Annual Director of Public Health Report 2020/21

Equality Challenges in Barking and Dagenham

Barking & Dagenham

Foreword

Every year, the Director of Public Health is asked to write a report outlining the work of the year, often focused on a particular issue, and making recommendations for the coming year. The past year has been challenging for us all. The first confirmed cases of COVID-19 in the UK came at the end of January 2020, and we have been living with the pandemic ever since. The pandemic has affected everybody's health and wellbeing, while most people who caught COVID-19 experienced mild symptoms and made a swift recovery, others became seriously ill and have felt the health impact for many months afterwards. Many have sadly lost family and loved ones.

Whilst COVID-19 did not create health inequalities in Barking and Dagenham, it has exposed and exacerbated long-standing health and social inequalities in the borough (as it has nationally) particularly those from minority ethnic communities and more deprived backgrounds. This Annual Public Health Report talks about these inequalities, the factors that lead to them and how we can collectively reduce them and improve health and wellbeing for all residents.

I would personally like to thank our residents for the way they have conducted themselves during the past 12 months in support of our efforts to suppress the virus. It is important that we continue to be vigilant and stick to the guidance to reduce risk and prevent further spread. I also wish to pay tribute to the work of all our local providers, partners, and organisations, including BD CAN , who came together when needed and have worked tirelessly throughout the pandemic to ensure residents received the services and support, they needed. I would like to give a special mention to Public Health England (London), our council staff, health and social care workers who have been working on the frontline throughout the pandemic.

As with seasonal flu and other infections, we are going to have to continue to live with COVID-19 for the foreseeable future, particularly as new variants emerge. This year has been an unprecedented challenge, but we have learnt, adapted, and are prepared for the next phase of our response to this pandemic.

I hope you enjoy reading this report as well as finding it of interest and value.

Matthew Cole
Director of Public Health
London Borough of Barking and Dagenham

Contents

Executive Summary 4

Chapter 1: Introduction 7

Chapter 2: The Population of Barking and Dagenham 11

- Barking and Dagenham: Diversifying Demographics 12
- Ethnicity Focused Demographic Analysis 14
- The Wider Determinants of Health 17
  - Employment 18
  - Income 20
  - Housing and Environment 21
- Conclusions 22

Chapter 3: COVID-19 and Inequalities 23

- Direct Impacts of COVID-19 24
  - COVID-19 Case Analysis by Ethnicity 24
  - COVID-19 Hospital Data 25
  - COVID-19 Impact on Adult Social Care Services 28
- Wider Impacts of COVID-19 28
  - Impact on Mental Health 30
  - Impact on Children and Young People 31
- Conclusions 32

Chapter 4: Addressing Inequalities As Part Of Our COVID Response And Recovery 34

- Response 35
  - Local Contact Tracing 35
  - Test and Trace 35
  - Community and Faith Groups 36
  - Supporting Those in Need 36
  - Supporting Our Children 34
  - Adult Social Care 38
- Recovery 39
  - Community and Faith Groups 39
  - Economy and Employment 42

Chapter 5: The Way Forward 43

- The Phases of the Inequalities work 45
  - PHASE 1 45
  - PHASE 2 45
  - PHASE 3 45
- What are the Key Questions the Report Raises for Further Discussion, Debate, or Exploration? 48
  - Next Steps 49

Acknowledgments 50

Supporting Documents and Appendices 51

Executive Summary

Health inequalities are avoidable differences in health outcomes across different groups of people within the population caused by life chances (or lack of) to lead a healthy life. These inequalities are visible when looking at different factors such as age, gender and ethnicity, highlighting differences in health status (e.g., life expectancy and frequency of health conditions); access to care (e.g., availability of treatments); quality and experience of care (e.g., levels of patient satisfaction); behavioural risks to health (e.g., smoking rates) and wider determinants of health (e.g., quality of housing). Inequality was recognised by the London Borough of Barking and Dagenham before the COVID-19 pandemic to be a key factor in the poorer outcomes of residents in the borough, compared to the London and national averages. This is also part of the Council's duty in regard to the Public-Sector Equality Duty outlined by the Equalities Act 2010 to Eliminate discrimination, harassment, and victimisation in the community Advance equality of opportunity for all residents, foster good relations between communities and residents . COVID-19 pandemic further widened the stark inequalities that already existed. This report aims to sum up what we know about the current inequalities in Barking and Dagenham; the relationship between the pandemic and inequality; the long-term effects on inequalities, the wider determinants of health and what that means for the health and wellbeing of our people in Barking and Dagenham.

COVID-19 and Inequalities in Barking and Dagenham

Barking and Dagenham COVID-19 Hospital data analysis for our residents over the last 12 months confirmed the above findings i.e., positive cases, admissions and hospital death rates were higher amongst certain Black, Asian and Minority Ethnic identifying groups, males, the older population, and those known to Adult Social Care services However, there were some differences compared to the national picture e.g., an under-representation of Black African and Black Caribbean amongst the positive cases, hospital admission rate amongst the Black Others (65+ age group) and the death rate amongst the Black Africans (all ages) were lower than expected. These are preliminary findings, and no inference can be drawn at this stage unless further participatory research and data analysis is carried out.

1 in 4 young people had reported worrying about their mental health during lockdown and the closure of schools has had a disproportionate impact on the education and health and wellbeing of the most disadvantaged. In early 2021, Children's Social Care experienced the greatest demand ever and residents claiming unemployment benefits rose to at least twice what they were at the beginning of 2020. The major employment sectors for residents have likely made them more vulnerable to exposure to COVID-19 and to job losses.

We analysed population-level data to identify inequalities in Barking and Dagenham. The data shows a rapidly changing demographics and ethnic composition i.e., 66% Black, Asian and Minority Ethnic, White Ethnic or White Other identifying groups in 2020 compared with 19% in 2001 and this trend is continuing. A higher proportion of Black, Asian and Minority Ethnic identifying residents live in older cohabiting households with dependent children as compared to White residents. A higher proportion of Black, Asian and Minority Ethnic identifying population is either obese or overweight (especially Black women) as compared to White British. Similarly, there is a higher proportion of Black children (especially Year 1 and Year 6) who are overweight or obese and there are more boys than girls who are overweight or obese. Long-term conditions affect Black, Asian and Minority Ethnic identifying much earlier, e.g., mean age of cancer diagnosis amongst Asian, African and Caribbean ethnic groups is 10 years earlier than White British/ White others. Similarly for diabetes, it manifests itself 7 to 8 years earlier for African/Caribbean as compared to White British/White Other residents. Multi-morbidity (i.e., 3 or more long-term conditions) are experienced 8 years earlier by African and Caribbean as compared to White British/White Other. A lower proportion of Black, Asian and Minority Ethnic identifying community who have 3 or more long-term conditions are in receipt of Housing or Council Tax benefit or both.

The Impacts from COVID-19

National and Regional evidence has highlighted that the key risk factors for COVID-19 and the health and social care factors leading to inequalities are similar i.e., old age, males, people from certain ethnic communities, long term conditions and socio-economic factors such as poor housing, air quality, deprivation, poverty, and certain frontline occupations put people at a higher risk of COVID-19 and inequalities. People living in overcrowded or multigenerational homes are at higher risk of infection. ONS data shows only 2% of White British households experienced overcrowding versus 30% Bangladeshi, 16% Pakistani and 12% Black households.

The national evidence further highlighted the indirect impacts of COVID-19 on mental health, economy, and other wider factors. Adults with moderate to severe depression had almost doubled from March to June 2020; the pandemic quadrupled the number of adults who experienced food poverty; the economic impact of lockdown may have been greater in some ethnic groups (i.e., Bangladeshi, Pakistani, Black African and Black Caribbean) and especially on men who are most likely to work in lockdown sectors.

Council's Response and Recovery

The report has highlighted the COVID-19 response and recovery efforts the council is continuing to deal with the pandemic and addressing inequalities. There have been many strengths in the Councils' response to COVID-19 pandemic, centred around system partnership approach to identify and support vulnerable groups, it is important that we learn from the successes of our response to improve recovery. Through the collection of good demographic data and using existing data we have been able to predict those most at risk and shielding to offer support. The information gathered allowed us to understand the engagement and reach of our services and also highlighted challenges that need to be overcome, for example high case rates in areas less accessible to test sites and low uptake of vaccines in certain groups. Through using data to lead action, we successfully established testing sites for those who need it most and through close partnership working with community-based organisations improved vaccination uptake for certain cohorts. The learnings throughout the pandemic should be implemented going forward to help identify, to reach out and to work with groups to tackle inequalities in all services. The report has been successful in identifying key relevant issues and in stimulating discussions with our key partners with the view to explore further and find solutions.

The Council and the community and voluntary sector have responded to the pandemic jointly, for example using our community and faith groups we have managed to gain useful understanding to better engage residents, encourage trust and understand barriers to accessibility. To gain better visibility of those in need and support them we must continue to work with and engage our communities to ensure better outcomes for our residents. This will be particularly important when coordinating the recovery efforts for children from our most deprived families who have been most greatly impacted.

Next Steps

The Council is reviewing its Equality and Diversity strategy in the light of the COVID-19 impact on inequalities, will take a deeper look at all the services that the council provides with the view to adapt accordingly to meet the needs of its population. The questions raised by this report and the further work planned over the next few months will help inform the Equality and Diversity strategy refresh, the Corporate Plan, and formulate a new strategic document 'No One Left behind' that will sit above the Corporate Plan in the strategic framework.

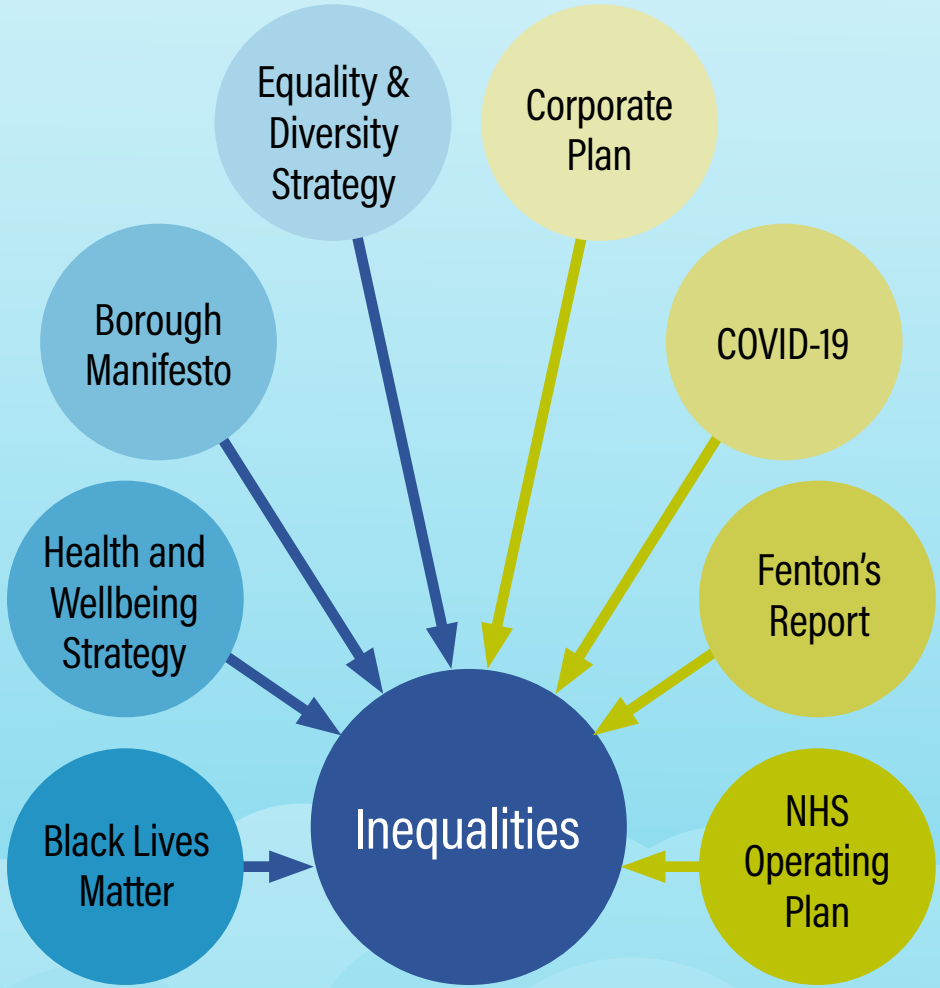
Chapter 1:
Introduction

Health inequalities are avoidable differences in health outcomes across different groups of people within the population caused by chances (or lack of) to lead a healthy life. Structural inequality occurs when the fabric of organisations, institutions, governments, or social networks contain an embedded bias which provides advantages for some members and marginalises or produces disadvantages for others.

Inequality can for example involve unequal access to health care, housing, education and other physical or financial resources or opportunities. The inequalities are visible when looking at different factors such as age, gender and ethnicity, highlighting differences in health status (e.g., life expectancy and frequency of health conditions); access to care (e.g., availability of treatments); quality and experience of care (e.g., levels of patient satisfaction); behavioural risks to health (e.g., smoking rates) and wider determinants of health (e.g., quality of housing).

Inequality was recognised by the London Borough of Barking and Dagenham before the COVID-19 pandemic to be a key factor in the poorer outcomes of residents in the borough, compared to the London and national averages. COVID-19 pandemic further widened the stark inequalities that already existed. The link between ill health and deprivation is important in understanding COVID-19 and its impacts on different groups, particularly in a place with high levels of deprivation such as Barking and Dagenham. This report aims to sum up what we know about the current inequalities in Barking and Dagenham; the relationship between the pandemic and inequality; the long-term effects on inequalities, the wider determinants of health and what that means for the health and wellbeing of our people in Barking and Dagenham.

As seen in the diagram opposite, apart from the impact of the COVID-19 pandemic on existing inequalities, there were many other factors which prompted us to focus this years' Annual Public Health report on inequalities. As a council, we have always acknowledged inequalities in the borough to be



a key driving force for everything we do. For example, Barking and Dagenham Together - Borough Manifesto[1] sets a long-term vision for Barking and Dagenham, positioning the borough as London's growth opportunity and outlining the way that growth can be achieved over the next two decades in a way that benefits everyone. The Borough Manifesto aims to improve a range of outcomes including healthy life expectancy (how many years of our life we can expect to live in good health), improving pay and educational success, which are reduced by inequalities.

> "Inequality is everyone's problem. It impacts health, both physical and mental, income, rates of violence, teenage pregnancy, and addiction. Inequality destroys relationships between members of the same communities, and it creates isolation, alienation, and anxiety. Inequality fuels inequality"[2]

No-one left behind – an assessment of poverty and structural inequality in Barking and Dagenham.

The current Joint Health and Wellbeing Strategy (2019-2023) focusses on reducing health inequalities by taking a preventative, system-wide approach with our partners (NHS, community and voluntary sector organisations such as charities, businesses, and residents) to three themes: the best start in life; early diagnosis and intervention; and building resilience. These themes have the largest potential to improve health inequalities. These issues are complex, we need to act in many ways to improve outcomes across the council's focus areas of *inclusive growth, participation and engagement, prevention, independence, and resilience.*

Inclusive growth is a priority for the council and focuses on distributing economic growth fairly across society and creates opportunity for all. In 2016, the independent *Barking and Dagenham Growth Commission*[3] report supported the vision of the Council to see the borough as London's Growth Opportunity and to deliver 50,000 new homes and 20,000 new jobs over the next 20 years. The Commission also set out a series of recommendations to enable the long-term ambitions for growth to be inclusive and for the benefit of everyone, in accordance with the Council's tag line: **"one borough; one community; no-one left behind."**

Following emerging evidence suggesting a disproportionate impact of COVID-19 on people from Black and Asian Minority Ethnic backgrounds, PHE undertook a review of data on disparities in the risk and outcomes from COVID-19. The PHE report into *Disparities in the risk and outcomes of COVID-19*[4] found that risk of dying among those diagnosed with COVID-19 was higher in those in Black, Asian, and Minority Ethnic groups than in White ethnic groups. The recent reinvigoration of the Global *Black Lives Matter campaign* has also highlighted that a change in our culture, approach and delivery of our community programmes is urgently needed to address this growing gap, to match the service provision with the needs of the community.

The NHS has released its most recent NHS 20/21 Priorities and Operational Plan guidance which places addressing inequalities as a key priority. The scale of the pandemic and its impacts on the economy and society means it is important to explore the impacts locally for our business plans, targets, strategies, policies and services we currently have and rethink the purpose of

1. https://www.lbbd.gov.uk/sites/default/files/attachments/Barking-and-Dagenham-Together-Borough-Manifesto.pdf
2. Barking and Dagenham Together – Borough Manifesto
3. No-one-left-behind-in-pursuit-of-growth-for-the-benefit-of-everyone.pdf (lbbd.gov.uk)
4. Fenton's Report
5. Disparities in the risk and outcomes of COVID-19 (June 2020), Public Health England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

these for the health and wellbeing of our residents. There are many lessons to be learnt from the pandemic including successful partnership between organisations, volunteers, and residents, and more flexible, digital means of service delivery which can be harnessed as we seek to build back better and fairer for the residents of Barking and Dagenham.

