensuring there is alignment to the pathways and support available from voluntary and community services Use networking meetings to strengthen alignments to pathways and involve VSCE services in conversations re support	No	Community Mental Health Delivery Group
Encourage MH services to create Winter Care Plans for residents at increased risk to self/to others/from others during winter. Mapping voluntary support available to inform residents care plan.	No	Community Mental Health Delivery Group
Launch the Hight Intensity Service Aim for an October launch of the HIU service as per the business case.	Yes	Proactive Care Delivery Group
Mental Health Teams and Primary Care to work together to identify residents who are likely to use services during winter and target support Use network meetings to strengthen working relationships and to share relevant resident information/plans	No	Community Mental Health Delivery Group
Improve the experience for people with Learning Disabilities accessing urgent care services Ensure that all residents who require one have a hospital passport. PELC to ensure a fast-track process is in place for hospital passports at the front door of emergency departments. Emergency department and Urgent Treatment Centres to ensure that reasonable adjustments are made	No	Learning Disability Partnership Board.
Target the Mental Health Investment Standard funding to increase capacity in community services to help demand for services.	Yes	Community Mental Health Delivery Group

6.5 Adults Long Term Conditions Actions

What else do we need to do to support residents for Winter?	Funding Required	Group / Person responsible for delivery

Supporting Adults with Long Term Conditions		
Ensure information is available on alterative pathways and services. Develop information tools on services that are available, as alternatives to emergency and Primary Care	Yes	Barking and Dagenham Communication and Coproduction Group (Supported by all delivery groups)
Raise residents understanding of the pharmacy offer and the minor ailments scheme (when live) Linked to the above action	Yes	
Support residents in acute respiratory to receive appropriate local care: To mobile the ARI Hub for Barking and Dagenham from October to March. The hub will cover both children and young people.	Yes	Long Term Conditions Delivery Group
Increase awareness for clinical teams of new services and pathways Ensure that teams are aware of new services such as the Respiratory Virtual Ward, CTT and Community Catheter Service.	No	Long Term Conditions Delivery Group
Continue the roll out of Proactive Care and improvements in Integrated Care Management. Launch of the five proactive care pilots in Barking and Dagenham. Alignment of the Proactive Care Model and ICM	No	Proactive Care Delivery group
Support residents with long term condition(s) to be equipped with the right self-care tools and kit to manage their condition. Self-management/educate to use pulse oximetry for respiratory patients to monitor saturation and flares up. Take a proactive approach to ensure that high risk residents have rescue packs and know how/when to use them. To identify residents and complete pre cold weather.	To be confirmed	Long Term Conditions Delivery Group
Target support to housebound patients Plan for risks for winter and maximise approaches to engagement such as use of virtual clinics, group consultations for diabetes patients for example. To identify residents and complete pre cold weather.	To be confirmed	Long Term Conditions Delivery Group
Ensure that high risk/acute residents have the correct medical equipment Identify residents and appropriate equipment required to support needs, consider areas such as pulse oximeters and blood pressure machines	To be confirmed	Long Term Conditions Delivery Group

6.6 Adults

What else do we need to do to support residents for Winter?	Funding Required	Group / Person responsible for delivery
Supporting Adults		
Ensure information is available on alterative pathways and services. Develop information tools on services that are available, as alternatives to emergency and Primary Care	Yes	Barking and Dagenham Communication and Coproduction Group (Supported by all delivery groups)
Raise residents understanding of the pharmacy offer and the minor ailments scheme (when live) Linked to the above action	Yes	
Proactive identification of people impacted by the cost-of-living challenge Confirm offer for residents potentially impacted by COL. Agree process to identify residents	Yes	Proactive Care Delivery group

