Barking & Dagenham, Havering and Redbridge
Joint Strategic Needs Assessment Profiles.

London Borough of Barking and Dagenham

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v4.1 2021

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Executive Summary

This is a refresh of the BHR JSNA 2020, with where possible there is a reflection on the impact of the Covid-19 pandemic The BHR JSNA 2020 was the first attempt at creating a single view of the challenges facing the partners represented at the BHR ICPB if they are to improve the health and wellbeing of people resident in the three boroughs and their experience of the health and social care system.

The differences between the three boroughs e.g., in terms of population structure, diversity, levels of disadvantage etc. are marked and are explored in the detail of this report. Nonetheless, the major challenges faced by the health and social care system are similar in all three boroughs and it is these overarching issues that are highlighted here.

Population growth has affected all the three boroughs in recent years. Further very significant growth, equivalent to the population of another borough, is predicted in the next 20 years. Population increase will be particularly high in areas identified for significant house building including Barking Riverside, Rainham, Romford and Ilford. New housing may have a significantly different (e.g., younger) demographic than the existing community. Otherwise, the existing population is projected to age; the very elderly cohort, with the most complex health and social care needs will see the greatest growth.

Health outcomes in BHR - Life expectancy has increased steadily over the last few decades but more recently the rate of improvement has slowed if not stopped entirely and much of the additional years of life achieved are marred by ill-health and dependency on health and social care services. Moreover, there are marked inequalities in health outcomes between communities and population groups.

Attaining good health for all is not in the sole gift of health and social care services. The health of future generations will be determined by the extent to which they:

- are born into loving, secure families and enter school ready to learn.
- are encouraged to aim high and achieve the best they can in school, further and higher education; to attain the qualifications and skills that will equip them for later life
- gain good employment that pays enough to enable them to fully participate in their community
- have safe, secure housing that adapts to their needs as they change through life
- live in communities that:
    - make healthier choices the easy and obvious choice
    - offer support and encouragement throughout life but particularly in times of need, including periods of poor physical and mental health and later in old age
- and finally have access to high quality health and social care services proportionate to their needs

To emphasise the many factors impacting on health outcomes, the JSNA describes the needs of the BHR population in terms of the 'four pillars of population health'[1].

Population health outcomes			
The wider determinants of health	Our health behaviours and lifestyles	The places and communities in which we live	An integrated health and care system

The lead agency for local action regarding the first three pillars will be Councils working with partners at borough level. NHS agencies have the opportunity to maximise the potential health benefits of relevant plans via participation in each borough's **Health and Wellbeing Board**[2] and through the newly formed **Place Based Partnerships and Integrated Care Board sub committees**[3], recently introduced through the Health and Social Care Act 2022. In addition to the crucial impact on the health of future residents, these plans will afford the opportunity to tackle some of the problems facing the health and social care system e.g. plans for **regeneration** could deliver a step change in the quality of local primary care facilities and offer key worker housing to attract hard to recruit health and social care professionals to live and work in BHR. The JSNA also highlights opportunities for health and social care services to contribute directly to improve the life chances of local residents e.g., by fulfilling their role as **'anchor institutions'** at the centre of the local community and economy.

Various international studies suggest that health and social care services contribute about 25% to the overall health of the population and immense benefit to individual patients. However, existing models of care are failing to deliver further improvements in population health and are struggling to cope with the challenge of demographic change, with much more to come.

In these circumstances far greater emphasis must be placed on **prevention** in its widest sense.

[1] Kings Fund 2018 A vision for population health – towards a healthier future https://www.kingsfund.org.uk/publications/vision-population-health

[2] To facilitate this, the JSNA comes in three variants: each presenting a bespoke analysis for one of the constituent boroughs within the BHR system regarding the wider determinants, lifestyle related behaviours and health related aspects of place and community.

[3] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

Addressing the wider determinants of health e.g., by improving educational attainment, employment opportunities or enabling someone to live in a safe secure home undoubtedly prevents physical and mental ill-health in the longer term. Similarly, recognition that exposure to Adverse Childhood Experiences (ACEs) increases the risk of a range of negative outcomes in later life opens up another approach to prevention. Nationally over half (55%) of people feel their health have been negatively impacted by the rising cost of living.

The places and communities in which we live affects our health in a variety of ways. Currently living in cities inevitably increases exposure to air pollution which causes significant harm to health. Local partners can minimise their direct contribution; put in place the infrastructure to enable residents to switch to electric vehicles and public transport, or better still walk and cycle choosing routes that minimise their exposure to pollutants.

Smoking has become far less common than previously and is increasingly limited to disadvantaged communities and specific population groups (e.g., people with SMI) where our efforts should now be focused. More recently, vaping has helped many more people to stop smoking and partners should actively encourage this trend.

But in working with residents to promote healthier lifestyles and behaviours we must recognise that our day-to-day decisions are shaped by how and where we live. The best example of this being obesity. For an increasingly high proportion of residents, obesity begins in childhood and will continue throughout life, greatly increasing their lifetime risk of a range of conditions including diabetes, CVD, cancers and MSK problems. Obesity will not be solved by simple advice to eat more healthily; we need to employ a whole system approach using all the levers available to assist residents to get a better balance between calories consumed and energy expended.

The analysis of the challenges facing the local health and social care system[4] is structured around the life course.

Population growth results in additional pressure on all services. The problem is particularly acute for maternity services, which have finite capacity and are already close to that limit. Social disadvantage and increases in levels of maternal obesity result in a significant number of complex pregnancies. So, in addition to action to further improve maternal and infant outcomes, action is needed to create additional capacity for low risk, midwife led deliveries in the community so hospital capacity can be focused on higher risk pregnancies.

Happily, most children are born in good health. Nonetheless, maternity and health visiting services offer essential support to all parents at a time that inevitably brings new and sometimes significant challenges. In addition, they can identify those families that are

[4] The JSNA commentary provides a single analysis regarding the whole BHR health and social care system as overarching priorities and policy will be agreed for the system as a whole. In addition, data are provided at borough and locality level to inform decisions regarding how BHR policy will be implemented locally.

struggling enabling early intervention e.g., to ensure children are ready to learn by school age.

A small proportion of children are born with or develop significant and lifelong problems. Children with Special Education Needs and Disability (SEND) may need support from health, social care and education professionals. The most common type of need is mild to moderate learning disability followed by speech, language and communication needs. The needs of a subset of children are captured in an Education, Health and Care Plan (EHCP). Autistic Spectrum Disorder is the most common primary need identified in EHCPs. Recent changes in legislation and understandable increases in parental expectations have combined to make SEND an area of financial concern to local government. Some children with particular needs have to be bussed long distances, at great expense, to specialist provision or in exceptional cases are in residential placements out of borough. Greater cooperation between boroughs may enable the creation of more specialist capacity, closer to home and at lower cost.

The mental health of children and young people is a significant and growing concern. CAMHS capacity is increasing significantly in response but even so, only a minority of CYP with a diagnosable condition will be under the care of specialist services at any point in time. Further effort is needed to improve the capability of GPs to support CYP with mental health problems and engage services commissioned by schools to make the most of overall capacity and ensure that cases are escalated when needed. In addition, there is a need to build the resilience of our CYP and give their parents, teachers, social workers etc. the skills and knowledge to identify and help CYP with mental health problems.

Safeguarding must be a priority for all partners. Early identification and intervention protects the child in the short term and reduces the likelihood of poor outcomes in later life associated with Adverse Childhood Experiences (ACEs). In most circumstances, it remains in the best interest of the child that they remain under the care of their parents with additional support. However, for some CYP, the best option is that they be taken into care. All looked after children (LAC) will have had complex and difficult childhoods; many will have mental health problems; often coupled with poor educational attainment; their long-term life chances are significantly poorer than the norm. Support to LAC from all partners should extend beyond timely access to excellent treatment and care to include support with housing and opportunities to gain employment e.g., in health and social care services.

Successful transition from children's to adult services is crucial to accommodate the changing needs of young people over time. Moreover, their eligibility for services and the team providing their care is also likely to change. Thorough and early planning is essential.

One in four adults experience mental illness and the total harm to health is comparable to that caused by cancers or CVD. Hence, it is right that the NHS is now committed to giving mental health parity of esteem with physical health. As with physical ill health, the burden of disease shows marked inequalities and there are significant opportunities to prevent mental illness throughout the life course. The impact of the wider determinants on mental health is particularly marked. Factors like debt, unemployment, homelessness, relationship breakdown

and social isolation predispose to mental illness. Action to address the wider determinants can aid recovery but people with mental health issues, particularly serious mental illness are much less likely to have stable accommodation or be in work. A coordinated, proactive approach on the part of multiple agencies is necessary. People in the criminal justice system and street homeless have particularly complex problems often including concurrent mental illness and drug and alcohol dependency. A relatively small number of patients live with serious mental illness. Priorities for action include a timely and effective response to crisis and action to reduce the gap in life expectancy between people with SMI and the population as a whole. A far bigger number of people are living with a common mental health condition. The ongoing development of IAPT has greatly increased the provision of talking therapies but further work is needed to increase uptake and achieve outcomes comparable to the best. At the same time, action is needed to increase the capacity and capability of primary care to better support the bulk of people living with mental health problems. Alongside improvements in care, action is needed to tackle stigma; build resilience and improve awareness of effective self-help options.

Cancers, with CVD, remains the big killer. A significant proportion of all cases are caused by avoidable risk factors like smoking, obesity and alcohol and hence are essentially preventable. Early detection remains the key to improving survival. Further effort is needed to increase public awareness of the early signs and symptoms of cancer and increase participation in screening programmes, particularly as a result of the Covid -19 Pandemic. Additional capacity, dependent on both more equipment and professional staff, is needed to facilitate timely diagnosis and subsequent treatment. As survival improves – and the incidence of disease increases with population ageing, more people are living with and beyond cancer; sometimes with significant ongoing health problems associated with treatments received.

Many people are at increased risk of developing cardiovascular disease (CVD) due to a combination of lifestyle and physiological risks factors. A significant proportion do not know they are at high risk of heart attacks and stroke. This despite the fact that NHS health checks are regularly offered to residents to identify this very risk.

This illustrates a more general observation that the number of people known to have a range of long-term conditions (LTCs) is considerably lower than expected indicating that a large number of cases remain undiagnosed and untreated. Hence our approach to the identification of residents with or at risk of a range of LTCs needs to be improved; making more of NHS health checks; complemented by community based, opportunistic interventions to engage people who don't normally attend their GP and ensuring that GPs regularly check patients with one condition for other LTCs – as they tend to share the same risk factors.

There is also strong evidence suggesting that a proportion of people with an LTC diagnosis miss out of one or more interventions that would reduce their risk of disease progression. Further improvement in the management of common LTCs is necessary to maximise the benefits of secondary prevention.

A small but growing proportion of residents live with multiple LTCs. Existing services struggle to meet their complex needs and as a result they frequently attend A&E and/or have unplanned hospital admissions. Although small in number, a disproportionate amount of resource is expended achieving less than satisfactory outcomes.

Similarly, frail, older people are at high risk of admission to hospital. Admission can lead to a rapid decline in physical abilities, equivalent to a year's additional age for each day of admission. Such deterioration can very quickly make a return home impossible.

The current model of care resulting in large numbers of A&E attendances and unplanned admissions in response to both relatively minor complaints and regular crises, some of them avoidable, is not improving population health outcomes, gives patients a poorer experience of care and is increasingly unviable financially given the significant and recurrent financial deficit affecting the BHR health and social care system.

A significantly different approach to organisation and delivery of health and social care is required.

We need to make better use of information to inform population health management as well as the clinical management of the individual patient. Stratification of the population by life stage and complexity of need will improve the planning and delivery of services for specific patient cohorts:

- People who are generally well who will benefit from primary prevention interventions to maintain good health; with more intensive support where people are currently well but at risk of developing LTCs.
- People with long term conditions, who in addition to the primary prevention interventions above, will benefit from early identification and treatment of LTCs, personalised care planning, self-management support, medicine management and secondary prevention services.
- Older people with complex needs or frailty, who in addition to the interventions above this cohort would benefit from a case management approach offering integrated, holistic, personalised, co-ordinated care with a high degree of continuity.

In each case, the precise interventions and delivery mechanisms will vary through the life course and in response to social factors. The NHS Long Term Plan sets out a very clear path for regarding the care of people with the most complex needs. It pledges to end the distinction between primary care and community services. Rather it envisages a new model, delivered within localities by general practices acting together as Primary Care Networks (PCNs), with community teams, social care, hospitals and the voluntary sector working together to help people with the most complex needs, to stay well, better manage their own conditions and live independently at home for longer. At times of crisis, a new NHS offer of urgent community response and recovery support will act as a single point of access for people requiring urgent care in the community; provide support within two hours of a crisis and a two-day referral for reablement care after discharge. Residents in care homes, some of the most vulnerable

patients will benefit from guaranteed NHS support providing timely access to out of hours support and end of life care when needed.

The extension of personalisation from social care to health care services will see the whole package of care brought together in a care and support plan reflecting the needs and assets, values, goals and preferences of the individual.

Development of personalised care plans is an opportunity to reset the relationship between professional and client focusing less on deficits and what they need by way of services and more on what they can do and the assets available to them including family and wider social networks. The role of health and social care being to provide any additional support and / or aids necessary, for a limited period, to return them to their former level of functioning and independence.

Developing the multidisciplinary and multiagency team necessary to deliver this new model of care for complex patients; involving non-professional peer support and voluntary sector input in addition to professional and statutory health and care staff will be an immediate and significant challenge for emerging locality teams.

But better management of complex patients will not of itself improve health outcomes and achieve a sustainable balance between the needs of a growing and ageing population and the capacity and capability of local health and social care services.

Greater capacity will be needed in the community if the far bigger group of residents with or at risk of a LTCs are all to be identified and thereafter managed in line with best practice. The introduction of new professional groups e.g., clinical pharmacists and physician assistants to complement GPs and practice nurses will help. As will better coordination and collaboration between practices working within PCNs; facilitated by improvements to premises and IT.

Innovative methods will be needed to identify residents who are at risk of disease who currently don't engage with general practice. The use of wearable technology will enable people to better understand and take more control over the management of their health.

Equally, health professionals and public will need to recognise the impact of personal circumstances and place on health and look beyond health care for more effective ways of improving wellbeing. Strong links between general practice, other statutory services such as housing and the Department of Work Pensions, the community and voluntary sector within the locality should be an essential element of locality working. The development of an effective social prescribing function; whereby patients are actively encouraged to access other forms of support will maximise the likelihood of success e.g., with 1:1 support from a care navigator. Partners and the community itself will also need to consider the assets available relative to needs and how any gaps may be filled[5]. Approaches such as local area coordination are needed

[5] The current JSNA currently describes the need for health and social care services at BHR and borough level. Data are provided at locality level and in the coming year, Public Health Services intend to work with developing locality teams to identify priorities for each.

to strengthen the capacity of communities to identify and support vulnerable people and hence reduce pressure on statutory services.

The switch to a more preventative approach will not be achieved by health and social care services alone. Currently many thousands of residents miss potentially lifesaving interventions such as immunisation and cancer screening or turn down the opportunity to have a NHS health check. Others will delay seeking help when they notice changes to their body that subsequently turn out to early signs of cancer.

We can and must seek to improve knowledge and awareness e.g., the 'be clear on cancer' campaign and remove any barriers to engagement by offering screening and health checks out of working hours or in the workplace.

However, people's decisions about engagement with health services and more widely regarding behaviours that impact on health are not made in isolation but rather are shaped by the place which they live, prevailing cultural norms, their previous experiences and aspirations for the future. A focus solely on the health and social care is not enough. We come back to the message underpinning this JSNA – that we cannot achieve significant improvement in health outcomes and a reduction in health inequalities without tackling all four pillars of the population health model.

Although not the lead agency, the health and social care system should give equal priority to the direct contribution it can make to tackling the wider determinants of health, throughout the life course e.g. by minimising exposure to and the harm caused by adverse childhood experiences; improving income and aspiration by creating apprenticeship opportunities for CYP in disadvantaged communities; helping people with physical and mental health problems into work or a secure home and reducing social isolation amongst older people.

1. Introduction

This family of profiles was produced at the request of the Barking, Havering and Redbridge Integrated Care Partnership Board (ICPB). The BHR ICPB brings together elected members, clinicians and officers from the three Health and Wellbeing Boards coterminous with the developing Barking Havering and Redbridge Integrated Care System (ICS).

Health and Wellbeing Boards have a duty to conduct a Joint Strategic Needs Assessment (JSNA) describing the current and future health, care and wellbeing needs of the local community to inform local decision-making.

Profiles have been produced for each of the three constituent boroughs and contain data regarding the 11 localities within the ICS.

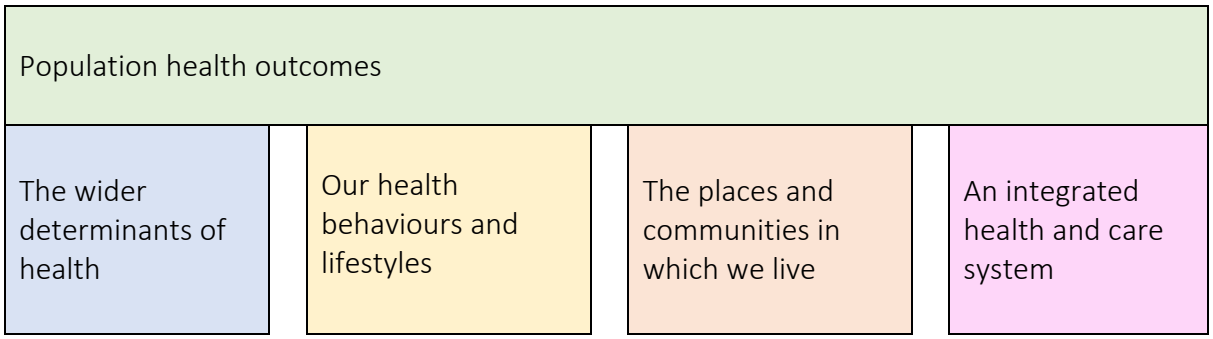
The process followed in developing the profiles is summarised here. They are a first attempt at producing a JSNA in a consistent way across the developing BHR ICS. An interactive, on-line product will be available in the near future.

Suggestions as to how the next iteration of the BHR JSNA can be further improved would be welcomed and should be sent here

NB. These profiles are designed to complement not replace existing borough based JSNA products.

Structure of the BHR JSNA profiles

The health of the population reflects the interaction of a variety of different factors. The framework for population health developed by the Kings Fund describes these factors in terms of four pillars underpinning health outcomes.



Various studies suggest that health and care services contribute about 25% to the overall health of the population. Therefore, any approach to maximise good health must address all four pillars or miss significant benefits to local residents and the opportunity to mitigate ever-increasing demand for health and social care services.

The JSNA profiles replicate the four pillars; a brief description of the local population is followed by a description of health outcomes in the area and a commentary regarding each of the four pillars. Each element of the report is accompanied by a dashboard containing a small number of relevant metrics. The commentary provides an interpretation of the data presented and suggests high-level priorities for action.

The commentaries regarding the first three pillars are unique to the individual borough profile as the lead agency for relevant plans and policies is likely to be the Council working at borough level. NHS partners in the ICPB have the opportunity to influence these plans to maximise the potential value to health via participation in borough level Health and Wellbeing Boards.

The commentary regarding the integrated care system is common to all three profiles as all partners are agreed that the overall approach to the development of integrated health and social care services will be agreed at BHR level and implemented at locality level.

Data are provided at locality level; Public Health Teams will engage with professionals leading the development of locality working in the coming year to agree a commentary regarding need at locality level and priorities for action.

2. The Population

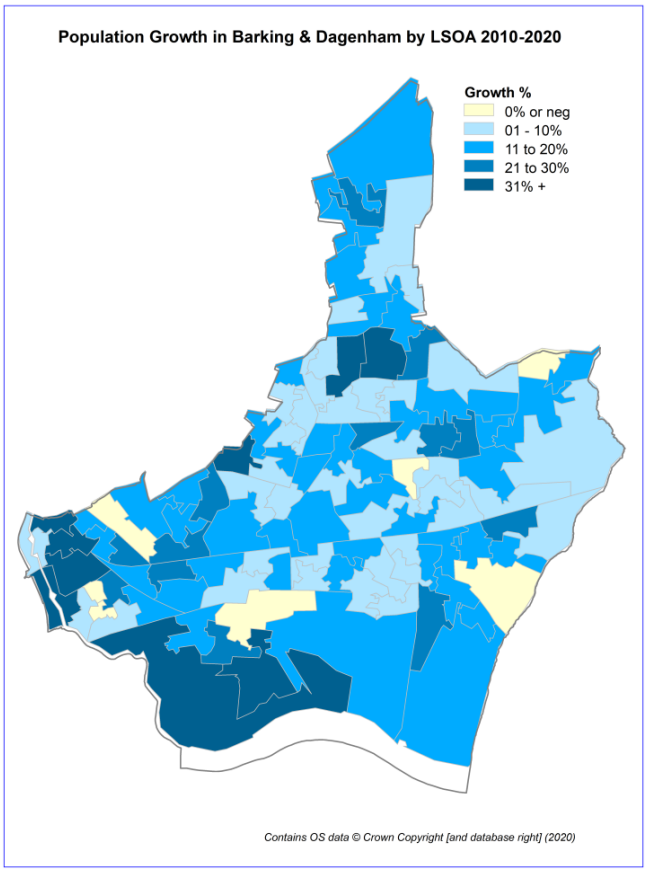
**Indicators and data used in this section can be accessed by clicking here*

2.1 Population Size & Growth

The resident population of Barking and Dagenham in 2020 was estimated to be 214K[6].

The population registered with a Barking and Dagenham GPs in 2021 is 187K[7]. The Barking and Dagenham GP registered population is 22% of the total patients registered with a GP in the 3 BHR boroughs.

Figure 1: Population Growth in Barking and Dagenham by LSOA 2010-2020



Source: ONS mid-year population estimates.

The population resident in Barking and Dagenham is estimated to have increased by 31K (17%) in the ten years from 2010.

Over the same period, population growth varied at ward level from 55% in Thames to 5% in Gascoigne (Figure 1).

Further significant population growth is likely within Barking and Dagenham, the population is projected to grow by another 4.4K (2.0%) from 217K in 2022 to 222K in the ten years to 2032.

[6] Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

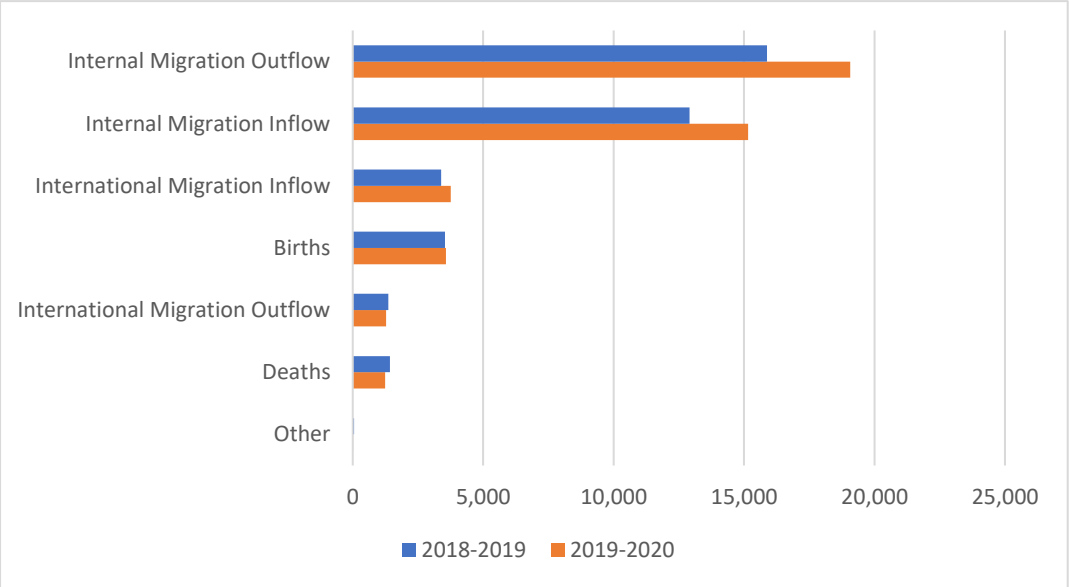
[7] B&D GP registrations derived from the UK Health Security Agency, Covid-19 Situational Awareness Explorer Portal. Vaccine Data - Power BI

Local and national impacts of COVID-19 pandemic on population changes

Rate of population change in Barking and Dagenham before the COVID-19 pandemic (2019-2020) is similar to population changes during the pandemic (2020-2021) (Figure 2). It has been noted that nationally internal and cross-border migration may have reduced in 2020 for reasons such as difficulties in travelling to different areas, changing personal circumstances, reduced job opportunities and an increase in people working from home[8]. However, local data does not indicate any significant changes.

Since March 2020, there have been significant national changes in international migration and mobility as well as a fall in the number of visa application issued for work and study to non-EU nationals[9]. This may explain the reduction in the rates of international migration into and out of Havering between 2019-2020 and 2020-2021.

Figure 2. Population Churn Estimates for 2018-19 and 2019-20



Data Source: ONS Mid-Year Population Estimates: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

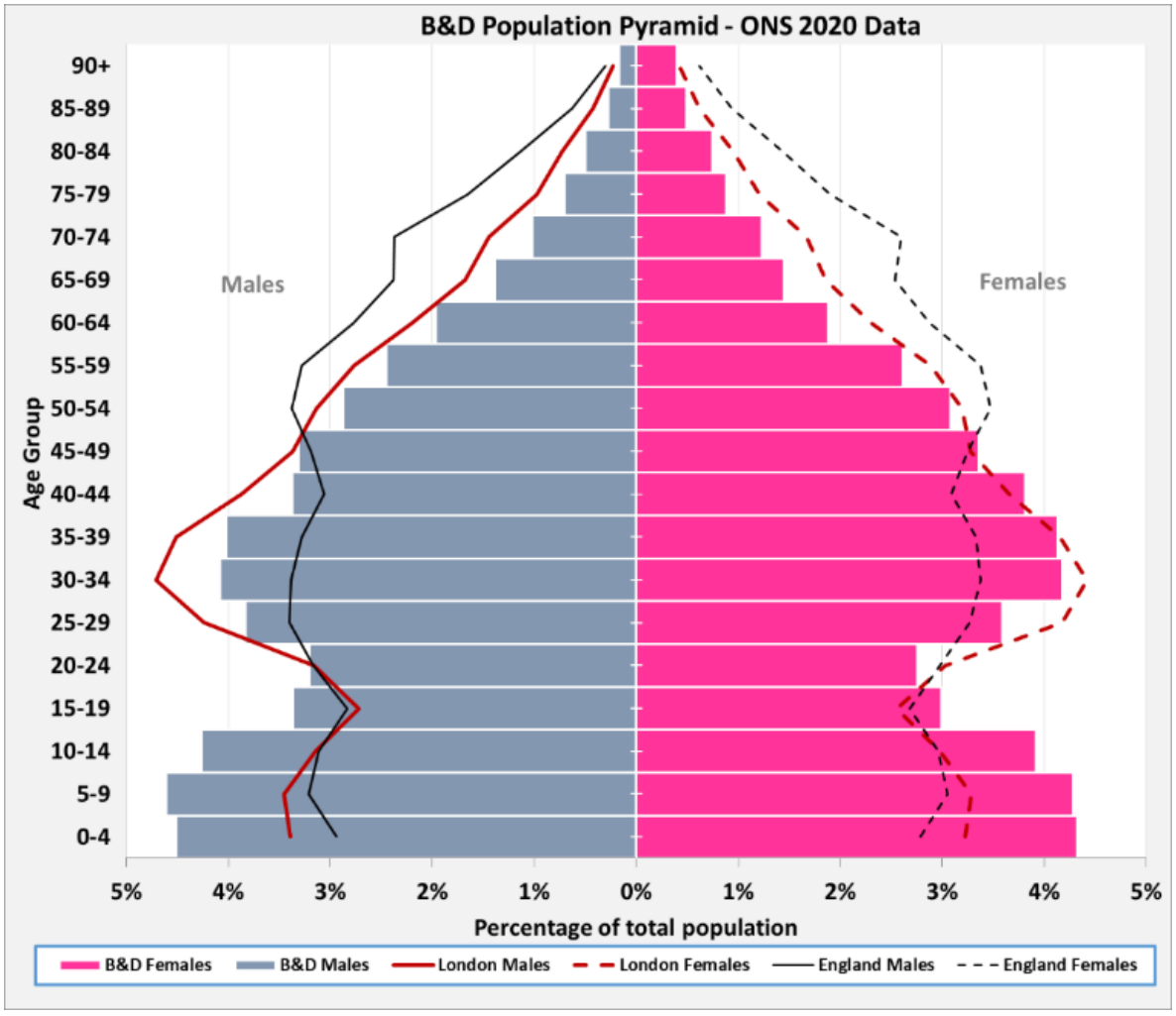
[8] Office of National Statistics 2021. What could impact the impact of COVID-19 be on UK demography? Available at: https://blog.ons.gov.uk/2020/12/07/what-could-the-impact-of-covid-19-be-on-uk-demography/

[9] Office of National Statistics 2020. International migration and mobility: what's changed since the coronavirus pandemic. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/articles/internationalmigrationandmobilitywhatschangedsincethecoronaviruspandemic/2020-11-26

2.2 Age Structure

After population size, age structure is the biggest single determinant of need for health and social care services.

Figure 3. Barking and Dagenham Population Estimates 2020



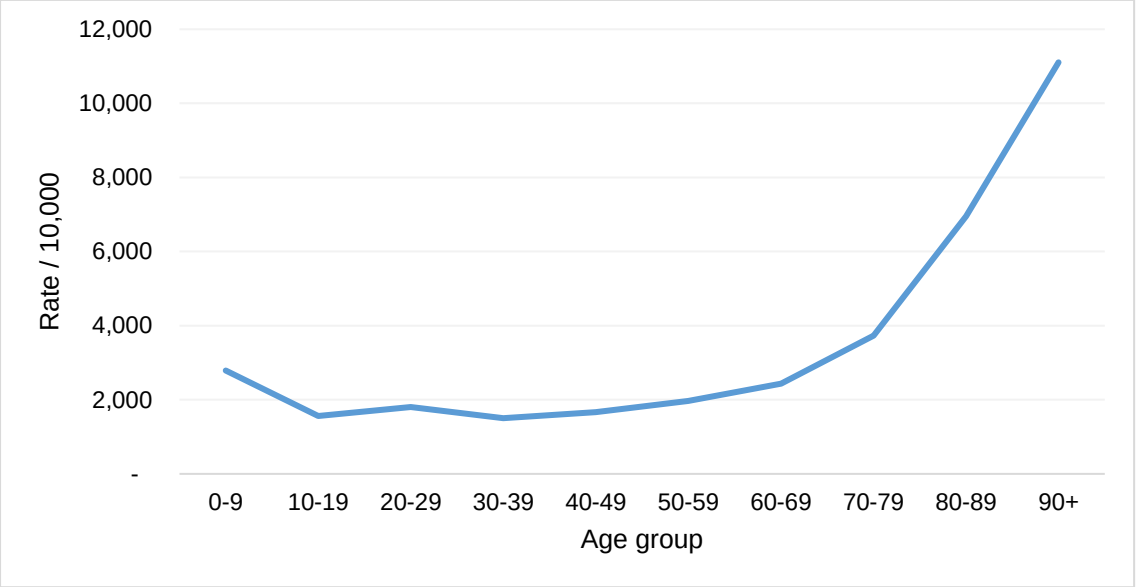
The population of Barking and Dagenham is a relatively young population compared to the aggregate population of London. Residents aged 9 and under make up 13.4% of all London residents, but 17.7% of Barking and Dagenham residents. Age groups containing residents aged 20 and over make up a smaller percentage of the Barking and Dagenham population than the London population, but the underrepresentation is modest. Underrepresentation peaks in adults aged 25-29, who make up 8.4% of the London population but 7.4% of the Barking and Dagenham population who are therefore underrepresented by 1.0%. Underrepresentation in the adult population of Barking and Dagenham reduces as age increases, reducing to 0.1% in the population aged 90 and above.

As well as growing, the age profile of Barking and Dagenham population is also projected to change with proportionally greater growth amongst older age groups. All age groups

containing residents aged 40 and older are projected to increase in absolute terms and as a percentage of the Barking and Dagenham population by the year 2030. The population of residents aged 60 and over is expected to increase by over 5.3K by the year 2030. Conversely, younger age groups are expected to contract in absolute and percentage terms over the same period, indicating an aging population projection.

The use of health services typically exhibits a 'j' shaped curve with much higher use in the first weeks of life and later in old age (Figure 4). For example, people aged 80-89 are 4 times more likely to attend A&E than adults aged 40-49 years. Utilisation of health and social care services is likely to be proportionally higher in Havering due to its relatively old population (see **Chapter 7.6 Older People & Frailty**).

Figure 4. BHRUT Hospitals A&E Attendance rate based on BHR CCG Population 2019-20



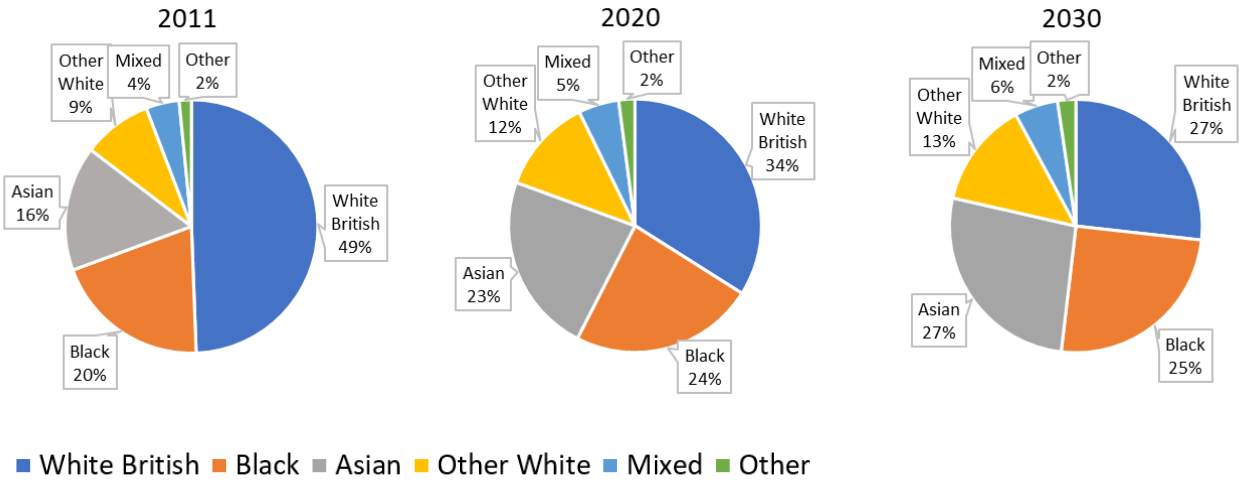
Source: NHS Digital

2.3 Ethnicity

Ethnicity influences health outcomes via multiple routes e.g., experiences of discrimination and exclusion, as well as the fear of such negative incidents, can have a significant impact on mental and physical health. Health-related practices, including healthcare-seeking behaviours, also vary between ethnic groups. Just as importantly, there are marked ethnic differences regarding the wider determinants of health. Taken together these factors result in a complex picture such that some minority ethnic groups appear to have better health status than the White British population and some much worse; with the pattern differing with life stage, disease and risk factor. Hence, it is difficult and potentially misleading to make generalisations. Nonetheless some groups, notably individuals identifying as Gypsy or Irish Traveller, and to a lesser extent those identifying as Bangladeshi, Pakistani or Irish, stand out as having poor health across a range of indicators.[10]

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf

Figure 5. Barking and Dagenham change in ethnic populations, 2011-2030



Data Source: GLA 2016-based Demographic Projections, 2017

Barking and Dagenham has become more ethnically diversity in the years from 2011 to 2020. The borough's BAME population made up 41.8% of the total population in 2011, in 2020 it has risen to 53.9%.

Projections of the population in Barking and Dagenham in 2030 estimate the borough is set to become more diverse. By 2030, BAME residents are projected to make up 59.7% of the borough's population.

Barking and Dagenham is a more diverse borough than Havering but has a smaller percentage of its population made up of BAME residents than Redbridge.

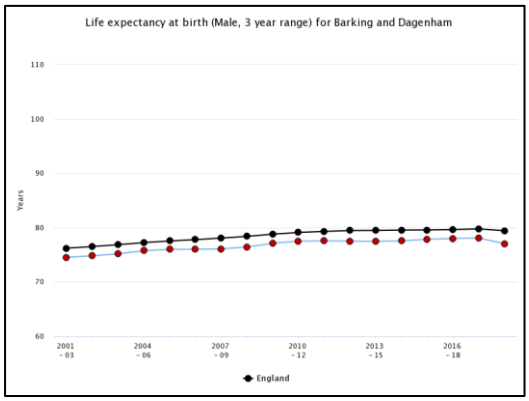
3. Population Health Outcomes

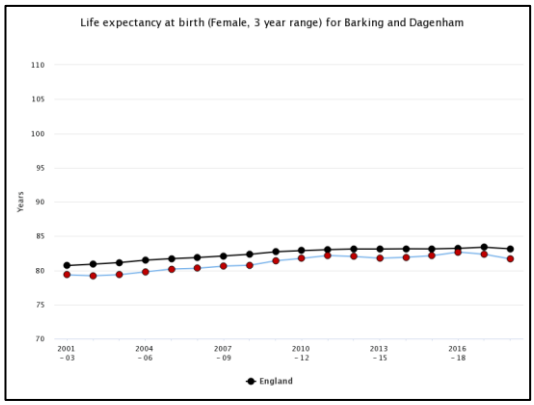
**Indicators and data used in this section can be accessed by clicking here.*

As is the case nationally, life expectancy at birth in Barking and Dagenham has increased steadily over recent decades but the rate of improvement has slowed markedly since 2000.

The most recent data available at borough level, for the period 2018-2020, shows that life expectancy in Barking and Dagenham reduced for both men (by 1.1 years to 77.0 years) and women (by 0.6 years to 81.7 years) and remains significantly worse than the national averages, which also experienced a downturn.

Figure 6 & 7: Female & Male Life Expectancy at Birth Barking and Dagenham 2018 -2020





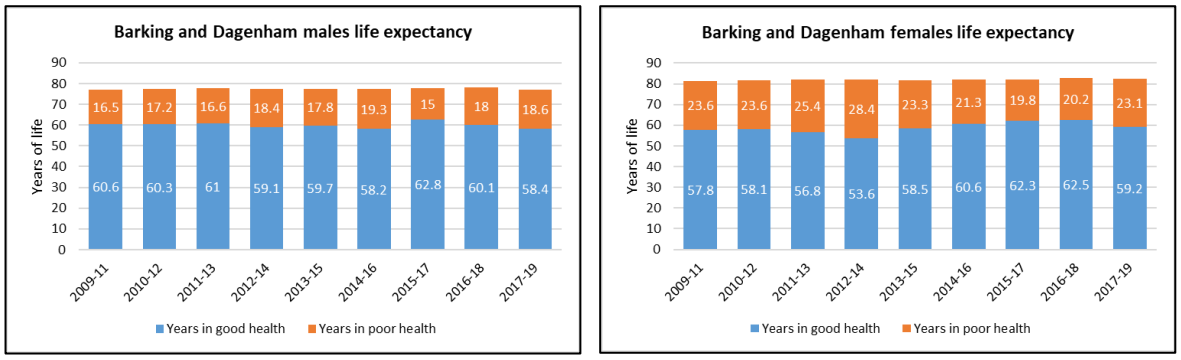
Source: PHE Fingertips

The impact of the pandemic is only partially captured in this period and a further reduction in life expectancy is likely when data for 2021 are included in borough level estimates (further analysis of life expectancy during pandemic at national and regional level is provided over leaf).

The pandemic is also likely to leave a legacy of persistent ill-health and disability. A summary of our early understanding of Long COVID is provided as section 7.5 and the implications for mental health in section 7.3.

This additional burden of ill-health will further emphasise the trend established before the pandemic whereby a significant proportion of life expectancy (19% for men and 23% for women) is impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services.

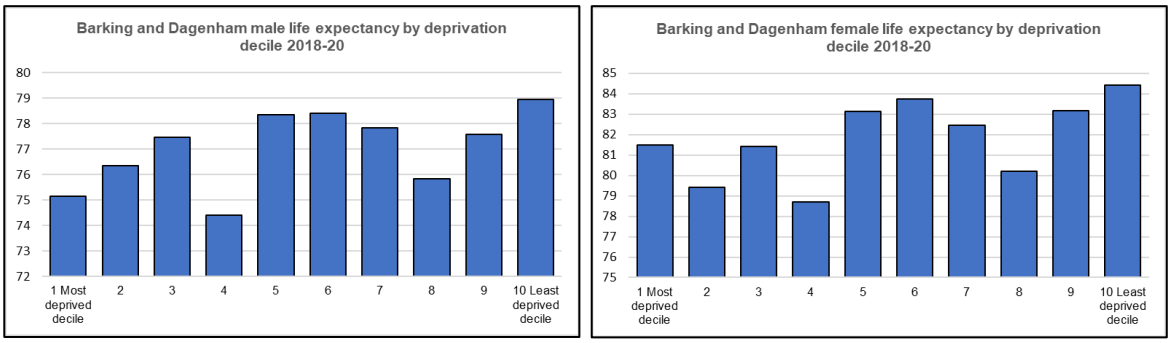
Figures 8 & 9: Barking and Dagenham Life expectancy 2009-11 to 2017-19



Source: Public Health England

Residents living in the most disadvantaged decile of the borough have a significantly lower life expectancy (3.8 years for males and 2.9 years for females) than peers in the least deprived decile (Figures 10 & 11).

Figures 10 & 11. Barking and Dagenham Life expectancy by Deprivation Decile, 2018-20



Source: Public Health England

As well as lower life expectancy, national evidence shows people living in disadvantage have proportionally less healthy life expectancy than less disadvantaged peers.[11]

Impacts of COVID-19 pandemic on life expectancy and death rates

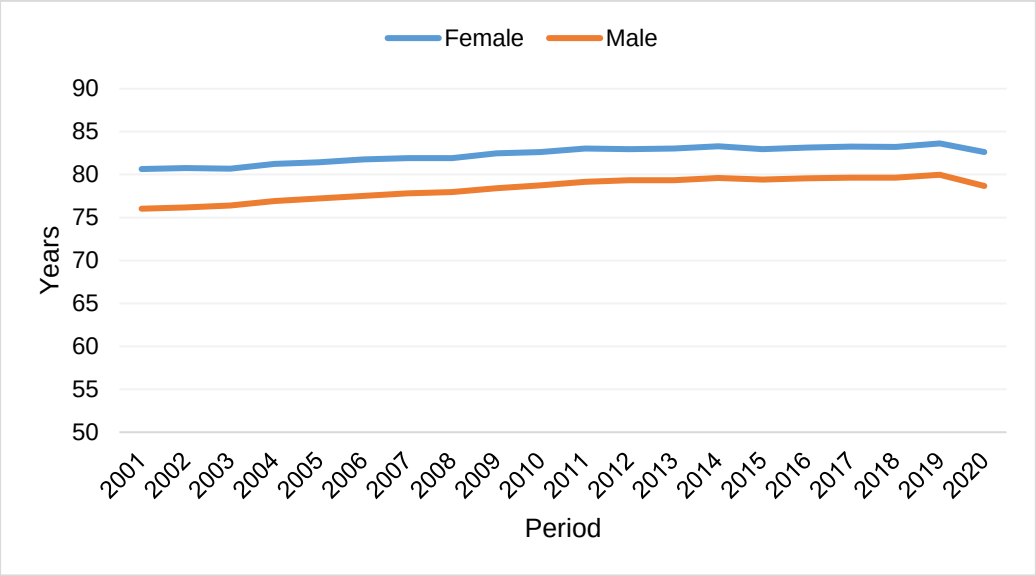
National impacts

The COVID-19 pandemic has had both direct and indirect impacts on life expectancy. Direct impacts being deaths from COVID-19 and indirect impacts including higher rates of otherwise avoidable deaths due to late presentation and/or impaired access to healthcare. The very high level of excess deaths due to the pandemic caused life expectancy in England to fall in 2020, by 1.3 years for males and 0.9 years for females [12] (Figure 12). This was the lowest life

[11] Life expectancy and healthy life expectancy at birth by deprivation - The Health Foundation
[12] Public Health England, Health Profile for England 2021. Found at: https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html#summary-5---life-expectancy (accessed 11 November 2021)

expectancy since 2011 for males and females. Regional data show that London experienced a still larger fall in life expectancy between 2019 and 2020 for both males (2.5 years) and females (1.6 years).

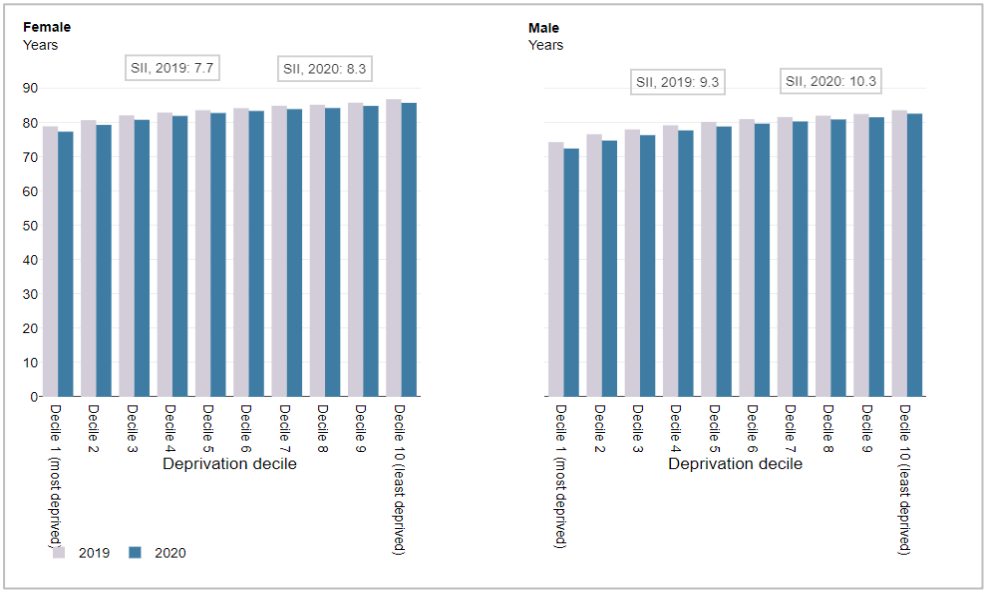
Figure 12. Life expectancy at birth, by sex, England 1981 to 2020



Source: Office for National Statistics

The COVID-19 pandemic has further increased inequalities across England, with the largest fall in life expectancy seen in the most deprived areas (Figure 13). The inequality in male life expectancy between the most and least deprived deciles of England was 10.3 years in 2020, 1 year larger than in 2019. For females, the gap was 8.3 years in 2020, 0.6 years larger than in 2019.

Figure 13. Life expectancy by Deprivation Decile, England, 2019 and 2020



Source: PHE Wider Impacts of COVID-19 on Health (WICH) tool

Similarly, the pandemic has replicated pre-existing inequalities between different ethnic groups. After adjusting for a number of different confounders, men of Black ethnic background

were 2.0 times more likely to die with COVID-19 than White males and females 1.4 times more likely. Males of Bangladeshi, Pakistani and Indian ethnic background also had a significantly higher risk of death (1.5 and 1.6 times respectively) than White males.[13]

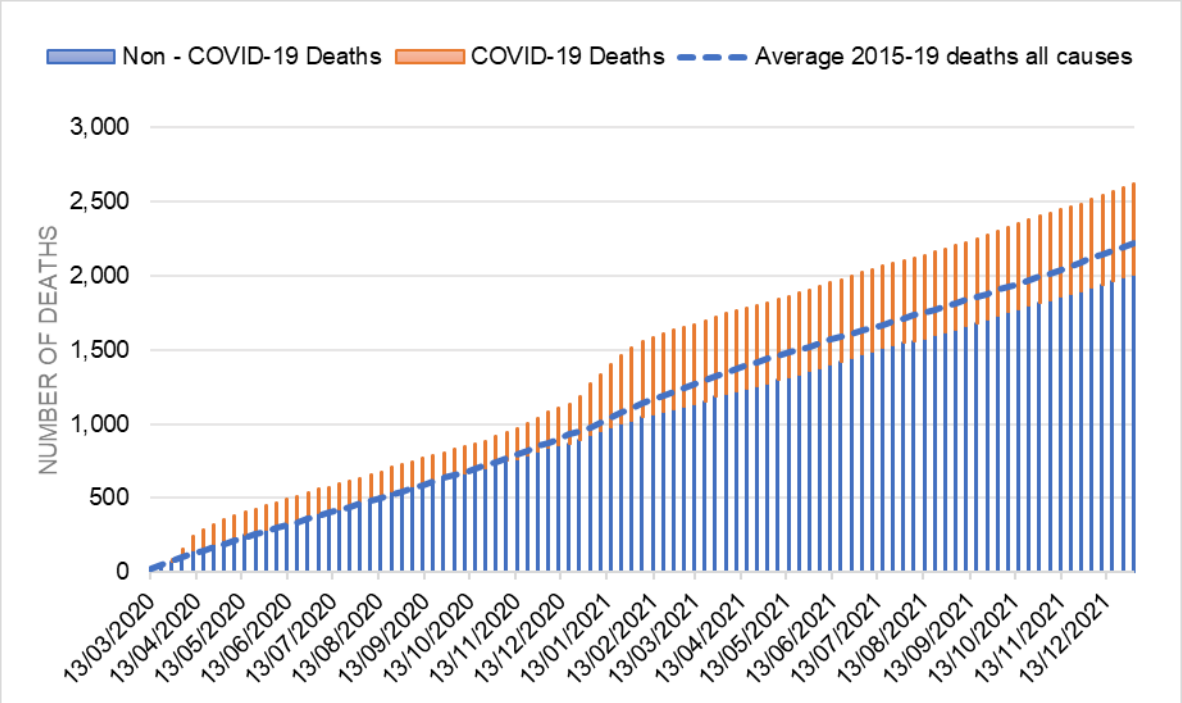
The causes of these inequalities are complex and in part reflect underlying inequalities in the wider determinants of health. In addition, a suspicion of statutory services, including the NHS and greater levels of hesitancy regarding vaccination have been implicated.[7]

Local impacts

Due to small numbers, life expectancy at borough level is calculated based on a rolling three-year period, currently 2018-2020. As such, the majority of the time period predates the pandemic. Nonetheless, life expectancy fell by 1.1 years to 77.0 years for men and by 0.6 years to 81.7 years for women and the size of the fall is likely to grow further as the period of analysis shifts to include the second year of the pandemic.

Figure 14 shows the cumulative number of deaths of Barking and Dagenham residents from March 2020, when the first death with coronavirus death was registered through to December 2021. Two distinct periods of excess mortality are evident, the first in April – May 2020 following the first wave of the original Wuhan variant, followed by another in January to February 2021 associated with the second wave caused by the Alpha (Kent) variant. Over the 20-month period as a whole, there were 610 deaths where COVID-19 was recorded as a contributory factor and the total number of deaths from any cause was 18% higher than the average in the preceding 5 years.