The importance of equality and diversity consideration is central to all aspects of the Council's work. The Council has a responsibility under the Public Sector Equality Duty outlined by the Equality Act (2010) to consider the nine protected characteristics outlined within the act:

- Age
- Disability
- Gender
- Gender Reassignment
- Pregnancy and maternity status
- Ethnicity
- Religion or belief Sexual orientation
- Marriage and civil partnership

Under the Equality Act 2010, we must ensure that steps to eliminate unlawful discrimination, harassment, victimisation, and other conducts prohibited by the act are taken. The Council has a duty to advance equality of opportunity and foster good relations across communities and residents. This duty is a central driving force for the development of the Council's Equality and Diversity strategy which the findings in this report will inform.

In this report, we: consider the existing inequalities; the population (who they are and what their needs are) the known impacts of COVID-19 on inequalities; what is happening to address the challenge locally and what the implications are for the future. Throughout the writing of this report, we have involved and discussed with colleagues within and outside the council to ensure the questions encourage thoughts to address our findings.

In this report we have used the terminology Black, Asian and Minority Ethnic (BAME), as it has been used frequently within the context of the impact of COVID-19 nationally and has been adopted by many race-equality focused organisations. However, the Council recognises that, whilst it is widely used in policy discussions, the term BAME is not universally supported amongst the people that it tries to describe. Language matters, and we continue to work with partners across the local government sector, our employees and community voices to identify the most respectful, accepted, and effective way to refer to people of diverse ethnicities in a policy and workforce context. Due to the differences within data collection and differing degrees of disaggregation based on ethnicity, we aim to use the most specific terms available.

There are a few caveats to our findings in this report, for example the hospital data analysis only captured COVID-19, admissions and deaths that happened in the hospital and did not include those who died in the community. Secondly from the available COVID-19 data, we could only understand the current picture and not the trends over a period of time. Due to limited time and capacity, we could not further interrogate the available data to understand the reasons why those inequalities exist nor were we able to get any qualitative data from the communities to understand their perspective and to find the cause. Therefore, further inequalities work is essential in the form of deep dives, participatory research and community involvement and engagement to understand the root causes of the problem and to be able to address them effectively. Further work on inequalities and the next steps are discussed in detail in chapter 5.

Chapter 2:

The Population of Barking and Dagenham

In chapter 2 we will explore demographics in depth (by age, sex and race) and population-level inequalities in Barking and Dagenham. We will consider the role of the wider determinants of health (wider social, economic and environmental issues which affect our health, including where we live, work and go to school, the friends and family networks that we have and how much we earn) and how factors such as employment and housing influence health and wellbeing and health inequalities with a focus on BAME communities. We will talk about the existing inequalities in the borough and consider how age, gender and race affect these.

Barking and Dagenham: Diversifying Demographics

Barking and Dagenham has become one of the fastest changing boroughs in the country, with a rapid population growth rate as seen in Figure 1 (increasing by 28% over the last 15 years). The borough has the highest birth rate in London changing the populations age demographic. The population has also been diversifying in terms of its ethnic composition, 66% of the resident population were estimated to identify as BAME, White Other or White Ethnic in 2020 contrasting with 19% in 2001 . As people move to outer London boroughs and birth rates increase, further population growth is expected with tens of thousands of new homes planned to be built in anticipation of this.

At present, the age profile of Barking and Dagenham is significantly different to the national average, less than a tenth of the population are over the age of 65 – about half of the England average (9.3% vs 18.4%). Around 30% of the population are under 18 (63,400) representing the highest proportion of residents in this age group not only in London but in the UK, Figure 2.

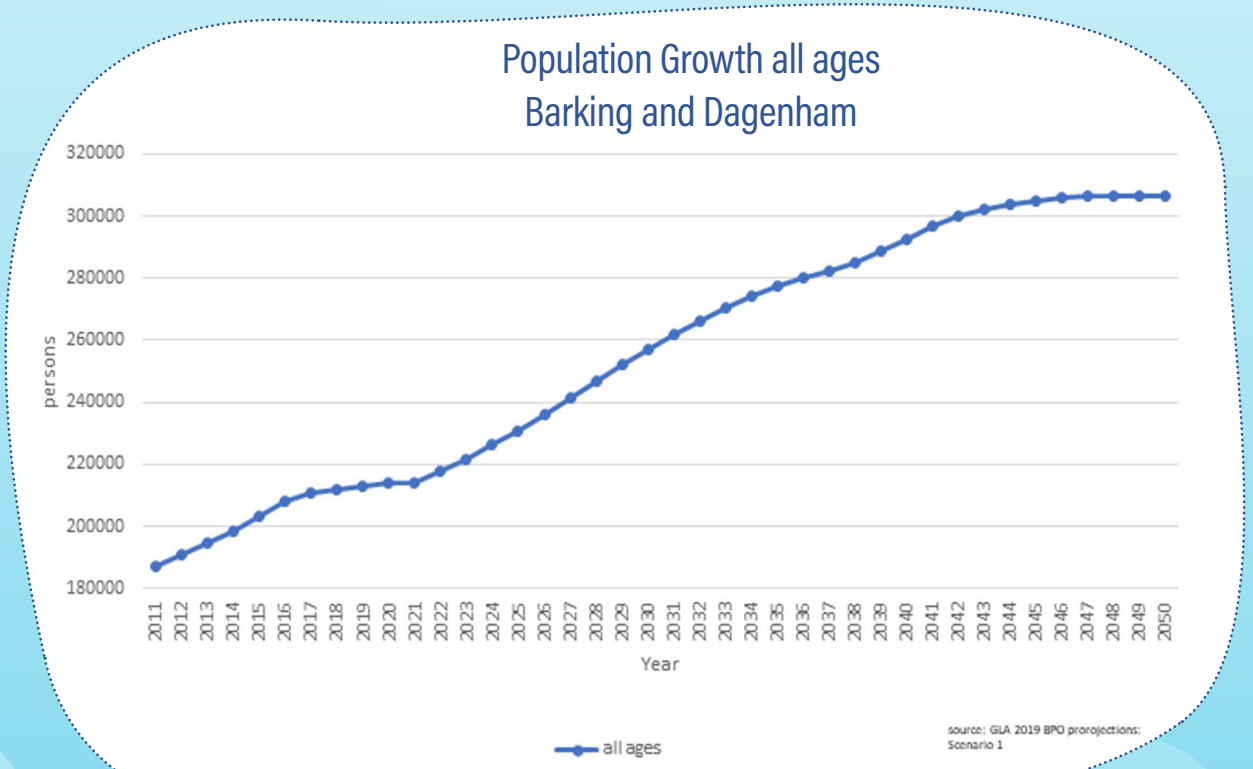


Figure 1: Population projection graph (GLA 2019-based BPO)

6. Ethnicity April 2020 (LBBD Experimental Ethnic Estimates: Residents Matrix 2020)
7. JSNA using Mid-Year Estimates (ONS) 2019

Population projections for the next few years are less certain than they were, mostly given the different trends in migration out of London in 2020. The Greater London Authority estimates that the population of Barking and Dagenham will be approximately 230,000 residents by 2025 and will exceed the 300,000 mark by 2042, Figure 1. The population projections estimate the size and makeup of the population using current birth rates, death rates, movement of people in and out of the borough, among other factors. These projections suggest that the population is likely to steeply increase in the future, despite the slower rate of growth in recent years. Population projections, Figure 1, are important for the Council and wider partners to consider when planning how they should commission and shape services to meet the evolving needs of a changing population.

As the total population of the borough grows, the number of people in different age groups is likely to change. Barking and Dagenham is already a young borough, with the highest birth rate across London[8]. According to the population projections, Figure 3, the numbers of children will continue to grow, there will be a shift to higher numbers of school-aged children and lower numbers of 0–5-year-olds by the year 2025. The number of residents aged over 90 years old will also increase, although the proportion of older people will stay small compared to other London boroughs and nationally.

Our population has become more ethnically diverse in the last two decades, with growth in residents from Black African, Eastern European, Bangladeshi, Indian and Pakistani heritage. At the time of the last census in 2011, 30% of our population was born outside the UK. Across the overall population, approximately two thirds of Barking and Dagenham residents are ascribed to these three ethnic groups: White British (34%), Black African (19%) and White Others (11%)[9]. A further 21% identified as part of the Asian ethnic group (Pakistani, Bangladeshi, Indian or other Asian); around a further 5% were of Mixed ethnicity, 3% Black Caribbean and 6% of other ethnic groups.

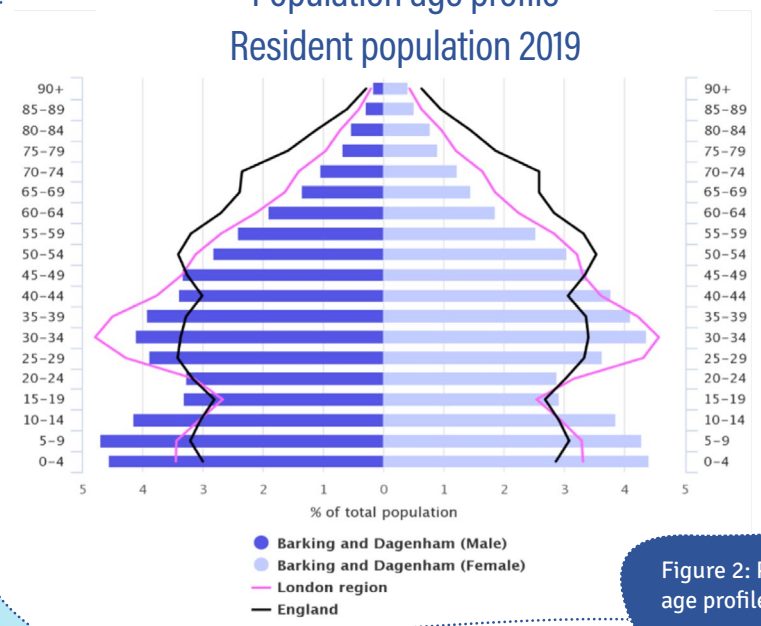


Figure 2: Population age profile from PHE

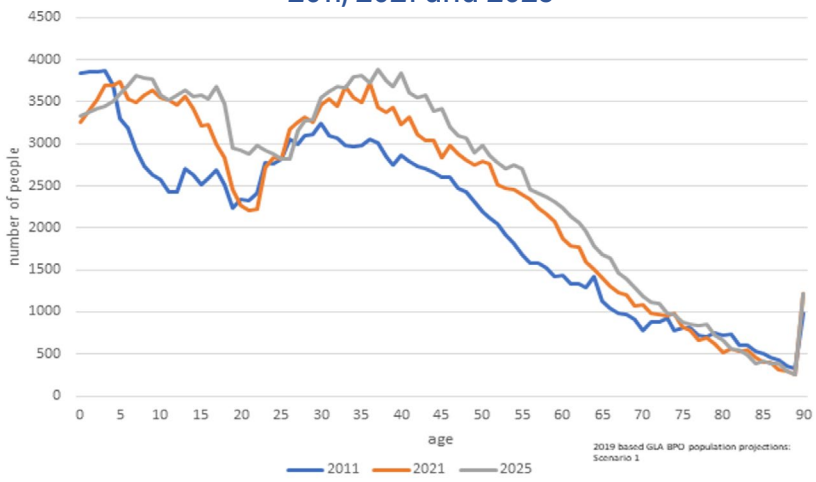


Figure 3: A graph demonstrating the change in the age structure of Barking and Dagenham's population (2019 based GLA BPO population projections scenario 1)

8. ONS Births in England and Wales: 2019
9. Greater London Authority (GLA) 2019 Populations estimates for 2021

The under 18 population is very diverse, 74% of the cohort identify as coming from a BAME background. In the under 18 population the number of children and young people who speak English as an additional language is more than 2.5 times than the national average. The proportion of primary school pupils who do not have English as their first language is 59% which is greater than the London average of 56%, further highlighting the boroughs diversity. Notably, the ethnic composition of adults who are of working age and retirement age is very different. Those aged 65 and above are mostly White British (71%), whereas less than half of the 19-64 age range are of a White British background, Figure 4. The younger the cohort, the more diverse it becomes with a more equal distribution of the population across all different ethnicities. Figure 4 demonstrates that the 0-18 age group is the most diverse, partially reflecting the patterns of migration to the borough over recent decades[10], Figure 5.

Ethnicity Focused Demographic Analysis

Given the context of the impact of COVID-19 on certain communities and the evolving diversity of the Barking and Dagenham population, we take an additional focus on the health of our BAME residents. Build Back Fairer: the COVID-19 Marmot Review, published in December 2020, concludes that such ethnic differences in health outcomes are the result of longstanding inequalities and structural racism. Some ethnic groups suffer disadvantage in many of the social determinants of health because of systemic racism; this could be understood as a contributing factor in the causes of poor health, Marmot advocates that there should be recognition and abolition of systemic racism. In Barking and Dagenham, we have developed our local BAME profile to examine health inequalities and committed to a range of work across the Council in the recognition and ending of systemic racism.

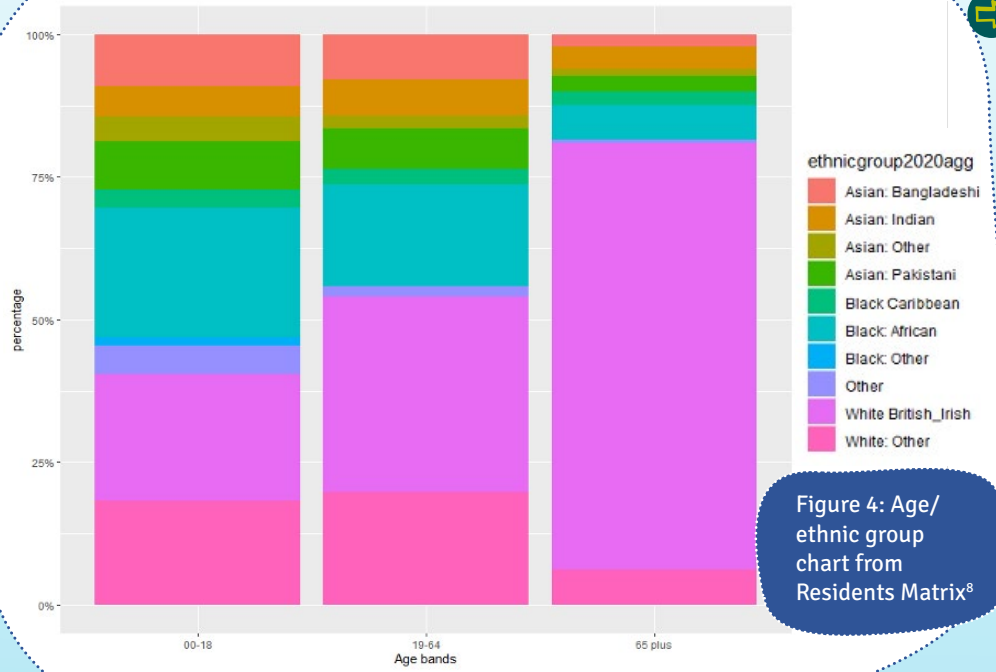


Figure 4: Age/ ethnic group chart from Residents Matrix[8]

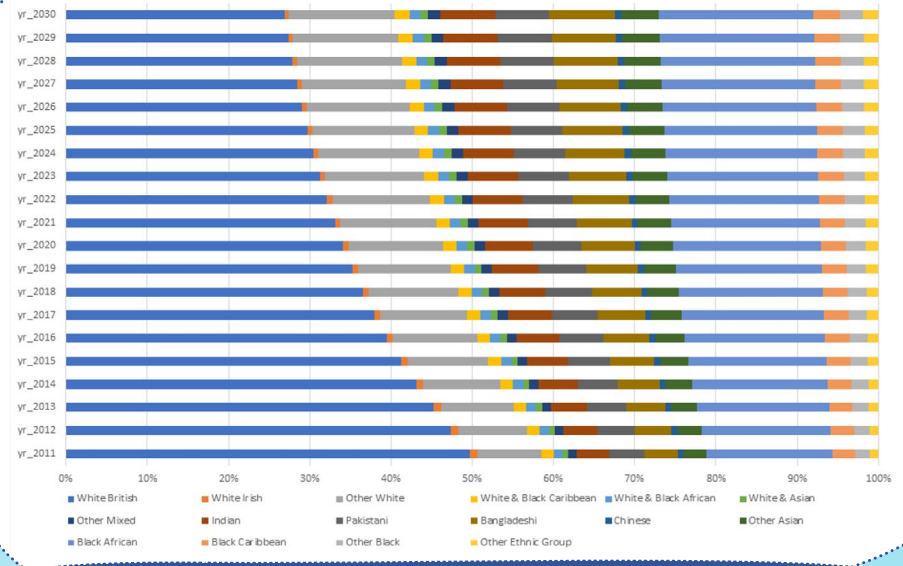


Figure 5: Population growth taking ethnicity into account (GLA ethnic group projections, using 2016 data)

10. London Borough of Barking and Dagenham, Residents Matrix 2020. *Note: The Residents Matrix is a tool developed by the London Borough of Barking and Dagenham which combines data held by the Council and NHS to provide a more up to date profile of the population than Census data. Since ethnicity data is not always routinely or systematically recorded, this can cause some difficulties recording people of Mixed ethnicity in particular. Therefore, in the Residents Matrix, Mixed groups are collapsed into the BAME category to which they refer, hence why there is no Mixed category on the chart. The population of all Mixed ethnicities is estimated to be around 5% of the total population.*

The BAME profile was developed using health and social care data in conjunction with household data, to consider health inequalities at a population level. This has highlighted that the frequency across a range of long-term conditions (including cardiovascular disease, which has been linked to higher risks of severe clinical outcomes and higher mortality from COVID-19) tends to be highest in those of Mixed ethnicity[11]. The average age of diagnosis is lower for those of BAME when compared to the White community across most long-term conditions. The earlier age of diagnosis of long-term conditions in BAME residents when compared to White residents can be over a decade earlier, suggesting that in Barking and Dagenham the age of onset for these conditions is often at a much younger age for Asian and Black ethnic groups.