Use the pop-up model to proactively support residents during winter. Holding a prewinter older people popup with a range of health, care and community groups to provide advice and support. Including areas such as toenail cutting, falls prevention, health check, heating advise etc. Target other communities where support pre and during winter would be helpful.	Yes	Proactive Care Delivery group
Review the support for Care Homes Bring together care home managers and attached GPs to identify areas that support would be helpfully targeted.	Yes	Kelvin Hankins / Zainab Jalil
Aim to reduce the waiting list for Community intermediate care Current waiting list 3 weeks, to reduce to more acceptable level. Consider options for the Home First Team to support	Yes	Discharge Delivery Group
Continue the roll out of Proactive Care and improvements in Integrated Care Management. Launch of the five proactive care pilots in Barking and Dagenham. Alignment of the Proactive Care Model and ICM	No	Proactive Care Delivery group
Ensure there is appropriate access to disease specific clinical advice Advice and support lines for Frailty and other specialists	No	BHRUT
Ensure that residents with identified therapy needs access the correct pathway Pilot a single front door for Reablement, IRS and Home First so residents are on the right pathway	No	Discharge Delivery Group
Support residents who access shelters to receive appropriate healthcare Launch of the new Outreach Service, ensure aligned and regular access to B&D Shelters	No	Homeless Health Delivery Group
Support residents living in hotels to receive appropriate healthcare and access community resources Pilot of clinical input to hotels, providing health checks, referral and advocacy of access to health services. Pilot a community navigation offer, ensuring that residents can access and develop community connections. Developing a small MDT team support residents in temporary accommodation.	Yes	Homeless Health Delivery Group

6.7 Each action has been allocated to a delivery group, who will have responsibility for developing the action, ensuring delivery and monitoring impact. The Barking and Dagenham PMO team will support the progress and ensure ongoing reporting of progress through the Barking and Dagenham governance.

7.0 Available Funding to support Winter Plan

7.1 As with previous years, funding for winter is expected to be delivered through existing funding resources. If national funding does become available later it is important that we take a structured targeted approach to how we use the funding, aligned to local system pressures and improved outcomes for residents.

7.2 Nationally there is an expectation that the Better Care Fund and its growth and Adult Social Care Discharge Grant is supporting winter, it is important to note that how both funds are allocated was agreed in June 2024 as part of the annual Better Care Fund review.

7.3 In addition, the ICB has allocated non-recurrent funding, which is provided to us as a grant from NHS England, to support the transformation at a place level aligned to the NEL UEC priorities and building resilience in the community. A separate allocation has been made to acute services. The funding is for service delivery, not historic cost pressures or ICB posts and can be used for testing and piloting new ways of working. Areas to consider include Admission Avoidance and Proactive Care, Discharge Improvement for complex areas such as neuro and stroke, discharge from mental health units and tackling inequalities where they align to the UEC priorities such as homeless health etc. If the proposals meet the criteria, we can use during the winter period as winter schemes.

7.4 The Barking and Dagenham allocation is £723k and will be subject to local and ICB sign off. The funding is subject to approval of the ICB Finance and Performance Committee at the end of September and is not able to be utilised until sign off is completed.

7.5 The proposed allocation of the funding is detailed in the below table. As per the terms of the allocation this is to be used not just for winter but aligned to our place priorities. The exact detail of the proposed spend and expected impact are still being developed.

Name of Scheme	Scheme Detail (Include detail of commissioning arrangement/workforce etc)	Total Scheme Value
Proactive Care	Support the proactive care pilots with additional resources. Detail to be confirmed	£80,000.00
Falls balance classes	Provide additional balance classes for residents at risk of falling	£15,000.00
HIU	This is a full year cost, but I can only commit 50%	£75,000.00
Respiratory Hub	Provide an ARI hub between October and March	£96,000.00
NELFT beds	Extension into April and May 2024. Already agreed	£15,455.94
NELFT beds	Proposed extension for Winter for additional beds. Shared between BHR boroughs.	£74,502
Engagement	To support the winter and INT engagement plan	£40,000.00
Asthma Coordinator	Supporting the borough approach to Asthma during winter. Exact detail of role to be confirmed.	£30,000.00
Community Pop up Clinics	Support an older people pop-up in addition to existing programme of pop-ups	£12,000.00
CYP Proactive Care	Care coordinator for 6 months to set up the Trinity Proactive Care Pilot	£30,000.00
LTC Actions	Self-management tools and various kit such as pulse ox	£10,000.00
Housebound Patients	Capacity to support health checks for housebound residents. Scheme to be developed.	£30,000.00
Support to care homes	To be confirmed	£10,000.00
Discharge Support	Detail to be confirmed with LBBD.	£200,000.00

8.0 Risks and mitigations

8.1 Risks are detailed within the report with ongoing pressure in the system, however actions detailed within the winter plan are in the process of being implemented. There are no specific risks identified with the delivery of the winter plan actions at this stage.