Figure 14. LB Barking and Dagenham, Weekly Cumulative Number of Registered Deaths in 2020-21 and the average over 2015-19



[13] Disparities in the risk and outcomes of COVID-19 (publishing.service.gov.uk)

Total registered deaths from 13th March 2020 to 31st December 2021	2,615
Total Average 2015-19 Deaths All Causes / Expected Deaths	2,220
Total Excess Deaths	395
Total COVID-19 related deaths	610
Total Non-COVID-19 deaths	2,005

Source: ONS Mortality Data

Deaths from COVID-19 have diminished but not stopped entirely as the protection afforded by vaccination was rolled out to more of the population from December 2020 onwards.

Higher rates of death from other causes such as cancers and cardiovascular disease are likely to continue as health and social care services recover from the cumulative impact of the pandemic.

The huge recovery challenge faced by the health and social care system should not obscure the fact that prior to the pandemic, communities elsewhere in England and abroad achieved much better health outcomes than those seen in Barking and Dagenham i.e., residents enjoy longer life expectancy, and a greater proportion of that longer life is lived in good health.

This is not because they benefit from significantly better health and social care services – although this maybe the case. Rather it is because they enjoy more favourable social-economic conditions and live in communities and environments that better support health and the adoption of healthy lifestyles.

Therefore, to achieve our aspiration of reducing inequalities and better health for all we must create the conditions that support good health as well as improving care services. Robust plans regarding all four pillars of population health are essential, taking into account the impacts of the COVID-19 pandemic.

This is the business of a wide variety of statutory agencies; private enterprise and communities themselves operating locally, nationally and internationally. Borough level Health and Wellbeing Boards (H&WBs) and new placed based partnerships (as part of the NEL ICS) offer a forum for partners to challenge the robustness of relevant local plans as a whole and ensure the health and social care system makes a full contribution as set out in the recommendations made in subsequent sections.

Recommendation 1: *All partners should participate in borough level H&WBs and placed based partnerships, to take the opportunity to ensure there are robust plans in place regarding all four pillars of the population health model.*

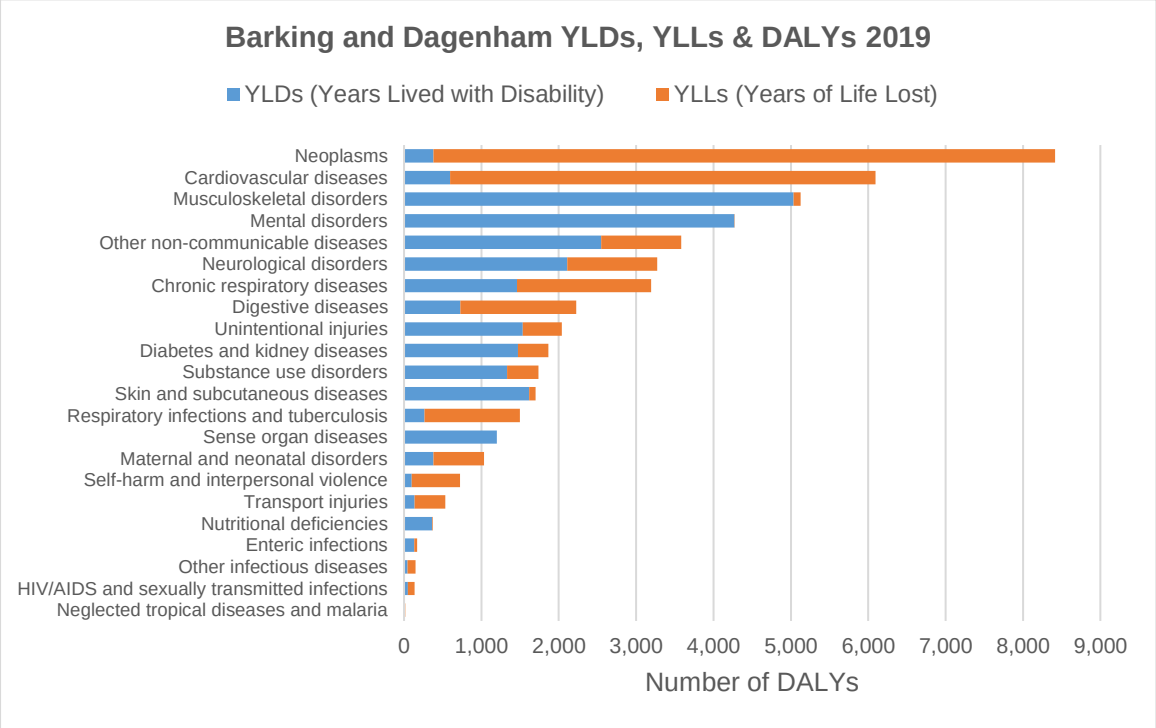
Life expectancy and other measures based on death rates highlight diseases that result in early death. Considerable harm to health is also caused by diseases that primarily result in prolonged illness and disability.

DALYs (Disability Adjusted Life Years) are a means of combining years of life lost (YLLs) due to premature death and the years of healthy life lost due to disability (YLDs) into a single measure of harm to population health.

Pre-pandemic, neoplasms (cancers) and cardiovascular diseases (e.g., heart attack and stroke) caused the greatest loss of good health as measured in DALYs, largely due to premature

mortality. Musculoskeletal conditions and mental health disorders caused the next greatest loss of DALYS but as a result of years of healthy life lost to disability.

Figure 15. Barking and Dagenham YLDs, YLLs & DALYs, 2019



Data Source: Global Burden of Disease, 2019

Recommendation 2a: *Plans regarding integrated health and social care services (pillar 4) should give the same priority to conditions resulting in ill health and disability as for conditions causing premature death.*

In the same vein, as we come out of the pandemic, we must remember that as well as the large number of lives lost, many survivors of COVID-19 infection will face persistent ill-health and disability as a result of Long Covid (see Section 7.5).

The opportunity to reduce the harm caused by premature death and long-term illness through improved prevention and treatment and care is discussed in sections 7.5. Prevention and treatment are equally important, and both must be at the heart of the developing integrated care system.

Recommendation 2b: *All partners within the developing integrated care system must give prevention and treatment equal priority if they are to succeed in improving health, narrow inequalities and provide high quality, affordable health and social care services.*

The health and social care system will face a massive recovery challenge as the pandemic recedes. This explored in some detail in section 4.2.

Simply reinstating traditional models of care will not suffice and learning can be gained from new ways of working needed through the pandemic. The health outcomes achieved for resident's pre-pandemic lagged behind the best and varied such that some communities and population groups experienced significant and persistent inequalities. Much of the ill health seen was both predictable and preventable.

As such, the case for a partnership of NHS, local authority and voluntary sector bodies, working together to deliver integrated health and social care services, informed by a population health management approach, is stronger than ever.

Recommendation 2c: Plans regarding the recovery of health and social care services from the pandemic are essential but must not divert from the commitment to adopt a population health management approach that seeks to prevent ill health and pre-empt crises by the timely, proactive offer of support, care and effective treatments to an empowered and informed population.

4. Pillar 1: The Wider Determinants of Health

**Indicators and data used in this section can be accessed by clicking here*

The wider determinants of health e.g., income, employment, education, housing etc. are the most important drivers of health/ill-health at population level.

They are the fundamental cause (the 'causes of the causes') of health outcomes, and health inequalities will continue so long as significant social inequalities persist.

4.1 Income

Income affects health in a variety of different ways:

- living on a low income is stressful and directly impacts on physical and mental health
- an adequate income enables us to buy health-improving goods and participate more fully in society
- low income is associated with unhealthy behaviours (See chapter 7.2)

People are unable to make healthy choices, as even before the pandemic three in four (74%) people living in the greatest deprivation would have to spend 75% of their disposable income to meet healthy eating guidelines; in Barking and Dagenham this would be over half (54%) of the population are in lowest 2 deciles.

Concerns that have been raised from the community include:

- Being unable to pay for medicines and care (e.g. 'prescription poverty', dental poverty)
- Poverty (e.g. 'eat or heat' decisions, increasing debt)
- Mental health and wellbeing of children and young people
- Social isolation
- Unhealthy weight and obesity (unable to afford good food an exercise)
- Generational unemployment

Median gross weekly pay of people living in Barking and Dagenham (£643pw) is below the London average (£728pw) but slightly higher than the England average (£613 pw). However, earnings of people who work in Barking and Dagenham (£623) are very similar to the England average suggesting that residents who work outside the borough e.g., commute into central London, attract a slightly higher rate of pay than peers who work locally.[14]

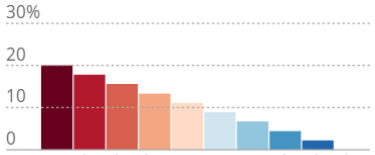
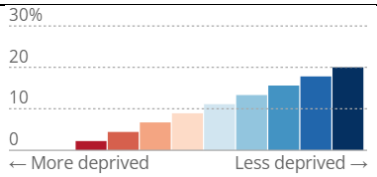
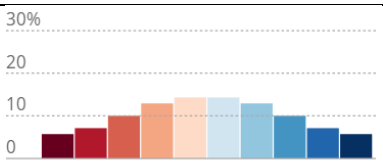
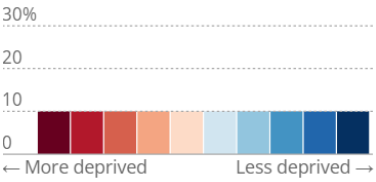
The proportion of adults in Barking and Dagenham that are income deprived[15] (19.4%) is higher than the national average (12.9%) and is the 2nd highest of the 32 London boroughs.

[14] ONS (2021) Annual survey of hours and earnings – residence analysis NOMIS Labour Market Profile - Barking and Dagenham

[15] IMD - Income Deprivation - score - measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people who are out-of-work, and those who are in work but who have low earnings (and who satisfy the respective means test).

ONS has grouped local authorities into four distinct income deprivation profiles according to the distribution of deprivation within them (see Table 1 below). Barking and Dagenham has a more income deprived profile with more neighbourhoods towards the deprived end of the scale.

Table 1: ONS income deprivation profiles

Income deprivation profile	Distribution graphic	Text description	Examples
More income deprived		More neighbourhoods towards the deprived end of the scale	Barking and Dagenham, Newham, Waltham Forest, Hackney, Tower Hamlets
Less income deprived		More neighbourhoods towards the least deprived end of the scale	Brentwood, Bromley, Kingston upon Thames, Richmond upon Thames
'n' shaped profile		More neighbourhoods with close to average levels of income deprivation	Havering, Redbridge, Barnet, Harrow
Flat profile		Similar % of neighbourhoods at all levels of income deprivation	Basildon, Southend, Bexley, Merton, Croydon

Source: Exploring local income deprivation (ons.gov.uk)

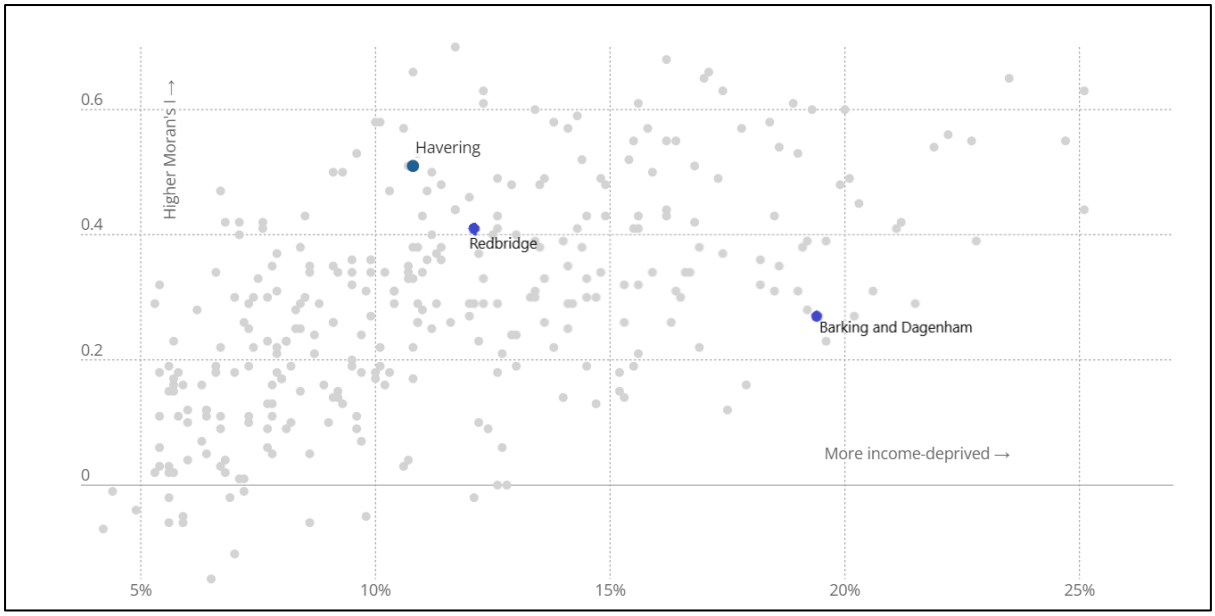
Approximately 39,000 adult residents in the borough are income deprived overall, and there is significant variation across Barking and Dagenham.

In the least deprived neighbourhood in Barking and Dagenham, 8.7% of people are estimated to be income deprived. In the most deprived neighbourhood, 34.1% of people are estimated to be income deprived. The gap between these two figures, the internal disparity in income deprivation is 25.4 percentage points in Barking and Dagenham. Generally, the local authorities in England with the greatest internal disparity (around 50%) have the highest levels of income deprivation overall. Local authorities with the smallest internal disparities, around 15%, tend to be rural, high income, and non-coastal.

ONS use a metric called Moran's I to quantify the extent to which neighbourhoods with higher levels of income deprivation are clustered together or alternatively, distributed evenly

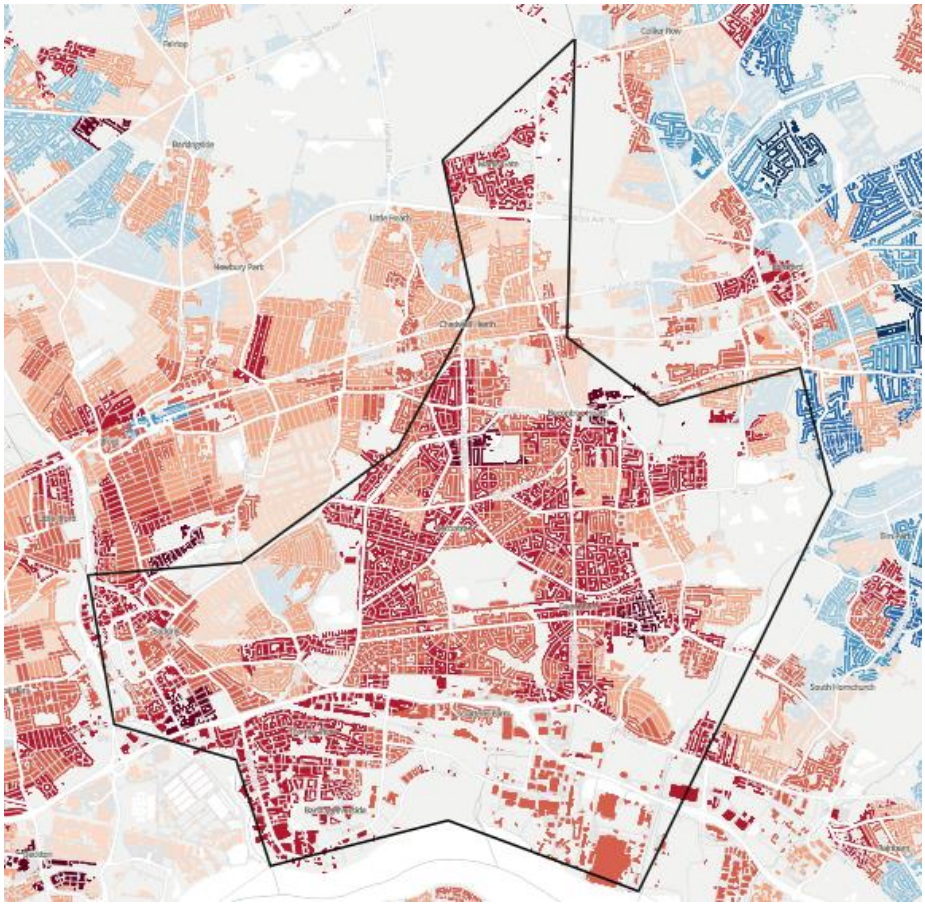
throughout a local authority. The Moran I is measured from -1 to +1, where +1 is highly clustered, 0 is random and +1 is highly clustered or separated. Generally, there is an association such that authorities with high levels of overall income deprivation have a high Moran's I (around 0.6) whereas areas with low levels of income deprivation have a low Moran's I (around 0). Barking and Dagenham has a Moran's I score of 0.27 as there is a relatively even spread of more income deprived residents across the borough. 49 of the 110 neighbourhoods in Barking and Dagenham were among the 20 percent most income-deprived in England. Clusters in the borough with very high levels of deprivation were Old Dagenham Park and Village (MSOA 014D), Central Park and Frizlands Lane (006C) and Gascoigne Estate and Roding (021B, 021C, 021F). No neighbourhoods in Barking and Dagenham were in the 20 percent least income-deprived in England, Eastbrook End (003B), which nears the border with Havering is one area with there are less deprived residents in Barking and Dagenham (see Figure 17).

Figure 16. Income deprivation by Moran's I, English local authorities, 2019



Source: Exploring local income deprivation (ons.gov.uk)

Figure 17. Distribution of income deprivation at neighbourhood level, Barking and Dagenham, 2019



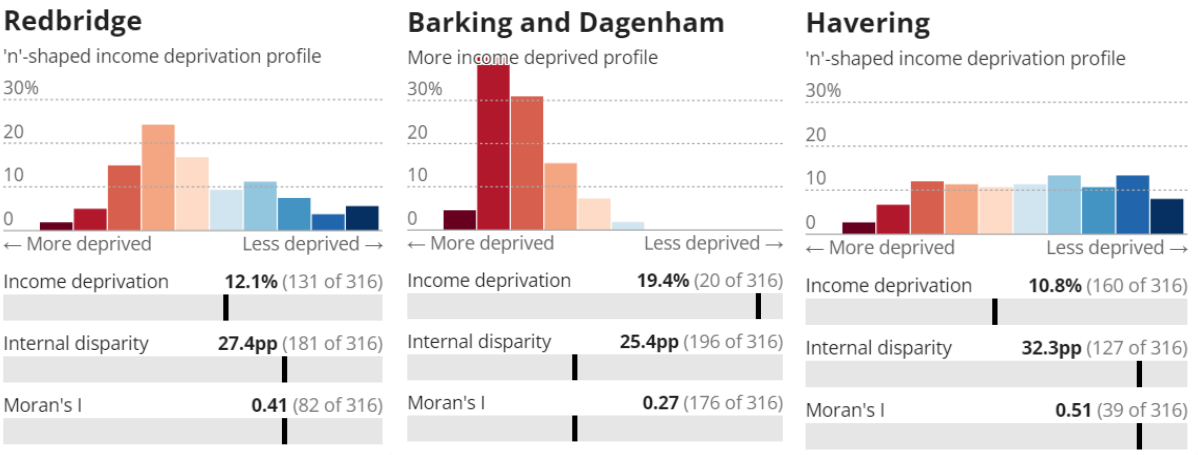
Source: Exploring local income deprivation (ons.gov.uk)

To avoid inequitable access to services, and reduce inequality in life outcomes, including health inequalities, decision makers must ensure that resources and service provision are married to the level of need at locality, if not sub-locality level, consistent with the principle of 'proportionate universalism'[16] advocated by Marmot et al[17].

The extent and distribution of income disadvantage is very different in each of the three BHR boroughs. In the case of Barking and Dagenham, the pockets of very high deprivation in the aforementioned areas have significantly greater need and will need proportionally greater resources.

[16] Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are universally available and able to respond to the level of presenting need in the area / community served.

[17] See LGA summary of the Marmot review into health inequalities in England and the role of local government in tackling the social determinants of health inequalities. https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives



Source: Exploring local income deprivation (ons.gov.uk)

4.2 Work

Work is of itself good for physical and mental health, and further benefits wellbeing through its association with higher income.

Rates of employment in Barking and Dagenham (62.6%) are lower than the London (73.8%) and England (74.7%) average.

The Job density rate (JDR)[18] in Barking and Dagenham (0.50) is below the London (1.03) and England average (0.88). Although the overall rate of employment is lower than London and national averages, it being higher than the JDR would suggest that a proportion of residents commute out of borough to work and may gain a higher rate of pay in doing so.

About 8,600 of the working age population in Barking and Dagenham is unemployed (9.1%), higher than the London (6.5%) and England averages (5.1%).

A much bigger proportion (30.9% - 43,100 individuals) of working age residents are economically inactive[19] for a variety of reasons including being a student, retirement, caring responsibilities and sickness. As with unemployment, this is a lower percentage than reported for London (21%) and England 21.6%. However, a relatively large proportion of economically inactive residents (27%, n = 11,700) nonetheless want a job.

Excluding NHS Trusts and the Council, Barking and Dagenham has few large employers - the majority of local businesses are small to medium enterprises (SMEs).

28% of working age adults resident in Havering are employed in management or professional roles – below both the national (50%) and London (62%) averages.

Conversely, Barking and Dagenham residents are overrepresented in administrative and secretarial roles and skilled trades, collectively accounting for 25.7% of the working population, compared with the England (19.2%) and London averages (15.6%). 25.6% of residents are employed in Process Plant & Machine Operations and Elementary occupations compared to 9.7% in London and 9.4% in England.

[18] Job density is the ratio of total jobs to population aged 16-64
[19] Economic Inactive: the section of the working age population that is not in employment or actively seeking employment.

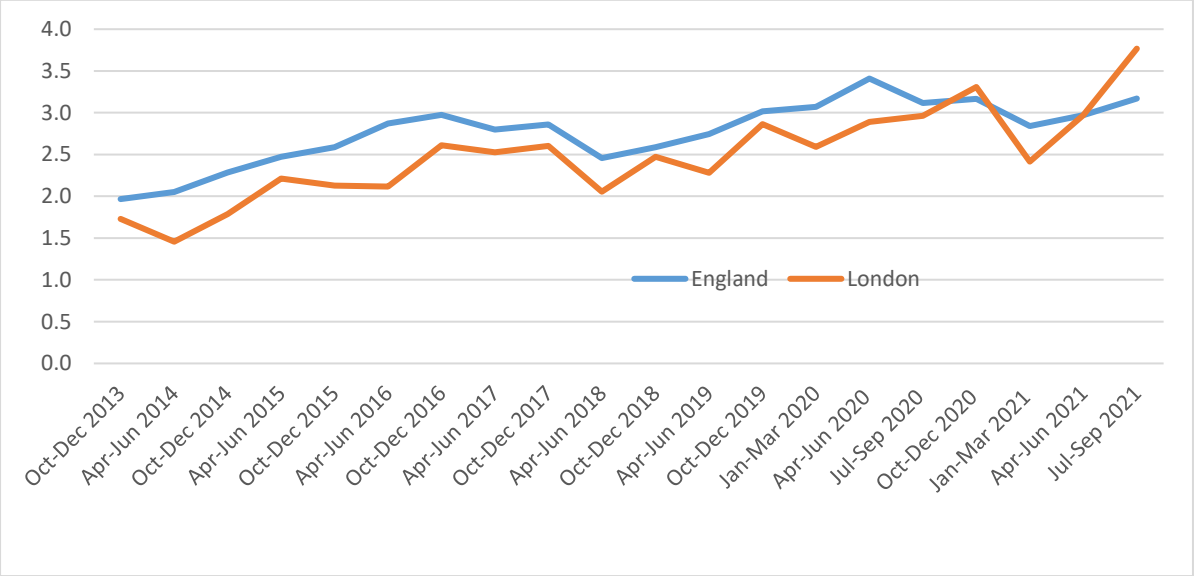
The wholesale and retail trades sector (19.0%), administration (12.1%), health and social care (10.3%), transportation (10.3%) and construction (6.0%) are the largest sources of employment for Barking and Dagenham residents.[20]

Recent and ongoing changes to the retail sector in favour of online sales and fewer administrative roles as automation and AI reduce staffing levels may alter established patterns of employment and require the acquisition of new skills and expertise.

Good work is better for health than bad work - work that involves adverse physical conditions, exposure to hazards, a lack of control and unwanted job insecurity.

Atypical employment including zero hours contracts (ZHCs), short-hour contracts and various self-employment options within the gig economy, as well as more established models including part-time employment, temporary positions and agency work have been the cause of much concern over the past decade, in part regarding the rights to which such workers are entitled to and whether they are being consistently upheld. The lack of certainty around income has been raised particularly in relation to ZHCs.[21]

Figure 18 - Percentage of people in employment on a zero-hours contract



A small (4% in London) but growing proportion of workers are on ZTCs. This rises to about 10% amongst the youngest workers (16-24). Rates are generally higher for women than men, and non-UK residents than UK residents. For some, ZTCs offer valuable flexibility but a quarter of people on ZTCs say they are under- employed i.e., want to work more hours, four times more than peers employed on other forms of contract.[22]

[20] NOMIS Labour Market Profile - Barking and Dagenham

[21] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772215/Resolution_Foundation_-_Atypical_approaches_-_Options_to_support_workers_with_insecure_incomes.pdf

[22] EMP17: Labour Force Survey: zero-hours contracts data tables https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/emp17peopleinemploymentonzerohourscontracts

NB. **People with poor health and / or disability are at particular risk of disadvantage in all its forms** e.g., people living with a long-term condition, mental illness or mental and physical disability are more likely to be living on a low income, be unemployed or in unsuitable housing putting them at additional risk of further decline. Effective action to address such problems can improve health and wellbeing and hence reduce the need for health and social care.

- 60% of people with LTC are in employment.
- 43% of people reporting a mental illness are in employment
- 74% of the general population are in employment

Source: Public Health England Health & Work Infographics

Recommendation 3: *Ensure Councils / NHS providers work with the DWP to offer residents excluded from employment due to disability and / or ill health including mental illness the opportunity to gain confidence, skills, work experience and ultimately secure employment.*

Impact of the pandemic

The response to the pandemic affected employment in a variety of ways e.g.

- a number of lockdowns were imposed
- working from home where possible, was recommended for long periods although this was not possible for many face-to-face service roles e.g., carers, transport workers, shop and factory workers – exposing them to high risk of infection
- various social distancing measures were introduced to reduce close contact between staff and between staff and customers

At the same time, Government introduced measures to protect businesses and their employees including the Coronavirus Job Retention Scheme (aka furlough) and the Self-Employment Income Support Scheme.

Nonetheless, the various non-pharmaceutical interventions employed to control the spread of infection affected the economy as a whole and hit some sectors disproportionately e.g., hospitality, personal services and leisure.

Unsurprisingly, the proportion of residents claiming out of work benefits increased during the pandemic, but rates have since begun to decline. Overall, the available evidence suggests that the UK labour market continues to recover from the pandemic. However, rates of self-employment have not recovered at the same rate and workers from ethnic minority groups, young workers, low paid workers and disabled workers, have been most impacted economically.[23,24]

Thus, the pandemic has tended to hit communities and groups already experiencing inequalities with regard to work. As such, health and social care partners should redouble their

[23] The Health Foundation (2021) Unequal pandemic, fairer recovery
[24] Research Briefing - Coronavirus: Impact on the labour market https://commonslibrary.parliament.uk/research-briefings/cbp-8898/

efforts to support these priority groups into employment, including providing opportunities to enter the health and social care professions and enable local SMEs to tender to provide services (see recommendation 11).

Residents' occupation affected their risk of infection and hence serious illness and death[25]. The reasons are complex and difficult to disentangle at the level of specific occupations[26] but it clear that those who were able to work at home were at less risk of exposure than peers who could not.

During the first lockdown, nearly half of all workers worked from home (49%). Lower earners, frontline workers, and men were less likely to be able to work from home[27]. Over a third of working adults (36%) report having worked from home at least once in the past seven days during the last two weeks of January 2022[28] and working from home is likely to persist in full or as part of hybrid working arrangements for the longer term.

Separate for COVID-19 related affects, working from home has positive and negative impacts for health and wellbeing and associated risk factors at an individual and population level, for example increase levels of obesity and reduced positive mental health

On the plus side, working from home can offer greater autonomy and flexibility; coupled with the time freed up by not commuting to work, workers may be able to achieve a better fit with caring responsibilities and leisure interests.

On the other hand, working from home can entail working in a poorly designed or completely unsuitable workstation with increased risk of back pain, headaches or eyestrain. Individuals who work from home are likely to have fewer social interactions and the line between work and personal life may become blurred posing a risk to mental health in the longer term. In addition, the removal of the daily commute can result in lost physical activity if not replaced with other alternatives.

Recommendation 4: Consider the impact working from home on the existing workplace health offer to employees and advice provided to local businesses.

Despite the provision of isolation payments, various studies have suggested that lack of job security and the non-availability of sick pay for some, e.g., those in the gig economy or on zero hour contracts - and the low rate of statutory sick pay for some on more traditional contracts

[25] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020

[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965094/s1100-covid-19-risk-by-occupation-workplace.pdf

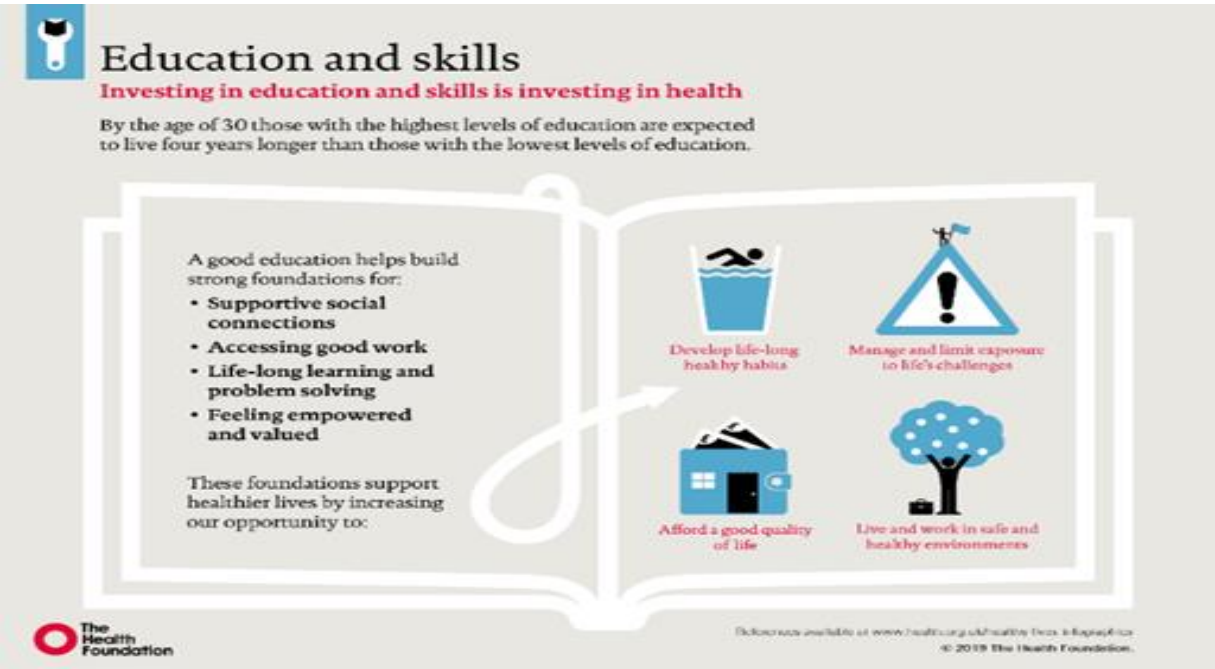
[27] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichjobscanbedonefromhome/2020-07-21

[28] Homeworking and spending during the coronavirus (COVID-19) pandemic, Great Britain - Office for National Statistics (ons.gov.uk)

has militated against full compliance with isolation contributing to enduring prevalence in some disadvantaged communities[29].

4.3 Educational Attainment

Educational attainment is strongly linked with health outcomes. The impact on health reflects associations with health-related behaviours as well as quality of work, income etc.



Adult education attainment in Barking and Dagenham is modest – 55.5% of working age adults have 'A' level or higher qualifications compared with 71% for London and 61% for the country as a whole.

This may translate into lower parental expectations for the next generation. See Section 4.3 for a discussion about the educational attainment of children and young people.

More immediately, lack of higher-level qualifications may limit the opportunity for residents to compete for higher paid jobs and / or secure employment in new roles and sectors, which may be necessary if opportunities in retail and administration continue to shrink.
Health and social care partners should consider how they can provide opportunities for entry into the caring professions for residents with the required commitment and aptitude but limited formal qualifications.

4.4 Housing

The impact of homelessness on health and wellbeing outcomes, particularly street homelessness, can be profound.

[29]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/983665/S1212_Places_of_enduring_prevalence.pdf

Poor housing in all its forms affects a much larger group, harming physical and mental health, at all life stages.
Furthermore, high housing costs put pressure on the household budgets of the many who are on moderate as well as low incomes.
Hence, high quality, affordable housing is a key element in ensuring the health and wellbeing of the population.

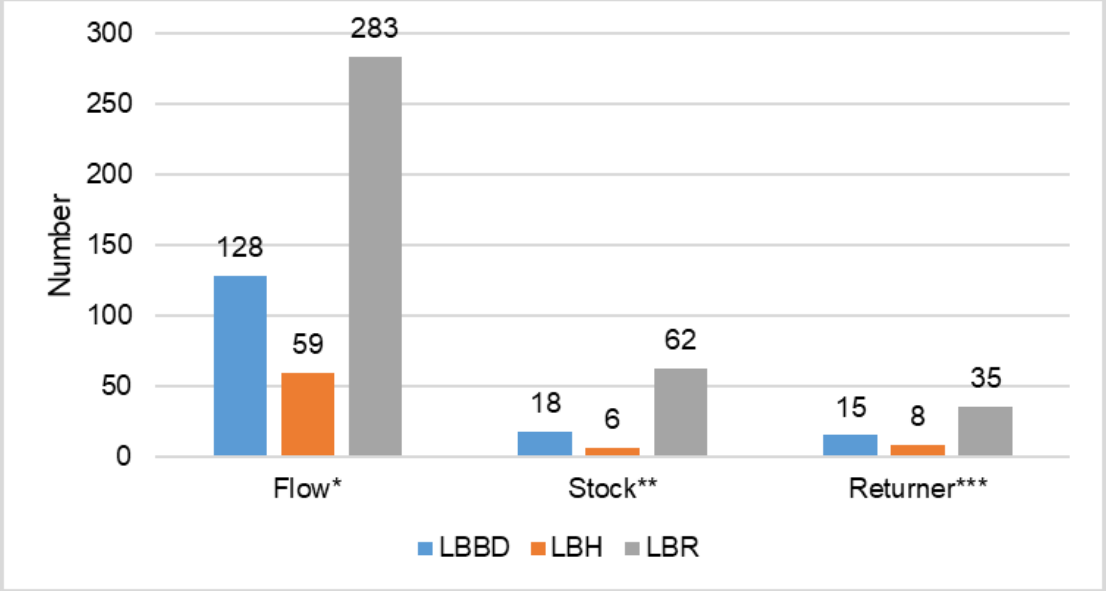
The health impact of street homelessness cannot be overstated: the average age of a homeless man at death is 47 years; the figure for women is even lower at only 43 years[30]. Hence the continued increase in the number of new rough sleepers recorded between 2018/19 (21) and 2020/21 (59) is of enormous concern.[31] Rough sleepers often have complex physical and mental health issues, including drug and alcohol dependency as well as good access to health and care services. Action regarding housing issues is more likely to succeed as part of a comprehensive, well-coordinated package of support delivered with health and social care partners.

***Recommendation 5**: Partner must work together to mitigate the worst harms of street homelessness and help those affected with the ultimate aim of enabling them to maintain suitable permanent accommodation.*

***Recommendation 5a:** To undertake a deep dive into the homeless population in Barking and Dagenham as part of an overall needs assessment of housing as part of the 2023 JSNA*

[30] Thomas, B. (2011) Homelessness: A silent killer - A research briefing on mortality amongst homeless people. London: Crisis. https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/health-and-wellbeing/homelessness-a-silent-killer-2011/
[31] Chain Annual Report: Outer Boroughs April 2020 – March 2021 https://data.london.gov.uk/dataset/chain-reports

Figure 9: Number of people seen rough sleeping, 2020-21



Data Source: London Datastore

*Flow – people who had never been seen rough sleeping prior to 2018/19 i.e., new rough sleepers
**Stock – people who were also seen rough sleeping the previous year
***Returners – people who had been seen rough sleeping in the past but not during the previous year.

Appropriate housing adaptions and/or access to supported housing options can enable vulnerable residents maintain their independence and facilitate timely discharge from hospital. Conversely, poor housing can increase the risk of poor health and potentially life changing accidents.

In 2020/21, 8.0% of Barking and Dagenham's housing stock fails the decent homes standard [32] (n = 1,361), this is lower than the mean for all London boroughs (exc. City) which is 9.9%[33].

Cold homes, whether due to poor design, inability to pay for heating or a combination of the two, contribute to excess winter mortality. The proportion of households in fuel poverty in Barking and Dagenham (22.5%) is above the national average (13.5%) and worse than the average for London (15.2%); nonetheless, more than 1:5 households are affected, and this figure can only increase given the very significant energy price rises planned for 22/23.

Houses in multiple occupation (HMO) are a part of the privately rented sector that causes particular concern given the inherent additional risks of overcrowding and consequent impact on safety and health. Only a small proportion (0.25%, n = 192) of dwellings in Barking and Dagenham are verified HMOs, much lower than the national (2.17%) and London (4.88%) figures but the number is increasing.

[32] DCLG 2006 A Decent Home: Definition and guidance for implementation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7812/138355.pdf
[33] GOV.UK Department for Levelling Up, Housing and Communities, Local authority housing statistics data returns for 2020 to 2021 (https://www.gov.uk/government/statistical-data-sets/local-authority-housing-statistics-data-returns-for-2020-to-2021)

Under supply of housing and unaffordability contribute to homelessness. In Barking and Dagenham housing growth is expected as the council, working in partnership with BeFirst, are aiming to achieve a target of 1,944 new homes each year until 2029. These proposals are set out in the draft Local Plan 2037[34].

Approximately 51% of the Barking and Dagenham population are homeowners, this is in-line with the London average (50%) but below the national average of 65%.

The average house price in Barking and Dagenham is 9.8 times average earnings. Houses in Barking and Dagenham have become significantly less affordable over the last decade and are less affordable than the national average (7.8 times). Nonetheless, homes in Barking and Dagenham remain more affordable than in many other London boroughs (see Fig 10 below).

Nationally, privately owned and social rental housing is becoming more common, particularly among young and lower income households and may become the norm for a growing proportion of the population unless the supply of affordable homes is significantly increased.

£1,200 is the monthly private rental cost in Barking and Dagenham. This is significantly higher than the national average (£755) but below the average for London as a whole (£1,425) which is skewed by the much higher prices in inner London boroughs (see Fig. 11 below).

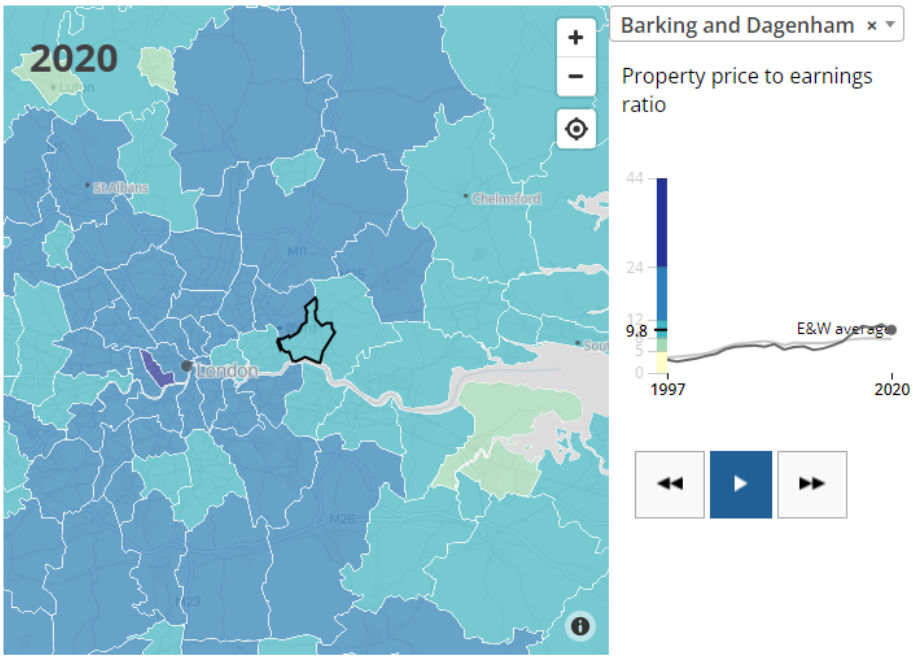
The cost of housing is a very significant charge on all household incomes. Saving for a deposit, on top of the cost of rental, may be too much for some, reducing the opportunity for more residents to buy and increasing the need for rental properties that meet the needs of individuals and families, throughout the life course.

Recruitment of health and social care professionals is a significant problem in the BHR health economy. As with many younger adults, they may struggle to meet the cost of housing, whether rental or ownership. Significant regeneration is ongoing in all three BHR boroughs. The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.

> ***Recommendation 6:*** *The wider partnership should consider the opportunities afforded by regeneration in all 3 BHR boroughs to offer affordable housing to attract and retain workers in hard to recruit professions.*

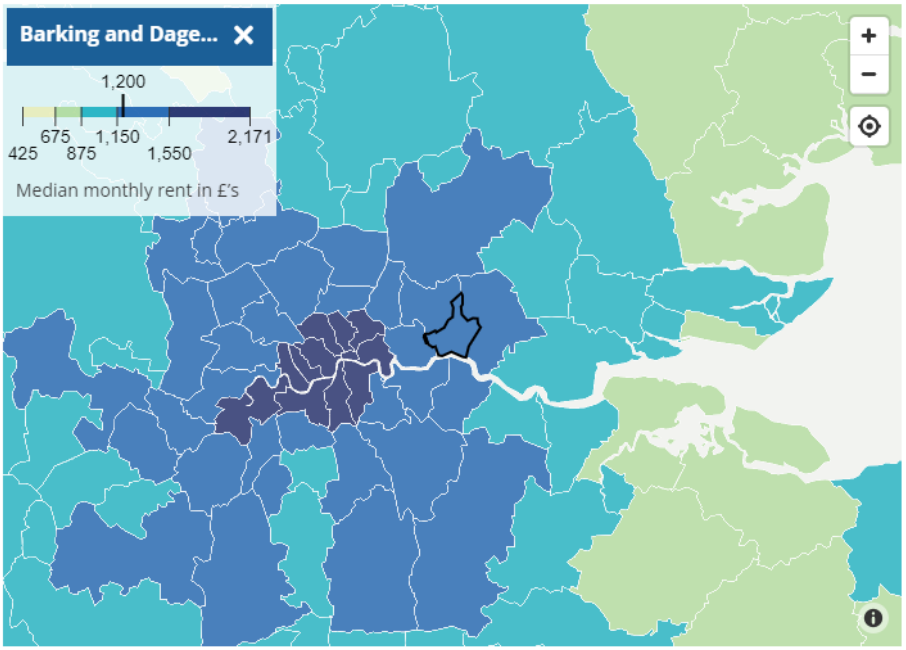
[34] London Borough of Barking and Dagenham draft local plan 2037 – Second revised regulation 19 consultation version (Autumn 2021) https://yourcall.befirst.london/submission-documents

Figure 10 - Housing affordability ratio by local authority district, England and Wales, 1997 to 2020 [35]



Source: House Price Statistics for Small Areas and Annual Survey of Hours and Earnings, ONS

Figure 11: Median monthly rental price, by local authority, all categories, 1st October 2020 – 30th September 2021 [36]



Source: Valuation Office Agency – Lettings Information Database, Office for National Statistics

35 https://www.ons.gov.uk/peoplepopulationandcommunity/housing/bulletins/housingaffordabilityinenglandandwales/latest#local-authority-analysis

36 https://www.ons.gov.uk/peoplepopulationandcommunity/housing/bulletins/privaterentalmarketsummarystatisticsinengland/october2020toseptember2021#local-authority-analysis

Impact of the pandemic on housing

The pandemic affected housing in a variety of ways, and housing affected the course of the pandemic.

Attempts were made to provide all rough sleepers with shelter during the first year of the pandemic, but street sleeping has resumed subsequently. Nonetheless, it is possible that the links made with services during this period may ultimately help find more permanent solutions for some of the hardest to reach.

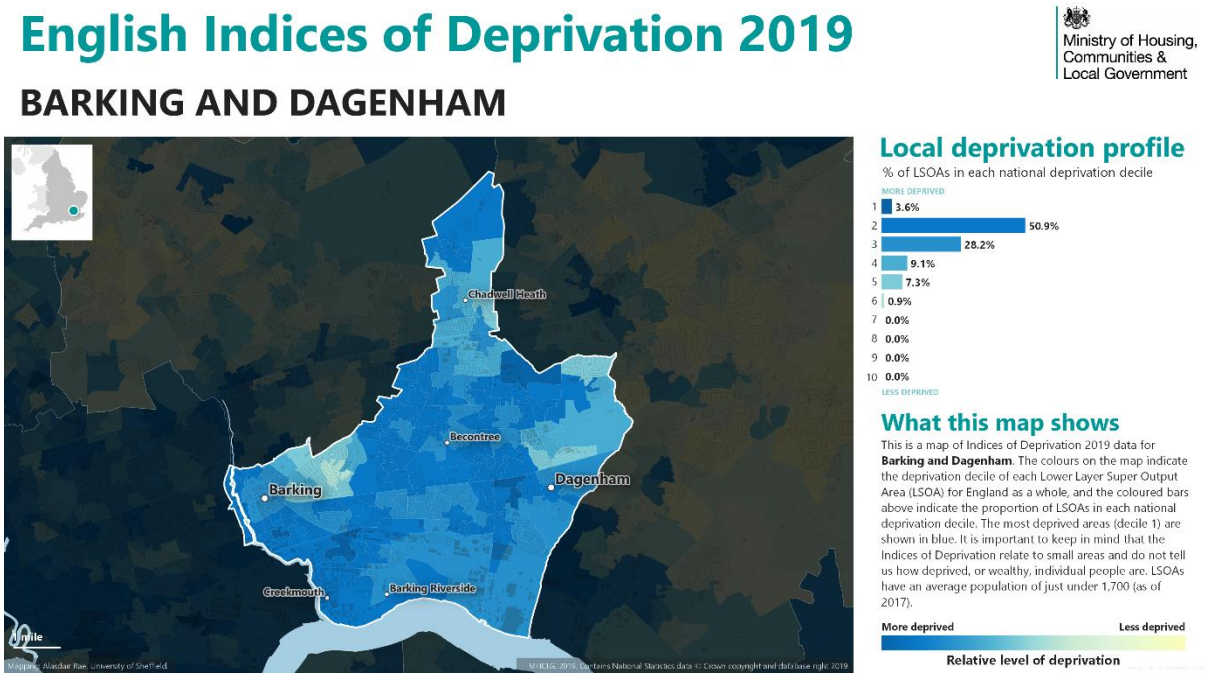
A range of measures including the furlough scheme, mortgage holidays and a halt on evictions of renters were implemented to mitigate the impact of the pandemic on housing and rates of homelessness in the short term. The longer-term impacts are unclear at this time, but those groups most vulnerable to inequality are again likely to be worst hit.

Housing problems, relating to poor-quality, affordability and overcrowding have been associated with an increased risk of coronavirus infection and severe disease[37].

4.4 Overall Disadvantage

The Index of Multiple Deprivation (IMD) combines many different facets of disadvantage into a single measure. The most deprived areas (decile 1) are shown below in blue. Levels of deprivation are high throughout Barking and Dagenham with almost 83% of LSOAs being in top 3 more deprived national deciles (deciles 1-3).

Figure 12: Barking and Dagenham % of LSOAs in national deprivation decile, 2019[38].



Source: Ministry of Housing Communities & Local Government

[37] The Health Foundation (2021). Unequal Pandemic, Fairer Recovery https://reader.health.org.uk/unequal-pandemic-fairer-recovery/changes-in-the-wider-determinants-of-health

[38] The Indices of Deprivation are typically updated every 3 to 4 years, but the dates of publication for future Indices have not yet been scheduled.

The strong association between levels of disadvantage and life expectancy (see Figures 10 &11) is evidence that the wider determinants are the most important driver of whether we are healthy or not.

At local level, the levers to affect the socio-economic determinants of health tend to lie with councils rather than the NHS, although they can impact on the way residents access health services.

Health and wellbeing boards give NHS partners the opportunity to ensure that local plans regarding tackling poverty, employment opportunities, educational attainment, housing etc. are robust, focused on reducing inequality and those groups most vulnerable to poor health and wellbeing. However, the health and social care system also has a direct role to play in tackling disadvantage. The NEL ICS has prioritised addressing health inequalities and the new placed based ICB committees will be required to act to address health inequalities at place (i.e., LBBD)

Residents living with physical and mental illness are at greater risk of disadvantage in all its forms, worsening their wellbeing still further. Effective action to support people with health problems into work or stable accommodation can improve health and reduce demand on health and social care services.

Recommendation 7: *Encourage health and social care professionals and patients / residents to consider the extent to which problems with employment, poverty, housing etc. are the underlying cause and / or exacerbate a presenting health issue and therefore might benefit from social prescribing[39] in addition to or instead of the tradition medical response.*

Recommendation 8: *Strengthen social prescribing as an effective alternative / adjunct to existing health and social care options. This should include action to identify and strengthen community capacity and self-help options as well as an effective signposting function and bring together NHS, council and CVS stakeholders.*

In addition, NHS agencies and Councils have the opportunity to directly impact on the wider determinants to the benefit of local people e.g., by spending a greater proportion of their budget (BHR CCGs' annual budget is circa £1bn) with local businesses. To this end, they should view themselves as 'anchor institutions[40]' and consciously seek to maximise the contribution they make to the local community over and above the direct provision of services e.g., by:

- Further strengthen links (e.g., through work experience, apprenticeships, bursaries etc.) between the health and social care system and local schools and colleges to increase the numbers of young people who aspire to and train towards a relevant career, prioritising more disadvantaged groups and hard to recruit to professions.
- Provide an exemplary workplace health scheme to employees and help local SMEs to improve the offer to their workforce.

[39] https://www.kingsfund.org.uk/publications/social-prescribing
[40] https://www.health.org.uk/newsletter-feature/the-nhs-as-an-anchor

- Routinely consider the potential for additional 'social value' when procuring goods and services; and how bids from local businesses can be facilitated

Recommendation 9: *Encourage councils, NHS providers, colleges etc. to become 'anchor institutions' within the BHR patch maximising the contribution they make to the local community over and above the direct provision of services.*

Recommendation 10: *Encourage all partners to adopt a Health in All Policies approach that takes into consideration health and wellbeing impacts in decision-making including on the social determinants of health to maximise the wellbeing of residents.*

Impact of the pandemic

Nationally, as well as locally, people living in areas of higher deprivation and minority ethnic groups have experienced higher rates of Covid-19 disease and death[41].