Table 1 shows multimorbidity is generally associated with age. Within Barking and Dagenham we have seen that our White British population, who make up 71% of our over 65+ age group, have a higher prevalence of multiple long term conditions. Those with multiple long-term conditions tend to develop them later in life; the boroughs demographics may contribute to the lower prevalence of multimorbidity within our BAME community due to the 65+ demographic comprising of mainly White British identifying individuals. Despite these demographic factors, in Barking and Dagenham, multimorbidity is likely to strike ethnic minority residents at a younger age with our Black residents experiencing multimorbidity, on average, 8 years earlier than their White neighbours.

Ethnicity	1st condition (Age)	2nd condition (Age)	3rd condition (Age)
BAME	**54.1**	**60.3**	**63.6**
Asian / Asian British	52.6	57.5	60.7
Black / African / Caribbean / Black British	49.8	55.0	57.8
Mixed / Multiple ethnic groups	55.4	62.2	65.6
White	55.4	62.1	66.2

Table 1: Diagnosis age of those who experience multimorbidity LBBD BAME Profile

Fewer members of the BAME community in the borough experience multimorbidity[12], as compared to the White population, the lowest level of multimorbidity occurs in the Asian and Black communities. The life expectancy of our ethnic population in Barking and Dagenham is lower than that of the White population which comprise most of our older population,

Key Findings from the BAME Profile

- Fewer members of the BAME community experience multimorbidity
- Long-term conditions are most prevalent in those identifying as Mixed ethnicity
- The average age of diagnosis for a third long-term condition is almost 8 years younger for our Black residents when compared to our White residents

11. Note that in this analysis, prevalence refers to crude prevalence in the adult population. It is not standardised (by age etc) so it Is not directly comparable to other areas.
12. We define 'multimorbidity' as having 3 or more of the following long-term conditions: asthma, atrial fibrillation, cancer, coronary heart disease, COPD, dementia, depression, diabetes, epilepsy, heart failure, hypertension, serious mental illness, stroke, and hypothyroidism.

When we considered some lifestyle risk factors for poorer health and long-term conditions, there were some interesting findings; the BAME community have far fewer current smokers, 11%, than the White community, 23%. Smoking rates are particularly low in the Black community with 4% being current smokers and 5% being ex-smokers, this is much lower than that in the White community with 23% and 16% respectively, as shown in Figure 6 below. The high level of smoking within the White community may also contribute to the higher prevalence of multimorbidity discussed earlier. Considering the earlier average age of diagnosis as well as the low levels of smoking in the Black community of many smoking-related long-term conditions, (COPD, coronary heart disease and stroke), it is implied that there are more than just "lifestyle" factors contributing to the incidence of illness.

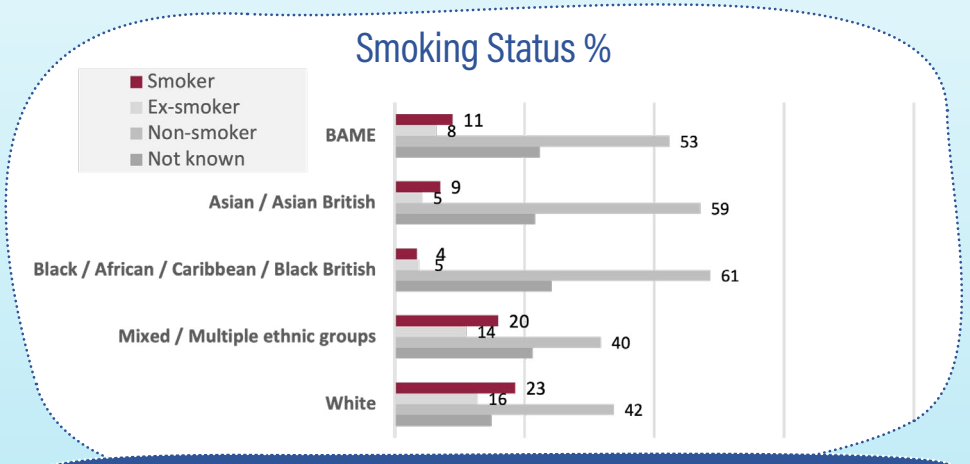


Figure 6: Analysis of resident smoking status by ethnicity in Barking and Dagenham

Obesity is a complex, chronic disease which results in impaired health, there are many drivers to weight gain which are complex, this can be genetic, biological factors and social factors such as the wider determinant of health. There were considerable differences in the proportion of obese and overweight adults by ethnicity in the borough; approximately 67% of our Black/African/Caribbean adults are overweight or obese, higher than our BAME population (61%) and our White adult population (57%), Figure 7. The difference becomes more evident when the data is analysed by gender as well as ethnicity, 72% of Black women are overweight or obese which is a large contrast to 55% of White women. In Year 6, 29.6% (1,075) of children are classified as obese, worse than the average for England.

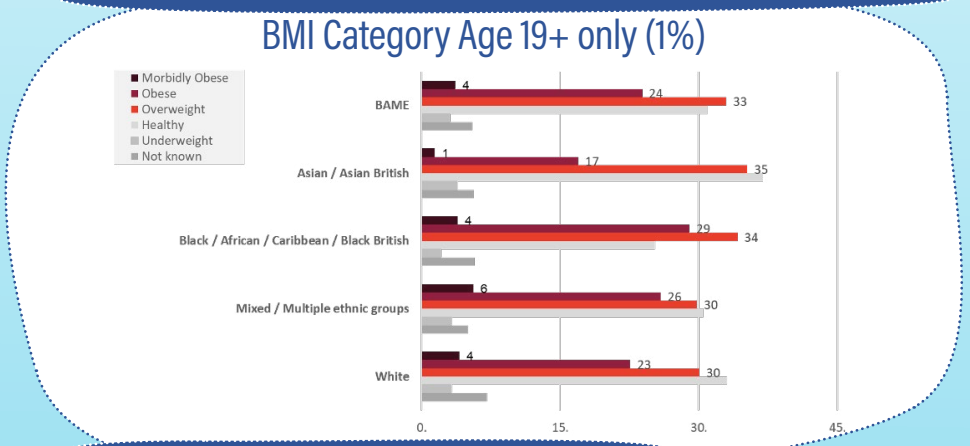


Figure 7: A graph illustrating weights within ethnic groups

In order to understand the differences in the lived experiences of health, such as earlier multimorbidity, higher rates of obesity and earlier diagnosis of long-term conditions, we must look to the other contributing factors i.e., the wider determinants of health to give a 360-degree perspective.

Lifestyle Factors in LBBD

- Fewer individuals who identify as BAME currently smoke
- 67% of our Black/ African/Caribbean/ Black British identifying adults are overweight or obese
- 72% of our Black/ African/Caribbean/ Black British female identifying residents are overweight or obese
- The rate of obesity in our year 6 children is higher than the national average

The Wider Determinants of Health

Good health does not only depend on access to health services; it also involves having decent accommodation and employment, eating nutritious food, getting enough exercise, feeling part of a community, and living in a healthy environment. These socio-economic and environmental factors which influence both people's physical and mental health are known as the wider determinants of health. Disadvantage within these wider factors often leads to social inequality which is the main driver of health inequalities. Marmot's 2010 report on health inequalities, Fair Society, Healthy Lives, outlined the public policy case for tackling the wider determinants health and this was emphasised again during the pandemic in his 2020 report Build Back Fairer. The key points made in Marmot's report underpins our Borough Manifesto, placing the wider determinants of health at the center stage which values independence, participation, and relationships with the community in tackling health inequalities. The pandemic has reiterated how important the wider determinants of health are – and increased the urgency that we act to reduce health inequalities throughout the system to ensure no-one is left behind.

> "We have deprivation that is not new. This is an ongoing issue within communities."[13]

Barking and Dagenham is one of the most deprived areas in the country; it has the highest overall deprivation score in London and the 17th highest nationally, with just over half of the borough population living in what is one of the most deprived areas in England. Within Figure 9[14] the darker the shade the higher the level of deprivation in the LSOA (geographic areas).

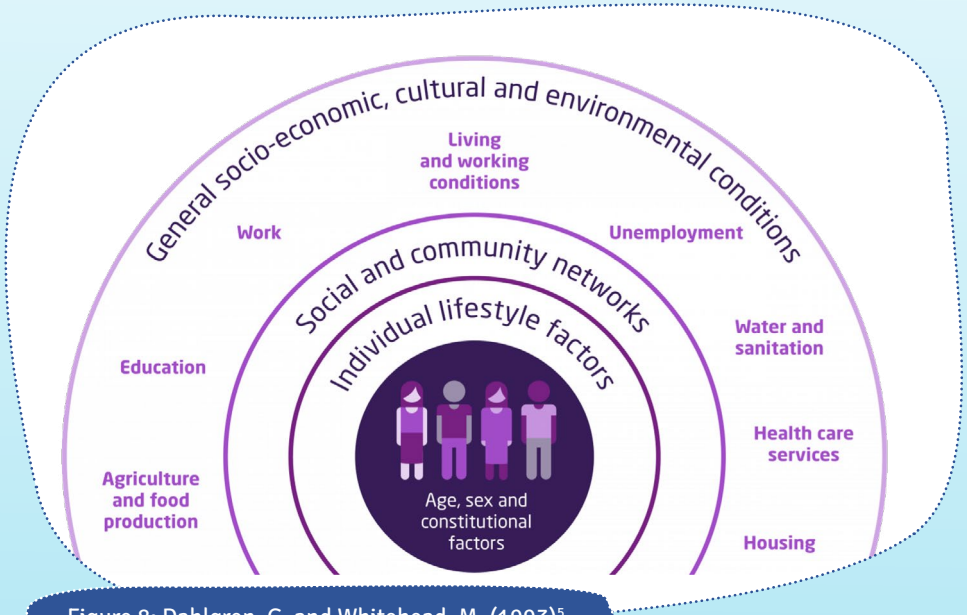


Figure 8: Dahlgren, G. and Whitehead, M. (1993)[5]

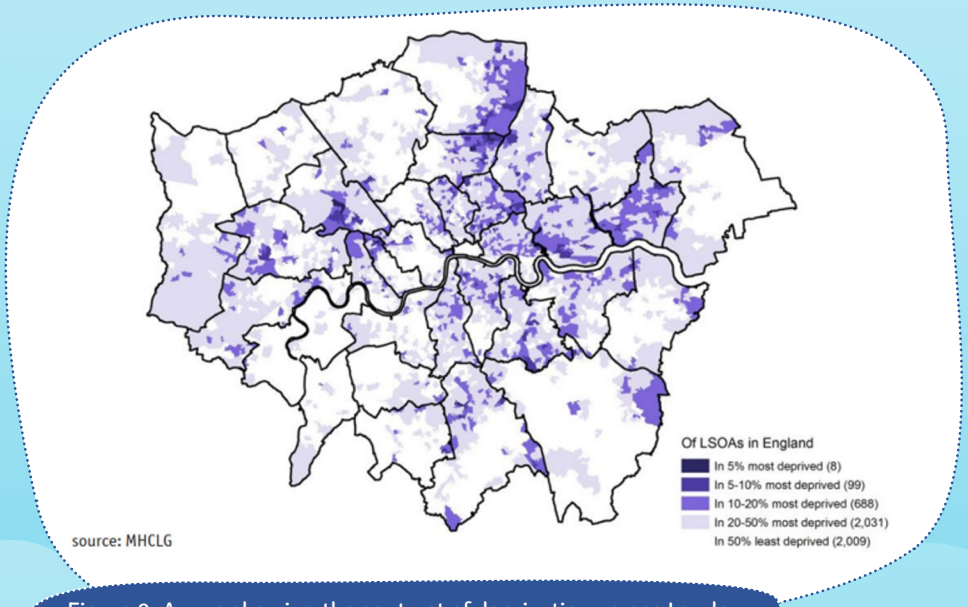


Figure 9: A map showing the contrast of deprivation across London (LSOA - Lower-layer Super Output Area)

13. Quote from stakeholder engagement sessions within the Fenton's Report involving over 4,000 people providing further insights into factors which may be influencing the relationship and impact of COVID-19 on BAME communities and approaches addressing inequalities.
14.MHCLG, English Indices of Deprivation 2019

Around 26% of children under 16 in the borough are living in low-income families, significantly above the England average of 18%.[15] The proportion of children entitled to free school meals in nursery and primary schools is on par with the national average, but the proportion in secondary schools is higher at 17% compared to 14% across England. Life expectancy for both men and women is lower than the England average. Life expectancy (average length of time we are expected to live) is 3.8 years lower for men and 3.4 years lower for women in the most deprived areas than in the least deprived areas in the borough. The rates of violent crime (hospital admissions for violence), under 75 mortality rates from cardiovascular diseases, under 75 mortality rates from cancer and employment (aged 16-64) are worse than the England average.

Deprivation and Health in Barking and Dagenham

- Deprivation is strongly linked to poorer health outcomes
- Barking and Dagenham has the highest deprivation score in London
- 26% of children under 16 are living in low-income families
- Higher than national average across a range of health and deprivation linked measures

Employment

Employment is an important factor of health and wellbeing and a large contributor to the differences in health. Work provides income allowing basic needs to be met and plays a key part of people's identity. Employment status adds to inequalities in mental and physical health. Unemployment is associated with poor health, including increased risk of cardiovascular disease and poor mental health. Before the pandemic, Barking and Dagenham had the highest rate of unemployment in London (6.8%)[16] and an employment rate (71.1%) which was one of the lowest in London.[17] Types of employment also matter. A good working environment is good for health, whereas poorer quality working environments (more dangerous working conditions, low levels of control over your job, low income, and lack of organisational fairness) can be damaging to health.