Uptake for the vaccine is also lowest amongst those living in the most deprived areas and in Black and other minority ethnic groups[42].

In addition to statutory intervention, health champions and partners from the voluntary and community sector (VCS) have been instrumental in supporting vulnerable and disadvantaged residents in the local response to Covid-19.

Recommendation 11: *Strengthen community resilience through continued partnership with the VSC. This includes building upon and mapping existing VCS capabilities, identifying gaps in community support and providing opportunities for skills development.*

[41] ONS (2020) Deaths involving Covid-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020 Deaths involving COVID-19 by local area and socioeconomic deprivation - Office for National Statistics (ons.gov.uk)
[42] Havering London Borough (2021) Coronavirus in Havering Coronavirus in Havering – Week 45, ending 12 November 2021 | The London Borough Of Havering

5. Pillar 2: Our Health Behaviours and Lifestyles

**Indicators and data used in this section can be accessed by clicking here*

Our health behaviours and lifestyles are the second most important driver of health after the wider determinants. The greatest harm to health results from smoking; the interrelated risk factors associated with poor diet, physical inactivity and obesity; and the use of drugs and alcohol.

Figure 13: Risk factors and percentage contribution to DALYs as measured by Population Attributable Fraction (PAF), BHR, 2019.[43]

Risk Factor	Havering	Barking & Dagenham	Redbridge	London	England
Tobacco	13.25%	12.65%	10.86%	11.72%	14.06%
High fasting plasma glucose	8.81%	7.58%	7.82%	7.93%	8.96%
High body-mass index	7.72%	6.6%	7.38%	8.11%	8.73%
Dietary risks	7.29%	6.59%	6.25%	6.12%	7.47%
High systolic blood pressure	6.53%	5.70%	5.64%	5.63%	7.05%
Alcohol use	4.26%	4.72%	4.67%	5.51%	4.76%
High LDL cholesterol	3.68%	3.44%	3.16%	3.02%	3.84%
Occupational risks	3.54%	3.49%	2.68%	2.81%	3.27%
Non-optimal temperature	2.29%	2.01%	1.74%	1.71%	2.18%
Air pollution	2.15%	2.22%	2.02%	1.92%	1.72%
Kidney dysfunction	1.69%	1.41%	1.57%	1.43%	1.74%
Drug use	1.56%	2.33%	2.02%	2.47%	1.92%
Child and maternal malnutrition	1.24%	2.44%	2.08%	2.00%	1.50%
Low physical activity	1.15%	0.89%	0.97%	1.00%	1.21%
Low bone mineral density	1.03%	0.75%	0.89%	0.79%	1.00%
Childhood sexual abuse and bullying	0.46%	0.59%	0.63%	0.63%	0.49%
Other environmental risks	0.39%	0.38%	0.30%	0.30%	0.36%
Unsafe sex	0.25%	0.45%	0.36%	0.46%	0.32%
Intimate partner violence	0.23%	0.29%	0.30%	0.30%	0.22%
Unsafe water, sanitation, and handwashing	0.04%	0.04%	0.04%	0.03%	0.04%

Behavioural	
Environmental / Occupational	
Metabolic	

Data Source: Global Burden of Disease, 2019

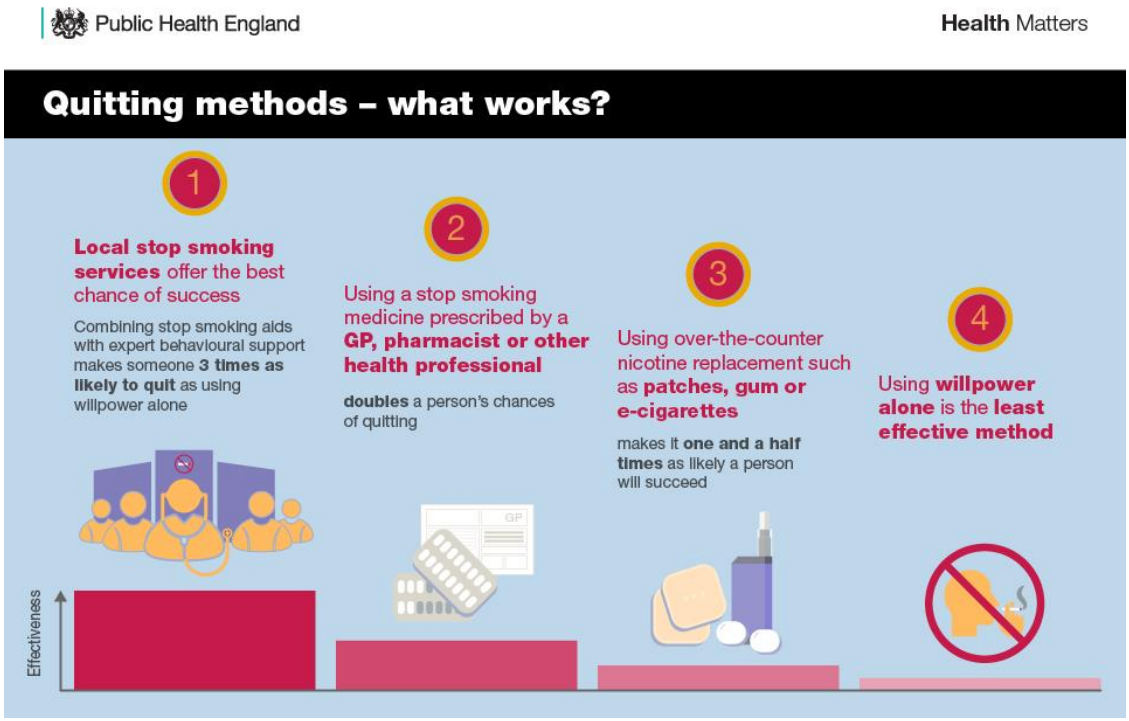
Smoking remains the leading preventable cause of premature mortality and ill health (Figure 13). Although smoking has been in decline since the 1950s, as of 2019, almost 27K (13%) adults in Barking and Dagenham continue to smoke.

[43] The contribution of a risk factor to a disease or a death is quantified using the population attributable fraction (PAF). PAF is the proportional reduction in population disease or mortality that would occur if exposure to a risk factor were reduced to an alternative ideal exposure scenario (e.g., no tobacco use). Many diseases are caused by multiple risk factors, and individual risk factors may interact in their impact on overall risk of disease. As a result, PAFs for individual risk factors often overlap and add up to more than 100 percent.
Global Burden of Disease (GBD 2019) | Institute for Health Metrics and Evaluation (healthdata.org)

The prevalence of smoking, and hence the harm caused, displays a marked social gradient, with much higher rates in communities and population groups living in disadvantage e.g., in 2019, the proportion of Barking and Dagenham residents in routine and manual occupations identifying as current smokers was 24.3%. This was 6.2 percentage points higher than the smoking prevalence of Barking and Dagenham adults (18+) at 18.1%. Smoking is also particularly high amongst people with serious mental illness and smoking rates increase with the severity of mental illness.[44] Differences in smoking prevalence are the immediate cause of a significant proportion of health inequalities.

Recommendation 12: Focus additional efforts in disadvantaged communities and / or cohorts known to have high prevalence of smoking e.g., people with mental health problems.

The majority of smokers want to quit and significant numbers try to quit each year However, most try to do so unaided, which is the least effective method. The chances of successfully quitting are increased by up to 3x if the individual makes use of face-to-face counselling support and pharmaceutical aids.[45]



Recommendation 13: Ensure that smokers who wish to quit can access face-to-face counselling support and pharmaceutical aids, including prescription only medication where clinically indicated.

[44] UKHSA Health Matters: Smoking and mental health. 2020
[45] PHE Health matters: stopping smoking – what works? 2019

E-cigarettes (vapes) are the most commonly used quit aid among smokers in England. The OHID maintain that vaping regulated nicotine products have a small fraction of the risks of smoking, and there is growing evidence of their effectiveness in supporting smokers to quit.[46]

***Recommendation 14**: Actively promote e-cigarettes to smokers as an effective quitting aid and a safer alternative to continuing to smoke.*

Over the last decade, the largest fall in smoking prevalence has been among 18–24-year-olds.[47] The majority of smokers will have already begun smoking by the time they reach this age range, which suggests that the Government's aspiration for a smoke free society by 2030 is achievable given the active support of all.

***Recommendation 15:** Contribute towards the aspiration of a smoke free society by 2030 e.g., by continuing the de-normalization of smoking in public spaces and homes; minimising the recruitment of new smokers through work with schools, rigorous enforcement of age-related sales regulations and minimising access to cheap smuggled or counterfeit tobacco.*

The total harm associated with an **unhealthy diet** (e.g. high intake of saturated fat, salt, free sugars, and processed meats; and low intake of whole grains, fruits, vegetables, legumes, oily fish and fibre) is similar in scale to the harm caused by smoking, in part because so many people eat unhealthily in one way or another e.g. in 2019/20, only 47.9% of adults in Barking and Dagenham were able to consume the recommended 5 portions of fruit and vegetables on a usual day.

The socioeconomic impacts of the COVID-19 pandemic (see Chapter 4 for further details) have left more people across England food insecure than before the pandemic. It is estimated that a fifth of households cut down or skipped meals since the pandemic started, with households with children more likely than other households to reduce meal sizes or skip meals due to not having enough money. Households with lower financial or food security were also more likely to have poorer diets than other households.[48]

***Recommendation 16:** Actively promote existing food and financial support mechanisms to low-income households and households with children e.g., LBBD Community Hubs, free school meals, school holiday meal scheme, Healthy Start scheme etc.*

A **sedentary lifestyle** results in a lesser but nonetheless very significant burden of ill health. In the period May 2020-21, more than one in three (36.6%) adults (aged 16+) in Barking and Dagenham were physically inactive, significantly more than the national average. The number of physically inactive adults in Barking and Dagenham increased by around 1.2% in comparison

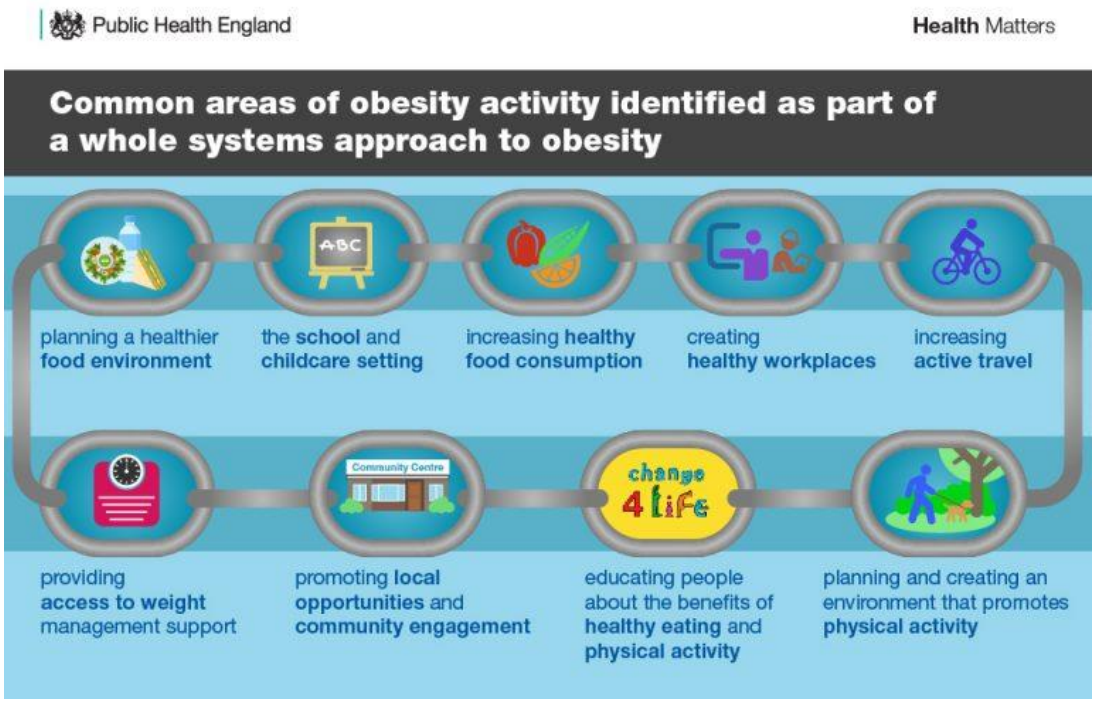
[46] Office for Health Improvement and Disparities (OHID) Smoking and tobacco: applying All Our Health, 2021
[47] ONS, Adult smoking habits in the UK: 2019
[48] PHE, National Diet and Nutrition Survey: Diet, nutrition and physical activity in 2020 - A follow up study during COVID-19, 2021

to the previous 12 months as a result of the national and tiered restrictions introduced to counter the coronavirus pandemic.[49]

Existing inequalities in physical activity levels have widened nationally as a result of the COVID-19 pandemic, with women, young people aged 16-34, over 75s, people living with disability or long-term health conditions, and those from BAME backgrounds disproportionately negatively affected.[50]

The changing balance between diet, in terms of energy consumed, and physical activity (energy expended) underpins the steady growth in levels of **obesity**. The proportion of adults in Barking and Dagenham living with overweight or obesity (66%) in 2019/20 was significantly higher than the London (56%) and national (63%) averages. People with learning disabilities and those living in social disadvantage are more likely to experience obesity than the rest of the population[51]. Obesity results in a separate and rapidly growing burden of disease and thus exacerbates the other health inequalities experienced by these groups.

The increase in the prevalence of obesity is the product of many interlinked factors. As a result, there is no single silver bullet; rather partners must commit to maintaining a 'whole system approach' over the long term.[52]

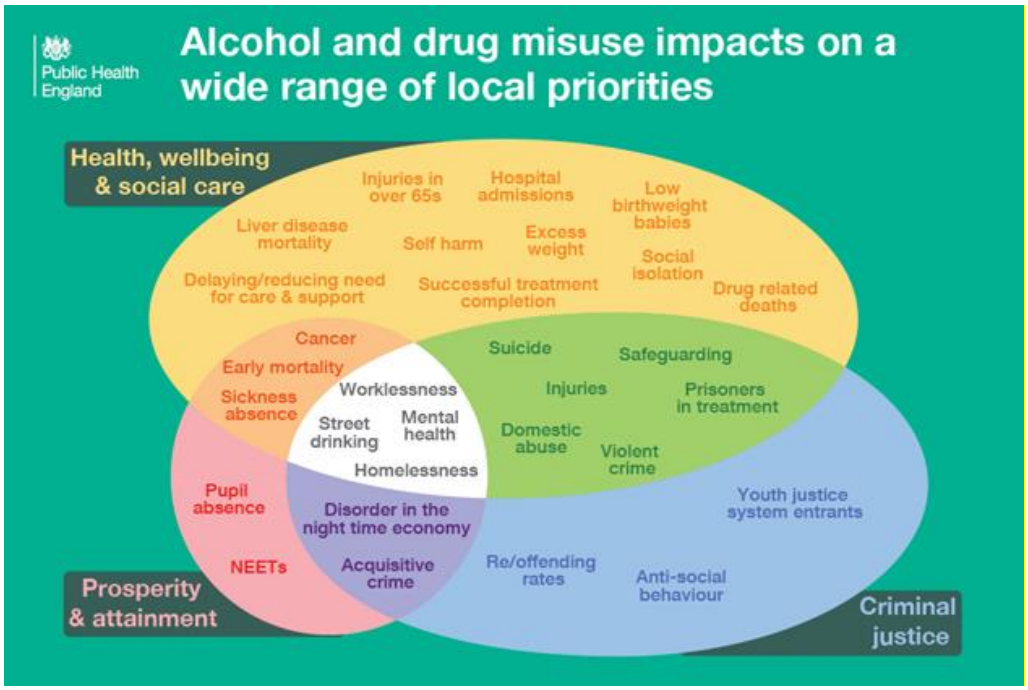


Recommendation 17: Ensure that there is a comprehensive whole system approach to tackling obesity across BHR as a whole with additional efforts aimed at supporting groups known to have higher prevalence of obesity.

[49] Sport England Active Lives data tables May 2020-21
[50] Sport England Active Lives Adult Survey May 2020-21 Report
[51] PHE Obesity and weight management for people with learning disabilities: guidance. 2020
[52] UKHSA, Health Matters: Whole systems approach to obesity, 2019

See Section 7.2 for analysis of childhood obesity.

The use of **alcohol and drugs** also results in significant harm.



In 2018-19, there was an estimated 2,105 adults in Barking and Dagenham with an alcohol dependency and potentially in need of specialist treatment. This represents 1.4% of the adult population aged 18 or over[53]

9.6% (n=1,293) of individuals aged between 15-64 in Barking and Dagenham were using opiates and / or crack cocaine between 2016-17[54]. The age-standardised mortality rate for deaths related to drug poisoning in Barking and Dagenham between 2018-20 was 5.8 per 100,000 – lower than the national average of 7.6. The age-standardised mortality rate for deaths related to drug misuse was 3.0 per 100,000, again lower than the national average of 5.0[55]. However, despite this, the number of drug-related deaths in England rose to its highest on record in 2020, with approximately half of all drug poisoning deaths involving an opiate.[56]

Increasing the number of individuals recovering from addiction not only has significant health and well-being benefits, such as increased longevity, reduced blood-borne virus transmission and improved physical and psychological health, it also reduces the harm caused within the wider community. In Barking and Dagenham during 2020, only 5.7% of the total number of opiate users in treatment successfully completed their treatment and did not re-present themselves to treatment again within 6 months[57] compared to 37.1% of alcohol users who

[53] Alcohol dependence prevalence in England - GOV.UK (www.gov.uk)
[54] Estimated prevalence of opiate and/or crack cocaine use - OHID public health profiles
[55] ONS. Drug-related deaths by local authority, England and Wales. 2021
[56] ONS. Deaths related to drug poisoning in England and Wales: 2020 registrations. 2021
[57] Successful completion of drug treatment - opiate users - OHID public health profiles

successfully completed structured alcohol treatment who did not re-present within 6 months[58].

A much larger group run a more modest, but nonetheless significant risk of harm because of drinking more than recommended – in the period 2015-18, almost 1 in 6 (15.8%) adults in Barking and Dagenham were drinking more than 14 units of alcohol over the course of a week[59].

Before the COVID-19 pandemic, there was an increase in alcohol-related hospital admissions and deaths across England, but the pandemic seems to have further accelerated these trends. From May 2020 onwards, there have been significant and sustained increases in the rates of unplanned admissions for alcoholic liver disease and total alcohol-specific deaths, with a large proportion (33%) of deaths occurring in the most deprived group.[60]

Recommendation 18: *Partners should work to:*

- *increase participation in drug and alcohol treatment, particularly the latter, with additional efforts aimed at supporting those who are more socially deprived*
- *improve the offer to people with drink and drug dependency and additional mental health problems*
- *effectively support people with drink and drug problems who are street homeless*
- *reduce and prevent harm to children and families arising from parental drink and drug problems.*

[58] Successful completion of alcohol treatment - OHID public health profiles
[59] Percentage of adults drinking over 14 units of alcohol a week. Local Alcohol Profiles for England. OHID
[60] PHE Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary. 2021

6. Pillar 3: The Places and Communities in Which We Live.

The places and communities we live in affect health and wellbeing in many other ways, both positively and negatively.

The local environment is an important influence on our health behaviors e.g., access to green space encourages physical activity and is good for mental wellbeing, whereas a high density of fast-food outlets may increase the consumption of energy rich food and contribute to obesity levels. Air pollution is a pervasive threat to good health particularly in urban areas.

A range of physical assets contributes to health including early years and youth provision, sports facilities, schools and colleges, community centres, libraries, children's centres etc. They not only benefit users but also increase footfall and hence contribute to the viability of adjacent businesses.

The capacity of individual residents, their families and of the wider community as a whole is perhaps its greatest asset e.g., there is strong evidence about the protective effects of social relationships and community networks, particularly on mental wellbeing[61].

Therefore, strengthening our communities and creating environments that promote healthier choices and protect residents from harm is a significant opportunity to improve health and reduce inequalities in health.

Climate change already poses a risk to the wellbeing of current residents and is an existential threat to humanity if left unchecked[62]. It is fundamentally a consequence of how we live. Shifting to a sustainable future will require changes at all levels including within local

[61] The Marmot Review 10 years on. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf
[62] Understanding the health effects of climate change - UK Health Security Agency (blog.gov.uk) https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/

communities e.g., how we as individuals travel from place to place; how our homes are built and heated etc.

Climate change is both an immediate risk to the health and wellbeing of residents and an existential threat to humanity in the longer term if left unchecked. Already we face increasingly frequent and extreme weather events, including prolonged heatwaves and flooding[63].

In England, during the summer of 2020, there were 3 periods, totalling 20 days that met Public Health England's heatwave definition. The total cumulative all-cause excess mortality over this period was 2,556 deaths. Just under 90% of deaths were people aged 65 and above, and half were aged 85 or older. About 20% of deaths were in London, consistent with the 'urban heat island' effect whereby cities tend to be hotter than surrounding rural areas. Mortality was significantly greater than that experienced in previous summers, raising the possibility that the concurrent risks of COVID-19 and heatwaves may amplify the harm caused by either alone[64].

Deaths from flooding in the UK are thankfully very infrequent. Nonetheless, there are long term negative impacts on the mental health of people whose lives are affected by flooding.

Bloomberg Associates, in collaboration[65] with the GLA, have produced London-wide climate risk maps showing the risk posed by excess heat, flood and overall climate risk. In Barking and Dagenham, the risk is higher in Abbey and Gascoigne wards.

***Recommendation 19a**: Partners should collaborate to reduce greenhouse emissions and mitigate the harms caused, ensuring that causes and impacts of climate change are considered in every policy and decision, including all new regeneration developments, for example, use of innovative heating and waste management methods to be more climate friendly in Barking Riverside.*

***Recommendation 19b**: Partners should collaborate to raise public understanding and awareness on causes and impacts of climate change, and how they can keep themselves safe.*

Cities consume 78% of world's energy and produce more than 60% of greenhouse gas emissions[66], with transport and buildings among the largest contributors. Cutting emissions will reduce the impact of climate change in the long term and improve air quality in the short term.

Air pollution is a huge public health problem now; 6.8% of all deaths in Barking and Dagenham are attributable to air pollution, higher than the national average (5.1%) and the figure for London as a whole (6.4%).

[63] Understanding the health effects of climate change - UK Health Security Agency (blog.gov.uk) https://ukhsa.blog.gov.uk/2021/11/09/understanding-the-health-effects-of-climate-change/
[64] Heatwave mortality monitoring report: 2020 - GOV.UK (www.gov.uk)
[65] https://gisportal.london.gov.uk/portal/apps/webappviewer/index.html?id=7322196111894840b5e9bae464478167
[66] https://www.un.org/en/climatechange/climate-solutions/cities-pollution

Long-term exposure to air pollution reduces life expectancy, mainly due to its contribution to cardiovascular and respiratory diseases and lung cancer, but it is also linked to dementia, cognitive decline, and risk factors in early life (for example low birth weight).

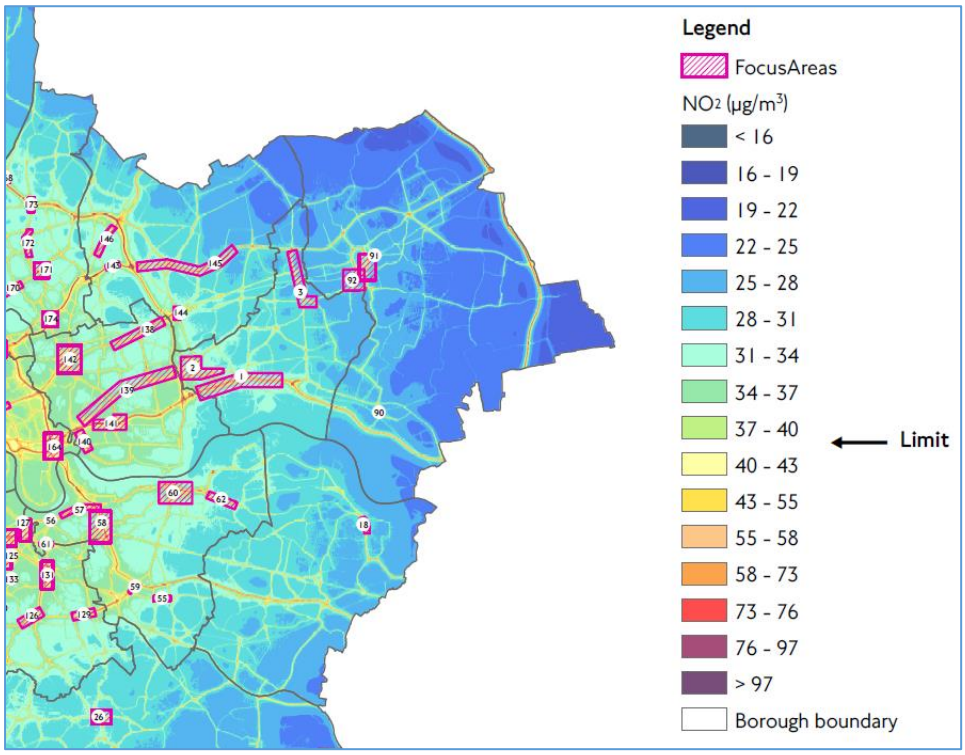
Some people will also experience immediate effects during episodes of particularly poor air quality, with reduced lung function and exacerbations of asthma contributing to an increase in respiratory and cardiovascular hospital admissions. In December 2020, a London Coroner concluded that Ella Adoo-Kissi-Debrah died, aged nine in 2013, from a combination of acute respiratory failure, severe asthma and air pollution exposure. The first time that air pollution had been listed as a medical cause on a death certificate in the UK.

The main pollutants of concern are nitrogen dioxide (NO2) and particulate matter (PM) produced by traffic, heating, and burning of solid fuels. Air quality in Barking and Dagenham is worse than London and national averages, the annual average concentration of fine particulate matter in Barking and Dagenham is 9.4 µg m^{-3} compared with the London average of 8.9µg m^{-3} and the England average of 6.9µg m^{-3}.

Local authorities have a statutory responsibility in Local Air Quality Management (LAQM). They must declare an Air Quality Management Area (AQMA) anywhere where the national air quality objectives will not be achieved. Barking and Dagenham have designated the whole borough as an AQMA due to levels of Nitrogen Dioxide. Local authorities designating their boroughs as AQMAs must produce an Air Quality Action Plan (AQAP) set out how local authorities, working with other agencies, will use their powers to meet the air quality objectives.

In addition, the Greater London Authority has identified 187 Air Quality Focus Areas that not only exceed the national air quality objective but also have high levels of footfall. Three locations in Barking and Dagenham are listed, one in Abbey ward, a second one stretching across Gascoigne, Eastbury and Thames wards and a third one across Whalebone and Chadwell Heath wards.

Figure 15: Air Quality Focus Areas in the three 'BHR' boroughs



Source: GLA Air Quality Team[67].

The pandemic demonstrated that poor air quality is not inevitable. During the spring 2020 lockdown, NO2 decreased by 59% in London[68]. More modest but nonetheless hugely beneficial improvements are attainable as recovery from the pandemic progresses e.g., by encouraging individuals to use public transport, and the adoption of cleaner fuels for transport, heating, and manufacturing.

***Recommendation 20**: Partners should collaborate to reduce air pollution and risks, and ensure the impact on air pollution is considered in every relevant decision.*

In parallel with action to reduce air pollution, residents can, if appropriately informed take action to reduce their personal exposure. Nationally, the Daily Air Quality Index (DAQI)[69] offers information on levels of air pollution and provides recommended actions and health advice. In London, the Mayor's air quality alerts system[70] advises Londoners on days where air pollution is elevated e.g., by sending warning emails to signed-up stakeholders. Similarly, subscribers to the airTEXT[71] system receive a text message, call or voicemail whenever moderate or high levels of pollution are expected. Such alerts enable residents to determine what steps they should take given the expected level of pollution. For example, taking a different route/mode

[67] https://data.london.gov.uk/dataset/laei-2013-london-focus-areas
[68] Latest lockdown had less impact on UK air pollution levels than the first, new analysis shows - News and events, University of York
[69] What is the Daily Air Quality Index? - Defra, UK
[70] https://www.london.gov.uk/what-we-do/environment/pollution-and-air-quality/monitoring-and-predicting-air-pollution
[71] https://www.airtext.info/

of transport to work, keeping their medication with them, or not exercising outside on certain days.

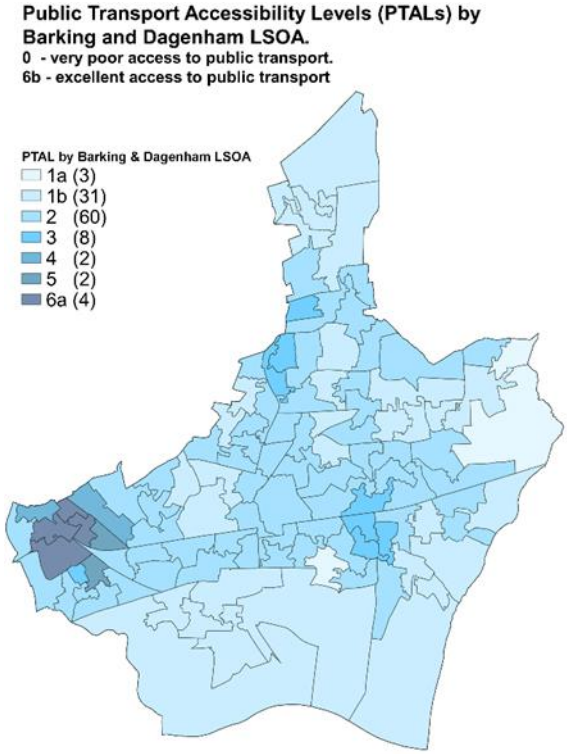
Recommendation 21: Partners should collaborate to raise public understanding and awareness of current local levels of air pollution using the 'air pollution forecast' and encourage residents to adjust their behaviour, accordingly, taking into account any health problems that might put them or their family at particular risk.

Encouraging residents to switch to public transport or active transport options i.e., walking and cycling will be a crucial element in plans to tackle air pollution and climate change.

Many people could incorporate some form of **active travel** with public transport during a longer journey or commute which would serve to reduce air pollution and provide the individual, who may otherwise be in a largely sedentary occupation with beneficial physical activity. Pre-pandemic, 19.8% of adults in Barking and Dagenham walked for travel three or more times per week, statistically similar to London average of 22.1%[72].

Barking and Dagenham is one of London's best-connected boroughs with excellent road and rail links to outside London and other boroughs. But public transport links within the borough is poor, with most LSOAs having Public Transport Accessibility Levels (PTAL) score of 2 or low[73].

Figure 16: Public Transport Accessibility Levels (PTALs) for LSOAs in Barking and Dagenham



Public transport Accessibility Level (TfL) – London Datastore https://data.london.gov.uk/dataset/public-transport-accessibility-levels (2015) *Contains OS data Crown Copyright (and database right) (2020)*

[72] Source: https://fingertips.phe.org.uk/

[73] https://data.london.gov.uk/dataset/public-transport-accessibility-levels

There has been a very modest increase in car ownership in recent years and rate of ownership in Barking and Dagenham are about 83 cars per 100 households in the borough.

Table 3: Cars registered per 100 households: 2019, 2020 and 2021

Borough	Havering	Redbridge	Barking & Dagenham	Greater London Average
2019	110.65	97.24	82.11	75.74
2020	109.50	96.63	81.98	75.07
2021	108.99	96.81	83.53	74.74

Sources: Vehicle licensing statistics: 2018, 2019 and 2020 report
Household's data from ONS. Household projections for England; Principal projection. Table 406: Household projections, mid-2001 to mid-2041

However, car ownership is not universal. in and not have access to a car; with higher rates amongst older people and disadvantaged communities who are most likely to make use of public services in general and health and social care in particular.

Table 4: % of households with no cars or vans; 2011

Area	England	London	Barking and Dagenham	Havering	Redbridge
% of households	25.8	41.6	39.6	23.0	27.9

Source: ONS 2011 Census: Key Statistics for local authorities in England and Wales

Recommendation 22: Partners should ensure that health and social care services are as accessible as possible by public and active transport options and encourage staff and users to leave their car at home when using public services as far as this is practicable.

Pre-pandemic, only 0.8% of adults in Barking and Dagenham cycled for travel purposes at least three times per week, significantly below the England and London averages, 2.3% and 4.1% respectively.

Recommendation 23: The Local Authority to work with partners to expand the active transport infrastructure in the borough. The health and social care system to advise residents of the health benefits of active travel whenever the opportunity arises.

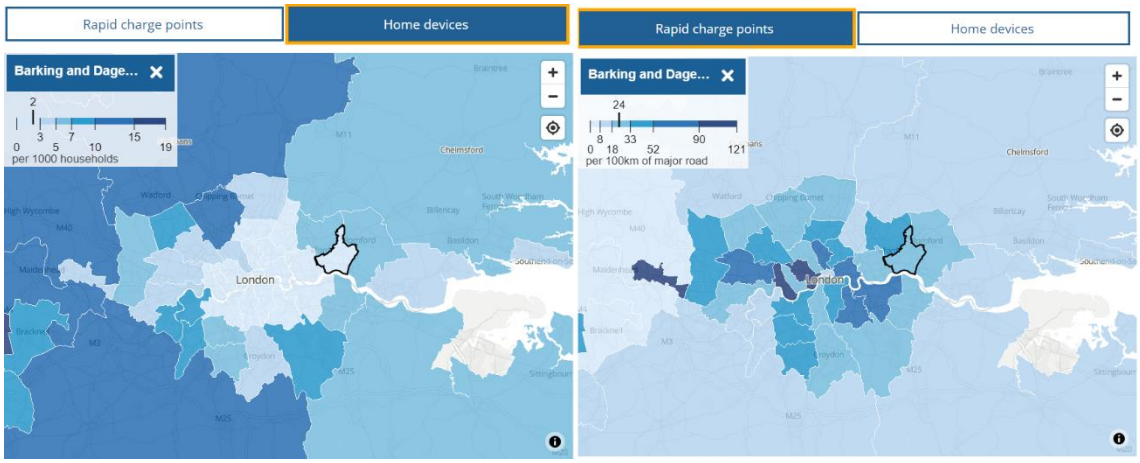
Pending a significant improvement in public and active transport infrastructure, cleaner forms of private transport e.g., car clubs and electric vehicles (EVs) may yield more rapid improvements in air quality.

The sale of new vehicles reliant on fossil fuels is set to end in the UK by 2030 and over half of younger drivers say they are likely to switch to electric in the next decade[74]. The initial cost of electric vehicles remains the biggest barrier to switching to EVs and currently ownership is

[74] https://www.ons.gov.uk/economy/environmentalaccounts/articles/overhalfofyoungerdriverslikelytoswitchtoelectricinnextdecade/2021-10-25

more common in areas with the highest disposable income. Difficulties recharging electric cars –"range anxiety" - is cited as another key factor against switching from conventional fuels.

Figure 17: Provision of public rapid charge points per 100km of motorway (October 2021) and home devices installed per 1,000 households (2013 to July 2021), UK



Source: ZapMap Logo, Department for Transport, and Office for National Statistics

Currently the public rapid charging network tends to be most developed in some inner London boroughs whereas home charging devices are more common in the Home Counties and more affluent rural communities. However, neither is remotely adequate given the Climate Change Committee estimates 325,000 public charging points will be needed to support a fleet of 23.2 million electric cars across the UK by 2032. Currently there are 26,000 for 460,000 plug-in cars. Massive expansion of charging points is essential.

Recommendation 24: All partners to facilitate the shift to electric vehicles including their own fleet. For example, by lobbying for national investment in charging infrastructure

About 39% of Barking and Dagenham's surface area is classified as green cover[75] - parks, green spaces, gardens, woodlands, rivers and wetlands, as well street trees and green roofs. The second highest proportion of any London borough and significantly lower than the London average (approximate 50%).

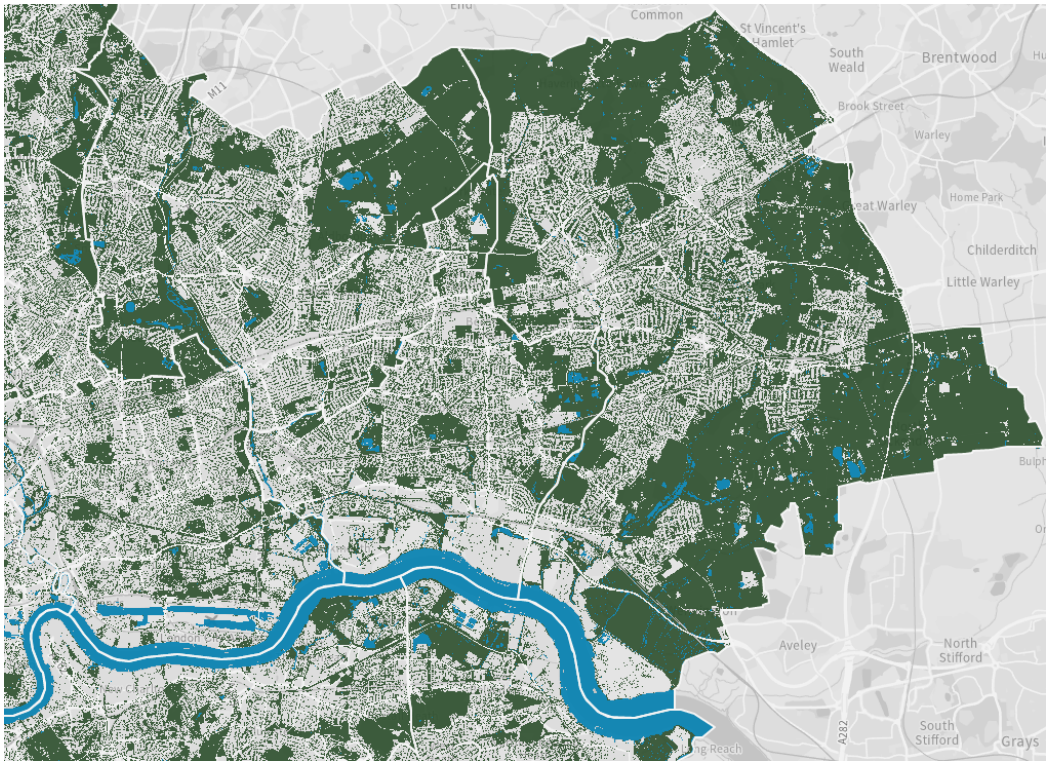
Green infrastructure is an important asset as it serves to: -

- promote healthier living, providing spaces for physical activity and relaxation
- cool the city and absorb storm water to lessen the impacts of climate change
- filter pollutants to improve air and water quality
- make streets clean, comfortable and more attractive to encourage walking and cycling
- store carbon in soils and woodlands

[75] https://data.london.gov.uk/dataset/green-and-blue-cover

- create better quality and better-connected habitats to improve biodiversity and ecological resilience

Figure 18: Green Cover, BHR boroughs



Source: GLA Environment Team

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The RSPH reports 'Health on the High Street [76] [77] investigated the relationship between local high streets and health. A healthy high street can provide the public with healthy choices, support community cohesion and social interaction, promote access to health services and do much to support individual wellbeing. The health promoting assets identified included libraries, pubs, greengrocers, gyms, pharmacists, and GP surgeries. Equally, high streets also facilitate activities that can have a detrimental effect on our health, particularly if provided in excess and in communities with greater vulnerability e.g., betting shops, tanning parlours, payday lenders and fast-food[78]. The RSPH created a league table of 146 high streets across London[78]. The two high streets in Barking and Dagenham in the league table were ranked 33 (Dagenham Heathway) and 45 (Chadwell Heath), where 1 was the least healthy and 146 the most healthy.

The authors noted that planning and licensing legislation did not necessarily prioritise health and wellbeing as it should, and Government was asked to provide Councils with stronger

[76] https://www.rsph.org.uk/static/uploaded/b6f04bb8-013a-45d6-9bf3d7e201a59a5b.pdf
[77] https://www.rsph.org.uk/static/uploaded/dbdbb8e5-4375-4143-a3bb7c6455f398de.pdf
[78] https://www.rsph.org.uk/our-work/campaigns/health-on-the-high-street/2018/london/league-table.html

powers to restrict the spread of unhealthy outlets, particularly in areas with a high density. In the absence of further powers, Councils were encouraged to

- introduce planning restrictions within 400 metres of schools (as part of the whole system approach to reducing obesity (see section 7.2).
- set differential rent classes for tenants based on how health promoting their business is.
- give business rates relief for businesses that try to improve the public's health e.g., by selling e-cigarettes but not cigarettes
- work with vape shops to ensure staff can sign post to stop smoking services
- work with betting shops and pay day loan providers so staff can sign post customers with debt problems to sources of support.

Recommendation 25: *the local authority to make use of the powers available to create a healthier offer on our high streets, prioritising disadvantaged areas with the unhealthiest offer, and taking into consideration the views of the local community.*

The wider environment, as well as the service offer available, affects the extent to which high streets support good health.

TfL's 2014 transport action plan[79] identified 10 indicators of a healthy street environment (see Fig. 19).

[79] https://content.tfl.gov.uk/improving-the-health-of-londoners-transport-action-plan.pdf

Figure 19: Indicators of a healthy street environment

Source: Lucy Saunders in *improving the health of Londoners*, TfL 2014

These directly benefit health e.g., by promoting physical activity or by reducing exposure to air pollution and noise; but also serve to make high streets more attractive and safe places to spend time – increasing the opportunity for social interaction, which is good for mental wellbeing, and the likelihood of residents spending money, thereby benefiting local businesses. The report noted that whereas most streets will have one or two positive characteristics, it often takes multiple positive characteristics to achieve a significant change in the number of people (enjoying) spending time on the street. Hence, regeneration, potentially driven by largescale house building and associated investment in appropriate community infrastructure, may offer the most realistic means to achieve a step change in the street scene and its benefit for current and future residents.

Access to good quality housing is an important determinant of population health (see section 4.4). An increase in housing stock is necessary given anticipated population growth (see section 2.1) and to maintain affordability (see section 4.4). As well as increasing the housing stock, **regeneration** is an opportunity to build in the physical infrastructure that will underpin healthy communities in the future e.g., green space, active travel infrastructure, healthy street environment, digital connectivity, etc. It is important that all regeneration and house building takes into account needs to the population which will inhabit these new homes and ensures that appropriate capacity for schooling, healthcare and community facilities is provided as part of the development.

Recommendation 26: *Ensure plans and policies shaping regeneration and housing growth e.g., borough level local plans serve to build healthier communities not simply additional housing. A formal health impact assessment of the Local Plan may help in this regard.*

Barking Riverside (LBBD), is part of the London Riverside opportunity area with a collective housing target of 26,500 new homes and 16000 new jobs[80]. Barking Riverside is a Healthy New Town demonstrator site embedding design principles which promote health and wellbeing and secure high quality health and care services[81].

Recommendation 27*: Boroughs, working with developers, should put in place processes to share learning from the healthy new town project at Barking Riverside*.

Residents now and in the future will have a range of needs – and these will change overtime. In developing our regeneration plans, we must aim to build communities that accommodate the needs of all, including young people leaving care, residents with physical and mental health problems and older people affected by frailty. The right housing and surrounding areas, in some cases coupled with the right support and care, will serve to maximise wellbeing and independence.

Recommendation 28*: Ensure that the housing needs of residents with specific needs e.g., relating to frailty, mental illness, physical and learning disabilities etc. are an integral part of plans for housing growth and regeneration.*

Appropriately qualified and experienced professionals are essential to the effective functioning of public services (health and social care, but also schools and colleges etc). Staff shortages are already a problem affecting quality of care and increasing the cost-of-service provision (see section 4.2). This can only worsen as the population grows unless local providers succeed in recruiting the next generation of professionals. The opportunity to buy or rent high quality, affordable housing could be part of a wider package (e.g. high performing schools, easy access to green space, safe and welcoming communities etc) BHR can offer to attract professionals into the patch.

Recommendation 29: *Consider if / how key worker housing might be made available to attract hard to recruit health and social care professionals into the BHR patch.*

Recommendation 30*: Building on regeneration plans in the three boroughs; develop an effective approach to promote the benefits of living in Barking, Havering and Redbridge as part of collective effort to fill hard to recruit health and social care vacancies.*

Crime, particularly violent crime, impacts negatively on the health of victims and the wider community. As well as health and the wider determinants of health are risk factors associated with being involved in crime

[80] https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas/london-riverside
[81] https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/

Fear of crime and antisocial behaviour has wider effects, deterring residents from using assets in the community and reducing social interaction.

Whereas a significant proportion of violent crime is within the home, knife crime, by or against vulnerable adolescents, is the cause of massive public concern and contributes disproportionately to fear of crime. Some serious violence is gang related; and gangs exploit young people and vulnerable adults in a variety of other ways resulting in serious and long-lasting harm to life chances.

Alcohol is a more commonly encountered driver of violent crime and crime figures are inflated by the borough's night-time economy which draws people in from adjacent boroughs.

Total notifiable offences (TNO) in Barking and Dagenham for the 12-month period Oct 2020 to Sept 2021 were 19,559, a rate of 91.4 per 1,000 residents, higher than the average for London (85.7) and England and Wales (81.8). The rate in 2020/21 was 1% higher than 2019/20 and 1% lower than 2018/19.

Domestic abuse accounted for over 20% of reported crimes in 20/21, a 1.3% increase from 2019/20. Reported domestic abuse in Barking and Dagenham was ranked 11th highest out of the 32 boroughs in London (excluding City of London). The rate of total domestic and sexual violence offences in 2021/22 was 17.3 offences per 1000 in Barking and Dagenham, the highest rate in London.

Violence against person was one of the highest reported crime categories during 20/21, ranked the 14th safest out of the 32 boroughs in London.

Knife crime is particular concern across London due to the increasing number of offences year on year from 2015/16 to 2019/20. Barking and Dagenham ranked 16th lowest in London in relation to number of knife crimes.

Health and social care services have a significant contribution to make in taking a public health approach to reducing violence, as part of a comprehensive multi-agency response to identify and support vulnerable residents from being involved and being impacted by violence in all forms and crime more generally.

Recommendation 31: Health and Social Care Partners should participate in Community Safety Partnerships and contribute to the delivery of agreed plans and strategies, taking a public health approach - focusing on areas of highest concern .

The pandemic demonstrated the importance of digital connectivity e.g., in allowing a proportion of the population to work from home, children to participate in education while restrictions on face-to-face learning were in force, families to keep in contact with loved ones via zoom and patients to access health care advice. However, it was equally clear that some of the population were excluded due to unaffordability and/ or lack of skills. This will remain an important barrier for many as we recover from the pandemic e.g., online applications are the usual means of accessing state benefits and job opportunities and digital competence is often a pre-requisite to access education and skills development. Residents with sensory and physical

disabilities may be particularly at risk of digital exclusion[82]. Although moving many support services online has meant that many harms e.g., domestic abuse, may have remained hidden.

Recommendation 32: The partnership must consider the needs of digitally excluded communities whenever it seeks to improve access to service by digital means.

Social networks with family, friends, work colleagues, neighbours etc can mitigate some of life's challenges and setbacks e.g., ill-health, relationship breakdown, job loss, experience of crime etc. Some groups and communities may be less likely to have strong networks and hence less resilient.

New housing developments or areas with a high level of population churn (see section 2.1) because of having more rental property, particularly HMOs, are likely to have a higher proportion of residents with weaker social networks.

In addition, new residents may be slow to (re-)engage with universal health services e.g., general practice and health visiting for families with young children, and as a result, make greater use of A&E and other walk-in services.

ONS[83] have identify three distinct cohorts as being more likely to self-report loneliness:

- Widowed older homeowners living alone with long-term health conditions.
- Unmarried, middle-agers with long-term health conditions.
- Younger renters with little trust and sense of belonging to their area.

Such social isolation is a risk factor for mental illness particularly in older residents.

Social prescribers working in GP practices, and local area coordinators are well placed to assist individual residents to build social networks.

At community level, Barking and Dagenham Council has community hubs to support the borough's most disadvantaged communities. In Barking, these are Gascoigne Children's Centre, Sue Bramley Community Hub, Barking Learning Centre and the Marks Gate Community Hub. In Dagenham there are four hubs; Becontree Children's Centre, Leys Children's Centre, Dagenham Library and the William Bellamy Community Hub[84]. The community hubs are designed with the community, with the intention of improving access to statutory services and support from the community and voluntary sector in the expectation that the timelier provision of advice and support, closer to home, will help stop problems escalating to crisis point. As such, community hubs shift the focus towards prevention and away from more costly and intrusive intervention by statutory services in response to a significant deterioration or crisis. To this end, the hubs provide an information service across the wider determinants of health including debt, housing, work, education as well as health and social care services and access to immediate support including a community food shop, access to computers and the

[82] https://www.lloydsbank.com/assets/media/pdfs/banking_with_us/whats-happening/lb-consumer-digital-index-2020-report.pdf

[83] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10

[84] The London Borough of Barking and Dagenham – Children's Centres (https://www.lbbd.gov.uk/childrens-centres)

internet alongside training and skills opportunities. Community hubs complement the 1:1 support provided by local area coordinators to individual residents. The borough also has a dedicated Family Information Service (FIS) which provides free, confidential, impartial guidance on childcare[85].

Recommendation 33: Partners, working with the community, should agree the need for action and how best to go about strengthening social networks and community capacity, prioritising areas with new housing developments, high population churn and significant disadvantage.

At different points in 2020 and 2021, during the Covid pandemic non-pharmaceutical interventions (NPIs)/public health measures of varying severity were imposed to control the spread of the disease. At times, a large proportion of the population were required to stay at home and forgo all but essential activities.

A variety of harms to the physical and mental health of residents have been reported subsequently e.g., increased levels of obesity and sedentary behaviour (see section 5) and poorer mental health (see section 7.3.3).

The Government is now signposting a return to normality in COVID-19 Response: Living with COVID-19[86].

However, there is considerable evidence that residents have not returned to pre-pandemic patterns of work and leisure and therefore, social interaction. Google's mobility data[87] shows how resident activity in various sectors has changed compared to their pre-pandemic baseline.

Table 4: % in change in visits to stated settings compared with pre-pandemic baseline, Feb 15th, 2022

	Greater London	LBBD	LBH	LBR
Retail and recreation	-29%	-15%	-10%	-22%
Supermarket and pharmacy	-15%	-14%	-7%	-9%
Parks	-22%	+43%	-12%	-34%
Public transport	-40%	-33%	-35%	-44%
workplaces	-47%	-45%	-41%	-53%
Residential	+12%	+8%	+10%	+10%

Source: COVID-19 Community mobility reports

Visits to retail and recreation, use of public transport and attendance at workplaces are still well below pre-pandemic levels. However, the effects are less marked in Barking and Dagenham than in central London probably because fewer residents are commuting into central London, but they do make some use of local infrastructure while working from home.

[85] The London Borough of Barking and Dagenham – Family Information Service (https://www.lbbd.gov.uk/family-information-service)
[86] https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19
[87] COVID-19 Community Mobility Reports (google.com)

It's probable that the pandemic will result in a permanent change in work patterns with an increase in the proportion of residents that regularly work from home. Employers will need to consider the implications of WFH on the health and safety of employees.

Recommendation 34: Partners to consider and respond to the needs of employees who, post-pandemic, routinely work from home to ensure their physical and mental health.