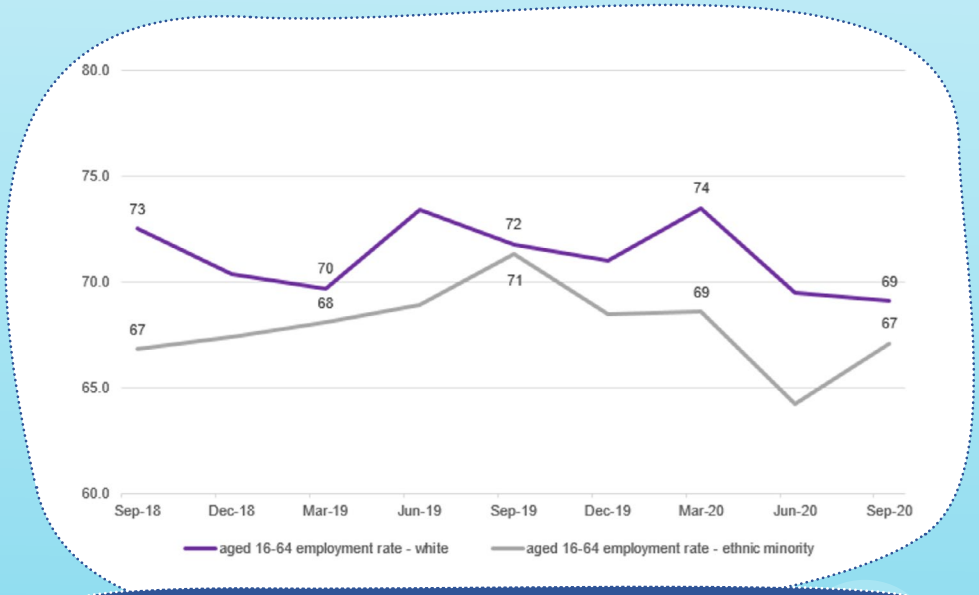


Figure 10: Employment Rate disaggregated by ethnicity. The 'White' ethnic group includes not only White British but also White Other

15. Children in relative low-income families, Department of Work and Pensions 2018 (referenced in JSNA and SEF)
16. About the Borough at https://www.lbbd.gov.uk/about-the-borough accessed 24/03/21
17. PHE Fingertips --- Source: Annual Population Survey - Labour Force Survey

In Barking and Dagenham there is a smaller number of people working in managerial and professional jobs and greater numbers in elementary occupations and zero-hours contracts than the average across London and England, Figure 11. This may indicate that our residents are more likely to be impacted by any financial and economic impacts. From the nationally published data on inequalities, a greater number of BAME communities work in frontline jobs compared to White British, making them more vulnerable to COVID-19 exposure and the social and economic impacts of COVID-19.

The largest employment sector in Barking and Dagenham was retail, with 15% of residents in employment working in a retail job. This is followed by health and social care work (14%) and construction (10%). Many of the jobs in these sectors would be considered frontline, so are unable to work from home, likely involve employees still going to a physical workplace and having contact with the public on a day-to-day basis throughout the pandemic.

These roles may have become less secure, causing people to lose their jobs, put on reduced hours, or being furloughed, which would have reduced their incomes and may mean they didn't have enough money to pay for the basic things they need (including housing, electricity, heating, food for example).

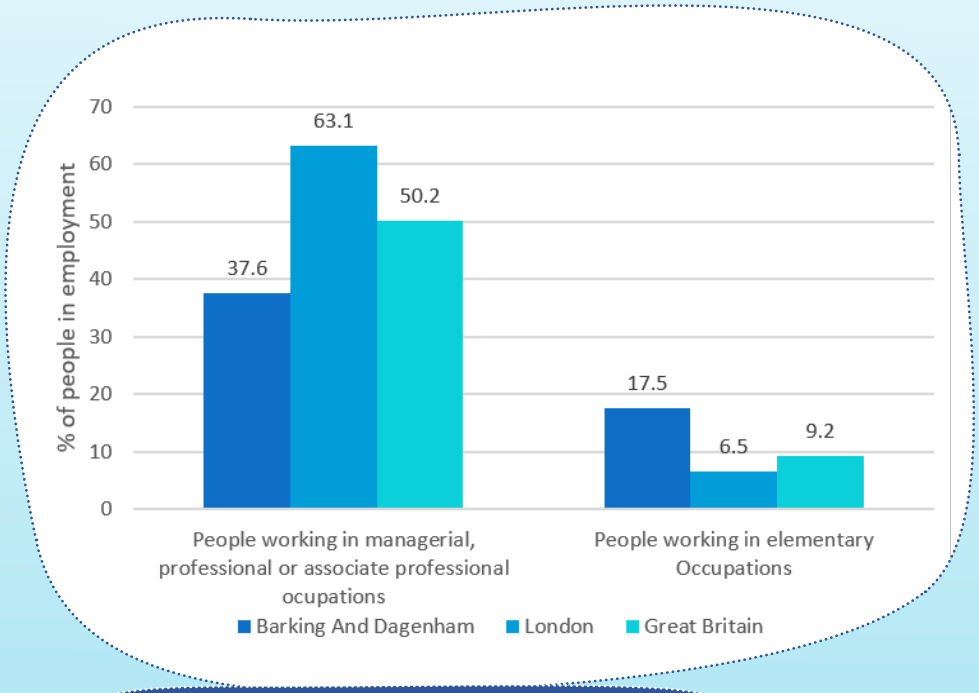


Figure 11: Employment by Occupation (Jan-Dec 2020)

Employment in the Borough

- Unemployment is associated with poorer physical and mental health outcomes
- Before the pandemic Barking and Dagenham had the highest rate of unemployment in London
- Greater numbers of residents are employed within elementary occupations than compared to both the London and national averages
- The largest employment sector for the borough was retail, health and social care and construction
- The main areas of employment have been badly impacted by COVID-19 and may have become less secure

Income

Barking and Dagenham has the lowest average annual household income in London, less than half of the highest household income in the capital in Kensington and Chelsea.[18] Only 74.2% of jobs in Barking and Dagenham are paid higher than the London Living Wage (hourly rate of pay reflecting the high cost of living in the capital) of £10.85 per hour, just below the London average of 80%.[19]

Housing Benefit (which can be claimed by those on a low income, as well as those unemployed) is claimed by about 20% the working age population in the borough, almost twice the England average (20.5% vs 11.5%), as seen in Figure 12.[20] In addition to high numbers of residents of working age who are on low incomes, Barking and Dagenham also has a higher proportion of older residents on low incomes. Pensioners in poverty are defined as those in receipt of Pension Credit. Almost a quarter of pensioner households in the borough are in receipt of Pension Credit, twice the England average (24.4% vs 12.6%).[21] The amount of personal debt per adult in the borough is £903.70 – about £200 higher than the England average.[22]

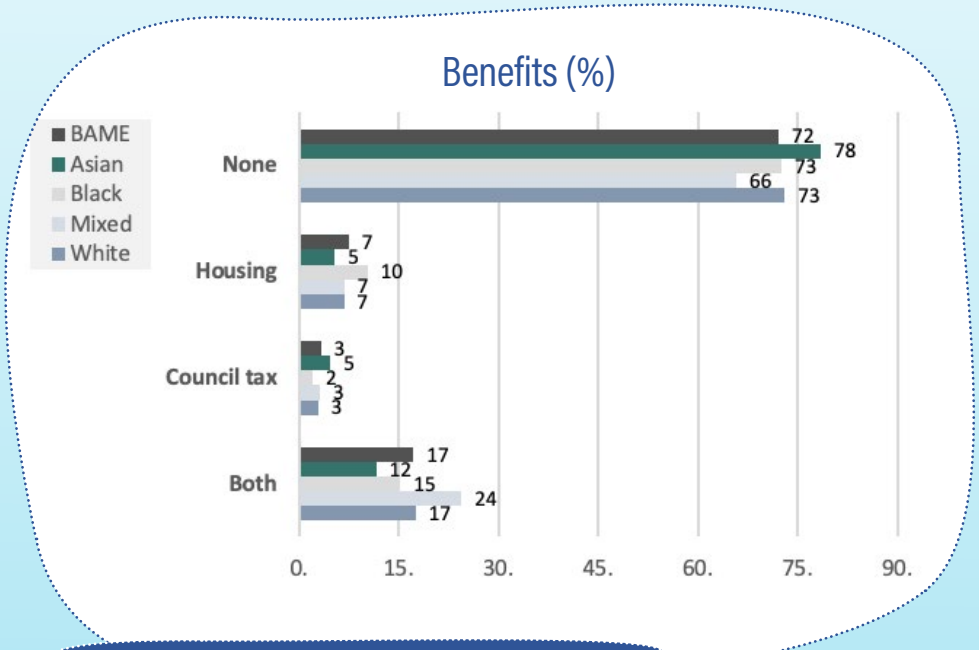
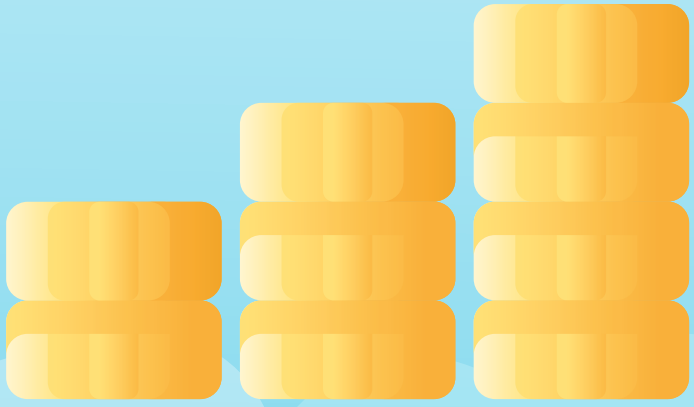


Figure 12: Employment by Occupation (Jan-Dec 2020)



18. Equivalised Income Estimates, CACI 2020
19. GLA – using ONS Annual Survey of Hours and Earnings (2018 provisional) MQ3367 - London Living Wage by borough (2).pdf
20. Department for Work and Pensions, May 2020 (in JSNA)
21. Department of Work and Pensions, February 2020 (JSNA)
22. UK Finance September 2019 (in JSNA)

Housing and Environment

In Barking and Dagenham, 1 in 5 households are overcrowded, more than twice the England average (20.1% vs 8.7%)[23] with the highest levels of overcrowding in River, Abbey and Eastbury wards.[24] A higher proportion of BAME residents live in older cohabiting households, cohabiting adult households with no children, single adult households and single adult households with dependent children, than White residents, Figure 13.[25] The high levels of overcrowding relative to the national average further demonstrates the implications of deprivation in the borough as those with less money are more likely to live in overcrowded housing.

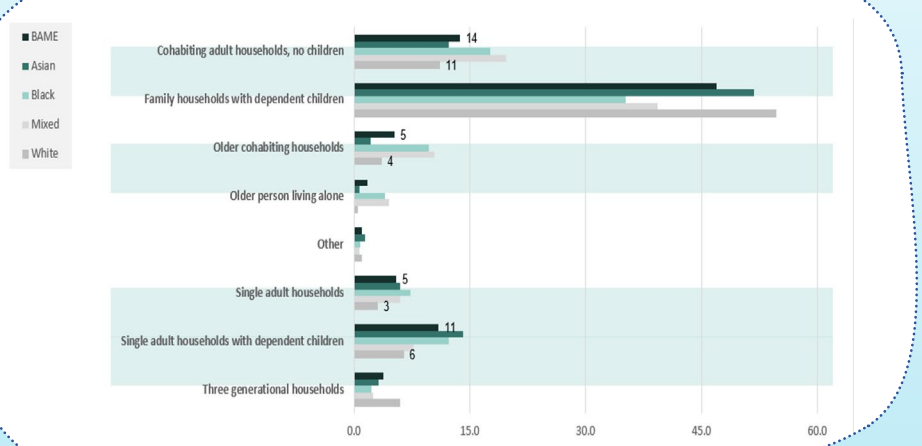


Figure 13: Analysis of resident housing disaggregated by ethnicity

> "Multiple generations living in one household mean elderly and vulnerable individuals may struggle, or be unable, to physically distance themselves in a safe manner. However, older people might have more support for essential activities. [26]"

Barking and Dagenham has over double the number of overcrowded homes compared to the national average and one of the highest percentages in London (35%) of people over 70 living in a multigenerational household. Before the pandemic Barking and Dagenham had the 5th highest rate of homeless people living in temporary accommodation in England, with one of the highest rates of homelessness in London. The Ministry of Housing, Communities, and Local Government estimate that there are 6,531 people homeless in the borough and is the 5th-highest homelessness rate nationally equating to one in every 32 people.

The quality of housing and the immediate environment is important for health and wellbeing generally, as well as in relation to COVID-19 infection and people's ability to tolerate the COVID-19 lockdown. If there is damp, limited insulation or a home is unsanitary then the risk of contracting and transmitting infections is much higher.

Homes and Environment

- In Barking and Dagenham 35% of those over 70 live in multigenerational household
- 1 in 5 households are overcrowded in the borough, twice England's average
- Barking and Dagenham has one of the highest rates of homelessness in London
- 6,531 people are estimated to be homeless in the borough

23. JSNA – using Census 2011 information
24. LBBD Borough Data Explorer
25. LBBD BAME Profile
26. Quote from stakeholder engagement sessions within the Fenton's Report involving over 4,000 people providing further insights into factors which may be influencing the relationship and impact of COVID-19 on BAME communities and approaches addressing inequalities.

Conclusions

Barking and Dagenham is a combination of a young, diverse and a rapidly changing population unlike other boroughs in London. The rapid change in demographic experienced since 2001 is set to continue across both increasing population size and increasing diversity. As one of the most deprived local authorities in England, Barking and Dagenham already had greater chance of health inequalities getting worse because the pandemic. Many of the underlying factors contributing to the health and wellbeing of our population, such as the wider determinants of health, drive health inequalities and reduce healthy life expectancy.

The data shows that the wider determinants of health in Barking and Dagenham are causing residents to live shorter lives and live in poorer health. Many of the underlying factors that threaten health equity such as overcrowding, unemployment and low income also threaten increased risk of exposure, transmission, and severe impact of COVID-19 in both direct and indirect ways. As COVID-19 worsened the already existing inequalities it is important to display high regard to them during recovery given the local prevalence of these factors. A system-wide approach is important to improving health outcomes while addressing health inequalities.

Questions for the future:

- How can we improve data collection to capture differences in ethnicity (around access and outcomes), improve approaches and service design to reduce inequality?
- What role can the Council and its partners play in reducing health inequalities at all levels across the health and social care system?
- How can we create more chances for user engagement and involvement to understand lived experiences of residents through the pandemic?
- How can we future proof our services looking at the existing and widening health inequalities and the rapidly changing demographics with an exponential increase in BAME population in the borough?

Chapter 3:

COVID-19 and Inequalities

Evidence shows the effects of COVID-19 pandemic have affected those from poorer areas and ethnic minority groups the most. In this chapter we consider the impacts of COVID-19 and the extent to which existing inequalities and poor health had an impact in Barking and Dagenham.

Three areas of particular concern to Barking and Dagenham from the early evidence on the relationship between COVID-19 and inequalities, are:

- Ethnicity
- Deprivation
- Impact on children and young people

The Fenton Report showed that COVID-19 is a disease associated with unequal risks and outcomes. It is likely to have resulted in worst outcomes for those who are older, male, of Black or Asian heritage and have underlying health conditions, such as obesity and diabetes. At Barking and Dagenham, we have analysed local data on COVID-19 related hospital admissions and mortality, as well as cases, to explore any evidence of disproportionate impact by ethnicity, age, and gender.

> "Our communities are more likely to have health conditions which make them more vulnerable to COVID-19, such as diabetes and CVD. Many didn't even know their GP was open, while others were afraid to go incase they caught COVID -19."[24]

Direct Impacts of COVID-19

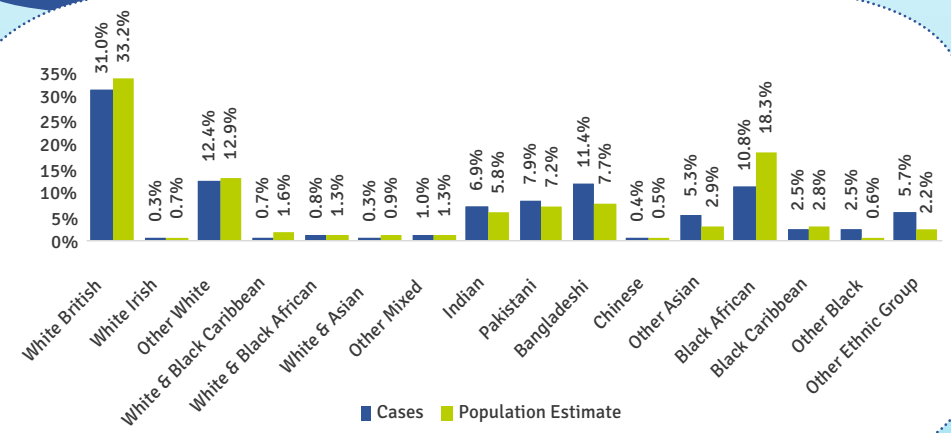


Figure 14: Distribution of confirmed COVID-19 cases by ethnicity. Note this excludes 3,357 cases with unknown ethnicities

COVID-19 Case Analysis by Ethnicity

Our analysis of confirmed COVID-19 cases in the borough between March 2020 and March 2021 in Figure 14, shows that there is an over-representation of Bangladeshi, Pakistani, Indian, Other Asian, Other Black, and Other ethnic groups and under-representation of White British, White Irish, Other White, Mixed White, Black African and Black Caribbean groups. The over presentation of certain BAME groups and lower presentation of COVID-19 cases amongst the White British and White others is in line with the nationally published data. However, the lower prevalence amongst the

27. Quote from stakeholder engagement sessions within the Fenton's Report involving over 4,000 people providing further insights into factors which may be influencing the relationship and impact of COVID-19 on BAME communities and approaches addressing inequalities.