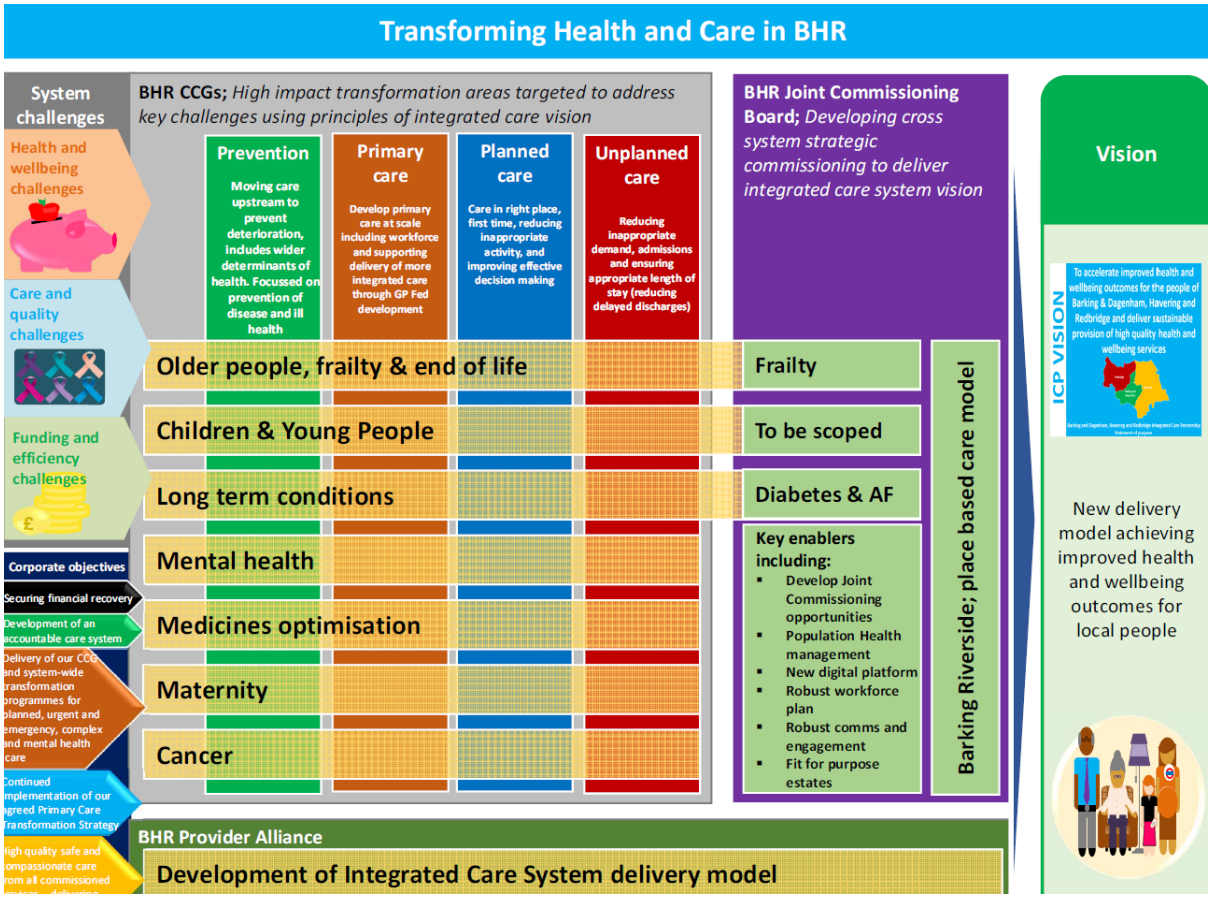
Outside of work, people who were particularly hard hit by the pandemic or who were thought to be particularly at risk e.g., residents who were asked to shield, may require more time and / or reassurances before they fully re-engage with the community. Until then, they will remain more isolated than otherwise would be the case despite the huge reduction in the risk of severe illness achieved through vaccination.

Recommendation 35: Partners should work to reassure the great majority of residents who may have shielded during the pandemic that vaccination, and antivirals for some patient groups, offer excellent protection against serious illness and hence the harms of continuing to 'self-shield' outweigh the benefits to physical and mental health to be gained from re-entering their community.

The recent health and social care reforms recognise the importance of place and communities play in determining health outcomes. Borough partnerships, bring together decision makers from across the health and social care system, with representatives of the community and voluntary sector to ensure the adoption of a population health management approach. The system will continue to work to ensure that patients can access excellent treatment and care when needed, but equally all partners will seek to tackle the causes of ill-health and shape the place we live in to improve health and reduce inequalities.

7. Pillar 4: Integrated Health & Social Care

A number of transformation boards have been established to lead the redesign and integration of health and social care services locally.



The JSNA considers each in turn, following a life course approach beginning with maternity and ending with end-of-life care.

7.1 Maternity

**Indicators and data used in this section can be accessed by clicking here*

There were about 11,300 live births to women resident in the three BHR boroughs in 2019. The fertility rate in LBBD (82.6/1000 women aged 15-44), LBR (73.4) and LBH (68.0) is significantly higher than the London (62.9) and national average (64.2). Fertility rates in LBBD and LBR have been at similarly high levels for the last decade. Rates in LBH also appear to have now plateaued having increased steadily over the last decade.

Notwithstanding any further changes in fertility rates, the number of pregnancies in all three BHR boroughs is likely to increase further in line with increases in the number of residents of childbearing age.

About 8,200 babies are born at Queens Hospital, making it one of the largest single site maternity units in the country. Nonetheless, a significant number of women residents in BHR, particularly women living in the west of LBR and LBBD have their babies in maternity units elsewhere in inner northeast London.

Given such patient flows across local health system boundaries, it makes sense to plan maternity services across a bigger footprint. The East London Local Maternity System (ELLMS)[88], a collaboration of maternity service providers and stakeholders, commissioners, voluntary organisations and service users fulfils this function ensuring there is adequate capacity across the whole of the NEL STP area and all providers deliver similarly high-quality care.

Women can choose to give birth at home, in midwife-led units, or in labour wards. The latter are more suited to the needs of higher risk mothers. The proportion of complex pregnancies is higher in more disadvantaged areas (e.g., LBBD) and has increased more widely because of increases in maternal obesity and related gestational diabetes. Given that the Queens Unit is more or less at capacity, there is a need to develop midwife-led care options to free up hospital capacity for higher risk mothers.

The great majority of pregnancies result in the live birth of a healthy baby. However, a small number end in stillbirth or neonatal death. Barking and Dagenham and Havering have a higher rate of stillbirths but have a lower rate of neonatal deaths. Redbridge conversely has a lower rate of stillbirths and a higher rate of neonatal deaths. Overall, BHR CCGs are on the agreed trajectory for a 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025.

The National Institute for Health and Care Excellence (NICE) recommends antenatal booking by 10 weeks of pregnancy[89]. This is an opportunity to gather the information needed to support a healthy pregnancy. Women booking after 20 weeks are considered a much higher risk as the opportunity for early screening to identify risk factors, such as infectious and inherited diseases, has passed. Data from the Maternity Services Dataset (MSDS) for 2018/19 shows that across BHR that 6,290 women (51.1%) had their booking appointment with a midwife within 10 completed weeks of their pregnancy. Less than half of Barking and Dagenham and Redbridge pregnant women had a 10-week booking, a trend noted across

[88] http://www.myhealth.london.nhs.uk/maternity/east-london/
[89] Antenatal care for uncomplicated pregnancies | Guidance | NICE

London at 47.8%. 58.6% of pregnant women in Havering had a midwife appointment within 10 weeks - outperforming BHR, London and National comparators.

Table 6: Midwife appointment within 10 weeks

	NUMBER OF WOMEN WHO HAD AN APPOINTMENT BOOKED WITHIN 10 WEEKS OF THEIR PREGNANCY	10-WEEK BOOKINGS AS A % OF THE TOTAL NUMBER OF PREGNANCY BOOKINGS IN THE PERIOD
LBBD	1,865	47.6%
LBH	2,055	58.6%
LBR	2,370	48.5%
LONDON	57,400	47.8%
ENGLAND	377,235	57.8%

Source: Maternity Services Dataset (MSDS) v1.5

Table 7. Number and rate (per 1,000) of stillbirths and neonatal deaths in BHR in 2020

BOROUGH	TOTAL BIRTHS (RATE)	STILLBIRTHS (RATE)	NEONATAL DEATHS*
LBBD	3,406 (15.9)	20 (5.8)	12
LBH	3,116 (12.0)	7 (2.2)	5
LBR	4,343 (14.2)	27 (6.2)	7
LONDON	111,688 (12.4)	485 (4.3)	285
ENGLAND	585,195 (10.3)	2,231 (3.8)	1,674

*Data for neonatal deaths in for 2019
Source: Total births and still births: ONS – Births in England and Wales: 2020
Neonatal deaths: Child and infant mortality statistics QMI (2019)

*Stillbirth is a baby born after 24 weeks completed gestation and which did not at, any time, breathe or show signs of life
**Neonatal death is defined as deaths at under 28 days

***The number of stillbirths and deaths under 28 days, per 1,000 live births and stillbirths (The number of stillbirths and deaths under 28 days, per 1,000 live births and stillbirths).

Smoking is a risk factor for stillbirth and neonatal death. The number of mothers known to be smokers at the time of delivery as a percentage of all maternities with known smoking status. A maternity is defined as a pregnant woman who gives birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in a NHS hospital in 2019-20 in: LBBD (7%), LBH (7.7%) and LBR (4.2%) is significantly lower than the national average (10.4%). Rates in LBBD and LBH having improved significantly in recent years, however they are considerably higher than the London average (4.8%).

The experience of childbirth is a uniquely personal event with potentially long-term impacts on mother and baby and their developing relationship. Hence, service user choice and experience

of care are particularly important aspects of overall quality of care. The CQC undertakes surveys of mothers across the country. Feedback from women attending Queens in February 2018 was broadly similar to the national average.

Table 8: The experience people receive care and treatment at BHRUHT Maternity services in 2020.

ASPECT OF CARE	PATIENT RESPONSE	COMPARED WITH OTHER TRUSTS
LABOUR AND BIRTH	8.7/10	About the same
STAFF	8.4/10	About the same
CARE IN HOSPITAL AFTER THE BIRTH	7.8/10	About the same

Source: https://www.cqc.org.uk/provider/RF4/survey/5

The benefits of breastfeeding are clear[90] and yet rates of breastfeeding across BHR are variable; LBR mothers (81%) are more likely to initiate breastfeeding than the England average (74.5%); rates in LBBD (73.6%) are similar to the England average whereas rates in Havering are significantly lower (59.7%). Action is required by many partners to make breastfeeding the norm, particularly in Havering.

The vision for maternity services nationally is set out in the Better Births report[91]. In response, the ELLMS has developed identified the priorities set out below to provide women with personalisation, safety and choice, and access to specialist care whenever needed.

In the London Borough of Barking and Dagenham, there were 3,395 domestic abuse offences – a rate of 16.5 per 1,000 population, the highest of all BHR boroughs. Domestic abuse incidents are also higher at 5,460; a rate of 26.5 per 1000.

	LBBD		LBH		LBR	
	Count	Rate per 1000	Count	Rate per 1000	Count	Rate per 1000
DOMESTIC ABUSE OFFENCES	3,395	16.5	2,560	10.2	3,121	10.4
DOMESTIC ABUSE INCIDENTS	5,460	26.5	4,393	17.5	5,019	16.7

Source: MOPAC Domestic and Sexual Violence Dashboard

Across every ward in Barking and Dagenham, Havering and Redbridge, Abbey ward in Barking and Dagenham has both the highest count of domestic and violence offences (273) and domestic violence incidents (419).

[90] https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/
[91] https://www.england.nhs.uk/ourwork/futurenhs/mat-review/

Recommendation 36: Enhance continuity of carer (CoC) ensuring as many women as possible receive midwife-led continuity of carer initially prioritising those identified as most vulnerable and high risk.

Recommendation 37: Strengthen personalised care and choice; increase the proportion of women with a personalised care plan, initially prioritising disadvantaged and vulnerable women whilst offering all women information and choice on place of birth.

Recommendation 38: Continuously improve maternal safety including by full implementation of the second version of the Saving Babies' Lives Care Bundle and work with Public Health to help expectant mothers to stop smoking to meet the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths, and intrapartum brain injury by 2025.

Recommendation 39: Improved quality of postnatal care for all women including enhanced support to vulnerable women (e.g., perinatal mental health, drug and substance misuse) and focusing on infant feeding.

Recommendation 40: Improve access to domestic violence support to all women accessing maternity services through the introduction of an early support and referral scheme for identified victims

Achievement of these priorities will be enabled by action to:

- Improve data monitoring and hence the quality and accuracy of available maternity metrics
- Grow and further develop a sustainable workforce
- Improved system working whereby maternity services, particularly ante- and post-natal, are provided alongside other family-orientated health and social services provided by statutory and voluntary agencies.

Impact of Covid

- The pandemic resulted in reduced NHS and community based/peer face to face support to pre- and post-natal parents. Therefore, the role of health visitors and third sector organisations is even more vital. The support needs could also include wider concerns relating to cg job insecurity, reduced income and general anxieties caused by the pandemic
- Late presentation due to anxieties about utilising health services may have also impacted on the health of the mother and baby. This would need review
- It has been reported that domestic violence has also risen during the pandemic, particularly during the periods of lockdown, and although it is not known if this has specific concern for pregnant women, maternity services are an ideal opportunity to identify those who would benefit from further support

- Covid-19 vaccine uptake of two vaccines by pregnant women reported on 20th October 2021 was 28.16% (B&D) 40.33% (Redbridge) and 43.05% (Havering). 4.2% (B&D) 5.55% (Redbridge) and 2.9% (Havering) women declined the offer. 36.17% (B&D) 25.07% (Redbridge) and 17% (Havering) had a no coded invite.

A Maternity Services Equity and Equality needs assessment was recently prepared by North East London Local Maternity System (November 2021).

The assessment offers equity and equality finding for health outcomes, community assets and staff experience.

Key findings are covered in appendix 5(b) (full report can be found here: PowerPoint Presentation (eastlondonhcp.nhs.uk)).

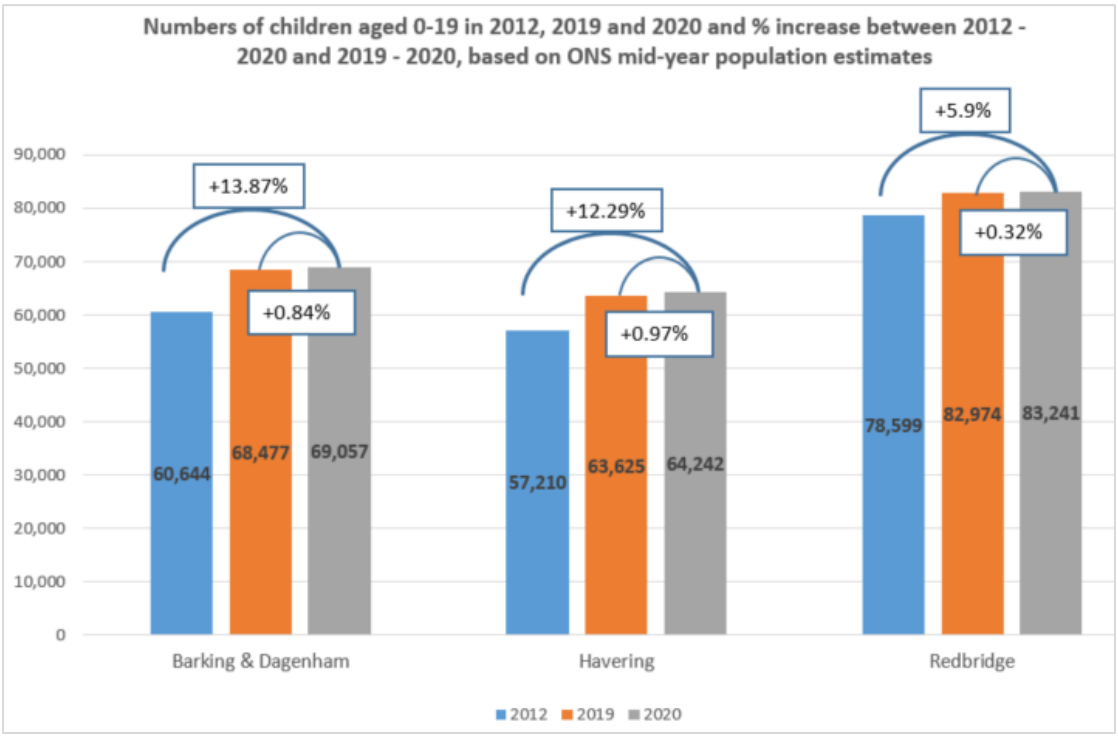
7.2 Children & Young People

**Indicators and data used in this section can be accessed by clicking here*

7.2.1 Population

The number of children and young people in the three BHR boroughs has increased significantly in recent years (see Appendix 2). LBBD and LBR are very young boroughs – with a very high proportion, and high numbers, of children and young people, with 32.2% and 27.2% of the resident population aged 0-19 years respectively. LBH has a smaller proportion of CYP aged 0-19 years (24.6%) but has experienced the greatest relative change in recent years, requiring existing services to expand rapidly to meet increasing demand (Figure 20).

Figure 20: Number of children aged 0-19 and % increase up to 2020



The proportion of BAME CYP in LBH has increased in recent years and will continue to do so but LBBD and LBR are much more diverse and representative of London as a whole in this regard (see Appendix 2). Mid-year population estimates for 2021 indicate that 74.6% of LBH total population is white British, compared to 32.7% in LBBD and 23.8% in LBR. Roughly one quarter of the local population in LBBD are Black/Black British and another quarter Asian/Asian British, whilst LBR has a predominantly Asian population, roughly half of the residents.

***Recommendation 41**: Boroughs will need to ensure that cultural competence is integral to the development of future services to meet the changing needs of the population. To reduce potential inequities in access to local services, cultural appropriateness of services, and English as a foreign language, should be considered in translating appropriate information and signposting to services.*

The growth in child numbers has been driven by the relatively high general fertility rate (GFR) in all three boroughs – higher than the average GFR for London (Appendix 3) and by children moving into the patch from elsewhere[92]. Changes in housing benefit and the relative affordability of housing in the three boroughs relative to elsewhere in London may be responsible. Irrespective of the cause, the movement of CYP from inner to outer London boroughs may serve to increase the complexity of need as well as the number of CYP in recipient boroughs.

***Recommendation 42:** Local Partnership Boards (linking to BHR transformation board for CYP) should consider a rolling programme of reviews to ensure that the overall capacity of universal services e.g., health visiting, community paediatrics, therapies, Speech and Language etc. within BHR is adequate and proportionate to the pace and scale of change in the CYP population in recent years.*

7.2.2 Health and Wellbeing Outcomes

There are relatively few population-level health outcome measures for CYP available at local authority level other than mortality rates. Following changes introduced in the Children and Social Work Act 2017 and the subsequent Child Death Review Statutory and Operational Guidance 2018, the three Local Authorities (LBBD, LBH, LBR) and Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group (BHR CCG) agreed to strengthen local working and develop a new Child Death Review (CDR) system. The Barking and Dagenham, Havering and Redbridge Child Death Overview Panel (BHR CDOP) began work in October 2019, putting processes in place across the BHR system to comply with the guidance and embedding the use of e-CDOP. This has resulted in a more robust review of child deaths, which allows identification of local patterns regarding cause of death, underlying modifiable factors and monitor trends over time.

The death of a child is thankfully a relatively rare event. The risk of death is greatest in the first year of life often linked to prematurity and / or congenital problems. Infant mortality rates for the period 2018-2020 in all three boroughs are similar to the national average, ranging from 2.3 per 1,000 in LBH to 2.8 per 1,000 LBR and 3.9 per 1,000 LBBD[93] . Between 2019 and 2021

[92] Havering data source: https://www.haveringdata.net/wp-content/uploads/jsna/this_is_havering/201819_Havering-Demographic-Profile-v4_2.pdf
[93] PHE Fingertips (2021) https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/3/gid/1938133228/pat/6/par/E12000007/ati/302/are/E09000016/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

the BHR CDOP was notified of a total of 103 deaths, of which 48 were reviewed by the CDOP. Such reviews provide the means of systematically identifying opportunities to prevent future deaths e.g., by improvements in health care services or public health action.

Recommendation 43: *Lessons learned through the CDR process should be shared with the Maternity and CYP Transformation boards, who may consider how to incorporate priority improvements to the health and social care system in their respective work plans.*

7.2.3 Wider determinants of health

The experience of **poverty** in childhood has significant and long-lasting effects and is associated with poorer outcomes regarding all aspects of life including health. LBBD is the most disadvantaged London borough, and 5th most deprived upper tier local authority in England[94]. LBH and LBR have lower levels of disadvantage overall but focused in smaller areas; LBBD has 4 LSOAs which fall into the first (most deprived) decile on IMD rankings and LBH has 1 LSOA in the first decile (LBR has none). The proportion of children affected by income deprivation varies in a similar fashion from 23.8% in LBBD (13.1K children) to 16.0% in LBH (7.7K) and 13.7% in LBR (9.3K) (Appendix 3). The percentage of children living in relative low-income families is highest in the most deprived wards[95]:

The Covid-19 pandemic is also likely to have had a **disproportionate impact** on families. Those families who experienced greater levels of disadvantage before the pandemic are therefore likely to have been more severely impacted by the pandemic, exacerbating their existing inequalities; data is still emerging on these issues.

School closures are likely to have disrupted access to the social care protection that the school environment provides. Children from disadvantaged backgrounds, BAME ethnic groups, children of lone parents or parents who are key workers are most likely to have been disproportionately affected. In LBBD 23.5% of households are lone parent, compared to 18.1% in LBR and 14.1% in LBH[96].

Whilst younger children may not have been as directly affected by Covid-19 infection as older adults, there is national evidence of an impact on their mental health and wellbeing, and disruption to education. Children and young people who are disadvantaged economically, teenage girls and youths with pre-existing mental health problems are associated with worse effects to their mental health and wellbeing as a result of the pandemic[97]. More comprehensive local data needs collecting to assess the ongoing impact of the pandemic on health and wellbeing of disadvantaged groups.

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[94] UK Government (2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/834001/File_11_-_IoD2019_Local_Authority_District_Summaries__upper-tier__.xlsx

[95] Data Intelligence Hub Deprivation Reports https://www.haveringdata.net/deprivation/report/view/bd0a5ebe1b4f41428c04a05ccd26dc80/E05000319/)

[96] ONS (2021) Data for LBBD, LBH and LBH for 12 months to September 2021. https://www.nomisweb.co.uk/

[97] HM Government (2021). Covid-19 Mental Health and Wellbeing Suveillance Report. Chapter 7: Children and Young People. https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/7-children-and-young-people

Free preschool education and childcare is available to all children from age 3 and to disadvantaged and / or children with additional needs from age 2. Hence the scheme is designed to provide additional support to those most in need but take up is incomplete and many children do not benefit as a result. However, the take-up of funded early education places by eligible 2-year-old children in 2021 has decreased by around 2% from 2018 in LBBD and LBH, with the largest reduction in take-up seen in LBR (12% reduction). This is likely due to the impact of the pandemic on nursery closures, discussed further below. In 2021, take up of places for 2-year-old children remained relatively higher in LBBD (76%) than LBH (54%) or LBR (45%). The take-up of 3–4-year-old places across the three boroughs is more evenly spread at 84% in LBBD, 90% in LBR and 89% in LBH, although again there has been around a 2-5% reduction in take up since 2018[98].

Preschool and nursery closures during the Covid-19 lockdown had wider impacts on parents' ability to work and the additional pressure home schooling placed on parents was exacerbated for those living alone with children. Women are more than twice as likely to be key workers as men. In addition, parents were more likely to be key workers than non-parents, with 39% of working mothers employed as key workers before the crisis began, compared to 27% of the working population as a whole. During the first lockdown, only a third of childcare providers remained open nationally and fewer than 100,000 children nationally attended on any given day[99].

A study conducted in October 2020 by Ofsted in 208 **early years providers** and maintained nursery schools found that the pandemic had significantly impacted the **learning and development** of children who had left and subsequently returned[100]. They were particularly concerned about children's personal, social and emotional development. Some children had returned less confident and more anxious. In some cases, children had also become less independent, for example returning to their setting using dummies or back in nappies having previously been toilet trained.

Recommendation 44: *Ensure opportunities to maximise awareness and uptake of free preschool education and childcare are taken e.g., via regular contacts with health professionals including midwifery, health visiting and with general practice and Local Authority Early Help teams/Children's Centres.*

Separate **assessments** are undertaken in early years settings and by health visitors (ASQ3) at age 2 – 2 ½ years. These reviews provide opportunities for health visitors and families to assess the child's physical, social and emotional needs, identify any potential issues or developmental delays early and enable support to be provided as early as possible. Undertaking these

[98] Data Source: https://explore-education-statistics.service.gov.uk/find-statistics/education-provision-children-under-5/2021

[99] Economics Observatory (2020). How has the Covid-19 Crisis affected preschool childcare? https://www.economicsobservatory.com/how-has-covid-19-crisis-affected-pre-school-childcare

[100] Ofsted (2020). Covid-19 Series: Briefing on Early Years , October 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933836/COVID-19_series_briefing_on_early_years_October_2020.pdf

assessments together or sharing results can help health and early years professionals arrive at a shared understanding of a child's needs and how they might best be addressed. The last available data regarding the proportion of children receiving an ASQ3 review is shown below in the section regarding health visiting services (Section 7.2.6, Table 4). Currently NELFT is unable to share the data collected in an anonymised, aggregate form. Sharing this information would assist with the design of interventions to enable universal services to better support the needs of children and improve our understanding of the need for specialist services e.g., Speech and Language Therapy.

Recommendation 45: Increase joint assessments by early years settings and health visitors. HV teams are recommended to implement a failsafe follow up procedure to capture all children eligible for the 2-year offer.

Recommendation 46: Ensure that anonymised aggregate data from the ASQ3 are available to inform health service planning and interventions to improve school readiness.

School readiness is measured at the end of the reception year to determine the level of development in 4–5-year-olds against the Early Years Foundation Stage (EYFS) learning goals. The last available data (2018-19) showed that at the end of reception year, the majority of children are assessed as having a good level of development. The proportion who achieved this good level of development in LBBD (72.4%) and LBH (71.7%) is similar to the England average (71.8%); the proportion in LBR (75.6%) is significantly better. Nonetheless, somewhere around 1000 children in each borough are already lagging behind their peers by this time. Children in receipt of free school meals are more likely to not achieve a good level of development particularly in LBH.

In addition, there is a gender inequality for the percentage of children achieving a good level of development at this time, with fewer boys than girls achieving this level of development. The gap is highest in LBBD (14.9 percentage points difference), with a difference of 11.0 and 11.1 respectively in LBR and LBH.

Unfortunately, the statistics release for the Early Years Foundation Stage Profile results in England for 2019-2020 and 2020-2021 were both cancelled. This was primarily as a result of school closures during Covid lockdowns compromising the established data collections. Local data collection for school readiness will be an important indicator for recovery.

Recommendation 47: Schools, HV and EYFS providers to work together to improve the percentage of children achieving at least expected level across all learning goals, and those achieving a good level of development. Consider an additional focus on the gender difference in school readiness.

Throughout the pandemic the Health Visiting providers across all three boroughs have experienced significant challenges in maintaining their ability to deliver the 2-2 ½ year checks. This has included lockdown impacting on ability to deliver face to face checks, and NHS staff redeployment to delivering vaccination which has reduced staff capacity. This is also the case nationally where respondents to an NIHR funded survey in June 2020 reported that Health visitors appeared to have experienced the highest level of redeployment to provide Covid care or vaccination across four professional groups including midwives, HV, community paediatricians and social workers[101].There is currently a lack of data in 2-2½ year checks due to issues in data quality; many of the checks were conducted remotely rather than in-person and were reliant on parents self-assessing their child.

Recommendation 48: Ensure 2-2 ½ year checks are delivered face to face, in partnership with early years staff, to ascertain current level of development need in school readiness. Use data from 2-2 ½ year checks to identify population groups and or communities at greater risk of being non-school ready and the reasons why; to inform the development and targeting of evidence-based interventions to enable parents and child care staff to support children back on to a trajectory towards school readiness. Use the same data set to ensure that there is adequate provision for children with more significant need requiring timely assessment and care from relevant specialist health care services.

GCSE Attainment for 2019/20, as measured in terms of average attainment 8 score, is similar to the national average (50.2 mean score) in LBBD (50.1) and significantly better than national in LBR (56.0) and LBH (52.2). Equivalent scores for children in receipt of free school meals are lower, particularly in LBH (34).

Recommendation 49: As part of a comprehensive approach to building greater aspiration and educational achievement particularly in disadvantaged and / or otherwise vulnerable groups. Consider the potential contribution of health and social care providers e.g., outreach to schools and career fairs; workplace experience; apprenticeships; career paths from less skilled lower paid roles into better paid, professional health and social care roles etc.

Employment – As discussed in section 5, employment is fundamentally good for health. Rates of youth unemployment across BHR are relatively low with 4.2% of 16-17 years olds in LBBD Not in Education, Employment or Training or whose activity is not known; 2.9% in LBH and 3.1% in LBR.

Homelessness – directly impacts on the health of children and young people e.g., children in temporary accommodation have poorer social networks and higher rates of mental health problems. In addition, homelessness can interfere with a child's studies further affecting their

[101] UCL/University of Oxford/NIHR (2020) https://www.ucl.ac.uk/children-policy-research/sites/children_policy_research/files/the_impact_of_the_covid-19_pandemic_on_services_from_pregnancy_through_age_5_years_interim_report_june_2020_0.pdf

life chances in the longer term. Rates of family homelessness in all three BHR boroughs (LBBD, 5.4/1000 households, n=426; LBH 2.5/1000, n= 256; LBR 3.4 /1000, n=381) are higher than the national average (1.7/1000). By July 2021, there were 314 households in LBH assessed as threatened with homelessness, or homeless, of which 49% were families with dependent children. In LBBD and LBR there were 219 and 32 households at risk of or homeless respectively, of which 58% and 60% were families with dependent children.

7.2.4 Behaviour and Lifestyle

In some respects, the current generation of children and young people are living more healthy lifestyles than preceding ones. Most notably, the prevalence of **smoking** among young people, when the great majority of adults start smoking, has fallen faster and further than for adults. Rates of smoking amongst 15-year-olds in all 3 BHR boroughs (LBBD 5.6%, LBH 5.8%, LBR 3.4%) are lower than the national average (8.2%).[102]

The same survey found that less than 5% of under 15-year-olds had used cannabis in the previous month – similar (LBH) or better (LBBD and LBR) than the national average and about 1% of 15-year-olds in BHR reported using drugs other than cannabis, similar to the national average.

> ***Recommendation 50:*** *Ensure that programmes to improve digital connectivity are supported by associated education and awareness of the health impacts of cyberbullying and screen addiction.*

There has been a noticeable change in use of digital media throughout the pandemic and providing digital connectivity has been essential to provide some services. Concerns have been raised about the **impact of screen and social media** use on the health and wellbeing e.g., cyberbullying and lack of sleep impacting on mental health. The Chief Medical Officer concluded there was no clear scientific consensus regarding the overall balance of pros and cons but adopting the precautionary principle issued guidance for parents and carers[103].

One lifestyle related risk factor that is going in the wrong direction and as such represents a significant threat to the health of the population is **childhood obesity**. Previously obesity was associated with middle age. Now 1 in 10 children are obese by the age 5, rising to 1 in 2 by age 11 at Year 6 (Table 9). Although a full data collection was made through the National Child Measurement Programme (NCMP) in 2019-2020, due to the restrictions imposed by COVID, a representative 10% sample was taken for the academic year 2020-21. The results for the 2020-21 year are therefore less robust. Nevertheless, the percentage of those overweight and obese remain high. Whilst the NCMP is a surveillance too, not a screening tool, children who are measured as above or below the healthy weight range should be offered appropriate support, such as through healthy schools' approaches or evidence-based weight management services.

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[102] Source: What About YOUth (WAY) survey, 2014/15

[103] United Kingdom Chief Medical Officers' commentary on 'Screen-based activities and children and young people's mental health and psychosocial wellbeing: a systematic map of reviews'

Table 8. Indicative Prevalence of overweight (including obesity) by school year and borough (unpublished 2020-2021 data).

Prevalence of overweight (including severe obesity)	LBBD	LBH	LBR
Reception	12.9%	10.1%	11.2%
Year 6	52.7%	24.3%	41.7%

Recommendation 51: *Boroughs to review and refresh their obesity strategies and consider options to implement Tier 2 and Tier 3 weight management approaches for CYP*

Type 2 diabetes is now a disease of childhood and very large numbers of residents will run the increased risk cancers, CVD, MSK etc. associated with excess weight for many more years of life. There is no single silver bullet. As stated in Section 5, careful and rigorous implementation of a 'whole system' approach, coupled with advocacy for further action by central Government offers a potential solution in the long term.

7.2.5 Community and place

NB. See also wider issues considered in Section 7.

Children and to a lesser extent young people have narrower horizons than adults, spending a large proportion of their time in the family home and / or educational settings.

The Mayor of London offers award schemes to encourage early years settings (Healthy Early Years London (HEYL)) and schools (Healthy Schools London (HSL)) to review and improve the extent to which their culture and environment support health. Settings in all 3 boroughs currently participate. Throughout the pandemic, schools and early years settings have continued to engage in the schemes, with several achieving bronze, silver or gold awards throughout this period.

Recommendation 52: *Encourage and support early years settings and schools to maximise the health and wellbeing benefit to children and young people in their care through participation in the relevant HEYL/HSL scheme or similar.*

More fundamentally, schools can provide a place of safety for our most vulnerable young people. Exclusion from school is indicative of poor education attainment. Moreover, excluded CYP are particularly vulnerable to exploitation in all its forms and an increased risk of

involvement in serious youth violence – as victim or perpetrator has been suggested if not universally accepted[104].

***Recommendation 53: Utilise the Borough Partnership approach to** work with schools to provide better support to pupils at risk of exclusion.*

The family home is by far the most important community for any child. A secure and loving family is the single best predictor of subsequent life chances and one that other agencies struggle to replicate. Nonetheless there is extensive evidence regarding the impact of negative factors experienced within the family home during childhood on later life. **'Adverse childhood experiences'** (ACEs) is one way of describing these negative factors.

UK studies[105] have suggested a simple dose/ response relationship between the number of ACEs experienced and the number and type of risky health behaviours engaged in, the social and community impact and impact on use of services as a result of these risky behaviours (Table 9).

Table 9. Likelihood of children with 4 or more ACEs engaging in risky behaviours and the impact on services by the consequences of those behaviours.

Health and wellbeing behaviours	Social and community impact	Impact on services
Those with 4 ACEs + are:		
2x more likely to have a poor diet	2x more likely to binge drink	2.1 x more likely to have visited their GP in the last 12 months
3x more likely to smoke	7x more likely to be involved in recent violence	2.2 x more likely to have visited A&E in the last 12 months
5x more likely to have had sex under 16 years	11x more likely to have been incarcerated	2.5 x more likely to have stayed a night in hospital
6x more likely to have been pregnant or got someone accidently pregnant under 18	11x more likely to have used heroin or crack	6.6 x more likely to have been diagnosed with an STD

An appreciation of ACEs raises the possibility of new opportunities to improve health and interrupt the transmission of a variety of negative outcomes from one generation to the next by: -

- **Preventing exposure to ACEs** in the first place e.g., help re. parental attachment; parenting skills courses; resilience building; education and awareness raising re. sex and relationships; drug and alcohol etc. in schools and colleges; anti bullying interventions etc.

[104] https://www.tes.com/news/we-need-reality-check-about-exclusions
[105] Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population

- Early intervention - effective safeguarding arrangements, identification and effective family focused treatment of parental MH and drug and alcohol problems; support for victims of domestic violence.
- Mitigation in support those affected – trauma aware services; Child and Adolescent Mental Health Services (CAMHS) and Youth Offending Services (YOS).

LBBD, for example, is continuing to work with the Early Intervention Foundation to better protect children from harm.

Recommendation 54: Put in place learning from joint working between EIF and LBBD. Ensure that the outcomes from the multi-agency working around Emotional Wellbeing and Mental Health (including family interventions and targeted support for vulnerable cohorts) are taken forward.

Impact of the Covid-19 Pandemic on ACEs

The stresses and strains of lockdown, illness, bereavement, coping with young children at home, whilst furloughed or experiencing a significant drop in income has also led to increased reports of domestic violence. As highlighted in chapter 6, domestic violence and sexual violence offences in Barking and Dagenham was 17.3 offences per 1000 and although we are unable to substantiate how many are reported by carers or parents, it is likely that a high proportion are witnessed by or are within households with children and so contributing to their Adverse Childhood Experiences. Pregnant women are more at risk of such violence as highlighted on p66.Nationally, data from the Ministry of Justice reports that calls for help via domestic abuse helplines and webchats/online support increased by 52% compared with pre-covid levels[106].

Reduction in income has also led to increased levels of food insecurity. Over the course of the pandemic, 5 million people in the UK living in households with children under 18 have experienced food insecurity since the lockdown started. 1.8 million experienced food insecurity solely due to the lack of supply of food in shops, leaving 3.2 million people (11% of households) suffering from food insecurity due to other issues such as loss of income or isolation[107]. This is double the level of food insecurity among households with children reported by the Food Standards Agency in 2018 (5.7%).

Safeguarding vulnerable adolescents from harm must be a priority for all partners (& is discussed further in section 7.2.7 below). The threat may come in many forms. Serious youth violence is an ACE of major concern, which has sadly resulted in the deaths of young people in each of the BHR boroughs. In some instances, violence is gang related. Criminal gangs may also involve vulnerable young people in the supply of drugs in 'county lines' operations. Young people are also at risk of sexual exploitation from individuals, organised groups and other

[106] Ministry of Justice (2020) Ministry of Justice Silver Command data: Domestic abuse and sexual violence demand reporting. Unpublished data.
[107] Food Foundation (2020) https://foodfoundation.org.uk/new-food-foundation-survey-five-million-people-living-in-households-with-children-have-experienced-food-insecurity-since-lockdown-started/

young people. Still others may be at risk of involvement in religious or politically inspired hate crime. Alongside a vigorous criminal justice response, a public health approach is recommended to tackle serious youth violence.[108]

A Public Health approach has 6 broad criteria:

- It is focused on a defined population
- It is established with and for communities
- It is not constrained by organisational or professional boundaries
- It is focused on generating long term, as well as short term, solutions
- It is based on data and intelligence
- It is rooted in evidence of effective practice

The same principles could equally be applied to develop comprehensive, evidence-based solutions to other complex threats to young people.

Recommendation 55: *Capitalise on relationships built through the Borough Partnerships to embed a public health approach to tackling serious youth violence focusing on adverse childhood experiences and addressing risk factors for gateways to youth crime.*

Youth offending - Contact with the Youth Criminal Justice System is an indicator of how crime can have a wide-ranging effect on people's health and wellbeing. Data from 2018/19 and 2019/20 showed that both LBBD and LBR had a rate of first-time entrants to the youth justice system significantly higher than the rate for England (377 and 280 per 10,000 respectively). Havering's rate was significantly better than England (at 183 per 10,000). However, the rate of youth justice custodial sentences and overall youth proven offending rate were significantly worse (higher) in all three boroughs than England (Appendix 6, refs 27 & 28). A significant proportion have significant mental health problems that maybe unrecognised and / or inadequately managed; in England, 72% of children in the youth justice system were assessed as having mental health concerns[109].

Teenage parents have poorer outcomes e.g., in terms of educational attainment, employment and earning power than peers who have children later in life. Their offspring are more likely to be raised in poverty with impacts on their life chances – hence teen pregnancy serves to transmit disadvantage from one generation to the next. Teen parents and their children benefit from support to develop parenting skills and maximise educational attainment, employability and earning potential.

7.2.6 Integrated health and social care system for CYP

[108] https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence
[109] Gov.UK (2021). https://www.gov.uk/government/statistics/youth-justice-statistics-2019-to-2020

Immunisation - Vaccines are often cited as the most cost-effective health intervention[110] and yet uptake is falling and cases of vaccine preventable disease notably measles are on the increase. Uptake rates have reduced in the majority of primary childhood vaccinations by age 5 years in both LBBD and LBH (Table 10.) Anti-vaccination messages are certainly unhelpful, but the National Audit Office suggest that more prosaic problems such as the way healthcare professionals remind parents to vaccinate their children and difficulty access vaccination services at a convenient time and location may be to blame[111].

Table 10. Percentage uptake of primary vaccinations by age 5 years in 2020-21 compared to pre-pandemic levels 2018-19 by local authority

Borough	Year	DTaP/IPV/ Hib	DTaP/IPV booster	MMR1	MMR2	Hib/MenC
LBBD	2018-19	*93.8*	*72.0*	*92.1*	*73.3*	*90.4*
	2020-21	*92.5*	*69.0*	*89.6*	*69.8*	*87.9*
LBH	2018-19	*96.7*	*82.2*	*95.1*	*83.9*	*94.2*
	2020-21	*96.0*	*79.2*	*93.8*	*79.7*	*92.9*
LBR	2018-19	*91.8*	*69.0*	*89.9*	*71.5*	*87.1*
	2020-21	*90.7*	*70.1*	*88.4*	*71.5*	*86.3*

Recommendation 56: *Review the delivery of childhood immunisation in BHR with the aim of increasing uptake to levels necessary to achieve herd immunity, including Covid vaccinations for 12–15-year-olds and 5–11-year-olds if and when approved by Government.*

Health visitors have a unique opportunity to engage with all children and their families in the family home. The current "4,5,6 model" of service delivery strikes a balance between universal health checks for all and targeted support to more vulnerable families; with a particular focus on 6 high impact areas.

Delivery of the 5 mandated checks across BHR is variable (Table 4.)[112]. As a result, opportunities to offer advice about issues of concern and identify families needing additional support are missed.

Table 11. Delivery of 5 mandated checks 2019-2020

Area	Antenatal	New birth	6-8 weeks	1yr (by 15mths)	2 – 2 ½ yrs.
LBBD	1,621	95.8%	75.9%	78.0%	74.5%
LBH	83	95.1%	20.1%	91.6%	85.4%
LBR	227	89.8%	61.4%	50.7%	39.5%
England	N/A	86.8%	85.1%	83.6%	78.6%

[110] https://www.parliament.uk/documents/post/postpn314.pdf
[111] https://www.nao.org.uk/wp-content/uploads/2019/08/Investigation-into-pre-school-vaccinations-Summary.pdf
[112] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011902/Annual_Health_Visitor_Statistical_Release_2019_2020_Aug_2020_update__1_.ods

Recommendation 57: Work with providers common to the patch to recover from the impacts of Covid and improve delivery of mandated early years checks as a priority.

Health visiting, early years services, nurseries and schools play a vital role in safeguarding children and reduced access to school, youth workers or other key points of contact for children during the Covid-19 pandemic and lockdowns may have led to increased vulnerability in children, particularly exploitation through gang associated activities, domestic abuse, online abuse or sexual exploitation.

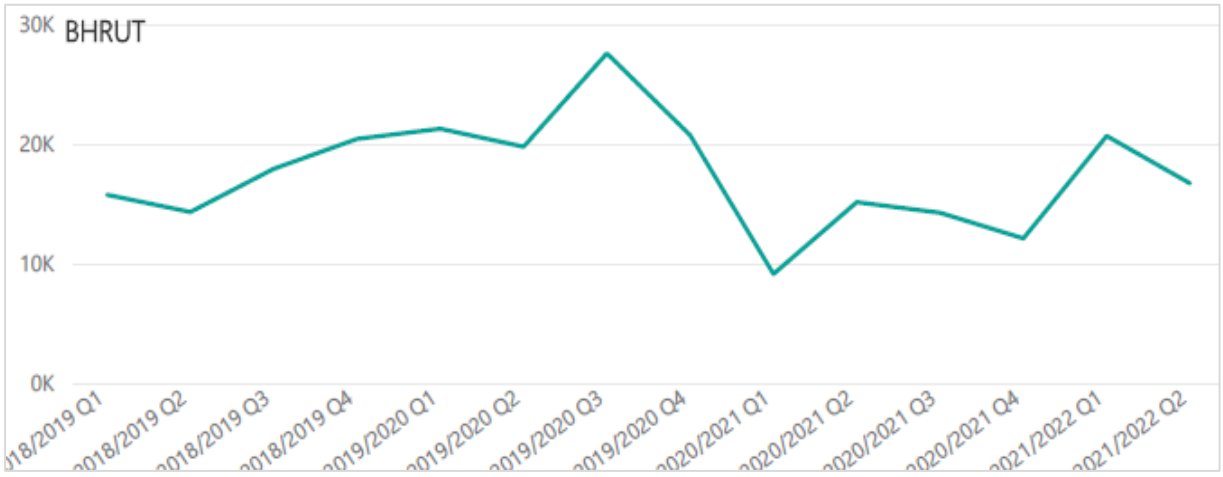
The pressure on community services has been immense, both to maintain face to face contact to complete the mandated early years checks and keep up with caseload increases in highly challenging circumstances.

The 2021 Annual Report of the Institute of Health Visiting showed that 80% of respondents to their survey (completed in October 2021) reported an increase in domestic abuse, 72% reported an increase in poverty affecting families and 71% reported an increase in child safeguarding cases. In LBH, for example, the number of initial child protection conferences attended by HVs increased from a total of 18 for April 2019 to March 2020; to 30 by the end of March 2021. In the first 2 quarters of 2021-22 (end September 2021) there have already been 50 initial CP conferences attended. Similarly, caseloads in LBH have increased from 595 per HV in June 2019 to 615 per HV by October 2021 despite significant investment to increase the numbers of HV staff. Staff shortages have been affected by redeployment to vaccination services, sickness, isolation and a number of staff reaching retirement age accompanied by shortages of new recruits to the service.

Recommendation 58: Health Visiting, School Nursing and Early Years staff are critical in the wellbeing of children and young people and early prevention of avoidable illness. CYP Transformation Boards and Local Authority Commissioners are recommended to prioritise review of these services to ensure they are fit for purpose. Seeking service user feedback and reporting findings to Commissioners will help facilitate any changes required to the delivery of the service.

Access to primary care as a first contact point is essential, especially to avoid inappropriate attendance at secondary care service. During lockdown (Q4 2019-20) attendance at A&E dropped significantly due to the pandemic at both major hospital trusts in NEL – BHRUT and Barts Health (Fig. 3). However, this returned to baseline levels by Q2 2021-22 (July to September 2021), suggesting both that the need for urgent care is still there, and that secondary care access may be the preferred choice of parents.

Figure 22. A&E attendances by patients aged under 18 years old at local secondary care providers (BHRUT and Barts Health) Q1 2018-19 to Q2 2021-22



F.Year	2018/2019				2019/2020				2020/2021				2021/2022	
Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
BHRUT	15,679	14,244	17,846	20,345	21,195	19,693	27,493	20,652	9,066	15,063	14,178	12,036	20,592	16,633
Barts	2,654	2,190	2,575	2,608	2,345	2,238	2,755	2,163	1,232	1,990	2,035	1,630	2,710	2,592
Total	**18,333**	**16,434**	**20,421**	**22,953**	**23,540**	**21,931**	**30,248**	**22,815**	**10,298**	**17,053**	**16,213**	**13,666**	**23,302**	**19,225**

Across NEL, rates of A&E attendances for children under 1 year old are significantly higher than England rates (957.4 per 1,000 persons) in LBR (1038 per 1,000) and similar in LBBD (983.2 per 1,000) and LBH (951.0 per 1,000)[113].

***Recommendation 59**: Statutory agencies to work in partnership with CCG, Early Years partners and children's centres, and build on the development of the Paediatric Integrated Nursing Service (PINS) to increase access to primary care services.*

[113] PHE/UKHSA Fingertips (2022) Rates of A&E attendances under 1 year 2018/19 data https://fingertips.phe.org.uk/indicator-list/view/iYi2ex7my0#page/0/gid/1/pat/6/par/E12000007/ati/302/are/E09000002/iid/90809/age/28/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

7.2.7 Safeguarding vulnerable CYP

Neglect, physical abuse, exposure to domestic violence, parental drug and alcohol dependency and mental illness can result in immediate harm to children. In addition, and as discussed above, exposure to Adverse Childhood Experience (ACEs) is linked a range of significant negative outcomes in later life. Safeguarding requires the active cooperation of a variety of partners. Borough level arrangements have recently been augmented by the addition of BHR wide collaboration developed and agreed by the DCS for each borough, the Nursing Director for BHR CCGs and the lead for the MPS.

Recommendation 60: The CYP Transformation Board should consider how best to support the development of joint working for better safeguarding as a priority workstream, ensuring staff across the ICS are clear on relevant pathways for raising and acting on safeguarding concerns.

The primary purpose of child protection arrangements is to protect children from further harm; in many instances, and following detailed assessment, this will entail remaining in the family home with appropriate support. Depending on the specific needs and strengths of the individual child and their family, child protection arrangements can be stepped up (or down) from child in need, to child protection or the child may be taken into the care of the Council.

Rates for all forms of safeguarding are generally similar or lower than the national average in LBH and LBR but higher in LBBD as would expect given the higher rates of disadvantage. Irrespective of the precise rates, significant numbers of children are subject to some form of child protection in all three boroughs.

Outcomes for looked after children such as educational attainment and mental and physical health tend to be poorer than those of children in the general population but given their experiences this isn't unexpected[114].

Subsequent life chances are also poorer, and the wider health and social care system should consider how they can assist LAC beyond their statutory duties e.g., by offering a variety of job opportunities giving LAC the opportunity to find 'good' employment.

7.2.8 Children with Special Education Needs and Disabilities (SEND)

SEND comprise a wide variety of problems that affect a child or young person's ability to learn. As a result, children with SEND need extra support, which can include help to take part in usual class activities or help communicating with others, through to a special learning programme and help with physical and personal care.

About 1 in 10 children and young people have SEND; reported rates in LBBD (14.5%) LBH (11.0%) and LBR (11.8%) are lower than the England average (14.4%).[115]

[114] https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children/#heading-top

[115] DfE Jan 2019 All Schools: number of pupils with special educational needs, based on where the pupil attends school

Delivery of the required help can involve contributions from schools, children's social care and NHS services (e.g., therapies, community paediatrics, CAMHs etc.). Complex care is captured in an Education Health Care Plan specifying the support needs of individual young people up to the age of 25 to achieve what they want in their life. The percentage of CYP in need with statements of SEN or an EHC Plan varies considerably across the patch - LBBD 7.5%, LBH 36.7%, LBR 54.0. In total, just under 4000 children and young people in BHR have an EHCP or statement.

The complex needs of small numbers of CYP cannot be met locally necessitating, in some cases, long journeys to specialist facilities and / or residential care. Greater collaboration across BHR or NEL as a whole may enable partners to meet the needs of more CYP closer to home.

Recommendation 61: *CYP transformation board and local based placed partnerships to champion improved partnership working to better meet the needs of CYP with SEND including joint reviews to better direct resources and options on Pan BHR commissioning to facilitate best use of scarce clinical resources and closer to home wherever possible.*

7.2.9 Mental health problems in CYP

About 1 in 10 CYP have a common mental health disorder. Estimated rates in LBBD (10.3%) are higher than the national average (9.2%) whereas rates in LBH (9%) and LBR (9%) are similar to the England average. In total circa 11K children in BHR aged 5 -16 are estimated to have a CMHD.