Black African and Black Caribbean population in Barking and Dagenham is a deviation from the national picture. One reason for the discrepancy could be due to a higher proportion of our younger population being a more diverse cohort; younger cohorts may be underrepresented due to their likelihood to be asymptomatic and therefore remain untested. To draw any formal conclusions further exploration is needed to find the reasons which may contribute to the discrepancy.

Figure 15 shows the number of cases linked to ages, the average age of positive cases in the borough is 37.6 years, and the average age of COVID-19 deaths is 74. There was an over-representation of cases amongst those aged between 20-59 and an under-representation amongst all the others. The over-representation of the younger age bands as compared to the older age bands is in accordance with the national picture to date and could be a combination of factors such as the vaccination programme. The programme was prioritised according to age and therefore vaccinations were received later for the younger cohort, majority of this cohort is of working age group with more exposure, vaccine hesitancy and some lack of compliance with the measures. In our younger groups (0-19) the under representation of cases may be due to less testing, this is a likely result of younger cohorts who are more likely to be asymptomatic and less likely to suffer from severe symptoms and mortality from COVID-19.

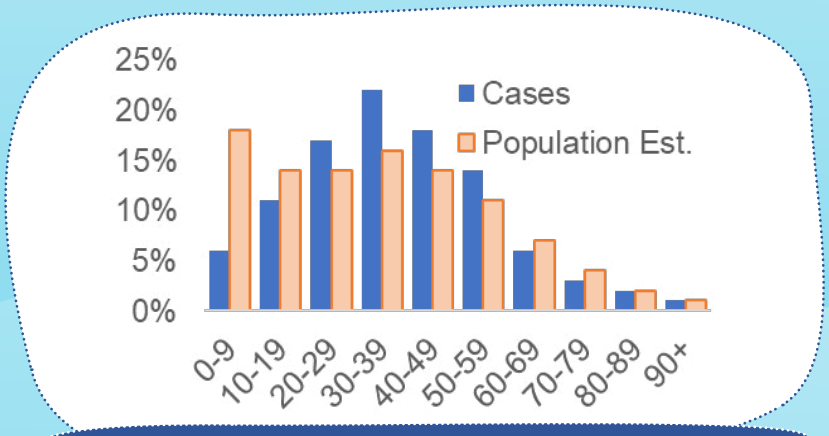


Figure 15: Distribution of confirmed COVID-19 cases by age bands

COVID-19 Hospital Data

We analysed Secondary Uses Services (SUS) NHS Digital Hospital data between March 2020 and March 2021 to see the impact of COVID-19 on residents. There are a few caveats; there is a possibility that if other risk factors were taken into consideration (such as more than one illness or disease) a different picture would have emerged. The available data and the small size of the cohort prevented firm conclusions to be drawn.

COVID-19 Hospital Admission by Ethnicity and Age

COVID-19 admissions were higher amongst certain groups such as White British, Bangladeshi or Pakistani, and Other Ethnic groups relative to their composition of the population. However, Black Africans had disproportionately lower hospitalisation rate than expected (9% vs 18%). The data also suggests that admissions amongst Asian groups, such as Pakistani and Bangladeshi in particular, were within the expected range. We may be able to attribute the higher rate of admissions amongst the White British due to the borough's older population which is predominantly White.

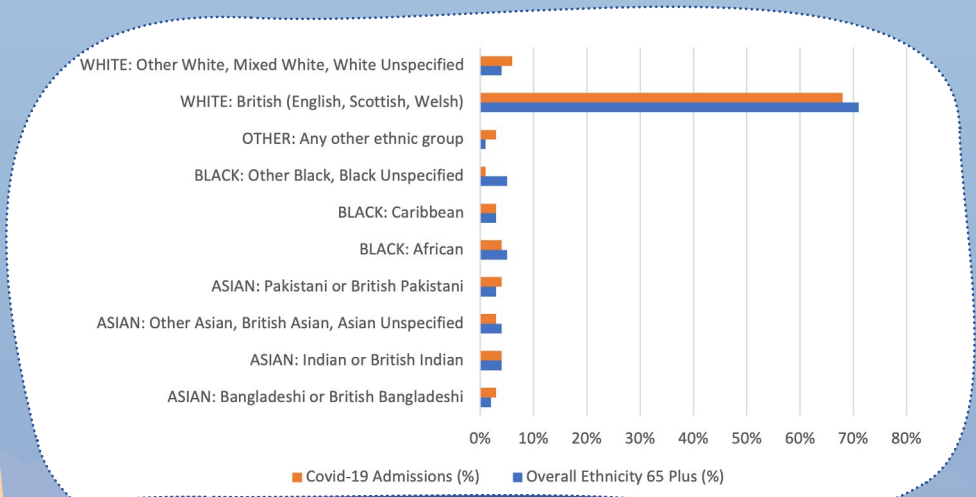


Figure 16: COVID-19 SUS Hospital Admissions (Age 65+) data analysis by ethnicity (Jan '20 - Feb '21)

In White British, Other/British/Unspecified Asian, Black African, and Black other groups, over 65 years-old, the admission rate is lower than expected Figure 17. As expected, the White British population have a lower admission rate in line with the national published data. The admission rate amongst Black Others (65+) is considerably lower than expected, it is unclear which factors are contributing to this, whether accessibility to services, uptake of vaccines or any behavioural or genetic factors.

COVID-19 admissions in the 18-64 cohort showed greater disproportionality across specific ethnic groups, Figure 18. The Bangladeshi population comprise 6% of Barking and Dagenham's population however they constituted 9% of all COVID-19 hospital admissions, indicating disproportionately, Figure 18. The rate of admission was slightly greater than the proportion of the demographic for the Other Asian, Other black and Other Ethnic groups, again suggesting disproportionality. However, in the Pakistani, Black Caribbean, Mixed other, Mixed White and Black African, and White Other groups the admissions were consistent with the borough's demographics, Figure 18. This again may show disproportionality as certain ethnic groups such as Pakistani should have a higher admission rate as per the nationally published data and may be due to issues with access, vaccine hesitancy or any cultural barriers. The admission rate was less than expected for the White British population, in line with national published data, but also for Indian and Black African ethnic groups. To conclude more from these findings, further exploration is needed into the contributing elements.

When looking at these findings relating to ethnicity and age, we saw that the average age of admission for the White British population was consistently older than other Ethnic groups across both the 65+ and the 18-64 age band. The average age for admission for the Black African and Black Other ethnic groups (aged 65+) was 7 years younger than the average age of admission for the White British population (80 years). The contrast in the average age of admission was even more evident for the more diverse 18-64 cohort. The average age of admission for the White British population was 51 years, contrasting to 44.5 years for the Bangladeshi, Asian Others and White Other ethnic groups.

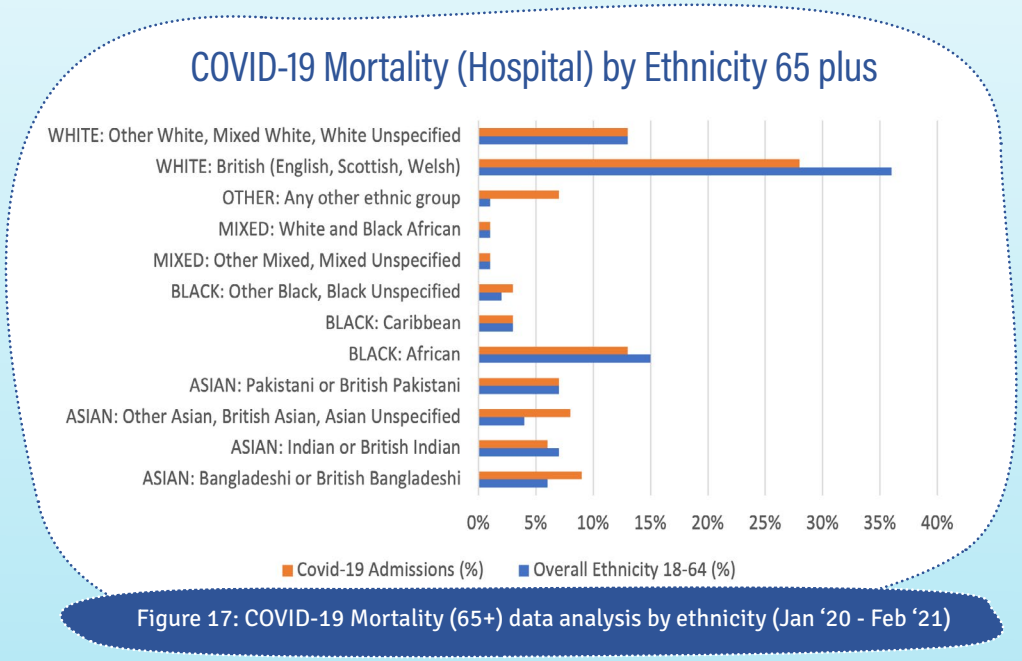


Figure 17: COVID-19 Mortality (65+) data analysis by ethnicity (Jan '20 - Feb '21)

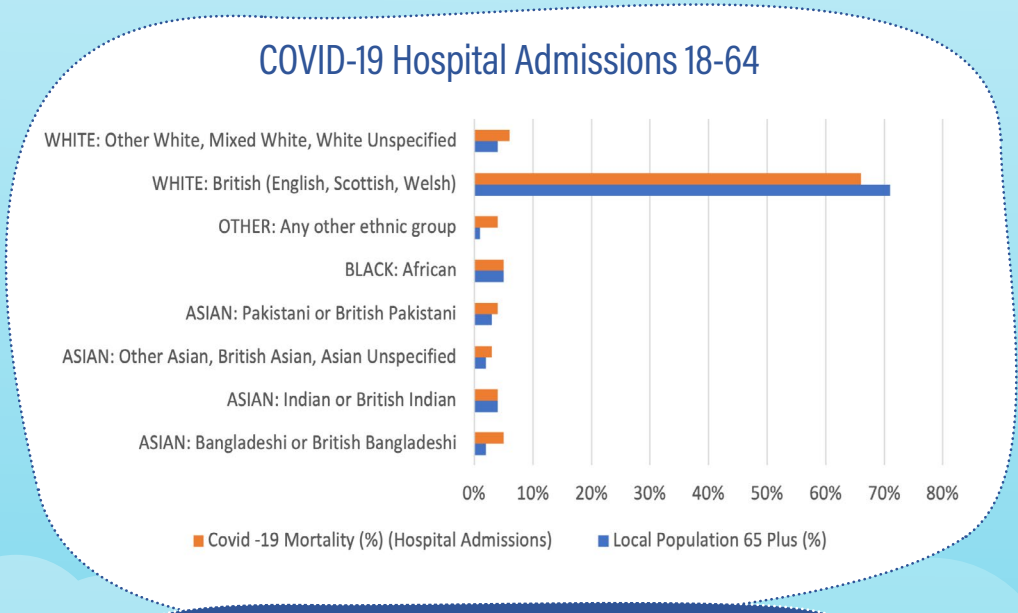


Figure 18: COVID-19 SUS Hospital Admissions (Age 18-64) data analysis by ethnicity (Jan '20 - Feb '21)

COVID-19 Hospital Mortality by Ethnicity and Age

For all ages, the COVID-19 mortality was higher among certain groups such as White British and Other ethnic groups. The higher rate of mortality amongst the White British is possibly due to the age factor – the percentage of older people in the White British population is 71% and higher compared to other groups. Nationally published data shows that the older population are at a significantly higher risk of morbidity from COVID-19, which links with a greater incidence of hospital admissions.

When analysing morbidity in the 65+, certain ethnic groups such as Bangladeshi (5% versus 2%), Pakistani (4% versus 3%), Other Asian (3% versus 2%), Other (4% versus 1%), and White Other (6% versus 4%) had a disproportionately higher rate of COVID-19 related mortality as compared to their relative populations in the borough, Figure 19. The 65+ Bangladeshi group represent 5% of the mortalities but only constitute 2% of the population. They are also likely to die younger than their White British counterparts, 76 years, and 81 years, respectively. The White British population on the other hand had a disproportionately lower mortality rate, 66%, despite constituting 71% of the population, reflective of national data. The Pakistani, Black African, and Black Caribbean groups have a lower average age at time of death whereas the White British population have the highest, with up to 12 years difference between them.

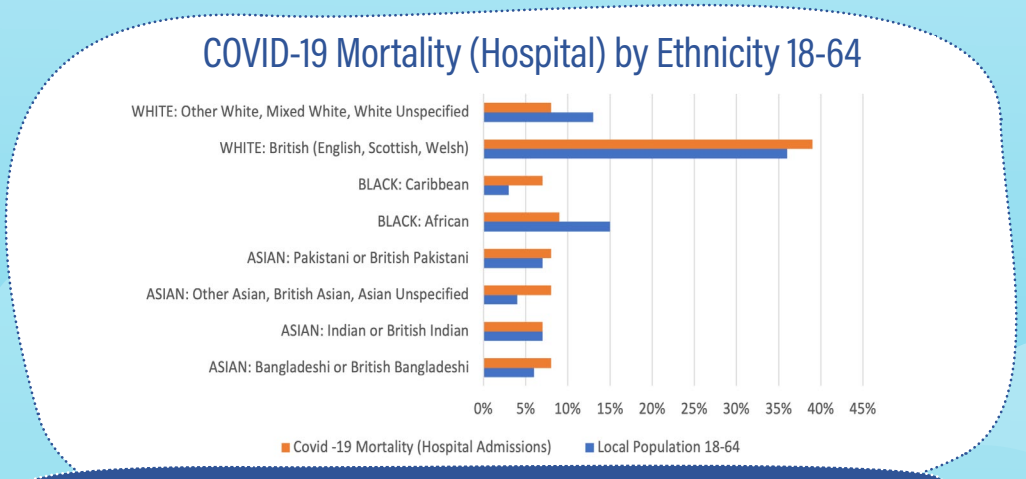


Figure 19: COVID-19 Mortality (18-64) data analysis by ethnicity (Jan '20 - Feb '21)

The numbers of COVID-19 deaths were much smaller in 18-64 age group, but a similar disproportionality is observed, Figure 19. Mortality among Bangladeshi, Pakistani, Other Asian, Black Caribbean and British White is higher than the expected. In contrast, the mortality amongst Black African group is significantly lower than expected, correlating with the hospital admissions for this group.

COVID-19 Mortality Analysis by Gender, Age and Ethnicity

In Table 2, we show COVID-19 mortality by gender for 18-64 and 65 plus age groups. In line with national data, more men died and at a younger age when compared to women across both the 65+ and the 18-64 groups.

Mortality by Gender (Age 65 +)	COVID -19 Mortality (Hospital Admissions)	Average Age
Female	46%	80
Male	54%	79
Mortality by Gender (18-64)	**COVID -19 Mortality (Hospital Admissions)**	**Average Age**
Female	47%	58
Male	53%	55

Table 2: COVID-19 Mortality data analysis by gender and age

The analysis by both gender and ethnicity demonstrates that men have been affected disproportionately by COVID-19, in some ethnic groups such as Bangladeshi men are 4 times more affected than women in terms of mortality, (Table 3) and in Pakistani, African, and Other ethnic groups men were twice as likely to experience mortality from COVID-19 when compared to women. Across all ethnicities, on average men were 1.3 years younger than women at the time of death, this will have implications on increasing the already existing differences in life expectancy by gender.

COVID -19 Mortality by Ethnic Groups (All age groups)	Female	Male	M:F Ratio
ASIAN: **Bangladeshi or British Bangladeshi**	21%	79%	4:1
ASIAN: **Indian or British Indian**	44%	56%	1:1
ASIAN: **Other Asian, British Asian, Asian Unspecified**	53%	47%	1:1
ASIAN: **Pakistani or British Pakistani**	38%	63%	2:1
BLACK: **African**	37%	63%	2:1
BLACK: **Caribbean**	67%	33%	1:1
OTHER: **Any other ethnic group**	33%	67%	2:1
WHITE: **British (English, Scottish, Welsh)**	49%	51%	1:1
WHITE: **Other White, Mixed White, White Unspecified**	45%	55%	1:1
Grand Total	**46%**	**54%**	**1:1**

Table 3: COVID-19 Mortality data analysis by Gender and Ethnicity

COVID-19 Impact on Adult Social Care Services

COVID-19 has had an impact on our Adult Social Care clients. 1 in 8 of our Adult Social Care clients have received a positive COVID-19 test result. Mortality of our Adult Social Care clients has increased by 1/3rd and reducing life expectancy by 1.8 years. Those known to Adult Social Care are 12 times more likely to die because of COVID-19. The lower life expectancy for those within the community known to adult social care may suggest that they are more at risk from severe consequence of COVID-19; further research and analysis should be done to understand why this may be the case.