Conduct disorders (severe and persistent behavioural problems) are the most common CMHD; affecting 5% of children aged 5-10 increasing to 7% in secondary school years. Conduct disorders are twice as likely to be experienced by boys/young men then girls/women[116].

Actual data (as opposed to estimated) on mental health needs is only known for children with an EHCP. Children with social, emotional and mental health needs identified as a primary need on their EHCP, as a percentage of all school-age children, is higher in LBBD (2.7%) than the national average (2.4%); rates in LBH (1.2%) and LBR (1.9%) are significantly lower.

Increasing CAMHS support is a priority in the NHS. The immediate target is to increase access to at least 35% of those with a diagnosable condition. Hence alongside the challenge of increasing CAMHS capacity, there is an equally pressing need to engage and maximise the contribution of non-NHS support e.g., counselling commissioned by schools and / or the CVS; improve the ability of universal services including schools and parents to support CYP with mental health problems and build greater resilience amongst CYP themselves.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814246/SEN_2019_Local_Authority_tables.xlsx

[116] Green et al 2005

Recommendation 62: *CYP and MH transformation Boards should work to: -*

- *Increase CAMHS capacity and strengthen links with other providers*
- *Develop the capacity and capability of professionals in universal services including health visiting, school nursing general practice and schools to support children with mental health problems and their families*
- *Support children and their families to be more resilient*

Self-harm is a particular indicator of emotional distress and is associated with a higher risk of suicide[117]. Rates of hospital admission for self-harm in all 3 BHR boroughs are less than half the national average. Amongst 10–24-year-olds, rates of hospital admissions as a result of self-harm per 100,000 are 166 in LBH, 136.2 in LBBD and 126.2 in LBR, However, hospital admission captures only a small proportion of cases. Data about attendances at A&E would give a better measure of the incidence of self-harm. Systems to follow up people attending A&E with self-harm are an element of robust suicide prevention plans.

Recommendation 63: *ICS partners to*

i) *consider how best to report attendances for self-harm in CYP;*

ii) *ensure that NICE guidance for psychosocial assessment after hospital attendance for self-harm is implemented.*

7.2.10 Physical health of CYP

All children will at some point experience ill health. In most cases, it is relatively mild and self-limiting. However, about 42000 children aged 0-4 and living in BHR attended A&E in 2017/18. The rate of A&E attendance for young children was significantly higher than the national average in all 3 BHR boroughs (See also section 7.2.6 above). Improving the management of minor illness and injuries is a high impact area for health visiting services.

Recommendation 64: *Consider how health visiting, children centres and other early years providers can work together to strengthen the ability of parents to manage minor childhood illness and injury (and their confidence to do so).*

A number of important long-term conditions can begin in childhood. Asthma is the most common. Effective management can minimise both the frequency of severe attacks and the day-to-day distress and inconvenience of poorly controlled asthma which in turn impacts school attendance and participation in physical activity. Rates of hospital admission for asthma vary significantly between the 3 BHR boroughs from higher than the national average (192/100,000) in LBR (238/100,000), and similar in LBBD (235/100,000) and LBH

[117] Repetition of self-harm and suicide following self-harm in children and adolescents: findings from the Multicentre Study of Self-harm in England, Hawton, K., Bergen H., et al, Jnl of child Psychology and psychiatry April 2012.

(190/100,000). However, young people have died from asthma in all three boroughs in recent years and the system has developed a detailed improvement plan in response to a Regulation 28 Letter from the local coroner following the inquest into one of these deaths.

Recommendation 65: *CYP Transformation Board, and Borough Partnerships to prioritise and consider how best to implement plans developed to improve asthma care in BHR.*

7.3 Adult Mental Health

**Indicators and data used in this section can be accessed by clicking here*

7.3.1 Prevalence and risk factors

> Mental health is important at every stage of life; specific concerns about other life stages are considered in the relevant chapters about maternity care, children and young people and older people.

While the great majority of people will experience problems with their mental wellbeing at some point in their lives, prevalence of poor mental health disproportionately affects those who experience other disadvantages. Wider determinants such as: poverty (debt, unemployment and housing), level of social support and relationships (including family/childhood, couple relationships and community), and discrimination (based on age, ethnicity and sexual orientation) all play a major part in mental health and wellbeing[118]. Whilst people from all walks of life can be affected at any point in their lives, there are groups who are more at risk of poor mental health, for example1 in 5 of older people living in the community and 40% of older people living in care homes are thought to be affected by depression, and as many as nine out of ten people in prison have a mental health, drug or alcohol problem.[119]

The modelled prevalence of common mental health disorders (any type of depression or anxiety) for adults in LBH and LBR is similar to the national average, but significantly higher in LBBD. Based on these estimates, there are likely to be more than 108K people with a common mental health problem living in the three BHR boroughs.
The GP recorded prevalence of depression for adults in each of the three boroughs is below the national average which may indicate unidentified need, particularly in LBBD and LBR where recorded prevalence is lowest. Almost 52k people across BHR are known to have depression.

A smaller number of the adult population have a severe mental illness (SMI) including schizophrenia, bipolar affective disorder and other psychoses. Rates of SMI are lower than the national average in all three boroughs – nevertheless more than 6,800 people have a SMI.

People from BAME are less likely to engage with mental health services other than at a time of crisis. People of African/Caribbean descent are over-represented at all levels of the psychiatric process; in particular they are more likely to be treated as inpatients, be sectioned or access mental health services via a criminal justice system pathway.[120]

Mental health problems are more common among people who are lesbian, gay, bisexual, trans, intersex, queer or questioning (LGBTIQ+).[121]

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[118] PHE Guidance: Wellbeing and mental health: Applying All Our Health Updated 28 August 2019
[119] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[120] https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities
[121] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-lgbtiq-people

Studies suggest that the rate of mental health problems in people with a learning disability is double that of the general population.[122]

Compared with the general population, common mental health conditions are over twice as high among people who experience homelessness, and psychosis is up to 15 times as high.[123] Many people who sleep rough have co-occurring mental ill health and substance misuse needs, combined with physical health needs and past experience of significant trauma.

Perinatal disorders are associated with increased risk of psychological and developmental disturbances in children.[124] It is estimated that between 1.3k and 2.7k of women in BHR experience adjustment disorders and distress in the perinatal period, and 273 women in BHR experience post-traumatic stress disorder as a result of traumatic events during labour or childbirth.

Prevalence of recorded dementia in BHR is two-thirds of that in England; almost 5k of registered patients have dementia. Evidence suggests that up to 40% of all cases of dementia are linked to modifiable lifestyle factors, but just a third of UK adults think it is possible for people to reduce their risk. Women are less likely than men to think it's possible (30% compared to 37%).[125] Smoking is one of the biggest risk factors and can double individual risk.[126]

7.3.2 Harm caused by mental illness

People with severe mental illness die on average 10 - 20 years sooner than the general population[127]. Cardiovascular disease, respiratory illness and cancers are the main causes of the observed gap in life expectancy, in part due to the very high prevalence of smoking (and heavier smoking) amongst people with mental health problems[128][129]. Over 1,700 people across BHR are recorded as smokers with SMI. Some of the drugs used to treat SMI can cause obesity and thus increase cardiovascular risk.[130]
Deaths from mental illness capture only a small element of the harm caused. In total, mental health problems are estimated to cause about 10% of all health lost to disability (YLD) and 5% of all health lost to disability and premature death (DALYs).[131]

[122] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/mental-health
[123] https://publichealthmatters.blog.gov.uk/2019/09/30/health-matters-rough-sleeping/
[124] Steain, A et al (2014) *Effects of perinatal mental disorders on the fetus and child*
[125] Alzheimer's Research UK *Public attitudes towards dementia*
[126] National Government (2018) *Dementia: applying all our health*
[127] Hayes JF, Marston L, Walters K, King MB, Osborn DPJ. (2017) Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000–2014. The British Journal of Psychiatry Jul 2017, bjp.bp.117.202606; DOI: 10.1192/bjp.bp.117.202606
[128] Kings Fund (2014) *Smoking and severe mental ill health*
[129] ASH (2019) *Factsheet: Smoking and Mental Health*
[130] NHS England (2019) Achieving more for people with severe mental illness
[131] JSNA Chapter 3 Population Health Outcomes

7.3.3 The impact of the pandemic on mental health

Anecdotally, BHR local authorities, local NHS agencies, and partner organisations such as schools and the voluntary sector have observed that not only are the pre-existing inequalities in mental health widening, but there are new mental health challenges emerging, fuelled by the experiences of living through a pandemic.

A national study observed that depression and anxiety levels were greatest during lockdowns, reducing when lockdowns were eased, although symptoms increased over Christmas 2021 and on a par with levels during lockdown at the start of 2021. This was driven by concerns about catching Covid-19, as well as concerns about finance. Working age adults were twice as likely to report concerns as older adults.[132] Further common causes for worry were being separated from friends and family, being unable to cope with uncertainty, how the mental health of one's own children will be affected by the pandemic, and making one's existing mental health problems worse.[133]

People have been using a wide range of strategies to cope, including walking, spending time in green spaces, and staying connected with others. Some people reported resorting to potentially harmful ways of coping, including increased alcohol consumption (19%), substance misuse, and over-eating (36%), putting their mental and physical health at greater risk.

7.3.3 Use and outcomes of local mental health services

The rate of referral to Talking Therapies (IAPT) across BHR boroughs is similar to the national average, which is a marked improvement compared to that described in the 2019 JSNA, when this was about half the national average. However, there are disparities across the borough, with lowest referral rates in B&D. The rate of people who achieved a reliable improvement is also similar to the national average, which again is an improvement.

The proportion of people in contact with adult mental health services in all 3 BHR boroughs is below the national average – in Q2 2019/20, 10,230 patients in BHR were in contact with services.

Rates of mental health admissions to hospital across BHR are lower than the national average. In total, there were 135 mental health hospital admissions in 2019/20.
The rate of people subject to the Mental Health Act in Q2 2019/20 is lower in LBH Compared to England; rates in LBR and LBBD are similar, 240 people across LBR during the quarter. It is unknown how many are repeat episodes.

The proportion of patients in concurrent contact with mental health services for substance misuse in LBBD is similar to the national average but much lower in LBH and LBR.

[132] UCL *Covid-19 Social Sudy*
[133] The Mental Health Foundation (2021) *Coronavirus: Mental Health in the Pandemic*

The percentage of people in contact with mental health services with a diagnosis or provisional diagnosis recorded Q2 2019/2020 is far below the averages for London (21.9%) and England (30%); B&D 8.9%, LBH 8.6%, LBR 7.3%. There is some disparity between expected levels of mental health disorders and levels known to health services, particularly in LBBD. This may reflect a reticence on the part of local residents to seek help and / or the need for a more systematic approach to the identification of people with mental health problems. Issues with mental wellbeing are an almost universal experience at some point in life. Self-help information and aids have been brought together by the NHS under the 'Every Mind Matters' banner, providing useful advice about how to cope with low level mental health issues.

Recommendation 66: Investigate whether groups at higher risk of mental ill health are proportionally represented at all levels of mental health service provision.

Recommendation 67: Raise public awareness of mental ill health, tackle associated stigma and strengthen personal resilience, including by making use of 'Every Mind Matters' resources and self-help aids; giving particular consideration to groups who appear less likely to seek help such as LGBT and BAME residents, and older people.

Poverty, unemployment, homelessness, relationship breakdown etc. predispose to mental health problems. With additional training, public facing staff in a wide range of services and in the community can encourage people experiencing disadvantage and personal problems to seek help, as well as identify and intervene where there is risk of suicide.

Recommendation 68: Promote the Making Every Contact Counts (MECC) approach by providing training to front facing staff across the wider partnership to promote awareness of mental health issues including stigma, suicide prevention and the benefits of Talking Therapies.

Talking Therapies (IAPT) are an effective means of helping the thousands of people living with common mental health services.

Recommendation 69: Improve understanding of public perceptions of Talking Therapies and how it be can promoted and delivered to maximise participation and successful completion and thereafter improve the promotion and delivery of Talking Therapies based on this insight.

At any one time, only a small proportion of people with common mental health problems are under the care of specialist mental health services. General practice cares for the majority of patients with common mental health problems. GPs also care for groups known to be at higher risk of mental health problems such as LGBT people, older people, people with LTCs and people with learning disabilities.

***Recommendation 70**: Continue to develop the capacity and capability of primary care to manage patients with common mental disorders and integrate consideration of mental health into the management of other care groups known to be at high risk of mental health problems.*

Care and support of people with mental health issues requires a joined up approach across the NHS, Councils (social care and housing), other statutory agencies such as DWP, and community and voluntary groups. Support to access services and strengthen social networks can benefit people with or at risk of mental illness. The Community Hub and social prescribers can assist with this.

***Recommendation 71**: Develop partnerships between primary care, specialist mental health services, other statutory services and the VCS at locality level to provide holistic support addressing the wider determinants as well as health and social care needs of people with mental health problems. An effective social prescribing function will assist patients to engage with relevant support.*

People with co-occurring substance misuse and mental health conditions have a heightened risk of other health problems and early death but are often excluded from services.[134] People in the criminal justice system and the street homeless have particularly complex social issues and are at high risk of both substance misuse and mental health problems. Effective care requires specialist input for both problems. Concurrent contact with mental health services for drug and alcohol misuse is much lower in LBR and LBH, compared to England.

***Recommendation 72:** Improve and increase joint working between mental health services and drug and alcohol services to improve outcomes for patients with co-occurring substance/alcohol misuse and mental health conditions.*

***Recommendation 73:** - Mental health and substance misuse services to work with relevant Council services to effectively outreach to and support the street homeless.*

***Recommendation 74:** Review arrangements for those in contact with the criminal justice system, including people who have left prison and their access to mental health services, and mental health service provision for offenders served with community orders, particularly for those subject to Alcohol Treatment Orders and Drug Rehabilitation Requirements*

Following changes in national policy, this JSNA has discontinued indicators describing the Care Programme approach that were previously used to describe quality outcomes for service users, and replaced with indicators describing 72-hour follow up for all adult patients discharged from inpatient care, as per NHSE and NHSI recommendations.[135] Patients followed up within 72 hours of discharge from adult acute beds in LBBD (80%) and LBH (87%) is higher than the national average (77%), but lower in LBR (70%). In the 6 month period to March 2021, 95

[134] PHE (2017) *Better care for people with co-occurring mental health and alcohol/drug use conditions*
[135] NHS England and NHS Improvement (2021) *position statement*

patients were not followed up within 72 hours across BHR. The national standard is 80%, with the evidence base showing that there is an increased risk of patients dying by suicide on days 2-3 following discharge from inpatient services.[136]

Recommendation 75: *MH services should audit readmissions to identify the underlying causes of readmission and whether improvements could be made as part of planned discharge, and ongoing treatment and support (including support from local authority housing teams).*

Recommendation 76: *Statutory services across BHR should be encouraged to offer people with health problems including mental health problems the opportunity to gain employment.*

The BHR system has relatively few inpatient mental health beds in comparison with other London areas. As reported in the 2019 JSNA, patients requiring admission had to be placed out of area. Further work is needed to understand whether the care provided to those in crisis is sufficient, given the size and complexity of the population now served and the prospect of further population growth. A 2019 audit of patients occupying inpatient beds has indicated that around a quarter were not previously known to mental health services.

Recommendation 77: *Review the management of patients in crisis ensuring there is adequate place of safety provision given population growth and increasing complexity of needs. Investigate where interventions might have previously prevented escalation to crisis and use the lessons learned to improve mental healthcare.*

The reasons for the mortality gap between people with SMI and the population as a whole are complex. One of the more obvious contributory factors is the very high prevalence of smoking for people with SMI. New approaches to assist people with SMI to adopt healthier lifestyles are needed to maximise the benefits of annual health checks for people with SMI.

Recommendation 78: *Improve the management of physical health of patients with SMI; ensure all get an annual health check and, through joining up initiatives across the system, improve effectiveness of support available to assist with lifestyle change, starting with smoking.*

Whilst rates of suicide across BHR are lower than the national rate, it remains the case that many suicides are preventable. The risks of suicide are increased when an individual has been previously bereaved by a suicide, has a history of self-harm, or a history of mental ill health, especially if there is co-existing substance misuse.

Despite concerns about a rise in suicide during the pandemic, early indications from real time suicide surveillance systems have not shown a significant increase in suicides when comparing pre and post lockdown periods. However these are provisional figures and further monitoring is essential. Periods of financial recession are known to impact suicide rates, which is a concern

[136] https://mentalhealthwatch.rcpsych.ac.uk/indicators/proportion-of-patients-discharged-from-adult-acute-beds-followed-up-within-72-hours

in the event of an economic downturn or increases in the costs of living, and the subsequent impact on employment and financial stressors such as unmanageable debt.[137]

Outside of the pandemic, rates of suicide and self-harm in under 24 year olds in England have been steadily increasing over the last decade.[138] It is suggested that around half of people who die by suicide have previously self-harmed. Reported rates of self-harm across BHR are lower than England, with 460 people admitted to hospital for intentional self-harm. However, the majority of self-harm is known to occur in the community and does not lead to hospital attendance.[139]

Recommendation 79: *Ensure there are comprehensive strategies/plans to prevent suicide. These should include (a) support to people bereaved by suicide and (b) systems to record episodes of self-harm and for subsequent follow up in the community.*

Recommendation 80: *Monitor suicides in real time to identify trends.*

[137] HM Government (2021) *Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives*
[138] ONS (2021) *Suicides in England and Wales*
[139] ONS (2021) *Suicides in England and Wales*

7.4 Cancer

**Indicators and data used in this section can be accessed by clicking here*

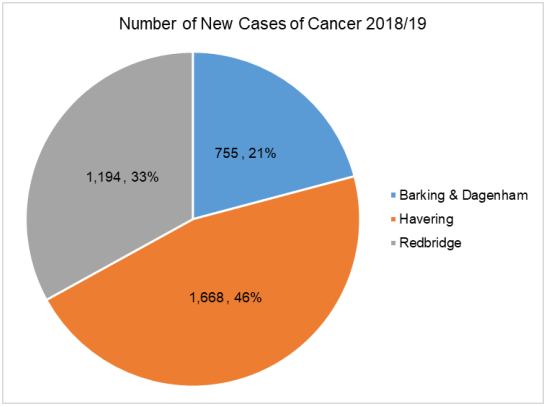
Cancer is the cause of enormous harm to health – accounting for 26 % of all years of life lost across BHR.[140] 1 in 2 people will be diagnosed with cancer in their lifetime. Adjusting for differences in age structure; the incidence of all cancers in LBBD and LBH is similar to the national average; the incidence of cancers in LBR is significantly lower (better) than the national average.

Nonetheless, more than 3,200 people in BHR are diagnosed with cancer each year.

Source: Cancer Research UK

More than half of new cases are cancer of the breast, prostate, lung or bowel.

The incidence of cancer increases steeply with age, peaking in the 85 to 89 age group. As a result, Havering, with its older population has a higher number of cases than other BHR boroughs.



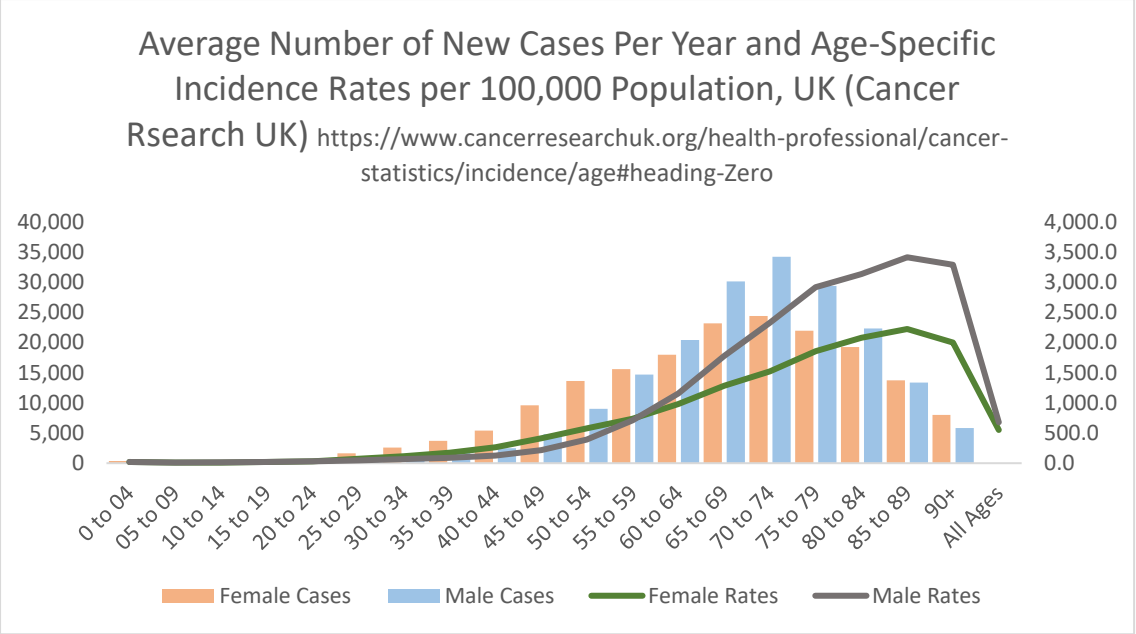
Source: Public Health England

The number of cancer cases in all three boroughs will increase as the population ages. More than 16,000 people locally are living with and beyond cancer (prevalence), almost half are resident in LBH. The number of people living with cancer will increase in line with increases in incidence and as survival continues to improve[141].

According to Cancer Research UK Incidence rates are strongly related to age for all cancers combined, with the highest incidence rates being in older people. In the UK in 2016-2018, on average each year more than a third (36%) of new cases were in people aged 75 and over.

[140] http://www.healthdata.org/gbd

[141] https://public.tableau.com/profile/transforming.cancer.services.for.london#!/vizhome/LondonCancerPrevalenceDashboard2017/PrevalenceDashboard



There is significant scope to reduce the burden of disease as around 4 in 10 cases are preventable.

Smoking remains the largest preventable cause responsible for 15% of cases followed by excess weight[142].

Preventable cases

Source: Cancer Research UK

NB. Action to tackle lifestyle related risk factors are discussed in section 6.
Vaccination against the Human Papilloma Virus (HPV) greatly reduces the risk of developing cervical cancer in later life. In 2019-20, coverage in BHR boroughs outperformed the national average. Nonetheless, more than 700 13–14-year-old girls in the three boroughs were not protected.

POPULATION VACCINATION COVERAGE – HPV VACCINATION COVERAGE (FOR ONE DOSE) *			
AREA	12-13 Female	13-14 Female**	12-13 Male
LBBD	86.8%	81.2%	83.9%
LBH	90.2%	83.3%	84.6%
LBR	86.0%	83.4%	82.7%
NATIONAL	59.2%	64.7%	54.4%

*PHE Fingertips 2019-20
** Two doses

[142] Brown KF, Rumgay H, Dunlop C, et al. The fraction of cancer attributable to known risk factors in England, Wales, Scotland, Northern Ireland, and the UK overall in 2015. BJ of Cancer 2018

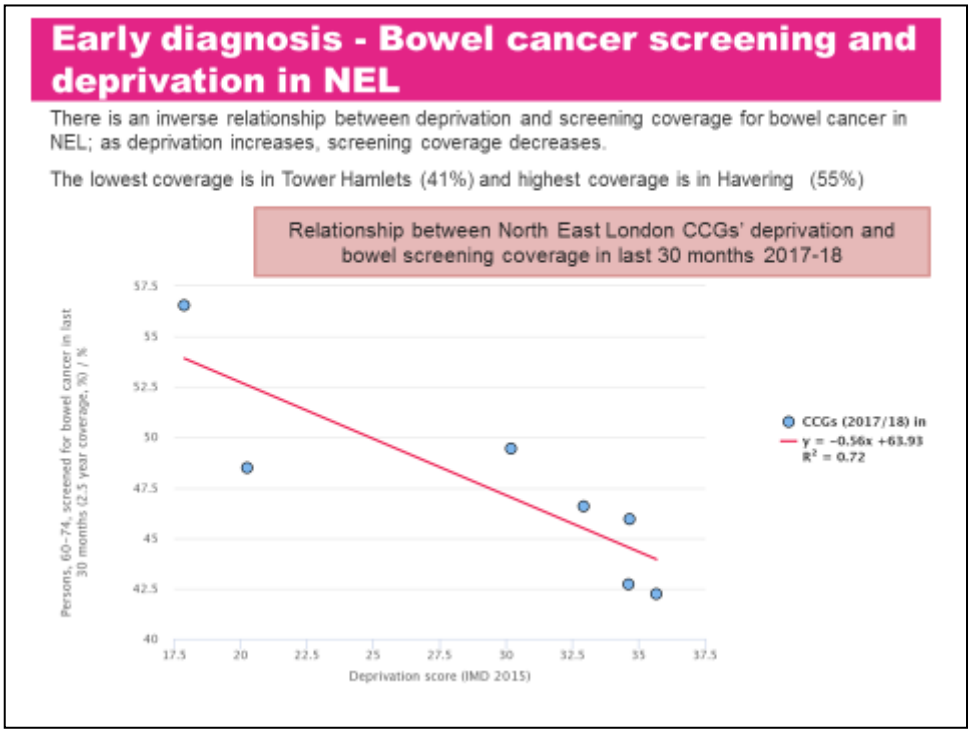
Recommendation 81: *Work with young people, parents and schools, as well as local providers to maximise uptake of HPV for boys and girls.*

Survival varies significantly depending on site. For example, and with regard to the common cancers, survival varies from more than 95% at 1 year for breast cancer to about 30% for lung cancer[143].

In all cases, 1-year survival is significantly better when cancer is diagnosed early.

One year survival has increased steadily in all three BHR boroughs e.g., for LBBD residents from 54.2% in 2002 to 69.7% in 2017. However, survival in all BHR boroughs has consistently lagged behind the national average – now 73.3%, particularly in LBBD at 69.7%.

For some cancers, screening offers a means of identifying cancers before any signs of disease are evident, increasing the likelihood of successful treatment.
Screening coverage for the three national screening programmes (bowel, breast and cervical) is lower than England in LBB&D and LBR. Coverage for breast and cervical screening is higher in LBH than the national average but coverage of bowel screening is significantly lower. There is a strong correlation between levels of disadvantage and screening coverage uptake. Hence, coverage in LBH is higher than that achieved in any other borough in NEL for all three screening programmes[144].



Source: Healthy London - Inequalities Toolkit

[143] https://www.cancerresearchuk.org/health-professional/cancer-statistics/survival
[144] https://www.healthylondon.org/resource/cancer-inequalities-toolkit/north-central-london-snapshot/

Irrespective of the precise uptake, many hundreds of eligible BHR residents do not participate in cancer screening programmes each year. Further exacerbated by Covid

CANCER SCREENING COVERAGE (2020) *				
	Cervical Cancer (25-49)	Cervical Cancer (50-64)	Breast Cancer	Bowel Cancer
LBBD	65.6%	72.9%	66.4%	50.2%
LBH	72.9%	77.6%	78.7%	62.3%
LBR	61.5%	74.6%	71.8%	55.3%
LONDON	61.8%	73.2%	67.2%	56.2%
ENGLAND	70.2%	76.1%	74.1%	63.8%

*NHS Digital via PHE Fingertips.

The national cancer screening programmes have recently been the subject of a review[145] by Prof Sir Mike Richards who has recommended fundamental change in terms of accountability for screening programmes – currently split between multiple organisations; improvements in IT to facilitate better call and recall; more rapid adoption of improved screening methods and approaches that better fit with peoples' busy lives, including improved access to cervical screening appointments. These factors are further exacerbated by those under served by not being registered with GPs, often having chaotic lifestyles and services are poorly engaged with these population groups

In addition, BHR CCGs are a pilot site for the SUMMIT Study, run by University College London Hospitals NHS Foundation Trust (UCLH) and UCL (University College London). The study aims to recruit 25,000 people aged 50-77 in north and east London, who are at higher risk of lung cancer, to take part in early screening. If a patient is eligible, they will be invited to have a low dose CT scan and provide a blood sample which will support the development of a blood test by GRAIL (a U.S. healthcare company focused on the early detection of cancer) to detect multiple types of deadly cancers, including in the lung.

***Recommendation 82**: - Continue to work to increase uptake of cervical screening by offering extended hours in general practice and bowel screening with the roll out of FIT[146] testing for diagnosing colorectal cancer and breast screening.*

***Recommendation 83**:* - undertake a deep dive/equity audit to understand which populations are not taking up screening and support a programme of community engagement, working with those identified as less likely to participate in screening programmes to increase uptake.

Where no screening programme exists, early diagnosis relies on people being aware of the risk and seeking help when they notice changes to their body and thereafter, their GP promptly referring patients with suspicious signs and symptoms for relevant investigations. However, referring without adequate cause can result in unnecessary anxiety to patients and overburden finite diagnostic capacity so that the investigation of patients with more concerning symptoms is delayed.

[145] https://www.england.nhs.uk/wp-content/uploads/2019/02/report-of-the-independent-review-of-adult-screening-programme-in-england.pdf
[146] https://www.cancerresearchuk.org/health-professional/screening/bowel-screening-evidence-and-resources/faecal-immunochemical-test-fit#FIT2

There is significant variation among general practices in Barking & Dagenham, Havering and Redbridge regarding the rate of two week wait referrals made (where cancer is suspected) and the proportion that subsequently result in a diagnosis of cancer.

The diagnosis of cancer cases in A&E or following an emergency admission may indicate that the disease has already progressed to being an acute problem before it is identified. On average, cases identified as an emergency have a poorer prognosis than cases identified elsewhere. Just under 1 in 5 cases of cancer in BHR are first diagnosed following an emergency presentation.

The percentage of cancers detected at stage 1 and 2 (early) in Havering is lower (worse) than other BHR boroughs and the current national average. The rate in all boroughs (about 50%) is a long way from the ambition stated in the NHS Long Term Plan that by 2028, the NHS will diagnose 75% of cancers at stage 1 or 2. it is still too early to tell the impact of Covid on late presentation.

Recommendation 84: *To undertake an audit to assess the impact of Covid-19 on Cancer screening and service delivery including emergency presentations post-pandemic*

Recommendation 85: *Continue efforts to raise awareness of signs and symptoms of cancer with the public and healthcare professionals.*

The timeliness of diagnosis and initiation of effective treatment are important measures of services quality. A variety of waiting time standards have been established to drive improvements in the delivery of cancer care.

Lack of capacity, both equipment and staff, remains the limiting factor slowing the improvement of cancer diagnosis and treatment. The NHS Long Term Plan commits to the roll-out of new Rapid Diagnostic Centres (RDCs) that will bring together modernised kit, expertise and cutting-edge innovation to achieve earlier diagnosis, with improved patient experience, for all patients with cancer symptoms or suspicious results. Separate to this investment in facilities; action will be needed to remedy shortages in key professions e.g., pathologists, radiologists, gastroenterologists (and other endoscopists).

Recommendation 86: *Continue to deliver sustained Cancer Waiting Time targets and implement and thereafter achieve the new 28-day Faster Diagnosis Standard (FDS)*[147]

Recommendation 87*: Implement the national optimal cancer pathways*[148]*.*

[147] https://www.england.nhs.uk/cancer/early-diagnosis/
[148] http://uklcc.org.uk/wp-content/uploads/2019/10/01-UKLCC-Pathways-Matter-Report-Final.pdf

More people than ever are living with and beyond cancer. In parallel with improvements in survival has come greater recognition that quality of life outcomes are just as important. Quality of life measurement is being introduced to improve understanding of the impact of cancer and its treatment and how well people are living after treatment. In addition, action is underway to provide personalised care and support – putting patients more in control of their recovery.

The personalised approach is also being applied to follow up so that people can be reassured of effective ongoing cancer surveillance, but require fewer face-to-face appointments, with rapid access to support, advice and interventions with the most appropriate clinicians when needed.

Further work is underway to improve the provision of services to manage the consequences of treatment, which cause poor quality of life and are often under-recognised. These include psychological difficulties, fatigue, pain, or bowel, bladder and sexual problems.

Recommendation 88: *Deliver personalised care for all cancer patients, resulting in improved patient experience and outcomes; specifically embed stratified pathways[149] for prostrate, breast and bowel cancer patients.*

Recommendation 89: *Work towards a step-change in patients' and clinical professionals' understanding of cancer, with it being thought of as a Long-Term Condition.*

NB. Continued collaboration with third sector partners is key and there are many large and well-established charities working in cancer – in particular Cancer Research UK which supports earlier diagnosis, and Macmillan Cancer Support provides support to people living with and beyond cancer.

[149] https://www.england.nhs.uk/wp-content/uploads/2016/04/stratified-pathways-update.pdf

7.5 Long Term Conditions

Indicators and data used in this section can be accessed by clicking here

What are Long Term Conditions?

Long term conditions, also known as chronic conditions, are those health conditions that require ongoing treatment or management over a period of years or decades. They may not be able to be cured or reversed but can be controlled with the use of medication and therapies (NHS England).

As described in *Section 4*, despite recent increases in life expectancy, most of the additional years of life gained are affected by ill health or disability. A significant proportion of this ill health is the result of long-term conditions (LTCs), and they contribute substantially to health inequalities by ethnicity and deprivation in England.

LTCs can affect almost every part of the body and often people may be dealing with more than one LTC at a time. Many LTCs may cause few symptoms initially whilst increasing the risk of serious acute events long-term, such as heart attack or strokes, which can lead to premature death or longer-term disability. This may mean that people are less likely to seek help at an early stage of their condition and LTCs may remain undiagnosed and unmanaged.

Appropriate management of LTCs through medication, lifestyle change, and therapies can lead to significant improvements in quality of life for individuals. Many LTCs are also preventable, through reducing key risk factors such as poor diet, smoking or low levels of physical activity. As a result, ensuring early detection, diagnosis and treatment of LTCs and effective prevention is important.

In addition to individual lifestyle factors, many LTCs are also linked to environmental exposures that may be outside of an individual's control. For example, a key risk factor for both chronic obstructive pulmonary disease (COPD) and asthma is regular exposure to poor air quality, which disproportionately affects areas of high deprivation. Similarly, areas of high deprivation often have poorer access to opportunities to be physically active and eat a healthy diet, increasing the risk of obesity related conditions such as diabetes and heart disease. This means that tackling LTCs requires action not just at an individual level but on the wider determinants of health and the environments around us.

Common Long-Term Conditions:

cardiovascular disease (CVD)
heart failure
atrial fibrillation (AF)
hypertension
chronic kidney disease (CKD)
diabetes
chronic obstructive pulmonary disease (COPD)
asthma

Who is most at risk from long term conditions?

Inequalities by age

The risk of developing an LTC increases with age, with 62% of people over 60 years old reporting at least one LTC compared to only 24% of those under 40 years old nationally (*ONS Annual Population Survey*, ONS, 2019). As a result, forecasted increases in the number of older individuals in the population (see Section 2.2) are likely to lead to increases in the number of individuals with LTCs without effective prevention, diagnosis and treatment.

Inequalities by ethnicity

There are substantial inequalities in the prevalence of LTCs by ethnicity, with South Asian groups, in particular Bangladeshi and Pakistani groups, and Black African groups at higher risk of developing many LTCs and experiencing worse outcomes in comparison to White groups (*Local Action on Health Inequalities*, PHE, 2019).

Inequalities by deprivation

Deprivation is a key risk factor for LTCs. Over half of the gap in life expectancy between the most and least disadvantaged nationally is a result of premature death from preventable LTCs such as heart disease, stroke and cancers *(NHS Long-Term Plan, 2020).*

On average nationally, individuals living in more disadvantaged areas develop more than one LTC 10-15 years earlier than those in more affluent neighbourhoods, substantially impacting on inequalities in quality of life (*NHS Long Term Plan*, NHS England, 2019). Type 2 diabetes is 60% more common among individuals in the most deprived quintile compared with those in the least deprived quintile in England.

Premature death rates from cardiovascular disease (CVD) in the most deprived 10% of the population are almost twice as high as rates in the least deprived 10%. Much of this disparity results from higher rates of preventable risk factors, such as smoking and poor diet, representing an opportunity for effective prevention to reduce health inequalities.

Impact of lifestyle and environmental factors

The risk of developing LTCs is only partly determined by non-modifiable factors such as age and ethnicity. An estimated 50-80% of CVD result from modifiable or preventable factors such as smoking, obesity, poor diet, harmful drinking and low levels of physical activity. This represents an important opportunity for effective prevention at an individual level to have a substantial impact on the prevalence of LTCs.

There are also important environmental exposures that increase the risk of LTCs. These include exposure to air pollution and environments that do not support physical activity and healthy eating (for example, lack of access to green space and over density of fast-food takeaways). Many of these environmental exposures are greatest in areas of high deprivation and make a substantial contribution to health inequalities. Local authorities and other partners in BHR have a key role in addressing these wider determinants of health to prevent LTCs.

What is being done to support those with Long Term Conditions?

Primary prevention of Long-Term Conditions

Primary prevention aims to prevent people developing long term conditions in the first place and is the most effective way to improve quality of life and prevent ill-health. Due to the strong link between modifiable lifestyle factors (such as alcohol, smoking and obesity) and long-term conditions, effective primary prevention should be prioritised to reduce the prevalence of long-term conditions and health inequalities.

NHS Health Checks

NHS Health Checks are an opportunity to identify people with, or at high risk of, CVD and related conditions including diabetes, hypertension and chronic kidney disease (CKD). Health Checks are offered to anyone aged 40-74 years who does not have a pre-existing LTC. Public Health England have previously estimated that for every 6 to 10 NHS Health Checks completed, one person is identified as being at high risk of CVD. Health checks provide an opportunity to encourage people to tackle lifestyle related risk factors before they cause ill health. It aims to connect these individuals with sources of support that might assist them to achieve change reflecting their needs and preferences.

A proportion of eligible patients are not offered or do not attend their NHS Health Check. This means that the full potential benefit of the programme is only partially realised and opportunities for primary prevention are missed. Currently, only Barking and Dagenham are achieving above the London average of 49.9% of eligible individuals receiving an NHS Health Check (see Table 7.5.1).

When broken down by relative local deprivation, in the period 2012/13-2017/18, all three boroughs have the lowest rate of health check attendance in those from the most deprived quintile (see Figure 7.5.1). In addition to having the lowest overall health check attendance, Havering also has the largest inequalities by deprivation, with a gap of 7.7 percentage points between the least and most deprived quintile (see Figure 7.5.1).

When broken down by broad ethnic group, in the period 2012/13-2017/18, Asian groups recorded the highest percentage attendance in all three boroughs, followed by Black groups and White groups. Despite the high percentage of attendance, non-White groups remain at greatest risk from experiencing poor health resulting from preventable LTCs and so remain a priority group to increase uptake of Health Checks. In all three boroughs, those of "any other ethnicity" (including those of mixed ethnicity and those with no ethnicity data recorded) recorded the lowest percentage of attendance. This suggests that there may be particular barriers to access for these groups requiring more detailed investigation and more comprehensive collection ethnicity data to understand these challenges.

Table 7.5.1. Percentage of eligible individuals invited and receiving an NHS Health Check Q1 2016/17 –2020/21 across Barking & Dagenham, Havering and Redbridge

	LBBD *(%)*	LBH *(%)*	LBR *(%)*	London *(%)*	England *(%)*
Percentage of eligible individuals invited for an NHS Health Check	85.4	71.9	82.1	73.4	71.8
Percentage of eligible individuals receiving an NHS Health Check	53.4	38.0	49.1	49.9	46.5

= Below London Average

= similar to London average

= Above London Average

Source: Public Health England Fingertips

Figure 7.5.1; Percentage of individuals attending an NHS Health Check after receiving an invitiation by relative deprivation quintiles within each local authority for ther period 2012/13-2017/18, based on the Index of Multiple Deprivation 2015 (Source: *N*

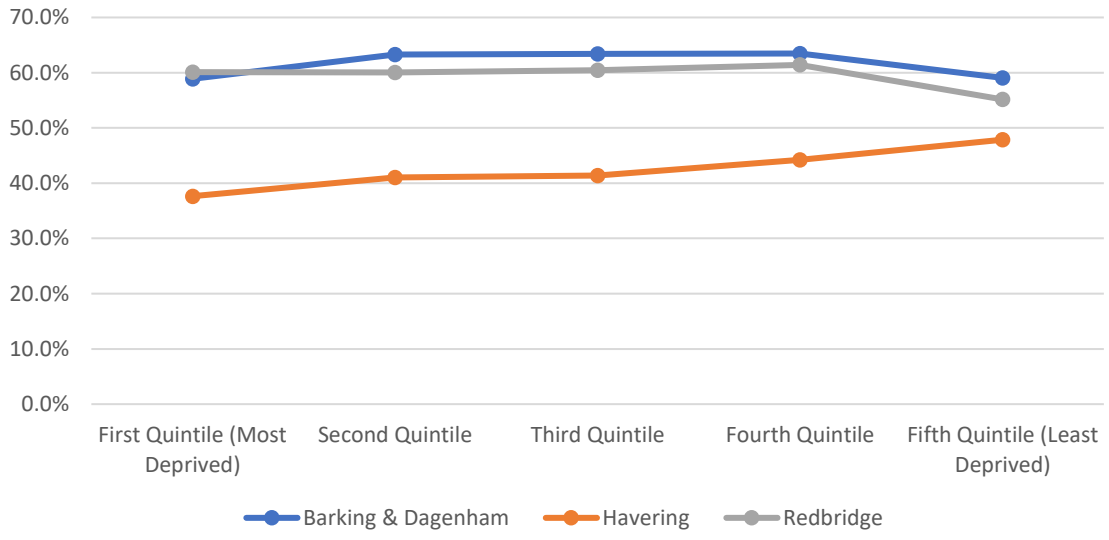
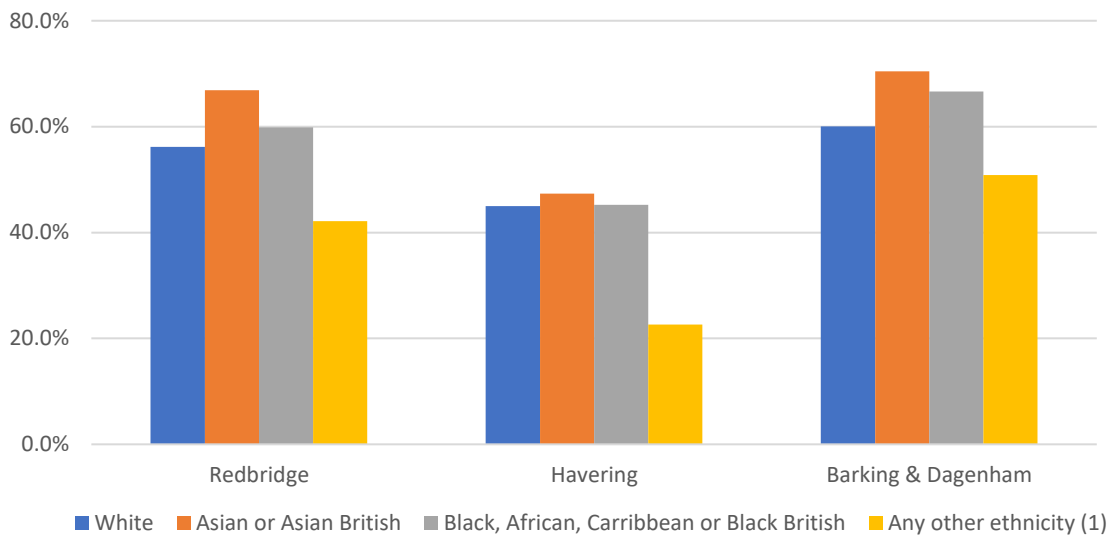


Figure 7.5.2; Percentage of individuals attending an NHS Health Check after receiving an invitation within each ethnic group and by local authority from 2012/13-2017/18
(Source: *NHS Digital*, Health Check Dashboard)



(1) "Any other ethnicity" includes those of mixed ethnicity, any other ethnic group and those without recorded ethnicity data)

On average, individuals in disadvantaged areas suffer from one or more long term conditions between ten to fifteen years earlier when compared to individuals residing in better off neighbourhoods[150]. In Barking and Dagenham work is currently underway to analyse the inequalities which may exist within the NHS Health Check programme. Data analysts from Public Health alongside colleagues within the Performance and Intelligence Team will explore the available demographic data on the NHS Health Check invitations sent to the Barking and Dagenham GP registered population and evaluate what proportion of this eligible cohort has come forward and received a NHS Health Check.

[150] NHS England » The Long Term Plan for tackling health inequalities

***Recommendation 90**: To review the care pathway and provision of support for patients found to be at high risk of LTCs following an NHS Health Check (or other identification route) to ensure that behaviour change support is effective, high quality and in line with best practice guidelines. This should include reviewing whether support is culturally appropriate for each borough's communities, with a focus on contributing to reductions in health inequalities by ethnicity and deprivation.*

Recommendation 91: *To reviewview the current service delivery model and approach to increasing the offer and uptake of NHS health checks in each borough and develop a robust action plan for improvements in uptake, particularly among those at greatest risk of poor health. Key opportunities to explore should include the accessibility of Health Checks appointments by time and geography, the role of PCNs and exploring the potential for delivery of workplace-based programmes.*

***Recommendation 92** To review the processes for analysis and reporting of key local data on preventative interventions to support local Public Health teams in improving delivery. This should include both the Health Check and National Diabetes Prevention programmes. There should be a focus on improving the granularity of data, both by geography (in particular by Primary Care Networks) and inequalities by ethnicity, deprivation and age, as well as regular reporting of data on invitation, uptake and outcomes.*

Secondary prevention of Long-Term Conditions

Secondary prevention aims to reduce or reverse the negative impacts of LTCs. The effects of many LTCs, such as diabetes, may be reversed or prevented through effective secondary prevention and so lead to substantial improvements in quality of life.

For most LTCs there is a significant difference between the proportion of the population expected to have the disease and the number actually diagnosed as a result many thousands of residents are unaware, they have an LTC. Moreover, of those that do have a diagnosis, many do not receive all the treatments that would benefit them leading to missed opportunities for effective prevention.

Healthier You: NHS Diabetes Prevention Programme (NDPP)

The NDPP is based on a strong evidence base that shows supporting people to maintain a healthy weight and be more active, can significantly reduce the risk of developing Type 2 diabetes. Individuals aged 18 years or over at high risk of progressing to Type 2 Diabetes (known as non-diabetic hyperglycaemia) are eligible for referral to the NDPP.

The intervention consists of a series of predominantly group-based sessions delivered in person across a period of at least nine months. There are at least 13 sessions, lasting between one and two hours, and at least 16 hours of contact time. Each session covers topics geared towards the NDPP's main goals of weight reduction and improved glycaemic control through

dietary improvements and increased physical activity and reduction in sedentary behaviour. They are underpinned by behavioural theory and involve the use of behavioural techniques. Sessions are offered in the community at various sites within BHR. In addition, a digital stream offers an alternative service to face-to-face programmes making use of technologies, including wearables and apps.

The NDPP was offered in BHR relatively late and there is a considerable way to go in terms of increasing participation and completion if the potential benefits are to be realised. The harm to residents is very great. Locally, diabetes is responsible for 1.6% of all Years of Life Lost, 4.4% of Years Lived with Disability and 3.1% of all Disability Adjusted Life Years. Nationally, about 9% of the total NHS budget is spent on the treatment of diabetes and the complications arising.

Years of Life Lost (YLL); YLL estimates the number of years of potential life lost due to premature deaths from a condition, based on the average life expectancy of a population.

Years Lived with Disability (YLD); YLD estimates the number of years lived with a disability resulting from a condition.

Disability Adjusted Life Years (DALY); DALYs measure the impact of a condition on both mortality and morbidity. DALYs are calculated through combining the Years of Life Lost (YLL) and Years Lived with Disability (YLD) measures for a condition. One DALY is equivalent to the loss of one year of healthy life.

Care and Support for those with Diabetes

Of the 49,000 people in BHR known to have diabetes, only two thirds received all eight care processes in LBBD and less than half in LBH and LBR (PHE *Fingertips*). This suggests there are significant improvements possible in ensuring all individuals with Diabetes receive the care they need. In addition, around 1 in 6 of the people with diabetes in BHR do not know they have the condition which is equivalent to 10,000 undiagnosed cases across the three boroughs not receiving effective treatment and at risk of poor outcomes.

Recommendation 93; *To review the local approach to maximising participation in the National Diabetes Prevention Programme and develop an action plan for improved uptake and outcomes. This should include actions to ensure that the NDPP is culturally appropriate for the different communities of BHR to reduce inequalities by ethnicity and deprivation.*

Recommendation 94*; To explore opportunities to expand the target populations for preventative interventions, including the NDPP and Health Checks programmes, beyond the statutory minimum to enable more effective early intervention and prevent ill health. This should include developing actions to increase uptake by under-served populations (such as homeless residents) and to support those outside the statutory minimum age range to access preventative support (currently 40-74 years for Health Checks and 35+ for the NDPP).*

LTCs following acute COVID-19 infection

Most children, young people and adults who have had an acute COVID-19 infection recover and return to normal health. However, some patients can have symptoms that can last for weeks or even months after recovery from acute illness. Persistent symptoms following a COVID-19 infection is commonly termed 'long COVID' but has also been referred to as 'ongoing symptomatic COVID-19' and 'post-COVID-19 syndrome'[151].

The Office of National Statistics has estimated that 1.2 million people in private households (1.9% of the population) were experiencing self-reported long COVID as of 2nd October 2021[152]. The types and duration of long Covid symptoms vary widely, with the main symptoms being fatigue, shortness of breath, muscle ache and difficulty concentrating[153]. Most individuals with long Covid are able to self-manage their symptoms and will only need generalist assessment, support and rehabilitation.
To support those with greater needs, a dedicated service for individuals with long Covid has been commissioned in Barking and Dagenham, Havering, and Redbridge, offering access to physical therapy, physical activity and mental health support.

***Recommendation 95**: Consider commissioning of further services for those with long Covid, based on learning from newly commissioned services in BHRUT. These should include dedicated support services and self-management, for example mobile apps, community exercise programmes and peer support groups.*

According to Greenhalgh et al, approximately 11% of patients with long Covid will need specialist assessment and management for specific long-term complications[154]. Emerging evidence suggests that these patients were previously hospitalised due to COVID-19, particularly those who were admitted to ICU. A study found that there were significantly more new diagnoses of respiratory disease, diabetes, major adverse cardiovascular event (MACE), chronic kidney disease and chronic liver disease following hospital admission due to acute COVID-19 infection[155]. Nevertheless, more information is needed to understand the emerging needs associated with long Covid.

[151] National Institute for Health and Care Excellence (2020) COVID-19 rapid guideline: managing the long-term effects of COVID-19 (NICE guideline 188). Available at: https://www.nice.org.uk/guidance/ng188
[152] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 4 November 2021. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/latest
[153] Office of National Statistics. Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 July 2021. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1july2021
[154] 'Long Covid': evidence, recommendations and priority research questions. Available at: https://committees.parliament.uk/writtenevidence/12345/pdf/
[155] Ayoubkhani D, Khunti K, Nafilyan V, Maddox T, Humberstone B, Diamond I et al. Post-covid syndrome in individuals admitted to hospital with covid-19: retrospective cohort study *BMJ* 2021; 372 :n693 doi:10.1136/bmj.n693

Long Covid clinics have been set-up across England, including a clinic in BHRUT based at King George's Hospital[156]. The clinic hosts professionals who provide physical, cognitive and psychological assessments for those referred by their GP for suspected long Covid. The clinic is for those with ongoing symptomatic COVID-19 (4-12 weeks post confirmed or probable infection) or post-COVID syndrome (more than 12 weeks after confirmed or probable infection) and need a programme of physical and/or psychological therapy.