Impacts of COVID-19 in Barking and Dagenham

- Hospital admissions for 65 + age group were disproportionately lower than expected for those who identified as White British, Other/British/Unspecified Asian, Black African, and Black other groups
- For 65 + age group: Average age at admission was 7 years younger for Black African and Black Other identifying population than White British population
- 18-64 cohort: Average age of hospital admission was 44.5 years for our Bangladeshi, Asian Others and White Other identifying groups, 6.5 years younger than the White British population
- Bangladeshi men are 4 times more affected than women in terms of mortality
- Men who died were on average 1.3 years younger than women
- 1 in 8 of those known to our Adult Social Care have received a positive COVID-19 test result

Wider Impacts of COVID-19

In the last year, the country has seen an economic decline and an increase in unemployment because of the closure of several sectors and industries regarded as non-essential. The recession has impacted unemployment rates nationally as well as locally. Employment rates have fallen across the White community (72% to 69%) and BAME groups (71% to 67%) from Sep 2019 to Sep 2020.[28]

28. Data source: NOMIS

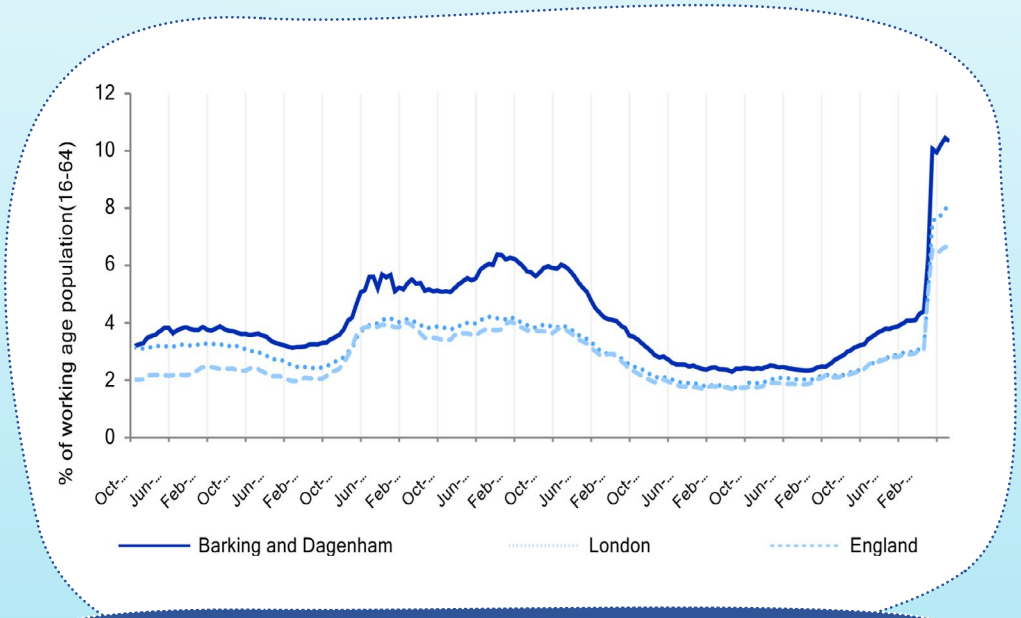


Figure 20: Unemployment benefit (Jobseekers Allowance/ Universal Credit) claimants from the Department for Work and Pensions

The Parliamentary Women and Equalities Committee highlighted mothers are more likely to have quit or lost their job, or to have been furloughed. Locally the number of individuals between the ages of 18 and 24 claiming out-of-work benefits doubled between March 2020 and February 2021 (1,020 individuals to 2,680 individuals) which is in line with national statistics, showing under 25s were more likely to be furloughed or unemployed during the pandemic.

National reports and data show that BAME groups were more likely to work in occupations with a higher risk to COVID-19 exposure and less able to work remotely. BAME men, are much more likely to work in health and social care key worker roles compared to White British men and Black African men are seven times more likely to work in this industry than their White British equivalents. Women who identify as BAME are more likely to be in health and social care employment. This difference in employment may contribute to the high risk of COVID-19 attributed to the BAME populations.

Poverty and deprivation are likely to worsen because of increasing unemployment and reduced income, further impacting on wider determinants of health such as housing and debt. Figure 20 shows in September 2020, the numbers of unemployment benefit claimants (Jobseekers Allowance and Universal Credit) were above the England average, at 10.3% compared to 6.6%. The number of claimants over the age of 50 were at least twice the England average (5.5% vs 2.6%). Figure 20 also shows that since the initial COVID-19 lockdown in March 2020, the numbers of unemployment benefit claimants have risen sharply – to at least twice what they were at the beginning of 2020. Local support services such as the Homes and Money Hub Services have seen an increase in demand for those between the ages of 19 to 44 as well as those who are over 65 with a decrease in the usage for those between 45 and 64 and mostly for males.

Whilst we have already acknowledged how deprivation can impact health and drive health inequalities in chapter 2, national studies found that deprivation also resulted in disproportionate numbers in deaths from COVID-19. The Office of National Statistics (ONS) found that COVID-19 mortality was more than double in the most deprived areas than the least deprived[29] ones.

Overcrowding and homelessness was already known as an important concern in the borough even before the pandemic as discussed in chapter 2; the pandemic has further strengthened the association between health and overcrowding through exacerbated risk associated with COVID-19 transmission, morbidity, and mortality. Overcrowding also has other indirect impacts in the context of the pandemic such as the inability to work from home effectively, and issues with childcare and maintaining education at home. Overcrowding can lead to increased COVID-19 transmission as people within the household are unable to effectively self-isolate. Nationally, overcrowding is a greater issue in BAME households than in White British households; BAME households are more likely to be intergenerational with grandparents living in the same house as grandchildren.

29. Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020

Although multigenerational living can have significant community and social benefits, the socially active young people may be more likely to aid transmission of COVID-19 to vulnerable elderly cohorts.

Poor housing conditions have harmful impacts on health; living in poor quality housing is a factor that may make the severity of Coronavirus more likely. The Public Health England review, Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities, found that "poor housing increases the risk of cardiovascular disease, respiratory disease, depression, and anxiety, as well as lack of sleep and restricted physical activity. All of these were mentioned as risk factors for worse outcomes with COVID-19 once infected". In the context of the pandemic, it was clear that overcrowding made self-isolation much more difficult and increased opportunities for within-household transmission for some ethnic groups.

General Impact of COVID-19

- Fall in employment rates in the borough by 7% for the White population and 4% for the BAME population
- The numbers of those aged 18-24 claiming out-of-work benefits has doubled
- Increased use of the Homes and Money Hub Services for those between the ages of 19-44 and 65+
- Deaths due to COVID-19 were over double in the most deprived areas than that of the least deprived

Impact on Mental Health

Recent studies have documented that the average mental distress was 8.1% greater in April 2020 than between 2017 and 2019. All demographic groups showed increased stress at the start of the pandemic with a larger change for younger adults, women and those identifying as BAME. The ONS survey found that the number of adults with moderate to severe depression had almost doubled from March – June 2020; key workers reported the largest increase, rising threefold from 6% to 18%. The 16–39 age range saw the highest proportion (31%, up from 11%), for 70 plus, it doubled.

Children and young people have experienced a particularly difficult time during the COVID-19 pandemic including bereavement, closures to educational settings, self-isolation and reduced social contact, a loss of routine, uncertainty about their futures, and a breakdown of support mechanisms. Disrupted education, cancelled assessments and the predicted economic downturn may mean that young people are increasingly stressed about their future. The pandemic may have exacerbated recognised risk factors of suicide, (defined as deaths resulting of intentional self-harm; and event of undetermined intent) which is the leading cause of death in 5–19-year-olds.

These circumstances, in addition to reductions in support services, could lead to a range of poor mental health outcomes. In July 2020, young volunteers from Barking and Dagenham carried out a survey of young people in Barking and Dagenham, Havering, and Redbridge. From the 1,239 responses: 1 in 4 young people reported worrying about their mental health during lockdown.

Children and young people in certain groups, such as those from poorer households, young carers and those with disabilities are already more affected by higher levels of mental health issues. For young carers this is due to their responsibilities, which may have increased due to reduced social service provision during the pandemic. They often care for somebody who is elderly or clinically vulnerable, which can escalate fears of passing the virus on.

Impact of COVID-19 on Mental Health

- The number of adults with moderate to severe depression doubled between March and June in 2020
- The group that showed the most increased stress was younger adults, women and those identifying as BAME
- 1 in 4 young people reported worrying about their mental health during lockdown

Impact on Children and Young People

Evidence shows that children and young people have been significantly adversely impacted[7], which is of particular concern to Barking and Dagenham, given that the borough has the highest proportion of children and young people in the country. Research has shown that children and young people in areas of disadvantage are more likely to be negatively affected by the COVID-19 pandemic, 26% of our children under 16 years old live in low-income families, this is considerably above the England average of 18%. They have been particularly impacted by the disruption to face-to-face learning, with digital inequalities limiting access to online learning and educational inequalities in the exam grading systems. For example, the Sutton Trust identified that 35% of households with the lowest income did not have access to enough devices for online learning, compared to only 11% for those on the highest incomes[8]. Children with special educational needs and their families were particularly disadvantaged through school closures.

In Barking and Dagenham, for most pupils, there has been a total of one full term of face-to-face learning over the past twelve months. The disruption and loss of learning during this period is likely to have a lasting impact on most pupils' educational outcomes and an impact on pupils' physical and mental health and wellbeing. Housing issues, such as homelessness and overcrowding, means some pupil's home environments are not suited to learning, which increases the chances of poor educational outcomes and longer-term impacts on education may not be fully seen for several years to come.

In some boroughs, 40% of Health Visitors were redeployed at the height of the pandemic, producing a backlog of 1 and 2-year-olds development reviews. London and Manchester showed the greatest fall in MMR vaccination during lockdown (43% reduction compared to the same period in 2019). Also, for many children, school closures have limited access to a place of refuge, and abuse patterns are less likely to be noticed by a professional. The Children's Social Care services in the borough are indicating increased vulnerabilities of children with influx of safeguarding, children in need and child protection referrals to their services following return to schools. The Children's Commissioner for England has warned that reduction of services may lead to many children becoming 'invisible', such as those receiving help from non-statutory services or those considered 'lower risk' by social workers.

Another impact that the pandemic has had on the health of children, is linked to weight and the inability to maintain healthy lifestyle behaviours. Excess weight gained may not be easily reversible and might contribute to obesity during adulthood if healthier behaviours are not re-formed. Data from the National Child Measurement Programme report 2018/19 demonstrated that childhood obesity is strongly correlated with socioeconomic status, as prevalence of childhood obesity was twice as high in those living in the most deprived areas compared to the least.

At the end of May 2020, London had the smallest proportion of children undertaking 60 minutes+ exercise per day of all English regions. Barking and Dagenham already has the highest prevalence of obese Reception children in London and the highest prevalence of obese Year 6 pupils in the country. Approximately 13% of Barking and Dagenham Reception pupils are obese, compared to a regional and national average of 10%. Prevalence is slightly higher in boys (14%) than in girls, and higher in pupils of Black ethnic origin (18%) than those of White (12%) and Asian (11%) ethnic origin. In Year 6, approximately 29% of pupils are obese, compared to a regional average of 23% and a national average of 20%. In a similar fashion, prevalence is higher in boys (31%) than in girls (27%), and higher in Black pupils (33%) than pupils of Asian (30%) and White ethnic origin. In Reception, obesity prevalence is higher in pupils living in more deprived areas.

Impact of COVID-19 on Children and Young People

- 35% of households with the lowest income did not have access to enough devices for online learning
- Obesity is likely to have worsened because of the pandemic
- There has been a total of one full term of face-to-face learning over the last 12 months in Barking and Dagenham

Conclusions

The higher risk in certain communities and groups can be credited to wider factors of health and social care including living in more deprived areas, working in high-risk occupations, living in overcrowded conditions and, in certain ethnic communities, more likely to have pre-existing health conditions.

During the pandemic frontline workers were at a high risk because they were doing essential work in the community. Some occupations have particularly high rates of deaths from COVID-19. These include jobs that cannot be carried at home, those that require working closely with other people, low paid jobs, and jobs in construction, transport, health, and social care more likely than others to be carried out by people from BAME communities.

Housing has increasingly become a key determinant of health and wellbeing especially during the COVID-19 pandemic. During the lockdowns, households have spent a significant amount of time in their homes, reducing activity levels and for some this has increased their exposure to unhealthy and overcrowded conditions and further led to increasing inequalities.

Control measures during the pandemic have led to an increase in the gap in inequalities in early years development and educational attainment. Children living in poverty, poor housing, those with special needs and poor mental health have been particularly vulnerable to the harmful effects of the pandemic.

Some Thoughts.....

Investing to give residents the Best Start in Life, a priority from the current Health and Wellbeing Strategy, positive parenting, recognising public and inclusive education as an essential service to the community, initiatives to improve balancing family and work life, child-friendly settings, working with a focus on future generations and intergenerational support.

Reversing the impact and reducing inequalities for disadvantaged children is a challenge, but short-term interventions to reduce family poverty and food poverty and improve access to mental health services must form a central role in addressing these issues. In the longer term, identifying funding for employment and training for young people and increasing support for good mental health will be critical.

"Building back better" from the pandemic could provide an opportunity to strengthen health creation and disease prevention, in line with the early diagnosis and intervention theme within the Health and Wellbeing Strategy, to bring more sectors together around the topic of health, including mental health and to enable residents to adopt healthier, more sustainable behaviours. Community action and social cohesion during the pandemic also provides opportunities to boost local level initiatives and networks.

Addressing the social determinants of health such as poverty, education, and housing to remove barriers to health will require action at the policy and systems level. Neighbourhood design, access to healthy, affordable food and beverages, access to safe and convenient places for physical activity can all impact obesity and support prevention and early management. Policy makers and community leaders must work to ensure that their communities' environments, and systems support a healthy, active lifestyle for all according to the Health and Wellbeing Strategy.

Questions for the future:

- How do we engage with groups to better understand their experience of the COVID-19 pandemic and the inequalities they face?
- How do we better support the role of people and communities in their health and wellbeing including through coproduction, volunteering, and social movements for health?
- Why are certain ethnic groups under-represented or over-represented in response to COVID-19, what are the causal factors behind those differences?
- Addressing the social determinants of health such as poverty, education, employment and housing to remove barriers to health will require action at the policy and systems level. How can we utilise the learnings from the pandemic to address these wider issues at a system level?
- This report has highlighted many structural inequalities in access and outcomes in certain groups exacerbated by the COVID-19 pandemic. What effective community engagement and communication approaches should the Council adopt in reaching out to those vulnerable groups and marginalised communities in formulating messages that are culturally sensitive, effective and proportionate to the need?

Chapter 4:

Addressing Inequalities as part of our COVID Response and Recovery

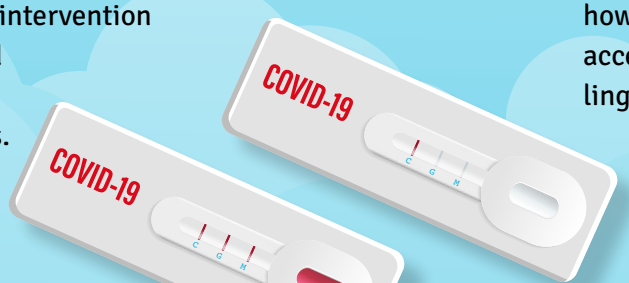
Response

The COVID-19 pandemic required a system response from our Public Health professionals, colleagues in the Council and system partners to keep residents safe and to help manage the immediate and longer-term impacts of the pandemic. In this chapter we describe some of the key actions taken in response to the pandemic, consider opportunities going forward to build on the learnings from the pandemic and how to continue this in our recovery phase to tackle inequalities effectively.

Local Contact Tracing

Contact tracing has been key during the COVID-19 pandemic, it is an important way to control the spread of infection and the process involves identifying those who have tested positive and tracing those that may have been in contact with them. Depending on the nature and duration these contacts may require further advice, testing or treatment to prevent further transmission of the disease.

Alongside Public Health England, Barking and Dagenham was one of the first boroughs to implement a local COVID-19 Contact Tracing Service. This locally delivered service steps in when NHS Test and Trace national teams cannot contact positive cases within 24 hours. It uses testing data from Public Health England to track and trace positive cases to provide them with advice and guidance on self-isolation, testing and available support offered by the council. Barking and Dagenham is among one of the few local authorities delivering face to face door knocking service for those not reached via telephone. The team ensure they contact 100% cases within 24 hours, successfully reaching over 70% of cases. The effectiveness of this service suggests the potential of this service to help support targeted intervention and help us to identify, reach out and support those with higher need and most impacted to reduce inequalities.