***Recommendation 96**: Borough partnerships should work with primary care clinicians and directly with the public to raise awareness of long Covid, opportunities for self-care and appropriate referral for specialist assessment.*

Tertiary prevention for long term conditions

Tertiary prevention for LTCs refers to efforts to reduce the negative impacts on health and quality of life for those with LTCs and prevent further complications. This is particularly challenging as individuals may have more than one LTCs affecting their lives. Key actions are likely to include supporting people to remain independent and manage their conditions to prevent avoidable negative outcomes such as unplanned hospital admissions.

Effective tertiary prevention can ensure those individuals with one or more LTCs are able to live as long and happy a life as possible and requires close working across many different health and social care organisations.

Of a sample of individual with LTCs surveyed locally, all three boroughs report that less than 50% felt they received all or some of the support they needed, below the national average of 54.9% (see table 7.5.2).

One method for assessing the effectiveness of care for those with LTCs is by looking at rates of preventable deaths and surgical procedures locally. With effective tertiary prevention in place, these deaths and procedures should be prevented. From 2017-2019, both Havering and Barking and Dagenham reported a mortality rate from preventable respiratory conditions for those under 75 years above the national and London averages, representing preventable deaths in part from LTCs (see table 7.5.2). From 2016/17-2018/19 all three boroughs also reported a rate of avoidable major lower limb amputations resulting from diabetes above that of the national average (see Table 7.5.2).

***Recommendation 97:** BHR should review current levels of preventable mortality and surgical procedures linked to LTCs, to understand in detail differences across the three boroughs. A robust action plan should be developed to reduce preventable mortality and procedures including understanding the missing population who are not being diagnosed and treated early*

[156] https://www.england.nhs.uk/2020/12/long-covid-patients-to-get-help-at-more-than-60-clinics/

Table 7.5.2 – summary data on avoidable negative health outcomes for individuals with LTCs (taken from Appendix 9: Long Term Conditions dashboard)

			Local authority				
Indicator	Period	Count	*Havering*	*Barking & Dagenham*	*Redbridge*	London average	England average
Percentage of individuals with LTCs reporting that they have received all or some of the support they need	2019/2020	798	46.5%	49.1%	46.8%	52.1%	54.9%
Under 75 mortality rate from respiratory conditions considered to be preventable (Rate per 100,000)	2017-2019	128	20.2	38.2	11.8	17.3	20.0
Major Diabetic lower-limb amputation procedures (Rate per 10,000)	2016/17-2018/19	40	9.2	10.7	13.3	N/A	8.2

= better than London/England average

= similar to London/England average

= worse than London/England average

Multiple Long-term conditions

An increasing proportion of people are affected by more than one LTC at a time, also known as "multimorbidity". Due to the added complexity of managing multiple conditions, multimorbidity has been identified as one of the greatest challenges facing the NHS and social care and has been highlighted in the UK Government's Health and Care White Paper (UK Government, 2021).

More than one in four adults nationally live with two or more LTCs ("Multiple Long-Term Conditions – making sense of the evidence" NIHR, 2021). A previous analysis by BHR CCGs in 2019/2020 identified nearly 24,000 patients with 2 LTCs, more than 12,000 with 4 LTCs and more than 400 with 6 LTCs.

Due to the challenge and complexity of managing multiple conditions, individuals affected by multimorbidity are also at substantially increased risk of poor mental health. One in three patients with multiple LTCs also experiences poor mental health, increasing the chances of individuals with multi-morbidity experiencing both poor physical and mental health outcomes.[157] Table 7.5.3 provides the most common range of LTCs experienced by those with six or more conditions as an example of the complexity of issues involved in delivering effective care for these individuals.

Table 7.5.3 Number of patients across BHR with different combinations of six LTCs concurrently

Combination of LTCs	Number of Patients
Asthma, CHD, CKD, COPD, diabetes, AF	7
Asthma, CHD, CKD, COPD, hypertension, AF	46
CHD, CKD, COPD, diabetes, hypertension, AF	127
Asthma, CHD, CKD, diabetes, hypertension, AF	85
Asthma, CHD, COPD, diabetes, hypertension, AF	104
Asthma, CKD, COPD, diabetes, hypertension, AF	53

Recommendation 98; *BHR should conduct a review of the current provision of prevention and care to those with multiple conditions and develop a robust action plan for improving local care pathways across all three boroughs to reduce levels of preventable ill health, morbidity and mortality.*

7.6 Older People & Frailty

**Indicators and data used in this section can be accessed by clicking here*

Older people experience more ill health and have greater need for health and social care than other age groups. It follows those improvements in the care of older people are likely to yield greater benefit, faster to the health and social care system than actions regarding other patient cohorts.

[157] "Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study", Salisbury, C. et al, *British Journal of General Practice* 2011; 61 (582): e12-e21. DOI: https://doi.org/10.3399/bjgp11X548929

There are large numbers of older people in all three BHR boroughs and every locality. However, the population of LBH is significantly older such that nearly half of the 16000 BHR residents aged 85 and above live in Havering.

Looking at data between 2018-20, an average female and male at age 65 in LBBD, and an average male at age 65 in LBH can expect to live 16.7, 19.8 and 18.2 more years respectively, which are significantly shorter than an average male and female of age 65+ in England expect to live (18.7 years for male and 21.1 more years for female). Nonetheless an average male and female of age 65+ in Redbridge can expect to live 19.2 and 22.0 more years which are similar to England averages.

In terms of healthy ageing, an average male aged 65 years in LBR, and an average female aged 65 years in LBBD can expect to live 8.4 and 8.5 more years respectively, thus they live a shorter proportion of their life in good health than England averages of 10.6 (M) and 11.1(F) more years. Healthy life expectancy at age 65 for both male and female in LBH, male in LBBD and female in LBR are similar to England averages.

In Section 4, we discussed that additional years of life added to life expectancy are often characterised by some degree of ill health and dependency on health and social care services. A greater focus on the **prevention** of ill health at every stage of the life including in old age is crucial to improve the quality of life and sustainability of health and care services.

Nationally, 20.8% more deaths occurred among residents of age 85 years and above during the winter months. The proportion of **excess winter deaths** among aged 85 years and above in LBBD (17.5%, 20 people aged 85+), LBH (18.4%, 70 people aged 85+) and LBR (25.6%, 60 people) are similar to England average. Therefore 150 out of 320 additional deaths across BHR in the winter of 2019/20 are aged 85 years and above. The bulk of excess winter deaths result from an increase in deaths from respiratory conditions, some linked to flu; dementia and CVD (heart disease and stroke)[158].

Flu vaccination along with adequate heating reduces the risk of excess winter deaths among the elderly. The flu vaccine coverage of patients aged 65 and older is below the national target of 75% in all three BHR boroughs and has been in slow decline over the last decade. LBH has started to see a modest increase in the last few years[159].

COVID booster vaccine: The International Journal of Epidemiology, which found that patients with SARS-CoV-2 and influenza virus coinfection were around twice as likely to die (odds ratio 2.27 (95% confidence interval 1.23 to 4.19)) than people with SARS-CoV-2 alone. Therefore, COVID booster vaccine and flu vaccination work synergistically to reduce illness and death among older people.

Recommendation 99: *Contact and support older people in receiving both flu vaccine and covid vaccine as recommended. Also review the status of pneumococcal and zoster vaccine.*

[158] ONS Excess winter mortality in England and Wales: 2019 to 2020 (provisional) and 2018 to 2019 (final).
[159] Source: https://fingertips.phe.org.uk

PHE estimates that 1 in 10 excess winter deaths are directly attributable to fuel poverty[160]. More than 1 in 10 households in BHR are affected by **fuel poverty** ranging from 9% in LBH to 12.3% in LBBD and 12.7% in LBR[161].

UK based surveys show that people can feel **lonely** at any stage of life, but that the experience is most severe among older people. Social networks shrink with retirement and the associated reduction in income may limit social activities. Additional contributory factors for loneliness in old age include the loss of a loved one. An estimated 35,000 BHR residents aged 65 and above live alone, of which 6,500 are LBBD residents[162]; health conditions that precipitate disability and loss of mobility; and caring responsibilities. Successful interventions to tackle social isolation reduce the burden on health and social care services; as such, they are typically cost-effective[163].

An early diagnosis of **dementia** can help people take control of their condition; plan for the future; potentially benefit from available treatments and make the best of their abilities. There is strong evidence that an early diagnosis helps someone with dementia to continue to live independently in their own home for longer[164]. In 2021, dementia diagnosis rate of Redbridge (63.5%) is the closest to the national target of 66%, whereas that of Havering and B&D trailed significantly at 53% and 58.9% respectively.

Recommendation 100: Maintain efforts to further increase the completeness of dementia diagnosis, and improve access to the information and support for patients and their families

Delirium

Delirium is 10 times more common in those with dementia. It can be brief and transient (resolved in 24 hours), but may persist (30% at a month, 20% at six months) or the person may not recover at all. Half of those with delirium on general and geriatric medical wards will die within six months.

Any medical condition can cause delirium, and more than half of cases have multiple potential causes. At the end of life this may be the underlying condition (cancer, hypoxia, infection), surgery, a complication, a drug side-effect (especially higher doses of opiates, anticholinergics such as hyoscine, and polypharmacy), or drug withdrawal (following de-prescribing, or alcohol withdrawal). About 1 in 3 cases of delirium can be prevented. It is important that the clinician can talk to someone who knows the person well and, hopefully, knows what has been happening recently. Delirium usually gets better when the cause is treated.

There is a high prevalence of **mental health** issues in older people so Comprehensive Geriatric Assessment is not complete without addressing both mood and cognition. Care that looks at a 'whole person' and that is undertaken by a geriatric MDT is the gold standard approach not to

[160] Public Health England & UCL Institute of Health Equity (2014) Local action on health inequalities: Fuel poverty and cold home-related health problems.
[161] Source https://fingertips.phe.org.uk
[162] Source poppi.org.uk
[163]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
[164] https://www.scie.org.uk/dementia/symptoms/diagnosis/early-diagnosis.asp

miss either physical or mental health conditions. **Depression** often co-exists with physical illness or dementia. In addition, the health of an older person could also be adversely impacted by hazardous drinking of alcohol.[165]

Falls are the most common cause of death from injury in the over 65s. A third of people over 65, and half of people over 80, fall at least once a year.[166] Falls are the number one precipitating factor for a person losing independence and going into long-term care. **Deconditioning** is the loss of physical, psychological, and functional capacity due to inactivity – can occur rapidly in older adults, and, among other health impacts, increases the risk of falls. Public Health England found that older people experienced a considerable reduction in strength and balance activity between March to May 2020, with the greatest change in the 70 to 74 age group with a 45% (males) and 49% (females) decrease observed in activity. Without mitigation, modelling predicts that:

• More older people (an increase of 3.9%) will fall as a result of reduced strength and balance activity during the pandemic

• The total number of falls could increase by 6.3% for males and 4.4% for females.

> ***Recommendation 101:*** *Refer older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitations services.*

Age standardised rates of hospital admission for falls for over 65's is better (lower) than the national average in all three BHR boroughs. Nonetheless, close to 2000 admissions were recorded in 2019/20.

Hip fracture is a particularly serious consequence of falls especially among those with osteoporosis, malnutrition, weak muscle strength, sensory impairment and frailty. One in three people with a hip fracture dies within a year. Rates of hospital admission for hip fracture are similar to the national average in LBH and LBBD but better (lower) in LBR than the national average. More than 600 were recorded in 2019/20.

Falls are not an inevitable consequence of ageing; the risk of falling and the harm caused can be reduced. The Falls and Fragility Fractures Pathway[167] defines the core components of an optimal service for people who have suffered a fall or are at risk of falls and fragility fractures. The pathway focuses on the three priorities for optimisation:

- Falls prevention
- Detecting and Managing Osteoporosis
- Optimal support after a fragility fracture

[165] https://academic.oup.com/ageing/article/42/5/598/18032?login=true
[166] https://publichealthmatters.blog.gov.uk/2014/07/17/the-human-cost-of-falls/
[167] https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

Higher value interventions include:

- Targeted case-finding for osteoporosis, frailty and falls risk
- Strength and balance training for those at low to moderate risk of falls
- Multi-factorial intervention for those at higher risk of falls
- Fracture liaison service for those who have had a fragility fracture

Recommendation 102: Ensure the BHR Falls prevention pathway is consistent with national guidance and equitably implemented according to need.

Falls, social isolation, and cognitive impairment are a few of the potentially preventable or modifiable risk factors that contribute to the development of frailty; others include alcohol excess; functional impairment, hearing problems, mood problems, nutritional compromise, physical inactivity, polypharmacy, smoking, and vision problems[168].

Recommendation 103: Ensure that the BHR Older People and Frailty Prevention offer currently under development is comprehensive, addressing socio-economic and behavioural risk factors and the early identification and management of modifiable conditions.

Frailty is a particular state of health experienced by a significant minority of older people - around 10% of people aged 65+ years (around 10,500 across BHR in mid-2019) live with frailty, rising to 25- 50% of 85+ years (4,000 to 8,000). Being frail can mean that a relatively minor problem results in disproportionate and prolonged harm to health and wellbeing e.g., someone with moderate frailty has three times the annual risk of urgent care utilisation, death and care home admission than an older person of the same age who is not frail.

A comprehensive approach to minimise the harm caused by frailty[169] includes:

- comprehensive prevention as described above
- population-based stratification to systematically identify people who are living with moderate and severe frailty
- coupled with targeted support to help older people living with frailty to stay well and live independently for as long as possible including:
  - Community multidisciplinary teams – focused on the moderate frailty population who are most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.
  - Urgent Community Response – crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.

[168] National Institute for Health and Care Excellence (NICE) - Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (https://www.nice.org.uk/guidance/ng16)
[169] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

Recommendation 104: *Ensure that patients at risk of frailty are systematically identified, using population health management approach; effectively supported by the local partners to stay well; or to receive urgent additional help in times of crisis.*

Polypharmacy

Over our lifetime we accumulate diagnoses, such that many people experience old age as a state of multimorbidity.[170] Multimorbidity thus breeds polypharmacy. In addition, polypharmacy promotes further prescribing. This can be the addition of drugs explicitly to manage side effects (e.g., laxatives and opiates) or when side effects are wrongly interpreted as new conditions through prescription cascades (e.g., furosemide and amlodipine). Multimorbidity, and thus polypharmacy, is linked to frailty.

Sometimes the balance between risks and benefits becomes lost and people are exposed to harm. Fortunately, polypharmacy can be addressed through deprescribing, which is a term for the discontinuation of medications in a systematic and considered manner. Currently there are few randomised controlled trial data to support its efficacy, but this has to be offset against the near complete lack of evidence that continuing medications in people with advanced frailty is beneficial. Deprescribing requires a thoughtful explanation to patients and carers. There needs to be some acceptance of the risk of withdrawal effects and disease or symptom recurrence, which necessitates monitoring and follow up. It can be aided by the use of multidisciplinary teams that include pharmacists and nurse specialists. Deprescribing is not about restricting the access of some people to healthcare but instead an acceptance of the limitations of medicines in some situations. Prescribing fewer drugs is not the same as offering less care.

Recommendation 105: *Ensure that there is a systematic approach of reviewing patients with multimorbidity and frailty that includes a medication review to maximise the benefits of medications and minimise side effects.*

COVID-19

COVID-19 disproportionately affect older people as the risk of severe disease and mortality increases substantially with age. Therefore, JCVI recommended 50 years and above in the first stage of vaccine roll out. Booster vaccine is also required to fully protect older people and it is seen that the booster becomes key in preventing severe illness including new variants. In the future COVID-19 vaccine will become a key intervention to reduce excess winter deaths.[171] It

[170] https://www.bgs.org.uk/blog/more-is-less-and-less-is-more-breaking-the-cycle-of-polypharmacy-with-deprescribing
[171] https://www.bmj.com/content/373/bmj.n1137

is found that the wider impact of covid such as deconditioning among older people can increase the risk of falls. [172]

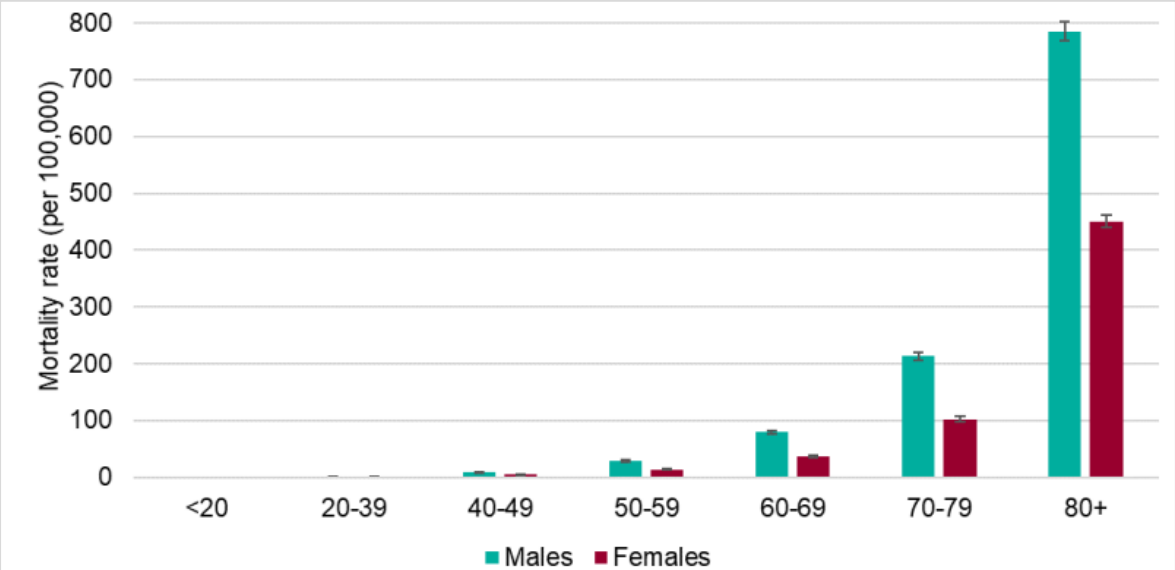


Figure Crude mortality rates of laboratory confirmed COVID-19 deaths per 100,000 population by age group and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

Hospital admission entails significant risks to the continuing independence of older people as a short period of inactivity can result in a disproportionately large decline in physical ability.

There is strong evidence that provision of **reablement** services after admission improves function and hence independence. LBH and LBR perform better than the national average in terms of the % of people aged 65 and over who were still at home 91 days after discharge from hospital and LBBD is similar to the national average.

Recommendation 106: Further improve the reablement offer in all three boroughs to maximise the proportion of patients who return home and stay home after admission to hospital.

Research suggests that, where possible, people prefer to stay in their own home rather than move into **residential care**. The rate of permanent admissions to care homes varies between the three boroughs. Redbridge has the lowest rate, followed by Havering. Both boroughs have rates are significantly below the England average. Barking and Dagenham has the highest rate in London although this represents a significant improvement on previous years.

172 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1010501/HEMT_Wider_Impacts_Falls.pdf

Nationally, one in seven people aged 85 and above live in a care home. The number of care beds varies significantly between three BHR boroughs.

Table 10. Care home beds, number and rate / 100 people aged 75+, 2021

Area	Number	Rate
LBBD	718	8.0
LBH	1,834	8.0
LBR	1,379	7.7
London	35,435	7.1
England	458,955	9.4

Source: Care Quality Commission (CQC) and Office for National Statistics (ONS)

Many people in care homes are not having their needs assessed and addressed as well as they could be, resulting in unnecessary unplanned and avoidable admissions to hospital. The Enhanced Health in Care Homes (EHCH) model is designed to put this right.

> ***Recommendation 107:*** *Develop plans to implement the Enhanced Health in Care Homes (EHCH) model to all care homes in BHR.*

End of Life Care: Few people would choose to die in hospital and yet more than half of all older people in BHR do so. The proportion of people dying in hospital in all three boroughs are significantly higher (worse) than England average. With adequate planning and support people can die with dignity in familiar surroundings; for some people this will mean a care home. The BHR end of life care workstream aim is to acknowledge a person's wishes and support their end-of-life needs in their preferred place of care and is addressing this challenge across three boroughs. Care Home Support, rapid response team and 24-hour support line are being implemented and the palliative care capacity is increased to improve the quality of the end-of-life care.

> ***Recommendation 108:*** *Strengthen end of life care to increase the proportion of people who are supported to die with dignity in their usual place of residence.*

Older people's mental health

The most common mental health condition in older people is depression, affecting 22% of men and 28% of women aged 65 or over, followed by anxiety.[173] 40% of older people who are living in care homes have depression; 30% of older carers experience depression at some point; and older people going through a bereavement are up to four times more likely to experience

[173] Health and Social Care Information Centre (2007). Health Survey for England, 2005: Health of Older People. [online] Available at: http://www.hscic.gov.uk/pubs/hse05olderpeople

depression than older people who haven't been bereaved.[174]

Older people living with dementia may struggle to express how they are feeling which also increases the difficulty of diagnosis.[175] Not only can dementia trigger mental health problems, with estimates suggesting that 20-40% of people living with dementia are depressed.[176]

It is important that older people are able to access services which are appropriate for their needs.[177] A target was set in 2011 to increase the proportion of older people referred to IAPT (Improving Access to Psychological Therapies) services to 12%. However, the proportion of users to the IAPT service who are over 65 has remained stagnant at or below 7% despite this age group making up 18% of the population.[178]

> ***Recommendation 109:*** *Services should be designed so that older people's needs can be met including mental health and dementia.*

[174] Independent Age (2018), Good grief: older people's experiences of bereavement, London: Independent Age. Available at: https://independent-age-assets.s3.eu-west-1.amazonaws.com/s3fs-public/2018-04/Good Grief report.pdf

[175] British Geriatric Society and Royal College of Psychiatrists (2019), Collaborative approaches to treatment: depression among older people living in care homes, London: British Geriatric Society. Available at: https://www.bgs.org.uk/sites/default/files/content/attachment/2018-09-12/Depression%20among%20older%20people%20living%20in%20care%20homes%20report%202018.pdf

[176] Alzhimer's society, 'Depression and dementia'. Available at: https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/depression

[177] Hamid, Abdul et al (2015), "Comparison of how old age psychiatry and general adult psychiatry services meet the needs of elderly people with functional mental illness: cross-sectional survey", British Journal of Psychiatry, 207 (5), pp. 440-443.

[178] Colins, N., and Corna, L. (2018), 'General practitioner referral of older patients to Improving Access to Psychological Therapies (IAPT): an exploratory qualitative study', BJPsych Bulletin, 42(3). pp. 115-118.

List of acronyms

Acronym	Meaning	Further information
ACEs	Adverse Childhood Experiences	
ASQ3	Ages and Stages Questionnaire Third Edition	Used to assess child development
BHR	Barking Havering and Redbridge Health and Social Care System	
BHR CCGs	Barking Havering and Redbridge Clinical Commissioning Groups	The local commissioner of health care services
BHRUHT	Barking Havering and Redbridge University Hospitals Trust	Provider of acute hospital services at Queens and King George Hospital sites.
BAME	Black, Asian and Minority Ethnic	
CAMHS	Children and Adolescent Mental Health Services	
CDR	Child Death Review	
CMO	Chief Medical Officer	
COPD	Chronic Obstructive Pulmonary Disease	
CPA	Community Programme Approach	
CQC	Care Quality Commission	Independent regulator of health and social care
CVD	Cardio-vascular disease	e.g., heart disease, stroke
CYP	Children and Young People	
DALYs	Disability Life Adjusted Years	Combine years of life lost to premature death and years of life lived with disability into a single measure
DWP	Department of Work and Pensions	
EHCP	Education, Health and Care Plan	
EIF	Early Intervention Foundation	A charity supporting the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes
ELLMS	East London Local Maternity System	
EL STP	East London Sustainability and Transformation Partnership	A partnership of health and social care commissioners and providers (including those in BHR) covering 8 boroughs and the city of London
EoLC	End Of Life Care	
FIT	Faecal Immunochemical Test	A test to identify people at increased risk of bowel cancer
HMO	Houses in Multiple Occupation	
H&WB	Health and Wellbeing Board	
IAPT	Improving Access to Psychological Therapies	'Talking therapies'
ICS	Integrated Care System	

Acronym	Meaning	Further information
ICPB	Integrated Care Partnership Board	
IMD	Index of Multiple Deprivation	
JSNA	Joint Strategic Needs Assessment	
LAC	Looked After Children	
LBBD	London Borough of Barking and Dagenham	Commissioner (and provider) of social care and public health services for residents
LBH	London Borough of Havering	ditto above
LBR	London Borough of Redbridge	ditto above
LGBT	Lesbian, Gay, Bisexual, Trans	
LTC	Long Term Condition	
MSK	Musculoskeletal Conditions	e.g., back and neck pain
NELFT	North East London Foundation Trust	provider of mental health and community health care services
NDPP	NHS Diabetes Prevention Programme	
PAF	Population Attributable Fraction	
PCN	Primary Care Network	
PHE	Public Health England	
SATOD	Smoking At Time of Delivery	A measure of smoking prevalence amongst pregnant women
SEND	Special Education Needs and Disability	
SMEs	Small and Medium Sized Enterprises	
SMI	Serious Mental Illness	
VCS	Voluntary and Community Sector	
YLD	Years Lived with Disability	
YLL	Years of Life Lost	

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Appendix 1: BHR JSNA Process

1 Background

1.1 To support the BHR ICP fulfil its functions, BHR Public Health teams worked jointly to produce a new product whose main focus is to identify priority health and social care needs and related wider determinants that impact on health and wellbeing in a consistent format at locality, borough and ICS level and make recommendations on appropriate interventions.

1.2 This product is to complement not replace the existing borough based JSNAs.

2 Governance

2.1 The BHR JSNA process was overseen by the Havering Director of Public Health and was supported by the other two directors.

2.2 The lead director received formal monthly updates during implementation and provided support as necessary. He was also the lead author, a task which included writing some sections and reviewing all drafts.

2.3 BHR Public Health Intelligence (PHI) leads facilitated data collection, analysis, interpretation and presentation of results.

2.4 Public Health Consultants/ service leads in consultation with transformation boards advised on content and were responsible for commentary on results including recommendations.

2.5 BHR PHI leads were responsible for the final report compilation.

3 Structure

3.1 The JSNA was structured around the four pillars of population health[179] namely:

i. The wider determinants of health e.g., income, education, housing.
ii. Our health behaviours and lifestyles e.g., smoking, alcohol consumption, diet and exercise.
iii. Places and communities e.g., environment, community networks and support systems, social relationships and culture.
iv. The integrated health and care system with a focus on the 4 priorities of the ICPB:
    - Children and young people
    - Mental health
    - Long term conditions

[179] https://www.kingsfund.org.uk/publications/what-does-improving-population-health-mean

- Older people and frailty

3.2 The JSNA also included sections on demography and population health outcomes.

4 Form and Content

4.1 Following several consultations between Public Health Consultants / service leads, PHI leads and transformation boards, indicators for each pillar were agreed. PHI leads facilitated data collation, analysis and presentation for indicators where data was available. The report therefore only includes analysis and commentary for indictors which data could be sourced within the provided timelines.

4.2 It's intended that this product will develop in an iterative manner with BHR PH consulting with stakeholders after publication of each edition to identify opportunities for improvement.

4.3 The initial edition is static, but BHR PH are currently working with an external provider to develop an interactive product that will be available to all stakeholders.

5 Final Report

The current report includes data analysis and commentary at borough and BHR levels. It includes some data at locality level but without commentary. This is due to time and specialist resource constraints experienced and will be included in the next iteration.

Appendix 2: Population & Health Outcomes dashboard

Click Chapter 2, 3 or 7.2 to return to respective chapters

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population & Health Outcomes

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower	No Data

		Indicator	Period	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
Resident Population	1	Percentage of resident population aged 0 - 4 years	2020	18,910	8.8	6.6	7.3	7.5	6.6	5.7	5.7	5.7
	2	Percentage of resident population aged 5 - 9 years	2020	19,042	8.9	6.6	7.0	7.4	6.7	6.3	6.3	6.3
	3	Percentage of resident population aged 10-19 years	2020	31,105	14.5	11.4	12.9	12.9	11.4	11.6	11.6	11.6
	4	Percentage of resident population aged 20-64 years	2020	125,243	58.5	57.5	59.9	58.7	63.1	58	57.9	57.9
	5	Percentage of resident population aged 65-74 years	2020	10,885	5.1	9.1	7.0	7.2	6.6	10	9.9	9.9
	6	Percentage of resident population aged 75-84 years	2020	6,069	2.8	5.9	4.0	4.3	3.9	6	6.1	6.1
	7	Percentage of resident population aged 85+ years	2020	2,853	1.3	2.9	1.8	2.0	1.7	2.5	2.5	2.5
	8	Total resident population	2020	214,107								
GP Registered Population	9	Percentage of GP population aged 0 - 4 years	2021	17,464	7.4	6.0	6.5	6.7	5.4	5.1	5.1	5.1
	10	Percentage of GP population aged 5 - 9 years	2021	19,670	8.4	6.4	6.9	7.3	5.8	5.8	5.8	5.9
	11	Percentage of GP population aged 10-19 years	2021	34,538	14.7	11.4	12.5	12.9	10.9	11.4	11.4	11.4
	12	Percentage of GP population aged 20-64 years	2021	143,563	61.2	58.8	61.9	60.9	66.9	60.1	60.1	60.1
	13	Percentage of GP population aged 65-74 years	2021	11,350	4.8	9.1	6.4	6.9	6.1	9.5	9.4	9.5
	14	Percentage of GP population aged 75-84 years	2021	5,708	2.4	5.7	3.5	4.0	3.4	5.8	5.8	5.8
	15	Percentage of GP population aged 85+ years	2021	2,477	1.1	2.6	1.5	1.8	1.4	2.3	2.3	2.3
	16	Total GP population	2021	234,770								
Ethnic Population	17	Percentage White British	2021	145,051	32.7	74.6	23.8	43.0	38.3			
	18	Percentage Black	2021	105,455	23.8	6.8	8.2	12.0	13.3			
	19	Percentage Asian	2021	104,671	23.6	7.6	50.5	28.9	20.5			
	20	Percentage Other White	2021	55,311	12.5	6.9	10.0	9.6	18.0			
	21	Percentage Mixed	2021	23,133	5.2	3.5	4.6	4.4	5.8			
	22	Percentage Others	2021	9,388	2.1	0.7	2.9	2.0	4.1			
Health Outcomes	23	Life expectancy at birth (Male)	2018-2020		77.0	79.7	80.5		80.3	79.4	79.4	79.4
	24	Life expectancy at birth (Female)	2018-2020		81.7	83.5	84.6		84.3	83.1	83.1	83.2
	25	Healthy Life Expectancy at birth (Male)	2017-2019		58.4	65.2	62.8		63.5	63.2	63.0	63.4
	26	Healthy Life Expectancy at birth (Female)	2017-2019		59.2	64.5	63.7		64.0	63.5	63.3	63.7

Appendix 3: Wider Determinants dashboard

To return to chapter 4: Wider Determinants - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: Wider Determinants of Health

Benchmark: England

Compared with Benchmark: Better | Similar | Worse | Not Compared | Higher | Lower

	Indicator	Period	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
			Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Median Annual Household Income (£)	2012/13		£29,420	£36,670	£36,670		£39,110	£30,600		
2	Gross Weekly Pay for Full Time Workers (£)	2020		£609	£690	£719		£716	£590	454.2	893.2
3	Index of Multiple Deprivation (IMD) 2019 Rank/Score	2019		32.8	16.8	17.2	21.3	21.8	21.7	45.0	5.5
4	Proportion of residents who are Income Deprived (%)	2019	39,312	19.4%	10.8%	12.1%			12.9%		
5	Proportion of residents aged 16 - 64 in employment (%)	2020	94,000	67.3%	77.5%	74.0%		75.3%	75.7%		
6	Proportion of residents aged 16 - 64 in management / professional roles (%)	2020-21	31,900	35.8%	50.0%	54.6%	48.5%	62.3%	50.2%		
7	Proportion of residents 16-64 who are economically inactive (%)	2020	35,800	25.6%	19.1%	24.6%	23.1%	19.9%	20.5%	12.6%	30.6%
8	Proportion of residents 16-64 who are economically inactive and want a job (%)	2020	9,500	26.5%	27.2%	19.0%	23.5%	25.8%	22.6%	9.6%	53.0%
9	Jobs Density Ratio for population 16-64	2019		0.50	0.61	0.49		1.03	0.88	0.40	102.30
10	Proportion of residents by level of education - NVQ 4 & Above (%)	2020	61,000	43.7%	40.2%	51.5%	45.7%	58.5%	42.8%		
11	Proportion of residents by level of education - No Qualifications (%)	2020	12,800	9.2%	6.5%	9.3%	8.4%	5.1%	6.2%		
12	Number of homeless people/households (rate per 1,000 estimated total households)	2017/18	512	6.5	3.2	4.4	4.6	4.2	2.4	9.4	0.2
13	Number of people in temporary accommodation (rate per 1,000 estimated total households)	2017/18	1,876	23.9	8.9	20.3		14.9	3.4		
14	Number of households on waiting list	2019/20		5350	1995	5979	13324	250992	1145501		
15	Proportion of homes that are not 'Decent Homes' (%)	2018-19	1,638	9.6%	0.7%	13.8%	7.5%		4.5%	37.2%	0.0%
16	Proportion of Households experiencing Fuel Poverty (%)	2019	16,739	22.5%	13.2%	15.4%	16.4%	15.2%	13.5%		
17	Rate of verifiable Houses of Multiple Occupation (HMOs) to dwellings (%)	2020	177	0.2%	0.1%	1.9%	0.8%	1.2%	0.56%	0.01%	6.10%
18	Estimated rate of HMOs to dwellings including the verifiable HMOs (%)	2020	192	0.3%	0.3%	3.7%	1.5%	4.9%	2.17%	0.02%	16.60%
19	Number of people seen rough sleeping in the year	2020	10	10	3	24	37	714	2688	242	0
20	Income deprivation affecting Children (under 16)	2019		23.8%	16.0%	13.7%	17.6%		17.1%	32.7%	3.2%
21	Child Development at age 5	2013/14		60.0	65.4	62.8		62.2	60.4		
22	Attendance levels from children who are persistently absent from school (%)	2018/19	4,251	11.2%	10.7%	9.9%	10.5%	10.1%	10.9%	3.4%	16.1%
23	Average Attainment 8 score (mean - score)	2019/20	145,612	50.1	52.2	56.0		53.4	50.2		
24	16-17 year olds not in education, employment or training (NEET) or whose activity is not known (%)	2019	210	3.5%	2.9%	3.1%		4.2%	5.5%		
25	Proportion of economically active population claiming Job Seekers Allowance (%)	2021	801	0.8%	0.6%	0.5%		0.6%	0.5%	1.5%	0.2%
26	Claimant count (16+) and claimants as a proportion of residents aged 16-64 (%)	2021	13,615	10.1%	5.7%	7.6%		7.4%	5.7%	10.8%	2.2%

Appendix 4: Health Behaviour & Lifestyle dashboard

To return to chapter 5: Health Behaviour & Lifestyle - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: Health Behaviours & Lifestyles

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Percentage of adults (aged 18+) classified as overweight or obese (ALS)	2019/20			65.5	67.3	60.6		55.7	62.8	78.3	41.6
2	Percentage of physically inactive adults (16+ ALS)	2020/21			36.6	37.8	30.6		26.7	27.5	27.2	27.8
3	Smoking Prevalence (% of adult population) (APS)	2019		26,982	18.1	13.2	13.4		12.9	13.9	13.6	14.1
4	Smoking Prevalence (%) in adults in routine and manual occupations (18-64) - current smokers (Persons, 18-64 yrs) APS)	2019			24.3	20.7	22.8		20.7	23.2	36.8	10.3
5	Percentage of adults drinking over 14 units of alcohol a week (HSE)	2015-18			15.1	20.7	10.7		20.1	22.8	41.3	7.9
6	Smoking prevalence in adults (age 18-64 years) - gap between current smokers in routine and manual occupations and other occupations (APS)	2019			1.5	1.8	1.9		1.9	2.5	5.7	0.7
7	Proportion of dependent drinkers not in treatment (%) (Current method) (NDTMS	2019/20		1,833	85.9	84.3	85.2		82.0	82.2	92.3	59.5
8	Successful completion of drug treatment - % opiate users (NDTMS)	2019		22	6.1	6.4	8.3		6.7	5.6	1.6	12.2
9	Proportion of the population meeting the recommended '5-a-day' on a 'usual day	2019/20			47.9	51.8	53.2		55.8	55.4	41.4	67.7

Appendix 5 (a): Maternity dashboard

To return to chapter 6: Maternity - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: HSC - Maternity

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Worst / Lowest	Best / Highest
1	Smoking status at time of delivery	2020-21		228	7.6%	6.7%	3.4%		4.6%	0.1	0.2	0.0
2	Number of live births	2019		3,574								
3	Number and percentage of stillbirths	2017-19		69	6.2%	5.2%	4.6%		4.5%	0.0		
6	Low Birth Weight of term babies	2020		130	4.2%	2.2%	4.5%		3.3%	0.0	0.0	0.0

Appendix 5 (b): Maternity dashboard

Maternity Services: Equity and Equality needs assessment

A *Maternity Services Equity and Equality needs assessment* was recently prepared by North East London Local Maternity System (November 2021).

The assessment offers equity and equality finding for health outcomes, community assets and staff experience, where the report forms the first part towards the production of an equity and equality action plan that aligns with the health inequalities work of the Integrated Care System (ICS) with the aim to improve maternity and neonatal care by: ensuring equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas, and also race equality for staff.

Along with this, North East London Local Maternity System is also working on supporting and strengthening the workforce to ensure all our BME women receive continuity of carer, alongside the rest of our population, by 2023.

The assessment suggests that East London has the highest birth rate in the UK. Where the health and care services need to cope with such growth and continue to ensure the best possible outcomes for mothers and babies. The endeavour is for babies born in North East London to have the best possible start in life and that their parents experience the best possible pregnancy and birth.

Key findings from the assessment – and where relevant key findings for BHR are highlighted:

The **stillbirths** among babies born to Black and Asian women are concentrated in 3 boroughs with rates markedly higher than for babies born to White women. Overall, across NEL there were 90 stillbirths in 20/21. The size of the sample means that any conclusions on the 'true' differences between ethnicities based on the sample may not be reliable. Across NEL, the rate of babies that were stillborn was higher for babies born to Black women (3.8 per 1000) and Asian women (4 per 1000) compared to the rate for those both to White women (2.6 per 1000). This compares with the national average of 3.8 per 1000 babies. Stillbirths to Asian and Black women tend to be concentrated in 3 boroughs: Hackney, Newham, and Waltham Forest

Babies born to Black and Asian women are more likely to have had a **neonatal admission** than those born to White women; On average, nearly a quarter of babies born in NEL were admitted to neonatal care (24%) although there is a much higher degree of variation between boroughs. Havering and Barking and Dagenham had the highest proportion of admissions (48% and 39%).

Babies born to Black and Asian women are also nearly twice as likely to **have a low birth weight** than those born to White women. Across NEL, 11% of babies born to Black and Asian women had a low birth weight – nearly double the rate for babies born to White women (6%). In Waltham Forest and Tower Hamlets this difference is twice as high.

In total across NEL there were 5 **women that died** within 42 days of delivery (i.e., direct deaths). However, collection and validation of data at on neonatal deaths or infant mortality was not available.

Black women are more likely to have **attended A&E** than White women within 6 months of delivery. On average across NEL, Black ethnicities (11%) had the highest percentage of women attending A&E within 6 months of delivery, compared to White (7%) and Other ethnicities (7%) who had the lowest percentage.

Women in Black, Mixed and Other groups tend to present to healthcare services at least 2 weeks later into their pregnancy than White women. On average across NEL, Mixed women take an average of 11 weeks into their pregnancy to present, Black women 11 weeks, and women from other ethnicities 10 weeks, compared to 8 weeks for White women.

Black and Asian women are also more likely to have attended A&E during their pregnancy than White women; on average across NEL, 37% of Black women and 31% of Asian women had at least one attendance to A&E during their pregnancy compared with 23% among White women. This pattern is consistent at the borough level, with Black women having the highest percentage of women with an A&E attendance during pregnancy in all 7 NEL boroughs. In Havering the rate among Black women (23%) is more than twice that for White women (11%).

Black women are also more likely than White women to have been admitted to hospital during their pregnancy.

Black pregnant women are almost twice as likely to be obese than White women; At the borough level, Black women also have the highest rates of obesity across every NEL borough except for women of Mixed ethnicity in Barking & Dagenham where the rate is as high as 45%.

Asian pregnant women are more than 3 times - and Black women more than two times – more likely to have diabetes than White women.

Black pregnant women tend to have higher rates of hypertension than White women.

Black and Asian women are less likely than White women to be taking folic acid in pre/early pregnancy although deprivation is potentially the more important driver underlying differences.

Black pregnant women are more likely to be out of employment compared with all other ethnicities.

There are no consistent trends in the rates for 'complex social factors' but this may be due to lack of reporting consistency; Redbridge (15%) and Barking & Dagenham (13%) have much higher rates of women that gave birth in 2021 having complex social factors, the accuracy of these findings may be undermined by inconsistent reporting practices.

The likelihood of a vaginal delivery is relatively similar across ethnicities, with larger variations in unplanned C-section deliveries, while the average rate of vaginal delivery for Mixed women across NEL is only slightly higher at 59%, the rate among this group this markedly higher than in any other ethnicity in three of the boroughs: Newham (71%), Redbridge (67%) and Havering (65%).

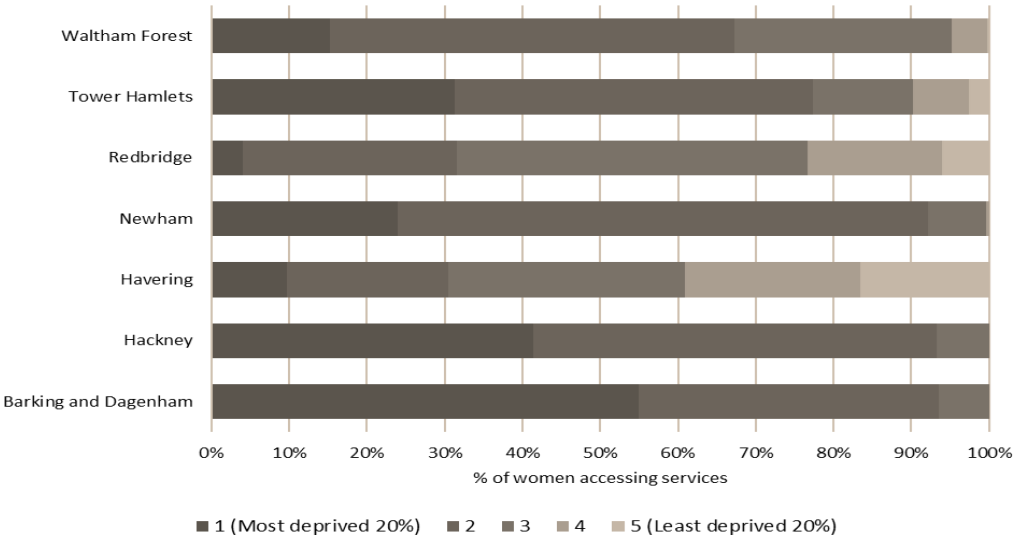
Black and Asian women are more likely to have an unplanned C-section compared with White women.

White women are twice as likely to deliver via forceps compared to Black women.

Deprivation profile of women accessing Maternity services:

As with both age and ethnicity, deprivation masks a lot of variations at the borough level, with over half of the women in this population in Barking and Dagenham living in the most deprived quintile compared with under 5% in Redbridge and 10% in Havering. These two boroughs also have the highest proportion of women living in areas that are in the two least deprived quintiles (23% and 39% respectively).

Figure 3: Breakdown (%) of all women accessing Maternity services by deprivation - IMD quintile (20/21)



Source: Data from SUS

Gestational age at first contact with NHS services:

Interestingly, the average gestational age at first contact for the most deprived pregnant women in Tower Hamlets (3 weeks) was at least 2 times earlier than in Newham (7 weeks) and Barking & Dagenham (8 weeks).

Figure 1: Average gestational age at first contact – by borough (2020/21)

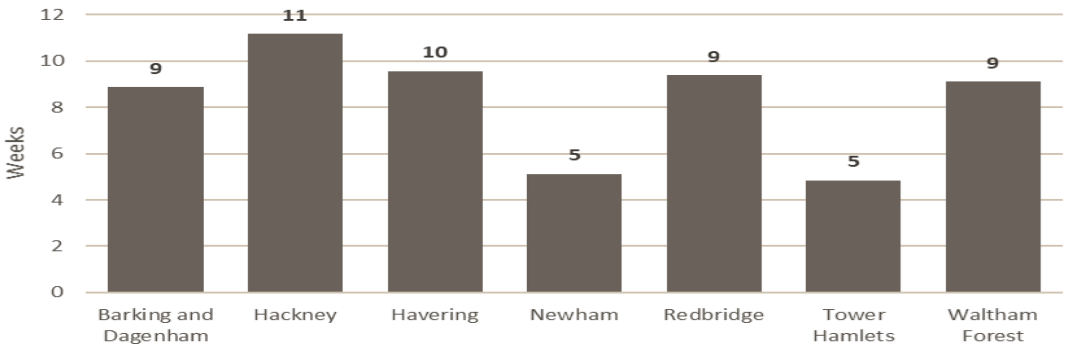
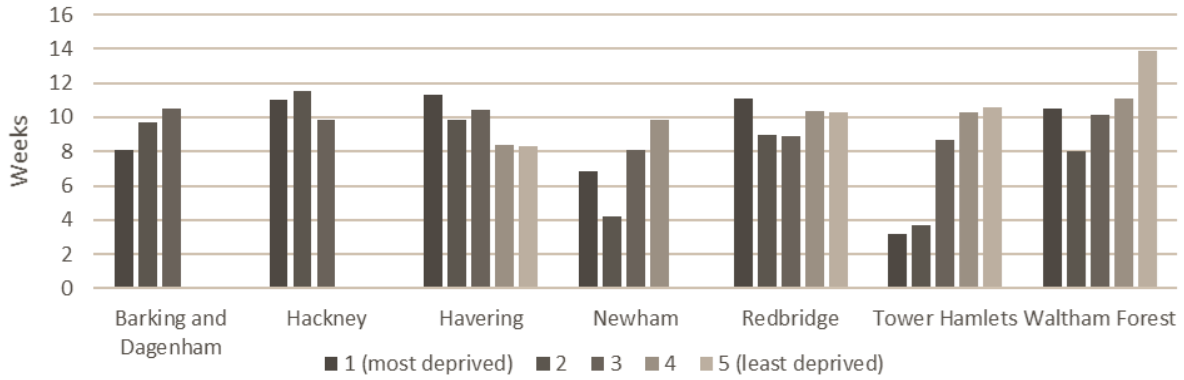


Figure 3: Average gestational age at first contact – by deprivation and borough (2020/21)



COVID-19 Infections by ethnicity and deprivation:

Across NEL, 4% of pregnant women were infected with COVID while pregnant. There were only small differences between boroughs, with all boroughs having an admission percentage between 4-5%.

In Barking and Dagenham and Redbridge the percentage of women from a Mixed ethnic background infected by COVID was twice that for White women.

Figure 1: % of pregnant women infected with COVID-19 - by borough (2020/21)

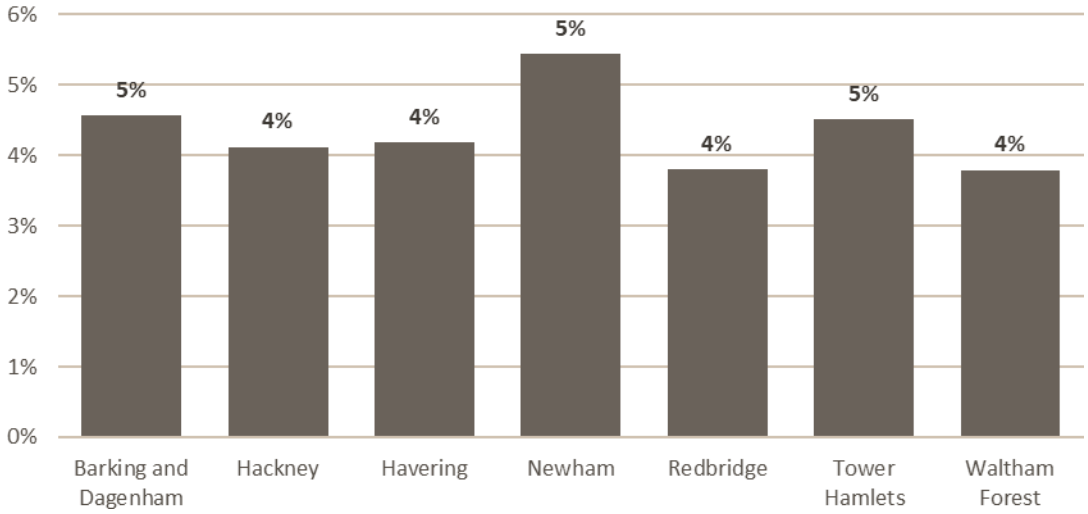


Figure 4: % of pregnant women admitted to hospital with COVID-19 - by borough (2020/21)

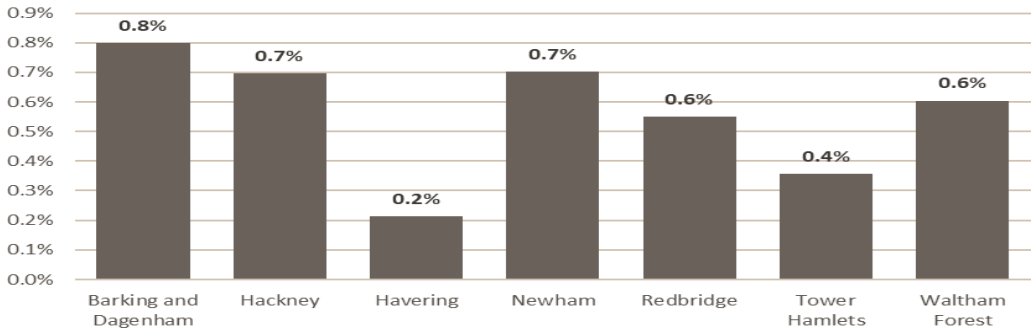
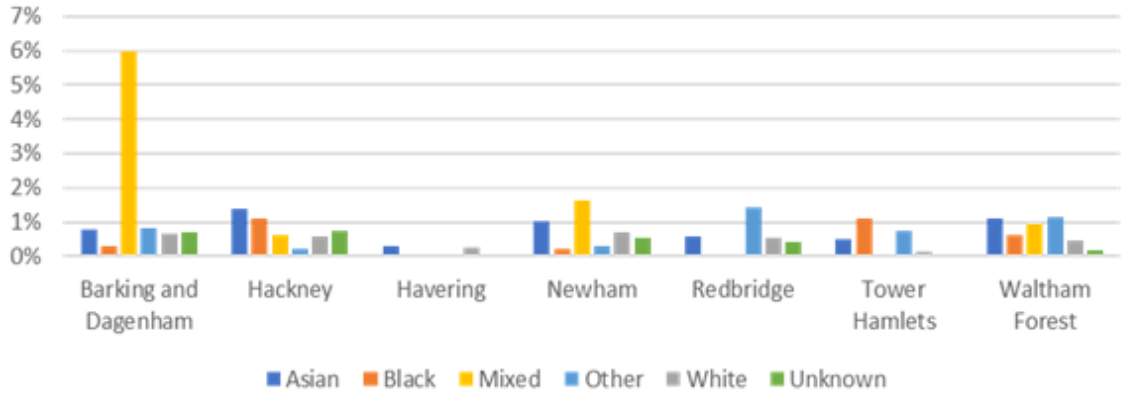


Figure 5: % of pregnant women admitted to hospital with COVID-19 - by ethnicity and borough (2020/21)

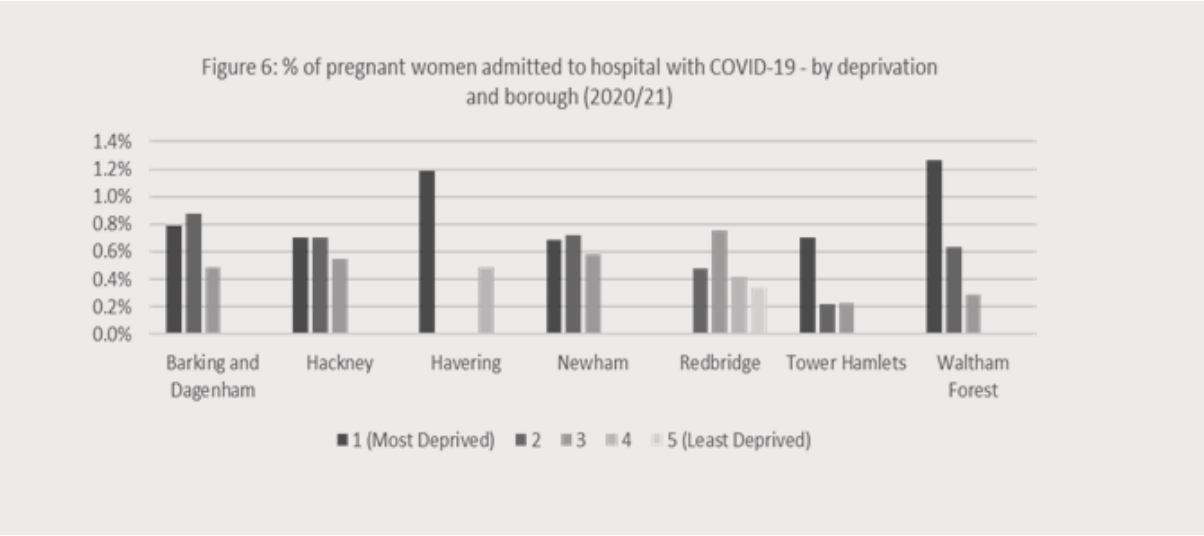


COVID-19 Admissions by ethnicity & deprivation:

Havering had the lowest percentage of women admitted to hospital at 0.2% while the percentage for Barking and Dagenham (0.8%) was 4 times greater.

In Barking & Dagenham, the percentage of pregnant woman admitted to hospital with COVID-19 of Mixed ethnicities (6%) is 6 times higher than the value for all other ethnicities in the borough (less than 1% for all).

Although the percentage of pregnant women admitted to hospital with COVID-19 by deprivation quintile is low for all boroughs, the percentage admitted falls from the most deprived quintiles to the least deprived in all boroughs except Redbridge.



Moving forward the North East London assessment suggests the need to have further data analysis, further community asset mapping and co-production, and to co-produce a five-year strategy based on the needs of our population, aligning to the ICS planning guidance.

Key findings – Barking & Dagenham:

- 2,805 births in 20/21 (11% of total NEL births)
- 50% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 30 years
- Has the second highest average rate across NEL of women giving birth to babies that are admitted to neonatal care.
- Has the second highest average rate across NEL of women having an unplanned C-section (22%) with rates among Black (24%), Asian (24%) and Mixed (24%) women higher than those among White women (20%).

- It has the second highest average rate across NEL of women having an unplanned C-section (22%) with rates among Black (24%), Asian (24%) and Mixed (24%) women higher than those among White women (20%).
- Black women twice as likely than White women to have attended A&E within 6 months of delivery (10% compared with 5%) and to have been admitted to hospital within 6 months of delivery (6% compared with 3%)

Key findings - Havering

- 2,010 births in 20/21 (8% of total NEL births)
- 31% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 31 years
- While it has the lowest rates of stillbirths per 1000 births overall, nearly half of women (49%) have babies that are admitted to neonatal care – although no notable differences across ethnicities with rates for BME babies the same of less than for those born to White women.
- It has the highest average rate across NEL of women having an unplanned C-section (24%) with rates for Black and Asian women which are markedly higher than for White women (32% and 28% compared with 22%)
- Black women are 10 times more likely and Mixed women 9 times more likely than White women to suffer post-partum haemorrhages (2.2% and 1.8% compared with 0.2%)
- Black women more than twice as likely as White women to have hypertension (11% compared with 5%)
- While it has one of the lowest overall average prevalence of diabetes across NEL (13%) the rate among Asian women is more than twice as high as for White women (25% compared with 10%).

Key findings – Redbridge:

- 3,757 births in 20/21 (14% of total NEL births)
- 59% of women that gave birth in 20/21 are BME
- Average age of pregnant women is 31 years
- It has the third highest average rate across NEL of women giving birth to babies that are admitted to neonatal care.
- Rates among babies born to Asian and Black women are much higher than those born to White women (37%, 34% compared with 25%)
- Black women are twice as likely to have attended A&E within 6 months of delivery compared with White women (11% compared with 5%) and are twice as likely to have been admitted to hospital over the same time frame (4% compared with 2%)
- Black women are much more likely to be obese than White women (34% compared with 21%).
- Black women are twice as likely and Asian women are three times more likely to have diabetes than White women.
- Black women are also more than twice as likely than White women to have hypertension (9% compared with 3%)

Appendix 6: Children & Young People dashboard

To return to chapter 7.2 Children & Young People - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: HSC - Children & Young People

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Pupils with special educational needs (SEN): % of school pupils with special educational needs (School age)	2018		5,958	14.4%	9.3%	10.9%		14.4%	14.4%		
2	Number and percentage of pupils with Special Educational Needs (SEN) based on where the pupil attends school	2020-21		6,481	14.5%	11.0%	11.8%	12.4%	15.3%	15.8%	11.0%	21.3%
3	Number and percentage of children and young people with EHC Plan (Denominator Age 0-25 ONS mid-2020)	2020-21		1,389	1.6%	1.6%	1.8%	1.7%	1.8%	1.9%		
4	Number and percentage of children (Age 5-15) with EHC Plan (Denominator Age 5-15 ONS 2018)	2020-21		1,215	2.1%	2.2%	2.5%	2.3%	2.4%			
5	Number of primary school pupils with EHCP - Education, Health and Care Plan (local data)	2021		540	2.2							
6	Number of secondary school pupils with EHCP (local data)	2021		367	1.9							
7	Number and rate SEND pupils resident and educated in Borough (Local data)	2021		1,286	92.7							
8	Estimated number of children and young people with mental disorders - aged 5 to 17 (count)	2017-18		5,122								
9	Percentage of school pupils with social, emotional and mental health needs (school age)	2020		1,104	2.5%	1.7%	1.9%		2.5%	2.7%	1.5%	4.4%
10	Hospital admissions as a result of self harm (Age 10-24) directly standardised rate per 100,000	2019-20		55	136.2	166.0	126.2		191.7	439.2	203.1	1105.4
11	Hospital admissions for asthma (under 19 years) - CCG data. Crude rate per 100,000	2019-20		125	158.8	149.8	180.9			158.3	48.5	376.7
12	Hospital admissions diabetes (under 19 years) Crude rate per 100,000	2019-20		15	22.3	63.1	36.2			51.1	49.9	52.3
13	Children on child protection plans: Rate per 10,000 children <18	2019/20		335	52.7	24.3	41.7	40.1	34.9	42.8	11.5	124.3
14	Children in Care (number of children looked after at 31st March (including adoption and care leavers)	2020		400	63.0	40.0	31.0		49.0	67.0		
15	The number and rate of children on a Child Protection Plan (CPP) as at 31st March 2020'	2020		335	52.7	24.3	41.7	40.1	34.9	42.8	11.5	124.3
16	The number and rate of Looked after Children (LAC) as at 31st March 2020	2020		402	63.3	39.8	31.1	44.0	49.3	66.6	23.0	223.0
17	The number and rate of Children in Need (CIN) as at 31st March 2020'	2020		2,352	370.1	297.6	279.4	313.8	336.7	323.7	141.9	931.5
18	The number and rate of children in the youth justice system (10-17 yrs)	2019-20		188	7.4	4.4	3.9		4.4	3.5		
19	Number of 2 year olds taking up offer of free nursery care (local data)	2021		1,118								

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: HSC - Children & Young People

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower
Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→No significant Change

				Barking & Dagenham		Havering	Redbridge	BHR	London	England		
	Indicator	Period	Recent Trend	Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
19	Number of 2 year olds taking up offer of free nursery care (local data)	2021		1,118								
20	Number and percentage of unauthorised school absence sessions	2018-19	↓	233,341	1.8%	1.1%	1.2%	1.4%	1.3%	1.4%	0.5%	2.6%
21	Reception: Prevalence of overweight (including obesity) %	2019/20	↓	545	24.6%	21.6%	22.3%		21.6%	23.0%		
22	Year 6 : Prevalence of overweight (including obesity) %	2019/20	↓	1,545	44.7%	38.1%	39.6%		44.7%	35.2%		
23	Reception: Prevalence of obesity (including severe obesity) %	2019/20	↓	285	12.9%	10.1%	11.2%		10.0%	9.9%		
24	Year 6: Prevalence of obesity (including severe obesity) %	2019/20	↑	1,005	29.0%	23.8%	25.0%		23.7%	21.0%		
25	Youth offending: first time entrants to the youth justice system, rate per 10,000	2018		646	377.0	183.0	280.0		251.0	211.0		
26	Youth justice custodial sentences per 10,000	2019/20		20	3.1	2.9	2.1		1.5	1.0		
27	Youth proven offending rate per 10,000	2018/19		88	13.7	9.0	11.2		8.0			
28	School readiness: percentage of children achieving a good level of development at the end of Reception	2018/19	↓	2,486	72%	72%	76%		74%	71.8%		
29	School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	2018/19	↑	2,744	80%	84%	83%		83%	82.2%		
30	Hospital admissions due to substance misuse (15-24 years) count and rate per 100,000	2017/18 - 19/20		55	67.7	78.6	73.8		55.6	84.7		
31	Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2019/20	→	2,929	100.0	100.0	100.0		91.1	92.6		
32	Number and rate (per 10,000) of children and young people accessing NHS funded community mental health services (CAMHS)	2020/21							400	491		
33	Percentage of children in need with statements of SEN or EHC plans	2019/20			8%	37%	54%			23%		
34	16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2019		7,360	4%	3%	3%		4%	6%		

Data Sources: *(Indicators 1,9-12,14,15,22-25,26,29-32 PHE Fingertips) (Indicators 2,3,4,16-19,21,27,28 Gov.uk) (Indicators 5-7,20 local data) (Indicators 33 NHS Digital)*

Appendix 7: Adult Mental Health dashboard

To return to chapter 7.3: Adult Mental Health - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: Health & Social Care - Mental Health

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Estimated prevalence of common mental health disorders - Age 16+	2017		34,276	22.4%	15.9%	17.7%	18.3%	19.3%	16.9%	11.6%	24.4%
2	Number and percentage of adults: Depression recorded prevalence - Age 18+ (QOF)	2019/20	↑	14,540	8.0%	10.1%	6.3%	8.0%	8.2%	11.6%	4.0%	18.5%
3	Rate of SMI (All Ages) (QOF)	2019/20	→	1,955	0.8%	0.7%	0.9%	0.8%	1.1%	0.9%	0.6%	1.5%
4	Adjustment disorders and distress in perinatal period (lower estimate): Estimated number of women	2017/18		443	443	386	535	1364	14431	73828		
5	Adjustment disorders and distress in perinatal period (upper estimate): Estimated number of women	2017/18		887	887	773	1070	2730	28863	147656		
6	PTSD in perinatal period: Estimated number of women	2017/18		89	89	77	107	273	2886	14766		
7	Number and percentage of school pupils with social, emotional and mental health needs	2020	→	1,104	2.5%	1.7%	1.9%	2.1%	2.5%	2.7%	2.7%	2.7%
8	Number of children in need due to family stress or dysfunction or absent parenting and rate per 10,000 children under 18	2017		578	93.6	46.6	46.8	61.7	97.9	93.8	0.0	265.9
9	Self reported wellbeing - Percentage of people with a high anxiety score	2019/20			20.1%	21.9%	19.9%		22.4%	21.9%	14.5%	29.2%
10	Number and percentage in concurrent contact with Mental Health Services for drug misuse	2016/17		76	20.0%	11.7%	12.9%	15.6%		24.3%	2.8%	60.7%
11	Number and percentage in concurrent contact with Mental Health Services for alcohol misuse	2016/17		45	22.0%	5.8%	6.7%	11.4%		22.7%	3.3%	72.5%
12	Percentage of adult social care users who have as much social contact as they would like - Age18+	2019/20		1,140	49.5%	48.3%	50.5%	49.5%	42.9%	45.9%	34.3%	56.6%
13	Access to IAPT services: people entering IAPT (month) as % estimated to have anxiety\depression	Sep-19	→	250	14.7%	17.8%	19.4%	17.6%		18.3%	7.0%	29.9%
14	APT reliable improvement: % of people in IAPT (quarter) who achieved reliable improvement (18+)	Q2 2019/20	→	285	71.3%	75.4%	72.6%	73.3%		71.7%	62.0%	79.2%
15	Percentage of social care users who suffer depression and anxiety	2018/20			51.9%	48.7%				50.5%	38.5%	63.6%
16	Dementia: QOF prevalence (all ages) Number and % of patients with dementia against total GP patients	2019/20	↓	900	0.4%	0.8%	0.6%	0.6%	0.5%	0.8%	0.3%	1.3%
17	Number and % of adults on GP list recorded as smokers with Serious Mental Illness	2014/15		523	40.2%	39.4%	30.4%	35.7%	38.9%	40.5%	27.2%	52.3%
18	Number of hospital admissions for mental health conditions and rate per 100,000 population	2019/20	→	35	55.1	68.5	78.7	68.1	64.5	89.5	26.3	249.7
19	Proportion of people (18-74) in contact with secondary mental health services rate per 100,000	Q2 2019/20	→	2,995	2016	1910	1498	1774	2201	2381.0	1208.0	4633.0
20	Number and age standardised mortality rate from suicide per 100,000 population (Persons)	2017/19		32	6.1	7.2	7.1		8.2	10.1	4.9	19.0
21	Number and directly age standardised rates for emergency hospital admissions for intentional self harm	2019/20	↓	135	63.9	73.5	44.5	59.2	81.6	192.6	44.5	457.6
22	Mental Health service users on Care Programme Approach (CPA)	Q2 2019/20	→	765	25.5%	19.9%	26.1%	23.6%	19.3%	15.0%	0.3%	51.3%
23	Stable and appropriate accommodation - % of people on CPA	Q2 2019/20	↑	595	83.2%	87.1%	58.6%	75.2%	59.2%	57.8%	57.5%	58.1%
24	CPA Adults in Employment	Q2 2019/20	→	50	7.0%	11.3%	5.1%	7.5%	7.2%	9.1%	0.0%	36.6%

Appendix 8: Cancer dashboard

To return to chapter 7.4: Cancers - Click Here

BHR Joint Strategic Needs Assessment 2019

London Borough of Barking & Dagenham

Population Health Pillar: Health & Social Care - Cancers

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

Recent Trend:	Data not available	↑ Increasing getting worse	↑ Increasing getting better	↓ Decreasing getting worse	↓ Decreasing getting better	→ No significant Change	↑ Increasing	↓ Decreasing

	Indicator	Period	Recent Trend	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
				Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	New cancer cases (Crude incidence rate: new cases per 100,000)	2018-19	→	755	328.0	589.0	363.0			529.0	217.0	728.0
2	All Tumours (Age standardised incidence rate per 100,000)	2017		949	744.6	727.9	630.5	694.9	653.5	713.9		
3	Incidence breast cancer (Age standardised rate per 100,000)	2017		128	181.2	160.6	161.2	165.3	164.8	166.7		
4	Incidence colorectal cancer (Age standardised rate per 100,000)	2018		91	79.7	74.0	52.3			69.0		
5	Incidence lung cancer (Age standardised rate per 100,000)	2018		131	119.5	74.4	61.8			75.8		
6	Incidence prostate cancer (Age standardised rate per 100,000)	2018		161	303.5	343.3	218.7			204.1		
7	The percentage of patients with cancer, as recorded on practice disease registers	2017/18	↑	3,128	1.4%	2.7%	1.7%	1.9%	1.8%	2.7%	4.2%	0.9%
8	Cancer 1 year survival rate (%)	2017		557	69.7%	73.2%	72.6%			73.3%		
9	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2018-19	↓	6,090	42.8%	56.3%	48.4%		49.2%	58.0%		
10	Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2018-19	↓	3,148	41.7%	56.5%	47.9%		47.9%	57.9%		
11	Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2019-20	↑	9,573	48.6%	62.0%	55.1%		55.6%	63.8%	45.1%	70.9%
12	Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2019-20	→	4,505	50.9%	63.7%	55.8%		56.8%	65.8%	45.9%	72.5%
13	Breast screening uptake (%)	2020	↓	11,209	66.4%	78.7%	71.8%		67.2%	74.1%	54.1%	81.7%
14	Cancer screening coverage - cervical cancer (aged 25 to 49)	2020	↓	32,056	65.6%	72.9%	61.5%		61.8%	70.2%	46.4%	80.1%
15	Cancer screening coverage - cervical cancer (aged 50 to 64)	2020		11,849	72.9%	77.6%	74.6%		73.2%	76.1%	59.2%	90.6%
16	Percentage of cancers detected at stage 1 and 2	2019		243								
17	Percentage of cancers diagnosed through emergency presentation	2018		340	54.4%	55.4%	60.2%		56.5%	55.0%	47.5%	76.5%
18	Premature mortality from all cancers (rate per 100,000)	2017-19		495	147.1	130.6	102.8		117.4	129.2	87.4	182.4
19	Premature mortality from lung cancer (rate per 100,000)	2017-19		233	70.8	52.9	34.8		48.0	53.0		
20	Premature mortality from breast cancer (rate per 100,000)	2017-19		39	19.1	20.8	20.9		19.6	20.0	15.6	26.1
21	Premature mortality from colorectal cancer (rate per 100,000)	2017-19		37	11.4	10.8	8.3		10.4	11.8	17.6	5.8
22	Excess cancer deaths and attributable life years gap; females, compared to England	2015-17		44	0.4	0.0	-0.4		-0.3	1.0	-0.8	1.0
23	Excess cancer deaths and attributable life years gap in most/least deprived quintile; females within area	2015-17		23	1.3	0.8	-0.1		1.0	1.4	-1.5	3.0
24	Excess cancer deaths and attributable life years gap; males, compared to England	2015-17		95	0.6	0.4	-0.7		-0.3	1.0	-1.0	1.0
25	Excess cancer deaths and attributable life years gap in most/least deprived quintile; males within area	2015-17		25	0.8	1.4	0.8		1.3	1.6	-0.8	3.2

Appendix 9: Long Term Conditions dashboard

To return to chapter 7.5: Long Term Conditions - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: HSC - Long Term Conditions

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

	Indicator	Period	Barking & Dagenham		Havering	Redbridge	BHR	London	England		
			Count	Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Diabetes: QOF prevalence (Age 17+) (%)	2019/20	14,582	8.6%	7.5%	9.1%	8.4%	6.8%	7.1%	3.6%	11.1%
2	Diabetes: Estimated prevalence (Age 16+) (%)	2017	14,973	9.2%	8.6%	10.5%			8.5%		
3	Major diabetic lower-limb amputation procedures (Per 10,000)	2016/17 - 18/19	25	10.7	9.2	13.3	11.1		8.2	27.0	3.4
4	Percentage of LTCs reporting that they have received all or some of the support they need (%)	2019/20	549	49.1%	46.5%	46.8%	47.5%	52.1%	54.9%	46.5%	61.2%
5	Coronary Heart Disease: QOF prevalence (All Ages) (%)	2019/20	4,403	1.8%	2.6%	2.4%	2.3%	1.9%	3.1%	1.2%	5.0%
6	Coronary Heart Disease: Estimated prevalence (Age 55-79) (%)	2015		9.6%	8.7%	7.6%	8.6%		7.9%	14.8%	6.7%
7	Emergency hospital admissions for coronary heart disease, standardised admission ratio	2019/20		114.0	85.9	113.6	104.5		102.1	78.6	127.2
8	Coronary Heart Disease: Mortality Under 75 (DSR per 100,000)	2017/19	162	47.7	37.7	33.4	39.6		37.5	108.5	16.1
9	COPD: QOF prevalence (All Ages) (%)	2019/20	3,508	1.5%	1.8%	0.8%	1.4%		1.9%		
10	COPD: Estimated prevalence (All Ages) (%)	2015		2.4%	2.8%	1.9%	2.4%		3.0%	4.9%	1.5%
11	COPD: Emergency hospital admissions standardised admission ratio	2019/20	405	597.0	363.0	266.0	408.7		415.0		
12	COPD: Mortality (DSR per 100,000)	2017-19	263	81.8	55.1	41.8	59.6		53.9		
13	Hypertension: QOF prevalence (All Ages) (%)	2019/20	26,337	11.3%	14.4%	11.7%	12.5%	11.0%	14.1%	7.4%	18.9%
14	Diagnosed Hypertension: Estimated prevalence (%)	2017	31,650	20.7%	26.3%	22.4%	23.1%	21.6%	26.2%	15.8%	32.8%
16	Hypertension: Mortality Under 75 (Require PCMD) (DSR per 100,000)	2017-2019	15	4.6	2.7	2.1	3.1	3.8	3.0	1.2	10.8
17	Under 75 mortality rate from respiratory conditions considered to be preventable (DSR per 100,000)	2017-19	114	38.2	20.2	11.8	23.4	17.3	20.0	44.7	6.4
18	Stroke QOF Prevalence (All Ages) (%)	2019/20	2,160	0.9%	1.6%	1.1%	1.2%	1.1%	1.8%	0.7%	2.9%
19	Emergency hospital admissions for stroke, standardised admission ratio	2019/20	215	175.1	144.0	155.2	158.1		170.2	298.1	110.3
20	Stroke - Under 75 Mortality (DSR per 100,000)	2017-19	62	17.6	12.1	12.7	14.1		12.5	24.7	6.8
21	Learning Disability QOF Prevalence (All Ages) (%)	2019/20	1,078	0.5%	0.4%	0.4%	0.4%	0.4%	0.5%	0.2%	0.8%
22	Learning Disability: Completed Health checks (%)	2018/19	652	66.2%	73.7%	61.2%	67.0%	58.2%	52.3%	3.4%	87.2%

Appendix 10: Older People & Frailty dashboard

To return to chapter 7.6: Older People & Frailty - Click Here

BHR Joint Strategic Needs Assessment 2021

London Borough of Barking & Dagenham

Population Health Pillar: HSC - Older People

Benchmark: England

Compared with Benchmark:	Better	Similar	Worse	Not Compared	Higher	Lower

	Indicator	Period	Barking & Dagenham	Havering	Redbridge	BHR	London	England		
			Value	Value	Value	Value	Value	Value	Lowest	Highest
1	Life expectancy at 65 (Years) - Females	2018-20	19.8	21.2	22.0		22.0	21.1	21.1	21.2
2	Life expectancy at 65 (Years) - Males	2018-20	16.7	18.2	19.2		19.2	18.7	18.7	18.7
3	Healthy life expectancy at 65 (Years) - Females	2017-19	8.5	10.8	12.1		10.0	11.1	2.4	16.7
4	Healthy life expectancy at 65 (Years) - Males	2017-19	8.5	10.9	8.4		9.7	10.6	6.1	16.0
5	Disability-free life expectancy at 65 (Years) - Females	2017-19	8.6	9.8	12.1		9.7	9.7	6.0	13.5
6	Disability-free life expectancy at 65 (Years) - Males	2017-19	9.3	10.8	10.0		10.0	9.9	7.0	15.1
7	Emergency hospital admissions due to falls in people aged 65 and over- Females (DSR per 100,000)	2017/18	1843.0	1862.2	2097.0		2542.4	2453.4		
8	Emergency hospital admissions due to falls in people aged 65 and over- Males (DSR per 100,000)	2017/18	1538.0	1588.7	1424.2		1981.5	1775.1		
9	Emergency hospital admissions due to falls in people aged 65 and over- Persons (DSR per 100,000)	2019/20	1670.4	1623.1	1743.2		2214.7	2221.8	1325.0	3394.0
10	Hip fractures in people aged 65 and over- Females (DSR per 100,000)	2017/18	710.0	705.5	712.7		611.7	697.1		
11	Hip fractures in people aged 65 and over- Males (DSR per 100,000)	2017/18	409.9	414.4	294.0		372.3	410.7		
12	Hip fractures in people aged 65 and over- Persons (DSR per 100,000)	2019/20	472.4	563.0	488.8		472.7	571.6	326.0	912.0
13	Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital (%)	2019/20	85.0	89.3	92.9	89.6	83.4	82.0	42.9	96.9
14	Emergency readmissions within 30 days of discharge from hospital (%)	2018/19	16.6	16.8	15.4	16.7		14.4	11.7	17.2
15	Delayed transfers of care from hospital, per 100,000	2019	5.7	6.2	5.3	5.7	6.8	10.8		
16	Percentage of deaths that occur in hospital (ages 65-74)	2019	55.3	54.2	61.3	56.6	56.1	48.3	35.4	63.6
17	Percentage of deaths that occur in hospital (ages 75-84)	2019	50.7	50.3	63.9	54.8	56.6	48.4	39.8	63.9
18	Percentage of deaths that occur in hospital (ages 85+)	2019	47.4	45.7	54.6	48.7	50.7	41.4	31.7	59.0
19	Rate of permanent admissions to residential and nursing care homes (ages 65+, per 100,000)	2019/20	677.5	631.6	401.5	555.3	431.3	584.0	61.0	1724.0
20	Older People who are Income Deprived (IMD) %	2019	26.1	11.7	19.5	17.4	20.6	14.2	5.0	43.9
21	Excess winter mortality	2018/19	26.2	20.5	17.7		13.7	14.6	-20.0	210.0
22	Population vaccination coverage - Flu (aged 65+)	2019/20	65.0	70.0	68.0		66.2	72.4	58.3	80.1
23	Care home beds, number and rate / 100 people aged 75+,	2021	8.0	8.0	7.7	7.9	7.1	9.4	2.3	17.2
24	People invited for an NHS Health Check per year	2020/21	4.5	2.3	4.5	3.7	3.6	3.1		
25	People receiving an NHS Health Check per year	2020/21	2.5	0.8	1.4	1.5	2.2	1.2	0.0	9.2
26	People taking up an NHS Health Check invite per year	2020/21	56.7	36.0	30.8	39.8	62.5	39.0		

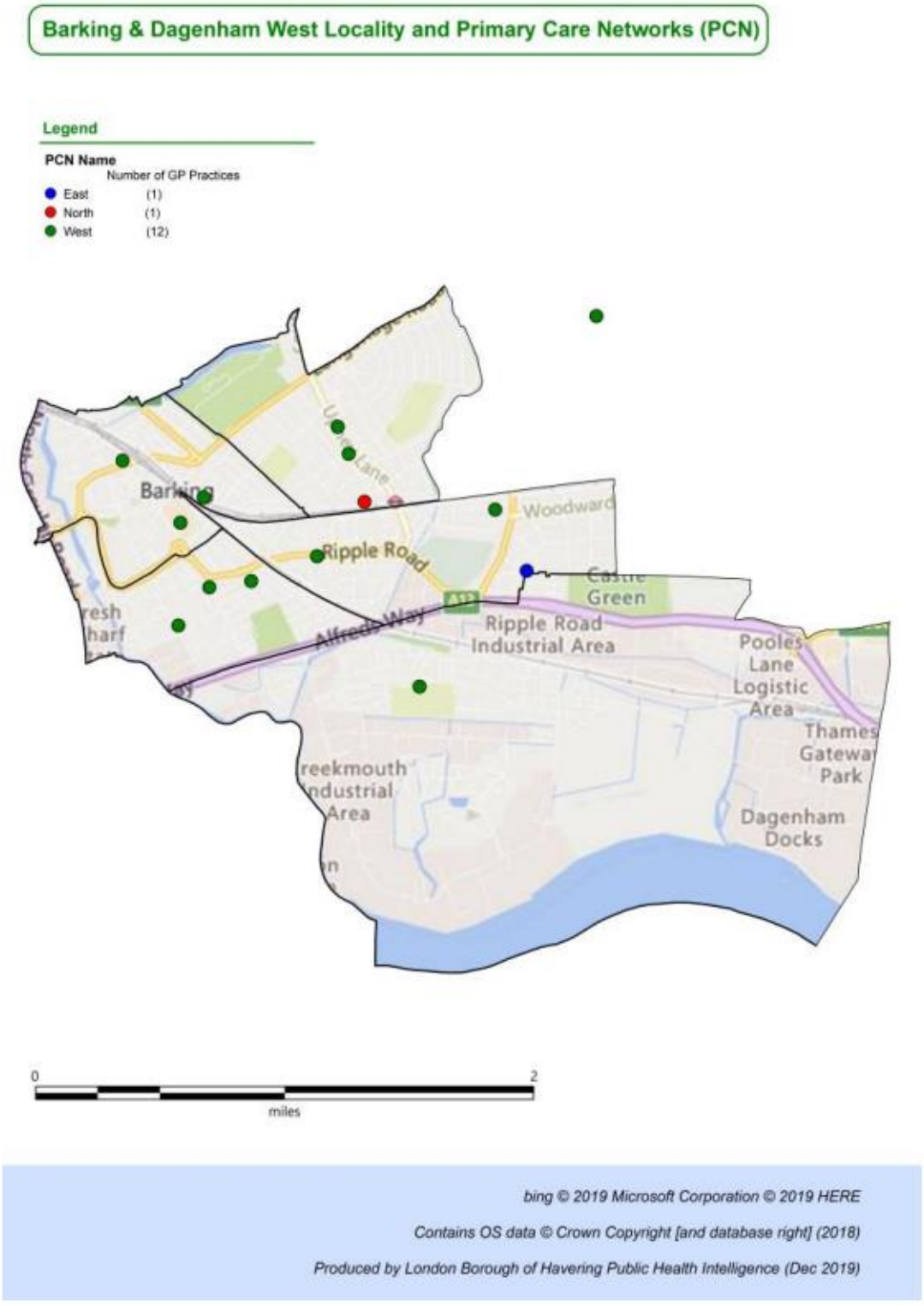
Appendix 11: Localities Data

London Borough of Barking and Dagenham (LBBD) – West Locality

1. Places and Communities

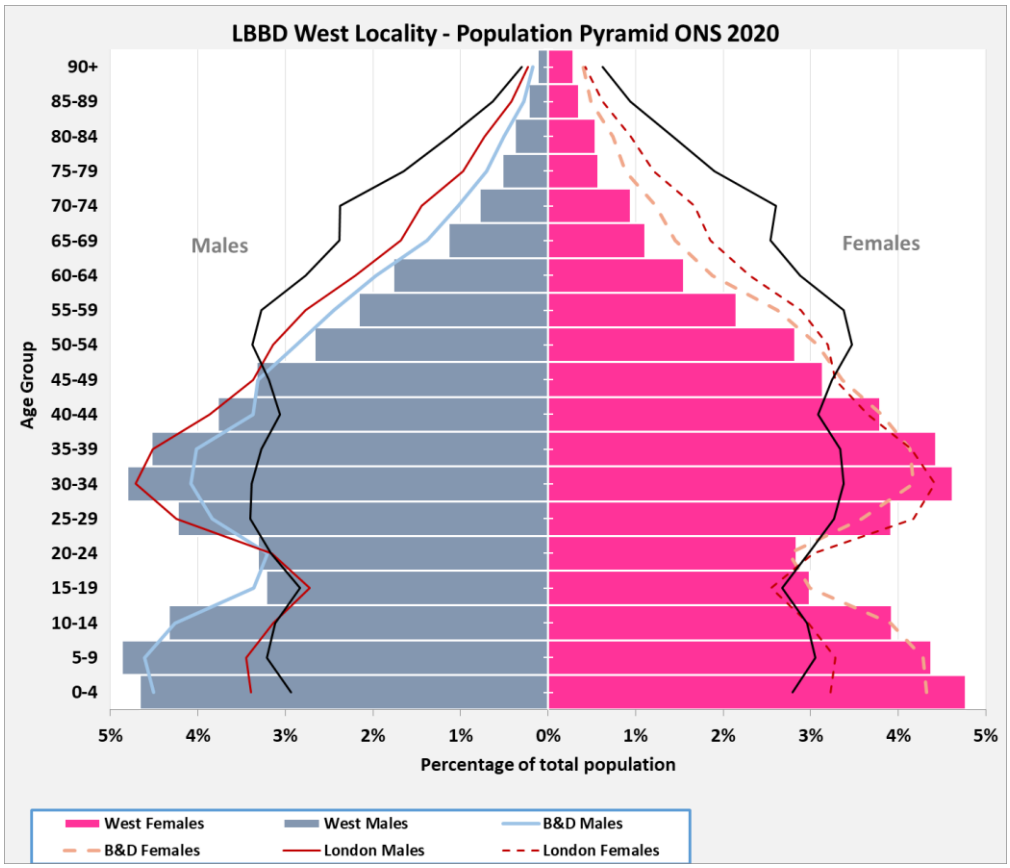
1.1 LBBD West locality map

Wards include Abbey, Eastbury, Gascoigne, Longbridge, Thames,



1.2 Estimated population of LBBD West locality residents by gender and five-year age groups - 2020

Age Band (Years)	Males	Females	Total
0-4	3,279	3,357	6,636
5-9	3,423	3,082	6,505
10-14	3,048	2,761	5,809
15-19	2,266	2,105	4,371
20-24	2,332	1,999	4,331
25-29	2,975	2,758	5,733
30-34	3,379	3,252	6,631
35-39	3,184	3,118	6,302
40-44	2,654	2,667	5,321
45-49	2,340	2,206	4,546
50-54	1,878	1,984	3,862
55-59	1,523	1,514	3,037
60-64	1,241	1,095	2,336
65-69	798	780	1,578
70-74	550	664	1,214
75-79	366	407	773
80-84	269	383	652
85-89	155	252	407
90+	82	204	286
Totals	35,742	34,588	70,330



Source: ONS 2020 Mid-Year Estimates

1.3 LBBD PCN Profile - GP population 5-year age groups

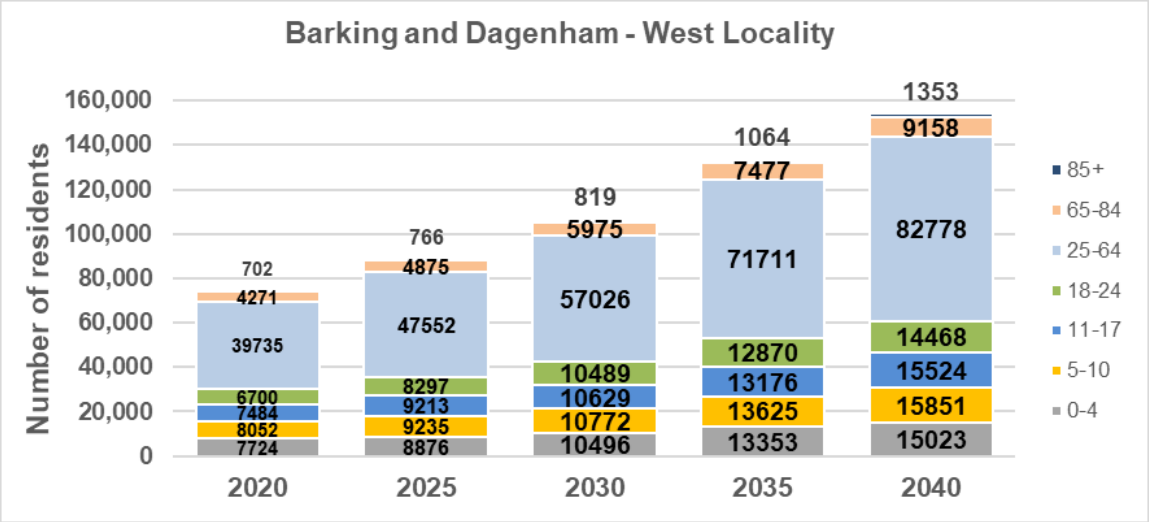
	East PCN			East One PCN			New West PCN			North PCN			North West PCN			West PCN		
Age Band	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**
0-4	1,804	1,952	3,756	1,697	1,756	3,453	1,245	1,257	2,502	1,721	1,739	3,460	1,103	1,091	2,194	1,442	1,412	2,854
5-9	2,137	2,262	4,399	1,961	2,018	3,979	1,398	1,369	2,767	1,992	2,012	4,004	1,398	1,413	2,811	1,531	1,646	3,177
10-14	1,990	2,120	4,110	2,028	2,178	4,206	1,341	1,508	2,849	1,933	2,015	3,948	1,379	1,519	2,898	1,528	1,515	3,043
15-19	1,502	1,604	3,106	1,682	1,873	3,555	1,211	1,194	2,405	1,665	1,795	3,460	1,209	1,360	2,569	1,323	1,448	2,771
20-24	1,425	1,277	2,702	1,587	1,627	3,214	1,069	1,081	2,150	1,487	1,598	3,085	1,013	1,057	2,070	1,401	1,452	2,853
25-29	1,661	1,543	3,204	1,858	1,895	3,753	1,361	1,216	2,577	1,825	1,855	3,680	1,145	1,114	2,259	1,693	1,713	3,406
30-34	2,335	2,035	4,370	2,208	1,961	4,169	1,566	1,553	3,119	2,170	2,060	4,230	1,294	1,186	2,480	1,901	2,082	3,983
35-39	2,355	2,449	4,804	2,088	2,065	4,153	1,612	1,676	3,288	2,182	2,134	4,316	1,512	1,343	2,855	1,833	2,124	3,957
40-44	2,074	2,263	4,337	2,040	1,977	4,017	1,401	1,558	2,959	1,893	2,012	3,905	1,363	1,347	2,710	1,611	1,875	3,486
45-49	1,618	1,880	3,498	1,789	1,841	3,630	1,099	1,369	2,468	1,692	1,898	3,590	1,158	1,217	2,375	1,324	1,704	3,028
50-54	1,356	1,562	2,918	1,616	1,716	3,332	1,025	1,150	2,175	1,551	1,746	3,297	1,062	1,164	2,226	1,192	1,434	2,626
55-59	1,037	1,154	2,191	1,390	1,518	2,908	726	871	1,597	1,433	1,542	2,975	973	918	1,891	1,103	1,197	2,300
60-64	700	776	1,476	1,045	1,149	2,194	512	630	1,142	1,094	1,196	2,290	689	715	1,404	837	976	1,813
65-69	512	474	986	792	757	1,549	347	389	736	923	845	1,768	514	457	971	660	636	1,296
70-74	382	289	671	615	566	1,181	256	237	493	668	617	1,285	365	357	722	516	412	928
75-79	289	195	484	516	383	899	190	139	329	535	419	954	291	240	531	365	271	636
80-84	201	120	321	328	234	562	108	79	187	377	275	652	221	130	351	306	205	511
85-89	125	82	207	244	143	387	69	43	112	256	149	405	144	95	239	170	125	295
90-94	82	33	115	128	62	190	30	17	47	129	77	206	81	33	114	88	39	127
95+	33	6	39	39	15	54	5	4	9	45	21	66	19	3	22	24	18	42
Total	**23,618**	**24,076**	**47,694**	**25,651**	**25,734**	**51,385**	**16,571**	**17,340**	**33,911**	**25,571**	**26,005**	**51,576**	**16,933**	**16,759**	**33,692**	**20,848**	**22,284**	**43,132**

Source: NHS Digital GP Registrations (April 2022)

1.4 LBBD West Locality Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
West	74,668	88,814	106,206	42.2%	133,276	78.5%	154,155	106.5%

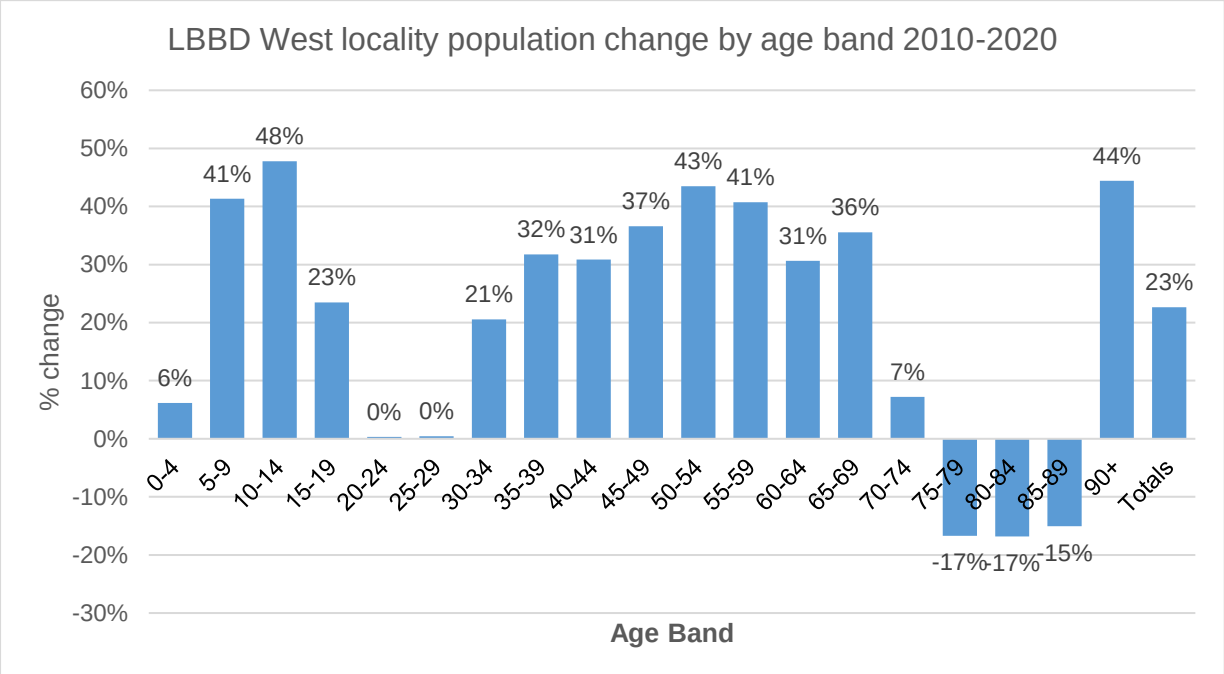
West	2020	2025	2030	2035	2040
0-4	7,724	8,876	10,496	13,353	15,023
5-10	8,052	9,235	10,772	13,625	15,851
11-17	7,484	9,213	10,629	13,176	15,524
18-24	6,700	8,297	10,489	12,870	14,468
25-64	39,735	47,552	57,026	71,711	82,778
65-84	4,271	4,875	5,975	7,477	9,158
85+	702	766	819	1,064	1,353
Total	74,668	88,814	106,206	133,276	154,155



Source: Greater London Authority (GLA) Population Projections. 2016-based ward level population projections

1.5 LBBD West Locality population change by age band 2010 – 2020

Age Band (Years)	2010	2020	Change	%
0-4	6,252	6,636	384	6%
5-9	4,602	6,505	1,903	41%
10-14	3,931	5,809	1,878	48%
15-19	3,540	4,371	831	23%
20-24	4,316	4,331	15	0%
25-29	5,707	5,733	26	0%
30-34	5,500	6,631	1,131	21%
35-39	4,783	6,302	1,519	32%
40-44	4,066	5,321	1,255	31%
45-49	3,328	4,546	1,218	37%
50-54	2,692	3,862	1,170	43%
55-59	2,158	3,037	879	41%
60-64	1788	2336	548	31%
65-69	1164	1578	414	36%
70-74	1132	1214	82	7%
75-79	928	773	-155	-17%
80-84	784	652	-132	-17%
85-89	479	407	-72	-15%
90+	198	286	88	44%
Totals	**57,348**	**70,330**	**12982**	**23%**



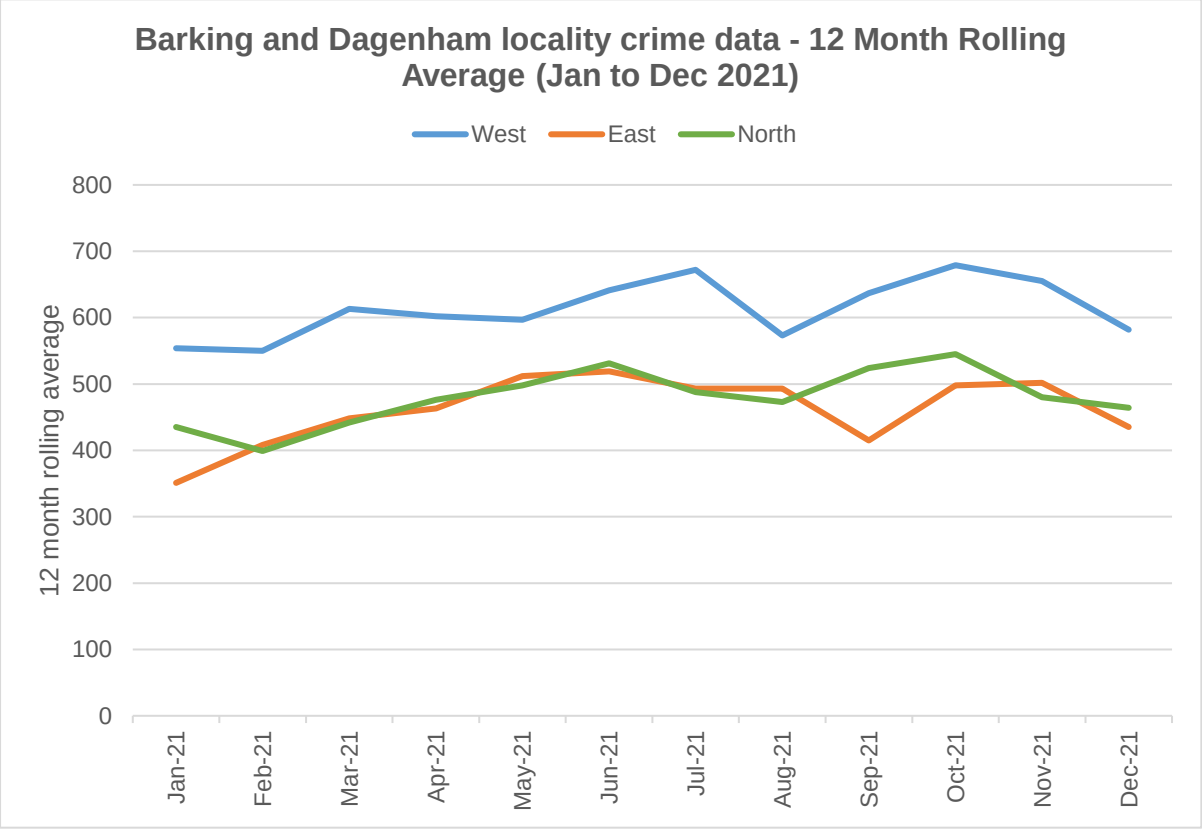
Source: ONS population estimates – Ward level population estimates

1.6 Ethnicity

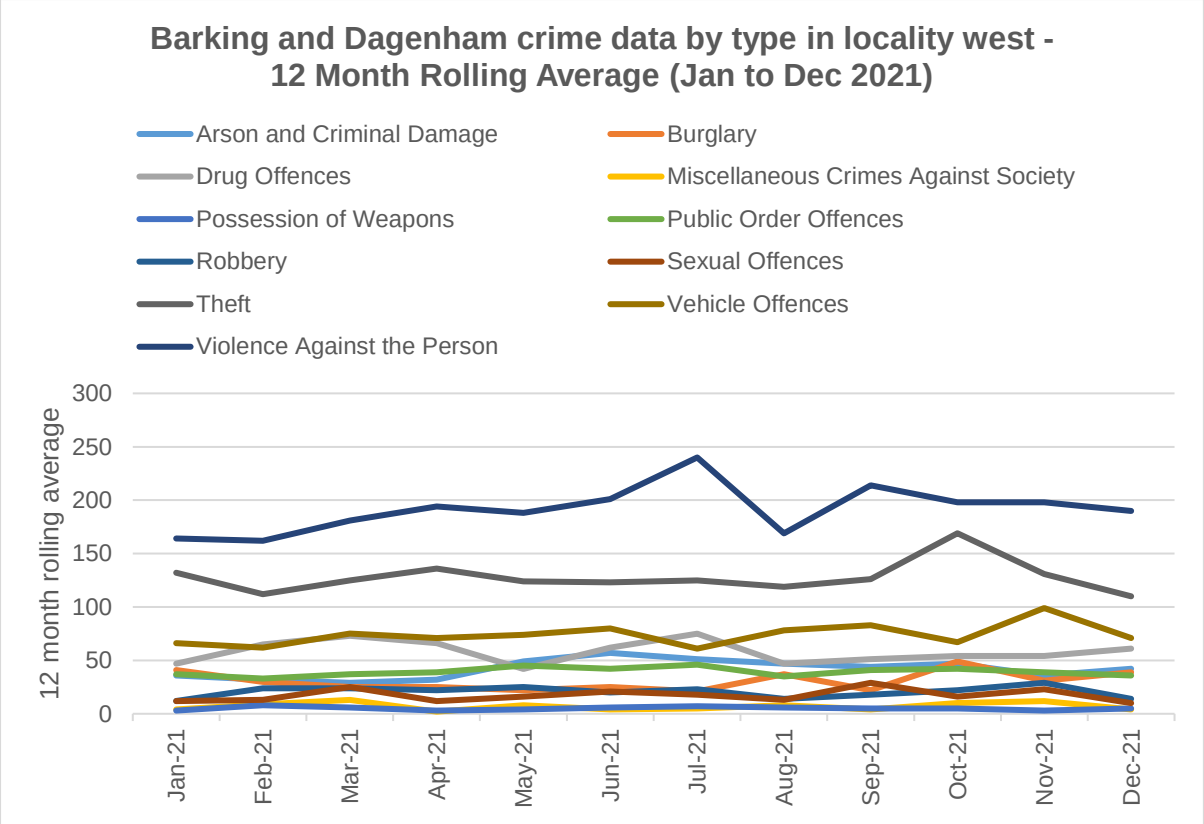
Ethnic Group	Number	%
British	18,900	32
African	10,702	18
Pakistani or British Pakistani	5,117	9
Bangladeshi or British Bangladeshi	4,507	8
Indian or British Indian	3,988	7
Caribbean	1,724	3
Baltic States	1,041	2
White and Black Caribbean	740	1
European Mixed	904	2
White and Black African	849	1
Other	10,596	18
Total	59,068	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in West Locality

The London Plan 2021 sets a ten-year housing target for Barking and Dagenham of 19,440 new homes between 2019/20 and 2028/29 or 1,944 per annum.