Test and Trace

Testing is essential for contact tracing and in breaking virus transmission pathways; it is important to prioritise testing accessibility for those who need it most. Throughout the duration of the pandemic several of our wards had high rates of COVID-19 at multiple intervals, in order to prioritise resources, we identified areas of high infection rates. Barking and Chadwell Heath had particularly high rates of infection therefore we established PCR test sites in these areas. Due to the dynamic nature of the pandemic, we identified Thames Ward as an area of high infection rate with limited accessibility to existing testing sites, we therefore set up our third PCR test centre at the Curzon Centre in January 2021.

Once lateral flow testing became available, we prioritised two sites based on the current case rates and where the need was greatest, one in Barking and the other in Dagenham. We wanted to protect our vulnerable children, so we also set up lateral flow test sites at 2 special schools to identify asymptomatic staff to protect vulnerable children from transmission. One of the key lessons learnt from this experience has been to review council services to determine how accessible they are to those who need them most. To provide a fair and accessible service we should consider location, timings, cultural differences, linguistic barriers, as well as other factors.

Community and Faith Groups

As we have established throughout this report, COVID-19 does not affect all groups of the population equally. Public health England report on 'the Impact of COVID on BAME groups' concluded that there is an association between belonging to some ethnic groups and disproportionate impact and therefore highlights the need to change the way public sector organisations communicate and engage with BAME communities.

Throughout the pandemic we have worked closely with our faith community partners to keep each other updated on guidelines, issues, and queries. The Council and the community have continued to work together to proactively address issues and provide support to our residents where needed. We have used our existing and well-established community networks to address their concerns around issues such as vaccination. The community and voluntary sector have supported us by sharing information with partner organisations and communities to raise awareness on how to stay safe. They have also alerted us to communities who may be more vulnerable to COVID-19, which has allowed everyone to come together to resolve issues.

Supporting Those in Need

During the pandemic, the Council was well-equipped to support our vulnerable residents, e.g., data platforms such as *One View* enabled the Council to accurately predict 93.6% of the individuals on the shielding list ahead of the pandemic. The early identification of vulnerable residents allowed for the deployment of interventions in a timely and practical manner to help provide food and further support, helping to manage resources and capacity effectively.

- Over 8000 shielding residents contacted to see if they need support
- 493 residents supported through Hardship Fund
- 196 residents supported through Winter Covid Support Scheme
- 807 job outcomes secured, despite Covid
- Accommodated 59 people rough sleeping, or at risk of, in emergency accommodation
- Over 1,500 parcels of food ordered and distributed through Central Food Hub
- 1,335 referrals made to BDCAN and ILA by Adult intake team
- 2,143 visits made to the Homes and Money Hub
- 20,715 calls by extended Adult Intake to support vulnerable residents
- 532 new Community Food Club members
- 731 Foodbank vouchers issued by Resident Conversation team
- 5,898 calls made to the Homes and Money Hub
- Over 1,000 businesses supported to value of £6.1m across grant schemes
- Resident Conversations called 2,157 over 60s to stay connected through Young at Heart
- Over 2,100 residents supported by BDCAN
- 1,767 attended online exercise classes

Figure 21: An overview of key facts and figures from Community Solutions since March 2020

Social Prescribing in LBBD

Over the last 12 months the council has launched its new social prescribing service to help tackle the wider determinants of health for residents. According to the national social prescribing academy 1 in 5 GP appointments are relating to social need and the wider determinants of health instead of medical need. Social Prescribing works alongside 33 GP surgeries across the borough improving access to council services.

703 onward referrals into services were made

73.9% of patients reported improved well-being

48% of patients were new to services

The Councils' frontline teams worked together with the community and voluntary sector in response to the pandemic, supporting residents who found themselves struggling due to the impact of COVID-19. This support has been invaluable in helping people to access essentials when they were shielding, managing their finances to help stay in their own homes, access food, find employment and to keep them connected when they were socially isolated.

Other initiatives run by the Council included Barking and Dagenham's Citizen's Alliance Network (BDCAN) which provides support to vulnerable residents in partnership with BD Collective (Community Voluntary sector partnership). Hubs were established across the borough run by local community organisations who connected volunteers with those who needed assistance. The service has also supported those not known to the Council or those not on the shielding list or self-isolating. As the vaccine roll out progressed, BDCAN contacted those who were vulnerable, to help book their vaccination.

As lockdown restrictions eased, the Council continued to support the residents to engage with BDCAN through one borough voice. BDCAN is still being shaped and will evolve and grow based on what our residents think, want, and need.

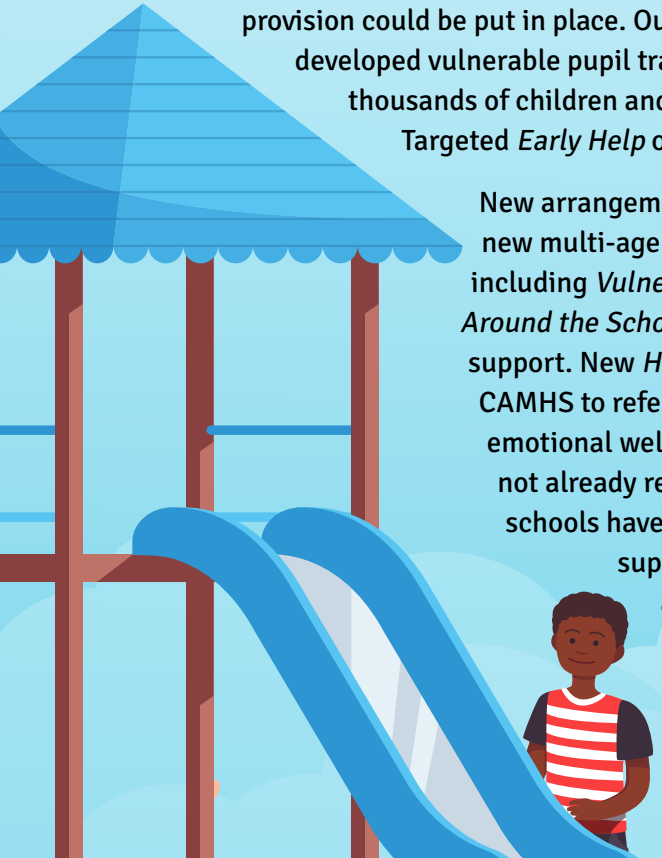
Supporting Our Children

Whilst COVID-19 does not tend to affect children directly, it has had significant indirect consequences such as disrupted education, reduced social contact with peers and long-term impacts on their physical and mental wellbeing, as discussed in chapter 3. Before the pandemic our children were less likely to reach a good level of development by the age of 5 compared to the rest of London, therefore we can assume the impact of the pandemic and its effects will have far greater implications on our own children limiting our ability to meet the best start in life priority of the Councils' Health and Well-being Strategy.

Due to the dynamic nature of the last 12 months and the challenges that have arisen Gold, Bronze and Silver Command meetings were set up within the council to manage the response to emerging risks and issues. These meetings

had a particular focus on managing response regarding vulnerable groups and safeguarding. Here emergency decisions were made to rapidly change processes and implement services to support children and families, from the provision of Free School Meals to protocols for social workers' virtual and face-to-face visits to children.

The Council and schools worked closely together to best ensure that all children were supported during the lockdown periods. This included working with *BD Together* to ensure that children eligible for Free School Meals had access to food, access to appropriate IT devices and internet provision for schoolwork. Schools remained open during lockdown for the children of key workers and vulnerable children, including those with an EHC Plan, risk assessed as having their needs better met in an educational setting. Together with community health colleagues, the complex medical needs of all special school pupils were tracked, whether at home or at school, so appropriate provision could be put in place. Our education inclusion service developed vulnerable pupil trackers with schools, to monitor thousands of children and make support available from Targeted *Early Help* or Social care where needed.



New arrangements have since been built with new multi-agency partnership meetings, including *Vulnerable Pupils' Hot Clinics* and *Team Around the School*, to track pupils and broker support. New *Hot Clinics* were established by CAMHS to refer children and young people for emotional wellbeing and support who were not already receiving CAMHS support. Many schools have undertaken further training to support children's wellbeing and resilience, since it was recognized that the last year and foreseeable future could be a challenging time.

Adult Social Care

Since the beginning of the pandemic, the Public Health team has supported adult social care colleagues and providers in care homes, supported living and domiciliary care and offered guidance and support on infection prevention control (IPC), Personal Protective Equipment (PPE) and in managing cases, clusters, and outbreaks. Public Health led on Incident Management Teams supporting care providers, covering issues including testing, infection prevention and control and vaccinations and provided a system response to dealing with outbreaks in care settings.

> "We already had people who had existing problems, but we know that because of the post-COVID economic issues that there are going to be disproportionate effects on those people who are from lower socio-economic backgrounds and there is a predominance of people from Black and Asian and Minority Ethnic groups in those lower socio-economic status backgrounds. Inequality further compounds the traumatic effects of COVID as well as the economic effects."[30]

As lockdown eases our approach towards COVID-19 will transition from response to long-term recovery. Recovery must aim to mitigate the pre-existing inequalities which lay the foundation for disproportionality not just inequalities worsened by the pandemic. The commitment to tackling inequalities is one cross-cutting theme across the system from Barking

30. Quote from stakeholder engagement sessions within the Fenton's Report involving over 4,000 people providing further insights into factors which may be influencing the relationship and impact of COVID-19 on BAME communities and approaches addressing inequalities.

and Dagenham's Ambition to the priorities of the NHS Operating Plan. The future model for recovery for health protection and improvement needs to be essentially linked with improvements in the wider determinants of health for our residents by ensuring inequalities are addressed widely throughout all council services. It is important that not only public health, but the whole council learn lessons highlighted by the pandemic and build back better to improves the lives and health of those impacted and develops opportunities that benefits all.

Recovery

Spotlight on Local Issues to Focus on for Recovery

The borough has high levels of people living in houses of multiple occupation (means more than one household under the same roof) this could be multiple different families renting separate rooms or a multi-generational household which consists of children, parents, and grandparents. A large proportion of those living in houses of multiple occupancy work in low-paid, frontline employment which may be unstable and often may not having sick pay as a benefit of the job.

The housing situation means that if they or another person in the household catches COVID-19 there is very little room for self-isolation away from other household members, and therefore they are not able to stop the spread within the household.

Their work situation also makes them 'financially fragile' and makes self-isolating difficult if they have COVID-19. Their financial situation may mean that they cannot afford to take 2 weeks off work, as they may not be eligible for financial support, and then must make a choice between doing what they are advised to do or working to earn money to keep a roof over their heads and food on the table. These are real choices that some of our residents had to make during the pandemic.

Community and Faith Groups

The community and voluntary sector have played a large role in the system-wide local response to COVID-19 and will continue to be important in the borough's recovery. The partnership working has helped increase vaccine uptake through understanding the concerns and barriers in communities to taking the COVID-19 vaccine. This has allowed us to work together within the community on initiatives such as vaccination of faith leaders, the creation of community and faith vaccine champions, vaccine Q&A sessions with local health leaders, local faith leaders and community members delivering information about the vaccine. The community-based messaging has helped improve the uptake in some of our most vulnerable and vaccine-hesitant populations. The close relationships developed within the community and voluntary sector will help support prevention and early intervention work in the future, helping to tackle mental health, social isolation and inequalities in health and its wider determinants. Through increased community engagement and using an asset-based approach we hope that we can support community and voluntary activities in their development throughout recovery increasing the power of our communities.

> "We cannot separate faith from people's lived experiences – faith is part of the solution."[31]

31. Quote from stakeholder engagement sessions within the Fenton's Report involving over 4,000 people providing further insights into factors which may be influencing the relationship and impact of COVID-19 on BAME communities and approaches addressing inequalities.

Spotlight on a Whole System Approach to Obesity

Obesity is one of the biggest health crises the country faces, disproportionately impacting certain ethnic groups. In Barking and Dagenham 72.7% of the adult population is classed as overweight or obese, placing us at the front of the crisis across London. The borough is also the worst ranked across London for childhood obesity for our Year 6 and second worst for our reception cohorts according to pre-pandemic data.

While excess weight does not increase your chances of getting COVID-19, it does increase your risk of becoming severely unwell or dying if you catch COVID-19. As an increasingly obese borough we are poised to suffer from an increased prevalence of the long-term effects of COVID, placing tackling obesity as a core priority for the system throughout recovery.

In response to the pandemic contributing to the worsening of the obesity epidemic we will work in partnership across organisations and sectors, and with residents, to ensure work tackling obesity is culturally sensitive in addressing inequalities. Both Adult and Children's weight management services will utilise the relationships built upon throughout the pandemic to offer training to community and faith groups to deliver culturally sensitive and appropriate weight management programmes.

Spotlight on Anti-Racism at LBBD

Conversations Around Anti-Racism And Next Steps

In the summer of 2020, the murder of George Floyd and the resurgence of the Black Lives Matter movement ignited a conversation around widespread racism and its impact on communities of colour in the USA and beyond. In Barking and Dagenham, hundreds of people marched to Barking Town Hall on 9th June 2020, urging people to wake up to systemic racism and make change happen. These events also happened amid the COVID-19 pandemic, which has had a disproportionate effect on marginalised groups, has served to further underscore the fact that systemic racial inequalities exist in our society.

These events affected many of us who work for the Council and prompted reflection. Teams across the Council held a variety of listening events for their staff and have given consideration as to how we may overcome some challenges as an organisation, such as the "glass ceiling effect" perceived by many black colleagues, racism experienced at work and greater understanding and empathy of the black experience. Suggestions put forward by staff will be used to shape and guide our progress to embedding anti-racist practice in our work and becoming a truly inclusive employer.

Workforce And Workforce Race Equality Standard (WRES) For Social Care

In 2020, Barking and Dagenham was one of the 18 local authorities across England to be selected as a pilot site for the WRES for Social Care. The WRES is a tool currently used in the NHS to collect data on the differences between staff of different ethnicities to begin evidence-driven action and to monitor progress against several indicators of workforce equality, including pay, progression, and likelihood of having formal disciplinary actions taken against them. Participation in the WRES pilot will aid the development of the action plan to address our workforce commitments. As a pilot local authority, our experience will inform a national report and establish the national action plan needed to improve the experience of being a BAME employee in social care today and we plan to apply the relevant learning from this to our wider workforce and encourage our partners to put in place similar actions.

STARE Network

A Staff Network was relaunched and reinvigorated in December 2020: (STARE – Standing Against Racism and Exclusion), after a number of discussions from the start of 2020. The purpose of the STARE Network is to:

1. Champion the needs and issues affecting BAME staff and the benefits of a diverse, inclusive, and fair working environment.
2. Work with the council to support and promote a culture of participation, diversity, and inclusivity where BAME staff feel equally valued and fairly treated.
3. To act as a critical friend to the Council in its aim to:
    - advance equality of opportunity, translating to equality in outcomes.
    - foster good relations within the council's workplace and the community it serves; and
    - Stop discrimination, harassment, victimisation, and any other improper conduct.

The STARE Network will be a welcome critical friend to challenge the actions the organisation takes in achieving the commitments pledged by the Council.

Economy and Employment

As already mentioned, it has been incredibly difficult for residents, with many being furloughed, losing jobs due to the pandemic, struggling to find new employment, or struggling to keep their business afloat, and many more working in sectors with low pay, no guaranteed hours, and limited job progression and training. Inclusive Growth within the Council are working hard to ensure the local economy recovers after COVID-19 with a focus on two distinct areas to shape recovery: rebuilding and reshaping our core sectors as well as nurturing and growing our new sectors.

Rebuilding and reshaping our core sectors will focus on supporting people and supporting businesses. Programmes to support people include Kickstart roles, traineeships, job shop, DWP work programs, apprenticeships, adult education, and sector specific training and skills - including employment support for the care and construction sectors. Support for businesses will include retail and care sectors focused business support programs, business grants, business engagement and support, high street reopening support, and growing our own new small-scale traders.

Nurturing and growing the new industries will increase spending on energy retrofit work and developing retraining pathways for green industries, build a supply chain for the new Dagenham film studios, and a '*Made in Dagenham skills to screen program*' developing a range of new pathways into the film sector, and a food activation program with the development of new 'food skills pathways', job brokerage and apprenticeship support. The vision for recovery is to increase the quality, progression, pay and security of jobs, by encouraging more resilient and higher value business models into the borough whilst protecting traditional employment opportunities for the area.