As of 1st September 2021, land was available for a total of 12,374[180] homes within Barking and Dagenham. There are plans for these to be delivered over a five-year period from 2021-21 to 2024-25.

Below is the approximate breakdown by Locality.

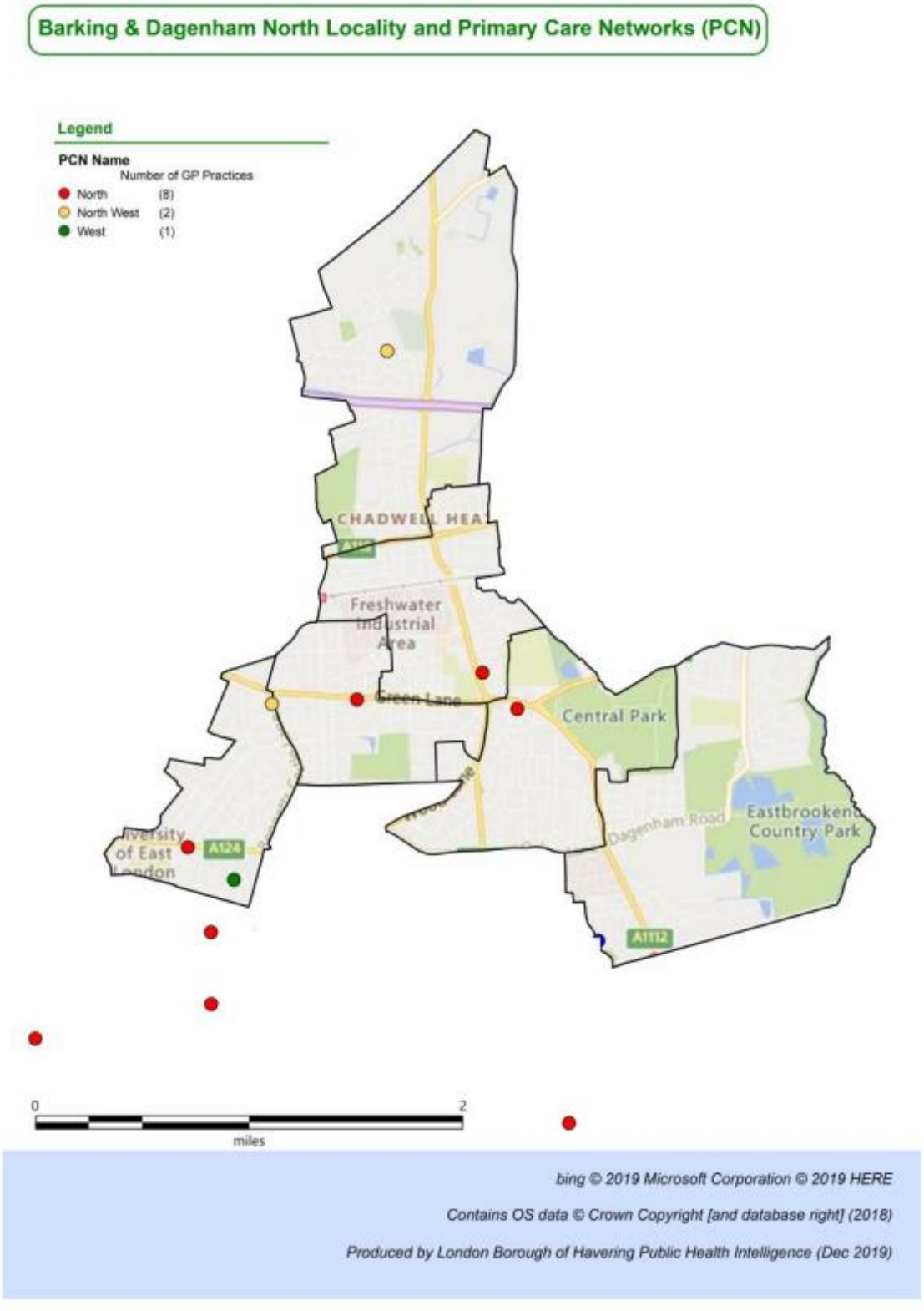
Locality	Number of houses
North	1,114
West	5,320
East	5,940
Total	**12,374**

[180] London Borough of Barking and Dagenham Interim Five-Year Housing Supply Statement: For the five-year period commencing 1st September 2021. Available from: https://www.lbbd.gov.uk/sites/default/files/attachments/Five%20year%20land%20supply%20statement%20October%202021.pdf

London Borough of Barking and Dagenham (LBBD) – North Locality

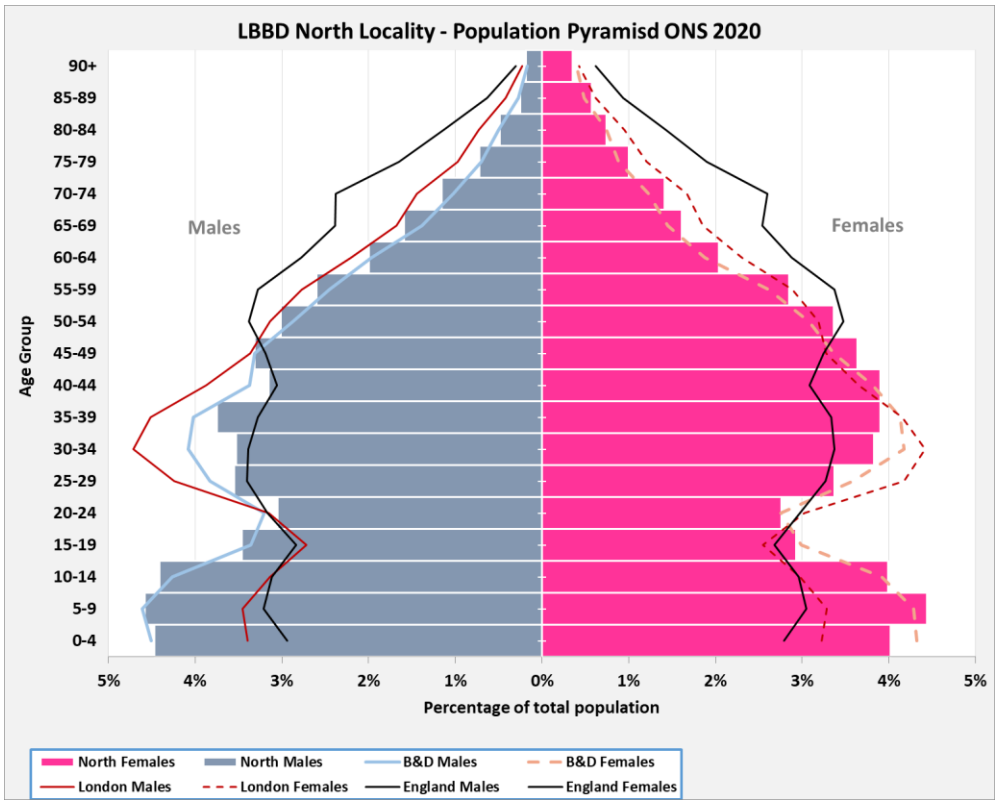
1. Places and Communities

1.1 Barking and Dagenham North locality map Wards include: Becontree, Chadwell Heath, Eastbrook, Heath, Valence, Whalebone



1.2 Estimated population of LBBD North locality residents by gender and five-year age groups

Age Band (Years)	Males	Females	Total
0-4	3,265	3,099	6,364
5-9	3,258	2,999	6,257
10-14	3,013	2,845	5,858
15-19	2,518	2,253	4,771
20-24	2,397	1,979	4,376
25-29	2,758	2,568	5,326
30-34	2,906	3,025	5,931
35-39	2,807	3,007	5,814
40-44	2,372	2,780	5,152
45-49	2,443	2,463	4,906
50-54	2,173	2,263	4,436
55-59	1,913	2,103	4,016
60-64	1,577	1,506	3,083
65-69	1055	1196	2,251
70-74	834	984	1,818
75-79	631	794	1425
80-84	472	690	1162
85-89	258	395	653
90+	155	402	557
Totals	36,805	37,351	74,156



Source: ONS 2020 Mid-Year Estimates

1.3 LBBD PCN Profile - GP population 5-year age groups

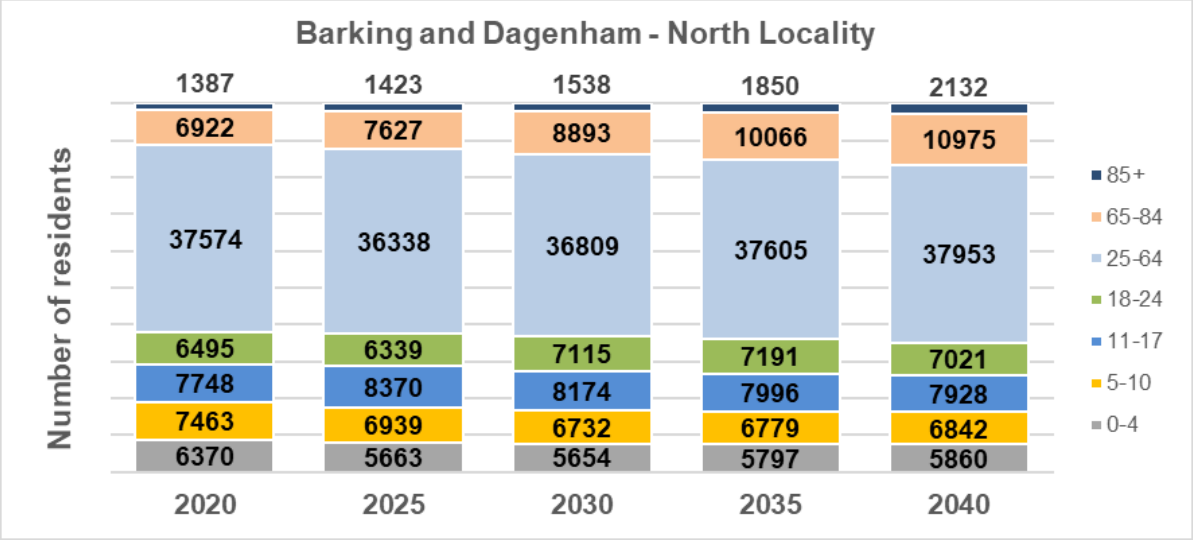
	East PCN			East One PCN			New West PCN			North PCN			North West PCN			West PCN		
Age Band	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**
0-4	1,804	1,952	3,756	1,697	1,756	3,453	1,245	1,257	2,502	1,721	1,739	3,460	1,103	1,091	2,194	1,442	1,412	2,854
5-9	2,137	2,262	4,399	1,961	2,018	3,979	1,398	1,369	2,767	1,992	2,012	4,004	1,398	1,413	2,811	1,531	1,646	3,177
10-14	1,990	2,120	4,110	2,028	2,178	4,206	1,341	1,508	2,849	1,933	2,015	3,948	1,379	1,519	2,898	1,528	1,515	3,043
15-19	1,502	1,604	3,106	1,682	1,873	3,555	1,211	1,194	2,405	1,665	1,795	3,460	1,209	1,360	2,569	1,323	1,448	2,771
20-24	1,425	1,277	2,702	1,587	1,627	3,214	1,069	1,081	2,150	1,487	1,598	3,085	1,013	1,057	2,070	1,401	1,452	2,853
25-29	1,661	1,543	3,204	1,858	1,895	3,753	1,361	1,216	2,577	1,825	1,855	3,680	1,145	1,114	2,259	1,693	1,713	3,406
30-34	2,335	2,035	4,370	2,208	1,961	4,169	1,566	1,553	3,119	2,170	2,060	4,230	1,294	1,186	2,480	1,901	2,082	3,983
35-39	2,355	2,449	4,804	2,088	2,065	4,153	1,612	1,676	3,288	2,182	2,134	4,316	1,512	1,343	2,855	1,833	2,124	3,957
40-44	2,074	2,263	4,337	2,040	1,977	4,017	1,401	1,558	2,959	1,893	2,012	3,905	1,363	1,347	2,710	1,611	1,875	3,486
45-49	1,618	1,880	3,498	1,789	1,841	3,630	1,099	1,369	2,468	1,692	1,898	3,590	1,158	1,217	2,375	1,324	1,704	3,028
50-54	1,356	1,562	2,918	1,616	1,716	3,332	1,025	1,150	2,175	1,551	1,746	3,297	1,062	1,164	2,226	1,192	1,434	2,626
55-59	1,037	1,154	2,191	1,390	1,518	2,908	726	871	1,597	1,433	1,542	2,975	973	918	1,891	1,103	1,197	2,300
60-64	700	776	1,476	1,045	1,149	2,194	512	630	1,142	1,094	1,196	2,290	689	715	1,404	837	976	1,813
65-69	512	474	986	792	757	1,549	347	389	736	923	845	1,768	514	457	971	660	636	1,296
70-74	382	289	671	615	566	1,181	256	237	493	668	617	1,285	365	357	722	516	412	928
75-79	289	195	484	516	383	899	190	139	329	535	419	954	291	240	531	365	271	636
80-84	201	120	321	328	234	562	108	79	187	377	275	652	221	130	351	306	205	511
85-89	125	82	207	244	143	387	69	43	112	256	149	405	144	95	239	170	125	295
90-94	82	33	115	128	62	190	30	17	47	129	77	206	81	33	114	88	39	127
95+	33	6	39	39	15	54	5	4	9	45	21	66	19	3	22	24	18	42
Total	**23,618**	**24,076**	**47,694**	**25,651**	**25,734**	**51,385**	**16,571**	**17,340**	**33,911**	**25,571**	**26,005**	**51,576**	**16,933**	**16,759**	**33,692**	**20,848**	**22,284**	**43,132**

Source: NHS Digital GP Registrations (April 2022)

1.4 LBBD North Locality Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
North	73,959	72,698	74,914	1.3%	77,284	4.5%	78,710	6.4%

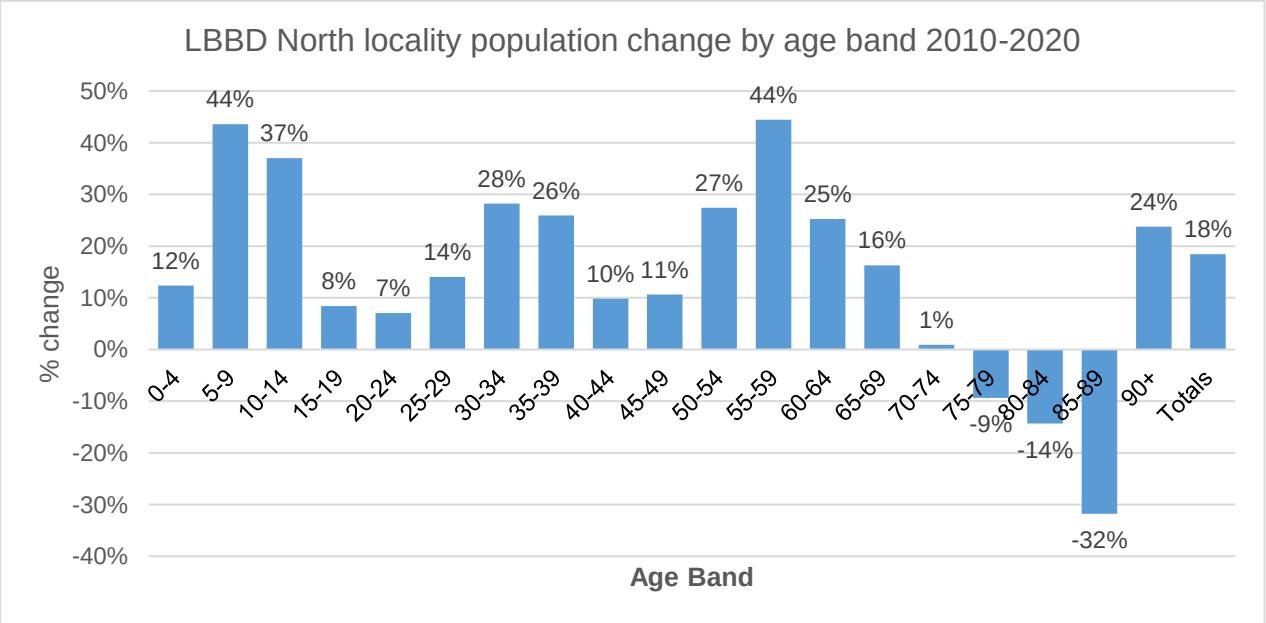
North	2020	2025	2030	2035	2040
0-4	6,370	5,663	5,654	5,797	5,860
5-10	7,463	6,939	6,732	6,779	6,842
11-17	7,748	8,370	8,174	7,996	7,928
18-24	6,495	6,339	7,115	7,191	7,021
25-64	37,574	36,338	36,809	37,605	37,953
65-84	6,922	7,627	8,893	10,066	10,975
85+	1,387	1,423	1,538	1,850	2,132
Total	73,959	72,698	74,914	77,284	78,710



Source: Greater London Authority (GLA) Population Projections. 2016-based ward level population projections.

1.5 LBBD North Locality population change by age band 2010 - 2020

Age Band (Years)	2010	2020	Change	%
0-4	5,664	6,364	700	12%
5-9	4,359	6,257	1,898	44%
10-14	4,276	5,858	1,582	37%
15-19	4,401	4,771	370	8%
20-24	4,087	4,376	289	7%
25-29	4,671	5,326	655	14%
30-34	4,625	5,931	1,306	28%
35-39	4,618	5,814	1,196	26%
40-44	4,691	5,152	461	10%
45-49	4,434	4,906	472	11%
50-54	3,482	4,436	954	27%
55-59	2,780	4,016	1,236	44%
60-64	2462	3083	621	25%
65-69	1936	2251	315	16%
70-74	1802	1818	16	1%
75-79	1572	1425	-147	-9%
80-84	1356	1162	-194	-14%
85-89	957	653	-304	-32%
90+	450	557	107	24%
Totals	62,623	74,156	11533	18%



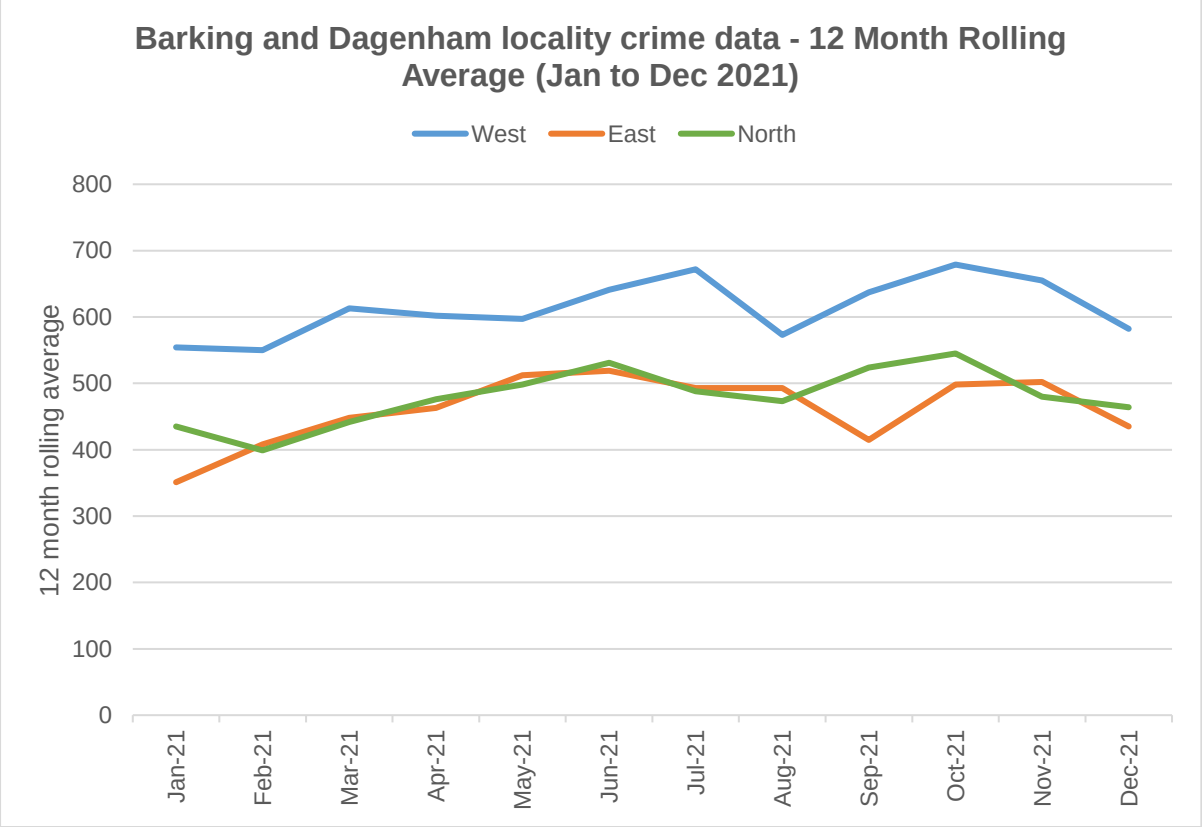
Source: ONS population estimates – Ward level population estimates

1.6 Ethnicity

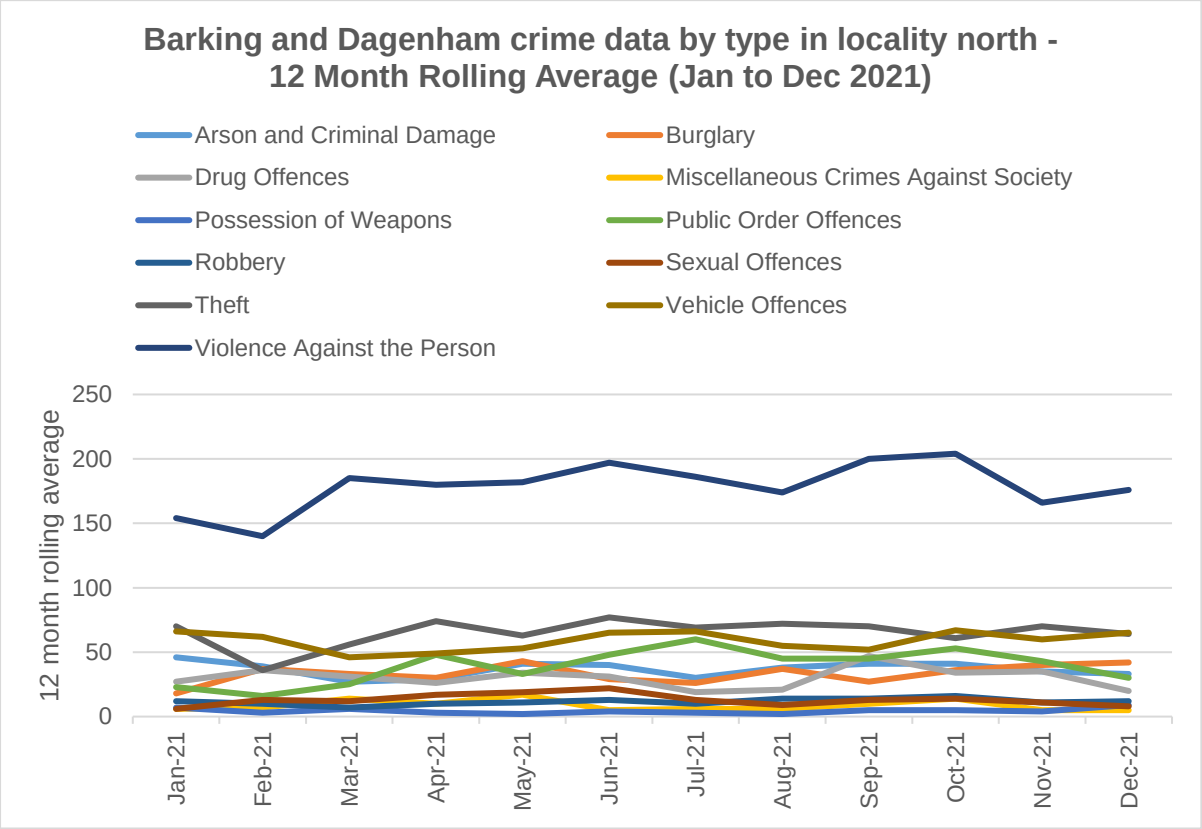
Ethnic Group	Number	%
British	36,390	57
African	7,776	12
Pakistani or British Pakistani	2,052	3
Bangladeshi or British Bangladeshi	1,824	3
Indian or British Indian	2,427	4
Caribbean	2,110	3
Baltic States	908	1
White and Black Caribbean	930	1
European Mixed	673	1
White and Black African	607	1
Other	7,603	12
Total	63,300	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in North Locality

The London Plan 2021 sets a ten-year housing target for Barking and Dagenham of 19,440 new homes between 2019/20 and 2028/29 or 1,944 per annum.

As of 1st September 2021, land was available for a total of 12,374[181] homes within Barking and Dagenham. There are plans for these to be delivered over a five-year period from 2021-21 to 2024-25.

Below is the approximate breakdown by Locality.

Locality	Number of houses
North	1,114
West	5,320
East	5,940
Total	**12,374**

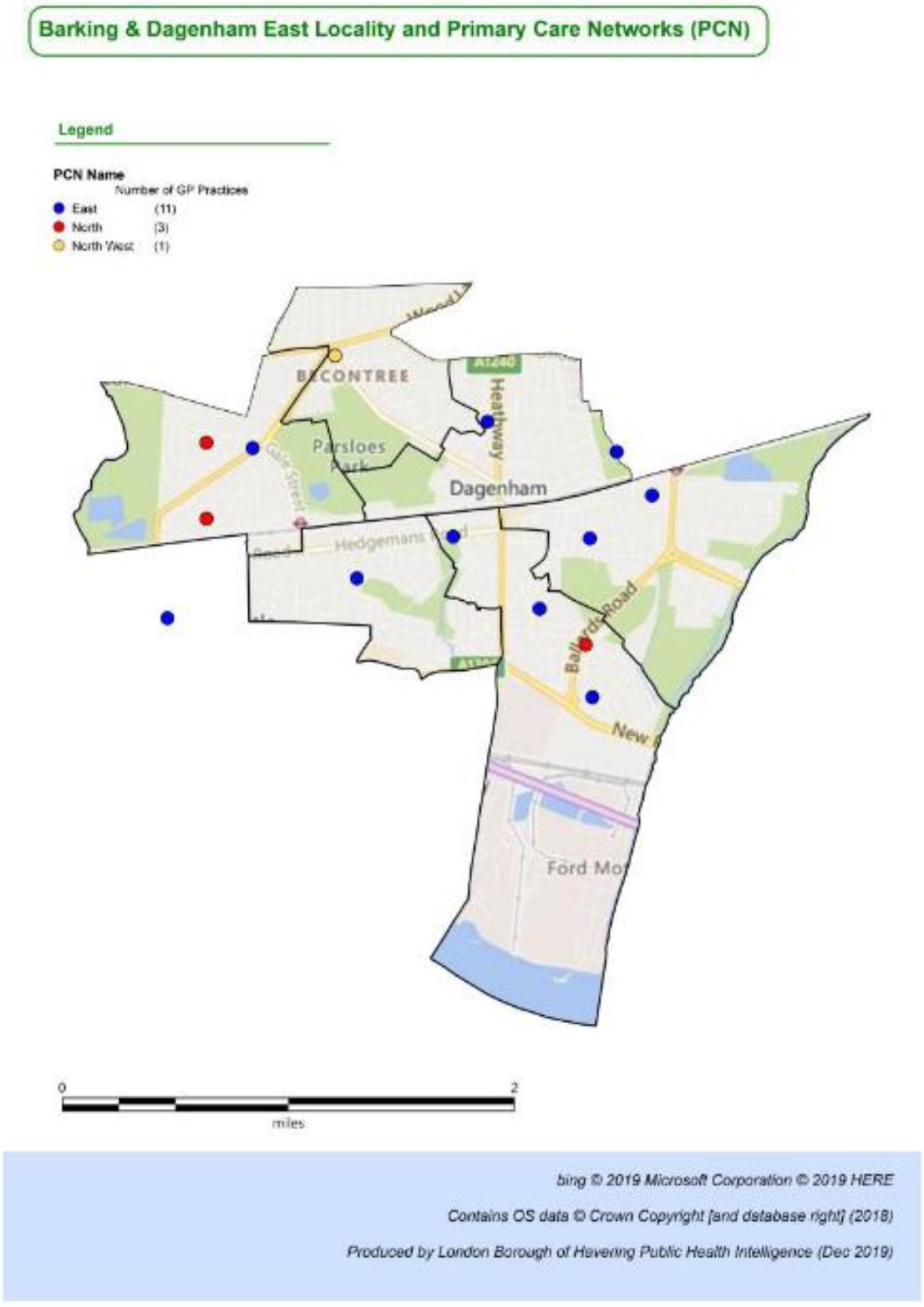
[181] London Borough of Barking and Dagenham Interim Five-Year Housing Supply Statement: For the five-year period commencing 1st September 2021. Available from: https://www.lbbd.gov.uk/sites/default/files/attachments/Five%20year%20land%20supply%20statement%20October%202021.pdf

London Borough of Barking and Dagenham (LBBD) – East Locality

1. Places and Communities

1.1 Barking and Dagenham east locality map

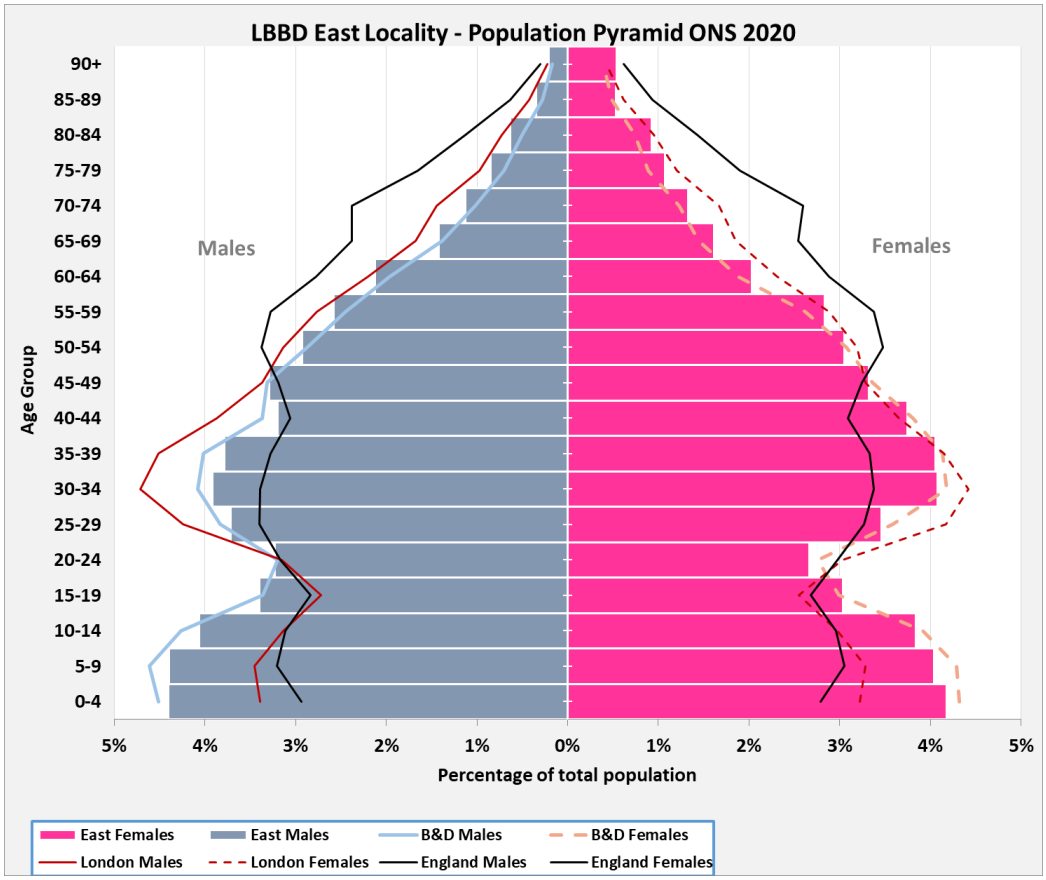
Wards include Albion, Goresbrook, Mayesbrook, Parsoles, River, Village.



1.2 Estimated population of LBBD east locality residents by gender and five-year age groups – 2020

Age Band (Years)	Males	Females	Total
0-4	3,111	2,799	5,910
5-9	3,188	3,092	6,280
10-14	3,070	2,779	5,849
15-19	2,409	2,038	4,447
20-24	2,123	1,924	4,047
25-29	2,472	2,349	4,821
30-34	2,455	2,666	5,121
35-39	2,611	2,718	5,329
40-44	2,192	2,715	4,907
45-49	2,307	2,534	4,841
50-54	2,095	2,342	4,437
55-59	1,808	1,984	3,792
60-64	1,388	1,421	2,809
65-69	1108	1125	2,233
70-74	807	984	1,791
75-79	505	696	1201
80-84	336	520	856
85-89	176	399	575
90+	129	246	375
Totals	34,290	35,331	69,621

Source: ONS Mid 2020 Population Estimates.



Source: ONS 2020 Mid-Year Estimates

1.3 LBBD PCN Profile - GP population 5-year age groups

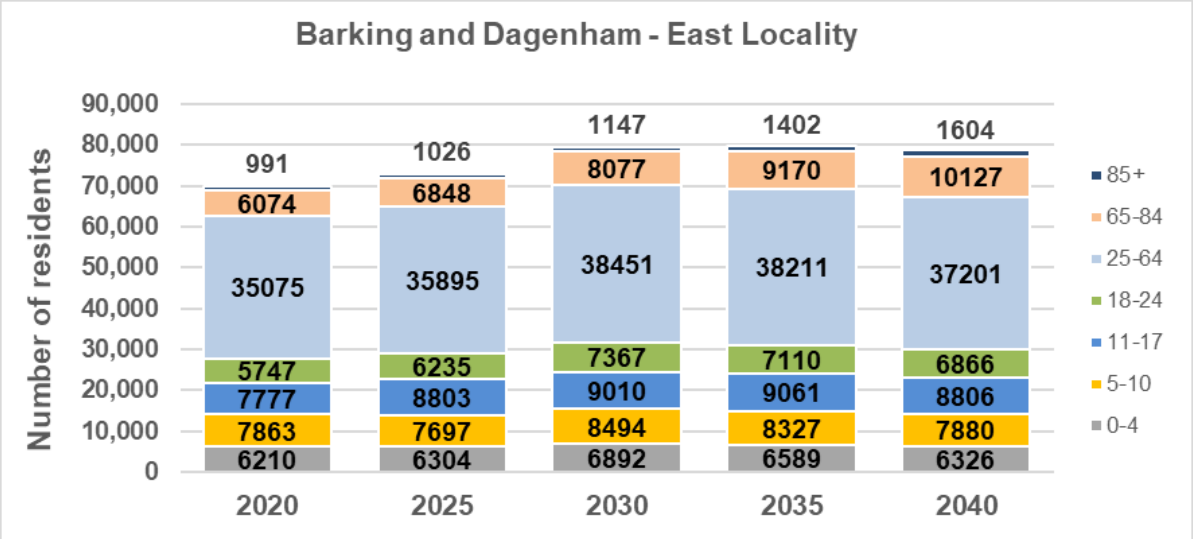
	East PCN			East One PCN			New West PCN			North PCN			North West PCN			West PCN		
Age Band	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**	**F**	**M**	**P**
0-4	1,804	1,952	3,756	1,697	1,756	3,453	1,245	1,257	2,502	1,721	1,739	3,460	1,103	1,091	2,194	1,442	1,412	2,854
5-9	2,137	2,262	4,399	1,961	2,018	3,979	1,398	1,369	2,767	1,992	2,012	4,004	1,398	1,413	2,811	1,531	1,646	3,177
10-14	1,990	2,120	4,110	2,028	2,178	4,206	1,341	1,508	2,849	1,933	2,015	3,948	1,379	1,519	2,898	1,528	1,515	3,043
15-19	1,502	1,604	3,106	1,682	1,873	3,555	1,211	1,194	2,405	1,665	1,795	3,460	1,209	1,360	2,569	1,323	1,448	2,771
20-24	1,425	1,277	2,702	1,587	1,627	3,214	1,069	1,081	2,150	1,487	1,598	3,085	1,013	1,057	2,070	1,401	1,452	2,853
25-29	1,661	1,543	3,204	1,858	1,895	3,753	1,361	1,216	2,577	1,825	1,855	3,680	1,145	1,114	2,259	1,693	1,713	3,406
30-34	2,335	2,035	4,370	2,208	1,961	4,169	1,566	1,553	3,119	2,170	2,060	4,230	1,294	1,186	2,480	1,901	2,082	3,983
35-39	2,355	2,449	4,804	2,088	2,065	4,153	1,612	1,676	3,288	2,182	2,134	4,316	1,512	1,343	2,855	1,833	2,124	3,957
40-44	2,074	2,263	4,337	2,040	1,977	4,017	1,401	1,558	2,959	1,893	2,012	3,905	1,363	1,347	2,710	1,611	1,875	3,486
45-49	1,618	1,880	3,498	1,789	1,841	3,630	1,099	1,369	2,468	1,692	1,898	3,590	1,158	1,217	2,375	1,324	1,704	3,028
50-54	1,356	1,562	2,918	1,616	1,716	3,332	1,025	1,150	2,175	1,551	1,746	3,297	1,062	1,164	2,226	1,192	1,434	2,626
55-59	1,037	1,154	2,191	1,390	1,518	2,908	726	871	1,597	1,433	1,542	2,975	973	918	1,891	1,103	1,197	2,300
60-64	700	776	1,476	1,045	1,149	2,194	512	630	1,142	1,094	1,196	2,290	689	715	1,404	837	976	1,813
65-69	512	474	986	792	757	1,549	347	389	736	923	845	1,768	514	457	971	660	636	1,296
70-74	382	289	671	615	566	1,181	256	237	493	668	617	1,285	365	357	722	516	412	928
75-79	289	195	484	516	383	899	190	139	329	535	419	954	291	240	531	365	271	636
80-84	201	120	321	328	234	562	108	79	187	377	275	652	221	130	351	306	205	511
85-89	125	82	207	244	143	387	69	43	112	256	149	405	144	95	239	170	125	295
90-94	82	33	115	128	62	190	30	17	47	129	77	206	81	33	114	88	39	127
95+	33	6	39	39	15	54	5	4	9	45	21	66	19	3	22	24	18	42
Total	**23,618**	**24,076**	**47,694**	**25,651**	**25,734**	**51,385**	**16,571**	**17,340**	**33,911**	**25,571**	**26,005**	**51,576**	**16,933**	**16,759**	**33,692**	**20,848**	**22,284**	**43,132**

Source: NHS Digital GP Registrations (April 2022)

1.4 LBBD East Location Population Projections 2020, 2025, 2030, 2035, 2040

Area	2020	2025	2030	% change	2035	% change	2040	% change
East	69,737	72,807	79,438	13.9%	79,868	14.5%	78,809	13.0%

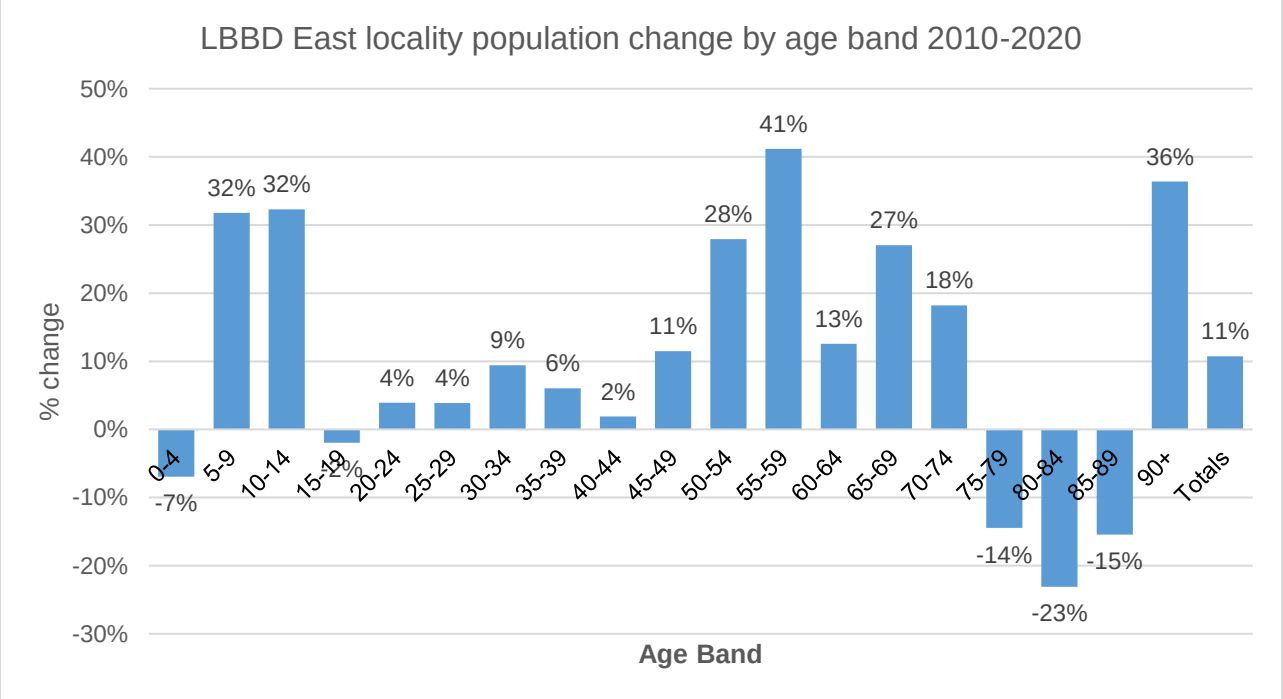
East	2020	2025	2030	2035	2040
0-4	6,210	6,304	6,892	6,589	6,326
5-10	7,863	7,697	8,494	8,327	7,880
11-17	7,777	8,803	9,010	9,061	8,806
18-24	5,747	6,235	7,367	7,110	6,866
25-64	35,075	35,895	38,451	38,211	37,201
65-84	6,074	6,848	8,077	9,170	10,127
85+	991	1,026	1,147	1,402	1,604
Total	69,737	72,807	79,438	79,868	78,809



Source: Greater London Authority (GLA) Population Projections. 2016-based ward level population projections.

1.5 LBBD East Locality population change by age band 2010 - 2020

Age Band (Years)	2010	2020	Change	%
0-4	6,349	5,910	-439	-7%
5-9	4,766	6,280	1,514	32%
10-14	4,421	5,849	1,428	32%
15-19	4,535	4,447	-88	-2%
20-24	3,895	4,047	152	4%
25-29	4,642	4,821	179	4%
30-34	4,680	5,121	441	9%
35-39	5,025	5,329	304	6%
40-44	4,816	4,907	91	2%
45-49	4,343	4,841	498	11%
50-54	3,468	4,437	969	28%
55-59	2,686	3,792	1,106	41%
60-64	2496	2809	313	13%
65-69	1758	2233	475	27%
70-74	1515	1791	276	18%
75-79	1404	1201	-203	-14%
80-84	1113	856	-257	-23%
85-89	680	575	-105	-15%
90+	275	375	100	36%
Totals	62,867	69,621	6754	11%



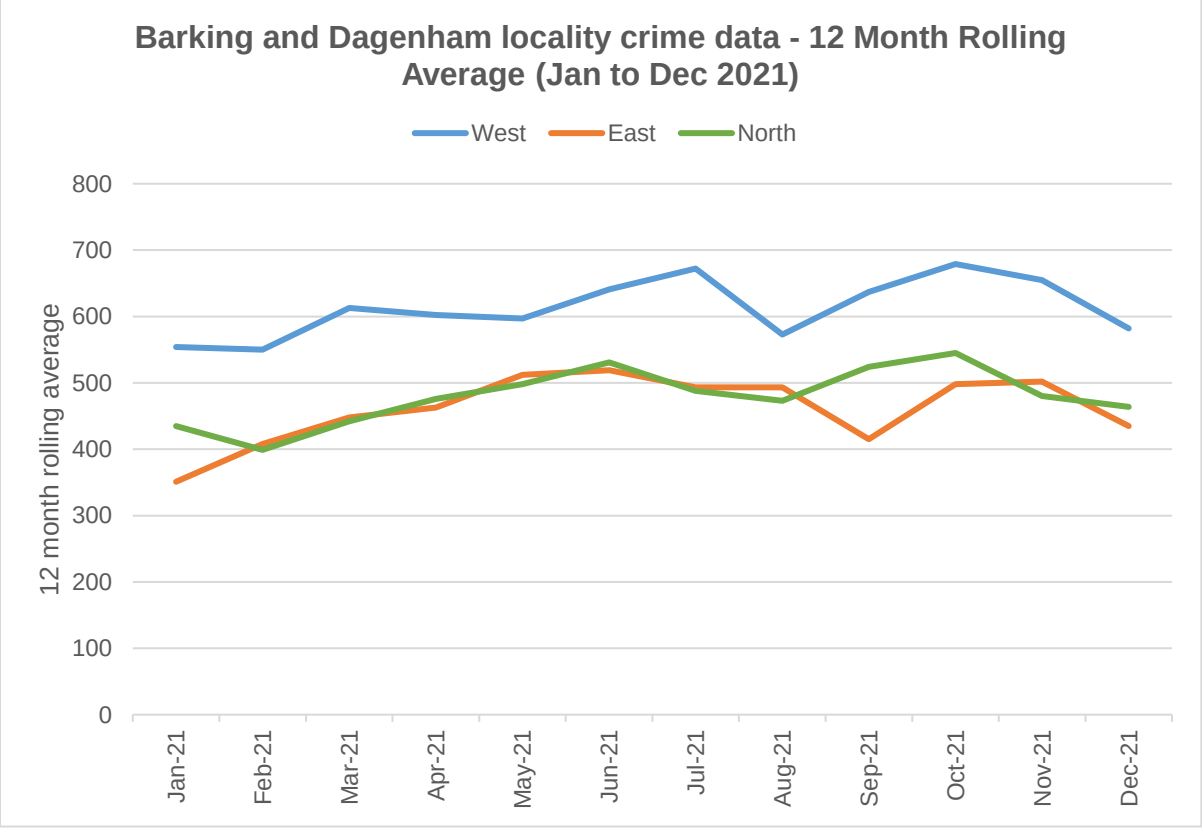
Source: ONS population estimates – Ward level population estimates

1.6 Ethnicity

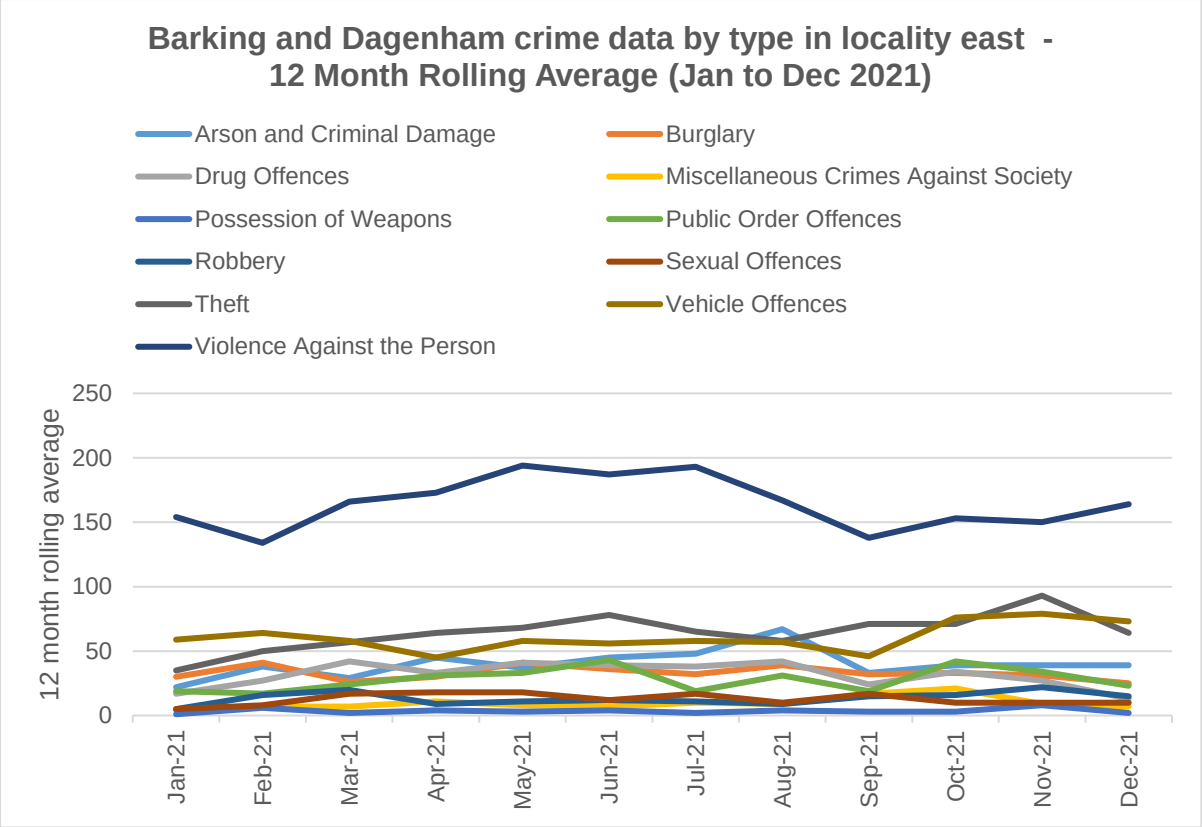
Ethnic Group	Number	%
British	37,738	60
African	9,985	16
Pakistani or British Pakistani	858	1
Bangladeshi or British Bangladeshi	1,346	2
Indian or British Indian	890	1
Caribbean	1,336	2
Baltic States	1,319	2
White and Black Caribbean	968	2
European Mixed	833	1
White and Black African	659	1
Other	7,073	11
Total	63,005	100

Source: Census 2011

1.7 Crime data – 12 month rolling average



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).



Source: Recorded Crime: Geographic Breakdown - London Datastore
MPS Ward Level Crime (most recent 24 months).

1.8 Projected new homes in East Locality

The London Plan 2021 sets a ten-year housing target for Barking and Dagenham of 19,440 new homes between 2019/20 and 2028/29 or 1,944 per annum.

As of 1st September 2021, land was available for a total of 12,374[182] homes within Barking and Dagenham. There are plans for these to be delivered over a five-year period from 2021-21 to 2024-25.

Below is the approximate breakdown by Locality.

Locality	Number of houses
North	1,114
West	5,320
East	5,940
Total	**12,374**

[182] London Borough of Barking and Dagenham Interim Five-Year Housing Supply Statement: For the five-year period commencing 1st September 2021. Available from: https://www.lbbd.gov.uk/sites/default/files/attachments/Five%20year%20land%20supply%20statement%20October%202021.pdf

Appendix 12: Contacts

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