To ensure the income recovery is inclusive of those most impacted by the pandemic in terms of employment the government has initiated a kickstart programme for 16 to 24-year-olds struggling to enter the job market after finishing education. B*arking and Dagenham 2020 and 2021* has helped to create over 200 new job placements within 30 local businesses and the council. The Kickstart scheme job placements come with a wraparound training and support offer delivered through Barking Dagenham employment and skills team, helping to improve their skills.

Questions for the future:

- What are the key lessons learnt from COVID-19 partnership working and how can we utilise and adapt them to address the existing equality challenges in the borough as a whole system approach?
- How can we work towards recovery in education alongside colleagues to achieve a community focused approach to tackling issues for children and families such as housing, mental health, and food education to prevent obesity?
- What recovery approaches should be adopted to improve and target engagement with health improvement programmes?
- Due the impact on health and social care programmes especially the prevention and screening programmes, what can we do differently as part of the recovery learning from the key findings to improve access and outcomes whilst targeting inequalities?

Chapter 5:
The Way Forward

Following emerging evidence suggesting a disproportionate impact COVID-19 on people from Black and Asian Minority Ethnic (BAME) backgrounds, Public Health England (PHE) undertook a review of data on differences in the risk and outcomes from COVID-19.

The PHE report into *Disparities in the risk and outcomes of COVID-19*[32] (commonly referred to as the Fenton's report) found that risk of dying among those diagnosed with COVID-19 was higher in those in Black, Asian, and Minority Ethnic (BAME) groups than in White ethnic groups. The recent reinvigoration of the Global *Black Lives Matter campaign* has also highlighted that a change in our culture, approach and delivery of our community programmes is urgently needed to address this growing gap, to match the service provision with the needs of the community.

The Council started this piece work to review the inequalities within Barking and Dagenham from an age, gender, and race angle to understand what inequalities exist here, the reasons why these exist and what can be done to reduce the increasing gap. The work aims to better understand the needs of our current population which will allow us to support residents to live healthier and fulfilling lives. This piece of work will help to develop the council's development through the cultural competence continuum, Figure 22. The cultural competence continuum was designed to provide a model for organisations to reflect and assess how the Council can improve further to achieve a change both at an individual and at an organisational level to ensure that challenges presented by inequalities are addressed in a culturally sensitive manner. From what has been described in chapter 4 regarding our response and recovery approaches to pandemic and related inequalities and the future work to be undertaken to address

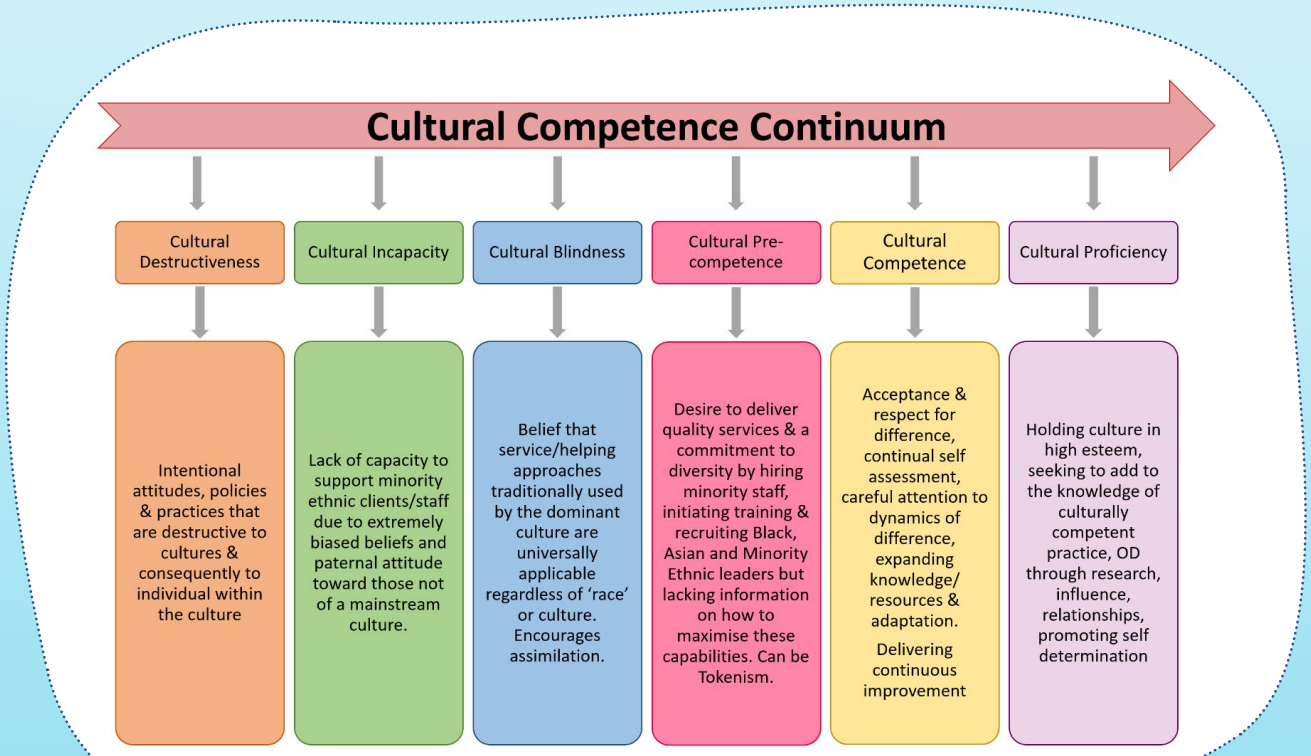


Figure 22: Cultural Competence Continuum Adapted by M. Spillett (2018) from Terry L. Cross et al 1998 & Julie Coffin 2007.

32. Disparities in the risk and outcomes of COVID-19 (June 2020), Public Health England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

the gaps as described below, it seems that we were at the cultural pre-competence level before the start of the pandemic. However, the learnings from the past 12 months and the actions taken by the Council to address the equality challenges has rightly pushed our journey towards the start of the cultural competence level but still much needs to be achieved to make further progress at this level.

The Phases of the Inequalities Work

The council formulated a council-wide Inequalities steering group consisting of Public Health, Performance and Intelligence, Behavioural Insights and Policy and Strategy teams accountable to People and Resilience Management Group (PRMG) to take this work forward. The purpose of the steering group was to examine inequalities at a population level, and within it service blocks such as People and Resilience services, to examine differences in outcomes and to identify and explore any equality challenges that might exist. The work was scoped with the key stakeholders and divided into the following phases. Phase I work was completed in May 2021 and represents this Annual Public Health report. Phases 2 and 3 are being led by the council's corporate team.

PHASE 1

- Identifying key messages from published reports
- NHS COVID-19 data analysis
- Data analysis at a population level to understand the risk factors
- Interactive sessions with key stakeholders to discuss the findings and the way forward

PHASE 2

- Directors to identify equality challenges in their service areas
- Data analysis to further explore equality challenges to help identify any inequalities including access to services and gaps in service provision plus qualitative analysis and to identify actionable insight

PHASE 3

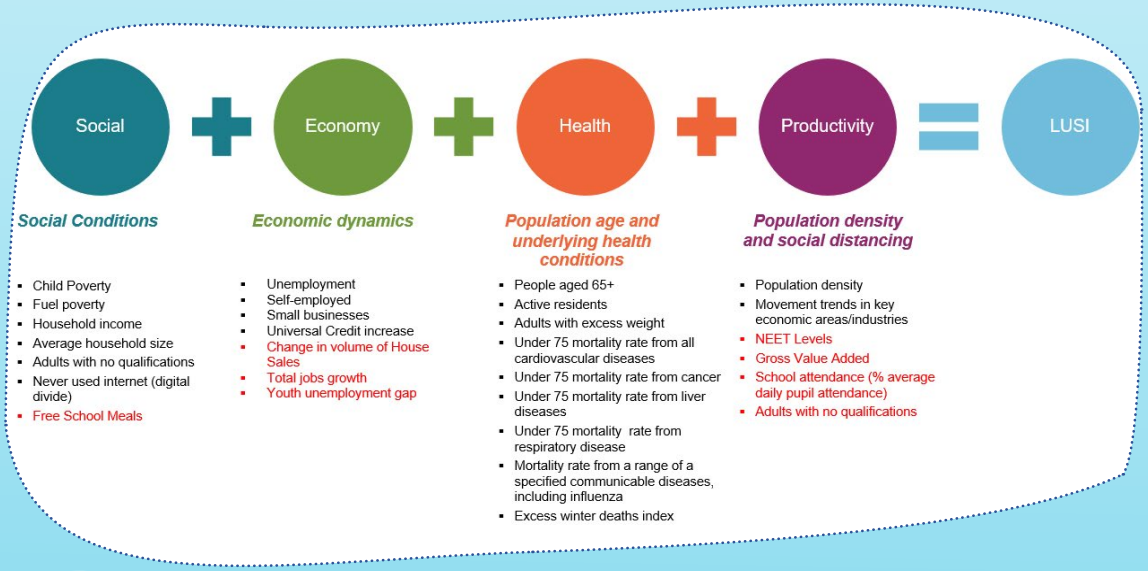
- Engaging communities and services
- Analysis used to inform the development of the next Corporate Plan

As we approach the end of 2021, the scope of the work will be expanded to include the wider population level equalities challenges facing Barking and Dagenham and its residents, considering the full range of protected characteristics where possible.

The insight and innovation team have developed a high-level model (below) that compares structural inequalities across various dimensions such as social, economic, and health. The dimensions take into consideration many of the wider determinants of health through the analysis and findings discussed in chapter 2. The model, levelling up from structural inequalities (LUSI), is designed to support the council's levelling up funding bids and visualise social economic inequalities in comparison to greater London. As the tool is further developed, more datasets will be built into the analysis thus strengthening our position in gaining funding to address inequalities in the future. The tool shows high levels of multidimensional inequality are largely concentrated in North East London boroughs. Barking and Dagenham and Newham seem to be the worst in London based on these four dimensions. Early results illustrate how systemic and structural deprivation has led to disproportionate levels of risk and outcomes from COVID-19 in Barking and Dagenham. It is intended that the above model is refreshed quarterly, providing the Council and its partners with a strong lobbying position.

The analysis that emerges from this approach will play a central role in the development of the Council's strategy for 2022-26, as set out in our next Corporate Plan.

The LUSI Tool



An integrated view

Combining all four dimensions of the model provides the following integrated view:

The tool shows high levels of multidimensional inequality are largely concentrated in North East London boroughs. Barking and Dagenham and Newham seem to be the worst in London based on these four dimensions.

What are the Key Questions the Report Raises for Further Discussion, Debate, or Exploration?

The report gives a snapshot of the inequalities picture in Barking and Dagenham and raises some important insightful questions to take this work forward. The report has been helpful to understand and highlight the equality issues that already existed and have been further highlighted by the pandemic. This work started further interest in the areas that were not explored at a population level. There were some local findings that did not align with the national picture such as some of the ethnic minorities were less effected by COVID-19 than expected despite having all the risk factors for COVID-19 and inequalities.

> "It's important that we reframe how we work with communities. We shouldn't wait for the data reports before taking action, but should be thinking now about what to do differently."[33]

There are a few key findings in the report highlighted by the individual chapters and the questions it raises. However, there are a number of unanswered questions, and these will need further exploration to understand the reason why these inequalities exist, who they affect, and how we might address them – i.e., the aim to reduce these inequalities and to achieve our vision. As part of the consultation and engagement process with key stakeholders and partners, we held workshops with teams within and outside the Council and at the Barking and Dagenham Partnership Board to discuss the key findings, start discussion on important findings and to raise a few suggestions and queries, as follows:

Key Themes and Questions

Further Exploratory Work

- How can we better collect data to capture the nuances of ethnicity to better identify inequalities in access, outcome and therefore improve approaches to reducing inequality through better messaging and service design in the future?
- Why have some community groups reacted differently to COVID-19 as compared to the national picture? Are there any cultural or access barriers or any behavioural factors which make them less or more vulnerable?

Barking and Dagenham System Partnership

- What role can the Council and its partners play in reducing health inequalities at all levels across the health and social care system including the wider determinants of health?
- What are the key lessons learnt from COVID-19 partnership working and how can we utilize these to address the equality challenges as a whole system approach?
- What approaches can the Council and its partners adopt in recovery strategies e.g., via B&D Partnership to actively reduce inequalities caused by the wider determinants of health to create long term sustainable change?
- Due to the significant indirect impact of COVID-19 on children and young people (CYP), we need to work jointly as a system towards recovery especially in early years and education to achieve a community-focused approach to tackling issues for children and families such as housing, mental health, food, education, and health. With the current list of priorities, how can the borough partnership play a key role to help reduce inequalities in this area?

User Engagement and Involvement

- How do we engage better with high risk and vulnerable groups to understand their experience of the COVID-19 pandemic and how it has exposed and widened the inequalities they face?
- How do we value, harness, and support the role of people and communities in their health and wellbeing including through coproduction, volunteering, and social movements for health?

Recovery

- How do we ensure that our resources, time, people, and assets, are targeted and balanced to the needs in our community?
- How can our work on economic recovery focus on creating well-being?
- How to integrate population health approaches including risk-stratification to plan and design our service delivery to target the vulnerable groups in the community?
- How can we further develop and utilize Levelling Up Structural Inequalities (LUSI) tool to bid for national and local funding to address structural inequalities?

Communication

- What evidence-based and culturally sensitive communication strategies should we adopt especially in the wake of the pandemic to ensure that our population understands what support we and our partners offer and how they should be able to access these effectively?

Future Proofing our Services

- How can we future-proof our services looking at the existing and widening health inequalities and the rapidly changing demographics e.g., with a significant increase in the BAME identifying population?

Next Steps

The Council is reviewing its Equality and Diversity Strategy in the light of the COVID-19 impact on inequalities. In the future, we will not have a separate Equality and Diversity Strategy. Instead, our Corporate Plan 2022-26 will describe and be centred around our key equalities objectives, with a new document in our Strategic Framework setting out the major challenges related to poverty, racism and structural inequality facing the Council, our borough, our wards and its residents. The questions raised by this report will sit at the heart of this analysis.

Acknowledgements

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Consultations:

Following groups were formally consulted to discuss the findings.

Adult's OMT, LBBD on 19 May 2021

GP Federation, B&D on 26th May 2021

Education OMT, LBBD on 08 June 2021

STARE Focus Group, LBBD on 17th June 2021

ComSol OMT, LBBD on 23rd June 2021

B&D Delivery Partnership Board on 25th June 2021

Disabilities OMT (virtual), LBBD on 29th June 2021

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Supporting Documents and Appendices:

Appendix 1: COVID-19 Risk Factors

- Ethnicity: BAME at a higher risk of getting infected and dying as compared to white ethnic groups. BAME groups are less likely to seek help & support when needed.
- Gender: Men are at greater risk of dying than women.
- Occupation: 1 in 5 Londoners who died were of working age. Workers in 'low-skilled' categories were at the greatest risk of dying. High risk occupations for men were construction, security, public transport drivers and for women caring, leisure, and other service occupations.
- Deprivation: Diagnosis rates are higher and mortality rates are more than twice as much in the most deprived areas than the least deprived areas in England.
- Age: Older people are at much higher risk of dying e.g., 80 yrs. or more, 70 times more likely to die compared to those under 40.
- Vulnerable groups: at a higher risk include: children with EHC plans, those missing vaccinations, on shielding list , adults with dementia and learning disabilities and care home residents.
- Overcrowding: People living in overcrowded or multigenerational homes are at higher risk of infection. ONS data shows only 2% of White British households experienced overcrowding versus 30% Bangladeshi, 16% Pakistani and 12% Black households.
- Air pollution: Harvard research found that a small increase in long-term exposure to fine particulate matter (PM2.5) leads to a large increase in the COVID-19 death rate and transmission.

Appendix 2: Key recommendations from the Fenton's Report

The following recommendations from the Fenton's report equally apply to our North East London Health and Social System.

Recommendations from Fenton's report:

- Mandate comprehensive and quality ethnicity data collection and recording in NHS and social care data collection systems, including at death certification.
- Support community participatory research to understand the social, cultural, structural, economic, religious, and commercial determinants and to develop solutions.
- Improve access, experiences and outcomes of NHS, local government and Integrated Care systems commissioned services including audits, equity in workforce and employment and rebuild trust.
- Accelerate development of culturally competent occupational risk assessment tools for a variety of occupational settings.
- Fund, develop and implement culturally competent COVID-19 education and prevention campaigns in partnership with local BAME and faith communities.
- Accelerate efforts to target culturally competent health promotion and disease prevention programs for non-communicable diseases.
- Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change.

Thank you

for reading our report

To find out more please visit:
www.lbbd.gov.uk/health-and-wellbeing-strategy

Barking & Dagenham